

State Budget's Effect on Women's Health Care

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In Proverbs, a book of the Christian and Jewish Bible, is an oft-quoted passage: *Without a vision, the people perish*. This prophetic saying was frequently used to encourage leaders to respond to the critical needs of their constituents. In modern times, it has been used to remind leaders that budgets should reflect a vision for what life should be like and not simply a compilation of numbers that must be in balance. This is apparently much easier said than done, for budgets are often developed in piecemeal fashion through line-items, and any possible overall vision is easily obscured.

The recent budgetary approach to the health care of women of reproductive age in North Carolina is a case in point. It seems reasonable to assume that our leaders would subscribe to a vision of our state in which all women of reproductive age have access to the information and services they need to maximize their own health status and to assure the best possible birth outcomes. The challenge is to keep that vision (and of course many others) when individual service programs are being considered. And unfortunately this challenge is exacerbated when economic downturns require that serious budget reductions be made.

By all accounts, both the state's administrators and the General Assembly have faced the greatest budgetary shortfall in more than a generation. And because the state's revenue picture became worse and worse during the legislative session, any hopes of holding on to a vision were overwhelmed by deadlines to balance the budget.

This is not to say that there are no positive pieces of the new budget. New appropriations were approved for folic acid/vitamin supplements for low-income women to reduce the occurrence of neural tube defects; health education and progesterone will be available for low-income pregnant women who have had a previous preterm birth; and teen pregnancy prevention initiatives will be enhanced. In addition, a special provision asks the Department of Health and Human Services (DHHS) to develop a federal Medicaid waiver request that would provide interconceptional care to low-income women who are at high risk for preterm birth. Finally, another provision instructs DHHS to submit a

Medicaid plan amendment to provide coverage to financially-eligible legally-resident pregnant immigrant women who have been in this country for less than five years.

It should be noted that most all of these pieces focus on the reproductive process itself (and therefore better birth outcomes) and do not respond to the greater vision of creating the healthiest possible cohort of women during their reproductive years. What is even more disappointing is that the budget contains huge reductions that have the potential to reverse the gains that have been made in infant mortality reduction in our state.

The General Assembly has taken the relatively rare step of requiring budget reductions within broad parameters while allowing the administrative departments to make the final decisions regarding the reductions. (The decision-making process will be ongoing for some time.) For example, the Division of Public Health is required to reduce contracts by more than \$5 million. These contracts include high-risk maternity care, the outreach/education campaign to reduce infant mortality, and a host of other services affecting women of reproductive age. All could be in jeopardy.

Perhaps worse, another item requires the reduction of more than \$200 million in case management services. While most legislators believed this would affect mental health services almost exclusively, this reduction is so deep that department personnel are seriously considering eliminating maternity care coordination, which has been acclaimed for more than a decade as a cost-saving, baby-saving support service for families.

For some time now, the practice and research communities have been developing a vision of knowledgeable, healthy women of reproductive age. This vision needs to become part of the legislative process. It is clearly not yet there, and one could say that the severe economic downturn will make it difficult to have this vision adopted. Historically, however, difficult times have usually produced the greatest prophets. We await ours.

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techniques such as guided imagery, meditation, breathing exercises, and hypnosis. Exercise reduces stress through a reduction in cortisol levels and an increase in circulating endorphins, thereby causing a physiologic response that reduces the effects of a stressful event.¹⁹

Substance use must be addressed when promoting a healthy lifestyle. Tobacco use is associated with cardiovascular disease, cancer, fetal growth restriction, stillbirth, and stroke. It

is estimated that 22% of all women in the US smoke and about 20% of those women will not quit smoking in pregnancy.¹ Smoking cessation programs and medications can be helpful when the commitment to quit is finalized; however, it is important to know that medications for smoking cessation are not recommended once pregnant.²⁰ Health care providers should refer women for formal treatment when use of recreational drugs is identified; the occasional drug user may