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EDUCATION

Wise & Humane: Private School Nursing In Massachusetts

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WHITE PAPER
No. 193 | March 2019

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PUBLIC POLICY RESEARCH

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Executive Summary

In recent decades, there have been marked increases in the complexity and severity of healthcare needs among students attending Massachusetts' public and private schools. The role school nurses play in effectively addressing these needs is pivotal. Nurses bring schools considerable benefits, the least of which are significant reductions in student absenteeism rates. Other benefits include improved education outcomes and consequential savings of both time and money.

Massachusetts law has long affirmed that both public and private school students are entitled to publicly funded health services provided by school nurses, and since the early 2000s, the Commonwealth's Essential School Health Services (ESHS) program has facilitated the provision of these services to students attending public *and* private schools. However, despite educating *no less* than 10 percent of the Commonwealth's total K–12 student population each year, private schools have been largely prevented from fully participating in ESHS.

Between 2008 and 2018, private schools have been denied an average of close to $1 million per year in ESHS-provided school nursing and health services. During this same decade, private schools *should* have received on average 11.67 percent of the annual ESHS allocation, but instead received only 3.96 percent on average. This is due to the inequitable funding formula the Massachusetts Department of Public Health (DPH) has utilized for private school participation in ESHS, random and arbitrary administrative changes to ESHS that have been ordered by DPH, and the department's inconsistent and inaccurate application of said formula.

Recommended solutions include administrative fixes to ESHS and establishing a publicly controlled fund that would provide to private schools at least partial redress for the accordant and unjustified losses in school-based healthcare they have sustained.

Wise and humane management of the patient is the best safeguard against infection.

Introduction

"Wise and humane management of the patient is the best safeguard against infection."[1] So wrote Florence Nightingale, one of history's most famous nurses. During the Crimean War,[2] the British public became outraged at reports about the horrid conditions at British base hospitals. In response to this outrage, the British Secretary of War asked Nightingale to oversee efforts to improve those conditions. Fulfilling her patriotic duty, Nightingale quickly reported with a team of three dozen nurses under her command to the British base hospital at Constantinople, where she immediately got to work imposing reforms that transformed that hospital's squalid conditions. At the same time, she personally attended to every soldier who languished there. Quickly reducing the hospital's death rate by two-thirds, her efforts earned for her the name "The Angel of Crimea." After the war ended, Florence Nightingale devoted the rest of her life to advocacy that eventually resulted in "worldwide healthcare reform."[3]

To state the obvious, the distance in terms of time, space, and context between that 19th century base hospital in Constantinople and any school—public or private—in the United States of America is quite wide. That said, Nightingale's influence on and vision of how healthcare ought to be delivered informs—or should inform—the delivery of school-based care to students living and studying in 21st century America.

During this century's first two decades, there have been marked increases in the complexity and severity of healthcare needs among students attending America's public and private schools.[4] For instance, between 2002 and 2012, the rate at which children were diagnosed with juvenile (Type I) diabetes increased 1.4 percent annually,[5] and from 2010 to 2016, the number of children diagnosed with severe allergies that made them prone to suffering anaphylactic shock has more than doubled.[6] These (and other) developments clearly demonstrate that ever-increasing numbers of public and private-school students report to school today with serious and potentially life-threatening conditions. These include not only diabetes,[7] asthma,[8] and allergies,[9] but also anxiety and depression.[10] Regarding the latter, a 2012 study determined that over the preceding 30 years the rate of anxiety/depression among teens had doubled,[11] and another study—this one from 2018—found that between 2003 and 2011, the percentage of 6-to-17 year olds diagnosed with anxiety/depression increased by 3 percent.[12] About these developments, one seemingly exasperated psychologist has recently commiserated, "For the first time, [children] are more stressed than their parents are. It used to be 'Enjoy your childhood. When you get to be an adult, you have mortgages and jobs.' And now, *for the first time ever*, it's flipped [emphasis mine]."[13]

[E]ver-increasing numbers of public and private school students report to school today with serious and potentially life-threatening conditions.

As the National Association of School Nurses Association puts it, "The school nurse serves in a *pivotal role* that bridges health care and education [emphasis mine],"[14] and as former U.S. Secretary of Education Arne Duncan said, "School nurses play a *vital role* in making sure children are healthy and ready to learn [emphasis mine]."[15] The role of school nurses is "pivotal" and "vital" because of their training and experience as healthcare professionals, which makes them, *in comparison to any other member of a school's staff*, the best equipped to oversee the school's response to and handling of any one (or any combination) of the myriad health challenges affecting its students. Stating emphatically that the role which school

nurses play is "crucial," the American Academy of Pediatrics asserts that *each and every school* ought to have on staff *at least one school nurse*.

> The Academy provides for school nursing the following definition:
>
> "A specialized practice of professional nursing that advances the well-being, academic success, and lifelong achievement of students. To that end, school nurses facilitate positive student responses to normal development; promote health and safety; intervene with actual and potential health problems; provide case management services; and actively collaborate with others to build student and family capacity for adaptation, self-management, self-advocacy, and learning."

Oversight of the school's response to and handling of any one (or combination) of the myriad health challenges affecting students is the primary role of school nurses. As noted in the definition above, this oversight includes collaborating with the rest of the school's staff, the child's parent(s)/guardian(s), and/or pediatrician/medical team. The role of school nurses also includes developing "an individualized healthcare plan for students with chronic conditions" and overseeing that plan's appropriate inclusion into the Individualized Education Plan (IEP) of any student(s) who has an IEP.[16]

The school nurse serves in a *pivotal* role that bridges health care and education.

In addition, school nurses serve as a sort of "chief health officer" in schools; in this role, school nurses promote the overall health of the school population (students and staff) by ensuring, for instance, that health mindfulness is part of the school's culture, health education is woven into the curriculum, and potential health hazards within the school's infrastructure are identified and, as appropriate, addressed.[17]

Nurses bring considerable benefits to schools. **Perhaps the greatest benefit is that school nurses can, in significant and substantial ways, help schools reduce student absenteeism rates**. This has been true since the very beginning of school nursing in the United States in 1902, when a Canadian-trained nurse named Lina Rogers went to work in four Manhattan schools. She did so at the behest of local officials who wondered whether the presence of a school nurse would improve attendance. It did. Within six months, absenteeism in those four schools fell by an astonishing 90 percent.[18]

It is well known that rates of absenteeism or, put positively, rates of attendance and education outcomes are to each other directly correlative.[19] This common-sense fact is helpfully illustrated by the adage, "90 percent of life is showing up." Since school is a significant facet of any child's life, it seems logical to conclude that attendance really matters. As the Brookings Institute explains, "Physically being present in school is one of the most basic conditions for a student's success."

Incidentally, the Brookings Institute lauds the fact that "most schools [throughout the United States] have daily attendance rates of well over 90 percent [emphasis mine]," which, as a fact, serves as a counter-illustration of another fact that the Brookings Institute laments, namely, that "about 8 million students in the United States missed more than three weeks of school during the 2015–16 school year."[20] Brookings and other organizations[21]—including the U.S. Department of Education[22]—call these students "chronically absent."

Could the presence of a school nurse in every school in the U.S. reduce each school's absenteeism rate by 90 percent, as occurred in those four New York City schools in 1904? Likely not. However, the presence of a school nurse in every U.S. school could significantly reduce the nation's aggregate absenteeism rate, "chronic" or otherwise.[23] According to a recent study of Florida high school students, 92.4 percent of absences are due to health issues.[24] It stands to reason, then, that in schools which employ a nurse, the rates of absenteeism are far lower than they would be if those schools did not have a school nurse. Case in point: In one rural public school district in Kentucky, the strategic utilization of school nurses reduced absenteeism by 44.89 percent.[25] In a Minnesota school district, a pilot program that placed nurses in schools in which there had previously been none resulted in rates of absenteeism dropping by up to 32 percent.[26]

[S]chool nurses can, in significant and substantial ways, help schools to reduce student absenteeism rates.

As noted above, there is a direct correlation between attendance rates and education outcomes. **Improved education outcomes**, then, are yet another significant benefit that school nurses provide. Studies suggest that poor attendance rates in the lower grades have a compounding, quasi-determinative negative effect on the likelihood that those students will be *appropriately* advanced to subsequent grade levels and/or ultimately graduate from high school.[27] Furthermore, as Secretary Arne Duncan once asserted, "[S]tudents need to be healthy in order to learn."[28]

Research—if not common sense alone—backs up Secretary Duncan's assertion.

Numerous studies have confirmed that students who contend with physical and/or mental-health challenges are much more likely than their relatively healthier peers to have behavioral issues, resort to drug and/or alcohol abuse, have unintended pregnancies, and suffer from cognitive malformation and learning disabilities. Furthermore, the necessity of visiting off-site medical practitioners and/or mental-health professionals can result, obviously, in higher rates of absenteeism and, less obviously, reduced time and capacity for

extracurricular activities.[29] Even though "[t]eacher effectiveness is the strongest school-related determinant of student success," it is the case that—as has already been presented above—"[s]tudents who attend school regularly have been shown to achieve at higher levels than students who do not have regular attendance."[30]

Even though school nurses are not miracle workers and cannot counteract *all* the negative effects of their respective students' physical and/or mental-health issues, it *is* the case that for a sizable portion of students, school nurses can and do significantly improve education outcomes. Though at times these benefits may seem insignificant, they are hardly trivial to the affected students and their families. Case in point: A kindergarten boy named Jose was having trouble sitting in class. Upon examining his mouth, his school nurse discovered that in place of some of Jose's teeth there were infected dry sockets. The little boy, whose family did not have dental insurance, was in tremendous discomfort. The nurse quickly found a dentist in the community who provided to Jose *pro bono* dental care. Thereafter, Jose had no trouble sitting or *learning*.[31]

School nurses… save [schools] time and money.

Increased attendance rates and improved student education outcomes are not the only positive effects that school nurses cause, however.

School nurses also save time and money. The time saved is for school teachers, staff, and administrators, and the savings accrue to society-at-large. Regarding the former, in a school without a nurse, administrators, teachers, and clerical staff must deal with necessary medical interventions. In fact, a 2010 study found that, on average, school nurses save administrators about an hour per day (six hours per week or nine days per year), teachers about 20 minutes per day (1.6 hours per week or 2.4 days per year), and staff about 46 minutes per day (3.83 hours per week or 5.74 days per year).[32]

Benjamin Franklin is purported to have coined the phrase "time is money." Vis a vis public education, this 2010 study found that Franklin's insight is demonstrably true. Citing $59.29, $53.90, and $26.19 as the average hourly wages of public-school administrators, teachers, and clerical staff, respectively, this study concluded that school nurses save *each* of the schools in which they are employed full-time $60,550 annually.[33]

In a 2014 study that focused on the to-be-discussed Commonwealth of Massachusetts' *Essential School Health Program* (ESHP), researchers discovered that, during Massachusetts' 2009–2010 school year, school nurses saved the state "more than twice" what they cost. According to this study, sources of the savings were the costs of the outside-of-school medical care that students would have had to receive in the absence of school nurses and, relatedly, the aggregate cost of lost productivity among teachers and parents. Calling those savings, which totaled $177 million, "just a drop in the bucket," one of the study's researchers posited that because this savings does "not include 'big savings' from averted emergency department visits and hospitalizations," the *per annum* aggregate savings proffered to both the state and the federal government by the Commonwealth's school nurses is most likely far greater.[34]

"Wise and humane management of the patient is the best safeguard against infection." When these words, written by Florence Nightingale, are considered in light of this paper, the "patient" is, collectively, the Commonwealth's public- and private-school students. The "infection" is all the detrimental effects on those patients—that is, students—school nurses prevent. For students especially, but also for schools and the wider society, the "management"—which is both "wise" and "humane"—is the kind that only school nurses can provide.

School health & education politics in Massachusetts

As mentioned in the previous section, the first school nurse in the United States was Lina Rogers, who is credited with reducing the absenteeism rate in four New York City schools by 90 percent. Bedazzled by this development, the New York City School Board promptly funded the hiring of an additional 27 nurses.[35] To other locales school nursing soon spread. In 1904, Los Angeles hired its first school nurse,[36] and the very next year Boston hired nurse Annie McKay. As Massachusetts' first school nurse, McKay was first assigned to three schools in Boston's South End. By early 1907, there were five nurses "working in 19 schools spanning six [Massachusetts] public school districts."[37] These developments mirrored what was happening across the nation: by 1911, 102 U.S cities were employing "*cadres* of school nurses [emphasis mine]."[38]

Until about 1923, the primary focus of school nursing—in Massachusetts and throughout the country—was the detection and treatment of communicable diseases such as tuberculosis. As Patricia Regan reports, during the earliest period in the history of school nursing in the U.S., "[p]hysicians relied upon school nurses to identify illness among school children and to carry out healthcare measures." Between 1924 and 1949, which Regan identifies as the "second time period" in school-nursing history, "the focus of school health programs changed" to include health education or, as the Joint Committee on Health Problems in Education and the National Conference for Cooperation in Health Education once called it, "health teaching." Significantly then, during this period school nurses came to be regarded as not only healthcare service providers, but also *educators*.[39]

During this same period, the Massachusetts Legislature adopted—in 1943—a health-screening bill to which subsequent amendments were made. Codified as Massachusetts General Law, Chapter 71, section 57 (M.G.L.c.71 s.57), the statute mandates school committees *or* municipal boards of

health to identify, via screenings, students who have sight, hearing, and mobility disabilities. All students attending public schools are to be screened, and any student who attends a private school and whose parents/guardians request it is to be screened by either the public school district (hereafter, "LEA"[40]) or the municipal board of health.[41] The fact that M.G.L.c.71 s.57 entitles Massachusetts' private-school students to *publicly funded* health screenings bears repeating.

Both in Massachusetts and throughout the country, there was increased cooperation between private schools on the one hand and LEAs and/or municipal boards of health on the other from 1943 through 1978.[42] The vast majority of school nurses who provided screenings and other health services to private-school students during these years were employed by local boards of health rather than by private schools themselves.

The reason? Because very few private schools had the financial wherewithal to do so.

Until 1978, certain Massachusetts LEAs loaned textbooks to private schools free of charge. However, this practice ended when the Massachusetts Supreme Judicial Court ruled in *Bloom v. the School Committee of Springfield* (1978) that "[t]he use of state or local funds to pay for textbook loans to pupils of private schools violates the state constitution."[43] The court based its ruling on the Massachusetts Constitution's anti-aid provision. Enshrined within Article XVIII of the constitution, it reads:

> No grant, appropriation or use of public money or property or loan of credit shall be made or authorized by the Commonwealth or any political subdivision thereof for the purpose of founding, maintaining or aiding any infirmary, hospital, institution, primary or secondary school, or charitable or religious undertaking which is not publicly owned...[44]

Even though the SJC's ruling in *Bloom* was narrow, that is, confined to the text-book issue, it addressed other forms of public aid to private schools. Significantly, the court differentiated between "substantial" and "insubstantial" aid to private non-public entities such as private schools.[45] Ruling that the publicly funded provision of textbooks to private schools constitutes substantial aid, the court concluded that "it would be a transgression of the Constitution for a city or town to loan textbooks to private primary and secondary schools."[46]

However, the court determined that along with "busing" and "subsidized school meals," M.G.L.c.71 s.57's "furnishing of health services" is *in*substantial aid. Such aid, the court found, is *in*substantial because private-school students *alone*—and not private schools—consume these services "entirely." By comparing these services to "police and fire protections," the court found that providing them to private-school students is essential to the maintenance of *public* health/safety.[47] Thus, the court ruled that the provision of publicly funded health screenings to private-school students is constitutional and, therefore, something to which private-school students have a legal right.

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The year before *Bloom* was decided, former Georgia Governor Jimmy Carter had taken office as president. Over the next four years, the stagflation which had begun earlier in the decade continued to grip and hinder the nation's economy.[48] Coupled with American setbacks and embarrassments on the international stage, the widespread economic woe of the Carter years caused a vast majority of Americans to become disenchanted with the president and, more generally, the platform of the Democratic Party.[49] As a result, in 1980 Americans elected to the Oval Office former California Governor Ronald Reagan. Reagan trounced President Carter in what remains one of the most dramatic victories in U.S. presidential election history. The so-called "Reagan Revolution"[50] swept into even historically Democratic-leaning Massachusetts, which was among the 45 states he won.[51] One of the Reagan Revolution's enduring principles was lower taxes, and Massachusetts voters endorsed that principle by overwhelmingly passing Question 2, better known as "Proposition 2½," which limited property taxes.[52]

Until that time, each LEA's school committee had enjoyed the authority to determine its own budget and, commensurately, the LEA's appropriation amount. Outside of taking their own school committees to court, municipal officials and private citizens across Massachusetts were powerless to challenge these budgets and appropriations. Furthermore, when they *were* challenged in court, the plaintiffs usually lost. Called "school committee fiscal autonomy," this system had the practical effect of assuring that school committees were fiscally accountable only to themselves.[53]

Earning the support of 59 percent of Massachusetts' voters,[54] Proposition 2½ put an end to this. By limiting the amount of taxes municipalities could levy, it reduced overall municipal budgets when it took effect in 1982. Because up to a third of most municipalities' tax revenues were earmarked to support their public-school systems,[55] most experienced budget cuts, some of them drastic. According to the Massachusetts

Department of Education (MSDE), "local education expenditures dropped by $136 million during the fiscal year 1982."[56] In June of 1983, one public-school advocate opined that the Proposition 2½-caused budgetary predicaments that public schools across the state were facing would necessitate laying off teachers, closing some schools, and eliminating certain education programs.[57] According to another public-school advocate writing in 2002, these dire predictions came true. "The effect of [Proposition 2½]," she wrote, "was swift. Many communities had to cut their budgets dramatically in the early 1980s, leading to school closings and the layoff of thousands of teachers and other municipal employees."

These effects continued into the current decade,[58] and as a result school-nursing expenditures have suffered. Case in point: In 2017, the Brookline Board of Selectmen appointed a Proposition 2½ Override Study Committee to "determine whether an operating tax override of Proposition 2½ [should] be recommended."[59] In its 2017 report to the Board of Selectmen, in which the Committee, incidentally, recommended that the Board should pursue an override, the Committee noted that there were gaps "between the amount of revenue available to the Schools and the costs of maintaining the ratio of students to professional staff" and that, as a result, "[t]he School Committee. . . *reduced the ratio of students to [non-teacher] professionals, including nurses* [emphasis mine]."[60] This reduction in the number of school nurses in Brookline is a microcosm of the reduction in school nurses that, since the early 1980s, has been occurring throughout the Commonwealth and, indeed, the entire nation.

These reductions have been most acute in private schools, due to the fact that, as explained above, the vast majority of school nurses who have served private-school students have been employed by local boards of health. Like most public-school budgets, the budgets of the Commonwealth's boards of health were significantly reduced after Proposition 2½ became law. These at-large, across-the-municipal-board budget contractions forced the vast majority of municipalities to drastically curtail spending. This, in turn, resulted in the vast majority of them failing to meet their obligation(s) under M.G.L.c.71 s.57 to provide nursing services to private school students.

The "Essential School Health Services Program"—*essential* for *all* students

However, the advantages school nurses provide to any school—public or private—were not forgotten in Massachusetts. The indirect impetus for this was a ballot petition that sought to augment the state tax on tobacco products. Approved by Massachusetts voters in November 1992, Question 1—the "Massachusetts Tobacco Tax Initiative"— imposed "a new [state] excise tax of one and one-quarter cents per cigarette (25 cents per pack of 20) and 25 percent of the wholesale price of smokeless tobacco." Significantly, revenue from this new tax would "supplement existing funding" for "school health education," among other programs and initiatives.[61]

The *Essential School Health Services Program* (ESHS) would be among the initiative's beneficiaries.

Launched in 1993 by the Massachusetts Department of Public Health (DPH), ESHS had four goals. According to former Massachusetts Director of School Health Services Ann Sheetz, those goals consist(ed) of (1) developing a school nursing "administrative infrastructure to support high quality [health] services for children," (2) promoting "health education" in schools (3) fostering collaboration between "school health services," "health care providers," and "public health insurance programs," and (4) implementing "[health] management information systems." ESHS would be "community based" and—significantly for private schools—be charged with "address[ing] the health service needs of *all children in a given city or town* [emphasis mine]."[62]

As a competitive grant program, ESHS would seek "applicant school districts," that is, LEAs, to apply for grants. Accordingly, each year since ESHS's existence, DPH has initiated what it calls a Request for Response (RFR). In these annual RFRs, DPH presents the details of the ESHS program, including the requirements that applicants and would-be grantees must fulfill to participate.[63]

During the first four years of ESHS's existence (1993–1997), only 36 LEAs (10.45 percent[64]) participated in the ESHS program. Each recipient LEA received an ESHS grant during each of these first four years, and each year these grants collectively totaled $2 million.

The vast majority of LEAs, however, did not participate. Therefore, to ensure that participation could be expanded, in 1997 DPH created an additional program called the "Essential School Health Services with Consultation Program" (ESHSC). Like ESHS, ESHSC was a competitive grant program; via ESHSC, each of the 36 LEAs that had previously received ESHS grants could apply for an annual $125,000.00 contract to offer to "recipient" LEAs "(a) monthly networking meetings for nursing leaders recipient schools, (b) consultation of the four ESHS [goals], (c) site visits to the recipient LEAs, and (d) telephone consultation." ESHSC awarded contracts to eight LEAs, which collectively provided to 53 "recipient" LEAs these consultative services. By 2000, 66 LEAs (17.74 percent)[65] were participating in ESHS and 11 LEAs had been awarded ESHSC contracts.[66]

Until that time, and despite the fact that "*all* children in a given city or town" were to have been provided access to ESHS-related services, private schools were not permitted to participate in ESHS. Therefore, private-school students were *still not receiving* the services to which both ESHS and already-existing state law entitled them.[67] By lobbying the Massachusetts legislature to include private schools in ESHS programming, a coalition of private-school advocates and

health organizations sought to change this.[68] This coalition's lobbying efforts were successful when, in 2002, language was finally added[69] that required each participating LEA to ensure, first, that all students attending private school(s) (*i.e.*, "non-public schools") located within said LEAs receive basic health assessments and screenings and, second, that private school(s) located within said participating LEAs receive assistance with establishing immunization record systems and identifying the primary care physician and healthcare provider of each private school student.[70] As a result of these requirements, 223 private schools would eventually participate in ESHS.[71]

223 private schools would eventually participate in ESHS.

Due to the "bursting of the technology bubble in stocks, production, and employment"[72] that accompanied the start of the new millennium, by 2003 the Massachusetts economy was "marked by a deep recession, huge job losses, and a widening budget deficit."[73] These economic woes prompted significant ESHS funding cuts.[74] In both 2002 and 2003, ESHS had been allocated $16,140,000,[75] but in 2004 the ESHS appropriation was slashed by 25.7 percent to $12,000,000,[76] where it would remain for the next two years.[77] Concerned about the negative impact of this cut on school nursing in private schools, the Parents Alliance for Catholic Education (PACE) and the Massachusetts School Nurse Organization (MSNO)—which were among the organizations that had successfully lobbied in 2002 for private-school inclusion in ESHS—lobbied once again, this time for restoration of ESHS funding. These lobbying efforts were successful; in 2007 the Massachusetts Legislature increased the ESHS appropriation by 25 percent to $15,000,000.[78]

Massachusetts' unwise administration of school health

Despite the central role the private-school community had played in restoring ESHS's allocation, in 2008 DPH inserted changes into the 2008 RFR that it claimed would "build on the Department's past experience" and further the expansion of "the number of Massachusetts school districts who benefit from Essential School Health Service Programs."[79] For private schools and their students, however, one of these changes would have the opposite effect: instead of *expanding* the number of private schools that participated in ESHS, it caused the number of participating private schools to *plummet*.

This change stipulated the following condition: If private schools were to continue to participate in ESHS, they would be required to have on their staffs a private-school-funded nurse.[80]

Most private schools did not employ school nurses before or during 2008. The reason was simple: as previously stated, the vast majority of Massachusetts private schools lack the resources to do so. Essentially then, this change in the 2008 RFR was a condition that the vast majority of the state's private schools themselves could not meet. As a result of this change—which was made to the surprise and, eventually, the chagrin of the private-school community—most private schools have ceased to participate in ESHS altogether. Unfortunately, in no way has this development been assuaged by the fact that, at least in theory, private schools can utilize volunteer nurses and/or co-fund and share a school nurse with other private schools.[81] For even this, most private schools lacked then (as they lack today) the necessary resources and financial wherewithal.

There are three possible explanations for DPH's decision to make this change in the 2008 RFR. The first is that DPH failed to consider the negative effects it would have on private-school participation in ESHS. The second explanation is that DPH was aware of but simply disregarded such negative effects. The third is that DPH operated under the erroneous assumption that a majority of private schools already employed school nurses. This explanation seems the most likely, for as the 2008 RFR itself put it, "Funding through this RFR cannot be used to supplant *any current [school nursing] services funded by the private school budget*, but rather to extend the number of hours currently funded, as appropriate [emphasis mine]."[82]

Despite the central role that the private-school community had played in restoring ESHS's allocation, in 2008 DPH inserted into the 2008 RFR changes that . . . caused the number of participating private schools to *plummet*.

Unfortunately for private-school students and their families, this change is not the only reason they have been denied the school nursing services to which they are entitled under ESHS and applicable state law. There are other reasons that are far more insidious.

As mentioned previously, ESHS is a competitive grant program to which LEAs can apply. ESHS provides to each grantee a minimum of approximately $50,000 for the establishment of "baseline" school nursing programs. In addition to this "baseline" funding, ESHS provides to grantees two opportunities for additional funding. The first is for grantees with "greater than 2,500 students." The second is for grantees, that is LEAs, in which there is located at least one private school. As explained in the RFR, recipient LEAs may "apply for $4000 to $14,000 for each private school [within it] that agrees to participate."[83] The specific amount granted to (or allocated for) each private school is based on that

school's enrollment. For this grant, the following allocation formula is utilized:

Enrollment range (# of students)	ESHS allocation amount
0 – 99	$4,000.00
100 – 249	$6,000.00
250 – 499	$8,000.00
500 – 749	$10,000.00
750 +	$14,000.00

In both its design and execution, this funding formula—which has been operative and unchanged since 2009[84]—is arbitrary, limited, and insufficient. More to the point, this funding formula is neither just nor fair. **A just and fair formula would ensure that the respective ESHS allocations to public schools and private schools would be *proportionally equitable*.**[85]

To illustrate what such an *equitable* and *proportional* allocation system could (or would) look like by way of a hypothetical example, let us imagine the following:

During a single year, the total ESHS allocation to the LEA of "Anytown, Massachusetts" is $100,000. Within the "Anytown" LEA there are a total of 5,000 students. Forty-five hundred (90 percent) of these students attend public schools. Five hundred (10 percent) attend private schools. Thus, the total ESHS allocation to public schools in "Anytown" would be $90,000 (90 percent of the total ESHS allocation), and the allocation to private schools in "Anytown" would be $10,000 (10 percent of the total ESHS allocation).

Unfortunately, this has not been the case. Since private-school participation in ESHS began in 2002, allocations to private schools have been utterly inequitable.

Case in point: in fiscal year 2009 (school year 2008–2009)—the earliest year for which data about annual ESHS allocations to private schools exist—the total funding amount for line item 4590-0250 was $15,000,000. The total ESHS allocation granted to private schools in Massachusetts that year was $1,089,000.[86] That school year, there were a total of 958,910 students enrolled in the Commonwealth's public schools (including charter schools),[87] and 118,755 students enrolled in the Commonwealth's private schools.[88] Thus, private-school students comprised 12.38 percent of the total K–12 student population. If the ESHS allocation to private-school students had been equitable and proportional, private-school students would have received 12.38 percent of that year's total ESHS allocation, which would have been $1,857,000. As stated above, however, private-school students received only 7.26 percent of the total ESHS allocation ($1,089,000), which amounted to $768,000 less than what they should have received if their allocation had been equitable and proportional.

A just and fair formula would ensure that the respective ESHS allocations to public schools and private schools would be *proportionally equitable.*

Due to the inherent arbitrariness, limitation, and insufficiency of the current private-school funding formula, such disproportional allocations have persisted to the present day. In fact, since 2008, the deficit has in many cases even increased, as shown in the following chart:

ESHS Public-School & Private-School funding detail (2008–2018)

School Year (Fiscal Year)	Total allocation to line item 4590–0250 (ESHS)[89]	Total # students in MA[90]	Total # *private*-school students in MA (Percentage of private-school students in MA)[91]	ESHS actual allocation to private-school students[92]	Proportional/equitable allocation based on total percentage of private-school students in MA	Allocation shortfall (percentage shortfall)
2008–9 (FY '09)	$15,000,000	958,910	118,755 (12.38)	$1,089,000.00	$1,857,000.00	$768,000 (41.35)
2009–10 (FY '10)	$13,422,121	957,053	117,893 (12.31)	$732,937.29	$1,652,263.10	$919,325.81 (55.64)
2010–11 (FY '11)	$11,597,967	955,563	115,474 (12.08)	$539,113.89	$1,401,034.41	$861,920.52 (61.52)
2011–12 (FY '12)	$11,597,967	953,369	114,510 (12.01)	$440,938.45	$1,392,915.84	$951,977.39 (68.34)
2012–13 (FY '13)	$11,597,967[93]	954,773	113,673 (11.90)	$404,723.43	$1,380,158.07	$975,434.64 (70.67)
2013–14 (FY '14)	$12,347,967	955,739	112,632 (11.78)	$358,830.07	$1,454,590.51	$1,095,760.44 (75.33)
2014–15 (FY '15)	$12,377,055	955,844	110,599 (11.57)	$389,360.26	$1,432,025.26	$1,042,665.00 (72.81)
2015–16 (FY '16)	$12,230,974	953,429	107,906 (11.31)	$375,132.30	$1,383,323.16	$1,008,190.86 (72.88)
2016–17(FY '17)	$12,157,830	953,748	106,448 (11.16)	$363,494.97	$1,356,813.83	$993,318.86 (73.20)
2017–18 (FY '18)	$12,069,395	954,034	97,646 (10.23)	$235,524.50	$1,234,699.11	$999,174.61 (80.92)
TOTALs	**$124,399,243**	**NA**	**NA**	**$4,929,055.16**	**$14,544,823.29**	**$9,615,768.00**

As demonstrated on the previous page, between 2008 and 2018 private schools *should* have received on average 11.67 percent of the annual ESHS allocation. Instead, during those years they received on *average* only 3.96 percent, which has resulted in an average loss of close to $1 million *per year* in school nursing and health services since the 2008–9 school year.

Since private-school participation in ESHS began in 2002, allocations to private schools have been utterly *in*equitable.

It can be presumed that such instances of inequity and lack of proportionality have been occurring since private schools began participating in ESHS in 2002. Extrapolating from the allocation trend/pattern between FY 2011 and FY 2018 lends confidence to the conclusion that said presumption is valid. Accordingly, it may also be concluded that because of the inadequate allocation formula, private-school students have, since 2002, lost *far in excess of* $10 million worth of ESHS-funded school nursing services. Although the exact amount of this loss is unknowable without annual ESHS private-school allocation data between 2002 and 2009, what *can* be confirmed with a fairly high degree of certainty is that the ESHS allocation to private schools has been neither equitable nor proportional.

Even though unavailable data prevents an exhaustive accounting of the reasons for this inequity, an at-least partial accounting *is* possible. This accounting falls along two instances of delinquency on the part of DPH. The first instance pertains to DPH's defective exercise of due diligence. The second pertains to deficient transparency and fairness in how DPH operates.

Occurring in 2015 and also very likely during other years, the first instance of DPH delinquency consists of two failures. The first is that *DPH allocated ESHS funds to private schools that no longer exist*. The second is that in its allocation to certain private schools, *DPH violated its own funding formula* and thus underfunded those schools.

Since these shrunken allocations practically fund no more than Band-Aids and bandages, these failures are *especially* galling.

Regarding DPH's first failure, it allocated $4,920 to Trinity High School in Newton, and $1,640 to the Mercy Center in Worcester.[94] However, the former school closed in the summer of 2012,[95] and the latter in June 2013.[96] As a result, ESHS funds that were supposed to have supported nursing and health services for private-school students in the Newton and Worcester LEAs were never utilized because those funds were allocated to schools that no longer existed. Where those funds went and what they were used for are anybody's guess, but the fact that DPH allocated funds to nonexistent schools for at least two years reveals a staggering administrative lapse. Whether such maladministration was intentional or unintentional, the fact is that private-school students never received the funding to which they were legally entitled.

Regarding DPH's second failure, 10 Catholic schools were among those private schools which received ESHS allocations that were less than they should have been according to the formula. For six of them, the discrepancy was more than 50 percent; for one, it was greater than 26 percent; for four, the discrepancy was 18 percent. This the chart below details.

DPH ESHS Private (Catholic) School Funding Discrepancies (2015)

School (City)	Enrollment	Warranted allocation	Actual allocation	Allocation shortfall (percentage shortfall)
St. Peter Marian HS (Worcester)	910	$14,000.00	$4,100.00	$9,900.00 (70.7)
Holy Name HS (Worcester)	710	$10,000.00	$4,100.00	$5,900.00 (59.0)
St. Peter Central (Worcester)	384	$8,000.00	$3,280.00	$4,720.00 (53.3)
Coyle & Cassidy HS (Taunton)	729	$10,000.00	$4,100.00	$5,900.00 (59.0)
St. Mary's (Taunton)	349	$8,000.00	$3,280.00	$4,720.00 (59)
Quincy Catholic (Quincy)	788	$14,000.00	$6,560.00	$7,440.00 (53.1)
St. Mary's HS (Lynn)	704	$10,000.00	$8,200.00	$1,800.00 (18.0)
Catholic Memorial HS (Boston)	750	$14,000.00	$11,480.00	$2,520.00 (18.0)
Holy Name (W. Roxbury)	486	$8,000.00	$6,560.00	$1,440.00 (18.0)
St. Jeanne D'Arc (Lowell)	461	$8,000.00	$6,560.00	$1,440.00 (18.0)
St. Joseph (Needham)	450	$8,000.00	$6,560.00	$1,440.00 (18.0)
St. John the Baptist (Ludlow)	302	$8,000.00	$4,920.00	$2,080.00 (26.0)
St. Margaret (Lowell)	289	$8,000.00	$6,560.00	$1,440.00 (18.0)
St. Michael (Springfield)	788	$14,000.00	$11,480.00	$2,520.00 (18.0)

Occurring much more recently, the second instance of DPH delinquency suggests that the department is neither transparent nor fair.

As explained previously, each LEA-recipient of ESHS funding in which there is a private school(s) that is willing to participate in ESHS can receive a grant between $4,000 and $14,000 per private school. In its effort to reduce its total ESHS expenditure, DPH determined in November of 2017 that there would be a 37 percent reduction in *only* the private-school ESHS allocation.[97] In other words, in its effort to save money, DPH decided to leave ESHS allocations for the provision of health and nursing services to public-school students untouched while at the same time ensuring that private-school students *alone* would bear the entire impact of the ESHS budget cut.

[P]rivate-school students alone [have borne] the entire impact of the ESHS budget cut.

In making this decision, DPH neither consulted with private-school officials nor provided any advance notice. Furthermore, when private-school officials asked DPH to explain its decision, officials offered no reasonable justification.[98] Instead, they merely resorted to citing that, on account of "recent budget reductions beyond [its] control,"[99] the total ESHS budget was facing a reduction. As shown previously,[100] this cut did indeed occur, but only by roughly $88,000. This begs the following question: Did such an insignificant, across-the-board reduction in the total ESHS allocation justify reducing *only* the already meager private-school ESHS allocation by an *additional* 37 percent?

The authors think not.

Conclusion and Recommendations

"Wise and humane management of the patient is the best safeguard against infection."

It was earlier suggested that when placed *in the context of this paper* the "infection" to which Florence Nightingale once referred is the collective and very detrimental effects that the absence of school nurses has on school children. If *that* absence could be reversed, then so also could some of the other kinds of absence that have deleterious effects on the lives of school children. These include not only ill health and absence from school, but also loss of the opportunities that are unique to childhood. Only by taking complete advantage of those opportunities can the next generation of citizens (and soldiers) alike have a greater-than-good chance of persevering—as did those British soldiers whom Florence Nightingale was once able to save—in the fight for a better and brighter tomorrow.

To assist in achieving this, we offer the following recommendations:

- Because school nurses greatly augment attendance rates and overall education outcomes, and because, as such, investing in school nurses leads to high rates of return on public investment, the Commonwealth should seek to increase the number of *publicly funded* school nurses. This could be achieved by seeking out creative and targeted ways to redirect certain percentages of the budgets of the Massachusetts Departments of Elementary and Secondary Education and Health toward (1) increasing the number of publicly funded salaries for public-school nurses, and (2) funding incentive programs such as state college/university tuition forgiveness that could effectively attract nursing students to seriously consider careers in school nursing.
- The language of the 2008 RFR (and all subsequent RFRs) requiring private schools to employ a school-funded nurse as a condition of participating in ESHS should be repealed.
- The ESHS funding allocation formula should be modified to permit full (or at least mostly) proportional ESHS funding for nursing and health programs for private-school students.
- The recent 37 percent decrease in funding for private-school participation in ESHS should be reversed.
- The Commonwealth of Massachusetts should establish a high-interest-bearing, private-school nursing/health account into which the total amount of ESHS funding that private-school students should have received since private-school participation in ESHS began in 2002 are deposited (no less than $10 million). Individual private schools and/or associations of private schools could apply for money from this fund for the establishment/support of private-school-based health initiatives. The Massachusetts Health Officers Administration or some other entity that is mostly comprised of public officials yet is *independent of DPH and MSDE* could be invited to administer this fund.

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50. During this same election, the Republican Party gained control of the U.S. Senate for the first time in 28 years. Cf. 270 to Win, "1980 Presidential Election," <**https://www.270towin.com/1980_Election/**>, accessed December 4, 2018.

51. Gerhard Peters and John T. Woolley, "Election of 1980," The American Presidency Project, <**http://www.presidency.ucsb.edu/showelection.php?year=1980**>, accessed September 15, 2018.

52. A summation of what Proposition 2½ mandated is as follows: In any given year, the tax levy limit can be increased to a total dollar amount that is *no greater* than 2.5 percent of the "full and fair cash value" of all of the taxable property in a municipality. Proposition 2½ also permits the levy limit each year to be increased by 2.5 percent of the preceding year's levy limit. A municipality may increase its levy limit to beyond 2.5 percent if its citizens approve a tax levy limit "override." Cf. Trevor J. Brown, "Strict Property Tax Caps: A Case Study of Massachusetts's Proposition 2 1/2, its Shortcomings, and the Path Forward," *University of New Hampshire Law Review*, Vol. 16, No. 2, Article 30, 359–392, 367.

53. Barbara Anderson, "Celebrating Prop 2½," *The Boston Globe*, November 4, 2005, <**http://archive.boston.com/news/globe/editorial_opinion/oped/articles/2005/11/04/celebrating_prop_2_12/**>, accessed September 16, 2018. Cf. also Katherine Bradbury, Helen Lad, & Claire Christopherson, "Proposition 2-1/2: Initial Impacts," Institute for Research on Educational Finance and Governance, School of Education, Stanford University, 7.

54. Cf. Brown, 367.

55. According to the Lincoln Institute of Land Policy, "The property tax is a critical funding source for elementary and secondary schools in the United States . . . [Since 1980], the share of public school funding coming from the local property tax has remained remarkably stable. With the exception of two years, the local property tax share has fluctuated between 33 and 37 percent [of the total tax revenue earmarked for the support of public schools]." Cf. Andrew Reschovsky, "The Future of U.S. Public School Revenue from the Property Tax," Lincoln Institute of Land Policy, July 2017. According to the Tax Policy Center, "For state and local governments, public education has been the single largest use of direct general spending in every year since 1977." Cf. Renu Zaretsky, "Taxes and Public Education: We get what we pay for . . .When we want it," TaxVox: State and Local Issues, May 2, 2018, Tax Policy Center < **https://www.taxpolicycenter.org/taxvox/taxes-and-public-education-we-get-what-we-pay-when-we-want-it**>, accessed September 17, 2018.

56. Susan G. Foster, "Massachusetts Schools 'Took the Brunt' of Proposition 2," *Education Week*, February 9, 1983 <**https://www.edweek.org/ew/articles/1983/02/09/03070021.h02.html**>, accessed September 16, 2018.

57. Susan G. Foster, "Effects of Proposition 2 1/2 Squeeze Mass. Budgets," *Education Week*, June 1, 1983, <**https://www.edweek.org/ew/articles/1983/06/01/03220020.h02.html**>, accessed September 16, 2018.

58. Laura Barret, "Better Schools, Better Funding: A Roadmap to Overriding Proposition 2½," Massachusetts Teachers Association, 2002, 2, <**https://massteacher.org/-/media/massteacher/files/advocating/better-funding-better-schools-override.pdf?la=en**>, downloaded December 4, 2018.

59. Brookline, Override Study Committee, "Charge to the Committee (as of September 5, 2017)," <**https://www.brooklinema.gov/1104/Override-Study-Committee**>, accessed September 16, 2018.

60. Override Study Committee, "Report to the Select Board of the 2017 Override Study Committee," February 9, 2018, 15, available for download via <**https://www.brooklinema.gov/DocumentCenter/View/13680/20180209-Override-Study-Committee-Report-No-Appendices?bidId=**>, accessed September 16, 2018.

61. 50.6 percent of voters approved the measure; 42.5 percent opposed it. Cf. Massachusetts Tobacco Tax Initiative (Question 1), 1992, Ballotpedia, <**https://ballotpedia.org/Massachusetts_Tobacco_Tax_Initiative,_Question_1_(1992)**>, accessed September 17, 2018.

62. Ann Sheetz, "Developing School Health Services in Massachusetts: A Public Health Model," *The Journal of School Nursing*, August 2003, Vol. 19, No. 4, 204–211, 204.

63. Massachusetts Department of Public Health (DPH), "Massachusetts Department of Public Health Essential School Health Request For Response (RFR) 900419," January 2008, 3.

64. The per-year number of LEAs in the Commonwealth between 1993 and 1997 and the per-year percentage of LEA participation are detailed in the following chart:

School Year	Number of LEAs	% participating in ESHS
1993 – 94	348	10.34
1994 – 95	331	10.87
1995 – 96	347	10.37
1996 – 97	352	10.22

The source of this chart's data on the number of LEAs during each year is as follows: Massachusetts Department of Elementary and Secondary Education, "School & District Profiles," Enrollment by Grade Report (District) <http://profiles.doe.mass.edu/statereport/enrollmentbygrade.aspx >, accessed December 1, 2018.

10.45 percent is the average percent of participation across those four years.

65. During school year 2000–01, the number of LEAs in the Commonwealth was 372.

66. Sheetz, "Developing School Health Services in Massachusetts: A Public Health Model," 206.

67. By "state law," I refer to the previously cited M.G.L.c.71 s.57.

68. This coalition consisted of the following 5 organizations: (1) the *Parents Alliance for Catholic Education* (PACE), (2) the Jewish Day Schools, (3) the *Massachusetts School Nurse Organization* (MSNO), (4) the *Massachusetts Nurses Association* (MNA), and (5) the *American Cancer Society*.

69. Said language was as follows: "[The ESSA allocation] shall be expended for the school health services program, including enhanced school health services . . . said services shall meet standards and eligibility guidelines established by the department of public health in consultation with the department of education; provided further, that funds shall be expended from this item for said services in public and non-public schools; provided further, that services shall include but not be limited to: (1) strengthening the infrastructure of school health services in the areas of personnel and policy development, programming, and interdisciplinary collaboration; (2) developing linkages between school health services programs and community health providers, and (3) incorporating health education programs, including tobacco prevention and cessation activities in school curricula and in the provision of school based health services." Cf. Commonwealth of Massachusetts, "An Act Making Appropriations for the Fiscal Year 2002 for the Maintenance of the Departments, Boards, Commissions, Institutions, and Certain Activities of the Commonwealth, for Interest, Sinking Fund and Serial Bond Requirements and for Certain Permanent Improvements," line-item 4590-0250.

70. Sheetz, 209.

71. Massachusetts Department of Health, "The Essential School Health Services Program Data Report, 2008–2009 School Year," DPH Office of Statistics and Evaluation, footnote 2, pg. 3.

72. Alan Clayton-Matthews, *The State of the State Economy: Economic Currents, Massachusetts Benchmarks*, Fall 2002, 4–9, 6.

73. Megan Woolhouse & Michael Rezendes, "As governor, Romney faced similar economic situation as Obama — with similar results," Boston.com, September 5, 2012, <https://www.boston.com/uncategorized/noprimarytagmatch/2012/09/05/as-governor-romney-faced-similar-economic-situation-as-obama-with-similar-results>, accessed September 20, 2018.

74. DPH, "The Essential School Health Services Program Data Report, 2008–2009 School Year," 3.

75. Commonwealth of Massachusetts, "An Act Making Appropriations for the Fiscal Year 2002; An Act Making Appropriations for the Fiscal Year 2003," line-item 4590-0250.

76. Commonwealth of Massachusetts, "An Act Making Appropriations for the Fiscal Year 2004," line-item 4590-0250.

77. Commonwealth of Massachusetts, "An Act Making Appropriations for the Fiscal Year 2005," line-item 4590-0250; "An Act Making Appropriations for the Fiscal Year 2006," line-item 4590-0250.

78. Commonwealth of Massachusetts, "An Act Making Appropriations for the Fiscal Year 2007," line-item 4590-0250. In 2008, the ESHS allocation was also $15,000,000. Cf. Commonwealth of Massachusetts, "An Act Making Appropriations for the Fiscal Year 2008," line-item 4590-0250.

79. DPH, "Massachusetts Department of Public Health Essential School Health Request For Response (RFR) 900419," 8.

80. Specifically, the 2008 RFR stipulates that each private school must "agree to fund school nursing coverage (RN) equal to a minimum of 5 hours per week of nursing services within the first 6 months of the grant. The private school will be required to increase this to 10 hours per week the second year and a minimum of 15 hours the third year and every year thereafter to participate in the program." Cf. DPH, "Massachusetts Department of Public Health Essential School Health Request For Response (RFR) 900419," Section VIII, 7, C, pg. 39.

81. Ibid.

82. Ibid., 18.

83. Ibid., 39.

84. This formula was provided by Christine Eggleton (Bureau of Community Health and Prevention, DPH) via email to Fr. Tom Olson on November 30, 2018.

85. As philosophers might say, this is a normative claim, which is (and could be) definitively justified by the following *de facto* descriptive claim: relative to parents whose children attend public schools, parents whose children attend private schools pay a proportionate and coequal amount of local and state taxes.

86. At the authors' request, information pertaining to annual private-school ESHS allocations was provided by the DPH on November 30, 2018. On October 26, 2018 via telephone and email, DPH informed the authors that *there exists no record of the annual ESHS allocation to private school students before 2009*. The documentation submitted by DPH to the authors on November 30 confirmed this.

87. Massachusetts Department of Elementary and Secondary Education, "School & District Profiles," 2009–10 <http://profiles.doe.mass.edu/statereport/enrollmentbygrade.aspx>, accessed December 1, 2018.

88. Massachusetts Department of Elementary and Secondary Education, "2009–10 Non-Public School Report," 2009–10 <http://profiles.doe.mass.edu/statereport/nonpublicschoolreport.aspx>, accessed December 1, 2018.

89. The authors consulted the FY budgets for each of the years listed in this chart. Cf. Commonwealth of Massachusetts, "An Act Making Appropriations for the Fiscal Year 'X'," line-item 4590-0250. Because at the time that this paper was being written the budgets for fiscal years before 2013 were not available on line, the authors requested and received from the Clerk of the Massachusetts Senate said budgets.

90. Massachusetts Department of Elementary and Secondary Education, "School & District Profiles," Enrollment by Grade Report (District).

91. Massachusetts Department of Elementary and Secondary Education, "School & District Profiles," Non-Public School Report, <http://profiles.doe.mass.edu/statereport/nonpublicschoolreport.aspx >, accessed December 1, 2018.

92. Cf. note 86.

93. As noted in note 89, FY budgets from FY '13 and onward are available online. Cf. <https://www.mass.gov/lists/previous-budgets> accessed, December 14, 2018.

94. DPH, "MADPH School Health Grants," FY 15 Funded Private Schools (Excel spreadsheet); sent via email to Steve Perla from Craig Andrade, Director, Division of Health Access.

95. Melanie Graham, "One Newton School Closes, Another Opens," The Patch, September 17, 2012.

96. Priyanka Dayal McCluskey, "Mercy Center to close special needs school," Worcester Telegram & Gazette, December 12, 2013.

97. Mary Gapinski, "For ESHS Nurse Leaders ONLY," official email sent by Mary Gapinski (Director of School Health Services, MA Department of Health) to "nurse leaders only," November 27, 2017.

98. This request was verbally made during an April 2, 2018 meeting at DPH headquarters between private school officials/representatives (Steve Perla, Kathy Mears, & Nancy Kriegel) and DPH officials.

99. Cf. Gapinski.

100. Cf. ESHS Public School & Private School funding detail (2008–2018), pgs. 22–23.

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Pioneer Institute is an independent, non-partisan, privately funded research organization that seeks to improve the quality of life in Massachusetts through civic discourse and intellectually rigorous, data-driven public policy solutions based on free market principles, individual liberty and responsibility, and the ideal of effective, limited and accountable government.

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