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"A Current Report on the Indian Health Service"

by

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Good Morning. Thank you for the opportunity to be here today to provide updated information about the Indian Health Service (IHS). Department of Health and Human Services (HHS) Secretary Michael Leavitt asked me to express his sincere regrets that he couldn't be here this morning to speak with you. Because of the short time we have this morning, I would like to quickly move on to the specific topics that the National Congress of American Indians (NCAI) has asked me to address: the Avian or bird flu pandemic as it is often called; the IHS FY 2007 budget; and the Indian Health Improvement Act reauthorization.

The IHS pandemic planning under the leadership of Dr. Richard Church is proceeding very well with many important goals already met. I recently sent a letter to all tribal leaders informing them of the many steps taken by the IHS to plan for this threat and care for their communities. The HHS Pandemic Influenza Plan was released in early November. In addition, HHS Secretary Leavitt is preparing an additional phase of the plan that will include general operational planning information from each of the Operating Divisions, including the IHS. This phase of the operational plan is a high-level document focused primarily on continuity of operations.

The IHS has begun to build upon the HHS plan to develop a more detailed operational plan that can be used across the IHS at the local level. This plan can also be used by tribal programs to develop their own specific plans. I have established an IHS core Pandemic Influenza planning group to develop a draft by March 1 so it can be distributed widely for review and comment. The final plan can be available for use by the end of June 2006. In addition, our staff is working to coordinate our activities with other federal agencies such as the Department of Homeland Security, Department of the Interior, and Veterans Health Administration, to name a few.

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We want to do everything possible to plan ahead for the safety and good health of our Indian communities. In partnership with Tribes, the IHS and the HHS can work together to ensure that all the possible protective measures have been carefully considered and put into place when appropriate.

Secretary Leavitt has initiated pandemic influenza summits to be held in each of the 50 states over the next 120 days. Visits to some of your states already have been completed. Representatives from HHS will go to each of the states to participate in these summits. A major purpose of these meetings is to reach appropriate individuals (other than public health officials) who will be instrumental in pandemic planning. For the remaining state meetings, I urge you to encourage representatives from your locality (including IHS, tribal, and Urban) to attend your respective State's summit.

Regarding the FY 2007 Budget, the proposed budget authority for the Indian Health Service is $3.2 billion. This is a $125 million, or approximately 4%, increase over the FY 2006 enacted budget level. Only the IHS and the Food and Drug Administration received budget increases out of all the HHS operating divisions. So that commitment to the IHS and its priorities by the Administration is impressive.

The FY 2007 budget request includes $94 million for sanitation construction – an increase of $2 million, or 2%, over FY 2006, to provide safe water and waste disposal systems to an estimated 22,500 Indian homes.

Overall in FY 2007, Tribes will control an estimated $1.6 billion, or approximately 54%, of the total IHS budget request. To enable Tribes to develop the administrative infrastructure necessary to successfully manage these programs, I am happy to say this budget includes a total of $270 million for contract support costs, which is a $6 million increase over FY 2006. The budget includes an additional $37 million for contract health service costs.

I want to be up front that this budget reflects some hard choices that were made about where funds can be used most effectively to improve the health status of American Indian and Alaska Native people. To meet the President's goal of cutting the deficit in half by 2009, some well-intentioned programs have been reduced or eliminated in the overall budget and IHS was not immune. And this budget reflects our effort to make those difficult choices in the wisest way. Overall, however, the request for IHS represents the commitment of the Administration to protect programs that have proven to be highly effective.

While the overall discretionary spending within the Department of Health and Human Services is proposed to be reduced by 2.1 percent, the request for IHS is a 4.1 percent increase (or +$125 million) over the FY 2006 enacted budget. The increases direct funding to the highest priorities expressed by Tribes during the budget consultation process. They have told us that funding of items to maintain the current Indian health system is where funding is needed first. Therefore, this budget includes an increase of $134 million to cover pay raises for IHS and tribal staff, the increased costs of delivering health care due to inflation, and increased services resulting from a growing American Indian and Alaska Native (AI/AN) population. An increase of $32 million is also included for new staff and operating costs at four new health centers and $11 million is included to cover the increased costs of implementing the Department's Unified Financial Management System within IHS. I am very pleased about these increases for our budget.

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On the other hand, the President's budget for the IHS contains some difficult choices. But I have to acknowledge that the decisions made are indeed consistent with the responsible budget principles applied throughout the President's budget request. There are 141 programs proposed for termination or reduction in the President's budget request. Some are proposed because their performance has not been satisfactory, others are proposed because their purposes are addressed in other agencies. The IHS Urban Indian Health Program was deemed to fall into this last category and therefore, the budget requests that funding for this program be eliminated in FY 2007. The Administration believes that American Indians and Alaska Natives living in urban areas can receive health care through a wide variety of Federal, State, and local providers. One health care provider available to low-income urban Americans is the Health Resources and Services Administration's Health Centers program, which served 7.3 million urban patients, and 125,000 Native Americans, in 2004. The budget requests $2.0 billion for Health Centers in FY 2007, sufficient to serve 8.8 million urban patients and 150,000 Native Americans. I want to stress that the Department is committed to ensuring that culturally sensitive health care services are available to all AI/AN people who find themselves living in urban areas.

Another area of hard choices is construction. The budget request for IHS health care facilities construction is $17.7 million, which is a reduction of $20 million from the FY 2006 enacted level. The requested amount will complete the construction of the Phoenix Indian Medical Center's Southwest Ambulatory Care Center. Construction on this facility will begin this fiscal year with FY 2006 appropriated funds. While the replacement of aging facilities is important for expanding access to care, this budget is intended to ensure that basic needs of all IHS and tribal programs throughout IHS are met. We chose to focus, during a tight budget year, on offering treatment and not just building infrastructure. The request for FY 2007 is consistent within the Department's overall facilities management strategy in that no new construction is funded in FY 2007.

This budget supports tribal priorities to maintain current services funding levels of the Indian health system. This budget will ensure continued access to high quality medical and preventive services as a means of improving health status. It reflects a continued Federal commitment to American Indians and Alaska Natives.

When Secretary Leavitt briefed the media on the HHS budget earlier this month, he explained five key principles that were at the core of shaping the 2007 budget. He stressed that the budget:

- Protects the health of Americans against the threats of both bioterrorism and a possible influenza pandemic;
- Provides care for those who need it;
- Protects life, family, and human dignity;
- It enhances the long-term health of our citizens; and
- It improves the human condition around the world.

Regarding the reauthorization of the Indian Health Care Improvement Act, the Senate Indian Affairs Committee on October 27, 2005, marked up S. 1057 approving changes to the bill as introduced before reporting it out. Chairman McCain amended the bill to address some of the significant concerns raised by the IHS/Administration. These changes were:

- Restore current law for the Section 104 Scholarship program funding distribution. This will maintain the program as a national program instead of splitting the scholarship funds up by area and tribe. Retaining the national character of the scholarship program maximizes the benefits of the approximate $14 million in IHS scholarships funding available annually to address the health manpower needs throughout Indian Country.
- Restore specific authority for the IHS to maintain diabetes coordinator positions at the area level. This change recognizes the valuable role of the area diabetes coordinators in agency efforts to provide critical program coordination and technical support to the tribal special diabetes initiative activities.

The bill was also amended to add new demonstration authority in the Behavioral Health title for an Indian Youth Telemental Health grant program. Senator Dorgan proposed this change to place a high priority focus on the continuing need to address the Indian youth suicide problems. The Alaska Dental Health Aide provisions of the bill were subject to significant committee debate. Senator Coburn of Oklahoma offered an amendment to restrict the scope of practice of Alaska Dental Health Aides and to eliminate the authorization of a study of the program. The Coburn amendments failed.

The committee did agree to strike the language which would have allowed for the expansion of the program to the lower 48 states. As the provision now stands, there can be no automatic expansion to the lower 48; Congress would have to explicitly approve any expansion beyond Alaska.

The committee action moves this important bill forward in the legislative process. A key area of concern for the Department is extension of Federal Tort Claim Act (FTCA) coverage to Title V, Urban Indian Health Programs, and expansion of FTCA to "638" Tribes who provide services to non-eligibles. Other areas of concern include requirements throughout the bill that require the development of regulations using Negotiated Rule-Making, which can be resource and staff intensive.

While the House has not introduced a reauthorization authority, I understand that companion bill may be introduced in the near future. I will continue to urge the Department to support the reauthorization of this key legislative authority. I remain optimistic that we can reach consensus on a bill that will meet the needs of Indian country in the coming years.

Another legislative proposal that is pending in the Congress is S. 1239, the American Indian Elderly and Disabled Access to Health Care Act of 2005. This bill proposes to authorize ITUs to use appropriated funds to pay the Medicare Part D premiums of eligible Indian beneficiaries. These premium payments would be for the AI/ANs enrolled in the prescription drug plans under Part D of title XVIII of the Social Security Act. Right now, these funds can be used for paying Medicare Parts A & B premiums, but not Part D. S. 1239, if authorized, would enable eligible Indian beneficiaries to enroll and participate in the Part D program, which began in January.

However, it is our understanding that there is opposition from some members of Congress to this proposal. The concern is that this would establish a precedence that would

allow one group of people (AI/ANs) to have assistance in paying their Part D Drug Premiums that goes beyond the Medicare Modernization Act of 2003 authorities. At this time, it is unclear whether or not this legislation will be enacted. There is no companion bill at this time. The Administration does not have a formal position on S. 1239.

Lastly, Senator McCain on October 20th of last year introduced S. 1899, a bill to amend and extend the Indian Child Protection and Family Violence Prevention Act of 2005. This bill would reauthorize and amend the current statute. The bill was referred to the Senate Committee on Indian Affairs. There has been no further action of the legislation at this time.

I believe I have a few more minutes remaining to speak about an extremely important charge that I have given to the IHS leadership recently at a National Combined Councils meeting.

I presented a new vision for the IHS and how we consider and relate to our patients, their families, and their communities. It is now time to develop an IHS-wide system of holistic care for each and every patient. By this I mean that we must look carefully at each of our patients and how we can best improve their mental, physical, social, and spiritual health throughout our hospital, clinic, or center. We must take that extra moment to connect our patients and their needs to our full range of existing services and evaluations. We intend to treat the whole patient and his or her family in the context of their Native community. It's clear that this is far and away the most effective, efficient, and long-lasting prescription for treating chronic illness.

As I have emphasized previously when speaking to the NCAI, I have established the Director's three initiatives of Health Promotion/Disease Prevention, Management of Chronic Disease, and Behavioral Health. These initiatives are linked together and have the potential to achieve positive improvements in the health of Indian people.

As always, a close working relationship with our tribal communities and their leaders is an optimal goal in our work. Tribal leaders who are engaged in improving the health and well being of their citizens are our leading allies in creating the change I have just spoken about. Recently I was very moved while reading a news story focusing on how Tesuque Pueblo Governor Gil Vigil is challenging his people to make better use of a new health facility that has a gym, weight room, senior center, and afterschool programs. At 23,000 square feet and a cost of $4.6 million, the new center is a testament to the Tesuque Pueblo's resolve for a healthier future. Yet it took Governor Vigil to encourage the community to "just move it" as we like to say. We wish him great success in achieving full community participation.

For many communities, such an extensive facility just isn't financially possible. But there are many other ways to stay healthy, including healthy walks, fun runs, and easy to understand guidance on healthy diets. Even the poorest Native community can take positive steps to lead tribal members back to the healthy life habits of their ancestors.

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