



# Seattle Indian Health Board

*For the Love of Native People*

TESTIMONY OF RALPH FORQUERA  
EXECUTIVE DIRECTOR  
SEATTLE INDIAN HEALTH BOARD  
FOR  
HOUSE APPROPRIATIONS SUBCOMMITTEE  
ON INTERIOR, ENVIRONMENT AND RELATED AGENCIES  
Tuesday, March 24, 2015, 3:30 p.m.

Chairman Calvert, Ranking Member McCollum and members of the Subcommittee on Interior, Environment, and Related Agencies, my name is Ralph Forquera. I am the Executive Director for the Seattle Indian Health Board, a contractor and grantee with the Indian Health Service as an urban Indian health organization (UIHO).

Seventy-one percent of Americans self-identifying as having heritage in an American Indian tribe live in American cities, according to the 2010 United States Census.<sup>1</sup> An additional 7% lived in non-reservation rural areas of the nation.<sup>ibid</sup> Both the urban Indian population and the non-reservation rural population do not live under tribal jurisdictions, yet based on Supreme Court decisions and Congressional proclamations, they continue to be subjects of the federal government's trust obligation toward Indian people.<sup>2,3</sup> This trend toward the urbanization of American Indians has been on-going since first documented with the 1970 census.

In FY 2015, Congress appropriated \$43,604,000 to assist urban Indians, less than one-percent of the overall Indian Health Service budget of over \$4.6 billion. While we appreciate the need to support health services for Indians on Indian reservations, there is an equal need to understand and help Indians living in cities.

You likely noted that the Indian Health Service did not ask for additional funding for urban Indian health during its recent testimony before this Subcommittee. You may also be aware that the President's FY 2016 budget also did not seek additional resources to aid urban Indians. We have faced this challenge many times in the past as the focus of the Indian Health Service has shifted away from serving Indians to serving Tribes. While we appreciate the unique relationship that exists between the federal government and federally-recognized Indian tribes, in the area of health, Congress has acknowledged that the federal obligation for health does not end at the reservation boundary.<sup>4</sup>

This lack of attention to the health needs of urban Indians over nearly four decades since the authority to aid urban Indians was created with the original Indian Health Care Improvement Act in 1976 has resulted in a need for explicit data on the health status of this group. Studies using data from national reporting surveys, like vital statistics and the

behavioral risk factor surveillance studies conducted by the Centers for Disease Control and Prevention (CDCP), that do not focus exclusively on Indian health still show a dramatic disparity in health status for urban Indians.<sup>5</sup> Surveys on social factors that influence health such as poverty, unemployment, a lack of health insurance, etc. are also found more frequently among urban Indians.<sup>6</sup> These findings call for a need to bring attention to the health of urban Indians and increase the nation's investment in their welfare.

While we support continued health investments for tribal citizens, we also believe that the needs of urban Indians deserve greater recognition. The 1921 Snyder Act gives the Congress broad discretion in allocating funds for the "care, benefit, and assistance of Indians throughout the United States."<sup>7</sup> This includes the nearly 3.7 million American Indians now living in cities.

In recognition of a renewal in the welfare of Indian people regardless of where they live, I am recommending consideration of a \$20 million increase to the urban Indian health funding for the FY 2016 fiscal year. Both the National Indian Health Board and the National Congress of American Indians have recommended a \$15 million increase for urban Indian health. Of the \$20 million requested, I am recommending that \$15 million be directed to support base funding increases for existing urban Indian health contractors and grantees and \$5 million be allocated for urban health programs' facility needs. Section 1659 of S. 1790 as it was incorporated by reference to Section 10221 of the Patient Protection and Affordable Care Act, P.L. 111-148 now authorizes funding for facility renovations and expansions. I recommend initiating funds for this purpose as we continue our efforts under health reforms.

I am also recommending that the Subcommittee instruct the Indian Health Service to evaluate how the agency's programs for and services to urban Indian have changed or need to change in light of health reforms, including the Affordable Care Act. I suggest that the Subcommittee ask the IHS to build into its FY 2017 budget justification a summary of how IHS views its role in serving urban Indian people, moving forward to implement both statutes – the Indian Health Care Improvement Act and the Affordable Care Act - now that urban Indian health is a permanent authority.

There are particular areas where greater attention is needed, including funds for children and youth mental health care, violence prevention, a greater focus on human trafficking among urban Indian youth, and additional aid for those struggling with substance abuse problems. Beyond diabetes, there are other chronic conditions needing attention such as asthma and arthritis. A greater focus on preventive medicine, such as immunizations and pre-natal care, has taken a back seat to our focus on chronic disease. While an important strategy, the needs of younger Indians should not be forgotten.

Recently, President Obama launched a broad-based youth initiative for Indian Country, Generation Indigenous. However, a closer review of the initiative indicates a continuing emphasis toward tribal communities, again by-passing urban Indian youth.

We endorse the President's "all-of-government" approach to addressing Indian concerns, but it is critical that the agencies directly responsible for Indian welfare like the Indian Health Service anchor these efforts. For this reason, expanding the role of this agency to reach all Indians by improving funding for the majority of Indian people who now call cities their home is an important first step.

Increasingly, more and more Indian people are no longer affiliated with a federally-recognized Indian tribe. Since individual tribes can determine criteria for membership, we find that more and more Indians find themselves unable to qualify for tribal enrollment. This is true for both Indians who inter-marry with someone from a different tribe and those who marry someone from a different racial group. The children of these unions are often unable to achieve tribal enrollment status. We here in cities are often asked the question whether being denied membership in a federally-recognized Indian tribe makes these individuals ineligible for the benefits and protections granted by the Congress for Indian people. In the sphere of health, the answer has always been that urban Indian health organizations can and do serve all Indians. The definition used for this program at the IHS includes many groups unable to get care at IHS facilities themselves (terminated tribes, state-recognized tribes, descendants, etc.).

In the report that accompanied the original Indian Health Care Improvement Act in 1976 that defined the IHS policy, the House noted that *"The most basic human right must be the right to enjoy decent health. Certainly, any effort to fulfill Federal responsibilities to the Indian people must begin with the provision of health services. In fact, health services must be the cornerstone upon which rest all other Federal programs for the benefit of Indians,* (H.R. Report No. 94-1026, pt. I at 13 (1976) *as reprinted in 1976 U.S.C.C.A.N. 2652, 2653*). I wholeheartedly endorse this premise and ask the while we cannot correct the past, we can determine the future. Therefore, I urge the Subcommittee to recommend a \$20 million increase for urban Indian and Alaska Native health in the FY 2016 IHS appropriation as a modest step toward realizing decent health for all Indian people regardless of where they choose to live.

<sup>1</sup>U.S. Census Bureau. (2010). Census 2010 American Indian and Alaska Native Summary File; Table: PCT2; Urban and rural; Universe Total Population; Population group name: American Indian and Alaska Native alone or in combination with one or more races.

<sup>2</sup>United States Supreme Court in *Board of County Commissioners of Creek County v. Seber*, April 19, 1943.

<sup>3</sup>Memorandum from the Assistant Solicitor, Division of Indian Affairs, Department of the Interior to the Commissioner of Indian Affairs, Dec. 9, 1971.

<sup>4</sup>Senate Report 100-508, Indian Health Care Improvement Act Amendments of 1987, September 14, 1988, page 25.

<sup>5</sup> Castor ML, Smyser MS, Tualii M, Park A, Lawson SA, Forquera R. (2006). A nationwide population-based study identifying health disparities between American Indians/Alaska Natives and the general populations living in select urban counties. *American Journal of Public Health*, 96(8), 1478-84.

<sup>6</sup> Urban Indian Health Institute, Seattle Indian Health Board. (2011). *Community Health Profile: National Aggregate of Urban Indian Health Organization Service Areas*. Seattle, WA: Urban Indian Health Institute.

<sup>7</sup> 25 U.S.C. §13, 1921.