Amendment 4035--- To prioritize patient care over administrative overhead.

S 1200 reauthorizes most Indian health programs, and authorizes the creation of additional programs and services for Native Americans. In total, it guides the work of the Indian Health Service and tribes in meeting the Federal government's obligations to provide health care to tribal members.

Funding has historically been scarce, and health outcomes for tribal members have consistently lagged behind other segments of our population.

The Indian Health Service (IHS) has struggled to keep pace as health care has progressed and as more tribes elect to administer their own programs. Tribes and tribal members are often stifled by an outdated bureaucracy.

Amendment 4035 simply requires that IHS maximize resources available for patient care, and minimize administrative expenses that drain scarce resources. At least 85 percent of funds made available for Indian health programs must go towards medical services authorized by this Act.

As a matter of principle, and as a matter of conscience, Congress must do all that it can to ensure that scarce resources get to those who most need it. Federal bureaucracies should be a partner in this progress, not a hindrance.

Health care funding for Native Americans is woefully inadequate.

Indian Health Service funding per capita was $1,664 in FY 2006. This compares to $5,799 for the Veterans Affairs Administration.[1]

Funded at $3.18 billion in FY 2007, appropriations have remained relatively flat for four consecutives fiscal years.

[1] http://www.congress.gov/erp/rl/pdf/RL33022.pdf

Preventative health funding, which is a critical aspect of modern medicine that saves lives and money, has remained low. For FY 2007, preventative health funding stood at $125 million.

During the FY 2006 appropriations debate, a Coburn amendment that would have dramatically increased funding for program like the Special Diabetes by over $100 million, received 17 votes in the United States Senate.

Tribal members are receiving below average health care services.

The Government Accountability Office (GAO) notes that Native Americans living in IHS Service Areas face "considerably higher mortality rates." "For Native Americans ages 15-44 living in those areas, mortality rates are more than twice those of the general population."[2]

The same GAO analysis shows wait times for appointments (for primary care) at four highlighted facilities ranging from two to four months. Services requiring the longest wait times include women's health care, general physicals and dental care.

In comparison, the Department of Defense's TRICARE Prime program is required to schedule routine appointments within 7 days and routine specialty within 30 days.

Gaps in services are resulting in treatment delays, with disastrous consequences for tribal members. GAO uncovered the following examples: "…tribal health board members at one facility described the case of an elderly woman who had complained of back pain and was diagnosed with cancer only when one of her legs broke. Tribal representatives at another facility cited the example of a young man whose lung condition was only properly diagnosed when, after months of treatment for pneumonia, **he went to an emergency room and was found to have a tumor that killed him 3 weeks later."**[3]

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[2] http://www.gao.gov/new.items/d05789.pdf GAO- 05-789, August 2005

[3] ibid

Reports throughout Indian Country indicate the current services are already being rationed. The Muscogee Creek Nation in Oklahoma reports having to ration care at its facilities, and it is certainly not alone[4].

The results of inadequate care are obvious and tragic.

According to the Congressional Research Service (CRS), "the average life expectancy at birth for the IHS service area population in 1999-2001 was 74.5 years, or 2.4 years less than the 76.9 years for the total U.S. population."[5]

Statistics provided by the Indian Health Service reveal that Native Americans, when compared to all other Americans, have higher rates of "tuberculosis (600% higher), alcoholism (510% higher), motor vehicle crashes (229% higher), diabetes (189% higher), unintentional injuries (152% higher), homicide (61% higher) and suicide (62% higher)."[6]

When compared to the rest of the population, Native Americans are facing much higher mortality rates. Mortality rates per 100,000: 1) Alcohol induced is 42.1 compared to 6.9; 2) Cervical cancer induced 4.5 compared to 1.4; Diabetes induced mortality is 73.3 compared to 25.3.[7]

There are 8.5 infant deaths per 1,000 live births for Native Americans compared to 6.8 for the general population. The same trends holds for maternal deaths. Native American mothers face a mortality rate of 12.5 per 100,000 versus 9.9 for the general population. [8]

Only 71 percent of Native Americans receive prenatal care, compared to 84 percent for the entire population.[9]

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[4] http://64.62.196.98/News/2007/000701.asp
[5] http://www.congress.gov/erp/rl/pdf/RL33022.pdf
[6] http://info.ihs.gov/Files/DisparitiesFacts-Jan2006.pdf IHS: Facts of Indian Health Disparities; January 2006
[7] Ibid

[8] ibid
[9] http://www.cdc.gov/nchs/data/hus/hus06.pdf#001

18.1 percent of Native American women smoke during pregnancy, compared to 10.7 percent for the whole population.[10]

The Centers for Disease Control reports the following[11]:

"In 2001, American Indians/Alaska Natives had the highest rate of Sudden Infant Death Syndrome (SIDS) of all racial/ethnic groups (124.2 per 1,000 live births), 2.2 times higher than the rate for all populations (55.5 per 1,000);"

"In 2003, American Indians/Alaska Natives had the highest death rate from Chronic Liver Disease and Cirrhosis (22.6 per 100,000), 2.4 times higher than the rate for all populations (9.3 per 100,000);"

"In 2004, the rate of Gonorrhea among AI/ANs was 117.7 per 100,000 per 100,000 population, 5.5 times higher than the rate among Asian Americans and Pacific Islanders, the group with the lowest rate;"

"The estimated rate of AIDS diagnoses for American Indian and Alaska Native adults and adolescents was 9.9 per 100,000 persons." This compares to 7.1 for white Americans and 4.4 for Asian Americans.

Given these dire statistics, it is absolutely critical that the Indian Health Service effectively maximize its resources for patient care. IHS has a long way to go.

IHS has 14,392 employees, including 2162 Commissioned Officers (CO). The latter CO's include 8 Assistant Surgeon Generals, 439 "Director Grade," 601 "Senior Grade." Salaries for the CO's total $135 million. Salaries for all other IHS employees is estimated at: $655 million. [12]

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[10] ibid

[11] http://www.cdc.gov/omhd/Highlights/2006/HNov06.htm

[12] http://www.ihs.gov/NonMedicalPrograms/BudgetFormulation/documents/IHS%202008%20Congressional%20Justification%20Budget-FINAL.pdf

The IHS spent $2.8 million on conferences in FY 2006 and $33.7 million on travel for the same period. [13]

According to the Office of Management and Budget (OMB), the Indian Health Service has an unobligated balance of $182 million for FY 2008. The Department of Health and Human Services has $247 million in unobligated balances for "Indian health facilities construction."[14]

In a recent follow up of audit recommendations, the agency Inspector General reported: "IHS did not resolve all audit recommendations in a timely manner because it did not follow departmental policies and procedures. As a result, ***IHS did not have reasonable assurance that it was exercising proper stewardship over Federal dollars.*** Based on the backlog of outstanding audit recommendations, we are also concerned that IHS will not resolve future recommendations in a timely manner."

Congress has a responsibility to ensure that every available dollar be used for patient care, and not by a federal bureaucracy

The Indian Health Service is not entirely to blame for the present situation. Certainly, it can and must operate as efficiently as possible, and in many areas, it is making strides.

Ultimately, Congress is to blame and it can take a small step forward by ensuring that health care dollars go to make people well.

The pending amendment will do just that.

[13] Department of Health & Human Services, Letter to Tom A. Coburn, MD; February 16, 2007
[14] http://www.whitehouse.gov/omb/budget/fy2009/pdf/balances.pdf