

Investing in America's Health:

A STATE-BY-STATE LOOK
AT PUBLIC HEALTH FUNDING
AND KEY HEALTH FACTS

2016



Acknowledgements

Trust for America's Health is a non-profit, non-partisan organization dedicated to saving lives by protecting the health of every community and working to make disease prevention a national priority.

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Introduction

For too long, the country has focused on treating people after they become sick instead of preventing diseases before they occur.

Investing in disease prevention is the most effective, common-sense way to improve health — helping to spare millions of Americans from developing preventable illnesses, reduce healthcare costs and improve the productivity of the American workforce so we can be competitive with the rest of the world.

Tens of millions of Americans are currently suffering from preventable diseases such as cancer, heart disease and type 2 diabetes. And, today's children are in danger of becoming the first generation in American history to live shorter, less healthy lives than their parents.

Americans across the country deserve and should expect basic health protections, no matter where they live. Yet, disease rates vary significantly from city to city and region to region. And, fundamental public health services — intended to protect our health — and the funding of these programs often vary dramatically from state-to-state and among communities within states. Currently, there is no systematic rationale for ensuring a minimum level of health services for all Americans or that the money spent on public health programs is being used in the most effective way to reduce and prevent disease and injury.

Public health departments have a unique role and responsibility as chief health strategist for communities — working to improve health in schools, workplaces and neighborhoods. This involves identifying the top health problems and developing strategies for how to address them. To be effective, public health

officials must have the capabilities to define the scope of health problems, set goals to improve health and recruit whoever can help make change happen.

But, the public health system has been chronically underfunded for decades. Analyses from the Institute of Medicine (IOM), The New York Academy of Medicine (NYAM), the U.S. Centers for Disease Control and Prevention (CDC) and a range of other experts have found that federal, state and local public health departments have been hampered due to limited funds and have not been able to adequately carry out many core functions, including programs to prevent diseases and prepare for health emergencies.^{1, 2, 3}

Investments in public health are essential for tackling the biggest health problems facing the country. They help prepare for and control emerging and persistent threats, from the Zika virus to the Middle Eastern Respiratory Syndrome (MERS) to antibiotic resistance to the dramatic rise in prescription painkiller and heroin use to contaminated water and other sources of lead poisoning in communities to obesity and tobacco use and related chronic diseases. Public health must constantly adapt to changes in trends. For example, after years of public health and medical advances contributing to longer life expectancies, there has been a significant rise in deaths among middle aged men in the past 15 years relating to increases in drug and alcohol poisonings, suicides, chronic liver disease and cirrhosis.⁴

Investing in America's Health *Public Health Report* SERIES



According to CDC, most infectious diseases and a majority of chronic diseases could be prevented — sparing millions unnecessary suffering and saving billions in healthcare costs. In fact, an analysis by the Trust for America’s Health (TFAH) found that an investment of \$10 per person per year in proven evidenced-based community prevention programs that increase physical activity, improve nutrition and prevent smoking and other tobacco use could save the country more than \$16 billion annually within five years — a return of \$5.60 for every \$1 invested.⁵

In this report, the Trust for America’s Health examines public health funding in combination with key health facts in each state to further the discussion about how to ensure public health is funded sufficiently and structured as effectively as possible to have real impact on improving health.

Investing in America’s Health:

- Provides the public, policymakers and a broad and diverse set of groups involved in public health with an objective, nonpartisan, independent analysis of the status of public health funding policies;
- Encourages greater transparency and accountability of the system; and
- Recommends ways to assure the public health system meets today’s needs and works across boundaries to accomplish its goals.

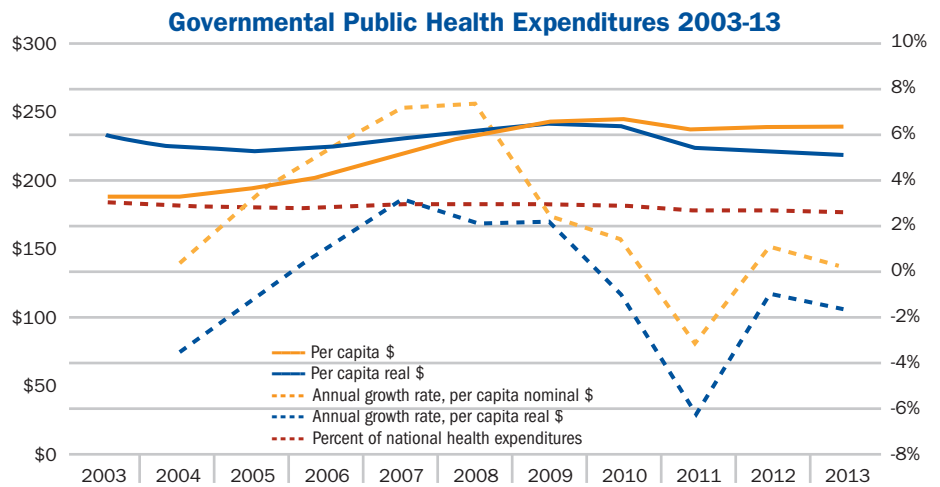
Overall, *Investing in America’s Health* concludes that the public health system must be modernized — and that a sustained and sufficient level of investment in prevention is needed at all levels of government to improve health in the United States. Improvements and closing the gaps in differences in disease rates will not be accomplished unless an adequate level of funding is provided to support public health.

MAIN FINDINGS

• National Public Health Funding:

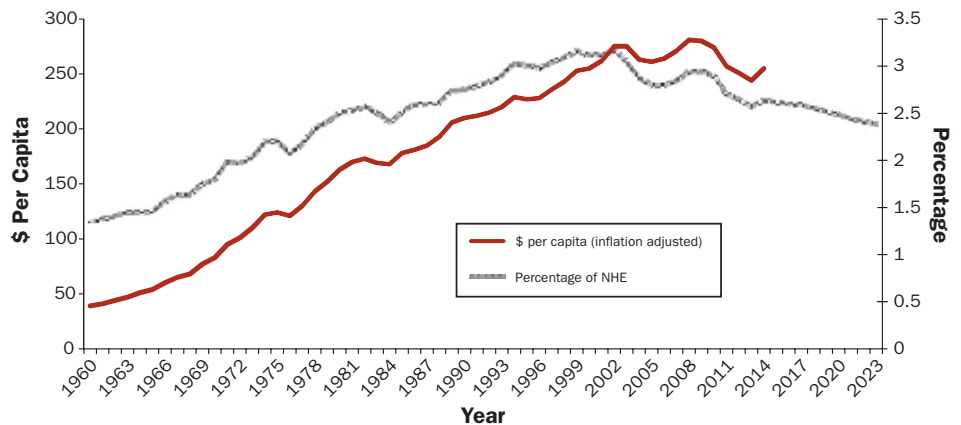
Public health spending is still below pre-recession levels. A review in the *American Journal of Public Health* found that in the last seven years, the combined federal, state and local public health spending per person has declined from \$281 per person in 2008 (2014 dollars) to \$255 per person in 2014, decreasing by approximately 9 percent.⁶

According to the Centers for Medicare and Medicaid Services (CMS), the nation's health spending is projected to grow in the next 10 years, an average rate of 6 percent per year. This is due to the rapid growth in prescription drug spending, health insurance expansions, cost sharing in insurance plans and an increase of baby-boomers' enrollment into Medicare.⁷ At the same time, public health's share of the total health spending is projected to decrease to 2.4 percent — declining 25 percent when the share peaked at 3.2 percent in 2002.⁸ The diminishing share is due to funding not keeping up with inflation, federal budget sequestration and cutting or defunding different public health programs and services, often as a result of discretionary budget caps enacted under the Budget Control Act.



Source: *Public Health Economics*, 2015

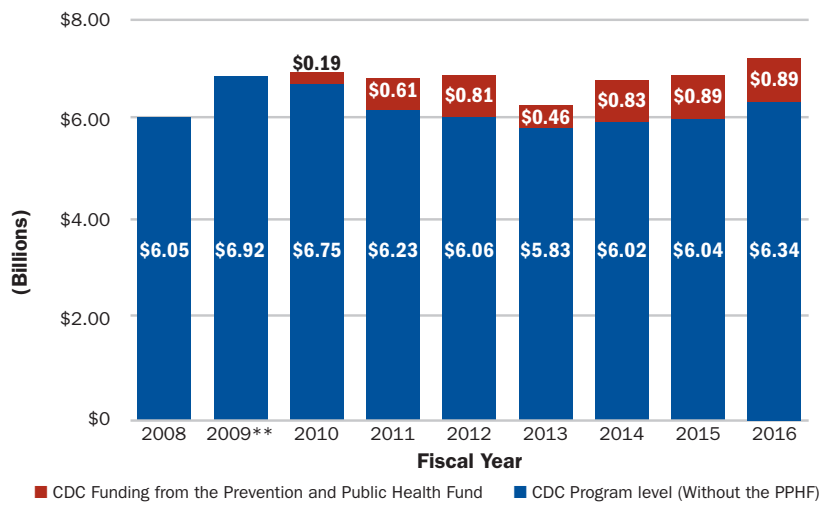
U.S. Public Health Expenditures in Dollars per Capita and as Percentage of National Health Expenditure (NHE): 1960-2023



Source: *American Journal of Public Health*, 2016

• **Flat Federal Funding:** Federal funding for public health has remained relatively level for years. The budget for CDC has decreased from a high of \$7.07 billion in fiscal year (FY) 2005 to \$6.34 billion in FY 2016, approximately \$600 million less than FY 2015.⁹ Spending through CDC averaged \$21.31 per person in FY 2016. And the amount of federal funding spent to prevent disease and improve health in communities ranged significantly from state to state, with a per capita low of \$15.99 in Indiana and a high of \$53.06 in Alaska. Variations in the federal support for states is largely related to the differences in competitive grants awarded to the states.

CDC Program Levels — Fiscal Year 2008 to Fiscal Year 2016*

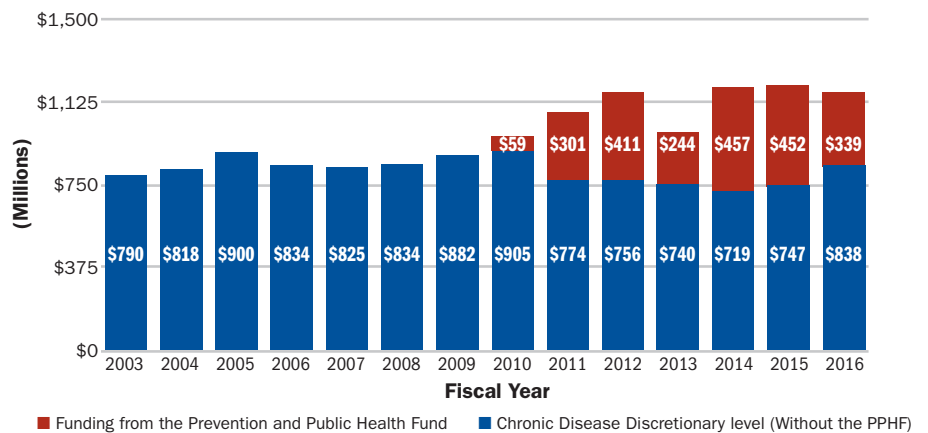


*This chart does not account for inflation, numbers are rounded
 **FY 2009 includes the 2009 Recovery Act

• **Chronic Disease Increases Important But Insufficient:**

• The Prevention and Public Health Fund (Prevention Fund) has provided increased support for evidence-based prevention programs (since fiscal year 2010) — but rates of obesity, smoking and chronic diseases remain high and require additional federal, state and local resources to adequately fund programs and services to show returns in reducing diseases.

Chronic Disease Funding — Fiscal Year 2003 to Fiscal Year 2016*

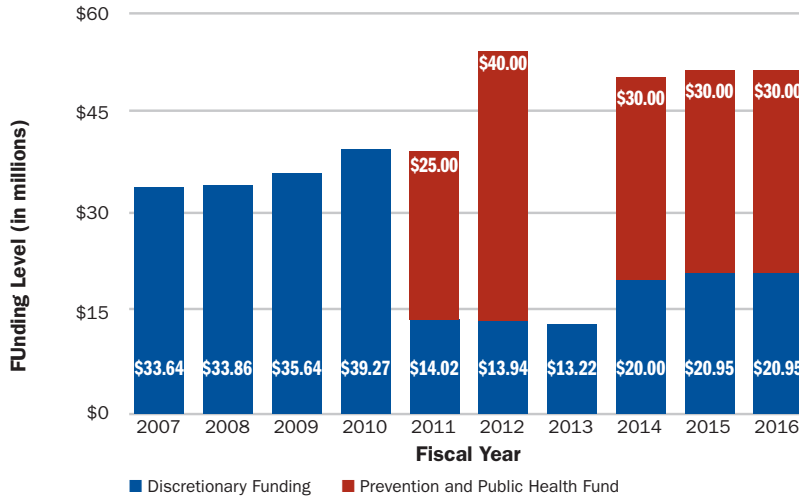


*FY 2010-2016 values are supplemented by the Prevention and Public Health Fund

- Racial and Ethnic Approaches to Community Health (REACH) funding — which provides support to community level programs that are culturally-tailored and evidence-based to reduce health

disparities — has dropped from \$64 million in FY 2012 to \$51 million in FY 2016. Rates of chronic disease, such as cancer, heart disease and diabetes, remain high among these populations.

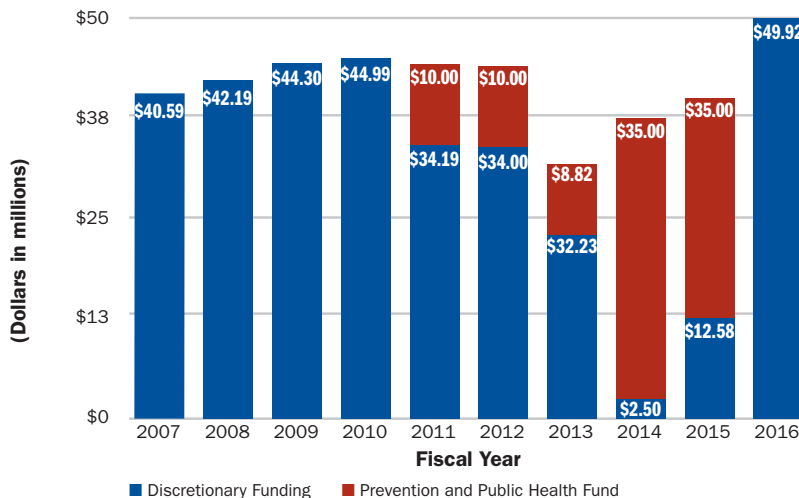
REACH Funding — Fiscal Year 2007 to Fiscal Year 2016



- CDC Division of Nutrition, Physical Activity, and Obesity (DNPAO) funding — which promotes healthy eating and active living for children and adults —

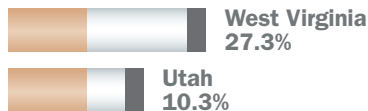
increased in FY 2016 to \$50 million but remains insufficient to combat the obesity epidemic occurring in this country.

CDC Division of Nutrition, Physical Activity, and Obesity Fiscal Year 2007 to Fiscal Year 2016



Only 7.1 percent of adults in Utah have diabetes compared to 14.1 percent in West Virginia.

Percent of Adults Who are Smokers—
West Virginia vs. Utah



● **Public Health Emergency Preparedness Cuts:**

- Public Health Emergency Preparedness (PHEP) Cooperative Agreement Funding — which provides support for states and localities to prepare for and respond to all types of disasters — has dropped from a high of \$940 million in FY 2002 to \$651 million in FY 2016.
- The Hospital Preparedness Program (HPP) has been cut from a high of \$515 million in FY 2004 to \$255 million in FY 2016, a cut of more than 50 percent including a more than \$100 million cut in FY 2014. The HPP provides grants and leadership to develop coalitions of healthcare organizations to prepare the healthcare system to respond to and recover from health emergencies.
- **Cuts in State and Local Funding:** According to a TFAH analysis, 16 states decreased their public health budgets from FY 2013-14 to FY 2014-15. Budgets in six states — Alabama, Indiana, Kansas, North Carolina, Ohio and Oklahoma — decreased for three or more years in a row. In FY 2014-15, the median state funding for public health was \$35.77 per person — up from the FY 2013-2014 level of \$31.06 — ranging from a low of \$4.10 in Nevada to a high of \$158.30 in Hawaii. The median per capita state spending in FY 2015 is around the same rate as in FY 2008

(\$33.71), however adjusting for inflation, this represents a cut of \$1.2 billion.

● **Wide Variation in Health Statistics**

by State: There are major differences in disease rates and other health factors in states around the country. For instance, only 7.1 percent of adults in Utah have diabetes compared to 14.1 percent in West Virginia, and only 10.3 percent of adults in Utah are current smokers while 27.3 percent of adults report smoking in West Virginia.

● **Wide Variation in Health Statistics by**

County: There are also major differences in disease rates and health factors within each state. *County Health Rankings*, published by the Robert Wood Johnson Foundation (RWJF) and University of Wisconsin Population Health Institute, provide county-level data on a number of key health factors for nearly every county in the country. The rankings assess health behaviors (tobacco use, diet, alcohol use, etc.), clinical care (access to and quality of care), social and economic factors (such as education, employment and income) and physical environment (environmental quality and the built environment such as housing and transportation). The Rankings highlight the healthiest and least healthy counties in every state and identify factors that influence health, outside of the doctor's office. The rankings do not currently include budget data by county.

ENSURING BASELINE PUBLIC HEALTH IN EVERY U.S. ZIP CODE: FOUNDATIONAL CAPABILITIES

Americans across the country deserve and should expect basic health protections, no matter where they live. Yet, disease rates vary significantly from city to city and region to region. And, fundamental public health services — intended to protect our health — and the funding of these programs often vary dramatically from state-to-state and among communities within states.

The Institute of Medicine and leading experts, including the Public Health Leadership Forum, have called for setting a stronger baseline standard set of cross-cutting “foundational capabilities” for public health departments to then be able to better carry out the “foundational services” of: 1) communicable/infectious disease prevention; 2) chronic disease and injury prevention; 3) environmental public health; 4) maternal, child and family health; and 5) access to and linkage with clinical care.^{10, 11}

This approach means changing siloed grant and budget structures that often fund different aspects of these core capabilities separately. For instance, current grants for epidemiological, laboratory and surveillance support are administered separately and are also divided by grants for diseases or conditions they are working to prevent or control — rather than contributing to increasing the performance of an overall integrated, coordinated system. A foundational capabilities model includes the ability and flexibility for health departments and community partners to build upon core capabilities to meet their specific needs and concerns — contingent on additional available resources. For instance, jurisdictions that demonstrate their ability to meet the foundational capa-

bilities could be given greater flexibility in their use of federal support for core public health functions. The ability to carry out foundational capabilities is contingent on having a trained, expert workforce, mechanisms for continuous quality improvement and stable, sufficient funding. The defined foundational capabilities include:

- Assessment (surveillance, epidemiology and laboratory capacity);
- Developing policy to effectively promote and improve health;
- Using integrated data sets for assessment, surveillance and evaluation to identify crucial health challenges, best practices and better health;
- Communicating with the public and other audiences to disseminate and receive health-related information in an effective manner, including health promotion opportunities, access to care and prevention;
- Mobilizing the community and forging partnerships to leverage resources (including funding);
- Building new models that integrate clinical and population health;
- Cultivating leadership — along with organization, management and business — skills needed to build and sustain an effective health department and workforce to effectively and efficiently promote and improve health;
- Demonstrating accountability for what governmental public health does directly and for those things that it oversees through accreditation, continuous quality improvement and transparency; and
- Protecting the public in the event of an emergency or disaster, as well as responding to day-to-day challenges or threats, with a cross-trained workforce.

EXAMPLES OF STATES ADOPTING FOUNDATIONAL CAPABILITIES

A number of states, including Colorado, Oklahoma and Washington, have taken steps to move toward a foundational capabilities approach within state and local public health departments.

For instance, in Washington state, they have: engaged stakeholders (such as hospitals, community health organizations, service providers and laboratories) to partner with public health departments to improve or increase health information exchange; reviewed state public health laws to identify governing power and regulations across jurisdictions; reviewed funding streams to determine what mandatory services may or may not be attached to funding; identified which services can be provided by state health departments versus local health departments; and engaged with policy makers to gain support of legislative changes needed to fully develop and implement foundational public health services. The state's Department of

Health estimated it would require an additional \$21.8 million (2013 dollars) — and local health jurisdictions in the state would need an additional \$99.9 million (2013 dollars) — to fully and effectively implement foundational capabilities.¹²

Ohio has also been developing strategies for implementing foundational capabilities, and has moved forward to consolidate some local health departments and cross-jurisdictional services and programs and to prioritize funding streams.^{13, 14} Colorado legally defined foundational “minimum quality standards,” and within two years has shown significant increases in the delivery of several program and service areas.¹⁵

The Public Health Cost Estimation Work Group has developed a methodology to help state and local health departments determine the cost of adopting foundational capabilities, and the data will be used to generate national estimates.^{16, 17}

Funding for Public Health

Public health programs are funded through a combination of federal, state and local dollars.

Each level of government has different, but important, responsibilities for protecting the public's health. While this report focuses primarily on federal funding to states, it also provides information about state funding.

TFAH analyzes federal and state funding for public health based on the most complete financial data currently

available. There is a significant delay from the time a President proposes a fiscal year budget to when appropriations legislation is signed into law to the time when the funds are disbursed. Thus in looking at federal public health funds that go to the states, TFAH uses FY 2015 data for this analysis, which is the most recent budget year for which the data is most complete and accurate.

A. FEDERAL INVESTMENTS IN PUBLIC HEALTH

FEDERAL FUNDING FOR STATES FROM THE U.S. CENTERS FOR DISEASE CONTROL AND PREVENTION



Katherine Welles / Shutterstock.com

Approximately 75 percent of CDC's budget is distributed to states, localities and other public and private partners to support services and programs.

These funds support a wide range of essential public health programs — to improve health, prevent diseases and injuries and to prepare for major health emergencies. However, the current federal public health funding structure does not actively promote a set of baseline, consistent capabilities that every community across the country should be able to achieve.

Most of the federal funding from CDC is distributed by categories — for important, but often siloed, health concerns. Federal funding is based on a mixture of population-based formula grant programs (often based on disease rates or other incidence formulas) and a series of competitive grants — where some states receive funding and others do not due to insufficient funds. Because of federal funding limitations, many states submit competitive grants applications that are “approved but unfunded” due to limited funds.

CDC FUNDING BY STATE 2015

State	Agency for Toxic Substances and Disease Registry (ATSDR)	Birth Defects, Developmental Disabilities, Disability and Health	CDC-Wide Activities and Program Support	Chronic Disease Prevention and Health Promotion	Ebola Response and Preparedness	Emerging and Zoonotic Infectious Diseases	Environmental Health	Health Reform - Toxic Substances & Environmental Public Health	HIV/AIDS, Viral Hepatitis, STI and TB Prevention
Alabama		\$1,770,279	\$2,411,588	\$12,830,858	\$2,886,905	\$959,399			\$9,638,919
Alaska	\$357,639	\$731,933	\$646,544	\$11,015,311	\$2,060,480	\$1,192,723			\$2,287,923
Arizona	\$428,973	\$892,396	\$1,928,186	\$12,761,669	\$3,353,906	\$2,077,288	\$702,988		\$9,341,745
Arkansas	\$374,054	\$1,937,058	\$1,463,357	\$9,055,038	\$3,823,882	\$1,025,970			\$3,932,665
California	\$789,039	\$3,083,358	\$10,569,631	\$58,616,382	\$18,410,031	\$7,840,093	\$4,401,882		\$103,399,245
Colorado	\$359,652	\$3,590,447	\$2,000,008	\$11,067,169	\$4,520,199	\$4,714,637	\$1,122,726		\$12,494,210
Connecticut	\$642,277	\$166,484	\$2,203,907	\$7,057,347	\$5,944,528	\$3,979,360	\$1,789,485		\$7,245,729
Delaware		\$412,739	\$389,143	\$9,099,461	\$2,501,728	\$734,024	\$102,113		\$2,414,577
D.C.	\$477,116	\$4,604,503	\$2,973,424	\$19,649,713	\$4,916,473	\$1,820,321	\$2,954,094		\$22,343,198
Florida	\$593,878	\$711,987	\$4,616,503	\$23,145,521	\$8,211,759	\$2,452,027	\$1,891,776		\$55,798,420
Georgia	\$215,805	\$2,561,094	\$7,344,422	\$37,067,391	\$14,515,760	\$6,039,329	\$1,887,144		\$26,954,295
Hawaii		\$237,797	\$1,300,218	\$8,177,277	\$1,728,796	\$850,238	\$515,000		\$2,942,635
Idaho	\$201,477	\$130,153	\$683,765	\$6,886,179	\$2,048,064	\$595,279			\$1,552,279
Illinois	\$1,417,116	\$6,037,813	\$3,643,654	\$29,707,236	\$14,489,750	\$3,364,165	\$1,654,875		\$30,424,643
Indiana		\$170,920	\$2,466,644	\$7,563,919	\$3,770,599	\$1,179,272	\$1,022,575		\$6,218,195
Iowa		\$2,119,997	\$1,775,497	\$7,419,061	\$5,718,442	\$1,823,838	\$891,901		\$2,253,338
Kansas			\$1,426,049	\$12,784,599	\$2,413,326	\$1,100,825	\$686,622		\$2,404,008
Kentucky		\$319,315	\$2,143,099	\$10,941,600	\$4,145,258	\$986,577	\$940,480		\$3,843,299
Louisiana		\$324,105	\$5,506,942	\$10,211,199	\$4,017,241	\$1,242,542	\$2,024,633		\$16,341,880
Maine		\$144,875	\$1,363,424	\$8,529,393	\$1,908,041	\$1,293,238	\$1,580,937		\$1,608,146
Maryland		\$4,567,513	\$3,148,495	\$21,452,338	\$13,728,111	\$8,905,679	\$2,598,440		\$26,768,575
Massachusetts	\$402,138	\$1,788,317	\$5,168,071	\$19,959,103	\$6,736,296	\$3,757,174	\$3,133,315		\$17,350,222
Michigan	\$440,581	\$1,675,000	\$6,646,974	\$27,665,661	\$5,088,078	\$2,236,346	\$1,865,680		\$14,602,688
Minnesota	\$451,912	\$789,930	\$3,976,626	\$18,996,395	\$7,706,439	\$7,532,340	\$2,402,515		\$6,648,124
Mississippi		\$111,345	\$2,321,667	\$11,998,970	\$3,346,530	\$802,373	\$133,306		\$7,193,126
Missouri	\$331,895	\$913,270	\$3,790,191	\$9,199,118	\$3,751,551	\$1,252,440	\$2,024,432		\$10,093,392
Montana		\$452,868	\$1,130,142	\$7,943,498	\$2,268,991	\$828,139	\$478,341	\$2,499,995	\$1,480,840
Nebraska	\$113,272	\$138,143	\$2,545,524	\$11,564,850	\$5,133,426	\$1,073,482	\$12,089		\$2,370,454
Nevada		\$468,813	\$716,113	\$9,109,367	\$3,734,690	\$789,971	\$375,004		\$4,181,590
New Hampshire	\$354,584	\$563,317	\$2,291,718	\$6,709,301	\$2,129,261	\$1,266,367	\$2,618,926		\$1,330,402
New Jersey	\$578,728	\$921,838	\$4,379,893	\$8,364,552	\$7,382,753	\$1,223,206	\$2,052,499		\$28,151,318
New Mexico	\$1,360,000	\$73,289	\$2,264,761	\$8,644,948	\$2,595,147	\$2,396,788	\$1,890,238		\$3,624,373
New York	\$826,166	\$4,882,665	\$10,987,209	\$41,361,839	\$15,986,126	\$8,747,102	\$4,933,314		\$97,424,368
North Carolina	\$320,138	\$3,652,220	\$4,094,772	\$19,461,269	\$6,908,879	\$1,435,283	\$925,366		\$14,120,259
North Dakota		\$455,582	\$504,547	\$4,825,414	\$1,795,447	\$666,113			\$1,294,238
Ohio		\$615,424	\$6,989,632	\$18,806,863	\$6,454,634	\$5,149,647	\$1,107,092		\$13,200,208
Oklahoma		\$327,750	\$1,539,651	\$11,314,392	\$2,285,356	\$834,827	\$276,357		\$4,395,414
Oregon	\$436,965	\$549,994	\$1,191,719	\$14,415,789	\$4,991,482	\$4,239,717	\$2,234,736		\$4,964,171
Pennsylvania	\$605,685	\$1,210,523	\$7,346,401	\$18,475,758	\$9,702,875	\$2,945,004	\$1,808,891		\$24,846,858
Rhode Island		\$606,000	\$833,217	\$11,480,618	\$2,122,262	\$1,215,391	\$1,267,610		\$2,824,683
South Carolina		\$4,353,080	\$2,075,176	\$15,218,639	\$4,415,979	\$1,365,787	\$750,078		\$10,232,265
South Dakota		\$119,066	\$352,638	\$8,089,923	\$1,997,647	\$693,667			\$1,359,560
Tennessee	\$277,550	\$868,107	\$2,570,161	\$9,123,282	\$5,240,607	\$5,369,239	\$531,401		\$12,770,383
Texas	\$542,173	\$1,079,794	\$6,338,584	\$17,912,328	\$12,680,593	\$2,141,478	\$389,850		\$53,255,565
Utah	\$222,845	\$1,104,505	\$1,588,534	\$12,951,745	\$6,123,227	\$1,913,383	\$2,371,877		\$2,258,977
Vermont		\$150,000	\$534,054	\$4,305,430	\$2,047,764	\$944,312	\$1,944,952		\$1,814,906
Virginia	\$374,192	\$143,337	\$3,598,240	\$19,064,601	\$7,052,252	\$2,307,475	\$1,491,502		\$14,837,498
Washington	\$533,600	\$255,926	\$1,672,449	\$22,780,006	\$4,911,570	\$2,181,662	\$1,351,683		\$13,596,002
West Virginia			\$1,471,870	\$7,786,088	\$2,801,286	\$1,123,412	\$285,256		\$1,906,159
Wisconsin	\$445,246	\$1,296,631	\$3,055,241	\$11,356,399	\$3,627,974	\$2,476,516	\$2,217,954		\$4,607,152
Wyoming		\$141,924	\$346,458	\$3,382,636	\$1,534,211	\$914,385			\$1,416,521
Grand Total	\$14,474,696	\$64,223,424	\$152,326,733	\$747,307,443	\$277,666,612	\$123,999,850	\$67,641,935	\$2,499,995	\$728,359,640

*D.C. was not included in the per capita rankings because total funding for D.C. includes funds for a number of national organizations.

[Source: CDC. For a detailed list of references, see Investing in America's Health at www.healthyamericans.org]

FEDERAL FUNDING FOR STATES FROM THE HEALTH RESOURCES AND SERVICES ADMINISTRATION (HRSA)

HRSA distributes approximately 90 percent of its funding in grants to states and territories, public and private healthcare providers, health professions training programs and other organizations.¹⁸ HRSA's funding is not distributed on a strictly

per capita basis. The bulk of HRSA funds are in its two largest programs, the community and migrant health centers and the Ryan White Act HIV programs, and these dollars are awarded on a competitive basis and/or based on disease burden.

FY 2015 HRSA Grants to States by Key Program Area (Selected Programs)

State	Primary Health Care	Health Professions	Maternal & Child Health	HIV/AIDS	HRSA Total (All Programs)**	HRSA Per Capita Total (All Programs)	HRSA Per Capita Ranking
Alabama	\$82,783,920	\$22,484,349	\$19,560,509	\$27,769,878	\$155,409,758	\$31.98	17
Alaska	\$68,526,048	\$2,529,518	\$6,838,688	\$2,556,039	\$82,859,237	\$112.21	1
Arizona	\$74,659,171	\$10,620,012	\$25,761,636	\$25,751,895	\$140,209,893	\$20.53	44
Arkansas	\$51,362,908	\$10,612,519	\$19,292,440	\$10,506,038	\$94,818,935	\$31.84	18
California	\$591,614,266	\$85,482,904	\$79,083,906	\$283,785,337	\$1,048,556,760	\$26.79	29
Colorado	\$98,483,850	\$15,598,922	\$23,516,389	\$24,085,511	\$166,478,433	\$30.51	20
Connecticut	\$52,285,573	\$14,074,792	\$17,645,804	\$26,012,151	\$110,392,687	\$30.74	19
Delaware	\$12,838,892	\$4,776,909	\$3,734,974	\$6,370,592	\$27,892,965	\$29.49	22
D.C.	\$25,157,424	\$19,425,336	\$20,646,440	\$64,648,379	\$131,356,297	N/A*	N/A*
Florida	\$218,252,548	\$26,779,240	\$42,148,410	\$226,080,901	\$518,852,495	\$25.60	32
Georgia	\$108,471,540	\$19,258,217	\$36,302,385	\$107,156,732	\$275,438,189	\$26.96	27
Hawaii	\$39,234,358	\$9,936,587	\$13,731,567	\$2,737,977	\$68,514,564	\$47.86	4
Idaho	\$45,123,583	\$3,685,389	\$8,315,929	\$3,069,184	\$61,921,469	\$37.42	11
Illinois	\$186,635,722	\$30,587,204	\$47,850,352	\$76,261,782	\$346,208,256	\$26.92	28
Indiana	\$64,829,390	\$7,003,902	\$28,350,945	\$18,471,485	\$122,867,573	\$18.56	47
Iowa	\$38,335,304	\$8,910,373	\$13,786,769	\$4,719,821	\$70,448,192	\$22.55	39
Kansas	\$37,418,874	\$2,775,881	\$18,860,683	\$4,920,215	\$69,536,639	\$23.88	35
Kentucky	\$67,176,456	\$8,620,806	\$17,277,980	\$11,880,117	\$110,314,016	\$24.93	33
Louisiana	\$88,213,399	\$14,726,249	\$28,021,343	\$50,142,292	\$184,207,540	\$39.44	9
Maine	\$40,144,011	\$2,815,109	\$5,711,148	\$2,836,574	\$55,870,536	\$42.03	7
Maryland	\$57,700,021	\$7,928,159	\$36,803,218	\$53,332,235	\$157,202,376	\$26.17	30
Massachusetts	\$117,627,815	\$33,848,364	\$28,868,543	\$42,063,724	\$223,772,852	\$32.93	14
Michigan	\$117,943,459	\$226,823,153	\$32,424,608	\$30,595,325	\$226,823,153	\$22.86	38
Minnesota	\$38,040,750	\$7,481,251	\$23,727,752	\$15,302,014	\$91,371,404	\$16.64	49
Mississippi	\$71,271,677	\$5,667,838	\$14,233,356	\$18,181,497	\$112,027,639	\$37.44	10
Missouri	\$93,674,412	\$22,119,492	\$19,755,443	\$28,458,827	\$167,444,083	\$27.52	26
Montana	\$40,238,229	\$4,897,100	\$4,251,412	\$1,630,863	\$55,612,013	\$53.84	2
Nebraska	\$18,850,713	\$5,225,908	\$8,037,393	\$4,478,023	\$39,375,062	\$20.77	43
Nevada	\$19,111,848	\$2,476,542	\$5,242,844	\$13,836,502	\$42,352,546	\$14.65	50
New Hampshire	\$23,962,260	\$2,427,152	\$9,865,504	\$1,559,809	\$40,313,061	\$30.30	21
New Jersey	\$73,457,881	\$8,638,259	\$28,294,097	\$82,594,046	\$193,621,768	\$21.61	41
New Mexico	\$67,611,686	\$4,646,946	\$12,716,575	\$5,768,301	\$93,778,691	\$44.98	6
New York	\$245,559,509	\$44,406,508	\$68,556,605	\$327,276,875	\$688,904,210	\$34.80	13
North Carolina	\$124,621,769	\$19,975,809	\$28,946,906	\$56,493,839	\$234,452,453	\$23.35	36
North Dakota	\$10,048,808	\$2,777,143	\$3,508,044	\$729,683	\$21,929,137	\$28.97	24
Ohio	\$127,577,574	\$39,809,459	\$45,266,710	\$36,890,578	\$253,534,569	\$21.83	40
Oklahoma	\$54,079,848	\$10,911,063	\$22,203,410	\$7,868,559	\$97,171,435	\$24.84	34
Oregon	\$88,945,750	\$4,788,212	\$21,117,087	\$12,612,129	\$130,178,952	\$32.31	16
Pennsylvania	\$118,758,294	\$76,645,269	\$47,555,761	\$80,343,417	\$328,495,128	\$25.66	31
Rhode Island	\$26,195,684	\$2,992,017	\$13,932,262	\$5,452,827	\$48,744,388	\$46.15	5
South Carolina	\$80,624,747	\$143,316,861	\$23,606,804	\$32,347,408	\$143,316,861	\$29.27	23
South Dakota	\$18,816,686	\$2,853,550	\$5,133,618	\$1,260,349	\$31,397,819	\$36.57	12
Tennessee	\$83,259,907	\$21,294,809	\$27,435,931	\$48,713,204	\$182,521,394	\$27.65	25
Texas	\$256,200,272	\$45,176,890	\$62,526,290	\$173,923,345	\$542,034,390	\$19.73	46
Utah	\$34,580,931	\$8,123,120	\$14,062,144	\$6,465,997	\$64,674,096	\$21.59	42
Vermont	\$17,821,101	\$1,551,207	\$4,586,510	\$1,424,094	\$26,248,226	\$41.93	8
Virginia	\$81,377,688	\$12,721,369	\$24,614,346	\$44,650,589	\$167,675,147	\$20.00	45
Washington	\$129,044,530	\$28,837,046	\$24,129,606	\$46,970,003	\$233,500,587	\$32.56	15
West Virginia	\$63,785,588	\$4,941,975	\$19,032,729	\$2,871,432	\$93,795,458	\$50.86	3
Wisconsin	\$43,430,795	\$14,932,299	\$25,834,653	\$11,589,246	\$99,121,642	\$17.17	48
Wyoming	\$8,792,809	\$1,089,585	\$1,788,047	\$957,171	\$13,634,115	\$23.26	37
U.S. TOTAL	\$4,344,560,278	\$1,140,028,573	\$1,184,496,505	\$2,176,404,811	\$8,687,179,089	\$27.03	N/A

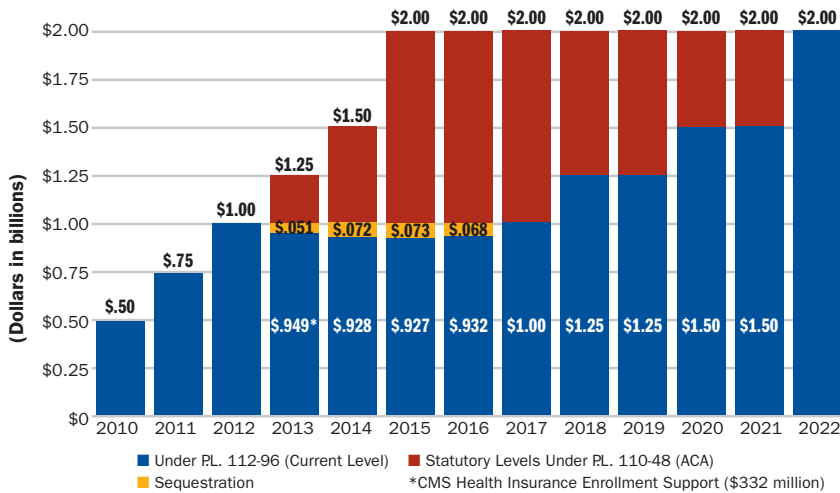
*D.C. was not included in the per capita rankings because total funding for D.C. includes funds for a number of national organizations. **The US total reflects HRSA grants to all states and D.C. [Source: HRSA. For a detailed list of references, see Investing in America's Health at www.healthyamericans.org]

THE PREVENTION AND PUBLIC HEALTH FUND

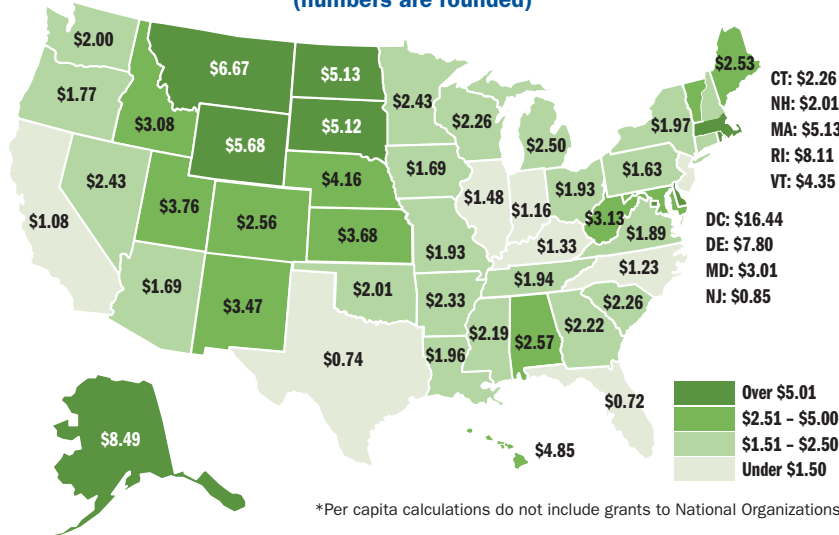
The Prevention and Public Health Fund — an integral part of CDC’s budget and programs — enables communities around the country to

invest in proven strategies to improve health. The Fund has the support of more than 900 national, state and local organizations.¹⁹

**Prevention and Public Health Fund Allocations (FY 2010 to FY 2022)
Current Funding Under P.L. 112-96 vs. Funding by P.L. 110-48 (ACA)**



**CDC Prevention and Public Health Fund Per Capita Allocations
by State (FY 2015)*
(numbers are rounded)**



PREVENTION FUND: SNAPSHOT OF SOME KEY PROGRAMS²⁰

Preventive Health and Health Services Block Grant

- Provides every state with flexible support to address what they determine to be their most important health needs.
- Block grant funds have doubled from \$80 million in FY 2013 to \$160 million in FYs 2014, 2015 and 2016 under the Prevention Fund.

Tips from Former Smokers Campaign

- Evidence-based tobacco education campaign — has helped 1.6 million Americans attempt to quit and 100,000 to successfully quit immediately. It has led to a 12 percent increase in quit attempts and prevented more than 17,000 premature deaths.
- ROI: \$480 spent per quitter with a \$2,800 return in premature death averted.

Immunization Grant Program (Section 317)

- \$324 million of funding from the Prevention Fund supports a vaccine safety net for uninsured people to receive all recommended vaccinations on schedule, up from \$210 million in FY 2015.
- Supports registries, surveillance, outbreak response, outreach and vaccine purchases and services.

Hospital Promoting Breastfeeding

- \$8 million from the Prevention Fund to support breastfeeding mothers and support hospitals in promoting breastfeeding.

State Public Health Actions to Prevent and Control Diabetes, Heart Disease, Obesity and Related Risk Factors and Promote School Health (“1305” awards)

- Provides \$33 million in funds annually to enhance key chronic disease prevention programs in all states and D.C.
- Supports cross-cutting approaches to prevent risk factors that contribute to chronic diseases.

State and Local Public Health Actions to Prevent Obesity, Diabetes, and Heart Disease and Stroke (“1422” awards)

- Four-year project to create community strategies to promote health and integrate with healthcare systems.
- \$69.5 million from the Prevention Fund given to 17 states and four large cities.

State Healthcare-Associated Infections (HAIs) Prevention Program

- \$12 million from the Prevention Fund supports coordination between public health and healthcare systems to reduce HAIs — helping to identify problem areas and improve prevention efforts.

Epidemiology and Laboratory Capacity (ELC) Grants

- \$40 million from the Prevention Fund supports improving a state’s ability to detect, diagnose and contain disease outbreaks.
- Supports cross-cutting advancements in surveillance systems, highly expert personnel and modern scientific equipment.

Million Hearts Campaign

- \$4 million from the Prevention Fund supports national initiative aimed at preventing 1 million heart attacks and strokes by 2017.
- Prevention activities focus on ABCS (aspirin, blood pressure, cholesterol and smoking cessation).

Alzheimer’s Disease Prevention Education and Outreach

- \$14.7 million from the Prevention Fund to expand specialized services and support adults with Alzheimer’s disease or related disorders.

Fall Prevention Grants

- \$5 million from the Prevention Fund aimed at evidence-based community programs to reduce falls, the leading cause of fatal and nonfatal injuries in seniors and adults with disabilities.
- Awards to 14 states and localities.

Garrett Lee Smith Youth Suicide Prevention Grants

- \$12 million from the Prevention Fund to expand program to 12 additional grantees for education, training, screening, hotlines and support services to prevent youth suicides.

Racial and Ethnic Approaches to Community Health (REACH)

- \$30 million from the Prevention Fund — \$50.05 million total — supports 39 grants for culturally-tailored, evidence-based strategies to reduce health disparities at the community level.

Good Health and Wellness in Indian Country (“1421” awards)

- \$11 million from the Prevention Fund for 22 grants to prevent and manage heart disease, diabetes and associated risk factors in American Indian tribes and Alaskan Native villages.

National Early Care and Education Collaboratives and Healthy Weight Taskforce

- \$4 million from the Prevention Fund supports collaboratives to promote children’s health by encouraging and supporting healthier physical activity and nutrition practices.
- Supports 1,200 programs across nine states.

Office of Smoking and Health

- \$126 million from the Prevention Fund to raise awareness and shift attitudes and beliefs in the harmfulness of tobacco use and in the exposure of secondhand smoke, targeting populations with the highest tobacco use.

B. STATE INVESTMENT IN PUBLIC HEALTH

State Public Health Budgets			
State	Nominal FY 2014-2015 (Not Adjusted for Inflation)	FY 2014-2015 Per Capita	Rank
Hawaii	\$224,753,616	\$158.3	1
Alaska	\$93,214,800	\$126.5	3
North Dakota	\$72,323,700	\$97.8	4
West Virginia	\$134,147,149	\$72.5	7
New York	\$1,874,587,954	\$94.9	5
Idaho	\$154,803,600	\$94.7	6
Alabama	\$287,264,301	\$59.2	8
Wyoming	\$33,068,221	\$56.6	9
California	\$2,182,461,000	\$56.2	10
Rhode Island	\$56,145,349	\$53.2	11
Massachusetts	\$335,705,756	\$49.8	12
Arkansas	\$145,412,143	\$49.0	13
Colorado	\$260,902,121	\$48.7	14
New Mexico	\$99,350,600	\$47.6	15
Tennessee	\$298,726,100	\$45.6	16
Vermont	\$28,181,164	\$45.0	17
Delaware	\$41,472,100	\$44.3	18
Nebraska	\$81,486,579	\$43.3	19
Maryland	\$237,627,036	\$39.8	20
Oklahoma	\$152,538,640	\$39.3	21
Iowa	\$120,929,906	\$38.9	22
Washington	\$269,800,500	\$38.2	23
Virginia	\$303,586,116	\$36.5	24
Virginia	\$303,586,116	\$36.5	24
South Dakota	\$30,362,138	\$35.6	25
MEDIAN \$35.77			
South Dakota	\$30,362,138	\$35.6	25
Kentucky	\$148,038,883	\$33.5	26
Utah	\$93,046,700	\$31.6	27
Connecticut	\$111,447,778	\$31.0	28
Texas	\$755,736,914	\$28.0	29
New Jersey	\$240,090,000	\$26.9	30
Oregon	\$105,442,057	\$26.6	31
Illinois	\$325,568,512	\$25.3	32
Michigan	\$239,432,700	\$24.2	33
Montana	\$22,679,943	\$22.2	34
Maine	\$28,852,183	\$21.7	35
South Carolina	\$100,480,255	\$20.8	36
Florida	\$402,412,648	\$20.2	37
Louisiana	\$92,493,577	\$19.9	38
Georgia	\$192,300,024	\$19.0	39
New Hampshire	\$20,944,920	\$15.8	40
Wisconsin	\$86,951,300	\$15.1	41
Minnesota	\$79,799,506	\$14.6	42
Pennsylvania	\$184,271,000	\$14.4	43
North Carolina	141941587	\$14.3	44
Ohio	\$159,705,848	\$13.8	45
Kansas	\$36,082,633	\$12.4	46
Indiana	\$81,746,582	\$12.4	47
Mississippi	\$36,065,124	\$12.0	48
Arizona	\$60,517,200	\$9.0	49
Missouri	\$35,679,606	\$5.9	50
Nevada	\$11,523,491	\$4.1	51
District of Columbia	\$91,997,000	\$139.6	2

Source: TFAH analysis. For a detailed methodology, see *Investing in America's Health* at www.healthyamericans.org

Every state allocates and reports its budget in different ways. States also vary widely in the budget details they provide. This makes comparisons across states difficult. For this analysis, TFAH examined state budgets and appropriations bills for the agency, department, or division in charge of public health services for FY 2013-2014 and FY 2014-2015 using a definition as consistent as possible across the two years, based on how each state reports data. TFAH defined “public health services” broadly, including most state-level health funding.

State funding ranges dramatically, often related to the different structures of a state’s public health department. Some departments are centralized, while others are decentralized wherein responsibilities rest more on local departments than at the state level. However, states and localities also place different priorities on public health, which also accounts for differences in funding. The state-by-state comparisons included in this report’s budget analysis do not include county or city revenues that are generated to support local health departments, which are also quite variable.

C. LOCAL INVESTMENT IN PUBLIC HEALTH

There are approximately 2,800 local health departments in the United States serving a diverse assortment of populations ranging from fewer than 1,000 residents in some rural jurisdictions to around eight million people, as in the case of the New York City Department of Health.²¹ Local health departments (LHDs) are structured differently in each state and may be centralized, decentralized or have a mixed function. Therefore, the level of responsibility and services provided by LHDs varies dramatically, and, correspondingly, the way resources are determined and allocated differs significantly. A 2014

NACCHO study found that median local public health spending was \$39 per capita in 2013 — up from \$30 in 2005, while funding ranged from less than \$15 per person in Connecticut, Indiana, New Jersey and Massachusetts to more than \$100 per person in New York and Maryland.^{22, 23} A July 2011 study in *Health Affairs* found that increased spending by local public health departments can save lives currently lost to preventable illnesses — increasing 10 percent of spending, for example, will significantly decrease heart disease deaths by more than 3 percent and infant deaths by almost 7 percent.²⁴

Effects Of Local Public Health Spending On Community Mortality Rates	
Mortality rate	Percent change per 10% increase in spending
Infant deaths per 1,000 live births	-6.85***
Heart disease deaths per 100,000 population	-3.22**
Diabetes deaths per 100,000 population	-1.44**
Cancer deaths per 100,000 population	-1.13**
Influenza deaths per 100,000 population	-0.25
All-cause deaths per 100,000 population	-0.29
Alzheimer’s deaths per 100,000 population	0.25
Residual deaths per 100,000 population	0.18

p < 0.05 *p < 0.01
Source: *Health Affairs*, 2011

Key Health Facts

ADULT HEALTH INDICATORS	U.S. Total	State with Highest/Worst	State with Lowest/Best
% Uninsured, All Ages (2014)	11.7%	Texas (19.1%)	Massachusetts (3.3%)
AIDS Cumulative Cases Aged 13 and Older (2013 Yr End)	1,201,247	New York (203,817)	North Dakota (210)
Alzheimer's Estimated Cases among Ages 65+ (2015)	5,426,300	California (590,000)	Alaska (6400)
% Asthma Prevalence (2013)	9%	Massachusetts (17.6%)	Texas (7.1%)
% Breastfeeding Exclusively at 6 Months from birth (2011)	18.8%	Mississippi (10.1%)	Vermont (29.6%)
Cancer Estimated New Cases (2015)	1,658,370	California (172,090)	D.C. (2,800)
Chlamydia Rates per 100,000 Population (2013)	456.1	D.C. (818.8)	West Virginia (254.5)
% Diabetes (2014)	N/A	West Virginia (14.1%)	Utah (7.1%)
Drug Overdose Deaths, Aggregate Crude Rates, Ages 12-25, All Intents (2011-2013)	7.3	West Virginia (12.1)	North Dakota (2.2)
Drug Overdose Deaths, Aggregate Rates, All Ages, All Intents (2011-2013)	13.4	West Virginia (33.5)	North Dakota (2.6)
Fruits per Day, % who met federal recommendations (2013)	13.1%	Tennessee (7.5%)	California (17.7%)
Human West Nile Virus Cases (as of 01/12/16)	2,060	California (730)	Maine & Oregon (73)
% Hypertension (2013)	N/A	West Virginia (41.0%)	Utah (24.2%)
% Obesity (2013)	N/A	Arkansas (35.9%)	Colorado (21.3%)
% Physical Inactivity (2013)	N/A	Mississippi (31.6%)	Colorado (16.4%)
% Pneumococcal Vaccination Rates, Ages 65 and Over (2014)	69.3%	Alaska (60.5%)	New Hampshire (76.1%)
% Seasonal Flu Vaccination Rates, Ages 65 and Over (2015)	66.7%	Wisconsin (57.2%)	North Carolina (76.8%)
Syphilis Rates per 100,000 Population (2014)	6.3	D.C. (17.9)	Idaho & Wyoming (0.7)
% Tobacco Use – Current Smokers (2014)	16.8%	West Virginia (26.7%)	Utah (9.7%)
Tuberculosis Number of Cases (2014)	9,421	California (2,145)	Vermont & Wyoming (2)
Vegetables, % who met federal recommendations (2013)	8.9%	Mississippi (5.5%)	California (13.0%)
CHILD HEALTH INDICATORS			
% Uninsured, under 18 (2013)	6.0%	Alaska (11.4%)	Massachusetts (1.5%)
AIDS Cumulative Cases Under Age 13 (2014 Yr End)	9,588	New York (2,443)	Wyoming (2)
% Asthma – High School Students (2013)	N/A	Hawaii (30.1%)	Nebraska (16.9%)
Fruit Indicator – % High School Students (2013)	N/A	Alabama (24.0%)	Utah (34.3%)
High School Dropout Rate (2011-2012)	3.3%	Alaska (7.0%)	New Hampshire (1.3%)
% Immunization Gap, Children Aged 19-35 Months Without All Immunizations (2014)	28.4%	West Virginia (36.6%)	Maine (15.3%)
Infant Mortality – Per 1,000 Live Births (2013 Final Data)	6.0	Mississippi (9.7)	Iowa (4.1)
% Low Birthweight Babies (2014 Final Data)	8.0%	Mississippi (11.3%)	Alaska (5.9%)
% Obesity – High School Students (2013)	N/A	Kentucky (18.0%)	Utah (6.4%)
% Obesity, 10 to 17 Year Olds (2011)	N/A	Mississippi (21.7%)	Oregon (9.9%)
% Pre-Term Births of live births (2014 Final Data)	9.6%	Mississippi (12.9%)	Oregon (7.7%)
% Tobacco Use – Current Smokers High School Students (2013)	N/A	West Virginia (19.6%)	Utah (4.4%)
Vegetable Indicator – % High School Students (2013)	N/A	South Carolina (9.7%)	New Mexico (17.5%)

Source: CDC. For a detailed list of references, see *Investing in America's Health* at www.healthyamericans.org

Recommendations

America's future economic well-being is inextricably tied to our health. High rates of preventable diseases are one of the biggest drivers of healthcare costs in the country. And, right now, Americans are not as healthy and productive as they could or should be to compete in the global economy.

The nation's public health system is responsible for keeping Americans healthy and safe. Public health is devoted to preventing disease and injury. If we kept Americans healthier, we could significantly drive down trips to the doctor's office or emergency room, reduce healthcare costs and improve productivity.

In addition to strengthening the core ongoing funds for public health, we need

to ensure the Prevention and Public Health Fund is used to build upon and expand existing efforts. The Prevention Fund is the nation's largest single investment in prevention, using evidence-based and innovative partnership approaches to improve the health of Americans. Without a strong investment in prevention, we will never advance in the fight to prevent diseases, curb the obesity epidemic or reduce smoking rates.





TFAH recommends that:

- Core funding for public health — at the federal, state and local levels — be increased;
- The first dollars of core funding should be used to assure that all Americans are protected by a set of foundational public health capabilities and services no matter where they live. For this to be accomplished, these capabilities must be fully funded, and funding should be tied to achieving and maintaining these capabilities;
- Funding be considered strategically — so funds are used efficiently to maximize effectiveness in lowering disease rates and improving health;
- The Prevention Fund should be fully allocated to support evidence-based and innovative approaches to improving the public health system and reducing disease rates;
- Stable, sufficient, dedicated funding should be provided to support public health emergencies and major disease outbreaks — so the country is not caught unprepared for threats ranging from Ebola to an act of bioterror — and is better equipped to reduce ongoing threats such as the flu, foodborne illnesses and the measles. Currently, inadequate and fluctuating resources, along with sequestration and budget caps, have left gaps in the ability to quickly detect, diagnose, treat and contain the spread of illnesses; and
- Accountability must be at the cornerstone of public health funding. Americans deserve to know how effectively their tax dollars are used, and the government's use of funds should be transparent and clearly communicated with the public.

Endnotes

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