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INDIAN HEALTH

HEARING

BEFORE THE

COMMITTEE ON INDIAN AFFAIRS
UNITED STATES SENATE

ONE HUNDRED NINTH CONGRESS

FIRST SESSION

ON

OVERSIGHT HEARING ON THE STATUS OF INDIAN HEALTH CARE

APRIL 13, 2005
WASHINGTON, DC

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INDIAN HEALTH

WEDNESDAY, APRIL 13, 2005

U.S. SENATE,
COMMITTEE ON INDIAN AFFAIRS,
Washington, DC.

The committee met, pursuant to notice, at 9:33 a.m. in room 485, Senate Russell Building, Hon. John McCain (chairman of the committee) presiding.

Present: Senators McCain, Burr, Coburn, Dorgan, Inouye, Murkowski, and Thomas.

STATEMENT OF HON. JOHN MCCAIN, U.S. SENATOR FROM ARIZONA, CHAIRMAN, COMMITTEE ON INDIAN AFFAIRS

The CHAIRMAN. Welcome to the committee oversight hearing on the status of Indian health care. While the Indian Health Service has reported progress, the mortality rate among Native Americans from causes as diverse as diabetes, tuberculosis, certain types of cancer and suicide remain shockingly high, above the national average and unacceptably high.

For a number of Congresses, this Committee has sought to reauthorize the Indian Health Care Improvement Act, but to date this has not been done. I hope that the testimony we receive today will inspire and inform our efforts as we again seek to update the law to reflect the current health needs in Indian Country.

Senator Dorgan.

STATEMENT OF HON. BYRON L. DORGAN, U.S. SENATOR FROM NORTH DAKOTA, VICE CHAIRMAN, COMMITTEE ON INDIAN AFFAIRS

Senator DORGAN. Mr. Chairman, thank you very much. We will hold many hearings in this committee, none more important than the issue of focusing on health care, because most other things in life are not very satisfactory if you do not have access to good health care.

I want to mention that we held a meeting in the Oval Office 1 day some years ago with certain tribal chairs, and they came in. One of them stood up and said, "I come from a Third World country," and he read for the President the data, the statistics about his reservation. They are likely similar to the statistics nationally. Native American youths are twice as likely to commit suicide, in the Northern Great Plains, 10 times more likely to commit suicide than other Americans statistically. They are five times more likely to die from alcoholism. They are six times more likely to die from

tuberculosis. The rate of death from diabetes is three to four times that of other Americans, twice the rate of accidental deaths.

So this is a very serious issue. I held a meeting, Mr. Chairman, several weeks ago in North Dakota because there had been a rash of five suicides of young people on an Indian reservation in North Dakota. I did not invite the press or others. We just had a long quiet meeting with a lot of people who were involved in these issues. It is heartbreaking.

You hear stories that are just devastating. I will not go into great length today, but I have spoken about Avis Little Wind, a young girl who took her life a while back after spending 90 days in bed in a fetal position, missing 90 days of school. I went up to that reservation and talked to all the people about it. They could not figure out how to put together somebody to help this young woman. Her sister committed suicide. Her dad had committed suicide. Her mother was dysfunctional.

And this goes on and on and on. I asked today to have some special testimony from some experts who are involved in mental health, and I am really pleased that Kathryn Power is with us today. We have others who will testify today about these issues. I just want to say that as we try to work through the health issues, I want to see if we can spend some time on this issue, particularly teen suicide on Indian reservations.

I also want to make the point that Medicare spends about $6,000 per person on health care. The VA spends about $5,200 per person; Medicaid about $3,900 per person. We spend about $3,800 per prisoner because we have Federal responsibilities for the health care of Federal prisoners. The Indian Health Service spends about $1,600 per person for health care of American Indians, and there we have a trust responsibility as well.

We have a very big challenge. I look forward to working with you, Mr. Chairman, and other members of this committee to address these health care issues, which we talk about every year and on which very slight progress is made and so much is yet to be done.

Mr. Chairman, thank you very much.

The CHAIRMAN. Thank you.

Senator Inouye.

STATEMENT OF HON. DANIEL K. INOUYE, U.S. SENATOR FROM HAWAII

Senator INOUYE. I thank you very much, Mr. Chairman. I wish to commend you for holding this hearing on such an important issue.

As you have indicated, Mr. Chairman and Mr. Vice Chairman, Indian health has improved over the years, but when you compare it to the general population of the United States, or for that matter to the Third World, we still rank the lowest on practically every health indicator. Preventive health programs and services are needed more than ever. A few weeks ago, we were once again tragically reminded that one's health involves much more than physical health. It is also mental health. I refer to the Red Lake, Minnesota Reservation. I hope that we can do much more than we are doing now.

Thank you very much.

The CHAIRMAN. Senator Coburn.

STATEMENT OF HON. TOM COBURN, M.D., U.S. SENATOR FROM OKLAHOMA

Senator COBURN. Mr. Chairman, thank you for holding this hearing. We have the largest number of Native Americans of any State in Oklahoma. We have a diversity of care given in our State. Hastings Hospital in Tahlequah does a wonderful job. They are overburdened because of the load they have, but we have other hospitals that do a terrible job. One of the markers for that is what we paid out in malpractice claims, the Federal Government did, for poor delivery of care in many places in Oklahoma.

Although I will not be able to stay for the hearing because I have two other committees going on at the same time, I think it is really important that what Senator Inouye said, prevention is our key, whether it is mental health, whether it is diabetes, and we need to be about putting more dollars into prevention than we do in treatment because we are going to save billions of dollars over the years.

The other point that I would make, and I think everybody ought to be aware of, in the long run we will not be able to continue to increase the funding for any of the programs for Native Americans if we do not get a handle on our other spending. As you look to see what the demands on Native American health care is going to be, and then the demands on the discretionary budget that we are going to be facing, it is very important that wherever we spend money, we spend it wisely. We spend the money not on facilities, but on programs that make a big difference in health.

So I appreciate your having this hearing. There is a lot of work to do in the Native American community to bring their health care up to par and to meet our obligations and our treaty obligations. Part of that is quality enhancement through the physicians that are working there. I hope to bring to you in the very near future an analysis of the malpractice claims paid through the Federal courts in this country by area so that you can see where we are lacking. There are significant areas where we do not have the quality individuals treating Native Americans that we should. Part of that is pay and part of it is other problems, but we can correct that and we should correct that, and we should bring up the standard.

The final thing that I would say is best practices are the way we do that. We need to incentivize that through Native American health and Indian health services so that they follow that. We have great programs that are out there now that will improve care, cut costs and increase availability of those services, and we ought to be about enforcing that that becomes a part of the Indian Health Service.

Thank you, Mr. Chairman.

The CHAIRMAN. Thank you very much.

Senator Thomas.

STATEMENT OF HON. CRAIG THOMAS, U.S. SENATOR FROM WYOMING

Senator THOMAS. Thank you, Mr. Chairman. I too have to go to another hearing this morning, but I did want to thank you for having this. The tribes in our State, this is probably one of the outstanding issues that we need to talk about. So I certainly want to work with this as we go, and I do not have an opening statement. I just wanted to tell you how important it is.

The CHAIRMAN. Thank you very much, Senator Thomas.

Our first panel is Dr. Charles W. Grim, who is the director of the Indian Health Service, Department of Health and Services; and A. Kathryn Power, the director of the Center for Mental Health, Substance Abuse and Mental Health Service Administration of the Department of Health and Human Services.

Dr. Grim, we will begin with you, and perhaps for the record, we can identify who is with you, and you as well, Ms. Power.

Mr. GRIM. Certainly, Mr. Chairman.

STATEMENT OF CHARLES W. GRIM, M.D., DIRECTOR, INDIAN HEALTH SERVICE, DEPARTMENT OF HEALTH AND HUMAN SERVICES, ACCOMPANIED BY CRAIG VANDERWAGEN, ACTING CHIEF MEDICAL OFFICER; AND GARY HARTZ, DIRECTOR, OFFICE OF ENVIRONMENTAL HEALTH AND ENGINEERING

Mr. GRIM. Mr. Chairman and members of the committee, my name is Charles Grim, director of the Indian Health Service. I will be the only one giving an opening statement today, but I have with me Gary Hartz, our director for the Office of Environmental Health and Engineering, and Craig Vanderwagen, our acting chief medical officer.

The CHAIRMAN. Welcome.

Mr. GRIM. We are very pleased today to be able to have this opportunity to testify on behalf of Secretary Leavitt on the status of Indian health. I will summarize my prepared statement and submit a complete written statement for the record.

The CHAIRMAN. Without objection.

Mr. GRIM. It is also a pleasure to testify along with Kathryn Power, the director of the Center for Mental Health Services with the Substance Abuse and Mental Health Services Administration. The Indian Health Service [IHS] and SAMHSA have strengthened our partnerships over the last several years and are doing more than we ever have together for Indian country around mental health and substance abuse issues.

You have asked us here today to discuss the status of Indian health by focusing on health disparities and other related issues such as urban Indian health, Indian health care facilities, Indian self-determination, and part D of the Medicare Modernization Act. I would also like to share with you our concerns and efforts related to the recent tragic events at Red Lake.

I spent part of last week at the Red Lake Chippewa Reservation in Minnesota and witnessed first-hand the results of the devastation brought by the shootings at the Red Lake High School. I met with the tribal chairman and the council. I met with our hospital staff who treated the victims, and I met with many of the mental

health teams that we had brought in to provide some additional surge assistance to the community.

I also saw a community that was beginning to unite and draw strength from the support of these mental health professionals and also from their tribal spiritual leaders and the various community traditional healing ceremonies they were having.

In the midst of the trauma and the upheaval caused by the shootings, I also saw a sense of hope and a spirit of collaboration among the community and the tribal leaders, among the State, and among the many Federal programs that were there. The IHS is working closely with SAMHSA, with the Administration for Children and Families, and its Administration for Native Americans, the Office of Minority Health and other departments within the Department of Health and Human Services to aid the tribe.

We have also been joined by the Department of the Interior, Bureau of Indian Affairs, the Department of Justice and the Department of Education. I want to thank all those Federal departments that are working together to help us improve the overall health of Indian people in the Red Lake community during this crisis.

The thing we need to ask ourselves is how do we prevent such incidents from occurring in the future. First, the IHS continues to focus on screening and primary prevention in mental health, especially for depression which manifests itself in our population in suicide, domestic violence and addictions. Second, we must continue to focus on the effective utilization of treatment modalities that are available and we are currently seeking to improve the documentation of our mental health problems.

The IHS is currently utilizing effective tools for documentation to the behavioral health software package and we are working with the communities who are focusing more on these mental health needs. Today, approximately 80 percent of the mental health budget and 97 percent of the alcohol and substance abuse budget in the IHS is going directly to tribally operated programs, and the tribes and communities themselves are now taking responsibility for their own healing. They are providing effective treatment and prevention services within their own communities, and in addition our fiscal year 2006 budget request included a $59-million increase for that mental services line item, which is a 7.7-percent increase over the 2005 level.

Fortunately, the incidence and prevalence of many of the infectious diseases that we once faced as the leading cause of death and disability among American Indians and Alaska Natives have dramatically decreased due to the increased medical care and public health efforts, including massive vaccination programs and sanitation facility construction programs. As the population lives longer and adopts more of a Western diet and often a more sedentary lifestyle, chronic diseases have emerged as the dominant factor in the health and longevity of Indian people. We are seeing increasing rates of cardiovascular disease, hepatitis C virus, obesity and diabetes. Many of the chronic disease are affected by lifestyles and behavioral health choices.

Our primary focus today is on the development of more effective prevention programs in American Indian and Alaska Native communities. We have begun many programs along with those commu-

nities to encourage the employees of the agency, as well as our tribal and health program partners, to lose weight and exercise. There are programs such as Walk The Talk, Just Move It, and the Take Charge Challenge. We have found that they are all cost-effective in that they help prevent both diabetes and many other chronic diseases and the sequela of them such as heart disease.

We are trying to address many of the things that we face in Indian country with three primary focus areas now. Those are health promotion, disease prevention, continued and increased focus on behavioral health, and the third focus area of chronic disease management. As you indicated in some of your opening comments, Indian health has progressively improved since the passage of the Indian Health Care Improvement Act in 1976. The IHS has honored its commitment to improve the health status of eligible American Indian and Alaska Natives as provided by the Indian Health Care Improvement Act, and has worked with tribes since the Indian Self-Determination and Education Assistance Act was enacted in 1975 to assist in the successful transition of IHS-administered health programs to tribal control and administration.

Prevention and health promotion programs continue to be a personal priority of mine and the Secretary, and they have received a $33 million funding increase in the President's fiscal year 2006 proposed budget for the IHS.

We recognize, however, that many health disparities continue to exist between American Indians and Alaska Natives and all other groups in the United States. We seek to address this through continued support of these health promotion and disease prevention programs targeted at some of the diseases that have the highest mortality rates in our population.

In addition, our scholarship and loan repayment programs provide opportunities to recruit and retain young Indian professionals to serve their communities, wile the Sanitation Facilities Construction Programs continue to provide safe water, wastewater disposal, and solid waste systems for the well-being of many communities. Through effective ongoing consultation with tribes, and urban Indian programs, the Federal Government is benefiting from the communication that enables all parties to understand the needs and the most effective ways to address them.

Mr. Chairman, this concludes my statement. Thank you for the opportunity to discuss the Indian health programs that are serving our communities today and their impact of the health status on American Indians and Alaska Natives. We will be happy to answer any questions the Committee might have.

[Prepared statement of Dr. Grim appears in appendix.]

The CHAIRMAN. Thank you very much.

Ms. Power.

STATEMENT OF A. KATHRYN POWER, DIRECTOR, CENTER FOR MENTAL HEALTH, SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES ADMINISTRATION, DEPARTMENT OF HEALTH AND HUMAN SERVICES

Ms. POWER. Good morning, Mr. Chairman and members of the committee. I am Kathryn Power, director of the Center for Mental

Health Services within the Substance Abuse and Mental Health Services Administration, SAMHSA.

I am very pleased to offer testimony this morning on behalf of Charles Curie, the administrator of SAMHSA. I will submit written testimony for the record.

The CHAIRMAN. Without objection.

Ms. POWER. I want to thank you for the opportunity to describe how SAMHSA is working to provide effective mental illness and substance abuse treatment services, as well as substance abuse prevention and mental health promotion services in Indian country.

It is also a privilege to testify along with Dr. Charles Grim, director of the Indian Health Service, particularly this morning about this very important issue. SAMHSA and IHS have developed a very strong working partnership reflected in our current interagency agreements to work efficiently and effectively together to help meet the public needs of American Indians and Alaska Natives.

My testimony will focus on two specific issues of great concern to the public health of American Indian and Alaska Native youth. These issues are suicide and violence. Sorrowfully, there are real-life examples to illustrate the impact of suicide and violence in Indian country. Recently, a suicide cluster occurred on the Standing Rock Reservation in North and South Dakota. Eight young people took their lives and dozens more attempted to do so.

Tragically, many other reservations have similar stories to tell. Suicide is now the second-leading cause of death behind accidents for Alaska Native and American Indian Native youth aged 15 through 24. The suicide rate for this population is 2.5 times or 250 percent times higher than the national average. More than one-half of all persons who commit suicide in Indian communities have never been seen by mental health providers.

For particular groups of American Indians, depression and substance abuse are the most common risk factors for completed suicide. Mental health and substance use disorders are also risk factors for violence. The recent example of violence in Indian country is the tragedy at Red Lake. On March 21, 2005, a 17-year-old high school junior shot and killed his grandparents, five students, a teacher and a security officer and himself. Red Lake Nation is an impoverished community. Thirty-nine percent of the population lives below the poverty line. Four out of five students at Red Lake High School qualify for free or reduced lunch. One-third of the teenagers on this reservation are not in school, are not working and are not looking for work, compared with about 20 percent on all reservations.

This event has led to community grief, to community turmoil and trauma. In response, SAMHSA has sent several staff on-site to coordinate services and technical assistance in collaboration with the IHS and the tribe. This involves support of the health care team, the educational programs, social services, support of the tribal council, and the community at large. SAMHSA staff has also provided technical assistance to the tribe in an effort to help them access emergency funds, especially those funds available through the SERGE grant mechanism.

With regard to programs that address violence and suicide, we know that in 1999 in response to school shootings in Kentucky, Arkansas, Oregon, and other States, Congress took action and launched the Safe Schools/Healthy Students Initiative under the collaborative leadership of the Departments of Education, Health and Human Services and Justice. The Safe Schools/Healthy Students Program awards 3-year grants of $1 million to $3 million per year to school districts to do the following: Collaborate with local law enforcement and mental health agencies; promote the healthy development of school-age children; and promote mental health and prevent violence in youth by using evidence-based programs with demonstrated long-term positive effects.

Two tribal sites were funded in the initial cohort of 54 grantees out of a pool of close to 500 applications. In particular, these two tribal grantees emphasized the poverty of their communities. Repeatedly, researchers from different fields have firmly established that poverty and its contextual life circumstances are major determinants of violence. Violence is most prevalent among the poor regardless of race. It is common knowledge that conditions on Indian reservations are deplorable, but the information presented by these applications was shocking nonetheless.

Our Safe Schools/Healthy Students grantee in Pinon, Arizona wrote in its application, and I quote,

> Within the boundaries of the richest country in the world exist a Third World nation. The Navajo Nation in Northern Arizona is among the poorest and most desolate regions of the United States. The area has only one paved road for travel, 92 percent of the children receive free or reduced-price lunches, and 60 to 90 percent of residents live without basic services such as plumbing, running water, kitchen, sewers, and telephones, compared to less than 1 percent of the U.S. population at large.

Close quote.

These are the problems that this Safe Schools/Healthy Students grantee worked to address and by and large they were successful in turning a school community away from violence and toward resilience and toward productive and meaningful lives. In January, SAMHSA launched the National Suicide Prevention Lifeline, 1-800-273-TALK. The national hotline is part of the National Suicide Prevention Initiative.

Additionally, SAMHSA under the authority of the Garrett Lee Smith Memorial Act announced the availability of fiscal year 2005 funds for State-sponsored youth suicide prevention and early intervention programs.

Mr. Chairman and members of the committee, SAMHSA takes very seriously the challenges present in Indian country, which include very few trained service providers, major transportation barriers, and multi-generational poverty. SAMHSA is engaged in addressing the issues and challenges in Indian country that rob communities of their most valuable resources, their children and their future. The vital treatment and prevention efforts that SAMHSA has undertaken are designed to address these problems and are improving services for all of the children, youth and families in Alaska and across Indian Country. These programs are working and our cooperation and collaboration with IHS is effective.

Mr. Chairman and members of the committee, thank you for the opportunity to appear before you today. I will be pleased to answer any questions you may have.

[Prepared statement of Ms. Power appears in appendix.]

The CHAIRMAN. Thank you very much.

Ms. Power, more than one-half of all persons who commit suicide in Indian communities have never been seen by a mental health provider. Is that right?

Ms. POWER. That is correct.

The CHAIRMAN. How does that compare with the non-Indian population?

Ms. POWER. I think that there are statistics, Mr. Chairman, that show that of those individuals who have committed suicide, that many of them have in fact seen a primary care physician prior to the completion of suicide, but statistically I probably will have to get you that information. But we do have indications that for those individuals, both children and adults, who have completed suicide, they do have usually an interaction with someone, whether it is a mental health provider or a primary care provider in the 90 days before the completed act of suicide.

The CHAIRMAN. Do you see a connection between substance abuse or alcohol abuse and suicide?

Ms. POWER. Absolutely, Mr. Chairman.

The CHAIRMAN. Is it usually associated with suicide?

Ms. POWER. There is often the presence of either a substance abuse disorder or the presence of the use of substances, either alcohol or drugs, prior to the completion of a suicide.

The CHAIRMAN. Is there a large percentage that are from single-parent homes?

Ms. POWER. Of those individuals, Mr. Chairman, who are suicidal?

The CHAIRMAN. Yes.

Ms. POWER. I think that the family conditions and the economic conditions contribute enormously to the presence of depression. We know that depression is the single most dominant indicator of presuicidal activity. If depression exists, then depression comes from a variety of not only internal factors, but also external factors. The fact that there may be disrupted family life, there may be a low socioeconomic condition. All of those contribute to the factors that would lead individuals who have experience of depression to then move further and consider taking their own lives.

The CHAIRMAN. Senator Murkowski probably knows more about this than I do, but is there an isolation factor here of tribes either in the Lower 48 or in Alaska that contributes to this?

Ms. POWER. I think both. This is certainly not just a Lower 48 issue. I think that the isolation leads to the social disconnectedness, which leads to the discontinuity, which leads to the lack of hope, which leads to the lack of belief in the future. I know that in particular the school violence that occurred in Bethel, AK and in Springfield and in Paducah was actually the reason why Congress developed the Safe Schools/Healthy Students Program.

So yes, in fact isolation is a major contributor to the identity of the culture, to the disconnectedness of their lives and to the belief and the hope of their own future.

The CHAIRMAN. Obesity or diabetes?

Ms. POWER. I am going to ask Dr. Grim.

Mr. GRIM. I think Ms. Power did an outstanding job of talking about the multi-factorial nature of suicide and depression. Certainly, people in our population that have obesity and have gone on to get other chronic diseases, diabetes and others, we have seen that, often they will have co-occurring depression along with the chronic disease. In many people, we are still educating them about the preventive aspects of diabetes, but for many, many years we would see youth that would automatically come into some of our facilities and say "when will I get diabetes and how long will it be before I die?"

With the moneys that Congress has given us over the last several years to work on the special diabetes program for Indian funding that is now at $150 million a year, those grants have made huge, huge impact on getting a lot more educational, physical activity and nutrition sorts of primary prevention programs out in the communities that are starting to impact that sort of a feeling of hopelessness about chronic diseases.

The CHAIRMAN. Switching gears just for a second, on January 31, the committee sent a letter to Secretary Leavitt seeking his commitment to reauthorizing the Indian Health Care Improvement Act. We still have not gotten a response. Do you know anything about that?

Mr. GRIM. I know that a response is being prepared, Senator. I was told that it should be on the way. The committee should have it shortly. I have not had an opportunity, as you know, Secretary Leavitt has been here less than 60 days, to speak with him directly about that, but I know they are preparing the response.

The CHAIRMAN. I know he has a very heavy schedule. I hope that you could schedule a phone call to him to ask him to get us a response.

I thank the witnesses.

Senator Dorgan.

Senator DORGAN. Mr. Chairman, thank you.

Dr. Grim, thank you.

Ms. Powers, thank you for being here.

Dr. Grim, let me ask you about Contract Health Services. I was on a reservation some months ago and they were telling me about the Contract Health Service problem. This is a reservation that has inadequate health care, inadequate facilities to address a chronic health problem that comes up in a short period. So you transport somebody or someone is moved to a hospital 60 miles away, gets service under Contract Health Services and then the bill is not paid. This goes on. They try to collect the bill from the patient. The patient gets a bad credit rating because the Contract Health Service's bill has never been paid.

There was a recent court decision about this with respect to two tribes, and the Supreme Court handed down a decision in the *Cherokee Nation of Oklahoma* v. *Leavitt* that the Indian Self-Determination Act required the Indian Health Service to pay tribes certain contract support costs, which the Federal Government had not been paying.

So how much does the IHS owe the tribes that were at the center of that case, number one, if you can tell me? And how much are owed to other tribes with respect to Contract Health Services that have no been paid?

Mr. GRIM. The case was just adjudicated. We estimate that the amount the agency owes the two tribes that were in that is approximately $15.6 million for contract support costs that were due the tribe between 1994 and 1997. From 1998 on, the Congress put a statutory cap on our contract support costs, which is a different line item within our budget than the other one you were asking about, contract health services. The contract health services line item does not have that statutory cap and we do distribute those funds on a formula basis throughout the Nation. As you indicated, each region of the country is asked to live within that budget on an annual basis because it is limited. Each area is at different levels throughout the year. I would ask our Chief Medical Officer if he would like to add anything to that, but the Supreme Court hearing affected contract support costs, and not our contract health service budget.

Senator DORGAN. Thank you.

Mr. GRIM. Is there anything you would like to add, Dr. Vanderwagen?

Mr. VANDERWAGEN. Senator, I think you highlighted a chronic issue that afflicts many communities, and that is, the inability to fully cover those costs that are accrued when we have to purchase care from a private sector environment. We have electronic payment systems now that we can turn most bills around in 45 days, but there continue to be problems with certain locations where we do need to fix that problem.

Senator DORGAN. I am going to send you some additional questions on that because, as I said, I have heard from people who say their credit rating is ruined despite the fact that they had approved contract health services that they accessed.

Let me tell you about the meeting I held recently, Ms. Power and Dr. Grim. What they were telling me, the people who came to that meeting, particularly from the Standing Rock Tribe, if a young kid is addicted to drugs or alcohol, there is virtually no opportunity to quickly get that person into long-term treatment that is able to shed that addiction. The treatment is just not available.

So you have these people that are hopelessly addicted, young kids that are hopelessly addicted to alcohol or to drugs who really need to be put in a program, an in-residence program, and it is not available. Is that true around the country on reservations generally?

Ms. POWER. I believe it is a difficulty, Senator, in terms of first of all identifying individuals who have those problems and who are willing to step forward and want to get into treatment. Then the second difficulty is access to the treatment. Is the treatment available to them in a location where they can actually get to it? And third, the difficulty that comes over the long term. You really do have to have a personal commitment to wanting to stay engaged in both drug and alcohol prevention and treatment programs.

I think one of the things that we have tried to do, particularly with Indian tribes, is to make sure that all of the American Indian

and Native Alaskan and tribal organizations, first of all, are eligible for all of our substance abuse prevention and treatment grants. That has really been an effort that my boss has really extended to us at the staff level, saying you will in fact do everything you can to make sure, unless there are overriding compelling reasons, to make sure that every opportunity for substance abuse prevention and substance abuse treatment grants are available to the tribal organizations.

We also, of course, are looking to use our resources at SAMHSA to make sure that the need is addressed, particularly through our Access to Recovery Program. We had several tribal organizations that competed for the Access to Recovery.

Senator DORGAN. Ms. Power, I am sorry for interrupting you, but isn't it the case, wouldn't you and Dr. Grim both agree that there simply are not enough treatment opportunities available around the country on reservations for those who are addicted to alcohol and drugs? I mean, we are woefully short of treatment. You are talking about what we are doing, and I appreciate all that, but isn't it the case that we are just way short of what is necessary to get a young person into a treatment facility when they are addicted to drugs and alcohol?

Ms. POWER. I think that certainly in talking about the access issue, Senator, I believe it is correct that it is very difficult for many people across America, and particularly on the tribes, to have access to those services, very difficult.

Senator DORGAN. Yes; some of those young people say it is impossible almost. At this meeting I held, we were talking about suicides and attempted suicides. They said that in 1 year on the Standing Rock Reservation there were 288 suicides or attempted suicides in 1 year; 288. They talked about the lack of mental health treatment available to them. They said, well you know, you have to go to your family, you have to reach out. And one young girl stood up and she said, "Well, you know, I was being raped repeatedly by my father when I was thinking about suicide. I could not go to him and I could not go to my mother. She was in a dysfunctional situation and would have been angry about it and no believe me in any event." So she said, "I had to work through this myself somehow." But she said, "There really was no avenue for me to express myself on these issues." She fortunately got through this.

But as you indicated, there are a lot of young kids that are not getting through it, and the young boy on the Red Lake Reservation, I do not know much about that case except what I have read in the press. But once again, a serious lack of mental health services, just a serious lack. I have had people at witness tables who were in charge of these issues for tribes, and who broke down in sobs saying, "I had to even beg to try to borrow a car to take a young kid to a clinic who was having a desperate time." This was a reservation where this little Avis Little Wind hung herself recently. She did not have access to psychological care that she should have had. There are lots of people who knew she needed it, but there was no access to get it to her in a remote location.

So the only point I am making is that this is a real serious crisis and we have to say that instead. I know we are making some progress in all these areas, and Dr. Grim, your testimony described

that. But I am much more interested not in the 16 percent improvement here or 18 percent improvement there. I am interested in how far are we from the goal, because I think Senator McCain indicated and my colleague Senator Inouye indicated, we are still, even with our improvements, which are reasonably small, we are still so far from where the rest of America's population is on these circumstances with respect to tuberculosis, mental health, all these issues.

So we just have to do much more. I appreciate very much the contribution, Ms. Power, you have made this morning on a very important issue. Dr. Grim, I hope that you will work closely with us to identify where are the urgent priorities here so that we can begin thinking through, Senator McCain and I and the committee, how we deal with them.

Thank you very much for your testimony.

The CHAIRMAN. Senator Inouye.

Senator INOUYE. Thank you.

It is true that statistically the health of Indian country has improved, but the demographic picture of Indian country is like any other community. You have your very wealthy and your very poor. My question is, are the improved statistics in some sense due to the self-help programs that Indians have had because they are making money?

Mr. GRIM. I think that certainly is a part of it, Senator Inouye. I do not know that we can statistically quantify what that is, but it is clear that tribes that have done well and are doing well economically have put some of those tribal revenues into health programs, both preventive as well as treatment. So we would have to say that certainly that is part of it. Plus, as you heard, the multifactorial nature not only of mental health and suicide issues, but of health in general. It is more than having just a clinic or a hospital in your community, but it is also having educational opportunities, good jobs and socio-economic development.

So I think there are many tribes that have seen that it is wise to put the moneys that they have made into the health of their people and they have done that in a variety of ways. I am not sure we can quantify that.

Senator INOUYE. I am certain you know that there are many tribes who run their own schools, run their own hospitals and clinics. Have they done well?

Mr. GRIM. Yes, sir; they most certainly have. They are able to make the decisions at a local level on the programs that they want to run. One of the things that we are looking forward to seeing the results of soon is that the Office of Management and Budget is going to be looking through their PART analysis at the tribal side of our health program. They have looked at the Federal side, at our facilities programs and sanitation facilities; at our Urban Indian Health Program and in this next cycle, they will be looking at that particular program. The preliminary data are showing outstanding results.

Senator INOUYE. In other words, if they were not helping themselves, the statistics would be much worse.

Mr. GRIM. That is perhaps a fair assessment.

Senator INOUYE. Can you tell us whether the budget that has been presented is a good and fair one? Or in your professional opinion, do you think we should get more?

Mr. GRIM. I think the President's budget proposal for 2006 for the IHS is a very good budget when you take a look at the priorities that are on the nation right now, The department has listened to tribal consultation throughout the country, and one of the things that you will see in this budget that you have not seen requested in a while is inflation and population growth. Tribal leaders have told the department and the Administration over the course of the last year's consultations that the Indian community was growing at a rate that needed to be addressed in the budget. So you do see a sizable increase for both population growth and in inflation in almost every line item of the budget. So we were very pleased with the budget.

Senator INOUYE. Are you suggesting that the budget that was presented would be adequate to cope with the problems that the Chairman and the Vice Chairman all indicated this morning?

Mr. GRIM. The issues that we all raised around the Red Lake incident, we are not sure if the resources that the department, speaking just for HHS here, the funds that we are making available have been what have been asked for to date. We are still waiting to see from the council what their overall list of needs are. We do not know whether those immediate crisis needs are going to be able to be met within the budget, but the priorities that were raised by the Chairman and the Vice Chairman this morning are addressed in the fiscal year 2006 budget.

Senator INOUYE. My last question, in determining the budget, is Indian country given an opportunity to provide an input? Do you consult with them?

Mr. GRIM. Yes, sir; we have regional consultations within each of the 12 regions of Indian Health Service. We also then have a national budget consultation around the formulation of this year's budget. It just so happens that today and tomorrow are the national budget formulation sessions for the fiscal year 2007 budget that we are holding with representatives from Indian country. So there is extensive input at the regional and national levels to our budget.

Senator INOUYE. So you are suggesting that Indian country is satisfied with the budget?

Mr. GRIM. You would have to ask them that, sir.

Senator INOUYE. In your consultation, did they say they were happy?

Mr. GRIM. They have asked for higher priorities in some areas in total dollar amounts, but the agency has always tried to follow the priorities that they have set out in categorical order when the budget is presented and in the intervening months with the department and OMB we have tried to follow those priorities consistently for the last 7 or 8 years that we have been holding these tribal budget consultations.

Senator INOUYE. Thank you.

The CHAIRMAN. Senator Murkowski.

Senator MURKOWSKI. Thank you, Mr. Chairman. I do have an opening statement that I would like included in the record.

The CHAIRMAN. Without objection.

[Prepared statement of Senator Murkowski appears in appendix.]

Senator MURKOWSKI. Thank you.

Welcome to you, Dr. Grim and welcome to you, Ms. Power.

As we look at those factors and those issues in our lives that cause things like depression that lead to suicide, there are certain things that are going to be tough in my State. We are always going to be a big State. We are probably never going to be connected like the rest of the Lower 48 is connected, but I would like to think that through the assistance of the communities, through the assistance of the State and others, we really can provide for that level of service.

The point was raised by the Vice Chairman in terms of access. We know that when it comes to treatment facilities, I would agree we are woefully lacking. It is an issue where we might know that we have a problem coming up. We might have a child who has sent the message, and yet we are not picking up on it. We do not know what to do quite with it. Both in the incident in Red Lake and the incident in Bethel, the young man had told others that they were going to do harm. I do not know whether it is we do not believe the kids, we do not know what to do next, but we are not picking up and we are not offering the help that needs to be given in a timely enough manner.

I want to ask you, the fact that in Bethel and the Red Lake High School, both of these were public high schools. They were not BIA schools, and yet IHS is the significant provider of behavioral health services in both of these communities. What kind of collaboration goes on between the public schools and the BIA and IHS in an effort to deal with instances like this? This is a question directed to either one of you.

Mr. GRIM. I will ask Dr. Vanderwagen if he would respond for the agency.

Mr. VANDERWAGEN. Senator, I have not seen you. Congratulations on the reelection.

I think in these small communities, we are the provider of the community. Because they are small communities, I think all the staff, whether they are on the public education side or whether they are on the health side, recognize a common purpose and a common need to act in a common way. I think in both Bethel and in Red Lake, well certainly in Red Lake, I can say that the psychology staff from our facility at Red Lake was working with the school system to try and assure that there were counseling services available.

I think that the Chairman and Mr. Inouye helped us back in the mid-1980's to try and get treatment center capacity, but we are at the state where we essentially have one treatment facility per State. I think in Alaska we split that into two, but that does not offer many opportunities for the school and us to refer children and youth when they have the kind of needs that you have just identified.

Senator MURKOWSKI. So then tell me what it is that we do. None of us want to repeat any of these incidents in any community across the country. When the signal is sent by the young person, are we intervening?

Mr. VANDERWAGEN. It is a fairly complex situation, but to simplify it as much as I can, it is family; it is educational systems and it is the health system and often the law and order system that have to work comprehensively in those small communities to provide the support structure. We know that foster care is a real challenge and a real issue, so that children for instance who have troubled families do not have many options within a community for referral, and that is a real challenge for tribal communities to work out.

It is very difficult because there are not always the full range of alternatives that we might have elsewhere in the country vis-a-vis dealing with isolation as it impacts on the availability of those resources and the use of those resources.

There is not a simple solution to these issues. It has to be a community-wide effort. Certainly, what we are trying to demonstrate with Red Lake is that there is a Federal-wide effort that has to be there to support the community. Those are the lessons we have learned about this thus far.

Senator MURKOWSKI. I think one of the lessons that we learned out of the Bethel incident was that after that horrific incident, the community came together and there was a healing process, for lack of a better term, but the community really galvanized. Unfortunately, it took multiple deaths in order to galvanize that community, in order to get that support. So we are not there if the action is coming after the deaths.

Mr. VANDERWAGEN. That is true.

Senator MURKOWSKI. Dr. Grim, I would like to ask you very quickly about village safe water and sanitation facilities. I am pleased to see that IHS sanitation facilities construction program has received a small bump-up in the President's budget. You have been working in conjunction with the EPA and rural development in USDA to move forward with some of the progress that we have made in my State to provide for sanitation facilities. I am disappointed because in the USDA budget and the EPA budget, in both of those, we have seen very significant reductions, which means that IHS sanitation facilities construction budget is the only one that is actually holding steady.

My question to you is, are you going to be able to do it alone? What does this do to the progress that we have made and that we continue to need to make in order to be able to meet the health and sanitation needs our in rural Alaska?

Mr. GRIM. I am going to ask Mr. Hartz to address that. He is our expert on sanitation facilities. We are doing everything we can to work with both those other agencies.

Mr. HARTZ. Senator Murkowski, thank you for the question. The cooperation that has come from the other agencies has been real critical, and especially what we have gotten through the State of Alaska. The 121 Program, as we have referred to sanitation facilities, brings in typically anywhere from 30 cents to 50 cents on every $1 appropriated to enhance further what we can get with the amount appropriated.

Secretary Thompson was extremely helpful in continuing to advocate for sanitation facilities funding, so we have been able to sustain our funding level. We are aware that what is happening else-

where could have some impact on funding, but we are really pleased at how the tribes and our own staff are using our dollars as seed money to try to continue to get additional resources to supplement our $93-plus million appropriation. Within the last year, we have actually had contributions in the range of nearly $50 million added to those appropriations.

Senator MURKOWSKI. We need to keep working on this one together, because you know that this is too significant in my State. I was just home this weekend and you make some progress with health statistics and then this weekend I read that the tuberculosis rate is now up again among Alaska Native people. You make progress on one end and then you lose it on another. So we need to keep working on this.

Thank you, Mr. Chairman.

The CHAIRMAN. Senator Burr.

Senator BURR. Thank you, Mr. Chairman.

I thank our panel.

I am going to try to keep focused on whether we have sufficiently addressed the funding need that is out there. By my calculation, the Administration's budget recommends about a 2-percent increase. Is there anywhere else in health care today where a 2-percent increase would meet the rising cost of health care?

Mr. GRIM. I am not sure about the answer to the question you pose about anywhere else that could be met with 2.1 percent. I think one of the things, if you look at our budget detail a little bit, we are taking a pause in construction for this year. That was an ability to shift those funds over into the health care side. What appears to be a $63-million increase really on the health care side ends up being around $146 million increase. So in essence that more than doubles that 2 percent increase.

Senator BURR. So now we are up to 4 percent. Is there anywhere in health care today that a 4-percent increase would meet the current inflation rate in health care?

Mr. GRIM. In general medical inflation, perhaps it would. In specifics, for example pharmaceuticals that are increasing at a greater rate, it does not keep pace with that level of inflation.

Senator BURR. There have been tremendous successes within the population, with the decrease of disease, the decrease of mortality specifically. Those decreases in mortality also bring a higher cost of maintenance. Is that figured into the model?

Mr. GRIM. It is very true what you say, that with the increased longevity of our population, and it has gone up significantly over the years that the IHS has been in operation. With that lengthening of their life span have come more chronic diseases that are more expensive to treat and often have higher levels of pharmaceutical care costs and things like that. Those things are being factors into the health system, but again the chronic diseases that we face have forced the agency to look at our initiatives and our priorities.

As I mentioned in my testimony, we are focusing very heavily on three areas now: Health promotion/disease prevention because we are trying to get ahead of that curve of the chronic diseases, and so we are putting more money and more time and energy into that, and focus very heavily on behavioral health in collaboration with

other agencies like SAMHSA and with tribal communities because not only the mental health needs of the communities, but many of the chronic diseases have behavioral health and lifestyle choice issues that we are working on. And then we are working more diligently on chronic disease management.

There are a lot of chronic disease management models out there that we do not have fully implemented in all of our programs that can allow us to be more cost-effective in the way we manage chronic diseases. I think we are doing an outstanding job and have been for a number of years in the way we manage diabetes as a chronic disease. We are starting to get a handle on that, I believe. But many of the emerging chronic diseases that we are facing now, cardiovascular disease, obesity, certain types of cancer and asthma and things like that, we could I think manage better. So we are looking at many chronic disease management models and trying to implement those.

So with the focus of those three areas, we are trying to get the most out of every dollar that we receive.

Senator BURR. I certainly commend you for the progress. Clearly, the individuals covered are benefited from that progress. I also look at the unique ability that we have to identify those genetic traits that come in the form of disease, and really other medical-related areas that we really can put our finger on and understand how much of an impact it has on select communities.

My only warning is, and I understand the constraints that we have in budgets, but the one thing that we have learned from health care is that if you try to shortcut the process, the back end is much more expensive; that our ability to educate, to insert prevention and wellness into the system saves us money from a standpoint of per-incident emergency treatment, in-patient care. We continue to vacillate in the entire health care atmosphere of where do we put our emphasis. Every time we go to prevention and education, the back-end savings are significant. I just do not want us to lose perspective.

I think it is difficult to do everything that you just talked about when we look at a 2- or a 4-percent increase. I know I am not telling you anything you do not already know, but I think it is important that we really keep in the center of this debate, that if we want to accomplish this, it is going to cost something.

I thank you, Mr. Chairman.

The CHAIRMAN. I want to thank the witnesses, and we look forward to seeing you again. Dr. Grim, I hope we can move forward on the reauthorization of the Indian Health Care Act. We need to have the Administration's position on it.

Mr. GRIM. Yes, sir.

The CHAIRMAN. Thank you very much.

Mr. GRIM. Thank you.

Ms. POWER. Thank you, Mr. Chairman and members of the committee.

The CHAIRMAN. Thank you.

Our next panel is H. Sally Smith, chairman, National Indian Health Board of Washington, DC. She is accompanied by J. T. Petherick, executive director, National Indian Health Board. Rachel Joseph, Cochairperson, National Steering Committee for the

Reauthorization of the Indian Health Care Improvement Act, and chairwoman of the Lone Pine Paiute Shoshone Reservation in Lone Pine, CA. She is accompanied by Buford Rolin, vice chairman, Poarch Creek Band of Indians; Georgiana Ignace, president, National Counsel on Urban Indian Health. She is accompanied by Beverly Russell, executive director, National Council on Urban Indian Health; Anslem Roanhorse, executive director, Navajo Nation, Department of Health, Window Rock, AZ.

Ms. Smith, we will begin with you.

STATEMENT OF H. SALLY SMITH, CHAIRMAN, NATIONAL INDIAN HEALTH BOARD, ACCOMPANIED BY J.T. PETHERICK, EXECUTIVE DIRECTOR

Ms. SMITH. Thank you very much.

Chairman McCain, Vice Chairman Dorgan, distinguished members of the Senate Indian Affairs Committee, I come from Dillingham, AK in the southwest part of Alaska. I am Yupik Eskimo. On behalf of the National Indian Health Board, it is an honor and a pleasure to provide a broad overview today of our public health needs in terms of access to care, health disparities and public health issues throughout Indian country.

In the coming weeks, we look forward to working with the committee on crafting and achieving the implementation of the reauthorization of the Indian Health Care Improvement Act. We hope that today this snapshot of health care in Indian country will assist the committee as we work toward this goal.

With limited time, Mr. Chairman, I am going to touch on a few topics. My written statement provides a far more extensive survey of health care in Indian country and I ask that it be included in the record.

The CHAIRMAN. All of the written statements of the witnesses will be included in the record without objection, including yours. Please proceed.

Ms. SMITH. Thank you.

The National Indian Health Board serves federally recognized American Indians' and Alaska Natives' tribal governments, and certainly we do this by advocating for health care, as well as upholding, as described earlier, the Federal Government's trust responsibility to the American Indians and the Alaska Natives.

I want to now go into a framework for discussion by saying that on September 11, 2001 the United States changed forever. While we knew the threats of terrorist attacks were possible, as a Nation we did not collectively confront the issue and make as necessary sweeping changes until the events of September 11 occurred. We are now facing a similar dilemma in Indian country. Across Indian country, the crisis in health care is well documented and well known to both lawmakers and Indian communities for which they are tasked with addressing basic human needs and health care needs as well.

For example, at several congressional hearings before this one, we have testified, and I go to my notes to make sure that I have this correct, the United States invests nearly twice the funds for the health care of a Federal prisoner as it does on an American Indian or Alaska Native, as earlier described by Mr. Dorgan.

Our life expectancy is nearly 6 years less than any other race or ethnic group in America; 13 percent of our deaths occur in those younger than 25, a rate three times higher than the average U.S. population.

Two years ago, the U.S. Commission on Civil Rights reported that American Indian youths are twice as likely to commit suicide, again underscoring earlier comments. Our people are 630 percent more likely to die from alcoholism; 650 percent more likely to die from tuberculosis; 318 percent more likely to die from diabetes; and 204 percent more likely to suffer accidental death as compared with other groups. All of this information is shocking, but none of it is new.

The health care crisis in Indian country continues. Nowhere is the need more urgent, as earlier again described, than the incidents that happened at the Red Lake Reservation. That tragedy has left Indian country with a heavy heart, but it has also brought to light the collective resolve and ability of our Native peoples to respond to tragedy in a supportive and awe-inspiring manner. Tribes across this Nation quietly delivered support and aid to the Red Lake community.

As in any community, unanswered need can foster unimaginable tragedy. As we review the status of health care delivery systems in Indian communities, we cannot afford to allow the behavioral and the mental health infrastructure in Indian country to continue unaddressed. Today, let us begin again and do as a great Lakota leader, Sitting Bull, said, "Let us put our minds together and see what life we can make for our children."

I want to touch a little bit on public health, to follow-up with my comments with regard to the incident at the Red Lake Reservation. In Indian country, we realize that we have a public health epidemic. There is a growing body of empirical evidence in the Americas, as well as across Europe, Asia and other continents, that very clearly demonstrates the effectiveness of prevention. Prevention works. It is much easier and less costly to prevent disease, disability, injury and premature death than to treat poor health conditions once present.

Today, little is known about the capacity for preventing disease and reducing mortality throughout Indian country. By leveraging the Indian Health Service shares, other public resources, and private revenues, many tribal governments make substantial contributions to prevention investments, but these investments are not the scale in order to address adequately the needs of an improved prevention infrastructure.

Tribes are increasingly developing ideas on new programs, services, capacities and approaches needed to help improve the health in Indian country. Additionally, Indian country is learning about changes in communities that impact both positively or negatively the health of Native populations. But these programs are grossly underfunded, and relative to State and county governments, tribes do not benefit equally from Federal and State resources intended for the public good.

I want to talk about the WIN! Initiative.

The CHAIRMAN. I would like to remind you, Ms. Smith, that we have about a 5-minute limit on opening statements, so please.

Ms. SMITH. Thank you.

The CHAIRMAN. Thank you.

Ms. SMITH. Thank you, very quickly.

The WIN! Initiative, earlier you were talking about prevention, the National Indian Health Board has launched this initiative and I would be happy to provide information for you. Again, it covers a new vision for preventing disease and promoting health in Indian country.

There is one area that my written testimony covers. It is a dental health aid program and the therapists in Alaska. I call your attention to that. I will not cover that at this time, but I do want to very quickly talk about the Medicare Modernization Act of 2003, as well as the drug card, and then close my comments. Thank you.

There are several provisions contained in the Medicare Modernization Act of 2003 that have the potential to seriously negatively impact the Indian health care system. Chief among these is a new prescription drug benefit. As implemented by the CMS, it will severely impact American Indians and Alaska Natives because of lost Medicaid revenue to the Indian health care system. The loss is estimated to be between $25 million to $50 million. The new provisions will severely impact Native people who are dual-eligible, those eligible for both Medicaid and Medicare, by eliminating the Medicaid prescription drug benefits, and with them a much-needed funding source.

With regard to the drug card, very quickly, there is no requirement in the drug card plan. CMS will chose, will be the ones that will work with Indian and tribal pharmacies. Further complicating the situation, the plan into which the Alaska Native and American Indian dual-eligible will be enrolled may not be the plan into which the local ITU pharmacy contracted. Our people receive prescription drugs from ITU pharmacies at no cost to them. I am asking very quickly that we need help in rectifying this particular issue.

In closing, on behalf of the National Indian Health Board, we certainly want to thank the Senate Committee on Indian Affairs for its investment of time, expertise and action into investigating and improving the health care delivery systems for American Indians and Alaska Natives.

Thank you for considering our testimonies, and we certainly, from the National Indian Health Board, pledge to work with the committee in any area that we can. Again, I will provide written testimony, but let me close by saying again what the great leader said, and that is, "Let us put our minds together and see what life we can make for our children." They are critically important.

Thank you.

[Prepared statement of Ms. Smith appears in appendix.]

The CHAIRMAN. Thank you very much.

Rachel Joseph.

STATEMENT OF RACHEL JOSEPH, COCHAIRPERSON, NATIONAL STEERING COMMITTEE FOR THE REAUTHORIZATION OF THE INDIAN HEALTH CARE IMPROVEMENT ACT, AND CHAIRWOMAN, LONE PINE PAIUTE SHOSHONE RESERVATION, ACCOMPANIED BY BUFORD ROLIN, VICE CHAIRMAN, POARCH CREEK BAND OF INDIANS, AND COCHAIRPERSON, NATIONAL STEERING COMMITTEE FOR THE REAUTHORIZATION OF THE INDIAN HEALTH CARE IMPROVEMENT ACT

Ms. JOSEPH. Mr. Chairman, Vice Chairman Dorgan, Senators of the committee, I am Rachel Joseph, chairwoman of the Lone Pine Paiute Shoshone Reservation and cochairperson for the National Steering Committee for the Reauthorization of the Indian Health Care Improvement Act.

Our project last year served 3,514 Indians, active users at three clinics. It takes 6 hours to drive north to south; 10 percent of our population is 65 years and older, 26 percent of our population is below the poverty level, and 15 percent of our households do not have telephones. Our pneumoccal vaccination rate is 48 percent below the Healthy People 2010 goal and our mammography rate is 49 percent below the Healthy People 2010 goal.

Our rate for diabetics having blood sugar levels within the recommended range of 15 percent above the Healthy People 2010 goal. And diabetics having blood pressure within the recommended range is only 4 percent below the Healthy People 2010 goal. We believe these two indicators are a reflection of our special diabetes funding and funding for cardiovascular risk reduction, which we receive through the competitive process.

Among the disparities articulated today was the significant rates of mental health disorders. There is approximately one psychologist per 8,333 American Indians, compared to one per 2,213 for the general population.

Medical inflation has grown over 200 percent since 1984. Unfortunately, the Government calculation is not the same rate used by the private sector. OMB uses a rate of 1.9 percent to 4 percent per year for inflation, when medical inflation is between 6.2 percent and 18 percent. This discrepancy has seriously diminished the purchasing power of our programs because pharmaceuticals, medical equipment and other costs are the same for the private sector and tribes. From yesterday's USA Today front page, "Drug Prices Outstrip Inflation, Costs Up 7.1 Percent." A number of months ago, I was looking at the inflationary cost for pharmaceuticals. I noted that among those inflationary costs, the drugs for diabetes and cardiovascular disease are the highest, only behind antidepressant meds. So we are affected even greater.

The Northwest Portland Area Indian Health Board estimates that the IHS budget has lost over $2.46 billion in purchasing power over the last 14 years. In California, like so many other programs in the country, we are seeing employee benefit take-backs, reduced hours of operation, and reductions in staffing levels, and more staff burnout.

As Dr. Grim testified, there is a request in the President's 2006 budget for $33 million for population growth, and we heartily support that because this is the first time in over a decade that we

have seen a request for population growth. The National Center for Health Statistics reports that our population is increasing at 1.7 percent a year, which translates to 70,000 additional Indians coming into the health care system annually.

In 1999, tribes consulted extensively and presented consensus recommendations on these issues, and these issues we want addressed in the reauthorization in the Indian Health Care Improvement Act. We wanted reauthorization to be responsive to the current needs and to enhance opportunities for more revenue and to facilitate more self-determination.

To accomplish these following recommendations, we included the authorization that scholarship assistance be tax exempt. We would authorize funding for critically needed dialysis programs, and to authorize screening for all scans for cancers, and not just mammographies. We want to authorize more options for tribes to address facility needs and to authorize a comprehensive continuum of behavioral health care which emphasizes a collaboration between alcohol and substance abuse programs, social services, and mental health care.

The conclusion of the 1928 Marion Commission, and I will summarize, reflects the status almost the same as it was then today. The inadequacy of appropriations has prevented the development of an adequate system of public health administration and medical relief work. I felt great frustration and even anger as I prepared my oral thoughts and testimony for today because our plight remains almost the same decade after decade.

I questioned myself, are we not telling the story? And I know we are, because I see it reflected in testimony after testimony. I see it in newspaper editorials and more recently in the reports from the U.S. Civil Rights Commission. I respectfully ask your support and assistance in doing whatever is necessary to reauthorize the Indian Health Care Improvement Act and help us deal with the many budget challenges that we face every single day. The statistics we talked about today are our grandparents, our nieces and our nephews, and our aunties.

Thank you for this opportunity to present testimony. My written testimony has been submitted. Thank you.

[Prepared statement of Ms. Joseph appears in appendix.]

Senator DORGAN. Ms. Joseph, thank you very much for your testimony.

Senator McCain had to attend another committee gathering, and so we will proceed. The next witness is Georgiana Ignace, the president of the National Council of the Urban Indian Health organization in Washington, DC. Ms. Ignace, you may proceed.

STATEMENT OF GEORGIANA IGNACE, PRESIDENT, NATIONAL COUNCIL ON URBAN INDIAN HEALTH, ACCOMPANIED BY BEVERLY RUSSELL, EXECUTIVE DIRECTOR

Ms. IGNACE. Chairman McCain and committee members, my name is Georgiana Ignace. I am Menominee from Wisconsin and president of the National Council on Urban Indian Health.

In 1998, NCUIH was formed and they have a membership representing urban Indian health programs in 34 cities. But first, let's briefly account how the Indians became urban Indians: The BIA

Relocation Act, the promise that the American Indian will have a better life, a job and education; the General Allotment Act, where many lost their land and were forced to move to nearby cities and towns; adoption of Indian children to non-Indian families; boarding schools where children were removed from their families to boarding schools far away from home.

Today, the urban Indians consider the Indian community in the cities their home.

Another statistic: In 1976, Congress passed the Indian Health Care Improvement Act. This act was to raise the status of health care for American Indians and Alaska Natives; 29 years, and those 22 years were a deadline for achieving it has passed. And yet today, Indians whether reservation or urban still continue to have the highest health care statistics that are negative.

What we know about the urban Indian, urban Indian unemployment is double that of all races. Urban Indian poverty levels are three times that of any other race. Urban Indian high school dropout rate is over 75 percent. Urban Indians have a high mortality rate from alcoholism and related causes than any other races. The urban Indian suicide rate is four times that of all other races, and urban Indians have three times the national rate for diabetes and heart disease.

How can the health status of urban Indians be improved? Certainly by the passage of the Indian Health Care Improvement Act and also adequate funding for IHS so that they may accomplish that goal set in 1976 by Congress.

NCUIH supports the recommendations of the national steering committee and with the reauthorization of the Indian Health Improvement Act, title V Access to Health Services, section 511 Grants for Alcohol and Substance Abuse-related Services, section 515, Federal Tort Claims Act coverage, section 521, authorization of appropriations. Also increased funding for urban Indian programs.

The urban Indian represents 60 percent of all Indian populations and receives only 1 percent of Indian health dollars. Although NCUIH requested a $6.4-million increase to the 2006 budget, urban Indian health programs only received an estimated increase of $1 million. NCUIH urges this committee and Congress to recognize this need and help increase the funding for these programs. Also, Federal medical assistance percentage, to place FMET back into the words of the Indian Health Care Improvement Act policy.

NCUIH urges this committee and Congress to help urban Indians expand State Medicaid funding. As you heard, America is nowhere near the lofty goal that they set in 1976.

In conclusion, I would like to take this opportunity to thank you for your support last year for making permanent section 512, Demonstration Projects in Oklahoma. As a result, these excellent clinics will be able to continue to provide very valuable health care services to urban Indians in Oklahoma City and Tulsa.

Also, in conclusion, NCUIH looks forward to working with this committee toward achieving the goal they set in 1996. Thank you for this opportunity on behalf of NCUIH to provide testimony on urban Indian health care issues.

Senator DORGAN. Ms. Ignace, thank you very much for being present and providing testimony to the committee today.

Finally, we will hear from Anslem Roanhorse, executive director, Navajo Nation, Department of Health, Window Rock, AZ.

Mr. Roanhorse, welcome, you may proceed.

STATEMENT OF ANSLEM ROANHORSE, EXECUTIVE DIRECTOR, NAVAJO NATION DEPARTMENT OF HEALTH

Mr. ROANHORSE. Vice Chairman Dorgan, distinguished members of the Senate Committee on Indian Affairs, my name is Anslem Roanhorse. I am the executive director for the Navajo Division of Health in Window Rock, AZ.

On behalf of the Navajo Nation, I am honored to present this testimony to you. I would like to highlight some of the information that we have given you in our written statement, and also we would like to request that our written statement be made part of the record.

Senator DORGAN. Without objection.

Mr. ROANHORSE. The Navajo Nation expands into three States and three Federal regional offices, region VI Texas, region VIII Colorado and region IX in California. The Navajo Division of Health operates with a budget of around $79 million. That includes Federal funds, State funds, tribal resources and we employ over 1,000 staff members that work with Indian people throughout the Navajo Nation.

We also administer 18 programs, that includes health education, nutrition services, alcohol and substance abuse counseling and treatment. We do diabetes prevention, public health nursing, and also work with breast and cervical cancer prevention.

The IHS is still the primary health care provider for the Navajo Nation. The health care network includes 5 hospitals, 6 health centers, 15 health stations, and 22 dental clinics. The Navajo Nation appreciates the slight increases to the IHS budget for the past fiscal year. Senators, those increases were absorbed by increasing medical costs, pharmaceutical and mandatory inflationary costs.

Although the fiscal year 2006 IHS budget request includes increases to the contract health services and preventive health, which we appreciate, it however reveals a cut to the health care facilities construction by nearly $86 million. Health care facilities construction has been the Navajo Nation's top priority for the past 3 fiscal years. Although the Navajo area has been very fortunate to receive Federal funds for new hospitals and new health care centers in recent years, there remains a great unmet need for new facilities on the Navajo Nation, with their current population of about 237,000 people and growing.

Some existing facilities are inadequate, too small, and require replacement. There are many areas within Navajo Nation that will require new hospitals and health centers in the coming years to support our increasing population. That being said, the Navajo Nation is grateful for the new staffing funds proposed for the Pinon Health Care Center and Four Corners Regional Health care Center in Red Mesa, AZ. A new health care center in Kayenta was recently added which we also ask for your support.

By the way, the Navajo Nation does not support the IHS plan to pause in construction. The Navajo Nation is challenged by numerous complex and unique barriers to reach its public health goals, including funding, facilities, transportation, information, technology and workforces. Despite these barriers, we are doing our best to provide services that include prevention services and also education.

Recruitment and retention of additional health care professionals is a great concern for the Navajo Nation. Currently, the Navajo Area Indian Health Services is experiencing a high vacancy rate for doctors, nurses, dentists, and pharmacists ranging from 17 percent to 20 percent. Recently, the Navajo Nation embarked on developing a trauma system development to reduce death and disability caused by traumatic injuries among the Navajo people. Presently after the initial care is provided by local hospitals, the majority of our critical care patients are transferred to off-reservation trauma centers. The Navajo Nation is now wanting to do something about this to try to work with facilities to establish and upgrade our own facilities.

Over the past 2 years, the Navajo Division of Health has been battling with increased numbers of transmission of syphilis and HIV cases. Again, we are trying to do our best to address some of these emerging needs.

Currently, the Navajo Department of Health Services operates two adolescent treatment centers, which is for approximately 35,000 Navajo adolescents who are in need of treatment. But again, we are doing our best to meet the unmet needs, and then the Division of Health also operates two adult treatment centers for population of about 179,000 Navajos. Again, we are trying to do our best to meet the needs. There is an emerging issue with methamphetamine and also of course we also have to deal with the alcohol abuse and substance abuse.

With respect to the Navajo Nation, we also have always included the use of traditional healers and our conventional medicine. Again, we would like to continue to work on expanding traditional services to incorporate it as part of our treatment modalities.

Then we also do our best to meet the needs of those people that are afflicted by cancers. Right now, we do not have any cancer center on the reservation, but again we have to work with the surrounding towns to have our patients treated. Especially diabetes is also another area that we have been doing a lot of work on, and we think that we beginning to make some impact. We are doing education. We are teaching patients on nutrition , and then also beginning to really promote exercise.

Poor roads in Indian country have been a great challenge for us. Right now because of the rising cost of gasoline, it is now also beginning to impact our services. Certainly, it is impacting the Navajo families because of the cost of gasoline which is, as you all know, over $2 per gallon. This is what the Navajo people have always been experiencing for the past several years. So again, a lot of these services have to be taken to remote and isolated communities.

In conclusion, on behalf of the Navajo Nation, thank you for your time and assistance in considering our issues and recommendations

to improve our health care in Indian country. I will be pleased to respond to any questions that you may have.

Thank you.

[Prepared statement of Mr. Roanhorse appears in appendix.]

Senator DORGAN. Mr. Roanhorse, thank you very much.

Let me ask a couple of questions and call on my colleagues, and then I will finish with a couple of additional questions.

Senator Burr asked a question of Dr. Grim and Ms. Power that I think is on point. I would ask any of you, with a roughly 2-percent increase in funding for Indian Health Services, is there any other conclusion but that we will lose ground on our health care issues on Indian reservations because we all know that the health care medical inflation is running at a very high rate, much above the amount that is requested for additional services in the budget. In addition to that, the one area where we see a rather substantial increase in population in my State, and I expect most States, is on Indian reservations. So the budget fails to not only keep pace with the increased population, but also medical inflation.

So isn't it a case, as I think Senator Burr was attempting to ask, isn't a case that we are almost certain to lose ground in our efforts here in trying to make progress in Indian health care? Ms. Smith, do you want to answer that?

Ms. SMITH. Thank you very much.

Absolutely. I come from Alaska. I have been in Alaska since 1970. The Native population in Alaska has doubled. With the type of funding, the slight increases that we have been receiving, and I appreciate the fact that we have, the Indian Health Service has received a slight increase, still and all across Indian country during the budget formulation process, it reverberates that we are funded at about 59 percent level of need.

Translated, there is not enough money out there to meet the needs of Indian communities. Many, many of our tribes and tribal organizations have compacted and contracted. In doing so, it brings the ability for us to be more flexible in delivering health care. We have tried to be as innovative, partnering, to stretch the dollar to make more services available, more culturally available. But your primary question is, no there is never enough money.

Senator DORGAN. But that is not my question, is there ever enough money. My question is more specific than that. Let me just say, I am going to ask the other three as well. I have always liked Dr. Grim. I think the Indian Health Service struggles with limited resources to do a very significant job.

But I also know that he would not be in that job very long if he came to this table to say, you know something, the President's budget here dramatically underfunds what we really need. He would not keep his job, so he cannot do that. He must come to this table to represent the Administration's budget. I understand that.

But I think the lack of the siren here that is necessary to say, we have a bona fide, full-scale crisis on many reservations, particularly with young children, but also the elderly and other not getting the care they need because we do not have a system that works and it is not funded properly. When I say we do not have a system that fully works, I mentioned earlier when kids have addictions or adults have addictions, there is just very few opportuni-

ties for them to get in-residence help for that addiction, which all of us understand is necessary to shed the addiction of substance abuse to alcohol or drugs and so on.

Ms. Joseph, do you want to respond?

Ms. JOSEPH. Thank you, Senator Dorgan.

As I stated, we are losing purchasing power. We are moving our resources around, reducing staff in some instances, shortening our hours of service. So we certainly are not going to gain ground when we have to approach health care delivery in that way.

Senator DORGAN. Ms. Ignace?

Ms. IGNACE. For the urban Indian health programs, the Federal Government only pays the States the regular Federal Medicaid matching rate. The urban Indians cannot really take advantage of this. As a result, we would certainly agree to increases in FMET.

Senator DORGAN. Okay.

Mr. Roanhorse.

Mr. ROANHORSE. Thank you for the question, Senator.

The 2 percent and 4 percent recommendation by IHS, this is not supported by the Navajo Nation. The instruction that was given to me as a representative from the Navajo Area to go to the national budget formulation process is to accept a minimum of 20 percent. So the tribal leaders on my reservation, the health care providers are seeing a huge gap and the need.

If I can maybe personalize this, and tell you about some of the things that we have to do. Just imagine that we have a person that is afflicted by cancer. Currently because of no cancer center close to the Navajo Nation, we are expected to send our clients to Albuquerque, NM, which is a 3-hour drive away, and in most cases 4 hours. Or they have to go to Phoenix, AZ. So just imagine that. These are the people that have limited income.

Sometimes they have to take off work in order to travel. And then once they get to Albuquerque, they have to figure out a way to maybe perhaps if they need to stay there for radiation therapy, then they need to dish out some money, whatever that they may have for overnight lodging, meals. And then in some cases, they may not even have any adequate transportation, no vehicles.

So what happens? What happens is that they just sit at home and then also just until it is too late, and they finally go to the hospital and the doctor will say, we are doing our best to treat you, but it may be a very advanced state. That is the situation that we encounter, Senator.

Senator DORGAN. I am going to ask about addiction treatment and some other issues, but let me call on my colleagues.

Senator Murkowski.

Senator MURKOWSKI. Thank you.

When we get to budget time, and I think it is universal, at least from the witness stand, that we do not have enough to do the job, and that is something that we have to reckon with. We have to deal with.

I have been very troubled by the statistics that face Alaska Natives in my State. We are at the top of all the bad categories for many, many reasons. But I have had multiple conversations with Dr. Grim and conversations with you, Ms. Smith, about the emphasis on prevention. We know that when we are talking about diabe-

tes, particularly the onset of adult diabetes, much of that is related to diet. When we look to, you mentioned the dental care issue in the State. Our children up north are wandering around with no teeth, and it is not because the baby teeth have come out. It is because the adult teeth are rotted by the time they are in high school.

So much of that is due to the diet, due to the fact that we do not have drinking water for the children to drink; that we do not have fresh milk for them to drink. And so much of this comes back to prevention. We can discuss at every budget hearing whether or not we have enough money, but until we take control of those things that we can control, and we can control our diet, and we can control aspects of our life about living healthier lifestyles.

I am not convinced that we are doing enough when it comes to the education component; when it comes to teaching our young people about healthy lifestyles. Ms. Smith, you mentioned an initiative I believe it was called the WIN! Initiative.

Ms. SMITH. Yes.

Senator MURKOWSKI. Are we giving the focus that you think we need to give when it comes to education and prevention so that we will in successive generations hopefully have healthier children, healthier people?

Ms. SMITH. Thank you very much.

Every time we have the opportunity to advance education in any area and particularly in the area of prevention, it is critical that we do so. Are we doing enough? We are beginning and moving forward today, but we are also just beginning this entire discussion about prevention. If we do not continue to build on health promotion and disease prevention today, we will not ever be able to afford down the road the causes of neglecting to put money into health promotion and disease prevention initiatives and programs.

I believe that the tribes and the tribal organizations across the Nation stand ready and are working very closely in collaboration with the IHS on the health promotion and disease prevention initiative, and recognize that we need to take the forward steps as tribes and as parents to see about prevention within our own families, within our own tribes, within our own nations.

And so every time that the question is asked, are we doing enough, for the moment maybe we are, but no, it is really never enough. So I am very excited about the WIN! Initiative that I mentioned from the National Indian Health Board. Again, I say it is a new vision; it is an ongoing vision of living healthy lives, making behavioral changes, and moving toward all American Indians at last being healthy at the onset, and not having to spend huge amounts of money later on in life when a good prevention program could have prevented such maybe tragic outcomes.

Senator MURKOWSKI. Let me ask you just one more question here. I appreciate your being here, Sally.

When we talk about how we might have prevented either the incident in Bethel or the incident in Red Lake, and we try to look for those warning signs, we try to pick up on them. The point was made earlier that we do not have access to appropriate or certainly enough treatment facilities.

So oftentimes, it is not the structured treatment facilities that we need. What we need are culturally appropriate or culturally significant programs within the communities that are going to make a difference, that are going to make a difference for that Evan Ramsay who would then feel part of his community and not feel that he has to react in the manner in which he did.

Do you feel that we are doing enough to provide for the flexibility through the funding to allow for communities to create programs that might work within their own unique situation? Do they have that flexibility currently?

Ms. SMITH. I will give you a two-part answer. With regard to flexibility, compacting and contracting tribes have the ability to be flexible in delivering a program. That is the flexibility part. With regard to the funding, it is critically important as funding comes into the country, that tribes and tribal organizations be mentioned specifically in the language so that the money can come from the funding agencies directly to tribes and tribal organizations.

That is a critical piece in making sure that at least within the American Indian and Alaska Native communities, the needs of those people, our people are being addressed, and addressed in that culturally compatible way that you just described.

Senator MURKOWSKI. Thank you, Mr. Chairman.

Senator DORGAN. Senator Murkowski, thank you very much.

Dr. Grim, could you scoot your chair back up? I want to ask you another question if I might, and ask others to respond to it. Thank you very much.

I mentioned at the start of this that the IHS spends $1,600 per person per year for health care. That is less than one-half of what we spend for Federal prisoners, and we have trust responsibility for American Indians, for health care. We also have sole responsibility for the health care of those we have incarcerated in Federal prisons.

If we spend $3,800 per person in Federal prisons for health care, and less than one-half of that for American Indians, compare that with $6,000 that Medicare spends per person, VA $5,200, Medicaid at $3,900. Can you describe for me the disparity here? Why would we spend one-half as much per person on Indian reservations for health care as we do for Federal prisoners?

Mr. GRIM. I do not know if I can explain the disparity to you in exactly the way you asked, Senator, but what I will say is that one of the things that the agency has done along with tribes as partners is that, and that the department itself has looked at a change in philosophy, is that it is not just Indian Health Service dollars that should be trying to serve our Indian population, but it should be moneys within SAMHSA, as Ms. Power pointed out, and within other parts of the department, too. And we are making many more grants available throughout the rest of the department.

We are also very actively, both tribes and the IHS, tapping into Medicare and Medicaid funding. We have the ability through the Indian Health Care Improvement Act to bill Medicare and Medicaid and private insurances and we are trying to bring additional resources through those programs into the agency, too. So we are looking at it as an entire Government responsibility, not just IHS,

and we are trying to reach out to other partners across the Government with tribes that perhaps in the past did not.

One of the things that Ms. Smith said that anytime new funding comes up, it should mention tribal governments. The department took a very strong effort and initiative to make sure that any grants within the Department of Health and Human Services that were appropriate for tribes, spelled out in fact in their grant announcement that tribes were available. So we have tried to make changes like that. While they may seem like they are changes on the margin, I think they are very important changes.

Senator DORGAN. You see, Dr. Grim, that is why I said I like you. You always see things, the glass is always half full for you. I say that with some admiration because I think it is important to be hopeful and to see things in a positive light.

On the other hand, with respect to health, if the glass if half empty, the half that is gone relates to people's ability to live a healthy lifestyle. In some cases, it relates to the difference between life and death. It relates to the difference between having a good day and a day filled with pain.

So I am not insistent on seeing the glass half full, but I am insisting on seeing if we have met our trust responsibilities. If not, why not? And if not, how do we start doing that?

When I asked the question about the amount of money we spend per Federal prisoner, and we have a responsibility when we incarcerate someone to meet their medical needs, and we do. From a small jail cell, even someone on death row, when they are ill, they are taken someplace to treat that illness. When they need surgery, they get surgery. The fact is, we have a responsibility and we meet it for people that we put in Federal prison.

We also have a trust responsibility for health care for American Indians. My sense is if it is not one-half of that which we spend on Federal prisoners, it is something still substantially below that which we spend on Federal prisoners. I am not certain how we get to the point where we meet our obligation if we always say, well, we are just making improvements.

We really have to set a baseline to say, here is the responsibility the Government has and here is how the Government meets that responsibility. I will give you a specific example. I toured a reservation. I do not remember. I think they have 7,000 people or somewhere in that neighborhood. They had one dentist working out of an old trailer house. Now, if you think taking care of your teeth is part of good health, and I do, and I think most people would, is that sufficient? If not, then how do we correct that?

Do you all see that kind of anecdotal evidence virtually everywhere you go? One dentist working out an old trailer house, trying to do the best he or she can, but dramatically understaffed on all these issues and underfunded and working long hours, but really not making much progress against a population base that is far too large.

Ms. Joseph.

Ms. JOSEPH. Thank you, Senator.

Among the family, we always hope to compliment each other. As Dr. Grim talked about the half-full glass, I will talk about the half-empty glass.

You know, the disparities in funding can take different approaches, but we did have a work group to address the Federal disparities index. It was early, you recall, to addressing the level of need funded.

Senator DORGAN. Yes.

Ms. JOSEPH. That work group primarily was constituted to make some recommendations on how the distribution from the Indian Health Care Improvement Fund would be made to death inequities. What they did, and it was I believe a very objective, scientific approach to addressing this disparities index. What they established as the yardstick was the Federal employees' benefit package. And then they moved that package around to 100 different geographic areas in the country and made a determination of what it would cost to provide that package of benefits to a Federal employee.

Of course, you know, the highest costs tended to be in Alaska and San Diego County. That was kind of the denominator. And then for the numerator, what they did was total the amount of dollars that was actually provided for personal health care. So that excluded wrap-around services such as community health representatives, public health nurses, health educators and emergency medical services need.

That denominator reflected a level of need or disparity in funding of the Indian programs compared to the benefits provided to the Federal employee. Based on that effort, it was determined it would take at least an additional $9 billion to $10 billion to address that disparity in personal health care services.

Senator DORGAN. Let me ask Dr. Grim about that. Again, you represent the Administration's budget. I understand that. I do not want you to lose your job. But I also want you to respond to the proposition Ms. Joseph has just advanced that if we really were going to provide parity with the meeting of our responsibility here, and in cases of the type I just described you would have not one dentist working out of a trailer house, you would have sufficient dentists to meet the population, just to take that small piece.

Isn't it the case if you were really trying to meet the parity that I think our trust responsibilities require, that there would need to be substantial additional funding?

Mr. GRIM. I could cite for you a number of statistics and we can provide those for the record about our access to care in dental that we have right now. It is between 20 and 25 percent of our population are able to access that. That is not the same in the Nation as a whole. It has been pointed our numerous times today the disparities in the various health indicators. And some of that is money issues, Senator Dorgan; some of it is access issues, recruitment and retention of providers. In many of our locations, it is the ability to have adequate housing for providers available when they come onsite.

So it is a very complex issue and I cannot answer the question as simply as you place it.

Senator DORGAN. But I think that if you say, for example, American Indians have access at the rate of 25 percent to dental services, that means 75 percent do not have access to dental services.

It means that we are substantially short of the resources necessary to provide at least that kind of care.

Is that not accurate?

Mr. GRIM. That would be an accurate statement.

Senator DORGAN. Yes; and let me go back just for 1 moment to the issue of substance abuse. One of the things that I was told at a meeting I had recently was that the young person who was for example hooked on methamphetamine, a deadly drug with dramatic addiction capabilities, or a young person who had become an alcoholic or addicted to some other drug, that person then goes into a cycle of dependency, depression, perhaps threatened suicide.

And to the extent that they reach out and find somebody in mental health in that tribe or in IHS, what happens they say is they are sent then to, perhaps they are sent to a psychiatric unit for evaluation, released in probably 1 or 2 days, and with no follow-up. And that goes on and on and on.

Again, in most cases, reservations, not all, but in most cases reservations are very remote, and so access, if you are referred to mental health treatment, is somewhere else, and if they turn you out in 2 days with no follow-up, you really have not addressed the fundamental issue.

Again, that gets back to the question of how many people are available to work in mental health on these reservations, psychologists, psychiatrists, and so on? The young woman named Avis Little Wind who took her life recently, there was one psychologist. I went and met with the school counselors, met with the young girl's classmates and others. It was quite clear that there was not the kind of health care capability for mental health that should have been available that might have saved this young girl's life.

I expect that is true on most reservations. That is why I raise the question today. Your testimony, Dr. Grim, is always helpful to us because it does describe where we are in fact making some progress. But I think we might be better off starting from the proposition of where we expect to be, where we should be, and then measuring the distance from there to where we are, and then describing how we get there and what kind of resources are necessary, what kind of reorganization is necessary. We seldom ever talk about it in those terms and I think we should because all of us who visit reservations and sit down and have long serious talks about the health care issue, and I should mention that we have a crisis not only in health care, but in housing and also in other areas as well.

I think that health care is just primary because if you do not have your health, you do not have the capability to live the life you want to live, and nothing else is able. You cannot hold a job. You cannot go to school.

So health care is primary and I think we really need to identify this as a crisis, an emergency, and try to look at this differently, rather than just each year saying, all right, we are short of money, this is a problem, let's incrementally move toward solving it. We need to re-think that. I know Senator McCain is very aggressive and very interested in addressing these health care issues in a positive way and so am I.

I would ask the panel as we close, any final last comment, and then I will ask Dr. Grim for a last comment.

Ms. JOSEPH. Senator Dorgan, I got a note here that said, Rachel, when you spoke about the disparity in funding, I stated $9 million to $10 million, and did I mean that. Absolutely, I did mis-speak. It is $9 billion to $10 billion.

Senator DORGAN. I think you said billion.

Ms. JOSEPH. Oh, that is right. I did mean to say $10 billion.

Senator DORGAN. In your testimony, I did not expect you were talking in $9 million or $10 million in quantity. [Laughter.]

Ms. JOSEPH. I appreciate your comments on the alcohol and substance abuse problems. In the reauthorization consultation process, we heard from tribal leader after tribal leader that urged us to authorize a comprehensive approach. Very often, we provide treatment in recovery programs, but do not provide the necessary aftercare, which will certainly facilitate the reduction of the recidivism rates that we are all challenged with.

Senator DORGAN. But isn't it true that most of the treatment is outpatient treatment and not the kind of treatment in most instances you need? In-residence treatment for addiction is critical and it exists in very few locations.

Ms. JOSEPH. Yes.

Senator DORGAN. I find that all over.

Ms. JOSEPH. Outpatient is mostly provided.

Senator DORGAN. Is there anybody else that feels like they want to make a final comment here? Then I am going to turn to Dr. Grim and then we are going to adjourn the hearing. All right, yes, Mr. Roanhorse.

Mr. ROANHORSE. Thank you, Senator Dorgan.

I just wanted to add a few more information to my testimony this morning. I appreciate your interest in behavioral health services. Again, the Navajo Division of Health through the Department of Health, behavioral health services is trying to meet a lot of demands for our work which has to do with addressing alcohol abuse, substance abuse, and then now with meth. And then also we do this by operating two adolescent treatment centers which only have a few beds.

Senator DORGAN. How many beds?

Mr. ROANHORSE. One has 20 beds, the second one has 24 beds. And then we also have 13 outpatient centers that serve over 11,000 clients. And then we also, this summer the Navajo Nation Council also passed the Controlled Substance Act of 2004, which I think would be one way of banning meth, but again it is a huge endeavor. We have to deal with some people that have to go into the remote areas of the Navajo Nation and then with $12 they can be able to purchase ingredients, and then they can in turn then sell for a huge amount of funds. And then that in turn causes a lot of behavioral problems. So these are some of the situations that we encounter on a daily basis.

And then another plan that we are trying to address is there is a 72-bed hospital that we are trying to, or a 72-bed residential treatment center that we are planning on setting up in Shiprock, NM. That is taking the former IHS facility, but in order to get to that point, it is going to cost of $10 million, so we have been going

to the State legislature. We have been going to the Navajo Nation Council just to raise funds to make sure that facility is renovated. So we hope that we can start at least the renovation started this summer.

So at least, these are some of the things that we are beginning to work on. Anything that you can do to help us out, I know money is tight everywhere, but I also think that, and I am reminded by my tribal leaders.

Senator DORGAN. Mr. Roanhorse, we must be brief. I asked for a brief comment.

Mr. ROANHORSE. I am sorry. Okay. So than you very much for allowing me to share these thoughts with you.

Senator DORGAN. Thank you for your testimony. Your testimony is very significant and we appreciate it.

Anyone else?

Ms. SMITH. Yes, thank you; thank you, Senator. I wanted to place on the record, earlier you mentioned about dental health care. In Alaska, our children are 2½ times the national rate for and the need for dental health care. I mean, it is just incredible up there. As part of meeting that challenge, the Alaska Native Health Board has gone on and took a step in something called the Dental Health Aid Therapist Program.

Senator DORGAN. I am familiar with that.

Ms. SMITH. Thank you very much, but I wanted you to know that again as part of recognizing that we have a need and being proactive about it, we are moving forward in that regard. So thank you very much.

Senator DORGAN. Thank you, Ms. Smith.

Ms. Ignace.

Ms. IGNACE. Yes; in the past several years, versions of the Indian Health Care Improvement Act did not include a reference to urban Indians. We would like that to remain in that policy, simply because we serve, we consider ourselves a multi-tribal clinic, where we serve not just one tribe, but many tribes that live in the city.

Senator DORGAN. All right. Thank you very much.

Dr. Grim, in the construction of the Administration's budget, I do not know whether you are able to provide this for me, but I would be interested in what the IHS request was to OMB for funding in this coming fiscal year. Do you have that at hand?

Mr. GRIM. I do not have that at hand. We could respond to you for the record.

Senator DORGAN. Was it substantially higher than that which now is in the President's budget?

Mr. GRIM. I just do not have that at hand, Senator, right now.

Senator DORGAN. Was it higher or lower?

Mr. GRIM. I do not recall. We can get that to you for the record.

I appreciate your support of Indian health issues.

Senator DORGAN. Dr. Grim, I said I liked you. [Laughter.]

Mr. GRIM. I have always liked you, Senator Dorgan.

Senator DORGAN. I find it hard to believe you do not know that. My expectation would have been that you would have asked for a rather substantial amount of money that is necessary to fund the Indian Health Service programs and that the Office of Management and Budget, as they kick these things up to the White House

where the President's budget has cut them substantially. But you do not know that at this moment, is that correct?

Mr. GRIM. I would prefer if I could respond for the record to you on that.

Senator DORGAN. All right. You respond for the record and I will make it a part of the record at the next hearing.

Mr. GRIM. Okay, thank you.

Senator DORGAN. Let me, Dr. Grim, thank you for being here, and let me thank the four witnesses on this panel. On behalf of Senator McCain and I, we pledge to continue to work hard on Indian health care issues because we think it is an urgent priority.

This hearing is adjourned.

[Whereupon, at 1:33 a.m., the committee was adjourned, to reconvene at the call of the Chair.]

APPENDIX

ADDITIONAL MATERIAL SUBMITTED FOR THE RECORD

PREPARED STATEMENT OF CHARLES GRIM, M.D., DIRECTOR OF THE INDIAN HEALTH SERVICE [IHS]

Mr. Chairman and members of the committee.

Good morning, I am Dr. Charles Grim, Director of the Indian Health-Service [IHS]. Today, I am accompanied by Robert G. McSwain, Deputy Director; Gary J. Hartz, Director, Office of Environmental Health and Engineering; and Dr. W. Craig Vanderwagen, Acting Chief Medical Officer. We are pleased to have this opportunity to testify on behalf of Secretary Leavitt on the status of Indian Health.

The IHS has the responsibility for the delivery of health services to an estimated 1.8 million federally recognized American Indians and Alaska Natives through a system of IHS, tribal, and urban [I/T/U] operated facilities and programs based on treaties, judicial decisions, and statutes. The mission of the agency is to raise the physical, mental, social, and spiritual health of American Indians and Alaska Natives to the highest level, in partnership with the population we serve. The agency goal is to assure that comprehensive, culturally acceptable personal and public health services are available and accessible to the service population. Our foundation is to uphold the Federal Government's obligation to promote healthy American Indian and Alaska Native people, communities, and cultures and to honor and protect the inherent sovereign rights of tribes.

Two major pieces of legislation are at the core of the Federal Government's responsibility for meeting the health needs of American Indians/Alaska Natives: The Snyder Act of 1921, Public Law 67–85, and the Indian Health Care Improvement Act [IFICIA], Public Law 94–437, as amended. The Snyder Act authorized regular appropriations for "the relief of distress and conservation of health" of American Indians/Alaska Natives. The IHCIA was enacted "to implement the Federal responsibility for the care and education of the Indian people by improving the services and facilities of Federal Indian health programs and encouraging maximum participation of Indians in such programs." Like the Snyder Act, the IHCIA provided the authority for the provision of programs, services and activities to address the health needs of American Indians and Alaska Natives. The IHCIA also included authorities for the recruitment and retention of health professionals serving Indian communities, health services for people and the construction, replacement, and repair of health care facilities.

We are here today to discuss the status of the Indian health by focusing on health disparities and other related issues such as Urban Indian health, Indian health care facilities, Indian self determination, and portions of the Medicare Modernization Act.

While the mortality rates of Indian people have improved dramatically over the past 10 years, Indian people continue to experience health disparities and death rates [1999–2001] that are significantly higher than the rest of the U.S. general population (2000):

- Tuberculosis—533 percent higher

- Alcoholism—517 percent higher
- Diabetes—208 percent higher
- Accidents—150 percent higher
- Suicide—60 percent higher
- Homicide—87 percent higher.

While some view these statistics as insurmountable facts, they are influenced by behavior choices and lifestyle. Making significant reductions in health disparity rates can be achieved by implementing best practices, using traditional community values, and building the local capacity to address these health issues and promote healthy choices. For fiscal year 2006, IHS is requesting a total budget of $3.8 billion, including an increase of $80 million for inflation and population growth which will allow for a renewed focus on health disparities.

It is the mission of the Indian Health Service to provide services and programs that promote healthy choices and assist in enabling tribes to educate their members about prevention and treatment programs that address the unique needs of their individual communities.

I just returned from the Red Lake Band of Chippewa Indians in Minnesota and saw firsthand the results of the devastation brought about by the shootings at the Red Lake High School. I also saw the community coming together and drawing strength from the support of mental health professionals and tribal spiritual leaders. There is much to do, yet there is a sense of hope and a spirit of collaboration among the community and tribal leaders, the State and Federal programs. Within the Department of Health and Human Services alone, the Office of the Secretary's Office of Intergovernmental Affairs as well as the Department's operating divisions, including the Substance Abuse and Mental Health Services Administration [SAMHSA], the Administration for Children and Families [ACF] and its Administration for Native Americans, and the Office of Minority Health are joining the Bureau of Indian Affairs [BIA] within the Department of the Interior, the Department of Justice [DOJ], and the Department of Education to assist the tribe and community. My thanks to all those involved that are working together to improve the overall health of Indian people in Red Lake and throughout Indian country.

How do we prevent such incidences from occurring? First, IHS focuses on screening and primary prevention in mental health especially for depression which manifests itself in suicide, domestic violence, and addictions. Second, we focus on the effective utilization of treatment modalities that are available; and, we are seeking to improve the documentation of mental health problems. IHS is currently utilizing effective tools for documentation through the behavioral health software package. And, we are working with communities who are focusing more on these mental health needs. In addition, our budget request includes $59 million for IHS mental health services, an increase of 7.7 percent over fiscal year 2005.

With 80 percent of the mental health budget and 97 percent of the alcohol and substance abuse budget in IHS going directly to tribally operated programs, the tribes and communities themselves are now taking responsibility for their own healing. They provide effective treatment and prevention services within their own communities.

A primary area of focus that I have identified based on these statistics is a renewed emphasis on health promotion and disease prevention. I believe this will be our strongest front in the ongoing battle to eliminate health disparities plaguing our people for far too long. Although IHS has long been an organization that emphasizes prevention, I am calling on the agency to undertake a major revitalization of its public health efforts in health promotion and disease prevention. Field, tribal, and urban participation in the initial stages of planning and implementation of this revitalization is critical to its success.

Fortunately, the incidence and prevalence of many infectious diseases, once the leading cause of death and disability among American Indians and Alaska Natives, have dramatically decreased due to increased medical care and public health efforts including massive vaccination and sanitation facilities construction programs. As the population lives longer and adopts more of a Western diet and sedentary lifestyle, chronic diseases emerge as the dominant factors in the health and longevity of the Indian population with the increasing rates of cardiovascular disease, Hepatitis C virus, and diabetes. Most chronic diseases are affected by lifestyle choices and behaviors.

The incidence and prevalence of diabetes has been increasing dramatically since 1972. American Indians and Alaska Natives have the highest prevalence of type 2 diabetes in the world. The prevalence of type 2 diabetes is rising faster among American Indian and Alaska Native children and young adults than in any other ethnic population, increasing 106 percent in just one decade from 1990 to 2001. As diabetes develops at younger ages, so do related complications such as blindness,

amputations, and end stage renal disease. We are hopeful, though, that we may be seeing a change in the pattern of diabetes mortality because the diabetes mortality rate for the entire American Indians and Alaska Natives population did not increase between 1996–98 and 1999–2001. In fact, the overall mortality rate for American Indians and Alaska Natives decreased approximately 1 percent between these same time periods. And there is good news that we have recently measured a slight, but statistically significant, decline in kidney failure in the American Indians and Alaska Natives diabetic population as well.

What is most distressing however about these statistics is that type 2 diabetes is largely preventable. Lifestyle changes, such as changes in diet, exercise patterns, and weight can significantly reduce the chances of developing type 2 diabetes. Focusing on prevention not only reduces the disease burden for a suffering population, but also lessens and sometimes eliminates the need for costly treatment options. The cost-effectiveness of a preventive approach to diabetes management is an important consideration, since the cost of caring of diabetes patients is staggering. According to a recent American Diabetes Association study, the managed care cost for treating diabetes annually per patient exceeds $13,000.

In 1997, the Special Diabetes Program for Indians [SDPI] was enacted and provided $150 million over a 5-year period to IHS for prevention and treatment services to address the growing problem of diabetes in American Indians and Alaska Natives. In 2001, Congress appropriated an additional $70 million for fiscal years 2001 through 2002, and an additional $100 million for fiscal year 2003. Then in 2002 Congress extended the SDPI through 2008, and increased the annual funding to $150 million with the directive to address "primary prevention of type 2 diabetes." These funds have substantially increased the availability of services—physical activity specialists, registered dietitians and nurses, wellness and physical activity centers, newer and better medications—which have led to a steady increase in the percentage of diabetics with ideal blood sugar control. We are proud to announce that our Division of Diabetes Treatment and Prevention launched a competitive grant demonstration project focused on primary prevention of type 2 diabetes in 35 American Indians and Alaska Natives communities in November 2004. This program is focusing on American Indians and Alaska Natives adults with pre-diabetes to determine if an intensive lifestyle intervention can be successfully implemented in American Indians and Alaska Natives communities. Our efforts are based on a model developed by the National Institutes of Health [NIH] that proved diabetes could be prevented. These programs will cover a 4-year period. The outcomes of the demonstration projects will enable us learn what may be applicable to other communities throughout Indian country.

Cardiovascular disease [CVD] is the leading cause of mortality among Indian people. The Strong Heart Study, a longitudinal study of cardiovascular disease in 13 American Indians and Alaska Natives communities, has clearly demonstrated that the vast majority of heart disease in American Indians and Alaska Natives occurs in people with diabetes. In 2002, we were also directed to address "the most compelling complications of diabetes,"which of course is heart disease with the increased SDPI funding. The IHS is working with other DHHS programs, including the Centers for Disease Control and Prevention and the National Institutes of Health's National Heart, Lung, and Blood Institute, to develop a Native American Cardiovascular Disease Prevention Program.

Also contributing to the effort are the IHS Disease Prevention Task Force and the American Heart Association.

Our primary focus is on the development of more effective prevention programs for American Indians and Alaska Natives communities. The IHS has begun several programs to encourage employees and our tribal and health program partners to lose weight and exercise, such as "Walk the Talk" and "Take Charge Challenge" programs. Programs like these are cost effective in that prevention of both diabetes and heart disease, as well as a myriad of other chronic diseases, are all addressed through healthy eating and physical activity.

In summary, preventing disease and injury, promoting healthy behaviors and managing chronic diseases are a worthwhile financial and resource investment that will result in long-term savings by reducing the need for providing acute care and expensive treatment processes. It also yields the even more important humanitarian benefit of reducing pain and suffering, and prolonging life. This is the path we must follow if we are to reduce and eliminate the disparities in health that so clearly affect American Indians and Alaska Natives people. We will spend $330 million on specific health promotion and disease prevention activities in fiscal year 2005.

IHS, Tribe and Urban Indian health programs could not function without adequate health care providers. The Indian Health Manpower program which is also

authorized in the Indian Health Care Improvement Act [Public Law 94–437, as amended] consists of several components:

- The IHS Scholarship Program;
- The IHS Loan Repayment Program; and
- The IHS Health Professional Recruitment Program.

The IHS Scholarship Program plays a major role in the production of American Indians and Alaska Natives health care professionals. Since its inception in 1977, more than 7,000 American Indians and Alaska Natives students have participated in the program, with the result that the number of American Indians and Alaska Natives health professionals has been significantly increased. The program is unique in that it assists students who are interested in or preparing for entry into professional training. Most scholarships only provide assistance to those who have been accepted into a health professional training program. By providing this preparatory assistance, the program ensures that even those participants who do not complete their health professions training are better prepared to return to their communities and become productive members.

The IHS Scholarship Program [LRP] has been the starting point for the careers of a number of American Indians and Alaska Natives health professionals now working in IHS, tribal, and health programs. Many are also involved in academia, continuing to help identify promising American Indians and Alaska Natives students and recruit them to the health professions, thereby helping to produce a self-sustaining program. We have had several instances of parents going through the program, followed later by their children, and in some cases, we have even seen children being followed by their parents. The average age of our students is 28 years, well above the norm for college students. It is not uncommon for students to have attended 5 or more colleges or universities during the course of their academic careers, not because they failed in the first four, but because they had to move in order to have the employment they needed to support their families.

The IHS Loan Repayment Program is very effective in both the recruitment and retention areas. The program provides an incentive both to bring health professionals into the IHS and to continue their employment with the agency. Keeping health professionals for longer periods of time provides a benefit to the overall Indian health program by increasing continuity of care.

The scholarship and loan repayment programs complement one another. Scholarships help individuals rise above their economic background to become contributing members of the community and participate in improving the well-being of the community. Loan repayment participants often graduate with large debt burdens which cause them to accept jobs with the highest salaries. The program is a way for them to provide service in return for assistance in repaying loans that could otherwise be overwhelming.

The recruitment program seeks to maximize the effectiveness of both programs, as well as to make the IHS more widely known within the health professional community and to assist interested professionals with job placement that best fits their professional and personal interests and needs. Our fiscal year 2006 request includes $32 million for Indian Health Professions, an increase of 3.6 percent over fiscal year 2005.

Another important aspect of our health care delivery system is the Urban Indian Health Program [UIHP] authorized by Congress in 1976 with the passage of the Indian Health Care Improvement Act. Title V of the IHCIA was intended to make health services available to communities that were not otherwise met by an IHS administered health program. Urban American Indians and Alaska Natives are often times not included in the urban community health planning process because they represent a smaller percentage of the population in the urban areas in which they reside.

For many urban Indians, the UIHP may serve as a primary care provider or may provide critical assistance in helping urban Indians to access health care in the urban community. In this regard, UlHPs are remarkably successful. All UIHPs conduct extensive eligibility determinations, education about services, training in how to access services, assistance in applying for and qualifying for and state health benefits' programs, assessment of patient needs and referral, and in some cases transportation to other health care sites. Many Urban Indians now get health care services from a variety of sources for which they are eligible as a result of the UIHP efforts. However, some may experience economic, cultural, and language barriers which can make it difficult for Urban Indians to access such programs. In addition, eligibility may vary over time in response to job conditions, personal circumstances and eligibility guidelines making continuity of care difficult to achieve.

In order to address the growing needs of Urban Indian populations, UIRP organizations partner with and received assistance and funding from many Federal health care agencies, including DHHS sister agencies, the Department of Veterans Affairs, and State and local governments. In fact, during 2003, title V funding represented 48 percent of all funding received by the UIHPs, with the remaining 52 percent received as a result of collaborations. Through these collaborative efforts, the U1HPs work to obtain maximum health care services for Urban Indians.

In summary, the UIHP was established to provide basic services to eligible Indians who are not living on or near a reservation where the IHS or a tribal program would otherwise provide for their healthcare. The UIHP is very successful in assisting eligible Urban Indians to utilize health care services when such services are available. When Urban Indians are not eligible for other programs, or lack access to basic health care, the UIHP provides basic services to Indian clients to the extent resources are available. Equal access and utilization of health care services by Urban Indians is achievable in combination with UIHP and other public and private sources. Our fiscal year 2006 request includes $33 million for Urban Health, an increase of 4.4 percent over fiscal year 2005.

The Environmental Health and Engineering program is a comprehensive public health program administered by IHS and tribes. Two examples are the sanitation facilities construction program which provides safe water, wastewater disposal, and solid waste disposal system; and the injury prevention program which focuses on unintentional injuries. As a result of these two successful programs, 88 percent of American Indians and Alaska Natives homes now have safe water and unintentional injuries have been reduced by 53 percent between 1972 and 1996. Unfortunately, 12 percent of the homes still lack adequate sanitation facilities compared to 1 percent of the rest of the United States population; and the leading cause of death for American Indians and Alaska Natives between the ages of 1 and 44 years of age is unintentional injuries. Improving in these areas is integral to our mission. Our fiscal year 2006 request will provide water and waste disposal services to 20,000 existing Indian homes.

The Environmental Health and Engineering program provides access to health care services through the health care facilities program which funds Federal and tribal construction, renovation, maintenance, and improvement of health care facilities where health care services are provided. There are 49 hospitals, 231 health centers, 5 school health centers, over 2000 units of staff housing, and 309 health stations, satellite clinics, and Alaska village clinics supporting the delivery of health care to American Indians and Alaska Natives people. The IHS is responsible for managing and maintaining the largest inventory of real property in the DHHS, with over 9.5 million square feet [880,000 gross square meters] of space and the Tribes own over 3.7 million square feet [353,000 gross square meters]. This is in part the result of tribally funded construction of millions of dollars worth of space to provide health care services by the Indian Health Service funded programs.

Over the past decade, $600 million in funding has been invested in the construction of health care facilities which include, 1 Medical Center, 5 Hospitals, 9 Health Centers, 3 Youth Regional Treatment Centers, 500 units of Staff Quarters, 27 Dental Units, and 21 Small Ambulatory Program construction projects. IHS has substantially improved its health care delivery capability in the newer health care facilities but we are still providing health care in a number of older and overcrowded facilities. At the same time, the resources to maintain and improve this space have remained steady over this past decade at $38 million 10 years ago to $49 million in fiscal year 2005.

In response to a Congressional request to revise the Health Care Facilities Construction Priority System, we have been working to better identify the health care delivery needs. This will enable us to prioritize the need for health care facilities infrastructure. We are using a master planning process to address the complex nature of health care delivery for American Indians and Alaska Natives communities. Both the Federal Government and Tribes will be able to use these plans to identify our greatest needs for services and health care facilities. In the time of fewer resources, we want to plan carefully on how to best utilize any possible resources. The IHS Health Care Facilities Construction program is fully prepared to address the needs identified through this process. The program recently received one of the highest Program Assessment Rating Tool scores in the Department of Health and Human Services.

The IHS has been contracting with Tribes and Tribal organizations under the Indian Self-Determination and Education Assistance Act, Public Law 93–638, as amended, since its enactment in 1975. IHS has implemented the act in a manner that re-affirms and upholds the government-to-government relationship between Indian tribes and the United States. The share of the IHS budget allocated to tribally

operated programs has grown steadily over the years to the point where today over 50 percent of our budget is transferred through self-determination contracts/compacts. This percentage includes 30 percent of our budget transferred to 303 tribes and tribal organizations through self-governance compacts and funding agreements. Our budget request for Contract Support Costs includes an increase of $5 million, sufficient to cover the contract support costs of the estimated number of new contract requests in fiscal year 2006.

As the principal author of major statutes affecting Indian health, this committee is aware that a primary goal has always been to involve Indian and people in the activities of the IHS. I would like to acquaint the committee with an initiative that I undertook last year to revise the policy that governs tribal consultation and participation in the activities of the IHS. Over the last 7 months, the IHS has worked closely with a representative group of tribal leaders and officials to revise our present Consultation policy with the intention of improving the process to ensure, to the maximum extent permitted by law, that leaders and officials are true partners with the IHS in policy development, budget allocation, and other activities. I anticipate that our "new" Consultation Policy and the improvements to the consultation process that it sets forth will be formally adopted by me next month, in May 2005. Our new policy will be our third revised Consultation Policy since 1997. The IHS is committed to improving consultation based on our experiences in this important area and our continuing discussions with Leaders concerning consultation activities in the IHS.

American Indians and Alaska Natives will also benefit from several provisions in the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 [MMA]. In 2004 and 2005, the transitional assistance credit of $600 per year for low-income Medicare beneficiaries, including American Indians and Alaska Natives, might provide additional Medicare revenue for prescription drugs dispensed at IHS facilities in fiscal year 2005. The Medicare part D prescription drug benefit program, when implemented in January 2006, will make the new part D prescription drug benefit available to American Indians and Alaska Natives Medicare beneficiaries. Other sections of the act authorize a 5-year expansion of benefits covered under Medicare part B for American Indians and Alaska Natives beneficiaries.

In addition, the MMA introduced a number of provisions that expanded preventive benefits coverage in January 1, 2005. Beneficiaries whose Medicare part B coverage begins on or after January 1, 2005, will be covered for an initial preventive physical examination within 6 months of enrollment. This exam includes counseling or referral with respect to screening and preventive services such as pneumococcal, influenza, and hepatitis B vaccinations; screening mammography; screening pap smear and pelvic exam; prostate cancer screening; colorectal cancer screening; diabetes outpatient self-management services; bone mass measurement; glaucoma screening; medical nutrition therapy services; cardiovascular screening blood test; and diabetes screening test which will be given to beneficiaries at risk for diabetes.

The cardiovascular screening blood test and diabetes screening test do not have a deductible or co-pays, so beneficiaries do not incur any cost. This is an additional incentive for those with limited resources who might not otherwise access these benefits.

The Centers for Medicare and Medicaid Services [CMS] is collaborating on education and outreach with the American Cancer Society, the American Diabetes Association, and the American Heart Association to help maximize attention to Medicare's new preventive benefits and help seniors to use them. CMS also plans to assist IHS in training IHS, tribal, and urban Indian health pharmacy staff on Medicare part D, so staff and Indian Medicare beneficiaries will better understand the new Medicare prescription drug benefit.

In summary, Indian health has improved progressively since enactment of the Indian Health Care Improvement Act in 1976. The IHS has honored its commitment to improve the health status of all eligible American Indians and Alaska Natives as provided by IHCIA and has worked with tribes since the passage of the ISDEAA in 1975 to assist in the successful transition of the IHS administered health programs to tribal control and administration. Prevention and health promotion programs continue to be a personal priority of mine and have received a $33 million funding increase in the President's fiscal year 2006 proposed budget.

We recognize, however, that health disparities continue to exist between American Indians and Alaska Natives and all other groups in the U.S., and we seek to address this need through continued support of health education and disease prevention programs targeted at diseases with some of the highest mortality rates. In addition, our scholarship and loan program provides opportunities to recruit and retain young Indian professionals to serve their communities, while the sanitation facilities construction program continues to provide safe water, wastewater disposal,

and solid waste disposal systems for the well being of many communities. And, through ongoing consultation, both Tribes and the Federal Government benefit from communication that better identify priorities and how they might best be addressed. Finally, enactment of the MMA will provide much needed prescription drug coverage in a manner intended to enhance the well being of tribal members.

Mr. Chairman, this concludes my statement. Thank you for this opportunity to discuss the Indian health programs serving American Indians and Alaska Natives and their impact on the health status of American Indians and Alaska Natives. We will be happy to answer any questions that you may have.

04/12/2005 14:38 FAX 002/003

Nez Perce

TRIBAL EXECUTIVE COMMITTEE
P.O. BOX 305 • LAPWAI, IDAHO 83540 • (208) 843-2253

April 12, 2005

Senate Committee on Indian Affairs
SH-836 Hart Senate Office Building
Washington, D.C. 20510-6450

Attn: Marilyn Bruce

Re: Oversight Hearing on Indian Health, SR-485

Dear Committee Members:

The Nez Perce Tribe would like to thank you for the opportunity to express its views on the state of Native American health care. As is common with the rest of the country, the rising cost of health care is a major concern among Native American populations. This concern is compounded by the fact that Native Americans suffer a significantly lower health status and disproportionate rates of disease compared with other Americans. This increased need for health care and higher costs in medical care mean larger portions of an individual's disposable income are taken up with health costs or can cause individuals to forgo certain types of rudimentary care. This increased need also puts added pressure on the health care system to deliver effective health services to Native Americans. However, a system that is under severe strain in having to treat high rates of diabetes, alcoholism, tuberculosis, and mental health conditions cannot do so if it is underfunded. Lack of funding causes many of the problems in the Native American health care. Low funding results in the loss of health care providers, increases in wait time for services and increases in the workload on those providing the services.

While the Nez Perce Tribe does not advocate simply throwing money at any problem, absent any solutions to halting rising health costs, maintaining or increasing funding for health care programs such as Medicaid is money well spent, especially if the funding is aimed at improving or aiding in the delivery of health care services to Native Americans. As a large portion of the Native American population falls in the lower income brackets, programs such as medicaid play a vital role in bridging the gaps in health coverage for these individuals. The importance of this coverage is magnified by the fact that many Native Americans eligible for such assistance are women who are pregnant or have families. Native American women and children that receive adequate and immediate care, including preventive care, can avoid longer lasting or permanent health problems in the future.

Funding is not the only solution to the overall problem. Having legislation like the Indian Health Care Improvement Act reauthorized are positive steps that can be taken by Congress to help improve the delivery of health care to Native Americans. As it stands, there is no simple solution to the myriad of problems that are involved in providing health care to Native Americans. However, the issue will not go away unless the proper legislative attention and funding is provided.

The Nez Perce Tribe would like to thank you for your hard work and attention to this matter.

Sincerely,

Anthony D. Johnson
Chairman

Testimony before the Senate Committee on Indian Affairs
By The Honorable Rachel A. Joseph

April 13, 2005

Good morning Mr. Chairman, Vice Chairman Dorgan and Senators of the Committee. My name is Rachel A. Joseph. I am Chairperson of the Lone Pine Paiute Shoshone Reservation, Co-Chair of the National Steering Committee for the Reauthorization of the Indian Heath Care Improvement Act (IHCIA), a Board Member of the California Rural Indian Health Board and Chairperson for the Toiyabe Indian Health Program, a consortium of nine Tribes which serves Mono and Inyo Counties in central California. I have served for several years on the Indian Health Service (IHS) National Budget Formulation team representing California and have been elected to represent the East Central California Tribes to the Area Office Advisory Board. In these capacities, and others, I have been fortunate to work with Tribal Leaders from across the Country in addressing health care issues. Today I will provide an overview of the history of Indian health care and how that history is reflected in the present; and, I will highlight some of the issues that need to be addressed.

Each Tribe is different and the history of first contact, conflict, compromise or subjugation varies by Tribe as does the specific development of health services in each tribal area. However, we have all experienced similar patterns in U.S. Indian relations and the development and shortfalls in funding of the Indian Health Service. Originally, the provision of health services by the Federal Government to Indians was in response to the need to protect Solders from infectious diseases. Later, some tribes were successful in securing provisions concerning health care in treaties. Over time the administration of health care was passed from the War Department to the Department of Interior. In 1921 Congress formalized this responsibility with the passage of the Snyder Act which states in part ..."from time to time Congress shall appropriate funds to hire doctors... and to provide for the general relief of Indians." Within a few years the quality and level of effort being given to provide for Indian health services was being questioned. In 1928 the Meriam Commission issued a report. That report identified a long list of issues that remain little changed to this day:

> "The health of the Indians as compared with that of the general population is bad. Although accurate mortality and morbidity statistics are commonly lacking, the existing evidence warrants the statement that both the general death rate and infant mortality rate are high. With comparatively few exceptions the diet of the Indians is bad... the housing conditions are conducive to bad health... The hospitals (and) sanatoria...maintained by the service, despite few exceptions, must be generally characterized as lacking in personnel, equipment management and design....***The inadequacy of appropriations has prevented the development of an adequate system of public health administration and medical relief work for the Indians...***"

The onset of the great depression in America and the general growth in federal programs had a positive affect on Indian heath. Unfortunately, this era of expanded programs was followed with a policy of termination which abrogated the rights of some tribes. A significant event of this era was the transfer of responsibility for heath services to the U.S. Public Health Service from the Bureau of Indian Affairs primarily because of poor administration of health care services by the BIA.

By the mid 1970's a change in federal Indian policy resulted in improvements to the Indian Health Service. This new policy directed by President Richard Nixon urged greater inclusion of Tribal Governments in the provision of services to their members. In 1975 Congress passed the Indian Self Determination and Education Assistance Act (ISDEA) to accomplish that goal by authorizing a system of federal contracting between Tribes and the U.S. government. In 1976, Congress passed the initial version of the Indian Health Care Improvement Act. (P.L. 94-437). That act set out a series of health status goals and authorized many significant new programs which included the IHS scholarship program, the Urban Indian Health Program and a new relationship between the IHS and federal programs Medicare and Medicaid. Over the years the Indian Health Care Improvement Act (IHCIA) has become the primary vehicle for updating and improving health services to American Indians/Alaska Natives (AI/AN).

After the initial passage of the ISDEA and the IHCIA, new resources and programs facilitated a renaissance in the provision of heath care services to Indian people. In the 1990's an era of neglect and under funding "set in". This recent era is well documented in two reports by the U.S. Civil Rights Commission. The first report "The Quiet Crisis: Funding Unmet Needs in Indian Country" focuses on all government programs of benefit to Indians. The second report "Broken Promises: Evaluating the Native American Health Care System" focuses exclusively on health. Reflecting this era of shrinking resources and strained relations is the continuing failure to reauthorize the Indian Health Care Improvement Act.

The provision of health care services to America's native people is a complex system that includes three modes of care delivery and multiple funding "streams". Forty years ago the IHS was totally dependent on its own appropriation from Congress. Today, as a result of changes brought about by ISDEA contracting and compacting and the IHCIA which authorized Urban programs, the IHS is referred to as the I/T/U System. In the I/T/U System the I stands for IHS directly operated programs; the T stands for programs operated under ISDEA Contracts and Compacts; and, the U stands for Urban Indian community grant operated programs.

TRIBAL CONTRACTING

IHS Tribal contracting, in some ways, began in California. California Indians were greatly devastated by the federal termination policy. The failed treaty process of the 1850's, the large number of scattered small tribes and the Congressional designation of California as a P.L. 83-280 State led to the removal of federal funded health services from the State. In the late 1960's, California Tribes organized to work for the return of IHS funded health care. We were successful in this effort and in 1973 Congress earmarked $72,000 to restart those services. This was prior to the passage of the ISDEA and those funds were distributed and administered under the Buy Indian Act. Prior to the passage of the ISDEA congressional staff and federal administrators reviewed the programs in California and saw an effective way to provide services to Indian people. At that time, the Tribal Health Program in my area was called the Tri-County Indian Health Program which operated a single clinic site with one physician. Today we provide services at a central facility on the Bishop Paiute Reservation and two satellite clinics at each end of our two county service area. Those early days were marked by battles of funding which eventually lead to a federal lawsuit which became known as the "Rincon case" named after one of the tribes that supported the litigation. That lawsuit began the changes within the Department of Health Education and Welfare (HEW) to establish mechanisms for identifying how much funding new tribes or tribes in a specific area should receive. Buy-Indian grants and later ISDEA contracts enabled the IHS to begin providing services to numerous small tribes east of the Mississippi, in California and the Northwest. To provide equity in funding to these programs the equity fund and later the Indian Health Care Improvement Fund were authorized by the IHCIA. However, funding inequities persist. One important improvement to prevent long term under funding for new tribes was the establishment, by the IHS, of a "new Tribes" funding policy in 2001. This policy states that new tribes be brought into the system with the same level of funding as the IHS national average.

The next phase of Tribal contracting and tribal compacting was the assumption of administration by Tribes of large portions of IHS programs. What started as a trend towards tribal management under ISDEA contracts of auxiliary public heath focused services grew into Tribal assumption of vertically integrated systems. This trend is reflected mostly in the Oklahoma, Phoenix and Alaska Areas. In some places, like the Cherokee Nation, it meant tribal control of a network of clinics and their attendant outreach and public heath programs while hospital services remained under IHS management. In other places, Tribes were awarded ISDEA contracts to run all direct health services; and, the size and scope of the directly operated system was diminished and often forced to restructure. The 1990's national policy to reduce the number of federal employees led to a different kind of downsizing that focused on IHS Headquarters and Area Offices and had a negative affect on IHS directly operated sites.

The expansion of ISDEA contracting and compacting saw the development of new administrative polices that greatly shaped the implementation of ISDEA contracting and ushered in an era of IHS Consultation with Tribes on policy issues. Among the first of these policies was clarifications in the ISDEA that tribes were eligible to receive contract support costs (CSC) for certain direct and indirect costs above the identified program funding provided for direct services. In providing these CSC funds, the IHS recognized tribal programs were subject to some costs that the IHS was not subject to and that certain pooled costs were considered as appropriate costs under government contracting

regulations and should be funded. Funding CSC removed a deterrent to tribal contracting. Another significant policy development that facilitated tribal contracting was clarification that all programs, services, functions and activities, regardless of the bureaucratic level at which they occurred within the agency, were subject to ISDEA contracting. This led to the development of a methodology for identifying specific portions of the IHS Headquarters and Area Offices programs known as "Tribal Shares" that were then subject to ISDEA contracting in whole or in part. Simultaneously, those programs, services, functions and activities that only a governmental agency could do were identified and designated IHS residual shares.

The ISDEA clarifications on what was contractible and the establishment of an orderly methodology to identify available funding led to an expansion in tribal contracting. The foundation in the development of these polices was the months long negotiated rule making authorized by Congress in ISDEA reauthorization. The negotiated rulemaking process led to the writing of an understandable set of regulations that resolved many former conflicts and disparities in the IHS contracting process. That same reauthorization initiated the Tribal compacting process as a further expression of Tribal self determination. These changes led to increases in tribal assumption of multiple levels of IHS programs. The epitome of tribal compacting is the All Alaska Compact which placed all IHS Area functions within a single compact under a statewide coalition of tribes and health programs. Today over 53% of IHS program funding is administered through ISDEA contracts and compacts.

URBAN PROGRAMS

Health services for urban Indians is authorized by P.L. 94-437 in Title V. These small grant programs initially provided planning to facilitate information and referral services; however, pressing needs and a lack of alternative sources of care changed the urban mission which expanded to include direct health care services. The growth of the Urban program was helped, especially in California, by the transfer of former National Institute for Alcohol and Alcohol Abuse (NIAAA) funded programs that served Indian populations. The urban programs still struggle to provide services to large populations with minimal funding. There are a few "flagship" programs in urban centers such as Seattle, Minneapolis, Oakland-San Francisco and Tulsa which provide comprehensive health care services and many urban programs that struggle. Of concern is the policy issue discussion as to whether the Title V programs overlap with the Community Health Center Program.

IHS DIRECT SERVICE PROGRAMS

The past thirty years have not been easy for the IHS direct service programs. The downward trend in IHS appropriations has directly affected the growth and quality of these programs. Additionally, forced restructuring when Tribes contract or compact away resources adds to the "squeeze" on limited resources. In some areas the IHS direct care system is kept in place partially due to the strong belief that this care is a Federal responsibility. There is also a shrewd analysis by some large land based tribes that the problems of recruitment and retention of professional health staff for small isolated systems could lead to deterioration in service levels and quality. Still, the IHS direct care system has proven resilient partly due to its public health oriented model and the vertical integration of its delivery system. Recent threats to this delivery system have come in the form of administrative initiatives to centralize services such as personnel services across all Health and Human Services (HHS) Departmental operating divisions. These threats and a commitment to improve health care has led to the development of a coalition of direct service tribes that meets annually.

The I/T/U system is more complex than the old IHS system partly because of its reliance on multiple funding streams. Initially, IHS funds were directly appropriated by the Interior Committees in Congress. In 1976 Title IV of the IHCIA gave the IHS statutory authority to bill the federal programs of Medicaid and Medicare for services provided in IHS facilities. The original authority implied that these funds would be used to maintain JCAHO accreditation at IHS operated hospitals and clinics. By this time, Tribally operated IHS grant programs in California had already begun to bill California's Medicaid program. In the late 1990's, the need to improve the capacity of the IHS direct service program to assist eligible Indians to apply for Medicaid and Medicare led to the "Business Office Initiative" which provided staff and training across the IHS system. The struggle to identify the appropriate use of these Medicaid and Medicare funds has resulted in various changes to the IHCIA. For example, sections of the Act identify how Area Offices must distribute collections back to the site of billing and directs Congress not to "off set" the IHS appropriation because of these collected funds. For the ease of administration, the Health Care Financing Administration (HCFA) allowed the IHS to establish an annually negotiated provider encounter rate for the purpose of billing Medicaid for ambulatory services. Initially, Tribally operated programs were only able to bill state Medicaid programs as fee for service providers. In 1996 an IHS/HCFA Memorandum of Agreement extended the IHS all inclusive or global encounter rate to Tribal Contractors like those in California.

The 1977 Balanced Budget Act created the State-Children's Health Insurance Program to provide health coverage for children up to the age of 19 who do not meet the poverty requirements for Medicaid. This expansion of coverage was particularly important to the Indian community which is younger than the nation as a whole. Combined collections from these three sources are not easy to quantify due to gaps in the data collection systems at both IHS and CMS. The IHS methodology for identifying funding shortfalls by operating unit asserts that 25% of all operating funds come from non IHS collections. It is clear that the bulk of these funds represent collections from the Medicaid program. For FY 2006 the Administration request is to authorize an IHS operating budget of $3,846,174,000 that includes $648,208,000 in projected third party collections
In response to the growing importance to Indian country of programs administered by the Center for Medicare and Medicaid Services (CMS) which includes the S-CHIP program, the National Steering Committee (NSC) for the reauthorization of the IHCIA and Tribes

recommended the establishment of a formal consultation body for CMS to assist in the development of CMS Indian policy and regulation. In response to these requests CMS established a Tribal-Technical Assistance Group (T-TAG).

The T-TAG has been active in reviewing the impacts of the recently passed Medicare Modernization Act (MMA). The first round of MMA implementation focused on the Transitional Assistance program which was touted as a "new benefit" for seniors, especially low income seniors. Unfortunately, the roll out was too slow and the program too confusing to have much affect in Indian country. Out of a nation-wide projected benefit of $12,000,000 only a little over $1,000,000 was actually collected by IHS and Tribal programs. The implementation of the permanent program (Medicare Advantage and Part D Pharmacy Benefits) is occurring under statute with less Indian specific language than the Transitional Assistance section. Of particular concern going forward is the affect of the MMA on dual eligibles who currently receive their pharmacy coverage through the Medicaid program. Low income elders make up a large portion of the Indian elder population. Like other elders they are confronting confusion of enrolling in a plan and face new co-payments for services. They will also experience the gap in coverage when their costs exceed the $1500 initial coverage limit. These clients will expect their IHS and Tribal Clinics to pay for their pharmaceuticals after they fully utilize their Part D coverage. Sadly, IHS expenditures will not be counted toward the threshold to qualify for catastrophic coverage under Part D. **IHS will have to absorb all pharmacy costs for Indian elders over the $1,500 annual threshold.**

Of equal concern is the issue of charging Indian clients premiums and co-pays. **We recommended that premiums and co-payments should be waived as was done in the State Children's Health Insurance program.** Some provisions of the MMA will be helpful to Indian country such as the "capping" of Contract Health Service payments at Medicare rates and reimbursement for hospital emergency treatments provided to undocumented aliens. These issues and the establishment of the CMS/T-TAG is reflective of recognition by both CMS and Tribes of the increasing importance of CMS programs to improving the health of the Indian communities.

HEALTH DISPARITIES

Today, Native Americans continue to experience significant rates of diabetes, mental health disorders, cardiovascular disease, pneumonia, influenza, and injuries. Specifically,

Native Americans are 517 percent more likely to die from alcoholism, 533 percent more likely to die from tuberculosis, 208 percent more likely to die from diabetes, 150 percent more likely to accidents, and 52 percent more likely to die from pneumonia or influenza than the rest of the United States, including white and minority populations. As a result of these increased mortality rates, the life expectancy for Native Americans is 71 years of age, nearly five years less than the rest of the U.S. population.

In their recent REACH 2010 Risk Factor Survey the Center for Disease Control (CDC) reported that American Indians and Alaska Natives had the highest prevalence of obesity, current smoking, cardiovascular disease, and diabetes among both men and women in minority groups; reported that among all minority men, AI/AN men had the highest prevalence of self-reported hypertension and high blood cholesterol levels; and reported that among all minority women, AI/AN women had the second highest prevalence of self-reported hypertension and high blood cholesterol levels.

As the CDC survey demonstrated in the REACH 2010 Risk Factor Survey, the prevalence of chronic diseases such as cardiovascular disease in Indian Country are increasing and require 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 need 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.

Native Americans/Alaska Natives continue to also experience significant rates of mental health disorders; and, there is approximately one (1) psychologist per 8,333 American Indians and Alaska Natives compared to one (1) per 2,213 for the general population. The suicide rate per 100,000 for AI/AN in (2001) was 10.6 per 100,000; and, the "Healthy People 2010" goal is to be at 5 per 100,000.

LONG TERM AFFECTS OF PERSISTENT UNDER FUNDING

The Indian Health Service Budget Formulation Process and the Federal Disparities Index (FDI) Workgroup have both established that the approximate level of funding needed to meet the health care needs of Indian people is $9-10

billion. This corroborates the long held view that less than 50% of true need is funded by the Indian Health Service budget. If funded at $9 billion, an additional phased-in facilities cost of $9-10 billion would be needed to house the expanded health care services and for new construction, rehabilitation and renovation. This is sometimes stated as a $20 billion need-based budget, but in reality, the annualized need after facilities is approximately $10 billion per year in 2005 dollars. A 10-year phase-in of the $20 billion budget can be achieved if the Congress and the Administration commit to several years of sizeable increases.[1]

Throughout the years, this Northwest Portland Area Indian Health Board (NPAIHB) analysis has sought to maintain the integrity of its estimates by not inflating amounts in the manner of conventional negotiations. The NPAIHB asserts there is nothing to be gained by overestimating the funding required to meet the health care needs of Indian people and invites discussion over every estimate presented in the following analysis.

The following graph illustrates the diminished purchasing power of the IHS budget over the past fourteen years. The graph demonstrates the compounding effect of multi-year funding shortfalls that have considerably eroded the IHS base budget. In 1993, the IHS health services accounts received $1.52 billion; and, had the accounts received adequate increases for inflation and population growth, that amount would be $5.2 billion today. The NPAIHB estimates that the IHS budget has lost over $2.46 billion over the last fourteen years.

[1] For more discussion on the "IHS Needs Based Budget," see: The True Health Care Needs of American Indians

The issue of funding equity has been of special interest to Tribes in California ever since the Rincon case was concluded. The court findings in that case ended what was base budget funding and established criteria for IHS budget distributions that they meet the threshold tests of being reasonable, rational and defensible. Unfortunately, in spite of improved data collection and new actuarial based methodologies for identifying funding needs the vast majority of the IHS appropriation is distributed on the basis of previous year distributions. The result is that little corrections to the identified local under funding has been done and unless a larger infusion of new funds are identified for this purpose it never will. This situation condemns some tribes to extreme under service while other tribes receive more acceptable levels of care. This problem is often compounded for small ambulatory care programs because the current systems of resource distribution does not link access to Contract Health Service funds to the lack of access to IHS operated or Tribally operated hospitals, diagnostic services or pharmacies. This lack of resource coordination affects not only the Indian clients but also local health providers who must absorb higher and higher levels of unfunded care. This is especially true for rural hospitals located near reservation lands.

The medical inflationary rate has grown over 200% since 1984. Unfortunately, the basis for calculating inflation used by government agencies is not consistent with that used by the private sector. The OMB uses an increase ranging from 1.9% to 4% per year to compensate for inflation, when the medical inflationary rate is between 6.2% and 18.0%. This discrepancy has seriously diminished the purchasing power of Tribal health programs because medical salaries, pharmaceuticals, medical equipment, and facilities maintenance cost Tribes the same as they do the private sector.

Health care spending for American Indians and Alaska Natives lags far behind spending for other segments of society. **For example, per capita expenditures for American Indian/Alaska Native 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 Veterans Administration beneficiaries. In fact, the federal government spends almost twice as much money for a federal prisoner's health care (FBP) than it does for an American Indian or Alaska Native (IHS).**

According to information provided by the National Center for Health Statistics, birth-death records indicate 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 into the Indian Health care system annually; and we have not received population growth funding in over a decade. However, the President's FY '06 budget request includes $33,495,000 for population growth and we heartily support that request.

The travesty in the deplorable health conditions of American Indians and Alaska Natives is knowing that the poor health indicators could be improved 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.

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and Alaska Natives, Northwest Portland Area Indian Health Board, June 2003: available at www.npaihb.org.

A fairly new source of significant funding to the I/T/U System is the Special Diabetes Program for Indians (SDPI). This initiative is funded through the Health Committees as a "set aside" from a National Diabetes Initiative and is now $150,000,000 per year. This increased appropriation is critical for a number of reasons. Foremost is that the Indian communities suffers the consequences of this disease at a rate that 208% higher than the rest of the U.S. general population. Also, this disease has significant consequences and is the major contributor to the increasing rate of cardiovascular disease in the Indian population and has resulted in a disproportionably high rate of amputations. The distribution of these funds through a formula distribution and competitive grants has fostered growth in local programs and the national interventions are having a positive affect on outcome measures for this disease. There is a distortion effect to funds when treatment for one disease becomes easily accessible and other health problems go unaddressed due to funding constraints. Ultimately it is better to fund a system of care not individual diseases.

OUTCOME MEASURES

Over the past five years one of the most important improvements in the operation of the ITU system is the development of standardized outcome measures pursuant to the Government Performance and Results Act (GPRA). GPRA indicators provide a benchmark against which levels of program competence can be measured. The California Area has demonstrated leadership in both GPRA system participation and movement towards national goals. National GPRA measurements are now available on seventeen indicators by IHS Area. They show IHS to be above the 2010 Healthy People Goals in the level of some screenings such as diabetic related screenings but below 2010 goals for important indicators of diabetic health status such as percentage of screened diabetics who have achieved good blood sugar control or blood pressure control.

Expanded reliance on information technology and telecommunications is a growing phenomenon. The IHS and Tribal programs are uniformly attached to the world wide web and most practice sites operate a local area computer networks. Some training is being done over the internet and less frequently via video conferencing. Conference calls are routinely used for program management and planning purposes. Nationally, and in California, the installation and use of new Electronic Practice Management systems and Electron Health Record systems will magnify our reliance on information technology and telecommunications. These latter applications require ever increasing band width to operate efficiently and increased technical expertise. Both of those come with cost. Under funded line charges in California alone have been calculated at $775,000 for the current year.

The provision of culturally competent and comprehensive health care services requires a large investment in staff to be successful. The pool of available health providers, management staff and support staff needs to be expanded by expanding educational opportunities for Indian people. Increased opportunities for staff training would help stem the outflow of existing staff and improve program quality. Currently in California, only three of the twenty four largest Tribal Health Programs are lead by American Indian Executive Directors. There is also a need for succession planning as much of the existing leadership will soon mature out of the work force.

The IHS facilities program recently received an above average score on the OMB Program Assessment Rating Tool (PART) review. A new formula for prioritizing which facilities get built has been years in the making. A significant unresolved issue is how to handle the proposals that are now on the Congressional to-be-funded list. Should they be forced to re-compete or go first? The current system has never constructed and staffed a single facility in the state of California in over thirty five years. The needs of small tribes and programs never seem to surface. The current system with its built in "final year of construction" increases for new manpower and equipment impinges on the rest of the system's new funds needed to address population growth and cost inflation. The current proposed moratorium on new facility construction may be a good thing. It will provide time for all areas of the IHS to complete new health services and facilities master plans. It also might allow for a realistic level of consultation on the new construction priority system formula.

CONSULTATION ON REAUTHORIZATION OF THE IHCIA

Beginning in 1999, for almost ten months, tribes engaged in a tribally-driven consultation process with the Indian Health Service (IHS) and urban Indian health providers regarding reauthorization of the Indian Health Care Improvement Act. This process began with the first Area consultation meeting in San Diego, December 1998, with over 100 participants who gathered to develop California Area recommendations for reauthorization. Subsequent to the San Diego meeting, each Area of the IHS convened meetings of Tribal leaders and urban providers to discuss the reauthorization of this important legislation. Discussions were held during several meetings with the expectation that Area concerns and recommendations would be forwarded to the next step in the consultation process. It was agreed, that the goal of the process was to build a consensus on issues and that draft legislation would be submitted to Congress and would reflect a consensus of the Indian Health Services/Tribes/Urban Programs (I/T/U), to ensure that when we speak of the reauthorization we would be "Speaking with One Voice".

Regional Consultation

From January to April 1999, four regional meetings were held across the United States. These regional meeting were intended to provide a forum for I/T/Us to provide input, to share the recommendations from each Area, and to build consensus among the participants for a unified position from each region and throughout Indian Country.

National Steering Committee (NSC)

Upon completion of the four regional meetings, the IHS Director convened a National Steering committee to develop a report on national policy issue recommendations and IHCIA reauthorization. The National Steering committee is composed of one elected tribal representative and one alternate from each of the twelve IHS Areas, a representative from the National Indian Health Board, National Council on Urban Indian Health and the Tribal Self-Governance Advisory Committee.

A 135 page matrix, comparing the recommendations from each of the four regions for every section of the IHCIA, was reviewed by the National Steering committee to develop a final consensus document. The work was divided into five teams as follows:

1. Health Services Workgroup for Titles I, II, V, and VII, Chaired by Dr. Taylor McKenzie;
2. Health Facilities Workgroup for Title III, Chaired by Julia Davis Wheeler and Robert Nakai;
3. Health Financing Workgroup for Title IV, Chaired by Buford Rolin;
4. Miscellaneous Workgroup for Titles VI and VIII, Chaired by Tony Largo; and,
5. Preamble Workgroup, Chaired by Henry Cagey.

Each group was responsible for final presentation of recommendations setting forth a framework for reauthorization legislation.

It was agreed by the NSC that, specific "draft bill language" would be developed and proposed by the National Steering committee to minimize any misinterpretations of our position. The NSC maintained an aggressive schedule of meetings as follows:

Rockville, MD	June 3, 4, 1999
Gaithersburg, MD	June 17, 18, 1999
Rockville, MD	July 7, 8, 9, 1999
Reno, NV	July 13, 14, 1999
Washington, DC	July 27, 28, 29, 1999 (National Meeting)
Salt Lake City, UT	August, 10, September, 1, 2, 1999
Rockville, MD	September 28, 29, 1999
Palm Springs, CA	October 5, 1999

National Forum

At the conclusion of all four regional meetings and after the NSC had met four times and developed draft consensus bill language, a national meeting, co-sponsored by the Senate Indian Affairs Committee was held here in Washington D.C. This meeting was to provide an opportunity for Tribal leaders, urban health representatives, national organizations, federal agencies, and friends of Indian Health, to provide "feedback" on the legislative proposal. Before this meeting, on July 16, 1999, the draft bill language was mailed to over 1200 tribal leaders, tribal health directors, I.H.S. officials, and urban health programs and other health organizations.

The Steering Committee addressed all of the approximately 1000 comments received and incorporated many comments and recommendations into the proposed bill to reauthorize the Indian Health Care Improvement Act. A copy of the draft bill was delivered on October 8, 1999 to both the Senate Indian Affairs Committee and the House Committee on Resources and other appropriate committees with jurisdiction. A copy of our proposed bill was mailed to every tribe and Indian organization.

The NSC sought to update the Act to make it more responsive to current "real world" Tribal Health Program needs; to enhance opportunities for attracting greater revenue into

the Indian Health system; and, to facilitate greater exercise of Indian self-determination in health care program decision-making and regulations.

Our recommendations were primarily reflected in S. 556 which was reported out unanimously by this Committee last November.

CONCLUSION

I have provided an overview of Indian Health today; thus, in closing, I must report that in California we are currently dismantling programs that we have spent the past thirty years developing. Consistent under funding is having the following affects: California, like the rest of the nation, is experiencing increasing levels of deferred care. California Tribally operated programs are placing more and more restrictions on what constitutes a life threatening emergency to which the program will provide coverage. We are seeing employee benefit "take backs" and reductions, reduced hours of operation and reductions in staffing levels. We are also seeing more staff "burn out" and increasing problems with staff retention.

There are no easy answers to the problems that confront the I/T/U system of health care. Funding is surely an issue but we need Congressional support in other ways too.

I respectfully urge you to do whatever you can to ensure passage of the reauthorization of the IHCIA this year; and, thank you for this opportunity to provide testimony.

FY 2006 BUDGET RECOMMENDATION: INDIAN HEALTH SERVICE A NATIONAL DISGRACE: INDIAN HEALTHCARE

Presented by:

Rachel Joseph, Chairperson

Lone Pine Paiute Shoshone Tribe, and Co-Chair

Indian Health Service Budget Workgroup

Don Kashevaroff, President

Seldovia Village Tribe, and Co-Chair

Indian Health Service Budget Workgroup

John Blackhawk, Chairman

Winnebago Tribe, and Vice-Chairman

National Indian Health Board

Jerry Freddie, Chairman

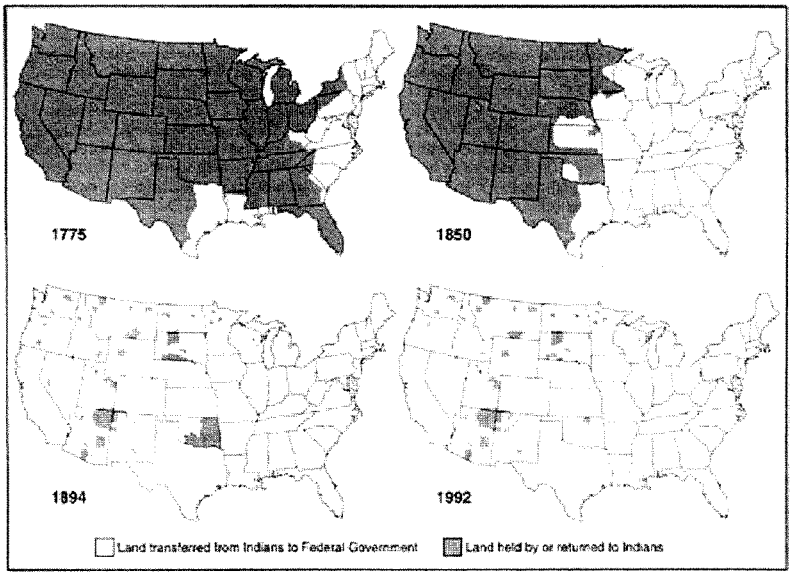
Navajo National Council – Health and Human Services Committee, and Representative

National Indian Health Board – Navajo Area

INTRODUCTION

The United States Commission on Civil Rights has reported the state of American Indian and Alaska Native health care "A Quiet Crisis." Tribal leaders have long recognized the crisis that exists in Indian Country. We are encouraged that the federal government has acknowledged the disparate health conditions that American Indians and Alaska Natives are forced to endure and we are committed to working with the Administration and the Department of Health and Human Services to address the health disparities that exist in Indian country.

American Indians and Alaska Natives have traded, at a great sacrifice, millions of acres of their precious homelands to the government in exchange for adequate healthcare, education, and other accoutrements of civilization such as farming. These lands contain valuable minerals, gold and water, all of which has only increased in value while the trade-offs promised have consistently decreased in value. Tribes continue to feel the loss and rely on the treaties to insure adequate healthcare. Confined to marginal lands, the majority of AI/AN now struggle to maintain and support their people in a healthy lifestyle."



Sanderson Associates

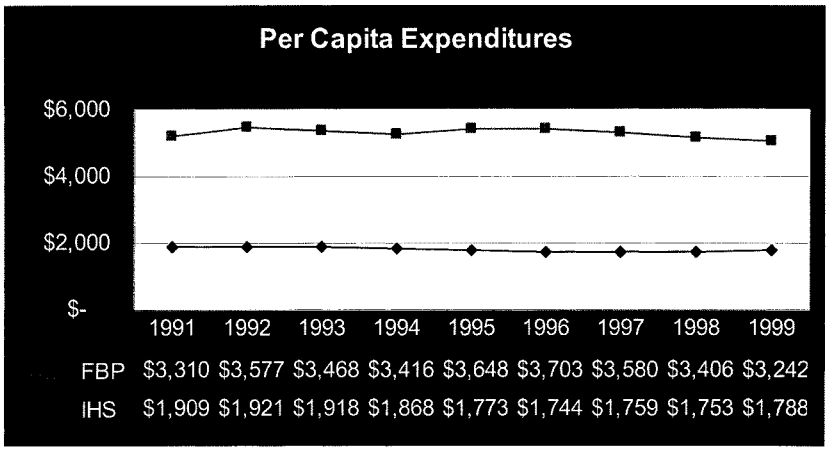
Tommy G. Thompson, Secretary of Health and Human Services, committed to improving the health of all Americans through implementation of "Healthy People 2010." Several targeted health indicators have been established to gauge the health improvement of our Nation's citizens. Indian Country shares in those goals, not only for American Indians and Alaska Natives, but for all. According to the latest progress reports for achieving Healthy People 2010, the targeted

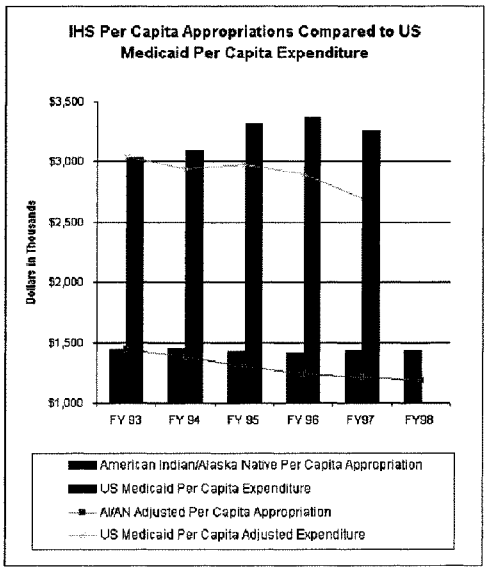
health goals will not be achieved without a major effort to address the poor health indicators in Indian Country.

A recent survey by the Centers for Disease Control and Prevention (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 and Alaska Natives who participated in the survey. **American Indians and Alaska Natives 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, AI/AN men also had the highest prevalence of self-reported hypertension and high blood cholesterol levels. Among women, American Indians and Alaska Natives had the second highest prevalence. The survey also showed that over 80% of American Indians and Alaska Natives 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.

The Indian Health Service should be commended for its consultation process in the development of budget recommendations. For the past six years, Tribal leaders have convened to develop budget recommendations based on actual need, as well as a percentage increase. The process is careful and deliberate to ensure that it is reflective of the health needs of Indian Country. Tribal governments and health providers meet throughout all of the areas of the Indian Health Service to develop budget priorities before convening at a national meeting.

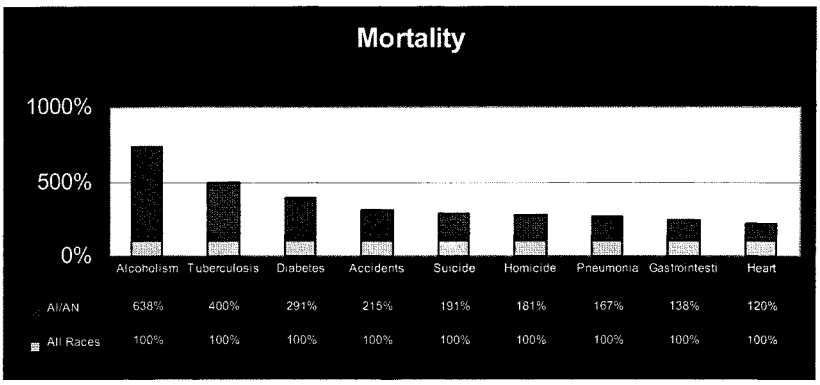
Tribal leaders continue to advocate for equitable health care funding. Health care spending for American Indians and Alaska Natives lags far behind spending for other segments of society. **For example, per capita expenditures for American Indian/Alaska Native beneficiaries receiving services in the IHS are approximately one-half of the per capita expenditures for Medicaid beneficiaries and one-third of the per capita expenditures for Veterans Administration beneficiaries. In fact, the federal government spends almost twice as much money for a federal prisoner's health care (FBP) that it does for an American Indian or Alaska Native (IHS).**





According to Indian Health Service statistics, American Indians and Alaska Natives have a life expectancy six years less than the rest of the U.S population. In several regions of the country life expectancy differences are drastically lower. A comparison of various mortality rates

between American Indians and Alaska Natives and all other races provides illustrates the dire need to address the health disparities that exist in Indian country.



Source - Regional Differences in Indian Health 2000-2001

The travesty in looking at the deplorable health of American Indians and Alaska Natives is recognizing that the poor health indicators could be improved 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

Tribal leaders met regionally and developed recommendations to improve the delivery of health care to American Indians and Alaska Natives. The tribal leadership then convened at the FY 2006 IHS/Tribal/Urban National Budget Work Session on April 28-29, 2004 and came to consensus on health priorities and increases needed for the I/T/U health system. Current funding 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.

The funding requests within this document are based on an overall percentage increase to the Indian Health Service budget. The funding requests however do not address the actual health needs in Indian Country, which for FY 2006 are equal to $19.7 billion. Realizing that the actual funding needs to provide adequate health care to Indian Country cannot be achieved in one year, an incremental approach can be utilized. This document contains funding requirements based on maintaining current services, as well as program increases to combat diabetes, behavioral health, cancer, heart disease, and others.

The continual under funding of the Indian Health Service affects our communities greatly through diminished health and well-being as well as higher mortality rates than the rest of the population.

CURRENT SERVICES - $289,340,000

FEDERAL/TRIBAL PAY COSTS

The Tribal and Urban Indian leadership requests an amount of $26,349,000 for Federal Pay Cost increases. The additional dollars will enable IHS to fund mandated federal employee pay increases for FY 2006. It is vital that health care providers and ancillary positions with the agency be maintained so that the essential functions of the IHS can be maintained. These expenses enable the Indian Health Service, Tribes and Urban Indian health programs (I/T/Us) to compete with the private sector for qualified employees

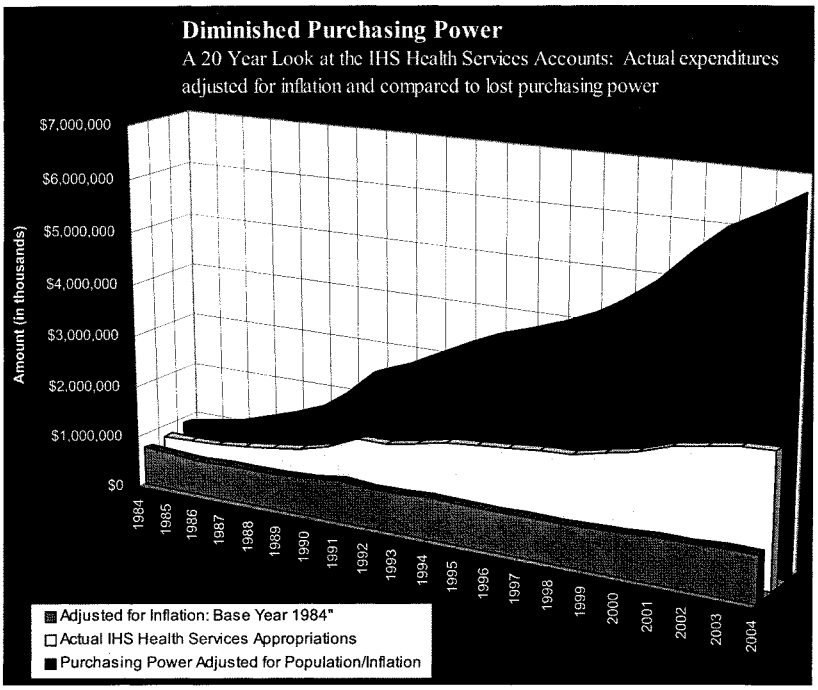
The tribal leadership also requests an additional $30,931,000 to the FY 2006 budget to allow Tribally operated health programs to provide comparable pay raises to their own staffs. These expenses enable the I/T/Us to compete with the private sector for qualified employees.

Funding for the Indian Health Service has not 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

INFLATION

The recommended budget includes $43,721,000 to address the increased cost of providing health services due to inflation. The recommendation follows information provided by the Office of Management and Budget (OMB) indicating the medical inflation rate will be 1.7% and the non-medical inflation rate will be 3.5% in FY 2006.

The inflation estimate that was calculated using the OMB-allowed medical inflation rates is insufficient to address the actual inflationary costs experienced by the I/T/U programs. The resources needed to address the true rate of medical inflation are important for programs dependent upon contract health services (CHS). The CHS program is most vulnerable to inflation pressures, as well as pharmaceutical costs. An additional amount of $12,000,000 is requested to maintain current services.



Diminished Purchasing Power:

A 20 Year Look at the IHS Budget and the Impact of Inflation and Population Growth

The medical inflationary rate has grown over 200% since 1984. Unfortunately, the basis for calculating inflation used by government agencies is not consistent with that used by the private sector. The OMB uses an increase ranging from 1.9% to 4% per year to compensate for inflation, when the medical inflationary rate is between 6.2% and 18.0%. This discrepancy has seriously diminished the purchasing power of Tribal health programs because medical salaries, pharmaceuticals, medical equipment, and facilities maintenance cost Tribes the same as they do the private sector.

In FY 1984, the IHS health services account received $777 million. In FY 1993, the budget totaled $1.5 billion. Still, ten years later, in FY 2003 the budget is $2.85 billion, when, just to keep pace with inflation and population growth, this figure should be more than $5.5 billion. This shortfall has compounded year after year, resulting in an under-funded system that cannot meet the needs of its people.
The graph above illustrates the discrepancy between actual IHS health services budget, the same budget adjusted for inflation, and the purchasing power of that budget if it included medical inflation and population growth over a twenty year period. The figure demonstrates that the IHS health services budget has suffered a cumulative loss of $6.7 billion from 1984 to 2004, assuming that the quality of care remains the same.

The difference between the actual health services budget for FY 2004 and the same budget adjusted for inflation and population growth from 1984 would be $4.2 billion. This is a direct result of the compounding effect of funding levels that fail to meet yearly inflation and population growth increases. If IHS appropriations had kept pace with medical inflation and population growth the increases required today would not be as significant!

POPULATION GROWTH

According to information provided by the National Center for Health Statistics, birth-death records indicate 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 into the Indian Health care system annually. The budget recommendations include $6 million to attempt to address the increased demand of a rapidly increasing population.

STAFFING FOR NEW FACILITIES

The FY 2006 budget recommendation includes $25,000,000 for staffing and operating costs for new facilities that will open in FY 2005 and FY 2006. The estimate includes several facilities recently constructed, or will be soon constructed. The investment in the construction of health care facilities should be accompanied by the resources necessary to operate them.

CONTRACT SUPPORT COSTS

Contract health services are vital 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 and recommend an additional $70,000,000 to alleviate the shortfall for current contracting and compacting. Of the $70,000,000, the IHS Budget Workgroup recommends that $10,000,000 be allocated for contract support costs associated with the operation of Sage Memorial Hospital.

HEALTH CARE FACILITIES CONSTRUCTION

The current average age of an IHS facility is 32 years. The budget recommendation under current services includes a total of $50,899,000 million increase for construction of new health facilities allowing IHS to replace its priority health care facility needs with modern health facilities and to significantly expand capacity at its most overcrowded sites.

RESTORATION OF FY 2004 RESCISSION

One of our priorities for the tribal/urban Indian leadership is to request a restoration of the $36.45 million rescission to the IHS appropriation for FY 2004. Given the unique mission of the

Indian Health Service as a direct service provider in comparison to other Health and Human Services agencies, a funding rescission to IHS translates into a reduction of health care delivery for American Indians and Alaska Natives. Other agencies merely reduce programs, while IHS must eliminate health programs and turn away patients. Medicare and Medicaid were not subject to such rescissions. Therefore, the Indian Health Service should be exempt from such rescissions in the same manner.

CONTRACT HEALTH SERVICE FUNDING

The President's FY 2005 Budget Request includes $497 million for contract health services, which provides an additional $18 million or 4 percent increase over the previous year's budget, for Contract Health Services.

Contract health service funds are used in situations where: (1) no IHS direct-care facility exists, (2) the direct-care element is incapable of providing the required emergency and/or specialty care, (3) the direct-care element has an overflow of medical care workload, and (4) to supplement alternate resources. The IHS purchases the needed basic healthcare services from private local and community healthcare providers. The current 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.

An informal poll of AI/AN health systems provided some real life examples of essential health care services that are denied or deferred due to a lack of funding:

- Dermatology – treatment for sebaceous cysts, skin pigment changes, etc.
- Dental – Orthodontics, dentures, root canals (extractions are routinely performed instead)
- Eyeglasses
- Medications for unique patient conditions
- Wheelchairs and other rehabilitation equipment
- Post brain injury rehabilitation
- Residential treatment for substance abuse (beyond adolescent age)
- Adult psychiatric hospitalization beyond emergent event
- Speech therapy
- Obesity surgery (e.g., gastric banding)
- Post mastectomy reconstruction
- Allergy testing or desensitization
- Genetic counseling
- Septoplasty (surgery to correct a defect of the nasal septum)

Budget Request for Contract Health Services

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 a modest increase of $24,572,786 million.

DIABETES TREATMENT AND PREVENTION/OBESITY

The Office of Civil Rights – A Quiet Crisis, reports that American Indians and Alaska Natives have the highest prevalence of Type 2 diabetes in the world, and rates are increasing at "almost epidemic proportions." Type 2 diabetes is largely preventable and can be managed with healthy eating, physical activity, oral medication, and/or injected insulin.

The leading cause of mortality for American Indians and Alaska Natives is heart disease. However, hidden in that statistic is the fact that the largest percentage of deaths from heart disease are caused by diabetes. Thus, diabetes is both devastating the community in terms of quality of life and "maiming and killing" American Indians and Alaska Natives.

Another startling fact regarding the prevalence of Type 2 diabetes is that it has recently become a significant threat to American Indian and Alaska Native children. Its incidence is rising faster among AI/AN children and young adults than any other ethnic population.

Add more information on the disparities.

Healthy People 2010 – American Indian and Alaska Native Progress Report

Diabetes Related Deaths (age adjusted per 100,000 standard population)
American Indian or Alaska Native (2001) – 105 per 100,000
HP 2010 Target – 45 per 100,000

Prevalence of diabetes (age adjusted per 1,000 standard population)
American Indian or Alaska Native (2002) – 113 per 1,000
HP 2010 Target – 25 per 1,000

A1C Test-at least two times a year - Persons with diabetes (age adjusted, aged 18 years and over)
American Indian or Alaska Native (2001) – 47%
HP 2010 Target – 50%

Annual foot examinations – Persons with diabetes (age adjusted, aged 18 years and over)
American Indian or Alaska Native (2001) – 62%
HP 2010 Target – 75%

End-Stage renal disease due to diabetes - new cases (per million population - adjusted for age, gender)
American Indian or Alaska Native (2000) – 507

HP 2010 Target – 78

End-stage renal disease – New cases (per million population - adjusted for age, gender)
American Indian or Alaska Native (2000) – 716
HP 2010 Target – 217

Cardiovascular disease deaths in persons with chronic kidney failure (per 1,000 patients)
American Indian or Alaska Native (2000) – 73
HP 2010 Target – 52

Budget Request for Diabetes Prevention and Treatment/Obesity

The Special Diabetes Program for Indians (SPDI) has enabled the Indian Health Service and American Indian/Alaska Native Tribal governments to begin to address the diabetes epidemic. However, the documented need for diabetes treatment and prevention far exceeds the funds appropriated for this purpose. Given the dramatic increases in Type 2 diabetes in AI/AN children, as well as the ongoing battle with obesity, additional funding in the amount of $38,497,635 is requested.

BEHAVIORIAL HEALTH

"A Quiet Crisis"

The most significant mental health concerns today are substance abuse, depression, anxiety, violence, and suicide. Of these, substance abuse, notably alcoholism, has been the most visible health disorder crisis, while depression is emerging as a dominant concern. These two illnesses are often a consequence of isolation on distant reservations, pervasive poverty, hopelessness, and intergenerational trauma, including the historic attempts by the federal government to forcibly assimilate tribes. American Indians and Alaska Natives are at a higher risk for mental health disorders than other racial and ethnic groups in the United States and are consistently overrepresented among high-need populations for mental health services.

The United States Surgeon General issued a report further indicating that the U.S. mental health system is not well equipped to meet these needs; specifically that IHS, due to both budget constraints and personnel problems, is mostly limited to basic psychiatric emergency care. There is approximately 1 psychologist per 8,333 AI/AN as compared to 1 per 2,213 for the general population.

The most significant mental health concerns today are substance abuse, depression, anxiety, violence, and suicide. Depression is emerging as a dominant concern and is often linked to isolation on distant reservations, pervasive poverty, hopelessness, and intergenerational trauma, including the historic attempts by the federal government to forcibly assimilate American Indians and Alaska Natives. Problems of depression and anxiety frequently underlie and complicate treatment for physical disorders, requiring considerable attention from caregivers. While Indian Health Service funding is based on acute care services, the burden of mental illness is frequently chronic.

Cirrhosis deaths (age adjusted per 100,000 standard population)
American Indian or Alaska Native (2001) – 22.6
HP 2010 Target – 3.0

Drug induced deaths (age adjusted per 100,000 standard population)
American Indian or Alaska Native (2001) – 6.6
HP 2010 Target – 1.0

Average age at first use of alcohol - Adolescents (aged 12 to 17 years)
American Indian or Alaska Native (1998) – 13
HP 2010 Target – 16.1

Average age at first use of marijuana - Adolescents (aged 12 to 17 years)
American Indian or Alaska Native (1998) – 12.8
HP 2010 Target – 17.4

Adolescents not using alcohol or illicit drugs in past 30 days (aged 12 to 17 years)
American Indian or Alaska Native (1998) – 72%
HP 2010 Target – 89%

Adolescents using marijuana in past 30 days (aged 12 to 17 years)
American Indian or Alaska Native (1998) – 8.9%
HP 2010 Target – .7%

Adults using illicit drugs in past 30 days (aged 18 years and over)
American Indian or Alaska Native (1998) – 8.4%
HP 2010 Target – 2%

Binge drinking - Adolescents (aged 12 to 17 years)
American Indian or Alaska Native (1998) – 11.1%
HP 2010 Target – 2%

Adult females exceeding guidelines for low-risk drinking (aged 21 years and over)
American Indian or Alaska Native (1998) – 85%
HP 2010 Target – 50%

Adult males exceeding guidelines for low-risk drinking (aged 21 years and over)
American Indian or Alaska Native (1998) – 97%
HP 2010 Target – 50%

Perception of risk associated with consuming 5+ alcoholic drinks once or twice a week – Adolescents (aged 12 to 17 years)
American Indian or Alaska Native (1998) – 47%

HP 2010 Target – 80%

Perception of risk associated with smoking marijuana once per month - Adolescents (aged 12 to 17 years)
American Indian or Alaska Native (1998) – 26%
HP 2010 Target – 80%

Perception of risk associated with smoking cocaine once per month - Adolescents (aged 12 to 17 years)
American Indian or Alaska Native (1998) – 64%
HP 2010 Target – 80%

Suicide (age adjusted per 100,000 standard population)
American Indians and Alaska Native (2001) – 10.6
HP 2010 Target – 5.0

Budget Request for Behavioral Health

Alcohol and Substance Abuse, depression, and other mental health diseases, continue to destroy the sanctity of countless American Indian and Alaska Native families. Current efforts to reduce the prevalence of these disorders are not effective. Therefore, further action and intervention is necessary. Additional funding in the amount of $40,545,097 is required to enable IHS and AI/AN Tribal governments to provide culturally appropriate mental health services in a more timely and efficient manner consistent with current emerging health problems.

CANCER

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 increased. 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, critical health resources are needed 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.

Healthy People 2010 – American Indian and Alaska Native Progress Report

Pap tests - Received within past 3 years (age adjusted, aged 18 years and over)
American Indian or Alaska Native (2000) – 76%
HP 2010 Target – 90%

Colorectal cancer screening - Adults receiving a fecal occult blood test (FOBT) within past 2 years (age adjusted, aged 50 years and over)
American Indian or Alaska Native (2000) – 38%
HP 2010 Target – 50%

Colorectal cancer screening - Adults ever receiving a sigmoidoscopy (age adjusted, aged 50 years and over)
American Indian or Alaska Native (2000) – 37%
HP 2010 Target – 50%

Mammograms - Adults receiving within past 2 years (age adjusted, aged 40 years and over)
American Indian or Alaska Native (2000) – 49%
HP 2010 Target – 70%

Budget Request for Cancer Treatment and Prevention

Because of funding inequities, as well as lack of access, American Indians and Alaska Natives are often diagnosed with cancer at a late stage. Therefore, the late diagnosis becomes a terminal diagnosis. Healthy People 2010 statistics illustrate the lack of proper screening and prevention efforts in Indian country. Additional funding in the amount of $10,648,207 is required to expand the ability of the Indian Health Service and AI/AN tribal governments to provide screening examinations, as well as to increase community education on diet, nutrition, physical activity, and weight control.

HEART DISEASE

As the CDC survey demonstrated in the REACH 2010 Risk Factor Survey, the prevalence of chronic diseases such as cardiovascular disease in Indian Country are increasing and require 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 Indian and Alaska Native 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.

Healthy People 2010 – American Indian and Alaska Native Progress Report

Blood pressure monitoring - Persons who know whether their blood pressure is high or low (age adjusted 18 years or older) American Indian or Alaska Native (1998) – 89% HP 2010 Target – 95% Blood cholesterol screening - Adults screened within preceding 5 years American Indian or Alaska Native (1998) – 58% HP 2010 Target – 80%

Budget Request for Heart Disease

Given the disproportionately high rates of nearly all negative health indicators, high rates of cardiovascular disease is no surprise. Additional funding in the amount of $9,010,022 is requested.

WATER AND SANITATION FACILITIES CONSTRUCTION

The Sanitation Facilities Construction Program provides technical and financial assistance to American Indian tribes and Alaska Native villages for cooperative development and continued operation of safe water, wastewater, and solid waste systems and related support facilities.

From 1959 through 2002, the cumulative appropriation for the construction of essential sanitation facilities for American Indians and Alaska Natives was approximately $1.9 billion. Those appropriated funds plus over $568 million in contributions from Tribal governments, other Federal agencies, and States agencies funded over 11,000 sanitation facilities construction projects. Those projects provide water, sewer and/or solid waste disposal facilities to over 254,000 American Indian and Alaska Native homes.

Additional funding in the amount of $5,733,650 is requested, with the anticipated outcome of a decrease in sanitation deficiencies, environmentally related communicable disease rates and consequently, the number of medical services required of the I/T health care delivery system.

INDIAN HEALTH CARE IMPROVEMENT FUND: FEDERAL DISPARITY INDEX (FDI)

The Indian Health Service is funded at approximately 60% of need. The IHCIF are funds appropriated by the Congress to reduce disparities and resource deficiencies among units with the IHS system. The funding formula targets funding deficiencies measured by the Federal Disparity Index (FDI) model. The FDI model was developed with national tribal consultation by a tribal/IHS workgroup working with health economists and actuaries.

The disproportionately high rates of AI/AN mortality, disease and disability are greatly exacerbated by disparate health care resources. Despite the significant funding needs for all IHS units, the most under funded units require immediate attention. The $5,733,650 of additional funds requested in FY 2006 begins to reduce disparities for the most deficient units (units funded below 60% level of need), but are still insufficient for the $1.8 billion system-wide deficiency identified by the FDI methodology.

HEALTH CARE FACILITIES CONSTRUCTION

Access to adequate health care is a common concern of all American Indians and Alaska Natives. Due to the lack of nearby facilities, or limited services offered at local facilities, patients often are left without access to proper health care. Tribal leaders have requested an additional $4,914,557 to expand current health facilities to enable such facilities to provide basic services to their populations.

INJURIES AND INJURY PREVENTION

"A Quiet Crisis"

Unintentional injuries are the leading cause of death for Native Americans under the age of 44 and the third leading cause of death overall. Injuries result in 46 percent of all Years of Potential Life Lost (YPLL) for Native Americans. This is five times greater than the YPLL due to the next highest cause, heart disease (8 percent). The age-adjusted injury death rate for American Indians and Alaska Natives is approximately 250 percent higher than that for the total U.S. population. Moreover, American Indians and Alaska Natives suffer injuries at rates 1.5 to five times the rate for other Americans. In real terms this translates to more than 1,300 deaths and more than 10,000 hospitalizations each year for more than 50,000 days of medical care. Outpatient clinics treat an additional 330,000 for injuries. The financial cost of treating these injuries is correspondingly high. Each year IHS spends more than $150 million to treat those suffering from unintentional injuries.

Healthy People 2010 – American Indian and Alaska Native Progress Report

Firearm-related deaths (age adjusted per 100,000 standard population)
American Indian or Alaska Native (2001) – 7.8
HP 2010 Target – 4.1
Deaths from poisoning (age adjusted per 100,000 standard population)

American Indian or Alaska Native (2001) – 7.2
HP 2010 Target – 1.5

Deaths from suffocation (age adjusted per 100,000 standard population)
American Indian or Alaska Native (2001) – 7.3
HP 2010 Target – 3.0

Deaths from unintentional injuries - (age adjusted per 100,000 standard population)
American Indian or Alaska Native (2001) – 51.6
HP 2010 Target – 17.5

Deaths from motor vehicle crashes - (age adjusted per 100,000 standard population)
American Indian or Alaska Native (2001) – 25.1
HP 2010 Target – 9.2

Residential fire deaths (age adjusted per 100,000 standard population)
American Indian or Alaska Native (2001) – 1.8
HP 2010 Target – 0.2

Drownings (age adjusted per 100,000 standard population)
American Indian or Alaska Native (2001) – 1.9
HP 2010 Target – 0.9

Homicide (age adjusted per 100,000 standard population)
American Indian or Alaska Native (2001) – 6.8
HP 2010 Target – 3.0

Budget Request for Injuries and Injury Prevention

The Healthy People 2010 statistics show the disproportionately high rates of unintentional injuries in Indian country. The statistics should serve as a "wake-up call" that immediate intervention is necessary. Additional funding in the amount of $4,095,466 is requested to reduce the incidence of injury hospitalization and injury related deaths. Additionally, funding will be utilized to increase the numbers of American Indians and Alaska Natives who use protective equipment, e.g., car seats, seat belts, and personal flotation devices (PFDs).

MATERNAL AND CHILD HEALTH

"A Quiet Crisis"

Infant mortality and maternal health rates are also considered to be indicators of health status for a particular community. Historically, Native Americans have suffered inordinately high infant mortality rates. Despite recent improvement, disparity persists. Native American infants continue to die at a rate two to three times higher than the rate for white infants. Moreover, Georgetown University's Center for Child and Human Development, National Center for Cultural Competence, reported that for Native Americans, the incidence of sudden infant death syndrome (SIDS) is more than three to four times the rate for white infants.

Not surprisingly, maternal health factors also indicate lower health status. Pregnant Native American women consistently hold the lowest percentage of women receiving early prenatal care when compared with women of other races and ethnicities. For example, the percentage of Native American women receiving early prenatal care was 66.7 percent in 1995, compared with 83.6 percent of white non-Hispanic women.

In sum, the health indicators discussed above document the reality that Native Americans have significantly higher mortality rates and markedly lower health status than the general population.

Healthy People 2010 – American Indian and Alaska Native Progress Report

Fetal deaths at 20 or more weeks of gestation (per 1,000 live births plus fetal deaths)
American Indian or Alaska Native (2001) – 5.9
HP 2010 Target – 4.1

Perinatal mortality rate (28 weeks or more gestation to less than 7 days after birth) (per 1,000 live births plus fetal deaths)
American Indian or Alaska Native (2001) – 6.7
HP 2010 Target – 4.5

All Infant deaths (within 1 year) (per 1,000 live births)
American Indian or Alaska Native (2001) – 9.7
HP 2010 Target – 4.5

Neonatal deaths (within first 28 days of life) (per 1,000 live births)
American Indian or Alaska Native (2001) – 4.2
HP 2010 Target – 2.9

Postneonatal deaths (between 28 days and 1 year) (per 1,000 live births)
American Indian or Alaska Native (2001) – 5.4
HP 2010 Target – 1.2

All Infant deaths (within 1 year) from birth defects (per 1,000 live births)
American Indian or Alaska Native (2001) – 1.5
HP 2010 Target – 1.1

All Infant deaths (within 1 year) from congenital heart defects (per 1,000 live births)
American Indian or Alaska Native (2001) – .6
HP 2010 Target – .38

Sudden Infant death syndrome (SIDS) deaths (per 1,000 live births, infants aged under 1 year)
American Indian or Alaska Native (2001) – 1.47
HP 2010 Target – .25

Child deaths - 1 to 4 years (per 100,000 population)

American Indian or Alaska Native (2001) – 48.8
HP 2010 Target – 18.6

Child deaths - 5 to 9 years (per 100,000 population)
American Indian or Alaska Native (2001) – 15.5
HP 2010 Target – 12.3

Child deaths - 10 to 14 years (per 100,000 population)
American Indian or Alaska Native (2001) – 28
HP 2010 Target – 16.8

Child deaths - 15 to 19 years (per 100,000 population)
American Indian or Alaska Native (2001) – 94.5
HP 2010 Target – 39.8

Child deaths - 20 to 24 years (per 100,000 population)
American Indian or Alaska Native (2001) – 11.7
HP 2010 Target – 49

Prenatal care - Beginning in first trimester
American Indian or Alaska Native (2002) – 70%
HP 2010 Target – 90%

Prenatal care - Early and adequate
American Indian or Alaska Native (2002) – 59%
HP 2010 Target – 90%

Low birth weight (LBW), infants (less than 2,500 grams)
American Indian or Alaska Native (2002) – 7.2%
HP 2010 Target – 5.0%

Very low birth weight (VLBW), infants (less than 1,500 grams)
American Indian or Alaska Native (2002) – 1.3%
HP 2010 Target – 0.9%

Total preterm births (less than 37 weeks gestation)
American Indian or Alaska Native (2002) – 13.1 %
HP 2010 Target – 7.6%

Preterm births - Live births at 32 to 36 weeks of gestation
American Indian or Alaska Native (2002) – 11.00%
HP 2010 Target – 6.4%

Preterm births - Live births at less than 32 weeks of gestation
American Indian or Alaska Native (2002) – 2.1%
HP 2010 Target – 1.1%

Women abstaining from cigarette smoking during pregnancy American Indian or Alaska Native (2002) – 80% HP 2010 Target – 100%

Budget Request for Maternal and Child Health

The Healthy People 2010 statistics show the disproportionately high rates of preventable health negative health conditions for AI/AN mothers and children. Additional funding in the amount of $4,000,000 is required to target prenatal care for pregnant mothers, particularly to reduce the number of AI/AN who smoke and consume alcohol during their pregnancies.

ELDER HEALTH

As with the general population, Indian country is seeing the demographic shift to an older population which translates in an increased utilization of health services. An additional $4,000,000 is requested to target awareness educational programs for elder health screenings and testing for heart disease, cancer, and stroke.

STAFF SHORTAGES

Critical health staffing shortages exist throughout Indian Country. Geographic location, obsolete facilities/equipment, and non competitive pay make it difficult to recruit and retain health professionals to serve in Indian country. Therefore, an additional $4,000,000 is requested to boost efforts to alleviate such barriers.

GOVERNMENT PERFORMANCE AND RESULTS ACT (GPRA) AND PROGRAM ASSESSMENT RATING TOOL (PART)

The Government Performance and Results Act (GPRA) addresses an array of concerns regarding government accountability and performance. The Indian Health Service and related programs have embraced the performance measures and have made vast improvements in several areas.

A few success stories –

Whiteriver Service Unit

In 2001, the WRSU (Whiteriver Service Unit) made a commitment to improving pneumococcal vaccination rates in persons aged 65 years or older. Additional funds were procured to improve data quality and carry out a campaign to vaccinate those who had not yet been vaccinated. The WRSU pneumococcal vaccination rate in persons 65 years or older increased from 58% in 2001 to 77% in 2002, 88% in 2003, and is presently at 93.4% for the first quarter of 2004 by GPRA analysis. WRSU has met the pneumococcal vaccination rate goals set by IHS, Healthy People 2000 and Healthy People 2010, and has additionally met the Healthy People 2010 overarching goal of eliminating disparity for pneumococcal vaccination in this American Indian community.

WRSU appears to have the highest community pneumococcal vaccination rate among IHS facilities or any state/territory of the United States.

Influenza vaccination is another success story. Using a multi-disciplinary approach, WRSU has increased influenza vaccination rates among those 65 years or older from 51% in 2001, to 60% in 2002, 74% in 2003, and 81.5% for the first quarter of 2004 by GPRA analysis. Again, WRSU has met IHS and Healthy People 2000 influenza vaccination rate goals for persons over 65 years, and has met the Healthy People 2010 goal of eliminating disparity for influenza vaccination rates in this American Indian community.

WRSU has improved rates in 15 of 17 indicators reported for the first quarter of 2004, and is presently evaluating the use of 12 additional HEDIS or developmental indicators for upcoming reports.

Colville Service Unit

Colville is an excellent example of an overall success. Previously, they previously met only 1 of the 7 GPRA indicators. The Colville CEO noticed the poor performance indicators and pledged to make GPRA clinical indicators a priority. He enlisted the help and guidance of a locally developed clinical quality team. Each member of the team (which included representatives from the entire clinic) was involved in developing appropriate ways to highlight the indicators, as well as ways to improve them. Their success stemmed his leadership, as well as the involvement of the entire staff. By the end of that year, they had met 6/7 of their indicators.

The intended purpose of the Program Assessment Rating Tool (PART), developed by the Office of Management and Budget (OMB) is to evaluate programs and link performance to appropriations. The Indian Health Service has been an active participant and has scored very well, especially in comparison to other federal agencies. The question consistently raised by Tribal leadership is why does the Indian Health Service continue to be under funded, despite scoring well according to OMB criteria? The answer that has been provide by OMB when confronted with such a question is that while PART is a tool that measures performance, it is not the only criteria utilized to determine appropriations. While Tribal leadership does not dispute such a response, we feel strongly that effective and cost efficient programs should be maintained and properly funded in order to carry out the essential functions of government.

CONCLUSION

American Indians and Alaska Natives are an at-risk population. It is our hope that the "Quiet Crisis" is acknowledged and Indian Country work in concert with the Department of Health and Human Services to target and address the health disparities that exist in Indian country.

In closing, we feel that Tommy G. Thompson will leave a lasting legacy in his capacity as Secretary of Health and Human Services for his role in reshaping the federal government to prevent and prepare for possible terrorist attacks. We believe the other component of his legacy is to improve American Indian and Alaska Native health care. Therefore, we request that American Indian and Alaska Native health be named a Secretarial priority for FY 2006.

FY 2006 Indian Health Service Budget Formulation Workgroup:

Aberdeen Area –	Carole Anne Heart
Alaska Area –	Paul Hansen
Albuquerque Area –	Tony Secatero
Bemidji Area –	Robin Carufel
Billings Area –	Riki Salazar
California Area –	Rachel Joseph
Nashville Area –	Brenda Shore-Fuller
Navajo Area –	Jerry Freddie
Oklahoma Area –	Rhonda Butcher
Phoenix Area –	Alida Montiel
Portland Area –	Jim Roberts
Tucson Area –	Reuben Howard
National Council on Urban Indian Health –	D.J. Lott
National Indian Health Board –	J.T. Petherick
National Congress of American Indians –	Christina Morrow
Tribal Self-Governance Advisory Committee –	Don Kasheveroff

OPENING STATEMENT OF SENATOR LISA MURKOWSKI
SENATE COMMITTEE ON INDIAN AFFAIRS
INDIAN HEALTH SERVICE OVERSIGHT
APRIL 13, 2005

Good morning to you Mr. Chairman and Vice Chairman Dorgan. I would also like to welcome my friend Sally Smith from Dillingham, Alaska, the Chair of the National Indian Health Board back to the committee.

In his remarks to the organizational meeting of the committee, Chairman McCain indicated that the reauthorization of the Indian Health Care Improvement Act would be a priority for the committee this year.

As a co-sponsor of the legislation in the 108th Congress I was glad to hear Senator McCain say this. I suspect that most of the people in the room feel the same way because most of the people in this room had a hand in crafting the legislation.

The legislation that we reported out of this committee in the 108th Congress was the product of thousands and thousands of hours of work by the real experts in Indian health care delivery – the people who deliver health services to our Native peoples. This is not top down, ivory tower

legislation. It reflects the desires, but more importantly the needs of Indian country.

It is not just a self governance bill. It is not a just a direct service tribes bill. It is not an urban bill or an Alaska bill. Thanks to the hard work of our Native health leaders and their willingness to put together an inclusive piece of legislation, it is all of these things and more.

Mr. Chairman – a great deal of work has gone into the bill that didn't reach the finish line in the 108th Congress and it is my hope that we will be able to revive this legislation and pass it this year if that is the judgment of Indian country. We have gone too far to turn back.

I would like to join with my colleagues in expressing my sympathy and the sympathy of all Alaskans to the Red Lake Chippewa Nation over the tragic shooting that occurred on March 21st. I would also like to call the committee's attention that this is not the first such incident in a predominantly Native community.

On February 19, 1997, in the community of Bethel, Alaska, a Yupik Eskimo community in Southwest Alaska, a sixteen year old student shot the Principal of Bethel High School and one other student to death. Two other students were injured.

The incident at Bethel was followed by similar incidents at schools like Pearl, Mississippi, West Paducah, Kentucky, Jonesboro, Arkansas, Edinboro, Pennsylvania, the Columbine High School tragedy near Littleton, Colorado, and another tragedy in Springfield, Oregon.

And now the tragedy in Red Lake – the second such incident to touch a Native community.

It will do us no good to ask whether these tragedies should have been prevented. The questions on my mind today center around what we must do to prevent future tragedies.

- What special role does the federal government have in preventing these tragedies in Native communities served by the Indian Health Service?

- Do the tribes and the federal agencies have the resources they need to attack the behavioral health issues that are so prevalent in our Native communities?

- And let me note that these behavioral health issues are not limited to school violence. We should all be deeply concerned about the incidence of suicide, domestic violence, Elder abuse and child abuse in our Native communities.

- I am interested in knowing whether a renewed commitment to traditional Native values might help reduce the incidence of violence in our Native communities.

On the role of Native culture in preventing violence, these words spoken by my friend Myron Naneng – a Yupik leader, might help to suggest a path forward.

Seven months after the shooting in Bethel, Myron told journalist Rhonda McBride that the shooting set in motion a rebirth of Yupik culture.

"Our people are more community oriented. They don't think of themselves as individuals. They think as a community."

Other leaders of the Bethel Native community agree. One, quoted in the Anchorage Daily News, said,

> "The shooting caused the town to look at the basic ways that human beings interact. Many have turned to the teachings of the Y'upik culture. They're universal values...they have been here from time immemorial." They are the ways of the people."

I ask unanimous consent that Rhonda McBride's reporting in the Anchorage Daily News entitled "Yupik Remedies See Rebirth" be printed in the Record.

I would like the Native people of the Red Lake Reservation to know that the people of Alaska stand with you in your moment of grief. We who have suffered along with you stand ready to assist in every way possible in your recovery.

Thank you, Mr. Chairman, for bringing us together in these difficult times.

1 of 1 DOCUMENT

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August 25, 1997, Monday, FINAL EDITION

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LENGTH: 703 words

HEADLINE: YUP'IK REMEDIES SEE REBIRTH

BYLINE: Rhonda Mcbride; Special To The Daily News

BODY:

The shooting tragedy that claimed the lives of a principal and student in Bethel has prompted a new effort to incorporate Native teachings into school and community life.

For Myron **Naneng** and other Natives in Bethel's Yup'ik community, the tragedy was a wakeup call, a symbol of how the negative impacts of urban life had not just encroached, but threaten to take over.

Naneng, president of the Association of Village Council Presidents, said the shooting set in motion a rebirth of Yup'ik culture that is also influencing newcomers to Bethel.

"Our people are more community-oriented. They don't think as individuals. They think as a community," **Naneng** said.

Evan Ramsey, the boy accused in the killings of principal Ron Edward and student Josh Palacios, lived near the **Naneng** family and had been a playmate of his children.

Several days after the Feb. 19 shooting, Native leaders conducted a purification ceremony in the school. **Naneng** used a raven's wing as a fan to spread the smoke from healing herbs throughout the building.

During the summer, a number of talking circles and community forums were held at which Natives and non-Natives came together. One of those gatherings was led by Mary Stachelrodt, director of the Yukon Kuskokwim Health Corp.'s alcohol treatment program. Stachelrodt believes the shooting has caused the town to reflect, to look at the basic ways human beings interact. Many, Stachelrodt said, have turned to the teachings of the Yup'ik culture.

"They're universal values," Stachelrodt said. "Thay have been here from time immemorial. They're basic laws, basic common sense with simple rules for relating to one another and the environment. Everyone in the community, Native and non-Native alike, are benefitting."

Stachelrodt is one of many Native leaders who is pushing for a return of the "Piciyarayaq" or the "ways of the people" into the school curriculum.

The new superintendent of the Lower Kuskokwim School District, Bill Ferguson, believes the Yup'ik culture is a great resource to draw on in the healing process.

"In Anchorage and larger communities, the grass roots of the dominant culture are gone. In Bethel, the grass roots are here. And they're the elders," he said.

Although Bethel is the hub community for more than 50 Native villages, the high school does not have Eskimo dancing and other cultural heritage programs that exist in the village schools. Ferguson, who spent two decades teaching in Native communities, said, "I want to see a well-worn path between the senior center and the high school."

Other pathways between the elders and youth are being formed. The Orutsaramuit Native Council, Bethel's traditional council, has just received a suicide prevention grant from a mentoring program that will pair youth and elders.

Sue Charles of ONC is excited to see the resurgence of Native culture in the aftermath of the shooting. "I think it helps people to become more tolerant of people's differences," she said.

Verbal harassment was among the circumstances leading up to the February shootings. Students acknowledged that Ramsey, 16, had been a frequent target of teasing. Bullying and teasing were also mentioned in a suicide note of a Bethel Native student who killed himself a few months before the **school shootings.**

"There are always going to be differences," Charles said. "We are going to have to make the most of these differences. We can help by having children start building up a more positive attitude about the culture and Nativeness."

An alternative education program, Project Reach, is being developed with students like Evan Ramsey in mind. It will pull at-risk students out of the mainstream so they can get intensive help. One of the architects of the program, Bob Medinger, said one of the cornerstones is getting the traditional Native extended family involved in the process.

"There's not a simple cookie-cutter approach that one answer fits all," Medinger said. "We need a variety of programs that truly treats each child's well-being and uniqueness as the priority." The program will also incorporate Native culture and traditions along with drug treatment and other therapy.

LOAD-DATE: August 26, 1997

Revised

Testimony
Before the Committee on Indian Affairs
United States Senate

SAMHSA's Efforts to Provide Mental Health and Substance Abuse Services to American Indians and Alaska Natives

Statement of

A. Kathryn Power, M.Ed.

Director
Center for Mental Health Services
Substance Abuse and Mental Health Services Administration
U.S. Department of Health and Human Services

For Release on Delivery
Expected at 9:30 a.m.
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Mr. Chairman and Members of the Committee, good morning. I am Kathryn Power, Director of the Center for Mental Health Services (CMHS) within the Substance Abuse and Mental Health Services Administration (SAMHSA). I am pleased to offer testimony this morning on behalf of Charles G. Curie, Administrator of SAMHSA, an agency of the U.S. Department of Health and Human Services (HHS). Thank you for the opportunity today to describe how SAMHSA is working to provide effective mental health and substance abuse treatment services along with substance abuse prevention and mental health promotion services in Indian Country.

It is also a privilege to testify along with Dr. Charles Grim, Director of the Indian Health Service (IHS) this morning. SAMHSA and IHS have developed a strong partnership reflected in our current Intra-Agency Agreement to work efficiently and effectively together to help meet the public health needs of American Indians and Alaska Natives.

My testimony will focus on two issues of great concern to the public health of American Indian and Alaska Native youth. These two issues are suicide and violence. Sorrowfully there are real-life examples to illustrate the impact of suicide and violence in Indian Country.

Suicide Among American Indian and Alaska Native Youth

Recently, a suicide cluster occurred on the Standing Rock Reservation, in North Dakota and South Dakota. Eight young people took their own lives and dozens more attempted to do so. Tragically, many other reservations have similar stories to tell. Suicide is now the second-

leading cause of death (behind unintentional injury and accidents) for American Indian and Alaska Native youth aged 15-24. The suicide rate for this population is 250 percent higher than the national average. American Indians have the highest rate of suicide among all ethnic groups in the United States, with a rate of 14.8 per 100,000 as reported in 1998. Rates were highest in Pacific Northwest, Northern Plains and Alaska Areas — five to seven times higher than the overall U.S. rates. More than one-half of all persons who commit suicide in Indian communities have never been seen by mental health providers.

In studies that examine risk factors among people who have completed suicide, substance abuse occurs more frequently among youth and younger adults, compared to older adults. For particular groups at risk, such as American Indians and Alaska Natives, depression and substance abuse are the most common risk factors for completed suicide. Mental health and substance abuse disorders are also risk factors for violence.

Violence Among American Indian and Alaska Native Youth

According to the National Center for Injury and Prevention Control within the Centers for Disease Control and Prevention (CDC), injuries and violence account for 75% of all deaths among Native Americans ages 1 to 19. As I mentioned earlier, suicide is the second-leading cause of death for Indian youth aged 15-24, followed by homicide, the third-leading cause of death for the same age group.

A recent example of violence in Indian Country is the tragedy at Red Lake. A 16-year-old junior at the Red Lake high school in Red Lake Minnesota took the lives of nine others and then his own. On March 21, 2005, the 16-year-old shot and killed his grandfather, his grandfather's partner, five students, a teacher, a security officer, and himself.

The statistical picture on the Red Lake reservation, home to about 5,000 Tribal members, is even bleaker than the national average. Red Lake Nation is an impoverished community. Thirty-nine percent of the population lives below the poverty line; 4 out of 5 students at Red Lake High school qualify for free or reduced fee lunch. A third of the teenagers on this reservation are not in school, not working, and not looking for work, compared with about 20 percent on all reservations. A survey last year by the Minnesota Departments of Health and Education found that young people on the Red Lake reservation are far more likely to think about suicide, be depressed, worry about drugs, and be violent with one another than children across the State. A state survey of ninth graders found that at Red Lake High, 43 percent of boys and 82 percent of girls had thoughts about suicide, with 20 percent of boys and 48 percent of girls saying that they had tried it at least once. This event has led to community trauma and turmoil. In response, SAMHSA has sent several staff on-site to coordinate services and technical assistance in collaboration with IHS and other HHS components, including the Office of Intergovernmental Affairs within the Office of the Secretary, the PHS Commissioned Corps, the Administration for Children and Families (ACF) and its Administration for Native Americans, and the Office of Minority Health, as well as the State of Minnesota and the Tribe. The Child Trauma program

within CMHS is available to assist, and counseling services have been set up and are being provided in this acute phase.

SAMHSA became a part of a major interagency effort to support the needs of the Red Lake Reservation. Planning in the initial phase established a coordinating and decision making process to assess the needs of and provide support for the communities involved. SAMHSA staff was immediately deployed to Red Lake to assist in the early phases of crisis care. This involved support of the health care team, educational programs, social services, Tribal council, and community at large. SAMHSA staff also provided technical assistance to the Tribe in an effort to help them access emergency funds, especially those funds available though the SAMHSA Emergency Response Grant (SERG) grant mechanism.

SAMHSA's Role in Better Serving American Indian and Alaska Native Populations

SAMHSA focuses attention, programs, and funding on improving the lives of people with or at risk for mental or substance use disorders. Consistent with President Bush's New Freedom Initiative, SAMHSA's vision is "a life in the community for everyone." The Agency is achieving that vision through its mission "building resilience and facilitating recovery." SAMHSA's direction in policy, program and budget is guided by a matrix of priority programs and crosscutting principles that include the related issues of cultural competency and eliminating disparities.

To achieve the Agency's vision and mission for all Americans, SAMHSA-supported services are provided within the most relevant and meaningful cultural, gender-sensitive, and age-appropriate context for the people being served. SAMHSA has put this understanding into action for the American Indian and Alaska Native communities it serves. It is important to note also that it is the SAMHSA Administrator's policy to level the playing field and to ensure that Tribal entities are eligible for all competitive grants for which States are eligible, unless there is a compelling reason to the contrary. In total, SAMHSA provides about $42 million to American Indians and Alaska Natives annually.

CMHS is transferring $200,000 to IHS to support programming and service contracts, technical assistance, and related services for suicide cluster response and suicide prevention among American Indians and Alaska Natives. One example is the development of a community suicide prevention "toolkit". This toolkit will include information on suicide prevention, education, screening, intervention, and community mobilization, which could be readily available to American Indian and Alaska Native communities via the Web and other digitally based media for "off the shelf" use.

To better assist Tribal organizations, SAMHSA funded a $1 million grant that was awarded to the Oregon Health and Science University to establish the One Sky Center - an American Indian and Alaska Native National Resource Center. The One Sky Center provides technical assistance, training, information dissemination, and communication to increase substance abuse prevention and treatment knowledge and skills among service providers, policy makers, Tribal communities,

funding organizations, and consumers. Today, the One Sky Center is a National Resource Center that, in addition to its many other services, maintains a comprehensive list of American Indian and Alaska Native programs that are currently funded by SAMHSA.

The Screening and Brief Intervention and Referral to Treatment (SBIRT) and Access to Recovery (ATR) programs are designed to intervene and provide treatment alternatives for individuals who require substance abuse treatment. These programs are available to Tribal organizations.

SAMHSA's commitment was especially noted in our efforts to encourage American Indian Tribes and Tribal organizations to apply for ATR funds. ATR is a Presidential initiative that provides funding to States and/or American Indian Tribes or Tribal organizations to expand substance abuse treatment capacity, to expand the array of providers, and to instill accountability into the substance abuse treatment system.

SAMHSA held 4 technical assistance briefings for States, and while many Tribes were free to attend these briefings, a fifth briefing was set up specifically for Tribes and Tribal organizations. As a result, 22 Tribes submitted applications, and a Tribal coalition, the California Rural Indian Health Board, received one of 15 grants awarded in FY 04. The President is asking for an increase of $51 million for this program, which should allow for an additional 7 awards for which Tribes would be able to apply.

The SBIRT program has awarded a grant to the Cook Inlet Tribal Council near Anchorage,

Alaska, to provide screening, brief intervention, and referral treatment for their population. SBIRT is designed to assist in reducing the suicide/violence in Indian Country by treating the underlying substance abuse that contributes to the problem. The FY 06 budget requests a $5.8 million increase in SBIRT funding.

Additionally, SAMHSA's Substance Abuse Treatment Targeted Capacity Expansion (TCE) grant program continues to expand treatment opportunities and capacity in local communities experiencing serious emerging drug problems. Tribes and Tribal organizations have received over $31 million in TCE funds, either in direct or indirect grant awards, during the past three years.

Regarding mental health services, SAMHSA also collaborates with IHS and the National Institute of Mental Health within the National Institutes of Health (NIH) on the Circles of Care grant program. The Circles of Care program supports the implementation of mental health service models designed by American Indian and Alaska Native Tribal and urban Indian communities that utilize a systems-of-care community-based approach to mental health and other supportive services for American Indian and Alaska Native children with serious emotional disturbances and their families.

SAMHSA's Comprehensive Community Mental Health Services for Children and Their Families Grant Program provides funding for direct services to improve systems of care for children and adolescents with serious emotional disturbance and their families. Seven Tribal organizations are

among the current total of 63 grantees.

With regard to programs to address violence and suicide, in 1999, in response to school shootings in Kentucky, Arkansas, Oregon, and other states, Congress took action and launched the Safe Schools/Healthy Students Initiative (SSHS), under the collaborative leadership of the Departments of Education, Health and Human Services, and Justice. The SSHS awards three-year grants of $1 million to $3 million per year to school districts to do the following:

- Collaborate with local law enforcement and mental health agencies;
- Promote the healthy development of school-age children; and
- Promote mental health and prevent violence in youth by using evidence-based programs with demonstrated long-term positive effects.

When this initiative was created, two Tribal sites were funded in the initial cohort of 54 grantees and out of a pool of close to 500 applications. In particular, these two Tribal grantees emphasized the poverty of their communities. Repeatedly, researchers from different fields, "have firmly established that poverty and its contextual life circumstances are major determinants of violence. Violence is most prevalent among the poor, regardless of race."

For instance, our SSHS grantee in Pinon, Arizona, wrote in its application, "The Navajo Nation in northern Arizona is among the poorest and most desolate regions of the United States. The area has only one paved road for travel, 92% of the children receive free/reduced price lunches, and 60-90% of residents live without basic services, such as plumbing, running water, kitchens,

sewers, and telephones, compared to less than 1% of the U.S. population at large." It is within the context of these problems that this grantee endeavored to bring about change, and by and large, it was successful in turning a school community away from violence and toward resilience and a productive and meaningful life.

In January, SAMHSA launched the National Suicide Prevention Lifeline, 1-800-273-TALK. The national hotline is part of the National Suicide Prevention Initiative. This collaborative effort, led by SAMHSA, incorporates the best practices and research findings in suicide prevention and intervention with the goal of reducing the incidence of suicide nationwide. Along with the national hotline, a new website is being launched at www.suicidepreventionlifeline.org.

Additionally, SAMHSA, under the authority of the Garrett Lee Smith Memorial Act (Pub. L. 108-355), announced the availability of FY 05 funds for state-sponsored youth suicide prevention and early intervention programs. (Requests for Application No. SM-05-014, SM-05-015, and SM-05-017)

SAMHSA takes seriously the current challenges in Indian Country, which include few trained service providers, major transportation barriers, and multi-generational poverty. SAMHSA is being proactive in addressing these challenges that rob communities of their most valuable resource: their children and their future. The vital treatment and prevention efforts that I have discussed today are designed to address these problems and are improving services for American Indian and Alaska Native children, youth, and their families.

Mr. Chairman and Members of the Committee, thank you for the opportunity to appear today. I will be pleased to answer any questions you may have.

Mr. Anslem Roanhorse, Jr., M.S.W.
Executive Director
Navajo Division of Health
The Navajo Nation

Written Statement to the
US Senate Committee on Indian Affairs

Hearing on Indian Health
Washington, DC
April 13, 2005

Introduction

Chairman McCain, Vice-Chairman Dorgan and distinguished members of the Senate Committee on Indian Affairs. My name is Anslem Roanhorse, Jr., I am the executive director for the Navajo Division of Health. On behalf of the Navajo Nation, I am honored to present important information on health care within the Navajo Nation. I also request that my testimony be entered into the record.

Navajo Nation Division of Health

In 1977, the Navajo Nation Council established the Navajo Division of Health Improvement Services, renamed the Navajo Division of Health in 1995. During fiscal year 2005, the division's operating budget totaled $79.3 million, of which 77 percent were federal funds, 7 percent state funds, 15 percent tribal funds, and 1 percent tribal trust funds. The Navajo Division of Health employs over 1,100 health professional, paraprofessional, and technical personnel stationed throughout the Navajo Nation. The Navajo Division of Health provides a variety of health-related services for infants, children, adolescents, adults, elderly and their families throughout Navajo communities. The Navajo Division of Health provides health education, nutrition, substance abuse counseling and treatment, public health nursing, processes applications for compensation for those Navajo individuals or their surviving spouse who have been subjected to uranium mining, diabetes prevention, breast and cervical cancer prevention, HIV/AIDS education, other health promotion and disease prevention efforts, food sanitation regulatory, and facility planning.

Existing Health Programs and Challenges

Indian Health Service (IHS)
The Indian Health Service is the primary health care provider on the Navajo Nation. The Navajo Area IHS serves two federally recognized Indian tribes, including the Navajo Nation and the San Juan Southern Paiute Tribe and it also serves other eligible beneficiaries through inpatient, outpatient, contracts for specialized care, "638" Self-Determination Contract providers, and an

urban Indian health program. In 2004, there were 4,027 federal staff at six IHS service units, an Area Office, and three "638" Self Determination contract providers.

The healthcare network includes five hospitals, six health centers, fifteen health stations and twenty-two dental clinics. The Navajo Area IHS is responsible for providing health care services to more than 200,000 patients. In Fiscal Year 2003, Navajo Area IHS budget amounted to $534.6 million, the majority of which are federal appropriation totaling $391.1 million and the remaining $143.5 million was generated in revenues from Medicaid, Medicare, CHIP, and private insurance. In FY 2004, the Navajo Area IHS budget amounted to $674,581,546, the majority of which are federal appropriations totaling $486,490,703 million and the remaining $188,090,843 million was generated in revenues from Medicaid, Medicare, CHIP, and private insurance. (NAIHS, Year 2005 Profile).

Contrary to the goal of eliminating racial disparities in health care, American Indians including the Navajo people have experienced disparities in health care funding and other resources in the United States for many years. Federal funding for Indian health care has not kept pace with factors such as the rising costs of health care, increasing costs of pharmaceuticals, and competitive salaries for recruitment and retention of qualified health care professionals. Table 3 depicts the impact of these disparities on the local Navajo Nation health care system.

		Table 3
Unfavorable compared to the U.S. population:	Navajo Area Rate (95% Navajos)	U.S. Rate
All Deaths	628.9	479.1
Diabetes Deaths	35.9	13.5
Cervical Cancer Deaths	4.6	2.5
Alcohol Related Deaths	49.8	6.3
Suicide Deaths	16.8	10.6
Homicide Deaths	19.7	8.0
Tuberculosis Deaths	2.4	0.3
Pneumonia/Influenza Deaths	30.8	12.9
Births	21.7%	14.5%
Teen Births (13-19 yrs)	16.9%	12.7%
Prenatal Care in First Trimester	56.4%	82.5%
Infant Deaths (under 1 yr. of age)	8.2	7.2
Post neonatal Deaths (28-360 days)	4.4	2.5

*Statistics from the Navajo Area Indian Health Service (9-25-03).

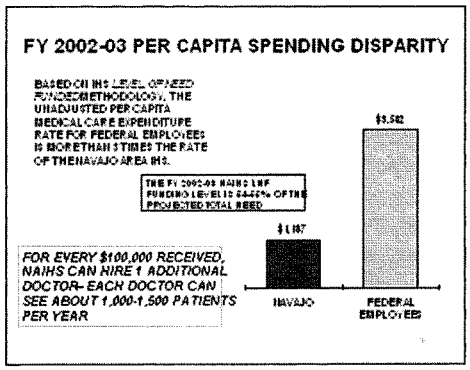
Navajo people compare favorably in the following areas. However, analysis of 30 year data indicates favorable Navajo rates are approaching general population rates and may surpass the U.S. rates over time as they have for other statistics (Table 4).

Fared better than the U.S. population in the following:	Navajo Area Rate (95% Navajos)	Table 4 U.S. Rate
All Cancer Deaths	87.5	125.6
Breast Cancer Deaths	11.5	19.4
Heart Disease Deaths	103.2	130.5
Low Weight Births	6.5%	7.5%

According to the IHS, in 2003, the Navajo Area IHS was funded at 55 percent of the projected total need and this means only half of the Navajo Nation health care needs are funded. There is no other recent data for the FY 2002-2003 Per Capita Spending Disparity. As the testimony of the U.S. Civil Rights Commission underscores, this is unacceptable and it demonstrates a glaring injustice to fully funding Navajo health care needs.

Using the Level of Need Funding methodology, the unadjusted per capita medical care expenditure rate for federal employees is more than three times the rate of the Navajo Area. In Fiscal Year 2002, $3,582 was spent on a federal employee's health benefits package as compared to only $1,187 spent on a single Navajo person's health care.

Overall, the federal funding for Indian health care has not kept pace with factors such as: 1) medical and escalating inflation; 2) rising costs of health care; 3) increasing costs of pharmaceuticals; and 4) offering of competitive salaries in the recruitment and retention qualified health care professionals. The figure below depicts the impact of these disparities on the local Navajo health care system.



These figures become more important with the following fact: For every $100,000 received, one additional doctor can be hired. Each doctor may see about 1,000 to 1,500 patients per year. More health care funding equates to expanded health care services that will sufficiently meet the health care needs of the Navajo Nation.

However, the data listed above includes only personal medical services and does not include critical areas such as community health and prevention-oriented services, integral programs in the Navajo health care system.

How can tribes and other partners in health care intervene effectively if the total unmet need is not considered? With high rates of substance abuse, homicide/suicide, and motor vehicle accidents primarily due to alcohol use, federal funding for Navajo health care must be appropriated to address the treatment aspects as well as the prevention components.

Staff Recruitment and Retention Issues

The recruitment and retention of additional health professionals is an area of great concern for the Navajo Nation. Currently, the Navajo Area is experiencing high vacancy rates for doctors, nurses, dentists, and pharmacists, ranging from 17% to 20%. Lack of housing and childcare services affect the ability to retain nurses and other health professionals. The turnover rate among nurses is 5 percent, according to Navajo Area IHS.

While recruitment and retention bonuses are offered for some professions such as doctors and nurses, to attract individuals to work in the Navajo Area and in Indian country, the limited budget will simply not allow for effective implementation of bonuses and other incentives to attract qualified individuals. This dilemma is compounded by the fact that the salary and pay levels are not competitive with those found in the private sector.

Loan repayment opportunities are also available. However, many individuals fulfill their obligations to the federal government and leave as soon as the obligations are met. There is no commitment and dedication to remain on the reservation and continue providing health care.

Health Care Facilities

From 2003 to 2006, Health Care Facilities Construction was considered the top priority during the Navajo Area budget formulation process. Local communities on the Navajo Nation support continued funding for planning, designing and constructing new hospitals and health centers. The Navajo Nation does not support the proposed decrease of $85.2 million for health care facilities construction in the FY 2006 Federal budget request.

Although the Navajo Area has been very fortunate to receive federal funds for a new hospital and new health centers in recent years, there remains a great unmet need for new facilities, particularly in our area, where the current user population is almost 237,000 and some existing facilities are inadequate, too small, and require replacement. On the Navajo Nation, there are 110 chapters, which are analogous to counties. The populations of the chapters range from 61 to 9,000. Some chapters are larger than many tribes in the U.S. The point I am making is that while it may be unrealistic to plan for a health center or hospital in each chapter, there are many areas on the Navajo Nation that will require a new hospital or health center in the coming years. This is precisely why the Navajo Nation has recognized health care facilities construction as a top priority.

Navajo Area is grateful for the new staffing funds proposed for the Pinon Health Center and the Four Corners Regional Health Center in Red Mesa, Arizona, for $9,807,000 and $5,328,000, respectively, in the FY 2006 proposed IHS budget.

A new health center in Kayenta, AZ was recently added to the IHS construction priority list; however, no funds to begin construction were included in the proposed budget. The Committee's support to continue funding for the construction of the new Kayenta Health Center and other needed new health centers and hospitals is requested.

There are four projects that the Navajo Area has in Phase III of the current priority system. Planning documents such as the Program Justification Documents (PJDs) still require approval prior to being placed on the national priority list and for consideration for funding by the U.S. Congress. Again, this highlights the continuing need for new facilities construction funds.

Moreover, there is a national moratorium or "pause in construction" proposed in the FY 2006 budget. The Navajo Nation is gravely concerned about this proposal. The momentum on addressing new facility construction needs in Indian country must continue and in fact should be accelerated.

Related to construction, the IHS is in the process of proposing a new facilities construction priority system methodology. I am pleased to be a new member of the Facilities Appropriations Advisory Board (FAAB), the group that is facilitating the process. The Navajo Nation's position

on the proposed new system is to grandfather the Navajo Area IHS Phase III projects into the revised methodology.

Federal officials do not permit the use of carryover funds for conventional site built construction, but allows for the purchase of modular buildings. Put another way, federal funds authorized for direct services cannot be used for construction. The primary issue with modular buildings is their lifespan. Poor foundations cause modular buildings to separate and shift which then cause roofs to leak, walls to crack, doors that cannot be fully closed, and windows that jam shut. We understand that Congress is the only entity that can authorize funding for construction through congressional appropriations. However, unused prior year carryover funds are approved for only modular buildings.

Furthermore, the Navajo Nation has accepted several buildings considered "surplus" to either the IHS or the Bureau of Indian Affairs. These buildings are generally in good condition, but they are usually very old. Costs associated with containing or abating hazardous conditions including asbestos, lead based paint, PCB's, and renovation to meet life safety codes, as well as licensure and/or certification requirements for proposed service delivery is expensive. Mechanical, electrical, plumbing, heating, air condition systems usually have to be upgraded. Flooring and roofing show considerable wear and tear as well. The Navajo Nation has accepted two former hospitals and is considering accepting another former hospital.

Navajo Nation Property Management and Facilities Maintenance are extremely limited to the amount of preventive maintenance and repairs they are able to provide. Other existing conditions include:

- Community Health workers often operate out of local chapter houses or limited office spaces afforded them from IHS facilities.
- Adequate housing is non-existent and is forcing much needed professionals to commute from nearby border towns, often 60 miles roundtrip per day.
- Tribally operated programs often do not have sufficient resources to offer competitive salaries. This negatively impacts recruitment and retention efforts. Too often, Navajo tribal programs "train" entry level staff and who then are recruited by higher paying off-reservation or non-tribally run programs.

Trauma System Development

Recently, the Navajo Nation embarked on development of a Trauma System Development (TSD). The primary intent is to reduce death and disability caused by traumatic injuries among the Navajo people. Presently, unintentional injury is a leading cause of death among Navajos from ages 1 through 54. Moreover, heart disease is the leading cause of death for all ages.

A localized trauma care center would provide life sustaining opportunities in the following matters:

- The 2003 Youth Risk Behavior Surveillance Survey (YRBS) indicates that 1in 5 students reported actual suicide attempts one or more times during the past 12 months. 20% of our students are at risk for carrying out suicide plans. The Suicide Rate for Native American/Alaskan Native is 12.6 per 100,000.
- Motor Vehicle crashes have a co-factor with alcohol induced motor vehicle injuries. The 2003 YRBS, Middle School students reported riding in a car with a person who had been drinking alcohol 33% of the time, that is 1 in 3 children; the results are similar with High School students who reported 32% of the time. Rural and remote highways/road areas have a high incidence of motor vehicle accidents in Indian country.

- The latter has a toll on Years of Potential Life Lost (YPLL). It impacts loss of earning – labor force participation rates, medical cost, as contributing to economic loss. Of the Navajo fatalities attributed to injuries and lack thereof a trauma center, calculated loss could be estimated into the thousands, if not millions, of dollars and of the years of life loss. For example, for the 11,867 males who died from injuries, an estimated 3.8 million life years are lost, 34 years per death, valued at $39.0 billion, or $349,030 per death (Economic Cost of Injury, 1985 data, p. 57).
- Navajo Nation Department of Highway Safety document months of high volume Motor Vehicle Crashes (MVC) during the months of January, July, and August. Most of the 1,802 recorded MVC are attributed to single and multiple, at 50.9% and 48.9%, respectively.

Presently, after initial care is provided by local hospitals, majority of critical care patients are transferred to off-reservation trauma centers/hospitals located throughout Arizona, New Mexico and Utah. The purpose of the Navajo Nation TSD is to establish and coordinate with affiliated agencies the capability of identified facilities on the Navajo Nation that could serve as a level 2 or 3 trauma center. It involves assessments of varying degrees that would determine the most viable option available to the Navajo Nation.

A critical process in developing the TSD is to acquire expert guidance and assistance from a Navajo Nation Trauma Planning Advisory Committee (NNTPAC). Once the NNTPAC is organized and authorized to begin planning, the group will begin to plan on the following tasks:

- Identify a Trauma Coordinator to provide medical and clinical guidance and direction.
- Contract for technical assistance with the New Mexico Injury Prevention and EMS Bureau, the New Mexico Trauma Foundation and the University of New Mexico, School of Medicine Trauma Services, and the EMS Academy.
- Data Collection and analysis using existing trauma data from various sources including Navajo Area IHS, Navajo Nation EMS and the states of Arizona, New Mexico and Utah. The data will help lead the planning processes and it will establish and motivate quality improvement activities.
- Develop the capacity to design a Navajo Nation Trauma Registry that the use of data using information collected from autopsies to analyze causes of mortality.
- Initiate existing facility and resource assessments, including personnel and equipment.
- Develop a centralized Enhanced 911 dispatch system.

Further, the NNTPAC plans to address ways to increase the number of health care personnel, such as EMTs, doctors, nurses and allied professionals that will be needed for the expansion and improvement of the current trauma care. The NNTPAC is also considering the establishment of a Trauma Nurse Coordinator position at each existing facility. A more coordinated TSD would also address cardiovascular diseases that are becoming a leading cause of death for all ages, in addition to unintentional injuries. The proposed Navajo Nation TSD is a major undertaking and will require full support. It is an initiative that is highly needed to address a serious issue. The planning and development of the TSD will involve time, commitment and resources.

Navajo Nation Emergency Medical Services

The high rate and incidence of traumatic injury is a major concern within the Navajo Nation. Many Navajo Nation residents and visitors are traumatically injured and require the service of the Navajo Nation EMS and area medical facilities.

In 2003 the Navajo EMS responded to 768 incident calls involving motor vehicle accident due to loss of control, without collision on the highway and motor vehicle accident involving re-entrant collision with another motor vehicle. The overall total response to all incidents involving other forms of medical injuries was 3,146 in the same year.

While in 2004, the Navajo EMS responded to 1,027 incident calls involving motor vehicle accident due to loss of control, without collision on the highway and motor vehicle accident involving re-entrant collision with another vehicle. The overall total response to all incidents involving other forms of medical injuries was 3,829 in the same year.

In 2003, the total annual mileage for Navajo EMS ambulance service responding to emergency medical incidents was 548,911 miles at a cost of $106,943.48. From 2001 to 2003, the total annual mileage for Navajo EMS ambulance service responding to all emergency medical incidents was 1,586,257 miles at a cost of $303,463.52. 2004 mileage rates are unavailable. Source: Navajo Nation Emergency Medical Services

STD/HIV/AIDS

Over the past two years, the Navajo Nation has faced an increasing challenge with the transmission of syphilis, which continues to increase and may only worsen. Between January and April 2005, 11 reported syphilis cases were identified. During calendar year 2004, 71 cases were reported. The increased number of syphilis cases presents a greater risk for HIV transmission. To combat this public health concern, the Navajo Nation Division of Health, Navajo Area IHS, and the Center for Disease Control and Prevention (CDC) joined forces to develop an Inter-Agency Memorandum of Agreement that would build the capacity of the Navajo Division of Health to investigate, control, and prevent STD. The Navajo Nation has received commitment from Arizona and the New Mexico Department of Health for providing financial support for public education and participating in case reviews.

Aggressive outreach targeting specific areas of high risk populations and the general community were initiated. Two assessments were completed. One assessment focused on the condition of the jails and the lack of health information that was made available to the population inside, and the second focused on recent syphilis patients and how many had a history of incarceration. These two assessments were highly informative and provided information on a population that is otherwise not seen. These assessments prompted service units to begin planning initiatives for screenings in their local facilities. Screening and testing in the correctional units at Window Rock, AZ was implemented. Soon after, the CHR/Outreach Program applied for funding to continue this initiative and was awarded a $253,836 grant for three years. This initiative, Navajo Nation STD Screening Project "Dine Unity" also establish a very unique collaboration between many Navajo Nation programs, including The Social Hygiene Program, The HIV Prevention Program, Health Education Program, Ft. Defiance Indian Health Services, Ft. Defiance Public Health Nurses, Department of Behavioral Health Services, Navajo AIDS Network , Public Safety Department and Indian Health Services. Since September 2004 a total of 314 contacts have been made. 112 male and 2 female inmates have accepted screening, with 0 positive results, 254 males and 14 females have received health education.

HIV cases on the Navajo Nation now number 198 cases with 23 cases occurring since January 2004. Initially, HIV/AIDS cases were those Navajo individuals who develop HIV in metropolitan areas and elsewhere. HIV was transmitted by these individuals to Navajo individuals residing on the reservation. More recently, however, cases are now being transmitted from Navajos living off the reservation to Navajos living on the reservation.

The greatest need for the Navajo HIV/AIDS program is funding for a prevention program. The Navajo Nation program is not funded as such by the Navajo Nation. The Navajo Aids Network., another HIV/AIDS program, is funded through the State of Arizona, but when numbers of cases increased in the metropolitan areas, funding for the Navajo Aids Network was reduced and redistributed to metropolitan areas.

Housing concerns need to be addressed. Poor living conditions equate to poor health which leads ultimately to death for immune compromised individuals. Adequate medical services are also needed for residents not accessing Gallup Indian Medical Center. Training is needed to enhance the capacity of service providers, including issues relating to AIDS-phobia and Homophobia. Improved transportation services to facilitate receipt of medical care and treatment by HIV/AIDS afflicted individuals are much needed.

Behavioral Health

Currently, the Navajo Department of Behavioral Health Services (DBHS) operates two adolescent residential treatment centers. One facility has 20 beds, while the other facility has 24 beds. However, due to staff shortage only 10 beds are available. In short, there are 30 beds for approximately 35,137 Navajo adolescents in need of residential treatment services. The DBHS also operates two adult residential treatment centers. One facility has 8 beds and the other has 10 beds for males; totaling to 18 beds for a population of 179,371 Navajos in need of residential treatment services. DBHS also operates one adult residential treatment center and one intensive outpatient treatment center. The adult residential facility has 8 beds to serve a total reservation population of approximately 180,000 people. The intensive outpatient facility has served over 1000 clients last year. The Navajo Nation does not operate medical or social detoxification centers. Acute care for intoxicated individuals is provided by IHS (screening and stabilization) and jails. DBHS purchased modular buildings with unused prior year service funds (carryover or carry forward dollars, see Health Care Facilities above).

While Methamphetamine use in the Navajo Nation is an increasing concern, alcoholism remains a tremendous problem among the Navajo, both as a discrete problem and contributor to other problems – accidents, mental diseases, problems of pregnancy, homicides, suicides, and cirrhosis. The health and social problems related to alcohol and substance abuse continue to rise and affect the lives of many Navajo youth, adults and their families. It is estimated that about 25 percent or about 44,843 of the total Navajos residing on the Navajo reservation have alcohol and substance use, abuse and addiction problems. Approximately 35 percent of the total Navajo population or 35,137 persons between the ages of 10 and 17 are in high-risk group, having been exposed to alcohol and substance abuse problems.

It is also estimated that about nine of ten or about 161,434 Navajo individuals of all ages are affected by alcohol, substance abuse and other related behavioral health problems. About 50 percent or 20,000 individuals that are impacted by alcohol and substance abuse are not receiving any services. Due to inadequate funds and resources, the Navajo Nation Department of Behavioral Health Services (DBHS) is unable to provide services to a large number of high-risk youths and young adults.

The DBHS provides treatment and counseling services to about 19,000 patients every year. Information and education on alcohol and substance abuse is provided to about 20,000 individuals and families every year and another 14,000 individuals receive prevention, education, treatment, and after care services through contracts with other providers. The DBHS delivers these services through its 11 outpatient treatment centers, four residential treatment

centers, two mobile and two outreach programs, and five mental health case management offices.

The occurrence of mental health problems and disorders affects 35 percent of the total Navajo Nation population between the ages of 15-54. About 13 percent of the total children and youth aged 9-17 experience serious emotional disturbance and one in five children and youth may have a diagnosable mental, emotional or behavioral problem. Prevalence of major depression among adults aged 45-64 is 2.3 percent of the total population. It is important to note that co-occurrence of mental and addictive disorders affect the Navajo population. About 37 percent of the total population abusing alcohol is also diagnosed with a mental disorder and 53 percent of the other drug abusers have diagnosed mental disorders as well.

The Navajo Nation promotes a seamless and comprehensive treatment model for behavioral health that is inclusive of substance abuse and mental health disorders. This approach provides a more effective way of assessing and treating an individual in a holistic manner and offering comprehensive care in one department, which prevents further referral of a client to several agencies for services. This new model was written into the Indian Health Care Improvement Act Reauthorization of 2003.

Traditional Healing

With respect to the sovereignty of the Navajo Nation, discussion of Navajo health care issues must always include the use of traditional healers as well as conventional medicine. A 1998 study (Arch Intern Med. 1998; 158:2245-2249) conducted on the Navajo Nation confirms the use and dependence on traditional healers as a continuing common occurrence. A cross-sectional interview of 300 Navajo patients indicated that 69 percent had used traditional healers with 39 percent using traditional healers on a regular basis (1998). The age range of traditional healer users was 18 through 90 years old. In a summarized table of concomitant use of traditional healers and medical providers, arthritis, abdominal pain, depression/anxiety and chest pain had the highest frequency.

The use of traditional healers is significant to IHS and other medical and health service providers. Many of the Navajo patients interviewed did not perceive a conflict between the two health systems; one patient stated that, "It is better to stand on two legs than on one". During the 1998 study, the researchers often had to use interpreters because Navajo was the first and main language of many of the Navajo individuals interviewed.

The study concludes, "Increased understanding of this deeply rooted system can improve communications between providers and patients and, therefore, can help medical providers improve the quality of care provided". The authors go on to add that further research is needed for a better understanding of issues such as the extent of native healer usage and "how conventional care and native healer care can interact with each other to increase the overall effectiveness of care provided to the patient".

This study supports the position of the Navajo Nation Division of Health that:

- Further research is needed to understand the importance of and impact of providing traditional healing care to Navajo patients who request such care.
- Further research is needed to determine the extent of traditional healer and health care beliefs and its impact on and relation to health disparities.
- The cost barrier of traditional healing services is an important consideration to ensure a comprehensive health care system that encompasses the rights of Navajo people to traditional healer services.

- Adequate time be provided for interpretation of conventional medical diagnoses, medication and other care needs to Navajo patients with limited English comprehension to:
  - Avoid misunderstanding of diagnosis
  - Avoid misunderstanding of medication
  - Ensure patient education of condition and other information
  - Ensure patient responsibility

Further, the Navajo DBHS continues to see a steady increase of referrals in the last five years. This is in part due to the Navajo Traditional Treatment Expansion Project, which was initiated through a 5-year grant from the Center for Substance Abuse Treatment. This has helped the DBHS establish positions for Traditional Practitioners in each of our treatment sites and to implement and significantly enhance the expansion of Navajo traditional treatment services.

Navajo teachings and ceremonies offer a means to restore a person to peace and harmony. Until recently, treatment programs that tried to assist the Navajos have failed to achieve measurable success. The Tribal Department recognizes the importance of incorporating traditional Navajo culture into treatment modality. To enhance appropriate treatment and services, the tribal department employs 99.9 percent Navajo-speaking personnel who are sensitive to the cultural practices and needs of the clientele.

During traditional healing ceremonies, families play a significant role as they exhibit support through prayers, meditation, and counseling. In that sense, the ceremony becomes family therapy approach. The DBHS primary counselors advocate for the parallel application of Navajo traditional healing services and Western treatment services to help clients restore harmony and balance into their lives.

Cancer Prevention Services

Cancer among Navajo people is a critical health care concern that is growing. The Navajo Nation currently operates two programs associated with cancer disease. The Breast and Cervical Cancer Program (BCCP) provides screening for breast and cervical cancer among Navajo women, while the Office of Navajo Uranium Workers provides education and information to former uranium workers and their families regarding compensation benefits pursuant to the Radiation Exposure Compensation Act (RECA) of 2000.

Both of these programs provide services and resources for Navajo people. However, the Navajo Nation, in partnership with entities involved with cancer issues, needs more resources to increase access, intervention, treatment and support for patients diagnosed with cancer. Presently, treatment facilities for cancer patients on Navajo Nation are nonexistent. Despite the fact that there are various forms of health education provided, more needs to be done to address prevention education to minimize cancer. Cancer is now the third leading cause of death on the Navajo Nation. Often, by the time full diagnosis is made, the disease has progressed to a stage requiring prolonged or ineffective treatment.

Currently, cancer treatment by IHS on Navajo consists of a case-by-case basis at each of the IHS Service Units and 638 facilities. Navajo area does not have a coordinated cancer treatment system or program but is working to develop a cancer registry as part of the Navajo Health Department system.

Partnerships include the Cancer Data Workgroup whose purpose is to work with the New Mexico Tumor Registry towards the analysis of Navajo specific data. Work has been done with the American Cancer Society and the Arizona Department of Health Services to develop a

comprehensive state cancer plan. Such a plan would address needs, gaps and priorities in cancer control.

Some identified concerns to reduce cancer incidence include addressing teen smoking, making cancer detection/screening exams more readily available in community settings. PSAs with Native Americans and others from all walks of life would also be helpful.

Diabetes

Diabetes Mellitus is a chronic disease that is an epidemic on the Navajo Nation. According to FY 2002 data, there were over 15,000 patients on the Navajo Area IHS registry. The diagnosis, treatment and follow-up care services are provided at these same sites. Frequently, there is denial of diagnosis and sometimes treatment gets delayed. Patient and family education are vital in self-management and glucose control. Family members often consult Traditional medicine people to try to assist patients and get an understanding of the disease.

Research findings show that it is the uncontrolled glucose that causes complication of eye, kidney, heart and nervous system problems. When complications develop such as blindness, kidney failure, heart attack and amputation, the medical and pharmaceutical costs become exorbitant. The diabetes prevention education program need to be better funded to alleviate these costs. Further, the secondary symptoms need professional care which requires retention and the recruitment of podiatrists, optometrists, occupational therapists, dieticians, etc who leave the health care facilities because the salary does not compare to the private sector.

The Navajo Nation Special Diabetes Project, funded since 1998 by the IHS, has been active in communities providing diabetes awareness and prevention education with all age groups. With supplemental funding in 2001, additional paraprofessional positions were added to include nutrition and physical activity education in communities, schools and worksites. There is a need for scholarships to continue workforce development and have professionals to staff wellness centers and provide public health services.

Below is an update on Navajo Diabetes program implementation:

- Federal funding of Navajo diabetes programs was a major contribution to community initiatives through "Walk Across Navajo Nation"; "Just Move It", establishment of Wellness Centers.
- The Navajo Health Education Program recorded 15,382 participants in diabetes-related events annually. Diabetes education also expanded to remote Navajo chapters such as LeChee, Pinon, Pine Springs, Ojo Amarillo, Counselor, and Kiabeto.
- Establishment of Life Style Balance sessions also reached additional population. Life Style Balance incorporates consumer health education such as nutrition label reading, promoting 30 minutes of exercise 5 days of a week, meal portion sizes, fat calories recording, identifying mental health issues that trigger eating disorders, and other "healthy living" series which last approximately 15 weeks.

During Fiscal Year 2004, the Navajo Special Diabetes Project provided education, information, and screening to over 11,000 Navajo people on the Navajo Nation through formal and informal presentations. These included presentations and screenings at chapter houses, local events, schools, and conferences. Individuals who are determined to have high levels of glucose are referred to health care facilities and providers for further treatment.

Because most of the Navajo Special Diabetes Project staff are para-professionals, it is becoming increasingly clear that more education is required to continue to upgrade their level of competence and qualifications.

Veterans

There are approximately 11,141 veterans registered with the Navajo Nation. Additionally, over 200 young people from the Navajo Nation are in active duty status. These numbers do not reflect all Navajo military personnel who may reside in urban areas.

There is an emerging health problem impacting veterans. According to the New England Journal of Medicine, it is expected that more Veteran who served in the Middle East war will be affected with mental disorders, including Post Traumatic Stress Disorder, drug or alcohol abuse and anxiety disorder. The Navajo Nation is aware that many Native American Veterans who return from the war may need additional mental health services.

The Navajo Nation continuously advocates for quality healthcare for our Navajo and all Native American veterans. The nearest veteran hospitals are located in Prescott, Ariz., Albuquerque, N.M. and Phoenix metropolitan area. The major problem is transportation to and from these off-reservation hospitals. Due to great distances between the Navajo Nation and these healthcare facilities, there is a definite need to form closer partnerships with the Veterans Administration, States and IHS to make these entitlement services accessible to all deserving Native American veterans.

Summary

Depressed economic conditions, social stress and pressures all contribute to Native American health problems. Alcohol abuse is implicated in many accidents, as well as other violent acts. Native Americans, including Navajo people consume western diet and embrace inactive lifestyle which contributes to chronic diseases such as cardiovascular disease and Type-2 diabetes. The implications of these conditions require a broad range of actions. A public health approach aimed at preventing diseases through improved diet and nutrition, better exercise program, improved sanitation, good housing, and improved behavioral health education is the goal of the Navajo Nation Division of Health. The Navajo Nation is challenged with numerous complex and unique barriers to reach its public health goal, including funding, facilities, transportation, information technology and workforce issues.

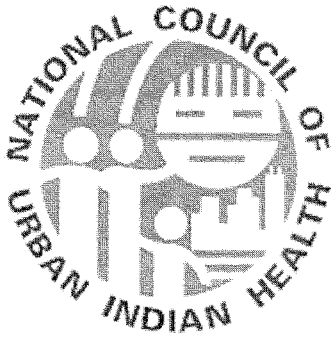
Adequately funded health care recruitment programs are much needed on the Navajo Nation. With a young Navajo population and a median age of 24 years, there are potential untapped resources in our youth. The Navajo Nation needs the support of federal, state, and other agencies to establish a Navajo Area Health Education Center to positively influence the young and offer recruitment, mentoring, and other programs on health careers. The staff recruitment and retention issues described above impact the quality of care and the continuity of health care to our people.

Poor roads in Indian Country can mean the difference between life and death. Tribal members, including the elderly, children and disabled, often must travel hundreds of miles to receive specialized care. Seventy-eight percent of our roads on Navajo Nation are unpaved. This combined with inadequate telecommunication capabilities and insufficient funding and resources for healthcare greatly increase these disparities. The rising cost of gasoline is now beginning to adversely impact the Navajo families as well as service providers.

The Navajo Nation urges the Federal government to meet its federal trust responsibility and treaty obligations to provide adequate healthcare funding to the Navajo Nation.

CLOSING REMARKS

On behalf of the Navajo Nation, thank you for allowing me to present testimony on Navajo Nation health care before the U.S. Senate Committee on Indian Affairs.



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THE URBAN INDIAN HEALTH CARE STORY: THE NEED FOR SERVICES

Testimony of

Beverly Russell, Executive Director
National Council of Urban Indian Health

Before the
Senate Committee on Indian Affairs
On
Urban Indian Health Care Issues

April 13, 2005

THE URBAN INDIAN HEALTH CARE STORY: THE NEED FOR SERVICES

"Between the intentions of the lawmakers and the reality of regulatory actions lies the *service gap* that confronts the urban Indian. The result is untold desperation and waste of human resources."

Final Report of the American Indian Policy Review Commission, Vol. 1, p. 436 (emphasis added).

I. INTRODUCTION

Honorable Chairman and Committee Members, my name is Beverly Russell, Executive Director of the National Council of Urban Indian Health (NCUIH). I am a member of the San Carlos Apache Tribe of Arizona. On behalf of NCUIH, and its 34 member programs, I would like to express our appreciation for this opportunity to testify before your Committee on urban Indian health issues.

Founded in 1998, NCUIH is the only national membership organization of urban Indian health programs. NCUIH seeks, through education, training and advocacy, to meet the unique health care needs of the urban Indian population. Title V urban Indian health programs provide a wide range of health care and referral services in 41 cities, actively serving approximately 150,000 urban Indians per year.[1] NCUIH is the successor organization to the American Indian Health Care Association, which provided advocacy and educational services on behalf of urban Indian health organizations for nearly 15 years prior to the establishment of NCUIH.

In general, my testimony will focus on the unique circumstances of urban Indians, the barriers they face in accessing health care and the Federal obligation to address urban Indian health care needs. I will also touch upon several significant issues in the proposed reauthorization of the Indian Health Care Improvement Act including the critical importance of providing Urban Indian Health Programs with access to the Federal Supply Schedule, as well as Federal Tort Claims Act coverage and a 100% Federal matching rate for Medicaid services.

II. GUIDING PRINCIPLES FOR URBAN INDIAN HEALTH PROGRAMS

In 1994, urban Indian health providers, during the tenure of the American Indian Health Care Association - NCUIH's predecessor organization - met in San Diego and adopted four "Guiding Principles." These principles still hold true for NCUIH's current efforts on behalf of

[1] According to the 2000 census, 66% of American Indians and Alaska Natives live in urban areas, up from 45% in 1970, 52% in 1980 and 58% in 1990.

urban Indians and directly address the relationships between and among urban Indians, Indian Tribes and the Federal government.

A. Sovereignty of the Tribes. The first principle addresses the understanding of urban Indians regarding the central importance of tribal sovereignty and the government-to-government relationship between Tribes and the United States:

> **Sovereignty of the Tribes:** ***We believe that tribal sovereignty, based on government-to-government treaties and trust responsibilities, along with certain moral obligations, of the United States government, is the foundation for all Indian affairs, including health care.***

In the National Steering Committee's deliberations there was recognition of the importance of emphasizing the sovereignty of tribal governments and the Federal government's trust obligation to Tribes and tribal peoples. There was also a recognition of the historical circumstances, largely a result of Federal government actions and policies, which gave rise to urban Indian communities consisting of Indians from a wide variety of tribal backgrounds (these circumstances are discussed in Section IV).

Although Congress has been specific about its commitment to both Tribes and urban Indians,[2] we recognize that, despite our common interest in health services, Tribes and urban Indians generally occupy different places in Federal Indian policy. Federally recognized tribes have sovereignty and a trust relationship with the United States; as a result there are many different federal laws addressing that relationship in such areas as land, water, criminal justice, and jurisdiction, which have no applicability to urban Indians. Although most urban Indians belong to federally recognized tribes, urban Indians do not aspire as such to be recognized as having sovereign powers or as being in a government-to-government relationship with the United States.

B. All Indian People. The second principle addresses the reality of the urban Indian experience.

> **All Indian People.** ***We believe that all Indian people, regardless of tribal affiliation, blood quantum, or their place of residence are entitled to all the necessary health resources and services to achieve the highest possible health status.***

Many Indians, from many different tribes have ended up in urban areas. As described in greater detail in Section IV below, for a variety of reasons, mostly traceable to federal government action, they find themselves among the ranks of the urban poor. Most are members of Federally recognized tribes; some are not. Many among the latter have become so disconnected from their tribes that it is difficult for them to obtain tribal membership, or their tribes have been terminated

[2] Congress has made clear, as set forth in the current Indian Health Care Improvement Act, "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).

or otherwise marginalized. Yet they are all Indian; they are recognized as Indian by their community; 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.

C. Traditional Medicine. For urban Indians, as much as for reservation Indians, traditional medicine is critically important to maintaining a connection with tribal and cultural identity and plays an important role in a holistic approach to their health.

> **Traditional Medicine.** ***We believe that traditional Indian medicine is intrinsic to our culture and essential to a holistic approach to healing the body, mind, and spirit of our people.***

Urban Indians stand shoulder-to-shoulder with their reservation brothers and sisters on the critical importance of preserving and integrating traditional medicine into Indian health programs.

D. Unified Urban/Tribal Partnership. We believe in working closely with the Tribes.

> **Unified Urban/Tribal Partnership.** ***We believe that a unified Indian partnership is vital to assure access to comprehensive health services to achieve the highest possible health status for all Indian people.***

Many tribal peoples live in urban areas; some permanently, some periodically.[3] However, in many urban centers, it is not practical for any one tribal government to set up an outreach to only its own tribal members. In fact, "in some urban centers, there are as many as 40 tribal governments nearby, and representation of tribes on urban Indian programs might include over 80 different tribes."[4] The urban Indians have developed skills necessary for survival (if not yet prosperity) in the urban environment;[5] the tribes are the great repository of cultural tradition and knowledge. The practical approach is the current approach: working together, Tribes and urban Indian health organizations can provide the best possible health care for our people. The extraordinary level of cooperation in the work of the National Steering Committee is proof positive of the value of this approach.

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[3] One Federal court has noted that the "patterns of cross or circular migration on and off the reservations make it misleading to suggest that reservations and urban Indians are two well-defined groups." United States v. Raszkiewicz, 169 F.3d 459, 465 (7th Cir. 1999)

[4] U.S. Congress, Office of Technology Assessment, *Indian Health Care*, OTA-H-290 (Washington, DC: U.S. Government Printing Office, April 1986), p. 38.

[5] "The Committee views the health dilemma of urban Indians as a serious obstacle in their quest to become self-sufficient and participating citizens. Fortunately, an evolving Congressional policy addressed to this problem has served to provide the essential experience and information for the provisions contained in Title V. That evolving policy has been built on the concept of self-determination with the Indians themselves managing federally subsidized health efforts tailored to fit the health circumstances of Indian populations residing in specific urban centers." H.Rep. No. 9-1026, 94th Cong., 2d Sess. 18, reprinted in 1976 U.S. Cong. & Admin. News (USCAN) p. 2652 and 2752.

III. HEALTH STATUS OF URBAN INDIANS

According to a fact sheet developed by the National Urban Indian Policy Coalition urban Indian unemployment is double that of all other races [in some cities, like Boston, there is evidence that the Indian unemployment rate is quadruple the rate for all other races]; urban Indian poverty levels are three times that of any other race; the urban Indian high school drop out rate is over 75%; the urban Indian business development rate is the lowest of any race; urban Indians have higher mortality rate from alcoholism and related causes than other races; the urban Indian suicide rate is four times that of all other races; and urban Indians have three times the national rate for diabetes and heart disease.

NCUIH has consulted with the Urban Indian Health Programs to identify 19 program priorities of equal importance to address the health care crisis among urban Indians. They are as follows:

- Diabetes
- Cancer
- Alcohol and Substance Abuse
- Heart Disease
- Mental Health
- Maternal and Child Health
- Dental Health
- Injuries
- Elder Health
- Respiratory / Pulmonary
- Violence / Abuse
- Infectious Disease
- Hearing Disease
- Eye Disease
- Health Promo / Disease Prevention
- Tobacco Cessation
- Information Technology Support
- Maintenance and Repair
- Facilities and Environmental Health Support

IV. BARRIERS TO MAINSTREAM HEALTH CARE EXPERIENCED BY URBAN INDIANS[6]

> **"The lack of employment opportunities leads to a downward spiral that reduces the urban Indian's life to a struggle for subsistence. For example, the private practice system of health care is certainly beyond the financial reach of most newly arrived urban Indian families. They must depend on public services. Yet here, the *service gap* reveals itself again."**
>
> Final Report of the American Indian Policy Review Commission, p. 437 (emphasis added).

The status of Urban Indian health is as poor as that for reservation Indians.[7] This section describes the many barriers that Urban Indians face in their efforts to access adequate health care in the urban environment:

Physical/geographic barriers can include (1) telephone availability; less access to transportation; and (3) high mobility. Many Native Americans do not have phones, increasing the difficulty in making appointments. For example, in Arizona, thirty percent of urban Indians have no household access to phone services. Indian people have much less access to private vehicles than the general population. Not having a vehicle creates barriers for people who must make arrangements with others to bring them to appointments. Public transportation (if available) makes for a longer travel time and can be costly. The high mobility of Indian people is another barrier to care. People who move often are not able to follow with the same provider, and this disrupts continuity of care and can lead to a decrease in the quality of care. When a person moves to another area, they must go through the system again to qualify for benefits, locate a provider, and receive care. In addition, movement back and forth between the reservation is common, which can significantly affect the ability of health professionals to provide prompt, quality follow-up care.

Financial/Economic barriers also contribute to the poor quality of urban Indian health care. People who do not have the resources, either through insurance or out-of-pocket, to pay for prevention and early intervention care may delay seeking treatment until a disease or condition has advanced to the stage where treatment is more costly and the probability of survival or correction is lower.

Medicaid is available for urban Indians, but difficult to access. Applying for Medicaid or other medical assistance is a long and detailed process, presenting many barriers to people who don't understand the system or lack the necessary skills to complete the paperwork involved. Furthermore, the required documentation is difficult for many urban Indians to obtain.

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[6] For more details on these issues see the September 30, 1989 report prepared for the American Indian Health Care Association, by Ruth Hograbe, R.D., M.P.H., Program Analyst and Donna Isham, Program Analyst. The framework for the report is the 1988 report Minority Health in Michigan: Closing the Gap.

[7] See Attachment A for a leading study on Urban Indian health: *Health Status of Urban American Indians and Alaska Natives*, Grossman et. al, Journal of the American Medical Association, Vol. 271, No. 11, p. 845.

For example, if one does not have a car, one may not have a drivers license. With high mobility among urban Indians, there is likely to be no documentation with the current address; or if they have just moved to the city from the reservation, there may be no birth certificate or identification. Once an individual is accepted, access to care is not guaranteed. Because of Medicaid reimbursement rates and restrictions, many providers are reluctant to accept Medicaid patients.

Health insurance coverage does not automatically remove financial barriers to care. Many persons, particularly those employed at or near minimum wage, have coverage through plans that do not cover preventive or major medical care. While professional positions generally provide health insurance, service and laborer positions generally do not. Urban Indians hold more of those occupations that do not provide health insurance benefits. Deductibles and co-payments are high enough that many persons who do have health insurance cannot afford to pay them and consequently do not seek care.

No insurance or assistance is another common barrier. Those who have no means to pay for care are often turned away. There is a high rate of urban Indians who are uninsured. For example, in Boston, 87% of the Boston Indian Center's clients have no health insurance, and two out of every three urban Indians in Arizona are uninsured.

Emergency room use is high among the poor, minorities and the uninsured. Unfortunately, emergency room use as a primary medical resource is costly and compromises quality care. Follow-up and preventive services are not possible with emergency room personnel serving as primary care providers. In Arizona, urban Indians use the emergency room 250% more often than the general public.

Cultural/structural barriers also exist for urban Indians receiving health care. The Indian Health Service conducted a survey which concluded that the majority of state, county and city health departments do not have the resources to meet the health care needs of urban Indians. Major stumbling blocks are inadequate funds and lack of staff trained to work with American Indians in a culturally sensitive way. Indians may be reluctant or unable to describe their health needs to strangers outside their own culture. Frequently, mainstream providers misunderstand or misinterpret the reticence and stoicism of some Indians. Other factors include a lack of trained Indian health professionals that get placed in urban Indian health programs and inadequate Indian outreach.

V. FEDERAL POLICIES AND THE URBAN INDIAN

> **"Most Indians who migrate to the cities say they would have preferred not to do so at all."**
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> Final Report of the American Indian Policy Review Commission, Vol. 1., p. 436.[8]

[8] For a more detailed summary of the history of off-reservation Indians see Attachment B, which is the relevant chapter from the Final Report of the American Indian Policy Review Commission.

The urban Indian is an Indian who has become physically separated from his or her traditional lands and people, generally due to Federal policies. 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. The result of this "course of dealing," however, is the same - a Federal obligation to urban Indians.[9]

A. The Federal Relocation of Indians. The BIA's Relocation program originated in the early 1950s as a response to adverse weather and economic conditions on the Navajo reservation. A limited program was initiated to relieve the crisis by finding jobs for Navajos who wanted to work off the reservation as little or no job opportunities existed on the reservation. Shortly afterward, the BIA converted its Navajo program into a full-fledged Bureau of Indian Affairs program applicable to many Indian tribes.

The BIA employees who developed the program made many mistakes and miscalculations. Even before the 1950's had ended there was concern that many relocatees were experiencing great difficulty adjusting to life in a large city, or to their jobs. Some felt they were being stranded far away from home. Solving reservation economic problems by relocating Indians off of their tribal lands is roughly the equivalent of the Federal government, during the Depression, sending Americans overseas to find work – something the Federal government would never have done. Many understood the relocation program as just another form of "termination." A Jesuit priest on the Fort Belknap Reservation noted that relocation programs drained the reservation of much of its potential leadership, further weakening tribal governments.

All told, between 1953-1961, over 160,000 Indians were relocated to cities.[10] Where they quickly joined the ranks of the urban poor.[11] Set forth below in *italics* is a description of the experience of Indians who relocated.

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[9] The unique legal relationship of the United States with Indian tribes and people is defined not only in the Constitution of the United States, treaties, statutes, Executive orders, and court decisions, but also in the "course of dealing" of the United States with Indians. As the Supreme Court noted in a major Indian law case, "[f]rom their very weakness and helplessness, so largely due to the *course of dealing* of the federal government with them, and the treaties in which it has been promised, there arises the duty of protection and with it the power." *United States v. Kagama* (1886) (emphasis added). Congress acknowledged this in its findings to the Native American Housing Assistance and Self-Determination Act (NAHASDA): "The Congress through treaties, statutes *and the general course of dealing* with Indian tribes, has assumed a trust responsibility . . . for working with tribes *and their members* to improve their housing conditions and good economic status so that they are able to take greater responsibility for their own economic condition." 25 U.S.C. 4101(4). Notably, NAHASDA also applies to state-recognized tribes. 25 U.S.C. 4103(12)(A).

[10] 1992 Roundtable Conference, Urban Indian Health Programs, Indian Health Service, "Working in Unity Toward our Future." p.2.

[11] "Unfortunately, far too many Indians who move to the cities, because of inadequate academic and vocational skills, merely trade reservation poverty for urban poverty." H.Rep. No. 9-1026, 94th Cong., 2d Sess. 18, reprinted in 1976 U.S. Cong. & Admin. News (USCAN) 2652, p. 2747.

URBAN GENOCIDE - THE INDIAN IN THE CITY (excerpts)[12]

"The economic status of the reservation Indian is far below the poverty bracket. This is due to the lack of employment both on and off the reservations with the exception maybe of the larger cities. The main source of employment to be found on most reservations is working with the Bureau of Indian Affairs. In this way, the "Bureau" can instill its white culture on the Indians and eventually brainwash them into working against their own people. The reservation towns bordering the reservations can offer no employment for Indian people because of the great amount of racism, discrimination and prejudice that exist among the whites and other non-Indians.

"Consequently, the bad conditions and individual economic situations that have evolved from these indignities have forced the Indians to seek other sources of employment and education. With 75 percent of the Indian population unemployed for three generations, parents of Indian children could not, and still cannot afford to send them to public schools and have to depend on the government to educate them in "free" government boarding schools. Since it was a law to send their children to school, small children were forced to leave their parents and be shipped off to school thousands of miles away from their homes. These Indian boarding schools, established in various areas, were the prime weapons used to inculcate the white culture among the children or, in the common terms used at that time, "to civilize the barbarians." Any part of the Indian culture was forbidden and the children were physically beaten if they used their native tongue or practiced their own dances. It has not been until just recently that this law has been officially lifted and is not in force, but the principle motive of de-Indianizing the Indians is still in effect.

"During the summer months while school is not in session, they send these Indian students to white homes to work as indentured servants. After graduation, they are sent directly out on relocation from the schools into the cities.

"Conveniently enough, the relocation program has been established to speed assimilation of Indians into the cities at this time of dead-end streets, reservation confusion and unemployment. Through this program they relocate the younger Indians from the ages of 18 to 36 on direct employment or vocational training. It is a one-way ticket to the city in hopes that you will melt with the melting pot and forget you are Indian or still have a reservation that the white man does not have yet.

"Numerous problems have developed as the result of the "dislocation program," therefore the following chapters will focus on the urban Indian situation.

What Happens to the Indians After Arrival in the Cities

"On arrival to the city on relocation, the individual Indian has in his possession an envelope with orders and instructions, telling where to go and what to do. First of all, he is to

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[12] This document was obtained from the National Urban Indian Policy Coalition. The author of this piece is unknown.

report to the Bureau of Indian Affairs if he arrives during office hours. If not, he reports to a BIA-approved hotel until the next day if he has any money.

"If they have time to see you the first day, they dole out a small amount of money to last until the end of the month if he is on the training program or until the next week if he is seeking employment. If they do not have time to see him the first day, he is to come back the following day at office hours and maybe some one will see him. In the meantime, he can sleep in the park or walk the lone deserted streets all night long.

"When he is received at the BIA headquarters in the city, he attends a short orientation period and an elderly lady will counsel him about sex and how to dial "0" for the operator on the telephone. A brief question and answer period follows and he is told to come back the next day at eight AM or to report to his designated school.

"The BIA locates his place of residence in the city and he is required to stay there if he is a student. They will discontinue his subsistence if he opposes and he will not be eligible for any more aid.

"The vocational school he is sent to may not be the particular training he originally signed up for back on the reservation, but this is the school he is required to attend.

"If the relocatee signed up for direct employment, he must take the first job available even if it is not his trade or type of work he wants. He is told it will be temporary until the type of job he wants comes up but after he receives his first salary on his temporary janitor job, he is cut off their records and cannot receive any additional help after he quits, gets fired or the job runs out.

"The "Bureau" pays the student's tuition in the vocational school directly to the school. The student receives subsistence twice a month, doled out in payments of $74.00. From this amount, he must budget $59.00 per month per rent, and the other $15.00 must be divided into his expenses for food, cab fare, medical care, clothes and whatever else that should develop during the month. This budget was made up in 1953 when the program first developed and has not taken into consideration the rises in living and the area or city he is in. California has the highest cost of living especially in San Francisco, which is the central concentration point of relocatees coming from every reservation in existence today. This income is far below the poverty bracket nation-wide, yet this is the "help" the Indian Bureau is giving.

"All persons on the relocation program are issued a medical card which they can present to a physician and receive medical help up to a six-month period. The only problem here is that these medical cards only guarantee to pay $4.00 of the entire bill when the office calls alone are $5.00 at the very minimum.

What Problems They Face and Why

"The cultural background of the American Indians differs extremely from the white culture, creating a problem of communication between the two. Not only this, but the Indian

culture has also been corrupted, bringing about a drastic change of social environment. This disintegration of culture has been attributed to disturbing early experiences in school, the generally poor level of education, poverty and the ambivalent position of the government in relation to the Indian.

"Prejudice and discrimination which does exist near reservations or anyplace where there is a large concentration of Indians, (although now in the city and away from being singled out as being an Indian), tends to have developed hostile and stereo-typed attitudes towards the other groups of society. The Indians have also collectively experienced a deterioration of personality, self-doubt, self-hate, impulsive and suspicious behavior, feelings of inferiority, deviant behavior, mental illness and suicidal tendencies.

"Depending on the environmental background, these adverse behaviors vary. Individual exceptions are due to the degree of orientation to the white culture or restored self-image through education.

"In dealing with the many Indian people who go through the BIA agencies, or any other type of agency established in the cities for employment or vocational training, the employees lack the experience of knowing the type of environment the individual Indian has been subject to and they do not know how to handle his particular situation. In many cases even where minority people hold agency positions, generally, they have developed superiority attitudes over the people they are trying to help and therefore stunt their full capabilities for helping others.

"[Many businesses] resent the BIA in its assistance of seeking employment for the Indian relocatees. This is due to the business' general dislike of any form of government transactions or to be told how to run their business concerns. This creates a great amount of conflict and the BIA, in order to retain a certain amount of prestige, often finds the Indian relocatee employment with a business concern that pays a low wage scale, hard labor with no company obligations, such as insurance policies, sick leave and vacation with pay. These small businesses often take no safety precautions and are constantly hood-winking the safety inspectors. Consequently, the Indian relocatees are more or less siding with the illegal aspects of the concern in which they are employed in order to retain their jobs. Employment competition is great and the relocatees can be dismissed from their job for little or no cause at all, and they are often plagued by this fear of being fired.

"In the event that a relocatee is fired for one reason or another and needs assistance, he cannot go back to the BIA for further help. The BIA tells him that his files have been sent back to his agency and they have no more funds or time to help him because their hands are tied with the other relocatees who are coming in.

"The budget set up for financing a student in vocational training are not only inadequate for one person's needs, but are not set to the area standards of living. In other words, they are transformed from one pocket of poverty to another, which in this case would be from a reservation to an urban ghetto.

"The vocational schools that Indian relocatees are sent to, in most cases are not accredited and after graduation from one of these schools, the relocatee cannot obtain a job. Most of the teachers in vocational schools are not qualified teachers, and there is a great shortage of instruction. The BIA gives the schools extra money for materials yet the conditions and facilities in these schools are still very bad. The students come out of these schools unqualified and inexperienced in the type of work for which they thought they had been trained and cannot find suitable employment.

"There are more and more students who are sick and tired of being treated as second-class people who do want to get a decent education and go to junior colleges and universities. The biggest problem here is not being able to get any finances, "Bureau" or otherwise. Also, Indian students' second-rate educations do not prepare them well enough for college work. Most reservation Indians are subject to irregular school and employment backgrounds and a great majority of the younger Indians have criminal or prison records. This does not mean that they cannot do the work academically; but, basically, they have never had the full opportunity to do so.

"The Bureau of Indian Affairs sends newly-arrived relocatees to unsanitary, immoral, crowded and unsafe places of residence. If the student wants to leave these conditions, the landlord promptly calls the BIA about the matter and the student is required to live there or have his subsistence discontinued. In one of the girls' boarding homes the landlady encouraged parties and drinking and let the girls' boyfriends come over. Then she would go into their rooms and take pictures of the different couples sleeping together. If the girls wanted to leave, she would then threaten to blackmail them with the pictures she had and in this way would keep her business. A business college for female relocatees also housed the students, putting four girls to one small room and charging $100 per person, not including food or utilities. This establishment also received additional money from the BIA for recreational purposes which the girls never did see. If the girls tried to leave their residence, they were threatened with expulsion from the business college and have their subsistence discontinued. Most of these young Indian girls were between the ages of 18 to 20 years, who were eventually expelled for little or no reason and left to roam the city streets. Individual follow-up showed that 80 percent of these girls got pregnant, were drinking excessively and were living with men from time to time. This college is still in operation receiving relocatees from the Bureau of Indian Affairs.

"A boys' boarding house in the city was over-crowded with four bunks to a room, no studying facilities, unsanitary conditions, inadequate food and displaying a sign in the front of the house, CONDEMNED.

"These are typical living conditions, Indian youth are subject to when placed in the city through relocation. When a young Indian approached a BIA counselor why they had to live under such adverse conditions and was told, "The filthiest conditions you Indians are put under, the more at home you will be."

"Landlords and vocational schools are getting wise to the BIA and are making the largest profit and racket out of the Indian business at the cost of young Indian lives.

"Indian health is generally poor due to the economic standards and lack of proper diet and nutrition. Free medical facilities are provided on all reservations due to the unsatisfactory health conditions. Tuberculosis, cirrhosis of the liver, sugar diabetes, and trichoma are a few of the more prevalent diseases which Indian people are susceptible to. Trichoma, which is an eye disease, is very rarely heard of among Indians. Poverty conditions breed diseases.

"The BIA believes that when an Indian leaves the reservation, he suddenly leaves his "Indianness" and becomes a healthy, happy human being, and needs no more of the medical services he had before. Consequently, Indian health in the city becomes twice as bad as it might have been before because he cannot afford good medical care.

"Pregnant Indian women risk possibly losing their child by having to return to the reservation their last month so that they can receive medical care upon delivery of their baby.

"From the time Indians were victims of wars, they lost their identity which comes from pride and self-esteem. Indians became a lost people exhibiting schizoid behavior at times. An Indian who does not like himself, does not like other Indians because he can see himself reflected in the others. An Indian suffers from inferiority plus self-hate that leads to trying to escape these unbearable conditions. By escaping, he is rejecting the society that has made him this way. His means of escape is either through alcohol or suicide which are 100 percent times higher than the national average among the American Indians.

"An internal problem of self-identity and lost culture plus an external problem of discrimination and racism by people in power has suppressed and made what is left of the American Indian today."

Today, the children, grandchildren and great-grandchildren of the 160,000 Indians relocated by the BIA are still in the cities. They maintain their Indian identity even if, in some cases, these "descendants have been unable to re-establish ties (including membership) with their tribes."[13]

B. Failure of Federal Efforts to Economically Develop the Reservations. The second major reason Indians have moved to the city is the near total failure of Federal programs to promote economic development on Indian lands, coupled with the ongoing success of the Federal efforts in the 1800's to undermine the economic way of life of Indian peoples, locking nearly all Indians into hopeless poverty which still plagues most reservations today. The long history of treaty-breaking by the Federal government is an important part of this tale. As a result, out of desperation, a number of Indians have left their homelands to go to the cities in search of work, even without the dubious benefit of the BIA's relocation program. Generally, these Indians were no better equipped to handle life in the city than the BIA relocatees and

[13] See Office of Planning, Evaluation and Legislation, Indian Health Service, Impact of the Final Rule Final Report, Contract No. 282-91-0065, "Health Care Services of the Indian Health Service" 42 CFR Part 36, p. 22-23.

quickly joined the ranks of the urban poor. Congress has noted the correlation between the failure of Federal economic policies and the swelling of the ranks of urban Indians: "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."[14]

C. Termination of Tribes. In 1953, Congress adopted a policy of terminating the Federal relationship with Indian tribes. Essentially, this was an abrogation of the Federal government's numerous commitments, in treaties, laws, executive orders, and through the "course of dealing" with Tribes, to protect their interests. Many tribes were coerced to accept termination in order to receive money from settlements for claims against the United States for misappropriation of tribal land, water or mineral rights in violation of treaties.[15] The results of termination were devastating: having lost Federal support, and without tribal sovereign authority over an established land basis, and with tribal members no longer eligible for Federal programs and IHS services, the Tribes collapsed. Some members remained in the area of their old reservations; many went to the cities, where they, too, joined the ranks of the urban poor.

D. Indian Patriotism -- World War I and World War II. Many Indians served the United States in time of war[16] and, subsequently, were stationed in or near urban centers. At the end of their service to the United States, seeing the poor economic conditions on their reservations (resulting from the Federal war on Indians), many chose not to go back. The fact that they chose to stay in an urban area did not make them any less Indian, nor did it reduce the Federal government's obligation to them.

E. The General Allotment Act. The General Allotment Act ("Dawes Act") had two principal goals: (1) by allocating communal tribal land to individual Indians it would breakdown the authority of the tribal governments while encouraging the assimilation of Indians as farmers into mainstream American culture; and (2) it provided for unalloted land (two-thirds of the Indian land base) to be transferred to non-Indians. CITE. The General Allotment Act succeeded at transferring the majority of Indian land to non-Indians and further disrupting tribal culture. For the purposes of this testimony, we only need to note that some Indians who received allotments became U.S. Citizens and, after losing their lands, moved into nearby cities and towns.

F. Non-Indian Adoption of Indian Children. The common practice of adopting Indian children into non-Indian families has created another group of Indians in urban areas who, because of the racial bias of the courts, have lost their core cultural connection with their tribal

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[14] Pub. L. 94-437, House Report No. 94-1026, June 8, 1976, 94th Cong., 2d Sess. 18, reprinted in 1976 U.S. Cong. & Admin. News (USCAN) 2652,at p. 2754.

[15] Office of Planning, Evaluation and Legislation, Indian Health Service, Impact of the Final Rule Final Report, Contract No. 282-91-0065, "Health Care Services of the Indian Health Service" 42 CFR Part 36, p. 23.

[16] It is in part because of their gallant service in World War I that the U.S. Congress granted U.S. citizenship as a group to American Indians in 1924.

people and homelands. Many of the adopted Indians have successfully sought to restore those connections, but because of their upbringing are likely to remain in urban areas.[17]

G. Boarding Schools. The Federal program of taking Indian children and educating them away from their reservations in boarding schools where they were prohibited from speaking their native language and otherwise subject to harsh treatment, created a group of Indians who struggled to fit back into the reservation environment. Eventually, some moved to the cities. The boarding school philosophy of "Kill the Indian, Save the Man" epitomizes the thinking behind this approach and the racist Federal effort to assimilate American Indians which, as a result, led to a number of Indians moving to urban areas.

H. The Fracturing of the Indian Nations. The result of these, and other Federal Indian policies, has been the fracturing of Indian tribes and the creation, in the urban setting, of highly diverse Indian communities with members who fall into one or more of the following categories: Federal relocatees; economic hardship refugees; members of Federally recognized tribes, terminated tribes, state recognized tribes, and unrecognized Tribes (that is, unrecognized by the Federal government);[18] and adoptees.

The urban Indian community consists of Indians from a wide variety of backgrounds, almost all of whom can tie their urban existence to some Federal policy or action. Many of these Indians are in urban areas due to some traumatic disruption in their connection with their Tribes, or because something has happened to their Tribes (termination or marginalization such that they are not currently federal recognized). As a result, unlike the Indian population on reservations, most, but not all are members of federally recognized tribes. Yet they are all Indian; they are recognized as Indian by their community; 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.[19]

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[17] In recognition of the severity of this problem, Congress passed in 1978 the Indian Child Welfare Act to give Tribes and Indian parents a greater say in the adoption process for Indian children. See Indian Child Welfare Act of 1978, 25 U.S.C. Sections 1901-1963.

[18] There are still scores of tribes working their way through the byzantine acknowledgement process, which is widely criticized for its glacial pace and alleged bias against certain Indian groups.

[19] The Executive Director of the Seattle Indian Health Board, Ralph Forquera, M.P.H., commented eloquently on this issue in a May 24, 2000 letter to NCUIH:

> "There are two principle reasons why I believe that the definition should remain as is [i.e., including certain Indian populations that are not federally recognized]. First, the Act itself continues to address the health needs of all Indian people, not just those living on or near reservations. The redesign of the Indian Health Service in 1996 and adoption of the I/T/U model further supports this claim. Clearly the Congress intended for there to be a separation between 437 and 638. Thus, the adoption of the 638 language now [which would have excluded certain Indians now covered by the Indian Health Care Improvement Act], in my opinion, would tarnish the original Congressional intent by shifting the Act to a tribally based orientation.
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> "Second, the conditions that lead to the original enactment of both the Act itself and Title V in particular have not changed. There remains a large and growing group of Indian people who are handicapped by poverty, inadequate education, and other socio-economic challenges that

VI. THE FEDERAL GOVERNMENT AND THE PROVISION OF HEALTH CARE TO URBAN INDIANS

The Congress has long recognized that its obligation to provide health care for Indians, includes providing health care off 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).[20] Congress has "a responsibility to assist" urban Indians in achieving "a life

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contribute to diminished health status. Many continue to be victimized by alcoholism, violence, and the myriad temptation that diminish one's capacity to achieve optimal health. The social dynamics that served to disenfranchise Indians throughout the century remain. Indians, particularly in cities, continue to struggle with identity and acceptance both within Indian Country and within the nation as a whole.

"But perhaps the most compelling reason to continue the broader definition of Indian is the psychological benefits. The ability of urban programs to provide the gift of acceptance to those Indians who by circumstances or policy were denied their rightful identity as an Indian person is vital, in my opinion, to improving the health status of this group. Only in the past few years have I personally begun to appreciate the tremendous emotional burden many Indian people have had to bare by being denied their identity through structural limitations. Not knowing who you are is one thing; but knowing and not feeling accepted by your peers has devastated many Indian people. I have had the good fortune to witness the positive effect that acceptance can play in the lives of several here in Seattle. The health effect of this simple practice is enormous."

[20] "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-determination and local control in establishing their own health programs."

of decency and self-sufficiency" and has acknowledged that "[i]t 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. Unfortunately, the same policies and programs which failed to provide the Indian with an improved lifestyle on the reservation have also failed to provide him with the vital skills necessary to succeed in the cities." House Report No. 94-1026 on Pub. Law 94-437, p. 116 (April 9, 1976).

The Supreme Court has also acknowledged the duty of the Federal government to Indians, no matter where located: "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 other 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).[21]

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).

The courts have also stated that there is a trust responsibility for individual Indians. "The trust relationship extends not only to Indian tribes as governmental units, *but to tribal members*

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.

[21] Federal responsibility for Indian health care is frequently declared "primary" but it is not exclusive and preemptive of state responsibility. See *McNabb v. Bowen*, 829 F.2d 787, 792 (9th Cir. 1987). 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.

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 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 . . . .*"
>
> 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,[22] but also in

[22] 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.

NAHASDA, that certain state-recognized tribes or tribal members are eligible for certain Federal programs. 25 U.S.C. Section 4103(12)(A).

VII. REAFFIRMING FEDERAL SUPPORT FOR URBAN INDIAN HEALTH CARE IN THE REAUTHORIZATION OF THE INDIAN HEALTH CARE IMPROVEMENT ACT

NCUIH has generally supported the recommendations of the National Steering Committee for the reauthorization of the Indian Health Care Improvement Act. However, in the course of previous testimony we have made several recommendations for refinements. One recommendation that I would like to highlight here is the need to assure that the IHCIA's policy statement clearly includes "urban Indians." The existing Indian Health Care Improvement Act includes urban Indians in the Congressional policy statement:

> "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.
>
> "(b) It is the intent of the Congress that the Nation meet the following health status objectives with respect to Indians *and urban Indians* by the year 2000:"

25 U.S.C. Section 1602(a)-(b) (emphasis added). Over the last several years, some versions of the Indian Health Care Improvement Act reauthorization legislation did <u>not</u> include a reference to urban Indians in the equivalent paragraphs. Removing "urban Indians" from this important policy statement would imply that the Congress no longer considers the health status of urban Indians to be a national priority. We have been informed that this was an oversight and ask that the Committee ensure that "urban Indians" are included as recommended below:

> ***"SECTION 3. DECLARATION OF HEALTH OBJECTIVES***
>
> *"Congress hereby declares that it is the policy of the United States, in fulfillment of its special trust responsibilities and legal obligations to the American Indian people--*
>
> *"(1) to assure the highest possible health status for Indians <u>and urban Indians</u> and to provide all resources necessary to effect that policy;"*
>
> *(2) to raise the health status of Indians <u>and urban Indians</u> by the year 2010 to at least the levels set forth in the goals contained within the Healthy People 2000, or any successor standards thereto;"*

VIII. HISTORIC PERCENTAGE DECLINE IN FUNDING FOR URBAN INDIAN HEALTH PROGRAMS

In FY 2005, Urban Indian Health Programs received 1.06% of the total Indian Health Service budget. The President has proposed in his FY 2006 budget to reduce Urban Indian programs to just 0.9% of the IHS budget. In 1979, at a time when off reservation American Indians/Alaska Natives made up a smaller percentage of the overall Indian population, the urban Indian programs received 1.48% of the Indian Health Service budget.

Disease knows no boundaries. As one Federal court has noted, the "patterns of cross or circular migration on and off the reservations make it misleading to suggest that reservations and urban Indians are two well-defined groups." *United States v. Raszkiewicz*, 169 F.3d 459, 465 (7th Cir. 1999). With the 2000 census showing that well over half of the Indian population now resides in urban areas, we strongly believe that the health problems associated strongly with the Indian population can only be successfully combated if there is significant funding directed at the urban Indian population, as well as the reservation population.

The National Council of Urban Indian Health has asked for a $12.2 million dollar increase to the President Bush's proposed FY06 budget for Urban Indian programs as a first-step towards addressing this funding gap. This increase will elevate the Urban Indian Health Program funding from $31,816,000 to $44,016,000. While this cannot address the total need, it will make a huge difference in access to and quality of care for American Indians/Alaska Natives living in urban areas.

The rationale for the proposed increases is based upon:

- The steady decline of funding since 1979 when the program received 1.48% of the IHS budget to 2005 when the program received 1.06% of the IHS budget.
- The unmet need of 2 billion dollars and the actual appropriation of only $30 million. The urban Indian health programs can only serve 100,000 Indians of the 1 million eligible Indians residing in the urban setting.
- The need to conduct a planning study on the18 new urban Indian health programs throughout the United States.
- To enhance the soon to be transferred urban Indian health program Alcohol and Substance Abuse programs into Title V.
- The development of the urban Indian health centers of excellence.
- The enhancement of the urban Indian health program epidemiology center in Seattle, Washington.
- To continue to establish an automated mutually compatible information system to capture health status and patient care data for urban Indian health programs.

- To enhance existing programs in order to enable them to be elevated to provide the highest level of quality health care.

IX. FEDERAL TORT CLAIMS ACT COVERAGE IS ESSENTIAL TO THE EFFECTIVE DELIVERY OF URBAN INDIAN HEALTH CARE SERVICES

The ability of Urban Indian Health Programs to provide cost-effective health services has been jeopardized by the lack of FTCA coverage commonly accorded other federally funded Indian health programs. The skyrocketing cost of malpractice insurance in recent years has compromised the scope of services that Urban Indian Health Programs can provide pursuant to contracts or grants that they receive from the Indian Health Service. Because of this, the fulfillment of the Federal government's trust responsibility to Indian peoples, as well as the effective implementation of IHS's Urban programs, has been seriously undermined.

Consistent with the Federal government's trust responsibility to Indian peoples, Congress has funded, through the Indian Health Service, 34 Urban Indian Health Programs. As the Senate has noted:

> "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).

Since 1990, FTCA coverage has been provided to tribes and tribal organizations that have contracts with the Indian Health Service. The Urban Indian Health Programs secure their Federal funding from the exact same source as the tribes and tribal organizations and for the exact same purpose – to provide health care services to Indians in accordance with the Federal trust responsibility. Notably, the FTCA coverage provided to tribes and tribal organizations also covers individuals who provide health care services under a personal services contract in an IHS facility (25 CFR 900.193), as well as services provided under a staff privileges agreement with a *non-IHS facility* where the agreement requires a health care practitioner to provide reciprocal services to the general population (25 CFR 900.194). If these individuals and these services have FTCA coverage, as well as tribes and tribal organizations, then urban Indian health programs should have similar coverage.

There is a mistaken impression that urban programs are serving non-Indians and that, therefore, they are not fulfilling a federal purpose and FTCA coverage is not appropriate. Those few Urban Indian Health Programs that serve non-Indians are already

classified as Community Health Centers, receive Section 330 funds and, therefore, have FTCA coverage. The vast majority of Urban Indian Health Programs limit their services to Indians, are not Section 330 Community Health Centers and, therefore, do not have FTCA coverage.

There is a mistaken impression that most, if not all, Urban Indian health programs can secure FTCA coverage as Federally Qualified Health Centers. Based on the experience of one urban Indian health program that sought FQHC status, the process is ambiguous (it does not clearly provide for urban Indian programs to receive such status), time-consuming (18 months), costly and, at the end, of dubious benefit (this program only secured "look-a-like" FQHC status which, apparently, does not include FTCA coverage). It is essential that the issue of FTCA coverage be clearly addressed for Urban Indian Health Programs.

According to a recent survey, only one of the 34 Urban Indian Health Programs has been the subject of a malpractice claim. Due to the relatively limited nature of the services they provide, the actual risk of a claim against an Urban Indian Health Program is low and, therefore, the cost to the United States of providing FTCA coverage would be low. However, this has not deterred the insurance companies from charging ever more exorbitant rates.

In some areas, there are few insurance carriers available, so the carriers use this leverage to make other demands. One Urban Indian Health Program, which serves a large number of Navajo patients and was located relatively closely to the Navajo reservation, had a carrier state that it would not renew coverage out of fear that it would get dragged into the tribal courts. Despite detailed explanations as to why this was unlikely, the carrier would not relent. At the last hour, the program changed the status of its doctors from employees to independent contractors in order to maintain insurance coverage. Although a fix was found, it caused substantial problems for all parties concerned.

The FTCA's limited waiver of the federal government's sovereign immunity is now extended to tribes, tribal organizations and to non-tribal community health centers. It is illogical, and undermines the fundamental purpose for establishing federally funded urban Indian health programs, to not extend coverage to them as well. Section 515 of the Indian Health Care Improvement Act (S. 556) is essential to the future well-being of these programs and to the provision of basic services to urban Indian communities and should be preserved in the final version of this important legislation.

X. FEDERAL SUPPLY SCHEDULE PRICING FOR PHARMACEUTICALS FOR URBAN INDIAN HEALTH PROGRAMS

The ability of Urban Indian Health Programs to provide cost-effective pharmaceutical services depends on access to the Federal Supply Schedule. Pharmaceutical costs have skyrocketed. Notably, many Americans now travel to Canada to purchase their prescription drugs. This option is not viable for most urban Indian communities and is not preferable to receiving properly dispensed pharmaceuticals from an urban Indian health program. Without access to the Federal Supply Schedule, the fulfillment of the Federal government's trust responsibility to Indian peoples, as well as the cost-effective implementation of IHS's Urban programs, is seriously impeded.

Only five of the 34 Urban Indian Health Programs have access to federally discounted pharmaceuticals. All five of these are accorded this savings by virtue of their status as Section 330 community health centers. The rest of the Urban Indian Health Programs do not have this status and are not in a position to readily attain it. Instead, they look for the cheapest supplier on the market, usually paying far higher than the Federal Supply Schedule rate. As a result, the average expenditure on pharmaceuticals by a UIHP is $134,000/year, which for these small programs is a disproportionately and unnecessarily high portion of their total budget that substantially restricts the provision of other services.

Tribes and tribal organizations that have contracts with the Indian Health Service already have access to pharmaceuticals at Federal Supply Schedule pricing. Tribes and tribal organizations receive this access based on the Federal trust responsibility and on a commonsense commitment to maximizing the value of Federal dollars, not based upon their status as governmental organizations. The Urban Indian Health Programs secure their Federal funding from the exact same source as these tribes and tribal organizations and for the exact same purpose – to provide health care services to Indians in accordance with the Federal trust responsibility. For the same reasons, therefore, urban Indian health programs which utilize federal funds should also have access to the Federal Supply Schedule.

Consistent with the Federal government's trust responsibility to Indian peoples, Congress has funded, through the Indian Health Service, 34 Urban Indian Health Programs. Urban Indian Health Programs are a direct and important manifestation of the Federal government's trust responsibility to Indian peoples. As the Senate has noted:

> "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).

A legislative solution to this inequity. Section 517 of the Indian Health Care Improvement Act provides, among other things, that urban Indian organizations that have entered into a Federal contract or received a Federal grant pursuant to that title shall have access to the same sources of supply as Federal agencies. This is a critically important provision since the Federal Supply Schedule often provides the lowest cost available for a wide range of items, including pharmaceuticals. Access to this schedule greatly expands the purchasing power of the Federal dollars that urban Indian organizations receive, which, in turn, advances the implementation of Federal health care policy in support of urban Indians. That policy, as noted above, is rooted in the Federal government's trust obligation to Indian peoples.

The Federal government's policy of establishing an urban Indian health program, consistent with the Federal trust responsibility, would be greatly advanced by Section 517 of the Indian Health Care Improvement Act. Access to the Federal Supply Schedule not only maximizes the value of federal dollars, but is consistent with the current policy of providing such access to tribes and tribal organizations that have IHS contracts – a policy based in practicality and the Federal government's trust responsibility, not the governmental status of those entities.

XI. THE NEED FOR A 100 PERCENT FEDERAL MATCHING RATE FOR MEDICAID SERVICES PROVIDED AT URBAN INDIAN HEALTH PROGRAMS

Urban Indian health programs may participate as providers in their state's Medicaid program and receive payment for services covered by Medicaid that they furnish to Medicaid-eligible American Indians. Whatever amount the state pays the urban Indian program for a visit by a Medicaid patient, the Federal government will match the state's expenditure at the state's regular Federal Medicaid matching rate, or FMAP. For example, Arizona receives 65 percent of the cost of each Medicaid patient visit from the Federal government, California 51 percent, Colorado 50 percent, etc. In contrast, if an American Indian who is eligible for Medicaid receives primary care services covered by Medicaid at an outpatient facility operated directly by the I.H.S., or from a facility operated by a tribe or tribal organization under contract with the I.H.S., the Federal government will match 100 percent of the cost of the service.

NCUIH supports raising the Federal Medicaid matching rate in all states to 100 percent for the costs of covered services furnished to a Medicaid beneficiary directly by an urban Indian health program receiving funds under Title V of the Indian Health Care Improvement Act. Note that under this proposal, the enhanced FMAP would *not* apply to services furnished by providers to whom an Indian Medicaid beneficiary has been referred by an urban Indian health program. CBO estimates the cost of providing this fiscal relief to the states at $60 million over 5 years and $150 million over 10 years.

XII. CONCLUSION

Notwithstanding the difficulties, urban Indian health organizations, working with limited funds, have made a great difference in addressing the health care service gap for urban Indians. However, there is much more work to be done. NCUIH thanks the Committee for its support in the past and thanks the Committee for this opportunity to provide testimony on the health status of urban Indians. NCUIH looks forward to working closely with the Committee in its work to assure the best possible health care for all American Indians.

Health Status of Urban American Indians and Alaska Natives

A Population-Based Study

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Objective.—To use vital statistics and communicable disease reports to characterize the health status of an urban American Indian and Alaska Native (AI/AN) population and compare it with urban whites and African Americans and with AI/ANs living on or near rural reservations.

Design.—Descriptive analysis of routinely reported data.

Setting.—One metropolitan county and seven rural counties with reservation land in Washington State.

Subjects.—All reported births, deaths, and cases of selected communicable diseases occurring in the eight counties from 1981 through 1990.

Main Outcome Measures.—Low birth weight, infant mortality, and prevalence of risk factors for poor birth outcomes; age-specific and cause-specific mortality; rates of reported hepatitis A and hepatitis B, tuberculosis, and sexually transmitted diseases.

Results.—Urban AI/ANs had a much higher rate of low birth weight compared with urban whites and rural AI/ANs and had a higher rate of infant mortality than urban whites. During the 10 years, urban AI/AN infant mortality rates increased from 9.6 per 1000 live births to 18.6 per 1000 live births compared with no trend among the other populations. Compared with rural AI/AN mothers, urban AI/AN mothers were 50% more likely to receive late or no prenatal care during pregnancy. Relative to urban whites, urban AI/AN risk factors for poor birth outcomes (delayed prenatal care, adolescent age, and use of tobacco and alcohol) were more common and closely resembled the prevalence among the African-American population except for a higher rate of alcohol use among AI/ANs. Compared with urban whites, urban AI/AN mortality rates were higher in every age group except the elderly. Differences between urban whites and AI/ANs were largest for injury- and alcohol-related deaths. All-cause mortality was lower among urban AI/ANs compared with rural AI/ANs and urban African Americans, although injury- and alcohol-related deaths were higher for AI/ANs. All communicable diseases studied were significantly ($P<.05$) more common among urban AI/ANs compared with whites. Tuberculosis rates were highest in the urban AI/AN group, but rates of sexually transmitted diseases were intermediate between urban whites and African Americans.

Conclusions.—In this urban area, great disparities exist between the health of AI/ANs and whites across almost every health dimension we measured. No consistent pattern was found in the comparison of health indicators between urban and rural AI/ANs, though rural AI/ANs had lower rates of low birth weight and higher rates of timely prenatal care use. The poor health status of urban AI/AN people requires greater attention from federal, state, and local health authorities.

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IT IS generally known that the health status of American Indians and Alaska Natives (AI/ANs) is far below that of other Americans.[1] However, this conclusion is based on statistical reports from the Indian Health Service (IHS), an agency of the Public Health Service, and tribally owned health programs on or near Indian reservations or Alaska Native lands. Little is known about the health status of urban AI/ANs despite the fact that 56% of the AI/ANs identified in the 1990 US Census now reside in urban areas.[2] The IHS was created by Congress and is currently directed to "assure the highest possible health status for Indians and urban Indians and to provide all resources necessary to affect that policy."[3] Congress recently established health status objectives specifically for AI/ANs that are to be accomplished by the year 2000.[3] Funding and politics have restricted most IHS activities to tribal members living on or near Indian reservations or Alaska Native lands.

Very little health information is available regarding AI/ANs in urban areas.[4] Most published studies of urban Indian health are based on data from clinics and hospitals and cannot be generalized to an entire urban AI/AN population.[5] In a comprehensive report on Indian health published in 1986, the Office of Technology Assessment concluded that "the IHS does not collect diagnostic patient care information from urban programs and does not analyze or publish vital statistics or population characteristics for urban AI/ANs except when these data are included with national level data on the reservation states."[6] Since the publication of this report, there have not been any large population-based studies that broadly describe the health status of any urban Indian population.

The purpose of this study was to use available vital statistics and health data to characterize the health status of the AI/AN population in the largest metropolitan county within the state of Wash-

ington and to compare its health status with three reference populations. The comparison populations are the white and African-American populations within the same metropolitan county and the AI/AN population living in rural Washington counties with tribal reservations.

Table 1.—Demographic Characteristics of Study Populations

Characteristic	Urban			Rural
	AI/AN*	White	African American	AI/AN
1990 population	17 305	1 255 339	72 453	18 064
Older than 25 years without high school diploma, %	24	10	21	34
Unemployed, %	8.4	3.7	11.3	21
Below 100% of federal poverty level, %	26	6.1	22	35

*AI/AN indicates American Indian and Alaska Native.

METHODS

Site

According to the 1990 US Census, the Seattle, Wash, metropolitan area has the seventh largest concentration of urban AI/ANs in the United States. King County, Washington, is a large metropolitan region with a population of 1 507 319.[2] There are three cities with more than 50 000 residents, the largest of which is Seattle. The 17 305 AI/AN residents comprise 1.1% of the King County population and 21% of the state's AI/AN population. Of the King County AI/AN residents, 1461 (8.4%) reported that they were of Eskimo or Aleut ancestry on the census. Data sets from which numerator data were derived do not allow stratification of Alaska Natives from American Indians. Within King County, there is one small reservation with a tribally operated clinic. The Seattle Indian Health Board, one of 34 nonprofit organizations partially funded by the IHS, operates a comprehensive community-based primary care program that cares for AI/ANs.

Comparison Groups

First, we compared the health status of AI/ANs with that of whites and African Americans within King County. Second, we compared health status indicators of the King County AI/ANs ("urban" AI/ANs) with those of AI/AN residents of rural Washington counties with tribal reservations, a population traditionally served by the IHS. These seven counties are classified by the Washington State Department of Health as "rural" (15 to 100 persons per square mile) or "remote rural" (<15 persons per square mile) counties and have reservation land belonging to federally recognized tribes. King County and the rural reservation counties account for 40% of the state's total AI/AN population. The remainder of the state's AI/AN residents live in other urban/metropolitan counties or rural counties without reservations.

Data Sources

Three main data sources were used to generate numerator data for vital statistics rate calculations. These included birth certificates, linked infant birth and death certificates, and death certificates from 1981 through 1990 from the Center for Health Statistics of the Washington State Department of Health. Communicable disease data were obtained from the Centers for Disease Control and Prevention and the Epidemiology Office of the Washington State Department of Health. Data from the 1980 and 1990 editions of the US Census provided the denominator and socioeconomic data for each of the comparison groups. Population estimates for urban and rural AI/ANs between 1980 and 1990 were generated by linear interpolation between 1980 and 1990 US Census counts while estimates for urban whites and African Americans were based on Washington Office of Financial Management demographic estimates. These Office of Financial Management estimates were unavailable for all counties in the study, so all AI/AN denominator estimates were derived using linear interpolation. The differences between the two denominator estimates (for the intercensus period) were quite small. The interpolation method gave a slightly higher number for each of the years, with a range of ratios from 1.02 to 1.06. This method consistently exceeded the Office of Financial Management estimate and resulted in a probable underestimate of mortality rates of urban AI/AN residents compared with other races.

We used the post-1989 National Center for Health Statistics definition of race for all infant birth and death rate calculations in the study. The National Center for Health Statistics currently defines an AI/AN birth as an infant born to a mother identified in the birth record as AI/AN, regardless of the father's race. We used linked birth and death certificates for infants in which the mother's race at birth defines the race at birth and death. Individuals self-report their race to the US Census.

Health Status Measures

The health status indicators used in this study were derived from routinely collected population-based health status data for which race-specific information was available. Mortality rate calculations included infant mortality, age-specific mortality rates in six age groups, cause-specific mortality, and alcohol-associated mortality. To assess alcohol-associated mortality, alcohol-related disease impact software was used.[7] This methodology, developed by the Centers for Disease Control and Prevention, uses the attributable risk from alcohol use for each cause of death to derive a composite rate of alcohol-associated mortality.

Maternal and infant health measures included the proportion at birth of preterm births (<37 weeks' gestational age), of low (<2500 g) and very low (<1500 g) birth weight, of unmarried mothers, of mothers who started prenatal care in the first trimester (on time care) or who had late (third trimester) or no prenatal care, and of mothers who smoked tobacco or consumed alcohol during pregnancy, and the school-age (ages 10 through 17 years) fertility rate. The data source for information on smoking and alcohol use during pregnancy and prenatal care was the birth certificate. Smoking data from 1986 through 1988 were used (question wording on Washington State birth certificates was changed in 1989). Assessment of alcohol consumption was added to the birth certificate in 1989. Maternal drug-use data are not routinely collected on Washington State birth certificates.

Because the AI/AN population is small, only reportable communicable diseases of high frequency were compared. These included sexually transmitted diseases (gonorrhea, syphilis, and chlamydia), tuberculosis, and hepatitis A and hepatitis B. Because detailed data for sexually transmitted diseases were unavailable for rural counties, these data were used for comparisons within King County only.

We used the following *International Classification of Diseases*[8] codes as definitions for cause-specific mortality: heart disease, 391 through 392.0, 393 through 398, 402, 404, 410 through 416, 420-429; cancer, 140-208; unintentional injury, E800 through E949; liver disease, 571; cerebrovascular disease, 430 through 434, 436-438; pneumonia and influenza, 480 through 487; homicide, E960-E969; diabetes, 250; chronic obstructive pulmonary disease, 491, 492, 496; suicide, E950 through E959; and all firearms, E922, E955.0 through E955.4, E965.0 through 965.4, E870, E985.0 through E985.4.

All disease and death rates were age-adjusted to the 1940 US population for

Table 2.—Prevalence of Risk Factors for Poor Birth Outcomes Among Urban American Indians and Alaska Natives (AI/ANs) Compared With Other Races and Rural AI/ANs

	Average Rates 1988 Through 1990 (Total Births)*			
	Urban			
Risk Factors	AI/AN (n=994)	White (n=52 261)	African American (n=4100)	Rural AI/AN (n=1061)
Low birth weight (<2500 g)	9.5 (7.7-11.5)	5.0 (4.8-5.2)†	13.0 (12.0-14.1)†	5.6 (4.3-7.2)†
Very low birth weight (<1500 g)	1.6 (1.0-2.7)	0.8 (0.7-0.9)†	2.8 (2.4-3.4)	0.8 (.35-1.7)
Preterm births (<37 wk gestation)	15.9 (13.5-18.6)	8.1 (7.9-8.4)†	17.7 (16.5-19.1)	13.0 (10.9-15.5)
Mother 10-17 y of age	9.1 (7.4-11.1)	1.7 (1.6-1.8)†	9.8 (9.0-10.8)	10.2 (8.5-12.2)
Single mother	59.1 (56.0-62.1)	15.7 (15.4-16.0)†	65.1 (63.6-66.6)†	64.6 (61.6-67.5)
Consumed alcohol‡	20.1 (16.3-24.4)	6.2 (5.9-6.5)†	11.0 (9.5-12.7)†	16.2 (13.5-19.3)
Smoker§	38.2 (34.7-41.7)	20.0 (19.7-20.4)†	33.5 (31.9-35.0)	40.6 (37.5-43.8)
Received first-trimester prenatal care	56.5 (53.1-60.0)	83.9 (83.6-84.2)†	59.2 (57.5-60.8)	64.0 (61.0-67.0)†
Received late or no prenatal care	15.9 (13.5-18.5)	3.4 (3.2-3.6)†	12.7 (11.6-13.9)	10.0 (8.3-12.0)†

*Data expressed as percentage (95% confidence interval). Infant race determined by mother's race on birth certificate. Urban AI/ANs are the reference group for all statistical comparisons.
†Significantly ($P<.05$) different from urban AI/AN rate.
‡Two-year average rates, 1989 through 1990.
§Three-year average rates, 1986 through 1988.

two reasons. A recent Centers for Disease Control and Prevention conference on age adjustment concluded that the 1940 US population would continue to be recommended by the National Center for Health Statistics as the standard population for US mortality data (primarily for purposes of comparability to historical national data).[9] Also, IHS uses the 1940 population as the reference in its annual statistical publications, widely cited sources for AI/AN health data; thus, use of the 1940 population will facilitate comparisons. Confidence intervals (CIs) for age-adjusted rates were compiled using the method of Chiang,[10] and CIs for proportional rates were calculated by the method of Fleiss.[11] Three- or 5-year rolling averages were used to assess trends, depending on the frequency of the outcome. Chi-square test for trend was used to determine the statistical significance of rate trends over time.

To determine whether the difference in low-birth-weight rates between urban and rural AI/AN populations could be entirely explained by differences in known behavioral and biologic risk factors, we conducted a logistic regression analysis to determine the model that best explained low-birth-weight variation. The outcome variable was defined as the presence or absence of low birth weight. The main independent variable was whether the birth occurred in an urban or rural location. The covariates included known maternal risk factors for low birth weight, including smoking, alcohol use, adolescent age, prior pregnancies, and the interpregnancy interval.

RESULTS

Socioeconomic Characteristics

Data from the 1990 US Census revealed that, compared with whites, the urban AI/AN population had fewer high school graduates and higher rates of unemployment and poverty (Table 1). However, rural AI/ANs appeared to be the most disadvantaged group in the study. A third of those older than 25 years living in rural counties were without a high school diploma. Unemployment (21%) and poverty rates (35%) were also highest among rural AI/ANs.

Birth Outcomes

The prevalence of low birth weight (<2500 g) was considerably higher among urban AI/ANs compared with urban whites and rural AI/ANs, but was lower than the rate of low birth weight among urban African Americans (Table 2). The prevalence of very low-birth-weight (<1500 g) births and premature deliveries shared similar patterns, although only the differences between urban AI/ANs and whites were significant.

Using low birth weight as the dependent variable and urban or rural status as the main independent variable, we found that after adjustment for the interval between births, history of prior pregnancy, adolescent age, use of prenatal care, and maternal smoking, the difference in low-birth-weight risk between the rural and urban groups was no longer statistically significant (odds ratio, 0.90; 95% CI, 0.56 to 1.4; $P=.66$). Thus, it appeared that most of the variation was attributable to differences in risk profiles of each group and not to a community risk or protective factor represented by the urban/rural variable.

Like low birth weight, the infant mortality rate averaged over 10 years was 80% higher among urban AI/ANs than among whites (Table 3). Neonatal and postneonatal mortality rates were higher among the urban AI/ANs (data not shown). Infant mortality rates among the urban AI/ANs were not significantly different than those among African Americans or the rural AI/ANs.

A significant increase in the urban AI/AN infant mortality rate occurred during the decade starting in 1981 (Figure). Five-year rolling average rates increased consistently every 5-year period from 9.6 per 1000 live births during 1981 through 1985 to 18.6 per 1000 during 1986 through 1990 (χ^2 test for trend, 5.1; $P<.05$). This decade-long trend was not evident among the other county residents or the rural population. The apparent upward trend among African Americans was not significant.

Prenatal Risk Factors for Poor Birth Outcomes

Rural and urban AI/AN mothers shared a similar prenatal risk profile (adolescent age, single marital status, and use of tobacco and alcohol during pregnancy) for poor birth outcomes (Table 2). However, urban AI/AN women were less likely than rural AI/AN women to initiate prenatal care in the first trimester (56.5% vs 64.0%; $P<.05$) and more likely to have late (third trimester) or no prenatal care (15.9% vs 10.0%; $P<.05$).

Urban AI/AN mothers had a much higher risk profile in comparison with urban white mothers (Table 2). Births among mothers aged 10 to 17 years, mothers who were single, or mothers who used tobacco or alcohol during pregnancy were all more common among AI/ANs. Similarly, the lower rates of first trimester prenatal care and high rates of late (third trimester) or no prenatal care seemed to place AI/ANs at higher risk of poor birth outcomes. This risk profile closely resembled that of African-American mothers across all variables except for prenatal alcohol consumption, where the risk among AI/ANs was significantly higher.

Table 3.—Urban American Indians and Alaska Natives (AI/AN) Mortality Rates Compared With Other Races and Rural AI/ANs by Age Group and Cause, 1981 Through 1990*

Mortality Rate	Urban			Rural AI/AN
	AI/AN	White	African American	
Infant (age 0-1 y), 10-y average rate, per 1000 live births (95% CI)†	14.7 (10.6-20.3)	8.0 (7.6-8.4)‡	17.5 (15.3-20.0)	23.2 (18.4-29.2)
Age-specific, y, 10-y average rate per 100 000 population (95% CI)				
1-14	56 (35-87)	29 (26.4-31.2)‡	39 (29.8-49.7)	62 (42-92)
15-24	162 (121-217)	83 (78.4-86.9)‡	131 (111.2-153.8)	265 (208-337)
25-44	335 (288-389)	127 (123.8-130.6)‡	279 (258.1-302.1)	386 (327-454)
45-64	1122 (992-1269)	693 (682.4-703.9)‡	1303 (1231.8-1378.8)	1092 (950-1255)
65-99	3099 (2685-3573)	4949 (4912.4-4984.9)‡	5158 (4951.3-5373.2)‡	5124 (4650-5643)‡
Total deaths	727	93 048	4525	921
Cause-specific, 10-y age-adjusted [to 1940] rate per 100 000 population (95% CI)				
All causes	597 (557-638)	473 (469.4-475.5)‡	729 (710.5-748.3)‡	747 (702-791)‡
Alcohol related	149 . . .	82 . . .	105 . . .	182 . . .
Heart disease	141 (120-163)	139 (137.1-140.3)	207 (195.8-217.6)‡	188 (164-212)‡
Cancer	76 (57-92)	127 (124.8-128.2)‡	175 (164.4-185.3)‡	93 (75-110)
Unintentional injury	69 (56-83)	29 (27.6-29.5)‡	39 (34.5-44.4)‡	118 (99-136)‡
Liver disease	50 (37-62)	9 (8.3-9.4)‡	15 (12.0-18.7)‡	44 (31-56)
Cerebrovascular	26 (16-35)	28 (27.7-29.1)	48 (42.5-53.1)‡	56 (42-70)‡
Pneumonia and influenza	22 (14-31)	12 (12.0-12.8)‡	13 (10.2-15.7)	15 (8-22)
Homicide	21 (14-28)	4 (3.8-4.5)‡	30 (25.7-34.0)	20 (12-27)
Diabetes	19 (11-27)	8 (7.8-8.7)‡	30 (25.4-34.3)	20 (12-29)
Chronic obstructive pulmonary disease	18 (10-26)	19 (18.5-19.8)	19 (15.1-22.1)	24 (15-33)
Suicide	17 (10-23)	14 (12.8-14.1)	9 (6.8-11.4)	26 (16-35)
All firearms	15 (9-21)	8 (7.9-8.9)‡	21 (17.3-24.2)	34 (24-45)‡

*CI indicates confidence interval. Ellipses indicate data not available.
†Based on linked birth and death files where mother's race is AI/AN.
‡Significantly different from urban AI/AN rate.

Age-Specific Mortality

Urban AI/AN age-specific mortality rates were higher in almost every age group compared with urban whites. The only exception was among the elderly (older than 65 years), in which the AI/AN rates were lower (relative risk [RR], 0.65; 95% CI, 0.56 to 0.75). The biggest difference was evident in the 25- to 44-year age group, though rates in the 1- to 14-year and 15- to 24-year age groups were nearly twofold higher than among whites. The only significant ($P<.05$) difference between urban AI/ANs and African Americans was in the oldest age group, in which rates for African Americans were higher.

Similarly, a comparison of death rates between urban and rural AI/ANs appeared to demonstrate slightly lower rates among urban AI/AN residents, although only the difference among the elderly (older than 65 years) reached statistical significance (RR, 0.60; 95% CI, 0.51 to 0.72; $P<.05$).

Cause-Specific Mortality

The overall age-adjusted mortality rate among urban AI/ANs was higher compared with whites, but lower compared with African Americans and rural AI/ANs (Table 3). Injuries and alcohol-related deaths accounted for the majority of excess mortality among AI/ANs. Urban AI/ANs had significantly ($P<.05$) lower age-adjusted all-cause mortality rates than rural AI/ANs as well as for heart disease, unintentional injury, cerebrovascular disease, and firearm injury. Rates for other specific causes of death (cancer, liver disease, pneumonia and influenza, homicide, suicide, diabetes, and chronic obstructive pulmonary disease) were not significantly different between the groups.

Within the urban county, the most striking differences in cause-specific mortality rates between AI/ANs and whites were for chronic liver disease and cirrhosis, unintentional injury, and homicide. Of the leading causes, only cancer was lower in the AI/ANs compared with whites. Compared with African Americans, the urban AI/ANs had lower all-cause death rates and lower rates from heart disease, cancer, and cerebrovascular disease, but higher death rates from unintentional injury and liver disease.

Communicable Diseases

Among communicable diseases, the prevalence of reported hepatitis A and hepatitis B was higher among urban AI/ANs than among rural AI/ANs, urban whites, and African Americans (Table 4). Similarly, urban AI/ANs also experienced a much higher reported prevalence of tuberculosis compared with all three other population groups. Reported prevalence rates of chlamydia, syphilis, and gonorrhea were much higher among urban AI/ANs compared with urban whites, but considerably lower than rates among urban African Americans. Race-specific rates of sexually transmitted disease were not available for rural AI/ANs.

COMMENT

The findings of this study confirm the existence of great disparities between the health of AI/ANs and whites living in one large metropolitan area. Urban AI/ANs have poorer health across almost every indicator we examined. The gap appears across almost all age groups and most causes of death. Many of the indicators were similar to those among urban African Americans, a group whose health status has repeatedly demonstrated the health inequities between whites and minorities in the United States.[12]

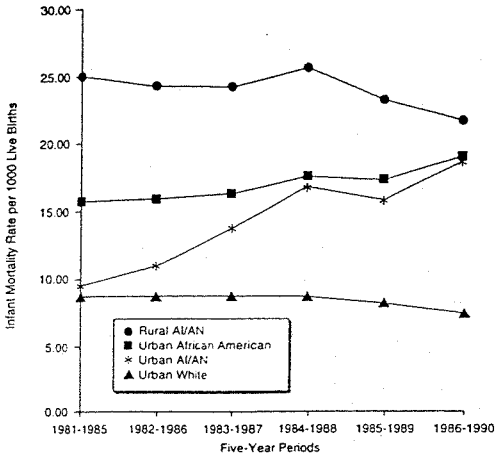
Our systematic comparison of health status indicators between urban and rural AI/ANs did not reveal a consistent pattern. Our most disturbing finding was the significant decade-long rise of the urban AI/AN infant mortality rate, a trend not shared by any of the other study populations. Rural AI/AN moth-

ers of newborn infants were more likely to have early and adequate prenatal care and were less likely to deliver a low-birth-weight infant than urban AI/AN mothers. This may be a result of access to comprehensive maternal and child health services offered by the IHS that include extensive public health nursing outreach systems. Access to these services in the rural IHS clinics may have led to earlier initiation of and follow-up with prenatal care. Though the earlier use of prenatal care and the lower rate of low birth weight appeared to demonstrate better maternal and infant health in the rural population, rural AI/AN infant mortality (including both neonatal and postneonatal mortality) was not lower in the rural counties. This surprising relationship between low birth weight and infant mortality rates may be a reflection of superior access to neonatal intensive care in the urban county.

The AI/AN mortality rates tended to be higher within the rural counties than within the urban area. The most striking age-specific difference was among the population older than 65 years. The higher rate of unintentional injury fatalities is not surprising since the incidence of fatal motor vehicle crashes is known to be higher in rural areas, especially among AI/ANs.[13] Almost all of the overall mortality difference can be explained by higher rates of the four leading causes of death (heart disease, cancer, injury, and cerebrovascular disease) among rural AI/ANs, compared with their urban counterparts.

Several limitations may have affected the results of this study. Although undercounting of AI/ANs in the census would have the effect of inappropriately increasing morbidity and mortality rates when the census population is used as the denominator, data from the 1980 and 1990 censuses suggest that the problem of undercounting of AI/ANs has diminished in comparison with earlier censuses.[14] Misclassification of race in vital records can result in substantial underestimates of mortality rates among AI/ANs.[15-17] We estimate that this differential misclassification affects mortality data by artificially minimizing some of the true disparity between whites and urban AI/ANs, ie, a conservative bias. We attempted to minimize the effects of racial misclassification for infant mortality rates and the prevalence of birth risk factors by using linked birth and death certificates and the current National Center for Health Statistics designation of race. However, estimates of AI/AN mortality rates for ages beyond infancy were not derived from linked files, raising the potential for significant racial misclassification and underestimation of the AI/AN rates. If misclassification of AI/ANs as other races was less likely to occur in rural areas (perhaps because morticians and coroners are more sensitive to the presence of a large AI/AN population), then urban rates would be selectively underestimated, thus accounting for some of the differences between urban and rural AI/ANs observed in this study. Indeed, in a study of racial misclassification of clients of the Seattle Indian Health Board, almost one third of persons who identified themselves as AI/AN to the clinic while living were classified as other races on death certificates, compared with approximately 12% inconsistent classification among primarily rural, IHS-registered AI/ANs in Washington.[18] Because the direction of this potential bias is known, study conclusions or policy implications should not be significantly affected. Data from birth certificates may be less susceptible to this potential bias.

In addition to racial misclassification on vital records, several studies in the Pacific Northwest have shown that morbidity rates calculated from registries of cancer,[16] AIDS,[19] end-stage renal dis-



Five-year rolling averages for infant mortality trends of urban American Indians and Alaska Natives (AI/ANs) compared with other races and rural AI/ANs. Data derived from linked birth and death certificates. Race classified according to maternal race.

Table 4.—Incidence of Communicable Diseases Among Urban American Indians and Alaska Natives (AI/ANs) Compared With Other Races and Rural AI/ANs

	Urban			
Disease	AI/AN	White	African American	Rural AI/AN
Hepatitis A†	151 (123-178)	42.0 (39.8-44.1)‡	43.4 (34.9-52.0)‡	106 (85-128)
Hepatitis B†	47 (31-63)	10.8 (9.7-11.8)‡	25.3 (18.8-31.9)	25 (14-35)
Tuberculosis§	60 (47-74)	3.0 (2.7-3.3)‡	16.8 (13.5-20.0)‡	20 (12-28)‡
Sexually transmitted diseases‖				
Chlamydia	516 (460-573)	255.5 (250.0-261.1)‡	1472.6 (1432.9-1512.2)‡	NA
Gonorrhea	298 (253-342)	81.0 (77.9-84.2)‡	2055.5 (2008.5-2102.5)‡	NA
Syphilis	47 (28-66)	4.9 (4.2-5.6)‡	183.7 (166.0-201.4)	NA

*All rates age-adjusted to 1940 US population. NA indicates not available. Data expressed as mean rates per 100 000 population (95% confidence intervals).
†Average rate, 1987 through 1990.
‡Significantly ($P<.05$) different from urban AI/AN rate.
§Ten-year average rate, 1981 through 1990.
‖Three-year average rate, 1988 through 1990.

ease,[20] and injury[21] may be underestimated among AI/ANs because of racial misclassification. Reporting bias is another potential concern in this study, primarily in the rates of communicable diseases. Care providers in the public sector, where indigent patients are more likely to seek care, may be more likely to report cases of communicable diseases to health authorities than private practitioners. The effect of this bias would be to overestimate the differences noted between whites and urban AI/ANs with respect to communicable diseases such as gonorrhea.

Should urban AI/ANs receive attention as a population with special health needs? More than half of AI/ANs now live in urban areas, but only a few of these areas, such as Albuquerque, NM, Phoenix, Ariz, and Anchorage, Alaska, offer direct IHS services. Title V of the Indian Care Improvement Act of 1976 was the first federal government recognition of the health needs of urban AI/ANs. Despite this recognition, few resources have been allocated to address these needs. The initial 1976 authorization called for a $15 million allocation for urban Indian communities to organize programs to "facilitate access to and, when necessary, provide health services to urban Indian residents."[22] In 1992, only $17 million was appropriated to urban Indian programs in cities where an IHS facility was not present, representing 1% of the total IHS budget. Because eligibility for the full scope of IHS services has been reserved for "persons of descent belonging to the Indian community served by the local facilities and program," it effectively excludes rural AI/AN residents who move to an urban area without an IHS direct care facility, perhaps in search of employment or family reunification.[6] Though the reasons for the presence of large urban AI/AN populations are not completely known, many urban AI/AN residents were coercively relocated from reservations by the federal government to the cities during a period in the 1950s known as the "termination era" in the history of relations between US Indians and whites.[23] This relocation policy separated AI/AN people from tribal land and culture, exposing them to the harsh social and economic conditions of the urban poor. Others migrated to the cities in search of employment and education. Many of these individuals and their families never returned to their reservations. Whatever the reason, many AI/AN people are firmly rooted in the cities.

The allocation of IHS funds to the urban Indian program has been a source of controversy between urban Indian and tribal leaders. Concerned that scarce resources would be redirected from the reservations to the cities, some tribal leaders have opposed the expansion of urban programs. Our data do not support the redirection of funds previously designated for rural AI/ANs living on native lands, since it appears that both populations are vulnerable and in similar great need of health services, epidemiologic surveillance, and prevention activities. The recent drive for health system reform may benefit the health concerns of the urban AI/AN population. Under President Clinton's proposed Health Security Act of 1993 (section 8302), urban AI/ANs will be eligible for the same full health care benefits extended to rural AI/AN residents. Under this plan, all AI/AN enrollees could receive their care in an IHS, a tribal, or an urban Indian facility. Until a solution is reached in the context of health system reform, the responsibility for the health needs of urban AI/ANs must continue to be addressed at local, state, and federal levels in consultation with existing urban Indian programs.

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CHAPTER NINE

OFF-RESERVATION INDIANS

Overview

Almost half of the United States Indian population lives outside the boundaries of Indian reservations. In 1970, 340,000 lived in cities and six cities had Indian populations which are larger than those of any reservation except the Navajo Reservation.[1]

Many of these people moved to cities because of Federal policies. The earliest movements of tribal people away from tribal lands were often the indirect result of policies which diminished the reservation land base to such an extent that Indians had to find homes elsewhere. Educational policies added to the trend by removing Indian children from their homes to off-reservation boarding schools where the children were taught skills which could not be used on reservations. Policies which neglected reservation development, of course, made reservations undesirable places to remain and also affected migration. Some policies, particularly following World War II, were more directly responsible for relocating Indians away from reservations. In addition to robbing reservations of some of their best talent, these policies have resulted in dire circumstances for the large numbers of Indian people who find themselves in urban ghettoes, today.

Despite the fact that the Federal Government must assume some responsibility for the pre-ent-day problems of urban Indians, the Government has actually refused to extend those services to urban Indians which they would otherwise receive if they lived on their reservations. Urban Indians do not receive the special Federal programs which are directed to Indians. Strangely enough, they often do not receive the services directed to non-Indians, either. Local, State and county welfare programs often refuse to serve Indians on the grounds that they are the responsibility of the Federal Government.

In this situation, the development of Indian community service centers has been the one optimistic factor. The Federal Government offers these centers little encouragement, however, and they become entangled in bureaucratic and jurisdictional fights.

New policy directions can have a very clear beneficial impact on the desperate urban Indian situation if administrative programs utilize and encourage urban Indian centers.

History[2]

This review of off-reservation Indian history will examine the ways Federal policies have splintered tribes and either forced or encouraged

[1] Sar A. Levitan and William B. Johnston, Indian Giving (Baltimore, 1975), 2-3.

Indians to move away from reservations in an effort to end the "Indian problem." It will also show how these moves have not solved the problems of poor health, poverty, limited employment opportunities, poor education, and alienation, but have merely transferred them to rural and urban settings.

In the late 19th century, after the Federal Government had succeeded in reducing Indian tribal holdings to small reservations, the policies of neglect, dependency, and assimilation were established. While there were some meager efforts at "reservation development," no significant system of economic and cultural protection was created to permit Indian tribes economic viability and independence. Reservations were often viewed as camps where assimilative tools would be provided prior to the Indian's dispersal among the white population.

Even reservations, however, posed a threat to the Federal Government because they provided a place where Indian people could not be effectively kept from maintaining their identity and culture. So, attempts were made to parcel out tribal lands to Indian individuals in an effort to destroy the communal cohesiveness of tribal society. The continuing assumption on the part of the Federal Government was that assimilation was the Indian's fate. Legislation was based on this assumption.

One of the most obvious examples of Federal action which broke up reservations, strained tribal cohesion, and encouraged subsequent migration of thousands of Indians to other areas was the General Allotment Act of 1887.[3] Indeed, it is not inaccurate to say that the migration of the Indians was a calculated result of this legislation.

The General Allotment Act was, of course, just one example of a long line of Federal legislation and administrative actions which were either designed to or inadvertently resulted in dispossessing Indians of their lands and driving them to seek jobs off the reservation.[4] Oftentimes, the Federal Government was the decisive influence weakening (and sometimes dissolving) [5] the tribal governing structures; it stood by while most of the Indians' choice lands were taken from their control and the resources from the remaining lands were destroyed; it moved Indians off the reservation for job training and employment. More often than not, job training in the cities turned out to be irrelevant, employment opportunities were nonexistent, and furthermore, the Federal Government neglected to provide meaningful assistance in housing, education, or health. As the final insult to those Indians who were victims of this concerted campaign to assimilate them, the Federal Government refused and largely still refuses to recognize its

[2] This historical review is condensed from an extensive history researched and written by Dennis Carroll for Task Force Eight.

[3] 24 Stat. 388.

[4] Also during the 1870's, the Federal Government began the Indian boarding school system which was "designed to separate a child from his reservation and family, strip him of his tribal lore and mores, force the complete abandonment of his native language and prepare him for never again returning to his people." 11 U.S. Cong. Senate Committee on Labor and Public Welfare, Indian Education: A National Tragedy—A National Challenge, S. Rept. No. 91-501, 91st Cong., 2d sess. 12 (1969.) Some 20 years later, the Indian Commissioner stated that it was the "settled policy of the Government to break up reservations, settle Indians upon their own homestead, incorporate them into the national life, and deal with them not as nations or tribes or bands, but as individual citizens." Rep. Comm. Ind. Aff., 1890 at VI.

[5] Felix Cohen described the systematical destruction of tribal governing structure and powers of the Five Civilized Tribes. F. Cohen, Handbook of Federal Indian Law, 427-434 (1942 ed.).

responsibility to provide them with the services they would receive on their reservations.

Education through the off-reservation boarding school was another method utilized to alienate Indian people from their culture. This educational model for Indian youth was directed at developing young men and women who could join the mainstream of white, Christian society. Instead, it left a legacy of frustration, depression, and alienation that made Indians unable to pursue the traditions of their fathers, but left them unequipped to participate in white-dominated economy.

The increasing number of Indian people living off-reservation was noticed in two Indian policy studies in the 1920's. The Senate Subcommittee on Indian Affairs' Survey of the Conditions of the Indians of the United States was followed by the well-known Meriam Report.

The Subcommittee conducted and published hearings across the United States, and largely provided the data base for the more concise Meriam Report. The subcommittee's hearings in California were particularly directed at the burgeoning problem of urban Indians. The Government was beginning to notice a new problem area in Indian affairs, but responsive policies would not be instituted within the next half-century. Whatever insights might have been gained from hearing testimony were lost when the Meriam Report published its chapter on "Migrated Indians", and relied on the material presented by Indians' employers rather than the Indians themselves. On this choice of information, the Meriam Report recommended that "no effort be devoted toward building up an independent organization in such cities for migrated Indians, but rather toward establishing cooperative relations with existing agencies which serve the population as a whole." [6]

The Snyder Act of 1921 had given the Commissioner of the Bureau of Indian Affairs broad latitude in spending appropriations for Indian affairs and in developing programs to meet Indians' needs. The legislation simply stated that appropriations were to be used for "Indians throughout the United States." Certainly that clause is broad enough to include those Indians who were forced away from reservations by land policies, by Federal encouragement, or by economic needs, but the Bureau did not choose to view its role in so expansive a way. The Meriam Report, no doubt, gave scholarly support to this bureaucratic timidness. For many years, the Bureau's failure to serve the increasing urban Indian population went unquestioned.

After World War II, Indian perceptions of reservations and cities began to change. The war showed many Indians a world they had never seen and seldom heard of. There were opportunities for achievement in the military service which they had never found on reservations. They proved themselves capable of using those opportunities and returned home with confident hopes that they could make their reservations better places to live. This hope soon turned to despair as they tackled the obstacles which impeded (and today still impede, *see* chapter 7) reservation development. Many Indians, however reluctant to leave their communities and families, decided that low quality subsistence was the only future for the reservations and set off for the cities to find work. By 1951, more than 17,000 Navajos

[6] Meriam, Lewis, The Problem of Indian Administration, "The Migrated Indians" ch. XII.

worked away from the reservation, primarily on railroads and agriculture.

At the same time, the Federal policy of assimilation manifested itself in a new way. A theory that reservations were overpopulated gained credence. By 1954, a congressional report entitled, "Survey Report on the BIA" generalized that "most of the reservations are overpopulated, and could not support the population at anything approaching a reasonably adequate standard of living."[7] Rather than pursuing a way to make Indian homelands financially secure places to live, the Federal Government chose to follow a simpler approach: relocation of Indians away from the reservations. Thinning out the population of reservations, however, did not solve the problem. The fact that Indians left the reservation did not mean they were willing to stop being Indians: and whether or not reservations bred some social problems, it could not have been assumed that those problems would be shed at the reservation boundaries. Nevertheless, Federal policy followed exactly that simplistic an approach. Transportation funds were provided, but relocation services were not.

The Federal Government not only failed to provide needed services to the Indians it relocated, but actually refused to provide those services. The Federal relocation program was to be initiated by the BIA but was left to be implemented by local, State and county assistance programs, or churches or humanitarian organizations. The only thing that was shrugged off at reservation boundaries, it turned out, was Federal responsibility.

Indians affected by relocation were not given an opportunity to tell their side of the story until the National Council on Indian Opportunity held hearings in five major cities in 1968 and 1969.[8] The numerous criticisms that were heard at this time fell into three categories: (1) The lack of orientation in relocating from reservations to cities; (2) the low quality of opportunities for work; (3) the confusion of where to turn for necessary services. Federal policy had ignored particular difficulties Indians faced in the cities, difficulties such as language barriers, questions of where to find services or help in emergencies, and the most fundamental problems of daily survival.

The special problems which Indians face when they are away from their reservations are another unique aspect of the Federal-Indian relationship. Whatever historical forces have contributed to these problems, it is apparent that the situation is significant enough to deserve Federal attention.

To solve these problems which the Federal Government largely created and then totally ignored, Indian people themselves have contributed the most recent and the most constructive development in the history of off-reservation Indians. That is the development of urban Indian service centers. Some of these centers have evolved from very small groups organized for recreational purposes into multifaceted operations capable of sustaining programs in educational and vocational training, defense of tenant rights against unscrupulous landlords, psychological and career counseling, various kinds of entertainment, and the provision of emergency relief. There can be no doubt that today the Indian centers are a sound and creative response to the Indians' frustrations with their urban environment.

[7] U.S. Congress, House Committee on Interior and Insular Affairs, "Survey Report on the Bureau of Indian Affairs," 1954, p. 23.

[8] National Council on Indian Opportunity, hearings in Los Angeles, Dallas, Minneapolis-St. Paul, San Francisco, and Phoenix, 1968-69.

The urban Indian service centers have not, however, completely solved the problems urban Indians face. In fact, they have encountered many obstacles which the Federal Government could remove, and have clarified a new policy problem in the administration of Federal programs for urban Indians. There is a unique relationship between the Federal Government and urban Indians, both because of the uniqueness of the problems urban Indians face and because of the uniqueness of the historical factors which made some Indians urban residents. How to administer that unique relationship has not yet been determined. Instead of taking the initiative and providing services to these Indian people, the Government has chosen to argue over responsibility and jurisdiction; these arguments continue to the present day.

Policy and Law Relating to Off-Reservation Indians

The following discussion examines briefly the concept and scope of the Federal trust responsibility to off-reservation Indians.[9] The exclusion of nonreservation Indians from the Federal trust relationship does not follow from a careful legal analysis but rather emanates from perceived practical considerations and the attitude, "it has always been done that way."

While the Federal trust responsibility extends from the Federal Government directly to the tribe, it must be noted the tribe as an entity does not exist without its people. Thus, it can be said that the ultimate beneficiary of the trust is the individual Indian as a member of his tribe.[10]

This is obviously true, for example, when the Federal Government acts to protect an individual Indian's land from being taxed by the State.[11] It is also true, however, when action is taken to protect a tribe's water resources on the reservation.[12] Individual Indians, including most of those living in urban and other nonreservation areas, generally identify themselves in the context of their tribal affiliation.

Probably few, if any, Federal administrators or legislators would disagree with the above comments. Dissent increases, however, when it is suggested that the Federal Government's trust responsibility applies to tribal members living off the reservation as well as to those living on Indian lands. This dissent results partially from the fixed thinking predominant in government that the Indian trust equates with land and nothing more, and partially from the mistaken notion that if an Indian leaves his reservation, it is with a conscious understanding that he is putting his tribe behind and assimilating to non-Indian society. As the historical review points out, more often than not, individual Indians who chose to leave reservations did so because they could not find jobs, or decent housing, or a quality education there. Moreover, many were practically forced to leave by BIA insistence, and in this situation the Federal responsibility is certainly clear.

[9] See ch. 4 for a complete discussion of the Federal trust responsibility.

[10] See *U.S. v. Holliday*, 70 U.S. 407 (1865).

[11] E.g., *Board of County Commissioners v. Seber*, 318 U.S. 705 (1943).

[12] *Winters v. U.S.*, 207 U.S. 564 (1908).

Most importantly, Federal policy should not be based on the Government's intention to dictate any group's culture. In discussing Indian policy, of course, this point becomes crucial. Assimilation has not succeeded and has largely been discarded. For urban Indians, however, there are many residual administrative obstacles which were constructed on the theory that off-reservation Indians gave up their tribal status, or should have given it up. The overwhelming majority of Indians in this country continue to be tribal members, regardless of where they live and regardless of whether or not their tribe is recognized by the Federal Government, and in spite of continuous policies aimed at destroying tribal society. The Federal Government's trust obligation to Indian tribes should extend to these tribal members as well as to their reservation brothers for there is no sound legal or political reason to discriminate against them.

No court, no general act of Congress, certainly no constitutional provision states that the Government's special responsibility to the Indian people stops at the reservation gate. The concept of trust responsibility is most often applied in the context of recognized reservation Indians, but several court decisions have found that the Government's legal duty is not so limited. For example, to benefit from the Federal responsibility to protect trust lands, the individual Indian need not reside on a reservation;[13] it makes no difference that he is a United States citizen as well as a tribal member, for "citizenship is not incompatible with tribal existence or continued guardianship."[14]

The unique need of nonreservation Indians has not been totally ignored in modern legislation,[15] but much of the intent of those Acts has been circumvented either by administrative neglect or outright refusal to provide services targeted to Indians.

Before 1921,[16] there had been no specific authorization for the appropriation and expenditure for most of the programs which the Bureau of Indian Affairs had come to maintain for the benefit of Indians. In the Congress, appropriations for the Bureau of Indian Affairs were subject to a point of order objection which frequently resulted in cumbersome and time-consuming maneuvering while Indian programs hung in suspense. This frustrating process was at least partially relieved by passage of the Snyder Act which authorized items of appropriations in nine broad program areas:

> The Bureau of Indian Affairs, under the supervision of the Secretary of the Interior, shall direct, supervise, and expend such moneys as Congress may from time to time appropriate, for the benefit, care, and assistance of the Indians throughout the United States for the following purposes:
>
> General support and civilization, including education.
>
> For relief of distress and conservation of health.
>
> For extension, improvement, operation, and maintenance of existing Indian irrigation systems and for development of water supplies.
>
> For the enlargement, extension, improvement, and repair of the buildings and grounds of existing plants and projects.
>
> For the employment of inspectors, supervisors, superintendents, clerks, field matrons, farmers, physicians, Indian police, Indian judges and other employees.
>
> For the suppression of traffic in intoxicating liquor and deleterious drugs.
>
> And, for general and incidental expenses in connection with the administration of Indian Affairs.

A pertinent interpretation of the Act was made in December, 1971, by Assistant Solicitor for the Division of Indian Affairs, Department of the Interior, Charles Soller. In that written opinion to the Commissioner of Indian Affairs, Mr. Soller stated that: "On its face, the underscored language is abundantly clear and requires no interpretation. Literally, it authorizes the expenditure of funds for the purposes within the named program categories for the benefit of any and all Indians, of whatever degree, whether or not members of federally recognized tribes, and without regard to residence so long as they are within the United States * * *. With language so unequivocal, it is subject to the general rule of the law that plain and unambiguous statutory language will be followed * * *."[17] The opinion states that the Snyder Act will support a broader eligibility for Bureau services, but it cautions the Bureau against extending BIA services to all Indians without first considering other "statutory limitations"[18] and without first consulting with appropriate congressional committees. Apparently, however, the Bureau never got a chance to take those other two steps because the Commissioner received specific instruction from the then Assistant Secretary, Harrison Loesch, not to divert the Bureau's "attention and limited funds from our basic responsibility of serving on-reservation Indians."[19]

Not only was the rationale weak which the Assistant Secretary presented for this limitation of services, but the statement itself shows a lack of understanding. He apparently understood that no off-reservation Indians were receiving Bureau services, except in special hardship cases. But, as explained in considerable detail by the Supreme Court in *Morton* v. *Ruiz*, the provision of BIA services "clearly has not been limited to reservation Indians" only.[20] Native Americans in Oklahoma and Alaska have received and still are receiving certain services from the BIA, whether they reside on or off the reservation.

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[13] *Mott* v. *U.S.*, 293 U.S. 848 (1931).

[14] *U.S.* v. *Nice*, 241 U.S. 591, 598 (1915).

[15] *E.g.*, sec. 302 of the Comprehensive Employment and Training Act of 1973, 87 Stat. 839, makes nonreservation Indian groups and organizations eligible as prime sponsors for manpower programs.

Under the Native American Programs Act of 1974, 88 Stat. 2323, the Office of Native American Programs in the Department of Health, Education, and Welfare has the objective to provide direct support for self-determination programs aimed at improving the health, education, and welfare of Native Americans both on and off reservations. Legislative history of the Act suggests that Congress intended ONAP to expend the largest share of its budget on programs for nonreservation Indians. Analysis of ONAP grants, however, indicated that approximately 60 percent of its budget is going to reservations.

Public Law 93-638, passed on Jan. 4, 1975 (88 Stat. 2203) also includes nonreservation Indians as eligible contractors under the provisions of the Act by defining a tribal organization as any "recognized governing body of any Indian tribe" or "any legally established organization of Indians which is controlled, sanctioned, or chartered by such governing body or which is democratically elected by the adult members of the Indian community to be served by such organization . . ." sec. 4(e).

The recent passage of P.L. 94-437, title V, indicated the Federal Government's recognition of the urban Indian's health problem; however, rather than solving the problem, it highlights many of the complex issues surrounding urban Indian health care. As well as other issues, P.L. 94-437 highlights the following needs: (1) identification of all public and private health service resources within the urban center which may be available to urban Indians; (2) assistance of urban Indians in becoming familiar with and utilizing such resources; and (3) provision of basic health education to urban Indians.

[16] 25 U.S.C. 13.

[17] U.S. Dept. of the Interior, Office of the Solicitor, Scope of the Snyder Act of Nov. 2, 1921, 42 Stat. 208, 25 U.S.C. sec. 13, memorandum of Commissioner of Indian Affairs from Asst. Solicitor Division of Indian Affairs, Dec. 9, 1971.

[18] *Ibid.*

[19] U.S. Dept. of the Interior, Office of the Assistant Secretary, Adherence to Our Long-Standing Policy of Not Providing Special Bureau of Indian Affairs Services to Off-Reservation Indians, Memorandum from Asst. Secretary for Public Land Management Harrison Loesch, to Commissioner of Indian Affairs, Jan. 16, 1970.

[20] 415 U.S. 199, 212 (1974). This is also true for services provided by the Indian Health Service.

The Indian relocation program and general assistance benefits connected with that program are extended to nonreservation Indians.[21] Special vocational training programs have long been made available to off-reservation Indians.[22] Educational services had similarly been extended to them by virtue of the Johnson-O'Malley Act.[23]

It is true that the Court in the *Ruiz* case did not interpret the Snyder Act as *requiring* the Bureau to provide its social services program benefits to all Indians. But it is equally true that the decision interpreted the Snyder Act in broad enough terms so that such an application would be permissible. It stated that:

> We need not approach the issue in terms of whether Congress intended for all Indians, regardless of residence and of the degree of assimilation to be covered by the general assistance program. We need only ascertain the intent of Congress with respect to those Indian claimants in the case before us.[24]

Thus, the Court chose to avoid a definitive judgment on the overall issue by limiting its holding that the Bureau of Indian Affairs has the duty to provide general assistance services to Indians living "on or near the reservation" and who maintain close economic and social ties to the reservation. In spite of this requirement, BIA Manual still blatantly states that it limits eligibility to "on-reservation" Indians plus Oklahoma Indians and Alaskan Natives.[25]

The persistent refusal of the Bureau of Indian Affairs to address the problems of off-reservation Indians and to accept responsibility for fostering programs which will meet the needs of these Indian people, underscores a very basic discrepancy in the United States Indian policy.

The agent entrusted to carry out the trust which the United States assumes in its relationship to Indian people, should be eager to carry out that trust in whatever area it may encompass. To deny the rights of Urban Indians is to question the position of all Indians in United States policy. As Syd Bean, Executive Director of the Phoenix Indian Center testified at a Task Force Eight hearing, "if the off-reservation Indian communities are forced to terminate their rights for special Indian services then the Federal Indian relationship is threatened for all Indians."[26]

The Urban Environment and Urban Solution

Between the intentions of the lawmakers and the reality of regulatory actions lies the service gap that confronts the urban Indian. The result is untold desperation and waste of human resources.

Most Indians who migrate to the cities say they would have preferred not to do so at all. Still, the census figures for the years 1960-1970 show a rate increase of from 30 to 45 percent, and an HEW report published in 1970 sheds some light on the reasons.[27] The report

[21] 25 U.S.C. sec. 471. *See Morton v. Ruiz*, 415 U.S. 199 (1974).
[22] *Morton v. Ruiz*, 415 U.S. 199 (1974).
[23] 25 U.S.C., sec. 452.
[24] 415 U.S. 199, 211 (1974).
[25] 66 Indian Affairs Manual, sec. 3, 4. *See* generally, V. Deloria, Jr., "Legislative Analysis of the Federal Role in Indian Education," contract for the Dept. of Health, Education and Welfare, 1975.
[26] Written testimony submitted by Syd Beane at a hearing conducted by Task Force Eight, Feb. 9, 1976, p. 14.
[27] "A study of Selected Socio-Economic Characteristics of Ethnic Minorities Based on the 1970 Census: vol. III, American Indians," Office of Special Concerns, Office of the Assistant

showed that the most apparent shift from reservation to city was among those of prime employment age, between 20 and 40. It also showed that older Indians—those beyond the age of peak employment—moved back to their reservation. The report concluded that the lack of job opportunities in rural and reservation areas lent impetus to the migration.

The survey and results of the hearings by Task Force Eight affirmed that most Indians move to urban areas with hopes for jobs or for finding better jobs than on the reservation and rural areas.[28]

Regrettably, this expectation has often remained for the most part unfulfilled. The HEW report suggests that low employment may be due to inadequate vocational training,[29] a conclusion supported by the Commission's finding in two areas. One is that educational facilities on reservations are limited in standard, and the reservation is where most Indians receive their education. The other is that Indians who are educated in programs initiated outside the BIA often find that the skills they learn are not salable, and that job placement activities are limited. To date, employment assistance has been geared toward placing Indians in low-paying, entry-level jobs, rather than orientation and training for positions that could lead to upward mobility.

It has only been in the last 5 years that the BIA has ostensibly changed their former "relocation" policies. The new thrust, announced by Commissioner Louis R. Bruce in 1972, was a policy advocating for the end of termination era programs. Some of the more imaginative uses of employment assistance funds has followed emphasizing on-reservation training for tribal economic programs. Unfortunately, this emphasis is too late for those Indians who have employment and social problems in the cities.

The lack of employment opportunities leads to a downward spiral that reduces the urban Indian's life to a struggle for subsistence. For example, the private practice system of health care is certainly beyond the financial reach of most newly arrived urban Indian families. They must depend on public services. Yet here, the service gap reveals itself again. Ineligible for Indian Health Service assistance because he is off the reservation, the urban Indian finds that other means of finding medical attention are closed off as well.

Non-Indian health service hospitals are often reluctant to admit Indian patients for fear they will not pay. Local welfare agencies and charitable organizations often have the same fear, compounded by a belief that all Indians are the responsibility of the Federal Government. These agencies already juggle funds and personnel to serve as many needs as possible and often deny Indians treatment entirely or serve them in a superficial way.

Yet, the urban Indian often has special problems requiring treatment that is costly, prolonged and, to be successful, must be based on understanding of complex sociological factors. Two examples are the high incidence of both alcoholism and drug abuse. Both leave the urban

[28] Response from 62 organizational questionnaires regarding the needs of urban Indian communities showed employment needs for the most frequently mentioned and respondents characteristically mentioned this before any other.
[29] *Ibid.* HEW report, p. 51.

Indian not only in wretched physical condition, but also in danger of social repercussions, jail, and repeated fines.

Few alternatives exist in the areas of housing. Urban Indians, unschooled in rents, mortgages, or leases because of their lives on the reservation, are often targets for unscrupulous and dishonest landlords. Lacking preparation, orientation, and money, the Indian often finds himself in overpriced, substandard housing located in marginal neighborhoods.

If he tries to ease the financial and emotional burdens by sharing living quarters with another family, the results are often unsatisfactory. Overcrowding and unhealthy living conditions are two immediate results, and harrassment from landlords is almost certain to follow. Families in particular often become discouraged at this point and return to the reservation, remaining only until resources are exhausted to try the cities once again.

This back-and-forth migration works to the Indian's disadvantage. The task of gathering information that will document the problem is difficult and programs that could be funded by grants are hard to justify. It also limits the experience of social welfare agencies with unique Indian problems. Thus it becomes hard for these agencies to become conversant with the specific problems and to assist Indians accordingly, even if funds and staff were available.

One solution has been proposed and tried, with some success. Until recently, the Snyder Act provided for equity grants to be used in making downpayments on homes. These grants were available to relocatees who remained in the same city for 3 to 5 years. The programs was recently cut back, a casualty of economic pressures that have reduced funding for social service programs. Reinstituting it would be highly effective, particularly if it were extended to all Indians.

THE URBAN CENTERS

In this bleak picture, the only real source of help for city Indians has been the urban centers that grew spontaneously out of informal Indian community get-togethers. Indians who moved to cities found that they shared many of the attitudes and the problems of other urban Indians. Across tribal differences, they immediately established friendly ties with Indians who were already established in the cities and sought to help Indian newcomers as they moved into the cities. Eventually, this feeling of comradeship inspired the idea that Indians could help each other out if they organized Indian Community Centers. These centers called "urban centers" present a number of options for Indians facing the urban world. Unfortunately, the Federal Government has failed to recognize the significance and utility of these centers for administering, or assisting in, the implementation of Federal programs for urban Indians.

For newly arrived urban Indians, the center's first function is to provide emergency care. This care may range from provision of food and clothing to finding housing by tracking down relatives or keeping up with available apartment and home listings. After dealing with these emergencies, services run the gamut from education to health care to psychological assistance.

It should be emphasized that urban Indians have done much to add to the cultural diversity and richness of many of the communities in which they live. Many cities have become justifiably proud of the Native American population. As a matter of fact, cities like Los Angeles have set the pace with support of Mayor Tom Bradley and other city officials in advocating for their Indian residents. Since this is particularly a discussion of the rule rather than the exception, we must say that the city of Los Angeles is one of the rare exceptions.

The reader should not suppose that each urban area is serviced by a highly integrated and consolidated agency called an "Indian Center." In many locations, this is a recent effort. In others, Indian centers have existed and worked with many other Indian organizations for a number of years. As Thomas Greenwood, acting president of the Indian Health Service, Inc., of Chicago, Ill., stated in his comments on the American Policy Review Commission's tentative final report:

> In Chicago and probably in many other cities as well, a network of more than twenty Indian organizations services the total population. Several are very general and inclusive in the programs that they offer; others concentrate on specific issues * * *. The reasons for the multiplicity of organizations are complex—relating to administrative convenience, tribal divergence, certain peculiarities in traditional modes of organization and attitudes toward power, circumstances in funding, and accidents of history. It is not clear whether a single comprehensive agency handling Indian programs in a given city is feasible—or desirable. To designate "Indian Centers" as the recipient of funds without considering the question is simply to invite problems.

Suffice it to say, however, that the model center providing multiple services seems to be the most efficient and practical method of delivering assistance whether run by one Indian center board of directors or by a board of several participating organizations.

Centers in many cities have set up educational programs, organized job banks and given moral support to those seeking employment. However, efforts are impeded because there is no mechanism for coordination of BIA vocational training programs. Though urban centers keep up to date lists of job opportunities, this knowledge is not used as the basis for the BIA vocational training program. Thus the BIA may train welders in cities offering opportunities for computer programers. Indians themselves have organized more innovative approaches to funding jobs in the city.

The Bureau of Indian Affairs continues to support Employment Assistance Offices in most cities with large Indian populations. Yet, these offices do not work with "unofficial" urban centers which are the point of contact for most Indians seeking work. BIA Employment Assistance is one of the most needed services for urban Indians, but ironically most urban Indians do not meet eligibility requirements. It is extremely unfortunate in that Federal programs neglect to use grassroots solutions to this problem.

The most difficult off-reservation service is health care. Physical requirements for facilities and fiscal requirements for personnel make it difficult for the urban center to attempt primary care, let alone the specialized therapeutic services that Indians need. Though Public Law 94-437, title V indicated the Government's recognition of the problem, it set up criteria for assistance that are difficult to fulfill.

The law states that an urban center must "determine the Indian population which are or could be recipients of health referral or care services . . ." and "identify gaps between unmet health needs of urban Indians and the resources available to meet such needs." The problem, of course, is the migratory patterns of urban Indians who, defeated by the lack of opportunities available to them in either reservations or cities, often move back and forth from reservation to urban centers Because population determinations are the basis upon which aid is provided, urban Indians are once again short changed.

NEW COMMUNITIES AND CONTINUING SERVICES IN NEW ENVIRONMENTS

Perhaps the most important contribution of the urban centers to the Indian living in cities has been a psychological one. Having left the tribal community, and often, their families, Indians feel isolation and loneliness. They developed these centers as places where such needs are partly satisfied and where they can join together in social gatherings that substitute for the personal security of the reservation. Some of the centers have evolved from very small groups organized for recreational purposes into multifaceted operations capable of sustaining programs in education and vocational training, defense of tenant rights against unscrupulous landlords, counseling, various kinds of entertainment and the provision of emergency relief. There can be no doubt that these Indian service and cultural organizations are a firmly based and creative response to Indian problems.

The Indian service centers present an ambitious range of services and objectives.

Unfortunately, they must rely on donations and volunteer work. Moreover, leaders who operate these centers are often volunteers and usually overworked. They serve out of a feeling of responsibility to the Indian community. While this is one of the dynamic and inspiring aspects of the development of urban centers, it has an unfortunate long-term effect in that there are necessarily frequent changes in leadership. While individual centers may expand or collapse, it is important to realize that the majority of urban centers have provided, and are continuing to provide, valuable services to people who are inadequately assisted through other channels. Moreover, they provide these services without usurping the relationship of the individual Indian to his tribe. The centers strengthen the urban Indian's ties to his cultural heritage by providing necessary facilities and services within an Indian setting. These organizations reinforce, rather than destroy, Indians' identification with their tribes and their heritage.

Because of the broadbased, highly sensitive services these urban centers provide, the Commission believes that their role in assisting Indians should be strengthened with trained staff and money. The Federal Government should realize that urban centers, created seperately and directed by Indians themselves, are an effective instrument for reaching the Government's goals of assisting urban Indians.

Indian centers suffer from a lack of management information and procedural standards. Like their reservation-based counterparts, tribal governments, they are often expected to know the rules when they do

not have them and to live up to unexplained standards. Provision of data on ways to effectively organize and manage the delivery of human services would be of great assistance in enriching the role for urban centers.

Fiscal and management assistance is necessary if these centers are to provide the kind of service that will enable their people to live productive lives. This assistance should be administered in several ways.

In employment, the most expedient way to provide assistance is to build on the philosophy of Indians operating Indian programs. This would entail turning over BIA Employment Assistance Offices and their programs to urban centers.

Furthermore, it would provide an administrative base necessary for an urban assistance program. Administration could be carried out by existing urban Indian centers in close cooperation with tribal governments.

The Commission devoted a great deal of time to studying this alternative. Part of the study involved contacting urban center directors. While many directors felt the centers could administer funds the best, they acknowledged that tribal governments should also play an important role. As these governments stabilize politically and economically, they could be practical mechanisms for managing funds for their own membership.

Many programs now directly administered by Federal, State, or local governments are often contracted out to private or public organizations. These are contract awards for urban services which would not be otherwise allocated to Indian tribes. Urban Indian organizations, however, are frequently discriminated against in these kinds of situations, and private non-Indian contractors benefit from contract opportunities which should properly be delegated to Indian professional people. Indian service centers, once given the opportunity and clear identification of the obligations that go with it, are very capable in hiring professionally qualified personnel.

RECOMMENDATIONS

The Commission recommends that:

1. The executive branch of the Federal Government conduct a detailed examination of assistance programs and need areas that would be most expeditiously administered by tribal governments.

2. The executive branch provide for the delivery of services to off-reservation Indians consistent with the Federal obligation to all Indians. Accordingly, Congress recommend that the executive branch deliver appropriate services when feasible through urban Indian centers.

URBAN CENTERS

3. The executive branch provide financial support for Indian centers in urban areas. This could be expedited by turning over BIA Employment Assistance Offices and other Federal contracting opportunities to urban service centers; and delegating Federal domestic assistance dollars directly to urban centers on a fair per capita share basis.

4. The executive branch consider the placement of Federal fun targeted for urban Indians under an Urban Indian Office as a pa of their considerations for the Consolidated Independent Indi Agency.

5. The Federal agency funding such urban center or centers dete mine the actual representation of such center or centers according t a process of membership certified to the agency.

EDUCATION

6. The executive branch mandate that urban centers receive:

Specific consideration for the receipt of Johnson-O'Malle funds;

Technical assistance and orientation in programing, budgetin regulations, and funding programs;

Specific roles in program and policy formation in curriculu development for teaching and administrative staff hiring f schools with Indian children;

Funding for administrative and program costs.

HOUSING

8. The executive branch mandate that urban Indian centers be su ported to provide:[30]

A real estate clearinghouse to provide information on availab living quarters;

Consumer education programs in the areas of credit procedur lease information, and general advice on moving from the rese vation to an urban area;

Grants for initial moving costs, immediate support, rent su plements, housing improvements; and

The Bureau of Indian Affairs reestablish the program former funded providing equity grants for downpayments to urban I dians who have lived in the city for more than 2 years.

HEALTH

9. The executive branch mandate that appropriate action be tak to provide urban Indians with health care facilities by providing t urban Indian center with funds to:

Administer Indian health care programs;

Provide information for health care;

Contract for Indian health care;

Establish health educational programs;

Establish health care programs on its premises; and

Act as a monitor for funds designated for urban Indian heal care.

[30] These funds are presently provided to the Bureau of Indian Affairs for the sa purpose.

CHEROKEE NATION
WRITTEN TESTIMONY OF CHAD SMITH
PRINCIPAL CHIEF, CHEROKEE NATION
BEFORE THE SENATE COMMITTEE ON INDIAN AFFAIRS
HEARING ON A BILL
TO REAUTHORIZE THE INDIAN HEALTH CARE IMPROVEMENT ACT
April 13th , 2005

INTRODUCTION

I am Chadwick 'Corntassel' Smith, Principal Chief of the Cherokee Nation. Today, I believe it is important that I communicate to the Senate Committee on Indian Affairs (SCIA) Cherokee Nation's comments regarding the Urban Issues within the Reauthorization of the Indian Health Care Improvement Act. I respectfully request that my written testimony be made a part of the Hearing record.

CHEROKEE NATION HISTORY

I would like to share with you some history and background about Cherokee Nation. Even before the infamous Trail of Tears, the Cherokee Nation was one of the largest tribes and occupied 126 million acres of land, an area that today includes parts of 8 states: Tennessee, Kentucky, Georgia, Alabama, South Carolina, North Carolina, Virginia and West Virginia.

Through 10 treaties, the first of which was in 1721, the Cherokee Nation ceded half its land base to the British, and 12 additional treaties with the new U.S. Government followed. Consequently, the Nation's land base was diminished to 12,000 square miles by 1819. In 1838, 7,000 federal troops were sent to remove the 16,000 Cherokees who lived in the southeastern United States, and 4,000 died on the Trial of Tears on the journey to Indian Territory (present day Oklahoma).

Following the removal, the Cherokee Nation rebuilt its infrastructure with the establishment of 150-day schools, two seminaries for higher education, lower and upper systems of courts, and a penal system, along with other vital functions. Then the most tragic days fell upon Cherokee Nation with the Dawes Act of 1887, which stripped lands and all government buildings and property from the Nation and paved the way for Oklahoma Statehood. Even the Cherokee National press was taken and sold under the Dawes Act.

Presently, Cherokee Nation has a Tribal Jurisdictional Service Area (TJSA) of 7,000 square miles (4.4 million acres or only 3.5% of our original lands), comprising all or part of 14 counties in northeastern Oklahoma. Cherokee Nation represents over 230,000 tribal citizens, nearly half of whom live within our TJSA and is the second largest Native American tribe. Cherokee Nation has approximately 1,900 tribal employees (making us one of the largest employers in Northeast Oklahoma), about one-third of whom work in the Nation's health services group.

In 1990, the Cherokee Nation was the first tribal government to enter into a self-governance agreement with the United States Department of the Interior under Title III (now Title V) of the Indian Self-Determination and Education Assistance Act, as amended. The Nation entered a second self-governance agreement with the Department of Health and Human Services (DHHS), Indian Health Service, as soon as it was authorized in Fiscal Year 1994. Under our self-governance agreement with DHHS, the Cherokee Nation provides comprehensive health services through 6 outpatient clinics, two nurse practitioner clinics, behavioral health system, women's health, Health Promotion/Disease Prevention, and other ancillary programs and services to approximately 126,000 American Indians. These same IHS beneficiaries are also served by two

Indian Health Services hospitals: Hastings Indian Medical Center and Claremore Indian Hospital. Therefore, Cherokee Nation has a strong understanding and experience as a health care provider.

URBAN CLINIC HISTORY

The Urban Indian health programs were authorized by Title V of the Indian Health Care Improvement Act (IHCIA) enacted in 1976, P.L. 94-437. The Tulsa and Oklahoma City Clinics were provided a unique status in the FY 87 Interior Appropriations Act as Demonstration Projects, with $500,000 transferred from Title V to create the new service units. Since that time the Demonstration Projects have been funded under the Indian Health Services (IHS) Direct Care Program, and are included in the "Hospital and Clinics" budget line item, which funds tribal and IHS facilities. Both the Tulsa and Oklahoma City Demonstration Projects have operated under a buy-Indian contract.

The Department of Justice challenged the feasibility of continued funding of urban Indian health programs through the Indian Health Service. Concern over this challenge prompted Congress to set the two clinics aside as Demonstration Projects. In 1992 the Indian Health Care Improvement Act further clarified how the two Oklahoma Demonstration projects should be treated. This clarification was made without Tribal Consultation. In any event, one primary reason the two urban programs in Oklahoma were under the Demonstration was due to their unique status as being the only two urban facilities located within tribal jurisdictional areas and "Contract Health Service Delivery Areas (CHSDAs)" of IHS.

The Indian Health Care Resource Center of Tulsa is located within the jurisdiction of the Muscogee (Creek) Nation. The Claremore Indian Hospital is located 20 miles Northeast of Tulsa. The Muscogee (Creek) Nation is currently building a new health care facility in Coweta, just 15 miles Southeast of Tulsa. Muscogee (Creek) Nation also operates a primary care clinic in Sapulpa, which is also within 30 miles of Tulsa.

Both the Tulsa and Oklahoma City Urban Clinics are 501(c)(3) nonprofit organizations that are governed by Boards of Trustees. Some, but not all members of the Boards are Native American. The primary funding source for these programs is from the IHS Direct Services Hospital and Clinic line item. Supplemental funding comes from additional sources including grants, contracts, and third party revenue. These programs have some of the best track records in the IHS of leveraging third party resources to expand the available health services.

Membership on the Boards of Trustees for the Demonstration Projects is not contingent on tribal membership, tribal representation or tribal affiliation. Members of the Boards are not elected by the tribes they serve. The Boards of all other Service Units, whether operated by the tribes or IHS, are either elected by the membership of the tribe within whose jurisdiction the clinic is located, or are appointed by the elected officials of such tribe. Because these independent organizations are not required to have such tribal representation, the Boards of Trustees for the Demonstration Projects are not accountable to the people they serve.

Due to high unemployment in rural areas, Cherokee citizens, like members of other tribes, were forced to move away from their traditional homes to urban communities to seek employment and provide for their families. Recent census information indicates that of the total Native American population, approximately 60% reside in urban areas. However, these Indians in urban residents have not historically accessed Urban Indian Health systems to the same degree experienced in rural areas. Choices and insurance allow for greater private sector utilization.

Cherokee Nation has been a strong collaborator with and advocate for the Indian Health Care Resource Center of Tulsa, Inc., one of these demonstration projects under Title V of the IHCIA. Cherokee Nation began its collaboration in 1976 with the establishment of a satellite Women's, Infants' and Children's nutrition program, which continues today. Three years ago, the Executive

Director was invited to serve on Cherokee Nation's Long Range Health Plan 2015 as a member of the Advisory Committee. This effort resulted in a set of comprehensive recommendations for developing infrastructure, programs, services, and potential future partnerships for Cherokee Nation through 2015.

CONCERN WITH PROPOSED LANGUAGE IN THE REAUTHORIZATION

Notwithstanding our unwavering support of the Tulsa demonstration program, Section 512 of the current reauthorization contains language that Cherokee Nation and other tribes deem as an attack on tribal sovereignty that needs to be corrected. Exempting these two programs from the ISDEAA would provide autonomy to a non-profit board of trustees, which essentially operate an IHS Service Unit within tribal jursidiction. The following is an excerpt of the language in question, Section 512, Reauthorization of IHCIA P.L. 94-437.

> SEC. 512 TREATMENT OF CERTAIN DEMONSTRATION PROJECTS.
> (a) Tulsa and Oklahoma City Clinics - Notwithstanding any other provision of law, the Tulsa and Oklahoma City Clinic Demonstration projects shall become permanent programs within the Service's direct care program and continue to be treated as service units in the allocation of resources and coordination of care, and shall continue to meet the requirements and definitions of an Urban Indian organization is this title, and as such will not be subject to the provisions of the Indian Self-Determination and Educational Assistance Act.
> (b) Report- The Secretary shall submit to the President, for inclusion in the report required to be submitted to the Congress under section 801 for fiscal year 1999, a report on the findings and conclusions derived from the demonstration projects specified in subsection (a).

The above styled language undermines the government-to-government relationship, which has existed with tribes and particularly with the Cherokee Nation, memorialized in treaties beginning in 1785, 220 years ago. Since passage of the Indian Self Determination and Education Assistance Act in 1975, the Congress has consistently upheld the concept and vision that the tribal governments, and the citizens thereby represented, should be in control of the federal programs and services provided to them.

REMEDY FOR TRIBAL GOVERNMENTS

We support the following language that represents the voice of tribal leaders serving on the National Steering Committee, Cherokee Nation, and the Inter-Tribal Council of the Five Civilized Tribes (Cherokee, Choctaw, Creek, Chickasaw and Seminole Nations).

> SEC. 512 TREATMENT OF CERTAIN DEMONSTRATION PROJECTS.
> TULSA AND OKLAHOMA CITY CLINIC – Notwithstanding any other provision of law, the Tulsa Clinic and Oklahoma City Clinic demonstration projects shall –
> (1) be permanent programs within the Service's direct care program;
> (2) continue to be treated as Service Units in the allocation of resources and coordination of care; and
> (3) shall be subject to the provisions of the Indian Self-Determination and Education Assistance Act, except that the programs shall not be divisible.

The above proposed language is consistent with the Congress' long-standing policy that Indian tribes themselves should have meaningful authority, control, funding and discretion to plan, conduct, redesign and administer programs, services, functions and activities that meet the needs of individual tribal communities. Non-profit organizations and businesses do not enjoy the government-to-government relationship -- no treaties have been signed between these entities and the U.S. Government. Any programs operated by these third parties, which are not tribal

organizations or tribes as defined by the ISDEAA, should remain accountable to the tribes that they serve. Therefore, the Cherokee Nation urges the Committees to include within Section 512 language that such service's direct care program and allocations to support those services be subject to the provisions of the Indian Self-Determination and Educational Assistance Act (ISDEAA).

The two existing 'demonstration projects', one in Tulsa and the other in Oklahoma City, are now seeking a 'permanent program' status within the Service's direct care programs and to continue to be treated as service units for allocations. Permanency is something that the Cherokee Nation supports, ***provided*** that the ISDEAA applies to these programs. Although being subject to ISDEAA allows for the funds to be assumed by tribes under either a compact or contract, our recommended language ensures sustainability for the delivery of urban Indian health care by making the funds for the programs indivisible. This means if tribes were to assume operation of the program under ISDEAA, the funds could not be divided into separate programs, but must be operated as one unit. This provides for both continuity of the program, as well as accountability of the program to tribal government.

Our recommended language provides a reasonable compromise: the programs are provided permanency and tribes gain consistency with Self-Determination policies previously articulated by the Congress. The Cherokee Nation believes, with this change, it is in the best interest of tribal citizens to ensure continuity of care through the provisions afforded with compacting or contracting.

During the last IHCIA Reauthorization push in the 108th Congress, Cherokee Nation continually advocated for application of the ISDEAA to the Oklahoma City and Tulsa Urban Clinics. Since the IHCIA Reauthorization did not pass in the 108th, Cherokee Nation began preparing to advocate for the application of ISDEAA within the IHCIA Reauthorization for the 109th. However, in the Fiscal Year 2005 Omnibus Appropriations Bill, language was inserted which gives the Oklahoma City and Tulsa demonstration projects permanency as well as an exemption from the ISDEAA:

> Notwithstanding any other provision of law, the Tulsa and Oklahoma City Clinic demonstration projects shall be permanent programs under the direct care program of the Indian Health Service; shall be treated as service units and operating units in the allocation of resources and coordination of care; shall continue to meet the requirements applicable to an Urban Indian organization under this title; and shall not be subject to the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.).
> ***H.R. 4818, P.L. 108-447***

Although this issue has been addressed in Appropriations Legislation, Cherokee Nation urges Congress to address the issue within the Reauthorization efforts in the 109th Congress. Cherokee Nation urges Congress to maintain its position to protect tribal sovereignty by supporting the compromised language that grants permanency to the Urban Clinics, while mandating that they be subject to the ISDEAA.

CONCLUSION

In conclusion, I, as the elected Principal Chief of Cherokee Nation, along with the chiefs and governors of the Five Civilized Tribes and other tribes echo the expressed voice of the National Steering Committee, urging the Senate and Congress to reauthorize the Indian Health Care Improvement Act with the above stated language, which is the product of the intense consultation between tribes.

This written statement and testimony provides evidence that neither tribal leaders nor tribal politics would create an injurious atmosphere regarding operations of the two 'demonstration projects' if assumed under the ISDEAA. If the tribes under the ISDEAA assumed the program, those tribes

or consortia of tribes would be committed to enhance and expand the capacity to provide services to American Indians. Such a process would only serve to combine the strengths of a tribe and either of the Urban Health programs, not to diminish the program.

The Cherokee Nation does not oppose making the Tulsa and Oklahoma City clinics permanent programs within the IHS direct care program, but strongly believes that the Congress has a responsibility to ensure that the sovereign rights of tribal governments are not diminished. It is well established that tribes have the inherent right to self-determination and to self-govern.

A strong difference exists between a tribe's commitment to their tribal members and an Urban Health board's commitment to their clients/customers. One operates as a government, the other a business. Tribes are the primary stakeholders and Congress should pass legislation that maintains the highest level of integrity and respect between our governments.

Cherokee Nation thanks you for this opportunity to provide a written statement and testimony to express our position on this vital legislation reauthorizing the Indian Health Care Improvement Act.

Wa-Do.

Chad Smith
Principal Chief

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Statement of H. Sally Smith, Chairman

National Indian Health Board

Oversight Hearing on

American Indian and Alaska Native Health

April 13, 2005 – 9:30 a.m.

Senate Russell Building, Room 485

Chairman McCain, Vice-Chairman Dorgan, and distinguished members of the Senate Indian Affairs Committee, I am H. Sally Smith, Chairman of the National Indian Health Board (NIHB). I am Yupik from Alaska and also represent the Bristol Bay Area Health Corporation in southwestern Alaska. On behalf of NIHB, it is an honor and pleasure to provide a broad overview of health needs, in terms of access to care, health disparities and public health issues, throughout Indian Country.

The NIHB serves 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, as well as upholding the federal government's trust responsibility to American Indian and Alaska Native Tribal governments. We strive to advance both the level and quality of health care and the adequacy of funding for health services that are operated by the Indian Health Service (IHS), 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.

Historical and Current Context

On September 11, 2001, the United States changed forever. We always knew the threats of terrorist attacks were real and looming, but as a nation we did not collectively confront the issue and make necessary, sweeping changes until after the events of September 11 occurred. We are now facing a similar dilemma in

Indian Country. Nowhere is the need for urgent action more poignantly articulated than in the tragedy that recently occurred on the Red Lake Reservation. It has left Indian Country with a heavy heart. However, it also brought to light the collective resolve and ability of American Indian and Alaska Native communities to respond to tragedy in a supportive and awe-inspiring manner. Tribes all across this nation quietly delivered support and aid to the Red Lake community. And while we all recognize that this type of violence and tragedy can happen anywhere, we must learn that unanswered need can foster unimaginable tragedy. As a part of surveying the status of the health care delivery system in Indian Country, it is clear that we cannot afford to allow the behavioral and mental health infrastructure crisis in Indian Country to continue, unaddressed.

Similarly, across Indian Country the crisis in health care is well documented and well known to both policy makers and the Indian Communities for which they are tasked with addressing basic human health care need and assuring access to adequate health care services. For example, several times before today, we have testified that the United States invests nearly twice the funds for the health care of a federal prisoner as it does or an American Indian or Alaska Native. We have testified that the life expectancy of AIs/ANs is nearly six years less than any other race or ethnic group in America. We have demonstrated that 13 percent of AI/AN deaths occur in those younger than 25, a rate three times higher than the average US population. The US Commission on Civil Rights reported in 2003 that "American Indian youths are twice as likely to commit suicide…Native Americans are 630 percent more likely to die from alcoholism, 650 percent more likely to die from tuberculosis, 318 percent more likely to die from diabetes, and 204 percent more likely to suffer accidental death compared with other groups." None of this information is new and the statistics have not worsened since 2003. Despite this, the health care disparities in Indian Country remain. The Red Lake tragedy should serve as a decisive indicator, like the canary in the mine shaft, that the health care crisis in Indian Country is real, tangible and, left unanswered, capable of tragedy. Today, let us begin again and do as the great Lakota leader, Sitting Bull, said: "Let us put our minds together and see what life we can make for our children."

Health Promotion/Disease Prevention Issues and Needs of Indian Country

In Indian country, we recognize we have a public health epidemic. As stated, our disease and mortality rates are higher than the rest of the U.S. population. We live on the average six years less than our fellow Americans. Our youth are more likely to commit suicide. 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. The prevalence of diabetes in our communities as we have come to rely on Western foods instead of our traditional diets is causing us to lose vital community members at earlier ages.

There is a growing body of empirical evidence in the Americas, as well as across Europe, Asia and other continents, that very clearly demonstrates the effectiveness of prevention. Prevention works. It's much easier and less costly to prevent disease, disability, injury, and premature death than to treat poor health conditions once present. But all too often, too many communities are left behind, and suffer from very poor health status. Today we will also share with you some compelling stories about pockets of documented progress and success stories. Despite these successes and progress, Native Americans continue bear some of the highest disease burdens of any society on earth.

According to the Indian Health Service (IHS), life expectancy of American Indians and Alaska Natives is 70.6 years compared to the U.S. population of 76.5 years, and the vast majority of illnesses and deaths are from diseases and conditions that are preventable. Despite America's vast resources, these inequities in health status continue to increase. We have already provided a statistical snapshot of just a few of these disparities. In addition, the prevalence of obesity in Native populations has increased dramatically over the past 30 years and obesity is a risk factor for diabetes that now affects over one quarter of the adult Indian population. About 40 percent of Native children are overweight and the number of Indian people with diabetes has doubled in the past five years.

Clearly, these statistics are staggering. Our young people across this great are crying out. Their cries are heard in these statistics. All of us at the National Indian Health Board are deeply saddened by the tragedy at Red Lake Chippewa Nation. We stand in unity with the entire Red Lake community and offer our deepest sympathy to Tribal members and all of those impacted. Such deeply unfortunate events give witness to nationwide statistics that demonstrate the tremendous need to increase our prevention efforts. While history shows that shootings can occur in any community, the significant disparities in available prevention funding are contributing to a growing epidemic; American Indians and Alaska Natives suffer from 70 percent higher suicide and more than double homicide rates, compared with non-Indian populations. Suicidal and violent behavior in our young people is an indicator of a larger problem related to the looming mental health crisis America faces. In fact, according the Substance Abuse and Mental Health

Services Administration, American Indians and Alaska Natives have the highest prevalence of severe mental illness of any racial or ethnic group in the nation.[i] The research study clearly documents the co-occurrence of serious mental illness and substance abuse disorders. So incidents like Red Lake, albeit sad, should be no surprise to us. Deeper budget cuts promulgated by poor public policy will simply exacerbate these challenges. We are facing a crisis of enormous proportions.

As we enter the 21st century, America remains the World's only sustained superpower. Yet, it is not among the industrialized nations' top ten for protecting and promoting the public's health. Recent data show the U.S. ranked 24th (down from 19th in 1989) among industrialized nations in infant mortality, the single most common public health indicator.[ii] We have all learned that poverty and other social and economic pressures are known contributors to the entire U.S. population's health status. According to a 2002 paper by the National Association of County and City Health Officials, entitled "Creating Health Equity through Social Justice," the "inequalities in health status in the U.S. are large, persistent, and increasing. Research documents that poverty, income and wealth inequality, poor quality of life, racism, sex discrimination, and low socioeconomic status are the major risk factors for ill health and health inequalities. Great social costs arise from these inequities, including threats to economic development, democracy, and the social health of the nation." Certainly, this is the situation we currently face in Indian country."[iii]

Certainly we have made some advances. Where we do see progress in health indicators, what makes the difference? Resources make the difference. But, not resources alone; rather, those specifically targeted to population health improvements work. According to the Institute of Medicine, public health practice is what "...we as a society do collectively to assure the conditions in which people can be healthy." Every one of us in this room benefited this morning from a strong public health system, or prevention infrastructure. It may be invisible to many of us, but think about it. When you awoke this morning, you probably showered, and brushed your teeth. You had running water. Water that is tested continually to be sure it is safe for human ingestion. Prevention capacity is not about medical care, but it targets entire populations and is extremely cost effective.

There is also a growing body of evidence that clearly shows the benefits of what The Robert Wood Johnson Foundation calls *Active Living by Design*. This impacts not only structures, but also the culture of entire communities. Research shows that children excel in these environments, and are less likely to abuse drugs, to

miss school, to loose sleep, and consequently, they perform better in school. Tribes are no strangers to this knowledge; many Tribes are building their own Wellness Centers. But these efforts require resources, training, and support, and too many communities cannot afford the buildings, staff, and equipment because all available funds are going to treat disease, injuries, substance abuse, and other health problems that are easily prevented.

The health disparities movement in the U.S. and abroad has helped shed light on these dramatic inequities in health status. While we know a great deal about these disparities, little action has been taken to address the inequity in available prevention capacity for all communities and governments. To fulfill its important leadership role in Indian country, NIHB hopes to change this by working with Congress, the US Department of Health and Human Services (DHHS), private partners, Area Indian Health Boards, and Tribes to strengthen their ability to protect and improve health.

However, little is known about the capacity for preventing disease and reducing mortality throughout Indian country. By leveraging IHS shares, other public sources, and private revenues, many Tribal governments make substantial contributions to prevention investments, but these investments are not to scale in order to address adequately the need for an improved prevention infrastructure. Tribes are increasingly developing ideas on new programs, services, capacities, and approaches needed to help improve the health of Indian country. Additionally, Indian country is learning about changes in communities that impact, both positively or negatively, the health of Native populations. But these programs are grossly under funded, and, relative to state and county governments, Tribes do not benefit equally from federal and state resources intended for public good.

According to the Institute of Medicine, the U.S. spends approximately $1.62 trillion dollars annually for medical care costs, and approximately 2 percent of these funds, or $32 billion dollars, are spent on prevention capacity. These funds are leveraged to strengthen public health capacity in counties, cities and states in areas of communications, disease surveillance, reporting, rapid response and mobilization, workforce development and training, and information technology. Indian communities have been largely overlooked despite our growing populations and health challenges. Indian country is going to experience our population health status falling even further behind if we do not take bold action to build our own culturally appropriate approaches to address health at a population level. Relative to our county and state counterparts, the prevention infrastructure available to

Tribes is sorely lacking in capacity. I appeal to Congress to earmark prevention dollars so that collectively we can build a more equitable prevention infrastructure throughout Indian country.

With decreasing public funds at state and county levels, Tribal public health agencies will be increasingly overlooked for funding opportunities made available by the DHHS agencies as well as numerous philanthropic organizations that specialize in improving health and quality of life for all peoples. Congressionally earmarked funding for states with AI/A populations living within state borders often fails to reach Tribes[iv], and state legislatures are increasingly pressured to divert tobacco settlement and other funds previously allotted for public health programs to building and maintaining roads and other basic services.

There are bright spots, and in some areas, DHHS agencies have made progress in ensuring Tribal government eligibility to compete for funding opportunities. Many Tribes recognize and appreciate this progress, but ensuring all public resources are equally available to Tribal governments and organizations and that application processes appropriately accommodate population health status needs of Indian country requires significantly more improvement. NIHB is working closely with new partners to ensure these improvements occur.

Public Health Workforce

Tribes face significant challenges with respect to preparing and sustaining a well-trained public health workforce. Using a virtual training center framework, NIHB is working with CDC and other partners to increase the number of American Indians/Alaska Natives in public health careers. Historically, we all know IHS is grossly under-funded to provide resources dedicated to direct primary, secondary, and tertiary health care services, leaving little resources for prevention activities. But we must assure that every community has access to the basic building blocks of public health systems, including assessment and epidemiologic capacity, a trained workforce, strong emergency preparedness systems, communications infrastructure, and program implementation capacity to improve health status. These capacities will enable Tribes to advance chronic disease prevention and health promotion, HIV/AIDS, STD and TB prevention, diabetes, injury prevention and control, non-ceremonial tobacco use, and nutrition, physical activity, obesity, etc. We also need to build strong partnerships outside of the health systems to address the myriad social factors such as a high unemployment rates that cause the poor health status of American Indian/Alaska Native populations. These functions require new partnership approaches outside the realm of health organizations, and

access to training and technical expertise. Despite the challenges inherent in such an undertaking, it is within our reach if we work together on developing national policy and funding that supports such innovation.

Additionally, rising health care costs coupled with the growing AI/AN population, the prevention investments are not keeping pace need. And in Indian Country, investments remain drastically behind county and city expenditures. We must act now to put better prevention systems in place. These funds can be wisely allocated to support comprehensive public health service delivery systems operated by Tribal Public Health Departments and Wellness Centers that can recruit and train staff in:

- establishment of Tribal public health departments and wellness centers
- community health assessment systems, which require trained epidemiologists
- communicable disease management systems (STDs, etc.)
- preventive health screening services (cardiovascular screening programs, etc.)
- occupational safety/injury prevention programs
- healthy worksite initiatives
- parent education programs
- substance abuse prevention (tobacco, alcohol, methamphetamines, and other drugs)
- domestic violence prevention
- suicide prevention
- teen health promotion
- restaurant and facility inspections, and animal/livestock control, which requires trained sanitarians

These capacities will enable Tribes to advance chronic disease prevention and health promotion efforts targeting HIV/AIDS, STD and TB prevention, diabetes, injury prevention and control, non-ceremonial tobacco use, cancer, fetal alcohol syndrome, and nutrition, physical activity, obesity, and other critical ingredients needed to grow and sustain healthy communities.

American Indians and Alaska Natives have rich cultural histories grounded in community harmony and well-being. Since 1978, through Public Law (P.L.) 93-638 programs, we have seen that facilitating culturally appropriate interventions through local control of delivery systems can produce powerful outcomes. An important element that must not be overlooked in helping our communities create

health is the importance of our traditional medicine. This is a great source of strength for our people. More recently, with the Federal government no longer outlawing the practice of our traditional beliefs and customs, there has been a widespread awareness and an increased desire to resume cultural practices. For many communities, the practice of traditional Tribal medicine and spiritual ceremony may be an important component of the overall approach to achieving good health and eliminating disease. The prevention and intervention concepts embedded in traditional ceremonies (such as sweat lodge and other ceremonies) reinforce and strengthen the family and community. Using the Native cultural approach addresses the concern that many Indian youth are growing up having never been exposed to the beliefs of their ancestors that coming into adolescence with increased experience, and knowledge of their culture may help in the self-identity process.

To address the impending shortage of public health workers nationwide, in March 2005, Senator Hagel introduced a Bill to "amend the Public Health Service Act to establish a scholarship and loan repayment program for public health preparedness workforce development to eliminate critical public health preparedness workforce shortages in Federal, State, local, and tribal public health agencies." NIHB is working with Senator Hagel's staff to ensure Tribal eligibility is clearly stated in the Bill, and we greatly appreciate this opportunity. As currently drafted, the Bill would require the Secretary to provide direct funding only to states, who would then have discretion over the engagement of Tribes: "The head of the State or local office that receives a grant under subsection (a) shall be responsible for contracting and operating the loan repayment program under the grant." Tribal governments work closely with state governments on a variety of programs. But history clearly shows that funding Tribes directly results in better outcomes. The federal government has a long history of funding Tribes, and through P.L. 93-638, Tribes have demonstrated success in operating effective, efficient, and culturally-relevant programs. Enticing our young people to the pursue careers in public health is important work, and will be 100 percent more effective if leadership from Tribal governments and organizations are stewards of this recruitment. Funding only the states and not the Tribes for loan repayment programs will predictably diminish the likelihood that Native American students will pursue public health careers.

Many things change, but an old adage still holds: *an ounce of prevention is worth a pound of cure.* It's time we made the same investments in prevention delivery systems. Relative to county and state counterparts, the prevention infrastructure available to Tribes is sorely lacking in capacity. It's time we worked together to

change this scenario. Science has taught us that prevention works. I am confident that we are all here today because we believe in the power of democracy. When it comes to public health, disease has no borders. America is only as healthy as our least healthy communities. I am urging Congress to work with Indian Country to create policy and provide funding that strengthens our prevention capacity. Let this be our legacy for tomorrow's children.

Contract Support Costs

In light of the recent United States Supreme Court in the Cherokee Nation and Shoshone Paiute Tribes of the Duck Valley Reservation Contract Support Costs case, it is an appropriate invest time in taking a hard look at the amount of funding appropriated each year for Tribal governments that elect to operate their own health care delivery systems through compacting/contracting with the Indian Health Service (IHS). The Court ruled unanimously in favor of the Tribes, requiring the Federal Government to pay money damages for failing to pay contract support costs to these tribes for Fiscal Years 1994 through 1997.

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, the costs associated with those responsibilities increase. Tribal programs have clearly increased the quality and level of services in their health systems fairly significantly over federally operated 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. Inadequate funding requires Tribes to scale back services and programs in order to cover the necessary administrative costs under the contract/compact.

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 functions will 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. Specifically, NIHB recommends an additional $100 million to meet the shortfall for current contracting and compacting; further, we recommend that funds additional to this increase be sufficient to support 20-25 new Tribal programs anticipated this Fiscal Year.

Department of Health and Human Services Tribal Consultation Policy

As one of his final actions as Secretary of Health and Human Services (HHS), on January 14, 2005, Secretary Tommy G. Thompson signed the U.S. Department of Health and Human Services - Tribal Consultation Policy. His signature concluded several months of hard work by the Tribal Consultation Policy Revision Workgroup (TCPRW), the Office of Intergovernmental Affairs, and federal participants from the various operating and staff divisions of the Department.

With the continued support of HHS Secretary Michael Leavitt, the policy will prove to be a valuable tool to institutionalize Tribal consultation throughout the Department. More importantly, it will provide the foundation for American Indian and Alaska Native Tribal governments to solidify working relationships with all operating divisions within the Department, which has previously not occurred. In the coming years, we look forward to increasing access to resources available at agencies in addition to those received from the Indian Health Service.

Health Facility Construction

The FY 2006 budget request includes 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. The remaining funds will be used for the construction of staff quarters at Fort Belknap, Montana. While the facilities at Fort Belknap are sorely needed, the rest of Indian country has equally critical facility construction needs.

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 President's budget proposes 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 efficient use of federal resources, in other words, it works. 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.

Diabetes

The July 2003 United States Commission on Office of Civil Rights report, A Quiet Crisis, found that American Indians and Alaska Natives have the highest prevalence of Type 2 diabetes in the world, and rates are increasing at "almost epidemic proportions." Type 2 diabetes is largely preventable and can be managed with healthy eating, physical activity, oral medication, and/or injected insulin.

The leading cause of mortality for American Indians and Alaska Natives is heart disease. However, hidden in that statistic is the fact that the largest percentage of deaths from heart disease is caused by diabetes. Thus, diabetes is both devastating the community in terms of quality of life and "maiming and killing" American Indians and Alaska Natives.

Another startling fact regarding the prevalence of Type 2 diabetes is that it has recently become a significant threat to American Indian and Alaska Native children. Its incidence is rising faster among AI/AN children and young adults than any other ethnic population.

The Special Diabetes Program for Indians is growing into a success story. It's developing a community spirit and Tribal governments and communities are working together in a proactive approach to combat diabetes. The recently-submitted report on the Special Diabetes Program for Indians to Congress shares many of the advancements Indian Country has made in the areas of: Increased prevention activities; Increased treatment; Integrated prevention and treatment activities in culturally appropriate methods and by a multidisciplinary approach; Improved Data; Information Sharing and Best Practices; Utilizing Tribal Consultation; and Developing partnerships with the non-Indian community to combat diabetes.

The Special Diabetes Program is currently funded at $150 million annually through FY 2008. Congress and IHS worked with Tribal Leaders to make this program possible and we stand committed to seeing it permanently authorized and made a permanent fixture in American Indian and Alaska Native Communities.

Government Performance and Results Act (GPRA) and the Program Assessment Rating Tool (PART)

The Government Performance and Results Act (GPRA) addresses an array of concerns regarding government accountability and performance. The Indian Health Service and related programs have embraced the performance measures and have made vast improvements in several areas.

Here are a few success stories.

Whiteriver Service Unit

In 2001, the WRSU (Whiteriver Service Unit) of the Indian Health Service made a commitment to improving pneumococcal vaccination rates in persons aged 65 years or older. Additional funds were procured to improve data quality and carry out a campaign to vaccinate those who had not yet been vaccinated. According to GPRA analysis, the WRSU pneumococcal vaccination rate in American Indians 65 years or older increased from 58% in 2001 to 77% in 2002, 88% in 2003, and is presently at 93.4% for the first quarter of 2004. WRSU has met the pneumococcal vaccination rate goals set by IHS, Healthy People 2000 and Healthy People 2010. Additionally, this service unit met the Healthy People 2010 overarching goal of eliminating disparity for pneumococcal vaccination in this American Indian community. WRSU appears to have the highest community pneumococcal vaccination rate among IHS facilities or any state/territory of the United States.

Influenza vaccination is another success story. Using a multi-disciplinary approach, WRSU has increased influenza vaccination rates among those 65 years or older from 51% in 2001, to 60% in 2002, 74% in 2003, and 81.5% for the first quarter of 2004 by GPRA analysis. Again, WRSU has met IHS and Healthy People 2000 influenza vaccination rate goals for persons over 65 years, and has met the Healthy People 2010 goal of eliminating disparity for influenza vaccination rates in this American Indian community.

WRSU has improved rates in 15 of 17 indicators reported for the first quarter of 2004, and is presently evaluating the use of 12 additional Health Plan Employer Data and Information Set (HEDIS) or developmental indicators for upcoming reports.

Colville Service Unit

Colville is an excellent example of an overall success. Previously, they had met only 1 of the 7 GPRA indicators. The Colville Chief Executive Officer noticed the poor performance indicators and pledged to make GPRA clinical indicators a priority. He enlisted the help and guidance of a locally developed clinical quality team. Each member of the team (which included representatives from each section of the clinic) was involved in developing appropriate ways to highlight and improve indicators. Their success stemmed his leadership, as well as the involvement of the entire staff. By the end of that year, they had met 6/7 of their indicators.

The intended purpose of the Program Assessment Rating Tool (PART), developed by the Office of Management and Budget (OMB) is to evaluate programs and link performance to appropriations. The Indian Health Service has been an active participant and has scored very well, especially in comparison to other federal agencies. The question consistently raised by Tribal leadership is why does the Indian Health Service continue to be under funded, despite scoring well according to OMB criteria? The answer provided by OMB when confronted with such a question is that while PART is a tool that measures performance, it is not the only criteria utilized to determine appropriations. While Tribal leadership does not dispute such a response, we feel strongly that effective and cost efficient programs should be maintained and properly funded in order to carry out the essential functions of government.

The Hidden Epidemic: Dental Health Care for Alaska Natives

The combination of Alaska Native populations doubling since 1970, the dearth of dental health care providers in Alaska and the number of Alaska Native children suffering from tooth decay at 2 1/2 times the national rate, there is an epidemic of tooth disease and decay in Alaska Native villages. While most mainland Americans have no idea that this crisis is occurring, this epidemic is not really hidden; rather, it is unveiled with every smile that reveals missing or decayed teeth in the mouths of Alaska Natives of all ages.

In 1991, a dental manpower study was conducted in Alaska. The study concluded that if the IHS/Tribal health system doubled the number of dentists in Alaska**, it would take 10 years to eliminate the unmet need for dental services**. Despite this modest recommendation, there have been no funding increases to pursue this effort, nor has the dental community provided funding to address the issue or offered a viable solution.

For the 85,000 Alaska Natives who live in the 200 villages without road access, the only time dental services are available is when a dentist flies in to conduct a dental clinic. Alaska Tribal Health Programs experience a 25 percent vacancy rate among dentists and a 30 percent average annual turnover rate. Tribal health programs have increased their dental budgets above the IHS allocation of funds so that they could increase salaries. Despite these measures, dentists do not choose to live in remote, isolated communities or to travel via small prop-planes on a weekly to even more remote villages to conduct clinics in buildings that do not even have running water. Volunteers cannot fill this gap: if they could, the need already would have been addressed. Instead, a new solution was needed.

Community Health Aide Program (CHAP)

In order to address this need, the Alaska Native Health Board took the proactive step of endorsing the Dental Health Aide Program as a means to begin planning, certification, and drafting standards for the establishment of the Dental Aide program. The board that carried out this process included experienced Public Health Dentists, local community members, Community Health Aide Practitioner Directors and Aides, attorneys and other experts as necessary. National funders have provided an extensive financial support to move this program into the implementation stage. The first class of Dental Health Aides has been trained and are now in their preceptorship training, with dentists, in regional hospitals.

The CHAP concept was developed by IHS in the 1950s in response to the tuberculosis epidemic, high infant mortality, and the high rate of injuries in remote villages of Alaska. CHAP was authorized, exclusively for Alaska, by Congress in the Indian Health Care Improvement Act in the 1970s. CHAP has become the backbone of health care for Alaska Natives who live in traditional villages that are inaccessible by road. Today there are 5000 Chas in Alaska providing over 300,000 patient visits each year. Community Health Aides (Chas) are mostly Alaska Native people chosen by their villages. They are thoroughly trained, carefully supervised and supported. Chas work under the supervision and standing orders of physicians who closely monitor and assess their skills and performance. The work of the CHAs, therefore, alleviates mid-level practitioners and physicians from some lower level duties thereby allowing them to focus limited health care resources on more demanding tasks.

CHAs are certified (and recertified every two years) by a federally appointed Board of health professionals from the IHS, State Department of Health and Social

Services, and Tribal health programs. They must participate in continuing education annually and have their work observed by a supervising dentist. The Community Health Aide Program has been a model for the world. President Bush used the program as a template for South Africa and Afghanistan. The Dental Health Aide Program (DHAP) is a local solution to a local crisis. Alaska Native people, through representation on the Alaska Native Health Board, endorsed this solution for the dental crisis. It will be as successful as the Community Health Aide Provider Program because local residents receive training and employment, and provide high quality care to their community. The Dental Health Aides will have had as many hours of educational clinical experience in the limited number of procedures they are permitted to do as most dentists receive during their educational program and be closely monitored by licensed dentists. They will be supported by telemedicine access to the dentist who will be able to actually view the same tooth and x-rays that the Aide is examining and be subject to biannual recertification and continuing education requirements. It is our expectation that Dental Aides will be the latest addition to the mid-level health care providers in America that have proven to be successful in delivering cost effective and safe health care services within their scope of practice.

Medicare and Medicaid

Preserving the Medicaid Program

NIHB is working with over 150 other organizations to save the Medicaid program from substantial cuts during the creation of the House and Senate Budget Resolutions and to realize the establishment of a Bipartisan Commission on the Future of Medicaid.

The purpose of the proposed Commission is to provide a one-year window of opportunity for this panel to produce a studied and thorough examination of the Medicaid program. Through this product, the Commission would offer Congress an informed blueprint for reform, rather than adopting the approach suggested in the President's budget: cut Medicaid to achieve savings. NIHB supports both bills and each enjoys strong bipartisan support. HR 985 has 135 Cosponsors (59 Republicans and 76 Democrats) and S. 338 has 32 Cosponsors (20 Republicans, 11 Democrats and 1 Independent.) Efforts to establish this Commission include urging both bill sponsors to amend their proposals to stipulate that at least on Commissioner be an American Indian with experience in the delivery of health care in Indian Country. In sum, the Bipartisan Commission on the Future of

Medicaid would offer a studied response and appropriate policy recommendations to Medicaid growth.

NIHB also opposes the proposed cuts that Congress currently is considering to the Medicaid program. We understand the costs of the Medicaid program are growing at an alarming rate; however, as the payer of last resort for million's of American's health care, the increase in costs is more indicative with underlying socioeconomic issues than with the Medicaid program, itself. A disproportionate number of American Indians and Alaska Natives comprise the Medicaid population. In Alaska, alone, 40 percent of Medicaid recipients are Alaska Natives. Therefore, cuts to the Medicaid program will have the unintended consequence of further limiting AI/AN access to critically needed health care services. During the Senate budget resolution debate, Senators Gordon Smith (R-OR) and Jeff Bingaman (D-NM) sponsored an amendment which sought to zero-out the Medicaid cuts and replace them with a reserve fund to operate the proposed Bipartisan Commission. While their effort was successful, a similar provision did not pass the House of Representatives. We are very hopeful, for the sake of the tens of thousands of AIs and ANs who benefit from the Medicaid program, that the proposal of Senators Smith and Bingaman will prevail.

Medicare Modernization Act

In comments recently-submitted to the Administrator for the Centers for Medicare and Medicaid Services (CMS), NIHB demonstrated that the Medicare Modernization Act of 2003 (MMA) contains provisions that will have serious and potentially negative impacts on the Indian health care system. Subsequently, in evaluating the Act and the proposed regulations to implement Parts C and D, we identified that a significant adverse impact of lost Medicaid revenue to the Indian health care system, or IHS/Tribal and Urban (I/T/U) health service programs, will occur. We estimate these to be between $25-50 million effective January 1, 2006, with the roll out of provisions of the Act that affect the so-called "dual eligible" Medicare/Medicaid enrollee. (*An I/T/U pharmacy is one operated by an Indian health program such as a Tribe, the Indian Health Service, a Tribal organization or an urban Indian health clinic. I/T/U pharmacies provide or reduced cost prescription drugs to people with Medicare who are American Indian or Alaska Native*).

On January 1, 2006, I/T/U pharmacies will lose the ability to collect from state Medicaid program payments for drugs for dual eligible enrollees who will then

have to enroll in a private sector Medicare drug benefit plan as the Medicaid drug coverage they previously enjoyed will be precluded by the MMA. This will result in an immediate loss to the I/T/U of $25-50 million Medicaid revenue which will not soon be recovered, or even recovered in whole at some later date, with the roll out of Part C and D Medicare plans. This lost revenue to the I/T/U, which supplements an already under-funded Indian health care system, will undoubtedly exacerbate the well known health disparities that already exist between American Indians/Alaska Natives (AI/AN) and the general U.S. population (reference is made to the recently released report by the U.S. Commission on Civil Rights entitled, Broken Promises: Evaluating the Native American Health Care System.)

Our evaluation of the proposed regulations for Parts C and D raises the concern that if private sector plans are not required to engage with I/T/U's, through either network or out-of-network arrangements, the bulk of the lost Medicaid revenue to the I/T/U's on January 1, 2006, will never be recovered under the MMA, and the Indian health care system will sustain a damaging set back. Congress recognized in 1976, the shortcomings of funding to the Indian health care system and legislated access to Medicare and Medicaid benefits for all eligible AI/AN's, and to the Indian Health Service and Tribal programs that serve them. We do not believe the implementation of the new MMA provisions are intended to do harm to these already grossly under-funded Indian programs. It remains our concern that, short of a legislative correction in the MMA the Indian health care system will suffer an adverse impact as a result of the roll out of MMA programs that affect the status of dual eligibles ("dual eligibles" are individuals who are eligible to receive care under both the Medicaid and Medicare programs). CMS has not corrected this problem with in the Regulations published earlier this year.

Because most Indian health facilities are located in remote areas far distant from the mainstream health system, they must also operate pharmacies so their patients can access needed medications. I/T/U organizations operate 235 pharmacies throughout Indian Country. IHS and tribes dispense pharmaceuticals to their Indian beneficiaries without charge, as is the case for all health services they offer.

A sizeable portion of the patient base for I/T/U pharmacies consists of dual eligibles. IHS estimates that there are between 25,963[1] and 30,544[2] individuals in the IHS patient database who are receiving both Medicare and Medicaid. Since this database does not include information from some tribally-operated facilities

[1] This number represents 85 percent of the three-year total of active users.
[2] This is the number of active users, defined as at least one visit in the past three years.

(those that do not use the IHS computerized data system) or information about Indians served by urban Indian clinics, the number of dual eligibles is even greater than the IHS database reveals.

While there is no comprehensive data on the per-capita drug costs for dual eligibles in the Indian health system, we have been able to make some rough estimates by examining average state per-capita spending for this population. In 2002, the average per-capita spending for dual eligibles was $918.[3] We believe this is a very conservative figure for Indian Country, in view of the higher rates of illness that have expensive drugs associated with their treatment, including diabetes and mental illness. Furthermore, the IHS calculates that the cost of pharmaceuticals has increased by 17.6 percent per year between FY 2000 and FY 2003. This includes the cost of new drugs, increases in drug costs and population growth. Thus, if we trend the average out to the year 2006, the expected average per capita spending on drugs for dual eligibles would be $1,756.

Using these population and per-capita spending data, we estimate that the Medicaid recovery for dual eligible drug costs in the Indian health system ranges between **$23.8 million**[4] **and $53.6 million**.[5] It is vital that these revenues, so critical to the Indian health system, not be interrupted or reduced when dual eligibles are removed from the Medicaid rolls for prescription drugs with the inauguration of Medicare Part D in 2006. In their present form, however, the proposed Part D rules would jeopardize the ability of I/T/U pharmacies to maintain this level of dual eligible reimbursements.

Barriers to Part D access of Indian Dual Eligibles

There are several reasons why the intended conversion of dual eligibles from Medicaid to Medicare could be extremely problematic in the Indian health system:

- Switching payment sources from Medicaid to Prescription Drug Plans (PDPs) under Part D will hurt AI/AN consumers and Indian health providers because most tribes are located in extremely rural areas where market forces do not make it advantageous for private plans to establish networks. Dual

[3] From Table 2, "Full" Dual Eligible Enrollment and Prescription Drug Spending, by State, 2002, in "The 'Clawback:' State Financing of Medicare Drug Coverage" by Andy Schneider, published by the Kaiser Commission on Medicaid and the Uninsured, June 2004.

[4] This low number was calculated using the 25,963 figure for dual eligibles in 2003 and the $918 per capita spending in 2002. It is probably unrealistically low for 2006 given the increase in aging population in Indian Country and the increase in drug prices.

[5] This higher number uses the 30,544 number of dual eligibles in 2003 and the $1,756 estimated spending in 2006.

eligibles in those areas will have difficulty accessing the Part D benefit unless they use an Indian health pharmacy admitted to PDP networks.

- Medicaid revenues have been an important source of income for Indian health facilities. **As drug coverage for AI/AN dual eligibles is removed from Medicaid and placed under Medicare, the amount of revenue in jeopardy is estimated to be between $23.8 million and $53.6 million.** Reductions in reimbursements for pharmaceuticals cannot be absorbed by raising rates for other services, as Indian patients are served without charge.

- The level of revenue an I/T/U would collect under Part D will very likely be less than it currently collects under Medicaid for dual eligible drug coverage. Therefore a "wrap around" payment from Medicare, consisting of the difference between the PDP/Medicare Advantage Prescription Drug Plan (MA-PD) contract amount and the amount the I/T/U would have received under Medicaid, must be utilized to "hold harmless" I/T/Us, if an I/T/U contracts with a PDP/MA-PD.

- If private prescription drug plans are not required to contract with I/T/U pharmacies, there will be little incentive for them to do so, as the service population of these pharmacies is comparatively small and the Indian population tends to be sicker. Without network status or payment for off plan services, an I/T/U pharmacy will not be able to collect for drugs dispensed to any AI/AN enrolled in a Part D plan. This would produce three negative results: (1) a loss of revenue to the I/T/U pharmacy; (2) no meaningful opportunity for the enrolled Indian to use his Part D benefit; and (3) a windfall for the PDP who collects premiums from CMS for a dual eligible, but pays no claims.

- Even if private plans are required to contract with I/T/U pharmacies, this command will be meaningless unless the regulations set out terms specifically drafted to address the unique circumstances of the IHS, tribal and urban Indian pharmacies.

- Even if an Indian beneficiary is enrolled in a Part D plan, the I/T/U pharmacy may not know what PDP or MA-PD to bill. Particularly with automatic enrollments, the AI/AN dual eligible may not know what PDP/MA-PD he or she has been enrolled in and it may be difficult for the I/T/U pharmacy to get this information. There may be additional delay in

accessing the benefit if the individual has to disenroll and then enroll in a PDP/MA-PD for which the I/T/U pharmacy is a network provider. This situation mirrors the disastrous consequences suffered by the I/T/Us when State mandatory Medicaid managed care enrollment programs were implemented.

- If delays in implementation occur, it is not clear how the I/T/U pharmacies will recoup payment for expenditures made during the period between when the AI/AN is switched from Medicaid to Medicare pharmacy benefits and when the I/T/U pharmacy is an established network provider or able to bill for out of network services. Even if the I/T/U pharmacy is allowed to bill for services provided from the beginning of 2006, they may not have the staff to deal with a backlog of billing. Confusion and lack of information could result in not billing for covered services.

The Part D program will also impact AI/AN Medicare beneficiaries who are not dual eligibles and must pay a premium for Part D participation. Since these individuals receive drugs at Indian Health Service and tribal health pharmacies without charge, there is no incentive for them to pay premiums to enroll in a Part D plan. In order to be able to collect reimbursements for drugs dispensed to those patients, CMS must facilitate group payer options for tribes who wish to pay premiums for these beneficiaries in order for their pharmacy to be reimbursed for drugs dispensed.

The Secretary of Health and Human Services, as the principal steward of Indian health, has a responsibility to assure that the MMA, which was intended to benefit *all* Medicare beneficiaries, does not produce the opposite result for *Indian* Medicare beneficiaries who use the Indian health care system. He can guard against such an outcome by exercising the broad authority granted to the Secretary by Section 1860D-4(b)(1)(C)(iv) of the MMA which authorizes him to establish standards to assure access to Part D for I/T/U pharmacies. By this provision, Congress recognized that access for Indian beneficiaries means the ability to utilize that benefit through I/T/U pharmacies.

AI/AN Medicare beneficiaries who are not eligible for low-income cost-sharing subsidies may receive drug coverage directly from I/T/U pharmacies or under CHS referrals. While these payments will count toward the AI/AN beneficiary's annual deductible, they will not count as incurred cost toward meeting the out-of-pocket threshold ($3,600 in 2006). The reason, in brief, is that "incurred costs" are defined

by section 1860D-2(b)(4)(C)(ii) of the Social Security Act to exclude payments by "insurance or otherwise." But this statutory provision does not expressly include the I/T/U programs in this term. Rather, it is CMS, not the law that has defined what is encompassed by the term "insurance or otherwise". The agency has chosen to include I/T/U health programs as "insurance or otherwise," – but has not explained the basis for that decision, nor analyzed the impacts of it on the IHS-funded system and affected Indian Medicare beneficiaries, nor acknowledged that failing to count I/T/U pharmacy contributions toward "incurred costs" would be a windfall to the PDP in which an affected Indian is enrolled. Perhaps CMS recognized that this matter requires additional thought, as it asks for comments on "how ... IHS beneficiaries will achieve maximized participation in Part D benefits."

The effect of CMS's decision to treat I/T/U programs as "insurance or otherwise" is to minimize, not maximize, participation of IHS beneficiaries in Part D benefits. As CMS itself acknowledges, "most IHS beneficiaries would almost never incur costs above the out-of-pocket limit." (69 FR at 46657). And, as CMS further recognizes, this policy "would likely provide plans with additional cost-savings." We do not believe that Congress intended Part D to be administered to minimize participation by AI/AN beneficiaries and to increase revenues for PDP and MA-PD plans at the expense of I/T/U programs. Yet that is precisely the result that the proposed rule achieves.

This is not required by the statute. Section 1860D-2(b)(4)(C)(ii) does not expressly prohibit payments by I/T/U programs from being treated as "incurred costs." By using the phrase "not reimbursed by insurance or otherwise," Congress intended to give CMS discretion to fashion a sensible definition consistent with federal policy. AI/ANs are not "reimbursed" by their IHS or tribal health care providers or by any insurance. Rather in the case of AI/AN beneficiaries, that federal policy is the trust responsibility of the United States to provide health care to AI/ANs pursuant to laws and treaties. And, as CMS acknowledges in the Preamble at p. 46651, the I.H.S. "fulfills the Secretary's unique relationship to provide health services to AI/ANs based on the government-to-government relationship between the United States and tribes." In other words, AI/AN Medicare beneficiaries have a different legal standing than other Medicare beneficiaries.

The final rule, however, does not recognize this "unique" legal relationship. Instead, the proposed rule would require those AI/ANs who are Medicare

beneficiaries, but not eligible for the low-income subsidy program, to pay substantial amounts out of pocket for their Medicare prescription drug coverage in order to meet the out-of-pocket threshold. In this way, the proposed rule violates the federal trust responsibility, under which AI/ANs are entitled to needed health care services, including prescription drugs, at the federal government's expense.

Section 1860D-2(b)(4)(C)(ii) specifies that costs shall be treated as incurred if they are paid "by another person, *such as* a family member, on behalf of the individual." (*emphasis added*). In the "unique relationship" between the federal government and AI/ANs, the I/T/Us are the functional equivalent of a "family member." Their mission, on behalf of the federal government, is to pay for prescription drugs and other health care services needed by AI/ANs. In terms of paying for prescription drugs, there is no functional difference between I/T/Us fulfilling their obligations to AI/ANs and family members fulfilling their obligations to one other. Again, there is nothing in the concept of family members paying incurred costs to suggest that Congress somehow intended that payments by I/T/Us on behalf of AI/ANs not be treated as incurred costs.

In the preamble of the rule, CMS explains that contributions made by charities would be considered "incurred costs" and describes in detail the reasons for a desirable objectives achieved by this decision. Many of the considerations recited there apply to the I/T/U system, particularly the outcome that Medicare beneficiaries who are not eligible for the low-income subsidy would be able to qualify sooner for the catastrophic coverage level. In other words, these beneficiaries would have a better opportunity to fully utilize their Part D benefit.

The outcome is just the reverse with regard to an Indian not eligible for subsidy who is served by an I/T/U pharmacy. That Medicare beneficiary would have to pay the same premium for Part D coverage (or have it paid on his behalf by the I/T/U program as CMS suggests at p. 46651), but the benefit received for that premium would be only slightly more than $1000 -- far lower than that of a non-Indian beneficiary. This is so because this Indian patient would never get out of the "donut hole" and thus would never be able to utilize the catastrophic coverage feature of the Part D benefit.

Access to Specialty Care

In many cases, health care facilities in Indian Country are found in remote or isolated locations and they suffer from severe chronic lack of adequate funding.

Many of these facilities have a "skeleton" healthcare staff and most do not benefit from specialized care such as gastroenterology, opthalmology, oncology, or dermatology. In order to receive health care by a specialist, many American Indians and Alaska Natives (AI/AN) must travel great distances, and many do so at great personal expense. While an adequate supply of specialists and primary care physicians in Indian Country remains elusive, effectively addressing this challenge will require innovation, imagination and funding.

Graduate Medical Education

Some innovations already exist. Graduate medical education (GME) is the period of training a physician (MD/DO) undergoes once he or she graduates from medical school. This residency training usually takes place in a hospital, academic medical centers or ambulatory care settings that possess a clinical base and provide health care services. GME funds are provided directly to the institutions where training takes place through Part A of the Medicare program and, to a lesser extent, from the Medicaid program. GME is an entitlement program. Payments to hospitals where residency training takes place are divided into two streams, Direct Costs, which, as implied, apply to the costs directly associated with Resident training, such as salary and benefits, stipends, housing and instructors while the Indirect Cost is provided to hospitals to cover costs such as heat and lights, malpractice insurance, patient care, etc. In 1995, the Medicare program spent $7.1 billion for residency training. According to the Centers for Medicare and Medicaid Services (CMS), the United States currently invests approximately $9 billion from Medicare and $2 billion from Medicaid in educating medical residents each year.

Hospitals in Indian Country are not benefiting from this $11 billion per year investment into health care facilities and physician manpower supply because GME isn't happening in Indian Country. The Omnibus Budget Reconciliation Act of 1997 created a national cap on the number of residency training positions that can exist in America. Two of the limited exceptions under which new residency training programs can be established are rural and underserved areas and in facilities where no such training has never before taken place. In sum, Indian Country is well-positioned to establish residency training programs at its hospitals. While the Federal government does not require teaching programs receiving public funds to be accountable to achieve any physician workforce goals, either in terms of the medical specialty the trainee enters or where he or she will practice medicine, should GME training commence in Indian Country the presence of the training programs and residents involved with bolster access to physicians substantially. In addition, health facilities in Indian country would have the

opportunity to benefit from the GME indirect funding enjoyed by other hospitals in America, both public and private. Hospitals where GME takes place receive, on average, approximately $100,000 per resident per year.

Support for further examination and establishment of GME training sites in Indian Country would be expedited if Congress would support NIHB's efforts to launch a demonstration project devoted to GME development in Indian Country

Telehealth

Telehealth, the practice of licensed health care providers providing health care using electronic forms of communication, is an innovation whose market has arrived: Indian Country. While there are few telehealth projects operating in Indian Country, some already are proving viable and effective. For example, it is utilized in Oklahoma by the UT Southwestern Medical Center is working with the Choctaw Nation with patients suffering from Alzheimer's disease. Once the patient is diagnosed, there need regular face-to-face periodic check-ups is alleviated. The tribe benefited from existing satellite connectivity because Tribal members can visit one of the local patient care centers and receive treatment from the UT Southwestern Medical Center via telehealth. This reduces staff and patient travel time, and allows physicians to assist a greater number of patients. With this added modality of care, physicians can better monitor both the medications they prescribe and any progress in the disease. Telehealth can be used to treat a variety of diseases from mental health care to oncology.

Senators Daniel K. Inouye (D-HI) and Maria Cantwell (D-WA) recently introduced legislation, S. 535, "The Native American Connectivity Act," which seeks to address the telehealth issue. Hopefully, S. 535, will achieve its stated purpose to "enhance the health of Indian tribal members through the availability and use of telemedicine and telehealth." NIHB supports the concept of this legislation.

End of Life Care and Assisted Living Services

Throughout Indian Country there remains a severe lack of End of Life facilities and assisted living facilities. In many cases American Indians and Alaska Natives must travel great distances to benefit from the services provided by nursing home, hospice and assisted living facilities. Those who do receive such care are often uprooted from their families and communities, cared for by strangers and die in this environment. Local facilities would end this scenario.

It is a benefit that the Native population in the United States is becoming increasingly healthier. Programs such as NIHB's Just Move It! Campaign seeks to further increase the health of our native populations. Many Native communities are unaware that they can use CMS-sponsored programs to create nursing home and assisted living facilities near their homes. In 2004, the Cheyenne River Sioux Tribe received a grant for over $200,000 to build a culturally appropriate nursing home facility on their reservation. NIHB believes that this type of assistance should be expanded for other communities.

NIHB recommends that any iteration of the Indian Health Care Improvement Act Reauthorization during the 109th Congress include authority for tribes to provide health care services, such as home health care, nursing care and hospice and assisted living care. We believe that these services are essential to the long term health care of all Native Americans, irrespective of age.

Conclusion

In closing, and on behalf of the National Indian Health Board, we thank the Senate Committee on Indian Affairs for its investment of time, expertise and action into investigating and improving the health care delivery systems used by American Indians and Alaska Natives. Thank you for considering our testimony and the recommendations that it contains. As the Committee works toward achieving the reauthorization of the Indian Health Care Improvement Act, NIHB is committed to assisting you in any way that we can. We will end this testimony as we began it:

Let us begin again and do as the great Lakota leader, Sitting Bull, said: "Let us put our minds together and see what life we can make for our children."

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[i] Epstein, Barker, Vorburger, & Murtha. *Serious Mental Illness and Its Co-Occurrence with Substance Use Disorders*, Substance Abuse and Mental Health Services Agency, Office of Applied Studies, 2002.
[ii] *Differentials, Income Distribution and Trends in Poverty*. Journal of Social Policy 18(3), 1989: p. 307-335; Norman Daniels, Bruce Kennedy and Ichiro Kawachi.
and, Justice is Good for Our Health: How Greater Economic Equality Would Promote Public Health, Boston Review (February/March, 2000): p. 4-9.
[iii] *Creating Health Equity Through Social Justice*. National Association of County and City Health Officials, September 2002.
[iv] *Public Health Infrastructure in American Indian and Alaska Native Communities*, Indian Health Service Roundtable, Rockville, MD, May 2002.

The American Indian/Alaska Native National Resource Center for Substance Abuse Services

Written Testimony of R. Dale Walker, MD, Director
One Sky Center: American Indian/Alaska Native National Resource Center for Substance Abuse and Mental Health Services
Oregon Health & Sciences University

Oversight Hearing on Indian Health
Before the United States Senate Committee on Indian Affairs
April 13, 2005

Chairman McCain, Vice-Chairman Dorgan, and members of the Committee, I am R. Dale Walker, MD, Director of the One Sky Center, and Professor of Psychiatry, Public Health & Preventive Medicine at Oregon Health & Sciences University in Portland, Oregon. I am a Cherokee psychiatrist with qualifications and 25 years' experience in the addictions field. I direct the One Sky Center, the first national resource center dedicated to improving the prevention and treatment of substance abuse and mental health among Native people.

I would like to thank the Committee for holding this important oversight hearing on Indian Health, and for the Committee's efforts to reauthorize the Indian Health Care Improvement Act (P.L. 94-437) this Congress.

I anticipate that the recent tragedy on the Red Lake Indian reservation will be a point of discussion at today's hearing, in addition to the related matter of mental health and substance abuse services in Indian country. One Sky Center has been working intensively on the Red Lake, Standing Rock, and other reservations that have experienced cluster suicides and violence. Our role is assessment of the situation and recommendations for fixing it.

The Center's assessments and recommendations may be helpful to this committee or other committees with jurisdiction for potential legislative efforts related to mental health, substance abuse prevention, and treatment of American Indian and Alaska Natives. Therefore, I am pleased to submit written testimony for the committee hearing record.

Mental Health Overview

According to the Indian Health Service, the highest suicide rate found for American Indians and Alaska Natives is between ages 15 to 34 (approximately 2.4 times the national rate). The overall rate of suicide for American Indians and Alaska Natives is 20.2 per 100,000, or approximately double the rate for all other racial groups in the United States.

Violence and trauma related disorders also occur at alarming rates in American Indian and Alaska Native communities. The rates of violence are higher for every age group among American Indians

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and Alaska Natives. In particular, the rate of violence for American Indians and Alaska Native youth ages 12 to 17 is 65% greater than the national rate for youth.

Domestic violence and childhood sexual abuse transmit the pathology from one generation to the next. The homicide mortality rate for American Indian and Alaska Native females ages 25 to 34 years is about 1.5 times that for the general population of females in this age group. Over crowding in homes, lack of employment, and other socioeconomic issues are associated with high rates of abuse and neglect. About 25.9% of American Indian and Alaska Native families are at or below the poverty level, a significantly higher rate than for the general population. Consequently, there are high rates of physical and mental health problems. The implications for American Indian and Alaska Native individuals, families, and communities are troubling.

These health disparities are attributable to long-term effects of cultural oppression, racism, loss of traditions, "assimilation policies" of boarding schools, severe erosion of family and parenting tradition, promotion of alcoholism and substance abuse. Consequently, sustained, multi-generational behavioral problems are prevalent in our American Indian and Alaska Native communities.

The United States has a trust responsibility and treaty obligation to provide quality health care to American Indians and Alaska Natives. Unfortunately, the Indian Health Service continues to be woefully under-funded. The Indian Health Service (IHS) is funded at $1900 per capita, which is one-half the amount federal prisoners are funded on a per-capita basis. Local resources cannot make up the difference. Some reservations are so destitute that there is no swimming pool or basketball court for the youth, let alone a counselor.

Mental health care including addictions treatment and prevention—if available—is crucial for the well-being of American Indian and Alaska Native people and their communities. Mental health care contributes to preventing tragedies such as we have recently witnessed and, when tragedies do occur, is essential to healing devastated families and communities.

The One Sky Center

The One Sky Center (www.oneskycenter.org) created in 2003, is the first national resource center dedicated to improving the prevention and treatment of substance abuse and mental health among Native people. The One Sky Center's reach is extended by consultants and subcontractors located throughout the country including the Alaska Native Tribal Health Consortium, the National Indian Youth Leadership Project in New Mexico, and United American Indian Involvement in California. A more detailed description is provided in the endnote.[1] Our mission includes assessing communities' needs and strengths, then developing strategic plans, both in culturally appropriate ways. One Sky Center helps to identify the numerous strengths communities have to face challenges including the prevention and treatment of substance abuse, and availability of mental health services. One Sky Center helps identify support and technical assistance from external sources to make changes happen.

Standing Rock, and Red Lake

One Sky Center has responded to federal requests for assistance in recent crises at the Standing Rock and Red Lake Indian reservations. Center staff joined a team of IHS and SAMHSA officials to conduct a community survey leading to a strategic plan (and some incidental psychiatric support for survivors). Persons affected by the suicides and violence, community leaders, school personnel, and

other service personnel participated in strategic planning, beginning with a collective community assessment. Although each tribe and reservation facing suicide and violence are unique, there are major commonalities.

One Sky Center's analysis is that three related initiatives are required. Tribal initiatives bring the key parties together to develop and follow a plan. SAMHSA initiatives include creating funding opportunities to support efforts at the local level and to provide technical assistance. Finally, Interagency initiatives create policy alignment, service coordination, and support among multiple agencies, resulting in a more effective response to community needs.

Recommended Tribal Initiated Activities

- Tribal Health Department should request the development of a suicide and violence prevention plan, which it will review, and refer to the Tribal Council for endorsement.
- Tribal Health Department should organize a *tribal interagency committee on suicide and violence prevention* to improve coordination, communication, and implementation of the tribe's suicide and violence prevention plan.
  - The tribal interagency committee should examine the current organizational structure of providing mental health, addictions, suicide prevention, violence prevention and other social support with the goal of creating a single system of behavioral health care.
  - The interagency committee should establish partnerships (faith-based, traditional cultural leadership, health, schools, law enforcement, etc) dedicated to implementing the plan.
  - The interagency committee should increase the number of professional, volunteer, faith community, traditional cultural leaders and other groups that integrate suicide and violence prevention activities and policies.
  - The interagency committee should promote accurate youth suicide and violence data collection, evaluate preventive interventions attempted on the reservation, and produce an annual report on youth suicide and violence.
- Identify a tribally appointed liaison to newspaper, radio, television, and other news media in regards to suicide and violence. This individual should have available written guidelines on the depiction of suicide, violence, substance abuse and mental illness and be able to represent these events on behalf of the tribe.
- The tribe should seek assistance in accessing federal funding to support suicide and violence prevention measures.

Recommended SAMHSA Activities

- ***Establish a Suicide/Violence Crisis Hotline*:** Hotline to be manned by youth and volunteers trained in programs similar to ones developed by the Oregon Partnership in Portland, Oregon. This team of hotline participants will also serve as a network support team for local crises and patient/family follow-up. The team will be comprised of an even mixture of adolescents and adults, with elders, healers, teachers, etc. welcome.
- ***Provide Support for Community Healing and Recovery*** delivered by traditional cultural leaders and others.
- ***Provide Technical Assistance*:** The Tribal health care systems are fragmented and understaffed. The tribes will require technical support from the beginning stages of developing their plans, to helping the tribal interagency committees on suicide and violence prevention work in an effective integrated fashion, to negotiating interagency support for the tribe. There

are local sources available to do the on-site work and the One Sky Center could assist in coordinating activities at the local, regional and national level. As a resource center, we will follow the issues closely, hoping that this effort may be a model for other reservations.

- ***Provide a Broad Range of Training and Educational activities***: There are several levels in which training and education are necessary.
  - Open community meetings to provide understanding of the issues and reduction of stigma.
  - Training for clergy, traditional cultural leaders, teachers and other school staff, corrections workers, children and youth case workers, child welfare personnel, juvenile justice personnel, child protection services and medical/behavioral health workers to help the community learn how to screen, identify, and respond to youth at risk for suicide.
  - Training for "adult mentors" and "peer mentors" to provide a more capable support system on a reservation with severe access and transportation problems.
  - Educational programs for family and friends focusing on recognition of and response to at-risk behavior.
  - Foster the education of providers of mental health and substance abuse services in dealing with youth at risk of suicide or violence.

Recommended Interagency Support Strategies

There are multiple local, state, and federal systems and agencies operating on reservations. At times, these systems do not interface well and that defeats logical, effective health care planning and implementation. It is critical that the various tribal programs be interconnected, coordinated and aligned. Among the benefits, interagency collaboration will increase early detection and remediation of potential suicide and violence.

Create an interagency task force comprised of an official from each of the agencies involved to address the issues below:

- Define and implement screening guidelines for schools, along with guidelines on linkages with service providers.
- Develop a systematic communications plan for all health care, social, educational, and legal services.
- Improve the quick access to behavioral health treatment for youth who are suicidal and potentially violent with underlying behavioral disorders.
- Improve the interface that youth experience between primary care, emergency care, and mental health.
- Change procedures and policies in certain settings, including primary care settings, hospital emergency departments, substance abuse treatment centers, specialty mental health treatment centers, and schools, to include screening and assessment of youth suicide risk.
- Ensure that youth treated for trauma, sexual assault, or physical abuse in any healthcare setting, including emergency departments, receive consultation, referral, mental health services, and support services. These support services may include domestic violence centers, rape crisis centers, etc.

This strategic plan is a model for addressing similar problems in other reservations and communities. In a broader sense, the model could be considered as a SAMHSA initiative on AI/AN suicide prevention, much like the Circles of Care grants.

Conclusion

1. The One Sky Center is willing to offer its expertise in the areas of substance abuse treatment and prevention, mental health, and best practices if the Committee should seek guidance on those matters. The One Sky Center is qualified to offer insight, experience, and recommendations addressing these problems for the Committee's consideration.

2. Both HHS and SAMHSA have seen the wisdom and advantages of cross agency support and funding for strategic nation-wide efforts. As the Nation's only National Resource Center in behavioral health for this population, it is our sincere recommendation that resources be directed to SAMHSA through HHS for a five year demonstration project to bring the full efforts of all federal and state agencies together to address the issues related to suicide and violence for all American Indian and Alaska Native communities across the nation. The demonstration project approach will allow model programs to develop in all regions of the country. They can be integrated with other native and nonnative communities.

It is safe to conclude that the Indian health community, a majority of federally-recognized tribes, and most Indian health organizations generally agree that the Indian Health Care Improvement Act reauthorization or any other moving legislative initiatives must include provisions to enhance or improve the delivery of mental health services for American Indian and Alaska Native communities. The alarming health disparities, domestic violence, suicide, and major crimes committed on Indian reservations are escalating, and show no signs of relenting unless crucial federal programs are fully funded, which includes critical mental health programs for American Indian and Alaska Native.

The nightmare of having a Columbine School scenario on an Indian reservation has now become a reality. The countermeasures include integrating substance abuse, mental health and social services into comprehensive behavioral health programs. Many tribes and tribal organizations, including the National Indian Health Board, support integrating programs which are nurturing, fulfilling, accountable, and responsible. These local efforts and federally supported programs offer an opportunity for wellness and balance in tribal communities.

Tribal communities are taking a leadership role in addressing the myriad of needs associated with behavioral health problems. Building upon that local leadership and initiative offers a strategic opportunity to improve coordination of local and federal services, to bring services up to critical level of capacity, and to get going a renaissance in American Indian and Alaska Native communities. One Sky Center has been honored over the past two years to help empower tribal communities with the tools and resources to be pro-active in creating their own better futures.

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[i] The One Sky Center's mission is to promote best practices in substance abuse and mental health services for American Indians and Alaska Natives. The goal of the One Sky Center is to improve prevention and treatment of substance abuse among native people. The objectives of the One Sky Center include (a) identifying culturally appropriate best practices in prevention science and treatment services designed for American Indians and Alaska Natives, (b) facilitating the implementation of evidence-based preventive programs and care systems for native people, (c) providing continuing education in substance abuse prevention and treatment so as to enhance the capabilities of educators and clinicians serving American Indian and Alaska Natives, and (d) recruiting native youth into education and health care training programs aimed at prevention and treatment of chemical dependency among American Indians and Alaska Natives.

These goals and objectives continue to be informed by advice from a nation-wide Council of Stakeholders representing consumers, families, educators, clinicians, youth, elders, spiritual leaders, healers, and tribal governments. The Center is overseen by a National Steering Committee representing tribal governments, educators, clinicians, the Indian Health Service, the Bureau of Indian Affairs, the Addiction Technology Transfer Centers, and the Centers for the Application Prevention Technology as well as the Substance Abuse and Mental Health Services Administration (SAMHSA). The National Steering Committee strengthens existing linkages to the Addiction Technology Transfer Centers and the Centers for Application of Prevention Technology.

The One Sky Center's reach is extended by consultants and subcontractors located throughout the country including the Alaska Native Tribal Health Consortium, the National Indian Youth Leadership Project in New Mexico, and United American Indian Involvement in California. In addition to conferences, workshops, and coalitions, distance learning technology is used to facilitate technology transfer, technical assistance, and consultation. The Center continues the University's linkages with tribal colleges and universities to facilitate entry of American Indian and Alaska Native youth into education and health careers focused on substance abuse prevention and treatment. Feel free to visit One Sky Center's website at www.oneskycenter.org for more information.

Our Mission

Promote best practices in substance abuse and mental health services for American Indians and Alaska Natives

Goals

Establish effective communication pathways for systems and individuals in need of resources

Identify and disseminate best practices

Provide consultation, technical assistance and training

Our Services

Consultation and technical assistance to tribes, communities, agencies and individuals on developing treatment and prevention programs

Referrals to behavioral health consultants, evaluators, and trainers nationwide

Web accessible *Native Program Directory* of Indian addiction treatment and prevention programs

Curriculum development to enhance training for treatment professionals

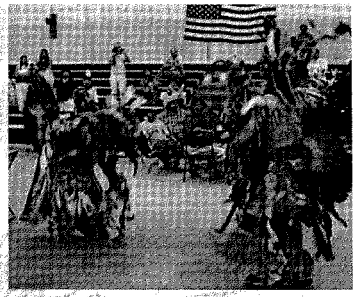
Advocacy to increase treatment capacity

Post-doctoral fellowships for Native professionals

Information dissemination on health, jobs, scholarships, culture, and grant funding

Lecture series on Indian health issues

Training on grant writing and Best Practices



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U.S. Department of Health and Human Services
Substance Abuse and Mental Health Services Administration (SAMHSA)
www.samhsa.gov

Who are we?

The One Sky Center is the first national resource center dedicated to improving the prevention and treatment of substance abuse and mental health among Native people.

The center's reach will be extended by consultants and partners located throughout the country:

- National Indian Youth Leadership Project
- Alaska Native Tribal Health Consortium
- United American Indian Involvement
- Northwest Portland Area Indian Health Board
- Jack Brown Adolescent Treatment Center

Organization

Advisory Council
Steering Committee
Executive Staff

R. Dale Walker, M.D., Director
Douglas Bigelow, Ph.D., Deputy Director

One Sky Center

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One Sky Center

The American Indian/Alaska Native National Resource Center for Substance Abuse and Mental Health Services

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April 7, 2005

The Honorable John McCain
Chairman
Committee on Indian Affairs
836 Hart Senate Office Building
Washington, DC 20510
Attn: Marilyn Bruce

Dear Chairman McCain:

Enclosed is a resolution and report from the American Bar Association supporting the efforts of the Tribal Steering Committee to reauthorize the Indian Health Care Improvement Act.

The resolution and report were provided to your Committee in the last Congress. As Co-Chair of the Native American Concerns of the ABA's Section on Individual Rights and Responsibilities, I request that these documents be included in the record of the hearing on reauthorization of the Indian Health Care Improvement Act scheduled for April 13. Thank you for your assistance on this matter.

Sincerely,

HOBBS, STRAUS, DEAN & WALKER, LLP

By: S. Bobo Dean
Co-Chair
Committee on Native American Concerns

Enclosures

cc: Elizabeth Bell
Co-Chair
Committee on Native American Concerns

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AMERICAN BAR ASSOCIATION

SECTION OF INDIVIDUAL RIGHTS AND RESPONSIBILITIES

RECOMMENDATION

RESOLVED, That the American Bar Association supports the efforts of the National Tribal Steering Committee to address the inadequacy of health care for many American Indians and Alaska Natives residing on Indian reservations, in other rural areas, and in urban communities through the reauthorization of the Indian Health Care Improvement Act, 25 United States Code 1601 et seq.

FURTHER RESOLVED, That the American Bar Association urges Congress and the Executive Branch to address the various areas where health care for American Indians and Alaska Natives is deficient, including: increasing the supply of health care professionals in the Indian health system; addressing the shortage of safe water and sewage facilities and hospitals, clinics, and other health facilities on reservations and other rural areas occupied by Indians and Alaska Natives; expediting third party reimbursement for health services to Indians and Alaska Natives, including Medicare and Medicaid; improving the services provided to urban Indians; and improving services available for behavioral health treatment and prevention, women's health, and health conditions resulting from adverse environmental circumstances.

FURTHER RESOLVED, That the American Bar Association supports the federal policy that encourages the administration of health care to Indian and Alaska Natives on reservations and other rural areas by Indian tribes and tribal organizations and urges Congress to exercise oversight to assure that the Indian Health Service continues to carry out its responsibilities based upon the federal policies of tribal self-determination and self-governance.

REPORT

Introduction

The American Bar Association has played a leading role in addressing legal issues supporting adequate health care. In 1990, and again in 1994, the ABA reaffirmed its support for legislation that would provide quality health care for every American. However, provisions for American Indians and Alaska Natives remains inadequate to control the increasing disparities between health care for this group and healthcare for the rest of the American population.

Historically, the United States has undertaken an obligation to provide health care to American Indians and Alaska Natives through numerous treaties and other agreements with Indian tribes. In many instances, these obligations were undertaken in part as compensation for many millions of acres of tribal land acquired by the United States. In 1980, the ABA urged the federal government to follow a policy of strict adherence to Indian treaty obligations. This proposed resolution builds upon this existing policy by urging the federal government to continue to fulfill its treaty obligation to improve the health care of American Indians and Alaska Natives.

In 1921, Congress enacted the Snyder Act, which authorized federal appropriations for the conservation of Indian health.[1] Initially, health services for American Indians were provided by the Bureau of Indian Affairs and for Alaska Natives, by the Bureau of Education. However, little progress was made to improve the health status of Native Americans until the creation of the Indian Health Service ("IHS") in 1954.[2]

Although substantial progress has been made in addressing Indian health needs since the founding of the IHS, serious problems continued, including high mortality rates for American Indians and Alaska Natives due to tuberculosis, influenza, and cirrhosis. Moreover, the infant mortality rate for American Indians remained well above the national average.[3] A recognition of these continuing problems led to the enactment of the Indian Health Care Improvement Act ("IHCIA") in 1976.[4]

The Act declared that it would be the policy of the United States, in fulfillment of its special responsibilities and legal obligations to American Indians and Alaska Natives, "to assure the highest possible health status for [reservation] Indians and urban Indians and to provide all resources necessary to affect that policy."[5] The IHCIA also authorized a number of specific programs under which the IHS was directed to proceed in accomplishing the legislation's stated policy.

This Recommendation, if approved, would urge the federal government to honor its legal obligations by reauthorizing the IHCIA and providing for the funding and programs necessary to ensure that these obligations are met.

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[1] Act of Nov. 2, 1921, ch. 115, 42 Stat. 208 (Snyder Act), (codified as amended at 25 U.S.C. § 13).
[2] Transfer Act of Aug. 5, 1954, ch. 658, 68 Stat. 674 (codified as amended at 42 U.S.C. §§ 2001–2005). The next year, what is now the Indian Health Service was created as a branch of the Public Health Service. FELIX COHEN'S HANDBOOK OF FEDERAL INDIAN LAW 698 (Rennard S. Strickland et al. eds., 1982).
[3] See section 2(d) of Pub. L. No. 94-437, Sept. 30, 1976, 90 Stat. 1400.
[4] Pub. L. No. 94-437, 90 Stat. 1400 (codified at 25 U.S.C. 1601 et seq).
[5] 25 U.S.C. § 1602(a).

Background

Since its enactment, the IHCIA has been reauthorized four times, most recently in 1992.[6] However, in 2000, the Act's authorizing provisions for federal funding and specific IHS programs expired. Congress extended the Act's funding authority through 2001, but since then has relied upon the original, and less specific, Snyder Act to justify federal funding for Indian health care.[7] Although the Snyder Act may provide broad authority for funding Indian health care generally, reauthorization of the IHCIA remains critical because of the specific program authorities and directives contained in the Act aimed at specifically bringing Indian health care into parity with the health services provided to the majority of other Americans.

Notwithstanding the progress that has been made since the founding of the IHS, American Indians and Alaska Natives continue to experience dramatic health disparities and high mortality rates compared to the rest of the American population. The mortality rate from diabetes for American Indians and Alaska Natives is 420 percent higher than that for the general population; from accidents, 280 percent higher; from suicide, 190 percent higher; and from alcoholism, 770 percent higher.[8] In addition, the cardiovascular disease rate among American Indians is significantly higher than that among the general American population and continues to rise.[9] American Indians and Alaska Natives have the highest Type 2 diabetes rate in the world,[10] with the IHS currently treating approximately 100,000 Native people with diagnosed diabetes.[11]

Indian children and women are particularly at risk. Although the infant mortality rate for American Indian and Native Alaskan children has decreased by 58 percent since the 1970's, it is still 22 percent greater than that of the general American population.[12] Native woman are often the victims of domestic violence, which is reported in 16 percent of all marital relationships among American Indians and Alaska Natives, with severe violence reported in seven percent of these relationships.[13] Native women often cope with prior domestic violence and other forms of victimization by escaping into alcohol and drugs.[14] Alcoholism, and its multigenerational effects, is at the root of many of the health problems experienced by Native women, as evidenced by the magnitudes of their death rates from alcoholism, cirrhosis, and other liver diseases. The mortality rate due to alcoholism is 10 times higher among American Indian and Alaska Native women than among American women of all races.[15]

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[6] Indian Health Care Improvement Act of 1992, Pub. L. No. 102-573, 106 Stat. 4526.
[7] *See* note 2 above.
[8] *Hearing on the Reauthorization of the Indian Health Care Improvement Act: Hearings on H.R. 2440 Before the House Resources Committee*, 108th Cong. (Oct. 1, 2003) (statement of Michel Lincoln, Deputy Director, Indian Health Service).
[9] *Id.*
[10] *Id.*
[11] *Id.*
[12] *Id.* at 9.
[13] Wihelmina A. Leigh, Ph.D and Malinda A. Lindquist, *Women of Color Health Data Book*, available at http://www.4women.gov/owh/pub/woc/native.htm.
[14] *Id.*
[15] *Id.*

Poverty, combined with the historical suppression of indigenous religions and medical practices, further increases the health risks faced by American Indians and Alaska Natives due to environmental degradation. These health risks result from living in poor quality housing, often with lead-based paint that puts children at risk, and exposure to local toxins. Half of all American Indians and Alaska Natives live in areas with uncontrolled hazardous waste sites.[16] Tens of thousands of American Indian and Alaska Native homes lack a safe water supply, sewage disposal system, or both, placing these residents at an increased risk of illness and disease.[17]

These figures show that the goals established in the IHCIA have yet to be met and that reauthorization of the Act remains critical to ensuring that American Indians and Alaska Natives receive adequate health care services.

Support for Reauthorization

In anticipation of the expiration of the IHCIA, a National Tribal Steering Committee, comprised of tribal leaders throughout the country and urban Indian representatives, developed draft legislation for the reauthorization of the Act. In 1999, the Steering Committee consulted with tribal representatives in Rapid City, S. D.; Reno and Las Vegas, Nev.; New Orleans, La.; and Washington, D. C., and revised the draft legislation ("Model Legislation") to reflect comments received during these consultations. Since completion of the Model Legislation, both the National Congress of American Indians, the largest national inter-tribal organization, and the National Indian Health Board have adopted resolutions supporting reauthorization of the IHCIA consistent with the model legislation.

During the 108th Congress, bills to reauthorize the IHCIA were introduced in both the House and the Senate.[18] Both bills are patterned after the model legislation; however, the House bill reflects important revisions made by the National Tribal Steering Committee to the model legislation to accommodate additional tribal concerns and comments made by congressional staff and the Administration. The proposed resolution generally supports provisions of the House bill, which contains eight separate titles, each addressing distinct areas in which American Indian and Alaska Native health care programs are presently deficient.

Human Resources (Title I)

Title I includes programs and incentives designed to increase the effectiveness and availability of Indian health care professionals and other health care providers. This title would require health professionals serving particular tribes to be educated in the history and culture of the tribe.[19] It would extend the authority to pay retention bonuses to health professionals in addition to physicians and nurses.[20] It provides that scholarships awarded under this title would not be

[16] *Id.*
[17] *Id.*
[18] H.R. 2440 and S. 556.
[19] H.R. 2440 § 116. The section retains the current law's provision that requires employees of the IHS who serve Indian tribes to be educated on the history and culture of the tribes they serve, but also would include education on the use and place of the traditional health care practices of those tribes. *Id.*
[20] *Id.* § 119.

subject to federal income tax.[21] The very successful community health aide program, which currently exists only in Alaska, would be authorized nationally with the provision that funding would not be diverted from the Alaska program.[22] It provides for encouragement of grants to tribally-controlled community colleges for health professional training programs.[23]

The House bill, reflecting one of the compromises agreed to by the National Tribal Steering Committee, includes a partial, rather than complete, decentralization of decision-making for award of scholarships for Indian health professionals.[24] Another compromise also resulted in the continuation of the eligibility of members of state-recognized tribes, in addition to federally recognized tribes, for scholarship programs in the health professions.[25] Title I provides for Indian preference for the IHS loan repayment program and establishes a scholarship and loan repayment recovery fund, which would be held by the Treasury for awarding future scholarships.[26]

Health Services (Title II)

The House bill includes a number of important changes in the provisions related to health services. The IHS program to address the high incidence of diabetes among American Indians and Alaska Natives is strengthened by the authorization of additional model projects and the authorization of appropriations for dialysis programs, equipment, and staff.[27] After considerable discussions among tribal representatives, it was determined that the IHS Catastrophic Health Emergency Fund should continue to be administered centrally in order to permit catastrophic needs to be addressed on a priority basis.[28]

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[21] *Id.* § 124.

[22] *Id.* § 121. The objective of the community health aide program is to provide health services by certified personnel to Alaska Natives living in rural villages. Through a proposed amendment to the Social Security Act, the bill would make these services eligible for Medicare reimbursement. The Alaska Medicaid program already makes CHAP services eligible for payment.

[23] *Id.* § 118(e).

[24] Decentralized funding applies only to the Indian Health Professions Scholarship Program, *id.* § 104 and the Tribal Scholarship Program, *id.* § 106. For Health Professions Scholarships, the formula for distribution of funds to the IHS areas would be developed through consultation with tribes, tribal organizations, and urban Indian organizations. *Id.* § 104. Scholarship recipients who are already receiving assistance under this program would be protected and would not be affected by any changes to the program. *Id.* For the Tribal Scholarship Program, the tribes would select recipients and the IHS would be responsible for administration of the scholarship program. *Id.* § 106.

[25] Members of State-recognized tribes are eligible under current law. *See* 25 U.S.C. § 1603(c)(1) (defining "Indians" to include "those recognized now or in the future by the State in which they reside").

[26] H.R. 2440 § 111. Indian individuals would have first preference, then persons recruited by tribal and urban Indian organizations, then other applicants. *Id.* The loan repayment recovery fund would hold repayments from scholarship recipients who breach service payback requirements, loan repayments, interest earnings and funds appropriated for scholarships. *Id.*

[27] *Id.* § 204. This section would focus on a national strategy, rather than naming individual community models, while continuing to authorize funding for model diabetes programs.

[28] *Id.* § 202. The Catastrophic Health Emergency Fund is designed to meet the extraordinary medical costs incurred by Indian programs that must treat catastrophically ill patients. Tribal leaders determined that the best way for the fund to address the unusually high cost of care in specific cases was for the funds to be distributed on a national basis as cases meeting the threshold requirements occur.

Title II also would require the IHS to establish an epidemiology center in each IHS administrative area where one does not now exist.[29] Authorization also would be provided for a variety of health programs for which only model projects now exist, including hospice care, long-term care, home and community-based programs, and certain public health functions.[30] Title II would expand the current tuberculosis authorization to cover all communicable diseases,[31] broaden the cancer screening program to include men,[32] and require the equitable distribution of research funding among IHS areas with competitive awards within IHS areas.[33]

Health Facilities (Title III)

Some of the most important changes proposed in the bill are intended to address the extreme shortage of health facilities in American Indian and Alaska Native communities.[34] The shortage applies both to water and sanitation facilities and to hospitals and clinics, especially in rural locations such as Alaska, the Northern Plains, and the Southwest.[35] Title III would expand the requirement for consultation with Indian tribes to cover all facility issues, rather than closures only, as current law does.[36] It also would require annual reporting on all Indian health facility needs, rather than identification only of the 10 top priority projects, as current law provides.[37] The initial report would be prepared by the General Accounting Office, followed by annual updates by the IHS.[38]

In order to encourage construction of vitally needed facilities, the current requirement that Davis-Bacon[39] wage rates apply to the construction of Indian health facilities would be modified to waive such rates where tribes have established minimum rates for the area where construction

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[29] *Id.* § 209.
[30] *Id.* § 213. The authorization also would cover traditional health care practices, including native healing practices for treating Indian individuals. *Id.*
[31] *See id.* § 212 (authorizing funding for projects to prevent and control tuberculosis, hepatitis, HIV, respiratory syncitial virus, hanta virus, sexually transmitted diseases, and H. Pylori).
[32] *Id.* § 207.
[33] *Id.* § 206.
[34] The IHS estimated in 2001 that, at the current rate of funding, it would take more than 30 years to fund the projects on the IHS health facilities construction priority list. Indian Health Service, *Health Facilities Fact Sheet* (Feb. 2001). Changes to help alleviate this problem include the Health Facilities Loan Fund, H.R. 2440 § 309; a revised IHS/tribal joint venture program, *id* § 311; new reporting requirements on the backlog of maintenance and improvement needs, *id.* § 313; and expansion of the Indian Health Care Delivery Demonstration Projects to include facilities such as hospice care, traditional healing, and childcare, *id.* § 306. In addition, the revised title would preserve the Small Ambulatory Care Facilities program for the replacement of such facilities. *Id.* § 305.
[35] The FY 1999 sanitation deficiencies for existing American Indian and Alaska Native homes and communities totaled $696 million. This amount would be needed to provide solid waste facilities and for operation and maintenance. Indian Health Service, Department of Health and Human Services, *Trends in Indian Health* 8 (1998-1999).
[36] *See. e.g.*, H.R. 2440 § 301(f).
[37] *Id.* § 301(c). The facilities priority list would report to Congress on the top-10 priority inpatient and outpatient facilities, as well as specialized care facilities, staff quarters, and hostels associated with health care facilities. All projects on existing priority lists would be exempt from the new system, retaining their places on the priority lists for future funding.
[38] *Id.* § 301(d).
[39] The Davis-Bacon Act, 40 U.S.C. § 276a-276a-5.

is taking place.[40] Inter-agency agreements would be authorized to expedite construction of water and sanitation facilities.[41] Various innovative approaches would focus funding on health facility construction, including the establishment of new loan and loan guarantee programs,[42] and would require that leases of tribal health facilities to the IHS be treated as "operating leases" under OMB guidelines, thus permitting construction financing to be amortized over a long-term lease period, as opposed to the direct IHS construction program, which requires all the funding to be appropriated before or during construction.[43] Construction also would be expedited by permitting new construction of health facilities that meet any accrediting standards recognized by the Secretary of Health and Human Services, not just the Joint Commission on the Accreditation of Healthcare Organizations.[44]

Access to Health Services (Title IV)

This title and a separate section of the bill amending the Social Security Act seek to eliminate obstacles to the availability of third party sources of funding for American Indian and Alaska Native health care. Current problem areas include Indian health programs' access to Medicare and Medicaid (M/M) and the Children's Health Insurance Program (CHIP), as well as to other third-party collections, such as private insurance coverage. M/M collections are vital sources of revenue for Indian health programs, now representing approximately one quarter of all funding that flows into the system.[45] The objectives of this title would be to increase access by the IHS, tribal health care providers, and urban Indian organizations to these third-party sources of revenue and to eliminate barriers to participation in these programs.

For example, the provisions related to Medicare would make the IHS and tribal programs eligible to receive Medicare reimbursement for all Medicare-covered services[46] and would allow all IHS and tribal clinics categorized as "free-standing clinics"[47] to collect Medicare reimbursements at the "all-inclusive" rate established for IHS hospital outpatient departments,[48]

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[40] H.R. 2440 § 303(b). This provision is similar to Section 104(b) of the Native American Housing and Self-Determination Act, 25 U.S.C. § 4114, which exempts a construction project from Davis-Bacon wages where a tribal wage rate has been established under tribal law.

[41] H.R. 2440 § 302(c)(8).

[42] *Id.* § 309. The fund would be available to tribes and tribal organizations for construction of health care facilities. Loans and loan guarantees could cover up to 100 percent of eligible costs. The section would authorize the IHS to develop a grant program for the purpose of repaying facilities construction loans that tribes and tribal organizations have secured for facility construction and renovation.

[43] *Id.* § 308. *See also id.* § 311 (providing for creative financing by Tribes for the construction of health care facilities by authorizing no-cost lease agreements with the IHS as a joint venture program); *id.* § 305 (providing for the replacement of small ambulatory care facilities); *id.* § 313 (addressing backlog of maintenance and improvement needs for replacing a facility when not economically feasible to repair it); and *id.* § 316 (authorizing the IHS to accept funding for construction of health care facilities from other sources, including federal and state agencies, and to enter into inter-agency agreements with such agencies to maximize funding opportunities for facilities construction).

[44] *Id.* § 301(a)(2).

[45] According to the IHS, the IHS and tribal programs collected $529 million in third-party revenues in FY 2002. Over 90 percent of this amount came from Medicaid.

[46] H.R. 2440 § 4(a)(1) (amending § 1880 of the Social Security Act). The facility-based focus in the current law would be eliminated to obtain reimbursement authority for all covered services regardless of whether the services are provided in a health care facility or other setting, such as the home or community. *See also id.* § 5(a) (amending § 1911 of the Social Security Act and providing the same flexibility for Medicaid reimbursements).

[47] A "free-standing clinic" is one that is not operated in connection with a hospital.

[48] *Id.* § 4(g)(3).

which would enable such clinics to access a reimbursement rate that more closely relates to actual costs. The provisions pertaining to Medicaid would include requirements for certain states to regularly consult with the IHS, tribes, and urban Indian organizations on the application of the Medicaid program in those states,[49] and for property held in trust by the United States, or property of unique religious or cultural significance, to be excluded from the determination of eligibility for Medicaid.[50] The title would authorize the Secretary of the Department of Health and Human Services to enter into agreements with a state and the IHS (or one or more tribes in the state) to operate a CHIP program with a portion of the funds the federal government makes available to that state for its CHIP program.[51]

Other provisions in the Title would address collection from third-party insurers and health care plans;[52] allow tribes, tribal organizations, and urban Indian organizations to use appropriated funds to purchase health benefit care coverage for IHS beneficiaries, including through tribally-owned and operated plans;[53] and provide a right to recover from any Medicaid managed care organization for covered health services.[54] The title would make an IHS, tribal, or urban Indian organization program the "payor of last resort" for services provided to IHS beneficiaries[55] and would authorize facility and services sharing arrangements with the Departments of Defense and Veterans Affairs.[56]

Health Services for Urban Indians (Title V)

Title V addresses the availability of health services for urban Indian organizations[57] providing health care to American Indians in urban areas.[58] According to the IHS, more than 605,000 American Indians reside in urban areas.[59] There are 36 urban Indian health organizations operating at 41 sites located in cities throughout the United States.[60] Title V would extend coverage to urban Indian organizations under the Federal Tort Claims Act[61] and establish

[49] *Id.* §409(b).
[50] *Id.* § 412(e).
[51] *Id.* § 410. The bill also would provide that where a State has an unexpended allotment of CHIP funds for a fiscal year, the Secretary could seek an agreement for the IHS or a tribe to operate a CHIP program with the portion of unexpended funds targeted for low-income Indian children who would be served by the IHS or tribal program.
[52] *Id.* § 403.
[53] *Id.* § 405.
[54] *Id.* § 413.
[55] *Id.* § 407.
[56] *Id.* § 406.
[57] "Urban Indian Organization" means a nonprofit corporate body that (a) is situated in an urban center (any community having a sufficient urban Indian population with unmet health needs); (b) is governed by an urban Indian-controlled board of directors; (c) provides for the participation of all interested Indian groups and individuals; and (d) is capable of legally cooperating with other public and private entities for the purpose of performing certain health care activities. H.R. 2440 § 4(28).
[58] "Urban Indian" means any individual who resides in an Urban Center and who meets one of more of the following criteria: (A) irrespective of whether the individual lives on or near a reservation, the individual is a member of a Tribe, band, or other organized group of Indians, including those Tribes, bands, or groups terminated since 1940 and those that are recognized by the states in which they reside, or who is a descendant in the first or second degree of any such member; (B) the individual is an Eskimo, Aleut or other Alaska Native; (C) the individual is considered by the Secretary of the Interior to be an Indian for any purpose; or (D) the individual is determined to be an Indian under regulations promulgated by the Secretary. *Id.* § 4(27).
[59] Indian Health Service, Department of Health and Human Services, *Trends in Indian Health* 6 (1998-1999).
[60] National Council of Urban Indian Health, http://www.ncuih.org/about_ncuih.htm.
[61] H.R. 2440 § 515; 28 U.S.C. §§ 1346(b), 2671 et seq.

programs for them similar to those provided for IHS and tribal programs in other parts of the IHCIA. The revisions would streamline current provisions relating to the standards and procedures for contracting and making grants to urban Indian organizations[62] and would require the agencies in the Department of Health and Human Services to consult with urban Indians prior to taking actions that would affect them.[63] A new provision to the title would require the Secretary of the Department of Health and Human Services to establish at least two youth treatment centers in each state in which urban Indian youth need alcohol and substance abuse treatment in a residential setting and there is a shortage of culturally competent residential treatment services available.[64]

IHS Organizational Improvements (Title VI)

The House version of this title would retain the current system where the IHS is headed by a Director and operated as an agency of the Public Health Service. The Senate bill, however, would elevate the IHS Director to the Status of Assistant Secretary of Indian Health, a change preferred by tribal leaders and supported by this Recommendation.

Behavioral Health Services (Title VII)

This title would address mental health, substance abuse, domestic violence, and child abuse programs. It would build upon current provisions regarding mental health services and authorize comprehensive behavioral health prevention and treatment plans and programs that emphasize collaboration among alcohol, substance abuse, social services, and mental health programs.[65] The title would merge current requirements for a Memorandum of Agreement between the Secretaries of Health and Human Services and the Department of the Interior regarding Indian mental health and Indian substance abuse programs, the objective of which is to ensure that the agencies update their agreements and consult with tribes and behavioral health service providers.[66]

Authorization for funding for various behavioral health programs also would be included. The bill would expand the current program, which addresses substance abuse among Indian women to include the broader category of behavioral health, require that the program address spiritual needs, and continue the present requirement that 20 percent of the funding go to address problems of urban Indian women. It would authorize IHS and tribes to provide additional programs to address fetal alcohol disorders, including programs for pregnant women, and would eliminate the present requirement that tribal community-based mental health programs be funded at 25 percent by the tribe. Overall, the title would require greater coordination and cooperation among federal agencies with responsibility for behavioral health programs for Indians.[67]

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[62] H.R. 2440 §§ 502–506.
[63] *Id.* § 514.
[64] *Id.* § 516.
[65] *Id.* § 701. Suggested components of the plans include assessment of specific behavioral health problems, the number of Indians being served who are directly or indirectly affected by behavioral health problems, assessment of progress toward providing a full range of behavioral health services and estimated funding needs.
[66] *Id.* § 702.
[67] *See, e.g.*, treatment of Indian women, *id.* § 706; Indian youth programs, *id.* § 707; fetal alcohol disorders, *id.* § 711; and child sexual abuse prevention and treatment, *id.* § 712.

Miscellaneous (Title VIII)

Title VIII would include provisions on several administrative issues within the IHS delivery system. One key section calls for the establishment of a National Bipartisan Commission on Indian Health Care Entitlement, which would examine whether Indian health should be made an entitlement rather than a discretionary program in the federal budget, as it is now.[68] Tribal health programs would be authorized to access pharmaceutical products from the Department of Veteran's Affairs prime vendor[69] and peer review panel documents would be protected from discovery in litigation.[70] The Title also would include authorization for a Negotiated Rulemaking Committee to prepare regulations to implement the Act.[71]

The Recommendation

This Recommendation would support the efforts of the National Tribal Steering Committee to address the inadequacy of health care for American Indians and Alaska Natives through the reauthorization of the IHCIA consistent with the House bill currently pending in the 108th Congress, unless otherwise stated in this Report. The proposed resolution also would urge Congress and the Executive Branch to address the various areas where health care for American Indians and Alaska Natives is deficient, including:

- Increasing the supply of health care professionals in the Indian health system;
- Addressing the shortage of water and sewage treatment facilities, hospitals, clinics, and other health facilities on reservations and in other rural areas occupied by Indians and Alaska Natives;
- Expediting third party reimbursement for health services to American Indians and Alaska Natives, including Medicare and Medicaid;
- Improving the services provided to urban Indians; and

[68] § 815. The provision would establish a 25-member National Bipartisan Commission consisting of members of Congress, members of Tribes, and appointees of the IHS Director. A Study Committee of the Commission would hold regional hearings and consult with Indian people, Tribes, tribal organizations, and urban Indian organizations on health services needs of Indians to gain ideas on what should constitute an Indian entitlement health care delivery system. The Commission would report to Congress recommending policies and legislation that fulfill the United State's responsibility to Indian people for delivery of health systems and that respect the sovereign status of Indian tribes. The Commission would have 18 months to complete its work.

[69] *Id.* § 813. For the purposes of accessing the pharmaceutical prime vendor, Tribes, and tribal organizations that operate health programs under the Indian Self-Determination and Education Assistance Act, 25 U.S.C. § 450 et seq., would be considered part of the IHS and would be permitted direct access to the prime vendor, enabling tribes and tribal organizations to obtain lower costs for pharmaceuticals. *See also* 25 U.S.C. § 450j(k) (deeming tribes or tribal organizations executive agencies and part of the IHS when carrying out an ISDEAA agreement for purposes of accessing federal sources of supply under section 201(a) of the Federal Property and Administrative Services Act of 1949 (40 U.S.C. § 481(a))).

[70] H.R. 2440 § 817. The IHS requested this provision to provide confidential and privileged status to records created as part of medical quality assurance programs.

[71] *Id.* § 802. Negotiated rulemaking would be initiated within three months of enactment, with publication of final rules to be accomplished no later than 18 months after enactment, at which time the authority to promulgate regulations would expire. A lack of promulgated regulations would not limit the effectiveness of the Act.

- Improving services available for behavioral health treatment and prevention, women's health, and health conditions resulting from adverse environmental circumstances.

Finally, the proposed resolution would support the administration of health care services to American Indians and Alaska Natives by Indian tribes and tribal organizations and would urge Congress to exercise oversight to ensure that the IHS continues to carry out its responsibilities based on the federal policies of tribal self-determination and self-governance.

Conclusion

The federal government historically has provided health care services to Indian tribes as fulfillment of its special responsibilities and legal obligations to American Indians and Alaska Natives. However, these services also historically have fallen short of providing Indian communities with a level of health care comparable to that received by the general American population. Although the IHCIA has helped to bridge the gap between the level of health care provided to American Indians and Alaska Natives and the rest of the American population, many disparities still remain, and with the expiration of the IHCIA, many of the programs, policy directives, and funding authorizations critical to addressing these disparities are at risk. Although the Snyder Act provides broad funding authority for Indian health care services generally, it does not grant the specific program authorizations and policy directives contained in the IHCIA that are critical to continuing to improve the health and well-being of American Indians and Alaska Natives.

Improving the quality of health care for every American, including American Indians and Alaska Natives, is fundamental to protecting human rights and is a critical national issue on which the American Bar Association should continue to speak, especially now that the reauthorization of the IHCIA is squarely before Congress. The proposed resolution supports the efforts of Congress and the National Tribal Steering Committee and others to reach broad consensus from tribal leaders, urban Indian representatives, congressional staff, and the Administration in drafting legislation for the reauthorization of the IHCIA and urges Congress and the Executive Branch to continue to improve areas where health care for American Indians and Alaska Natives is deficient.

Respectfully submitted,

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Section of Individual Rights and Responsibilities

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