National Indian Health Board Meeting

"State of the IHS"

by

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Good afternoon. I am very happy to have this opportunity to attend your Board meeting and speak before you today. Over the past years, the National Indian Health Board and the Indian Health Service have forged a strong partnership effort in addressing health issues of importance to Indian County. I look forward to working with all of you here today as we continue to build upon that partnership in the years to come.

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 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.

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 HHS and Indian Tribes, as well as their desire

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that we revise both the HHS and IHS 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.

Another example of consultation that works is the IHS reorganization. This effort was underway before I became Director. When HHS announced plans to reorganize and restructure 4 years ago, it was acknowledged up front that the IHS portion of that restructuring would require Tribal Consultation. In addition, Tribes made it clear at these sessions 2 years ago that they did not want IHS Human Resource programs included in the consolidation of all other HHS Human Resource programs. The Secretary heard your concerns, and as a result, today the responsibility for IHS HR functions remains within the IHS. As the one who participated in that internal decision-making process, I can tell you without question that your voices were heard.

Let me now take a few minutes 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.

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 were full pay cost increases, contract support costs, 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 CDC, a reduction in excess of $400 million for ACF, and a reduction in excess of $800 million for HRSA, to name but a few.

The proposed IHS budget authority for FY 2006 is $3 billion. As I said, 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.

The challenge for the IHS is to continue to provide access to quality health care for an increasing population. An estimated 1.8 million American Indians and Alaska Natives will be eligible for IHS services in 2006, an increase of 1.6% over 2005 and 9.4% since 2001. The FY 2006 budget includes new funds to help provide for the additional 29,000 people who are expected to seek services in FY 2006, cover increased pay costs for the Federal and Tribal employees who provide these services, and meet rising costs. Funds will go primarily to Clinical Services (operation of hospitals and clinics, and purchase of medical care), but also to other IHS programs that are providing additional services and support functions. Some highlights of the FY 2006 proposed budget include:

- An additional $32 million toward covering increased Federal and Tribal employee pay costs.
- A total of $3 million to fund the construction of 24 units of new and 5 units of replacement staff quarters for the Harlem and Hays outpatient facilities in Montana.
- An additional $35 million to add staffing for six outpatient facilities
- An additional $5 million for contract support costs, for a total of $269 million.
- An additional $27 million for contract health service costs.
- $150 million for diabetes prevention and treatment grants. Through the Special Diabetes Program for Indians, the IHS has awarded $650 million in grants over the past 5 years to over 300 Tribes and Indian organizations to support diabetes prevention and disease management at the local level.

I believe that now more than ever before, we need to be people working together to achieve our mission — the Tribal programs, the IHS Service Units, the Area Offices, Headquarters, and even the Department are a whole community of people, working together in our own ways to improve the health status of

Indian people. I would like to talk to you today about a number of things going on within this community of people working to improve Indian health care. I hope you will join me in working on some of the initiatives that I am going to talk about, as you engage in consultations on budget and other Indian health issues.

The growths in American Indian and Alaska Native population and chronic disease rates, as well as socioeconomic constraints, are increasing the challenge of effectively improving the health status of this population. Therefore, as an Agency, the IHS is establishing three major focus areas, or director's initiatives. They are:

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

Early on in my tenure as Director of the Indian Health Service, I announced my Health Promotion and Disease Prevention Initiative. 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:

- Indian Health Summit; Health Promotion and Disease Prevention Policy Advisory Committee; Area HP/DP coordinators; Healthy Native Communities Fellowship; "Just Move It Campaign"; Boys and Girls Clubs; MOUs with Canada and NIKE… to name a few.
- 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 this month. Jean Charles-Azure is taking the lead with this very complex and important work.

As I mentioned earlier, 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 asked Dr. Kelly Acton and Dr. Craig Vanderwagen to bring together a team to develop a strategic plan to address chronic disease. They had

their first meeting in December and I look forward to hearing about their recommendations for our health systems.

Addressing behavioral health and mental health issues in our communities is also 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. We also need to work with organizations such as the Substance Abuse and Mental Health Services Administration, as well as many of the Tribal organizations and foundations that can help us with these problems.

I have highlighted several of the actions that I have taken to jump start a change in the culture of the IHS 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.

Another issue of concern to all of us in Indian country is the status of the reauthorization of the Indian Health Care Improvement Act. 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. He has scheduled an oversight hearing on the health status of American Indians and Alaska Natives for April 13th. We understand that soon after this hearing, he will decide on the contents of an IHCIA reauthorize bill he wants to introduce. I believe he will look at the reauthorization proposal reported by the committee in mid-September of last year as a starting point for consideration by the Department and other congressional committees that have jurisdiction of the IHCIA, such as the Senate Health Committee, Education, Labor and Pensions, as well as the Senate Finance

Committee. The Department and IHS will work with the congressional committees when the reauthorization proposal is introduced. 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.

We understand the House Resource Committee, the committee of primary jurisdiction for the IHCIA, is currently considering their approach to the reauthorization of the IHCIA. Their leadership 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.

I would also like to take this opportunity to mention an important milestone in the history of the Indian Health Service. 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. Throughout FY 2005 there will be special acknowledgements of our 50th year in a variety of places. I hope all of you here will join us as we recognize this important date in the history of the Indian Health Service.

Thank you for inviting me to speak here today. I appreciate all the good work you do on behalf of the health and wellness of American Indian and Alaska Native people, and look forward to continuing our partnership efforts.

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