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MAR 15 1976

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The Honorable James G. Abourezk
United States Senate

Dear Senator Abourezk:

This is in response to your April 30, 1975, and subsequent requests for information on (1) allegations, made by two nurses formerly employed at the Indian Health Service Hospital at Shiprock, New Mexico, of insanitary conditions and inadequate patient care at the hospital, (2) Indian Health Service agreements with other Government agencies, (3) Indian Health Service compliance with Indian preference laws, (4) the propriety of contractor and consultant selection by the Indian Health Service's Phoenix area office and Office of Research and Development in Tucson, and (5) the adequacy of data provided by the Indian Health Service to Indian health boards. We are still obtaining data on two other of your requests concerning voluntary sterilization and medical experimentation on human subjects. Findings on these topics will be reported when that work is completed.

We discussed the results of our review with officials of the Indian Health Service, Department of Health, Education, and Welfare. Their comments have been recognized in preparing this report. However, they did not review the report nor provide written comments on its content. Our observations are summarized below, and the detailed information we obtained is contained in the enclosure.

SHIPROCK HOSPITAL

We reviewed allegations concerning the hospital's poor quality health care, uncleanliness, inadequate nursing staff, and low staff morale.

The Indian Health Service acknowledged the need for improving the cleanliness of the hospital, hospital grounds and staff housing. In 1972, the Joint Commission on Accreditation of Hospitals revoked the hospital's accreditation because of its structural and administrative deficiencies, not direct patient care. At the time of our review, September 1975, the Indian Health Service was taking steps to improve the situation and had reapplied for accreditation.

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Shiprock Hospital has been reporting a shortage of nurse for several years. A slight shortage might exist and might be affecting the quality of care provided. An assessment by a non-Indian Health Service medical team concluded the nursing staff level was too low.

After examining medical records, facilities, equipment, staffing patterns, staff qualifications and after discussions with staff and patients, we concluded that the quality of health care seems adequate for a facility of this size.

Due to the increased attention being paid to the Shiprock Hospital as the result of the allegations, Indian Health Service actions, and our presence, we did not draw any conclusions concerning the staff morale at Shiprock. However, the data regarding staff turnover and discussions with staff did not indicate severe morale problems. (See pp. 1 to 6 for detailed data on the Shiprock Hospital review.)

INTERAGENCY AGREEMENTS

Interagency agreements exist between the Department of Health, Education, and Welfare (Indian Health Service) and the National Aeronautics and Space Administration and the Agency for International Development. The Indian Health Service informed us they have no interagency agreements with the Department of Defense; however, some Indian Health Service areas may have made arrangements to refer selected Indian patients to military hospitals on a reimbursable basis. (See pp. 6 and 7.)

INDIAN PREFERENCE LAWS

Commission on Civil Rights and Department of Health, Education, and Welfare reports indicated that the Indian Health Service had only a few Indians in the higher grade positions (both Civil Service and commissioned corps). The reports implied that the Indian Health Service was not fully complying with Indian Preference Laws (25 U.S.C. 45, 472; see also 42 U.S.C. 2001). We could not get a copy of the draft contract report (prepared by Urban Associates) which you requested.

However, more current Indian Health Service personnel statistics indicate that the Indian Health Service has an increasing trend to employ and promote Indian employees. (See pp. 7 and 8.)

SELECTION OF CONTRACTORS AND CONSULTANTS FOR RESEARCH PROGRAMS

We reviewed the procedures followed by the Office of Research and Development and the Phoenix area office in selecting research contractors and consultants. We specifically reviewed the relationship of the University of Arizona with these offices and the possibility that former Indian Health Service employees and friends were being improperly selected as consultants.

We could not conclude, on the basis of information available in contract files and discussions with contracting officials, that research contractors or consultants had been improperly selected. However, documentation in the contract files as required by procurement regulations was often lacking. (See pp. 8 to 11.)

ADEQUACY OF DATA PROVIDED TO INDIAN HEALTH BOARDS

Although not required by law, the Indian Health Service has encouraged, and Indian tribes have established, Indian Health Boards at the service unit, area, and national levels to provide for (1) communication between the Indian Health Service and the Indians and (2) tribal participation in program planning and evaluation. We obtained information on the data being provided by the Indian Health Service to five service unit boards and five area boards, in order to analyze whether or not health boards have been adequately supplied with such data.

For 9 of the 10 boards reviewed, most tribal board members interviewed stated the information provided by the Indian Health Service was generally adequate. The types of data and how often IHS provided it to the nine boards was not always the same. Generally, they received information on budgets, health care statistics, agency programs, and legislation affecting Indian health programs. (See p. 11.)

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As agreed during a December 1, 1975, meeting with your staff, we will send a copy of this report to Senator Edward Kennedy.

Sincerely yours,

Comptroller General
of the United States

Enclosure

NARRATIVE SUMMARY OF INFORMATION

OBTAINED BY TOPIC REVIEWED

SHIPROCK HOSPITAL

The Shiprock Hospital has 75 beds (32 pediatric, 12 obstetric, and 32 surgical and other medical beds) and provides inpatient and outpatient services. It is the basic health resource of the Shiprock Service Unit, which serves an estimated 34,000 people. The Shiprock Service Unit is the largest of eight service units in the Navajo area.

The Joint Commission on Accreditation of Hospitals revoked the Shiprock Hospital's accreditation in 1972. The commission cited deficiencies in medical records (late, incomplete, and imprecise), several problems in the building area, as well as overcrowding in the outpatient clinic. The service unit director said the hospital has reapplied for accreditation and expects a visit from the commission team later this year.

We interviewed Navajo area office and Shiprock Service Unit officials and employees, inspected the hospital and grounds, reviewed selected records, and assessed staff qualifications and nursing staff levels.

Allegations made by two nurses

Two nurses formerly employed at the hospital made several allegations which initially appeared in the "letters to editor" section of the Navajo Times on December 5, 1974. The major allegations and our findings are discussed below.

ENCLOSURE

Allegation	Finding
1. "The grounds around the hospital and housing areas are always heavily scattered with garbage; this lures packs of wild dogs (which continuously roam the compound) and encourages rodents."	The grounds were reasonably clean during our audit: August 7 to 14 and September 15 to 19, 1975. No wild dogs or rodents were observed. The Shiprock Indian Health Board said, at times, the wind blows trash from a nearby low-income housing area onto the hospital and staff housing grounds.
2. "The hospital is in equally poor condition."	The hospital interior appeared reasonably clean. The hospital's 1976 Program Plan identifies the need for two additional housekeepers. The plan indicates that the hospital has less staff than the National Housekeeping Institute recommended level and that the housekeepers also serve as drivers who transport patients.
3. "We found our assigned apartments in extremely poor condition. The first problem is the absolute filth. One of the apartments we were to occupy had been vacant one or more months prior to our arrival, allowing more than ample time for maintenance repairs and cleaning."	The allegation is correct. We did not examine the apartments but noted area office correspondence of January 8, 1975, to Indian Health Service (IHS) headquarters which acknowledged that one apartment was not inspected. The service unit director said steps have been taken to improve the staff apartments by painting, general repair work, and installing new appliances.
4. "We brought this open and immediate proolem [filth and apparent vandalism] to the attention of the appropriate officials at the hospital and the response received was 'we've tried but nothing works'."	IHS has contracted for guard service as a means of reducing break-ins and vandalism of staff quarters. The service unit director feels this action has partially succeeded.
5. "Staff is not adequate to meet patient needs * * *. Because of the lack of adequate staffing it is physically impossible to do anything but the minimum."	Discussed on pages 5 and 6.
6. "* * * a physician refused to examine a patient who had just fallen out of bed because * * * [the physician] had been sleeping and was upset over being woken up."	Review of the patient's case file and the hospital report file on this incident and an interview with the physician in question indicated the patient was examined after falling out of bed. The physician said his examination was limited to examining the patient's head and questioning the patient about being in pain elsewhere. Since no injuries were apparent, the physician said he returned to his quarters. The physician said the nurse felt he should have made a complete physical examination. According to the patient's case file, the patient was released 2 days later without further reference being made to possible injuries from the fall.
7. "* * * lack of communication between all levels of staff and staff and patients."	Review was limited to the nursing department where communication seems lacking between the Director of Nursing and her staff. The director does periodically meet with her nursing supervisors but not with her entire nursing staff. The Bernalillo County Medical Center, in a 1-day review of the facility, also identified the need for improved communication and visibility between the director and her staff. The director said she does not have time to establish greater visibility to her staff and relies on her nursing supervisors to inform her of problems. She added, however, that she has an "open door policy" for nurses wanting to see her. The area director said IHS intends to provide the nursing director with some supervisory management training as a possible solution to the problem.

Staff morale at Shiprock Hospital

Even though interviews of randomly selected employees indicated that staff morale was satisfactory at the time of our review, interviews showed that the allegations by the two nurses had stimulated tremendous emotion and controversy among staff members. Concern over the controversy and turmoil was shown in a resolution passed by the Shiprock Service Unit Indian Health Board on February 6, 1975. The resolution stated

> "* * * that in the event the two nurses are to be reinstated after the Civil Service Commission investigation is completed and/or after the law suit is decided in court that the two nurses be reassigned someplace other than within the Shiprock Service Unit Hospital." 1/

The board stated that the quality of health care would be jeopardized if the two nurses were allowed to return to the hospital.

In random interviews, 19 of 212 employees of the Shiprock Service Unit thought the hospital's staff morale was:

Very good	Satisfactory	Poor	Did not know
1	12	3	3

The three employees who said they did not know were either new or not familiar with the people working in the hospital. No specific reasons were given by the three employees who felt morale was poor. Two of the three did indicate, however, that they felt overworked.

A comparison of the turnover of all staff for the Shiprock Service Unit and the entire Navajo IHS area for fiscal years 1974 and 1975 is shown below. The differences appear insignificant.

	Turnover rate	
	Navajo area	Shiprock Service Unit
	(percent)	
1974	25.3	24.9
1975	21.7	21.7

1/IHS said no lawsuit had been filed as of Mar. 9, 1976.

The Shiprock Hospital nursing staff turnovers for the same periods were 42 and 29 percent, respectively. Comparable data for the Navajo area was not readily available; but, the Department of Health, Education, and Welfare (HEW) reported that Public Health Service nursing turnovers average 38 percent each year.

Quality of health care at Shiprock Hospital

In March 1975, a medical team from the Bernalillo County Medical Center, Albuquerque, New Mexico, made an independent, 1-day review of the quality of health care at Shiprock Hospital. They concluded that, based on a random review of medical records, the quality of medical care and nursing was satisfactory.

We visited the Shiprock Hospital in September 1975. After examining medical records, facilities, equipment, staffing patterns, and staff qualifications and after discussions with staff and patients, we concluded that the quality of health care provided appeared adequate for a facility of this size.

Adequacy of nursing staff

Shiprock Hospital may not have enough nursing positions. Our work was limited to comparing Shiprock's current nursing coverage to that recommended by other sources.

In 1969, IHS made a study of nursing staff needs at Shiprock Hospital, using the Commission on Administrative Services in Hospitals (CASH) methodology. The study identified a need for 35 more nursing positions.

According to the study, the quality of patient care was slightly below an acceptable level, because nurses were overworked and medical records and nursing care plans were inadequately documented.

A comparison of the hospital's fiscal year 1970 and 1975 outpatient visits, average daily patient load (inpatient), and actual full-time nursing staff at the end of the fiscal year is shown below.

	Outpatient visits	Average daily patient load (inpatient)	Actual full-time nursing staff at end of fiscal year
1970	62,696	62	55
1975	a/44,975	46	a/63
Addition or (difference)	(17,721)	(16)	8

a/Does not include 24,803 visits at the Maternal and Child Health Clinic and its related staff. Services were previously provided by the hospital but now are provided in a separate facility funded by the Health Services Administration of HEW.

Even though we did not do a CASH study using 1975 data, we did apply ratios derived from the 1969 CASH study to fiscal year 1975 workload data. These ratios showed a need for about nine more nurses. The Shiprock Service Unit program plans for fiscal years 1974-76 have identified a need for seven to nine more nurses.

The Bernalillo County Medical Center report indicated that the nursing staff was low compared to national standards. According to the report, the national average was 5.0 hours of nursing care every 24 hours for intermediate care patients; and 12.5 hours, for intensive care patients. The report showed that Shiprock Hospital's medical-surgical unit, which averages one or two intensive care patients a day, offers only 3.0 hours of care every 24 hours. According to the report this was too low. It did not identify the number of additional nurses required.

We compared the nursing care hours available per patient for three Shiprock Hospital departments from February 16 through March 1, 1975, with staffing standards recommended in the CASH study. The comparison also showed a need for more nursing coverage.

Department	Nursing care hours per patient (note a) Available 2/16/75 to 3/1/75	CASH study recommendations
Medical-surgical	3.5	4.2
Obstetrics/nursery	2.7	4.2
Pediatrics	5.4	6.5
Average	3.6	5.0

a/These comparisons assume the mixture of patient characteristics, such as age, type of illness, or severity of illness, were the same in 1975 and 1969.

We compared average nursing hours available to a patient each day at the Shiprock Hospital with the average nursing hours available at 140 Government hospitals of the same size range (as found in a study by the American Hospital Association). Shiprock's fiscal year 1975 average was 6.3 nursing hours compared to 6.4 nursing hours stated in the study.

IHS INTERAGENCY AGREEMENTS

The Office of Research and Development, IHS, was involved in only one joint venture, with the National Aeronautics and Space Administration (NASA). IHS had agreements with the Agency for International Development (AID), Department of State, to loan them IHS staff. IHS informed us they have no interagency agreements with the Department of Defense; however, some IHS areas may have made arrangements to refer selected Indian patients to military hospitals on a reimbursable basis. Information on the NASA and AID agreements is summarized below.

NASA agreement

The Office of Research and Development, the Papago Indian Tribe, and NASA are involved in a joint project called Space Technology Applied to Rural Papago Advanced Health Care. The principal objective of the project is to develop and evaluate a health care system for rural and remote areas. The system is designed to use mobile medical facilities with audio and video communications with a primary health facility.

The project was begun by HEW and NASA in 1972. Communities wanting to participate in the project were subsequently advised to submit proposals. In April 1973, HEW and NASA accepted a joint proposal submitted by IHS and the Papago Tribe to demonstrate the project on the Papago reservation. The project became operational in April 1975.

NASA will provide project funds for nonmedical costs for the first 2 years of operation; IHS will be responsible for all aspects of the project's medical operations, including personnel. In the interim, IHS and the Papago Tribe must decide whether they want to maintain the project after the 2-year period.

AID agreements

Under one agreement, IHS has been providing technical assistance to the John F. Kennedy Medical Center in Monrovia, Liberia, since 1967. The agreement provides that AID will reimburse IHS for costs related to its personnel working with key Liberian staff at the Medical Center. As of July 1975, IHS had nine individuals working in areas such as hospital administration, internal medicine, pharmacy, medical records, hospital engineering, and business management. Fiscal year 1975 level of funding by AID was $459,000.

In fiscal year 1975, IHS made another agreement with AID to provide an additional team of three advisors to assist the Liberian Ministry of Health in implementing a pilot project for rural health. The estimated cost to AID for fiscal year 1975 was $90,000; $175,000, for fiscal year 1976.

Both projects were approved under the terms of a 1966 general agreement signed by the Secretary of HEW and the Administrator of AID. IHS reasons for participating in the project were to provide (1) career development for IHS staff and (2) needed assistance to another Federal agency in carrying out its mission.

IHS COMPLIANCE WITH INDIAN PREFERENCE LAWS

Urban Associates prepared a draft report on compliance with Indian preference laws. We requested a copy of it from R.J. Associates (formerly Urban Associates), the contracting officer at HEW, and IHS. All three stated they did not have a copy. R.J. Associates stated that the draft was destroyed in the process of writing the final report.

Urban Associates' final report, dated August 1974, implies IHS is not fully complying with Indian preference laws, especially in the higher grade positions, based on the percentage of Indian employees.

The Commission on Civil Rights has issued at least four reports which also comment on the percentage of IHS Indian employees and their low grade positions.

Our analysis of IHS compliance with the Indian preference laws was directed at a comparison of Indians and non-Indians employed by IHS as of September 30, 1971, through 1974, and June 30, 1975, (table I, p. 12) and discussions with IHS officials. IHS provided the data used in the comparative analysis. All employee categories showed a slight increase in the percentage of Indians employed during this period, except for student stipend and temporary employees. The overall percentage decrease for this category was less than 1 percent, and the employees in this category represented less than 5 percent of all IHS employees.

Classification Act employees (over 60 percent of IHS employees) showed the largest percentage gain. Table II (p. 13) contains a further breakdown of employees in this category.

The commissioned corps employees represented the smallest percentage of Indian employees. An IHS official said this category consists of medical professionals, including physicians, dentists, registered nurses, pharmacists, and health educators. The official attributed the small percentage of Indians in this category to the shortage of Indians with these professional qualifications and willing to work for IHS.

IHS said the areas now have equal employment opportunity officers and an Indian equal employment opportunity office at the IHS headquarters to monitor compliance with the Indian preference laws. The headquarters equal employment opportunity officer said that during the last year two complaints were made. IHS determined that the Indian preference laws had not been violated.

SELECTION OF CONTRACTORS AND CONSULTANTS FOR RESEARCH PROGRAMS

We reviewed research and consultant contracts from fiscal years 1972 through 1975. For this period, congressional appropriations for IHS did not earmark funds for specific research programs on disease.

We could not conclude, on the basis of information available in contract files and discussions with contracting officials, that research contractors or consultants had been improperly selected by the Office of Research and Development or the Phoenix area office. However, documentation in the contract files as required by procurement regulations was often lacking. For those cases, we got information from discussions with IHS officials and their recollections of

transactions. IHS reported that no consultants were hired by the Phoenix area office to do work on research projects.

Since fiscal year 1972, the following research-related contracts were awarded by the Phoenix area office:

Contract number	Contractor	Effective date and amount of award		Contract description
HSM73-71-264	Samaritan Health Services, Inc. Phoenix, Arizona	6/28/71	$226,000	Development of a maternal and infant health care system at White Mountain Apache Reservation.
		7/ 1/72	226,000	
		7/ 1/73	226,000	
		7/ 1/74	226,000	
		7/ 1/75	226,000	
HSM73-75-84	Samaritan Health Services, Inc. Phoenix, Arizona	6/28/74	26,000	Study of lower respiratory diseases at White Mountain Apache Reservation.
HSM73-73-307	The University of Arizona Tucson, Arizona	6/21/73	62,000	Development of Otitis Media control program.
		3/ 1/74	23,280	
HSM73-73-289	The University of Arizona Tucson, Arizona	6/15/73	4,902	Research and evaluation of treatment for toxicity of INH (a drug for treatment of tuberculosis) overdosage.
		6/ 1/74	6,000	
		6/ 1/75	2,950	

Contract number 264 was awarded to Samaritan Health Services because it was considered the most qualified. Proposed work specifications were sent by the Phoenix area office to at least four prospective contractors. Responses were received from the University of Arizona and Samaritan Health Services. The following statement from the contract file summarizes why IHS selected Samaritan Health Services:

> "Both proposals were acceptable but it was felt by the majority of people reviewing that the Samaritan Health Services proposal should be accepted because the consulting staff of physicians who would be guiding their program have been consultants at the Phoenix Indian Medical Center for some time. They have been assisting our staff in caring for Indian mothers and infants at Phoenix Indian Medical Center and consequently would be more familiar with the problems and the methods of Indian Health Service."

According to the contracting officer, the University of Arizona was just beginning medical research, and this created some reservations about awarding the contract to the university.

In a report on the White Mountain Apache Reservation (FGMSD-75-47, Aug. 12, 1975), we reported that IHS considered the maternal and child health care project successful. This program has contributed to a dramatic decrease in the infant mortality rates on that reservation.

The bases for awarding contract numbers 84, 307, and 289 were not documented in the Phoenix area office contract files. The contracting officer gave us his recollection of the award basis of each contract.

Contract number 84 was awarded on the basis of an unsolicited proposal received from Samaritan Health Services, which was working at the White Mountain Apache Reservation on contract number 264.

Contract number 307 had three responses to the request for proposals: from the University of Chicago, Richard D. Zonis and Associates, and the University of Arizona. The latter was considered the only qualified bidder.

Contract number 289 was awarded to the University of Arizona without soliciting other proposals because the amount was small and IHS felt the University of Arizona could do the job. IHS officials acknowledged that this award was contrary to regulations.

Only one contract relating to disease research has been awarded by the Office of Research and Development since July 1, 1971. The $12,000 contract was for a 1-year project to develop a community project for alcohol and drug abuse prevention on the Papago Indian Reservation. It was awarded on the basis of the Buy Indian Act (25 U.S.C. 47). 1/

IHS identified four consultants hired by the Office of Research and Development from fiscal years 1972 through 1975. The total fees paid each consultant ranged from about $9,500 to $31,300. The director of the office said none of the consultants were former IHS employees but one had been an employee of the University of Arizona. The latter received a total of $31,306 in consultant fees during this period for technical guidance in the design, implementation, and

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1/The Government can buy from an Indian noncompetitively.

analysis of research projects on specific subsystems of a comprehensive health delivery system. As a consultant he assisted in evaluating products produced by contractors for the Office of Research and Development.

INDIAN HEALTH BOARDS

Although not required by law, IHS has encouraged, and Indian tribes have established boards at the service unit, area, and national levels to provide for (1) communication between IHS and the Indians and (2) Indian participation in program planning and evaluation. We obtained information on the data being provided by IHS to five service unit boards and five area boards. Table III (p. 14) contains general information on each board reviewed.

Adequacy of data provided boards

For 9 of 10 boards reviewed, most board members interviewed stated the information IHS provided was generally adequate. The exception was the Albuquerque Service Unit Board. This board was organized in August 1974. A previous board had been organized, but it was dissolved after becoming dormant. At the time of our review, the board had not received any statistical or fiscal data on its service unit. The service unit director said he plans to start regularly providing the board concise statistical and fiscal reports giving an overview of service unit activities.

The types of data and how often IHS provides it to the boards is apparently at the discretion of the service unit and area directors. We did not locate any IHS criteria specifying the kinds of data and how often it had to be provided the boards.

The types of data and how often it is provided to the other nine boards reviewed was not always the same. Generally, they received information on budgets, health care statistics, IHS programs, and legislation affecting Indian health programs.

We noted that health care statistics were not being regularly provided to the Navajo and Oklahoma area boards. Both area directors stated this type of data is important to their boards and they plan to start providing it regularly.

DISTRIBUTION OF INDIANS AND NON-INDIANS EMPLOYED BY INDIAN HEALTH SERVICE FROM 1971 TO 1975

Table I

Employee categories	Distribution as of 9/30/71	9/30/72	9/30/73	9/30/74	6/30/75
Classification Act employees (note a):					
Indian	2,812	3,124	3,096	3,458	3,707
Non-Indian	2,334	2,354	2,233	2,392	2,447
Total	5,146	5,478	5,329	5,850	6,154
Percent Indian	54.6	57.0	58.1	59.1	60.2
Commissioned corps:					
Indian	7	8	13	11	15
Non-Indian	1,102	1,176	1,160	1,155	1,201
Total	1,109	1,184	1,173	1,166	1,216
Percent Indian	.63	.67	1.10	.94	1.23
Wage board:					
Indian	1,205	1,343	1,218	1,218	1,223
Non-Indian	183	205	170	141	151
Total	1,388	1,548	1,388	1,359	1,374
Percent Indian	86.8	86.8	87.8	89.6	89.0
Student stipend and temporary employees:					
Indian	190	211	221	212	213
Non-Indian	87	120	145	115	100
Total	277	331	366	327	313
Percent Indian	68.6	63.7	60.4	64.8	68.1
Total (all categories):					
Indian	4,214	4,686	4,548	4,899	5,158
Non-Indian	3,706	3,855	3,708	3,803	3,899
Total	7,920	8,541	8,256	8,702	9,057
Percent Indian	53.2	54.9	55.1	56.3	57.0

a/Each year includes 7 to 15 employees whose GS classification was unknown due to miscellaneous coding errors in compiling the data.

DISTRIBUTION OF INDIAN HEALTH SERVICE CLASSIFICATION ACT EMPLOYEES FROM 1971 TO 1975

Table II

	Distribution as of				
	9/30/71	9/30/72	9/30/73	9/30/74	6/30/75
GS-1 through 5:					
Indian	2,231	2,472	2,381	2,579	2,795
Non-Indian	612	551	470	510	534
Total	2,843	3,023	2,851	3,089	3,329
Percent Indian	78.5	81.8	83.5	83.5	84.0
GS-6 through 10:					
Indian	460	518	568	692	715
Non-Indian	1,210	1,271	1,210	1,267	1,287
Total	1,670	1,789	1,778	1,959	2,002
Percent Indian	27.5	29.0	31.9	35.3	35.7
GS-11 and 12:					
Indian	93	104	110	135	136
Non-Indian	323	336	352	374	373
Total	416	440	462	509	509
Percent Indian	22.4	23.6	23.8	26.5	26.7
GS-13 and 14:					
Indian	18	25	31	40	44
Non-Indian	160	165	178	213	218
Total	178	190	209	253	262
Percent Indian	10.1	13.2	14.8	15.8	16.8
GS-15 and 16:					
Indian	2	4	3	6	6
Non-Indian	22	24	19	26	31
Total	24	28	22	32	37
Percent Indian	8.3	14.3	13.6	18.8	16.2

ENCLOSURE

ENCLOSURE

INDIAN HEALTH BOARDS REVIEWED

Table III

Boards reviewed		Population served	Number of board members	Method of selecting board members		Number of service unit boards	Number of tribes represented	Frequency of board meetings	Date organized	Date incorporated	Number of IHS contracts administered
Area	Service unit			Appointed	Elected						
Aberdeen		47,913	20	X		9	17	Quarterly	1968	5/74	3
	Rapid City	2,715	11		X	-	(a)	Biweekly	1970	6/71	1
Albuquerque		37,000	9	X		2	26	Quarterly	1970	Not incorp.	(c)
	Albuquerque	16,877	27	X		-	9	Monthly	b/1974	" "	(c)
	Santa Fe	12,250	14	X		-	14	Monthly	1972	" "	(c)
Navajo		150,000	16	X	X	8	1	Quarterly	1970	Not incorp.	(c)
	Shiprock	34,000	16		X	-	1	Monthly	1972	" "	(c)
Oklahoma City		112,941	38	X		9	36	Quarterly	1969	12/72	5
	Claremore	36,182	19	X		-	14	Eight times a year	1969	11/74	0
Phoenix		53,097	12	X		10	16	Quarterly	1969	7/73	1

a/Serves urban Indian population.

b/Reorganization date.

c/A board must be incorporated to administer IHS contracts.