Indian Health Service

2006 Self-Governance Spring Conference

Keynote Address
"Tribal Self-Governance: Strength in Numbers"

by

Dr. Charles W. Grim, D.D.S., M.H.S.A.
Assistant Surgeon General
Director, Indian Health Service
May 9, 2006

Good morning. It is a pleasure to be here today to speak to all of you at the 2006 Tribal Self-Governance Spring Conference. I would like to begin by acknowledging and thanking the Self-Governance Communication and Education Tribal Consortium, and the other conference planning committee members, for the excellent job they did in organizing this conference. I realize planning a conference like this takes a lot of hard work and coordination, and we can see what a great job you have done.

The theme of this meeting, "Tribal Self-Governance –Strength in Numbers," could be interpreted in many ways. Certainly, there is the concept of the strength of many voices speaking together; of many strong people working in unison toward a common goal – the health and wellness of American Indian and Alaska Native people. I firmly believe in the full application of self-governance and self-determination in Indian health, and in its importance in ensuring high-quality health care for our beneficiaries.

I also have some important concrete, factual numbers for you that demonstrate the commitment and accomplishments of IHS and tribal components to the concept and realization of self-governance and self-determination. In the past 10 years:

- The number of Self-Governance compacts and funding agreements has more than doubled, going from 29 compacts and 41 funding agreements in 1996 to 72 compacts and 92 funding agreements in 2006.
- The number of Tribes in the Tribal Self-Governance Program has risen from 225 (representing 42% of federally recognized Tribes) to 321 (representing 57% of federally recognized Tribes).

The text is the basis of Dr. Grim's oral remarks at the Self-Governance Conference on May 9, 2006. It should be used with the understanding that some material may have been added or omitted during presentation.

- The funding level for the Tribal Self-Governance Program has more than tripled, and the percent of the overall IHS budget that is allocated to the program has more than doubled.

From these numbers, we can clearly see the strength of the self-governance program growing; we see more Tribes exercising their self-determination rights; and we see more of the Indian Health Service (IHS) budget going directly to Tribes to exercise that right. And we can see the commitment of the IHS and tribal communities to supporting and strengthening the concept of self-determination through increased self-governance.

Self-Governance is fundamentally designed to provide tribal governments with more control and decision-making authority over the federal financial resources provided for the benefit of Indian people. More importantly, Self-Governance fosters a partnership between Indian Tribes and the United States in their government-to-government relationships. Self-Governance provides, administratively, the opportunity for tribal governments to exercise their sovereignty with minimal intrusion and involvement.

As one great Self-Governance leader, Joseph DeLaCruz, former President of the Quinault Indian Nation, declared:

> *No right is more sacred to a nation, to a people, than the right to freely determine its social, economic, political, and cultural future without external interferences. The fullest expression of this right occurs when a nation freely governs itself.*

The number of Tribes who are exercising their right to self-governance is a growing strength that will serve us well as we continue to work together in improving the health of Indian people.

The bottom line is — self-governance works. As Director of the Indian Health Service, I have been able to witness first hand the many achievements related to Indian health that have resulted from tribal participation in the self-governance process.

Tribes participating in the Tribal Self-Governance Program consistently report that the program has had a significant positive impact on the health and well being of their constituents. The self-governance process places greater control of the administration and management of the health programs into the hands of tribal governments, which provides them with the flexibility to tailor their health programs to meet the diverse and unique needs of their people. Putting the power in the hands of the people most affected by the decisions being made is the most effective way to ensure their needs are met.

The success of the Self-Governance program has yielded some innovative healthcare approaches that could theoretically be applied nationwide or even worldwide. Tribes have expressed their desire to help IHS and the Department of Health and Human Services (HHS) reduce the current health disparities that exist throughout the country by offering recommendations of best practices that have proved effective in their constituent areas. Such activities involve participating in nationwide studies and data collection efforts that will heighten awareness of such disparities on a nationwide level. We have also met with health leaders from other countries to discuss and share some of these best practices and lessons learned.

Tribal Consultation is a very important part of the implementation of self-governance and self-determination, one that has a profound influence on the direction of Indian health. Speaking of strength in numbers, here are some more "hard" numbers that illustrate the strength of tribal consultation:

- HHS began regional tribal budget consultations in May 1999. Between FY 2002 and 2005, HHS funds expended for Tribes increased by $530 million, or almost 13%.
- By FY 2005, the total HHS resources that were provided to Tribes or expended for the benefit of Tribes increased to approximately $4.7 billion.
- These gains came in both appropriated funding as well as increased tribal access to non-earmarked funds and increases in discretionary set asides.

Consultation works, and we at the Indian Health Service are dedicated to the application and promotion of consultation for all Indian health issues. We have repeatedly seen the results and positive effects of involving Indian people in the formulation of health policies that directly affect them, such as in the development of the IHS budgets and other areas, and I am confident we will increase those benefits with our newly revised consultation policy.

At regional consultation sessions over the past 3 years, tribal leaders have been very clear about the critical role consultation plays in the government-to-government relationship between the Department of Health and Human Services and Indian Tribes, as well as their desire that we revise both the HHS and IHS consultation policies. We heard you, and with your help, have worked to strengthen the consultation process.

The policy revision process was itself a significant consultation event spanning several years. Tribal representatives and HHS staff from many divisions worked diligently for many months to craft recommended revisions to these two policies. Former Secretary Thompson signed the revised HHS Tribal Consultation Policy on January 14, 2005, and Secretary Leavitt transmitted the policy to Tribes on March 11, 2005. The IHS policy was signed on January 18, 2006.

In the coming year we will witness other HHS Divisions revising their consultation policies and plans to comply with the revised HHS policy. The work of this tribal/federal team will no doubt serve as a model for HHS Divisions to follow as they undertake this policy revision process.

The IHS serves as an advocate in strengthening relationships between Tribes and the federal government. The IHS will continue to actively promote tribal consultation throughout HHS, as well as in other federal and non-federal agencies and organizations

The President's FY 2006 Budget for the Indian Health Service clearly reflected the importance of consultation and advocacy. Despite tight budget constraints across the federal government this year, the IHS did receive a budget increase. Our increase, although modest compared to the needs we know are out there in Indian country, is still a good indication of the power of consultation, and the strength in numbers of many voices advocating for Indian health issues.

The IHS received increases this fiscal year for several items that are critical for maintaining services provided at IHS, tribal, and Urban Indian programs. Although two rescissions were enacted, the IHS still ended up with a $60 million increase over the FY 2005

funding level. Decisions on allocating the increases and decreases have been made, and all of the funds remaining after the rescissions have been allocated to the Areas. The two rescissions were both applied across the board to all budget activities as required. To recap the distribution of the increases:

- The pay increase was allocated in October 2005. The methodology for the tribal pay increase was based on the recurring amounts of tribal compact and contract funding within each Area. The methodology for the federal pay increase was based on actual payroll costs within each Area.
- The population growth increase was also allocated in October 2005. The distribution of the population growth funds was based on each Area's share of the overall 1.6% growth in the American Indian and Alaska Native population.
- New staffing increases were allocated to the appropriate Areas in October as well.
- The inflation increase was allocated in March, based on the recurring base funding of each Area and Headquarters.
- The contract support costs increase was also allocated in March to address the existing shortfall in tribal compacts and contracts.

The FY 2006 appropriation also included two budget decreases. One was for efficiencies gained from the use of Information Technology and one for was efficiencies gained in administrative activities. Both of these decreases were allocated in March based on the recurring base funding of Areas and Headquarters.

- For the most part, the 0.476% rescission enacted in the Interior appropriations bill was taken from the pay costs before they were distributed last October. In cases where there were no pay costs to take the rescission from, like with the Contract Health Services budget, the rescission amount was then taken from the inflation amount for that budget activity.
- The 1% rescission, which was enacted at the end of December, was allocated in March and it was applied to all increases and the base funding of each budget activity.

Even though the appropriation bill was signed early and the apportionment approved early as well, there are several reasons why all of the funds could not be distributed on October 1. The main reason was that data for the allocations were still being obtained from the Areas. And as many of you know, the possibility of a second rescission was still very real, and the IHS had to consider how that might be managed within the allocations.

I am pleased to say, however, that the recurring base funds and most of our appropriated increases including the pay costs, population growth, and new staffing funds, were allocated to the Area offices in October.

The President's FY 2007 Budget request for the Indian Health Service is another clear indicator that your priorities as communicated through the consultation processes are being heard. The FY 2007 budget request focuses on current services needs, which have been your highest priority for the past several years.

During the 2007 Regional Tribal Consultation Sessions and the HHS Budget Consultation Session, Tribes were very clear about the need for additional resources as well as their budget priorities. Those priorities included full pay cost increases, increases to address population growth, and funds to address the increasing cost of providing health care. The Department responded, and worked very closely with others in the Administration to include those priorities in the 2007 President's Budget Request.

We all agree that needs remain to be addressed; however, in this extremely difficult budget environment, the IHS is recommended for an increase of $124 million. This is in sharp contrast to a reduction of more than $350 million for the Centers for Disease Control and Prevention, a reduction of over $900 million for the Administration for Children and Families, and a reduction in excess of $350 million for Health Resources and Services Administration, to name but a few.

The proposed IHS budget authority for FY 2007 is $3.2 billion. This is a more than $124 million, or approximately 4 %, increase over the FY 2006 enacted budget level. Adding in funds from health insurance collections estimated at $678 million, designated diabetes appropriations of $150 million, and $6 million for staff quarters rental collections, increases the proposed budget for the IHS to $4.0 billion in program level spending.

As you can see clearly from the consistent budget increases, consultation, advocacy, and communication of needs are essential components of our efforts to improve the health and wellness of Indian people. On-going communication with the Tribal Self Governance Advisory Committee, Indian Organizations, and non-Indian organizations, as well as other key players, also plays an integral role in increasing our "strength in numbers." The more input we have, the better our decisions will be on the vital issues surrounding health care and wellness in Indian communities.

I would like to spotlight the Tribal Self-Governance Advisory Committee as an example of the power of strength in numbers. This committee was established in 1996 as a key advisory committee, charged with acting on the behalf of Self-Governance Tribes to clarify health delivery issues that affect all compacting Tribes. The committee's role is to confer, discuss, and come to consensus on specific self-governance issues, and then provide verbal and written advice about self-governance issues to me.

I want to express my appreciation to the Advisory Committee's tribal leadership for consistently providing timely guidance, recommendations, and actions. They assist in devising strategic options to some of the most complex policy issues we face within the Indian health system. I know they spend many days away from their families, homes, and friends to represent the power and strength of numerous voices across Indian country in order to eliminate health disparities. To each of you, I say thank you.

One important issue that the Advisory Committee is currently working on is the development of a Title V Health Status Reporting Tool. The committee is working with the IHS to support the development of *voluntary* measures and tools that will assist Tribes in evaluating their programs. These tools should have several key elements:

- They must be useful for internal planning, program evaluation, and program development purposes;
- They should provide for the implementation of training and resource requirements;

- They should provide for benchmarks with other similar type programs both inside and outside the IHS;
- They must ensure availability of tribal scores in a manner useful for tribal participants;
- They certainly must ensure confidentially of individual scores; and
- They should allow aggregation of scores for all Self-Governance programs.

Significant improvements have been made in the administration of tribal health programs over the years that have resulted in improvements in the quality, quantity, and accessibility of services provided to American Indian and Alaska Native people. This means that federal funds are being more effectively and efficiently used in addressing the health care needs of Indian people. The Tribal Self-Governance Program promotes improved program and fiscal accountability, ensuring that tribal governments and health administrators are held directly accountable by and to their service population.

The IHS supports the concept that compacts or funding agreements negotiated between the Secretary and a Self-Governance Tribe should include a provision that requires the Self-Governance Tribe to report on health status and services delivery; but these reports should only impose minimal burdens on the Self-Governance Tribes. The reports should be derived from existing data elements currently collected by Self-Governance Tribes. The IHS will work with representatives of Self-Governance Tribes, in coordination with the Tribal Self Governance Advisory Committee, to develop a mutually defined annual voluntary uniform subset of data that is consistent with Congressional intent, minimizes reporting burdens, and responds to the needs of the Self-Governance Tribe.

These tribal reports enable the Secretary to prepare reports required under Title V and to develop the budget request. The reporting requirements are not intended as a quality assessment or monitoring tool, although this may be included at the option of the Self-Governance Tribe.

Thank you for allowing me to speak to all of you here today on these important issues. All of you play an important role in the achievement of our mutual goal of improving the health status of American Indian and Alaska Native people, and I am proud and honored to be your partner, along with all the employees in the IHS, in this endeavor.

The text is the basis of Dr. Grim's oral remarks at the 2006 Self-Governance Spring Conference in Acme, MI, on May 9, 2006. It should be used with the understanding that some material may have been added or omitted during presentation.