



**USDA Rural Development Policy Conference Panel:  
“Working Effectively with American Indian and Alaska Native Communities”  
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Good afternoon. It is an honor and a privilege to speak with you today as the Director of the Indian Health Service (IHS). Today, as I discuss my vision of the future of the IHS and my priorities, I hope you will see that the emphasis the USDA Office of Rural Development (ORD) is placing on financing health clinics and hospitals in rural areas has the potential to play an important role in our efforts to improve the Indian Health Service.

Let me begin by stating the IHS mission: *The IHS Mission, in partnership with American Indian and Alaska Native people, is to raise their physical, mental, social, and spiritual health to the highest level.* The IHS, together with other HHS agencies, is working in partnership with Tribal Nations and tribal organizations, as well as with various other organizations, to fulfill this mission. I am grateful that there is a growing appreciation that we must address all types of health to promote wellness in an individual and in our communities.

The IHS is different from other agencies in HHS because it is a healthcare system, and our business is healthcare. We provide services through a comprehensive primary care network of hospitals, clinics, and health stations on or near Indian reservations, and we provide a range of clinical, public health, and community services. Our facilities are managed by IHS, tribes, and urban Indian health programs. Our focus is on our patients; the American Indian and Alaska Native (AI/AN) people that we serve.

American Indians and Alaska Natives have benefited from ORD programs through the IHS Sanitation Facilities Construction Program, which receives ORD contributions to augment IHS appropriated funds for construction of water, sewer, and solid waste disposal facilities in Indian Country. Since fiscal year 2000, the ORD has contributed between \$6 million and \$38 million annually directly to IHS sanitation facilities construction projects that provide community water, sewer, and solid waste systems to serve AI/AN homes. The ORD may be providing more

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funding directly to tribes that is also used for sanitation facilities construction. The IHS and tribes appreciate this assistance.

The IHS also welcomes any assistance that the ORD could offer to tribes or the IHS in augmenting funding available for health care facilities that provide access to medical care services for AI/ANs.

The IHS and tribal health care facilities provide access to a comprehensive health service delivery system for approximately 1.9 million AI/ANs who belong to 564 federally recognized tribes in 35 states. The IHS and tribes together operate 695 installations providing access to health care services for AI/ANs nationwide. The average age of the IHS facilities is greater than 30 years. The average age of health care facilities in the private sector is between 9 and 10 years. The IHS provides staffing and operating funds in all of these facilities. However, tribes often provide funding and support programs in addition to what is provided by the IHS.

For most AI/AN people, IHS-supported programs are the only source of health care. No alternative sources of medical care are available in many cases, especially in isolated areas.

The current IHS Healthcare Facilities Construction Priority List consists of 19 projects that require approximately \$2.6 billion to complete. These are major construction projects to replace or to expand and modernize existing facilities. Most of these projects have been identified as a priority for nearly 15 years and, based on current funding levels, are unlikely to be constructed in the near future.

However, this priority list does not represent the total need for facilities space to provide access to health services for AI/ANs. Current health services and facilities master plans, prepared by IHS Areas in consultation with tribes, show that there are many other locations in Indian country that require new facilities or renovation, modernization, or replacement of existing facilities. Many of the facilities identified in these master plans are small clinics in AI/AN communities that could benefit from grants, loans, or loan guarantees that the ORD might offer.

Many tribes are trying to address the need for space by seeking funding outside the IHS. Some tribes have combined various sources of funding to develop a project for a health care facility. The IHS supports these efforts within the constraints of available funding.

Under the IHS Small Ambulatory Program, the IHS provides up to \$2,000,000 for construction or renovation of a tribal health care facility. Many tribes have combined these funds with other federal and non-federal funds to obtain the facility they require. The IHS funding for the Small Ambulatory Program is sporadic. No authorization to increase staffing levels is included for this program, so the facility must be sized for available staff.

Under the Joint Venture Construction Program, a tribe constructs a facility using its own funds, including funds obtained through programs such as the ORD. The IHS is authorized to provide equipment, staffing, and operating funds for these facilities. IHS funding for the Joint Venture

Program is also sporadic. The IHS and the tribe must enter into an agreement before the project begins, so that requests for staffing can be placed in the budget.

Under the Tribally Built Equipment Program, the IHS appropriation regularly includes funds to purchase medical equipment that are designated for allocation to tribally built facilities.

Examples of Indian health care facilities in which ORD funds have been used for health care facility construction:

- The Feather River Tribal Health program constructed a clinic in Oroville, California, using a loan guaranteed by the ORD, and medical equipment funds provided by the IHS. In addition the IHS provides funding for some staffing and operation at the facility.
- In New Mexico, the communities of Canonicito and Santa Domingo obtained ORD loans to help construct health care facilities to replace existing facilities. The IHS provided medical equipment and continues to provide operating and staffing funds for these facilities.
- In Wales, Alaska, the ORD assisted the Norton Sound Health Corporation with construction of a clinic. This clinic serves the entire Wales community, which is predominantly Alaska Native, and is operated by Norton Sound Health Corporation. The Corporation compacts with the IHS to provide health care services to Alaska Natives under Title V of Public Law 93-638, the Indian Self-Determination and Education Assistance Act.

The IHS appreciates the Office of Rural Development's contributions to the health of American Indians and Alaskan Natives through loans and other means to tribes for construction of health care facilities. Tribes developing health care facilities projects that involve additional IHS funding should coordinate planning efforts with the IHS.

The challenges we face in the Indian healthcare system are driven by a host of medical, cultural, geographic, and socio-economic factors, including:

- Population growth – that results in an increased demand for services
- Rising costs/medical inflation – especially in rural areas
- Increased rates of chronic diseases – such as diabetes and cancer
- Difficulty recruiting and retaining medical providers in our remote sites
- Challenges of providing rural healthcare
- Old facilities and equipment
- Lack of sufficient resources to meet demand for services
- And in the face of all these challenges, trying to balance the needs of patients served in IHS, tribal and urban Indian health programs.

Partnerships with other agencies and organizations such as USDA are vital in addressing these diverse issues that contribute to low health status. We cannot do it alone.

It is clear that a lack of adequate resources is a huge barrier to fully meeting the mission of the IHS. For example, per capita expenditures for IHS are much lower than those for other federal healthcare sources, such as Medicare, VA, Medicaid, etc. And even though the IHS budget has

shown some small increases over the years, its buying power has actually decreased, due to inflation and escalating medical costs.

Because of these challenges, it wasn't a surprise to hear a great call for change as I did in my work on the Transition Team. In listening sessions with tribes, they indicated the need for both new funding and change and improvement of the IHS. President Obama has stated his goal of quality and accessible care for First Americans. He voted for increased funding and co-sponsored the Indian Healthcare Improvement Act reauthorization while he was a Senator. His administration is all about change and the President's proposed 13 % increase in the Indian Health Service budget is a sign of that commitment.

The issues that contribute to health disparities among AI/ANs require addressing an entire spectrum of socioeconomic, psychological, judicial, and political issues, as I mentioned before, as well as individual lifestyle changes. We must continue to work to coordinate resources across a broad range of federal, private, and educational agencies and organizations in order to effectively address these complex issues. This where the USDA Office of Rural Development efforts can play an important role.

I am optimistic that in this time of hope and change, we have an extraordinary opportunity to look at what we are doing and come up with some creative solutions to our most difficult challenges.

The work ahead is daunting and the challenges are enormous. But when in our history have we had this opportunity – a supportive President, bipartisan support in Congress, a new and supportive administration, and the call for change from our communities and our patients? I believe that we have an extraordinary opportunity to make significant strides in improving the health of American Indian and Alaska Native people. I hope you all can join us in this critical work over the next few years. Thank you.