

WRITTEN TESTIMONY

**Recommendations Regarding
Urban Indian Health For H.R. 1328:
The Indian Health Care Improvement Act Amendments of 2007**

**U. S. House of Representatives
Committee on Energy and Commerce
Subcommittee on Health**

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Room 2322 Rayburn House Office Building**

submitted by:

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Seattle, Washington**

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by

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Seattle Indian Health Board
Seattle, Washington

Mr. Chairman and members of the Subcommittee on Health to the House Committee on Energy and Commerce, thank you for inviting me to testify regarding H.R. 1328, a bill to reauthorize and extend the Indian Health Care Improvement Act. My name is Ralph Forquera. I am Executive Director for the Seattle Indian Health Board, one of 34 private, non-profit organizations that contract with the Indian Health Service under Title V of the Act we are discussing. I am an enrolled member of the Juaneño Band of California Mission Indians, a state-recognized Indian tribe from the San Juan Capistrano region of Southern California.

For the past 25 years, I have worked to address the health needs of urban Indians first in San Diego, and for the past 17 years, as the Director for the Seattle program. During that time I have seen a steady migration of Indian people into American cities and according to the 2000 U. S. Census, 67% of the 4.1 million Americans self-identifying as American Indian or Alaska Native are living in cities. My agency provides direct health care to 7,000 individuals, about 4,000 of whom are American Indian or Alaska Native. Through our outreach,

community services, health education, and organizational work, we estimate that we interact with close to 10,000 Indians yearly, about one-third of the local Indian population in the Seattle area. Many of our non-Indian clients are family members of Indian households.

Through our work at the Urban Indian Health Institute at my agency, we have documented severe health disparities among urban Indians in all 94 U.S. Counties served by an urban Indian health organization. Factors such as poverty, inadequate education, homelessness, and other social conditions contribute to these inequities. Additionally, many urban Indians lack health insurance that limits their ability to receive adequate levels of health care. Like most health care institutions, we are experiencing an epidemic of chronic health conditions. Because we offer only primary health care as one element of our services through our organizations, access to specialty care has become increasingly limited. This problem inhibits some patients from seeing the type of improvement in their health that could be achieved with a more comprehensive system available for their needs.

The urban Indian health program within the Indian Health Service, outlined as Title V of this Act, is the foundation for our work. The resources and support we receive through the Indian Health Service is the anchor for our local planning and development that allows for direct participation by the local community in the planning and implementation of programs and services as envisioned by the

current policy of Indian self-determination. Most all urban Indian health organizations receive non-Indian Health Service funds from local, state, private, and other federal sources to expand their service capacity and address specific needs. Currently, the IHS funding leverages approximately \$2.00 from other sources for every IHS dollar invested.

Urban Indians are a diverse group of aboriginal people. Many are enrolled members of federally-recognized tribes who live in cities. Some belong to state-recognized Indian tribes. 41 states currently recognize nearly 150 Indian tribes with many not recognized by the federal government due to the termination and relocation policies of the 1950s and historical events that have prevented federal acknowledgement. Urban Indians are also descendents of adoptees, Indian children taken from their families in the early 20th century and placed in non-Indian homes in an attempt to “civilize” and assimilate them. In recent years, there are a growing number of Indian people who are of either mixed-race heritage or mixed-tribal affiliation that prohibits them from membership in a tribe. Since individual tribes can determine membership, criteria to join are not automatic and tribal rolls may be closed or restricted by individual tribal choice.

Urban Indian communities are also geographically dispersed throughout metropolitan areas. They are often small compared to other minorities in cities. For this reason, advocacy and local involvement is critical to assure that urban Indians are not overlooked in local planning.

Finally, the majority of urban Indians do not have the option of returning to their home reservations for health care as is often claimed by opponents of the urban Indian health programs. Many do not have a reservation to return to or live a long distance from their home reservation, and those who do return may not be eligible for services or the services they need may not be available at their tribal program. In these instances, access through urban Indian health organizations is critical to their welfare.

The Indian Health Service (IHS) focuses its work on Indians living on or near Indian reservations and members of federally-recognized tribes. Title V is intended to provide core funding to allow local urban Indian communities to organize and build health capacity in cities. This effort has been overwhelmingly successful over the past 30 years since this legislation was first enacted. Receiving barely 1% of the overall IHS funding each year, just under \$34 million in FY07, urban Indian health organizations have successfully maintained community-based programs and services sensitive to cultural concerns and effective in reaching out to urban Indians generally overlooked by other institutions. For this reason we believe that the Indian Health Care Improvement Act must be reauthorized and that the urban Indian health program be retained because health disparities continue to exist.

As you are well aware, the Bush Administration has proposed eliminating funding for urban Indian health in both the FY07 and FY08 Presidential budgets. Fortunately, the Congress has not agreed to this proposal and has continued its modest financing of our work. I have attached suggestions for changes to the bill that I believe will strengthen the standing of the urban Indian health program and will assure our continued involvement in the Indian health initiative. Our services are an essential part of the Indian health agenda for we have the capacity to reach out to all Indians throughout the nation and assure that their needs are addressed.

The Indian population has expanded beyond the boundaries of the reservation and many Indians in cities face enormous challenges that threaten their health. Urban Indian health organizations have amassed knowledge and experience that assures that Indians living in cities are not forgotten and that their needs are recognized and assistance is provided. With the trend toward urbanization to likely continue for decades to come, the importance of our work cannot be over stated. Therefore we ask for your earliest passage of this important bill and your continued recognition of the standing of urban Indians by passing the Act with the Title V provisions intact.

Thank you for the opportunity to provide this testimony. I appreciate your allowing me to share my thoughts on this important legislation for Indian people.

Appendix A

Recommendations for Changes in HR 1328

In Section 2 of the bill, FINDINGS: I believe that inserting the attached language consistent with Congressional intent and practice will serve to strengthen the standing or urban Indian health as an intentional initiative to address health concerns of urban Indians.

Proposed language:

() the government's responsibility to provide health care services to Indians does not end at the borders of an Indian reservation, but follows that individual. Urban Indians maintain their standing as Indians when living in cities and, thus, the urban Indian health program is designed to assure that Indians living in cities are assisted in achieving improvements in their health status.

Congress has made similar statements in reports (including Senate Report 100-508, Indian Health Care Improvement Act of 1987, September 14, 1988, p. 25, and elsewhere) but has not done so in statute. By adding this paragraph to the FINDINGS Section, the Congress will reassert its consistent intention to address health throughout Indian Country today, and will define that Title V, Health Services for Urban Indians, is your way of implementing this policy.

In Section 3: Declaration of National Indian Health Policy, I am requesting that the bill return to the language included in P.L. 102-573 that includes the words "and urban Indians" in paragraph (1) of this statement so that after the words "highest possible health status for Indians" adding, "and urban Indians." We have found that when urban Indians are not specifically spelled out in legislation, regulation, or grant and contract proposal requests, that the assertion is that we are NOT included. Therefore, if the bill intends to include urban Indians as a part of the national policy, I believe it essential that this be clearly stated in the language of the Act.