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INDIAN HEALTH SERVICE RECRUITMENT PROBLEMS

HEARINGS

BEFORE THE

SUBCOMMITTEE ON INDIAN AFFAIRS

OF THE

COMMITTEE ON INTERIOR AND INSULAR AFFAIRS

UNITED STATES SENATE

NINETY-THIRD CONGRESS

FIRST SESSION

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

NOVEMBER 19 AND 20, 1973

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INDIAN HEALTH SERVICE RECRUITMENT PROBLEMS

MONDAY, NOVEMBER 19, 1973

U.S. SENATE,
SUBCOMMITTEE ON INDIAN AFFAIRS,
OF THE COMMITTEE ON INTERIOR AND INSULAR AFFAIRS,
Washington, D.C.

The committee met at 10 a.m., pursuant to notice, in room 3110, Dirksen Office Building, Hon. James Abourezk, chairman, presiding.

Present: Senator Abourezk.

Also present: Jerry T. Verkler, staff director; Forrest Gerard, professional staff member; and Ella Mae Horse, staff assistant.

Senator ABOUREZK. The hearing will come to order.

OPENING STATEMENT OF HON. JAMES ABOUREZK, A U.S. SENATOR FROM THE STATE OF SOUTH DAKOTA

This is an open public hearing to take testimony today and tomorrow from private and public witnesses on a crisis situation which has arisen in the area of Indian health.

This crisis is related to the 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.

Prior to June 30, 1973, the Indian Health Service utilized the Doctor Draft Act as the main source for their supply of needed physicians and dentists.

Under the provisions of this act, doctors and dentists were authorized to serve 2 years in the Public Health Service in lieu of their military commitment to the U.S. Government.

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 authority on June 30 has had the practical effect of eliminating this stable source of physicians for assignment to the Indian Health Service.

And even at this early date, since the expiration of this authority, the Indian Health Service has encountered difficulties in meeting physician staffing requirement for its various health facilities.

In this connection the Indian Health Service normally maintains a complement of 520 physicians and anticipates that it will be necessary to replace 170–200 physicians leaving the service upon completion of their 2-year in lieu military requirement.

By the fall of 1972, about 100 physicians had applied to the Indian Health Service for assignments to begin on July 1, 1973.

This contrasts with comparable recruitment periods in 1971, 1970, and 1969 when 300, 500, and 700 physicians applications respectively were received by the service to fill the 170 to 200 physician vacancies.

For the past several months Indian people in ever-increasing numbers have called to my attention physician and other health personnel shortages in the health facilities operated by the Indian Health Service in the three-State area of North Dakota, South Dakota, and Nebraska.

Within that area 44 physician positions have been authorized for the current fiscal year, and 37 have been filled.

However, on June 30, 1974, 17 of the physicians currently on duty will complete their 2-year-in-lieu military requirement and leave the service.

Unfortunately, the prospects are bleak, given the current dilemma, that the Indian Health Service will be able to meet the physician staffing level by July 1, 1974, in the three-State area.

What this deplorable state of affairs adds up to is that the Indian people stand in serious jeopardy of having their glaring health deficiencies met, unless alternative solutions can be quickly devised.

I am hopeful that this 2-day hearing will enable the committee to develop a thorough hearing record on this serious health recruitment problem and that intermediate and long-range alternatives will be forthcoming to alleviate the problem.

Several of the health professionals invited to present testimony today are Indians themselves and understand the Indians' concerns and views on the question before the committee.

In addition, former Indian Health Service officers along with staff currently on duty will testify. And rightfully, the administration has demonstrated its deep concern of the problem by agreeing to send its top health official from the Department of Health, Eduction, and Welfare to testify at these hearings.

The first witness will be Dr. Everett R. Rhoades, National Committee on Indian Health of the Association on American Indian Affairs.

Dr. Rhoades, I would like to welcome you to the committee and tell you that we are happy to have you here and we are pleased to have your testimony.

STATEMENT OF DR. EVERETT R. RHOADES, VICE CHAIRMAN, NATIONAL COMMITTEE ON INDIAN HEALTH OF THE ASSOCIATION ON AMERICAN INDIAN AFFAIRS

Dr. Rhoades. Thank you, Senator Abourezk. It is a pleasure to be able to appear before this subcommittee and offer some experience related to the problem you have outlined in the statement.

I have a prepared statement I would like to read, and I understand it has been distributed.

My name is Everett Rhoades. I am a member of the Kiowa Tribe, currently serving as the vice chairman of that tribe. I am a professor of internal medicine and microbiology at the University of Oklahoma College of Medicine.

I was president of the Association of American Indian Physicians in 1972 and am active in that organization. I am vice chairman of the Indian Health Committee of the Association on American Indian Affairs.

I have served on tribal health committees and area advisory boards and was involved in setting up the area Indian Health Advisory Board in Oklahoma.

Also, I serve as a volunteer physician in a free urban Indian clinic in urban areas.

First, I would like to express my sincere appreciation at being permitted to offer testimony before this group on behalf of the Association on American Indian Affairs and its National Committee on Indian Health.

My tribe and the organizations I am active in appreciate the interest and support of this subcommittee for Indian programs.

I cannot help commenting upon certain aspects of Indian-United States relationships which have helped contribute to the present problem.

In some ways these are rather amusing. For example, in the past the result of governmental action in many instances was to put Indians on reservations where no one in their right mind would choose to live.

Now the Government is concerned about why white people don't want to live in those areas where the Indians were forced to live.

Another interesting aspect is that the Government has been spending hundreds of thousands of dollars trying to help Indians get off reservations and at the time trying to find ways to get non-Indians to live there.

Although I tend to speak specifically of physicians, I, in effect, use the word "physician" as a kind of shorthand for all health professionals.

The problem of manpower shortage in the Indian Health Service cannot be separated from a number of larger Indian community problems and the professional shortages being discussed merely reflect the traditional lack of support for Indians and Indian programs.

Those of us working in Indian affairs have long been accustomed to lack of services, lack of personnel, lack of facilities and lack of supplies, all resulting from inadequate funding of the Indian Health Service.

That these hearings here today may reflect some degree of emergency must not obscure the fact that we find ourselves in a situation different only in degree from that which we have lived with for many years.

In considering this shortage one must take into account the Bureau of Indian Affairs and its many programs, the social and political organization of Indian communities, the diversity of Indian groups, and many other relationships between Indians, Indian tribes, and non-Indian governmental agencies.

In addition one must consider existing Indians serving in the health professions and their relationship to health care systems. For analysis it is necessary to consider some of these areas separately.

First it is necessary to reiterate certain assumptions. The first of these is that the Indian Health Service is the only delivery system for the great majority of Indians.

The second assumption is that there are at present inadequate numbers of professional health workers within the Indian Health Service.

Third, there are multiple barriers to the entrance of professional workers into the Indian Health Service.

Fourth, any program to be successful must be directed to overcoming as many of these barriers as possible.

Fifth, one must assume that there is someone who genuinely cares whether or not these barriers are broken down or at least overcome, and gentlemen, there is by no means any general consensus in the Indian community that anyone does indeed care.

This attitude itself, correct or incorrect, constitutes an additional barrier to the ingress of health professionals into Indian health programs.

Physicians constitute a portion of the general population that can only be described as deviant from the normal population.

Physicians have needs shared by other people and they have certain needs that seem more important within themselves as a group. Some of these needs needs include:

One, financial security. Although there is a general impression that younger physicians are considerably less motivated toward financial security than most of us over age 35, I suspect that this conclusion is only tentative and as a matter of fact may not even be correct.

At any rate, there is no way that one can interpret present dollar remuneration of physicians in the Indian Health Service as representing financial security.

The financial rewards for physicians in the Indian Health Service will never be able to offset the negative effect of ending the doctor draft, for example.

Second, community amenities. It is generally agreed that physicians as a group, demand a different level or different type of community activity.

The items most frequently mentioned as being necessary include such things as a symphony orchestra, library, theater, and other such culture items.

Even though this is pretty much erroneous as far as physicians go, it does seem to be a fact that physicians find themselves marrying individuals who do indeed expect this sort of exogenous psychological and mental stimulation and this, of course, has the same effect on physician placement as if the physician himself appreciated such finer things.

Even though this characteristic is highly overrated and may be less and less important, it must be considered in the catalog of needs for physicians when asking them to serve in certain communities.

Third, professional growth. Nearly all physicians require an atmosphere permitting professional growth and development. This includes attending professional meetings or short courses and establishing a relationship with the nearest medical educational center.

Physicians ordinarily require considerable intellectual stimulation from their peers.

Fourth, a different standard of housing, recreation, and for such things as adequate schools for children. These have been thoroughly discussed in other places and are generally pretty well known.

Needless to say, these factors in general make most Indian communities less than competitive for the graduating physician.

Presently, the Indian Health Services enjoys a rather comfortable level of respect and warmth from the Indian community and not just because it performs in a manner visibly superior to the Bureau of Indian Affairs and other Government agencies.

The philosophy in the Indian Health Service of delivering services to individuals, of course, is commendable. One of the strengths of the Indian Health Service is that it is a defined and circumscribed entity and hence, can be dealt with by the Indian people.

At present the Indian Health Service enjoys the presence of a really outstanding director who is loved and respected not only by the Indian community but by professional groups and other governmental agencies.

In general, the personnel of the Indian Health Service, especially those in the professional component are competent and the equivalent of other professional groups.

It has been pointed out that the Indian Health Service is the only example of a really functional rural health delivery system. More importantly, the Indian Health Service has foreseen the need to strengthen tribal structure and government and has pioneered in the development of these requisites. More needs to be done.

The drawbacks of the Indian Health Service include the following:

One, it is a Government bureaucracy subject to all the problems and defects of most other Government bureaucracies. This aspect of the Indian Health Service has been described by Kane and Kane entitled "Federal Health Care—With Reservations, Springer Verlag, 1972," and need not be further discussed here.

Two, the major problem with the Indian Health Service is that it is underfunded. Testimony offered by the Association on American Indian Affairs to Congress during this fiscal year clearly pointed out the very great discrepancy between the needs of the Indian people and the funding provided.

It appears that budget increases are miniscule and many areas are effectively ignored.

The following figures indicate the gross inadequacy of physician placement in the past 3 years.

	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

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

Thus, it can be seen that the number of vacancies has progressively increased and that there has been an actual drop in the number of physicians between fiscal year 1973 and fiscal year 1974 in spite of continually increasing need.

In the spring of 1972, it became evident that draft legislation would be allowed to expire July 1, 1973, when its option became renewable; in fact, by the summer of 1972, the IHS found itself with 22 physician vacancies.

By the fall of 1972, the IHS had applications from only approximately 100 physicians wishing to begin service as of July 1973; this is in comparison to the fall of the years of 1971, 1970, and 1969, when it had received 300, 500, and 700 applications respectively.

As of November 1, 1973, IHS had received less than 50 applications from physicians wishing to serve as of July 1974.

The IHS ordinarily must fill between 170 to 200 vacancies created by departing physicians, usually after 2 years of service.

One can only conclude that the recruitment problem will get much worse as physicians understand that the doctor draft has in reality ended.

It is entirely conceivable that without some drastic action, the functioning of the IHS will be seriously threatened.

It is not inconceivable that the IHS may indeed be unable to continue to deliver health and medical services.

Staffing data relating to other health workers are of further interest.

	On duty	Authorized	Needed
Community health representatives, fiscal year—			
1971	410	410	703
1972	618	618	779
1973	718	718	786
Community health medics (excludes Alaska), fiscal year—			
1971	0		65
1972	0	0	65
1973	25	31	65

These data indicate that although more numbers of these types of health workers are needed, if funding is available, they can readily be recruited.

Similar data is available for the Alsaka community health aide program and for pharmacists. It only seems reasonable that if greater numbers of nonphysician practitioners are available that the requirement for physicians may be eased and the physician undoubtedly be happier also.

With relation to tribal governments, it is generally agreed that the weakest component of all those involved is that of the tribal governing bodies themselves.

There are many reason for this. Indians are caught in a changing world where their own ways of managing human relations have been destroyed and there has not been the opportunity to develop a social structure which is capable of governing itself efficiently, wisely, and fairly.

In the past, many of the policies of the BIA served to accentuate the problem of inadequacies in tribal governing structures.

These matters require discussion because they are directly related to the problem of locating physicians on reservations and because the best recruiting agency should be the tribe itself.

It is easy to see the frustration that a physician must feel in having to deal with some of the people serving on tribal governing boards.

This is why it is so important to have programs which improve the ability of the tribe to function more effectively and at the same time strengthen tribal identity.

Greater funding for community development is needed to permit the tribes to participate in the recruitment of health workers.

Programs for introducing non-Indian health workers to local Indian culture must be strengthened. Mechanisms for permitting physicians to enjoy Indian culture must be funded as well.

As far as tribes are concerned it is important to remember the fantastic disadvantage under which tribal members now operate.

There is no situation in which an encounter between an Indian and a non-Indian is ever really satisfactory for the Indian.

There is always some constraint to the Indian. The major mechanisms for reaction to the frustration of this situation is one of two.

The Indian usually withdraws and ignores the "rude" white person or the Indian may become hostile. Both types of reactions add to the difficulty of the encounter because the non-Indian then must react in a psychologically protective way which also may be one of withdrawal or hostility.

A therapeutic situation is then effectively destroyed. A much greater emphasis upon general education of Indians is also necessary because of many mistaken ideas such as that Indian Health physicians aren't really doctors at all but only "interns."

The effect this has on personnel morale is obvious and it is also obvious that this in turn influences recruitment adversely.

With regard to Indian health professionals, the most desirable recruitment in the long run may in fact arise from an increase in numbers of Indians who are health workers.

It is assumed that Indians themselves would be much more likely to remain on a reservation to work, especially among their own people.

There is in my opinion sound basis for this assumption. All of the members of the Association of American Indian Physicians strongly express a desire to work with Indian people. Most, however, do not wish to work through the Indian Health Service which is the only mechanism at present for being able to work on reservations.

Based upon the projected need of 661 physicians in the Indian Health Service in fiscal year 1974, and considering that many Indians themselves may not be able to work on reservations and considering the number of Indians accepted into medical schools, it is easy to see that it will be a long time before this method of correcting the situation will be successful.

On the other hand, this solution has so much merit that it must be given greater emphasis. In spite of the obvious importance of increasing the number of Indian health workers, the Department of Health, Education, and Welfare recently dismantled the program for minority recruitment headed by an Indian and relegated that position to one of impotence.

Such shortsighted action can only be condemned. Naturally, in carrying out this reorganization the Indian community was not consulted in any way.

There must be a defined, visible, office within HEW funded and made functional, whose primary mission is the recruitment of Indians into health professions.

The Association of American Indian Physicians passed a resolution supporting such a program at its annual meeting last August and forwarded it to the Secretary of HEW.

We were stunned when the resolution was routinely routed to Dr. George Blue Spruce for answer as it was his office which was being abolished.

How are Indians supposed to react when the Federal Government behaves in this way?

Recommendations

INDIAN HEALTH SERVICE

(1) Give stronger consideration to the funding needs of the Indian Health Service as testified to by the Association of American Indian Affairs to the present Congress.

These needs include an increase of not less than $10 million for program activities, to be distributed as follows:

(*a*) $4 million for the development of Indian health boards.
(*b*) $2,300,000 for eye care.
(*c*) $1 million for otology program.
(*d*) $1,300,000 for dental services.
(*e*) $1,150,000 for mental health services.
(*f*) $250,000 for nutritional aides.

There, of course, must be adequate staffing for the positions to carry out these responsibilities. Such increased ability of the Indian Health Service to carry out its functions will result in increased morale which will in turn increase recruitment.

The dollars allocated for development of Indian health boards will be helpful in improving tribal ability to aid with recruitment.

(2) Provide adequate financial remuneration for professionals in the Indian Health Service. Consideration should be given to such benefits as not requiring income tax for those remaining on a reservation for perhaps 18 months, or up to 4 or 5 years.

This can be justified on the basis of remoteness of the duty station. Just as there are overseas assignments which require greater financial consideration for filling positions, it should be possible to provide a pay differential for those serving in certain areas of the country where experience has shown that recruiting is difficult.

(3) Increased attention to the health worker's family must be given. Funding of travel to a national meeting for the spouse of a health worker might have a very beneficial effect on recruitment.

(4) Increase the professional benefits for health workers. This would include adequate funding for attendance at short courses, scientific meetings, affiliation with teaching centers, et cetera.

This type of activity should not be a privilege to the physician but should be an important prerequisite for daily work.

(5) The Indian Health Service must be given greater visibility within HEW. I know of more than one individual who has written HEW about information relating to a career in the Indian Health Service only to receive no reply.

The Indian Health Service frequently seems to have difficulty locating money to pay trainees who are obligated to a future career in the Indian Health Service. This does not help recruitment.

(6) Consideration should be given to vastly increasing the use of nurse practitioners, physicians assistants, or community health medics.

One physician can supervise several personnel of this nature. There must be greatly increased effort put into communication networks to provide instant consultation between the supervisor and the assistant.

TRIBAL STRUCTURES AND GOVERNMENTS

Support for the community development programs of the Indian Health Service must be increased. Special educational programs in Indian Health and the Bureau of Indian Affairs must be set up for the continued training of Indians in self-government.

Grants for tribal newspapers must be given to correct the critical lack of information presently existing.

THE INDIAN HEALTH PROFESSIONAL WORKER

(1) Reestablish an effective Indian recruitment program that will not be lost among other minority groups. Establish an Indian desk with specified funding and recognition with an Indian director.

(2) Establish an Institute for American Indian Health. Such a center should be located on or adjacent to an existing medical school.

It should be run by Indians with a high degree of concern for the Indian as consumer. It should be a center of learning and stimulation as well as having a major interest in recruiting Indians into health professions.

It should be empowered to coordinate research and studies relevant to Indian health and serve as a focal point to which persons could be attracted to study Indian health, Indian life, and in turn to work in Indian communities.

Such an institute should have "line-item" budgeting which could be shared by the Bureau of Indian Affairs and the Indian Health Service.

This institute would conduct special tutorial programs for Indian students marginally qualified for entrance into professional schools.

(3) The establishment of an American Indian School of Health Sciences should proceed. Careful consideration should be given to the location of such a school to insure adequate patients for study, suitable living accommodations, relationship to Indian communities and a curriculum emphasizing the unique and useful attributes of Indian life.

Such a school would train all types of health profession workers.

Senator ABOUREZK. Thank you. That was an excellent statement, Dr. Rhoades.

I wonder if you would be willing to explain to the committee why you are not employed by the Indian Health Service.

Dr. RHOADES. Yes; that is obviously a fair question.

At the time I completed my medical training and completed by obligated military time, as a matter of fact, I might just interject parenthetically, it was not possible for me to complete my medical specialty training so I accepted a commission in the Air Force that permitted me to complete my medical specialty training in medicine for which I had to pay back 5 years to the Air Force.

I would have been most happy to have done the same thing in the Indian Health Service, had such a program been available at that time.

However, there are two other considerations. I, like a number of other Indian professionals, have certain needs and motivations that direct me in a certain direction.

I felt number one that my interests and capabilities could best be utilized in a clinical research and teaching setting, which meant that I basically had to work in a medical school setting.

By one of those chances of fate, a particular opening became available for me in my home State which I felt I could not turn down. So, I chose to go into a medical school.

Second, I recognized even at that time that the weakest link did exist in Indian governing bodies and my contribution from that time on I felt should be directed toward helping correct that deficiency.

If I had gone into an existing governmental agency I felt it would not be possible for me to speak out on behalf of the Indian communities and I actually would not be able to participate in tribal activities.

Those were the reasons I chose not to go into the Indian Health Service.

Senator ABOUREZK. Are you satisfied that the Department of Health, Education, and Welfare is doing an adequate job of seeking highly qualified men and women and encouraging them to pursue medicine as a career?

Dr. RHOADES. There are actually a number of programs designed to seek out qualified Indian students to direct them toward the track leading toward a degree in the health field.

It would seem to me at the present time in my part of the country funding for this and program activity is probably adequate from a program basis.

In Oklahoma there are three different agencies which are directed toward recruitment of Indians in the health professions. One of these is the Association of American Indian Physicians and another is a grant by the Cherokee Nation itself, and then the medical school has a smaller grant directed toward Indian recruitment.

If the proper coordination were available, this would function optimally. I believe this is the case.

My problem at the present time is that just at a time when it appeared that one would expect we could capitalize on this program, in effect it has been dismantled.

In my opinion it existed basically only for 2 years. It is my anticipation that the Association of American Indian Physicians, which is a contract in the neighborhood of $65,000 to $70,000 probably will not receive this funding next year as a direct result of this reorganization in HEW.

Senator ABOUREZK. Do you have any specific recommendations you can offer to increase the number of Indian doctors?

Dr. RHOADES. One must begin a recruitment at a much earlier age than we have presently been able to do. Unfortunately this cannot correct a deficiency just by its very nature within the next 2 or 3 years.

That is, we must find students at an age early enough to get them on an escalator relating to a health career and this must exist at a grade school or high school level.

If I had one area I could choose to develop at this time it would be a greater increased effort toward that aspect. This would include tribal participation, educational change in the schools, and reorienting and reeducating counselors who give very, very bad advice to Indian students advising them basically because they are Indians they should not conceive that they should become a physician.

Surprisingly, this attitude is still in existence. I would direct my efforts—efforts are very small in that particular area.

Senator ABOUREZK. Do you think HEW has been overly reliant on the Doctor Draft Act and that has probably contributed to their present failure to take the necessary steps to increase the number of Indian doctors?

Dr. RHOADES. My interpretation is that must be the case. I believe they have failed to give attention to the problem.

I must say again, only because the participation would be rechanneled to Indian participation.

Senator ABOUREZK. Has the Indian Health Service hired you as a consultant or adviser at this time?

Dr. RHOADES. No; the Indian Health Service has utilized the organization of the Association of American Indian Physicians in an informal consulting fashion, and, as a matter of fact, I have had many conversations and conferences with the Association of American Indian Physicians, including informal consultations with myself as a member of that organization.

Senator ABOUREZK. With respect to the end of the Doctor Draft Act, were you or other physicians interested in Indian health programs?

Were you ever consulted on this which would insure an adequate supply of physicians around the country?

Dr. RHOADES. As far as I know, none of the Indian medical community was consulted by HEW. On the other hand, Dr. Johnson, from the Indian Health Service, did anticipate a problem and did discuss with the Association of American Indian Physicians the possibility of developing perhaps some unique new approaches.

These are still in the process of negotiation. Having been brought about, not because of the failure of the Indian Health Service, but because of the fact that the Association of American Indian Physicians is only 2 years old and is presently made up of 25 individuals of varying backgrounds, I am not sure we can meet the need.

As I said earlier, Indian communities themselves should serve as the best recruiter and Indian communities are not in a position, they don't have the information needed to serve as recruiters for physicians.

The Association of American Indian Physicians does possess this in some of its members. We should be able to take consultation through Indian Health Service in an Indian community, to guide the Indian community, and to work on an equal basis with the Indian community helping him to recruit.

It is my anticipation that the association will be able to enter into some kind of contract arrangement with the Indian Health Service to do these kinds of things.

How successful that will be, I do not know.

Senator ABOUREZK. If HEW does not adopt contingency plans to overcome this recruitment problem we have been discussing, what do you think will be the immediate and long-range effects of this lack of physicians on the health situation of the American Indian people?

Dr. RHOADES. I had originally hoped and anticipated that because of the different motivation of medical students at the present time that greater numbers of them would be motivated to serve in an Indian community.

I am now not so sure that is the case. As a medical educator, we seem to be fairly successful in redirecting the more humanistic motivation

of medical students during their process of receiving a medical education so that by the time they finish their medical education they no longer seem to have this motivation.

It seems to me, based on inadequate data perhaps, but relating to this past fiscal year, that we are really faced with a catastrophe, and I think we already are faced with a catastrophe in the Aberdeen area where in effect it is not a great exaggeration to say there is no effective functioning medical officers.

I can only see this spreading, although I can see it spreading more desirably in a general sense—areas such as Arizona, Florida, and the Northwest Pacific coast, recruitment for these areas seems to be proceeding reasonably well.

In certain areas there is a real problem, and I see no alternative to either increasing contractual arrangements for providing health care or closing down health facilities. There will be no one there to operate these.

Obviously, if you are in a remote area of the country there are no physicians to contract with. So, we are faced with a stark reality of closing out health facilities or else having community health medics, nurse practitioners, attempt to provide a basic level of health care, which seems to be the only reasonable alternative to try to approach the problem.

Senator ABOUREZK. In my part of the country in South Dakota the doctors in the non-Indian communities that surround the reservations are pretty well overworked. Right now, they cannot take the extra load even to supervise and train health workers.

I think Dr. Allen will have testimony on that later on. I have talked about it with him and other doctors in that area and it is a very depressing situation when you think about the snowballing effect it is going to have.

Would you recommend that the Indian Health Service pay a bonus to any doctors willing to spend 2 years on a reservation?

Dr. RHOADES. Sure.

Senator ABOUREZK. Do you believe that would alleviate part of the problem?

Dr. RHOADES. I think it would serve toward alleviating part of the problem, but that cannot be depended on as the only solution.

I think like experience in the military service raising the financial level to what approximately one would make in a private setting would have very small effect on service retention.

The military is not comparable to the Indian Health Service by any means. But, to overstate it, I am sure there are many people in the IHS who would stay no matter how much money they were paid.

On the other hand, I believe it is an insult to an individual to ask them to work at what I believe is the existing basis yearly salary base of $16,000 for some individuals in the health service.

This is one-half of what those individuals would make to begin a practice. Fringe benefits don't absolutely make up for that deficiency either.

I think one must justify adequate financial remuneration on the basis it is needed, whether or not recruitment were a problem.

Senator ABOUREZK. Being that I'm from a rural State I have been interested for some time in rural medicine and rural health delivery.

Do you believe the Indian Health Service can become a model for rural health systems and that the permit system will change with paramedic teams supervised by doctors that you discussed in your testimony with fairly comprehensive medical service for outlying areas?

I would like your comments on that.

Dr. RHOADES. I believe the Indian Health Service at the present time is already a very fine model unrecognized by academicia and the institutions of learning in this country.

They probably have had sort of a down-the-nose attitude toward the Indian Service like they have had toward the military service, and I think they fail to recognize this is the case.

I think the IHS should perhaps be given support even—moral support—to actually be recognized as a health maintenance oragnization, like HMO for example, operating in rural areas.

I am not really aware of any other functioning rural delivery system in this country. I think there are many things to be learned.

I think there are programs; for example, on the Navajo Reservation with cooperation between the Navajo; the Health Authority of the University of New Mexico, the University of Arizona, and the Indian Health Service are serving to amalgamate delivery system.

For instance, a mobile clinic increased communications network using a police radio system really should provide the basis for training of all of the other vast problems of rural health in this country that are non-Indian.

Senator ABOUREZK. In your opinion are Government programs designed to upgrade Indian community development in general?

Dr. RHOADES. Yes; I think they are, at least in intent. I think all of the programs such as the great problem of contracting of services to the tribes, increased dollar flow to tribes, increased proliferation of activities that Indian communities may participate in and find themselves in for important decisions all will have a long-term effect in upgrading Indian communities.

Senator ABOUREZK. Are those that are designed that way, successful?

Dr. RHOADES. In my opinion they are nonsuccessful, and my experience is based upon the western part of the State of Oklahoma, and I do not have recent data relating for instance to the Zunis who have been in this business somewhat longer than others, and the Miccosukees in Florida, and I don't know the facts on those programs.

But, in my opinion, I have not seen any success result from these problems but that may be because just not enough time has elapsed.

Senator ABOUREZK. What do you sense as the major obstacles facing a young physician who wants a career in the Indian Health Service?

Dr. RHOADES. The major obstacles besides those already mentioned, like financial security, a place that the physician would interpret as being a desirable place to raise his family and to entertain his wife, the uncertainties of professional growth and professional development so that a physician would anticipate that he would come out of the Indian Health Service hopefully at a remote time in the future more highly trained, more highly experienced, more qualified to care for individuals, and relief from all of those small and large problems that one would categorize as bureaucratic problems dealing with—well, for example, we have addressed ourselves to the professional compo-

nent, but in my opinion the nonprofessional lack in the Indian Health Service is just as great.

There are not enough clerks, there are not enough typists, there are not enough receptionists either in the Indian Health Service.

All of these add up to a daily maddening load for the physicians in western Oklahoma in the Indian Health Service with whom I am fairly closely acquainted.

Let me just add to that. If we in America had the imagination and the determination it seems to me that, for example, Government boarding schools should be models of excellent education so that children like mine, for example, should want to go to those schools because they would be much better prepared to face life than they would otherwise.

That should be true of the Indian Health Service. It should be a place that is so exciting where new data is being gathered, where new insights into disease processes are being studied because of very special relationships Indians have, that Indians would seek to serve there because of the benefits to them directly.

Now, I am not smart enough to know how to set this up at the present time, but I think the knowledge exists in this country; a body of people could be brought together who could do this.

Senator ABOUREZK. In addition to that, what are the barriers that face Indian physicians who want to serve on the reservation?

Dr. RHOADES. This has to be recognized also, and these are multiple in addition. For example, many of the young Indian medical students I have counseled with in the last couple of years have pointed out to me a situation I felt as well; that is, an Indian who leaves a community to go get any kind of education, not just medical, and who returns to that reservation, has to jump through the hoop again, has to prove himself to the tribal members that they have not been altered in some way that should in effect ostracize them from the group.

And, quite frankly, many individuals who leave an Indian community cannot jump through that hoop to get back because of their own psychological barriers.

This is a real problem.

Number two, as a matter of fact an Indian physician, for example, cannot make a living working in an Indian community unless he serves in the Indian Health Service.

This is a real barrier, also.

Senator ABOUREZK. Do you think the Indian Health Service should be phased out entirely in favor of some other type of delivery service?

Dr. RHOADES. No; most emphatically not. I don't say that from the insecurity that the Indian community would feel by phasing out any identifiable Government agency with which they deal.

We recently had a conference which directed itself to this question and it became apparent to me that if the Indian Health Service were phased out this would have a very deleterious effect on the short term and probably on the long term by effectively denying access to health facilities by Indians generally.

Now, you qualified your question by saying if some other system were developed. If there were some other system that were developed that was identified as an Indian program that the Indians would not be diluted out of and as a matter of fact excluded from, then I would be willing to discuss what form that might take.

I am very alarmed, for example, with the anticipated real passage of some form of national health insurance in the next few years.

The first question that will arise is, why not phase out the Indian Health Service. After looking at the problem in some depth, I believe the Indian Health Service must not be phased out in lieu of national health legislation.

For example, giving an Indian a medicare card is not going to satisfy many of those communities in the Dakotas or in Oklahoma where they don't have any place to take that card to.

Senator ABOUREZK. Would the establishment of Indian medical schools be of much value in what we are discussing here today?

Dr. RHOADES. The establishment of an Indian medical school, of course, has been seriously debated and there are a number of arguments that would be relatively persuasive against the identification of a specific ethnic medical school let's say for this country.

A strong argument is against the isolation that might in effect occur by having Indian students receive their education separate from non-Indian communities.

On the other hand, it has become apparent to me, as I have been involved in Indian recruitment, that the lag for really increasing the number of Indian physicians through existing medical schools is so long that in my opinion an Indian medical school certainly is justified, and there is no reason why that Indian medical school in the future could not be phased into a different type of student as the need arose.

I think this is the only reasonable way to greatly increase the number of Indian medical students currently. Even now I have to admit based on terms of dollar investment, this is a relatively inefficient way to produce 40 or 50 medical students after a lag period of 4 years there.

In my opinion, I believe it is likely that an Indian medical school will be developed in this country. People will say an Indian medical school will probably be the last medical school developed in this country and that may be true also.

Senator ABOUREZK. If somebody can come along with an American Indian bank, then one should be able to come up with an Indian medical school, which to me is needed a lot more than a bank at this point in time.

Dr. RHOADES. As a matter of fact, I have tried to emphasize in the past that producing a greater number of health workers would have a very important effect on raising the socioeconomic status of American Indians, and it should be looked at that way also.

Senator ABOUREZK. In closing, may I ask if you have any other views you might want to bring up and discuss at this time that you have not already discussed?

We appreciate very much hearing your testimony. It has been very valuable to the committee, and hopefully we will get some kind of public exposure so that additional support will be made available for improving Indian medical programs.

Is there anything else you wish to say?

Dr. RHOADES. I have nothing else to add at the present time. I would like to express my gratitude to you, the chairman of this subcommittee, and members of this subcommittee for permitting me to testify.

Senator ABOUREZK. I saw a television program yesterday afternoon by one of the networks that was directed toward the issue involved in Wounded Knee and the subsequent changes following the siege.

It was the conclusion of the network as well as the people they interviewed that nothing had really changed.

Some people even said it had slowed Indian progress on the Pine Ridge Reservation, and some of the militants interviewed said that the seige had not helped the Oglala Sioux but had increased Indian opportunities elsewhere because it frightened the Government into taking some kind of action.

Very frankly, I haven't seen a great deal of action on the part of anybody. I don't know if it helped or hurt.

I think in spite of all of the destruction, it did make the American people aware of the problems that exist between the Indian people and the U.S. Government. And because of that conflict I think there is a vague awareness now in the American people of this problem.

When I held hearings out in Pine Ridge following the Wounded Knee confrontation I called up a journalist of the Washington Post concerning the hearings, and mentioned to him that during the entire confrontation very few journalists did anything to outline the issues that were underlying the siege and the conflict out there.

All they did in my opinion was photograph Indians silhouetted against the sky with a gun in their hands. That was the news of the day.

The alleged purpose of the confrontation was to get the Indian story out to the country. That never happened. So, when I explained that this would be an excellent opportunity to explore the causes of Wounded Knee and the testimony I knew would reveal with some depth what the grievances and the problems were and still are.

The journalist, who is a pretty good guy, responded, "I would like to go but very frankly, the management news editors on my paper are not interested in Indians unless they are shooting at each other."

I don't know how you get the Indian Health Service to move on what really needs to be done. I don't know how you get the BIA to move.

It is very frustrating to me, and I am sure it must be much more frustrating to the Indian people.

If you have any ideas as to how to make people aware of the real problems of the Indian people we would appreciate that as well, because it really does take public support to get these things done, or Presidential support, which we apparently do not have.

The Congress is unable to get any programs like these moving. I just advise you to sit long enough to listen to that.

Dr. RHOADES. I was afraid you were going to ask me to discuss my attitudes toward Wounded Knee and all that represented it, and I am relieved that you asked me only if I had some ideas as to how to go forward.

In my opinion, we will not be able to move forward at an accelerated pace until that movement comes from the existing tribal structures, the tribes existing as entities.

I certainly don't want to be put in a position of defending or appraising existing Government programs and agencies, although in many instances we must recognize the Bureau of Indian Affairs has served as a scapegoat for frustrations elsewhere and was unjustified.

The fact of the matter is, my own tribe organizationally is totally unable to respond to a number of the programs that are available.

For example, Federal revenue sharing should have a very important ameliorating effect on tribal programs that we ourselves could take advantage of. And, for a number of reasons, we are unable to really effectively take advantage of this. We are unable to mobilize ourselves to take care of what was admittedly a crash program when the moneys became available for Indian education at the last round for example.

I have serious doubt whether we will be able to submit a proposal for the coming December deadline for education. We are bound down.

We cannot function until efforts are directed to permit us to take advantage of those things that are in existence currently.

I am not sure that piling on more Government programs will have an effect toward improving that. Now, I am not against any of the programs, any program should be weighed for its merit, which is what it will deliver to an individual Indian, which is the only way to measure it.

But, I don't know, there are things—unless they are dramatically different, and I don't have ideas as to what those dramatically different approaches might be—doing more of the same thing will increase it very, very slightly.

Indian tribal government has got to be developed to a point where the Indians themselves—I have no question whatsoever that they will be able to do this—they will be able to generate new, innovative approaches and in my opinion the barrier that exists between a group getting a program instituted by the Federal Government very likely is less for Indian tribes than for many other groups with the exception of say the milk industry or labor unions, the airlines, and groups like that.

I must say I believe that the manifestation of many, if not the majority of members of Congress that I have had to deal with, and individuals in the Indian Health Service, are not prohibited by a lack of desire or attitude.

I think they wish to help. There is no question that that is not enough. Harm is done by people who wish to help just as often as harm from those who do not wish to help but choose to ignore.

I am sorry I have not answered your question but perhaps I have given you some filling in of the spaces.

Senator ABOUREZK. I did not ask a question, I was preaching more than anything else.

Once again I want to thank you.

Rosemary Wood is the next witness. She is chairman of the American Indian Nursing Association.

Miss Wood, I want to welcome you to the committee and tell you we appreciate your coming here to testify. We are ready to listen to you now.

STATEMENT OF ROSEMARY WOOD, PRESIDENT, AMERICAN INDIAN NURSING ASSOCIATION

Ms. WOOD. I would like to give you my experience first in the health care delivery system. I am a psychiatric nurse specialist with the Oklahoma State Department of Mental Health.

I have been in direct nursing practice, I have been in nursing education as an assistant professor at the University of Oklahoma; I have also done research, and one of the research studies which I have conducted was a study of the relationship between the deliverers of health care services and the consumers of health care services within the Indian community.

My testimony today will draw heavily upon that study. Testimony is also based on information gained during my term as president of the American Indian Nurses' Association.

I wish to thank you for the opportunity to appear on behalf of the Association on American Indian Affairs.

With the abolishment of the draft of medical doctors into the service, it has become dramatically apparent that alternatives must be found to the present health care system within Indian Health Service.

If truly viable and long-lasting alternatives are to be found, attention must be focused not only on the medical doctors in isolation but consideration of the total system within which the physician is asked to function must be discussed.

On the delivery level the physician is but one unit working with other units within the total health care system; other units are consumer groups, other health professions—nurses, social workers, psychologists—support staff, and the various tribal health worker.

Indian Health Service, in recent years, has made tremendous strides in the consumer and tribal group units through the establishment of Indian health advisory boards, the development of direct contracts with the tribes themselves, and work with various associations composed of Indian professionals.

Much more needs to be done in this area relative to community development. However, this is not the focus of my statements today, and there are others here who are more involved in that aspect of the health care system—Dr. Everett Rhoades, for example.

What I will focus on is the other professionals within the health care system, specifically nursing and nursing relationship to medicine.

I will attempt to demonstrate how physicians can be enabled to gain satisfaction and thus increase recruitment and retention of physicians in Indian Health Service.

Let me first differentiate between medical care and health care. Medical care primarily concerns itself with the detection, diagnosis, and treatment of disease, illness, or pathology.

Health care not only includes the diagnosis and treatment of disease and infirmity but also focuses on the promotion of optimum physical, emotional, and mental well-being of individuals, families, and communities.

The physician is the most highly trained, educated, and skilled member of the health team in the area of the diagnosis and treatment of disease.

The nurse and other health professions work with the physician in this area, sometimes on a collaborative basis and sometimes carrying out his direct orders.

In the other areas of health care—that is, the promotion of physical, mental, and emotional well-being—the professionally prepared nurse has been educated and trained to work independently, calling on the physician when pathology or disease is found or suspected.

For example, there are nurse-run prenatal clinics in which healthy expectant mothers are monitored throughout pregnancy for early detection of pathology and referred to the physician.

However, in the absence of disease or pathology the nurse teaches individual patients and groups of patients relative to health needs; for example, adequate nutrition and food preparation; pelvic and related muscle exercises in preparation for labor and delivery, early infant care—bathing, nursing, temperature control and regulation, et cetera; the nurse practitioner utilizes auditory and visual aids, calls on active participation of the patient, patient groups, and family members.

Given the proper structure the nurse goes into the home and community as an active participant in the individual's and the family's continuous striving for and learn about health in relation to the total ecological, economic, and social environment.

The nurse practitioner also counsels with the expectant mother concerning any fears and anxieties of labor, delivery, and/or the new responsibilities of motherhood; she is prepared to discuss intrafamily relationships, sibling rivalry and even the simple but important activities of everyday living and working while pregnant.

There are other types of nursing clinics which focus on various aspects of health; for example, well-baby clinics, nurse-operated primary care clinics and community mental health programs.

In other words, nursing clinics are not limited to prenatal care. I used the prenatal clinic as an example or model to demonstrate how optimum utilization of the nurse practitioner can increase utilization, satisfaction, and retention of physicians within Indian Health Service.

Few physicians are specifically trained in this area of health care, nor is this an area of particular interest to the average physician; and, even if it were, does the economy of time allow him to spend the necessary hours in this type of activity which can be done by nurse practitioners specifically trained in this area and who consider the teaching and promotion of health their most important and valuable contributions to the health team?

Through utilizing the nurse practitioner the physician is relieved of the less complicated minor illnesses and free to care for the many, many expectant mothers who are in some type of pathological difficulty and who are in need of his special training and knowledge.

During the 11-month research study referred to earlier, 100 percent of the 2-year physicians interviewed stated dissatisfaction with the system within which they were being asked to practice relative to being free to practice their profession to the uppermost of their capabilities.

One of the major areas of dissatisfaction was expressed very strongly by the following statement:

> I went to school for over 10 years in order to learn how to cure sick people; I am proud of what I have learned and I want to use what I have learned.
>
> Instead, all I do is look at sore throats all day. What makes it worse is when someone comes in who is really sick, and I know I could treat them, and I want to treat them, I don't have the appropriate amount of time to spend with them.
>
> Then later they come back and say that I am a lousy doctor or that I don't care—and even if they don't say it I know that is what they think.

Now, this young doctor and many like him are not talking about having a lot of fancy equipment or the latest complex machinery, but

they are asking to have time to practice medicine and to obtain some degree of satisfaction for themselves and their patients.

Many individuals define this situation as a, "problem of misuse by doctors' time by patients." By viewing the situation without consideration of the total health system one solution would be to limit patient entrance into the system by fee or some other methods.

However, this is a narrowsighted, ultrasimplistic and possibly dangerous alternative. One public health nurse noting the same phenomena defined it as a health problem; not a pathological or medical problem.

This nurse recalled that not too many years ago the big push within Indian Health Services was simply to get the patients to come to clinic.

Now to begin pushing patients away again would be progress in reverse. This public health nurse also pointed out that knowing how and when to utilize clinics and western medical services is truly a learned process.

The non-Indian population has used clinics and medical services for centuries and knowing how and when is a part of their enculturation into the society.

The proper intervention into the problem, therefore, is health teaching and not closure of the system. By viewing patient utilization of medical services from the health model rather than medical model we learn that patients' time is being misused in addition to the misuse of physicians' time.

Here, again I am using a clinical example from actual data to demonstrate the need to consider the total health care system in discussion of medical care, utilization of physician time and resultant satisfaction and retention of the physician within Indian Health Service; and, in so doing to again point out the beneficial utilization of nurse practitioners within Indian Health Service in the basic level of health teaching.

The nursing division of Indian Health Service is aware of the potential impact of nursing clinics within the health system. There are at least two nurse clinics in Oklahoma which are fairly successful.

But in order to truly be comprehensive, there must be moneys available to compete in the market for family nurse practitioners, nurse midwives, pediatric nurse practitioners, psychiatric nurse specialists, et cetera.

Moneys must also be made available for nurses already in Indian Health Service to receive long-term training. Here I am not referring to the community health medic training which is geared toward training individuals to assist the medical doctor in diagnosis and treatment of disease.

I am referring to masters level nurse practitioners who are qualified not only to work under the direct supervision of the physician but who are also highly educated and trained in the area of health. For example, prenatal clinics, well-baby clinics, community mental health, immunizations, nutrition and a host of other health related areas.

Expanded nursing practice will not only improve the health of the individual with whom the nurse has direct contact, but will also provide the physician with the opportunity to practice medicine and to utilize his special skills and training which are now in such great danger of being lost from Indian Health Service.

I strongly urge and request that legislation be enacted soon which will provide Indian Health Service—Nursing Division with the moneys and physical means by which to develop comprehensive nurse managed clinics throughout the Indian communities.

The need for nurse practitioners is in no way intended to indicate that present nursing functions and activities are not needed.

In fact, need for the more traditional nursing personnel is also great and is continuously increasing. The following charts show that by 1973, 329 additional RN positions will be needed with a number of vacancies of authorized positions of 129 giving a total need of registered nurses of 458.

The projected need of the other nursing personnel—nonprofessional—is 983 additional positions needed and 83 authorized position vacancies giving a total of 1,066 paraprofessional nursing personnel needed by 1974.

By 1974 the grand total of all nursing staff and personnel needed in 1974 is 1,524.

NURSING PERSONNEL—INDIAN HEALTH SERVICE

	Authorized	On duty	Vacancies	Additional positions needed
R.N.'s—including PHN's, fiscal year—				
1970	1,101	967	134	
1971	1,118	1,015	103	
1972	1,165	1,012	153	
1973	1,169	1,017	152	
1974	1,156	1,027	129	329
All other nursing personnel, fiscal year—				
1970	1,221	1,164	57	
1971	1,278	1,225	53	
1972	1,285	1,221	64	
1973	1,264	1,161	103	
1974	1,231	1,148	83	983

As stated above, the concept of advanced nurse practitioners—on masters level—and nursing clinics is not intended nor can it replace or displace the physician or the present bachelors in 3-year nurse.

A comprehensive advanced nurse practitioner program will not only improve the total quality of health care but it would immediately have direct bearing on expanding the role of physicians and increase the satisfaction with his own opportunities to practice, and therefore increase retention of physicians in Indian Health Service. Retention is as important as recruitment.

Presently the turnover rate among physicians in Indian Health Service is 170 to 200 per year. In view of the present 40-percent vacancy level coupled with the dim prospects of entrance it is quite clear that if immediate interventions are not instigated, the numbers of physicians will near zero in a very short time.

Indian Health Service does not yet have available exact statistical data relative to the turnover rate among registered nurses. But, there are strong indications that that too is greater than desirable.

By expansion of the nursing role Indian Health Service should also increase satisfaction with practice and decrease turnover rate.

Although the initial cost may be greater the cost effectiveness will soon stable off and eventually cost drop due to (1) decrease cost of entrance and exit from the system of large numbers of nurses and physicians, (2) greater numbers of patients being cared for by pro-

fessionals who receive fewer dollars, and (3) acute illness requiring highly technical and specialized equipment and personnel would decrease as a result of health teaching and preventive medical care.

In summary, I would like to emphasize that the focus of recruitment and retention of physicians must be viewed from a systems approach.

If the ultimate outcome is to be viable and more than a stopgap measure with another crisis to follow upon the heels of the present one. I am entering into the written record statistical data showing that there is no real problem as far as paramedical staffing and nursing personnel below the advanced levels are concerned.

Example: Community health medics and community health representatives. Concerted efforts are needed in the masters level and above.

SELECTED STAFFING, INDIAN HEALTH SERVICE 1971–73

	On duty	Authorized positions	Needed
CHR:			
1971	410	410	730
1972	618	418	779
1973	718	718	786
CHM:			
1971	0	0	65
1972	0	0	65
1973	25	[1] 31	65
Pharmacists:			
1971	137	137	307
1972	157	157	307
1973	158	158	323

[1] Not considered "on duty" until graduation.

Recommendations

1. Funding and establishing a comprehensive network of nurse-run clinics and advanced practitioners at a pay scale that is competitive on the market.

2. Immediate and strong efforts at recruiting nurses at all levels which has been designated as need and which will be entered into the written record.

3. Comprehensive increase in salaries for physicians.

4. Programs for physicians and nurses that provide periods of rest and recuperation for themselves and their familes in an attempt to offset the loneliness and isolation frequently associated with outreach assignments.

5. Comprehensive programs for community development to offset and allow the American Indian communities to redevelop after years of suppressed autonomy.

Dr. Rhoades has already spoken about the need to mobilize in the Indian communities.

Senator Abourezk. Do you attach the same importance to it that he does?

Ms. Woods. Yes, over two centuries have gone in which the tribal governments have not been governing in a realistic manner for various reasons.

In a study we did conduct we saw some very heartbreaking experiences within the Indian communities because of the lack of tribal unity—or, not even unity—but know-how of western medicine.

The little Indian children grow up, it is a part of their growing up, but Indian people have not learned that it is not their fault. This is where the Indian clinics come in.

Senator ABOUREZK. Why would you not work for the Indian Health Service, Rosemary?

Ms. WOOD. Because of the lack of support staff and the lack of programs which I tried to ascribe for advanced nurse practitioners.

I would be able to do little more than just pass out pills and give injections. Right now I work for the State Department of Oklahoma and I am doing individual therapy. I do research, I am teaching nurses and interviewing the nurses.

In the Indian Health Service they have little time to do anything other than just the bare minimum, giving injections, emptying bedpans and that sort of thing.

And, another thing, the Indian people themselves in the past have viewed other people in the Indian Health Service as people who do not measure up.

Whether it is rational or irrational, I don't want to be associated with that image of my people looking at me and thinking, well, you are not going to do anything.

Senator ABOUREZK. Do you think the facilities are utilized to their fullest in the Indian Health Service?

Ms. WOOD. Definitely not, the research study we conducted pointed out dramatically that they are not being utilized.

And, going back, I think a lot of it is the lack of other professionals like the physicians, they go to school a long time.

One physician told me in his own words, I have gone to school for 10 years in order to treat sick people, I really want to treat sick people, but all I do is look at sore throats.

And then when somebody comes in who is truly sick and I want to treat them, I know how to treat them, there is no time to treat them.

It is frustrating. And then later on the patients come back and say I am a lousy doctor, you don't care.

Senator ABOUREZK. That example is in your written statement.

You think support personnel for the doctors themselves would be the answer?

Ms. WOOD. I want to make it clear that primarily I am talking about nursing clinics, advanced nursing practitioners. These are good programs. They run from 4 months to a year. They work under the direct supervision of a physician.

But, nurses with a bachelors degree level or a masters degree level want to do the health care services as well as working under the direct supervision of a physician.

So, I don't want it to be said that you can get 2-year nurses or unprepared 3-year nurses and that would take care of the problem. I think if anything, you will just complicate the problem.

Senator ABOUREZK. Any other alternatives you might suggest to improve conditions for support personnel?

Ms. WOOD. Not only with the professional nurses but I think it would be really necessary at some point, and I don't know if it would come under education or health, but research needs to be done to investigate what happens to individuals during the long process of professional socialization.

We have young men and women coming in with the idea of wanting to serve, wanting to help, but something happens to them and they are no longer interested in going into these areas.

I think if that could be investigated—I should say researched—and really determine what the problems are in that area, I think steps could be taken.

We would not only be having Indians returning to Indians, we would have non-Indians working in ghetto areas and in reservations.

Senator ABOUREZK. Do you have any other conclusions or suggestions that would be helpful to the Indian health program?

Ms. WOOD. No, Senator, I don't. I would like to express my thanks for being here and the opportunity to give you my views.

Senator ABOUREZK. We are grateful to you for appearing and presenting your views and it will be very helpful.

Once again I want to thank you. You have a very famous name, by the way, Rosemary Wood.

Ms. WOOD. I don't have any tapes.

Senator ABOUREZK. It is about 18 minutes to 12. Rather than start with Dr. Allen at this point, I think we will recess until 1:30 and resume the hearings, rather than go for 15 minutes now and then interrupt Dr. Allen's testimony.

I think it would be fair to do it that way.

So, the committee will be in recess until 1:30 this afternoon.

[Whereupon, at 11:43 a.m., the hearing was recessed, to reconvene at 1:30 p.m. this same day.]

AFTERNOON SESSION

Senator ABOUREZK. Gentlemen, I want to apologize, but they have called 10 rollcall votes in a row, one right after the other.

Our next witness will be Dr. Charles Allen, Rosebud Indian Health Service Hospital, Rosebud, S. Dak.

We would like to hear your testimony now.

STATEMENT OF DR. CHARLES ALLEN, ROSEBUD INDIAN HEALTH SERVICE HOSPITAL, ROSEBUD, S. DAK.

Dr. ALLEN. I want to thank Senator Abourezk and the other members of the subcommittee for this opportunity to testify on the urgent matter of continued health care to the Indian people.

A few initial comments off the record might be revealing.

Similar to the BIA but to a lesser degree, the Indian Health Service has been cussed and discussed.

We have been categorized as a "nickel and dime outfit." We have been called "Yellow Berets."

On leaving the District of Columbia airport, I directed the cab driver to a downtown hotel. He said that in 5 years of being a cab driver in the District of Columbia he had never had a previous fare for that hotel.

The bellhop at the hotel informed me without knowing my position that the Indians used that hotel. So we do have an image problem.

In this vast Nation of ours, the problems of the Indian people are often considered unique or remote to the real problems of the day. The

total budget for the Indian Health Service is but a drop in the total flow of funds in and out of Washington.

Perhaps these image problems reflect a deeper problem; the failure of this society and its Government to recognize and support the very real and humanly vital goals of the Indian Health Service.

In the past year the tribal leadership at Rosebud has shown increasing concern about the future of their health care facility. This concern has continued through the recent election and is a matter of serious importance to the newly elected administration. I have acted as a consultant to the Rosebud Sioux Tribe on health matters. It is in that capacity and at the request of the subcommittee that I appear here today.

I would like to congratulate Dr. Rhoades and Ms. Wood on their excellent testimony. I agree with Ms. Wood that increased use of well-trained nurse practitioners and physicians' assistants, particularly of Indian descent, will go far in relieving some of the staffing problems.

Indeed, the Indian Health Service is in a unique position to develop imaginative and bold new approaches in the delivery of health care based on the full utilization of such personnel.

I would caution, to this degree, that such a program is useful in extending the capabilities of the physician but in no way can this approach be developed as a substitute for the physician.

I would also like to state my complete agreement in substance and principle with the testimony of Dr. Rhoades.

In particular, the point that the only real and lasting solutions to problems in the Indian communities must and will come from the Indian people themselves.

These are historical, cultural, economic, and geographical differences between the native peoples of the United States that make generalization most difficult. The solution to a problem in one community may differ substantially from the appropriate solution to the same problem in another community.

Much of our difficulty in devising a program is our inability to incorporate the necessary flexibility to reach an individual solution.

Each group of people requires individual assessment—hopefully, self assessment.

I can only speak with a semblance of authority about the health care problems at Rosebud. Insofar as generalizations are meaningful, the problems at Rosebud may be considered representative of those existing throughout the Indian Health Service.

My own qualifications include: A doctor of medicine degree from Columbia University in 1961, certification in general surgery by the American Board of Surgery in 1971, 10 years as a commissioned officer in the U.S. Public Health Service, with the current rank of senior surgeon, 5 years experience in direct health care with the Indian Health Service including tours of duty at San Carlos, Ariz., the Alaska Native Medical Center in Anchorage, Alaska, and 4 years at Rosebud, S. Dak.

My current position is staff surgeon at Rosebud.

The obligation of the people of the United States through their Government to make health care available to the native peoples of this Nation has not been seriously questioned.

The Dakota people in particular have rights to health care specifically mentioned in the Treaty of Laramie in 1868.

In addition, the Dakota people share in the commitment of all native peoples as annually reaffirmed by congressional appropriation.

They also are entitled to the assistance available as citizens of the United States.

It is important to realize these facts as it is far to easy for most of us to lapse into the point of view that these programs are like welfare assistance, or are part of a missionary spirit and therefore might be construed as an undeserved gift.

This point of view is simply erroneous; worse, prejudicial.

At certain times the form by which these obligations have been fulfilled has taken different form, but the basic obligation has been accepted for over 100 years.

In the most recent 15 years, the form of health care delivery to the Indian people has been that of the Indian Health Service of the U.S. Public Health Service.

The accomplishments of the Indian Health Service have been nothing short of outstanding. Some of these accomplishments are graphically represented in the documents submitted by the Aberdeen area office.

Examples are the progress in percent of children immunized, marked improvements in maternal and infant mortality rates, infectious disease control, better housing, improved sanitation, increasing longevity as well as the daily provision of medical care.

I would not be honest if I did not point out that substantial problems remain and include an alarming death rate, particularly for young people as a result of injuries, particularly automobile accidents and fires from still inadequate housing.

I must mention the very high alcoholism and suicide rates, the still tragically high incidence of infectious diseases and many other major health problems.

Furthermore the gains realized through the Indian Health Service require continued effort and vigilance lest they be lost. The recent Rosebud experience with 40 new active cases of tuberculosis in 5 short months is a frightening example of the loss due to limited resources of a formerly effective program.

Senator ABOUREZK. Is there some kind of an epidemic going on?

Dr. ALLEN. The episode we experienced this past summer at Rosebud would be termed epidemic. That is the way we would term it.

Senator ABOUREZK. A high level——

Dr. ALLEN. Tuberculosis, for example, is ten times the national average. So for this reason it might be termed chronically epidemic or endemic in this community. But our recent experiences have been epidemic by any definition. Nonetheless, on balance there are few Federal programs that can claim the return on each tax dollar spent than the Indian Health Service.

But now the continuation of these effective programs indeed the very future of the Indian Health Service is currently in doubt.

The Indian Health Service has always operated with marginal financing particularly when compared to the resources available to university centers or to the private sector.

The return in benefits for each marginal dollar spent remains high. IHS has never been plush. Indeed, the resources of the IHS have never been adequate to the real health needs of the Indian peoples.

In the past 2 years I have personally witnessed a deterioration in the resources available relative to the needs.

This is readily visible at Rosebud in the increasing incidence of infectious diseases, particularly TB, hepatitis, and dysentery.

It is further visible in our increasing workload statistics when viewed alongside our stable personnel and budget levels.

It is documented in our long list of deferred surgical cases. It is revealed in our inability to refer patients to contract facilities other than for life or limb threatening problems.

Our failure to respond to needed medical attention is shamefully revealed in the 30 percent of our schoolchildren with hearing problems as a result of inadequately treated otitis media. It is reflected in our deteriorating physical plants and in the long hours and excess workloads borne by all of our presonnel.

The recent deterioration in ability to deliver services may be in part attributed to a number of factors that have been developing simultaneously over the past few years.

I would like to briefly review some of the statistics on the Rosebud health service.

No. 1. The increasing cost of purchasing contract care in the private market and through other Government facilities.

No. 2. Inflation and the increased costs of delivering health care through the Indian Health Service itself.

No. 3. Although total appropriations have increased, the increases have not been sufficient to cover the increased costs or the increased demand for services.

No. 4. Deterioration in the physical plants.

No. 5. Increasing population.

No. 6. Increasing utilization of services.

No. 7. The economic changes in budgetary restrictions of recent times.

No. 8. The loss of the doctor draft.

The seriousness of the effects of these events on the Indian Health Service can be appreciated when it is realized that the overall budget of the Indian Health Service is estimated to be about 30 percent short. The deficit in the Aberdeen area, and at Rosebud in particular approaches 50 percent.

It has been most difficult to fill physician vacancies. There will be an anticipated rate of 25 percent vacancies or 44 physicians in the West River Aberdeen area alone in July of 1974.

At Rosebud, we face the loss of four out of six physicians with little hope for their replacement, at the present time.

There have been many suggestions as to how to cope with these problems. The possibilities raised by the establishment of a 4-year medical school in South Dakota, HMO legislation. The prospect of national health insurance are real and hopeful. But it must be realistically faced that the majority of Indian people live in relatively isolated reservation communities where there is no alternative to the Indian Health Service, at least in the short run. All alternatives suggested are complex new systems requiring time and coordination of resources that simply cannot be medically realized in the terms of actual delivery of health care. Thus the transition period between what is provided today by the Indian Health Service and whatever the health

care delivery system of the future might be becomes of critical importance. In my opinion, the Indian Health Service has encouraged, insofar as possible, educational programs for Indian people, community involvement, and administrative participation by the communities served. In my opinion it has been the direction of the Indian Health Service program, that the Indian people might one day be self-sufficient in health matters. But today we see the evolutionary period in danger of being compressed into the space of 1 or 2 years, leaving the Indian people without moded facilities, inadequate equipment, insufficient staff and budget, and unable to recruit and retain professional staff. It is simply unrealistic to expect such programs to succeed when they are without additional substantial support on their own. The danger in service disruption in medical care to Indian people includes health disaster for the Indian communities themselves, a rising infectious disease risk to Indian and non-Indian alike, the virtual inundation of the private practioners in the area which are already in critically short supply.

South Dakota, for example, has one of the lowest physician to patient ratios, and serious drain on the State resources as well as the ever-present risk of violent confrontations if essential services are denied.

Thus it seems to me imperative that a fresh and objective look be taken now that the health care needs of the Indian people and at what is necessary to insure the continued effectiveness of the Indian Health Service.

Central to the problems for the Indian Health Service in recruiting and retaining health professionals is the issues of progressive and well-supported clinical programs. There is a tremendous job to be done in the Indian Health Service, and the professional and personal rewards are great. Given adequate hospitals and clinics, sufficient staff to do the job without undue hardship, and a budget commensurate with the documented need, and additional personal and professional incentives, it is my personal opinion that adequate numbers of health professionals can indeed be recruited to continue and expand the work of the Indian Health Service.

To reverse the unfavorable trends of the past few years, as described above, substantially a divisional resources are necessary. However, it is possible, with sufficient resources for the Indian Health Service to provide a model system for health care delivery. This experience would be particularly applicable to the health needs of minority groups, to populations in rural areas, and to the development of comprehensive health care delivery systems. A corps of competent health professionals in Federal service, experienced in these areas would be considered a national asset, in my opinion, in coping with the future problems associated with national health insurance, international health problems, as well as the continuing problems in health care delivery to rural population, minority groups and in developing comprehensive health care systems.

Suggestions of areas for legislative effort that might be of help in furthering Indian Health Service programs include the following:

Financial support for health education in return for a period of obligated services with particular focus for people of Indian descent. There are such programs in existence today. An assessment of the true needs of the Indian Health Service in modernizing, in correcting the deficiencies in its direct health care program.

Personal and professional incentives that might be of help include the military pay bonus bill, provision of adequate funds for postgraduate education and continuing medical education.

A reassessment of staffing needs, construction funds and contract care funds.

A consideration to the promotion of more flexibility for the Indian Health Service in meeting the needs of individual communities. For example, the development of academic affiliations with university medical sisters, the development of a referral house.

The development of prepared health care contracts with private groups; a bill for Indian Health Service to collect and utilize locally existing third party payment mechanisms for which the Indian people are eligible.

Legislation which assists the Indian people themselves in developing their own administrative organizations, in permitting their own community and economic development.

Authority to develop the concept of integrated health facilities where specifically requested by a tribal organization, along with adequate protection for their continued quality of health care to the Indian people themselves.

Finally, I would like to reemphasize Dr. Rhoades point, that the most effective and lasting solutions to problems of all types faced by the Indian communities will and must come from the Indian people themselves. Economic, administrative, and political strength of the Indian people will certainly lead to more adequate association and medical programs in the future. However, central to creating the climate in which such development can and will take place in the provision of sound educational and health care programs now to the Indian youth of this country. Now, I would like to review some of the health care statistics from the Rosebud Service unit to give an individual illustration of the scope of the problem and the magnitude of the resources necessary for an individual service unit, with particular reference to this as an example from the Aberdeen area.

Senator ABOUREZK. I wonder if I could interrupt and ask a question that has just occurred to me. In your view—and if you feel you don't want to answer this, please feel free to say so—but what is the obstacle in the way of adequate funding for the Indian Health Service? Is it the Office of Management and Budget? Is it the Congress? The Indian Health Service itself? What do you see as the obstacle itself?

Dr. ALLEN. I think all of those are true but take place on different levels. The ability of the Indian Health Service to collect documentary evidence of the need over the past 5 to 10 years has suffered. It has been virtually nonexistent until the recent development of computer systems.

Senator ABOUREZK. Is it lack of money?

Dr. ALLEN. Lack of money and lack of resources. In this whole nation we have been very late in developing comprehensive analysis of community problems in terms of health care. It is a relatively recent development in health care systems.

So it is only in the last few years that the Indian Health Service has developed the documented statistics, the evidence, of the substantial health care problems that do exist.

The Congress has annually, usually, voted more funds than the administration has requested, and yet even those funds fall far short

of the needs of the Indian communities and the Indian people. Once the funds are appropriated, our experience last year and our anticipated experience this year is that some of the funds appropriated by the Congress might not be spent, might not be utilized. Perhaps not until later, they make them so late in the year as to be virtually useless for developing any meaningful program.

Does that answer your question?

Senator ABOUREZK. Yes, I believe it does. In essence what you are saying, is even if Congress tried to appropriate more money, which we have not really taken the lead in, but it would not be spent if you did get it?

Dr. ALLEN. No, I don't mean to say that. This was the experience last year. Congress voted some $10 million over and above the appropriations requested, but this was not done until later in the year. I believe it was May or June that these funds were released.

At that late stage of the game, particularly for personnel, they are absolutely useless.

I don't know this from personal experience, but from hearsay, for example, I can relate the information that in the entire history of the Indian Health Service, there have been only two hospitals that have been funded through normal channels. We have dozens of hospitals in need of replacement throughout the Indian Health Service, one in Rosebud.

What good does it do to be No. 1 on the list or No. 10 on the list if none of them are going to be funded. The history of the Indian Health Service receiving funds through normal channels consists of just two hospitals. One hospital burned and had to be replaced. It took 12 years from inception through actual construction.

The majority of the new hospitals that have been achieved through the Indian Health Service have come through a special appropriation and as a result of a special bill, and this is an example, that it reflects the inability somehow of obtaining the appropriations that are legitimately needed.

May I go ahead on the review?

Senator ABOUREZK. Please do. I am sorry I interrupted you. I will just move in and out of here as we get a call for a vote. But I do want to emphasize that this in no way minimizes the importance of your testimony to the committee.

Dr. ALLEN. I have submitted this document to the subcommittee separately. My first page of information is a summary of the surgically treated health problems that have been identified at the Rosebud service unit over the past 5 months.

The identifiable backlog which includes cases diagnosed by the physician, surgery has been advised but deferred as of November 9, 1973, and include: Biliary tract 99, chronic otitis media, 33; voluntary sterilization, 23; hernia, 15, other, 52 for a total of 222.

The unidentified backlog, estimated from known incidence, population at risk, and corrected for those cases identified and who have received surgery are: Biliary tract, 445; chronic otitis media, 113; total 558.

The maintenance surgical load, based on birth rate, incidence figures, and the annual experience of the unit, is: Biliary tract, 60; chronic otitis media, 20; emergencies, 100; other, 70; for a total of 250 cases per year.

Now I would like to give a brief summary of the population served by the Rosebud Service Community.

The land area of the reservation proper is 5,500 square miles. The official base population, Indian only, 6,700.

Actual charts of record, 18,800. Active charts estimated, 11,000. Number of individuals seen in fiscal year 1973 was 7,000.

Thus I conclude with the population served, and these can only be estimated, for comprehensive medical care, Indians on the reservation, 7,500 individuals.

Indians off the reservation, 1,500.

Or a total of 9,000 individuals for comprehensive medical care.

For intermittent emergency care, Indians off reservation, 1,500. Non-Indians on and off the reservation, approximately 500. A total of 2,000 individuals. And thus arriving at the total active charts of 11,000.

Now some socioeconomic data.

Reservation Indian only: The median age is 15.6 years.

Our population is young, the male/female ratio is approximately equal.

The unemployment rate of the available labor force seeking employment approximates 20 percent.

The annual per capita income from all sources is $760 per individual.

The average family size is 4.7 individuals.

The percentage of households with telephones is 10 percent.

The percentage of households with access to a car is 66 percent.

The health care resources available to the people living in the Rosebud area include the following:

The U.S. Public Health Service Indian Hospital at Rosebud, total bed space, 46.

Staff physicians, 82, including 6 medical doctors and 41 medical nursing positions.

The total budget for fiscal year 1973 and the same for 1974, the only difference being some mandatory increases.

The total for hospital health, contract care, and field medical services, is approximately $1,420,000.

The doctor/patient ratio is 1/2000, approximately.

The health care costs per capita per year is less than $150.

The private sources of medical sources in the area include the following: Within a 50-mile radius of the Rosebud community, in Winner, S. Dak., there is a 35-bed hospital with one general practitioner, and one surgeon.

In Valentine, Nebr., there are three general practitioners, one surgeon, and one pediatrician, and a new developing county hospital.

In Martin, S. Dak., there are two general practitioners, and a 20-bed hospital.

The non-Indian population served is estimated at 11,000 individuals.

Referral sources of medical care to the Rosebud community include the following:

A community hospital with specialists at Rapid City, S. Dak., 185 miles distant.

A community hospital with no specialists at Pierre, S. Dak., 110 miles.

A medical center at Sioux Falls, S. Dak., 285 miles distant.

The University Medical Center with all specialists represented, 558 miles distance, in Minneapolis, Minn.

A University Medical Center, the same facilities, in Omaha, Nebr., 380 miles, and Denver, Colo., 442 miles.

There are Veterans' Administration hospitals at Hot Springs, S. Dak., and at Sioux Falls, S. Dak.

I made the best estimate possible of the sources of funding available to the Indian people. No accurate statistics that I am aware of exist, and I made the best attempt at approximating these figures that I could.

Veterans, it is estimated that 5 percent of the population have Veterans' Administration benefits.

Individuals who have an adequate income to afford all of their medical care are estimated to be 1 percent of the population.

Individuals who have health care insurance as a job-related benefit, comprehensive health care insurance, are estimated to be 3 percent of the population.

Individuals who qualify for medical benefits under the medicare legislation, are estimated to be 15 percent of the population.

Individuals who qualify or who are currently on aid to the disabled or welfare benefits, include about 15 percent of the population.

Sixty-one percent of the population are estimated to be entirely dependent on the Indian Health Service alone for all of their medical care.

In addition, the individuals who have other benefits from the above distant figures described and the availability of private medical care in the area, then it becomes apparent that the Rosebud facility is relatively isolated and even though an individual has Veterans' benefits, he still must and does seek medical attention from the local facility at Rosebud.

At present the Indian Health Service is unable to collect compensation for services rendered to people who have insurance or benefits under another program.

Next, I would like to describe a few of the health services represented at the hospital at Rosebud.

Under mental health, alcoholism, 22 percent of the population. The death rate, from trauma, 22 percent of the deaths, which is four times the national average. The suicide rate, both attempts and death are three times the national average.

Infectious diseases. Hearing deficits in schoolchildren, 30 percent, hearing orders which have been inadequately treated in the past.

The death rate from tuberculosis, 14.9 per 100,000 per year.

The incidence of otitis media, 40 times the national average.

The incidence of hepatitis eight times the national average.

Cases of hepatitis in the past year, an estimated 60.

Cases of TB in the past 6 months, an estimated 40, active cases, and including 2 deaths.

One hundred and fifty cases of dysentery, and at least two deaths of infants.

Medical surgical problems. We have a known incidence of diabetes, known, 30 percent of the population over the age of 20, and a known incidence of gallstones, 30 percent of the population over 20. Our birth rate is two times the national average.

These are meant simply to be examples. They are not meant to be comprehensive. But I think they do substantiate a contention that

the Indian people living in the Rosebud community have substantial unmet health needs.

In terms of the unmet need for the Rosebud facility alone and this again is used as an example of the type of resources required by Indian Health Service alone, in the short term renovations to the existing hospital, to permit efficient use of the personnel, and to cope with the current workload, $250,000.

Additional equipment and building space, $250,000.

An increase in the budget by 40 percent, annually.

On the long term, to replace the existing hospital, an estimated $7,500,000, for replacement with a new 66-bed hospital for the Rosebud community which is based upon the existing guidelines and personnel and equipment and physical plant of the Public Health Service itself, and increase in budget and staff for our current workload, $2,500,000.

This 66-bed hospital, staffed by 22 physicians and 85 nurses, with a cost of approximately $8 million for the building alone, and an annual budget of $2½ million a year.

This contrasts with our existing 46-bed hospital, our 6 medical officers, and our 41 nursing positions.

Indeed, I have with me a handwritten analysis of the physical plant at Rosebud by a State Health Department officer which documents that the Rosebud hospital, if it had to comply with existing State legislation and requirements for safety and for adequacy of the health care facility, the existing Rosebud hospital would not receive approval from the State Health Department in Pierre.

In addition, I think the subcommittee has this document prepared by the Aberdeen Area Office, entitled "A Report on the Funding and Staffing of The Aberdeen Area Office of the Indian Health Service," dated October 1973.

In this the disease experiences, the needs on an areawide basis for personnel, for funding, and in particular the development of the needs of an area referral center are all documented.

Finally, I would like to include some operational statistics from the Rosebud hospital itself.

Outpatient visits in fiscal year 1963 totaled 14,000. In fiscal year 1967, 21,000. In fiscal year 1973, 36,000.

Admissions for those same years were 1,800; 1,500; and 2,500.

Inpatient days, for each year, 14,000; 12,000; and 12,000.

Average daily patient load, 37.9; 33; and 33.

Operations in the operating room for those respective years were 70; 30; and 310.

The obstetric deliveries were 186; 169; and 207.

The percent of deliveries in the hospital, for those respective years, were 85 percent; 95 percent; and 99 percent.

The respective figures for prenatal care were, for mothers to be obtaining prenatal care, 60 percent; 70 percent; and 90 percent.

Now a little bit of interpretation of those figures is necessary. The marked increase, the actual tripling in a decade for total outpatient visits from 14,000 to 36,000 reflects the acceptance of the Indian people or of the health care service available to them.

The relatively stable number of admissions in inpatient days represents the limitations of the physical plant.

The increase in the average daily patient load and the increase in the number of patients admitted is simply impossible due to bedspace limitations. However, we have cut down on the average length of stay. So we have an increase in the total number of admissions. The increase in the percent of deliveries occurring in the hospital and the number of people seeking prenatal care simply reflects again the acceptance of the Indian people of the health care available to them.

Our most recent workload figures which are for the month of October 1973, on the projected annual basis, include a total of 36,000 outpatient daily visits; 2,700 admissions; 13,000 inpatient days; average daily patient load 36; and 204 deliveries.

This is a bit hazardous projecting as 1 month's experience for the year, but the trend of the first 3 months is on this order of magnitude.

Now, finally, I would like to give two representative case histories, and I will cite one anecdote that helps to gain some understanding of the type of problems I am trying to portray.

First is the case of a 10-year-old girl who was first brought for attention for an earache, at about age 6 months. Over the next several years there were repeated notes on the chart, documenting recurrent otitis media. Annually there are consultation reports on the chart from a specialist in ear, nose and throat.

In the first year, he suggested early treatment with penicillin and decongestants for middle ear disease.

In the second consultation, he recommended a tonsillectomy and adenoidectomy.

In the third consultation, he again recommends a tonsillectomy and adenoidectomy, and furthermore predicts on the chart that unless it is done there is a high risk of recurrent loss of hearing.

The next consultation documents, perforation in the eardrum which is chronic and which is draining. And this same notation is developed over several years with a final consultation which states nothing can be done. The child has a permanent and disabling loss of hearing.

Following each consultant's note in the chart is a note by the Indian Health Service physician which states: "Recommended treatment cannot be provided due to limitations of funds."

A second case history. A 57-year-old woman presented to me this past year with jaundice. There was documentation on the record 8 years ago that she had gallstones. In 1968, there was a note on the chart that the woman was requesting treatment for her gallstones, which at that time was recommended to be an operation to remove the gallbladder, and it was specifically noted on the chart that it was impossible to provide this service because funds were not available.

This notice repeated at several intervals of about a year. When I saw her, she was jaundiced and I performed an operation on her, and found that she had inoperable, incurable carcinoma of the gallbladder which I presumed to be a result of chronic gallstones not treated.

She died about 3 months later.

The anecdote. There is an individual on the Rosebud Reservation whose name is Henry Crow, and one day he was talking to me about medical care. He said, I know when somebody has a sore throat and you give a shot of penicillin, I know that is good medicine. I knew they get better. But, he said, that medicine is not waukon. Waukon is the

Dakota word for mysterious or holy. He says, if you doctors will get together with some of the people like myself, the old traditional medicine men, and if we perform the proper service, he said that penicillin, the medicine that you give, will be waukon. And it would be more than good; it would be holy; much more powerful.

Now, in short, I think there was a message there. The problems of delivering health care to the Indian people, their own sensibilities, their own wishes, their own traditional framework, I think is something that has to be respected.

The experience of the Indian Health Service, I think, gives us an opportunity to respect some of these wishes.

It is easy to think of what the university doctor or the very busy private practitioner, what his reaction would be to this man's suggestion.

Thank you.

[The additional material referred to in Dr. Allen's statement follows:]

PROGRAM PACKAGE, ROSEBUD—FISCAL YEAR 1974

I. INTRODUCTION

Substantial additional input of resources for health care in the Aberdeen Area generally and at Rosebud in particular are considered necessary both immediately and in the future if the Indian Health Service is to approach meeting the real needs of the Indian people.

The Rosebud Service Unit provides comprehensive health care to a population estimated at 10,000 (6,500 officially). This population has a median age of 15 years. The morbidity and mortality rates are much higher than for non-Indian populations. The unemployment rate is 20% of the available labor force; and the annual per capita income is $760.00. The people live in widely scattered small rural communities over an area of 20,000 square miles. Over 50% of households have electricity, indoor plumbing, and television. Two-thirds of the people have access to a car. Less than 10% have telephones. The doctor to patient ratio at current staffing is 1:2000.

A recent proposal for a new hospital for Rosebud based on Indian Health Service guidelines and the current workload calls for 66 (52) beds, a physician staff of 12 (6), and a nursing staff of 85 (41). Using this year's budget figures, the annual expenditure for comprehensive medical care is $140.00 ($215.00 for base population) per capita. By comparison, the Health Maintenance Organization guidelines call for an annual expenditure of $300.00 per capita for less comprehensive services for a healthier population.

Based on current staffing and workload the *average* workload per general duty physician includes: 2.6 admissions, 35 outpatient visits, the care of 9 inpatients, reading 11 x-ray studies, and performing 0.26 obstetric deliveries per day. Night call averages 2 shifts per week, (32 hours on duty). In addition, there are case summaries, referrals, correspondence, teaching, preventive medicine, and public health programs, administrative duties, and committee meetings. Most of our physicians and nurses are just out of internship and nursing school and are ill prepared to cope with this quantity and breadth of responsibilities.

The complexity of medical problems receiving *all* of their care successfully at Rosebud in the past year includes: gunshot wound of the heart, diabetic acidosis, traumatic pancreatitis requiring pseudocyst decompression and hyper alimentation for 3 months, crushed chest requiring 2 weeks of controlled ventilation, severe pre-eclampsia with premature labor and fetal distress, diverticulitis with perforated colon and peritonitis. It is *not unusual* for the physician on call to care for a heart attack, 2 fractures, 2 cases of pneumonia, 2 obstetric deliveries, and 20 emergency outpatients *all in one night* on call. About once a month the staff is faced with a real disaster: 4–12 people with multiple injuries from a single automobile accident.

The workloads on the nursing, laboratory, x-ray, medical records, and other supportive departments are comparable.

Because of limited resources, physicians must deny needed medical and surgical thereapy to individuals daily. The usual euphemism recorded in hundreds of

charts reads: "Procedure advised but postponed for lack of funds." Our surgical backlog list contains 150 cases accumulated in just four months. There are an estimated 800 people who would benefit from surgery at the present time.

We have been referring cases on a "life or limb threatening" basis only in the past six months. There are a dozen amputees and paraplegics in need of prosthetics and rehabilitation services for over a year. Our own surgical program has been fully operative for just 8 months in the past two years and has been inoperative for the past six months. It is a routine necessity that physicians and nurses must compromise on workups, diagnostic evaluations, hospital care, and referrals because of inadequate bed space, staffing, and funding. We have had no Field Health physicians for two years. We are now facing an epidemic of hepatitis, dysentary, and tuberculosis.

The sick respond in large numbers when staff and resources are relatively abundant. They simply suffer at home when supplies are short. Thus our workload figures have always reflected our capacity to deliver *not* the true community needs. Staff illness, vacation times, and the end of the year budget crunch are usually reflected in the statistical reports.

Last year an emergency request for additional support of the surgical program at Rosebud was granted by Headquarters. The requests at that time were very modest—the real needs were not revealed since the requests were held to a bare minimum before presentation to Headquarters. Projects funded at that time that to this date have not been fully realized include: the ICU, the CCU, the surgical clinic, funding to pay for the additional positions, and the consultation funds. Nonetheless, 310 surgical procedures were done at Rosebud in FY 1973 and we operated on a relatively limited contract care budget. During this same period of time workload figures other than surgery increased about 25% over the previous year! Needless to say, the nurses accumulated hundreds of hours in overtime, there were 8 beds in the hall routinely, and all hospital services were grossly overtaxed. The staff has determined that such efforts are impossible on a sustained basis. It is not surprising that our nuring staff turnover this Spring was 75%, that we lose 100% of physicians completing service obligations, and that we have lost critical personnel in x-ray, lab, and other departments. It seems reasonable to anticipate difficulty in the recruitment of physicians for these working conditions without the threat of the draft.

It is fair to conclude that funding, staffing, and the physical plant at Rosebud are not and never have been adequate to meet the real needs of the people. The gap between promise and delivery is grossly out of balance in spite of the real and admirable accomplishments of the Indian Health Service.

The situation at Rosebud is considered representative of the conditions in the Aberdeen Area generally. It is simply *not possible* to control contract care expenditures until the Service Units are in a position to deliver the needed services themselves. To do so is to *deny* access to needed medical care.

It is not the place for this document to advise Headquarters on how to allocate their limited resources or on administrative policy. The questions as to contract versus inservice care, the need for an Area referral center, the very future of the Indian Health Service, the development of HMO organizations, medical school affiliations, residency credit for Indian Health Service physicians, the bonus pay bill, etc., are beyond the scope and influence of this discussion.

The intent of this proposal then is to indicate the magnitude of the problem, to quantitate the additional resources needed to safely continue the current workload on a sustained basis, and to suggest courses of action for the future. Should the necessary resources be unavailable, it is simply necessary to restrict services further and where possible, seek alternatives.

II. AREA PROBLEMS

The Aberdeen Area is now facing the worst health care crisis in its history. The loss of the "Doctor Draft" is the precipitating factor. Aberdeen has been less successful than other Areas in recruiting and retaining health professionals. Major program deficiencies are thought to be responsible and include:

1. Outdated and inadequate physical plants.
2. Funding insufficient for pressing clinical needs.
3. Staffing patterns that necessitate excessive workloads and poor or unsafe clinical care.
4. Lack of an Area Referral Center.
5. Lack of academic affiliations.
6. Inability to solve real and pressing problems due to limited personnel and funds with a "crisis care" only approach.

7. The political impact on Federal Health Care Delivery programs.
8. Urgent need for an identified physician recruitment program in the Aberdeen Area.

III. PREMISES FOR DISCUSSION

All Service Units in the Aberdeen Area are in serious trouble. In discussing solutions to their problems, it is assumed that the Federal government is recognized as being responsible for making health care available to the Indian people; that in remote areas it is preferable to provide as much definitive care locally as feasible; that for the retention of health professionals it is necessary to have a progressive clinical program; and that the appropriations of Congress and the policy of the Administration place real limits on what can be accomplished.

IV. EXAMPLE SERVICE UNIT

The Rosebud Service Unit has been selected as the example for indepth discussion because:

1. The staff has prepared this proposal for consideration.
2. There is a Tribal Health Planning Committee in existence that supports this proposal.
3. The medical staff is *unwilling* to continue to work under the existing conditions.

V. SUMMARY: ROSEBUD

Since 1971 the workload at Rosebud has increased steadily (Table I). In Fiscal Year 1972 a surgical program was started with inadequate support. Funding and staffing since 1971 have not been adequate to correct pre-existing deficiencies *or* to keep pace with the increased workloads (Table II). The physical plant is outmoded and represents the current final limiting factor in the delivery of services (Table III). In the past year personnel turnover has been excessive. The surgical program has been fully operative for less than 8 months in the past 2 years. At current levels of support, services *must* be curtailed and the surgery program *must* be terminated (Table IV).

VI. PROPOSED INTERIM (3 YEAR) SOLUTIONS—ROSEBUD

In order to maintain services at the level of Fiscal Year 1973, to facilitate the retention and recruitment of staff, and to provide a smooth transition to the proposed new facility in Fiscal Year 1977, the medical staff has developed an interim (3 year) proposal (Table V) which includes:

	Increase over budgeted fiscal year 1974	Total requested annually
1. Increased contract care funds	$30,000	$300,000
2. Increased hospital health care funds (includes funding for 33 additional positions and recurring equipment funding)	505,000	1,541,000
3. Equipment funding, fiscal year 1974 only	50 000	
4. Alterations in the physical plant, fiscal year 1974 only	466,000	
5. Field medical services (add 2 positions and funding allocated positions)	54,000	126,000
6. Academic affiliations, medical student and consultant level	30,000	30,000
7. Fexibility in working with local consultants and private practitioners in the area. Full coordination of development plans with private vendors	[1]	
Total additional dollar cost, fiscal year 1974	1,135,000	
Nonrecurring cost, fiscal year 1974	516,000	
Recurring (annually) cost	619,000	

[1] $16,000 costs figured in consultant funds.

VII. LONG RANGE PROGRAM—ROSEBUD (10 YEARS)

A Health Planning Committee was formed this year at Rosebud by the current Tribal administration to examine the health care needs and resources in the area and to make recommendations. This committee is now looking at the feasibility of an integrated health facility under Tribal administration utilizing the combined resources of the Indian Health Service, the State Health Department, private hospitals and practitioners, and local collection and use of private and third party fees. Whether or not these ideas are realized, immediate planning and commitment to long range plans are vitally necessary for the Indian Health

Service if the health needs at Rosebud are to be met over the next decade. For consideration are:

1. A new 66-bed acute care general hospital occupancy scheduled for Fiscal Year 1977—$7,500,000.

2. A convalescent center (conversion of present hospital) containing: a child day care center, 40-bed nursing home, a physical therapy unit, an alcoholism treatment center with detoxification unit (10-bed) and mental health offices. This facility could be developed and administered by the Tribe. Occupancy FY 1977.

3. Integration of the Service Unit into a health care center for *all* residents of the Rosebud area over a five-year period.

4. Gradual assumption of Tribal administrative control.

5. Academic affiliations at the Family Practice Residency level by FY 1978. Immediate consultation with State officials concerning a cooperative program for the development of a 4-year medical school is advisable in this regard.

6. Community Development by Tribe: Housing, own or rent; recreational.

VIII. ABERDEEN AREAWIDE PROPOSALS

Each community and reservation must be individually evaluated as to its own resources and need to equalize capacity to deliver health care throughout the Indian Health Service. An Area-wide plan should be developed to make appropriate changes to conserve and to efficiently utilize limited resources with consideration of the following:

1. Prepaid capitation contracts with private vendors.

2. Modern and adequately supported Indian Health Service facilities.

3. Area-wide Indian Health Service Referral Center.

4. Affiliations with existing or developing medical schools, residency programs, medical centers, and other Federal hospitals (e.g., Veterans Administration).

5. Development of Tribal administrative responsibilities.

6. Organized program for recruiting and retaining health professionals.

IX. STATEMENTS OF SUPPORT

These proposals have the support of the Rosebud Tribal Council, the Rosebud Health Planning Committee, the Rosebud medical staff, the South Dakota State Health Department, the private practitioners in the Rosebud area, and the Aberdeen Area office.

X. SECONDARY BENEFITS

Secondary benefits of these proposals would accrue to the local economy, to the State, to health care delivery in rural areas, to the development of a four-year medical school in South Dakota, the medical school in North Dakota, and to the education of Indian people in the health care field.

XI. SUMMARY AND CONCLUSIONS

The loss of the Selective Service obligation as an incentive to recruiting physicians to the Indian Health Service has precipitated a major health care crisis in the Aberdeen Area. Because of chronic program deficiencies this Area is unable to continue to meet its responsibilities to the Indian people without massive input immediately and over the next few years. A progressive clinical program is recognized as being the major factor necessary for the recruitment and retention of health professionals. The Rosebud Service Unit has been discussed in detail as to immediate and long-term needs as an example of the type and amount of resources deemed necessary. Academic affiliations, integrated health care systems, prepaid contracts with private sources, and Tribal administrative control all should be considered where and when appropriate. An Area Referral Center affiliated with a medical school or other suitable institution should be considered.

The Indian Health Service must have the flexibility to develop and utilize a variety of resources. Coordination of Indian Health Service efforts, with State and private planning, offers advantages of efficiency and conservation of resources.

Should the support leveles indicated not be available or considered inadvisable within Indian Health Service, the alternatives must be considered and include: greater reliance on private vendors, stationing selected Indian Health Service Personnel in private hospitals, more comprehensive contracts on a capitation

basis and shifting responsibilities to other Federal systems or to private institutions. Problems that would be encountered in implementing these alternatives include massive increase in contract care costs and the very limited capabilities of local private vendors.

The increased awareness of the Indian people as to their own health needs, the increased economic and political power of Tribal organizations, and the increased emphasis on treaty obligations together with militant activity combine with a demonstrably long neglected need and demand for services to make bold and imaginative effort in the management of Indian Health Service mandatory at this time and in this Area.

TABLE I.—WORK LOAD, ROSEBUD

	Fiscal year—		
	1971	1972	1973
OPD visits	36,000	34,000	36,000
Admissions	1,483	1,991	2,551
Inpatient days	8,460	10,543	11,947
ADPL	23.9	28.8	32.7
Operations (O. R.)	137	215	310

TABLE II.—FUNDING AND STAFFING, ROSEBUD

	Fiscal year—			
	1971	1972	1973	1974 (tentative)
Hospital health	$748,148	$1,013,117	$1,039,698	$1,034,963
Contract care	$202,785	$168,412	$201,623	$270,000
Field health	$73,521	$88,176	$90,495	$72,033
Hospital staff	65	72	82	82
Field health staff	6	7	7	5
General duty medical doctors	5	5	5	4

TABLE III.—PHYSICAL PLANT, ROSEBUD

	Current facility	Current alterations	Proposed alterations
Total beds	46	46	49
Adult	22	22	31
M & S	22	17	26
ICU	0	4	4
CCU	0	1	1
Obstetric	6	6	6
Pediatric	18	18	12
OPD exam room	5	6	11

Inadequacies alleviated by proposed alterations:

1. Insufficient Clinic Exam Rooms
2. Nonexistent Doctor's Office and Workrooms
3. Nonexistent OPD space for Paramedical Personnel
4. Insufficient Inpatient adult beds
5. Crowded Administrative Offices
6. Inadequate lab work and storage space
7. No physically separate OB—Newborn Wing
8. Cramped and outmoded Dental Unit

TABLE IV—SERVICES IMPOSSIBLE TO PROVIDE AT CURRENT BUDGET AND STAFF

I. Personnel Losses

2 Medical Doctors;
1 Administrative Officer;
2 Nursing Positions; and
10% lapse rate all positions

II. Eliminate or Curtail
Professional meetings, M.D.'s
Training Courses, Nursing
Consultants—Pathology, Orthopedic, Surgery, Radiology, Anesthesia
Medical Student, Medex, Trainees
Sinte Gleska Nursing Training
Training for Ambulance Drivers; CHR's; Tribal Health Board; Sinte Gleska lectures
III. Service Cutbacks
Limit Diagnostic Studies
Terminate Surgery Program
Restrict Inpatient load to ADPL/25 (from 33).
Restrict OPD Load to/30,000 (from 36,000).
Contract Services—Life or Limb threatening only
IV. Procedural
No effort at Accreditation
Eliminate Committees—Tissue Infection, Space Utilization, Equipment Needs
Curtail Program Planning

TABLE V.—INTERIM (3-YEAR) PROPOSAL

Recurring costs	Increase over fiscal year 1974 budgeted	Total requested annually
Contract care funds (assumed full surgical program)	$30,000	$300,000
Hospital health funds (includes 31 additional positions, funding to fill current positions, recurring equipment needs)	505,000	1,541,000
Field M.S. (2 positions and funding present positions)	54,000	126,000

Nonrecurring costs—fiscal year 1974 only

	Cost
Equipment needs (see appendix IV)	$50,000
Alterations in physical plant:	
Dental unit (old unit outmoded; new unit can be relocated with new hospital)	157,000
OPD	17,760
Adult beds	30,200
Prenatal clinic; well baby clinic	40,478
Administrative	26,013
Doctor's office, library, X-ray reading, medical records dictating	12,740
Supply unit	30,000
Field health unit	36,000
Other (OB wing, ward clerks, X-ray, lab. office, DOW office, EKG, dietician etc.) medical records	115,809
Total	466,000

Procedural—Academic Affiliations
Medical student: 2 students—3 or 4 year; 3 mo. rotations X 3. 4 students—second year USD; 3 mo. rotations X 1.
Cost: $30,000.
Consultants: Radiology, Pathology, Anesthesia, Orthopedics, Opthalmology.
Cost: (included in hospital health) $16,000.
Flexibility in working with.—Provided in contract care and consultation funds:
Local consultant.
Local hospitals: LCM Baptist, Winner; Cherry County, Valentine; Bennett-Clarkson; Sioux Falls V.A. (PM & R).
Tribal health planning: HMO; Integrated Services; Area Referral Center.
Total costs:

Recurring	$619,000
Nonrecurring	516,000
Total fiscal year 1974	1,135,000

APPENDIX I

BUDGET HOSPITAL HEALTH—ROSEBUD

	Authorized but not funded	Additional funds needed over fiscal year 1974 budget	Total budget request 1974
Positions	5	31	113
11.00 Personnel compensation	$93,000	$297,000	$1,110,000
12.00 Personnel benefits	12,000	30,000	114,000
Total personal services	$432,000		1,224,000
21.4A and 21.41 Travel, training		16,000	16,000
21.51 and 21.5A Meeting travel		1,000	2,500
21.2M Temporary duty travel			1,000
21.2A Patient and escorts		500	1,500
21.2B Rent GSA vehicles			1,400
Total 2100 travel		17,500	22,400
22.21 Rental GSA trucks			1,000
22.90 Other transportation			250
Total 2200 transportation			1,250
23.11, 23.31, 23.43 Rentals		200	4,000
23.60 Communications—1000		3,000	19,000
23.70 Utilities		1,500	18,000
Total 2300 rent, communications, utilities		4,700	41,000
Total 24.10 Printing and reproduction		900	1,000
25.11 Reimbursement and advances (BIA)			3,500
25.40 Fee basis consultation		16,000	20,000
25.9Y Project contract (Amb.)			14,000
25.9L Laundry and towels		4,000	14,000
25.2C–25.2E Lab services		10,000	15,000
25.7 Repairs, alterations, maintenance		1,000	5,000
25.9Y Other contract services		2,000	11,000
Total 2500 other services		33,000	82,500
26.11–26.21 Drugs, medicine, vaccine		15,000	60,000
26.61–26.71 Subsistence		2,000	18,000
26.8H Fuel		3,000	19,000
26 Balance, miscellaneous supplies and materials		13,000	88,000
Total 2600 supplies and materials		33,000	185,000
31.20 7H Equipment (capital)		10,000	10,000
31.9 Equipment (noncapital)		5,000	5,000
Total 31.00 equipment		15,000	15,000
Subtotal hospital services		536,000	1,572,000
—2.5 percent lapse rate personnel		—31,000	—31,000
Current budget fiscal year 1974		1,035,000	
Total hospital services		1,541,000	1,541,000
Additional required fiscal year 1974		505,000	

APPENDIX II

Contract care details

Total utilized fiscal year 1973	$176,000
Total authorized fiscal year 1974	270,000
Total requested fiscal year 1974	300,000
Increase fiscal year 1974	30,000

Justification

At authorized funding levels life and limb threatening emergencies only can be referred. Rosebud has already required additional funding in Fiscal Year 1974 1st quarter of $35,000 over the original budgeted. The revised total for Fiscal Year 1974 is thus $270,000. The additional funds were obtained by transferring $100,000 from the Winnebago account and $10,000 add-on for the ambulance.

In order to permit elective contract care such as PM&R, prosthetics, and other specialty care, an additional $30,000 is requested: These figures assume full operation of the surgery program locally; without this, an additional $500,000 for the anticipated surgical load would be required.

Possible sources: Headquarters allocation; reassignment from within Area if facilities terminated; reassignment locally if indicated.

Services contracted.

APPENDIX III: PERSONNEL REQUESTS, TOTAL POSITIONS, 33

Position	Quantity	Grade level	Salary	Benefits
Lab technician	1	GS-5	$7,694	$769
Supply clerk	1	3	6,128	613
Medex	3	7	9,508	951
Janitor	1	WO-3	6,947	695
Medical records librarian	1	9	11,614	1,161
Clerk n	1	4	6,882	688
Clerk	1	3	6,128	613
LPN	5	5	7,694	769
Clerk, nursing	2	3	6,128	613
Nurse, RN	3	7	9,508	951
Supervising tech X-ray	1	7	9,508	951
Clerk X-ray and EKG	1	3	6,128	613
Telephone operators	2	3	6,128	613
Dietitian (or cook)	1	11	13,996	1,400
Maintenance assistant	1	WO-3	6,947	695
Maintenance, electrician	1	7	9,508	951
Housekeeping	1	3	6,128	613
Medical doctors:				
Internist	1	14	26,938	2,694
Pediatrician	1	14	26,938	2,694
GMO	1	13	19,700	1,970
Out of field health:				
PHN supervisor	1	11	13,996	1,400
LPN	1	5	7,694	769
Lab clerk	1	2	5,432	543
Total costs			319,000	32,000

APPENDIX IV

Equipment needs (fiscal year 1974 only):

Laboratory	$10,000
Monitors and defibrillators (ICU, ER, OR)	17,000
Clinical	23,000
Total	50,000

ITEMIZED LIST

1—Vitalor (Pulmonary function testing)
1—Multi Channel EKG Write-Out
2—Remote
1—4-Channel Non-Fade Scope
1—Bed Side Monitor Unit with Defibrillator
1—Physio Control Lifpak
1—Burdick EK5 EK6 Machine with Datajack
1—Ether Vaporizer #8 for Circle Absorber
2—Nasal Inhalers (Adult and Child)
1—Anesthesia Ventilating Attachment
1—Blood Gas Machine (Corning or IL)
1—Hypothermia Unit
1—Colonscope
1—Doppler Diagnostic Instrument
2—Constant Flow IV Monitors

1—Constant Flow Pump
2—Refrigerators (Reagent); Miscellaneous X-ray (Cassettes, Positioners)
3—Centrifuges; Miscellaneous Surgical Instruments; Miscellaneous Inhalation Therapy
1—Refrigerator (Blood Bank)
1—Fetal EKG Monitor (Doppler); Miscellaneous Clinical

SUMMARY: PROGRAM PACKAGE, ROSEBUD, FISCAL YEAR 1974

	Budgeted fiscal year 1974	Additional requested	Total budget fiscal year 1974 required
I. Recurring costs:			
A. Hospital health:			
Positions	82	31	113
Personal services	$720,000	$390,000	$1,110,000
Pers. benefits	72,000	42,000	114,000
Travel and transportation	6,000	18,000	24,000
Comm. and utilities	36,000	5,000	41,000
Other services	50,000	34,000	84,000
Supplies	152,000	33,000	185,000
Equipment		15,000	15,000
Total, hospital health	1,036,000	505,000	1,541,000
B. Field medical services: Budget	[1] 72,000	[2] 54,000	[3] 126,000
C. Medical students		30,000	30,000
D. Contract cost	270,000	30,000	300,000
Subtotal recurring costs	1,378,000	619,000	1,992,000
II. Nonrecurring costs:			
A. Equipment	50,000		
B. Outbuildings:			
Dental unit	157,000		
Field health office	36,000		
Supply building	25,000		
C. Alterations hospital	248,000		
Subtotal nonrecurring costs	516,000		
III. Total additional cost, fiscal year 1974	1,135,000		

[1] 6 positions.
[2] 2 positions.
[3] 8 positions.

Summary: Surgically treatable health problems, Rosebud, S. Dak.

Identified backlog

Cases diagnosed, surgery advised but deferred as of November 9, 1973:

Biliary tract	99
Chronic otitis media	33
Voluntary sterilization	23
Hernia	15
Other	52
Total	222

Unidentified backlog

Estimated from known incidence, population at risk, and corrected for those cases identified and who have received surgery:

Biliary tract	445
Chronic otitis media	113
Total	558

Maintenance surgical load

Based on birth rate, incidence figures, and the annual experience of the unit:

Biliary tract	60
Chronic otitis media	20
Emergencies	100
Other	70
Total (cases per year)	250

Summary: Population, Rosebud, S. Dak.

	Sq. Miles
Land area of reservation proper	5,500
Official base population (Indian only)	6,700
Actual charts of record	18,800
Active charts (estimated)	11,000
Number of individuals seen, fiscal year 1973	7,000
Population served (estimated)	
Comprehensive medical care:	
Indian on reservation	7,500
Indian off reservation	1,500
Total	9,000
Intermittent/emergency care:	
Indian off reservation	1,500
Non-Indian on and off reservation	500
Total	2,000
Total active charts	11,000
Socioeconomic data	
Reservation Indian only:	
Median age (years)	15.6
Male/female	1/1
Unemployment rate (of available labor force seeking employment, percent)	20
Annual per capital income (all sources)	$760
Average family size	4.7
Household with telephones, percent	10
Household with cars, percent	66

HEALTH CARE RESOURCES, ROSEBUD AREA

USPHS Indian Hospital, Rosebud

Bed spaces, total	46
Adult medical-surgical	17
Intensive care unit	4
Coronary care unit	1
Obstetrics	6
Pediatrics	18
Staff positions, total	82
Medical doctors	6
Nursing	41
Budget, fiscal year 1973, same 1974:	
Hospital health	$1,050,000
Contract care	300,000
Field medical services	70,000
Total	$1,420,000
Doctor/patient ratio, 1/1700:	
Health care costs per capita per year (including comprehensive health services, dental, drugs, mental health, preventive)	$150

Private sources

50 mile radius of Rosebud:
Winner, S.D., 1 GP, 1 Surgeon, 35 bed hospital.
Valentine, Neb., 3 GP, 1 Surgeon, 1 Ped., County Hospital.
Martin, S.D., 2 GP, 20 bed hospital.
Non-Indian Population Served: Estimated—11,000.

Referral sources

Rapid City, S.D., 185 miles, Community Hospital with specialists.
Pierre, S.D., 110 miles, Community Hospital with no specialists.
Sioux Falls, S.D., 285 miles, Medical Center.
Minneapolis, Minn., 558 miles, University Medical Center.
Omaha, Neb., 380 miles, University Medical Center.
Denver, Colo., 442 miles, University Medical Center.
Hot Springs, S.D., V.A. hospital.
Sioux Falls, S.D., V.A. hospital.

Sources of funding

Indian only—Estimated:	Percent
Veterans	5
Fee for service	1
Insurance	3
Medicare	15
Welfare/disabled	15
Indian health only	61

SELECTED HEALTH PROBLEMS, ROSEBUD, S. DAK.

Mental health

Alcoholims—22% of Population.
Death Rate, Trauma—22% of Deaths (4 times the National Average).
Suicide Rate—(3 times National Average).

Infectious disease

Hearing deficits in school children—30%.
Death rate TBC—14.9/100,000.
Incidence Otitis Media—40 times the National Average.
Hepatitis—8 times the National Average.
Cases of Hepatitis in past year—60 (Estimated).
Cases of Tb in past 6 months (Active)—40 (Estimated).
TB deaths in past 6 months—2 (Estimated); Recent figures give Rosebud highest incidence in Nation.
Dysentary Cases past 6 months—150 (Estimated).
Dysentery Deaths past 6 months—2 (Estimated).

Medical-surgical

Diabetes (Known)—30% of Population over 20.
Gallstones (Known)—30% of population over 20.
Birth Rate—2 times the National Average.

OPERATIONAL STATISTICS, ROSEBUD, S. DAK.

	Fiscal year—		
	1963	1967	1973
OPD visits	14,000	21,000	36,000
Admissions	1,800	1,500	2,500
Inpatient days	14,000	12,000	12,000
ADPL	37.9	33	33
Operations (OR)	70	30	310
OB deliveries	186	169	207
Deliveries in hospital (percent)	85	95	99
Prenatal care (percent)	60	70	90

WORKLOAD FIGURES, OCTOBER 1973

	Month	Projected annual
OPD visits	3,243	36,000
Admissions	222	2,700
Inpatient days	1,109	13,000
ADPL	35.8	36
Births	15	204

ESTIMATED NEED: ROSEBUD

Short term

Renovations existing hospital—$250,000.00.
Additional equipment, buildings—250,000.00.
Increase budget by 40%—600,000.00.

Long term

Replace existing hospital—$7,500,000.00.
Increase budget, staff—2,500,000.00.

Areawide problems—Aberdeen West

I refer you to the prepared document entitled "A Report on the Funding and Staffing of the Aberdeen Area Office Indian Health Service" dated October 1973, prepared by Indian Health Service, Aberdeen Area Office.

A REPORT ON THE FUNDING AND STAFFING OF THE ABERDEEN AREA OFFICE INDIAN HEALTH SERVICE

INTRODUCTION

PURPOSE OF REPORT

In the afternoon of October 24, 1973, the Area Director, Aberdeen Area Indian Health Service received a call from Mr. Robert Alvarez, Staff Assistant to Senator James Abourezk.

Mr. Alvarez requested that the Indian Health Service Area Office furnish Senator Abourezk with specific and detailed information regarding the Indian Health Service program in the Western Tier (South Dakota, North Dakota, and Nebraska). This information is to be used in hearings that Mr. Abourezk is planning to conduct in the near future.

He asked for a description of the various Indian Health Service programs and accomplishments, the cause and impact of the Aberdeen Area's current physician shortage, the projected outlook for physician staffing level next June, the present level of funding and staffing of each major program, the adequacy of this funding and staffing relative to the health needs of the reservations, the causes for these inadequacies which exist, and the measures presently being taken by the Area Office to solve some of these problems within existing funding.

As was requested, special emphasis is being given to those areas of difficulty which would confront any "Comprehensive Health Delivery System" operating on Indian reservations, regardless of the source of funding, and irrespective of management and administrative structure.

DESCRIPTION OF AREA AND POPULATION SERVED

There are forty-six Indian reservations and/or separate Indian groups in the Aberdeen Area.

The Indian Health Service, Aberdeen Area Office has within its jurisdiction approximately 67,815 Indian people (Estimate 7/1/72 - FY 73). About 46,448 of these live in the four states known as the Western Tier. Some 30,456 live in South Dakota; 12,355 in North Dakota; 2,995 along the northern border of Nebraska; and 642 in Iowa. There are eleven reservations and one large Indian community in the Dakotas; three reservations in Nebraska; and one settlement in Iowa. The Bemidji Sub-Area Office of

the Aberdeen Area has responsibility under the guidance of the Area Office for the health of the remaining 21,367 Indian people in the Great Lakes Region: Michigan, Wisconsin, and Minnesota.

Indian population density (1970 census) has one Indian individual per 5 square miles compared to 48.5 individuals per square mile for All Races of the Aberdeen Area seven states.

The total reservation land encompasses approximately 25,697 square miles, or 5.5% of the total land area 470,212 square miles in the Aberdeen Area seven states. Between extreme points the Aberdeen Area is approximately 1,075 miles east to west and 625 miles north to south.

DESCRIPTION OF INDIAN HEALTH SERVICE OPERATIONS

The health problem of the Indian people is directly affected by and related to their geography, socio-economic conditions, cultural beliefs and educational level. To meet the basic health needs of the Indian population the program has been designed to be responsive, flexible, and comprehensive and of both curative and preventive nature, each inter-relating and dependent upon the other. There is emphasis not only on treating and curing diseases, but also upon preventive medicine, environmental improvement, education, consultation as well as Indian involvement in solving the health problems.

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 component is responsible for field health services which includes field medical services, environmental health services, dental services, public health nursing services, health education, and mental health services. Community Health Representatives are funded under this program by contract with the tribal organizations.

There are 12 Service Units in the States of South Dakota, North Dakota, and Nebraska serving 15 Indian reservations. There are 14 Service Units serving 31 Indian reservations in Minnesota, Wisconsin, and Michigan.

Each of the health activities is described in greater detail in the section of this report entitled "Background Data and Supportive Information".

A SUMMARY

OF THE PROBLEM

Historically there have been annual funding increases in all major activities. Increases to most categories were intended to cover nothing more than mandatory increases (salary increases, etc.) and to a limited extent offset inflation. The few categories receiving sizeable program increases were the consumer oriented activities such as Public Law 86-121 Construction, and the Community Health Representative programs.

Unfortunately, the Patient Care Activities have not received comparable increases. The basic health programs of Direct Patient Care and Contract Health Services have been neglected, mainly because they are not popular "trend oriented" activities.

Even though there has been considerable health benefits from the expanded programs 1/, the imbalance of funding has resulted in an unbalanced comprehensive health program. Because there was no real increase in Office Services funding or staff, the Direct Patient Care activities had to compete more strongly for administrative services such as financial management, contracting and procurement, personnel services, and property and supply. Further aggravating this already undesirable situation was the lack of funds to maintain, repair, update, and replace deteriorating hospital buildings and equipment.

Because of Indian Health Service efforts to motivate the Indian people to seek better health care, there has been a continuous increase in hospital admissions and outpatient medical visits 2/. Although this is certainly a desirable result of health education activities, it has, along with outmoded facilities and equipment, placed an enormous burden on the physicians, nurses, laboratory and x-ray technicians and technologists, and other hospital employees. This is primarily because a commensurate increase in patient care personnel has never been authorized. Eighty hour weeks are now somewhat common among the physicians. Nurses and lab technicians are resigning because they have to work fifty and sixty hour weeks with no weekends. Kitchen personnel are complaining of long hours and low pay.

1/ Refer to the decrease in environmentally related diseases depicted in Exhibits D and E of the Appendix.

2/ Refer to the trends depicted in Exhibits B and C of the Appendix.

It will be noted in Exhibits B and C in the Appendix that contract medical care has not increased. Previous experience in the Aberdeen Area indicates that contract medical service costs roughly twice the amount that the same service costs when provided by the Indian Health Service. Contracts were used as a supplemental service only. There has been little pressure in the past to increase contract services. Thus, there is no funding cushion in this activity; therefore, the hospitals and clinics do not have the option of resorting to contracts to reduce workloads. In fact, the opposite is happening. Recent increases in contract service costs (See Exhibit A in the Appendix) have further restricted the buying power of these limited funds. The Indian Health Service hospitals and clinics now paradoxically find themselves in even greater demand.

Recent difficulties in retaining and recruiting physicians and health professionals will place even heavier workloads on remaining personnel if corrective measures are not taken immediately. Fuel shortages, drastic increases in charges by other governmental and private medical facilities, severe increases in cost of materials, equipment, supplies, and labor have now compounded this problem in a very short period of time.

If an attempt is made at this time to divert funds from the preventive medicine, health education, and environmental improvement programs, there will surely be a resulting increase in the incidence of "preventable" diseases. This would probably result in increasing the workload by an amount greater than the diverted funds would increase curative capability.

The fact must now be faced that patient care is the most fundamental component of any comprehensive health program and as such it should be adequately funded and staffed on its own merits.

FUNDING AND STAFFING ANALYSIS

FUNDING

The primary purpose of this section of the report is to accurately summarize the Indian Health Service Aberdeen Area's incremental funding needs above the anticipated funding level of FY 1974 in order to continue to operate at the level maintained during FY 1973. This figure is presented under Column (4) of Table I for each category of health service activity.

The secondary purpose of this section is to summarize the incremental funding need above that necessary to maintain the FY 1973 operational level, so as to provide an appropriate and reasonable level of health care. This figure is presented under Column (5) of Table I for each category of health service activity.

Table II summarizes the Non-Recurring Funding necessary to make Hospital Improvements, Alterations, and Construction. These are listed in descending order of priority.

The data and information supporting these figures are presented in the following section of this report.

The increases which are considered to have the highest priority are those designated for Patient Care Activities and those for the construction of and improvement to hospitals and clinics.

STAFFING

The degree of the Indian Health Service's success in previous years efforts in patient care and preventive health is indicated by Exhibits D and E of the Appendix of this report. Noticeable reductions in both incidence and rates of disease are clearly evident. Even though these achievements are noteworthy for any program, they are truly outstanding for a program which is faced with a continuing workload increase (see Exhibits B and C in the Appendix) and a simultaneous erosion in staffing levels. This program has been continuing because of Herculean efforts on the part of dedicated health professionals and supportive staff. Twenty to thirty hours of weekly overtime (often voluntary) have become commonplace. Leave is routinely sacrificed. Work is routinely done on weekends. This has all been done under the belief that funding and staffing relief would be available in the future. Unless the staff can be assured that this is not a false hope, they cannot sustain this superior level of performance.

Table III entitled "Aberdeen Area Staffing Analysis" summarizes the additional positions and funds needed to carry out an appropriate and reasonable comprehensive health program. Table IIIa portrays the physician staffing outlook for the next year.

TABLE I

SUMMARIZATION OF FUNDING LEVELS FOR IHS ACTIVITIES FY 72-74 AND INCREMENTAL INCREASES NECESSARY

	(1) FY 1972 Base Allowance	(2) FY 1973 Base Allowance	(3) FY 1974 Anticipated Allowance	(4) FY 1974 Recurring Incremental Need Above Column (3) to Provide FY 73 Program Level	(5) FY 1974 Recurring Additional Funds Above Column (4) To Fulfill Operating Needs
PATIENT CARE					
Hospital Health	$6,150,700	$7,242,000	$7,896,900	$ 700,000	$3,024,000 1/
Maintenance & Repair	446,100	532,700	571,000	-0-	100,000
Public Nursing School	89,000	93,500	93,500	-0-	53,790
Contract Hlth. Services	3,040,700	3,485,700	3,861,000	2,851,102	386,000
FIELD HEALTH					
Environmental Health	566,000	770,000	824,000	-0-	236,000
Dental	529,700	581,000	610,300	-0-	375,124
Public Health Nursing	469,400	505,500	528,900	-0-	430,524
Health Education	164,800	176,000	184,400	-0-	71,506
Field Medical Services	1,342,900	1,436,500	1,744,700	176,900	424,700
Mental Health	412,000	412,000	398,000	44,300	179,200
Community Hlth. Reps.	641,000	1,092,700	1,203,090	-0-	30,000
AREA OFFICE SERVICES	~~779~~,000	1,066,000 ~~93,500~~	1,079,000 ~~93,500~~	-0-	89,790
CONSTRUCTION					
Indian Sanitation Facilities Construction	3,016,000	3,116,312	3,000,000	-0-	-0-

1/ Includes Regional Referral Center at Rapid City, expanded positions and quarters, conversion of commissioned officer positions to Civil Service at an increased rate of approximately $20,000 each and additional supply and equipment needs.

TABLE II

Summarization of Non-Recurring Funding Needed For
Hospital Improvements, Alterations, and Construction

1. Alterations and improvements to IHS hospitals to meet program needs.

A.	Rapid City, South Dakota Indian Hospital Major renovations necessary to provide Area Referral Center, interim to new construction.	$1,600,000
B.	Pine Ridge, South Dakota Indian Hospital Provide additional exam rooms and surgical clinic exam area, relocate and expand dental clinic and miscellaneous changes resulting from above major changes.	330,000 ~~175,000~~
C.	Sisseton, South Dakota Indian Hospital Miscellaneous alterations and improvements to laboratory, nurses station, x-ray and emergency room, dental clinic. storage and administrative areas.	150,000 ~~60,000~~

2. Construction program. IHS hospitals - Maior alterations, additions, or replacements.

A.	Rosebud, South Dakota Indian Hospital (Master planning phase completed)	8,160,000 ~~$7,000,000~~
B.	Pine Ridge South Dakota Indian Hospital	4,400,000 ~~5,700,000~~
C.	Sisseton, South Dakota Indian Hospital	2,400,000 ~~2,700,000~~
D.	Eagle Butte, South Dakota Indian Hospital	3,000,000 ~~1,000,000~~
E.	Fort Yates. North Dakota Indian Hospital	600,000
F.	Winnebago. Nebraska Indian Hospital	4,000,000
G.	Regional Referral Center, Rapid City	10,000,000

TABLE III

ABERDEEN AREA STAFFING ANALYSIS

	1974 BASE PROGRAM		FY 1974 ADDITIONAL OPERATING NEEDS	
	POSITIONS	DOLLARS	POSITIONS	DOLLARS
I. PATIENT CARE	565	$6,446,483	144	$1,656,901
A. Direct				
1) Hospital Services	551	6,297,379	143 1/	1,634,347 1/
2) M&R	0	0	0	0
3) PN School	11	84,441	0	0
B. Indirect				
1) Contract Health Services	3	64,663	1	21,554
II. FIELD HEALTH SERVICES	299	$3,492,903	118	$1,358,441
A. Field Medical	110	1,290,200	23	290,984
B. OEH	54	679,982	5	78,540
C. Dental	48	531,086	12 2/	146,124
D. PHN	43	468,434	55	599,115
E. Health Education	11	156,701	8	69,300
F. Mental Health	33	366,500	13	144,378
G. Community Health Representative	0	0	2	30,000
III. AREA OFFICE SERVICES	68	$ 975,900	9	$ 89,790
GRAND TOTAL	932	$10,915,286	270	$3,105,132

1/ Includes Regional Referral Center, Rapid City, (55) positions at $628,595. Excludes special program request for Rosebud Surgery Program proposed and submitted by Rosebud Sioux Tribe.

2/ Excludes Regional Dental Lab, Rapid City which has been approved in Congressional FY 1974 budget.

TABLE IIIa

OUTLOOK FOR PHYSICIAN STAFFING

Service Unit	PHYSICIAN POSITIONS Authorized	Filled October 30, 1973	Anticipated Filled* July 1974
Belcourt	5	3	4
Chamberlain	1	0	0
Eagle Butte	4	1	1-3
Ft. Berthold	2	1	1
Ft. Yates	5	4	2-4
Ft. Totten	1	1	0-1
Pine Ridge (Wanblee)	9	9	5-7
Rapid City	4	4	4
Rosebud	6	7	3-6
Sisseton	2	2	1-2
Wagner	2	2	0-2
Winnebago	4	3	3

* Number of physicians anticipated unless funding and staffing relief is obtained.

HOSPITAL HEALTH SERVICES

The Aberdeen Area Indian Health Service provides direct patient care through its hospitals, health centers, and clinics. There are 6 hospitals serving the South Dakota Reservations, 2 hospitals serving the North Dakota Reservations, and 1 hospital serving the Nebraska Reservations. The data regarding these facilities are summarized in Table IV. Direct patient care is also provided in health centers and clinics but this is covered under the activity designated as Field Health.

Referring to Exhibits B and C, it is evident that there is a definite upward trend in workload. This has been placing a continually increasing burden on the Hospital, Health Center, and Clinical staff. The Indian population in the Aberdeen Area has a much higher incidence of disease than the national average for All Races. This is clearly illustrated in Exhibit K of the Appendix.

Reservation infant death rates are much higher than the national average. This also is clearly evident in Exhibit L of the Appendix, but it is dramatically evident that the deaths are occurring after they leave the hospital, 28 days to 11 months. The last bar in this graph also shows that there was a 65% reduction in infant death rates over the 14 year period Indian Health has been in operation. Exhibit M also verifies this fact.

The incidence of Tuberculosis as shown in Exhibit N has also declined 47% in seven years. This is due to better medical treatment, environmental improvements, preventive medicine, and health education.

THESE RESULTS ARE A CLASSIC EXAMPLE OF THE BENEFITS OF A COMPREHENSIVE HEALTH PROGRAM.

Even though these results are dramatic there is still a great need to reduce these health problems even further if the national average is to be approached. These can be reduced further with increased investment in an already successful program. However, many problems confront hospital services. They are summarized in the following paragraphs.

GENERAL PROBLEMS CONFRONTING HOSPITAL HEALTH SERVICES

PROBLEM I. INCREASED DIFFICULTY IN RECRUITING AND RETAINING PHYSICIANS.

Reason A. The military draft was abolished July 1, 1973. Now there is no longer an incentive for physicians to become Commissioned Officers in the Public Health Service.

Reason B. There are insufficient funds to offset difference in cost between pay scale for Commissioned Officer and Civil Service personnel systems.

TABLE IV

HOSPITALS

Service Unit	Number of Beds	Authorized Number of Physicians	Present Number of Physicians	Service Population	Outpatient Visits	1973 Average Daily Patient Load	Types of Services Provided
South Dakota							
Cheyenne River	33	3	1	4,030	20,798	17.8	General Medicine General Pediatrics Routine Obstetrics
Pine Ridge	58	6	6	10,366	40,609	29.9	General Medicine General Surgery General Pediatrics Routine Obstetrics Limited Psychiatric Service
Rapid City	86	3	3	2,593	19,583	18.4-GM 14.2-TB	General Medicine General Pediatrics Routine Obstetrics
Rosebud	52	5	5	6,942	31,136	32.7	General Medicine General Pediatrics Obstetrical Services General Surgery Limited Psychiatric Service
Sisseton-Wahpeton	32	1	1	2,325	17,310	11.5	General Medicine General Pediatrics Routine Obstetrics
Yankton	25	2	2	1,170	13,911	11.2	General Medicine General Surgery General Pediatrics Routine Obstetrics

(continued)

TABLE IV (continued)

HOSPITALS

Service Unit	Number of Beds	Authorized Number of Physicians	Present Number of Physicians	Service Population	Outpatient Visits	1972 Average Daily Patient Load	Types of Services Provided
North Dakota							
Turtle Mountain	50	3	3	6,130	38,202	23.4	General Medicine General Pediatrics Routine Obstetrics General Surgery
Standing Rock	30	3	3	3,899	17,215	18.9	General Medicine General Pediatrics Routine Obstetrics
Nebraska							
Omaha-Winnebago	60	4	2	2,193	17,054	29.0	General Medicine General Pediatrics Routine Obstetrics

Reason C. Unacceptable grade levels. Civil Service classification standards limit grade levels for family practice type physician in small hospitals or clinics. Individual qualifications and experience of applicants may be excellent, but size and type of facility in which work was done often restricts their grade level.

Reason D. Undesirable living conditions for physicians and their families. Lack of suitable housing, lack of recreational facilities, poor schools, lack of cultural facilities, poor shopping areas. Inadequate quarters (either furnished or unfurnished). Single physicians sometimes end up with three-bedroom homes - must pay for heat, lights, etc. Wives of physicians demand and expect good quality furnishing and attractive quarters (particularly if site is especially desolate, isolated, etc.) Need something to contrast with environment.

Reason E. Unreasonable workloads and working hours. Need premium pay on annual basis for overtime, standby, etc.

1. Inadequate staffing places unnecessary demands on physicians (and others) for overtime, standby, etc.

2. A 12 to 16 hour day, six days per week, is common at Service Units.

3. Many physicians would be attracted by basic 40-hour week at less pay <u>if</u> overtime was on lesser scale.

Reason F. Inadequate funds and facilities to provide for professional growth and development.

1. Inadequate funds for physician training. Physicians expect and demand training and attendance of professional meetings to maintain proficiency levels.

2. No funds to provide for coverage while in training.

3. Need for career development opportunities for young physicians. Need regional medical center to accomplish this.

Reason G. Tribal interference with internal operation of hospitals.

Reason H. Inadequate funding of recruitment programs.

PROBLEM II. DIFFICULTIES IN RECRUITING AND RETAINING OTHER HEALTH PROFESSIONALS

Reason A. Pay scale not competitive with pay scales for comparable jobs in more desirable locations for all health professionals.

1. Civil Service regulations do not compensate the more experienced and better qualified nurse. As it is now, all are paid same (GS-7) unless they go into supervisor or administrative positions.

2. Nurses expect and deserve either premium pay on annual basis, or incentive pay for overtime, call back, etc.

3. Nurses and other health professionals should receive hazardous duty pay for patient escort air transportation.

Reason B. Inadequate salary for Medical Technologists and X-Ray Technicians because Indian Health Service cannot support higher grade levels under Civil Service standards. (Most limited to GS-7; need GS-9 to GS-11).

Reason C. Indian Health Service cannot meet salary requirements for Medical Records Librarian. The Accredited Records Technician is not recognized by Civil Service standards.

Reason D. No funds for pre-employment interviews of health professionals.

Reason E. Some categories of health personnel not allowed payment of travel and transportation to first duty station.

Reason F. Unreasonably long working days and too much overtime for health professionals because of inadequate authorized staffing patterns as well as inadequate funds.

Reason G. Inadequate funds for professional growth and development.

Reason H. Poor working conditions because of deteriorating facilities.

Reason I. Social needs of personnel are not met due to isolation factor.

Reason J. Housing at Service Units is inadequate or unavailable.

Reason K. No recreational facilities are available at Service Units.

PROBLEM III. DIFFICULTIES IN NUTRITION AND DIETETIC PROGRAM

Reason A. Food costs have increased.

Reason B. Number of positions are inadequate and funding is insufficient to properly operate the existing nutrition and dietetic program. The October 16, 1973, Journal of the American Hospital Association lists a cost of $1.57 per meal. Indian Health Service is funded for $1.01 per day.

Reason C. Food handling facilities in existing hospitals are inadequate and outmoded.

Reason D. Funds for continued education and training of personnel in nutrition and dietetics and food handling are inadequate.

Reason E. Pay scale for personnel is not sufficiently competitive with pay scale in more desirable locations throughout the country.

1. Salaries for dietitians under grade level restrictions are inadequate. We cannot recruit.

2. Indian Health Service cannot pay for pre-employment interviews.

3. Training funds are not adequate.

PROBLEM IV. DIFFICULTY WITH AMBULANCE SERVICES

Reason A. Funds are inadequate at all facilities.

Reason B. To meet Department of Transportation regulations, Indian Health Service needs 90 positions to serve as ambulance drivers.

Reason C. Additional funds are required for special care training.

Reason D. Funds are needed to purchase ambulances. GSA has not been able to provide them.

PROBLEM V. PROBLEMS FACING HOSPITAL MAINTENANCE AND HOUSEKEEPING

Reason A. Outmoded facilities make it virtually impossible to maintain sanitary conditions.

Reason B. Prevalence of emergency conditions ~~is~~ all too often dictates that maintenance and housekeeping employees serve as ambulance drivers.

Reason C. Funds are inadequate for even routine maintenance and repair.

Reason D. Funds are inadequate to adequately staff existing facilities. Most facilities are grossly understaffed. The pay scale is adequate but additional positions and funds are needed.

Reason E. Additional funds are needed for specialty training. (Some funds are presently provided by Upward Mobility.)

PROBLEM VI. THERE IS NO INDIAN HEALTH SERVICE REFERRAL MEDICAL CENTER LOCATED IN SOUTH DAKOTA.

Reason A. No funds nor legislation to support this.*

Reason B. Medical educational facilities in South Dakota (or North Dakota, Montana, or Wyoming) are non-existent.

Reason C. Medical specialists to act as consultants and provide services for Indian Health Service hospitals and clinics are not available.

PROBLEM VII. REPLACEMENT OF ANTIQUATED EXISTING INDIAN HEALTH SERVICE HOSPITALS AT ROSEBUD, SISSETON, WAGNER, RAPID CITY, PINE RIDGE.

Reason . No legislation has been passed to provide for replacement.

PROBLEM VIII. DIFFICULTIES IN RECRUITING AND RETAINING QUALIFIED SERVICE UNIT DIRECTORS

Reason A. Indian Health Service has no authority to pay travel for pre-employment interviews.

Reason B. Indian Health Service does not have adequate funds for training and continuing professional development.

Reason C. Grade levels are inadequate under Civil Service standards. Actually, Civil Service has no applicable standards. The level of responsibility at larger Indian Health Service Aberdeen Area stations coupled with complexisty and magnitude of problems easily warrant a GS-14 grade level, possibly a GS-15.

* There is no Regional Medical Center of any type in South Dakota.

MAINTENANCE AND REPAIR (M&R) PROGRAM

In addition to the operating M&R Program, major program emphasis since FY 1972 has been to accomplish as much as possible of the Backlog of Essential Maintenance and Repair (BEMAR) and correction of fire safety deficiencies, especially in the inpatient care facilities. This backlog is approximately $700,000. Fire and safety deficiencies are approximately $400,000.

In addition, due to expanding medical workload and age of existing structures, various minor alterations and improvements are required to permit increased efficiency and ability to respond to medical workload demands. A recurring incremental increase would permit meeting program needs without curtailing regular M&R and completion of BEMAR.

RAPID CITY PRACTICAL NURSE SCHOOL

For a number of years the Areas have been allocated $1,200 per student who attends either the Rapid City or Shiprock Training Program. This $1,200 is given from the Headquarters LPN School reserve funds to cover costs of the students' travel and per diem, and the cost of a temporary replacement on the hospital staff while the students are away.

In spite of marked increases in salaries of replacements and increases in costs of travel and per diem since 1963, there has been no comparable increase in reimbursement funds to Areas.

A review of the current costs associated with sending students to these courses and employing replacements during the students' absence is as follows:

Average cost of travel per student	$ 165.00
Per Diem while in travel status - 2 days at $25.00	50.00
Per Diem granted while in school (for first 60 days) $4.75 per day	285.00
Per Diem granted while in school (for next 30 days) $2.85 per day	86.00
Replacement salary, GS-3/1, (90 days) at $3.08 per hour	2,218.00
Replacement benefits at 8.5% of salary	189.00
TOTAL	$ 2,993.00

Areas have been reluctant to offer this opportunity for upward mobility on the career ladder for Indian nursing employees because of inadequate replacement funds and inadequate staffing in the hospitals. To permit even one employee to leave for advanced training for a 3-month period without having a replacement during her absence places a serious hardship on remaining staff and thereby reduces the level of safe patient care. Realistic funding is absolutely necessary if the Indian people are going to be provided the best possible care and if Indian practical nurses are going to have the opportunity to improve their knowledge and skills so as to be better prepared to enter professional nursing programs. Therefore, the minimum amount of additional funding needed for the Aberdeen Area LPN program is $53,790 (30 students x $1,793).

CONTRACT HEALTH SERVICES

The Contract Health Services program is a component of the Area's health delivery system which provides supplemental, specialty, and emergency services to round out the basic services available through the Service Unit programs. It also delivers health services on many smaller reservations where Public Health Service professionals are not available. The basic purpose of Contract Health Services is to purchase professional services from non-Indian Health Service sources at a reasonable rate and in a rational manner. 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, drugs, eye care, dental services, and Area administration.

PROBLEMS CONFRONTING CONTRACT HEALTH SERVICES

PROBLEM I. INCREASED MEDICAL CARE RATES 1/

Reason A. Inter-agency hospital per diem rate was increased from $46 to $126.

Reason B. Rates charged to IHS by private hospitals were more than doubled (in some cases tripled) in the last four years.

Reason C. Costs of drugs and supplies have increased drastically in the last two years.

1/ The Graph, Exhibit A, portrays the increase in medical cost rates for government and private health facilities. The dramatic jump in costs in FY 1974 is especially noteworthy. No increase in base funding has yet been provided to Indian Health Service to cover this sudden tripling of costs.

PROBLEM II. INCREASED WORKLOAD 2/

Reason A. Increase in population served.

1. Requirements for eligibility to receive health services were lowered.

2. Increasing numbers of Indians are returning to reservations because of improved living conditions and job opportunities.

3. Motivation of Indians to seek health services has increased.

Reason B. Decrease in Indian Health Service ability to provide direct patient care because of manpower needs and facility needs.

1. Inability to recruit and retain physicians and other health professionals.

2. Insufficient funds are available to maintain, modernize existing facilities.

3. Virtually no funds are available to expand existing facilities.

PROBLEM III. INCREASED NUMBER OF HEALTH CONTRACTS WITH INDIANS FOR HEALTH SERVICES

Reason A. Ambulance program.

Reason B. Contract for health care with Indian groups.

Reason C. Student health program.

2/ The Graph, Exhibit B, entitled "Admission of Patients" depicts the trend in patient admission in the Aberdeen Area. The total will probably continue to climb, contract hospital admissions will increase, and Indian Health Service admissions will decrease in FY 1974 and FY 1975. Any inability for Indian Health Service to provide direct patient care will result in soaring costs. The Graph, Exhibit C, entitled "Outpatient Medical Visits" portrays a similar picture for outpatient services.

OFFICE OF ENVIRONMENTAL HEALTH

The staff of the environmental health program provides basic environmental health services, engineering and technical support in the development of sanitation facilities projects, coordination with Federal and tribal housing agencies, negotiation of agreements, securing of tribal participation in the work, logistical support and supervision of the installation of facilities, and provides essential training to Indian people in sanitation practices and the operation, maintenance, and care of sanitation facilities completed under the Public Law 86-121 sanitation facilities construction activity.

Basic Environmental Health Activities

A continuing program of consultations and services is made available to Indian families and communities to assist them in implementing a comprehensive environmental health program. Consultations help the Indian Natives to identify and correct environmental conditions which are detrimental to their health status. This insures sustained improvement in the quality of their lives. Services of an occupational health and safety nature are being expanded. An essential element of the services provides that emphasis be placed in furthering community guidance of program activities. This permits their integration into the total health, social, and economic structure of Indian Native communities.

In addition to the foregoing, the basic environmental health activities incorporate a consultative service to assure that a high level of environmental sanitation is maintained in Federal facilities serving Indians.

Sanitation Facilities Construction Activity

The sanitation facilities construction activity complements the basic environmental health activity by providing tangible support in those situations where the need for facilities exceeds the available resources of the Indian people. The Indian Health Service is authorized to provide this assistance under Public Law 86-121, The Indian Sanitation Facilities Act (42 USC 200 4 a et. sequ). The activity employs a coordinated tribal-federal attack to correct gross deficiencies in individual and community water supplies, waste disposal, and other sanitation facilities. Staffing to implement this work is supported under the field health activity of the Indian Health Service budget.

In the construction activity Indians participate in project planning and construction and assume responsibility for the operation and maintenance of the completed facilities. The staff effort devoted to project engineering, technical support and motivation and training of Indian families and groups has resulted in notable Indian participation in the forms of men, money, and materials.

Since the passage of Public Law 86-121 in 1959, the Indian Health Service has been constructing sanitation facilities for Indian homes and communities. This fact, together with the growing accomplishments of housing programs of other Federal agencies, has done much to improve the water and waste disposal problems of these people. However, many families still lack basic facilities and are subject to the serious health hazards associated with such environmental deficiencies.

The attached graphs for the Aberdeen Area are indicative of the success of the sanitation facilities construction program and housing programs in combating respiratory and digestive system diseases.

Unmet Needs

The recurring incremental need (Column 5 of Table I) will provide personnel to implement a comprehensive injury control and accident prevention program on the reservations in the Aberdeen Area. Exhibits F and G in the Appendix illustrate the need for such a program. A successful preventive program in this Area would significantly reduce Indian Health Service patient care costs as well as improve the health of the Indian people.

In addition, the funds listed in Column 5, Table I would provide additional personnel to work with Indian families and communities as the operation and maintenance of the sanitation facilities. The number of families and communities with adequate sanitation facilities has increased significantly since the implementation of the Public Law 86-121 program and this has increased the need for technical assistance to the Indian people on the establishment of utility organizations and the proper operation and maintenance of sanitation facilities.

DENTAL PROGRAM

In FY 1973 the Aberdeen Area - Western Tier provided 90,164 direct dental services in the Indian Health Service facilities and 17,942 services by contract with private vendors.

During FY 1973 43% of the population in the Aberdeen Area was examined. Of those examined 43% of their required services were provided. This means that less than half of the Indian population received a dental examination in FY 1973, and of those examined less than half of their needed services were provided. We can therefore see a tremendous need for dental services in the Indian population that cannot be met by existing resources over a short period of time. The Indian Health Service has established priorities of dental services to concentrate its approach on preventive services for young people. Adults frequently are unable to receive the complicated restorative dental services they require.

By utilizing an incremental care approach, concentrated on school age children, the dental health of the population can gradually be elevated.

Unmet Needs

1. Several sites have been identified for satellite dental clinics to bring services to the communities or schools. Requests for consideration for projects to install available equipment have as yet been unanswered. Other sites are in need of modernization or expansion in order to better meet the needs of the service populations.

2. There is a need to establish a position of Aberdeen Area Dental Equipment and Facilities Maintenance Man. At present, significant Construction and Maintenance and Dental Branch time is spent on consultant requests confirming dental equipment repair or installation. Cost would include estimated salary $10,500; per diem for approximately 180 days travel estimated to be $4,500; and car rental and mileage estimated to be $1,500. Total cost would be around $16,500.

3. There is a need for a Regional Dental Laboratory. The 43% receiving services were predominantly children and this has resulted in several Service Units reaching the maintenance level in children so that more services can be provided to adults. With this, there is a need for more dentures and laboratory services but beneficiaries are unable to pay commercial laboratory costs. These services can be provided in an Indian Health Service laboratory at less cost to the government. One part of the former Rapid City Outpatient Clinic is being renovated to contain the laboratory, along with the dental clinic which has been located in the building for four years. The Regional Laboratory will have the capacity to fabricate approximately 5,000 units each year. The lab will employ Indian people to the greatest extent possible. Staff for this lab will be trained in the Indian Health Service Albuquerque Regional Laboratory. Rapid City was chosen because it is strategically located to provide efficient and timely services to dental clinics in both the Aberdeen and Billings Areas, which it will serve. Mail service is adequate and adequate rental units are available. One-hundred fifty thousand dollars ($150,000) and 15 positions have been authorized by Congress for the FY 1974 budget. It is essential that this funding be released so that construction can be accomplished and positions filled.

Position Needs and Costs

Service Unit	Dental Officer	Dental Assistant	Dental Operatory	Cost	
Rapid City	1	1	2	Dental Officer Salary	$ 59,412
Eagle Butte		1		Dental Ass't. Salary	86,712
Ft. Totten		1		Supplies	6,400
Ft. Thompson		1		Start-up Supplies	15,000
Pine Ridge	2	4	6	Change of Station	20,400
Rosebud		1		Training	2,700
Ft. Yates		1		12 Dental Operatories	168,000
Belcourt	1	2	2		
Winnebago			2	Total	$358,624
	4	12	12		

These additions are above the FY 1974 budget request and are calculated to bring staffing and facility levels closer to those described in the Dental Program Criteria and Standards document.

PUBLIC HEALTH NURSING

The increasing involvement of Public Health Nursing staff with the Indian community such as the increase in the number of tuberculosis and hepatitis cases, the problems relating to maternal and child health, drug abuse, alcoholism, impetigo, and other health problems, as well as the necessity to expand the role of the professional nurse, emphasizes the critical need for increased positions and funds.

For several years the professional and supportive clerical and other nursing staff has been insufficient to meet the needs of the Indian community. Existing conditions have been further aggravated due to budgetary restrictions on drugs and on vehicle replacements because the public health nursing staff cannot reach the community without vehicles; nor can the staff provide necessary medications if funds are not available to buy them. According to professional staffing criteria (55) extra positions are required at a cost of $430,524.

HEALTH EDUCATION

The national demand for knowledge and training on proper health practices is great, but for the Indians residing in the Aberdeen Area the need is critical. Too many Indians suffer disability due to illness, disease and accidents that could have been prevented through Health Education. The

Problems Confronting Mental Health Branch

Problem I - Personnel costs have risen beyond the funding level of the program because salaries have risen as the staff has gained seniority and funding has not been increased accordingly.

Problem II - Insufficient funds to provide for training of paraprofessionals will drastically limit their effectiveness to the extent that it may jeopardize the patient's health. It will then be necessary to have a few trained professionals to replace the Indian paraprofessionals who would have to be terminated.

Problem III - Insufficient funds will necessitate reduction in mental health consultation contracts.

Provlem IV - Insufficient funds will limit travel. Travel is essential to the conduct of this program.

Unmet Needs

In order to carry out a reasonable and proper mental health program commensurate with the needs, an additional (13) positions should be provided with adequate funds to support them. (Total need - $179,200.)

COMMUNITY HEALTH REPRESENTATIVE PROGRAM (CHR)

The CHR program is operated and managed by Tribal Councils through contracts with the Indian Health Service. A part of this program management responsibility is the planning of health services to be provided by CHR's and the setting of program objectives aimed at specific health problems which a tribe has identified as being priority health problems in the reservation community. Because poor health levels exist in every reservation area, tribal program objectives and services are directed toward complementing existing health resources such as Indian Health Service health services or State operated programs. As a result of this coordination of existing resources and local CHR Program services, the tribes are striving to form comprehensive health services programs in the reservation areas which are responsive to the needs of the population served.

The Fiscal Year 1974 authorized level of support for this program will provide (139) community health representatives and a total budget of $1,299,740.

The Program is currently undergoing a change from the CHR generalist who performed mostly case finding, health services utilization motivation, developing awareness to health problems, referring individuals to service agencies, and patient transportation. The current trend of tribal programs is toward the development of CHR specialists and clinically oriented personnel to work with specific priority health problems in addition to performing generalist duties.

The Program has been growing steadily and providing an excellent health service to the communities. In addition, it has enabled tribal leaders to gain experience in managing health services. No funds have been provided for the Indian Health Service administration of the program however. A need for (2) positions and $30,000 is shown on Table I and Table II.

ABERDEEN AREA MENTAL HEALTH PROGRAM

The Area Mental Health Branch provides a wide range of services for the treatment and prevention of emotional and family problems. Treatment is offered through outpatient services, consultation, and some emergency inpatient services. The staff includes psychiatrists, psychologists, social workers, and paraprofessional mental health workers. Prevention efforts are through assisting community groups in their attempts to improve the quality of life for Indian people.

The problems faced by Indian people such as poverty, housing, discrimination, unemployment, and disintegrating culture produce a wide variety of mental health problems including depression, anxiety, alcoholism, suicides, delinquency, family strife, learning disabilities, and sometimes psychosis. The treatment of these problems requires skill, perseverance, and commitment to improving the quality of life for Indian people. Referrals to the program come from health professionals, social agencies, churches, tribal groups, schools, and the patients themselves when the service becomes known in the community. Whenever possible, state and local mental health services are utilized, but they are generally non-existent in the Dakotas or are very far away from reservations. When mental health services are not provided by Indian Health Service, they are not available to Indian people.

The backbone of the program is the paraprofessional mental health worker. Two-thirds of the mental health positions are filled by paraprofessionals. They are the primary service providers. This program began about two and a half years ago and is based on employing local people and training them to provide a high quality mental health service. This type of training is a long process which requires ample opportunities for exposure to the mental health field through supervision, workshops, seminars, and observation of other mental health services in Indian Health Service and the general population. To carry out the training program successfully, the professional workers must also receive training in paraprofessional supervision and development. It is an ambitious program designed to produce a core of people in Indian communities with high quality mental health skills.

Prevention of mental health problems requires community involvement in the identification of mental health needs and in the designing of community efforts to meet those needs. Indian Health Service mental health staff assist Indian communities in these efforts with some noteworthy success. However, clinical services are so much in demand that the present resources provide little time for adequate preventive measures.

solution to this problem can only be reached through planned ongoing programs consisting of: (a) community health information programs and medical self-help training; (b) teaching of formal health courses - K-12 in the schools; (c) hospital patient and outpatient education programs including community followup; (d) training to tribal community health representatives and tribal health board members on health information and communications skills; (e) supportive educational and promotional services to Indian Health Service staff.

To operate at a proper program level, an additional $71,506 is needed to set up and staff six new health education trainee positions at Rosebud, Pine Ridge, Winnebago, Eagle Butte, Belcourt, and Sisseton and two new health education specialist positions at Rapid City and Fort Totten. Salary and equipment costs would be $71,506.

FIELD MEDICAL SERVICES

Field medical services in the Aberdeen Area are those health care services rendered outside of the hospital. There are some instances,however, where the services are rendered by Field Medical personnel, but utilizing some part of the hospital, e.g., nurse-midwifery, maternal and child health clinics, eye care program, some parts of Public Health Nursing services are among the most important. The Field Medical Services are extremely important part of the health care program in that they furnish the primary care to preventive medicine portions of the Aberdeen Area Indian Health Service. It is vital in order to reduce the overall costs of medical care that patients utilize preventive medicine services and ambulatory direct care patient services as early and often as possible to prevent more expensive hospitalization care.

Program Trends

Ambulatory patient care visits to Service Unit health centers, health stations, and other satellite clinics for Fiscal Year 1973 totaled 58,293 visits. The leading diagnosis or conditions were: (1) Upper respiratory infections - 7.8%; (2) Diabetes Mellitus - 4.3%; (3) Physical examinationss-3.8%; (4) Acute otitis media - 3.4%, (5) Medical or surgical aftercare - 3.4%.

Tables V and VI summarize the workload of the Health Centers and Clinics in respect to the physician staffing.

Problems Facing Field Medical Services

The problems and causes of problems facing Field Medical Services are virtually identical to those facing Hospital Health, the only difference being one of scale and location. Refer to the section on Hospital Health for details.

TABLE V

HEALTH CENTERS AND CLINICS

Facilities	Authorized Number of Physicians	Present Number of Physicians	Service Population	1973 Outpatient Visits
Chamberlain Health Center and Clinics	1	0	2,538	9,716
Ft. Berthold Health Center and Clinics	2	1	2,326	15,668
Ft. Totten Health Center and Clinics	1	1	1,814	13,904
School Health Centers	0	0	0	15,122

TABLE VI

HEALTH CENTERS AND CLINICS
ASSOCIATED WITH HOSPITAL SERVICE UNITS
(Funded by Field Health)

Service Unit	Authorized Number of Physicians	Present Number of Physicians	1973 Outpatient Visits
Cheyenne-River Clinics	1	0	3,727
Omaha-Winnebago	0	0	3,394
Pine Ridge Health Center & Clinics	2	2	20,170
Rapid City Health Center	1	1	19,538
Rosebud Clinics	1	1	4,831
Sisseton-Wahpeton Clinics	0	0	1,248
Standing Rock Health Center & Clinics	1	0	8,273
Turtle Mountain Clinics	2	0	4,163
Yankton	0	0	2,888

AREA OFFICE SERVICES

This activity provides administrative support to program operations and direct medical care facilities in the Aberdeen Area. Overall activities include provision of some health services, direction, and consultation as well as Financial Management functions, Procurement and Contracting, Property and Supply; Maintenance and Repair of all Indian Health facilities and Physical Plants; and all Personnel Management activities.

Due to increases in Service Unit inpatient and outpatient care, new programs without provision for administrative cost, impact of data processing, medical staff turnover, and staff shortages, workloads in the areas of Area Office Services have increased and continue to increase considerably. An increased need of (9) positions is required to adequate provide support services for the Patient Care, Field Health, and Construction activities.

The increase in workload throughout the Area has hindered the efforts to maintain efficiency due to the lack of supportive staff to adequately cover all aspects of Administrative Services (Procurement, Contracting, Office Services, and Property and Supply). Lack of personnel qualified or individuals interested and with potential to assume property and supply positions at the Service Units is a major problem.

COST INCREASES AT REFERRAL CENTERS

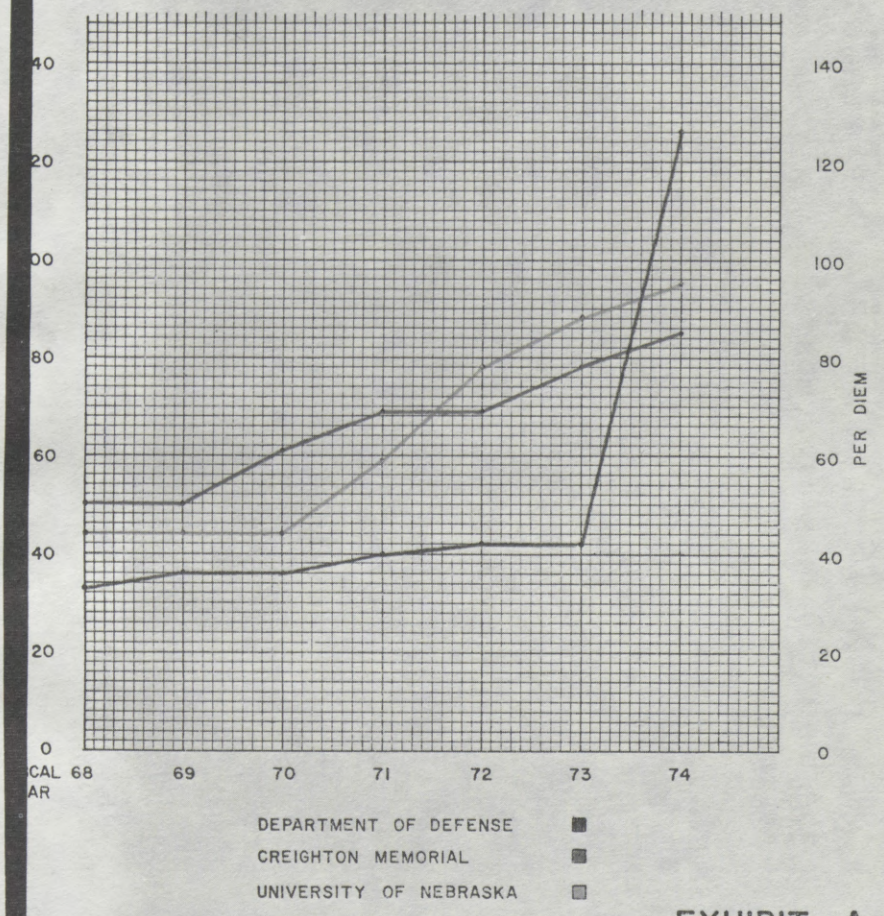


EXHIBIT A

27-262 O - 74 - 6

ADMISSIONS OF PATIENTS

PHS INDIAN AND CONTRACT HOSPITALS

ABERDEEN AREA

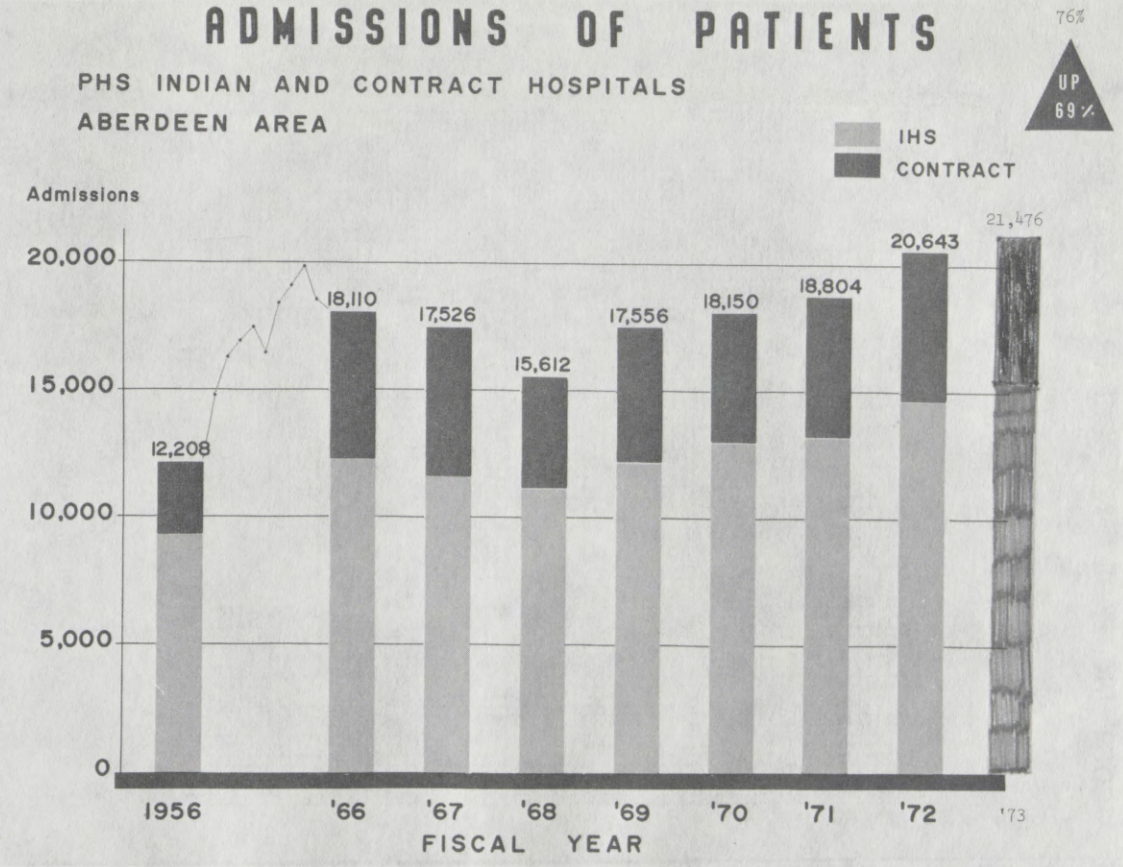


EXHIBIT B

OUTPATIENT MEDICAL VISITS*

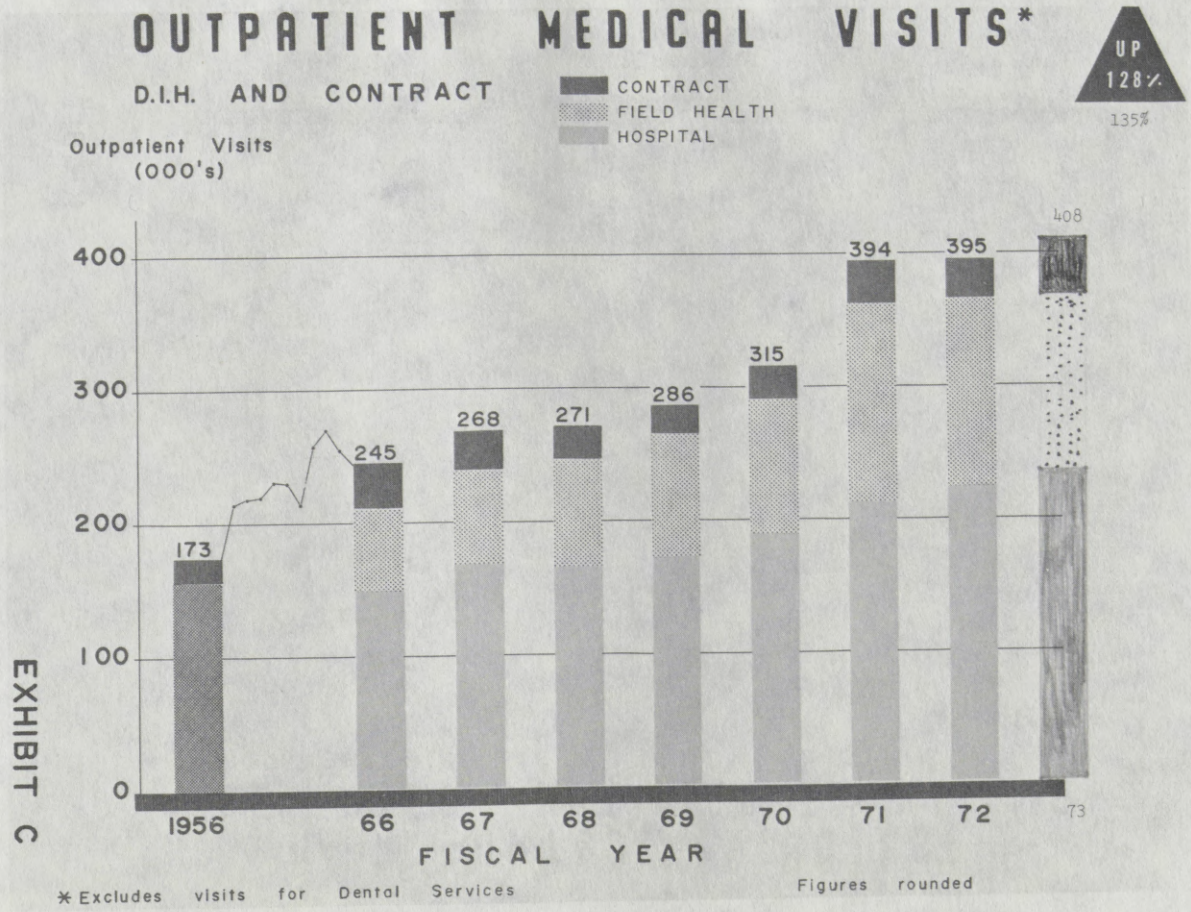


EXHIBIT C

REPORTED INCIDENCE
SELECTED NOTIFIABLE DISEASES
ABERDEEN AREA INDIAN 1966-1971

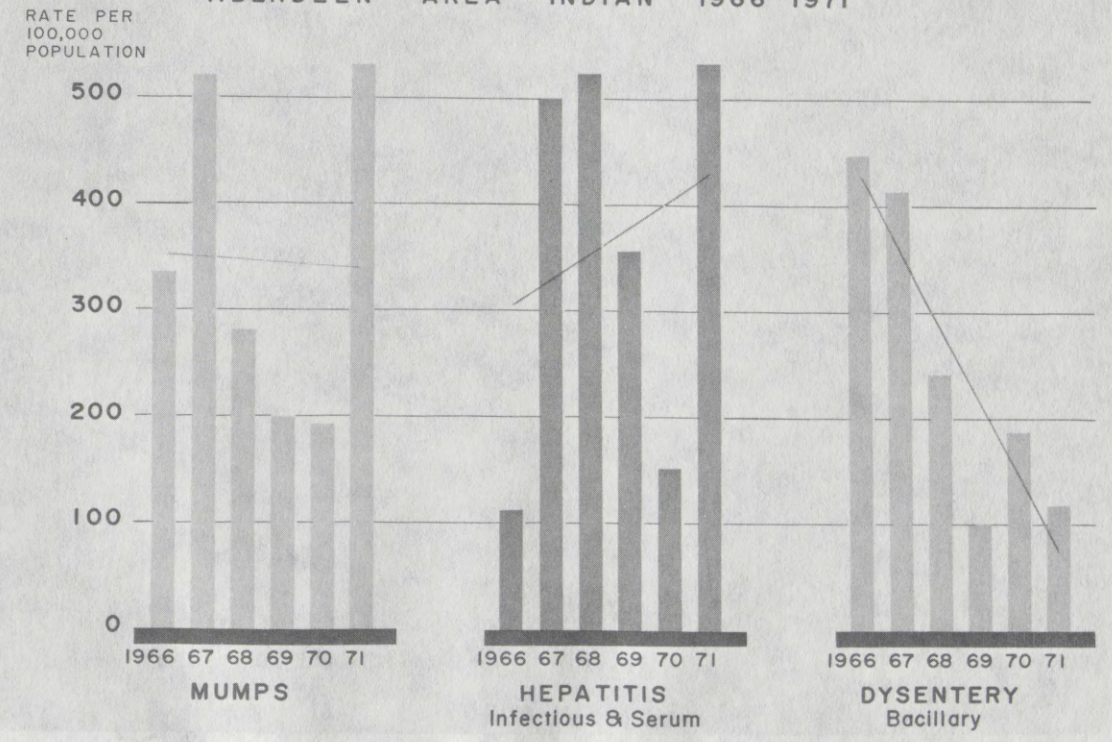


EXHIBIT D

TRENDS IN CAUSES OF HOSPITALIZATION

PHS INDIAN HEALTH SERVICE & CONTRACT HOSPITALS

FISCAL YEARS 1962-1972

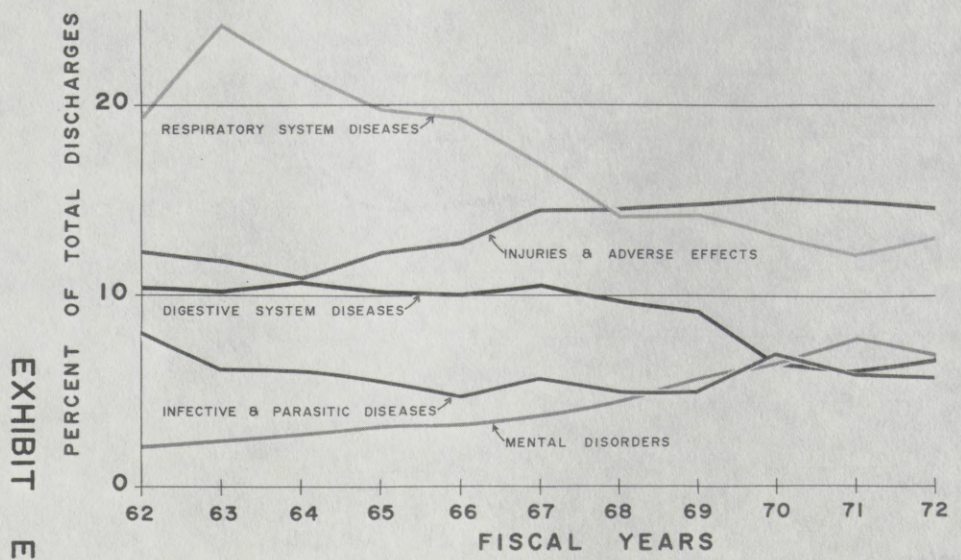


EXHIBIT E

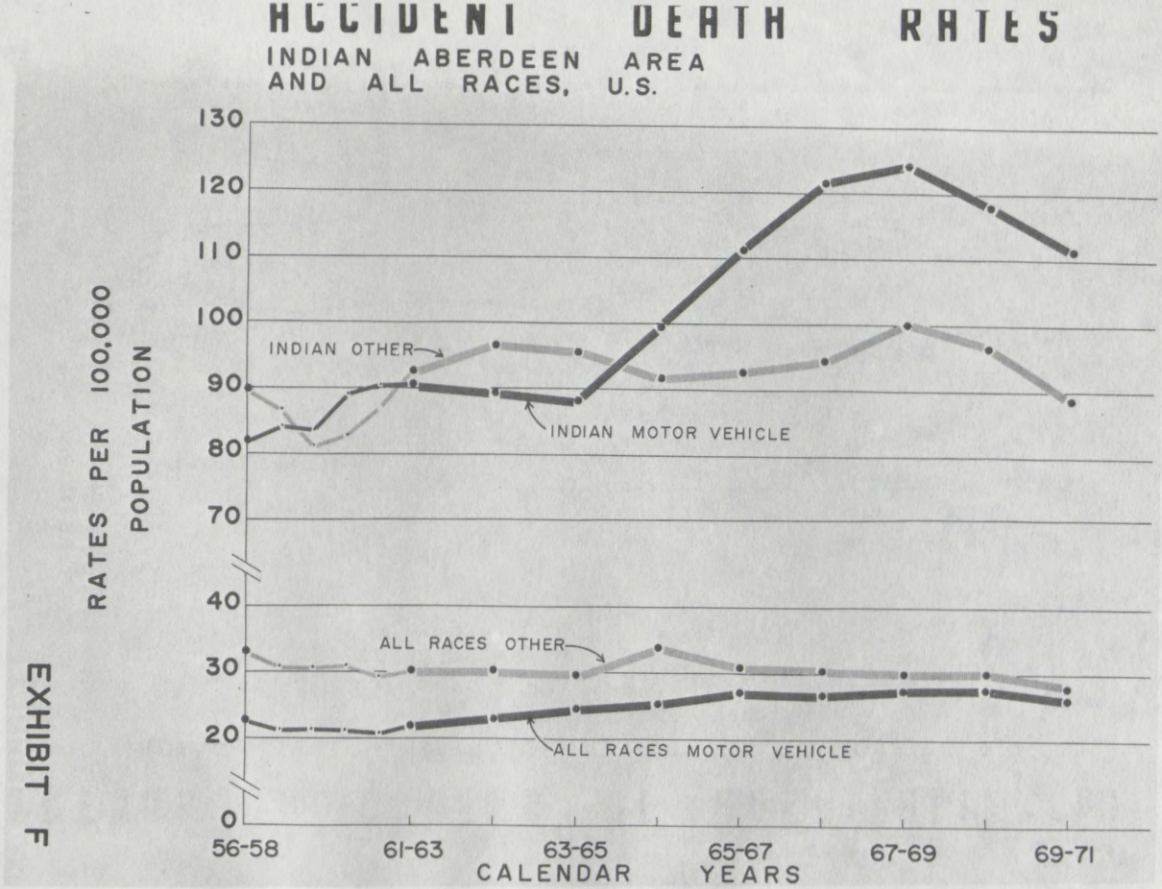

ACCIDENT DEATH RATES
INDIAN ABERDEEN AREA
AND ALL RACES, U.S.
RATES PER 100,000 POPULATION
130
120
110
100
90
80
70
40
30
20
0
INDIAN OTHER
INDIAN MOTOR VEHICLE
ALL RACES OTHER
ALL RACES MOTOR VEHICLE
56-58
61-63
63-65
65-67
67-69
69-71
CALENDAR YEARS

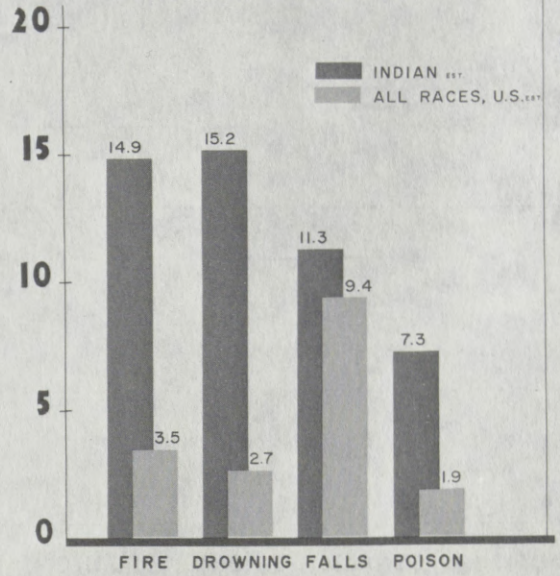
EXHIBIT F

NON - VEHICULAR ACCIDENTS

INDIAN ABERDEEN AREA & ALL RACES, U.S.

DEATHS

LEADING CAUSES OF DEATH
1969-71 AVERAGES
RATE PER 100,000 POP.



HOSPITALIZATION

PHS INDIAN HOSPITALS
1970-72 AVERAGES
RATE PER 100 DISCHARGES FOR INJURIES

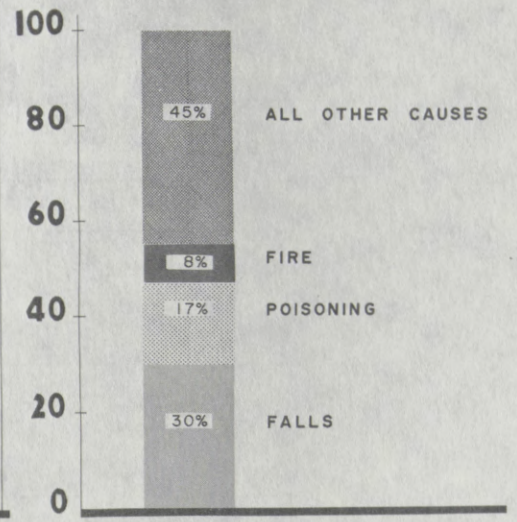


EXHIBIT G

NCHS

Excludes Motor Vehicle Accidents, Injuries Inflicted By Others, And Self-Inflicted Injuries

ORAL HEALTH - PERCENT OF INDIAN PEOPLE EXAMINED

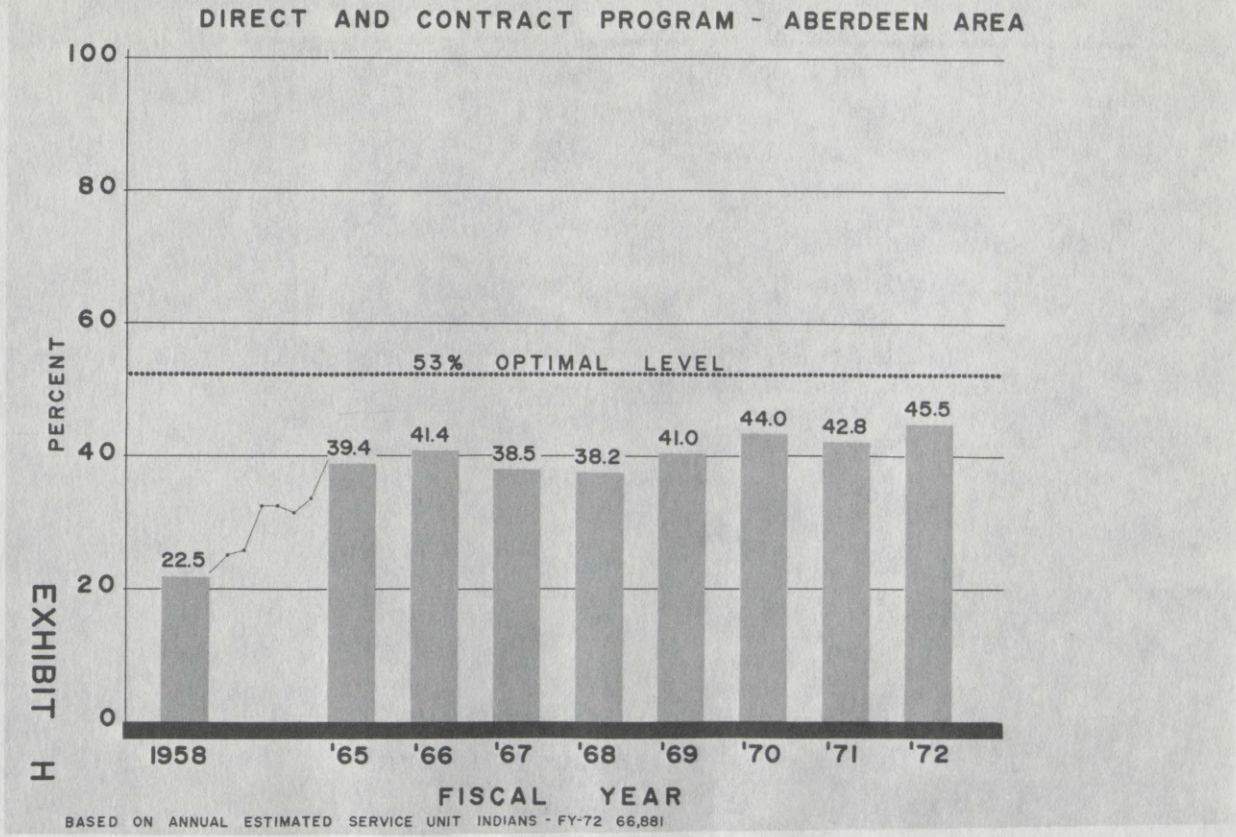
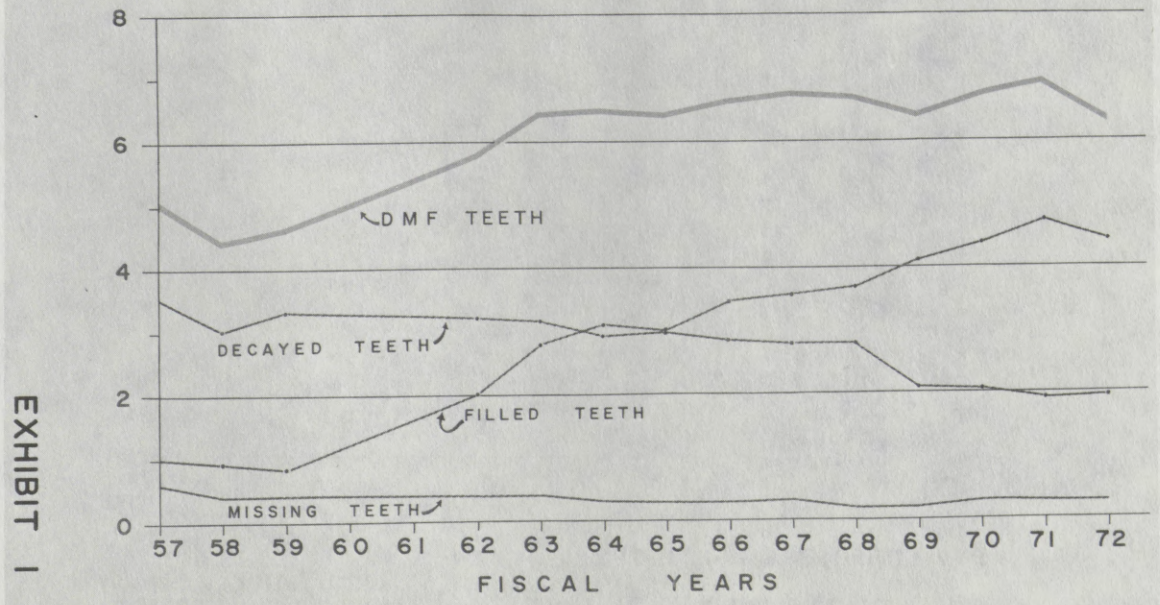


EXHIBIT H

AVERAGE NUMBER OF PERMANENT TEETH DECAYED MISSING OR FILLED PER PERSON

AGES 6-17 (1957-1969)
5-19 (1970 UP)

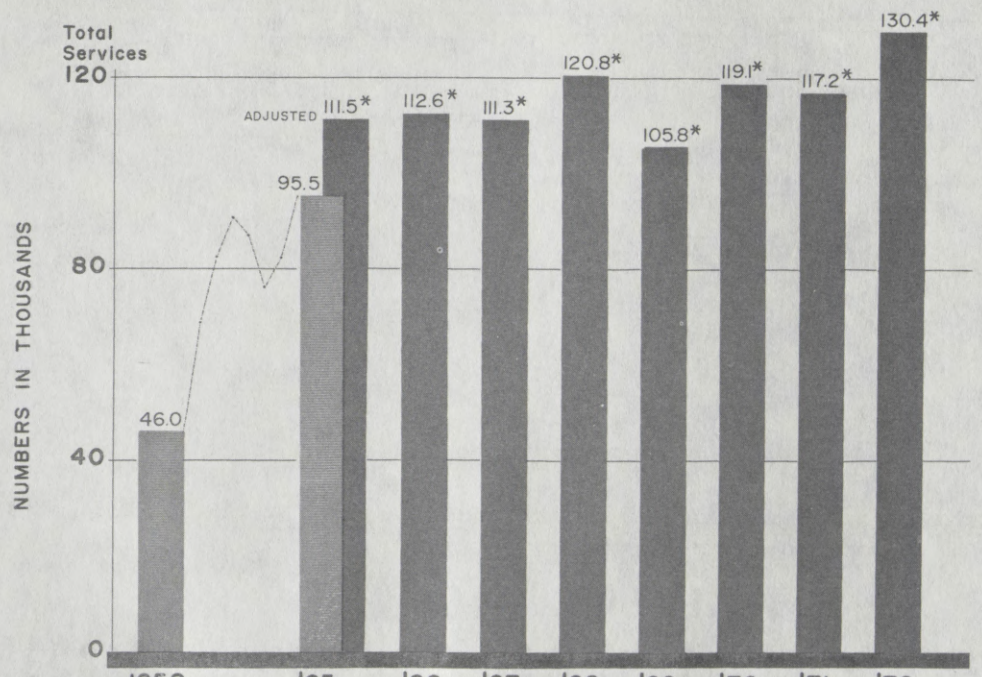


DERIVED FROM DIRECT SERVICE EXAMINATIONS

EXHIBIT I

ORAL HEALTH - TOTAL SERVICES PROVIDED

DIRECT AND CONTRACT PROGRAM - ABERDEEN AREA



* EXAMS ADDED, DIAGNOSTIC SERVICES DROPPED, AND OTHER MINOR CHANGES

EXHIBIT J

RATES FOR SELECTED REPORTABLE DISEASES

INDIAN ABERDEEN AREA 1971 AND ALL RACES 1970 (Calendar Years)

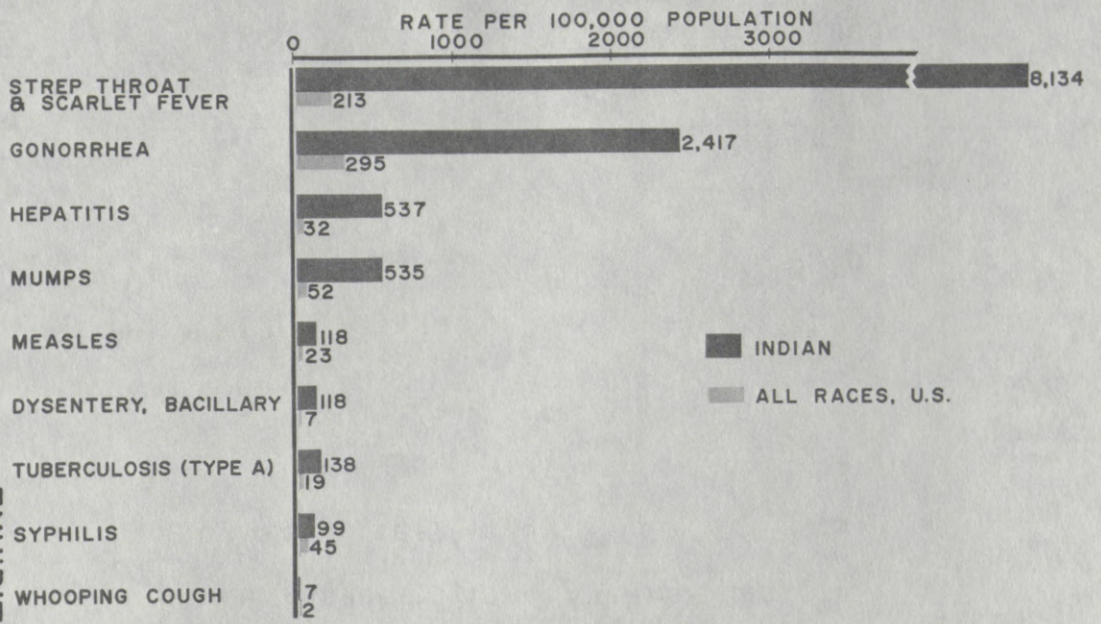


EXHIBIT K

INFANT DEATHS BY AGE GROUP

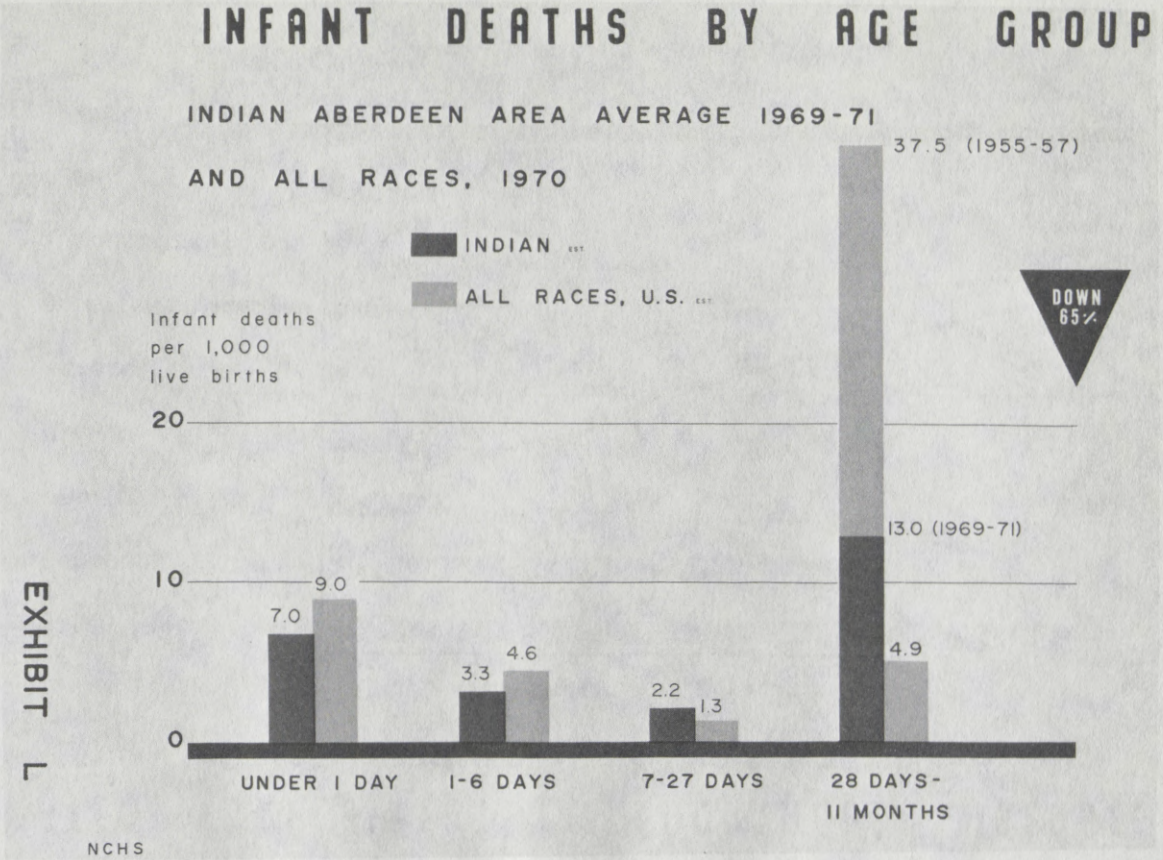
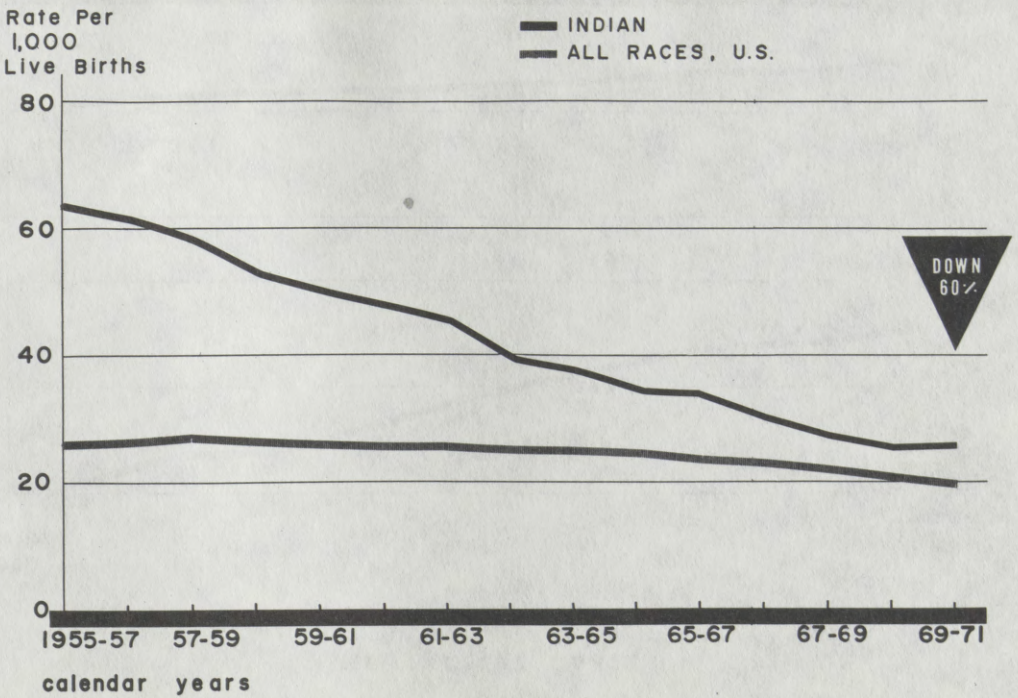


EXHIBIT L

INFANT DEATH RATES

INDIAN ABERDEEN AREA AND ALL RACES, U.S.



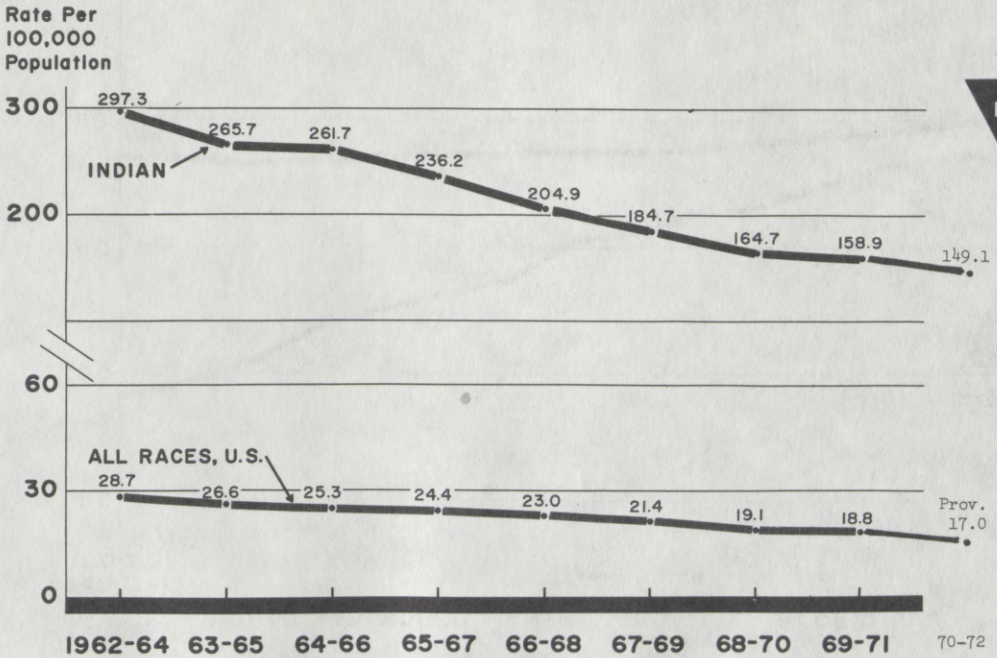
ALL RACES RATES REPRESENT SINGLE YEARS COMPARABLE TO THE MID-POINT OF THE 3-YEAR PERIOD

EXHIBIT M

INCIDENCE OF TUBERCULOSIS

NEW ACTIVE CASES

INDIAN ABERDEEN AREA AND ALL RACES, U.S.



All races rates represent single years comparable to the midpoint of the 3-year period for Indian.

EXHIBIT N

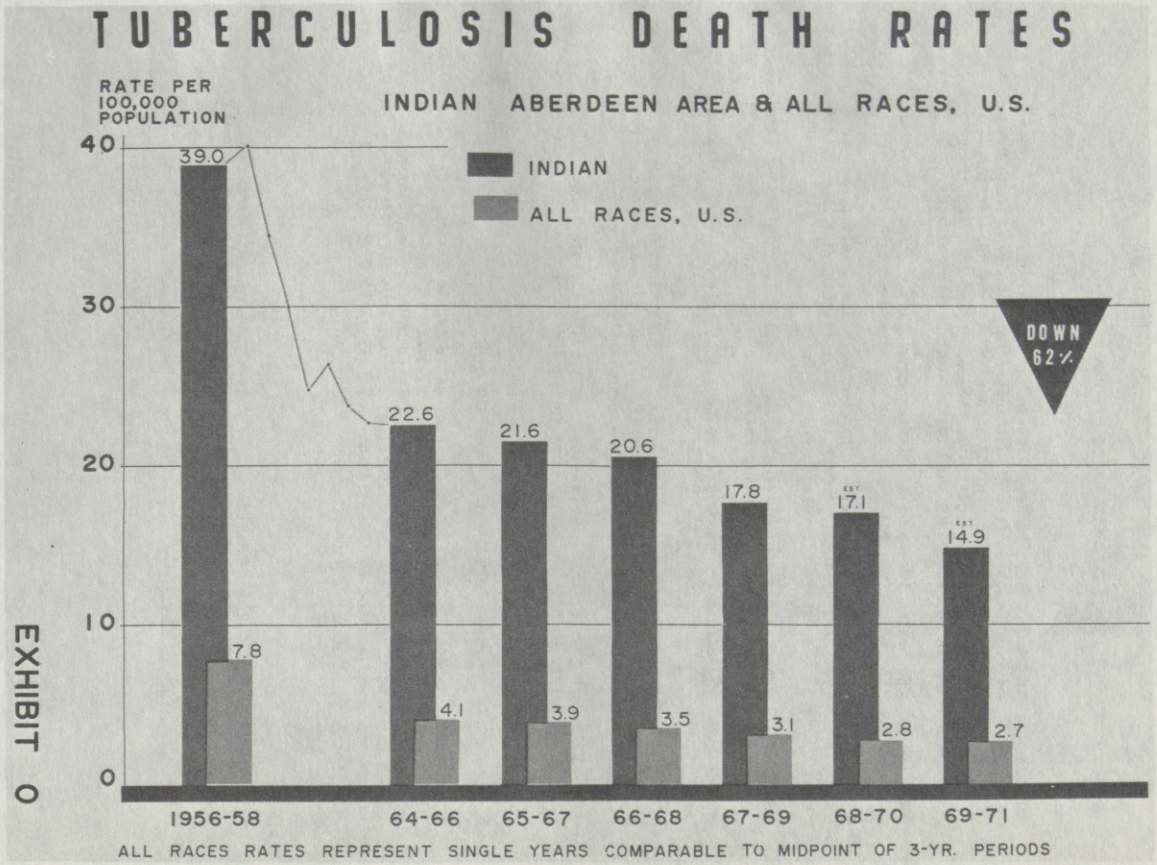

TUBERCULOSIS DEATH RATES
RATE PER 100,000 POPULATION
INDIAN ABERDEEN AREA & ALL RACES, U.S.
INDIAN
ALL RACES, U.S.
40
30
20
10
0
39.0
7.8
22.6
4.1
21.6
3.9
20.6
3.5
17.8
3.1
EST 17.1
2.8
EST 14.9
2.7
DOWN 62%
1956-58
64-66
65-67
66-68
67-69
68-70
69-71
ALL RACES RATES REPRESENT SINGLE YEARS COMPARABLE TO MIDPOINT OF 3-YR. PERIODS

EXHIBIT O

FOUR STATE ABERDEEN AREA INDIAN HEALTH BOARD

RESOLUTION NO. 73-01

WHEREAS, The Four State Aberdeen Area Indian Health Board, consisting of representates from the States of North Dakota, South Dakota, Nebraska, and Iowa, serves as advisor to the Aberdeen Area Indian Health Service and is the recognized advocate of the Indian population in the provision of health services, and

WHEREAS, the health levels of the Indian population are far worse than that of the general U. S. population, and

WHEREAS, the Indian Health Service has not been adequately funded to provide increased services to combat existing health problems in the Reservation areas, and

WHEREAS, Congress has appropriated an additional 7.315 million dollars to be added to the Indian Health Service budget, and

WHEREAS, these funds, appropriated by Congress, have not been released by the Office of the President.

NOW, THEREFORE BE IT RESOLVED, that the Four State Aberdeen Area Indian Health Board fully supports any action that may be necessary to have these funds released immediately, and

BE IT FURTHER RESOLVED, that the President must release these funds necessary to provide health care to the Indian people.

C E R T I F I C A T I O N

I, the undersigned, as Chairman of the Four State Aberdeen Area Indian Health Board, hereby certify that the Advisory Board is composed of eighteen (18) Tribal groups of whom 13 were present constituting a quorum for a meeting, which was duly called and convened this 14th day of November, and adopted this Resolution by an affirmative vote of 13 members, and 0 opposing, 5 absent.

Reuben McCloskey
Chairman, Four State Aberdeen Area Board
Reuben McCloskey

Date Nov. 14, 1973

Germaine Means
Secretary, Four State Aberdeen Area Board
Germaine Means

Date Nov. 14, 1973

Senator ABOUREZK. Dr. Allen, thank you very much. We have some questions we would like to ask and I would like to say before you leave, tonight we want a chance to visit with you about this other matter that we talked about today.

Off the record.

[Discussion off the record.]

Back on the record. I want to ask you if you had in this chart you presented—was there a deficit of the resources of the Indian Health Service?

Dr. ALLEN. The deficit I had as a whole was 30 percent. In fiscal year 1974 to deliver the same services as in fiscal year 1973, both for the Aberdeen area and Rosebud itself, it approaches 40 to 50 percent.

Senator ABOUREZK. In your mind or in your opinion, are there any alternatives for health care other than the Indian Health Service?

Dr. ALLEN. In the short run, with a majority of people served by Indian Health Service in the Rosebud, there are no alternatives to the Indian Health Service care. This is the reason I included the distances of the number of private practitioners and the number of hospital beds in the area and the documentation that those physicians are already seriously overworked.

I have had personal discussion with several private practitioners in the area and it is their uniform response they would essentially have to close their doors if it were not for the Indian Health Service. They simply would not be able to cope.

Senator ABOUREZK. That is what I continue to hear. What types of specific legislation would you think would be of benefit to the Indian Health Service in fulfilling its obligations to the Indian people?

Dr. ALLEN. I think the first step is a clear understanding, but how this would be achieved, I do not know. But a clear understanding on the part of the Congress, on the part of the Indian Health Service, and the administration, the development and definition of admission to the Indian Health Service, and a clear understanding that it is, at least in the near future, the proper organization to provide these needed services.

A redefinition of the mission of the U.S. Public Health Service and the Indian Health Service.

Senator ABOUREZK. In what way would you redefine that mission?

Dr. ALLEN. Under consideration are several bills which would redirect the activities in the Public Health Service. There is the Perkins committee report on personnel organization or system in the Public Health Service which recommends changes to make it a more attractive career system for career professionals.

There have been several reorganizations of the Public Health Service by the administration which actually have tended to terminate or to minimize health programs, particularly direct health care services of the Public Health Service which have actually been detrimental to the Indian Health Service.

Over the years, many of our physicians have come from the Division of Hospitals. Most of our specialists have been trained in the Division of Hospitals, and the potential loss of this training ground has been detrimental to the Indian Health Service for recruitment programs.

So a realization that merchant seamen, that Indian people, that beneficiaries of the Department of Defense, do have something in common, and that is the U.S. Public Health Service and the services it provides in direct health care might be of benefit.

Additional legislation might include the military pay bonus bill. Our average starting salary for a physician in the Indian Health Service under the Commission Corps systems is about $14,000–$15,000 a year. Most of these physicians at least from my word of mouth experience, have all been offered jobs at at least twice or three times that income, as beginning salaries.

Community development, the area—this is something the tribal leadership can take steps in the direction of, of developing the communities, of making housing available, of developing community resources for recreation, and for cultural type attractions.

The legislation that would permit the Indian Health Service to utilize third party sources of payment, and utilize it locally. For example, if I did an insurance physical on an Indian patient, and the insurance company stated they were going to pay $15 for this service, under the present system that check has to be endorsed over to the Treasury of the U.S. Government. It cannot even be utilized locally at the Indian Health Service hospital for medical improvements.

The same thing, we are simply unable to collect third party payment programs, such as medicare, title XIX, or private insurance, or maybe there could be some flexibility or maybe legislation could be developed to permit our funding from these various sources to be collected and used locally.

I mentioned others in my testimony. In addition, Dr. Rhoades mentioned quite a number of them, and I would support individually all of the ones that Dr. Rhoades mentioned.

Perhaps the most important one is the development of academic and teaching affiliations. It is possible a 4-year medical school will be established and will develop in the State of South Dakota. The opportunity for the Indian health budget and the Indian health facilities to be used in conjunction with a 4-year medical school both for delivery and health care to Indian people and also to the education of practitioners of medicine, particularly in the rural areas of South Dakota would benefit everybody, and it would go a long way toward our ability to recruit and retain health professionals at the community level.

Senator ABOUREZK. Is that the major change needed in a personnel system, in your opinion?

Dr. ALLEN. That is more a change in development of resources than in relationship between the Indian Health Service and other groups.

Existing in the Phoenix and Gallup area now are full teaching affiliations. That would not require a personnel change.

When I say a personnel change, I mean a career system for professionals in the Indian Health Service, attention to retirement details, attention to vacation time, attention to progress in job responsibility, opportunities for professional advancement, and opportunity for professional education. This is what I mean by personnel system.

And the Perkins committee report is, I think, the most comprehensive review on this subject.

Senator ABOUREZK. We would like to establish for the record whether or not the Indian people have greater needs for medical care than the average American citizen, and if so why are those needs greater?

Dr. ALLEN. I think the disease incidence reports, as documented in the report from the Aberdeen area office substantiates some of the affirmative answer in this regard.

Infectious disease, in particular, tuberculosis, otitis media, strep throat, hepatitis, dysentery, these all have an incidence in the Indian population of from anywhere from 10 to 80 times in the non-Indian population. In regard to trauma, automobile accidents, the death rate and injury rate, is far higher than it is for the non-Indian population, and it is the leading cause of death in young individuals.

I have before me the figures for automobile accidents. The figures are five times that of the non-Indian population in the Aberdeen area for motor vehicles. There are three times the incidence, the death rate for non-Indians in other types of injuries, in trauma.

The incidence of biliary tract disease, given us 30 percent of the population over 20, is a very high figure.

The incidence of diabetes, 30 percent over the age of 20, is a very high figure.

Within Indian Health Service, the highest known incidence or prevalence of diabetes of any known group in the world is recorded among the Pima Indians.

Thus, certain types of health problems are far more prevalent among the Indian people than they are among non-Indian people. There are certain types of problems which have other types of frequency. One is carcinoma. The death rate from carcinoma is low.

Senator ABOUREZK. What is carcinoma?

Dr. ALLEN. Cancer. The death rate from heart attacks is lower. So the answer to the question has to be documented for individual health problems in terms of frequency, in terms of visits to the doctor per unit of population is far greater for the Indian people at Rosebud than it is for non-Indian people in the area. We average some six or seven visits per year per person.

Senator ABOUREZK. Does the low standard of living of the Indian people injure the Indian people as far as their status is concerned?

Dr. ALLEN. I think it does. Crowded living conditions, inadequate heating and insulation certainly magnifies the risk of infectious disease. Likewise, the dormitory-type living of Indian boarding schools is a high risk to infectious disease.

Our experience at Rosebud with house fires as a result of poorly insulated and constructed homes—we had eight deaths in the fall of 1972 alone from house fires. The house burns to the ground in about 20 minutes flat.

Senator ABOUREZK. Is that that new housing development you are talking about? The Rosebud 400?

Dr. ALLEN. Yes. There have been steps taken since that experience to correct the problem.

Most of those deaths were children who could not get out of the house.

Senator ABOUREZK. Dr. Allen, you have answered most of our questions during the course of the testimony, except for the ones we have just asked.

Do you have anything else you would like to add in the way of recommendations or additional statistics? We would like to hear them.

Because that is the end of my questioning at this point.

Dr. ALLEN. Thank you very much, Senator.

Senator ABOUREZK. Thank you very much, Dr. Allen, for your testimony.

The next witness is Dr. Philip K. Olson, a former physician at the Rosebud Indian Health Service Hospital, Rosebud, S. Dak.

Dr. Olson, I want to apologize to you for being so late, in getting you on the stand here. But as you understand, we have had an awful lot of activity over on the floor today.

We will be pleased to have your testimony now.

STATEMENT OF DR. PHILIP K. OLSON, FORMER PHYSICIAN AT ROSEBUD INDIAN HEALTH SERVICE HOSPITAL, ROSEBUD, S. DAK.

Dr. OLSON. I am Philip K. Olson. I am a medical doctor. I spent 2 years as a general medical officer in the Rosebud Indian Health Service in 1971 through 1973. I was medical director at the Rosebud Indian Health Service Hospital during the year 1972, and for one-half year undertook interim administrative duties.

Currently, and since July of 1973, I am in medical practice at the Elliot Park Clinic in Minneapolis, Minn.

I have taken in my point of orientation in this testimony to be a representative for those 2-year physicians who for some years have formed the backbone of the Indian Health Service practice.

It is this type of person who is currently needed in the health manpower crisis, and it is these physicians who have repeatedly failed to continue medical practice in the Indian Health Service so the current crisis is basically twofold. Inability to recruit young physicians and inability to retain those physicians who came in on a 2-year commitment.

I have chosen to cast my presentation in terms of the young physician looking for a job. I have discussed this with many colleagues, those who have not been in the Indian Health Service and with quite a few who have spent 2 years in Indian Health Service positions.

The physicians who are looking for a job you must remember have had 8 to 10 years of education after the high school level. Many of them are married, have children; they have accumulated educational debts through their educational time. I personally accumulated about $9,000 worth of personal debt in medical school, and this is not unusual.

Also the expectations of young physicians in terms of financial reward, in terms of professional security, are rather high. Going to school until the age of 26 delays a great deal of financial gain.

There is also a great deal of idealism among youthful physicians. They are looking for a challenging, necessary position.

If you were a young physician—he might look for a job in one of the three different places. We would hope he would look at the Indian Health Service, we would hope that he would look at the military service system, and of course, he would look at the private sector.

I plan to review the opportunities in the Indian Health Service, in the Air Force, and in the private sector.

In responding to a job with the Indian Health Service, the young physician might decide to visit a reservation to look for a job. When he

comes to one of these reservations—and I will take the Rosebud Reservation in particular—he would find an area that is markedly impoverished. Many of the people who are there speak a foreign language.

In many ways, the reservation appears to him as a foreign country, growing up in a middle class area as most physicians have.

He will notice the substandard housing. He will notice substandard roads. He will notice substandard schools. And he might think, my children will attend here if I were to come.

He will notice these are primarily rural areas, often miles away from any cultural activities. He might take a trip to the hospital. He will notice it is an inadequate facility, crowded, outdated, and he might talk with somebody and find out what the purpose of this facility is.

He is told it is to fulfill a Federal commitment to health care.

The next thing he might do is go and talk to some of his associates, any doctors he might be working with if he took the job. They are young. They look haggard, and they are in a hurry. They are surprised to see him. They are surprised to see him show up to look for this job because they have not been expecting anybody to come to replace them.

He talks with them and he gets the distinct impression that most of them are eager to leave. They cannot wait to get on with the rest of their lives.

Many of them will relate enjoyable, interesting clinical experiencs, challenging work. But they have many complaints. They state the hours are long, on the basis of health, educational and welfare standards we are each doing the work of two doctors. They complain of the lack of personnel.

They complain particularly on the lack of means to keep those people who have been doing a good job, even though they might be Indian people who have been well trained, who have been doing a good job, but these people are frequently plucked away by the private sector despite their zeal and interest in staying on the reservation.

They complain of the lack of essential equipment to do the job. The lack of adequate laboratory facilities. They complain of the disruption of their system by small problems.

For instance, a complete OR staff that is held up for a month for failure to obtain one critical person. The complaint of an old X-ray machine that has been out there for 15 years, up for replacement, repeatedly. Often breaking down to the point where the radiographic studies are down for periods of 3 or 4 months.

Then they will also complain of their bureaucratic responsibilities, the widespread implication within the Indian Health Service, that doctors don't know how to manage anything. When there becomes need for administrative personnel on a pinch-hit basis, they turn to the doctors and say, help us organize these problems.

As to the doctors, it adds to the doctor's responsibilities and frequently to his frustration.

And then comes probably the most important and frustrating aspect of their job.

The frequent necessity to both deny and to delay essential medical care. They have been told that inadequate funds are available. They are frequently told by superiors, you better not overspend the Federal

budget; there are prison terms waiting for those who overspend the Federal budget.

I have been told that on several occasions. It has been stated sometimes in jest but sometimes more seriously.

The types of medical problems that are denied and delayed and some of which have been mentioned—the problem of chronic draining ears—these doctors sometimes get the impression that every kid has pus coming out of his ears—the hearing deficit approaches 30 to 40 percent in 6-year-olds.

There are hundreds of diseased gallbladders walking around the reservation that need to come out. But for lack of adequate care, these people are seen frequently at night and given a shot for their pain.

Any medical evaluations of a chronic nature are held up because of lack of funds. Children with seizures, children with congenital and acquired heart disease, requiring extensive evaluation and surgery, patients with renal failure who do not qualify under the current medicare and medicaid proposals.

Tuberculosis becomes a great problem for some people. Inadequate timing, inadequate personnel, in this particular area, in Rosebud, have made an epidemic of the tuberculosis problem in general.

The response to these problems is we can deal with the crises but we have to of necessity neglect the things that do not have to be done today.

Then they state, we have complained about these things to those who are superiors over us. We are told that there is no money. We are told we just have to do the best we can and basically, there is an appeal to your missionary mentality, to keep in there and do the best you can. This is sort of a missionary effort.

Basically, the responses, the system responds to political pressure, rather than medical needs. So if you want something done you have to get the tribe to make a big fuss or get the militants to make a big fuss, and then we can get some money.

Just establishing and classifying the need is not adequate.

Now the next thing you might do is go and look at the people in the area where you are going to work. The Indians are the first Americans. They have an interesting culture and background. It is a poverty culture that has an individual annual income of about $760 a year.

They are poorly educated. There is increased militancy among the young people. And they are suspicious of you as a white man.

You talk to some of them and ask them about the hospital and they say, those doctors up there are only interns; as a matter of fact, some of them will tell they have never been to medical school. They are out here practicing and if they like it, they are going to go.

You are also told they don't know anything. They come and go. But of course, they also tell you it is the only place I can afford to go when I am sick.

Then the most important thing for a doctor is, you look at the health problems. Doctors in this country are particularly interested in disease. If you are not interested in disease you are not a good doctor. And you came to the right place. Because there are lots of diseases. You can be very interested in this.

You might look at tuberculosis. There is eight times the national incidence in Indians, and on the Rosebud Reservation there is a real epidemic.

You might say to yourself, here is a real epidemic. Here is the opportunity for me to become a real expert. But as you reflect on that, you can become an expert but the only place you could work would be Indian Health Service. You would have very little carryover in the rest of this country because you couldn't do that much tuberculosis work anywhere else.

The suicide rate, three or four times the national average.

Alcoholism, a very serious problem.

A very minimal potential.

Other infectious diseases primarily affecting children are extensive and require a great deal of medical attention.

Traumatic problems in terms of violence. Accidents are also part of your job. Car accidents amazingly are prevalent. The automobile mortality on the roads of the reservation in 1972 was seven times that in the rest of the State of South Dakota on a per capita basis.

Mental health problems are extensive, with very few resources available.

Now, after looking at this job, the people, and the place, you might review what benefits you get for working there.

The salary, housing, the fringe benefits, add up to approximately $17,000 to $18,000. You might summarize this opportunity as an interesting job, very sick people, a great need, long hours, frustrating work, no medical meetings, 30 days vacation, and low pay.

Now, after looking at the Indian Health Service you might go to a nearby Air Force base. You look at the facility, the place you have to work. It's a well staffed beautiful hospital. There is more than adequate equipment. Your associates, you will notice, are three to four times the number on a per capita basis.

The doctor-patient ratio is 1–4 to 500. The doctors there play good golf. They play good pool. They spend large portions of their day doing nonmedical work. They have time in the evening to do additional work and add to their income.

The health problems of the people you see are probably less than the usual incidence of disease. They are young, they all have to pass stringent physicals to get in, so you don't have to deal much with disease.

The benefits for this job are the same as the Indian Health Service except for the fact you are able to earn extra money in many situations. It is easy to get away to a medical meeting. It is a fairly dull job. They are healthy people.

Short hours. Thirty days vacation. But again, fairly low pay.

Now, if you turn to the private sector, you might send a letter to one of the State medical associations in South Dakota or Minnesota, as I did.

You will find that within the next 2 or 3 weeks you get over a hundred offers for jobs. You will find these vary between rural and urban situations.

Virtually most of these have accredited hospitals. You can work in the ER or as a hospital-based physician, you can work on a percent or salary basis, you often have very liberal fringe benefits, tax shelters, you have vacations of 4 to 6 weeks, almost universally you can go to medical meetings for 1 or 2 weeks a year on a full-paid basis, your associates are usually interested in staying there for the rest of their

lives. They are usually content. They are participating in their communities. They have community support.

The doctor/patient ratio is 1 to 1,000 or 2,000, and they have routine health needs.

The salary and benefits amount to $30,000 to $50,000, depending on what you choose.

So you might summarize this job as fairly interesting, average need, moderate hours, and good pay.

To summarize, the Indian Health Service offers an interesting challenge to young doctors which has a potential but has frustrations to do service because of the lack of financial and administrative support which creates high levels of professional frustration.

The current pay scale reflects a lack of appreciation of the current competitive market for medical personnel and further discourages job interest on the part of physicians.

Conclusions. Unless the total program is better supported and unless individual physicians receive more competitive benefits, the physician shortage will persist and will probably intensify.

I suggest that you dramatize the current lack of Federal support to the Indian Health Service and that an appraisal be made on a comparison of military health services and Indian Health Services on a per capita basis, on the basis of minimal figures I can assure you this will turn up a difference of 300 to 400 percent in terms of commitment, of men and money, to the maintenance and health needs by the Federal Government.

Senator ABOUREZK. Dr. Olson, I think you have probably already answered this question, but why did you decide against making the Indian Health Service your career?

Dr. OLSON. I can add a couple of things. I was seriously considering continuing in an Indian Health Service career. During the 2 years I was there, the crisis in which we are now involved was predicted by a number of us, and I was virtually certain that this crisis was coming.

Various measures in terms—including the physician bonus bill—was suggested as possible alternatives. I was interested in staying and particularly if that bonus bill was passed.

This was continually delayed, continually pushed off. I finally decided I would stay even if it was not passed. However, it was an accumulation of local frustrations.

The straw that broke the camel's back, I got interested in a clinical problem out there that is unique to the reservation. I was interested in doing a little medical research. I made a request for $300 to look into what I know to be a very important clinical problem. And I was refused.

I thought it was a request that was not unreasonable. It was certain of general medical interest, of general medical value, and I was told we do not have the money.

That was only the straw that broke the camel's back. I did not leave simply because of that, but that was the juncture at which I left.

Senator ABOUREZK. Do you think trying to hold existing doctors in the Indian Health Service is more important as a priority than the recruitment every 2 years?

Dr. OLSON. By all means. Something I didn't go into extensively in my statement, there certainly are difficulties with 2-year doctors coming into communities like this, and attempting to deliver health care.

I think on the one hand the community notes the fragmentation, the youthfulness of the physicians, the lack of ability to develop trust relationships with physicians. The physicians themselves have a certain adjustment to make in these type of communities.

I think retention is a much more important priority than continuing the simply 2-year-men type of system. I think this would be more satisfactory in the long run both in the long run to the communities and the physicians.

I think if professionals were there for a longer time, their approach to some of these very important problems could be more thorough going.

Senator ABOUREZK. Dr. Olsen, I want to express my thanks and gratitude to you for coming up here to testify. I appreciate it very much. It is a good and different insight than what we have had. We appreciate it. I think it is going to be very helpful to the committee in formulating our requests for what we want to do to improve the Indian Health Service, to try to avert this kind of crisis that is coming up. I want to express my gratitude to you. Thank you.

The next witness is Sonny Waln.

STATEMENT OF SONNY WALN, DIRECTOR OF HEALTH SERVICES, ROSEBUD SIOUX TRIBAL COUNCIL

Mr. WALN. Mr. Chairman, my name is Sonny Waln.

Senator ABOUREZK. I want to welcome you here. It is very good to see you again, Sonny. Please proceed with your testimony. I am going to have to go and vote because they have called another vote.

The staff will just continue putting your stuff into the record here, and ask whatever questions we have prepared for you. I don't want you to think we minimize your testimony because of that, but it is the only way we are going to be able to get through this thing before midnight, if we just keep going.

So please, just start out.

Mr. WALN. Before you do, Senator, I would just like to thank you for giving me the opportunity to appear before you here at the committee.

Senator ABOUREZK. We thank you for coming here to do it.

Mr. WALN. Mr. Chairman, my name is Sonny Waln. I am from Rosebud, S. Dak., and an enrolled member of the Rosebud Sioux Tribe.

I was recently elected to the tribal council. I have been director of the community health representative program at Rosebud for 2 years. I have been appointed director of health programs of the Rosebud Sioux Tribe by Mr. Robert Burnette, tribal president.

The Rosebud Sioux Tribe are part of the group of people called the Dakota, who settled on the Great Sioux Reservation in the late 19th century as result of the Treaty of Laramie in 1868.

My people were not defeated.

They accepted a negotiated peace with the U.S. Government and the terms of this peace included the right to occupy certain lands, and to receive food, blankets, tools, and medical care.

I don't need to remind you what happened to the reservation lands. Since this original agreement the promise of the people of the United States to the Dakota people for medical care has been repeatedly re-

stated—by Congress, and by the President as recently as the last inaugural address.

The right to medical care has historically been given to all native peoples of the United States.

And recently with proposals for national health insurance the right to medical care is implied to all Americans.

So first I want to remind this committee that the Dakota people have the promise of medical care from the U.S. Government at several levels.

First, as a treaty obligation; second, as a native people of the United States; third, as repeatedly affirmed by Congressional legislation; fourth, as stated by President Nixon in his inaugural address; and fifth, as citizens of the United States.

Further, I would like to point out that the economic reality of the situation is that if the people of Rosebud are to have any medical care at all it must be financed by outside sources. The total income from all sources of the Indian people at Rosebud is about $5.5 million. The current cost of our health care program is about $1.8 million.

This is more than 30 percent of our total income. How can the head of a family earning $3,600 per year be expected to spend $1,000 of this on medical care?

Our per capita income is $760 per year. Can you budget $200 of this for medical care when food, clothing, and all other expenses must be provided?

So if we, as a people, are to have medical care it must be paid for through most part by funds outside the reservation.

The method by which the Federal Government has fulfilled its promise for health care to my people for the past 15 years is the Indian Health Service of the U.S. Public Health Service.

I realize that much has been accomplished by the Indian Health Service.

Tuberculosis death rates are down. Infant and maternal mortality rates are down. My people have come to realize that modern medicine can do much to improve the quality of their life and they have responded to the health education program of the IHS by coming to trust and to depend on the medical care provided by the IHS. My own program is an example of IHS efforts to reach out to the communities to make a better life available through good health care.

And now when the promise is about to bear fruit, when our young people are being immunized, our mothers are delivering their babies in the hospital, when the younger generation has come to accept and trust modern medicine, I see the promise in danger of failing.

I see our hospital badly in need of repair. I see our wards overcrowded with beds in the halls. I see our nurses working many hours of overtime without pay.

Example: Because of the shortage of nurses, the CHR's are working at the hospital in well baby, prenatal, and general clinic. And I see our doctors leaving after their 2-year obligation is fulfilled and not willing to stay 1 day longer.

And now the IHS tells us that we can no longer get doctors for Indian health because of the loss of the Doctor Draft.

Now I know better. And my people know better. And our tribal president, Mr. Burnette, knows better.

Once again the Government of the United States is going back on its promise to the Indian people.

Worse, the Government is about to promise medical care to all people of the United States when it lacks the goodwill to deliver on its age-old promise to the Indian people.

Properly supported, properly funded, properly staffed, the Indian Health Service could continue its excellent record. More, the experience gained through well-supported Indian Health Service could be studied and used in planning comprehensive health care programs for the people in the United States.

But this does not appear to be in the interest of our Government at this time.

Mr. GERARD. Thank you, Mr. Waln.

There are two questions that Senator Abourezk raised.

No. 1, as a consumer of the Indian Health Services, what is your general impression of the treatment given to you and other members of the tribes by the Indian Health Service?

Mr. WALN. At the present time?

Mr. GERARD. Yes.

Mr. WALN. I personally feel we are not getting the proper service that we should because our doctors are understaffed. We don't have the funds to send out people on contract service. They need operations, you name it. It is just about all there.

Mr. GERARD. There is a high degree of acceptability, as you pointed out, among the Rosebud, in other words who are responding to the preventive programs in this and other areas.

Mr. WALN. Yes.

Mr. GERARD. Do you see any alternatives to the current program of the Indian Health Service?

In other words, are there any ways in which the same service could be provided to the members of the Rosebud Tribe?

Mr. WALN. Other than the Indian Health Service?

Mr. GERARD. Yes.

Mr. WALN. Not at the present time.

Mr. GERARD. Those are the only two questions Senator Abourezk had prepared. I would say this, in looking at your statement, I think it does provide us with an opportunity to probably prepare a couple of questions to use with witnesses of the administration who will appear here tomorrow.

Now Senator Abourezk has asked me to recess the hearing until 10 a.m. tomorrow, when Dr. Edwards from the administration will present testimony.

Mr. WALN. Thank you.

[Whereupon, at 5 p.m., the hearing was recessed, to reconvene Tuesday, November 20, 1973, at 10 a.m.]

INDIAN HEALTH SERVICE RECRUITMENT PROBLEMS

TUESDAY, NOVEMBER 20, 1973

U.S. SENATE,
SUBCOMMITTEE ON INDIAN AFFAIRS,
OF THE COMMITTEE ON INTERIOR AND INSULAR AFFAIRS,
Washington, D.C.

The subcommittee met, pursuant to notice, at 10 a.m., in room 3110, Dirksen Office Building, Hon. James Abourezk, chairman, presiding.

Present: Senators Abourezk [presiding], and Bartlett.

Also present: Jerry T. Verkler, staff director; Forrest Gerard, professional staff member; and Ella Mae Horse, staff assistant.

Senator ABOUREZK. The hearing will come to order.

Our first witness this morning will be Dr. Charles C. Edwards, Assistant Secretary for Health, Department of Health, Education, and Welfare, accompanied by Dr. John Zapp, Deputy Assistant Secretary for Legislation, HEW, Dr. Emery A. Johnson, Assistant Surgeon General and Director, Indian Health Service, and do you have any other people from your Department here this morning, Dr. Edwards?

Dr. EDWARDS. Mr. Lee Smith, Director, Personnel Services, who is directly behind me.

Senator ABOUREZK. Would you like him to come up and sit with you?

Dr. EDWARDS. That would be fine. Mr. Smith is Director of the Office of Personnel Management for the Public Health Service.

Senator ABOUREZK. We want to welcome all of you here to the hearing this morning. As you know, the committee, the Indian people throughout the country are very concerned about the impending health crisis which has already reached some reservations, as I have understood it. We want to impress upon HEW the emergency nature of this matter and we want to try to do what we can to find a solution of this problem and so we would be pleased to hear what you have to say about it. I would like to hear from you now.

STATEMENT OF DR. CHARLES C. EDWARDS, ASSISTANT SECRETARY FOR HEALTH, DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE; ACCOMPANIED BY DR. JOHN S. ZAPP, DEPUTY ASSISTANT SECRETARY FOR LEGISLATION, HEW; DR. EMERY A. JOHNSON, ASSISTANT SURGEON GENERAL AND DIRECTOR, INDIAN HEALTH SERVICE; AND LEE SMITH, DIRECTOR, OFFICE OF PERSONNEL MANAGEMENT, PUBLIC HEALTH SERVICE, DHEW

Dr. EDWARDS. Thank you, Mr. Chairman. We are delighted to have this opportunity to meet with you and discuss this problem. It is

certainly a very critical and a high priority problem as far as we are concerned.

What I would like to do is read a short prepared statement and then we would be delighted to answer any questions that you or any of the members of the committee might have.

The Department of Health, Education, and Welfare's Health Services Administration is one of the Federal Government's principal agencies dealing with the health care needs of American citizens. The Indian Health Service, as an element of the Health Services Administration, addresses its efforts to the health needs of that segment of the American citizenry which makes up a significant portion of the American Indian and Alaska Native population.

Prior to 1955, responsibility for providing for the health care needs was vested in the Secretary of the Interior. On that date, Public Law 93–568 transferred all of his responsibilities and authorities for the preservation and conservation of the health of Indians and Alaska Natives to the Department of Health, Education, and Welfare. These authorities and responsibilities are now discharged through the Indian Health Service.

Since this transfer, the authorities carried out by the Indian Health Service have been expanded. Illustratively, Public Law 85–151 authorizes funds to be used to assist in the construction of community hospitals with a guaranteed number of beds for Indians. Also illustrative of increased Indian Health Service authorities is Public Law 86–121 which amends the so-called Transfer Act, permitting the Indian Health Service to construct safe water and sanitary waste disposal facilities for Indian homes and communities.

The Indian Health Service program is decentralized so that program operations are managed to the highest degree possible on the local level. This has been possible because of the availability of a competent manpower pool from which the Indian Health Service could draw. This has enabled the Indian Health Service to build a health system to serve a predominantly rural group.

Descriptive characteristics of the Indian Health Service system are its 86 service units, 51 hospitals, 83 health centers, and over 300 health stations and satellite clinics. During fiscal year 1974, it is estimated that some 436,000 Indians and 53,000 Alaska Natives will in some way be cared for under the program. In fiscal year 1973, there were 2,329,160 outpatient visits and 547,050 inpatient days of care provided.

In order to provide these services in fiscal year 1973, the Indian Health Service employed about 7,200 persons of which about 1,700 were physicians, dentists, and nurses. This group in fiscal year 1973, was made up of 514 physicians, 186 dentists, and 1,017 nurses. In fiscal year 1974 circumstances, unfortunately, have changed. Of the some 514 physicians, turnover resulted in the loss of about 200. Through intensive efforts, most have been replaced; today there still remain some 31 physician vacancies. Total physicians, as of November 1973, are 492. These people, together with 186 dentists and 1,027 nurses, are on duty while budget authority for this fiscal year would permit employment of 523 physicians, 186 dentists, and 1,156 nurses. As these figures indicate, the greatest disparity between onduty strength and that which is authorized occurs among the physician and nurse categories.

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 CHM's 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 effect 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 and telecommunications directed toward improving the care to Indians with use of sophisticated technologic support. The ATS–1—Applications Technologic Satellite—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 ATS–S—Applications Technologic Satellite—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 telecommunication mechanisms.

These are examples of efforts to increase the quality and efficiency of care provided to Indians; availability of such support may in addition improve the attractiveness of working in the Indian Health Service and providing a broader range and higher quality of care to more beneficiaries.

During the 25-year existence of the military draft, the Public Health Service experienced no difficulty in obtaining physician manpower since young male professionals completing training could serve their 24-month Selective Service obligation in the Public Health Service or the military services. During that time we enjoyed an application rate of about three physicians for every available position to be filled each year. Following the end of the draft, however, on June 30, 1973, we experienced a shortage of about 200 physicians throughout the PHS. This shortage was minimized for the fiscal year 1974 since there were about 900 physicians who chose to remain in the Service to complete the last 12 months of their draft-obligated services. In other words, our physician manpower problem will increase in fiscal year 1975, barring the remedies necessary to attract and retain these professionals in the Federal service.

Recognizing this, 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 1972–1973 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 of 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 residency 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 public section, particularly with regard to retention.

The disparity between income levels of a 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 financial 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.

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.

That concludes our prepared statement and we will be delighted to answer any questions you or your staff may have.

27-262—74——8

Senator ABOUREZK. Thank you for your statement, Dr. Edwards.

I wonder if you would describe briefly for the purposes of putting this on the record the history of the commissioned corps of the Public Health Service and its relationship to other components of the Armed Forces of the United States. Identify the various professional health categories found in the rank of the commissioner corps.

If you want to ask any of your staff with you to respond to some of these questions which might be a bit technical, feel free to do so.

Dr. EDWARDS. I would like to have Mr. Smith do this. He is an Assistant Surgeon General and is responsible for all of the personnel actions.

Mr. SMITH. The commissioned corps of the Public Health Service came into existence in 1880's as a result of an act of Congress in 1889. It was originally established to provide a physical manpower group for the Public Health Service and was limited to that group of health professionals. During the early 1900's it was expanded to include other categories and in the 1930's and 1940's further expanded to other categories of health disciplines. The last expansion to include a broader group of health professionals was in 1944.

Presently we have 11 categories of health professionals within the commissioned corps of the Public Health Service, including physicians, nurses, pharmacists, veterinarians, scientists, and a group that is identified as the Health Services categories, which is a composite of a large group of health professionals, including hospital administrators, masters level scientists, social workers, physical therapists, and others.

Presently the maximum authorized strength of the commissioned corps is 7,000. We now have on duty about 5,600 officers in the various categories. The greatest majority of these over the last number of years have entered the Public Health Service as a result of the selective service in which 24 months of service satisfies that obligation.

Our major area of difficulty has been within the physician category and we would anticipate that would continue.

The number of officers that are serving a selective service obligation is approximately 60 percent of our total strength.

Senator ABOUREZK. And the other 40 percent are just volunteers?

Mr. SMITH. No, this would be the career regular corps persons who have been on duty 5 years or more.

Senator ABOUREZK. Are commissioned corps medical officers subject to reassignment to other duty stations when such assignments are in the interests of the Public Health Service's statutory responsibilities? In other words, is there a high degree of mobility of the commissioned corps medical personnel?

Dr. EDWARDS. I think that is one of the real advantages, Mr. Chairman, that they are assignable to any Public Health Service activity and as a result that gives us more mobility in terms of assignments.

Senator ABOUREZK. I wonder if I might ask either of you to give a verbal response now, or you can submit a written statement for the record later if you don't happen to have the information with you; what type of health facilities, exclusive of the Indian Health Service facilities, does the Public Health Service operate? Where are these facilities located? Who are the major beneficiaries of those services?

Dr. EDWARDS. Mr. Chairman, we can at your pleasure either submit this for the record in some detail——

Senator ABOUREZK. Yes, that is what we would like to have.

Dr. EDWARDS. We would be delighted.

[Subsequent to the hearing the following information was submitted:]

Federal Health Programs Service operates all of the PHS Health Facilities exclusive of those operated by the Indian Health Service. These FHPS facilities include: 8 PHS hospitals, 1 specialty hospital, 30 PHS outpatient clinics; in the U.S. Coast Guard medical program medical care is provided at 10 major shore facilities, 98 minor shore facilities, 10 mobile dental units, 27 high endurance cutters and 69 smaller ships; and in the Federal Prison medical care program services are provided at 25 Federal Prisons and 3 prison camps. The location and beneficiaries of these PHS hospitals and outpatient clinics are as follows:

USPHS LISTING

Location	Street address	Area code	Telephone No.
HOSPITALS			
Baltimore, Md. 21211	3100 Wyman Park Dr	301	338–1100
Boston (Brighton), Mass. 02135	77 Warren St	617	782–3400
Carville,[1] La. 70721 (express and freight)	Baton Rouge, La	504	642–5421
Galveston, Tex. 77550	4400 Avenue North	713	763–1211
New Orleans, La. 70118	210 State St	504	899–3441
Norfolk, Va. 23508	6500 Hampton Blvd., Marchmont	703	423–5800
San Francisco, Calif. 94118	15th Ave. and Lake St	415	752–1400
Seattle, Wash. 98114	Box 3145 or 1131 14th Ave. South	206	325–8000
Staten Island, N.Y. 10304	Bay and Vanderbilt Sts	212	447–3010
Express address	Stapleton, Staten Island, N.Y		
Freight	Tompkinsville, Staten Island, N.Y		
OUTPATIENT CLINICS			
Annette Island, Alaska 99920			
Atlanta, Ga. 30333	1600 Clifton Rd. NE	404	633–3311
Balboa Heights, Canal Zone			
Buffalo, N.Y. 14203	227 Post Office Building, 121 Ellicott St	716	842–2017
Charleston, S.C. 29403	214 Federal Bldg. 334 Meeting St	803	577–4171, ext. 256, 257
Charlotte Amalie, Virgin Islands 00802	Post Office Box 8 or Knud-Hansen Memorial Hospital 00801.	809	774–1321
Chicago, Ill. 60613	4141 Clarendon Ave., North	312	525–6340
Cincinnati, Ohio 45202	Post Office and Courthouse Bldg., 5th and Walnut Sts.	513	684–2115
Cleveland, Ohio 44113	New Post Office Bldg., West 3d St. and Prospect Ave.	216	522–4524
Detroit, Mich. 48215	14700 Riverside Dr	313	822–9300
Honolulu, Hawaii 96807	Box 1410 or 591 Ala Moana Blvd	808	546–5670
Houston, Tex. 77002	204 U.S. Customs Building, 701 San Jacinto St.	713	226–4871
Jacksonville, Fla. 32201	Box 4788 or 328 Federal Bldg., 311 West Monroe St.	904	791–3541
Juneau, Alaska 99801	St. Ann's Hospital, 419 6th St.		
Memphis, Tenn. 38104	969 Madison Ave	901	725–9550
Miami, Fla. 33130	Box 34 or 51 SW 1st Ave., room 712	305	350–5385; 350–5388
Mobile, Ala. 36602	125 Federal Bldg	205	433–3581
New York, N.Y. 10014	245 West Houston St	212	620–3261
Philadelphia, Pa. 19106	225 Chestnut St	215	597–7395
Pittsburgh, Pa. 15219	U.S. Post Office and Courthouse, 7th Ave. and Grant St.	412	644–3376 or 3377
Port Arthur, Tex. 77640	209 Federal Office Bldg., 5th St. and Austin Ave.	713	982–2732
Portland, Maine 04103	331 Veranda St	207	775–3131, ext. 210
Portland, Oreg. 97205	220 Courthouse, Broadway and Main St	503	226–3361, ext. 501
St. Louis, Mo. 63103	1520 Market St	314	622–4851
San Diego, Calif. 92101	2105 Fifth Ave	714	293–6440
San Juan, Puerto Rico 00904	Box 3788 or 8½ Fernandez Juncos Ave	809	723–5200
San Pedro, Calif. 90731	Box 831 or 825 South Beacon St	213	832–0213; 639–6376
Savannah, Ga. 31402	P.O. Box 9625 or York and Abercorn Sts	912	232–4321
Tampa, Fla. 33601	P.O. Box 1611 or 601 Florida Ave	813	228–7711, ext 351, 353
Washington, D.C. 20201	HEW South Building, 4th and C Sts., SW	202	963–6473 963–4451

[1] Leprosy hospital (all others general).

Class of patient	Services authorized			
	Hospital	OPD	Physical examination	Immunization
BENEFICIARIES FOR WHOM PHS IS OBLIGATED TO PROVIDE MEDICAL SERVICES (PRIMARY BENEFICIARIES)				
American seamen:				
(a) Seamen employed on vessels documented under laws of the United States	X	X	X	X
(b) Civilian seamen employed on State school ships or vessels of the U.S. Government of more than 5 tons burden	X	X	X	X
(c) Owner-operators of documented commercial fishing vessels	X	X	X	X
(d) Seamen trainees				
Merchant marine cadets and State maritime cadets	X	X	X	X
Coast Guard:				
(a) Uniformed service personnel on active duty	X	X	X	X
(b) Applicants for enlistment, appointment, and promotion in the U.S. Coast Guard and retirement therefrom			X	
(c) Inactive Coast Guard reservists referred for quadrennial physical examination			X	
Former lighthouse service personnel: Active duty	X	X	X	X
National Oceanic and Atmospheric Administration:				
(a) Active duty crew members and noncommissioned ship's officers	X	X	X	X
(b) Active duty commissioned officers	X	X	X	X
Public Health Service:				
(a) Active duty commissioned officers	X	X	X	X
(b) Applicants for appointment, reappointment, and promotion in the PHS commissioned corps and retirement therefrom [1]			X	
(c) PHS inactive reserve officers [1]			X	X
BENEFICIARIES ELIGIBLE FOR MEDICAL SERVICES AT PHS FACILITIES (PHS UNDER NO OBLIGATION TO SUPPORT SERVICES OBTAINED ELSEWHERE)				
Nonreimbursable:				
American seamen:				
(a) Seamen applying for certificate of service			X	
(b) Former American seamen applying for reinstatement as seamen (previously declared physically or mentally unfit)			X	
(c) Applicants (nonseamen) for positions as food handlers aboard vessels			X	
(d) Motor boat operators (nonseamen) referred by Coast Guard for periodic color vision examination and applicants for original license as motorboat operators referred by Coast Guard for physical examination			X	
Former lighthouse service personnel [2]: Retired	X	X	X	X
National Oceanic and Atmospheric Administration [1]:				
(a) Retired crew members and noncommissioned ships' officers	X	X	X	X
(b) Dependents of crew members and noncommissioned ships' officers (active duty and retired)	X	X	X	X
Leprosy patients	X	X		
Bureau of Employees' Compensation patients:				
(a) Federal employee beneficiaries of BEC	X	X	X	
(b) Longshoremen and harbor workers referred by BEC for evaluation of injuries			X	
Civil Service Commission:				
(a) Selectees for appointment in the Federal classified service			X	
(b) Civil service employees referred for evaluation of fitness for duty			X	
(c) Civil service employees referred for disability retirement evaluation			X	
Health, Education, and Welfare:				
(a) HEW employees required to take medical examinations for purpose of qualifying for a U.S. Government motor vehicle operator's card			X	
(b) Claimants or potential claimants against HEW under the Federal Tort Claims Act			X	
Immigration and Naturalization Service patients:				
(a) Aliens for examination other than "Extension of Stay Exams."			X	
(b) Aliens for hospitalization and/or outpatient treatment	X	X		
Quarantine patients	X	X	X	
State Department: Foreign Service personnel and their dependents leaving for foreign areas when traveling under official orders				X
U.S. Government employees—immunizations: U. S. Government officials and employees, and their dependents, leaving the United States under official travel orders, and other persons traveling in behalf of the Government under official travel orders				X
Private citizens requesting yellow fever vaccination				X
Reimbursable: Foreign seamen	X	X	X	X
Reimbursable or nonreimbursable: emergency nonbeneficiaries (includes Medicare)	X	X		

See footnotes at end of table.

Class of patient	Services authorized			
	Hospital	OPD	Physical examination	Immunization
OUTPATIENT CARE NON-REIMBURSABLE				
Active duty uniformed services personnel of the Army, Navy, Air Force, and and Marine Corps	×	×	×	×
Entitled to care on a space available basis:				
Retired uniformed services personnel of the Army, Navy, Air Force , Marine Corps, Coast Guard, NOOA, and PHS	×	×	×	×
Dependents of uniformed services personnel (active duty, retired, or deceased) of the Army, Navy, Air Force, and Marine Corps	×	×	×	×
Dependents of uniformed Coast Guard personnel (active duty, retired, or deceased) and of PHS and NOAA commissioned personnel (active duty, retired, or deceased) (nonreimbursable)	×	×	×	×
Foreign NATO personnel (Army, Navy, Air Force) and their dependents	×	×	×	×
BENEFICIARES ENTITLED TO CARE UNDER THE ECONOMY ACT (REIMBURSABLE)				
Coast Guard: Coast Guard civilian personnel employed in hazardous occupations			×	
Army:				
(a) Applicants for employment with contractors of the Army Corps of Engineers for military construction work outside the United States			×	
(b) Army National Guard technicians referred by the Army for medical examination to evaluate their suitability for assignment to nuclear weapons duties			×	
(c) Applicants for enlistment in the Army who are referred by the Army for physical examination or for emergency medical care in those instances where the applicant suffers acute illness or injury while awaiting or undergoing processing at recruiting stations and Department of Defense medical facilities are not available	×	×	×	
Bureau of Employees' Compensation (Department of Labor):				
(a) War risk insurance beneficiaries	×	×	×	
(b) WPA, NYA, CCC, PRRA beneficiaries of BEC (former relief employees of the Works Project Administration, National Youth Administration, Civilian Conservation Corps and Puerto Rico Reconstruction Administration	×	×	×	
Immigration and Naturalization Service:				
(a) Nonimmigrant aliens who request an extension of temporary stay in the United States claiming physical inability to travel			×	
(b) Federal employees being considered for position of immigration patrol inspector			×	
General Accounting Office: Employees of the GAO selected for overseas assignment			×	
National Guard: Individuals injured or taken ill in the line of duty while on active duty with National Guard	×	×		
Post Office Department: Employees of the Post Office Department being considered for promotion to position of postal inspector			×	
State Department:				
(a) Recruits and candidates for the Foreign Service			×	
(b) Foreign Service personnel	×	×	×	
(c) Dependents of Foreign Service personnel	×	×	×	
Veteran's Administration: Veterans referred by regional VA office	×	×	×	
Civil Aeronautics Administration: Employees of the Civil Aeronautics Administration selected for overseas assignment			×	
Indians: Referrals from the Indian Health Service, PHS	×			
Civil Service Commission: Annuitants of deceased civil service retired personnel to determine whether survivor is capable of self-support			×	
Food and Drug Administration: Inspector and chemist employees of the FDA working as import food and drug examiners at docks, piers, and airports, who in conducting official business are subject to contact with persons coming from foreign countries				×
Library of Congress: Applicants for employment, and employees of the Library of Congress to determine fitness for duty.			×	
Department of Justice, Internal Revenue Service, and other law enforcement agencies: Persons, subject to prosecution by Department of Justice, Internal Revenue Service, or other Federal law enforcement agency, who claim physical inability to appear in court.			×	
Other Government agencies:				
(a) Employees of other Departments of the Government referred for medical examinations to determine their fitness to operate Government motor vehicles.			×	
(b) Claimants and potential claimants against other Government departments under the Federal Tort Claims Act.			×	
Federal Bureau of Investigation (Department of Justice): Employees of the FBI referred for periodic physical examinations.			×	
Railroad Retirement Board: Beneficiaries of the Railroad Retirement Board, disability retirement examinations.			×	

See footnotes at end of table.

Class of patient	Services authorized			
	Hospital	OPD	Physical examination	Immunization
BENEFICIARIES ENTITLED TO CARE UNDER THE ECONOMY ACT (REIMBURSABLE)—Continued				
U.S. Government employees, immunizations: U.S. Government employees working in or traveling in official capacity to endemic areas within the United States and its possessions, who do not qualify as PHS beneficiaries.				X
Bureau of Family Services (SRS–HEW): Beneficiaries of the Bureau of Family Services—Mentally ill U.S. Nationals (repatriated from foreign countries).	X			
Bureau of Public Roads (Department of Transportation): Highway personnel of the Bureau of Public Roads referred for immunizations.				X
Peace Corps beneficiaries (Department of State): Peace Corps candidates and personnel referred for medical services	X	X	X	
Bureau of Prisons (Department of Justice): Bureau of Prisons patients (prisoners)	X			
Office of Economic Opportunity:				
(a) Job Corps applicants and enrollees referred for medical services	X	X	X	
(b) VISTA volunteers, applicants and enrollees referred for medical services.	X	X	X	
COOPERATIVE COMMUNITY PROGRAMS (SEC. 328(B) OF PHS ACT)				
Reimbursable (not an exhaustive list):				
Model cities concentrated employment program (CEP)			X	
Neighborhood Youth Corps (NYC)			X	
Renal hemodialysis	X	X		
Work incentive program (WIN)		X	X	
Nonreimbursable (not an exhaustive list):				
Family planning clinic		X	X	
Mental health center	X	X		
Health services for Head Start children	X	X	X	
Preventive dental therapy		X		
SPECIAL STUDY				
Special study, NIH collaborative program	X	X		
Special study, NIH direct grant	X	X		
Special study, NIH university grant	X	X		
Special study, other support	X	X		
Special study, malaria research volunteers	X	X		
Special study, nonreimbursable	X	X		

[1] Eligible for care only at PHS hospitals and outpatient clinics.
[2] Eligible at PHS contract physician facility.

Senator ABOUREZK. We will give you the question after the meeting today.

To what extent are career commissioned officers utilized in staffing such facilities? To what extent are civil service personnel utilized in staffing these health facilities?

Mr. SMITH. The majority of the health professionals are commissioned officers. This would include, of course, our responsibilities within the Public Health Service hospitals. There has been an increase in the last 6 to 8 years, of civilians through use of the civil service system for some of the staffing of our facilities. The major categories are physicians, dentists, scientists, pharmacists, and others. There is still a rather extensive proportion that would exceed 90 percent which are in the commissioned corps. We have been extending our efforts to offer the use of both systems in order to broaden our capability of attracting personnel.

Senator ABOUREZK. Since several of the Public Health Service hospitals are located in metropolitan centers, that is, Baltimore, New Orleans, San Francisco, Seattle, et cetera, would it be accurate to state that alternative coverage for the beneficiaries utilizing these facilities is not a serious problem because of the availability and accessibility of private doctors and hospitals?

Dr. EDWARDS. I think that is certainly a very fair statement, Mr. Chairman. I wouldn't say it wasn't a problem, but it certainly is a very resolvable problem. We are contemplating closing some of the Public Health hospitals. We did make tentative contractual agreements with providers in metropolitan areas to provide these services.

Senator ABOUREZK. Do you have this information with you? What is the doctor population ratio for the general population of this country?

Mr. SMITH. It is 1 to 650.

Senator ABOUREZK. And also what is the doctor population ratio for the beneficiaries served by the Public Health Service hospitals, exclusive of the Indian Health Service hospitals?

Mr. SMITH. I do not have that figure, but I will be glad to get it for you.

Senator ABOUREZK. We would like to ask you to submit that, if you would, please?

[The information follows:]

Federal Health Program Service beneficiary estimates for FY 1974 are listed below. The exact categories of beneficiaries and their entitled care are outlined in the material provided on page 12. The beneficiary-physician ratios by program are difficult to compute because eligibility for care in different programs varies. For examples, Coast Guard active duty personnel are eligible for care in the PHS hospitals and clinics and in Coast Guard medical facilities. Seamen, however, are eligible for care in the PHS hospitals and clinics but not in Coast Guard medical facilities. A similar anomaly exists for Federal prisoners.

FHPS Beneficiary Estimates for FY 1974

American seamen, all categories	190,500
Active duty Coast Guard	37,682
National Oceanographic and Atmospheric Administration (NOAA) personnel	1,200
PHS officers	6,800
Patients with leprosy	3,000
Federal prisoners	22,300
Subtotal	261,482

The population of active duty Coastguardsmen, PHS and NOAA beneficiaries is considered accurate. Determining the population of American seamen eligible for care at any one time is difficult, since not all seamen are eligible at all time for care. Thus, there are at any one time many more seamen eligible for care than there are seafaring jobs. Regulations state that in order to be eligible a seamen must be actively, or recently, employed in the seafaring trade. Eligibility for care ceases if the seaman has not been so employed within 90 days of the time he presents himself for medical care. Since many seamen sail intermittently, eligibility status may change many times over a period of a few years. Seamen who are under "continuous" [1] medical attention and those in a "not fit for duty" status are also eligible. These factors make it virtually impossible to present accurate population estimates.

Subtotal from above	261,482
Dependents of Coast Guard, NOAA, and PHS personnel	130,000
Coast Guard retired personnel	14,610
PHS retired personnel	1,440
NOAA retired personnel	Not known
Department of Defense (DOD) active duty personnel	2,232,902
DOD dependents	4,800,739
DOD retired	1,017,271
Total	8,458,444

[1] Seamen being treated for a problem which occurred while eligible for care are entitled to continuous treatment for that specific problem even though they are no longer eligible for medical care.

The number of beneficiaries in all other categories such as: Office of Federal Employees' Compensation patients, Immigration and Naturalization Service patients, quarantine patients, Foreign Service Personnel and their dependents, private citizens requesting Yellow Fever Vaccination, Foreign seamen, Foreign NATO personnel and their dependents, Peace Corps beneficiaries, Job Corps applicants, etc. are impossible to estimate. The specific categories were delineated earlier in this testimony.

Listed below are the number of physicians that were on duty during FY 1973 by program element. These figures do not include M.D.'s in full-time training (internships and residencies), in research activities, or in full-time administrative positions. Last year there were 58 interns and 167 residents on duty.

Program category:	*Number of physicians*
Eight PHS GMS hospitals and 30 outpatient clinics	[1] 311
Carville leprosarium	9
Coast Guard medical program	36
Prison medical program	48
Total	404

[1] 25 of these are civil service physicians.

Using these beneficiary data it is possible to develop only a gross physician/beneficiary ratio of 1 to 647 primary beneficiaries and a ratio of 1 to 20,936 total beneficiaries. The actual ratio probably fall some where between these two extreme figures.

Senator ABOUREZK. What is the administration's current policy with respect to the future status of the Public Health Service hospitals, exclusive of the Indian Health Service hospitals?

Dr. EDWARDS. The administration, Mr. Chairman, has made the recommendation that the Public Health Service hospitals be closed. As you, I am sure, know, this is still a debatable subject and a final resolution of the problem has not been reached. In the meantime we are continuing, of course, in the spirit of the law, to run the Public Health Service hospitals.

Senator ABOUREZK. I wonder if you would identify all relevant HEW and Public Health Services formal training programs designed to increase the number of doctors and other key health personnel?

Dr. EDWARDS. May we provide that for the record?

Senator ABOUREZK. Yes. We would appreciate your doing that.

[The information follows:]

Identification and Funding Levels for HEW and Public Health Service Training Programs Designed To Increase the Number of Doctors and Other Key Health Personnel

[Fiscal year 1974 funding level]	*Millions*
Health professions student loan program	$36.0*
Health professions scholarship program	14.6
National Health Service Corps scholarship program	3.0*
Family medical residency support program	9.5
Health professions loan repayment program	0.4
Physician shortage area scholarship program	2.0*
Continuing dental education program	0.2*
Dental fellowship program	0.025*
Nursing student loan program	22.8
Nursing scholarship program	19.5
Nursing traineeships (advanced training)	13.0
Loan repayment program for nursing	1.6*
Full utilization of nursing talent	0.622
Nursing research training grant program	0.700*
Nursing fellowship program	0.650*
Nursing special project grants	19.0
Public health traineeships	9.1
Allied health traineeships	3.6
Allied health full utilization program	0.100
Area health education centers	12.0*
Physician assistant training program	8.0*
Special health career opportunity grants	6.975*
Health professions special project grants	50.8

NOTES

Undergraduate students are also supported by the National Direct Student Loan Program administered by the Office of Education. Information is not available on the dollar amounts expended for doctor or other key health personnel training because it is impossible to determine which students will eventually enter the health field.

Funding levels reflect the 5% option provided the Administration in the DHEW Appropriations Act. Those amounts with a * are the appropriated amount.

CIVIL SERVICE

Years service	Normal promotion pattern when authorized	GS pay scale
Entry [1]	GS–11 step 10	$19,072
2	GS–12 step 6	20,412
3	GS–13 step 3	22,055
4	GS–14 step 1	24,247
5	GS–15 step 1	28,263
6	GS–15 step 2	29,205
7	GS–15 step 3	30,147
9	GS–15 step 4	31,089
11	GS–15 step 5	32,031
13	GS–15 step 6	32,973
18	GS–15 step 7	33,915
21 years, if EOD was GS–15, thence to step 10		36,741

[1] After completion of internship, residency and practice experience will allow physicians to enter at higher levels.

COMMISSIONED CORPS

Years service/grade pay purposes	Base pay, monthly	Base pay, annual	Quarters, with dependents [1]	Quarters, without dependents [1]	Subsistence	Incentive pay [2]	Continuation pay [3]	Total with dependents	Total without dependents
Entry 03 (over 4 years service) [4]	$1,050.30	$12,603.60	$2,347.20	$1,900.80	$574.56	$1,200.00	0	$16,725.36	$16,278.96
After 1 years, 04 (over 6 years service)	1,130.40	13,564.80	2,584.80	2,145.60	574.56	1,200.00	0	17,924.16	17,484.96
After 3 years, 04 (over 8 years service)	1,180.80	14,169.60	2,584.80	2,145.60	574.56	1,800.00	0	19,128.96	18,689.76
After 6 years, 05 (over 10 years service)	1,311.90	15,742.80	2,865.60	2,379.60	574.56	3,000.00	$5,247.60	27,430.56	26,944.56
After 12 years, 06 (over 16 years service)	1,776.90	21,322.80	3,099.60	2,541.60	574.56	4,200.00	7,107.60	36,304.56	35,746.56
After 21 years, 06 (over 26 years service)	2,189.70	26,276.40	3,099.60	2,541.60	574.56	4,200.00	8,758.80	42,909.36	42,351.36

[1] Not paid when quarters are provided rent free by the Government.

[2] 2 years service, $100 per month. 2 to 6 years service, $150 per month. 6 to 10 years service, $250 per month. Over 10 years service, $350 per month.

[3] 5 years of active duty with PHS or military service as a physician (up to 3 years may be credited for residency training), will qualify a physician for additional pay which is roughly equivalent to months base pay. He may elect to receive continuation pay anytime during the years on an annual basis.

[4] After completion of internship, residency and practice experience will allow physicians to enter at higher levels.

Senator ABOUREZK. Does the proposed military pay bill, S. 368, include the Commissioned Corps officers?

Dr. ZAPP. It doesn't, as submitted, but as Dr. Edwards said in his statement, we are proposing to forward an amendment to the Armed Services Committee to include the Commissioned Corps on the same basis as the Department of Defense personnel.

Senator ABOUREZK. When do you anticipate that will happen?

Dr. ZAPP. I would assume within the next few weeks.

Senator ABOUREZK. What is the Department's position with respect to the legislation?

Dr. ZAPP. Well, it is an administration bill, Mr. Chairman. We are in support of it and certainly would support any amendment to include the Commissioned Corps.

Senator ABOUREZK. Do you know where the Office of Management and Budget stands on the question of extending the provisions of this legislation to the Commissioned Corps officers?

Dr. ZAPP. The amendment that we talked about now?

Senator ABOUREZK. Yes.

Dr. ZAPP. The Office of Management and Budget is in support of the transmission of an amendment to include the Commissioned Corps.

Senator ABOUREZK. I am informed by the staff that there has been a position taken by the Office of Management and Budget that that coverage should extend only to medical practitioners, not to administration people. Do you know if that distinction has been made by the Office of Management and Budget?

Dr. ZAPP. To my knowledge, Mr. Chairman, I don't think the Secretary and the Office of Management and Budget have arrived at exactly which personnel within the Public Health Service Commissioned Corps would be included. It is defined as those in the shortage categories and obviously the practicing physicians are the greatest need at this time.

Dr. EDWARDS. We are very hopeful that there will be a very broad interpretation of the shortage areas, because we do have a number of very critical professional roles to play other than the direct laying on of hands in a clinical sense of the word. So we are hopeful that shortage areas will be defined rather broadly and I have reason to believe that they will be.

Senator ABOUREZK. Mr. Gerard has a followup question to that.

Mr. GERARD. Dr. Edwards, what would be the situation if our report is correct that the Office of Management and Budget wants to restrict the coverage of the pay bill to only those doctors who are actually practicing clinical medicine? Let's assume that went through and you had a doctor assigned to one of the Indian programs. He was covered by the bonus but later on he was promoted, say, to Washington and to an administrative post. Would this not put the administration in a rather unusual position of having to decide whether or not that pay bonus extended to the individual once he moved out of the clinical setting?

Dr. EDWARDS. I think it would put is in a difficult position because, certainly, as I mentioned earlier, that is one of the great advantages of having the Commissioned Corps, that we do have some flexibility in terms of asigning them. Part of one's career is administrative, and I

think that is as it should be, in my judgment, and this would put us in a difficult position.

Mr. GERARD. One final question. Are you free to release your proposed amendment to the committee for part of the hearing record?

Dr. ZAPP. I think it would depend, Mr. Gerard, on the length of time the committee record will be open. The thing we wanted to do was to be able to bring before the subcommittee the assurance that we are going to be going forward in amending the bill. The amendment is not yet drafted.

Senator ABOUREZK. Our record will be open for 2 weeks and we would like to ask you now to submit it before that 2-week period, if you would.

Dr. ZAPP. We will make every effort.

Senator ABOUREZK. It would be very relevant to the purposes of this hearing, I think.

Dr. EDWARDS. We will certainly convey that.

[Subsequent to the hearing the following information was received:]

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE,
January 15, 1974.

Hon. F. EDWARD HÉBERT,
Chairman, Committee on Armed Services,
House of Representatives, Washington, D.C.

DEAR MR. CHAIRMAN: There is before your Committee a bill, S. 2770, "To amend chapter 5 of title 37, United States Code, to revise the special pay structure relating to medical officers of the uniformed services."

The bill, which was passed by the Senate on December 21, 1973, is based upon a draft bill proposed by the Department of Defense. Among its other purposes, the bill would authorize an experimental program to reduce the gap between the incomes of civilian and military physicians by substituting an improved variable incentive pay in place of the existing continuation pay for armed forces physicians and dentists.

We are enclosing an amendment to that bill which would expand this provision to include physicians of the Commissioned Corps of the Public Health Service.

For the past twenty years, this Department has been almost wholly dependent on draft-related recruitment to provide physicians for its health programs, including those of the Indian Health Service hospitals and clinics, medical services to the Coast Guard and the Bureau of Prisons, the intramural research activities of the National Institutes of Health, and the National Institute of Mental Health, the Epidemic Intelligence Service of the Center for Disease Control, and, more recently, for the National Health Service Corps. The Department now employs more than 3,200 physicians

We plan to reduce these numbers significantly through the transfer of Saint Elizabeths Hospital to the District of Columbia, the assumption by the Department of the Navy of medical services to the Coast Guard, contracting with outside physicians wherever possible, and generally making better use of physicians. (Also, as you know, we have tried for two years to close the Public Health Service Hospitals or transfer these inpatient services to local facilities, but the Congress has prevented our doing this.) However, despite our best efforts to use all practical alternatives, we must continue to employ substantial numbers of physicians for the Department's essential health services.

Employment applications submitted to the Department from physicians have dropped at a precipitous rate since the end of the military draft. We believe that this development is due in large measure to the fact that, as with the Defense Department, the pay and other attractions are noticeably less generous than those which are wisely available to private sector physicians in comparable salaried practice, and which, of course, fall far short of the average net incomes of private practitioners. Moreover, many of our assignments, such as service in remote Indian reservations, in urban ghettoes, and in Federal prisons, are comparatively unattractive and difficult.

Because our Department draws on the same physician pool as the Department of Defense for its recruitments, our proposed amendment is needed to maintain

basic parity between service with the PHS Commissioned Corps and service in the Armed Forces. Maintaining this parity has been the practice over many years, and is now essential if we are to meet our statutory obligations for the provision of medical services. The Defense Department concurs in this amendment.

We share the Defense Department's view that this improved variable incentive pay for physicians should be administered in a carefully targeted, selective manner. We would offer such additional financial incentives, under the terms of the amended bill, only to physicians, below the grade of O–6, whom the Secretary determines to be qualified in a critical medical specialty where shortages are being experienced.

We estimate that the added annual costs to this Department of the amendment will be in the range of $10 to $15 million.

The Office of Management and Budget has advised that there is no objection to the submission of this amendment, enactment of which would be in accord with the program of the President.

Sincerely,

(S) CASPAR W. WEINBERGER,
Secretary.

Enclosure.

AMENDMENT TO S. 2770, AN ACT IN THE HOUSE OF REPRESENTATIVES, DATED DECEMBER 21, 1973

On page 4, line 2, insert "officer above the pay grade of O–5" after "medical".

On page 4, lines 10 and 18, after "Defense", and on page 5, lines 12 and 19, after "Defense,", insert "or by the Secretary of Health, Education, and Welfare, as appropriate,".

On page 4, line 11, strike out "or" the second time it appears.

On page 4, line 12, insert "or a medical officer of the Public Health Service," after "officer,".

Senator ABOUREZK. I wonder if you would provide the committee with a brief description of the health organizational structure within HEW, including the Indian Health Service.

Dr. EDWARDS. The health establishment under the Assistant Secretary for Health is composed of six agencies, the National Institutes of Health, the Food and Drug Administration, the Health Services Administration (of which the Indian Health Service is a part), the Health Resources Administration, the Center for Disease Control at Atlanta, and a new agency, the Alcoholism, Drug Abuse, and Mental Health Administration. These are six independent agencies, all reporting to the Assistant Secretary, and the Indian Health Service is a major unit of the Health Services Administration.

Senator ABOUREZK. What does your organizational chart look like? What do you have starting up here at the top, Secretary of HEW?

Dr. EDWARDS. Yes, the top box, of course, is the Secretary of HEW, and the Under Secretary and I report directly to the Secretary. And the agency heads report directly to me, and, then, of course, Dr. Johnson, who heads the Indian Health Service, reports directly to the agency head.

Senator ABOUREZK. To which agency head?

Dr. EDWARDS. Mr. Buzzel, who heads the Health Services Administration.

Senator ABOUREZK. Is it true that the Indian Health Service is right at the bottom of the totem pole in the chart?

Dr. EDWARDS. Quite the contrary. It has the same status as any of our major activities. I will give you an example. The Food and Drug Administration, which I was involved with, includes the Bureau of Drugs, which is the group that regulates all of the pharmaceutical in-

dustries in this country. The Bureau of Drugs reports directly to the Commissioner of the Food and Drug Administration. The Indian Health Service has the same kind of relationship to the Administrator.

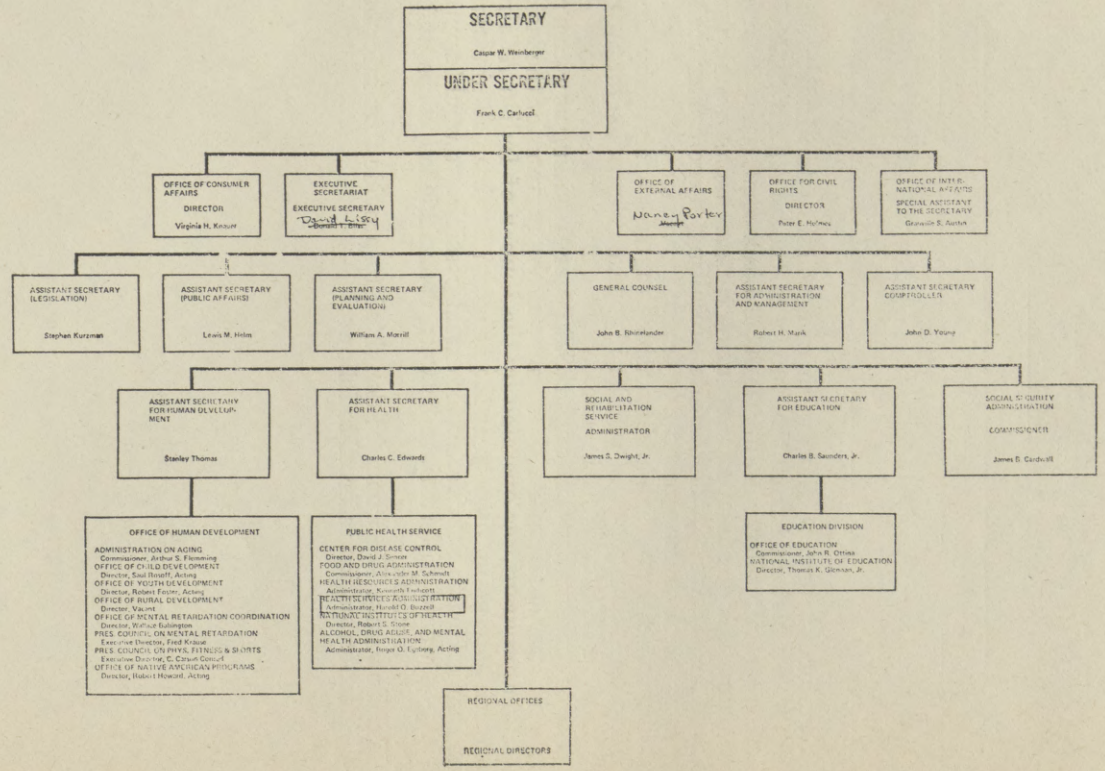
Senator ABOUREZK. Do you happen to have an original chart with you?

Dr. EDWARDS. No, but I certainly could provide one to you.

Senator ABOUREZK. We would appreciate it, if you would provide that.

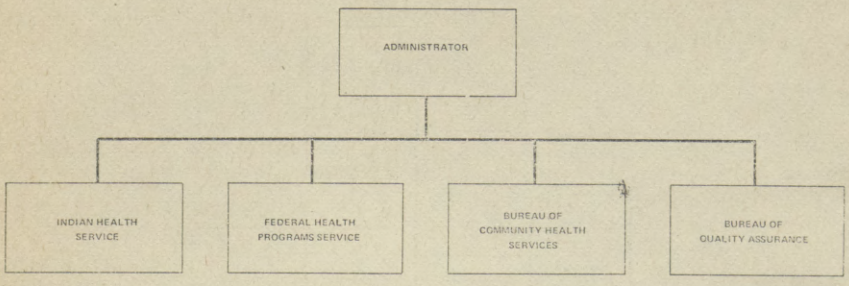
[The chart referred to above follows:]

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE



DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
PUBLIC HEALTH SERVICE

HEALTH SERVICES ADMINISTRATION



Senator ABOUREZK. The health responsibility for Indians, as you said, was transferred from the Bureau of Indian Affairs to the Public Health Service effective July 1, 1955. Since that time, encouraging progress has been achieved in reducing certain communicable diseases, that is, tuberculosis among Indians resulting in increasing their life-span. Much of the progress can be traced to an increase in professional staffing in the preventive and curative programs operated by the service for the Indian people. I wonder if you would provide for the record a list of all IHS facilities by size, location, and population served.

The committee would also appreciate your providing us with a report reflecting professional health staffing of the program for the last fiscal year the program was operated by the Bureau of Indian Affairs and for each succeeding fiscal year the program has been administered by the Public Health Service. To the extent possible, we would appreciate it if you would differentiate between commissioned corps and civil service personnel.

Dr. EDWARDS. We would be delighted to provide that information.

[The information referred to follows:]

MAJOR PHS INDIAN HEALTH FACILITIES BY AREA AND STATE (AS OF JULY 1, 1973)

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, 1973)—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	445	Sequoyah.
16,566	Tahlequah (W. W. Hastings) (57)	2,310	Okmulgee		
		1,078	Pawhuska		
		20,542	Shawnee		
9,287	Talihina (94)	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)				
11,552	Phoenix (173)				
6,817	Sacaton (35)				
5,931	San Carlos (36)				
6,814	Whiteriver (Fort Yuma)(52)				
California: 1,669	Winterhaven (14)			639	Riverside.
Nevada:					
2,065	Owyhee (17)			461	Stewart.
6,853	Schurz (26)				
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)				

INDIAN HEALTH SERVICE PERSONNEL ON DUTY BY CATEGORY, 1955–73

[Data as of June 30 each year]

	1973	1972	1971	1970	1969	1968	1967	1966	1965	1964	1963	1962	1961	1960	1959	1958	1957	1956	[1] 1955
Physicians	479	479	458	449	425	392	357	335	318	299	270	256	208	216	203	209	204	195	125
Dentists	155	171	154	129	129	125	111	105	105	100	100	91	82	81	78	78	70	64	40
Graduate nurses	1,079	1,057	1,073	1,057	981	984	930	909	928	913	890	875	868	809	792	828	865	790	783
Pharmacists	141	141	119	113	103	98	74	77	67	65	61	58	49	45	33	32	27	20	7
Social workers	80	76	69	70	62	61	54	48	41	42	42	39	34	30	21	21	20	18	8
Public health educators	21	20	19	17	15	17	14	9	9	8	7	6	6	8	7	7	6	5	4
Dietitians	27	30	31	26	24	27	26	24	26	26	27	24	23	22	20	19	24	22	16
Nutritionists	14	19	18	13	10	12	10	8	10	11	11	11	10	9	6	5	4	2	1

[1] Professional staff on duty at time of transfer.

Senator ABOUREZK. Is it true that a policy decision was made shortly following the transfer in 1955 to phase out civil service doctors and utilize only commissioned corps doctors?

Mr. SMITH. I am not aware of that policy. I was not within the office of personnel at that time. I do know there was a significant shift of a number of persons who were employed in civil service to the commissioned corps of the Public Health Service, but I think from my knowledge of it, it was more related to the compensation and benefits aspect of the commissioned corps as related to civil service at that time.

Senator ABOUREZK. Dr. Johnson, do you happen to know if that decision was made at the time?

Dr. JOHNSON. No; I am not aware that any specific decision was made. I think, though, that there are certain management reasons for looking to the commissioned corps rather than the civil service for providing health manpower, particularly physicians. I think the civil service personnel system is not particularly structured to be responsive to the 24-hour a day, 7-day week activity that must take place at remote medical facilities. As you know, the civil service system is set up on a 40-hour week with overtime and standby time and a whole series of other issues that have to go on. I would assume from a management sense that it would have been appropriate for them to emphasize commissioned corps officers who are paid a straight salary, to the Veterans Administration medical system.

Senator ABOUREZK. It appears there has been a very subtle policy decision that perhaps is not enunciated but was at least in the minds of the people making the decisions in those days, because apparently the shift did take place without any kind of a policy announcement.

Dr. JOHNSON. Yes; I have never seen anything officially that identified that as a policy. I am just suggesting to you that from a management point of view there are some reasons for looking for a commissioned type program or a VA type of program for health officials.

Senator ABOUREZK. Are the physical requirements for acceptance into the commissioned corps more rigid than requirements for entering the civil service component?

Mr. SMITH. Yes, they are. As you may know, we are one of the seven uniform services and assistance such as our retirement and medical benefits that are provided to commissioned officers of the Service are quite extensive and the obligation of the Government is significant. We, therefore, have medical standards that protect the Government against unwarranted obligations. We have over the years continued to review those standards and considerable latitude has been provided, particularly as it relates to the reserve corps of the Public Health Service, and we have made exceptions for limited periods of time when the condition is one that over a short term would not result in an obligation.

Senator ABOUREZK. Would the more rigid requirements rule out the acceptance of some doctors who might want to practice in the Indian Health Service or the Public Health Service?

Mr. SMITH. We have had a few situations where that was so. I would suggest that they were very small in numbers.

Senator ABOUREZK. Do you know how many? Do you have any idea?

Dr. JOHNSON. I am about to point out at this time, Mr. Chairman, that in the Indian Health Service, we recruit equally for commissioned or civil service physicians. We have a number of physicians in the commissioned corps who were transferred over to civil service because in the early years the pay is better on the civil service side. It makes no difference to us at the moment which of the personnel systems one is in. The number that are disqualified for physical reasons, though, for commissions is relatively small, though there are a number of people. But those people then have the opportunity to come into the service as a civil service physician so they are not eliminated from participating in the program at all.

Senator ABOUREZK. What is the maximum pay a doctor can receive under civil service as opposed to the commissioned officer corps?

Dr. JOHNSON. Roughly, early on, and these are approximations, maybe Mr. Smith has the exact numbers, a commissioned officer starting out would get somewhere in the neighborhood of $16,000 a year. If he stayed with us for 16 years or so he would get up into the high twenties. Civil service doctors, it would seem to me, would start at $19,000, $20,000, and can then get up into the high twenties up around the $30,000 range with overtime. We can provide the precise figures. I am sure Mr. Smith has them.

Senator ABOUREZK. If you can, submit those for the record.

Mr. SMITH. I would be glad to.

[The information follows:]

CIVIL SERVICE

Years service	Normal promotion pattern when authorized	GS pay scale
Entry [1]	GS–11 step 10	19, 072
2 yrs	GS–12 step 6	20, 442
3 yrs	GS–13 step 3	22, 055
4 yrs	GS–14 step 1	24, 247
5 yrs	GS–15 step 1	28, 263
6 yrs	GS–15 step 2	29, 205
7 yrs	GS–15 step 3	30, 147
9 yrs	GS–15 step 4	31, 089
11 yrs	GS–15 step 5	32, 031
13 yrs	GS–15 step 6	32, 973
18 yrs	GS–15 step 7	33, 915
21 yrs if EOD was GS 15 thence to step 10		36, 741

COMMISSIONED CORPS

Years service/grade pay purposes	Base pay monthly	Base pay annual	Quarters with dependents [2]	Quarters without dependents [2]	Subsistence	Incentive pay [3]	Continuation pay [4]	Total with dependents	Total without dependents
Entry 03 (over 4 yr service) [1]	1, 050. 30	12, 603. 60	2, 347. 20	1, 900. 80	574. 46	1, 200	0	16, 725. 36	16, 278. 96
After 1 yr, 04 (over 6 yr service)	1, 130. 40	13, 564. 80	2, 584. 80	2, 145. 80	574. 56	1, 200	0	17, 924. 16	17, 484. 96
After 3 yr, 04 (over 8 yr service)	1, 180. 80	14, 169. 60	2, 584. 80	2, 145. 60	574. 56	1, 800	0	19, 128. 96	18, 689. 76
After 6 yr, 05 (over 10 yr service)	1, 311. 90	15, 742. 80	2, 865. 60	2, 379. 60	574. 56	3, 000	5, 247. 60	27, 430. 56	26, 944. 56
After 12 yr, 06 (over 16 yr service)	1, 776. 90	21, 322. 80	3, 099. 60	2, 541. 60	574. 56	4, 200	7, 107. 60	36, 304. 56	35, 746. 56
After 21 yr, 06 (over 26 yr service)	2, 189. 70	26, 276. 40	3, 099. 60	2, 541. 60	574. 56	4, 200	8, 758. 80	42, 909. 36	42, 351. 36

[1] After completion of intership, residency and practice experience will allow physicians to enter at higher levels.

[2] Not paid when quarters are provided rent free by the Government.

[3] 2 years service, $100 per month. 2 to 6 years service, $150 per month. 6 to 10 years service, $250 per month. Over 10 years service, $350 per month.

[4] 5 years of active duty with PHS or military service as a physician (up to 3 years may be credited for residency training), will qualify a physician for additional pay which is roughly equivalent to 4 months base pay. He may elect to receive continuation pay anytime during the years on an annual basis.

Senator ABOUREZK. I wonder if you would describe the major provisions of the Doctor Draft Act and the date this act became available to the Public Health Service?

Mr. SMITH. The specific Doctor Draft Act was established in 1949, in which physicians, dentists, and other health professionals—there are five groups—in which they could be deferred if entering medical school, veterinary medicine, optometry, then came under the special draft call which was initiated by the Department of Defense for a specified number of these particular professions. The Public Health Service was included under that and remained under the coverage of the act until it expired on June 30 of this year.

I might point out that the Public Health Service was not authorized to issue a call. All of the persons who volunteered to the Public Health Service did, however, satisfy their obligation by such service. We did not issue a numbers call through the Selective Service System.

Senator ABOUREZK. When did the Department learn that this Draft Act was likely to come to an end?

Dr. EDWARDS. I am not sure that I can answer that question, Mr. Chairman.

Dr. ZAPP. I would have to say I don't think we had any inside information that exceeded that of Congress and the general public as to what might happen to the draft. I would certainly think it was only in the last year that there was any certainty on that point.

Senator ABOUREZK. In other words, when you started acting to make alternate provisions for supplying doctors, was it sometime last year?

Dr. ZAPP. I would say in the last year, near the close of the last Congress when the Department of Defense's bonus bill for health professions was before the House Armed Services Committee. We went before that committee and asked that the bonus bill be amended to include the PHS commissioned corps into it, which was done. I think the scholarship provisions that we have discussed for this year indicates we had an indication we were going to be without the services of a doctor draft.

Senator ABOUREZK. Did you make any other contingency plans to assure that doctors would be maintained for staffing these Indian facilities when you did learn finally that the act would come to an end?

Dr. EDWARDS. I think that we, Mr. Chairman, have certainly investigated all of the avenues that were available to us; namely, the bonus approach which is still very uncertain in terms of just what it will provide us with, but we feel it is a possibility. We are also obviously pursuing the possibilities of having to go to contractual relationships with physicians and other health professionals.

Senator ABOUREZK. You mean to contract with people in those localities?

Dr. EDWARDS. Yes.

Senator ABOUREZK. Dr. Edwards, I assume you will look over the hearing record when this is all done?

Dr. EDWARDS. Absolutely.

Senator ABOUREZK. Or someone in your department will.

We had testimony yesterday from former Public Health Service doctors who worked in the Indian Health Service, who advised us, as a matter of fact, in South Dakota, that doctors practicing in private practice near the Indian reservations are already overworked and, in

my opinion, if you were able to pay those doctors twice as much for services rendered to the Indian people they wouldn't be able to handle the caseload because they are overworked now and are having a tough time getting doctors to move into those rural areas to begin with.

I just want to say that I should hope that you would not depend upon that kind of approach. I don't think it would work.

Dr. EDWARDS. Mr. Chairman, I totally agree with you, being an ex-Nebraskan, I know whereas I speak, like you. This will not work. This is not the final answer, certainly, particularly in rural areas. I think it has some possibilities in the more metropolitan areas where there are larger doctor populations, but our big problem today is to get doctors to go to the rural areas. As long as the health care system is as it is, I think the chance of getting doctors to go into the rural areas is rather remote, either with the use of bonus or anything else. I think it is going to be a tough go, a tough road for us to move down. I think that is why we have to look at other ways of delivering health services, the team approach, and there are many, many others, better transportation and so forth.

Senator ABOUREZK. Before we go on with the questioning, which we have intended to develop as a way of trying to arrive at some solutions since the staff in the Indian Health Service and Public Health Service are very well aware of what these problems are, as far as providing medical staff, and should then, therefore, have a great many more answers than anybody else we can think of, I want to say that we are interested in doing something as rapidly as possible. This committee is interested in doing something right away, this month, so far as legislation is concerned, to remedy what we see as a very serious shortage.

In other words, we would hope that once these hearings are over that this is not all forgotten. We want to work with you in drafting whatever legislation we find is necessary and try to push it through as rapidly as we can to correct the situation. So we will go on with the questioning here. But that is really what we want to come out of these hearings, some immediate action.

Dr. EDWARDS. You can rest assured that we will cooperate to the fullest with you in trying to jointly solve this problem.

Senator ABOUREZK. To continue with this questioning, I wonder if you would explain, in general, the current staffing situation throughout the Indian Health Service with respect to doctors, dentists, nurses, and supporting personnel. And if you would, provide for the record either now or later on a listing of those facilities where, in your professional medical judgment, you believe that patient care stands to be jeopardized due to staff deficiencies.

Dr. JOHNSON. The basic issue, of course, is one of physicians, Mr. Chairman. At the moment we have some 31 vacancies. If they were uniformly spread throughout the system, that wouldn't be too bad. Unfortunately, the bulk of the general medical vacancies are right in North and South Dakota. Out of 25 medical vacancies we have 13 of those in the Dakotas and in Nebraska.

There are a number of reasons for this. I am sure you are well aware of the general scarcity of physicians in rural Dakota, in that part of the country. The climate, the absence of a medical center in either one of those States that somehow seems to help to attract people. The problem of the facilities themselves, the ability of the physician to do

the job when he gets there, all these things, I think, have compounded the problem in that particular area.

At the moment we are fully staffed in dentists.

We have roughly a 10-percent shortage at the moment of nurses, and, again, that is a complex problem. It is not there, I think, as much a problem of the pay or things like that as it is the frustrations and the burden of work the nurses are under, coming to a remote place, understaffed, the necessity to cut corners, to attempt to do more than they can reasonably do. Over time, because of the staff shortages people get sick. They get tired. Then people leave, and that sort of compounds your problem.

I think with the physicians, the same sort of thing pertains. The concern, I think, that we will share there, is that you set up a vicious cycle under this circumstance.

It is my belief, and I have to be very careful about this, that we are able to provide reasonable care within our facilities because our staff has simply had to set up the priorities, to cut out certain desirable but not absolutely essential health care activities, in order to maintain the care within the facilities at the minimal safe level. In this process, of course, we have done such things as close beds in a number of hospitals in order to conserve nursing staff, and conserve other resources. We have had to discontinue some of the field activities, some of the preventative programs. As unfortunate as that is in the long run it is necessary in order to maintain a minimal standard of care that is required in the hospital.

In other words, when you get short you tend to contract to the central location where you can provide that kind of service and leave others to handle the field work. In the long run, of course, that is self-defeating. In the short run we feel we have no alternative but to pursue that.

Senator Abourezk. To follow up that question, if your present staffing deficiency is about 31 doctors, does that take into account, Dr. Johnson, the fact that Indian Health Service might establish too low a level in any one hospital or service unit. I know the chronic problem I have seen and heard about in a lot of Indian Health Service hospitals is that you may have a full staff, according to the level that you set, but that staff is tremendously overworked, as you said, there ought to be a higher staffing level set. Can you assure the committee that all of these levels that have been set for a unit, hospital, whatever, are adequate levels at this point?

Dr. Johnson. No, I can't assure you that they are adequate. If you will look at what needs to be done, the ratio of physicians to the population in the Indian Health Service is roughly 1 to 1,000 as compared to 1 to 650 in the general population. That is not a completely fair comparison. We do not feel that we need the 1 to 650. We feel, and our studies would indicate, that by using the nurse-practitioner, by using the midwife, by using medics, the other team members that we have, that if we got down to 1 to 750, that would be an adequate, almost optimum number of physicians. The same thing pertains to staffing in general.

The staff in our facilities generally runs about two-thirds as high as the staffing in comparable community facilities. Now, again, we feel that by certain management approaches that we have taken, certain

efficiencies within the program, that we do not need precisely what community hospitals need, but certainly we need something between where we are and the general community. If it was not, Mr. Chairman, for the kind of people that we have out there, and I think you know many of them yourself, they just work, they just get that job done—there is no way that we could have maintained the service either in quantity or quality that we have now. We are in a position of stretching and stretching and stretching and you get to a point where you can't go beyond that.

Senator ABOUREZK. Yes, I understand that. That really does start the cycle that you talked about. I have been told that on the Rosebud Indian Reservation in South Dakota, that there are approximately 300 to 400 Indian people who are in need of corrective surgery. I think Dr. Allen, here in the audience could be more specific because I think the information comes from these statistics. That these people's lives are being shortened dramatically simply because the Indian Health Service does not have the money to send them to a surgeon or to another hospital to have that done, and with that fact in mind, I don't know if you dispute that number or the fact that there are a number of people who need that kind of surgery——

Dr. JOHNSON. No, I don't.

Senator ABOUREZK. With that fact in mind why doesn't the Indian Health Service request more money to provide the people with the necessary medical services that they need just to keep a normal life?

Dr. JOHNSON. Let me first state that I am sure that Dr. Allen's figures for Rosebud are quite precise. But I must point out that the situation at Rosebud is not at all unique. We have thousands of patients that we can identify throughout Indian communities that are in need of surgery and other types of medical care for which we are not at the present time funded to provide.

As I pointed out, it is a very discouraging position for a physician to be in, to have patients who need care and yet be unable to give it. It is frustrating for nurses to know what patients need and somehow simply not be able to pull it all together.

The problem, Mr. Chairman, is one of, I guess, competing priorities within the Federal budget. I do the best that I can to present the facts as I have stated them to you here, as I have stated them to the Appropriations Committee now for 5 years and to the Department and the Office of Management and Budget. And people at the Department level and on up simply have to take these needs and balance them against other priorities.

Senator ABOUREZK. To back up a little bit on that, does the Indian Health Service make a request to anybody, as you submit your budget to HEW do you make a request for an adequate amount of money to take care of these people who need care, first of all?

Dr. JOHNSON. Yes, I think we do.

Senator ABOUREZK. You make it to whoever you have to hand your budget to in HEW?

Dr. JOHNSON. Health Services Administration.

Senator ABOUREZK. Do they grant that request or does it get cut there or somewhere else?

Dr. EDWARDS. I might jump in here——

Senator ABOUREZK. Anybody.

Dr. EDWARDS. Each of the agencies prepares its own budget. We get some broad figures that we have to shoot for within the health establishment and within each of the agencies. Then each of the programmatic areas in each of the agencies submit their estimated budget, their proposed budget to the Administrator and then we, as a health unit, have to sit down and develop our priorities within the budgetary limitations that we get from the Office of Management and Budget, and our own controller. I think it is fair to say that HEW certainly in the health field has done, in my judgment, a very poor job over the years in developing its health priorities. One of the things that we have tried to do in the last 6 to 8 to 10 months is to set in motion a system which we hope, when it becomes subtly sophisticated, will give us a much better look at our priorities and will allow us to much better utilize the limited funding that we likely will have for some time to come. I don't think this has been done too well in the past, but this is the budgetary process. Then the health budget is submitted to the Controller's office and they take an appropriate cut at it. We finally get it back and we always have that right of appeal, and the programmatic people have the right to appeal. Sometimes it is accepted and sometimes it is not.

Senator ABOUREZK. Let me ask you this, Dr. Johnson or Dr. Edwards, if you were to establish a figure—what is the budget for fiscal year 1974 for the Indian Health Service?

Dr. JOHNSON. The congressional appropriation for Indian Health Services, that is the activities, the delivery of health care primarily, is approximately $184 million.

Senator ABOUREZK. If you were to take care of the immediate medical needs of the people we have just been talking about, the surgery that has to go undone because of lack of money throughout the Nation in the Indian Health Service, how much more would you need for that?

Dr. JOHNSON. Well, if you are looking at surgery alone, Mr. Chairman, looking at the contract side of the house, what we have contracted out, we would see a need for something in the neighborhood of $19.6 million.

Senator ABOUREZK. In addition to the $184 million?

Dr. JOHNSON. That is correct.

Senator ABOUREZK. Then, if you were to try to pay doctors, or offer sufficient pay to doctors to fill the staffing vacancies at the various Indian reservations where there are vacancies, how much additional would you need for that?

Dr. JOHNSON. We would be talking about another $10 million. I am just taking this off the top of my head—that one off the top of my head.

Senator ABOUREZK. Is that for just the vacancies at the existing pay levels?

Dr. JOHNSON. No, my feeling is that the best recruiting we have is to retain those that you already have, people that are out there, in the communities, that would stay if you could give them an adequate inducement to stay.

Senator ABOUREZK. This is either a bonus or an increase in salary and that would make it competitive with other kinds of medical practices?

Dr. JOHNSON. No way are we ever going to be competitive, it seems to me, with the private sector. I don't think we are ever going to get

to the position where we are going to pay $50,000 to $80,000 for a general practitioner. $150,000 for a pathologist or radiologist. I think that is unreal. But I think once you get beyond a certain minimal level of salary for a physician, the kind of guy that we need who will come out and willingly work on the reservation, isn't that all hung up on fantastic amounts of money in private practice. I think there is a tremendous disparity. It is the very minimal salary that they are now getting that is the problem. I think if you could get it up so you could depend on the $30,000 to $40,000 range we would keep a significant number of physicians if some other things happened. It is not just salary. I don't think we should be led to believe that salary alone is the issue.

Senator ABOUREZK. That is true. I understand that very well.

Does this $10 million include other incentives that might be offered to doctors to go out and practice in the rural areas, on the Indian reservations such as trips to medical meetings for them and their wives, for example?

Dr. JOHNSON. Yes, I would think that would be very important.

Senator ABOUREZK. Is that included in the $10 million?

Dr. JOHNSON. In my rough calculation? To look at this, we would have to calculate it with a fine pencil but it is a significant amount of money, that is the important point here.

Senator ABOUREZK. In this do you include other medical disciplines, such as nurses?

Dr. JOHNSON. No.

Senator ABOUREZK. Do you have in mind a figure that you would need to make certain that there is an adequate staff of nurses throughout the Indian Health Services?

Dr. JOHNSON. If we were going to put together a health system with the appropriate mix of staff, I think that is the next thing I really wanted to talk about. It is important to have a balanced program so you have physicians that are adequately supported by nurses, by technicians, by the clerical help, so that they can practice to the utmost of their skills and to have the amenities of practice related to the quality that we are taught to practice. You are talking about a very substantial issue. You are talking about not only staff itself, you are talking about the facilities in which one has to work. You know Rosebud very well. You know Pine Ridge very well. They are not the kind of facilities that are terribly attractive to practice medicine in. You would need to address the problem of replacing or having major modernizations of many of the facilities. So the figure would have to be broken down into the capital cost of bringing the facilities up to standard, to meet fire and safety codes, for example, to meet the quality standards of the Joint Commission on Accreditation of Hospitals.

Senator ABOUREZK. Do you have that kind of a budget prepared at this time?

Dr. JOHNSON. Yes, we have these kinds of budgets prepared; yes, sir.

Senator ABOUREZK. Do you have them with you?

Dr. JOHNSON. I don't have it with me.

Senator ABOUREZK. I wonder if you could today submit that for the hearing record?

Dr. JOHNSON. Surely.

[The information referred to follows:]

INDIAN HEALTH FACILITIES—5-YEAR PLAN, 1974 THROUGH 1979—BASED ON 1975-79 FORWARD PLAN, APRIL 27, 1973

[In thousands of dollars; amounts subsequent to 1975 are general magnitude costs and subject to revision]

Priority	Hospitals, new and replacement	Description	1974 congressional submission	1975	1976	1977	1978	1979
1	Zuni, N. Mex.	35- to 45-bed replacement	4,378					
2	Claremore, Okla.	70- to 80-bed replacement		8,565				
3	Philadelphia, Miss.	30- to 40-bed replacement						
4	Owyhee, Nev.	9- to 15-bed replacement						
5	Santa Fe, N. Mex.	45- to 55-bed replacement		7,500				
6	Acoma-Laguna-Canoncito, N. Mex.	30- to 40-bed new hospital		5,433				
7	Bethel, Alaska	75- to 80-bed replacement			14,300			
8	Harlem, Mont.	30- to 40-bed replacement			[1]5,060			
9	Crownpoint, N. Mex.	60- to 70-bed replacement			[1]7,800			
13	Tahlequah, Okla.	60- to 80-bed replacement			[1]8,200			
25	Winslow, Ariz.	65-bed replacement			[1]8,300			
18	Schurz, Nev.	30- to 40-bed replacement				[1]5,200		
24	Anchorage, Alaska	225-bed replacement				32,000		
33	Talihina, Okla.	70-bed replacement			1,500	[1]8,000		
34	Winnebago, Nebr.	30-bed replacement				[1]4,000		
17	Parker, Ariz.	30- to 40-bed replacement				[1]5,500		
26	Ft. Yuma, Calif.	15-bed replacement				[1]3,900		
16	Cherokee, N.C.	30- to 40-bed replacement					[1]5,300	
21	Pawnee, Okla.	30- to 40-bed replacement					[1]5,500	
23	Chinle, Ariz.	125-bed new hospital					[1]10,000	
29	Tanana, Alaska	25-bed replacement				700	9,300	
39	Ada, Okla.	125-bed new hospital					[1]10,000	
30	Kanakanak, Alaska	25-bed hospital					700	9,300
	Total, new and replacement		4,378	21,498	45,160	59,300	40,000	9,300

Priority	Hospitals, modernization and repair	Description	1974 congressional submission	1975	1976	1977	1978	1979
10	Shiprock, N. Mex	Modernization		6,600				
11	Whiteriver, Ariz	do		6,200				
12	Sacaton, Ariz	do		385	5,500			
19	Browning, Mont	do		300	4,300			
20	Rosebud, S. Dak	do		490	6,200			
14	Pine Ridge, S. Dak	do			330	4,400		
15	Red Lake, Minn	do			200	2,800		
22	Clinton, Okla	do				90	920	
27	Crow, Mont	Dental (expand)				15	200	
32	Fort Yates, N. Dak	Add 20 beds				50	590	
28	San Carlos, Ariz	Alterations					15	180
31	Eagle Butte, S. Dak	Modernization					200	2,800
35	Sisseton, S. Dak	do					150	2,400
36	Rapid City, S. Dak	Alterations					40	600
37	Fort Defiance, Ariz	Modernization					270	4,100
38	Cass Lake, Minn	Alterations					30	550
	Fire and safety projects:							
	1. Anchorage, Alaska	Complete sprinkler system and detection system						
	2. Mount Edgecumbe, Alaska	Fire alarm and sprinkler system and extend fire alarm communication system						
	3. Bethel, Alaska	Firehydrant and sprinkler system						
	Total, modernization and repair			13,975	16,530	7,355	2,415	10,630
	Total hospitals			44,655	61,690	66,655	43,315	19,930

	Description	1974 congressional submission	1975	1976	1977	1978	1979
Outpatient care facilities:							
Riverside, Calif	School health center		275				
Lummi-Marietta, Wash	Health center		250				
Conehatta, Miss	Health station [2]		190				
Bogue Chitto, Miss	do [2]		190				
Low Mountain, Ariz	do		200				
Supai, Ariz	do		250				
Thoreau, N. Mex	do		250				
Wolf Point, Mont	do		280				
San Juan, N. Mex	do		220				
Tohatchi, N. Mex	Dental clinic		120				
Gila Crossing, Ariz	do		90				
Jemez, N. Mex	do		90				
Fort Hall, Idaho	Addition and modernization		375				
Galena, Alaska	Health center		45	780			
Pinon, Ariz	do		35	400			
St. Mary's, Alaska	Center		70	650			
Lame Deer, Mont	Replacement center		50	500			
Fort Yukon, Alaska	Center		60	800			
Hotevilla, Ariz	Health station			150			
Carrizo, Ariz	do			150			
East Fork, Ariz	Station			250			
Toppenish, Wash	Center (expansion)			50			
Whiteriver, S. Dak	Station			200			
Toadlena, N. Mex	Dental 5-chair			200			
Rough Rock, Ariz	Dental			100			
Salt River, Ariz	Dental addition			180			
Hays, Mont	Center			50	500		
Aniak, Alaska	do			100	1,000		
Cibicue, Ariz	do			30	450		
Unalakleet, Alaska	do			80	820		
Rocky Boy's, Mont	do			50	620		
Acomita, N. Mex	Station				180		
Lapush, Wash	do				180		
Houchk, Ariz	do				200		
Lapwai, Idaho	Center (expand and dental wing)						
Nespelem, Wash	Center (modernization)				200		
Tahlah, Wash	Expansion				50		
Huerfano, N. Mex	do				30	480	
Chemawa, Oreg	Center				30	480	
Huerfano, N. Mex	do				30	400	
Stewart, Nev	Health center				35	580	
Arapahoe, Wyo. (pending reprogr. of Lander)	do				45	680	

Unalaska, Alaska	Center				100	1,000	
Cameron, Ariz	Station					180	
Red Rock, Ariz	do					180	
Zia, N. Mex	Health station					150	
Wellpinit, Wash	Add dental wing-expansion					100	
Warm Springs, Oreg	Air-conditioning					50	
Lukuchukai-Tsali, Ariz	Center					40	550
Tucson, Ariz	do					20	285
Fort Washakie, Wyo	do					50	700
White Earth, Minn	do					50	700
Espanola, N. Mex	do					18	300
Alamo, N. Mex	Health station						100
Portland area	4 dental clinics						193
Torreon, N. Mex	Health station with dental						220
Kamiah, Idaho	Station [3]						160
Total, outpatient care facilities			3,040	4,720	4,540	3,978	3,208
Community facilities: Havre, Mont		530					
Sanitation facilities:							
New or improved housing with other agencies	8,500 units per year, 1974–79	22,515	25,214	28,242	31,630	35,424	35,007
Existing housing at new housing sites	1,500 units per year, 1974–77; 1978, 1,000 units; 1979, 500 units.	9,430	10,561	11,829	13,248	6,570	3,261
	Reappraisal			(14,367)	(15,638)	(21,036)	(27,452)
Existing housing in other Indian communities	1975–77, 5,000 units; 1978, 4,000 units; 1979, 3,000 units.	3,779	12,831	13,829	14,922	19,906	25,932
Special projects		455	494	600	700	800	1,000
Total, reappraisal				(55,038)	(61,216)	(63,830)	(66,720)
Total, forward plan		36,179	49,100	54,500	60,500	62,700	65,200
Personnel quarters:							
Tuba City, Ariz	207 units		5,500				
Owyhee, Nev	13 units		370				
Shiprock, N. Mex	33 units		1,026				
Lummi-Marietta, Wash	2 units		56				
Fort Hall, Idaho	3 units		88				
Supai, Ariz	1 unit		29				
Tohatchi, N. Mex	5 units		140				
Wolf Point, Mont	7 units		189				
Bethel, Alaska	26 units			2,100			
Harlem, Mont	17 units			460			
Pinon, Ariz	6 units			162			
Lame Deer, Mont	9 units			243			
Crownpoint, N. Mex	15 units			450			
Browning, Mont	27 units			729			
Rosebud, S. Dak	15 units			405			
Lapwai, Idaho	3 units				85		

See footnotes at end of table.

	Description	1974 congressional submission	1975	1976	1977	1978	1979
Rocky Boy's, Mont	6 units				162		
Nespelem, Wash	5 units				135		
Taholah, Wash	2 units				54		
Parker, Ariz	15 units				450		
Schurz, Nev	do				450		
Hays, Mont	12 units				324		
Cibicue, Ariz	6 units				162		
Talihina, Okla	11 units				297		
Wellpinit, Wash	4 units					110	
Tanana, Alaska	do					320	
Arapahoe, Wyo	5 units					155	
Crow Agency, Mont	6 units					162	
Chinle, Ariz	226 units					6,100	
Kanakanak, Alaska	12 units						900
Fort Washakie, Wyo	2 units						54
Fort Defiance, Ariz	73 units						2,190
Lukuchukai-Tsali, Ariz	19 units						593
Current program deficiency of approximately 700 units must be considered.							
Total, quarters		0	7,398	4,549	2,119	6,847	3,737
Grand total		41,717	104,193	125,459	133,814	116,840	92,075

[1] Design-construct process will be utilized based on performance specifications and system-components developed for previously constructed projects which precludes need for advance planning funds.

[2] In tandem with Philadelphia hospital.

[3] To be deleted from plan per area request.

Senator ABOUREZK. So that we will have on record what the Indian Health Service actually needs just as a matter of catching up right now in terms of new equipment that might be needed, supporting staff, nursing staff, doctors staff, so on, and the contracting work that we talked about, also. I think that is extremely important. What we might be able to do so far as these competing priorities are concerned, is to talk the Pentagon into doing with one less F–4 fighter plane, just one, I think, would do it. We might be able to talk somebody out of that money.

Dr. JOHNSON. Mr. Chairman, I would like to suggest that for good management, of course, one would not expect to meet all of your unmet needs at one time. It seems to me as we have approached the budget over a period of time that it is best to identify incremental development of the program so you are taking a piece of the unmet need year-by-year until you get to the point where you are doing it. If you tried to do it all at once you would not be able to get the facilities in place, you wouldn't be able to recruit, train, and so forth, all the people. For example, in the dental program, we developed a program where by doing things over a period of 5 years you could get in place a dental system which would provide for the total dental needs of the Indian community and would be at such a level that it could be maintained at that level from that point on. You wouldn't have a big crash program, overdevelop resources to meet the backlog and then end having to dismantle part of it in the future. I think that is the type of budget plan we would do.

Senator ABOUREZK. I understand that, and we would like to have that kind of a budget request. Well, whatever your budget needs might be we would like to have that submitted today, if you have it already prepared. You can just send it here. I can assure you we will make an effort to try to get that money made available soon because that in my mind is very essential to the health care needs of the Indian people.

I wonder if you are aware, if you know the ratio of doctors to people in the military services?

Dr. JOHNSON. I don't.

Dr. EDWARDS. We can find out and provide that for the record.

Senator ABOUREZK. Yes, if you would.

[The information referred to follows:]

RATIO OF PHYSICIAN POPULATION IN THE MILITARY

According to a recent Community Health Service report information from the Defense Department reveals a ratio of one physician per seven hundred and seventy-two population (1:772).

Physicians on duty	12,992
Population served	10,026,826

Senator ABOUREZK. The reason I am asking is that armed services patients, those people in the military services are the healthiest in the country. We had testimony yesterday that pointed out an obvious fact that you have to pass a rigid physical to get into the armed services and therefore the medical problems are almost nil once they are in there. It would be interesting to see the comparison of the doctor population ratio in the armed services as compared to the Indian Health Services.

Dr. EDWARDS. We can provide that.

Senator ABOUREZK. Do you know what the per capita expenditures for Indian health as compared to military health? If you know provide that as well. We would appreciate it and also for the Veterans' Administration, if you could give us that per capita expenditure.

[Subsequent to the hearing the following information was received:]

WORKLOAD COMPARISON FOR IHS AND ALL U.S. PHYSICIANS PROVIDING DIRECT PATIENT CARE, 1971

Category	IHS physicians [1]	All U.S. physicians [2]	Department of Defense
Total patient visits per week	135.85	123.57	(3)
Office (outpatient) visits per week	88.65	92.36	73.5
Hospital (inpatient) visits per week	47.20	34.48	(3)
Hours worked per week	60	53.6	54.3
Hours direct patient care per week	55	46.3	39.5

[1] IHS figures based on 485 physicians on duty in 1971 providing patient care; 2,235,881 outpatient visits; 595,235 inpatient-days.

[2] Overall U.S. figures from "Reference Data on Profiles of Medical Practice," AMA 1973. These figures originally reflected patient productivity per week only for weeks actually worked. Therefore, they were adjusted to reflect annual producitivity based on 52 weeks.

[3] Estimate. Most IHS physicians are not paid overtime so exact figures are not available.

Gross comparison of per capita expenditures for patient care of selected Federal programs for fiscal year 1974

Beneficiary populations:	
Department of Defense	[1] 10,026,826
Veterans' Administration	([2])
Indian Health Service, DHEW	[3] 488,800
Fiscal year 1974 budget outlays:	
Department of Defense	$2,280,738,000
Veterans' Administration	2,425,000,000
Indian Health Service, DHEW	156,853,000
Estimated per capita expenditures for patient care:	
Department of Defense	227
Veterans' Administration	([2])
Indian Health Service, DHEW	321

[1] See following table:

Active Forces	2,234,610
Dependents of Active Forces	3,418,953
Retired personnel	1,075,714
Dependents of retired personnel	2,774,142
Survivors of retired personnel	782,398
Civil employees (overseas)	25,329
Dependents of civilian employees (overseas)	15,680
Total	10,026,826

[2] Not available.

[3] Indian Health Service estimate based on a projection of the 1970 census.

Senator ABOUREZK. If, as you say, the mobility of the Commissioned Corps officers of the Public Health Services does exist, isn't it possible, Dr. Edwards, to immediately reassign some career physicians from Public Health Service hospitals in metropolitan areas to the Indian hospitals which are currently unpopular as far as physicians are concerned?

Dr. ZAPP. Mr. Chairman, I might say as a result of the signing of the Military Procurement Act yesterday, there is a stipulation that we are required at this time to operate the Public Health Service hospitals at the same level of care that was generally available and given in January 1973, which would mean that we will have difficulty

there meeting the new mandatory requirements as a result of the signing of that bill.

Dr. EDWARDS. Mr. Chairman, I think the real issue is that, yes, we could reassign some of these officers to other places, but I think the fact of the matter is that we are in rather dire need of these. We are understaffed at practically all of the Public Health Service hospitals right now so it would be robbing Peter to pay Paul in a sense.

Senator ABOUREZK. If I might take issue with that, Dr. Edwards, just briefly; in the metropolitan areas you have a much better chance at contracting out services because you have a greater availability of private physicians in Baltimore than you do in Todd County, S. Dak., for example.

Dr. EDWARDS. That is true.

Senator ABOUREZK. In view of the extreme needs and the extreme emergency out in some of these rural areas, especially in the Dakotas, wouldn't it seem to you to be reasonable to transfer at least a few doctors from the metropolitan areas out to the rural areas until that shortage is alleviated out in the rural areas?

Dr. EDWARDS. I am certainly understanding of what you are saying. I think there are two points I would like to make. No. 1, of course, there are a lot of Public Health physicians, for instance, maybe in Baltimore, that if we would suggest we send them to South Dakota might certainly become civilian employees, no longer Public Health Service employees. We can't force them to go. We are required by law to maintain staffing at certain levels within the Public Health Service hospitals. This is the law and so our flexibility here again in trying to juggle our manpower around is not quite as much as one might anticipate, but I think more could be done, perhaps, along the lines you are suggesting.

Senator ABOUREZK. Assuming, which is probably a good assumption, that the cost of obtaining a medical education is a factor which confronts qualified Indian men and women in pursuing a medical career, the committee would be interested in hearing what specific steps, if any, HEW has adopted to accomplish and attempt to identify academically qualified young Indian men and women to interest them in a medical career?

Dr. JOHNSON. Well, this isn't basically within the Indian Health Service program, but I will sketch out for you what has been done, because obviously we are very much interested in this.

The Bureau of Health Manpower Education, formerly in NIH and now over in the Health Resources Administration, has had a special program now for some 3 years that looked to identify Indian men and women as early as they could identify them, looking really down into the junior high schools and high schools. One of the initiatives that we were personally involved in was the establishment of the Association of American Indian Physicians. I think you had some testimony yesterday from Dr. Rhoades, who was the first president, and Dr. Spruce, who was last year's president of that association. They were funded by the Bureau of Health Manpower Education and have carried on a rather extensive recruitment program, members of the association who have gone out into the Indian communities to attempt to provide role models, to attempt to stimulate the com-

munity and school systems, to look for professional education for Indian boys and girls.

The Bureau has also funded some special programs. A project up at Dartmouth, one at the University of North Dakota Medical School, which again is an attempt to find Indian students before medical school, provide them with the science, mathematics type of background which we know so frequently is deficient in rural school systems, and to stimulate them in that way.

The major efforts for that kind of recruitment, then, have been through the Bureau of Health Manpower Education. In the Indian Health Service we have very limited ability to respond directly. But we have used the authority that we have in this way: We have a program called COSTEP (commissioned officer student training and extern program) program. It is a program to pick up professional students before they graduate. In other words, we can pick a medical student while he is in medical school for periods of time and so we have picked up these Indian medical students and given them summer experience of 2 or 3 months. It helps them to pay their bills and also gives them experience in the medical field. We made a commitment to pick up any Indian medical student who qualified in our senior commissioning program that Dr. Edwards talked about a few minutes ago. Any Indian medical student in the senior year we will pick up and support him through the senior year. These are relatively minor ways in which we can respond in the Indian Health Service right now.

We are looking forward to the scholarship program because it seems to me that this gives us a wonderful opportunity to give preference again, to the extent the Indian Health Service can influence it, to Indian students who want to go to medical school. This would give us an opportunity to support them through 4 years of medical school.

Senator ABOUREZK. Dr. Edwards, you were reportedly quoted by the New York Times of November 6 of this year, as saying that the administration had foreseen a surplus of physicians and that the administration has proposed to slash manpower funds for medical schools. How will this affect the recruitment of Indians into medicine as a career?

Dr. EDWARDS. Well, let me first say, Mr. Chairman, that was a misquote. I suggested to the Association of American Medical Colleges that it was time we all took another look at the financing of medical education. I think that the cost of medical education program has gotten out of hand a bit. I also suggested that because of a number of factors, which I am sure you do not want to go into this morning, we may well have in the immediate years ahead a surplus of physicians. We could have a surplus of physicians and still not have physicians covering the rural areas where we need them so badly and that we are talking about this morning. I think in order to have sufficient physicians to really push the physicians out into the rural and less attractive areas, perhaps, it would take far more physicians than we are ever likely to have, so I do not think the two are necessarily related.

Senator ABOUREZK. If you cut manpower funds for physician training, doesn't that——

Dr. EDWARDS. We are not suggesting you cut manpower. If we keep our medical schools at the current level of operation, the manpower,

I don't have the exact figures with me, but the increases in professional manpower, particularly physician manpower is going to be sufficiently increased over the next 10 years. So it isn't as though we are in any way recommending that we maintain the status quo or anything else. We think if the funding should maintain itself at about its present level.

Senator ABOUREZK. So what you are saying is that the administration is not going to cut minority manpower funds?

Dr. EDWARDS. Absolutely not.

Senator ABOUREZK. In your statement, Dr. Edwards, you set out your efforts for promising recruitment and your hope that many of those presently in the Commissioned Corps service will stay in the service. What if neither of these hopes materialize? With the workloads increasing dramatically as the shortage of health personnel increases, what is the authority that you have and what is your contingency plan to keep health care on some of the Indian reservations from totally collapsing?

Dr. EDWARDS. I think that we might say if, one, the bonus arrangement doesn't work as planned and we are unable to maintain a sufficient personnel force, professional personnel force, then the only contingency is trying to provide some of at least the essential health care needs for these people outside of their own immediate environment, in some kind of transportation system that will get them the medical care. Because I think so long as your financing system, the way we finance health care in this country remains as it is today the chances of our, in the next 10 or 15 years, getting a sufficient number of physicians that will actually migrate to the rural areas is just about impossible. We are going to have to draft doctors to do these kinds of things, that is, if these other programs that we are suggesting, like the scholarship program and so forth, are not effective.

Senator ABOUREZK. I think you, Dr. Edwards, have to make a decision between providing for Indian health care and regular health care in other Public Health Service hospitals, because of the unique relationship between the Government and the Indian people of this country.

Dr. EDWARDS. Absolutely.

Senator ABOUREZK. I am not sure that HEW has made that distinction, because it seems that as medical care decreases on some of the Indian reservations not as much is being done about that particular problem as is done in some of the urban areas. I just want to offer a strong reminder that you do have that trust responsibility.

Dr. EDWARDS. I certainly agree with you, and I think that we have a responsibility to this sector of our society to provide adequate health care. The only point I was making is that what the answer to this problem is is a very difficult one if these measures that we have been discussing this morning do not work, and do not provide us with the kind of professional help we need. We may have to go back to the doctor draft.

Senator ABOUREZK. To the doctor draft?

Dr. EDWARDS. I say certainly one of the options if these other things do not work, may require doctor drafts. I think that is something the Congress sometime in the future will have to consider.

Senator ABOUREZK. Do you think it would be advisable for Congress to keep that mechanism available, while not implemented, so that in the event doctors are needed that the mechanism will be there instantly for that kind of need?

Dr. EDWARDS. No, I am not sure that I would go that far, but I think it always has to be maintained as an option. I think that we have sufficient lag times that I don't think it necessarily has to emanate as a statute, but nevertheless it can be an option.

Senator ABOUREZK. You think it can be cranked up?

Dr. EDWARDS. I think so.

Senator ABOUREZK. The Association of American Indian Physicians has informed me that out of 520 physicians now on duty with the Indian Health Service, only three are American Indians and that there are only 52 American Indian physicians nationwide. Why are only 3 of the 52 American Indian physicians nationwide serving in the Indian Health Service? If you know, I would like to have the answer to that. Of the three Indian physicians reportedly serving in the IHS, where are they assigned and what is their grade?

Dr. JOHNSON. The three Indian physicians in the Indian Health Service are Dr. McKenzie, who is a surgeon and the Service Unit Director at Ship Rock in New Mexico. Dr. McKenzie is a medical director which is basically the highest grade that we have in the Commissioned Corp in the Indian Health Service.

The second Indian physician is Dr. Lionel DeMontigny, who is the Director of the Division of Indian Community Development here in our Rockville office. That is one of the four major divisions of the Indian Health Service. Dr. DeMontigny is also medical director.

The third is Dr. Vernon Dyer, who is currently in an obstetrics residency program in the Midwest. Dr. Dyer graduated from the University of Arizona Medical School just a couple of years ago, so he is early in his career and when he finishes his obstetrics residency he will be coming back to serve in one of the Indian facilities.

The Indian physicians, basically, are in two categories. There are quite a number of them who are in private practice, and have been in private practice for many, many years. There are two or three of them that I know personally, who are in Government medicine, not Indian Health Service. One is a native of South Dakota, Dr. Alfred Reifel, who is Dr. Ben Reifel's brother, and who is a physician with the Veterans' Administration in California.

Why this group lives in metropolitan areas rather than coming back to the reservation to practice, I think, is due to many personal reasons.

The second major group are those who are just now completing training and we have some reason to believe that a high percentage of those who are now in training, now medical students, in my discussions with the members of the Student Affiliate of the American Indian Physicians, would suggest that more of them may in fact be willing to come back home when they complete their training and serve their own people. Time will tell over the next 4 or 5 years as they finish their medical school training, their residency training, whether in fact they will come back to the reservation or whether they will go as their predecessors primarily have into private practice in the more affluent society.

Senator ABOUREZK. For fiscal year 1973, the administration has impounded about $6.2 million that had been added on the IHS budget

by the Congress. Were these funds ever made available for use by the Indian Health Service, and if so, when were they made available?

Dr. JOHNSON. Yes, sir. Well, $1.5 million of that $6.2 million was approved by the Congress for reprograming. Another $2 million was released in June of last year. The final $2.7 million was actually released in August, based on special amendments to the public works bill. Congress gave us authority to spend fiscal year 1973 funds actually after the end of the fiscal year. So that all of the $6.2 million was spend for the purposes which Congress had appropriated it for or for approved reprograming.

Senator ABOUREZK. As far as the 1974 fiscal year appropriations for opening programs and construction, has Congress added anything to that request you made?

Dr. JOHNSON. Yes.

Senator ABOUREZK. How much has that been?

Dr. JOHNSON. They added $7.3 million to the activities and services budget and about $8.2 million to the construction budget.

Senator ABOUREZK. Have these funds been made available to the Indian Health Service?

Dr. EDWARDS. We have made the request to the Office of Management and Budget. I have reason to believe that we will be shortly——

Senator ABOUREZK. In other words, the answer to my question is they have not yet been made available?

Dr. EDWARDS. Not yet made available, that's right.

Senator ABOUREZK. When do you anticipate they would be made available by OMB?

Dr. EDWARDS. I am hopeful in the next several weeks.

Senator ABOUREZK. How urgent is the need for that money?

Dr. EDWARDS. The answer to that is, it is very urgent. Unfortunately, in a lot of our programs the money is very urgent. We are hopeful they will come through within a matter of several weeks.

Senator ABOUREZK. I will yield to Senator Bartlett.

Senator BARTLETT. I am sorry I haven't been here throughout the day, and I am also sorry that I missed the hearings yesterday which I understand were very informative and very important.

The Interior Committee had one of its more important bills being debated and voted upon on the floor of the Senate having to do with the energy shortage yesterday, and I was on the floor and involved with that most of the time.

They also had another committee meeting concurrently with this one. I do not think we are supposed to have that situation arise, but, anyway, it did this morning, so I apologize for not being here.

I would like to ask Dr. Edwards what do you consider the quality of the health care provided the Indians by the Indian Health Service?

Dr. EDWARDS. I think perhaps Dr. Johnson is in a better position to answer your question. I think it varies from probably very good to less than average, but I think we are trying to—I think, as Dr. Johnson pointed out, what we are trying to do is where we cannot maintain a certain level of quality we are trying to either move these patients elsewhere or not providing the services. We feel that we have to maintain a certain level of quality if we are going to continue to operate these Indian health operations.

Senator BARTLETT. I noticed you are short 31 doctors. Certainly that takes its effect.

Dr. EDWARDS. No question about it, it has an adverse effect on the quality of health care that is rendered.

Senator BARTLETT. Do you anticipate that the number of vacancies will increase or decrease?

Dr. EDWARDS. I think it is probably a little too early to tell, Senator. I think this bonus bill that we are discussing may have some effect. I think our ability as recruiters, I mean how well we can recruit, will have some effect. It is probably too early to attempt an accurate assessment of that. I am hopeful, though, that it will not get any worse, but I think we have to be very frank and say that is a possibility.

Senator BARTLETT. I take it from the way you answered the question, and mentioned it depends to some extent on your recruiting efforts, that you have a new approach or a new emphasis on recruitment.

Dr. EDWARDS. I don't think we have any new approach, but I think we can say we have a new emphasis on the need for recruiting. Hopefully, in carrying out the new emphasis, we can develop perhaps some new initiatives in trying to lure these well-intentioned medical students and others into our service. There are some very rewarding careers to be had in the Public Health Service. I think we have tended to rely on the draft and not perhaps to play these up as much as we could play up the advantages.

Senator BARTLETT. What is the average length of service of the career of the Indian Health Service physician? What I am really getting at is that I happen to know one particular doctor who just left the Indian Health Service. I am not quite sure what the circumstances were, but I know his age is about 55. I just wondered is there a tendency to leave at an earlier age than would be normal for a doctor to retire?

Mr. SMITH. Within the commissioned corps, there is the opportunity to apply for retirement after 20 years of active service. An extensive review of our first 11 years of the use of that authority, our average age for career officers retiring was appoximately 56 with an average period of service of about 26 years. We do have those instances where an individual with 20 years of service who may well be in his late 40's ar early 50's is eligible and may request retirement.

Senator BARTLETT. Have you found, I am not sure I understood it completely, but did you say that you have had the 20-year retirement program for 16 years?

Mr. SMITH. No; we have had it since 1960. After the first 12 years we did a rather extensive review with the averages that I indicated of age and length of service.

Senator BARTLETT. Did you find the 20-year retirement program increased in incidents of early retirement?

Mr. SMITH. Yes, it did; but it also at the same time, I think, had a very good effect on the retention. Officers with 8 to 10 or 12 years of service looking forward to the potential of being eligible to consider retirement in another 8 or 10 years. Our retention rate of midcareer people significantly increased. If they had to look forward to another 18 years we probably would have lost a considerable number of them in midcareer. Our midcareer losses have been minimized by the availability of the 20-year retirement authority.

Senator BARTLETT. Has there been any effort made to continue those in service longer than the retirement age at 55 if the individual is in good health?

Mr. SMITH. Yes, sir; we have made an attempt at utilization and other opportunities, and we are presently in the process of reviewing with Dr. Edwards some other alternatives as to what we can build into the system subsequent to the 20-year period that would encourage the individuals to remain and to more broadly use some of the authorities that would provide them the opportunity for continuing education at that point with continued service and further advancement and development.

Senator BARTLETT. Is that meeting with some success?

Dr. EDWARDS. I think, Senator, that over the past year, year and a half, the full issue of the future of the Commissioned Corps has been under rather serious study by the Department. When Secretary Richardson was Secretary of HEW, he had a blue ribbon committee look into the Commissioned Corps and made some recommendations as to the future of the Commissioned Corps. I must say that I feel quite strongly that, call it whatever you will, the Public Health Service has to have some kind of a career professional service. It doesn't have to be called a Commissioned Corps, but it has to for all practical purposes serve that role. What we are looking into is a number of issues, one of which is how do we keep those in midcareer—I think the point that Mr. Smith made, that the 20-year rule is as much of an inducement for coming in as it is for retention—I meant at one end as it is at the other. I think that many, many career officers come in because of the 20-year retirement feature. We are looking at all the things and I think we will be improving the program significantly as we move along.

Senator BARTLETT. I know of such a program in law enforcement—the Oklahoma Highway Patrol adopted a 20-year retirement program some years ago. It, I think, has achieved its objective, which is a little different. First an objective of attracting qualified people to the highway patrol, the same as the objective achieved with Indian Health Service. Also, I think the objective, too, was to maintain a younger person in the highway patrol and so it is very difficult really for an individual in our highway patrol to decide to stay on very long after 20 years because he can have a very fine rewarding job at a good salary and in addition receive his retirement benefits. So, I think it fulfills the total mix of the highway patrol very well.

It would seem to me that there would need to be in the case of the Indian Health Service something of a supplementary nature to the 20-year retirement in order to provide inducements for experienced, qualified people to stay on for their entire service, and this could—of course, I don't know your rules, but comparing it to private medicine could easily go up to age, 60 or 65, under normal conditions. Is this an area that you think does need some new thinking and new programs to take advantage of the good people that you have.

Dr. EDWARDS. Absolutely. You might want to speak to that, Mr. Smith?

Mr. SMITH. Yes; in our discussions with the military, there have been considerable conversations around the total retirement package that would potentially build in incentives by increasing the retirement percentage in the latter years of the 30-year career. I would like to point out that over the last 4 or 5 years we have been maintaining rather close cognizance over the number of people who are requesting

retirement short of our obligation to grant that retirement. That has varied from 8 to 13 percent of the total number of people that are eligible. So that in fact we have approximately only 10 percent of our people who are eligible to so request retirement short of 30 years service do so. I would not consider that is an extremely high percentage.

Senator BARTLETT. What percentage of Indians receiving medical care where physicians are involved are receiving it from private physicians where it has been contracted out?

Dr. JOHNSON. Roughly, Senator Bartlett, I would say roughly a quarter on the average would be getting it through the private physician contract mechanism.

Senator BARTLETT. Could you briefly describe where and how that exists?

Dr. JOHNSON. Yes. There are several reasons for the use of the contract physicians. One is to provide specialty care. For example, things like neurosurgery, cardiovascular surgery, to very complicated organ transplants, things like that, where it is necessary for the physician to be engaged full time in that kind of specialty and the populations that we serve, Indian populations, would not permit realistically that type of specialist on our staff. So we would say to the Indian community send it to the medical center within the State—Oklahoma, for instance, using the Oklahoma University Medical Center for much of the specialty medical care.

The second is to provide care for the Indian groups that are small but live within scattered locations where again it would not be efficient to have a full-time physician. I am thinking here of places like Nevada, where we have some 20 or 30 small colonies, small Indian communities throughout the State. There may be 20, 30, 40, maybe 100 people in that little group. There is no purpose in stationing a physician to serve that small group nor is it appropriate, it seems to me, or good medical care to require them to travel long distances to see the Federal physician, so we have a contract with the physicians in that particular community.

And then the third, of course, would relate to simply the overload factor within our own facilities. There is a limit to what a physician and facility can handle. Under some circumstances we have worked out with communities a sharing of certain facilities. For example, I was in South Dakota this week, in Sisseton, where we discussed with the Sisseton Tribe, and the local health community, the possibility of perhaps combining the obstetric service which again seems to me a reasonably responsive way of maintaining quality and not duplicating a relatively scarce and expensive resource.

So these are the general grounds. All of these, of course, Senator Bartlett, are contingent upon the availability of funds to do this. One of the facts of economic life in health care delivery is that when you have your own facility you can put another patient in and provide them with care for a very minimal cost. In other words, it costs about three-quarters as much to maintain an empty bed in a hospital as a full bed. So for a few dollars for the drugs, medical supplies, laundry and food, you can put an additional patient in one of your own hospitals or a physician can see an additional patient or a few in an outpatient clinic. There are limits to this but it can be done, whereas if you go the contract route, if you put a patient in the contract hospital, you are

medically encumbering 100 percent of the cost of that day's hospital care. So the financial problems in the contract health service program, of course, are a significant limitation to our ability to use contract physicians to satisfy these three basic purposes.

Senator ABOUREZK. Wouldn't it make sense in that connection, for example, in the Rosebud Reservation where it has been testified that there are 300 or 400 Indian people walking around with a fairly urgent need for some kind of an operation. Rather than spend a lot of money on contracting to send those people out somewhere else to secure that surgery performed, wouldn't it make sense to bring in two or three surgeons for a specified period of time and performed the operations needed within 3 or 4 weeks? Wouldn't it make more sense to have that care done in the Indian health service hospital?

Dr. JOHNSON. Certainly it is desirable to have the surgery done as close to home as it can be done and maintain quality. I think there are some types of surgery that would not be appropriate to do in Rosebud, such as organ transplants, cardiovascular surgery, that kind of thing, but most of the cases that are out there are cases that with the appropriate equipment, if we had the nursing staff, the backup support staff, it could, in fact, be done right there.

Of course, in the long run it is most effective to do it in our own facility, given the understanding that you must, in fact, have the facility, the quality of staff support, the equipment and so forth. That certainly would be desirable on our part, and I think it would be much more satisfactory to the patients. They would much sooner have their surgery close to home, family and friends, rather than going to a distant, alien facility.

Senator ABOUREZK. But, in fact, before you can do either you need the additional money that we were talking about earlier, is that correct?

Dr. JOHNSON. You have to have adequate staff and facilities that would permit you to do this. You have to maintain quality, not just get it done.

Senator ABOUREZK. Just on this line, before I yield to Senator Bartlett again, how much does the Office of Management and Budget allow the Indian Health Service to pay community hospital per day under contract?

Dr. JOHNSON. We negotiate with community hospitals for the best rate that we can get. Usually what they do is charge us their going rate, whatever they charge the general community.

Senator ABOUREZK. Do you have a maximum amount you are allowed to pay?

Dr. JOHNSON. The Office of Management and Budget has no restrictions on the amount we pay. We pay, apparently, whatever the traffic will bear.

Senator ABOUREZK. Senator Bartlett.

Senator BARTLETT. If you had the additional funds—you indicated, to increase the number of patients who might be given health care by contract, that additional funds would be necessary?

Dr. JOHNSON. That is correct.

Senator BARTLETT. To provide additional services through the Indian Health Service, to staff doctors, would require additional funds also.

Dr. JOHNSON. That is also correct.

Senator BARTLETT. If additional funds were available in some amount how would you want to balance out that additional money, what percentage would you suggest should go in contracting, how would you view the share that contracting would take of the total?

Dr. JOHNSON. Well, this would be different over a sequence of time. As to the first, if we were going to start something tomorrow morning, it would seem to me about a 60 and 40 split between the direct services and the contract. Sixty percent into direct services to bring them up to their maximum potential to serve, and 40 percent to the contract services, up to a point where you really saturate the ability of your direct services to provide care. Then, of course, a good bit will have to go out into contract, and, certainly, some of the very technical services will always, in my opinion, have to, and should for quality services, be done in the medical centers. We would not propose, it would not be correct from the standpoint of quality or cost effectiveness to attempt to do such things in Indian hospitals. Some of these would require specialized medical care facilities.

Senator BARTLETT. I have been informed that a Blue Cross-Blue Shield type of hospital medical care program would be cheaper and more comprehensive than the service provided by Indian Health Service. Would you comment on that?

Dr. JOHNSON. Well, I couldn't comment specifically on that statement because you have to know first of all where it is and what you are getting for your benefit package, what kind of rating. Is it going to be a community rating of the population or are you going to provide an experience rating for the Indian population, which, I think, we all know has a higher burden of illness and the backlog of medical care. These factors would affect how the contract was written. I don't think you can say that because you can now buy a policy for the average member of the community that necessarily the same underwriting experience and cost would in fact be granted if you were going to go out into an Indian community and provide them with the health insurance program. So that is one thing that would certainly have to be carefully reviewed before you could say yes or no.

The second part of it, of course, is the thing we have been discussing earlier today here, and that is that a Blue Cross-Blue Shield insurance contract in fact provides you with nothing but payment if in fact you can find the physician and hospital who will do it. In much of the Indian country that we are talking about here, well, the Blue Shield contract will be of little or no value to you at all because the delivery of health care, except by the Indian Health Service facilities and staff, simply is not there. So those are the two major issues that one would have to resolve before you could answer specifically that kind of a question.

Senator BARTLETT. Has there been a study of this, of the utilization of such a medical and health care program as to how it might fit in, in part filling the medical hospital needs?

Dr. JOHNSON. We have one now that is being done by a private group supported by an HEW grant to attempt to develop a health maintenance type of program. We are not at the point yet where one could give any answer on that. One of the reasons, Senator Bartlett, that we have not pursued this with great vigor up to this point is that we are

precluded by our statute from entering into an insurance or a prepayment type of mechanism. We have asked for this authority, but without that authority, of course, the necessity for doing a relatively costly study on this did not seem to us to be of an urgent nature.

Senator BARTLETT. Dr. Edwards, if I could ask you pretty much the same question, but whether you view the prepayment or insurance hospital care as a means of providing a lesser or a greater amount of health care to our American Indians?

Dr. EDWARDS. I think it is a very viable way of providing health care, prepaid health care. The problem, I think, as Dr. Johnson pointed out is, it is one thing to say you want to put a so-called HMO into one of the reservation areas and another thing getting people to staff it. I think if we were successful in getting the kind of people necessary, it would be a very real way of providing health care, but I have some question in terms of our success of being able to accomplish the latter. That would be my only objection to such an operation.

Senator BARTLETT. Would either of you think there would be some value in Oklahoma, for example?

Dr. EDWARDS. I think the probability of it being successful in Oklahoma would be much greater than in South Dakota or North Dakota for the simple reason you do have an outstanding medical center in Oklahoma City, Tulsa and other places, and I think you could perhaps draw more from that than the more isolated areas to provide some kind of a prepaid system.

Senator BARTLETT. Is the study that you mentioned, Dr. Johnson, sufficient to evaluate the utilization of insurance type programs, or should there be, in your opinion, additional studies made?

Dr. JOHNSON. Well, this gives you only the first cut at the issue and I don't think that this study would be a definitive one. Certainly, the circumstance around this initial study are considerably different than those that you find in Oklahoma. We have also got another development of that type going on up in Alaska with the Norton Sound Health Corporation which is another approach to this. I think, there again, the circumstances are a bit different. What we are trying to do, Senator Bartlett, is to provide, within the limited scope of our authorities, for as many opportunities as possible to develop options. I would reject out of hand any simplistic one approach to the solving of the problems of health care in Indian communities. I believe in that first on a practical standpoint because I don't think you can say that the program which would respond to the needs of the Indians in the Everglades of Florida or to the Eskimos on the North Slope of Alaska would necessarily look the same or be the same.

I would reject it next on the basis that our policy and the policy of the administration and the basic policy of the Congress is to be responsive to the desires of the Indian community in the way in which their health care is being provided. Therefore, if you were going to engage in the development of these types of mechanisms, I think it is terribly important that the tribal government being served, for example, the people being served would be a party to the determination of what way they want to go and to have really, in a sense, an option of going insurance, HMO, direct services, whatever the options may be. That is to me a fundamental part of the administration's policy.

Senator BARTLETT. Would you favor legislation which would call for a definitive study of the role that could be played by health and medical and hospital insurance in the total health care for Indian areas?

Dr. JOHNSON. I wouldn't believe that one would need such legislation to do this. I think the authority within the Department is already sufficient to do that. I think what is necessary very clearly is that in our authorizing legislation we would have language that would permit us to utilize this or let's go a step further, to be able to utilize medicare, medicaid, private insurance money that is now, in theory at least, available to support health care for Indian people but is, because of the way the law is written, not now available; legislation which might open that source of funding up to Indian communities, I think, should also be looked at.

Senator BARTLETT. You would recommend that?

Dr. JOHNSON. I would, yes, sir.

Senator BARTLETT. I understand that, Dr. Edwards, you have a speech to give and I am sorry I got so close to the time of that speech. I thank you all very much and I appreciate your answers. I have a few other questions that I might present to Dr. Zapp.

Dr. EDWARDS. My colleagues would be delighted to stay. I would normally, but I did promise to give a speech.

Senator ABOUREZK. I only have two or three more questions. We are going to submit a great many more that we will ask you to respond to in writing because we do want—as a matter of fact your specific answers, because on some of these you are the only one who can answer.

Dr. EDWARDS. We will certainly be delighted to provide you any answers you want and my apologies for leaving.

Senator ABOUREZK. Thank you for appearing today.

Senator BARTLETT. I don't know whether you have this information readily available. If you do not, I would appreciate it to be made available for the record. Could you provide information that would show a comparison between the doctors in the various services, military, health service, and the private sector, as to the number of hours of service performed or the number of patients seen or some relationship. I am not trying in any way to place the Indian Health Service at a disadvantage, so I would be happy to have it include any comparisons that you would want it to include, but I would like to see also the comparisons with the private sector recognizing that I would expect to find, because of the private enterprise motive of the private physician, a heavier workload.

Dr. JOHNSON. We would be glad to provide that for the record.

[Subsequent to the hearing the following information was received:]

Workload statistics comparing M.D. workloads in the military, private sector and IHS must be interpreted in an extremely cautious fashion. For workload data to be comparable, it would imply provision of care of equitable quality and sophistication, an identical distribution of types of cases treated and conditions under which services were rendered, e.g.: inpatient, outpatient, case mix, specialty services age distribution of patients, morbidity experience of the populations served and an equal mix of physicians by specialty.

This is not the case. IHS facilities suffer from a lack of efficiency of scale, e.g.: an isolated station with no other sources of care accessible might have one physician on duty although theoretically by workload statistics only two-thirds of a physician is required. Another major factor that tends to lower IHS productivity relates to delivery conditions; in order to serve many remote

health stations IHS physicians spend considerable travel time to and from their base stations. This necessary transit time during which they could care for patients is not reflected in productivity figures. Likewise, IHS specialists spend considerable time traveling to distant, widely scattered field facilities to provide staff consultation and teaching services. Their teaching time and transit time—which could be spent treating patients—is not weighted in productivity figures. Moreover, IHS physicians spend considerable time providing community preventive health service and health education, not reflected in patient visit productivity figures.

Senator BARTLETT. Do you have any comment to make generally on that?

Dr. JOHNSON. Well, the work week of the average physician in the Indian Health Service, I would predict, is longer than that of the physician in private practice. I think when you add to that some of the intangibles that one can't identify. The supporting staff, for example, that you have in private practice, the ability to have secretaries and other people who can do part of your work for you, whereas our physicians, they write up their own reports longhand, the inability to have enough nursing staff so that a doctor can in fact see patients in the most efficient fashion, the shortage problems in outpatient clinics, for example, where you are limited in your space, whereas in private practice you simply go out and get a bigger number of examining rooms so that you can be more efficient. I think in spite of that, Senator Bartlett, you will find the productivity of our staff measures up very well.

Senator BARTLETT. Doctor, what do you see for the future as far as Indian hospitals are concerned, what changes, what improvements, what problems, just very briefly.

Dr. JOHNSON. I think the policy of this administration is to provide for Indian communities the opportunity for having a high quality health delivery system that is accessible to them, available to them, and responsive to their needs. How you get to that point, I think, has many different options. I would see in some places the development on the part of the tribe itself of a mechanism to deliver that care and develop their own health service delivery mechanism, incorporating, perhaps, in the early stages at least the facility, the staff that is already there. As a matter of fact, I spent last week with the Chairman of the Mississippi Choctaw Tribe and together we started the practice of developing with them the mechanism by which they can develop and ultimately run the health delivery system for their own people. This is contingent upon completion of a new facility there, so it can be brought up to standard and hopefully the other programs can be sufficiently funded in such a way that they can run a first-class operation, training and recruitment, and so forth. I see that mechanism.

As I pointed out, we have been working with the native groups in Alaska in some places for the development of health care corporations where, again, they will deliver themselves the basic services to their own people. There are other groups that have put together health authorities, health departments, health corporations, whatever you want to call them, directed not toward direct delivery as such but doing the planning, the priority setting, the evaluation type of thing, but to control it, say, as a health planning council might do it in a larger community, even though the hospitals in your community, for example, might be operated by a number of different agencies.

Some have gone in that direction. In other Indian communities, they are not now at the point of wanting to be concerned with the health question as such. They feel they have other priorities and other concerns and they say leave us out of it for the moment.

I think we see the whole spectrum. We see another interesting opportunity and that is in a number of isolated areas where the Indian community says we need to have an opportunity to share our facility with the general community. As part of the economic development of our reservation we need to be able to have a hospital to take care of non-Indians on the same basis as others.

I am sure you know Senator Bible has introduced legislation which again would give us that kind of authority. But the critical issues in that legislation, of course, are really two things. Number one, that that community hospital concept could only be undertaken at the express request of the tribe. In other words, the tribe would make that decision not the Secretary. Second, that in no way could opening the hospital to the general community be permitted to compromise the quality or quantity of care being provided to the Indian community. With those two safeguards, I think that opens another opportunity for developing a comprehensive health care delivery system in a rural area which could have as its base the Indian Health Service facility.

Senator BARTLETT. Doctor, I would like to make arrangements to visit the Indian hospitals in Oklahoma right after the first of the year. Who would be the one to contact on that?

Dr. JOHNSON. Dr. Hillary Connor is the acting area Director at this time.

Senator BARTLETT. I should make arrangements with him?

Dr. JOHNSON. Right. We would be glad to help you in making the arrangements.

Senator BARTLETT. I will work with you then, if that is all right, in setting that up. I think possibly Senator Bellmon would like to also join in with me. We have discussed it and I know he would if he can.

Mr. Chairman, thank you very much.

Senator ABOUREZK. There is a vote that has been called. I would like to get in a couple of questions and then we will adjourn for the day.

Has the Department considered requesting the authority to hire alien physicians for neutral counties to supplement the available physician manpower?

Mr. SMITH. We already have the authority to employ noncitizen physicians from allied countries. We do not have the authority, as the Veterans' Administration does, to employ noncitizen physicians from nonallied countries. We have reviewed that and there is discussion in the Department to request such legislative action.

Senator ABOUREZK. You haven't yet decided as to whether you want the authority?

Mr. SMITH. We have made an attempt within the Department to obtain that authority.

Senator ABOUREZK. How would the Department of HEW doctors respond to a specific bonus or pay bill designed to recruit and maintain health manpower for the Indian Health Service with the bonus tied to the shortage of doctors at any specific time?

Dr. ZAPP. I would think, Mr. Chairman, that we would prefer not to have, as far as the Commissioned Corps is concerned a bill dealing just with the particular portions of the service because I am sure you

realize we have an equal need with the National Health Service Corps, which a number have already deployed in the Dakotas and other scarcity areas of the country. Because there is mobility between the services, as you pointed out earlier, between the Indian Health Service, the National Health Service Corps and other parts of the Public Health Service, we would prefer to have a recruitment and incentive in a form of bonus or otherwise be uniform for the shortage categories across the Public Health Service.

Senator ABOUREZK. Would that really work, because I am sure you would have to offer more money for somebody to stay on the Indian reservations out away from everything, more than you would have to offer in San Francisco, for example.

Dr. ZAPP. I would certainly hope, Mr. Chairman, that the Department doesn't become involved in sending National Health Corps individuals to the bay area, in San Francisco.

Senator ABOUREZK. Most people would want to pay to go to the bay area.

Dr. ZAPP. We do have an equal problem because in the National Health Service Corps we have a number of areas that have been approved for a period of time and we have been unable to get people in the Commissioned Corps assigned to those areas. There are some great similarities, some problems as getting them to stay in the Indian Health Service areas, in getting them assigned to the very rural and remote areas within the National Health Service Corps.

Mr. SMITH. I might point out as well that we are responsible for medical care to the Federal prisons and that is an equally difficult assignment position to meet. We are having equal problems in staffing prison hospitals.

Senator ABOUREZK. Those are all the questions that we have at this point. We would like to submit, as I said, questions for you to answer in writing and we are specifically interested in the additional amounts of money that the Health Service needs just as a matter of catchup.

I want to express my gratitude to Dr. Zapp, Dr. Edwards, Dr. Johnson, and Mr. Smith for appearing here today and responding as you have, and I just once again want to emphasize the very serious nature and how serious we consider it to be.

I would hope that the Department can provide the help that is needed on the Indian reservations, because there is that special relationship that we all have to concern ourselves with.

Thank you very much.

[Whereupon, at 12:25 p.m., the hearing was adjourned.]

APPENDIX

[Under authority previously granted, the following statements and communications were ordered printed:]

WOUNDED KNEE LEGAL DEFENSE/OFFENSE COMMITTEE,
Rapid City, S. Dak., November 20, 1973.

Mr. CHAIRMAN: My name is Richard Walden, and I am an attorney with the Wounded Knee Legal Defense/Offense Committee. Since my testimony deals with the state of public health facilities in southern South Dakota, I believe I should also highlight just a bit of my background in the public health field. I was trained as a medic in the U.S. Army and was based at Brook Army Hospital, Ft. Sam Houston, Texas, in 1968. In 1969, I was Administrator of the O.E.O.-funded Southeast Philadelphia Neighborhood Health Center, a multi-service public health facility. During my year in this position I helped develop every facet of the Center's programs. During my tenure at the University of Pennsylvania Law School (1969–1972), I concentrated heavily on public assistance and public health law. In 1972, I became Assistant General Counsel of the Health Services Administration of New York City, the largest urban public health system in the world. While my title connotes a somewhat legal orientation, in fact much of my time has been spent developing and implementing programs in the fields of child health, alcoholism, mental health and drugs. I am also serving as a counsel to Resources for Human Development, a Pennsylvania non-profit corporation which operates a number of community-based health programs in many of the fields just mentioned. I am also attaching as an addendum to this testimony, a professional resume.

On three separate occasions this year, during the months of May, September and October, I had the opportunity to observe the conditions on both the Pine Ridge and Rosebud Reservations in South Dakota, as well as those of the Sioux San Public Health Hospital in Rapid City. It is my opinion that the current state of availability of health services is appalling. While the Sioux San Hospital compares favorably in regard to cleanliness with any hospital I have seen, it has little else of merit. On four different occasions, I escorted my clients from the Pennington County Jail to the hospital for emergency treatment of a variety of ailments. While we received courteous and prompt attention, conversations with the attending physician indicated that there were only two physicians then on staff at Sioux San (May, 1973)—each of whom being there to fulfill a conscientious objector, alternate service requirement. There was no medical specialization and indeed most of the more serious illnesses had to be referred elsewhere. The relevant observation is not that the Sioux San Public Health Hospital had been remiss in its staffing, but rather that the U.S. Public Health Service has been unable to locate and place the necessary resources in its public health hospitals. For instance, I can think of almost no more appropriate geographical setting for a comprehensive alcohol detoxification unit. These units exist in Public Health Service hospitals in the New York City area, a remarkable fact given that New York City's own Bureau of Alcoholism has a $10 million budget for just such programs and has already set up a number of them throughout the city. It would appear, then, that Sioux San, in an area with a large number of alcoholics, has been neglected by the Public Health Service in funding such a program.

Hand-in-hand with the above neglected area is mental health. New York City's response to a suicide rate of 30 per year out of a detention facility population of over 100,000 (approximately 10,000 at any one time, with an average stay of 34 days), has been to set up a prison mental health program consisting of no less than 50 psychiatrists and psychologists working in the 6 detention facilities. While I recognize that for all of Rapid City there are barely one dozen physicians of any stripe, the U.S. Public Health Service has much wider access to health resources. As you know, the suicide rate on Indian

reservations in general runs more than 15 times the national average, yet there is very little, with the exception of some questionably-effective religious counselling, in the way of "crisis intervention" available to Native Americans. I have personally met a half-dozen unsuccessful suicide victims from Pine Ridge, and, while not pretending any expertise in the medical aspects of this field, I feel very strongly that any number of programs could be of help. I hasten to add at this point that all of the public health programs I am describing can be nothing more than a band-aid approach to a much more serious underlying problem of lack of resources in a fashion not unlike that which exists in urban ghettos. This problem can be traced historically to a near-total neglect of Native Americans on the part of the United States Government. It has done no more than set up a monstrous bureaucracy full of recalcitrant bureaucrats whose interests appear to lie more in rationalizing their own existence than in resolutely serving Native Americans.

The U.S. Public Health Hospital located in Pine Ridge is, with the exception of a somewhat busier emergency room, not on a par with Sioux San. It, too, is understaffed and inadequately provided with essential equipment both for preventive and curative services. In July, a delegation of Oglala Sioux, including Leonard Crow Dog, the Medicine Man, met with Dr. Joseph A. Cimino, New York City's Commissioner of Health, and presented a very long "shopping list" of equipment which they felt was essential for a properly-run public health facility. The Commissioner was somewhat astonished that with all the federal money available for testing children's hearing, there was not an audiometer to be found on the Pine Ridge Reservation. He was likewise stunned at the near-total lack of preventive dentistry and dental equipment on the Reservation. Similar problems exist in the areas of optical equipment and optometrists, supplemental food programs and nutritionists, and both pediatric and geriatric programs.

It has been my personal experience that none of these programs are difficult to set up, that personnel to staff these programs are readily available *provided* adequate remuneration is given, and that people whose job titles indicate that they are working solely for the benefit of Native Americans should be willing to "go to the mat" with budgetary officials in order to insure that adequate funding is forthcoming. I am reminded of Clyde Bellecourt's "15–45–60" speech in which he says that the per capita income of an Indian family is $1500; without the B.I.A. bureaucracy, $4500; and without the added Department of the Interior bureaucracy, $6000. If the trickle-down theory of government were effective, this observation would be specious; but it has not worked and those suffering are those meant to be helped.

Given the above described situation, the prospect that both the Pine Ridge and Sioux San Hospitals may be closed is incredible. The United States Air Force Hospital at Sturgis, South Dakota, has been asked to raise its per diem inpatient rate from $44.00 a day to $132.00 a day. At the same time, the Indian Public Heatlh Service has not been granted a corresponding increase in its funds for the reimbursement of inpatient care. Thus, it appears that a two-thirds reduction in the amount of reimbursable patient days at this hospital alone is imminent.

The response by the residents of the Pine Ridge and Rosebud Reservations has been to begin setting up a makeshift health facility in Porcupine, South Dakota. At this time, with no money, the best we can hope for is a series of one-month commitments by volunteer doctors and nurses who will fly into South Dakota from the West Coast to staff this facility. I am coordinating a mass appeal for medical equipment and supplies on a nation-wide basis. If the residents of the Pine Ridge and Rosebud Reservations are to be ignored by the United States Government, they will have to help themselves as best they can. The significance of this abandonment shall not be lost on them in their future dealings with the United States Government.

Thank you, Mr. Chairman.

RICHARD M. WALDEN.

ROLLA, N. DAK., *December 3, 1973.*

Senator JAMES ABOUREZK,
Interior Subcommittee, U.S. Senate,
Washington, D.C.

DEAR SENATOR ABOUREZK: We are writing in response to your phone conversation with Ms. Mary R. Cornelius on November 27, 1973, concerning our Public Health Service Indian Hospital in Belcourt, North Dakota, which is located on the Turtle Mountain Indian Reservation.

My position at this unit is a Nurse's Aid. I and several others in this community have taken an active part against the procedures the Tribal Council had taken when our administrator was requested to transfer. This request was in the form of a resolution written by the Tribal Council and sent directly to Dr. Emery Johnson's office without due process. This resolution is still invalid as a legal document because it has never been approved by Mr. Frank X. Morin the Reservation Superintendent, Mr. Wyman Babby the Aberdeen Area Director, or Mr. Rogers C. B. Morton the Secretary of the Interior. All our steps of legal procedures were by-passed.

The Tribal Members on this reservation hold the Tribal Council totally responsible for the near closure of the Public Health Service Indian Hospital. The cause for this unfortunate incidence was due to petty and unfounded accusations brought against the Service Unit Director by five persons who received either a verbal reprimand or persons who were not satisfied with their performance ratings. This P.H.S. unit gives medical services to 8,000 on and off reservation Indians, who still have no services from 10:00 P.M. to 8:00 A.M. We have lost two very good medical doctors and the only psychiatrist due to a protest in support of Mr. R. Salacinski the Service Unit Director who was relieved of his duty as results of the allegations being brought to the Tribal Council, not to the Civil Service board for action.

We have now four doctors and are still operating on an emergency basis. We must send our patients to either Rolla Community Hospital or Rolette Hospital, this procedure is costing the Government monies that are being contracted out. At present there are two heart patients in the Rolla Intensive Care Unit, that could be in our own hospital.

When we requested that this hospital issue be reviewed before the Aberdeen Area Office on October 4, 1973, Mr. Fred Reiff the Acting Area Director for Indian Health Services, stated that our group from the Turtle Mountain Indian Reservation would have no input into this meeting, but he appointed a non-Indian who lives in the Aberdeen Area who knows nothing of how we feel and think about Indian Issues, to speak for us. This person he appointed for our behalf, made paper airplanes and did not ask any questions about the critical state our Hospital is in. We were also told that Mr. George Decoteau (Councilman Dist. 4) was the person who was appointed to represent our tribe on issues such as this one. However he never attends any of these meetings of importance. At this point we were asked to step to the BACK of the room.

We have many tribal people working in the Public Health Service Indian Hospital who are not Civil Service Employees. For instance there is one person in the laboratory a person in X-Ray, about nine or ten nursing assistants, and several people in the housekeeping and maintenance department whose salaries are paid either from N.Y.C., Mainstream, on the job training, and Emergency Employment Assistance which are all tribal funding programs. However, this personnel is needed to maintain the function of our hospital, but on the other hand, Health, Education and Welfare is leaving the door open to invite Tribal Politics into our Hospital system.

We have reviewed the past performances of both the Tribal Politics involved and the actions taken by the Public Health Service and came to the conclusion that the only people being punished for the actions of both agencies, is the Indian Citizen on our reservation, because medical services are being denied to the Children, the Senior Citizen, and the Helpless.

Our Indian People who are on the Bureau of Indian Affairs General Assistance are not entitled to receive medical services at off reservation hospitals unless the G. A. recipient has been authorized by one of the Public health service doctors prior to an emergency, or only to be treated if the person is a referral to one of the outside hospitals. These services exclude blue-cross, blue shield, medic-aid and medi-care, glasses and dentures for those over the school age child and sometimes even the child due to the lack of funds.

In respect to your position we are now giving your committee our Indian direction in the form of constructive recommendations as follows:

1. The tribal council and members of the health board should be made aware that they only hold the capacity of an advisory committee, they cannot hire or terminate any civil service employee's position.

2. To eliminate any further tribal politics within the Public Health Service Indian Hospital, leave positions open so that they can be filled as Civil Service Employees as they are needed. There are many positions needed to be filled as of this date.

3. No tribal politics in the Public Health Service Indian Hospital during the working hours.

4. The need for a new X-Ray Machine with optional equipment for x-ray scans (we must contract out for these services and any test called for x-ray) the machine we no have, breaks down frequently.

5. We need permanent medical staff at our hospital such as, an anaesthetist, a resident doctor, a psychiatrist, a pediatrician, a laboratory technician, an x-ray technician and two trained ambulance drivers with two trained medical assistants for the ambulance. At present the ambulance drivers are the hospital maintenance men. The psychiatrist would be more than an asset to the people in our community (we have school children unable to adjust and other programs that need the guidance of such a person).

6. There should be an area through the Public Health Service Indian Hospital to cover burial of the poor Indian.

7. Budgeting of our hospital expenses should be a requirement for both the hospital and the community it serves.

8. The position of Service Unit Director has not been filled for this hospital, so far we have been operating under only temporary Acting Service Unit Directors, therefore we are requesting the reinstatement of Mr. Richard Salacinski to our hospital position, as we feel he would best qualify to direct and carry out the demands required of him.

There will be a surgeon to join our hospital staff soon. And at this time we also have a well equipped operating room that has been used and can still be used. We have many patients sent out for surgery and special testing, these services can be properly executed here in our own hospital without the extra expense of contracting for these services.

Your assistance on our Indian Input (direction) will be greatly appreciated.

Very Sincerely

Mary R. Cornelius, subcouncilwoman, district 2; Debbie White, high school student; Belva Decoteau, N.W.R.O. Secretary; Raelena Montriel, (diabetic child), Head Start student; Joy Cornelius, student nursing aid; Elizabeth Montriel, nursing aid; Alice Christjohn, N.C.C. for North Dakota; Anjie Slattery (AFDC child), Belcourt Grade School student; Rick Cornelius, junior high school student.

Belcourt Hospital Issues Policy Information

The following information is intended to help understand some of the Indian Health Service policy that is in effect. This information will be of assistance to both the Indian people that are within priorities for medical services at the Belcourt Indian Hospital, and medical facilities that provide services and patient transportation for members of the community. This document is intended to clarify policies in order to avoid costly misunderstandings incurred by the Indian people and also the off-reservation health providers.

Due to unexpected expenditures in the Belcourt Indian Hospital Contract Health Services account, we are forced to restruct some of the health services that are normally paid from this account. The services that must be restricted are Patient care, and Private or Community Ambulance service.

I. Patient care at the Belcourt Indian Hospital:

The Belcourt Indian Hospital is presently offering out-patient clinic services during the hours of 8:00 a.m. to 5:00 p.m. daily. Emergency cases will be seen from 5:00 p.m. to 10:00 p.m. and on week ends. The Belcourt Indian Hospital is not offering in-patient care service at present because of a full staff of physicians.

The present Belcourt Indian Hospital clinic and emergency hours schedule are as follows:

Out-patient clinic services are being conducted at the Belcourt Indian Hospital from 8:00 a.m. to 5:00 p.m. daily (except week ends)

Emergency cases will be examined during the hours from 5:00 p.m. to 10:00 p.m. daily and week ends.

All emergency cases should be taken to one of the Contract Health Facilities such as the hospitals at Rolla, Rolette, or other facilities during the hours from 10:00 p.m. to 8:00 a.m. daily and on week ends.

Weekends:

Emergency patients will be examined at the Belcourt Indian Hospital from 8:00 a.m. to 10:00 p.m. on Saturday and Sundays. Some cases that appear to be

semi-emergency situations will be seen between the hours of 1 :00 p.m. to 3 :00 p.m. on weekends.

II. Patient Care at Contract Facilities :

The following restrictions must be implimented to conserve the Contract Health Services Funds so as to extend patient care services over a longer period of time.

1. The person presenting himself-herself for medical services must be within the scope of the Indian Health program.

PERSONS TO WHOM SERVICES MAY BE PROVIDED

A person may be regarded as within the scope of the Indian Health program if he is not otherwise excluded therefrom by provision of law, and :

A. Is of Indian and or Alaskan Native descent as evidenced by one or more of the following factors :

(1) Is regarded by the community in which he lives as an Indian or Alaska Native.

(2) Is a member, enrolled or otherwise, of an Indian or Alaska Native Tribe or Group under Federal supervision,

(3) Resides on tax-exempt land or owns restricted property,

(4) Actively participates in tribal affairs,

(5) Any other reasonable factor indicative of Indian descent ; or

B. Is an Indian of Canadian or Mexican origin recognized by any Indian tribe or group as a member of an Indian community served by the Indian Health program ; or

C. Is a dependent (Indian or non-Indian) of a person qualifying under A. or B. above, and resides in the household of such qualifying person.

2. The Indian person presenting himself-herself for medical services at a contract health service facility such as the hospitals at Rolla, Rolette or other facilities must have a written referral notice signed by the Belcourt Indian Hospital physicians if the Indian Health Service is expected to pay the cost or part of the cost for treatment. This restriction will apply to cases when treatment or hospital admission occurs between the hours of 8 :00 a.m. and 10 :00 p.m. daily.

If the person presents himself-herself for treatment at a contract health service facility without a written referral from the I.H.S. physician between the hours of 8 :00 a.m. and 10 :00 p.m. daily, he must expect to pay all of his treatment cost incurred at the contract facility. If the person's entire treatment is to be paid by another resource he-she may utilize any other facility as suggested by the alternate resource.

3. Persons who come within the scope of the Indian Health program may present himself-herself at a contract health service facility for only emergency treatment during the hours from 10 :00 p.m. to 8 :00 a.m. daily. The Belcourt Indian Hospital will honor payment for services to this person. P'ease use sound judgement when determining emergency care for yourself and family.

Emergency : (As defined by the I.H.S. Aberdeen Area Office Contract Health Services Branch)

"The patient must receive care immediately to preserve life, viability of a limb or organ or to prevent otherwise serious complications."

"Examples : A compound communited fracture of the femur requiring specialist care and pinning ; puncture wound of eye into the anterior or posterior chamber ; intussussception ; incarcerated hernia ; acute bleeding ; infantile convulsions of unknown origin on admission ; coronary occlusion ; (normal term delivery when IHS hospital beds are not available)"

III. Private or Community Ambulance Service :

The Belcourt Indian Hospital does have two ambulances available for service throughout the normal work day and night emergencies. The Belcourt Indian Hospital Contract Health Services funds are being depleted at a more rapid rate than was anticipated when the Contract Health Services budget was developed, therefore, the following priorities are established.

A. The ambulance service avai'able at the Be'court Indian Hospital will be uti'ized first, before other ambu'ance services, whenever possible.

B. Ambulance services, other than the Belcourt Indian Hospital ambulance may be used if the patient must receive immediate medical care to preserve life, viability of an organ or limb or to prevent otherwise serious complications.

Please contact the Belcourt Indian Hospital by telephone prior to rendering this service if possible.

C. Transportation costs for a patient other than in an emergency situation or upon the request of an Indian Health Service physician will not be paid by the

Indian Health Service. The preceding sentence rules out the transporting of patients to a facility for treatment by a specialist unless the circumstances dictate it is an emergency. This is an attempt to reduce the transportation costs generated by using transportation services other than those that are readily available at the Belcourt Indian Hospital.

CHARLES ANYWAUSH,
Service Unit Director, PHS Indian Hospital, Belcourt, N. Dak.

SISSETON-WAHPETON SIOUX TRIBE OF THE LAKE TRAVERSE RESERVATION,
Sisseton, S. Dak., December 5, 1973.

Senator JAMES ABOUREZK,
New Senate Building,
Washington, D.C.

DEAR SENATOR ABOUREZK, We are submitting the following testimony for your hearings on Indian Health. We request inclusion of this testimony into the documented records of your hearings.

FIDELITY: ADHERENCE OR ABERRATION

On February 19, 1867, a Treaty was negotiated by the United States with the Sisseton and Wahpeton Bands of the Sioux, in which Article 1 clearly enunciates the relationship between two parties:

> "The Sisseton and Wahpeton bands of Dakota Sioux Indians, represented in Council, will continue their friendly relations with the Government and people of the United States, and bind themselves individually and collectively to use their influence to the extent of their ability to prevent other bands of Dakota or other adjacent tribes from making hostile demonstrations against the Government or people of the United States."

In light of current developments directly impinging upon the well being of Sisseton Wahpeton members, developments which appear to jeopardize this well-being; and, as a matter of fact, give evidence of sheer genocide, the Sisseton and Wahpeton bands of Dakota Sioux Indians, represented in Council, may be forced individually and collectively to put asunder their friendly relationships with the Government and people of the United States. The prevention of hostile demonstrations would not be a part of the compact agreed upon with the United States. In the event of hostility, the Sisseton and Wahpeton Sioux would set the precedent of being one of the few Tribes to breach a Treaty.

The foregoing observations may impress some as idle whims of fantasy. For the "grassroots" Dakota, however, frustration borne from diminishing annual funds for Indian Health Serivce provides cause for rebellion. Thoughts about planned strategy for racial genocide easily are acquired. Perhaps, a desired effect is achieved: a physically infirm people who cannot find medical help.

There is basis for such suspicion. The enclosed report from the local IHS Service Unit Director briefly outlines the crisis in health—care for the Sisseton Wahpeton Sioux:

Inadequate Facility: Monies are not available, we are told, to redesign or construct a new hospital and clinic. Presently, members of our Tribe receive care in a facility constructed in 1938. There is no room for isolation, coronary care, etc. Our x-ray equipment are ideal pieces for the Smithsonian, and accurately would depict methods of diagnosis in vogue fifteen (15) to thirty (30) years ago. In our facility, pediatric chest films and spine examinations are impossible to perform. Our equipment has very high radiation output too. Our radiological equipment included two portable units, one a "Picker" vintage 1931, which lacked safety features. We want to simply replace our x-ray unit with one having 150 KVP at 500 MA with image intensification. Also, new equipment would provide for the safest radiation environment, which would decrease exposure to our patients and personnel. We were casually informed however, that NO FUNDS ARE AVAILABLE. We note that our out-paitent clinic presently consists of a converted house-trailer.

2. Personnel: Currently, we have been successful in keeping a highly dedicated contract physician and a civil service psysician on duty. We want financing to continue these positions. While the tempest of Watergate rages, and thousands of dollars are expended to justify a few offices, members of our Tribe are served by two (2) over-worked physicians, whose pay and compensation are meager.

We ask the question: Where is justice?

Since, 1867, well beyond one century, the members of the Sisseton Wahpeton Sioux Tribe have been faithful in its promise to "keep friendly relations with the Government and people of the United States".

We now ask the Congress of the United States whether or not it intends to reciprocate in this relationship? Are you indeed charting for us a destiny whose course ends in racial genocide? Are you insistent upon keeping our people physically infirm? We await your response.

Respectfully,

EDWARD M. RED OWL,
Tribal Planning Director.

Enclosures.

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE,
PUBLIC HEALTH SERVICE,
SISSETON PHS INDIAN HOSPITAL,
Sisseton, S. Dak., November 28, 1973.

MRS. IRENE GRONAU,
Chairman, Sisseton-Wahpeton Tribal Health Council,
Sisseton, S. Dak.

DEAR IRENE: This material is in response to your request for background data on the hospital. Attached is a report giving detailed breakdowns.

I can give you some summary highlights on the detailed information.

Physical Plant: The Sisseton Indian Hospital was built in 1938. The problem is not with bed capacity, but with age and design. As you will see in the blueprints (these blueprints were drawn for a proposed remodeling; they show the basic lay-out), most beds are in four-bed wards with little individual room space. This design often presents problems in handling isolation cases, critical patients, emotional patients, and younger patients.

The nurses station is in a poor location to monitor patients. Emergency room patients have to come in the main door and be swung through the nurses station to the emergency room. Lab space is completely inadequate with poor ventilation. Storage space is at a premium.

There have been attempts to up-date plumbing and wiring but these have not been totally successful.

The out-patient clinic is an attached double trailer. Much better than what was before, but it is likely to have a short life-expectancy.

Personnel: There is currently a contract physician and a Civil Service physician on duty. This is adequate for the current level of operation. The main problem here is financing the positions. Additional funds have not yet been received to make up the difference in cost between the Commissioned Corps physicians and current staff.

Nursing has a continual problem maintaining a full staff of trained professionals. Those that are on duty need to have continued education to keep abreast of new developments. Since they all have families it is often difficult to send them away for any training longer than two-three days. Even for this, training funds are limited.

Laboratory personnel has been a major problem. The lab space makes for hard working conditions plus the work-load is very high. There is difficulty in recruiting and retention. The x-ray technican is on temporary appointment because there is no permanent position available.

Specalized consultants such as radiological, pathologist, physical therapists would be useful to have make periodic on-site visits, but we have not been able to afford such consultants in a routine basis.

Equipment: You have previously received a list of equipment needs. To replace the out--dated equipment would cost in the neighborhood of $100,000. It is hard to imagine such money becoming available.

Finances: All accounts are very tight. We have not received money to support new pay increases. Contract Health is being rigidly controlled to keep it anywhere close to funds allocated. General increases in supply costs continually exceeds our estimates. I understand some relief is being worked on; it has not yet reached us.

I believe this presents the general picture shown in the data. Please contact me if you need any more clarification.

Sincerely,

GARY R. LOUNSBERRY, *Service Unit Director.*

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