

**STATEMENT OF THE INDIAN HEALTH SERVICE**  
**HEARING ON THE**  
**INDIAN HEALTH CARE IMPROVEMENT ACT**

**MARCH 8, 2000**

Mr. Chairman and Members of the Committee:

Good morning, I am Dr. Michael Trujillo, Director of the Indian Health Service (IHS). Today, I am accompanied by Mr. Michel Lincoln, Deputy Director, Mr. Gary Hartz, Acting Director of the Office of Public Health, and Dr. Craig Vanderwagen, Director, Division of Clinical and Preventive Services, Office of Public Health. We are pleased to have this opportunity to testify.

The IHS has the responsibility for the delivery of health services to Federally recognized American Indian and Alaska Natives through a system of IHS, tribal, and urban (ITU) operated facilities and programs based on treaties, judicial determinations, and Acts of Congress. The mission of the agency is to raise the physical, mental, social, and spiritual health of American Indians and Alaska Natives (AI/AN) to the highest level, in partnership with the population served. The agency goal is to assure that comprehensive, culturally acceptable personal and public health services are available and accessible to the service population. Our foundation is to uphold the Federal government's obligation to promote healthy American Indian and Alaska Native people, communities, and cultures and to honor and protect the inherent sovereign rights of tribes.

We are here today to discuss reauthorization of the Indian Health Care Improvement Act (IHCIA) and the recently completed consultation process that reviewed the existing IHCIA in the context of the many changes that have occurred in our country's health care environment since the law was first enacted in 1976.

Two major pieces of legislation are at the core of the federal government's responsibility for meeting the health needs of AI/AN: The Snyder Act of 1921 and the Indian Health Care Improvement Act, Public Law 94-437. The Snyder Act authorized regular appropriations for "the relief of distress and conservation of health" of AI/AN. The IHCIA of 1976 was enacted "to implement the federal responsibility for the care and education of the Indian people by improving the services and facilities of Federal Indian health programs and encouraging maximum participation of Indians in such programs." Like the Snyder Act, the IHCIA provided the authority for the programs of the federal government that deliver health services to Indian people, but the IHCIA also provided additional guidance in several areas. The IHCIA contained specific language that addressed the recruitment and retention of a number of health professionals serving Indian communities, focused on health services for Urban Indian people and addressed the construction, replacement, and repair of health care facilities.

On April 29, 1994, President Clinton issued a Memorandum to the Heads of Executive Departments and Agencies requiring that a consultation policy be in effect based on the special relationship between sovereign governments, the United States and AI/AN tribal governments. To support this Executive Memorandum, the IHS established the Tribal Consultation and Participation Policy and tribes and urban programs are considered partners with IHS in the

delivery of health care to AI/AN. In addition, a provision in the Indian Self-Determination and Educational Assistance Act, PL 93-638, states, "Congress ... recognizes the obligation of the United States to respond to the strong expression of the Indian people for self-determination by assuring maximum Indian participation in the direction of ... Federal services to Indian communities so as to render those services more responsive to the needs and desires of those communities." Based on this partnership, the IHS has and continues to provide technical assistance to tribes, as they examine the existing IHCA and seek consensus on potential changes in a tribal reauthorization bill. The proposed reauthorization bill was submitted to Congress by Tribes directly and does not necessarily represent the Administration's views or policies.

The first step in the consultation process, held on June 8-9, 1998, was a Roundtable discussion with tribal leaders, urban providers, IHS program experts, national Indian health organizations, researchers, and other policy makers. The purpose of the Roundtable was to stimulate discussion and develop recommendations regarding the IHCA. Specific recommendations regarding the manner in which the tribal consultation meetings would be carried out were developed at this Roundtable. From these recommendations, the Roundtable participants developed a consultation approach that included pursuing consensus on what changes were needed, without consideration of any resource limitations or other budget issues, and concentrating on identifying opportunities for change, identifying area and regional differences ahead of time, promoting a partnership environment for tribes, urban Indians, and the IHS, and establishing a core group to review materials. By not focusing on budget or financial issues, the product of these deliberations included many policies that are not reflected in the President's FY 2001 Budget. Since this draft legislation contains a wide-ranging list of provisions, many of which have significant budget and

management implications across Federal agencies, a thorough review and careful consideration are necessary.

Beginning in the fall of 1998, tribal representatives participated in 12 Area meetings to begin discussing concerns and recommendations related to the IHClA. Each of the twelve (12) geographic Areas facilitated a consultation process with providers in their Areas. These discussions were held over the course of one or several meetings. The expectation was that these Area concerns and recommendations would be forwarded to the next step in the consultation process. These Area level meetings were completed by January 1999.

Four regional consultation meetings were held across the country from January to April in 1999. These regional meetings were intended to provide a forum for tribal to provide input, to share the recommendations from each Area, and to build consensus among participants for a unified position from each regional meeting. From these four meetings a 135-page matrix of recommendations for each of the sections in the IHClA, as well as proposals for new provisions was developed. Over 900 providers participated in the four regional meetings.

Upon the completion of the four regional meetings, IHS convened a National Steering Committee (NSC) composed of elected tribal representatives and urban health program directors. Many of the members of the steering committee had participated in the Area and regional consultation meetings. The NSC developed a draft consensus bill based on the Area and regional consultation meetings. The draft bill was mailed to every tribal and urban program in the nation with a 30-day period for additional comments. The draft bill was then presented at a national meeting in

Washington, DC in late July of last year. Attendees at this national meeting included tribal leaders, urban Indian health leaders, congressional members and staff, as well as several administration and departmental officials. The NSC received well over 1000 written comments. The Committee decided to draft actual bill language. This was accomplished between the end of July and October 6 when the NSC submitted the tribal draft to the President, the Secretary of Health and Human Services, to my office, and to each of the authorizing committees in the House and Senate. The House Committee on Resources introduced its version of the new bill, H.R. 3397, on November 16 – in language identical to that proposed by the tribes.

The Department is in the process of reviewing the many new provisions proposed in the tribal draft legislation in the context of the President's FY 2001 Budget. At the completion of that thorough review and analysis, the administration will be able to present its position on this tribal bill.

Mr. Chairman, this concludes my statement. Thank you for this opportunity to discuss the Indian Health Care Improvement Act and the consultation process that the ITU utilized in the examination and development of the tribal bill to reauthorization this legislative authority. My staff and I will be happy to answer any questions related to the consultation process and our technical support role. However, we are not prepared to discuss the Administration's views on the many new provisions proposed in the tribal draft legislation, as the Department is in the process of reviewing that legislation in the context of the President's budget and legislative agenda.