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"Perspectives on the Health of the IHS"

by

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I appreciate the opportunity to speak and meet with you today. Yesterday the President and Secretary announced their request for a 2.6% increase in the Indian Health Service budget for fiscal year 2004. Because of the budget formulation process of the IHS, which involves the Tribes and urban Indian program representatives, you know what 2.6% means. In non-budgetary terms it means that we once again combine our efforts to meet the health needs of our people to the best of our abilities and to the extent of our resources. In this era of war and economic challenges, there are austere budgets for many government programs, and any increase is viewed as a success.

As the President presented his vision for the nation for the upcoming year through his recent state of the union address and in subsequent remarks, I would like to share with you my vision and priorities for the Indian Health Service, and the Indian health system, for 2003 and for the years to come.

In 2 years we will mark 50 years of service to American Indian and Alaska Native people as part of the Department of Health and Human Services. We have come a very long way from our beginning 48 years ago, even further from more than a century of the government providing health services to Indian people through programs that ultimately evolved into the Indian Health Service.

I am pleased that I can serve Indian people as the Interim Director of the Indian Health Service for as long as the President and Secretary wish me to serve. The Department has forwarded my name, along with their endorsement, for the White House to submit my nomination before the Senate for confirmation. As the Interim Director, appointed by the President, I have all of the responsibilities and authorities to carry out the work of the Agency for the benefit of American Indian and Alaska Native people. It would be an honor to serve as the 7th Director for an agency that has done so much for Indian people.

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One crucial area of concern to all of us is the IHS budget for the upcoming years. As I mentioned, the President released his budget request for fiscal year 2004 yesterday – while we are still operating under a Continuing Resolution at the 2002 funding levels. We do not know with any certainly how the 2003 budget issues will be resolved; whether we will be at more or less than the 2002 funding levels – the 2003 budget that was requested for the IHS was an increase of 2%. But however it is resolved; we will have 8 months remaining in this fiscal year to deal with whatever the outcome will be. I am sure that we will be creative in how we rise to the challenge.

The Senate has presented an omnibus bill, and the House is working on their version. Based on the Senate bill the IHS budget for 2003 would be more austere than that proposed by the President for 2004. The Senate bill provides for an increase of $66 million, and our inflation and pay costs and other mandatory expenses usually account for $125 to $150 million of our budget every year. There is also consideration for an across-the-board rescission of anywhere from 1 to 2.9 percent. If the rescission is 1 percent that would mean a reduction of about $30 million for the IHS which would bring down the Senate's budget increase for the IHS to $36 million.

As we face the potential for difficult budget years, we are also trying to look at other programs within the Department that could benefit Indian people. For example, the Community Health Centers program of the Health Resources and Services Administration. We are working closely with HRSA to identify opportunities for tribal programs to benefit from the Community Health Centers program. Another example is the Substance Abuse and Mental Health Services Agency and their Alcohol and Substance Abuse funding. Over the next three years SAMHSA will receive $600 million to help addicted Americans find treatment. There may be opportunities within that program to possibly fund some of the IHS, Tribal and urban Indian alcohol and substance abuse programs as well as for faith based and traditional health programs in Indian country. There are also large increases for bioterrorism and homeland security and we should all look at ways to participate in those activities and receiving funding for the additions and changes our programs will encounter in order to increase the country's readiness and response levels.

Our collaborations with other agencies of the Department do produce results. A recent success was with the Centers for Medicare and Medicaid Services regarding their implementation of a new fee structure, the Outpatient Prospective Payment System. We discussed with them the impact implementation would have on Indian country. We also presented information to the Department and they took an active interest in the outcome – and, as you may now know, the IHS and Tribes are exempt from implementing the OPPS system. This collaboration alone saved $30 million in one year for implementation and it saves us $17 million a year on a recurring basis. This type of collaboration and involvement can pay big dividends for Indian country.

The request for 2004 funding levels began with a base of the President's 2003 request. As a result of the process of tribal consultation in our budget formulation process, through presentations by the Tribes and the agency to the Department of Health and Human Services, and through the submission to the Office of Management and Budget of the Department of Health and Human Services overall request – and the many meetings and telephone calls to refine the request – we are seeing a overall 2.6% increase.

The President's 2004 budget request will include $114 million for IHS sanitation construction projects -- a $20 million increase over the fiscal year 2003 budget and the largest sanitation increase in more than a decade. The money would go toward increasing the number of homes with safe water systems, assisting with emergencies that may occur over the year, and to help in the clean up or replacement of open dump sites. Almost 8% of Indian homes still lack a safe indoor water supply, compared to 1% of all U.S. homes. In some areas, such as Alaska, up to 35% of homes lack safe indoor water supplies. For the Tribes within the IHS Nashville Area, the rate is 10% of homes.

The proposed budget also includes an additional $35 million toward covering increased Federal employee pay costs and to allow tribally-run health programs to provide comparable pay raises to their staffs. An additional $25 million is included to complete staffing for two new hospitals. Contract Health Services will also see a funding increase; the budget includes an additional $25 million for CHS costs; an amount that will support the purchase of approximately 511,000 outpatient visits, an increase of 17,000 from FY 2003. This increase is recognition by the Administration of the great need to purchase care from the private sector regardless of hard economic times. And the budget request includes $150 million for diabetes prevention/treatment grants, an increase of $50 million over FY 2003 levels.

I cannot overemphasize the influence that successful documentation of IHS, tribal, and urban Indian health program performance has on the outcome of the Administration's budget request process. With

documentation of performance and health status and health need, we are able to support recommendations for increases to the IHS budget.

One example of successful efforts to improve data collection are the nationwide Government Performance and Results Act pilot projects, which the Indian Health Service provided funding for. The Mississippi Band of Choctaw and the United South and Eastern Tribes are participating in the GPRA pilot projects. This collaboration provides for innovative data collection that is critical for appropriations and accountability.

The Secretary is very interested in how the OPDIVs can work together to address a health need of the nation's people. And there are suggestions on what OPDIV programs can be strengthened or focused on a particular health issue such as asthma, diabetes, AIDS, obesity, nutrition and exercise. All of the health issues are reflected to some degree in Indian country. The Department has in excess of 320 health programs and initiatives, 90 of them specifically targeted to the American Indian and Alaska Native population, but Tribes are accessing only 46 of them. It is our goal to see that number increase substantially.

And it isn't just within the Department where we should explore opportunities for addressing health issues of Indian country. For example, the American Cancer Society has a program to help individuals and communities access timely and quality health care services and to help them navigate around access barriers in the health care system. The program, aptly called "Patient Navigation," is one that can benefit American Indians and Alaska Natives. The program works by providing patients with a person from the community who can help them move through the system and access timely prevention services and treatments. This concept of patient navigation is also mentioned in legislation before the Congress – information about the legislation and the program itself can be obtained from the American Cancer Society. This is just one example where helping a program succeed for all communities can then specifically assist Indian communities.

And to help eliminate health disparities, we need to focus on disease prevention and treatment. Preventing disease and injury I consider a worthwhile financial and resource investment that will result in long-term savings by reducing the need for providing acute care and expensive treatment processes. As part of the Department's focus on eliminating health disparities for Indian people, the Secretary restarted the Intradepartmental Council on Native American Affairs – a Council where I serve as a co-chair along with the Director for the Administration for Native Americans. This is an internal working council of the Department where policy issues affecting American Indian and Alaska Native people can initially be considered. Another primary interest of the council is to conduct a harder look at the programs of the Department and which ones Tribes are accessing and which ones they aren't and why. The IHS cannot meet all the health needs of Indian country; it will take the entire Department.

The topic of restructuring the IHS Headquarters has received a great deal of attention, and I am overwhelmed and respectful of the interest Tribes and organizations have shown. I can assure you that the reorganization, whatever the ultimate outcome will be, will be structured along some basic principles – that tribal shares will not be affected and that the long-term consequences to the agency and Indian Country, health programs and services, and, most importantly, that Tribal sovereignty and the government-to-government relationship will be considered and reflected in any changes.

The proposals for restructuring the IHS and the IHS Headquarters coincide with consolidation activity of the Department. While each has an affect on the other, let me first talk about the restructuring associated with the IHS and then offer a few comments regarding the Department's consolidation efforts.

The first proposed reorganization of the IHS Headquarters that was provided to you was just that, the first – something to begin with. No functions were changed, only moved around. No functions were added. And no tribal shares were affected.

The reason we are considering restructuring the Headquarters offices and staff is to help it become more responsive to Tribes as well as responsive to the Department. In order to be responsive to the Department, particularly to the Office of the Secretary staff, and to maintain our responsiveness to the Tribes, we are considering ways to effectively restructure. Restructuring the IHS Headquarters was also in response to the IHS-wide restructuring recommendations and guidance of the Tribes and urban representatives presented through the Restructuring Initiative Workgroup efforts and consultation. The Workgroup allowed Headquarters the flexibility to restructure to support the Workgroup recommendations and meet the support functions and advocacy efforts for the Department.

The feedback the agency has been receiving on the IHS Headquarters restructuring also includes comments on the HHS consolidation initiatives. The Department is moving forward with consolidating

Human Resources and Equal Employment Opportunity services. But there continues to be details to work out and issues to consider. The intent of the Department is to establish reduce the 40 different personnel offices and programs into four personnel/EEO service centers. They will be located in Baltimore, Bethesda, Rockville, and Atlanta. The support services for the Indian Health Service will be provided out of the Baltimore location. On your agenda is a presentation by Rear Admiral Gary Hartz and Bob McSwain regarding Headquarters restructuring and they will share some of their insight into the consolidation efforts underway.

It is my understanding that once the Department has established the HR and EEO service centers, their next priority is to consolidate Information Technology services and, as they have announced in the past, there continues to be interest in the Department providing public affairs, legislative, and facilities services to the Operating Divisions.

Another area of interest is in the upcoming decisions I will make regarding the distribution methodologies for Alcohol and Substance Abuse funding, for Contract Health Service funding, and the funding distribution of the additional $50 million for the diabetes initiative.

As I have stated, I will be making a decision regarding the Alcohol and Substance Abuse funding and Contract Health Service funding once the 2003 appropriation has been finalized. My final decision will include a provision for distribution of funds on a recurring basis. In general, three formula options have been presented for my consideration – maintain the current formula, change to a new formula, or blend the current and the new formulas. Because of the critical need for Contract Health Service care, I have also determined that my decision on that funding will include a "hold harmless" clause so that no Tribe will receive less CHS funding than they currently receive.

In closing, as always, there is a lot of activity taking place within a national environment of economic, security, and health challenges. We are operating within a dynamic and ever-changing set of factors that will influence decisions affecting Indian health programs now and for years to come. We must continue our efforts to conduct "business as usual" and at the same time look for opportunities to strengthen our programs and partnerships. Our people are counting on us.

Thank you for inviting me to join you and I look forward to working with you as we continue our journey of health leadership together. Following Mr. Tiger's remarks, we will have time to respond to your questions.

Thank you.

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