DEPARTMENT OF HEALTH AND HUMAN SERVICES

STATEMENT

OF

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BEFORE THE

THE HOUSE RESOURCES COMMITTEE,

OFFICE OF NATIVE AMERICAN AND INSULAR AFFAIRS

ON H.R. 2440, INDIAN HEALTH CARE IMPROVEMENT ACT AMENDMENTS OF 2003

AND

H.R. 151, TO ELEVATE THE POSITION OF DIRECTOR OF THE INDIAN HEALTH SERVICE WITHIN THE DEPARTMENT OF HEALTH AND HUMAN SERVICES TO ASSISTANT SECRETARY FOR INDIAN HEALTH

OCTOBER 1, 2003

STATEMENT OF THE INDIAN HEALTH SERVICE
HEARING ON THE
REAUTHORIZATION OF THE INDIAN HEALTH CARE IMPROVEMENT ACT
AND THE ELEVATION OF THE INDIAN HEALTH SERVICE DIRECTOR TO
ASSISTANT SECRETARY FOR HEALTH

October 1, 2003

Mr. Chairmen and Members of the Committees:

Good morning, I am Michel Lincoln, Deputy Director of the Indian Health Service (IHS). We are pleased to have this opportunity to testify on behalf of Secretary Thompson on H.R. 2440, the Indian Health Care Improvement Act Amendments of 2003 and H.R. 151, the bill to elevate the position of Director of the Indian Health Service within the Department of Health and Human Services to Assistant Secretary for Indian Health. At the Committee's request, I will discuss Title I - Indian Health, Human Resources, and Development of H.R. 2440; and H.R. 151, the bill to elevate the IHS Director.

The IHS has the responsibility for the delivery of health services to more than 1.6 million Federally-recognized American Indians and Alaska Natives (AI/ANs) through a system of IHS, tribal, and urban (I/T/U) operated facilities and programs based on treaties, judicial determinations, and Acts of Congress. The mission of the agency is to raise the physical, mental, social, and spiritual health of AI/ANs to the highest level, in partnership with the population we serve. The agency goal is to assure that comprehensive, culturally acceptable personal and public health services are available and accessible to the service population. Our foundation is to promote healthy American Indian and Alaska Native people, communities, and cultures and to honor and protect the inherent sovereign rights of Tribes.

Two major pieces of legislation are at the core of the Federal government's responsibility for meeting the health needs of American Indians/Alaska Natives (AI/ANs): The Snyder Act of 1921, P.L.67-85, and the Indian Health Care Improvement Act (IHCIA), P.L.94-437. The Snyder Act authorized regular appropriations for "the relief of distress and conservation of health" of American Indians/Alaska Natives. The IHCIA was enacted "to implement the Federal responsibility for the care and education of the Indian people by improving the services and facilities of Federal Indian health programs and encouraging maximum participation of Indians in such programs." Like the Snyder Act, the IHCIA provided the authority for the programs of the Federal government that deliver health services to Indian people, but the IHCIA also provided additional guidance in several areas. The IHCIA contained specific language that addressed the recruitment and retention of a number of health professionals serving Indian communities.

I am here today to discuss reauthorization of the IHCIA and tribal recommendations for change to the existing IHCIA in the context of the many changes that have occurred in our country's health care environment since the law was first enacted in 1976. H.R. 2440 reflects the product of an extensive tribal consultation process that took two full years and resulted in a tribally drafted reauthorization bill. IHS and other HHS staff provided technical assistance and support to the Indian Tribes and urban Indian health programs through this lengthy consultation. However, we recognize that our programs overlap and have implications for other Department agencies and their programs, and we are continuing to work with them to develop a comprehensive Administration position on this legislation.

Health Disparities

While the mortality rates of Indian people have improved dramatically over the past ten years, 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 is influenced by behavior choices and lifestyle. 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.

A primary area of focus that I have identified based on these statistics is a renewed emphasis on health promotion and disease prevention. I believe this will be our strongest front in our ongoing battle to eliminate health disparities plaguing our people for far too long. Although we have long been an organization that emphasizes prevention, I am calling on the Agency to undertake a major revitalization of its public health efforts in health promotion and disease prevention. Both field and tribal participation in the initial stages of planning and implementation are critical.

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, chronic diseases emerge as the dominant factors in the health and longevity of the Indian population 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 significantly higher than 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 Disease Prevention Program. Also contributing to the effort is the IHS Diabetes Program, the IHS Disease Prevention Task Force, and the American Heart Association. The primary focus is on the development of more effective prevention programs for AI/AN 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 have been 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. Today, however, I want to report to you that we may be seeing a change in this pattern. In CY 2000 we have observed for the first time ever a decline in mortality. I must note that this is preliminary mortality data that needs to be further examined.

What is most distressing however 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 sometimes eliminates the need for costly treatment options. The cost-effectiveness of a preventative 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.

Another area of concern is in behavioral health, specifically the identification and treatment of depression and strategies for prevention of depression. A recent study from Washington University in St. Louis has revealed that untreated depression doubles the risk for chronic diseases like diabetes and cardiovascular disease, not to mention the risks for alcoholism, suicide, and other violent events. This study also showed that of those individuals with chronic disease, unrecognized and untreated depression doubles the risk for complications of the chronic disease (e.g., amputations and renal disease in diabetics). We must find the best practices that will allow us to prevent depression primarily, or at the least recognize and treat it early if we are to reduce the disparities that affect Indian communities.

A well trained, caring staff, supported by sufficient funding, is the best means of successfully addressing these disparities. Programs authorized in Title I help us to obtain these people. Even better, three programs help us to "grow our own," in that they support the development of Indian health professionals.

The most influential of these programs are the scholarship program, authorized in sections 103 and 104, and the loan repayment program, authorized in section 110. Over the years, the scholarship program has helped over 7,000 Indian students attend pre-professional and professional school. Its influence can readily be seen in the fact that since 1981, the proportion of IHS health professional staff that is Indian has increased by 131%.

The loan repayment program has served both to attract and retain health professionals. Since its inception in 1988, more than 3,000 health professionals have participated. Many have stayed well beyond the time it took to repay their loans, having found that the IHS practice is what they are seeking.

National shortages in nursing, dentistry, pharmacy, and other health professions are having an impact on Indian health programs. We continue our efforts to attract the best. These programs, and others authorized in Title I, help in this effort.

H.R. 151 - Elevation of the IHS Director to Assistant Secretary for Indian Health

H.R. 151 proposes to establish within the Department of Health and Human Services an Office of the Assistant Secretary for Indian Health. The IHS is the principal point of contact on behalf of the Department on health matters related to Tribes. It exists because of the solemn promises the Federal 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 Indian Health needs of the nation's more than 550 federally-recognized Indian Tribes.

Currently, the Director of the IHS enjoys direct access to the Secretary in the Department on all health services issues that have an impact on Tribes and Tribal organizations. In addition, the Director serves as Vice-Chair of the Secretary's Intradepartmental Council for Native American Affairs. The Council serves as an advisory body to the Secretary and has the responsibility to assure that Native American policy is implemented across all Divisions in the Department including human services programs. The Council also provides the Secretary with policy guidance and budget formulation recommendations that span all Divisions of HHS. A profound impact of this Council on the IHS is the revised premise within HHS that all agencies bear responsibility for the government's obligation to the Native people of this country.

It is our view that the Director as the Vice Chair of the Intradepartmental Council for Native American Affairs currently enjoys an elevated status in the Department. He facilitates advocacy, promotes consultation, reports directly to the Secretary, collaborates

directly with the Assistant Secretary of Health, advises the heads of all the Department's divisions and coordinates activities of the Department concerning matters related to Native American health and human services issues. This authority is provided in the Native American Programs Act of 1974. Consistent with the statute, Secretary Thompson has taken steps to assure that this Council receives the highest levels of attention within the Department.

Moreover, the Secretary and Deputy Secretary have traveled widely to Indian Country with their senior staff. These trips have raised the awareness of tribal issues and have contributed greatly to our capacity to speak with one voice, as One Department, on behalf of tribes. Secretary Thompson and Deputy Secretary Allen are daily committed to working with Tribal leaders on Indian health concerns.

The Director, then, currently is assured the same access to the highest levels as other agencies in the Department and it is not necessary to elevate the IHS Director to the level of Assistant Secretary over other agencies serving American Indians/Alaska Natives (AI/AN).

Summary

In summary, 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. This is the path we must follow if we are to reduce and eliminate the disparities in health that so clearly affect AI/AN people.

As we continue our thorough review of this far-reaching, complex legislation on reauthorization, we may have further comments on Title I. However, we wish to reiterate our strong commitment to reauthorization and improvement of the Indian health care programs. We will be happy to work with the Committees, the National Tribal Steering Committee, and other representatives of the American Indian and Alaska Native communities to develop a bill fully acceptable to all stakeholders in these important programs.

Mr. Chairman, this concludes my statement. Thank you for this opportunity to discuss the reauthorization of the Indian Health Care Improvement Act and other issues. We will be happy to answer any questions that you may have.