

Excerpts from:
Part 1
Developments In Aging: 1976

A Report
of the
Special Committee On Aging
United States Senate

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**SIGNIFICANT STEPS FOR OLDER
NATIVE AMERICANS**

The first National Indian Conference on Aging was held in Phoenix, Ariz., June 15 to 17, 1976. Sponsored by the National Tribal Chairmen's Association and funded principally by the U.S. Administration on Aging (AoA), this gathering brought together more than 1,000 Indian and Alaskan Native people representing 171 tribes. Participants attended sessions and workshops on income, environment, legal problems, physical well-being, and legislation. A summary of the conference, containing the recommendations of all workshops, was issued in November 1976.⁸

This conference presented an unprecedented opportunity for Indian elders to meet on immediate and long-range issues. An August follow-up meeting of the National Indian Task Force on Aging in Tulsa, Okla., voted to incorporate as the National Indian Council on Aging. The council received a 3-year grant from the AoA on September 30, 1976, and appointed Mrs. Juana Lyon as its executive director. This grant will provide the council with \$242,367 in fiscal year 1977 for development of its organizational structure and activities; the grant amounts for the subsequent 2 years should be about the same amount.⁹ The council will pursue the recommendations of the conference through advocacy for changes in legislation, service provider policies, and regulations, as well as through intercession on behalf of individual tribes where appropriate. Council officials met in Washington with representatives of Federal agencies involved in Indian services; and legal counsel has been retained to

provide expertise and liaison in the Nation's Capital.

Indian Health Care Improvement Act

The first significant action taken by the council was to urge White House approval of the Indian Health Care Improvement Act, S. 522. This legislation was enacted as Public Law 94-437 on September 30, 1976. It resulted from a congressional finding that:

...the unmet health needs of the American Indian people are severe and the health status of the Indians is far below that of the general population of the United States....All other Federal services and programs in fulfillment of the Federal responsibility to Indians are jeopardized by the low health status of the American Indian people.¹⁰

Specifically, the Congress found that further improvement in the health status of Indians was hampered by inadequate, outdated, inefficient, and understaffed facilities, and was further exacerbated by a lack of access due to poor communications and transportation and by a shortage of potable water and sanitary waste disposal facilities. The act declares it to be the national policy to provide a level of health services adequate to provide the highest possible health status to Indians. To this end, it authorizes the following appropriations for the recruitment and education of Indian health professionals, expansion of health services, the construction and renovation of service facilities, and for the establishment of programs to meet the medical needs of Indians residing in urban areas:

⁸Summary Report, National Indian Conference on Aging, available from the National Indian Council on Aging, P.O. Box 2088, Albuquerque, N. Mex. 87103. \$2.

⁹Conversation with Sandra Fisher, Office of Special Projects, AoA, Feb. 8, 1977.

¹⁰This language is contained in Sec. 2 (d) and (e) of Public Law 94-437.

Authorized Appropriations Under Public Law 94-437,
The Indian Health Care Improvement Act

[Fiscal years]

Title and program	Authorized appropriations (millions)		
	1978	1979	1980
Title I—Indian Health Manpower:			
Health professions recruitment program	\$0.9	\$1.5	\$1.8
Health professions, preparatory scholarship program8	1.0	1.3
Health professions scholarship program	5.45	6.3	7.2
Indian health service extern program6	.8	1.0
Continuing education allowances1	.2	.25
Title II—Health services:			
Patient care	(1)	8.5	16.2
Field health	(1)	3.35	5.55
Dental care	(1)	1.5	1.5
Mental health	(1)	3.4	5.075
Maintenance and repair	(1)	3.0	4.0
Alcoholism treatment and control	4.0	9.0	9.2
Title III—Health facilities:			
Hospitals	67.18	73.256	49.742
Health centers and stations	6.96	6.226	3.72
Staff housing	1.242	21.725	4.116
Safe water and sanitary waste disposal facilities	43.0	30.0	30.0
Title V—Health services for urban Indians:			
Contracts with urban Indian organizations	5.0	10.0	15.0
Rural health projects	Not more than 1 percent of the annual authorized appropriations for title V are available for 2 pilot outreach programs for Indians residing in rural communities near reservations.		

(1) All programs except Alcoholism share \$10,025,000 in fiscal year 1978.

Note: For titles I, II, and III, there are authorized to be appropriated, for fiscal years 1981-84, such sums as may be specifically authorized by an act to be enacted in the future.

The act also provides for the reimbursement of eligible facilities through the Medicaid program.

Clarification Needed on Categories

The Indian and Native Alaskan populations of the United States now fall into three broad legal groupings:

(a) Federally recognized tribes and Alaska regional corporations whose members may reside on reservations or other trust land, in rural nonreservation areas, or in urban centers;

(b) Indian tribes or groups recognized by a State with members residing on State-recognized reservations, in rural nonreservation areas, or in urban centers; and

(c) Individuals not falling into categories (a) or (b) but nevertheless claiming to be of Indian descent or heritage.

As seen by participants at the Phoenix Conference, the importance of these distinctions lies in the fact that only individuals within category (a) are generally

entitled to certain services of the Federal Government. Those benefits are based upon specific commitments made in treaties, laws, and Executive orders, giving substance to the status of federally recognized tribes as quasi-autonomous sovereign entities whose relationship with the central Government takes precedence over the laws of individual States.

Indian individuals falling within categories (b) and (c) depend for their services primarily upon the States, counties, and cities within which they reside. Generally, their eligibility for such services is determined by the same criteria as are applied to the non-Indian populations. While protests about the inequity of the distinctions between federally recognized and other Indians were voiced at the conference, its summary report makes no recommendation as to a resolution and suggests that affected individuals work for a solution through the appropriate judicial and legislative avenues.

A desire for the direct funding of tribes to carry out programs on behalf of elderly Indians was also voiced repeatedly at the Phoenix conference. A step in that direction was taken by AoA in May 1976. An information memorandum¹¹ issued at that time requires each State with federally recognized tribes within its boundaries to submit an action plan for serving elderly Indians as part of its State plan. The action plan must insure that elderly Indians will receive a level of services under Title III of the Older Americans Act that provides benefits equivalent to those received by non-Indian elderly. If the Commissioner determines that this is not the case, and that tribal members would be better served by a direct grant, the Commissioner shall reserve from sums that would be otherwise allotted to such State for area planning and social services 150 percent¹² of an amount which bears the same ratio to the State's allotment as the population of affected Indians over 60 bears to the total State population aged 60 and older. In a question-and-answer session at the Phoenix conference, AoA Commissioner Arthur Flemming stated that he believed this equivalency ratio should be extended to include Title VII (meal program) activities.

The extension of present policy will not, however, meet the objections which have already been voiced by both tribal and State officials. Indian representatives have expressed the opinion that this allocation of State funds fails to grant recognition to their sovereign status, is administratively cumbersome where tribal residence extends beyond a single State's boundaries, and will benefit large tribes more than small ones.

Some State officials have told the committee that this new policy could cripple current aging programs. For example, direct funding for the 10.6 percent of Arizona's 60-plus population comprised of Indians would mean a 15.9 percent reduction in present State aging funds. These officials also note that the absence of service delivery to Indians often results from a tribe's refusal to deal through the State agency as an assertion of sovereignty. Arizona would have no objection to direct funding if the dollars are not taken from the present State aging budget.¹³

Other Developments

In May 1976, a revised statement of understanding concerning the improvement of services to elderly American Indians was issued.¹⁴ The original agreement had been initiated by AoA and the Office of

Native American Programs in October 1975. The revision added four signatories: The Indian Health Service, Public Services Administration, Office of Indian Education, and Department of Transportation. The document commits the six participating agencies to the promotion of better services through expansion of the base of knowledge about elderly Indian needs; the testing of new service modes; the expansion of public awareness; the enlargement of direct tribal and Indian organization involvement; an increased number of Indian professionals in service delivery; and a greater commitment of monetary and personnel resources.

Native American Elders United began to function in 1976. This organization was incorporated the previous year as an outgrowth of the National Council on the Aging's American Indian Caucus. Its purpose is the promotion of a better life for older Indians through the gathering of basic data, the dissemination of information to the general public, and direct appeals to all levels of government. The first step toward this goal was the mailing of a questionnaire to almost 500 tribes asking for identification of the needs and problems of the elderly. NAEU also publishes a quarterly newsletter.¹⁵

Committee on Aging hearings have included testimony on the needs of older Indians. For example, at an August 18 hearing on "The Rural Elderly" in Sioux Falls, S. Dak., Senator Dick Clark listened to testimony by Jack Claymore,¹⁶ project director at the Cheyenne River Reservation in Eagle Butte. Mr. Claymore has developed a new form of long-term care facility for invalid Indians. His manor house concept provides efficiency apartments and supportive services-on-reservation for Indians who would otherwise have to be placed in distant nursing homes. This enables the residents to obtain vital services, avoid isolation, and remain close to familiar cultural roots.

LOOKING AHEAD TOWARD THE 1985 MID-DECADE CENSUS

The first mid-decade census is scheduled for 1985. It holds out the possibility of timely updating of basic data about Americans while at the same time permitting a breadth of questioning beyond that of the regular census. The Special Committee on Aging believes that the mid-decade census will offer an excellent opportunity for increasing our knowledge of the status of older Americans, particularly minority elderly. It plans to consult with demographic experts and with minority senior representatives with a view toward submitting suggested questions to the Bureau of the Census. Planning for the mid-decade census is scheduled to be finalized during 1980.

¹¹AoA-IM-76-62, May 3, 1976, attachment D. (See p. ... of this report. Ed.)

¹²A range of 100-150 percent for this situation is required by the 1975 amendments to the Older Americans Act; see 42 U.S.C. 3001, title III, sec. 303(b) (3) (A).

¹³Conversation with Bob Thomas, acting bureau chief, Arizona Department of Economic Security; R. Alice Drought, director, Area Agency on Aging; and Lloyd Brown, assistant director, program services division, Arizona Department of Economic Security; Phoenix, Ariz., June 17, 1976.

¹⁴AoA-IM-76-67, May 10, 1976. (See p. ... of this report. Ed.)

¹⁵Interested persons may contact Native American Elders United by writing to 808 Ivy Street, Carson City, Nev. 89701.

¹⁶"The Nation's Rural Elderly," part 5, Aug. 18, 1976.

CONCLUSIONS

The economic deprivation of elderly minority groups has intensified because of the 1974-75 recession. By whatever barometer one would use, their quality of life is less satisfying than that of aged whites. Major policy changes are needed to improve the economic well-being of aged blacks, Spanish-speaking persons, Indians, and Asian-Americans.

The committee recommends that the income standards for the SSI program be raised to a level to eliminate poverty for the elderly.

Additionally, the committee urges:

- The Department of Labor to take prompt action to assure that national organizations representing the minority elderly are actively involved in the administration of Title IX senior community service employment projects.
- The Department of Housing and Urban Development to make more section 202 housing for the elderly loans to minority sponsors.
- The Administration on Aging to continue its efforts to involve minority organizations more actively under Older Americans Act programs.

In 1977, the committee plans to undertake a major examination of the treatment of minority groups under social security. Moreover, the committee plans to focus on their special needs in other areas as well: employment, services, health, housing, and others.

ELDERLY MINORITY GROUPS IN 1971 AND 1976

Four special concerns sessions at the 1971 White House Conference on Aging focused on the special problems of aged minority groups: elderly Asian-Americans, blacks, Indians, and Spanish-speaking persons. Several common themes emerged from these four sessions, despite cultural and other differences among these groups. All agreed that the minority aged suffer greater intensity of deprivation than older anglos. There was also widespread agreement that far too little attention has been devoted to the minority

aged's special needs. In addition, the groups emphasized the need to develop more complete and accurate data to enable policymakers to make key decisions on issues affecting aged Asian-Americans, blacks, Indians, and Spanish-speaking persons.

A priority proposal in practically every case was the need for a guaranteed annual income, ranging from \$6,000 for individuals and \$9,000 for couples at the aged and aging blacks special concerns session to \$3,375 for single persons and \$4,500 for married persons at the Spanish-speaking elderly meeting.

The minority groups also focused on unique problems confronting them. The elderly Indians, for instance, urged that the Older Americans Act be amended to permit direct funding of Indian tribes. The Asian-Americans recommended that food assistance programs should take into account their cultural differences. An earlier eligibility age for social security benefits was proposed for aged black males and elderly Spanish-speaking persons because of their shorter life expectancy.

Elderly minority groups have benefited from enactment of several measures affecting older Americans, including:

- Social security increases;
- The establishment of a cost-of-living adjustment mechanism for social security and the supplemental security income program;
- Creation of SSI;
- Establishment of a national hot meals program for older Americans at conveniently located centers;
- Extension of Medicare coverage to disabled social security beneficiaries.

However, the needs of elderly minority groups are so great that considerably more needs to be done before the next White House Conference on Aging. In addition, the proposals for special actions have produced few concrete results. One exception is that the Commissioner on Aging is now authorized to provide direct funding of Indian tribes under Title III upon a determination that (a) Indian tribe members are not receiving benefits equivalent to other older persons in the State, and (b) they would be better served through direct funding.¹²

¹²Older Americans (Act) Amendments of 1975, Public Law 94-135, approved Nov. 28, 1976.