FY 2009 BUDGET RECOMMENDATION:
HONORING THE PROMISE

PRESENTED BY:

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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 (the “I”), Tribally-operated (the “T”), and Urban Indian health programs (the “U”) herein referred to as the I/T/U. Representatives from each of the twelve IHS Areas serve on the I/T/U budget work team to discuss their health and budget priorities and to 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) and the Office of Management and Budget (OMB). The recommendations are presented in this report.

EXECUTIVE SUMMARY - “FUNDING TRUE NEED”

The provision of health services to American Indian and Alaska Native (AI/AN) people is a direct result of treaties and executive orders entered into 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 numerous court decisions, Presidential proclamations, and Congressional laws. Given the significant health disparities that Indian have, funding for AI/AN health programs should be given the highest priority within HHS. Many of the diseases that AI/ANs suffer from are completely preventable and/or treatable with adequate funding.

For some time now, the United States has not funded the true need of health services for AI/AN people. The medical inflationary rate over the past ten years has averaged 11 percent. The average increase for the IHS health services accounts over this same period has been only 4 percent. This means that I/T/U health programs are forced to absorb the mandatory costs of inflation, population growth, and pay cost increases by cutting health care services. There simply is no other way for the I/T/U to absorb these costs. The basis for calculating inflation used by government agencies is not consistent with that used by the private sector. OMB uses an increase ranging from 2–4 percent each year to compensate for inflation, when the medical inflationary rates range between 7-13 percent. This discrepancy has seriously diminished the purchasing power of Tribal health programs because medical salaries, pharmaceuticals, medical equipment, and facilities maintenance cost Tribes the same as they do the private sector.

In FY 1984, the IHS health services account received $777 million. In FY 1993, the budget totaled $1.5 billion. Still, thirteen years later, in FY 2006 the budget for health services is $2.7 billion, when, to keep pace with inflation and population growth, this figure should be more than $7.2 billion. This shortfall has compounded year after year, resulting in a chronically under-funded health system that cannot meet the needs of its people.

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2 Ibid
The graph above illustrates the discrepancy between actual IHS health services budget, the same budget adjusted for inflation, and the purchasing power of that budget if it included medical inflation and population growth over a 22 year period. The approved FY 2006 health services budget was $2.7 billion. The graph demonstrates that the IHS health services budget has suffered a cumulative loss of $4.6 billion from 1984 to 2006, assuming that the quality of care remains the same. This is a direct result of the compounding effect of funding levels that fail to meet yearly inflation and population growth increases. If IHS appropriations had kept pace with medical inflation and population growth, the increases required today would not be as significant!

To address this shortfall, the I/T/U work group has developed their FY 2009 budget recommendations totaling $781 million in addition to the restoration of the Urban program. This proposed budget recommendations will ensure IHS the ability to provide AI/AN with access to quality primary and secondary health and basic preventative services, and the infrastructure to supply those services. The recommendations will adequately support pay costs, inflation, population growth, staffing for new facilities and address the backlog of facilities construction.

**TOP FIVE HEALTH PRIORITIES**

**Diabetes** - Diabetes was identified as the number one common health problem as it is a major cause of death among AI/ANs nationwide. AI/ANs the highest rates of diabetes and diabetic complications in the world. According to the American Diabetes Association, in the United
States, 12.5% of AI/ANs 20 years or older who received care through IHS in 2003, had diagnosed diabetes, compared to 8.7% of non-Hispanic whites with diabetes. Nationally, diabetes was the cause of 5.7% of deaths in AI/AN in 2004 (National Center for Injury Prevention and Control, Leading Causes of Deaths Reports, 1999-2004). Among all age groups, the highest increase in diabetes prevalence has occurred among the AI/AN adolescent aged 15–19 years, with a 106% increase from 1990 to 2001. (Interim Report to Congress, Special Diabetes Program for Indians, IHS National Diabetes Program, December 2004). Diabetes is associated with many other detrimental health effects that result in increased costs for treating patients. Complications of this disease, including blindness and vascular insufficiency leading to amputation and End Stage Renal Disease (ESRD), occur in higher rates in AI/AN than in the general U.S. population. Several studies have confirmed the value of glycemic and blood pressure control in delaying or preventing these complications.

Effective Solutions

- Primary prevention efforts are critical, and resources and expertise must be committed for the long-term as preventive educational services, physical fitness and screening activities will make a difference. Reducing the epidemic of this disease in the AI/AN population can be achieved by increasing rates of education regarding nutrition and other diabetes topics through the distribution of educational materials at Tribal forums and assisting Service Units and Tribal programs to achieve Integrated Diabetes Education Recognition Program status.

- Continually improving the capacity in the Indian health care delivery system to expand secondary prevention services is required to address this critical health issue. Effective programs cited by tribes include: educating individuals on self-care; implementing patient case management services; and incorporating traditional healing approaches as they provide effective methods for sustained wellness.

- Implementing the IHS Diabetes Standards of Care and the Clinical Practice Guidelines for Staged Diabetes Management nationwide must be a national effort.

Cancer – How AI/ANs diagnosed with cancer access healthcare services through I/T/U programs and contract health providers in the private sector can be very complex. Policy issues related to the patient referral processes, contract care eligibility and access to various pharmaceutical interventions create challenges in the coordination of cancer care for AI/ANs. According to the Surveillance, Epidemiology, and End Results (SEER) Cancer Statistics Review, 1975-2003, the age-adjusted mortality rate for cancer in AI/AN for 2000-2003 was 127 per 100,000 population. The mortality rates for the following cancers were higher among AI/AN than they were for other racial groups: stomach, liver and intrahepatic bile duct, cervix (female), and kidney and renal pelvis. The age-adjusted incidence rate for all cancers in AI/AN from 1999-2002, was 325.8 per 100,000 population and the top seven cancer sites were colon and rectum, lung and bronchus, breast, prostate and stomach. When comparing five-year survival rates between 1975-1987, and 1988-1997, survival rates for all racial groups have improved; however, the survival rates for AI/AN remain lower than those for other races/ethnic groups and the five-year survival rate for all cancers was 20% lower in AI/AN when compared to non-Hispanic whites (46.5 compared to 58.0) (SEER Cancer Statistics Review, 1975-2003) due primarily to problems with late diagnosis and access to care.
Effective Solutions

- Additional resources are needed to improve early detection and treatment of cancer throughout the I/T/U health care system. The Indian Health Service, tribes, and urban Indian health programs have considerable experience in instituting patient education programs. It is recommended that an initiative focusing on educating patients on the importance of regular screening examinations be instituted throughout IHS for the early detection of breast, colon, rectum, cervix, prostate, testis, oral cavity, and skin cancers. Further, an evaluation should be an integral part of this education/early detection program to identify which programs are most effective and how and if screening rates increase and cancers diagnosed in later stages of development are reduced.

- Coupled with the efforts of tribes and urban Indian health programs an effective cost saving measure to address cancer caused by the use of commercial tobacco is to make available smoking cessation programs across Indian Country and by providing pharmaceutical smoking cessation aids. Anti-smoking or chew tobacco programs should be implemented for adolescents prior to initiation of usage.

- It is imperative that needs of the Tribal communities be identified with the aim of improving prevention education and screening and cancer care services. The recommended approach is to make available for tribes, community-based grants to assist tribes in the following ways:
  - to identify gaps in services and design and improve various pathways of cancer care available to patients;
  - to identify and then eliminate barriers to accessing cancer care;
  - to identify issues in management of pain and improve pain management;
  - To identify rates of depression in cancer patients and develop effective programs to address depression, particularly as it has an effect on stress hormones, such as cortisol, and thus on potential survival;
  - to identify existing supportive services, to identify best practices for supportive services, to identify gaps in existing services and to develop patient support services;
  - to identify the effect of cancer diagnosis and treatment on functionality and once identified to develop programs for assistance in those activities of daily living; and
  - to develop culturally appropriate cancer-related education materials both for AI/ANs diagnosed with cancer and their families. These materials will cover the cancer continuum from prevention, to early detection, to treatment, clinical trials, palliative care, supportive care, and end of life care.

- The Arizona and New Mexico Cancer Registry reports valuable data regarding AI/ANs that reside or receive diagnosis and treatment within these two states. The development of this registry was the result of persistent efforts through IHS/State/Tribal collaboration. Tribes across the country that are not participating in a registry likewise are seeking to develop a Tribal Cancer Registry and/or participate in their respective state registry. Strategies that proved to be effective in Arizona and New Mexico should be documented.

Heart Disease – Cardiovascular disease is a critical health issue as it has become the leading cause of death among AI/ANs and Alaska Natives nationwide, especially effecting the age groups from 25 to 65 years of age and older. (National Center for Injury Prevention and Control, Leading Causes of Deaths Reports, 1999-2004). Data from the 2003, National Health Interview Survey show that 13.8% of AI/AN had heart disease, 8.2% had coronary heart disease, and
23.9% had hypertension. The rates among whites were slightly lower: 11.4% had heart disease, 5.9% had coronary heart disease, and 20.5% had hypertension.

The diabetes epidemic also contributes to the rise in cardiovascular disease rates. Efforts currently underway in the Indian health care system to improve early detection of the disease must be enhanced. In addition, access to specialty treatment services must be improved. The IHS/Tribal programs provide basic primary care and very few specialty services are available because of the limited CHS budget. Almost all advanced heart disease must be referred to specialists outside the IHS system, and this is accomplished at considerable expense. Most IHS beneficiaries live in rural areas and access to specialty treatment is difficult to obtain and adds to costs that include transportation.

Effective Solutions

☐ To curb the high rate of death due to heart disease critical budgetary and policy issues must be addressed. These include funding for and a commitment to establish wellness programs in every Tribal community and making available commercial tobacco cessation programs. Health promotion and disease prevention activities should be consistent throughout the I/T/U system.

☐ Lessening the burden on the contract health care line item by providing resources to recruit non-invasive cardiologists to work at IHS and Tribal facilities to meet the increasing demands related to heart disease is another important measure that needs to be achieved.

☐ Contract health care resources need to be increased so that AI/ANs that rely on the program access intensive and specialty treatment services that include cardiac rehabilitation and hypertension management. Additional resources are also vital so that Indian Health Service is able to keep up with drug advancements to fight heart disease, which has resulted in further-escalating pharmaceutical costs.

☐ IHS, Tribal and urban Indian providers must receive education on the IHS guidelines for cardiovascular care, in addition to implementing the national standards for high blood pressure and high blood cholesterol developed by the Joint National Committee on Prevention, Detection, Evaluation and Treatment of High Blood Pressure and the Adult Treatment Panel III.

☐ IHS partnerships with Tribal health programs and Tribal organizations to begin a serious conversation with Tribal leaders on this critical health issue needs to be as effective and intense as the major effort surrounding diabetes.

Alcohol/Substance Abuse- Alcohol and substance abuse continues to be a major issue and correlates to injuries, domestic violence and other behavioral health and social 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 of age and older (National Center for Injury Prevention and Control, Leading Causes of Deaths Reports, 1999-2004). Another report indicates that from 2002-2005, AI/ANs across all age groups were more likely than other racial groups in the United States to have a past year alcohol use disorder, defined as alcohol dependence or abuse (10.7 vs. 7.6 percent) and more likely to have a past year illicit drug use disorder, defined as illicit drug dependence or abuse (5.0 vs. 2.9 percent). (Results from the 2005 National Survey on Drug Use and Health (NSDUH): National Findings, Office of Applied Studies, SAMHSA).
Tribes report continued efforts to address prevention, treatment, and aftercare services within their communities. Frontline professionals are also faced with the need to address co-existing behavioral and mental health disorders. According to a report published by the Journal of the American Medical Association, 37% of alcohol abusers and 53% of drug abusers also have at least one serious mental illness. Of all people diagnosed as mentally ill, 29 percent abuse either alcohol or drugs. (Information available online on the Mental Health America website: http://www.mhha.org/).

Tribal officials also report an increase in methamphetamine use in many areas of the country. The serious influence of this drug on human behavior and the neurological and physical damages caused by this drug will demand highly aggressive prevention and intervention services. Succinct data on this urgent health issue is being investigated, but 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 (50%) and amphetamine-related conditions (49.3%) 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.

Effective Solutions

☐ Tribes remain vigilant and ask the same of the Indian Health Service and Federal partners to pursue coordination of effort to address alcohol and substance abuse. Disruption to families is far reaching and the healing process requires in many instances, significant coordination by counselors and behavioral health staff with Tribal social services, and the Tribal legal system.

☐ In support of the IHS Director’s Behavioral Health Initiative Tribal leaders place great emphasis on the further development and management of the Alcohol and Substance Abuse Program. Many people have been helped by able-minded and caring staff. Yet their ability to increase their caseloads to help a new generation of children decline without hesitation to abuse alcohol, take drugs or to seek services before their personal health is in jeopardy requires sustained support. Tribal nations advocate for additional resources to expand IHS funded prevention, detoxification and treatment programs.

☐ Tribes seek additional funding for the operational costs of existing Youth Regional Treatment Centers (YRTCs), as IHS funding has remained level. Further, it should be a high priority of HHS and IHS to assure that YRTCs are established in all IHS Areas, as required by law, to provide residential inpatient treatment services for our youth. Valuable services are offered at these facilities and they need the tools to provide the intensive level of services that is required to impact the lives of the young people and the families that are served.

☐ Funding made available to IHS, Tribal and urban Indians communities to address methamphetamine use would be effectively utilized across Indian country to address this critical health issue. Tribes understand the need for a comprehensive approach that involves amending Tribal laws and ordinances and expanding public health codes. Numerous Tribal
governments are seeking to develop comprehensive methamphetamine response plans that identify the activity of the departments/divisions that are responsible within the tribes. These would include first responders, corrections, Tribal drug court interventions and changes in policies and strategies involving Tribal housing, environmental programs, and schools.

**Mental Health** - Tribal leaders continue to place great emphasis on the implementation of the HIS Director’s three health initiatives: health promotion disease prevention, chronic disease management and behavioral health. They agreed that mental health is a major health priority and pointed out that emergency, outpatient and inpatient psychiatric services are limited due to lack of funding. Psychological services are necessary to improve outreach, education, crises intervention and treatment of mental illness such as depression, schizophrenia and contributing factors leading to suicide and violence. National suicide rates for AI/ANs/Alaska Natives have consistently been over twice the U.S. national average for all races and even higher for young Indian males. AI/ANs and Alaskan Natives have the highest rate of suicide in the 15 to 24 age group (CDC 2004). In 2002, suicide was the second leading cause of death among AI/ANs and Alaska Native women of that age group (Office of Minority Health). 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.

The average annual prevalence rate of persons coming into Phoenix Area IHS with depression-related conditions between 2000, and 2005, was 2,072 per 100,000 population (2.1%) and the average rate of anxiety-related conditions was 561 per 100,000 (RPMS Data for Phoenix Area IHS). According to the National Institute of Mental Health, in the United States, the prevalence of major depressive disorder among adults 18 years and older in any given year is approximately 6.7%. The average prevalence rate of persons coming into Phoenix Area IHS with schizophrenia between 2000 and 2005 was 228 per 100,000 population (0.2%) (RPMS Data for Phoenix Area IHS). According to the National Institute of Mental Health, in the United States, the prevalence of schizophrenia in any given year among adults 18 years and older is approximately 1.1%.

**Effective Solutions**
- Nationwide the tribes stressed the importance of essential staffing of Mental Health programs throughout the I/T/U health system. Inadequate mental health staffing I/T/U facilities result in unacceptable delays in obtaining Mental Health appointments.
- The goals to improve mental health services include increased community education on mental health issues to overcome the stigma attached to mental illness which often leads to lack of investment in screening, assessment and referral services.
- Effective linkage to substance abuse programs to address co-occurring disorders would be assisted by continuing education and training in the arena of co-occurring disorders extended to all professionals in the behavioral health field.
- A comprehensive initiative to effectively educate Tribal communities about suicide prevention is strongly recommended.
- Behavioral health protocols on a number of topics need to be in place where emergency and direct care is provided. Screening and referrals systems that fit the unique system of care at each tribe should be identified. How referrals link to off-reservation services should also be clearly defined.
MANAGEMENT INITIATIVES AND BUDGET GOALS

Management Initiatives:

Government Performance and Results Act (GPRA)

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 demonstrated commitment to accountability. The IHS, Tribes and related programs have embraced performance measurement and strive towards continued improvement. In FY 2006, the IHS did not meet targets for six measures; whereas Tribal programs did not meet targets for three measures: poor glycemic control, influenza, and retinopathy examination.

Tribal leaders continue to see a direct correlation between the extremely marginal increases or flat line funding for the IHS budget over the past 5 years and ability to increase access or even meet static targets associated with the GPRA indicators. Without an aggressive increase in funding, AI/ANs and Alaska Native communities will continue to suffer from health disparities; and Tribal programs will not be able to expand access, continue to realize difficulties in meeting performance targets, and in fact, will most likely face a decrease in health status.

The requested budget will address what Tribal leadership feels is necessary and a positive step in the direction of eliminating racial and ethnic health disparities and increasing access to health services for AI/ANs and Alaska Natives.
BUDGET PRIORITIES

Current services increases are essential for maintaining health program base funding. Program services increases are essential for expanding access to care. Both types of funding increases are necessary and equally important if any progress is to be made in addressing the health priorities described previously.

CURRENT SERVICES INCREASES

(Funding increases in thousands)

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<thead>
<tr>
<th>Description</th>
<th>Amount</th>
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<td>Pay Costs</td>
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<td>Inflation</td>
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<td>Additional Medical Inflation</td>
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<tr>
<td>Contract Support Costs</td>
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<tr>
<td>Population Growth</td>
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<tr>
<td>Health Care Facilities Construction</td>
<td>$100,000</td>
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<tr>
<td>Staffing New/Replaced Facilities</td>
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<td><strong>TOTAL CURRENT SERVICES:</strong></td>
<td><strong>$356,236</strong></td>
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Federal/Tribal Pay Costs

The Tribal and Urban Indian leadership requests an amount of $35.8 million for Federal Pay Cost increases. The additional dollars will enable IHS to fund mandated Federal employee pay increases for FY 2009. The Tribal leadership also requests an additional $38.7 million within the FY 2009 budget to allow Tribally-operated and Urban health programs to provide comparable pay raises to their own staffs.

These expenses enable the IHS, Tribal, and Urban Indian health programs to compete with the private sector for qualified employees. It is vital that IHS, Tribal, and Urban programs are able to maintain the salary base for their health care providers and ancillary positions in order that the essential functions of the IHS be maintained.

Inflation

Funding for the IHS has not kept pace with inflation. While mandatory programs such as Medicaid and Medicare have accrued annual increases of 5 to 10 percent in order to keep pace with inflation, the IHS has not received these comparable increases.

The recommended budget includes $66.4 million to address the increased cost of providing health services due to inflation. The recommendation is consistent with the economic indicators.
used for the FY 2007 President’s budget, for which medical inflation is projected at slightly more than 4%.

The inflation estimate that was calculated using these OMB medical inflation rates is insufficient to address the actual inflationary costs experienced by the I/T/U programs. The resources needed to address the true rate of medical inflation are important for programs dependent upon contract health services (CHS). The CHS program is most vulnerable to inflation pressures, as well as pharmaceutical costs. An additional amount of $18 million is requested to address the actual inflation rates expected for FY 2009.

**Contract Support Costs**

Contract Support Costs are vital to support Tribal efforts to develop the administrative infrastructure critical to their ability to successfully operate IHS programs. The present shortfall creates a disincentive for Tribes to compact or contract and diminishes health care program funding as these budgets must absorb the shortfall.

These resources provide assurance that Tribes under the authority of their contracts and compacts with the IHS deliver the highest quality health care services to their Tribal members. Tribal programs have clearly increased the quality and level of services in their health systems fairly significantly over direct service programs, and failing to adequately fund Contract Support Costs is defeating the very programs that appear to be helping improve health conditions for AI/ANs.

We strongly urge consideration of this line item and recommend a $71.7 million to alleviate the shortfall for current contracting and compacting. Full funding of the contract support costs shortfall is needed to support new P.L. 93-638 assumptions in addition to growing Tribal management needs for ongoing program operations.

**Population Growth**

According to information provided by the National Center for Health Statistics, birth-death records indicate that the AI/ANs and Alaska Native population is increasing at 1.6% per year. The 1.6% population increase translates to approximately 30,000 new patients into the Indian Health care system annually. The budget recommendations include $20.7 million to attempt to address the increased demand of a rapidly increasing population.

**Health Care Facilities Construction**

The current average age of an IHS facility is 32 years. The continuing “pause” on facility construction delays addressing the aging facilities within the IHS system. The budget recommendation under current services restores base funding to the $100 million level for construction of new health facilities allowing IHS to replace its priority health care facility needs with modern health facilities and to significantly expand capacity at its most overcrowded sites.

**Staffing for New Facilities**

The FY 2009 budget recommendation includes $5,037,000 for staffing and operating costs for new facilities that will open in FY 2009. The investment in the construction of health care facilities should be accompanied by the resources necessary to operate them.
Exemption from Rescissions
One of our priorities for the Tribal/Urban Indian leadership is to request an exemption from rescissions. Given the unique mission of the IHS as a direct service provider in comparison to other Health and Human Services agencies, a funding rescission to IHS translates into a reduction of health care delivery for AI/ANs. Other agencies merely reduce programs, while IHS must eliminate health programs and turn away patients. Medicare and Medicaid were not subject to such rescissions. Therefore, the IHS should be exempt from such rescissions in the same manner.

PROGRAM SERVICES INCREASES

(Funding increases in thousands)

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<thead>
<tr>
<th>Service</th>
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<tbody>
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<td>Hospitals &amp; Clinics</td>
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<td>Maintenance &amp; Improvement</td>
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<td>Facilities &amp; Environmental Health Support</td>
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<tr>
<td>Equipment</td>
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<td>Joint Venture, Small Ambulatory, YRTC</td>
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TOTAL PROGRAM SERVICES INCREASES $424,896
Hospital & Clinics
The FY 2009 budget recommendation includes a request for $110 million to support IHS and Tribal programs in the treatment and care of chronic diseases, including diabetes, cancer, heart disease, as well as sustained programs for health promotion and disease prevention.

Indian Health Care Improvement Fund: An additional $40 million is recommended for the Indian Health Care Improvement Fund within the H&C budget. The IHS is funded at approximately 60% of need. The IHCIF are funds appropriated by the Congress to reduce disparities and resource deficiencies among units with the IHS system. The funding formula targets funding deficiencies measured by the Federal Disparity Index (FDI) model. The FDI model was developed with national Tribal consultation by a Tribal/IHS workgroup working with health economists and actuaries.

The disproportionately high rates of AI/AN mortality, disease and disability are greatly exacerbated by disparate health care resources. Despite the significant funding needs for all IHS units, the most under funded units require immediate attention. The $40 million of additional funds requested in FY 2009 begins to reduce disparities for the most deficient units and promote greater equity of health care funding, but is still insufficient for the $1.8 billion system-wide deficiency identified by the FDI methodology.

Information Technology: An additional $5 million is recommended for Information Technology within the H&C budget. Developing the infrastructure and support services for the implementation of electronic health records and telemedicine capability in the I/T/U Health system at the local level is critical. Tribes request a $5 million dollar increase for this need. Many Tribal communities are located at long distances from specialists or inpatient facilities. They noted the need for inter-connectivity and that advanced information technology cannot be met on the existing outdated hardware. Developing uniform health data collection and reporting and remaining vigilant on billing procedures for third party resources were identified as priorities. The transition to the Electronic Health Record nationwide is seen as a major improvement. Tribal leaders are cognizant of budgets being consolidated, but emphasized the fact that this is one area that should receive increases to keep projects moving forward.

Dental Health
The FY 2009 budget recommendation includes an increase of $20 million for the Dental budget. Dental conditions are deplorable, and the cause of future health problems. AI/ANs and Alaska Natives have some of the highest rates of tooth decay and gum disease in the US. Dental services are currently extremely limited because of funding levels. For example, root canals and dentures services are not available, and when funding is low, services are rationed and limited to emergency procedures and services for children and diabetic patients. One recommended approach is for the IHS to assist tribes in developing their own expanded duty dental auxiliaries. This would include expansion of the Community Health Aide Program (CHAP), Dental Health Aide Therapy Program established in Alaska in 1992 to the lower 48 states. This will help address the critical shortage of dental staff on reservations and assist Tribes in establishing community-based oral disease prevention programs presently not being offered by IHS dental clinics.
Mental Health
Depression and other mental health diseases, continue to destroy the sanctity of countless AI/ANs and Alaska Native families. Mental health services are inadequate to meet present and growing needs of mental health disorders. Psychological services are necessary to improve outreach, education, crises intervention and treatment of mental illness such as depression, schizophrenia and contributing factors leading to suicide and violence. Further action and intervention is necessary. Therefore, additional funding in the amount of $25 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 emerging health problems.

Alcohol and Substance Abuse Program
The last budget increase received provided for increased services and community interventions, however alcoholism and substance abuse continues to be a major issue and correlates to injuries, domestic violence and other health and social problems. Methamphetamine and inhalant abuse are epidemic on reservations. The Tribal budget recommendations for FY 2009 include an increase of $30 million to address these serious health problems.

Contract Health Care
The documented need for the Contract Health Service Program in Indian Country 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. We recommend a modest increase of $110 million for this budget.

Contract health service 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. The IHS purchases the needed basic healthcare services from private local and community healthcare providers. The current level of funding is so limited that only life-threatening conditions are normally funded. In most other cases, failure to receive treatment from providers outside the IHS and Tribal health system forces people in Indian country to experience a quality of life that is far below the level normally enjoyed by non-Indian Americans.

AI/AN health systems provided some real life examples of essential health care services that are denied or deferred due to a lack of funding:
- Dermatology – treatment for sebaceous cysts, skin pigment changes, etc.
- Dental – Orthodontics, dentures, root canals (extractions are routinely performed instead)
- Eyeglasses
- Medications for unique patient conditions
- Wheelchairs and other rehabilitation equipment
- Post brain injury rehabilitation
- Residential treatment for substance abuse (beyond adolescent age)
FY 2009 Budget Recommendation: Honoring The Promise

- Adult psychiatric hospitalization beyond emergent event
- Speech therapy
- Obesity surgery (e.g., gastric banding)
- Post mastectomy reconstruction
- Allergy testing or desensitization
- Genetic counseling
- Septoplasty (surgery to correct a defect of the nasal septum)

Preventive Health – Public Health Nursing, Health Education, And Community Health Representatives

The Tribal recommendation for FY 2009 includes an increase of $9 million for the Preventive Health budget line items. 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

The FY 2009 budget recommendation includes a request for a $3.5 million increase for the Urban programs. The request includes the assumption that the Urban base funding is restored to the FY 2008 budget.

Included in the FY 2008 President’s Budget justification is discussion regarding the availability of other health care for Urban Indians and the indication that Urban programs are duplicative of other services. The other available health care does not offer the services that AI/ANs are typically used to or have a legal right to; a legal right that is not relinquished when an AI/AN moves to an urban location. Urban Indian health programs fulfill an important function in the Indian health care system.

Indian Health Professions

An additional $1 million is requested for Indian health professions programs. Loan repayment is one of the most attractive recruitment tools for IHS and Tribal programs. However, the current Loan Repayment Program is not a guaranteed program and the ability of the Indian Health Service to attract physicians is hampered by competition among States, Tribes, other Federal health care systems and of course the private sector.

Tribal Management

The Tribal recommendation for Tribal management grant funding is to increase this budget by $1 million in FY 2009. These funds are important for enhancing Tribal management capacity through feasibility studies and strategic planning.

Self-Governance

An additional $160,000 is requested for self-governance planning grants to encourage additional Tribal compacting.
Contract Support Costs
An increase in Contract Support Costs is necessary because as Tribal governments continue to assume control of new programs, services, functions, and activities under Self-Determination and Self-Governance, additional funding is needed. In FY 2009, $2.8 million is requested for this need.

Maintenance and Improvement
Tribes are concerned over the adequacy of funding for the maintenance and improvement (M&I) of Federal-owned and Tribal-owned space used for the provision of health care services. A $10 million dollar increase is recommended for this line item. M&I funds are used to support and enhance the delivery of health care and preventative health services and to safeguard interests in real property. The 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 2009 includes an increase of $20 million for Sanitation Facilities Construction. Availability of adequate plumbing systems in homes has a direct correlation with prevention of diseases. Currently, 12 percent of AI/ANs and Alaska Native homes do not have an adequate water supply.

Facilities and Environmental Health Support
An increase of $2.4 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 utilities and maintenance personnel to operate hospitals and health clinics.

Equipment
The FY 2009 Tribal budget recommendations include an increase of $5 million for medical equipment replacement. Additional funding is needed to keep pace with technology change and the ever-increasing cost of medical equipment.

Joint Venture, Small Ambulatory Program, and Youth Regional Treatment Centers
This request is a separate health care facilities construction request to ensure ongoing and adequate funding of these three programs. An additional $30 million is requested to fund these programs that are critical in providing a means for Tribes to replace outdated and inadequate health facilities and expand access to alcohol and substance abuse treatment for youth.

CONCLUSION
The AI/AN populations have been relying upon the legal and moral obligations of the United States contained in over 800 ratified treaties, reaffirmed in Supreme Court rulings, Presidential and Congressional decrees to receive healthcare. To date, the greatest nation on earth cannot seem to help the people who first inhabited that nation.
The Indian Health Service has shown that it can properly manage its scant resources. IHS has scored better in PART scores than CMS, HRSA and the VA. This however has not helped increase the budget. Now IHS is starting to lose ground according to the GPRA indicators. It is imperative that IHS’ budget is increased to address the disparities and help the first Americans who have such poor health status. Improvements have been made when resources have been allocated, but those improvements are in danger of being swallowed up by medical inflation’s effect on the Indian healthcare system. The Administration must at a minimum allocate $356 million to cover medical inflation and population growth and keep the IHS from losing ground. In addition, the Administration needs to allocate $425 million to fund the identified priority areas and start making an impact at reducing health disparities.
FY 2009 Budget Recommendation: Honoring The Promise

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Statistical References


