STATEMENT OF

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ASSISTANT SURGEON GENERAL, DIRECTOR

INDIAN HEALTH SERVICE

BEFORE THE

INDIAN AFFAIRS COMMITTEE

OF THE

UNITED STATES SENATE

BUDGET OVERSIGHT HEARING

ON

THE PRESIDENTS FY 1999 BUDGET REQUEST

FOR THE

INDIAN HEALTH SERVICE

FEBRUARY 25, 1998

Mr. Chairman and Members of the Committee:

Good morning. I am Dr. Michael H. Trujillo from Laguna Pueblo, New Mexico. I am the Director of the Indian Health Service. Accompanying me today are Mr. Michel E. Lincoln, Deputy Director; Kermit Smith, D.O., Chief Medical Officer; and Mr. Gary J. Hartz, Director, Facilities and Environmental Engineering. We are pleased to be here today to discuss the President's fiscal year (FY) 1999 budget request for programs funded by the Indian Health Service.

Mr. Chairman, this April will mark four years since your Committee and I, as the Director of the Indian Health Service, began working to improve the health status of American Indian and Alaska Native people. The health of Indian people is the result of many factors, the delivery of health care is one of those aspects, and I want to acknowledge the Committee's positive influence over other programs that affect Indian people. Your influence has greatly assisted our agency, and our tribal and urban health partners to address many of the health care needs of Indian people.

I consider our success to be the result of the Committee's support of the Indian Health Service, the considerable dedications of those who work for us to ensure we are able to address the needs of Indian people through our decisions, and also because we consult with and listen to the people we serve. Our decisions reflect our commitment to the legacy that the treaties between the United States Government and Tribal Nations began in 1784. I remain committed to working with the Committee to address any questions you and other committee members may have regarding the President's FY 1999 budget request for the Indian Health Service.

The provision of Federal health services to American Indians and Alaska Natives is based upon a special government-to-government relationship between Indian tribes and the United States, which has been reaffirmed throughout the history of this Nation. One example of this special recognition was made by President Lincoln in 1863. He presented to the then governors of the pueblo tribes of New Mexico, a silver-headed cane in recognition of their political and legal right to land and self-government. Today these canes are kept by the governors of each of those pueblos as a symbol of their authority during their terms of office. The relationship has been repeatedly reaffirmed by all three branches of this Nation's government. In 1997, the President issued an Executive Memorandum directing all Federal Departments and Agencies to implement policies and procedures for consulting with Indian Tribes on matters that effect Indian people.

American Indians and Alaska Natives believe strongly in the treaties our forefathers signed with the United States Government and in the status of their tribes as sovereign nations. Many of our ancestors lost their lives forging this government-to-government relationship. They gave up land, water rights, mineral rights, and forests in exchange for, among other things, health care. I believe it is our solemn responsibility to provide the best health care this Nation has to offer as we carry out the commitment the United States is honor bound to keep.

The Indian Health Service provides a comprehensive health system in partnership with Indian people to develop and manage programs to meet their health needs. In addition, the Indian

Health Service also acts as the principal federal health advocate for Indian people. Our goal is to raise the health status of American Indians and Alaska Natives to the highest level possible.

We have made much progress over the years. Infant mortality rates, maternal death rates, morbidity and mortality from infectious diseases have all decreased dramatically over the past 40 years. The resultant increase in the life expectancy Indian people enjoy today is something in which we take pride. However, it is important to note that American Indians and Alaska Natives still bear an increased burden of illness and premature mortality compared to other U.S. populations. Health conditions related to life style choices such as diabetes, heart disease, substance abuse, and domestic violence are especially troublesome. Poverty, lack of employment and educational opportunities, and communities whose social fabric has been tom all contribute to these health problems. In addition, while the Indian Health Service has made great strides in improving the water and sanitation systems of many reservation communities, 12 percent of all American Indian and Alaska Native homes lack safe water and adequate means of waste disposal.

Although we maintain accreditation for most of our health facilities, the aging health facility infrastructure in Indian country requires costly upkeep and maintenance which diverts precious resources away from health care. While the average age of our health facilities is nearing forty years, some facilities are in excess of eighty years old. Geographic isolation also contributes to lack of access to health professionals and services, and lower per capita health care expenditures add to this increased burden of illness and premature mortality.

The American Indian and Alaska Native population experienced a decrease in the number of physicians per 100,000 population from 99.7 in FY 1982 to 89.8 in FY 1994. The physician ratio for non-Indian communities is 229 per 100,000 population. By comparison, in the four state region of the Indian Health Service Aberdeen Area, the ratio for the Indian population is 87 physicians per 100,000. In fiscal year 1997, the IHS per capita health care expenditure was $1,382, compared to the U.S. civilian per capita expenditure of $3,261.

The President's fiscal year 1999 budget request for the Indian Health Service is $2.118 billion which a net $19.7 million increase in budget authority, +0.94 percent, over FY 1998. The request assumes collections of $328 million from third party health carriers for Indian patients which is a $25 million increase over FY 1998 projected collections. Increased funding is provided for Presidential initiatives on alcohol and substance abuse, +9. 0 minion; breast and cervical cancer, +5.0 million; and first and second phase construction of two replacement health facilities, +25 million. The President's request also includes reductions of $10 million in the Hospital and Clinics, $5 million in the Sanitation Facilities, and $3.8 million in Maintenance and Improvement.

Over 30 percent of the funds requested by the President for Indian Health Service supported programs are administered by Indian Tribal governments for eligible American Indians and Alaska Natives under the Indian Self Determination Act. In the sixth year of implementing the Self-Governance demonstration program, there are now 39 compacts and 55 Annual Funding Agreements in place. In addition, 34 urban Indian health programs administer $25.583 million

for health services utilized by tribal members living in metropolitan areas throughout the nation.

All tribes and urban Indian organizations are being included in the processes of the Agency to ensure fairness and balance. No major decisions of the Agency are made without consideration of the viewpoints and concerns of tribes: those that contract, those that compact, and those that choose to stay within the federal system of health care delivery. The Agency includes urban Indian organizations in the decision making process of the Agency, particularly in policy decisions that would impact on them.

Decisions on the allocation and administration of the $30 million appropriated by the 1997 Balanced Budget Act and $3 million by fiscal year 1998 Interior Appropriations Act for the Indian diabetes initiative were made based on tribal and urban recommendations. Consultation on these new funds began at the 1997 National Indian Health Board Annual Consumer Conference in Spokane, Washington, in October 1997, where tribes and urban representatives initiated the development of area-wide recommendations.

In November 1997, a Diabetes Work Group comprised of tribal leaders representing the National Indian Health Board, and the Tribal Self Governance Advisory Committee; urban Indian health leaders; and, Indian Health Service and outside Diabetes experts was convened to review and analyze the recommendations. This work group used the tribal and urban recommendations to develop proposed options for the distribution and use of the grant funds which the Agency relied upon to make final decisions in January, 1998. The administration of the diabetes grant funds is now proceeding on a timetable that will enable the funds to reach the local service delivery points no later than June 1, 1998. Use of the grant funds will include both preventive and treatment activities, and, in fiscal year 1998 only, tribal/IHS data systems improvement activities.

I committed the Agency to increase the opportunity for tribal participation in developing the annual budget request for Indian Health Service-funded programs. The Indian Health Service Tribal consultation policy, the Indian Self Determination Act, and Government Performance Results Act (GPRA) require significant tribal and urban involvement from the beginning of the budget formulation process. Therefore, the fiscal year 1999 budget process provided expanded opportunities for tribal and urban participation in establishing the initial budget request funding levels, identifying health priorities, and proposing program performance measures.

We conducted two day Government Performance Results Act (GPRA) and budget formulation workshops in each of the 12 Areas of the Indian Health Service to more fully explain the performance based federal budgeting process. The local health priorities and associated program performance measures proposed by the local Indian Health Service/Tribal/Urban (I/T/U) health programs were used in the development of the Indian Health Service Annual Performance Plan. Twenty five performance measures proposed by the plan include 14 treatment, 4 prevention, 3 capital programming/infrastructure, and 4 consultation/partnership/advocacy/core functions indicators. The final Indian Health Service plan ranks as one of the two top plans within the Department of Health and Human Services, according to OMB.

Each of the 12 Indian Health Service Area offices has established an Area-wide budget formulation team comprised of local I/T/U health leadership to manage the local input and ensure local I/T/U participation in the Indian Health Service headquarters, Departmental and OMEB executive review and decision making processes. The intent of the new process is to foster improved government to government discussions on national budget priorities between Indian tribes and Federal government so that Indian health needs can be given equal consideration to other national domestic needs. I remain committed to strengthening this new collaborative approach to budget development.

Federal funding for Indian health programs must remain a priority for this Nation. I look forward to working with the members of the Committee to honor and strengthen this commitment and to work toward realizing the goal of elevating the health status of American Indian and Alaska Native people to the highest possible level.

Mr. Chairman, this concludes my statement. We will be pleased to answer any questions you may have. Thank you.