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HEALTH CARE

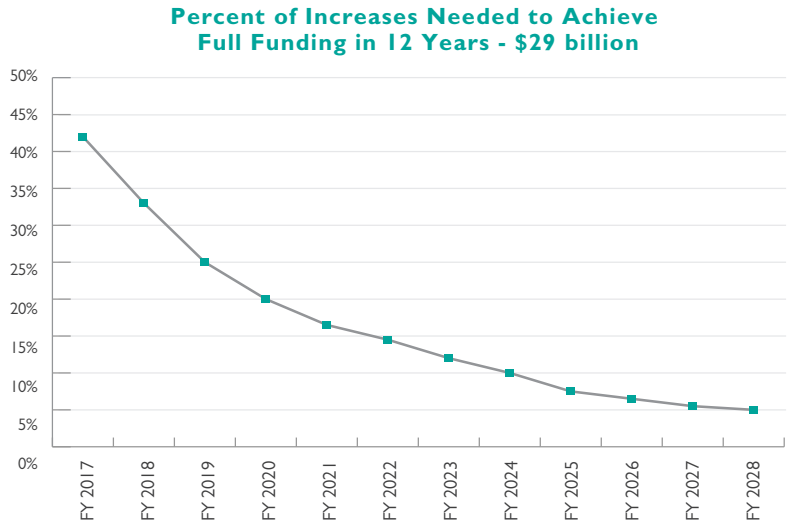
REDUCING DISPARITIES IN THE FEDERAL HEALTH CARE BUDGET

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 $3,107, compared to $8,097 per person for health care spending nationally. When looking at medical spending only, IHS per capita is only about $1,940. 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 2017 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. However, these increases have only served to meet existing mandated obligations and cover inflation costs; there have been few dollars, if any, to expand services necessary to bring true health parity for AI/AN. While these increases to the IHS budget are appreciated, a significant gap still exists when comparing per capita health spending between Indian health and other federal healthcare programs.

In FY 2015, for example, IHS received an increase of $207.9 million, most of which is being used to cover inflation and binding obligations and to restore cuts from FY 2014. Similarly, in FY 2014, IHS received an increase of $304 million over FY 2013 enacted levels. Most of this increase was required to fully fund contract support costs (CSC), as well as new staffing packages, at the direction of Congress. These mandatory directives led the agency to cut an additional $10 million from Services to pay for CSC and staffing costs. No funds were available to restore sequestration cuts from FY 2013, nor to adjust for actual inflationary increases and population growth. As a provider of direct healthcare services, the IHS must be treated like other federal health provider agencies and be held harmless from future sequestration. When budgets are developed, they must fund current services, and must provide a meaningful increase to make an impact on chronic health disparities.

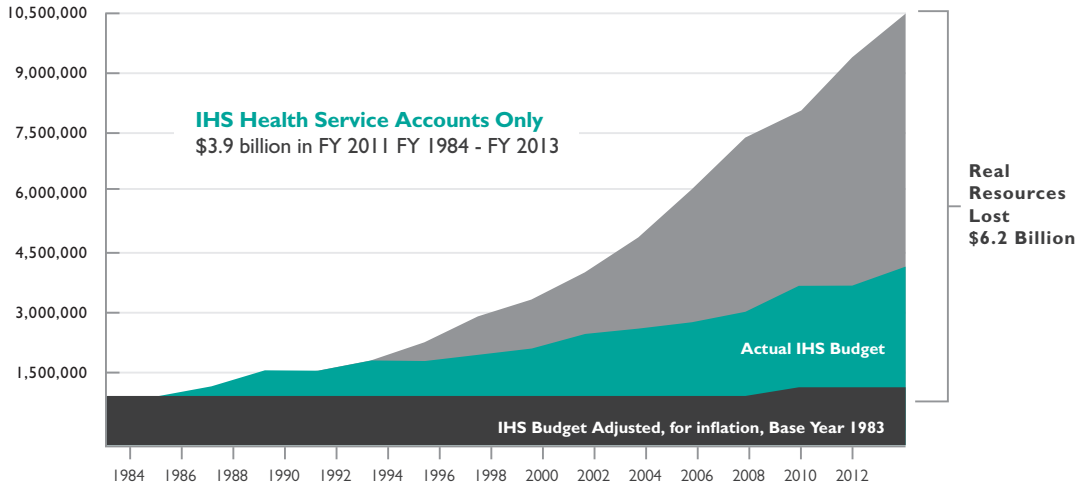


To allow the existing funding gap to continue for both IHS Services and Facilities budget lines is to disregard the health and lives of all Native Americans. Our elders, our youth and our tribal citizens ask: "Why not us? Why do our lives not count the same as other citizens?" It is time to end the unnecessary death and suffering occurring every day in Indian communities—centuries of neglect have now become an urgent humanitarian cry for justice for our people.

For the IHS budget to grow sufficiently to meet the true and documented needs of tribal nations over a twelve-year period would require the federal government to commit an additional $2 billion per year. After a decade, the increase would fully fund the IHS at the $29.96 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.

Diminishing Purchasing Power – A thirty-year look at the IHS Services Accounts: Actual expenditures adjusted for inflation and compared to lost purchasing power when adjusted for inflation and population growth. (Fiscal Years 1984 to 2013)



Key Recommendations

DEPARTMENT OF HEALTH AND HUMAN SERVICES

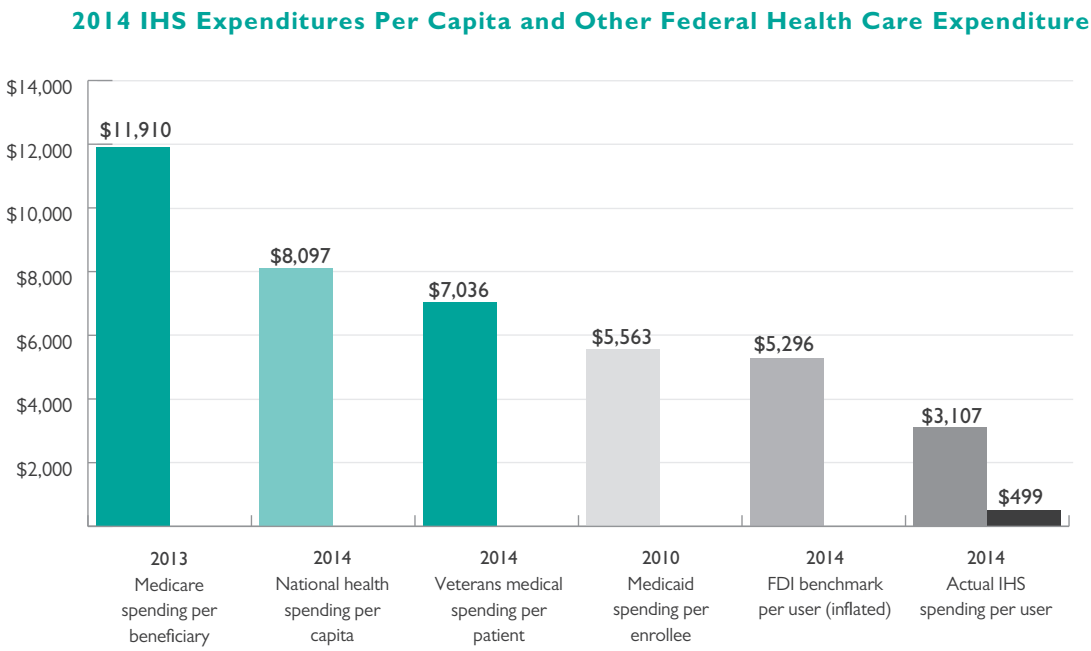
Interior - Environment Appropriations Bill

Indian Health Service (IHS)

- *Provide $6.2 billion for the Indian Health Service in FY 2017. This includes an increase of $482.4 million above the President's FY 2016 Request to maintain current services and an increase of $640 million for program expansion.*

The FY 2017 tribal budget request above the President's FY 2016 Budget addresses funding disparities between the IHS and other federal health programs (Figure 6) while still providing for current service costs (Table 1). About $482.4 million of that increase is necessary simply to maintain current services, a top priority for tribes. The remainder of the requested budget increase is a modest increase to fund specific programs (Table 2).

Figure 6: 2014 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 2017 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 2017 CURRENT SERVICE COSTS	
CURRENT SERVICES	
Tribal Pay Costs	$9,989,000
Federal Pay Costs	$8,173,000
Inflation Costs (Medical and Non-Medical)	$71,828,000
Population Growth Costs	$67,450,000
BINDING AGREEMENTS	
Contract Support Costs	$150,000,000[27]
Staffing Costs for New & Replacement Facilities	$75,000,000
Health Care Facilities Construction Costs	$100,000,000
TOTAL CURRENT SERVICE COSTS AND BINDING AGREEMENTS	**$482,440,000**

FY 2017 SERVICE COST INCREASES

New costs in FY 2017 include increases in both tribal and federal pay costs, medical and non-medical inflation costs, standard increases in health care facilities construction costs, and staffing costs for new and replacement facilities. In addition, NCAI recommends increases in funding to address Contract Support Costs and projected population increases.

Contract Support Costs: An estimated $150 million is requested for reasonable costs for activities that tribes/tribal organizations must carry out to support health programs and for which resources were not otherwise provided. The Indian Self-Determination and Education Assistance Act requires that 100 percent of these costs be paid. In FY 2014, more than $2.5 billion of the IHS appropriation was administered by tribes/tribal organizations under contracts and compacts, and the assumption of programs, services, functions and activities by tribes/tribal organizations under the Act continues to grow.

Population Growth: The request for $67.450 million will address the increased service costs arising from the growth in the American Indian and Alaska Native population, which is increasing at an average rate of 1.9 percent per year.[28] Failure to fund medical costs related to population growth translates into real erosion of existing health care dollars to meet current demand for services.

PROGRAM EXPANSION INCREASES (NOT INCLUDING CURRENT SERVICES INCREASES)	
SERVICES	
Hospitals and Clinics (H&C)	200,000,000
Dental Services	31,185,900
Mental Health	67,495,900
Alcohol and Substance Abuse	77,600,900

PROGRAM EXPANSION INCREASES (NOT INCLUDING CURRENT SERVICES INCREASES)	
Purchased/Referred Care	200,000,000
Public Health Nursing	584,000
Health Education	457,000
Community Health Representatives	557,000
Alaska Immunization	3,000
Urban Indian Health	10,000,000
Indian Health Professions	564,000
Tribal Management Grants	
Direct Operations	128,000
Self-Governance	328,000
Contract Support costs New and Expanded	2,799,000
FACILITIES	
Maintenance and Improvement	21,589,000
Sanitation Facilities	13,927,000
Health Care Facilities Construction	7,560,000
Facilities and Environmental Health	438,000
Equipment	5,000,000
TOTAL PROGRAM INCREASES	**640,216,700**

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:

Dental Services: +$37.2 million

Dental health is a top tribal health priority. The $37.2 million increase includes inflation plus $31.2 in program increases to address this growing health disparity. Poor oral health can affect overall health and school and work attendance, nutritional intake, self-esteem, and employability. Poor oral health is preventable when appropriate public health programs are in place.

According to the IHS, over 80 percent of AI/AN children ages 6-9 years suffer from dental caries, while less than 50 percent of the US population ages 6-9 years have experienced caries. AI/AN children ages 2-5 years exhibit an average of six decayed teeth, while the same age group in the US population averages one decayed tooth. Furthermore, preventative care is one of the most critical aspects to ending dental disease for AI/ANs and we urge the Administration to support preventative dental programming in its FY 2017 budget.

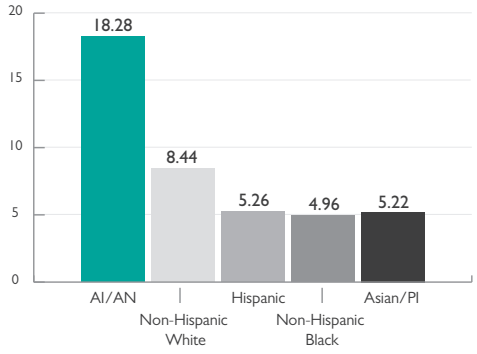
The IHS Dental program supports the provision of dental care through clinic-based treatment and prevention services, oral health promotion, and disease prevention activities, including topical fluoride application and dental sealants. The demand for dental treatment remains high due to the significant dental caries 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 I/T/Us 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.

For the general US population there are approximately 1,500 patients per dentist, while there are more than 2,800 AI/AN patients per dentist employed by the IHS and tribal dental clinics. It is essential that dental clinics serving the AI/AN population operate efficiently while also devoting time and dollars to the primary prevention of dental disease. Most dental professionals do not receive adequate training in terms of either clinic efficiency or community-based prevention.

Mental Health: +$70.4 million

Tribal leaders identified mental health as a top priority and recommend a $54.243 million increase above the Fiscal Year 2015 Budget Request. Without a major infusion of resources in FY 2017, 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.

Suicide Rates Among Persons 10-24 Years of Age, by Race/Ethnicity, 2009



American Foundation for Suicide Prevention

Access to adequate care, from local paraprofessional providers to contracted specialty care providers is critical to address the vast mental health needs for American Indians and Alaska Natives who seek care from their Tribal health and direct service facilities. Many tribes recognize historical trauma as the root of disproportionate rates of depression, suicide, reoccurring trauma from domestic violence and sexual assault. Historical trauma, which Duran refers to as "Soul wounding" can be described as unresolved generational trauma, generated by historical policies of genocide, boarding schools, relocation and more currently child welfare practices. These experiences, and the subsequent loss of traditional kinship systems, traditional language, spiritual practices and cultural values impact the core of self-worth and identity, and has left a legacy of familial and community grief, and a cycle of economic conditions that continue to contribute to the extraordinary mental health needs.

In 2007, the National Center for Health Statistics noted that AI/ANs experience serious psychological distress 1.5 times more than the general population. Of particular concern, AI/AN represent the highest rates of suicide of any group in the US for all ages. An eleven-year study (1999-2010) by Dr. Jacqueline Gray, University of North Dakota, reveals the suicide rate for AI adolescents and young adults from 15-34 is 2.5 times the national average for that age group. Unlike other groups where the suicide rate increases with age, AI/AN rates are highest among the youth and decrease with age.

Alcohol and Substance Abuse Treatment: +$85.3 million

Of the challenges facing AI/AN communities and people, no challenge is more far reaching than the epidemic of alcohol and other substance abuse. Tribal leaders understand this and have once again identified it as a top budget priority for FY 2017. The Tribal Budget Formulation Workgroup recommends a program increase of $85.3 million over FY 2016 (for both inflation plus $77.6 million for program expansion). Without a major infusion of funding, AI/AN people will continue to be consistently over represented in statistics relating to alcohol and substance abuse disorders in which higher rates of methamphetamine, cocaine and marijuana use are reported.

Now that tribes manage a majority of alcohol and substance abuse programs, IHS is in a supportive role to assist the tribes plan, develop and implement a variety of treatment modalities. The collaboration has resulted in more consistent evidenced-based and best practice approaches to address substance abuse disorders and addictions in a more cultural appropriate manner. At the community level, this is accomplished through individual and group counseling, peer support, and inpatient and residential placement. Treatment approaches also include traditional healing techniques that link the services provided to traditional cultural practices and spiritual support for the individual AI/AN that tribal programs have found successful. The Wellbriety Movement, based on the teachings of Native elders, includes a variety of holistic treatment programming for AI/ANs struggling with substance abuse. The term Wellbriety conveys both sobriety and wellness. The GONA (Gathering of Native Americans) process reflects the Native concept of the four levels of human development and responsibility, providing a structure for community gatherings addressing substance abuse. These are just two examples of cultural approaches that aid in healing.

Urban Indian Health: +$11.7 million

Our request is for a program increase of $10 million, plus inflation over the FY 2016 base, for a total of $11.7 million. Thirty-six Urban Indian Health Programs provide health care and substance abuse services in fulfillment of the federal trust responsibility to more than 100,000 AI/ANs each year. Operating in 21 states, these programs are funded from an IHS line item of only $43.6 million, which is less than one percent of the total IHS budget. Urban Indian Health Programs are unable to access PRC funding and other resources from the general IHS budget, and consequently have become adept at leveraging their modest base funding with additional health care dollars from other federal agencies, states, and foundations. Urban Indian Health Programs offer services to all AI/ANs.

Purchased/Referred Care Program (PRC): +248.3 million

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 $760.855 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.

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.