2001 GENERAL STATEMENT

	FY 1999 Actual	FY 2000 Final Appropriation	FY 2001 Estimate	Increase Or Decrease
Health Services	$1,948,380,000	$2,074,173,000	$2,271,055,000	+$196,882,000
Facilities	291,965,000	316,555,000	349,374,000	+$32,819,000
Total, Budget Authority	$2,240,345,000	$2,390,728,000	$2,620,429,000	+$229,701,000
Reimbursement	$339,586,000	$409,290,000	$409,290,000	---
Diabetes 1/	30,000,000	30,000,000	30,000,000	---
Total, Program Level	$2,668,931,000	$2,830,018,000	$3,059,719,000	+$229,701,000

1/ The Balanced Budget Act of 1997 transfers $30,000,000 annually to IHS for diabetes prevention and treatment from FY 1998 through FY 2002.

NOTE: Y2K funds appropriated to Treasury in FY 1999.

United States Government and Indian Nations

The provision of Federal health services to American Indians and Alaska Natives (AI/AN) is based on a special relationship between Indian tribes and the United States provided by Article I, Clause 8, of the United States Constitution. Numerous treaties, statutes, and court decisions first expounded in the 1830's by the U.S. Supreme Court under Chief Justice John Marshall have reconfirmed this relationship. Principal among these is the Snyder Act (25 U.S.C.) of 1921 which provides the basic authority for most health services provided by the Federal Government to AI/AN.

President Clinton acknowledged the special government-to-government relationship at the historic meeting at the White House with American Indian and Alaska Native tribal leaders in April 1994. President Clinton pledged to fulfill the trust obligations of the federal government and vowed to honor and respect tribal sovereignty. President Clinton said, "I don't want there to be any mistake about our commitment to a stronger partnership between our people," and he showed that by signing a government directive. The directive requires every executive department and agency of government to remove all barriers that prevent the government from working directly with tribal governments and to make certain that any action affecting tribal trust resources have tribal government consultation before a decision is made.

In carrying out the Executive Order for a stronger partnership between the government and tribal governments, the Department of Health and Human Services, the Office of the Secretary and IHS have conducted regional meetings with tribes on an annual basis since 1995. The meetings continued the national dialogue begun in 1994 on health care reform by facilitating federal, state, and tribal discussions about state and region-specific reform activities. The meetings fostered new partnerships between the government, state, and tribes to meet the health needs of Indian people. In

Fiscal Year 1999, the Deputy Secretary of Department of Health & Human Services and the Director of Indian Health Service initiated a series of listening conferences with tribal government leaders on critical health and human service issues.

The Indian Health Service and Its Partnership with Tribes

For more than 120 years, the responsibility of AI/AN health care passed among different government branches. In 1955, the responsibility for providing health care to AI/AN was officially transferred to the Public Health Service (PHS).

In the 1970's, federal Indian policy was re-evaluated by the Nixon Administration, and the Indian self-determination policy was adopted. This policy emphasizes tribal administration of Federal Indian programs, including health care. Self-Determination does not lessen any federal treaty obligation, but provides an opportunity for tribes to assume the responsibility of providing health care for their members.

The Indian Self-Determination and Education Assistance Act of 1975, as amended, and the Indian Health Care Improvement Act of 1976, as amended, gave new opportunities and responsibilities to the IHS and tribes in delivering care. These included specific authorizations for providing health care services to Indian urban populations, an Indian health professions program, and the ability to collect from Medicare/Medicaid and other third party insurers. Under the Indian Self-Determination Act, many tribes have assumed the administrative and program direction roles that were previously carried out by the federal government. Tribes through Self-Determination contracts or Self-Governance compacts administer over one-third of IHS resources. The remaining resources are utilized by IHS facilities and providers for the direct provision of services to AI/AN where tribes have elected not to contract or compact their health program at this time, and to purchase care from private health care providers and facilities.

With participation from the Indian people, the IHS has explored ways to improve essential health programs and administrative support to Indian communities. In January 1995, the Director convened 29 representatives of the primary stakeholders in Indian health care to establish the Indian Health Design Team (IHDT). The IHDT, which included 22 tribal and 7 IHS representatives, submitted a report recommending changes in the organization and operation of the IHS. Following their guidance many of the recommendations relating to IHS headquarters were implemented.

To continue strengthening the federal-tribal partnership, IHS implemented a new budget formulation procedure for FY 1999 integrating the Government Performance and Results Act (GPRA), Public Law 93-638 consultation, and annual budget formulation requirements into an iterative process which gives local I/T/U more opportunities for annual budget policy input and review. This process was continued in developing the FY 2001 budget request. Work sessions in all 12 Areas initiated the FY 2001 formulation process and established the health priorities with associated budget priorities on which the FY 2001 budget is based. This new process will continue to be used and refined on a collaborative basis with Indian tribes and urban Indian health programs in FY 2002 and future fiscal years. The IHS Tribal Consultation policy incorporates this new approach to budget policy development reflecting President Clinton’s commitment to honoring

and upholding the government to government relationship and Indian self determination.

The Mission, Goal, and Vision

The mission of the agency is to raise the physical, mental, social, and spiritual health of AI/AN to the highest level, in partnership with the population served.

In November 1994, the Director of the IHS articulated his vision for the Agency. His vision is for the IHS to continue to be the best primary care, rural health system in the world. A system that, with tribes, continues its goal of assuring that comprehensive, culturally acceptable personal and public health services are available and accessible to the service population. To reach its goal, the clinical program is made up of many separate activities including maternal and child health; fetal alcohol syndrome; diabetes; alcoholism; mental health; emergency medical services; community health representatives; hepatitis B; dental services; and many others. These programs possess curative and preventive components to a degree unparalleled in any similar program. In addition to these clinically based programs, the Agency also encourages a community based environmental health program, sanitation facilities construction program and health facilities construction program.

The IHS program is delivered to more than 1.3 million AI/AN users through 151 Service Units composed of 554 direct health care delivery facilities, including 49 hospitals, 218 health centers, 7 school health centers, and 280 health stations, satellite clinics, and Alaska village clinics. Within this system, Indian tribes deliver IHS funded services to their own communities with over 42 percent of the IHS budget in 13 hospitals, 160 health centers, 3 school health centers, and 236 health stations and Alaska village clinics. Tribes who have elected to retain the federal administration of their health services, or to defer tribal assumption of the IHS program until a later time receive services with about 58 percent of the IHS budget in 36 hospitals, 58 health centers, 4 school health centers, and 44 health stations. The range of services includes traditional inpatient and ambulatory care, and extensive preventive care, including focused efforts toward health promotion and disease prevention activities.

In addition, various health care and referral services are provided to Indian people in off-reservation settings through 34 urban programs. Another integral part of the program is the purchase of services from non-IHS providers to support, or in some cases in lieu of, direct care facilities. This Contract Health Services program represents about 20 percent of the IHS Budget. The IHS Fiscal Intermediary in FY 1998 processed claims at a total billed amount of $378.4 million. The total paid amount after contract and alternate resource savings was $173.9 million.

Service Units

Service Units, local administrative units, serve a defined geographic area and are usually centered around a single federal reservation in the continental United States, or a population concentration in Alaska. Within these 151 administrative units, health care is delivered through 218 health

centers, 7 school health centers, 120 health stations, 160 Alaska village clinics, and 49 hospitals by tribally and federally operated Indian health programs.

Area Offices

Twelve Area Offices provide resource distribution, program monitoring and evaluation activities, and technical support to all operations whether IHS direct or tribally operated. They serve to support the Service Units and their points of service delivery.

Headquarters

The Headquarters operations are determined by statutes and administrative requirements set forth by the Department of Health and Human Services, the Administration, the Congress, and field operations (Area Offices and Service Units). Headquarters is involved with the Department in formulating and implementing national health care priorities, goals, and objectives. It is involved with the Administration through the Department by providing advocacy for Indian health programs in budget formulation and legislative initiatives, responding to congressional inquiries, and appropriate interaction with other governmental entities. It provides Area Offices and Service Units with general program oversight and direction, policy formulation, and resource distribution. It provides expert technical expertise, maintains national statistics, and project trends and needs for the future.

ACCOMPLISHMENTS

Since its inception in 1955, the IHS has demonstrated the ability to effectively utilize available resources to improve the health status of the AI/AN people. With the funding appropriated between 1972 and 1993, dramatic improvements in mortality rates were realized including:

- infant mortality reduced 54 percent
- Years of Potential Life Lost decreased 54 percent
- overall mortality reduced 42 percent
- maternal mortality reduced 65 percent
- gastrointestinal disease mortality reduced 75 percent
- TB mortality rate reduced 80 percent

It is indeed discouraging that recent mortality data (FY 1994) available from the National Center for Health Statistics show a small upward trend in the deaths of AI/AN people since FY 1992 from cancer, diabetes, heart disease, suicide, alcohol, drugs, HIV/AIDS and tuberculosis.

During the past 5 years major strides have been made in reducing traumatic injury among American Indians through the implementation of a broad array of public health measures. These measures include injury surveillance; extensive training for community health practitioners, board-based community coalitions and implementation targeted interventions. A recent analysis of injury deaths indicates a significant downward trend in unintentional injury mortality. For instance, the Navajo Nation motor vehicle deaths have been reduced by almost 40 percent. The IHS Injury Prevention Program Plan describes the necessity of building basic tribal

capacity in order to institutionalize change. The IHS Director has identified Injury Prevention as one of the Agency's key health initiatives. Since 1997, IHS has fostered the development of tribal injury prevention programs toward identifying community-specific injury patterns and in implementing targeted injury intervention projects. Annually, more than 300 tribal health and IHS personnel are trained in injury prevention practitioner skills. These people are working in their communities to reduce the incidence of severe injury and death. Although significant progress has been made, much needs to be done to reduce the major burden on the health and well being of Indian communities. Even today, many reservations experience injury death and disability at rates 2-5 times higher than other Americans do. The right programs are in place and new resources will enable the agency to expand its successful model to other tribes.

In fulfillment of the federal policy to afford Indian tribes the right to control the health care programs serving AI/AN, IHS and Indian tribes negotiated 48 self-governance compacts and 59 annual funding agreements, which will transfer approximately $569 million to 213 tribes in Alaska and 41 tribal governments in the lower 48 States under the Self-Governance Demonstration Project in FY 2000.

A Memorandum of Agreement (MOA) with the Health Care Financing Administration was implemented in 1997 for the purpose of extending the 100 percent Federal Medical Assistance Payment (FMAP) to States for services provided to AI/AN in tribal facilities. Previously, the States were only eligible to receive the 100 percent FMAP for services provided in IHS direct facilities. Overall, the MOA has been successful by simplifying the billing process and reducing administrative time spent negotiating tribal leases.

In addition, the IHS, through a sub-contract, completed an evaluation of four tribal demonstration programs. These sites were authorized under the Indian Health Care Improvement Act to directly bill and collect for Medicaid and Medicare services. Because of the high degree of success, a legislative proposal to allow all tribal programs the authority for direct billing and collection is currently being considered by Congress.

In FY 2000, approximately $2.5 million was awarded in continuation grants for community-based prevention, intervention, and treatment initiatives that will lead to decreased rates of child abuse and domestic violence, and improved health of women and elders. Seventy tribal, urban and non-profit organization proposals were received for the Indian Child Protection and Child Abuse Prevention Demonstration Grant Program totaling approximately $10.5 million, of which six 5-year grants were funded. The Women's Health Grant Program received 46 proposals, of which 9 were funded. In its first year, the Elder Health Care Initiative Grant Program received 81 grant applications. All the approved grants are continued in FY 2000.

Special Concerns

Within the vast IHS program, there are certain categories of health conditions that are of special concern in FY 2001. Program increases are proposed for specific disease entities identified as priority areas by the I/T/Us and responsible for much of the health disparities in health status for AI/AN population. These include dental diseases, injuries, mental

health, alcoholism, and cancers. Investments in public health infrastructure and information systems are also included in the request. In addition, the Balanced Budget Act of 1997 provided $150 million over a 5-year period to address diabetes in Indian country. Diabetes is epidemic among AI/AN and has been identified as a top health problem in all Areas of the IHS. The Director supports priority activities designed to increase the capacity to address these health concerns and serve the needs of the most vulnerable segments of the AI/AN population including: children, women and elders.

Health care and related facilities construction are another priority essential to assuring further progress in preventing infectious diseases and improving the quality of life.