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Statement of Julia Davis-Wheeler

Chairperson

National Indian Health Board

On the

President's Fiscal Year 2004 Budget for Indian Programs

February 26, 2003 – 10:00 a.m.

Senate Russell Building, Room 485

Chairman Campbell, Vice-Chairman Inouye, and distinguished members of the Senate Indian Affairs Committee, I am Julia Davis-Wheeler, Chairperson of the National Indian Health Board. I am an elected official of the Nez Perce Tribe, serving as Secretary, and also Chair the Northwest Portland Area Indian Health Board. On behalf of the National Indian Health Board, it is an honor and pleasure to offer my testimony this morning on the President's Fiscal Year 2004 Budget for Indian Programs.

The NIHB serves nearly all Federally Recognized American Indian and Alaska Native (AI/AN) Tribal governments in advocating for the improvement of health care delivery to American Indians and Alaska Natives. We strive to advance the level of health care and the adequacy of funding for health services that are operated by the Indian Health Service, programs operated directly by Tribal Governments, and other programs. Our Board Members represent each of the twelve Areas of IHS and are elected at-large by the respective Tribal Governmental Officials within their regional area.

As we enter the 108th Congressional session, we call upon Congress and the Administration to address the funding disparities that continue to hamper Indian Country's efforts to improve the health status of American Indians and Alaska Natives. No other segment of the population is more negatively impacted by health disparities than the AI/AN population and Tribal members suffer from disproportionately higher rates of chronic disease and other illnesses.

Indian Country has continuously advocated for equitable health care funding. Health care spending for AI/AN's lags far behind spending for other segments of society. For example, per capita expenditures for AI/AN beneficiaries receiving services in the IHS are approximately one-half of the per capita expenditures for Medicaid beneficiaries and one-third of the per capita expenditures for VA beneficiaries. Sadly, the federal

government spends nearly twice as much money for a federal prisoner's health care that it does for an American Indian or Alaska Native. The failure of the federal government to provide equitable health funding for American Indians and Alaska Natives reflects a tragic failure by the United States to carry out its solemn Trust responsibility to American Indian and Alaska Native Tribal governments.

Further exacerbating the current funding situation are the challenges our Nation faces relating to the war on terrorism, a sluggish economy and probable military action in Iraq, which has further shifted fiscal priorities away from American Indian/Alaska Native health-related initiatives. While we certainly realize the significance of these challenges, we must also ensure that the health needs of American Indians and Alaska Natives are protected during this time.

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

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

Public health indicators, such as morbidity and mortality data, continue to reflect wide disparities in a number of major health and health-related conditions, such as Diabetes Mellitus, Tuberculosis, alcoholism, homicide, suicide and accidents. These disparities are largely attributable to a serious lack of appropriated funding sufficient to advance the level and quality of adequate health services for American Indians and Alaska Natives. Recent infant mortality data indicates that the infant mortality rate for American Indians and Alaska Natives is 25% greater than all other races in the United States. Recent studies reveal that almost 20% fewer American Indian and Alaska Native women receive pre-natal care than all other races and they engage in significantly higher rates of negative personal health behavior, such as smoking and alcohol and illegal substance consumption during pregnancy.

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

Cancer is the third leading cause of death for American Indians of all ages, and is the second leading cause of death among American Indians over age 45. According to the IHS, American Indians and Alaska Natives have the poorest survival rates from cancer of any other racial group. Also, our women have disproportionately high incidences and

mortality rates for cervical cancer, and it occurs at a younger age than it does in other racial groups.

Oral health is also a great problem. Nearly 80 percent of Indian children aged 2-4 years have a history of dental decay, compared to less than 20 percent of the remaining U.S. population. Further, 68 percent of our adults and 56 percent of our elders have untreated dental decay and gum disease.

Trust Obligations of the Federal Government

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

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

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

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

Second, the Indian Self Determination and Education Assistance Act of 1975 changed forever the nature of relationships between Tribal organizations and the federal government and revolutionized the manner in which health services were delivered in Indian country. The Act provided guidance and direction to IHS to enable it to work with Tribes to develop Tribal based health systems in which Tribal organizations were given tools with which to operate their own health programs.

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

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

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

The President's FY 2004 IHS Budget Request

As you know the FY 2003 Budget was just signed by the President last Thursday, February 20, 2003. I understand that some of the numbers we are using for FY 2004 will be modified based on the enacted budget of last week. The IHS FY 2004 budget request is $2.89 billion, an increase of $40 million over the FY 2003 enacted amount for the Indian Health Service. Even if the $50 million dollar increase for diabetes funding is included the budget request is still over $200 million short of what is needed to maintain current services. It is estimated that a $325 million increase is required provide the same level of health care services provided in FY 2003. This amount would be sufficient to cover pay act costs, population growth,

The President's budget includes $114 million for sanitation construction, an increase of $20 million over the FY 2003 Budget Request. This 20 percent increase represents the largest increase provided for sanitation construction in over a decade. This provision and significant increase is applauded and demonstrates the Administration's

commitment to providing safe water and waste disposal to an estimated 22,000 homes, an increase of 2,600 over the number of homes served in 2003. Proper sanitation facilities play a considerable role in the reduction of infant mortality and deaths from gastrointestinal disease in Indian Country.

The President's budget request also reflects the $50 million increase in the Special Diabetes Program for Indians funding approved during the 107th Congress. We are grateful to the Administration and Congress for recognizing the success and effectiveness of the Special Diabetes Program for Indians as a tool to reduce the incidence and harmful effects of Diabetes in Indian Country.

As a result of the Special Diabetes Program, today there are over 300 diabetes prevention and treatment programs serving American Indians and Alaska Natives. The funding allows Tribal governments to develop and improve wellness centers, purchase newer medications which are effective in preventing Type II diabetes, establish education programs, and other activities. It is not only an effective tool in preventing and treating Diabetes, it also provides opportunities to reduce the incidence of diabetes related blindness, amputations, and end stage renal disease. We ask that the increase in funding for the Special Diabetes Program does not come at the expense of other vitally important IHS programs.

Health Facility Construction: The budget includes a total of $72 million 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. The request will complete outpatient facilities at Pinon (Navajo Reservation, Arizona) and Metlakatla (Annette Island, Alaska); continue construction of the Red Mesa Outpatient Facility (Navajo Reservation, Arizona) and begin construction of a new outpatient facility to replace the Sisseton hospital (Sisseton– Wahpeton Sioux Tribe, South Dakota). When the Sisseton hospital is closed, IHS will purchase inpatient and emergency care from non–IHS facilities such as the nearby Coteau Des Prairies hospital.

Pay Costs: The budget includes an additional $35 million to cover increased pay costs for IHS's 15,021 FTEs and to allow tribally run health programs to provide comparable pay raises to their own staffs.

Approximately one year ago, Tribal Leaders' came together to develop a "Needs-Based Budget" for Indian Health Service funding. The needs-based budget was developed through a careful and deliberate process to ensure that it was reflective of the health needs of Indian Country.

The budget documented the IHS health care funding needs at $18.2 billion. President Bush's proposed appropriation of $2.89 billion falls well short of the level of funding that would permit Indian programs to achieve health and health system parity with the majority of other Americans.

Failure to adequately increase the Indian Health Service clinical services budget will force numerous Tribal health providers to cut back services, worsening the plight of an already severely at-risk population and jeopardizing greater public health. Staff cuts would also result, increasing waiting periods to get appointments, as well as reducing clinic hours. Also, without adequate funding, several successful programs throughout Indian Country would have to be eliminated, such as patient outreach, nutritional programs, preventive care, referral services, dental and optometric services.

Funding for the Indian Health Service has failed to keep 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. Current Indian Health Service funding is so inadequate that less than 60 percent of the health care needs of American Indians and Alaska Natives.

As we have carefully reviewed the President's FY 2004 IHS Budget Request, several provisions would seriously affect the agency's ability to carry out its responsibilities pertaining to the health and welfare of American Indians and Alaska Natives. Below, I will briefly discuss several of these provisions.

Contract Health Service Funding

The President's Budget Request includes $493 million, which provides an additional $25 million or 5 percent increase over the previous year's request, for Contract Health Services. While are very thankful for any increase, the proposed level of funding is so limited that only life-threatening conditions are normally funded. In most other cases, failure to receive treatment from providers outside the IHS and Tribal health system forces people in Indian country to experience a quality of life that is far below the level normally enjoyed by non-Indian Americans.

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

Contract Support Costs

The President's FY 2004 Budget Request includes $271 million, the same as the FY 2003 enacted budget, to support tribal efforts to develop the administrative infrastructure critical to their ability to successfully operate IHS programs. An increase in Contract Support Costs is necessary because as Tribal governments continue to assume control of new programs, services, functions, and activities under Self-Determination and Self-Governance, additional funding is needed. Tribal programs have clearly increased the quality and level of services in their health systems fairly significantly over direct service programs and failing to adequately fund Contract

Support Costs is defeating the very programs that appear to be helping improve health conditions for American Indians and Alaska Natives.

We strongly urge reconsideration of this line item in the proposed budget. As Tribes increasingly turn to new Self Determination contracts or Self Governance compacts or as they expand the services they have contracted or compacted, funding necessary to adequately support these is very likely to exceed the proposed budgeted amount. We ask you to fund contract support costs at a level that is adequate to meet the needs of the Tribes and to further the important Trust responsibility charged to the federal government. We recommend an additional $150 million to meet the shortfall for current contracting and compacting.

Tribal Management/Self-Governance Funding

According to the President's FY 2004 Budget, the number of tribally managed IHS programs continues to increase, both in dollar terms and as a percentage of the whole IHS budget. Tribal governments will control an estimated $1.6 billion of IHS programs in FY 2004, representing 53 percent of the IHS's total budget request. Because of this, it is critical that funding for self-governance be provided in a manner reflective of this. Therefore, we feel it is necessary to provide funding over and above the proposed amount of $12 million. The enacted FY 2003 budget cut the office of Self-Governance funding by 50% without any notice to tribes.

Proposed IHS Management Initiatives/Administrative Reductions

The President's budget includes savings of $31 million from administrative reductions and better management of information technology. The IHS proposes to achieve these savings primarily by reducing the use of Federal staff. IHS also plans to reduce administrative costs and to achieve efficiencies through the development, modernization and enhancement of IHS information systems.

The National Indian Health Board and Tribal governments have long been concerned about "cost-saving" provisions contained in the President's Budget Request, both in FY 2003 and FY 2004. The result will be the elimination of potentially hundreds of full-time staff at the headquarters and area levels, which would add new burdens to the provision of health care to American Indians and Alaska Natives, rather than addressing the widespread health disparities throughout Indian Country.

Over the last several years, the IHS has made significant efforts to streamline the agency. IHS has previously reduced upper and middle management positions by 60 and 58 per cent, respectively, and streamlined the Headquarters organizational structure from 140 to 40 organizational units. The restructuring was made in accordance with the IHS Tribal consultation policy and the resources gained through the reductions were reinvested into front-line health delivery positions, which increased by 12 percent. This achievement ought to be rewarded rather than ignored. Given the ongoing

restructuring efforts at IHS, any further reductions would severely hamper the ability of the IHS to carry out its mission.

In order to fully explore the possible effects and potential advantages of any reorganization efforts put forth by the Administration, we feel it is appropriate that the President's Management Initiatives be delayed for a period of one year in order for the IHS Restructuring Initiative Workgroup to create feasible alternatives, which will be developed through a comprehensive tribal consultation process. Additionally, any savings derived from such restructuring should be exclusively reinvested in IHS mission-related activities.

The Need for Homeland Security Funding in Indian Country

The President's FY 2004 budget request for the Department of Health and Human Services (DHHS) reflects the priorities of the United States with regard to health and safety concerns relating to Homeland Security. It reflects the Administration's commitment to anticipating future threats to America's public health care, health infrastructure and human services systems. It is important to note that, along with the Department of Defense and Veteran's Affairs health systems, the Indian Health Service occupies a unique position within the Federal government as a direct health care provider.

Therefore, we are requesting funding be added during FY 2004 to help the Indian Health Service and Tribal governments prepare for and respond to potential terrorist attacks, including increases for Data Systems Improvements and much needed funds to expand the capacity of tribal epidemiology centers.

Conclusion

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