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Briefing Report to Congressional Requesters

August 1997

FEDERAL PERSONNEL

Public Health Service Commissioned Corps Officers' Health Care for Native Americans

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GAO

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August 27, 1997

The Honorable Ben Nighthorse Campbell
Chairman, Committee on Indian Affairs
United States Senate

The Honorable John McCain
United States Senate

This briefing report responds to your request that we provide information on Public Health Service (PHS) Commissioned Corps officers and others who are involved in providing Native American health care through the Indian Health Service (IHS) or tribal associations. As agreed with your offices, this document provides information on (1) Corps officers' historical involvement in providing health care to Native Americans; (2) the extent of nationwide participation in Native American health care by Corps officers and non-Corps providers in fiscal year 1996; (3) how health-care provider vacancies were filled in selected geographic areas—sections of Alaska, Arizona, New Mexico, and Oklahoma—and the number of such vacancies filled by Corps officers; (4) how tribal representatives, IHS officials, and medical facility staff in the locations we visited perceived Corps and non-Corps providers and their perceptions of the potential effects that converting Corps officers to civil service status might have on Native American health care; and (5) changes in the Native American health care system that might affect those providing health care to Native Americans, whether Corps or non-Corps personnel.

This report summarizes the substance of our August 18, 1997, briefing.

Background

IHS is an operating division within the Department of Health and Human Services (HHS). Its mission is to provide a comprehensive health-services delivery system for Native Americans and Alaska Natives (collectively referred to as "Native Americans"). Until 1988, when it became a separate agency, IHS was a component of PHS. IHS employs both PHS Commissioned Corps officers and federal civil service health care personnel. In fiscal year 1996, IHS employed 14,613 nationwide, including about 6,300 health care providers. A total of 2,237, or about 35 percent, of these health care providers were Corps officers, and the remaining 65 percent were civil service employees working as counterparts of the Corps' professional categories. IHS' total fiscal year 1996 budget was $2.2 billion.

The PHS Commissioned Corps is a uniformed personnel system. Corps officers are health professionals whose pay and allowances are equivalent to those of the armed forces, as authorized by title 37 of the U.S. Code. Although health care professionals hired under this system perform functions that are essentially the same as those of civil service employees, they are given rank and compensation equivalent to those of U.S. Navy officers. Corps officers' military-like compensation is based on the Corps' temporary service with the armed forces during World Wars I and II. Corps officers are entitled to wear uniforms similar to those of naval officers, with PHS insignia, but they do not belong to the military. When they are detailed to the Coast Guard or the Department of Defense (DOD), they are subject to the Uniform Code of Military Justice, which governs the conduct and discipline of armed forces members.[1]

The Native American health care system consists of 533 health care facilities funded through IHS; 150 of the facilities are operated by IHS, and 383 facilities are operated by tribes or associations of Alaska Native villages under various contract agreements. IHS facilities are staffed by Corps officers and civil service personnel. Tribal facilities are staffed by Corps officers and civil service staff detailed from IHS and other nonfederal personnel hired by the tribe. Staffing decisions at tribally operated facilities are made by the tribes.

Results in Brief

The Bureau of Indian Affairs (BIA), in the Department of the Interior, was responsible for Native American health care until 1955. In 1954, Congress gave the Surgeon General, then operating head of the PHS, responsibility for Native American health care. In 1955, PHS established a Division of Indian Health, which became IHS in 1968. Commissioned Corps officers were detailed to BIA to provide Native American health care from 1926 until 1955 and have been part of IHS since its creation. From 1978 through 1996, they constituted, on average, about 17 percent of the total IHS workforce.

Our analysis of fiscal year 1996 IHS and tribal data for 6,260 health care providers nationwide in 6 professions—physician, registered nurse, dentist, pharmacist, engineer, and sanitarian—in the Native American health care system showed that about 46 percent were federal civil service employees, and about 31 percent were Corps officers. The remaining

[1]Under a 1902 statute, the President can incorporate the Corps into the armed forces in the event of war or national emergency. Since all military members are subject to the Uniform Code of Military Justice, Corps officers, after being incorporated into the military, would be subject to the code. This situation has not occurred since 1952.

providers were nonfederal employees directly hired by tribes or Alaska Native health care associations. While most physicians and registered nurses were civil service employees, most dentists, pharmacists, sanitarians, and engineers were Corps officers. Tribally hired employees were not the largest part of the workforce in any of the six categories, but they represented from about 20 to 30 percent of physicians, pharmacists, dentists, and registered nurses.

To fill 139 health-provider positions between July 1, 1995, and June 30, 1996, in the areas we visited, IHS and tribal governments generally used a competitive selection process. None of these filled positions, nor 100 unfilled positions we reviewed in these areas, were reserved exclusively for Corps officers. Corps officers filled 36 of the 139 recently filled vacancies (26 percent); of the 36 vacancies, only Corps officers applied for 17 of them.

Interviewees' perceptions of health care providers varied. Many interviewees expressed no opinion on the skills and dedication of Corps and non-Corps health care providers. Of those expressing an opinion, most said they saw no difference between the skills of Corps officers and others providing health care to Native Americans; but most interviewees perceived Corps officers as being more dedicated than non-Corps providers. Further, most IHS officials, medical facility staffs, and tribal representatives said that converting Corps officers to the civil service personnel system might have negative effects in terms of costs and health care in their areas or facilities. Most based their predictions on the premise that some Corps officers would not make the conversion. Fewer interviewees predicted no negative impact resulting from the Corps' conversion to another personnel system, while others said any impact would depend on the extent to which Corps officers make the transition to a non-Corps system.

About one-half of the interviewees preferred Corps over non-Corps health care providers. Many said that having Corps officers provide health care was less costly to them than using civil service or direct-hire providers and that civil service employees caused an administrative burden. More interviewees cited advantages than disadvantages in having Corps officers provide health care, and cost was cited most frequently as an advantage.

Large-scale changes are occurring in the Native American health care system. Tribes are moving toward administering their own health care facilities and resources. IHS has projected that by 1999, tribes may control

as much as 57 percent of the IHS budget, as opposed to 32 percent in 1994. Further, in response to recommendations by an Indian-health design team, IHS officials said the agency is decentralizing its operations, with managerial and resource allocation decisions to be made at the health facility level. While these changes may reduce the need for Corps and civil service health care providers, they may not eliminate the perceived need entirely. Although some tribes are planning to replace Corps or civil service providers with tribally hired medical personnel, others said they anticipate a continuing need for the Corps.

Scope and Methodology

To gather information on Corps officers' historical involvement in providing health care to Native Americans, we obtained and reviewed PHS and IHS documents and historical material.

To gather information on the extent of participation in Native American health care by Corps officers and non-Corps providers in fiscal year 1996, we obtained and reviewed nationwide data on the number of employees in health care professions working in IHS or directly hired by the tribes. For IHS employees, we obtained information from IHS' personnel database as of September 30, 1996, that included records for Corps officers and civil service health care professionals. Because IHS does not maintain data on the number of health care providers directly hired by tribes, we obtained this information by using a data-collection instrument that we sent to IHS area offices nationwide, requesting data as of June 30, 1996, on health care providers directly hired by tribes and Alaska Native health associations. We focused on collecting information on the following six professions—physician, registered nurse, dentist, pharmacist, engineer, and sanitarian—because these professions were comparable between IHS and tribal direct-hire personnel and were substantially represented in the Native American health care system.

To determine how selected health-provider vacancies were filled in the areas we visited and whether any of these vacancies were reserved for Corps officers, at each facility we visited, we requested information concerning current and recently filled vacancies in the six professions. We selected a number of tribes and medical facilities to visit in these states, based upon tribal populations, patient workloads, and geographic locations. We also reviewed records on 139 vacancies that had been filled during the period July 1, 1995, to June 30, 1996, and 100 vacancies that had not been filled at the time of our visits (from August through November 1996).

In 40 interview sessions, we interviewed tribal leaders, Alaska Native health association officials, IHS area office officials, tribal medical facility representatives, and IHS facility representatives to gather information on their perceptions of (1) Corps and non-Corps health care providers and (2) the potential effects that converting Corps officers to civil service status might have on Native American health care. We also interviewed senior IHS headquarters officials regarding changes in the Native American health care system that might affect Corps and non-Corps health care providers. As requested, we simply gathered and presented interviewees' perceptions of those providing health care to Native Americans. We did not attempt to corroborate what we were told in our interviews.

It should also be noted that more than 1 person participated in 25 of the 40 interview sessions. Ten of the 40 sessions consisted of both tribal and medical facility representatives or representatives from more than one medical facility; in these sessions, we received viewpoints from more than 1 representative. In 6 of the 25 sessions, tribal representatives were present, together with IHS staff—either Corps officers or civil service employees or both. We do not know what effect, if any, group composition had on the views expressed in the interview sessions. (For more details about the methodology we used to meet our reporting objectives, see app. I.)

We obtained information on changes in the Native American health care system that might affect Corps and non-Corps providers by reviewing IHS documents and interviewing officials from IHS and the National Indian Health Board. We also reviewed reports of an Indian-health design team.

We did our audit work between May 1996 and July 1997, in accordance with generally accepted government auditing standards. A complete list of the locations in which we did our audit work appears in appendix III.

We requested comments on a draft of this report from the Secretary of HHS. HHS' comments are discussed in the following section.

Agency Comments and Our Evaluation

HHS, in a letter dated July 29, 1997, provided written general and technical comments on a draft of this briefing report. These comments and our responses to certain of the technical comments are contained in appendix II.

Although HHS generally agreed with the information we presented, in some cases its characterization of our presentation was not accurate. For example, it referred in several places to findings and conclusions. In neither the draft nor this final briefing report did we, as indicated by HHS, reach conclusions on the substance of the role played by Corps officers in the Native American health care system. The scope of our field work was limited, by agreement with the requester, to four states, thus by definition excluding many facilities and tribal representatives. Our statements in the report concerning perceptions of Corps providers by tribal representatives do not constitute findings; they are simply a compilation of views expressed by those whom we interviewed. Further, as previously indicated, we did not attempt to corroborate any of the statements interviewees made to us; and we therefore cannot say whether or to what extent the statements reflect actual conditions.

Similarly, contrary to HHS' characterization, we did not find that the skills, dedication, and professionalism of Corps officers led to a general tribal preference or choice for using Corps officers on detail when positions cannot be filled with local tribal hires. Although advantages of using Corps officers were cited primarily from the standpoints of cost and personnel administration, many of our interviewees expressed no opinion on the skills and dedication[2] of Corps and other health care providers. Of those interviewees who did express an opinion, most saw no difference in their relative skills but did perceive Corps providers as more dedicated than non-Corps providers.

In discussing future changes in the Native American health care system, we made no finding as to the role Corps officers may have in the system as it moves toward more tribal self-determination. We took note that representatives of Alaska Native health associations saw a continuing need for Corps providers, while a representative of the Navajo Nation did not see such a need.

We are sending copies of this briefing report to the Ranking Minority Member, Senate Committee on Indian Affairs; the Secretary of HHS; HHS' Assistant Secretary for Health; the Director of IHS; and other interested parties. Copies will be made available to others upon request.

[2]We did not seek views on the professionalism of health care providers.

Major contributors to this report are listed in appendix IV. If you have questions about this report, please call me on (202) 512-8676.

L. Nye Stevens
Director
Federal Management and
Workforce Issues

Contents

Abbreviations

BIA	Bureau of Indian Affairs
DOD	Department of Defense
HHS	Department of Health and Human Services
IHS	Indian Health Service
PHS	Public Health Service
SEARHC	Southeast Alaska Regional Health Consortium

IHS, the Commissioned Corps, and the Native American Health Care System

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Briefing Objectives

Provide information on

- History of Corps officers' involvement in Native American health care
- Corps and non-Corps' nationwide participation in Native American health care system
- How health care vacancies are filled
- Perception of Corps and non-Corps providers
- Changes in Native American health care that might affect health care providers

Briefing Objectives

The objectives of this briefing report are to provide information on

- Corps officers' historical involvement in providing health care to Native Americans;
- the extent of nationwide participation in Native American health care by Corps officers and non-Corps providers in fiscal year 1996;
- how health care provider vacancies were filled in selected geographic areas—sections of Alaska, Arizona, New Mexico, and Oklahoma—and the number of such vacancies filled by Corps officers;
- how tribal representatives, IHS officials, and medical facility staff in the locations we visited perceived Corps and non-Corps providers and their perceptions of the potential effects that converting Corps officers to civil service status might have on Native American health care;
- changes in the Native American health care system that might affect those providing health care to Native Americans, whether Corps or non-Corps personnel.

GAO Scope and Methodology

- Reviewed IHS documents
- Collected nationwide data on health care providers
- Fieldwork in AK, AZ, NM, and OK:
  - reviewed current and recently filled vacancies and
  - interviewed medical facility staff, tribal representatives, and IHS officials

Scope and Methodology

We obtained and reviewed PHS and IHS documents concerning the representation of Corps officers over time as well as the present and future structure of health care for Native Americans.

We obtained and reviewed nationwide data on the IHS workforce from IHS' personnel database. Since IHS does not keep data on health care providers hired directly by tribes, we obtained this information from the tribes by means of a data-collection instrument distributed nationwide to the IHS area offices.

As agreed, we did our fieldwork in the states of Alaska, Arizona, New Mexico, and Oklahoma. We selected a number of tribes and medical facilities to visit, based upon populations served. At each facility, we obtained data on current and recently filled vacancies, reviewed records on selected vacancies, and interviewed medical facility staff and representatives of the tribes served by the facilities to obtain their perceptions on various aspects of providing health care to Native Americans. We did not attempt to corroborate what we were told in our interviews. Instead, as requested, we have simply gathered and presented interviewees' perceptions.

Appendix I contains a detailed discussion of our objectives, scope, and methodology.

GAO Background: PHS Commissioned Corps

- Uniformed personnel system for health care professionals
- Corps officers assigned to 11 professional categories, each having a civil service counterpart
- Corps officers receive military rank (Navy equivalent) and compensation, but do not belong to military

Background: PHS Commissioned Corps

Unlike the Marine Corps or the Peace Corps, the Commissioned Corps is not a separate organization with a unique function, but a uniformed personnel system. The Surgeon General's office in HHS makes overall policy for the system, which is administered by an operating division of HHS. Corps members are supervised by officials of the agency to which they are assigned. As of September 30, 1996, the Corps had 6,124 officers: 2,237 working in IHS, 2,762 in other HHS agencies, and the remainder detailed to agencies outside HHS. Officers are assigned to one of the following 11 professional categories: physician, registered nurse, dentist,

pharmacist, sanitarian, engineer, scientist, dietician, physical therapist, veterinarian, and health service officer (a category covering professions ranging from biologist to social worker to hospital administrator). Corps professional categories have civil service counterparts, and civil service staff and Corps officers in the same profession often work in the same facilities.[1]

Corps officers have ranks equivalent to those of Navy officers and are entitled to wear uniforms similar to those worn by Navy officers. Corps officers also receive the same pay and allowances as military members, under title 37 of the U.S. Code. However, they do not belong to the military; and they are not subject to the Uniform Code of Military Justice (which governs the conduct and discipline of armed forces members), except for the small number detailed to DOD or the Coast Guard. Under a 1902 statute, Corps officers can be transferred to the military by the President in the event of a national emergency; this has not happened since 1952. Corps officers' entitlement to naval rank and military compensation originated in their incorporation into the military during the world wars. However, as we opined in May 1996, Corps officers did not meet the criteria set forth in a DOD report as justification for military compensation.[2] HHS did not agree with our opinion.

[1]While the Corps requires all of its officers to have at least a baccalaureate degree in order to be commissioned, civil service entry-level nurses and sanitarians need not have a college degree.

[2]Federal Personnel: Issues on the Need for the Public Health Service's Commissioned Corps (GAO/GGD-96-55, May 7, 1996); The Fifth Quadrennial Review of Military Compensation, DOD, Washington, D.C., Jan. 1984.

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Background: IHS Today

- Fiscal Year 1996: IHS employed 14,613 nationwide, with total budget of $2.2 billion
- IHS headquarters in Rockville, MD
- 12 area offices, mostly in Midwest or West

Source: IHS.

Background: IHS Today

IHS is an operating division within HHS. Its mission is to provide a comprehensive health-services delivery system for Native Americans and Alaska Natives. As of the end of fiscal year 1996, IHS had 14,613 employees, including 6,306 health care providers (physicians, registered nurses, dentists, pharmacists, sanitarians, engineers, dieticians, physical therapists, scientists, and health service officers). A total of 2,237 of these providers were Corps officers; the remainder were civil service employees working as counterparts of the Corps' professional categories. IHS' total budget for fiscal year 1996 was $2.2 billion.

IHS headquarters is located in Rockville, MD. IHS also has 12 area offices located in Aberdeen, SD; Anchorage, AK; Albuquerque, NM; Bemidji, MN; Billings, MT; Sacramento, CA; Nashville, TN; Navajo Reservation (Window Rock, AZ); Oklahoma City, OK; Phoenix, AZ; Portland, OR; and Tucson, AZ. Each IHS area office has oversight of Native American health care in one or more entire states (except for the Navajo Reservation office, which covers portions of northeast Arizona, northwest New Mexico and southeast Utah; and the Tucson office, which covers one-eighth of the state of Arizona). Area offices provide resources and support for comprehensive health programs, including medical facilities run by IHS or by tribal governments and Alaska Native associations. The area offices also provide administrative support and internal controls to the IHS service units, which are the local offices of IHS that administer IHS facilities and public health programs and provide support to tribal facilities.

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Background: Native American Health Care System

Facility	IHS operated	Tribally operated
Hospitals	38	11
Health centers	65	132
Health stations	47	73
Alaska village clinics	0	167
Total	**150**	**383**
Type of personnel	Corps officers and civil service	Direct tribal hire, plus Corps officers and civil service detailed from IHS

Note: Data are as of October 1, 1995, the most recent date for which complete data were available.

Source: IHS.

Background: Native American Health Care System

The Native American health care system consists of 533 health care facilities, 150 operated by IHS and 383 operated by tribes, or Alaska Native health associations formed by a number of Native villages, under various contract agreements.

Personnel in IHS-run facilities are either Commissioned Corps officers or in other federal personnel systems (General Schedule or Wage Grade). Tribal governments or Alaska associations can directly hire their own personnel, who are employees of the tribe rather than of the federal government. Tribes can also obtain the services of Corps officers or civil service employees on detail from IHS, provided IHS is able to make such employees available.

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Background: Native American Health Care System (cont.)

- Legislation allows tribes to operate (or contract for) their own health programs, including medical facilities, with federal funds
- IHS estimates about 1.4 million Native Americans are eligible for federally provided health care in 1997
- About 91,000 admissions and 6.3 million outpatient visits at IHS and tribal facilities in fiscal year 1994

Source: IHS data.

Background: Native American Health Care System (cont.)

Under the Indian Self-Determination and Education Act of 1975 and subsequent legislation, tribes and Alaska Native associations can operate their own health programs, including medical facilities, or contract with a third party to do so, using federal funds obtained from IHS. Tribes can assume control by means of a self-determination contract under title I of the act, or by a self-governing compact under title III, which gives the tribe or association more autonomy and latitude in administering IHS-provided resources than does a self-determination contract. Although tribes must adhere to federal regulations, contracting or compacting tribes can operate with flexibility in designing their health care systems.

IHS estimated that 1.43 million Native Americans living on or near reservations, plus Native Americans living in urban areas,[3] are eligible for health care in fiscal year 1997. This eligibility estimate does not necessarily mean that this number of tribal members seeks medical treatment from IHS or tribal facilities In fiscal year 1994, the last year for which complete data were available, IHS and tribal hospitals had about 91,000 admissions, and IHS and tribal medical facilities had 6.3 million outpatient visits.

[3]IHS is not certain how many Native Americans there are living in urban areas who would be eligible for health care in facilities other than those on or near reservations.

Makeup of Workforce in the Native American Health Care System

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History: Origins of IHS and History of Corps Officers in IHS

- Legislation transferred Native American health care from Bureau of Indian Affairs to PHS in 1955
- Corps officers first detailed to BIA in 1926, continued to work in BIA until July 1955
- Corps officers averaged 17 percent of IHS workforce, 1978-1996

Source: IHS.

History: Origins of IHS and History of Corps Officers in IHS

The Bureau of Indian Affairs (BIA), a component of the Department of the Interior, was responsible for providing health care for Native Americans until 1955. In 1954, Congress, in response to widely held views in the public health community that Native American health care should be the responsibility of an agency dedicated to health matters, enacted the Transfer Act, which assigned responsibility for Native American health care to the Surgeon General, operating through PHS.[4] PHS created a Division of Indian Health in 1955 to administer Native American health care; this division became IHS in October 1968. Between that time and 1988, IHS was a component of various other PHS organizations—Health Services and Mental Health Administration, Health Services Administration, and the Health Resources and Services Administration. In 1988, IHS became a separate agency. On October 1, 1995, IHS became an operating division of HHS.

Involvement of the PHS Commissioned Corps in Native American health care began in 1926, when two senior Corps physicians were detailed to BIA to assume supervisory medical positions. Corps officers continued to serve on detail to BIA until the PHS Division of Indian Health came into existence in July 1955.

Continuous data on Corps officers in IHS was available only from 1978 onward. These data show that on average, about 17 percent of the IHS workforce were Corps officers during the period from 1978 through 1996. The percentage ranged from 15.2 percent in 1978 to 18.5 percent in 1986.

[4]At the time the Transfer Act was enacted in 1954, and until 1966, the Surgeon General was operating head of PHS.

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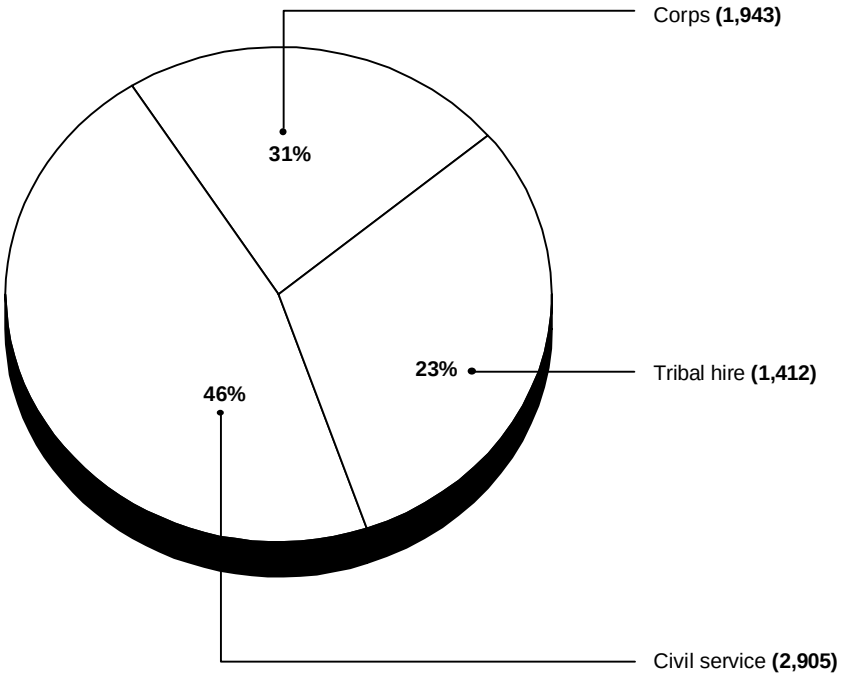
Workforce: Health Care Providers in Native American Health Care System

Comparison of Corps, civil service, and tribal hire providers



N = 6260

Note: Chart includes health care providers in the six professions on which we focused—physician, registered nurse, dentist, pharmacist, engineer, and sanitarian.

Sources: IHS database and tribal data.

Workforce: Health Care Providers in Native American Health Care System

We received nationwide data from both IHS and tribes/Alaska Native associations on 6,260 providers in 6 professions, including physician, registered nurse, dentist, pharmacist, engineer, and sanitarian. (We requested data from tribes and Alaska associations for only these professions, because these professions were comparable between IHS and tribal personnel and were substantially represented in Native American health care.) Of the health care providers working in the Native American health care system in the 6 professions, about 46 percent (2,905) were civil service (as of October 1996), about 31 percent (1,943) were Corps officers (as of October 1996), and about 23 percent (1,412) were nonfederal employees hired directly by tribes and Alaska associations (as of July 1996).

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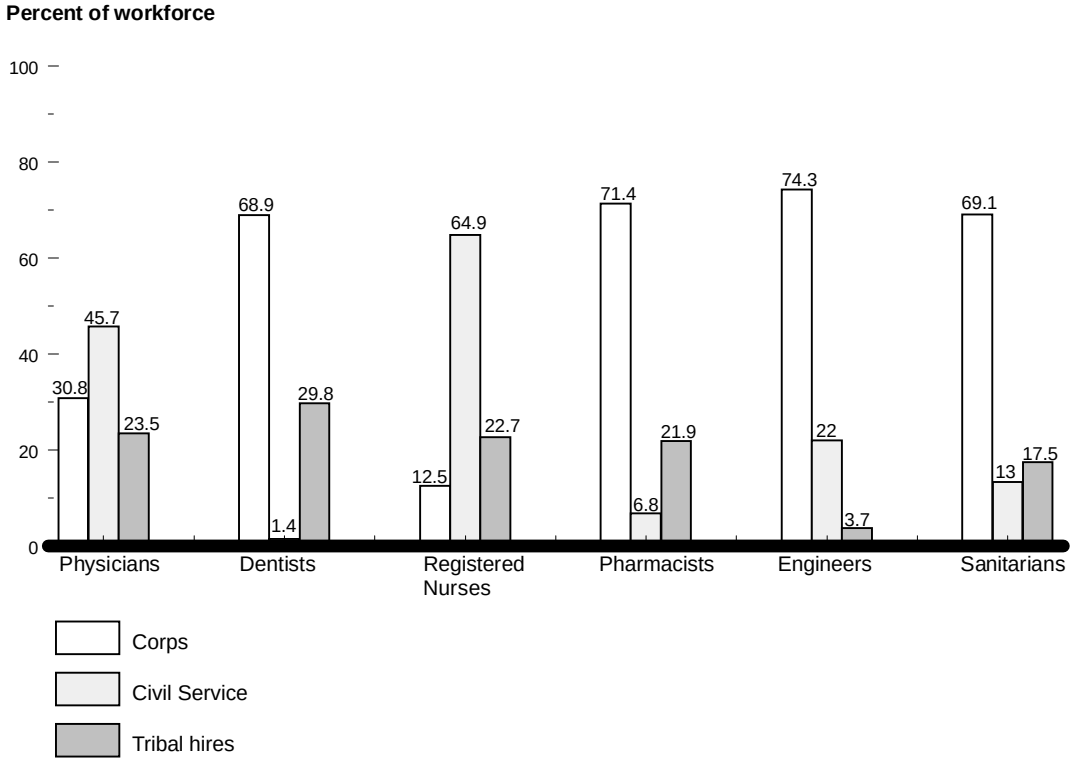
Workforce: Providers in Native American Health Care System (cont.)



Note: Percentages may not add to 100 due to rounding.

Sources: IHS database and tribal data.

Workforce: Providers in Native American Health Care System (cont.)

The six health care provider professions we reviewed had varying proportions of Corps, civil service, and tribal direct-hire personnel. Civil service workers predominated among registered nurses, while Corps officers constituted the largest share of dentists, pharmacists, sanitarians, and engineers. Almost one-half of the physicians were civil service employees, while almost one-third were Corps, and the remainder were tribal direct-hire employees. Tribally hired employees were not the largest part of the workforce in any professional category, but they represented from about 20 to 30 percent of pharmacists, dentists, and registered nurses as well as physicians. Very few tribal-hire employees were sanitarians or engineers.

Health Care Vacancies and the Commissioned Corps

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Vacancies: Health Care Positions at IHS and Tribal Facilities, 1995-1996

- Active recruiting efforts
- Competitive selection process with no positions reserved for Corps officers
- Corps officers filled 26 percent of vacancies reviewed

Source: IHS and tribal facilities.

Vacancies: Health Care Positions at IHS and Tribal Facilities, 1995-1996

At the IHS and tribal medical facilities we visited, we discussed with staff the vacancies—physician, dentist, registered nurse, pharmacist, engineer, and sanitarian—filled during the period July 1, 1995, through June 30, 1996, and positions that were vacant at the time of our visit. We found that active recruiting efforts were made to seek out candidates for health care provider vacancies. Recruiting for positions in the IHS facilities was done by the facilities, by IHS area offices, and by IHS headquarters, which carries out a nationwide search for health care providers. Tribes or Alaska Native associations can obtain IHS assistance to fill tribal facility positions, including having IHS staff, if available, detailed to the facilities. Recruiters visited college campuses and job fairs, and advertised in newspapers and in professional journals.

IHS and the tribes we visited generally used a competitive selection process to fill medical facility vacancies. According to information from facility officials concerning vacancies at the facilities we visited, there was a competitive selection process for 135 of 139 recently filled vacancies and for 93 of 100 unfilled vacancies. (Competitive selection was not used in some cases for reasons such as a prior employee returning to the job or a vacancy being filled by reassigning a current employee.) No positions were reserved exclusively for Corps officers. Corps officers filled 36 of the 139 recently filled vacancies (26 percent); only Corps officers applied for 17 of these vacancies.

Perceptions of Corps and Non-Corps Providers

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Perceptions: Skills and Dedication of Corps and Non-Corps Providers

- Many interviewees expressed no opinion on skills or dedication
- Of those expressing an opinion,
  - most saw no difference in skills between Corps and non-Corps providers, a few said that Corps providers were more skilled than non-Corps providers, and most said Corps providers were more dedicated than non-Corps providers

Perceptions: Skills and Dedication of Corps and Non-Corps Providers

We asked the 51 tribal representatives, IHS area office officials, and medical facility staff for a comparison between Corps and non-Corps health care providers in the six professions, including differences in their skills and dedication. Many expressed no opinion.

Most interviewees who expressed an opinion on skills saw no difference between Corps and non-Corps providers. For example, 28 interviewees saw no difference in skills between Corps and non-Corps physicians, 16 saw no difference between Corps and non-Corps dentists, 19 saw no difference for pharmacists, and 28 saw no difference for registered nurses. Four interviewees said Corps physicians were more skilled than non-Corps physicians. Further, three interviewees said Corps engineers and sanitarians were more skilled than non-Corps providers in these professions; seven said Corps dentists were more skilled, while six said the same for Corps pharmacists and five said Corps registered nurses were more skilled.

In contrast, most interviewees who expressed an opinion saw a difference in dedication between Corps and non-Corps providers. Eighteen interviewees saw Corps physicians as being more dedicated, while eight saw no difference in dedication. Fourteen interviewees saw Corps dentists, physicians, and registered nurses as being more dedicated than non-Corps counterparts; 2 interviewees saw no difference for dentists, 4 for pharmacists, and 10 for registered nurses. Ten interviewees perceived Corps engineers as being more dedicated than non-Corps, and 8 believed the same about Corps sanitarians; 4 interviewees believed there was no difference in dedication for engineers, and 2 expressed the same opinion about sanitarians.

No interviewee said non-Corps providers in any category were more skilled or dedicated than Corps providers.

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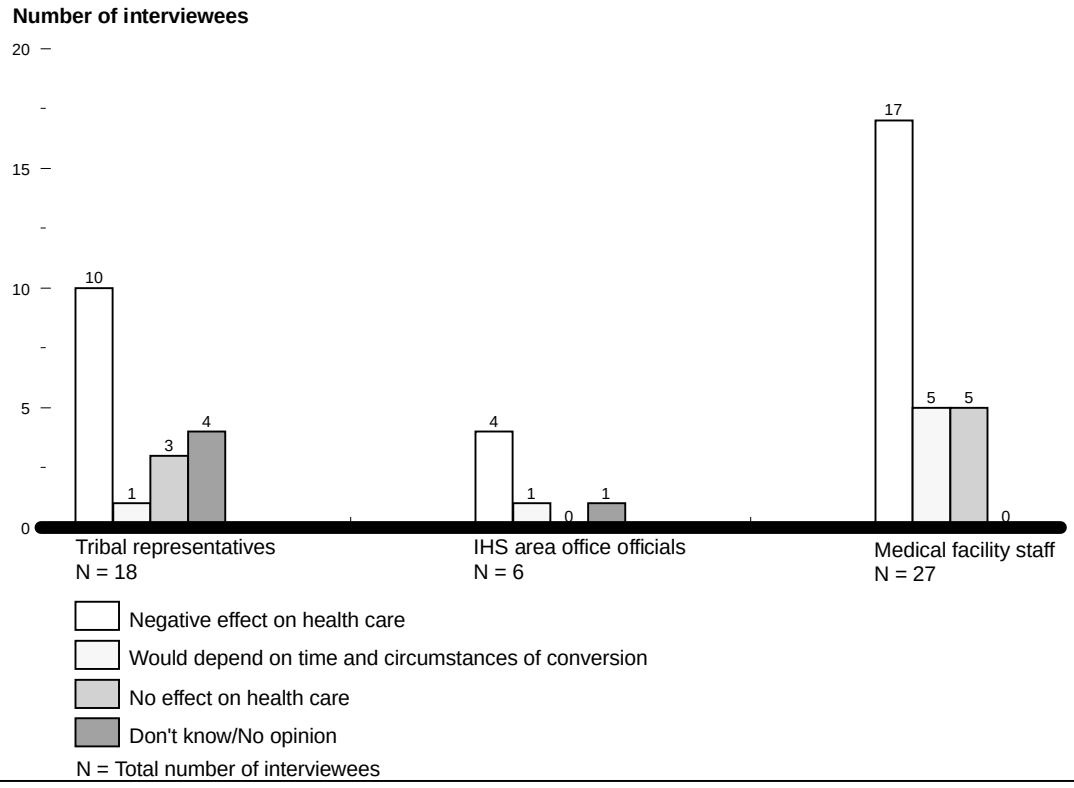
Perceptions: Effect of Corps Officers' Conversion to Civil Service



Source: GAO interviews.

Perceptions: Effect of Corps Officers' Conversion to Civil Service

When questioned about potential effects in the event of an initiative to eliminate the Corps as a health care provider (i.e., provide Corps officers the opportunity to convert to civil service), tribal representatives, IHS area office officials, and medical facility staff raised some concerns.

Thirty-one of the 51 interviewees (10 of 18 tribal representatives, 4 of 6 IHS area office officials, and 17 of 27 medical facility staff), said there would be increased costs or reduced care in their facilities if Corps officers were converted. Most of the 31 who predicted negative impacts based their predictions on the premise that some Corps officers would not make the conversion. Interviewees who said there would be a negative effect included Corps and civil service staff representing the W. W. Hastings Indian Hospital in Tahlequah, OK, who predicted that increased costs in the form of overtime pay and salaries for civil service employees would result in cuts to medical programs and services. Also, the head of the Zuni Pueblo tribal council and other tribal members, and the director of the local IHS hospital, a civil service employee, forecast deteriorating health care from the loss of Corps officers in their New Mexico location, which, according to those interviewed, has historically proven unattractive to medical professionals because of its remoteness and poor housing.

Of the 51 interviewees, 20 did not predict a negative effect. Of these 20 interviewees, 7 said that the effect on their facility would depend on the circumstances of the conversion. For example, the Corps officer managing the Wilma P. Mankiller Health Center, a tribal medical facility serving the Cherokee Nation of Oklahoma, expressed the opinion that Corps officers "hold the system together," and said that the effect of conversion on medical care would depend on the extent to which these officers make the transition to a non-Corps system. Of the 20 interviewees who did not predict a negative impact, 8 said there would be no effect, and 5 had no opinion.

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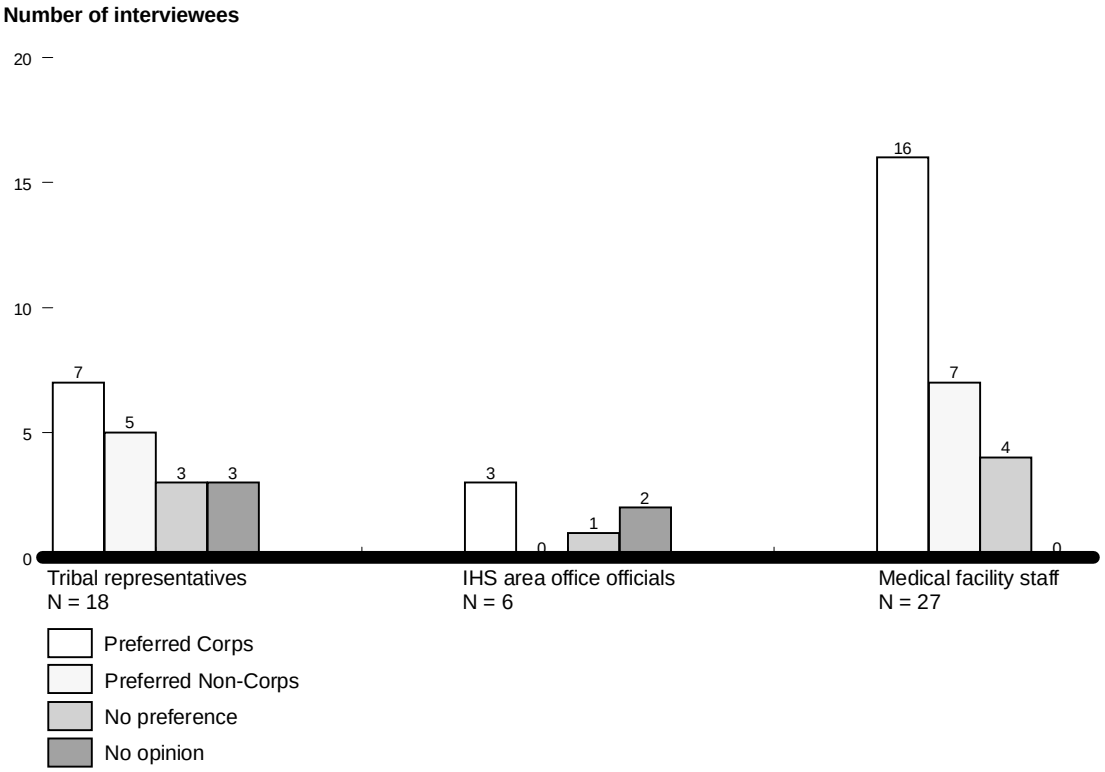
Perceptions: Preferences for Corps or Non-Corps Health Care Providers



Source: GAO interviews.

Perceptions: Preferences for Corps or Non-Corps Health Care Providers

We asked tribal representatives, IHS area office officials, and medical facility staff whether it would make a difference to them if health care providers were Corps or non-Corps if sufficient resources were available to obtain quality medical personnel from any source. Twenty-six of 51 interviewees (including 7 of 18 tribal representatives, 3 of 6 IHS area office officials, and 16 of 27 medical facility staff) said that they would prefer to

have Corps providers. It should be noted that some were unable to exclude cost as a factor in stating their preference. Interviewees preferring the Corps included the President of New Mexico's Jicarilla Apache tribe, and the director of the IHS-run local health center, a Corps officer, who cited work schedule flexibility and not having to compensate officers for overtime work[5] as reasons for their preference. Also, the Vice President, Operations, of the Southeast Alaska Regional Health Consortium (SEARHC) (a tribal direct-hire) and other medical staff, speaking for the Consortium's Mt. Edgecumbe Hospital, said the Corps attracts individuals who are willing to make sacrifices in personal income and lifestyle to deliver quality health care.

Twelve of the 51 interviewees preferred non-Corps providers. These 12 interviewees included the tribal direct-hire Director of Medical Services for the Cherokee Nation of Oklahoma, speaking for the tribally run Nowata Indian Health Clinic, who said tribal direct-hire staff can be offered benefits and incentives that are tied to performance, which serve to increase productivity. Also, the director and medical staff of an IHS hospital in New Mexico (civil service employees) said that civil service employees tend to be more willing to work with hospital management to meet hospital needs than are Corps officers because civil service employees are more likely to be local residents who wish to remain in the community.

Eight interviewees had no preference for either Corps or non-Corps providers, and five had no opinion.

[5]Corps officers do not receive extra pay when they work outside the regular 40-hour workweek, while most non-Corps employees are eligible to receive compensation for working more than 40 hours a week.

GAO

Perceptions: Views on Corps' Advantages and Disadvantages

- More interviewees cited advantages than disadvantages
- Advantages: majority of advantages focused on lower personnel costs, Corps professionalism, training, and commitment
- Disadvantages: centered on officers' medical availability (rotations, assignments to nonclinical positions)

Perceptions: Views on Corps' Advantages and Disadvantages

We asked tribal representatives, IHS area office officials and medical facility staff for their perceptions of the advantages and disadvantages of having Corps officers as health care providers. Advantages were cited by 47 of 51 interviewees, including 14 of the 18 tribal representatives. Interviewees most commonly cited as an advantage reduced costs to the facilities, such as not having to pay overtime for Corps officers.[6] Interviewees also cited Corps officers' professionalism, training, and

[6]Interviewees were not asked about costs to the government. Our May 1996 report elaborated on such costs.

commitment as an advantage. For example, a group of civil service staff and Corps officers representing the IHS hospital and clinic in Sells and Santa Rosa, Arizona cited Corps officers' professionalism and savings in overtime pay. The Chairman of the Tohono O'odham Nation in Arizona cited officers' professionalism and commitment to service on the reservation. In New Mexico, the president of a Navajo tribal chapter and the directors (civil service employees) and several Corps staff from the IHS medical center and clinic mentioned overtime savings and said that Corps officers serve where they are needed and possess higher levels of expertise than non-Corps staff (e.g., a Corps registered nurse must have a bachelor of science degree in nursing).

Thirty-seven of the 51 interviewees, including 14 tribal representatives, cited disadvantages of Corps officers as health care providers. The disadvantages included limited availability due to shortages and rotations of Corps officers and using officers in positions other than direct medical care. For example, a Corps officer detailed as the Executive Director, Division of Health of the Navajo Nation and the Governor of Santo Domingo Pueblo in New Mexico both said that sometimes rotation of Corps officers disrupts continuity of patient care. Also, leaders of the Acoma Pueblo, Laguna Pueblo, and the Canoncito Navajo tribe in New Mexico expressed the opinion that too many officers are being used in IHS area office management positions rather than being assigned to fill direct health care needs.

GAO

Perceptions: Views on Civil Service Advantages and Disadvantages

- More cited disadvantages than advantages
- Advantage: good source for recruiting medical personnel
- Disadvantages: difficult personnel system to manage, cost of overtime compensation

Perceptions: Views on Civil Service Advantages and Disadvantages

Asked about their perception of civil service employees as health care providers, more interviewees—tribal representatives, medical facility staff, and IHS area office officials—cited disadvantages than cited advantages.

Twenty-eight of the 51 interviewees cited a variety of advantages of the civil service personnel system, including its value as a potential source of medical staff. For example, the Principal Chief of the Creek Nation in Oklahoma said the civil service is regarded as a promising recruiting ground, especially for registered nurses.

Thirty-eight of the 51 interviewees cited disadvantages, including difficulty in administering the civil service personnel system and the costs incurred by compensating employees for overtime work. For example, in Alaska, officials of the Yukon-Kuskokwim Health Corporation said paying overtime was a disadvantage; representatives of the Maniilaq Association cited personnel system complexity and overtime as negatives; and spokespersons for SEARHC said the system was administratively complex and would not be considered for filling vacancies.

GAO

Perceptions: Views on Tribal Direct-Hire Advantages and Disadvantages

- Many interviewees had no experience with tribal direct-hire
- Principal advantage: tribal ability to manage personnel independent of IHS
- Disadvantages: high personnel costs and lower quality personnel

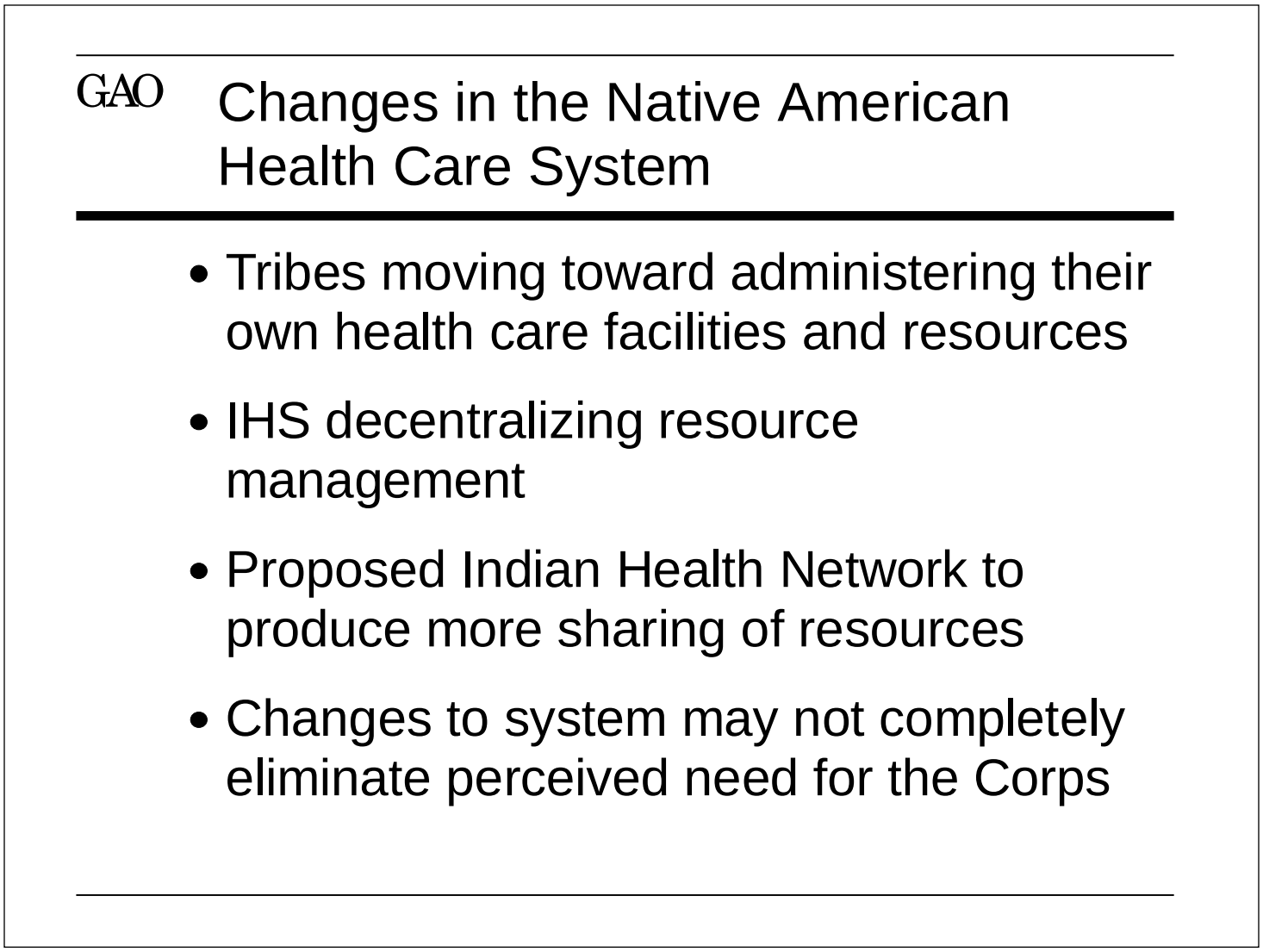
Perceptions: Views on Tribal Direct-Hire Advantages and Disadvantages

Many interviewees were generally unfamiliar with tribal direct-hiring. (About 40 percent of the 51 tribal representatives, medical facility staff, and IHS area officials were not knowledgeable about tribal direct-hiring and the advantages or disadvantages of this personnel system.)

Twenty-six interviewees cited advantages of tribal direct-hire, primarily the independence and flexibility it gives tribes in managing personnel, independent of IHS. For example, officials of the Choctaw Nation in Oklahoma said that hiring directly enables a tribe to be flexible and competitive in salary negotiations. Officials of the Southeast Alaska Regional Health Consortium (direct-hire personnel and a Corps officer) said that work schedules for direct-hire employees can be adjusted to meet individual needs and salaries can be adjusted to offer incentives in high cost areas.

Twenty-two interviewees cited disadvantages to tribal direct-hire; 15 cited high personnel costs and 10 cited lower quality of personnel. Specifically, the Choctaw Nation officials said that directly hired providers came with high salary and relocation costs and were relatively lacking in medical experience and dedication to Native American health care. Officials at the Maniilaq Association in Alaska, who themselves were tribal direct-hire employees, told us they prefer to directly hire medical personnel; however, getting such personnel was sometimes difficult and costly due to the remote location of the medical facility.

Changes in the Native American Health Care System



Changes in the Native American Health Care System

The Native American health care system is undergoing large-scale change. Tribal governments are increasingly moving toward assuming control of health care facilities and resources. In 1994, 32 percent of the total IHS budget was under the control of tribal governments or Alaska Native health care associations. IHS projects that by 1999, the tribally controlled part of the budget may be as high as 57 percent.

IHS itself plans significant structural change in the near future. An Indian-health design team, appointed by IHS' Director and composed

mostly of tribal representatives, recommended in November 1995 and February 1997 reports that IHS functions be decentralized, with managerial and resource allocation decisions being made at the facility level. The report also recommended the establishment of an Indian Health Network, which would interconnect medical facilities using advanced communication technology, thus enabling tribes and IHS facilities to share health care resources. Senior IHS officials said that these recommendations have been accepted and are in the process of being implemented.

While these changes in the system may reduce the need for Corps and civil service health care providers, they may not eliminate the perceived need entirely. Some tribes in the Albuquerque and Oklahoma IHS areas that have assumed control of tribal health care or plan to do so want to hire providers directly rather than use Corps officers or IHS civilian personnel. An official of the Navajo Nation, which plans to take over control of health care in the next several years, said that as Corps or civil service providers leave, they will be replaced by directly hired personnel. On the other hand, officials of Alaska Native associations, which have been managing Native health care for some years, told us they continue to need Corps officers for some difficult-to-fill health care positions.

Objectives, Scope, and Methodology

In March 1996, the Chairman, Senate Committee on Indian Affairs asked us to review the role of the Public Health Service (PHS) Commissioned Corps in the Indian Health Service (IHS). As agreed with the Committee, we did our field work in the states of Alaska, Arizona, New Mexico, and Oklahoma. Our objectives were to provide information on

- Corps officers' historical involvement in providing health care to Native Americans;
- the extent of nationwide participation in Native American health care by Corps officers and non-Corps providers in fiscal year 1996;
- how health care provider vacancies were filled in the locations we visited—sections of Alaska, Arizona, New Mexico, and Oklahoma—and the number of such vacancies filled by Corps officers;
- how tribal representatives, IHS officials, and medical facility staff in the locations we visited perceived Corps and non-Corps providers and their perceptions of the potential effects that converting Corps officers to civil service status might have on Native American health care;
- changes in the Native American health care system that might affect those providing health care to Native Americans, whether Corps or non-Corps personnel.

To gather information on the history of PHS Corps officers' involvement in providing health care to Native Americans, we obtained and reviewed PHS and IHS documents and historical material.

To provide information on the extent of participation of Corps and non-Corps providers in Native American health care in fiscal year 1996, we obtained and reviewed nationwide data on the number of employees in health care professions working in the IHS or directly hired by tribes. The professions we focused on were physician, registered nurse, dentist, pharmacist, engineer, and sanitarian, because these professions were comparable between IHS and tribal direct-hire personnel and were substantially represented in the Native American health care system. Using IHS' personnel database as of September 30, 1996, we identified the number of Corps officers working in IHS. Using the database and a table of equivalent civil service job series given us by the Office of the Surgeon General in our previous work on the PHS Commissioned Corps,[1] we determined the number of civil service personnel in IHS working in the same professions as Corps officers. The information provided in this report includes both full-time and part-time employees. Further, we did

[1]Federal Personnel: Issues on the Need for the Public Health Service's Commissioned Corps (GAO/GGD-96-55, May 7, 1996).

not differentiate between experience or levels of responsibility within the selected professions. For example, the information in this report includes both supervisory and nonsupervisory personnel in each profession.

Because IHS does not maintain data on the number of health professionals that are hired directly by the tribes, we supplemented the IHS data by sending a data-collection instrument nationwide to IHS area offices, requesting data as of June 30, 1996, on health care providers directly hired by tribes and Alaska Native health associations. We received the returned instruments from all IHS area offices between July 1996 and February 1997. We did not verify the accuracy of IHS' personnel database, the civil service equivalency tables, or the responses to our data collection instrument.

To determine the tribes and medical facilities to visit in the requested states, we obtained and reviewed information on tribal populations, patient workloads, and geographic locations. Using this information and logistical considerations, we judgmentally selected for review a sample of tribes and medical facilities that offered variety in size and geographic location. Our selection included 18 tribes and Alaska Native associations and 27 medical facilities.

To determine how selected health-provider vacancies were filled in the areas we visited and whether any of these vacancies were reserved for Corps officers, we requested, at each facility we visited, information concerning current and recently filled vacancies for physicians, dentists, registered nurses, pharmacists, sanitarians, and engineers. We received information from 20 facilities on 239 vacancies in these 6 professions, 139 of which were filled during the period July 1, 1995, to June 30, 1996, and 100 of which remained unfilled at the time of our visits (from August through November 1996).

We obtained interviewees' perceptions on the use of Corps and non-Corps health care providers and on the potential effects of converting Corps officers to civil service status by interviewing representatives of tribes served by the medical facilities we visited, IHS officials at the IHS regional area offices for the four states in our review, and staff of the medical facilities. We interviewed representatives of 15 tribes and 3 Alaska Native health associations. (App. III identifies the tribes and associations we visited.) For each of the tribes and associations we visited, we attempted to speak with the official leader of the tribe or the association (i.e., the governor, president, or chief) or the tribal or association official responsible for health care and, if possible, with both. For 14 tribes, we

met with a tribal official (i.e., the governor, president, or chief). The spokesperson for the other tribe was a Corps officer. For the three Alaska Native associations, we met with the president, vice president, or executive director.

In most of our meetings with tribal representatives, medical facility representatives, or IHS regional area office officials, other associates or staff were also present to assist the representative in answering our questions. In all, we held 40 interview sessions, 25 of which were attended by more than one person. In 10 of the 25 sessions, we met with both tribal and medical facility representatives or representatives from more than 1 medical facility; in these sessions, we received viewpoints from more than 1 representative. In 6 of the 25 sessions, tribal representatives were present with IHS staff—either Corps officers or civil service employees, or both. We do not know what effect, if any, group composition had on the views expressed in the interview sessions. Although the 40 sessions contained more than 51 attendees, we considered 51 as the number of interviewees because they were the spokespersons during the interviews, and thus our key interviewees for purposes of counting responses—18 tribal representatives, 6 IHS area office officials, and 27 medical facility representatives.

We then reviewed and summarized responses to interview questions. For some items, we were able to develop a set of categories for characterizing interviewees' responses. In those instances in which we classified answers into response categories, all classifications were reviewed to ensure the appropriateness and completeness of the categorizations. As requested, we gathered interviewees' perceptions of those providing health care to Native Americans. We did not attempt to corroborate information we were given in our interviews.

We obtained information on changes in the Native American health care system that might affect Corps and non-Corps health care providers by interviewing senior IHS officials at IHS headquarters in Rockville, MD, and reviewing IHS documents. We also interviewed the Chair and Executive Director of the National Indian Health Board, which is a Native American advisory committee to IHS, and reviewed the reports of an Indian-health design team, a group of tribal leaders and IHS officials formed to prepare a plan for the restructuring of Native American health care.

We provided a draft of this briefing report to the Secretary of HHS for review and comment. HHS' written comments are summarized and evaluated on pages 5 and 6 and are presented in full in appendix II.

We did our audit work between May 1996 and July 1997, in accordance with generally accepted government auditing standards. A list of the sites at which we did audit work appears in appendix III.

Comments From the Department of Health and Human Services

DEPARTMENT OF HEALTH & HUMAN SERVICES — Office of Inspector General

Washington, D.C. 20201

JUL 29 1997

Mr. L. Nye Stevens
Director, Federal Management
and Workforce Issues
United States General
Accounting Office
Washington, D.C. 20548

Dear Mr. Stevens:

Enclosed are the Department's comments on your draft report, "Federal Personnel: Public Health Service Commissioned Corps Officers' Health Care for Native Americans." The comments represent the tentative position of the Department and are subject to reevaluation when the final version of this report is received.

The Department appreciates the opportunity to comment on this draft report before its publication.

Sincerely,

Michael Mangano
for June Gibbs Brown
Inspector General

Enclosure

The Office of Inspector General (OIG) is transmitting the Department's response to this draft report in our capacity as the Department's designated focal point and coordinator for General Accounting Office reports. The OIG has not conducted an independent assessment of these comments and therefore expresses no opinion on them.

COMMENTS OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES (HHS)ON THE U.S. GENERAL ACCOUNTING OFFICE'S DRAFT REPORT, "FEDERAL PERSONNEL: PUBLIC HEALTH SERVICE COMMISSIONED CORPS OFFICERS' HEALTH CARE FOR NATIVE AMERICANS"

General Comments

Based on interviews with Indian Health Service (IHS) area office officials, tribal representatives, and medical facility staff, the GAO report concludes that officers of the Commissioned Corps (Corps) of the Public Health Service (PHS) have been and continue to be an integral part of the delivery of health care services to American Indians and Alaska Natives (AIs/ANs). In addition, a majority of interviewees cited more advantages than disadvantages in having Corps officers provide health care, and most interviewees said that converting Corps officers to the civil service personnel system would have a negative impact on health care.

We concur with these GAO findings. Corps officers have played a vital role in the delivery of health care services to AIs/ANs populations for more than 70 years. Many of the health status indices of AIs/ANs have improved dramatically since the health care responsibilities were transferred from the Department of the Interior to the Department of Health, Education, and Welfare (now HHS) in 1955. For example, the IHS 1996 Trends in Indian Health reported that (1) infant mortality dropped from 62.7 deaths per 1,000 live births in 1955 to 8.8 deaths per 1,000 in 1992, and (2) tuberculosis deaths dropped from 253 deaths per 100,000 population in 1955 to 19 deaths per 100,000 in 1992. A wide array of Corps health professionals were employed in those years, including medicine, dentistry, nursing, pharmacy, social work, engineering, sanitation, and other health disciplines. They all contributed to a vital public health perspective. Also, most of the leadership positions at IHS headquarters, area offices, and service units have been led by Corps officers in the early years. Corps leadership has continued into the present.

In addition to ongoing efforts to protect and enhance the health care of AIs/ANs, IHS personnel, including Corps officers, have worked diligently over the years to expand self-determination among tribes and tribal organizations. Efforts in this area have shown great progress as more AIs/ANs than ever before are now fully trained health professionals and more tribes than ever before are administering their own health care programs.

We believe the progression toward tribal self-determination will continue. However, as the GAO findings seem to indicate, Corps officers will continue to play a vital role in providing health care services and consultation to AIs/ANs. There are currently

over 450 Corps officers assigned to tribal health care facilities under Memorandums of Agreement (MOA). This supports the GAO finding of a general tribal preference to utilize Corps officers, if health care positions can not be filled with local tribal hires.

The Department concurs with the GAO findings that tribal respondents to GAO's survey had a generally favorable view of Corps officers' skills, dedication, and professionalism. Tribes want the option, if needed, to be able to obtain Corps officers through MOAs. The current use of Corps officers on detail to tribes is an indicator of tribal choice on the subject.

Technical Comments

Text modified.
See p. 1.

Page 2, paragraph 1, sentence 4 & 5

Percentages are not mentioned on this page, but later the Corps is usually listed as 16 percent of the total IHS workforce rather than being 35.1 percent of the IHS health care providers. If the report is addressing views on what would happen to health care if the Corps were converted to civil service, focus should be made on the health care provider segment. It is recommended that the Fiscal Year 1996 data be addressed in the following fashion:

> "Fiscal Year 1996 data show that the IHS employed 6,664 health care providers, both Corps and civil service, out of a total workforce of 14,1613 (45.6%). The Corps health care providers numbered 2,339; while this represented 16 percent of the total workforce, it was 35.1 percent of the health care providers."

See comment 1.

It is further recommended that later comparisons in the report focus on the Corps and civil service health care providers component. Since the Corps consists only of officers, who are in health care or related professions, and there are no "enlisted" personnel, the officers should be compared directly with their counterpart civil service professionals. To make a comparison with a larger, mixed group of professionals and nonprofessionals would detract from a central question in the report.

See comment 2.

Page 2, paragraph 2, sentence 1:

Since Congress created the PHS Commissioned Corps as one of the uniformed services, this sentence should be revised to read:

> "The PHS Commissioned Corps is a uniformed service with mobility requirements and rank structure that are comparable to the officer components of the Armed Forces."

Text modified.
See p. 2.
See also comment 3.

Page 2, paragraph 2, sentence 2:

The PHS Commissioned Corps was established in 1871 under the regulatory authority of the Department of the Treasury. The Corps was modeled after the military, with Corps officers having a rank structure based on that of the military services. The Corps was officially authorized by an act of Congress on January 4, 1889. **Thus, the basic rank structure for the Corps was established long before World Wars I and II.**

Prior to 1949, each of the uniformed services had separate pay authorities that created confusion and inequities among the services. The purpose of the Career Compensation Act of 1949 (Public law 81-351, enacted October 12, 1949) was "...to establish for the uniformed services a compensation pattern which will tend to attract and retain first-class personnel in the armed services, Coast Guard, Coast and Geodetic Survey, and the Public Health Service." The legislative history of the Career Compensation Act of 1949 does not suggest that the Public Health Service was being included because of its activities during the World Wars. Rather, the 1949 Act and subsequent laws clearly indicate that PHS officers have been extended military pay and allowances based on the fact that the Public Health Service is a uniformed service with a special, separate, and unique mission to protect and enhance the Nation's health status.

Thus, this sentence should be revised to read:

> "All Corps officers are health professionals whose pay and allowances are the same as those of the Armed Forces as authorized pursuant to Title 37 of the United States Code."

Text modified.
See p. 2.

Page 2, paragraph 2, sentence 3:

The Uniform Code of Military Justice (UCMJ) is a statutory code of conduct for the members of the Armed Forces. The UCMJ contains a lengthy list of various types of misconduct and sets forth both administrative and criminal sanctions to be imposed against those who are found guilty of misconduct. The UCMJ is not a management tool that is used to recruit, train, deploy, or retain military personnel. Moreover, at the current time, Armed Forces officers who do not have contractual obligations may voluntarily leave the military under conditions equivalent to their counterparts in the PHS Commissioned Corps.

Thus, this sentence should be revised to read:

> "Corps officers wear uniforms similar to those worn in the U.S. Navy, but with distinctive Public Health Service insignia. When detailed to one of the Armed Forces such as the Coast Guard, Corps officers are subject to the Uniform

Code of Military Justice (UCMJ), which governs the conduct and discipline of Armed Forces members. The Corps itself is not subject to the UCMJ, except as directed by the President in time of war."

Now on p. 2, para. 3.
See comment 4.

Page 5, paragraph 1, last sentence

We recommend either deleting this sentence or adding the following statement after a semicolon:

"The percentage of Corps officers among health care providers was higher and averaged . . ."

Now on p. 2, para. 4.
See comment 5.

Page 5, paragraph 2, sentence 3:

We recommend removing *sanitarians* from this sentence, since IHS corrected February 1997 data show a majority of sanitarians are in the Corps, i.e., 140 officers (83.3%) and 28 civil servants (16.7%).

Text modified.
See p. 15, footnote 1.

Page 15, paragraph 2, last sentence:

To capture differences as well as similarities, we recommend adding a third sentence:

"However, while the Corps requires all of its officers to have baccalaureate or higher degrees in order to be commissioned, the civil service does not require nurse or sanitarian applicants at the entry level to possess a college degree."

Now on p. 15.
See comment 6.

Page 15, paragraph 3:

This paragraph restates some of the same language commented upon on page 2 above. In addition, the last sentence of this paragraph states that: "However, as we reported in May 1996, Corps officers did not meet the criteria set forth in a DOD report as justification for military compensation."

The Department submitted a strong and comprehensive rebuttal to this conclusion, which was contained in GAO's May 1996 report regarding the Corps. Therefore, we recommend that this statement be amended to show clearly that this conclusion was the opinion of GAO.

Based on the comments set forth above, we recommend that paragraph 3 on page 15 be revised as follows:

"Corps officers have ranks equivalent to those of U.S. Navy officers and wear Navy-style uniforms with distinctive Public Health Service insignia. Corps officers also receive

the same pay and allowances as military officers pursuant to Title 37 of the United States Code. Unless detailed to one of the Armed Forces such as the Coast Guard or ordered by the President in time of war, Corps officers are not subject to the Uniform Code of Military Justice, which governs the conduct and discipline of Armed Forces members.

The PHS Commissioned Corps was last militarized during the Korean Conflict. In 1996, there were approximately 160 Corps officers detailed to the Coast Guard. Based on a review of the Corps, a May 1996 GAO report concluded that Corps officers did not meet the criteria set forth in a Department of Defense report as justification for military compensation. The Department of Health and Human Services did not concur with this conclusion."

Text modified. See p. 17.

Page 17, paragraph 2, sentence 4 & 5:

To truly capture the breadth of the IHS, one must appreciate that it includes programs that are not necessarily facility-based; likewise, tribes may contract or compact an IHS program without taking over a facility. The following word changes would help to capture this aspect. In sentence 4, we recommend that *medical facilities* be changed to *comprehensive health programs*. In sentence 5, we recommend adding *and public health programs* after *IHS facilities*.

Text modified. See p. 20.

Page 20, figure 6, bullet #1:

We recommend inserting *health programs/* before *medical facilities*.

Text modified. See p. 21.

Page 21, paragraph 1, sentence 1:

We recommend inserting *health programs, including* before *medical facilities*.

Text modified. See p. 23.

Page 23, paragraph 1, sentence 4:

We recommend replacing this sentence with:

"The IHS was a bureau in the Health Services Administration, which later merged into the Health Resources and Services Administration of PHS until 1988 when the IHS became a separate agency."

Chart modified. See p. 26.

Page 26, figure 9, last data set:

Correct *sanitarian percentages* reported on page 5 above; the 83.3 percent for Corps officers and 16.7 percent for civil service

would be altered slightly, when the GAO factors in the tribal sanitarians from their data.

Page 27, paragraph 1, sentence 2:

Remove reference to *sanitarians*.

Page 29, footnote #5:

We recommend rewording to say:

"In accordance with Title 25, U.S. Code 472, IHS personnel rules require that Indian Preference be applied in initial hires and promotions, i.e., that an AIs/ANs candidate must be selected, if one or more qualified AIs/ANs make the selection panel."

Page 35, footnote #6:

Replace *some* with *most*.

Text modified.
See p. 27.

Now on p. 29.
See comment 7.

Text modified.
See p. 35, footnote 5.

GAO Comments

1. We believe our analysis appropriately compares Corps officers in six key health care professions with their counterparts among federal civil service employees. We based our analysis on an equivalency table supplied by PHS for civil service employees, which we modified based on discussions with IHS to exclude two job series which did not include health care providers. Based on this modification, we reduced the number of civil service sanitarians in our workforce data, which in turn reduced the total number of IHS health providers from 6,664 to 6,306.

2. Although Corps officers have a rank structure comparable to Navy officers, we do not agree that the Corps' mobility requirements are comparable to the armed forces. According to PHS officials whom we spoke to in our 1996 review of the PHS Corps, Corps officers have a degree of control over whether or when they will relocate, since many positions in PHS are filled by taking applications and interviewing applicants. Corps officers can therefore choose whether or not to apply for a position. In addition, we were told by a PHS official that Corps officers in most PHS agencies do not relocate regularly and that many officers stay at one geographic location throughout all or most of their careers. We therefore do not believe it would be accurate to say that the PHS Commissioned Corps has mobility requirements comparable to the officer components of the armed forces.

3. We modified our report language concerning title 37 of the U.S. Code along the lines suggested by HHS. However, we disagree with HHS' background information concerning the history of the PHS Corps' rank structure. It is true that the PHS Corps had a rank structure prior to World War I. However, at that time the only ranks used were nonmilitary and medically related (i.e., Surgeon General, Assistant Surgeon General, surgeon, assistant surgeon, etc.). PHS ranks were explicitly made equivalent to military ranks by the Joint Service Pay Act of 1920. The legislative history of this act indicates that this action was taken because of Corps officers' service in the military during World War I.

4. We could not calculate the percentage of Corps officers among health care providers from 1978 to 1996, as suggested by HHS, because data was not readily available on tribal direct-hire providers during that same period. Thus, as in our draft report, we were only able to include the percentage of Corps officers among total health care providers during 1996, using data provided directly by the tribes and associations at our request.

5. After discussions with IHS officials, we revised the letter and section II of the briefing document to reflect a lower number of civil service sanitarians. We used revised data as of fiscal year 1996, however, in order to portray all six professions as of the same date.

6. We modified page 15 of our report to indicate that it was our opinion that the Corps did not meet the criteria for military compensation as set forth in the DOD report and that HHS disagrees. However, we did not fully incorporate HHS' suggested language because its essence was already contained in this report.

7. In our draft report, we stated that the nonuse of competitive selection in filling some vacancies was in part due to Indian Preference. HHS suggested that we clarify our definition of Indian Preference. We reviewed our vacancies data after receiving the comments and found that only one filled vacancy involved a candidate with Indian Preference; while this candidate was the only one considered, a competitive selection process was in fact used for this vacancy. We have accordingly revised our report to indicate that one additional vacancy was filled using competitive selection, and we have removed the textual references to Indian Preference and the explanatory footnote.

Audit Work Locations

Alaska

Alaska Area IHS Office, Anchorage
Maniilaq Medical Center, Kotzebue
Maniilaq Association, Kotzebue
SouthEast Alaska Regional Health Consortium (SEARHC), Juneau
SEARHC Health Center, Ketchikan
SEARHC Mt. Edgecumbe Hospital, Sitka
Yukon-Kuskokwim Health Corporation, Bethel
Yukon-Kuskokwim Hospital, Bethel

Arizona

Bylas Health Center, San Carlos
Gila River Health Care Corporation, Sacaton
Hu Hu Kam Memorial Hospital, Sacaton
Navajo Area IHS Office, Window Rock
The Navajo Nation, Window Rock
Navajo Nation Council, Health & Social Services Committee, Window Rock
Phoenix Area IHS Office, Phoenix
San Carlos Apache Tribe, San Carlos
San Carlos PHS Indian Hospital, San Carlos
Santa Rosa PHS Indian Health Center, Sells
Sells PHS Indian Hospital, Sells
Tohono O'odham Nation, Sells
Tucson Area IHS Office, Tucson
Winslow PHS Indian Health Center, Winslow

Washington, D.C.

National Indian Health Board[1]

Maryland

IHS Headquarters, Rockville

New Mexico

Acomita Canoncito Laguna PHS Indian Hospital, San Fidel
Albuquerque Area IHS Office, Albuquerque
Albuquerque Area Indian Health Board, Inc., Albuquerque
Canoncito Navajo Chapter, Canoncito
Dulce PHS Indian Health Center, Dulce
Dzilth-Na-O-Dith-Hle PHS Indian Health Center, Bloomfield
Huerfano Navajo Chapter, Bloomfield
Jicarilla Apache Tribe, Dulce
New Sunrise Regional Treatment Center, San Fidel

[1]Officials of the National Indian Health Board were interviewed in Washington, D.C.; the offices of the Board are located in Denver, CO.

Northern Navajo Medical Center, Shiprock
Pueblo of Acoma, Pueblo of Acoma
Pueblo of Jemez, Jemez Pueblo
Pueblo of Laguna, Laguna
Pueblo of Sandia, Bernalillo
Pueblo of Zuni, Zuni
Ramah Navajo School Board, Inc., Pine Hill
Santa Fe PHS Indian Hospital, Santa Fe
Santo Domingo Pueblo, Santo Domingo
Taos ~ Picuris Indian Health Center, Taos
Taos Pueblo, Taos
Zuni PHS Indian Hospital, Zuni

Oklahoma

Broken Bow Health Clinic, Broken Bow
Cherokee Nation of Oklahoma, Tahlequah
Chickasaw Nation of Oklahoma, Ada
Choctaw Nation Health Services Authority, Talihina
Choctaw Nation of Oklahoma, Durant
Claremore Indian Hospital, Claremore
Creek Nation Community Hospital, Okemah
Creek Nation of Oklahoma, Okmulgee
Eufaula Health Center, Eufaula
Nowata Primary Health Care Clinic, Nowata
Oklahoma City Area IHS Office, Oklahoma City
Sapulpa Health Center, Sapulpa
Wilma P. Mankiller Health Center, Stilwell
W.W. Hastings Indian Hospital, Tahlequah

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