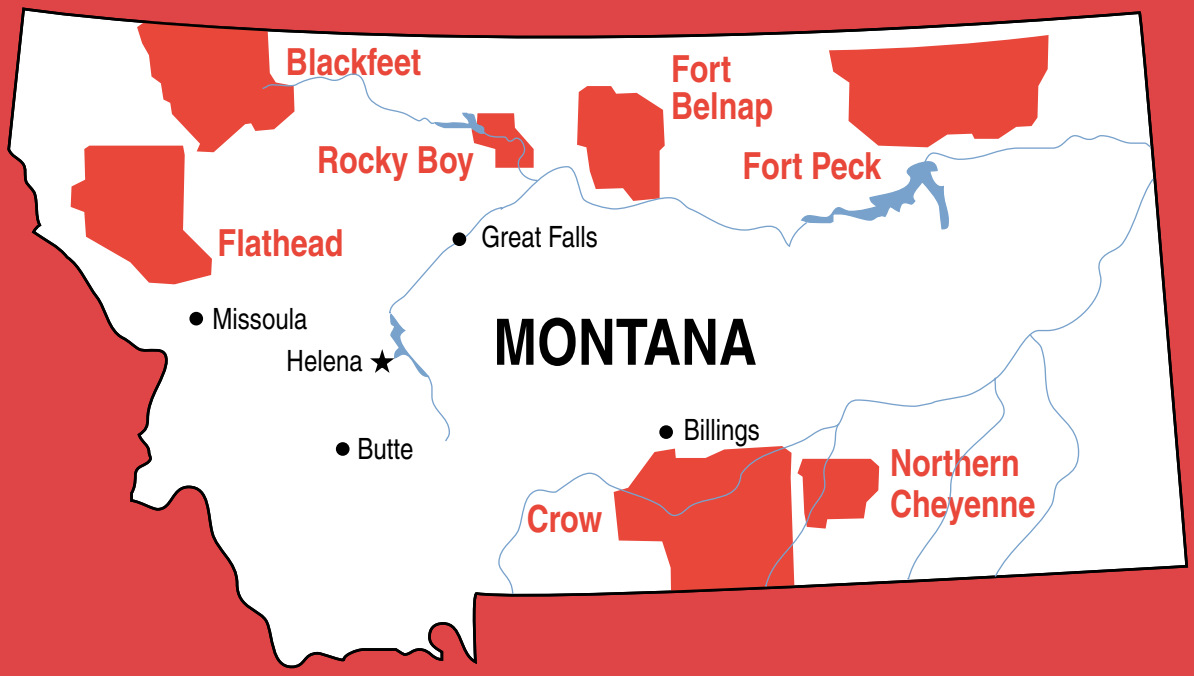

Living Sicker, Dying Younger

Montana's Indian People Suffer from Inadequate Healthcare

By Dana Warn

Northwest Federation of Community Organizations (NWFCO)

Montana People's Action / Indian People's Action

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Executive summary

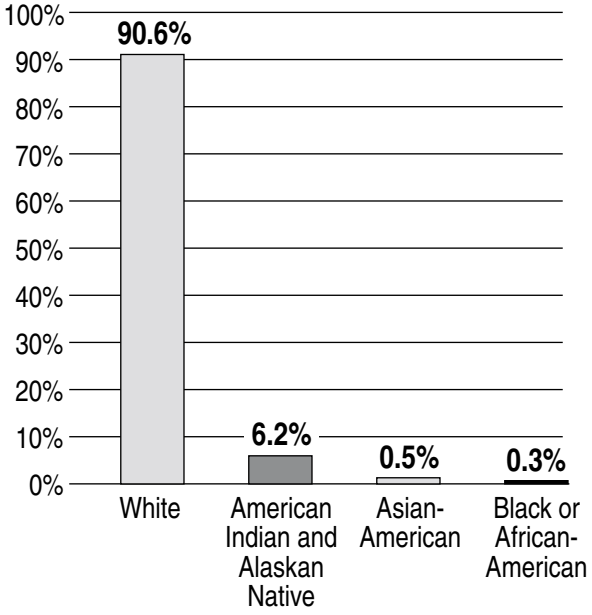
Montana's Indian people have poorer health, higher disease rates, lower life expectancy and greater difficulty obtaining healthcare than other Montanans. Nearly 40 percent of American Indian Montanans are uninsured. Many are ineligible for Indian Health Services (IHS) because they do not live on a reservation and/or are not a member of a federally recognized tribe. And the American Indian Montanans who do have access to IHS do not receive comprehensive healthcare; they must deal with severe underfunding and understaffing, as well as long wait lists and rationed care. Many Indian people are unable to receive needed care.

The Medicaid program is a key component in improving access to healthcare for American Indian Montanans. Over 23 percent of American Indians in Montana rely on the Medicaid program. Cuts to Montana's Medicaid program impact Indian people who receive IHS care, as well as urban Indians. And strengthening Medicaid will benefit Montana's Indian people. Right now, Montana has the opportunity to keep Medicaid strong by investing already available federal fiscal relief funds. By investing in Medicaid, Montana can help strengthen public healthcare programs and reduce the dramatic health disparities Indian people face in Montana.

Living sicker, dying younger

According to the 2000 Census, American Indians and Alaskan Natives make up over 6 percent of Montana's population. The remaining population is over 90 percent white, with Asian- and African-Americans making up less than 1 percent of the population, and Hispanic people of any race comprising 2 percent.[1] The over 66,000 American Indian Montanans[2] live across the state in rural and urban areas that include numerous cities and seven reservations. And they face significant health problems, and difficulties obtaining healthcare.

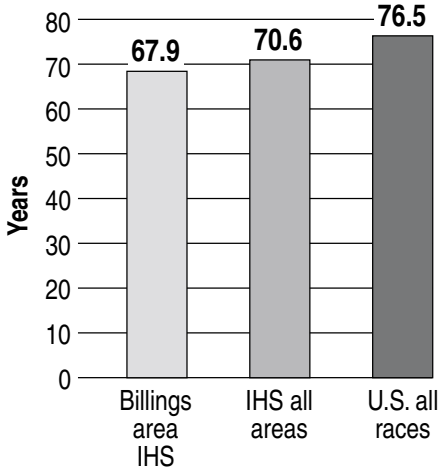
Montana population by race[4]



American Indians and Alaskan Natives have long had poorer health status and significant health disparities for many health measures compared to other Americans. Native Americans rank at or near the bottom of virtually every health indicator and have a lower life expectancy than any other group.[3]

Nationally, the life expectancy of American Indians and Alaskan Natives born today is 70.6 years — almost six years less than the 76.5 year life expectancy of the U.S. population of all races.[5] In the Billings Indian Health Service (IHS) area — which includes Montana and Wyoming — the American Indian life expectancy is well over eight years lower than the U.S. population as a whole, at 67.9 years.[6]

Life expectancy, 1996-1998[7]

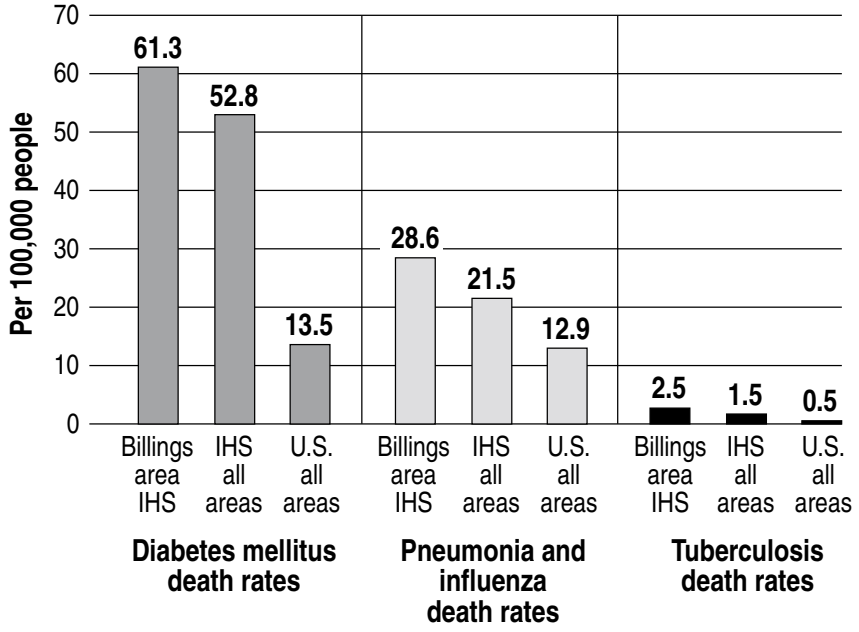


Rates of diabetes and respiratory infections are two to three times higher among American Indians and Alaskan Natives than among the general U.S. population. Nationwide, about 15.3 percent of American Indians and Alaska Natives have diabetes, compared with 7.3 percent for all U.S. adults.[8] In addition to having these illnesses at higher rates, American Indians and

Native Americans rank at or near the bottom of virtually every health indicator and have a lower life expectancy than any other group.

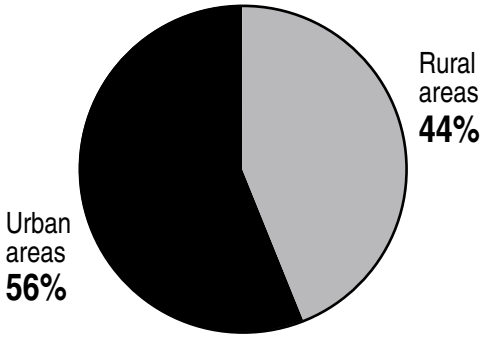
Alaskan Natives, both nationally and in the Billings IHS area, are more likely to die from illnesses including: diabetes, pneumonia, influenza, and tuberculosis.[9] Nationally, Indian people are 650 percent more likely to die from tuberculosis, and 318 percent more likely to die from diabetes than the general U.S. population.[10]

Mortality rates per 100,000 population, 1996-1998[11]



Much of the information on health disparities for American Indians and Alaskan Natives comes from IHS health status data; this information primarily pertains to people who live on or near reservations. But this is far from the full picture: according to the 2000 U.S. Census, 61 percent of American Indians and Alaskan Natives live in urban areas.

Proportion of Montana Indian population in urban areas, 2000[12]



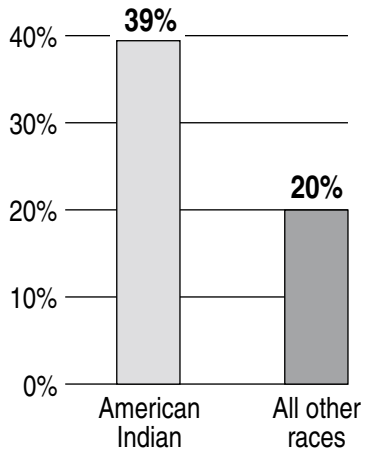
Urban Indian health disparities

Less is known about the health status of urban Indians. The few completed studies suggest that health measures are similar for Indian people who reside on or near reservations, and for those in urban areas.[13] For example, compared with urban whites, urban American Indians and Alaska Natives experience higher rates of low birthweight and infant mortality, higher rates of tuberculosis, higher risk factors for poorer birth outcomes, and higher mortality rates for every age group except the elderly.[14]

No access to healthcare

One of the main reasons for the health disparities experienced by all Native Americans is lack of access to adequate, culturally sensitive health care. The unmet healthcare needs of American Indians and Alaska Natives are among the most severe of any group in the U.S.

Percent uninsured by race, Montana residents 0-64 years old[15]



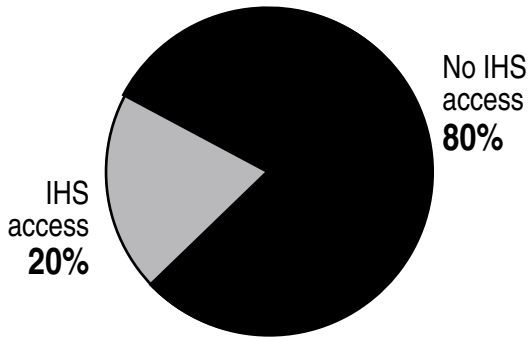
In Montana, as is the case across the U.S., American Indians disproportionately lack access to healthcare. American Indians are more likely to be uninsured than all other groups in Montana.

Greater needs, fewer resources: the Indian Health Service

The Indian Health Service (IHS) is the agency that is supposed to carry out the federal government's trust responsibility to provide healthcare services to American Indians and Alaska Natives. IHS provides services by running clinics and hospitals, contracting with tribes to run these facilities, and by purchasing services not available through its own facilities through the contract health service. In Montana none of the IHS facilities are located in urban areas. The vast majority of IHS' limited resources focus on the needs of American Indians living on reservations in rural areas.

Eligibility for IHS services does not extend to all American Indians; key eligibility criteria include enrollment in a federally recognized tribe, and residency on tribal lands. Eligibility rules limit the population IHS serves to about 1.5 million of the 2.5 million to 4.1 million people who identify themselves solely or partially as American Indian and Alaska Native.[16]

Percent of American Indians/Alaska Natives (Ages 0-64) who report access to Indian Health Services[17]



Eligibility for IHS services does not extend to all American Indians.

People living on reservations with access to IHS facilities have limited access to care due to severe underfunding and understaffing.

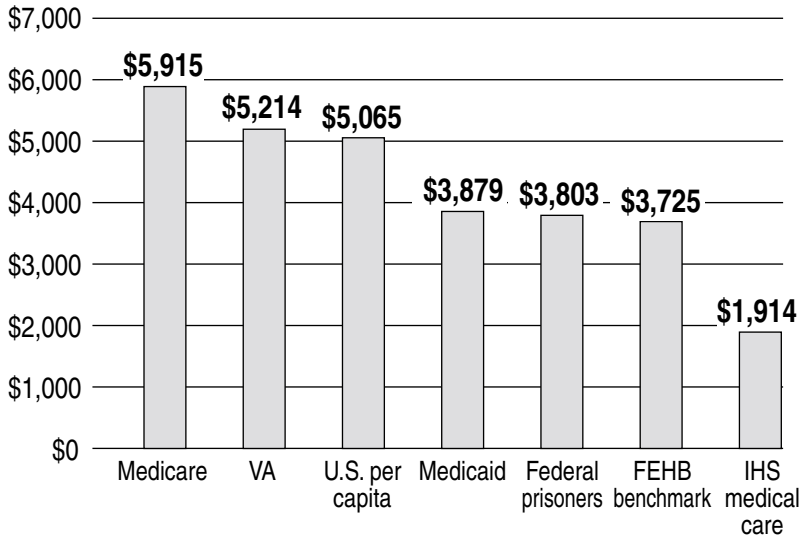
The monetary value of IHS care is significantly less than the average per capita healthcare spending for all Americans. When adjusted for inflation and population growth, IHS spending has fallen over time. Although the population served by the IHS is growing by about 2 percent each year, and medical costs are rising at about 10 to 12 percent a year, the agency's budget has remained nearly flat.[18] IHS operates with an estimated 59 percent of what it needs to provide adequate healthcare.[19]

IHS spends less per capita on its service users than the government spends on any other group receiving public health care — federal prisoners and Medicaid patients each receive more than twice the amount spent on IHS health care.

This disparity is even more drastic considering IHS has higher costs for healthcare due to the increased health problems of the community its serves.[20] And estimates of IHS underfunding do not take into account the unmet needs of urban Indians or other American Indians and Alaska Natives not included in the IHS eligible population.[21]

IHS facilities are lacking or inadequate in numerous locations — the average age of IHS facilities is 32 years, compared to nine years for the U.S. private sector.[22] Many facilities are severely overcrowded. At the current rate of funding for replacement facilities, it will take more than 30 years to fund projects on the IHS facilities construction priority list. And there are insufficient resources for ongoing operation and maintenance of these facilities.[23]

Comparison between IHS appropriations per capita and other health expenditures, 2003[24]



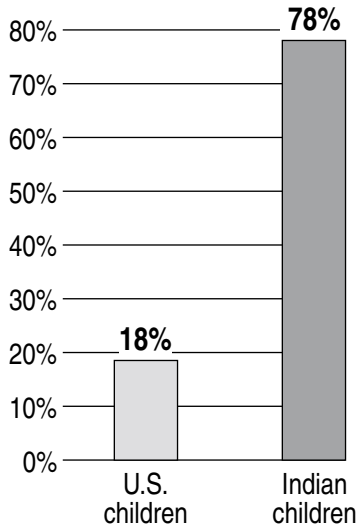
IHS also has severe staff shortages — including critical shortages of nurses, pharmacists, dentists, optometrists, and health technicians.[25] Relative to the general U.S. healthcare system, IHS has approximately half the number of doctors and nurses per person.[26]

Dental care is a good example of the problems people seeking healthcare through IHS face. In 1999, tribal and IHS dental programs were able to provide dental care to only about 25 percent of those who needed care.[27] Dental care is limited in part because of a dental workforce crisis — around 22 percent of the dentist positions in IHS are vacant.[28] In the general U.S. population there is one dentist for every 1,200 people. The IHS rate is much lower; IHS has only one dentist for every 5,000 people.[29] And Indian children are far more likely to have dental decay than the general U.S. population: based on a 1999 IHS survey, 78 percent of Indian children aged two to four years old had a history of dental decay, while less than 20 percent of children aged two to four of the general U.S. population had similar problems.[30]

IHS has severe staff shortages of nurses, pharmacists, dentists, optometrists, and health technicians.

Many services are not available at IHS facilities and are provided at other facilities — such as local hospitals — under the Contract Health Services (CHS) program. These services are severely underfunded as well — almost two-thirds of the needed care for American Indian and Alaska Native families that is

Percent of children aged 2-4 years with a history of dental decay[31]

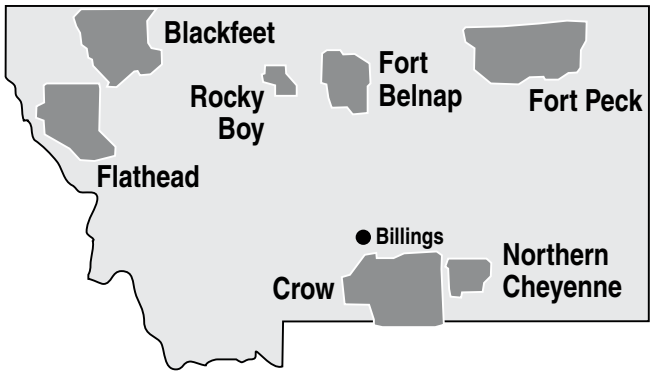


unavailable through IHS or tribal run programs is denied.[32] The program is based on medical priority, so people often must be very ill to receive care. Between 1995 and 1999, there was a 43 percent increase in the denial of CHS care.[33]

IHS facilities in Montana

In Montana, there are IHS service units in each of the following reservations: Blackfeet, Crow, Fort Belknap, Flathead, Fort Peck, Northern Cheyenne, and Rocky Boy. Three of the service units — Blackfeet, Crow, and Fort Belknap — have hospitals that provide inpatient and outpatient care.[35] Generally, eligible tribal members can only access care at the service unit on the reservation that serves the tribe in which they are enrolled.[36]

Map of Montana reservations with IHS service units[34]



IHS facility

IHS unavailable to most urban Indians

Most Indian people living in urban areas of Montana cannot use IHS for their healthcare. IHS is mainly a rural health-care delivery system; in Montana, the hospitals and clinics run by IHS — or by tribes under contract with IHS — are all located on reservations in rural areas.

IHS provides services only to eligible American Indians and Alaska Natives — not all American Indians and Alaska Natives. Important eligibility criteria include: area of residence and tribal membership. These eligibility rules exclude most urban Indians from receiving IHS care.

Eligibility rules exclude most urban Indians from receiving IHS care.

Jane Doe

I have gingivitis and have been getting serious infections in my gums; my gums are so infected that I will likely lose my teeth soon, unless I can get treatment.

My only major health problem is my lack of regular dental care — but the infections in my gums cause me numerous other health problems including vomiting and headaches. It is hard to function, and to take care of my family when I am in so much pain.

Recently, my health problems because of my gum infections were so bad I had to go to the emergency room. I never saw a dentist at the hospital. The doctor gave me antibiotics and pain medication, but I could not get any follow-up treatment.

I do not have access to regular dental care through IHS. The nearest IHS facility I can use is 45 miles away. Because I have lived off of the reservation for over 180 days, the only services I can use there are pharmacy and emergency dental services. Emergency dental services are only provided from 8 a.m. to 9 a.m. on a first-come first-served basis. The line forms early, and often the line is so long everyone does not receive care. Even if I could get regular care, I have no way to get there and back: I have no car, there is no public transportation, and I have no money to pay for transportation, gas, or a babysitter for my four children.

In order to be eligible for IHS services, Indian people generally must be enrolled with a federally recognized tribe, and live on the reservation. In order to be enrolled, a person must be registered with a tribe, which requires showing proof that their lineage is at least one quarter of the tribe in which they are enrolling. A person can only enroll in one tribe. Many urban Indians do not have access to IHS because they are not enrolled members of federally-recognized tribes, and are therefore not eligible for IHS services.[37]

Indian people who are members of federally recognized tribes and live off of reservation lands for a certain period — in Montana, usually 180 days — lose access to IHS care, and must then live on the reservation for a certain period (again, often 180 days) to be eligible again. Policies, services and access differ between reservations and depend on which tribe a person is enrolled in. All of these factors can make navigating the system extremely complicated.

Even if urban Indians did have access to IHS facilities, the extremely long travel distances in areas without any public transit, and the lengthy wait lists for limited IHS care would make using IHS facilities for regular healthcare impossible.

Urban Indian health centers

Nationally, about one percent of IHS resources are directed to a small urban Indian health program that began 20 years after IHS was established. In 2001 this amounted to just under $30,000 nationally.[38]

The purpose of the urban Indian health centers is to make outpatient health services accessible to urban Indians directly or through referral. Non-profit organizations, controlled by urban Indians, provide these services through funds from contracts with IHS and other sources.[39] The actual ser-

Tina Snell

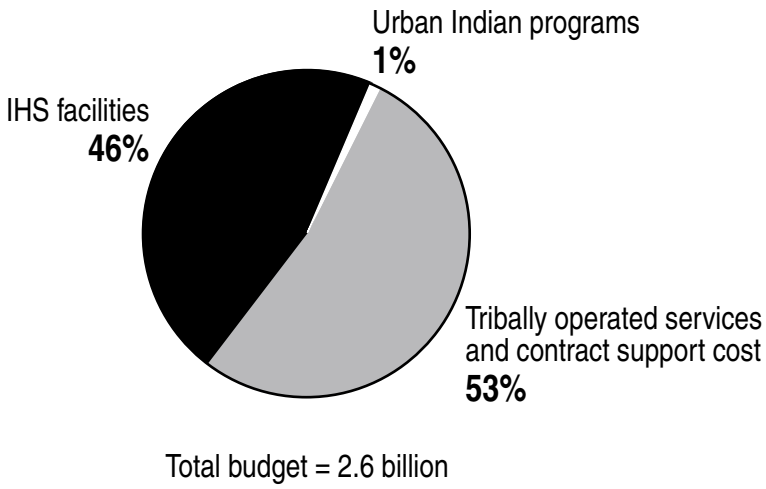
I have numerous health problems including thyroid problems, fibromyalgia and an associated sleeping disorder, acid reflux, and irritable bowel syndrome. I cannot get Medicaid because my husband's income disqualifies us. I have some limited health insurance through my husband's employer. But even with this insurance, I have spent years trying to find a doctor who will help answer questions about my conditions and help me manage the pain.

The copay requirements of my health insurance mean many services are out of reach for me, because I have no way to pay them. I have trouble getting the prescription drugs I need. The Missoula Indian Center is only an outreach and referral center, not a clinic. The center cannot supply any of the medical treatments or prescription medications I need.

I am in an enormous amount of pain and have very little information about my medical problems. I need some answers about my conditions and some pain treatment so I can start to live life again.

vices provided vary widely depending on available funding, and many centers primarily provide referrals. These centers often provide very limited services on a sliding fee basis; none of the centers in Montana are designed or able to provide comprehensive healthcare.

Indian Health Service Budget Allocations[40]

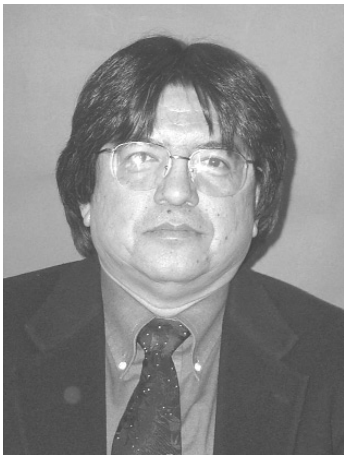


Because of limited funds, urban Indian health centers cannot provide comprehensive healthcare.

Although the urban Indian population is increasing dramatically, funding for urban Indian health programs has remained around one percent of IHS's budget since 1979.[41] These programs are severely underfunded as they try to meet some of the needs of a growing urban Indian population.

Montana's urban Indian health centers

The Billings area IHS contracts with five non-profit corporations to provide varying levels of health care services to Indians living in Billings, Butte, Great Falls, Helena, and Missoula urban areas. Three of



Ralph Forquera, MPH
Executive Director, Seattle Indian Health Board
Director, Urban Indian Health Institute

In Montana and nationally, urban Indians have a difficult time getting the health care they need. Congress continues to allocate just 1 percent of the Indian Health Service budget annually to serve urban Indians that now represent more than 60 percent of Indians in the U.S. Only about half of the 34 Indian run organizations that receive funding from the IHS provide direct medical care; and even the largest urban providers offer only primary care medicine, a long way from the comprehensive services needed.

The nation as a whole is struggling with escalating health care costs and declining insurance benefits. Having Medicaid and Medicare helps. State cuts in Medicaid will further reduce access to health care for many urban Indians. Imposing premiums and co-payments will force many to delay seeking care and prevent buying needed prescription drugs.

As costs rise, fewer and fewer doctors can afford to provide health services for those who cannot pay. For this reason, urban Indian health programs are more important than ever. Urban Indian health programs can help Indian people enroll in Medicaid and Medicare as well as help find providers who will care for clients with this coverage. Medicaid is a critical resource for low income Indians, especially women and children. Cuts in state Medicaid programs will directly effect urban Indians and will perpetuate the health disparities that Indian people face in Montana and elsewhere.

the urban programs, in Billings, Great Falls, and Helena, provide limited primary medical care services, in addition to outreach and referral, health education, transportation, limited mental health services, and substance abuse counseling services. The other two programs, in Butte and Missoula, provide outreach and referral, health education, transportation, and substance abuse treatment.[42]

Specific services vary between clinics. Because of limited funds, these programs must focus on acute problem-focused healthcare, rather than preventative care; they cannot provide comprehensive healthcare. Some clinics mention problems providing enough services. For example, very little dental care or prenatal care is available through Montana's urban Indian clinics. And many of the clinics only operate a few days a week. For example, the Billings clinic offers a medical clinic that is open three half days each week.[43]

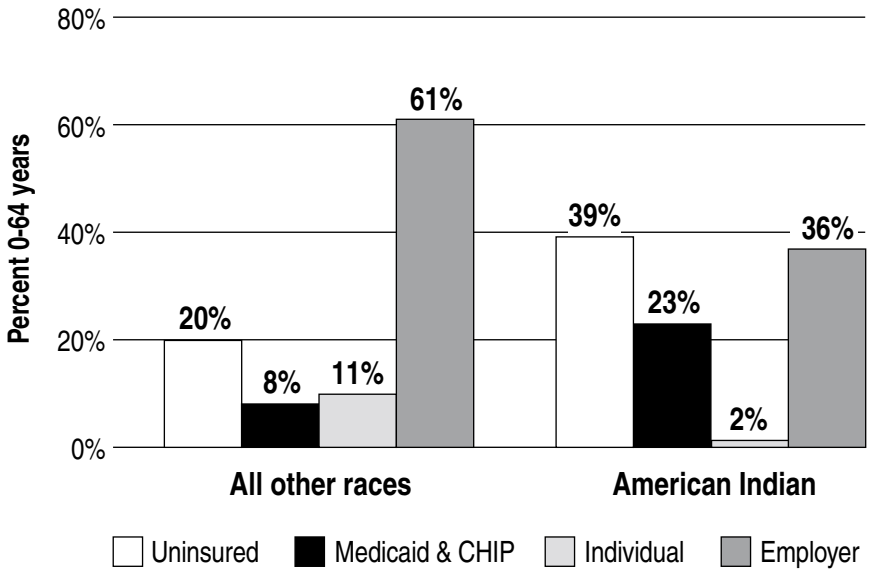
The five Billings area urban programs are:

Indian Health Board of Billings, Incorporated (IHBBI), Billings, Montana
North American Indian Alliance (NAIA), Butte, Montana
Native American Center, Incorporated (NACI), Great Falls, Montana
Helena Indian Alliance (HIA), Helena, Montana
Missoula Indian Center (MIC), Missoula, Montana

Improving access to healthcare for Indian people in Montana

American Indians face dramatic health disparities, and serious difficulties obtaining healthcare in Montana. But right now Montana legislators and decision makers have the opportunity to change the situation.

Insurance Coverage by Race, Montana Residents 0-64 Years Old[44]



Medicaid and CHIP make a difference

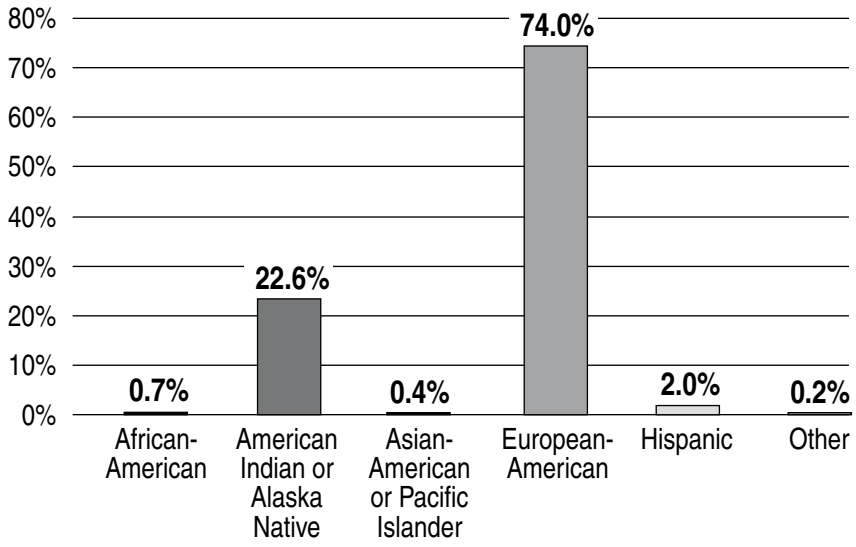
Like other Americans, Indians are eligible for Medicaid and the Children's Health Insurance Program (CHIP) if they meet the eligibility requirements.

Public healthcare programs like Medicaid and CHIP provide crucial healthcare coverage for American Indians. For many urban Indians, Medicaid is the only comprehensive healthcare they can rely on. And access to healthcare is a crucial step in reducing the dramatic health disparities Indian people experience.

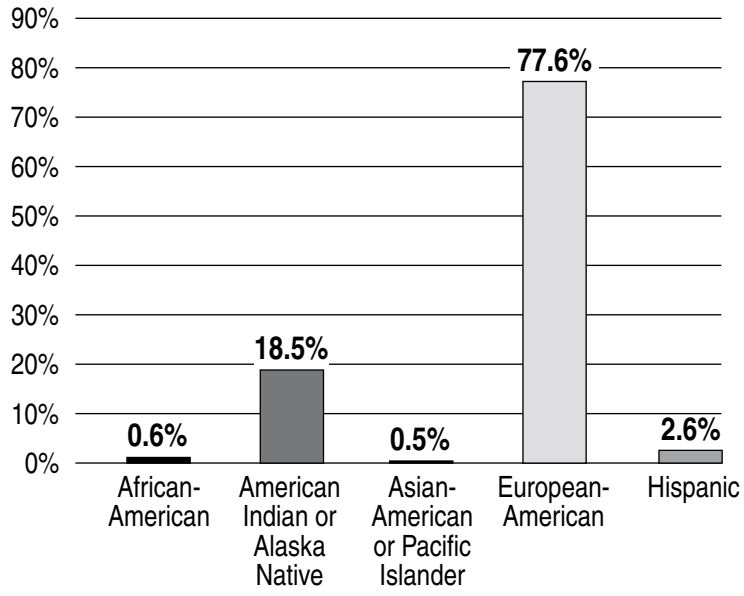
Public healthcare programs like Medicaid and CHIP provide crucial healthcare coverage for American Indians.

In Montana, nearly 39 percent of American Indian residents depend on Medicaid for their healthcare, while only slightly over eight percent of all other people use Medicaid.[45] Nearly 23 percent of Montana's Medicaid enrollees are American Indian, as are 18 percent of the children enrolled. And six percent of children enrolled in CHIP are American Indian. Of Medicaid income eligible American Indian parents and children in Montana, 57 percent are enrolled in the program.[46]

Medicaid Enrollment by Race, 2002[47]



Children Enrolled in Medicaid by Race, 2002[48]



Any cuts Montana makes to public healthcare programs will only increase the dramatic health differences between American Indians and the general population

Montana's Medicaid cuts harm Indian people

Cuts made in the Medicaid program decrease access to desperately needed healthcare. Any cuts Montana makes will only increase the dramatic health differences between American Indians and the general population in Montana and across the nation.

Medicaid cuts harm both urban Indians and those living on tribal lands — both groups lose crucial access to healthcare.

Many Medicaid beneficiaries receive care directly from IHS facilities. In IHS facilities, the federal government pays for 100 percent of Medicaid services. But the care that is covered is determined by the state's Medicaid program. When the state cuts a service, that service is no longer covered for Medicaid recipients living on tribal lands- even though these services are entirely paid for by the federal government.

A number of drastic cuts were made to the Medicaid program during the 2003 biennium, and in the 2005 biennium budget a number of these cuts were continued,

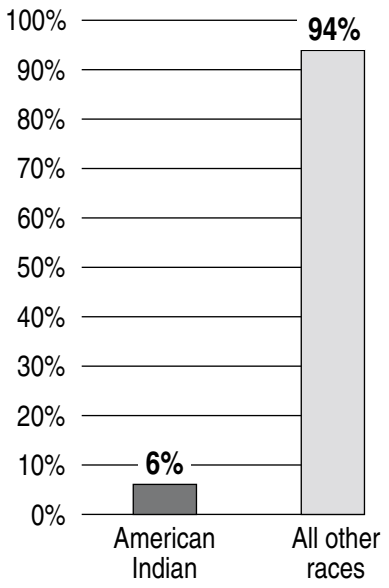
Idella Rattler

I have Medicaid coverage for myself and my two children. I had a serious back injury, and Medicaid allowed me to get physical therapy. Being in chronic pain can make you hopeless, but through physical therapy I was learning to take care of myself and to strengthen my back. I was getting so much better that I thought I would soon have learned enough to manage my condition myself. Just when I thought the end to my chronic pain was in sight, my physical therapy coverage was reduced due to budget cuts.

I have two small children, and I'm going to school. I tried to keep doing physical therapy myself, but my back has gotten much worse. I used to be very active, but now I am constantly bothered by back pain. Walking to school, and walking up and down stairs is incredibly painful. It has been hard to keep up with my classes and care for my children while being in constant pain.

I also need oral surgery, but have not been able to get dental care through Medicaid due to budget cuts. Because I am a student I can still access some IHS contract healthcare, but doing so is incredibly difficult. I'm trying to see if I can get the surgery I need covered, but even if it is covered, there are extremely long wait lists. And if I do get an appointment, the nearest reservation where I can receive care is over 60 miles away and I do not have any transportation.

CHIP Enrollment by Race, 2002[49]



and additional cuts were made. Further rule changes by the Department of Public Health and Human Services may affect the Medicaid program as well; many of these decisions will be based on how the state decides to use fiscal relief funding.

Montana has the opportunity to invest in Medicaid now

Right now, Montana has the opportunity to keep Medicaid strong. As of April 1, 2003, the federal government has increased the federal matching rate for Medicaid — officially known as the Federal Medical Assistance Percentage (FMAP). The increased rate will last through June 30, 2004. By spending the same amount of state dollars on the Medicaid program, this spending will draw in about

By drawing down federal fiscal relief funds, and increasing outreach to insure all eligible people are enrolled in Medicaid, Montana can help strengthen public healthcare programs and reduce the dramatic health disparities Indian people face in Montana.

Dr. Mark Garnaas

I work as an ob-gyn physician at a practice in Missoula. At our practice, 15-20 percent of our patient load is Medicaid patients.

At present, my partners and I will not hold back on Medicaid patients. However, if the state fails to set a reimbursement rate adequate to cover the overhead of our practice, including staff, we will be forced to make a business decision in determining to take on new Medicaid patients. We do stand committed to continuing care for our current Medicaid patient pool, but might not be able to make that commitment to new patients if it means taking heavy losses.

I want to be able to provide care for all patients who come to me with health problems, regardless of their ability to pay on their own. But realistically, if the state will not reimburse at a level sufficient to cover overhead because of the lack of state budget support for medical costs, we'll have no choice but to cut patient care.

Montana should support its citizens by adequately funding Medicaid. This investment will help Montanans who desperately need care and doctors who are struggling to provide it for them.

$23 million in increased federal funding. Montana also has been granted $50 million in general federal fiscal relief funds that will go a long way toward strengthening public programs in Montana.

A number of states have already used this funding to strengthen their Medicaid program.[50]

By drawing down these federal funds, and increasing outreach to insure all eligible people are enrolled in Medicaid, Montana can help strengthen public healthcare programs and reduce the dramatic health disparities Indian people face in Montana.

Conclusion

Medicaid provides crucial healthcare for urban Indians in Montana. By using federal fiscal relief funds for the Medicaid program, Montana has the opportunity to invest in Medicaid right now. Doing so can help provide healthcare that may help reduce the enormous health disparities American Indians face.

Endnotes

1 U.S. Census Bureau, Montana: 2000, August 2002.

2 U.S. Census Bureau, Montana: 2000, August 2002. Data for American Indian alone or in combination with one or more other races.

3 U.S. Commission on Civil Rights, Native Americans' Civil Rights Compromised by Federal Government: Report Finds Inadequate Funding, Unmet Needs, Press Release, July, 2003.

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5 Indian Health Service, Public Affairs, "Facts on Indian Health Disparities," September, 2002.

6 Indian Health Service, Statistics Program, "Regional Differences in Indian Health 2000-2001," July, 2002.

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About the organizations releasing this report

Founded in 1982, **Montana People's Action** (MPA) is a statewide economic justice organization with over 6,000 member families in Billings, Bozeman, and Missoula. For over two decades MPA has been the primary voice for low- and working-income Montanans around the issues of housing, access to credit and banking services, access to health care, economic development policy, and income security.

Organized as an MPA chapter in 1997, **Indian People's Action** (IPA) builds the voice of urban Native Americans while working for systematic change to alter the balance of power. With over 350 members in Billings, Butte, and Missoula, IPA builds strength in numbers through direct action strategies to impact policies in local and state government, the public school system, law enforcement, and various state and local agencies.

Northwest Federation of Community Organizations (NWFCO) is a regional federation of four statewide, community-based social and economic justice organizations located in the states of Idaho, Montana, Oregon, and Washington: Idaho Community Action Network (ICAN), Montana People's Action (MPA), Oregon Action (OA), and Washington Citizen Action (WCA). Collectively, these organizations engage in community organizing and coalition building in 14 rural and major metropolitan areas, including the Northwest's largest cities (Seattle and Portland) and the largest cities in Montana and Oregon.

For more information, contact:

Montana People's Action / Indian People's Action
208 E Main • Missoula, MT 59802
Voice & Fax: (406) 728-4095
Statewide toll free: 1-888-290-5711
Web: http://www.mtpaction.org

The Northwest Federation of Community Organizations
1265 S Main Suite 305 • Seattle, WA 98144
Voice: (206) 568-5400 • Fax: (206) 568-5444
Web: http://www.nwfco.org

This report is available electronically at www.nwfco.org.