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PRESIDENT AND CEO, KODIAK AREA NATIVE ASSOCIATION
HOUSE COMMITTEE ON APPROPRIATIONS
SUBCOMMITTEE ON INTERIOR, ENVIRONMENT, AND RELATED AGENCIES
"AMERICAN INDIAN AND ALASKA NATIVE PUBLIC WITNESS HEARING"
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My name is Andy Teuber, I am the Chairman and President of the Alaska Native Tribal Health Consortium (ANTHC) a statewide tribal health organization that serves all 229 tribes and more than 166,000 Alaska Native and American Indian (AN/AI) people in Alaska. ANTHC and Southcentral Foundation co-manage the Alaska Native Medical Center, the tertiary care hospital for all AN/AIs in Alaska. ANTHC also provides statewide health services, including construction and operational support for rural sanitation projects, and technical assistance to other tribal health organizations for the maintenance and repair of regional hospitals and clinics including construction of new facilities.

I am also the President and CEO of the Kodiak Area Native Association (KANA) a regional non-profit tribal organization formed in 1966 to provide health and social services to AN/AI people in the Kodiak Island Area. The KANA service area includes the City of Kodiak and six Alaska Native villages. ANTHC and KANA are both self-governance tribal organizations that compact with IHS to provide health services to AN/AIs under the authority of the Indian Self-Determination and Education Assistance Act, P.L. 93-638.

I want to acknowledge and thank this Subcommittee for its work toward providing substantial funding increases for the Indian Health Service budget in FY 2018, and in particular the increases to the Maintenance and Improvement (M&I) and Sanitation Facilities Construction line items. Both of these programs are extremely important for Alaska Native communities and AN/AI people. Despite the considerable increases provided last year, additional resources are still needed for both of these programs due to the backlog of unfunded projects that have accumulated over the years.

My testimony today will focus on alternative approaches for construction of health care and public health infrastructure needs in tribal communities. The health care infrastructure throughout Indian Country is in great need of improvement and expansion. With the exception of the FY 2018 budget, most increases in Indian Health Service funding over the past several years, have been directed towards inflationary and fixed costs, for things such as population growth and pay costs increases, which has left the funding needs of Indian health care infrastructure behind.

I am going to limit my testimony to addressing three areas where, in addition to increased funding, policy changes could improve the current system for tribes— these areas are: IHS health care facilities construction, sanitation facilities construction and village built clinics.

<u>Alternative Approaches are needed to Fund Health Care Facilities</u>

In 1999, Congress directed the IHS to work closely with Indian tribes, to review and revise the health care construction Priority System. Congress recognized and noted that several issues needed to be considered in revising the Priority System and that "a more flexible and responsive program can be developed that will more readily accommodate the wide variances in tribal needs and capabilities." While a new Priority System has been developed it does not include the innovative approaches to facilities construction that Congress may have expected. This is one of the reasons that Congress continues to encourage the IHS to examine alternative means of financing and delivering health care services to AN/AI people in appropriations report language.

According to the IHS 2016 Report to Congress on health care facilities need, over half of all IHS-owned health care facilities are over 30 years and the average age of IHS hospitals is 40 years old, nearly four times the average age of private-sector hospitals. And unfortunately the number of antiquated IHS facilities is only going to get worse unless alternative approaches to funding are taken. At the recent rate of IHS health care facility construction funding, a new facility built in 2018 would not be scheduled for replacement for over 400 years.

The IHS report estimated that a total of $10.3 billion would be needed for construction of adequate health care facilities to serve all AN/AIs. The estimated cost just to complete the 13 inpatient and outpatient facilities currently on the IHS planned facilities construction list is approximately $2.1 billion. At the current level of funding for IHS health care facilities it would take 20 years to complete construction of the existing list, before any funding would be available to address the other $8.2 billion needed for facilities construction. In Alaska alone, there is a need for $2.16 billion for health care facility construction, and there are no Alaska facilities on the existing construction priority list. As no funds are currently provided to IHS for renovation or expansion of existing facilities, the current system leaves most IHS Areas, all of which have very old facilities, without a way to improve them.

I would like to commend this subcommittee for the substantial Maintenance and Improvement funding increase in FY 2018 which will ensure that all IHS Areas have access to at least some resources to renovate and expand existing IHS and tribal health facilities. However, continued future M&I increases are needed, as historically the funding for IHS M&I was insufficient for even basic maintenance and repair deficiency needs. This has led to a backlog at the end of 2017 of nearly $515 million for deferred maintenance, alteration and repair.

Also, an alternative approach to ensure that all IHS Areas have access to resources to address facility needs would be to establish an area distribution fund as authorized by the Indian Health Care Improvement Act reauthorization in 2010.

The establishment of an area distribution fund for the renovation and expansion of existing health care facilities would provide funding for all IHS Areas and also address the dire unmet need to renovate and expand existing IHS and tribal health facilities to provide more efficient and better care to AN/AIs throughout Indian Country.

<u>Sanitation Facilities Construction</u>

Sanitation facilities play a critical role in the health of our communities. Babies in communities without adequate sanitation are 11 times more likely to be hospitalized for respiratory infections and five times more likely to be hospitalized for skin infections. In villages with very limited water service, one in three infants requires hospitalization each year for lower respiratory tract infections.

In Alaska, there are more than 49,000 people in 140 communities in rural Alaska who would benefit from critical water and sewer projects, including 31 communities that have never had water or sewer service. According to the State of Alaska in 2015, over 3,300 rural homes have been identified as lacking running water and a flush toilet. Most of these are Alaska Native homes in the 31 unserved communities.

IHS cooperation and support is critical to providing water and sewer services to most of the 31 remaining unserved rural Alaska communities. Many of these unserved communities cannot be served by a traditional piped water system, and therefore need an alternative solution.

With support from IHS, in December of 2013 ANTHC began a pilot project, what ultimately became known as the portable alternative sanitation system (PASS), to install completely home-based system to address basic sanitation needs in nine homes. A report on PASS was just issued (see Attachment) that was very positive regarding the effectiveness of the system. We would like to expand PASS to other homes in Kivalina as well as other communities in Alaska and hope for expanded support from IHS for PASS or other such alternative systems that are necessary to reach the communities in Alaska that cannot be reached by conventional piped water systems.

Funding for IHS sanitation facilities construction finally saw an unprecedented increase in FY 2018, but that was after many years of little to no increases. In Alaska alone we still currently have approximately $1.8 billion in unmet need for sanitation facilities construction. Given the enormous, growing unmet need and the significant health benefits derived from sanitation facilities continued support at the current level of funding for IHS sanitation facilities construction is essential.

Village Built Clinic Lease Program

Established in 1970, the Village Built Clinic (VBC) program serves as the foundation of the tribal health care delivery system in Alaska, providing the only local source of care for over 44,000 Alaska Native people living in rural, isolated communities across the state. As of June 2016, there were over 160 clinics supported through the VBC program.

These clinics are primarily staffed with Community Health Aides (CHAs) or Community Health Practitioners (CHPs), both essential to carrying out the Congressionally-mandated Community Health Aide Program (CHAP) authorized by section 119 of the Indian Health Care Improvement Act. Over 80% of clinics supported by VBC leases are owned and operated by small, rural communities.

VBCs serve as the base for visiting physicians, mid-level practitioners, pharmacists, dentists, optometrists, and other medical specialists, as well as the referral link to the tribal regional

hospitals and to the Alaska Native Medical Center based in Anchorage. VBCs are the local contact and emergency station for public health and emergency preparedness efforts in these communities.

Over time, the cost to operate and maintain VBCs has increased due to the expanding scope and level of medical services provided; expanded healthcare programming and technology to better integrate clinics into the tribal health care delivery system; as well as meeting the higher accreditation standards necessary for certification by the Joint Commission.

Yet current funding from the Indian Health Service only covers approximately 30 percent of the clinic's ongoing operating costs. Current lease payments for most of the clinics had not been increased in over 20 years until increases in FY 2017. In addition, the current VBC lease amounts provide virtually no funds for long-term maintenance and improvements, depreciation, or replacement reserves needed to sustain services in the community. This lack of funding poses an immediate and significant threat to the substantial investment made by the federal government in establishing the VBC program.

Without adequate VBC funding, community health aides are forced to provide services in unsafe facilities with insufficient resources. Individual communities are increasingly forced to subsidize the day-to-day operating costs of their clinics, defer long-term maintenance and improvement projects, reduce clinic operations, and forgo funding depreciation and replacement reserve funds. Nearly all of these communities are not located on the road system and without access to the electrical grid, have virtually no tax or revenue base.

Many of Alaska's villages are unable to maintain support of their VBC, with serious consequences for the health and safety of residents living these remote communities. Tribal health organizations have subsidized emergency and routine costs with their limited funds, but they cannot sustain these subsidies while continuing to operate their other programs.

In fact, some VBCs have closed, suspending CHAP services and cutting off the only local source of care. This lack of access at the local level necessitates costly travel as primary and preventive services become increasingly unavailable, diminishing the otherwise available resources at the secondary and tertiary levels of care.

The IHS has a responsibility to fully fund the VBCs. IHS provided the first substantial step in fulfilling its responsibility by providing an increase of $9 million in appropriations in FY 2017 for full service leases that are not eligible for maintenance and improvement funds. However, it is essential that IHS provide funding for VBCs that fully cover the costs to operate them.

Conclusion

I thank the Subcommittee for its consideration of my recommendations to encourage IHS to develop alternative approaches to facilities construction and continued additional funding for infrastructure.