

DEPARTMENT OF HEALTH AND HUMAN SERVICE

STATEMENT OF

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ASSISTANT SURGEON GENERAL, DIRECTOR

INDIAN HEALTH SERVICE

BEFORE THE

INDIAN AFFAIRS COMMITTEE  
OF THE  
UNITED STATES SENATE

OVERSIGHT HEARING ON FY 1997 BUDGET REQUEST

APRIL 19, 1996

OPENING STATEMENT  
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ASSISTANT SURGEON GENERAL  
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Honorable Chairman and Members of the Committee:

I am Dr. Michael H. Trujillo from Laguna Pueblo, New Mexico. I am the Director of the Indian Health Service (IHS). Accompanying me today are Mr. Michel E. Lincoln, Deputy Director; Dr. W. Craig Vanderwagen, Acting Associate Director, Office of Health Programs; Mr. Gary J. Hartz, Acting Associate Director, Office of Environmental Health and Engineering; and Mr. Reuben T. Howard, Deputy Associate Director, Office of Administration and Management. We are pleased to be here today to discuss the President's fiscal year (FY) 1997 budget request for the Indian Health Service.

Mr. Chairman, as the Director of the Indian Health Service and as an American Indian I want to express my appreciation for the critical support which you and this committee have given to Indian health programs during the past year. Your support enabled the Indian Health Service to respond to dramatic changes and enormous pressures confronting Indian people and their health system. Together we are dealing with immense pressure to reorganize and streamline our operations, while the demand for resources continues to increase. I am committed to working with the Committee to review the Indian health priorities for fiscal year 1997 and address any concerns you or other Committee members may have about the Indian Health Service budget request.

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. This relationship was first set forth in the 1830s by the U.S. Supreme Court and has subsequently been reconfirmed by numerous treaties, laws, constitutional provisions, court decisions and executive orders. The IHS, as the Federal Agency charged with administering the principal health program for American Indians and Alaska Natives provides a comprehensive health services delivery system in partnership with Indian people to develop and manage programs to meet their health needs. In addition, the IHS also acts as the principal federal health advocate for Indian people. The goal of IHS is to raise the health status of American Indians and Alaska Natives to the highest level possible.

This description of the government's responsibility, purpose and goal is extremely important so I would like to restate it from a different perspective. American Indians and Alaska Natives believe strongly in the treaties our forefathers signed with the United States Government. Many of our ancestors lost their lives to establish the legal, legislative, executive and constitutional basis for the unique government-to-government relationship with the United States. 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 to assure that we elevate the health status of American Indians and Alaska Natives to the highest possible level. The trend to reduce the size of the federal government cannot result in the reduction or dilution of historic treaty and trust obligations.

As an organization, the IHS maintains a truly unique health delivery system that provides its customers with wide-ranging medical services. Those services respect and attempt to blend traditional healing beliefs with the latest advances in medical technology. The IHS employees work with more than 547 federally recognized tribes and 34 urban Indian organizations in the delivery of health care to communities that range from Point Barrow, Alaska, to Hollywood, Florida, and from Maine to California. Care is provided in some of the most remote and beautiful locations in the nation, as well as within the metropolitan areas of major cities.

Direct and contract patient care, although a mainstay of our community based primary care system, is only a part of the picture at the IHS. With tribal participation, we also provide environmental planning and maintenance services, build and maintain clean water treatment systems, carry out educational outreach and preventive health programs, and assist in groundbreaking research and application of scientific information. This combination of patient care and preventive health activities has produced unequalled improvements in the health of American Indians and Alaska Natives. A few examples of pioneering achievements include: development and application of advanced life support for trauma victims; development of a world model plague control program, and the introduction of federal health care resource sharing programs.

American Indians and Alaska Natives continue to bear an increased burden of illness and premature mortality compared to other U.S. populations, although their health status has improved dramatically over the past 25 years. American Indians and Alaska Natives have less access to health care than does the general U.S. population and the number of physicians per 100,000 population has decreased from 99.7 in FY 1982 to 89.8 in FY 1994. In 1995, the IHS estimates for per capita health care expenditure was \$1,153, compared to the U.S. civilian per capita expenditure of \$2,912. In other words Indian people served by the IHS only receive 40 percent of the health care funding of the general population.

The IHS has historically been oriented to the delivery of acute medical services as well as public health services such as immunizations and sanitation facilities construction. The Agency has directed its resources in this manner because epidemiologic evaluation and other analytic tools have indicated that the health needs of American Indians and Alaska Natives could best be served through these program emphasis areas. This approach is consistent with the principles of community oriented primary care. The Institute of Medicine has recently defined primary care as "the provision of integrated, accessible health care services by clinicians who are accountable for addressing a large portion of personal health care needs, developing a sustained partnership with patients, and practicing in the context of family and, community." The Indian Health Service practices community oriented primary care by including needs and resources of Indian communities in defining its health care system.

The Agency has been effective in using community oriented primary care. Successes include dramatic decreases in death rates for infant and mothers, as well as reductions in the number of deaths associated with alcoholism, injuries, tuberculosis, gastroenteritis, and other conditions. I also believe that these achievements underscore the success of intervention targeted at specific desired outcomes. A comprehensive curative and preventive health system based on the specific needs of communities has proven to be very beneficial to the people we serve.

Last year the Indian Health Service responded to dramatic changes taking place inside and outside the government. The causes for these changes included federal deficit reduction measures, the greater and welcomed involvement of American Indian and Alaska Native governments and urban Indian organizations in the Indian health care system, and technological innovations. For example, under the Indian Self-Determination Act amendments, Indian tribes can compact or contract for programs and functions carried out at all levels of the organization by Indian Health Service and redesign them to meet local tribal needs. This accelerates the rate at which participating compact and contracting tribal governments are assuming direct control of Indian Health Service programs and thus will require the Agency to transfer resources in a more expeditious manner.

Almost 14 years ago I gave a speech and identified pressures facing the Indian Health Service. They were: an increasing number of beneficiaries for health services; demand for all services; costs for health services, other goods and staff; number of elderly; and increasing mandates for cost containment. I saw politics beginning to play a larger role in the health care arena replacing the historic health based focus of the Indian Health Service. Changing patterns of disease to more chronic conditions also were influencing social and economic factors and the quality of life for American Indians and Alaska Natives. .

Today those pressures of 14 years ago still exist, but have been intensified by an environment of unparalleled federal budget reductions, the transfer of many federal programs and resources to individual states, decreases to discretionary programs in the federal budget, the skyrocketing costs of providing medical care, and the changing patterns of disease. These are the forces that challenge our ability to provide quality health care to American Indian and Alaska Native people.

The environment in which the IHS, tribal, and urban programs operate has also changed. The population is aging. Although the birth rate is still high, increasingly the health issues are those of an aging population. Survival in infancy has led to greater challenges in meeting the health needs of children and youth. Survival into adult life has led to greater stressors on the economic capacity of the communities in which people live. Survival into later adult life has led to changes in social roles and disease patterns.

Correspondingly, communities are seeing different health problems. Economic hardship contributes to a variety of health problems. Assimilation into the dominant society has led to disruptions in family and community values. Suicide, homicide, family violence, and chemical dependency are more significant issues than in the past. Raising children and encouraging young people in this environment is difficult. Accidents still claim a disproportionate number of young people. There are a significant number of homes without access to water and sewer systems. An increasing population of elders, who are dependent on the family and community, at a time of such pressure adds to the stressors in the environment. The chronic diseases of an aging population such as diabetes and end stage renal disease also demand special program interventions. But these issues vary from community to community. The Agency budget proposes health program increases to address the changing health needs of these vulnerable populations.

This year we will be crossing bridges that none of us have crossed before. To succeed we must continue to forge an even stronger partnership with the Congress and Indian people. One of our challenges is the reorganization of the agency. We are working with Indian people to change and restructure the agency to better meet their health needs. The guidance for the design of a new Indian Health Service is provided by the Indian Health Design Team. Of the 29 people serving on this team, 22 are representatives of Indian communities. In November, the Indian Health Design Team submitted its report titled, "Design for a New IHS", to Indian people and the IHS. The report includes 50 recommendations for designing a new IHS.

Redesigning the IHS is to be accomplished in two phases. Phase 1 is focused on Headquarters restructuring and is to be completed in 1997. Phase 2 implementation involves Area restructuring and is to be completed in 1998. The Indian Health Design Team is committed, and I support their position, to an approach that ensures that Area level restructuring be guided by the health needs of Indian people. Progress thus far on our redesign includes a reduction of more than 900 administrative positions. Local service units have gained about 400 staff in the process, and we have transferred about \$16 million which had formerly supported IHS program operations to tribal programs. Because I believe absolutely in the Indian Health Design Teams's principal that "patient care comes first", I will continue to direct those resources recovered from future streamlining efforts to federal and tribal health care. These efforts will continue along with working closer with tribal and urban programs so that better health care is provided to American Indians and Alaska Natives.

To help the Agency become more efficient and effective will involve the participation of a number of other partners, in addition to Indian organizations. We have to look to foundations, universities, independent organizations, and others who can assist us in the delivery of care. We must expand our search for partners in the health care arena.

During my tenure, there is going to be continued emphasis throughout the Agency and in our interactions with other health partners for complete recognition of the Indian Self-Determination process. All tribes and urban Indian organizations will be included in the processes of the Agency to ensure fairness and balance. Major decisions of the Agency will include all tribes; those that contract, those that compact, and those that choose to stay within the federal system of health care delivery as well as urban Indian organizations. I also want the development of the Indian Health Service budget to reflect the commitment to Self-Determination by including tribal and urban Indian participation in the budget process. At the present time, almost one-third of the Indian Health Service budget is going to tribes and urban Indian organizations through contracts and compacts. I expect over the next 3-5 years for that to increase to at least half, if not more, while maintaining the direct delivery services of the Agency.

We recently participated in the government shutdown which caused considerable hardship within Indian communities. One result of staff furloughs was difficulty in processing funds for direct services and to contracting and compacting tribes so the delivery of health services could continue. Those staff that continued providing health services were not paid on time. Threats to shut off utilities to our health facilities and even to stop food deliveries were endured. We reached a point where some private sector providers indicated that they might not accept patients

who were referred from Indian Health facilities because of the Federal shutdown. I am proud to say that not one tribal program or compacting tribe considered, much less voiced, halting the delivery of care. There were some urban programs that were faced with closing because they had exhausted their resources. By working closely with the IHS they were able to remain open. I believe that we stood together with confidence in one another, and with faith in the strength of the treaties Indian governments have with the government of the United States, and that it is because of our faith that we came through and continued to provide services for Indian people.

In spite of these challenges, we continue to look to the future and to strive for better health and better lives for Indian people. In the coming year I will continue to emphasize programs in elder care, women's health, child abuse, and injury prevention. The needs of urban Indians is also of special concern to me. This population, while residing in major metropolitan areas has extremely poor access to culturally appropriate health care. The rapid growth of the urban Indian Population has made it difficult to keep pace with their needs. Therefore, this budget request includes provisions for increased access to health care for urban Indians. In addition, we are requesting an increase of \$46 million for Contract Support Costs and an increase of \$43 million for Sanitation Facilities Construction of water and sewer lines to Native American homes.

The fiscal year 1997 budget request for the IHS is \$2.4 billion which is an 8.7 percent increase over FY 1996. Additional funds will be used primarily for sanitation construction, to make it easier for tribes to take over operation of their local health programs, to provide additional staff in six new or expanded health facilities and to increase services for the most vulnerable segments of the population such as women, elderly, children and urban Indians. The request assumes collections of \$222 million from third party health carriers for Indian patients consistent with the FY 1996 levels.

This year will be very important and challenging for the Indian Health Service and American Indian and Alaska Native people. Federal deficit reduction measures, the possibility of transfer of other federal programs vital to the Indian Health Service to the states, and anti-government sentiment by the American public are relatively new and vastly different from the pressures we faced in the past. These external pressures are a challenge to the quality of life for all American Indians and Alaska Natives. We are responding to these pressures by strengthening our priority and commitment to patient and preventive health care. We must meet these challenges as we maintain our accomplishment in elevating the health status of Indian people. With the partnership between IHS, tribes, Indian organizations and the support of this Committee, we will strive to be the best primary health care system in the world.

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