Sioux Nation of Indians
Dahcotah-Nakota-Lakota
Dahcotah Territory
Sioux Country
Treaty of 1851 & 1868

Testimony of *Universal Embassador* Dr. Vahan Setyan
under the auspices of
The Original Oceti Sakowin Treaty Nation
Dahcotah Government Branch
7 Council Fires
Sioux Nation of Indians
Treaty 1851-1868

Before the House Committee on Appropriations,
Subcommittee on Interior, Environment and Related Agencies

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Good afternoon Madam Chair Granger and Honorable Members of the House Appropriations Committee and Subcommittee:

Thank you for this opportunity to be in your presence and in the presence of my fellow colleagues to provide this testimony on the funding appropriations to Indian Health Service (IHS), which is a federal agency within the Department of Health and Human Services. More specifically, this testimony relates to the capabilities and responsibilities of IHS for providing direct medical and public health services to the members of the federally recognized Native American tribes and Alaska Native people, which of course includes our Native American veterans. In addition, this testimony covers past and current track record of IHS, the merit behind the continuous request of higher funding, and the immediate real-world health and wellness solutions that have severe barriers to entry in Native health.

Indian Health Service (IHS) was established in 1955 when the Department of Health, Education, and Welfare's Public Health Service (PHS) took over the initial mission of the Department of the Interior and Office of Indian Affairs, which in turn, was preceded by the Department of War and its attempt to provide health services for the needs of American Indian and Alaska Natives (AI/AN) in the United States.[1] According to its own website, it is the *"principal federal health care provider, health advocate for Indian people, and its goal is to raise their health status to the highest possible level."*[2] Its strategic goals include ensuring that comprehensive, culturally appropriate personal and public health services are available and accessible to AI/AN, promote excellence and quality through innovation of the *Indian* health system into an optimally performing organization, and strengthen its institutional program management and operations.[3] In principle this is noble, however in reality, it's a different situation.

[1] Champagne, D. (2001). *The Native North American Almanac.* Farmington Hills, MI: Gale Group, pp. 943-945.
[2] https://www.ihs.gov/aboutihs/overview/
[3] Ibid

It is the 21st century and Native Americans in the United States continue to suffer at an unprecedented scale. They have long experienced lower health status when compared with other Americans. Diseases of the heart, malignant neoplasm, unintentional injuries, and diabetes are the leading causes of their deaths (2009- 2011). Natives continue to die at higher rates than other Americans in many categories, including chronic liver disease and cirrhosis, diabetes mellitus, unintentional injuries, assault/homicide, intentional self-harm/suicide, and chronic lower respiratory diseases. The prevalence of chronic diseases within the American Indian and Native Alaskan (AI/NA) populations are at their highest levels, negatively affecting health, the quality of life, and leading many to hospitalization and death. Chronic disease prevention and management at both reservation and urban levels are scarce to non-existent, lacking accessibility and availability to meet the needs of this demographic. The relatively higher health status enjoyed by most Americans and the lingering health disparities of American Indians and Alaska Natives is a national health emergency.

American Indians and Alaska Natives have the highest prevalence of diabetes among all racial/ethnic groups in the United States. They are 2.3 times more likely to be diagnosed with diabetes than is the general US population, and in 2004 the prevalence of diabetes was 16.3% among American Indians and Alaska Natives aged 20 years and older. Mortality attributable to diabetes is 3 to 4 times higher among American Indians and Alaska Natives than among other racial/ethnic groups. Diabetes is the strongest predictor of cardiovascular disease (CVD) among American Indians, and coronary heart disease appears to be fatal more often among American Indians and Alaska Natives than among other populations. American Indians and Alaska Natives have the highest rate of premature deaths from heart disease among all racial/ethnic groups, with a rate nearly 2.5 times the rate for Whites. Among Native Americans, 36.0% of deaths from heart disease occur among persons younger than 65 years.[4] The mortality disparity rates between 2009-2011 of Natives in the IHS Service Areas compared to all other race groups indicate that Natives had higher mortality rates in heart disease, cancer, accidents, diabetes, alcohol-induced deaths, chronic lower respiratory diseases, stoke, chronic liver disease and cirrhosis, influenza and pneumonia, drug-induced deaths, kidney disease, suicide, septicemia, homicide, and essential hypertension diseases.[5] Natives are 50% more likely than others to have a substance use disorder, 60% more likely to commit suicide, twice as likely to smoke, twice as likely to die during childbirth, three times more likely to die from diabetes and five times more likely to die from tuberculosis.[6]

Contrary to popular belief, lack of funding or solutions are not the main barriers contributing to the broken Native Health System. In his book titled, "The Government Racket: Washington Waste from A to Z," Martin L. Gross states that "no one is happy with the state of Indian affairs, yet no one seems to know what to do about it, except to throw $5 billion at the problem each year." This criticism points to one of the most vital barriers contributing to the broken health system in Indian Country, which are the lack of knowledge and acknowledgement of real-world solutions that can have the strength for real impact. The constant arguments of IHS being underfunded are circulating every year in various platforms including at the National Congress of American Indians (NCAI),

[4] Mortality Disparity Rates - https://www.ihs.gov/newsroom/factsheets/disparities/

[5] The Never-Ending Crisis at the Indian Health Service https://www.rollcall.com/news/policy/never-ending-crisis-indian- health-service

[6] National Health and Nutrition Examination Survey III, 1988-1994.

where its budget and expenditures per capita are compared to other federal health care expenditures per capita (i.e., Medicare, Veterans Medical Spending, Medicaid). An agency's inability to fix a healthcare system with a constant injection of billions a year is not a budget issue. More than half a century of billions raked in, if properly managed by experienced management, will turn any failing system into a thriving one. In many respects, red tape and bureaucracy prevent needed services to penetrate both the IHS and 638 facilities to reach the population that requires them. For example, hundreds of thousands of hospice and palliative care patients virtually receive no care on tribal lands, and those who need the assistance in urban native communities, there are no resources recommended by tribal leaders nor tribal agencies on such care, barring the patients from knowing their rights and their options to post-acute care. Keeping such vital information from those who qualify, decreases the chances of them and their families to know about such needed services, which in turn, lowers hospice service utilizations. At the same time, procurement and contracting processes are tedious and lengthy, creating a detriment to both the patients who need the assistance and the providers who are offering them.

Much praise should be given to tribes that attempt to take control over and self-manage their healthcare infrastructure as it mitigates failures from the past experiences all while improving management for improved processes for the future. However, there are still opportunities for improvement, including 638 partnerships with strong ancillary services. Many tribal healthcare systems continue to rely on non-tribal hospitals for surgery, intensive and subacute care, as they have limitations of services on reservations. Slow tribal healthcare progress means detriment to tribal members who rely on such services. For instance, we can do away with unnecessary amputations and maximize the use of in-home dialysis programs that are otherwise unavailable. While healthcare sees innovation and progress in all fronts, tribal health is suffering, lacking even the most fundamental levels of care. Lastly, there is a significant disparity of Native American healthcare professionals compared to the members of other demographics. Therefore, proper and working healthcare infrastructure should entice tribal members to not only reap the benefits of adequate healthcare, but also see it as an industry to be a part of.

Native Veterans Health

More than 8,000 Native Americans volunteered and served during World War I, and well over 24,000 served during World War II. During World War II it was through the service of the Navajo Code Talkers, a group of volunteers who did top- secret work using a secret code in Navajo that could not be broken. This concept of using Native American languages for military communications goes back to World War I when 141st Infantry Division used eight Choctaws to relay military commands by telephone. Native Americans serve in the American forces in greater numbers per capita than any other ethnic group in United States. According to the Department of Defense report of 2011, there were more than 137,000 Native American Veterans living in the United States and they have participated with distinction in United States military for more than 200 years; their courage, determination, and fighting spirit recognized by American military leaders as early as the 18th century. Not only do Native veterans deal with disability, living in crowded conditions and living homeless on their reservations and beyond, they also face health issues including the development of post-traumatic stress disorder PTSD) and other mental illnesses that go untreated. Health issues also force them to commute large distances and endure long-waiting hours at the available few medical centers or hospitals that can serve them. Do all

our veterans receive healthcare, adequate housing, and the proper attention and respect they deserve from the system we have in place?

We should fully commit to the betterment of the economic and health situation of our veterans. Native Americans were involved in the American Revolution against the British, and we can technically assert that we have been fighting for this country before it was a country. Considering the population of the United States is approximately 1.4 percent Native and the military is 1.7 percent Native, Native American people have the highest per-capita involvement of any population to serve in the U.S. Military. We have a duty and obligation to serve them as they have served for us, protecting this country and its freedom. However, we find veterans living in dire circumstances and in poor health, unable to get the care they should. As we speak today, the VA system is having an issue even creating contracts with IHS to have veterans on the reservation have proper care and access to quality healthcare.

Conclusion

Tribal governments should find it essential and critical to create a better platform for a healthcare system to thrive. And despite obvious IHS challenges, there is no excuse for poor healthcare. Solutions are among us. It would be of benefit to Native Health for tribal council members to have a thorough understanding of healthcare and innovation to create effective decisions and form resolutions. Tribal government leaders should be working with tribal private enterprises and non-tribal companies to create viable solutions on tribal lands and urban Native American communities. The simplest solution for Native healthcare would be to turn all IHS and 628 healthcare facilities and hospitals profitable and/or sustainable. However, Tribal governments need to build on their self-empowerment and invite organizations that are willing and equally empowered, to address the healthcare and economic woes of this time. There is no other way to lead to innovation and progress.[7]

Thank you for your time and consideration.

Dr. Vahan Setyan
Universal Embassador

Wasu Duta
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The Original Oceti Sakowin Treaty
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Reviewed

[7] Setyan, V. (2000). The Tipping Point: Healthcare Woes, Covid-19, and the Future of Native Health. Academia.edu.