FY2012 Tribal Budget Recommendations to the U. S. Department of Health & Human Services

Advancing a New Tribal and Federal Government Partnership: Investing in Indian Health to Achieve a Sustainable Model for National Health Care Reform

March 4, 2010

"….if we're going to bring real and lasting change for Native Americans, we need a comprehensive strategy, as I said before. Part of that strategy is health care. We know that as long as Native Americans die of illnesses like tuberculosis, alcoholism, diabetes, pneumonia, and influenza at far higher rates than the rest of the population, then we're going to have to do more to address disparities in health care delivery."

President Barack Obama, Tribal Nations Conference, November 05, 2009

"Moreover, the IHS has been characterized over the past decade as a 'broken' system. The truth is that the IHS system is not so much broken as it is 'starved'. The IHS has been grossly underfunded for decades and as such cannot be expected to function optimally. Such inadequate funding has created the perception that the system is broken."

Jefferson Keel, Vice President, National Congress of American Indians, June 11, 2009, before the Senate Committee on Indian Affairs, *Hearing on Reforming the Indian Health System.*

Mark Trahant writes in a column for *Kaiser Health News* (9/17/10) that the Indian Health Service is not only "unfairly maligned as a 'disaster,'" but in fact is a "sustainable" agency that could serve as a model for national health reform in the US. According to Dr. Donald Berwick, the "Indian Health Service can, and will be, one of the leading prototypes for healthcare in America." This is explained in part by the standards of efficiency the IHS has adopted over the years in response to chronic underfunding. Although major health problems persist in American Indian communities, Trahant said there are "hopeful signs of a turnaround."

Chairman Ned Norris, Tohono O'Odham Nation

Chairman Mervin Wright, Pyramid Lake Paiute Tribe

Executive Summary

The National Indian Health Service (IHS) Tribal Budget Formulation Workgroup recognizes that the President's Budget is not only a fiscal document; it demonstrates the Administration's core values and, in the case of IHS, its commitment to addressing the health care needs of Indian Country. The budget request for IHS determines the extent to which the United States is honoring its sacred responsibility to American Indians and Alaska Natives.

This Administration's powerful commitment to Indian Country has been confirmed in the FY 2010 and FY 2011 budget requests—requests which were also consistent with many of the Workgroup's priorities. Building on this commitment, the Budget Formulation Workgroup recommends a minimum $735 million increase to the Indian Health Service budget for Fiscal Year 2012. Such a budget will carry forward the trust responsibility and support tribal self-determination as a key element of health care reform while continuing the Administration's partnership with Tribes to improve Indian health.

The Budget Formulation Workgroup also calls for a longer-term plan that, over time, brings Native American health care into parity with the general American population. This is necessary because, despite notable increases in FY 2010 and FY 2011, the Indian Health Service remains severely underfunded. For the IHS budget to grow sufficiently to meet the true and documented needs of Indian Country over even a ten-year period would require the federal government to commit an additional $1.7 billion per year, in order to fully fund IHS at the $21 billion amount that would be required to achieve parity with the general American population. This recommendation was forwarded in fiscal year 2011. A more direct approach would be to achieve parity within 7 years, requiring dedicated funding of $2.7 billion dollars per year... Developing and implementing a plan to achieve parity is critical to the future of Indian health and to fulfilling the United States' trust responsibility to Indian Tribes.

Significant investments to achieve a fully funded Indian Health Service remains imperative. The Budget Formulation Workgroup supports the development of an aggressive plan to achieve full funding in 7 years. Tribal leadership recognizes the need to develop this plan in true partnership with the Administration, and acknowledges an incremental approach developed with Tribal consultation is needed. As part of that process, the Budget Workgroup begins with a minimum $735 million request set forth here. This request reflects a delicate balance between the reality of the current fiscal climate and the imperative to feed a starved system. During the coming year the Workgroup urges the Administration to work with tribal leadership in crafting a long term solution that addresses the deeper problems in the IHS-funded health care system: one that finally achieves health parity for all First Americans.

The Workgroup request focuses specific increases to the Indian Health Service that reflect both the priorities of tribal leaders from the 12 Areas and the Agency-wide goals expressed by Dr. Roubideaux: to "build and sustain healthy communities; provide

accessible, quality health care; and foster collaboration and innovation across the Indian health system."

The FY2012 tribal budget recommendation of $735 million above the President's FY 2011 Budget reflects a 16.6% increase in funding to meet current services. Nearly one-half of that increase is necessary simply to maintain current services. This, of course, is the top priority for all Tribes. The remainder of the recommended budget permits limited advances in certain select priority areas, including:

Recommended Priority Service Increases
FY 2012 National IHS Tribal Recommendations
March 3, 2010

Hospitals & Clinics	$ 90 million
Contract Health Care	$118 million
Indian Health Care Improvement Fund	$ 15 million
Urban Indian Health	$ 9 million
New Staffing for new and replacement health care facilities	$ 25 million
Contract Support Costs	$145 million
Targeted Program Increases:	
· Mental Health	$ 4 million
· Alcohol & Substance Abuse	$ 10 million
· Dental	$ 10 million

These increases will allow expanded services to more patients in critical service areas. Hospitals & Clinics (H&C) and Contract Health Care (CHC) funds are the main funding categories funds used to address local health priorities such as diabetes, heart disease, cancer, respiratory/pulmonary diseases, and focused health promotion/disease prevention initiatives. Increases in these activities will help reduce disparities in medical care for both facility-based and contract care-based tribal communities. For example, ***Vacancy Statistics (Active Jobs) by Indian Health Services*** **a**s posted on *www.ihs.gov*, February 22, 2010, reports that there are currently 37 family practice physician vacancies, 48 dentist vacancies and 41 pharmacist vacancies. If just the physician positions are filled, 37 additional physicians would each be able to see 16 additional patients per day, four days per week for 42 weeks per year, resulting in an additional 99,456 patient visits per year. Patients would have increased access to health care professionals, resulting in

increased opportunities to address disease prevention and health promotion issues. Similarly, a $10 million increase for alcohol and substance abuse and a $4 million increase for mental health will, when combined with the Centers for Medicare/Medicaid Services (CMS) American Indian all-inclusive rate of $269 per encounter, purchase an additional 52,238 encounters for mental health. So, too, a $118 million increase in the Contract Health Service (CHS) line item will increase specialty practice purchasing power and significantly reduce denials and deferrals of services due to lack of funds. Finally, every $10 million in increased Contract Support Cost (CSC) payments permits the restoration of 243 health care positions that are lost due to contract support cost shortfalls.

Indian Country looks forward to working with the Administration to realizing these recommended increases. With President Obama's commitment to honoring the Nation's treaty obligations and trust responsibility, and to supporting tribal self-determination, a powerful partnership has been forged between the Administration and Indian Country that will strengthen the well-being of all tribal communities.

Background

National IHS Tribal Budget Formulation Workgroup

In order to assess the true needs and health priorities of American Indians and Alaska Natives, the IHS works through a budget formulation and consultation process with Tribes to develop the agency's budget. This process begins with each of the 12 IHS Areas producing their regional, tribally-driven recommendations. The IHS Tribal Budget Formulation Workgroup, consisting of tribal representatives from each of the 12 IHS Areas, then consolidates all the Area recommendations and, working with IHS Headquarters and national Indian organizations, develops a consensus national tribal budget and health priorities document. The document is then formally presented to the U.S Department of Health and Human Services in March, eleven months before the President presents his Budget to Congress.

Consistent with President Obama's commitment to transparency and to a new tribal-federal partnership, during the 2009 budget development period for FY 2011, the Workgroup had an opportunity to share its FY 2011 recommendations directly with the Office of Management and Budget (OMB). This occurred in recognition that budget development is a dynamic process with many decisions and factors arising along the way that impact the final IHS budget request. Regular OMB interaction with Tribes in the budget development throughout the process is essential. The Workgroup urges that the past year's OMB consultation process be expanded this year to include regular high-level consultation meetings between OMB and Tribes throughout the budget development process. Consulting with Tribes prior to critical decision-making represents true consultation, honors the government-to-government relationship, helps Tribes make more informed long-term decisions in the planning and management of their own health care programs and priorities, and equips key OMB decision-makers with the information they

need to support the most appropriate IHS budget. Given the central role that OMB plays in the budget formulation process, Tribal Leadership makes the following formal recommendation:

Recommendation: The Department should work with OMB to establish an ongoing budget consultation regimen throughout the budget development process.

Federal Trust Responsibility: Legal and Historical Roots

The provision of health services to American Indians and Alaska Natives is the direct result of treaties and executive orders that were made between the United States and Indian Tribes, and of two centuries of Supreme Court case law which developed in the wake of those treaties.

Through the cession of lands and the execution of treaties, the federal government took on a trust responsibility to provide for the health and welfare of Indian peoples.

> *"Indian people have given up a lot, they really feel like they have, in a sense, prepaid for this health care with loss of land, natural resources, loss of culture."*
>
> **Dr. Yvette Roubideaux**
> **December 2, 2009**
> **The New York Times**

It is this federal trust responsibility that is the foundation for the provision of federally funded health care to all enrolled members of the 564 federally recognized Indian Tribes, bands, and Alaska Native villages in the United States.[1]

Overview of Indian Health Care Delivery System

The Indian Health Service is responsible for overseeing the Indian health care delivery system and for ensuring the delivery of that care to all American Indians and Alaska Natives. The Indian health system consists of services and programs provided directly by the IHS; services provided by Indian Tribes and tribal organizations exercising their rights of self-determination and self-governance; and services provided by urban organizations that receive IHS grants and contracts (collectively, the "Indian health system" or "I/T/U"). This system is community-based and reflects a culturally-appropriate approach to delivering health care to a population suffering severe health disparities and massive rates of poverty within the most remote and rural areas of America. The Indian health system has a current user population of 1.4 million people out of a total service population of 1.9 million people.

There is no consistent "core" service, no consistent health benefits "package," across Indian Country. Basic health services available to meet the needs of AI/AN peoples vary from geographic Area to Area. Some Tribes rely on IHS to operate their facilities, some

Tribes operate their IHS health facilities on their own, some Tribes rely entirely on Contract Health Services (CHS) to secure purchased care from the private sector, and some Tribes undertake a strategic blend of some or all of these approaches.

What is consistent, however, is that there is an overwhelming lack of funding to support the basic health care demands of American Indian and Alaska Native communities. Although it can fairly be said that, as a result of the trust responsibility, Indian health care is 'pre-paid,' funding is also capped at woefully insufficient levels. As a result, the federal government has historically failed to dedicate sufficient funds to meet its trust responsibility and eliminate the health disparities that exist between American Indian and Alaska Native peoples and the overall American population.

Indian Country extends an open invitation to the Secretary to visit our communities to see first hand the challenges our communities face, and the state of health care delivery amongst our Areas. The needs we have "on the ground" in health service delivery are diverse. Indian Country extends our willingness to foster an open dialogue with the Secretary's Office, We respectfully ask that you visit our communities, talk with our leaders and perhaps, as importantly, our health care providers to obtain a clear picture of Indian Country's undertaking to further our common interest; to improve the health status of American Indian/Alaska Native peoples.

FY 2012 Tribal Budget Recommendations

CURRENT SERVICES

The first and fundamental budget principle of the IHS Budget Formulation Workgroup is *to preserve the basic health care program currently being funded.* The FY 2012 budget recommendations thus maintain current services while allowing for marginal program increases for improved access to care. The following budget request will assist with forward progress toward eliminating health disparities among AI/AN's and is essential to maintaining current services. Under a 7 year full funding plan, the aggregate need illustrated below could be achieved, with a total dedication toward all health services accomplished with just over a $12 billion dollar investment in that commitment.

AIAN Health Care Funding Need – An Aggregate Cost Estimate

GROSS COST ESTIMATES

Source of funding is not estimated

			Need for Existing Users at I/T Sites	Need Expanded for Eligible AIAN at I/T/U Sites*
			1,482,000	2,000,000
SERVICES		$ Per Capita	Billions	Billions
Medical Services	Medical services and supplies provided by health care professionals; Surgical and anesthesia services provided by health care professionals; services provided by a hospital or other facility, and ambulance services; Emergency services/accidents; Mental health and substance abuse benefits; Prescription drug benefits	$ 4,612 (Based on 2008 FDI benchmark ($4,100) inflated to 2011 @4% per year)	$ 6.84 ($ per capita * Users)	$ 9.22 ($ per capita * Eligilbe AIAN)
Dental & Vision Services	Dental and vision services and supplies as covered in the Federal Employees Dental and Vision Insurance Program	$ 483 (2008 BCBS PPO Vision ($87) and Dental benchmarks ($342) inflated to 2011 @4% per year)	$ 0.72 ($ per capita * Users)	$ 0.97 ($ per capita * Eligilbe AIAN)
Community & Public Health	Public health nursing, community health representatives, environmental health services, sanitation facilities, and supplemental services such as exercise hearing, infant car seats, and traditional healing.	$ 1,082 (19% of *IHS* $ is spent on Public Health. Applying this ratio, $1,082 per capita = (.1981*$4612).	$ 1.60 ($ per capita * Users)	$ 2.16 ($ per capita * Eligilbe AIAN)
Total Annualized Services		$ 6,176	$ 9.15	$ 12.35
FACILITIES		$ Per Capita	Billions	Billions
Facility Upgrades Upfront Cost		*na*	$ 6.50	$ 8.77
Annualized for 30yr useful life			$ 0.38	$ 0.51

IHS assessed facilities condition (old, outdated, inadequate) and has estimated a one-time cost of $6.5b to upgrade and modernize. A 30yr useful life assumption is used to estimate the annualized cost (assuming 4% interest) of the upgrades.

TOTAL	Billions	Billions
Total Annualized Services + 1-Time Upfront Facilities Upgrades	$ 15.65	$ 21.12

Gross costs for mainstream health care to AIAN and facilities upgrades are based on typical cost factors. The actual costs that wold be experienced among I/T/U sites would vary. Gross costs are estimated expenses without specifying sources of payment. Under current law, a portion of gross costs would be paid by Medicare, Medicaid, and private insurance depending on the # of AIAN eligible - which varies place-to-place and time-to-time. The extent that gross costs would be offset is not precisely known. For certain planning assumptions, IHS assumes a crude 25% nation-wide.

*Crudely--AIANs residing in service areas, including urban areas, discounted for AIAN already partially served by I/T sites.

Federal Pay Costs: It is recommended that $12 million be provided for federal pay cost increases and that $13 million be provided for tribal pay costs.

Inflation: Funding for IHS programs has not kept up with inflation, while Medicaid and Medicare have accrued annual increases of 5 to 10% per year. For FY 2012 it is

recommended that $63.3 million be provided to fund non-medical inflation, and that $54.8 million be provided to fund medical inflation associated with hospital and clinic functions and the CHS program.

Contract Support Costs: The IHS Budget Formulation Workgroup recommends a $145 million increase to fully fund Contract Support Costs (CSC) in FY 2012. The tribal self-determination and self-governance initiatives have been widely recognized as the single greatest contributor to improved heath care in American Indian and Alaska Native communities. This model promotes an environment which is less paternalistic and sets the stage for self-care management leading to improved outcomes that target health promotion and disease prevention objectives. The choice of Tribes to operate their own health care systems and their ability to be successful in this endeavor depends critically upon the availability of CSC funding to cover fixed costs. Absent full funding, Tribes are forced to reduce direct service funding by leaving direct service positions vacant, in order to cover the government's shortfall in required payments.

Adequate CSC funding assures that Tribes, under the authority of their contracts and compacts with IHS, have the resources necessary to administer and deliver the highest quality healthcare services to their members without sacrificing program services and funding. It has been demonstrated that tribal programs have increased the quality and level of services over IHS-operated direct service programs. Failing to provide adequate CSC funding is counterintuitive to supporting the very program that has most improved the quality and level of health care for American Indian and Alaska Native people.

Population Growth**:** It is recommended that $42.9 million be provided to meet the growing demand on the IHS system. The National Center for Health Statistics estimates that the American Indian and Alaska Native population is increasing at approximately 1.5% per year. This increase translates to approximately 30,000 new patients entering the Indian health care system annually. Failure to fund medical costs related to population growth translates into real erosion of existing health care dollars to meet current demand for services.

Health Care Facilities Construction**:** It is recommended that $94 million be provided for health facility construction projects, of which $10 million is recommended for the small ambulatory construction program. The Workgroup further recommends that the IHS and Department encourage Congress to include appropriations language to allow staffing and equipment funding for the small ambulatory construction authorities (Pub. L. No. 102-573). This is necessary to realign the facilities construction program to provide consistent opportunities for Tribes to address health facility construction needs throughout Indian Country. (See recommended language attached.)

Staffing for New Facilities**:** It is recommended that $25 million be provided to fund staffing and operational costs at new facilities in FY 2012. Investments made in the construction of healthcare facilities must be accompanied by the necessary resources to meet their updated staffing and operating costs.

PROGRAM INCREASES FY 2012 Tribal Budget Recommendation

Hospital & Clinics: It is recommended that an additional $105 million be provided to support IHS and tribal programs in the treatment and care of chronic diseases, including diabetes, cancer, and heart disease, as well as sustained programs for health promotion and disease prevention.

Indian Health Care Improvement Fund: From the amount recommended above, we recommend that $15 million be made available for the Indian Health Care Improvement Fund (IHCIF). IHCIF funds are appropriated by Congress to reduce disparities and resource deficiencies between IHS operating units. The IHCIF directs funding through the Federal Disparity Index to the lowest funded operating units.

Dental Health: It is recommended that an additional $10 million be provided for the Dental Health subaccount. American Indians and Alaska Natives have the highest rates of tooth decay and gum disease in the United States. Dental services are extremely limited, and routine procedures such as root canals and dentures services are generally unavailable. It is not uncommon for facilities to ration or defer dental care when funds are low. In 2008, the IHS GPRA Summary Report indicated only 25% of American Indians and Alaska Natives had access to dental care. This is substantially below our Healthy People 2010 goal of 40 percent.

Mental Health: It is recommended that an additional $4 million be provided for increased mental health services. Behavioral health services are inadequate to meet the present and growing needs of patients with mental health disorders. Psychological services that are culturally relevant are necessary to improve outreach, education, crisis intervention and the treatment of mental illness.

Alcohol and Substance Abuse Program: It is recommended that an additional $10 million be provided for Alcohol and Substance abuse programs and community-based prevention activities. Despite recent increased services and community interventions, there remains an overwhelming demand for alcoholism and substance abuse treatment and aftercare prevention. Aggressively addressing this disease has direct implications for reducing injuries, accidental deaths, domestic violence, suicide, cirrhosis and other chronic health and social problems.

Contract Health Services: It is recommended that an additional $118 million be provided for Contract Health Services (CHS). This is a very modest increase, since it is estimated that the unfunded need in the CHS program *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.

Maintenance and Improvement (M&I): It is recommended that an additional $10 million be provided to address the Backlog of Essential Maintenance and Improvement Repairs (BEMAR) necessary on existing health facilities. M&I funds support and

enhance the delivery of health care services and protects real property investments from costly deterioration. The American Recovery and Reinvestment Act (ARRA) provided $100 million for M&I projects. As IHS prepared to distribute these funds, a substantial number of new deficiencies were identified in health facilities, increasing the overall BEMAR backlog to $476.1 million.

Sanitation Facilities Construction: It is recommended that an additional $14 million be provided for Sanitation Facilities Construction. Currently, 12% of American Indian and Alaska Native homes do not have an adequate potable water supply. In most cases, sanitation construction projects ensure a central water or waste point within American Indian and Alaska Native communities. This request is modest given that it would only cover improved centralized water and waste-haul systems, not piped water and sewer to individual homes.

Equipment: It is recommended that an additional $5 million be provided to fund equipment requirements at newly constructed tribal joint-venture projects. These equipment requirements are necessary for clinical diagnosis and effective therapeutic procedures in new facilities.

Urban Program: It is recommended that an additional $9 million be provided for the Urban Indian Health Program (UIHP). Often, UIHP clinics are the only health care providers in urban centers that provide culturally appropriate health services to urban Indians. Without this program American Indians and Alaska Natives living in urban centers have no choice but to return to their home reservations to seek care—often times delaying care for months or years.

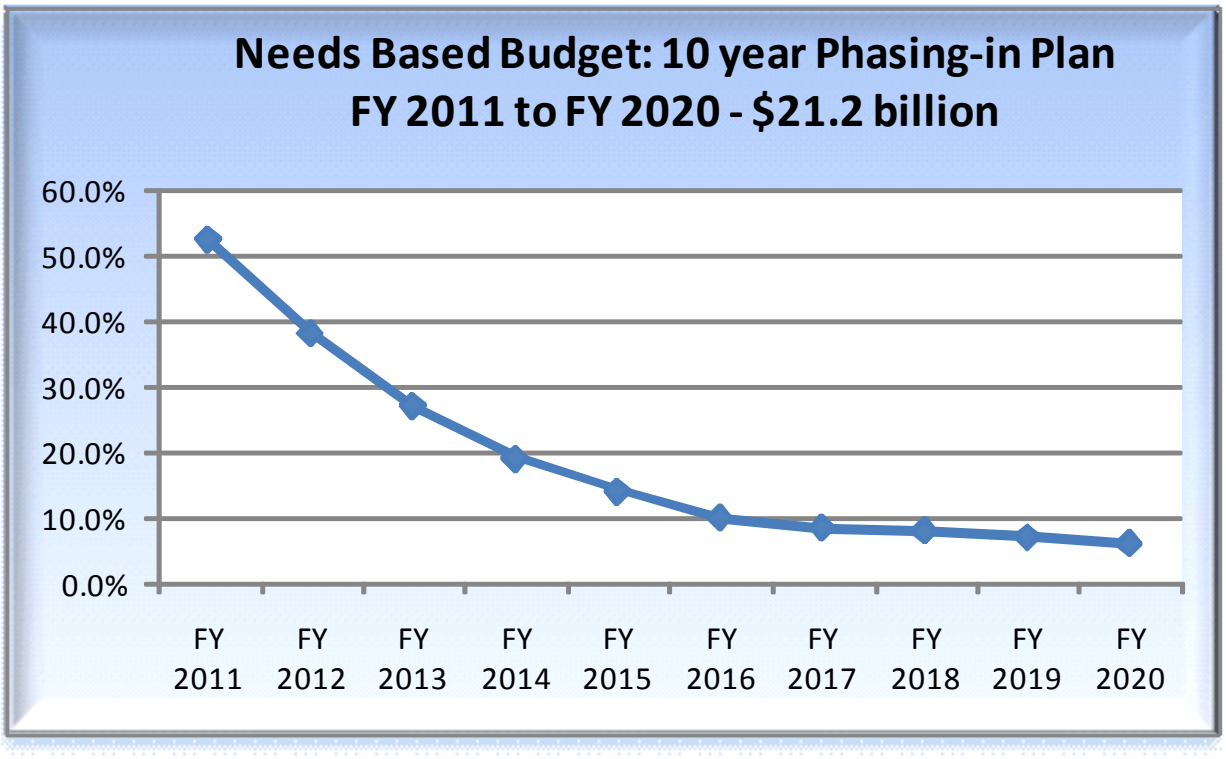
FY 2012 NATIONAL IHS BUDGET
TRIBAL RECOMMENDATIONS

		Recommended
PLANNING BASE -- FY 2011 President's Budget		4,406,429,000
Total $ Increment to Spread Among Items		730,000,000
Balance of Increment to Spread		0
CURRENT SERVICES **	604,100,000	397,000,000
Federal Pay Costs	26,900,000	12,000,000
Tribal Pay Costs	29,200,000	13,000,000
Inflation (medical & non-medical)	63,300,000	63,300,000
Additional Medical Inflation	54,800,000	54,800,000
Population Growth	42,900,000	42,900,000
Contract Support Costs - Shortfall	115,000,000	145,000,000
Health Care Fac.Constr. (5-Yr Plan, dtd Feb 2010) Includes:	272,000,000	66,000,000
PROGRAM INCREASES BY BUDGET LINES **	225,000,000	333,000,000
SERVICES		
New Staffing for New/Replacement Facilities	35,000,000	25,000,000
Hospitals & Clinics		90,000,000
Indian Health Care Improvement Fund (subset of H&C)		*15,000,000*
Dental		5,000,000
Mental Health		4,000,000
Alcohol and Substance Abuse		10,000,000
Contract Health Services		118,000,000
Public Health Nursing		0
Health Education		0
Community Health Representatives		0
Alaska Immunization		0
Urban Indian Health		9,000,000
Indian Health Professions		0
Tribal Management		0
Direct Operations		0
Self-Governance		0
Contract Support Costs - New & Expanded	10,000,000	0
FACILITIES		
Maintenance & Improvement	50,000,000	10,000,000
Sanitation Facilities Construction	40,000,000	14,000,000
Health Care Fac. Construction		18,000,000
Joint Venture	10,000,000	
Small Ambulatory	90,000,000	10,000,000
Facilities & Environmental Health Support	15,000,000	0
Equipment	10,000,000	5,000,000
SUBTOTAL Current Services + Program Increases	829,100,000	730,000,000
BASE APPROPRIATION	*4,406,429,000*	4,406,429,000
GRAND TOTAL	*5,235,529,000*	5,136,429,000

A Seven Year Plan: Phasing in of the Needs Based Budget

The IHS Budget Workgroup and Tribes understand that immediately funding the total NBB of $21.12 billion is unlikely in an environment of equally important competing national priorities such as military actions in Iraq and Afghanistan, balancing the budget, and the current national economic crisis. Furthermore, we recognize that even if we were provided the full level of proposed funding in one year, the IHS and Tribal health programs do not have the adequate health infrastructure necessary to accommodate immediately expanded services.

To address this in a responsible manner, the Tribes developed a 10-Year Phased Funding Plan for the NBB in the fiscal year 2011 request. The 10-Year Plan would require a sizable increase in the first two years, but the increases thereafter will be moderate. The most significant aspect of the 10-Year Plan, however, is that it will involve a multiple year commitment of several years by the Congress and the Administration to enact a budget designed to impact significant improvement in the health status of AI/AN people.



The chart demonstrates that if the first year increase of $2.1 billion in FY 2011 is appropriated, the following year's increases would decline gradually until they approximate 6% in FY 2020. The amount thereafter would be tied to actual medical inflation. The increase proposed in the first year is justified when considering the $4.9 billion lost to inflation over the last twenty-five years. Beginning in FY 2012, increases

in funding would taper down and adjust for inflation and population growth with occasional standard proposals for services and facility enhancements. With facility needs addressed and initial funding to propel the development and institutionalization of health services for chronic diseases, prevention, and behavioral health, maintaining current services for each year can be the focus. Failing to address the need for initial costs in FY 2011 will continue to weaken Indian health services at an exponential rate. The cumulative lost purchasing power over the last two decades has had immeasurable damage, now only repairable by committing to fully fund the health needs outlined in the Needs Based Budget.

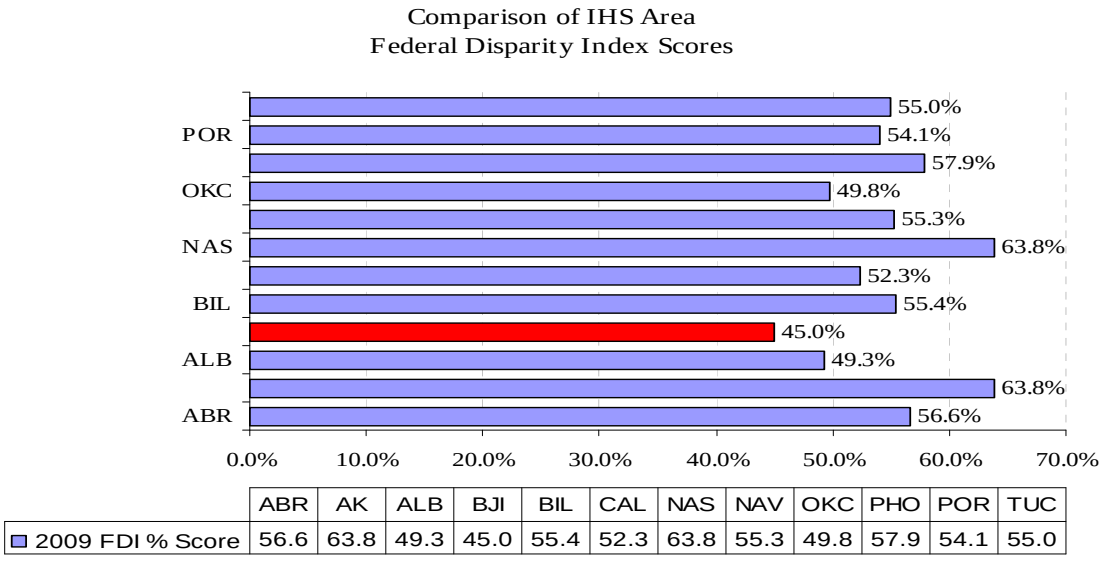
The Tribes would like to take this plan one step further and recommend the Administration aggressively address this issue. A 7-Year Plan to achieve parity, developed in consultation and in partnership with the Tribes, would well demonstrate the commitment to improve AI/AN health status. The improvements in overall AI/AN health status and achieving levels to that of the rest of the United States population will decrease the medical costs related to access to care and preventative and behavioral health services that is so severely impacting Indian communities today.

Recommendation: The Department should work with Tribes to develop a 7 year plan to achieve full funding of the IHS.

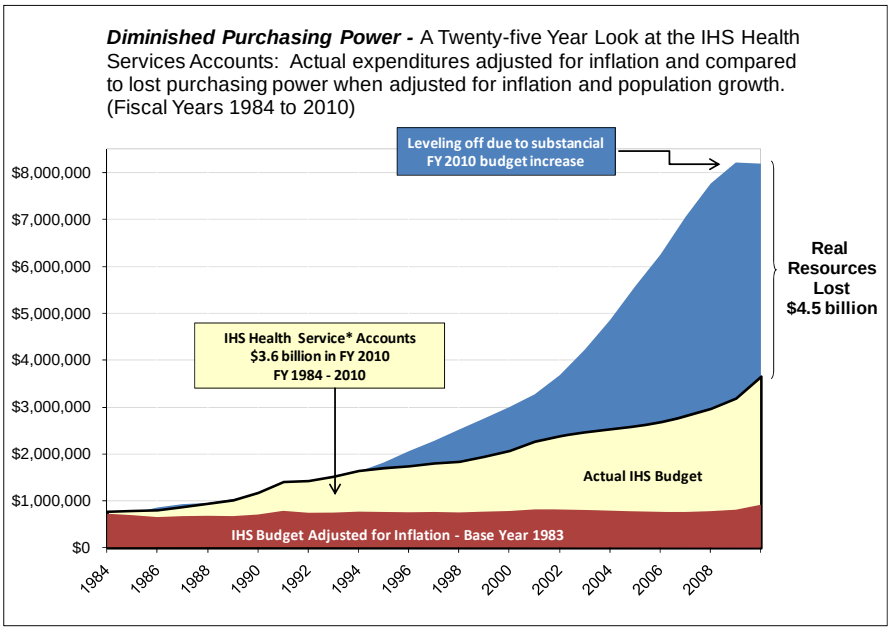
Closing the Gap: The Need for Commitment

Disparity Index Area to Area

Tribes have long known the devastating and lingering effects of health disparity. In comparison to the rest of the nation, based on the Federal Disparity Index, on average, over half of the health needs of AI/AN beneficiaries remain unmet.



Diminished Purchasing Power



The graph illustrates the escalating divide between the actual IHS budget, the IHS budget adjusted for inflation and the purchasing power of the budget accounting for medical inflation and population growth. As indicated, the IHS budget has suffered a cumulative loss of $4.9 billion in purchasing power from 1984 to 2008. The commitment to achieve a fully funded IHS, capable of providing AI/AN's needed access to quality primary care, secondary health care, basic preventative services is critical to decreasing the disparities that exist. A fully funded IHS will achieve the necessary care that should be provided AI/ANs while enhancing access to services through increased purchasing power for secondary care and wrap around services.

2012 Tribal National Health Care Priorities

In addition to the budgetary line items that comprise the budget, the Workgroup focuses on health care priorities to identify the most pressing health care issues across Indian Country. In the face of half of the health care need being unaddressed, establishing areas of primary care health focus is essential for development of effective use of the limited dollars received by IHS. This must be accomplished through consultation between the Department and the Tribes. The trust obligation of the Federal government to address the health care needs of AI/AN's *does not rest solely within the HIS;* it encompasses *all of the agencies within DHHS.* The Tribal Budget Formulation Workgroup asserts that the health care priorities identified are best addressed through a multi-disciplinary/multi-agency approach that creates initiatives in consultation with Tribes to better address community specific needs and eliminate the disparities that exists. Many of the most serious health care priorities would be best addressed through innovations involving multiple federal agencies. The Tribal Budget Formulation Workgroup thus recommends

that the Department establish a Tribal Advisory Group to the Intergovernmental Council on Native American Affairs. Such an advisory group would provide Tribes the opportunity for ongoing consultation at the Departmental level to ensure that regular consultation with Tribes is occurring across all agencies. The Intergovernmental Council should also consult with Tribes in producing it's legally mandated annual report to Congress, and should share that report with Tribes in order to enhance the Department's overall consultation process, to facilitate enhanced inter-agency support for Indian health care improvement, and to provide Tribes with the best possible information needed to help them prepare for consultation.

Recommendation: The Department should establish a Tribal Advisory Group to the Intergovernmental Council on Native American Affairs.

FY 2012 Tribal National Health Care Priorities
Aggregated Area Consultation Results
March 3, 2010

1. Diabetes
2. Cancer
3. Behavioral Health/Alcohol/Substance Abuse/Mental Health
4. Health Promotion/Disease Prevention
5. Heart Disease/Stroke
6. Injuries/Injury Prevention
7. Maternal & Child Health
8. Dental
9. Water and Sanitation
10. CHS

Below are descriptions and brief narratives for each of the tribal national health priorities:

1. Diabetes

Combating diabetes remains Indian Country's number one national priority. The rates of diabetes for American Indians and Alaska Natives are the highest in the United States, with rates of diagnosed diabetes in adults reaching 60 percent in some communities. Between 1997 and 2004 the prevalence of diabetes increased by 45 percent in all major

regions (all ages) served by IHS. The highest rate of increase was among young adults aged 25-34 years, with a 160 percent increase from 1990 to 2004. Alarmingly, type-2 diabetes rose 128% in adolescents 15 to 19 years old. According to Government Performance Results Act (GPRA) data, in 2009 one-fifth of all American Indians and Alaska Natives in the Tucson Area suffered diabetes at an estimated cost of $21 million for diabetic care.

The prevalence of diabetes in American Indians and Alaska Natives under the age of 35 increased by 133% between 1990 and 2004. In 2003, approximately 70% of American Indians and Alaska Natives over 35 had both diabetes and hypertension. Diabetes mortality is more than 3 times higher in the American Indian and Alaska Native population than in the general population (1999-2001). Complications of diabetes lead to much higher incidence rates of blindness, vascular insufficiency leading to amputation, and End Stage Renal Disease (ESRD) than in the general population. For instance, the New Mexico age-adjusted lower-extremity amputation rate in 2000 was 3.5 times higher for American Indians and Alaska Natives with diabetes than for non-Hispanic whites. In 2001, the age-adjusted ESRD incidence among American Indians in the Southwest was 2.4 times higher than the general population. In 2002, one in every four (24.8 percent) American Indian or Alaska Native elders over age 65 years had coronary heart disease potentially resulting from diabetes.

The prevalence of diabetes varies among Tribes, but is increasing across all IHS Areas. A recent analysis of the IHS system patient data for American Indians and Alaska Natives under age 35 years showed that the prevalence rate of diagnosed diabetes doubled in just 10 years—rising from 8.5 cases per 1,000 people in 1994 to 17.1 cases per 1,000 in 2004. These data are based only on the 60% of American Indians and Alaska Natives who were able to access the IHS system during the 10-year period. There is general consensus among tribal leaders and health care professionals that more funds are needed to successfully address this high priority disease burden in Indian Country.

2. Cancer

Cancer is the second leading cause of death among American Indians and Alaska Natives over the age of 45.[2,3] Cancer mortality rates among men and women in the Northern Plains and Alaska Areas are significantly higher than for the general population.[4] Late diagnosis, commonly caused by insufficient CHS funding which results in delayed access to diagnostic and treatment options, is a major contributor to cancer-related mortality for American Indians and Alaska Natives. After being diagnosed with cancer, access to needed services through I/T/U programs and private sector contract health care providers can be complicated and overwhelming, with insufficient CHS funding, once again, playing the largest role. Complex policies and procedures related to patient referrals, contract care eligibility and access to pharmaceutical interventions creates added challenges in the coordination of cancer care. On the prevention side, continuing efforts are needed on initiatives dedicated to smoking cessation and promoting and providing access to routine early screening.

3. Behavioral Health/Alcohol/Substance Abuse/Mental Health

Behavioral health is a serious healthcare priority, and the availability of culturally appropriate emergency, outpatient and inpatient psychiatric services are severely limited, once again due to chronic underfunding. Psychological services are necessary to improve outreach, education, crisis intervention and the treatment of mental illness including depression, unresolved childhood trauma, schizophrenia and other factors contributing to suicide and violence.

a) Alcohol & Substance Use - Alcohol and substance abuse continues to be a major issue and correlates to injuries, domestic violence and other behavioral health problems across tribal communities. The impact of these issues on individual health status is evident. Liver disease is the sixth leading cause of death for all American Indians and Alaska Natives, especially affecting individuals 35 years and older.[5] In 2007, American Indians and Alaska Natives aged 12 years or older had the highest rate of current illicit drug use (12.6%). This population was also more likely than other racial groups to have some form of alcohol use disorder (28.3%).[6] Although Tribes carry out aggressive efforts to address prevention, treatment, and aftercare services within their communities, short staffed frontline professionals are often faced with the need to address co-existing behavioral and mental health disorders. Medical staffs are overwhelmed with inebriated emergency room cases crowding further understaffed ER facilities in which alcohol or drug related cases are contributing factors and often this becomes a deterrent in the ability of Tribes to retain medical staff.

b) Suicide - Suicide is a critical issue in American Indian and Alaska Native communities. According to the Suicide Prevention Resource Center, the Centers for Disease Control and Prevention reported that from 1999 to 2004 suicide was the eighth leading cause of death for AI/ANs, and that 16% of the youth attending BIA schools in 2001 had attempted suicide during the previous 12 months. According to one estimate,[7] the 1998 suicide rate among American Indians and Alaska Natives was 13.4 per 100,000, representing an 8.1% increase from 1990 and a substantial departure from the target rate for Health People 2010. National suicide rates for American Indians and Alaska Natives have consistently been over twice the national average for all races, and even higher for young Indian males. Among American Indians and Alaska Natives ages 10 to 34 years, suicide is the second leading cause of death.[8] Current reports indicate these trends are not abating.[9, 10]

4. Health Promotion and Disease Prevention

Tribes have long been concerned with the lack for resources available to provide effective overall health promotion and disease prevention (HP/DP) initiatives, which ranks fourth on the national tribal health focus priority. Current funding limitations require that almost all resources go toward treatment, rather than prevention, modalities; proven to be a far more costly approach to healthcare. Holistic, culturally appropriate health promotion and disease prevention programs that incorporate both traditional and western medicine techniques can save lives, reduce health disparities and, when adequately funded and implemented at the community level, significantly improve the quality of life of American Indians and Alaska Natives.

The Tribal Health Promotion/Disease Prevention recommended focus areas for the IHS in FY 2012 are:

- *Asthma*
- *Diabetes*
- *Nutrition*
- *Obesity*
- *Physical Activity/Exercise*
- *Tobacco Cessation*
- *Access to Health Care*
- *Cardiovascular Disease*
- *Immunization*
- *Injury and Violence*
- *Mental Health*
- *Oral Health*
- *Responsible Sexual Behavior*
- *Substance Abuse*
- *Traditional Healing*
- *Environmental Quality*

Prevention is cost effective. Physical fitness, tobacco cessation programs, and early screening initiatives can reduce current levels of diabetes, cardiovascular disease and cancer. Given the significant cost of treating critical health outcomes (i.e., diabetes, HIV, heart disease), public health research has consistently found a wide range of wellness programs to be cost-effective, including diabetes prevention programs, weight-reduction programs, STD/HIV prevention, and tobacco cessation. Focusing on wellness is thus good public health practice and reflects the traditional cultural values of Indian Tribes. The National Institutes of Health in a study on drug use prevention conducted in 1997, found that, "*For every dollar spent on drug use prevention, communities can save $4 to $5 dollars in costs for drug abuse treatment and counseling.*" This clearly demonstrates the return on the investment prevention dollars generate in the picture of overall health care delivery.

5. Heart Disease/Stroke

Diseases of the cardiovascular system are responsible for over 40% of deaths in the general American population and low-income and minority populations suffer a disproportionately high burden of death and disability from such diseases.[11] In 2001, heart disease was the leading cause of death among all American Indian and Alaska Native people (accounting for 20% of all deaths) and stroke was the fifth leading cause of death (accounting for 5% of all deaths).[12] Although heart disease mortality declined 43%

for the general population over the last 30 years, it declined only 4% in the American Indian and Alaska Native population.[13]

Addressing heart disease and stroke is a major and increasing component of both inpatient and outpatient medical expenditures by the IHS and tribal health programs. Almost all advanced heart disease must be referred to specialists outside the IHS system, but such care is either unavailable due to remoteness or prohibitively expensive. When American Indian and Alaska Native patients enter an Emergency Room for cardiovascular emergencies, they are typically faced with bills that they are simply unable to pay.

6. Injuries/Injury Prevention

Among all American ethnic groups, American Indian and Alaska Native children experience the highest rates of injury mortality and morbidity. While injury mortality rates for American Indian and Alaska Native children have decreased during the past quarter century, it still remains almost double the rate for all children in America.[14, 15] Fatality rates for motor vehicle occupant injuries are 3 times higher for American Indian and Alaska Native children than for Caucasian and African American children.[16] Among all age groups, American Indians and Alaska Natives have an injury rate nearly twice that of all races, with motor vehicle crashes causing the greatest number of injury deaths.[17,18]

Critical and recognized risk factors for unintentional injury mortality among American Indian and Alaska Native children include poverty, alcohol abuse, substandard housing, and limited access to emergency medical services, rural residence, and low rate of seatbelt use. The high rates of injury-related death and disability make it especially important to emphasize and intensify injury prevention efforts within this population. Of special concern is that suicide and assaults have become more visible as rapidly emerging injury prevention issues. This alarming data suggests the need for comprehensive and collaborative efforts involving Tribes, IHS, and other DHHS agencies, the Bureau of Indian Affairs, the Department of Justice, and state, county and local public health and law enforcement agencies.

7. Maternal and Child Health

Successful maternal and child health (MCH) services reduce the numbers of children suffering Fetal Alcohol Syndrome (FAS), Fetal Alcohol Effect (FAE) and other developmental disabilities.[19] Early MCH care has also been shown to reduce obesity among American Indian and Alaska Native youth.[20,21,22] MCH wellness efforts in tribal communities have focused on breastfeeding, childhood nutrition, dental care, physical activity, education, parent-child interactions and obesity prevention programs.[23] For instance, breastfeeding has been shown to improve both the health of the mother and the infant and would increase the impact of preventing the onset of diabetes, obesity, some

types of cancers, and many other health problems.[24,25] Similarly, improving overall pre-conception health of American Indian and Alaska Native women between the ages of 15 and 44 has improved pregnancy-related outcomes.[26] But access to prenatal care is limited and American Indian and Alaska Native women typically initiate their first prenatal visit later in their pregnancy, and complete fewer doctors' visits, than their counterparts in the general population.[27]

8. Dental

The IHS dental health program is primarily limited to children. For adults, it typically provides only emergency care—if anything at all. The Dental Program is challenged to provide these limited services to an increasing population with some of the highest rates of tooth decay and gum disease in America. For instance, among American Indian and Alaska Native adults, the rate of periodontal disease is 2.5 times greater than in the general population.[28] Dental decay among American Indian and Alaska Native children is even more significant, with children between the ages of 2 and 4 suffering tooth decay rates that are 5 times the national average.[29] A shocking 79% of children suffer tooth decay, with 60% of these children having severe early childhood caries (baby bottle tooth decay).[28, 29] For children aged 6–14 years, 87% suffer tooth decay—twice the national rate. Overall, 68% of American Indian and Alaska Native children have untreated dental caries, 33% of school children report missing school because of dental pain, and 25% report avoiding laughing or smiling because of the way their teeth look.

Basic dental services, such as dental emergency care, education and prevention, and basic restorative care are not available to most American Indian and Alaska Native people. The dental program recommends a three directional approach involving community education, facility construction, and recruitment.[30] Community education covers continuous Dental Health Promotion and Disease Prevention awareness within communities along with excellent one-on-one dental patient education. The facility priority recognizes the need for quality materials applied with quality dental equipment, housed in a quality facility and surrounded by quality housing for providers.[31] Recruiting consumes most of the Area Dental Program's efforts because qualified dentists are in short supply nationwide (with approximately 40% of dental positions in community health centers currently vacant).[32]

The tribally-initiated DENTEX Dental Health Aide Therapist (DHAT) program in Alaska is an example of a successful needs-based innovation.[33] The DENTEX program trains DHATs as mid-level providers in order to enhance access to dental services in rural Alaska. DHATs focus on prevention, pain and infection relief, and basic restorative services. The World Health Organization cites 42 countries that currently use DHATs, and the DHAT program in Alaska was largely modeled on the DHAT programs from New Zealand, the United Kingdom and Canada.[34] DHATs are significantly improving access to year-round oral health care for individuals who previously might only see a dentist once each year.3241

9. Water and Sanitation

The availability of adequate plumbing systems in homes has a direct correlation with the prevention of gastrointestinal diseases, respiratory and skin infections.[35] Despite tremendous effort to improve water and sanitation facilities across Indian Country, including recent stimulus funding, approximately 11% of American Indian and Alaska Native homes still lack safe water in the home.[36] The provision of water and sanitation facilities to existing homes and communities is a critical part of preventative health as well. Sanitation facilities construction needs for Tribes are prioritized and funded by IHS using a database called Sanitation Deficiency System (SDS). SDS contains needed water, sewer and solid waste projects for all existing homes.[37] At the end of FY 2008, the total sanitation facilities unmet needs for all Tribes was $2.59 billion, consisting of $1.18 billion in "feasible" projects and $1.41 billion in economically "unfeasible" projects costing more than $47,000 per home (for projects located in New Mexico or Utah) and $48,000 per home (for projects located in Arizona).[38] In Alaska, most projects focus on safe community water single access points and safe waste-dumping facilities, since piped water and sewer to individual homes is presently unrealistic.

10. Contract Health Service

CHS funds are used in situations where: (1) no IHS direct care facility exists, (2) the direct care element is incapable of providing the required emergency or specialty care, (3) workload exceeds the capacity of the direct care element, or (4) to supplement alternate resources. Given severe funding constraints, the agency applies stringent eligibility and medical priority rules. Due to insufficient funding, most IHS and tribal health programs are on "Priority One" status, meaning only life- or limb-threatening conditions receive access to CHS care.

Contract Health Service (CHS) are those services purchased that are unavailable directly at IHS or Tribal service sites. CHS is often utilized to purchase specialty diagnostic and care provider services; cardiology, osteopathic and oncology practice specialists that are not readily available. Presently, less than one-half of the CHS need is being met, leaving too many Indian people without access to critically necessary medical services. Many tribally operated health programs no longer report deferred or denied services because of the expense associated with tracking and reporting deferred or denied services. More disturbing is that many IHS users no longer even visit health facilities because they know they will be denied care due to insufficient CHS funding. As the availability of CHS funds diminishes, the investment in direct services becomes more important. Brick and mortar infrastructure development are crucial in a balanced approach to primary care delivery availability and CHS specialty care purchasing.

ARRA Funds Increase Access and Help Build Indian Communities

The American Recovery and Reinvestment Act of 2009 was signed into law by President Obama on February 17, 2009. ARRA is an unprecedented effort to jumpstart the economy, create or save millions of jobs, and put a down payment on addressing long-neglected challenges. The Act includes measures to modernize our infrastructure, enhance energy independence, preserve and improve affordable health care, and protect those in greatest need. The IHS received $500 million in ARRA funding to serve American Indian and Alaska Native communities. This funding included $85 million for health information technology. IHS also received an additional $90 million of ARRA funds from the Environmental Protection Agency (EPA) for additional Sanitation Facilities Construction projects. Below are just a few examples of how ARRA funded Facilities projects have and will improve health services in Indian Country:

<u>$227 million for health facilities construction</u>

- ***Norton Sound Regional Hospital, Nome Alaska***
  9,333 users (FY2003) and 10,435 projected users (FY2015), 13,900 square meters
  $167.6M to replace existing hospital with 13,900 square meters of new space
  Additional space will provide access to the following additional services: ambulatory surgery, EMS/air ambulance, GOCADAN, health aide training, maternal health, pre-maternal home, village-based counseling, village health services and WIC

<u>$100 million for maintenance and improvements</u>

- **Fort McDermitt Health Station, Fort McDermitt, Nevada**
  424 users and 2,893 annual outpatient visits
  $534,368 project completed October 21, 2009 demolished and replaced the Fort McDermitt Health Station with a state-of-the-art, energy efficient, modular clinic with new equipment that meets current healthcare design standards

<u>$68 million for sanitation facilities construction</u>

- **Elwha Valley Water Storage Tank, Lower Elwha Indian Reservation, Washington**
  $147,510 - project completed February 11, 2010 provided work for 6 construction companies to construct an 119,000 gallon concrete water storage tank meeting state design standards that will serve 126 homes and 8 non-residential buildings and allow for modest growth in this Lower Elwha S'Kallam community

<u>$20 million for health equipment</u>

- ***Penobscot Community Health Care, Indian Island, Maine***
  1,342 users and 4,036 annual outpatient visits
  $42,982 - project completed December 21, 2009 included replacement of existing dental x-ray unit, power exam tables, Doppler monitors and other manual equipment

Increased efficiency of dental services enhanced patient comfort and satisfaction and supported clinical best practices.

Additional ARRA and IHS investments in Facilities projects will build on this success. Investments in health care and sanitation facility construction, facility maintenance and improvement and environmental health support increase the availability of health care, improve access to health care and safe drinking water, improve the quality of care, improve the health status of tribal communities and protect the value of previous facility investments. Facilities investments can also reduce energy costs, create and maintain jobs in tribal communities, and help to stimulate local economies through tribal contracting and purchasing.

Artist's rendering of new Norton Sound Regional Hospital, Nome, Alaska - Project is currently on winter shut down. Construction is scheduled to re-start in March. A web cam at the job site allows future users and others to follow the project live - http://209.124.149.186/view/viewer_index.shtml?id=100.

Closing

Tribes were especially pleased to see the demonstrated commitment of President Obama and his Administration in fiscal year 2011, standing on the principle of strengthening Tribal communities, and, increasing desperately needed funding in the IHS budget to continue to address the needs of health care to AI/AN peoples.

The President, through the US Department of Health and Human Services, can continue to demonstrate his commitment to honoring Treaties and living up to the promises made "for as long as the grass grows and the wind blows" by supporting a planned incremental increase to full funding during his Administration. Through continued consultation with the 564 federally recognized Tribes in the United States, the opportunity is now at hand to demonstrate the success of government run health care. It can be achieved. It is time to advance ***a New Tribal and Federal Government partnership, to invest in Indian Health to achieve a sustainable model for national health care reform.*** The challenges of meeting the health care needs of American Indian/Alaska Natives in the United States are many, the answers are not easy, and urgency is upon us. America's first citizens are ready; we can, and will be, the leading prototype for healthcare in America.

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