California State Assembly Republican Caucus

Tribal Health Meeting

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“Investing in Health”

by

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Good morning. I appreciate the opportunity to speak to you today about the health status of American Indian people and how, through strengthening and expanding the tribal, state, and federal partnership, we can make a difference in the health of the citizens of California.

By understanding the health challenges that face our communities, I believe new strategies and partnerships will emerge that will strengthen best practices for providing health services to the people of California, no matter where they live. Such cooperative efforts can help enhance effective programs reaching Indian communities and coordinate approaches to address all the factors that play a role in health status. Your attendance at this meeting today shows that you are willing to take up the challenge of doing more than just talk about the problem, but are willing to work towards integrating our approaches toward the same goal – raising the health status of American Indians to the same level enjoyed by all Americans.

The Administration, the Department of Health and Human Services, and the Congress all consider the health of Indian people a priority. Their concern is reflected in the funding of programs directed toward Indian people. In addition to the $3.5 billion Indian Health Service budget, HHS programs also expend an additional $663 million on programs directly targeted for the benefit of Indian people. In addition, many grants are awarded to Indian Tribes and organizations from other programs administrated by the Department. As Dr. Carmona mentioned, the awarding of the Substance Abuse and Mental Health Administration grants is one such example.

In addition, I had the pleasure yesterday, along with Dr. Valdez, of representing Secretary Tommy G. Thompson and presenting a grant award of $650,000 to the San Diego Family Care center. This award was part of an $11 million grant program for 19 communities to extend health care services to low-income and uninsured Americans; a category that, unfortunately, includes a large number of American Indian people. These awards are part of President Bush’s 5-year community health centers initiative to expand health centers in underserved rural and urban communities. There are approximately 40 million Americans without health insurance, and American Indians and Alaska Natives are the population group least likely to have health insurance. Since 2002 this initiative, managed by the Health Resources and Services Administration, has brought health care services to some 2 million additional Americans, and these 19 new grants will extend services to an estimated 150,000 more people. For the people of California, in addition to the San Diego Family Care center – a $450,000

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grant went to the Brookside Community Health Center in San Pablo; a $376,000 grant to Community Health Systems in Bloomington; and a $325,000 grant to North East Medical Services in San Francisco. The California total of $1.8 million will provide additional access points for providing care to approximately 41,000 people more than can currently be served. It is expected these California citizens will receive more than 138,000 services each year.

There is also the program administered jointly by the National Institutes of Health and the IHS that has established Native American Research Centers for Health. This $5 million program has established 11 research centers focused on medical research relevant to Indian communities. One award established a research center for the California Indian Health Council that is assessing Type 2 diabetes risk factors in American Indian youth.

Another way the President and Secretary are investing in the health of Indian people is through their support of the Indian Self-Determination and Education Assistance Act. Amendments to this Act have increased the choices Tribes have for the delivery of their health services – through contracts with the IHS, through the transfer of tribal shares of IHS of funds directly to the tribes, and through the IHS as their primary provider. The Secretary has consistently stated that the responsibility for the health status of American Indians and Alaska Natives is the responsibility of the Department and not just the IHS. The expansion of local control over Federal programs also opens up opportunities for state governments to also help meet the health needs of their Indian and non-Indian populations.

And the Secretary's emphasis on tribal consultation and tribal involvement in the decisions that affect their health reflects findings from a study of indigenous people that political oppression and lack of self-governance, if allowed to continue, can have a devastating impact on health indicators. The United States broke that mold with the passage of the Indian Self-Determination and Education Assistance Act in 1975. Over the years, I have repeatedly witnessed that putting the power to make important decisions in the hands of those most directly affected by those decisions results in better and more efficient use of scarce resources. Just as the federal government is transferring programs and resources to local control, I believe that the Indian Self-Determination and Education Assistance Act can serve as a model for state governments to transfer programs and resources to tribal control.

The Secretary has also has reenergized the Intradepartmental Council on Native American Affairs, and has supported the inclusion of other Department programs as subject to assumption by the Tribes of those portions that directly provide services to the Tribe. Currently almost 52% of the IHS budget is transferred to Tribes in contracts and compacts; almost $15 million of the compact funds are transferred through funding agreements to the Tribes of California and an additional $95 million is contracted with the Tribes. And the 8 urban Indian health programs in California receive over $7 million of IHS funds to augment their operating costs. This $117 million federal investment in the health programs of Indian people in the state of California contributes to meeting their health needs and also contributes to the economy of California. Studies indicate that each dollar spent cycles through the local economy 5 to 7 more times. Additional income and jobs are generated when employee salaries are spent on retail goods, housing, food, and professional services. In turn, these local businesses re-circulate the money for salaries, goods, and services. In economic terms, the investment into the health and welfare of Indian people through programs of the IHS multiples to between $200 million and $500 million in financial activity in the California economy and improves the quality of life for everyone.

The commitment of the President and the Secretary, and the IHS, does not stop with these few examples, but my time constraints will have to let those few highlights serve to make the point that investing in the health of American Indian and Alaska Native people is a good investment that brings results.

Increasing the health status of Indian people is also a concern of the Congress, on both sides of the aisle. Pending before committees of Congress are bills to extend the Indian Health Care Improvement Act through fiscal year 2015. A number of California congressional members co-sponsored the House version of the reauthorization bill. As your representatives in Congress, their sponsorship and support of the reauthorization bill is appreciated.

The bill also contains various proposals to continue and to increase the authority of the Indian Health Service, Tribal governments, and urban Indian organizations to provide services to American Indian and Alaska Native people. One provision will help California improve the access to health care for California Indians by reauthorizing the provision that designates the entire state as a Contract Health Service Delivery Area, thereby continuing your access to contract health funds. Title 8 of the bill acknowledges the historical barriers and other difficulties experienced by California Indian Tribes and their members by broadening the definition for eligibility for IHS-funded health care by California Indians. The bill also contains statutory authority for health care facility

construction designed to ensure the inclusion of small Tribes, many of which are located in California, through the Small Ambulatory Grant program.

Title 7 of the proposed Act recognizes the unique needs of a state the size of California by reauthorizing the continued construction of 2 youth regional treatment centers for California that will address alcohol and substance abuse rehabilitation and other behavioral health needs, like inpatient mental health services. One of the treatment centers is to be built in Northern California and the other in Central/Southern California. The project justification documents for both facilities have been submitted and are under review. The exact site selection will be made through several tribal consultation meetings. Each treatment center will have 32 beds and we expect that at least 96 youths annually will receive services. The investment is an economic one; it would cost $7-8 million a year to purchase the same inpatient services from the private sector, whereas it will only cost approximately $3 million a year to provide those services in the treatment centers. The $4 to $5 million in savings can then be redirected to help provide other health services for American Indians and Alaska Natives, which, in most cases, would be purchased from the private sector.

There will be two hearings on the bills in July. The two primary committees of jurisdiction, the Senate Committee on Indian Affairs and the House Committee on Resources, are working to have the bill enacted this year. In the event the bill is not passed this year, a lot of the groundwork can be completed so that the bill can receive attention the early part of next year.

It is critical that the Indian Health Service and the 107 federally recognized Tribes of California establish effective partnerships to maximize our efforts and resources for improving health status. And Indian Tribes are excellent partners. For example, in the area of diabetes treatment and prevention services, the California Tribes have certainly demonstrated their resourcefulness.

According to the 2000 Census, the State of California is home to the largest population of American Indians and Alaska Natives in the country. The diabetes prevalence rate for this population is 15%. The IHS California Area Office annually receives $5.3 million in Special Diabetes Program for Indians funding. The funds are distributed through grants to 29 tribal and 8 urban diabetes programs, with 1 grant going to the IHS Area Office for data improvement. Since the start of the special diabetes grants, a total of $19 million has been awarded to California Tribes – money well spent. One tribal health program increased the acceptable blood glucose levels of their diabetic patients by 21% since the start of the program in 1997. Another tribal community program increased the physical and active play of children, established a culturally relevant nutrition program associated with the Tribe's Head Start programs, and encouraged and involved families in implementing healthy lifestyle behaviors and choices. Another program increased the number of diabetics receiving an annual dental exam by 48%, raising it to 85% in 2002 and surpassing the Health People 2010 target of 75%. All of this is another example of an investment in Indian health that paid off in terms of achieving goals and improving health for today and for the future.

These programs also show what we know and believe, that community-based and local control of culturally sensitive and family focused prevention programs, carried out by culturally competent staff, offer the greatest hope for prevention and also for recovery.

However, we need to understand that improving the health status of American Indian and Alaska Natives is more than an access to care issue. Every member of state and federal government and legislature can take an action to improve the health status of all Americans, including Indians. What affects a person's health is not just health promotion, disease prevention, and treatment programs. Health status is the result of an interwoven tapestry of factors such as socioeconomic status, educational status, community and spiritual wellness, cultural and family support systems, and employment opportunities, to name a few. The connection between poverty and poor health cannot be broken just by access to health services or treatment alone. Health status can be an indicator of a successful and thriving community, or a community in crisis.

There is something each of us can do to improve and ensure the health and well-being of the members of the 107 federally recognized Tribes in California for today, for tomorrow, and for all the generations to come. I echo the Surgeon General's perspective that there are many opportunities for all of us to work together toward common goals and shared responsibilities.

Let us know how we can help you to help us. Thank you for attending this important meeting.

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