

TALKING POINTS for Senator Tom Coburn, M.D.

Improving the health of American Indians is widely-supported goal. Senator Dorgan's heart is in the right place regarding this bill, and he has spent countless hours seeking to reauthorize the Indian Health Care Improvement Act.

However, I believe that, as drafted, this legislation doesn't fix the underlying problems that we see in the Indian Health Service—rationing, wait lines, and inferior quality. Business as usual is no longer acceptable. Members of Congress, tribal leaders, and citizens of this country can longer tell tribal citizens that the current system of health care delivery in Indian Country is tolerable. A system that turns away those most in need, and that rewards bureaucracies and punishes innovation, cannot be allowed to persist.

Reauthorization of a Broken System Isn't "Improvement"

Those who say that a failure to reauthorize the Indian Health Care Improvement Act is a violation of our trust obligations—are correct. However, simply reauthorizing the same old system with minor modification is an ever greater violation of that commitment.

Dozens of tribal leaders are not expressing enthusiasm for the current structure. Instead, there is constant and consistent theme of frustration, anger, and resolve that we must do better, that we must unlock the potential of tribes to design their own health care systems that recognize the unique needs of the community. This country needs a system that maintains the flexibility of tribes to seek outside investment, and that rewards innovative health practices, instead of punishing those whose try to make the lives of their citizens better.

The myriad of problems facing health care in Indian Country, are many of the same issues confronting health care delivery throughout rural America. They are compounded, however, by a system that refuses to recognize its own role in holding back health care delivery for tribal citizens.

In designing health care reform, markets work when they are allowed to: they lower the price of all goods and services and they attract much needed outside investment. Many tribes in Oklahoma are at the forefront

of new and innovative health care delivery systems, and they are poised to become a model for delivery throughout the system. Congress must ensure, however, that their efforts aren't discouraged or stopped altogether by the current system. Furthermore, there is no good reason that forward thinking tribal governments should be prevented from developing market driven health care centers of excellence that will attract researchers, physicians and patients for cutting edge, life-saving treatments.

Furthermore, this legislation fails to focus on empowering individual tribal members. Individual patients tend to receive better, more effective care when they are empowered to make their own health care decisions. Congress should explore ways to accomplish this objective, and give tribal citizens a reason to invest in their own health. Long lines, bureaucratic headaches and rationed, substandard care completely disallow this sort of investment.

There will be differences on the specific steps, but there can be no doubt that we all agree on the urgent need to deliver higher quality health care in Indian Country. To that end, Congress should work to bring about a system that upholds its commitments and best serves all tribal citizens.

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

¹ Congressional Research Service

under the Indian Health Service—tribal members suffer from health outcomes far worse than the rest of the population.

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.

Rationing Plagues the Indian Health Service

² Congressional Research 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

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.

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

- 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:

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

- 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.

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.

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.

The bill would allow IHS to pay for yoga and witch doctors rituals

The bill provides funding for traditional health care practices. While traditional health care practices may comprise an important cultural role, the health care provided by the federal government should be scientifically proven effective. One example of “traditional health care practices” in Oklahoma included yoga and night sessions in the medicine circle of fire. The following is a quote from the website of the traditional healing site:

“The treatment process...including the **reading of their journal and commenting upon what has been written**, reviewing art they may have produced on assignment, general processing and integration of their experiences and what they are learning, **hypnosis and/or imagery, body therapy, acupuncture, therapeutic touch,**

projective techniques including the use of native American images, shields, or animal images; and ceremony. The work might include **mediation, Reiki and energy healing, yoga**, craniosacral therapy, homeopathic consultation in these individualized programs. Clients are introduced to the use of ceremony in therapy and for their own personal growth. **Night sessions may take place outside in the medicine circle with a fire**...if they are strong enough or ready, are taken to the **top of a nearby mountain to sit for the night and perhaps receive a vision**. During the intensive healing retreat, several helpers...assist participants to explore self and spirit...**and to forge relationships with their inner parts necessary for healing.**”

It is possible to respect the traditions of the Indian people, and appreciate their traditional healing practices. However, taxpayers should be funding care that is proven to be scientifically effective. Congress doesn't need to be in the business of paying for or even questioning the value of traditional health practices. Congress should stay out of it altogether.

The bill distracts Medicaid and Medicare from their core missions

The bill includes changes to Medicare and Medicaid law that will distract the focus of those programs from the population that they are intended to serve.

This bill would weaken the eligibility documentation requirements that every other citizen of this country must provide. This is especially concerning when some state-recognized tribes have been selling membership to thousands of illegal aliens—for a bargain price of \$50—claiming they can achieve legal status by joining the groups.⁹

This bill would allow individuals to be eligible for Medicaid—a program intended for poor Americans—even if they own a million dollar home or a lucrative casino on Indian lands.

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<http://www.washingtontimes.com/apps/pbcs.dll/article?AID=/20070818/NATION/108180051/1002&template=printart>

This bill would also give Indians special treatment that no other poor person in this country gets. Under current Medicaid law, States may ask for minimal cost-sharing for Medicaid services--\$2-3 for a visit to the doctor—less than the price of a cup of Starbucks coffee. Cost-sharing isn't about the money, it's about letting patients be a part of the health care process. This bill would specially exempt Indians from very minimal cost-sharing requirements—that every other poor person participates in.

Expanding services to these four new categories will significantly weaken basic medical services

We'll have either an unacceptable increase in total funding (at a time when the country is \$9.2 trillion in debt--\$30,000 for each American citizen) or underfunding of the most critical areas—provision of clinical health services to reservation Indians.

Resources should be most effectively spent where the need is the greatest.

Furthermore, Native Americans that qualify for Medicare and Medicaid—those truly in need for assistance—are already eligible for hospice, long-term care, and home-and-community-based services.

The fact that politicians are debating this in Washington—what types of health care services we're going to give or not give and what can we afford—is exactly why America should not go the route of a single payer system for all its citizens. Do we really want politicians in Washington deciding what your health care looks like?

The Bill Lacks the Real Reform that Indians Deserve

What most concerns me is the lack of real reform in this bill. Instead of taking a long hard look at what needs to fundamentally change with this bill, we've simply added on more of the same. That does a fundamental disservice to the very people we claim to want to help.

Congress should consider innovative approaches to care—like a demonstration project that will allow tribal citizens to receive health care wherever is best for them with dollars the IHS might have otherwise

misused. While this will not provide a perfect panacea, in more developed regions, it will inject competition into a sector that desperately needs it.

The Indian Health Services is simply a microcosm of what is happening full scale in many European countries and Canada.

Rationing, wait lines, and inferior quality inevitably plague single-payer systems. Socialized medicine “pays for itself” by rationing care and allowing people to die before their time.

Access to cancer treatment became a major national crisis in Britain when patients were having to wait a year or more after being diagnosed to begin chemotherapy treatment. The British government now is spending a fortune in an effort to reduce that waiting time to three months by 2010.¹⁰

In Sweden, patients sometimes have to wait 25 weeks for heart surgery.

Canadian Supreme Court Chief Justice Beverly McLachlin said it best in a 2005 ruling: “access to a waiting list is not access to healthcare.”

One Canadian doctor described his experience in a Canadian ER: it overflowed with elderly people on stretchers, waiting for admission. Some, it turned out, had waited five days. The air stank with sweat and urine.¹¹

Some of his patients had to wait for practically any diagnostic test or procedure, such as the man with persistent pain from a hernia operation whom we referred to a pain clinic — with a three-year wait list; or the woman with breast cancer who needed to wait four months for radiation therapy, when the standard of care was four weeks.

Government researchers now note that more than 1.5 million Ontarians (or 12% of that province's population) can't find family physicians. Health officials in one Nova Scotia community actually resorted to a lottery to determine who'd get a doctor's appointment.

¹⁰ Galen Institute: <http://www.galen.org/healthabroad.asp?docID=950>

¹¹ David Gratzner, Investor's Business Daily: <http://www.ibdeditorials.com/IBDArticles.aspx?id=270338135202343>

More than 1 million Britons must wait for some type of care, with 200,000 in line for longer than six months.

In France, the supply of doctors is so limited that during an August 2003 heat wave — when many doctors were on vacation and hospitals were stretched beyond capacity — 15,000 elderly citizens died. Across Europe, state-of-the-art drugs aren't available.

As America listens to the Presidential candidates debate health care, we should remember that nearly every country with a single-payer system is moving away from that system:

- Canada's Supreme Court recently struck down a law that banned access to private health care for the citizen's of Quebec after an elderly Montrealer waited a year for a hip replacement.
- Britain's Labour Party — which originally created the National Health Service — now openly favors privatization.
- Sweden's government, after the completion of the latest round of privatizations, will be contracting out some 80% of Stockholm's primary care and 40% of its total health services.

The conditions in single-payer European countries and Canada sound remarkably similar to the conditions in the Indian Health Service.

There are two big lessons to learn from this

First, as Congress discusses Indian health care over the next several days, America as a country should take note of what a single payer system really means in terms of the quality of care that we can expect. America should not go the route of a single-payer system—the promise may sound alluring, but the reality is inevitably negative.

Second, fixing the system for Indians demands more than just adding on more new programs and services. We need a fundamental overhaul of the system. The members of federally-recognized tribes—that we have a trust obligation to provide health care for—deserve better than this bill. They deserve choice, quality, and the health care outcomes that the rest of this country enjoys.

Throughout the debate on this bill, you'll hear the same statistics on rationing and wait lines from both Democrats and Republicans.

Some will argue that the solution involves just passing this bill that's loaded with new programs. However, that's just "more of the same." Every time we pass an "Indian Health Care Improvements Act" bill we cite the same terrible statistics. We pass the bill because we "need to do SOMETHING." **But each time we've passed the "Improvement Act," Indian health care never improves.**

Indian health care never improves because we never fix the inefficiency that plagues the Indian Health Service—we just reauthorize and add new bureaucratic regulations to the same dinosaur.

Statistics for the Indian Health Service:

- The Indian Health Service 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.
- The IHS spent \$2.8 million on conferences in FY 2006 and \$33.7 million on travel for the same period—and the travel numbers don't even include reimbursements!¹²
- The Office of Management and Budget (OMB) estimates that IHS carries an unobligated balance of \$162 million. The actual number for FY 2005 was \$183 million.¹³

Reauthorizing a system that is failing its target population should not be our goal. We have a duty to ensure that scarce resources go to patient care.

This latest iteration of the Indian Health Care Improvement Act "improves" the problems instead of "improving" the solutions.

¹² Department of Health & Human Services, Letter to Tom A. Coburn, MD; February 16, 2007

¹³ <http://www.whitehouse.gov/omb/budget/fy2008/pdf/balances.pdf>

What we need to be focusing on are results for American Indians. We need to empower individual Indians with choice and give them real health care—not access to a waiting line.