Joint Hearing before the Senate Committee on Indian Affairs and the House Resources Committee, Office of Native American and Insular Affairs

on

S. 556, a bill to reauthorize the Indian Health Care Improvement Act and H.R. 2440, Indian Health Care Improvement Act Amendments of 2003

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Oral Statement

of

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Mr. Chairman and Members of the Committee: Good morning, I am Dr. Charles Grim, Interim Director of the Indian Health Service (IHS). Today, I am accompanied by Gary Hartz, Acting Director of the Office of Public Health; Richard Olson, Acting Director, Division of Clinical and Preventive Services, Office of Public Health; and Rae Snyder, Acting Director of the Urban Indian Health Program. We are pleased to have this opportunity to testify on behalf of Secretary Thompson the Senate and House bills for the "Indian Health Care Improvement Act Reauthorization of 2003."

For the record, I am submitting a written statement that contains specific information about the agency, including the legislative and legal history that established the government-to-government relationship between Tribal Nations and the United States, and some of the national health challenges to improving the health of American Indians and Alaska Natives. My written statement also contains comments on aspects of the proposed legislation that I will not cover in my oral statement so that we can conserve time.

As I testified last April, there is no single piece of legislation that will affect the future health status of American Indians and Alaska Natives more than the "Indian Health Care Improvement Act Reauthorization of 2003." For the past 28 years, the Indian Health Care Improvement Act has been the basis for extending the life span of Indian people by 7 years (still 6 years below that of the rest of the nation), addressing the basic health needs of a population that was not benefiting from the technological and medical advances of an industrialized nation, and assisting in identifying current and future health challenges.

To continue to make progress in raising the health status of Indian people to at least the level of the rest of the nation requires us to modify the Indian Health Care Improvement Act of 1976 to reflect the health status of the Indian population of 2003 and, as best we can, to have it reflect the health status of Indian people as we project it to be into the future until the next reauthorization.

The legislation under consideration today reflects the proposed language developed over a 2-year period by Indian tribes across the nation and adopted by both the Committees of Congress. Our nation faces many priorities today, many of which overshadow but do not diminish the importance of other priorities such as meeting the treaty commitments of the Federal government.

As requested by the Committee, I am focusing my brief remarks on highlighted areas of health disparity, health care facilities, and urban Indian health.

My written statement includes some health statistics, but I would like to present three simple statements to remember regarding American Indian and Alaska Native health disparity. Indian people continue to experience disease and illness at greater rates than the rest of the nation. Indian people continue to prematurely die at rates greater than the rest of the nation. Indian people continue to experience reduced access to health services and care compared to the rest of the nation.

It is well publicized and referenced that Indian people continue to experience health disparities and death rates that are significantly higher than the rest of the U.S. general population. Many American Indians and Alaska Natives who receive a diagnosis of diabetes, high blood pressure and cholesterol levels, cardiovascular disease, alcoholism, obesity, etc., consider it a fatal diagnosis. The proposed language of the Indian Health Care Improvement Act can help the Indian health system of the Indian Health Service, Tribal health programs, and urban Indian health programs develop and implement health promotion and disease prevention strategies so that healthy behavior choices and lifestyles will begin to significantly reduce the health disparity rates. It also yields the even more important humanitarian benefit of reducing pain and suffering, and prolonging life. We were successful in working with Indian nations in conquering infectious diseases, and I believe we can do it again for chronic diseases with the help of Tribal governments, urban Indian health programs, and the Congress.

The IHS health care facilities program, including the tribal facilities programs, is responsible for managing and maintaining the largest inventory of real property in the Department of Health and Human Services, with over 9 million square feet (850 gross square meters) of space. In the proposed bill, section 302(b)(3)(C) specifically proposes that IHS sanitation facilities construction funds not be used to support the service of sanitation facilities in Department of Housing and Urban Development (HUD) homes. The bill is not clear that homes constructed through HUD should also include the necessary infrastructure to make a home complete, including safe water and sewer and wastewater disposal systems for the home. The IHS and HUD have cooperated over many decades on the construction of homes in reservation communities – with IHS providing the expertise and development of supporting sanitation and sewerage systems that the HUD home would then hook into. Without clarity in the language there may come a time when interpretation may result in IHS funds being expended on sanitation systems of HUD homes, which would, in turn, redirect IHS funds from providing services to existing homes without water, sewer, and solid waste facilities. Newly constructed HUD homes should be funded to cover everything, including the home itself and "to the street" hookup. We request that you consider clarifying this point in the proposed Bill.

Title V of the Indian Health Care Improvement Act provides specific authority focused on the provision of health services for urban Indian people with funds appropriated to IHS. The IHS currently contributes funds toward the operating expenses of 34 independent urban Indian programs nationally, as well as the Oklahoma City Clinic and the Indian Health Care Resource Center of Tulsa. These programs provide a range of services. In 1978, the entire State of Oklahoma was designated as a Contract Health Service Delivery Area, which means that Indian beneficiaries could reside anywhere in the state and maintain their eligibility for both direct services and contract health services. The 1992 Congress amended the Indian Health Care Improvement Act to establish two demonstration projects with the Tulsa and Oklahoma City clinics, "to be treated as service units in the allocation of resources and coordination of care." This new and innovative approach to ensuring health services are accessible to all eligible populations in Oklahoma has resulted in a hybrid system: each program maintains its status under Title V as an "urban Indian organization," yet the programs function like other IHS service units and report data to the Resources and Patient Management System of the IHS that is used for consideration in the allocation of resources. Both

service population and overall utilization of services has dramatically increased since these programs became demonstration projects and since 1994 specific Congressional line item funding increases. They have been able to use the best of both urban and IHS structures to build a community controlled, high-quality health system in a state designated as a contract health service delivery area. On the other hand, this hybrid system has raised a few concerns with some Oklahoma Tribes that operate their own health programs under the Indian Self Determination and Education Assistance Act, Public Law 93-638, as amended. The issue in most basic terms is that the two urban programs have some aspects of a service unit, but their funding is not subject to transfer to the Tribes under 638 contracts or compacts as our non-hybrid service units are. In an environment of resources reduced by an increasing population and greater health need, it is expected that the issue of tribal shares of urban Indian program funds will receive more attention than they have in the past.

As the review of this far-reaching, complex legislation continues, we may have further comments. However, we wish to reiterate our strong commitment to reauthorization and improvement of the Indian health care programs. We will be happy to work with the Committees, the National Tribal Steering Committee, and other representatives of American Indian and Alaska Native communities to develop a bill fully acceptable to all stakeholders in these important programs.

Mr. Chairman, this concludes my statement. Thank you for this opportunity to discuss the reauthorization of the Indian Health Care Improvement Act. We will be happy to answer any questions that you may have.