THE URBAN INDIAN HEALTH CARE STORY: THE NEED FOR SERVICES

Testimony of

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Before the
Senate Committee on Indian Affairs
And the
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On the
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S. 1057

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"Between the intentions of the lawmakers and the reality of regulatory actions lies the *service gap* that confronts the urban Indian. The result is untold desperation and waste of human resources."

Final Report of the American Indian Policy Review Commission, Vol. 1, p. 436 (emphasis added).

I. INTRODUCTION

Honorable Chairman and Committee Members, my name is Georgiana Ignace, President of the National Council of Urban Indian Health (NCUIH). I am a member of the Menominee Tribe and serve on the board of the Gerald L. Ignace Indian Health Center, Inc., which provides health care services to the Milwaukee urban Indian community. On behalf of NCUIH, and its 34 member programs, I would like to express our appreciation for this opportunity to testify before your Committee on urban Indian health issues.

Founded in 1998, NCUIH is the only national membership organization of urban Indian health programs. NCUIH seeks, through education, training and advocacy, to meet the unique health care needs of the urban Indian population. Title V urban Indian health programs provide a wide range of health care and referral services in 41 cities, actively serving approximately 150,000 urban Indians per year.[1] NCUIH is the successor organization to the American Indian Health Care Association, which provided advocacy and educational services on behalf of urban Indian health organizations for nearly 15 years prior to the establishment of NCUIH.

In general, S. 1057 contains many provisions that will support urban Indian programs. In this testimony I address the critical importance of providing Urban Indian Health Programs with access to the Federal Supply Schedule, as well as Federal Tort Claims Act coverage and a 100% Federal matching rate for Medicaid services. My testimony also focuses on the unique circumstances of urban Indians, the barriers they face in accessing health care, and the Federal obligation to address urban Indian health care needs. As set forth below, the Federal government has long acknowledged that its trust obligation to Native peoples is not just based on reservation geography, but extends in some measure to wherever Native people live within the United States.

II. GUIDING PRINCIPLES FOR URBAN INDIAN HEALTH PROGRAMS

In 1994, urban Indian health providers, during the tenure of the American Indian Health Care Association - NCUIH's predecessor organization - met in San Diego and adopted four

[1] According to the 2000 census, 66% of American Indians and Alaska Natives live in urban areas, up from 45% in 1970, 52% in 1980 and 58% in 1990.

"Guiding Principles." These principles still hold true for NCUIH's current efforts on behalf of urban Indians and directly address the relationships between and among urban Indians, Indian Tribes and the Federal government.

A. Sovereignty of the Tribes. The first principle addresses the understanding of urban Indians regarding the central importance of tribal sovereignty and the government-to-government relationship between Tribes and the United States:

> **Sovereignty of the Tribes:** ***We believe that tribal sovereignty, based on government-to-government treaties and trust responsibilities, along with certain moral obligations, of the United States government, is the foundation for all Indian affairs, including health care.***

In the National Steering Committee's deliberations there was recognition of the importance of emphasizing the sovereignty of tribal governments and the Federal government's trust obligation to Tribes and tribal peoples. There was also a recognition of the historical circumstances, largely a result of Federal government actions and policies, which gave rise to urban Indian communities consisting of Indians from a wide variety of tribal backgrounds (these circumstances are discussed in Section IV).

Although Congress has been specific about its commitment to both Tribes and urban Indians,[2] we recognize that, despite our common interest in health services, Tribes and urban Indians generally occupy different places in Federal Indian policy. Federally recognized tribes have sovereignty and a trust relationship with the United States; as a result there are many different federal laws addressing that relationship in such areas as land, water, criminal justice, and jurisdiction, which have no applicability to urban Indians. Although most urban Indians belong to federally recognized tribes, urban Indians do not aspire as such to be recognized as having sovereign powers or as being in a government-to-government relationship with the United States.

B. All Indian People. The second principle addresses the reality of the urban Indian experience.

> **All Indian People.** ***We believe that all Indian people, regardless of tribal affiliation, blood quantum, or their place of residence are entitled to all the necessary health resources and services to achieve the highest possible health status.***

Many Indians, from many different tribes have ended up in urban areas. As described in greater detail in Section IV below, for a variety of reasons, mostly traceable to federal government action, they find themselves among the ranks of the urban poor. Most are members of Federally recognized tribes; some are not. Many among the latter have become so disconnected from their

[2] Congress has made clear, as set forth in the current Indian Health Care Improvement Act, "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).

tribes that it is difficult for them to obtain tribal membership, or their tribes have been terminated or otherwise marginalized. Yet they are all Indian; they are recognized as Indian by their community; 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.

C. Traditional Medicine. For urban Indians, as much as for reservation Indians, traditional medicine is critically important to maintaining a connection with tribal and cultural identity and plays an important role in a holistic approach to their health.

> **Traditional Medicine.** ***We believe that traditional Indian medicine is intrinsic to our culture and essential to a holistic approach to healing the body, mind, and spirit of our people.***

Urban Indians stand shoulder-to-shoulder with their reservation brothers and sisters on the critical importance of preserving and integrating traditional medicine into Indian health programs.

D. Unified Urban/Tribal Partnership. We believe in working closely with the Tribes.

> **Unified Urban/Tribal Partnership.** ***We believe that a unified Indian partnership is vital to assure access to comprehensive health services to achieve the highest possible health status for all Indian people.***

Many tribal peoples live in urban areas; some permanently, some periodically.[3] However, in many urban centers, it is not practical for any one tribal government to set up an outreach to only its own tribal members. In fact, "in some urban centers, there are as many as 40 tribal governments nearby, and representation of tribes on urban Indian programs might include over 80 different tribes."[4] The urban Indians have developed skills necessary for survival (if not yet prosperity) in the urban environment;[5] the tribes are the great repository of cultural tradition and knowledge. The practical approach is the current approach: working together, Tribes and urban Indian health organizations can provide the best possible health care for our people. The

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[3] One Federal court has noted that the "patterns of cross or circular migration on and off the reservations make it misleading to suggest that reservations and urban Indians are two well-defined groups." United States v. Raszkiewicz, 169 F.3d 459, 465 (7th Cir. 1999)

[4] U.S. Congress, Office of Technology Assessment, *Indian Health Care*, OTA-H-290 (Washington, DC: U.S. Government Printing Office, April 1986), p. 38.

[5] "The Committee views the health dilemma of urban Indians as a serious obstacle in their quest to become self-sufficient and participating citizens. Fortunately, an evolving Congressional policy addressed to this problem has served to provide the essential experience and information for the provisions contained in Title V. That evolving policy has been built on the concept of self-determination with the Indians themselves managing federally subsidized health efforts tailored to fit the health circumstances of Indian populations residing in specific urban centers." H.Rep. No. 9-1026, 94th Cong., 2d Sess. 18, reprinted in 1976 U.S. Cong. & Admin. News (USCAN) p. 2652 and 2752.

extraordinary level of cooperation in the work of the National Steering Committee is proof positive of the value of this approach.

III. HEALTH STATUS OF URBAN INDIANS

According to a fact sheet developed by the National Urban Indian Policy Coalition urban Indian unemployment is double that of all other races [in some cities, like Boston, there is evidence that the Indian unemployment rate is quadruple the rate for all other races]; urban Indian poverty levels are three times that of any other race; the urban Indian high school drop out rate is over 75%; the urban Indian business development rate is the lowest of any race; urban Indians have higher mortality rate from alcoholism and related causes than other races; the urban Indian suicide rate is four times that of all other races; and urban Indians have three times the national rate for diabetes and heart disease.

NCUIH has consulted with the Urban Indian Health Programs to identify 19 program priorities of equal importance to address the health care crisis among urban Indians. They are as follows:

- Diabetes
- Cancer
- Alcohol and Substance Abuse
- Heart Disease
- Mental Health
- Maternal and Child Health
- Dental Health
- Injuries
- Elder Health
- Respiratory / Pulmonary
- Violence / Abuse
- Infectious Disease
- Hearing Disease
- Eye Disease
- Health Promo / Disease Prevention
- Tobacco Cessation
- Information Technology Support
- Maintenance and Repair
- Facilities and Environmental Health Support

IV. BARRIERS TO MAINSTREAM HEALTH CARE EXPERIENCED BY URBAN INDIANS[6]

> **"The lack of employment opportunities leads to a downward spiral that reduces the urban Indian's life to a struggle for subsistence. For example, the private practice system of health care is certainly beyond the financial reach of most newly arrived urban Indian families. They must depend on public services. Yet here, the *service gap* reveals itself again."**
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> Final Report of the American Indian Policy Review Commission, p. 437 (emphasis added).

The status of Urban Indian health is as poor as that for reservation Indians.[7] This section describes the many barriers that Urban Indians face in their efforts to access adequate health care in the urban environment:

Physical/geographic barriers can include (1) telephone availability; less access to transportation; and (3) high mobility. Many Native Americans do not have phones, increasing the difficulty in making appointments. For example, in Arizona, thirty percent of urban Indians have no household access to phone services. Indian people have much less access to private vehicles than the general population. Not having a vehicle creates barriers for people who must make arrangements with others to bring them to appointments. Public transportation (if available) makes for a longer travel time and can be costly. The high mobility of Indian people is another barrier to care. People who move often are not able to follow with the same provider, and this disrupts continuity of care and can lead to a decrease in the quality of care. When a person moves to another area, they must go through the system again to qualify for benefits, locate a provider, and receive care. In addition, movement back and forth between the reservation is common, which can significantly affect the ability of health professionals to provide prompt, quality follow-up care.

Financial/Economic barriers also contribute to the poor quality of urban Indian health care. People who do not have the resources, either through insurance or out-of-pocket, to pay for prevention and early intervention care may delay seeking treatment until a disease or condition has advanced to the stage where treatment is more costly and the probability of survival or correction is lower.

Medicaid is available for urban Indians, but difficult to access. Applying for Medicaid or other medical assistance is a long and detailed process, presenting many barriers to people who don't understand the system or lack the necessary skills to complete the paperwork involved. Furthermore, the required documentation is difficult for many urban Indians to obtain.

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[6] For more details on these issues see the September 30, 1989 report prepared for the American Indian Health Care Association, by Ruth Hograbe, R.D., M.P.H., Program Analyst and Donna Isham, Program Analyst. The framework for the report is the 1988 report Minority Health in Michigan: Closing the Gap.

[7] See Attachment A for a leading study on Urban Indian health: *Health Status of Urban American Indians and Alaska Natives*, Grossman et. al, Journal of the American Medical Association, Vol. 271, No. 11, p. 845.

For example, if one does not have a car, one may not have a drivers license. With high mobility among urban Indians, there is likely to be no documentation with the current address; or if they have just moved to the city from the reservation, there may be no birth certificate or identification. Once an individual is accepted, access to care is not guaranteed. Because of Medicaid reimbursement rates and restrictions, many providers are reluctant to accept Medicaid patients.

Health insurance coverage does not automatically remove financial barriers to care. Many persons, particularly those employed at or near minimum wage, have coverage through plans that do not cover preventive or major medical care. While professional positions generally provide health insurance, service and laborer positions generally do not. Urban Indians hold more of those occupations that do not provide health insurance benefits. Deductibles and co-payments are high enough that many persons who do have health insurance cannot afford to pay them and consequently do not seek care.

No insurance or assistance is another common barrier. Those who have no means to pay for care are often turned away. There is a high rate of urban Indians who are uninsured. For example, in Boston, 87% of the Boston Indian Center's clients have no health insurance, and two out of every three urban Indians in Arizona are uninsured.

Emergency room use is high among the poor, minorities and the uninsured. Unfortunately, emergency room use as a primary medical resource is costly and compromises quality care. Follow-up and preventive services are not possible with emergency room personnel serving as primary care providers. In Arizona, urban Indians use the emergency room 250% more often than the general public.

Cultural/structural barriers also exist for urban Indians receiving health care. The Indian Health Service conducted a survey which concluded that the majority of state, county and city health departments do not have the resources to meet the health care needs of urban Indians. Major stumbling blocks are inadequate funds and lack of staff trained to work with American Indians in a culturally sensitive way. Indians may be reluctant or unable to describe their health needs to strangers outside their own culture. Frequently, mainstream providers misunderstand or misinterpret the reticence and stoicism of some Indians. Other factors include a lack of trained Indian health professionals that get placed in urban Indian health programs and inadequate Indian outreach.

V. FEDERAL POLICIES AND THE URBAN INDIAN

> **"Most Indians who migrate to the cities say they would have preferred not to do so at all."**
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> Final Report of the American Indian Policy Review Commission, Vol. 1., p. 436.[8]

[8] For a more detailed summary of the history of off-reservation Indians see Attachment B, which is the relevant chapter from the Final Report of the American Indian Policy Review Commission.

The urban Indian is an Indian who has become physically separated from his or her traditional lands and people, generally due to Federal policies. Some of these federal policies were designed to force assimilation and to break-down tribal governments; others may have been intended, at some misguided level, to benefit Indians, but failed miserably. The result of this "course of dealing," however, is the same - a Federal obligation to urban Indians.[9]

A. The Federal Relocation of Indians. The BIA's Relocation program originated in the early 1950s as a response to adverse weather and economic conditions on the Navajo reservation. A limited program was initiated to relieve the crisis by finding jobs for Navajos who wanted to work off the reservation as little or no job opportunities existed on the reservation. Shortly afterward, the BIA converted its Navajo program into a full-fledged Bureau of Indian Affairs program applicable to many Indian tribes.

The BIA employees who developed the program made many mistakes and miscalculations. Even before the 1950's had ended there was concern that many relocatees were experiencing great difficulty adjusting to life in a large city, or to their jobs. Some felt they were being stranded far away from home. Solving reservation economic problems by relocating Indians off of their tribal lands is roughly the equivalent of the Federal government, during the Depression, sending Americans overseas to find work – something the Federal government would never have done. Many understood the relocation program as just another form of "termination." A Jesuit priest on the Fort Belknap Reservation noted that relocation programs drained the reservation of much of its potential leadership, further weakening tribal governments.

All told, between 1953-1961, over 160,000 Indians were relocated to cities.[10] Where they quickly joined the ranks of the urban poor.[11] Set forth below in *italics* is a description of the experience of Indians who relocated.

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[9] The unique legal relationship of the United States with Indian tribes and people is defined not only in the Constitution of the United States, treaties, statutes, Executive orders, and court decisions, but also in the "course of dealing" of the United States with Indians. As the Supreme Court noted in a major Indian law case, "[f]rom their very weakness and helplessness, so largely due to the *course of dealing* of the federal government with them, and the treaties in which it has been promised, there arises the duty of protection and with it the power." *United States v. Kagama* (1886) (emphasis added). Congress acknowledged this in its findings to the Native American Housing Assistance and Self-Determination Act (NAHASDA): "The Congress through treaties, statutes *and the general course of dealing* with Indian tribes, has assumed a trust responsibility . . . for working with tribes *and their members* to improve their housing conditions and good economic status so that they are able to take greater responsibility for their own economic condition." 25 U.S.C. 4101(4). Notably, NAHASDA also applies to state-recognized tribes. 25 U.S.C. 4103(12)(A).

[10] 1992 Roundtable Conference, Urban Indian Health Programs, Indian Health Service, "Working in Unity Toward our Future." p.2.

[11] "Unfortunately, far too many Indians who move to the cities, because of inadequate academic and vocational skills, merely trade reservation poverty for urban poverty." H.Rep. No. 9-1026, 94th Cong., 2d Sess. 18, reprinted in 1976 U.S. Cong. & Admin. News (USCAN) 2652, p. 2747.

URBAN GENOCIDE - THE INDIAN IN THE CITY (excerpts)[12]

"The economic status of the reservation Indian is far below the poverty bracket. This is due to the lack of employment both on and off the reservations with the exception maybe of the larger cities. The main source of employment to be found on most reservations is working with the Bureau of Indian Affairs. In this way, the "Bureau" can instill its white culture on the Indians and eventually brainwash them into working against their own people. The reservation towns bordering the reservations can offer no employment for Indian people because of the great amount of racism, discrimination and prejudice that exist among the whites and other non-Indians.

"Consequently, the bad conditions and individual economic situations that have evolved from these indignities have forced the Indians to seek other sources of employment and education. With 75 percent of the Indian population unemployed for three generations, parents of Indian children could not, and still cannot afford to send them to public schools and have to depend on the government to educate them in "free" government boarding schools. Since it was a law to send their children to school, small children were forced to leave their parents and be shipped off to school thousands of miles away from their homes. These Indian boarding schools, established in various areas, were the prime weapons used to inculcate the white culture among the children or, in the common terms used at that time, "to civilize the barbarians." Any part of the Indian culture was forbidden and the children were physically beaten if they used their native tongue or practiced their own dances. It has not been until just recently that this law has been officially lifted and is not in force, but the principle motive of de-Indianizing the Indians is still in effect.

"During the summer months while school is not in session, they send these Indian students to white homes to work as indentured servants. After graduation, they are sent directly out on relocation from the schools into the cities.

"Conveniently enough, the relocation program has been established to speed assimilation of Indians into the cities at this time of dead-end streets, reservation confusion and unemployment. Through this program they relocate the younger Indians from the ages of 18 to 36 on direct employment or vocational training. It is a one-way ticket to the city in hopes that you will melt with the melting pot and forget you are Indian or still have a reservation that the white man does not have yet.

"Numerous problems have developed as the result of the "dislocation program," therefore the following chapters will focus on the urban Indian situation.

What Happens to the Indians After Arrival in the Cities

"On arrival to the city on relocation, the individual Indian has in his possession an envelope with orders and instructions, telling where to go and what to do. First of all, he is to

[12] This document was obtained from the National Urban Indian Policy Coalition. The author of this piece is unknown.

report to the Bureau of Indian Affairs if he arrives during office hours. If not, he reports to a BIA-approved hotel until the next day if he has any money.

"If they have time to see you the first day, they dole out a small amount of money to last until the end of the month if he is on the training program or until the next week if he is seeking employment. If they do not have time to see him the first day, he is to come back the following day at office hours and maybe some one will see him. In the meantime, he can sleep in the park or walk the lone deserted streets all night long.

"When he is received at the BIA headquarters in the city, he attends a short orientation period and an elderly lady will counsel him about sex and how to dial "0" for the operator on the telephone. A brief question and answer period follows and he is told to come back the next day at eight AM or to report to his designated school.

"The BIA locates his place of residence in the city and he is required to stay there if he is a student. They will discontinue his subsistence if he opposes and he will not be eligible for any more aid.

"The vocational school he is sent to may not be the particular training he originally signed up for back on the reservation, but this is the school he is required to attend.

"If the relocatee signed up for direct employment, he must take the first job available even if it is not his trade or type of work he wants. He is told it will be temporary until the type of job he wants comes up but after he receives his first salary on his temporary janitor job, he is cut off their records and cannot receive any additional help after he quits, gets fired or the job runs out.

"The "Bureau" pays the student's tuition in the vocational school directly to the school. The student receives subsistence twice a month, doled out in payments of $74.00. From this amount, he must budget $59.00 per month per rent, and the other $15.00 must be divided into his expenses for food, cab fare, medical care, clothes and whatever else that should develop during the month. This budget was made up in 1953 when the program first developed and has not taken into consideration the rises in living and the area or city he is in. California has the highest cost of living especially in San Francisco, which is the central concentration point of relocatees coming from every reservation in existence today. This income is far below the poverty bracket nation-wide, yet this is the "help" the Indian Bureau is giving.

"All persons on the relocation program are issued a medical card which they can present to a physician and receive medical help up to a six-month period. The only problem here is that these medical cards only guarantee to pay $4.00 of the entire bill when the office calls alone are $5.00 at the very minimum.

<u>What Problems They Face and Why</u>

"The cultural background of the American Indians differs extremely from the white culture, creating a problem of communication between the two. Not only this, but the Indian

culture has also been corrupted, bringing about a drastic change of social environment. This disintegration of culture has been attributed to disturbing early experiences in school, the generally poor level of education, poverty and the ambivalent position of the government in relation to the Indian.

"Prejudice and discrimination which does exist near reservations or anyplace where there is a large concentration of Indians, (although now in the city and away from being singled out as being an Indian), tends to have developed hostile and stereo-typed attitudes towards the other groups of society. The Indians have also collectively experienced a deterioration of personality, self-doubt, self-hate, impulsive and suspicious behavior, feelings of inferiority, deviant behavior, mental illness and suicidal tendencies.

"Depending on the environmental background, these adverse behaviors vary. Individual exceptions are due to the degree of orientation to the white culture or restored self-image through education.

"In dealing with the many Indian people who go through the BIA agencies, or any other type of agency established in the cities for employment or vocational training, the employees lack the experience of knowing the type of environment the individual Indian has been subject to and they do not know how to handle his particular situation. In many cases even where minority people hold agency positions, generally, they have developed superiority attitudes over the people they are trying to help and therefore stunt their full capabilities for helping others.

"[Many businesses] resent the BIA in its assistance of seeking employment for the Indian relocatees. This is due to the business' general dislike of any form of government transactions or to be told how to run their business concerns. This creates a great amount of conflict and the BIA, in order to retain a certain amount of prestige, often finds the Indian relocatee employment with a business concern that pays a low wage scale, hard labor with no company obligations, such as insurance policies, sick leave and vacation with pay. These small businesses often take no safety precautions and are constantly hood-winking the safety inspectors. Consequently, the Indian relocatees are more or less siding with the illegal aspects of the concern in which they are employed in order to retain their jobs. Employment competition is great and the relocatees can be dismissed from their job for little or no cause at all, and they are often plagued by this fear of being fired.

"In the event that a relocatee is fired for one reason or another and needs assistance, he cannot go back to the BIA for further help. The BIA tells him that his files have been sent back to his agency and they have no more funds or time to help him because their hands are tied with the other relocatees who are coming in.

"The budget set up for financing a student in vocational training are not only inadequate for one person's needs, but are not set to the area standards of living. In other words, they are transformed from one pocket of poverty to another, which in this case would be from a reservation to an urban ghetto.

"The vocational schools that Indian relocatees are sent to, in most cases are not accredited and after graduation from one of these schools, the relocatee cannot obtain a job. Most of the teachers in vocational schools are not qualified teachers, and there is a great shortage of instruction. The BIA gives the schools extra money for materials yet the conditions and facilities in these schools are still very bad. The students come out of these schools unqualified and inexperienced in the type of work for which they thought they had been trained and cannot find suitable employment.

"There are more and more students who are sick and tired of being treated as second-class people who do want to get a decent education and go to junior colleges and universities. The biggest problem here is not being able to get any finances, "Bureau" or otherwise. Also, Indian students' second-rate educations do not prepare them well enough for college work. Most reservation Indians are subject to irregular school and employment backgrounds and a great majority of the younger Indians have criminal or prison records. This does not mean that they cannot do the work academically; but, basically, they have never had the full opportunity to do so.

"The Bureau of Indian Affairs sends newly-arrived relocatees to unsanitary, immoral, crowded and unsafe places of residence. If the student wants to leave these conditions, the landlord promptly calls the BIA about the matter and the student is required to live there or have his subsistence discontinued. In one of the girls' boarding homes the landlady encouraged parties and drinking and let the girls' boyfriends come over. Then she would go into their rooms and take pictures of the different couples sleeping together. If the girls wanted to leave, she would then threaten to blackmail them with the pictures she had and in this way would keep her business. A business college for female relocatees also housed the students, putting four girls to one small room and charging $100 per person, not including food or utilities. This establishment also received additional money from the BIA for recreational purposes which the girls never did see. If the girls tried to leave their residence, they were threatened with expulsion from the business college and have their subsistence discontinued. Most of these young Indian girls were between the ages of 18 to 20 years, who were eventually expelled for little or no reason and left to roam the city streets. Individual follow-up showed that 80 percent of these girls got pregnant, were drinking excessively and were living with men from time to time. This college is still in operation receiving relocatees from the Bureau of Indian Affairs.

"A boys' boarding house in the city was over-crowded with four bunks to a room, no studying facilities, unsanitary conditions, inadequate food and displaying a sign in the front of the house, CONDEMNED.

"These are typical living conditions, Indian youth are subject to when placed in the city through relocation. When a young Indian approached a BIA counselor why they had to live under such adverse conditions and was told, "The filthiest conditions you Indians are put under, the more at home you will be."

"Landlords and vocational schools are getting wise to the BIA and are making the largest profit and racket out of the Indian business at the cost of young Indian lives.

"Indian health is generally poor due to the economic standards and lack of proper diet and nutrition. Free medical facilities are provided on all reservations due to the unsatisfactory health conditions. Tuberculosis, cirrhosis of the liver, sugar diabetes, and trichoma are a few of the more prevalent diseases which Indian people are susceptible to. Trichoma, which is an eye disease, is very rarely heard of among Indians. Poverty conditions breed diseases.

"The BIA believes that when an Indian leaves the reservation, he suddenly leaves his "Indianness" and becomes a healthy, happy human being, and needs no more of the medical services he had before. Consequently, Indian health in the city becomes twice as bad as it might have been before because he cannot afford good medical care.

"Pregnant Indian women risk possibly losing their child by having to return to the reservation their last month so that they can receive medical care upon delivery of their baby.

"From the time Indians were victims of wars, they lost their identity which comes from pride and self-esteem. Indians became a lost people exhibiting schizoid behavior at times. An Indian who does not like himself, does not like other Indians because he can see himself reflected in the others. An Indian suffers from inferiority plus self-hate that leads to trying to escape these unbearable conditions. By escaping, he is rejecting the society that has made him this way. His means of escape is either through alcohol or suicide which are 100 percent times higher than the national average among the American Indians.

"An internal problem of self-identity and lost culture plus an external problem of discrimination and racism by people in power has suppressed and made what is left of the American Indian today."

Today, the children, grandchildren and great-grandchildren of the 160,000 Indians relocated by the BIA are still in the cities. They maintain their Indian identity even if, in some cases, these "descendants have been unable to re-establish ties (including membership) with their tribes."[13]

B. Failure of Federal Efforts to Economically Develop the Reservations. The second major reason Indians have moved to the city is the near total failure of Federal programs to promote economic development on Indian lands, coupled with the ongoing success of the Federal efforts in the 1800's to undermine the economic way of life of Indian peoples, locking nearly all Indians into hopeless poverty which still plagues most reservations today. The long history of treaty-breaking by the Federal government is an important part of this tale. As a result, out of desperation, a number of Indians have left their homelands to go to the cities in search of work, even without the dubious benefit of the BIA's relocation program. Generally, these Indians were no better equipped to handle life in the city than the BIA relocatees and

[13] See Office of Planning, Evaluation and Legislation, Indian Health Service, Impact of the Final Rule Final Report, Contract No. 282-91-0065, "Health Care Services of the Indian Health Service" 42 CFR Part 36, p. 22-23.

quickly joined the ranks of the urban poor. Congress has noted the correlation between the failure of Federal economic policies and the swelling of the ranks of urban Indians: "It is, in part, because of the failure of former Federal Indian policies and programs on the reservations that thousands of Indians have sought a better way of life in the cities. His difficulty in attaining a sound physical and mental health in the urban environment is a grim reminder of this failure."[14]

C. Termination of Tribes. In 1953, Congress adopted a policy of terminating the Federal relationship with Indian tribes. Essentially, this was an abrogation of the Federal government's numerous commitments, in treaties, laws, executive orders, and through the "course of dealing" with Tribes, to protect their interests. Many tribes were coerced to accept termination in order to receive money from settlements for claims against the United States for misappropriation of tribal land, water or mineral rights in violation of treaties.[15] The results of termination were devastating: having lost Federal support, and without tribal sovereign authority over an established land basis, and with tribal members no longer eligible for Federal programs and IHS services, the Tribes collapsed. Some members remained in the area of their old reservations; many went to the cities, where they, too, joined the ranks of the urban poor.

D. Indian Patriotism -- World War I and World War II. Many Indians served the United States in time of war[16] and, subsequently, were stationed in or near urban centers. At the end of their service to the United States, seeing the poor economic conditions on their reservations (resulting from the Federal war on Indians), many chose not to go back. The fact that they chose to stay in an urban area did not make them any less Indian, nor did it reduce the Federal government's obligation to them.

E. The General Allotment Act. The General Allotment Act ("Dawes Act") had two principal goals: (1) by allocating communal tribal land to individual Indians it would breakdown the authority of the tribal governments while encouraging the assimilation of Indians as farmers into mainstream American culture; and (2) it provided for unalloted land (two-thirds of the Indian land base) to be transferred to non-Indians. CITE. The General Allotment Act succeeded at transferring the majority of Indian land to non-Indians and further disrupting tribal culture. For the purposes of this testimony, we only need to note that some Indians who received allotments became U.S. Citizens and, after losing their lands, moved into nearby cities and towns.

F. Non-Indian Adoption of Indian Children. The common practice of adopting Indian children into non-Indian families has created another group of Indians in urban areas who, because of the racial bias of the courts, have lost their core cultural connection with their tribal

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[14] Pub. L. 94-437, House Report No. 94-1026, June 8, 1976, 94th Cong., 2d Sess. 18, reprinted in 1976 U.S. Cong. & Admin. News (USCAN) 2652,at p. 2754.

[15] Office of Planning, Evaluation and Legislation, Indian Health Service, Impact of the Final Rule Final Report, Contract No. 282-91-0065, "Health Care Services of the Indian Health Service" 42 CFR Part 36, p. 23.

[16] It is in part because of their gallant service in World War I that the U.S. Congress granted U.S. citizenship as a group to American Indians in 1924.

people and homelands. Many of the adopted Indians have successfully sought to restore those connections, but because of their upbringing are likely to remain in urban areas.[17]

G. Boarding Schools. The Federal program of taking Indian children and educating them away from their reservations in boarding schools where they were prohibited from speaking their native language and otherwise subject to harsh treatment, created a group of Indians who struggled to fit back into the reservation environment. Eventually, some moved to the cities. The boarding school philosophy of "Kill the Indian, Save the Man" epitomizes the thinking behind this approach and the racist Federal effort to assimilate American Indians which, as a result, led to a number of Indians moving to urban areas.

H. The Fracturing of the Indian Nations. The result of these, and other Federal Indian policies, has been the fracturing of Indian tribes and the creation, in the urban setting, of highly diverse Indian communities with members who fall into one or more of the following categories: Federal relocatees; economic hardship refugees; members of Federally recognized tribes, terminated tribes, state recognized tribes, and unrecognized Tribes (that is, unrecognized by the Federal government);[18] and adoptees.

The urban Indian community consists of Indians from a wide variety of backgrounds, almost all of whom can tie their urban existence to some Federal policy or action. Many of these Indians are in urban areas due to some traumatic disruption in their connection with their Tribes, or because something has happened to their Tribes (termination or marginalization such that they are not currently federal recognized). As a result, unlike the Indian population on reservations, most, but not all are members of federally recognized tribes. Yet they are all Indian; they are recognized as Indian by their community; 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.[19]

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[17] In recognition of the severity of this problem, Congress passed in 1978 the Indian Child Welfare Act to give Tribes and Indian parents a greater say in the adoption process for Indian children. See Indian Child Welfare Act of 1978, 25 U.S.C. Sections 1901-1963.

[18] There are still scores of tribes working their way through the byzantine acknowledgement process, which is widely criticized for its glacial pace and alleged bias against certain Indian groups.

[19] The Executive Director of the Seattle Indian Health Board, Ralph Forquera, M.P.H., commented eloquently on this issue in a May 24, 2000 letter to NCUIH:

> "There are two principle reasons why I believe that the definition should remain as is [i.e., including certain Indian populations that are not federally recognized]. First, the Act itself continues to address the health needs of all Indian people, not just those living on or near reservations. The redesign of the Indian Health Service in 1996 and adoption of the I/T/U model further supports this claim. Clearly the Congress intended for there to be a separation between 437 and 638. Thus, the adoption of the 638 language now [which would have excluded certain Indians now covered by the Indian Health Care Improvement Act], in my opinion, would tarnish the original Congressional intent by shifting the Act to a tribally based orientation.
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> "Second, the conditions that lead to the original enactment of both the Act itself and Title V in particular have not changed. There remains a large and growing group of Indian people who are handicapped by poverty, inadequate education, and other socio-economic challenges that

VI. THE FEDERAL GOVERNMENT AND THE PROVISION OF HEALTH CARE TO URBAN INDIANS

The Congress has long recognized that its obligation to provide health care for Indians, includes providing health care off 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).[20] Congress has "a responsibility to assist" urban Indians in achieving "a life

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> contribute to diminished health status. Many continue to be victimized by alcoholism, violence, and the myriad temptation that diminish one's capacity to achieve optimal health. The social dynamics that served to disenfranchise Indians throughout the century remain. Indians, particularly in cities, continue to struggle with identity and acceptance both within Indian Country and within the nation as a whole.
>
> "But perhaps the most compelling reason to continue the broader definition of Indian is the psychic benefits. The ability of urban programs to provide the gift of acceptance to those Indians who by circumstances or policy were denied their rightful identity as an Indian person is vital, in my opinion, to improving the health status of this group. Only in the past few years have I personally begun to appreciate the tremendous emotional burden many Indian people have had to bare by being denied their identity through structural limitations. Not knowing who you are is one thing; but knowing and not feeling accepted by your peers has devastated many Indian people. I have had the good fortune to witness the positive effect that acceptance can play in the lives of several here in Seattle. The health effect of this simple practice is enormous."

[20] "The American Indian has demonstrated all too clearly, despite his recent movement to urban centers, that he is not content to be absorbed in the mainstream of society and become another urban poverty statistic. He has demonstrated the strength and fiber of strong cultural and social ties by maintaining an Indian identity in many of the Nation's largest metropolitan centers. Yet, at the same time, he aspires to the same goal of all citizens—a life of decency and self-sufficiency. The Committee believes that the Congress has an opportunity and a responsibility to assist him in achieving this goal. It is, in part, because of the failure of former Federal Indian policies and programs on the reservations that thousands of Indians have sought a better way of life in the cities. His difficulty in attaining a sound physical and mental health in the urban environment is a grim reminder of this failure."

"The Committee is committed to rectifying these errors in Federal policy relating to health care through the provisions of title V of H.R. 2525. Building on the experience of previous Congressionally-approved urban Indian health prospects and the new provisions of title V, urban Indians should be able to begin exercising maximum self-determination and local control in establishing their own health programs."

of decency and self-sufficiency" and has acknowledged that "[i]t is, in part, because of the failure of former Federal Indian policies and programs on the reservations that thousands of Indians have sought a better way of life in the cities. Unfortunately, the same policies and programs which failed to provide the Indian with an improved lifestyle on the reservation have also failed to provide him with the vital skills necessary to succeed in the cities." House Report No. 94-1026 on Pub. Law 94-437, p. 116 (April 9, 1976).

The Supreme Court has also acknowledged the duty of the Federal government to Indians, no matter where located: "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 Comm'rs v. Seber*, 318 U.S. 705 (1943). In other 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).[21]

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." 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).

The courts have also stated that there is a trust responsibility for individual Indians. "The trust relationship extends not only to Indian tribes as governmental units, *but to tribal members*

Pub. L. 94-437, House Report No. 94-1026, June 8, 1976, reprinted in 1976 U.S. Cong. & Admin. News (USCAN) 2652 at p. 2754.

[21] Federal responsibility for Indian health care is frequently declared "primary" but it is not exclusive and preemptive of state responsibility. See *McNabb v. Bowen*, 829 F.2d 787, 792 (9th Cir. 1987). 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. Cond Cong. & Admin. News (USCAN) 2652, 2657.

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 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,[22] but also in

[22] 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.

NAHASDA, that certain state-recognized tribes or tribal members are eligible for certain Federal programs. 25 U.S.C. Section 4103(12)(A).

VII. REAFFIRMING FEDERAL SUPPORT FOR URBAN INDIAN HEALTH CARE IN THE REAUTHORIZATION OF THE INDIAN HEALTH CARE IMPROVEMENT ACT

NCUIH has generally supported the recommendations of the National Steering Committee for the reauthorization of the Indian Health Care Improvement Act. However, in the course of previous testimony we have made several recommendations for refinements. One recommendation that I would like to highlight here is the need to assure that the IHCIA's policy statement clearly includes "urban Indians". The existing Indian Health Care Improvement Act includes urban Indians in the Congressional policy statement:

> "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.
>
> "(b) It is the intent of the Congress that the Nation meet the following health status objectives with respect to Indians *and urban Indians* by the year 2000:"

25 U.S.C. Section 1602(a)-(b) (emphasis added). Over the last several years, some versions of the Indian Health Care Improvement Act reauthorization legislation did <u>not</u> include a reference to urban Indians in the equivalent paragraphs. 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. We are happy to see that S. 1057 provides a definition for "Indians" which would appear to include "urban Indians" as well. Still, it would be valuable if urban Indians were specifically named in Section 3, since they are also separately defined in the law, as recommended below:

> ***"SECTION 3. DECLARATION OF HEALTH OBJECTIVES***
>
> *"Congress hereby declares that it is the policy of the United States, in fulfillment of its special trust responsibilities and legal obligations to the American Indian people--*
>
> *"(1) to assure the highest possible health status for Indians <u>and urban Indians</u> and to provide all resources necessary to effect that policy;"*
>
> *(2) to raise the health status of Indians <u>and urban Indians</u> by the year 2010 to at least the levels set forth in the goals contained within the Healthy People 2010, or successor objectives;"*

VIII. HISTORIC PERCENTAGE DECLINE IN FUNDING FOR URBAN INDIAN HEALTH PROGRAMS

In FY 2005, Urban Indian Health Programs received 1.06% of the total Indian Health Service budget. The President has proposed in his FY 2006 budget to reduce Urban Indian programs to just 0.9% of the IHS budget. In 1979, at a time when off reservation American Indians/Alaska Natives made up a smaller percentage of the overall Indian population, the urban Indian programs received 1.48% of the Indian Health Service budget.

Disease knows no boundaries. As one Federal court has noted, the "patterns of cross or circular migration on and off the reservations make it misleading to suggest that reservations and urban Indians are two well-defined groups." *United States v. Raszkiewicz*, 169 F.3d 459, 465 (7th Cir. 1999). With the 2000 census showing that well over half of the Indian population now resides in urban areas, we strongly believe that the health problems associated strongly with the Indian population can only be successfully combated if there is significant funding directed at the urban Indian population, as well as the reservation population.

The National Council of Urban Indian Health has asked for a $12.2 million dollar increase to the President Bush's proposed FY 2007 budget for Urban Indian programs as a first-step towards addressing this funding gap. This increase will elevate the Urban Indian Health Program funding from $31,816,000 to $44,016,000. While this cannot address the total need, it will make a huge difference in access to and quality of care for American Indians/Alaska Natives living in urban areas.

The rationale for the proposed increases is based upon:

- The steady decline of funding since 1979 when the program received 1.48% of the IHS budget to 2005 when the program received 1.06% of the IHS budget.
- The unmet need of 2 billion dollars and the actual appropriation of only $30 million. The urban Indian health programs can only serve 100,000 Indians of the 1 million eligible Indians residing in the urban setting.
- The need to conduct a planning study on the18 new urban Indian health programs throughout the United States.
- To enhance the soon to be transferred urban Indian health program Alcohol and Substance Abuse programs into Title V.
- The development of the urban Indian health centers of excellence.
- The enhancement of the urban Indian health program epidemiology center in Seattle, Washington.
- To continue to establish an automated mutually compatible information system to capture health status and patient care data for urban Indian health programs.

- To enhance existing programs in order to enable them to be elevated to provide the highest level of quality health care.

IX. FEDERAL TORT CLAIMS ACT COVERAGE IS ESSENTIAL TO THE EFFECTIVE DELIVERY OF URBAN INDIAN HEALTH CARE SERVICES

The ability of Urban Indian Health Programs to provide cost-effective health services has been jeopardized by the lack of FTCA coverage commonly accorded other federally funded Indian health programs. The skyrocketing cost of malpractice insurance in recent years has compromised the scope of services that Urban Indian Health Programs can provide pursuant to contracts or grants that they receive from the Indian Health Service. Because of this, the fulfillment of the Federal government's trust responsibility to Indian peoples, as well as the effective implementation of IHS's Urban programs, has been seriously undermined.

Consistent with the Federal government's trust responsibility to Indian peoples, Congress has funded, through the Indian Health Service, 33 Urban Indian Health Programs. As the Senate has noted:

> "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).

Since 1990, FTCA coverage has been provided to tribes and tribal organizations that have contracts with the Indian Health Service. The Urban Indian Health Programs secure their Federal funding from the exact same source as the tribes and tribal organizations and for the exact same purpose – to provide health care services to Indians in accordance with the Federal trust responsibility. Notably, the FTCA coverage provided to tribes and tribal organizations also covers individuals who provide health care services under a personal services contract in an IHS facility (25 CFR 900.193), as well as services provided under a staff privileges agreement with a *non-IHS facility* where the agreement requires a health care practitioner to provide reciprocal services to the general population (25 CFR 900.194). If these individuals and these services have FTCA coverage, as well as tribes and tribal organizations, then urban Indian health programs should have similar coverage.

There is a mistaken impression that urban programs are serving non-Indians and that, therefore, they are not fulfilling a federal purpose and FTCA coverage is not appropriate. Those few Urban Indian Health Programs that serve non-Indians are already

classified as Community Health Centers, receive Section 330 funds and, therefore, have FTCA coverage. The vast majority of Urban Indian Health Programs limit their services to Indians, are not Section 330 Community Health Centers and, therefore, do not have FTCA coverage.

There is a mistaken impression that most, if not all, Urban Indian health programs can secure FTCA coverage as Federally Qualified Health Centers. Based on the experience of one urban Indian health program that sought FQHC status, the process is ambiguous (it does not clearly provide for urban Indian programs to receive such status), time-consuming (18 months), costly and, at the end, of dubious benefit (this program only secured "look-a-like" FQHC status which, apparently, does not include FTCA coverage). It is essential that the issue of FTCA coverage be clearly addressed for Urban Indian Health Programs.

According to a recent survey, only one of the 33 Urban Indian Health Programs has been the subject of a malpractice claim. Due to the relatively limited nature of the services they provide, the actual risk of a claim against an Urban Indian Health Program is low and, therefore, the cost to the United States of providing FTCA coverage would be low. However, this has not deterred the insurance companies from charging ever more exorbitant rates.

In some areas, there are few insurance carriers available, so the carriers use this leverage to make other demands. One Urban Indian Health Program, which serves a large number of Navajo patients and was located relatively closely to the Navajo reservation, had a carrier state that it would not renew coverage out of fear that it would get dragged into the tribal courts. Despite detailed explanations as to why this was unlikely, the carrier would not relent. At the last hour, the program changed the status of its doctors from employees to independent contractors in order to maintain insurance coverage. Although a fix was found, it caused substantial problems for all parties concerned.

The FTCA's limited waiver of the federal government's sovereign immunity is now extended to tribes, tribal organizations and to non-tribal community health centers. It is illogical, and undermines the fundamental purpose for establishing federally funded urban Indian health programs, to not extend coverage to them as well. Section 515 of the Indian Health Care Improvement Act (S. 556) is essential to the future well-being of these programs and to the provision of basic services to urban Indian communities and should be preserved in the final version of this important legislation.

X. FEDERAL SUPPLY SCHEDULE PRICING FOR PHARMACEUTICALS FOR URBAN INDIAN HEALTH PROGRAMS

The ability of Urban Indian Health Programs to provide cost-effective pharmaceutical services depends on access to the Federal Supply Schedule. Pharmaceutical costs have skyrocketed. Notably, many Americans now travel to Canada to purchase their prescription drugs. This option is not viable for most urban Indian communities and is not preferable to receiving properly dispensed pharmaceuticals from an urban Indian health program. Without access to the Federal Supply Schedule, the fulfillment of the Federal government's trust responsibility to Indian peoples, as well as the cost-effective implementation of IHS's Urban programs, is seriously impeded.

Only five of the 33 Urban Indian Health Programs have access to federally discounted pharmaceuticals. All five of these are accorded this savings by virtue of their status as Section 330 community health centers. The rest of the Urban Indian Health Programs do not have this status and are not in a position to readily attain it. Instead, they look for the cheapest supplier on the market, usually paying far higher than the Federal Supply Schedule rate. As a result, the average expenditure on pharmaceuticals by a UIHP is $134,000/year, which for these small programs is a disproportionately and unnecessarily high portion of their total budget that substantially restricts the provision of other services.

Tribes and tribal organizations that have contracts with the Indian Health Service already have access to pharmaceuticals at Federal Supply Schedule pricing. Tribes and tribal organizations receive this access based on the Federal trust responsibility and on a commonsense commitment to maximizing the value of Federal dollars, not based upon their status as governmental organizations. The Urban Indian Health Programs secure their Federal funding from the exact same source as these tribes and tribal organizations and for the exact same purpose – to provide health care services to Indians in accordance with the Federal trust responsibility. For the same reasons, therefore, urban Indian health programs which utilize federal funds should also have access to the Federal Supply Schedule.

Consistent with the Federal government's trust responsibility to Indian peoples, Congress has funded, through the Indian Health Service, 33 Urban Indian Health Programs. Urban Indian Health Programs are a direct and important manifestation of the Federal government's trust responsibility to Indian peoples. As the Senate has noted:

> "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).

A legislative solution to this inequity. Section 517 of the Indian Health Care Improvement Act provides, among other things, that urban Indian organizations that have entered into a Federal contract or received a Federal grant pursuant to that title shall have access to the same sources of supply as Federal agencies. This is a critically important provision since the Federal Supply Schedule often provides the lowest cost available for a wide range of items, including pharmaceuticals. Access to this schedule greatly expands the purchasing power of the Federal dollars that urban Indian organizations receive, which, in turn, advances the implementation of Federal health care policy in support of urban Indians. That policy, as noted above, is rooted in the Federal government's trust obligation to Indian peoples.

The Federal government's policy of establishing an urban Indian health program, consistent with the Federal trust responsibility, would be greatly advanced by Section 517 of the Indian Health Care Improvement Act. Access to the Federal Supply Schedule not only maximizes the value of federal dollars, but is consistent with the current policy of providing such access to tribes and tribal organizations that have IHS contracts – a policy based in practicality and the Federal government's trust responsibility, not the governmental status of those entities.

XI. THE NEED FOR A 100 PERCENT FEDERAL MATCHING RATE FOR MEDICAID SERVICES PROVIDED AT URBAN INDIAN HEALTH PROGRAMS

Urban Indian health programs may participate as providers in their state's Medicaid program and receive payment for services covered by Medicaid that they furnish to Medicaid-eligible American Indians. Whatever amount the state pays the urban Indian program for a visit by a Medicaid patient, the Federal government will match the state's expenditure at the state's regular Federal Medicaid matching rate, or FMAP. For example, Arizona receives 65 percent of the cost of each Medicaid patient visit from the Federal government, California 51 percent, Colorado 50 percent, etc. In contrast, if an American Indian who is eligible for Medicaid receives primary care services covered by Medicaid at an outpatient facility operated directly by the I.H.S., or from a facility operated by a tribe or tribal organization under contract with the I.H.S., the Federal government will match 100 percent of the cost of the service.

NCUIH supports raising the Federal Medicaid matching rate in all states to 100 percent for the costs of covered services furnished to a Medicaid beneficiary directly by an urban Indian health program receiving funds under Title V of the Indian Health Care Improvement Act. Note that under this proposal, the enhanced FMAP would *not* apply to services furnished by providers to whom an Indian Medicaid beneficiary has been referred by an urban Indian health program. CBO estimates the cost of providing this fiscal relief to the states at $60 million over 5 years and $150 million over 10 years.

XII. URBAN INDIAN DEMONSTRATION PROJECTS – A THANK YOU

With leadership from this Committee, the Congress made permanent the Section 512 Demonstration projects, which include the Oklahoma City Indian Clinic, which I oversee in my capacity as president of the of the Central Oklahoma American Indian Health Council, Inc., operators of the Oklahoma City Indian Clinic. I would like to take this opportunity to formally thank you for your support. As a result, our excellent clinic will, in a stable environment, be able to continue to provide invaluable health care services to urban Indians in Oklahoma City.

XIII. CONCLUSION

Notwithstanding the difficulties, urban Indian health organizations, working with limited funds, have made a great difference in addressing the health care service gap for urban Indians.

However, there is much more work to be done. NCUIH thanks the Committee for its support in the past and thanks the Committee for this opportunity to provide testimony on the health status of urban Indians. NCUIH looks forward to working closely with the Committee in its work to assure the best possible health care for all American Indians.