President Bush sent Congress his budget for fiscal year 2008 (FY08) with recommendations regarding the fate of various federal programs and agencies. The House and Senate will develop their own budgets, often incorporating some of what the members hear from advocates.

Although neither house of Congress will accept the president’s budget without change, his proposal does, nevertheless, set directions and make critical choices. The budget document reflects the administration’s values. We at FCNL hope you will consider whether the president’s budget reflects your values and your community’s values.

Many of the president’s recommendations would affect native peoples. Two major agencies are responsible for American Indian and Alaska Native programs. The Indian Health Service, serving 1.9 million people, would receive $212 million more than in the FY07 continuing resolution. To put this figure in perspective, one F-22 Raptor fighter plane costs more than $230 million. The Bureau of Indian Affairs (BIA), which includes almost all the other Native American programs, would receive $1 million less than in the FY07 continuing resolution. One Apache helicopter costs $17 million—a sum that would go a long way in Indian Country.

For FY08, the president has given thumbs up to:
- funding law enforcement to stop the spread of methamphetamine in Indian Country;
- raising student and BIA school performance to meet No Child Left Behind goals through more funding; and
- providing modest funds to deal with a growing number of Indian patients and medical inflation.

The president has given thumbs down to:
- the urban health program for Native Americans (eliminated);
- the program providing extra assistance to Indian children attending public schools (eliminated);
- the housing organization that conducts training and provides advice in the field (eliminated);
- the housing improvement program (eliminated);
- school construction (cut back);
- health facilities construction (cut back); and
- basic sanitation facilities construction (cut back).

Before Congress accepts the president’s proposal for less money for sanitation projects, it should consider facts about remote areas. On Native American lands, 11.7% of residents lack complete plumbing facilities. Instead of flushing toilets, residents in some [Alaska] villages have to use a device called a “honeybucket,” a large bucket with a toilet seat on top. Dispensing with vital programs or cutting back their scope will make daily life even harder for many First Americans.

Consequences for Families

A tribal chairman told me: “My two daughters are living in rehabilitated trailers. . . . They heat those trailers with wooden stoves. The trailers have no plumbing. There is no running water and no indoor toilets.” This is in South Dakota.... [The U.S. has] provided $600 billion for the war [in Iraq]. But when we have needs here at home, it does not matter whether it is health care needs or housing or perhaps energy needs, the Administration tells us we cannot afford to spend for that.

—Sen. Byron Dorgan, Congressional Record, 1/29/07
HEALTH PROGRAM GETS MODEST FUNDING INCREASE

Treaties and court rulings make clear that the federal government has a legal responsibility to provide health services to Native Americans. Yet, the availability and adequacy of medical care for American Indian and Alaska Native families have long been deemed borderline at best.

Despite the government’s trust responsibility, the native health system is not structured as an entitlement program like Medicaid and Medicare. Since money for the system comes out of discretionary funds, native leaders must advocate each year to sustain or enhance the program.

“This health delivery system is considered ‘prepaid’ with the land ceded by tribes in more than 800 ratified treaties and presidential executive orders,” — Urban Institute report, 2005

The Indian Health Service (IHS), the principal federal agency providing health care to Native Americans, would receive more than $4 billion under President Bush’s proposed fiscal year 2008 (FY08) budget, giving the agency a net increase of 6.9% or $212 million. The increased funds would offset some of the expense of serving a larger patient group and costs arising from medical inflation.

While more money is welcome and essential to providing medical help, the chronically underfunded agency falls a little further behind every year. Since 2001, IHS has seen a 16% increase in funds; but in the same period general inflation has offset these funding gains. In such circumstances IHS faces difficulty in providing adequate facilities, infrastructure, and services, despite a track record of agency efficiency and effectiveness commended by the executive branch.

Wellness Programs in Jeopardy

Plumbing and clean water help to cut the high number of deaths from intestinal disease. Since 1959, more than 265,000 Indian homes have been provided with sanitation facilities, but thousands of homes still lack either a safe water supply or sewage disposal or both. Most people in the U.S. have benefitted from stronger environmental protection standards; only 1% of the population has to confront problems of unsafe water. But among American Indians and Alaska Natives, that figure is 12%.

The White House’s proposed budget would cut allocations for equipment, maintenance and improvement of health facilities, sanitation facilities construction, and health care facilities construction funds. After years of

(continued on page 3)
minimal funding, very few new IHS facilities are in the planning pipeline and, yet, putting off construction of buildings and infrastructure means higher government expenditures in the long run.

Specialized Care Is Hard to Afford

Insufficient funds to send patients outside the system, when an Indian health clinic cannot provide specialized care, can mean denial of services. This, in effect, amounts to rationing of care on reservations. In one instance, an American Indian woman with severe chest pains was sent by ambulance to the hospital. As she was being put on a gurney, a staffer found a note taped to her leg saying the patient or hospital would have to assume all costs. The local IHS clinic had sent the woman for treatment but could not pay because it had too little in its budget for contract services from private sector providers. The low-income woman later received a bill for $10,000.

The difficulties of recruiting and retaining professionals also make specialized care less available to Native Americans. Many positions in IHC clinics and hospitals remain unfilled: the vacancy rate for dentists is 28%, for those who do medical imaging 27%, for nurses 17%, and the list goes on.

Urban Health System Could Be Disbanded

The president’s budget proposal would close 34 urban Indian health sites serving around 120,000 people. More than 60% of Native Americans now live in metropolitan areas. The administration argues that urban Indians have access to the same medical services as other individuals and recommends that they use community health services. However, the National Association of Community Health Centers says such centers lack the resources to handle additional patients.

In response to ending the program, one Native American patient said: “It sends the message that our government does not care about the health of this vulnerable population... unless of course, they live on reservations. Thus, the message becomes: American Indians do not deserve their earned right to health care unless they isolate and segregate themselves from the rest of the country.” A native urban health client provides some context: “I came to California in the 1960s through the relocation program from my reservation, Cheyenne River Sioux Tribal. I am very satisfied culturally and health wise with our [IHS] center. Also, happy to be near other Native Americans.”

The National Council of Urban Indian Health notes the benefits of using culturally sensitive providers who may know native languages and can communicate with elders. The availability of native health clinics results in lower utilization of emergency room services, focuses attention on a high-risk population with lower life expectancy and serious chronic diseases such as diabetes, and improves health through prevention and early intervention. In addition, if native families living in urban settings are forced to travel to their home reservations for medical care, rural services will become even more over-burdened. A previous White House proposal also zeroed out $33 million in funding for the urban programs, but Congress restored the money.

National Indian Health Board (NIHB) Chair H. Sally Smith, in testifying on the FY 08 budget said: “Except for the urban Indian program, we realize that IHS fared quite well compared to other agencies.... NIHB recognizes that there are many realities that confront the federal government that create enormous fiscal challenges.” Appealing to members of the Senate Committee on Indian Affairs she added, “However, it is critical to realize that even the status quo for American Indian and Alaska Native health should not be acceptable to Congress—it would not be acceptable for your families.”

Native Advocacy Resource Paper

FCNL’s new 185-page educational paper, “Native Americans and the Public: A Human Values Perspective,” provides pictures, ideas, and first-person narratives that can help change the often stereotypical and simplistic public portrayal of the First Americans. Order this social justice publication for the students and teachers in your family. Use it for youth or adult education, libraries, action programs, and outreach to local media.

The paper is available for $20. Please send an email with your contact information to Liz Welton at lizw@fcnl.org.
Pentagon officials were taken to task in highly publicized congressional hearings for the inadequate out-patient care that soldiers injured in the Iraq war have received at Walter Reed Army Medical Center. But, away from the cameras, recent hearings highlighted the role of the Department of Justice (DOJ) in blocking passage of a bill to provide better health care for another group whose needs have been ignored—American Indians and Native Alaskans.

At a Senate Committee on Indian Affairs hearing on March 8, senators from both parties expressed skepticism over Deputy Assistant Attorney General C. Frederick Beckner's statement that DOJ had “cooperated” with the committee in working last year for passage of legislation to reauthorize the Indian Health Care Improvement Act (IHCIA). Committee members suggested “foul play” had occurred in September 2006 when department action derailed the reauthorization bill.

Legislation to revise and update IHCIA has been repeatedly introduced over the last eight years. The bill to modernize the Indian health care delivery systems cleared three Senate committees last year. On September 15, it was “hotlined” and poised to pass the Senate by unanimous consent. But on September 29, just before Congress recessed, the bill was waylaid by DOJ even though department attorneys had been part of the deliberations for two years. DOJ sent an unsigned, six-page critique to a few senators that resulted in two senators placing “holds” that blocked a final vote on the bill. The department did not give copies either to Indian Affairs Committee Chair Senator John McCain (AZ) or to the ranking member, Senator Byron Dorgan (ND).

In questioning Beckner, Senator Dorgan, who now chairs the committee, characterized DOJ’s actions: “You say it was an unauthorized release, a mistake, but we know how it works: Justice tubed this bill.”

In opening remarks at a separate House Natural Resources Committee hearing March 14, Chair Nick Rahall (WV) said, “I wonder how many young Indian children suffered needlessly because of that [Justice] action.”

**New Commitment to Reauthorization**

The leaders of the House Natural Resources Committee and the Senate Committee on Indian Affairs, the two congressional committees with jurisdiction over Native American programs, say that reauthorizing IHCIA is their top priority in the 110th Congress. Representative Frank Pallone (NJ) introduced the IHCIA Amendments of 2007 (H.R. 1328) on March 6 with 33 cosponsors, an encouraging show of support. A companion bill is expected to be introduced in the Senate shortly.

**Take Action:** Urge your representative to cosponsor IHCIA (H.R. 1328). Encourage him or her to work to assure that native communities will at long last have 21st century health care.

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