

WRITTEN TESTIMONY OF KEN LUCERO
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CHAIRMAN, ALL INDIAN PUEBLO COUNCIL HEALTH COMMITTEE,
CHAIRMAN, INDIAN HEALTH SERVICE ALBUQUERQUE SERVICE UNIT
INDIAN HEALTH BOARD
BEFORE THE
UNITED STATES HOUSE
COMMITTEE ON ENERGY AND COMMERCE
ON
THE REAUTHORIZATION OF
THE INDIAN HEALTH CARE IMPROVEMENT ACT

JUNE 07, 2007

Chairman Pallone, Ranking Member Congressman Deal and Members of the Honorable Subcommittee on Health:

My name is Ken Lucero and I am a Councilman from the Pueblo of Zia. I am here on behalf of the men, women and children of Zia Pueblo and the 19 Pueblo Nations of New Mexico. I bring greetings from Zia and the All Indian Pueblo Council. I thank Congresswoman Wilson for her invitation to testify on the Indian Health Care Improvement Act Reauthorization bill, H.R. 1328, to House Energy & Commerce Committee, Subcommittee on Health. Her recognition of the need for the Pueblo Nations in New Mexico to articulate their needs concerning health care is greatly appreciated. Congresswoman Wilson is genuinely concerned about the challenges faced by the Albuquerque Area Service Units and specific issues related to diabetes, dental care and youth suicide. Thank you on behalf of the Pueblo of Zia and the All Indian Pueblo Council.

The Indian Healthcare Improvement Act (“Act”) was originally passed by Congress in 1976 and signed by the Late President Gerald R. Ford. The Act expired in FY 2000 and since then American Indian Alaska Native leaders and Indian health advocates have petitioned Congress to reauthorize the Act so that Indian health care may be modernized and that disparities in Indian health can be positively addressed.

Unfortunately, the reauthorization of this important, life saving, Act has not happened. For nearly a decade, Tribal leadership from many tribal nations have come before Congress and have shared their tribe’s health care tragedies that have befallen their

elderly and their children alike. Today, I add my voice to those honorable tribal leaders that have come before me in calling for the reauthorization of the Indian Health Care Improvement Act.

In 2003, the U.S. Commission on Civil Rights issued “A Quiet Crises: Federal Funding and Unmet Needs in Indian Country.” This report highlighted the Federal government’s failure to provide adequate funding and meet trust obligations reported that American Indian health care is funded at only half of what is needed to meet the statutory goal of eradicating the health disparities of Native Americans. Among the Commission report’s other findings, Native Americans are:

318% more likely to die from diabetes

630% likely to die from alcoholism

650 % more likely to die from tuberculosis

Honorable members of the Committee, these statistics are gathered from tribal communities; tribal members, grandparents, grand children, mothers, daughters, husbands, nephews, nieces. These statistics are real.

I understand how it is difficult for this committee and your fellow Members of Congress to identify with the stories and data buried in the mounds of testimony provided on behalf of the Act.

So, let us say that the House of Representatives is a Pueblo in New Mexico and the Senate represents other groups of Americans. Picture your fellow law makers as

members of your community. You are all somehow related and you view each other as a large extended family.

How would this report affect your community?

In the case of diabetes, if 1 Senator died from complications of the disease, you could expect 14 of your members to also die from diabetes. If 1 Senator dies from alcoholism, 27 are expected to do the same within your membership. Finally, if 1 member of the Senate dies from tuberculosis, 28 of your colleagues will meet the same fate.

In New Mexico alone, the state's 205,000 Native Americans have the highest rates of death among the state's total population for diabetes, alcoholism, pneumonia and influenza. Our children suffer the highest rates of behavioral health risks such as substance abuse, smoking, illicit drug use, and obesity. The five major reasons for outpatient care at Indian Health Service ("IHS") facilities, according to the 2006 Albuquerque Area IHS Annual Report are: Diabetes, respiratory Infections, hypertensive disease, well child care, and prenatal health care.

With such demand for these important health care services, it is disheartening to report that IHS health care programs are being ended completely or are being drastically reduced. Santa Fe IHS no longer provides birthing services. Albuquerque IHS services are severely limited due to the lack of adequate funding, as the Honorable Congresswoman Wilson knows very well.

As stated in testimony offered by Senator Jeff Bingaman before the Senate Finance Committee on March 22, 2007, “The Indian Health Service has struggled for years to meet the needs of the Indian population, but continues to face enormous challenges. Aging facilities, staff shortages, and funding shortfalls are emblematic of the challenges facing the Indian Health Service.” Senator Bingaman went on to show a graph that compares historic funding levels to those for Medicare and Medicaid. It showed that per capita spending has grown steadily over the past decade to nearly \$8,000 through Medicare and \$4,500 through Medicaid, while the IHS national average funding remained almost flat at \$2,130.

In the Albuquerque Area, the funding disparities are even greater. It would take an additional \$48,158,854 to achieve the IHS national average of \$2,130. If Congress were to bring the Albuquerque Area up to the U.S. average per capita for health expenditures of \$6,423, it would require an additional \$380,947,921 in Federal funding.

While full and adequate Federal funding is extremely important, it is also important that the United States provide the quantity and quality of health services which will permit the health status of Indians to be raised to the highest possible level **and** to encourage maximum participation of Indians in the planning and management of their health care services.

Our message is simple: The Indian Health Care Improvement Act must be reauthorized. Reauthorization of the Act would:

- Modernize Indian Health care;
- Recruit and retain highly qualified Indian doctors and nurses;
- Address behavioral and mental health care needs; and
- Allow for in-home health care for Indian elderly

Furthermore, the Indian Health Care Improvement Act¹:

- Establishes objectives for addressing health disparities of Indians as compared with other Americans
- Enhances the ability of Indian Health Services and tribal health programs to attract and retain qualified Indian health care professionals
- Provides innovative mechanisms for reducing the backlog in health facility needs
- Establishes a continuum of care through integrated behavioral health programs—both prevention and treatment –to address alcohol/substance abuse problems and the social service and mental health needs of Indian people
- Facilitates greater decision-making regarding program operations and priorities at the local tribal level in order to improve services to tribal populations.

The Pueblo of Zia, The Albuquerque Service Unit Indian Health Board, and the All Indian Pueblo Council support H.R. 1328 as Amended. Additionally, we strongly support the following key provisions:

¹ Items provided by the National Indian Health Board.

TITLE I-INDIAN HEALTH, HUMAN RESOURCES, AND DEVELOPMENT-

Sec. 102. Health Professions Recruitment Program for Indians-This program has in the past and will continue to provide opportunities for tribes and individuals to enter careers in the health professions.

TITLE II-HEALTH SERVICES

Sec. 201. Indian Health Care Improvement Fund-This section authorizes the Indian Health Service to expend funds for the purposes of eliminating deficiencies and health resources of all Indian Tribes as well as to eliminate the backlog in the provision of health care services to Indians. For the Albuquerque Area, any funds appropriated should go to the Indian Healthcare Fund. These funds would then be allocated within the Area based on the following funding priorities:

- Hospital and Clinics
- IHS Employee Cost of Living Adjustment
- Contract Health Service
- Inflation-including pharmacy costs
- Dental
- Population Growth
- Mental Health

Sec. 203. Health promotion and disease prevention services-This section seeks to improve the health and well being of Indians and to reduce the expenses for health care in Indians. In the Albuquerque Area the number one reason for outpatient visits is Diabetes. A disease that is controllable and visits that are avoidable.

Sec. 204. Diabetes prevention, treatment, and control-This disease is the number one reason for visits in the Albuquerque Area. Fortunately, we are seeing progress due to the Special Diabetes Program (SPDI) for Indians provided by Congress. The Pueblos respectfully request that the Congress continue to support this initiative

Sec. 209. Epidemiology centers-This section mandates that all IHS Areas establish and operate an epidemiology center. There are many reasons that make it necessary for establishing an epidemiology center in each IHS Area. Without an epidemiology center tribes and urban American Indian populations in the area are unable to: (1) access timely and accurate tribe-specific data that would help them develop and expand health service infrastructure; (2) develop both tribal and regional health plans; (3) make informed decisions about meeting their own health needs; or (4) foster the workforce development, academic interest, mentoring, and training that will allow them to actively participate in regional and national-level health discussions and initiatives.

The Albuquerque Area is fortunate to have recently established the Albuquerque Area Southwest Tribal Epidemiology Center. However, there is already a need to request additional funding to support this Center.

Sec. 213. Authority for Provision of Other Services Specifically, hospice care, assisted living, long term care and home- and community based services. It is so important for the Pueblos to ensure that its Elders remain within the community to pass along the stories and traditions of our people.

TITLE III-FACILITIES-This title authorizes the process for determination of construction of health facilities including inpatient, outpatient and specialized health care

facilities such as long-term care and alcohol and drug abuse treatment centers. Wellness centers, staff quarters and sanitation facilities are included in this title as well.

The New Mexico Pueblos support Title III Facilities as drafted in H.R. 1328. And the Pueblo of Zia specifically supports Sec 310-IHS/ Tribal Joint Venture as it prepares to construct a new ambulatory care facility with funds secured from the New Mexico State Legislature and New Mexico Governor Bill Richardson. The Pueblo of Zia has sent a letter of intent to utilize this innovate process.

TITLE VI-ORGANIZATIONAL IMPROVEMENTS-Sec. 601 (a) (2) Assistant Secretary of Indian Health. The establishment of an Assistant Secretary of Indian Health will elevate the status of the Indian Health Services Director to be consistent with similar positions in the Bureau of Indian Affairs and the Department of Housing and Urban Development.

The New Mexico Pueblos support the language in Section 601 of H.R. 1328 elevating the Director of IHS to Assistant Secretary of Indian Health.

TITLE VII-BEHAVIORAL HEALTH PROGRAMS-The purposes of Title VII are numerous and much needed with an emphasis on developing a comprehensive behavioral health prevention and treatment program. Title VII provides information, direction and guidance to Federal, State and Tribal programs in areas of mental illness, dysfunction and self-destructive behavior. Title VII will establish a continuum of care

through integrated behavioral health programs—both prevention and treatment—to address alcohol/substance abuse problems and the social service and mental health needs of Pueblo people. Most importantly it provides a framework for the development of tribally appropriate and culturally sensitive programs that are of the greatest benefit to our people.

In Conclusion, based on a January 2005 Indian Health Service, “Facts on Indian Health Disparities”, the passage of this act affects only 1.8 million Federally-recognized American Indians/Alaska Natives and the IHS budget is only 2.8 billion. The 1.8 million represents less than 1% of the United States population and the existing IHS budget of 2.8 billion is an even smaller piece of a \$697 billion Department of Health & Human Services budget. With its comparatively small service population, The Indian Health Service should be the shining example of health care in the U.S. It offers so much potential. With a solid policy, additional funding and a lot of hard work, the Indian health care can be the gold standard of health delivery. Through the combined efforts of Tribes, Congress and the Executive, we can provide serious meaningful benefits to Indian country and to this country as a whole.

Mr. Chairman, Ranking Member and Members of this Honorable Committee, I strongly encourage you to take this opportunity to raise the standards of care provided by the Indian Health Service and to begin the work to ensure that American Indians receive the best possible health care. I ask the committee for unanimous support of H.R. 1328 and passage at the earliest possible date.

NEW MEXICO PUEBLO HEALTH CARE AND RELATED STATISTICS

Population and Demographics

- 19 Pueblo Reservations in NM for a total land base of 3485 sq. miles (2000 U.S. Census Bureau)
- Pueblo Tribes include: Acoma Pueblo; Cochiti Pueblo; Isleta Pueblo; Jemez Pueblo; Laguna Pueblo; Nambe Pueblo; Picuris Pueblo; Pojoaque Pueblo; Sandia Pueblo; San Felipe Pueblo; San Ildefonso Pueblo; San Juan Pueblo; Santa Clara Pueblo; Santo Domingo Pueblo; Taos Pueblo; Tesuque Pueblo; Zia Pueblo; Zuni Pueblo.
- Total NM Pueblo population is 63,404: 3.5% of NM population (2000 U.S. Census Bureau)
 - Females – 32,530
 - Males – 30,874

Pueblo Health Facts

- Pueblo Birth account for 3.1% of all NM resident births (2002 NM Tribe Specific Vital Statistics Report; NM Dept. of Health)
- 73.6 % of Pueblo births are to single mothers (2002 NM Tribe Specific Vital Statistics Report; NM Dept. of Health)
- 21.2 % of Pueblo Births are to teenage mothers (2002 NM Tribe Specific Vital Statistics Report; NM Dept. of Health)
- Resident deaths with Pueblo affiliation ages 1-65 account for 28.7 % of NM American Indian deaths and 1.9 % of all NM resident deaths (2002 NM Tribe Specific Vital Statistics Report; NM Dept. of Health)
- Five leading causes of death for NM Pueblo residents 1991-1999 (2002 NM Tribe Specific Vital Statistics Report; NM Dept. of Health)
 - Heart disease at 13 % deaths to Pueblo individuals
 - Accidents (unintentional injuries) 12.6 %
 - Malignant neoplasms-Cancer 12.2 %
 - Diabetes Mellitus 10.5 %
 - Chronic Liver Disease and Cirrhosis 8.3 %
- Native Americans in New Mexico experience the worst rates of health disparities and have the highest rates of death due to diabetes, pneumonia and alcohol.
- Native American youth have the highest behavioral health risk factors in New Mexico for adolescent smoking, drinking, illicit drug use, and obesity.
- The Indian Health Service is cutting back on basic outpatient health and maternal care at the Albuquerque and Santa Fe Service Units.

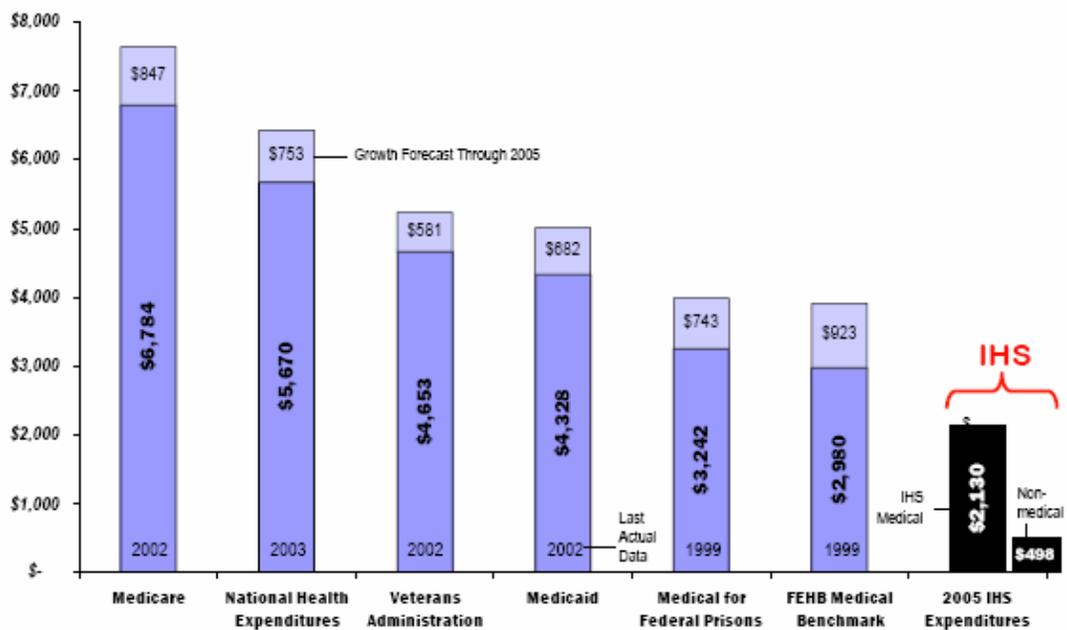
- Contracted tribal health care programs are under funded and provide limited services.

ALBUQUERQUE AREA FUNDING FACTS

- The National IHS Average is half of the funding provided to federal prisoners
- Per User, overall funding for the Area is 1/3 less than the National IHS Average
- Loss of over \$1 million per year in uncovered pay increases
- All Albuquerque Area facilities fund only Priority One CHS cases.



2005 IHS Expenditures Per Capita Compared to Other Federal Health Expenditure Benchmarks



See notes on reverse for data sources and forecast assumptions.
January 2006

ALBUQUERQUE AREA INDIAN HEALTH SERVICES

COMPARISON TO NATIONAL IHS AND U.S. AVERAGE

FY2006

FUNDING ALLOCATION DEFICIT TO NATIONAL IHS AND U.S. AVERAGE

	NATIONAL IHS AVERAGE	U.S. AVERAGE	
FY2006 AAIHS User Population	77,519	77,519	(b)
IHS National and U.S. Per Capita Average	\$2,130	\$6,423	
Funding Required Based on IHS Per Capita Avg	\$165,115,470	\$497,904,537	
Actual Recurring & 3rd Party Collections	\$116,956,616	\$116,956,616	(a)
Estimated Deficit to IHS Average	<u>\$48,158,854</u>		\$48,158,854
Estimated Deficit to U.S. Average		<u>\$380,947,921</u>	\$380,947,921
Funding Per User (a) \ (b)	<u>\$1,509</u>	<u>\$1,509</u>	

PAY Funding Shortfall

	FY2005	FY2006	
Mandatory Pay Increase	\$1,592,472	\$1,835,168	
Actual Funding Distribution	\$316,597	\$666,850	
Pay Funding Shortfall	<u>\$1,275,875</u>	<u>\$1,168,318</u>	\$2,444,193
Percent Funded	<u>19.88%</u>	<u>36.34%</u>	