

Statement of Buford L. Rolin
Chairman and Nashville Area Representative
National Indian Health Board
on
S. 979, Tribal Self-Governance Amendments of 1999
July 28, 1999

Chairman Nighthorse-Campbell, Vice Chairman Inouye, and distinguished members of the U.S. Senate Committee on Indian Affairs, I am pleased to offer testimony on behalf of the National Indian Health Board (NIHB) on S. 979, Tribal Self-Governance Amendments of 1999, to provide for greater self-governance by Indian Tribes, and for other purposes. The NIHB represents all 558 Tribal governments in advocating for the improvement of health care delivery. Our Board Members represent each of the twelve Indian Health Service Areas, and are generally elected at-large by Tribal governmental officials within their respective regional Areas.

The NIHB has a duty to represent the sovereign right of all Tribal governments to promote the highest levels of health for American Indians and Alaska Natives, and to advise the federal government in the development of responsible health policy. It is my understanding that more than 800 treaties, executive orders, and statutes were negotiated between the United States and our native ancestors. These ancestors were men and women who shed blood and witnessed the massacre of their people, by the U.S. Army and other non-Natives who sought to carry out "Manifest Destiny". American Indian and Alaska Native governments were forced to turn over more than 450 million acres of land with the promise that their sovereign nationhood would be preserved. In exchange for this precious land, which had sustained for them a quality lifestyle, our Indian leaders were promised health care, education, housing, and other forms of federal assistance, all intended to enable Indian people to retain their self-sufficiency.

Much of what was promised has historically not been provided, and many of our people have since then fallen out of self-sufficiency. This fact is well documented. As a result of the initiative of many Tribal leaders, the historical preference of the legislative branch of the United States government that self-sufficiency of tribes be fostered and encouraged, and the foresight of the presidential administration at that time, the Indian Self-Determination and Education Assistance Act was enacted into law in 1975 as P.L. 93-638. Under this Act, and the many subsequent amendments, the process by which Tribes may manage their own affairs has developed into a viable option for Tribes to take care of themselves. After all, are not the tribes, as a local form of government, best suited to take care of their own people, if they only have the resources to do so?

What I would like to share with you today is that the policy of Self-Determination and Self-Governance is working out very well. This point is borne out by the experience of my own Tribe, by the Tribes of many other Tribal leaders with whom I have frequent contact, and, as I will discuss today, by a study recently finished by the National Indian Health Board.

NIHB POSITION ON S. 979

Before I comment on the specific findings of this national study, I want to convey the position of Tribal Governments on the merits of S. 979. Early last year, the Board of Directors of the National Indian Health Board met to discuss the first legislative proposal, H.R. 1833, a bill to permanently establish the Self-Governance program within the Indian Health Service. Bearing this information, each of our Board Representatives were to return to the twelve Areas of the Indian Health Service to elicit the position of their respective Tribal Governments on whether these governing authorities supported the former legislation permanently authorizing Self-Governance as a policy within the Indian Health Service.

During our Annual Board Meeting held on October 5, 1998, the NIHB received resolutions from five Areas: the Alaska Native Health Board; the California Rural Indian Health Board; the Montana-Wyoming Health Board; the Northwest Portland Area Indian Health Board; and the United South and Eastern Tribes, which collectively represent the views of 331 Tribal Governments who supported H.R. 1833. Upon polling the Board Representatives of the remaining seven Areas of the Indian Health Service, we understand that four Areas have chosen to not endorse or oppose the policy of Self-Governance as they feel it is a matter of tribal choice to contract or compact for health services. These four Areas with neutral positions are Albuquerque, Bemidji, Phoenix Area and Tucson Areas. Two other Areas had not met to consider the policy, these Areas include Navajo and Oklahoma Areas. (At the present time, the Navajo Nation is now preparing to enter into Self-Determination contracting for their health care services with an implementation date planned in Fiscal Year 2000.) Finally, the Aberdeen Area Tribal Chairman's Health Board issued a resolution in opposition to permanent establishment of Self-Governance.

After lengthy discussion and extensive deliberation, the National Indian Health Board set forth the following position on H.R. 1833. The NIHB affirms the solemn right of Tribal Governments to determine their own respective position on the policy of Self-Governance. This position is not for or against the matter of permanent self-governance within the Indian Health Service, our position merely supports the right of each Tribal Government to determine it's own destiny.

While we understand that today's hearing is on the matter of S. 979, we feel the new bill under consideration is quite similar in nature to H.R. 1833 and we maintain our position set forth at our 1998 Annual Board Meeting. Our Board of Directors will not be meeting until December 7, 8 and 9, 1999, and I anticipate they will consider the official position of the National Indian Health Board on S. 979, if deemed necessary.

NATIONAL STUDY ON SELF-DETERMINATION AND SELF-GOVERNANCE

With funding from the Administration for Native Americans and the Indian Health Service, the NIHB has gathered and summarized information on the effects of tribal control of health care programs from those in the most appropriate position to evaluate the impacts: the tribes themselves.

The purpose of the study was to explore from a tribal perspective how Self-Determination and Self-Governance was working, and what could be done to further the policy. The final report includes a financial analysis, as well as an assessment of the changes in services and facilities, management changes and challenges, and the impacts on quality of care. The study also considered the opportunities and barriers to contracting and compacting, the issue of tribal sovereignty, future trends, and recommendations from tribal leaders.

RESEARCH APPROACH

Four different types of research were conducted: 1) review of previous studies; 2) financial analysis using the Department of Health and Human Services (DHHS) Financial Data System; 3) survey of tribes; and 4) analysis of training needs. An Advisory Committee was formed to help guide the development of the tribal survey and to review draft reports.

The survey of tribes was the most critical element of the study, since it provided the tribal perspectives necessary to accomplish the goal of the study: evaluating the impacts of tribal choices in health care. Two surveys were conducted, one of tribal leaders and one of tribal health directors. The questionnaire used to survey tribal leaders was intended to be brief and policy-oriented. The health directors questionnaire was longer, and it requested more detailed quantitative information.

A total of 210 tribes and tribal organizations participated in this study. This represents 36 percent of the 587 tribes and tribal organizations that received questionnaires. It is about 38 percent of the 554 federally-recognized tribes.

Every IHS administrative Area was represented in the study. The rate of participation by tribes within the Areas ranged from 24 percent to 100 percent.

For the tribal leader survey, 171 questionnaires were received. This is 29 percent of the total 587 mailed and 31 percent of the 554 federally-recognized tribes. Tribal leaders from every Area participated with a response rate ranging from 16 percent to 100 percent by Area. Tribal leaders from every type of tribe participated, with 40 from IHS direct service tribes, 36 from contracting tribes and 95 from compacting tribes.

The health director survey was sent to 256 people in 239 organizations. A total of 71 questionnaires were received representing 30 percent of the organizations. Every Area was represented, with response rates ranging from 15 percent to 100 percent. Health director questionnaires were received from 21 IHS direct service tribes, 31 contracting tribes and 19 compacting tribes.

Overall, the survey sample appears to be representative of the whole. Where responses from an Area are low, they have been combined with those from other Areas to form larger groups for some types of analysis. It should be noted that this survey presents a tribal perspective giving equal weight to every federally-recognized tribe regardless of the number of members enrolled or the amount of the IHS budget allocated to the tribe or the number of facilities serving the tribe.

CONCLUSIONS OF THE STUDY

The study provided the opportunity to survey a broad cross-section of tribal leaders and health directors from every Area of the IHS and every type of health care delivery system. In combination with financial analysis, the information obtained provides a quantitative and qualitative assessment of the impacts of self-determination contracting and self-governance compacting on the system of health care services for American Indians and Alaska Natives. It is significant because it offers a tribal perspective on the changes that have occurred in the past 3-4 years in which tribal self-governance demonstration projects have become part of the landscape of Indian Country. Evidence presented in this study suggests the following conclusions:

The federal policy of self-determination contracting and self-governance compacting is working, but it could be improved. Overall, self-determination is working in that tribes that have chosen to manage their health care programs are very successful. However, a significant number of leaders of IHS direct service and contracting tribes felt that they had no choice, or that their choices were more limited than the law provides. Furthermore, the lack of Indian Self-Determination (ISD) contract support funding is preventing some tribes from exercising their options.

The health of American Indian and Alaska Native people has improved at the same time that there has been a growth in tribal management of programs. Numerous indicators show that the health status of American Indian and Alaska Native people has improved, and there is no direct evidence that tribal management has caused a decline in the health status of American Indians and Alaska Natives. In fact, tribal management has led to many improvements in the health systems that serve these communities, and many of these improvements are illustrated in the results of this study.

On average, every type of tribe – IHS direct service, contracting, and compacting – has achieved a higher level of health care since the self-governance demonstration project began. Tribally-managed programs have an even better track record than IHS direct service programs in the addition of new services and facilities. Clearly, some tribes feel that their services and facilities have suffered due to a combination of problems, including population growth, inflation, and unfunded mandates. Most tribes in the study, even those that have seen dramatic improvements, feel that there are many more health care services needed and that this requires greater funding by Congress.

When tribes assume control of health care, they give a high priority to prevention programs.

When tribally-operated programs have had the opportunity to add or expand services,

prevention has been the leading area for expansion. When forced to eliminate programs, IHS direct service was more likely to eliminate prevention services than tribally-operated programs.

Tribes more commonly perceive an improvement in the quality of care when they manage their own health care systems. Tribal leaders and tribal health directors in this study more commonly rated the quality of care over the last 3 - 4 years as “better”, especially if they represented compacting tribes. In addition, the tribal leaders and health directors that rated the quality of care as “worse” were more commonly from IHS direct service tribes.

Population growth and inflation have reduced the purchasing power of Congressional appropriations for Indian health. Despite slight increases in actual Congressional appropriations, there has been an 18 percent decline in the adjusted per capita expenditures, or purchasing power, of IHS dollars from FY 1993 to FY 1998. This reduction is affecting all types of tribes in all Areas of the IHS. A significant increase in Medicaid rates provided some relief during the period of this study.

Tribes do not have more difficulty than the IHS in recruiting and retaining health care professionals. Recruitment and retention of health professionals is a problem for all parts of the Indian health system, due in large part to location of health facilities in remote, rural areas. Tribes report fewer problems recruiting health care professionals than the IHS direct service programs. There appears to be little difference in retention of health care professionals between IHS direct service Tribes and Tribally-operated programs.

The motivation for compacting is not just increased funding. When tribal leaders were asked the reasons they chose their form of health care management, a majority of leaders of compacting tribes cited tribal sovereignty and local control. Other reasons included management flexibility to meet the needs of tribal members and the opportunity to improve the quality of care. Only 7 percent cited maximizing funding.

As the federal system of Indian health care changes, integration of services is occurring through tribally-controlled organizations. While tribes want more local control, many tribes are improving efficiency by entering into multi-tribal agreements for purchasing and delivering services. Multi-tribal agreements are expected to increase in the next five years according to the tribal leaders.

Self-governance compacting is not hurting most other tribes. While many tribes in this study said that they were hurting from lack of adequate federal funding, few reported that they were hurting as a result of other tribes compacting. The direct negative consequences that were reported were the loss of discretionary funds to cover budget shortfalls at the end of the year and the shift of some responsibilities to the Service Unit level. Overall, most of the tribes that were not compacting reported improvements in services, management, and quality of care.

The federal government could do more to assure tribes that self-determination contracting and self-governance compacting will not lead to termination. Many tribal leaders who participated in this study would feel more comfortable about the future if there were changes at the federal level

to protect their sovereignty. The types of changes suggested include laws, funding approaches, flexibility in regulations, increased consultation, and more training in Indian law for Congress and federal employees.

The trend toward increased self-determination contracting and self-governance compacting will make the Indian health system look different in five years. If tribes make the changes they predict in this study, the Indian health system will have 6 percent of tribes receiving IHS direct services, 38 percent of tribes contracting, and 56 percent compacting. While these projections are based on the definitions used in this study, the indication by tribes is clear that they plan to exercise more control over their health care delivery systems.

More research is needed on the effects of tribal management on Indian health. Follow up studies are needed to more fully explore some of the issues identified in this report. It is important to continue the work begun by the Indian Health Service Baseline Measures Workgroup to further define ways of measuring quality of care indicators so that data may be aggregated nationally, by region and/or by type of tribe for purposes of monitoring trends and comparing performance. While the financial information presented in this report provides a quantitative assessment of the impacts of contracting and compacting, the picture will certainly continue to change and it is necessary to monitor those changes. The changes in the system predicted by the tribal leaders should be monitored in the context of changes in federal policies that affect barriers and opportunities.

If the Federal government wants to encourage Tribal management, policies could be changed to remove barriers and increase opportunities. According to the findings of this study, these could include:

- Full funding for both direct and indirect costs for Tribal management of health services;
- Remove limits on the number of compacting tribes
- More training available locally to provide entry for Tribal members into health careers;
- More training and technical assistance to help tribes acquire and maintain management expertise;
- and
- Changing attitudes in those few IHS Area Offices where tribes perceive that compacting is discouraged.

CONCLUDING REMARKS

On behalf of the National Indian Health Board, I thank the Committee for considering our testimony on S. 979, which seeks to permanently establish Self-Governance in health care in Indian Country. As you can see, the National Indian Health Board has determined that Self-Determination and Self-Governance is working well, and has identified ways to make it work even better. I urge you to keep these findings in mind as you consider making the Self-Governance program permanent for Indian health, and as you consider the form such legislation will take.

I call upon my American Indian and Alaska Native friends and peers to work together with the Senate Committee on Indian Affairs to help attain the goals our ancestors sought to acquire for us; to ensure that it is possible for all of our Tribes to redevelop the ability to take care of their own people. Personally, my own tribe, the Poarch Band of Creek Indians which is located in Alabama, has become a Self-Governance Tribe operating under a compact this year. There are definite advantages and greater flexibility which we have realized this year, as compared to our previous experience operating under a Self-Determination compact. Under either policy framework, our Tribe has been successful and we look forward towards even greater improvements in our health care programs.