

State Funding for Local Public Health: Observations From Six Case Studies

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The purpose of this study is to describe state funding of local public health within the context of state public health system types. These types are based on administrative relationships, legal structures, and relative proportion of state funding in local public health budgets. We selected six states representing various types and geographic regions. A case study for each state summarized available information and was validated by state public health officials. An analysis of the case studies reveals that the variability of state public health systems—even within a given type—is matched by variability in approaches to funding local public health. Nevertheless, some meaningful associations appear. For example, higher proportions of state funding occur along with higher levels of state oversight and the existence of local service mandates in state law. These associations suggest topics for future research on public health financing in relation to local accountability, local input to state priority-setting, mandated local services, and the absence of state funds for public health services in some local jurisdictions.

KEY WORDS: performance-based funding, public health finance, public health systems

Local public health agencies are the vehicle for delivery of essential public health services within states, with a large majority of them being entities of county government.^{1(p14)} Since state governments provide on average 23 percent of local health department (LHD) funding (excluding federal pass-throughs),² characteristics of the state-local relationship can reveal much about the resources and constraints affecting local public health services. Past studies have classified these relationships on the basis of administrative structure,³ le-

gal authority,⁴ and the relative proportion of state contributions to LHD budgets.⁵

At least six different methods have been documented to be in use by states to finance LHDs: a combination of per capita funding and activity-specific or staff-specific grants; negotiated contract for local services; formula incorporating variables of health status and financial resources of the local population; per capita distribution of state funds based on local population statistics; reimbursement of allowable expenditures for a preestablished set of services; and state funding for local agencies that are extensions of the state agency.^{6(pp422–423)} In addition, performance-based budgeting is a new but increasingly important management tool for states to use with local public health services.^{3,5,7}

The purpose of this study is to describe state funding of local public health within the context of state public health system types. The results of this analysis are intended to provide a foundation for further study of the financial implications of the state-local relationship for the local public health services.

● Methods

We developed case studies to describe state funding formulas for LHDs within the context of

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TABLE 1 ● Comparative overview of six case studies of state funding for local public health*

	Florida	Missouri	New Mexico	New York	Pennsylvania	Texas
State public health agency	Freestanding DOH	Within dual-purpose agency	A division of the DOH	Freestanding DOH	Freestanding DOH	Within a superagency
State-local relationship ^{3,4}	Centralized, top-down	Decentralized; bottom-up	Centralized; top-down	Mixed; hybrid	Mixed; hybrid	Mixed; hybrid
LHD type(s)	state-run & mandated, about one per county	Local-run, optional at county level	State-run & mandated, about one per county	Local-run & mandated, one per county	(1) state-run; (2) local-run with state grant; (3) local-run & funded	Local-run, optional, minority of counties
Mandated services	Yes—state provides	No	Yes—state provided	Yes—state funded	Yes—state funded in part	No
State contribution to LHD budgets ⁵	76%–100%	0%–25%	76%–100%	51%–75%†	25%–50%†	51%–75%†
Per capita allocations	Yes—subject to funding floor	One of several factors; no funding floor	No	Yes—subject to funding floor	Yes	No
State & federal grants	Competitive and noncompetitive	Noncompetitive	Noncompetitive	Competitive and noncompetitive	Competitive and noncompetitive	Competitive and noncompetitive
Performance-based funding	For specified services	Limited to contracts	Limited to contracts	Yes	No	Limited to contracts

*DOH indicates Department of Health; LHD, local health department.
 †Informants disputed this previously published estimate. See text for details.

administrative-legal authority, to validate or correct past reports, to document how the state health department receives local input, and to note whether jurisdictions receive state public health funds in the absence of locally governed LHDs. We selected seven states with various state-local administrative relationships that also represented different geographic regions and different past-reported proportions of state and local spending. Each case study was developed from statutes, Web sites, and previous publications, and was reviewed by a representative of the state health department. One of the seven states was eliminated when efforts to identify a state representative failed. All of the six remaining case reviews took place during March and April of 2006. An institutional review board determined that the case studies and official confirmations were exempt. Not included in the cases studies was information about Medicaid payments, Tobacco Master Settlement funds, and federal emergency preparedness grants since states vary considerably as to whether and how much of these funds are included in public health budgets.

● **Case Studies**

Table 1 summarizes the six case studies.

Florida^{8-10,*}

The Department of Health (DOH) is a freestanding agency whose head is a secretary appointed by the Governor. There are no state or local boards of health, but local interests are represented by 11 regional health councils whose boards are appointed by county commissions. Past studies characterizing Florida as having a centralized state-local administrative relationship³ and a top-down distribution of legal responsibility⁴ are confirmed. LHDs are statutorily partnerships between the state and each county’s board of commissioners. Local public health services are mandated: each county must provide the core services of public health (community health assessment, policy development, and assurance). County health department workers are state employees. Also confirmed is Florida’s classification as having a high state share (76%–100%) of the local public health budget.⁵ State funds are allocated annually to the LHDs in both categorical (restricted) and noncategorical streams and are typically distributed as a per capita allocation. The funding floor for each LHD is \$246,000 in noncategorical general revenue, \$123,500 for primary care, and \$40,000 for school health programs. Counties contribute some funding, and LHDs generate revenues

*P. Street, written communication, March 2006.

from grants. LHDs receive some federal block grants passed through the state, either competitively or based on disease-incidence data; most require no local matching funds. Funding for performance may be tied to service output data, such as the number of permits issued or the number of encounters provided, in selected programs such as Healthy Start and environmental health.

Missouri^{4,5,7,10-14,*}

The Department of Health and Senior Services (DHSS) is a dual-purpose superagency with a director appointed to the governor's cabinet. A board of health advises the director. The DHSS does not provide population-based services. Missouri's prior classification as decentralized^{3,4} is correct. State law permits counties to enact a property tax to support local public health, and these local governments directly operate a total of 114 LHDs independently from the DHSS. The majority of LHDs have an elected board of trustees, but others are governed by county commissions or councils. Missouri does have a low state share (0%–25%) contributed to local public health budgets.⁵ On average, LHDs in Missouri receive almost half of their revenue from local taxes and another 10 percent from other local funds; except that in small counties, the state proportion of funding is higher. Most LHDs charge fees for services to fund their local health programs. All counties receive DHSS State Core Public Health Functions Funds with allocations based on population levels, historical base funding, core public health activities funding, local resources, and a formula that assigns a numerical score to each county based on factors including poverty levels, collaboration with other public health providers, and tax revenue. The DHSS awards federal block grants by contract, the allocations of which are determined by indicators similar to those used for the Core Public Health Functions Funds. DHSS ties fiscal incentives to certain contracts and uses outcome measures for all contracts.

New Mexico^{7,14,15,†}

Public health functions are situated within a public health division under a director who reports to the Secretary of Health. The public health division administers five regions that operate approximately 53 local public health offices. Local interests are represented by recently created local public health councils, which currently number about 20. New Mexico's past classification as centralized administratively³ and legally⁴ is con-

firmed. State employees provide all core public health services at the local level, and there is generally one local public health office per county. As previously reported, New Mexico has a high state share (75%–100%) of the local public health budget.⁵ The budgets of local health offices are fully provided for by the state. Allocations are based on historical factors, with some recent modifications. Some counties operate and fund autonomous health departments to provide environmental services. Factors in the determination of federal block grant distribution among the regional and local offices include the number of people served and disease incidence-prevalence data. New Mexico uses performance-based funding for contractors (eg, for certain primary care services). Performance review processes are used for contracts, requests for proposals, and grants.

New York^{14,16,‡}

The commissioner of health is appointed by the Governor. A public health council with members appointed by the Governor and state legislature has health facility regulatory functions but is not a board of health. The DOH has a central office, four regional offices, three field offices, and nine district offices across the state. New York has, as previously reported, a mixed administrative³ and a hybrid legal⁴ relationship with its LHDs. There are 58 county health departments including that of New York City. Typically, large counties have a board of health and in smaller counties the legislative body may assume this function. The previous estimate of as having a moderately high state share (51%–75%) of state funds in LHD budgets⁵ is probably too high. Each county finances its own LHD, and a program called State Aid provides partial reimbursement for certain county programs. State Aid is nominally allocated at a per capita rate of \$0.55, but each county receives a minimum of \$550,000 (or \$406,000 if the state provides the county's environmental health services), and the three counties with over a million residents receive additional \$0.55 per capita funds. State Aid also reimburses counties for 36 percent of the additional costs of core services and 36 percent of optional services. Many state-funded grants—both competitive and needs-based—are available to LHDs and generally do not require local matching funds. Federal block grants are either passed through to counties or awarded competitively. Under a performance reporting system, the commissioner may withhold State Aid, in whole or part, if standards are not met.

*A. Lock, oral and written communication, April 2006.

†W. Wiese, oral communication, March 2006.

‡S. Pirani and M. Miller, oral and written communication, March 2006.

Pennsylvania^{14,*}

The Secretary of Health is appointed by the Governor. An advisory health board is also appointed by the Governor. The DOH administers six multicounty health districts, each led by a district executive director. Pennsylvania, as previously described, has mixed administrative³ and legal⁴ relationships with its LHDs, of which there are three types. First, in six counties and four cities, LHDs independent from the DOH are governed by local boards of health and qualify for state-matching grants to fund specified public health services. Second, the DOH operates a state health center in each county not served by a qualifying LHD. State health centers provide only clinical public health services and typically have only two to five staff members, so their respective district offices provide some additional services. Third, many boroughs, townships, and cities have locally governed municipal health authorities that are also independent from the DOH but that do not qualify for state funds. Pennsylvania's past classification as contributing moderately low state funds (26%–50%) to local public health⁵ is oversimplified: the actual contribution depends on the type of LHD. State health centers are funded entirely by the state. Municipal health authorities receive no state funds. The 10 qualifying LHDs receive state-matching grants of 50 percent of the costs for mandated personal health services up to a maximum of \$6 per capita, plus \$1.50 per capita for the optional environmental health services. Pennsylvania offers grants—competitive, needs-based, and population-based—which originate from both federal and state sources. The DOH uses performance management for contracts with outside vendors. For LHDs that qualify for state-matching grants, DOH annually determines how well community needs are met with state funds.

Texas^{5,17–19,†}

The Texas Health and Human Services Commission is a superagency whose executive commissioner is selected by the Governor. A nine-member state health services council is also appointed by the Governor. Within the commission, a department of state health services maintains public health offices in eight health service regions. Past studies are correct in characterizing Texas as having mixed administrative³ and a legal⁴ relationship with its LHDs. Localities are empowered by state law to create independent boards of health, and LHDs serve the majority of the population in urban and suburban

county, city-county, and multicounty units. State laws guide but do not impose mandates or minimums for LHD services. Most other (rural) counties have no LHD and are served instead by a state regional unit. Texas has been classified as having a moderately high state share (51%–76%) contributed to local public health budgets,⁵ but this may be based on outdated information. Currently, LHDs receive state and federal funds from the local public health services grant. These are noncompetitive grants having no requirement of local matching funds, which are renewed on the bases of funding history as well as past performance. The state also uses contracts to fund local public health services provided by both public-sector LHDs and private-sector entities. However, many LHDs in Texas operate entirely on locally derived revenues, either choosing not to duplicate existing programs or preferring to maintain local program control rather than be bound by state requirements. Performance is a factor in grants and contracts: failure to fulfill performance requirements carries the risk of nonrenewal.

● Analysis

In comparing case study states, the administrative-legal classifications have only weak associations with the funding of LHDs. The three case study states with “mixed” administrative relationships—New York, Pennsylvania, and Texas—were also quite different from one another in mandating LHDs and in funding them. LHDs in both Pennsylvania and Texas are optional under state law and independent both financially and administratively from the state health departments. LHDs in New York are required at the county level and are dependent on the state health department for oversight and a substantial proportion of their budgets. Florida and New Mexico, both centralized and both with high state contributions to LHD budgets, have different approaches to allocating state funds and a different relationship with local governments.

Patterns of state funding for LHDs do appear when considering other factors. For example, state-mandated public health services at the local level are associated with state payments for those services. This is evident when a state (Florida; New Mexico) directly provides mandated services or when a state funds services in whole or in part (New York; Pennsylvania). Also, a higher proportion of state funding for LHDs occurs with state employment of local agency workers (Florida, New Mexico, and Pennsylvania state health centers).

Funding used explicitly as either a performance incentive or, conversely, a with-hold for failure to

*M.S. Davis, oral and written communication, March 2006.

†R. Danko, N. Curry, M. Pharr, J. Lawson, P.F. Czepiel, oral and written communications, March 2006.

meet a performance standard is typically as a feature of contracts in the case study states. Only in Florida and New York is performance tied to the state's basic allocation to LHDs. Notably, both of these states have established policies and procedures to accommodate performance criteria.

In three of the six case study states there are local jurisdictions without locally governed LHDs. In Missouri, such jurisdictions do receive state funds for public health services, but in Pennsylvania and Texas, such jurisdictions may receive state services but funding comes only through grants and contracts rather discretionary allocations.

This study has two limitations. First, inferences for all states within any classification based on these observations are not appropriate. Second, only state health department officials confirmed the case studies, and local officials might interpret their states' financing practices differently.

● Conclusions

An analysis of the case studies reveals that the variability of state public health systems—even within a given type—is matched by variability in approaches to funding local public health. These case studies reveal some characteristics and associated features of local funding that can guide further research. First, they provide evidence that the degree of state oversight and the procedures used for oversight of local budgets and programs are related to funding levels. A more detailed study of relevant policies and procedures in all 50 states might reveal distinctive patterns of state funding and local accountability. Second, the case studies suggest an association between service mandates on LHDs and levels of state funding, which points to the importance of representing local needs and priorities at the state level, whether by local boards of health or regional advisory groups. Further research should document and compare the policies and institutions for this purpose as used by the various states. Third, state mandates for local public health services appear from these case studies typically to be funded mandates, an observation that should be confirmed among all 50 states. Finally, case study states differ as to funding in the absence of locally governed LHDs. Local jurisdictions may lack sufficient resources to meet population health needs without access to state funds for discretionary programs.

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