

DEPARTMENT OF HEALTH AND HUMAN SERVICES

STATEMENT OF

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**BEFORE THE
COMMITTEE ON INDIAN AFFAIRS**

OF THE

UNITED STATES SENATE

**HEARING
ON**

**URBAN INDIAN HEALTH CARE PROGRAMS AND HEALTH CARE PERSONNEL
NEEDS**

JULY 31, 2001

**STATEMENT OF THE INDIAN HEALTH SERVICE
BEFORE THE SENATE COMMITTEE ON INDIAN AFFAIRS**

Good morning, Mr. Chairman and Members of the Committee. I am Dr. William C. Vanderwagen, Acting Chief Medical Officer, the Indian Health Service (IHS), Department of Health and Human Services.

I am pleased to be here this morning to testify before the Senate Indian Affairs Committee about two important areas within the IHS service responsibilities.

The first issue of health manpower, providing and retaining sufficient health professionals for our health care delivery system, is one shared by the country overall. The second matter concerns the operation and challenges facing the urban Indian health programs.

In meeting our goals, the IHS has adhered to its policy of working with our tribal and urban partners and constituents, on key decisions and actions. Efforts to improve program delivery of services are greatly improved by such consultation and cooperation.

The IHS health care delivery system is comprised of 49 hospitals, 219 health centers, 7 school health centers and 293 health stations. The American Indian and Alaska Native eligible population, in fiscal year 2000 was approximately 1.51 million. This service population is increasing at a rate of about 2.3 percent per year, and this estimate excludes the effect of the additions of new Tribes. *[Trends 1998-1999]

Patient admissions into our IHS, tribal and contract general hospitals, in fiscal year 1997, were about 85,000. Main causes for admission were births and pregnancy complications. The

ambulatory statistics in fiscal year 1997 show over 7.3 million medical visits provided through the IHS-funded operations.

There are additional data to be found in our IHS 1998-199 Trends publication, but the main purpose of this review is to provide the backdrop against which much of our discussions will take place this morning.

Health Manpower

It is to the credit of our personnel, health professionals and others, that all of our IHS and tribally operated health facilities had achieved accreditation by the Joint Commission on Accreditation of Health Care Organizations (JCAHCO). This rating was true as of January 20, 1999.

To fulfill our primary goal of ensuring that we achieve the highest possible health status among American Indians and Alaska Natives, the health professions activities are critical but could be tested over the next 5 years. The IHS could lose a substantial number of its staff for a variety of reasons, including age-eligible retirement and the fulfillment of service obligations.

As of the end of June 2001, nearly 22 percent of our 13,000 federal employees, throughout the whole system, had 20 or more years of service. Within the health professions, 18 percent of the 8,600 health-related employees in the 600 personnel series, in which most of the health professionals are found, are in the 20-plus years category. Finally, of the three most numerous health professions, nurses, pharmacists, and dentists, all of these groups have more than 12 percent of their staffs in this group age-eligible retirement category. Physicians have 8 percent of all of our IHS physicians are in the 20-plus years category.

Our plans for addressing this pending situation include the institution of even more vigorous recruitment efforts and a greatly increased emphasis on retention. Such activities include:

1. Increased advertising in professional journals
2. Increased Health Educational Institution Recruitment Visits
3. Increased web-based Advertising

Retention has been a major factor in reaching our current status. The average length of service for all IHS employees is just over 12 years. For those in the 600 series, it is just over 11 years.

Of our four most numerous professions, nurses have the longest average length of service, at nearly 11 years. Physicians, with 8 years, have the shortest, while dentists and pharmacists average just over 9 years each. The difficulty, however, is that we lose many of our new recruits before they have served 5 years. Therefore, retention of new employees must remain a priority.

These difficulties in retention include culture and transition issues, within rural and often disadvantaged communities. Additionally, the competition for such qualified individuals is huge. Many of these professionals are often approached by other health care institutions with more attractive employee benefits packages and placements. This situation, of competing health care systems, is only going to grow in future years as our population, national and in Indian communities continue to live longer and more productive lives.

Our scholarship and loan repayment programs offer us the opportunity to attract highly qualified staff. In FY 2000, 37 new scholarships were awarded to participants in two undergraduate scholarship programs in the Health Professions with 46 extensions. Forty-five new awards were

made in the Preparatory Pregraduate scholarship program with 61 extensions, and 60 new awards were made to students in a health professions graduate programs with 287 extensions.

In fiscal year 1996, the average debt load of a new loan repayment program participant was \$32,000. In FY 2000, it was \$64,000. We anticipate that this individual debt load will be even higher this year.

Such educational financial assistance, in turn, assures the IHS of a service commitment by the individual who receives such aid. Service “payback” commitment can range from 2 to 4 years. Once such commitment is completed, an individual may have private practice goals or family obligations that preclude their further employment within the Indian health care system.

Urban Indian Health Program (UIHP)

Today 62.3% of all American Indians and Alaska Natives identified in the 1990 Census reside off-reservation. This figure represents 1.39 million of the 2.24 million American Indian/Alaska Natives identified in the 1990 Census updated by Indian Health Service. The updated 1994 Census identifies 1.3 million (58/%) of the American Indian/Alaska Natives residing in urban areas. For comparison purposes the Indian Health Service total service population is 1.4 million with active users at 1.2 million. This figure includes 427,100 eligible urban Indian active users who reside in geographic locations with access to and Indian Health Service or Tribal facility.

In 1976 Congress passed the Indian Health Care Improvement Act (IHCIA) (P.L. 94-437). Title V of the (IHCIA) targeted specific funding for the development of supporting health programs for American Indians/Alaska Natives residing in urban areas. Since passage of this landmark legislation, amendments to title V have strengthened Urban Indian Health programs (UIHPs) to

expand to direct medical services, alcohol services, mental health services, HIV services, and health promotion and disease prevention services. (P.L. 100-713, P.L. 101-630, P.L. 102-573).

The UIHPs consist of 34 nonprofit 501(C)(3) programs nationwide funded through grants and contracts from the Indian Health Service, under title V of IHCA, P.L. 94-437, as amended.

Sixteen (16) of the 34 programs receive Medicaid reimbursement as Federally Qualified Health Centers (FQHCs) and others receive fee for service under Medicaid for allowable services, i.e, behavioral services, transportation, etc. The other programs are automatically eligible by law but may not provide all of the necessary primary care service requirements mandated by FQHC legislation. Over 10 million dollars are generated in other revenue sources.

In the Omnibus Budget Reconciliation Act (OBRA) of 1993, title V of the IHCA, and Tribal 638 self-governance programs were added to the list of specific programs automatically eligible as FQHCs. The range of contract and grant funded programs below are provided in facilities owned or leased by the Urban organizations. Pursuant to title V, the Indian Health Service is required by law to conduct an annual program review using various-programs standards of Indian Health Service and to provide technical assistance to the Urban Indian Health Programs.

The range of Indian Health Service/Urban grant and contract programs services can include: information, outreach and referral, dental services, comprehensive primary care services, limited primary care services, community health, substance abuse (outpatient and inpatient services), behavioral health services, immunizations, HIV activities, Health Promotion and Disease prevention, and other health programs funded through other State and Federal, and local resources, e.g., WIC, Social Services, Medicaid, Maternal Child Health.

Sixteen (16) of the 34 programs are certified as a Federally Qualified Health Centers. The other programs are automatically eligible by law but may not provide all of the necessary primary care service requirements mandated by FQHC legislation.

Today the Indian Health Service provides funding to the 36 (34 title V of the IHCA and two demonstration programs) urban Indian health centers and to 10 urban Indian alcohol programs. The urban Indian health programs, range from comprehensive primary care centers to referral and information stations. In Fiscal Year 2001 Congress appropriated \$29,843 million for Urban Indian Health. These centers continue to receive funding, as well, from a variety of other federal, state and private sources.

Mr. Chairman, this concludes my prepared statement. I will be happy to respond to any questions you and other Committee Members may have.