REAL CUTS – REAL PEOPLE – REAL PAIN

The Effects of the Fiscal Crisis on Women and Girls in Massachusetts

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About the Commission

The Massachusetts Commission on the Status of Women is an independent state agency that was legislatively created in 1998. The purpose of the Commission is to advance women toward full equality in all areas of life and to promote the rights and opportunities for all women. The Commission exists to provide a permanent, effective voice for women across Massachusetts.

The Commission is overseen by a board of 19 Commissioners drawn from diverse racial, ethnic, religious, age, sexual orientation and socioeconomic backgrounds from throughout the Commonwealth. Commissioners are appointed by one of four governing authorities: the Governor, the Speaker of the House, the Senate President, and the Caucus of Women Legislators.

The Commission is empowered to: study, review and report on the status of women in the Commonwealth; advise executive and legislative bodies on the effects of proposed legislation on women; inform leaders of business, education, health care, state and local governments and the communications media of issues pertaining to women; provide referrals and serve as a resource of information on issues pertaining to women; identify and recommend qualified women for positions at all levels of government; promote and facilitate collaboration among local women's commissions and among women's organizations in the state; serve as a liaison between government and private interest groups concerned with issues affecting women.

About the Massachusetts Budget and Policy Center

The Massachusetts Budget and Policy Center provides independent research and analysis of state budget and tax policies, as well as economic issues, that affect low and moderate income people in Massachusetts. The analysis and data in this report was prepared by the Massachusetts Budget and Policy Center and should not be attributed to The Massachusetts Commission on the Status of Women or any of the report's sponsors.

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Executive Summary

During the budget crisis that began in fiscal year 2002, Massachusetts cut almost three billion dollars from the state budget. Because women and girls benefit in many significant ways from the work that government does, the funding cuts made between fiscal years 2001 and 2005 have had a significant impact on their lives.

Women and girls are the primary beneficiaries of many of government's essential services:

- In 2003, 68 percent of the students graduating from state colleges were women, and 64 percent of community college graduates were women.

- Sixty-five percent of adults covered by Medicaid in Massachusetts are women.

- More than ninety percent of families receiving Transitional Aid to Families with Dependent Children are headed by women.

- Seventy-two percent of families living below the federal poverty line in Massachusetts are headed by single mothers and thus supports provided to low-income families like housing subsidies and child care disproportionately help women.

- In 2004, seventy-eight percent of the recipients of elder home care services in Massachusetts were women.

This report compares funding levels for various public services today to levels before the fiscal crisis, and describes how reductions in funding have led to reductions in services for women and girls. To determine cuts in constant or "real" dollars, the report provides data in inflation-adjusted terms as well as in nominal dollars. The findings from the report reveal the following:

- Funding for public higher education was cut in real terms by 21 percent between fiscal years 2001 and 2005. In addition to reducing the resources available for public colleges, this cut led to higher student fees as well. Funding for state colleges, where 68 percent of graduates are women, was cut in real terms by $30.5 million (15 percent) between fiscal years 2003 and 2004, resulting in an increase in average tuition and fees totaling nearly $780 or 20 percent after adjusting for inflation; that increase followed a 24 percent real increase in the previous school year for these institutions.

- There has been a real cut of 55 percent ($20.9 million) in the Employment Services Program, a job search and training program for individuals receiving cash assistance and trying to enter the workforce. Almost all of the program participants are women.

- Between fiscal years 2002 and 2005, funding for subsidized child care was reduced by $31.2 million or 11 percent in real terms. Between fiscal years 2002 and 2003 when funding for subsidized child care was cut by $10.7 million (a four percent reduction), the number of children served fell from 79,887 to 72,227 (a ten percent decline).

- Specific programs funded by the Department of Education have been considerably scaled back or eliminated. Between fiscal years 2002 and 2004 funding for early literacy was cut by 82 percent. Massachusetts also eliminated support for after school programs and class size reduction, programs proven to provide measurable benefits to girls.

- Between fiscal years 2001 and 2005 the Commonwealth cut funding for Adult Basic Education by $5.1 million or 15 percent in inflation-adjusted terms. In fiscal year 2004, services were provided to 10,300 individuals – 5,500 of whom were women – while 23,400 remained on the waitlist for Adult Basic Education programs.

- The fiscal crisis led to reductions in benefits, limitations on eligibility, and increased out-of-pocket costs for enrollees in the state's publicly-funded Medicaid health insurance program. Benefits eliminated included coverage for dental benefits for adults, chiropractic therapy and eyeglasses. As there are nearly twice as many women as men participating in the Medicaid program, these health care cuts have had a significant impact on women.

- Cuts in substance abuse services led to the closing of more than half of the state's capacity for residential detoxification, and cuts in HIV/AIDS and Hepatitis C programs means that thousands fewer women will be screened for these deadly diseases, and will be at risk of transmitting infection to others.

- Although smoking has a direct link to heart disease and cancer – the number one and two killers of women – the state has almost completely eliminated its nationally-recognized successful smoking prevention program, reducing funding from $48.2 million in 2001 to $3.8 million in fiscal year 2005.

- The state had made significant gains in reducing the rate of teenage pregnancy and reducing the infant mortality rate, but since 2001 Massachusetts has cut teen pregnancy prevention programs from $6.0 million to less than $1.0 million, and has also reduced funding for other reproductive health programs from $5.9 million to $4.5 million in real terms.

I. Introduction

During the budget crisis that began in fiscal year 2002, the state implemented almost three billion dollars in budget cuts.[1] This report examines the impact that those cuts have had on women and girls in the Commonwealth. State fiscal policy often appears to be a dry and distant topic, but a careful examination of the state budget over the past four years shows that there have been real cuts that are causing real pain to real people.

Women and girls are the primary beneficiaries of many of the essential services that government provides. While some of the most important state services help mothers to raise their families, other equally important services help women to participate successfully in the workplace. Other services help women and girls maintain healthy and safe lives within their communities. For example, by providing child care assistance, state government helps tens of thousands of low-income women to balance work and family obligations. By providing publicly-funded health insurance, state government helps women and girls get access to high-quality health care.

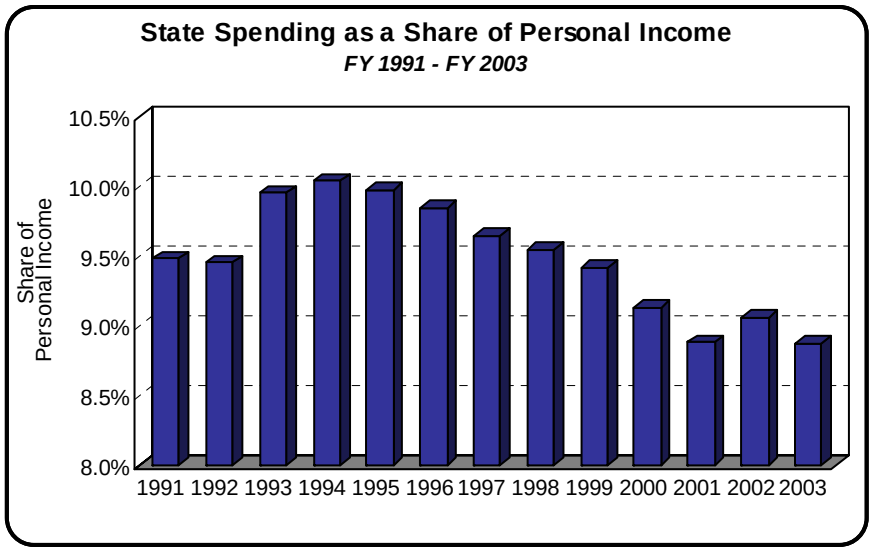
Sixty-six percent of the graduates from our state and community colleges are women. Virtually all of the participants in employment and training programs run by the Department of Transitional Assistance are women. The majority of students in state-funded Adult Basic Education are women. Close to two-thirds of adults covered by Medicaid are women. In many instances, women and girls receive relatively more benefit from state services than do men and boys, and therefore are disproportionately affected by reductions in those services.

In many cases the state's efforts to provide economic security, expand opportunity, and protect the well-being of women and girls have been directly harmed by budget cuts enacted during the state fiscal crisis. This report describes the benefits state services provide for women and girls, tracks funding for these services since the fiscal crisis began, and examines the impact of budget cuts. The report looks both at areas where women are the primary beneficiaries of services and at other areas where women and men participate equally, but the economic impact on women is particularly significant.

The cutbacks described in this report have occurred during the fiscal crisis that began in 2002. While the weakness of the national and state economies contributed to the budget shortfalls that led to these cuts in programs, it is important to recognize that policy choices played a major role in creating the fiscal crisis.

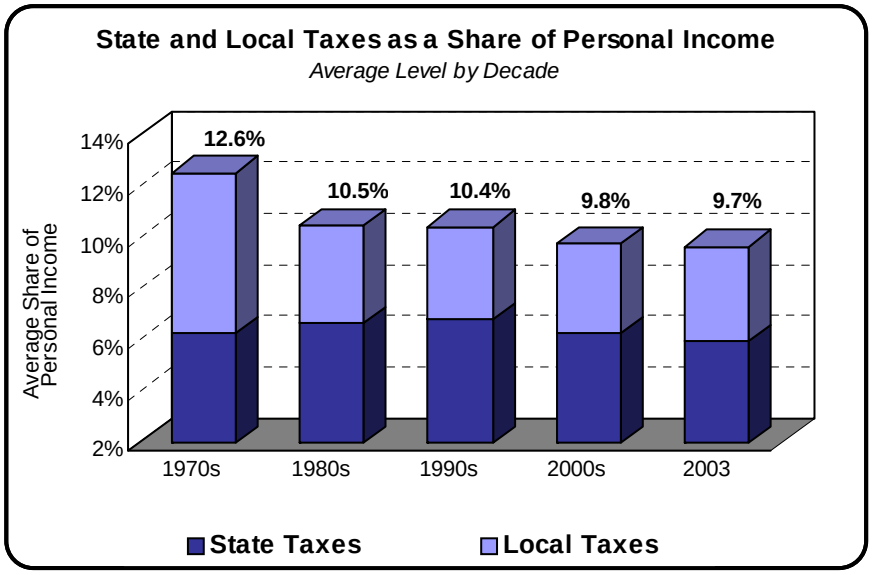
During the 1990s, as personal incomes rose year after year, the state implemented over $3 billion in tax cuts.[2] As incomes rose, the state took a smaller percentage of total income in the form of taxes. Thus, as Figure 1 indicates, state spending as a share of personal income dropped steadily during the economic boom of the middle to late 1990s.

Figure 1



As incomes were rising rapidly during the 1990s, the state was able to reduce the share of income that was paid in taxes without severely cutting programs. But when the economic bubble burst in 2001, it became clear that the decade of tax cuts had created a structural budget deficit.[3] The cuts described in this report are among the steps that the Commonwealth has taken to pay for those tax cuts.

Figure 2



As Figure 2 shows, the state and local tax burden in the Commonwealth in 2003 was lower than it had been in each of the last three decades. While the differences in the percentage of total income being paid in taxes may appear modest, the impact on the state budget has been significant. Had state and local governments taxed in 2003 at the average level of the prior decade, there would have been an additional $2 billion available to fund essential services such as those described in this report. Furthermore, had state and local taxes in 2003 been at the level of the early 1990s (when taxes were above the decade's average), there would have been $3 billion in additional revenue available to provide basic public services. In 2003, the most recent year for which data are available, 9.7 percent of personal income in Massachusetts was paid in taxes to support state and local government, the lowest level in several decades.[4] Taxes and fees are also a smaller percentage of personal income in Massachusetts than in 46 of the 50 states.[5]

The services provided by state government are often unheralded but important: education for our children; health care for nearly one million people; long term care for elders; police and fire protection; courts, prosecutors and prisons; state parks, playgrounds, pools and rinks; services for people with mental retardation or mental illness; child care; affordable housing; environmental protection; roads and bridges; job training, higher education, and other economic development efforts.

Every day, millions of women in Massachusetts help to pay for the costs of state government through their taxes and fees. Every day, some of these same women and their daughters benefit from the services paid for by these taxes. The trade-off becomes clear: there is a direct connection between the revenues raised by the Commonwealth and the services provided. Cuts in revenues led to profound budget cuts that had real impacts on the lives of real women and girls.

In considering the ways in which government assists women, and the cutbacks that have been made in those programs, it is worth asking whether we believe these cuts are necessary, whether further cuts should be implemented to finance additional tax cuts, or whether restoring some of the services that have been cut would be worthwhile even if it requires moving the rate of taxation back towards where it was during the 1990s.

This report reviews funding patterns and connects specific reductions to the availability of services. Unless otherwise noted, budget figures come from General Appropriation Acts and related supplemental budgets. To determine the "real" impact of funding cuts, the analysis provides inflation-adjusted as well as nominal dollar amounts.

This report is divided into sections, roughly paralleling some of government's essential functions in the lives of women and girls. The following section describes programs that provide for the economic security of women and girls. Section III discusses government's role in funding early education and care, and Section IV reviews state

funding for K-12 and higher education for women and girls. There are two sections on health care (Sections V and VI). The first of these sections covers the Commonwealth's investment in health insurance as a means of providing access to health care. The second of these sections describes several public health programs that are important to women and girls. The final section details some of government's role in protecting the well-being of older women.

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[1] *State Budget '04: The Long Road Back*, Massachusetts Taxpayers Foundation, January 2004, p. 10, available at www.masstaxpayers.org/data/pdf/reports/budget04.pdf.

[2] "A Matter of Choice," Massachusetts Budget and Policy Center, May 28, 2004, available at http://www.massbudget.org/matterofchoice.pdf.

[3] St. George, J., and Nolan, S., *Trading Places: The Role of Taxes and Spending in the Fiscal Crisis*, Massachusetts Budget and Policy Center, February 2003, p. 15, and Na'im, A., Legg Greenberg, C., *Cuts that Hurt: An Examination of Some of the Painful Cuts in the FY2004 State Budget,* Massachusetts Budget and Policy Center, January 2004, p. 2.

[4] Based on data from the Massachusetts Executive Office for Administration and Finance.

[5] "Massachusetts' Tax Burden Falls to Bottom Tier of States," Massachusetts Taxpayers Foundation, September 8, 2004, available at www.masstaxpayers.org/data/pdf/bulletins/MassachusettsTaxBurdenNRFINAL.PDF

II. Providing Economic Security to Women and Families

The Department of Transitional Assistance (DTA) administers income support programs that assist low-income families and individuals. In addition to the state's cash assistance programs, DTA oversees and works with other agencies to administer shelter services, domestic violence support services, child care assistance, and education and job search assistance for individuals receiving cash assistance. Since the Commonwealth reformed its welfare system in 1995, caseloads for cash assistance programs have declined overall, but recent policy changes and the poor state of the economy have led to increased participation in certain programs and increasing demand for services.

Transitional Aid to Families with Dependent Children

In 1995, Massachusetts was one of the early states to implement reforms focused on moving women off of welfare and into the workforce. The Commonwealth's welfare system was renamed Transitional Aid to Families with Dependent Children (TAFDC) and was modified to emphasize work and to impose stricter time-limits on the receipt of cash benefits – two years within a five year period.[6] Exemptions from the time limit are permitted for certain individuals who are unable to work due to a disability, their age, or their children's age.[7] For example, parents with children under two years of age are exempt; parents with children between two and six years of age were originally subject to the time limit but not the work requirement. The fiscal year 2004 budget implemented comprehensive work requirements for parents with children between two and six years of age, though parents were permitted to meet this requirement by participating in education and training activities. The fiscal year 2005 budget expanded work requirements for parents with school-aged children, requiring parents with children between the ages of six and nine years of age to work 24 hours per week; parents with children older than nine years of age must work 30 hours per week. This group of parents was previously required to work 20 hours per week. The fiscal year 2005 budget additionally allows all parents to meet their work requirement by participating in education or training activities – a right which was previously extended only to parents with children between two and six years of age.

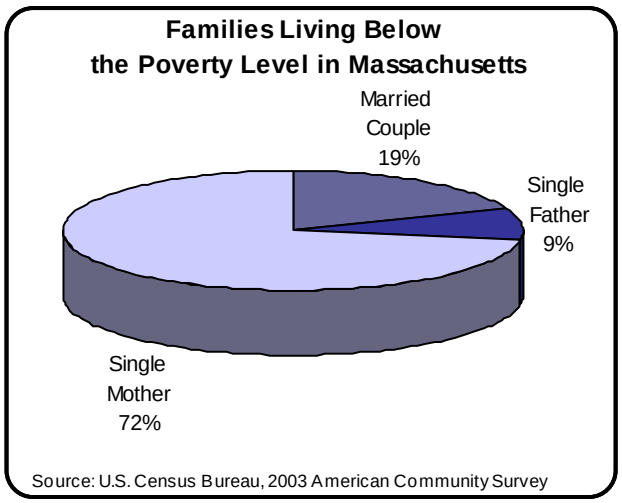
Impact on Women and Girls

The TAFDC program is designed to assist families with little or no income. Families with or expecting children receive cash assistance through the program and, based on their low incomes, are eligible for other programs and services including health insurance, child care subsidies, as well as education, training, and job search assistance. As the majority of adult TAFDC recipients are female (94 percent), the provision of these benefits and services plays a major role in the lives of very low-income women and

girls.[8] Across the country, recent cuts in many of these social safety net programs have jeopardized the well-being of low-income families.[9]

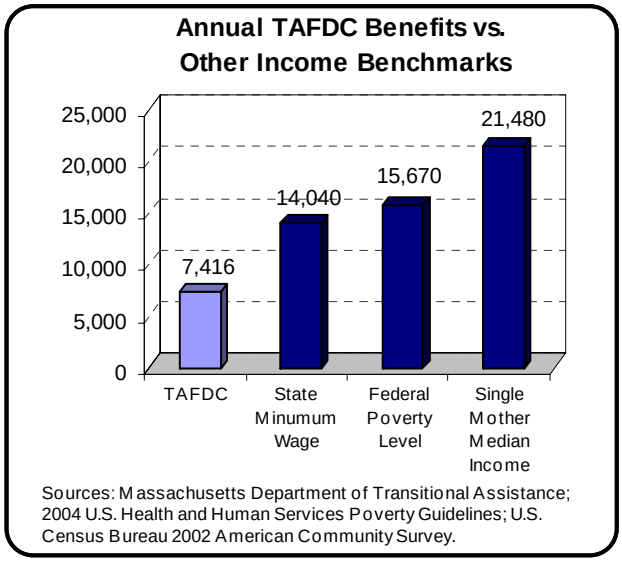
Figure 3 shows that families living in poverty are disproportionately headed by single mothers. According to 2003 Census data for Massachusetts, 72 percent of families with children living below the poverty level are headed by a single mother. Thus, female-headed families are more likely to need, and to benefit from, cash assistance programs like TAFDC and other safety net programs.

Figure 3



The elements of welfare reform – work requirements, time limits, and financial work incentives – were designed to reduce dependency and foster self-sufficiency.[10] Yet, the cash benefits provided through TAFDC are less than sufficient to maintain a family's economic security. A family of 3 receives a maximum monthly benefit of $618 or $7,416 annually.[11]

Figure 4



Note: The TAFDC and Federal Poverty Level are for a family of three. The State Minimum Wage does not adjust for income taxes, and assumes employment at 40 hours per week for 52 weeks.

In 1999, the Department of Transitional Assistance commissioned an evaluation to assess the employment status and earnings, financial self-sufficiency, and other general characteristics of former TAFDC recipients. (To date, this is the most recent study of former TAFDC recipients released by the state.) The report, *After Time Limits: A Study of Households Leaving Welfare Between December 1998 and April 1999*, revealed that:

- After leaving the cash assistance program, the majority of individuals were employed (71 percent), and earning more than minimum wage ($8.21 per hour on average for those who reached their time-limit, $8.62 for the non-time limit group).[12] Many employed individuals were working in a part-time position (less than 30 hours per

week). Lack of full-time opportunities at their current job was cited as the primary reason for not securing full-time employment.[13]

- Thirty percent of respondents were not employed at all. Individuals were most likely to cite lack of work experience or education as a barrier to securing employment.[14]

- Industries where former recipients were employed include retail/sales, clerical, housekeeping, child care, health care, food services, and factory work.[15]

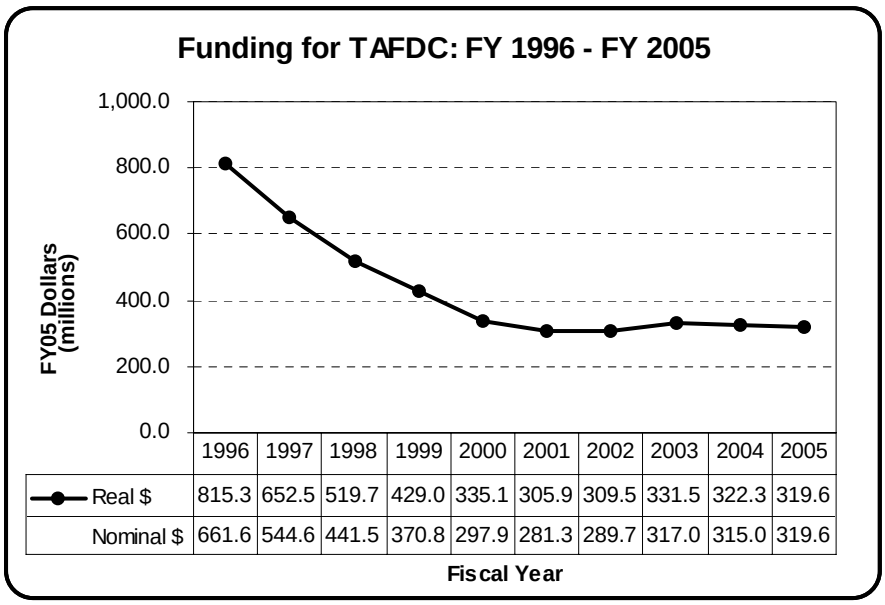
- After leaving TAFDC, former recipients were still eligible for and received vital publicly funded support services including Medicaid (MassHealth), housing assistance, food stamps, and child care subsidies. Despite these income supplements, a number of households demonstrated signs of increased food insecurity.[16]

Despite the overall goal of moving families from welfare to work, the industries in which former recipients were employed, as well as the wages that they earned were not likely to ensure their family's economic-sufficiency. Although welfare reform efforts have had a somewhat limited impact on improving families' economic well-being, the network of social services that are available to TAFDC recipients are still necessary to help to promote positive outcomes for many families with very low incomes. Following its initial reform efforts, the state invested more heavily in education, training, and job placement opportunities for individuals receiving TAFDC benefits. Several reports, including a review by the Brookings Institution, have indicated that the most successful programs aimed to move individuals from welfare to stable, self-sufficient work integrate education, training, and work activities.[17] Though limited in scope, the Massachusetts' Employment Services Program provides such opportunities to current and transitioning TAFDC recipients. The summary on the Employment Services Program will detail the state's investment in these areas and assess the impact of recent budget cuts to these services.

Funding

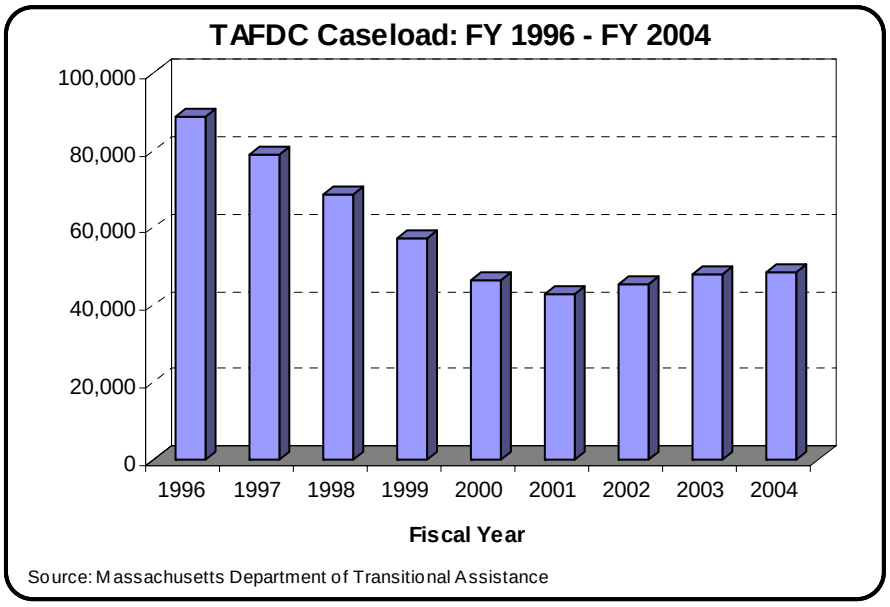
Figure 5 shows state funding for TAFDC since welfare reform legislation was passed.[18] Between fiscal years 1996 and 2001, funding fell by $509.4 million or 62 percent in real terms. The decrease in spending generally reflects the overall decline in the caseload as shown in Figure 6. During this same period, the TAFDC caseload shrank by more than 46,300 recipients or 52 percent. The decline in the caseload is generally attributed to changes in policy like time limits and work requirements, as well as to the economic expansion of the late 1990s, though researchers are at odds over which aspect had the stronger effect. A 2001 review of the literature and research on this issue by the Urban Institute shows that the influence of changing economy was greater than that of policy changes.[19] Still, it is likely that changes in state policies have had some effect on whether individuals were able to access benefits provided through TAFDC.

Figure 5



Just as the caseload fell when the economy was expanding, the caseload grew when the economy began to contract. As Figure 6 indicates, the TAFDC caseload grew by 14 percent between fiscal years 2001 and 2004. Overall funding for TAFDC also rose during the fiscal crisis, though not at the same pace as the caseload.

Figure 6

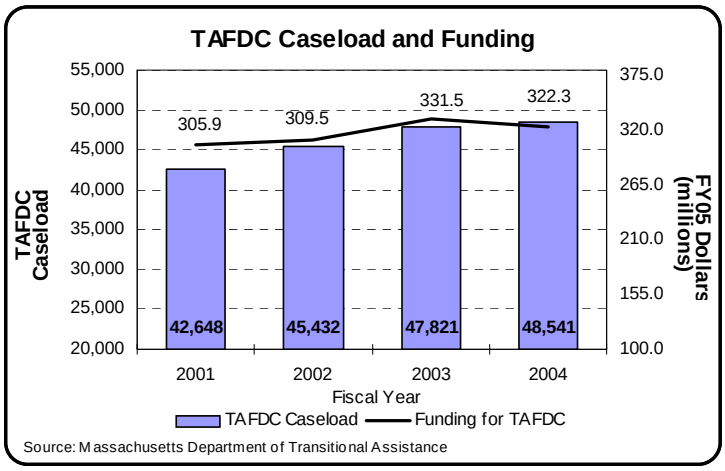


Note: Figures represent average monthly caseload, which includes non-exempt and exempt individuals.

Impact of Funding Cuts

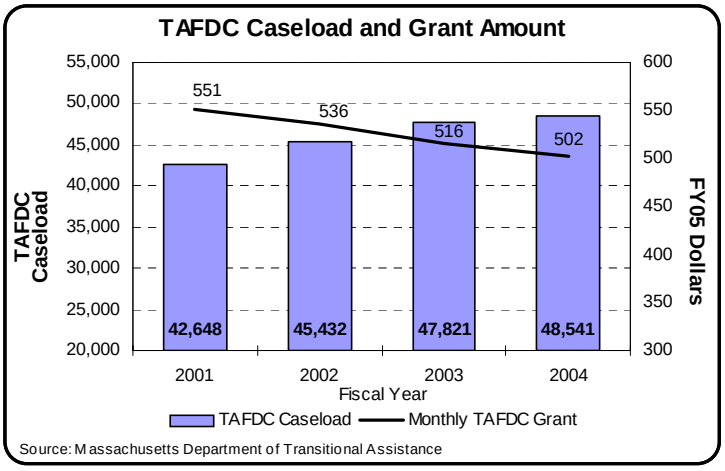
When the economy performs poorly, many individuals and families turn to income support programs like TAFDC. Although overall appropriations for TAFDC were not reduced during the fiscal crisis, funding did not keep pace with caseload growth. Between fiscal years 2001 and 2004, the Commonwealth's average monthly caseload for TAFDC climbed from 42,648 to 48,541, a 14 percent increase. During this same period, funding TAFDC rose only by 5 percent after adjusting for inflation.

Figure 7



Note: Figures represent average monthly caseload, which includes non-exempt and exempt individuals.

Figure 8



Note: Figures represent average monthly caseload, which includes non-exempt and exempt individuals.

There has been a decline in the average amount of the TAFDC grant, thereby lowering the amount of cash assistance provided to each family. During the economic downturn, the real value of the average monthly grant decreased. Nominally, the decrease in the grant roughly represents a $15 per month decline. In real terms, the average monthly grant fell by roughly $50 per month or approximately $600 annually.

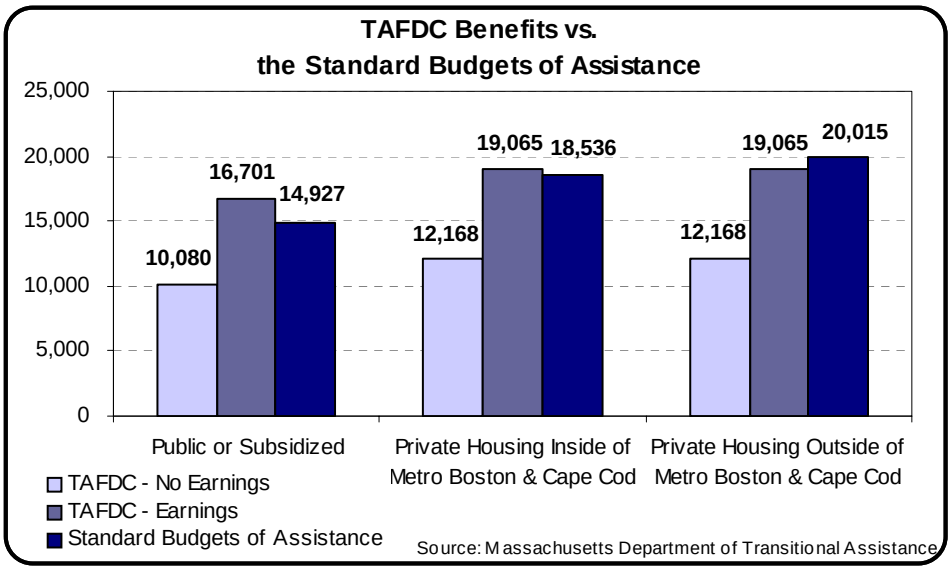
There were two primary causes for the reduction in the average inflation-adjusted value of the grant. The first was simply that the state did not adjust the grant to account for the erosion of purchasing power due to inflation. Thus, each year the value of the grant declined as inflation increased costs and grant values were not adjusted proportionately.

The second reason for the real decline likely has to do with other welfare policy changes. Grant values declined because an increasing number of DTA recipients were working. In June of 2002, five percent of the total caseload was employed, and by June of 2004, this

proportion had grown to 10 percent.[20] Because a share of all earnings is deducted from grant amounts, when more people work, the average grant size declines. The data available from the Department of Transitional Assistance do not show who these new workers were, but since new work requirements were imposed on parents of young children, it is likely that their new wages helped to drive down the size of the average grant. It is important to note, however, that the state also had to provide child care to allow many of these parents to work. The cost of that child care does not show up in the DTA budget.

The Department of Transitional Assistance acknowledges that the level of benefits provided to TAFDC families does not adequately meet the basic needs of these families. Using the typical components of a family's budget – housing, utility costs, food, and clothing – to derive the *Standard Budgets of Assistance*, DTA reported to the Legislature in 2004 that the TAFDC payment to families would have to increase by and additional 70 to 113 percent to meet this benchmark.[21] DTA states in this report that since earnings from employment brings families' earnings close to or slightly higher than the Standard budget of Assistance (see Figure 9), the agency places a strong emphasis on helping individuals to secure employment. Other data from DTA show, however, that only 10 percent of the TAFDC caseload is employed in a paying job, and that the majority of other types of work activities are unpaid community service assignments.

Figure 9



Note: Each budget assumes a three person family. The TAFDC totals include allowances for clothing and rent and incorporate food stamp benefits. Earnings assume minimum wage employment at 20 hours per week.

The declining value of cash assistance grants is actually only a small part of a larger story of cumulative negative effects of state policies on low-income families during the fiscal crisis. In addition to funding reductions for subsidized child care and training programs,

other services upon which these families rely have been hit particularly hard. For example, low-income families, including those receiving TAFDC, are eligible for several state and federally funded rental assistance programs, but budget cuts for many rental assistance programs have posed a particular challenge. The Massachusetts Rental Voucher Program – a rental assistance program for households earning less than 200 percent of the poverty level – was cut in real terms by $15.2 million or 40 percent between fiscal years 2001 and 2004. New applicants for this program can no longer receive assistance through this program, as vouchers are frozen upon turnover. Families in emergency shelters overwhelmingly are headed by low-income single mothers, as 87 percent of homeless families in shelters are headed by a female and 73 percent receive TAFDC or some other form of assistance.[22]

The goals of the TAFDC program – to provide financial assistance to families in need – were compromised during the fiscal crisis. Appropriations for other social safety net programs and employment supports, like the Employment Services Program were also reduced. As most of these families are headed by single-mothers, this poses a particular challenge for women.

The Employment Services Program

The Department of Transitional Assistance administers the Employment Services Program (ESP), a set of programs which provide education, training, and job search assistance to current and former TAFDC recipients up to one year after their benefits are terminated. While programs feature a "work first" approach, there are a few programs focused more on education and training, including GED classes for teen parents, targeted skills training, and two-year college programs. It is important to note that although two-year college programs fulfill the work requirement, these programs are not subsidized by the Employment Services Program. The Commonwealth does, however, support related expenses like child care and transportation.

Activities Offered through the Employment Services Program[23]

Work Activities

Community Service – Provides unpaid work experiences for individuals who are not able to secure paid employment.

Supported Work – On-the-job training program that provides wages to TAFDC recipients. Individuals receive a reduced TAFDC grant while they gradually transition to unsubsidized employment.

Full Employment Program – Fully-subsidized employment program for TAFDC recipients.

Job Search Assistance

Structured Job Search – Intensive program for TAFDC recipients who have six or fewer months of eligibility remaining.

Basic Job Search – Program designed for individuals with some work experience and no serious barriers to employment. Services include assessments, job search support, case management, and job placement.

Training

Skills Training – Includes free-standing as well as integrated short-term skills training and education programs.

Post-Employment Services – Skill enhancement and job retention programs offered to former TAFDC recipients up to one year after benefits cease.

Education

Basic Education – Education programs for adults with limited skills. Programs include remedial assistance in specific subjects, English for Speakers of other Languages (ESOL), and preparation for the GED exam.

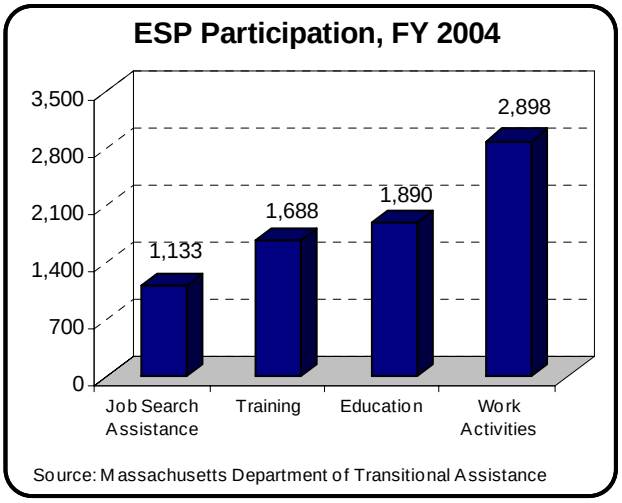
Young Parents Program – Provides literacy and other skills training to pregnant teens or teen parents who have not received a high school diploma or GED.

Two-Year College – Certificate program for TAFDC recipients which integrates academic and occupational learning with the ultimate goal of job placement.

Impact on Women and Girls

Since welfare reform has been implemented in Massachusetts, between 4,000 and 15,000 individuals have annually participated in activities offered through the Employment Services Program.[24] The majority of individuals using these services are women as they represent more than 90 percent of the TAFDC caseload. While most of these participants were enrolled in job search assistance or employment programs, Figure 10 shows that in fiscal year 2004 nearly 1,700 people participated in skills training and 1,890 people enrolled in education programs.[25]

Figure 10



Note: Employed individuals are not counted in the work activities category; individuals participating in supported work activities are included in this category as their support is partially subsidized through the Employment Services Program.

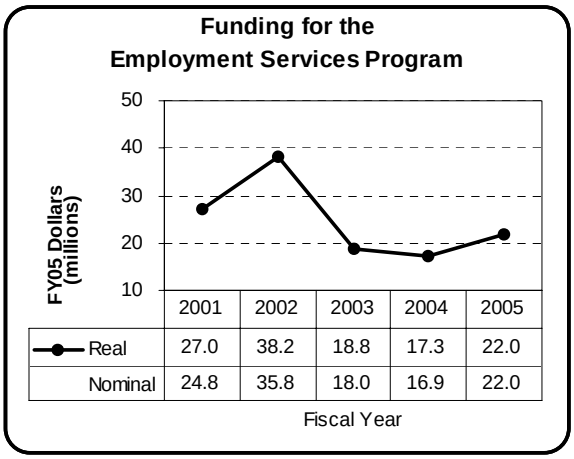
Individuals with limited skills and work histories require education and training to succeed in the work place. In general, welfare recipients are less skilled and have received less formal education than individuals not receiving benefits.[26] As earnings increase with education, the availability of education and training programs can positively impact TAFDC recipients' earnings. National research points to the benefits of providing both types of opportunities – education and training as well as job search assistance – to individuals receiving cash assistance.[27] In fact, the most recent and comprehensive national evaluation of welfare-to-work programs, the National Evaluation of Welfare-to-Work Strategies (NEWWS), shows that welfare recipients who participated in programs that combine the two approaches experienced higher earnings and a greater degree of stable employment than those in programs solely focused on one approach.[28]

Funding

Since fiscal year 2002, funding for the Employment Services Program has fallen considerably. Between fiscal years 2002 and 2004, funding for the Employment Services Program fell by $20.9 million or 55 percent, as shown in Figure 11. In fiscal year 2002, state support totaled $35.8 million. In fiscal year 2003 the Legislature initially appropriated $28.0 million, but the Governor's mid-year cuts further reduced the budget for the Employment Services Program by $10.0 million.[29] The fiscal year 2005 budget funds these services at nearly $22.0 million, a $5.0 million nominal rise over fiscal year 2004.[30]

While the 2005 appropriation appears to be a substantial increase, policy changes have placed new demands on ESP. In addition to increased work requirements for parents of school aged children, the fiscal year 2005 budget permits parents to meet the work requirement by participating in education or training programs. It remains to be seen whether the additional funding will be sufficient to meet the added demand for services.

Figure 11

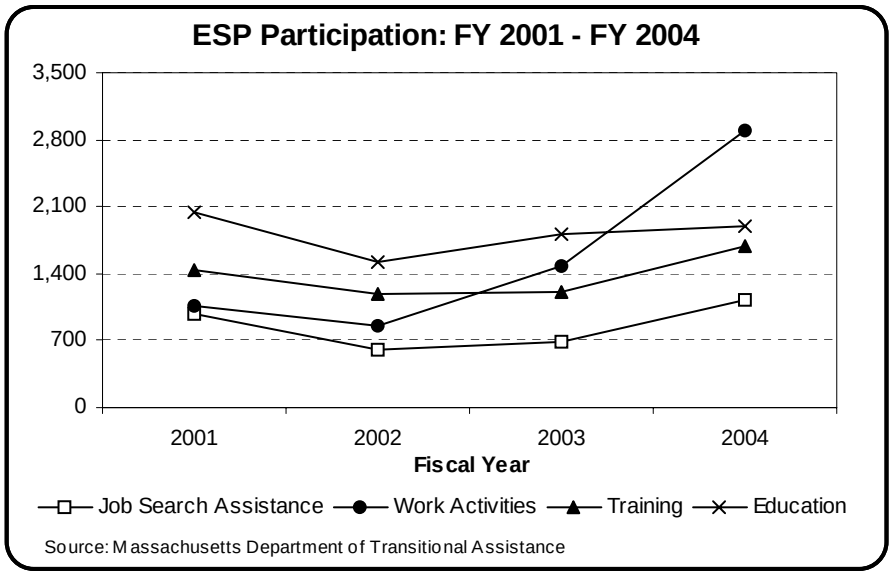


Note: The FY04 total includes $5.9 million one-time funding from the federal Reed Act; the FY05 total includes $3.0 million from a federal reimbursement for state expenditures on education and training for individuals receiving food stamps.

Impact of Funding Cuts

Since the fiscal crisis began, overall demand for services provided through the Employment Services Program have increased. Between fiscal years 2001 and 2004, participation numbers in each type of services offered by the Employment Services Program have increased overall except for education services as shown in Figure 12. The fiscal year 2004 budget implemented changes to the work requirements for parents with children between two and six years of age. These changes added nearly 2,700 individuals between June 2003 and June 2004.[31]

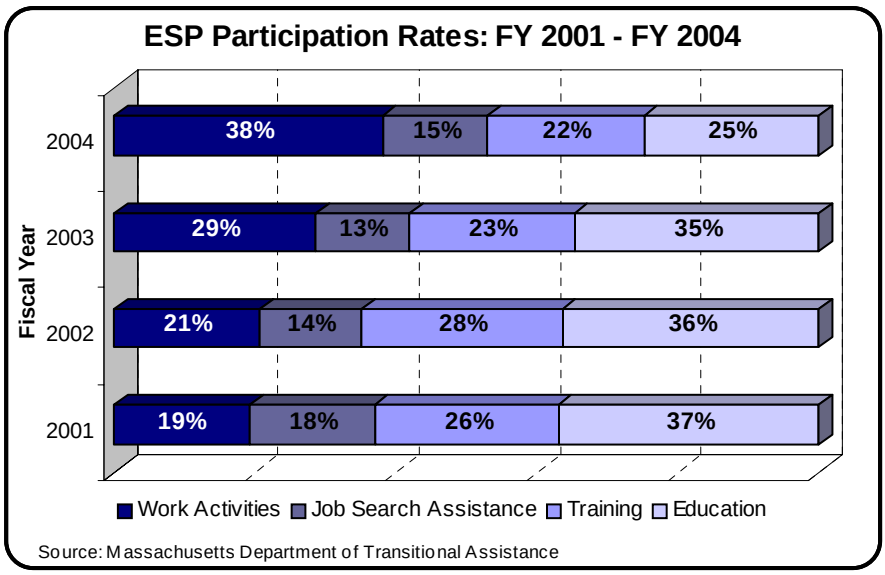
Figure 12



Note: Data represents participation numbers for June of each fiscal year, which may not reflect fluctuations in participation throughout the year.

Although overall participation has increased in the Employment Services Program, the Commonwealth has provided fewer resources to meet this demand. One consequence is that the Commonwealth has begun shifting ESP participants into less costly activities. During the fiscal crisis, the proportion of individuals participating in education and training programs fell and the proportion of those in work activities rose, as illustrated by Figure 13. In fiscal year 2002, 36 percent of individuals participating in the Employment Services Program were enrolled in education programs and 28 were enrolled in training programs;[32] by fiscal year 2004, these percentages fell to 25 and 22 respectively.[33] Participation in work activities rose from 21 percent in fiscal year 2002 to 38 percent in fiscal year 2004.[34] It is worth noting that of the 2,900 individuals who were in the work activity category for 2004, nearly all of them (more than 2,000) were participating in unpaid community service. This shift in participation is likely due to reductions in available resources since work activities – virtually of which are unpaid community service placements – are less costly, in the short-term, than education and training programs.

Figure 13



Note: Data represents participation numbers for June of each fiscal year, which may not reflect fluctuations in participation throughout the year.

Shifting resources to other less costly areas may save money in the short-term, but it is counter to the goal of fostering economic self-sufficiency for TAFDC recipients. Ample research shows the benefits of providing education and training opportunities to individuals transitioning off of welfare benefits. Although the NEWWS evaluation highlights the benefits of mixed approaches to helping individuals transition off of welfare, it also shows that individuals who participated in education and training programs increased their long-term earnings. In three of the NEWWS sites, non-high school graduates who increased their reading skills experienced a 13 percent increase in earnings at the three-year follow up; those who increased their skill levels or obtained

their GED increased their earnings by 30 percent. Non-graduates who enrolled in basic education and also participated in job training or other post-secondary programs experienced considerably larger increases in earnings; their earnings increased by 37 percent at the three-year follow up.[35]

The reduction in funding for the Employment Services Program will make it harder to continue progress in improving economic self-sufficiency for individuals receiving TAFDC or moving to the workforce. By shifting resources away from education and training, the Commonwealth has failed to make the longer term investments needed to help low-income women acquire marketable skill sets.

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[6] TAFDC is funded in part with state dollars, and in part with funds from the federal Temporary Assistance for Needy Families (TANF) block grant.
[7] Unless otherwise noted, this report refers to non-exempt families receiving TAFDC benefits.
[8] Gender breakdown of the TAFDC caseload comes from "TAFDC Caseload Demographics," Massachusetts Department of Transitional Assistance, current as of July 2004, available at www.mass.gov/portal/index.jsp?pageID=eohhs2terminal&L=4&L0=Home&L1=Researcher&L2=Basic+Needs&L3=Financial+Assistance&sid=Eeohhs2&b=terminalcontent&f=dta_r_finassist_tafdc&csid=Eeohhs2.
[9] McNichol, E., Harris, M., *Many States Cut Budgets as Fiscal Squeeze Continues,* Center on Budget and Policy Priorities, April 26, 2004, available at www.cbpp.org/4-22-04sfp.pdf.
[10] *After Time Limits: A Study of Households Leaving Welfare Between December 1998 and April 1999,* Executive Summary, Massachusetts Department of Transitional Assistance, November 2000.
[11] "TAFDC Caseload Demographics," Massachusetts Department of Transitional Assistance, current as of July 2004.
[12] *After Time Limits: A Study of Households Leaving Welfare Between December 1998 and April 1999*, Massachusetts Department of Transitional Assistance, November 2000, p. 31.
[13] Ibid., p. 24-25.
[14] Ibid., p. 25-26.
[15] Ibid., p. 22.
[16] Ibid., p. 79-80.
[17] Gueron, J., Hamilton, *G., The Role of Education and Training in Welfare Reform,* The Brookings Institution, April 2002, p. 3.
[18] Under the TANF block grant program, Massachusetts receives $459.4 million in federal funding and contributes $358.9 million in Maintenance of Effort funds (MOE). In order to receive the full amount of the TANF block grant, states are required to meet a basic Maintenance of Effort requirement. In Massachusetts, the MOE amount is 75 percent of the state's historic spending level based on FY94 spending. The state uses the sum of these funds to provide cash assistance as well as other supports like child care, job search assistance, and transportation. It is important to note that the value of the TANF block grant has fallen considerably as this amount is not adjusted for inflation. Since FY96, the real value of the block grant has fallen by 22 percent.
[19] Bell, S., *Why Are Welfare Caseloads Falling?* Discussion Paper 01-02, Urban Institute, March 2001, p.59.
[20] Percentages of employed individuals come from the Massachusetts Department of Transitional Assistance.
[21] *FY04 Report to the Great and General Court of the Commonwealth of Massachusetts on Standard Budgets of Assistance for the Transitional Aid to Families with Dependent Children*, Massachusetts Department of Transitional Assistance, February 2004, p. 13.
[22] Meschede, T. et al., *The Characteristics of Homeless Families Accessing Massachusetts Emergency Shelters, 1999-2001,* Center for Social Policy, John W. McCormack Graduate School of Policy Studies, University of Massachusetts Boston, April 2003, p. 7, 10.
[23] From Massachusetts' State Plan for Temporary Assistance for Needy Families, at: www.mass.gov/portal/index.jsp?pageID=eohhs2terminal&L=5&L0=Home&L1=Researcher&L2=Basic+Needs&L3=Financial+Assistance&L4=Welfare+Reform&sid=Eeohhs2&b=terminalcontent&f=dta_r_reform_tanf&csid=Eeohhs2.

[24] Totals come from June Caseload Breakout Reports (or equivalent reports) for fiscal years 1996 through 2004, Massachusetts Department of Transitional Assistance.
[25] *TAFDC Caseload Tracking Breakout Report Unduplicated Activities for June 2004,* Department of Transitional Assistance, June 2004.
[26] Johnson, H., and Tafoya, S., *The Basic Skills of Welfare Recipients: Implications for Welfare Reform,* Public Policy Institute of California, 1999, p. 20, 27.
[27] Gueron, J., and Hamilton, G., *The Role of Education and Training in Welfare Reform,* The Brookings Institution, April 2002, p. 3.
[28] Ibid., p. 3-4.
[29] The Governor has the power to cut state spending unilaterally within a fiscal year if the budget is in deficit. These reductions are also referred to as "9C cuts."
[30] In FY04, funding for the Employment Services Program totaled $16.9 million after accounting for federal Reed Act funding. The FY05 total includes $3.0 million dollars in reimbursements for food stamp recipients.
[31] *TAFDC Caseload Tracking Breakout Report Unduplicated Activities for June 2004,* Department of Transitional Assistance, June 2004.
[32] *Breakdown of Active TAFDC Cases with June 2002 ESP Participation or Earnings,* Department of Transitional Assistance, June 2002.
[33] *TAFDC Caseload Tracking Breakout Report Unduplicated Activities for June 2004,* Department of Transitional Assistance, June 2004.
[34] *Breakdown of Active TAFDC Cases with June 2002 ESP Participation or Earnings,* Department of Transitional Assistance, June 2002 and *TAFDC Caseload Tracking Breakout Report Unduplicated Activities for June 2004,* Department of Transitional Assistance, June 2004.
[35] Bos, J. et al, *Improving Basic Skills: The Effects of Adult Education in Welfare-to-Work Program,* Washington, D.C.: U.S. Department of Health and Human Services, Administration for Children and Families, Office of the Assistant Secretary for Planning and Evaluation, and the U.S. Department of Education, as cited in Martinson, K., Strawn J., *Built to Last: Why Skills Matter for Long-Run Success in Welfare Reform*, Center for Law and Social Policy, April 2003, p. 18.

III. Caring for Young Children

The Massachusetts government provides funding for early education and care in several contexts. In most cases, child care is provided to help low- and moderate-income parents, who would otherwise have trouble working, by having their children cared for in educational and enriching environments. In Massachusetts, as in other states, initiatives to expand child care are focused on three major issues: quality, affordability, and access. Addressing each of these issues affords working parents – men and women – the opportunity to provide economic security for their families. In practice, however, it is primarily women whose economic opportunities have been restricted by the lack of affordable child care and who are most helped when government helps to fund such care. Currently, funding for early education and care is provided through two state agencies, the Office of Child Care Services and the Department of Education. In fiscal year 2005, the Legislature created a new Department of Early Education and Care, which is responsible for developing a comprehensive early education plan for the Commonwealth's three, four, and five year old preschool children. Ultimately, this new department will serve as the agency to administer all public and private early education and care services in the Commonwealth.

Child Care Assistance for Working Parents

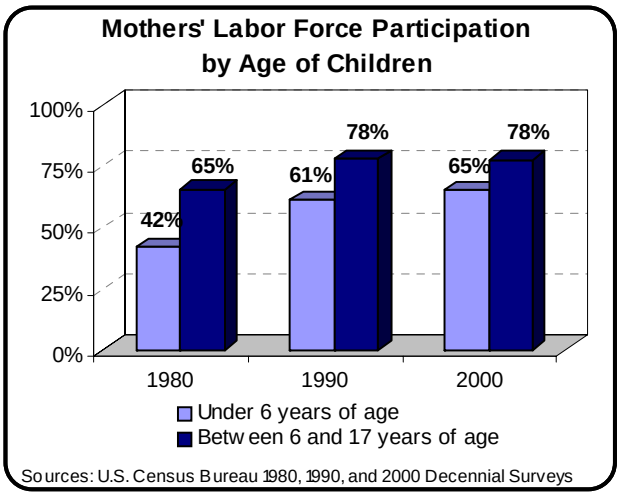
Welfare reform's focus of moving women into the workforce resulted in increased funding for a variety of employment supports designed to help welfare recipients and other low-income working families achieve economic security.[36] Providing subsidized child care for families in financial need became a principal strategy, with those receiving or transitioning off of welfare assigned the highest priority. Accordingly, funding for subsidized child care for these families makes up the bulk of funding for the Office of Child Care Services (OCCS).

The Office of Child Care Services subsidizes early education and care costs for eligible low-income families by contracting directly with providers or by providing vouchers to eligible families.[37] Cost to families are based on a sliding fee scale that takes both income and family size into account, and range between zero dollars and the full amount owed to the provider, depending on the type of care. Initial income-eligibility standards for subsidized care require that a family earn no more than 50 percent of the state median income, which for a three person family is roughly $30,000 annually; once enrolled, this cutoff changes to 85 percent of state median income, approximately $50,000 annually. Subsidies help defray all or some of the cost of early education and care, which enables low-income parents to work or to further their education. Subsidized child care plays an important role in the lives of women, as women have been entering the workforce in increasing numbers and low-income families, in particular, are disproportionately headed by single mothers.

Impact on Women and Girls

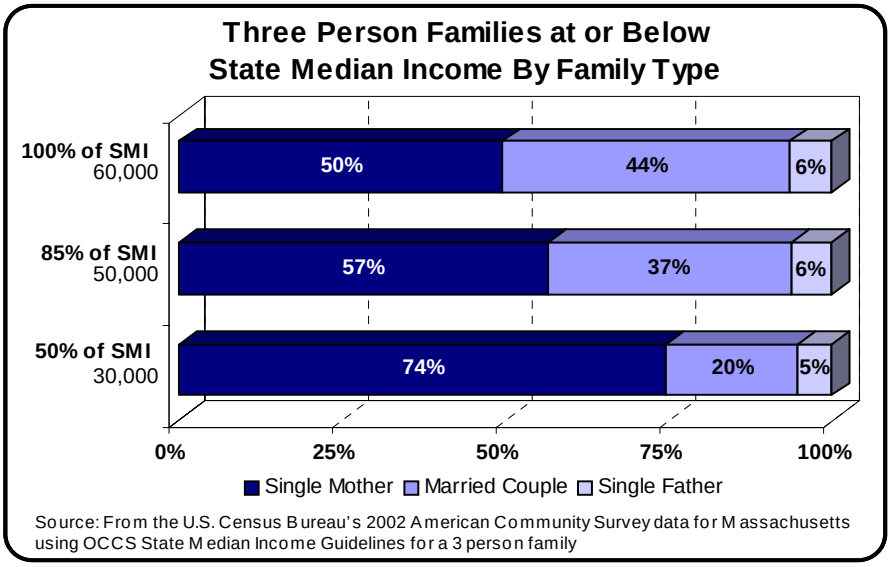
While as late as 1960 a majority of mothers stayed home to care for their children full-time, that has not been the case the past few decades. As Figure 14 indicates, by 1990 fully 78 percent of mothers (and 61 percent of mothers of young children) were in the labor force.[38] Moreover, primary responsibility for raising children most often falls on mothers. According to figures from the Bureau of Labor Statistics, women spend at least twice as much time caring for children as men do, even when both parents are working.[39]

Figure 14



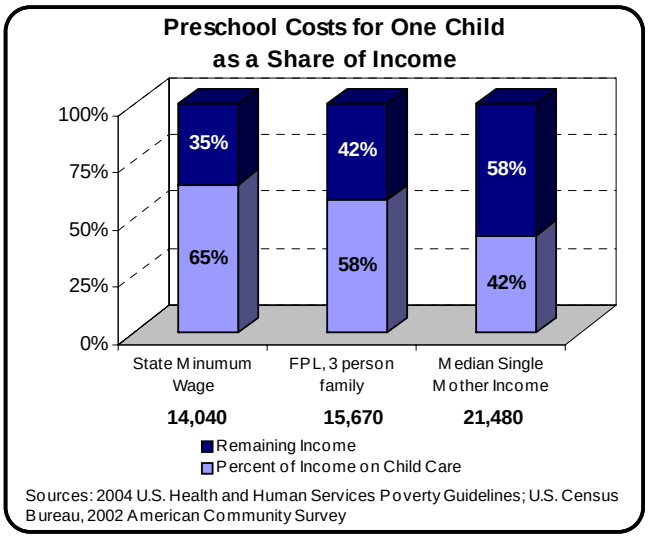
Single mothers are disproportionately affected by the high cost of early education and care, as they represent the highest proportion of all low-income families. For many single mothers, working to support their families would be impossible without some public subsidy of child care. For example, a single mother earning $21,480 per year (the state's median income for single mothers in 2002) would pay more than 40 percent of her income on preschool costs for one child.[40] Using OCCS income guidelines for subsidized care, Figure 15 shows the proportion of families at or below 100 percent, 85 percent, and 50 percent of state median income – approximately $60,000, $50,000, and $30,000 annually. The graph shows that the lower the income threshold, the higher the percentage of single mothers in that income group.

Figure 15



With annual costs of licensed child care averaging between $9,100 for preschool and $12,735 for infant care, low-income families who cannot secure subsidies face an overwhelming financial burden.[41] Figure 16 illustrates the portion of income that would have to be spent on full-time, non-subsidized preschool care for one child based on different family earnings using the most recent data available for each family structure.

Figure 16



Notes: The total for the state minimum wage does not adjust for income taxes and assumes employment at 40 hours per week for 52 weeks.

While many of the elements of the welfare reform policies of the 1990s were controversial and their effectiveness is still being debated, it does seem clear that the $88.1 million increase in funding for subsidized care between fiscal years 1998 and 2002 reduced barriers that impeded women's ability to enter the workforce and improve the living conditions of their families.[42]

- The General Accounting Office reported in 1994 that subsidizing child care costs positively impacts mothers' decision to work.[43] This report's findings contributed to welfare reform legislation focus on job supports like child care.

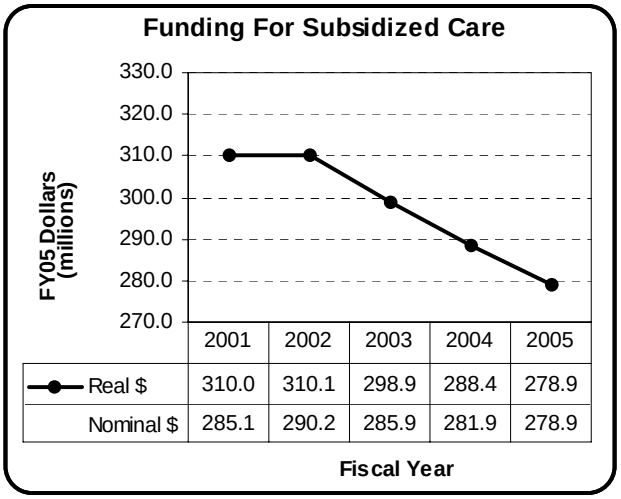
- A report by the Economic Policy Institute reveals that child care subsidies increase length of employment for mothers regardless of welfare status, providing a strong opportunity to experience real wage growth in the long-run.[44]

- A study of child care and the welfare to work transition in Massachusetts indicates that child care costs affect mothers' labor force participation.[45] This study also found that the probability of maternal employment increases as the budget for child care subsidies increases.[46]

- A report by the Center for Law and Social Policy shows that low-income mothers on public assistance who access subsidized child care are likely to secure work.[47]

Funding

Figure 17



Between fiscal years 2002 and 2005, funding for subsidized care fell in real terms by a total of $31.2 million or 11 percent. Prior to fiscal year 2003, subsidies for parents participating in the Employment Services Program, teen parents, low-income parents using in-home or relative care, and other low-income families were funded through separate appropriations. The fiscal year 2003 budget consolidated these separate line-items into one account for low-income families, and reduced funding in real terms by $11.2 million or 4 percent. In fiscal year 2004, funding for subsidized early education and care was cut by nearly $10.5 million in real terms. In fiscal year 2005, the appropriation is reduced by an additional $9.5 million after adjusting for inflation.

Impact of Funding Cuts

Budget cuts to subsidized care have limited the availability of services to low-income families and their children. Between fiscal years 2002 and 2003, when funding was cut by $11.2 million in real terms (a four percent reduction), the number of children in subsidized slots fell from 79,887 to 72,227 (a 10 percent decline).[48] During this same period, the waitlist for subsidized care climbed from 17,610 to 19,235.[49]

Cuts to subsidized early education and care compromise the benefits of affordable, quality care for parents, especially low-income mothers, and their children. Limiting the availability of subsidized care jeopardizes employment and economic gains for low-income single mothers. Furthermore, as they face the high cost of care, many mothers will likely turn to less expensive lower quality alternatives. The following describes the impact of budget cuts to another funding mechanism for early education and care – the Community Partnerships for Children Program.

Community Partnerships for Children

The Department of Education administers a variety of early childhood education programs through early learning and school readiness programs. A large portion of the funding for these services supports the Community Partnerships for Children (CPC) program. Governed by local councils, this program provides subsidies to low- and moderate-income families earning up to 125 percent of the State Median Income. Councils also fund quality enhancement initiatives, including trainings and support with accreditation. Child care programs participating in the CPC program are required to work toward national accreditation within three years.

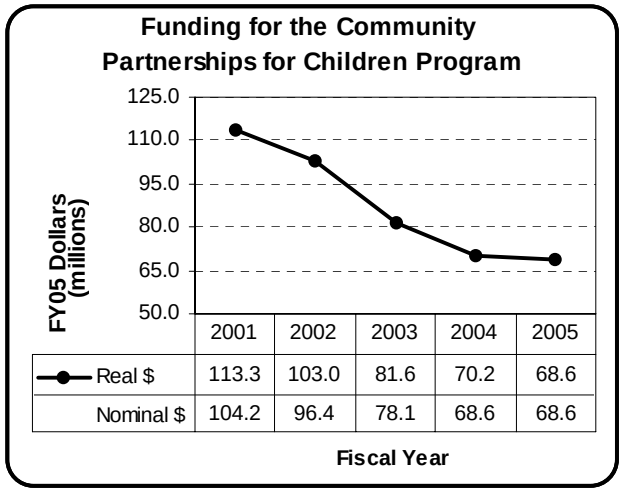
Impact on Women and Girls

Access to quality early education and care benefits women and their families. Employers report that workers with reliable, early care arrangements demonstrate reduced turnover, lower absenteeism, and increase productivity.[50] Quality early childhood education increases children's cognitive, emotional, and social skills, and contributes to positive outcomes like school readiness.[51] For example, a recent study indicates that the majority of the Commonwealth's publicly-administered preschool programs meets or exceeds national quality standards.[52] The CPC program contributes to the Commonwealth's high standing by providing high quality care to at least 15,000 children between three and four years of age, instilling thousands of low- and moderate-income working mothers with the confidence that their children are being well prepared for school while being cared for during the work day.

Funding

Funding for the Community Partnerships for Children Program totaled $104.2 million in fiscal year 2001. The fiscal year 2004 appropriation totaled $68.6 million, a $43.2 million or 38 percent cut, after adjusting for inflation. The fiscal year 2005 budget provides level funding for the CPC program, which does not restore funding and services cut over the past few years.

Figure 18



Impact of Funding Cuts

Between fiscal years 2003 and 2004, the number of children served through the CPC program fell from approximately 18,100 to about 16,600.[53] In addition to reductions in the number of children served, the CPC program was also forced to cut back comprehensive services and investments in quality initiatives.

- Comprehensive services offered through CPC programs benefit more than 50,000 families throughout Massachusetts, as many activities are available to children and families not directly subsidized by a CPC program.[54] Funding for these services, which include transportation, literacy development, mental health services, and supplemental services for children with Individualized Education Plans, was considerably reduced in fiscal year 2002 (more than 60 percent) and further reduced in fiscal years 2003 and 2004 (15 and 20 percent respectively).[55]

- Funding for quality initiatives, which support training for providers, accreditation, and resource materials was also impacted by recent budget cuts. In fiscal year 2002, funding fell by 26 percent and, in fiscal year 2003, funding for these purposes fell by an additional 21 percent.[56] Shortfalls for fiscal year 2004 are not as substantial, as projections estimate a seven percent decline.[57]

Budget cuts to comprehensive services and quality initiatives put at risk recent accomplishments of the CPC program. Findings from a 2001 study of Massachusetts' preschool classrooms indicate that the quality of these classrooms are "good," but there are clear differences in the quality of centers serving low-income families and those serving moderate to high-income families.[58] According to the Office of School Readiness, these findings suggest that additional funding is necessary for programs to make improvements in areas like language and reasoning ability.[59]

The availability of services like those offered through CPC programs directly benefit women and their children. These programs provide child care assistance to low- and moderate-income mothers, and offer enriching settings for their children. Cutting funding for the CPC program puts at risk the progress made in providing opportunities which promote the well-being of women and girls.

Child Care Resource and Referral

As local non-profit agencies under contract wit the Office of Child Care Services, Child Care Resource and Referral Agencies (CCR&Rs) are designed to ensure that families have access to affordable, quality child care while helping to build the capacity and quality of the child care system. CCR&Rs provide guidance and referrals to families

seeking licensed child care, information on state-funded subsidies and related processes, training and assistance to providers, and management of waitlists for subsidized child care.

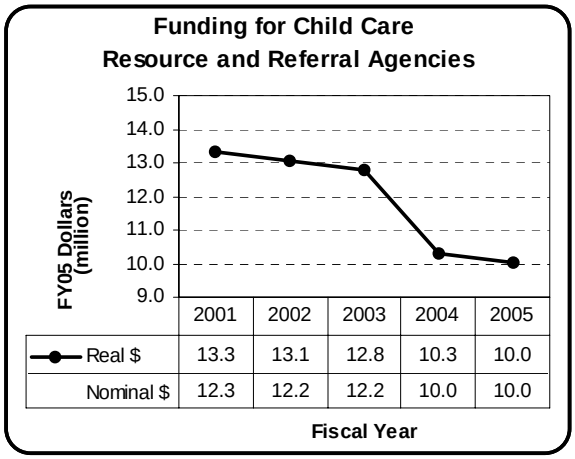
Impact on Women and Girls

Child Care Resource and Referral agencies were created to help families navigate the often complex system of finding and securing child care subsidies and locating safe, quality care. As detailed above, subsidized care has its own benefit to low-income mothers and their children. Child care providers, 94 percent of whom are women, also benefit from the training and professional development opportunities provided by CCR&Rs.[60] A recent report by the Children's Defense Fund indicated that funding for resource and referral programs is one of several strategies states should use to improve the quality and expand the supply of child care.[61]

Funding

Between fiscal years 2001 and 2003, state funding for Child Care Resource and Referral Agencies remained relatively stable at around $12.2 million. In fiscal year 2004, funding was reduced to $10.0 million, and the fiscal year 2005 budget provides the same level of funding. If budget appropriations for this program had kept pace with inflation since fiscal year 2001, $13.3 million would have been allocated in fiscal year 2005.

Figure 19



Impact of Funding Cuts

The 20 percent inflation-adjusted reduction in funding between fiscal year 2003 and fiscal year 2004 led to a loss of 54 full-time equivalent CCR&R staff positions statewide.[62] Fewer staff positions required many offices to curtail their hours of operation and to reduce the resources available to parents and providers, thereby limiting the availability of many services.[63] Figure 20 below notes the number of families and children who benefited from services offered by CCR&Rs. While only calendar year data are available, it is clear that low-income families were directly affected by the decline in funding between fiscal year 2003 and fiscal year 2004. The decrease in the number of beneficiaries for calendar year 2003 is a direct result of the budget cuts implemented for at least the first half of fiscal year 2004, since that fiscal year ran from July of 2003 to June of 2004.

In addition to serving fewer families overall in fiscal year 2004, CCR&Rs also offered fewer services for families with special needs children and their providers. Local agencies scaled back consultation and referrals for working families with special needs children as well as technical assistance and access to appropriate materials for providers caring for children with special needs (Braille books, for example).[64] The impact of these reductions affect women as both providers and consumers of child care, as women are very often the primary caregivers of young children both inside and outside the home.

Figure 20

CCR&R Beneficiaries: 2000-2003

Calendar Year	Families	Children
2000	21,965	28,032
2001	21,550	27,486
2002	19,877	25,543
2003	16,168	21,049

Source: Massachusetts Child Care Resource and Referral Network.

[36] Pursuant to the Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) of 1996, states are permitted to transfer portions of their TANF block grant to either the Child Care Development Fund or the Social Services Block Grant for various employment supports. This report does not distinguish between state and federal allocations, though in recent years the state portion has declined.

[37] This section only discusses subsidized child care provided through the Office of Child Care Services. Subsidized child care is also available through Community Partnerships for Children program, which is funded by the Massachusetts Department of Education.

[38] According to U.S. Census Bureau data for Massachusetts from the 1990 Decennial Survey.

[39] "Time-Use Survey—First Results Released by BLS," Bureau of Labor Statistics, U.S. Department of Labor, September 14, 2004, p. 3.

[40] Single Mother State Median Income comes from the U.S. Census Bureau's 2002 American Community Survey for Massachusetts

[41] Massachusetts Child Care Resource and Referral Network, as cited in Traill, S. Wohl, J., *The Economic Impact of the Child Care and Early Education Industry in Massachusetts*, National Economic Development and Law Center, 2004, p. 12.

[42] Much of this increase was from federal funding sources.

[43] *Child Care: Child Care Subsidies Increase Likelihood that Low Income Mothers Will Work*, U.S. General Accounting Office, December 1994, p. 1-5.

[44] Boushey, H., *Staying Employed After Welfare: Work Supports and Job Quality Vital to Employment Tenure and Wage Growth,* Economic Policy Institute, 2002, p. 1-2.

[45] Lemke, R. et al., *Child Care and the Welfare to Work Transition*, Wellesley College Working Paper 2001-02, Department of Economics, Wellesley College, March 13, 2001, p. 18-19.

[46] Ibid.

[47] Mezey, J., *Child Care Programs Help Parents Find and Keep Jobs: Funding Shortfalls Leave Many Families Without Assistance*, Center for Law and Social Policy, February 10, 2004, p 1-3.

[48] Data are from the Massachusetts Office of Child Care Services.

[49] Ibid.

[50] "*Investing in Early Education is Essential,"* Strategies for Children, at www.strategiesforchildren.org/images/pdfs/Why%20Investing.pdf.

[51] For more, refer to: (1) *The Children of the Cost, Quality, and Outcomes Studies go to School,* National Institute of Child Health and Human Development, June 1999. (2) Shonkoff, J. and Phillips, D. eds., *From Neurons to Neighborhoods: The Science of Early Childhood Education,* Board of Children, Youth, and Families, Commission on Behavioral Sciences and Education, National Research Council and Institute of Medicine, Washington, D.C., National Academy Press, 2000. (3) *Starting Points: Meeting the Needs of Our Youngest Children,* Carnegie Corporation of New York, August 1994.

[52] Marshall, N. et al., *The Cost and Quality of Full Day, Year-Round Early Care and Education in Massachusetts: Preschool Classrooms,* Wellesley Centers for Women and Abt Associates, Inc., 2001.

[53] Figures are from the Office of School Readiness, Massachusetts Department of Education.

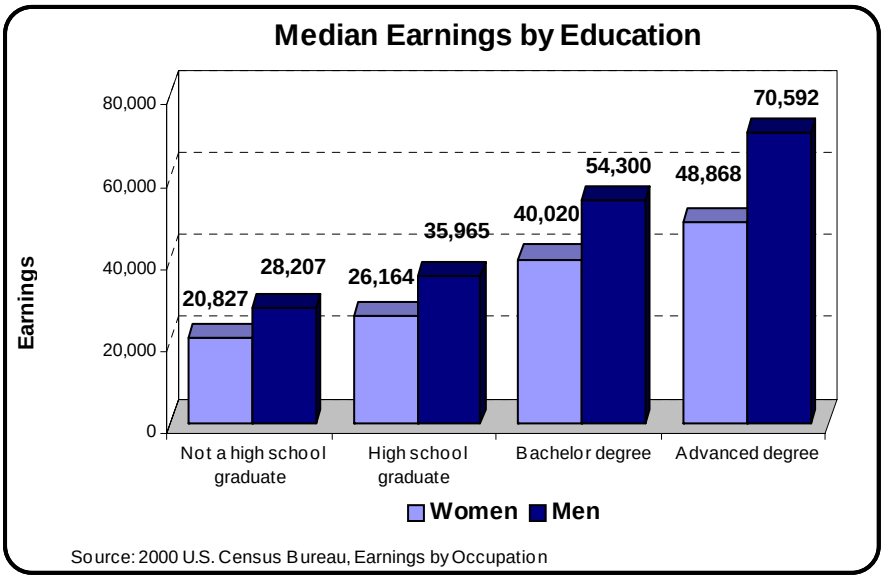
[54] Ibid.
[55] Ibid.
[56] Ibid.
[57] Ibid.
[58] Marshall, N. et al., *The Cost and Quality of Full Day, Year-Round Early Care and Education in Massachusetts: Preschool Classrooms,* Wellesley Centers for Women and Abt Associates, Inc., 2001, p. 45-46.
[59] "Community Partnerships for Children: Building a System of Early Childhood Education in Massachusetts," Office of School Readiness, Massachusetts Department of Education, March 2004.
[60] Percentage of female child care providers come from the U.S. Census Bureau's Standard Occupational Classification results for Massachusetts.
[61] "Good Child Care Assistance Policies Help Low-Income Working Families Afford Quality Care and Help Children Succeed," From *Key Facts: Essential Information about Child Care, Early Education, and School Age Children,* Children's Defense Fund, 2003, p. 148.
[62] "Line Item 4130-3100: Providing Child Care Voucher Subsidies, Workforce Development, Consumer Information Services to Families, Business, and Citizens Throughout the Commonwealth," Fact Sheet, Massachusetts Child Care Resource and Referral Network, 2004.
[63] Ibid.
[64] "Impact of $1.5 M Cut in Line Item 4130-3100," Fact Sheet, Massachusetts Child Care Resource and Referral Network.

IV. Educating Women and Girls

Close to one million children benefit from public education each year in Massachusetts. Although in some institutions of higher education women represent a significant majority of students, that is not why this report identifies education as a critical issue for women. Education is examined not because it is a benefit provided primarily to girls, but rather because of the importance of education in the lives of women and girls. The overwhelming majority of girls in the Commonwealth receive – through public education – the skills they need to succeed in the modern economy, the knowledge that enables them to participate effectively in our democratic society, and the talents and abilities that help them to build satisfying and fulfilling lives. For most women, education is the most important way in which their lives are affected by state government.

Budget cuts to all levels of public education compromise the economic security of women who must attain higher levels of education to advance their earnings. Comparing the earnings of men and women by education level shows two stark trends: men have higher earnings at each level of educational attainment; and earnings rise substantially for men and women as they receive additional education. From the perspective of being able to provide economic security for their families, the data suggests that women may need the benefits of education even more than men. While the median earnings of men who have not graduated from high school total $28,207, women without a high school degree earn only $20,827. Only with a high school degree do women have earnings that approach those of men without a high school degree.[65] The same trend continues at each step of further education as shown in Figure 21.

Figure 21



K-12 Education

In 1993, Massachusetts instituted comprehensive statewide changes for public school districts. The Education Reform Act of 1993 demanded accountability for student learning; set statewide standards for students, schools, and districts; and required greater and more equitable funding to schools. Pursuant to this law, Massachusetts adopted several major reforms: statewide curriculum frameworks for core academic subjects; an assessment tool to measure students' academic achievement and schools' and districts' performance; professional development and stronger certification requirements for teachers; and a new foundation budget designed to provide adequate per-pupil-expenditures across all school districts. The state requires specific local contributions from each municipality and provides enough state aid (called "Chapter 70 Aid") to ensure that every district can spend at the foundation budget level.[66] In addition to Chapter 70 Aid, the state has also provided funding for K-12 education through the Department of Education's grants and reimbursements programs for specific purposes, such as reducing class sizes.

Education reform has brought about measurable benefits for public school students. There has been considerable progress on the Massachusetts Comprehensive Assessment System (MCAS), for example. Increasing proportions of students have scored at the "Advanced" or "Proficient" levels on this assessment.[67] Students' performance on the National Assessment of Educational Progress (NAEP) – the nation's standard test of student achievement – has also shown noticeable improvement, with higher percentages of "Advanced" or "Proficient" than the national averages.[68] There is also evidence that the majority of public school graduates in Massachusetts are likely to continue their education at a post-secondary institution. Although comprehensive data on college enrollment for public high school graduates are not available, a report by the Massachusetts Department of Education shows that more than three-fourths of high school graduates (77 percent) from the class of 2003 intended to continue their education at a two- or four-year college, up from 69 percent in 1993.[69]

Although more work needs to be done to provide adequate funding for school districts and achieve higher performance levels on the MCAS within certain communities – two issues that are in many ways interrelated – overall achievement results show that throughout the 1990s public schools improved their capacity to prepare students for post-secondary education and lifelong learning.

Impact on Women and Girls

Overall, reductions in funding for K-12 education have affected both girls and women. Girls have been affected as they represent half of the school age population. Additionally, as a higher percentage of females than males intend to pursue post-secondary studies after graduating (81 percent versus 69 percent), budget cuts to public school districts can have negative longer-term consequences on women and their families, since higher levels of educational attainment lead to higher earnings.[70] Women, as well, have been affected by funding cuts as they are overrepresented among teachers – 69 percent of all elementary and middle school teachers are women.[71]

Funding

Funding for public K-12 education in the Commonwealth is primarily financed through state and local revenue, as the federal government only contributes 5.4 percent of the total amount.[72] In Massachusetts, state funding for K-12 education is comprised of Chapter 70 Aid and the Department of Education's grants and reimbursements programs. Chapter 70 Aid is the largest state allocation to local municipalities for public education and ensures that every district is able to spend a specified minimum necessary amount known as the foundation budget. In addition to Chapter 70 Aid, the Department of Education awards grants for specific purposes to various districts. Together, these two primary sources of funding represent state support for public schools.

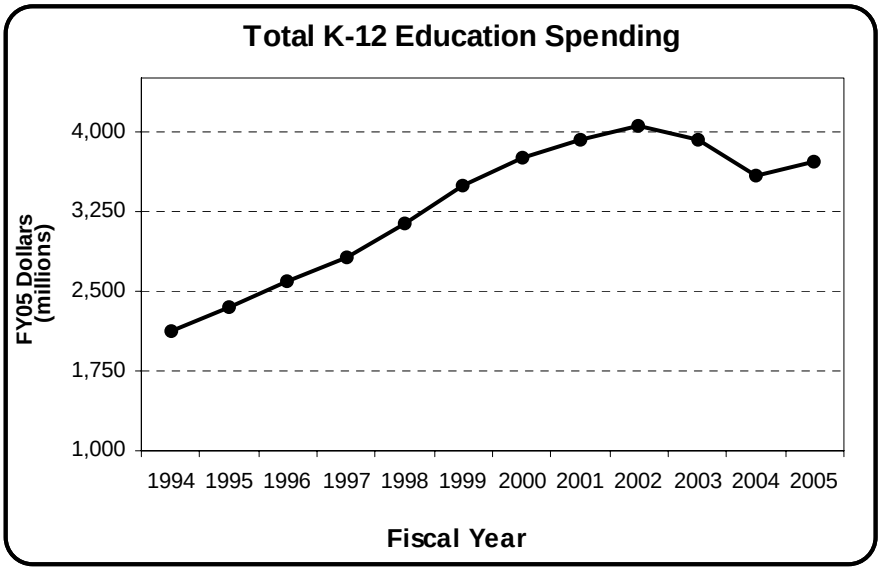
Before examining the impact of the fiscal crisis on K-12 education, it is useful to first review general patterns in overall funding arising from the Education Reform Act's mandate for increased spending on public schools.

- Between fiscal years 1994 to 2002, overall state funding for K-12 education rose from $1.7 billion to $3.8 billion. This represents a six percent inflation-adjusted average annual growth rate.

- After peaking in fiscal year 2002, overall appropriations fell to $3.5 billion in fiscal year 2004, a decline of $473.0 million or twelve percent in real terms. In fact, between fiscal years 2002 and 2004, Massachusetts led the nation in real cuts to per pupil state funding for public education.[73]

- Appropriations for fiscal year 2005 total $3.7 billion. This amounts to a $141.6 million increase over the previous year in real terms, but is still below the overall inflation-adjusted funding level for fiscal year 2003.

Figure 22



Between fiscal years 2002 and 2003, funding for Chapter 70 Aid rose nominally by 1.5 percent, which is slightly less than the 2.2 percent inflation rate over these years (see Figure 23). Between fiscal years 2003 and 2004, funding fell by $230.5 million or seven percent in real terms. The fiscal year 2005 budget essentially level funds Chapter 70 Aid at $3.183 billion. If funding had kept pace with inflation since fiscal year 2002, $3.433 billion would have been appropriated in fiscal year 2005, which is $250.0 million more than the actual allocation.

Between fiscal years 2001 and 2004, appropriations for the Department of Education's grants and reimbursements programs decreased in real terms by $260.0 million or 39 percent (see Figure 24). Although the current budget increases funding in many areas, most programs are level-funded. In fact, budget cuts in fiscal year 2004 reduced funding such that certain programs were scaled back considerably or eliminated. The fiscal year 2005 budget did not restore most of these cuts.

Figure 23

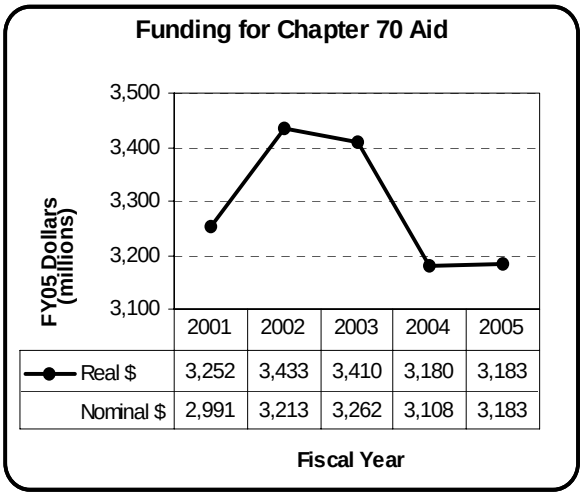
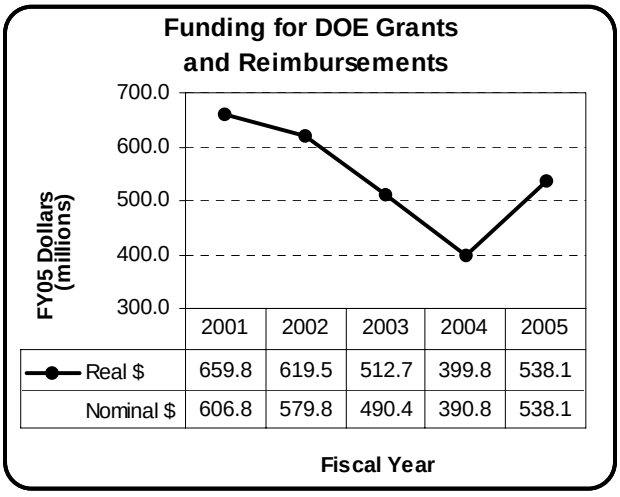


Figure 24



Impact of Funding Cuts

Reductions in state funding for education have forced local school districts either to reduce the resources available in their schools, or to increase local property taxes, or both. Between 2002 and 2003 the number of teachers and other people employed by schools in Massachusetts fell by 3 percent, from 159,933 to 155,913.[74] These reductions increased the overall pupil to teacher ratio and harmed the capacity of schools to meet the needs of their students, girls and boys alike. More specifically, the state cut funding for a number of services that had improved the educational experience for thousands students, including the following: targeted literacy efforts; funding to reduce class sizes; after schools programs; and adult education classes for older students seeking their high school equivalency. In addition to the negative effects on students, thousands of women who teach in our schools have seen their jobs become more difficult as reduced staffing levels add to the challenges of educating our students effectively.

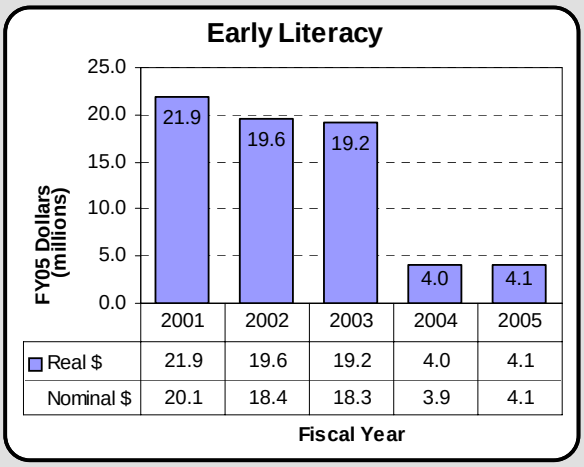
Budget cuts also have long-term consequences, as potential reductions in quality may hinder girls' opportunities to further their education and increase their earnings. The following two pages highlight budget cuts to four grants and reimbursements programs.

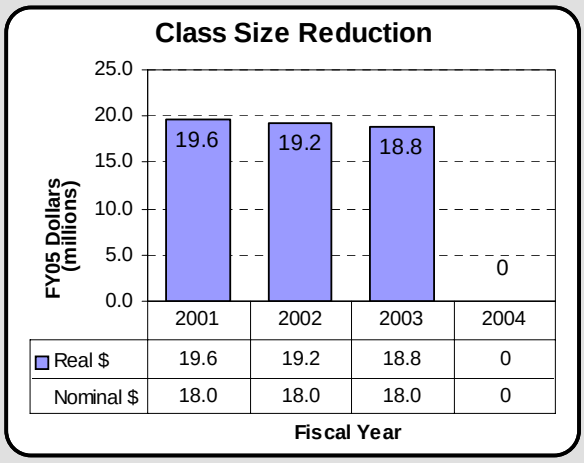
Early Literacy – The budget appropriation for early literacy supports programs that improve the reading ability of children in grades K-3 as well as trainings designed to keep teachers current on the latest research findings and literacy teaching techniques. Funding for these services was reduced from $20.1 million in fiscal year 2001 to $18.3 million in fiscal year 2003. Significant cuts in fiscal year 2004 further reduced funding to $3.9 million dollars, nearly 80 percent less than the previous year. The fiscal year 2005 budget appropriation of $4.1 million provides a slight increase over the fiscal year 2004 budget, but is well below the fiscal year 2003 total. Reductions in funding for early literacy initiatives jeopardize the state's commitment to help students become effective readers by the end of the third grade.

Class Size Reduction – This program, prior to its elimination in fiscal year 2004, provided funding to districts in which at least 22 percent of the student population came from low-income families. Between fiscal years 2001 and 2003, funding for this program to reduce class sizes in the early grades totaled $18.0 million per year. Despite research which directly links student achievement with efforts to reduce class sizes in the lower grades, the state eliminated funding for this program in fiscal year 2004.

After School Programs – When Massachusetts reduced funding for after school programs, it removed support for programs that provide positive benefits to girls. There is evidence that after school programs specifically geared towards middle school girls can improve body image, assertiveness, self-esteem, and competence.[75] In fiscal year 2002, $3.1 million were appropriated for this purpose, down considerably from $11.7 million in the previous year. Despite evidence supporting successful interventions, funding for after school programs through the Department of Education was eliminated in fiscal year 2003.[76]

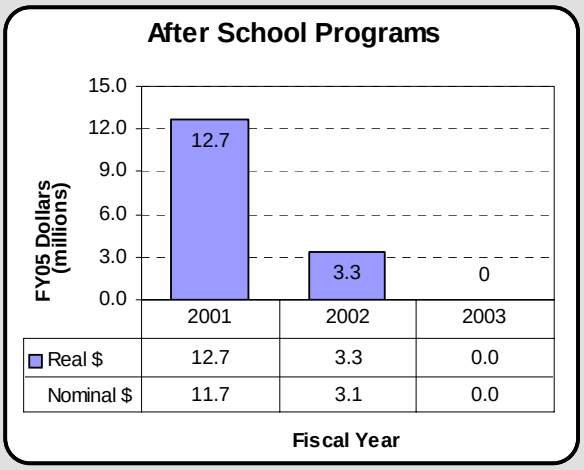
Adult Basic Education - The Department of Education funds Adult Basic Education programs, which provide a variety of services, including classes for high school equivalency (GED), and English for Speakers of Other Languages (ESOL). These classes – of which more than half (53 percent) of the students are women – are designed to develop the literacy skills needed to qualify for further education, job training, and better employment.[77] State funding for ABE fell from $30.2 million in fiscal year 2001 to $27.8 million in fiscal year 2004, an eight percent reduction (a 13 percent decline in real terms). Funding for these programs has not kept up with demand. In fiscal year 2004, 23,400 individuals were on the waitlist for ABE programs, while only a fraction – roughly 10,300 individuals, 5,500 of whom were women – accessed services offered by these programs.[78] ABE is vital to supporting economic self-sufficiency for women, as there are substantial differences between those who drop out and those who get a high school equivalency, not only in their ability to find a job but also in the wages they earn.

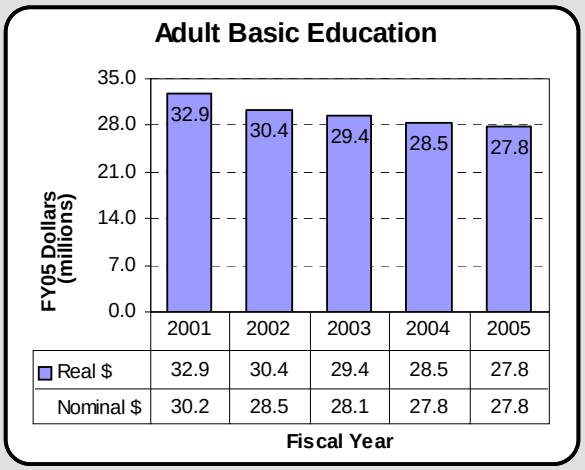




Early Literacy:
Cut 81 percent
between FY 2001 and FY 2005

Class Size Reduction:
Eliminated in FY 2003





After School Programs:
Eliminated in FY 2002

Adult Basic Education:
Cut 15 percent
between FY 2001 and FY 2005

Higher Education

While quality K-12 education provides a solid foundation on which to build later in life, post-secondary education provides opportunities for individuals to develop skills and, in turn, improve their earnings upon joining the workforce. Increasingly, a high school degree is no longer enough to compete in today's economy. While Massachusetts is known for its private institutions of higher learning, the majority of high school graduates who stay in Massachusetts to further their education do so at a public college or university.[79] Furthermore, upon graduation, the majority of students who attend public colleges live in Massachusetts. Between 80 and 85 percent of graduates from Massachusetts' state and community colleges live and work in the Commonwealth, directly contributing to the state's economy.[80] Public colleges and universities can play a critical role in enhancing individuals' earnings, as they provide quality education at a cost more affordable to individuals with low and moderate incomes.

Impact on Women and Girls

In Massachusetts, women make up significantly more than half of the total enrollment in public colleges and universities. At state and community colleges, enrollment rates for women are even higher; in the 2002-03 academic year, women represented at least 60 percent of students enrolled at these institutions.[81] These institutions accordingly award a higher percent of degrees to female students. In 2002-03, 68 percent of degrees from state colleges and 64 percent of degrees from community colleges were conferred upon women.[82]

Figure 25

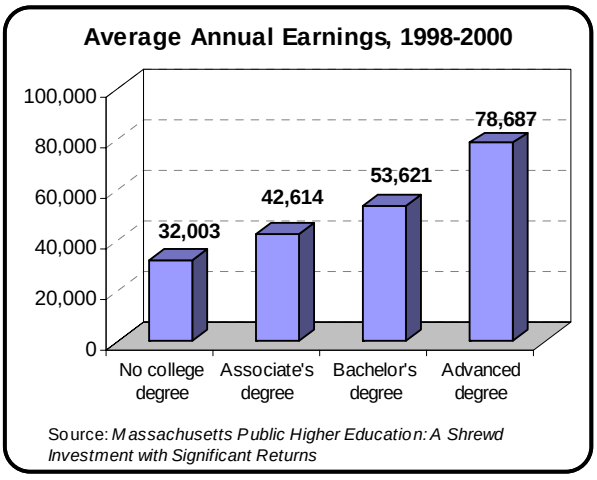
Percentage of Women Enrolled in and Awarded Degrees from Massachusetts' Public Colleges and University System

Enrollment	**2000-01**	**2001-02**	**2002-03**
UMass	51%	51%	51%
State Colleges	63%	63%	63%
Community Colleges	60%	61%	62%
Total	**58%**	**58%**	**59%**
Degrees Awarded	**2000-01**	**2001-02**	**2002-03**
UMass	55%	55%	55%
State Colleges	66%	67%	68%
Community Colleges	64%	64%	64%
Total	**61%**	**61%**	**62%**

Source: Office of Planning, Research, and Assessment, Massachusetts Board of Higher Education.

While completing high school is the first step toward securing economic self-sufficiency, additional credentials are increasingly required in today's economy, as shown above in Figure 21 above. Associate's degree programs should not be ignored in this context. Although data on median earnings by gender do not provide a category for associate's degree holders, data on total earnings show that acquiring an associate's degree substantially increases earnings. Individuals with an associate's degree earn $10,000 or 33 percent more per year than those with lower levels of educational attainment. Given the high proportion of women enrolled in community colleges, associate's degree programs are a viable option for increasing earnings.

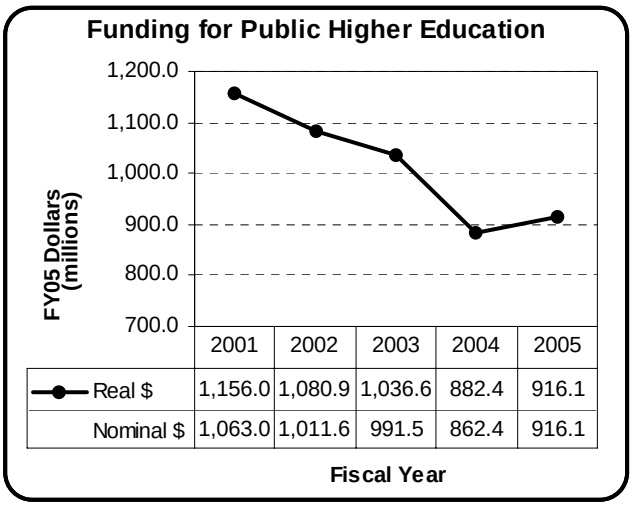
Figure 26



Funding

As in many other areas of the fiscal year 2005 budget, state appropriations for higher education provide a modest increase over the fiscal year 2004 funding level. Total state appropriations for higher education rose from $862.4 million in fiscal year 2004 to $916.1 million in fiscal year 2005. This amounts to a $33.7 million or four percent increase after adjusting for inflation. The additional funding, however, is a small step in reversing several years of budget cuts to higher education. Between fiscal years 2001 and 2004, total funding for higher education fell by $200.6 million or 24 percent in real terms. During this same period, appropriations for state colleges dropped by $30.4 million or 15 percent; support for community colleges declined by $35.9 million or 15 percent; and funding for UMass campuses fell by $132.1 million or 25 percent. (These reductions are all represented in real terms.)

Figure 27



Additionally, state funding for financial assistance programs have been substantially reduced:

- In fiscal year 2001, the state appropriated $100.1 million to the primary budget account that supports financial aid and scholarships. By fiscal year 2005, this amount totaled $82.4 million, 23 percent less than in fiscal year 2001, after adjusting for inflation.

- Funding for a scholarship called Tomorrow's Teachers was eliminated from the fiscal year 2004 budget. This program – which provided a full, four-year scholarship for any public college or university in the state in exchange for the student's commitment to teach at a Massachusetts public school – was last funded at $4.0 million.

Impact of Funding Cuts

To compensate for budget reductions, public colleges and universities have shifted some of their costs to students. For example, when Massachusetts' allocation to state colleges was cut in real terms by $30.5 million (15 percent) between fiscal years 2003 and 2004, average tuition and fees rose by approximately $780 or 20 percent after adjusting for inflation.[83] That increase followed a 27 percent real increase in the previous school year for these institutions.[84] At the same time, financial assistance designed to help students with tuition and fees, has also been cut. In particular, the Tomorrow's Teachers program described above would have likely benefited female students as prospective and current teachers are predominately women. Cuts to other financial aid programs have come at a time when individual federal financial aid awards are also declining.

Funding reductions to higher education jeopardize the Commonwealth's ability to provide quality educational opportunities at its own public colleges and universities. Higher education, in turn, is a means to secure economic self-sufficiency for women and men. Although higher education is not generally considered a "women's issue," the fact that women represent a significant majority of students in Massachusetts' public colleges and universities makes it one.

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[65] Earnings represent median earnings for individuals between 21 and 64 years of age. Data are from "Employment, Work Experience, and Earnings by Age and Education," 2000 Census, U.S Census Bureau.
[66] Recommendations from a recent lawsuit (*Hancock v. Driscoll*) indicate that there will be additional requirements for the Commonwealth to increase the level of funding for K-12 education.
[67] *Spring 2004 MCAS Tests: Summary of State Results*, Massachusetts Department of Education, September 2004, available at www.doe.mass.edu/mcas/2004/results/summary.pdf.
[68] "State Profile for Massachusetts," National Center for Education Statistics, U.S. Department of Education, available at http://nces.ed.gov/nationsreportcard/states/profile.asp.
[69] Ibid.
[70] Percentages are from "Plans of High School Graduates: Class of 2003," Massachusetts Department of Education. May 26, 2004, available at www.doe.mass.edu/infoservices/reports/hsg/03/.
[71] Based on data from the Massachusetts Department of Education.
[72] *Public Education Finances: 2002*, 2002 Census of Governments, Vol. 4 Government Finances, U.S. Census Bureau, August 2004, p. 5.

[73] Reschovsky, A., "The Impact of State Government Fiscal Crises on Local Governments and Schools," Robert M. La Follette School of Public Affairs, University of Wisconsin, Madison, December 2003.
[74] Based on data from local government employment for Massachusetts from the Bureau of Labor Statistics, U.S. Department of Labor.
[75] "Making the Case: A Fact Sheet on Children and Youth in Out-of-School Time," National Institute on Out-of-School Time, Center on Research on Women, Wellesley College, January 2004.
[76] Although the Department of Education no longer provides funding for after school programs, the fiscal year budget 2005 budget provides $2.0 million for after school programs through the Targeted Cities Initiative – a program designed to reduce high rates of juvenile delinquency, teen pregnancy, and high school dropouts. This program was last funded at $455,000 million in fiscal year 2003. In fiscal year 2002, $10.0 million in funding for after school programs was also included in the budget appropriation for MCAS remediation, was eliminated in the following year, and has not been restored.
[77] Gender breakdown is from the Adult and Community Learning Services, Massachusetts Department of Education.
[78] Waitlist data are from the Adult and Community Learning Services, Massachusetts Department of Education. Of this total, 6,379 are on the waitlist for basic education programs; 17,313 were on the waitlist for ESOL classes.
[79] Coelen, S. et al., *Massachusetts Public Higher Education: A Shrewd Investment with Significant Returns, University of Massachusetts, Amherst and the Massachusetts Board of Higher Education,* January 2002, p. 7-8.
[80] *Mindpower in the Massachusetts: The Commonwealth's Natural Resources,* Massachusetts Board of Higher Education, 1997, p. 17.
[81] *Fall 2003 Admissions and Enrollment Tables,* Office of Planning, Research, and Assessment, Massachusetts Board of Higher Education, January 2004, p. 33.
[82] *Degrees Awarded 2003,* Office of Planning, Research and Assessment, Massachusetts Board of Higher Education, January 2004, p. 8.
[83] Data on tuition and fees are from "Tuition and Fees at Massachusetts Public Colleges and University," Massachusetts Board of Higher Education, available at www.mass.edu/p_p/includes/ir/Tuition&Fees88-04.pdf.
[84] Ibid.

V. Providing Access to Health Care for Women and Girls

There are a variety of factors that affect a woman or girl's ability to access health care. For low-income women in particular, the list of access challenges can become quite long. Women and girls can experience linguistic or cultural barriers in finding health care providers who speak a familiar language and approach health care in a culturally familiar way. Women without access to transportation face the challenge of finding health care providers who are geographically accessible or conveniently located. Women with responsibility for young children or women struggling with job responsibilities face the challenge of finding the time to take care of their own health care needs.

One of the most significant barriers to health care access for women and girls is economic. Health care is extremely expensive to pay for out of pocket, and health insurance to pay for medical care is rapidly becoming less affordable. Even for women with publicly-funded health insurance, because of the rate structure by which these providers receive reimbursement for their services, finding health care providers in certain medical specialties can be a daunting task.

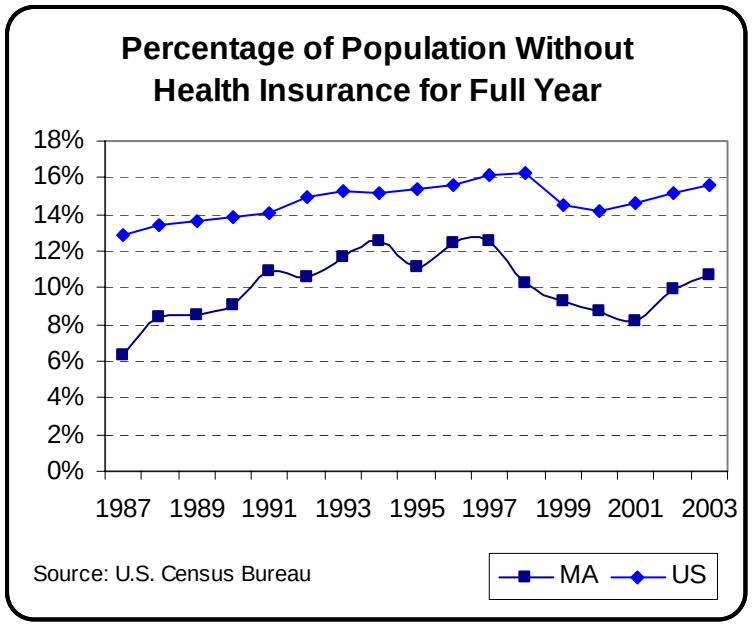
Poor access to health care has significant implications for all aspects of women's lives, including their ability to maintain their own health and well-being, their ability to care for their families, and their ability to meet the responsibilities of regular employment.

The Commonwealth plays several crucial roles in improving access to care for women and girls. One of the primary functions of the Massachusetts Department of Public Health and other departments within the Executive Office of Health and Human Services is to improve access to health care for vulnerable populations. In fact, the Commonwealth has recently reorganized the structure of these agencies in order to facilitate better coordination across the service spectrum and across age ranges. These departments identify areas of need within the Commonwealth, and develop targeted programs to serve the needs of particularly vulnerable populations, including girls and women of all ages. The services and supports directly provided by these agencies are an important component in the web of care for women and girls.

This report will discuss some of those efforts in a subsequent section. In addition to these direct services, however, the Commonwealth plays an important role in providing health insurance for a large segment of the population who would otherwise be uninsured.

Providing Health Insurance for the Otherwise Uninsured

Figure 28

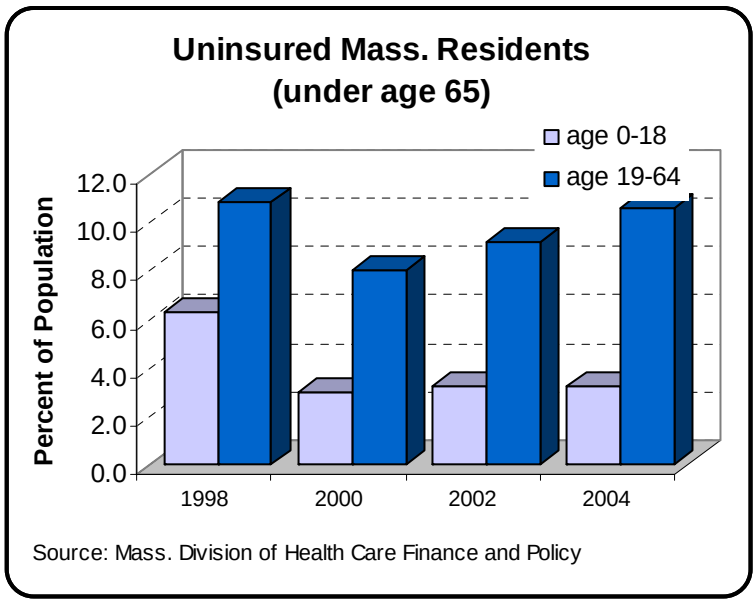


According to recent data from the Census Bureau, there are close to 45 million people in the United States who reported not having health insurance during 2003, almost one in every six persons, or 15.6 percent. In Massachusetts, the number is closer to one in every ten persons, or 10.7 percent of Massachusetts residents (see Figure 28). The Census Bureau estimates that in 2003 there were close to 685,000 individuals in Massachusetts without health insurance.[85]

Although the percentage of the population without health insurance has declined since the mid-1990s, the uninsured rate has increased since the economic recession and state fiscal crisis in the early part of this decade.

A recent survey published by the Massachusetts Division of Health Care Finance and Policy presents a similar picture. This survey showed that approximately 460,000 Massachusetts residents were without health insurance at the time of the survey in early 2004, close to 7.4 percent of the population (see Figure 29).[86] Although the rates of children without health insurance dropped markedly in the late 1990s with the introduction of state-supported targeted insurance programs and has stayed relatively stable at approximately three percent, the percentage of adults between the ages of 19 and 64 without health insurance has

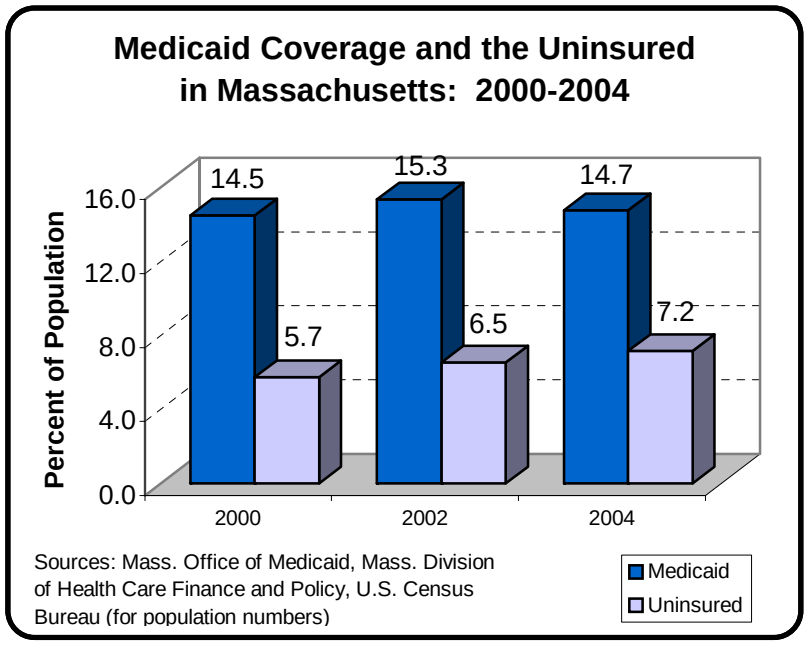
Figure 29



grown from 8.0 percent in 2000 to 10.6 percent in 2004 – almost as high as the percentage of uninsured adults in 1998 before the targeted insurance expansions were fully implemented.

In a recession, one might expect that joblessness and poverty would increase, thereby increasing the number of persons without private employer-sponsored health insurance. One might also expect that as private health insurance rates decline, and the portion of the state's population without health insurance grows, the state's safety net of public health insurance programs would increase to ensure that the Commonwealth's residents continue to receive health care.

Figure 30



Unfortunately, as Figure 30 demonstrates, publicly-funded health insurance enrollment through the state's Medicaid program declined after 2002, even as the portion of the population without insurance coverage rose during that time.

According to these data from the Office of Medicaid and the Mass. Division of Health Care Finance and Policy, the percentage of the total population without insurance rose from 6.5 percent to 7.2 percent between 2002 and 2004, and the percentage of the population covered by Medicaid declined from 15.3 percent to 14.7 percent.[87] (Every one-tenth of one percentage point represents more than 6,000 people.)

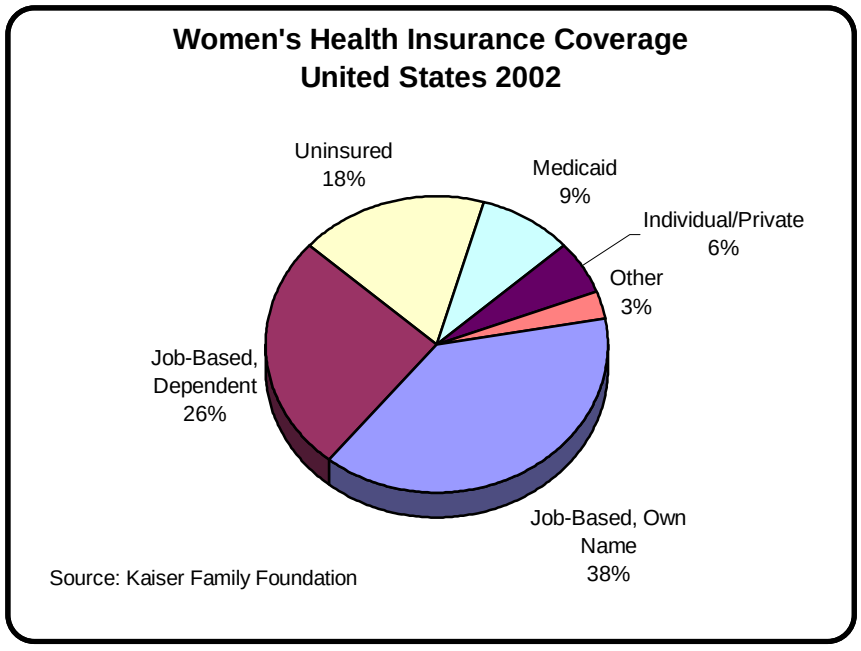
One of the factors that may have led to the decline in Medicaid enrollment was an explicit intention on the part of the Commonwealth to slow enrollment growth in reaction to fiscal concerns. According to a June 2004 statement to the federal Centers for Medicare and Medicaid Services, "many of the outreach and marketing efforts [for Medicaid enrollment] were scaled back beginning in 2002 to slow enrollment (rather than reduce or cap eligibility) in reaction to the state budget crisis. . . ."[88]

Impact on Women and Girls

In Massachusetts, the health insurance rate is higher than the national rate, and Massachusetts also has a higher percentage of women with health insurance than the nation as a whole. Estimates from the Massachusetts Department of Public Health indicated that in 2002 approximately 9.9 percent of men and 5.9 percent of women were without health insurance.[89] One of the reasons that women have a better insured rate is that they are more likely than men to be eligible for publicly-funded health insurance.

Women in general have a different pattern of health insurance coverage than men, and even though they are more likely to be insured, their insurance is also likely to be more at risk than is men's. Although women are just as likely as men to have job-based health insurance overall, they are less likely to be insured through their own job, and more likely to have dependent coverage from a spouse. Because women are more reliant on dependent coverage than men, they are more vulnerable to losing health insurance if they become divorced or widowed, and are also more vulnerable to changes in their spouse's employment or health insurance status.

Figure 31



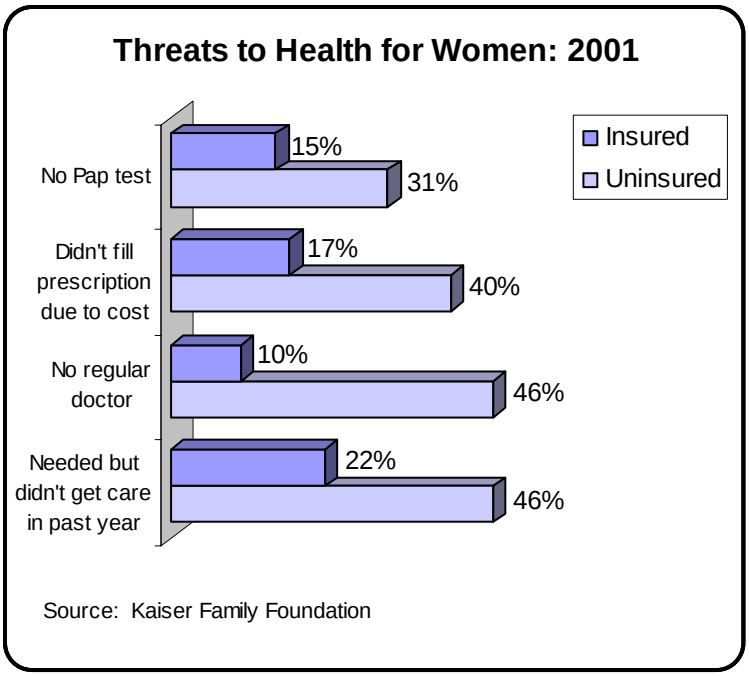
In 2002, approximately 38 percent of women between the ages of 18 and 64 nationally had their job-based insurance from their own job (see Figure 31), compared to 53 percent of men. Some of the difference in these rates can be explained by the fact that women are less likely than men to work full-time, and are therefore less likely to be eligible for full employment benefits.

Women are also more likely than men to be working in low-wage employment that does not provide extensive health benefits. While only 13 percent of men receive health insurance as a spouse's dependent, 26 percent of women have dependent coverage.[90] According to national data, women at the greatest risk of being uninsured are younger, are poor or near-poor, and are likely to be women of color. Women without health

insurance are at greater risk for poorer health outcomes, and they are more likely to postpone care or forego preventive care entirely.

Health insurance is extremely important to the health care of women and girls. Having health insurance is a major determinant of whether women have access to health care services, and whether women will actually receive appropriate health care over the course of their lifetimes. According to data from the Kaiser Family Foundation (see Figure 32), women without health insurance are much more vulnerable to a number of significant threats to their health than are women who are insured.

Figure 32



Uninsured women are more than twice as likely as insured women to delay filling needed prescriptions, more than twice as likely to delay crucial health screenings such as Pap smears, and more than twice as likely not to have received medical care (including preventive health care) within the past year. Furthermore, women without health insurance are more than four times as likely as women with health insurance to not have a regular doctor.[91]

For low-income women and girls, Medicaid – the publicly-funded health insurance program – provides a crucial safety net of health insurance coverage, and does so without full cost to the state since the federal government reimburses the state for more than half of Medicaid expenditures.[92] Federal standards require that Medicaid recipients be low-income and either children, pregnant women, parents of dependent children, or elderly, blind or disabled and eligible for federal Supplemental Security Income. States also have the option of expanding Medicaid coverage to other persons at higher income levels within these mandatory groups. Moreover, state's have the option of receiving waivers from the federal government that allow for expansions of coverage to other groups (such as the long-term unemployed.)

Women are more likely to be eligible for Medicaid than are men because women are more likely to be the primary caregivers of dependent children in single-parent households, because women tend to be poorer, and because women are more likely to live longer than men and therefore require Medicaid-supported long-term care for a

longer period of their lives. Nation-wide, women make up close to 70 percent of the population on Medicaid over the age of 15,[93] and in Massachusetts 76 percent of the adult family enrollees are women.[94] Nationally, Medicaid provides health insurance coverage for close to one in five children, and pays for close to 30 percent of the nation's childbirths. In Massachusetts, Medicaid pays for almost one in four childbirths.[95]

Because women are enrolled in Medicaid at higher rates than men, they are disproportionately affected by changes in Medicaid policy or practice. This is particularly the case when states react to declining revenues by attempting to rein in health care costs with restrictions to Medicaid eligibility or benefits.

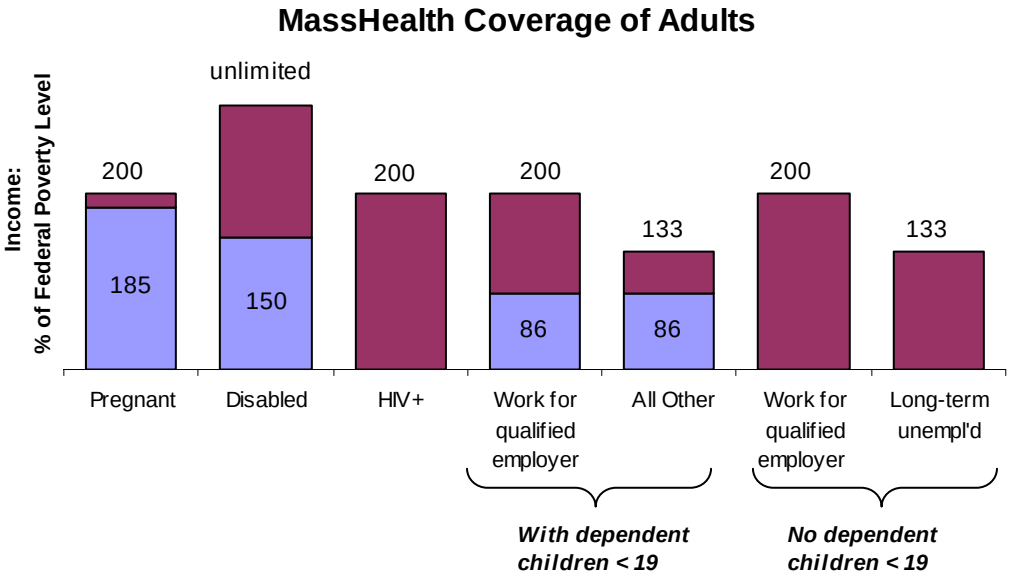
Medicaid Expansions in 1997

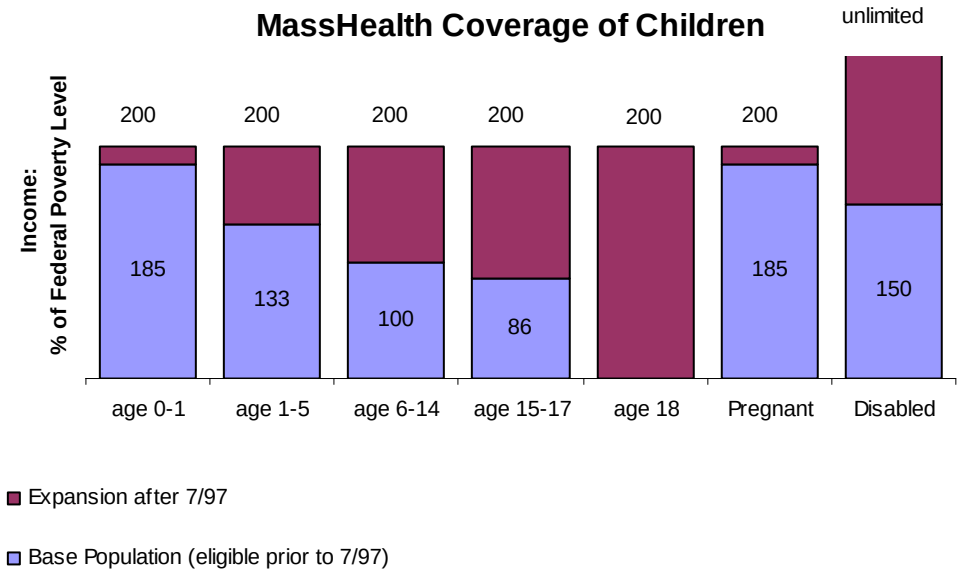
In 1997, Massachusetts initiated a major expansion of health care coverage through the Commonwealth's Medicaid program, also known as MassHealth. The intent of this expansion effort was to increase health insurance coverage among needy uninsured and underinsured residents. This expansion of the Medicaid program also provided the associated benefit of generating federal matching funds for additional enrollees, and also minimized the rapidly-growing costs associated with uncompensated care provided by the state's hospitals.[96]

In order to implement the expansions of MassHealth eligibility, the state received a waiver from the federal government (known as a Section 1115 waiver). This waiver allowed the state to expand eligibility for MassHealth beyond the mandated eligibility categories. Over the next two years, the state expanded eligibility for MassHealth from 86 percent of the federal poverty level to 133 percent for parents of dependent children, and provided coverage for all children under age 19 up to 200 percent of the federal poverty level. The state also expanded coverage for pregnant women from 185 percent of the poverty level to 200 percent. There were also expansion programs that provided premium assistance for private insurance coverage for childless adults up to 200 percent of the federal poverty level, and coverage for low-income people who are HIV-positive. There was expanded coverage as well for the long-term unemployed. In addition to these programmatic expansions for persons with low income, the Commonwealth expanded the MassHealth program to include people with disabilities of all income levels (see Figure 33).

Because these programs – the CommonHealth programs for children and adults – had previously been fully state funded, bringing them under the MassHealth program waiver allowed for a portion of the costs of coverage of these disabled individuals to receive federal matching dollars. The CommonHealth program provided these benefits, charging premiums to the enrollee, based on income.[97]

Figure 33

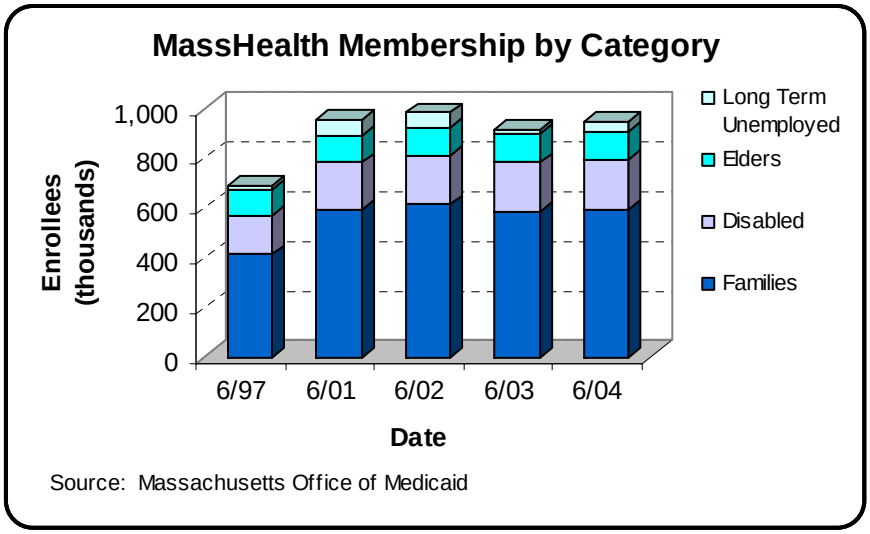




Source: Quigley, Shelto and Turnbull, Massachusetts Health Policy Forum

These expansions in the late 1990's began a rapid increase in the number of people eligible for MassHealth, dramatically improving access to health care coverage for more low-income women and girls. For example, MassHealth membership quickly grew from close to 680,000 members in June 1997 to more than 950,000 in June 2001 with the addition of new population groups eligible for coverage (see Figure 34).[98]

Figure 34



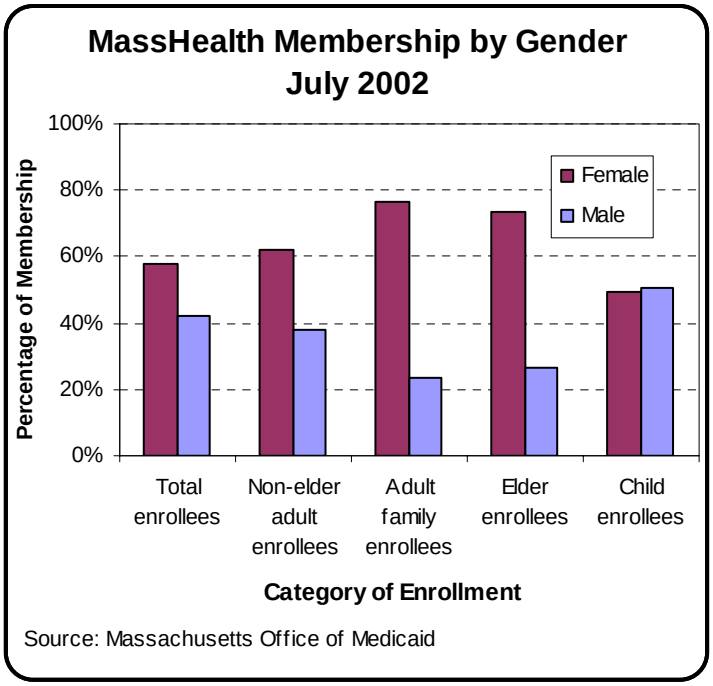
By 2001, family membership in MassHealth had grown by 43 percent over 1997. The Medicaid expansion programs allowed over 100,000 additional children and 80,000 additional parents to be added to the MassHealth programs.[99] Enrollment in the MassHealth programs reached a peak in August 2002, with an enrollment of just under 1,000,000 members – more than 570,000 adults, and more than 425,000 children.[100]

In Massachusetts, since close to two-thirds of adult enrollees are women, it is clear that the expansions of the MassHealth programs – particularly those that provided health insurance to an additional 100,000 children and 80,000 parents – provided health care security to tens of thousands of women and their families.

Impact of Changes during the Fiscal Crisis

After 2001, appropriations for MassHealth grew at a faster rate than the rest of the state budget. However, these increases reflected dramatic rises in the cost of health care, and actually masked real cuts being made in MassHealth during this period. Starting in fiscal year 2002, the Commonwealth began implementing significant cutbacks in the MassHealth program with the stated intent of reducing costs. The impact of the fiscal crisis, therefore, did not show up primarily as budgetary funding decreases, but rather in a variety of programmatic cutbacks and policies that scaled back eligibility and benefits.[101]

Figure 35



Because the MassHealth program serves many more women than it does men, women were hard hit by the changes in Medicaid during the fiscal crisis (see Figure 35).[102] In July 2002, at the beginning of the state's fiscal crisis, among all enrollees the program was approximately 58 percent female. Looking at specific populations served by MassHealth, however, the percentages are more striking. Among all non-elder adults, 62 percent of the members were women. In July 2002, this was approximately 286,000 women. Among the adults who were eligible for MassHealth based on their status as being low-income parents ("adult family enrollees"), however, the percentage was even greater. Seventy-six percent of adult family enrollees were women – approximately 164,000.

As Figure 36 indicates, although the proportion of women enrolled in MassHealth has remained relatively stable since 2002, the numbers of women enrolled in the program have dropped (with the exception of elder enrollees.) The total number of women and girls receiving MassHealth dropped from approximately 578,000 in 2002 to 551,000 in 2004. The number of female non-elder adult enrollees dropped by approximately 17,000, and the number of women family members dropped by approximately 8,000.

Figure 36

MassHealth Membership by Gender: July 2002 and July 2004

2002	*Female*	*Male*	*Total*
Total	**577,868**	**418,345**	**996,213**
Non-elder adult	285,731	172,679	458,410
Adult family	164,243	50,470	214,713
Elder	84,821	30,978	115,799
Child	207,316	214,688	422,004
2004	*Female*	*Male*	*Total*
Total	**550,600**	**394,007**	**944,607**
Non-elder adult	268,765	157,571	426,336
Adult family	156,058	48,203	204,261
Elder	85,014	31,604	116,618
Child	196,821	204,832	401,653

Many factors contributed to this decline in the number of women and girls receiving health insurance through MassHealth: eligibility cutbacks, including the elimination of coverage for some immigrants; higher premiums and other out-of-pocket costs, which created burdens and discouraged participation for some; the

elimination of outreach programs that had been designed to help people enroll; people being "lost" during gaps in coverage; and other administrative changes in the programs that discouraged enrollment.

Elimination of Specific Benefits for Adults

In March 2002, the state eliminated all dental benefits for adults on MassHealth, including dental hygiene, fillings, and other preventive dental care. There were estimates that eliminating this benefit would "save" $22 million, 50 percent of which would be a reduction in actual state costs and the other 50 percent would be foregone federal matching dollars.[103]

Because routine dental care is an important component of preventive medicine, attempts to realize cost savings in the short term could lead to higher costs over the longer term associated with the neglect of oral hygiene. For example, if a woman were to receive a routine oral exam, dental cleaning and have a dental cavity filled, the cost would have been approximately $137 in 2002. If that same woman were unable to pay for those routine dental procedures, and instead waited until she needed to go to a hospital emergency room for treatment, the cost of the exam, the extraction of a severely-damaged tooth, and the cost of partial dentures could cost as much as $343.[104]

Unfortunately, the reduction of dental health benefits can have a significant impact on the health of the low-income and disabled women who rely on the MassHealth programs for access to health care. Poor dental health can have obvious negative impacts on a woman's ability to eat healthfully, and has also been linked to heart disease, lung disease, and low birth weight infants. Without preventive dental care, a low-income woman's only recourse for severe tooth decay would be the extraction of affected teeth.

Starting in July 2002, the Commonwealth attempted to rein in skyrocketing drug costs by creating a list of higher cost prescription medications that would require prior authorization before a member could receive MassHealth coverage for the cost of that medication. As fiscal year 2003 progressed, more restrictions were added to coverage for additional classes of prescription drugs.

Effective January 2003, the Commonwealth eliminated MassHealth coverage for dentures, chiropractic therapy, prosthetic devices, orthotics and eyeglasses (although most orthotic and prosthetic benefits were restored by fiscal year 2004.) Again, eliminating coverage for prosthetic devices, chiropractics and eyeglasses has the potential for causing people to substitute higher-cost care that would be covered by insurance for these lower-cost services.

Other cuts in fiscal year 2003 included the discontinuation of coverage for emergency detoxification services, post-detoxification residential services for adults, and payment for acute hospital stays of more than twenty days for adults.

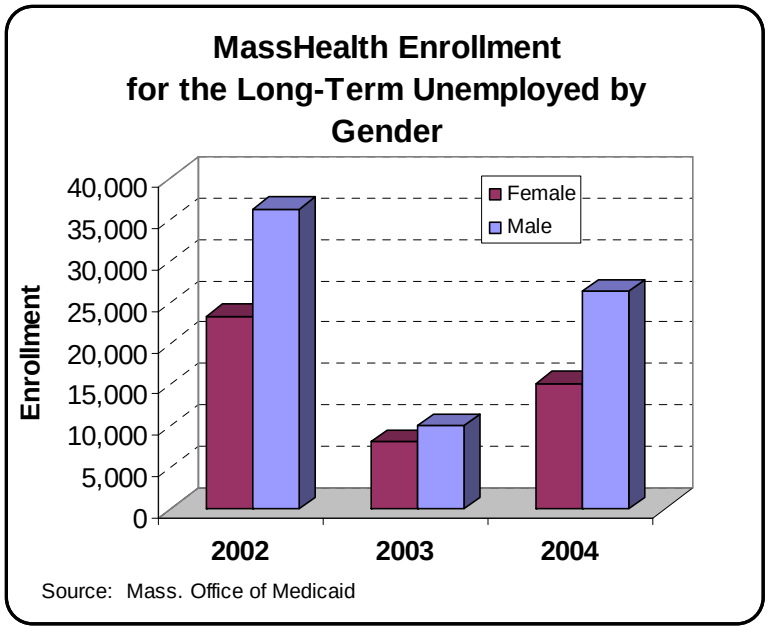
Reductions in MassHealth Eligibility

Another approach to controlling MassHealth costs was to eliminate health care coverage for certain populations. Eliminating health insurance for low-income populations does not, however, prevent those persons from requiring health care. Instead, the lack of health insurance often delays accessing health care, and often results in ultimately more costly emergency care later on.

One of the programs eliminated at the start of the fiscal crisis was a planned expansion program for uninsured women with breast or cervical cancer. This program provided federal funding for screening for breast and cervical cancer, and then ensured federally-matched Medicaid coverage for treatment and follow-up for low-income women without insurance. In the beginning of 2003 emergency budget cuts delayed the start of this program, but funding for it was restored in fiscal year 2004.[105]

In April of 2003, the state removed close to 36,000 long-term unemployed adults from the MassHealth Basic program, leaving them without health insurance. Whereas in July 2002 there were approximately 23,000 long-term unemployed women enrolled in the MassHealth Basic program, by July 2003 there were just over 8,000 (see Figure 37.) When at the end of 2003 the state created a new, more limited MassHealth program called MassHealth Essential, it was assumed that many of those who had been cut from MassHealth Basic would enroll in this new program. However, by July 2004, there were approximately 15,000 women enrolled in the MassHealth programs for the long-term unemployed: 5,000 in MassHealth Basic, and 10,000 in MassHealth Essential.

Figure 37



Switching the benefits from MassHealth Basic to MassHealth Essential had significant implications for the persons receiving the coverage.

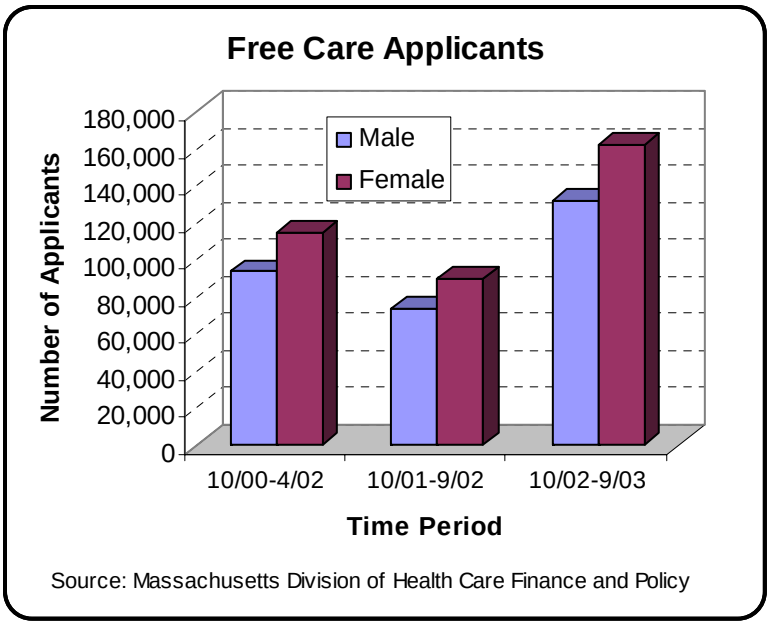
First of all, the MassHealth Essential program had a lower income eligibility threshold, and also provided fewer benefits than the MassHealth Basic program. Clearly, even though MassHealth Essential restored coverage to some long-term unemployed adults, the number never returned to its former level. Furthermore, with the gap in coverage, it is likely that some portion of potentially eligible adults were "lost" to the system during the transition from one program to the other.

Any time the state changes eligibility guidelines and some people lose coverage, those people are unlikely to receive appropriate preventive or primary care during that gap in coverage. In fact, lack of coverage and therefore a tendency to forego preventive and primary care tends to result in a population that is sicker and has higher-cost health needs.

Just as MassHealth Basic reduced its enrollment, the state saw demands on hospital emergency departments increase, as evidenced by the growing number of applicants for uncompensated or "free" care during this time (see Figure 38).[106] When MassHealth began its systematic program reductions in fiscal year 2002 and 2003, applications for free care increased by 79 percent, from more than 164,000 applicants to close to 295,000 applicants.

Even though the demand for free care increased during the fiscal crisis with the elimination of MassHealth Basic coverage and with the rapid increase in health care costs, the state eliminated funding in September 2002 for special demonstration projects that had been designed to reduce demands for "free" care by providing outreach for the MassHealth program or by providing access to other forms of primary care.

Figure 38



Source: Massachusetts Division of Health Care Finance and Policy

In fiscal year 2004, the Commonwealth attempted additional eligibility cuts that included asset tests for adults, and lowering the income eligibility threshold for persons receiving MassHealth in the HIV program. The Commonwealth lowered the eligibility threshold for the MassHealth HIV program to 133 percent of the poverty level (down from 200 percent.) Eligibility was returned to the 200 percent level in the fiscal year 2005 budget, and the proposed asset tests were never implemented. The fiscal year 2005 budget also allows 36,000 people to enroll in the

MassHealth Essential program, but if the program reaches that cap, the Commonwealth will initiate a waiting list and deny access to health insurance to those people unable to enroll.

In August 2003, 10,000 legal immigrants lost health care coverage under MassHealth. Of these low-income Massachusetts residents, 3,000 who were elderly or disabled immigrants had their coverage restored in June 2004, but this coverage was scheduled to run out in September 2004. Included in this group are persons who were fleeing persecution in their home countries awaiting asylum, as well as legal permanent residents who do not yet qualify for federal benefits. There is pending legislation that might allow the continued coverage of some of these immigrants, based on evaluation of certain aspects of their immigration status.

Increased Out-of-pocket Costs for MassHealth Members

Another method by which the Commonwealth sought to stave off the rising costs of health care within the MassHealth program was to generate revenue by charging enrollees with increased co-payments, premiums and other out-of-pocket charges. Again, starting in January 2003, co-payments for prescription drugs increased from $0.50 to $2.00 per prescription. By fiscal year 2004, co-payments for certain prescription medications increased to $3.00.

There were also increases in the premiums for children on the Premium Assistance Program and the Family Assistance Program, increases in premiums for disabled children and adults on the CommonHealth program, and new premiums for enrollees with HIV. These premiums were targeted to families with incomes between 100 and 150 percent of the federal poverty level.

With the implementation of these premiums, the Commonwealth projected "saving" up to $15 million annually.[107] However, any time out-of-pocket costs are increased for low-income women, their ability to access health care for themselves and their children is threatened. There is a significant risk that out-of-pocket costs drive people to delay or forego needed care, once again risking the substitution of low-cost primary care with higher-cost emergency care.

Each of these steps to increase costs for participants in the MassHealth programs have the potential for limiting access to health care for women and girls across the state. Even as the Commonwealth moves out of the economic recession, the lingering impacts of the state's fiscal crisis have already had substantial impacts on the ability of women and girls across the state to gain access to affordable health care. Furthermore, any time that the Commonwealth reduces state spending on the Medicaid program, the state also is foregoing available federal Medicaid dollars that would have supported health care access for low-income women and girls.

[85] *Historic Health Insurance Tables,* "Table HI4: Health Insurance Coverage Status and Type of Coverage by State, All People: 1987-2003," U.S. Census Bureau, Current Population Survey, 1988 to 2004 Annual Social and Economic Supplements, last revised August 26, 2004, available at www.census.gov/hhes/hlthins/historic/hihistt4.html.

[86] "460,000 Massachusetts Residents Report That They Have No Health Insurance," press release from the Massachusetts Division of Health Care Finance and Policy, August 26, 2004, available at www.mass.gov/dhcfp. A comparison of survey methodologies by the Congressional Budget Office may explain some of the differences in the estimated numbers of uninsured individuals in Massachusetts. This comparison suggests that although the Census Bureau reports its findings as representing the number of people without health insurance for the entire year, their estimates may better reflect an estimate of the number of persons who have been without health insurance at a specific point during the year, as opposed to the number of people who have been uninsured for the entire year, or the number of people who have been without health insurance at any point during the year (Congressional Budget Office, "How Many People Lack Health Insurance and For How Long?" May, 12, 2003, available at www.cbo.gov). Furthermore, many of the national surveys base their estimations on assumptions that sometimes overestimate the number of uninsured individuals in Massachusetts. For example, a survey that uses national assumptions about the percentage of people receiving Medicaid may underestimate Medicaid coverage rates in Massachusetts because of this state's historically above-average income eligibility thresholds. Secondly, estimates about health insurance are sensitive to assumptions about rates of employer-provided insurance, which may also distort estimates.

[87] Medicaid enrollment numbers are from the Massachusetts Office of Medicaid MassHealth enrollment snapshots, uninsured estimates are from the Massachusetts Division of Health Care Finance and Policy, and population estimates are from the U.S. Census Bureau.

[88] "MassHealth Waiver Extension Request," Office of Medicaid, Commonwealth of Massachusetts, submitted June 30, 2004, p. 10.

[89] *A Profile of Health Among Massachusetts Adults, 2002: Results from the Behavioral Risk Factor Surveillance System*, Massachusetts Department of Public Health, April 2004, Table 2.1.

[90] "Women's Health Insurance Coverage," Kaiser Family Foundation, June 2004, available at www.kff.org/womenshealth/loader.cfm?url=/commonspot/security/getfile.cfm&PageID=37684.

[91] All of the differences between uninsured women and insured women are statistically significant at $p < .05$. "Women's Health Insurance Coverage," Kaiser Family Foundation, June 2004, available at http://www.kff.org/womenshealth/loader.cfm?url=/commonspot/security/getfile.cfm&PageID=37684.

[92] The Medicaid program is jointly funded by the federal and state governments. The net cost to the state of one dollar spent on Medicaid is typically fifty cents, although there are particular programs and services that receive a higher rate of federal reimbursement. Funding changes in Medicaid, therefore, do not have a direct one-to-one impact on the state budget, and in fact state funding cuts to Medicaid result in foregone federal revenue to the state.

[93] *Women's Access to Care: A State-Level Analysis of Key Health Policies*, Kaiser Family Foundation, June 2003, p. 41, available at www.kff.org/womenshealth/3326-index.cfm.

[94] Membership figures from the Massachusetts Office of Medicaid.

[95] Douglas Brown, "MassHealth Overview: March 2003," PowerPoint Presentation, available at www.bcbsfoundation.org/foundationroot/en_US/documents/massHealthoverview.pdf.

[96] Quigley, K., Shelto, A., and Turnbull, N., "MassHealth: Dispelling Myths and Preserving Progress," Issue Brief, Massachusetts Health Policy Forum, June 2002, p. 9.

[97] For a complete description of the eligibility guidelines for the various MassHealth programs in 2001 reflecting the major Medicaid expansions, see the health insurance resources "Roadmap" at the Center for Health Policy and Research at the University of Massachusetts Medical School, available at www.umassmed.edu/healthpolicy/roadmap.

[98] Membership figures from the Massachusetts Office of Medicaid.

[99] Greenberg, Josh, *The Facts on MassHealth: What it Is. Why it Works*, Health Care for All, March 2002, p. 4.

[100] Membership figures from the Massachusetts Office of Medicaid.

[101] For a comprehensive listing of the reductions in eligibility and benefits, and the increases in out-of-pocket costs for enrollees, see "Chronology of Health Access Cutbacks in 2002-2004," compiled by the Massachusetts Law Reform Institute, February 2004, available at www.masslegalservices.org/docs/Cutbacks_2002-4_Highlights.doc.

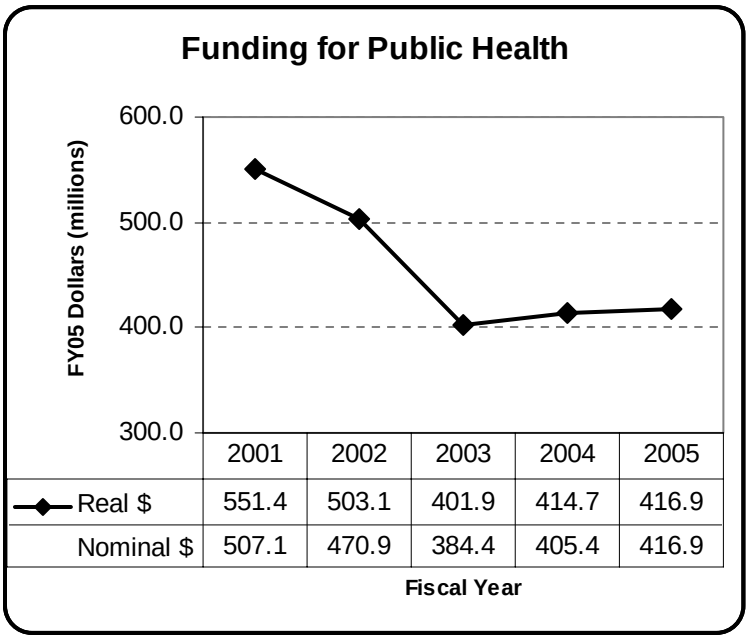
[102] Membership figures from the Massachusetts Office of Medicaid.

[103] *The MassHealth Cuts: What They Are. Why They Don't Work. What We Can Do*, Health Care For All, November 13, 2002, p. 1, available at www.hcfama.org.
[104] Testimony by Robert Alconada, Massachusetts Dental Society, April 9, 2002, cited in: *The MassHealth Cuts: What They Are. Why They Don't Work. What We Can Do,* Health Care For All, November 13, 2002, p. 11, available at www.hcfama.org.
[105] *The People's Budget for Fiscal Year 2004*, Massachusetts Human Services Coalition, p. 25.
[106] See Quigley, K., Shelto, A., and Turnbull, N., "MassHealth: Dispelling Myths and Preserving Progress," Issue Brief, Massachusetts Health Policy Forum, June 2002, p. 12-13, and also *Uncompensated Care Pool Annual Reports,* Massachusetts Division of Health Care Finance and Policy, available at www.mass.gov/dhcfp/pages/dhcfp_22.htm#gen_info.
[107] *The People's Budget for Fiscal Year 2004,* Massachusetts Human Services Coalition, p. 17.

VI. Safeguarding the Health of Women and Girls

Public health services play a critical role in improving and safeguarding the health and well-being of women and girls. There are public health programs that screen for certain diseases, others that prevent certain diseases from occurring, and those that provide access for vulnerable populations who are at risk for inadequate care.

Figure 39



Note: In order to facilitate year-to-year comparisons, these figures do not include funding for the Children's Medical Security Plan or the Healthy Start Program for which the Office of Medicaid shares responsibility. These figures do include the costs of the public health hospitals, and the costs of domestic violence programs which were moved to the Department of Social Services in fiscal year 2004.

The state has identified ten Leading Health Indicators recommended by the United States Health Service for monitoring state and local progress towards improving the Commonwealth's public health. Among these Leading Health Indicators are: access to health care, substance abuse and tobacco use, responsible sexual behavior, and injury and violence.

The dramatic reductions in overall public health funding have had an impact on the direct public health programming that had been successful in the past, and also have had a significant impact on the Commonwealth's ability to monitor the health status of women and girls since the fiscal crisis began. In real terms funding for public health programs dropped significantly between fiscal year 2001 and 2005, from $551 million in 2001 to $417 million in 2005 – a 24 percent reduction (see Figure 39).

One of the central functions of the Department of Public Health is the prevention of disease through the analysis of trends in illness across the Commonwealth, and in the monitoring health status. Unfortunately, the ability of the Department to track, monitor and evaluate trends has been severely affected by the reductions in funding for Department's operations.

For example, funding for at Health Statistics program within the Department was eliminated in Fiscal Year 2003. Funding for the Division of Health Care Quality stagnated during this period. Even within existing programs, the evaluation and analysis

functions within those programs were eroded as funding levels dropped. For example, within the state's smoking prevention efforts, research and evaluation of the program was funded at more than four million dollars in Fiscal Year 2000, but this funding was almost eliminated by Fiscal Year 2005.

As dollars for public health funding became scarce, administrators have concentrated remaining resources as much as possible in those areas that provide direct services to vulnerable people in the Commonwealth. As crucial as the direct service role of the Department of Public Health might be, reducing its role in planning, program development, health surveillance and evaluation also has significant consequences for the women and girls of the Commonwealth.

The Department of Public Health, in conjunction with local health departments, is the state's front line protecting the safety and integrity of the Commonwealth's water supply and food supply, and is the lead agency for protecting against and preventing outbreaks of infectious disease and epidemic. With lessened ability to monitor, evaluate, document and track unusual spikes or patterns in illness across the Commonwealth, the Department is constrained in its ability to prevent outbreaks of communicable disease.

As essential as the core functions of the Department of Public Health are to maintaining the health of the Commonwealth, there is also an important story in an analysis of several of the state's public health programs. This report looks at the Commonwealth's substance abuse programming, the smoking prevention programs, the Commonwealth's reproductive health programming, services for teenage parents, some of the efforts to protect women and girls from infectious disease, and services to address domestic violence.

These programs are not the only ones that suffered significant cuts during the state's fiscal crisis, but they serve as examples in which the cuts were significant and with dramatic and direct consequences for the health and well-being of women and girls. Furthermore, these particular programs also speak directly to the mission of the Department to measure its own success through the nation's identified Leading Health Indicators.

Preventing Substance Abuse

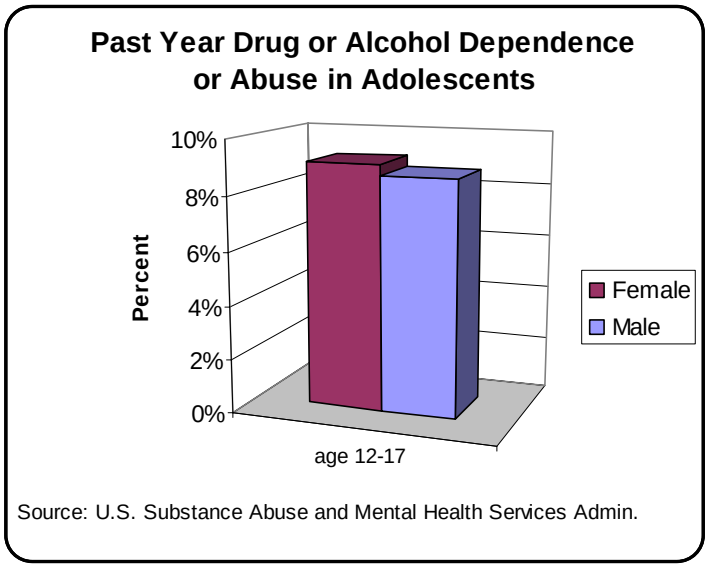
The abuse or misuse of alcohol and illegal substances, as well as the inappropriate use of legal substances such as inhalants or medications have an impact on both the long- and short-term health of people in the Commonwealth and are part of the challenges presented in the Leading Health Indicator of "substance abuse."

Impact on Women and Girls

Although for some women and girls substance abuse is connected to mental health or public safety concerns, the treatment of substance abuse remains a public health issue. There are a variety of substances subject to abuse, each of which presents different challenges in the areas of prevention and treatment. In addition to illegal substances such as marijuana, cocaine or heroin, the non-medical use of medications such as over-the-counter cold remedies or the abuse of prescription medications are of concern to health officials. Furthermore, the abuse of alcohol by adults and under-age drinking by girls and adolescents present their own set of challenges. Finally, the use of tobacco presents a significant public health issue that this report will address separately.

During the period 1999 to 2001, close to 6.5 percent of persons nation-wide age 12 and over reported the use of an illicit drug during the previous month. In this instance, "illicit drug" refers to marijuana/hashish, cocaine, inhalants, hallucinogens, heroin, or prescription-type medications used non-medically. During this same period, the rate for the greater metropolitan Boston area was 11.7 percent, with the rate for young adults (age 18 to 25) as high as 29 percent.[108]

Figure 40



Source: U.S. Substance Abuse and Mental Health Services Admin.

Substance abuse is an issue that particularly affects teenage girls. Although males have a higher rate of substance abuse than women in general, among adolescents there is almost no difference in the rates for boys and girls. According to a national survey in 2003, adult males (age 18 and over) were almost one-third more likely to be classified as having had illicit drug or alcohol dependence or abuse in the past year as were females. Just over 12.6 percent of adult males were substance and alcohol abusers, compared to 9.5 percent of women. For teenagers, however, the rate for boys and girls was essentially the same, with girls slightly higher than boys – 8.7 percent for boys and 9.1 percent for girls (see Figure 40).[109]

There have been a variety of estimates of the cost savings associated with the prevention of substance abuse. One study published by the National Institutes of Health estimated that for every dollar spent on substance abuse prevention, a community can save up to ten dollars in costs associated with counseling and treatment for drug abuse.[110] Furthermore,

while in 2000 the average cost of housing an inmate for one year in a facility run by the state Department of Correction was over $36,000, the cost of substance abuse treatment for one year ranged from $1,800 to under $7,000 per year.[111]

Appropriate substance abuse treatment can have a significant impact on the health of women and children. According to data from the Department of Public Health, in fiscal year 1999, there were 59 healthy babies born to the women in specialized residential settings for pregnant and postpartum women with substance abuse problems. Had these women remained untreated during pregnancy, the children would have been at risk for Fetal Alcohol Syndrome or fetal drug exposure. Children born with these conditions often require neonatal intensive care which could cost close to $66,000 per child, and are at risk for life-long learning and behavioral disabilities.[112]

Preventing substance abuse and providing treatment for persons addicted to or abusing substances is most successful when there is a comprehensive approach, using multiple strategies in a variety of settings. However, for treatment to be successful, individuals must remain in treatment for a sufficient period of time to allow them to learn to manage their addiction and to cope with the possibility of relapse. In most instances, people require approximately three months of treatment before they can make significant improvement.[113]

The Department of Public Health provides prevention services, residential treatment (short- and long-term), direct counseling and treatment on an outpatient basis, case management for individuals in recovery, services for the homeless, and services for people cited with first or second offenses of driving under the influence. Its short-term (less than 30 days) residential treatment programs provide medically monitored detoxification services for persons withdrawing from alcohol or other substances.

Several of the programs administered or funded by the Department of Public Health target the particular needs of women and girls. In particular, funding has supported long-term residential placements for pregnant and postpartum women that provide coordinated prenatal and pediatric care. There are also specialized residential services for women that allow women to receive treatment and maintain custody of their children, and specialized services for homeless families, providing shelter to families when the caretaking parent has a substance abuse problem. Homeless individuals and pregnant women are also among the high-risk populations given priority for short-term residential treatment.

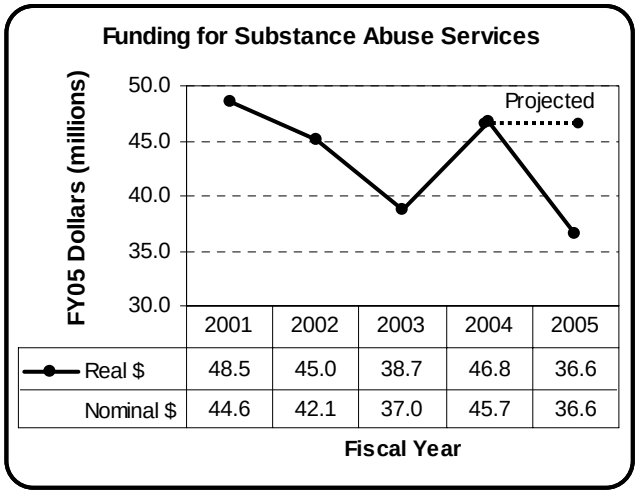
Clients of the Department of Public Health's Bureau of Substance Abuse Services are assessed a fee, based on their ability to pay. The Bureau pays for services for individuals who do not have coverage by private or public health insurance, and is the only payer for transitional support services. The Bureau is also the primary payer for residential rehabilitation services.[115]

Incarcerated women are a population particularly in need of substance abuse treatments. Although system-wide data are difficult to obtain, a survey of women incarcerated in western Massachusetts in the Hampden County Correctional Center found that between 75 and 90 percent of the inmates were addicted to substances, and 80 percent of their crimes were related to their addictions.[116] Not only is substance abuse treatment important during the period of incarceration and rehabilitation, there is need for continuing support upon release.

Funding

Funding for substance abuse services within the Commonwealth's budget was cut dramatically after fiscal year 2001 (see Figure 41). The Bureau of Substance Abuse Services within the Department of Public Health received $44.6 million in 2001, equivalent to $48.1 million in inflation-adjusted dollars. In just the one year between 2002 and 2003, the Bureau's annual budget was reduced by 14 percent in real terms. A supplemental budget passed at the end of fiscal year 2004 restored an additional $11.9 million dollars to that year's budget. This restoration, however, was on top of an original $3.9 million reduction in 2004, and reductions each of the prior years. Without this supplemental appropriation, the state would not have met certain federal guidelines for support for substance abuse services during the fiscal year, and federal dollars would have been lost. It is likely that state appropriations for substance abuse service funding will fall short of these guidelines once again in fiscal year 2005, necessitating a mid-year supplemental appropriation to ensure receipt of federal money. Even with these supplemental appropriations, however, services would be unlikely to return to their 2001 level.

Figure 41



Impact of Funding Cuts

The substantial cuts to substance abuse treatment programs in Massachusetts have had a dramatic impact on women struggling with substance abuse and addictions. Since the fiscal crisis beginning in fiscal year 2002, close to half of the state's residential treatment beds at detoxification facilities were shut down. Whereas the state previously funded 997 beds, there are now only 370. Out of 22 detoxification facilities, six have been shut down – in spite of the fact that the state has been facing a new heroin epidemic. Five of the residential recovery programs, affecting 267 persons, were removed from service.[117]

Admissions of women to substance abuse treatment services have leveled off since fiscal year 2001. In fiscal year 2001, 31,793 females were admitted to treatment in facilities licensed by the state Bureau of Substance Abuse Services (see Figure 42). By the following year, admissions started to increase slightly: in fiscal year 2002, 31,364 adult women were admitted to substance abuse treatment facilities, and 924 adolescents, for a total of 32,288 female admissions. Only 30,922 adult women and 841 adolescents were admitted in fiscal year 2003. Analysts from the Department of Public Health note that this change has been due to a reduction in capacity for treatment rather than a decrease in need for services.[118] It is important to note that data are not readily available for more recent years – again, because of the Department's diminished capacity to monitor and track public health activities.

Figure 42		
Adult (18+) Women Substance Abuse Admissions		
FY 2001	*FY 2002*	*FY 2003*
30,795	31,364	30,922
Female Adolescent Substance Abuse Admissions		
FY 2001	*FY 2002*	*FY 2003*
998	924	841

With recent reductions in capacity, some programs have had to initiate waiting lists for services which have important clinical implications for treatment. Currently, an individual seeking treatment might have to wait for several weeks before an opening becomes available. In certain parts of the state, such as in the area surrounding Lawrence, there are limited facilities available, and some are a significant distance away. Unfortunately, the window of time in which some people with substance abuse addictions are ready to become sober can be very small, and if a bed is not available at the time the person is ready to make the change, the opportunity for treatment can be lost.

In April 2003, along with the closing of a significant portion of the state's detoxification capacity, health care coverage for some poor women under the MassHealth Basic program was eliminated.[119] Without treatment beds or health care coverage, women seeking help for their addictions were sent for alcohol and substance abuse treatment to the Department of Corrections facility in Framingham for 30 days of substance abuse treatment. In 2002, there were 149 women civilly committed to MCI-Framingham. In just the first half of 2003, there were already 127 women civilly committed. These women tend to place a high demand on the health and supportive systems within the correctional facilities. With diminishing financial support for resources within the community, judges and families have had to look to the correctional system to provide a safety net of public health, mental health and other human services for women.[120] However, there are real risks in taking this approach. According to a Justice within the Quincy District Court, "We cannot simply commit a 17-year –old young man to the Bridgewater Detox with other men who have been alcoholics for 20 to 30 years or a young woman to MCI-Framingham, because there are no other options."[121]

According to a recent study conducted for the Massachusetts Division of Health Care Finance and Policy, each person who remains untreated for drug or alcohol abuse costs society more than $12,000 per year.[122] Even with recent spending increases allocated to substance abuse services for fiscal year 2004, only a portion of this money will be available to rebuild the state's treatment capacity, and the Commonwealth remains a long way from providing adequate treatment, follow-up, and prevention services sufficient to meet the needs of the women and girls in Massachusetts.

Preventing Tobacco Use

The Commonwealth's smoking prevention program presents a dramatic and clear picture of how funding public health programming can have an impact on the Leading Health Indicator of "tobacco use," and on the health of women and girls in the Commonwealth.

Impact on Women and Girls

Smoking has a direct link to the number one and number two killers of women: heart disease and cancer. Lung cancer is the single most deadly form of cancer for women in the U.S. The American Cancer Society estimates that 68,000 women will die of lung cancer in the U.S. in 2004, and approximately 1,600 of these women will be from Massachusetts.[123] Ninety percent of these deaths may be linked to cigarette smoking.[124] Furthermore, the American Cancer Society estimates that there will be more than 4,000 new lung cancer cases diagnosed in Massachusetts in 2004, approximately 1,900 of them women.[125]

"Smoking is the single greatest cause of avoidable morbidity and mortality in the United States," said the U.S. Surgeon General in May 2004 in his report, "The Health Consequences of Smoking." The relationship between smoking and a number of serious health effects has been well documented. Reports have drawn a definite causal link between smoking and cancers of the lungs and larynx, chronic bronchitis, cardiovascular disease, and adverse reproductive outcomes. In March 2004, the U.S. Surgeon General reported that there is a direct causal link between smoking and disease in almost every organ of the body.[126]

The adverse health outcomes due to smoking create enormous economic costs. A study published by the Massachusetts Department of Public Health determined that in 2000, $2.8 billion in personal health care expenditures, and $1.6 billion in lost productivity due to premature death could be attributed to smoking. Moreover, almost $20,000 each day was spent in Massachusetts on neonatal health care costs associated with women who smoked and had given birth the prior year.[127] According to estimates published by the

National Center for Tobacco-Free Kids, $817 million annually is spent by the state for Medicaid coverage of the direct health costs associated with smoking.[128]

Although more men smoke than women, the gender gap has narrowed significantly. According to a study published in April 2004 by the Massachusetts Department of Public Health, in 2002 approximately 20 percent of adult men (age 18 or older) reported that they were smokers, and approximately 18 percent of adult women reported that they were smokers.[129] According to the Surgeon General, national data indicate that poor women and women with lower levels of education are more likely to be smokers, with smoking rates highest among women below the poverty line and with only nine to eleven years of education.[130]

Smoking and Young Women

Close to ninety percent of adults who smoke report that they started smoking before their twenty-first birthday. Half of all adults who smoke report that they were regular smokers by the time they had turned eighteen.[131] In Massachusetts in 1993, 22 percent of high school girls had smoked a whole cigarette for the first time before they were 13 years old. More than 29 percent of high school girls had smoked cigarettes at some point during the previous month.[132] Notably, 64 percent of female high school students had tried to quit, and 63 percent of female high school smokers wanted to quit completely.[133]

There is also significant evidence that quitting smoking is extremely difficult, even for the most motivated to quit. For women and girls in particular, a study conducted in Massachusetts noted that women and girls are resistant to attempting to quit smoking because of concerns about weight gain.[134] Public health departments can play a crucial role both in supporting the efforts of these women and young girls in their attempts to quit, as well as supporting their efforts to withstand inclinations to begin smoking in the first place.

The Massachusetts Tobacco Control Program

Fortunately, there are well-documented strategies that are effective at reducing smoking rates in a population. According to recommendations from the Surgeon General, successful programs should follow a multi-stage approach that involves both the health care system in general and the individual efforts of patients and physicians: "[T]he magnitude and rate of change in smoking behaviors are significantly related to the level and continuity of investments in comprehensive program efforts."[135]

In 1992, the Massachusetts voters passed a referendum to impose a 25¢ per pack tax on cigarettes. This money was made available to fund the Massachusetts Tobacco Control Program (MTCP) within the Department of Public Health, which quickly became one of

the nation's most successful tobacco prevention programs. The MTCP had three main goals:

- Preventing young people from ever starting the use of tobacco products through education and reducing access to those products;
- Encouraging smokers to quit smoking;
- Protecting non-smokers by reducing exposure to environmental tobacco smoke.[136]

By fiscal year 2000, the Massachusetts Legislature voted to supplement the dedicated funding from the cigarette tax with funding from a multi-state master settlement with the tobacco companies. Under the agreement of this settlement, tobacco companies must make annual payments to the settlement states. In Massachusetts, the Legislature determined that these monies would partially be deposited in a permanent trust fund, part of which would be available to fund health-related services.

The first component of the state's comprehensive strategy for preventing smoking was to develop programs that reduce smoking by young people, and prevent them from becoming addicted in the first place.[137] In October 1993, the MTCP developed a media campaign to "Make Smoking History." This broad-based media campaign was designed with the intent of reaching a large audience with information about the negative health effects of smoking. Evaluations of the effectiveness of the ad campaign suggest that it was well-targeted. In particular, young people responded to a series of ads featuring a man whose wife had died of lung cancer at age 46 ("I guess I never thought of 23 as middle-aged!")[138] These ads were aired especially during television shows popular with a young audience, and interestingly, given that people with lower levels of education are more likely to become smokers, people with lower levels of education were more likely to have rated these anti-smoking ads as effective.[139]

The MTCP also worked with the advertising agency developing the ad campaigns to target at-risk and vulnerable populations. There were particular advertising campaigns refined to target non-English speaking smokers, with advertisements translated into Spanish, Portuguese, Chinese, and Vietnamese. The MTCP ran community-based focus groups within these populations in order to develop these specialized media campaigns.[140]

Also starting in late 1993 and early 1994, the MTCP began funding for a wide range of local programs, community-based coalitions, and support for the work of local boards of health and health department programs to combat smoking. The MTCP worked directly with schools and school-based health services and nurses to coordinate and support the anti-smoking messages already delivered to students by the school health services, and also to supplement these efforts with additional resources and materials.[141] The MTCP also developed a system of community-based peer leaders to facilitate efforts to reach

young people. The MTCP brought over 1,700 young people into these "youth action alliances" between 1998 and 2000, and close to two-thirds of these youths were girls.

In addition to the media efforts attempted to motivate current smokers to quit, the MTCP developed a variety of educational and treatment efforts to help smokers quit. Local tobacco treatment services, often based within local health care or social service agencies, were a system of evidence-based nicotine addition treatment services provided to smokers.[142]

There were several aspects of the program that were designed specifically to target the particular vulnerabilities of women and girls. Some services provided transportation and child care, in order to make the direct smoking cessation programs accessible to women. In addition, the ability of the tobacco treatment specialists to provide one-on-one community based support allowed the workers to visit women in their homes, thus better meeting the needs of women with young children. MTCP also supported treatment in "safe houses" for women fleeing domestic abuse, mental health day treatment facilities, group homes for pregnant and parenting teens, and retirement communities.[143]

Another one of the major initiatives of the MTCP was the development of a statewide telephone counseling and on-line support service. Designed both for health care provides and individuals, these services provide information, motivation, referral to services and treatment, and counseling. The MTCP online service, www.trytostop.org, provides smoking cessation information and support in thirteen languages.

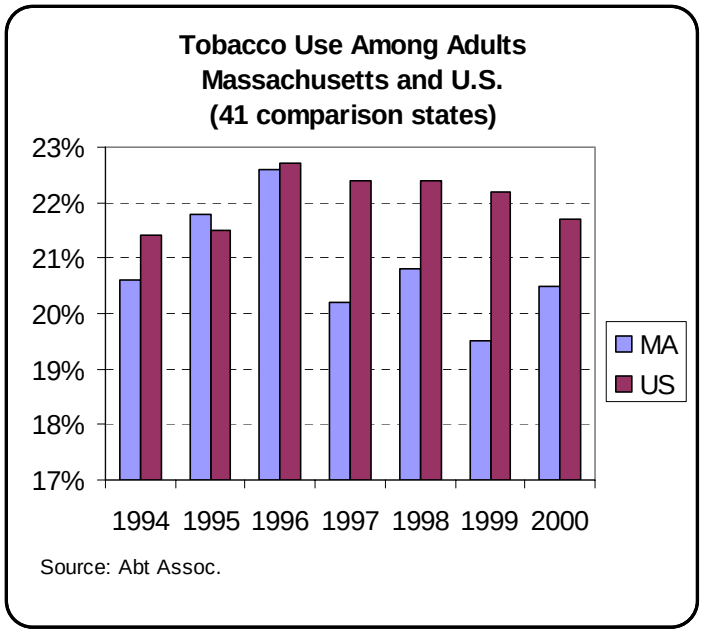
Success of the Massachusetts Program

By fiscal year 2002, the Massachusetts smoking prevention and cessation programs were considered to a model smoking program nation-wide. In fact, according to the Campaign for Tobacco-Free Kids, the fully-funded Massachusetts program was one of only two states (along with California) described as successful due to its being a "long-term and comprehensive public health program."[144]

An analysis of the program determined that the drop in cigarette consumption in Massachusetts between 1990 and 2001 was significantly greater than the drop in consumption nation-wide. In Massachusetts, there were approximately 126 packs of cigarettes sold annually per adult in Massachusetts in 1990, and approximately 72 packs sold annually 2001, a 43 percent drop. Nationally, the rate dropped from 141 packs per capita to 102 packs, a 28 percent decline.[145]

In conjunction with the smoking prevention and cessation efforts, the state implemented an additional increase in the sales tax on cigarettes. At this point, there was strong evidence that the smoking rate in Massachusetts was beginning to drop dramatically. Compared to 41other states nation-wide, the rate of tobacco use among adults dropped

Figure 43

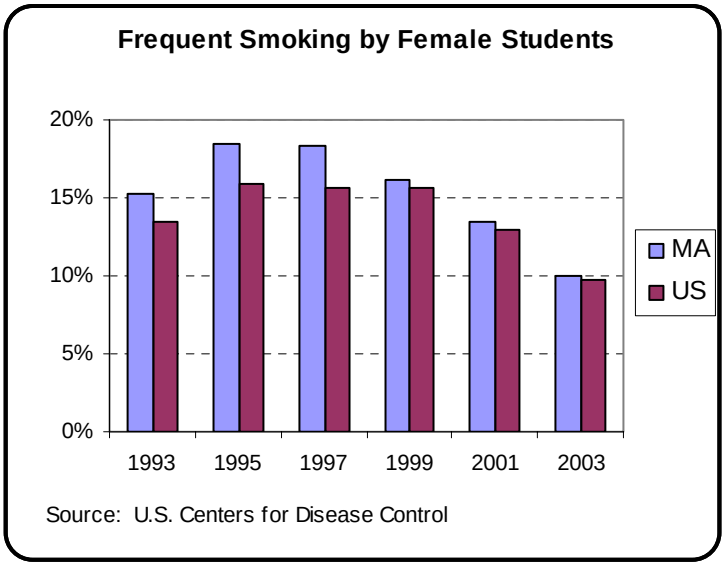


from 22.6 percent in 1996 to 20.5 percent in 2000 (see Figure 43). During this same time, the national rate dropped from 22.7 percent to 21.7 percent, a reduction of only four percent.[146]

Significantly, smoking among young people also declined in Massachusetts. Among high school students in Massachusetts, smoking declined by 27 percent between 1992 and 2001, from 35.7 percent to 26 percent.[147]

The MTCP had an influence on smoking among adolescent females as well. Although the rate of frequent smoking among these teenagers was higher than the national average by several percentage points at the inception of the MTCP, as the program progressed, the percentage of female adolescents who were frequent smokers (defined as smoking twenty or more cigarettes during the past month) dropped more rapidly in Massachusetts than in the nation as a whole. According to the national Youth Risk Behavior Survey, frequent smoking by adolescent girls (as measured by having smoked cigarettes on twenty or more of the past thirty days) in Massachusetts dropped by 46 percent between 1995 and 2003, from 18.5 percent of students to 10 percent. During that same time, the national reduction in frequent smoking among adolescent females was only 39 percent (see Figure 44).

Figure 44



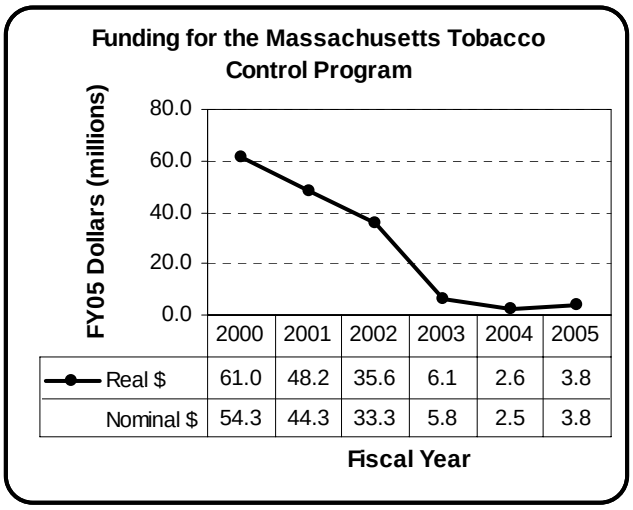
Even more dramatically, smoking during pregnancy in the Commonwealth declined during the years of the MTCP. Between 1993 and 2000, smoking among pregnant women fell from 17 percent in 1993 to 10 percent in 2000, a 39 percent decline. This

drop is much steeper than the national rate during that same period which was 24 percent.[148]

Funding

Since the state fiscal crisis began in fiscal year 2002, the successful Massachusetts Tobacco Control Program has been decimated (see Figure 45). From its peak in 2000, when the MTCP was funded at $54.2 million, or $61.0 million in inflation-adjusted dollars, continual cuts have almost entirely eliminated all phases of the program.

Figure 45



	2000	2001	2002	2003	2004	2005
Real $	61.0	48.2	35.6	6.1	2.6	3.8
Nominal $	54.3	44.3	33.3	5.8	2.5	3.8

Although there was a real reduction of $12.6 million between fiscal year 2001 and 2002 – a reduction of more than 26 percent of the MTCP budget – the steepest decline in funding was between fiscal year 2002 and 2003. During that period, the program sustained a real reduction of $29.5 million, reducing its budget another 83 percent. Continued reductions through fiscal year 2004 brought the program's funding level down to $2.6 million when adjusted for inflation. Even with the $1.2 million increase in the fiscal year 2005 budget, between fiscal year 2000 and fiscal year 2005, funding for the Massachusetts Tobacco Control Program had been reduced by close to 94 percent in real terms.

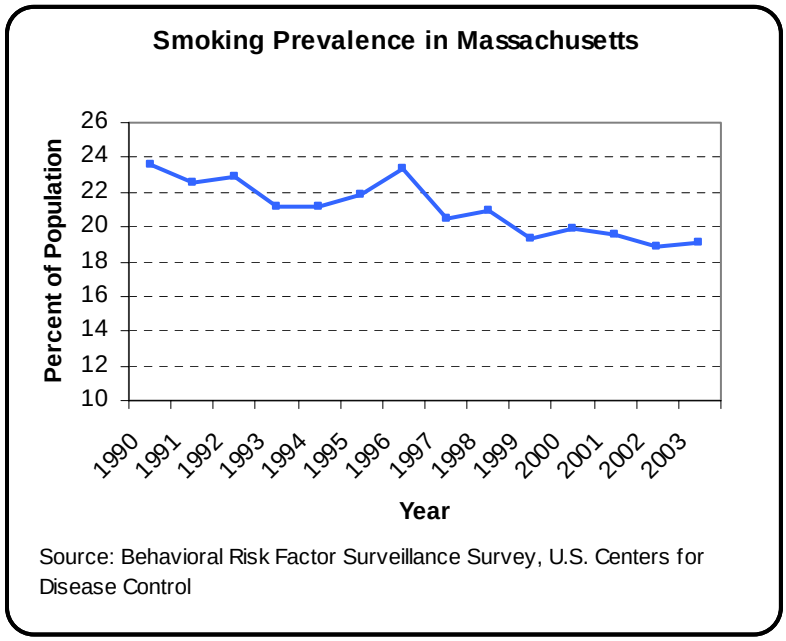
Impact of Funding Cuts

The reductions in funding for the Massachusetts Tobacco Control Program eliminated most of the innovative prevention programs run by the Department of Public Health. By 2003, the media campaign and the community-based programs suffered the most substantial cuts. In real terms, funding for the media campaign dropped from about $22.5 million in 2000 to zero by 2004.

It was not just the media campaign that sustained deep cuts during this time, however. Local program funding dropped from $27.5 million (in 2005 dollars) to approximately $1.5 million, with small amounts of money only available to support local boards of health and community coalitions.[149] In addition, innovative marketing grants that had included local advertising and pre-movie advertising − a special initiative directly targeted at preventing young people from starting smoking − were also eliminated by fiscal year 2003,[150] as was funding for smoking cessation and treatment services.

By fiscal year 2003, many of the specialized outreach programs that had especially met the needs of women smokers were eliminated, such as home-based services for women with young children who would be unlikely to go to a health center-based tobacco treatment program.

Figure 46



Source: Behavioral Risk Factor Surveillance Survey, U.S. Centers for Disease Control

One of the hallmarks of the Massachusetts Tobacco Control Program when it was fully funded was an evaluation component that allowed the Department of Public Health to continually refine its program operations based upon what was successful. Whereas $4.6 million (in real dollars) had been allocated for research and evaluation in fiscal year 2000, only $20,000 was left for research and evaluation in fiscal year 2004. Accordingly, the Department no longer has the capacity to track effectively the services provided by the program and to evaluate the impact of the reduction in those services.

Nevertheless, the evidence that does exist seems to suggest that after deep cuts in the Massachusetts Tobacco Control Program, smoking rates stopped declining (see Figure 46). Recent data from the Behavioral Risk Factor Surveillance System of the federal Centers for Disease Control suggest that the decline in the prevalence of smoking in Massachusetts has leveled off. Whereas the rate of smoking in 2003 as measured by the Centers for Disease Control was 18.9 percent of the population, in 2004 it was 19.1. Additional research is needed however because the sample sizes in this survey are not sufficient to demonstrate that this difference is statistically significant.[151]

The reduction in funding for the services provided by the Massachusetts Tobacco Control Program may also be allowing an increase in the illegal acquisition of cigarettes by minors. Although data are not yet available on statewide or national youth smoking rates for 2004, a recent study conducted by Tobacco Free Mass indicated that communities that experienced dramatic reductions in tobacco control funding have experienced a corresponding increase in illegal sales of cigarettes to minors.

Retail compliance is measured by sending a minor, under adult supervision, into a retail establishment to purchase cigarettes illegally. Between 2002 and 2003, retail non-compliance jumped from eight percent of attempted undercover purchases to almost 14 percent in communities with reduced tobacco control programs. In those communities where tobacco control funding was completely eliminated, the average rate of illegal sales to minors almost doubled – from 7.7 to 15.4 percent.[152]

In response to the release of these data, Massachusetts Attorney General Thomas Reilly stated, "This survey shows what can happen when funding is cut – more kids get access to tobacco."[153] Just as the Massachusetts Tobacco Control Program was an example of demonstrable success in protecting the health of women and girls in Massachusetts, the state's fiscal crisis and the budgetary decisions that resulted threatened the ability of the Commonwealth to protect the health of women and girls and prevent or treat smoking.

Providing Access to Reproductive Health Care

Another of the Leading Health Indicators is "responsible sexual behavior." The Department of Public Health provides services to influence women's reproductive health in the family health programs, the communicable disease prevention programs, and the HIV/AIDS Bureau. Assisting women in achieving healthy pregnancies and outcomes has a significant impact on the health of the entire community.

According to results from a survey conducted by the Massachusetts Department of Public Health in 2002, among sexually-active women of reproductive age (18-44) who were currently pregnant or had been pregnant within the past five years, 25 percent reported that they had had an unplanned pregnancy. Among these women, the rate of unplanned pregnancy was five times higher for women aged 18-24 than for women aged 35-44. Of even more concern is that unplanned pregnancies tend to be associated with women who are younger, who have lower levels of education, and who live in lower income households.[154]

Family planning services are essential for helping women prevent unintended pregnancies, especially since women with unintended pregnancies and their babies tend to have poorer health outcomes.[155] According to a recently-published report by the Institute of Medicine, children born from unintended pregnancies are at greater risk of being born at a low birth-weight, being victims of abuse, or being born into circumstances where there are insufficient resources for healthy development.[156]

There are many direct benefits to reducing teen pregnancy rates in particular. Fewer than one-third of teenagers who begin their families before the age of 18 ever earn a high school degree, and only 1.5 percent earn a college degree by the age of 30. Teen mothers are more likely to have low weight gain during pregnancy, complications of pregnancy,

and certain health problems later in life. Children born to teen mothers are more likely to be born with low birth weight and other health problems. Children born to teen mothers are also at higher risk for receiving inadequate parenting, or being abused or neglected.[157] Furthermore, the state Department of Transitional Assistance has reported that more than 70 percent of teen mothers at some point require public assistance.[158]

Once a woman is pregnant, strong reproductive health programs can ensure access to appropriate prenatal care, can reduce complications during childbirth, and can provide treatment of complications if, and when, they occur.[159] These efforts require a "public health strategy that is culturally and linguistically appropriate and ensures that women receive high-quality health services, including family planning counseling, prenatal and pregnancy care, and care after childbirth for both physical and mental health needs."[160] The reproductive health services of the Massachusetts Department of Public Health have been designed to fit into this public health strategy. As stated by the Department of Public Health in its own description of the Family Planning Program:

> [F]amily planning services aid individuals and families in making choices regarding the spacing and number of their children. Family planning is an integral component of the Department of Public Health's efforts to prevent unintended pregnancies and STDs including HIV/AIDS, reduce infant mortality and morbidity, and improve the health of women and men of all ages.[161]

Publicly-supported family planning services are provided throughout the Commonwealth, in more than 80 sites sponsored by more than a dozen different agencies. These clinic-based programs provide gynecological exams, breast exams, screening for cervical cancer, diagnosis and treatment of sexually transmitted diseases, birth control counseling and access to birth control devices, pregnancy testing, follow-up and referral for identified medical problems, preconception care for women planning a pregnancy, and counseling and testing for HIV/AIDS. These clinics also provide education and outreach to promote healthy and responsible decision-making about sexuality and reproduction.[162]

Services at these publicly-supported clinics are provided to women and adolescents at or below 200 percent of the federal poverty level; half of the people served live below 100 percent of the poverty level.

Impact on Women and Girls

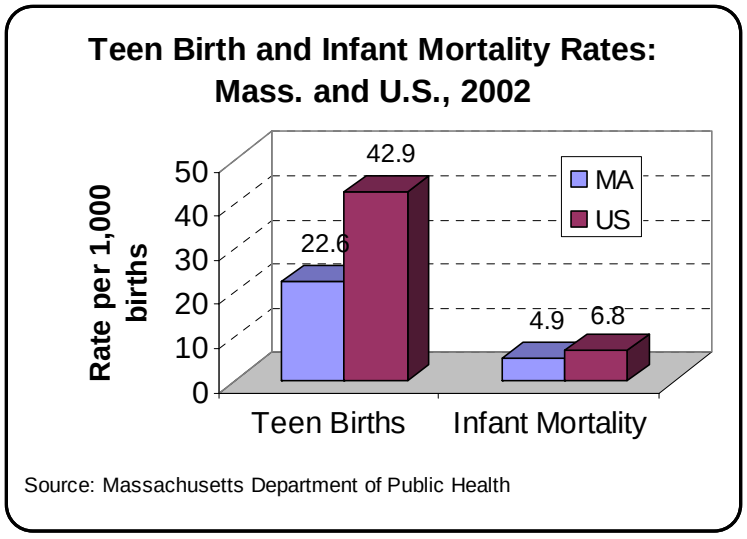
The intent of the state's support for reproductive health initiatives is to improve pregnancy and birth outcomes for women of all ages and to reduce the rate of sexually-transmitted disease. There is substantial evidence that the Commonwealth's public health efforts in the area of reproductive health have done exactly that.

For many low-income women and children, the network of state-funded family planning and reproductive health centers provide their only access to reproductive counseling,

gynecological care and prevention services. This health network has been particularly crucial to the state's strategy for reducing the number of unintended pregnancies in the Commonwealth, particularly among teenagers.

One of the targeted state efforts to prevent teen pregnancy has been the Teen Challenge Fund Program. Started in the late 1980s, the intent of this effort was to develop locally-based initiatives to increase community awareness of the risks and problems associated with teen pregnancy. The goals of this program were to increase abstinence, and to delay the onset of sexual activity among pre-adolescent and adolescent males and females, and to reduce the rate at which young people engage in risky behaviors, including risky sexual behavior. Ultimately, the goal of the program was to decrease the incidence of teen pregnancy and births, and the rate of sexually-transmitted diseases and HIV infection.[163] The Challenge Fund supported seventeen coalitions in communities with socio-economic characteristics that put them at high risk for a higher rate of teenage pregnancy.

Figure 47



In addition, starting in 1998 Massachusetts implemented a federally-funded state-wide media initiative promoting abstinence. This program has targeted its efforts in the Hispanic and African-American communities that have had disproportionate numbers of births to teenagers.

Improvements in several public health measures give encouraging support to arguments for adequate funding of public health services. According to a study released by the Department of Public Health in February 2004, the teen birth rate in Massachusetts is at its lowest rate ever, and is 47 percent below the national average (see Figure 47). For young women ages 15-19 in Massachusetts, the birth rate was 35.4 births per 1,000 women in 1990, and just 22.6 in 2002. The national rate in 2002 was 42.9 births per 1,000 women.[164]

Equally important, as the figure indicates, the infant mortality rate in Massachusetts has also continued to decline. In 2002, there was the second lowest number of infant deaths in Massachusetts history. Upon the release of this information, Commissioner of Public Health Christy Ferguson stated: "We need to remain diligent to continue making progress in the reduction of teen pregnancies and in the infant mortality rate and to address

disparities. Overall, this report indicates that Massachusetts has a lot to be proud of concerning the health of its mothers and their babies."[165]

According to national data, by the period from 1999 to 2001, the Commonwealth ranked fifth best among all states in the percentage of women who received early and adequate prenatal care, a rate of 83 percent. From the period of 2000 to 2002, Massachusetts ranked eleventh best in the percentage of women receiving Pap smears.[166]

Funding

Since fiscal year 2001, funding for women's reproductive health services has been significantly reduced (see Figure 48). Funding for family planning programs remained essentially level during fiscal years 2001 and 2002, but the cut in fiscal year 2003 represented a decrease of 20 percent, or $1.2 million in real dollars. There was an additional 42 percent real cut in fiscal year 2004. Restoration of funding in fiscal year 2005 returned the level of support for family planning to just under the amount funded fiscal year 2003 in real dollars, but even at this level there has been a 25 percent reduction in funding when adjusted for inflation since fiscal year 2001.

Figure 48

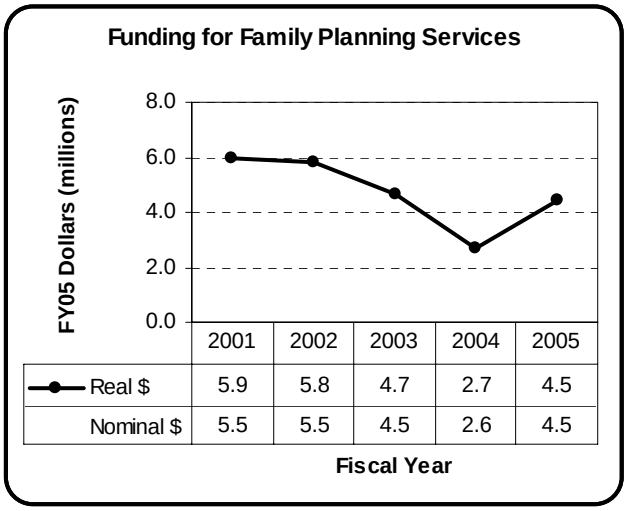
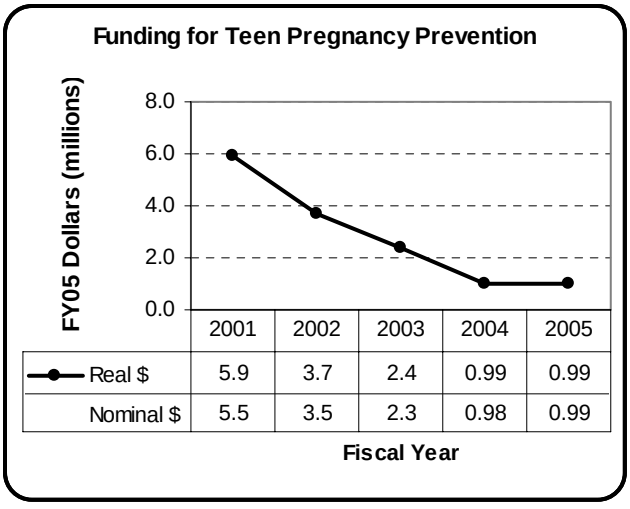


Figure 49



The teen pregnancy prevention programs were cut even more dramatically than the family planning programs (see Figure 49). In real terms, funding for the teen pregnancy prevention programs was $6.0 million dollars in 2001. A one-year cut between fiscal year 2001 and 2002 reduced support by 38 percent in real terms; and then funding was cut the subsequent year by another 35 percent.

Between fiscal year 2001 and 2005, in real terms funding was cut by more than $5.0 million. For a program that only started with $6.0 million, this represented a reduction of more than 83 percent.

Impact of Funding Cuts

Among the dollars cut from family planning services was a $1 million reduction in funding for outreach services. Because the earliest weeks of fetal development are crucial to the ultimate health of an infant, eliminating the supports that get high-risk women into prenatal care at the earliest part of their pregnancies has the potential to have a significant impact on birth outcomes. Poor early prenatal care can have an impact on infant birthweight and whether the mother will carry the infant to full term. There are estimates that over 16,000 women and adolescent girls will lose access to screening for sexually-transmitted disease, screening for breast or cervical cancer, or other family planning services with these funding reductions.[167]

Starting in fiscal year 2002, deep cuts to services were also felt in teen pregnancy prevention programs. According to the Massachusetts Alliance on Teen Pregnancy, in 2003 there were seventeen Teen Challenge Fund Program coalitions. These coalitions provided services to adolescent girls from within 97 community agencies. Close to 24,400 youth, parents and community members had been reached by these public health programs.[168] By fiscal year 2004, fifteen of these coalitions had been eliminated, leaving only two. Funding cuts have dramatically limited the scope of these programs, particularly outreach and prevention.

Although there is a slight funding increase in the teen pregnancy program for fiscal year 2005, the budget earmarks $500,000 of the funding for specific communities in western Massachusetts. The remaining $490,000 is available to serve the rest of the state. The Department of Public Health intends to use these dollars for direct services, and only in seven communities. This will leave many communities of the Commonwealth with no resources with which to address teen pregnancy prevention, whether through outreach, education or direct services.[169]

Tracking the impact of funding reductions in reproductive health supports always involves a time lag. However, over the next few years it will be important to monitor any changes in the rates of teen pregnancy, low birthweight infants, and incidents of sexually-transmitted diseases or cervical or breast cancers in low-income women and girls.

Services for Teen Parents and their Families

In addition to coordinating with the Department of Public Health on early intervention strategies, the Office of Child Care Services administers its own program for at-risk newborns. The Healthy Families/Newborn Visiting Program provides services to first time parents under the age of 21 and their families. Comprehensive, prevention-oriented services are delivered by trained home visitors at or before the child's birth, and until the child is three years of age. Families receive information on childbirth and infant care,

and also training on basic life skills like developing a family budget or mapping educational goals.

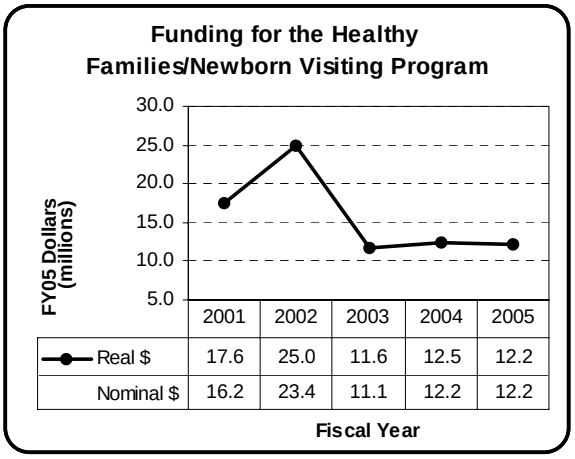
Impact on Women and Girls

More than 13,000 families have benefited from the Healthy Families/Newborn Visiting Program since its start in 1997.[170] According to data from fiscal year 2003, of those participating in the program, nearly 60 percent enrolled during their pregnancy, a fundamental precursor to positive birth outcomes.[171] The program also provided services to very young mothers; approximately 20 percent of participants were 16 years and younger.[172] Despite the overwhelming odds teen parents face, the program appears to be achieving desired results: 84 percent of mothers enrolled in the program have graduated from high school or are continuing their education; 87 percent of participating families have not had a substantiated case of child abuse or neglect; only 6 percent of these teen mothers have experienced a repeat birth while enrolled in the program over a three year period.[173] The home visiting program helps teen mothers and their children to escape negative consequences often associated with teen parenting.

Funding

Between fiscal years 2002 and 2004, funding for home visits for at-risk newborns fell substantially. Between fiscal years 2002 and 2003, funding fell from $23.4 million to $17.1 million, a 28 percent reduction in real terms (see Figure 50). In fiscal year 2003, mid-year budget cuts further reduced funding for this program by $6.0 million. Although the fiscal year 2005 budget level-funds home visits at $12.2 million, the amount appropriated is $12.7 million or 51 percent below the fiscal year 2002 level after adjusting for inflation.

Figure 50



Impact of Funding Cuts

Budget cuts have limited this program's ability to provide effective, preventive services to teen mothers and their families. Annually, more than 6,200 teenagers give birth for the first time in Massachusetts, but the program has never been funded to serve all first-time parents for a full three years.[174] In fiscal year 2003, mid-year cuts led to the elimination of 150 staff positions, and approximately 1,000 families were prematurely discharged from the program. In fiscal year 2004, when the budget was cut by nearly $5.0 million

from the initial fiscal year 2003 appropriation, the number of families receiving services fell from 5,402 to 4,442.[175] The fiscal year 2005 budget essentially level-funds this program at $12.2 million, which is enough to provide services to 4,346 individuals.[176] Budget cuts to this program jeopardize a program with a proven track record.

By limiting the availability of services, Massachusetts runs the risk of reversing the above mentioned accomplishments. The program's positive effect on low occurrence of child abuse is substantial since one-third of the participants are victims of abuse themselves and are at greater risk for perpetuating abuse or neglect.[177] The low occurrence of repeated birth among participants is also significant. Compared to teen mothers with only one child, teen mothers who have two or more children exhibit lower educational attainment, face a greater likelihood of poverty, and run a greater risk of impairing their children's health.[178]

Protecting Women and Girls from Infectious Disease

There is a close relationship among the services provided to improve the reproductive health of women and girls and the services specifically targeted to controlling the spread of infectious disease, particularly the diseases spread most commonly through substance abuse or those that are sexually-transmitted. A recent study published by the National Center on Addiction and Substance Abuse at Columbia University found that there is "a tight connection between teen sexual behavior and dating and teen risk of smoking, drinking and using illegal drugs."[179]

Although Massachusetts often ranks well compared to other states in a number of public health measures, in one compilation of a wide variety of public health measures affecting women, 38 states had lower AIDS rates among women than Massachusetts, and 24 states had lower rates of Chlamydia.[180] Compared to other states, Massachusetts has a higher rate of many sexually transmitted diseases, especially among adolescents. This is particularly problematic for young women, as the presence of other sexually transmitted diseases makes them more vulnerable to infection with HIV/AIDS.[181]

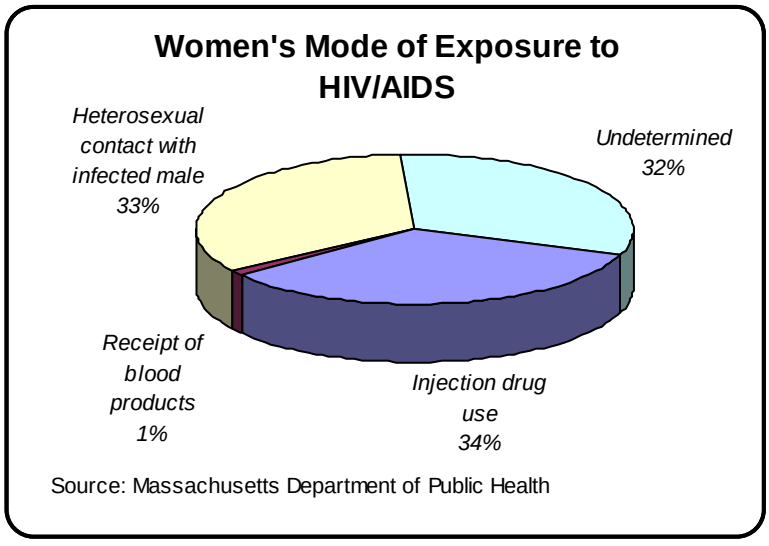
Hepatitis C, which may be transmitted through sexual activity, is more frequently associated with direct blood to blood transmission. This can happen through intravenous drug use, unsanitary tattoos or piercing equipment, or any other way that someone might come in contact with tainted blood. Hepatitis C is the most common blood-borne virus in the nation, and there is no vaccine to prevent it. Hepatitis C can lead to cirrhosis of the liver, liver cancer, liver failure or death, and is the leading indication for liver transplants. However, some people with Hepatitis C may be relatively symptom-free for years, and might be at risk of transmitting the disease to others while infected.

Since the presence of Hepatitis C is the leading indicator for liver transplants, preventing, detecting and slowing the progress of Hepatitis C can have significant impacts on costs to the health care system. Primarily because of the connection to substance abuse, Hepatitis C is often closely related to HIV. There are estimates that 60-80 percent of HIV-infected intravenous drug users are also infected with Hepatitis C. Similarly, there are estimates that 10-20 percent of Hepatitis C-infected drug users are co-infected with HIV.[182] Within the correctional system, 44 percent of the female inmates in Massachusetts are infected with Hepatitis C.[183]

Impact on Women and Girls

AIDS is increasingly becoming a women's health issue. In 2001 women represented 30 percent of all new AIDS cases nation-wide. Furthermore, AIDS is taking a particular toll on women of color, especially African-American women. Even though African-American women are only 12 percent of the nation's population, 64 percent of new HIV infections in women occurred in African-American women. Hispanic women are also over-represented among those with new HIV infections: in 2001 they were 13 percent of the population, but 18 percent of all new HIV infections.[184]

Figure 51



These percentages are consistent with trends in Massachusetts. According to the Massachusetts AIDS Surveillance Report, 29 percent of Massachusetts residents with AIDS in 2003 were women. Also similar to the national statistics are racial/ethnic disparities in the incidence of AIDS among women: the prevalence of AIDS among African-American women in Massachusetts is 19 times greater than for white women; and the prevalence for Hispanic women is 13 times greater than for white women. In addition to representing an increasing proportion of the HIV/AIDS diagnoses, women represent an increasing proportion of the HIV/AIDS-related deaths. In 1990, 12 percent of deaths among persons reported with AIDS were women. By 2002, 27 percent were women.[185]

Women have a pattern of exposure to HIV/AIDS that differs from the ways that men are exposed. Whereas the most frequent form of exposure for men (currently alive with HIV

or AIDS in Massachusetts) to the virus was through homosexual contact with an infected male (41 percent), 28 percent of men were exposed through injection drug use.[186] For women, the most frequent form of exposure to the virus was through injection drug use (34 percent – see Figure 51).

The other significant source of exposure for women is through heterosexual contact with an infected male partner (33 percent). Given these statistics, there is a public health imperative to help women learn how to protect themselves from being infected and then exposing others.

The state provides services to women with HIV/AIDS through program called AIDS Care and Treatment Now (ACT – Now) at a network of clinical sites funded by the Department of Public Health. These clinics provide prevention education and counseling, screening, and primary and preventive medical care to low-income and uninsured or underinsured people with HIV/AIDS. In the spring of 2004, the state listed fifteen ACT – Now sites across the state.

Just as the family planning programs funded by the Department of Public Health provide direct reproductive and prenatal care to women, they have also been instrumental in screening women and treating them for Hepatitis C, HIV/AIDS and other sexually-transmitted diseases (STDs). In addition to the sites providing primary care, the Department of Public Health also provides funding to a larger network of sites across the state that provide HIV counseling, testing, and screening for at-risk individuals, as well as vaccination for viral Hepatitis and screening or referral for other sexually-transmitted diseases.

The dramatic reductions in the number of infants born infected with HIV provide evidence for the benefits of the state's public health efforts. An evaluation of the Massachusetts HIV/AIDS services suggests that the state's screening program may have had a significant impact on the number of infants born infected with HIV. This evaluation makes the connection between perinatal transmission of HIV infection and the availability of screening programs. It states:

> The percentage of known HIV infection transmitted perinatally among mothers known to be HIV positive who gave birth in Massachusetts has decreased markedly in the past ten years, from 26% . . . in 1992 to 0% in 2001. The decrease in transmission rate has been attributed to screening programs for pregnant women and increased use of antiretroviral therapy in pregnant women and their infants. In 2001, 100% of HIV-positive women who know their status before giving birth received antiretroviral therapy during pregnancy and/or during labor and delivery. This marks an increase from 89% in 1996.[188]

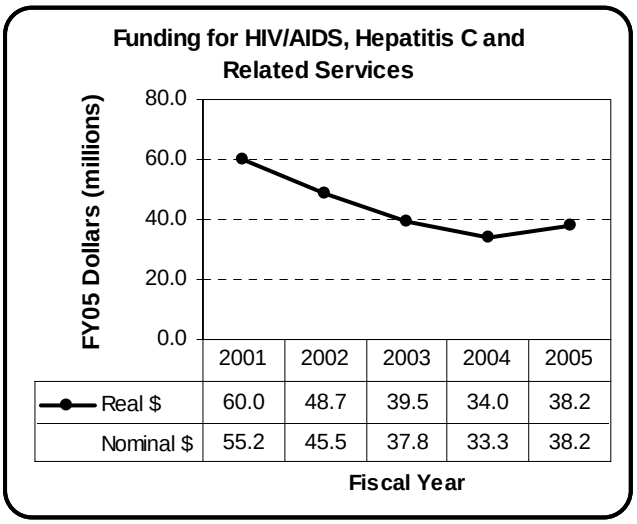
State programs have been effective at slowing the spread of HIV/AIDS, and also at improving the health of women living with HIV/AIDS. There is evidence that declining

rates of AIDS diagnosis may suggest the delaying of severe disease.[189] According to the Department of Public Health, the state's aggressive approach which combined outreach, prevention education, counseling, testing, and clinical care services made Massachusetts a national leader in reducing deaths from AIDS, limiting and identifying new HIV infections, and encouraging responsible and protective behaviors among persons at risk for infection or transmission.[190]

Funding

Funding for the infectious disease programs, including funding for the Hepatitis C program, the AIDS Bureau within the Department of Public Health, and special funding for housing programs for people living with HIV/AIDS, has dropped dramatically since the beginning of the state's fiscal crisis (see Figure 52).

Figure 52



Between fiscal year 2001 and 2005, funding dropped from $60.0 million to $38.2 million, a reduction of close to $22 million in real terms. Between fiscal years 2001 and 2002 and between fiscal years 2002 and 2003, there were cuts of 19 percent. Although the reductions were less severe in following years, the total reductions have been significant – a reduction of more than 36 percent between fiscal year 2001 and fiscal year 2005. The recent addition of funding in a supplemental budget allocated to fiscal year 2005 still does not bring funding for these services back to the level they were before the fiscal crisis. Funding is still at only two-thirds the level it had been previously.

Impact of Funding Cuts

The Commonwealth has made dramatic reductions to HIV/AIDS prevention and treatment services. Thousands of people lost the case management and transportation services which helped them maintain complicated medical regimens.[191] Without these essential supports, women infected with HIV/AIDS are less likely to take appropriate care of themselves, and are more likely to spread the infection.

Cuts in fiscal year 2003 reduced funding available for HIV screening programs, thereby eliminating funding for 10,000 HIV tests. Funding reductions also eliminated screenings

and access to prevention services for HIV, Hepatitis C and other sexually transmitted diseases in the houses of correction.[192] Cuts in fiscal year 2003 also eliminated special funding for model housing programs for persons with AIDS.

In fiscal year 2004, there were further reductions in services. The number of HIV tests conducted by clinics was reduced by close to 6,000. Furthermore, the AIDS Bureau eliminated a program serving women in recovery from addiction and a program for other high-risk women with substance abuse problems.

In fiscal year 2004, the Commonwealth eliminated a special budgetary allocation targeted to prevention and screening for Hepatitis C (often affecting women in prison and women who are intravenous drug users.) With the elimination of this dedicated funding stream, it became necessary to reallocate other money to meet the specific needs of this population. Even though Hepatitis C and HIV/AIDS are often co-morbid infections, they require very different treatments and approaches.

It is also important to keep in mind that changes in the MassHealth program during the fiscal crisis also significantly affected persons with HIV/AIDS. Because many people who become sick with AIDS are increasingly unable to work as the disease progresses, they are more likely to have an income level low enough to qualify for MassHealth. The changing eligibility thresholds, the increased premiums for services, as well elimination of certain benefits such as dental services also significantly affected this population at the same time they were losing direct services through the Department of Public Health.

Treating and Preventing Domestic Violence

Funding for domestic violence services increased substantially in the mid to late 1990s. In 1992, after a sharp increase in domestic violence-related homicides, Massachusetts declared this issue to be a public health crisis. Currently, the Massachusetts Department of Social Services (DSS) is the main agency charged with overseeing services for survivors of domestic abuse. Working with other agencies, including the Department of Transitional Assistance, DSS provides resources to both treat and prevent domestic violence. Services include batterer intervention programs, shelters and safe houses, and community-based programs for survivors of domestic abuse.

There are many other state-funded programs that are not primarily focused on preventing domestic violence, but are likely to work toward this end. For example, the Department of Transitional Assistance's Teen Living Program provides shelter and other services to teen mothers receiving TAFDC. While the primary focus of the Teen Living Program is not to prevent or end abuse, providing shelter for teen mothers and their children may assist with this goal, as many of the mothers were or are victims of domestic violence.

This section will highlight only the services that are principally designed to treat or to prevent domestic violence.

Impact on Women and Girls

Domestic violence affects women far more often than men. According to data from the Department of Justice, 85 percent of victims of domestic violence are women.[193] Abuse – whether it is physical or emotional – negatively affects the physical, mental, and economic well being of women and their children.

- In addition to harming women's physical health, domestic violence often leads to mental health issues like depression and anxiety. A survey on women's health by the Commonwealth Fund reported that women who had been abused were nearly twice as likely to have depressive symptoms or to have been diagnosed with depression or anxiety.[194] The study also found that abused women were twice as likely as other women to have problems with accessing health care.[195] Other findings suggest that women with a history of violence or abuse were more likely to have a disability or illness that limits their work or daily activities.[196]

- Very often children of abused mothers are abused themselves or suffer from witnessing violence in their homes. These children are at risk for or may exhibit developmental delays, irreversible psychological damage, or replication of violent behavior.[197]

- Domestic violence poses a serious barrier to women securing and maintaining employment. A review of research by the General Accounting Office indicates the effects of domestic violence can impact women's professional performance and hinder their ability to maintain or advance in their job.[198] Abusive partners may also undermine women's efforts to become financially independent.[199]

- Although domestic violence affects women of all socioeconomic backgrounds, the incidence of abuse among TAFDC recipients is high. A 1997 report on the prevalence of domestic violence within the TAFDC caseload indicates that 20 percent of recipients had been abused by a current or former boyfriend or husband within 12 months of the study.[200] Nearly two-thirds (65 percent) had been abused by a current or former boyfriend or husband at some point in their lives.[201]

In 1987, the Department of Social Services began to provide targeted services to battered women and their children, as children are often abused in these families. One specific strategy was the establishment of a Domestic Violence Unit, in which specialists directly advocate on behalf of abused women and their children.[202] Domestic Violence Specialists also train DSS case managers and social workers to identify victims of domestic violence and to develop strategies to serve affected families; they also

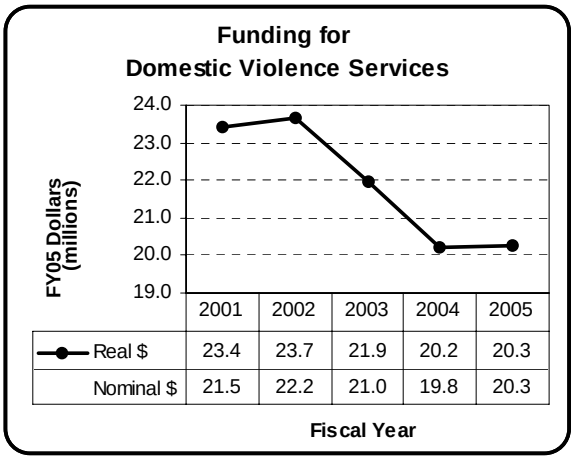
collaborate with other agencies and organizations to educate the community about the relationship between domestic violence and child welfare.[203] Currently there are Domestic Violence Specialists in area offices for both the Department of Transitional Assistance and the Department of Social Services.

Between fiscal years 1992 and 2002, resources were devoted to assisting survivors of domestic abuse and treating their batterers and overall funding for domestic violence services grew from $7.5 million to $21.6 million (or $23.1 million in 2005 dollars). Collaborations among the Departments of Public Health, Transitional Assistance, Social Services, and Housing and Community Development led to increased access to services including: batterer's intervention, community-based intervention and treatment programs, and shelters and transitional housing. Massachusetts also provides waivers for abused TAFDC recipients, which allow exemptions or extensions from the two-year time limit on benefits and work requirements, though only a small proportion of the entire caseload actually receives them.[204]

Funding

Between fiscal years 2002 and 2004, overall funding for domestic violence services fell by $3.4 million or 16 percent in real terms (see Figure 53). Prior to fiscal year 2004, funding for domestic violence services was distributed among four different agencies. The fiscal year 2004 budget consolidated funding sources such that programs previously funded through the Department of Public Health and Department of Housing and Community Development now fall under the purview of the Department of Social Services. Although there likely were administrative savings from consolidating resources, savings were also achieved by eliminating actual services. For example, the Refugees and Immigrants Safety Enrichment (RISE) program was completely eliminated.

Figure 53



Impact of Funding Cuts

RISE operated fifteen programs across the Commonwealth, offering outreach, crisis intervention, and advocacy services to immigrant and refugee communities.[205] This program, which in fiscal year 2002 served roughly 1,000 women and nearly 2,000 children, provided culturally and linguistically appropriate strategies to prevent domestic violence.[206] The RISE program was a valuable resource, as it offered services in 18 different languages and to women from 25 different ethnic backgrounds.[207] In addition to

counseling and intervention services, the RISE program referred women to housing, employment, legal, and educational services.[208]

Other budget cuts are likely to compromise both the availability and quality of domestic violence services. These reductions come at a time when demand for such services is high. Between fiscal years 2001 and 2003, the number of intakes for domestic violence shelters and safe homes grew from 2,754 to 3,752.[209] In fiscal year 2003, shelters and safe homes reported roughly 6,000 incidents when individuals were turned away from such services.[210] These resource shortages occur in conjunction with cuts in other areas that provide supports to survivors of domestic violence, particularly housing and employment supports, which are reviewed in Section II: Providing Economic Security to Women and Families. Securing a safe place to live and a sufficient income is essential for women who wish to escape violent circumstances.[211] Despite the threat domestic violence poses to women and their families, the Commonwealth has reduced its support for treatment and intervention.

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[112] See "Substance Abuse Treatment Outcomes and System Improvements," Bureau of Substance Abuse Services, Massachusetts Department of Public Health, June 2000, p.2, available at www.mass.gov/dph/bsas/publications/forms/outcomes.pdf.
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[118] "Substance Abuse Fact Sheet: Adult Women Admissions," Bureau of Substance Abuse Services, Massachusetts Department of Public Health.
[119] Even with the introduction of the MassHealth Essential program to replace health care coverage for some of the people who lost coverage with the elimination of MassHealth Basic, there was no recovery of the substance abuse treatment capacity.
[120] See *Correctional Health: The Missing Key to Improving the Public's Health and Safety,* Massachusetts Public Health Association, October 2003, p. 22, available at www.mphaweb.org/home_correctionalhealth10_03.pdf.
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[134] Beiner, L., "Tracking Change in Response to the Massachusetts Tobacco Control Program," Summary Findings, available at www.phs.bgsm.edu/sshp/rwj/FundedGrants/FindingsSummaries/Beiner.html.
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[136] The MTCP has now also developed a fourth goal: Identifying and eliminating tobacco-related disparities among specific population groups.
[137] The following description of the development of the Massachusetts Tobacco Control Program is adapted from overviews of the program in Connolly, G., Robbins, H., "Designing an Effective Tobacco Control Program – Massachusetts," and Hamilton, W., diStefano Norton, G., and Weintraub, J., at Abt Associates, Inc., "Independent Evaluation of the Massachusetts Tobacco Control Program, 7th Annual Report - January 1994 to June 2000." These reports are available at www.mass.gov/dph/mtcp/reports/reports.htm.
[138] This ad is described in full in as a Causemarket.com "pick of the month" available at www.causemarketer.com/picks.html.
[139] Beiner, L., "Tracking Change in Response to the Massachusetts Tobacco Control Program," Summary Findings, available at www.phs.bgsm.edu/sshp/rwj/FundedGrants/FindingsSummaries/Beiner.html.
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[144] "Program and Funding Guidelines for Comprehensive Tobacco Control Programs," Campaign for Tobacco-Free Kids, at www.tobaccofreekids.org/reports/settlements/cdc-report.shtml.
[145] Although some of the reduction in cigarette purchasing in Massachusetts could be a result of cross-border cigarette purchases in New Hampshire, an analysis of purchasing trends in Massachusetts and New Hampshire between 1992 and 1998 determined that even if the entire increase in cigarette sales in New Hampshire during this period were attributed to Massachusetts smokers crossing the border to purchase cigarettes, there was still a 24 percent reduction in per capita cigarette consumption in Massachusetts. It is therefore reasonable to assume that a significant portion of the decline in Massachusetts is a result of an actual decline in smoking prevalence. See also Hamilton, W., Rodger, C., Chen, X., Njobe, T., Kling, R., Norton, G., "Independent Evaluation of the Massachusetts Tobacco Control Program, Eighth Annual Report: January 1994-June 2001," Abt Associates Inc., chapter 1, p. 12-13, available at www.mass.gov/dph/mtcp/reports/reports.htm.

[146] The national comparison excludes California, which also had a comprehensive tobacco control program in place at the time. Other states excluded from the analysis had incomplete data. These prevalence rates were adapted from the national Behavioral Risk Factor Surveillance System, conducted by the U.S. Centers for Disease Control. See Hamilton, W., Rodger, C., Chen, X., Njobe, T., Kling, R., Norton, G., "Independent Evaluation of the Massachusetts Tobacco Control Program, Eighth Annual Report: January 1994-June 2001," Abt Associates Inc., chapter 2, p. 30, available at www.mass.gov/dph/mtcp/reports/reports.htm.
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[154] "A Profile of Health Among Massachusetts Adults, 2002: Results from the Behavioral Risk Factor Surveillance System," Health Survey Program, Massachusetts Department of Public Health, April 2004, p. 62.
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[156] See Nass, S., Strauss, J., *New Frontiers in Contraceptive Development: A Blueprint for Action*, Institute of Medicine of the National Academies, January 2004, p.17.
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[158] See "FY2005 Budget Requests for the Department of Public Health" at www.mphaweb.org.
[159] "Safe Motherhood: Promoting Health for Women Before, During, and After Pregnancy 2004," U.S. Department of Health and Human Services, and U.S. Centers for Disease Control and Prevention.
[160] Wanda K. Jones, Director, Office on Women's Health, quoted in "Safe Motherhood: Promoting Health for Women Before, During, and After Pregnancy 2004," U.S. Department of Health and Human Services, and U.S. Centers for Disease Control and Prevention.
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[162] Described on the Massachusetts Department of Public Health website at www.mass.gov/dph/fch/famplan.htm.
[163] Described on the Massachusetts Department of Public Health website at www.mass.gov/dph/fch/challengefund.htm.
[164] *Massachusetts Births 2002*, Massachusetts Department of Public Health, January 2004, p. 11, p. 18 and p. 51, available at www.mass.gov/dph/bhsre/birth/02/births_a_02.doc.
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[172] Ibid.
[173] Information on Healthy Families from the Children's Trust Fund website. http://www.mctf.org/sp.cfm?id=97.
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[176] Ibid.

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[190] *The People's Budget For Fiscal Year 2004*, Massachusetts Human Services Coalition, p. 88.
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[192] Na'im, A., Legg Greenberg, C., *Cuts that Hurt: An Examination of Some of the Painful Cuts in the FY2004 State Budget,* January 2004, Massachusetts Budget and Policy Center, p. 24.
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[194] Scott Collins, K. et al., *Health Concerns Across a Woman's Lifespan: The Commonwealth Fund 1998 Survey on Women's Health*, The Commonwealth Fund, May 1999, p. 7.
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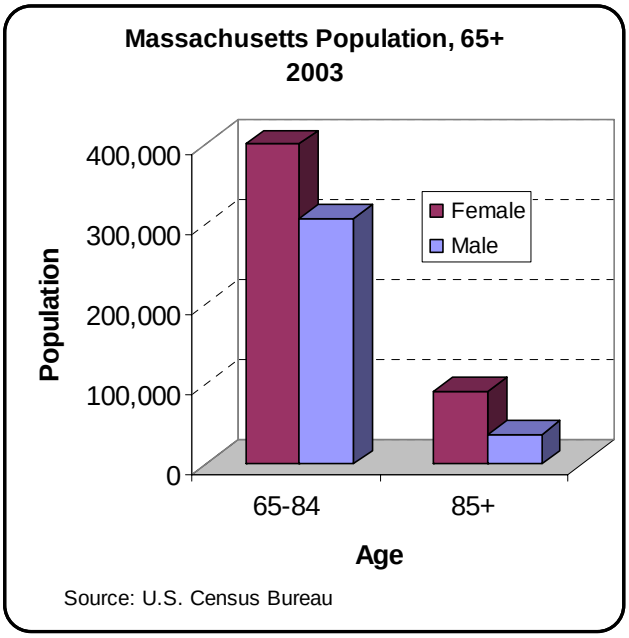
VII. Protecting the Well-being of Older Women

Because of demographics, publicly-funded services for elders disproportionately affect women. In 2003 the U.S. Census Bureau estimated 13 percent of the Commonwealth's population was 65 years of age or over. However, a striking characteristic of the population is that the ratio of men to women changes dramatically as the population ages. Of the Massachusetts population age 65 and over in 2003, close to 60 percent were women, but of the population 85 and above, 71 percent were women (see Figure 54).[212]

Figure 54



Poverty among the elderly is also disproportionately concentrated among women. According to figures from the U.S. Census Bureau, approximately 9.4 percent of the Commonwealth's elders age 65 and above live below the official poverty threshold. Of these 75,000 persons, more than 53,000 – or 71 percent – are women.[213]

The average older woman lives six years longer than the average man, and is therefore likely to be widowed and living alone. In Massachusetts, 37 percent of women age 65 and over live alone, compared to 18 percent of men.[214] More than half of the Commonwealth's women 65 and over are separated or have been divorced or widowed.[215]

Older women living alone are particularly vulnerable to poverty. Data from the 2003 Census Bureau estimates indicate that approximately eleven percent of women 65 and over in Massachusetts live below the poverty level, compared to approximately seven percent of men.[216] According to research conducted by the Massachusetts Institute for a New Commonwealth (MassINC), "of all the factors associated with poverty in old age, the most critical is to be a woman without a husband."[217]

There are a variety of factors that lead to this relatively high poverty rate among older single women. Older women are more likely to have had an employment history interrupted by the responsibilities of raising children or caring for other family members. Women are also more likely to have spent some portion of their employment working part-time, and are more likely to have had employment with relatively lower wages. These lower lifetime earnings lead to women's increased economic vulnerability at

retirement. In addition, because women typically rely upon retirement income associated with their spouse's employment, and because women typically outlive their spouses, the financial status of married older women often changes dramatically when their husbands die.

Community-based Elder Care Services

The population of elders living within the community is becoming increasingly frail – both because of the aging of that population, but also because of the extensive network of services available in the Commonwealth that are explicitly designed to allow frailer elders to remain in the community and at home.

Among the elders living in the community, women tend to be frailer than men. According to data from the 2002 Census, in Massachusetts 21 percent of women aged 65 and over living in the community (that is, not in a nursing home or other institution) reported having two or more disabilities. The disabilities included in this survey were sensory disabilities, physical disabilities, mental disabilities, disabilities in self-care, and disabilities that would affect the elder's ability to go outside alone. Only 17 percent of men reported having two or more disabilities.[218]

Almost one-quarter of American households provide care to older friends or relatives, and nearly three-quarters of the caregivers to elders are women.[219] In order to live in the community, elders – particularly those who are frail – draw heavily on support from an informal caregiving network of family and friends. Women are both the primary beneficiaries of these networks and primary caregivers in them. According to a recent study, 28 percent of frail elders drew on spouses for support, 18 percent relied upon a daughter, and 13 percent relied upon a son.[220]

There is a very low rate of women over age 65 without health insurance, because most elders have health insurance through the federally-funded Medicare program. Medicare (Parts A and B) cover hospital inpatient care, as well as outpatient care such as physician care, tests, durable medical equipment, hospice care, skilled nursing care and some home health care. Medicare Part C ("Medicare Advantage") provides for Medicare benefits via private health plans. Medicare Part D – a new prescription drug benefit that will be implemented in 2006 – will provide coverage for some prescription medications.[221] Many elders also purchase private "Medigap" insurance policies to cover some of the areas not covered by Medicare. Medigap policies also typically pay for some of the Medicare deductibles and co-payments.[222]

Although Medicare provides coverage for many acute care health needs, it is not comprehensive. Most significantly, Medicare does not cover what is known as "custodial care," or non-medical long term care. Nationally, approximately 20 percent of women receiving Medicaid are age 65 or older.[223] For low-income elders the Medicaid program

("MassHealth") provides wrap-around coverage for people dually eligible for Medicare and Medicaid, and also is a significant payer for long term care. In 2002, Massachusetts spent approximately $3.64 billion on Medicaid for dually-eligible people. Of that total, $2.49 billion was for the costs associated with long term care. Because of the federal match available for Medicaid services, however, roughly half of this was state dollars.[224]

For very low-income women who are dually eligible for Medicare and Medicaid and whose income is low enough to qualify for federal Supplemental Security Income cash assistance (74 percent of the federal poverty level), Medicaid covers prescription drugs, long term care and home health care, as well as payment for Medicare cost-sharing (premiums and co-payments) and deductibles.

Long term care for elders in Massachusetts is available through a broad continuum of services, paid for through a combination of private resources, and state and federal dollars.[225] When elders have a friend or family member to rely on, they will, and many elders pay privately for long term care. However, when an elder is poor, or without people to rely on, or when the elder becomes increasingly frail, it is often difficult for the elder to coordinate all of the supports that he or she might need to remain in the community. Without appropriate supports in the community, the elder runs the risk of increasing frailty. As one analysis summarized:

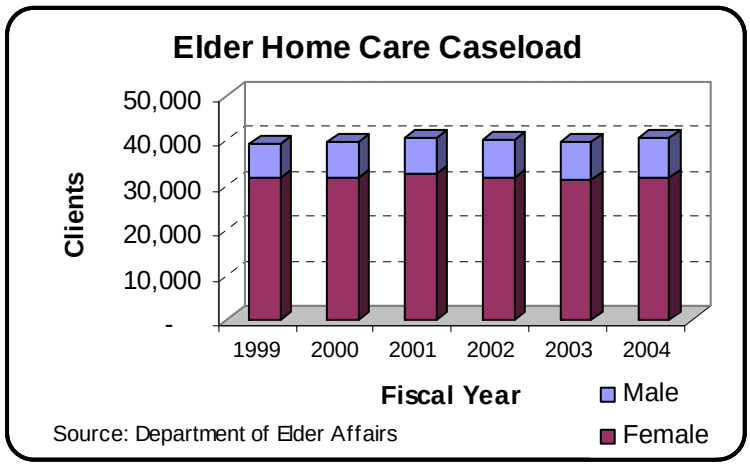
> Institutional care is the only place where there is an established integrated system to pay for elder meals, a bed, chore services, protective services, public safety, medications, mental health supports, medical care, and case management. It is the default locus of care when any gap in services for the poor becomes so great that an illness or significant frailty results.[226]

Nation-wide, more than 80 percent of elders who receive long term care or support live in the community (rather than in a long term care facility.) Massachusetts developed the Elder Home Care program to begin to address some of the needs of elders in the community. Administered by the Executive Office of Elder Affairs through a locally-based network of Aging Services Access Points (ASAPs), the Home Care Program provides a variety of supports to elders who need assistance in daily living skills. The ASAPs also serve the critical function of coordinating care and screening elders for eligibility in the range of programs available. Community supports and services are designed to allow elders to remain independent and in their homes in the community as long as possible. There are also particular programs within the system of services available for elders that provide support to the caregivers of elders in the community.

Eligibility for the state's elder Home Care program rests on three criteria: age, functional need, and finances. Services are available for persons 60 years of age or older, or for persons under the age of 60 with a diagnosis of Alzheimer's disease and in need of respite services. Each applicant is evaluated for level of functioning, based on a number

of activities such as meal preparation, mobility, and ability to dress one's self. Finally, elders must have low or moderate incomes to receive home care services, and for some elders there is a required co-payment. Respite services are available to all eligible elders, based on a sliding fee scale.

Figure 55



The Elder Home Care program is a program largely for women (see Figure 55). Of the 40,000 elders receiving services from the program, between 77 and 80 percent of them are women. Because women are more likely to be the caregivers in a family, an elder male is more likely to have a spouse capable of providing daily care than is a married older woman. Furthermore, since women outlive men, elders living alone and therefore in need of some sort of community-based care are more likely to be women.

In addition to the state-funded Elder Home Care Program, the state has used funding available through a Home- and Community-Based Waiver Program within the Medicaid program to develop an extensive network of services that blend the supports paid for by Medicaid with the state-supported community-based long term care. Among the coordinated models the state has developed is the Community Choices Program which allows for Medicaid coverage of an expanded list of intensive community services elders who would otherwise be eligible for nursing home placement.

Along with Community Choices, the Commonwealth has implemented the federal Program of All-Inclusive Care of Elders (PACE), which provides a comprehensive array of medical and social services to frail nursing home eligible elders. These services – which may be delivered in the home, in an adult day health care setting, or in particular inpatient settings, are coordinated by a team of health professionals from one of six community-based health care facilities. Persons participating in the PACE program receive health care benefits under the MassHealth Standard program.[227]

The Senior Care Options Program, implemented in the spring of 2004, combines Medicare and Medicaid services with social service supports to allow elders to remain in the community. This voluntary managed care program includes coverage of primary and preventive care, inpatient care, community- and institution-based long term care, as well as a variety of other supports.

In addition to these particular programs, there are assisted living facilities, continuing care retirement communities, home health and visiting nursing organizations, and councils on aging – all of which combine to create a broad array of supports that allow the Commonwealth's elders to remain in the community.

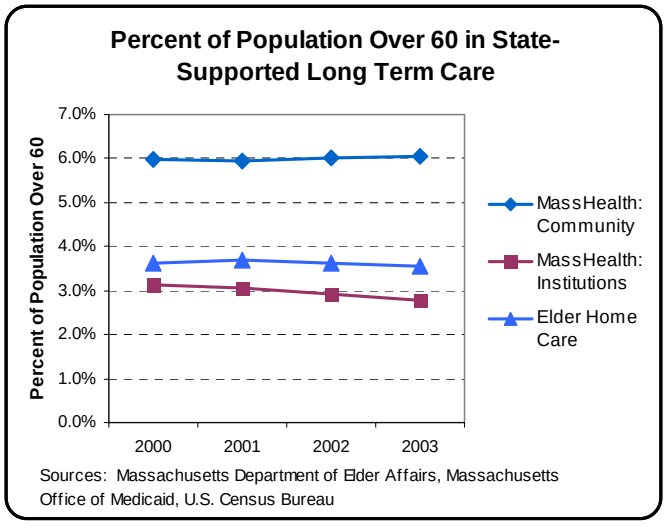
Impact of Changes during the Fiscal Crisis

Because of the complex interplay of state funding for community-based long term care services, and the addition of federal Medicaid dollars to supplement that funding, tracking the direct budgetary impacts of the fiscal crisis on payment for long term care for women in the Commonwealth is problematic. However, there are several points to keep in mind:

- The share of elders in the state's population is growing, and will continue to increase with the aging of the "Baby Boomer" generation.
- The older population is growing increasingly older as life expectancies increase.
- Elders are more likely to be single women, and living in the community, rather than in institution-based long term care facilities.
- Institutional long term care is typically more expensive than community-based long term care, but that difference diminishes as the elders in the community become frailer.

During the fiscal crisis, as Figure 56 indicates, the state's network of long term care supports did not keep pace with the growing demands of an aging population. MassHealth enrollment in the programs for community-based supports for elders, MassHealth enrollment in the programs providing payment for institutionally-based long-term care, and enrollment in the Elder Home Care program all remained relatively flat, or slightly declined as a percentage of the state's population.

Figure 56



Similarly, not only did long term care support for women not keep pace with the growing population, the total number of women receiving MassHealth support for both community-based care and institutional care declined. The number of women receiving MassHealth for institutional care between 2002 and 2004 declined by approximately six percent or close to 1,500 women (from 25,300 to 23,800). This decline was not matched by an increase in MassHealth support

for community care, however, since those programs increased only by just 400 women – an increase of only one percent (from approximately 48,000 to 48,400 women).[228] Between 2002 and 2004, the Elder Home Care Program caseload increased by only ten women.[229]

During the fiscal crisis, the Commonwealth continued its intention to expand the community-based options for frail elders, in order to stave off institutionalization. At the same time, the Commonwealth attempted to ease the costs to the state of Medicaid-funded long term care by tightening eligibility thresholds, proposing increases in asset tests for program eligibility, and changing the rate structure for nursing homes.

For example, in January 2003 the Acting Governor determined that an elder living in the community (the "community spouse") would be able to keep fewer of the joint assets of his or her marriage when his or her spouse applied for MassHealth to pay for the costs of nursing home care. Later that year, new rules required that the spouse living in the community ("the community spouse") would no longer be able to keep some of the nursing home resident's income and all of their joint savings in order to meet his or her personal financial needs. These rules required that the community spouse give up half of his or her jointly-held assets to the nursing home, and their joint income (rather than their assets) would be counted as the primary means of support for the community spouse. Under these rules, if the spouse in the nursing home were to die, the joint income of the surviving "community spouse" would drop, and jointly-held assets would have already been depleted to pay for the costs of qualifying for Medicaid-supported nursing home care. The "community spouse" would be at real risk of impoverishment.[230] These rules were modified again during the course of fiscal year 2005 budget proceedings.

The Commonwealth has also attempted through the budgetary process to expand the ways in which assets are counted for Medicaid-funded long term care as a way to limit access to the program. In fiscal year 2004, the Legislature initially directed MassHealth to seek a federal waiver that would allow Massachusetts to increase the amount of time it could "look back" into an elder's financial transactions to determine whether that elder had improperly disposed of assets presumably to qualify for Medicaid. If a person gives away assets sufficient to qualify for Medicaid asset limitations within 36 months of application for Medicaid, or if a person gives assets to a trust within 60 months of that application, the elder would be deemed ineligible for Medicaid for a certain period of time.[231] Although this proposal has not yet been implemented pending federal approval, it signals the clear intent of the Commonwealth to continue to increase the share of elder's assets used to pay for long term care.

Older women in the Commonwealth are financially vulnerable, and have become more so with the implementation or intended implementation of the kinds of proposals that leave them with fewer and fewer resources to remain independent, financially-solvent, and in the community. With continued attempts to encourage the use of federally-funded

Medicare-supported home health care, and shifting more of the costs to the income and assets of elders in the community, the state has responded to the fiscal crisis by attempting to limit its share of the rapidly rising costs of long term care.

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[212] Census figures are from the U.S. Bureau of the Census, Table 2: Annual Estimates of the Population by Sex and Age for Massachusetts: April 1, 2000 to July 1, 2003 (SC-EST2003-02-25), available at http://www.census.gov/popest/states/asrh/SC-EST2003-02.html.

[213] "Poverty Status in the Past 12 Months by Sex by Age," Table P114, 2003 American Community Survey Summary Tables, U.S. Census Bureau, http://factfinder.census.gov/serlet/DTTable?_bm=y&context+dt&-ds_name=ACS_2003 available at http://factfinder.census.gov/servlet/DTTable?_bm=y&-context=dt&-ds_name=ACS_2003_EST_G00_&-CONTEXT=dt&-mt_name=ACS_2003_EST_G2000_P114&-tree_id=303&-redoLog=true&-all_geo_types=N&-_caller=geoselect&-geo_id=01000US&-geo_id=04000US25&-format=&-_lang=en.

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[215] See "Massachusetts Community Health Information Profile, Elder Health Report," available at http://masschip.state.ma.us/InstantTopics/three.asp?Rptid=200&Geo+2961&lvl=2.

[216] "Poverty Status in the Past 12 Months by Sex by Age," Table P114, 2003 American Community Survey Summary Tables, U.S. Census Bureau, http://factfinder.census.gov/serlet/DTTable?_bm=y&context+dt&-ds_name=ACS_2003 available at http://factfinder.census.gov/servlet/DTTable?_bm=y&-context=dt&-ds_name=ACS_2003_EST_G00_&-CONTEXT=dt&-mt_name=ACS_2003_EST_G2000_P114&-tree_id=303&-redoLog=true&-all_geo_types=N&-_caller=geoselect&-geo_id=01000US&-geo_id=04000US25&-format=&-_lang=en.

[217] Munnell, A.., Cahill, K., Eschtruth, A., Sass, S., *The Graying of Massachusetts: Aging, the New Rules of Retirement, and the Changing Workforce*, MassINC, June 2004, p. 56.

[218] See www.geront.umb.edu/Demographics/disabilities.htm.

[219] *Faces of Caregiving: 2001 Mother's Day Report,* Older Women's League, p. 3-4, available at www.owl-national.org/owlreports/mothersday2001.pdf.

[220] Babcock, E., and Watt, H., "Keeping Elders Home: New Lessons Learned About Supporting Frail Elders in Our Communities," Massachusetts Health Policy Forum Issue Brief, No. 17, December 2002, p.5, available at http://sihp.brandeis.edu/mhpf/Keep_Elders_Home.pdf.

[221] For a complete description of the implementation of the new Medicare Part D benefit, see Smith, Vernon K., Gifford, Kathleen D., and Kramer, Sandra J., *The New Medicare Prescription Drug Law: Implications for Massachusetts State Health Programs*, Massachusetts Medicaid Policy Institute and the Massachusetts Health Policy Forum, September 2004.

[222] "Massachusetts Bulletin for People with Medicare," Massachusetts Executive Office of Elder Affairs, February 2004.

[223] "Medicaid's Role for Women," Issue Brief, Kaiser Family Foundation, November 2004, available at www.kff.org/womenshealth/7213a.cfm.

[224] "Medicaid Expenditures for Dual Eligibles (Full & Partial by State, 2002)," Kaiser Commission on Medicaid and the Uninsured, available at http://www.kff.org/medicaid/7024.cfm.

[225] For a summary of these programs, see Thomson, Deborah and Ford, John, "Back to the Future: The Future of Long Term Care in Massachusetts," Gerontology Institute, University of Massachusetts Boston.

[226] Babcock, E., and Watt, H., "Keeping Elders Home: New Lessons Learned About Supporting Frail Elders in Our Communities," Massachusetts Health Policy Forum Issue Brief, No. 17, December 2002, p.7, available at http://sihp.brandeis.edu/mhpf/Keep_Elders_Home.pdf.

[227] "Access to Health Care in Massachusetts," Massachusetts Division of Health Care Finance and Policy, May 2004, p. 32.

[228] Membership figures from the Massachusetts Office of Medicaid.

[229] Figures from the Massachusetts Executive Office of Elder Affairs.

[230] See The People's Budget for Fiscal Year 2004, The Massachusetts Human Services Coalition,, p. 155.

[231] Thomson, Deborah and Ford, John, "Back to the Future: The Future of Long Term Care in Massachusetts," Gerontology Institute, University of Massachusetts Boston, p. 19.

VIII. Conclusion

As this report has demonstrated, many of the reductions in state spending enacted since fiscal year 2001 have had a particularly harsh impact upon women and girls, either because they represent a disproportionate share of the beneficiaries of particular social programs or because they depend more heavily upon such programs than their male counterparts. In fact, women represent more than six out of every ten students in Massachusetts' public colleges, nearly two out of every three adult MassHealth beneficiaries, nearly eight out of every ten participants in the Commonwealth's Elder Home Care program, and nine out of every ten TAFDC recipients. None of these areas has been spared as the Commonwealth has struggled to close billions of dollars worth of budget deficits over the past several years.

The cuts described in this report are causing real pain today, but they may lead to even greater damage in the years ahead. When preventive health care programs and investments in education and training are cut it often takes years for the damage to appear. For example, the reductions in benefits and changes in eligibility for publicly-funded health insurance can lead to greater health care costs as individuals seek routine care through emergency rooms. Deep cuts to prevention and treatment programs in public health will endanger the health of thousands of residents of the Commonwealth over the long run. Cuts in funding for employment and training programs, for child care subsidies, and for student financial assistance will diminish the Commonwealth's productive capacity and darken its economic future.

As the Commonwealth's fiscal and economic situation begins to stabilize, it is time to begin to ask whether the negative impacts of budget cuts on women and girls is something that should simply be accepted as inevitable, or whether new policies should be adopted in the years ahead to reverse the cuts that have caused real harm to women and girls across the Commonwealth.