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H.R. 151 AND H.R. 2440

LEGISLATIVE HEARING

BEFORE THE

COMMITTEE ON RESOURCES
U.S. HOUSE OF REPRESENTATIVES

ONE HUNDRED EIGHTH CONGRESS

FIRST SESSION

Wednesday, October 1, 2003

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C O N T E N T S

	Page
Hearing held on Wednesday, October 1, 2003	1
Statement of Members:	
Carson, Hon. Brad, a Representative in Congress from the State of Oklahoma, Prepared statement on H.R. 151 and H.R. 2440	5
Kildee, Hon. Dale, a Representative in Congress from the State of Michigan, Prepared statement on H.R. 151 and H.R. 2440	5
Nethercutt, Hon. George R., Jr., a Representative in Congress from the State of Washington	6
Prepared statement on H.R. 151	7
Pombo, Hon. Richard W., a Representative in Congress from the State of California	1
Prepared statement on H.R. 151 and H.R. 2440	2
Rahall, Hon. Nick J., II, a Representative in Congress from the State of West Virginia	3
Prepared statement on H.R. 151 and H.R. 2440	4
Udall. Hon. Tom, a Representative in Congress from the State of New Mexico, Prepared statement on H.R. 2440	58
Statement of Witnesses:	
Davis-Wheeler, Julia, Co-Chair, National Indian Health Board	39
Prepared statement on H.R. 151 and H.R. 2440	41
Hunter, Anthony, Board President, National Council of Urban Indian Health	31
Prepared statement on H.R. 151 and H.R. 2440	33
Lincoln, Michel, Deputy Director, Indian Health Service	12
Prepared statement on H.R. 2440	14
Shirley, Joe, Jr., President, Navajo Nation	25
Prepared statement on H.R. 151 and H.R. 2440	27

LEGISLATIVE HEARING ON H.R. 151, TO ELEVATE THE POSITION OF DIRECTOR OF THE INDIAN HEALTH SERVICE WITHIN THE DEPARTMENT OF HEALTH AND HUMAN SERVICES TO ASSISTANT SECRETARY FOR INDIAN HEALTH, AND FOR OTHER PURPOSES; AND H.R. 2440, TO IMPROVE THE IMPLEMENTATION OF THE FEDERAL RESPONSIBILITY FOR THE CARE AND EDUCATION OF INDIAN PEOPLE BY IMPROVING THE SERVICES AND FACILITIES OF FEDERAL HEALTH PROGRAMS FOR INDIANS AND ENCOURAGING MAXIMUM PARTICIPATION OF INDIANS IN SUCH PROGRAMS, AND FOR OTHER PURPOSES. (INDIAN HEALTH CARE IMPROVEMENT ACT AMENDMENTS OF 2003)

Wednesday, October 1, 2003
U.S. House of Representatives
Committee on Resources
Washington, DC

The Committee met, pursuant to notice, at 10:20 a.m., in Room 1324, Longworth House Office Building, Hon. Richard Pombo [Chairman of the Committee] presiding.

Present: Representatives Pombo [The Chairman] Gibbons, Hayworth, Renzi, Cole, Pearce, Rahall, Kildee, Pallone, Christensen, Inslee, Napolitano, Tom Udall, Mark Udall, Carson, Bordallo and Baca

STATEMENT OF HON. RICHARD W. POMBO, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF CALIFORNIA

The CHAIRMAN. The Committee on Resources will come to order. The Committee is meeting today to hear testimony on two bills dealing with health care for Native Americans: H.R. 151 and H.R. 2440, sponsored by Mr. Nethercutt and Mr. Young of Alaska, respectively.

Under Rule 4(g) of the Committee Rules, any oral opening statements at hearings are limited to the Chairman and Ranking Minority Member. This will allow us to hear from our witnesses sooner and help members keep to their schedules. Therefore, if other members have statements, they can be included in the hearing record under unanimous consent.

I would like to welcome all of the members and witnesses to this hearing on H.R. 151 and H.R. 2440. H.R. 151 is a bill to elevate the position of Director of Indian Health Service within the Department of Health and Human Services to Assistant Secretary of Indian Health.

H.R. 2440 is the Indian Health Care Improvement Act Amendments. This is a huge bill which provides for health care delivery to over two million American Indians and Alaska Natives.

H.R. 151 will provide a greater administrative focus on Native health issues by elevating the Director of the Indian Health Service within the Department of Health and Human Services to the Assistant Secretary of Indian Health. By providing a more visible internal role within the Department, the head of IHS will be a better advocate of Native health issues.

While Secretary Tommy Thompson has certainly elevated the Director of IHS to a top level policy position, and he is to be applauded for this, previous Administrations have not placed such a premium on that position. I think that as we work on the larger Indian Health Care Improvement Act, we should look at whether elevating the Director to the Assistant Secretary level is good policy.

The hearing on H.R. 2440 will focus on Title I, Indian Health Manpower. Title I of the bill strives to increase to the maximum extent feasible the number of American Indians and Alaska Natives entering the health professions. It also seeks to assure an adequate supply of health professionals to the Service, Indian tribes, tribal organizations, and urban Indian organizations involved in the delivery of health care to American Indians and Alaska Natives.

By expanding Title I, tribes can get culturally proficient health care providers,. thereby increasing health care professionals. Further, the expansion of Title I will begin to address the challenges with recruitment and retention of direct health care providers for the most isolated, rural and remote American Indian and Alaska Native communities.

I now recognize Mr. Rahall.

[The prepared statement of Mr. Pombo follows:]

Statement of The Honorable Richard Pombo, a Representative in Congress from the State of California

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STATEMENT OF HON. NICK J. RAHALL, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF WEST VIRGINIA

Mr. RAHALL. Thank you, Mr. Chairman.

Mr. Chairman, my home State of West Virginia has the distinction of being. although relatively small in population, still the distinction of singlehandedly causing the election of two United States Presidents. The first was John F. Kennedy who, by winning over largely Protestant West Virginia, dispelled the notion in certain quarters that he would be a Catholic President beholden to the Pope in Rome.

The second, of course, was George W. Bush, because if West Virginia had voted the way it historically had done, Al Gore would be in the White House today, regardless of what happened in Florida.

I raise this in reference to JFK because he was so moved by the poverty he saw in West Virginia during his campaign that when he became President he did something about it, by starting what became known as the Appalachian Regional Commission. A centerpiece of this initiative aimed at economic rejuvenation was ensuring that the region was equipped with adequate health care facilities to serve the public. Indeed, under the ARC, hospitals, treatment facilities and child care facilities were constructed as a means to help lift the people from poverty.

We face the same task in Indian Country today. Yet, the Appalachian Regional Commission went from concept in 1963 to reality in 1965, in a shorter period of time than it has taken Congress to reauthorize the Indian Health Care Improvement Act. I find this situation to be intolerable.

I understand that the issues involved here are complex, but the landmark National Steering Committee proposal was delivered to Congress in 1999. The law technically expired in 2001. A hearing record has been established and I am sure today's hearing will be beneficial and I thank the witnesses for being with us.

But the fact remains that people are suffering in Indian Country. Compared to all races in the United States, Native Americans suffer a death rate that is 533 percent higher from tuberculosis, 420 percent higher from diabetes, 770 percent higher from alcoholism, and 71 percent higher from influenza and pneumonia.

We must not stand idle any longer. We must move now to reauthorize the Indian Health Care Improvement Act so that we can better provide for the delivery of health services for American Indians and Alaska Natives throughout the Nation.

I thank you, Mr. Chairman, for calling this hearing today, and thank you for your help on this issue as well.

[The prepared statement of Mr. Rahall follows:]

Statement of The Honorable Nick J. Rahall II, a Representative in Congress from the State of West Virginia

Mr. Chairman, West Virginia has the distinction of being the State which, although relatively small in population, singlehandedly caused the election of two U.S. Presidents. The first was John F. Kennedy, who, by winning over the largely Protestant West Virginia, dispelled the notion in certain quarters that he would be a Catholic President, beholden to the Pope in Rome.

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Thank you.

The CHAIRMAN. Thank you.

I would now like to introduce our first witness, Congressman George Nethercutt, who represents the 5th District of the State of Washington and who is the lead sponsor on H.R. 151.

Let me take this time to remind all of today's witnesses that under our Committee Rule, oral statements are limited to 5 minutes. Your entire written testimony will appear in the record.

Mr. KILDEE. Mr. Chairman.

The CHAIRMAN. Mr. Kildee.

Mr. KILDEE. I have another markup on my other committee. Could I submit comments for the record? I am a cosponsor of both these bills.

The CHAIRMAN. Are they good comments?

Mr. KILDEE. They're great comments.

[Laughter.]

The CHAIRMAN. Without objection.

Mr. KILDEE. Thank you, Mr. Chairman.

[The prepared statement of Mr. Kildee follows:]

Statement of the Honorable Dale E. Kildee, a Representative in Congress from the State of Michigan

Good morning. Mr. Chairman, I would like to thank you scheduling this hearing today.

I would like to express my strong support for two very important bills, H.R. 2440, the reauthorization of the Indian Health Care Improvement Act, and H.R. 151, the bill to elevate the Director of Indian Health Service to Assistant Secretary status. I am proud to be an original cosponsor of both bills.

The Indian Health Care Improvement Act, first enacted in 1976, is the keystone federal law that made vast improvements in the delivery of heath care provided to American Indian and Alaska Native people.

Reauthorization of this Act will provide a more comprehensive approach to the delivery of medical care to Native people.

This bill is based upon the recommendations made by the Indian Health Community including tribal leaders, tribal health directors, health care experts, and Native patients themselves.

Its primary objective is to improve access to quality medical care for the Native American population.

Previous amendments to the Indian Health Care Improvement Act reflect advancements in health care delivery, respond to the desire of tribes for greater responsibility over programs, and target high incidence of certain diseases that have plagued the Native American segment of the American population.

The proposed changes to the bill will build upon the basic framework of the Indian Health Care Improvement Act.

Mr. Chairman, by elevating the Director of Indian Health Service to Assistant Secretary status, Congress will be sending a clear message to Indian Country that their Indian health needs are a priority for us.

The disparity of health care delivery to American Indians and Alaska Native communities is disproportionately less than the general population in the United States.

Native Americans suffer from diabetes, alcoholism, tuberculosis, and heart disease at far higher rates than non-Indians.

Having an Assistant Secretary that directly reports to the Secretary of DHHS is a major step toward addressing the health needs in Indian communities whose health needs exceed $15 billion.

I look forward to hearing from the witnesses. Thank you.

Mr. CARSON. Mr. Chairman, could I also ask your indulgence to do the same?

The CHAIRMAN. Without objection, Mr. Carson will also introduce a statement into the record.

[The prepared statement of Mr. Carson follows:]

Statement of The Honorable Brad Carson, a Representative in Congress from the State of Oklahoma

Chairman Pombo, Ranking Member Rahall, I would like to thank you both for conducting a hearing on these two critically important pieces of legislation. I am a cosponsor and strong supporter of both H.R. 151, legislation to elevate the Indian Health Service (IHS) Director to the Assistant Secretary for Indian Health, and H.R. 2440, legislation to reauthorize the Indian Health Care Improvement Act.

Every year, raising the standard of health care for every American is a high priority for Congress. However, this continuing debate often ignores the standard of health care in Indian country.

To illustrate my point, I refer to a report published in July 2003, by the United States Commission on Civil Rights, titled, "Quiet Crisis: Federal Funding and Unmet Needs in Indian Country." This report states:

> "Native Americans receive less funding per capita than any other group for which the federal government has health care responsibilities, including Medicaid/Medicare recipients, veterans, and prisoners. The legal and moral obligation to provide health care to Native Americans has not been met, and unless IHS receives an exponential increase in funding, health conditions are not likely to improve and will likely worsen."

Further, the report states that the national per capita health expenditure for the average American will be $5,775 in 2003. Compare this to the $1,914 that IHS is projected to spend per capita in 2003. To put it simply, 3 times more is spent on

the health care of average American citizens than on the Indian people of this nation.

In looking at these statistics, I am puzzled as to why the principle health care provider and advocate for Indian Health Care is not an Assistant Secretary position. While the goal of IHS is to raise the health status of American Indians and Alaska Natives to the highest level possible, the current administrative structure limits the IHS Director's authority to set and implement health policy for American Indians. By elevating the IHS Director to an Assistant Secretary position, we will greatly strengthen the voice of Indian Country as we all work together to raise the standard of health care in this country and to address urgent unmet health care needs.

I also want to say a few words of support regarding H.R. 2440. The most recent reauthorization of the Indian Health Care Improvement Act was in 1992. Since that time the Indian population has grown and the disparity between the health status of Indian people as compared to other Americans has grown. To address these changing circumstances more fully and effectively, a reauthorization is desperately needed to reflect these changes since the last reauthorization 11 years ago. In recent years, the Indian health care community, namely the National Steering Committee, has been working hard to draft reauthorization legislation, and H.R. 2440 is the product of their diligence. It is time for Congress to do its part and move this legislation forward for eventual enactment into law.

The CHAIRMAN. Mr. Nethercutt. Welcome to the Committee. It's nice to have you here today. You know the rules and you can begin.

STATEMENT OF HON. GEORGE R. NETHERCUTT, JR., A REPRESENTATIVE IN CONGRESS FROM THE STATE OF WASHINGTON

Mr. NETHERCUTT. I will, Mr. Chairman. I thank you very much, to you and the Ranking Minority Member and all the members of the Committee for holding this hearing on H.R. 151. I am especially thankful to my friend, Congressman Hayworth, for cosponsoring, and others for giving this bill so much consideration, and other cosponsors who are sitting on this panel.

We have submitted a statement for the record and I would ask that it be submitted in its entirety, and I will just summarize my remarks this morning to emphasize the importance that I think this bill holds for American Indian and Native American communities across this country. It would elevate the position of the Director of the Indian Health Service within the Department of HHS, Health and Human Services, to Assistant Secretary for Indian Health.

I think it's an appropriate thing to do, given our national commitment to our Native American and Alaska Native populations across this country, and also in recognition of the fact that our American Indian and Alaska Native population suffer disproportionately certain kinds of diseases, chronic conditions such as diabetes. I know many of you are part of the Diabetes Caucus in the House, the largest caucus in the House that focuses on the chronic disease of diabetes.

Its impact on minority populations, and especially our American Indian and Alaska Native populations, is profound. Its impact is disproportionate to the rest of the population.

In addition, I have visited in my own State, and in my own district, a number of Indian Health Service facilities, Indian health clinics and other health delivery services that exist on our tribal lands today. They are struggling, these various tribal organizations and entities. They are in need of additional attention on the very

critical issue of human health as it relates to our Native American and Alaska Native populations.

So this bill is a logical second or third step in our focus on what is necessary to help meet the health care needs of our Native American and Alaska Native populations; that is, to give greater priority within the Department that implements these programs by elevation of this Director of Indian Health Services to an Assistant Secretary for Indian Health. By doing so, this Assistant Secretary will sit at the table with the Secretary and discuss, on a day to day, week to week, annual basis the health care needs of the populations that the Assistant Secretary would serve, and also advocate very strongly for additional funding, additional programs, or additional assistance to our Native American populations, who struggle mightily in the area of chronic disease.

So I would just say to the Committee, and to you, Mr. Chairman, and all the others, this is a good bill. It's a fair bill. It is one that I think addresses the critical need of Indian health care in this United States, and I think it certainly pays adequate respect to our Native American populations and their special needs in this country, especially as it relates to diabetes and other health care conditions.

So I would urge you to favorably consider this legislation, report it out expeditiously, and hopefully we could pass it in the House and Senate, and then do justice to those who are in the greatest need in our country, who are part of this great heritage of Native Americans and Alaska Natives. I think, in passing this legislation, we will pay proper respect to them and their particular health care needs, as well as the tradition of providing health care assistance to our Native American populations since this country was formed. So I would urge your favorable consideration.

I would be happy to answer any questions, and I thank you so much for taking the time today to hold this hearing and allow this testimony, not just from me but from the other very distinguished panels that will follow, who will testify in support of this measure.

Thank you, Mr. Chairman.

[The prepared statement of Mr. Nethercutt follows:]

Statement of The Honorable George R. Nethercutt, Jr., a Representative in Congress from the State of Washington

Thank you for the opportunity to appear before you today in support of H.R. 151. As you know, the Indian Health Service (IHS) is the lead agency in providing health care to the more than 550 Indian tribes in the United States. Each year the IHS serves 1.3 million American Indians and Alaska Natives. The services the IHS oversees range from facility construction to pediatrics.

As Co-Chair of the Congressional Diabetes Caucus, I have worked closely with the IHS. The statistics for Native Americans with diabetes are staggering. Over 15 percent of the Native Americans receiving care from IHS have diabetes. Prevalence of type 2 diabetes among Native Americans over 19 years of age is 12.2%. This compares to a 7.3% prevalence rate for the U.S. population as a whole. One tribe in Arizona has the highest rate of diabetes in the world. About 50% of these adults between the ages of 30 and 64 have diabetes. Diabetes has reached epidemic proportions among Native Americans. Complications from diabetes are major causes of death and health problems in most Native American populations. The serious complications of diabetes are increasing in frequency among Native Americans. Of major concern are increasing rates of kidney failure, amputations and blindness. I believe that H.R. 151 will afford IHS a stronger advocacy function within HHS, and allow for increased representation during the budget process.

Currently, the ability of the IHS to affect budgetary policy is limited, in part, by the Director's inability to directly participate in budget negotiations. As you may know, the IHS director position currently falls under the authority of the Public Health Service. The IHS employs approximately 15,000 employees and consists of 594 direct health care delivery facilities, yet IHS does not have the direction of an Assistant Secretary.

Each year the IHS provides health care services to 559 Indian tribes in 35 states. The purchasing power of the IHS budget is steadily declining and efforts to address Indian health care needs have not greatly helped. The disparity between Indian and non-Indian communities in Federal health care expenditures is growing.

Mr. Chairman, the Federal Government is not meeting the needs of Indian people. The lack of broad-based advocacy for Native American health needs is partially to blame and I believe this legislation is a step in the right direction. If H.R. 151 is enacted into law, it would be much easier for the director of IHS to ensure that HHS funding is available to meet the health needs of Indian communities. I hope that this bill will receive favorable consideration by your Committee and the entire Congress.

Mr. GIBBONS [presiding]. Thank you very much, Mr. Nethercutt.

Are there any questions for Mr. Nethercutt? Mr. Pallone.

Mr. PALLONE. Thank you, Mr. Chairman.

I don't know if this directly relates, but I do support your legislation. I think we should try to move the legislation as quickly as possible.

Two things. One, you know that there is a chronic shortfall in funding for the Indian Health Service, which all of us bemoan and in which I think a lot of us would like to see a significant increase. So I have two questions.

One, do you think this would be beneficial in the sense that maybe this person at a higher level is better able to advocate for more funding? That's number one. And the second thing is—and I don't know the details, but there is this proposal by the Bush Administration that would transfer a lot of the people who are in the Indian Health Service over to the Secretary of Health and Human Services office, which again people in Indian country seem to think is a bad idea because it will dilute their—In other words, if they are directly under the Secretary rather than a part of the Indian Health Service, there may be a negative impact on the Indian Health Service.

I was wondering how that would relate to this legislation as well, how you feel about that and whether or not elevating this position at the same time the Administration is trying to transfer these people to the Secretary's office, how you feel about the interaction there. Those are the two questions.

Mr. NETHERCUTT. Well, Congressman Pallone, I thank you for the questions.

I serve on the Appropriations Committee, the Interior Subcommittee, which does the funding for the Indian Health Service. We are trying our best to increase those Federal funds that go for Indian health, so we will advocate for that very strongly.

I think that having this Assistant Secretary position in place will allow for that greater advocacy. I think the Director comes to our Subcommittee and testifies in favor of additional resources. But I think internally, in the Department of Health and Human Services, there will be a greater opportunity for advocacy for additional moneys that will also flow into other subcommittees, so I think the net

effect will be positive on funding and also on advocacy opportunities.

With respect to your second question about the movement of staff positions, I can testify first hand that Secretary Thompson is such a strong advocate for the subject of diabetes and diabetes funding and assistance, and he was a strong advocate for the extra $750 million over 5 years that goes to type II Native American disease research. So it may be that the net impact will be positive rather than negative, if that, in fact, happens. I don't have a good sense of whether it will or it won't. But I know Secretary Thompson is such a strong advocate for those in Indian country who suffer from diabetes and otherwise and will be a strong voice within the Department and perhaps this will bolster this argument that we need to enhance the amount of money that we spend and the time and attention we spend on Indian health. So that's my hope.

Mr. PALLONE. I guess the problem that I have—and again, I don't have all the details in front of me—is that on the one hand I agree with what you just said, that the elevation of this position certainly helps in terms of having a greater advocate and somebody who can maybe get more funds. But if you transfer a lot of the positions over to the Secretary's office, it seems to me that it dilutes the fact that you want to put all these people under one director, in this case somebody who is being elevated and becoming more important, and it sort of undercuts your efforts by having these people transferred to the Secretary's office.

You know, it is hard to quantify that, but that would be my impression. But you don't seem to feel that that's true?

Mr. NETHERCUTT. I guess my sense of it would be this. If we pass H.R. 151 and report it out and it gets favorable consideration, maybe then we are in a position to go to the Secretary or to the Administration and say we have now elevated the Director to Assistant Secretary and are you sure you want to make these transfers, is this something that's valid to do. So maybe this action by this Committee and the House and the Senate might then lead to the kind of result which I think we all want, and that is more attention to Indian health and more advocacy for it and more adequate staffing to make sure the job gets done.

Mr. PALLONE. Thank you. I appreciate that, and I support the bill.

Thank you, Mr. Chairman.

Mr. GIBBONS. Thank you, Mr. Pallone.

Anybody else? Mr. Rahall.

Mr. RAHALL. Thank you, Mr. Chairman.

I want to thank the gentleman from Washington for not only his recognition of the problem but for his leadership, especially from his position on the Appropriations Committee.

My question relates to the position of the Administration, the testimony of which is about to be presented to us. I understand they are going to testify that we do not need to elevate the Director of Indian Health Services to that of Assistant Secretary because they have elevated him "in house" by giving him direct access to the Secretary. My thinking is that this does not necessarily give him better budget authority access and it doesn't provide the next Secretary with the same direct access.

So my question is, how do you feel about the Administration's position on this issue?

Mr. NETHERCUTT. Well, I would just say, Mr. Rahall, that I support H.R. 151. I think it's the right result and I think it's the right action to take. I think you make a good point relative to the next Secretary that might be in the position.

I know this Secretary to be a very honorable man and very dedicated to the issue of Indian health and also diabetes, so there is open access. I think that's a good thing.

But institutionally, I prefer to see H.R. 151 passed and enacted into law, and then we have assurance relatively in perpetuity that there would be that access and there would be that advocacy at the table for budget items and other things that might come to affect Indian health. So I respect the Administration, as you know, but I also have high regard for our bill and I think it's the right thing to do.

Mr. RAHALL. Thank you.

Thank you, Mr. Chairman.

Mr. GIBBONS. Thank you, Mr. Rahall.

Mrs. Christensen.

Mrs. CHRISTENSEN. Thank you, Mr. Chairman. I want to thank you for holding this hearing and I want to thank our colleague for introducing the bill.

I wanted to say that the health task forces of the minority caucuses have been working together to create and introduce a bill which was to have actually been introduced today but is delayed, and within that bill we include your bill, the Indian Health Care Improvement Act, so we are glad to see it here before us today and offer our support.

We know how health care disparities have affected our Native American population, and we intend to continue to include this bill within the more comprehensive bill that addresses the health care disparities for all people of color and we also hope that our colleagues will support the larger bill as well as we seek to bring equity and accountability into health care for everyone.

Mr. NETHERCUTT. Thank you so much.

I would just add, too, that our minority populations in this country suffer disproportionately certain kinds of chronic health care conditions, diabetes being a very important one. Our Hispanic populations, our black populations, our Native American populations, all of them have a disproportionately higher incidence of the disease.

So my goal, as Co-Chairman with Diana Degette and others in the House, is to really focus on chronic disease conditions. As we put more money in, as we advocate harder and stronger, I think we will get a better handle for generations to come on all minority populations, and that's the right thing to do for our country.

Mrs. CHRISTENSEN. If I could just add, that bill is also included in our comprehensive bill.

Mr. NETHERCUTT. Thank you so much.

Mr. GIBBONS. Mrs. Napolitano.

Mrs. NAPOLITANO. Thank you, Mr. Chairman.

I am one of the cosponsors, so you know I support the bill.

Mr. NETHERCUTT. Good.

Mrs. NAPOLITANO. My question, again dovetailing on some of the comments my colleagues have made, is that the IHS employs about 15,000 employees, almost a quarter of all of HHS personnel. Is this adequate? Is this something where personnel is not focusing on the issues that affect the Indian Nation? Why is there not enough support then if there is this number of employees?

Mr. NETHERCUTT. Well, I think the critical issues—there are a lot of issues that affect Native Americans, for example, and in the Indian Health Service it's a monumental task out there among I think 559 tribes across this country. I think the goal is to make sure those 15,000 employees, or however many there are, dispersed through the Government that focus on Indian health are going to do good work and have effective solutions to the problems that face all of our tribal organizations as well as those who are affected by chronic disease.

Maybe I'm not answering your question as precisely as you would like, but as I understand it, I think there is more advocacy to be gained and there is also more effective advocacy to be gained within Government agencies today. I'm not so sure we should look at it just from the number of employees, but we have to look at what is the advocacy level, what are the issues that they're stressing prominently, and what are the results. So I think our goal with this $750 million over 5 years of mandatory funding, as well as additional money for diabetes, for example, we have to make sure that money is well spent.

So to the extent those employees can help make sure that money is well spent and that we have good plans in place for Indian health, we're all going to be better off and so are those affected by it are better off.

Mrs. NAPOLITANO. I understand that. Coming from a State legislature, I have found that sometimes some of those positions are used for other purposes.

Mr. NETHERCUTT. Sure.

Mrs. NAPOLITANO. Certainly there needs to be more of a focus. I know these issues have been identified before, and at that joint hearing we held with the Senate, all those issues were brought out.

I would hope that we focus on what we have found, what the Indian Nation representatives have spoken to, that we do not let those issues go by the wayside. You talked just about diabetes. There are other issues that were brought up, including, of course, alcoholism, asthma, a lot of the issues that the young children are beginning to show. We should not let those sit by the wayside while we're arguing over whether or not we need to get the programs going.

Mr. NETHERCUTT. I understand. I think maybe the elevation of this Indian Health Service Director to Assistant Secretary would give greater authority and greater opportunity to collect the resources of Government for the right purposes that you're speaking of.

Mrs. NAPOLITANO. But it's not creating another bureaucracy, I hope.

Mr. NETHERCUTT. I don't think so. I think we're really just giving greater ability and greater authority of that particular director to manage in an effective way within the agency and bureaucracy of

government. I say that respectfully. I think this may be a better way to have efficiency, rather than creating an additional bureaucracy. I think it's just the opposite. I think it will be greater efficiency and greater opportunity, greater authority on the part of that person to lead the charge for Indian health improvement.

Mrs. NAPOLITANO. Thank you.

Mr. GIBBONS. Thank you very much.

Are there other members who have questions at this point in time? If not, Mr. Nethercutt, we thank you for your presentation and we will excuse you for now and call up our second panel.

Mr. NETHERCUTT. Thank you, Mr. Chairman.

Mr. GIBBONS. I would now like to call up the second panel on this issue, Mr. Michel Lincoln, Deputy Director, Indian Health Service.

Mr. Lincoln, we have a policy in this Committee of swearing in our witnesses, so if you will rise and take the oath, we would appreciate it.

[Witness sworn.]

Let the record reflect that the witness answered in the affirmative. Mr. Lincoln, welcome to the Committee. The floor is yours. We look forward to your testimony.

STATEMENT OF MICHEL LINCOLN, DEPUTY DIRECTOR, INDIAN HEALTH SERVICE

Mr. LINCOLN. Thank you, Mr. Chairman, and members of the Committee. I am privileged to be here today in front of the Committee to testify on behalf of the Indian Health Care Improvement Act and Title I of the Indian Health Care Improvement Act.

It is my pleasure to say that, indeed, the Department and the Secretary support the reauthorization of the Indian Health Care Improvement Act.

I know it is difficult to talk about Title I in the absence of talking about other issues that are prominent throughout Indian country, and many of those have just been discussed between the dialog with Congressman Nethercutt and members of this Committee.

I should also add another qualification, Mr. Chairman—and I will be giving a brief oral statement—in that I have the distinct privilege, I guess, to have lived as long as I have and had the privilege in 1976 to be around and working in health when the original Indian Health Care Improvement Act was passed by this Congress. I had the privilege, indeed, in follow up to the passage of that Act, to work in help writing the specifications that resulted in the regulations implementing Title I of this Act, primarily the Indian health professions piece, the scholarships, and the loan repayment piece. So I have a little bit of history relative to the impact.

I would like to say, though, as this Committee knows, the Indian Health Service is the primary provider for health care services on behalf of the Federal Government for approximately 1.6 million American Indians and Alaska Natives throughout our great Nation. The mission of the agency is indeed to raise the physical, mental, social and spiritual health of American Indians and Alaska Natives to the highest level, in partnership with the population we serve.

This particular piece of legislation, combined with the Snyder Act, which was passed in 1921, really serves as the basis, the foundation, if you will, for Indian health legislation in this Nation—indeed, the policy that is articulated within those two documents. They are both important documents, especially when taken together, as you look at improvements made over the years.

I would like to say that this bill that is before you has been the result of extensive work between tribal governments, among tribal governments, among Indian health professionals, among the Indian Health Service certainly, and with our colleagues throughout the Department of Health and Human Services. It is a product of genuine thinking, genuine collaboration, and genuine disagreement in many instances. We look forward to working with the Committee as you all consider this bill and move this piece of legislation forward.

I would like to reiterate a couple of statistics that were given for the health status throughout Indian country. I don't believe it is possible to talk about health professions scholarship or health facilities or health services or any other piece of the Indian Health Service programs, or health programs in general, without acknowledging some of the basic statistics.

One of those statistics, indeed, is that alcoholism mortality is 770 percent, the data mentioned before, seven times the U.S. all-races deaths due to alcoholism. Diabetes is four times, accidents are three times higher, suicides two times higher, and homicides two times higher.

I think what is important about these statistics, and maybe the tragedy of what is going on, is that, for the most part, these chronic diseases that Congressman Nethercutt spoke of, certainly including diabetes, but the others that I have mentioned, are all preventable. It seems to me that certainly our new Director, Dr. Charles Grim, is revitalizing and reemphasizing preventive health programs throughout this Nation. There must be a preventive piece in here, not only from a health care standpoint but from a conscience standpoint. It just seems like it's the right thing to do.

I do want to describe these health programs also within the context of great demands and great needs for community development, for economic development, for education opportunities, for all the individuals within the community settings where our families, children and parents live. I believe it is especially important that we not forget about the community view of what this piece of legislation brings in front of us.

I would certainly mention a couple of additional diseases that need to be reemphasized. Congressman Nethercutt, more than I could, has been at the forefront of diabetes, preventing diabetes and treating diabetes. Through the legislation that Congress passed, we will certainly see improvements in diabetes mortality, and hopefully we will see over time a reduction in the incidence of diabetes.

The same needs to be said relative to cardiovascular disease, though. It is indeed the leading cause of death of Indian people throughout this country. It is increasing at a time when cardiovascular disease in most other populations in this Nation is decreasing. So there is the opposite trend, the inverse that is occur-

ring relative to cardiovascular disease in Native American populations.

I would like to move very quickly into a summary and to let you know about very specific information that is not part of my testimony on the health professions piece.

These programs of scholarships and loan repayment have made an impact in Indian country. In 1981, there were only 697 Indian people who were health providers through the Indian Health Service system. In 2002, there are now in excess of 2,500 American Indian and Native Alaska people who are health providers within this health delivery system.

Thirty-seven percent of all of our health providers are now Indian people. In my opinion, that would not have happened in the absence of a focus, a concentrated effort to increase the number of Indian people pursuing the health professions and, quite frankly, providing the opportunities through loan repayment and other kinds of incentives and encouraging those individuals to return to their communities to provide services to their own people.

Mr. Chairman, if I may give you one more set of statistics, I will then end my testimony. An example of the kinds of vacancy rates that are currently within Indian country, indeed, in many ways might mirror the rest of the population for a few of the professions, but in general are worse in Indian country. Right now, today, our vacancy rate for nurses, for professional nurses, is 14 percent. Today, the vacancy rate for physicians is 10 percent. The vacancy rate for dentists is at 22 percent, and for some specialties within these professions, like nurse anesthetists, the vacancy rates are 33 percent. There is a need for Title I to assist these health programs, both tribal, Federal and urban programs, in filling these much needed health providers.

Thank you, Mr. Chairman.

[The prepared statement of Mr. Lincoln follows:]

Statement of Michel Lincoln, Deputy Director, Indian Health Service

Mr. Chairmen and Members of the Committees:

Good morning, I am Michel Lincoln, Deputy Director of the Indian Health Service (IHS). We are pleased to have this opportunity to testify on behalf of Secretary Thompson on H.R. 2440, the Indian Health Care Improvement Act Amendments of 2003, and H.R. 151, the bill to elevate the position of Director of the Indian Health Service within the Department of Health and Human Services to Assistant Secretary for Indian Health. At the Committee's request, I will discuss Title I—Indian Health, Human Resources, and Development of H.R. 2440; and H.R. 151, the bill to elevate the IHS Director.

The IHS has the responsibility for the delivery of health services to more than 1.6 million Federally recognized American Indians and Alaska Natives (AI/ANs) through a system of IHS, tribal, and urban (I/T/U) operated facilities and programs based on treaties, judicial determinations, and Acts of Congress. The mission of the agency is to raise the physical, mental, social and spiritual health of AI/ANs to the highest level, in partnership with the population we serve. The agency goal is to assure that comprehensive, culturally acceptable personal and public health services are available and accessible to the service population. Our foundation is to promote healthy American Indian and Alaska Native people, communities and cultures and to honor and protect the inherent sovereign rights of Tribes.

Two major pieces of legislation are at the core of the Federal government's responsibility for meeting the health needs of American Indians/Alaska Natives (AI/ANs): The Snyder Act of 1921, P.L.67-85, and the Indian Health Care Improvement Act (IHCIA), P.L.94-437. The Snyder Act authorized regular appropriations for "the relief of distress and conservation of health" of American Indians/Alaska Natives. The IHCIA was enacted "to implement the Federal responsibility for the care and edu-

cation of the Indian people by improving the services and facilities of Federal Indian health programs and encouraging maximum participation of Indians in such programs." Like the Snyder Act, the IHCIA provided the authority for the programs of the Federal government that deliver health services to Indian people, but the IHCIA also provided additional guidance in several areas. The IHCIA contained specific language that addressed the recruitment and retention of a number of health professionals serving Indian communities.

I am here today to discuss reauthorization of the IHCIA and tribal recommendations for change to the existing IHCIA in the context of the many changes that have occurred in our country's health care environment since the law was first enacted in 1976. H.R. 2440 reflects the product of an extensive tribal consultation process that took two full years and resulted in a tribally drafted reauthorization bill. IHS and other HHS staff provided technical assistance and support to the Indian Tribes and urban Indian health programs through this lengthy consultation. However, we recognize that our programs overlap and have implications for other Department agencies and their programs, and we are continuing to work with them to develop a comprehensive Administration position on this legislation.

Health Disparities

While the mortality rates of Indian people have improved dramatically over the past ten years, Indian people continue to experience health disparities and death rates that are significantly higher than the rest of the U.S. general population:

- Alcoholism—770% higher
- Diabetes—420% higher
- Accidents—280% higher
- Suicide—190% higher
- Homicide—210% higher

Those statistics are startling, yet they are so often repeated that some view them as insurmountable facts. But every one of them is influenced by behavior choices and lifestyle. Making significant reductions in health disparity rates, and even eliminating them, can be achieved by implementing best practices, using traditional community values, and building the local capacity to address these health issues and promote healthy choices.

A primary area of focus that I have identified based on these statistics is a renewed emphasis on health promotion and disease prevention. I believe this will be our strongest front in our ongoing battle to eliminate health disparities plaguing our people for far too long. Although we have long been an organization that emphasizes prevention, I am calling on the Agency to undertake a major revitalization of its public health efforts in health promotion and disease prevention. Both field and tribal participation in the initial stages of planning and implementation are critical.

Fortunately, the incidence and prevalence of many infectious diseases, once the leading cause of death and disability among American Indians and Alaska Natives, have dramatically decreased due to increased medical care and public health efforts that included massive vaccination and sanitation facilities construction programs. Unfortunately, as the population lives longer and adopts more of a western diet and sedentary lifestyle, chronic diseases emerge as the dominant factors in the health and longevity of the Indian population with the increasing rates of cardiovascular disease, Hepatitis C virus, and diabetes.

Cardiovascular disease is now the leading cause of mortality among Indian people, with a rising rate that is significantly higher than that of the U.S. general population. This is a health disparity rate that the President, the Secretary of Health and Human Services, and the IHS are committed to eliminating. The IHS is working with other HHS programs, including the Centers for Disease Control and Prevention and the National Institutes of Health's National Heart Lung and Blood Institute, to develop a Native American Cardiovascular Disease Prevention Program. Also contributing to the effort is the IHS Diabetes Program, the IHS Disease Prevention Task Force, and the American Heart Association. The primary focus is on the development of more effective prevention programs for AI/AN communities. The IHS has also begun several programs to encourage employees and our tribal and urban Indian health program partners to lose weight and exercise, such as "Walk the Talk" and "Take Charge Challenge" programs.

Diabetes mortality rates have been increasing at almost epidemic proportions. American Indians and Alaska Natives have the highest prevalence of type 2 diabetes in the world. The incidence of type 2 diabetes is rising faster among American Indians and Alaska Native children and young adults than in any other ethnic population, and is 2.6 times the national average. As diabetes develops at younger ages, so do related complications, such as blindness, amputations, and end stage renal disease. Today, however, I want to report to you that we may be seeing a change

in this pattern. In CY 2000 we have observed for the first time ever a decline in mortality. I must note that this is preliminary mortality data that needs to be further examined.

What is most distressing however about these statistics is that type 2 diabetes is largely preventable. Lifestyle changes, such as changes in diet, exercise patterns, and weight can significantly reduce the chances of developing type 2 diabetes. Focusing on prevention not only reduces the disease burden for a suffering population, but also lessens and sometimes eliminates the need for costly treatment options. The cost-effectiveness of a preventative approach to diabetes management is an important consideration, since the cost of caring for diabetes patients is staggering. Managed care estimates for treating diabetics range from $5,000-$9,000 per year. Since the Indian health system currently cares for approximately 100,000 people with diagnosed diabetes, this comes out to a conservative estimate of $500 million just to treat this one condition.

Another area of concern is in behavioral health, specifically the identification and treatment of depression and strategies for prevention of depression. A recent study from Washington University in St. Louis has revealed that untreated depression doubles the risk for chronic diseases like diabetes and cardiovascular disease, not to mention the risks for alcoholism, suicide and other violent events. This study also showed that of those individuals with chronic disease, unrecognized and untreated depression doubles the risk for complications of the chronic disease (e.g., amputations and renal disease in diabetics). We must find the best practices that will allow us to prevent depression primarily, or at the least recognize and treat it early if we are to reduce the disparities that affect Indian communities.

A well-trained, caring staff, supported by sufficient funding, is the best means of successfully addressing these disparities. Programs authorized in Title I help us to obtain these people. Even better, three programs help us to "grow our own," in that they support the development of Indian health professionals.

The most influential of these programs are the scholarship program, authorized in Sections 103 and 104, and the loan repayment program, authorized in Section 110. Over the years, the scholarship program has helped over 7,000 Indian students attend pre-professional and professional school. Its influence can readily be seen in the fact that since 1981, the proportion of IHS health professional staff that is Indian has increased by 131%.

The loan repayment program has served both to attract and retain health professionals. Since its inception in 1988, more than 3,000 health professionals have participated. Many have stayed well beyond the time it took to repay their loans, having found that the IHS practice is what they are seeking.

National shortages in nursing, dentistry, pharmacy and other health professions are having an impact on Indian health programs. We continue our efforts to attract the best. These programs, and others authorized in Title I, help in this effort.

H.R. 151—Elevation of the IHS Director to Assistant Secretary for Indian Health

H.R. 151 proposes to establish within the Department of Health and Human Services an Office of the Assistant Secretary for Indian Health. The IHS is the principal point of contact on behalf of the Department on health matters related to Tribes. It exists because of the solemn promises the Federal government has made to Indian people. On matters of health care, the head of the Indian Health Service acts principally as the administrator of the vast Indian Health Service system, as well as an advocate on behalf of the Indian Health needs of the nation's more than 550 federally recognized Indian Tribes.

Currently, the Director of the IHS enjoys direct access to the Secretary in the Department on all health services issues that have an impact on Tribes and Tribal organizations. In addition, the Director serves as Vice Chair of the Secretary's Intradepartmental Council for Native American Affairs. The Council serves as an advisory body to the Secretary and has the responsibility to assure that Native American policy is implemented across all Divisions in the Department, including human services programs. The Council also provides the Secretary with policy guidance and budget formulation recommendations that span all Divisions of HHS. A profound impact of this Council on the IHS is the revised premise within HHS that all agencies bear responsibility for the government's obligation to the Native people of this country.

It is our view that the Director as the Vice Chair of the Intradepartmental Council for Native American Affairs currently enjoys an elevated status in the Department. He facilitates advocacy, promotes consultation, reports directly to the Secretary, collaborates directly with the Assistant Secretary of Health, advises the heads of all the Department's divisions and coordinates activities of the Department concerning matters related to Native American health and human services issues.

This authority is provided in the Native American Programs Act of 1974. Consistent with the statute, Secretary Thompson has taken steps to assure that this Council receives the highest levels of attention within the Department.

Moreover, the Secretary and Deputy Secretary have traveled widely to Indian Country with their senior staff. These trips have raised the awareness of tribal issues and have contributed greatly to our capacity to speak with one voice, as One Department, on behalf of tribes. Secretary Thompson and Deputy Secretary Allen are daily committed to working with Tribal leaders on Indian health concerns.

The Director, then, currently is assured the same access to the highest levels as other agencies in the Department and it is not necessary to elevate the IHS Director to the level of Assistant Secretary over other agencies serving American Indians/ Alaska Natives (AI/AN).

Summary

In summary, preventing disease and injury is a worthwhile financial and resource investment that will result in long-term savings by reducing the need for providing acute care and expensive treatment processes. It also yields the even more important humanitarian benefit of reducing pain and suffering, and prolonging life. This is the path we must follow if we are to reduce and eliminate the disparities in health that so clearly affect AI/AN people.

As we continue our thorough review of this far-reaching, complex legislation on reauthorization, we may have further comments on Title I. 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 the 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 and other issues. We will be happy to answer any questions that you may have.

Mr. GIBBONS. Thank you very much, Mr. Lincoln.

As we continue our discussion on H.R. 2440, I had a question for you with regard to Title I. Does Title I authorize program funding to provide for training in management health programs, like information technology and business administration?

Mr. LINCOLN. At the current time, this piece of legislation does not include scholarship support or funding for those individuals that are in hospital administration or, quite frankly, as an example, on the business side of the programs and the need that exists within the Indian health programs, both tribal, Federal and urban.

Mr. Chairman, given the complexity of Medicare legislation alone, and the need to be able to fully explain to individuals in Indian country what their entitlements are when they're eligible for Medicaid, requires a slightly different kind of professional working in the community and in these facilities.

We believe your Committee and the Congress should consider these additional professionals as part of a health delivery team, not just the providers.

Mr. GIBBONS. Well, Mr. Lincoln, section 124 of the bill makes the benefits of the scholarship program non-taxable. If this were to happen, would you be able to extend the amounts appropriated for this activity so you could increase the number of scholarships awarded and take into consideration some of these other programs?

Mr. LINCOLN. Mr. Chairman, I very much appreciate your question. As we reviewed this bill, it became fairly apparent that this section 124 is something that we strongly support. It is my understanding that a similar provision exists for the Department of Defense programs and for the National Health Service Corps. We strongly believe this is an important aspect of this bill.

Recent estimates have been given to me that it would increase the number of scholarships of about—I believe the number is between 75 and 100. That sounds like a small number, but given our need, it is a very important group where we could expand access to these programs.

Mr. GIBBONS. Considering the fact that Congress did exempt the National Health Service Corps and the Department of Defense scholarship benefits from being taxed, doesn't the Indian Health Service administer similar scholarship programs to that, like the National Health Service Corps or the Department of Defense, and are they tax-exempt, and if not, should they be tax-exempt?

Mr. LINCOLN. Mr. Chairman, they are very similar programs. Obviously, the Indian health professions piece of the Indian Health Care Improvement Act expands on the one hand efforts to increase the number of Indian people in the health professions in hard-to-recruit locations, and we believe our program should be treated in a similar manner as the National Health Service Corps. This piece of legislation does that.

Mr. GIBBONS. I have just one final question for you, and it has to do with section 110 of the bill, which authorizes loan repayment programs, changing the existing law which would require Indian applications be funded first.

Can you explain how the current authority works and is the amendment contained in section 110 the appropriate change for that? I would ask you to explain for the benefit of the Committee that issue.

Mr. LINCOLN. In section 110, which is where the loan repayment program is described, and the various elements of the loan repayment program, the way the program currently works is that the current law requires the Indian Health Service to identify and prioritize, by profession, the hard-to-fill locations—actually, all the locations throughout the county. So we identify for the industry, as an example, all of the hard-to-fill locations and we rank them, where we are required by law to rank them. The same would be said of nursing, would be said of medicine and the other health professions that are covered by the legislation.

Then we proceed to go forward and use our loan repayment program and give priority to individuals who are going to accept positions in those most difficult positions and locations to be filled.

It is my understanding that this bill continues to require the Indian Health Service to do what I just described, to identify the most needy locations and to prioritize them, but it also requires two other things that are different.

One of the things that it requires is the prioritization of American Indian and Alaska Native applicants for positions. It actually describes that, in doing this and providing this increased priority, it overrides—I think is the language that's used in this legislation—it overrides the priority system that we are required to provide.

The second thing that is required from my understanding of the legislation that is different is that it then establishes a second priority, a second way to look at the filling and awarding of these loan repayments. It gives priority to Indian health programs, tribal health programs and urban programs.

The third priority is then given to other programs, and the way we are understanding the legislation is that that third group, if you will, will be those Indian Health Service employees and locations. So those are the differences between the current legislation and this current bill.

It is our sense that Title I was created to do a couple of things. One of them was to fill the hard-to-fill locations. There are places in this country and Alaska, in the Northern Plains, the Southwest and other places, that are just extremely difficult to recruit health professionals to those locations, and then to keep them and retain them there.

This bill, through its scholarship program, certainly emphasizes the creation of Indian health professionals, and we believe we have already seen recipients of the loan repayment program and others stay longer over time in their jobs than other individuals, so we believe there is a success story.

We would ask that the Committee work with us in reviewing these provisions that you have just mentioned. There must be a way of accomplishing both, of increasing the number of American Indian and Alaska Native health professionals and at the same time filling these hard-to-fill locations.

Mr. GIBBONS. Thank you very much, Mr. Lincoln.

Does anybody else have questions? Ms. Christensen.

Mrs. CHRISTENSEN. Thank you, Mr. Chairman. Good morning.

I am looking at some of the testimony from the next panel, and the representatives of the National Council of Urban Indian Health, the Navajo Nation, and also the National Indian Health Board all support 151, the elevation.

A few of us were talking about this just last week. When we look back at David Satcher, for example, as Surgeon General, many of us feel that the strengthening of his tenure as Surgeon General really had a lot to do with the fact that he was Assistant Secretary as well as Surgeon General.

Is it your sense that raising him to the Assistant Secretary would in any manner diminish his or her ability to carry out the responsibilities on behalf of tribal governments? I'm not sure why the Department does not support 151. Can you just help me better understand that?

Mr. LINCOLN. I believe there is a sincere effort and a reasoned effort on behalf of the Secretary and the Department when it says the current Director of the Indian Health Service has more access to decisionmaking forums and decisionmakers than any other previous Director of the Indian Health Service.

Again, I have had the privilege of being in Washington, D.C., originally from Navajo, for the last 10 to 11 years, so I have had the privilege of working directly as the Deputy Director for three Directors of the Indian Health Service—for Dr Everett Rhoades, for Dr. Michael Trujillo, and now for Dr. Charles Grim. I can unequivocally tell you that Dr. Grim has more access, enjoys more access and more participation with decisionmaking groups than either of the two previous Directors.

I believe the Department and the Secretary sincerely believe that they are providing him with the kind of access not only to themselves but to the other agency heads that make decisions for

funding. This Intradepartmental Council for Native American Affairs, that is mentioned in our testimony, is becoming a central group where the needs of Indian country are not only left at the doorstep of the Indian Health Service to solve and to meet, but now are included with the Administrator for SAMHSA, the Commissioner for the Food and Drug Administration and others. I truly believe the Administration, the Department and our Secretary, believe that in those ways they have opened up the door to Indian country already.

Mrs. CHRISTENSEN. The Secretary won't be there forever. The Council is a creation of the Secretary, and the interaction that now exists, which sounds exemplary, is not guaranteed.

Wouldn't this be a way to ensure that that same relationship to the other agencies would continue to exist, but even beyond that, increase the authority of the Director to influence what happens in SAMHSA? Because right now, yes, they are able to talk with them and are able to access them, but they are not able to influence how those agencies respond to the needs of the tribal governments and the tribes.

Mr. LINCOLN. Two points, Congresswoman. One, the Intradepartmental Council for Native American Affairs is a statutorily created council. It is created within the Native Americans Act, where it identifies this group.

What is unique about this group is that it is now operational. You're correct, in that the Secretary and the Deputy Secretary have breathed life into this Council and have required that these other agency heads, like Mr. Curie of SAMHSA or Dr. Gerberding of CDC and others, to actually set on that Intradepartmental Council for Native American Affairs. So I believe the intradepartmental council will continue because of the statutory basis.

But how any Secretary uses any council like this is at the discretion of the Secretary. I think it might be inappropriate for me to speculate in the future. I think it is more important for me to say that the access is exemplary now, and I think we will be able to measure the increased access to non-IHS, Department of Health and Human Services funds in a very objective way in the near future.

Mrs. CHRISTENSEN. It would just seem to me that since you have established this, the best way to continue it would be to elevate that position.

Thank you, Mr. Chairman.

Mr. GIBBONS. Thank you.

Miss Napolitano.

Mrs. NAPOLITANO. Thank you, Mr. Chair.

I'm going back to services, and under the provision of Title I, it would establish a Native American psychological research program at the University of North Dakota, and it would also provide substance abuse and mental health counseling and coordinate with tribal colleges and other universities to expand such services. That is a critical area in my thinking, in being able to deal with some of the issues that Native Americans and others face.

Is that the only university that is being considered, because as you well know, our tribes are dispersed throughout the United

States. How is that going to work with other universities for that expansion? The provision is not quite clear on that.

Mr. LINCOLN. Thank you for the question.

The Quentin N. Burdick centers—and there are a couple—that are at the University of North Dakota, certainly one of them is to increase Indian people into psychology programs.

Another at the University of North Dakota, a long-standing program, is called the INMED program, which is designed to increase the number of Indian physicians throughout the Nation, a very successful program by the way.

There are other programs throughout the Nation that we believe are necessary, especially in the area of psychology. The other behavioral health sciences, there is great need in Indian country.

Mrs. NAPOLITANO. Sir, I know that. I am aware of that. What I'm asking is how is this going to be dispersed amongst the Indian tribes to be able to help them. I know they are established in North Dakota and other universities, but how are they going to avail themselves or how is that university going to be able to help all the different issues the tribes have?

Mr. LINCOLN. Right now those universities have Indian students from all over the country, not just from that northern tier of States. So they have opened their doors.

What I was going to say, Congresswoman, is that we believe in the Indian Health Service there is greater need for these kinds of programs in other geographic locations. We would want to work with the Committee to discuss with you where those locations would be most logical.

The University of Colorado would be a good example where programs are being developed. The University of Washington has a certain number of programs that exist with that institution, and there are others. The University of New Mexico is another good example. We need to expand their efforts.

Mrs. NAPOLITANO. I understand. That's why I'm asking the question. California has a number of tribes. I don't know which colleges or universities in California are rendering those services to which we can refer some of our Indian population that reside in our districts. So I'm wanting to find out how is this going to be expanded to help all the different tribes in the areas, because all of them, I would think without exception, have issues that can be dealt with under some of these titles.

Mr. LINCOLN. We would be glad to explore this, and we would be glad to bring not only our scholarship people but our—if we're looking at behavioral health, we will bring our Director of Behavioral Health and work with you and your staff. I think we can be a little more detailed at that point.

Mrs. NAPOLITANO. I would appreciate it, Sir. I am the Co-Chair of the Mental Health Caucus, and that's one of the reasons I'm asking. Thank you.

Mr. LINCOLN. Thank you.

Mr. GIBBONS. Thank you.

Mr. Pallone.

Mr. PALLONE. Thank you, Mr. Chairman.

Let me start out by saying I appreciate the fact that the Committee is having this hearing today, because when we had the

joint hearing back with the Senate in the summer, one of the points that many of us made was that the Resources Committee on the House side needed to have some hearings on its own on the issues of the Indian Health Care Improvement Act, because it is such an important bill to Indian country. I think it needs more attention by us on the House side.

Keeping that in mind, though, although I appreciate that we're having the hearing, I wanted to mention, Mr. Chairman, that it really is a hearing on two bills, both of which are important, and my understanding is that the hearing today is only on Title I of the Indian Health Care Improvement Act. I hope that means we're going to have hearings on the other titles, and if you could pass that on to the "powers that be", I would appreciate it.

Could I inquire, is that the case, or don't we know yet?

Mr. GIBBONS. I would have to ask the Chairman of the Committee on that question.

Mr. PALLONE. All right. If we could pass that along, I think it is important to have hearings on the other titles. But I do appreciate that we're doing this today.

What I wanted to ask Mr. Lincoln is by way of background. First of all, I wanted to say that our Congresswoman Christensen and Congresswoman Hilda Solis did a great job of putting together this health disparities legislation that the Democrats are going to introduce in the next couple of weeks. I want to commend them again for doing that because I think it relates directly to Indian country. Although it deals with a number of other minorities, it does relate directly to Indian country.

An important part of that bill, one of the principles that they put forward in this Democratic initiative, is the need to diversify the health care workforce and to increase the number of minorities, be they Native American or whoever, that are involved in delivering health services. The main reason they say that is because they believe, at least from what they tell me, that if you have a diversified workforce and you have more Native Americans involved, then it just means in the long run not only better quality but also more attention is going to be devoted to the issue in some fashion. So I think that Title I is very important in that regard.

There are so many questions that I have about Title I, let me just ask you these. First of all, do you support Title I and do you support the larger Indian Health Care Improvement Act, in general?

Mr. LINCOLN. Yes, we do.

Mr. PALLONE. OK. That's very important because I think it's a good bill and I am one of the cosponsors of it. So I appreciate that.

I believe there is a crisis, not only in Indian health care in general, the quality of the delivery of services, but also a crisis in terms of lack of personnel who are Native American, or even personnel in general. The numbers are unbelievable from what I have seen.

I guess my question is, I believe that this bill accomplishes a great deal in terms of moving in the proper direction, but I wanted to ask you about the specifics in terms of what we're trying to achieve. Obviously, we need more Native Americans who are nurses and doctors, but we also need a lot more people in Indian

country at the IHS hospitals and clinics in addition, whether they're Native American or not, it seems to me. The problem is not only in terms of recruiting people and having adequate scholarships, but also making them stay in some of these rural and remote areas.

So if you could just answer questions about that. In other words, do you think we have done enough or that we're making significant strides in terms of getting Native Americans to become health care professionals, as opposed to non-Native Americans? Do you think we need to emphasize more on just recruiting people to these remote areas, where it's difficult to get people? Third, if you could comment on not only our ability to get people to enter these health professions, but also to stay there long term, because a lot of these things keep them there maybe for a couple of years but are they going to keep them there for a lifetime.

I know that's a lot.

Mr. LINCOLN. Congressman, it's a very, very complex question, and maybe I can break it down in a way that will describe support for the entirety of the Indian Health Care Improvement Act. But I will give you some data that is preliminary but I think important to address the issue of retention and how it might relate to Title I.

The breadth of the Indian Health Care Improvement Act is necessary because if the objective is not just to provide medical care to individuals, but if the objective is to actually improve the health status of those individuals and the communities within which they live, and, if you will, Indian people in general, that's a very complex task. That requires more than just a physician's visit with an individual given an acute episode that's going on. It's incredibly important that that is dealt with, that visit is dealt with, in a culturally appropriate manner, and that the clinical outcome is what is desired.

But the breadth of the Indian Health Care Improvement Act addresses, as an example, replacing these old, outdated facilities that exist in many locations throughout Indian country. I know you have visited Indian country, Congressman, and I think you may have seen some of the best and some of the worst at the same time. But this bill moves us forward relative to the infrastructure that is going to be necessary to provide health care services in this decade that we are now embroiled in.

How does just that one example relate to increasing recruitment and retention? It is more likely that a physician or a nurse coming out of a medical school, a school of nursing, a school of dentistry, or a school of pharmacy, it is more likely they will come to a new facility, one where they can practice the kind of medicine that they've just been trained to practice in. So the idea of being able to recruit and retain somebody, the facilities have a bearing on that.

We know that in our newer constructed facilities the likelihood of somebody staying there is greater than if you're isolated and you don't have the proper staff support, and you're in a building and you don't have the equipment that you need. It is just a common sense kind of thing.

Second, the Indian Health Care Improvement Act, as we think about it in the way it focuses resources and the delivery of health services themselves, the way it prioritizes those services, I think paints an honest picture of what the health status of Indian people is throughout this country, and the kind of interventions that might make sense, both in terms of the basic health care program, focusing on primary care services, ambulatory care within that, it's the kind of a practice that we need to be honest about.

That's what people are going to see. Eight million outpatient visits this last year, that's what you're going to see when you deliver health care, and you're going to see an array of women's health issues, you're going to see an array of issues of youth. The leading cause of death for Indian people between 5 and 45, the highly productive years of young people, are injuries due to automobile collisions. I purposely do not use the word "accidents" because they're rather predictable. If you go out on Friday night and you drink to excess, and you drive on a road that is 50 or 60 miles, narrow and unlit—I'm speaking for our engineers at the moment—it's pretty predictable that the accidents and death mortality is going to be high because people are young and driving fast, and they're driving on roads that aren't well lit, and they may be intoxicated.

If you look at our data and really use the statistics in the way they're supposed to be used, and the way the full bill allows us to analyze, you will come to the conclusion that these deaths due to automobile collisions are not merely accidents. They are not acts of God. You can predict them. Maybe you can't predict the moment, but you can describe that they're going to occur on Friday and Saturday evenings, late in the evening, and they're going to occur as a result of somebody who is tired or somebody who has abused alcohol or some other drug.

This bill, I believe, provides the needed specificity for describing how the Federal Government, working in partnership with tribes, can intervene to improve their health status. I truly believe that, Congressman Pallone.

I also believe that this bill, with additional work, working in collaboration with tribes, the Department, our sister agencies, and the Department of Transportation and the Department of Housing and Urban Development, et cetera, can truly make a difference. I believe this bill needs some additional work and we're prepared to join the Committee, along with the tribes, in doing that work.

Mr. PALLONE. Thank you very much.

Mr. GIBBONS. Thank you very much, Mr. Pallone.

Mr. Lincoln, thank you very much for your testimony here today before the Committee. It's been very enlightening. With that, we will excuse you and call up our third panel today.

Mr. LINCOLN. Thank you, Mr. Chairman.

Mr. GIBBONS. The third panel will be President Joe Shirley, Jr., from the Navajo Nation; Anthony Hunter, President, National Council of Urban Indian Health; and Julia Davis-Wheeler, Co-Chair, National Indian Health Board.

Before you all take your seats, let's me once again swear you in, as is the policy of this Committee.

[Witnesses sworn.]

Let the record reflect that each of the witnesses responded in the affirmative.

With that, I am going to turn to my colleague from Arizona, Mr. Renzi, to introduce one of the witnesses. Mr. Renzi.

Mr. RENZI. Thank you, Mr. Chairman.

I have the distinct pleasure today to welcome from the largest Native American Nation America, the President, Mr. Joe Shirley, Jr. He is our new President of the Navajo Nation, of a proud and honorable people, a people who have served this Nation particularly given the times we're in and in times of war, a nation of fighting men and women. I am grateful and honored to have you here today, sir.

His experience is vast, not just in public service but in the field of social service, helping particularly children in the Navajo Division of Social Services, where he served as Executive Director. He helped in Northern Arizona as our Apache County Supervisor in 1984, where he retired and recently ran for office and won, overwhelmingly, upon the Navajo Nation. His leadership and his passion is well-known throughout all of Northern Arizona, as well as the Southwest.

President Joe Shirley, I am honored to have you here today. Thank you for coming all the way and making this trip.

Mr. Chairman, thank you for the time.

Mr. GIBBONS. Thank you, Mr. Renzi. With that, we will turn to each of our witnesses here today and thank them for their appearance. We will begin with Mr. Shirley. Welcome.

STATEMENT OF HON. JOE SHIRLEY, JR., PRESIDENT, THE NAVAJO NATION, ACCOMPANIED BY ANSIEM ROANHORSE, JR., EXECUTIVE DIRECTOR, NAVAJO DIVISION OF HEALTH

Mr. SHIRLEY. Thank you, Chairman, Congressman Renzi. It is an honor to be here before you and other distinguished members of the Committee on Resources. Thank you for allowing us to be heard today regarding H.R. 2440, the Indian Health Care Improvement Act Reauthorization Amendments of 2003.

My name is Joe Shirley, Jr., President of the Navajo Nation. First, it is in the best interests of the Navajo Nation and other Native Americans that the 108th Congress reauthorize the Indian Health Care Improvement Act. The Act serves nearly 300,000 Navajos residing on and off Navajo land. Native Americans, including the Navajos, have experienced severe disparities in health care and funding for it for many decades. This condition is contrary to the Federal Government's trust responsibility to deliver and fund health care services based on treaties and legislation.

The Navajo Nation, through a 15-member National Steering Committee put in place by the Indian Health Service, assisted with the development of a final agreement between tribes that was submitted to the Indian Health Service and the appropriate committees at the U.S. House of Representatives and Senate.

The unmet health care needs of Native Americans are enormously high compared to the mainstream in the U.S. Heart disease is the number one killer among Navajo people. Health care disparities on Navajo land could be reduced by the improvement of bad dirt roads. Seventy-eight percent of our roads are dirt. Tribal

members, including the elderly, children and the disabled, often must travel hundreds of miles to receive specialized care. Improved roads can mean the difference between life and death. Bad roads, combined with our inadequate communications network, and insufficient funding and resources for health care, increase the health care disparities.

Further, there is a severe Navajo land nursing and dentist shortage. In Fiscal Year 2003, the Indian Health Service awarded 130 Indian Health Service scholarship awards. By expanding Title I, it would help address the challenges with recruitment and retention of direct health care and specialized providers for the most isolated, rural and remote Native American communities.

The Navajo Nation supports a fully funded Indian Health Service scholarship program for a wider range of health care disciplines to be implemented through area offices, not through the Indian Health Service's headquarters office. Working with our area offices allows for a better understanding of the needs of our communities. This is especially valuable to Navajo communities where English is not the only spoken language. Knowledge of our Navajo language, culture and history is vital to communication.

Further, the Navajo Nation supports section 216, which designates the State of Arizona as a contract health service delivery area for the purpose of providing contract health care services to members of federally recognized tribes in Arizona. Considering the high number of Navajos living in urban areas throughout the State of Arizona, and due to their need for quality health care, the Navajo Nation recommendations that section 216 be adequately funded.

Further, Title III would require the Secretary of Health and Human Services to consult with tribes to determine tribal preferences during facilities construction. Consultation with tribes is absolutely necessary. Moneys earmarked for facilities construction costs need to be spent in ways that are consistent with tribal needs and preferences. Additional costs are incurred when corrective actions are undertaken for inconsistencies.

Further, section 301(c) establishes a health care project priority system that is based upon need. The methodology creates a priority listing. The top ten priority inpatient care facilities, outpatient facilities, and specialized care facilities will be listed, along with justifications, costs and methodologies. The Navajo Nation supports this provision because it provides for a government-to-government consultation with tribes and establishes a criteria system that addresses the greatest needs first.

The Navajo Nation requests that those projects currently in phase three of the existing Indian Health Service health facilities construction priority system be grandfathered and integrated into any new proposed facilities priority system. This is critically important for the Navajo Nation, as it has five projects currently in phase three.

Further, the Navajo Nation boundaries span across three States—Arizona, New Mexico and Utah, and three Federal regions and 13 counties. It is estimated that over 80,000 Native American beneficiaries in the Navajo area are eligible for Medicaid, and the majority are members of the Navajo Nation. Currently, Navajo in-

dividuals in three States seeking medical assistance from State Medicaid programs are subjected to three different sets of rules. It is for this reason that the Navajo Nation is planning to establish the Navajo Nation Medicaid Agency, which would also be more culturally relevant.

Section 414 of Title IV would authorize the Navajo Nation as a single state agency for purposes of providing medical assistance to eligible Native Americans residing within the boundaries of the Navajo Nation. The Navajo Nation Medicaid Agency intends to streamline the various requirements and procedures for eligibility, payments, and other functions.

Further, Title V would expand health care assistance for Native Americans residing in urban areas. The Navajo Nation supports Navajo people residing off Navajo land. Navajos are often forced to relocate to urban settings in order to pursue education or employment, and many end up without proper health care.

Still further, most Native American communities suffer from health and social problems related to alcohol and substance abuse. As a result, the Navajo Nation supports a comprehensive treatment model for behavioral health which addresses substance abuse and mental health disorders. Title VII provides a more effective assessment and treatment of an individual in a holistic manner and offers comprehensive care in one department which prevents further referral of a client to several agencies for services.

Still further, the Navajo Nation supports the establishment of a 25-member National Bipartisan Commission on Indian Health Care to study the provision of health care as an entitlement to Native Americans. Health care as an entitlement would serve as a mechanism to improve the delivery of health care services to Native Americans.

Last, regarding H.R. 151, the Navajo Nation supports the elevation of the Director of the Indian Health Service to an Assistant Secretary within the Department of Health and Human Services.

Thank you. I have Mr. Ansiem Roanhorse, Jr. here with me to help answer questions, if there are any questions. Thank you, gentlemen.

[The prepared statement of Mr. Shirley follows:]

Statement of Joe Shirley Jr., President, The Navajo Nation

Introduction

Mr. Chairman, Mr. Vice Chairman and distinguished members of the Committee on Resources, thank you for allowing us to present today:

My name is Joe Shirley Jr., President of the Navajo Nation. On behalf of the Navajo Nation, we are honored to testify on H.R. 2440, the Indian Health Care Improvement Act Reauthorization Amendments of 2003 ("Act"). We firmly believe that it is in the best interest of the Navajo Nation and other American Indians and Alaska Natives that the 108th Congress reauthorizes the Indian Health Care Improvement Act. While the Navajo Nation supports the majority of H.R. 2440, we recommend that minor amendments be made to this Act in order to better address the needs of the Navajo Nation.

The United States Congress enacted the Indian Health Care Improvement Act in 1976 to provide a comprehensive and integrated approach to elevate the health status of American Indians and Alaska Natives to the highest level. The Act has been reauthorized four times over the past 27 years with the most recent reauthorization in 1992. The Act provides authority for appropriation of funding for the following: 1) health professional development; 2) clinical care; 3) preventive health services; 4) facility construction and maintenance of community sanitation improvement; 5) recovery of health care cost from Medicare and Medicaid; 6) urban Indian health

programs; 7) provision of mental health, alcohol and substance abuse, and domestic violence programs; and 8) establishment of a 25-member National Bipartisan Commission to study the provision of health care to American Indians and Alaska Natives as an entitlement.

Over the past several years, in preparation for the reauthorization of the Indian Health Care Improvement Act, the Indian Health Service formed a 15-member "437" National Steering Committee and sponsored a series of Area-wide, Regional, and National Tribal Consultation meetings to discuss specific health care concerns in Native communities and to make recommendations regarding the reauthorization of the Act. The Navajo Nation staff actively participated in the "437" National Steering Committee work and assisted with development of the final proposed "consensus bill" that was submitted to the Indian Health Service and appropriate committees of the United States House of Representatives and the United States Senate.

The Act is critical for purposes of providing health care to over 1.6 million federally recognized American Indians and Alaska Natives through direct Indian Health Service, tribal, and urban Indian health programs. The Act serves over 295,000 Navajo individuals residing on and off the Navajo reservation. American Indians and Alaska Natives, including the Navajo people, have experienced severe disparities in health care, funding and other resources for many decades. This condition is contrary to the federal government's trust responsibility to deliver and fund health care services to the American Indians and Alaska Natives based on treaties and subsequent legislation.

Although the Indian Health Service is severely underfunded, the Navajo Area Indian Health Service has made some positive strides improving the health status of the Navajo people in certain areas. According to the Navajo Area Indian Health Service data, the health status of the Navajo people is better than the general U.S. population in the following areas: 1) cancer deaths particularly breast cancer deaths; 2) heart disease deaths; and 3) low weight births. However, the federal funding for Indian health care has not kept pace in the following factors: 1) medical and overall inflation; 2) rising costs of health care; 3) increasing costs of pharmaceuticals; and 4) offering of competitive salaries and benefits to recruit and retain qualified health care professionals. According to the Indian Health Service Level of Need Funded Methodology, the Navajo Area Indian Health Service receives funds to meet only 54 percent of the health needs of the patient population, and it provides health care services at $1,187 per person while the national average is about $3,582 per person. The unmet health care needs of the American Indians and Alaska Natives are enormously high.

Comments and Recommendations

Title I

The Navajo Nation recognizes, as does the federal government, the severe nationwide nursing shortage. The Navajo Nation believes that education is the foundation for a strong, stable and accountable sovereign tribe. In 2002, the Navajo Nation received over 13,170 applications for tribal scholarship from aspiring Navajo youth who wanted to pursue post secondary education. The Navajo Nation provided scholarship support for only 5,920 applicants and had to turn down over 7,200 Navajo students due to limited tribal resources. Additionally, about 130 Navajo students received Indian Health Service scholarship awards in Fiscal Year 2003. By expanding Title I, the Navajo Nation can get culturally proficient health care providers thereby increasing health care professionals. Further, the expansion of Title I will begin to address the challenges with recruitment and retention of direct health care providers for the most isolated, rural and remote American Indian and Alaska Native communities. Thus, the Navajo Nation continues to support a fully funded Indian Health Service scholarship opportunity, through the Area Office, that funds a wider range of health care disciplines. The Navajo Nation recommends that a greater degree of flexibility and autonomy be provided to the Indian Health Service, tribes and urban Indian health programs to implement Title I. The Navajo Nation appreciates the intent of Title I, which is to increase opportunities for Indian people so that they may return home and become health care providers. This is particularly valuable to American Indian and Alaska Native communities like the Navajo Nation where English is not the only language spoken. The Navajo population includes both traditional and non-traditional people, some of whom speak only Navajo, who need health care providers knowledgeable in Navajo culture, history and language. The Navajo Nation supports efforts where Indian people are educated in health care-related fields and are allowed to return to their communities.

Title II

This Title focuses upon various health initiatives. The Navajo Nation has special interest in Section 215. This section calls for the study and monitoring of programs to determine trends that exist in health hazards posed to Indian miners and Indians on or near reservations and in Indian communities as a result of environmental hazards that may result in chronic and or life-threatening diseases. The Navajo Nation further supports the inclusion of studies with summaries of findings, reports and plans of action. In addition to the provision of Section 215, the Navajo Nation supports compilation of accurate data regarding environmental health issues among Navajos, along with components for education, prevention and treatment while requiring entities charged with causing the health problems to take responsibility and rectify the damages.

Section 216 designates the State of Arizona as a contract health service delivery area for the purpose of providing contract health care services to members of federally-recognized Indian tribes of Arizona. Considering the high number of Navajos living in urban areas throughout the State of Arizona and due to other need for quality health care, the Navajo Nation encourages Congress that Section 216 be adequately funded so that it can be properly implemented.

Title III

This Title focuses on funds spent on construction and/or renovation of Indian Health Service facilities. According to this Title, the Secretary of Health and Human Services shall consult with any Indian tribe that is significantly affected by the facilities expenditure for the purpose of determining and honoring tribal preferences concerning that facility. This type of consultation is absolutely necessary.

Without tribal input regarding the undertaking of any construction and renovation of facilities, there exists a concern regarding self-determination. Also, there is a concern that monies earmarked for such construction costs will not be spent in ways that are inconsistent with tribal needs or preferences and that additional expenses will be incurred when efforts to correct these issues are undertaken.

Section 301(c) establishes a health care project priority system that is based upon need. The proposed methodology is to create a priority list for planning, design, construction and renovation needs. Thereafter, the top ten priority inpatient care facilities, outpatient facilities and specialized care facilities will be listed, along with justifications, costs and methodologies. The Navajo Nation supports this proposal because it: 1) provides for government-to-government consultation with tribes; and 2) establishes a criteria system that addresses the greatest needs first. The Navajo Nation recommends that those projects currently in Phase III of the existing Indian Health Service Health Facilities Construction Priority System be "grandfathered" and integrated into any new proposed facilities priority system. This is of particular importance for the Navajo Nation, as the Navajo Nation has five projects in Phase III, including one alternative rural hospital in Kayenta, Arizona; three health centers in Dilkon, Arizona, Pueblo Pintado, New Mexico, and Bodaway/Gap, Arizona; and a new hospital in Gallup, New Mexico. Technical assistance from the Indian Health Service is critical to place these projects on the national funding list.

The Navajo Nation is seriously concerned with Section 302(c)(3)(A). If this provision were approved, it would gravely widen an already massive backlog of homes to be served with adequate sanitation facilities. Although, despite the availability of amenities, such as running water and electricity, in the majority of homes in the U.S., a home without proper sanitation facility is an all too common reality, especially on the Navajo Nation. In fact, 31.9% of homes on the Navajo Nation lack proper plumbing facilities. The Navajo Nation recommends that the U.S. Congress provide for proper sanitation facilities in all new and existing homes on or in American Indian and Alaska Native communities and homes in order to achieve good public health outcome and to elevate the health status of American Indians and Alaska Natives to the highest possible level, without adversely affecting the funding source of future and existing Indian Health Service programs.

Title IV

The Navajo Nation boundaries span across three states (Arizona, New Mexico and Utah), three federal regions and 13 counties. It is estimated that over 80,000 American Indian beneficiaries in the Navajo Area are eligible for Medicaid and the majority are members of the Navajo Nation. It is for this reason that the Navajo Nation is planning to establish the Navajo Nation Medicaid Agency.

Section 414 of Title IV would authorize the Navajo Nation as a Single State Agency for purposes of providing medical assistance to eligible American Indians and Alaska Natives residing within the boundaries of the Navajo Nation. Currently, on the Navajo Nation, there are three sets of rules with respect to Medicaid services—

one from the State of Arizona, New Mexico and Utah. The Navajo Nation Medicaid Agency intends to streamline the various requirements and procedures for eligibility, payments and other functions. The Navajo Nation anticipates that the medical services will be more culturally relevant to the Navajo population.

Title V

This Title is to expand health care assistance for American Indians and Alaska Natives relocated to, and residing in, urban areas. The Navajo Nation fully supports Indian people residing in off-reservation locations. These individuals are often forced to relocate to off-reservation settings in order to pursue education or employment and many end up without proper health care.

Title VII

The health and social problems related to alcohol and substance abuse continue to rise and affect the lives of many Navajo youth, adults and their families. It is estimated that about 25%, or about 44,843, of the total Navajos residing on the Navajo reservation have alcohol and substance use, abuse and addiction problems. Approximately 35% of the total Navajo population or 35,137 between the ages of 10 and 17 are in the high-risk group, having been exposed to alcohol and substance abuse problems. It is also estimated that about nine of ten or about 161,434 Navajo individuals of all ages are affected by alcohol, substance abuse and other related behavioral health problems. About 50% or 20,000 individuals that are impacted by alcohol and substance abuse are not receiving any services. Due to lack of adequate funds and resources, the Navajo Nation Department of Behavioral Health Services ("Department") is unable to provide service to a large number of high-risk youths and young adults. The Department does provide treatment and counseling services to about 19,000 patients every year. Information and education on alcohol and substance abuse is provided to about 20,000 individuals and families every year and another 14,000 individuals receive prevention, education, treatment and after care services through contracts with other providers. The Tribal Department delivers these services through its 10 outpatient treatment centers, three residential treatment centers, four mobile and outreach programs, and five mental health case management offices.

The occurrence of mental health problems and disorders affects 35% of the total Navajo Nation population between the ages of 15 and 54. About 13 % of the total children and youth aged 9-17 experience serious emotional disturbance and one in five children and youth may have a diagnosable mental, emotional or behavioral problem. Prevalence of major depression among adults aged 45-64 is 2.3% of the total population. It is important to note that co-occurrence of mental and addictive disorders affect the Navajo population. About 37% of the total population with alcohol abuse are also diagnosed with a mental disorder and 53% of the other drug abusers have diagnosed mental disorders as well.

The Navajo Nation staff worked closely with the "437" National Steering Committee and assisted with development of a seamless and comprehensive treatment model for behavioral health that is inclusive of substance abuse and mental health disorders. This new model was incorporated in Title VII and it will provide a more effective way of assessing and treating an individual in a holistic manner and offering comprehensive care in one department, which prevents further referral of a client to several agencies for services.

Title VIII

The Navajo Nation supports the establishment of a 25-member National Bipartisan Commission on Indian Health Care Entitlement to study the provision of health care to American Indians and Alaska Natives as an entitlement. This provision serves as a mechanism to improve delivery of health services to American Indians and Alaska Natives and, as such, the Navajo Nation firmly supports it.

Conclusion

On behalf of the Navajo people, I proudly present our concerns and recommendations to the members of the Committee as a testament to the continual need and improvement to the health and welfare of the Navajo people. Your support and consideration in the area of education, health care reform and self-determination is appreciated. Upon the passage of H.R. 2440 and S. 556, the Navajo Nation hopes that the Indian Health Care Improvement Act fulfills its intent to eliminate the health disparities plaguing Indian Country, thereby enhancing the ability of the Indian Health Service, tribal governments and urban Indian health programs to provide efficient health care services. Mr. Chairman, this concludes my testimony. Thank you for the opportunity to make my statement about the Indian Health Care

Improvement Act Reauthorization of 2003. We will gladly answer any questions that you may have.

Mr. GIBBONS. Thank you very much, Mr. Shirley.

We now will turn to Mr. Anthony Hunter, President of the National Council of Urban Indian Health. Mr. Hunter.

STATEMENT OF ANTHONY HUNTER, PRESIDENT, NATIONAL COUNCIL OF URBAN INDIAN HEALTH

Mr. HUNTER. Good morning, Mr. Chairman. Thank you, members of the House Resources Committee.

I am also a member of the Shinnecock Nation of Eastern Long Island, as well as current President of the National Council of Urban Indian Health, which we affectionately refer to as NCUIH.

On behalf of NCUIH, I would like to express our appreciation for this opportunity to testify before the Committee on H.R. 151 and 2440.

Founded in 1998, NCUIH is the only national organization representing urban Indian health programs. Our programs operate in 41 cities and are often the main source of health care and health information for urban Indian communities. According to the 200 Census, 66 percent of American Indians now live off reservations, and almost all of those Indians live in urban areas.

Over the past few years, the urban Indian health programs have, on average, received slightly more than 1 percent of the Indian Health Service budget. In 1976, Congress passed the Indian Health Care Improvement Act, and the original purpose of this Act was set forth in a contemporaneous House report, which was to raise the status of health care for American Indians and Alaska Natives over a period of 7 years, equal to a level equal to that enjoyed by other American citizens.

It has been 27 years now since that commitment was made, and 20 years since the deadline for achieving it has passed. And yet, Indians, whether reservation or urban, continue to occupy the lowest rung on the health care ladder, with the poorest access to America's extraordinary health care system.

How can this be changed? First, Indian people need a stronger voice in the health care debate. Too often, our views are literally drowned out in the din created by other health care interests. Elevating the position of Director of Indian Health Service to Assistant Secretary for Indian Health will greatly strengthen the voice of Indian country, whether in the halls of the Department of Health and Human Services, or the corridors of Congress, or wherever the health care debate occurs and decisions are made. NCUIH fully supports H.R. 151.

Second, it is important to reauthorize the Indian Health Care Improvement Act. Overall, NCUIH supports H.R. 2440, but we have a number of important concerns that need to be addressed in the legislation before we believe it should be adopted into law.

We have the following recommendations: Regarding Title I, the Indian Health Professions and Scholarship Program, we would like to thank Congress for its support in making the program available to State-recognized Indians. This will greatly broaden the base of Indian people going into that system.

Urban programs are able to take advantage of this to the degree that we are funded to support health professionals. As you may know, some of our programs are outreach and referral programs, very small programs, a very limited number of health professionals available, and very limited funding. Also, the Federal tort claims, which is provided for in the Indian Health Care Improvement Act Reauthorization, would help to support urban programs being able to recruit and retain Indian health care professionals in their programs.

We recommend that the policy statement be amended to restore key references to urban Indians. The congressional policy statement in the existing Indian Health Care Improvement Act specifically references both Indians and urban Indians, which are separately defined terms. However, the equivalent section of H.R. 2440, section 3, paragraphs (1) and (2), do not include a reference to urban Indians. Removing urban Indians from this important policy statement would imply that the Congress no longer considers the health status of urban Indians to be a national priority. This is a very important issue to us and we urge you to maintain the current policy of including both Indians and urban Indians in the policy statement.

Second, to spell out the definition of Indian and Indian tribe. The definition of Indian has been substantially revised in H.R. 2440 from current law, principally by separating out subdefinitions that chiefly apply to urban Indians. NCUIH accepts the definitions, but recommends that instead of defining Indian by referring to another statute, the Indian Self-Determination and Education Assistance Act, that the definition be spelled out.

We have the same concern for the definition of Indian tribe. In Title I, section 123, we ask that urban programs be included in the chronic shortage demonstration projects. In section 127, we ask that urban programs be included in the development and technical assistance programs for community education.

In Title II, we ask that urban programs be included in the Indian Health Care Improvement Fund and the catastrophic health emergency fund. Also in Title II, section 212, we ask that urban programs be rendered the same technical assistance regarding communicable and infectious diseases available to other IHS funded programs. In Title II, section 213, we ask that urban programs be eligible for home- and community-based services, public health functions, and traditional health care.

Urban programs do not participate in the IHS facility priority system established in Title III, which concerns facility construction, maintenance, and enhancement. A good facility is a key part of a good program and we ask for your consideration and including urban programs in this title.

Title V is the urban title of H.R. 2440, which we strongly support. We would like to emphasize particular support for section 512, which makes the Oklahoma City and Tulsa clinic demonstration programs permanent. These two projects have been very successful, and that success is justification for making them permanent.

In conclusion, the entire Indian population, both reservation and urban, is deserving, morally and legally, of support from the

Federal Government in achieving the highest level possible of health care. In my written testimony I have described at length the Federal trust responsibility as it applies to all Indians. NCUIH does not believe that this obligation stops at the reservation boundary. As much as their reservation counterparts, urban Indians have been affected by Federal programs and policies, including the BIA's relocation program of over 160,000 Indians to cities between 1953 and 1962, and the Federal policy of terminating tribes in the 1950s and 1960s.

America is nowhere near the lofty goal set by Congress in 1976 of achieving equal health care for American Indians. I challenge this Committee to think in terms of that goal as it considers H.R. 151 and H.R. 2440. NCUIH thanks the Committee for this opportunity to provide testimony on those bills.

Thank you.

[The prepared statement of Mr. Hunter follows:]

Statement of Anthony Hunter, President,
National Council of Urban Indian Health

Introduction

Honorable Chairman Pombo and Committee Members, my name is Anthony Hunter. I am the President of the National Council of Urban Indian Health (NCUIH) and a member of the Shinnecock Nation of Long Island, N.Y. I am also the Health Director for the American Indian Community House in New York City, N.Y. On behalf of NCUIH, I would like to express our appreciation for this opportunity to address the Committee on H.R. 151, the elevation of the position of the Director of the Indian Health Service within the Department of Health and Human Services to Assistant Secretary, and H.R. 2440, the Indian Health Care Improvement Act Amendments of 2003, and how they impact American Indian/Alaska Natives living off reservation.

Founded in 1998, NCUIH is a membership organization representing 34 urban Indian health programs. Our programs provide a wide range of health care and referral services in 41 cities. Our programs are often the main source of health care and health information for urban Indian communities. In this role, they have achieved extraordinary results, despite the great challenges they face. According to the 2000 census, 66% of American Indians live in urban areas, up from 45% in 1970 and 52% in 1980 and 58% in 1990. We expect that these percentages will continue to increase over the next ten years. It should be added that the American Indian population is widely considered the most undercounted group in the Census. Although the total number of Indians may actually be low, our experience is that the relative percentage of urban versus reservation Indians is accurate. Like their reservation counterparts, urban Indians historically suffer from poor health and substandard health care services.

Federal Responsibility for Urban Indians

As with Indian tribes, there is a specific Federal obligation to urban Indians. Congress enshrined its commitment to urban Indians in the Indian Health Care Improvement Act where it provided:

> "That it is the policy of this Nation, in fulfillment of its special responsibility and legal obligation to the American Indian people, to meet the national goal of providing the highest possible health status to Indians and urban Indians and to provide all resources necessary to effect that policy."

25 U.S.C. Section 1602(a) (emphasis added). In so doing, Congress has articulated a policy encompassing a broad spectrum of "American Indian people." Notably, as originally conceived, the purpose of the Indian Health Care Improvement Act was to extend IHS services to Indians who live in urban centers. Very quickly, the proposal evolved into a general effort to upgrade the IHS. See, A Political History of the Indian Health Service, Bergman, Grossman, Erdrich, Todd and Forquera, The Milbank Quarterly, Vol. 77, No. 4, 1999.

Similarly, in the Snyder Act, which for many years was the principal legislation authorizing health care services for American Indians, Congress broadly stated its commitment by providing that funds shall be expended "for the benefit, care and assistance of the Indians throughout the United States for the following

purposes:...For relief of distress and conservation of health." 25 U.S.C. Section 13 (emphasis added). Congress enunciated its objective with regard to urban Indians in a 1976 House Report: "To assist urban Indians both to gain access to those community health resources available to them as citizens and to provide primary health care services where those resources are inadequate or inaccessible." H.Rep. No. 9-1026, 94th Cong., 2d Sess. 18, reprinted in 1976 U.S. Cong. & Admin. News (USCAN) 2652, 2657. As noted above, in Acts of Congress, as well as in both Senate and House reports, there has been an acknowledgment of a Federal responsibility for urban Indians.

The Supreme Court and other Federal courts have also acknowledged that there is a Federal responsibility towards Indians, both on and off their reservation. "The overriding duty of our Federal Government to deal fairly with Indians wherever located has been recognized by this Court on many occasions." Morton v. Ruiz, 415 U.S. 199, 94 S.Ct. 1055, 39 L.Ed.2d 270 (1974) (emphasis added), citing Seminole Nation v. United States, 316 U.S. 286, 296 (1942); and Board of County Commissioners v. Seber, 318 U.S. 705 (1943). In areas, such as housing, the Federal courts have found that the trust responsibility operates in urban Indian programs. "Plaintiffs urge that the trust doctrine requires HUD to affirmatively encourage urban Indian housing rather than dismantle it where it exists. The Court generally agrees." Little Earth of United Tribes, Inc. v. U.S. Department of Justice, 675 F. Supp. 497, 535 (D. Minn. 1987). "The trust relationship extends not only to Indian tribes as governmental units, but to tribal members living collectively or individually, on or off the reservation." Little Earth of United Tribes, Inc. v. U.S. Department of Justice, 675 F. Supp. 497, 535 (D. Minn. 1987) (emphasis added). "In light of the broad scope of the trust doctrine, it is not surprising that it can extend to Indians individually, as well as collectively, and off the reservation, as well as on it." St. Paul Intertribal Housing Board v. Reynolds, 564 F. Supp. 1408, 1413 (D. Minn. 1983) (emphasis added).

> "As the history of the trust doctrine shows, the doctrine is not static and sharply delineated, but rather is a flexible doctrine which has changed and adapted to meet the changing needs of the Indian community. This is to be expected in the development of any guardian-ward relationship. The increasing urbanization of American Indians has created new problems for Indian tribes and tribal members. One of the most acute is the need for adequate urban housing. Both Congress and the Minnesota Legislature have recognized this. The Board's program, as adopted by the Agency, is an Indian created and supported approach to Indian housing problems. This court must conclude that the [urban Indian housing] program falls within the scope of the trust doctrine...."
>
> Id. at 1414-1415 (emphasis added).

This Federal Government's responsibility to urban Indians is rooted in basic principles of Federal Indian law.

The United States has entered into hundreds of treaties with tribes from 1787 to 1871. In almost all of these treaties, the Indians gave up land in exchange for promises. These promises included a guarantee that the United States would create a permanent reservation for Indian tribes and would protect the safety and well-being of tribal members. The Supreme Court has held that such promises created a trust relationship between the United States and Indians resembling that of a ward to a guardian. See Cherokee Nation v. Georgia, 30 U.S. 1 (1831). As a result, the Federal government owes a duty of loyalty to Indians. In interpreting treaties and statutes, the U.S. Supreme Court has established "canons of construction" that provide that: (1) ambiguities must be resolved in favor of the Indians; (2) Indian treaties and statutes must be interpreted as the Indians would have understood them; and (3) Indian treaties and statutes must be construed liberally in favor of the Indians. See Felix S. Cohen's Handbook of Federal Indian Law, (1982 ed.) p. 221-225. Congress, in applying its plenary (full and complete) power over Indian affairs, consistent with the trust responsibility and, as interpreted pursuant to the canons of construction, has enacted legislation addressing the needs of off-reservation Indians.

The Federal courts have also found, that the United States can have an obligation to state-recognized tribes under Federal law. See Joint Tribal Council of Passamaquoddy v. Morton, 528 F.2d 370 (1st Cir. 1975). Congress has provided, not only in the IHCIA, but also in NAHASDA, that certain state-recognized tribes or tribal members are eligible for certain Federal programs. 25 U.S.C. Section 4103(12)(A).

In sum, the Federal government's trust obligation to protect American Indians does not stop at the reservation boundary.

Federal Policy and the Development of Urban Indian Communities

Urban Indian communities have principally developed as a result of misguided Federal programs or actions, such as the Bureau of Indian Affairs relocation program, which relocated 160,000 Indians to cities between 1953 and 1962. Today, the children, grandchildren and great-grandchildren of these Indians continue to reside in these cities. They maintain their tribal identity even if, in some cases, they have been unable to re-establish ties, including formal membership, with their tribes. While most, but not all, urban Indians are enrolled in federally recognized tribes, all are Indian descendants. Their circumstances are principally the result of Federal Indian policies; they are deserving, morally and legally, of support from the Federal government in achieving the highest possible health status.

There are a number of Federal programs and policies which have led to the formation of the urban Indian population, including:

- The BIA relocation program relocated 160,000 Indians to cities between 1953 and 1962. Today, the children, grandchildren and great-grandchildren of these Indians are still in these cities;
- The failure of Federal economic policies on reservations has forced many Indians to seek economic refuge in the cities;
- The Federal policy of "terminating" tribes in the 1950s and 1960s, many of which have not yet been restored to recognition;
- The marginalization of tribal communities such that they exist but are not federally recognized;
- Indian service in the U.S. military brought Indians into the urban environment;
- The General Allotment Act resulted in many Indians losing there lands and having to move to nearby cities and towns;
- Court-sanctioned adoption of Indian children by non-Indian families; and
- Federal boarding schools for Indians.

Some of these federal policies were designed to force assimilation and to breakdown tribal governments; others may have been intended, at some misguided level, to benefit Indians, but failed miserably. One of the main effects of this "course of dealing," however, is the same: the creation of an urban Indian community.

Funding Inequities

Since the first official funding for urban Indian health through the Indian Health Service in 1979, the urban Indian health program has received just over 1% of the total Indian Health Service annual appropriation (although, as noted above, 66% of Indians now live in urban areas).

During the decade of the 1990s, Congress increased funding for urban Indian health by 113% from $13,049,000 in 1990 to $27,813,000 in 2000. During this same period, the number of Indian people moving to American cities was on the increase. Estimates from the 1990 census found that more than 1.3 million Indian people were living in American cities out of the 2.4 million people self-identifying at that time. The 2000 census shows that of the 4.1 million people self-identifying as American Indian or Alaska Native, 2.87 million are urban. Just like the on-reservation programs, urban Indian programs have experienced a constant increase in the demand for our services. In fact, the increase in the urban area is likely greater than the increase on the reservation.

Throughout its history, the urban Indian health program has never received a substantial boost to its funding base. Annual increases offered by the Congress average only about $30,000 per program in new funding each year. While we are grateful for any and all new dollars allocated to Indian health, the reality is that urban programs are finding themselves with increasing numbers of people in need and a declining supplemental financial base to cover rising costs. As a result of this lessened funding, urban Indian programs can only service 95,767 of the estimated 605,000 urban Indians eligible to receive services.

For FY 05, the National Council of Urban Indian Health recommended a $6 million increase to the Urban Indian Health line item of the IHS budget. Subsequently, the Senate Committee on Indian Affairs recommended an increase to the urban Indian health program from its current proposed 2004 funding level of $32 million to $48 million, a 50% increase. NCUIH believes that an adjustment of $6 million or more would be an important step in reinforcing urban Indian health efforts for this nation.

As Urban Indian Health Programs prepared for the FY05 Budget we have identified 19 program priorities of equal importance. These priorities are:

1. Diabetes
2. Cancer
3. Alcohol and Substance Abuse
4. Heart Disease

5. Mental Health
6. Maternal and Child Health
7. Dental Health
8. Injuries
9. Elder Health
10. Respiratory / Pulmonary
11. Violence / Abuse
12. Infectious Disease
13. Hearing Disease
14. Eye Disease
15. Health Promo / Disease Prevention
16. Tobacco Cessation
17. Information Technology Support
18. Maintenance and Repair
19. Facilities and Environmental Health Support

With the Urban Indian Health Program occupying only 1% of the total IHS Budget it is extremely imperative for urban programs to obtain supplemental funding to remain in operation. Urban Indian Health Programs access roughly $7 million in federal funds outside of the Indian Health Service. These funds include Sections 229, 330, 340 of the Public Health Service Act, Maternal and Children's Health Block grant, and Title V Public Health Care Service, and Women, Children and Infant Program, a supplemental of WIC.

NCUIH acknowledges that there are some sound reasons why the lion's share of the IHS budget should go to reservation Indians. However, we believe that the disparity is too great. All Indian people are connected. Disease knows no boundaries. There is substantial movement back and forth from reservation to urban Indian communities. The health of Indian people in urban areas affects the health of Indian people on reservations, and visa versa. We strongly believe that the health problems associated with the Indian population can be successfully combated only if there is significant funding directed at both the urban and reservation populations.

Elevation of the Indian Health Service Director—H.R. 151

NCUIH strongly supports the elevation of the Director of the Indian Health Service to Assistant Secretary for Indian Health as provided for in H.R. 151. One reason why the status of Indian health has improved so slowly since Congress announced its commitment in 1976 is that Indian people do not have sufficient influence in the health care debate. Too often, our voices are literally drowned-out by the cacophony of other health care interests. For example, when we hear that the Director of IHS cannot attend certain meetings because of his lesser position, it is time for a change. Protocol should never come at the price of common sense and the health needs of Americans, Indian or otherwise. Elevating the position of the Director of Indian Health Service to Assistant Secretary for Indian Health will greatly strengthen the voice of Indian country, whether in the halls of the HHS, the corridors of Congress, or wherever the health care debate occurs and decisions are made.

Indian Health Care Improvement Act

In 1976, Congress passed the Indian Health Care Improvement Act. The original purpose of this act, as set forth in a contemporaneous House report, was "to raise the status of health care for American Indians and Alaska Natives, over a seven-year period, to a level equal to that enjoyed by other American citizens." House Report No. 94-1026, Part I, p.13 (emphasis added).

The Senate has recognized that Congress also has an obligation to provide health care for Indians, that includes providing health care to those who live away from the reservation.

> "The responsibility for the provision of health care, arising from treaties and laws that recognize this responsibility as an exchange for the cession of millions of acres of Indian land does not end at the borders of an Indian reservation. Rather, government relocation policies, which designated certain urban areas as relocation centers for Indians, have, in many instances, forced Indian people who did not [want] to leave their reservations to relocate in urban areas, and the responsibility for the provision of health care services follows them there."

Senate Report 100-508, Indian Health Care Amendments of 1987, Sept. 14, 1988, p. 25 (emphasis added).

Although the road ahead to equal health care still appears to be a long one for Indians, including urban Indians, NCUIH believes H.R. 2440 is a step in the right direction. As a general matter, NCUIH supports H.R. 2440, although we do

recommend certain changes to maintain Congress' commitment to urban Indians in H.R. 2440.

Definitions

The definition of "Indian" has been substantially revised in H.R. 2440 from current law, principally by separating out sub-definitions that chiefly apply to urban Indians. NCUIH has accepted the new structure, but has recommended that instead of defining "Indian" by referring to another statute (ISDEAA), NCUIH believes that the definition should be spelled out for clarity's sake. Therefore the definition should read: "The term 'Indian' means a person who is a member of an Indian tribe." This also avoids any concern that the definitional change is intended to incorporate other aspects of the ISDEAA.

TITLE I

SEC. 123. HEALTH PROFESSIONAL CHRONIC SHORTAGE DEMONSTRATION PROGRAMS.

Under this section, urban programs are not eligible to apply for chronic shortage demonstration projects. Urban programs are not immune to the same chronic shortages of health professionals that IHS and Tribal Health Programs face. NCUIH urges amendment of this section to include the urban programs as possible sites for demonstration projects.

SEC. 127. MENTAL HEALTH TRAINING AND COMMUNITY EDUCATION PROGRAMS.

This section includes urban Indian programs in the study of mental health providers that will develop the training criteria for those providers. However, this section fails to ensure that urban Indian health providers are included in the development and technical assistance for community education. This is a concern because urban programs are often left out of training and technical assistance programs that are provided for tribal and IHS personnel.

TITLE II

Urban Indian Health Programs are not authorized in the current or proposed legislation in sections 201 and 202 to benefit from the Indian Health Care Improvement Fund (IHCF) or the Catastrophic Health Emergency Fund (CHEF). Lack of authorization for urban ICHF requires that urban programs divert funding from their current contracts to address community health needs or seek other funding sources outside of the Indian Health Service. If urban Indian health programs were authorized to access IHCF there would be more of a focus on development and provision of services to Indian patients versus the total patient population, which includes insured non-Indian patients who are seen in their clinic. IHCF for urban Indian health programs also would reduce the need for urban Indian health programs to diversify their funding sources to the extent that some programs have, e.g. one program has as many as 60 different funding sources. The administrative savings would benefit all urban Indian health programs. Currently, tribal members who reside in the New York metropolitan area, without any type of insurance, who have a catastrophic illness or are a victim of a disaster have only three options: 1. Seek care at their home reservation and wait for up to 6 months until the tribal/IHS contract health care eligibility guidelines apply; 2. Apply for Medicaid and other indigent care insurance; or 3. Nothing.

SEC. 212, PREVENTION, CONTROL, AND ELIMINATION OF COMMUNICABLE AND INFECTIOUS DISEASES

This section includes urban programs in the consultation and reporting processes but limits project and technical assistance funding that is available to tribes and tribal organizations. We urge that this assistance also be extended to urban programs.

SECTION 213

This section eliminates urban Indian health programs from authorization of funding for certain critical services, primarily home- and community-based services, public health functions and traditional health care. These services are highly needed within urban Indian health centers. Although, the urban population may not be located in an isolated rural community, a need exists to be able to provide in-home care to elderly and disabled persons who are not able to navigate the urban area due to lack of transportation or failing health.

TITLE III

This section is limited to facility construction, maintenance and enhancement. Unlike tribes and Indian Health Service, both current and proposed legislation does not permit urban programs to participate in the facility priority system for funding of health clinics. Several urban Indian health programs have either purchased or built their own facilities through commercial loans, capital improvement funds or utilization of third party revenue received. However, these types of funding are often difficult to secure and most times are not available to limited direct service and outreach/referral programs. A good facility ensures that the community has a stable location. Urban centers that lease are faced with increasing rental costs and no sense of ownership by the community. Programs that have had to move have found it very expensive and time consuming.

TITLE IV

This section speaks to the federal trust responsibility through the authorization to disregard payments received by tribes, tribal organizations and urban programs in determining funding appropriations for health care and services to Indians. In recent years Indian health programs have not received adequate funding to provide comprehensive services to Indian people. Although, it appears that appropriations have increased, these increases have not kept up with medical rate of inflation, general inflation increases, salary increases or population growth.

This section also authorizes urban Indian health programs to recover reasonable charges for services for individuals who have private or public medical insurance. It is very important for urban health programs to receive reimbursement from health insurance, Managed Care Organizations, CHIP, Medicare and Medicaid when the Indian patient is enrolled with the plan, although urban Indian health organizations are considered to be an "out of network provider."

TITLE V

Title V is the heart and soul of the IHCIA for the urban Indian health programs. This section creates 36 urban Indian health programs and 12 urban alcohol a.k.a. "NIAAA" programs. This section also serves as the guidelines for creating other urban Indian health programs.

Items of note include the ability of current programs to create satellite clinics to better address the health needs of the Indian community. This is vital because many programs are located in large metropolitan cities such as Los Angeles, San Francisco, Chicago or Denver and have a large concentration of Indian people in their area.

Section 509 authorizes, for the first time, grants to urban programs for the lease, purchase, renovation, construction or expansion of these facilities. It also establishes a revolving facilities loan fund that will be used solely for the purposes of urban facilities. The proposed fund would be self-sustaining. Facilities funding is a great need for almost every urban Indian health program. An important note in this section is that the urban programs do not have access to funds for maintenance and improvement of their facilities. The program in Boston currently resides in a very old State institution that utilizes skeleton keys for some of its offices.

Section 511 deals only with the issue of substance abuse; however throughout Title VII urban Indian health programs and urban Indians are included in this behavioral health section. Not to discount the substance abuse needs of urban Indians, it would better serve the urban Indians to be carried throughout Title VII because of its comprehensive look at both mental health and substance abuse issues for Indian people.

NCUIH recommends that Section 512, the Oklahoma City and Tulsa Clinics provision, should be made permanent and not subject to the Indian Self Determination and Education Assistance Act. As you may know, the Oklahoma City and Tulsa Clinics have been very successful. That success is the justification for making these projects permanent. It is not, however, a justification for changing their status as urban Indian programs. While their success is an incentive for some to urge such a change, there is a real risk that a change, for no substantive reason, could unnecessarily jeopardize the success of these programs and undo all of their accomplishments.

TITLE VIII

The establishment of a National Bipartisan Commission on Indian Health Care Entitlement is welcome. Healthcare for Indian people must be viewed as an entitlement versus a discretionary program.

Conclusion

America is nowhere near the lofty goal, set by the Congress in 1976, of achieving equal health care for American Indians, whether reservation or Urban. It has been twenty-seven years since Congress committed to raising the status of Indian health care to equal that of other Americans, and yet, Indians, whether reservation or urban, continue to occupy the lowest rung on the health care ladder, with the poorest access to America's vaunted health care system. NCUIH challenges this Committee to think in terms of that goal as it considers H.R. 151 and H.R. 2440. We believe that these legislative measures will result in the betterment of health for all Indian people regardless of where they live, and reduce health disparities for Indian people. NCUIH thanks this Committee for this opportunity to provide testimony. We strongly urge your positive action on the matters we have addressed today.

Mr. RENZI [presiding]. Mr. Hunter, I want to thank you for your articulation. In speaking with staff, I want you to know that the silence on the definition as it relates to urban Indians is no intention to omit. You have our commitment that we will work with you now to fix it before markup, so that at markup the language will be included.

I would ask that we please get together. I know there was representatives from the urban Indian association that were included in the beginning, and if we need to move forward with some technical changes, we are willing to do that, OK?

Mr. HUNTER. Thank you.

Mr. RENZI. You deserve it, you absolutely deserve it.

We're going to move now to Julia Davis-Wheeler, who is Co-Chair of the National Indian Health Board. Julia.

STATEMENT OF JULIA DAVIS-WHEELER, CHAIRPERSON, NATIONAL INDIAN HEALTH BOARD

Ms. DAVIS-WHEELER. Good morning, distinguished members of the House Resources Committee. As stated, my name is Julia Davis-Wheeler, and I am Chairperson of the National Indian Health Board. I also serve as Co-Chair of the Steering Committee on the Indian Health Care Improvement Act.

I would like to have the House Resources Committee also recognize another Board member that is with me, Chairwoman from the San Carlos tribe, Kathy Kitcheyan. She is sitting behind me. She is also a member of the National Indian Health Board.

As I stated, the NIHB has served since 1972 all the federally recognized American Indian and Alaska Native governments in advocating for the improvement of Indian health care delivery to American Indians and Alaska Natives.

I would like to speak to you about the elevation of the Director of the Indian Health Service to the Assistant Secretary level. I'm just going to say a few words before I do, though, about Secretary Tommy Thompson.

As a tribal leader, I have publicly stated that I feel very comfortable in saying that Secretary Thompson has been a most accessible Cabinet Secretary in this Administration. He has made every effort possible to visit with tribal leaders. Just last month, he toured several villages throughout the State of Alaska and capped off his visit by hosting a listening session with tribal governments from the States of Alaska, Idaho, Oregon and Washington.

Tribal leaders have long pushed for the elevation of the status of the Indian Health Service Director to the Assistant Secretary level. This has been going on for the past 6 years. The National Indian Health Board, as well as the National Congress of American Indians, have passed resolutions at our General Assembly sessions supporting this elevation.

H.R. 151, elevating the Director, is quite appropriate. As stated earlier, it reflects the government-to-government relationship between the United States and the tribal governments. It is very important to Indian country that we are extremely hopeful that it finally is signed into law this year. The National Health Board supports H.R. 151 as it ensures American Indians and Alaska Natives that their health issues remain a priority beyond this current Administration.

As we advance this legislation, we would like to take adequate steps to ensure that we build on the improvements that have been made within the DHHS over the past few years in addressing tribal issues, and further, that the Indian Health Service does not become isolated from other DHHS's. We recommend that the legislation, indeed, places the IHS Director at the level of Assistant Secretary, but it do so in a manner which does not diminish the Secretary's responsibilities to carry out the Federal Government's trust responsibility.

As I mentioned previously, over the past several years American Indians and Alaska Natives have slowly crept into the mindset of nearly all areas of DHHS. The raised awareness is attributable to several things, including the informed personnel within the office of the Secretary and the hard work of the DHHS officials to advance issues internally and, most importantly, the persistence of tribal governments to ensure that the purpose and intent of the Executive order mandating tribal consultation is properly carried out.

One of the more significant examples of the increased awareness and acknowledgment of the importance of Indian issues within the Department is the revival of the Secretary's Intradepartmental Council on Native American Affairs, which the Indian Health Service Director serves as vice-chair. We, as tribal leaders, feel that it is appropriate that H.R. 151 incorporate language that places the IHS Director as Chair or Co-Chair of the Secretary's Intra-departmental Council on Native American Affairs. The IHS Director currently serves as Vice-Chair.

Now I would like to speak to you on the Indian Health Care Improvement Act Reauthorization. I am going to be brief this morning. I realize that the Committee members are quite of the need and the purpose of the reauthorization.

In addition to me as Chair of the National Indian Health Board, I stated earlier that I serve as Co-Chair of the National Steering Committee, with Rachel Joseph, Chairperson of the Lone Pine Paiute Shoshone Tribe. The National Ateering Committee was formed in 1999 to develop and submit recommendations for changes to the Indian Health Care Improvement Act.

Over the last several years, the National Steering Committee has worked closely with American Indian and Alaska Native tribal leaders, the Administration, Congress and the Indian Health Service to develop amendments to the Indian Health Care Improvement

Act. We have proceeded with this process in a spirit of cooperation and negotiation and the language has gone through numerous changes. The end product is the language of H.R. 2440.

At this time I would like to discuss Title I, the Indian Health Human Resource Development. While other titles may garner more attention due to their potential fiscal impact, Title I addresses the critical need to increase the number of American Indian and Alaska Natives entering the health professions. Health care remains the top priority in Indian country. It is critical to the existence of our people.

I see that the light is on. I just need to break away from my summation comments and let the House Committee members know here today that it is, indeed, a legislation that we feel as a national steering committee that we would truly and honestly like to see passed in the 108th Congress.

I just flew in last night from St. Paul. The National Indian Health Board is having their conference there. Dr. Grim is at that meeting right now. I informed the assembly before I left that I was coming to testify. There is so much support from all of the American Indians and Alaska Native governments for this legislation. I impose on you to look at this legislation very carefully and to consider the under-funding that we, as tribal governments, have gone through for years and years, and give this legislation its proper passage.

Thank you.

[The prepared statement of Ms. Davis-Wheeler follows:]

Statement of Julia Davis-Wheeler, Chairperson,
National Indian Health Board, Council Member, Nez Perce Tribe

Chairman Pombo, Ranking Member Rahall, and distinguished members of the House Resources Committee, I am Julia Davis-Wheeler, Chairperson of the National Indian Health Board. I am an elected official of the Nez Perce Tribe, serving as Council Member. On behalf of the National Indian Health Board, it is an honor and pleasure to offer my testimony this morning on efforts to elevate the Indian Health Service Director to the position of Assistant Secretary of Health and to reauthorize the Indian Health Care Improvement Act.

The NIHB serves nearly all Federally Recognized American Indian and Alaska Native (AI/AN) Tribal governments in advocating for the improvement of health care delivery to American Indians and Alaska Natives. We strive to advance the level of health care and the adequacy of funding for health services that are operated by the Indian Health Service, programs operated directly by Tribal Governments, and other programs. Our Board Members represent each of the twelve Areas of IHS and are elected at-large by the respective Tribal Governmental Officials within their regional area.

Indian Health Service Director Elevation to Assistant Secretary of Indian Health

Before I begin discussing H.R. 151 to elevate the Indian Health Service Director to the position of Assistant Secretary of Indian Health, I would like to say a few words about the Secretary of Health and Human Services, Mr. Tommy G. Thompson. As a Tribal leader, I have publicly stated that I feel very comfortable in saying that Secretary Thompson has been the most accessible Cabinet Secretary in this Administration. He and his immediate staff have been available at every possible opportunity to visit with tribal leaders and to see firsthand the health needs of our people. Just last month, he toured several villages throughout the State of Alaska, and capped off his visit by hosting a listening session with Tribal governments from the States of Alaska, Idaho, Oregon and Washington.

Also, the National Indian Health Board is very pleased to have Dr. Charles Grim serving as Director of the Indian Health Service (IHS). We have supported his nomination from the beginning and, in fact, our Vice Chair, H. Sally Smith, held the Bible that was used to swear-in Dr. Grim. We appreciate his willingness to take on

such a significant role. He is actually in Saint Paul, Minnesota, today participating in our annual conference.

Tribal leaders have long pushed for elevating the status of the IHS Director as a means to recognize the importance of the federal government's functions in carrying out its trust responsibility to American Indian and Alaska Native Tribal governments. The intent of H.R. 151 is quite appropriate as it does just that in a manner consistent with the government-to-government relationship between the United States and Tribal governments. H.R. 151 is very important to Indian Country and we are extremely hopeful that it is finally signed into law this year. The National Indian Health Board is very supportive of H.R. 151 as it ensures American Indian and Alaska Native health issues remain a priority beyond this current Administration.

As we advance this legislation, we want to take adequate steps to ensure that we build on the improvements that have been made within the Department of Health and Human Services (DHHS) over the last few years in addressing Tribal issues and further, that the Indian Health Service does not become isolated from other areas of DHHS. We feel that this can be accomplished with minor revisions to H.R. 151.

We recommend that the legislation indeed places the IHS Director at the level of Assistant Secretary of Indian Health, but do it in a manner which does not diminish the Secretary's responsibilities to carry out the federal government's trust responsibility to Tribal governments.

As I mentioned previously, over the past several years, American Indian and Alaska Native issues have slowly crept into the mind-set of nearly all areas of DHHS. They raised awareness and are attributable to several things, including the informed personnel within the Office of the Secretary, the hard work of DHHS officials to advance issues internally, and, most importantly, the persistence of Tribal governments to ensure that the purpose and intent of the Executive Order mandating Tribal consultation is properly carried out.

One of the more significant examples of the increased awareness and acknowledgment of the importance of Indian issues within the Department is the revival of the Secretary's Intradepartmental Council on Native American Affairs, which the Indian Health Service Director serves as Vice Chair. We feel that it is appropriate that H.R. 151 incorporate language that places the IHS Director as Chair of the Secretary's Intradepartmental Council on Native American Affairs.

Because of the many critical issues that need to be addressed within the Department of Health and Human Services, we feel that any changes to the structure of the Department must be done in a manner that does not isolate Indian health issues, but instead makes these issues a common thread among all Department areas.

Indian Health Care Improvement Act Reauthorization

Given the previous joint House and Senate hearing on the Indian Health Care Improvement Act, I'm going to be brief this morning. I realize the Committee members are quite aware of the need and purpose of the reauthorization; therefore I would like to focus on the efforts of Tribal leaders to craft H.R. 2440 in a way that addresses previous concerns raised by the Administration and responds to the current political realities facing Congress.

National Steering Committee for the Reauthorization of the Indian Health Care Improvement Act (IHCIA)

In addition to my position as Chair of the National Indian Health Board, I also serve as the Co-Chair of the National Steering Committee for the Reauthorization of the Indian Health Care Improvement Act (IHCIA). Rachel Joseph, Chairperson of the Lone Pine Paiute Shoshone Tribe, serves as the other Co-Chair. The NSC was formed by the Indian Health Service in 1999 to develop and submit recommendations for changes to the Indian Health Care Improvement Act. The NSC is comprised of elected tribal representatives throughout Indian Country, and also includes urban health program representation.

Over the last several years, the NSC has worked closely with American Indian and Alaska Native Tribal leaders, the Administration, Congress, and the Indian Health Service to develop amendments to the Indian Health Care Improvement Act. We have proceeded through this process in a spirit of cooperation and negotiation and the language has gone through numerous changes. The end product is the language of H.R. 2440.

As the Committee is well aware, funding for the Indian Health Service lags far behind other segments of the population and has failed to keep pace with population increases and inflation. Current Indian Health Service funding is so inadequate that

less than 60 percent of the health care needs of American Indians and Alaska Natives are being met. In order to address the need for additional health care resources, Title IV of the Indian Health Care Improvement Act addresses access to Medicare, Medicaid and other third party reimbursements. It is one of the most important provisions of the Indian Health Care Improvement Act as it makes IHS hospitals eligible for Medicare reimbursements, and also makes IHS facilities eligible for Medicaid reimbursements. Title IV makes it possible for Medicare- and Medicaid-eligible American Indians and Alaska Natives to utilize these benefits.

Since the passage of the Indian Health Care Improvement Act in 1976, Medicare and Medicaid payments have become vital sources of revenue for basic Tribal hospital and clinic operations. In FY 2002 alone, IHS and tribally operated hospitals and clinics collected $460 million for services provided to Indian people enrolled in these programs. This amount enhances the resources available for the IHS hospitals and health clinics budget by nearly 30%.

In order to further improve the ability of Indian Country health providers to access third-party resources, the NSC developed several changes to Title IV that were included in S. 212 introduced during the 107th Congress. When asked to respond to the language contained in S. 212, several concerns were raised by Health and Human Services Secretary Tommy G. Thompson regarding the proposed changes to Title IV. The concerns were primarily related to costs. I would like to note that S. 556, introduced during this Congress, is identical to S. 212 and therefore many of the concerns raised in regards to S. 212 remain.

In response to those concerns, the National Steering Committee revised their recommendations for the reauthorization and those changes are reflected in H.R. 2440. I think it was quite helpful to hold the joint House Resources Committee and Senate Committee on Indian Affairs hearing in July as it illustrates the efforts of both houses to pass a bill this session. Although the bill was introduced in the House, it was developed with input and involvement from both House and Senate members and their staffs.

H.R. 2440 reflects several changes made to the original tribal proposal prepared in 1999 by the National Steering Committee (NSC). The legislation includes revisions to the 1999 proposal in response to Secretary Thompson's concerns. I will now briefly discuss the most significant changes made in H.R. 2440 that respond to the Administration's concerns about S. 212.

Qualified Indian Health Program (QIHP). This provision has been removed. The NSC designed QIHP as a new provider type through which Indian health programs and urban Indian health programs could more fully exercise their statutory authority to receive payments under Medicare, Medicaid and SCHIP. Secretary Thompson expressed concern that QIHP was complex and would be administratively burdensome. Tribal leaders acknowledged that the CBO score of this provision—in excess of $3 billion over ten years—could be a barrier to Congressional acceptance of QIHP and therefore removed it.

In place of the QIHP proposal, Tribal leaders seek a comprehensive study by the Department of Health and Human Services (DHHS) of reimbursement methodologies of Medicare and Medicaid for the Indian Health Service (IHS), Tribal health programs, and health programs of urban Indian organizations. The new provision found in H.R. 2440 directs the Secretary to perform such a study and report the findings to Congress. The Secretary is to examine whether payment amounts under current methodologies are sufficient to assure access to care and whether these methodologies should be revised consistent with those applicable to the "most favored" providers under the Social Security Act. The current "all-inclusive" rate system through which IHS and tribal hospitals and some clinics now receive Medicare and Medicaid reimbursements would remain in place until the Secretary's recommendations are reported to Congress and Congress decides whether to make any changes.

Extension of 100% Federal Medical Assistance Percentage (FMAP). Tribal leaders also agreed to delete a provision that would have extended the 100% FMAP to services provided to Medicaid eligible Indians referred by IHS or tribal programs to outside providers, such as referrals made through the contract health services program. Under current interpretation of the Centers for Medicare and Medicaid Services (CMS), the 100% FMAP is made available to States only for reimbursements for services provided directly in an IHS or tribal facility, even though the only reason the patient required care outside the IHS or tribal facility was that the facility could not directly provide the service and had to rely on an outside provider.

While State governments are very supportive of the 100% FMAP expansion, DHHS objected that its cost was too high—more than $2 billion over ten years—and that its financial benefits would flow only to the States, not to Indian health programs and their Indian beneficiaries. While the NSC disagrees with the

Department's interpretation of the statute and their conclusions about the effect of the proposed amendment, we agreed to delete the provision from the IHCIA.

Waiver of Medicare Late Enrollment Penalty. The 1999 tribal proposal (and S. 212 and S. 556) sought to waive the premium penalty for any Medicare-eligible Indian who did not timely enroll in Medicare Part B because of a number of barriers. The DHHS strongly objected to this provision as it would treat Indians differently than other Medicare-eligible persons who do not timely enroll. The DHHS asserts that the penalty is needed to encourage eligible persons to enroll and begin paying Part B premiums when they first become eligible, rather than waiting until they become ill and need to use their Medicare coverage. Tribal leaders also agreed, reluctantly, to delete this provision.

Regulations. Secretary Thompson objected to the tribal leaders' call for all regulations—including Social Security Act regulations affecting Indian health providers—to be prepared through Negotiated Rulemaking with tribal representatives. He asserted that the large number and complexity of Social Security Act regulations makes negotiated rulemaking unfeasible. In response to this concern, tribal leaders eliminated Social Security Act changes from the bill's negotiated rulemaking provision.

We believe the changes to the original tribal proposal submitted in 1999 significantly reduce the bill's federal budget impact. S. 212 (identical to S. 556) was scored in 2001 as having a federal budget impact of $6.9 billion over ten years. Deletion of the QIHP and the 100% FMAP provisions together reduce the bill's score by about 70 percent. We ask that the Committee submit a request to the Congressional Budget Office to either score S. 556 without the above-mentioned provisions, or provide a fiscal budget impact on H.R. 2440.

Centers for Medicare and Medicaid Services Tribal Technical Advisory Group (TTAG)

At the request of Tribal leaders, the Centers for Medicare and Medicaid Services (CMS) established the Tribal Technical Advisory Group (TTAG) to advise CMS on Medicare, Medicaid, and Children's Health Insurance (CHIP) policy issues related to American Indians and Alaska Natives. An informal TTAG was formed in 2001 and consists of Tribal leaders, Area Indian Health Boards, and designated national Tribal organizations, including the National Indian Health Board. The activities of the TTAG are coordinated primarily through the Intergovernmental and Tribal Affairs Office within CMS.

The TTAG has forwarded several recommendations to Congress and CMS regarding recommended changes to the reimbursement methodologies in place for the Indian Health Service, Tribal health programs, and Urban Indian programs. The informal TTAG is adamant in its position that any reform or changes in the Medicare, Medicaid or CHIP programs must allow for Tribal allocation or other direct funding mechanisms that authorize Indian health programs access to Centers for Medicare & Medicaid Services (CMS) program funding.

The TTAG has worked closely with the National Steering Committee to develop the changes to Title IV of the Indian Health Care Improvement Act that are reflected in H.R. 2440, which are the most recent NSC recommendations.

Conclusion

On behalf of the National Indian Health Board, I would like to thank the Committee for its consideration of my testimony and for your diligence in making the health of American Indian and Alaska Native people a high priority of the 108th Congress. I have been involved with the National Steering Committee since its inception in 1999 and have seen the hard work and compromises that Tribal leaders have made. Tribal leaders have come to the table to work out the more contentious provisions and we urge the Committee to act swiftly on this important piece of legislation. In order to reduce the terrible disparities between the health of American Indians and Alaska Natives compared to other Americans, we need to provide Tribal governments and the Indian Health Service with the proper framework to function in the most effective and efficient manner. Further, we request that the Committee urge the Administration to raise any concerns regarding this legislation in a timely manner so that passage of this bill during this session is not jeopardized.

[An attachment to Ms. Davis-Wheeler's statement follows:]

INDIAN HEALTH SERVICE SCHOLARSHIP PROGRAM AWARDS FY 1990 - FY 2001

FY	TOTAL IHS Scholarship AWARDS	Awards to *Navajo* Students	*% of Total Awards to Navajo Students*
1990	474	**89**	18.78
1991	639	**119**	18.62
1992	632	**136**	21.52
1993	659	**138**	20.94
1994	743	**160**	21.53
1995	553	**116**	20.98
1996	253	**56**	22.13
1997	434	**75**	17.28
1998	625	**143**	22.88
1999	635	**174**	27.40
2000	522	**101**	19.35
2001	486	**95**	19.55
2002	716	**132**	18.44
2003	***716***	**130**	18.16
2004			
TOTAL	**8087**	**1664**	**20.58**

Mr. RENZI. Thank you, Julia. I'm grateful.

I want to also thank you for recognizing Chairwoman Kathy Kitcheyan of the San Carlos Apache tribe, a former teacher and real strong leader down there in southern Arizona, as well as nationally, in the health care field. We look forward to her testimony tomorrow as it relates to some water issues on the San Carlos reservation. All three of you, thank you so very much for your testimony.

We're going to move to a 5-minute question and answer period, if you don't mind. I would like to begin by recognizing the gentlelady from the Virgin Islands, Ms. Christensen.

Mrs. CHRISTENSEN. Thank you, Mr. Chairman.

I want to say that on H.R. 2440 you do get two bites at the apple. As I said earlier, it's in our minority health bill, which we hope to introduce in the next couple of weeks. I guess I could presume to say that you have the support of all of the other minority caucuses in the House. As some of the amendments are incorporated into H.R. 2440, as you are recommending and as everyone has pledged to work with you to adopt, those will be incorporated as well.

Co-Chair Wheeler, you had said in your testimony on H.R. 151 that the elevation to Assistant Secretary of Indian Health should be done in a manner which does not diminish the Secretary's responsibilities to carry out the Federal Government's trust responsibilities to tribal governments. I just wonder if there is any concern that that elevation could, in any way, undermine the sovereignty of the tribes, moving from the Director into the Department as an Assistant Secretary.

Ms. DAVIS-WHEELER. There is some concern from tribal governments. I guess the upside to that is that the Director would be brought up to the level of Assistant Secretary, but that is why we put the comment in the testimony, that the Secretary of DHHS still needs to honor those treaties that were signed by all the tribal governments.

Mrs. CHRISTENSEN. Thank you.

President Hunter, having had some summer fellows who were from urban tribes, I know that within all of the disparities in health care and the disparities in all services that the tribes face, the urban tribes perhaps are more adversely impacted.

Just speaking to Title I, are you satisfied that there will be improvement in Title I? Is there enough outreach in that to ensure that urban tribal members get the outreach and get the scholarships to get into the health professions, or do we need to do something more there?

Mr. HUNTER. Congresswoman, you used a very interesting word—and that word is "outreach"—regarding the program. I would have to say no, there has not been enough outreach regarding that program's availability to urban Indians and urban populations.

For example, just recently I found out that, as part of the package, urban programs are eligible to provide for tuition reimbursement, and we knew that for a while. We have known that we are eligible as sites for the placement of scholarships, but we didn't know that there would be additional tuition reimbursement. So I have been trying to get that word out. But that probably has been in place for some time and we were not aware of it. So I do see the need for additional outreach and information coming out of the IHS to urban programs regarding Title I and its benefits.

Mrs. CHRISTENSEN. Thank you.

I also have a question for President Shirley. In your comments on Title I, you say that the Navajo Nation recommends that a greater degree of flexibility and autonomy be provided to the Indian Health Service tribes and urban Indian health programs to implement Title I. I wonder if you could elaborate on what you

mean by the flexibility. What kind of flexibility are you recommending be allowed under the Act?

Mr. SHIRLEY. What I am alluding to there is more consultation with tribes and more input, meaningful input from tribes into the legislation and services that are being provided out there in Indian country.

Mrs. CHRISTENSEN. And even the types of health providers perhaps, that the tribe be able to look at what their specific needs are and make sure that, within whatever is included in Title I, that you have some flexibility to decide what kinds of health providers you need and so forth; I would imagine that's what you're also referring to.

Mr. SHIRLEY. That's exactly right, Congresswoman.

Mrs. CHRISTENSEN. Thank you.

Thank you, Mr. Chairman.

Mr. RENZI. I thank the gentlelady.

I would like to recognize the gentlelady from the great State of California, Ms. Napolitano.

Mrs. NAPOLITANO. Thank you, Mr. Chairman.

In my questions and comments to Mr. Michel Lincoln, the Deputy Director, do you have any comments on what I was alluding to—mental health assistance, in being able to provide other universities access so that the jurisdiction of tribes in those areas could be helped?

Ms. DAVIS-WHEELER. Acting Chairman Renzi, could I respond to that?

Mr. RENZI. Yes, Ma'am.

Ms. DAVIS-WHEELER. Some of the factors include the lack of opportunity for American Indians and Alaska Natives to receive quality medical education, disproportionate pay for health professions, inferior equipment, outdated facilities, and the geographic remoteness of most of our tribal health facilities. Indian country has to compete with health providers with governmental facilities that are funded at a much higher level, as well as the private sector. It is nearly impossible to offer a competitive employment package to potential health professionals without proper incentives. Title I of the Indian Health Care Improvement Act provides Indian country with the proper tools to employ qualified health professionals.

One of the other things that I would like to state is that I would recommend to this Committee that you work diligently to ensure that the Indian Health Service is properly funded to offer competitive pay for health professionals and top rate equipment and facilities, and for them to serve American Indians and Alaska Natives.

Thank you.

Mrs. NAPOLITANO. Mr. Chair, one of the things she is saying is quite true. I also know that a lot of the women and young people need education in math and sciences in order to be able to access getting into many of the professions, including the health professions.

Now, that being said, I don't know whether that is a focus in your schools, or in the schools that are in Native American tribes, and whether or not some of the people who are unemployed could be helped by giving them additional instructions on math and science so as to be able to apply for entry-level health professions,

such as certified nurse assistant, which is right now in dire need throughout the United States, which leads into the professions of RN, LPN, medical assistant, whatever you want.

Now, is there any of that being addressed through your services or through any of the tribal offices, or the health board, or anybody, because we have a dire need of individuals to be brought up to a par that they can participate in entry-level jobs for the medical services. Without that, you can try to make available training, but if they don't qualify, you're going to have to have remedial classes for them, whether at the college level or OP or any other institution.

Ms. DAVIS-WHEELER. Chairman Renzi, I would like to respond to that.

Mr. RENZI. Yes, Ma'am.

Ms. DAVIS-WHEELER. Congresswoman Napolitano, the National Indian Health Board has been working with the National Congress of American Indians through a health information systems task force, which is addressing exactly what you're talking about, working with the tribal colleges, getting some computers set up at the colleges and at the tribal headquarters, and within the tribal structure, to enhance those people that we have now and bring their skills up.

Also, the National Indian Health Board has been working with the American Indian Physicians Association. We had a couple of Indian physicians at our conference yesterday that spoke to us about the need to collaborate more with them, to get those health sciences, math and everything, out to those professions that we need.

Mrs. NAPOLITANO. Thank you, Miss Davis-Wheeler. Not that you're missing the point, but this instruction has got to be begun even in the grammar schools.

Ms. DAVIS-WHEELER. Yes.

Mrs. NAPOLITANO. By the time you're in high school, the youngsters are no longer able to get enough instruction to be qualified to enter these professions. I would hope that this would be one of the things you would look at as you look at the whole ramification of not only this bill, but also how to address the issue with every tribe, because I'm sure everybody has the same problem. It isn't just one tribe or one State. It is generic. Everybody has the same problem.

So how do we address that by beginning to help, to either fund it or address it in the education system, to address it into the medical system.

Thank you, Mr. Chair.

Ms. DAVIS-WHEELER. A point well taken, and we will as a Board look at that very closely. Thank you.

Mr. RENZI. The gentleman from New Mexico.

Mr. TOM UDALL. Thank you, Chairman Renzi.

Let me say to Chairman Renzi, he and I share the Navajo Nation in our two Congressional Districts, and we work very closely together on these issues. We look forward to doing so in the future.

It is wonderful, President Shirley, to have you here today representing the wonderful Navajo Nation. I think you have made a very strong statement. In particular, I'm looking at the Navajo area

health service and the successes you have had. It is really a wonderful thing to see when the Navajo people are doing better than the general U.S. population in cancer deaths, particularly breast cancer, heart disease deaths, low weight births. I mean, those are some real successes and you should be very proud of those.

One of the things that you do highlight is what we spend on health care services. The treaty that the U.S. Government entered into with the Navajo Nation talked about providing good, high-quality health care. When you have numbers where the Indian Health Service is spending a little over a thousand dollars a person, and the average is close to $3,500 a person, clearly there are problems there.

Could you tell us the position of the Navajo Nation in terms of how you think it would change if we had the health care dollars up to the amount that the average is, and what difference that would make in terms of health care on the Navajo Nation?

Mr. SHIRLEY. Congressman Udall, I think what it would mean is more health care professionals being there on Navajo land delivering health care services to Navajo people, and not only to Navajo people but all Native Americans that are within the Navajo Nation boundaries. In terms of giving dollars to Native Americans, there would be facilities not as far off. I earlier alluded to bad dirt roads as being one of our problems. If there could be more dollars, there would be more facilities out there with health care professionals to where they are more locally accessible. I think that's what it means. If we can have sufficient funding, adequate funding, we will have better health care delivery services on Navajo land.

Mr. TOM UDALL. Thank you.

One of the parts of this—and you mentioned it, and you just alluded to it now—is Title I, which has the purpose of really trying to get young Native Americans educated in health care fields and being able to return to the reservation, return to the Navajo Nation and work with their community and up the level of health care. We haven't seen the successes that we should in that particular area.

I like the idea that you put in here of saying we need to do more, we do more of an increase in that area. So anything that you can tell us that would move us along in terms of getting more young Native Americans into health care education fields, we would be happy to hear it on this Committee.

Now, you mentioned Title II. You and I have worked, and I know Chairman Renzi knows about this, with the Navajo uranium miners. The mining on the reservation has just been devastating to the Navajo people. We have created a program in order to compensate Navajo miners who have died of lung cancer and many other kinds of cancer. But there is still a lot of suspicion out there that this is more widely dispersed than just people that went into the mines, that the families may have been impacted.

What you have called for here under Title II is a section for studying and monitoring programs to monitor the trends. One of the areas is the families. As you well know, these Navajo families that had a miner and the miner came home and had the mining dust and uranium on their clothes, and brought rocks in, not know-

ing that they were dangerous and had uranium in them, they need to be monitored.

I think that's what you're talking about in a general way, isn't it, that there are a lot of suspicions in terms of all of the mining, and we just need to be able to assure people that we are monitoring their health and following this situation?

Mr. SHIRLEY. Exactly, Congressman. I would point out, too, the points awarded to the different afflictions that are caused by uranium radiation I think needs to be re-looked at. Before compensation can be had, the Federal Government says you have to have a certain amount of points before that can happen. But there are members of my people out there and families where they were also afflicted by the uranium and radiation but are being told they are not eligible. I think that needs to be relooked at.

That's where I bring out the point that a lot of what's going on in Native country in trying to get compensation to those miners who were afflicted and the families who were afflicted needs to be revisited.

Mr. TOM UDALL. Thank you, President Shirley. I see my time is up.

I just want to tell you, please let Congressman Renzi and myself know, as we move along with this legislation, if there are other changes that you see and if there are things that pop up that you didn't realize now are going to be detrimental to the Navajo Nation, we want to help with them.

I have another commitment and I won't be able to stay for the full hearing, but I thank you very much for your leadership, and your presence here is really setting a very high standard in the early months of that presidency.

Thank you, Chairman Renzi.

Mr. SHIRLEY. Thank you, Congressman.

Mr. RENZI. I want to thank Congressman Udall. He speaks the truth when he talks about a partnership and the friendship that exists between the two of us to work together. I'm thankful for his leadership and some of his mentorship that he has shown me in being a new Congressman. I appreciate that, sir.

Many may not expect it—I know Mr. Hunter probably knows the next gentleman—but one of the best fighters for Native American rights and issues comes from the State of New Jersey, of all places. The gentleman from New Jersey.

Mr. PALLONE. Thank you. Is that comment partially based on the fact that you are from Long Branch, NJ too?

[Laughter.]

I shouldn't say that.

Mr. RENZI. I was born there. But I'm an Arizonan, remember?

Mr. PALLONE. I know. I know. I appreciate what the gentleman said, though. Thank you.

I wanted to ask Miss Davis-Wheeler. You know, I agree with you 100 percent, that the main goal here in the Committee and in the House in general is to try to get this bill passed and moved as soon as possible, because it has been a number of years now since the National Steering Committee put this together, and I know there have been some changes. But given that we do have a crisis, or I think we do have a crisis with regard to the Indian Health Service

and Indian health care, it is important to move the bill, and we all share that.

You mention in your written testimony that you had tried to address some of the concerns that had been raised in the past about the legislation. I think it was primarily the cost, because I know in the last session, when we were going around and trying to get a hearing here, many of the members said this is very costly. I know that the bill that has been introduced now is somewhat different.

Could you maybe summarize that in a way, because I think it's important in terms of our ability to get it moved, to talk a bit about the changes that have been made to address the cost, overall cost.

Ms. DAVIS-WHEELER. Yes, thank you, Congressman Pallone.

Well, since the passage of the Indian Health Care Improvement Act in 1976, Medicare and Medicaid payments have become vital sources of revenue for basic tribal hospital and clinic operations. In Fiscal Year 2002 alone, IHS and tribally operated hospitals and clinics collected $460 million for services provided to Indian people enrolled in these programs. This amount enhances the resources available for the IHS hospitals and clinics budget by nearly 30 percent.

In order to further improve the ability of the Indian health providers to access third party resources, the National Steering Committee developed several changes to the Title IV that were included in S. 212 during the 107th Congress.

When asked to respond to the language contained in S. 212, several concerns were raised by the Health and Human Services Secretary, Tommy Thompson, regarding the proposed changes in Title IV. The concerns were primarily related to costs.

I would like to note that S. 556, introduced during this Congress, is identical to S. 212 and, therefore, many of the concerns raised in regards to S. 212 still remain.

In response to the National Steering Committee revising their recommendations for the reauthorization, I think it was quite helpful to hold the joint House Resources Committee and Senate Committee on Indian Affairs hearing that was held in July. This was developed with input and the involvement of both House and Senate members and their staff.

I don't know if that adequately answers your question regarding the costs, but I know Title I has been looked at very closely by our National Steering Committee members.

Mr. PALLONE. Thank you.

I know a part of this has already been asked, and it's kind of a broad question, but to President Shirley, in terms of Title I, the problem in terms of not having enough health professionals, Native American or not, just addressing Indian country, particularly in the more remote areas—I will look at it from a threefold question. I asked this before.

Is the problem that a lot of people have difficulty in gaining entrance to nursing schools or medical schools, or is it that they can't afford it and we need more scholarships? Or is the problem the third thing, maybe they take advantage of these scholarship programs and they serve in Indian country for a few years, but then don't stay and move on to another area?

I know that the numbers have not really increased much in the last few years, so obviously in Title I we're trying to address that. But if you could just talk about maybe those various stages.

Mr. SHIRLEY. Thank you, Congressman.

Well, I think one of the problems on the upper Navajo land is that the Navajo Nation, as a government, has never made education its priority. It has always been down to the number eight, nine, ten, in there somewhere. But this time around, through my administration, the Navajo Nation as a whole nation and as a government has never had education as its number one priority. So why we aren't having enough people going into the health professions is one of the things we are looking at.

The biggest problem we have in getting people into the health professions, as well as the other professions, is the lack of scholarships. If the Committee here, and the Congress and the Senate can adequate fund the scholarship program within the Indian Health Service bill, that would go a long ways toward helping us to move with our people toward getting them into the health professions.

A lot of our students aren't having problems getting into the universities or colleges. That's not a problem. They get themselves eligible and they get admitted, but then they go looking for scholarships and it's not there. The Navajo Nation at this point in time is doing what it can to fund as many of its members as it can to try to encourage them to go to higher learning.

The other thing, too, is that we like to graduate more doctors, nurses, dentists, but there needs to be a guarantee put into where, when they graduate and get their doctor's degree or a medical degree, they need to return to Navajo land and to Indian country to give service to the people. There needs to be a mechanism put in to where that will happen. Of course, like I said, for the Navajo Nation, education is our number one priority. We are looking at mechanisms just like that, Congressman.

Thank you.

Mr. PALLONE. Thank you.

Thank you, Mr. Chairman.

Mr. RENZI. I thank the gentleman.

Last week we passed a land exchange that helped the Eastern Band of Cherokee, and this next gentleman was absolutely key in making sure we got it through. He worked across both aisles, Democrats and Republicans coming together.

I'll tell you, personally, I have had a chance to work with him and develop a friendship. If I was going into battle, I would want him on my side. So I want to thank the gentleman from California, Mr. Baca, for being here today. I will shift to him for his questions.

Mr. BACA. Thank you very much, Mr. Chairman, and thanks for your concern for Native Americans as well. And I'm not from New Jersey. As he stated, I'm from California and not from Arizona.

One of my questions would be that we're all very much concerned with improving the quality of life, especially in the health professions. I do agree with Ms. Davis-Wheeler, that we really need to put in a lot more funding. If we really want parity, and if we look at sovereign countries as well, we must have that same opportunity that others have. There seems to be a lack of funding when it comes to sovereignty and sovereign countries.

One of the things we have to do is make sure that in order for health services to be provided, funding has got to be equal, because you can't provide the health services where a lot of our reservations are also growing and our needs are also growing in the health field, especially if you look at diabetes. Diabetes and type II diabetes in the area is very important, so we need to develop not only the educational programs, but are the educational programs there right now, and if not, what kind of educational programs do we need to develop and what additional funding do we need to provide, especially as diabetes affects many of our Native Americans compared to others. I know that Hispanics are very high in type II.

What can be done in these areas?

Ms. DAVIS-WHEELER. Congressman Baca, I am very glad that you asked that question. I'm just returning from Hawaii. I attended a meeting over there a week before last and met with the Native Hawaiians. The Native Hawaiians have a high rate of diabetes, just as much as Native Americans.

I met with a man who was a teacher of the Hawaiian language, and he was an amputee. He spoke about the lack of funding that we, as indigenous people, have to address the diseases that we have. I couldn't help but look at him, and I tried to avert my eyes to not stare, but you could tell that he was suffering from this disease.

One of the things that the National Indian Health Board and the National Congress of American Indians is looking at is maximizing that money, the diabetes money that has been appropriated by Congress, through I would like to say the leadership of Congressman Nethercutt—and he was here earlier and spoke to the bill that would elevate the Director. I went outside in the hallway to speak to him because I really wanted him to know, as a tribal leader, that we appreciate his efforts in what he's doing.

My recommendation to this Committee would be the continuation of the appropriation for diabetes to the Native American governments, whether it be through the Indian Health Service or to the Indian governments themselves. I have seen an increase of awareness, the prevention education programs that have been developed by the different tribes across the United States, and I think we should get the appropriations increased.

There was a question earlier about how much more do we need. I think that $2.4 billion is not very much to ask for to increase the Indian Health Service budget to enhance the health professions and the other areas that we need to look at.

Thank you.

Mr. BACA. I agree with you. I don't think it's enough, because when you look at the prevention programs and others that actually improve the quality of life, in order for the quality of life to improve you have to be able to provide the services that are there. It is difficult, even from the point of recruitment, if you're looking at scholarships—we have many of our students going on—but you also want to make it competitive in terms of salary. So if you're trying to draw them back into the reservations, you have to have the competitive salaries. Otherwise, they're going to go somewhere else. They get educated and they're working in some other health field.

I also agree that we've got to do a better job in making sure that we're competitive in terms of salaries to attract our Native Americans who are going on to school to come back; isn't that correct?

Ms. DAVIS-WHEELER. That's correct.

Chairman Renzi, if I may also add, the Indian Health Service is not tax-exempt for its scholarship benefits. That is one thing that I think needs to be looked at. The scholarship program that the Indian Health Service has really needs a boost to get those students to come, and that tax-exempt benefit would assist a lot.

Mr. BACA. One final question, Mr. Chair, if I can. I know my time has run out.

Do you believe the changes in the duties of the Director of the Indian Health Service to the new Assistant Secretary for Indian Health, is that a way to improve the trust responsibility or not? Do you think this new change is positive based on H.R. 151?

Ms. DAVIS-WHEELER. Congressman Baca, I think that it would enhance us, as tribal governments, to be accessible to other agencies within the DHHS. It would also give that recognition to us as Native American tribes to those other areas across the United States that are receiving funding and that we are not receiving funding for. So I think elevating the Director up to the Assistant Secretary level would be excellent in terms of getting that information out to the other Federal agencies.

Mr. SHIRLEY. Congressman Renzi, if I can answer the last question?

Mr. RENZI. Go ahead, Mr. President.

Mr. SHIRLEY. I think the elevation of the Director to Assistant Secretary position, what it would do for Native Americans and the Navajo Nation is that we like to work with people who have the authority to make decisions. Right now, we're having to go through the bureaucracy and the red tape of trying to get answers. I think if we can have inside access to an Assistant Secretary position, who has the authority to make decisions, it will make the services of the delivery system much better.

And then if you can allow the Native nations to work with an Assistant Secretary position, along with the Secretary position, you're honoring the tribes and Native Americans, also.

Mr. BACA. Right. And you would have accountability as well. That's part of it, too, right?

Mr. SHIRLEY. Exactly.

Ms. DAVIS-WHEELER. Right.

Mr. BACA. Thank you very much.

Mr. RENZI. I thank the gentleman from California.

I just have a few questions and then we'll wrap up. Julia, I really am grateful for the teachings that you share here today. You went to the issue of the tax-exempt status. Congress has set aside legislation, or has created legislation, that exempts the National Health Service Corporation, as well as the Department of Defense, on their scholarship benefits.

If we were able to provide a tax-exempt status for IHS scholarships, what kind of figures do you think we're looking at? How big is the program right now? I guess we could start there.

Ms. DAVIS-WHEELER. Wow. How big is the program?

Mr. RENZI. On the scholarship side. It's OK. I didn't mean to stump you. What I'm looking for is, we really need to provide that same kind of equality—is Joe Shirley helping?

Ms. DAVIS-WHEELER. Yes. We have a chart here, the Indian Health Service Scholarship Program. The total IHS scholarship awards are 8,716 this year.

Mr. RENZI. Different scholarships? That many students, President Shirley?

Ms. DAVIS-WHEELER. Yes.

Mr. RENZI. So if we can achieve that kind of a tax status, it's a major benefit that will help close to 10,000 students and families. It's time, I think. We will look forward to pushing ahead on that.

Ms. DAVIS-WHEELER. If I may add, we will get information from the National Indian Health Board and we will send that in to you, too.

Mr. RENZI. That would be great. Thank you.

Mr. Hunter, I want to thank you for your testimony. It was interesting how you articulated and pointed out the definitions and how it affects all the way through on the different titles. I appreciate that research and depth of effort you provided to us.

I really didn't get a chance to get a depth of feeling on the national programs, and you spoke about the underfunding for some of the national programs. Could you give me maybe the top three national programs that you would like to see fully funded, or where those national programs would go if we had the proper funding behind it?

Mr. HUNTER. That is a difficult question to answer. We did in our preparations for consultation on the Fiscal Year 2005 budget come up with 19 priority areas that were considered, that covered both health care areas and facilities and construction.

It's difficult to say. Even though the priorities were not prioritized, I think amongst the top ones would be diabetes, alcoholism and behavioral health. I would say the third, again not to exclude other health care priorities, would be facilities. We have to get more money into facilities at urban programs. We don't have access to those benefits right now.

Mr. RENZI. You do a good job of outlining, and then your vision of where we need to go with the priorities. I'm grateful.

Mr. HUNTER. Thank you.

Mr. RENZI. President Shirley, thank you for coming all this way. It's good to have a friend and brother here. I'm grateful for your testimony.

You compassionately spoke about the dirt roads and the contribution that makes to respiratory and poor health. You spoke of the lack of communication and the inability to respond properly. I thought you were very articulate when it came to the nursing and dental shortages, not only in your testimony but in answering the questions. I need you to teach me now as a friend.

On section 216 you talked about Arizona as a contract area. Can you tell me a little more about that?

Mr. SHIRLEY. I believe that's a provision in the legislation that allows the whole State of Arizona as a contract health services delivery system, but that has never been adequately funded. If that could be fully funded, I think it would deliver more services to

Navajos out there and in the urban areas. We find Navajos, you know, in all the counties.

Mr. RENZI. True.

Mr. SHIRLEY. And not only Navajos, but also Native Americans, the federally recognized tribes living in the State of Arizona. Many of them are not living on their own Native land, so when they go off the land, they need to have a plug into the health services facilities in the urban metropolitan areas. If the contract services provision for the whole State of Arizona is fully funded, Navajos living off Navajo land would then have access to quality health care services throughout the State.

Mr. RENZI. Thank you, Mr. President.

Is there anything else any of the witnesses would like to share? Is there anything in your hearts that didn't come out today during the testimony?

Mr. Shirley.

Mr. SHIRLEY. Congressman Renzi, I would like to give input or respond to the question you posed to Miss Wheeler regarding what are our priorities.

On the whole, I would say manpower training. That's why these scholarships should be given an adequate amount of money for health professions is very important. Again, like you said, we need built-in mechanisms where the return to Native country is guaranteed. I think one Congressman said we need comparable salaries. That is very important.

The second one would be the prevention aspects of health care delivery systems in Native country. In our case, the diabetes program is really working and we appreciate the Congress and U.S. Government for funding prevention programs for diabetes. That certainly should continue, to put money into prevention.

The third one that we would zero in on is behavior health services. Of course, we have substance abuse, much of it alcohol, that is very pervasive throughout Navajo land. We're trying to do the best we can to arrest the problem. If more moneys could be had for our behavior health services program to address substance abuse, that would go a long ways toward helping us alleviate the alcoholism culprit.

Thank you, Congressman.

Mr. RENZI. Well said.

Mr. Hunter.

Mr. HUNTER. If I may, thank you.

I think one of the things that is most important is that when we come to Congress every year and we're looking at the budget, we're identifying that additional funding is needed. Very often I think to myself, well, where are we going to get that money? Well, in the past I proposed that taxes be increased but that doesn't go over very well.

I think one of the solutions that could be proposed, particularly within our social services programs, would be something called "social entrepreneurship." We at NCUIH fully support and recognize tribal sovereignty. We completely support the recognition of the Federal Government's trust responsibility for Native Americans, and we also recognize that we must also help ourselves. So if within our social programs we are able to generate funds that can

be devoted and turned back into those programs so that we are more self-sufficient at expanding health care services, I think it will be a great step in the right direction.

Mr. RENZI. So social entrepreneurship is profit centers within the health arena?

Mr. HUNTER. I'm sorry?

Mr. RENZI. Social entrepreneurship is essentially a profit center, making a profit within the health arena, profitable clinics or whatever?

Mr. HUNTER. Right. For example, one project that we're interested in working on at AICH in New York is when we sponsor conferences and workshops, particularly since we are responsible to outreach to non-Native providers of health care and educate them to developing our education program so that we can offer education units that are recognized by nursing and other professions, so that we can develop or charge the people for taking those education programs and support our programs.

Mr. RENZI. That's creative. Thank you, Mr. Hunter.

Mr. HUNTER. Thank you.

Mr. RENZI. Julia, you get to finish.

Ms. DAVIS-WHEELER. Thank you.

First of all, I would like to tell you that, as a policy person for my tribe, it is an honor to sit here and testify in front of the Committee. I appreciate the time that you have made.

I really would like to say that honoring the treaties that all of us have signed as American Indians, Alaska Natives, is the utmost in my mind. Having just come in last night from the conference and listening to the comments and remarks made at the conference, health is just one component of the treaty. We have education, land, water, et cetera.

But the vision I would like to see, and speaking here today for the National Indian Health Board, is to see that our people have adequate health care for our people at home. The ones who are there that can't speak, we are here for them. The ones that can't walk, we're here for them. It really means a lot to me, and I know my colleagues here on the panel feel the same way.

The appropriate funding for us as American Indians and Alaska Natives has to come up to the level of the general population. So giving us this time to come in and speak was excellent. I would like to encourage the Committee to have more hearings, and if there is any way that we can help as the National Indian Health Board, we will put that effort forward.

Thank you.

Mr. RENZI. The words are nice, but we have got to deliver. I think that's your message.

I want to thank all the witnesses for your valuable testimony, particularly to the members for their questions. The members of this Committee may have additional questions for the witnesses, and we will ask that you respond to these in writing. The hearing record will remain open for these responses.

If there is no further business, we again thank our valuable witnesses and the Committee stands adjourned.

[Whereupon, at 12:30 p.m., the Committee was adjourned.]

[The prepared statement of Mr. Tom Udall follows:]

Statement of The Honorable Tom Udall, a Representative in Congress from the State of New Mexico, on H.R. 2440

Mr. Chairman, thank you for holding this hearing today to discuss the reauthorization of the Indian Health Care Improvement Act (IHCIA).

Created in the spirit of the United States' trust duties, the IHCIA has become an essential element of the health and welfare of American Indian communities. It is the primary federal statute that establishes the structure for operation of health programs for American Indians and Alaska Natives by the Indian Health Service (IHS).

The chronic under-funding of the IHS has severe ramifications on the Indian population. Tuberculosis, cardiovascular disease, alcoholism, SIDS, fetal alcohol syndrome, and, increasingly, AIDS, plague America's Native communities at incidence rates far greater than for other Americans. Diabetes is especially prevalent in these communities.

I am acutely aware of the diabetes problem, both in New Mexico, the state I represent, and across the nation. According to a recent 2002 health audit from the Navajo Area Indian Health Service, there are 15,805 patients on its diabetes registry, out of a total 180,462 population.

Similarly, the Pueblo of Santo Domingo in New Mexico reports that since 1997, there was a 105% increase in diabetes patients, and an increase of 1038% in patients categorized as needing assistance with chronic diseases.

In addressing the diabetes epidemic, I believe we should strongly emphasis prevention and education. It is far better to tackle this disease up front with prevention and education rather than at the tail end, during end-stage renal disease and dialysis treatments, where enormous expense is involved and quality of life and health of the individual cannot be ensured.

Although Congress and the President recently acknowledged the severity of diabetes among Native Americans by providing historic funding for prevention and treatment programs, I believe we must increase our commitment in order to take advantage of the unprecedented scientific opportunities we have for advances leading to better treatments, a means of prevention and, ultimately, a cure for this devastating disease.

As such, I strongly support the reauthorization of the Indian Health Care Improvement Act so that we may continue to address the healthcare needs of Indian communities.

Thank you.