

National Indian Health Board



926 Pennsylvania Avenue, SE | Washington, DC 20003 | 202-507-4070 | 202-507-4071 fax | www.nihb.org

The Red Feather of Hope and Healing

**TESTIMONY OF
JESSICA BURGER, MEMBER-AT-LARGE and BEMIDJI REPRESENTATIVE
NATIONAL INDIAN HEALTH BOARD**

BEFORE THE U.S. SENATE COMMITTEE ON INDIAN AFFAIRS

**FY 2010 INDIAN HEALTH SERVICE BUDGET PRIORITIES
March 12, 2009**

Mr. Chairman, Mr. Vice Chairman and Members of the Committee:

I am Jessica Burger, Executive Committee Board member for the National Indian Health Board and Health Director for the Little River Band of Ottawa Indians in Manistee, Michigan. I am honored to appear here today to give you the National Indian Health Board's views on priorities for the FY 2010 Indian Health Service budget. Our NIHB Chairman, Reno Keoni Franklin, regrets that he was not able to travel here from California to deliver this testimony himself.

NIHB was pleased to learn that the Obama Administration is proposing what is described as a "significant" increase in the Indian Health Service (HIS) budget request for FY2010, to a figure in excess of \$4 billion. While we do not yet have any details about the programs and projects for which increases are requested, we are hopeful that the Administration's budget will reflect the recommendations for FY2010 made in March, 2008, by the tribal leaders who comprise the Indian Health Service's National Tribal Budget Workgroup. The Workgroup's detailed recommendations, set out in its paper titled "Restoring the Trust and Leaving a Legacy", were supplied to the Obama Transition Team. NIHB supports and endorses those recommendations and they are attached to my written testimony.

The Workgroup recommended increases in the Indian Health Service Budget totaling \$908 million above the expected FY2009 funding levels. These recommendations focus on two types of needed increases:

Current Services Increases are essentially those budget increments needed to enable the Indian health system to merely continue to operate at its current level of service. This category contains such items as pay cost increases (for IHS, tribal and urban program employees); medical inflation; contract support costs; funding for population growth; facilities construction and staffing; urban program funding (which the Bush Administration sought to eliminate); and restoration of rescission amounts from FY05 and FY06. Without these increases to base funding, we would experience a decrease in our ability to care for our service population. The Workgroup recommends an increase of \$449.3 million for these items. [A chart outlining the recommended increase for each item is attached.]

Program Services Increases refer to the recommended increases in IHS budget accounts to enable our programs to improve and expand the services they provide to Indian patients. As you know, the IHS has long been plagued by woefully inadequate funding in all programmatic areas, a circumstance which has made it impossible to supply Indian people with the level of care they need and deserve. The Workgroup recommended \$458.7 million be added to identified program and facilities accounts. [I attach a chart itemizing the recommended increase for each account.]

Budget Management Issues. I want to call to your attention two structural issues involved with budget management which require special attention and instructions.

First, it has been OMB's practice for the past several years to apply the non-medical inflation factor to the IHS budget. This is wrong, as it greatly underestimates the amount needed to keep up with inflation. Instead, the medical inflation factor should be applied to the IHS budget to more correctly reflect the increased amount needed for this system which is responsible for providing direct care to patients and for purchasing care from public and private providers through the Contract Health Services program. Using the non-medical inflation factor is a sleight-of-hand way of depressing the budget and results in understating the system's true need. For Congress to make informed appropriation decisions, it needs to have accurate estimates of the amount needed to cover inflation in medical care costs.

Thus, please ask the Budget Committee and the Appropriations Committee to instruct IHS budget developers and OMB to apply the medical inflation rate to all subsequent IHS budget requests.

Second, the IHS budget must be shielded from Administration rescissions and Congressional across-the-board cuts. Our system provides direct care to patients. It is unfair – and inhumane – to make IHS programs vulnerable to budget devices employed for the sole purpose of achieving arbitrary budget ceilings. It would be difficult enough to absorb these reductions if the IHS system were funded at its true level of need. But where, as here, our system is funded at 60% of need at best, arbitrary, un-planned for, cuts to program funding puts prudent patient care at severe risk.

Thus, NIHB asks for bill language to protect the IHS budget from all rescissions and across-the-board cuts imposed by the Administration or Congress.

Specific Programs. In the time remaining, I want to mention a few programs targeted by the Workgroup for vital programmatic increases and tell you why I believe you should support these recommendations.

- **Contract Health Services.** This Committee is well aware of the CHS program's critical role in addressing the health care needs of Indian people, having held a hearing last year dedicated to this program alone. The CHS program exists because the IHS system is not capable of supplying directly all the care needed by our service population. In theory, CHS should be an effective and efficient way to purchase needed care – especially specialty care – which Indian health facilities are not equipped to provide or which are cost-effective to offer at every location. But the reality is that the gross underfunding of CHS means that we cannot purchase the quantity and types of care needed. Thus, too many of our Indian patients are left with un-treated and often painful conditions which, if addressed in a timely way would improve quality of life and be more economical to treat. Instead, these conditions worsen over time until they become life- or limb-threatening and wind up being very costly to treat.

The Workgroup proposed what I believe is a very modest \$110 million increase for CHS, although by many estimates the program should be increased by more than \$300 million annually. I urge this Committee to continue its advocacy for a more humane level of funding for the CHS program.

- **Contract Support Costs.** I just cannot understand why Indian Country must constantly implore Presidents and Congress to fully fund contract support costs. Since 1975, when the Indian Self-Determination and Education Assistance Act became a cornerstone of Federal Indian policy, Indian tribes have, in good faith, sought to carry out this policy by exercising the right that law provides to take over direct operation of IHS programs. Yet, by refusing to properly fund CSC, the Federal Government actually impedes its own policy and forces contracting and compacting tribes to divert health care dollars to cover the contracting costs we incur. NIHB supports the Workgroup's recommendation that the CSC line item be increased by \$143.3 million for FY2010, and that all subsequent budgets provide full funding for these costs.
- **Hospitals and Clinics.** This is the core account which funds our system's medical care programs. It also includes funding for the Indian Health Care Improvement Fund (IHCIF) which provides separate funding for distribution to selected operating units in order to reduce resource disparities between units within the IHS system. Without an appropriate level of support in the Hospitals and Clinics account, the United States' trust responsibility for Indian health cannot be met and Health Directors like me are unable to fulfill our health care mission. We urge you to accept the Workgroup's recommendations to increase the overall Hospitals and Clinics account by \$107.4 million, and to supply an additional \$61.2 million for the IHCIF.
- **Healthcare Facilities and Sanitation Facilities.** We call to the Committee's attention the Workgroup's recommended increases in various facilities-related accounts – Healthcare Facilities construction (+\$93.5 million); maintenance and improvement

(+\$8.1 million); Sanitation Facilities construction (+\$26.2 million); and facilities and environmental health support (+\$4.1 million). The Committee knows as well as I do that many, many of our healthcare facilities are inadequate and in poor repair. Funding for new construction had been on a "pause" under the prior Administration, and maintenance and improvement funding has been insufficient to meet demand.

We are very grateful for the generous funding for healthcare and sanitation facilities construction and maintenance provided in the American Recovery and Reinvestment Act, as it will help make up some of the ground lost over the past several years. This is only a one-time boost in resources, however. We need the Obama Administration and the Congress to commit to provide more appropriate levels of support for these facilities accounts – and to do so on a *continuing, recurring basis*.

I appreciate the opportunity to address the Committee today on these important matters. I am happy to answer your questions.