Local Health Department Funding Experiences

Developed by the Center for Public Health Systems at the University of Minnesota School of Public Health

Final Project Report

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Local Health Department Funding Experiences Final Project Report

Developed for the National Association of County and City Health Officials (NACCHO) by the Center for Public Health Systems (CPHS) at the University of Minnesota School of Public Health. CPHS was established in 2021 and has a core staff of talented practitioners, academic researchers, and collaborating faculty with diverse expertise from the University of Minnesota and other institutions. All are deeply committed to solving challenging problems and improving public health systems and outcomes. CPHS benefits from the University of Minnesota's ground-breaking and innovative environment that supports collaboration around issues of individual and population health.

CPHS Project Team

Project Director
Jason M. Orr, PhD, MPH

Project Staff
Hank Stabler, PhD, MPH Hawking Yam, MS Phillip Nguyen, BS

Contractors
J. Mac McCullough, PhD, MPH

Activity Experts and Support Staff
Rachel Schulman, MSPH, CPH
Sarah Trachet, CPA
Feather LaRoche, MTAG

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Introduction

The U.S. public health system is currently experiencing large shortfalls in necessary funds, and there is an urgent need to increase and sustain disease-agnostic funding to bolster public health infrastructure. The Trust for America's Health 2023 annual report *The Impact of Chronic Underfunding on America's Public Health System: Trends, Risks, and Recommendations*, states that "public health experts estimate an annual shortfall of $4.5 billion" that are essential for state and local health departments to provide comprehensive services in the communities they serve.[1] Health agencies in the United States disproportionately rely on funding from the Centers for Disease Control and Prevention (CDC), which, directly and/or indirectly, provides a significant share of funding to state and local health agencies to implement a range of public health programming. The CDC is composed of different centers, institutes, and offices (CIOs) that oversee their respective portfolios of public health programming. These CIOs are generally focused on specific public health challenges (e.g., chronic disease prevention) and/or advancing public health capabilities (e.g., immunizations).[2] For FY 2023, the CDC's core budget supporting the CDC's public health programming was $9.269 billion.[2] This includes the grants and cooperative agreements dispersed by the CDC to state and local health agencies across the country to support the nation's public health system.

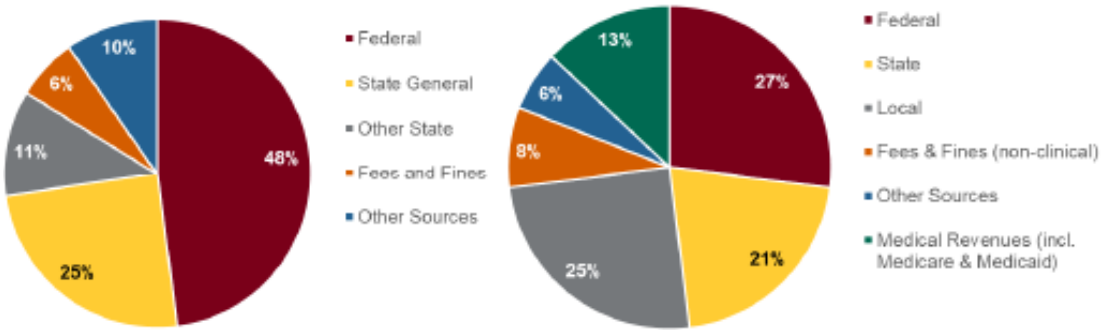
Currently, the CDC has two primary modes of funding: grants and cooperative agreements. Per their definitions, grants are a funding mechanism for providing "money, property, or other direct assistance" to support programming that meets a "public purpose."[3] A grant is also used when there is no anticipated need for significant programmatic oversight from the CDC. Cooperative agreements are financial arrangements to support approved programming, but unlike grants, also include regular communications with representatives of the CDC to ensure both the CDC and health department are well coordinated through the period of performance. Like other federal agencies, the CDC issues periodic notices of funding opportunity (NOFOs) during the 'pre-award' phase on grants.gov, the federal repository of funding announcements. Most of these NOFOs are competitive, meaning there is a requirement for potential grantees to submit an application that lays out their planned programming to meet the NOFO's stated goals and objectives, and which will be compared with other potential grantees' applications to determine which organizations are funded. Some NOFOs are noncompetitive, meaning a certain agency or organization has been predetermined by Congress to be the optimal awardee. Once funding is granted and a contractual agreement is made between the grantee and the CDC, there is an expectation that each grantee will follow the administrative requirements for managing the grant once they begin to draw down funds. These requirements, while often necessary, are sometimes onerous and may impede delivery of services. A prior series of case studies of local health departments discussed how characterizing funding requirements and synthesize learnings on LHDs' experiences delivering upon agreements and the impacts of facilitating and impeding requirements.[4] These case studies are available on the NACCHO webpage for Public Health Finance - Cooperative Agreement Case Studies.

The amount and distribution of overall funds available to governmental public health are of critical importance. Most federal funds are awarded to state health departments. While a few very large local health departments have some direct funding from the federal government, the vast majority of local health departments rely on their state to decide whether and how federal resources will be "passed through," or given to local health departments to support their work.

The average state health department receives approximately half of its funding from federal sources—via contracts, grants, and cooperative agreements—approximately a third of its funding from state sources, and the balance from other sources.[5] The average local health department receives approximately a quarter of revenues from federal sources (including direct awards and federal funds passed through the state), a fifth of funds from state sources (general fund and special revenue funds), a quarter of funds from local sources, and the balance from other sources.[6] The overall distribution of funds for state and local public health as of 2019 is illustrated in **Figure 1**. Funding streams and total amounts changed substantially during the COVID-19 pandemic as major additional revenue sources flowed into many state and local public health agencies. Pre-COVID-19 funding distribution data is used here to illustrate historical trends. Funding provided during the pandemic does not necessarily reflect how local and state health departments have traditionally been structured, or the types and amounts of revenues that may be available for health departments in the future.

Figure 1. General Distribution of State and Local Revenues (pre-COVID-19)

General Distribution of State Revenues, 2015(1) General Distribution of Local Revenues, 2019(2)



Sources: (1) ASTHO *Profile of State and Territorial Public Health*, Volume 4 (2017). (2) NACCHO's 2019 *Profile Study* Interactive Report (2020).

Public health has faced significant challenges due to unsustainable and unpredictable cash flow ("funding") and pressures to cut costs, which has led to a *reactive* approach to dealing with emergencies, rather than a *preventative* approach that works to mitigate or ward off emergencies. Federal funding ebbs and flows depending upon current events such as disease outbreaks; a vicious "boom and bust cycle." This has had significant ramifications for both state and local health departments. Because so much of local health agencies' funding comes from state agencies, they often must operate at the discretion of decisions made by state health agency partners; e.g., funding allocations decided by complex state formulas; decisions concerning the amount of funding the state agency needs to oversee a given grant or contract. Health departments have observed cuts over the past several decades across almost all revenue streams, from federal funding to state and local funding, to fee revenues from decreased clinical services. The pandemic led to an increase in short-term federal funding for state and local health agencies, such as the Public Health Infrastructure Grant (PHIG), which was meant to improve health agency capacity across three domains: data modernization, workforce development, and foundational capabilities.[7] However, programs like PHIG are time-bound, with one-time federal investments in workforce and annual appropriations needed to

continue investments in data modernization and foundational capabilities. The CDC may face further cuts to its annual budget appropriations, which, in conjunction with the sunsetting of other COVID-era funding, could have significant effects on federally supported health agency capacity. Funding from state governments is critical to guarantee minimum service levels, support collaboration and coordination of governments, or to shore up critical gaps in service delivery.

Adequate funding for public health services influences the public's health, and studies have suggested that public health expenditures are related to improved outcomes; for example, a 10% increase in per capita public health spending may decrease mortality rates by up to 7%.[8] Critical public health services are not consistently nor comprehensively available to all residents of the U.S., leaving the system unable to protect and promote the health of residents. While perhaps unintended, this is a result of policy choices over decades by federal, state, and local governments. For most residents, this is also likely the case: where you live matters. The COVID-19 pandemic presented a stark example of the impact of these policy choices. Governmental public health systems seek a solution for this chronic and widespread underfunding; however, they alone do not have agency to correct it. In 2012, the Institute of Medicine (IOM) produced a comprehensive report, *For the Public's Health: Investing in a Healthier Future,* which found there was a mismatch between health spending and desired health outcomes.[9]

The report also acknowledged that "the allocation of public health spending also is not commensurate with need or with achieving the greatest value: conditions responsible for the highest preventable burden of disease are considerably underfunded."[9] It also suggested that funding for public health services should be part of the solution, suggesting that public health can "bend the curve" on health risks, to decrease the need for clinical healthcare while improving health outcomes.[9] There exists the potential to enhance flexibility in federal or state grants and allow unspent award funding to be allocated towards local priorities, once deliverables are successfully completed. This approach may also include consideration of bonuses similar to those offered in the private sector. However, that might require support from local policymakers and the need to prevent those unspent award funds from being directed into the local general fund.

These measures aim to address issues of inflexibility and inadequate funding in cooperative agreement funds while promoting transparency, local input, and efficient resource allocation to better serve community health needs.

Purpose

The aim of this project was to host informal discussions with local public health representatives to better understand funding mechanisms available to them and their experiences with those funding mechanisms, including health departments receiving direct awards from the CDC and indirect awards via pass-through entities, such as state health departments and third parties. These discussions were to be informed from existing knowledge of local public health challenges and opportunities, such as those described above. Common themes and notable findings were to be extracted from those discussions that may inform learnings and key recommendations for policy and practice.

Methods

We selected nine local health departments that represented differing perspectives; for example, differential patterns of CDC funding, located in different geographic locations, serving populations of different sizes and demographics. We then conducted semi-structured, informal discussions with available staff from those local health departments, including senior executives, financial officers, and program supervisors. In lieu of a structured interview protocol, we utilized an informal interview format that allowed participants flexibility in their responses. Discussions progressed organically, with no prescribed approach nor pre-determined questions. Through these discussions, health department staff shared their experiences and perceptions regarding different funding mechanisms, notable challenges and opportunities associated with funding, impacts or implications related to funding, and any notable lessons learned. Discussions also afforded recommendations for federal, state, and local level stakeholders about opportunities to overcome and manage challenges, and suggestions related to funding programs, infrastructure, and core capabilities.

Each discussion was approximately one hour in length, with the option for follow-up sessions, and offered local public health practitioners an opportunity to share their priority insights. With consent, interviews were recorded by the Zoom communications platform for research purposes. Recorded interviews were transcribed, and original media and transcriptions were loaded into NVivo 12 Plus to identify common themes. A coding infrastructure was developed to classify participant statements related to experience with different funding sources, contractual requirements, grant management activities, interviewee recommendations to change funding or requirement paradigms, and other topics. Key themes were identified from perspectives shared across the nine participating health departments.

Results

The nine participating health departments represented a diverse cross-section of health departments across the nation that included six of ten U.S. Department of Health and Human Services (HHS) regions; a mix of departments serving fewer than 50,000 persons (2 LHDs), 50,000–500,000 persons (5 LHDs), and more than 500,000 persons (2 LHDs); decentralized or largely decentralized governance (7 LHDs), centralized governance (1 LHD), and shared governance (1 LHD).

Context and Background of Participants

The funding mix and proportions of federal funds received by the participating health departments varied widely, ranging from less than a quarter of the budget to greater than ninety percent of the budget. In terms of their perceived financial situations, participants felt that critical services were under-funded and were generally pessimistic about the future, recognizing that more recent resource gains, such as crisis funds for COVID-19 and PHIG workforce dollars, are not likely to last. Several participating health departments discussed their state's statutory "aid-to-local" funding formula, which dictated how the state distributed federal and state funds to locals. Though the formulas differed somewhat between states, each formula established how that state's annual allotment may be distributed, such as providing each jurisdiction with an equal amount of "base" funding plus a distribution of remaining

funds according to population served. Several participants noted that their states' funding formulas were devised decades earlier and had not been revised, even as the public health landscape shifted. Some funding formulas, and certain state or federal funds, required a matching contribution from the local jurisdiction as a condition of receiving the funding, such as some recent U.S. Department of Agriculture awards requiring a 20–25% local match.

All participating local health departments reported receiving federal funding. Most participating health departments described the majority of federal public health funding being subawarded to their agencies, typically coming through the state health department. Additionally, most participants described a strong reliance upon funding from the CDC, with several participants indicating that they were almost entirely reliant upon federal awards or subawards, which often fully funded entire local public health programs. Grants directly awarded by the CDC to a participating local health department were rare and more likely for larger health departments that served more persons in their community. Participants also reported large differences in typical state or local investments in public health. Respondents from one state noted that there were little to no state funds provided to any local health departments in that state, whereas others described some core investments by states. One respondent discussed how, following the dissolution of a local hospital, an endowment was created from those assets and earmarked for indigent care and public health. Those funds had been used as flexible dollars to supplement gaps and assure services in the face of funding constraints. However, the endowment will be depleted within the next decade and the local health department has begun contingency planning. Several participating health departments desired more direct awards, though they were not eligible for them. Notably, nearly all respondents discussed—without being prompted by discussion facilitators—receiving federal awards passed through NACCHO and each described the process favorably.

Key Findings

Following discussions with the nine participating local health departments, some key observations were made by participants:

- Most participants felt that critical services were under-funded and were generally pessimistic about the future.
- Most participants relied upon CDC funding; several participants indicated being almost entirely reliant upon federal funding.
- Nearly all participants (unprompted) discussed receiving federal awards passed through NACCHO, with favorable processes.
- Many participants favored block grants and other grants (e.g., Public Health Infrastructure Grant, COVID-19 Health Disparities grant) that allow substantial flexibility for local priorities.
- Very few awards consider factors such as inflation or cost increases over time, which leads to substantial funding gaps while being required to achieve similar objectives.
- Blending or braiding multiple related funding streams or consolidating terms and conditions sometimes resulted in confusion, lacking clarity on requirements, and discordance at the state health department.
- Participants also noted challenges inherent with the expectations of maintaining the same level of services despite reduced funding.
- There are restrictions associated with certain awards, which may impede local public health objectives.
- Multiple participants noted instances of distrust with state health departments due to lack of transparency and coordination with local public health.
- Participant experiences with direct awards by the CDC were favorable overall, though most participants had few or infrequent opportunities to receive direct awards.

Recent History and Financial Changes

Participants discussed some positive experiences related to funding, such as new or increased funding. They described a general favorability of awards that allow local flexibility in decisions related to activities or spending to achieve local objectives. Participants favored block grants as well as the PHIG, COVID-19 health disparities grant, and Build Higher grant as offering substantial local flexibility for local priorities. Participants also described accessing new funding opportunities, such as funding available through NACCHO, that were preferable over direct CDC awards and receiving funds through the State. Participants discussed how new funding allowed for expansions of services able to be delivered, such as new community health education initiatives.

Multiple participants described substantial challenges related to stagnant or decreasing funding over time. While multi-year awards were preferred by all participants, almost none of those awards consider factors including inflation or cost increases, which leads to substantial funding gaps over time while being required to achieve similar objectives. For example, one participant described receiving level funding for their immunization program over the past two decades which covered less and less staff time each year. Nearly all participants shared the need to maintain or grow levels of services while receiving the same dollar amount as received in previous years (or less), while costs increase each year. Respondents identified additional challenges for health departments that may compete against local clinical partners for services or against other health departments for competitive funding opportunities. These losses, in turn, led to the discontinuation of services due to their being unable to compete with other agencies.

Participants described general declines in resources over many years, both due to losses in funding and stagnation of funds as costs grew. These declines then led to corresponding decreases in their ability to provide services. Several participants noted decreases in staff, with one local health department losing approximately 40% of their staff over a decade ago, with no ability to regrow. In recent years, however, many respondents noted improvements in financial status, albeit short-term. Crisis funding related to the COVID-19 pandemic and flexible funding made available through health equity and public health infrastructure grants, as well as other new funding, were viewed favorably and allowed for capacity building. For example, several participants noted creating new programs or services or expanding existing services such as HIV and AIDS prevention programming due to new funding.

Respondents noted the myriad implications associated with reduced or stagnant funding. Among some respondents, general declines were reported such as staff departures due to organizational changes or separations of employment. General declines are also seen in financial resources, such as some losses of federal grants or reserve funds. For example, one county was previously served by a multi-county health department that was joined with an FQHC but, following a dissolution, became a sole-county health department without access to the other organization's resources. Multiple participants described insufficiency in necessary resources, such as inadequate space for staff (e.g., offices, clinical spaces) or inadequate space for storage (e.g., vaccines, supplies).

Challenges Associated with Funding

There was agreement among participants that there is a general insufficiency in public health funding, at least with respect to achieving objectives expected of those funds. Participants reported consistently facing challenges related to insufficient and unstable funding, which limited their ability to hire and retain staff, support programs activities, and deliver services. Participants disclosed multiple challenges related to sustaining funding, such as inadequate and unpredictable funding, insufficient support from state and federal partners, and constraints that limited coverage of program activities. A commonly identified issue was that grant funding often did not account for inflation or cost changes over time, often impeding coverage of long-term employee salaries. Multiple participants discussed how insufficient funding led to staff shortages and shortfalls; this was then compounded when there was insufficient funding to hire, such that vacancies persisted. In certain instances, salary increases regrettably led to layoffs or changes in services. These issues were exacerbated by a lack of dedicated resources and difficulties in retaining qualified staff due to funding instability or insufficiency.

Participants also discussed barriers they had faced when seeking new funding, such as limited capabilities related to applying for new funds, eligibility concerns (e.g., inadequate population size), and a perceived bias from funders towards larger departments. Many participants did not have dedicated grant writers, though several felt they may be valuable additions to their departments to afford them the capability to apply for new funding.

Participants discussed experiences when different federal and state funds were blended or braided together, though several participants noted that it was not always clear when the State had combined funding or what effects resulted from those activities. While blending or braiding multiple related funding streams into a single award or consolidating terms and conditions was believed to be more efficient and effective than needing to manage separate funding streams, participants noted that doing so sometimes resulted in confusion, lacking clarity on requirements, and discordance at the state health department. Receiving a single award of blended or braided funds did not always mean there was a single program or a single project officer at the state health department, and several participants described instances of requesting assistance from the State, which involved separate programs and sometimes conflicting guidance or requirements between those programs.

Participants also noted some logistical issues associated with blending and braiding, such as complexities in timelines and insufficient time to complete projects. Participants were also asked about whether state health departments or any other pass-through entity layered on additional terms and conditions for local health departments beyond that included in the agreement between the CDC and the pass-through entity. Several participants noted that they were not aware of or could not distinguish add-on requirements from terms and conditions that originated from the CDC. Some participants did note certain onerous add-on requirements, such as multiple layers of bureaucracy and administration for receiving approvals or agreement modifications.

Due to funding insufficiency and other challenges, there were many implications for agency operations. Participants described facing different operational challenges, including the need to hire inexperienced staff and difficulty attracting skilled professionals. These financial limitations required participants to strategically approach business planning and be adaptable to manage resources effectively. Participants from smaller health departments struggled with

staff shortages and vacancies, partly due to funding issues, which impeded offering competitive salaries. This also resulted in certain staff being overloaded with responsibilities and wearing multiple hats. Participants also noted challenges inherent with the expectations of maintaining the same level of services, despite reduced funding. However, multiple participants shared how reduced funding led to reductions in services, sometimes at the detriment to communities and persons in need. As described by one participant:

"We rely on [funding], I would least say 99.9%, because if these, if the funding source go away, so will the resource, and so will the programs."

Experiences with Awarded Funding

Participants described general experiences with the awards they received, irrespective of whether received through direct awards or passed through. The focus of discussions was funding provided by the CDC, but some other experiences were notable. Participants agreed that certain grants were much more flexible in use of funds or activities. In particular, the PHIG and Health Equity grants* allowed use of funds for locally important activities (e.g., trainings, consultation, general supplies, refugee or parolee services), supplies, and equipment. Grants such as the REACH grant and Immunizations and Vaccines for Children grant were viewed favorably toward achieving local priorities such as community health improvement plan activities. However, there were sometimes restrictions associated with certain awards, which impeded local public health objectives. For example, crisis funds for COVID-19 allowed for a variety of participant's necessary expenditures but disallowed others. For example, some early FEMA crisis funding did not explicitly allow for testing kits to be purchased, which was discovered much later at the time of audit and required repayment. Lastly, certain grants provide uniform funding across jurisdictions, but needs may not be uniform, leading to resource shortages and excesses. Participants noted that these limitations each contributed to situations where grant funding may have been available locally but could not be directed toward critical priorities—priorities which may arise or change within a funding period.

Receipt of direct awards was rare among participants, typically available to few beyond the largest agencies. One participant who had experience with direct awards felt that the terms and conditions of those grants were typically more flexible than awards passed through their state and that CDC program officers were more receptive toward making necessary modifications to agreements. Respondents felt that, overall, reporting requirements for direct awards were easier than those through the State. Several respondents noted, however, that reporting portals made available by the CDC may differ by grant or program and may be more challenging to navigate or use.

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* The federal cooperative agreement titled "*National Initiative to Address COVID-19 Health Disparities Among Populations at High-Risk and Underserved, Including Racial and Ethnic Minority Populations and Rural Communities Funding*" is commonly referred to as the "COVID-19 Health Equity grant" or "Health Equity grant."

Though participants noted a lack of trust when working with their state health departments, participants agreed that terms and conditions from the State were generally favorable. There was also an acknowledgement that state health departments, as recipients of federal awards and charged with administering and subawarding those funds, have necessary roles and obligations, some of which arise from terms and conditions of those awards. However, it was noted by multiple participants that it may be challenging to modify an agreement with the State because there may be different offices or departments involved, or even the CDC.

Experiences with Funders

Participants were decidedly more mixed in their opinions when describing their experiences with receiving indirect funding. Participants had mixed experiences with their state health agencies, many predicated on how well their states shared power and resources, communicated, and were able to work together. Participants reported many positive experiences in working with state health departments, including building strong relationships with local public health during COVID-19 or through the Overdose Data to Action (OD2A) program. Respondents recognized the necessary role of state health departments in receiving and subawarding federal funding as well as facilitating programmatic activities. They also generally agreed that state health departments enhanced local activities and offered some consistency across the state. A key benefit shared by participants pertaining to federal awards passed through state health departments is that local health departments can discuss those grant activities and issues with partner jurisdictions. Those agencies receiving direct awards from the CDC are far fewer and are rare for partner jurisdictions in a state to each receive direct awards that may be discussed.

However, participants also noted some stark contrasts with this and described instances where working with the State was challenging; these issues were noted primarily by the local public health participants from decentralized state-local governance paradigms. One notable issue described by multiple respondents was that the state health departments often disregard local public health when deciding upon workplans for funding distributions. More broadly, respondents expressed much distrust in state health departments' lack of transparency and coordination in decisions related to uses and distributions of funding. Participants shared frustrations in not being allowed to view the proposals or terms and conditions of the federal awards that local public health are bound to when receiving subawards. One participant described how their state health department decided to keep overdose prevention grant funds at the State and not distribute them locally, which led to a loss in overdose prevention services across the state. Several participants felt that local public health was at the bottom of the public health power structure, which became a source of frustration.

Additionally, multiple respondents described frustrations related to the PHIG, in that their state health departments did not work with local public health when developing the State's PHIG proposal, nor did the state health departments share workplans and objectives with local public health, leading to mistrust and consternation. Relatedly, several respondents shared concerns with the lack of transparency in how their state health departments expended funds received for PHIG, including decisions on distributing to local public health. Lastly, a participant from a state with shared or mixed state-local governance noted the benefits of having local employees as extensions of the State but that there were resultant compensation equity issues, such as when a State-supported hygienist working in a county received a substantially higher salary than a locally supported hygienist.

Participants also shared experiences in receiving federal funds through third-party organizations, notably NACCHO. Absent any prompting, most participants described receiving subawards from NACCHO. These experiences were overwhelmingly positive, and participants discussed having good working relationships with NACCHO staff. Those participants agreed that the NACCHO staff appeared to be more knowledgeable and supportive than other funders, often having a better understanding of local public health issues and needs. One participant exemplified this feeling:

"I think I just would reiterate that the funds… that we have received through [NACCHO], and those that come directly from CDC have been really user friendly. I said that before, and I mean that both in the financial management of them, but also in the application for program changes."

Most respondents were generally positive when describing their experiences with receiving direct funding from the CDC. Several respondents described their perceived flexibility in use of directly awarded funds; though, the awards directly received may have been more flexible than other awards, such as those received to address the COVID-19 pandemic. Participants viewed their relationships with CDC program officers to be positive and supportive, more so than in their relationships with the state. Experiences with the CDC in direct awards were favorable overall, though most participants had few or infrequent opportunities to receive awards directly from the CDC. Participants did not note any other third-party funders.

Discussion

While the nine respondents were not nationally representative, the perspectives and experiences of the participating health departments are likely shared by other local health departments in the country. Many health departments have negative perceptions toward their current financial situations and future outlooks. Stagnation of funding or loss of funds appear commonplace in contemporary public health.

Contemporary public health financial statuses are both highly variable and highly volatile, at present. Local public health agencies are simultaneously under-resourced and possess excess resources that are challenging to expend. Governmental public health has seen substantial losses in funding, both due to cuts or changes in funding priorities and in stagnant funding paired with rising costs. These challenges have undercut public health infrastructure and resiliency. As noted in the Introduction, public health has often seen "boom and bust" cycles of funding, rather than stability in resourcing.

In the past several years, substantial additional funding has been made available, both related to the COVID-19 pandemic and through capacity-building awards such as the health equity and public health infrastructure grants, which had been asked for by local public health. While those awards have allowed for more flexibility than other federal awards, there still exist restrictions on the uses of those funds. For example, some health departments possess crisis funds earmarked for responding to COVID-19, but are facing other public health challenges that require more immediate resources and attention. However, the existing funds may not be flexible enough to support those needed activities. Reforming categorical or siloed funding

structures may encourage more flexible and braided funds from governments and robust grants from public and private partners.[9] These solutions are neither simple nor quick, but may need longer-term, strategic initiatives with broad support.

Much funding available to local public health, such as federal pass-throughs, state directed dollars, and local funding, have been stagnant for decades while costs have increased substantially; the value of public health investments has generally decreased over time. This has led to substantial erosion of public health infrastructure and has allowed for various funding gaps to fester and vital public health services to atrophy. Compounding these issues of chronic underfunding of governmental public health are fragmentation and instability—"dys-funding"—associated with preventable mortality, increases in disease frequency and severity, and hindered social and economic growth.[10] Similarly, a common barrier to delivering high-quality services is the categorical nature of funding streams (i.e., associated with specific diseases, health conditions, or other priorities), which may also be characterized as "rigid" or "siloed," referring to the limited or specific purposes of funding.[9] The funds, however, are ubiquitous and have differing impacts on local health departments and public health services. In an ideal world, local and state priorities influence one another (e.g., the work that locals do contributes to achievement of state strategic priorities, or the state sets its priorities based on local level issues and provides locals with funding to address them).

As shown in **Figure 1**, state and local public health receive revenues from a variety of sources. Local public health typically receives a more diverse mix of funding, including funds from the state health department. The share of federal funding, as a proportion, differs widely across the nation and within states. As each state government makes its own decisions on if and how much state and federal funds may be distributed to local public health and how those funds may be distributed, there is little national consistency in state-to-local funding paradigms. In part this may reflect the diverse range of state public health governance. But also, there has been no standard model or method in place for designing public health funding formulas or their elements, at any geopolitical level. Local health departments can make improvements toward service delivery and financial health through the diversification of funding streams and revisiting financial structures.[11,12] As the CDC and other federal agencies do not have the capacity to directly award all governmental public health jurisdictions, it is commonplace for state health departments to be in the position of receiving those direct awards and then subawarding funding to local health departments. Discussions with participants afforded varied positive and negative perspectives on working with the state health department to receive federal funds passed through.

Though many formula-based allocations have a primary component for population size or need, there are multiple elements of funding formulas that support activities for fluctuating needs, such as for disease investigation and regulatory or enforcement activities. Research has shown that successful formulas have elements with inputs that are "simple, stable, available and timely, logical, and broadly and equitably representative of need."[13] States do not have to use funding formulae to distribute resources to LHDs and can directly appropriate funds to specific jurisdictions or facilitate competitive award processes. And state health departments, due to routinely receiving federal funds to be subawarded, have experience with developing or coordinating data reporting systems and local workplans.

Notably, administrative requirements play a role in the perceived flexibility of awards and achievement of objectives. The focus on the present project was on experiences related to different funding mechanisms and not challenges associated with grant requirements, nor

how state governments may create add-on requirements, but many participants discussed difficulties in achieving grant objectives due to the presence of different terms and conditions. Separately, most participants reported positive experiences of receiving subawards through NACCHO, as a third party, and described positive experiences related to both grants management and project support. Additional evidence for local public health experiences with grant requirements are available through case studies made available through NACCHO.[4]

There is often no recourse for local public health when a state health department makes decisions with adverse consequences for local jurisdictions. Local public health generally has no opportunity to engage with the state health department when the state applies for funding nor in devising workplans or funding distribution schemes for state awards. Though less commonplace than state health departments, third party funders that may subaward federal funds to local health departments are not uncommon. Many states have engaged with third parties to support local public health objectives. For example, the state of New York leverages its local public health association, the New York State Association of County Health Officials (NYSACHO), and other partners such as the S2AY Rural Health Network and Health Research, Inc. to facilitate and subaward federal funds.[14] It was unexpected that multiple participants would volunteer that they had received federal funds through NACCHO. Participant experiences with a third party, such as NACCHO, illustrate that there may be opportunities for alternative intermediaries for public health funding.

Recommendations

The following recommendations were offered by participants, with statements refined and rephrased by project team members. The recommendations are not exhaustive but represent the key concerns of interest to the participating local health departments.

Recommendations for Local Public Health

1. **Prioritize developing a strong grants administration infrastructure, including hiring experienced grant writers and procuring a grants management system.**

   To maintain adequate diversification of revenues and sufficient funding, local health departments need to pursue additional funding opportunities and provide sufficient resources toward those ends.

2. **Find a programmatic focus area and apply for multiple grants in the same area, prioritizing awards with longer periods of performance (e.g., three-year grants).**

   Many health departments have found success in dedicating time toward procuring a diverse portfolio of funding for specific programmatic areas with sustained investment.

Recommendations for Funders

1. **Pass-through entities (e.g., state health departments) should disclose all relevant proposals, award terms and conditions, and workplans with local health departments sub-awarded to carry out work.**

   Many local health departments experience a lack of trust and difficulty perceiving objectives when not being fully apprised of the scope and scale of objectives and clarity on their role.

2. **The CDC and their recipient pass-through entities (e.g., state health departments) should work to clarify and align reporting such to create efficient and effective processes.**

   Local health departments presently face numerous information systems, reporting cycles, and duplicative entry as a result of receiving awards from many separate funding streams and involving terms and conditions from both the CDC and the pass-through entity.

3. **The CDC and their recipient pass-through entities (e.g., state health departments) should work toward providing longer-term award cycles that may allow for better consistency and economy of scope.**

   Some federal grant programs, or their administrations by recipient pass-through entities, lead to short award cycles for local public health (e.g., one year or shorter) which requires repeated administrative activities and may impede long-term or sustained objectives; three- to five-year awards are preferable for local public health. State health departments should also be planful in forecasting local public health application and awarding timeframes with respect to State award timeframes.

4. **The CDC and their recipient pass-through entities (e.g., state health departments) should work toward allowing reasonable increases in funding over time and reasonable modifications in response to situation changes.**

   Local public health faces substantial difficulties toward delivering upon grant objectives when funding may be flat or decreasing over time and costs increase. Additionally, public health situations may change rapidly and may require similar flexibility toward responding rapidly with adequate resources.

5. **The CDC should work toward producing awards that allow for local flexibility in use of funds and prevent pass-through entities (e.g., state health departments) from creating add-on requirements.**

   Local public health experiences with contemporary grants such as the health equity grant and the public health infrastructure grant illustrated the power, favorability, and effectiveness of allowing local flexibility in decision-making while avoiding additional onerous requirements created by state health departments.

6. **Federal and state governments should identify non-financial resource supports that may benefit local public health activities.**

   Some non-financial resource supports can be extremely helpful, such as access to scholarly journals and other materials and discounted software (e.g., SAS). This avoids delays or workarounds to access information or services that are needed by practitioners.

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