HEALTH CARE

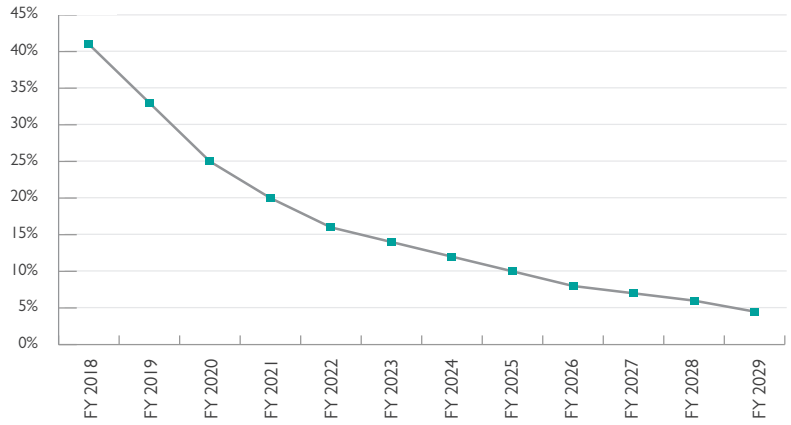
REDUCING DISPARITIES IN THE FEDERAL HEALTH CARE BUDGET

The Indian health care delivery system faces significant funding disparities, notably in per capita spending between the IHS and other federal health care programs. The IHS has been and continues to be a critical institution in securing the health and wellness of tribal communities. In 2014, the IHS per capita expenditures for patient health services were just $3,136, compared to $8,760 per person for health care spending nationally. New health care insurance opportunities and expanded Medicaid in some states may expand health care resources available to AI/ANs. However, these new opportunities are no substitute for the fulfillment of the federal trust responsibility, and the budget gap will remain. The FY 2018 budget for the IHS should support tribal self-determination, uphold the trust relationship, and work to reduce health disparities for Indian people.

Since FY 2009, tribes have seen moderate increases within the IHS budget and increased access to other funding opportunities within the Department of Health and Human Services. Many of the increases over the last several years, while important, have not allowed for program expansion. For instance, the FY 2017 President's budget request proposes an increase of $377 million for IHS over the FY 2016 enacted level. Of this increase, $159 million (57 percent) is for federal and Tribal pay costs; non-medical and medical inflation; and population growth. Contract Support Costs comprise another $82 million (21 percent) of this increase, which are mandated to be paid in full. This FY 2018 NCAI budget request for IHS takes political factors into account so that we can finally see a world where the first Americans are not last when it comes to health.

FY 2018 represents an opportunity for a new President and Administration to continue to build on the gains of the last several years. This budget is also chance to fully break with the travesties of the past that have been suffered (and continue to affect) the First Peoples of the nation and move towards solidifying the commitments made to tribes. The budget presented in FY 2018 is a chance for the new President to make a mark for Indian health. We can reduce and also eliminate the health disparities suffered by so many of our people. The target for the IHS budget is $30.8 billion over 12 years. Embarking on a pathway toward full funding will change the conversation on Indian Health and will bring a measure of hope for a better life for the next generation of our indigenous peoples.

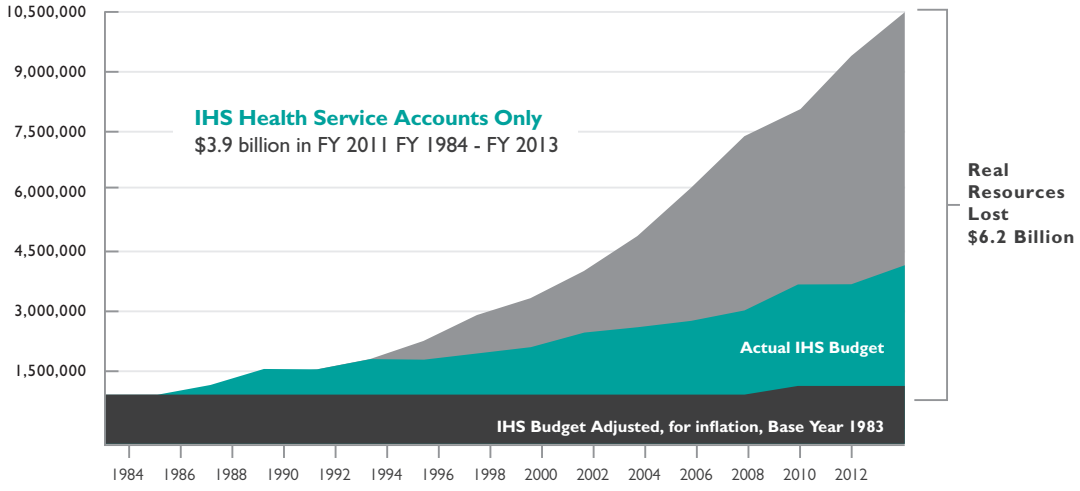
Figure 5: FY 2018 Tribal Needs Based Budget
% of Increases Needed to Achieve
Full Funding in 12 Years - $30.7 billion



For the IHS budget to grow sufficiently to meet the true and documented needs of tribal nations over a twelve-year period will require the federal government to commit an additional $2 billion per year. After a decade, the increase would fully fund the IHS at the $30.8 billion amount required for Native peoples to achieve health care parity with the rest of the American population. This request has been put forward as part of the Indian Country Budget Request for the past five budget cycles. Developing and implementing a plan to achieve parity is critical to the future of Indian health and to the fulfillment of the federal trust responsibility to tribal nations.

The requests listed below focus on specific increases to the IHS that reflect both the priorities of tribal representatives from the 12 IHS Areas and the Agency-wide goals expressed by IHS.

Figure 6: Diminished Purchasing Power:
A thirty-year look at the IHS Health services Accounts:
Actual expenditures adjusted for inflation and population growth



Key Recommendations

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Interior - Environment Appropriations Bill

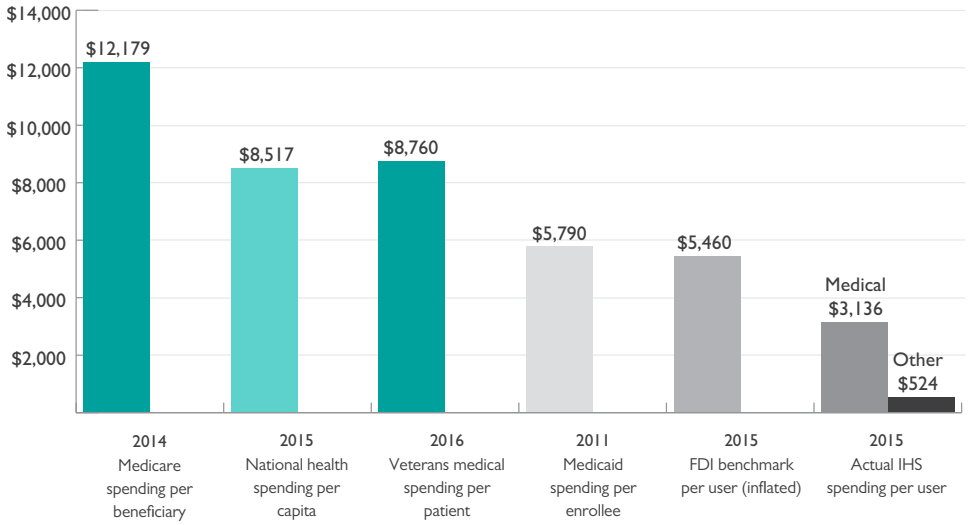
Indian Health Service (IHS)

- *Provide a total of $7.1 billion for the Indian Health Service in FY 2018.*
- *Increases above the FY 17 budget request planning base of $5.1 billion include:*
  - *an increase of $314.9 million to maintain current services*
  - *an increase of $1.39 billion for IHS services program expansion*
  - *an increase of $172.7 million for IHS facilities program expansion*

The FY 2018 tribal budget request above the President's FY 2017 Budget addresses funding disparities between the IHS and other federal health programs (Figure 7) while still providing for current service costs (Table 1). About $314.9 million is necessary simply to maintain current services, a top priority for tribes. The remainder of the requested budget increase is an increase to fund specific programs.

Figure 7: 2015 IHS Expenditures Per Capita and Other Federal Health Care Expenditures Per Capita

[Note: "Other" refers to Indian Health Service expenditures for facilities.]



Source: The National Tribal Budget Formulation Workgroup's Recommendations on the Indian Health Service Fiscal Year 2018 Budget

CURRENT SERVICES

Maintaining current funding levels so that existing services can be provided is a fundamental budget requirement and a top priority for tribal leaders. These base costs, which are necessary to maintain the status quo, must be accurately estimated and fully funded before any real program expansion can begin. Any funding decreases would result in a significant reduction of health care services and prolong the state of emergency facing the IHS. To address this situation, the following budget increases are necessary.

TABLE 1 – FY 2018 TRIBAL RECOMMENDED INCREASES TO PLANNING BASE	
PLANNING BASE – PRESIDENT'S FY 2017 BUDGET	**$5,185,015,000**
REQUESTED INCREASES	
CURRENT SERVICES	
Federal Pay Costs	$7,964,000
Tribal Pay Costs	$11,946,000
Inflation (non-medical)	$10,385,000
Inflation (medical)	$70,068,000
Population Growth	$68,711,000
BINDING AGREEMENTS	
New Staffing for New & Replacement Facilities	$62,500,000
Health Care Facilities Construction (Planned)	$83,333,000
Subtotal, Current Services + Binding Agreements	**$314,907,000**
SERVICES, PROGRAM EXPANSION INCREASES	
Hospitals & Health Clinics	$422,536,330
Dental Services	$80,433,813
Mental Health	$186,849,208
Alcohol and Substance Abuse	$155,882,258
Purchased / Referred Care (formerly CHS)	$422,454,388
Public Health Nursing	$14,295,199
Health Education	$9,019,524
Community Health Representatives	$26,948,771
Alaska Immunization	$7,373
Urban Indian Health	$46,630,329
Indian Health Professions	$22,320,781
Tribal Management Grants	$23,964
Direct Operations	$2,847,980
Self-Governance	$5,294,109
Services, Program Expansion Increases, Subtotal	**$1,395,544,027**
CONTRACT SUPPORT COSTS	
Contract Support Costs - Estimated Need	$26,080,000
Contract Support Costs - New and Expanded	$2,451,659

TABLE 1 – FY 2018 TRIBAL RECOMMENDED INCREASES TO PLANNING BASE		
REQUESTED INCREASES	**Contract Support Costs Subtotal**	**$28,531,659**
	FACILITIES, PROGRAM EXPANSION INCREASES	
	Maintenance & Improvement	$43,750,655
	Sanitation Facilities Construction	$51,726,449
	Health Care Facilities Construction-Other Authorities	$49,302,308
	Facilities & Environmental Health Support	$19,292,528
	Equipment	$8,700,624
	Facilities, Program Expansion Increases, Subtotal	**$172,772,564**
	TOTAL INCREASES TO PLANNING BASE	**$1,911,755,250**
GRAND TOTAL, REQUESTED FY 2018 IHS BUDGET		**$7,096,770,250**

PROGRAM SERVICES INCREASES

In addition to increased costs as part of maintaining Hospital and Clinic Program costs, including the Indian Health Care Improvement Fund, NCAI recommends the following Program Services increases. Included in these requested increases are the amounts for program expansion as well as increases to maintain current services.

Dental Services: Increase of $86.9 million ($80.4 million for program services expansion plus $6.4 million to maintain current services)

Dental health is a top tribal health priority. Tribes recommend $80.4 million in program increases plus $6.4 million to maintain current services. Poor oral health can affect overall health and school and work attendance, nutritional intake, self-esteem, and employability. Oral health disparities are preventable when appropriate public health programs are in place. Oral health care access is one of the greatest health challenges tribal communities face. In the general U.S. population, there is one dentist for every 1,500 people, but in Indian Country, there is only one dentist for every 2,800 people.

Within Great Plains IHS Area alone, American Indian preschool children have the highest rate of tooth decay than any population group in the country. On the Pine Ridge Reservation, the W.K. Kellogg Foundation found 40 percent of children and 60 percent of adults suffer from moderate to urgent dental needs, including infections and other problems that could become life-threatening.

The IHS Dental program supports the provision of dental care through clinic-based treatment and prevention services, oral health promotion, and disease prevention activities, including topical fluoride application and dental sealants. The demand for dental treatment remains high due to the significant dental cavities rate among AI/AN children. Funds are used for staff salaries and benefits, contracts to support dental services, dental lab services, training, supplies, and equipment. These funds are needed primarily to improve preventive and basic dental care services, as over 90 percent of the dental services provided by IHS are used to provide basic and emergency care services. More complex rehabilitative care (such as root canals, crown and bridge, dentures, and surgical extractions) is extremely limited, but may be provided where resources allow.

Mental Health: Increase of $190 million ($186.9 million for program expansion and $3.1 million to maintain current services)

Tribal leaders identified Mental Health as a top priority and recommend a $190 million increase above the Fiscal Year 2017 Budget Request. Without a major infusion of resources in FY 2018, IHS and tribal programs will continue to have limited staffing for their outpatient community based clinical and preventive mental health services. Further, any inpatient and intermediate services, such as adult and youth residential mental health services and group homes, which are sometimes arranged through states and counties, will have to be accessed outside of tribal communities.

This increase would mean a 171 percent increase in funding for behavioral health services in Indian Country. This significant increase is needed to increase the ability of Tribal communities to develop innovative and culturally appropriate prevention programs that are so greatly needed in Tribal communities.

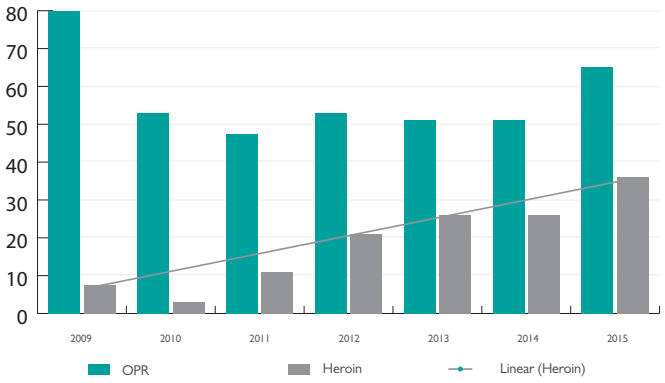
American Indian/Alaska Native (AI/AN) people continue to demonstrate alarming rates of psychological distress throughout the nation. However, tribal health continues to receive inadequate funding resources to address these issues. Without a significant increase in funds for FY 2018, Indian Health Services (IHS) and tribal programs will continue to experience difficulty with properly staffing outpatient community based mental health treatment facilities. Likewise, despite the need for mental health services throughout AI/AN communities, limited resources restrict the ability to hire qualified, culturally competent and licensed providers to relocate to rural areas.

Research has demonstrated that AI/ANs do not seek Mental Health services through Western models of care due to lack of cultural sensitivity; furthermore, suggesting that American Indians and Alaska Natives are not receiving the services they need to help reduce these alarming statistics. Moreover, added resources will ensure that in-patient psychiatric services for youth and adults will be available locally within the tribal health system while offering culturally responsive treatment and increasing service utilization. Additionally, increased funding will offer an expansion of services promoting wellness and prevention to help reduce the astonishing rates of mental health issues we continue to observe today. The geographical remoteness of most American Indian reservations and Alaska Native villages demand unique and innovative treatment options to address comprehensive mental health, substance abuse and psychiatric services. Furthermore, aftercare including case management, outreach and prevention are critical in reducing mental health issues. Use of innovative technology is critical to help support an expansion of services to the most remote communities.

Alcohol and Substance Abuse Treatment: Increase of $163.6 million ($155.9 million for program expansion and $7.7 to maintain current services)

Closely linked with the issue of mental health is that of alcohol and substance abuse. AI/AN communities and people continue to be afflicted with the epidemic of alcohol and other drug abuse. Tribal leaders agree that this topic remains a high priority for FY 2018. The Tribal Budget Formulation Workgroup recommends a program expansion increase of $155.9 million above the FY 2017 budget request and a $7.7 million increase to maintain current services. That is a 70 percent increase over the FY 2017 budget request.

Figure 8: Overdose Deaths Associated with OPR or Heroin, 2009 – 2015



Tribal leaders recognize that AI/AN people will continue to be over represented in statistics relating to alcohol and substance abuse disorders unless new culturally adapted strategies and targeted funding are identified. For instance, in 2012, drug overdose deaths in Alaska were astonishingly higher than the national rate for heroin related overdose deaths (3.0 vs 1.9 per 100,000 individuals). Furthermore, in comparison to the rest of the United States, Alaskan drug overdoses by prescription opioid pain relievers was more than double the rate (10.5 vs 5.1 per 100,000 individuals).[69] The increase in use of more lethal drugs is consistent with the reports throughout Indian Country. Also, with more stringent regulations around prescription opioids, more people are turning to heroin as a relatively cheap and more easily accessible alternative. Several hospitals are reporting an alarming increase of infants born in 2014 addicted to heroin and tribal leaders are testifying about the devastation heroin, meth and opioids are causing in their communities. The growing use of heroin in particular has spurned a resurgence of public health issues like Hepatitis and other sexually transmitted diseases.

Again, effects from historical trauma, poverty, lack of opportunity, and lack of patient resources compound this problem. AI/ANs have consistently higher rates relating to alcohol and substance abuse disorders, deaths (including suicide and alcohol/substance related homicides), family involvement with social and child protective services, co-occurring mental health disorders, infant morbidity and mortality relating to substance exposure, the diagnosis of Fetal Alcohol Syndrome (FAS) and other Fetal Alcohol Spectrum Disorders (FASD), partner violence, diabetes complications and early onset as a result of alcohol abuse, and other related issues.

According to a study in 2009-2010 American Indian and Alaska Natives were almost twice as likely to need treatment for alcohol and illicit drugs as non-Native people. The study found that AI/ANs needed treatment at a rate of 17.5 percent compared to the national average of 9.3 percent. A health study conducted by the New Mexico Department of Health in 2013 indicated that Alcohol-related Death Rates is the highest for Native Americans in the State of New Mexico and is 4 times higher than the US rate for alcohol-related deaths.

Current alcohol and substance abuse treatment approaches (offered by both the IHS and Tribal facilities) employ a variety of treatment strategies consistent with evidenced-based approaches to the treatment of substance abuse disorders and addictions (such as outpatient group and individual counseling, peer counseling, and inpatient/residential placements, etc.) as well as traditional healing techniques designed to improve outcomes and align the services provided with valuable cultural practices and individual and community identity. IHS-funded alcohol and substance abuse programs continue to focus on integrating primary care, behavioral health, and alcohol/substance abuse treatment services and programming through the exploration and development of partnerships with stakeholder agencies and by establishing and supporting community alliances. Adult and youth residential facilities and placement contracts with third party agencies are funded through the IHS budget for alcohol and substance abuse treatment. However, as a result of diminishing resources, placement and treatment decisions are often attributed more to funding availability than to clinical findings. Providing this treatment is costly to the community. Gaps in funding mean that treatment is often inconsistent from year to year across Indian Country. Because funding is never guaranteed, vulnerable people and communities can slip through the cracks and back into drug habits when grant resources run out.

Purchased/Referred Care Program (PRC): Increase of $474.4 million ($422.5 million for program expansion and $51.9 to maintain current services)

Included in this requested increase is a $422.5 million program services increase and a $51.9 increase to maintain current services. The Purchased/Referred Care program pays for urgent and emergent and other critical services that are not directly available through IHS and tribally-operated health programs when: no IHS direct care facility exists, or the direct care facility cannot provide the required emergency or specialty care, or the facility has more demand for services than it can currently meet.

The PRC budget supports essential health care services from non-IHS or non-tribal providers and includes inpatient and outpatient care, emergency care, transportation, and medical support services such as diagnostic imaging, physical therapy, laboratory, nutrition, and pharmacy services. These funds are critical to securing the care needed to treat injuries, cardiovascular and heart disease, diabetes, digestive diseases, and cancer, which are among the leading causes of death for AI/ANs. The recent trend to construct smaller joint venture outpatient ambulatory care centers will likely increase the reliance on PRC resources for hospital-based care. In FY 2013, IHS denied 146,928 eligible PRC cases amounting to a total of $760.9 million in unmet need. This demonstrates that the PRC need continues to grow in the IHS system and that additional resources are needed to address this chronic and underfunded need.

At current funding levels, many IHS and tribally-operated programs are only able to cover Priority I services to preserve life and limb and are often unable to fully meet patients' needs of even this one PRC service category. Because PRC is only treating the most desperate of cases at current funding levels, any shortfall in the program correlates to increased death rates for some communities in Indian Country.

Advance Appropriations for the Indian Health Service. In June 2014, NCAI passed a resolution supporting the enactment of Advance Appropriations for the Indian Health Service. An advance appropriation is funding that becomes available one year or more after the year of the appropriations act in which it is contained. Providing Advance Appropriations for the Indian Health Service Budget would be consistent with other federal programs that provide critical health care services to vulnerable populations.

Tribal health programs must make long-term decisions without the guarantee of sustained funding. Often programs must determine whether and how they can enter into contracts with outside vendors and suppliers, plan programmatic activities, or maintain current personnel. Advance appropriations would allow Indian health programs to effectively and efficiently manage budgets, coordinate care, and improve health quality outcomes for AI/ANs. This change in the appropriations schedule will help the federal government meet its trust obligation to tribal governments and bring parity to federal health care system. The Veterans Health Administration achieved this status in 2009. IHS, like the VHA, provides direct care to patients as a result of contractual obligations made by the federal government.

IHS Facilities Increase of $272.9 million ($172.7 million for program expansion, $83.3 million for binding agreements, and $16.9 million to maintain current services)

In FY 2018, we recommend increasing appropriations for IHS facilities by $272.9 million over the FY 2017 budget request. Included in this is $172.7 million for program expansion. Tribes are keenly aware that the lack of facilities is a major barrier to access to adequate health care in Indian Country. Dedicated resources for construction should be one of the highest priorities of the new Administration and is necessary to improve quality of health care for AI/ANs. Some of the existing facilities are very dated with an average age of 40 years and have surpassed their useful lives. This is four times longer than the national average.

A 40 year old facility is about 26 percent more expensive to maintain than a 10-year facility. The facilities are grossly undersized for the identified user populations, which has created crowded, even unsafe, conditions among staff, patients, and visitors. In many cases, the management of existing facilities has relocated ancillary services outside the main health facility; often times to modular office units, to provide additional space for primary health care services. Such displacement of programs and services creates difficulties for staff and patients, increases wait times, and create numerous inefficiencies within the health care system. Furthermore, these aging facilities are largely based on simplistic, and outdated design with make it difficult for the agency to deliver modern services.[70]

While budgets in some areas of IHS have been increasing, facilities improvements have not received increases needed to maintain current facilities or to replace aging facilities. Studies have shown that medical errors in healthcare can be linked to the physical environment of the health facility and improving these facilities can lead to better patient outcomes.[71] Improving healthcare facilities are essential for:

- *Eliminating health disparities*
- *Increasing access*
- *Improving patient outcomes*
- *Reducing operating and maintenance costs*
- *Improving staff satisfaction, morale, recruitment and retention*
- *Reducing medical errors and facility-acquired infection rates*
- *Improving staff and operational efficiency*
- *Increasing patient and staff safety*

The absence of adequate facilities frequently results in either treatment not being sought, sought later prompted by worsening symptoms and/or referral of patients to outside communities. This significantly increases the cost of patient care and causes travel hardships for many patients and their families. The amount of aging facilities escalates maintenance and repair costs, risks code noncompliance, lowers productivity, and compromises service delivery.[72]

AI/AN populations have substantially increased in recent years resulting in severely undersized facility capacity relative to the larger actual population, especially capacity to provide contemporary levels of outpatient services. Consequently, the older facility is incapable of handling the needed levels of services even if staffing levels are adequate.

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Tribal Access to Health Programs

Much of the funding that supplements IHS resources for tribal health programs, including funding that supports public health programs in Indian Country, comes from agencies within HHS outside of the IHS. The federal government's trust responsibility extends to the whole federal government, not just the IHS or BIA. IHS services are largely limited to direct patient care, leaving little, if any, funding available for public health initiatives such as disease prevention, education, research for disease, injury prevention, and promotion of healthy lifestyles. This means that Indian Country continues to lag far behind other communities in basic resources and services. Our communities are therefore more vulnerable to increased health risks and sickness.

To that end, tribes support increased funding specifically dedicated to tribes at other HHS agencies. Tribes are eligible to apply for many federal grants that address public health issues, however, many of these programs have little penetration into Indian Country because tribes have difficulty meeting the service population requirements, match requirements, or are under resourced to even apply for the grants. NCAI recommends creating specific tribal funding set-asides for block grants such as Preventive Health and Health Services Block Grant; Community Mental Health Services Block Grant; Community Service Block Grant; and the Social Services Block Grant. Federal agencies should also create funding streams that parallel the state flagship grant system. These large flagship grants provide funds to organizations and efforts within the state, but also provide the funding to sustain the infrastructure within state health departments. Denying this stable source of funding to tribes denies them a significant opportunity to create the infrastructure required to address their own public health priorities.

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Labor, HHS, Education Appropriations Bill

Diabetes Prevention

- *Continue to provide $1 million for the On the TRAIL (Together Raising Awareness for Indian Life) to Diabetes Prevention program.*

IHS has successfully funded the On the TRAIL program since 2003, serving nearly 12,000 Native American youth ages 7-11 in over 80 tribal communities. The program curriculum is an innovative combination of physical, educational, and nutritional activities that promote healthy lifestyles. The program also emphasizes the importance of teamwork and community service. Members apply decision-making and goal-setting skills when completing physical activities and engage in service projects to improve health lifestyles in their communities. Continued funding of this program sustains a tested program and represents one of the few national youth-oriented diabetes prevention initiatives.

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Labor, HHS, Education Appropriations Bill

Health Resources and Services Administration (HRSA)

Native Hawaiian Health Care Systems Program

- *Provide $14.4 million to fund the Native Hawaiian Health Care Systems Program.*

The Native Hawaiian Health Care Systems Program provides critically needed support for the health and well-being of Native Hawaiians. Since the Native Hawaiian Health Care Systems Program was first established in 1988, it has provided direct health services, screenings and health education to hundreds of thousands of Native Hawaiians, and supported hundreds of Native Hawaiians in becoming medical professionals, including physicians, nurses, and health research professionals. Allocating this funding would ensure the continuation of an already established and necessary resource for Native Hawaiians.