

**TESTIMONY OF ANDREW JOSEPH, JR.**

CHAIRMAN, HUMAN SERVICES COMMITTEE,  
DIRECT SERVICES TRIBE ADVISORY COMMITTEE

PORTLAND AREA BOARD MEMBER, NATIONAL INDIAN HEALTH BOARD  
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Chairman Pallone, Ranking Member Deal and distinguished members of the committee, I am Andrew Joseph Jr. testifying on the behalf of the Direct Services Tribe Advisory Committee (DSTAC). I serve as a Tribal Council Member of the Confederated Tribes of the Colville Reservation. Also, I serve as the Chairman of the Northwest Portland Area Indian Health Board and the Portland Area Representative to both the National Indian Health Board and National Steering Committee for the Reauthorization of the Indian Health Care Improvement Act (IHCIA).

Thank you for inviting the DSTAC to testify today on H.R. 2708 - the *Indian Health Care Improvement Act Amendments of 2009*. The DSTAC represents those Tribes that have elected to receive their health care services directly from the IHS (Direct Service Tribes or DST). The Direct Service Tribes consider the decision to receive primary health care directly from IHS as an exercise of self-determination and the fulfillment of the federal trust responsibility owed to the Tribes. Out of the 564 federally recognized Tribes, IHS provides direct health care services to over 100 Tribes. The Direct Service Tribes account for over 50% of the total IHS population served and of the IHS resources. Many consider the Portland Area to be comprised entirely of self-governance Tribes and while 90% of our Tribes manage their programs under contracting or compacting agreements with IHS, there are five Tribes that continue to have IHS manage their health programs, which account for approximately 45% of the Portland Area budget. From a fiscal standpoint, this makes the Portland Area evenly split between direct service and tribally operated health programs. We appreciate the Committee's recognition to provide the DST the same consideration in providing testimony today as those Tribes who choose to exercise their self-determination rights by operating their own health services facilities.

Also, I would like to thank Congressman Pallone for introducing H.R. 2708 earlier this year. While H.R. 1328 was not passed last year, I hope we can build on the momentum from the last Congress and see H.R. 2708 passed this year. Since 1999, Tribes have been seeking reauthorization of the IHCIA. As you know, the reauthorization, or modernization, of the IHCIA is necessary so that improvements are made in the Indian health system to raise the health status of Indian people to the highest level possible. However, for reasons it is difficult to understand, passage of an IHCIA reauthorization bill has been obstructed each year by concerns of unrelated non-Indian legislation and issues, by an uncooperative Administration, or by non-Indian interests groups. I hope that the Committee will work with us to ensure that this bill is not sidetracked this year and this bill is passed as soon as possible.

### **Treaty and Federal Trust Responsibility for Health Care**

The United States government has a duty to ensure that comprehensive health care is provided to all AI/AN, at a level, which should be comparable to the care provided to any other American. For AI/AN people, the federal responsibility to provide health services represents a "pre-paid" right, paid for by the cession of over millions acres of land to the United States as documented by our treaties. DST hold and affirm that the treaties with the federal government ensure that health care will be delivered effectively in our communities in exchange for the millions of acres of valuable land that our ancestors ceded and that our treaties would be honored, "*as long as the grass grows and the rivers flow.*" In many of the treaties negotiated between the Tribes and the United States government, specific provisions were included for basic health care, such as the services of a physician and the construction and maintenance of hospitals and schools. The treaties are the sacred words of our ancestors, carrying the hopes, beliefs and assurances that the trust

obligation of the federal government will be fulfilled resulting in healthy individuals, communities and Tribes.

In 1976, Congress enacted the Indian Health Care Improvement Act (IHCIA), which forever changed the face of Indian health policy. With the IHCIA, Congress intended to honor the federal government's duty to provide health care; to address long-standing deficiencies in Indian health care; to increase the number of health professionals serving Indian communities; to authorize services to urban Indian populations; to rectify health facility problems; and to provide access for Indian patients to other federal health resources such as Medicaid and Medicare.

Today, the IHCIA continues to be a vitally important policy that serves as the foundation for the delivery of health care to AI/AN. Yet, the AI/AN population still suffers vast disparities in overall health status, and the funding appropriated to the IHS is abysmal relative to the per capita health care amounts provided to other federally-funded population groups (e.g., federal employees, Medicaid beneficiaries and even federal prisoners). IHCIA needs to be reauthorized to assure this baseline authority for providing direct health care to AI/AN is in place.

The Indian health delivery system also needs to incorporate many of today's health care practices. The American health care delivery system has been revolutionized while the Indian health care system has not. For example, mainstream American health care has moved away from hospital based treatment of disease to primary preventive care. The focus on prevention has been recognized as both a priority and a treatment. Also, the delivery of care has moved from the hospital settings to home and community based service providers, which is less expensive and more appropriate. The coordination of mental health, substance abuse, domestic violence, and child abuse services into comprehensive behavioral health programs is now standard practice. Reflecting these improvements in the IHCIA is a critical aspect of the reauthorization legislation.

### **Key Provisions in H.R. 2708**

Health care remains the top priority in Indian Country, and reauthorization of the IHCIA holds the most promise of improving the health status and outcomes in Indian Country. The IHCIA is a comprehensive piece of legislation like the Indian health programs that it authorizes. It addresses every aspect of what it takes to provide a true system of care for AI/AN people. I would like to speak to few provisions of H.R. 2708 that would have significant impact for the Direct Service Tribes.

#### ***Development of Health Care Professionals***

Title I addresses the critical need to increase the number of AI/AN entering the health professions, as well as ensure a sufficient supply of health providers throughout Indian Country. It is critical to the existence of our people that we have the most qualified and dedicated health personnel available. Unfortunately, many factors serve as barriers to the development, recruitment, and retention of qualified health personnel to serve in Indian Country. Such factors include the lack of opportunity for American Indians and Alaska Natives to receive quality medical education, disproportionate pay for health professionals, and the geographical remoteness of most health facilities. Continuity of care is dependent on the ability of a facility or Tribe to retain health

professionals. Title I seeks to fix many of the problems that hinder our ability to bring the best and brightest physicians, dentists, nurses, and other health professionals to Indian Country.

### ***Long-Term Care – An Innovation for Indian Country***

Sections 204 and 212 of Title II provides for the authorization for the Indian Health Service and Tribally-operated health systems to provide long-term health care, assisted living, home health services, hospice, and other related programs. If the Indian health system is to be modernize, then the Indian health programs must be authorized to make these services available for their patients. While the life expectancy of AI/AN is substantially lower than the rest of the general population, the ability to provide health care and related services for the elderly population remains one of the most pressing issues for Indian Country. If you were to ask American Indians and Alaska Native what services or programs are absent and/or inaccessible in Indian Country, the response you will receive is long-term health care, quality nursing homes, home-health programs, hospice and other similar programs.

### ***Elevation of the Indian Health Service Director***

Tribal leaders have long advocated for “elevation” of the IHS Director to that of an Assistant Secretary. We believe “elevation” is consistent with the government-to-government relationship and the trust responsibility to AI/AN Tribal governments throughout all agencies of the Department of Health and Human Services (HHS). While HHS has made great strides over the past several years to address tribal issues, the elevation of the IHS Director to that of an Assistant Secretary would facilitate the development of AI/AN health policy throughout the Department and provide greater collaboration with other agencies and programs of the Department concerning matters of Indian health.

The Direct Service Tribe’s close relationship with the IHS relies on the active support and partnership of the IHS, led by the IHS Director. The identification of service priorities for DST is the responsibility of the IHS Director working with the area office personnel serving our people at the local community level. Elevation of the IHS Director of an Assistant Secretary within the HHS would be a strong step in creating a direct link to the needs of the DST and the IHS budget priorities. The DSTAC and the IHS collaborative efforts would be enhanced through government to government dialogue with an Assistant Secretary position that would ensure tribal input, thus assisting the federal government in meeting its treaty obligations.

### ***Behavioral Health Programs***

Indian Country strongly supports Title VII authorizing the development of comprehensive behavioral health prevention and treatment programs which reflect tribal values and emphasize collaboration among social service programs, mental health programs, and alcohol and substance abuse programs. Title VII addresses all age groups and authorizes specific programs for Indian youth including suicide prevention, substance abuse and family inclusion. Improving the health status of AI/AN cannot be achieved without fully integrating behavioral strategies and services in every aspect of our systems of care.

## **Additional Recommendations**

In the recently introduced Senate bill S. 1790 to reauthorization of the IHCA, two key recommendations were included and should be included in H.R. 2708.

### ***Permanent Authorization of the IHCA***

As noted, this process to have the IHCA reauthorized has been long with considered investment of the tribes. As a tribal leader, I have to be able to justify the resources that our Tribe puts into trips to Washington, D.C. to seek to have legislation passed over the past 10 years. Recognizing the chronic underfunding of our health programs, I know that these vital resources could be put toward critical patient care. However, I and my tribe also understand the importance of ensuring that the IHCA reauthorized. To honor our treaties and to ensure the authority for our programs and for appropriations for our delivery care system, the bill should be amended to ensure the authorization for appropriations is permanent.

### ***Establishing an Office of Direct Service Tribes***

H.R. 2708 should also be amended to include the establishment of an office of Direct Service Tribes located within the office of the Director, or preferably, office of Assistant Secretary. The responsibilities of this office would include, among other things, providing technical support to the DST and serving as a point of contact for tribal consultation between DST and IHS.

### ***Tax Exemption for IHS Scholarships and Loans***

A full workforce of health professionals is a critical part of delivery of health care. Scholarship programs were designed to recruit and support AI/AN students into health profession and to link scholarship recipients to work directly in IHS and Tribal programs. To provide additional support to such recruitment and retention efforts, the NSC recommends adding a provision to make such scholarships and loans non-taxable to the recipient. This provision, incorporated in a previous IHCA reauthorization bill, would provide the same tax-exempt status to IHS scholarships as those awards provided to members of the National Health Service Corps.

## **Conclusion**

There are many important provisions in this bill that could be highlighted. As the Congress and Administration move toward developing health care reform policy for the United States, passage of the IHCA represents a modernization of the Indian Health care delivery system, and is essential for IHS and Tribal health programs to become viable partners in health care reform options.

I wish to thank the Committee for the opportunity to provide these comments and will be pleased to answer any questions the Committee may have.