

Statement of Buford L. Rolin, Chairman
National Indian Health Board
on
S. 1770, A Bill to Elevate the Director of the Indian Health Service
to
Assistant Secretary for Indian Health
within the Department of Health and Human Services
July 22, 1998

Chairman Ben Nighthorse Campbell, Vice-Chairman Daniel Inouye, and distinguished members of the United States Senate Committee on Indian Affairs, I am pleased to offer testimony on behalf of the National Indian Health Board (NIHB) on S. 1770, a bill to elevate the Director of the Indian Health Service to Assistant Secretary for Indian Health within the Department of Health and Human Services. I am equally pleased as well to present the views of the NIHB to the distinguished members of the United States House Committee on Resources. The NIHB serves all 558 Tribal Governments in advocating for the improvement of health care delivery. Our Board Members represent each of the twelve Areas of the Indian Health Service (IHS) and are generally elected at-large by their respective Tribal Governmental Officials within their regional area. We have the duty to ensure that the solemn treaty commitments of our ancestors are upheld in all matters related to health and human services.

It is the obligation of the United States Government to ensure that comprehensive health care is provided to all American Indian and Alaska Native citizens, at a level which should be comparable to the care provided to any other American.

However, the health care available to Indian people is terribly under-funded and it is overlooked by many. Despite new technological advances, Indian people are suffering and dying premature deaths, due in large part to reductions in Indian Health Service spending over the past four years. Specifically, the IHS has realized a \$1.12 billion reduction in budget authority in the past four years stemming from the lack of initiative by the Administration and the Congress, to ensure that fixed costs are included in the base budget of the IHS at its earliest inception during the annual budget formulation process.

Today, I will speak briefly about four major reasons why the Congress should pass S. 1770 and why the Administration should enact this important legislation into public law.

Before, I proceed, I want to express our appreciation to Senator John McCain for his willingness to “endeavor to persevere” on this most important legislative proposal.

Chief Dan George was quite remarkable in his role as a Cherokee Indian in the movie, “The Outlaw Josey Wales”. And the advice he conveyed is most descriptive of Senator McCain’s legislative effort to advance the health of Indian people by elevating the position of Director of the Indian Health Service to Assistant Secretary. This bill has been considered in three different Congressional periods, and quite remarkably, Senator McCain continues to seek this worthy goal.

Reason # 1 - American Indians and Alaska Natives are suffering and even dying from lack of IHS funding.

If you asked the Indian people in the audience who might have family members or loved ones who are now being challenged by Cancer, Diabetes, or Heart Disease, more than 50 percent will raise their hands. I know that every other person I meet has one of these three medical conditions. American Indians and Alaska Native people experience mortality rates for alcoholism, substance abuse, accidents, homicide, suicide, tuberculosis, pneumonia and influenza at rates far higher than all other races in the general population. As an elected Tribal Official, I hear from many in my community of their limited access to quality health care. As Chairman of the National Indian Health Board, I've heard the pleas of many other elected Tribal officials and health care providers on the needless suffering of hundreds of Indian people who are being denied contract health care.

With only 15 of the 515 Indian health facilities nationwide equipped to handle tertiary-level care, the majority of Indian patients who need basic surgery or specialized health care rely heavily on Contract Health Care to access this level of care. Ten years ago, we used to implement Priority One in making referrals for specialized care, in the last quarter of the fiscal year. Now we have to impose Priority One, which only allows for referral for hospitalization and specialized care in life-threatening situations, in the first quarter of the fiscal year. So for the remaining nine months, we understand that pain has become the new standard for determining who can access basic surgery and other specialized care. If an Indian patient needs gall bladder surgery, he or she will likely be denied a referral to surgery, unless this patient is in terrible pain and ready to pass their gall stones. If an Indian elder needs to have cataract surgery to see better or might require a referral to see a heart specialist to determine potential heart damage, they will likely be denied care, until something more serious arises like blindness, heart attack or stroke.

Limited funding is the primary cause for this health care injustice. And one of the key reasons for such limited funding is the inability of the Indian Health Service to get any respect. Three years ago the IHS employed 25 percent of all of the employees within the Department of Health and Human Services. Now the IHS employs approximately 20 percent of the DHHS workforce. It would seem very logical that the IHS would command the respect and advocacy necessary to increase the IHS budget, thereby improving health services in Indian Country. At least within the Department, however, this is not the case. Instead, the Director of the Indian Health Service, is treated as a second-class Administrator, within the agency and the IHS budget continues to be whittled away from within.

The FY 1999 President's Budget recommendations for programs within the Department of Health and Human Services demonstrates the disparity and lack of regard for Indian Health programs. In FY 1999, the budget for the NIH was recommended for an increase of \$1.15 billion (8.5 percent). At the present time, very little of the research dollars in the variety of Institutes at the NIH trickle down into meaningful research in Indian Country. The other winners in the Department of Health and Human Services include the

following: the Food and Drug Administration which is increased by \$200 million (17.7 percent); the Agency for Health Care Policy Research which is increased by \$25 million (17 percent); the Substance Abuse and Mental Health Administration which is increased by \$132 million (6.1 percent); the Health Resources and Services Administration which is increased by \$161 million (4.5 percent); and the Centers for Disease Control which is increased by \$78 million (3.3 percent). These six agencies alone were recommended to receive a \$1.7 billion increase this year as proposed by the Administration, while the Indian Health Service is slated for a less-than-one percent increase. Clearly Indian Health Service and tribal programs are losing further ground this year, and the people who will suffer are Indian people back in our home communities.

In the past two years, the National Indian Health Board has joined forces with the Tribal Self-Governance Advisory Committee and the National Urban Indian Health Council to recommend a \$454 million increase in the FY 1998 and FY 1999 IHS budget. We humbly asked the Congress and the Administration to consider this level of funding, however, knew deep in our hearts that even this level of funding would only meet 34 percent of the need.

For FY 2000, we just completed development of a tribally-driven budget for the IHS, involving all Tribes. It is anticipated that we need to increase the IHS budget by \$5.9 billion to achieve a needs-based budget, in addition to the \$2.1 billion already appropriated. To achieve parity with the non-Indian population, \$8 billion is needed in Fiscal Year 2000. We cannot continue to strive to secure funding for a rationed health system, so we are determined to educate the public as to why the IHS, our health system, requires a \$8 billion budget to provide equitable health care to that of any other American. This is what we secured when we gave the United States more than 450 million acres of land.

During the coming weeks, the Interior Appropriations Subcommittees in both Houses will finalize their deliberations on the FY 1999 Indian Health Service Budget. The House has recommended a \$147.5 million increase (7.03 percent) and the Senate has recommended a \$53.5 million increase (2.55 percent). While these amounts will still fall seriously short of meeting the health needs of Indian people, we hope the Members of the Congress will support even a greater level of funding.

And, we ask that Members in the House recede to the Senate on the matter of a moratorium on Contract Support Costs for tribal health programs operating under Indian Self-Determination Contracts and Self-Governance Compacts. We are not certain if this moratorium would limit new, additional funding for IHS Contract Support Costs or if the moratorium would prohibit tribes who are starting Indian Self-Determination contracting or Self-Governance compacting from receiving Contract Support Costs.

Whatever is proposed. If this language was adopted as part of the House Interior Appropriations bill, the Congress would threaten the sovereignty of Tribal Governments who chose to exercise Indian Self-Determination and Self-Governance. As an elected official of a Indian Self-Determination Tribe, which is now entering into Self-Governance, I find it incomprehensible for the Congress or the Administration to reverse itself by 180 degrees on the 25 year old policy of Indian Self-Determination.

The primary issue here is not who delivers health care to Indian people. In either case, the federally-operated and the tribally-operated health care programs are seriously under-funded. This under-funding arises from the lack of positive regard provided to the IHS during the entire budget formulation process, from within the Department, to the Office of Management and Budget, and on to the Congress.

Reason # 2 - Serious Unmet Health Needs

We are most pleased that Vice-Chairman Inouye held a hearing on May 21st, 1998 titled, "Developing A Partnership for the New Millennium to address Unmet Health Needs." During the hearing, which included the views of 33 witness, we heard the most tearful stories of how health care is being denied to our most vulnerable. We learned that only 22 percent of the women who need breast and cervical cancer screening are accessing this type of preventive care. Children testified on the pain they were suffering from watching their friends commit suicide and dying from alcoholism. And we learned that there is a desire by the consumers, the providers, and many national organizations to seek improvements in Indian health care.

A resounding message was delivered in support of the elevation of the Director of the Indian Health Service to the position of Assistant Secretary of Indian Health. And the record was clear that this position should be over all matters related to Indian health, not just the Indian Health Service. For there is a growing need for other agencies within the Department of Health and Human Services to assume their share of responsibility for Indian people. As citizens of the United States, Indian people justly and more appropriately need for agencies like the Centers for Disease Control and the National Institutes of Health to consider their needs, rather than shun or shift their responsibility to the under-funded Indian Health Service.

We presented testimony on the disparity in health care funding, our recommendations for enhancing funding within the Department of Health and Human Services, and a need for improved cancer prevention and treatment and tobacco prevention.

As far as disparities go, a patient within the IHS secures less than one third of what is available to a person on welfare. In fiscal year 1997, the per capita expenditure for an Indian person was \$1,430 as compared to \$3,369 for a Medicaid beneficiary, \$3,489 for an inmate in the Bureau of Prisons, and \$5,458 for a Veterans' Administration beneficiary.

The difference between the expenditure for an Indian in an IHS program as compared to a Medicaid beneficiary is \$1,939.

The difference between the expenditure for an Indian in an IHS program as compared to a Bureau of Prison beneficiary is \$2,059.

The difference between the expenditure for an Indian in an IHS program as compared to a Veterans Administration beneficiary is \$4,028.

As you can well observe, Indian Health Service programs are failing to meet the Trust obligation, as demonstrated by the FY 1999 IHS Budget. It is quite obvious that American Indians and Alaska Natives in IHS and Tribal programs are treated unequally when compared to Medicaid recipients, Federal Prisoners and Veterans who secure services in other Federal programs.

During the past seven years, the enacted appropriations for the IHS grew very slowly with increases between 1 and 3 percent per year. Although these increases may have been comparable to or slightly in excess of many federal discretionary programs during this period, they were less than the increases provided to the major federal health care entitlement programs. Medicaid averaged over 10 percent growth per year which is over 4 times the levels of growth in the IHS budget over the same period.

Thus the Senate examination of unmet health needs is indeed appropriate. Particularly when the majority of the citizens within the United States are benefiting from the advancements of new health care technologies, managed care practices, use of superior drug therapies and developments resulting from biological and molecular research. Despite these advances, Indian people are suffering and dying premature deaths, due in large part to reductions in Indian Health Service spending over the past four years.

Meanwhile, the overall effort of the Federal Government to control the deficit and balance the budget, is beginning to kill our most vulnerable. While our appointed leaders within the Federal Government suggest that now is the time to prepare for the new millennium with greater research and efforts to end racial health disparities, each of our Tribes know of many who are in pain. Inequity and disparity of health resources where Indian people secure less than 34 percent of what is provided to the Nation's poorest under Medicaid is deplorable. As a consequence, IHS and tribal health programs cannot afford to even ask for more prevention dollars, because the acute care of Indian people is being prioritized.

It is one thing to ask the Indian people to share the burden of a reduced federal budget during "the worst of times" but these are "the best of times" economically for our

country. A budget surplus is being projected for 1999. It is immoral to deny health care to American Indians and Alaska Natives under these circumstances. How can you cut the Hospitals and Clinics budget this year knowing that it is already 56 percent below what you and other Americans receive for health care?

With the elevation of the IHS Director to the position of Assistant Secretary for Indian Health, the IHS will be able to provide a direct line of communication to Secretary Shalala, and other Agency leaders, on the unmet needs of Indian people. This bill certainly will provide the IHS with organizational independence and the capacity to advocate for itself at a higher level with more authority.

Reason #3 - Lack of Broad-based Advocacy within the Department

There is a widespread misperception that the Federal Government is meeting 100 percent of the needs of Indian people. This misperception filters down from the highest levels of the Federal Government in which all other agencies believe that the Indian Health Service and the Bureau of Indian Affairs are fully financed and meeting the needs of Indian people.

We respectfully request the Congress to consider having the General Accounting Office examine the amount of funding made available to Tribal Governments versus State Governments for all other programs outside the IHS, yet within the Department of Health and Human Services, which are intended to improve the health of all Citizens. When funds are provided to State Governments, very little ever reaches Indian communities particularly as part of the grant programs offered by the Centers for Disease Control, in the Substance Abuse and Mental Health Services Administration and in the National Institutes of Health. Financial data is needed to validate or invalidate the myths operating within the DHHS about Indian health care needs.

If S. 1770 is enacted into law, it would be much easier for Dr. Michael Trujillo to ensure that other DHHS funding is available to meet the health needs of Indian communities. By utilizing the data established in a review of funding made available to State Governments for our nation's citizens, including the American Indian and Alaska Native population, we believe there would be greater resources available to address Indian health needs.

Presently, we are working with Deputy Secretary Kevin Thurm's office to ensure that new opportunities are examined between the Federal Government, Tribal Governments and State Governments. The National Indian Health Board worked very closely with former Assistant Secretary for Health, Philip Lee, M.D., and Dr. Michael Trujillo, Director of the Indian Health Service, in both 1994 and 1995 to ensure that widespread collaboration was implemented on a government-to-government basis. These meetings opened many doors for Tribal Governments, particularly in improving their Medicaid and Medicare collections. With potential elevation of the Director position to Assistant Secretary for Indian Health, we can continue our efforts to ensure that State Governments are working with Tribes on issues like Managed Care, Children's Health Insurance Programs and other health matters.

The President's Executive Order dated May 14, 1998, and the Policy Statement issued on April 29, 1994, on Government-to-Government relationships between the United States and Tribal Governments supports tribal consultation. It is time to act on these policies and allow Tribal Governments to present their concerns directly to the Secretary and the White House thru an Assistant Secretary for Indian Health, rather than thru four levels of bureaucracy.

Reason # 4 - Nationwide Support for Elevation of the Director's position to Assistant Secretary for Indian Health

Mr. Chairman, I want to assure you that there is nationwide support by all Tribal Governments for passage and enactment of S. 1770. I have attached the resolution of the National Indian Health Board on the earlier version of S. 1770, which was S. 311. Our resolution is numbered NIHB Resolution # 96-20. As the active Chairman of the National Congress of American Indians' Health Subcommittee, I am also pleased to present you with a copy of NCAI Resolution # GRB-98-10, which supports enactment of S. 1770. The National Congress of American Indians is oldest and largest organization representing all Tribal Governments on matters involving the health, safety, welfare, education, economic and employment opportunities, and preservation of cultural and natural resources. Each of our national organizations stand together and will assist you in securing passage of S. 1770.

We hope that in the coming weeks both the Senate Indian Affairs Committee and the House Resources Committee will report this bill favorably and seek final passage. And we have faith in the Clinton Administration, that they too will recognize the importance of recommending final passage of S. 1770.

Conclusion

In closing, I want to extend an invitation to each of you to participate in two very important meetings organized by the NIHB. On September 2 and 3rd, 1998, the NIHB is hosting a national meeting called, "Indian Health, Medicaid and Managed Care: A Call to

Action". The purpose of the meeting is develop consensus on federal legislation that protects American Indian and Alaska Native consumers and providers in the managed care environment of Medicaid. We are examining the best practices of how these systems work from the perspectives of nine states. We are presently wrapping up our study of these practices in the states of Arizona, California, Michigan, Minnesota, New Mexico, New York, Oklahoma, Oregon and Washington. Even if you don't reside in these states, you will learn more about Managed Care, especially if you participate in the workshops scheduled before the national meeting, on August 31 and September 1st, 1998, in Denver, Colorado.

I also want to invite you to our 16th Annual Consumer Conference to be held in Anchorage, Alaska, on October 5 to the 8th, 1998. The theme of the conference is "Sustaining our Sovereignty, Protecting our Environment, and Restoring our Health". With an emphasis on Sovereignty and the Environment, we hope to present you with comprehensive training and information, from a national and Alaska Native perspective.

Finally, I want to congratulate my friend Dr. Michael Trujillo on his 2nd successful Senate Confirmation to the current position of Director of the Indian Health Service. As Director of the Indian Health Service, Dr. Trujillo has worked many long hours, been absent from the family he loves so dearly and taken many risks to ensure that Indian health care improves. It is a difficult job, with all of the down-sizing and budget restrictions, still he too has "endeavored to persevere". I hope that you can elevate him to the position of Assistant Secretary for Indian Health, which will allow him front door access to the White House. For he presently cannot enter the same doors as his peer in the Department of Interior's Bureau of Indian Affairs (BIA).

When Tribal Governments meet with the President, the Vice-President and Members of the Cabinet, on matters of national policy and Tribal Sovereignty, I want Dr. Trujillo to be invited to sit at the table. After all, the responsibility he bears in financial terms exceeds that of the Assistant Secretary of Indian Affairs with the BIA. And it is only appropriate that Tribal Governments and their health care leader are afforded greater authority within the United States Government.

Thank you for inviting me to testify on behalf of the National Indian Health Board. I stand ready to answer any questions you might have.