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Statement of H. Sally Smith, Chairman

National Indian Health Board

On the

Fiscal Year 2005 Budget for American Indian and Alaska Native Programs

February 11, 2004 – 9:30 a.m.

Senate Russell Building, Room 485

Chairman Campbell, Vice-Chairman Inouye, and distinguished members of the Senate Indian Affairs Committee, I am H. Sally Smith, Chairman of the National Indian Health Board. I am Yupik from Alaska and also represent the Bristol Bay Area Health Corporation in southwestern Alaska. On behalf of the National Indian Health Board, it is an honor and pleasure to offer my testimony this morning on the President's Fiscal Year 2005 Budget for Indian Programs.

The NIHB serves nearly all Federally Recognized American Indian and Alaska Native (AI/AN) Tribal governments in advocating for the improvement of health care delivery to American Indians and Alaska Natives. We strive to advance the level 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 regional area.

I am here today calling upon Congress and the Administration to address the funding disparities that continue to hamper Indian Country's efforts 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. A few examples of those disparities were just released by the Centers of Disease Control and Prevention (CDC) and include:

Chronic diseases - Heart disease and cancer are the leading causes of death for Native Americans. The prevalence of diabetes is more than twice that for all adults in the United States, and the mortality rate from chronic liver disease is more than twice as high, according to 2002 data.

Infant Mortality - The infant mortality rate is 1.7 times higher than non-Hispanic whites. The sudden infant death syndrome (SIDS) rate is the highest in the nation; more than double that of the white population in 1999.

Sexually transmitted diseases (STDs) - In 2001, the syphilis rate was 6 times higher than the rate among the non-Hispanic white population, the Chlamydia rate was 5.5 times higher, the gonorrhea rate was 4 times higher and the AIDS rate was 1.5 times higher.

Injuries - Unintentional injuries are the third leading cause of death and the leading cause for Natives aged 1-44 years. Death rates for unintentional injuries and motor vehicle crashes are 1.7 to 2.0 times higher than the rates for all racial/ethnic populations, while suicide rates youth are 3 times greater than rates for whites of similar age.

Indian Country has continuously advocated for equitable health care funding. Health care spending for AI/AN's lags far behind spending for other segments of society. For example, per capita expenditures for AI/AN beneficiaries receiving services in the IHS are approximately one-half of the per capita expenditures for Medicaid beneficiaries and one-third of the per capita expenditures for VA beneficiaries. In fact, the federal government spends nearly twice as much money for a federal prisoner's health care that it does for an American Indian or Alaska Native.

Further exacerbating the current funding situation are the challenges our Nation faces relating to the war in Iraq and the fight against terrorism, which have further shifted fiscal priorities away from American Indian/Alaska Native health-related initiatives. While we are aware of the fiscal challenges facing our Nation, and as American Indians and Alaska Natives continue to serve in the military at higher rates than other segments of the population, we ask that you ensure that the health needs of American Indians and Alaska Natives are protected during this time.

At this point in my testimony, I would like to illustrate the challenges we face as Tribal leaders as we desperately fight to improve the status of our people.

According to the Indian Health Service, American Indians and Alaska Natives have a life expectancy six years less than the rest of the U.S population. Rates of cardiovascular disease among American Indians and Alaska Natives are twice the amount for the general public, and continue to increase, while rates for the general public are actually decreasing. American Indians die from tuberculosis at a rate 500 percent higher than other Americans, and from diabetes at a rate 390 percent higher.

Public health indicators, such as morbidity and mortality data, continue to reflect wide disparities in a number of major health and health-related conditions, such as Diabetes Mellitus, Tuberculosis, alcoholism, homicide, suicide and accidents. These disparities are largely attributable to a serious lack of appropriated funding sufficient to advance the level and quality of adequate health services for American Indians and Alaska

Natives. Recent studies reveal that almost 20% fewer American Indian and Alaska Native women receive pre-natal care than all other races and they engage in significantly higher rates of negative personal health behavior, such as smoking and alcohol and illegal substance consumption during pregnancy.

The greatest travesty in looking at the deplorable health of American Indians comes in recognizing that the vast majority of illnesses and deaths from disease could be preventable if funding was available to provide even a basic level of care. It is unfortunate that despite two centuries of treaties and promises, American Indians are forced to endure health conditions and a level of health care funding that would be unacceptable to most other U.S. citizens

Trust Obligations of the Federal Government

The federal responsibility to provide health services to American Indians and Alaska Natives reflects the unique government-to-government relationship that exists between the Tribes and the United States. The importance of this relationship is reflected in the provisions of Article I, § 8, clause 3 of the United States Constitution, which gives the federal government specific authorities in its dealings with Indian Tribes.

Article VI, § (2) of the United States Constitution refers to all treaties entered into under the Authority of the United States as the "Supreme Law of the Land". Treaties between the federal government and our ancestors – negotiated by the United States government in return for the cession of over 400 million acres of Indian lands – established a Trust obligation under which the federal government must provide American Indians with health care services and adequate funding for those services. Additional Treaties, Statutes, U.S. Supreme Court decisions and Executive Orders have consistently reaffirmed this Trust responsibility.

The Snyder Act of 1921 has been the foundation for many federal programs for Tribes that have been instituted since its enactment, including programs targeting Indian health. It gives broad authority to Congress to appropriate funds to preserve and improve the health of American Indians and Alaska Natives.

Since 1964, three public laws have dramatically changed the delivery of health care to the Tribes. First, the Transfer Act of 1954 removed responsibilities for health care of American Indians and Alaska Native from the federal Department of the Interior to the, then, Department of Health, Education and Welfare. Essentially, one major Indian program was excised from a Department that had been responsible for a number of key programs for the Tribes. The subsequent transfer of Indian health to a Department with equal standing in the federal system elevated the health and welfare of American Indians and Alaska Natives to a status in which they became a primary focus of Department efforts.

Second, the Indian Self Determination and Education Assistance Act of 1975 changed forever the nature of relationships between Tribal organizations and the federal

government and revolutionized the manner in which health services were delivered in Indian country. The Act provided guidance and direction to IHS to enable it to work with Tribes to develop Tribal based health systems in which Tribal organizations were given tools with which to operate their own health programs.

With approximately half of all service funding through IHS now going to programs that are operated directly by Tribes, health care systems offering locally accessible, coordinated services that are capable of being more responsive to the needs of individual Tribal members are now widely available and expanding. In the 1998 NIHB study "Tribal Perspectives on Indian Self Determination and Self Governance in Health Care Management", 94 percent of the Tribal leaders and health system directors surveyed reported plans to enter into Self Determination or Self Governance agreements with the IHS. Tribally operated systems reported significantly greater gains in the availability of clinical services, community-based programs, auxiliary programs and disease prevention services. In most cases, Tribes contracting or compacting with IHS reported improved and increasingly collaborative relationships with the agency, with both IHS Area Offices and Tribal organizations working together to facilitate the transfer of program management.

Finally, with its comprehensive, far-reaching provisions, the Indian Health Care Improvement Act of 1976 created opportunities for enhancement of services to Tribes through innovative interventions that are responsive to the health needs of the Tribes and their members. Areas in various Tribes and the IHS have intervened to achieve positive changes under the Act include: virtually every component of service delivery; health profession training, recruitment and retention; targeted disease prevention and treatment; funding of health systems; and, mechanisms for integrating Tribal systems with federal programs, such as Medicaid and Medicare. Additionally, through periodic Reauthorizations, one of which will hopefully occur during this session, authority is given by Congress for IHS and Tribes to develop new strategies to improve components of programs in response to administrative, technical and professional trends and advances.

Yet, despite these Acts to achieve critically needed improvements in health systems serving Tribes, easily preventable health problems continue to plague the 1.6 million American Indians and Alaska Natives being served by the Indian Health Service and Tribal health providers.

The President's FY 2005 IHS Budget Request

The IHS FY 2005 budget request is $2.97 billion, an increase of $45 million over the FY 2004 enacted amount for the Indian Health Service. This continual under funding of the Indian Health Service costs our communities through diminished health and well-being as well as higher mortality rates than the rest of the population.

For the past two years, Tribal leaders have developed a "Needs-Based Budget" for Indian Health Service funding. The needs-based budget is developed through a careful

and deliberate process to ensure that it is reflective of the health needs of Indian Country.

The "Needs Based Budget" developed for FY 2005 documents the IHS health care funding needs at $19.4 billion. The FY 2005 budget request amount of $2.97 billion 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.

As we have carefully reviewed the President's FY 2005 IHS Budget Request, several provisions would seriously affect the agency's ability to carry out its responsibilities pertaining to the health and welfare of American Indians and Alaska Natives. Below, I will briefly discuss several of these provisions.

Sanitation Construction: The President's budget includes $103 million for sanitation construction, an increase of $10 million or less than 10 percent over the FY 2004 Budget Request. This increase is appreciated and demonstrates the Administration's commitment to providing safe water and waste disposal to an estimated 22,000 homes. Proper sanitation facilities play a considerable role in the reduction of infant mortality and deaths from gastrointestinal disease in Indian Country.

Epidemiology Centers: We are pleased that the Administration has requested $3 million for new epidemiology centers to serve the Navajo, Oklahoma, Billings and California areas as well as increasing support for the seven existing centers, which currently serve about half of the IHS-eligible service population.

Health Facility Construction: The budget includes a total of $42 million, a decrease of $52 million from FY 2004. The Administration proposes that the requested amount will provide necessary staff housing and complete construction of two health facilities. The thirteen units of staff housing at Zuni, New Mexico, and Wagner, South Dakota, will replaced 16 house trailers constructed during the 1950s and 1960s. With improved housing conditions, the Administration expects recruitment and retention of health professionals to increase at these sites. Once completed, the new Red Mesa Outpatient Facility on the Navajo reservation in Arizona will offer 24-hour emergency care. For the Sisseton-Wahpeton Sioux Tribe in South Dakota, their new outpatient facility will replace the Sisseton hospital built in 1936. These outpatient facilities will allow an additional 36,000 provider visits when construction is completed.

Pay Costs: The budget includes an additional $36 million to cover increased pay costs for IHS's 16,251 FTEs. This amount includes the new 106 additional FTEs proposed for the Indian Health Service. The Administration also proposes that the additional amount will allow tribally run health programs to provide comparable pay raises to their own staffs.

Contract Health Service Funding: The President's Budget Request includes $497 million, which provides an additional $18 million or 4 percent increase over the previous year's budget, for Contract Health Services. While we are very thankful for any increase, the proposed level of funding is so limited that only life-threatening conditions are normally funded. In most other cases, failure to receive treatment from providers outside the IHS and Tribal health system forces people in Indian country to experience a quality of life that is far below the level normally enjoyed by non-Indian Americans.

The documented need for the Contract Health Service Program in Indian Country exceeds $1 billion. At present, less than one-half of the CHS need is being met, leaving too many Indian people without access to necessary medical services. We recommend an increase of at least $175 million, which would raise American Indian and Alaska Native tribes to approximately 60 percent of need.

Contract Support Costs: The President's FY 2005 Budget Request includes $267 million, the same as the FY 2004 enacted budget, to support tribal efforts to develop the administrative infrastructure critical to their ability 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 and failing 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.

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 $100 million to meet the shortfall for current contracting and compacting.

Tribal Management/Self-Governance Funding: According to the President's FY 2005 Budget, the number of tribally managed IHS programs continues to increase, both in dollar terms and as a percentage of the whole IHS budget. Tribal governments will control an estimated $1.8 billion of IHS programs in FY 2005, representing 56 percent of the IHS's total budget request. Because of this, it is critical that funding for self-governance be provided in a manner reflective of this. Therefore, we feel it is necessary to provide funding over and above the proposed amount of $8 million. The FY 2003 budget cut the office of Self-Governance funding by 50% without any notice to tribes. The enacted budget for FY 2004 and the proposed FY 2005 budget both fail to increase the funding beyond $8 million enacted from FY 2003. For Tribal governments to continue managing IHS programs and other Direct Service Tribes to consider compacting, we ask that funding for self-governance be increased to $20 million.

The Need for Increased Preventative Health Efforts in Indian Country

A recent survey by the Centers for Disease Control (CDC) demonstrates the health problems faced by American Indians and Alaska Natives. The CDC contracted with the National Opinion Research Center at University of Chicago to conduct the REACH 2010 Risk Factor Survey. The survey was conducted during June 2001--August 2002 in 21 minority communities in the United States, two of which included 1,791 American Indians who participated in the survey. American Indians had the highest prevalence of obesity, current smoking, cardiovascular disease, and diabetes among both men and women in these four groups. Among all minority men, American Indians also had the highest prevalence of self-reported hypertension and high blood cholesterol levels. Among women, American Indians had the second highest prevalence. The survey also showed that over 80% of Americans Indians surveyed had one or more adverse risk factor or chronic condition while 35% had three or more. This survey by the CDC represents the health challenges faced by Indian Country and the need for additional resources to combat these deadly diseases and risk factors.

As the CDC survey demonstrates, the prevalence of chronic diseases such as cardiovascular disease in Indian Country is increasing and requires immediate attention. Due to a lack of adequate preventative care and education for American Indians and Alaska Natives, heart disease has become the leading cause of death among American Indians and Alaska Natives according to the CDC's 1997 report on cardiovascular disease risk factors. The prevalence of risk factors such as hypertension, current cigarette smoking, high cholesterol, obesity, and diabetes among American Indians and Alaska Natives needs to be addressed. As such, the Indian Health Service and Tribal health centers must receive additional resources to aggressively treat the risk factors and improve the overall health and well being of American Indian and Alaska Native communities.

Cardiovascular disease is also the leading cause of death among American women according to the American Heart Association. The prevalence of this disease among American Indian and Alaska Native women will continue to grow if steps are not taken to prevent hypertension, obesity, high cholesterol, poor diet and lack of exercise, which all combine to put a woman at risk for a heart attack or other coronary event. In 2001, the CDC addressed this problem through its WISEWOMAN demonstration projects. WISEWOMAN stands for Well-Integrated Screening and Evaluation for Women Across the Nation. The WISEWOMAN program provided low-income, under insured, and uninsured women aged 40-64 years in 12 different states with chronic disease risk factor screening, lifestyle intervention, and referral services in an effort to prevent cardiovascular disease. In southern Alaska and South Dakota, the program focused on screening for American Indian and Alaska Native women. This type of project is still needed on a permanent basis in the Indian Health Service and Tribal health clinics.

Along with cardiovascular disease, diabetes, and obesity, cancer increasingly affects American Indian and Alaska Native communities. According to a CDC report in 1998,

lung, colon, prostate and breast cancers constituted 53% of all cancer-related deaths in the United States. The report compared cancer-related deaths by sex and race/ethnicity from 1990-1998. While generally concluding that death rates from these cancers declined among men and women in the United States, lung cancer in women and lung, colorectal, and breast cancer in American Indians and Alaska Natives. Among men, death rates from lung and bronchus cancer decreased 1% to 2% per year for each race/ethnicity except American Indians and Alaska Natives. Among American Indians and Alaska Natives, death rates increased 1.7% per year among men and 2.9% per year among women. The report concluded that increases in death rates for American Indians and Alaska Natives most likely reflected increases in smoking rates. American Indians and Alaska Natives have among the highest smoking rates in the United States according to a report issued by the Centers for Disease Control on January 30, 2004. Considering the prevalence of numerous risk factors for chronic diseases and the under funding of our health systems for preventative care, we ask Members of Congress to provide critical preventative health resources to help build up our communities. We cannot build a strong future for the coming generations if we continue to lose our population to these devastating illnesses.

Homeland Security Funding in Indian Country

The President's FY 2005 budget request for the Department of Health and Human Services (DHHS) reflects the priorities of the United States with regard to health and safety concerns relating to Homeland Security. It reflects the Administration's commitment to anticipating future threats to America's public health care, health infrastructure and human services systems. It is important to note that, along with the Department of Defense and Veteran's Affairs health systems, the Indian Health Service occupies a unique position within the Federal government as a direct health care provider.

Therefore, we are requesting funding be added during FY 2005 to help the Indian Health Service and Tribal governments prepare for and respond to potential terrorist attacks, including increases for Data Systems Improvements.

Conclusion

On behalf of the National Indian Health Board, I would like to thank the Committee for its consideration of our testimony and for your interest in the improvement of the health of American Indian and Alaska Native people. If we are to reduce the terrible disparities between the health of American Indians and Alaska Natives compared to other Americans, we need to properly fund the Indian Health Service and we urge the Senate to significantly increase the IHS funding level during this fiscal year. IHS and the Tribes are continuing to work diligently to develop health systems of sufficient quality and with levels of services that our people desperately need. We look forward to working with you on this budget.