Indian Health Service

2005 Self-Governance Spring Conference

"Self-Governance Works"

Keynote Address

by

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Good morning. It is a pleasure to be here today to speak to all of you at the 2005 Self-Governance Spring Conference. The theme of this meeting, "Self-Governance Works," is very appropriate, since it speaks to a concept 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.

I would like to begin by acknowledging and thanking the Self-Governance Communication and Education Office Tribal Consortium and Office for the excellent job they did in ensuring this will be a successful conference. A lot of careful planning and hard work go into a conference such as this, and I am appreciative of their efforts and the excellent outcome of their work.

I would like to spend a few minutes on a very important topic that has a profound influence on the direction of Indian health: Tribal Consultation. Consultation works, and we at the Indian Health Service (IHS) are dedicated to the application and promotion of consultation for all Indian health issues. 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 text is the basis of Dr. Grim's oral remarks at the Self-Governance Conference on May3, 2005. It should be used with the understanding that some material may have been added or omitted during presentation.

At regional consultation sessions over the past 2 years, Tribal leaders have been very clear about the critical role consultation plays in the government-to-government relationship between the Department of Health and Human Services (HHS or Department) and Indian Tribes, as well as their desire that we revise both the HHS and IHS consultation policies. We heard you, and with your help, we are working to strengthen the consultation process.

Suffice to say that the policy revision process was itself a significant consultation event spanning several years. Tribal representatives and HHS staff from many divisions worked diligently for many months to craft recommended revisions to these two policies. Their work on the HHS policy is complete, and their work on the IHS policy is nearly complete. In the coming year we will witness other HHS Divisions revising their consultation policies and plans to comply with the revised HHS policy. The work of this Tribal/Federal Team will no doubt serve as a model for HHS Divisions to follow as they undertake this policy revision process.

I would like to provide you with information regarding my main focus areas for the IHS in the coming years. These include three closely related initiatives:

1. Behavioral Health
2. Health Promotion and Disease Prevention, and
3. Chronic Disease Management

Addressing behavioral health and mental health issues in our communities is crucial. We need to focus on screening and primary prevention in mental health. The recent shooting incident at Red Lake 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.

We know that mental health issues such as depression can also make chronic disease management more difficult and less effective. In order to adequately address mental health issues, we need to work 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.

Early on in my tenure as Director of the Indian Health Service, I announced my Health Promotion and Disease Prevention Initiative (HP/DP). As a Nation we are struggling with chronic diseases such as diabetes, heart disease, obesity, cancer, asthma, and depression. This initiative is a reflection of my conviction 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, I have taken a number of actions aimed at health promotion and disease prevention, which include the following:

- The Indian Health Summit held in D.C. last September;
- The establishment of a Health Promotion and Disease Prevention Policy Advisory Committee;
- The appointment of Area HP/DP coordinators;
- The Healthy Native Communities Fellowship;
- Various partnerships to promote healthy lifestyles, such as
    - Participation in the "Just Move It Campaign";
    - Increasing the number of Boys and Girls Clubs;
    - Establishing Memoranda of Understanding with Canada and NIKE to address these issues; and

    - Stop The Pop Campaign - 8 emerging leaders from the Department of Health and Human Services have been assigned to work on this campaign.
- An obesity workgroup will be launched in April. Jean Charles-Azure is taking the lead with this very complex and important work.

As I just mentioned, as a nation and in Indian country, we are struggling with chronic diseases such as 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.

I have highlighted several of the actions that I have taken to jump start a change in the culture of our organization to one that not only continues to provide exceptional health care, but also one that really does make preventive health, behavioral health, and chronic disease management a priority. We can no longer simply complain about the scarcity of resources for preventive health, behavioral health and chronic disease management -- we have to do something about it.

Maintaining the level of resources necessary to best meet the health needs of Indian people is an ongoing challenge, so I would like to say a few words on the status of the IHS FY 2005 and 2006 budget appropriations.

The fiscal year 2005 budget authority for the IHS is $2.99 billion. This is a $63 million, or approximately 2.2%, increase over the fiscal year 2004 enacted budget level. Adding in funds from health insurance collections estimated at $633 million, designated diabetes appropriations of $150 million, and $6 million for staff quarters rental collections, increases the budget for the IHS to $3.8 billion in program level spending.

The FY 20005 budget also allows us to fund 2 additional epidemiological centers. We funded one in Oklahoma last year, and this year we will be funding an epidemiological center for California and one for the Navajo Area.

The President's FY 2006 Budget request for the Indian Health Service is a clear indicator that your priorities as communicated through the consultation processes are being heard. The FY 2006 budget request focuses on current services needs, which have been your highest priority for the past several years.

During the 2005 Regional Tribal Consultation Sessions and the HHS Budget Consultation Session, Tribes were very clear about the need for additional resources as well as their budget priorities. Those priorities included full pay cost increases, increases to address population growth, and contract health services. HHS responded and worked very closely with others in the Administration to include those priorities in the 2006 President's Budget Request. We all agree that needs remain to be addressed; however, in this extremely difficult budget environment, the IHS is recommended for an increase of $63 million. This is in sharp contrast to a reduction in excess of $500 million for the Centers for Disease Control and Prevention, a reduction in excess of $400 million for the Administration for Children and Families, and a reduction in excess of $800 million for Health Resources and Services Administration, to name but a few.

The proposed IHS budget authority for FY 2006 is $3 billion. This is a $63 million, or approximately 2%, increase over the FY 2005 enacted budget level. Adding in funds from health insurance collections estimated at $642 million, designated diabetes appropriations of $150 million, and $6 million for staff quarters rental collections, increases the proposed budget for the IHS to $3.8 billion in program level spending.

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Another issue of concern to all of us in Indian country is the status of the reauthorization of the Indian Health Care Improvement Act (IHCIA). In fact, I understand there is a meeting of the national Tribal steering committee for the 437 reauthorization is scheduled for immediately after the conclusion of this conference, and will be held at this same hotel.

During the second session of the 108th Congress, the IHS and the Department worked with the congressional committees to resolve areas of concern with the pending legislative proposals. Time ran out before a bill could be finalized that would address the Department's concerns.

In the 109th Congress we have a new Chairman of the Senate Committee on Indian Affairs, Senator John McCain of Arizona, and a new Vice-Chairman, Senator Byron Dorgan of North Dakota. Last month, I met with Senator McCain and he understands the importance of passage of a reauthorization bill, and considers it a priority for the committee.

On April 13th, the Senate Committee on Indian Affairs held a hearing on the status of health among American Indians and Alaska Natives and I presented testimony on behalf of the IHS and the Department. The witnesses included the National Steering Committee on the Reauthorization of the IHCIA, the National Indian Health Board, the National Council on Urban Indian Health, and the Navajo Nation. Based on this hearing we understand Senator McCain will decide on what provisions to include in a bill to reauthorize the IHCIA. We understand this bill should be introduced soon, with possible hearings to follow. When a reauthorization bill is introduced, IHS and the Department are prepared to work with the congressional committees of jurisdiction to have an enacted IHCIA bill as soon as possible.

I am confident that we can pick up where we left off last year with the reauthorization effort and reach agreement on a bill that will include changes and additions to the IHCIA that will enhance Indian health programs' ability to provide needed services to elevate the health status of American Indians and Alaska Natives.

The leadership of the House Committee on Resources remains the same as in the last congress: Rep. Richard W. Pombo of California, Chairman, and Rep. Nick J. Rayhall II of West Virginia. Other committees of jurisdiction over the IHCIA in the House are the Committee on Energy and Commerce, and the Committee on Ways and Means. The later committee would have jurisdiction over any legislative proposal that includes Medicare amendments or provisions. The Department would be working with committees on both chambers as an IHCIA proposal is under consideration in the Congress.

Let me take a few minutes at this point to update you on our progress with the IHS Headquarters Restructuring. First, I want to make you aware of some of the things I have done to reorganize Headquarters and the way we do business. This year there were significant changes to the Headquarters organizational structure. These changes are intended to improve our support of those in the field, our responses to the Department and Congress, and achieve the management and performance goals of the President and the Secretary. I am in the process of filling key Headquarters positions, beginning with the selections of Robert McSwain as the IHS Deputy Director and Phyllis Eddy as the Deputy Director of Management Operations for the IHS.

I would like to take this opportunity to mention an important milestone in the history of the Indian Health Service, which many of you here today are probably aware of already. 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.

In FY 2005 we are embarking on a special year of celebrations and acknowledgements. A 50th Anniversary reference library of historical documents and photographs is being compiled, which will be available on the IHS website and on a special 50th Anniversary CD. Also, we are publishing a new 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.

I would like to thank all of you for attending this conference. All of you here today play an important role in the achievement of our mutual goal of improving the health status of American Indian and Alaska Native people, and I am proud and honored to be your partner, along with all the employees in the IHS, in this endeavor.

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