FY 2010 BUDGET RECOMMENDATION:
Restoring the Trust & Leaving a Legacy

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Introduction

Each year, the Indian Health Service (IHS) budget is developed using a budget formulation process that involves IHS direct operated programs, tribally-operated programs, and Urban Indian health programs, commonly referred to as the I/T/U. Representatives from each of the 12 IHS Areas serve on the I/T/U budget work team to discuss their health and budget priorities and develop funding recommendations. The work team, along with IHS headquarters and national organizations, come together to develop consensus on the IHS budget priorities for that year, and to present their recommendations before the Department of Health & Human Services (HHS). In previous years, tribal representatives were allowed to make budget presentations to the Office of Management and Budget (OMB)—however despite repeated requests by the IHS budget formulation work group—this has not happened for the past seven years.

Executive Summary

We are here today with all of the same concerns that we voiced last year. While our health and budget priorities have not changed, tragically, several things have. In the last year, nearly 3,000 American Indians and Alaska Natives (AI/AN) died of cardiovascular disease, over 16,500 were diagnosed with a sexually transmitted disease, 5,000 were diagnosed with diabetes for the first time, over 22,000 are now living with cancer (45% of which were diagnosed in the late-stages), and 400 took their own life. These are our community members and our tribal leaders, our daughters and sons, our mothers and fathers, our brothers and sisters.

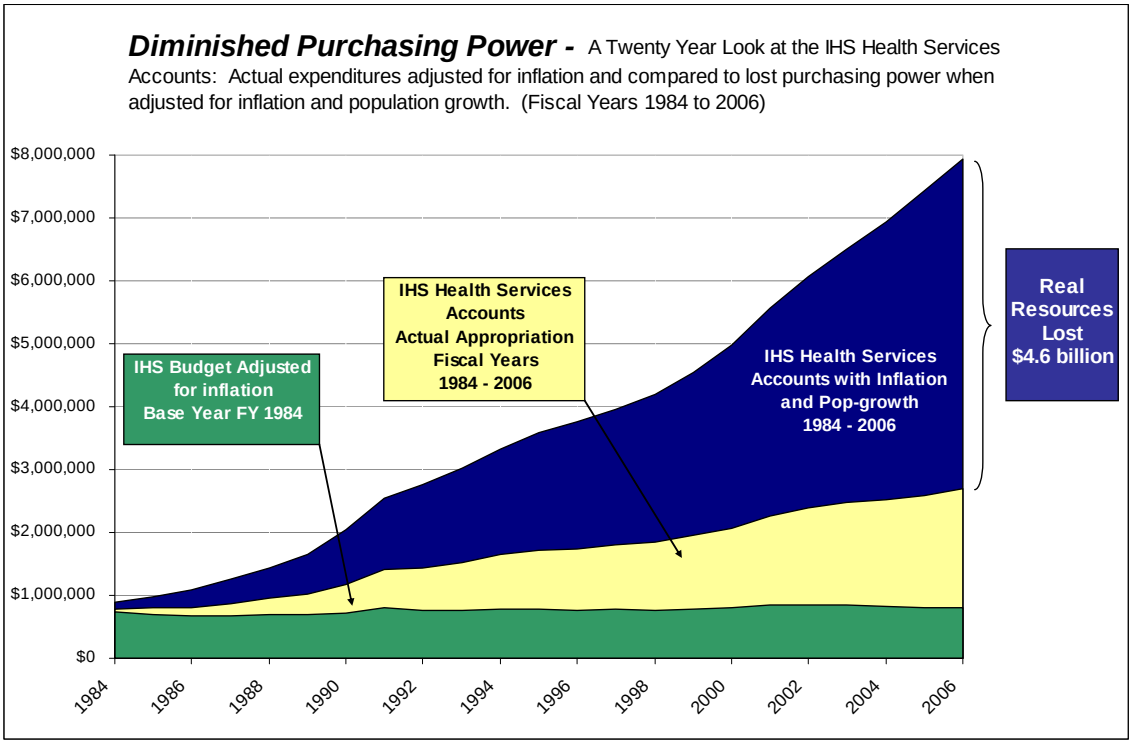
The urgency of this situation should not be taken lightly. For over 100 years, Native people have experienced inferior health outcomes; our life expectancy is still five years less than that of other Americans. Adequate funding is needed to end this lasting injustice, and uphold the federal trust responsibility of the United States and the Federal government.

This year marks the tenth anniversary of the HHS Tribal consultation process. Each year, Tribal leaders have testified about AI/AN health disparities and critical health care needs in tribal communities. In order to address these needs, Tribal leaders have repeatedly testified that mandatory costs like pay increases, inflation, population growth, and administrative costs must be funded in order to maintain current services. If current services are not maintained, the overall health program is eroded. If not funded, the only alternative to absorb mandatory costs is to cut health services to people that need health care the worse. Because tribal requests have not been well funded, Tribal leaders have become cautious about the effectiveness of the HHS Budget Consultation process. Many Tribal leaders have lost faith and question the Administration's commitment to uphold the responsibilities of the Federal trust relationship. For Tribes, the ultimate policy document to uphold the Federal trust relationship is the Administration's budget. Clearly, our Tribal budget requests have not been sufficient to meet the needs of Indian Country and do not honor the Federal trust relationship.

The IHS Federal Disparity Index (FDI) measures the proportion of funding provided to the Indian health system, relative to its actual need, by comparing healthcare costs for IHS

beneficiaries in relation to beneficiaries of the Federal Employee Health Benefits (FEHB) plan. This method uses actuarial methods that control for age, sex, and health status. In 2002, per capita healthcare spending totaled $1,914 for AI/ANs, compared to $3,545 in other public sector financing programs serving the non-elderly population.1 It is estimated by the FDI, that the IHS system is funded at less than 60% of its total need.2 To fully fund the clinical and wrap-around service needs of the Indian healthcare system, the IHS budget would need an additional $15 billion dollars. 3

Instead, OMB has routinely used non-medical inflation estimates to calculate budget increases for the IHS budget, vastly underestimating true healthcare inflation rates. To be consistent, OMB should use the same inflations rates for IHS as are applied to Medicaid and Medicare. Compounded over the last eight years, the IHS has received insufficient funding to cover population growth and the increasing cost of medical salaries, medical equipment, facility maintenance, and service administration (i.e. Contract Support Costs). This underestimation has seriously diminished the purchasing power of Tribal health programs.



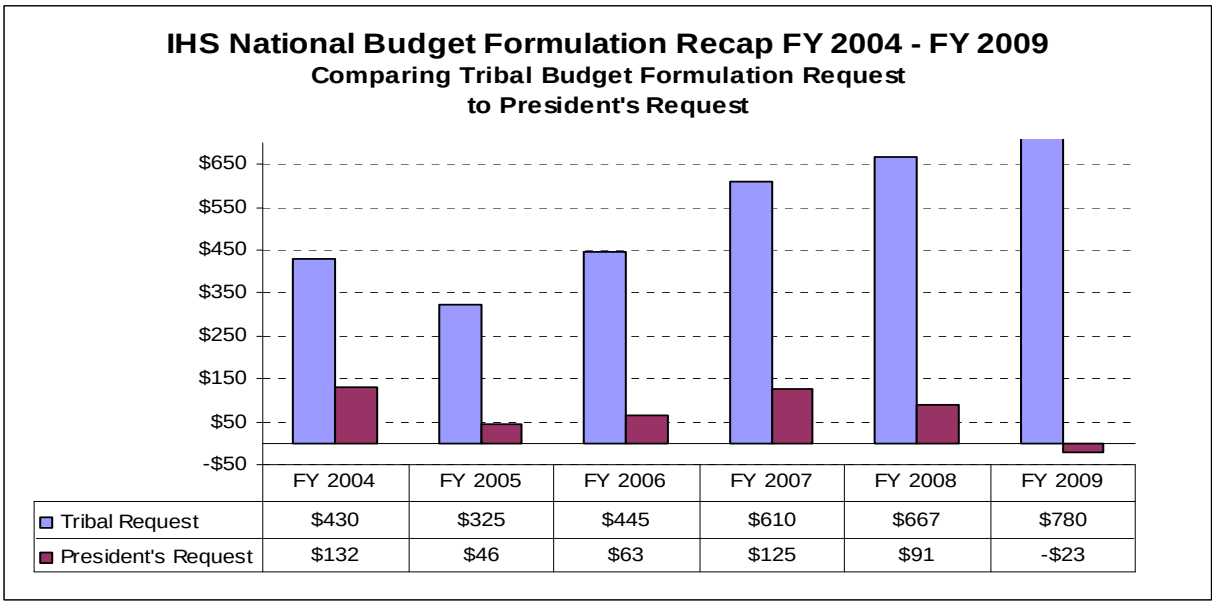
The graph above illustrates that in FY 1984 the IHS health service accounts (does not include facilities) were funded at $777 million. In FY 1993 the budget totaled $1.5 billion. By FY 2008, the budget for health services had increased to only $3.3 billion. Were this budget to keep pace with inflation and population growth, this figure would have exceeded $7.2 billion dollars. This graph illustrates the mounting divide that has emerged between: (1) the actual IHS budget; (2) the IHS budget adjusted for inflation, and; (3) the purchasing power of the budget accounting for medical inflation and population growth. As demonstrated, the IHS budget has suffered a cumulative loss of $4.6 billion in purchasing power from 1984 to 2006.

To address this shortfall, the I/T/U workgroup has developed budget recommendations for FY 2010 totaling $908 million. Funds included in this recommendation will offer IHS the ability to provide AI/ANs with access to quality primary and secondary healthcare, basic preventative services, and the infrastructure needed to support those services. The following budget accounts for the actual inflationary costs experienced by I/T/U programs, population growth, the staffing needs of new facilities, and the long-needed backlog of facility construction.

To restore trust, a strong, collaborative commitment is needed by the Administration, the Federal government, and the Congress.

Restoring Trust: The Legal & Historical Roots of the Federal Trust Responsibility

The provision of health services to AI/ANs is the direct result of treaties and executive orders that were made between the United States and Indian Tribes. This federal trust responsibility forms the basis of providing health care to AI/AN people. This relationship has been reaffirmed by judicial decisions, executive orders, and congressional law. Arizona senator and former chair of the Indian Affairs Committee, John McCain, recently charged that, "the federal government has continually reneged on its trust and moral obligations to meet the educational, health care, and housing needs of Indians, and these needs far outweigh the imperceptible contribution that the proposed cuts will make to reducing the deficit."4



	FY 2004	FY 2005	FY 2006	FY 2007	FY 2008	FY 2009
Tribal Request	$430	$325	$445	$610	$667	$780
President's Request	$132	$46	$63	$125	$91	-$23

In 2002, we came to this meeting and requested an increase of $430 million to meet the healthcare needs of Tribes (the budget formulation process precedes the request by two years). When the President released his FY 2004 budget, the request for the IHS was a mere $132 million. For 2005, Tribes requested $325 million and only received and increase of $46 million. For 2006, the Tribal request was $445 million and the President only requested $63 million. This pattern has continued year after year until finally in FY 2009, for which the Tribal request was $780 million, the President cut the IHS budget by $23 million. This pattern of consistent

disregard hampers meaningful consultation. Consultation is more than just an exchange of words. Action is needed.

As this Administration prepares its last budget submission, for the FY 2010 budget cycle, it has an opportunity to restore the trust back into the HHS budget formulation process. It has an opportunity to restore the faith that this Administration will honor the Federal trust relationship. The Administration can restore the trust by providing an adequate increase for the IHS budget that will fully fund mandatory costs and allow for program increases that will address the significant health disparities that AI/AN people face. Restoring this trust will honor the legal and moral obligations that are owed under the Federal trust relationship. Restoring this trust will leave this Administration's legacy on the federal trust relationship and demonstrates it's commitment to address the health care needs of AI/AN people.

2010 Health Care Priorities

Tribal leaders continue to place great emphasis on the implementation of the IHS Director's three health initiatives: 1) chronic disease management, 2) behavioral health, and 3) health promotion disease prevention.

1) **Chronic Disease Management** - The three most serious and pressing chronic diseases that affect AI/ANs includes cardiovascular disease, cancer, and diabetes.

   a) *Cardiovascular Disease* - With the increasing prevalence in AI/AN communities of risk factors for CVD, such as diabetes and high blood pressure, the burden of CVD in tribal communities is expected to increase, a literal health care ticking time bomb. Diseases of the cardiovascular system are responsible for over 40% of deaths in the US general population, and low-income and minority populations carry a disproportionately high burden of death and disability.5 In 2001, heart disease was the leading cause of death among all AI/AN people (accounting for 20% of all deaths) and stroke was the fifth leading cause of death (accounting for 5% of all deaths).6 More AI/AN men and women over the age of 45 now die of CVD than any other single disease. While CVD mortality has decreased in the last several decades for the U.S. population as a whole, rates are rising among AI/ANs and now exceed those of the general population.7 Heart disease mortality declined 43% in the general US population in the last 30 years, but only declined 4% in the Native population.8

      CVD 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, and this is either not available, or if available, is accomplished at considerable expense. Most IHS beneficiaries live in rural areas and access to specialty treatment is difficult to obtain.

   b) *Cancer* - Cancer is currently the second leading cause of death for American Indians, and is the leading cause of death for Alaska Natives.9 Late diagnosis is a major contributor to cancer related mortality for AI/ANs. After being diagnosed with cancer, access to needed services through I/T/U programs and contract health providers in the private

sector can be complicated and overwhelming. Policies related to patient referral processes, contract care eligibility, and access to various pharmaceutical interventions creates added challenges in the coordination of cancer care for AI/ANs.

c) *Diabetes* - AI/AN diabetes prevalence rates are among the highest in the world. The prevalence of diabetes and the extent of diabetic complications have reached epidemic proportions. The age-adjusted prevalence for AI/AN adults is more than twice that of other U.S. adults. Complications from diabetes, includes blindness and vascular insufficiency leading to amputation and End Stage Renal Disease, occur in higher rates in AI/AN people than in the general U.S. population.

2) **Behavioral Health** - Tribal leaders agree that behavioral health is a serious healthcare priority, pointing out that the availability of emergency, outpatient, and inpatient psychiatric services are limited due to chronic under-funding. Psychological services are necessary to improve outreach, education, crises intervention, and the treatment of mental illness such as depression, unresolved childhood trauma, schizophrenia, and factors contributing to suicide and violence.

a) *Drug and Alcohol Use* - Alcohol and substance abuse continues to be a major issue and correlates to injuries, domestic violence, and other behavioral health problems in tribal communities. The impact of these issues on individual health status is evident. Liver disease is the sixth leading cause of death for all AI/ANs, especially effecting individuals 35 years and older.10 Between 2002 and 2005, AI/ANs in all age groups were more likely than other racial groups to have a past year alcohol use disorder (10.7% vs. 7.6%), and more likely to have a past year illicit drug use disorder (5.0% vs. 2.9%).11 Tribes make continued efforts to address prevention, treatment, and aftercare services within their communities. Under-staffed, frontline professionals are often faced with the need to address co-existing behavioral and mental health disorders.

b) *Methamphetamines* - Tribal officials also report an increase in methamphetamine use in many areas of the country. Highly aggressive prevention and intervention services are demanded because of the severe influence of this drug on human behavior and the neurological and physical damages caused by this drug. The extent of the problem is difficult to ascertain because the present ICD-9 coding in the IHS data system includes ‘amphetamine,’ not ‘methamphetamine’ indicators. For example, the Phoenix Area, serving Tribes in Arizona, Nevada, and Utah, reports that the annual rate of amphetamine-related conditions increased dramatically from 100 cases per 100,000 population in 2000 to 695 cases per 100,000 population in 2005. The workload visits of persons coming into Phoenix Area IHS with amphetamine-related conditions increased from 135 in 2000 to 1,024 in 2005 and half of all persons with alcohol-related conditions and amphetamine-related conditions were between 25 and 44 years old. Tribal leaders express urgency regarding the need to assess the extent of the problem of increasing methamphetamine use on Indian reservations.

c) *Suicide* - Suicide is a sensitive issue, but one that is of great concern in AI/AN communities. According to an estimate by Keppel et al. (2002), the 1998 suicide rate

among AI/AN 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 AI/ANs have consistently been over twice the U.S. national average for all races and even higher for young Indian males. IHS service population data indicate that suicide is an even greater problem among AI/AN youth and males. Among AI/ANs ages 15-to-34 years, suicide is the second leading cause of death.12 Current reports indicate these trends are not abating. For example, Pine Ridge Service Unit reported a 65% increase in suicide gestures for 2004, and 250% increase in attempts and completions from 2004 to 2005.

3) **Health Promotion and Disease Prevention** - Holistic, culturally appropriate health promotion and disease prevention (HP/DP) programs can save lives, reduce health disparities, and when adequately funded, drastically improve the quality of life of AI/ANs. The prevention priorities for IHS in 2008 are:

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

Prevention is cost effective. Despite limited financial resources, IHS has made great progress in many healthcare domains by providing holistic preventative care. Primary prevention efforts are crucial to this effort, and ongoing resources and expertise must be committed to the provision of long-range HP/DP services. 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 found a variety of wellness programs to be cost effective, including diabetes prevention programs, STD/HIV prevention, and tobacco cessation.

Prevention is good public health practice & reflects our Cultural Values. To proactively address each of these issues, strategies are needed to expand the prevention capacity of the Indian health care delivery system. Tribes cite a variety of effective strategies, including: community-based health education, patient case management, screening and early detection campaigns, training for healthcare professionals, and incorporating traditional healing approaches to improve wellness. Traditional, culturally-appropriate prevention programs must be recognized as “best practice” by state and federal agencies. Holistic prevention activities integrate the physical, emotional, spiritual, and social dimensions of health behavior and self-care.

2010 Budget Request

The following budget request will maintain and prevent decreasing AI/AN access to adequate health services, allowing us to continue out work in eliminating health disparities among AI/ANs. The Current Services Increases budget outlined below is essential for maintaining the base funding for IHS programs. Similarly, the Program Services Increases budget is necessary to maintain current access to care. Explained in more detail below, both types of funding are equally crucial if any progress is to be made in addressing our aforementioned healthcare priorities.

FY 2010 Current Services Increases		
Pay Costs	$	47,730,000
Inflation	$	51,038,000
Additional Medical Inflation	$	36,349,000
Contract Support Costs	$	143,259,073
Population Growth	$	22,544,792
Health Care Facilities Construction	$	93,556,187
Staffing New/Replaced Facilities	$	15,118,568
Restore Urban Programs	$	35,000,000
Restore FY 2005 Rescission	$	3,500,000
Restore FY 2006 Rescission	$	1,250,000
TOTAL CURRENT SERVICES:	**$**	**449,345,620**

Pay Costs (both Federal & Tribal): The Tribal and Urban Indian leadership requests an amount of $22.9 million for "Federal Pay Cost" increases. This will enable IHS to fund the pay increases of mandated Federal employees for FY 2010. Tribal leadership also requests an additional $22.8 million to allow Tribally-operated and Urban health programs to provide comparable pay raises to their own staff. This is needed to enable the I/T/U programs to compete with the private sector for qualified employees. Maintaining the salary base for I/T/U healthcare providers and ancillary positions is vital to maintain the essential functions of the IHS.

Inflation: Funding for the IHS has not kept up with inflation. While mandatory programs such as Medicaid and Medicare have accrued annual increases of 5-10% to keep pace with inflation, the IHS has not received comparable increases. Our budget recommendation includes $51.0 million to address the increased cost of providing health services due to inflation. The inflation rate now used by OMB is insufficient to address the actual inflationary costs experienced by I/T/U programs. Funding to makeup for the true medical inflation rate is crucial to programs dependent upon Contract Health Services (CHS) funding. The CHS program is most vulnerable to inflation pressures and rising pharmaceutical costs and purchasing inpatient and outpatient hospital care. An additional $36.3 million is requested to address the actual inflation rates expected in FY 2010.

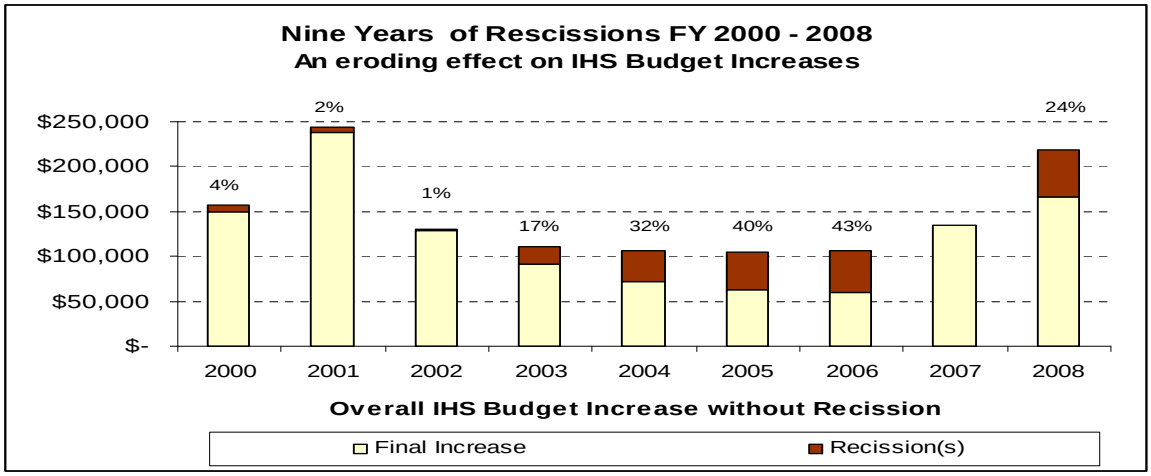
Contract Support Costs: "Contract Support Costs" are vital to support tribal efforts to develop the administrative infrastructure needed to successfully operate IHS programs. The present shortfall creates a disincentive for Tribes to compact or contract, and diminishes available healthcare funding, as budgets must absorb the shortfall. Adequate funding will assure that Tribes, under the authority of their contracts and compacts with the IHS, have the ability to deliver the highest quality healthcare services to their members. Tribal programs have increased the quality and level of services in their health systems fairly significantly over direct service programs. Failing to adequately fund "Contract Support Costs" defeats the very program that most appears to improve health conditions for AI/ANs. We strongly urge consideration of this line item, and recommend $143.3 million to alleviate the shortfall for current contracting and compacting.

Population Growth: According to information provided by the National Center for Health Statistics, birth-death records indicate that the AI/AN population is increasing at 1.6% per year. This increase translates to approximately 30,000 new patients entering the Indian Healthcare system annually. The 2010 budget recommendation includes $22.5 million to meet new demands produced by population growth.

Health Care Facilities Construction: The current average age of an IHS facility is 32 years. The continuing "pause" on facility construction has delayed attempts to address the aging healthcare facilities within the IHS system. The 2010 budget recommendation restores funding to $93.6 million, allowing IHS to replace its priority healthcare facilities with modern facilities, and to significantly expand capacity at its most overcrowded sites.

Staffing for New Facilities: The FY 2010 budget recommendation includes $15.1 million for the staffing and operating costs of new facilities that will open in FY 2010. Investments made in the construction of healthcare facilities must be accompanied by the necessary resources to operate them.

Exemption from Rescissions: Tribal and Urban Indian leaders vigorously request an exemption for the IHS budget to any rescissions that are passed down by Health and Human Services.



Given the unique mission of the IHS as a direct health care provider, and consistent with other government health service agencies like the Department of Defense and Veterans Health Administration, the IHS should be exempt from rescissions. Rescissions equate to a reduction in healthcare delivery and mean elimination of health programs, turning away patients in need. IHS health programs are subject to the same rates of medical inflation that VA and DOD programs are and deserve the same consideration. IHS programs also provide services to veterans that may not be able to travel great distances from reservations to VA hospitals to receive care. If the Administration and Congress are resolved to address Indian health disparities, they must restore past year's rescissions and exempt them from future cuts.

FY 2010 PROGRAM SERVICES INCREASES

Health Accounts		
Hospitals & Clinics	$	107,391,447
Indian Health Care Improvement Fund (subset of H&C)	$	61,205,765
Information Technology (subset of H&C)	$	4,927,850
Dental	$	17,266,383
Mental Health	$	23,592,385
Alcohol and Substance Abuse	$	32,561,359
Contract Health Services	$	109,833,578
Public Health Nursing	$	7,895,049
Health Education	$	4,392,135
Community Health Representatives	$	8,102,018
Alaska Immunization	$	54,927
Urban Indian Health	$	3,121,335
Indian Health Professions	$	1,555,099
Tribal Management	$	4,976,344
Direct Operations	$	622,357
Self-Governance	$	142,068
Facilities		
Maintenance & Improvement	$	8,103,413
Sanitation Facilities Construction	$	26,195,488
Facilities & Environmental Health Support	$	4,169,464
Equipment	$	1,690,656
HFC Priority System Area Distribution*	$	20,000,000
Other Priority Recommendations		
Ambulatory/Outpatient	$	5,671,807
Pharmacy	$	1,250,000
Diabetes	$	3,151,004
Injury Prevention	$	833,333
TOTAL PROGAM INCREASES	**$**	**458,705,264**

* The ADF funding methodology is currently under review by the IHS and HHS.

Hospital & Clinics: The FY 2010 budget recommendation includes a request for $107.4 million 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: An additional $61.2 million is recommended for the Indian Health Care Improvement Fund (IHCIF) within the Hospitals & Clinics budget. The IHS is funded at approximately 60% of need. IHCIF funds are appropriated by Congress to reduce disparities and resource deficiencies between units within the IHS system. The funding formula targets funding deficiencies measured by the Federal Disparity Index. The FDI model was developed through national tribal consultation, by a Tribal/IHS workgroup, health economists, and actuaries.

The disproportionately high rates of AI/AN morbidity, mortality, and disability are greatly exacerbated by disparate healthcare resources. Though there are significant needs for all IHS units, the most under funded units require immediate attention. The additional $61.2 million requested in FY 2010 will begin to reduce disparities for the most deficient units, and will provide greater equity in funding, but does not eliminate the $15 billion system-wide deficiency identified by the FDI methodology.

Information Technology: An additional $4.9 million is recommended for "Information Technology" within the H&C budget. It is critical that we develop the infrastructure and support systems needed to implement electronic health records and telemedicine capabilities in the I/T/U system. Many tribal communities are located at great geographic distance from specialists or inpatient facilities. Tribal leaders consistently voice the need for improved inter-connectivity. Advanced information technology services cannot be supported using existing outdated hardware. It is a priority for the Indian health system to develop uniform data collection to enhance surveillance, reporting, accountability, and to vigilantly bill third party resources when appropriate. Moving to a nationwide Electronic Health Record system will produce vast improvements in care and administration. While tribal leaders are cognizant that many budgets are being consolidated, this is one area that must receive increased funding to keep projects moving forward.

Dental Health: The FY 2010 budget recommendation includes an increase of $17.3 million for the "Dental Health" budget. Dental conditions are deplorable in Indian Country, and are the cause of significant health problems. AI/ANs have among the highest rates of tooth decay and gum disease in the US. Dental services are extremely limited. For example, root canals and dentures services are not available, and when funding is low, services are rationed. Nationally in 2007, GPRA indicators indicated that current access to dental care for the IHS user population was only 25%, substantially below our Healthy People 2010 goal of 40%.13 To address this, we recommend that the IHS assist Tribes in developing their own expanded duty dental auxiliaries.

Mental Health: Depression and other mental health diseases continue to destroy the sanctity of countless AI/AN families. Behavioral health services are inadequate to meet the present and growing needs of mental health disorders. Psychological services are necessary to improve

outreach, education, crises intervention, the treatment of mental illness such as depression. Stronger action and intervention is necessary. To address this, additional funding in the amount of $23.6 million is requested to enable IHS and AI/AN Tribal governments to provide culturally appropriate mental health services in a more timely and efficient manner consistent with current health problems.

Alcohol and Substance Abuse Program: Last year's budget increase provided for increased services and community interventions, yet alcoholism and substance abuse continue to be a major issue, associated with injuries, domestic violence, and other health and social problems. Methamphetamine and inhalant abuse have reached epidemic proportions on reservations. The tribal budget recommendation for FY 2010 includes an increase of $32.6 million to address these serious health problems.

Contract Health Services: We recommend a modest increase of $109.9 million for Contract Health Services (CHS). The documented need for the CHS program in Indian Country easily 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.

It is estimated that the unmet need for CHS resources is at least $301 million based on FY 2005 data, a figure that could be significantly higher if all CHS data were available. Many tribally-operated health programs no longer report deferred or denied services because of the expense associated with tracking and reporting un-provided services. More disturbing is that many IHS users do not even visit health facilities, because they know they will be denied services due to funding shortfalls. The $109.9 million estimate is quite conservative, and when added to the current IHS budget line item, the CHS budget should be at least $800 million.

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 and/or specialty care, (3) the direct-care element has an overflow of medical care workload, and (4) to supplement alternate resources. In order to budget the CHS resources so that as many services as possible can be provided, the agency must apply stringent eligibility rules and use a medical priority system. Non-emergency services must be pre-authorized and emergency services are only authorized if notification is provided within 72 hours of the patient's admission for emergency treatment. CHS regulations prioritize medical need when funds are insufficient to provide the volume of care needed. Because of insufficient funding in the CHS program, most IHS and Tribal health programs are often placed on "Priority One" status. The following is a description of "Priority One" care:

> *Priority One - Emergent/Acutely Urgent Care Services*: Diagnostic or therapeutic services that are necessary to prevent the immediate death or serious impairment of the health of the individual, and which, because of the threat to the life or health of the individual, necessitate the use of the most accessible health care available. "Priority One" represents those diagnoses and treatments of injuries or medical conditions that, if left untreated, would result in uncertain but potentially grave outcomes.

In Areas where there are no hospitals, many Tribes begin the year in "Priority One" status because they obligate new fiscal year funds to clear the previous year's denied and deferred services.

Preventive Health – Public Health Nursing, Health Education, CHRs, and Alaska Immunization: The tribal recommendation for FY 2010 includes an increase of $20.4 million for the "Preventive Health Budget" line item. Public health nurses, health educators, and community health representatives are vital to addressing health disparities in Indian communities. As part of a comprehensive public health program, these activities are integrated into the I/T/U health system to support the health care provided within the hospitals and clinics and are a key component of health promotion and disease prevention.

Urban Program: This FY 2010 budget recommendation restores and increases the Urban Indian Health Program (UIHP) to a level of $38.1 million. The President's FY2009 budget argued that AI/AN living in urban centers could seek care from HRSA operated Community Health Centers (CHC) and any other local, state, and federal health resources; however, this position ignores the substantial barriers to care faced by AI/AN. The National Association of Community Health Centers has consistently stated that, since 2006 when the President first proposed the elimination of the UIHP, the CHCs have neither the funds nor the expertise to absorb the 150,000 patients annually served by UIHP clinics.

UIHP clinics are the only health care providers in urban centers providing culturally appropriate services. Without this program AI/AN living in urban centers would most likely return to their home reservations to seek care—oftentimes delaying necessary care for months (if not years) until they return home, which would raise the cost of care. No study or consultation has ever taken place addressing the impact that the elimination of the UIHP would have upon Tribes. The UIHP represents approximately 1% of the Indian Health Services; but it is a necessary and congressionally-mandated part of Native health system. Continuing attempts to eliminate the UIHP sends a troubling message: that the Administration seeks to substantially rescind its trust responsibility. This FY2010 budget recommendation reaffirms the trust relationship between the Federal government and Native American peoples.

Indian Health Professions: An additional $1.6 million is requested for the Indian health professions programs. Health professions recruitment, such as scholarship and loan repayment programs, are important incentives and attractive recruitment tools for IHS and tribal programs. The IHS and tribal programs experience high vacancy rates hampered by competition among States, Tribes, other Federal health care systems, and the private sector. A lack of adequate funding limits the ability of Tribes to fill needed health professions positions.

Tribal Management and Self Governance: Our recommendation for tribal management funding is to increase the budget by $5 million in FY 2010. These funds are important for enhancing tribal management capacity through training, technical assistance and strategic planning. An additional $142,068 is requested for self-governance planning grants to encourage additional tribal compacting.

Maintenance and Improvement: Tribes are concerned about the adequacy of funding for the maintenance and improvement (M&I) of Federal- and Tribe-owned space used for the provision of healthcare services. M&I funds are also substantially lower than what are needed. Base M&I funding to sustain the facilities in their current condition is estimated at $80 million annually. In addition, the backlog of maintenance is currently estimated by IHS to be $371 million. A relative modest $8.1 million dollar increase is recommended for this line item. M&I funds are used to accommodate requests for IHS and tribal services and facilities, to support and enhance the delivery of healthcare and preventative health services, and to safeguard interests in real property. Tribes recommend that increased funding be allocated to M&I to prevent undue deterioration of federal and tribal facilities.

Sanitation Facilities Construction: The tribal recommendation for FY 2010 includes an increase of $26.2 million for "Sanitation Facilities Construction". Availability of adequate plumbing systems in homes has a direct correlation with prevention of diseases. Currently, 12% of AI/ANs and Alaska Native homes do not have an adequate water supply.

Facilities and Environmental Health Support: The level of funding for this line has stayed relatively flat or received small increases (less than 2%). With the rising cost of salaries and double digit annual increases in energy costs, this funding line is not keeping pace. An increase of $4.2 million is recommended for "Environmental Health Support" (EHS) and "Facilities Support" (FS). EHS staff provides engineering services for the sanitation facilities program and for community environmental health services. FS supports utility costs and maintenance personnel to operate hospitals and clinics.

Equipment: The FY 2010 tribal budget recommendation includes an increase of $1.7 million for medical equipment replacement. Additional funding is needed to keep pace with technology change and the ever-increasing cost of medical equipment. The standard replacement cycle for medical equipment is 6 years. IHS Equipment is funded on 18 year replacement cycle. Full funding would prevent using operational funds which takes away from direct patient care

Area Distribution Fund (ADF) for Facilities Construction: This request funds a new recommendation made by the Facilities Appropriation Advisory Board to implement an ADF that provides $20 million for high priority facility construction in the IHS Areas. It is noted that the FAAB funding methodology for the ADF is currently under review by the IHS and HHS.

Other Priority Recommendations: An additional $10.9 million is recommended to address the growing need for ambulatory/outpatient care, the increased costs of providing pharmaceuticals, and additional funding for diabetes management and injury prevention activities.

Closing

Tribal performance on Government Performance and Results Act (GPRA) measures demonstrates the commitment of Tribal programs to improving the health status of the AI/AN population served, as well as a commitment to accountability. The IHS, Tribes, and related programs have embraced performance measurement and strive towards continued improvement. Likewise, the IHS has shown that it can properly manage its scant resources. IHS has scored better in PART scores than CMS, HRSA and the VA. This commitment to quality and compliance with PART has not resulted in adequate increases for the IHS budget.

Tribal leaders continue to see a direct correlation between the extremely marginal increases or flat line funding for the IHS budget over the past over the past five years, and their ability to increase access or even meet static targets associated with GPRA indicators. Without an aggressive increase in funding, Tribal communities will continue to suffer from health disparities, Tribal programs will not be able to expand access, and programs will continue to face difficulty meeting performance targets.

Our First Nations are now last in many health indicators. It is imperative that the IHS budget be increased to address these disparities. A minimum allocation of $449.3 million is needed to cover costs associated with maintaining current services (pay increases, medical inflation, population growth, and contract support costs). In addition, $458.7 million is needed for programs to address past year's chronic under funding.

By restoring the trust to the budget formulation process, this Administration can leave a legacy. One by which all other Administrations can be measured. This is an opportunity to make meaningful change. Let this budget serve as your lasting legacy to eliminating health disparities and honor the Federal trust relationship!

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