

Funding Cuts to Public Health in Massachusetts: Losses over Gains

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The opinions expressed in this Issue Brief are solely those of the authors and do not reflect the opinions of the institutions with which the authors are affiliated.

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Executive Summary

Traditionally, the Commonwealth of Massachusetts has enjoyed a well-deserved reputation for its commitment to and successes in the field of public health. Overall, Massachusetts residents have been healthy—for the most part, healthier than their counterparts in other states. This good health has not been accidental. It has come from a longstanding public commitment to support an array of preventive and protective health mandates and services for the Commonwealth's residents. Unlike health care, which addresses the treatment of medical conditions, public health functions to prevent illness and disease and to protect the population from threats to health and safety. Since the mid-1990s Massachusetts had been a national model of expanding access to health care and insurance for its residents, but more recently its public health infrastructure has been imperiled by severe and drastic cuts to the state budget.

There has been approximately 30% cut in funding in Department of Public Health programs from Fiscal Year 2001 through Fiscal Year 2004, for a total of \$158 million in cuts. These cuts are disproportionately larger than those of any other agency within the Executive Office of Health and Human Services and are further exacerbated by cuts in Local Aid to cities and towns, which in turn have had to reduce their own support for public health programs.

While the state legislature works to restore some of the public health budget, this report takes a sober look at deteriorating levels of public health service in the Commonwealth brought about, at least in part, by decreases in state funding during each of the last four years. The impact of recent losses in public health funding following steady improvements in health in the Commonwealth over the past several decades is examined in this report. The report focuses on a range of public health concerns, chosen because they provide compelling examples of what public health does and what the cuts in public health can mean and whom they affect:

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|---|--|
| ■ Children's Health | ■ Public Health Infrastructure |
| ■ Family Planning and Teen Pregnancy Prevention | ■ Tobacco Control |
| ■ Infant Mortality and Low Birth Weight | ■ HIV/AIDS, STDs, and Hepatitis C |
| ■ Chronic Disease Prevention and Treatment | ■ Substance Abuse (alcohol and other drugs) |
| ■ Environmental Health | ■ Domestic Violence and Sexual Assault (including batterer intervention) |

Based on an examination of the above areas, the report concludes with several observations:

Health disparities based on race, ethnicity, and social class are widening.

Many of the budget cuts during the last several years will exacerbate disparities in access, appropriateness, and cost of care, creating greater inequity in our society and reversing gains made in the previous decade.

Data collection, analysis, and reporting remains essential to informed allocation of scarce public health resources.

Policymakers need useful and reliable data to make informed decisions about allocating resources in public health. The cuts in public health infrastructure have reduced the capability at the state and local level to maintain information systems to track health outcomes and utilization of services at the community and state level.

More research is needed to measure the impact of public health budget cuts on health status and on access to primary health care.

Each of the areas of budget cuts highlighted in this Issue Brief beg additional research to ascertain the relationship between loss of preventive services and the demand on the primary health care system.

Recommendations

Public health funding must be restored to levels that assure the public that its health is not endangered.

Any restoration of public health funding now must be weighed against the net effects of the severe cuts over the past several fiscal years. As the Legislature and Administration work to enact partial restoration of funds for public health, the public health system must be rebuilt.

Proposals to cut funds for public health should be accompanied by a health impact statement.

Because the effects of these cuts are often not immediate or are cushioned by actions and expenditures elsewhere that will not show up as a public health program, it is important to relate the cuts to the programs concerned, the people served, and the agencies involved.

Establish a prevention caucus in the State Legislature.

Establishing a Prevention Caucus within the legislature will encourage broad consideration of the public health impacts in a range of legislative areas. It can focus not only on educating legislators, but also on coordinating a legislative agenda, along with advocates, that incorporates the scope and expertise of a broad range of interested legislators.

Funds that come to the state to subsidize public health or medical care should be used only for health related purposes.

Chief among these are the Tobacco Master Settlement Agreement funds generated by the successful suits by the attorneys general against the tobacco industry.

The Commonwealth should fund and support innovations already operating at the community level.

Healthy Communities partnerships, healthy housing collaborations, and many initiatives across the state show promise for both improving health and saving money. Sustainable change at the local level that addresses the determinants of health should be a priority for the state.

The Commonwealth should commit itself to achieving comprehensive state health insurance coverage.

The Governor and Secretary of Health and Human Services have announced their intention to provide a universal system of coverage. Until that is achieved, the state could ensure adequate coverage by fully funding the existing health insurance and public health programs. Eliminating waiting lists and ending the exclusion of eligible children and adults from the Children's Medical Security Plan, MassHealth, and school health would restore health access and coverage to tens of thousands of people in Massachusetts who now have no access to health insurance or services.

It is ironic that many of the public health programs and support that led Massachusetts to achieve some of the best health outcomes in the nation either have been eliminated or are being dismantled. Just as it took years of program growth and support to achieve Massachusetts' high standards of health, it may take just as many years before the decrease in health status is noted and increases in premature deaths and morbidity result from a less responsive public health system.

Introduction

Traditionally, the Commonwealth of Massachusetts has enjoyed a well-deserved reputation for its commitment to and successes in the field of public health. Overall, Massachusetts residents have been healthy—for the most part, healthier than their counterparts in other states. This good health has not been accidental. It has come from a longstanding public commitment to support an array of preventive and protective health mandates and services for the Commonwealth's residents. Unlike health care, which addresses the treatment of medical conditions, public health functions to prevent illness and disease and to protect the population from threats to health and safety. Since the mid-1990s Massachusetts had been a national model of expanding access to health care and insurance for its residents, but more recently its public health infrastructure has been imperiled by severe and drastic cuts to the state budget. There is no facile separation of public health from the system in which health care is provided and paid for, just as there is no firewall between poor child health, poverty, unsafe housing, violence, and low MCAS scores. But, it *is* possible to distinguish the unique functions of public health, and of a public health department that exists as the sole state agency for protecting the public's health from hazards, risks, and unsafe conditions, and works to prevent illnesses and health care costs that are avoidable. Simply put: no one else does it.

Over the past several years, even as funds from the federal government have flooded into our anti-bioterrorism efforts, state budget cuts have weakened our public health capacity with serious consequences for residents of the Bay State. This is a dangerous proposition, particularly when those budget cuts coincide with, or in some cases precede, new emerging threats such as SARS and West Nile Virus, the reemergence of long dormant threats like whooping cough, hepatitis A, and tuberculosis, and the new, epidemic proportions of asthma, obesity, and diabetes. While Massachusetts is not alone in this convergence of strains on our public health

infrastructure, it does earn distinctions that reflect poorly on its ability to cope.¹ Three years of budget cuts that have reduced public health spending by almost a third mean that Massachusetts is no longer the leader in public health it once was. In a recent national ranking of states on their support for public health, Massachusetts (and Colorado) had the largest drops in state funding for public health from FY02 to FY03; Massachusetts ranked 22nd in 2003, down from 4th in 2002 and 1st in 1990.² Soon after, the February 2004 issue of *Governing Magazine* examined public health trends and actions in the 50 states, and cited Massachusetts as one of only three states described as a “trouble spot.”³

Funding for public health programs and services is provided by federal, state, and local sources. The structure and funding of the state-centered public health system in the Commonwealth warrant a closer look as we come to the end of one state fiscal year and look forward to a new one.

While the state legislature works to restore some of the public health budget as this Issue Brief is released, this report takes a sober look at deteriorating levels of public health service in the Commonwealth brought about, at least in part, by decreases in state funding during each of the last four years. Its purpose is to illuminate some of the effects these cuts have had and will continue to have on the health of Massachusetts residents, and to:

- Highlight the degree to which public health has sustained disproportionate cuts;
- Issue a warning about the still unrecognized effects of the reductions;
- Describe impacts to the public health infrastructure caused by budget shifts or cuts; and
- Remind policy-makers and the public of the reasonable practice of investing in the public's health.

Health Status in Massachusetts: A History of Public Health Success

The relatively good overall health status of Massachusetts residents is largely a result of the state's long and strong commitment to public health and health protection programs. The Commonwealth historically has been willing to back these programs, financially and politically, and to support the existence of and access to a viable medical care system. Although the health status of Americans lags behind that of a number of other industrialized nations and certain indicators are inferior to those of less developed nations, in many respects Massachusetts residents enjoy a higher standard of health than residents of many other states.

Since the 1990's, Massachusetts has generally ranked among the five states with the best rates of mammography, pap tests, prenatal care, teen pregnancy, and infant mortality. It has been among the best three states in rates of pediatric immunizations, teen deaths, and motor vehicle deaths. With a national rank of 34th in age-adjusted rate of deaths per 100,000 people, Massachusetts just makes it into the top third of states.

Massachusetts' overall good health standing is the result of other factors as well:

- Expanded insurance coverage, including 100% coverage for children up to 18 years old, through federal and state public programs, during the past 20 years;
- A broad and robust array of community health centers in traditionally underserved areas;
- An excellent tertiary care system, providing many residents with access to state-of-the-art medical technology and treatment;
- Insurance coverage for a large percentage of Massachusetts residents provided by high quality managed care organizations⁴;
- One of the highest rates of spending on medical care in the nation;
- Viable partnerships between and among

various branches of the health care system, including municipal and state public health agencies, hospitals, schools, managed care organizations, and insurers.

- A diverse and broad range of community-based social service, advocacy, and educational organizations, working with local and state agencies to address both widespread and rarer social and public health concerns.

Certainly, the generally encouraging state of health in Massachusetts owes much to innovative public health programs, a vibrant public health infrastructure, and sufficient spending on health programs. These programs—on their own, as well as in tandem with other factors such as those listed above—have helped Massachusetts achieve forward motion in overall health status and have served as models for other states. There is also a vibrant and active advocacy community in public health in Massachusetts, representing a vast array of residents, providers, recipients, academics, and laymen concerned about the public's health. Massachusetts also has many public health training and research resources from institutes for community health workers and outreach educators to three schools of public health and a number of combined programs of public health and other professions.⁵

Nonetheless, there have been notable exceptions to this rosy scenario, even at the best of times. Massachusetts has done less well in:

- Immunizing adults for flu and pneumonia, ranking 12th and 23rd, respectively, preventing deaths from heart disease (14th);
- Deaths from cancer;
- Cases of venereal disease including syphilis, gonorrhea, and chlamydia;
- Incidence and prevalence of AIDS; and
- Substance abuse.

Meanwhile, health disparities persist and worsen in many areas. Pregnancy rates among Asian and Latina teens and rates of low birth weight,

preterm birth, and childhood immunization among Latinos are worse than the national average. The health status of African-Americans and Latinos and their access to services are generally inferior to that of whites, and, in some pockets of the state, the infant mortality rate for blacks is four times that of whites. The number of Massachusetts children using drugs and alcohol is among the highest in the nation. The Commonwealth's hope of making progress in these areas depends on adequate funding for outreach and services.

What Public Health Programs Do and What Funding Pays For

The overall health enjoyed by Massachusetts residents is the result of public health initiatives that have been funded by governmental programs for the past two hundred years. From the first use of smallpox inoculation in 1721 and the first pure food legislation in 1785 through the 1902 school health law and the 1989 Toxic Use Reduction Act, Massachusetts has led the nation in championing the importance of public health to the success of the civic endeavor.

"Public Health" is a term that most people recognize and associate with positive practices, yet relatively few are able to explain what those practices are—what exactly public health funding pays for. In 1988, the Institute of Medicine described public health in the United States as "in disarray" and identified three core functions of public health: (1) assessment, to determine the health status of populations and disparities among them; (2) policy development, to develop programs, regulations, and standards to improve health status and eliminate disparities; and (3) assurance, to evaluate what works, how, and why, and to continue those programs that work.

Six years later, federal, state, and municipal health organizations agreed on Ten Essential Public Health Services necessary to maintain and protect the public's health:

- Maintain the safety and security of air, water, and food.
- Inspect and supervise the physical and operating conditions of agencies, institutions, businesses, schools, and buildings.
- Track disease, health status, and outbreaks of illness.
- Provide education, outreach, and services tailored to the needs of various groups and communities.
- Establish and maintain early intervention programs to identify unsafe and unhealthy conditions, disease, and abuse.
- Create a system of referrals and follow-up to assure that policies are maintained, and programs implemented.
- Ensure that services are provided to those state residents who are fragile, marginalized, impoverished, or powerless.
- Supply local health authorities with accurate information about dangers to the public's health and safety.
- Mobilize communities to solve health problems.
- Evaluate effectiveness, accessibility, and quality of health services.

Public health authorities know that individuals and communities can prevent a great deal of ill health by self-initiated changes in behavior. However, behavioral change is often beyond the means of an individual or family, without broader community or institutional support. Public health officials and experts have increasingly worked to:

- Identify the social, environmental, and economic factors that determine ill health;
- Understand the systemic problems that lead to health disparities;
- Organize through community coalitions a variety of partnerships to provide the information, the means, the support, and the infrastructure to support behavioral change⁶; and

-
- Sponsor public information campaigns (e.g., anti-smoking, seatbelts).

Over time, the Commonwealth has made painstaking—if not always dramatic—progress toward understanding these issues and establishing structures to deliver health-related information and services to its residents. Thus, we have come to believe that Massachusetts is performing conscientiously as a steward and advocate of public health and that progress will continue. However, the events of the past three years are wiping out gains that in some areas have taken decades to achieve.

Public health is a public good, as essential as police and fire services to protect the public, and as important as education in promoting public welfare. It benefits every individual within a community, providing clean air and water, safe food and medical products, and providing services and education to improve health overall. Deep cuts in funding for community programs and core services predictably will have a negative and widespread impact on communities and individuals alike. Over time the magnitude of these cuts will result in a commensurate increase in premature deaths and morbidity, as well as a public health system significantly less equipped to protect the health and well-being of the residents of Massachusetts.

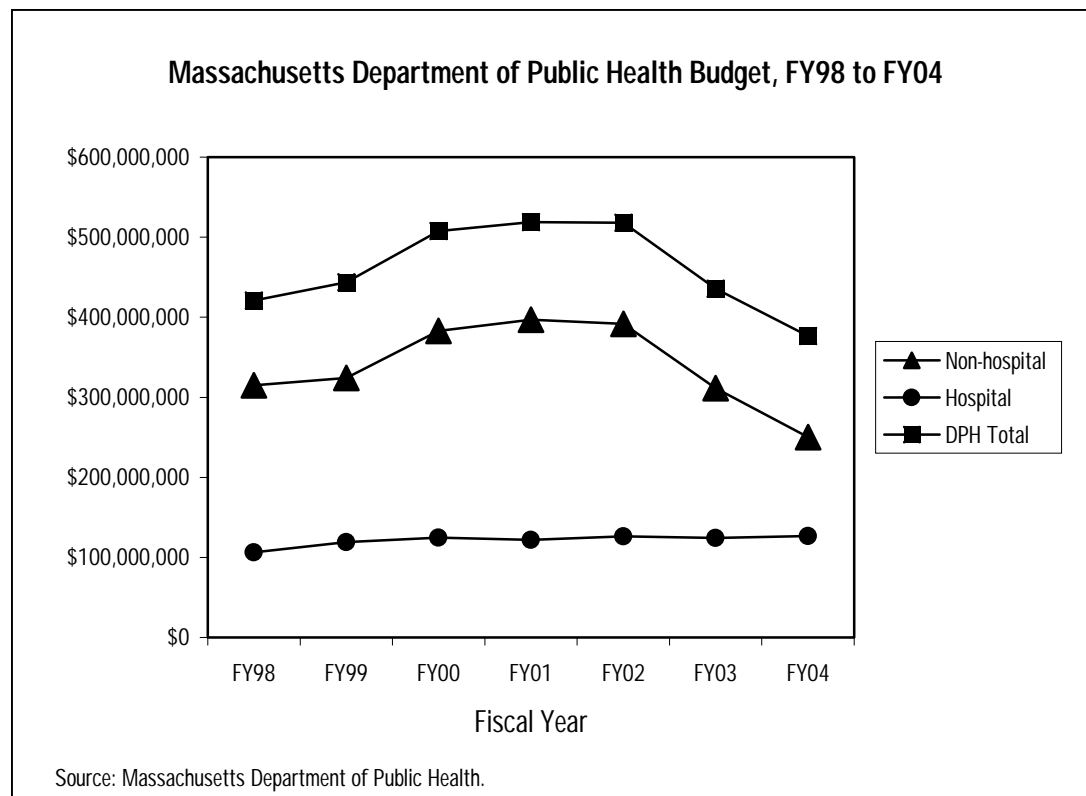
Immunizations for hepatitis A are a tiny fraction of the cost of treatment, and the infection puts others at risk. In July 2003 the state eliminated funding for the hepatitis A vaccine, for which Massachusetts has been paying since it was approved. Within six months hepatitis A infections in Boston doubled, the worst rate in a decade.

The impact of budget cuts has reduced health security for everyone in the Commonwealth. Inadequate public health is not a zero-sum game; by saving money now, we guarantee that we will pay more in years to come, in illness, disability, and premature death as well as in dollars.

Impact and Magnitude of Public Health Cuts

There has been approximately 30% cut in funding in Department of Public Health programs from Fiscal Year 2001 through Fiscal Year 2004, for a total of \$158 million in cuts. When the public health hospitals are excluded, funds for community-based programs and statewide infrastructure resources, such as data reporting, public education, and provider training, were reduced by more than one third (35%). These cuts are disproportionately larger than those of any other agency within the Executive Office of Health and Human Services and are further exacerbated by cuts in Local Aid to cities and towns, which in turn have had to reduce their own support for public health programs.

It is ironic that many of the public health programs and support that led Massachusetts to achieve some of the best health outcomes in the nation (e.g., infant mortality, teen births, mammography screening for women, immunizations, etc.) either have been eliminated or are being dismantled. Just as it took years of program growth and support to achieve Massachusetts' high standards of health, it may take just as many years before the decrease in health status is noted and increases in deaths and morbidity result from a less responsive public health system. Thus far the decline in health security for families and communities is evident mostly to those involved in providing services and to the more vulnerable members of our society.



The recent cuts have eliminated almost all state funds for prevention, outreach, and technical assistance to local public health and community programs, and training for providers. They have also seriously impaired the data and information systems needed to track changes necessary to make improvements at the local and state level or to identify or respond to “hot spots” of concern. The few prevention programs that remain are those required by federal grants and cooperative agreements. Other state funds, such as those for the development and maintenance of an electronic vital statistics system to record births, marriages, and deaths and for the state laboratory testing system, have been reduced or eliminated as well.

The following sections give a more detailed view of some programs and cuts for specific areas related to a range of public health concerns:

- Children’s Health
- Family Planning and Teen Pregnancy Prevention

- Infant Mortality and Low Birth Weight
- Chronic Disease Prevention and Treatment
- Environmental Health
- Community Health Centers
- Public Health Infrastructure
- Tobacco Control
- HIV/AIDS, STDs, and Hepatitis C
- Substance Abuse (alcohol and other drugs)
- Domestic Violence and Sexual Assault (including batterer intervention)

These areas were chosen because they provide compelling examples of what public health does and what the cuts in public health can mean and whom they affect.

Children's Health

The health of children and youth depends on a variety of conditions being in place: they must be covered by comprehensive, affordable health insurance programs; services must be accessible and sensitive to the needs of the children and their families; and children and their families should have access to information about healthy behaviors, programs to promote good habits, and organizations to support healthy activities. All of this, of course, is in addition to the social and economic supports that help them and their families to live safe, secure lives. Massachusetts has often led the nation in matters of children's health: the nation's first comprehensive lead paint poisoning law⁷; a state Healthy Start initiative to cover all Massachusetts women for prenatal and birth care, years before the enactment of a federal program⁸; a commitment to immunization that began with the first inoculations for smallpox in 1721.⁹ In the mid-1990s, after the defeat of the Clinton universal health coverage initiative, Massachusetts added to its child health services to address the persistent and serious gaps in children's health. These additions included:

- Creation of the Children's Medical Security Plan funded by an increased tax on tobacco (another precursor to federal action);
- Expansion of School Based Health Centers, based on a model developed by Dr. Phil Porter of Cambridge Hospital in the 1970s;
- Enhanced School Health Services designed to incorporate into a single program model the "best practices" identified in various schools throughout the Commonwealth;
- The Massachusetts Maternal and Child Health Immunization Program; and
- The Massachusetts Tobacco Control Program, with a particular emphasis on preventing smoking among children and adolescents and stopping the sale of cigarettes to teenagers.

School Health

The school health infrastructure has been essential to identifying problems early and getting children the care they need. Massachusetts had funded a wide range of school-based health centers and an enhanced school health program, which funded nurses in many public and private schools. Funding for these services was cut in half in FY04, from \$21.2 million to \$12 million (of which \$8.9 million funds Enhanced School Health Services and \$3.1 million funds School Based Health Centers).¹⁰

It has been suggested that cities and towns use their Chapter 70 school-assistance funds to replace these state budget cuts. Unfortunately, the increased costs from state and federal education mandates and loss of funds for the neediest school districts added to losses in local aid make this a challenge nearly impossible to meet.

School-Based Health Centers (SBHCs) are primary health care facilities located in 45 school sites (including elementary, middle, and high schools); in 2003, 63 SBHCs were operating with state support. There are now SBHC sites in 8 public schools throughout Boston, and their future is uncertain due to a series of cuts in state and local funds, warns a recent Boston Public Health Commission report.¹¹ Many of the children served by these health centers have limited or no access to anything other than emergency room care, are often found to have undiagnosed disease, or need expert assistance in the management of chronic disease.

"Time and again, it is school nurses who first identify a health problem . . . and then make sure the student is referred to a clinic or doctor."

Boston Globe Editorial, February 24, 2004

SBHCs are cost-effective when compared to the alternatives of increased emergency room visits, outpatient clinical care, and preventable hospitalizations for asthma. Because children seen at school-based health centers are six times more likely to be uninsured than all children in Massachusetts, the location of clinics in schools reduces access barriers faced by these children and adolescents.¹² The centers are operated as satellite clinics of community health centers and hospitals and their core services include:

- Comprehensive primary health care, such as well-child exams, immunizations, diagnosis and treatment of illness and injury, management of chronic health conditions, and health education and counseling;
- Comprehensive risk assessments, with promotion of positive health behaviors and risk reduction counseling, including violence and suicide prevention;
- Mental and behavioral health services;
- Oral health care; and
- Care coordination.

The centers are staffed by interdisciplinary teams with the goal of both providing and coordinating the full range of health and medical services. These school clinics have provided a safe place for many adolescents, especially males, to receive services that they will not seek from other providers or in other settings.¹³ Mental health problems, including suicide prevention, are among the main reasons adolescents seek help in the school-based clinics.¹⁴

Enhanced School Health Services (ESHS) are designed to incorporate into a single program model the “best practices” identified in various schools throughout the Commonwealth. The funds for school health services at the local level are administered through the local school committee or the local board of health (for example, there are 18 in operation in parochial and charter schools in Boston). These funds are used to (1) strengthen the administrative

In addition to losing money for vaccines, school health clinics and health services are cut. Whooping cough among Boston’s public school students for the first quarter of 2004 is 600% greater than in each of the two previous years; active TB appears in the classroom.

infrastructure of the school health service program (staffing requirements, health assessments, policies, emergency care, individual health care plans, etc.), (2) ensure implementation of K-Grade 12 comprehensive health education, including tobacco prevention and cessation programs, (3) link school health service programs with community-based health providers, local health activities, and public health insurance programs, and (4) develop management information systems that will help to effectively monitor the program. School departments, physicians, federal and state governments, and numerous academics and foundations have documented the importance and the need for school health services:

- Children who lack health coverage do not have other sources of medical and health care services other than a hospital emergency department.
- For children whose parents work during the day, the school nurse is a critical coordinator of care with the child’s primary care provider.
- Medical science and technology have made it possible for many children with chronic disease and disability to attend regular school where they need to be monitored and assisted with medication and disease management.
- Because children are in school for six to eight hours a day, teachers often notice problems that need attention but may not be obvious to a child’s family and friends.
- School performance problems are often a result

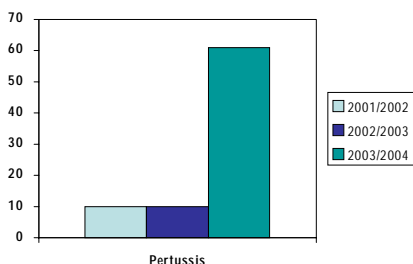
of physical and mental illness, and changes in performance are often the best indicators of underlying disease or conditions.

- School nurses are often the sentinels who identify poor indoor air quality that is a ubiquitous problem in Massachusetts school buildings.

Maternal and Child Health Immunization Program

Another important reason that Massachusetts enjoyed good health outcomes for children and youth in the past decade was a well funded immunization program that distributed vaccine to public and private providers, free of charge, in order to protect *all* children against specific vaccine preventable diseases. The Massachusetts Maternal and Child Health Immunization Program has enabled Massachusetts to achieve some of the highest immunization rates for two-

Reported Cases of Pertussis, Boston
(3rd Quarter Comparison)



Source: Boston Public Health Commission

year-olds and children entering school through assessment and immunization tracking, as well as targeted education, outreach, and referral for children most at-risk of not being immunized.¹⁵

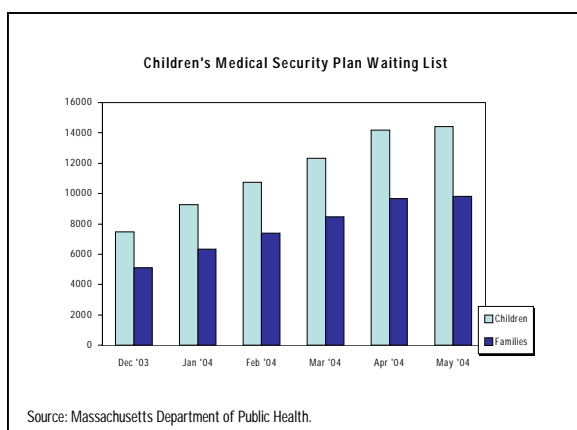
Immunization for only some people with a patchwork of coverage will lead to cases of disease within the state. The FY04 budget discontinued coverage for pertussis, or whooping cough, vaccine. The number of whooping cough cases in Boston alone has increased 6 times from that of the previous two years.¹⁶

Children's Medical Security Plan

The Children's Medical Security Plan (CMSP) once enabled Massachusetts to have full coverage for all children and youth up to 19 years of age. CMSP was designed to ensure access to preventive and primary care services through a health insurance program for uninsured children under age 19 not eligible for MassHealth. Once the centerpiece of expanded health care access for the Commonwealth's uninsured, this program has been characterized during the past several years by serious erosion—of its covered services, of its ranks of insured children, of its outreach and referral component, and of its support of a healthy population.

CMSP covers primary and preventive services including well-child checkups, immunizations, acute care visits, medically necessary specialty care, oral health, and mental health services. It does not, however, cover emergency room care (eliminated in 2002) or inpatient hospitalization (except through linkage to the Uncompensated Care Pool).¹⁷ Under this program and other initiatives to enroll children in insurance programs, the percentage of uninsured children in the past few years had been reduced to about 3% of the total population.¹⁸ These children often live in families who receive no other government services, do not know their eligibility, have been mistakenly rejected or dropped from government programs, are suspicious of government services, or have other barriers to enrollment. Outreach and education programs have successfully enrolled many of these children; additional efforts using community-based organizations, if available, should have reduced the 3% to nearly 0%. However, these outreach and education programs have been significantly reduced or eliminated since 2001.

This safety net and coverage for health insurance for all children and youth was reduced beginning in FY02 and increasingly through the FY04 budget.¹⁹ Both the previous administration and the present one capped the CMSP budget and created waiting lists of children who satisfied all eligibility requirements but who weren't enrolled



before the cap was reached. In addition eligibility requirements were raised and concomitant copays increased. In November 2003 premiums were instituted for families earning 150-200% of poverty and quadrupled for those earning 200-400% of the poverty level. FY04 put new constraints on the participants in CMSP by adding new and increased premiums and instituting a waiting list.²⁰ As of May 2004, there are approximately 14,400 children in 9,800 families on a waiting list for coverage, and this number is growing.²¹

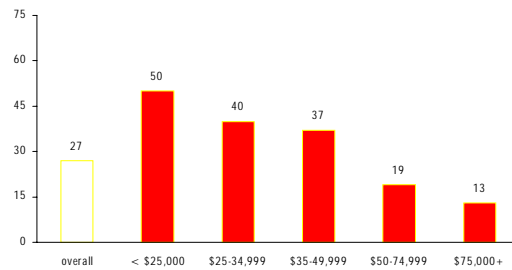
Family Planning and Teen Pregnancy Prevention

One of the most effective ways to protect the health of children is to provide women and girls who are not able to physically, emotionally, or financially bear children the means to plan their families. Since children born to adolescents are among the most vulnerable in our society, it is essential that young girls and teenagers have information and assistance to prevent pregnancy. Access to family planning and teen pregnancy prevention services have made it possible for Massachusetts, unlike most other states of our size, to enjoy low teen birth and infant mortality rates.

Family planning programs provide comprehensive family planning services for low-income women, men, and adolescents. These reproductive and gynecological services are keys to prevention and early diagnosis of sexually transmitted diseases (STDs), which if undiagnosed can lead to severe complications including death, sterility, and HIV/AIDS. Services are contracted to thirteen community-based agencies that directly or through subcontracts provide care at more than eighty sites statewide. Funding supports medical services, including cervical cancer screening and STD screening and treatment, a full range of contraceptive methods including emergency contraception, individual health education and counseling, outreach, and education to local communities and high-risk populations. Family planning programs also provide HIV prevention services and HIV counseling and testing services, either on-site or by referral.

Family planning services are necessary in order to prevent unplanned pregnancies in women of all ages; women with unplanned pregnancies have poorer health outcomes, as do their babies. In Massachusetts in 2000, 78% of women aged 18-44 reported using birth control and 27% reported having an unplanned pregnancy.²² The percent with unplanned pregnancies ranged from 50% of women in households making less than \$25,000 per year to 13% of women in households reporting more than \$75,000 per year. Black

Percentage of women aged 18-44 who had an unplanned pregnancy in the past 5 years, by household income, BRFSS 2000



Source: Massachusetts Department of Public Health, Center for Health Information, Statistics, Research, and Evaluation.

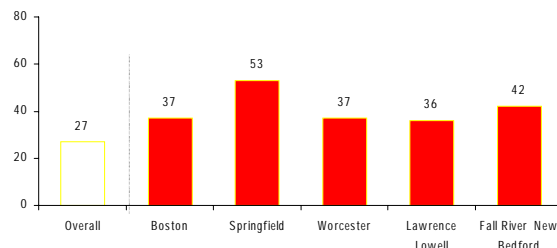
women and young women aged 18-24 had the highest percentages of unplanned pregnancies. And there are wide geographic variations between cities, with Springfield's unplanned pregnancies among women aged 18-44 nearly double the state average.

Over the past three years family planning services have been cut by eliminating the outreach and education line item (\$1 million) and by reducing the family health services account (which had \$4.46 million for family planning services). Because of these cuts, over 16,000 women and adolescents no longer have access to screenings for cancer and STDs or to traditional family planning services.²³ Massachusetts will likely see an increase in undiagnosed diseases and in the rate of STDs, unwanted pregnancies, abortions,

and infant mortality.

In response to alarming teen birth and pregnancy rates, teen pregnancy prevention programs, called the Challenge Fund, began in the late 1980s. Through them, Massachusetts has consistently lowered the teen birth rate over the past decade, reducing the rate of teen childbearing in communities with the highest number of teen births by 28%. The Challenge Fund's network of coalitions were located in 17 communities with historically high rates of teen births and other related health, education, and socioeconomic indicators, such as low incomes, high unemployment, and low MCAS scores. They developed a range of primary prevention services intended to increase abstinence, delay the onset of early sexual activity and reduce the rate of

Percentage of women aged 18-44 who reported an unplanned pregnancy, by city, 2000

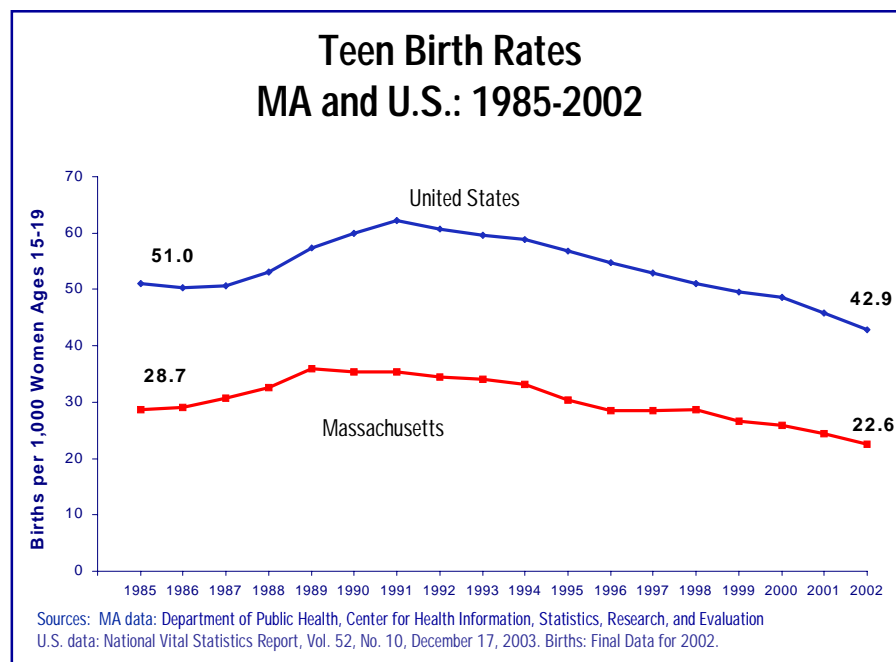


Source: Massachusetts Department of Public Health, Center for Health Information, Statistics, Research, and Evaluation.

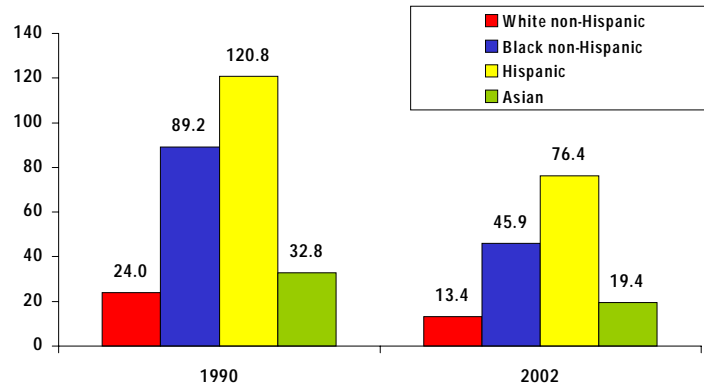
teenage pregnancy and other related high-risk health behaviors. The primary target population in each community was at-risk youth, ages 10 to 19, with additional education and awareness activities for parents and other community members. Funded communities brought youth, parents, faith communities, health and human service, business, education and municipal leaders and other interested individuals together into an active, diverse coalition that then funded direct service programs based on current research and best practices. In FY01 the 17 community coalitions funded programs through 97 community agencies, which served a total of 24,400 youth, parents, and community members through on-going events. In addition, 128,400 youth, parents, and community members were served through one-time events. Budget cuts in the last three years have eliminated Challenge Fund coalitions and a wide range of services for youth and parents across the Commonwealth. Teen pregnancy prevention funds were reduced by 82% from \$5.5 million in FY01 to \$975,000 in FY04.

Teen pregnancy by definition is a responsibility and burden that falls on young girls; cuts in these programs along with cuts in family planning and school health clinics leave these girls without resources.

Local school departments have been important partners in the effort to reduce teen pregnancy but they cannot maintain school programs or curriculum in the face of these budget cuts; most schools are facing additional costs from both federal and state mandates, decreased budgets because of local aid cuts and budget diversions, and the loss of those school health personnel who often led the efforts within school systems. When teen birth rates begin to rise along with increases in infant mortality and STDs, racial and ethnic disparities among youth will also increase.



Teen Birth Rates by Race/Hispanic Ethnicity Massachusetts: 1990 and 2002



Source: Massachusetts Department of Public Health, Center for Health Information, Statistics, Research, and Evaluation.

Infant Mortality and Low Birth Weight

Of course, one of the first steps to having healthy children is having healthy babies. Infant mortality rates are considered an important mark of the overall health and well-being of a society; disparities in that rate are also an indication of the fairness and equality of health care services and systems. Massachusetts rates indicate success in the former and continued deficiencies in the latter. Although Massachusetts has one of the lowest rates in the nation of infant mortality for black babies, black infants still die almost three times more often than white babies. The rate of babies born at low birth weight also reflects serious problems in the health care system and indicates that many babies born at risk are only alive because of expensive technology and not because of improved health conditions, especially for women.

The rates for infant mortality and low birth weight will not decrease unless the overall health and safety of women is addressed and improved. Women of childbearing age need access to health insurance, safe housing, and employment that provides child care and health benefits. There is sufficient documentation, myriad studies, and a general acceptance of that fact that prematurity results in developmental and learning delays, extraordinary risks at the beginning of life and often throughout. These mean high costs to the health care, education, transportation, and social

service systems in addition to the high emotional to children and families.

Because of the alarming rates of high infant mortality in the 1980s, both the state and the city of Boston convened task forces to address the issue; the major message for policy makers was that the solutions to infant mortality had to be social and political as well as medical.

Fortunately, the state initiated a successful Healthy Start insurance and outreach program in Massachusetts in 1985, far in advance of the federal program. This program is designed to pay for prenatal care for all women with no health insurance, including coverage for undocumented women whose infants are U.S. citizens. In addition, the Healthy Start outreach workers have doggedly conducted outreach into all communities, especially those of color, and helped enroll women in MassHealth and/or Healthy Start. At the present time, however, a poor woman has access to MassHealth only when she is pregnant; there is no coverage between pregnancies or births.

The FY04 budget (\$6.2 million) transferred the Healthy Start program to MassHealth for administration, requires the Division of Medical Assistance to spend only the funds appropriated, and eliminated the outreach and referral component. The estimated need to cover all

eligible women in FY05 is \$12.8 million. All of the babies born will be American citizens, eligible for MassHealth. If four of every hundred eligible women who will not get prenatal services deliver a low birth weight baby who requires intensive care, the state will pay more than it would have if it had provided prenatal care for all of the women.²⁴

In addition, all of the outreach workers in Healthy Start and in community-based settings have been eliminated; since these workers were usually connected to the multilingual and bicultural communities they served, this will in effect reduce access to a program needed by poor women, women of color, and those for whom English is not a first language.

Another key to a low infant mortality rate was the state's investment in WIC (the Special Supplemental Nutrition Program for Women, Infants, and Children) in the early 1990s by making the program an entitlement for all pregnant women and poor children up to age six in the Commonwealth. WIC provides nutrition education and counseling, checks to purchase nutritious foods, and health and social services referrals. WIC also provides immunization screening and referrals and distributes coupons for fresh produce redeemable at local farmers' markets. Studies have repeatedly shown that pregnant women who participate in WIC have improved diets, receive prenatal care earlier, and have better pregnancy outcomes. Infants born to mothers using WIC have better birth weights and are less likely to be premature. WIC offices are located in 159 community sites, with 903 participating retail stores and pharmacies across the Commonwealth. The Massachusetts economy has been in recession, fuel prices are higher, housing prices escalating, and transportation costs up – all of these have a greater impact on the poor whose income is almost entirely devoted to necessities; the WIC program has been one of the few programs that insulated the budget of eligible poor families from the competing demands for heat, housing, and health care.²⁵ That is no longer the case.

Ensuring the health of mothers and infants and reducing infant mortality takes a comprehensive approach linking social and medical systems and programs designed to improve pregnancy outcomes, reduce infant mortality, promote infant health and development, and support healthy families. The key is that a woman must be healthy *before* childbearing in order to ensure that her baby is healthy. The easiest and most cost-effective way to do this is to ensure that girls and women have access to comprehensive services, especially reproductive services. Barriers to care such as lack of transportation or child care in order to make health care appointments, inadequate economic resources to meet basic

If four of every hundred eligible women who will not get prenatal services deliver a low birth weight baby who requires intensive care, the state will pay more than it would have if it had provided prenatal care for all of the women.

physical needs (housing, food, and clothing), violence, and unmet personal or family mental health or substance abuse needs must be eliminated. These can be major obstacles to achieving optimum health before, during, and after pregnancy, as well as good health for life. Thus, recent budget cuts to social and public health programs risk an increase in infant mortality rates.

Perinatal primary care programs in community health centers and other community-based primary care sites provide additional services that enable pregnant women to access early and consistent prenatal care. These “wraparound” services include care coordination for high-risk pregnancies, social services, nutritional services, counseling and mental health services, specialized screening and follow-up for women with alcohol and drug use, and others.

Chronic Disease Prevention and Control

A cornerstone of Public Health is disease prevention and health promotion; one of the most important means of preventing disease is through outreach, education, screening, and early diagnosis. Many diseases can be prevented through good education and organizing to change environments, conditions, behavior, and habits. The major health behaviors associated with higher rates of disease and death are tobacco use, poor nutrition, lack of physical activity, and alcohol abuse.²⁶ If the disease cannot be prevented, most often early detection and treatment can cure or ameliorate the consequences of the disease, especially if the sufferer has access to good care and/or the ability to change the conditions that help cause the disease or make it worse.

Recent years have seen progress in understanding the causes of disease, of developing successful interventions, and of identifying new ways to reach people. When combined with greater access to medical services (more often the case with children than with adults) there have been real improvements. Health disparities, the differing rates of disease suffered by ethnic and racial minorities, can also be associated with economic, educational and social disparities that restrict the ability to change one's environment and limit access to services.²⁷

Many programs that historically have provided outreach, education, and support for community

efforts to encourage screening and early diagnosis have been cut during the last several years. Death rates from prostate and breast cancer are higher among African-Americans than among whites; diabetes deaths higher for African-Americans and Latinos; other cancer rates are higher among Asians; yet the state has totally eliminated many of these screening programs and severely cut the others. Among the more prominent cuts are funds for breast cancer, prostate cancer, osteoporosis, and colorectal cancer, although funds have also been cut for a number of other diseases.²⁸

In addition, no new programs have begun, despite the fact that detectable diseases such as diabetes are at epidemic proportions and that new and accurate tests exist for treatable cancers. There are no programs for education or screening for diseases that are concentrated in occupations, such as bladder cancer in firemen or chemical workers, connective tissue disease and lupus in others. Public health programs do not keep up with the technology that has made it possible to identify risk.

Breast and Cervical Cancer

Seventy percent of funds for breast and cervical cancer funds are gone from the state budget. As part of the state's Cancer Prevention and Control Initiative, these funds provided breast and cervical cancer screenings for income eligible women over forty and younger women at high risk. This program triggered federal funds, which will now also be lost.

Breast cancer remains the most commonly diagnosed cancer among women and the second leading cause of cancer deaths in women in Massachusetts. American Cancer Society estimates for 2003 were for 4,700 new cases of breast cancer diagnosed and 900 deaths from breast cancer in Massachusetts in 2003.²⁹ One in eight women will develop breast cancer; black women die at higher rates than whites, in part because of later diagnosis. Cervical cancer is one of the most treatable forms of cancer, when detected early through screening.

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In May of 1992 Massachusetts became the first state to declare breast cancer an epidemic. The Massachusetts legislature designated \$3 million as part of the FY93 budget for a breast cancer early detection program. The initial program included public education, outreach and screening for uninsured women and women at high risk for breast cancer as well as clinical research and professional education. Since that time, the funding has steadily increased, and in FY02 the appropriation totaled \$9.3 million, with \$3 million earmarked for breast cancer research and \$1.95 million earmarked for environmental research on breast cancer. This funding enabled the Department of Public Health to provide comprehensive early detection services to nearly 14,000 women annually and to maintain a diverse breast cancer research program. Most of these women have no other means of receiving services that are provided to women within the Commonwealth who are from 40 to 64 years old, low-income, and uninsured or underinsured. However, over the course of FY03 and FY04, this funding was abruptly slashed by 70%, a cut of \$6.9 million.

These state funds, in combination with federal funds from the CDC's National Breast and Cervical Cancer Early Detection Program, support the Women's Health Network (WHN). The goal of WHN is to provide high quality, comprehensive integrated screening, and diagnostic services to low income, uninsured women through a statewide network of community-based, culturally appropriate providers. In addition, WHN seeks to educate women about the benefits of preventive health care and healthy lifestyles. The early detection of breast and cervical cancer saves women's lives by detecting the diseases in their earliest, most treatable or preventable stages. Although effective early detection and prevention screening tests are available, many women do not receive these tests on a regular basis. In particular, women who lack health insurance coverage for screening tests are far less likely to be screened.

Prostate Cancer

Prostate cancer is the most commonly diagnosed cancer in men and the second leading cause of cancer death among men. In 2003, the American Cancer Society estimates the number of new cases of prostate cancer in Massachusetts at approximately 5,700 while the number of deaths due to prostate cancer is estimated at 740.³⁰ In FY95 the state legislature first appropriated \$1 million for a program to educate men, their families, and their health care professionals about the importance of early detection, the availability of screening, and the specifics of various treatment options for prostate cancer. Funding for the program had increased to \$3.2 million by FY01. But as of FY04 the funding had been reduced to \$1 million—this, despite the fact that one in six men will develop prostate cancer, black men die from prostate cancer at a rate twice that of white men, and that early detection of prostate cancer increases survival rates.

The Department of Public Health has a statewide Prostate Health Program through funded agencies to provide prostate cancer screening to high-risk uninsured and underinsured men across the Commonwealth—men who for the most part would have no other access to services. (The number of new cases of prostate cancer and the number of deaths due to prostate cancer is approximately twice as high among African American men as among white men.) Many of these men have been identified through the Chronic Disease for Under-served Populations Program, which promotes early detection of prostate cancer among high-risk refugee, immigrant, and established minority populations.

The Prostate Health Program conducts education and outreach to high-risk men through community breakfasts held throughout the Commonwealth. These events have been instrumental in providing men with the information needed to make informed decisions regarding prostate cancer screening. In addition, the program sponsors an annual symposium in central Massachusetts, to which as many as 700 men and their families come to learn about

diagnostic and treatment options from experts in the field and to discuss quality of life issues with health care professionals. While the program does not cover treatment, it does fund a statewide network of prostate cancer support groups. These groups can be seen as an intervention designed to address both the mental and physical consequences of prostate cancer. Seventy percent of funds for such prostate cancer education have been cut from the state budget.

Osteoporosis

Beginning in FY94, the Legislature designated \$500,000 to fund a statewide osteoporosis education and prevention program. This program was initiated (1) to develop or identify educational materials to promote public awareness of osteoporosis, (2) to develop or identify professional education programs for health care providers, (3) to develop and maintain a list of current providers of specialized services for the prevention and treatment of osteoporosis, and (4) to provide training and technical assistance to local prevention and health education programs. All osteoporosis prevention funding was cut from the state budget in FY04, resulting in elimination of the program.

Osteoporosis is a chronic condition characterized by an excessive loss of bone tissue and an increased susceptibility to fractures of the hip, spine, and wrist. Over twenty-eight million Americans have osteoporosis—80% of them women. Prevalence increases with age: half of women after menopause are affected, and by age 75, the prevalence increases to 90%. The number fractures caused by osteoporosis is expected to increase dramatically in the next 50 years,

All osteoporosis prevention funding was cut from the state budget in FY04, resulting in elimination of the program.

reflecting population growth and increasing life expectancy.³¹

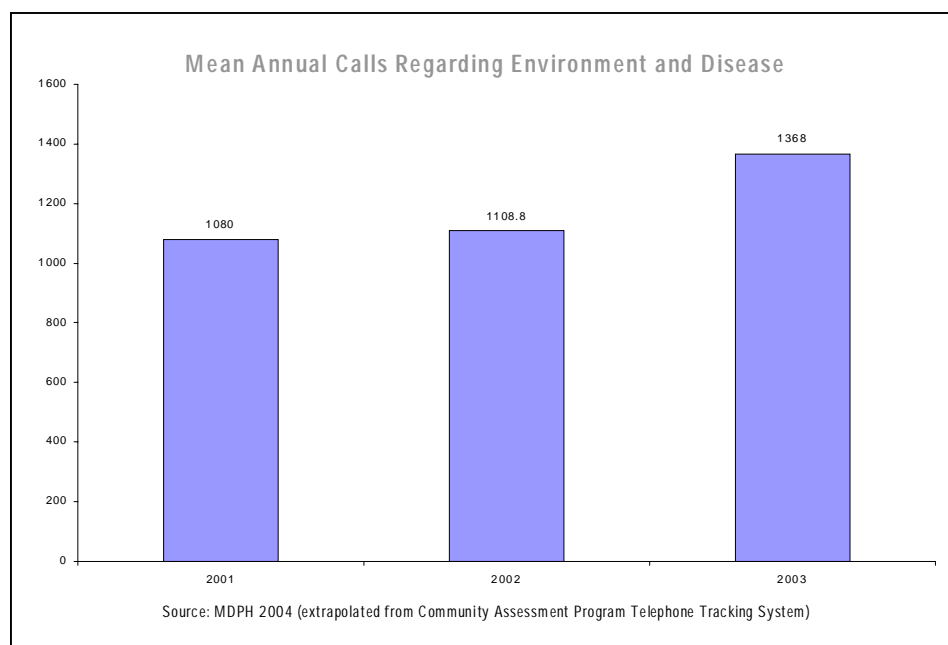
Environmental Health

Environmental health services performed by the Massachusetts Department of Public Health's Bureau of Environmental Health Assessment include the tracking or surveillance of important diseases, such as childhood asthma, childhood and other cancers, and lead poisoning. It is the expertise within this bureau that designs

The dangers of environmental toxins and chemicals are only beginning to be understood as both causes of and triggers to acute and chronic disease. With an overall cut of 37% of its budget from FY01 to FY04, the Bureau's ability to protect the public from environmental danger is severely compromised.

community-based studies and conducts investigations to clarify whether an environmental agent is correlated to illness. As the funding to the Bureau for its community studies has fallen by 39% since FY 2001, the number of calls received by its Community Assessment Program has taken the opposite course—trending upward at a rate of 22% over the same period.

The work of the Bureau, however, extends far beyond its well-known study of contaminated drinking water exposure to mothers and subsequent diagnoses of leukemia in their children in Woburn. The Woburn leukemia problems became the subject of the book and movie, *A Civil Action*. The loss of \$1.9 million in Department of Public Health funding for research on environmental hazards and breast cancer has effectively stopped almost all of this research in Massachusetts. In addition to community cancer investigations, the Department maintains several registries related to indoor



environmental hazards and exposures and health outcomes.

Many ongoing investigations have been discontinued in the middle of the investigation and other studies will go into a longer waiting time for execution. A recent Boston Globe article reported the frequency of calls to the health department for help in answering a question about excess cases of disease in a community and the difficulty in conducting environmental risk analyses.³² A decrease in staff and/or a delay in investigations is inevitable due to budget cuts. Those suffering from the burden of an illness may not get clarifying answers about the origins of their disease, and communities threatened by dangerous environmental hazards or increases in disease may not know the causes or the extent of the danger.

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Public Health Infrastructure

In a recent report ranking public health indices among all fifty states, support for public health³³ in Massachusetts fell from a rank of #1 in 1990 to #4 in 2002 and most recently to #22 in 2003.³⁴ This indicator validates the impact of social, health, and other state and local budget cuts on public health services. As mentioned earlier, in 2003 Massachusetts experienced one of the two biggest decreases in spending on public health.³⁵ The implications of these drops in rank are reflected in the loss of public health capacity on both the state and local levels in the Commonwealth.

The public health infrastructure is characterized as the "nerve center of public health."³⁶ And it is built on precious resources—both fiscal and human. The Healthy People 2010 Objectives for the nation include objectives regarding public health infrastructure in several areas: data and information systems, skilled workforce, effective public health organizations, resources, and prevention research.³⁷ Because of the importance of public health's role in local and national security and preparedness for all hazards, there is more interest and attention on building an effective and sustainable public health

infrastructure today than in recent history. But the more than \$28 million in federal funds flowing to state and local health departments from the Centers for Disease Control and Prevention and the Health Resources and Services Administration is dwarfed by the cuts of almost \$160 million in state funds to the Department of Public Health and local health agencies. The federal support of preparedness for bioterrorism and other emergencies, which should have enhanced and expanded the state's efforts, can neither outweigh nor prevent the deterioration of the public health infrastructure in Massachusetts.

Local Public Health

Massachusetts is fortunate to have both a strong state public health department as well as able and creative local health agencies. Local boards and commissions of health throughout the Commonwealth provide outreach and information that is locally appropriate and accessible, monitor outbreaks of disease, inspect facilities, provide immunizations and screenings, and enforce health codes and regulations. They are central to the administration of public health and the guarantors of local health quality. Massachusetts has 351 cities and towns, each with its unique Board of Health. Depending on the size of the community and resources, public

The loss of over \$4 million in state funds to local health authorities for tobacco control initiatives has resulted in a jump in illegal sales of tobacco to minors.

health activities are performed by the local agency alone and/or with the support of the state health department. Programmatic cuts to local programs often reduce tiny staffs to part-time or non-existent ones, and program losses are felt immediately. For instance, the loss of over \$4 million in state funds to local health authorities for tobacco control initiatives has

resulted in a jump in illegal sales of tobacco to minors. The Massachusetts Association of Health Boards reports the tripling of sales of tobacco products to teen-agers, since most local health departments have had to end their programs of monitoring and enforcing local regulations prohibiting tobacco sales to minors. Already stretched to the limits of their resources, local health departments have for years assumed regulatory responsibilities that have been unaccompanied by concomitant funding, and enforcement of the long-awaited statewide workplace smoking ban is the most recent example of this.³⁸

"We lost all of our cell phones and two-way radio capabilities, so we have fewer staff covering more jobs and territory, but no way to stay in touch."

The health departments in the larger cities have also experienced the loss of funds for critical services such as AIDS education, substance abuse services, homeless services, immunizations, chronic disease screenings, and school health services. At the same time that cuts have devastated local capacity, there have arisen new public health dangers for which local health authorities have either monitoring and surveillance responsibilities or are expected to be first responders. Local authorities' ability to respond to SARS, the West Nile virus, the next major flu epidemic, or food-borne disease outbreak is compromised. In addition to the cutbacks in funds and program support from the state to local health departments, cities and towns through the Commonwealth have lost millions in local aid funds, funds that have been used to support local public health. So, rather than municipalities having the ability to replace lost funds, they have even less capacity to maintain their share of funding.

Compounded by losses in local aid, local health agencies are eliminating some functions and reducing the amount of time spent on others. In addition, restaurant inspections and other required inspections and investigations take

“We are on a job freeze. Fifty-two people took early retirement, and we were allowed to replace only 20 of them. So now there are less people to do the work. There are only 2 health inspectors.”

longer to accomplish and sometimes suffer in quality. This has meant the elimination of local health capacity in many instances, the total destruction of successful programs in others, the erosion of already scarce staff in many small communities, and an inability to carry out their traditional and new responsibilities.³⁹

Ignoring the day-to-day responsibilities of local public health departments may lead to emergencies (e.g., delayed food inspections at restaurants can lead to food-borne illness and communicable disease). A recent example of how this can overwhelm the local system was observed in Arlington, Mass. The local health department mobilized quickly to conduct clinics for thousands of restaurant patrons needing inoculation to protect them from hepatitis A.

Marked reductions in the public health workforce are noted not only in the local departments, but at the state department of public health as well. Since the first budget cuts in 2001, the Massachusetts Department of Public Health has sustained an overall reduction of its workforce. Cuts in public health funding in FY02 and FY03 equated to layoffs of 1200 people, representing hundreds of years of irreplaceable expertise, experience, and institutional memory.

Data Collection, Analysis, and Reporting

The cuts in public health infrastructure have reduced the capability at the state and local level to maintain information systems to track health outcomes and utilization of services at the community and state level. The production of data at the local level in a timely manner is critical for state and local policymakers to assess need, monitor the impact of new interventions or the impact of budget cuts, and to allocate resources. Cuts in tracking systems make it impossible for policymakers to monitor the true effects of cutbacks.

- How many people who lose insurance because of waiting lists or caps now end up in emergency rooms and cost far more to treat?
- How many students now have no access to health services because their school clinic has closed or their school nurse is unavailable?
- Who is being treated for advanced states of cervical, breast, or prostate cancer who would have benefited from earlier treatment at a fraction of the dollar and personal cost?

Cuts in tracking systems make it impossible for policymakers to monitor the true effects of cutbacks.

Local data in the past have enabled communities to identify and address infant mortality and teen birth⁴⁰ issues, to recognize growing and changing problems in substance abuse and sexually transmitted disease, to identify causes and locations of food- and animal-borne outbreaks of disease, and to track new and emerging infections.

The state public health department has been lauded for its outstanding and timely data reports. The Trust for America's Health distinguished the MDPH for the quality of its cancer data and cited

its Cancer Registry's Gold rating by the North American Association of Central Cancer Registries.⁴¹ The MDPH has received national recognition and a state award for MassCHIP,⁴² a user friendly, free on-line system, designed and administered by the department's Center for Health Information, Statistics, Research, and Evaluation. MassCHIP provides community health profiles and maintains health, economic, and social data over time that can be accessed for various levels of geography, from census tract to city and town to region. In addition, the state health department, in partnership with local city and town clerks, maintains vital records for births, marriages, and deaths. All of these systems were being updated to web-based electronic systems to make them easier to access in the future.

Recent budget cuts in the administrative account for the department and all the programmatic accounts have curtailed much of the data production and dissemination work in the department. Program areas such as HIV/AIDS, substance abuse, and chronic disease no longer have funds available to support the survey questions and information systems needed to understand the impact of a particular disease or track the risk behaviors and conditions that exaggerate the development of the disease or its consequences. The assessment function of public health has been greatly limited by the recent department budget cuts, since each of the program areas has supported the information system infrastructure in the past.

Community Health Centers

The state budgets from FY01 to FY04 reduced funds for community health centers by 30%, from \$6.2 million to \$4.4 million. Many community health centers have been forced to reduce the services they offer despite actions such as mergers with other Centers to lower administrative costs. They have *reduced* staff as demand is *growing*. Codman Square Health Center and Dorchester Multi-Service Center, for example, have tried all of these strategies, but these cuts still represent a 25% budget loss for both entities.

Since community health centers (CHCs) do tend to be in medically underserved areas and serve populations who are uninsured or underinsured and often at risk for inferior services and health outcomes, the cuts to community health centers will exacerbate the risk that health disparities will grow in Massachusetts as medical costs rise. The network of non-profit community health centers serves 1 out of every 10 patients in the Commonwealth.

CHCs provide comprehensive primary and preventive health care, including medical, dental, social, and mental health services. CHCs are an integral part of the Massachusetts "Safety Net," providing high quality care at reasonable cost to otherwise medically disenfranchised state residents. The number of visits to CHCs has continued to rise over the past four years, while state support has decreased. In 2003, 50 CHCs provided over 3 million visits through 181 sites statewide.⁴³ As proposals to reform the Commonwealth's Uncompensated Care Pool include shifting care for some patients away from hospitals and toward community health centers, the burden to CHCs is expected to increase.

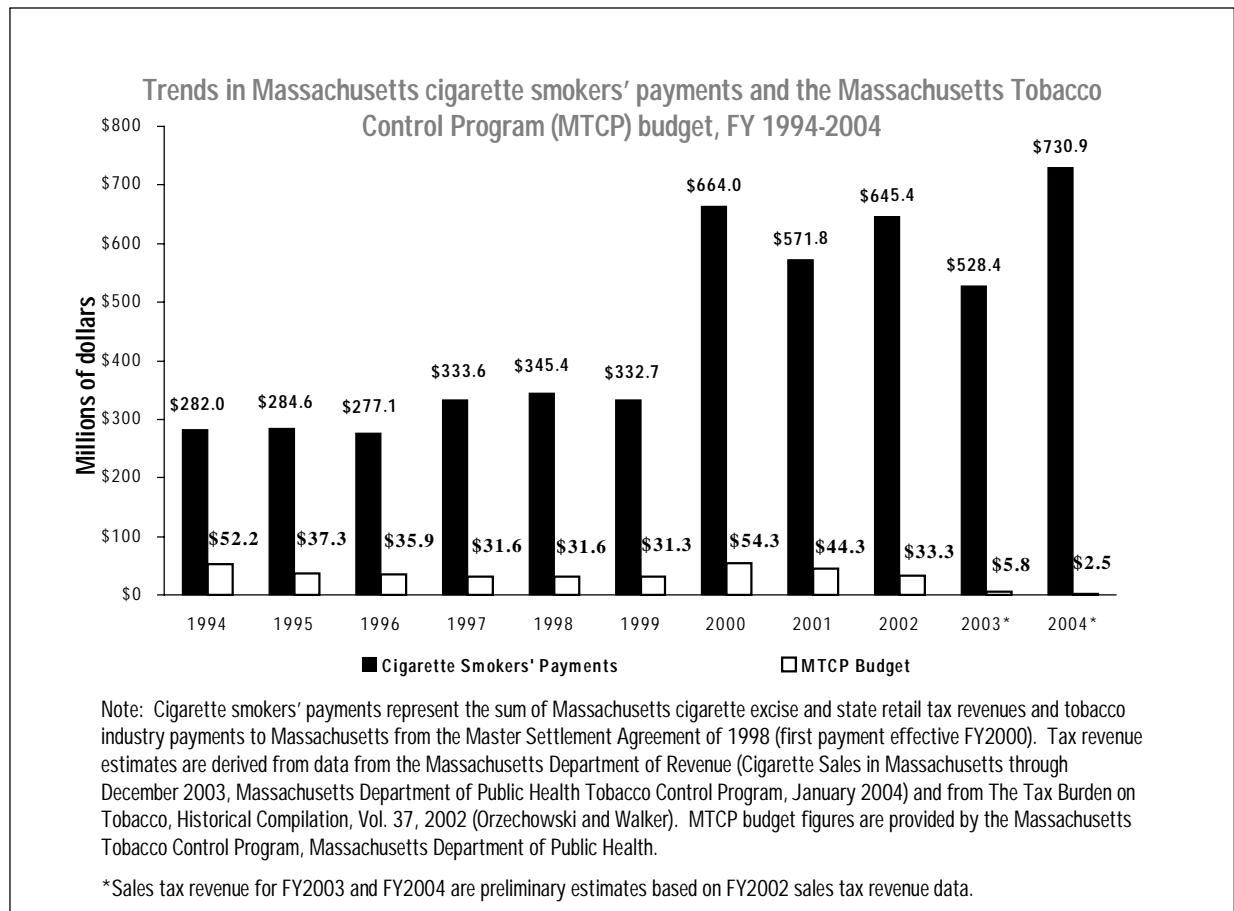
Tobacco Control

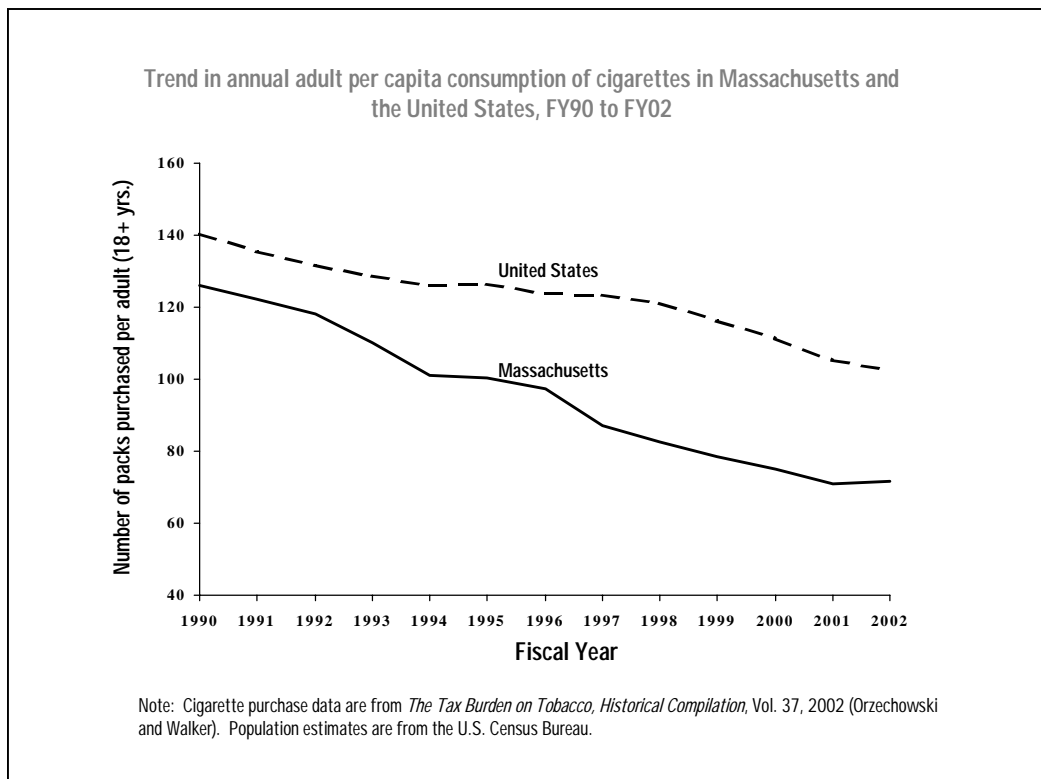
Perhaps the starkest and most dramatic example of the state budget cuts to cost-effective, health-protecting, and disease-preventing public health programs is that of the Massachusetts Tobacco Control Program (MTCP), once a national leader in tobacco control. The program was established in 1993 and funded in part through a ballot referendum passed by Massachusetts voters to raise the tax on tobacco products. The program developed a 10-year track record of reduction in youth and adult smoking. Even though the program had demonstrated successful outcomes in terms of youth and adult tobacco use and in reducing the public's exposure to environmental tobacco smoke, the program has been slashed from over \$48 million to approximately \$2.5 million in just the past two years. This reduction in funding earned Massachusetts a rank of 40th among states' investments in tobacco control by

the Campaign for Tobacco Free Kids, based on its spending at a mere 7.1% of the CDC-recommended level.⁴⁴

Although the money coming to the state from smoking has steadily increased in the past five years and in fact doubled since 1998, the amount spent on tobacco prevention and control activities has decreased by 95% from FY01 to FY04. In a recent survey of states, the federal government reported that, after spending only 4% of its FY03 Master Settlement Agreement payment on tobacco control, Massachusetts expects to spend 0% of the Master Settlement funds on tobacco control in FY04 and instead is allocating 100% for non-health, general purposes.⁴⁵

With the Legislature's recent enactment of a historic statewide workplace smoking ban, the successes of the MTCP are well documented and accompanied by powerful statistics about





protection of the health of Massachusetts residents. With an average budget of \$31 million dollars annually through FY02, the MTCP provided a range of statewide and local services, including youth prevention programs, tobacco treatment services, boards of health, community mobilization networks, school-based education programs, media campaigns, tobacco product regulations, a tobacco quit line, and training, to the communities of Massachusetts. The three MTCP goals are to prevent young people from starting to use tobacco and reduce their access to tobacco, to help adult smokers stop smoking, and to protect nonsmokers by reducing their exposure to environmental tobacco smoke. Reducing tobacco use among teen-agers is the most difficult of any tobacco control program. Massachusetts finally managed to do that after 10 years of aggressive and creative work, but now the tobacco control program is all but eliminated.

As one of the many examples of “you get what you pay for” in public health – like the great success with teen pregnancy and the progress on infant mortality – smoking reduction could be the poster child of public health practice. Using education, outreach, regulations, and

collaboration and having the money to support all of those, Massachusetts led the nation. Massachusetts funded its own program initially through a tobacco tax and should have access to even greater Master Settlement funds. The money invested and the programs designed have had clear and documented success.

Tobacco is the leading cause of preventable death in Massachusetts, accounting for close to 9,300 deaths each year. Smokers lose over 118,000 years of potential life annually. The health care costs of caring for people with smoking related illnesses

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surpass \$2.7 billion dollars a year.⁴⁶ Massachusetts developed one of the most successful tobacco control programs in the world during the last decade.

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The Massachusetts Tobacco Control Program is responsible for many positive outcomes. Massachusetts per capita cigarette consumption (age 18+) has fallen 41%, from 117 packs in 1992 to 69 packs in 2002. This decrease is two and one-half times the rate observed for the rest of the nation. The prevalence of current adult smokers (18.3.0%) in 2001 decreased from 20.0% in 2000, and remained below the base rate of 22.6% in 1993. The average number of cigarettes smoked per day fell from 19.7 in 1993 to 16.7 in 2001. Similarly, the daily smoking rates of adults in

Massachusetts continued to decline, falling from 19% in 1993 to 14.5% in 2001.⁴⁷

Current cigarette smoking (30 days prior to survey) among adolescents in Massachusetts had decreased significantly from 35.7% in 1995 to 26.0% in 2001.⁴⁸ This change represents a 27% decline in the smoking rate among adolescents in the past six years. There has been a steady and significant decline in adolescent smokeless tobacco use from 1993 (9.4%) to 1997 (6.0%) to 2001 (4.4%). This represents more than a 53% decline in the use of smokeless tobacco among adolescents.

Massachusetts leads all states in the *decline* in percentage of women who smoke during pregnancy. In Massachusetts, the number of women who smoked during pregnancy declined 58%, from 25.3% in 1990 to 10.8% in 1999. In 2002, that figure fell to 7.9%.⁴⁹ In the 1990s, the percentage of Massachusetts women aged 15-19 years who smoked during pregnancy declined 32%, from 31.3% in 1990 to 21.2% in 1999. This decline is double the national rate for the same period of time.

Massachusetts adults report a decrease in exposure to secondhand smoke in the workplace from an average of 4.6 hours per day in 1993 to 1.4 hours per day in 2001. The percentage of private worksites in Massachusetts with an indoor smoking ban increased from 53% in 1993 to 82.2% in 2001. The proportion of Massachusetts adults who live in smoke-free households has increased from 40.7% in 1993 to 71.2% in 2001.

The number of Massachusetts residents protected by tobacco control ordinances has grown since Question 1 was passed in 1992. Major cities, beginning with Boston, have banned restaurant smoking, taken the lead on smoking in public buildings, and encouraged prohibitions on workplace smoking. From 1993 through 2001, Massachusetts cities and towns, with a combined population in excess of 5.5 million, adopted provisions requiring permits for tobacco retailers. The population of cities and towns with each type

of provision (public building smoking and youth access) has more than quadrupled over that period. Smoking provisions now cover more than two-thirds of all residents of the Commonwealth.

The evidence shows that when they are sustained over time, comprehensive, well-funded tobacco prevention programs save lives and money. Two recent studies show that California has saved tens of thousands of lives by reducing smoking-caused birth complications, heart disease, strokes, and lung cancer. Other studies have shown that California and Massachusetts (which started their tobacco prevention programs in 1990 and 1993, respectively) have saved as much as \$3 in smoking-caused health care costs for every \$1 spent on tobacco prevention.

A recent study from the CDC published in the *Journal of Health Economics* provides some of the most powerful evidence yet of the effectiveness of comprehensive tobacco prevention programs. The study found that states with the best funded and most sustained tobacco prevention programs during the 1990s—Arizona, California, Massachusetts, and Oregon—reduced cigarette sales more than twice as much as the country as a whole (43 percent, as compared with 20 percent). This is the first study to compare cigarette sales data from all the states and to isolate the impact of expenditures on tobacco prevention programs from other factors that affect cigarette sales. The study shows that the more states spend on tobacco prevention, the greater the reductions in smoking, and the longer states invest in such programs, the larger the impact. The study concludes that cigarette sales nationwide would have declined by twice as much as they did between 1994 and 2000 had all states fully funded tobacco prevention programs.⁵⁰

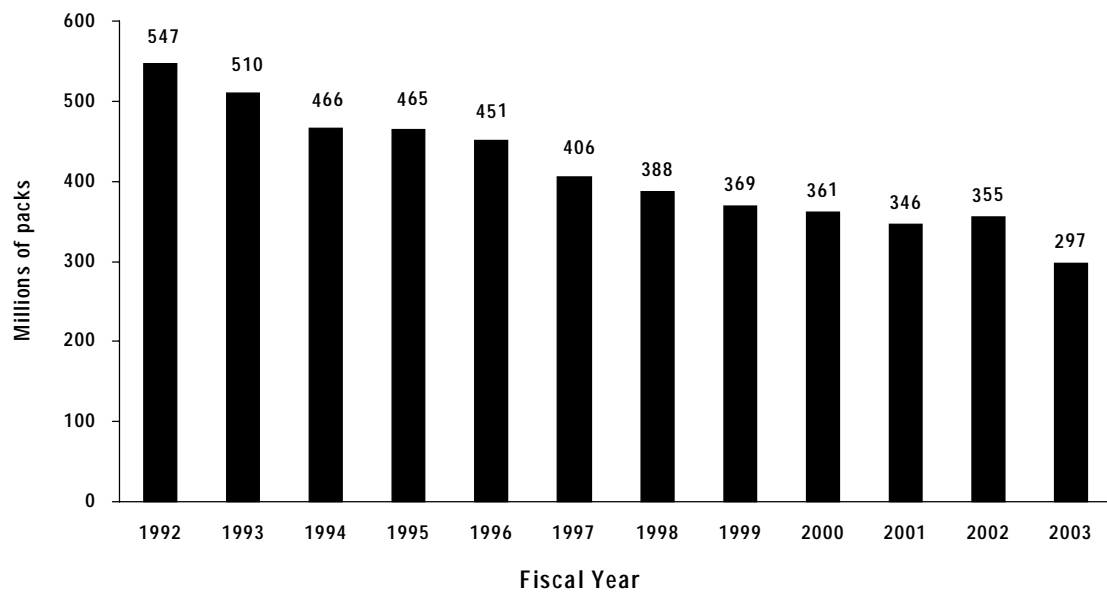
All of these successes came as a result of Massachusetts having one of the best tobacco control programs with all of the components recommended by the Centers for Disease Control and Prevention. Essential components of the program, such as the media campaign, community-based tobacco treatment programs,

The Massachusetts' ranking among states for funding for tobacco prevention, which is done annually by the Campaign for Tobacco-Free Kids, dropped from one of the top five to 37th in FY03 and to 40th in FY04.

and youth prevention programs, have been eliminated and other essential components, such as the boards of health funds for compliance checks and community mobilization networks, have been drastically reduced. Not surprisingly, these drastic cuts already have resulted in increased levels of smoking by youth.

The first results of these cuts can be seen in the sharp rise of illegal sales to minors in communities across the Commonwealth.⁵¹ After illegal sales to minors had fallen from 39% in 1994 to just 10% in 2001, the proportion of retailers who sold tobacco to minors in 2003 (12.3%) increased 68% over the proportion recorded in 2002 (7.3%). In 2003 there was an increase in tobacco sales to minors in communities with no funding to boards of health; these communities had 17.4% illegal sales to minors, as compared with 12.3% in the communities who had funded boards of health. This increase in illegal sales to minors has two important implications: (1) youth smoking rates are increasing, and (2) federal substance abuse funding to Massachusetts may be in jeopardy because the state cannot make the targets for illegal sales to minors as established by the Synar amendment. The Massachusetts' ranking among states for funding for tobacco prevention, which is done annually by the Campaign for Tobacco-Free Kids, dropped from one of the top five to 37th in FY03 and to 40th in FY04.

Cigarette packs sold in Massachusetts: FY92 to FY03



Note: Data are from the Massachusetts Department of Revenue and represent the sum of packs taxed, calculated from tax revenue. Data source: *Cigarette Sales in Massachusetts through December 2003*, Massachusetts Department of Public Health Tobacco Control Program, January 2004.

HIV/AIDS, Hepatitis C, and STDs

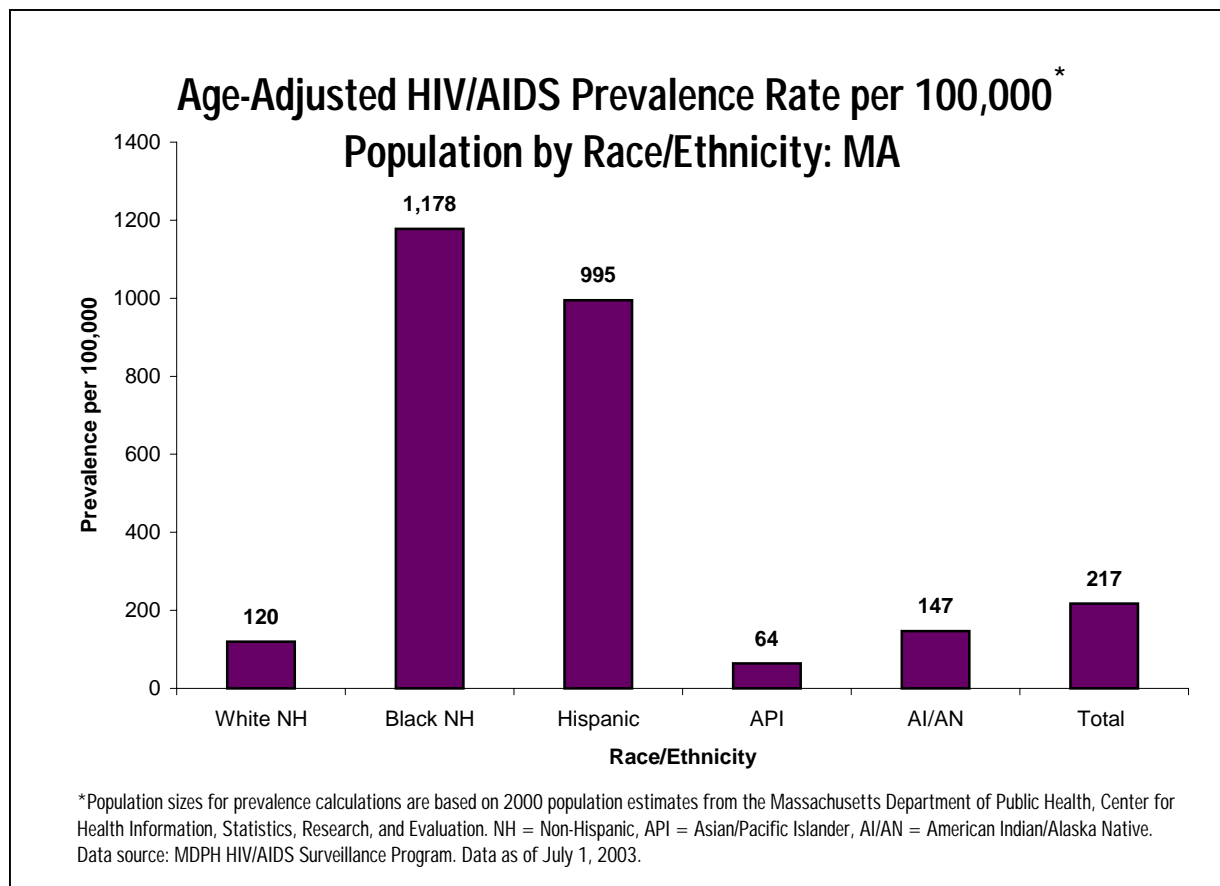
HIV/AIDS

HIV/AIDS, sexually transmitted diseases (STDs), and hepatitis C are linked with each other and with services for substance abuse. Both HIV/AIDS and hepatitis C are transmitted through intravenous drug use; HIV/AIDS is usually more aggressive in the presence of another sexually transmitted disease. Unprotected sex is the primary means for spreading AIDS, as well as all other sexually transmitted diseases. In addition to the dangers of intravenous drug use, unprotected sex is more likely to occur when at least one of the parties has used alcohol or drugs.

In 1985, less than two years after the disease was identified, the Massachusetts HIV/AIDS Bureau was established. Since 1983, when Governor Michael Dukakis convened the Massachusetts Task Force on AIDS, Massachusetts has been a leader in the fight against this deadly disease.

AIDS prevention and education through various programs have greatly affected the prevalence and incidence of HIV in the Commonwealth – sending the trend on a downward spiral for much of the late 1990s. However, in 2002 over 7,600 Massachusetts women and men were reported to be living with AIDS and an additional 6,000 were reported to be living with HIV. They constitute the largest number of people known to be living with HIV/AIDS in the state at any point since the beginning of the epidemic. In total approximately 20,000 to 22,000 people in Massachusetts were living with HIV/AIDS in 2002.

HIV/AIDS program funding has been cut 37% from FY01 to FY04. These program cuts have eliminated community prevention programs, severely limited outreach and early identification, and decreased the amount of treatment and other support services to individuals with HIV/AIDS. These cuts are even more devastating since they have been implemented simultaneously with



major cuts to STD programs, family planning, and a range of treatment services for substance abuse. All of these services complemented each other and reinforced messages of responsible and healthy behaviors.

It is estimated that as many as 7,000 Massachusetts residents are infected with HIV but do not know it. We do know that the growth in AIDS cases is disproportionately high in young people aged 13-24 and in women of color, and that there is resurgence in the gay male population; yet one of the areas that have been cut most severely is testing and counseling for HIV/AIDS.

Confidential testing and counseling is one of the primary methods for stopping the spread of AIDS. Budget cuts have ended more than a third of all testing and counseling sessions, and concomitant cuts in substance abuse programs and family planning, which also often included an AIDS component, have eliminated a number of community-based avenues that provided information and referrals. The DPH's goal of decreasing the number of new HIV infections as well as limiting secondary conditions and other diseases in individuals living with HIV/AIDS in the future will be a great challenge.

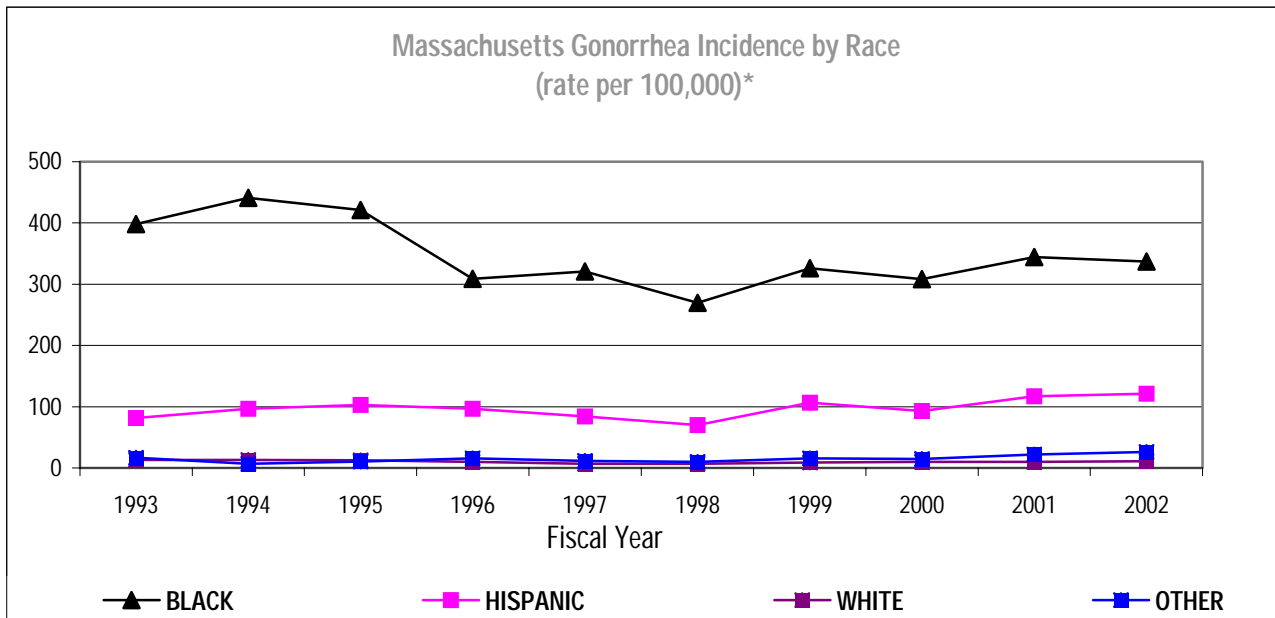
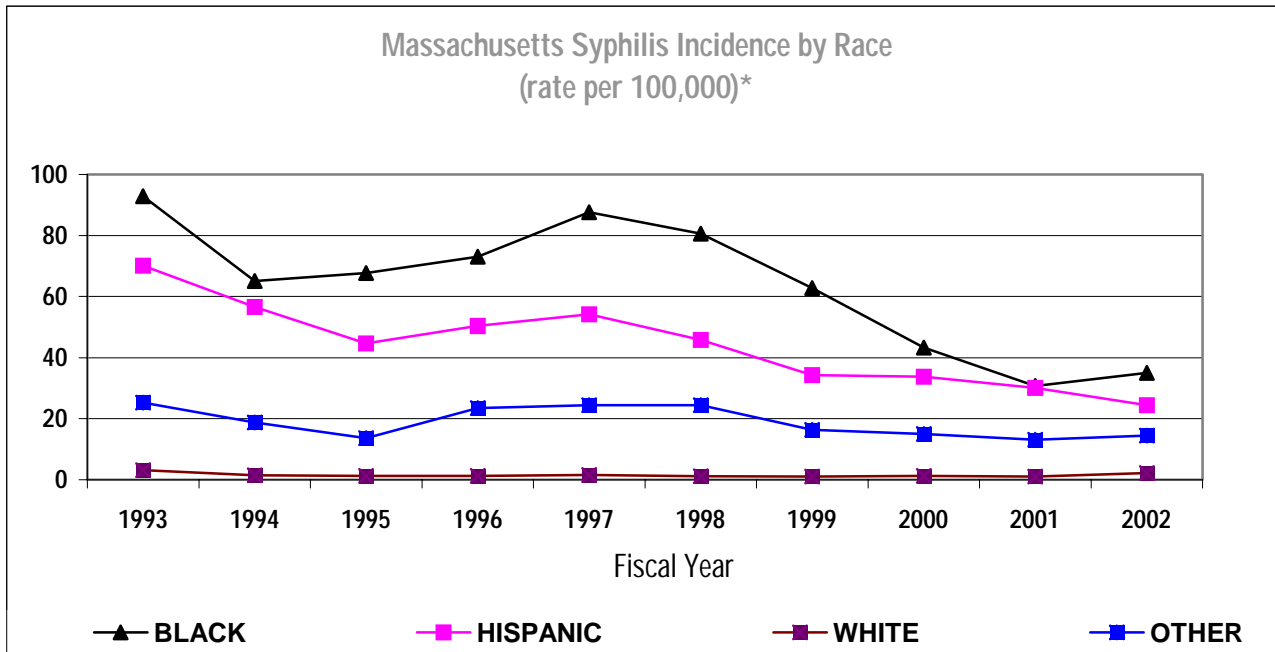
Hepatitis C

Hepatitis C is the most common blood-borne virus in Massachusetts and can lead to cirrhosis, liver failure, liver cancer, and death; approximately 110,000 Massachusetts residents are currently infected with the hepatitis C virus, and most of them don't know it. It is estimated that 60-80% of HIV-infected injection-drug users are also co-infected with hepatitis C, and 10-20% of hepatitis C-infected drug users are co-infected with HIV. Another study found that about 90% of all clients in methadone treatment have hepatitis C.⁵² Since there is no vaccine to prevent hepatitis C, it is essential to educate those most at risk for becoming infected, or in the early stages of infection, when treatment appears most effective. The hepatitis C program was funded for \$2.75 million in FY01 and FY02 and provided resources to implement a range of prevention, detection, and treatment services related to hepatitis C. These funds were reduced by 80% in the FY04 budget, eliminating case management programs and severely curtailing other outreach and support services. At the same time, hepatitis C, with a specific earmark of funds, was transferred to the AIDS funding stream. The impact of these cuts was compounded by simultaneous cuts in HIV/AIDS and substance abuse services.

*Sexually Transmitted Diseases:
Chlamydia, Gonorrhea, and Syphilis*

The cuts in resources to HIV/AIDS, MassHealth (especially the elimination of MassHealth Basic in April 2003), family planning, and school-based health services also affect the delivery of sexually

transmitted disease (STD) services within the state. The incidence of new cases of chlamydia, gonorrhea, and syphilis have been increasing since budget cuts began in 2001. This is problematic since an increase in STD incidence is likely to accelerate the number of new cases of

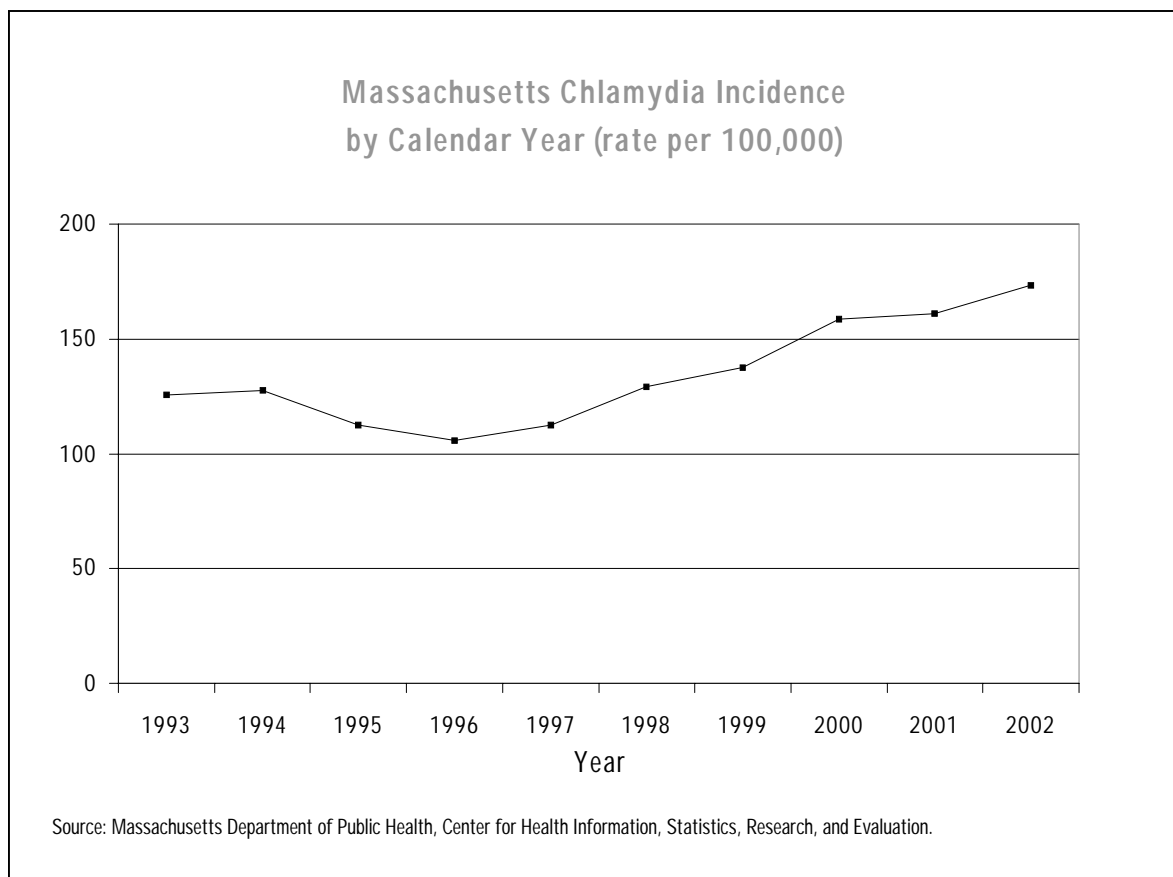


*Source for syphilis and gonorrhea figures is the Massachusetts Department of Public Health, Center for Health Information, Statistics, Research, and Evaluation.

HIV/AIDS. This is especially troubling at a time when a new form of gonorrhea that cannot be treated with standard antibiotics has been detected in Massachusetts.⁵³

Massachusetts has higher rates than the national average in many sexually transmitted diseases, especially among adolescents. For girls especially, STDs often serve as the gateway to HIV/AIDS. STDs are also linked to other, sometimes life-threatening diseases and to sterility.

In 2002, the state supported 13 STD clinics in hospitals and community health centers; in the 8 clinics that remain, administered with 50% fewer funds than in 2002, 6,000 fewer patients will be able to get essential STD services.



Substance Abuse

Substance abuse is another area where Massachusetts does not rank well compared with other states. The findings from national and state surveys consistently show that the New England states are higher than the national average in the use of alcohol, marijuana, and other drugs.⁵⁴ Massachusetts is always in the top 20% when compared with other states, depending on the age group and the substance considered, ranking between first and fifth. Substance abuse services have been cut by 24% (\$10.8 million) from FY01 to FY04. Moreover, the Commonwealth is at risk of a penalty totaling over \$9 million in federal funding because of the failure to achieve a federally required maintenance of effort.

More specifically, among adults (aged 18 and over) in 2001, 70% indicated using alcohol in the past thirty days, and 6% reported illicit drug use (e.g., heroin, cocaine, marijuana, ecstasy, etc.) in the past thirty days.⁵⁵ Use among young adults (aged 18–24) was more alarming: in 2001, 52% of young adults reported binge drinking (five or more drinks on any one occasion within the past thirty days) and 21% had used illicit drugs in the

past thirty days. Illicit drug use is prevalent across all income groups, with the highest current illicit drug use in the \$35,000–\$49,999 household income group.

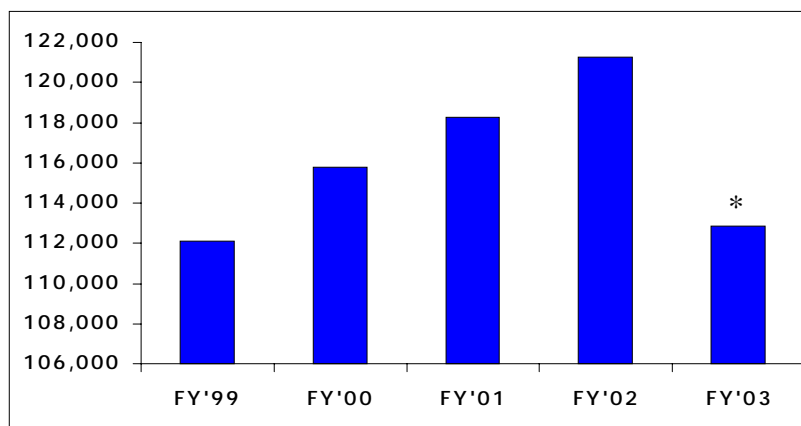
The Massachusetts Youth Health Survey conducted in 2002 indicated the following substance use within the past thirty days: 21% of middle school students (grades 6, 7, and 8) reported alcohol use, 41% of ninth graders reported using alcohol, 8% of middle school students reported marijuana use, 26% of ninth graders reported marijuana use and about 1% of both middle and high school students reported heroin use. On a positive note, the age of first use of alcohol increased from 9 to 10 years of age in 1999 to 11 to 12 years age in 2002.⁵⁶

Of particular concern is the alarming and widespread use of heroin across all geographic areas of the Commonwealth and among all age, economic, and racial and ethnic groups. Heroin use has increased over the past decade due to higher purity levels, lower price, and changing cultural attitudes toward its use. Associated with this increase in use are parallel increases in deaths, hospitalizations, emergency room use, and treatment admissions and new cases of HIV and hepatitis C due to heroin injection.⁵⁷ From 1999 to 2001, opioid-related fatal overdoses increased by 48%.⁵⁸

The heroin epidemic is evident in the characteristics of adults (18 and older) entering substance abuse treatment services. For example, the number and proportion of clients seeking services for heroin addiction in Massachusetts has increased from fewer than 20,000 (16% of all admissions) in 1992 to 48,496 (43.2%), the largest proportion of *all* admissions in 2003; currently, 90.3% of adult admissions in Short Term Residential Services (detox and other acute treatment services) report heroin as their primary drug. Due to reductions in system capacity during 2003, total admissions dropped, but heroin users still constituted the largest proportion of all adult admissions.⁵⁹

After more than 25 years of rescuing alcohol and drug addicts in the Cambridge-Somerville area, CASPAR loses half its funding from state cuts; it closes its intervention center and detox beds and turns away people it knows have no other recourse. Rather than being returned to productive lives, addicts are showing up in local emergency rooms and jails. It costs, at most, \$200 a night to support a homeless person in a shelter, often much less; it costs upwards of \$1500 for an overnight hospitalization; jails' costs are between these two.

Substance Abuse Treatment Admission Trend FY99 to FY03



*Lower admissions are a result of a reduction in public resources.

Statistics reported on this slide are for adults 18 and older.

Source: Massachusetts Department of Public Health, Center for Health Information, Statistics, Research, and Evaluation.

These alarming statistics on youth and adult substance use and abuse in Massachusetts illustrate the need for a continuum of substance abuse services including primary prevention, screening, and early identification; ambulatory and inpatient short and long term treatment and rehabilitation services; and recovery/after-care services. These services are needed with equal access for individuals in every community across the Commonwealth. There were not enough services in place in the continuum to meet the need even before the cuts began in FY 02. For example, it is conservatively estimated that over 527,000 Massachusetts residents aged 12 and older fit the clinical criteria defining treatment need. During 2002, only about 90,000 received treatment services across payer systems.

Three years of cuts to substance abuse services in public health have resulted in cuts to all parts of the continuum of services, including a 54% reduction in ambulatory services, a loss of 5 residential recovery programs or reduced capacity by 89 beds, elimination of outpatient and pre-treatment programs for youth, elimination of all child-care and parent support programs, elimination of all outreach and referral staff in

shelters who provide links to treatment, a reduction of 38 beds in Transitional Support Services, elimination of Driver Alcohol Education services for 1140 indigent offenders, and reductions in capacity in supportive housing programs to link individuals leaving treatment with housing and other services. In addition, even though it is known that the majority of persons incarcerated in the county houses of correction or state prisons have drug related offenses, there has been a 30% reduction in services to the county houses of corrections and the elimination of treatment services for women at MCI Framingham.⁶⁰

The most dramatic impact of both the DPH cuts and those in MassHealth has been on Acute Treatment Services (ATS). The elimination of MassHealth Basic and Level B (or "step-down") ATS beds in April 2003 caused a reduction from approximately 900 beds to 527 in one year. Six out of 22 ATS facilities have closed in the middle of the heroin epidemic—in Framingham, Greenfield, Leominster, Quincy, Boston, and Somerville. Massachusetts enjoyed a dramatic initial decline in MassHealth spending in 1993 (62%), when clients were directed from inpatient

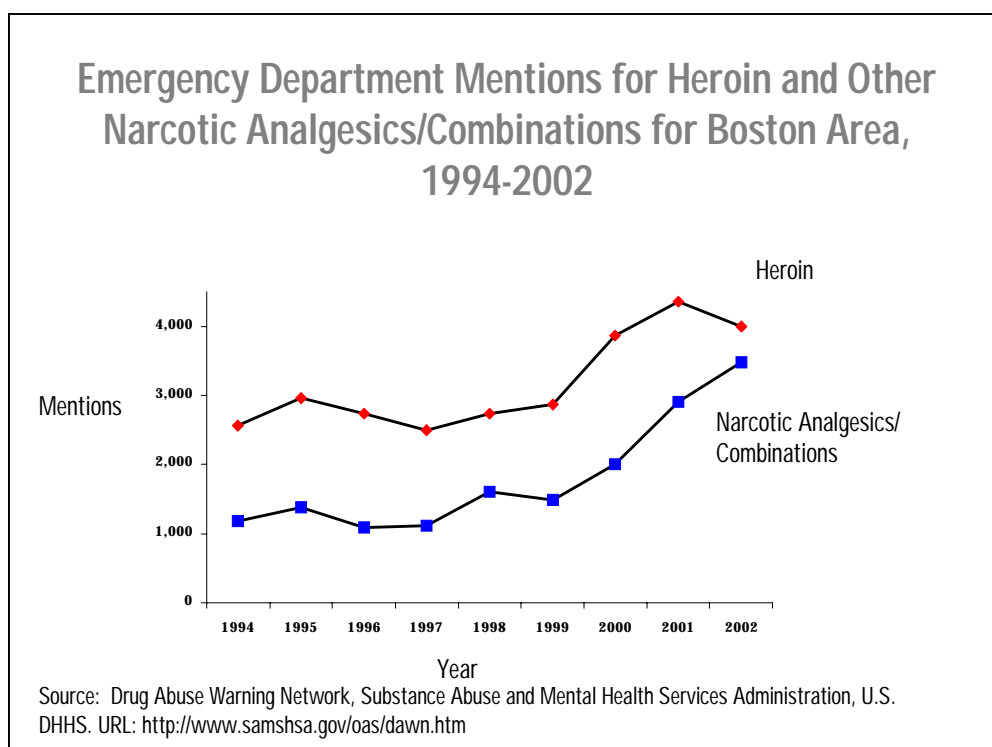
hospital settings to non-hospital based community clinics for substance abuse treatment.⁶¹ This trend has reversed with decreased capacity and access to treatment programs.

The existing programs are operating in very precarious times. Most providers, mindful that there is often a short window of opportunity when an addict is ready to go into detox, are trying not to reduce beds further, but reduce non-personnel costs, then staff. However, most have had to eliminate the follow-through counseling, monitoring, and assistance services that they have found to be key to success following detox. All of the service cuts are happening in an environment where rates for services are being reduced as well; substance abuse service rates are being cut by 2% (except for detox which is being cut by 1%).

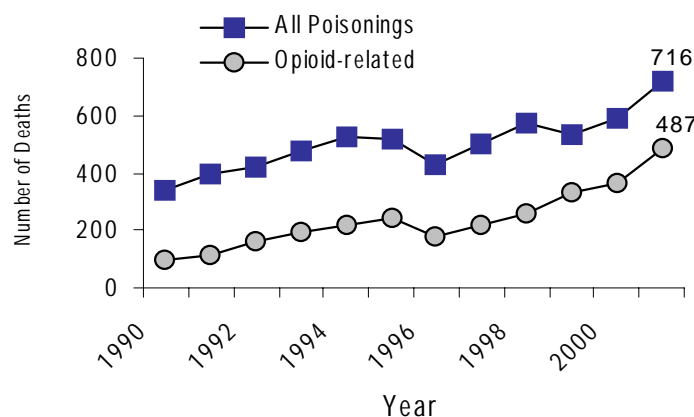
These rate and program cuts are on top of a provider system that is already beleaguered after a decade of funding with no increases to cover salaries and other operational costs. The Mental Health and Substance Abuse Corporations of

Massachusetts, Inc., a statewide trade association of 100 mental health and substance abuse service providers, estimates that 41% of their provider members experienced losses on operations in FY02; 45% of all human services employees cannot afford health insurance and their average weekly salary is about half of the average salary for all services industries in Massachusetts.⁶²

Many cuts in public health will not be manifest as increased disease or death for some time, but emergency rooms are already seeing the results of these cutbacks in substance abuse funds, eligibility, and services. In addition, budget cuts in substance abuse and in local aid to support police have preceded an increase in crimes in all communities across the Commonwealth.⁶³ Similarly, cuts in substance abuse and homelessness supports have resulted in a growing number of homeless individuals.⁶⁴ Increased deaths (from 50 in 1998 to 88 in 2001) due to the heroin epidemic in concert with decreasing services have been documented by the Boston Public Health Commission. In addition, deaths



Poisoning and Opioid-Related Fatal Overdoses, MA Residents, 1990-2001



Rates increased for both males and females and among all age groups 15-54.

Source: Registry of Vital Records and Statistics, MDPH.

due to drug overdoses “skyrocketed” in 2001; most of the 22% increase in deaths by overdoses were attributable to narcotics and hallucinogenic drugs. An example of what can happen with a compromised ATS system was reported recently in the MetroWest Daily News. The story describes the life and treatment history of a 19-year-old who unsuccessfully sought treatment for his addiction to heroin and died of an overdose in a shelter.^{65,66} During this time of budget cuts, there has been discussion within the legislature about the utility of methadone as a treatment for heroin addicts. The goal of treatment for all individuals addicted to heroin, alcohol, and/or other drugs is abstinence from the substance and a lifetime of recovery with no relapses. Individuals addicted to heroin are provided a continuum of treatment options including detox, outpatient therapy and counseling, and residential rehabilitation.

Reductions in the substance abuse line item in DPH, in addition to the elimination of MassHealth Basic and the Level B beds for detox for adults 18 years and older have drastically reduced the capacity for treatment. Given that there is a heroin epidemic in Massachusetts with a steady increase in use, deaths, hospitalizations, interpersonal violence, and crime, these cuts in substance abuse services will aggravate an already serious problem.

Domestic Violence and Sexual Assault

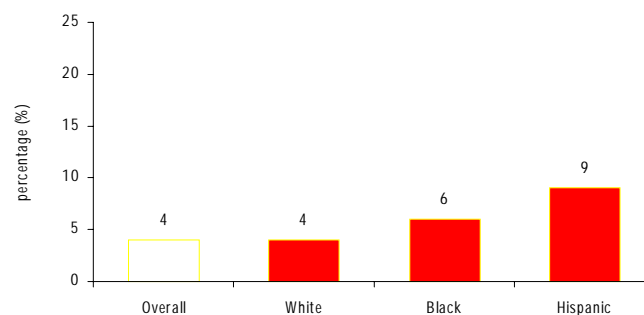
Cuts in family planning and teen pregnancy prevention programs are compounded by cuts in services to prevent or protect the victims of domestic violence and rape. Reduction in resources for all three areas have the effect of reducing the independence and physical and mental health as well as the safety of women. In FY04, state funds for domestic violence prevention (\$170,000) and batterer's intervention (\$900,000) were moved to the Department of Social Services, funds for the Sexual Assault Nurse Examiner program were drastically reduced (\$2.3 million to \$0.8 million), and funds for refugee and immigrant violence support services (\$780,000) were completely eliminated. A strong campaign by Jane Doe Inc., the statewide coalition against sexual assault and domestic violence, resulted in partial restoration of funds for sexual assault through a supplemental appropriation, however not before over 300 requests for rape crisis services were turned away or wait-listed.

Domestic violence is the leading cause of injury to women between the ages of 15 and 44,⁶⁷ and a Commonwealth Fund study showed that one in five girls of school age had been the victim of physical or sexual violence.⁶⁸ In 2000, 23% of

Massachusetts women aged 18-59 reported they had ever experienced sexual assault. In 2001, 4% of Massachusetts women reported experiencing intimate partner abuse in the past year, which is defined as experiencing physical violence or feeling fear of safety from anger or threats from an intimate partner (e.g., spouse, boyfriend/girlfriend, live-in partner, date). Hispanic women reported abuse twice as frequently as did white women. Violence such as sexual assault or intimate partner violence can result in serious injury or even homicide. The other health implications are also profound and include depression, poor reproductive health, and poor pregnancy outcomes, unintended pregnancy, STD and HIV transmission, the exacerbation of chronic health problems from stress related to trauma, and risky health behaviors. Ironically, the state's cuts to programs that have helped women, men, and children escape from and recover from physical and sexual violence and abuse come at the same time that our society, including law enforcement, hospitals, schools, and churches, is starting to confront the extent and seriousness of violence against women.

Because violence against women is a public health concern as well as a criminal offense, programs supported by the Department of Public Health

Percentage of women aged 18-59 who experienced intimate partner abuse, by race/ethnicity, 2001



Source: Massachusetts Department of Public Health, Center for Health Information, Statistics, Research, and Evaluation.

have been developed at the community level to reach and help people across the economic, racial, ethnic, and geographical spectrum. It is essential that communities who may have ignored or denied violence in their midst come to realize that it affects every group in our society. Crisis services, counseling programs, community education and outreach efforts serve an important role both in helping victims and educating communities about the impact of violence against women and supporting them in ending the violence.

Violence Prevention and Intervention Services at the Department of Public Health supports programs for survivor-centered prevention and intervention services, such as Refugee and Immigrant Safety and Empowerment, Sexual Assault Prevention and Survivor Services, Batterer Intervention Services, Domestic Violence Prevention, and the Sexual Assault Nurse Examiner Program. Together these programs provide a range of education, outreach, prevention, intervention, and surveillance services to prevent and reduce sexual assault, domestic violence, and related threats to the safety of women, children, and families. In addition, the programs also collaborate with other private and government agencies on policies and practices concerning violence against women.

Refugee and Immigrant Safety and Empowerment (RISE) provided intensive linguistically and culturally specific domestic violence services including crisis intervention, interpretation, victim support, victim advocacy with police, courts and social services, and education and outreach to isolated immigrant communities about rights and services. All funding for RISE was eliminated in FY04.

Sexual Assault Prevention and Survivor Services (SAPSS) support community-based rape crisis centers across the Commonwealth to provide crisis counseling and support to sexual assault survivors and their significant others, as well as Llamanos, the statewide, 24-hour Spanish-language sexual assault crisis hotline. These

programs provide prevention education to communities and professionals and work with Jane Doe, Inc., to develop standardized curricula and best practice standards. Cuts to funds in FY04 resulted in a drastic reduction of hours of operation for Llamanos, the elimination of medical and police advocacy at rape crisis centers, and the establishment of waiting lists for crisis counseling services. There have been drastic reductions in funds for SAPSS in FY04, with a partial restoration of some funds in December 2004.

Domestic Violence Prevention provides violence prevention outreach and education to communities of faith in the Boston area and across the Commonwealth, as well as public education campaigns and service outreach and awareness to gay and bisexual men.

Batterer Intervention Program Services provides certification of programs for adolescent and adult batterers to promote cessation of dating and domestic violence, batterer accountability, and victim safety. The program also funds certified programs to provide services to indigent batterers and outreach and referral to their partners.

The Sexual Assault Nurse Examiner (SANE) program provides specialized training and certification of qualified registered nurses, Sexual Assault Nurse Examiners (SANEs). The SANEs provide quality medical care and expert forensic evidence collection for sexual assault victims in designated hospital emergency rooms. They collaborate closely with rape crisis centers, police, and district attorneys, and provide expert testimony at trial.

Conclusions

Based on the foregoing description of budget reductions, eliminations, and strains in the Commonwealth's public health system, several implications emerge.

Health disparities based on race, ethnicity, and social class are widening.

With the great success of Massachusetts public health during its history, there are glaring exceptions. Among those are racial and ethnic disparities in health status, often stemming from disparities in access, appropriateness, and cost of care. Many of the budget cuts during the last several years will exacerbate those disparities, creating greater inequity in our society, and reversing gains made in the previous decade. And the recent series of budget cuts also are disproportionately falling on the poor, on women, and on children. Some examples:

- The state has cut school health programs, including clinics and nurses, and capped the insurance program for poor children, many of whom have no other source of regular health care;
- Compared with whites, death rates from prostate and breast cancer are higher among African-Americans, diabetes deaths are higher for African-Americans and Latinos, and other cancer rates are higher among Asians, yet the state has totally eliminated many of the screening programs and severely cut the others;
- Teen pregnancy by definition is a responsibility and burden that falls on young girls; cuts in these programs along with cuts in family planning and school health clinics leave these girls without resources;
- Black infant mortality is almost three times that of whites, yet funds for WIC, the Healthy Start program, and Early Intervention have all been drastically cut;
- Latinos are proportionately the largest ethnic group of the working poor who lack insurance, and their age-adjusted death rate is ten times that of whites;
- The growth rates of venereal diseases among teen-agers are of alarming proportions and the growth rate in HIV/AIDS is greatest among people of color, especially women of color; venereal disease is an accelerant of HIV/AIDS. However, the state is cutting programs for AIDS education and training, AIDS and STD screenings, and family planning, which has both STD and AIDS education and screening components.

Data collection, analysis, and reporting remains essential to informed allocation of scarce public health resources.

Policymakers need useful and reliable data to make informed decisions about allocating resources in public health. Without a solid data and information system, the public health system can neither quantify nor respond to the need for resources to maintain and improve the public's health. The cuts in public health infrastructure have reduced the capability at the state and local level to maintain information systems to track health outcomes and utilization of services at the community and state level. The production of data at the local level in a timely manner is critical for state and local policymakers in order to assess need and monitor the impact of new interventions or the impact of budget cuts. Cuts in tracking systems make it impossible for policymakers to know the true effects of cutbacks. How many people who lose insurance because of waiting lists or caps now end up in emergency rooms and cost far more to treat? How many students now have no access to health services because their school clinic has closed or their school nurses are unavailable? Who is being treated for

advanced states of cervical, breast, or prostate cancer who would have benefited from earlier treatment at a fraction of the dollar and personal cost? Particularly during times of drastic reductions in fiscal resources, the ability to evaluate the impacts of the investments made in public health is at its most critical.

The infrastructure of community-based organizations is weakening.

The cuts in public health are reversing years of progress in addressing some of the thorniest and most resistant problems in our society. For the past four decades a trend begun in Massachusetts and adopted across the nation has created an infrastructure of private, community-based organizations and agencies that provide local services to pregnant women, children with disabilities, the mentally ill, substance abusers, the elderly, linguistic minorities, and others. Local community-based organizations also are developing partnerships addressing asthma, obesity, smoking, homelessness, and teen pregnancy. Replacing large state institutions, they have demonstrated the ability to reach populations often ignored by larger, more centralized agencies. They have shown flexibility and responsiveness to different conditions, to changing populations, and the availability of new approaches and therapies. This positive result also has some disadvantages: the state no longer has any fallback or failsafe method for providing services and community-based organizations are vulnerable to changing priorities, changing ideologies, and changing funding. They are dependent on state funding and therefore often reluctant to criticize state agencies or policies. Cutbacks have now eliminated some of the most successful and innovative programs and are leaving some of the most vulnerable clients without services.

More research is needed to measure the impact of public health budget cuts on health status and on access to primary health care.

Just as the gains in health status and health outcomes in Massachusetts have come with a long history of investment in health protection and prevention, so will the real losses to our health status and health system take some time to be measured. Each of the areas of budget cuts highlighted in this Issue Brief beg additional research to ascertain the relationship between loss of preventive services and the demand on the primary health care system.

Stress on the Uncompensated Care Pool and MassHealth is increasing.

Many of the state budget cutbacks in disease prevention and health promotion are perverse, given the fact that not everyone has comprehensive health insurance, a primary care physician, nor will otherwise receive the information and services that these programs provide. Eleven percent of adults are uninsured in Massachusetts and the number is growing; the state itself has so reduced safety net programs that the challenge of meeting the needs of the uninsured continues to mount. The state's actions and proposals to cap eligibility for health insurance and emergency programs, to cut the free care pool, and to limit payments to providers of last resort mean that a safety net full of holes is now being cut from its moorings.

The connection between cuts in MassHealth and the increased burden on the Uncompensated Care Pool has been discussed in an earlier Massachusetts Health Policy Forum.⁶⁹ Elimination of preventive health protection programs funded by the state will increase the need for primary care, disproportionately so among the poor and uninsured, thus increasing the strain on both MassHealth and the Uncompensated Care Pool. Much of the work done with the support of state public health funds has been to reach populations who do not or cannot access the medical care system, to design and distribute more user-friendly information, and to pursue research avenues and policy ideas that are not supported by current funding priorities.

Recommendations

Public health funding must be restored to levels that assure the public that its health is not endangered.

Any restoration of public health funding now must be weighed against the net effects of the severe cuts over the past several fiscal years. As the Legislature and Administration work to enact partial restoration of funds for public health, the public health system must be rebuilt. Essential to doing this in a productive and fair manner is a commitment to inclusion, participation, transparency, and sharing of information. Many of the steps recommended below will ensure that decision-making on public health programs and expenditures is a shared civic endeavor and not misdirected budget-cutting. Consideration of new revenue sources will be necessary as the economy begins to recover, and so will new means to deliver services and new accountability.

If this is to be meaningful reform and restructuring, then the collection, dissemination, and translation of health data and expanded access to budget and health status information is an absolute requirement.

Proposals to cut funds for public health should be accompanied by a health impact statement.

Proposed cuts in the public health budgets of Massachusetts should be examined by several criteria. Because the effects of these cuts is often either not immediate or is cushioned by actions and expenditures elsewhere that will not show up as a public health program, it is important to relate the cuts to the programs concerned, the people served, and the agencies involved.

Attached to this report is list of programs that have had their budgets cut by more than a third over the past few years. The reader is advised to examine these cuts and others in light of several criteria:

- Does the problem addressed by these programs still exist? Is it likely to continue in at least the same magnitude?
- Have the programs had success in improving the health of Massachusetts residents? Have rates of disease or accident or dangers to the public health declined because of them or kept Massachusetts healthier or safer compared with national averages?
- Do the cuts exacerbate health disparities based on income, employment, gender, race, ethnicity, or geography?
- Do the cuts affect other goals of our society, such as equal education and equal protection under the law?
- Will the cuts endanger a public health infrastructure that is being called on to do more in the face of federal cuts, new federal mandates, new and emerging diseases, and bioterrorism?

There are other criteria that may be more difficult to quantify and uncomfortable to think about. Do the cuts shift costs to sectors of the economy that cannot refuse them, such as families, cities and towns, hospital emergency rooms, prisons? Do these cuts, combined with cuts or caps in other services (such as legal aid, housing assistance, unemployment payments), disproportionately and egregiously hurt the elderly, women, children, the poor, minorities? Will cuts in data gathering and information dissemination make it more difficult for the public to see and assess the harm done? Are cuts made knowing that programs will be reinstated, but also knowing that the delays will mean services hazardedly delayed or permanently denied? Do these cuts result in burdens to the poor that make it impossible for them to improve their situations?

Proposed cuts to public health and health insurance programs should include an economic impact statement.

Since most cuts to public health programs merely shift the responsibility and cost to other budgets and to other sectors of our society – from state to local governments, from government to private hospitals or caregivers, from health budgets to law enforcement, education, social services, and from a community enterprise to individual families – programs that suffer higher reductions than the overall average of cuts in the state budget should be subject to an *economic impact statement* that addresses the following questions:

- What effect will this cut have on the budgets of other levels of government – local, regional, and county?
- What effect will this cut have on the budgets of other programs, such as education, Medicaid, homeland security, corrections?
- What additional costs can be anticipated in the future because of program losses now that prevent disease, diagnose illness, begin early intervention, change behavior, and monitor abrogations of the law or regulations?
- What expenditures will likely occur elsewhere because of these cuts? Will families, providers, businesses, charities be expected to replace the lost programs or funding? Where will those occur and how will the costs be distributed?
- Will the cuts make it more expensive to address these problems if and when funding is restored?
- What funds will be lost because of these cuts? There should be an accounting of all cuts in public health programs that trigger a cut in non-state funds, such as federal research grants, matching funds, reimbursements, and charitable donations and gifts.

Such an economic impact statement should also provide a comparison with tax expenditures that would reduce revenue for these programs. This comparison should include an assessment of the likelihood that public expenditures would immediately be spent in the local and state economies.

During the past four years, cutbacks in state services have often meant the lowest levels of federal compliance, endangering federal matching funds. Thus, the drastic cuts proposed in substance abuse programs on top of those already enacted could cost the state another \$9 million in federal funds; tobacco funds, which also require some maintenance of effort, are also threatened. Previous cutbacks or delays in implementation, such as those for breast and cervical cancer treatment, were only restored when the federal government threatened to punish the state for non-compliance.

Establish a prevention caucus in the state Legislature.

Establishing a Prevention Caucus within the Legislature will encourage broad consideration of the public health impacts in a range of legislative areas. Modeled on the successful and inclusive Children's Caucus, a Prevention Caucus can focus not only on educating legislators, but also on coordinating a legislative agenda, along with advocates, that incorporates the scope and expertise of a broad range of interested legislators. This model integrates the work of committees whose jurisdictions include health-related issues, including, but not limited to, Education, Natural Resources and Agriculture, Housing and Urban Development, and Transportation, as well as the more predictable ones of Insurance, Medicaid, Human Services and Elder Affairs, Homeland Security and Federal Affairs. Leadership on public health issues, provided primarily by the Joint Committee on Health Care, will be strengthened by a broad array of interested and knowledgeable legislators.

Funds that come to the state to subsidize public health or medical care should be used only for health related purposes.

Although the federal government has cut public health funding to the state in many areas, there are funds that come to the state for health and medical purposes that are diverted to other areas. Chief among these are the Tobacco Settlement funds generated by the successful suits by the attorneys general against the tobacco industry.

Massachusetts led the nation in the creativity, reach, and effectiveness of its tobacco education and control efforts. The programs, messages, and materials created and used in the state have been models for reducing adult and youth smoking. The tobacco control program throughout the state is in shambles, as the millions that come to the state from the settlement, meant to reduce the use of tobacco, especially among young people, is instead diverted to other, non-health purposes. The harm to the next generation is twofold: in the amount of disease that will occur because of smoking, and the additional costs for health care that will have to be paid by smokers and nonsmokers alike in the future.

The Commonwealth should commit itself to achieving comprehensive state health insurance coverage.

Every cut in state-subsidized or state-supported health insurance results in additional costs elsewhere:

- to other parts of the health care system such as to private, employer-based health premiums (as has happened with the latest round of cuts) or to the free care pool, among others;
- to individuals, families, or charitable organizations who now must provide services, personnel, time, or benefits, to replace services previously covered;
- to the economy as a whole because workers (especially working poor and legal immigrants) lose time due to their own illness or that of family members, and businesses face increased health premiums.

Universal, comprehensive health coverage has been shown in Europe, Canada, and countries in Asia and Latin America to decrease overall costs of health care while increasing health status. From a poor country like Costa Rica to a rich one like Germany, comprehensive health coverage costs less than that of the United States, with better outcomes.

Massachusetts is not a nation-state, but with 6 million people, a broad and diverse array of health and medical services, already high expenditures on fragmented and uncoordinated services, and people and institutions who both study and advise the rest of the world, it is not at all far-fetched to imagine a universal, comprehensive system of health coverage for all the residents of Massachusetts. Numerous study commissions, task forces, and committees have been convened, but almost always with limited agendas.

Since the haphazard, self-defeating, and often cruel cuts the state has endured and is undergoing do not save money in the long-term and do endanger public health and safety, it seems the perfect time to commit to establishing a system of universal, comprehensive health services for everyone in Massachusetts. It is feasible, reasonable, and smart to do so, but requires agreement that a reasonable, cost-effective plan *will* be implemented.

The Governor and Secretary of Health and Human Services have announced their intention to develop a universal system of coverage. Many advocacy groups intend to revive the campaigns that led to the brief promise of full coverage under the Dukakis administration. Until that is achieved, the state could

ensure adequate coverage by fully funding the existing health insurance and public health programs. Eliminating waiting lists and ending the exclusion of eligible children and adults from the Children's Medical Security Plan, MassHealth, and school health would restore health access and coverage to tens of thousands of people in Massachusetts who now have no access to health insurance or services.

The Commonwealth should be aggressive and inclusive in finding long-term and creative solutions to many of the health problems and systems problems it faces.

Many of the budget cuts over the past several years have had the effect of transferring responsibility and costs for the health and safety of Massachusetts residents from the state to community agencies, cities and towns, and charities and private citizens, who should be included in the decision-making. All of these organizations have a great deal to contribute to solving some of the more intractable problems of public health and in addressing some of the continuing high costs of ill health. Advocates, providers, community agencies, experts, and lay people have much to offer in ideas, experience, knowledge, and vision. They should be engaged in a meaningful way in addressing problems, proposing solutions, and attempting new approaches.

The challenges are not contained within a single state agency, and the reform and rebuilding of the health of our commonwealth must be done system-wide. The state should be aggressive and generous in developing ways for community-based organizations and local health departments to make greater savings in operations while expanding access to health insurance.

Two areas where work has already been done lend themselves to more immediate action:

Expand and strengthen the Healthy Communities initiatives that already exist and expand activities to any community that wants to use it.

The Massachusetts Office of Healthy Communities in the Department of Public Health provides a vehicle for organizing and supporting community-based and community-wide prevention initiatives across the Commonwealth. Based on a World Health Organization Initiative and recommendations of the Institute of Medicine reports on the future of public health, Healthy Communities incorporates a view of health that includes social and economic determinants of health, recognized local conditions and assets, and empowers communities to mobilize existing resources to solve problems. Healthy Communities requires that the state's resources, expertise, data, and personnel be made available to communities organized to solve problems. This partnership of state and municipal government, and local private and public organizations, including businesses, schools, and not-for-profit agencies, social and fraternal organizations, develop cost-effective and sustainable solutions to difficult and previously intractable problems. Many Healthy Communities initiatives are locally initiated, but hospitals and other health care entities have used the resources of the Office of Healthy Communities and the Regional Centers for Healthy Communities to conduct needs assessments required for accreditation and community benefits obligations. Dozens of communities across the state, from Boston to North Quabbin, from Fall River to Springfield, have embarked on Healthy Communities initiatives with small but dedicated state support. The state should more fully encourage those efforts, provide funds for staff, and make state funding flexible and responsive to local planning.

Pool private resources to provide technical assistance, operating support, administrative services, and flexibility to overburdened public and private agencies.

Many of the budget and program cuts assume that charitable organizations and individuals will take on the responsibility being eschewed by government. It is unlikely that charity should or could replace the

functions of government, but there is a role for both not-for-profit and charitable organizations and businesses. The skills and resources of corporations and organizations should be mobilized to a far greater extent to develop creative and efficient solutions to both present problems caused by decreased revenues and continuing problems caused by soaring costs of health and housing in the Commonwealth. The state has extraordinary convening powers to accomplish this and could serve as a central clearinghouse and organizer of services, which could include operating and administrative services and support, technical assistance in software, consulting services, hardware, training, and financial, management, and legal services.

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- ⁴ Massachusetts has one of the highest percentages of people enrolled in managed care, both under private insurance and in government-sponsored programs. This has a direct effect on the rate of certain preventive and screening procedures. Pediatric immunizations, mammography, pap tests, prostate cancer screening, and timeliness of prenatal care are among the disease prevention standards under HEDIS (Health Plan Employer Data and Information Set), which rates managed care plans. The combination of public health programs that provide outreach, education, and community services for those without health insurance and the strong prevention and screening programs of Massachusetts' managed care organizations has led to some of the best compliance rates in the nation. Minnesota and California, which also have high rates of managed care enrollment but not the same extensive public health programs, have not had the same results.
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- ²⁰ A detailed analysis of the cuts to the Children's Medical Security Plan is provided by the Children's Health Access Coalition at www.hcfama.org/acrobat/cuttingchildrenscare.pdf.
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Appendix: Department of Public Health FY01–FY04 Budgets

Source: Massachusetts Public Health Association. Available at: www.mphaweb.org.

Line Item	Appropriation Account	Final FY01 Budget	Final FY02 Budget	Final FY03 Budget	Final FY04 Budget	FY01 to FY04 Three Year Impact	3 Year % Change
4510-0099	Fees from Health Facility Licensing, Inspections & Records				6,000,000	6,000,000	
4510-0100	DPH Administration	18,334,674	18,386,369	18,686,950	18,302,427	(32,247)	0%
4510-0106	End of Life Care Commission (RR)			0	75,000	75,000	
4510-0110	Community Health Centers	9,348,035	5,708,401	4,637,561	4,427,109	(4,920,926)	-53%
4510-0150	Managed Care Cmty. Health	3,806,262	3,516,115	2,505,747	2,461,461	(1,344,801)	-35%
4510-0600	Environmental Health Services	4,128,667	4,274,690	2,732,245	2,709,962	(1,564,728)	-37%
4510-0615	Nuclear Power Reactor Monitoring (RR)	1,315,176	1,340,957	1,324,195	1,324,195	(16,762)	-1%
4510-0616	HIV Drug Registration & Monitoring (RR)	557,347	558,086	551,110	551,110	(6,976)	-1%
4510-0617	Seabrook Monitoring	91,500	91,500	90,356	0	(91,500)	
4510-0710	Health Care Quality & Improvement	7,785,404	8,114,771	7,688,550	7,684,400	(430,371)	-5%
4510-0711	Office of Patient Protection		508,432	0	0	(508,432)	-100%
4510-0712	Health Care Quality Monitoring (RR)	1,320,220	1,291,540	1,326,495	1,304,922	(15,298)	-1%
4510-0720	Nurse's Aide Training	1,000,000	1,000,000	600,000	250,000	(750,000)	-75%
4510-0721	Bd. Reg. Of Nursing			1,434,717	1,456,313	1,456,313	
4510-0722	Bd. Reg. Of Pharmacy			385,507	469,285	469,285	
4510-0723	Bd. Reg. Of Medicine			1,660,862	1,639,554	1,639,554	
4510-0725	Multiple Bds. Of Registration			324,308	384,898	384,898	
4510-0726	Board of Medicine (RR)			0	300,000	300,000	
4510-0750	Determination of Need	146,806	138,763	0	0	(146,806)	-100%
4510-0790	Regional Emerg. Medical Services	1,400,000	1,365,424	646,896	1,246,896	(153,104)	-11%
4510-0810	Sexual Assault Nurse Examiner Prog.	900,000	837,540	845,116	733,409	(166,591)	-19%
4510-9110	Community Dental Health		852,200	0	0	(852,200)	-100%
4512-0103	AIDS Prevention, Treatmt. & Svcs.	51,136,334	41,477,990	35,847,286	32,056,975	(19,079,359)	-37%
4512-0106	HIV Rebates (RR)	1,200,000	1,200,000	1,200,000	1,200,000	0	0%
4512-0110	AIDS Housing	118,800	110,555	0	0	(118,800)	-100%
4512-0200	Substance Abuse Services	44,598,407	42,137,046	37,034,491	33,789,274	(10,809,133)	-24%
4512-0225	Gambler's Treatment	1,000,000	1,000,000	654,942	654,942	(345,058)	-35%
4512-0500	Dental Health Services	1,320,917	1,443,000	1,398,440	1,399,150	(43,850)	-3%
4512-0501	Tufts Dental Prog. Equip.		518,920	0	0	(518,920)	-100%
4512-1300	Family Planning Services	1,000,000	1,000,000	0	0	(1,000,000)	-100%
4513-1000	Family Health Services	13,542,108	12,828,292	11,161,761	4,840,000	(8,702,108)	-64%
4513-1001	Batterer's Treatment	916,419	867,158	867,158	0	(916,419)	-100%
4513-1002	WIC Nutrition Services	14,087,495	13,879,500	13,289,385	12,571,048	(1,516,447)	-11%
4513-1005	Healthy Start	7,463,118	7,005,297	7,221,618	0	(7,463,118)	
4513-1010	Early Intervention (RR)	3,700,050	2,700,050	2,700,050	2,700,050	(1,000,000)	-27%
4513-1012	WIC (RR)	23,230,000	23,230,000	23,230,000	23,230,000	0	0%

4513-1020	Early Intervention Services	28,413,525	29,897,655	28,823,278	29,188,130	(709,525)	-2%
4513-1021	Early Intervention Respite Services	1,000,000	500,000	0	0	(1,000,000)	-100%
4513-1022	Domestic Violence Prevention	990,000	1,000,000	1,172,680	0	(1,172,680)	-100%
4513-1023	Newborn Hearing Screening	100,000	93,060	0	83,060	(16,940)	-18%
4513-1026	Suicide Prevention		500,000	115,280	125,000	(375,000)	-75%
4513-1111	Osteoporosis Prevention	502,644	548,196	45,000	0	(548,196)	-100%
4513-1112	Prostate Cancer Education	3,200,000	3,500,000	537,270	1,000,000	(2,500,000)	-71%
4513-1113	Colorectal Cancer	247,000	185,260	0	0	(247,000)	-100%
4513-1114	Hepatitis C	2,750,000	2,750,000	730,833	0	(2,750,000)	-100%
4513-1115	Multiple Sclerosis	500,000	438,700	0	0	(500,000)	-100%
4513-1116	Renal Disease	30,000	30,000	0	0	(30,000)	-100%
4513-1118	Neurofibromatosis		150,000	0	0	(150,000)	-100%
4513-1119	Cardiac Surgery Data	300,000	300,000	0	0	(300,000)	-100%
4513-1120	Dis. Screening & Prevention				0	0	
4516-0263	Blood Lead Testing (RR)	1,491,830	1,505,368	1,486,551	1,486,551	(18,817)	-1%
4516-1000	State Laboratory Institute	10,201,152	10,530,675	10,247,936	9,701,774	(828,901)	-8%
4516-1022	Fees from Tuberculosis Testing			0	300,000	300,000	
4516-1001	Univ. of MA Med. School	1,437,109	1,229,424	0	0	(1,437,109)	-100%
4516-1003	Drug Lab. Equipment	100,000	100,000	0	0	(100,000)	-100%
4518-0100	Health Statistics	1,218,068	1,193,032	0	0	(1,218,068)	-100%
4518-0200	Health Statistics & Vital Records (RR)	242,500	265,000	261,687	261,687	(3,313)	-1%
4530-9000	Teen Pregnancy Prevention	5,474,228	3,473,833	2,324,636	975,000	(4,499,228)	-82%
4570-1500	Early Breast Cancer Detection	9,933,719	9,383,719	3,002,733	3,029,488	(6,904,231)	-70%
4580-1000	Universal Immunization Program	27,464,896	17,561,403	20,658,293	19,152,068	(18,112,828)	-49%
4580-1001	Pneumococcal Vaccine	9,800,000	6,392,256	0	0		
4580-1230	Medical Respite	300,000		0	0	(300,000)	-100%
4590-0250	School Health Services	12,800,000	37,867,379	15,593,432	12,622,966	(16,302,034)	-56%
4590-0300	Smoking Cessation	50,511,265	50,342,217	4,960,598	2,535,000	(47,976,265)	-95%
4590-0301	School Health Services (RR)				6,000,000	6,000,000	
4590-0450	School Based Health Centers	4,500,000		0	0	(4,500,000)	-100%
4590-0451	School Health Serv.	16,125,000		0	0		
4590-0550	Smoking Prevention & Cessation				0	0	
4590-0901	Consolidated Hospitals Chargeback				0	0	
4590-0905	CSMP Co-Pays & Premiums				0	0	
4590-0906	Childrens Med Security Plan (CMSP)	16,210,797	15,330,222	13,797,200	0	(16,210,797)	
	SUB-TOTAL, Non-Hospital	408,260,543	392,449,995	283,803,153	250,223,104	(174,599,836)	
	(Corrected for Transfer Funds)			(3,805,394)	26,482,149	22,676,755	
	CORRECTED TOTAL, Non-Hospital	408,260,543	392,449,995	279,997,759	276,705,253	(151,923,081)	-37%
4590-0901	Public Health Hospitals Chargeback	150,000	150,000				
4590-0903	County Inmate Medical Svcs. Chargeback	1,900,000	2,800,000				
4590-0908	Hosp. Bureau/Pharm.	5,894,092	6,351,209				
4590-0909	Tewksbury Hospital	41,257,480	42,737,518				
4590-0910	Mass. Hosp. School	13,453,429	13,936,186				
4590-0911	Lemuel Shattuck Hosp.	46,558,036	48,119,461				

4590-0912	W. Mass. Hosp. Federal Reimb.	12,691,701	13,406,167	13,363,793	13,686,256		0%
4590-0913	Med Svcs for County Inmates Fees	500,000	500,000	500,000	500,000		0%
4590-0915	Consolidated Public Health Hospitals	600,271	0	106,930,178	109,386,776		
4590-0916	Maint./ Repairs to Hosp.	2,204,579	1,204,579	0	0		
	Sub-Total, Hospital	125,209,588	129,205,120	120,793,971	123,573,032	(1,636,556)	-1%
	DPH GRAND TOTAL	533,470,131	521,655,115	400,791,730	373,796,136	(153,559,637)	-29%
	(Corrected for Transfer Funds)				400,278,285		