

INDIAN HEALTH CARE AMENDMENTS OF 1987

SEPTEMBER 14 (legislative day, SEPTEMBER 7), 1988.—Ordered to be printed

Mr. INOUE, from the Select Committee on Indian Affairs,
submitted the following

REPORT

[To accompany S. 129]

The Select Committee on Indian Affairs, to which was referred the bill (S. 129) to authorize and amend the Indian Health Care Improvement Act, and for other purposes, having considered the same, reports favorably thereon with an amendment in the nature of a substitute and recommends that the bill, as amended, do pass.

PURPOSE

The purpose of S. 129, the Indian Health Care Amendments of 1987, is to reauthorize the Indian Health Care Improvement Act of 1976 through fiscal year 1991, to make amendments to the Indian Health Care Improvement Act, and to authorize appropriations to carry out the provisions of the Indian Health Care Improvement Act.

BACKGROUND AND NEED

The Indian Health Care Improvement Act of 1976 (25 U.S.C. 1601, et seq.) and the Snyder Act of 1921 (25 U.S.C. 13) comprise the basic legislative authority for the health care programs that are administered by the Indian Health Service (IHS), an agency of the Public Health Service within the Department of Health and Human Services (DHHS). The Indian Health Care Improvement Act was enacted into law in 1976 based upon findings that the health status of American Indians and Alaska Natives continued to rank far below that of the general population, and that all other Federal services and programs were jeopardized by the low health status of American Indian people. The Act was amended and ex-

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tended in 1980, continuing authority for appropriations for the provision of health care services to Indian and Alaska Native people through September 30, 1984.

Legislation to reauthorize the Act (S. 2166) was introduced in the 98th Congress, but was vetoed by the President following the sine die adjournment of the 98th Congress. Reauthorization legislation was again introduced in the Senate (S. 277) in the beginning of the 99th Congress. A companion House bill (H.R. 1426) was passed by the House on September 18, 1986, and was passed by the Senate by the Senate on October 8, 1986 with an amendment. The House concurred in the Senate amendment with amendments on October 10, 1986, and the Senate concurred in the House amendments to the Senate amendment with an amendment on October 18, 1986. The bill was not acted upon again by the House of Representatives before the sine die adjournment of the 99th Congress. The programs authorized in the Indian Health Care Improvement Act have been extended by appropriations acts of the Congress through fiscal year 1989.

Although significant gains have been realized in improving the health status of Indian and Alaska Native people since the passage of the Act of 1976, health status parity with that of the general United States population has yet to be achieved. The age-adjusted mortality rate among American Indians is 330 percent higher than the general U.S. population, all races, for all forms of tuberculosis; 300 percent higher for chronic liver disease and cirrhosis; 210 percent higher for diabetes mellitus; and 170 percent higher for pneumonia and influenza. And, although the Indian population is the fastest growing population in the United States in numbers of births, the postneonatal mortality rate among native infants is 170 percent higher than the rate for the U.S. all races. Deaths attributable to accidents exceed national averages by 250 percent.

In exchange for lands ceded to the United States by Indian tribes under the provisions of treaties, executive orders, and various acts of the Congress, the Federal government has provided health care services to Native Americans since the early nineteenth century. Federal programs for the benefit of American Indians were first administered by the U.S. War Department, but in 1849, the responsibility for the provision of health care services to Indian people was transferred, along with the Bureau of Indian Affairs, to the Department of the Interior. In 1921, Congress enacted the Snyder Act, establishing the first legislative authorization for appropriations for the "relief of distress and conservation of health" of Indian people. Later, in 1955, the responsibility for the provision of health care services to Indian people was again transferred, this time to the Division of Health in the Department of Health, Education and Welfare, under the authority of an Act to Transfer the Maintenance and Operation of Hospital and Health Facilities for Indians to the Public Health Service (42 U.S.C. 2001, et seq.). The Division of Health subsequently came to be known as the Indian Health Service within the reorganized Department of Health and Human Services, where the responsibility for Indian health care continues to be vested.

The early focus of the Indian Health Service (IHS) was on the elimination of the infectious diseases that were widespread in the

Indian population and on chronic care for the large numbers of Indian people suffering from tuberculosis. Currently, the mission of the IHS, in carrying out the policy established by the Congress in the Indian Health Care Improvement Act, is to raise the health status of American Indians and Alaska Natives to the highest possible level. IHS defines its service delivery responsibilities to include a comprehensive range of inpatient and ambulatory medical services, dental care, mental health and alcoholism services, preventive health (immunizations and environmental services such as sanitation and water safety), health education, and Indian health manpower development programs. A broader definition of IHS responsibilities is applied in isolated rural areas on or near Indian reservations, because the infrastructure of roads, utilities, and public services that support health care delivery to non-Indian rural residents is often lacking on Indian reservations. IHS also operates a health facilities construction component that provides hospitals, clinics, and living quarters for IHS facility staff for reservation-based IHS services. Programs for Indians residing in urban areas do not directly provide hospital care, but do offer a range of ambulatory medical, dental, mental health, alcoholism treatment, support and referral services.

The Indian Health Service operates the largest direct health care delivery system within the Department of Health and Human Services, with over 11,400 permanent employee positions. IHS administers health care programs to Indians and Alaska Natives through eight area offices and four program offices, each of which has the responsibility for the provision of health care services within its respective geographic area. The area offices and program offices also have responsibility for overseeing the administration of IHS service units, the most local administrative entity, through which services are provided directly or by contract to the eligible Indian population. Each service unit may include one or more IHS hospitals, health centers, school health centers, health stations, or health locations. A health center is a facility that is open a minimum of forty hours per week and offers acute and chronic care services on an outpatient basis. A health station is a facility that may be mobile and which provides outpatient services on less than a forty hour per week basis. A health location is a site for the periodic provision of outpatient health services often provided by traveling health care professionals. In areas in which there are no IHS facilities or where an IHS facility lacks the capacity to provide certain types of health care services, the IHS contracts with private health care providers for the provision of health care services to Indian patients. IHS also provides technical assistance in the construction and operation of sewage treatment and clean water facilities.

With the enactment of the Indian Self-Determination and Education Assistance Act in 1975, Indian tribal governments, tribal organizations, Alaska Native communities, and Alaska Native regional health and village corporations have begun to assume the responsibility for the provision of health care under contract with the Indian Health Service. In addition, IHS programs, such as the Community Health Representative program, that are administered directly by Indian tribal governments, have done much to heighten

awareness of the importance of preventive health care and health education in Indian communities.

A report released by the U.S. Congress Office of Technology Assessment (OTA) in February, 1987, projects that IHS will experience serious physician shortages in the near future. In past years, the Indian Health Service physician supply has come primarily from the National Health Service Corps, a scholarship program operated by the Public Health Service that requires a service payback obligation as an exchange for scholarship assistance in medical school and residency training. National Health Service Corps obligees can elect to fulfill their obligations through service in the Indian Health Service. However, because of the phased elimination of the scholarship program, there will be only two obligees available for service in 1992. Recognizing the need for additional manpower, IHS has proposed to initiate a program that would recruit volunteers into the Service, but the Office of Technology Assessment projects that the IHS initiative will not be sufficient to meet the need, given the low salaries that IHS must offer and unattractive working and living conditions that are associated with the provision of health care on Indian reservations. For the past two years, the President's Budget has also proposed the phased elimination of the Indian Health Service scholarship program—the last remaining source of health care professional supply to the Indian Health Service.

To ascertain the need to reauthorize the Indian Health Care Improvement Act of 1976, the Select Committee on Indian Affairs held six hearings in the 98th Congress. Hearings were held in conjunction with the House Interior and Insular Affairs Committee in Phoenix, Arizona on March 31, 1983. The Senate Select Committee on Indian Affairs held further hearings on the need for reauthorization of the Act in Grand Forks, North Dakota on June 2, 1983; in Anchorage, Alaska on June 3, 1983; in Seattle, Washington on June 8, 1983; in Billings, Montana on July 8, 1983; and in Washington, D.C. on July 28, 1983. The Committee received testimony from Indian tribes, urban Indian health care programs, tribal organizations, physicians and other health care professional employees of the Indian Health Service, representatives of the Department of Health and Human Services, as well as physicians and health care professionals from the private sector. Testimony received by the Committee strongly supported the need to reauthorize the Indian Health Care Improvement Act, given the outstanding unmet health care needs of Indians and Alaska Natives that were documented in the hearing process.

On November 18, 1983, Senator Mark Andrews, Chairman of the Senate Indian Affairs Committee, introduced S. 2166, a bill to reauthorize the Indian Health Care Improvement Act of 1976 through fiscal year 1988. The Committee held two hearings on the bill in Washington, D.C. on February 29, 1984, and in Denver, Colorado on March 17, 1984. In response to testimony received from national Indian organizations, professional medical associations, Indian tribes, urban Indian health care organizations, professional medical associations, and Administration representatives, the Committee made several changes to the bill as introduced, and an amendment in the nature of a substitute to S. 2166 was unanimously approved

by the members of the Select Committee on Indian Affairs in a May 9, 1984 mark-up of the bill to reauthorize the Indian Health Care Improvement Act. S. 2166 was passed by both houses of the Congress in the 98th session of the Congress, but was vetoed by the President on October 19, 1984, following the sine die adjournment of the 98th Congress.

Recognizing that the unmet health care needs of Native Americans were continuing to worsen, the Chairman of the Indian Affairs Committee introduced a bill to reauthorize the Act (S. 277) at the beginning of the 99th session of the Congress. Largely due to the efforts of tribal leaders seeking a dialogue between the Administration and the Congress to avoid the possibility of another veto, the Office of the Secretary of the Department of Health and Human Services agreed to enter into discussions with Select Committee representatives. Several months of discussions yielded a version of the reauthorization bill to which the Administration was not opposed. Following two additional hearings in the 99th Congress, the Committee reported S. 277 on May 16, 1985.

LEGISLATIVE HISTORY

On January 6, 1987, Senator Inouye introduced the Indian Health Care Amendments of 1987 (S. 129) for himself and Senators DeConcini, Matsunaga, Kennedy, Evans, Murkowski, Bingaman, Stevens, McCain, Melcher, Pressler, Evans, Cranston, Durenberger, Cochran, Nickles, Hatfield, Baucus and Domenici. S. 129 was referred to the Select Committee on Indian Affairs. Given the thorough hearing record established in the two previous sessions of the Congress, and the results of discussions with the representatives of the Department of Health and Human Services, the Chairman requested that the Committee proceed to consideration of S. 129 without further hearings. S. 129 was ordered reported with an amendment in the nature of a substitute on January 23, 1987, and further amendments to the amendment in the nature of a substitute were ordered reported on March 19, 1987. A bill to authorize and amend the Indian Health Care Improvement Act (H.R. 2290) was introduced in the House of Representatives on May 5, 1987 by Congressman Udall, for himself and Congressmen Richardson, Campbell, Johnson of South Dakota, Lowry of Washington, Lewis of Georgia, Vento, Young of Alaska, Lagomarsino, Bereuter, and Rhodes. H.R. 2290 was jointly referred to the Committee on Energy and Commerce, and to the House Interior and Insular Affairs Committee. The bill was ordered reported by the House Interior and Insular Affairs Committee on June 3, 1987 with amendments, and by the Subcommittee on Health and the Environment of the House Energy and Commerce Committee on October 9, 1987, with amendments.

SUMMARY OF MAJOR PROVISIONS

TITLE I

Indian health manpower programs and scholarship assistance

In its total workforce of approximately 11,400 (1985 estimates), the Indian Health Service employs approximately 750 physicians,

including physicians in administrative roles at IHS headquarters and area offices, nearly 2,000 professional nurses, 800 practical nurses, 300 pharmacists, and 275 dentists. A recent report of the U.S. Congress Office of Technology Assessment evaluated clinical staffing needs in the Indian Health Service, and found that unless current policies change, there will no physicians available from the National Health Service Corps (NHSC) scholarship program by 1992. The National Health Service Corps scholarship program has served as a major source of physician supply to the Indian Health Service in past years. The scholarship program requires one year of obligated service in the Indian Health Service for each year of scholarship assistance received by an NHSC program participant. The Office of Technology Assessment report states, "Arguing that the growing surplus of physicians nationally will diffuse to underserved areas, thus eliminating the need for the NHSC, the Administration has sought to phase out the program by restricting new scholarship awards. Recently, IHS has been able to recruit 40 to 50 voluntary physicians annually; but its ability to recruit enough volunteers to replace lost NHSC physicians has not been tested. The PHS (Public Health Service) Commissioned Corps, which has made valuable contributions to IHS professional staffing over the years, like the NHSC, has been targeted by the current Administration for reduction or elimination." The OTA report concludes that, "Thus a national physician surplus will improve medical manpower and services for Indians only if it greatly increases recruiting of voluntary physicians into IHS, which does not seem likely in the near future, given the other organized practice alternatives available to physicians, the undesirability of many IHS sites, and uncompetitive IHS salaries and benefits."

Title I reauthorizes programs that provide for the recruitment, training and professional development of Indian people to serve in the Indian Health Service. Funding is authorized for the continuation of the health professions recruitment program for Indians and for the health professions preparatory scholarship program through fiscal year 1991. The recruitment program is designed to provide information to junior and senior high school students that are interested in entering the health professions, and the preparatory scholarship program is aimed at assisting students that display an aptitude for subjects relevant to training in the health professions training.

Based upon prior actions of the Department that denied scholarship assistance to applicants on grounds that were not intended by the Congress to be the basis for such denials, language in the bill makes clear that the Secretary is not to deny scholarship assistance to an applicant otherwise eligible to participate in the preparatory scholarship program, solely on the basis of the applicant's scholastic achievement if the applicant has been admitted to, or has maintained good standing at an accredited institution.

The bill also provides authorization for funding for the continuation of the Indian Health Service extern program, a program that enables health professions students to work in Indian Health Service facilities during non-academic periods.

The bill further provides for the extension of the Indian health professions scholarship program, a program that requires one year

of obligated service in the Indian Health Service in exchange for each year of scholarship assistance received by a student pursuing a degree in the health professions. The active duty service obligation associated with such scholarship assistance can be satisfied by service in the Indian Health Service, in a program conducted under a contract entered into under the authority of the Indian Self-Determination and Education Assistance Act, in an urban Indian health care program, or in the private practice of a health profession if the practice is located in a physician or other health professional shortage area and addresses the health care needs of a substantial number of Indians. The bill also makes clear that students in schools of psychology, social work, and osteopathy are eligible to participate in the scholarship assistance program.

In addition, recognizing the importance to the overall retention of personnel within the IHS, the bill provides authority for appropriations for the continuing education of IHS health care professionals.

Although not to be administered by the Indian Health Service, the bill also authorizes a health professions scholarship program for Native Hawaiians. The Native Hawaiian scholarship program is authorized in response to findings of a 1986 report of the Department of Health and Human Services which documented shortages of health care professionals available to serve the Native Hawaiian patient population. To participate in the Native Hawaiian scholarship assistance program, an applicant must be a citizen of the United States, a resident of the State of Hawaii, and a descendant of the aboriginal people who, prior to 1778, occupied and exercised sovereignty in the area that now constitutes the state of Hawaii.

Community health representatives

In many isolated Indian and Alaska Native communities, Community Health Representatives (CHRs) are the only trained health care personnel within close proximity to the reservation or community, and thus often are the only source of health care available in a medical emergency. Community health representatives administer emergency treatment, and often provide emergency transportation to the nearest Indian Health Service facility. Community health representatives provide home health care services to elderly and non-ambulatory patients, and provide health education to members of the community. The reduction of the incidence of fetal alcohol syndrome and the reduction in the rate of infant mortality in Indian and Alaska Native communities can be attributed in part to the efforts of CHRs in providing health care education to pregnant women and mothers. Several years ago, in response to an Administration proposal that the Community Health Representative program be eliminated, over 300 Indian Health Service physicians signed a petition expressing their support for the CHR program and emphasizing the importance of CHRs to the overall health care delivery system. CHRs are typically Indian men and women from the local community, that speak the tribe's native language, and are thus able to facilitate the acceptance of modern medical technology amongst members of the community that are accustomed to relying upon traditional medicine practitioners. Although the program has been in existence for almost twenty years, the program

