

Coburn Amendment #4036 Prioritizes scarce resources to basic medical services over program expansions.

The Indian Health Service is plagued by rationing on a “life or limb basis” and quality of care for Indians is below what the rest of Americans enjoy. Instead of fixing the problems with basic medical services, the bill includes “more of the same.” The bill expands the burden of the IHS to fund hospice, long-term care, home-and-community based services, and long-term care.

This amendment would require funding go to what has already been promised to tribal members before we expand to new promises. IHS would have to prioritize basic medical services before paying for new programs.

Health Status of Tribal Members Ranks Below the General Population

The federal government has been providing health care to tribal members for more than 170 years. The earliest statutory authorization and appropriation explicitly for federal Indian health care was the act of May 5, 1832 that authorized Indian agents to employ local or U.S. Army doctors to provide smallpox vaccinations to Indians, and appropriated \$1,200 for that purpose.

The Snyder Act of 1921 provided a broad and permanent authorization for federal Indian programs, including for the “conservation of health.”

So we’ve been providing health care to tribal members for more than 170 years, and last year alone we spent \$3.18 billion on it.¹ Despite that amount of time to figure out how to get it right—and universal coverage under the Indian Health Service—tribal members suffer from health outcomes far worse than the rest of the population.

¹ Congressional Research Service

Indians—in comparison with the general population—are 6.5 times more likely to die from alcoholism, 6 times more likely to die from tuberculosis, almost three times more likely to die from diabetes, and 2.5 times more likely to die in accidents.

According to the National Library of Medicine: “statistics show Native Americans 2.6 times more likely to have diabetes mellitus as non-Hispanic whites of similar age.”

Only 71% of Native Americans receive prenatal care, compared to 84% for the entire population.

6.4% of live births involving Native Americans are from teen mothers; that compares to 3.4% for the whole population.

18.1 % of Native Americans women smoke during pregnancy; that compares to 10.7 % for the whole population.

American Indians suffer from a great death rate for chronic liver disease and cirrhosis. For Native Americans, the death rate is 22.7 per 100,000 population. For whites that number drops to 9.2 per 100,000 and for African Americans, the number drops further to 7.9 per 100,000.

In terms of life expectancy, IHS has found that “American Indians and Alaska Natives born today have a life expectancy that is 2.4 years less than the U.S. all races population (74.5 years to 7.9 years, respectively).²

Clearly, the health services being provided by the Indian Health Service, at best, need significant improvements and repair. At worst, these services are complete failures.

² Congressional Research Service

Rationing Plagues the Indian Health Service

Native Americans, the general population, Democrats, and Republicans have all decried the rationing in the Indian Health Service.

Senator Dorgan has held numerous hearings and even spoken on the Senate floor about the rationing crisis in the Indian Health Service.

Indian Health Service facilities typically ration services on the basis of whether or not it will save a “life or limb.”³

For 2005, the per capita federal health expenditure by the IHS was \$2,130—about one-half the per capita spending for federal prisoners' health care. IHS per capita spending was far below the estimated per capita benchmarks of Medicare at \$6,784 and the Veterans Administration at \$4,653.⁴

IHS has job vacancy rates of 32% for dentists, 17% for nurses, 13% for optometrists, and 12% for physicians and pharmacists.⁵

It's common to hear “Don't get sick after June” in Indian country because there isn't sufficient funding to treat patients that late in the fiscal year.⁶

Dr. Charles Grim, Director, IHS: "We're only able to provide a certain level of dental services in certain populations. We're only able to refer a certain level or number or types of referrals with our contract health service budget into the private sector.... But I guess one generalized statement would be that we have a defined population and a defined budgetBut it has led to rationing in some parts of our health care system."⁷

³ Senator Byron Dorgan <<http://www.indiancountry.com/author.cfm?id=778>>

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⁵ Indian Health Service: Health Care Delivery, Status, Funding, and Legislative Issues *CRS Report for Congress*

⁶ http://www.fcni.org/issues/item.php?item_id=1949&issue_id=109

⁷ Political Transcripts by CQ Transcriptions, "HOUSE COMMITTEE ON APPROPRIATIONS, SUBCOMMITTEE ON INTERIOR, ENVIRONMENT AND RELATED AGENCIES HOLDS A HEARING ON INDIAN HEALTH SERVICE," April 17, 2007

According to a 2005 GAO report entitled *Indian Health Service: Health Care Services Are Not Always Available to Native Americans*, there are wait times and insufficient care.

- GAO visited 13 IHS-funded facilities (in 2005) and found that waiting times at 4 IHS-funded facilities ranged from 2 to 6 months for women's health care, general physicals, and dental care.
- 3 facilities said that all same-day appointments were filled within 45 minutes of the phone lines being opened; they were turning away at least 25 to 30 patients a day.
- 3 IHS-funded facilities reported that many Native Americans were required to travel over 90 miles one-way to obtain care. Hence, rather than go and wait all day at the facility to see a provider, patients would wait to seek care until their condition became an emergency that required a higher level of treatment.
- Most facilities did not have the staff or equipment to offer certain services on site, so resorted to contract care. However, contract care was not readily available because care was rationed on the basis of relative medical need at 12 of the 13 facilities.

Gaps in services result in diagnosis or treatment delays that exacerbate the severity of a patient's condition and create a need for more intensive treatment, and mean that many Native Americans live with debilitating conditions.

- IHS reports that their facilities are required to pay for all "Priority I" services but admits that, at many of their facilities, available funds are expended before the end of the fiscal year and payment is not made.
- 21 percent of their maternity patients had three or fewer prenatal care visits, well below the recommended number. The American College of Obstetricians and Gynecologists recommends a minimum of 14 visits for a full-term (40-week) pregnancy with no complications.

Funding Disparities⁸:

- The IHS does not provide the same health care services in each area it serves. IHS shortfalls in medical personnel contribute to this unevenness in health care delivery. Most IHS funding is not allocated based on formulas but rather on historical patterns of recurring "base funding" as adjusted by annual built-in increases to keep programs at current levels. Therefore, allocations do not take into account changes in population, health needs, and health services.
- FDI studies found significant funding variations within the IHS -- estimating, for instance, that in FY2004 161 (61%) of the 266 operating units were funded at or below 60% of FEHBP-equivalent (or adequate) services, while 49 (18%) operating units were funded at over 80% of need.
- And funding shortfalls in other service areas: facilities maintenance was funded at 27.5% of need for FY2004; replacement of biomedical equipment was funded at about 20% of need in FY2004; and health professions scholarships were funded at 10% of new applications in FY2005.

Under an overburdened system like this, drastically expanding services offered—to 4 broad new areas—will only drain the resources available to the basic core medical services. Making new promises, when current promises aren't being kept, doesn't help Indians.

It's kind of like taking out a loan on a brand new car, when you can't even buy food for your family. We need to take care of the most basic medical services first.

Specifically, the bill seeks to add long-term care, assisted living, hospice, and home- and community-based services.

⁸ CRS Report RL33022, "Indian Health Service: Health Care Delivery, Status, Funding, and Legislative Issues"

While no one will argue that these aren't nice services to have, it is important to note that Medicare and Medicaid pay for these types of services for those that really need the financial help.

Indians that qualify for Medicare and Medicaid—seniors and poor folks—can already get long-term care, hospice, and home- and community-based services paid for by the government.

Hospice care is covered under Medicare, long-term care services are mostly handled by Medicaid, with some Medicare involvement, and home- and community-based services are covered by Medicaid.

So the vulnerable populations are already covered—we don't need to increase the burden on IHS.

Expanding these programs will eventually eat up a huge portion of IHS, at a time we really need to focus on fixing basic problems. In fact, long term care consumed 34.2% of Medicaid's \$300 billion budget last year--\$104.4 billion.

Instead of Fixing the Problems, This Bill Is More of the Same

This bill barely scrapes the surface of what is required to change that. Instead this bill, just includes “more of the same.” Instead of a focus on improving basic medical services, the bill expands health services, adding a vast array of new services and strains on an already overburdened system.

For example, why would we expand the definition of “health promotion” to include “personal capacity building” or “healthy work environments” or “improving the physical, economic, cultural, psychological, and social environments” at a time when the Indian Health Services is rationing basic services on a “life or limb” basis?

This bill dramatically expand the type of health services—long term care, assisted living, home- and community-based services, and hospice—when the Indian Health Service can't even provide basic medical services without “life or limb” rationing. Furthermore, Medicare already pays for hospice and home- and community-based

services. Long-term care costs make up a significant portion of the Medicaid program—that many Native Americans qualify for. When IHS per capita expenditures are \$2,130 compared to a per capita expenditure of \$4,328 in Medicaid or \$6,784 in Medicare, expanding IHS services will most certainly weaken the provision of basic medical services.

This amendment is about priorities. It isn't saying that IHS can't fund these new programs, it's just saying that we need to focus on BASIC medical services first. In a system as bad as the IHS, keeping our promises means nothing less.