N A T I O N A L I N D I A N H E A L T H B O A R D

101 Constitution Ave. N.W., Suite 8-B02 • Washington, DC 20001
Phone: (202) 742-4262 • Fax: (202) 742-4285
Website: www.nihb.org

Testimony of the National Indian Health Board

Presented by Kathy Kitcheyan

Chairwoman – San Carols Apache Tribe

And Board Member

National Indian Health Board

On the

President's Fiscal Year 2007 (FY07) Budget for

American Indian and Alaska Native Health Programs

February 14, 2006 – 2:30 p.m.

"The most basic human right must be the right to enjoy decent health. Certainly any effort to fulfill Federal responsibilities to the Indian people must begin with the provision of health services. In fact, health services must be the cornerstone upon which rest all other Federal programs for the benefit of Indians."

H.R. Rep. No. 94-1026, pt. 1, at 13 (1976)
Indian Health Care Improvement Act of 1976

Chairman McCain, Vice-Chairman Dorgan, and distinguished members of the Senate Indian Affairs Committee, I am Kathy Kitcheyan, Chairwoman of the San Carlos Apache Tribe, located in San Carlos, Arizona - and Board member of the National Indian Health Board (NIHB). I am here today to represent the NIHB by testifying on the Fiscal Year 2007 (FY07) Indian Health Service (IHS) budget advanced by the President. On behalf of the National Indian Health Board, it is an honor and pleasure to offer my testimony on the President's FY07 Budget for Indian Programs.

Established in 1972, NIHB serves Federally Recognized American Indian and Alaska Native (AI/AN) Tribal governments by advocating for the improvement of health care

delivery to American Indians and Alaska Natives, as well as upholding the federal government's trust responsibility to American Indian and Alaska Native Tribal governments. We strive to advance the level and quality of health care and the adequacy of funding for health services that are operated by the Indian Health Service, programs operated directly by Tribal Governments, and other programs. Our Board Members represent each of the twelve Areas of IHS and are elected at-large by the respective Tribal Governmental Officials within their Area.

The Budget

The President recommends increases in nearly every line item of the Indian Health Service's budget, requesting that Congress appropriate about $3.2 billion dollars this year for health care delivery to America's Native Peoples and another $.8 billion in third party recoveries (such as Medicaid, Medicare and other third party insurance). NIHB notes with appreciation that the FY07 budget request continues the Administration's trend of slight increases to the IHS each year – but, with calculation for population growth included, as well as inflation, America's Native populations cannot maintain even the status quo under this budget. Further, the budget seeks to completely cut funding to urban Indian clinics – a significant block in the foundation of the Indian health care delivery and a recommendation that is completely unacceptable to us. Indeed, in the current economic environment, the President's request is appreciated.

We also realize the IHS fared quite well compared to other agencies; however, it and the Tribal governments providing health care services cannot begin to provide adequate health care with a 4% funding increase, especially considering inflation and, according to information provided by the National Center for Health Statistics, birth-death records indicating that the American Indian and Alaska Native population is increasing at 1.7% per year. The 1.7% population increase translates to approximately 70,000 new patients entering into the Indian Health care system annually.

The "Needs-Based Budget" developed for FY06 documents the IHS health care funding needs at $19.7 billion. The FY07 budget request amount of $4,003,906 (including third-party recovery and mandatory spending) falls well short of the level of funding that would permit American Indian and Alaska Native programs to achieve health and health system parity with the majority of other Americans.

However, it is critical to realize that even the status quo for American Indian and Alaska Native health should not be acceptable to Congress – it would not be acceptable to your families - and is not acceptable to us. **We request a financial and policy commitment from Congress to help America's Native People's move beyond the status quo and begin to achieve true progress in changing the reality of health care inferiority known to us. A ten percent increase over current funding levels would be a convincing articulation of that commitment.**

Indian Country is acutely aware of the funding challenges faced by the federal government. The release of the President's budget last week confirmed the reality that federal spending for all non-defense discretionary programs will be extremely limited. American Indians and Alaska Natives have long been supportive of national security

efforts and will continue to do so. However, we call upon Congress and the Administration to work with Indian Country to find innovative ways to address the funding disparities that continue to hamper Indian Country's efforts to improve the health status of American Indians and Alaska Natives. Funding for the IHS has not adequately kept pace with population increases and inflation. While mandatory programs such as Medicaid and Medicare have accrued annual increases of 5 to 10 percent in order to keep pace with inflation, the IHS has not received these comparable increases. **We will be working with Congress during this appropriations cycle to increase funding for the IHS by 10 percent over the FY06 appropriated levels.**

We in Indian Country deeply feel the challenges facing our nation. One of the most pressing challenges is restoring the lives of those ravaged by brutal forces of nature - the hundreds of thousands forced from their homes, moved to distant and strange locations and wondering whether relief will be swift and complete, or when it will happen, at all. There are entire cities to be rebuilt and lives to be reconstructed. American Indians and Alaska Natives understand what this is like and we support Congress's efforts to assist these disaster victims with rebuilding their lives, their families and their cities. On another front, America is at war both in distant lands and here in our own homeland and I remind you that as citizens of this great nation, American Indians have the highest per-capita participation in the armed services of any ethnic group. There is a record deficit. These and many other realities confronting the federal government create enormous fiscal challenges. American Indians and Alaska Natives support disaster relief, national security, and fiscal responsibility and will continue to do so. The release of the President's budget last week made clear federal spending will be remarkably limited. We must, however, once again call upon Congress to work with Indian Country and the Administration to confront and make measurable progress in addressing the funding disparities that persist and promote our mission and the law of this land to improve the health status of American Indians and Alaska Natives.

No other segment of the population is more negatively impacted by health disparities than the AI/AN population and Tribal members suffer from disproportionately higher rates of chronic disease and other illnesses.

American Indians and Alaska Natives lag behind every other group in America in most economic indicators – but we are in 1st place for health disparities – in some cases – such as in the speed with which we acquire HIV and AIDS in certain age groups and in infant mortality in the Northern Plains – we are first in the whole world. But in the richest, most powerful country in the world, a country whose very foundation – quite literally – sits on the American Indian homeland that was largely traded for guarantees of peace and health care, among other things– can't we do better? A Nation that can produce the space program cannot produce health equity for its Native Peoples? When the United States of America is contemplating methods through which it can provide universal healthcare to the people of Iraq – we simply ask that our Nation look within its own borders first – and invest and commit to its first relationship – its relationship with Native America. Let's make the health care system for American Indians a model for the world – a model we would be proud to export to any Country we genuinely seek to help. And one they would welcome – not fear.

Poor Health Funding = Poor Health Status:

We request $200 million for the Well Indian Nations Initiative – crafted to undertake disease prevention and health promotion activities in Indian Country.

American Indians and Alaska Natives have a lower life expectancy and higher disease burden than others. Approximately 13 per cent of AI/AN deaths occur among those under the age of 25, a rate three times that of the total U.S. population. Our youth are more than twice as likely to commit suicide, and nearly 70 per cent of all suicidal act in Indian Country involve alcohol. We are 670 percent more likely to die from alcoholism, 650 per cent more likely to die from tuberculosis and 204 per cent more likely suffer accidental death. Disproportionate poverty, poor education, cultural differences, and the absence of adequate health service delivery are why these disparities continue to exist.

Public health is the underpinning for wellness in Indian Country and public health includes clean, safe drinking water and sanitation services as well as disease prevention through education, immunization and screening programs for early detection and intervention; mental health; dental health; social services; nutrition counseling; public health nursing; substance abuse treatment and injury prevention.

Funding Commitments=Improved Health Status

The United States has made tremendous strides as a nation when it comes to public health. This is due largely to the federal government's commitment to health research as well as disease prevention and health promotion action. This became evident with the National Institutes of Health (NIH) when a bipartisan effort to double their funding became a successful movement in the first session of the 105th Congress and was accomplished at a level of $27.221 billion by 2003.

Senators, the United States has made tremendous strides as a nation when it comes to public health outcomes, as evidenced by increased life expectancy rates for the overall population. Let's take cancer as an example, which is the second leading cause of death for all Americans. Last week it was announced that for the first time in more than 70 years, the number of people dying of cancer in the United States has declined. The report, hailed as a milestone, comes from an analysis of death statistics gathered by the federal government. Nationwide in 2003, 369 fewer people died from cancer than the year before. All told, about 557,000 people died from cancer. But until 2003, every year we saw an increase in cancer deaths. Officials say the overall drop results from declines in lung, breast, prostate and colorectal cancers. Earlier diagnoses, better treatments and a decline in smoking have contributed to the decrease.

However:

- Lung cancer is the leading cause of cancer death among American Indians and Alaskan Natives.

- Cancer is the second leading cause of death for all American Indians and Alaska Natives 45 years of age and over.

- Cancer is the leading cause of death for Alaska Native Women.

- Cancer is the third leading cause of death for all American Indian and Alaska Natives of all ages.

- American Indians and Alaska Natives have the poorest survival from most cancer sites in comparison with other racial and ethnic groups in the US (e.g. African American, White, Hispanic, Asian American and Pacific Islander).

- Gall bladder cancer is more commonly diagnosed among American Indians from the southwestern region of the US than another minority group.

- Alaska Native women have the highest incidence of mortality from colorectal cancer of any other racial and ethnic group in the US.

- American Indians have the poorest survival from lung cancer of another other US racial or ethnic group.

- American Indians have very high rates of exposure to cancer risk factors, particularly cigarette smoking.

- Over 53% of American Indian men and 33% of American Indian women are cigarette smokers.

- In some communities the smoking rate is as high as 73% total (tribal nation in north central states).

- American Indians have a 42 % tobacco usage rate, the highest of all minority groups in the US.

- The death rate among American Indians due to tobacco abuse is twice that of the US population. An average of 2 out of every 5 American Indian smokers die of tobacco abuse.

- Alaska Native mean and women each have the highest incidence rate of kidney cancer of any other racial group.

Yet, of 217 native languages spoken in America today most do not include a word for "cancer."

<u>Diabetes</u>

Again, American Indians and Alaska Natives are first in the Nation for incidence of Diabetes: It is an epidemic. In Indian Country we are 318 per cent more likely to die from diabetes compared to others and about 73 per cent of people with diabetes also have high blood pressure. Congress established a Special Diabetes Program for Indians yet critical funding to continue basic clinical exams, laboratory tests, screening, education and awareness are set to end next year (2008). The renewal of the Special Diabetes Program funding is a top priority for NIHB and we ask that it be a top priority for Congress, as well.

There is little doubt that these statistics could be radically improved if adequate funding was available to provide consistent, basic health care and to enhance and continue public health programs that promote healthy lifestyles. The Special Diabetes Program for Indians is a successful example that health promotion and disease prevention work.

Contract Support Costs (CSC)

We request an additional $90 million over the current request in order to assure that contract support costs obligations will be met.

The President's FY07 budget request includes a $5.586 million increase in contract support costs. We understand that these are difficult budgetary times and that this increase represents successful efforts on behalf of the Administration and Tribal Leadership to increase funds for contract support costs. In that spirit of appreciation, it also must be stated that the demonstrated need for contract support costs is in excess of $90 million over existing appropriated levels. The President's request of a $5.586 million increase is the first step toward meeting the government's obligations and we request that Congress continue to seek opportunities to advance this effort and provide the necessary resources to Tribal governments operating their own health care systems

The $90 million gap is between current funding and the funding needed for the contracts with tribes into which IHS already has entered. The President's budget request for IHS contract support costs will not begin to address existing contractual obligations. The "Justification of Estimates for the Appropriations Committee" published by the Department of Health and Human Services (HHS) to explain the budget requests for the Indian Health Service states:

"Finally, in continuing to manage CSC funding, and in response to the March 2005 Supreme Court decision in *Cherokee Nation vs. Leavitt* - the IHS as issued additional guidance concerning any new or expanded contracts or compacts being entered into for the balance of FY06 or anticipated in FY07. This guidance requires that tribes and the IHS reach agreement concerning the amount of ISD/CSC funding available and the obligation of the IHS to fund CSC pursuant to the appropriations "cap" on CSC. If there is no agreement on the part of the Tribe then the new or expanded program request will likely be declined. These principles need to be adhered to in the face of limited CSC appropriations, or in instances where the CSC funding may not be available in order for the IHS to enter into new contracts or compacts under the Indian Self-Determination and Education Assistance Act *(ISDEAA – acronym added)*. If the Tribe and the IHS could

not reach agreement, the proposal to contract for the new and expanded PFSA/PFSA would be declined."

This statement suggests that IHS intends to enter into only pre-paid contracts or compacts. And, at the current level - considering the backlog of payment and the level of funding requested by this budget - the outcome is that there would not be funding for any new contracts or compacts in 2007 - or else current contracts or compacts would have to be renegotiated to allow for new compacts or contracts under ISDEAA.

If this is a correct interpretation of the justifications offered to Congress by HHS, it would appear that Tribes would be compelled to sign away their statutory rights as a condition to securing a contract to take on any new or expanded programs.

We strongly urge reconsideration of this line item in the proposed budget. As Tribes increasingly turn to new Self Determination contracts or Self Governance compacts or as they expand the services they have contracted or compacted, funding necessary to adequately support these is very likely to exceed the proposed budgeted amount. We ask you to fund contract support costs at a level that is adequate to meet the needs of the Tribes and to further the important Trust responsibility charged to the federal government. We recommend an additional $90 million to meet the shortfall for current contracting and compacting, and to allow for funding in anticipation of the 20-25 additional Tribal programs anticipated.

This funding is critical to supporting tribal efforts to develop the administrative infrastructure gravely necessary to successfully operate IHS programs. An increase in Contract Support Costs is necessary because as Tribal governments continue to assume control of new programs, services, functions, and activities under Self-Determination and Self-Governance, additional funding is needed. Tribal programs have clearly increased the quality and level of services in their health systems fairly significantly over direct service programs. Failure to adequately fund Contract Support Costs is defeating the very programs that appear to be helping improve health conditions for American Indians and Alaska Natives.

Urban Clinics

The President's FY07 budget recommends cutting all funding to the urban health programs for American Indians and Alaska Natives.

We strongly support the continuation of the urban Indian Health Programs and request they are funded at FY06 levels while enjoying the same 4% increase the general ledger of IHS is recommended to receive under the President's FY07 budget.

Urban Indian health programs, which receive only one percent of IHS funding, provide unique and non-duplicable assistance to Urban Indians who face extraordinary barriers to accessing mainstream health care. Community Health Centers cannot come close to matching the effectiveness of the Urban programs in addressing the needs of urban Indians. Through a culturally savvy and cultural-competency-based approach to Native health, these programs overcome cultural barriers to health care delivery. Many Native Americans are reluctant to go to health care providers that are unfamiliar with Native cultures. Through disease prevention and health promotion activities, urban Indian health programs save money and improve medical outcomes for the patients they serve. As stated in the Indian Health Care Improvement Act, Congress has recognized the value of these programs by stating 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 the HHS FY07 Justification of Estimates for the Appropriations Committee, the rationale for cutting this program is:

"IHS resources have always been targeted to providing health care to communities on or near reservations. For many of these communities, health care from outside the IHS does not exist…One important source of health care for all low income urban Americans is the Health Centers Program."

The assumption is that American Indians and Alaska Natives will seek health care from community health centers through the Health Centers Program. First of all, American Indians and Alaska Natives receive health care through IHS not because they are poor, although it is clear that most are economically disadvantaged; rather, it is because they are **Indian**. Providing health care is part of the Federal Government's trust responsibility toward America's Native People and is not an obligation that is determined by geography-alone.

Second, the fact is that no one knows what will happens if the urban clinics are closed. It is possible that because community health centers are not trained in American Indian cultural competency and are not adequately funded to absorb this new population, urban Indians will either forego seeking care or return to their reservations or Native communities to acquire medical attention. Further, even the National Association of Community Health Centers, Inc. does not support this policy. In a February 10, 2006 letter to the President, they state that "we believe that elimination of the UIHP would be detrimental to the operations of health centers in the 34 communities currently served by Urban Indian Health Organizations." The letter goes on to state that according to the

Indian Health Service's most recent estimates, only 22 percent of the projected need for primary care services among urban Indians is currently being met. Further, "IHS has identified 18 additional cities with AI/AN populations large enough to support" an urban program.

Third, if urban Indians return to there reservations or communities to seek health care, there is contained in this budget no subsequent increase in funding to the Tribes to accommodate this potential increase in patients. **Because there could not only be an impact on the Tribes, but the potential exists for a *substantial impact* on the Tribes – we request that HHS Tribal Consultation takes place before any policy decisions are made to close the Urban Indian Clinics.**

Finally, in the 21st Century it is imperative that the Federal Government act more prudently when making policies that will clearly create upheaval of large numbers of American Indians. American Indians and Alaska Natives are the most vulnerable population in this Nation, and it is an unacceptable US Policy that enters into a plan concerning us for which no clear outcome is known. **Therefore, if closing Urban Indian health clinics is a goal of the US Government, in addition to Tribal Consultation, we also request that the General Accountability Office be engaged to conduct a study to estimate possible outcomes and recommend fact-based options – and that no such plan be wholesale foisted upon the Nation's Native People – but, a demonstration project in a single Area be undertaken to ensure continuity of care.**

Health Facility Construction: The One Year Pause of '06 Continues

We request a restoration of facilities construction funding at FY05 levels

In the FY06 budget, the President requested a staggering decrease, in excess of $85 million for health care facilities construction (HCFC), leaving only $3.32 million in the entire health care facilities budget. This cut was characterized as a "one year pause." Now the "One Year Pause" - which implies a restoration of funds once the pause is over – becomes an even deeper cut: the opposite of what was promised. Mr. President, we are asking you to be true to your word restore the funding for this program. Members of the Senate Committee on Indian Affairs, please help us realize the restoration of these funds and pause the one year pause of '06.

This section of the budget includes construction of new facilities, such as inpatient hospitals, outpatient hospitals, staff quarters for health professionals, regional treatment centers and joint venture construction programs. It also includes the small ambulatory program and the construction of dental facilities. These elements constitute the entire physical infrastructure of the health care delivery system in American Indian and Alaska Native communities. The proposal reflects a desire to institute a "one year pause in new health care facilities construction starts in order to focus resources on fully staffing facilities that have been constructed and are opening in Fiscal Years 05 and 06." While the goal of achieving full staffing in American Indian and Alaska Native clinics and hospitals is commendable, and one we support, disease processes and illnesses do not

take a "pause." Funding to provide adequate facilities to address disease and illness for Native Peoples cannot afford to take a "pause." Stalling health care construction for one year, if it indeed is only for one year, will achieve a setback from which it will take Indian Country a decade to recover. Additionally, the Program Assessment Rating Tool (PART) for FY 2006 measured the IHS HCFC program as "effective," which is an indication that the HCFC program is an effective use of federal resources. The Indian Health Service has taken many steps to operate in an efficient manner and cutting programs that utilize federal dollars responsibly serves as a disincentive.

Indian Health Care Improvement Act

Finally, Mr. Chairman, I would be remiss if I did not mention it has been nearly 14 years since the Indian Health Care Improvement Act (IHCIA) was updated. Indian Country is grateful to you and Senator Dorgan and to the members of the Senate Committee on Indian Affairs for your leadership, commitment of the Committees time and staffing resources and the personal time and energy you have invested into achieving the reauthorization during this Congress. As you know, the United States has a longstanding trust responsibility to provide health care services to American Indians and Alaska Natives. This responsibility is carried out by the Secretary of the United States Department of HHS through the Indian Health Service. Since its passage in 1976 the IHCIA has provided the programmatic and legal framework for carrying out the federal government's trust responsibility for Indian health. The IHCIA is the law under which authority under which health care is administered to American Indians and Alaska Natives. That is why it is so important to all American Indians and Alaska Natives that this law be modernized and reauthorized this year. The National Indian Health Board is committed to seeing IHCIA successfully reauthorized during the 109th Congress.

In Conclusion

On behalf of the National Indian Health Board, I thank the Committee for inviting us to be here today and for its consideration of our testimony. We are grateful for your commitment and for your concern for the improvement of the health and well-being of American Indian and Alaska Native people. We must abate the terrible disparities between the health of American Indians and Alaska Natives when compared to other Americans and that demands a greater increase in funding of the Indian Health Service. Specifically, we request a financial and policy commitment from Congress to help America's Native People's move beyond the status quo and begin to achieve true progress in changing the reality of health care inferiority known to us. A Ten percent increase over current funding levels would be a convincing articulation of that commitment.

We urge you to do so and we look will work with you to realize that end.