Calendar No. 560

105TH CONGRESS, 2d Session | SENATE | REPORT 105–319

TO ELEVATE THE POSITION OF DIRECTOR OF INDIAN HEALTH SERVICE TO ASSISTANT SECRETARY OF HEALTH AND HUMAN SERVICES, TO PROVIDE FOR THE ORGANIZATIONAL INDEPENDENCE OF THE INDIAN HEALTH SERVICE WITHIN THE DEPARTMENT OF HEALTH AND HUMAN SERVICES, AND FOR OTHER PURPOSES

SEPTEMBER 9, 1998.—Ordered to be printed

Mr. CAMPBELL, from the Committee on Indian Affairs, submitted the following

REPORT

[To accompany S.1770]

The Committee on Indian Affairs, to which was referred the bill (S. 1770) to elevate the position of Director of Indian Health Service to Assistant Secretary of Health and Human Services, to provide for the organizational independence of the Indian Health Service within the Department of Health and Human Services, and for other purposes, having considered the same, reports favorably thereon with an amendment and recommends that the bill as amended do pass.

PURPOSE

The purpose of S. 1770, as amended, is to elevate the position of the Director of the Indian Health Service to the status of an Assistant Secretary within the Department of Health and Human Services. The bill establishes the Office of Assistant Secretary for Indian Health in order to further the unique government-to-government relationship between Indian tribes and the United States, facilitate advocacy for the development of Indian health policy, and promote consultation on matters related to Indian health.

BACKGROUND

In exchange for the cession of millions of acres of land to which Indian tribes held aboriginal title, the United States entered into treaties with the Indian nations. Many of the treaties provided that

health care services would be provided to the citizens of Indian country in perpetuity. Some have asserted that these contracts between the United States and the Indian governments represent the first pre-paid health care plan in America.

The federal obligation for the provision of health care services in Indian country also arises out of the special trust relationship between the United States and Indian tribes, which reflects the authority found in Article I, Section 8, Clause 3 of the U.S. Constitution, and which has been given form and substance by numerous treaties, laws, Supreme Court decisions, and Executive Orders.

The first federal statue authorizing the appropriation of federal funds to carry out the United States' trust and treaty responsibilities was the Snyder Act of 1921, 25 U.S.C. 13. In 1976, the Indian Health Care Improvement Act was enacted into law. The Act was the first comprehensive statute specifically addressing the provision of health care in Indian country and the federal administration of health care.

A. EVOLUTION OF THE INDIAN HEALTH SERVICE

The Bureau of Indian Affairs within the U.S. Department of the Interior was initially charged with carrying out the United States responsibilities for the provision of health care to federally-recognized tribes and tribal members. However, in 1954, in response to a growing concern by the public health community that Indian health care responsibility to the Surgeon General. Acting through the Public Health Service (PHS), the Surgeon General established the Division of Health (DIH) to administer the Indian health program. In 1968, the Division became the Indian Health Service (IHS) and operated as a sub-agency of other agencies within the Public Health Service including the Health Resources and Services Administration. In 1988, the Indian Health Service was established as a separate agency within the Public Health Service.

On October 1, 1995, the Department of Health and Human Services (DHHS) reorganized its internal administrative structure and the Indian Health Service, along with the other agencies of the Public Health Service, became a separate operating division of the department. The Director of the Indian Health Service is appointed by the President and is subject to Senate confirmation pursuant to 25 U.S.C. 1661(a). Under current law, the IHS Director reports to the DHHS Secretary through the Assistant Secretary for Health.

After the reorganization of the Department, all agencies, operating divisions, and programs within the Department, including those previously part of the Public Health Service and under the direction of the Assistant Secretary for Health, are required to report directly to the Secretary. Under the DHHS restructuring, the position of Assistant Secretary for Health was combined with the position of Surgeon General and the Office of Public Health and Science (OPHS) was established. The Assistant Secretary for Health directs the OPHS, serves as the Secretary's senior advisor for public health and science, and provides leadership and coordination across the Department on public health and science issues.

A key component to the IHS health care system is the Public Health Service's Commissioned Corps. The Corps was established by the Congress in 1889, as part of the Marine Hospital Service,

which later became the Public Health Service. The original mission of the Corps was to provide medical care to sick and disabled navy and merchant seamen. While the Corps' duties were expanded during World Wars I and II, its original mission now serves as the basis for its continuing status as a uniformed service. The Surgeon General is statutorily responsible for supervising the activities of the Commissioned Corps. The Corps is also charged with providing technical and financial assistance to a variety of other federal agencies, state, and local public health departments.

At the request of this Committee, the General Accounting Office (GAO) conducted a study of the role of the Corps in the Indian Health Service system. Corps officers have been assigned to Indian health agencies since 1926 and the Corps continues to provide many of the physicians, registered nurses, dentists, pharmacists, engineers, and sanitarians in Indian health facilities. As of March 1995, the Public Health Service employed 6,276 Corps officers of which 2,401, or about 35%, were assigned to the Indian Health Service.

Like its legislative predecessors in previous sessions of the Congress, S. 1770 seeks to honor the government-to-government relationship between the United States and Indian tribes, to provide the necessary leadership within the Administration on Indian health issues, and to bring focus and national attention to the health care status of American Indians and Alaska Natives. The bill is intended to enhance the federal capacity to respond to the ongoing health crisis in Indian country and the continuing frustrations of Indian patients that their needs and concerns are not adequately addressed under the current administrative policy and budgetary processes.

B. INDIAN HEALTH CARE AND STATUS OF THE IHS

The IHS employs approximately 15,000 employees or about 25% of all DHHS personnel. The IHS is a comprehensive health care delivery system operating nationwide through a variety of health care facilities. The IHS provides health care services directly and through tribally contracted and operated health care programs. Health services are also purchased from more than two thousand private providers. As of 1996, the IHS system consisted of 533 health care facilities funded through the IHS: 150 of these were directly operated by the IHS and 383 were operated by tribes. These facilities include, among others, 37 hospitals, 65 health care centers, 50 health stations, five school centers, and 34 urban Indian health projects.

Each year the IHS provides health care services to 559 Indian tribes and in 1996 provided services to 1.4 million American Indians and Alaska Natives. In FY94, IHS and tribal hospitals had about 91,000 admissions and IHS and tribal medical facilities had 6.3 million outpatient visits.

Previous legislative attempts to bring attention to Indian health care needs and concerns within the Administration have not successfully bridged the gaps or affected the steady decline of the IHS budget. The disparity between Indian and non-Indian communities in federal health care expenditures continues to grow. Current IHS Medicaid statistics reflect a $3,261 per capita outlay for non-Indi-

ans, compared with a $1,382 per capita expenditure for Indians. The Committee believes that the institutionalization of a senior policy official responsible for Indian health within the DHHS is necessary to bring parity to Indian health care needs.

The Committee has been notified by the tribes of the Administration's failure to incorporate tribal concerns in the final budget request, despite tribal participation throughout the budget process. As an example, prior to the FY99 budget request, the tribes met with the Administration to provide their input, but the FY99 budget request was $153 million below the expected Presidential request.

The tribes expressed disappointment that the President's FY99 budget request for the IHS included only a 0.9% increase over the FY98 budget levels. The IHS budget requested by the Administration ignored factors such as: rising inflation of health care costs, mandatory cost increases for federal personnel, limited third party cost collections (such as Medicaid, Medicare and private insurance), a 2% annual service population increase, and increasing chronic and acute care costs because of a lack of screening, diagnosis and early treatment.

At current budget levels, the IHS estimates that it can meet only 62% of tribal health care needs, whereas, the tribes estimate that the current funding levels meet only 36% of their health care needs. These deficits are even more startling in light of the fact that almost half the Indian population is now under the age of 25 and half of those under age five live in poverty. The gap between health care needs and federal funding levels has never been more apparent or more critical. The growing and alarming disparity between the health status of American Indians and Alaska Natives as compared to other Americans is well documented. On May 20, 1998, the Assistant Secretary for Health reported to the Committee on Indian Affairs that Indians have the second highest infant mortality rate in the United States, the lowest prenatal care rate and lower breast and cervical cancer screening and treatment rates because of limited access to screening and treatment. In addition, Indian teen pregnancy rates are double that of their white counterparts, cardiovascular disease continues to be the leading cause of death, diabetes rates are two to three times the national average, and as many as 40% of Indians over the age of 18 use tobacco.

S. 1770 is intended to complement and strengthen the two Executive Orders issued by the current Administration. The Executive Order issued in April 1994 recognized the government-to-government relationship between the United States and the tribes and the recent May 1998 Executive Order directed executive agencies to consult with Indian tribes prior to any federal action that would affect the tribes.

C. THE ROLE OF THE ASSISTANT SECRETARY FOR INDIAN HEALTH

On August 6, 1998, President Clinton announced that the Administration is committed to working with the Congress to elevate the position of the Indian Health Service Director to the rank of Assistant Secretary for Health and Human Services. President Clinton declared that "(b)y elevating the head of the Indian Health Service, we can ensure that the health needs of our Native Ameri-

cans get the full consideration they deserve when it comes to setting health policy in our country."

The Committee acknowledges the Administration's support for the elevation of the IHS Director. The Committee also recognizes the role of the Assistant Secretary for Health (Surgeon General) in addressing the health needs of all citizens of this country, including the American Indian and Native Alaska populations. S. 1770 does not alter the important role the Assistant Secretary for Health (Surgeon General) serves, particularly as principal adviser to the Secretary of DHHS for public health matters affecting the general population. It is the Committee's hope that a close collaboration between the Assistant Secretary for Health and the Assistant Secretary for Indian Health will be a model of interagency cooperation and partnership that will integrate their respective responsibilities and raise the health status of American Indian and Alaska Natives.

S. 1770 elevates the position of the IHS Director, but more importantly, this legislation recognizes the unique government-to-government relationship between federally recognized Indian tribes and the United States. The Assistant Secretary for Indian Health will provide the necessary leadership and consultation to the Secretary, the Assistant Secretary for Health, and others, on the important health issues facing Indian people. S. 1770 supports the federal policy of tribal self determination and ensures that Indian people are heard and their concerns are brought to the table when important policy and budget decisions are made.

The establishment of an Assistant Secretary for Indian Health will ensure that there is at least one senior official in current and future administrations who is knowledgeable about the United States' legal and moral obligations to Indian people, the mission of the IHS, and who has the status to advocate within the DHHS and the Office of Management and Budget (OMB) for the funding resources and policies that are necessary to effectively and efficiently address the health care needs and concerns of the Indian people. S. 1770 places this important and special leadership role with the Assistant Secretary for Indian Health.

The Committee substitute amendment makes three changes to the original bill, S. 1770, as introduced. The first change clarifies the authority of the Assistant Secretary for Indian Health in section 1(e). The second change strikes section 2 from the bill, which provides for the organizational independence of the IHS from the Public Health Service. The third change makes conforming and technical changes to section 601 of the Indian Health Care Improvement Act for creation of the position of Assistant Secretary for Indian Health.

The Committee substitute responds to the concerns raised by the Administration to the original proposed bill. While the Administration stated its support for the direct elevation of the IHS Director to an Assistant Secretary, it did not support the reorganization of the IHS as an independent agency. The Committee agreed to strike section 2 from this legislation in order to focus S. 1770 on the elevation of the IHS Director. The Committee intends that the concept of the IHS as an independent agency will be further evaluated in the next Congress during the overall reauthorization of the Indian

Health Care Improvement Act. The Committee believes that the IHS independence deserves further input, debate, and evaluation by Indian country, the IHS, and the Congress.

LEGISLATIVE HISTORY

S. 1770 was introduced on March 17, 1998 by Senator McCain for himself, and Senators Campbell, Inouye, and Conrad, and referred to the Committee on Indian Affairs. The bill was the subject of a joint hearing held by the Senate Indian Affairs Committee and the House Resources Committee on June 22, 1998. S. 1770 was ordered to be reported to the full Senate on June 29, 1998.

SECTION BY SECTION ANALYSIS

Section 1. Office of Assistant Secretary for Indian Health.

Subsection (a) provides that the Office of Assistant Secretary for Indian Health is established within the Department of Health and Human Services.

Subsection (b) provides that the Assistant Secretary for Indian Health shall report directly to the Secretary on all policy and budget related matters affecting Indian health, collaborate with the Assistant Secretary for Health on Indian health matters, advise other Assistant Secretaries and others within DHHS concerning matters of Indian health, perform the functions of the Director of the Indian Health Service, and other functions as designated by the Secretary of Health and Human Services.

Subsection (c) provides that any references to the Director of the Indian Health Service is deemed to refer to the Assistant Secretary for Indian Health.

Subsection (d)(1) provides a technical change to comply with the section. The elevation of the Director of Indian Health Service to Assistant Secretary would increase the number of assistant secretaries to seven.

Subsection (d)(2) abolishes the position of the Director of Indian Health Service.

Subsection (e)(1) amends section 601 of the Indian Health Care Improvement Act, 25 U.S.C. 1661, and other Acts by deleting all provisions referring to "the Director" or "Director of Indian Health Service" and inserting in lieu thereof "the Assistant Secretary for Indian Health."

Subsection (e)(2) further outlines and clarifies the duties of the Assistant Secretary for Indian Health.

Subsection (f) provides that the individual serving as the IHS Director at the time of the enactment of this Act may serve, at the pleasure of the President, as the Assistant Secretary for Indian Health.

Subsection (g) provides for conforming amendments to other statutes to comply with this Act.

Amends the title to read: "A 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, and for other purposes".

COMMITTEE RECOMMENDATION AND TABULATION OF VOTE

On June 29, 1998, the Committee on Indian Affairs, in an open business session, considered an amendment to S. 1770 offered by Senator McCain. The bill, as amended, was ordered favorably reported with a recommendation that the bill, as amended, do pass.

COST AND BUDGETARY CONSIDERATION

The cost estimate for S. 1770, as amended, as calculated by the Congressional Budget Office, is set forth below:

U.S. CONGRESS,
CONGRESSIONAL BUDGET OFFICE,
Washington, DC, August 13, 1998.

Hon. BEN NIGHTHORSE CAMPBELL,
Chairman, Committee on Indian Affairs,
U.S. Senate, Washington, DC.

DEAR MR. CHAIRMAN: The Congressional Budget Office has prepared the enclosed cost estimate for S. 1770, a bill to elevate the position of Director of the Indian Health Service to Assistant Secretary for Indian Health.

If you wish further details on this estimate, we will be pleased to provide them. The CBO staff contact is Dorothy Rosenbaum.

Sincerely,

JUNE E. O'NEILL, *Director.*

Enclosure.

CONGRESSIONAL BUDGET OFFICE COST ESTIMATE

S. 1770—A bill to elevate the position of Director of the Indian Health Service to Assistant Secretary for Indian Health, and for other purposes

CBO estimates that enacting this bill would have no significant effect on the federal budget. Because the bill would not affect direct spending or receipts, pay-as-you-go procedures would not apply. S. 1770 contains no intergovernmental or private-sector mandates as defined in the Unfunded Mandates Reform Act and would not have a significant impact on the budgets of state, or tribal governments.

S. 1770 would establish the position of Assistant Secretary for Indian Health in lieu of the current position of Director of the Indian Health Service. The duties and responsibilities of the office would not be changed significantly. The rate of pay would increase from level V to level IV of the Executive Schedule, an increase of about $8,000. This change would not affect the salary of the current Director of the Indian Health Service. Michael H. Trujillo, whose pay is governed by the pay structure of the Public Health Service Commissioned Corps.

The CBO staff contact for this estimate is Dorothy Rosenbaum. This estimate was approved by Robert A. Sunshine, Deputy Assistant Director for Budget Analysis.

REGULATORY IMPACT STATEMENT

Paragraph 11(b) of rule XXVI of the Standing Rules of the Senate requires that each report accompanying a bill to evaluate the

regulatory paperwork impact that would be incurred in carrying out the bill. The Committee believes that S. 1770 will have minimal regulatory or paperwork impact.

EXECUTIVE COMMUNICATIONS

Kevin L. Thurm, Deputy Secretary of the Department of Health and Human Services, testified on July 22, 1998, that while the Administration strongly supports the elevation of the Director of the Indian Health Service to the Assistant Secretary level, there was a strong belief, within DHHS, that the Indian Health Service should remain a part of the Public Health Service. Mr. Thurm's statement is included below.

TESTIMONY OF KEVIN L. THURM, DEPUTY SECRETARY OF HEALTH AND HUMAN SERVICES

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 ap-

proved 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 HHS 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 HHS. 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 de-

creased 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 in-

directly. 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 proc-

esses 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 service 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.

CHANGES IN EXISTING LAW

In compliance with subsection 12 of rule XXVI of the Standing Rules of the Senate, the Committee states that enactment of S. 1770 will result in the following changes in the following statutes as noted below, with existing language which is to be deleted in brackets and the new language which is to be added in italic:

Section 1. Office of Assistant Secretary For Indian Health

(D) Rate of Pay.—(1) Section 5315 of title 5, United States Code: "Level IV of the Executive Schedule applies to the following positions, for which the annual rate of basic pay shall be the rate determined with respect to such level under chapter 11 of title 2, as adjusted by section 5318 of this title:

Assistant Secretaries of Health and Human Services **[**(6)**]** *(7)*."

(2) Section 5316: "Level V of the Executive Schedule applies to the following positions, for which the annual rate of basic pay shall be the rate determined with respect to such level under chapter 11 of title 2, as adjusted by section 5318 of this title:

[Director, Indian Health Service, Department of Health and Human Services.**]**"

Duties of Assistant Secretary of Indian Health.—(1) Section 1661 of title 25 of the United States Code: (a)*(1)* Establishment

In order to more effectively and efficiently carry out the responsibilities, authorities, and functions of the United States to provide health care services to Indians and Indian tribes, as are or may be hereafter provided by Federal statute or treaties, there is established within the Public Health Service of the Department of Health and Human Services the Indian Health Service. The Indian Health Service shall be administered by **[**a Director**]** *The Assistant Secretary for Indian Health,* who shall be appointed by the President, by and with the advice and consent of the Senate. **[**The Director of the Indian Health Service shall report to the Secretary through the Assistant Secretary for Health of the Department of Health and Human Services. Effective with respect to an individual appointed by the President, by and with the advice and consent of the Senate, after January 1, 1993, the term of service of the Director shall be 4 years. A Director may serve more than 1 term.**]** *The Assistant Secretary for Indian Health shall carry out the duties specified in paragraph (2).*

(2) The Assistant Secretary for Indian Health shall—

(A) report directly to the Secretary concerning all policy- and budget-related matters affecting Indian health;

(B) collaborate with the Assistant Secretary for Health concerning appropriate matters of Indian health that affect the agencies of the Public Health Service;

(C) advise each Assistant Secretary of the Department of Health and Human Services concerning matters of Indian health with respect to which that Assistant Secretary has authority and responsibility;

(D) advise the heads of other agencies and programs of the Department of Health and Human Services concerning matters of Indian health with respect to which those heads have authority and responsibility; and

(E) coordinate the activities of the Department of Health and Human Services concerning matters of Indian health.

(c) Conforming Amendments.—

(1)(A) Section 601 of the Indian Health Care Improvement Act (25 U.S.C. 1601):

(i) "(c) The Secretary shall carry out through the **[**Director of the Indian Health Service**]** *Assistant Secretary for Indian Health*—

(1) all functions which were, on the day before November 23, 1988, carried out by or under the direction of the individual serving

as [Director of the Indian Health Service] *Assistant Secretary for Indian Health*."

(ii) "(d)(1) The Secretary, acting through the [Director of the Indian Health Service] *Assistant Secretary for Indian Health*, shall have the authority—"

(B) Section 816(c)(1) of the Indian Health Care Improvement Act (25 U.S.C. 1680f(c)(1): "Cross utilization of services (1) Not later than December 23, 1988, the [Director of the Indian Health Service] *Assistant Secretary for Indian Health* and the Secretary of Veterans Affairs shall implement an agreement under which—* * *"

(2)(A) Section 203(a)(1) of the Rehabilitation Act of 1973 (29 U.S.C. 761(a)(1)): "(a) Establishment; membership; meetings, (1) In order to promote coordination and cooperation among Federal departments and agencies conducting rehabilitation research programs, there is established within the Federal Government an Interagency Committee on Disability Research (hereinafter in this section referred to as the "Committee"), chaired by the Director and comprised of such members as the President may designate, including the following (or their designees): the Director, the Commissioner of the Rehabilitation Services Administration, the Assistant Secretary for Special Education and Rehabilitative Services, the Secretary of Education, the Secretary of Veterans Affairs, the Director of the National Institutes of Health, the Director of the National Institute of Mental Health, the Administrator of the National Aeronautics and Space Administration, the Secretary of Transportation, the Assistant Secretary of the Interior for Indian Affairs, the [Director of the Indian Health Service] *Assistant Secretary for Indian Health*, and the Director of the National Science Foundation."

(B) Subsections (B) and (E) of Section 518 of the Federal Water Pollution Control Act (33 U.S.C. 1377 (b) and (e)): "(b) Assessment of sewage treatment needs; report: The Administrator, in cooperation with the [Director of the Indian Health Service] *Assistant Secretary for Indian Health*, shall assess the need for sewage treatment works to serve Indian tribes, the degree to which such needs will be met through funds allotted to States under section 1285 of this title and priority lists under section 1296 of this title, and any obstacles which prevent such needs from being met."

"(e) Treatment as States: * * * Such treatment as a State may include the direction provision of funds reserved under subsection (c) of this section to the governing bodies of Indian tribes, and the determination of priorities by Indian tribes, where not determined by the Administrator in cooperation with the [director of the Indian Health Service] *Assistant Secretary for Indian Health*. The Administrator, in cooperation with the [Director of the Indian Health Service] *Assistant Secretary for Indian Health*, is authorized to make grants under subchapter II of this chapter in an amount not to exceed 100 percent of the cost of a project. * * *"

(C) Section 803B(d)(1) of the Native American Programs Act of 1974 (42 U.S.C. 2991b–2(d)(1)): "(d) the Intra-Departmental Council on Native American Affairs: * * * The [Director of the Indian

Health Service] *Assistant Secretary for Indian Health* shall serve as vice chairperson of the council."

○