Indian Health Service

Coalition for Health Funding

Membership Meeting

"Improving Indian Health"

by

Charles W. Grim, D.D.S., M.H.S.A.

Assistant Surgeon General
Director, Indian Health Service

July 28, 2005

Good afternoon. Thank you for inviting me to speak at this meeting today, and for the chance to share some information on the goals and progress of the Indian Health Service (IHS) in delivering quality health care to American Indian and Alaska Native people across the nation. I would like to take this opportunity to thank all the members of the Coalition for Health Funding for the work they do in supporting the improvement of health outcomes for all Americans.

As I am sure all of you here realize, health status depends on a wide spectrum of contributing factors, ranging from the quality of prenatal care to the availability of employment opportunities. And it takes a wide spectrum of resources and approaches to address all these myriad factors. That is why it is important to have all federal and state public health agencies, as well as other public and private organizations, working together as part of a continuum to improve health and eliminate health disparities. We must affirm together a commitment to improving the physical, mental, cultural, social, environmental, and economic health of all people and communities in America, if we hope to eliminate health disparities and raise the health status of all Americans.

Let me begin by giving some background information on the Indian Health Service, and the Indian health care system, for those of you who may not be familiar with us. The IHS is an agency within the Department of Health and Human Services and is the primary federal agency responsible for carrying out the treaty obligations of the U.S. Government to provide health services for members of federally recognized Tribes.

The IHS, in partnership with Tribes, Tribal organizations, and Urban Indian programs, provides healthcare services to a service population of approximately 1.8 million American

The text is the basis of Dr. Grim's oral remarks at the meeting of Coalition of Health Funding on July 28, 2005. It should be used with the understanding that some material may have been added or omitted during the presentation.

Indians and Alaska Natives who are members of more than 560 federally recognized Tribes, representing a wide diversity of people and cultures. The goal of the IHS is to ensure that comprehensive, culturally acceptable personal and public health services are available and accessible to the service population.

The Indian health care system consists of 12 regional (or Area) offices and 157 Service Units, which administer health care services through a system of 48 hospitals, 238 health centers, 167 health stations, 180 Alaska village clinics, and 34 urban projects. The location of these facilities range from remote rural locations to heavily populated urban areas; although most are in rural reservation communities in 35 states, mostly in the western United States and Alaska.

Health services are provided either directly by the IHS or through tribally contracted and operated health programs, as well as through services purchased from private providers. The IHS directly provides services at 33 hospitals, 59 health centers, and 50 health stations. In addition, the IHS supports 34 Urban Indian health programs that provide a variety of health and referral services. Through P.L. 93-638 Self-Determination contracts and Self-Governance compacts, Tribes and Alaska Native corporations administer 15 hospitals, 179 health centers, 117 health stations, and 180 Alaska village clinics.

All 33 IHS-operated hospitals and all 15 of the tribally operated hospitals have JCAHO accreditation or CMS certification. In 2003, there were almost 9 million outpatient visits at IHS and Tribal health facilities.

The IHS strives for maximum Tribal involvement in meeting the needs of its service population, a goal backed by legislative history. Federally recognized American Indian Tribes and Alaska Native Corporations have a unique government-to-government relationship with the United States that has been reinforced through numerous treaties, Supreme Court decisions, legislation, Executive Orders, and the U.S Constitution.

The principal legislation authorizing federal funds for health services to federally recognized Indian Tribes is the Snyder Act of 1921. It authorized funds "for the relief of distress and conservation of health . . . [and] for the employment of . . . physicians . . . for Indian Tribes throughout the United States."

Congress passed the Indian Self-Determination and Education Assistance Act (Public Law 93-638, as amended) to provide Tribes the option of assuming from the IHS the administration and operation of health services and programs in their communities, or to remain within the IHS administered direct health system. Congress subsequently passed the Indian Health Care Improvement Act (P.L. 94-437), which is a health-specific law that supports the options of P.L. 93-638.

The goal of P.L. 94-437 is to provide the quantity and quality of health services necessary to elevate the health status of American Indians and Alaska Natives to the highest level possible, and to encourage the maximum participation of Tribes in the planning and management of those services.

The IHS is strongly committed to the concepts of Tribal Self-Governance and Self-Determination, as upheld by Federal law. Self-Governance promotes a partnership between Indian Tribes and the United States based on mutual respect and input into the government-to-government relationship.

How to exercise their rights of Self-Governance and Self-Determination is ultimately the choice of each Tribal Government. Each Tribal Government determines its relationship

with the United States and the IHS; a relationship that may include either direct Federal service delivery, Self-Determination contracts, Self-Governance Compacts, or some combination of these options.

Whatever decision is made regarding the delivery of health services, the ability of Tribal Governments to determine their own destiny and shape their own future creates a more meaningful government-to-government relationship between Tribes and the United States.

Tribal Self-Governance and Self-Determination are not only concepts that we embrace in the abstract; they are concepts that have practical applications in health care management and delivery. To put it briefly, Self-Governance WORKS. It works because it is based on a principle that all of us who work in Indian health are very aware of and dedicated to: that having health services planned and delivered at the local level is the most effective and efficient means of ensuring high-quality health care for our beneficiaries. And this planning begins with Tribal input and consultation.

A vital component of Self-Governance is Tribal/Federal consultation. We at the IHS are dedicated to the application and promotion of consultation for all Indian health issues. The agency's consultation policy has facilitated the involvement of Tribal Governments and Indian people in policy development and agency decision-making, including participation in setting program and budget priorities and advocating for their health needs. We have repeatedly seen the results and positive effects of involving Indian people in the formulation of health policies that directly affect them, such as in the development of the IHS budgets and other areas, and I am confident we will increase those benefits as we revise and refine the consultation process.

The Indian health care system presents a successful model for rural and urban health programs as well as for indigenous people around the world because of its respect for cultural beliefs, its blending of traditional practices with the modern medical model, and its emphasis on public health and community outreach activities.

The Indian health model and the participation of Indian people in decisions affecting their health has produced significant health improvements for Indian people: Indian life expectancy has increased by more than 9 years since about 1973, and mortality rates have decreased by approximately 82% for tuberculosis, 65% for infant deaths, 53% for maternal deaths, and 60% for unintentional injuries and accidents, to name just a few.

Although we are very pleased with the advancements that have been made in the health status of Indian people thus far, we recognize there is still progress to be made. The current Indian life expectancy of 72.9 years, while much improved from 50 years ago when the IHS was officially established, is still about 4 years less than that for the U.S. general population.

Despite impressive advances in sanitation construction, almost 12% of Indian homes still lack a safe indoor water supply, compared to 1% of all U.S. homes. In some areas, such as Alaska, up to 35% of homes lack safe indoor water supplies.

The IHS also funds construction of new and replacement hospitals and ambulatory care facilities and staff quarters. However, the average age of IHS hospitals and clinics is 33 years; compared to the average age of U.S. hospitals and clinics at 9.4 years. The oldest facility is 73 years old, and the newest facility was completed 1 year ago.

And there are still wide gaps in general health status between Indian people and the rest of the U.S population. Complicating the situation is the type of health problems confronting American Indian and Alaska Native communities today. Death rates for tuberculosis, alcoholism, diabetes, accidents, suicide, and homicide, among others, are significantly higher

for Indians compared to the U.S. general population. The mortality rates from tuberculosis and alcoholism are more than 6 times the all U.S. All-Races rate. Mortality rates from diabetes are 3 times as high as in the rest of the U.S. And American Indian and Alaska Native death rates for unintentional injuries and motor vehicle crashes are 2½ to 3 times higher than the national rates. Also, suicide and homicide rates are nearly twice as high in the Indian population.

Although the IHS, Tribal, and Urban Indian health programs have demonstrated the ability to effectively utilize limited available resources to significantly improve the health status of American Indians and Alaska Natives, there is still concern about the health care funding deficiencies for Indian health programs.

A stakeholder workgroup has conducted an actuarial study to determine what it would cost to provide services to Indian people similar to those of a mainstream health insurance plan. The findings of the study indicated that in general, expenditures for personal health services for Indian people are approximately 40% lower than for other U.S. citizens. If you compare the IHS per capita Federal appropriation to other Federal Health Expenditure Benchmarks, such as Medicare, IHS is at the very bottom -- even below prisoners in the U.S.

That is one reason the work the Coalition for Health Funding is doing in support of health outcomes is so important to the health status of American Indian and Alaska Native people, and why we are appreciative of your efforts to keep health funding a visible issue as Congress and the Administration set Federal budget priorities.

It has become obvious to all of us in Indian health care that the health disparities for American Indians and Alaska Natives cannot be addressed solely through the provision of health care services. The IHS public health functions that were effective in eliminating certain infectious diseases, improving maternal and child health, and increasing access to clean water and sanitation, are not as effective in addressing health problems that are behavioral in nature, which are the primary factors in the current mortality rates. The prevalence of diabetes, in particular, has reached epidemic proportions in Indian communities. Changing behaviors and lifestyles and promoting good health and a healthy environment are critical in preventing disease and improving the health of American Indians and Alaska Natives.

Through Tribal consultation, Self-Governance, and Self-Determination processes, the IHS and Tribes have worked together to identify focus areas for Indian health that address these issues and make the most of limited resources. I have established three main focus areas, or Director's initiatives, to address these issues:

Behavioral Health
Health Promotion and Disease Prevention, and
Chronic Disease Management

The IHS and Tribes are working closely together on these focus areas to help achieve significant improvements in health that are critical to the future of Indian communities. These focus areas are being targeted at health outcomes that will have a beneficial impact, demonstrate measurable achievements, and attempt to change basic practices and procedures as well as unhealthy behaviors.

Behavioral Health may be the underlying thread through all three initiatives. It has become obvious to all of us in the Indian health system that addressing behavioral health and mental health issues in our communities is crucial, and that we need to increase our focus on screening and primary prevention in mental health.

The recent shooting incident at Red Lake Reservation has been a tragic reminder to all of us in Indian Country, as well as to the Nation as a whole, of the importance of increasing our efforts to effectively address mental health issues in our youth.

In particular, the high level of mental illness and suicide rates among American Indian and Alaska Native youth are of paramount concern to the Indian health system and Indian communities. Not only is suicide the third leading cause of death for Indian youth ages 15-19, but the tragic truth is that the rates of suicide among Indian youth are the highest of any racial group in the nation.

These are statistics that hit at the heart of the tragic effects of mental illness on the rates of disease and mortality in Indian communities. We know that mental health issues such as depression can make chronic disease management more difficult and less effective. In order to adequately address mental health issues, Tribes and the IHS are working in concert with federal, public, and private organizations to address all the contributing factors to mental illness, such as poverty, lack of educational opportunities, domestic violence, social isolation, and perhaps most devastating of all, low expectations and the hopelessness of our youth.

As a Nation we are struggling with chronic diseases such as diabetes, obesity, cardiovascular disease, cancer, and injuries. This is an area that we have long been aware of in Indian country. We know that we must address the primary prevention of these chronic diseases if we are to critically influence the future health of our patients and our communities. To that end, the IHS and Tribes have taken a number of actions aimed at health promotion and disease prevention, which include various programs and partnerships to promote healthy lifestyles, including, among many others:

- The establishment of the Healthy Native Communities Fellowship to mobilize local groups to improve community health;
- Working with *the National Boys & Girls Clubs of America* to help reach their goal of increasing the number of Boys and Girls Clubs on Indian reservations to 200 by 2005. There are now approximately 185 Boys and Girls Clubs on Indian reservations;
- Working with the *NIKE Corporation* to focus on the promotion of healthy lifestyles; and
- Participation in the "Just Move It Campaign" with a goal of getting one million Native people *up and moving*.

As I just mentioned, in Indian country, we are struggling with chronic diseases, especially diabetes, heart disease, obesity, cancer, asthma, and depression. We must address not only the primary prevention of these chronic diseases if we are to critically influence the future health of our communities, but we must look at better chronic disease management in our clinical care of our patients.

With the adoption of a model for managing chronic diseases in a more effective and efficient manner, we believe we will see, over time, an improvement in our years of potential life lost due to chronic disease. A multidisciplinary team has been tasked with looking at the Chronic Disease models that would best meet our needs and that could be adapted to our programs. Within the IHS, our model of care for chronic disease will prioritize preventive health, behavioral health, and chronic disease management. This model is being developed based on the "chronic care model" of clinically supported patient self-management and

empowerment. The Indian health system model will include new tools for prevention and treatment, tools that include improved applications of standards of care, community and organizational partnerships, and newer technologies and approaches to care.

In July of 1955, the Indian Health Service was officially transferred from the Bureau of Indian Affairs to the Public Health Service, making FY 2005 the 50th anniversary year for the Indian Health Service, an important milestone in the history of the Indian Health Service. In FY 2005 we have embarked on a special year of celebrations and special events. A 50th Anniversary reference library of historical documents and photographs is being compiled, which will be available on the IHS website. Also, we are publishing a special edition of the "Gold Book," which was first published in 1957 as a comprehensive report to Congress on the status of the health of American Indians and Alaska Natives around the time of the transfer. The new version will show the progress made in the last 50 years, and our plans for facing the challenges of the next 50 years.

I hope all of you here will join us as we recognize this important date in the history of the Indian Health Service.

In closing, I would like to again thank all of you for the work you do to support the improvement of the health status of all Americans, including the nation's "first Americans." Working together, I am confident we help ensure a healthier future for America.

Thank you.

* * *

The text is the basis of Dr. Grim's oral remarks at the meeting of Coalition of Health Funding on July 28, 2005. It should be used with the understanding that some material may have been added or omitted during the presentation.