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HOUSE COMMITTEE ON NATURAL RESOURCES
SUBCOMMITTEE ON INDIAN, INSULAR AND ALASKA NATIVE AFFAIRS
"IMPROVING AND EXPANDING INFRASTRUCTURE IN TRIBAL AND INSULAR COMMUNITIES"
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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 158,000 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.

My testimony today will focus on the health care and public health infrastructure needs in tribal communities. The health care infrastructure in tribal communities is in great need of improvement and expansion. While there have been some increases in Indian Health Service funding over the past several years, the large majority of it went towards inflationary and fixed costs, for things such as population growth and pay costs increases, which has left the Indian health care infrastructure largely behind.

I am going to limit my discussion to three areas in particular where, in addition to increased funding, policy changes could improve the current system—IHS health care facilities construction, sanitation facilities construction and village built clinics.

Health Care Facilities

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 things change. At the recent rate of IHS health care facility construction funding, a new facility built in 2016 would not be scheduled for replacement for over 400 years.

As existing facilities age, without renovation or expansion, they become increasingly inefficient to operate and costly to maintain. The age of facilities also negatively impacts the ability of IHS

and tribal health programs to efficiently and effectively provide health care services to AN/AIs in overcrowded and outdated facilities. The quality of health care is also compromised when facilities are not adequately maintained and kept up to date.

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.

One way to ensure that all IHS Areas have access to at least some resources to renovate and expand existing IHS and tribal health facilities would be to ensure that the IHS Maintenance and Improvement (M&I) line item is increased. Beginning in FY 2011 through 2015, 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 2015 of nearly $500 million for deferred maintenance, alteration and repair.

Another option to ensure that all IHS Areas have access to resources to address facility needs would be to establish an area distribution fund. The reauthorization of the Indian Health Care Improvement Act (IHCIA) in 2010 (S. 1790) amended section 301 of IHCIA to direct the Secretary ensure that the "renovation and expansion needs of Service and non-Service facilities…are fully and equitably integrated into" the IHS health care facility priority system, and to consult and cooperate with tribes to develop innovative approaches to address unmet need for construction of health facilities.

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.

Sanitation Facilities Construction

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 alone we had over $1.2 billion in unmet need for sanitation facilities construction in 2016. Funding for IHS sanitation facilities construction finally saw an increase in FY 2016, but that was after many years of no increases. Given the enormous, growing unmet need and the significant health benefits derived from sanitation facilities continued support of

IHS sanitation facilities construction is essential, but regulatory and policy flexibility is also needed.

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 sanitation facilities construction funding complements funding provided through EPA and USDA. Unlike funding through the Environmental Protection Agency (EPA) and the United States Department of Agriculture (USDA), IHS funding has no minimum operation and maintenance score requirements. While systems that have robust operation and maintenance programs are more likely to be funded, this does not prevent funding from being allocated. Additionally, rural Alaska communities often struggle to obtain qualified and certified operators. EPA funding requires systems be operated by certified operators, whereas IHS funding does not have this requirement.

Because of regulatory barriers on USDA and EPA grants for water and sewer, 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.

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 have not been significantly increased in over 20 years, aside from a small increase in FY 2016. In addition, the current VBC lease amounts provide virtually no funds for basic rent, 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 legal responsibility to fully fund the VBCs. IHS provided the first step in fulfilling its responsibility by providing an increase of $2 million in payments in FY 2016 and a larger step by including an addition $7 million in the IHS FY 2017 Congressional Justification. It is essential that IHS provide funding for VBCs that adequately cover the costs to operate them.

Conclusion

I commend this Committee for holding this hearing on this important subject. It is clear that additional support and policy changes are needed to address the sagging Indian health care infrastructure. Thank you for the opportunity to provide this testimony.