IHS National Councils
Combined Annual Conference

February 9 – 13, 2003
San Diego, California

"Prevention as a Primary Health Care Strategy"

by

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February 10, 2003

It is a privilege to speak to you today as the Interim Director of the Indian Health Service. I am pleased to serve Indian people as the Interim Director for as long as the President and Secretary wish me to serve. The Department has forwarded my name, along with their endorsement, for the White House to consider and then submit my nomination before the Senate for confirmation. As the Interim Director, appointed by the President, I have all of the responsibilities and authorities to carry out the work of the Agency for the benefit of American Indian and Alaska Native people. It would be an honor to serve as the 7th Director for an agency that has done so much for Indian people.

One of my primary areas of focus that I have identified during my tenure is a renewed emphasis on health promotion and disease prevention. I believe this will be our strongest front in our ongoing battle to eliminate the health disparities that have plagued our people for far too long. Although we have long been an organization that emphasizes prevention, I am asking this Agency to undertake a major revitalization of its public health efforts in health promotion and disease prevention. I also feel that both field and tribal participation in the initial stages of planning and implementation is critical.

Prevention is also an area where we can gain the most economic return for our investment. In my 20 years with the Indian Health Service, I have served alongside health teams at the service unit, Area Office, and headquarters of this Agency, and have witnessed or helped participate in many successful prevention efforts.

Since assuming the responsibilities of Director for the Agency last August, and as someone who has a field and Area perspective, I can assure you that Headquarters staff are not "out of touch" with what is happening at the local level. Every increase in funding that this agency receives is the result of efforts by the local level on up to the senior leadership and in concert with our tribal and urban Indian health program partners. And because of the excellent work done in the field, and the supporting documentation of it, the agency achieved the highest scores in the Departmental and OMB analysis of performance, in some cases by a wide margin.

All of these efforts influenced the 2004 President's budget request and without them we would not have received increases in Contract Health Services, pay costs, staffing of new facilities, diabetes, and sanitation facilities construction.

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I understand that there is great interest in the budget activities and proposals that are taking place in Washington, D.C. We continue to operate under a continuing resolution at 2002 funding levels while debate still continues on what a final 2003 budget appropriation may be – and at the same time the President has released his budget request for 2004.

While Mr. Lincoln will go into more details about the budget later this afternoon, I want to discuss some budgetary issues and highlights.

We do not know with any certainly how the 2003 budget issues will be resolved; whether we will be at more or less than the 2002 funding levels – the 2003 budget that was requested for the IHS was an increase of 2%. But however it is resolved; we will have 8 months remaining in this fiscal year to deal with whatever the outcome will be. I am sure that we will be creative in how we rise to the challenge.

The Senate has presented an omnibus bill, and the House is working on their version. Based on the Senate bill, the IHS budget for 2003 would be more austere than that proposed by the President for 2004. The Senate bill provides for an increase of $66 million, and our inflation and pay costs and other mandatory expenses usually account for $125 to $150 million of our budget every year. There is also consideration for an across-the-board rescission of anywhere from 1 to 2.9 percent. If the rescission is 1 percent, that would mean a reduction of about $30 million for the IHS, which would bring down the Senate's budget increase for the IHS to $36 million.

The request for 2004 funding levels began with a base of the President's 2003 request. As a result of the process of tribal consultation in our budget formulation process, through presentations by the Tribes and the agency to the Department of Health and Human Services, and through the submission to the Office of Management and Budget of the Department of Health and Human Services overall request – and the many meetings and telephone calls to refine the request – we are seeing an overall 2.6% increase, which is an increase of about $74 million for 2004. The operative word is "increase."

We all understand what a 2.6 percent budget increase or a 1 percent recession in our funding level means. We know what it means as a health system, which is a critical component in the survival of our tribal nations. And we know what it means on a personal level. I know that my children's access to care will be affected. I know that difficult health decisions will have to be made. I know that my friends and families may have to change their expectations regarding the services they may be able to receive. As a provider I know that there will be some services I can provide and others that will have to be delayed or denied. Every decision any of us have to make in carrying out the mission of this Agency also has a personal consequence. These are not strangers who we serve; they are our family and friends.

As I said, the operative word for the 2004 budget is that it is an increase. Given the current circumstances facing the nation on the security, economic, and health fronts, any budget increase should be viewed as a success.

The President's 2004 budget request will include $114 million for IHS sanitation construction projects -- a $20 million increase over the fiscal year 2003 budget and the largest sanitation increase in more than a decade. The money will go toward increasing the number of homes with safe water systems, assisting with emergencies that may occur over the year, and to help in the clean up or replacement of open dump sites. Almost 8% of Indian homes still lack a safe indoor water supply, compared to 1% of all U.S. homes.

The proposed budget also includes an additional $35 million toward covering increased Federal employee pay costs and to allow tribally-run health programs to provide comparable pay raises to their staffs. An additional $25 million is included to complete staffing for two new hospitals and a health center. Contract Health Services will also see a funding increase; the budget includes an additional $25 million for CHS costs; an amount that will support the purchase of approximately 511,000 outpatient visits, an increase of 17,000 from FY 2003. This increase is recognition by the Administration of the great need to purchase care from the private sector regardless of hard economic times. And the budget request includes $150 million for diabetes prevention/treatment grants, an increase of $50 million over FY 2003 levels.

With what looks to be several years, at the very least, of less than current service level budgets, we must now, and over the long term, increase our focus and efforts on disease prevention and health promotion activities. As Director, I have requested that actions be initiated to strengthen the use of scientifically proven interventions targeting these health issues.

We should understand that within the priorities facing the nation today – issues such as war, the economy, and health – Indian health programs and American Indians and Alaska Natives are not forgotten. We all share in the disappointment when what is able to be allocated falls short of our expectations, but our disappointments should not overshadow our accomplishments. We remain firmly committed to address the health needs of the people we serve.

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The budget appropriation process is not the only way we can help our people. We have succeeded in saving the agency and Tribes approximately $30 million in first year implementation costs and lost revenue and $17 million in lost revenue on a recurring basis thereafter through our work with the Centers for Medicare and Medicaid Services. We actively engaged them in discussions regarding their implementation of a new fee structure, the Outpatient Prospective Payment System, and the impact it would have on our programs and Indian country. We also presented information to the Department-- and they took an active interest in the outcome – and, as you may now know, the IHS and Tribes are exempt from implementing the OPPS system. This type of collaboration and involvement can pay big dividends for Indian country. The annual budget occurs once a year, but throughout the year we need to look for opportunities to supplement our appropriation through collaborations that result in cost savings and cost avoidance, as well as funding increases.

As we face the potential for difficult budget years, we are also trying to look at other programs within the Department that could benefit Indian people; for example, the Community Health Centers program of the Health Resources and Services Administration. We are working closely with HRSA to identify opportunities for tribal programs to benefit from the Community Health Centers program. Another example is the Substance Abuse and Mental Health Services Agency and their Alcohol and Substance Abuse funding. Over the next 3 years, SAMHSA will receive $600 million to help addicted Americans find treatment. There may be opportunities within that program to possibly fund some of the IHS, Tribal, and urban Indian alcohol and substance abuse programs as well as for faith-based and traditional health programs in Indian country. There are also large increases for bioterrorism and homeland security and we should all look at ways to participate in those activities and receive funding for the additions and changes our programs will encounter in order to increase the country's readiness and response levels.

The Secretary recognizes that it will take the resources of the Department to make further inroads in raising the health status of American Indian and Alaska Native people. To that end he initiated the Intradepartmental Council on Native American Affairs. This is an internal working council of the Department where policy issues affecting American Indian and Alaska Native people can initially be considered.

Another primary interest of the council is to conduct a harder look at the programs of the Department and which ones Tribes are accessing and which ones they aren't and why. The Secretary views the Department as having the responsibility to strengthen programs or focus Department resources on a particular health issue such as asthma, diabetes, AIDS, obesity, nutrition and exercise. All of the health issues are reflected to some degree in Indian country. The Department has in excess of 320 health programs and initiatives, 90 of them specifically targeted to the American Indian and Alaska Native population, but Tribes are accessing only 46 of them. It is our goal to see that number increase substantially.

We should explore opportunities for addressing health issues of Indian country outside of the Department as well. For example, the American Cancer Society has a program to help individuals and communities access timely and quality health care services and to help them navigate around access barriers in the health care system. The program, aptly called "Patient Navigation," is one that can benefit American Indians and Alaska Natives. The program works by providing patients with a person from the community who can help them move through the system and access timely prevention services and treatments. This concept of patient navigation is also mentioned in legislation before the Congress – information about the legislation and the program itself can be obtained from the American Cancer Society. This is just one example where helping a program succeed for all communities can then specifically assist Indian communities.

It is totally unacceptable to me, both as an American Indian and the Interim Director of the Indian Health Service, that in our prosperous nation, Indian people continue to experience health disparities and death rates that are significantly higher than the rest of the U.S. general population:

- Alcoholism - 770% higher
- Diabetes - 420% higher
- Accidents - 280% higher
- Suicide - 190% higher
- Homicide - 210% higher

Those statistics are startling, yet they are so often repeated that some view them as insurmountable facts. But every one of them are influenced by behavior choices and lifestyle. Today you will hear from others who will fill in the details of how we are going to approach preventing disease and promoting health. We must further distribute the "Best Practices" and make a personal commitment to implement them so that our clinical practice staff can experience a lightened workload in the long run. Making significant reductions in health disparity rates, and even eliminating them, can be achieved by implementing best practices, using traditional community values, and building the local capacity to address these health issues and promote healthy choices.

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To help us focus our efforts and achieve our goals for health promotion and the elimination of health disparities, the IHS now has a strategic plan. It has been developed over the last 18 months by a diverse group of clinical and business stakeholders from the IHS, Tribes, and urban Indian health programs. There are four primary goals:

1. Build healthy communities
2. Achieve parity in access by 2010
3. Provide compassionate quality health care, and
4. Embrace innovation.

These goals are ambitious, but I believe they can be achieved and I am counting on you to help make them a reality because of the benefit to our families, our communities, and the future of Indian Country.

Some of the outcomes are to decrease obesity rates for children, decrease the years of potential life lost, increase the number of homes in Indian country with a safe and adequate drinking water supply, increase the number of Indian children who receive dental sealants, and assure that we do everything we can so that those receiving health care from IHS facilities perceive it to be good, very good, or excellent.

Achieving goals is hard work. But we show time after time that we can do it. For example, our providers have shown, with adequate resources, that they provide excellent care to their patients. We have consistently shown increases in our ability to provide excellent care to our diabetic patients. Our screening hemoglobin A1c rates are already higher than the Healthy People 2010 goal. These results, and more, are highlighted in our recent FY 2002 GPRA Report. Meeting our goals can be measured by increases in our budget; our budget is a reflection of our dedication to raising the health status of Indian people. By every measure the Office of Management and Budget and the Department employ, such as GPRA and PART, we rank consistently among the highest, by a wide margin, among all the Operating Divisions.

And achieving goals takes resources. We have estimated that in addition to mandatory cost increases, securing an additional 10 percent increase in available health care resources each year through 2010 will help us make significant progress toward these goals. As the President, the Secretary, and the IHS, Tribal, and urban Indian leadership know – the IHS cannot do it alone. As I mentioned earlier, our appropriation is only one source of our income and we need to seek out opportunities for increasing our resources throughout the year and not just during budget time. There are opportunities within the Department; remember there are approximately 320 health programs in the Department – and the Indian Health Service is only one of those programs, and there are opportunities for coalitions and partnerships outside of the Department as well.

The strategic plan also supports the health promotion initiative of the agency. Individuals and communities can impact their health status. I hope our behavioral health programs can help bring this message to Indian country and help us all make healthier choices. We can choose to eat healthier foods, exercise more, wear seat belts, drive responsibly, avoid risky behaviors, and promote healthy communities and lifestyles for our people. Or we can choose to continue to have high rates of diabetes, accidents, suicides, and alcoholism. In making these choices, it is our future, and our children's future, that we decide. Our grandfathers and grandmothers created an opportunity for Indian people to enjoy better health. Our efforts to make individual healthy decisions can honor that legacy.

And behavioral health and poor lifestyle choices are not just an Indian problem:

- More than 108 million adults are either obese or overweight. Nearly 21 percent of American adults were obese in 2001 – up from 19.8 percent in 2000.
- Obesity and overweight cost our nation $117 billion a year in direct and indirect costs.
- Roughly 300,000 Americans die each year due to weight-related illnesses.
- Diabetes is reported to be increasing at alarming rates throughout the U.S. population: 17 million Americans have diabetes, and 16 million have pre-diabetes. Each year, there are 1 million new cases and 200,000 people die from diabetes. Diabetes costs $100 billion a year in direct and indirect costs.
- Additionally, high blood pressure, high cholesterol, asthma and arthritis are associated with obesity and being overweight.
- The latest National Household Survey on Drug Abuse showed that there were approximately 3 million youths aged 12 to 17 who thought seriously about suicide or attempted suicide in 2000; deaths from car accidents are the leading killer of U.S. youth
- Of those who die each year, seven of 10 people – or more than 1.7 million Americans – die of a chronic disease, more than 125 million Americans are living with a chronic disease. 75% of our nation's health care budget is spent on treating these chronic diseases. Yet, only 5 percent of the budget is spent preventing them.

Preventable diseases take a terrible toll on the lives of all Americans. It's time we as health leaders help our communities to take seriously the simple facts we

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already know: to eat right, exercise regularly and stop smoking. We must encourage our family members, friends, and other loved ones to take steps to promote good health – taking a walk, riding a bike or simply playing sports with their families, reducing food portions, or to stop smoking.

Clearly, there is a great need for strong, effective behavioral health programs throughout the nation, and throughout Indian country. And those of you here today are dedicated to building these programs for Indian people and addressing these disparities in ways that will impact on American Indian and Alaska Native people for generations to come.

Instead of waiting until people get sick, and then spending millions of dollars to make them well, we should make a commitment up front to prevent them from getting sick in the first place. And we need to examine and evaluate how programs are developed so that we have an opportunity to consider prevention activities early on in the progress of disease rather than setting criteria to where a disease must progress to a critical or life-threatening stage before we can intervene with medical services or resources.

Disease prevention must be a priority, including addressing both the naturally occurring and deliberately introduced communicable diseases. To respond to the emerging possibility of bioterrorism, as well as outbreaks of naturally occurring infectious diseases, the IHS envisions a coordinated approach to epidemiological surveillance and response in Indian County. The IHS is working to provide opportunities for IHS, tribal, and urban Indian programs to participate in bioterrorism programs and resources and participate in the Health Alert Network that has been established as part of homeland security measures. We are also focusing on coordinating responses with other Federal and state agencies, and encouraging epidemiological tracking and attention on Indian populations.

Fortunately, the incidence and prevalence of many infectious diseases, once the leading cause of death and disability among American Indians and Alaska Natives, have dramatically decreased due to increased medical care and public health efforts that included massive vaccination and sanitation facilities construction programs. Unfortunately, as the population lives longer and adopts more of a western diet and sedentary lifestyle, we are beginning to see chronic diseases as the dominant factors in the health and longevity of the Indian population. We are particularly concerned with the increasing rates of cardiovascular disease, Hepatitis C virus, and diabetes.

Cardiovascular disease is now the leading cause of mortality among Indian people, with a rising rate that is already almost double that of the U.S. general population. This is a health disparity rate that the President, the Secretary of Health and Human Services, and the IHS are committed to eliminating. The IHS is working with other HHS programs, including the Centers for Disease Control and Prevention and the National Institutes of Health's, National Heart Lung and Blood Institute, to develop a Native American Cardiovascular Prevention Program. Also participating in this effort is the IHS Diabetes Program, the IHS Disease Prevention Task Force, and the American Heart Association. This program is working to develop even more effective prevention programs for our communities. The IHS has also begun several programs to encourage employees and our tribal and urban Indian health program partners to lose weight and exercise, such as "Walk the Talk" and "Take Charge Challenge" programs.

Diabetes mortality rates are also increasing at almost epidemic proportions. American Indians and Alaska Natives have the highest prevalence of type 2 diabetes in the world. The incidence of Type 2 diabetes is rising faster among American Indians and Alaska Native children and young adults than in any other ethnic population, and is 2.6 times the national average. As diabetes develops at younger ages, so do related complications such as blindness, amputations, and end stage renal disease.

What is most distressing about these statistics is that type 2 diabetes is largely preventable. Lifestyle changes, such as changes in diet, exercise patterns, and weight can significantly reduce the chances of developing type 2 diabetes. Focusing on prevention not only reduces the disease burden for a suffering population, but also lessens and sometime eliminates the need for costly treatment options. The cost-effectiveness of a preventive approach to diabetes management is an important consideration, since the cost of caring for diabetes patients is staggering. Managed care estimates for treating diabetics range from $5000-$9000 per year. Since the Indian health system currently cares for approximately 100,000 people with diagnosed diabetes, this comes out to a conservative estimate of $500 million just to treat this one condition.

Establishing culturally relevant preventive programs at the community level to promote healthy lifestyles, as well as strengthening early treatment efforts, must be the focus of present and future efforts to address the health issues confronting Indian country.

As we look to the future in Indian health care, we are faced with the inexorable fact that a shift in emphasis from disease control to disease prevention is essential. Promoting disease prevention, through changes in lifestyles and increased emphasis on wellness, is the path

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we must follow. Primary prevention, with maximum involvement at the community and individual level, is the most effective and cost-effective approach to chronic disease management. To this end, the IHS is supporting community wellness programs and initiatives that promote better eating habits, increased physical activity, smoking cessation, drug and alcohol avoidance, mental health, and responsible sexual behaviors.

Preventing disease and injury is a worthwhile financial and resource investment that will result in long-term savings by reducing the need for providing acute care and expensive treatment processes. It also yields the even more important humanitarian benefit of reducing pain and suffering, and prolonging life.

The IHS must also continue to foster collaborations with other Federal agencies and private foundations, universities, and organizations to bring all possible resources to bear on Indian health issues. Health status is not determined just by the availability of health services or pharmaceuticals. It is the result of an interwoven tapestry of factors such as social-economic status, educational status, community and spiritual wellness, cultural and family support systems, and employment opportunities, to name a few.

We must begin to weave a network of supports systems and partnerships that will help to address all these contributory factors to the health and well-being of the people we serve.

Thank you.

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