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THE UNIVERSITY OF OKLAHOMA

GRADUATE COLLEGE

THE RELATIONSHIP BETWEEN FEDERAL HEALTH PROGRAMS AND FEDERALLY RECOGNIZED INDIAN TRIBES AND ALASKAN NATIVES

A DISSERTATION

SUBMITTED TO THE GRADUATE FACULTY

in partial fulfillment of the requirements for the degree of

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BY

JOSEPH N. EXENDINE

Oklahoma City, Oklahoma

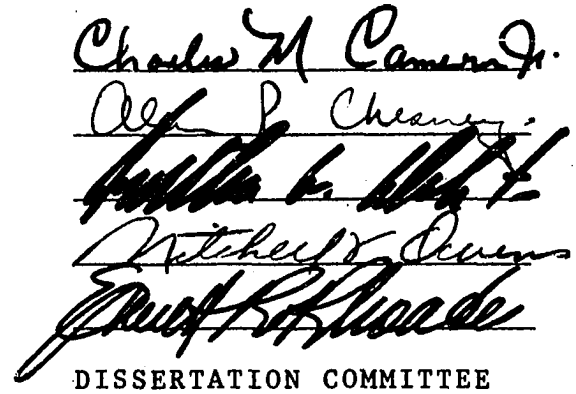
1974

THE RELATIONSHIP BETWEEN FEDERAL HEALTH PROGRAMS

AND FEDERALLY RECOGNIZED INDIAN TRIBES

AND ALASKAN NATIVES

APPROVED BY



DISSERTATION COMMITTEE

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TO

CHARLOTTE B. MANGSETH

THE RELATIONSHIP BETWEEN FEDERAL HEALTH PROGRAMS AND FEDERALLY RECOGNIZED INDIAN TRIBES AND ALASKAN NATIVES

CHAPTER I

INTRODUCTION

Statement of the Problem

A question long at issue is "Should American Indians and Alaskan Natives share equally in federal programs as other citizens of this country since they have exclusive rights to the various services administered by the Bureau of Indian Affairs (BIA)[1], United States Department of the Interior and the Indian Health Service (IHS)[2], United States Department of Health, Education and Welfare?"

As citizens, Native Americans say "Yes," but they also express a desire for these rights with certain conditions.

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[1] S. Lyman Tyler. A History of Indian Policy. United States Department of the Interior, Bureau of Indian Affiars, Washington, D. C., 1973. passim.

[2] The Indian Health Program of the U.S. Public Health Service. U.S. Department of Health, Education, and Welfare, Public Health Service, Health Services and Mental Health Administration, Rockville, Maryland, August, 1972. passim.

The non-Indian, on the other hand, has been somewhat skeptical, and has generally looked on such discussion with mixed emotions.

Native Americans have long held a special relationship with the federal government, a relationship created and nurtured by hundreds of treaties and laws legislated and enacted between the tribes and the U.S. government.[1] In exchange for those specified services and the trust relationship, tribes have surrendered millions of acres of land in the territorial boundaries of the United States; thus should treaties deny Indians the right to other program benefits as other citizens of this country?[2]

Throughout the years, both the federal government and those states where the majority of tribal reservations are located have attempted at one time or another to sever this special relationship.[3] While in some cases these efforts have been successful, in many other cases such attempts have failed.

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[1]Felix S. Cohen, Handbook of Federal Law. Revised Edition: Federal Indian Law, U.S. Department of the Interior, Office of the Solicitor, Government Printing Office, 1958.

[2]For Health Programs, see Memorandum of Agreement between the Department of Health, Education and Welfare; the U.S. Office of Civil Rights; the Indian Health Service, and the Medical Services Administration; making it clear that "No recipient of Federal financial assistances may refuse to certify as eligible or fail to provide health services to Indians on the grounds that IHS services are available."

[3]Vine Deloria, Jr., Custer Died for Your Sins. The Macmillan Company, New York, 1969, Chapter 3. passim.

Two distinct directions are evident from past efforts on the part of the federal government and the states: (1) to abolish that special relationship and/or, (2) to route federal monies earmarked for the tribes through the states, in which case the respective states would assume all the responsibilities for administering Indian programs now under the jurisdiction of federal officials.[1]

During these periods of varying national emphasis, as the pendulum swung back and forth from one administration to another, tribal governments have insisted that they, as legal entities (for example Worchester v. Georgia (1832); Cherokee Nation v. United States, 202 U.S. 101 (1838); United States v. Kagama, 118 U.S. 375 (1886); Scott v. Landford, 60 U.S. 393 (1956),[2,3] be given the opportunity to develop their own economic base and to administer their own programs as do other local and state governments.

Today, in Indian country, there is an even stronger desire among Indians to be self-governing, to control and manage programs, and to become a self-determined people.

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[1]Theodore W. Taylor. The States and Their Indian Citizens. U.S. Department of the Interior, Bureau of Indian Affairs, Washington, D. C., 1972, pp. 27-39.

[2]Congressional Record, Proceedings and Debates of the 92nd Congress, First Session, Vol. 117, No. 151, Washington, D. C., Tuesday, October 12, 1971, pp. 1-5.

[3]Office of the Solicitor, U.S. Department of the Interior, Federal Indian Law, U.S. Government Printing Office, Washington, D. C., 1958, Chapter VI.

Proof of that desire can be seen by the restlessness expressed towards those now managing programs "for" Indians. However great this desire, the Native Americans cannot escape the fact that little opportunity is available, particularly in the field of health. Major legislation has been written that effectively prohibits tribal officials from managing health programs, thus blocking their course of self-determination in the field of health. In addition there remains some question whether tribal governments qualify for funding in the same manner as state or local governments, or political sub-divisions as specified in the applicant and eligibility requirements of federal health programs.[1]

Equally frustrating is the doubt as to whether tribal peoples are currently participating in the federal health programs funneled through the states, and to which they are entitled as citizens of the United States.

Federal funds are allocated to the states on a formula basis based on a state's total population and the per capita income of residents, or some combination of such factors. Clearly, Native Americans on federal reservations in the states play a major role in determining a state's share of federal appropriations.

Based upon these issues, this study explores the

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[1] Catalog of Federal Domestic Assistance. Office of Management and Budget, Superintendent of Documents, U.S. Government Printing Office, Washington, D.C., 1973, pp. 123-165.

relationship between federal health programs, with emphasis on federal formula grant health programs that are funded to the states for administration and federally recognized American Indians and Alaskan Natives residing on Federal Indian Reservations. This study is exploratory with the hope that the tentative results will stimulate others to further examine in depth the relationship between federal health programs and Indians.

Setting the Precedent at the National Level

Federal health programs are basically administered at three organizational levels: (1) the national offices of the Department of Health, Education and Welfare located in Washington, D. C. and Rockville, Maryland; (2) its ten regional offices situated geographically throughout the United States,[1] and (3) those programs channeled to the respective states[2,3] via regional offices. In recent months a reorganization has occurred in the health section of the

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[1]Regional Boundaries and Regional Offices, U.S. Department of Health, Education and Welfare, Washington, D. C., 1974.

[2]David H. Lissy. Decentralization Decision Memorandum for Health Resource Administration Programs. Office of the Secretary, U.S. Department of Health, Education and Welfare, July 5, 1974.

[3]Acting Assistant Secretary for Administration and Management. Decentralization Decision Memorandum for Health Service Administration Programs. Office of the Secretary, U.S. Department of Health, Education and Welfare, June, 1974.

Department of Health, Education and Welfare shifting the programs included in this study from the now-defunct Health Services and Mental Health Administration to six primary divisions within the Department of Health.[1]

Historically, tribal governments have dealt with these health programs at the national level. This precedent was established early in history and is now a largely accepted and trusted relationship.

Wendel Chino, President, Mescalero Apache Tribe, best states the Indian's position on this relationship:

> The first Congress of the United States reserved unto itself the power to deal and negotiate with Indian Tribes, showing a wisdom that was not fully appreciated until recent times. The Indian Tribes were then, and are now legally considered as pseudo-sovereign nations -- exercising the powers of residual sovereignty. As early as 1775, Article Nine of the Articles of Confederation asserted: "The United States in Congress assembled shall also have the sole and exclusive right and power of...regulating the trade and managing all affairs with the Indians ..." This Article was approved in Congress in 1777. In 1887, the Constitution clearly established the Federal relationship to Indian Tribes in the commerce clause which reads in part "...to regulate commerce with foreign nations, and among the several states, and with the Indian Tribes."[2]

Past Regional and State Experiences

While the tribes have had vast experiences in dealing

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[1]Department of Health, Education and Welfare, Public Health Service. "Reorganization Order" Federal Register, Vol. 38, No. 130, Washington, D. C., July 9, 1973, pp. 18262-18263.

[2]Wendell Chino, President, Mescalero Apache Tribe. A New National Indian Policy. Field Hearings Senate Subcommittee on Indian Affairs, Isleta Pueblo, New Mexico, August 29, 1973, p. 7.

with the national offices, they have had little or no experience with the regional offices despite the fact that these offices are located geographically much closer to tribal reservations. While the tribes may look at regional offices with suspicion, they view the states with open mistrust. When President Nixon announced his "New Federalism Plan,"[1] Native Americans shuddered, since it re-ignited a long-held fear that they would come under the exclusive jurisdiction of the states. Basically, the thrust of this new federalism was "the return of power and the shifting of money and authority from Washington to the states and local governments."[2]

In reacting to this course of action and to such terms as "decentralization" and "regionalization,"[3] tribes were skeptical as to whether the guidelines and policies as specified excluded them from continuing to deal directly at the national level, forcing them to deal with the states.

In order to fully understand the apprehension and

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[1]This Basic Domestic Administrative Policy is covered in detail in the New Federalism, National Journal, Vol. 4, No. 51, (December 16, 1972). passim.

[2]Timothy B. Clark, John K. Iglehard and William Lilly, III, "The New Federalism: Theory, Practice, Problems," National Journal, (March 17, 1973), p. 2.

[3]These terms are clarified in the definitions section of this paper.

fear held by Native Americans, a clear understanding is needed of the past relationships between the tribes and the states, as well as the tribes and the regional offices. Equally important is a full understanding of the roles of Bureau of Indian Affairs[1,2] and the Indian Health Service[3] including their authorities and capabilities, since these have provided background for those decisions by program officials which have kept tribes from participating in health programs which could be of great benefit for tribal development and improved health for Native Americans.

While much literature pertaining to Indians has been written on such subjects as alcoholism, mental health and the health conditions and status of Native Americans as a whole, little has been written about programmatic relationships between the states and Native Americans. Taylor best summarized this neglect in his statement, "There is a gap in Indian literature on the Indian activities of the states and the localities."[4]

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[1]Tyler, op. cit.

[2]Federal Indian Policies...from the Colonial period through the early 1970's. Bureau of Indian Affairs, U.S. Department of the Interior, 1974.

[3]The Indian Health Program, op. cit., passim.

[4]Taylor, op. cit., p. 1.

CHAPTER II

LITERATURE REVIEW

Conflicts With the States

The relationship between the states and the tribes from the Indian perspective has been viewed as an unhealthy one, characterized by turmoil and strife. In recent years this conflict has become more pronounced as tribes have come in direct confrontation with states over civil rights issues, competing for equal access to health and education programs, land and water rights, and other issues which the Indians viewed as present and past inequities. In some cases, this conflict has been a struggle by the tribes for survival and preservation as people. Today the encroachment of whites is being met with more open resistance, and confrontation is more public since tribes feel the necessity of being more aggressive than in the past.

Among the many factors that have widened the gap throughout the years, none had more impact than the Dawes Severalty Act.[1] This act opened up the reservations to local whites, enabling them to acquire millions of acres of

[1]Taylor, op. cit., p. 20.

land; this resulted in dividing the land base essential for tribal unity and economy. Burnett, Tribal Chairman, Rosebud Sioux, best illustrated this by stating: "The nefarious Severalty Act, in reality a public spectacle of white greed, cruelty, hypocrisy and dishonesty, is pictured as a boon to the Indian by a kind-hearted administration."[1] He continues, quoting a modern day Indian: "When the white man first came to Indian country, they had the Book and we had the land; now they've got the land and we've got the Book."[2] There is recognized a deep bitterness among Indians over the land issue, and it is the local whites whom Indians accuse even though the federal officials led the way.

Indians are also fully aware of the past, as illustrated in Woodward's book about the Cherokees,[3] Jackson's writings on the Delaware and Sioux,[4] Josephy Jr.'s writings on the Nez Perce,[5] and Sandoz' writings on the Cheyenne.[6]

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[1]Robert Burnett and John Koster. The Road to Wounded Knee. Bantam Books, Inc., New York, 1974, p. 65.

[2]Ibid. p. 56.

[3]Grace Steele Woodward. The Cherokee. University Oklahoma Press, Norman, 1972.

[4]Helen Hunt Jackson. A Century of Dishonor. Harper and Row Publishers, Inc., New York, Reprinted, 1965.

[5]Alvin M. Josephy, Jr. Nez Perce Indians and the Opening of the Northwest. Yale University Press, New Haven, Conn., 1965.

[6]Maria Sandoz. Cheyenne Autumn. Avon Books, New York, 1953.

In more recent times the memory of the ill-fated Termination Act[1] is recalled, and failure of the states to care for Indian citizens on an equal basis with their other citizens. The tribes look to the fate of the Menominees in Wisconsin,[2] the Klamaths in Oregon,[3] and the numerous tribes in California[4] which prompted Secretary Finch, Department of Health, Education and Welfare to earmark monies directly for the tribes of that state and later, to be supported in legislation and additional dollars by the Congress.

Even more recently, Native Americans have spoken openly of the clash between Bernalillo County Medical Center and the tribes of New Mexico where federal monies were contracted to the hospital to provide health services for Indians. The services came sparingly and with rancor, as

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[1]Deloria, Jr., op. cit. Chapter 3, passim.

[2]Debora Shames. Coordinating Editor, Freedom With Reservations. Impressions, Inc., Madison, Wisconsin, 1972.

[3]Edgar S. Kahn. Our Brother's Keeper, The Indian in White America. New Community Press, Inc., Washington, D. C., 1969, pp. 16-23.

[4]"Indian Health Through Indian Help." HSMHA World, Vol. 7, No. 1, HSM-72, Superintendent of Documents, U.S. Government Printing Office, Washington, D. C., Jan-Feb., 1972, pp. 2-4.

noted by Williams and Kekahbah.[1] A similar situation prevailed in what is known as the "Minnesota Plan." The Indian Health Service contracted with the State of Minnesota for health services for Indians through a program in which the funds filtered down to local levels; where social, welfare and other local officials decided whether Indians were sick and then authorized them to obtain health services. The Minnesota Chippewas compelled the Indian Health Service and the State of Minnesota to reconsider their contractual arrangements; specifically, the tribes wanted to receive the federal health monies going to the state so that they, the Indians, could negotiate directly for health services at the local level.

In the past, states have made some feeble attempts to provide services to Indians on reservations. In the early 1950's a move was initiated with the encouragement of Federal officials. For example, Acting Commissioner Zimmerman of the Bureau of Indian Affairs said in reference to the State of California: "...in my judgment, if the federal government were to withdraw, the state could provide more services in the long run than we are now providing."[2] In spite of

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[1]Rosemary Williams and Janice Kekahbah. A Study of the Patterns of Relating Between the Deliverers of Health Care Services and the Consumers of Health Care Services in the Indian Community. A Research Study for the U.S. Public Health Service, 1972.

[2]Taylor, op. cit. p. 576.

this, the BIA today has maintained a strong field office in Sacramento, with satellite offices throughout the state, and, as cited earlier, HEW re-entered the picture in 1968 with the blessing of Congress.

A related example was the Governor's Interstate Indian Conference held in Salt Lake City, May 12, 1950. Taylor summarizes the states' position: "They (the state representatives who were mostly governors) agreed that most states had been derelict in their duties in dealing with Indians and had tried to push the whole responsibility on the federal government."[1] He continues: "Historically, many states have recognized responsibilities but have not performed them."[2] Cresap, et al., notes: "Generally, state governments lack interest in their Indian population, and spend relatively small amounts of money on their Indian programs."[3]

Nevada, for example, in 1955, enacted a law whereby the state would assume civil and criminal jursidiction for Indians.[4] But "eight counties, even though the Indians

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[1]Taylor, op. cit., p. 42

[2]Taylor, op. cit., p. 103

[3]Cresap, McCormick and Paget, Inc. Evaluation of DHEW Health Manpwer Training Programs Relative to Indians. Management Consultants, New York, (February, 1972), Part II, p. 7.

[4]Taylor, op. cit., p. 100

therein petitioned the county to take jurisdiction, asked the governor to exclude them because of budget limitations."[1]

Most states receive funds for such services for Indian residents.[2] As Robert Jim, Chairman, Yakima Tribe, observes: "Why don't we go to the Omnibus Crime Act and see what they fund them directly to the states who allow these crimes to happen on Indian reservations? Why don't they directly fund them to Indian reservations who know what the crime problems are?"[3] Or as Robert Bruce emphasized at the same meeting: "Now there are funds available through the Safe Streets Act and the Juvenile Act which Justice earlier in the year in a report to Congress said they were going to enlarge the special funds available to the states to facilitate more money for Indians and Indian groups and other such special groups."[4] He continues: "There was a legislative proposal that was in the Congress to have Indian tribes defined as a state so that they could receive separate money under these acts, and Justice, in an effort to get around

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[1]Taylor, op. cit., p. 36.

[2]Omnibus Crime Act, P.L. 90-351, Title I, 201, 82 Stat. 198, June 19, 1968.

[3]Robert Jim, Chairman Yakima Tribe. "Meeting With Affiliated Tribes of Northwest Indians," Transcript of Regional Hearings on President's Indian Message and Attendant Legislative Package. Spokane, Washington, (September, 1970) p. 26.

[4]Robert Bruce, Member, National Council of Indian Opportunity, Ibid. p. 20.

this, said that they would make more money available (to the states) and would pressure the states."[1]

At the same session, Jim continues: "The state, when we break one of their laws, has 25 or 30 game wardens down there. But when Indians are being harassed for fishing, then by God, they are not there to protect it."[2]

Sundquist observes: "Effective and fair state and local government is a must for Indian acceptance. This type of state and local government is not evident to many Indians and some react to memories of recent discriminatory history..."[3]

New Federalism Theory

When the rumblings of the New Federalism Plan, delegating the power from Washington to the states, filtered into the Indian country, the tribes opposed the plan, as indicated earlier.

Chino, Chairman, Mescalero Apache Tribe, probably best expresses the feeling of most Tribes: "Let us not

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[1]Bruce, op. cit. p. 20.

[2]Jim, op. cit. p. 26.

[3]James L. Sundquist and David W. Davis. Making Federalism Work. The Brookings Institution, Washington, D. C., 1969, p. 270ff.

be lulled into accepting programs from the states."[1] He continues:

> The 'New Federalism' advocated by the new administration has no appeal or interest for me as presently enunciated and I'll tell you why. The concept of the 'New Federalism' that I hear is that all grants-in-aid and all federal funding of projects and programs are going to be channeled through the states.[2]

Chino also notes that,

> 'New Federalism' could work for the Indian people if it is handled in the right way. For the 'New Federalism' to work among the Indian tribes, tribes must be dealt with on the same basis as the several states. Federal assistance must be granted to the Indian tribes in the same way it is granted to the states -- DIRECTLY! For federal Indian help to be channeled through the states will result only in tokenism. We need only to look at the Omnibus Crime Law. Have any of our tribes really gained or received any benefits from this law, a law which grants funds to the several states for administration? At Mescalero, we have not received one iota of services or benefits from the federal grant to the state of New Mexico.[3]

In an article concerning decentralization, Meredith states:

> The present policy of decentralization of power is as important to Indians as it is to more responsible governments throughout this nation. Although the states as local units serve the needs of the majority of the population

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[1] Wendell Chino, President Mescalero Apache Tribe, Indian Affairs -- What Has Been Done and What Needs to be Done. The Keynote Address at the 25th Annual Convention of the National Congress of American Indians, Albuquerque, New Mexico (October 6, 1969) p. 6.

[2] Ibid, p. 4.

[3] Ibid, p. 5.

in the United States, they are inadequate in serving the various Indian nations.[1]

In a paper by Indian Health Service for staff discussion, in preparation for an Indian Health Service position on the issue, it was emphasized: "It can be anticipated that being subject to state and other external standards, review, and compliance procedures would be unacceptable to most tribes."[2] The statement proved valid, for almost simultaneously the OMB Circular A-95[3] was initiated, a procedure requiring grant applications to flow through a state designated clearinghouse. And states interpreted this as including proposals prepared by tribes. The tribes rebelled, for it forced them to be under state control. As a body, the tribes pressured Frank Carlucci, then Acting Director, OMB, for a decision on their behalf. In a letter dated April 19, 1972, Carlucci states: "We have determined that applications for federal assistance from federally recognized Indian tribes should not be subject to the requirements of Circular A-95."[4]

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[1]Howard L. Meredith. The Native American Factor. The Executive Council of the Episcopal Church, N.Y., 1973, p. 70.

[2]A Draft Position Paper Developed by Indian Health Service Staff in Relationship to Pending National Legislation, 1972, p. 7.

[3]Circular A-95, Federal Register, Vol. 38, No. 228 Part II, Office of Management and Budget, Washington, D. C., Wednesday, November 28, 1973.

[4]A letter from Frank Carlucci, Executive Office of the President, Office of Management and Budget, Washington, D.C., to Wendell Chino, Mescalero, New Mexico, April 10, 1972.

Chino stresses the stand of most tribes:

> The direct relationship between the federal government and recognized Indian tribes must be maintained. No state nor other unit of local government should have jurisdiction over these lands. The governments of the peoples residing on those lands have the power to residual sovereignty and are to be considered autonomous, ceding jurisdiction only to the federal government. For the purposes of the administration of federal programs, Indian tribes should be eligible for all programs that states are eligible for and should be accorded a status at least equal to state government.[1]

But as with federal formula grant programs, few programs make provisions for tribal participation. Of the 62 federal health programs[2] analyzed in this study, only Childhood Lead-Based Paint Poisoning Control, Indian Health Services and Sanitation facilities made provisions for Indians. Most assume the posture stated by the Inter-Agency Staff Study Report:

> Even legislative actions aimed at improvement of Federal program machinery, such as the Intergovernmental Personnel Act and the Intergovernmental Relations Act, do not include Indian tribes in the benefits available to states and local governments.[3]

Federal Formula Grant System to States

Based on the experiences between the tribes and the states, there seems doubt that the formula grant system can be even minimally declared a success concerning

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[1] Chino, op. cit. pp. 6-10.

[2] Federal Domestic Catalog, op. cit. pp. 125-165.

[3] Inter-Agency Staff Study Report -- Federal Field Organization for Indian Programs. Office of Management and Budget, Washington, D. C., June, 1972, p. 12.

tribes. Yet, tribes, in such states as New Mexico, Arizona, North and South Dakota are a significant part of the state population when considering the guidelines of the formula grant system. States are allocated federal funds based on a formula using a state's total population and the per capita of same, or some combination of the two. Thus, Indians are a major source for obtaining the federal monies, when considering the aspect of per capita of individuals. Tribal people on reservations are usually at far below the poverty level set by the government.

Under the best of conditions tribes are wary of the states, therefore, the formula grant system must be considered within the same parameters. The Standing Rock Sioux, North Dakota, contend, "The state formula system is simply unacceptable...the administrative system is, at best, inadequate."[1]

Secakaku, Ute Indian Tribe, Utah, states: "...we are going to tell the state we don't want to have anything to do with you."[2] Baker puts it this way: "I just want to

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[1]Standing Rock Sioux Tribe Committee, Review Commentary on OMB's Inter-Agency Staff Study Report on Federal Field Organization for Indian Programs, Fort Yates, North Dakota, March 7, 1973, p. 40.

[2]Statement by Homey Secakaku, Ute Tribe, Fort Duchesne Reservation, Fort Duchesne, Utah, Transcript of Regional Hearings on Indian Message and Legislative Package, Ibid. p. 19.

go on record for the Assiniboine Tribe. They (Fort Peck Tribes of Montana) have the same hangup of the state."[1]

In similar actions in which there were indications that federal agencies were disbanding specific Indian programs (in particular the IHS and the BIA) and placing them under the direction and supervision of state agencies similar to federal formula grant programs, the tribes reacted vehemently. Chino, in response to such a plan, presented a decisive viewpoint:

> Most of our Indian people do not now have, nor have we ever had, political or legal relations with state governments... Our experience with the state's administration of federal funds in behalf of Indians has not been good. Only recently have we been allowed to vote in many states...[2]

Lewis, Governor, Zuni Pueblo states:

> These two agencies (IHS and BIA) are the only true advocates for Indian people, and breaking them up and scattering their activities among other agencies will result in Indians being forced to compete with a wealthier and more experienced majority for services guaranteed by treaties and legislation.[3]

Taylor says:

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[1]Statement by Hanson Baker, Fort Peck, Montana, Ibid. p. 19.

[2]Chino, op. cit., p. 6

[3]Robert E. Lewis, Governor, Zuni Pueblo, New Mexico. Statement to the U.S. Senate Subcommittee on Indian Affairs. Albuquerque Indian School, Albuquerque, New Mexico, August 30, 1973, p. 2.

> Most tribes would probably resist this process if a direct wholesale approach was made to transfer the present special BIA and IHS services to states along with the funds.[1]

The Federal Assistance Review Study,[2] a study conducted by representatives from several federal agencies under the auspices of the Office of Management and Budget, left the tribes with a similar view. As the report itself states:

> Probably the most significant federal actions that are repeatedly cited by Indians as evidence of contradiction and inconsistency are...the FAR objectives of placing greater reliance on the state and local governments for the administration of federal programs. The latter is interpreted throughout Indian country as meaning that states are eventually to take over all federal programs for Indians...[3]

State and Local Fiscal Assistance Act

One of the rare instances where legislation did make provisions for tribes was the State and Local Fiscal Assistance Act of 1972, better known as the Revenue Sharing Act.[4] The law provides for Indian tribal governments:

> If within a county area there is an Indian tribe

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[1] Taylor, op. cit., p. 141.

[2] Inter-Agency Staff Study Report on the Federal Field Organization for Indian Programs, Office of Management and Budget, Washington, D. C., June, 1972.

[3] Inter-Agency Staff Study Report, op. cit., p. 5.

[4] Public Law 92-512, 92nd Congress, H.R. 14370, October 20, 1972.

> ...which has a recognized governing body which performs substantial governmental functions, then ...a portion of the amount allocated to the county is for the entitlement period which bears the same ratio to such amount as the population of that tribe...[1]

The sums received by some tribes were minimal. For example, in Alaska some communities received total amounts of $28.00, $82.00, $135.00 and $151.00.[2] In the lower 48 states, some of the totals ran as low as $26.00, $59.00 and $176.00.[3] These sums were obviously not sufficient to initiate viable projects.

In spite of inadequate funding, the intent is in keeping with tribal desires to be self-governing, and to assume the direct management of programs. The Indian Desk, formerly in the Office of Economic Opportunity but now transferred intact to the Department of Health, Education and Welfare, has met those requirements, and as a result, is a popular program among the tribes. Meredith best reflects this sentiment:

> The most important of these was the anti-poverty program, not so much for its intended benefits, but because generous funding went directly into the Indian and Eskimo communities...this allowed for

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[1] Section 108(b),(4) of Public Law 92-512: Indian Tribes: Alaskan Native Villages.

[2] Indian Tribes: Alaskan Native Villages. Payment Listing Calendar Year 1972 Entitlements. Department of the Treasury, Office of Revenue Sharing. passim.

[3] Ibid. passim.

Native leadership opportunities.[1]

Summary

Are the tribes participating in Federal Formula Grant Programs allocated to the states? Do past experiences influence those benefits? Are there mechanisms assuring compliance by the states? These and many other relevant questions must be considered when one contemplates the status of programs administered by the various states. On the surface, the state's efforts appear weak, considering the millions of dollars appropriated annually.[2,3,4] Where states have assumed jurisdiction there is a question of fulfillment of the intent of the law. O'Toole and Tureen contend:

Such assumption of authority by the State of Maine

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[1]Meredith, op. cit. p. 1.

[2]See, for example Public Health Service Grants and Awards, fiscal year 1971 funds, Superintendent of Documents, U.S. Government Printing Office, Washington, D. C., DHEW Publication No. (NIH) 73-198.

[3]Public Health Service Grants and Awards, Fiscal year 1972 funds, Superintendent of Documents, U.S. Government Printing Office, Washington, D. C., Stock No. 1740-00365.

[4]For fiscal years 1973 and 1974 funding computer printouts were obtained by the Author from the National Institutes of Health, Division of Research Grants, Statistics and Analysis Branch, Bethesda, Maryland.

> has been questioned from time to time on the premise that the Constitution places full power over the Indians in the federal government and that unless the federal government provides for state assumption by specific statute such assumption is not valid.[1]

Thus Maine, as was true in California, Oregon and Wisconsin, may not be in compliance with state laws which rule it mandatory to assist Indians.

On the other hand, the tribes perhaps appear to be precipitating this division, contending that by right and by law, and more importantly, by experience, they should deal with the programs at the national level and not be under the jurisdiction and control of states.

The American Indian Law Center, Albuquerque, New Mexico, in reviewing the Federal Field Organization for Indian Programs states:

> The committee seeks to preserve the direct relationship between the tribes and the federal government, without the intervention of states or other forms of organization imposed by the federal government.[2]

The states, more often than not, operate independently of tribal governments, even in programs where the states indicate their gestures are for the benefit of the

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[1] Francis O'Toole and Thomas N. Tureen. "State Power and the Passamaquoddy Tribe: 'A Gross National Hypocrisy'," Maine Law Review, Vol. 23, No. 1, 1971.

[2] Inter-Agency Staff Study Report Federal Field Organization for Indian Programs, American Indian Law Center, University of New Mexico School of Law, Albuquerque, New Mexico, June 1972, p. 6.

tribes. Williams, Tulalip Tribe, stresses:

> And the state of Washington without any consultation with the Indians in this state applied for a bloc grant (to HUD) for Indian 701 planning in the State of Washington.[1]

One of the most decisive statements is that expressed by Taylor:

> ...political spoils, lack of accountability resulting from the long ballot, poorly staffed legislation committees, incompetent officials, overlapping jurisdiction, and accepted discriminatory practice against minority groups are still all too prevalent in some state and local governments.[2]

Chino, in discussing the merits of federal aid programs going to the states which are based on the premise of serving all people, stresses: "I think a change of this thinking is needed."[3] But even more strongly he says: "Indian Tribes will deal directly with federal agencies as individual units of government."[4]

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[1]Wayne Williams, Tulalip Tribe, Transcript of Regional Hearings, Ibid. p. 18.

[2]Taylor, op. cit. p. 132.

[3]Wendell Chino, Indian Communities in Rural Areas. Testimony before the National Advisory Commission on Rural Poverty. December 13, 1968, p. 5.

[4]Chino, A New National Indian Policy, op. cit. p. 10.

CHAPTER III

REGIONAL OFFICES AND THE TRIBES

The possibility of tribes dealing with regional offices would appear to have merits if already existing Indian programs could be maintained. Most of the present programs in the regions have authorities which could vastly enhance tribal governments' capabilities to become self-governing, much in the same manner as local governments. Also important, although difficult to prove to individuals, regional programs have program authorities that neither the Indian Health Service nor the Bureau of Indian Affairs currently possess.

Regional programs are more diversified; their granting system provides more opportunities for adaptation to tribal thinking. On the other hand, contracts force contractees to behave in the manner of middle class whites. Most minorities have little problem with this type of an arrangement. But Indians, especially those on reservations, harbor no such desires. Herein lies much of the confusion that exists between Indians and state and local officials. Herein lies the key to any success the regions might have if they are to deal with tribes. Also, if regional offices

attempt to sever Native American's trust status with the United States Government, they will alienate the tribes.

Because of misconception and misunderstanding, regional offices have dealt infrequently with tribal governments, and the same could often be said of the programs at the national level. Urban Associates, Inc., in a recent study, characterizes regional offices in this fashion:

> Like the rest of HEW, most regional offices have had little experience in working with reservation Indians and comparatively little with urban Indians. They tended to view Indian health as exclusively an Indian Health Service concern. The region's primary constituents have been states and, secondarily, local governmental units.[1]

Cresap, et al., documents the past relationships this way:

> Several regional offices have defined their roles in Indian affairs as focusing interest and attention on urban Indians, while the Indian Health Service is focusing attention on reservation Indians and non-reservation, rural Indians.[2]

The Indian Health Service staff paper assessing the situation reports,

> ...they (Indians) often are unfamiliar with, and little use the regional office, state-local government avenue. As a result, Indians are not

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[1] A study of the Indian Health Service and Indian Tribal Involvement in Health. Department of Health, Education and Welfare, Office of the Secretary (330 Independence Avenue, S.W., Washington, D.C., and Urban Associates, Inc., 1018 Wilson Boulevard, Arlington, Virginia) March, 1974.

[2] Cresap, McCormich and Paget, Inc. op. cit. pp. VIII - 3.

> fully aware of and do not fully participate in many health programs for which they are eligible and which could help them.[1]

The Inter-Agency Staff Report reveals: "From the viewpoint of Indian Tribes, federal field officials as a rule have not been either responsive or sympathetic to Indian needs."[2]

An Assistant Secretary of Health maintains: "it is true that most regional offices have been minimally involved with Indian tribes..."[3]

In a study to assess the impact of health manpower training programs at the regional level, Cresap, et al., states:

> Virtually none of the health manpower training programs administered by the regional offices are designed for Indians. Nine of the regions responded that there were no such programs administered within their regions.[4]

Furthermore, in probing deeper into the subject, the report contends:

> Five of the regions reported that there has been no Indian involvement. Four of the remaining regions

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[1] IHS Draft Paper, op. cit. p. 13.

[2] Inter-Agency Staff Study Report, op. cit. p. 27.

[3] Analysis of the Inter-Agency Staff Study Report - Federal Field Organization for Indian Programs. Assistant Secretary for Administration and Management, June 20, 1972, p. 19.

[4] Cresap, McCormick and Paget, Inc., op. cit. p. VII - 3.

> reported that there may be Indian involvement, but that there are no data available to substantiate this belief.[1]

In a time when the regions were afforded an excellent opportunity to win the trust of tribes soon after the President's Indian Message in 1970, they quickly lost this advantage. For example, the Standing Rock Sioux in a rare move submitted program proposals to Region VII. They describe those efforts this way:

> The Standing Rock Sioux Tribe has had difficulty in developing program relationships with the Department of Health, Education, and Welfare. Within the last three years, two serious proposals have been submitted. A proposal for Comprehensive Alcoholism Development which was approved by the Kansas City Region but not funded, and a Youth Development Proposal which was also approved by the same region but not funded.
>
> From past experiences, the Standing Rock Sioux Tribe now views HEW as an unresponsive agency with little understanding for Indian Tribal development. Nearly all programs administered by HEW have been designed to be delivered through a state system. The tribe finds this unacceptable... The committee (Standing Rock Sioux) urges that HEW programs for Indian tribes in the future be funded directly to the tribal governing body.[2]

Two highly important aspects are worth noting in the Kansas City case. First, the Standing Rock Sioux are judged as one of the most progressive tribes in this country, reputed to possess one of the most sophisticated and capable planning staffs anywhere.

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[1] Cresap, McCormick and Paget, Inc. op. cit. p. VII - 3.

[2] Standing Rock Sioux Tribe Committee on FAR Review. op. cit. p. 38.

Members of the Standing Rock Sioux tribe are active in such organizations as the United Sioux Tribes of South Dakota, the United Tribes of North Dakota, the National Tribal Chairman's Association, which consists of Tribal Chairman from the 250 tribes in the United States and Alaska, and the National Congress of American Indians which consists of thousands of individuals from the various tribes and serves as a forum where much dialogue among Indians occurs.

If the Standing Rock Sioux, with their capabilities, are unable to penetrate the regional offices, what are the chances of the smaller tribes with little or no staff and limited experiences? One must also be aware of the "Indian Moccasin Telegraph" which is where tribal members discuss in full such issues and exchange experiences at annual meetings that bring the tribes together. These discussions are primarily to assist each other but, equally important, to protect themselves since staff, money and other resources are scarce.

Regionalization

Until recently, strong Indian desks were located in the various departments at the national levels. This provided the tribes important contact points, but more importantly, the Indian desks either had monies to assist the tribes or had line authority to implement programs within their agencies. The change, regionalizing the programs,

eliminated the Indian desks.

In this changed situation the tribes felt that what personal progress they might have achieved in recent years was being lost, and they were being placed at the mercy of the regions. They point out candidly that regions are local, state and city-oriented.

Even those who had some limited contact with the regions rejected the move. Jourdain, Chairman, Red Lake Chippewa, puts it this way:

> We have a strong suspicion that the EDA (Economic Development Administration) being set up in Chicago (Region V) is going to be Chicago-oriented, period, like we have with the housing office (Housing and Urban Development) in Chicago right now. Those people, when they look over a plan of operation as far as the housing program is concerned, are only concerned with what kind of a program they had here in this ghetto area or in Chicago. They are not concerned about the Indian reservations, or their unique needs.[1]

Two critical points emerge from the above statement: (1) tribes are aware that regions have long by-passed them in favor of city and state programs and (2) that non-Indians administering programs for Indians tend to reshape Indian proposals into concepts of what they think life should be for the Indian rather than accept what the tribes want. Indian desks, largely managed by Indians, are fully aware of the intricacies and cultural implications of Indian proposals.

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[1] Inter-Agency Staff Study Report Federal Field Organization for Indian Programs. op. cit., p. 56.

Another significant statement related to this issue came from the American Indian Law Center:

> If tribes are parceled out to the regions, we will have to duplicate each victory ten times at the regional level. The problems of tribes are too great and the need for quick action is too urgent to submit to a regional system that splits the tribes into ten regions and robs them of the few advantages they enjoy.[1]

The same position was stressed in a document from the Office of the Secretary, Department of Health, Education and Welfare:

> Indian leaders are strongly opposed to these recommendations. They contend that they are just now developing the knowledge, skills, and mechanisms to work with the bureaucracy and therefore see any major organizational changes as disastrous to this progress. At least two Indian organizations (The National Tribal Chairman's Association and the Inter-Tribal Council of California) have passed resolutions... opposing federal decentralization and regionalization of Indian programs.[2]

The Standing Rock Sioux, in support of the tribes from New Mexico, stated:

> HUD realignment is opposed by the New Mexico tribes and this action should be deferred until such time as an Area Office is established in New Mexico or the Indian leadership is otherwise convinced that the Dallas-Fort Worth Regional Office will be more responsive.[3]

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[1] Inter-Agency Staff Study Report Federal Field Organization for Indian Programs. op. cit., p. 56.

[2] Analysis of the Inter-Agency Staff Study Report - Federal Field Organization for Indian Programs. Assistant Secretary for Administration and Management. op. cit., p. 24.

[3] Standing Rock Sioux Tribe Committee on FAR Review. op cit., p. 35.

In addition to the apprehension of jeopardizing their trust status, tribes are aware of the fact that the possibility exists that such channeling of special Indian monies to the regions would lead to absorption of those dollars into a "grab bag" fund for state and local governments. Specifically, it would require Indians to compete with other governments for services from agencies with which tribes are unfamiliar and have received practically no services in the past.

Regional Indian Task Forces

Soon after the President's Indian message, some of the regions busied themselves with the creation of Indian Task Forces, issuing directives to staff members,[1] letters of good intent to other agencies,[2] and a mass of other actions which were intended to "identify and describe the specific conditions causing problems to the effective delivery of HEW services to Indians, both reservation and non-reservation."[3]

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[1]Rulon R. Garfield, Regional Director. Task Force on Indians. Memorandum to Regional Commissioners, Regional Representatives, and Task Force Designees, Region VIII, U.S. Department of Health, Education and Welfare, Denver, Colorado, January 8, 1973.

[2]For example, letter from Rulon R. Garfield, Region VIII Director to Charles S. McCammon, M.D., Phoenix, Arizona, IHS Area Director, February 6, 1973.

[3]Garfield, op. cit.

To illustrate the lack of knowledge and experience in dealing with tribes the regions, in creating the Task Forces overlooked a highly essential ingredient -- Indians. Such ommissions could cause tribes to distrust the regional offices more than they do.

Programs and approaches contrived by non-Indians have had little or no success among Indians. Evidence of this abounds on every reservation where Indians lack control or voice in the planning. On reservations where tribes have assumed control and do have a voice in programs, success is high; the Warm Springs Reservation in Oregon, the Mescalero Apache Reservation in New Mexico, the Miccosukee in Florida serve as examples. Their successes show that tribes can make regional programs work, if the regions are also committed to their success.

Regional Councils

A brief word about Regional Councils seems appropriate in relation to Indian programs. Regional Councils, despite their intentions to meet community needs in toto, do not have total program or funding authorities. Many program authorities and monies presumably regionalized are still retained at the national level, in spite of the well-intended issuances and policies. With this in mind, it would be hazardous for Regional Councils to create false expectations within tribal communities. Thus, it becomes

increasingly important that tribes know the capabilities of the regions. All too often, after lengthy negotiations at the regional level, proposals are then forwarded to the national offices for final approval and/or funding. About the second time this occurs, word will spread to the tribes, and they will do what they have previously done -- go straight to Washington, by-passing the regions.

Summary

Regional offices must re-evaluate the reasons for their existences, particularly in relation to Indians. The deficiencies are obvious enough:

> The Regional Councils and their emerging coordination role were virtually unknown to Indian tribes, and Councils have shown little interest in Indian problems...[1]

It also notes:

> Another startling finding...was the polarization of opinions between the regional offices and Indian people. For example, the regional offices often strongly supported recommendations to which the Indian people were adamantly opposed.[2]

Up to now, there appears to have been little communciation and relationship between the tribes and the regional offices, particularly in the field of health. As a DHEW Assistant Secretary report declares: "Tribal knowledge

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[1] Analysis of the Inter-Agency Staff Study Report. op. cit., p. 5.

[2] Analysis of the Inter-Agency Staff Study Report. op. cit., p. 35

of Regional Councils is even at a lower level than Council awareness of the reservations."[1]

In summary, three prevailing quotes seem appropriate at this time. First, as Meredith succinctly writes:

> The promise of greater control of their own affairs has led only to greater frustration for the Indians because of the lack of conviction on the part of the non-Indian.[2]

Second, the IHS staff paper recognizing its own shortcomings in providing Indians opportunities in the health field, stresses:

> ...give the Indians the opportunity to increase their awareness of, and participation in, all health programs for which they are eligible on the same basis as all others who qualify.[3]

Finally:

> Many observers, tribal Indians and federal bureaucrats, are most skeptical about the possibility that power will really flow from Washington to the regional offices, and if it doesn't the regionalization program will accomplish nothing -- Washington will still be the place to go for action. It must be admitted that Indians and Indian tribes have influence in Washington...it is an advantage that would be lost in the regional offices. The tribes would be most foolish to surrender that advantage without a struggle.[4]

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[1] Analysis of the Inter-Agency Staff Study Report. op. cit., p. 50.

[2] Meredith, op. cit., p. 66.

[3] IHS Draft Paper. op. cit., p. 4.

[4] Inter-Agency Staff Study Report Federal Field Organization for Indian Programs. op. cit., p. 12.

CHAPTER IV

DESIGN OF THE STUDY

It is the intention of this study to examine the relationship between federal health programs and federally recognized Indian Tribes and Alaskan Natives, with particular emphasis on those federal formula grant programs going to the states.

Because the magnitude and scope of this study is large, the amount of data eventually collected is too extensive for total analysis. For this reason the first part of the study is descriptive. Specifically, the descriptive investigation recorded the number and dollar amounts of grants to tribes; it documented provider's perception of whether tribes do or do not meet program requirements for funding; and, it documented federal official's perception of the administrative levels that have review, rejection, approval and funding authority of federal health programs.

The analysis of these data will facilitate some greater understanding of the relationship between federal health programs and federally recognized Indian tribes and Alaskan Natives.

Assumptions

1. The tribes are receiving minimal or no services from federal health programs (other than from the Indian Health Service) regardless of the level of administration: national, regional, or state.

2. The tribes are receiving more funds from the national offices than from the regional offices.

3. National or regional offices have no clear knowledge of their legal authorities to directly fund the tribes.

4. The regional offices do not agree upon their authorities for final approval and funding of proposals.

5. Other variables influence final decisions in dealing with tribes: the presence of services provided by Indian Health Service and the Bureau of Indian Affairs programs, attitudes of Federal officials, and others.

Relationship Assumption

In the portion of the study investigating interactions between the states and the tribes, efforts were made to identify certain variables that might influence the relationship between the two sovereignties. It was also the intent of the investigation to collect baseline data that would stimulate further study and ultimately provide for more active participation of tribes in formula grant programs. This was seen as particularly significant since

little research has been conducted relating to the states and the tribes in the health field.

As indicated earlier, for many years prior to the "New Federalism Plan," tribes had negotiated for services at the national level. It has been difficult to redirect them to the states and to the regional offices. Although many attempts have been made, none have been successful. Many explanations have been made as to why tribes are reluctant to deal at these two levels. Thus the decision was made to focus the research on the relationship between the states and the tribes. From the beginning, certain assumptions prevailed; however, one major assumption predominated: a variety of inter-related variables influence the relationship between the states and tribes.

Hypotheses

The basic hypotheses formulated for this study are as follows:

Hypothesis I: There is no significant difference between the opinions of state health officials and those of Tribal Chairmen and IHS Service Unit Directors indicating states have jurisdiction to provide services on Federal Indian Reservations.

Hypothesis II: There is no significant difference

between the opinions of state health officials who indicated they have provided services on Federal Indian Reservations and the opinions of Tribal Chairmen and IHS Service Unit Directors who indicated they have received state services on Federal Indian Reservations.

Hypothesis III: There is no significant difference between the sentiment of state health officials who stipulate they are willing to provide services on Federal Indian Reservations and the sentiments of Tribal Chairmen and IHS Service Unit Directors who stipulate they are willing to accept services from the state.

Hypothesis IV: There is no significant difference between the replies of state health officials and those of Tribal Chairmen and IHS Service Unit Directors who indicate that they have applied for state services.

Hypothesis V: There is no significant difference between responses of state health officials from those of the Tribal

Chairmen and IHS Service Unit Directors who indicate that an Indian health facility, on behalf of a tribe or individual, has applied for state services in the past two years.

Hypothesis VI: There is no significant difference between the answers of state health officials from those of Tribal Chairmen and IHS Service Unit Directors who maintain there is an Indian member who resides on a reservation on a state-operated health advisory board.

Hypothesis VII: There is no significant difference between the ability of state health officials and Tribal Chairmen and IHS Service Unit Directors to name the tribal member on state health advisory boards.

Hypothesis VIII: There is no significant difference between the abilities of state health officials and Tribal Chairmen and IHS Service Unit Directors to name the tribe of the tribal member on the state health advisory boards.

Hypothesis IX: There is no significant difference of opinion between state health officials who think that it is legal to grant to tribes and tribes and IHS who think it is legal for tribes to accept state health programs.

Hypothesis X: There is no significant difference between the opinions of state health officials who are willing to grant/contract to tribes, tribes' willingness to assume control, and IHS opinion that tribes are capable of managing state programs, or portions thereof.

Hypothesis XI: There is no significant difference between the opinions of state health officials and Tribal Chairmen and IHS Service Unit Directors who feel that the formula grant monies now apportioned to the states should go directly to tribal governments for application on reservations.

Hypothesis XII: There is no significant difference between the opinions of state health officials and Tribal Chairmen and IHS Service Unit Directors who feel

that the term Tribal Governments or Indians should be included in the application and eligibility requirements of federal health programs.

Hypothesis XIII: There is no significant difference between the responses of state health officials from Tribal Chairmen and Indian Health Service Unit Directors with regard to coordination occurring between the state and the tribes in the development of State Plans.

Hypothesis XIV: There is no significant difference between the replies of state health officials from Indian Health Service Unit Directors and Tribal Chairmen who say they have been informed of state health services.

Definitions

The following terms and definitions are delineated to clarify their usage in this study:

Federal Health Programs -- The federal health programs listed in the Catalog of Federal Domestic Assistances, Office of Management and Budget, 1973, pp. 125-165 (See Appendix E).

Regional Health Programs -- The federal health

programs that are managed and controlled at the regional level (See Appendix E).

State Formula Grant Programs -- The federal health formula grant programs that are apportioned to the states for application (See Appendix E).

Federally Recognized Indian Tribes and Alaskan Natives -- Tribes that still retain the trust status with the U.S. government because of treaties and laws legislated or enacted.

Regionalization -- "Is the strengthening of the Office of the Regional Directors to accomplish overall effective management and coordination of federal activities in the field."[1]

Decentralization -- "Is the movement of the federal role to the regional offices or, more specifically, the transfer of certain headquarters' functions, authorities and resources to their field counterparts."[2]

The Settings

In this study no attempt was made to randomly select federal health programs, federally recognized Indian Tribes and Alaskan Natives, or Indian Health Service Units. Rather, the decision was made to focus on the entire population

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[1]Under Secretary, Office of the Secretary, Department of Health, Education and Welfare, "Decentralization," Memorandum Issuance, Washington, D. C., March 26, 1973, p. 1.

[2]Ibid, p. 1.

within each of these categories. From the outset it was recognized that to enumerate the whole population would lead to enormous amounts of data. For this reason, it was determined to limit the relationship portion of the study to the federal formula grant programs apportioned to the states. Thus, a descriptive study was to be performed on the programs at the regional and national levels.

One exception prevails concerning the above information: specifically, no data collection for this study was conducted in Regions I, II, and III since there are no federally recognized Indian tribes residing in these areas. Efforts were therefore concentrated in Regions IV, V, VI, VII, VIII, IX, and X, plus the national offices.

Research Methodology

Since limited data existed pertaining to this problem, an exploratory investigation was felt to be the most appropriate research method.

In that the study was to be conducted across many states, covering vast distances, the decision was made to use the questionnaire technique for obtaining the necessary data. By using questionnaires it was possible to query a larger audience in a shorter time period. Such factors as training interviewers and the ultimate cost of travel and interviewing time was also instrumental in the final decision. Based on the shortage of past research studies in

this field, it was the intention of this study to determine if tribes have participated in federal health programs. The ultimate goal, also, was to identify variables where changes might be made which could correct any inequities.

Limitations

Several limitations exist within this study:

1. A degree of vagueness and ambiguity always exist in constructing questions for inclusion in questionnaires.

2. Fixed alternative-type questions tend to control the areas of interest rather than permit the development of other areas of interest.

3. Because of the lack of other studies, the data sought in this investigation emerged from the limited sources dealing with this topic.

4. Bias is associated with mailed questionnaires, in that those who ultimately returned them may, or may not, represent the opinions of those who neglected to return questionnaires.

5. The amount of data collected does not lend itself to total interpretation because of volume.

Research Instrumentation

The development of the questionnaires for this investigation was somewhat inductive in nature. In the initial questionnaire to the national and regional offices

for the descriptive study, exploratory discussions were conducted with several Regional Health Directors, officials at the national level, and the Director of the Indian Health Service. Upon completion, the questionnaire was subsequently submitted to these individuals for final constructive comments. A copy of the questionnaire appears in Appendix A.

Part I of the questionnaire sought the descriptive data of grants/contracts made to tribes in fiscal years 1972 and 1973, the name of the tribe, the amount of funding, the period of funding, and the type of grant/contract. In Part II, information was sought as to the legal enablement of the programs to grant to or contract with tribes, if no grants/contracts had previously occurred. Specifically, the purpose was to gain information about the status of programs in relation to tribes: (1) if tribes do or do not meet program requirements for direct funding because of law; (2) if tribes do or do not meet program requirements for direct funding because of policy; or (3) if tribes do meet the requirements for direct funding. In this section, space was provided for comments and elaboration. An open-ended question was asked seeking statements as to any corrections needed to improve and facilitate grants to or contracts with tribes. The third part was designed to determine the various administrative levels that have review, rejection, approval and funding authority for

submitted proposals seeking federal health program monies.

The questionnaire directed to the states, the tribes and the Indian Health Service Units solicited basic data of an exploratory nature. The design for the responses was based upon data obtained from the initial descriptive study, statements which the author solicited from ten tribal chairmen, and general discussions with individuals closely connected with and knowledgeable about Indian affairs. Fixed alternative questions were used to compare the responses of the states with the tribes and with the Indian Health Service Units. At the same time, the decision was made to analyze each scale item individually in relation to responses made by the state, the tribes, and the Indian Health Service Units. With some minor changes for adaptions to the particular recipient, the questions were identical in all three sets of questionnaires. Copies of these questionnaires appear in Appendices B, C, and D.

Questions, for the most part, were designed to be answered with a "yes" or "no" response. A space for "unknown" was provided; however, this response was treated as a neutral response and had no bearing or influence on the final results. Thus, only the specific responses were measured.

In the descriptive study, the pre-testing primarily involved two Regional Health Directors, a Regional Liaison Officer from the national office, the Director

of the Indian Health Service, and other officials located in Rockville, Maryland. In the relationship study, the pre-testing involved five people each from the National Tribal Chairman's Association, Directors from Indian Health Service Units and state programs. These Indian Health Service Unit Directors were not included in this study.

The pre-testing identified areas for correction in question structure and design, in tabulation, and in the analysis of data.

In the questionnaires, question number three was not designed to assess whether or not relationships existed. Rather, it was designed merely to determine what tribes or service units had received services, and what kind. It was assumed that whatever services might have been received, the larger tribes were more apt to obtain them. At the same time, it was felt that whatever services the Indian Health Service Units received would be in areas of their own deficiencies. Again, no effort was made to establish the existence of or degree of relationships. The same is true for questions number seven and eight. A descriptive ranking was the initial intention.

The Study Population

This study provided for a sample of the total population in all categories. This method enabled a comparison of quantitative measures among the groups. Also, it enabled the application of statistical testing of the groups.

For the populations included in the descriptive investigation, refer to Appendix E. Note that the regional and state programs are also listed, and are identified by asterisks.

Fifty-three of the 62 program officials at the national level and 158 of the 196 program officials from the seven regions returned questionnaires in the descriptive study. The high percentage of returns was most likely due to the insistence from the then Acting Director of the Health Services and Mental Health Administration. Thus 85.4 percent of the national officials and 80.6 percent of the regional officials returned questionnaires.

In the state's portion of the relationship study, 118 of the initial 264 questionnaires were returned within 30 days. Follow-up procedures were used to obtain an additional 105 state questionnaires. This represents a total return of 84.4 percent. The procedures are outlined in the section on collection of data.

In the tribal portion of the relationship study, 55 of the 194 initial questionnaires were returned within 30 days. Follow-up procedures were used to obtain an additional 33 questionnaires for a total return of 40.2 percent.

In the Indian Health Service Unit portion of the relation study, 71 of the initial 86 questionnaires were returned within 30 days. Since this represented a high

percentage (80.2%), no attempt was made to solicit additional questionnaires from the Indian Health Service Unit Directors.

Finally, it can possibly be surmised that the early returns are indicative of a willingness to cooperate in the study; thus, they represent a fraction of the total population, while the late returns could, perhaps, be indicative of a completely different type of response. No effort, however, was made to distinguish between the early and late returns in data analysis.

Collection of Data

For the collection of data at the seven regional offices and the national level, permission was obtained from the Acting Director of the Health Services and Mental Health Administration. In order to achieve a high percentage of returns, discussions were held with various high level officials who, in turn, discussed the purpose of the study with various field and headquarters staff. As a result, cooperation was excellent. Subsequently, questionnaires were mailed to program officials at both levels. No follow-up procedures were conducted in this study since it was, more or less, an inductive approach to the state investigation. As it has been noted, however, the returns were more than had been expected due, no doubt, to the interest and commitment of program administrators in Rockville,

Maryland.

In comparison, the data obtained from the states were sought in a less conspicuous manner. It was suggested the regional health directors take the initiative to solicit the responses from the state officials. But it was the feeling of the author that a more candid and frank response would be forthcoming if state officials were not pressured from those who regulated and monitored the allocations and programs. As a result, in the solicitation the author represented himself simply as a student seeking information to obtain worthwhile data to complete work for a dissertation. Perhaps, the weakness in such an approach is evident from the number of "no responses," or blank responses (both treated equally), in the initial mailing.

Follow-up questionnaires were sent to state program officials who had failed to return the document, or who had returned it without responses. In some of the states, particularly North Dakota and Washington, state health directors returned one questionnaire, indicating that the same answers applied to other questionnaires previously sent to other program officials. Since distinct monies are earmarked to separate state health program entities, a follow-up questionnaire was mailed a third time. A special notation concerning the Regional Medical Program questionnaire is important at this time. Only one usable questionnaire was returned from the initial mailing. However, the majority

of the Regional Medical Program officials returned blank questionnaires with somewhat similar remarks: "We are not a State Operating Health Program. Therefore, this questionnaire does not apply to me." A correction was made in a follow-up letter and questionnaire. The results were reasonably successful.

Another statement worth noting, also, is that since Alaska and Oklahoma do not have Federal Indian Reservations per se, a special notation was added to the questionnaire sent to the state, tribal and Indian Health Service officials in those states (See Appendix B, special notation).

A somewhat different approach was used in the second follow-up letter to the tribes. Instead of mailing the questionnaires directly, individuals in the various states who are acquaintances of the author, were asked to solicit replies to the questionnaires. No effort was made by these individuals to solicit the data by interview. Their efforts merely centered on the need for the information, depending solely on the introductory statement accompanying the questionnaire and the questionnaire itself for obtaining the data.

Several of the leading "Indian States" failed to return questionnaires. For example, in the initial inquiry, North Dakota, New Mexico, South Dakota, Washington and California returned only one from the original submission of 11 inquiries.

It was decided at this point, since New Mexico and South Dakota were two prominent "Indian States," that the author would conduct personal interviews. It was also decided that a standardized interview would be conducted, that is, the author would use the specific wording as in the questionnaires. However, upon completion of this structured questioning it was intended to provide opportunity for more open discussion.

On the morning scheduled for the interview in South Dakota, the headlines read, "AIM Declares State a War Zone."[1,2] After two interviews it was quite apparent that to continue the interviews would be futile. The responses came hesitantly, preceded by guarded statements rather than direct responses. New Mexico, with a rare exception, also was difficult. Obtaining time schedules of state program officials was almost impossible. In some cases they were completely denied, even when the author indicated that time was irrelevant, permitting the state officials to set any future time and date they so wished. In instances where no interview occurred, a questionnaire was given to the secretary. This proved successful in only one case.

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[1]Russell Means, an American Indian Movement (AIM) leader, had declared the State a War Zone, threatening to impound all out-of-state vehicles.

[2]"AIM Declares State a 'War Zone'", Aberdeen American News, May 7, 1974, p. 1.

The data collection for the descriptive study covered a two-month period. Review and tabulation was done without the aid of automated data processing equipment. The data collection for the relationship study covered a period of approximately three months. The data was coded on form sheets, and then key punched on cards. Tabulation was accomplished by means of an electrical card sorter and counters. The computation was performed on an electrical calculating machine. Chi Square comparisons were made between the state and the tribes, and the state and the Indian Health Service Units after the data was classified, sorted, and tabulated according to the individual items within the questionnaires. Of the total 544 individuals in the relationship study, 382 were eventually returned in usable form for a response rate of 70.22 percent.

It is recognized that perhaps bias could bave been introduced into the study because of the different data collection mechanisms. This was unavoidable in order to insure a sufficient number of returns. However, any bias that might have been introduced into the study is not viewed as a serious limitation; it is comparable to the inevitable bias inherent to any research.

CHAPTER V

FINDINGS

The responses of the states, the tribes, and the IHS Service Unit Directors are presented in this Chapter in raw data form, percentages, and Chi Square results. The purpose of the presentation of the raw data is to enable others to perform analyses in areas of importance to them. This is essential since limited research has been conducted in this field. Also, the visual presentation of the raw numbers enables one to observe the magnitude of the differences between the percentages. In other instances, rankings are used for the presentations.

In the descriptive study, Part I data illustrates the total number of grants or contracts awarded to the tribes in fiscal years 1972 and 1973 (Table 1). Part II shows the opinions of federal officials as to the legality of granting to or contracting programs to the tribes; specifically, if tribes do or do not meet program requirements for funding because of law or policy. In all instances, the results reflect the opinions of individual program directors from the national offices and those officials from Regions IV, V, VI,

VII, VIII, IX, and X. The third part reflects the understanding of federal officials from national and regional offices of the levels that have review, rejection, approval and funding authority for submitted proposals.

In the relationship study between the states and the tribes, and the states and IHS, the results and the interpretation of the hypotheses are presented as they appeared in Chapter IV. Therefore, attention will be focused on the hypotheses in that order.

Note that Chi Square tests were not completed on all of the hypotheses. Some of the hypotheses were incompatible with Chi Square analysis due to the small numbers within the cells of the matrix. Percentages are presented for this data. These percentages are provided to represent the response characteristic of the respondents and to indicate the tendency toward differences.

A 2 X 2 Chi Square analysis with a significant level of .05 and 1 degree of freedom was used to test the data. Since the data was of nominal[1] nature, the Chi Square test[2] emerged as the most appropriate statistical test. It is also appropriate because the hypotheses address themselves to the existance of differences between groups and not the magnitude

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[1]Bernard S. Phillips. Social Research Strategy and Tactics. The Macmillan Company, New York, 1970, pp. 215-217.

[2]Ralph H. Kolstoe. Introduction to Statistics for the Behavioral Sciences. The Dorsey Press, Homewood, Illinois, 1973, p. 234.

of the differences.

While viewing the raw data, particularly the percentage lines, one must ask: "Is it likely that the magnitude of the differences between the percentages...could arise merely by chance in samples of this size?" or "if all those who received questionnaires had responded, would the percentages be the same in each group as those shown?"[1] The assumption is that the percentages should be the same, and that the results shown would be identical regardless of how many samples were obtained. Yet the differences, or similarities, might have arisen by chance. Thus, caution must be exercised in drawing conclusions prior to viewing the results and interpretations of the Chi Square Analyses.

In Table 2 the opinions expressed by the national and regional program directors reflect their understanding of the legality of granting or contracting their programs directly to the tribes.

Several essential factors must be noted in relation to Table 1. First, the dollar figures are those reported on the returned questionnaires. Next, since this study concentrated primarily on Reservation Indians, Urban Indian contracts were excluded from the totals. Also, many of the regional (and national) offices listed the contracts which

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[1]Bradford Hill. Principles of Medical Statistics, Oxford University Press, New York, 1967, p. 153.

TABLE 1

DIRECT FEDERAL HEALTH PROGRAM FUNDINGS TO TRIBES
FY 1972 AND 1973

	Fiscal Year 1972		Fiscal Year 1973	
Program Offices	Applications Funded	Total Dollars	Applications Funded	Total Dollars
National	5	$ 317,503	4	$ 244,464
Region IV	0	0	1	30,000
Region V	1	709,605	1	500,720
Region VI	0	0	0	0
Region VII	0	0	0	0
Region VIII	0	0	1	64,085
Region IX	0	0	0	0
Region X	0	0	2	43,147
Totals	6	$1,027,108	9	$882,416

were culminated because of President Nixon's special efforts[1] -- $10 million specifically earmarked for Indian health programs: Otitis Media programs; Mental Health programs, including alcohol and drug abuse activities; Nutrition; Maternal and Child health programs, including family planning services; Community Health projects; and Manpower development. In that this action forced program directors to initiate actions in behalf of tribes with special monies, the decision was made to exclude these dollars; rather, the decision was to focus on the national and regional office appropriations including those funds allocated to respective programs which are intended, by law, to benefit all citizens. Specifically: "are the national and regional federal health programs doing anything in relation to the tribes unless it is mandatory?"

Contracts awarded to non-Indian organizations on behalf of Indians were excluded in the totals. As one regional questionnaire response stated, "Non-specific also includes non-Indian population."[2] Numerous awards were consummated in this manner. As was evidenced in a research study previously cited,[3] such arrangements are not in the

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[1]Office of Health Resources, "The President's $10 Million Fund for Indian Health: A Progress Report for Fiscal Year 1971, 1972 and 1973." Prepared by Office of Health Resources, Indian Health Service, Health Services Administration, U.S. Department of Health, Education and Welfare, February 5, 1974.

[2]As specified in the introductory section of the mailed questionnaire, the source will be kept confidential.

[3]William and Kekahbah, op. cit.

best interest of Indians.

Many of the national offices took credit for regional awards, or vice versa, or each level attempted to assume credit for Indian Health Service awards. For example, several of the regions listed Community Health Representative contracts with tribes, which monies, in reality, are an appropriation made to the IHS budget by Congress, and not a part of other program funds.

Finally, according to the returns from the national and regional offices, tribes have received few or no grants or contracts in spite of the enormous amounts of monies appropriated to the offices annually.

There is much confusion among program directors as to the legality of funding directly to the tribes. In most instances program directors were divided as to whether direct funding was prohibited or permissible. In combining 'prohibited by law' or 'policy' and 'unknown', 61.14 percent of those reporting indicate tribes are ineligible for direct funds. In some cases, this is correct, particularly when one considers Comprehensive Health Planning (314a) and Crippled Childrens Services as examples. Regardless, it would appear that program directors should have a more in depth knowledge and understanding of their program authorities.

TABLE 2

FEDERAL HEALTH PROGRAMS

NATIONAL AND REGIONAL PROGRAM DIRECTORS' OPINIONS REGARDING THE LEGALITY TO CONTRACT/GRANT DIRECTLY WITH TRIBES

OMB Code and Programs		Prohibited by Law	Policy	Permissible	Unknown	Totals
13.200	Disease Control-Consultation and Technical Assistance	1	1	2	1	5
13.201	Disease Control-Laboratory Improvements	2		1	1	4
13.202	Disease Control-Research Grants	2		1	1	4
13.203	Disease Control-Training Public Health Workers	1		2	2	5
13.204	Disease Control-Tuberculosis	2		1	1	4
13.205	Disease Control-Venereal Disease	4	1	2		7
13.206	Comprehensive Health Planning-Areawide Grants	3		2	1	6
13.207	Comprehensive Health Planning-Grants to States	5				5
13.208	Comprehensive Health Planning-Training, Studies and Demonstrations	3		1		4
13.210	Comprehensive Public Health Services-Formula Grants	2			1	3

TABLE 2 (continued)

OMB Code and Programs		Prohibited by Law	Prohibited by Policy	Permissible	Unknown	Totals
13.211	Crippled Children's Services	3	1			4
13.211	Crippled Children's Services (Project Grants)					0
13.212	Dental Health of Children	3	1	1		5
13.213	Emergency Health-Civil Defense Medical Self-help	1		1	1	3
13.214	Emergency Health-Community Preparedness	2		2		4
13.215	Emergency Health-Hospital and Ambulatory Services			2		2
13.216	Emergency Health-Medical Stockpile	1		1	1	3
13.217	Family Planning Project	2		2		4
13.218	Health Care of Children and Youth	2		1	1	4
13.220	Health Facilities Construction-Grants	4		1	1	6
13.223	Health Facilities Construction-Technical Assistance	4				4
13.224	Health Services Development-Project Grants	3			1	4

TABLE 2 (continued)

OMB Code and Programs		Prohibited by Law	Prohibited by Policy	Permissible	Unknown	Totals
13.225	Health Services Research and Development - Fellowships and Training	2			1	3
13.226	Health Services Research and Development - Grants and Contracts	2			1	3
13.227	Health Statistics Training and Technical Assistance					0
13.228	Indian Health Services					0
13.229	Indian Sanitation Fac.					0
13.230	Intensive Infant Care Projects	3	1	1		5
13.231	Maternal and Child Health Research	3		2	1	6
13.232	Maternal and Child Health Services	1		2		3
13.232	Maternal and Child Health Services (Project Grants)	4		3		7
13.233	Maternal and Child Health Training	2		1	1	4
13.234	Maternity and Infant Care Projects	3	1	2		6
13.235	Mental Health-Community Assistance Grants for Narcotic Addiction and Drug Abuse			2	2	4

TABLE 2 (continued)

OMB Code	and Programs	Prohibited by: Law	Policy	Permissible	Unknown	Totals
13.238	Mental Health-Hospital Staff Dev. Grants	2		1		3
13.239	Mental Health-Narcotic Addiction Treatment					0
13.240	Mental Health-Community Mental Health Centers	2		1		3
13.240	Mental Health-Community Mental Health Centers (Construction)				1	1
13.241	Mental Health Fellowships			1	1	2
13.242	Mental Health Research Grants			1	1	2
13.243	Mental Health Scientific Communications and Public Education				1	1
13.244	Mental Health Training Grants			1	1	2
13.246	Migrant Health Grants	1		2		3
13.247	Regional Medical Programs	1		2		3
13.248	Disease Control - Nutrition	2		2		4
13.249	Regional Med. Prog. - Operational and Planning Grants			2		2

TABLE 2 (continued)

OMB Code and Programs		Prohibited by: Law	Policy	Permissible	Unknown	Totals
13.251	Mental Health-Community Assistance Grants for Comp. Alcoholism Service			1	1	2
13.252	Mental Health - Direct Grants for Special Projects (Alcoholism)			3		3
13.253	Health Facilities Construction-Loans and Loan Guarantees	3		1		4
13.254	Mental Health-Direct Grants for Special Projects (Narcotic Addiction and Drug Abuse)			2	1	3
13.256	Health Maintenance Organization Service	3		3		6
13.257	Mental Health - Alcohol Formula Grants	1			1	2
13.258	National Health Service Corps		2	2		4
13.259	Mental Health - Children's Services	2		2		4
13.260	Family Planning Services - Training Grants			2		2
13.261	Family Health Centers	1		2		3
13.262	Occupational Health - Research Grants			1		1

TABLE 2 (continued)

OMB Code and Programs		Prohibited by: Law	Policy	Permissible	Unknown	Totals
13.263	Occupational Health - Training Grants	1		2	1	4
13.264	Occupational Health - Special Fellowships			2	1	3
13.265	Occupational Health - Demonstration Grants			2	1	3
13.266	Childhood Land-Based Paint Poisoning Control			4		4
13.267	Urban Rat Control			3		3
13.268	Disease Control Project Grants	1		1		2
13.269	Drug Abuse				1	1
Totals		90	8	82	31	211
Percentages		42.66	3.79	38.86	14.69	100.0

Program Health Directors from the national and seven regional offices expressed their opinions as to the following: (A) Entry Point: the level at which a proposal must be submitted, either local, areawide 314b, state, regional, or national offices (Central); (B) Rejection Authority: the level that has rejection authority of proposals; (C) Final Approval Authority: the level that has the final approval authority of proposals; and (D) Funding Authority: the level that has the funding authority (See Appendix G for specific programs). The figures represent the responses from the national and regional program directors as to their understanding of the four areas covered in this section of the questionnaire.

For example, in the first illustration (13.200 Disease Control - Consultation and Technical Assistance) in the Entry Point Section: one 13.200 program director indicated submission must occur at the local level, one indicated the Areawide 314b level, and one indicated that submission must occur at the regional level.

Table 2 shows there is no agreement among national and regional program directors as to (A) where proposals should initially be submitted; (B) who has rejection authority of proposals; (C) who has final approval authority of proposals; and (D) who has the funding authority. The data shows (Appendix G) that directors need a better understanding of the procedural methods of programs.

Many of the officials have indicated that proposals are to be submitted at local levels. When the initial entry point is at these levels, several crucial factors can affect tribes. First, by the time all levels have had an opportunity for personal editorial input, the proposal may be other than originally designed, and there has been a significant lapse of time. Both of these aspects are critical in relation to Indian tribes: time and alterations of proposals. Too, experience has shown that the more local the rejection authority, the more unlikely it is that tribes will succeed in obtaining program funds. As expressed in the Albuquerque Journal, "The society which surrounds them (Indians) is fearful and hostile."[1]

There are also discrepancies in the final approval and funding sections. For example, program directors vary in opinion as to the level that has final approval or final funding of proposals. Such variations frequently create problems. For example, where regional offices review and approve potential grantee proposals they will often forward the same proposal to the national office, seeking yet another approval or funding, or both. Various outcomes and opinions do often occur at the higher level: the

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[1] _____ "Sioux Receive Blow." Albuquerque Journal, Albuquerque, New Mexico, Sunday, August 4, 1974, p. A-5.

national office might notify the region that no funds are available, even after the expected grantee has been assured of funding and eagerly awaits the monies. Or, the national office might start re-negotiations with the prospective grantee, reviving the long process of restructuring the proposal to fit the expectations of the new person in control; or, the proposal is rejected. This action can take place even after approval by the regions.

The opposite often happens: that is, where all the responsibilities have clearly been delegated to the regions, a region might not accept the responsibility, particularly on controversial or political issues. As a result the regional official will hurriedly put the burden of decision on the national office, abrogating the decision-making authority that he, the week previous, had complained so vigorously about not possessing.

In the absence of previous data assessing whether states have jurisdiction on Federal Indian Reservations in the field of health, it became increasingly important to seek the consensus of the states, the tribes, and IHS Service Unit Directors. While opinions are not laws, they lend credence to what generally occurs. Moreover, without the positive belief that the right does exist, more often than not the action will not follow.

As shown in Table 3 the percentages shown in the line "States <u>do not</u> have jursidiction" suggest that, of the

JURISDICTION

Hypothesis 1: There is no significant difference between the opinions of state health officials and those of Tribal Chairmen and IHS Service Unit Directors indicating states have jursidiction to provide services on Federal Indian Reservations.

TABLE 3

STATES JURISDICTION ON FEDERAL INDIAN RESERVATIONS

	Tribe		IHS		State	
	Number	Percent	Number	Percent	Number	Percent
Number indicating States do have jurisdiction on reservations	30	63.83	53	74.65	25	11.21
Number indicating States do not have jurisdiction on reservations	17	36.17	18	25.35	198	88.79
Totals	47	100.0	71	100.0	223	100.0

Variables	Chi Square	Probability
States versus Tribes	66.2605	p > .001
States versus IHS	111.1858	p > .001

states responding, State officials (88.79%) feel strongly that they do not have jurisdictional rights on Federal Indian Reservations. While at the same time, of the Tribe and IHS reporting, the tribes (63.83%) and IHS (74.65%) do feel that states have jurisdiction on reservations. The analysis of tribal data shows that 28.4% of those initially contacted responded to the questionnaire. This sample may not represent the opinions of those who failed to return questionnaires, or who indicated "Unknown."

In Hypothesis 1 it was expected that the states, the tribes, and the IHS Service Unit Directors would conclusively feel that states do have jurisdictional rights to provide health services on reservations.

The findings do not support these assumptions. The thinking of the three distinct groups vary. While the Tribes and the Service Unit Directors are more inclined to think states do have jurisdictional rights, the states strongly feel these rights do not exist.

Two aspects suggest themselves in Table 4. First, in the previous Table (3), 198 state officials responded that they do not have jurisdiction on Federal Indian Reservations. Yet, in this Table (4), 156 (78.79%) state officials indicated they have gone to a reservation and provided services; second, of those reporting, larger portions of services provided by the states have been in connection with Indian Health Service Units (88.68%). No attempt was made

PROVIDING SERVICES AND RECEIVING SERVICES

Hypothesis 2: There is no significant difference between the opinions of state health officials who indicated they have provided services on Federal Indian Reservations and the opinions of Tribal Chairmen and IHS Service Unit Directors who indicated they have received state services on Federal Indian Reservations.

TABLE 4

COMPARISON OF SERVICES PROVIDED BY THE STATES AND THE SERVICES RECEIVED BY THE TRIBES AND IHS

	Tribe		IHS		State	
	Number	Percent	Number	Percent	Number	Percent
Number indicating they have provided/or received services	25	58.14	47	88.68	156	78.79
Number indicating they have not provided/or received services	18	41.86	6	11.32	42	21.21
Totals	43	100.0	53	100.0	198	100.0

Variables	Chi Square	Probability
States versus Tribes	8.0556	p > .01
States versus IHS	2.6447	NS[1]

[1]NS represents non-significant

to determine the degree or amount of services provided by a state.

It was anticipated in Hypothesis 2 that the states, the tribes and IHS Service Units would agree that states have provided services on reservations. In the case of the IHS Service Units and the states, this assumption was true , indicating that state health programs have provided some services to the Service Units. On the other hand, the tribes have disagreed with the states. This is most striking when one compares the results in Hypotheses 2 to the previous results (Hypothesis 1). For example, the states contended they do not have jurisdictional rights on reservations. Yet, they expressly vouch they have provided services (Hypothesis 2), which finding is supported by IHS, but not by the tribes. Based on these analyses, one must wonder whether, in the eyes of state officials, IHS facilities are considered a part of, or apart from, tribes and tribal reservations.

The rankings in Table 5 were based solely on the number of reservations where each State Health Program Director identified services as having been provided. Where programs failed to list reservations, it was, of course, not included. Specifically, then, citing the Venereal Disease Control program, of the 24 Venereal Disease Control Offices queried (24 Reservation States), those reporting listed as having provided services to 19 Indian Reservations. The small number of reservations served indicates that even the highest

TABLE 5

RANKING OF STATE FORMULA GRANT PROGRAMS BASED ON THE NUMBER OF RESERVATIONS WHERE STATE HEALTH DIRECTORS INDICATED SERVICES WERE PROVIDED

Ranking	Program	Number of Reservations Listed
1	Venereal Disease Control Serivces	19
2	Alcohol Abuse Services	18
3	Mental Health Services	18
4	Crippled Children's Services	16
5	Public Health Services	14
6	Immunization Services	13
7	Drug Abuse Services	12
8	Regional Medical Programs	11
9	Maternal and Child Health Services	7
10	Comprehensive Health Planning	4
11	Health Facilities Construction	3

ranking service is serving a small proportion of the 250 Indian Reservations.

The programs listed are strictly federal formula grant programs to the states; therefore, they should not be presumed to be programs funded directly to the tribes, by-passing the states.

Moreover, a decision was made not to solicit State Areawide 314b programs, but rather to go directly to the State Comprehensive Planning Agencies. This was based on discussions with tribal leaders who related two unfortunate experiences. Repeatedly, they pointed out, they could not get approval from local 314b agencies, much less the state 314a agencies. In California, in an attempt to circumvent this frustration, a tribe[1] submitted a proposal, after repeated rejections by the local 314b agency, directly to the State Comprehensive 314a Agency. It was rejected, stipulating it was mandatory to secure 314b approval. The CHP office in North Dakota reacted in much the same manner, refusing to even entertain a submitted request from a state tribe.[2] Thus it was the intent to determine how many State Comprehensive Planning Agencies (314a) have had experiences with tribes.

Again, the rankings in Table 6 were based solely on the number of state health programs that IHS Service Unit

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[1,2]Upon request of both tribes involved, their names are ommitted.

TABLE 6

IHS SERVICE UNIT RANKINGS OF SERVICES
PROVIDED BY STATE HEALTH PROGRAMS

Ranking	Program	Number of Programs Listed
1	Crippled Children's Services	22
2	Mental Health Services	12
3	Public Health Services	12
4	Venereal Disease Control Services	10
5	Immunization Services	9
6	Maternal and Child Health Services	9
7	Alcohol Abuse Services	5
8	Drug Abuse Services	0
9	Regional Medical Programs	0
10	Health Facilities Construction	0
11	Comprehensive Health Planning Services	0

TABLE 7

TRIBAL CHAIRMEN RANKING OF SERVICES PROVIDED BY STATE HEALTH PROGRAMS

Ranking	Program	Number of Programs Listed
1	Immunization Services	8
2	Alcohol Abuse Services	4
3	Maternal and Child Health Services	2
4	Venereal Disease Control Services	1
5	Mental Health Services	1
6	Public Health Services	1
7	Comprehensive Health Planning	1
8	Crippled Children's Services	0
9	Drug Abuse Services	0
10	Regional Medical Programs	0
11	Health Facilities Construction	0

Directors listed as having provided services. As an example again, of the 71 IHS Service Unit Directors responding, 22 reported that they have received services from States' Crippled Children's Programs, for a 30.9% rate. The rankings are startling, in that one must assume that IHS Service Unit Directors, being highly regarded professionals, are providing accurate data and that services are not being provided to all the IHS facilities or Service Units.

The rankings in Table 7 were derived from the responses of tribal chairmen who listed the state health programs which have provided services on reservations. Of the 88 tribal chairmen responding, eight indicated the Immunization Program as having provided services on reservations. From the low numbers (less than 9% receiving immunization services), it is obvious that tribes are unfamiliar with state health programs.

Table 8 indicates that the state, the tribes, and the IHS Service Unit Directors feel that the states are more than willing to provide health services on rservations, and the tribes and IHS Service Units are more than willing to accept state health services.

The question, then, that one must pose in viewing the above data is: Is it likely that the similarities among these percentages suggest that tribes are truly willing to accept services from the states, in addition to receiving services from IHS or providing them, themselves? The

WILLINGNESS TO PROVIDE AND ACCEPT STATE SERVICES

Hypothesis 3: There is no significant difference between the sentiment of state health officials who stipulate they are willing to provide services on Federal Indian Reservations and the sentiments of Tribal Chairmen and IHS Service Unit Directors who stipulate they are willing to accept services from the state.

TABLE 8

COMPARISON OF STATES' WILLINGNESS TO PROVIDE SERVICES TO INDIANS ON RESERVATIONS AND THE TRIBES AND IHS WILLINGNESS TO ACCEPT STATE SERVICES

	Tribe		IHS		State	
	Number	Percent	Number	Percent	Number	Percent
Number willing to provide/or accept state serivces	42	92.86	36	92.31	117	92.86
Number willing not to provide/or accept state services	6	7.14	3	7.69	9	7.14
Totals	48	100.0	39	100.0	126	100.0

Insufficient data for Chi Square Test

tribal response to this question may be effected by the methodology for this research. Those tribes responding are more likely to work with state government than those not responding. Furthermore the tribal leaders might have been more willing to state their doubts about state agencies in a personal interview than in a questionnaire.

Insufficient numbers on the cells of the matrix prohibited a Chi Square test.

In Table 9 the difference in the percentages between the states (40.69%) and the tribes (73.33%) in the line "has not applied" strongly suggest that tribes rarely apply for services from the states. On the other hand, IHS Service Unit Directors are more inclined to seek state health services. The underlying issue embraces the question as to whether IHS facilities seek state health services in areas of their own shortcomings.

Hypothesis 4 suggests that the IHS has applied to the states for health services and that tribes have not applied and are unaware of the efforts of IHS in this area. The data reveals a communication gap between IHS and the tribes with regard to application for state services and monies.

Analysis of this data shows that only IHS and state health officials are in agreement. This indicates, therefore, IHS Service Units have applied for state health services. Tribal data, on the other hand, indicates that tribes have not applied for state health services.

APPLIED FOR STATE SERVICES

Hypothesis 4: There is no significant difference between the replies of state health officials and those of Tribal Chairmen and IHS Service Unit Directors who indicate that they have applied for state services.

TABLE 9

COMPARISONS OF STATE HEALTH OFFICIALS, TRIBAL CHAIRMEN, AND IHS SERVICE UNIT DIRECTORS RESPONSES OF HAVING APPLIED FOR STATE HEALTH SERVICES

	Tribe		IHS		State	
	Number	Percent	Number	Percent	Number	Percent
Number indicating Tribe or IHS has applied for State Health Services	12	26.67	46	71.88	121	59.31
Number indicating Tribe or IHS has not applied for State Health Services	33	73.33	18	28.12	83	40.69
Totals	45	100.0	64	100.0	204	100.0

Variables	Chi Square	Probability
States versus Tribes	15.7900	$p > .001$
States versus IHS	3.2732	NS[1]

[1] NS represents non-significant

IHS APPLIED FOR SERVICES ON BEHALF OF TRIBES

Hypothesis 5: There is no significant difference between responses of state health officials from those of the Tribal Chairmen and IHS Service Unit Directors who indicate that an Indian health facility, on behalf of a tribe or individual, has applied for state services in the past two years.

TABLE 10

COMPARISONS BETWEEN THE RESPONSES OF THE STATE, TRIBE, AND IHS CONCERNING WHETHER IHS HAS MADE APPLICATION FOR STATE HEALTH SERVICES FOR A TRIBE OR TRIBAL INDIVIDUAL

	Tribe		IHS		State	
	Number	Percent	Number	Percent	Number	Percent
Number indicating IHS has applied for services for Tribe or individual	6	19.36	27	69.23	122	64.21
Number indicating IHS has not applied for services for Tribe or individual	25	80.64	12	30.77	68	35.79
Totals	31	100.0	39	100.0	190	100.0

Variables	Chi Square	Probability
States versus Tribes	22.0015	p > .001
States versus IHS	0.3588	NS[1]

[1] NS represents non-significant

From the data in Table 10, it appears that considerably more IHS Service Units (69.23%) have applied for services for tribes or tribal individuals than the tribes (19.36%) have indicated. In retrospect, the question in the IHS questionnaire may have been misinterpreted; that is, Service Unit Directors could have interpreted this to mean that they were attempting to secure services for their own facility rather than assisting the tribe or individual to obtain control and manage state health programs. The same logic could be applied to the responses of the state.

A weakness, it appears, exists in Question six of the questionnaires. No follow-ups occurred to test this premise. Based on the results reported however, Hypothesis 5 postulates, according to the tribes, that IHS has not exerted any effort in their behalf concerning outside resources.

From one standpoint as seen in Table 11, states rate tribes considerably higher than tribes rate the states. The IHS, unlike the tribes, rate states considerably higher also. There are, no doubt, many reasons why tribes rate states low in cooperation, unrelated, possibly to program cooperation. Herein lies another excellent research study from this initial investigation.

TABLE 11

RATING OF STATES BY TRIBES AND IHS
AND RATING OF TRIBES BY STATES

Scale	How States Rate Tribes		How Tribes Rate States		How IHS Rate States	
	Number	Percent	Number	Percent	Number	Percent
Outstanding	9	4.0	1	1.7	15	21.1
Good	98	44.0	8	13.8	21	29.6
Average	52	23.3	10	17.2	25	35.2
Poor	16	7.2	25	43.1	7	9.9
No Comment	48	21.5	14	24.2	3	4.2
Totals	223	100.0	58	100.0	71	100.0

The data in Table 12 could be viewed from many perspectives. What is acceptable as a basis for inference depends a great deal upon ones own interest. Nevertheless, one cannot overlook the fact that the states, in seeking Tribal information, seek out a variety of sources. It may well be concluded the entity contacted depends entirely on the information wanted. In the questionnaire (Question 8), the names of entities or agencies were purposely omitted. In addition, no reference to "health" was made in the question. It was intended to permit the respondent to name the

TABLE 12

CONTACT POINTS BY STATES, TRIBES AND IHS WHEN SEEKING STATE AND TRIBAL INFORMATION

Entity	Who States contact when seeking Tribal Information		Who Tribes contact when seeking State information		Who IHS contacts when seeking State information	
	Number	Percent	Number	Percent	Number	Percent
Indian Health Service	35	20.2	2	4.7	13	19.1
Bureau of Indian Affairs	23	13.3	1	2.3	0	0.0
State Indian Affairs Commission	34	19.7	6	14.0	1	1.5
Tribal Organization	25	14.4	2	4.7	0	0.0
Tribal Individual	13	7.5	0	0.0	0	0.0
State Health Programs	2	1.2	10	23.2	35	51.5
Local Health Departments	1	0.6	2	4.7	9	13.2
Others	40	23.1	20	46.4	10	14.7
Totals	173	100.0	43	100.0	68	100.0

organization of his own choosing. An interesting observation occurs in the IHS column, where IHS in seeking state information, first contacts a colleague for initial information.

INDIAN MEMBERS ON STATE HEALTH BOARDS

Hypothesis 6: There is no significant difference between the answers of state health officials from those of Tribal Chairmen and IHS Service Unit Directors who maintain there is an Indian member who resides on a reservation on a state-operated health advisory board.

TABLE 13

STATE, TRIBAL, AND IHS RESPONSES STIPULATING THAT TRIBAL MEMBERS RESIDING ON RESERVATIONS ARE ON STATE HEALTH BOARDS

	Tribe		IHS		State	
	Number	Percent	Number	Percent	Number	Percent
Number indicating Tribal member who resides on reservation is on State Board	10	25.00	24	55.81	119	58.91
Number indicating Tribal member who resides on reservation is not on State Board	30	75.00	19	44.19	83	41.09
Totals	40	100.0	43	100.0	202	100.0

Variables	Chi Square	Probability
States versus Tribes	15.4256	p > .001
States versus IHS	0.1400	NS[1]

[1] NS represents non-significant

Tribal Chairmen (25.00%) have a different interpretation of what constitutes a tribal member, residing on a reservation than do the state officials (58.91%) and the IHS Service Unit Directors (55.81%). Are state officials viewing Indian Board members as "Indians" rather than participating tribal members? For example, in reviewing the tribal names listed by one state official, it appears that the Indians selected for board membership was more for tokenism than for their active roles in tribal government. Specifically, of the two Indians listed by one state official, one was a retired Bureau of Indian Affairs Superintendent and the other was a Superintendent of a middle class, white, public school located on the reservation.

Regardless, Hypothesis 6 suggests that Indian members residing on reservations are members of state operated health advisory boards. Yet, analysis of the data shows that significant difference of opinions exist between the state and tribal officials. IHS Service Unit Directors appeared to uphold the states conviction that tribal members are on state health boards. Perhaps, as pointed out, the criteria Tribal Chairmen use in validating tribal membership in undoubtedly different from those used by the state and IHS officials. Tribes evidently may not view retired BIA Superintendents or Public School Superintendents as authentic tribal representatives, particularly if they belong to a different tribe.

ABILITY TO NAME INDIAN MEMBERS ON STATE HEALTH BOARDS

Hypothesis 7: There is no significant difference between the ability of state health officials and Tribal Chairmen and IHS Service Unit Directors to name the tribal member on state health advisory boards.

TABLE 14

ABILITY OF STATE, TRIBE, AND IHS TO NAME TRIBAL MEMBER ON STATE HEALTH BOARD

	Tribe		IHS		State	
	Number	Percent	Number	Percent	Number	Percent
Number that could name Tribal member on State Health Board	5	100.0	20	90.91	34	34.34
Number that could not name Tribal member on State Board	0	0.0	2	9.09	65	65.66
Totals	5	100.0	22	100.0	99	100.0

Variables	Chi Square	Probability
States Versus Tribes	Insufficient Data	
States versus IHS	23.3070	p > .001

From the data, both the tribes (100.0%) and the IHS Service Unit Directors could recall the name of the tribal member on State Health Boards while state officials (34.34%) have less ability to name the tribal member. Viewed differently, in Table 13 where state officials indicated 119 tribal members were on their state health boards, they could name only 34, for a 34.34% recall. While the tribes indicated five Indian members and IHS twenty-four members, the tribes could name all five for a 100.00% recall and the IHS named 20 for an amazing 90.91% recall.

The ability to name the tribal member on state health boards could strongly eliminate the suspicion that Indian board members are appointed for tokenism. There appears to be a marked inability on the part of state officials to name the Indian members on the state health boards. Contrarily, IHS Service Unit Directors appear to work considerably closer with selected Indian state health board members than do the state officials. Insufficient data within the cells of the tribal matrix prohibited Chi Square analysis.

The impression one obtains from the data in Table 15 is that the states, the tribes and the IHS Service Units are obviously working closely with certain individuals. The reasons are obvious enough: the state (31 for 93.94%) could name the tribe of the 34 Tribal individuals recalled in Table 14. This has meaning for many reasons since the

ABILITY TO NAME TRIBE OF TRIBAL MEMBERS

Hypothesis 8: There is no significant difference between the abilities of state health officials and Tribal Chairmen and IHS Service Unit Directors to name the tribe of the tribal member on the state health advisory boards.

TABLE 15

ABILITY OF STATE, TRIBE, AND IHS TO NAME THE TRIBE OF THE TRIBAL MEMBER ON STATE HEALTH BOARD

	Tribe		IHS		State	
	Number	Percent	Number	Percent	Number	Percent
Number that could name Tribe of Tribal member on State Health Board	5	100.0	20	100.0	31	93.94
Number that could not name Tribe of Tribal member on State Health Board	0	100.0	0	100.0	2	6.06
Totals	5	100.0	20	100.0	33	100.0

Insufficient data for Chi Square Test

knowledge of tribal affiliation carries credence, particularly with Indians; it also substantiates a working relationship with certain tribal people. The tribes (100%) and IHS (100%) showed an extremely close working relationship with certain individuals. On the other hand, one could assume that 85 of the original 119 tribal members listed by the states are

functioning ineffectively, purposely or otherwise. The total number of Indian board members is questionable and should be scrutinized by tribes to determine if Indian members are truly a part of the functioning tribal governments.

One of the possible avenues for tribal governments to obtain control of programs (and also to improve methods for their own health delivery services) is through obtaining contracts with states, via the federal health programs which are channeled through the states. This is particularly true where federal health programs, with restricted Public Laws, cannot contract directly with tribes. Therefore, the implied assumption in Hypothesis 9 seeks to answer whether states, within their authorities, can grant to or contract with tribes, and, whether tribes, within their authorities, can contract with states. All indications suggest that both the states and the tribes do have this authority. Herein lies a possible avenue for tribal resources.

Hence, 80.85 percent of state health officials reporting have stated that it is legal within their authorities to contract their programs to tribes. The tribes (93.62%) at the same time, indicate that within the legal authorities of Tribal Governments it is permissible to accept grants/contracts from the states. There appears to be less confusion on this issue at the state, tribal and IHS level than at the regional and national level.

LEGALITY OF GRANTING OR CONTRACTING STATE HEALTH PROGRAMS

Hypothesis 9: There is no significant difference of opinion between state health officials who think that it is legal to grant to tribes and tribes and IHS who think it is legal for tribes to accept state health programs.

TABLE 16

COMPARISON OF OPINIONS OF STATE, IHS, AND TRIBAL OFFICIALS WHO INDICATE IT IS LEGAL TO GRANT OR ACCEPT STATE HEALTH PROGRAMS

	Tribe		IHS		State	
	Number	Percent	Number	Percent	Number	Percent
Number indicating it is legal to grant/contract (State) or control (Tribe) State Health Programs	44	93.62	34	89.47	152	80.85
Number indicating it is not legal to grant/contract (State) or control (Tribe), State Health Programs	3	6.38	4	10.53	36	19.15
Totals	47	100.0	38	100.0	188	100.0

Variables	Chi Square	Probability
States versus Tribes	1.6760	NS
States versus IHS	1.6130	NS

WILLINGNESS TO GRANT, TO ASSUME CONTROL AND CAPABILITY TO MANAGE

Hypothesis 10: There is no significant difference between the opinions of state health officials who are willing to grant/contract to tribes, tribes willingness to assume control, and IHS opinion that tribes are capable of managing state programs, or portions thereof.

TABLE 17

WILLINGNESS OF STATES TO GRANT/CONTRACT TO TRIBES, TRIBES WILLINGNESS TO ASSUME CONTROL, AND IHS OPINION THAT TRIBES ARE CAPABLE OF MANAGING STATE PROGRAMS, OR PORTIONS THEREOF

	Tribes Willingness to assume control of State Health Programs		IHS opinion tribes capable of managing State Health Program		States willingness to grant/ contract with Tribes	
	Number	Percent	Number	Percent	Number	Percent
Yes	42	93.33	43	82.69	123	91.11
No	3	6.67	9	17.31	12	8.89
Totals	45	100.0	52	100.0	135	100.0

Variables	Chi Square	Probability
States versus Tribes	Insufficient Data	
States versus IHS	2.6691	NS

As a follow-up to Hypothesis 9 which ascertains the legal aspects of contracting state programs to tribes, Hypothesis 10 explored the willingness of states to grant or contract their state health programs, or portions thereof, to the tribes, and the tribes willingness to enter into contracts with the states. Insufficient tribal data on this issue prohibited a Chi Square analysis.

It may be that the percentages above are indicative of state, tribal and IHS officials intent, even among those who failed to report on this particular issue. On the other hand, this may not be true. IHS officials (82.69%) feel quite confident that the majority of Tribal Governments possess the capacity to assume control and manage state health programs, or portions thereof. On the surface, it would seem that the states (91.11%) and the tribes (93.33%) would accept this route, if necessary.

Additional research should be conducted before any deductions are made on this issue because there appears to be a weakness in the question structure, in that Question 11 of the State Questionnaires asked: "Would your office be willing to grant to or contract your program, or portions thereof, to local Tribal Governments...?" In the IHS Service Unit Questionnaire, Question 11 asked "...is the tribe, or tribes, at your Service Unit capable of assuming control and managing a state health program, or portions thereof, for their tribe?"

Specifically, IHS was asked to judge the capability of tribes to assume control of state health programs while states were asked if they were willing to grant their programs to tribes.

In spite of the assumptions one could draw from the previous Table 17, a more definitive and pronounced stand was taken on Question 12 of the questionnaire by state and tribal officials. Specifically, 88.89% of the state officials reporting do not feel that federal formula grant monies should go directly to Tribal Governments. At the same time, 100% of tribal chairmen feel otherwise. IHS Service Unit Directors tend to agree with the tribes, but not overwhelmingly. There appears to be evidence that tribes much prefer to by-pass states unless no other avenue is available.

Viewed in light of Table 18, one would also assume that tribes, unmistakably, would opt for dealing directly with the federal health programs. On the other hand, if such opportunities are not available, it appears that tribes would settle for an alternative state route, but reluctantly.

FORMULA GRANT MONIES DIRECTLY TO TRIBAL GOVERNMENTS

Hypothesis 11: There is no significant difference between the opinions of state health officials and Tribal Chairmen and IHS Service Unit Directors who feel that the formula grant monies now apportioned to the states should go directly to tribal governments for application on reservations.

TABLE 18

OPINIONS OF STATE, TRIBAL AND IHS OFFICIALS AS TO WHETHER FEDERAL FORMULA GRANT MONIES, NOW APPORTIONED TO THE STATES, SHOULD GO DIRECTLY TO THE TRIBES

	Tribe		IHS		State	
	Number	Percent	Number	Percent	Number	Percent
Number indicating Federal formula grant monies should go directly to the Tribes	50	100.0	39	69.64	15	11.11
Number indicating Federal formula monies should not go directly to the Tribes	0	0.0	17	30.36	120	88.89
Totals	50	100.0	56	100.0	135	100.0

Variables	Chi Square	Probability
States versus Tribes	126.5000	p > .001
States versus IHS	66.8691	p > .001

SHOULD THE TERM TRIBES OR INDIANS BE INCLUDED IN FEDERAL HEALTH PROGRAM APPLICATION AND ELIGIBILITY REQUIREMENTS

Hypothesis 12: There is no significant difference between the opinions of state health officials and Tribal Chairmen and IHS Service Unit Directors who feel that the term Tribal Governments or Indians should be included in the application and eligibility requirements of federal health programs.

TABLE 19

STATE, TRIBAL AND IHS OPINIONS AS TO WHETHER THE TERM TRIBAL GOVERNMENTS OR INDIANS SHOULD BE INCLUDED IN THE APPLICATION AND ELIGIBILITY REQUIREMENTS OF FEDERAL HEALTH PROGRAMS

	Tribe		IHS		State	
	Number	Percent	Number	Percent	Number	Percent
Number indicating term Tribal Government/ Indians *should* be included in FHP application and eligibility requirements	47	94.00	55	91.67	69	50.00
Number indicating term Tribal Government/ Indians *should not* be included in FHP application and eligibility requirements	8	6.00	5	8.33	69	50.00
Totals	55	100.0	60	100.0	138	100.0

Variables	Chi Square	Probability
States versus Tribes	30.0690	$p > .001$
States versus IHS	31.0815	$p > .001$

Here again, both the tribes and the IHS Service Unit Directors strongly contend that the term "Tribal Governments," or "Indians," should be included in the application and eligibility requirements of federal health programs, but the states, to a degree, feel otherwise. In viewing the state's percentages, state health officials are divided on this issue (yes: 50% and no: 50%). The tribes (94.00%) evidently would welcome this opportunity, perhaps thinking such an avenue would result in more dividends than they now receive from federal health programs.

An investigation as to the differences between the state responses, themselves, would be an appropriate and worthwhile study. This, as with other findings in this study, would add considerable knowledge to the relationships between the states and tribes and the results could have international implications, especially in developing countries such as South America, or Australia, where similar tribal groups are being manipulated by local, state and federal governments apparently much in the same manner as tribes in this Country.

According to the results regarding Hypothesis 13, there was a significant difference of opinion between state health officials and tribal chairmen as to whether there has been coordination between the states and tribes in the development of State Plans. Conversely, the IHS Service Unit Directors indicated that such coordination has occurred

COORDINATION WITH TRIBES IN DEVELOPMENT OF STATE HEALTH PLANS

Hypothesis 13: There is no significant difference between the responses of state health officials from Tribal Chairmen and Indian Health Service Unit Directors with regard to coordination occurring between the state and the tribes in the development of State Plans.

TABLE 20

STATE, TRIBAL, IHS OPINIONS WHETHER TRIBES HAVE BEEN INVOLVED IN THE DEVELOPMENT OF STATE HEALTH PLANS

	Tribe		IHS		State	
	Number	Percent	Number	Percent	Number	Percent
Number indicating Tribe/IHS have been involved in the development of State Health Plans	1	9.09	5	26.32	27	46.55
Number indicating Tribe/IHS have not been involved in the development of State Health Plans	10	90.91	14	73.68	31	53.45
Totals	11	100.0	19	100.0	58	100.0

Variables	Chi Square	Probability
States versus Tribes	5.3800	$p > .05$
States versus IHS	2.4131	NS

between the two entities. A thought in retrospect again, the criteria governing what represents "Tribal Representatives" could have influenced the results.

Impressions from the above data, however, show the states have prepared State Plans without input from the tribes. Of those reporting between the tribes and IHS, 90.91% and 73.68% respectively, indicate they have not been involved in the coordination of State Health Plans. The states take a somewhat different position; only 53.45% contend tribes have not been involved.

One of the stipulations of most formula grant programs is that state citizens must be notified as to the location and kinds of services available in the programs. Tribal Chairmen (73.33%), however, report in this study that they are not informed as to the location and kinds of state health services available.

Specifically, Table 21 suggests that whatever information that is distributed from the state health offices, IHS receives most of it (72.86%). However, the results, as with other Chi Square results, show that IHS Service Units receive insufficient information from state health officials in spite of the percentages. Tribal leaders receive even less information than do IHS Service Unit Directors.

It could be concluded, then, that states have made little effort in informing tribes or IHS Service Units as

INFORMING TRIBES/IHS OF STATE HEALTH SERVICES

Hypothesis 14: There is no significant difference between the replies of state health officials from Indian Health Service Unit Directors and Tribal Chairmen who say they have been informed of state health services.

TABLE 21

STATE, TRIBAL, IHS OPINIONS WHETHER TRIBES HAVE BEEN INFORMED AS TO LOCATION AND KINDS OF STATE HEALTH SERVICES THAT ARE AVAILABLE

	Tribe		IHS		State	
	Number	Percent	Number	Percent	Number	Percent
Number indicating Tribes/IHS have been informed of location and types of State Health services available	12	26.67	51	72.86	159	87.36
Number indicating Tribes/IHS have not been informed of location and types of State Health services available	33	73.33	19	27.14	23	12.64
Totals	45	100.0	70	100.0	182	100.0

Variables	Chi Square	Probability
States versus Tribes	71.5231	p > .001
States versus IHS	7.6589	p > .01

to the location and kinds of services available in state health programs.

In concluding this Chapter, it might be of interest to the reader that the non-responses would probably have generated more rather than less of a difference of opinions between the groups. Further clarification of this statement can be found in the following Chapter.

CHAPTER VI

DISCUSSION AND IMPLICATIONS

In their struggle toward a more self-determined life, American Indians and Alaskan Natives have been telling the majority culture, especially the federal government, that their basic goal is a better way of life, determined and directed toward the values and methods understandable and acceptable to them as a group of people. From the earliest attempts to destroy tribal life down to the acculturation period of the 1950's, federal administration policies have vacillated regarding Indians and their destiny. The Nixon administration began another transitional period largely dedicated to permitting Indians to remain Indians, and developing tribes into economically sound sovereignties.

There are many facets to be developed in the growth of any viable society, and certainly health is a major component. For Indians to grow and become self-sufficient while remaining Indians, opportunities for health must be provided the tribes. Therefore, if this effort toward self-sufficiency is to become a reality, Indians must control and manage programs as do other governing bodies at local levels. Until now, the trend has been to do "for"

Indians, rather than provide opportunities to Indians to do for themselves. This is particularly true in the field of health.

Although some tribes have not acquired the necessary managerial or professional knowledge in health fields, progress is being made by many tribes. Initial credit can be given to the liberal philosophy of the former Director of the OEO Indian Desk, Dr. Jim Wilson, Oglala Sioux, and Dr. Emery A. Johnson, Director, Indian Health Service. Their willingness to understand tribal ways of accomplishing tasks and their confidence in tribal governments set the stage for tribes to function within the parameters where they felt most comfortable, even when such actions were contrary to white, middle class expectations. Many of the tribal accomplishments can be explained simply by the fact that tribes, for the first time, administered programs within the framework of Indian philosophy and thinking.

If additional opportunities are to be forthcoming in the health field, the national offices remain the crucial force in assisting tribes, supported by appropriate actions in regional and state offices. Opportunities lie at these levels for permitting tribal control of programs. The national and regional levels must provide proper interpretations of guidelines and establish policies which are supportive of Indians and their particular needs. Consequently, any responsibility for successes or failures in

tribal participation in federal health programs rests at these levels.

The intent of this dissertation was to investigate the relationship between federal health programs and federally recognized Indian tribes and Alaskan Natives, with particular emphasis on those federal formula grant programs funded through the states. Also, the intent was to collect baseline data that could lead to more definitive research and ultimately provide guidance for more active participation of Indians in federal health programs. This study was seen as especially important since minimal significant research and investigation has been conducted relating to the tribes and federal health programs.

The descriptive investigation recorded the number and dollar amounts of grants to tribes, documented providers' perceptions of whether tribes do or do not meet program requirements for funding of federal health programs, and their perception of the administrative levels that have review, rejection, approval, and funding authorities for their programs. The relationship investigation, an exploratory study, identifies the variables that influence the relationship between the state formula grant programs and Native Americans. It also analyzes the perception of tribal leaders, state officials, and IHS Service Unit Directors toward each other and toward these formula grant programs.

Federal Health Programs and Indians

As pointed out elsewhere in this paper, direct funding to tribes has been limited, and certain underlying assumptions of federal health officials seemingly influence their decisions regarding Native Americans.[1] The following quotes give additional insight into the basis of confusion among national and regional program directors as to the legality of funding directly to tribes. Program directors at these two levels appear divided as to whether direct funding is prohibited or permissible:

> Tribes must become incorporated in order to be eligible to receive assistance under project grants.
>
> Applicants must be non-profit or public organizations.
>
> The regional office is limited in its rejection authority due to the wording in the law; political sub-divisions, local health authorities, non-profit organizations. Tribes do not qualify under these terms.
>
> The Secretary (DHEW) is authorized to make project grants to states and, in consultation with State Health Authority, to political sub-divisions of states, this is interpreted by---------- to exclude Indian tribes.
>
> Our programs are for state and local governments. Since Indian tribes are not a state or a local government entity, they are not eligible.

Although these examples should not be considered as representative for all programs, the attitude appears rather

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[1] These and other quotes were extracted from the returned questionnaires. Their confidentiality will be respected.

widespread among federal program officials. In describing Public Health Laws and Regulations as they relate to Indians, federal health program directors vary considerably within the same programs. It seems incumbent upon federal officials or the General Counsel, or both, to ascertain the eligibility of tribal governments for federal health programs. Specifically: "Do federally recognized American Indians and Alaskan Natives qualify under the terms as written in the eligibility and applicant requirements of federal health programs?"

Also, program officials have different opinions as to where proposals should be submitted and who has rejection, approval, and funding authority. A detailed discussion of this subject was provided in Chapter V. It is re-emphasized however, that if practical and possible, uniformity should be instituted within each of the programs.

Federal/State Formula Grant Programs

Chi Square tests were conducted to determine if any differences between the states and the tribes and the states and IHS were due to sampling bias. The states were divided into two equal groups: northern and southern. This was essential since samples from certain areas were not large enough to test as individual states and a disproportionate number of responses were received from some states. Since more returns came from certain geographical areas,

TABLE 22

COMPOSITE DATA - STATES AND TRIBES

	States	Tribes	Total
North	107	39	146
South	116	49	165
Totals	223	88	311

χ^2 = .341 Probability - NS

TABLE 23

COMPOSITE DATA - STATES AND IHS

	States	IHS	Total
North	107	37	144
South	116	34	150
Totals	223	71	294

χ^2 = .3676 Probability - NS

particularly tribal returns, it was essential to see if such geographical sampling influenced the results. A divisional line, from the northern boundary line of California eastward, was used to divide the states into two equal groups, 12 states each.

Chi Square analyses show that the results obtained were not due to sampling bias generated by non-responses. There is no evidence to believe that significant differences presented in Chapter V can be explained as being a result of differential response rates from varying parts of the country among the three groups.

In Table 24, the differences of opinions, or agreements, between the states and the tribes and the states and IHS are presented in summary form. The lack of sufficient data in some of the cells of the matrix prohibited Chi Square analyses. The author feels that had these data been obtained, a difference of opinions would have occurred between these groups. Possibly some individuals within the groups have had no experience in the related programs and, as a result, responded with blanks or unknowns. Any experience, it is deduced, were reported as favorable or unfavorable -- yes or no.

Considered another way, in instances where there were favorable experiences or unfavorable ones, these individuals were more apt to respond to the specific questions. Those who had no experiences were more or less at a loss

as to the appropriate answer and thus replied with "unknown" or gave no answer whatsoever.

It can be concluded from Table 24 that more differences of opinions exist between the tribes and the states (9) than between the states and IHS (5). The tribes and IHS however, both differ from the state in some areas (5). The state and IHS were different than the tribes in other areas (3). In commenting on the jursidiction question, many state officials (198) feel strongly that they have no jurisdiction on reservations.

This can best be illustrated by relating an incident that occurred recently between the Paiutes (Pyramid Lake Indian Reservation) and the State of Nevada. According to tribal sources,[1] the tribe, hiring qualified professionals, conducted a study verifying and documenting the need for a nursing home facility. The tribe offered unlimited land for site construction and $95,000 cash in support of their need for the facility, which was verified by the study.

The Paiutes request for the nursing home was rejected by the State of Nevada Advisory Council, which gave the lack of jurisdictional authority as the factor in denying the request.

The following comments by regional and state Hill-Burton officials will provide additional insight into the

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[1]Personal conversation with Ted James, former Chairman, Pyramid Lake Indian Reservation, Nevada.

TABLE 24

SUMMARY OF HYPOTHESES

Hypotheses	Variables	States vs Tribes	States vs IHS
1	States Jurisdiction on Reservations	S[1]	S
2	States Having Provided Services	S	NS[2]
3	Willing to Provide/and Accept State Services	L[3]	L
4	Applied for State Health Services	S	NS
5	IHS Applied in Behalf of Tribes	S	NS
6	Indians on State Health Boards	S	NS
7	Ability to Name State Indian Board Members	L	S
8	Ability to Name Tribe of State Indian Board Members	L	L
9	Legality to Grant to/or Accept State Health Programs	NS	NS
10	Willingness to Grant to/or Accept State Health Programs	L	NS
11	Federal Formula Grant Monies Directly to Tribes	S	S
12	Term: Indians Included in Federal Eligibility Requirements	S	S
13	States Coordination with Tribes in State Plans	S	NS
14	States Informing Tribes/IHS of Available Services	S	S

[1]S indicates there is a significant difference of opinions between the groups.

[2]NS indicates there are no significant differences of opinion between the groups.

[3]L indicates a lack of sufficient data in the cells of the matrix to run Chi Square tests.

jurisdiction question:

> To our knowledge there has not been a grant made for facilities within the confines of an Indian reservation. This is primarily because of the reluctance of the tribes to allow state authorities to license facilities.
>
> We can't provide funds for Indians on reservations; there has to be other people in the area besides Indians.
>
> The answers to Nos. 14 and 15 are answered in the negative because our State Plan for construction requires the utilization of Hill-Burton monies to provide a community service. Reservation facilities provide services to a restricted clientele.
>
> We do not have the problem as no health facilities are on Indian reservations.

Another regional official states, after citing some laws and regulations:

> Based on the above requirements, facilities constructed (by other than Indians) with Hill-Burton monies would be available to members of tribes; however, the State Agency could not recommend nor regional office approve grants for facilities to tribes as applicants.

It appears that tribes, through no fault of their own, are being penalized for being within the confines of reservations.

IHS Service Units (25.35% reporting) may be limiting possible opportunities for tribal people: "These services are not provided by the state on the reservation as the state has no legal jursidiction on the reservation." Based on this quote, it appears that IHS staff should also clarify the question of state services on reservations. In this situation it is altogether possible that local

tribal governments or health boards have instructed IHS staff to reject state services. A tribal member commented: "Direct funding would solve many of the problems related to state-assumed jurisdiction since on the one hand we need and desire the services but cannot agree with state jurisdiction over regulation and enforcement."

Hill-Burton legislation may be replaced in the near future, but the implications and fallacies of such laws and regulations remain. Another weakness implied by the tribes was the fact that state boards, for the most part, are appointees of the governors and do not adequately represent Indians. It was maintained that the majority of the state board members were non-Indians from larger cities. Also, some tribes indicated that the Indians that were on the boards were not necessarily the ones tribal governments would select if given the opportunity to do so.

It might be added that prior to the mailing of the questionnaire, there had been an approval of Hill-Burton monies for a nursing home facility on a reservation. Yet this was not common knowledge among other Hill-Burton officials, or they possessed a completely different attitude about tribes. Arizona, which gave the approval, transferred its certification and licensing authorities to the Indian Health Service. This procedure, perhaps, could be applied to other federal health programs where tribes are reluctant to deal with the states.

The fallacy in such laws and regulations as Hill-Burton and other formula grant programs is that millions of federal dollars have gone to the states in behalf of tribes.

This was questioned on several fronts:

> State Official: "In ---- as elsewhere, organizations will proclaim they are going to serve reservations with the federal money they apply for, but little or no services ever reach the reservations.
>
> State Official: Indian statistics are used to gain federal dollars without consulting the tribes and seldom provide services when the money comes.
>
> IHS Official: There is a strong belief that the state 'uses' Indian presence and does not give tribal people their fair share of federal monies. There is considerable distrust among Indian people and state agencies, exacerbated by many years of court battles over treaty rights and fishing especially.
>
> IHS Official: All too often the Indian people are included in state statistics for grant and funding purposes and then rapidly are converted to wardship (Federal) status upon receipt of the monies.
>
> IHS Official: Indian needs are, in my opinion, largely by-passed unless politically expedient at a given time.
>
> Tribal Official: This topic was discussed with the chief. He felt that some state agencies use the numbers (people) on the reservation but we did not receive our 'just' share.
>
> Tribal Official: If Tribal members are counted in determining state's appropriation of federal grant monies toward state health programs, then our Tribal Council and local health board would like to know what these programs are.

TRIBES AND THE IHS AND BIA

More often than not, difficulty is encountered by the tribes or tribal members because they happen to be associated with but not regulated by the Indian Health Service or Bureau of Indian Affairs:

> Students applying ..... training courses must have approval of the supervisor of their agency -- local, state, or federal. Reservation Indians normally approved by the Indian Health Service Unit Director or Area Office.
>
> Indians have their own program in the Indian Health Service.
>
> ..... has an agreement with IHS that IHS will provide care on reservations while ..... provides care to communities in need off-reservation.
>
> The BIA doesn't want us to serve or work with Indian people.

Neither the IHS nor BIA has any regulatory control, or laws, influencing tribes in relation to federal health programs. Secondly, the author's experience indicates that the IHS, and presumably the BIA, welcomes additional resources to tribes because of their restricted budgets. Also, many federal health agencies have programs and accompanying program authorities which the tribes need that do not exist in either the IHS or BIA.

Tribal Capabilities

Until the Indian Reorganization Act, tribes had little experience in controlling programs. In recent years, tremendous strides and advances have occurred within many

tribes and, today, their abilities are comparable to other local governments. They may be more capable, in fact, than local governments when program application pertains to tribal people on reservations. Yet, the misconception that tribal governments are inept still exists among many program officials:

> ..... grants are scientific, technical, and/or educational. Tribes do not have the requisite expertise and resources to be eligible.
>
> Technical requirements for ..... grants/ contracts would be beyond the interest and expertise of the subject groups.
>
> These are awarded nationally and Indians are eligible to attend, but such grants could not be carried out by a tribe.
>
> Lord no! They can't do a thing for themselves. They've had things done for them so long they can't do a thing. We'd be throwing money away.
>
> It appears to me the Indians are getting their fair share, however, they really haven't learned how to manage same as yet. I don't think BIA or Indian Health Service is helping to solve their problems in many situations.
>
> Indians don't know how to deliver health care. Definitely no!

Lack of data in the cells of the matrix relating the willingness of states to contract to tribes and tribes' willingness to do so prohibited Chi Square analysis. Here again, the unknown and no responses would probably influence a greater difference of opinion. The data between the states and IHS (82.68%) reflects that tribes are capable of managing health programs, as illustrated by the following:

> Rocky Boy has a working health board that could handle programs now being administered by the state and PHS; hopefully they could take over the PHS clinic in a couple of years.

On the other hand, not all IHS Service Unit Directors (17.31%) possess the same confidence about the tribes in their areas:

> The paranoia about unfair practices towards Indians is understandable, but giving tribes money to develop their own health programs in lieu of per capita funding of state programs would be disastrous in my view.

While tribes and tribal governments have progressed tremendously the past few years, significant variations in management sophistication do exist among the tribes. As a result, it would seem unwise for federal officials to categorize all tribal units into a single stereotype since an overwhelming majority of tribes do possess effective and capable tribal management offices. Given the opportunity others will become equally adept.

Tribal Health Authorities/Organizations

Within many tribal government structures, tribal health authorities have emerged with highly capable staff. Developing tribal health authorities are hiring health professionals: physicians, health administrators, dentists, registered nurses, health planners, sanitarians, as examples, with advanced university degrees.

This suggests that tribes have, or are in the process of developing, capable health program entities.

Currently, the Navajo, Oglala Sioux, the United Southeastern Tribes, the California Rural Indian Health Board, the Papagos, and others have established functioning health components. The majority of the 250 tribes have health advisory boards. In addition, there are 12 area and one National Indian Health Board which functions in behalf of tribes. The question remains: "Are these health authorities and/or tribal governments eligible for direct funding from federal health programs?"

One regional official, when responding to the question regarding situations needing correction before grants/contracts can be made to tribes declared: "This is a stupid question, but one answer might be to get Congress and the Administration to amend the law to read 'to make grants to state health or mental health authorities' and all Indian tribes! None of the above are recommended. Funds under this authority may be expended for services on a reservation or by the tribes <u>if</u> the states elect to distribute the funds to them."

As has been observed in Chapter V, however, these are relevant and important issues to the tribes. The statement "if states elect" indicates that tribes are at the mercy of the states with the results showing that states have not displayed an eagerness to provide services on reservations. "Amending the laws" could take many years. This would entail waiting until each law neared termination

and then expeditiously attaching an amendment in behalf of tribes to the newly written law. A more immediate approach exists via executive orders by presidents, as former President Lyndon B. Johnson enacted in his Indian message of March 6, 1968: "To launch an undivided, government-wide effort in this area, I am today issuing an Executive Order..."[1]

The remaining issues cited by the quoted regional official possibly reflect the feelings of some state officials. The author, therefore would leave any interpretation of these to the reader.

Tribes Subjected to States

The data in services to tribes shows that states, areawide offices, and local health departments hold considerable power over programs going to reservations. For example, Areawide 314b and 314a agencies have approval or disapproval authority for many federal health programs. There appears a lack of logic and rationale to such procedures, since state members at these two levels have had little or no direct contact or involvement with the tribes on reservations:

> ...funds are allocated to the states who set their own priorities.
>
> Direct and/or consultative services are provided by our personnel only with the knowledge and consent of appropriate local authorities.

---

[1]President Lyndon B. Johnson. "The Forgotten American." A Special Indian Message to Congress, March 6, 1968, p. 3.

> The state immunization program has no direct role in providing vaccines to Indian tribes. County Health Departments provide these services.
>
> It is my understanding that a tribe is eligible for Section 314b CHP grants...the Navajo Nation is negotiating with Arizona 'A' Agency.

The Navajos have developed a 314b planning agency. However, is the statement "the Navajo Nation is negotiating" a futile exercise since all subsequent proposals still must have state 314a approval? Several states only recently permitted Indians to vote (Arizona, 1948; Maine, 1955; New Mexico, 1962), but only after federal courts rendered it mandatory. The key point is, however, whether national and regional offices have made any provisions whereby state-appointed boards and councils, local health departments, areawide and state CHP offices, will assure that tribes do receive services from these programs, or appropriate and just review of tribal proposals. Is it logical and rational to have mandatory conformity to federal health rules and regulations?

If the tribal share of formula grant monies continues to be allocated to the states, then not only state officials but also regional officials must develop mechanisms to assure that tribal people share proportionately in these funds. The following comments by state officials provide evidence that in many instances services are not reaching reservations:

> We have relied on the federal authorities to provide health services to the ..... reservation.

Not as long as appropriations for health services are made to the Indian Health Service of DHEW.

The Indian Health Service provides adequate enough services.

On-reservation health problems in the ..... reservation to federal authorities.

In an instance where federal monies filter down to county levels, a Service Unit Director states: "There is apparent lack of teeth in state laws which place responsibility for ambulance services for the indigent within the counties. The counties have not accepted this responsibility as it pertains to the Indian population."

A Tribal Chairman commenting on a similar situation contends: "The state is allowed funds to help purchase ambulances through the Emergency Medical Officer from the Department of Transportation; but when applied for, we are told that we were not a political sub-division of the state."

Again, the responsibility for assuring that tribes benefit from such programs appears to remain solely with regional officials. Providing funds to states and assuming they will carry out the intent of the laws is a substantive political issue. That is, the federal government is putting all its resources into state and local governments to fulfill the intent of health programs. When state and local governments fail, of course, programs fail. They may fail, again, because no formal mechanisms have been established

to insure that states comply with the existing laws. In such cases, such categorical programs must be funded directly to tribes. Not only could tribes be assured of participation, but tribal management would insure a higher success rate. The use of tribal community health representatives, IHS medical facilities, tribal health professionals, community and reservation health boards, and other approaches, above all, tribal knowledge and expertise, would insure community participation, and enhance the possibilities of a higher rate of program accomplishment.

State, tribal and IHS Service Unit officials varied as to the number of identified services that have been provided to reservations. The data indicates that state health programs are reaching only a small number of the 250 federal Indian reservations. In the literature review we noted that tribes strongly indicated a preference not to deal with the states. The implications from the data, however, indicate that tribes (92.86% of those reporting) would accept state services. Lack of sufficient data prohibited testing the authenticity of such feelings. Perhaps tribes that reported (42) have had successful experiences with state programs, or in the face of desperately needed services are willing to accept state services. Others may assume the position as expressed by one state official: "Recent developments, as far as I know, indicate that the Indians will and prefer to provide their own health services and

have asked the local health department to discontinue their services in Child Health."

Knowledge of tribal characteristics and traits is of value in such instances. Tribal members, particularly the more traditional Indians, are inclined not to respond or react to unwelcome situations, if at all possible. Thus, rather than create more tension between themselves and states, tribes responded by "unknowns" or gave no response at all. These two areas, as indicated earlier, would probably create more of a divergence in opinions rather than a similarity of feelings.

Use of Formula Grant Monies

Other crucial issues came to the forefront in the comment sections of the questionnaires. For a clearer understanding of these issues that primarily pertained to the expenditure of state formula grant monies, state comments are presented:

> Cooperation in payment by BIA for expensive procedures is not very manifest and they cry "poor" using us for primary resources.
>
> In the past we contracted to provide services to Indians but they stopped the contract, so we stopped providing services to Indians on reservations.
>
> We used to do so by contract with the Federal government (IHS) and would do so again, if reimbursed for the services rendered.
>
> We have not been able to get a contract with IHS for any of our services because they maintain that the Indians as citizens of .... are

entitled to all services.

These services presently are not available; however, we will consider them (Indians) when they do become available.

Tribal Official: ..... always has promised to Indian people any type of financial assistance related to health problems but, when approached for assistance their funds are always running short or either no money is available at this time.

IHS Official: The State Regional Director in ..... is very adament in charging Indians full fees because they do not pay taxes.

The total dollar amounts funded to state formula grant programs in the 24 reservation states can be seen in Appendix I. An important factor to remember is that the monies apportioned to the states are for the benefit of all citizens, thus are not to be construed as sums intended for Native Americans only. With that in mind, however, the issue remains: what are the limitations, the restrictions, or possibilities of state formula grant funds?

The data clearly shows that tribes and IHS Service Units (Hypotheses 11 and 12) prefer that formula grant monies go directly to tribes, or that tribes be in a position to negotiate directly with federal officials for programs rather than with state officials. States, on the other hand, object to such procedures. This is understandable since it is difficult to surrender control of large sums of monies under any circumstances. It is also understandable that tribes prefer the direct method. The

reasons are obvious, as evidencedearlier: Tribes are reluctant to deal with states for fear this would lead to eventual termination of their special status with the U.S. Government. It could enable tribes to build on their tribal health authority management base, which most are capable and eager to do. And, of course, it could enhance the prospects for improving their own health status, which is far below that of the rest of the United States.

Cost effectiveness alone would appear to support direct funding and tribal management of programs. For example, Indians in general live in rural, isolated communities. Some speak little or no English, and others speak English as a second language. In general, they have maintained their traditional culture in language, religion, social organizations and values which, in some cases, conflict with those of the majority society. As a result, "doing for" falls drastically short of any well-designed intentions by outsiders.[1]

A tribal chairman, in commenting on state health programs, declared: "State laws, as written, fail to consider Indians. Their programs are designed for the non-Indian community. They were asked to establish a family planning nurse. They insisted on running the program themselves."

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[1] The Indian Health Program. Superintendent of Documents, U. S. Government Printing Office, Washington, D. C., August, 1972, p. 1.

Because of isolation and remoteness, many Indians must travel long distances over primitive roads and difficult terrain to reach any kind of facility. In Alaska there are virtually no roads in areas where the Natives live. This alone has and does prevent others from implementing programs because of physical inaccessibility.[1]

Because of inaccessibility, along with cultural factors, tribal governments and/or tribal health authorities, with their ready resource of community health representative workers, community and reservation health councils, professional staff and IHS facilities and manpower, could achieve a far greater degree of success than an outside group attempting to overcome such obstacles. Lack of unity or coordination alone would not only confuse tribal people, but automatically spell failure for outside groups.

For example, in 1968 there were 121 programs which operated on the Oglala Sioux Reservation. The tragedy of this was that the tribal government controlled only three of these programs: (1) the OEO component, (2) the fledgling community health representative program, and (3) the functions of tribal business surrounding the tribal council. The remaining programs operated freely throughout the reservation.

Sam Deloria, a Standing Rock Sioux then working

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[1]The Indian Health Program, op. cit., p. 1.

for the Oglala Sioux Tribe, attempted to initiate efforts to consolidate the many programs and place them under the control and management of the tribe. He desired to eliminate duplication of programs and to provide better services through a more uniform approach. His efforts were futile ones since outside programs were found to have no obligation or legal commitment to tribal governments. Perhaps tribal governments should initiate tribal laws making it mandatory for outside programs, prior to operating on reservations, to have tribal government approval. Where practical, tribal governments or tribal health authorities should manage such programs.

> We have often assumed that because the government is obliged to provide certain services for Indians, it therefore must administer those same services -- but there is no reason for this assumption.
>
> Federal support programs for non-Indian communities... are ordinarily administered by local authorities.
>
> We have concluded that the Indians will be more effectively expended if the people who are most affected by these programs are responsible for operating them.[1]

Tax-Exempt Status of Indian Lands

In order to bring the major issues between the states and Indians into the total context of this study, an additional topic is introduced at this point: tax-exempt status of Indian lands. For many years the tax-exempt status of Indian lands has been a hotly debated issue among the states,

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[1]Nixon's Indian Message, op. cit. p. 4.

local county governments, tribes and the federal government. States and local county governments contend that because of the lack of revenue from Indian lands they are affected in their ability to provide services to reservation Indians. But tribes, and others, contend they have prepaid their share of such taxes:

> For their part, the Indians have often surrendered claims to vast tracts of land.[1]

Two major points will be presented in regard to this issue:

(1) Local governments generate revenue as have the tribes; therefore, are local governments more entitled to federal monies than Indians?

(2) States seek Indian-related funds (BIA, IHS, other sources); therefore, are federal monies to tribes similar to county tax monies? Counties generate monies through county taxes, and tribes generate monies through the federal government (BIA, IHS, Others); thus should tribal monies be diverted to states before services are provided when states do not divert or control county monies yet provide services to the counties?

In summary, this discussion has attempted to analyze the relationship between federal health programs and Native Americans. Implications were also presented as to how such findings could affect tribal governments. The implications

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[1]Nixon, op. cit. p. 2.

related to both studies, federal health programs at the national and regional levels and the state formula grant programs. Neither the discussions nor the implications were intended to be all-inclusive. They were intended to stimulate extensive thinking in relation to the programs and the tribes.

CHAPTER VII

SUMMARY AND CONCLUSIONS

Summary

This study assesses the relationship between federal health programs and Native Americans residing on reservations. The dissertation is generated by the assumption that tribes on reservations are receiving little or no services from federal health programs regardless of the level of administration: national, regional, or state. Also, it is the assumption that interrelated variables influenced the relationship between federal health programs at all levels and federally recognized Indian tribes and Alaskan Natives, and that those variables are ultimately responsible for the amount of services provided by these programs to the tribes.

Descriptive data was obtained on 62 health programs administered at both the national level and seven regional offices located near the 24 reservation states. Relationship data was obtained from 11 program health directors receiving federal formula grant monies in each of 24 reservation states, from tribal chairmen whose reservations are

located within these states, and from IHS Service Unit Directors whose Service Units are also in these states.

It was determined that only limited direct funding and services to the tribes had occurred from the health programs administered from the national and regional offices. Such factors as the misconception about the role and authorities of the Indian Health Service and the Bureau of Indian Affairs, apparent weaknesses written into public health laws, and attitudes of health officials were instrumental in the lack of funds and services going to the tribes. It was also shown that discrepancies existed between directors within the same programs as to the legality of funding directly to tribes; there were also variances between the various administrative levels as to where proposal (or service) requests should be submitted, who had rejection authority, where proposal approval can be obtained, and the level of funding authority.

This exploratory study pointed out that state health formula grant programs have provided limited services to Indians on reservations, and that a number of variables influenced this lack of service. Among these, misunderstanding of state jurisdiction on Federal Indian reservations was a major influence on the limited services. It was also found that tribal officials and state health officials were in more disagreement than state health officials and officials of IHS Service Units as to factors that would

influence the relationship between state health programs and Native Americans.

Conclusions

Exploratory studies do not lend themselves to definitive conclusions. Such studies, however, may point out certain ideas (or variables) which represent fruitful areas for additional research. From these beginnings additional investigations can be designed to obtain a more thorough understanding of the issues. Certain conclusions, however, are apparent:

(1) If tribes are to participate in health programs administered by the national and regional offices, federal health program directors at these levels or the General Council, or both, must clearly determine if tribal governments meet the applicant and eligibility requirements of these programs.

(2) Tribes, or tribal organizations must analyze in depth the laws, and the applicant and eligibility requirements of federal health programs. Where programs prohibit direct funding, or uncertainties exist (similar to the Hill-Burton program) applicable to tribal needs, efforts should be initiated to change such laws, either through amendments or Executive Orders, or Federal Court tests.

(3) Attitudes held by some national, regional, and state officials should be altered on certain issues: (A) Tribes are equally entitled to federal health program

benefits in addition to receiving services from the Indian Health Service and the Bureau of Indian Affairs and, (B) some tribal governments or tribal health authorities possess the managerial capabilities to manage and control health programs.

(4) National, regional and state officials should realize that tribal governments are the key to tribal success, and they should be dealt with in the same manner as municipal and state governments.

(5) Tribal governments should establish measures to control all programs coming onto reservations.

(6) The jurisdictional results suggest that states, tribes, and IHS must clarify states' rights and obligations to provide services on reservations. In addition, IHS Service Units must ascertain whether tribes desire the solicitation of state services directly to IHS facilities.

(7) The data suggest that IHS Service Units should work closer with and assist tribes in obtaining outside health resources for tribal control and management.

(8) Since the tribes (and IHS) desire that Indians fair share of federal formula grant monies be funded directly to tribal governments, and that the term "Tribal Government" or "Indians" be included in appropriate federal health program applicant and eligibility requirements, actions should be initiated to amend appropriate legislation. However, if

such actions are unsuitable then regional offices need to establish mechanisms to assure that tribes share in federal formula grant monies.

(9) The findings suggest that tribes should make an analysis of Indian members on state health boards/councils to determine if such members are representative of tribal governments; tribes should evaluate the role and effectiveness of such representatives. In selection of Indian members for health organizations, tribal governments should request that those appointments be made through them.

(10) In the area of tribal coordination in the development of state health plans, the results suggest that tribes should take a more active role in the development of such plans to initially insure their participation in the resulting allocation of federal monies.

(11) Regional officials must develop mechanisms to assure that state formula grant programs do inform tribes as to kinds and location of health services, but equally important, should provide technical assistance.

(12) The logic and rationale of local, areawide, and state agencies possessing approval or rejection authorities over tribal request for federal health program services should be evaluated since such agencies have little or no contact with tribal governments and tribal needs.

(13) Tribes and IHS officials should explore the possibility of transferring health program authorities,

where appropriate, to the IHS much in the same manner Hill-Burton authorities were transferred from the State of Arizona to the IHS.

Historically, tribal governments have had little experience in managing health programs, leaving the responsibility in the hands of non-Indians. But in recent years, the emergence of tribal health authorities, reservation tribal advisory boards, community health councils, and a resource of professional and community health workers, give strong indication that tribal governments are nearing, or have attained, the necessary capabilities to conduct and control health programs much in the same manner as other local health authorities.

It seems altogether fitting, then, that health resources, particularly federal health programs, provide tribal governments the opportunity necessary for growth and stability in the health field. Until now the opportunities have been scarce for tribal control. Much of the fault could be attributed to the inabilities of tribes to manage programs. The evidence today, however, does not support such a misconception. The evidence suggests that tribal governments do possess such skills and do want to be provided with the various health program options for tribal control and implementation.

For those who currently have limited management capabilities certain options still must be made available,

since many tribes, living in remote and isolated areas, appear to be in the best position to provide the kinds of services not now available, or that can be provided by outsiders.

Finally, it must be clearly understood that all tribal groups do not fall into a single bureaucratic mold. Each tribe is unique within itself; how it will go about accomplishing a task, where it places its emphasis, and at what speed it plans to get there will vary. Adequate funding is essential to strengthen and stabilize tribal governments over the long approach and funds should be provided much in the same manner as to universities and other non-profit organizations to develop or maintain administrative staff and achieve desired goals. Specifically, tribes must receive sufficient funds to establish and maintain tribal health bases on reservations, and not be forced to finance this base themselves.

Recommendations for Future Research

As has been seen in this exploratory study, additional research is needed regarding federal health programs and Native Americans. While this study concentrated primarily on reservation Indians the urban Indian's need for health programs is equally as important.

Numerous areas lend themselves to future studies, each capable of adding to the understanding of the relationship between tribes and the federal health programs. For

example, a study could be conducted to analyze contracts made to non-Indian organizations in behalf of Indians. Analysis of the organizational structure of non-Indian projects on or near reservations would be another appropriate area of research. Frequently, such projects are organized on standards of the majority society. Such standards generally eliminate Indians since tribal people often have not had experience with such systems.

Analysis is also needed of the procedures involving proposals submitted to regional offices: (A) What happens to proposals when they enter the system at the regional level? (B) Why are certain tribal proposals funded and others not? Is there a respository of proposals, both funded and unfunded, so that tribes can draw upon the knowledge and experience of other tribes?

Related studies should be conducted as to why some tribes, both small and large in population, have been successful in management success, and why others have failed.

Research studies should address themselves to possible alternate health delivery systems appropriate to reservation settings and tribal characteristics and values.

In recent years IHS has established liaison offices in regional health offices of several of the regions. What impact have these offices had in the regions? What has emerged as their role? Have tribes received additional regional programs and funds?

A worthwhile study would be the assessment of the position held by staff of both the BIA and the IHS as to the philosophy and direction of both organizations -- that of assisting tribes to become self-governing and self-sufficient.

Suitable and worthwhile areas for future research are extensive. But two points should take precedence prior to any research: (1) No research should be conducted in relation to tribes for the mere exercise of doing research, since tribes have been researched too much; and (2) all research should have the approval of the involved tribal governments. Such research, if possible, should be conducted by the involved tribal government, or by tribal organizations.

In conclusion, tribal governments have made remarkable progress the past few years; however, greater progress lies ahead if Native Americans are provided the opportunities to manage health programs much in the same manner as other local governments.

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APPENDIX A

TO: Deputy Administrators, HSMHA

FROM: Acting Deputy Administrator for
Health Services Delivery, HSMHA

SUBJECT: Health Services and Mental Health Administration Activities

Recently, there has been more effort to involve federally recognized American Indian Tribes and Alaskan Natives in the program activities of the Health Services and Mental Health Administration. Therefore, as an initial effort, it is necessary to determine the relationship and status of the HSMHA program activities to tribes.

Enclosed are questionnaires which will provide this information. It would be appreciated if the appropriate staff would complete the questionnaire for their program. A master list is enclosed to coordinate the collection of the completed forms.

Once the forms have been completed, please forward them to Mr. Joe Exendine, Box 6279, Moore, Oklahoma 73040. Please return the completed form as soon as possible.

Your effort and interest are deeply appreciated.

/s/ Emery A. Johnson, M.D.
Assistant Surgeon General

Enclosure
cc: Federal Health Program Directors

REGIONAL/HEADQUARTERS QUESTIONNAIRE

In the past few months there has been greater effort to involve Federally Recognized American Indian Tribes and Alaskan Natives (Hereafter referred to as Tribes) in the program activities of the Health Services and Mental Health Administration (HSMHA).

Most Tribes have legally constituted governing councils, with Community and Reservation Health Boards that direct the health activities within their respective locale. Also, there are 10 Area Health Boards consisting of representatives from Reservation Boards as well as a National Indian Health Board consisting of representatives from Area Boards. Each conducts the health affairs at their respective levels.

As Tribes, according to Federal law, are recognized as legal units of government and are eligible for benefits of numerous programs, the specific purpose of this study is to determine the relationship and status of HSMHA program activities to Tribes.

This study does not include HSMHA efforts for Indians off reservations, with the exception of Federally Recognized Tribes in Oklahoma and Alaska.

Questionnaire Instructions

Please answer all questions that relate to your program activity. The return of each questionnaire is needed if the results are to be truly representative. Your response will be kept confidential.

The term grant/contract is used as an all inclusive term, indicating the specific services that are provided within each activity; i.e., the term grant/contract is used to indicate such words as: contracts, grants, technical assistance, services, training, advisory services, counseling, request for services, dissemination of technical information, and other terms within the activities.

There is indication that some HSMHA activities will not be extended beyond the present fiscal year. Regardless, the 1972 and 1973 fiscal year information is pertinent from those activities for this study.

_____ _____

Title of Organization Title of Program

QUESTIONNAIRE

Check the level you represent: Regional Office ___ HSMHA Headquarters___

PART I - GRANT/CONTRACT FUNDING: Please indicate the grants/contracts from your office made to Tribes in FY 1972 and in the present FY 1973. A space follows for any comments. If no grants/contracts were made, please indicate. Do not leave blank.

TOTAL 1972 FY			TOTAL 1973 FY		
# Grant/Cont. Appl. Subm. by Tribes	# Grant/Cont. Appl. funded to Tribes	Total Dollar Amount	# Grant/Cont. Appl. Subm. by Tribes	# Grant/Cont. Appl. funded to Tribes	Total Dollar Amount
		$			$

SPECIFIC 1973 DATA: This is an inventory of FY 1973 activities. If your office has made a grant/contract to a Tribe, please complete this section: On line 4 briefly describe the grant/contract.

1. Name of Tribe: _____ Address of Tribe: _____
2. Amount of funding: $ _____ _____
3. Period of funding: _____ _____
4. Type of Grant/Contract: _____

_____

_____

1. Name of Tribe: _____ Address of Tribe: _____
2. Amount of funding: $ _____ _____
3. Period of funding: _____ _____
4. Type of Grant/Contract: _____

_____

_____

Comments: _____

(If additional space is needed, please attach additional sheets)

PART II - LEGALITY OF GRANTS/CONTRACTS: Three sections are provided to indicate the status of grants/contracts to Tribes. Complete the section that relates to your activity. Please do not leave blanks.

(1) Section A is to be completed if Tribes do not meet eligibility requirements of program or programs administered by your office because of a Public Law or Executive Order. Space is provided for the Public Law number and the regulation or guideline from your manual that implements the law.

(2) Section B is to be completed if Tribes do not meet requirements of program or programs administered by your office because of a policy, whether the policy be issued formally, implied, assumed, or because of historical actions.

(3) Section C is to be completed if Tribes do meet eligibility requirements of program or programs administered by your office.

Please complete the Section that applies to your activity.

(A) Prohibited by Law (Yes) ___ (No) ___ (If yes, please complete the following)

Public Law number _____
Regulation/Guideline _____
What situations need correcting before a grant/contract can be made to a Tribe: _____
_____

(B) Prohibited by policy (Yes) ___ (No) ___ (If yes, check one of the following)

Policy issued by DHEW _____ Assumed _____
HSMHA Headquarters _____ Historical Action _____
Regional Office _____
What situations need correcting before a grant/contract can be made to a Tribe: _____
_____

(C) Permissible (Yes) ___ (No) ___ (If permissible, complete the following)

Public Law number _____ Policy _____
Regulation/Guideline _____ Written _____
Assumed _____
What situations need correcting to improve granting/contracting to Tribes: _____
_____

PART III - GRANTS/CONTRACTS REVIEW AND AWARD PROCESS: The data are to determine the levels a grant/contract passes before monies are actually allocated to an organization. This part pertains not only to Tribes but for any grant/contract submitted to any organization.

Line 1 is to indicate the initial level a grant/contract application must be submitted and various levels it passes before funds are awarded.

Line 2 is to indicate the levels that have rejection authority only for the same grant/contract application regardless of its initial entry level.

Line 3 is to indicate the level that has the final approval authority of a grant/contract application.

Line 4 is to indicate the level which has the final award authority of monies for a grant/contract application. In some cases it may, or may not be, the same as in Line 3.

Please check the blanks that apply to your activity. If more than one granting authority exists in your program, please specify the other granting authorities. If additional space is needed, please attach necessary pages, and complete the information below accordingly.

Grant Authority Title	Local Health Agency	Area-wide Agency	State Agency	Regional Agency	HSMHA Agency	DHEW Agency
1. Grant/Contract Process Steps:						
2. Rejection Authority:						
3. Final Approval Authority:						
4. Funding Authority:						

Grant Authority Title						
1. Grant/Contract Process Steps:						
2. Rejection Authority:						
3. Final Approval Authority:						
4. Funding Authority:						

Comments: _____

APPENDIX B

STATE QUESTIONNAIRE

_____
Code Number

There are various opinions as to the jurisdiction and responsibility of State operated programs on Federal Indian Reservations. In some instances such as law and order and education, jurisdiction and responsibilities for services are clearly defined. However, in many other instances, such as State operated health services, jurisdictions and responsibilities are not as clearly defined. Therefore, this questionnaire is part of a nationwide study to determine the role of State health programs to Federally Recognized Indian Tribes, and individuals thereof, (hereafter referred to as Indians or Tribe). The study will also assist to fulfill the requirements toward my dissertation at the University of Oklahoma, School of Public Health, Oklahoma City, Oklahoma.

Please answer all questions to the best of your ability. Your response will be kept in strict confidence. Your State health program is one of a carefully selected sample and if the results are to be truly representative, the return of each questionnaire is needed.

IMPORTANT: The term, services, in the questionnaire is used as an all inclusive term, indicating the benefits of each selected State operated health program; i.e., the term, services, is used to indicate such State health program benefits as directed services, training of personnel, screening, and diagnostic surveys, technical assistance, grants, contracts, construction of facilities, dissemination of information, counseling, special projects, programs, and other benefits within the authorities of your State health program.

It would be appreciated if the questionnaire could be returned as soon as possible. A self-addressed envelope is enclosed for mailing.

Joe Exendine
Box 6279
Moore, Oklahoma 73060

For the States, Alaska and Oklahoma, the following comment was added: It is recognized that no Federal Indian Reservations, per se, exist in your State.

1. As indicated earlier, there is some question as to the jurisdiction and responsibility of States on Federal Indian Reservations. As a result, does your Department consider reservations to be beyond the jurisdiction of your State Health Program?

   _____ Yes _____ No _____ Unknown

2. If no, has your Department gone to a reservation to provide services to Indians or Alaskan Natives in the past two years?

   _____ Yes _____ No _____ Unknown

3. If such services have been provided on a reservation, please specify:

	RESERVATION	TYPE OF SERVICE
a.	_____	_____
b.	_____	_____
c.	_____	_____

4. If there are no jurisdictional questions but you have not provided services, would your Department be willing to provide services to Indian and Alaskan Natives on reservations?

   _____ Yes _____ No _____ Unknown

5. In the past two years has a Tribe or Indian organization applied to your Department for services for a reservation?

   _____ Yes _____ No _____ Unknown

6. Has an Indian Health Service facility, on behalf of a Tribe or individual, applied to your department for services in the past two years?

   _____ Yes _____ No _____ Unknown

7. How would you rate the Tribal governments as a whole in your state as to their willingness to cooperate with State programs?

   _____ Outstanding _____ Good _____ Average _____ Poor _____ No Comment

8. If you had to obtain general information about Tribal governments, or Tribal groups, in your State, whom are you most likely to contact?

_____ _____
Name P.O. Box or Street

_____
City and State

9. Is a State advisory board/council required for your program?

_____ _____ _____
Yes No Unknown

If a board/council is required, is there a member on your board who is a Tribal member who resides on a reservation?

_____ _____ _____
Yes No Unknown

If yes, please specify: Name: _____

Tribe: _____

Address: _____

10. Within your authorities, is it legal to grant to or contract the services of your program, or portions thereof, to Tribal governments for application on reservations?

_____ _____ _____
Yes No Unknown

11. If yes to No. 10, would your office be willing to grant to or contract your program, or portions thereof, with local Tribal governments for application on reservations?

_____ _____ _____
Yes No Unknown

12. In order to eliminate the issue of state services on reservations, should Federal formula grant monies, which are now apportioned to the states, go directly to Tribal governments for application?

_____ _____ _____
Yes No Unknown

13. In order for Tribes to receive a fair share of all applicable Federal funds on an equitable basis, should the term Tribal Governments or Indians, along with states, political subdivisions thereof, local health authorities, non-profit organizations, etc., be included in the applicant and eligibility requirements of Federal health programs?

_____ Yes _____ No _____ Unknown

14. If your program requires a State Plan for Federal funding, has any coordination with Tribal groups occurred in the development of such a plan in the past two years.

_____ Yes _____ No _____ Unknown

If yes, please specify: Tribal Group: _____

Person Contacted: _____

Address: _____

15. Has your office informed the Tribes in your State as to the location and kinds of services that are available in your program?

_____ Yes _____ No _____ Unknown

Please add any comment you would like to make about any issues or questions addressed in this questionnaire, or any related issue to the field of health services and programs for Indians. (Your view will be held in strict confidence.)

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APPENDIX C

TRIBAL QUESTIONNAIRE

Code Number

There are various opinions as to the jurisdiction and responsibility of State operated programs on Federal Indian Reservations. In some instances, such as law and order and education, jurisdiction and responsibilities for services are clearly defined. However, in many other instances, such as State operated health services, jurisdictions and responsibilities are not as clearly defined. Therefore, this questionnaire is part of a nationwide study to determine the role of State health programs to Federally Recognized Indian Tribes, and individuals thereof, (Hereafter referred to as Indians or Tribe). The study will also assist to fulfill the requirements toward my dissertation at the University of Oklahoma, School of Public Health, Oklahoma City, Oklahoma.

Please answer all the questions to the best of your ability. Your responses will be kept in strict confidence. Your Tribe is one of a carefully selected sample and if the results are to be truly representative, the return of each questionnaire is needed.

IMPORTANT: The term, services, in the questionnaire is used as an all inclusive term, indicating the benefits of each selected state operated health program; i.e., the term, services, is used to indicate such state health program benefits as direct services, training of personnel, screening, and diagnostic surveys, technical assistance, grants, contracts, construction of facilities, dissemination of information, counseling, special projects, programs, and other benefits within the authorities of your state health program.

It would be appreciated if the questionnaire could be returned as soon as possible. A self-addressed envelope is enclosed for mailing.

Joe Exendine
Box 6279
Moore, Oklahoma 73060

For the States, Alaska and Oklahoma, the following comment was added: It is recognized that no Federal Indian Reservations, per se, exist in your State.

1. As indicated earlier, there is some question as to the jurisdiction and responsibility of States on Federal Indian Reservations. As a result, do State health programs have jurisdiction to provide services on your reservation?

_____ Yes _____ No _____ Unknown

2. If yes, has your Tribe received services from a State operated health program on the reservation in the past two years?

_____ Yes _____ No _____ Unknown

3. If such services have been received on the reservation, please specify the program, or programs:

	PROGRAM	TYPE OF SERVICES
a.	_____	_____
b.	_____	_____
c.	_____	_____

4. If there are no jurisdictional questions but your Tribe has not received services from a State health program, would your Tribe be willing to receive services, in addition to Indian Health Service services, from a State health program?

_____ Yes _____ No _____ Unknown

5. In the past two years has your Tribe, or an Indian organization, applied to a State health program for services for your reservation?

_____ Yes _____ No _____ Unknown

6. Has the Indian Health Service, on behalf of the Tribe, applied for services from a State health program in the past two years?

_____ Yes _____ No _____ Unknown

7. How would you rate State programs as a whole in your state as to their willingness to cooperate with your Tribe?

_____ Outstanding _____ Good _____ Average _____ Poor _____ No Comment

8. If you had to obtain information about State programs in your State, whom are you most likely to contact?

   Name: _____ Organization: _____

   Address: _____

9. In some cases, advisory board or councils are required for State operated health programs. To your knowledge, is there a Tribal member on a State operated health program advisory council?

   _____ Yes _____ No _____ Unknown

   If yes, please specify:

   Name of Tribal member: _____

   Name of State Council: _____

10. Within your Tribal authorities, is it legal to accept grants or contracts from State health programs?

    _____ Yes _____ No _____ Unknown

11. In instances where State health programs have legal authorities to grant to or contract with Tribal governments for programs, or portions thereof, would your Tribe be willing to assume control and manage a State health program, or portions thereof, for your reservation?

    _____ Yes _____ No _____ Unknown

12. In order to eliminate the issue of State services on reservations, should Federal formula grant monies, which are now apportioned to the States, go directly to Tribal governments for application?

    _____ Yes _____ No _____ Unknown

13. In order for Tribes to receive a fair share of <u>all</u> applicable Federal funds on an equitable basis, should the term <u>Tribal Governments</u> or <u>Indians</u>, along with States, political subdivisions thereof, local health authorities, non-profit organizations, etc., be included in the application and eligibility requirements of Federal health programs?

    _____ Yes _____ No _____ Unknown

14. Most State health programs which receive Federal grant monies require a State Plan. Has your Tribe been involved in the development of a State Health Plan?

_____ Yes _____ No _____ Unknown

If yes, please specify:

State program: _____

15. Has your Tribe been informed by any State Health Program as to the location and kinds of services that are available in their program?

_____ Yes _____ No _____ Unknown

Please add any comment you would like to make about any issues or questions addressed in this questionnaire, or any related issue to the field of health services and programs for Indians. (Your views will be held in strict confidence).

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APPENDIX D

IHS SERVICE UNITS QUESTIONNAIRE

Code Number

There are various opinions as to the jurisdiction and responsibility of State operated programs on Federal Indian Reservations. In some instances, such as law and order and education, jurisdiction and responsibilities for service are clearly defined. However, in many other instances, such as State operated health services, jurisdictions and responsibilities are not as clearly defined. Therefore, this questionnaire is part of a nationwide study to determine the role of State health programs to Federally Recognized Indian Tribes, and individuals thereof, (hereafter referred to as Indians or Tribes). The study will also assist to fulfill the requirements toward my dissertation at the University of Oklahoma, School of Public Health, Oklahoma City, Oklahoma.

Please answer all the questions to the best of your ability. Your responses will be kept in strict confidence. Your Service Unit is one of a carefully selected sample and if the results are to be truly representative, the return of each questionnaire is needed.

IMPORTANT: The term, services, in the questionnaire is used as an all inclusive term, indicating the benefits of each selected state operated health program; i.e., the term, services, is used to indicate such state health program benefits as direct services, training of personnel, screening, and diagnostic surveys, technical assistance, grants, contracts, construction of facilities, dissemination of information, counseling, special projects, programs, and other benefits within the authorities of your state health program.

It would be appreciated if the questionnaire could be returned as soon as possible. A self-addressed envelope is enclosed for mailing.

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Moore, Oklahoma 73060

For the States, Alaska and Oklahoma, the following comment was added: It is recognized that no Federal Indian Reservations, per se, exist in your State.

1. As indicated earlier, there is some question as to the jurisdiction and responsibility of States on Federal Indian Reservations. As a result, do State health programs have jurisdiction in your Service Unit area?

Yes _____ No _____ Unknown _____

2. If yes, has your Service Unit received services from a State operated health program on the reservation in the past two years?

Yes _____ No _____ Unknown _____

3. If such services have been received on the reservation, please specify the program, or programs:

	PROGRAM	TYPE OF SERVICES
a.	_____	_____
b.	_____	_____
c.	_____	_____

4. If there are no jurisdictional questions but your Service Unit has not received services from a State health program, would your Service Unit be willing to receive services from a State health program?

Yes _____ No _____ Unknown _____

5. In the past two years has your Service Unit applied to a State health program for services for your Service Unit area?

Yes _____ No _____ Unknown _____

6. In the past two years, has your Service Unit applied, on behalf of a Tribe, for services from a State Health program?

Yes _____ No _____ Unknown _____

7. How would you rate State programs as a whole in your State as to their willingness to cooperate with your Service Unit?

Outstanding _____ Good _____ Average _____ Poor _____ No Comment _____

8. If you had to obtain information about State programs in your State, whom are you most likely to contact?

   Name: _____ Organization: _____

   Address: _____

9. In some cases, advisory boards or councils are required for State operated health programs, to your knowledge, is there a Tribal member on a State operated health program advisory council?

   _____ Yes _____ No _____ Unknown

   If yes, please specify:
   Name of Tribal member: _____

   Name of State Council: _____

10. To your knowledge, is it legal to grant to or contract the services of State health programs, or portions thereof, to Tribal Governments for application at your Service Unit?

    _____ Yes _____ No _____ Unknown

11. In instances where State health programs have legal authorities to grant to or contract with Tribal governments for programs, or portions thereof, is the Tribe or Tribes, at your Service Unit capable of assuming control and managing a State health program, or a portion thereof, for their Tribe?

    _____ Yes _____ No _____ Unknown

12. In order to eliminate the issue of State services on reservations, should Federal formula grant monies, which are now apportioned to the States, go directly to Tribal governments for application?

    _____ Yes _____ No _____ Unknown

13. In order for Tribes to receive a fair share of <u>all</u> applicable Federal funds on an equitable basis, should the term <u>Tribal Governments</u> or <u>Indians</u>, along with States, political subdivisions thereof, local health authorities, non-profit organizations, etc., be included in the applicant and eligibility requirements of Federal health programs?

    _____ Yes _____ No _____ Unknown

14. Most State health programs which receive Federal grant monies require a State Plan. Has your Service Unit been involved in the development of a State Health Plan?

_____ Yes _____ No _____ Unknown

If yes, please specify:

State program: _____

15. Has your Service Unit been informed by any State Health Program as to the location and kinds of services that are available in their program?

_____ Yes _____ No _____ Unknown

Please add any comment you would like to make about any issues or questions addressed in this questionnaire, or any related issue to the field of health services and programs for Indians. (Your views will be held in strict confidence.)

_____

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APPENDIX E

FEDERAL HEALTH PROGRAMS

Code	Title of Program
13.200	*Disease Control - Consultation and Technical Assistance
13.201	*Disease Control - Laboratory Improvements
13.202	*Disease Control - Research Grants
13.203	*Disease Control - Training Public Health Workers
13.204	***Disease Control - Tuberculosis
13.205	***Disease Control - Venereal Disease
13.206	**Comprehensive Health Planning - Areawide Grants
13.207	***Comprehensive Health Planning - Grants to States
13.208	*Comprehensive Health Planning - Training, Studies and Demonstrations
13.210	***Comprehensive Public Health Services - Formula Grants
13.211	***Crippled Children's Services
13.211	**Crippled Children's Services (Project Grants)
13.212	*Dental Health of Children
13.213	*Emergency Health - Civil Defense Medical Self-Help
13.214	*Emergency Health - Community Preparedness
13.215	*Emergency Health - Hospital and Ambulatory Services
13.216	*Emergency Health - Medical Stockpile
13.217	**Family Planning Projects
13.218	**Health Care of Children and Youth
13.220	***Health Facilities Construction - Grants
13.223	*Health Facilities Construction - Technical Assistance
13.224	**Health Services Development - Project Grants
13.225	*Health Services Research and Development - Fellowships and Training
13.226	*Health Services Research and Development - Grants and Contracts
13.227	*Health Statistics Training and Technical Assistance
13.228	*Indian Health Services
13.229	*Indian Sanitation Facilities
13.230	**Intensive Infant Care Projects
13.231	*Maternal and Child Health Research
13.232	***Maternal and Child Health Services
13.232	*Maternal and Child Health Services (Project Grants)
13.233	*Maternal and Child Health Training
13.234	**Maternity and Infant Care Projects
13.235	*Mental Health - Community Assistance Grants for Narcotic Addiction and Drug Abuse
13.237	**Mental Health - Hospital Improvement Grants
13.238	**Mental Health - Hospital Staff Development Grants
13.239	*Mental Health - Narcotic Addiction Treatment
13.240	**Mental Health - Community Mental Health Centers
13.240	***Mental Health - Community Mental Health Centers (Construction)
13.241	*Mental Health Fellowships

FEDERAL HEALTH PROGRAMS (Continued)

Code	Title of Program
13.242	*Mental Health Research Grants
13.243	*Mental Health Scientific Communications and Public Education
13.244	*Mental Health Training Grants
13.246	**Migrant Health Grants
13.247	***Regional Medical Programs
13.248	*Disease Control - Nutrition
13.249	*Regional Medical Programs - Operational and Planning Grants
13.250	*Disease Control - Smoking and Health
13.251	*Mental Health - Community Assistance Grants for Comprehensive Alcoholism Service
13.252	*Mental Health - Direct Grants for Special Projects (Alcoholism)
13.253	**Health Facilities Construction - Loans and Loan Guarantees
13.254	*Mental Health - Direct Grants for Special Projects (Narcotic Addiction and Drug Abuse)
13.256	*Health Maintenance Organization Service
13.257	***Mental Health - Alcohol Formula Grants
13.258	*National Health Service Corps
13.259	**Mental Health - Children's Services
13.260	*Family Planning Services - Training Grants
13.261	**Family Health Centers
13.262	*Occupational Health - Research Grants
13.263	*Occupational Health - Training Grants
13.264	*Occupational Health - Special Fellowships
13.265	*Occupational Health - Demonstration Grants
13.266	**Childhood Lead-Based Paint Poisoning Control
13.267	**Urban Rat Control
13.268	**Disease Control Project Grants
13.269	***Drug Abuse

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*National Programs

**Regional Programs

***State Fromula Programs Controlled by Regional Offices

APPENDIX F

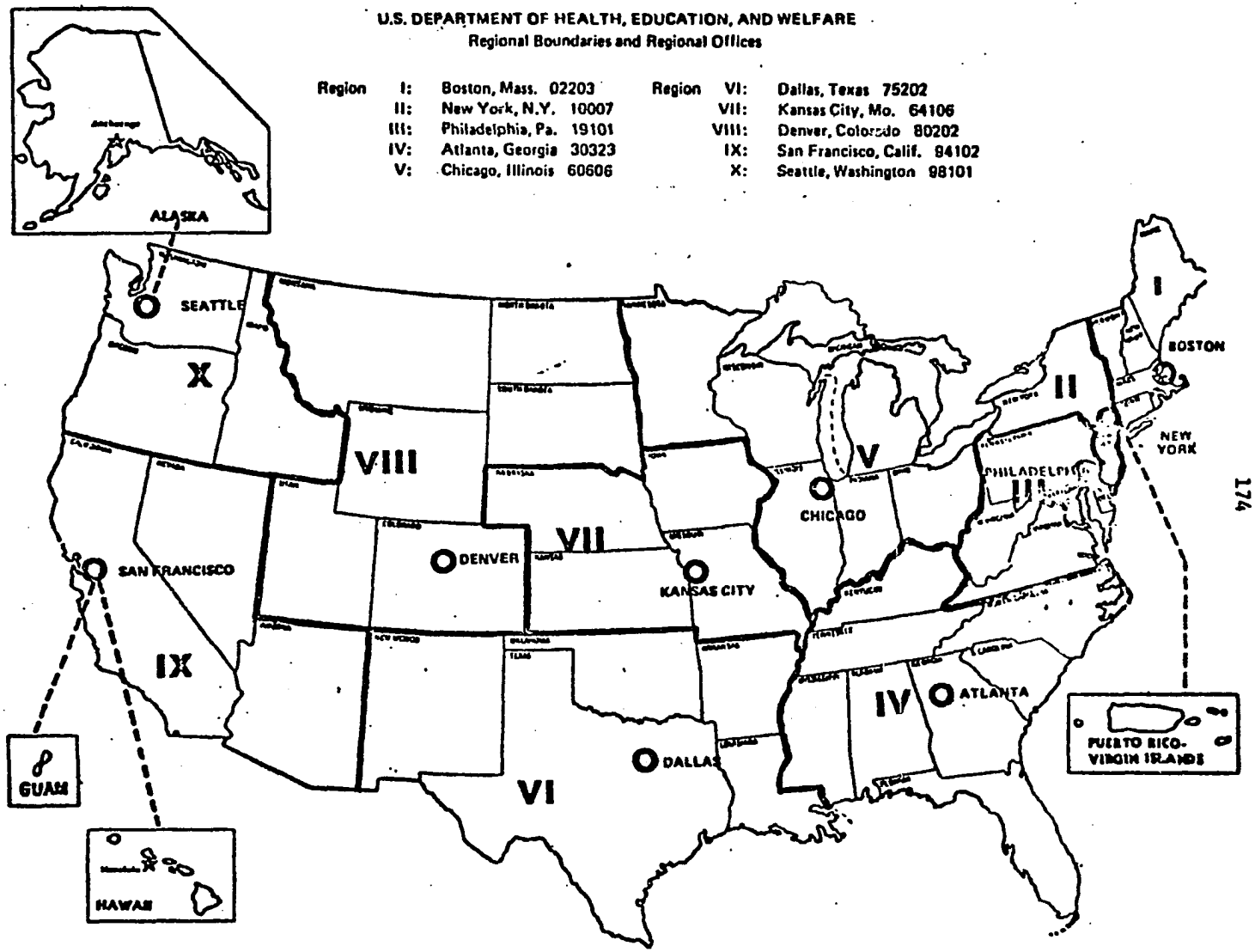
TWENTY-FOUR RESERVATION STATES

Alaska
Arizona
California
Colorado
Florida
Idaho
Iowa
Kansas
Michigan
Minnesota
Mississippi
Montana
Nebraska
Nevada
New Mexico
North Carolina
North Dakota
Oklahoma
Oregon
South Dakota
Utah
Washington
Wisconsin
Wyoming

U.S. DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

Regional Boundaries and Regional Offices

Region	I:	Boston, Mass. 02203	Region	VI:	Dallas, Texas 75202
	II:	New York, N.Y. 10007		VII:	Kansas City, Mo. 64106
	III:	Philadelphia, Pa. 19101		VIII:	Denver, Colorado 80202
	IV:	Atlanta, Georgia 30323		IX:	San Francisco, Calif. 94102
	V:	Chicago, Illinois 60606		X:	Seattle, Washington 98101



APPENDIX G

OPINIONS OF NATIONAL AND REGIONAL PROGRAM DIRECTORS OF THE REVIEW AND AWARD PROCESSES OF FEDERAL HEALTH PROGRAMS

Code and Program	Entry Point					Rejection Authority					Final Approval Authority					Funding Authority				
	Local	Area	State	R.O.	Central	Local	Area	State	R.O.	Central	Local	Area	State	R.O.	Central	Local	Area	State	R.O.	Central
13.200 Disease Control - Consultation and Technical Assistance	1	1		1					1	1				1	1				1	1
13.201 Disease Control - Laboratory Improv.	1		1		1					2					2				1	1
13.202 Disease Control - Research Grants					1					1					1					1
13.203 Disease Control - Training Public Hlth Workers																				
13.204 Disease Control - Tuberculosis	1		1	1					2					2	2				1	2
13.205 Disease Control - Venereal Disease	1	1	3	2	1			2	4	1				4	1				4	1
13.206 Comprehensive Hlth Planning Areawide Grants		2	2	2	1			4	1	2				3	2				3	2

(Continued)

Code and Program	Entry Point					Rejection Authority					Final Approval Authority					Funding Authority				
	Local	Area	State	R.O.	Central	Local	Area	State	R.O.	Central	Local	Area	State	R.O.	Central	Local	Area	State	R.O.	Central
13.207 Comprehensive Hlth Planning Grants to States		1	2	2					1					2					1	1
13.208 Comprehensive Hlth Planning Training Studies and Demonstrations		1	1	1	1				1						1					1
13.210 Comprehensive Public Health Service - Formula Grants		2	2	3					1	1				3					2	1
13.211 Crippled Children's Services		1	5	3					3	3				3	3				3	3
13.211 Crippled Children's Services Proj. Grants		1	3	1	1			1	1	2			1	2	1			1	2	1
13.212 Dental Health of Children	3	1	2	1			1	2	3					3	3			1	2	3
13.213 Emergency Health Civil Defense Medical Self-Help																				

(Continued)

Code and Program	Entry Point					Rejection Authority					Final Approval Authority					Funding Authority				
	Local	Area	State	R.O.	Central	Local	Area	State	R.O.	Central	Local	Area	State	R.O.	Central	Local	Area	State	R.O.	Central
13.214 Emergency Health Community Preparedness																				
13.215 Emergency Health Hospital and Ambulatory Services																				
13.216 Emergency Health Medical Stockpile																				
13.217 Family Planning Projects		2	2	2	1				1	2				1	3		1	1	1	2
13.218 Health Care of Children and Youth	2	2	2	1		1	1	1	3					3	3				2	3
13.220 Health Facilities Construction Grants		3	4	1			1	2	3	1				4					4	
13.223 Health Facilities Construction - Technical Assistance	1	1	1	1				1	1					4	1				3	2
13.224 Hlth Services Development-Project Grnts		1	1	2	1		1		2	1				3	1				3	1

(Continued)

Code and Program	Entry Point					Rejection Authority					Final Approval Authority					Funding Authority				
	Local	Area	State	R.O.	Central	Local	Area	State	R.O.	Central	Local	Area	State	R.O.	Central	Local	Area	State	R.O.	Central
13.225 Hlth Services Research and Development Fellowships and Training					1				1	1					1					1
13.226 Hlth Services Research and Development Grants and Contracts		1	2	2	1					2					2					2
13.227 Hlth Statistics Training and Technical Assistance																				
13.228 Indian Health Service																				
13.229 Indian Sanitation Facilities				1						1				1					1	
13.230 Intensive Infant Care Projects	2	2	2	1		1	1	2	3					3	4				2	5
13.231 Maternal and Child Health Research					3					3					3					3

(Continued)

Code and Program	Entry Point					Rejection Authority					Final Approval Authority					Funding Authority				
	Local	Area	State	R.O.	Central	Local	Area	State	R.O.	Central	Local	Area	State	R.O.	Central	Local	Area	State	R.O.	Central
13.232 Maternal and Child Health Services	1	1	3	1	1			1	3	3				4	1				4	1
13.232 Maternal and Child Health Services Project Grants	1		1	3	1			1	2	1				2	2				2	2
13.233 Maternal and Child Health Training	1		1	1	2			1	1	2				1	2				1	2
13.234 Maternity and Infant Care Projects	1	1	2	2	1			2	3	1				3	4				2	5
13.235 Mental Health Community Assistance Grants for Narcotic Addiction and Drug Abuse	1	1	1	1	1		1	1	1	1				1	1				1	1
13.237 Mental Health Hospital Improvement Grants		1	2	2	1			1	3	1				3	1				4	
13.238 Mental Health Hosp. Staff Dev. Grants		1	2	2	1				4					2	2				3	1

(Continued)

Code and Program	Entry Point					Rejection Authority					Final Approval Authority					Funding Authority				
	Local	Area	State	R.O.	Central	Local	Area	State	R.O.	Central	Local	Area	State	R.O.	Central	Local	Area	State	R.O.	Central
13.239 Mental Health Narcotic Addiction Treatment																				
13.240 Mental Health Community Mental Health Centers	1	2	2	2	1			1	3	2				2	1				3	
13.240 Mental Health Community Mental Health Centers (Construction)	2	1	1	2	1			2	3	2				2	1			1	3	
13.241 Mental Health Fellowships					1					1					1					1
13.242 Mental Health Research Grants					1					1					1					1
13.243 Mental Health Scientific Communications and Public Education																				
13.244 Mental Health Training Grants																				

(Continued)

Code and Program	Entry Point					Rejection Authority					Final Approval Authority					Funding Authority				
	Local	Area	State	R.O.	Central	Local	Area	State	R.O.	Central	Local	Area	State	R.O.	Central	Local	Area	State	R.O.	Central
13.246 Migrant Health Grants		3	2	2	1		1	2	1	2				2	1				2	1
13.247 Regional Medical Programs				1					1					1						1
13.248 Disease Control - Nutrition					1					1					1					1
13.249 Regional Medical Programs - Operational and Planning Grants																				
13.250 Disease Control Smoking and Health		2	2	2	1		1	1	1	2				2	2				2	1
13.251 Mental Health - Community Assistance Grants for Comprehensive Alcoholism Services		1	1		1		1	1		1					1					1
13.252 Mental Health - Direct Grants for Spec. Projects (Alcoholism)																				

(Continued)

Code and Program	Entry Point					Rejection Authority					Final Approval Authority					Funding Authority				
	Local	Area	State	R.O.	Central	Local	Area	State	R.O.	Central	Local	Area	State	R.O.	Central	Local	Area	State	R.O.	Central
13.253 Health Facilities Construction - Loans and Loan Guarantees		1	1	1					1					1					1	
13.254 Mental Health Direct Grants for Special Projects (Narcotic Addiction and Drug Abuse)																				
13.256 Health Maintenance Organization Service		2	1	2	2				3	3					3				1	3
13.257 Mental Health Alcohol Formula Grants			2	2					3	1				3					2	1
13.258 National Health Service Corps		1	1	2	2				3	2				1	2				1	2
13.259 Mental Health Children's Services		1	1	2	1			1	2	1				2					2	
13.260 Family Planning Services - Training Grants	1		1		1				1	1					1					1
13.261 Family Hlth Centers	1	1	2	2	1			1	2	1				2	1				2	

(Continued)

Code and Program	Entry Point					Rejection Authority					Final Approval Authority					Funding Authority				
	Local	Area	State	R.O.	Central	Local	Area	State	R.O.	Central	Local	Area	State	R.O.	Central	Local	Area	State	R.O.	Central
13.262 Occupational Health Research Grants				1					1					1					1	
13.263 Occupational Health Training Grants					1					1					1					1
13.264 Occupational Health Special Fellowships																				
13.265 Occupational Health Demonstration Grants																				
13.266 Childhood Lead-based Paint Poisoning Control		2	2	2	1				3	2				3	2				3	2
13.267 Urban Rat Control		2	2	2	1				3	1				3	1				3	1
13.268 Disease Control Project Grants		1	1	1					1	2				1					1	
13.269 Drug Abuse																				

APPENDIX H

POPULATION FIGURES TWENTY-FOUR RESERVATION STATES

State	IHS Service Population[1]	Respective State Populations[2]	Percentage
Oklahoma	111,980	2,559,229	4.3
Arizona	100,984	1,770,900	5.7
New Mexico	77,337	1,016,000	7.6
Alaska	53,906	300,382	17.9
South Dakota	31,700	655,507	4.8
Montana	24,894	694,409	3.6
Washington	19,081	3,409,169	.56
North Dakota	12,698	617,761	2.0
Minnesota	10,596	3,804,971	.27
Wisconsin	8,996	4,417,731	.20
Nevada	8,713	488,738	1.8
Utah	6,204	1,059,273	.58
Idaho	4,768	712,567	.67
Wyoming	4,094	332,416	1.2
North Carolina	3,221	5,082,059	.06
Mississippi	3,197	2,216,912	.14
Oregon	3,162	2,091,385	.15
Nebraska	2,848	1,483,493	.19
Florida	2,668	6,789,443	.39
Colorado	2,206	2,207,259	.09
Michigan	2,038	8,875,083	.02
California	913	19,953,134	.004
Kansas	845	2,246,578	.03
Iowa	672	2,824,376	.02

[1]Statistical Branch, Indian Health Service, Health Service Administration, U.S. Department of Health, Education and Welfare, Rockville, Maryland, July, 1974.

[2]United States Bureau of Census, Department of Statistics, U.S. Government Printing Office, Washington, D. C., 1970.

APPENDIX I

FORMULA GRANT FUNDING

FISCAL YEARS 1971 - 1974

ALASKA

	1971[1]	1972[2]	1973[3]	1974[3]
Alcohol Abuse	0	200,000	200,000	200,000
Comprehensive Health Planning	76,800	76,800	90,000	100,000
Crippled Children's Services	275,021	194,673	191,500	191,400
Health Facilities Construction	224,040	0	148,000	0
Maternal and Child Health Services	195,461	196,495	204,191	213,900
Mental Health Services	65,000	65,000	65,000	65,000
Public Health Services	323,100	329,100	332,600	335,400
Drug Abuse	0	0	50,000	100,000
Immunization	59,085	161,671	127,198	47,914
Venereal Disease Control	0	75,000	201,145	38,520
Regional Medical Program	_____	_____	_____	_____
Total	1,218,507	1,298,739	1,609,634	1,292,134

[1]Public Health Service Grants and Awards, Fiscal Year 1971 funds. Superintendent of Documents, U.S. Government Printing Office, Washington, D.C., DHEW Publication No. (NIH) 73-198.

[2]Public Health Service Grants and Awards, Fiscal Year 1972 funds. Superintendent of Documents, U.S. Government Printing Office, Washington, D.C., Stock No. 1740-00365.

[3]Figures obtained from the National Institutes of Health, Division of Research Grants, Statistics and Analysis Branch, Bethesda, Maryland.

FORMULA GRANT FUNDING

FISCAL YEARS 1971 - 1974

ARIZONA

	1971	1972	1973	1974
Alcohol Abuse	0	254,507	261,205	985,156
Comprehensive Health Planning	82,400	76,800	90,000	100,000
Crippled Children's Services	453,155	460,400	536,900	526,600
Health Facilities Construction	150,000	518,318	336,556	C
Maternal and Child Health Services	425,973	438,742	427,684	416,252
Mental Health Services	137,800	140,000	142,800	145,700
Public Health Services	780,800	793,600	809,400	820,357
Drug Abuse	0	0	76,301	241,069
Immunization	175,699	214,065	174,950	156,035
Venereal Disease Control	56,355	301,293	419,445	177,001
Regional Medical Program	817,812	1,917,835	395,270	614,416[1]
Total	3,079,994	5,115,560	4,670,511	4,182,586

[1]1974 figure from January, 1974 to May, 1974.

FORMULA GRANT FUNDING

FISCAL YEARS 1971 - 1974

CALIFORNIA

	1971	1972	1973	1974
Alcohol Abuse	0	2,472,403	2,490,900	6,660,137
Comprehensive Health Planning	491,500	500,500	618,000	688,800
Crippled Children's Services	2,525,849	2,702,900	2,813,100	2,809,200
Health Facilities Construction	10,283,394	0	11,216,018	1,310,639
Maternal and Child Health Services	2,834,834	2,846,178	2,910,939	3,156,900
Mental Health Services	981,000	999,300	1,013,100	1,022,500
Public Health Services	5,558,900	5,662,800	5,740,700	5,793,900
Drug Abuse	0	0	965,270	2,149,422
Immunization	1,596,080	1,485,120	997,190	873,854
Venereal Disease Control	207,900	1,027,259	2,404,259	2,430,087
Regional Medical Program	7,058,236	14,508,068	6,044,278	4,590,909
Total	31,537,493	32,204,546	37,214,268	31,486,348

[1]1974 figure from January, 1974 to May, 1974

FORMULA GRANT FUNDING

FISCAL YEARS 1971 - 1974

COLORADO

	1971	1972	1973	1974
Alcohol Abuse	0	305,630	309,470	487,723
Comprehensive Health Planning	82,400	76,800	90,000	100,000
Crippled Children's Services	509,686	519,234	579,000	583,700
Health Facilities Construction	464,888	0	1,230,740	0
Maternal and Child Health S.	678,683	480,121	489,700	504,100
Mental Health Services	154,500	159,500	121,650	163,490
Public Health Services	875,800	903,800	919,000	926,800
Drug Abuse	0	0	161,527	273,661
Immunization	198,900	205,589	122,684	233,537
Venereal Disease Control	16,170	191,126	241,083	181,700
Regional Medical Program	2,907,348	1,309,504	2,600,442	1,503,121[1]
Total	5,888,375	4,151,334	6,865,296	4,957,832

[1] 1974 figure from January, 1974 to May, 1974

FORMULA GRANT FUNDING

FISCAL YEARS 1971 - 1974

FLORIDA

	1971	1972	1973	1974
Alcohol Abuse	0	971,731	982,357	3,705,045
Comprehensive Health Planning	214,206	203,144	258,800	292,400
Crippled Children's Services	1,412,687	2,955,797	1,562,629	1,602,100
Health Facilities Construction	4,363,894	2,011,144	3,320,580	1,110,896
Maternal and Child Health Services	1,604,726	0	1,659,063	1,205,019
Mental Health Services	384,300	401,300	415,100	420,400
Public Health Services	2,177,400	2,273,800	2,352,500	2,382,600
Drug Abuse	0	0	332,021	887,167
Immunization	508,452	462,044	334,400	311,200
Venereal Disease Control	455,565	1,088,483	1,175,000	1,533,831
Regional Medical Program	1,265,412	2,566,025	661,189	1,166,978[1]
Total	12,386,642	12,933,468	13,063,639	14,617,636

[1] 1974 figure from January, 1974 to May, 1974

FORMULA GRANT FUNDING

FISCAL YEARS 1971 - 1974

IDAHO

	1971	1972	1973	1974
Alcohol Abuse	0	200,000	200,000	232,285
Comprehensive Health Planning	76,800	76,800	90,000	100,000
Crippled Children's Services	276,339	305,370	360,547	359,300
Health Facilities Construction	520,136	1,074,453	304,740	0
Maternal and Child Health Services	234,870	243,870	254,200	271,600
Mental Health Services	87,000	85,900	85,800	87,000
Public Health Services	493,200	487,000	486,200	493,000
Drug Abuse	0	0	104,619	104,619
Immunization	135,950	116,982	0	60,266
Venereal Disease Control	0	57,001	45,272	31,042
Regional Medical Program	0	551,115	0	0[1]
Total	1,824,295	3,198,491	1,931,378	1,739,112

[1]1974 figure from January, 1974 to May, 1974

FORMULA GRANT FUNDING

FISCAL YEARS 1971 - 1974

IOWA

	1971	1972	1973	1974
Alcohol Abuse	0	396,464	393,709	1,052,695
Comprehensive Health Planning	91,600	85,700	85,700	112,600
Crippled Children's Services	916,212	866,242	897,416	1,118,900
Health Facilities Construction	461,615	2,650,331	2,605,760	0
Maternal and Child Health Services	680,398	706,502	723,339	794,094
Mental Health Services	191,700	192,700	193,900	195,100
Public Health Services	1,086,500	1,091,900	1,098,900	1,105,400
Drug Abuse	0	0	237,588	338,627
Immunization	208,250	204,791	236,186	149,503
Venereal Disease Control	12,622	180,965	182,000	144,014
Regional Medical Program	629,860	1,337,823	477,219	478,337[1]
Total	4,278,757	7,713,418	7,131,717	5,489,270

[1]1974 figure from January, 1974 to May, 1974

FORMULA GRANT FUNDING

FISCAL YEARS 1971 - 1974

KANSAS

	1971	1972	1973	1974
Alcohol Abuse	0	307,503	300,953	804,686
Comprehensive Health Planning	82,400	76,800	90,000	100,000
Crippled Children's Services	559,493	590,300	439,725	613,500
Health Facilities Construction	692,749	840,319	374,016	0
Maternal and Child Health Services	483,732	458,400	474,873	535,881
Mental Health Services	166,800	163,600	120,600	158,000
Public Health Services	882,733	883,000	911,200	895,600
Drug Abuse	0	0	258,045	258,984
Immunization	182,650	183,952	164,425	167,486
Venereal Disease Control	6,736	173,626	173,000	132,108
Regional Medical Program	1,151,663	2,013,709	1,751,840	804,102[1]
Total	4,208,956	7,294,209	5,058,677	4,470,347

[1] 1974 figure from January, 1974 to May, 1974

FORMULA GRANT FUNDING

FISCAL YEARS 1971 - 1974

MICHIGAN

	1971	1972	1973	1974
Alcohol Abuse	0	1,148,688	1,145,128	3,061,827
Comprehensive Health Planning	256,700	239,100	287,200	309,000
Crippled Children's Services	1,967,632	1,920,026	2,021,153	1,990,100
Health Facilities Construction	5,270,380	870,000	1,599,122	50,000
Maternal and Child Health Services	2,027,090	1,936,538	1,990,200	2,007,100
Mental Health Services	482,000	483,500	493,400	488,100
Public Health Services	2,731,600	2,740,100	2,796,100	2,766,100
Drug Abuse	0	0	563,117	970,728
Immunization	382,260	487,414	201,260	185,652
Venereal Disease Control	261,756	732,496	780,039	676,160
Regional Medical Program	1,029,651	2,646,241	1,347,169	1,072,136[1]
Total	14,409,069	13,204,103	13,223,888	13,576,903

[1] 1974 figure from January, 1974 to May, 1974

FORMULA GRANT FUNDING

FISCAL YEARS 1971 - 1974

MINNESOTA

	1971	1972	1973	1974
Alcohol Abuse	0	522,299	525,249	1,404,403
Comprehensive Health Planning	119,200	112,600	135,400	151,200
Crippled Children's Services	1,256,268	1,075,936	1,060,029	1,114,600
Health Facilities Construction	2,740,719	1,788,559	111,825	0
Maternal and Child Health Services	905,063	928,649	927,462	949,150
Mental Health Services	238,000	241,600	244,100	243,900
Public Health Services	1,349,000	1,369,200	1,383,000	2,743,006
Drug Abuse	0	0	373,985	447,624
Immunization	252,600	296,543	247,539	214,815
Venereal Disease Control	14,600	279,795	282,000	144,000
Regional Medical Program	1,251,176	1,731,135	312,271	783,484[1]
Total	8,126,626	8,346,316	5,602,860	8,196,182

[1] 1974 figure from January, 1974 to May, 1974

FORMULA GRANT FUNDING

FISCAL YEARS 1971 - 1974

MISSISSIPPI

	1971	1972	1973	1974
Alcohol Abuse	0	417,271	397,485	436,360
Comprehensive Health Planning	68,262	107,500	113,700	121,300
Crippled Children's Services	1,079,784	1,066,600	1,121,300	1,128,200
Health Facilities Construction	1,920,280	4,276,279	697,763	64,360
Maternal and Child Health Services	1,123,047	1,048,233	1,081,800	1,472,628
Mental Health Services	204,800	195,400	186,500	186,100
Public Health Services	1,160,400	1,107,000	1,056,700	1,054,300
Drug Abuse	0	0	311,980	336,923
Immunization	244,150	269,488	197,016	224,278
Venereal Disease Control	93,060	332,134	340,000	215,440
Regional Medical Program	1,208,896	507,711	1,263,314	556,686[1]
Total	7,102,679	9,327,616	6,767,558	5,796,575

[1]1974 figure from January, 1974 to May, 1974

FORMULA GRANT FUNDING

FISCAL YEARS 1971 - 1974

MONTANA

	1971	1972	1973	1974
Alcohol Abuse	0	200,000	200,000	218,408
Comprehensive Health Planning	82,400	76,800	90,000	100,000
Crippled Children's Services	339,988	256,356	286,001	271,100
Health Facilities Construction	863,329	85,515	677,060	10,000
Maternal and Child Health Services	222,453	242,257	230,755	248,100
Mental Health Services	83,600	83,600	62,700	83,600
Public Health Services	473,400	474,000	473,700	474,000
Drug Abuse	0	0	50,000	100,000
Immunization	68,150	106,293	60,659	80,656
Venereal Disease Control	0	47,814	61,890	84,000
Regional Program	0	0	0	0[1]
Total	2,133,320	1,572,635	2,192,765	1,669,864

[1]1974 figure from January, 1974 to May, 1974

FORMULA GRANT FUNDING

FISCAL YEARS 1971 - 1974

NEBRASKA

	1971	1972	1973	1974
Alcohol Abuse	0	205,314	206,323	551,665
Comprehensive Health Planning	82,400	76,800	90,000	100,000
Crippled Children's Services	399,551	439,319	453,600	453,300
Health Facilities Construction	376,292	1,240,701	954,475	0
Maternal and Child Health Services	346,591	353,291	363,321	353,225
Mental Health Services	121,700	121,900	123,200	122,800
Public Health Services	689,700	690,700	698,400	695,900
Drug Abuse	0	0	114,045	177,662
Immunization	110,850	168,761	83,619	127,194
Venereal Disease Control	11,298	154,111	155,000	116,025
Regional Medical Program	1,431,693	212,097	652,477	313,393[1]
Total	3,570,075	3,662,994	3,894,460	3,011,164

[1] 1974 figure from January, 1974 to May, 1974

FORMULA GRANT FUNDING

FISCAL YEAR 1971 - 1974

NEVADA

	1971	1972	1973	1974
Alcohol Abuse	0	200,000	200,000	200,000
Comprehensive Health Planning	18,950	76,800	90,000	100,000
Crippled Children's Services	266,705	244,223	286,800	262,879
Health Facilities Construction	813,277	712,063	0	2,431,055
Maternal and Child Health Services	200,211	204,266	207,994	210,548
Mental Health Services	65,000	67,900	68,600	69,600
Public Health Services	379,300	384,700	390,200	394,500
Drug Abuse	0	0	54,677	100,000
Immunization	74,730	34,700	54,927	89,928
Venereal Disease Control	9,405	64,261	89,694	53,125
Regional Medical Program	0	0	0	0[1]
Total	1,827,578	1,988,913	1,442,892	3,911,635

[1] 1974 figure from January, 1974 to May, 1974

FORMULA GRANT FUNDING

FISCAL YEARS 1971 - 1974

NEW MEXICO

	1971	1972	1973	1974
Alcohol Abuse	0	200,000	200,000	394,542
Comprehensive Health Planning	76,800	76,800	19,200	100,000
Crippled Children's Services	330,493	379,653	494,100	468,200
Health Facilities Construction	1,046,434	192,980	226,000	0
Maternal and Child Health Services	397,458	329,145	342,200	340,800
Mental Health Services	103,400	104,000	103,500	105,300
Public Health Services	586,200	589,200	586,700	596,600
Drug Abuse	0	0	50,000	145,922
Immunization	163,950	138,157	14,000	95,000
Venereal Disease Control	44,062	183,708	281,952	209,173
Regional Medical Program	1,093,221	2,564,217	821,796	593,798[1]
Total	3,842,018	4,757,860	3,139,448	3,049,335

[1] 1974 figure from January 1974 to May, 1974

FORMULA GRANT FUNDING

FISCAL YEARS 1971 - 1974

NORTH CAROLINA

	1971	1972	1973	1974
Alcohol Abuse	0	792,901	787,390	864,397
Comprehensive Health Planning	196,000	188,300	213,300	231,500
Crippled Children's Services	1,974,386	2,028,000	2,142,085	4,222,178
Health Facilities Construction	4,666,965	5,470,548	488,000	0
Maternal and Child Health Services	1,908,325	1,680,547	1,911,072	2,524,231
Mental Health Services	350,600	340,900	334,000	334,700
Public Health Services	1,986,600	1,931,800	1,893,000	1,896,500
Drug Abuse	0	0	653,533	672,239
Immunization	412,400	406,207	242,533	140,000
Venereal Disease Control	187,995	560,987	570,000	580,000
Regional Medical Program	2,326,821	253,376	1,790,506	1,002,034[1]
Total	14,010,092	13,654,466	11,025,436	12,467,779

[1] 1974 figure from January 1974 to May, 1974

FORMULA GRANT FUNDING

FISCAL YEARS 1971 - 1974

NORTH DAKOTA

	1971	1972	1973	1974
Alcohol Abuse	0	200,000	200,000	202,505
Comprehensive Health Planning	76,800	76,800	90,000	100,000
Crippled Children's Services	242,699	285,700	271,500	271,400
Health Facilities Construction	588,500	1,841,555	656,219	10,811
Maternal and Child Health Services	216,561	224,121	220,350	312,900
Mental Health Services	80,500	80,100	81,400	79,400
Public Health Services	456,400	453,800	461,000	437,625
Drug Abuse	0	0	80,621	100,000
Immunization	84,150	107,301	55,378	80,025
Venereal Disease Control	0	49,923	45,629	77,000
Regional Medical Program	296,294	433,653	166,428	139,793[1]
Total	2,041,904	3,752,953	2,328,525	1,811,459

[1]1974 figure from January, 1974 to May, 1974

FORMULA GRANT FUNDING

FISCAL YEARS 1971 - 1974

OKLAHOMA

	1971	1972	1973	1974
Alcohol Abuse	0	387,949	390,870	1,045,104
Comprehensive Health Planning	95,900	90,400	105,000	117,000
Crippled Children's Services	666,832	725,315	754,200	1,200,400
Health Facilities Construction	1,620,934	1,930,519	1,591,344	0
Maternal and Child Health Services	602,965	620,388	627,587	778,300
Mental Health Services	189,500	189,500	189,100	189,200
Public Health Services	1,073,900	1,075,100	1,071,300	1,060,923
Drug Abuse	0	0	168,570	335,073
Immunization	170,650	210,394	121,800	43,676
Venereal Disease Control	27,383	312,907	316,000	325,771
Regional Medical Program	927,010	284,198	887,159	494,760[1]
Total	5,375,074	5,825,860	6,222,930	5,590,207

[1] 1974 figure from January, 1974 to May, 1974

FORMULA GRANT FUNDING

FISCAL YEARS 1971 - 1974

OREGON

	1971	1972	1973	1974
Alcohol Abuse	0	288,598	296,212	792,008
Comprehensive Health Planning	82,400	76,800	90,000	100,000
Crippled Children's Services	563,302	565,500	584,900	627,900
Health Facilities Construction	1,208,433	1,701,477	1,622,501	0
Maternal and Child Health Services	536,415	546,456	539,104	584,500
Mental Health Services	151,400	153,900	157,400	157,400
Public Health Services	857,600	872,400	892,000	891,700
Drug Abuse	0	0	152,215	259,008
Immunization	149,218	282,119	178,164	208,321
Venereal Disease Control	14,271	176,100	208,753	173,453
Regional Medical Program	944,660	55,531	1,187,605	0[1]
Total	4,507,699	4,718,881	5,908,854	3,794,290

[1] 1974 figure from January 1974 to May, 1974

FORMULA GRANT FUNDING

FISCAL YEARS 1971 - 1974

SOUTH DAKOTA

	1971	1972	1973	1974
Alcohol Abuse	0	200,000	200,000	214,417
Comprehensive Health Planning	76,800	76,800	90,000	100,000
Crippled Children's Services	248,501	265,592	280,000	522,300
Health Facilities Construction	410,000	1,000,000	728,120	0
Maternal and Child Health Services	182,917	199,743	230,150	259,600
Mental Health Services	82,000	82,700	62,100	82,500
Public Health Services	464,900	468,900	469,300	455,700
Drug Abuse	0	0	88,139	100,000
Immunization	89,600	114,571	68,134	112,492
Venereal Disease Control	10,890	65,882	72,600	69,000
Regional Medical Program	0	288,844	0	0[1]
Total	1,565,608	2,763,032	2,800,998	1,916,009

[1]1974 figure from January 1974 to May, 1974

FORMULA GRANT FUNDING

FISCAL YEARS 1971 - 1974

UTAH

	1971	1972	1973	1974
Alcohol Abuse	0	200,000	200,000	415,403
Comprehensive Health Planning	76,800	76,800	90,000	100,000
Crippled Children's Services	357,465	324,589	346,278	346,300
Health Facilities Construction	161,544	212,412	823,433	0
Maternal and Child Health Services	181,558	409,061	423,050	616,600
Mental Health Services	435,724	105,400	73,550	508,610
Public Health Services	516,742	597,100	412,500	527,700
Drug Abuse	0	0	154,158	154,158
Immunization	99,300	104,710	58,944	84,421
Venereal Disease Control	0	64,764	71,845	54,808
Regional Medical Program	3,109,870	4,099,257	338,776	1,298,934[1]
Total	4,939,003	6,194,093	2,992,534	4,106,934

[1] 1974 figure from January, 1974 to May, 1974

FORMULA GRANT FUNDING

FISCAL YEARS 1971 - 1974

WASHINGTON

	1971	1972	1973	1974
Alcohol Abuse	0	443,755	453,332	1,212,114
Comprehensive Health Planning	92,500	89,950	116,700	127,900
Crippled Children's Services	689,782	784,027	790,200	972,800
Health Facilities Construction	595,160	5,000,000	6,266,819	0
Maternal and Child Health Services	872,651	805,421	832,700	981,300
Mental Health Services	214,300	216,400	218,200	218,600
Public Health Services	1,214,200	1,226,100	1,236,500	1,239,000
Drug Abuse	0	0	95,498	383,608
Immunization	221,100	253,200	108,338	5,361
Venereal Disease Control	14,850	299,067	0	411,659
Regional Medical Program	1,478,613	2,704,044	587,517	1,024,283[1]
Total	5,393,156	11,821,964	10,705,804	6,576,625

[1] 1974 figure from January, 1974 to May, 1974

FORMULA GRANT FUNDING

FISCAL YEARS 1971 - 1974

WISCONSIN

	1971	1972	1973	1974
Alcohol Abuse	0	616,909	620,844	1,660,004
Comprehensive Health Planning	126,300	130,900	161,900	179,100
Crippled Children's Services	1,049,513	1,209,929	1,239,800	1,702,100
Health Facilities Construction	1,433,287	72,800	2,595,541	0
Maternal and Child Health Services	1,004,099	956,656	1,032,757	1,331,600
Mental Health Services	265,200	273,400	278,600	279,300
Public Health Services	1,502,600	1,549,300	1,578,900	1,582,600
Drug Abuse	0	0	459,754	529,360
Immunization	335,750	145,691	158,550	159,240
Venereal Disease Control	27,700	218,256	222,000	266,567
Regional Medical Program	1,074,609	3,776,181	1,332,097	923,686[1]
Total	6,819,058	8,950,022	9,680,743	8,613,557

[1]1974 figure from January, 1974 to May, 1974

FORMULA GRANT FUNDING

FISCAL YEARS 1971 - 1974

WYOMING

	1971	1972	1973	1974
Alcohol Abuse	0	200,000	200,000	200,000
Comprehensive Health Planning	60,000	76,800	90,000	100,000
Crippled Children's Services	171,983	183,440	186,412	188,600
Health Facilities Construction	2,067,362	853,348	16,334	0
Maternal and Child Health Services	204,043	180,193	165,012	211,500
Mental Health Services	65,000	65,000	65,000	65,000
Public Health Services	348,300	353,700	355,000	353,300
Drug Abuse	0	0	50,000	100,000
Immunization	41,240	84,784	57,848	36,887
Venereal Disease Control	0	40,708	34,344	34,439
Regional Medical Program	0	0	0	0[1]
Total	2,957,928	2,037,973	1,220,000	1,289,726

[1]1974 figure from January, 1974 to May, 1974