The original documents are located in Box 57, folder "9/30/76 S522 Indian Health Care Improvement Act (1)" of the White House Records Office: Legislation Case Files at the Gerald R. Ford Presidential Library

9/30/76

APPROVED
SEP 30 1976

Statement issued 10/1/76

THE WHITE HOUSE

WASHINGTON

ACTION

Last Day: October 1

September 30, 1976

MEMORANDUM FOR: THE PRESIDENT

FROM: JIM CANNON

SUBJECT: Enrolled Bill S. 522 - Indian Health Care Improvement Act

TOAR-Kiuos 10/1

This memorandum is to present for your decision enrolled bill S. 522, the Indian Health Care Improvement Act.

PURPOSE

This bill authorizes new categorical programs and increases appropriation authorization levels for Indian Health Service (IHS) programs of the Department of Health, Education, and Welfare.

DISCUSSION

S. 522 is aimed at improving the health status of Indians and Alaskan natives and includes the following major provisions:

-- establishes a new scholarship program for Indians in health training, as well as assistance to those serving Indians;

-- authorizes numerous new programs for the delivery of health services;

-- authorizes funds for the construction and modernization of health facilities, including water supply and waste disposal facilities;

-- removes the prohibition against Medicare and Medicaid reimbursements to Federal Indian Health Service facilities; and

-- establishes a new program of services for non-federally-recognized Indians living in urban areas.

This legislation was approved in the Senate by unanimous consent and in the House by a 310-9 vote. The Senate concurred in the House-passed bill by a 78-0 vote on September 9, 1976.

Each of these provisions is discussed in Jim Lynn's memorandum (attached at Tab A).

BUDGET IMPACT

S. 522 would authorize a total of $480 million for the first three years of the bill, fiscal years 1978-1980, including $145 million for fiscal year 1978. The clear legislative intent is that the amounts authorized to be appropriated be in addition to current appropriation levels. The 1977 budget proposed $395 million for Indian health programs, but the Interior appropriation bill for fiscal year 1977, which you approved, contains $425 million for the IHS.

A detailed summary of the amounts authorized by S. 522 for Indian health programs is on page 10 of Jim Lynn's memorandum (Tab A).

ARGUMENTS IN FAVOR OF APPROVAL

1. S. 522 is designed to concentrate Federal resources on meeting deficiencies in Indian health services and facilities through a sustained and coordinated effort. Health statistics and other indicators of health status -- e.g., incidence of tuberculosis, infant mortality, ratio of physicians -- demonstrate the need for targeting special resources on Indian health problems.

2. There are indications that the Congress believes it has met important Administration objections, e.g., the potential cost of S. 522 has been reduced from $1.6 billion to $481 million in response to HEW opposition (this was accomplished by reducing the number of years with specific authorization amounts from seven to three and authorizing the outyears at "such sums"). Despite the high authorizations, more realistic appropriations levels can probably be achieved through the budget process.

3. S. 522 has broad Congressional and interest group support. It was approved by both Houses by nearly unanimous votes and has been endorsed by several national health organizations, including the American Dental Association, the American Academy of Pediatrics and the American Medical Association.

4. Congressional proponents, Interior and HEW suggest that your approval of S. 522 would demonstrate a positive commitment to solving Indian health care problems and would signify to Indian people a recognition of one of their priority problems and a real concern for interest in them.

5. Although S. 522 duplicates many existing HEW programs, it could be viewed as a follow-on step to other laws enacted in recent years -- e.g., the Indian Financing Act, the Indian Self-Determination and Education Assistance Act, the Indian manpower component of the Comprehensive Employment and Training Act of 1973 -- which have been directed toward improving the economic, educational and social status of Indians.

6. Although an argument against new categorical programs is that all of the proposed program activities could be conducted under the broad flexible legislative authorities of the Snyder Act and other laws, in fact, many of these program activities are not being conducted under those legislative authorities, either because of a lack of initiative and creativity or because of active policy opposition.

ARGUMENTS AGAINST APPROVAL

1. OMB says that S. 522 is an example of unnecessary and inappropriate Congressional enactments. The bill would add some 20 new categorical programs and appropriation authorizations to an already large array of existing Federal activities aimed at improving the health of Indians. The proposed program activities could be conducted under the broad flexible legislative authorities of the Snyder Act and other laws.

2. OMB says that the authorization levels in S. 522 are significantly higher than warranted because substantial Federal funds are already being spent on Indian health. The Administration has indicated its strong commitment to improving the health status of Indians and Alaska natives by approving a 1977 level of $425 million for the Indian Health Service, a 230% increase since 1970.

3. Improvements have been made over the past several years in the health status of Indians. Dramatic reductions are apparent in such areas as Indian and infant death rates and the incidence of tuberculosis, influenza and pneumonia, gastritis and related diseases.

4. The provisions singling out non-reservation Indians living in urban areas for special health programs not only duplicate existing narrow categorical programs, e.g., community mental health centers, which provide services to all members of the community including Indians and other disadvantaged groups, but are conceptually at odds with your health block grant proposal that would give the States Federal funds and clear authority and responsibility in this area.

STAFF AND AGENCY RECOMMENDATIONS

HEW	Approval. "Approval of this bill would reaffirm the Administration's real concern for and interest in Native Americans; disapproval would adversely affect the view Native Americans and others have as to the Administration's commitment to Native Americans."
Interior	Approval. "As the Department primarily charged with carrying out the Federal responsibility to Indians, and promoting their general welfare, we believe it is essential that the President affirm the commitment to improved Indian health as embodied in S. 522, and which has received the overwhelming endorsement of the Indian people."
OMB	Disapproval. "We believe S. 522 is a particularly egregious example of unnecessary legislation that will result in highly unrealistic expectations among the very group it is intended to help." ". . .We do not find any of the arguments . . . sufficiently compelling to recommend approval. . ., particularly in light of the special priority already given to Indian health programs."

Buchen (Kilberg)	Approval. "The trust responsibility which the Federal Government has to federally recognized tribes is unique and must be weighed very carefully before turning down programmatic legislation." . . . ". . . physical defects in Indian health facilities are not limited to the lack of eight foot wide halls. . . I think a tour of Indian health facilities would reveal buildings and equipment in such condition as to raise serious questions about the health care and safety of patients. Also, visits indicates staff-patient ratio that were troublesome." (Memorandum attached at Tab B).
Marsh	Approval.
Baroody (Patterson)	Approval. (Memorandum attached at Tab C).
Friedersdorf	Approval. "Rhodes and Fannin very strong for this bill. Veto cannot be sustained."
Seidman	Disapproval.

RECOMMENDATION

I join HEW, Interior and most of the White House staff in recommending that you sign S. 522.

Congressional and interest group support for this bill is strong. Letters urging your approval have been received from Senators Bartlett, Dole, Domenici, Fannin, Goldwater, Hatfield, Packwood and Stevens and from Congressmen Clausen, Rhodes and Steiger. Congressman Rhodes notes in his letter, "Your support of this bill would go a long way towards demonstrating that your Administration is sensitive to the health needs of the first Americans, and supports. . .measures to upgrade their lives."

The signing statement, attached at Tab D and the veto statement, attached at Tab E have been approved by The Counsel's Office, Robert T. Hartmann, Jack Marsh, Max Friedersdorf, Jim Lynn and Bill Seidman. The enrolled bill is attached at Tab F.

DECISION

MR ___ Approve S. 522 and issue signing statement attached at Tab D (HEW, Interior, Buchen, Marsh, Baroody, Friedersdorf, Cannon)

_____ Disapprove S. 522 and issue veto statement attached at Tab E (OMB, Seidman)

STATEMENT BY THE PRESIDENT

I am today signing S. 522, the Indian Health Care Improvement Act.

This bill is not without its faults, but after personal review I have decided that the well-documented needs for improvement in Indian health manpower, services and facilities outweigh the defects in the bill.

While spending for Indian Health Service activities has grown from $128 million in FY 1970 to $425 million in FY 1977, Indian people still lag behind the American people as a whole in achieving and maintaining good health. I am signing this bill because of my own conviction that our First Americans should not be last in opportunity.

Some of the authorizations in this bill are duplicative of existing authorities and there is an unfortunate proliferation of narrow categorical programs. Nevertheless, S. 522 is a statement of direction of effort which is commendable.

Title VII of this bill provides for future reports to the Congress from the Secretary of Health, Education, and Welfare, including a review of progress under the terms of the new Act. I believe the Administration can in this way bring to the attention of the Congress any changes needed to improve the provisions of S. 522.

On balance, this bill is a positive step and I am pleased to sign it.

THE WHITE HOUSE

ACTION MEMORANDUM WASHINGTON LOG NO.:

Date: September 30 Time: 315pm

FOR ACTION: Sarah Massengale
Bobbie Kilberg
Max Friedersdorf
Robert Hartmann
Brad Patterson

cc (for information): Jack Marsh
Jim Connor
Ed Schmults
Paul O'Neill
Bill Seidman

FROM THE STAFF SECRETARY

DUE: Date: September 30 Time: asap

SUBJECT:

Signing Statement - S.522 Indian Health Care

ACTION REQUESTED:

____ For Necessary Action ____ For Your Recommendations

____ Prepare Agenda and Brief ____ Draft Reply

__x__ For Your Comments ____ Draft Remarks

REMARKS:

please return to judy johnston,ground floor west wing

PLEASE ATTACH THIS COPY TO MATERIAL SUBMITTED.

If you have any questions or if you anticipate a delay in submitting the required material, please telephone the Staff Secretary immediately.

James M. Cannon
For the President

S. 522 - Indian Health Care Improvement Act Signing Statement

I am today signing S. 522, the Indian Health Care Improvement Act.

This bill is not without its faults, but after personal review I have ~~determined~~ decided that the well-documented needs for improvement in Indian health manpower, services and facilities outweigh the defects in the bill.

While spending for Indian Health Service activities has grown from ~~$107~~ 128 million in FY ~~1969~~ 1970 to ~~an estimated~~ $~~417~~ 425 million in FY 1977, Indian people still lag behind the American people as a whole in achieving and maintaining good health. I am signing this bill because of my own conviction that our First Americans ~~must~~ should not be last in opportunity.

Some of the authorizations in this bill are duplicative of existing authorities and there is an unfortunate proliferation of narrow categorical programs. ~~But still,~~ Nevertheless, S. 522 is a statement of direction of effort ~~and, as such, it meets with my personal approval~~ which is commendable.

Title VII of this bill provides for future reports to the Congress from the Secretary of Health, Education and Welfare, including a review of progress under the terms of the new Act. I believe the Administration can in this way bring to the attention of the Congress any changes needed to improve the provisions of S. 522.

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Statement by the President

[S. 522 - Indian Health Care Improvement Act Signing Statement]

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Title VII of this bill provides for future reports to the Congress from the Secretary of Health, Education and Welfare, including a review of progress under the terms of the new Act. I believe the Administration can in this way bring to the attention of the Congress any changes needed to improve the provisions of S. 522.

On balance, this bill is a positive step and I am pleased to sign it.

To- J. Johnston 9-24-76 8:30 p.m.

EXECUTIVE OFFICE OF THE PRESIDENT
OFFICE OF MANAGEMENT AND BUDGET
WASHINGTON, D.C. 20503

SEP 23 1976

MEMORANDUM FOR THE PRESIDENT

Subject: Enrolled Bill S. 522 - Indian Health Care Improvement Act
Sponsor - Sen. Jackson (D) Washington and 24 others

Last Day for Action

October 1, 1976 - Friday

Purpose

Authorizes new categorical programs and substantially increases appropriation authorization levels for Indian Health Service programs of the Department of Health, Education, and Welfare (HEW).

Agency Recommendations

Office of Management and Budget	Disapproval (Veto message attached)
Department of Health, Education, and Welfare	Approval
Department of the Interior	Approval

Discussion

S. 522 would authorize approximately 20 new categorical programs at substantial funding levels, with the stated objective of improving the health status of Indians and Alaskan natives. The bill was considered by four different Congressional committees during this Congress. The Committees' clear intent is that the appropriation authorizations be in addition to current funding levels.

This legislation was approved in the Senate by unanimous consent and in the House by a 310-9 vote. The Senate concurred in the House-passed bill by a 78-0 vote on September 9, 1976.

TO THE SENATE

I return without my approval, S. 522, the "Indian Health Care Improvement Act."

I return this bill to Congress reluctantly because I strongly support any responsible efforts that will result in improving the health of our first Americans. The "Interior and Related Agencies Appropriations Act, 1977," which I approved just last July, included $425 million for Indian health programs. This amounts to spending by the Indian Health Service alone of $771 for every Indian and Alaskan Native, or $3,084 for a family of four, and an increase in funding levels of 230% just since 1970. I believe this growth reflects a strong commitment to the health needs of Indians and Alaskan Natives. No other segment of American society receives comparable Federal resources for health.

At the same time, I must oppose unnecessary and undesirable legislation. S. 522 is objectionable because it would unnecessarily authorize 20 new categorical health programs at funding levels which can only raise unrealistic expectations. The administration of Indian health programs--which currently benefit from flexible and discretionary authorities--would be made considerably more complicated by S. 522.

Substantial improvements have been made over the past few years in the status of Indian health. Dramatic reductions have been made under current authorities in such areas as Indian adult and infant mortality rates, as well as in the incidence of tuberculosis, influenza and pneumonia, gastritis and related diseases. There is no demonstrable evidence that a vast infusion of funds, such as proposed by S. 522, would achieve better or faster

results than are being achieved under orderly program growth.

Indian health programs have received, and will continue to receive, ample funding under existing program authorizations. I am confident that the priority given to this area in the past will continue without S. 522.

THE WHITE HOUSE

September , 1976

THE WHITE HOUSE

WASHINGTON

Rec. 9/25/76 12:15 pm

ACTION MEMORANDUM LOG NO.:

Date: September 25 Time: 1000am

FOR ACTION: Brad Patterson
Max Friedersdorf
Bobbie Kilberg
Robert Hartmann
Spencer Johnson
Bill Seidman

cc (for information): Jack Marsh
Jim Connor
Ed Schmults
(veto message attached)
Dick Parsons
George Humphreys

FROM THE STAFF SECRETARY

DUE: Date: September 27 Time: 500pm

SUBJECT:

S. 522-Indian Health Care Improvement Act,

ACTION REQUESTED:

____ For Necessary Action ____ For Your Recommendations

____ Prepare Agenda and Brief ____ Draft Reply

x
____ For Your Comments ____ Draft Remarks

REMARKS:

please return to judy johnston, ground floor west wing

9/25/76 Copy sent for researching. sp

9/27/76 Researched copy returned. sp

Signature & Statement attached

Veto Statement OK

PLEASE ATTACH THIS COPY TO MATERIAL SUBMITTED.

If you have any questions or if you anticipate a delay in submitting the required material, please telephone the Staff Secretary immediately.

James M. Cannon
For the President

TO THE SENATE

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Substantial improvements have been made over the past few years in the status of Indian health. Dramatic reductions have been made under current authorities in such areas as Indian adult and infant mortality rates, as well as in the incidence of tuberculosis, influenza and pneumonia, gastritis and related diseases. There is no demonstrable evidence that a vast infusion of funds, such as proposed by S. 522, would achieve better or faster

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THE WHITE HOUSE

September , 1976

A

EXECUTIVE OFFICE OF THE PRESIDENT
OFFICE OF MANAGEMENT AND BUDGET
WASHINGTON, D.C. 20503

SEP 23 1976

MEMORANDUM FOR THE PRESIDENT

Subject: Enrolled Bill S. 522 - Indian Health Care Improvement Act
Sponsor - Sen. Jackson (D) Washington and 24 others

Last Day for Action

October 1, 1976 - Friday

Purpose

Authorizes new categorical programs and substantially increases appropriation authorization levels for Indian Health Service programs of the Department of Health, Education, and Welfare (HEW).

Agency Recommendations

Office of Management and Budget	Disapproval (Veto message attached)
Department of Health, Education, and Welfare	Approval
Department of the Interior	Approval

Discussion

S. 522 would authorize approximately 20 new categorical programs at substantial funding levels, with the stated objective of improving the health status of Indians and Alaskan natives. The bill was considered by four different Congressional committees during this Congress. The Committees' clear intent is that the appropriation authorizations be in addition to current funding levels.

This legislation was approved in the Senate by unanimous consent and in the House by a 310-9 vote. The Senate concurred in the House-passed bill by a 78-0 vote on September 9, 1976.

The major provisions of S. 522 would:

-- establish a new program of scholarships for Indians desiring to pursue health training, as well as assistance to those serving Indians,

-- authorize numerous new narrow categorical programs for the delivery of health services,

-- authorize a specific program for the construction and modernization of health facilities, including water supply and waste disposal facilities,

-- remove the existing prohibition against Medicare and Medicaid reimbursements to Federal Indian Health Service facilities, and

-- establish a new program of services for non-federally-recognized Indians living in urban areas.

The Senate and House Interior and Insular Affairs Committees both expressed the view that S. 522 is needed because Indian and Alaska natives suffer a health status considerably below that of the general population. The Committees attribute the lower health status to inadequate and understaffed health facilities, lack of access to health services, and lack of safe water and sanitary waste disposal services. HEW, in testimony and reports to the Congress, strongly opposed enactment of the legislation, except for the extension of Medicare and Medicaid reimbursements to eligible beneficiaries in Indian Health Service facilities. HEW's position was based on marked improvement in the health status of Indians over the past decade, generally liberal funding levels for Indian health activities, and the fact that all of the proposed activities can be conducted under existing legislation. Moreover, HEW stated that the authorization levels would raise unrealistic expectations of the resources the Federal Government could afford to devote to this purpose.

Major provisions

Student assistance. S. 522 would authorize 5 new programs designed to increase generally the number of health professionals serving Indians and to increase specifically the number of Indians receiving health training. The programs would:

-- provide grants and scholarships to recruit, prepare, and enroll Indians in health professions schools,

-- authorize scholarship grant recipients to be employed in the Indian Health Service (IHS) during nonacademic periods, and

-- authorize continuing education allowances to all IHS health professionals for professional consultation and refresher training courses.

These programs would be in addition to HEW's broad programs of assistance to medical students and schools under which HEW can already give priority to disadvantaged students, including Indians.

Health services and facilities. S. 522 would authorize a broad range of new programs and substantially increase the numbers of health service personnel over current levels; e.g., it would authorize an increase of 425 new personnel in 1978, 515 in 1979 and 593 in 1980--a total of 1,533. This would be in addition to the current IHS staffing level of 8,800. Programs specified in S. 522 would include patient care, field health, dental care, mental health (including community and inpatient mental health services, model dormitory mental health services, therapeutic and residential treatment centers, and the training of traditional Indian practitioners in mental health) and alcoholism treatment and control. The bill would also direct HEW to apportion at least 1% of all funds authorized for Indian health services for research in each health service area.

In addition, S. 522 would specifically authorize the construction and renovation of Indian hospitals, health centers, health stations and staff housing as well as safe water and sanitary waste disposal facilities in Indian homes and communities. The enrolled bill would make eligible for federally provided sanitation facilities certain Indian tribes currently not eligible for such assistance, e.g., the Senecas and Mohawks of New York. This provision would have the effect of expanding the eligible Indian population by approximately 7,000. Preference to Indian firms would be authorized in awarding construction and renovation contracts for IHS facilities and for the construction of clean water and sanitation facilities for Indians.

Medicare and Medicaid reimbursements. Under current law, IHS hospitals, as Federal facilities, cannot receive reimbursement from Medicare or Medicaid for either Indians or non-Indians. These facilities, however, serve as the principal health delivery system for reservation Indians. S. 522 would make them eligible for Medicare and Medicaid reimbursement as long as they meet required standards or have an acceptable plan to bring a facility into compliance within 2 years. HEW favored this provision, but opposed related provisions in S. 522 that would:

-- prohibit consideration of third-party reimbursements received by IHS in determining appropriation levels for IHS facilities, and

-- require the Federal Government to reimburse 100%--rather than 50% to 80% under current law--State Medicaid agencies which in turn reimburse IHS facilities.

The Secretary would be required to maintain a special revolving fund into which these reimbursements would be paid to be used solely for facilities improvement.

Urban Indian programs. S. 522 would authorize HEW to enter into contracts with organizations of Indians living in urban areas for the purpose of enabling the organizations to identify and assist in providing needed health services. The bill also specifies criteria HEW must consider in selecting the urban Indian organizations, contract conditions, and reporting requirements.

Other provisions. In addition, S. 522 would:

-- authorize HEW to conduct a study to determine the need for and feasibility of establishing a school of medicine to train Indian health professionals;

-- require HEW to promulgate regulations to implement the Act, to develop and submit to Congress--within eight months--a plan for implementation of the specific authorities in S. 522, and to submit annual reports to the Congress and additional reports on expenditures and recommendations for additional appropriation authorizations,

-- authorize HEW to enter into leases of up to 20 years with Indian tribes to construct health facilities. The purpose of this provision is to allow Indians to construct, staff, equip and maintain health facilities and lease them at full cost--including salaries, drugs and equipment--to the IHS. Cost for this would be in addition to the specific amounts authorized and would involve long term commitments for Federal funds.

Cost and budget impact. S. 522 would authorize a total of $480 million for the first three years of the bill, fiscal years 1978-1980, including $145 million for fiscal year 1978. The clear legislative intent is that the amounts authorized to be appropriated be in addition to current appropriation levels. The 1977 budget proposed $395 million for Indian health programs, but the Interior appropriation bill for fiscal year 1977, which you approved, contains $425 million for the IHS--a 230% increase over the 1970 appropriation of $128 million. Even if adjusted at a liberal inflation rate of 10% per year, the increase in funding since 1970 amounts to more than 100%.

A detailed summary of the amounts authorized by S. 522 for Indian health programs is attached to this memorandum.

Arguments in favor of approval

1. The Congressional committees believe that S. 522 would concentrate Federal resources on meeting deficiencies in Indian health services and facilities through a sustained and coordinated effort. The Committees state that health statistics and other indicators of health status--e.g., incidence of tuberculosis, infant mortality, ratio of physicians--demonstrate the need for targeting special Federal resources on Indian health problems.

2. There are indications that the Congress believes it has met important Administration objections, e.g., the potential cost of S. 522 has been reduced from $1.6 billion to $481 million in response to HEW opposition (this was accomplished by reducing the number of years with specific authorization amounts from seven to three and authorizing the outyears at "such sums"). Despite the high authorizations, more realistic appropriations levels can probably be achieved through the budget process.

3. S. 522 has broad congressional and interest group support. It was approved by both Houses by nearly

unanimous votes and has been endorsed by several national health organizations, including the American Dental Association, the American Academy of Pediatrics and the American Medical Association.

4. Congressional proponents, Interior and HEW suggest that your approval of S. 522 would demonstrate a positive commitment to solving Indian health care problems and would signify to Indian people a recognition of one of their priority problems and a real concern for and interest in them.

5. Although S. 522 duplicates many existing HEW programs, it could be viewed as a follow-on step to other laws enacted in recent years--e.g., the Indian Financing Act, the Indian Self-Determination and Education Assistance Act, the Indian manpower component of the Comprehensive Employment and Training Act of 1973--which have been directed toward improving the economic, educational and social status of Indians.

Arguments against approval

1. S. 522 is a prime example of unnecessary and inappropriate Congressional enactments. The bill would add some 20 new narrow categorical programs and appropriation authorizations to an already large array of existing Federal activities aimed at improving the health of Indians. All of the proposed program activities can be conducted under the broad flexible legislative authorities of the Snyder Act and other laws. For example, Indians and non-Indians desiring to serve in reservation areas are already given special consideration under HEW's health professions and National Health Service Scholarship programs.

2. The authorization levels in S. 522 are significantly higher than warranted and raise highly unrealistic expectations of what the Federal Government can or will provide. Moreover, the cost reduction claimed by Congressional proponents of S. 522 is spurious at best, since it was achieved by substituting "such sums" language for specific authorization amounts for the last 4 years of the 7-year authorization period. Other hidden additional costs would arise from contractual arrangements and lease agreements with Indian tribes and Indian organizations. As the minority members of the House Interstate and Foreign Commerce Committee stated, "These levels are grotesque when viewed in the light of budgetary increases totaling over 200% in

the past eight years, and the definite progress in improving Indian health through priorities given to these programs over many competing demands."

3. Substantial Federal funds are already being spent on Indian health. The Administration has indicated its strong commitment to improving the health status of Indians and Alaska natives. As noted above, you have approved a 1977 level of $425 million for the Indian Health Service, a 230% increase since 1970 which amounts to $771 for each Indian or $3,084 for an Indian family of four. These amounts do not include services provided to the eligible Indian population from other Federal health programs.

4. Contrary to the negative emphasis in Congressional committee reports, very substantial improvements have been made over the past several years in the health status of Indians. Dramatic reductions are apparent in such areas as Indian and infant death rates and the incidence of tuberculosis, influenza and pneumonia, gastritis and related diseases. No evidence has been developed to warrant the conclusion that a vast infusion of funds for additional and traditional health services such as proposed in S. 522 will significantly improve the health status of Indians.

To a large extent, alcoholism, suicide and accidents are a part of cultural and reservation conditions not readily amenable to traditional health and mental health services. Moreover, it is not clear that forcing IHS hospitals to comply to Joint Commission on Accreditation of Hospitals (JCAH) standards at high cost will result in improved quality of care since many of the standards JCAH applies, e.g., requiring halls to be 8 feet in width cannot be directly related to quality, particularly when the small size of IHS facilities is considered.

5. The provisions singling out non-reservation Indians living in urban areas for special health programs not only duplicate existing narrow categorical programs, e.g., community mental health centers, which provide services to all members of the community including Indians and other disadvantaged groups, but are conceptually at odds with your health block grant proposal that would give the States Federal funds and clear authority and responsibility in this area.

Recommendations

HEW, in its attached views letter on S. 522, recommends approval, stating: "At this stage ...the Administration can only approve or disapprove the bill as a whole." Noting that S. 522 would for the first time permit Indians to effectively use Medicare and Medicaid benefits, HEW states "If Native Americans are to be fully integrated into the mainstream of the American health care system, and in particular in terms of a future national health insurance program, they must be given meaningful participation in, and develop familiarity with, the most extensive programs we have in this area to date." HEW concludes that "approval of this bill would reaffirm the Administration's real concern for and interest in Native Americans; disapproval would adversely affect the view Native Americans and others have as to the Administration's commitment to Native Americans."

Interior also recommends approval of S. 522. Interior states "...we believe it is essential that the President affirm the commitment to improved Indian health as embodied in S. 522, and which has received the overwhelming endorsement of the Indian people."

* * * * * * * *

We believe S. 522 is a particularly egregious example of unnecessary legislation that will result in highly unrealistic expectations among the very group it is intended to help. As pointed out previously, all of the program activities authorized by S. 522 can be accomplished under existing legislative authority.

Moreover, funding of Indian health activities has been increased substantially during the past few years and has resulted in dramatic improvements in the status of Indian health. In 1977, $425 million will be spent by a force of over 8,800 Federal employees. No other segment of American society receives comparable Federal resources for health.

We do not find any of the arguments offered by the Congress or by the Departments of HEW or Interior sufficiently compelling to recommend approval of S. 522, particularly

in light of the special priority already given to Indian health programs. Accordingly, on the merits, we recommend that you veto S. 522 and have attached a draft veto message for your consideration.

Paul H. O'Neill
Acting Director

Enclosures

Attachment

S. 522--Indian Health Care Improvement Act
(Budget Authority in $ millions)

	Fiscal Years 2/		
	1978	1979	1980
Student assistance			
Recruitment and post-secondary assistance	.9	1.5	1.8
Scholarships:			
Preparatory	.8	1.0	1.3
Health professions	5.5	6.3	7.2
Indian Health Service extern program	.6	.8	1.0
Subtotal	7.8	9.6	11.3
Continuing professions education	.1	.2	.3
Health services			
Patient care	-	8.5	16.2
Field health	-	3.3	5.5
Dental care	-	1.5	1.5
Mental health	-	3.4	5.1
Alcoholism	4.0	9.0	9.2
Maintenance	-	3.0	4.0
Subtotal	14.0 1/	28.7	41.5
Health facilities			
Hospitals	67.2	73.3	49.7
Health centers	7.0	6.2	3.7
Staff housing	1.2	21.7	4.1
Subtotal	75.4	101.2	57.5
Sanitation and safe water construction			
Existing homes	43.0	30.0	30.0
New homes	"such sums"	"such sums"	"such sums"
Health services for urban (non-reservation) Indians	5.0	10.0	15.0
Total, specific authorizations	145.3	179.7	155.6

1/ Includes $10 million for all of the health services programs other than alcoholism.

2/ The bill authorizes "such sums" for fiscal years 1981-1984.

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

The Honorable James T. Lynn
Director, Office of Management
and Budget
Washington, D. C. 20503

SEP 23 1976

Dear Mr. Lynn:

This is in response to your request for a report on S. 522, an enrolled bill "To implement the Federal responsibility for the care and education of the Indian people by improving the services and facilities of Federal Indian health programs and encouraging maximum participation of Indians in such programs, and for other purposes."

In summary, we recommend that the President sign the enrolled bill because he will thereby affirm in the eyes of Indians and others this Administration's strong commitment to advancing the welfare of our Native Americans; the bill's provisions largely overlap existing legal authority but represent a congressional statement of support for Indian health activities.

The enrolled bill would provide additional appropriation authorizations of approximately $480 million for the fiscal years 1978 through 1980 for specific Indian health programs in the areas of manpower training, services, and facilities; under present law, funds may be appropriated for Indian health activities up to any amount. The Administration recommended $395 million in appropriations for Indian health services and facilities for fiscal year 1977. The enrolled bill would also permit Indian Health Service (IHS) facilities to receive Medicare and Medicaid funds for services provided to eligible persons under those programs. Each IHS facility not presently meeting Medicare or Medicaid standards would be required within six months of enactment of the enrolled bill to develop a plan to meet the requirements of those programs. The facility could then receive Medicare and Medicaid funds for one year without meeting the usual requirements of those programs, but after that only if those

requirements had been met. The Federal government would completely reimburse States for Medicaid funds paid to IHS facilities. S. 522 would in addition direct the Secretary to conduct a study concerning the need for and feasibility of an Indian school of medicine, to promulgate regulations under the enrolled bill within ten months of enactment, and to develop a plan of implementation within 240 days of enactment. Funds appropriated under S. 522 would remain available until expended.

We opposed this bill consistently during its consideration by the Congress because it would authorize a number of specific programs duplicating our present general authority in this area and because the additional appropriation authorizations implied a congressional desire to exceed our budget requests in the area of Indian health. At this stage, however, we feel that other considerations strongly suggest that the President sign S. 522.

The enrolled bill would for the first time permit Native Americans effectively to use Medicare and Medicaid benefits for which they are eligible; these benefits cannot under present law be used in Federal facilities (except in certain restricted situations). If Native Americans are to be fully integrated into the mainstream of the American health care system, and in particular in terms of a future national health insurance program, they must be given meaningful participation in, and develop familiarity with, the most extensive programs we have in this area to date.

The enrolled bill does not contain, as did earlier versions of the bill, any authorizations for fiscal year 1977. In any event, the bill's authorizations merely duplicate existing authority. The enrolled bill, moreover, is viewed by many Native Americans, Congressmen, and other persons concerned with the welfare of Native Americans as a statement of Federal commitment to advance the welfare of our Native Americans. During congressional consideration, our objections to provisions in the bill were part of a dialogue in developing the best possible approach in the area of Indian health. At this stage, however, the Administration can only approve

or disapprove the bill as a whole. The President's approval of this bill would reaffirm the Administration's real concern for and interest in Native Americans; disapproval would adversely affect the view Native Americans and others have as to the Administration's commitment to Native Americans.

The enrolled bill was passed by the Senate by a vote of 78 to 0, and in an earlier version by the House by a vote of 310 to 9.

We recommend that the President sign the enrolled bill.

Sincerely,

Marjorie Lynch

Under Secretary

B

THE WHITE HOUSE

WASHINGTON

September 28, 1976

MEMORANDUM FOR: JIM CANNON

FROM: BOBBIE GREENE KILBERG

SUBJECT: S. 522 - Indian Health Care Improvement Act

I recommend that the President sign the Indian Health Care Improvement Act for the following reasons:

(1) S. 522 would provide Medicare and Medicaid reimbursement for Indian Health Service hospitals. HEW states that this would enable Native Americans to effectively use the Medicare and Medicaid benefits for which they are eligible.

(2) In arguing against new categorical programs, OMB states that all of the proposed program activities could be conducted under the broad flexible legislative authorities of the Snyder Act and other laws. However, in fact, many of these program activities are not being conducted under those legislative authorities, either because of a lack of Departmental or bureaucratic initiative and creativity or because of active policy opposition.

(3) The trust responsibility which the Federal government has to federally recognized tribes is unique and must be weighed very carefully before turning down programmatic legislation.

(4) It is my perception that Indian life expectancy rates are significantly lower and Indian infant mortality rates are significantly higher than the rates for the general population in the United States. Dan McGurk says that this statement cannot be borne out when one eliminates alcoholism, suicide and accident rates. Ted Marrs, however, had consistently asserted that the figures

were still substantially different from the national average even when alcoholism, suicide and accidents are not counted. Further, S. 522 would authorize new programs specifically aimed at the alcoholism, suicide and accident rates which take such a serious toll in Indian lives. According to the OMB memo, S. 522 programs would include mental health (including community and inpatient mental health services, model dormitory mental health services, therapeutic and residential treatement centers, and the training of traditional Indian practitioners in mental health) and alcoholism treatment and control.

(5) I strongly agree with Brad Patterson's statement that the physical defects in Indian health facilities are not limited to the lack of 8 foot-wide halls, as No. 4 of OMB's arguments against approval might imply. From my personal experience, I think a tour of Indian health facilities would reveal buildings and equipment in such condition as to raise serious questions about the health care and safety of patients.

(6) While S. 522 contains a significantly higher authorization than OMB believes is warranted, OMB does indicate that more realistic appropriations levels can probably be achieved through the budget process.

(7) While I agree with OMB's criticism of the urban Indian provision in S. 522, I would not recomment veto of the bill because of it.

(8) It is my understanding that Congress will override a Presidential veto and that a majority of Republican Senators and Congresspersons will vote for that override. This includes Congressman Rhodes, who has written the President requesting that he sign the bill; Senator Fannin, ranking minority member of the Senate Interior & Insular Affairs Committee; and apparently Congressman Skubitz, ranking minority member of the House Interior & Insular Affairs Committee, and Senators Dole, Goldwater, Bartlett, Domenici, Stevens and Hatfield.

(9) As a political matter, a veto of this bill will be portrayed as direct Presidential action against the improvement of health care for the Native American community, a group which the majority of people in this

country still has substantial empathy for. The fact that we have made significant progress in the area of Indian health care and are devoting substantial resources to it will be lost in the negative headlines.

cc: Phil Buchen

THE WHITE HOUSE

WASHINGTON

September 27, 1976

MEMORANDUM FOR THE PRESIDENT

FROM: BRADLEY H. PATTERSON, JR.

THROUGH: WILLIAM J. BARODY, JR.

SUBJECT: S. 522 -- The Indian Health Care Improvement Act

I respectfully recommend that you sign S. 522 and issue the attached statement (Tab A).

Most of my reasons for this recommendation are not reflected in the Enrolled Bill Memorandum; they are as follows:

1. For seven years there has been an unbroken series of Presidential actions which have reversed and rectified the past decades of neglect for Native Americans. It has been a brilliant executive/legislative accomplishment in which you and a bipartisan Congress fully share. A veto of this bill would be the first turnaround in that seven-year record and, as such, would have symbolic impact greater than the merits of the bill considered by themselves.

2. This symbolic impact could not come at a more inopportune time.

   (a) Our experience with Indian matters from Alcatraz to Wounded Knee has shown us that while the Indian community itself is small, the latent interest in and sympathy for Indian people in the population generally is widespread, is undiscriminating and is a magnet for media exploitation. The symbolic force of a veto here risks galvanizing that latent sympathy into an attention-getting political backlash among

conservative and independent people, as well as among Democrats.

(b) Carter's staff is keeping close track of Indian matters; (he has sent Messages to all the recent Indian meetings.) A veto of this bill will raise the whole area of Indian affairs up into his target sights.

(c) You have just (properly) vetoed a less important bill on early retirement for non-Indian federal employees. The two vetoes together will have a synergistic effect. Three weeks from today the National Congress of American Indians assembles in Salt Lake City; vetoing the Indian Health bill will convert the Conference into a minor political disaster for us in addition to its longer term negative opinion effect among Indian leaders.

3. The bill is only an authorization measure. While it is true that the Indian community and the Indian Health Service will be encouraged by your signature to recommend appropriations for the full amounts, you and OMB can handle any unjustified requests through the budget machinery, and in that discriminating way -- next December -- rather than through the sledgehammer of a veto -- in October, protect the budget from excesses. The draft statement (Tab A) makes it clear that your signing the bill does not constitute overpromising or making a commitment to budget the amounts authorized.

4. Contrary to the impression which may be given at the bottom of page 6 of the Enrolled Bill Memorandum, Republican support for this bill is strong; a veto (unless it is of the "pocket" variety) will be overridden.

(a) Joe Skubitz, ranking on the House Interior Committee, joined in the successful effort to have the earlier version of the bill amended, stating:

> If the amendments are adopted, it is a bill which I personally believe the President can sign in good conscience. . .
>
> I can truthfully say that the Interstate

> committee has done its best to report a responsible bill, which in our judgment, should be both fiscally and philosophically acceptable to the administration."

(b) On House passage, the following members of the Minority of the House Interior Committee joined Mr. Skubitz in voting for the bill: Messrs. Bauman, Clausen, Johnson, Lagomarsino, Pettis, Smith and Symmes.

(c) Congressman Rhodes is a co-sponsor of the bill and has written you a special letter urging you to sign it.

(d) Senators Dole, Fannin, Goldwater, Bartlett, Domenici, Stevens and Hatfield are supporters of the amended bill.

5. We are on somewhat slippery grounds in opposing the final, amended bill. In unusual steps, both Ranking Member Skubitz and Ranking Member Fannin went out of their way to castigate HEW generally and Secretary Mathews personally for being unwilling earlier on to sit down with the Committees and staffs to work out an acceptable compromise. 53 weeks ago, Senators Fannin and Bartlett had lunch with Secretary Mathews to start this process, but HEW never followed up. The Skubitz and Fannin statements are attached here as Tab B.

6. The Indian Health facilities lack more than "eight-foot-wide halls". When the House and Senate Committee reports pointed out that 25 out of 51 IHS hospitals failed of accreditation by the Joint Commission on Accreditation of Hospitals, they added:

> "Many of them are old one-story, wooden frame buildings with inadequate electricity, ventilation, insulation and fire protection systems and of such insufficient size as to seriously jeopardize the health and safety of patients and staff alike."

7. I share Paul O'Neill's concern about special health programs for urban Indians, but the draft signing statement recommended here includes a special instruction to Secretary Mathews to use the bill's authority to avoid duplication.

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TO THE SENATE OF THE UNITED STATES:

I return without my approval, S. 522, the Indian Health Care Improvement Act.

I return this bill to Congress reluctantly because I strongly support any responsible efforts that will result in improving the health of our first Americans. The "Interior and Related Agencies Appropriations Act, 1977," which I approved just last July, included $425 million for Indian health programs. This amounts to spending by the Indian Health Service alone of $771 for every Indian and Alaskan Native, or $3,084 for a family of four, and an increase in funding levels of 230% just since 1970. I believe this growth reflects a strong commitment to the health needs of Indians and Alaskan Natives. No other segment of American society receives comparable Federal resources for health.

At the same time, I must oppose unnecessary and undesirable legislation. S. 522 is objectionable because it would unnecessarily authorize 20 new categorical health programs at funding levels which can only raise unrealistic expectations. The administration of Indian health programs -- which currently benefit from flexible and discretionary authorities -- would be made considerably more complicated by S. 522.

Substantial improvements have been made over the past few years in the status of Indian health. Dramatic reductions have been made under current authorities in such areas as Indian adult and infant mortality rates, as well as in the incidence of tuberculosis, influenza and pneumonia, gastritis and related diseases. There is

no demonstrable evidence that a vast infusion of funds, such as proposed by S. 522, would achieve better or faster results than are being achieved under orderly program growth.

Indian health programs have received, and will continue to receive, ample funding under existing program authorizations. I am confident that the priority given to this area in the past will continue without S. 522.

THE WHITE HOUSE,

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