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Exploring 2021 State Public Health Funding Estimates Using State Health Compare

Authors

Hannah Geressu, BA
Research Assistant, SHADAC

Caroline Au Yeung, MPH
Research Fellow, SHADAC

About State Health Compare

SHADAC's State Health Compare is a user-friendly online data tool for obtaining state-level estimates on a range of topics related to health and health care. Analysts and policymakers can use State Health Compare to view measures of insurance coverage, access, cost, utilization, and outcomes, as well as social and economic measures related to health, health behaviors, and health outcomes. State Health Compare allows users to compare these measures across states and look at trends over time through user-generated maps, bar charts, trend lines, and tables. Users can also explore these measures within states by characteristics (e.g., age, race/ethnicity, education level, etc.). Click here to access a full list of data measures and sources currently available on State Health Compare.

INTRODUCTION

In the United States, vital public health activities such as disease surveillance, sanitation services, and emergency preparedness rely on funding from various sources at the federal, state, and local levels. The U.S. Congress plays a major role in public health funding, appropriating funds for all federal agencies in accordance with its Constitutionally granted power of the purse. Public health funds appropriated by Congress flow through three primary federal agencies: the Centers for Disease Control and Prevention (CDC), the Office of the Assistant Secretary for Preparedness and Response (ASPR), and the Health Resources and Services Administration (HRSA).[1] Federal funds are typically awarded via competitive or merit-based processes, although some federal funds are allocated based on a pre-determined formula specified by law.[2] While much public health funding originates at the federal level, state governments are the predominant source of public health funding. State governments raise public health funds from their own revenues (e.g., state-generated revenue from taxes, fees, fines, etc.) and also serve as an important link between the federal and local levels of the public health system, directing funds from federal agencies to county and city health departments.

Despite federal, state, and local governments spending $93 billion on public health annually, America's public health system remains underfunded, understaffed, and overburdened.[3-4] Budget cuts and historical prioritization of clinical medicine over preventive public health services have left health departments across the U.S. inadequately prepared to address public health threats like COVID-19. Experts estimate that the U.S. must invest an additional $13 per person – totaling $4.5 billion – every year to fully support core public health activities needed to promote and protect the health of its entire population.[5] Tracking data on state public health funding can help identify which states are well-positioned to absorb potential decreases in federal funding (assuming no recourse to additional state-level funding) and improve efforts to distribute scarce public health resources most effectively nationwide. New data from Trust for America's Health (TFAH), a non-partisan, non-profit health advocacy organization that monitors public health funding in the U.S., show persistent gaps in per-capita public health funding among the states. These findings raise questions about why some states consistently spend far more public health dollars per person compared to other states and signal a need to bolster public health funding in different parts of the country.

Measuring State Public Health Funding

This brief provides an overview of current state public health funding estimates based on FY 2021 data collected by TFAH. TFAH calculates state public health funding through analyses of state spending on public health for each budget cycle using publicly available budget documents through state government websites. Depending on which information is available, TFAH uses: executive budget documents listing actual expenditures, estimated expenditures, or final appropriates; appropriations bills enacted by the state's legislature; and documents from legislative analysis offices to calculate public health spending. TFAH defines "public health" broadly to include all health spending with the exception of Medicaid, CHIP, or comparable coverage programs for low-income residents. In most cases, all state funding – regardless of whether it is general revenue or other state funds (e.g., fee revenue) – is included in TFAH's calculations.

Other Public Health Funding Measures from TFAH

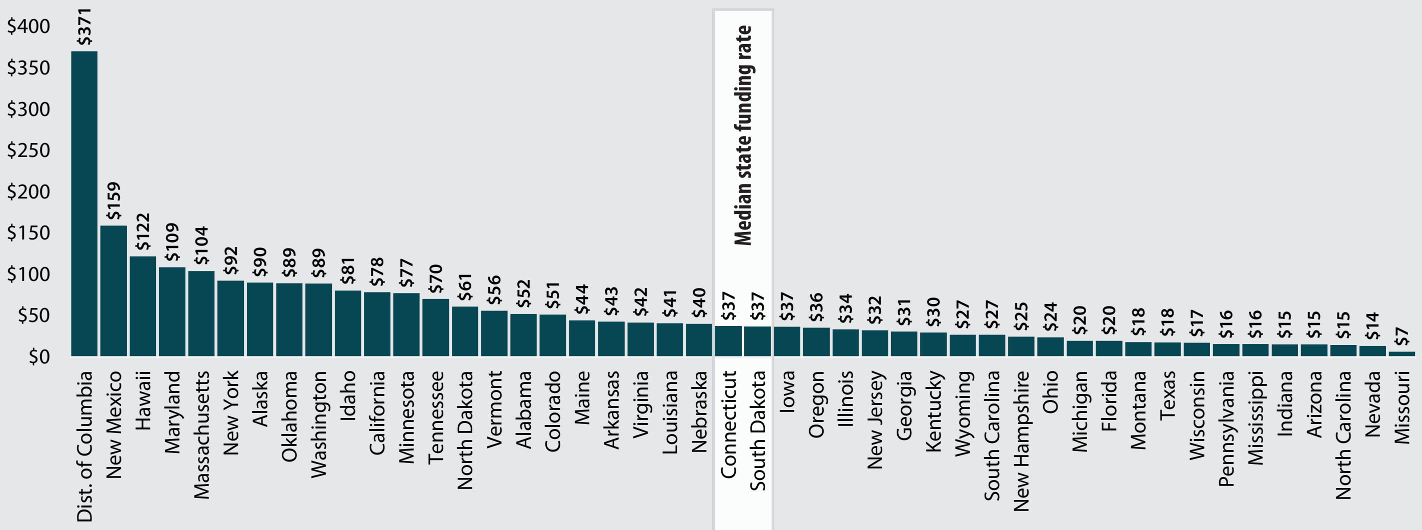
In addition to measuring state public health funding, TFAH tracks federal public health program funds from the CDC and the Health Resources and Services Administration (HRSA). These funds are generally disease/condition and/or population-specific (e.g., Vaccines for Children). TFAH gathers data about CDC and HRSA funds from the CDC's Financial Management Office and HRSA's Health Resources and Services Administration Data Warehouse.

SHADAC's State Health Compare provides access to TFAH's estimates of state public health funding, which is standardized to the estimated population of each state to create per-capita estimates. State-specific data are available for the years 2005 through 2021 (with the exception of data year 2006, for which no estimates are available) and can be downloaded or visualized using a map, rank bar chart, trend line, or table.

Trend of Wide Variation in State Public Health Funding Continued in 2021

Public health funding per capita varied widely across states in 2021, consistent with TFAH data from 2019 and 2020. For the third year in a row, the District of Columbia ranked first ($371 per capita) and Missouri ranked last ($7 per capita). The District of Columbia's per-capita funding rate has risen steadily in recent years – up from $363 per capita in 2019 and $365 per capita in 2020 – while Missouri's rate has stagnated at $7 per capita since 2019. As in the previous two years, the District of Columbia's funding rate was far ahead of the second highest-ranked state (New Mexico, which spent $159 per capita) in 2021. The mean state public health funding rate was $55.04 per capita in 2021, higher than the median funding rate of $37.26 per capita (averaged between Connecticut and South Dakota) for that year.

Figure 1. Per Person Public Health Funding, 2021

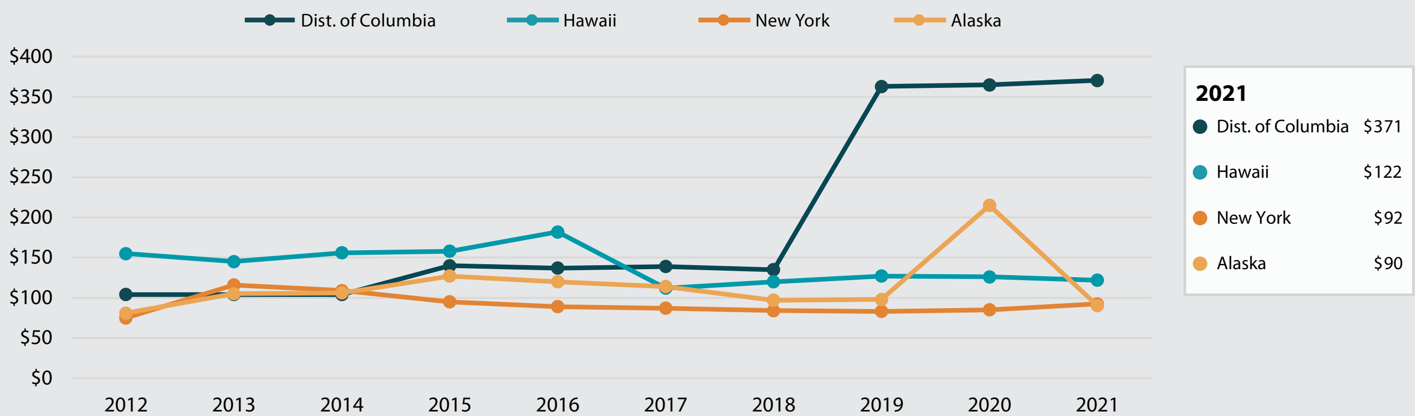


Note: Data not available for Delaware, Kansas, Rhode Island, Utah, and West Virginia.

Top States for Public Health Funding Over the Past Decade

Three states – Alaska, Hawaii, and New York – and the District of Columbia have consistently ranked among the top ten states for public health funding over the past decade (2012 through 2021), with the District of Columbia and Hawaii each holding the top spot for four years during that period. Compared to Alaska, Hawaii, and New York, the District of Columbia had the largest increase in per-capita public health funding in the last ten years, rising from $104 per capita in 2012 to $371 per capita in 2021.

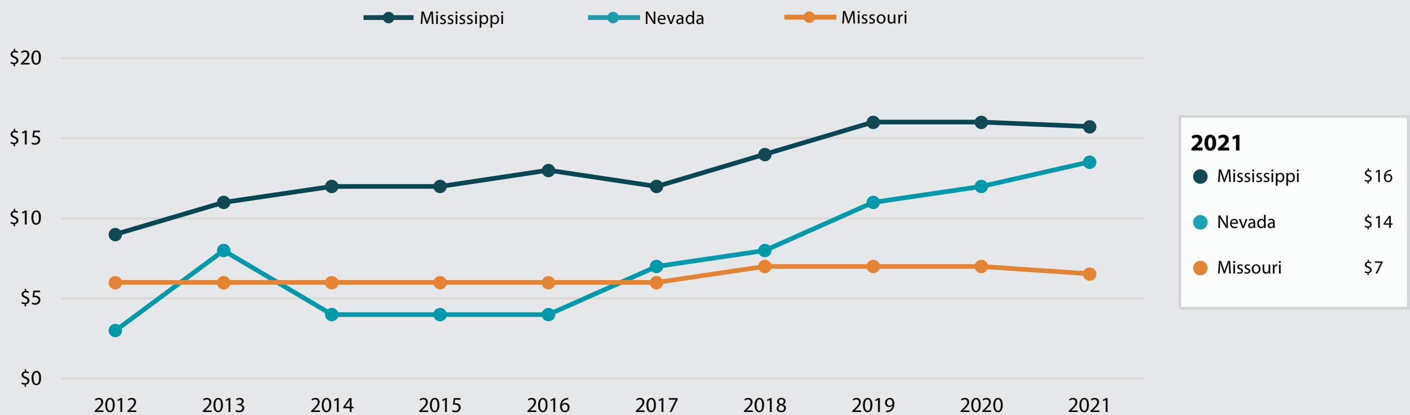
Figure 2. States Consistently among the Top 10 for Per Person Public Health Spending, 2012-2021



Bottom States for Public Health Funding Over the Past Decade

Mississippi, Missouri, and Nevada have ranked in the bottom ten states for public health funding every year from 2012 through 2021. Missouri has consistently ranked last since 2017, and Nevada has ranked last four times (2012, 2014, 2015, and 2016) in the past decade. Between 2012 and 2021, per-capita public health funding increased by $11 in Nevada and by $7 in Mississippi, whereas Missouri's per-capita spending increased by just $1 during that period.

Figure 3. Bottom States for Per Person State Public Health Funding, 2012-2021



The Challenge of Comparing Public Health Funding Across States

According to TFAH, comparisons of public health funding levels across states are difficult because every state allocates and reports its budget in different ways and because states vary widely in the budget details they provide. For example, some states do not differentiate between state and federal public health funding in their totals, and others count public health dollars toward health care spending totals. Both of these cases demonstrate how it can be difficult to distinguish state public health funding from other budget items. Some of the observed variation in state public health funding is likely due to state variation in budget allocation, reporting, and details.[6] Non-methodological sources of interstate variation in state public health funding may also include the relative performance of individual state economies (since state public health funding is often cut during economic downturns), as well as the relative tax bases of individual states along with state population counts. To illustrate this point, the District of Columbia, which had the highest fiscal year 2021 per-capita state public health funding, collected about $13,410 per person ($8.98 billion total) in 2021 state tax revenue; on the other hand, Missouri had the lowest fiscal year 2021 per-capita state public health funding and collected significantly less state tax revenue per person in 2021 than the District of Columbia, at $2,449 per capita ($15.1 billion total).[7]

Variation in State Budgeting Procedures

The ways that states produce their budgets vary due to structural differences across states, including: the nature of a state requirement to balance the budget; an annual or biennial budget cycle; the governor's authority to revise the enacted budget; and whether earmarked or federal funds are subject to the appropriations process. States also use different types of budgets, including line item, program-based, performance-based, and modified zero-based (i.e., with every budget item needing approval each year). Additionally, state fiscal years vary; most end on June 30th, but four states follow a different schedule.

Explore Additional Public Health Data Using State Health Compare

Visit State Health Compare to explore state-level estimates for two additional public health indicators: Adult Flu Vaccinations and Child Vaccinations. State Health Compare also features a number of other indicator categories, including: health insurance coverage, cost of care, access to and utilization of care, quality of care, health behaviors, health outcomes, and social and economic factors.

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