URBAN INDIANS AND HEALTH CARE IN AMERICA

Testimony of

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Before the
Senate Committee on Indian Affairs
On the FY 2004 President's Budget Request

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Introduction. Honorable Chairman and Committee Members, my name is Kay Culbertson. I am the president of the National Council of Urban Indian Health (NCUIH) and a member of the Fort Peck Assiniboine & Sioux Tribes from Poplar, Montana. I am also the Executive Director of Denver Indian Health and Family Services in Denver, Colorado. On behalf of NCUIH, I would like to express our appreciation for this opportunity to address the Committee on the FY 2004 President's Budget Request and its impact on the off reservation Indian population.

Founded in 1998, NCUIH is a membership organization representing urban Indian health programs. Our programs provide a wide range of health care and referral services in 41 cities. Our programs are often the main source of health care and health information for urban Indian communities. In this role, they have achieved extraordinary results, despite the great challenges they face. According to the 2000 census, 66% of American Indians live in urban areas, up from 45% in 1970 and 52% in 1980 and 58% in 1990. We expect that these percentages will continue to increase over the next ten years. It should be added that the American Indian population is widely considered the most undercounted group in the Census. Although the total number of Indians may actually be low, our experience is that the relative percentage of urban versus reservation Indians is accurate. Like their reservation counterparts, urban Indians historically suffer from poor health and substandard health care services.

Federal Responsibility for Urban Indians. NCUIH believes that there is a Federal obligation to urban Indians. Congress enshrined its commitment to urban Indians in the Indian Health Care Improvement Act where it provided:

> "that it is the policy of this Nation, in fulfillment of its special responsibility and legal obligation to the American Indian people, to meet the national goal of providing the highest possible health status to Indians *and urban Indians* and to provide all resources necessary to effect that policy"

25 U.S.C. Section 1602(a)(emphasis added). In so doing, Congress has articulated a policy encompassing a broad spectrum of "American Indian

people." Similarly, in the Snyder Act, which for many years was the principal legislation authorizing health care services for American Indians, Congress broadly stated its commitment by providing that funds shall be expended " for the benefit, care and assistance of the Indians *throughout* the United States for the following purposes: . . . For relief of distress and conservation of health." 25 U.S.C. Section 13 (emphasis added). As noted above, in Acts of Congress, as well as in both Senate and House reports, there has been an acknowledgment of a Federal responsibility for urban Indians.

The Supreme Court and other Federal courts have also acknowledged that there is a Federal responsibility towards Indians, both on and off their reservation. "The overriding duty of our Federal Government to deal fairly with Indians *wherever located* has been recognized by this Court on many occasions." *Morton v. Ruiz*, 415 U.S. 199, 94 S.Ct. 1055, 39 L.Ed.2d 270 (1974) (emphasis added), citing *Seminole Nation v. United States*, 316 U.S. 286, 296 (1942); and *Board of County Comm'rs v. Seber*, 318 U.S. 705 (1943). In areas, such as housing, the Federal courts have found that the trust responsibility operates in urban Indian programs. "Plaintiffs urge that the trust doctrine requires HUD to affirmatively encourage urban Indian housing rather than dismantle it where it exists. The Court generally agrees." *Little Earth of United Tribes, Inc. v. U.S. Department of Justice*, 675 F. Supp. 497, 535 (D. Minn. 1987).[1] "The trust relationship extends not only to Indian tribes as governmental units, *but to tribal members living collectively or individually, on or off the reservation*." *Little Earth of United Tribes, Inc. v. U.S. Department of Justice*, 675 F. Supp. 497, 535 (D. Minn. 1987)(emphasis added). "In light of the broad scope of the trust doctrine, it is not surprising *that it can extend to Indians individually*, as well as collectively, *and off the reservation*, as well as on it." *St. Paul Intertribal Housing Board v. Reynolds*, 564 F. Supp. 1408, 1413 (D. Minn. 1983) (emphasis added).

> "As the history of the trust doctrine shows, the doctrine is not static and sharply delineated, but

[1] Congress enunciated its objective with regard to urban Indians in a 1976 House Report: "To assist urban Indians both to gain access to those community health resources available to them as citizens and to provide primary health care services where those resources are inadequate or inaccessible." H.Rep. No. 9-1026, 94th Cong., 2d Sess. 18, reprinted in 1976 U.S. Cond Cong. & Admin. News (USCAN) 2652, 2657.

> rather is a flexible doctrine which has changed and adapted to meet the changing needs of the Indian community. This is to be expected in the development of any guardian-ward relationship. *The increasing urbanization of American Indians has created new problems for Indian tribes and tribal members.* One of the most acute is the need for adequate urban housing. Both Congress and Minnesota Legislature have recognized this. The Board's program, as adopted by the Agency, is an Indian created and supported approach to Indian housing problems. *This court must conclude that the [urban Indian housing] program falls within the scope of the trust doctrine . . . .*"
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> Id. At 1414-1415 (emphasis added).

This Federal government's responsibility to urban Indians is rooted in basic principles of Federal Indian law. The United States has entered into hundreds of treaties with tribes from 1787 to 1871. In almost all of these treaties, the Indians gave up land in exchange for promises. These promises included a guarantee that the United States would create a permanent reservation for Indian tribes and would protect the safety and well-being of tribal members. The Supreme Court has held that such promises created a trust relationship between the United States and Indians resembling that of a ward to a guardian. See *Cherokee Nation v. Georgia*, 30 U.S. 1 (1831). As a result, the Federal government owes a duty of loyalty to Indians. In interpreting treaties and statutes, the U.S. Supreme Court has established "canons of construction" that provide that: (1) ambiguities must be resolved in favor of the Indians; (2) Indian treaties and statutes must be interpreted as the Indians would have understood them; and (3) Indian treaties and statutes must be construed liberally in favor of the Indians. See *Felix S. Cohen's Handbook of Federal Indian Law*, (1982 ed.) p. 221-225. Congress, in applying its plenary (full and complete) power over Indian affairs, consistent with the trust responsibility and as interpreted pursuant to the canons of construction, has enacted legislation addressing the needs of off-reservation Indians.

The Federal courts have also found, that the United States can have an obligation to state-recognized tribes under Federal law. See *Joint Tribal Council of Passamaquoddy v. Morton*, 528 F.2d 370 (1st Cir. 1975). Congress has provided, not only in the IHCIA,[2] but also in NAHASDA, that certain state-recognized tribes or tribal members are eligible for certain Federal programs. 25 U.S.C. Section 4103(12)(A).

In the context of all of this law, NCUIH strongly believes that the Federal government's trust obligation to protect American Indians does not stop at the reservation boundary.

Urban Indian communities have principally developed as a result of misguided Federal programs or actions, such as the Bureau of Indian Affairs relocation program, which relocated 160,000 Indians to cities between 1953 and 1962. Today, the children, grandchildren and great-grandchildren of these Indians continue to reside in these cities. They maintain their tribal identity even if, in some cases, they have been unable to re-establish ties, including formal membership, with their tribes. While most, but not all, urban Indians are enrolled in federally recognized tribes, all are Indian descendents. Their circumstances are principally the result of Federal Indian policies; they are deserving, morally and legally, of support from the Federal government in achieving the highest possible health status.

There are a number of Federal programs and policies which have led to the formation of the urban Indian population, including:

(1) the BIA relocation program relocated 160,000 Indians to cities between 1953 and 1962. Today, the children, grandchildren and great-grandchildren of these Indians are still in these cities.
(2) the failure of Federal economic policies on reservations has forced many Indians to seek economic refuge in the cities;

[2] As originally conceived, the purpose of the Indian Health Care Improvement Act was to extend IHS services to Indians who live in urban centers. Very quickly, the proposal evolved into a general effort to upgrade the IHS. See, *A Political History of the Indian Health Service*, Bergman, Grossman, Erdrich, Todd and Forquera, The Milbank Quarterly, Vol. 77, No. 4, 1999.

(3) the Federal policy of "terminating" tribes in the 1950s and 1960s, many of which have not yet been restored to recognition;
(4) The marginalization of tribal communities such that they exist but are not federally recognized;
(5) Indian service in the U.S. military brought Indians into the urban environment;
(6) the General Allotment Act resulted in many Indians losing there lands and having to move to nearby cities and towns;
(7) court-sanctioned adoption of Indian children by non-Indian families; and
(8) Federal boarding schools for Indians.

Some of these federal policies were designed to force assimilation and to break-down tribal governments; others may have been intended, at some misguided level, to benefit Indians, but failed miserably. One of the main effects of this "course of dealing," however, is the same: the creation of an urban Indian community.

Indian Health Care Improvement Act. In 1976, Congress passed the Indian Health Care Improvement Act. The original purpose of this act, as set forth in a contemporaneous House report, was "to raise the status of health care for American Indians and Alaska Natives, *over a seven-year period*, to a level equal to that enjoyed by other American citizens." House Report No. 94-1026, Part I, p.13 (emphasis added).[3]

[3] "The American Indian has demonstrated all too clearly, despite his recent movement to urban centers, that he is not content to be absorbed in the mainstream of society and become another urban poverty statistic. He has demonstrated the strength and fiber of strong cultural and social ties by maintaining an Indian identity in many of the Nation's largest metropolitan centers. Yet, at the same time, he aspires to the same goal of all citizens—a life of decency and self-sufficiency. The Committee believes that the Congress has an opportunity and a responsibility to assist him in achieving this goal. It is, in part, because of the failure of former Federal Indian policies and programs on the reservations that thousands of Indians have sought a better way of life in the cities. His difficulty in attaining a sound physical and mental health in the urban environment is a grim reminder of this failure."

"The Committee is committed to rectifying these errors in Federal policy relating to health care through the provisions of title V of H.R. 2525. Building on the experience of previous Congressionally-approved urban Indian health prospects and the new provisions of title V, urban Indians should be able to begin exercising maximum self-

The Senate has recognized that Congress also has an obligation to provide health care for Indians, that includes providing health care to those who live away from the reservation.

> "The responsibility for the provision of health care, arising from treaties and laws that recognize this responsibility as an exchange for the cession of millions of acres of Indian land *does not end at the borders of an Indian reservation.* Rather, government relocation policies which designated certain urban areas as relocation centers for Indians, have in many instances forced Indian people who did not [want] to leave their reservations to relocate in urban areas, and *the responsibility for the provision of health care services follows them there.*"

Senate Report 100-508, Indian Health Care Amendments of 1987, Sept. 14, 1988, p. 25 (emphasis added).

It has been twenty-seven years since Congress committed to raising the status of Indian health care to equal that of other Americans, and eighteen years since the deadline for achieving it has passed. And yet, Indians, whether reservation or urban, continue to occupy the lowest rung on the health care ladder, with the poorest access to America's vaunted health care system.

FY 2004 Budget Request. Although the road ahead to equal health care still appears to be a long one for Indians, including urban Indians, NCUIH believes that increased funding for Indian health is a step in the right direction. The FY 04 President's Budget request for the Indian Health

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determination and local control in establishing their own health programs."

Pub. L. 94-437, House Report No. 94-1026, June 8, 1976, reprinted in 1976 U.S. Cong. & Admin. News (USCAN) 2652 at p. 2754.

Service is $3.6 billion, a net increase of $130 million. However, the Budget request keeps spending for urban Indian programs flat. Of course, NCUIH supports any increase to the IHS budget, but that same increase should also be reflected in the specific budget for urban Indian programs. Just like the on-reservation programs, urban Indian programs have experienced a constant increase in the demand for our services. In fact, the increase in the urban area is likely greater than the increase on the reservation. We also must address the medical inflation rate. A zero percent (0%) increase in the FY 2004 budget for urban Indian programs really amounts to a devastating decrease in our actual ability to serve our client populations.

Urban Indian Health Programs are funded within the Indian Health Service budget at a small fraction of the percentage of urban Indians in the Indian population. In FY 2003, Urban Indian Health Programs received 1.12% of the total Indian Health Service budget, although urban Indians, according to the 2000 census, constituted 66% of the total American Indian population. In 1979, at a time when urban Indians made up a smaller percentage of the overall Indian population, the urban Indian programs received 1.48% of the Indian Health Service budget. These figures indicate a dramatic decline in the level of funding for urban Indian health programs. As a result of this lessened funding, urban Indian programs can only service 95,767 of the estimated 605,000 urban Indians eligible to receive services.

NCUIH acknowledges that there are some sound reasons why the lion's share of the IHS budget should go to reservation Indians. However, we believe that the disparity is too great. All Indian people are connected. Disease knows no boundaries. There is substantial movement back and forth from reservation to urban Indian communities. The health of Indian people in urban areas affects the health of Indian people on reservations, and visa versa. With the 2000 census showing that 66% of the Indian population now resides in urban areas, we strongly believe that the health problems associated with the Indian population can be successfully combated only if there is significant funding directed at both the urban and reservation populations.

To address this disparity, in an amount that urban Indian programs could

effectively put to use immediately, NCUIH recommends a $6 million dollar increase to President Bush's proposed FY 2004 budget for Urban Indian programs. This would lift funding for such programs from $29,947,000 to $35,947,000. While this will not address the total need, it will help to further increase access to and provide quality of care for urban Indians as a beginning to close the funding disparity for off reservation tribal people

The proposed increase would have a huge positive impact on the provision of urban Indian health care. A $6 million increase for urban Indian health programs would provide much needed resources to allow the recruitment and retention of personnel essential to the provision of health care in the urban centers and would enhance the integration of clinical expertise from medical, behavioral health, and community health staff in order to more effectively address the top identified health problems. In addition, such an increase in funding would enable the urban Indian programs to offset increasing expenses as a result of inflation, which is greater in the medical field than in other areas, and continue to build an information infrastructure that is essential to the provision of quality services for these Indian communities. Consistent information infrastructure for urban Indian communities is vitally needed, often state and local statistics misclassify or provide little information regarding American Indians in their states due to the size of the population when compared with other ethnic groups.

The unmet need for Urban Indian Healthcare is $1.5 billion. The Indian Health Service has the ability, within its proposed FTE levels, to expend the proposed $6 million if appropriated. The increase will enable Urban Indian Health to elevate the level of services in several urban centers from outreach and referral services to the provision of direct medical services, provide resources to existing urban Indian Health programs to improve basic health care for a increasing urban Indian population in the areas of alcohol & substance abuse, diabetes, cancer, mental health, elder health, heart disease, dental health, domestic & community violence, and infectious disease. The increase will facilitate the establishment of at least one center of excellence to provide resources for training and technical assistance to the urban Indian health programs and to augment the resources of the newly

developing Urban Indian Health Institute Epidemiology Center in Seattle, Washington.

Diabetes Funding Urban Indian health programs received a 5% set aside, $5,000,000 to provide primary and secondary treatment for diabetics. This increase in funding has allowed programs to provide services that were not provided in the past. Although many urban health programs now have diabetic registries, fitness programs, weight loss groups, and increased access to specialty care; there is a continued need for medication purchase, dental care, renal care and treatment for other diabetic complications.

NCUIH supports the establishment of a ten-percent (10%) set-aside of IHS diabetes funding to be provided to urban Indian diabetes programs. Diabetes has reached epidemic proportions, not only for reservation Indians, but also for the urban Indian community. For example, the prevalence level of diabetes mellitus among the urban Indian community served by the Boston urban Indian health program is 10.4%; for the Portland, Oregon urban Indian community it is 10%. It is important to educate and address the entire Indian community on this issue if true progress is going to be made.

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[5] As originally conceived, the purpose of the Indian Health Care Improvement Act was to extend IHS services to Indians who live in urban centers. Very quickly, the proposal evolved into a general effort to upgrade the IHS. See, *A Political History of the Indian Health Service*, Bergman, Grossman, Erdrich, Todd and Forquera, The Milbank Quarterly, Vol. 77, No. 4, 1999.

Conclusion. America is nowhere near the lofty goal, set by the Congress in 1976, of achieving equal health care for American Indians, whether reservation or urban. NCUIH challenges this Committee to think in terms of that goal as it considers the President's FY 04 Budget Request and provide additional funding that will result in the betterment of health for all Indian people regardless of where they live and reduce health disparities for Indian people. NCUIH thanks this Committee for this opportunity to provide testimony. We strongly urge your positive action on the matters we have addressed today.