

TESTIMONY OF  
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BEFORE THE  
SENATE COMMITTEE ON INDIAN AFFAIRS  
AND  
HOUSE COMMITTEE ON RESOURCES

REGARDING S. 1770, THE ASSISTANT SECRETARY FOR INDIAN HEALTH ACT

JULY 22, 1998

Good morning, Chairman Campbell, Chairman Young, and Members of the Committees on Indian Affairs and Resources. I am pleased to appear at today's joint hearing to convey the views of the Department on S. 1770, the Assistant Secretary for Indian Health Act of 1998, and to discuss our shared concern for the health and well-being of the nation's American Indian and Alaska Native people.

The Administration strongly supports the elevation of the Director of the Indian Health Service to the Assistant Secretary level, and we look forward to continuing to work with you on statutory language to achieve our shared goal.

Mr. Chairman, provision of federal health services to American Indian and Alaska Native communities is based upon the special government-to-government relationship between Indian Tribes and the United States. This relationship has deep historical, legal, and moral roots. These deep roots reach back not only to the signing of the first treaties between the United States government and the Tribal Nations in 1784, but to the earliest encounters between European

settlers and the original inhabitants of the Americas over five centuries ago. It is a relationship born of solemn promises. It was forged at great cost and sacrifice. The sovereign Tribal Nations gave up land, water rights, mineral rights, and forests in exchange for guarantees of peace, security, and among other things, health care. Over the years, the special relationship between Indian Tribes and the United States has been reaffirmed by all three branches of the federal government.

Through several important initiatives, the Administration and the Department of Health and Human Services are working to fulfill the promises made between the United States and Indian Tribes. For example, President Clinton has directed all federal agencies to implement policies and procedures for consulting with Indian Tribes on matters that affect Indian people. In response to the President's directive, an HHS Tribal Consultation Working Group developed the Department's plan to engage in meaningful consultation with Tribes. The plan was approved by Secretary Shalala and announced in October, 1997. As an initial step in implementing our plan, I traveled last November to Santa Fe, New Mexico, where I attended the annual conference of the National Congress of American Indians and had opportunities to meet with elected Tribal leaders and delegates from throughout the United States. I will again be traveling this fall, and will be inviting Tribal representatives to listening sessions in regional locations.

Also at the President's direction, special efforts are being made to support Tribal colleges and universities. These institutions, chartered by Tribal governments, play a vital role in providing higher education opportunities to American Indian and Alaska Native students and preparing them for future leadership and service to their communities. On February 2, 1998, the presidents of the Nation's Tribal colleges and universities were in Washington and met with HAS officials. I

chaired the meeting, which was attended by Department principals, senior advisors, and staff. We heard the delegation of Tribal college presidents share their concerns and expectations for this relationship with HAS. Several of our Operating Divisions are participating in this year's Washington Internship for Native Students (WINS) program in conjunction with American University, and the entire Department has been enriched by the presence of a group of American Indian students interns.

Also within the Department, the Racial and Ethnic Health Disparities Initiative is now underway. The President has committed the nation to an ambitious goal by the year 2010: the elimination of disparities in six areas of health status experienced by racial and ethnic minority populations while continuing the progress we have made in improving the overall health of the American people. These six areas of health status -- infant mortality, child and adult immunizations, diabetes, cardiovascular diseases, cancer screening and management, and HIV/AIDS -- include some of the most important health issues for American Indian and Alaska Native people.

In these and other efforts, the Indian Health Service fulfills a critical mission. Under the continued leadership of Dr. Michael Trujillo, and in partnership with American Indian and Alaska Native communities and Tribal governments, the IHS provides a comprehensive system of primary health care, prevention, and public health services. The IHS also acts as the principal federal health advocate for Indian people.

As both Dr. Trujillo and Assistant Secretary for Health and Surgeon General, Dr. David

Satcher reported to the Committee on Indian Affairs in June, there have been some important gains in the health status of Indian people during recent years. Infant mortality rates, maternal death rates, deaths due to unintentional injuries, and morbidity and mortality from infectious diseases have decreased dramatically. The work of the Indian Health Service has been a cornerstone in achieving these successes.

But as American Indian and Alaska Native families and communities know only too well, there continue to be major challenges. Diabetes, heart disease, substance abuse, and domestic violence continue at especially troubling rates. Poverty, unemployment, and lack of educational opportunities complicate intervention efforts.

In his remarks upon introducing the "Assistant Secretary for Indian Health Act" on March 17, 1998, Senator McCain characterized the health problems facing Indian people as an "epidemic crisis." The real challenge before us is how best to mobilize and allocate resources in response to this situation.

S. 1770 proposes to establish within the Department of Health and Human Services an Office of the Assistant Secretary for Indian Health. We support the elevation of the IHS Director to the Assistant Secretary level, and look forward to continuing ongoing discussions with you and your staff on the design of this legislation. We share your goals, Mr. Chairman, and those of Senators McCain, Inouye, and Conrad, to address the health challenges in American Indian and Alaska Native communities and to effectively position the Indian Health Service for this effort within the changing environment of Tribal self-governance. We commend all of you for the depth

of concern and sincerity of purpose that your legislation demonstrates.

We recognize that the Indian Health Service is not just a program serving the interests of one among a number of minority constituencies. Rather, the IHS is the organizational embodiment of the government-to-government relationship between the United States and the Indian Tribes. It exists because of the solemn promises this government has made to Indian people. On matters of health care, the head of the Indian Health Service acts principally as the administrator of the vast Indian Health Service system, as well as an advocate on behalf of the needs of the nation's more than 550 federally-recognized Indian Tribes. The elevation of the IHS Director to the position of Assistant Secretary is consistent with the government-to-government relationship and unique political status of American Indian and Alaska Native people.

In conveying our support for the proposal to establish an Office of the Assistant Secretary for Indian Health, we should note, at the same time, that issues of Indian health are the concern of the entire Department of Health and Human Services. Elevating the IHS Director to the position of Assistant Secretary will strengthen the government-to-government relationship and facilitate communication and consultation with the Tribes on matters of Indian health. But in making this change, I think we all want to be sure that we continue to utilize the resources and expertise that exist within every Operating Division of HHS to address Indian health needs, either directly or indirectly. Whether it is the National Institutes of Health or the Centers for Disease Control and Prevention, each component of the Department has dedicated staff who have made Indian health the focus of their professional work.

In this same connection, the Assistant Secretary for Health is empowered by the President and the Congress to attend to the health needs of all of our citizens, regardless of their racial or ethnic background. The people of the United States are privileged to be served in this role by Dr. David Satcher, who has reaffirmed a commitment to continue the work of his predecessor, Dr. Philip Lee, to work closely with Tribal leaders on Indian health concerns.

As we move to elevate the head of the Indian Health Service to the Assistant Secretary level, we look forward to working with you and your staff to recognize in statute the important ongoing responsibilities of the Office of the Assistant Secretary for Health. The work of the ASH is vital to ensuring that research, resources, and policies are integrated in ways that benefit all the people of the United States.

Our support for the proposal to elevate the IHS Director to the position of Assistant Secretary reflects our commitment to consultation with the nation's Indian Tribes. While in Santa Fe last fall, I listened closely as Tribal leaders discussed their views on the proposal and described their hopes for what the change might accomplish. We have reviewed resolutions and correspondence from the National Congress of American Indians, Tribal governments, and other bodies representing Tribal interests. While elevating the IHS Director to the level of Assistant Secretary will not have an immediate impact on how decisions are made about IHS administration and budget, it will raise awareness of Indian health concerns throughout HHS and the entire federal government. We do not underestimate the importance of increased awareness, because heightened awareness is the first step toward meaningful action.

We have closely reviewed the proposal in S. 1770 to separate the IHS from the Public Health Service. As we have conveyed to your staff, we believe that the present organizational structure of the Public Health Service -- especially its ability to flexibly utilize the resources of the Commissioned Corps -- benefits the Indian Health Service and the individuals, families, and Tribal governments that receive services through its programs.

Through the combined and complementary resources of its component agencies, the PHS offers the nation - *and under-served or remote communities in particular* - unsurpassed medical treatment, health promotion and disease prevention services, public health and biomedical research, and health professions education programs.

The close ties and collaboration between PHS components directly benefit American Indian and Alaska Native people. For example, during last year's bipartisan discussions about the need to allocate more resources to diabetes prevention and treatment, scientists of the Centers for Disease Control and Prevention worked closely with medical personnel from the Indian Health Service to provide information and technical assistance. The support of the CDC helped assure that funds authorized for diabetes interventions would not only provide immediate, short-term assistance to Indian Tribes and communities, but also be a long-term investment in identifying effective prevention strategies that respect American Indian culture. CDC support would assure that future generations of American Indian children, not yet born, will benefit from this important effort.

Another example of how existing relationships and collaboration between PHS components benefits American Indian people is the integrated research on non-surgical intervention for refractory periodontal disease being conducted by the IHS and the National Institute on Dental Research (NIDR), part of the NIH. The IHS and NIDR recently entered into an agreement to repeat an important clinical trial on the effectiveness of this method for treating a troublesome form of gum disease, in order to validate the results of an earlier trial on the same protocol. The State University of New York (SUNY) at Buffalo is also a partner in this project. The original protocol was developed and tested by IHS, NIDR, and SUNY in the Phoenix Area between 1995 and 1997. The new testing will be done in the Albuquerque Area. Data indicate that this treatment may offer clinicians an exciting new non-surgical tool to combat tooth loss, especially among those with diabetes. Inter-agency collaboration of this kind means that lower cost, less-invasive medical treatments will continue to become more widely available.

While Sen. McCain's bill makes provisions for the IHS to use officers or employees of the Public Health Service, the assignment of PHS personnel and Commissioned Corps officers to the IHS will be complicated by additional administrative procedures that must be used when details of these personnel are made outside of a PHS agency. Currently, for example, Commissioned Corps personnel -- personnel that comprise the backbone of the health professional cadre in IHS -- can be assigned to the IHS directly, utilizing administrative processes that are common to all PHS agencies using common authorities contained in the PHS Act. The IHS can then, in turn, assure that Tribes receive health professional personnel appropriate to the need. IHS currently uses these shared PHS-wide processes which help to minimize personnel overhead costs and assure optimal efficiency.



If the IHS is separated from the PHS, Commissioned Corps personnel will need to be detailed to the IHS and Tribal facilities under multiple, Tribe- or location-specific detail agreements, utilizing unique administrative processes which will undoubtedly be more expensive and complex to administer. Operating through this type of administrative process would also complicate personnel supervision, thus impeding the ability to respond promptly to personnel concerns and performance issues.

It is also important to note that we can maintain IHS as part of the Public Health Service without impeding the direct reporting relationship to the Secretary, that we all support. All heads of PHS Operating Divisions, including the Director of the IHS, currently report directly to Secretary Shalala without having to go through any intermediate level of management authority. There is no filtering of information between operating division heads and the Secretary. Budget requests for the IHS are handled in the same way as budget requests for every other component of the Department.

In short, we believe strongly that the IHS should remain part of the Public Health Service. In our view, there is nothing to gain in administrative relationships or patient care by separating the IHS from the PHS, but there is potentially much to lose.

We share the concerns of Members of these Committees that the IHS be positioned and structured in the best possible way to respond to a future of growing needs, changing expectations, and developing operational and management methods. As the system of delivering Indian health services evolves, organizational independence for the IHS must be balanced against

the recognized need to collaborate with federal and Tribal partners, leveraging maximum benefit from limited resources, and being able to bring all appropriate aspects of the Department's talents to bear.

Mr. chairman, the Department of Health and Human Services looks forward to continuing our effort to develop consensus legislation to elevate the IHS to the Assistant Secretary level. We stand ready to work with Congress and Tribal governments as, together, we seek to fulfill the solemn promises to which we are committed. We look forward to a vital partnership and pledge continued -- and thoughtful -- responsiveness to changing health care and public health needs in Indian country.

Thank you, Chairman Campbell, Chairman Young, and Members of the joint Committees. I appreciate the opportunity to share the Department's views on these matters, and look forward to answering any questions you may have.