Testimony by

Dr. Thomas S. Walker, Ho-Chunk Health

Good Morning, Mr. Chairman, members of this distinguished body. It is an honor to be invited to provide testimony on Indian Health Care.

I am Dr. Thomas Stuart Walker, an Internal Medicine Physician and Medical Director for the Ho-Chunk Nation of Wisconsin. I am the son of Melvin Walker, a member from the Mandan, Hidatsa, Arikara Nation and Hattie Thundercloud Walker, a member of the Ho-Chunk Nation.

I graduated from the North Dakota School of Medicine and belong to the Indians into Medicine program in Grand Forks, ND. Also I am a recipient of the Indian Health Service (IHS) scholarship program, Section 103 and 104, which helped fund my medical education. Since completing my residency in internal medicine at Sinai Samaritan in Milwaukee, I have worked for the Ho-Chunk Nation.

First, I wish to acknowledge and thank you for reinstating Section117. INMED, Indians into Medicine Program. While attending medical school, the INMED program was invaluable and I can say with no hesitation that I would not be here today as an Indian physician without such help and support. I have included a list of physicians that are too numerous to mention now, who have also participated in this program. The University of ND and INMED have given us the opportunity to serve our tribal communities which are underserved, under-funded in rural areas. Our Indian communities need more Indian health care professionals.

As physicians working in our tribal communities, we are well-aware that our facilities that we work in are chronically under-funded. It is for this reason I recommend the passage of the Reauthorization of the Indian Health Care Improvement Act. However, I want you to realize this passage is a stepping stone to the real matter- -fully-funding this Act.

Accordingly, I call to your attention, Section 3. "Declaration of National Indian Health Policy, Part (1) to assure the highest possible health status for Indians and to provide all resources necessary to effect that policy." I see the passage of the IHCIA as more the "status quo". Unless it is adequately funded, this legislation still will not bring American Indians even close to parity of other Americans. Why do I say this? One of two reasons: IHS is in the discretionary budget. The discretionary budget is subject to the rescissions of events such as the War on Terror and natural disaster relief.

The second reason is the impact of the dual budget rescission on IHS monies. The first rescission occurs through Department of Interior and the other occurs through Department of Health and Human Services. It is troublesome that the IHS budget, one which can barely provide a 59% level of need nationally, is in double jeopardy through the overall budget process. Unlike other programs, IHS is a <u>direct</u> provider of medical

services and should not be subject to any rescissions. Moreover, in the region where I practice, the funding is the lowest of the 12 IHS regions. For example, IHS funds only 39% of the level need for our Health department that last year had over 36,000 patient visits. I am of the opinion the long term solution to improving the health care of American Indians rests in moving IHS out of the United States discretionary budget and into the entitlement budget with mandatory, full-funding that is not at the mercy of current world and national events.

Which brings me to my next concern about the IHCIA, the language in this Act offers grants to supplement the inadequate funding. For example, Section 204 (c) provides for continued funding for existing diabetes projects as implemented to serve Indian tribes. The Ho-Chunk Nation Health Department has received both the competitive and non-competitive Special Diabetes Grants for Indians. With these grants, we have seen patients reduce their weight, Body Mass Index (BMI), cholesterol levels, and fasting blood sugars. Because of these changes, the Ho-Chunk Nation was recognized for the "highest decrease in Poor Glycemic Control from 20% to 13%." Prevention is a proven strategy to reducing chronic diseases rates and disparities. These grants, at a minimum, offer the Nation a taste of possible prevention health programs. But it is difficult to sustain any long-term benefits with these short-term grants. Also, competitive grants cause problems in the health arena because some tribes or tribal organizations receive these grant awards and other do not. It is our concern that the short-term grants will not meet the criteria set forth in Section 204(c). Therefore, I am advocating for a fully-funded IHS budget that does not have to be supplemented with grants.

Another frustrating concern that I wish to call your attention to is the under-funded Contract Health Services (CHS), Section 201(a)(4) . Many of you have heard of this program since it is a common but horrific statement used in our communities as the "don't get sick after June" program. We cannot take care of all our patients' health care needs in our clinics; patients must be referred to outside health care providers and hospitals. The patient doesn't always have the necessary health insurance, so he/she relies on the Contract Health Services to pay the third party vendors. Due to the low level funding, our Contract Health Service dollars do not stretch throughout the entire fiscal year. In the past two years alone, the Ho-Chunk Nation has supplemented this program with approximately $1.8 million. When our tribe supplements this program, the non-member natives are eliminated from the services and only those tribal members with life or limb, priority 1 cases are funded. I am extremely frustrated by this whole scenario knowing my referrals for a preventive treatment, such as a chronic ulcer goes unfunded. Yet when this same chronic ulcer threatens my patients' -life or limb, I can refer these patients to a surgeon to have their limbs amputated and get funded.

Lastly, I wish to call your attention to Section 807(c) (2) Health Service for Ineligibles Persons. As a sovereign nation, and a tribe operating our health facilities using a contract, we did not believe a joint determination for eligibility is required, but we do need to consider the two elements outlined under (c)(1)(B)(i) the denial or diminution of health services and (ii) no reasonable alternative. However, the IHS believes that the

tribe and IHS must jointly determine these two elements. I urge you to clarify this language by adding subsections "(i) and (ii)" to the last sentence of (c)(2).

In closing, I wish to express a special thanks to the Honorable Representative Ron Kind of Wisconsin for the invitation to provide testimony and for co-sponsoring the Reauthorization of the Indian Health Care Improvement Act.

Thank you for listening me and now I am available to answer any questions you may have.