**RESOLUTION # 15-04-02**
**NORTHWEST PORTLAND AREA**
**INDIAN HEALTH BOARD**

**RESOLUTION #315-07-15**
**CALIFORNIA RURAL INDIAN**
**HEALTH BOARD**

# JOINT RESOLUTION

## In Support of System-wide Funding Equity for Indian Health

**WHEREAS**, the Northwest Portland Area Indian Health Board (NPAIHB) is a tribal organization under P.L. 93-638 that represents 43 federally recognized Indian tribes in Oregon, Washington and Idaho and is dedicated to assisting and promoting the health needs and concerns of Indian people in the Northwest; **AND**

**WHEREAS,** the California Rural Indian Health Board, Inc. (CRIHB), founded in 1969 for the purpose of bringing back health services to the Indians of California, a statewide tribal health organization as defined by P.L. 93-638, representing 30 federally recognized tribes in 21 counties with 11 member American Indian Health Programs; **AND**

**WHEREAS,** the Indian Health Service (IHS) is significantly underfunded compared to other federal health agencies, in 2013 expending only $2,849 per American Indian and Alaska Native (AI/AN) patient, compared to Medicare, which spent $12,103 per patient and the Veterans Administration, which spent $6,976 per patient; **AND**

**WHEREAS,** AI/AN continue to suffer from significant health disparities including life expectancy 4.1 years less than the rest of the U.S. population; according to IHS data, AI/AN die at higher rates than other Americans from alcoholism (552% higher), diabetes (182% higher), unintentional injuries (138% higher), homicide (83% higher), and suicide (74% higher); because of these disparities, Purchased/Referred Care/Contract Health Service (PRC/CHS) dependent areas require additional resources than those areas that have access to IHS hospital facilities; **AND**

**WHEREAS**, although the majority of tribes in IHS areas are served by IHS hospitals and facilities, there are no facilities to serve Indians in Idaho, Oregon, Washington, or California, where tribal members are served exclusively by tribal primary care clinics, who must stretch their PRC/CHS to cover inpatient/outpatient hospital services, emergency room services, Medi-Vac or Life Flight care, urgent care, and specialty care for their patients; **AND**

**WHEREAS**, despite numerous applications submitted by tribes in California and Portland Areas to the IHS Facilities Construction Priority List, not a single facility has ever made it on the list, **AND**

**WHEREAS,** this lack of IHS facilities, combined with the way IHS base funding is distributed, has created a significant inequity in funding and access to inpatient and specialty care for tribes in the California and Portland IHS Areas, as documented by three US General Accountability Office Reports issued in 1982, 1991, and 2012; and

**WHEREAS**, while the PRC/CHS formula has been adjusted to provide a slight increase to PRC/CHS-dependent areas like California and Portland Areas, this funding is insufficient to address the inequity in base funding allocation and system wide funding differences, which is complicated by a lack of transparency demonstrated by IHS; **AND**

**WHEREAS,** because IHS has significant discretion in how it allocates appropriated funding within line items like hospitals and clinics or PRC/CHS, even the PRC/CHS-dependency factor itself is not enough to address long-standing funding disparities that negatively impact AI/AN patients in the California and Portland Areas; **AND**

**WHEREAS**, the current method for funding IHS system-wide lacks transparency, reliability, and any basis in actual data, and the PRC/CHS Distribution formula as implemented does not meet the standards established for IHS resource allocation under the *Rincon v. Harris* action, which held that IHS resource allocations processes must be reasonable, rational and defensible. 618 F.2d 569 (9th Cir. 1980).

**THEREFORE BE IT RESOLVED**, Congress directs the IHS to address health status and resource deficiency, as defined in 25 USC 1621 in order to implement a new system-wide funding methodology that takes into account all available health resources provided by the IHS as well as health resources provided by any other federal program, private insurance, or state or local government, as well as regional variations in cost, operating unit variations in IHS resource availability per active user and operating unit level variations in access to IHS direct hospital based services.

**THEREFORE BE IT RESOLVED**, that boards request that Senate Committee on Indian Affairs and the House Natural Resources Committee request the General Accountability Office to review the history of the IHS Construction Priority List and the adverse impact this has had on access to care and equity in resource allocations across the PRC/CHS dependent areas and direct the IHS to address these weaknesses in the funding allocation methodology.

## CERTIFICATION

The foregoing joint resolution was adopted at a duly called regular joint meeting of the Board of Directors of Northwest Portland Area Indian Health Board and California Rural Indian Health Board (***NPAIHB*** *vote 23 For and 0 Against and 0 Abstain;* ***CRIHB*** *vote 13 For and 0 Against and 0 Abstain*) held this 10th day of July 2015 in Lincoln, California and shall remain in full force and effect until rescinded.

**NORTHWEST PORTLAND AREA INDIAN HEALTH BOARD**
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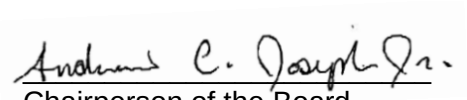

Chairperson of the Board

Attest

**CALIFORNIA RURAL INDIAN HEALTH BOARD**
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Chairperson of the Board

Attest