Joint Hearing before the Senate Committee on Indian Affairs and the House Resources Committee, Office of Native American and Insular Affairs
on
S. 556, a bill to reauthorize the Indian Health Care Improvement Act and H.R. 2440, Indian Health Care Improvement Act Amendments of 2003
Washington, D.C.
July 16, 2003

Oral Statement
of
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Assistant Surgeon General
Interim Director, Indian Health Service

Mr. Chairman and Members of the Committee: Good morning, I am Dr. Charles Grim, Interim Director of the Indian Health Service (IHS). Today, I am accompanied by Gary Hartz, Acting Director of the Office of Public Health; Richard Olson, Acting Director, Division of Clinical and Preventive Services, Office of Public Health; and Rae Snyder, Acting Director of the Urban Indian Health Program. We are pleased to have this opportunity to testify on behalf of Secretary Thompson the Senate and House bills for the "Indian Health Care Improvement Act Reauthorization of 2003."

For the record, I am submitting a written statement that contains specific information about the agency, including the legislative and legal history that established the government-to-government relationship between Tribal Nations and the United States, and some of the national health challenges to improving the health of American Indians and Alaska Natives. My written statement also contains comments on aspects of the proposed legislation that I will not cover in my oral statement so that we can conserve time.

As I testified last April, there is no single piece of legislation that will affect the future health status of American Indians and Alaska Natives more than the "Indian Health Care Improvement Act Reauthorization of 2003." For the past 28 years, the Indian Health Care Improvement Act has been the basis for extending the life span of Indian people by 7 years (still 6 years below that of the rest of the nation), addressing the basic health needs of a population that was not benefiting from the technological and medical advances of an industrialized nation, and assisting in identifying current and future health challenges.

To continue to make progress in raising the health status of Indian people to at least the level of the rest of the nation requires us to modify the Indian Health Care Improvement Act of 1976 to reflect the health status of the Indian population of 2003 and, as best we can, to have it reflect the health status of Indian people as we project it to be into the future until the next reauthorization.

This is an unofficial copy of Dr. Grim's oral statement at the Senate Committee on Indian Affairs hearing of July 16, 2003, in Washington, D.C., on the Reauthorization of the Indian Health Care Improvement Act. It should be used with the understanding that some material may have been added or omitted during presentation. The official copy of the oral statement is contained in the Congressional Record of the hearing. Refer to Dr. Grim's written statement for additional testimony information.

The legislation under consideration today reflects the proposed language developed over a 2-year period by Indian tribes across the nation and adopted by both the Committees of Congress. Our nation faces many priorities today, many of which overshadow but do not diminish the importance of other priorities such as meeting the treaty commitments of the Federal government.

As requested by the Committee, I am focusing my brief remarks on highlighted areas of health disparity, health care facilities, and urban Indian health.

My written statement includes some health statistics, but I would like to present three simple statements to remember regarding American Indian and Alaska Native health disparity. Indian people continue to experience disease and illness at greater rates than the rest of the nation. Indian people continue to prematurely die at rates greater than the rest of the nation. Indian people continue to experience reduced access to health services and care compared to the rest of the nation.

It is well publicized and referenced that Indian people continue to experience health disparities and death rates that are significantly higher than the rest of the U.S. general population. Many American Indians and Alaska Natives who receive a diagnosis of diabetes, high blood pressure and cholesterol levels, cardiovascular disease, alcoholism, obesity, etc., consider it a fatal diagnosis. The proposed language of the Indian Health Care Improvement Act can help the Indian health system of the Indian Health Service, Tribal health programs, and urban Indian health programs develop and implement health promotion and disease prevention strategies so that healthy behavior choices and lifestyles will begin to significantly reduce the health disparity rates. It also yields the even more important humanitarian benefit of reducing pain and suffering, and prolonging life. We were successful in working with Indian nations in conquering infectious diseases, and I believe we can do it again for chronic diseases with the help of Tribal governments, urban Indian health programs, and the Congress.

The IHS health care facilities program, including the tribal facilities programs, is responsible for managing and maintaining the largest inventory of real property in the Department of Health and Human Services, with over 9 million square feet (850 gross square meters) of space. In the proposed bill, section 302(b)(3)(C) specifically proposes that IHS sanitation facilities construction funds not be used to support the service of sanitation facilities in Department of Housing and Urban Development (HUD) homes. The bill is not clear that homes constructed through HUD should also include the necessary infrastructure to make a home complete, including safe water and sewer and wastewater disposal systems for the home. The IHS and HUD have cooperated over many decades on the construction of homes in reservation communities – with IHS providing the expertise and development of supporting sanitation and sewerage systems that the HUD home would then hook into. Without clarity in the language there may come a time when interpretation may result in IHS funds being expended on sanitation systems of HUD homes, which would, in turn, redirect IHS funds from providing services to existing homes without water, sewer, and solid waste facilities. Newly constructed HUD homes should be funded to cover everything, including the home itself and "to the street" hookup. We request that you consider clarifying this point in the proposed Bill.

Title V of the Indian Health Care Improvement Act provides specific authority focused on the provision of health services for urban Indian people with funds appropriated to IHS. The IHS currently contributes funds toward the operating expenses of 34 independent urban Indian programs nationally, as well as the Oklahoma City Clinic and the Indian Health Care Resource Center of Tulsa. These programs provide a range of services. In 1978, the entire State of Oklahoma was designated as a Contract Health Service Delivery Area, which means that Indian beneficiaries could reside anywhere in the state and maintain their eligibility for both direct services and contract health services. The 1992 Congress amended the Indian Health Care Improvement Act to establish two demonstration projects with the Tulsa and Oklahoma City clinics, "to be treated as service units in the allocation of resources and coordination of care." This new and innovative approach to ensuring health services are accessible to all eligible populations in Oklahoma has resulted in a hybrid system: each program maintains its status under Title V as an "urban Indian organization," yet the programs function like other IHS service units and report data to the Resources and Patient Management System of the IHS that is used for consideration in the allocation of resources. Both

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service population and overall utilization of services has dramatically increased since these programs became demonstration projects and since 1994 specific Congressional line item funding increases. They have been able to use the best of both urban and IHS structures to build a community controlled, high-quality health system in a state designated as a contract health service delivery area. On the other hand, this hybrid system has raised a few concerns with some Oklahoma Tribes that operate their own health programs under the Indian Self Determination and Education Assistance Act, Public Law 93-638, as amended. The issue in most basic terms is that the two urban programs have some aspects of a service unit, but their funding is not subject to transfer to the Tribes under 638 contracts or compacts as our non-hybrid service units are. In an environment of resources reduced by an increasing population and greater health need, it is expected that the issue of tribal shares of urban Indian program funds will receive more attention than they have in the past.

As the review of this far-reaching, complex legislation continues, we may have further comments. However, we wish to reiterate our strong commitment to reauthorization and improvement of the Indian health care programs. We will be happy to work with the Committees, the National Tribal Steering Committee, and other representatives of American Indian and Alaska Native communities to develop a bill fully acceptable to all stakeholders in these important programs.

Mr. Chairman, this concludes my statement. Thank you for this opportunity to discuss the reauthorization of the Indian Health Care Improvement Act. We will be happy to answer any questions that you may have.

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The Future Indian Health Care System

by Michael H. Trujillo, M.D., M.P.H.
Assistant Surgeon General
Director, Indian Health Service

The Indian health care system for American Indians and Alaska Natives is comprised of three elements: the Indian Health Service (IHS) programs, tribally operated health care facilities, and urban health care services. The Indian health system faces a future of increased demand for urban programs and services, increased tribal administration and operation of health care programs, and increased reliance on information systems and technology, such as telemedicine. I foresee a substantial increase in the direct delivery of health services to American Indians and Alaska Natives by tribal health programs, and a reciprocal decrease in the direct delivery of direct health services by the Indian Health Service. I expect the level of environmental, community, and public health programs to increase; however, the Indian Health Service may very well evolve into a model system of support to tribes and programs directed toward providing health services to American Indian and Alaska Native people. It is possible that the Indian Health Service will move into providing direct health services from regional specialty referral hospitals and referral centers. A specialty center for cardiac care currently exists; there is a cardiac program in Tucson with the University of Arizona Medical School for American Indians and Alaska Natives that serves Indian people of the Southwest. Similar specialty centers for neurology, orthopaedic, pediatric, and rehabilitation may become established Indian Health Service referral centers in conjunction with other specialty centers. I also anticipate further expansion of Indian urban programs and services, and their increased collaboration with other health care systems in metropolitan areas.

Management of Health Programs by Indian Tribes

I expect tribes to use a variety of programs to care for their people. It is certainly possible that a number of Tribal Health Maintenance Organization programs will evolve. Health promotion and disease prevention activities and personal

accountability will take on increased importance in whatever health care system and organization comes to be.

Direct Health Care Services

Indian Health Service facilities will remain in those areas where tribes elect to have direct federal health care services. These facilities will, however, increase their technological ability to conduct consultation, patient diagnosis, and specialty medical procedures through various forms of telemedicine. These health specialty centers could provide culturally relevant health services for all American Indians and Alaska Native patients without regard to reservation or tribal affiliation. Reservation based health services can be assumed by the tribes, urban based services will continue, and Indian Health Service specialty medical centers will support both. The method of delivery of health care will change in the future Indian Health Service, but the U.S. government's commitment to providing health care for eligible American Indians and Alaska Natives will remain constant.

|| Date posted: May 5, 1997 ||

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Despite decades of hard work by tribal and Indian Health Service (IHS) programs, in the year 2003 large disparities remain in the health status of American Indian and Alaska Native people compared to other population groups in the U.S. Simply stated, this means that in many ways Indian people bear a disproportionate burden of disease, disability, suffering, and death. Eliminating these health disparities will require a long and complicated journey for Indian people, Indian communities, and those who provide health services to them. To help us make this journey, we need a map that is straightforward and clear both to Indian communities and their health service providers. This map should contain milestones so that we can measure the progress we have made in raising health status, and the distance yet to be traveled.

Additional I Health Prio

Measuring health status can be a complicated and bewildering task. The best known system of measuring health in the U.S. is Healthy People 2010, which contains a total of 467 separate indicators of the health of the country. It would be impossible for Indian communities to use this entire document as their guide for improving health. However, a small subset of health indicators, called Primary Prevention Focus Areas, can serve as the roadmap Indian communities need for assessing current health status, designing and implementing programs to improve health, and evaluating the effectiveness of these programs. These focus areas can be used as "building blocks for community health initiatives".

The Primary Prevention Focus Areas have been carefully selected on the basis of the following general criteria:

- They are relevant and important to all communities.
- For each focus area there is a known preventive health activity that can be implemented by individuals and communities.
- Each focus area represents an aspect of health that can be accurately measured, and thus the results of efforts to improve health can be evaluated for effectiveness.

The IHS Director's Prevention Initiative is currently working with tribes, tribal organizations, IHS staff, and health consultants to develop a systematic and comprehensive way to focus prevention activities on these areas. The various sections listed below will provide Indian communities and health care programs with many of the tools they need to move ahead. In addition, the Prevention Initiative is working to mold the below Focus Areas into a useful and usable set of guidelines tailored specifically to help Indian communities (a) assess their current health status, and (b) monitor health status over time as prevention programs are implemented. Once the guidelines are completed, the Prevention Initiative plans to develop the capacity to assist Indian communities in utilizing this Indian-specific set of Focus Areas.

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ISSUE

There exist significant disparities in the health status of American Indian and Alaska Native people compared to the general U.S. population. Clinical and community based health strategies to prevent disease and promote health are an essential part of decreasing these inequities.

CURRENT SITUATION

Tribal leaders as well as Indian Health Service cite diabetes, unintentional injuries, and alcoholism and substance abuse as rising to crisis proportions in American Indian/ Alaska Native communities. Currently, Indians experience disproportionately higher mortality rates compared to other Americans - 627% higher for alcoholism; 249% higher for diabetes and 204% for injuries. The Indian Health Service (IHS) is the only source of health care coverage for 55% of Indians; only 28% have employment related insurance. The most serious health problems are long-term intractable issues that will are greatly affected by social-economic conditions in Indian communities and the lack of adequate resources to respond to them.

The newly revised Indian Health Service Strategic Plan includes specific goals, objectives and activities that will help decrease health disparities. In addition, our Government Performance and Results Act (GPRA) includes specific objectives and targets that address these same health disparities.

CURRENT PLANS

The Interim Director has developed short term management priorities that include a focus on decreasing health disparities. A preventive task force was appointed in November 2002 to help design and implement specific strategies to meet this goal throughout Indian country. This group currently includes representatives from National Council of Clinical Directors (NCCD), National Council of Chief Medical Officers (NCCMO), National Council of Service Unit Directors (NCSUD), and the National Council of Nurses (NCON). A National Policy Advisory Committee on Health Promotion/Disease Prevention has been convened, and includes representatives of Tribal Self Governance Advisory Committee (TSGAC), National Indian Health Board (NIHB), National Congress of American Indians (NCAI), and National Council of Urban Indian Health (NCUIH) as well as representatives from the Office of the Secretary and other operating divisions. In addition, The Secretary's Steps to HealthierUS: Putting Prevention First initiative was launched on April 15, 2003. Tribes will be participating in this as well as coordinating events with the IHS Prevention Initiative.