Photo credit: © Army Medicine/Flickr

Health Care

Reducing Disparities in the Federal Health Care Budget

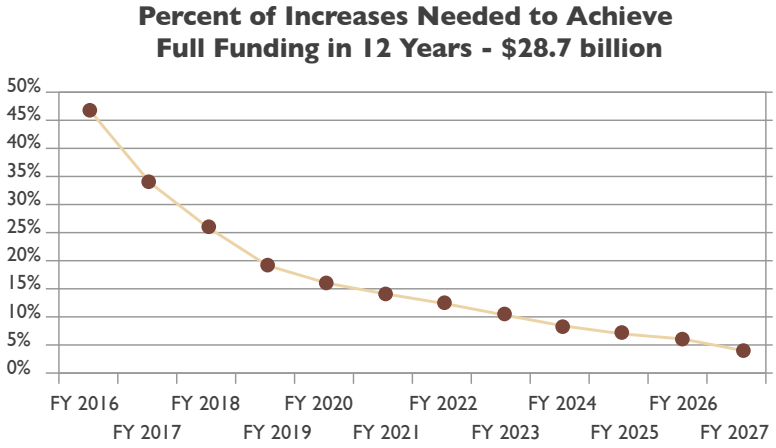
The survival and prosperity of tribal communities depend on the safety, health, and wellness of our citizens. Despite the federal government's trust responsibility to provide health care to our people, American Indians and Alaska Natives (AI/AN) suffer disproportionately from a variety of health concerns.

The federal government's trust responsibility, mandated by treaties, statute, and federal doctrine, is based on need. Funds to the Indian Health Service (IHS) are prepaid obligations between the United States and tribal nations. American Indians and Alaska Natives have long experienced health disparities when compared with other Americans. Shorter life expectancy and the disease burdens carried by American Indians and Alaska Natives exist because of inadequate education, disproportionate poverty, discrimination in the delivery of health services, and cultural differences. These are broad quality of life issues rooted in economic adversity, poor social conditions, and decades of historical trauma.

The AI/AN life expectancy that is 4.2 years less than the rate for the US all races population. According to IHS data from 2005-2007, AI/AN people die at higher rates than other Americans from alcoholism (552 percent higher), diabetes (182 percent higher), unintentional injuries (138 percent higher), homicide (83 percent higher), and suicide (74 percent higher). Additionally, AI/AN people suffer from higher mortality rates from cervical cancer (1.2 times higher); pneumonia/influenza (1.4 times higher); and maternal deaths (1.4 times higher). Clearly, this data calls for a better funded Indian health care delivery system.

The Indian health care delivery system, in addition to significant health disparities, also faces significant funding disparities, notably in per capita spending between the IHS and other federal health care programs. The IHS has been and continues to be a critical institution in securing the health and wellness of tribal communities. In 2013, the IHS per capita expenditures for patient health services were just $2,849, compared to $7,717 per person for health care spending nationally. Compared to IHS calculations of expected cost for a blend of Federal Employee Health Benefits, average IHS per user spending in 2013 was only 59 percent of calculated full costs. The actual percentage varies between IHS areas, with some funded at much less than 59 percent of need. New health care insurance opportunities beginning in 2014 and expanded Medicaid in some states may expand health care resources available to American Indians and Alaska Natives. However, these new opportunities are still no substitute for the fulfillment of the federal trust responsibility, and the budget gap will remain. It will be

some time before reliable data is available to determine the impact of these changes on American Indians and Alaska Natives. The FY 2016 budget for the IHS should support tribal self-determination, uphold the federal government's partnership with tribes to improve Indian health, and work to reduce health disparities for Native people. It is unconscionable that, America's first nations are often the last when it comes to health.



To allow the existing funding gap to continue for both IHS Services and Facilities budget lines is to disregard the health and lives of all Native Americans. Our elders, our youth, and our tribal citizens ask: "Why Not Us? Why do our lives not count the same as other citizens?" It is time to end the unnecessary suffering and death occurring every day in Indian communities – centuries of neglect have now become an urgent humanitarian cry for justice for our people.

In order to build on the foundation of this partnership, NCAI calls for a long-term plan that brings American Indian and Alaska Native health care into line with the rest of the American population. Despite historic increases since 2009, the IHS remains severely underfunded at only 59 percent of total need. In FY 2013, sequestration cuts devastated tribal communities throughout the United States. In a health care delivery system that has been chronically underfunded for decades, this was pure disaster for clinics across Indian Country. Losing these dollars, combined with a calamitous federal government shutdown at the start of FY 2014, has nullified many of the funding gains of the last six years. When compounded with rising medical inflation and population growth, Indian health budgets are quickly trending backwards.

The Tribal Budget Formulation Workgroup for IHS estimates that a true Needs Based Budget for IHS would be $28.7 billion.

For the IHS budget to grow sufficiently to meet the true and documented needs of tribal nations over a twelve-year period would require the federal government to commit an additional $2 billion per year. After a decade, the increase would fully fund the IHS at the $28.6 billion amount required for Native peoples to achieve health care parity with the rest of the American population. This request was put forward as part of the Indian Country Budget Request in FY 2012, 2013, 2014, and 2015. Developing and implementing a plan to achieve parity is critical to the future of Indian health and to the fulfillment of the United States' trust responsibility to tribal nations.

The requests listed below focus on specific increases to the IHS that reflect both the priorities of tribal leaders from the 12 IHS Areas and the Agency-wide goals expressed by the IHS.

Key Recommendations

Department of Health and Human Services

Interior – Environment Appropriations Bill

Indian Health Service (IHS)

- ***Provide an increase of $814.8 million to the Indian Health Service over the FY 2015 President's proposed budget. This increase includes $368.9 million in order to maintain current services and $445.8 million for program expansion.***

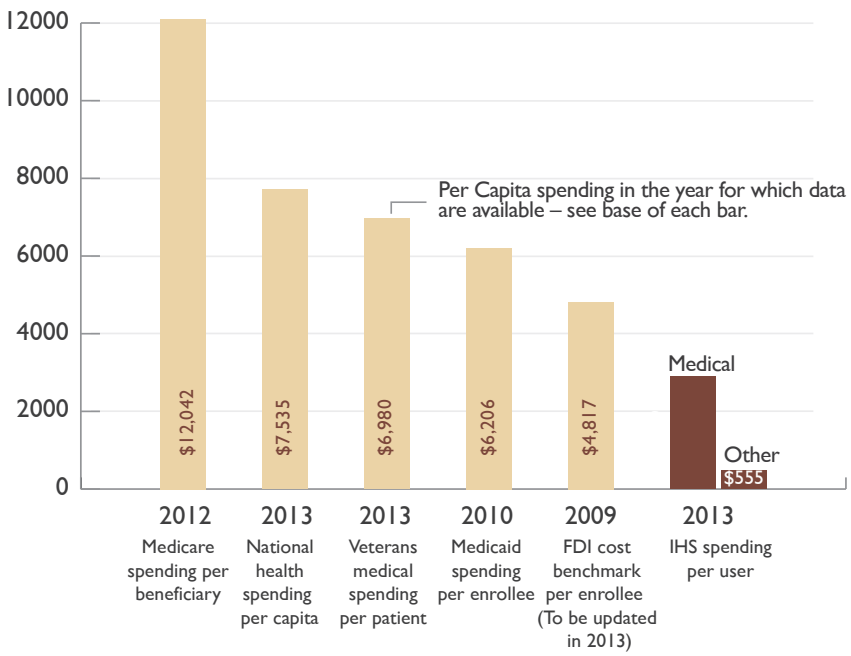
The FY 2016 tribal budget request above the President's FY 2015 Budget addresses funding disparities between the IHS and other federal health programs (Figure 8) while still providing for current service costs (Table 1). About $368.9 million of that increase is necessary simply to maintain current services, a top priority for tribes. The remainder of the requested budget increase is a modest increase to fund specific programs (Table 2).

Current Services

Maintaining current funding levels so that existing services can still be provided is a fundamental budget requirement and a top priority for tribal leaders. These base costs, which are necessary in order to maintain the status quo, must be accurately estimated and fully funded before any real program expansion can begin. Any funding decreases would result in a significant reduction of health care services and delivery and prolong the state of emergency facing the IHS. To address this situation, the following budget increases are necessary (Table 1).

FIGURE 8

2013 IHS Expenditures Per Capita and Other Federal Health Care Expenditures Per Capita



[Note: "Other" refers to Indian Health Service expenditures for facilities.]

Source: The National Tribal Budget Formulation Workgroup's Recommendations on the Indian Health Service Fiscal Year 2016 Budget

TABLE 1 – FY 2016 INCREASES TO MEET CURRENT SERVICE COSTS AND BINDING AGREEMENTS	
Tribal Pay Costs	$9,936,000
Federal Pay Costs	$7,806,000
Inflation Costs (Medical and Non-Medical)	$80,877,000
Population Growth Costs	$67,450,000
Contract Support Costs	$43,153,000[41]
New Tribes	$13,895,000
Staffing Costs for New & Replacement Facilities	$70,818,000
Health Care Facilities Construction Costs	$75,000,000
TOTAL CURRENT SERVICE COSTS	**$368,935,000**

Fy 2016 Service Cost Increases

New costs in FY 2016 include increases in both tribal and federal pay costs, medical and non-medical inflation costs, standard increases in health care facilities construction costs, and staffing costs for new and replacement facilities. In addition, NCAI recommends increases in funding to address Contract Support Costs and projected population increases.

Contract Support Costs: The ability of tribes to operate their own health care systems is consistent with the federal policy of tribal self-determination. However, the ability of tribes to be successful in this endeavor depends upon the availability of CSC funding to cover fixed costs. Without full funding, tribes are forced to reduce direct services in order to cover the CSC shortfall. Adequate CSC funding assures that tribes, under the authority of their Self-Determination Act contracts and Self-Governance compacts with IHS, have the resources necessary to administer and deliver the highest quality healthcare services to their members without sacrificing program services and funding. Most importantly, full funding of contract support costs is a contract obligation that the federal government must honor by law.

Population Growth: The request for $67.450 million will address the increased service costs arising from the growth in the American Indian and Alaska Native population, which is increasing at an average rate of 1.9 percent per year.[42] Failure to fund medical costs related to population growth translates into real erosion of existing health care dollars to meet current demand for services.

TABLE 2 – FY 2016 PROGRAM SERVICES INCREASES	
HEALTH ACCOUNTS	
Hospitals and Clinics (H&C)	$119,300,000
Dental	$11,141,000

TABLE 2 – FY 2016 PROGRAM SERVICES INCREASES (CONT.)	
Mental Health	$51,500,000
Alcohol and Substance Abuse	$41,980,000
Urban Indian Health	$15,000,000
Purchased/Referred Care	$145,402,000
Health Education	$5,415,000
Community Health Representatives	$3,040,000
Indian Health Professions	$1,013,000
FACILITIES	
Maintenance and Improvement	$14,477,000
Sanitation Facilities Construction	$13,173,000
Health Care Facilities Construction	$17,432,000
Equipment	$5,000,000
TOTAL PROGRAM INCREASES	**$445,836,000**

Program Services Increases

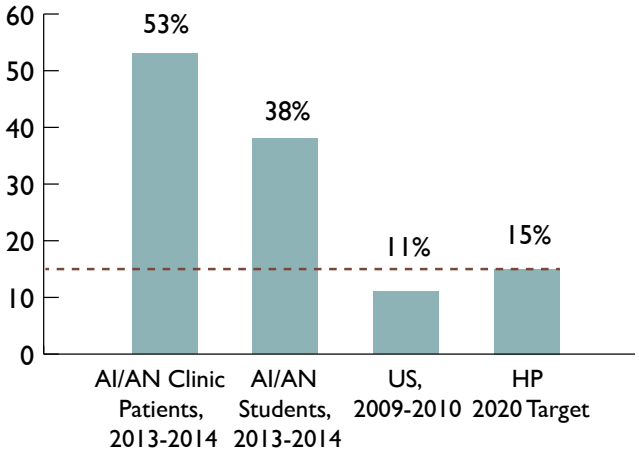
In addition to increased costs as part of maintaining Hospital and Clinic Program costs, including the Indian Health Care Improvement Fund, NCAI recommends the following Program Services increases:

Dental Services: +$17 million

A $17 million increase (including the program increase of $11 million plus pay costs, inflation and population growth, $6 million) above the FY 2015 President's budget level is necessary to support oral care, due to the high dental needs facing tribal nations where dental decay among Native children between the ages of two and four is five times the national average.[43] By two years of age, 44 percent of AI/AN children already have cavities, supporting the fact that prevention interventions must be implemented with pregnant women and infants.[44] In order to prevent dental caries in the primary teeth, we must intervene before the first cavity develops, working with both mothers and infants.

FIGURE 9

Prevalence of untreated decay in the permanent teeth of AI/AN dental clinic patients and students compared to the U.S. population and the Healthy People 2020 target, 13–15 years of age.



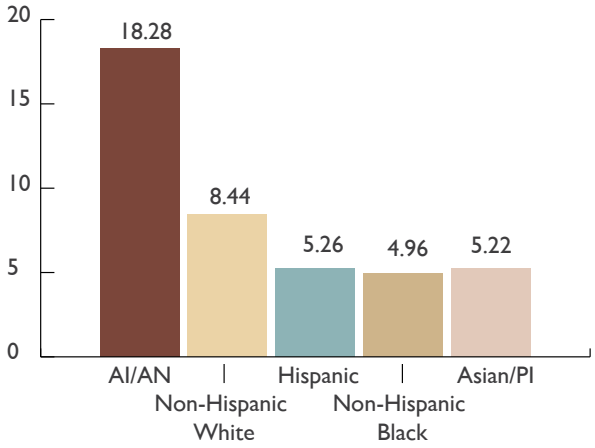
These funds will provide preventive and basic dental care services, as over 90 percent of the dental services provided by the IHS are basic and provide emergency care services. Dental disease can affect overall health and school and work attendance, nutritional intake, self-esteem, and employability. This disease is preventable when appropriate public health programs are in place. Funds are used for staff salaries and benefits, contracts to support dental services, dental lab services, training, supplies, and equipment. These funds are needed primarily to improve preventive and basic dental care services, as over 90 percent of the dental services provided by Indian Health Service, tribal, or Urban Indian (I/T/U) health care facilities are used to provide basic and emergency care services.

Mental Health: +$54.2 million

Tribal leaders identified that Mental Health is a top concern and recommended a $54.243 million increase (including the $51 million program increase plus $3 million for pay costs, inflation and population growth) above the Fiscal Year 2015 Budget Request. Without a major infusion of resources in FY 2016, IHS and tribal programs will continue to have limited staffing for their outpatient community based clinical and preventive mental health services. Further, any inpatient and intermediate services, such as adult and youth residential mental health services and group homes, which are sometimes arranged through states and counties, will have to be accessed off the reservation.

FIGURE 10

Suicide Rates Among Persons 10-24 Years of Age, by Race/Ethnicity, 2009



Access to adequate care, from local paraprofessional providers to contracted specialty care providers is critical to address the vast mental health needs for American Indians and Alaskan Natives who seek care from their tribal health and direct service facilities. Many tribes recognize historical trauma as the root of disproportionate rates of depression, suicide, reoccurring trauma from domestic violence and sexual assault. Historical trauma can be described as unresolved generational trauma, generated by historical policies of genocide, boarding schools, relocation and more currently child welfare practices. These experiences, and the subsequent loss of traditional kinship systems, traditional language, spiritual practices and cultural values impact the core of self-worth and identity, and has left a legacy of familial and community grief, and a cycle of economic conditions that continue to contribute to the extraordinary mental health needs.

In 2007, the National Center for Health Statistics noted that AI/ANs experience serious psychological distress 1.5 times more than the general population. Of particular concern, AI/AN represent the highest rates of suicide of any group in the US for all ages. An eleven-year study (1999-2010) by Jacqueline Gray, University of North Dakota, reveals the suicide rate for AI adolescents and young adults from 15-34 is 2.5 times the national average for that age group. Unlike other groups where the suicide rate increases with age, AI/AN rates are highest among the youth and decrease with age.

Alcohol and Substance Abuse Treatment: +$49.5 million

Treatment of Alcohol and Substance Abuse is a top concern for tribes all across the country and an increase of $49.5 million (including a $42 million program increase plus $7.5 million for pay costs, inflation, and population growth) over the FY 2015 President's Requested level is needed to address this critical problem. In the FY 2015 Budget an increase of $7.4 million is limited to the provision of medical inflation, additional staffing at three new healthcare facilities and a small portion for new tribes. Without a major infusion of funding, AI/AN people will continue to be consistently overrepresented in statistics relating to alcohol and substance abuse disorders in which higher rates of methamphetamine, cocaine, and marijuana use are reported. Now that tribes manage a majority of alcohol and substance abuse programs, IHS is in a supportive role to assist the tribes plan, develop and implement a variety of treatment modalities. The collaboration has resulted in more consistent evidenced-based and best practice approaches to address substance abuse disorders and addictions. At the community level, this is accomplished through individual and group counseling, peer support, and inpatient and residential placement. Treatment approaches also include traditional healing techniques that link the services provided to traditional cultural practices and spiritual support for the individual AI/AN that tribal programs have found successful.

Urban Indian Health: +$16.6 million

Tribal leaders recommended a $16.6 million increase (including a $15 million program increase and $1.6 million for pay costs, inflation, and population growth) over the President FY 2015 level. Thirty-eight Urban Indian Health Programs provide health care and substance abuse services to more than 100,000 AI/ANs each year. Operating in 21 states, these programs are funded from an IHS line item of only $40.7 million, which is less than 1 percent of total IHS budget. Urban Indian Health Programs provide affordable, culturally-competent primary medical care and public health case management, as well as wrap-around services for urban Natives who do not have access to the resources offered through IHS and tribally-operated health care facilities.

Purchased/Referred Care Program (PRC): +$198.2 million

Tribal leaders recommended a $198.2 million increase (including a $145.4 million program increase, $3.5 million for binding agreements, and $49.3 million increase for pay costs, inflation, and population growth) over the FY 2015 President's request. The Purchased/Referred Care program pays for urgent and emergent and other critical services that are not directly available through IHS and tribally-operated health programs when: no IHS direct care facility exists, or the direct care facility cannot provide the required emergency or specialty care, or the facility has more demand for services than it can currently meet.

Funding for PRC remains a critical priority for all tribes. The PRC budget supports essential health care services from non-IHS or non-Tribal providers and includes inpatient and outpatient care, emergency care, transportation, and medical support services such as diagnostic imaging, physical therapy, laboratory, nutrition, and pharmacy services. These funds are critical to securing the care needed to treat injuries, cardiovascular and heart disease, diabetes, digestive diseases, and cancer, which are among the leading causes of death for AI/ANs. The recent trend to construct smaller joint venture outpatient ambulatory care centers will likely increase the reliance on PRC resources for hospital-based care. In FY 2012, IHS denied 186,353 eligible PRC cases eligible, and; again in FY 2013 denied services for 213,360 PRC eligible PRC cases AI/ANs. This upward trend demonstrates that the PRC need continues to grow in the IHS system and that additional resources are needed to address this chronic and underfunded need.

At current funding levels, many IHS and tribally-operated programs are only able to cover Priority I services to preserve life and limb and are often unable to fully meet patients' needs of even this one PRC service category. Because PRC is only treating the most desperate of cases at current funding levels, any shortfall in the program correlates to increased death rates for some communities in Indian Country.

Advance Appropriations for the Indian Health Service. In June 2014, NCAI passed a resolution supporting the enactment of Advance Appropriations for the Indian Health Service. An advance appropriation is funding that becomes available one year or more after the year of the appropriations act in which it is contained. Providing Advance Appropriations for the Indian Health Service Budget would be consistent with other federal programs that provide critical health care services to vulnerable populations.

Tribal health programs must make long-term decisions with only short-term money guaranteed. Often programs must determine whether and how they can enter into contracts with outside vendors and suppliers, plan programmatic activities, or maintain current personnel. Advance appropriations would allow Indian health programs to effectively and efficiently manage budgets, coordinate care, and improve health quality outcomes for AI/AN people. This change in the appropriations schedule will help the federal government meet its trust obligation to tribal governments and bring parity to the federal health care system. The Veterans Health Administration (VHA) achieved this status in 2009. IHS, like the VHA, provides direct care to patients as a result of contractual obligations made by the federal government. To tribes, enacting IHS advance appropriations is a civil rights issue and a matter of equality.

Indian Health Care Improvement Act New Authorities: The permanent authorization of the Indian Health Care Improvement Act (IHCIA) was passed in 2010 as part of the Patient Protection and Affordable Care Act (P.L. 110-148), yet few funds have been appropriated to achieve many of the new authorities in the law. The implementation of IHCIA remains a top priority for Indian Country. At least an additional $300 million is critically needed in order to begin to implement and fund the new priorities in IHCIA. The IHCIA Reauthorization achieves the following:

- Updates and modernizes health delivery services, such as cancer screenings, home and community based services and longterm care for the elderly and disabled.
- Establishes a continuum of care through integrated behavioral health programs (both prevention and treatment) to address alcohol/substance abuse problems and the social service and mental health needs of Indian people.

The battle for IHCIA renewal was over a decade in the making. When this historic law was signed, Indian Country was elated by the promise of a new and more efficient health care delivery system for AI/AN people. However, four years later many of the provisions of the Act remain unfunded, and in many ways, the Act represents yet another broken promise for Indian people.

Department of Health and Human Services

Labor, HHS, Education Appropriations Bill

Diabetes Prevention

- ***Continue to provide $1 million for the On the T.R.A.I.L. (Together Raising Awareness for Indian Life) to Diabetes Prevention program.***

IHS has successfully funded the On the T.R.A.I.L. program since 2003, serving nearly 12,000 Native American youth ages 8-10 in 83 tribal communities. The program curriculum is an innovative combination of physical, educational, and nutritional activities that promote healthy lifestyles. The program also emphasizes the importance of teamwork and community service. Members apply decision-making and goal-setting skills when completing physical activities and engage in service projects to improve health lifestyles in their communities. Continued funding of this program sustains a tested program and represents one of the few national youth-oriented diabetes prevention initiatives.

Department of Health and Human Services

Labor, HHS, Education Appropriations Bill

Health Resources and Services Administration (HRSA)
Native Hawaiian Health Care Systems Program

- ***Provide $14.4 million to fund the Native Hawaiian Health Care Systems Program.***

The Native Hawaiian Health Care Systems Program provides critically needed support for the health and well-being of Native Hawaiians. Since the Native Hawaiian Health Care Systems Program was first established in 1988, it has provided direct health services, screenings and health education to hundreds of thousands of Native Hawaiians, and supported hundreds of Native Hawaiians in becoming medical professionals, including physicians, nurses, and health research professionals. Allocating this funding would ensure the continuation of an already established and necessary resource for Native Hawaiians.