DEPARTMENT OF HEALTH AND HUMAN SERVICES

STATEMENT OF

MICHAEL H. TRUJILLO, M.D., M.P.H.
ASSISTANT SURGEON GENERAL, DIRECTOR

INDIAN HEALTH SERVICE

BEFORE THE

INDIAN AFFAIRS COMMITTEE
OF THE
UNITED STATES SENATE

BUDGET OVERSIGHT HEARING
ON
FY 1998 BUDGET REQUEST

FEBRUARY 26, 1997

OPENING STATEMENT
MICHAEL H. TRUJILLO, M.D., M.P.H.
ASSISTANT SURGEON GENERAL
DIRECTOR, INDIAN HEALTH SERVICE

Mr. Chairman and Members of the Committee:

Good morning. I am Dr. Michael H. Trujillo from Laguna Pueblo, New Mexico. I am the Director of the Indian Health Service. Accompanying me today are Mr. Michel E. Lincoln, Deputy Director; Ms. Luana L. Reyes, Director, Headquarters Operations; Dr. W. Craig Vanderwagen, Acting Associate Director, Office of Health Programs; and Mr. Gary J. Hartz, Acting Associate Director, Office of Environmental Health and Engineering. We are pleased to be here today to discuss the President's fiscal year (FY) 1998 budget request for the Indian Health Service.

Mr. Chairman, I want to acknowledge the Committee's continuing support of the Indian Health Service. Its support for the principal health program for Indian people and its positive influence over other programs that affect Indian people has greatly assisted our agency, and our tribal and urban health partners in meeting many of the health care needs of Indian people. We depend on the Committee's continued support as we begin another year of delivering health services to America's first citizens. I am committed to working with the Committee in reviewing the Indian health priorities for fisca1 year 1998 and to address any questions you and other committee members may have regarding 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 which has been reaffirmed throughout the history of this Nation. In the 1860s, President Lincoln presented the then governor of my tribe a cane which symbolized that special relationship. Subsequently the relationship has been repeatedly reaffirmed by all three branches of this Nation's government. During the President’s first term, he hosted two National tribal meetings at the White House. In each of those meetings, be issued policy statements acknowledging the government-to-government relationship between the Indian Tribes and the United States. Most recently, the President issued an Executive Memorandum directing all Federal Departments and Agencies to implement policies and procedures for consulting with Indian Tribes on matters that effect Indian people.

American Indians and Alaska Natives believe strongly in the treaties our forefathers signed with the United States Government and in the status of their tribes as sovereign nations. Many of our ancestors lost their lives forging this government-to-government relationship. 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 as we carry out the commitment the United States is honor bound to keep.

The Indian Health Service provides a comprehensive health system in partnership with Indian people to develop and manage programs to meet their health needs. In addition, the Indian

Health Service also acts as the principal federal health advocate for Indian people. Our goal is to raise the health status of American Indians and Alaska Natives to the highest level possible.

We have made much progress over the years. Infant mortality rates, maternal death rates, morbidity and mortality from infectious diseases have all decreased dramatically over the past 40 years. The resultant increase in the life expectancy Indian people enjoy today is something in which we take pride. However, American Indians and Alaska Natives continue to hear an increased burden of illness and premature mortality compared to other U.S. populations. Health conditions related to life style choices such as diabetes, heart disease, substance abuse, and domestic violence are especially troublesome. Poverty, lack of employment and educational opportunities, and communities whose social fabric has been torn all contribute to these health problems. In addition, while the Indian Health Service has made great strides in improving the water and sanitation systems of many reservation communities, 12 percent of all American Indian and Alaska Native homes lack safe water and adequate means and waste disposal.

Although we maintain accreditation for most of our health facilities, the aging health facility infrastructure in Indian country requires costly upkeep and maintenance which diverts precious resources away from health care. While the average age of our health facilities is nearing forty years, some facilities are in excess of eighty years old. Geographic isolation also contributes to lack of access to health professionals and services, and lower per capita health care expenditures add to this increased burden of illness and premature mortality.

The American Indian and Alaska Native population experienced a decrease in the number of physicians per 100,000 population from 99.7 in FY 1982 to 89.8 in FY 1994. The physician ratio for non-Indian communities is 229 per 100,000 population. By comparison, in the four state region of the IHS Aberdeen Area, the ratio for the Indian population is 87 physicians per 100,000. In fiscal year 1996, the IHS per capita health care expenditure was $1,578, compared to the U.S. civilian per capita expenditure of $3,920.

The fiscal year 1998 budget request for the Indian Health Service is $2.122 billion which is a 3 percent increase over FY 1997. The additional funds will be used primarily for increased pay costs for both tribal and Indian Health Service employees, first phase construction of two replacement health facilities, contract health care services, for tribes assuming the operation of their local health programs, additional staff in four new health facilities, sanitation facilities construction, and for improved services for the most vulnerable segments of the population such as women, elderly, children and urban Indians. The request assumes collections of $285 million from third party health carriers for Indian patients consistent with the FY 1997 levels. This request also includes an increase of $12 million for Indian Self-Determination Fund and an increase of $2 million for Sanitation Facilities Construction of water and sewer lines to Indian homes.

Dramatic change remains a constant factor in the operation of the health programs of the Indian Health Service, tribal, and urban Indian health organizations. Meeting the evolving challenges facing the Indian health system is accomplished first by working with tribal and urban Indian health leaders to gauge the impact of change on their programs. Then, assessing and undertaking the most effective approach to effectively assist Indian communities in addressing their own

health needs. The guidance for the design of a new Indian Health Service organizational structure was provided by the Indian Health Design Team under the leadership of tribal and urban representatives. The final report, titled "Design for a New IHS" included 50 recommendations for redesigning the IHS in two phases. Phase One is focused on Headquarters restructuring and is to be completed in 1997, with implementation of a streamlined corporate structure to begin next month. This year the IHS Headquarters will be consolidated from 132 organizational units into less than 50. Selected components that support field programs will be transferred to the field. New headquarters core functions will focus on advocacy and leadership for Indian health, the advancement of a community based approach to health care, documentation of Indian health needs, and the support of a nationwide Indian health network. Phase Two implementation involves Area restructuring and is to be completed in 1998. Among the recommendations suggested to make the Area Offices more supportive of increased autonomy of local tribal, urban, and Indian Health Service health programs are the formation of area office work-sharing arrangements for functions that are no longer practical or economica11y feasible for a single area to perform efficiently and to build incentives into policies, governance structure, and performance standards to meet tribal and urban Indian expectations.

I remain committed to an approach that ensures that Area level restructuring is guided by the health needs of Indian people. A shared principal of the Indian Health Service and the Indian Health Design Team is that "patient care comes first." That principal requires that we direct resources recovered from future streamlining efforts to federal and tribal health care programs. To further that effort we have developed, jointly with tribal leaders, a business plan to integrate more corporate business planning practices into key segments of Indian Health Service operations.

All tribes and urban Indian organizations are being included in the processes of the Agency to ensure fairness and balance. No major decisions of the Agency are made without consideration of the viewpoints and concerns of all tribes: those that contract, those that compact, and those that choose to stay within the federal system of health care delivery. The Agency also includes urban Indian organizations in the decision making process of the Agency, particularly in policy decisions that would impact on them.

In the fifth year of implementing the Self-Governance demonstration program, there are now 34 compacts and 48 Annual Funding Agreements in place. At the present time, more than one-third of health services for Indian people are being provided by tribal and urban Indian health programs through contracts and compacts. The Agency budget request proposes a 60 percent increase in the size of the Indian Self-Determination Fund (from $7.5 million to $12 million) to assist tribes with building their local health program administration capability.

I have committed the Agency to increase the opportunity for tribal participation in developing the IHS budget request. The budget formulation process for fiscal year 1999 will provide expanded opportunities for tribal and urban participation in establishing budget request funding levels, addressing health priorities, and identifying performance measures of success. We are conducting 2 day budget formulation workshops in each of the 12 Areas of the Indian Health Service to more fully explain the federal budgeting process and begin developing budget priorities for FY 1999.

In context of the proposed 5 year federal budget, the FY 1998 budget request for IHS is critical to the future viability of the Indian health system it supports. Federal funding for Indian health programs must remain a priority for this Nation. The trend toward downsizing the role of the Federal Government cannot be used to abrogate historic treaty and trust obligations. I look forward to working with the members of the Committee to honor and strengthen this commitment and to work toward realizing the goal of elevating the health status of American Indian arid Alaska Native people to the highest possible level.

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