



INVESTING IN OUR LOCAL HEALTH DEPARTMENTS:

HOW OUR FUNDING DECISIONS TODAY
WILL DETERMINE CALIFORNIA'S FUTURE

JUNE 2020

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INTRODUCTION

“The health emergencies of the past year—from flooding to wildfires, vaping-associated lung injuries to the novel coronavirus (COVID-19)—are a stark reminder of the critical importance of a standing-ready public health infrastructure and workforce. Such a public health system requires adequate and sustained funding”

— Trust for America’s Health²

People know what it means to go to the doctor when they get sick, yet many are unaware that there is a less visible workforce protecting their health before a trip to the doctor is ever needed. Public health touches every aspect of our day, from the water we drink to the air we breathe. When all is well, public health professionals are largely invisible, but now, amid COVID-19, many are learning what public health means for the first time and why having well-resourced public health departments is critical to keeping communities across California safe and healthy.

Our local health departments (LHDs) are like firefighters on the frontlines in providing essential services in the communities they serve, such as organizing testing, collecting data on health outcomes, creating nutrition and active living programs, and more. LHDs work year-round to address the social factors that touch our lives, like access to safe and stable housing, increased food security, and expanded employment opportunities. They also work to build authentic relationships with community members and community-based organizations, which makes them key partners both immediately during a public health emergency like COVID-19, and long-term as we work toward a just recovery.

We don’t expect our fire departments to fight fire without water, and yet, because of budget decisions by political leadership at all levels, we are expecting our local health departments to protect the public’s health without the critical resources that they need. Almost all funding sources for local health departments have been declining at the same time that public health threats are growing. LHDs are consistently underfunded and, even now, during the worst pandemic in our lifetimes, are facing further funding cuts. Under-resourced, dedicated public health workers are putting in long hours to address the COVID-19 response, while departments are understaffed, and challenges are swelling. Our public health systems are woefully unprepared to address future challenges lurking around the corner, including wildfires and extreme heat threats, rising rates of chronic and communicable diseases, and persistent health inequities.

This lack of preparedness undermines the ability of local health departments to keep communities safe and healthy during times of crisis, especially low-income and communities of color who will bear the disproportionate burden of future public health and climate emergencies. Centuries of historic disinvestment and structural racism

made low-income and communities of color more susceptible to the impacts of COVID-19 and continue to leave them vulnerable to future challenges. We know that racism is a public health crisis, and local health departments have been leaders in advancing health equity by collecting disaggregated data at the local level, advancing policy changes, and developing targeted interventions to close the race life expectancy gap. This work has become increasingly hard to do with diminishing resources and increasing public health and climate threats. Not all local health departments have resources for full-time health equity staff members or for widespread data collection and dissemination. Recent events have amplified the need to reform our systems even more. Yet our public health systems are not adequately funded to address these inequities. Most local health departments also do not have dedicated staff to work on climate change, despite *The Lancet* calling it the “biggest global health threat of the 21st century.”¹

Inadequate funding for our local health departments is a grave threat at a time when the essential services that our public health system provides are absolutely critical. We can focus on fixing the deficiencies and securing a better future, or we can continue de-prioritizing the lives of those most impacted by inequities. Public

health has a compelling vision—communities where everyone can live to their full potential, where people have enough stability in their work, homes, schools, and environment to enjoy life, and where we come together to ensure no one is left behind. What is needed during COVID-19 and beyond is a fierce call to action for rebuilding and strengthening our public health systems at all levels, especially at the local level where city and county health departments are working on the frontlines, ensuring the health and safety of the most impacted communities.

This brief explores the important role local health departments play in keeping us safe and healthy and explains how years of funding cuts to public health left us vulnerable to a public health emergency like COVID-19. It concludes with a bold vision for funding more robust and resilient local health departments. We define a call to action to invest in our local health departments, with proposed strategies to ensure they have the resources needed to respond to both future public health emergencies, and the everyday needs and essential services of the communities they serve. We have more knowledge than ever about successful ways to ensure that everyone in our communities has the opportunity to live full, healthy lives, but we need the political will and flexible funding to make it a reality.



WHAT DO LOCAL HEALTH DEPARTMENTS DO?

Local health departments (LHDs) are responsible for protecting the health, safety and general welfare of the residents within their jurisdictions. They are closer to the ground than the federal and state government, and by working with community partners, understand the unique local community conditions, historic inequities, and needs better than most other government agencies.

Because LHDs work to support the optimal public health of the population, they are often focused on addressing disparities so everyone has the opportunity to be healthy. This means LHDs are also at the forefront of advancing health equity, or addressing the root causes of poor health. They move “beyond the clinical walls” with investment in community-based initiatives to improve non-clinical, yet health-related factors, such as racism, transportation or neighborhood safety, and the cross-sector partnerships supporting these non-traditional health interventions.³ As a result, investments in LHDs are investments in the communities themselves. Research shows that health departments with a strong commitment to health equity have high-quality, adaptive leaders and “seem to be better equipped to prioritize programs and policies, use descriptive epidemiology and disease surveillance, conduct multiple types of evaluation, communicate with different stakeholder groups in different ways, and use evidence-based decision making” compared to their colleagues with weaker commitments to health equity.⁴

In California, there are 61 local health departments — 58 at the county level and three at the city level (Berkeley, Long Beach, Pasadena). LHDs provide a broad menu of core public health services, including the 10 Essential Public Health

FIGURE 1

What are the Essential Public Health Services provided by Local Health Departments?

1. Monitor health status to identify and solve community health problems
2. Diagnose and investigate health problems and health hazards in the community
3. Inform, educate, and empower people about health issues
4. Mobilize community partnerships and action to identify and solve health problems
5. Develop policies and plans that support individual and community health efforts
6. Enforce laws and regulations that protect health and ensure safety
7. Link people to needed personal health services and assure the provision of health care when otherwise unavailable
8. Assure competent public and personal health care workforce
9. Evaluate effectiveness, accessibility, and quality of personal and population-based health services
10. Research for new insights and innovative solutions to health problems.

SOURCE: U.S. Centers for Disease Control and Prevention, the Public Health System and 10 Essential Public Health Services

Services identified by the CDC, outlined in Figure 1. Their work falls into several foundational areas, identified in Figure 2. Many LHDs go above and beyond these core areas and work on a broader range of social determinants of health, through multi-sector coordination and a **Health in All Policies** approach.⁵

FIGURE 2

Public Health Foundational Capabilities and Areas

There are six main skills and capacities needed to ensure community health and achieve equitable health outcomes:

- Assessment/Surveillance
- Emergency Preparedness & Response
- Policy Development and Support
- Communications
- Community Partnership Development
- Organizational Competencies

The foundational areas that public health covers are:

- Communicable Disease Control
- Chronic Disease & Injury Prevention
- Environmental Public Health
- Maternal, Child & Family Health
- Access to and Linkage with Clinical Care

SOURCE: Public Health National Center for Innovations, Foundational Public Health Services



WHY ARE LOCAL HEALTH DEPARTMENTS ESSENTIAL?

Local public health departments work to prevent illness and injuries, before people end up in the hospital. The work of LHDs yields important social and economic returns. LHDs work to keep people safe and healthy and reduce the need for greater health care spending. For every one dollar we invest in prevention-focused initiatives, our health care system yields an average \$5.60 in savings.⁶ In Los Angeles County, every \$10 per capita we spend on public health would result in:⁷

- 7,271 years of life gained among county residents⁸
- 2,222 more people in very good or excellent health⁹
- A decrease of 822 gonorrhea cases per year and 343 early stage syphilis cases per year¹⁰

- A decrease of 403 cases of salmonella per year¹¹
- 204 fewer new cases of HIV, hepatitis A and B, and tuberculosis¹²

Despite the demonstrated cost savings generated from public health interventions that create a healthier population, we are not funding our public health system adequately. The fiscal and social returns on investment are huge, but we often do not realize the need to fund public health until there is an emergency, at which point it is very difficult to be nimble and responsive. Public health is also not funded on an even playing field with other government agencies that provide essential services during both emergencies and on an everyday basis. Public health is “always the bridesmaid” and rarely the bride.¹³

FIGURE 3

Return on Investment: Health care system savings as a result of direct investment in prevention-focused initiatives



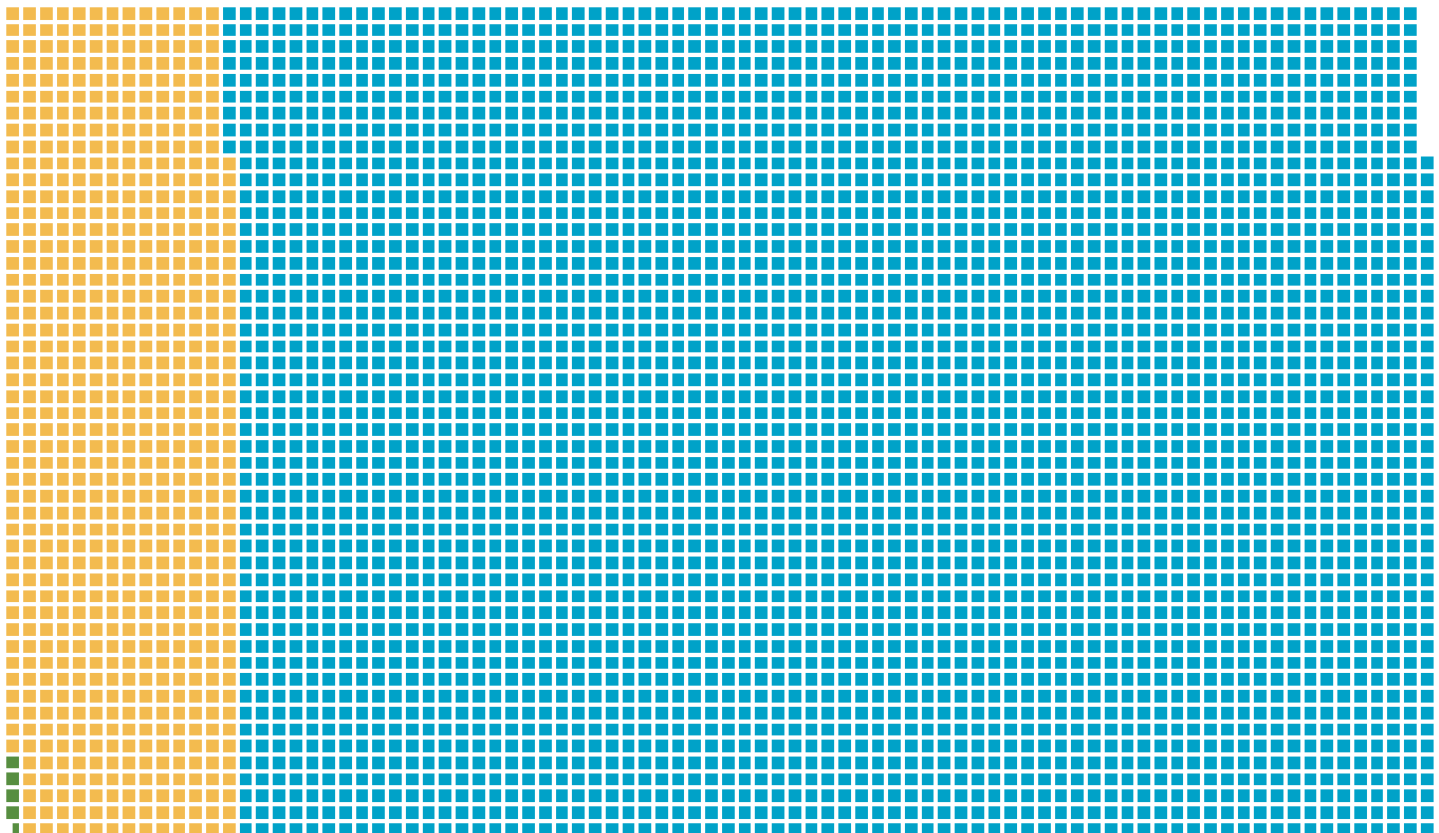
SOURCE: Trust for America's Health¹⁶

For every health dollar spent in the U.S., 97 cents goes to medical care and 3 cents goes to public health and prevention.¹⁴ We currently spend around \$19 per person on public health. But to put in place the most essential services needed to protect public health, we would need approximately \$32 per person per year.¹⁵ This \$13 gap per person amounts to a \$4.5 billion annual gap in funding. Compared to the \$3.6 trillion we spend annually on health care, this is a relatively modest investment, and the positive outcomes from it would make truly healthy communities a reality.

FIGURE 4

Requested Public Health funds in comparison to Military and Health Care spending

Each block represents **\$1 Billion Dollars**



- **HEALTH CARE:** Across the private and public sector, Americans spend \$3.6 Trillion on Health Care annually.
- **MILITARY:** For FY 2019, the U.S. budgeted \$686 Billion for the Department of Defense.
- **PUBLIC HEALTH:** The \$4.5 Billion funding gap public health departments need to protect the health of all and be prepared for the next emergency.

SOURCE: HEALTH CARE: Centers for Medicare & Medicaid Services, National Health Expenditure Data Historical.¹⁷ MILITARY: U.S. Department of Defense FYI 2019 Defense Budget.¹⁸ PUBLIC HEALTH: “Developing a Financing System to Support Public Health Infrastructure.” Resolve Public Health Leadership Forum.¹⁹

HOW DID WE GET HERE?

What Decisions Weakened Our Local Health Departments?

Historical and longstanding disinvestment, coupled with the structural limitations of public health funding, have depleted public health readiness.

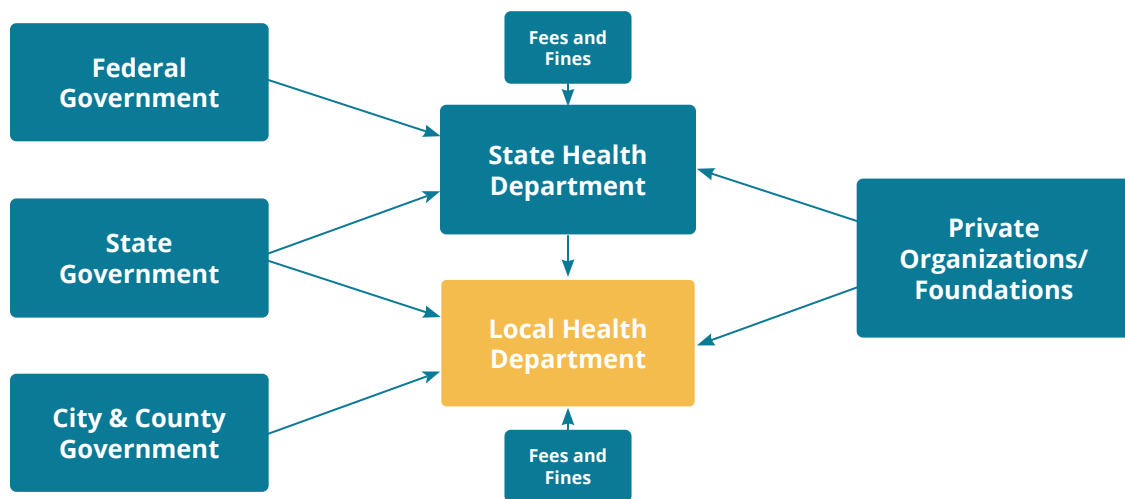
Funding Sources for Local Health Departments

Funding for LHDs comes from multiple sources, including federal, state and local sources.²⁰ Federal funding primarily comes from the U.S. Centers for Disease Control and Prevention (CDC) and U.S. Department of Health and Human Services (HHS). Several other agencies also provide funding for specific programs like the U.S. Department of Agriculture (USDA), which provides funding to LHDs to administer nutrition assistance programs.

In California, federal funding is typically funneled through the state first, which then allocates it based on specific funding formulas and methodologies particular to each funding stream. The State of California also funds LHDs through its

There are more than 200 categorical funding streams for public health. Only about 5% of public health funding is flexible.

FIGURE 5
Funding flow



SOURCE: Institute of Medicine, For the Public's Health: Investing in a Healthier Future

General Fund, 1991 Realignment, and dedicated state funding sources for public health. At the local level, LHDs receive funding from city and county general funds, taxes and fees, grants, and special local level funds. Most of this funding is categorical, restricted to specific uses, with more than 200 categorical funding streams for public health. Only about 5% of public health funding is flexible.²¹ While most local government agencies have a mix of categorical and flexible funding, they tend to have a higher share of flexible funding. For example, in 2013, K-12 education spending in California shifted from a model of one-third categorical spending and more than 30 funding programs to a much more flexible Local Control Funding Formula that provides greater funding flexibility and local control.²² Figure 3 provides an overview of how funding typically flows to LHDs from various sources.

A History of Funding Cuts

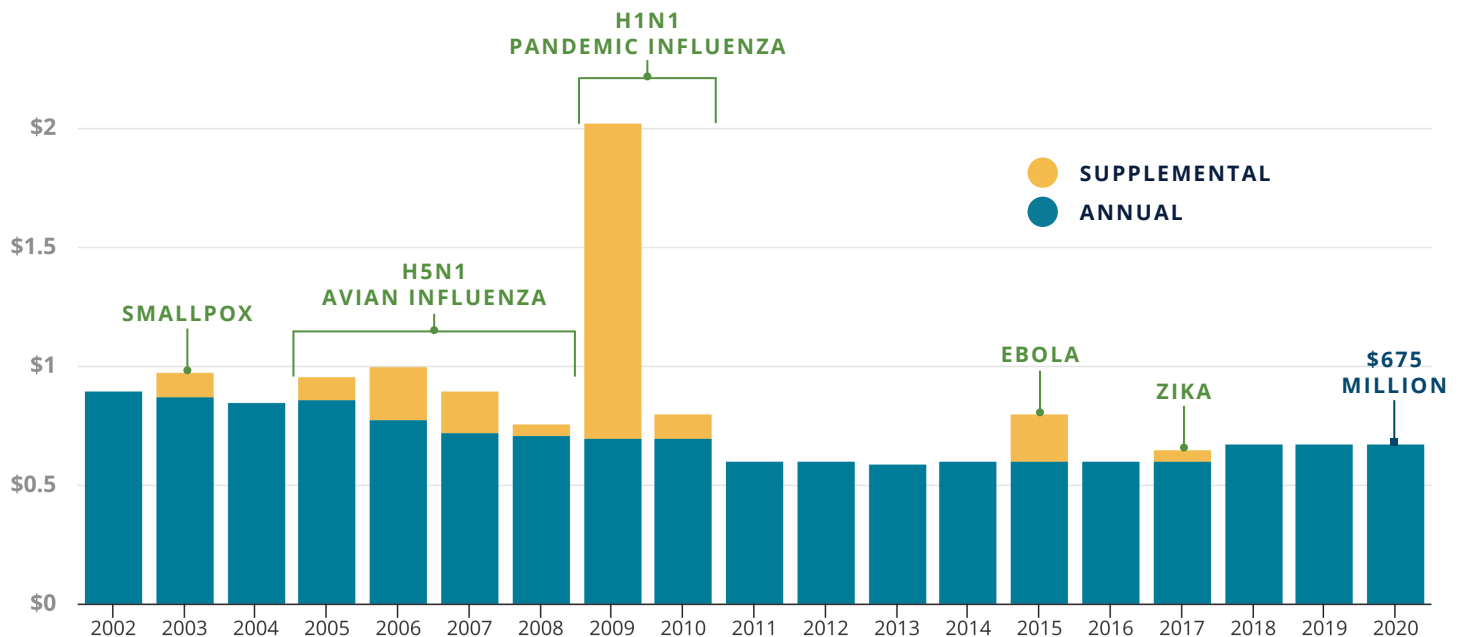
For close to 20 years, political leaders at the state and federal level cut almost all funding sources for LHDs, at the same time that threats to public health are increasingly growing:

- Over the past decade alone, local and state health departments lost 20% of their workforce,²³ and LHD budgets shrank by as much as 24%.²⁴
- State and federal decisions have led to California’s LHDs receiving \$177 million less in total funding in 2018-2019 versus 2007-2008.²⁵
- State lawmakers decreased the portion of general funds to LHDs by \$90M over this span of time, including:²⁶
 - » Infectious disease control: While the overall amount increased by \$38 million, when categorical funding is excluded, the

FIGURE 6

Additional health funding surges in times of disease, outbreaks, pandemics

PUBLIC HEALTH EMERGENCY PREPARATION AWARDS (IN BILLIONS)



SOURCE: Institute of Medicine, For the Public’s Health: Investing in a Healthier Future

“The funding cuts, particularly to federal grants meant to bolster local preparations, have left Riverside County with “fewer trained staff to conduct case investigations and contact tracing, fewer epidemiologists to assist with analysis, fewer lab staff (public health microbiologists) and less funding for updated laboratory equipment.”

— Kim Saruwatari, Director, Riverside University Health System-Public Health⁴⁶

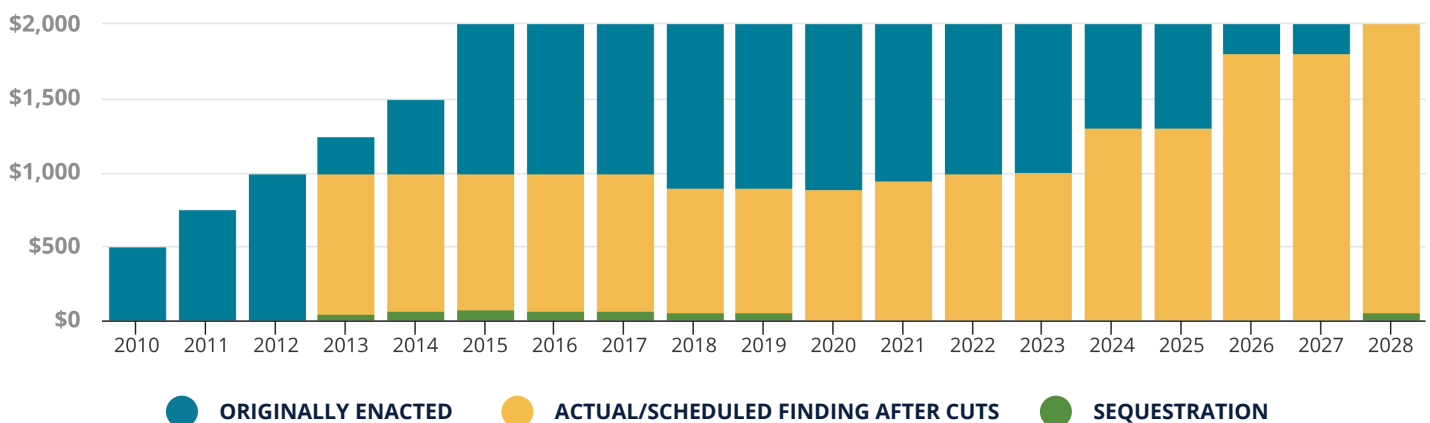
amount flowing to LHDs is \$8.5 million less than 2007-08. While this means that LHDs have some increased support for specific diseases specified by the categorical funding, it does not give them the flexible funding they need to address root causes that impact all diseases or to build the infrastructure across programs to be prepared for new threats, like COVID-19.

- » Chronic Disease: While the total amount increased by \$26 million, when tobacco-related diseases are excluded, chronic disease funding actually fell by \$15.4 million, even though chronic diseases are a key driver of disparities in quality of life and life expectancy.
- » Emergency Preparedness: Funding is \$10.7 million less than 2007-08 despite an increasing number of weather and climate-related disasters like heat waves and wildfires.

- The State of California’s recently approved budget cuts public health funding from \$3.4 billion in FY2019-2020 to \$3.2 billion in FY2020-21, a 6.3% decrease, despite the ongoing pandemic and calls from LHDs and public health associations to increase LHD funding.²⁷
- Prior to COVID-19, the rate of all infectious diseases combined increased by 45% over the past decade, and there were inadequate resources to address their spread.²⁸ California legislators agreed to a one-time \$40 million budget allocation in 2019 for communicable diseases, but this was a temporary fix requested before the COVID-19 pandemic unfolded.²⁹
- The CDC and HHS decreased allocations to California LHDs from \$81 million in 2010 to \$65 million in 2019, a 25% decrease.³⁰
- 11 local public health labs in California closed over the past 15 years because of funding cuts, limiting the capacity during COVID-19

FIGURE 7

Cuts to Prevention Fund Since Creation FY 2010-2028 (IN MILLIONS)



SOURCE: Trust for America’s Health⁴⁷

“One-time, emergency money is great, but it’s not how you hire the right people or get the right supplies for future crises. A forest fire is not the right time to start hiring firemen and buying firetrucks and equipment. It’s too late.”

— John Auerbach, President and CEO, Trust for America’s Health⁴⁸

to scale up testing and staffing needed to adequately meet the state’s phased reopening goals.³¹

- County general funding remains flat and LHDs have to compete with other agencies for funding. For example, in Riverside County the health department has a budget of approximately \$100 million per year, and the Board of Supervisors allocates \$12 million from the County General Fund, but this amount has been flat for years amid competing priorities while public health are growing.³² As a result, Riverside has had to cut its LHD staff by about 60% over the past decade.³³
- Due to COVID-19, sales tax and vehicle license fee revenues have declined, leading to a \$1.7 billion loss in county revenue that will impact LHD budgets.³⁴
- National policymakers have decreased funding for Public Health Emergency Preparedness from \$940 million in 2002 to \$675 million in 2020.³⁵ These decisions meant funding cuts for vital programs despite 14 weather and climate disasters nationally in 2019 that each cost at least \$1 billion. Even 10 years ago, we only had 7 weather/climate events meeting that threshold.³⁶
- Congress has stated that the federal Prevention & Public Health Fund should be budgeted at \$2 billion per year, but they only provided \$892.5 million in FY2020 due to diversions to other programs.

Categorical Funding and Limited Flexibility

The categorical nature of public health funding makes it difficult to shift funding to address other priorities or emergencies. LHDs are not able to be as nimble in emergency situations when they need to respond quickly. Local funding sources

are typically the most flexible, as well as California 1991 Realignment funding, but the latter is currently about \$130 million below 2006 revenues and the state legislature and counties themselves often divert these funds to other county agencies in response to other priorities.³⁷ Realignment and other local sources are largely dependent on fluctuating sales tax revenue, vehicle license fees and other taxes and fees, which are all currently projected to plummet as a result of the COVID-19 pandemic, making it even less reliable when the need for robust public health department infrastructure is extremely high.

Lack of Sustained Funding

When there are increases in public health funding, they are often one-time, temporary allocations to address a specific issue or emergency. While essential, once the funding goes away, LHDs are often left without the staffing and resources to prepare for the next emergency. LHDs need to recruit and retain a well-trained workforce, and one-time funding undermines that critical goal. The lack of sustained funding significantly limits the ability of LHDs to perform their essential core functions and build up their infrastructure to cover the foundational capabilities and core areas. Many LHDs do not have the staffing or equipment they need for their everyday work, and have sounded alarms for years about the threat of a pandemic and the limited resources they have for an adequate and sustained response.³⁸

An Aging Workforce Pipeline

LHDs experience workforce challenges due to the highly technical and complex nature of many duties. This makes it difficult to recruit for some of these positions, such as public health nurses, especially in rural areas.³⁹ Many workers are reaching retirement age—approximately 25% of the public health workforce was eligible for

retirement in 2020.⁴⁰ In addition, short-term and categorical funding means health departments cannot quickly hire and retain experts with the necessary skills to advance core health and equity priorities.⁴¹ Public health departments need consistently funded staff with the skills and experiences necessary to execute efforts to address the social determinants of health and effectively liaison with communities, other departments, and community advocates.⁴²

Limited Resources to Address Health Equity and Climate Change

Disinvestment in public health agencies and infrastructure leaves little room for departments to imagine and work toward a health equity agenda, or to address climate change in a proactive and systemic way.⁴³ A national study found nearly universal agreement among public health partners that a lack of sufficient funding and current limitations made engaging in work outside of mandated services, like addressing the social determinants of health, very difficult.⁴⁴ Public health plays a uniquely valuable role and helps to “shift the narrative” when it uses its expertise and data to educate non-health sectors and policymakers about the role of structural factors and community conditions in creating and perpetuating racial and health inequities. By disinvesting in LHDs and limiting their ability to address health equity, we are in turn disinvesting in the communities that experience the worst health inequities and are the most vulnerable to public health emergencies, such as COVID-19 and climate change.

Public health is well positioned to work with residents of communities that face multiple, intersecting inequities and challenges to health and safety.⁴⁵ They can connect key health data and information with these inequities and tie it to policy and system change. For example, people in neighborhoods with higher levels of pollution may avoid outdoor exercise because of poor air quality. This leads to higher rates of chronic diseases in impacted communities, putting individuals more at risk for the negative health impacts of COVID-19. These same neighborhoods are also often targeted by fast food and soda companies. Well-resourced public health

The Media Highlights Disinvestment in Public Health Infrastructure

USA Today, March 2, 2020:

‘This is not sustainable’: Public health departments, decimated by funding cuts, scramble against coronavirus

New York Times, March 14, 2020:

The Coronavirus Swamps Local Health Departments, Already Crippled by Cuts

San Francisco Chronicle, March 16, 2020:

Even before coronavirus, infectious disease was on rise in California — but spending got cut

LA Times, March 20, 2020:

Officials long warned funding cuts would leave California vulnerable to pandemic. No one listened.

Associated Press, April 5, 2020:

In years before outbreak, investment in public health fell

NY Times, April 9, 2020:

The U.S. Approach to Public Health: Neglect, Panic, Repeat

Detroit Free Press, April 4, 2020:

Panic, then neglect: Prior pandemics gave us lessons to fight the coronavirus. But funding dried up.

Los Angeles Times, June 15, 2020:

Public health funds are needed more than ever but lack ‘lobbying muscle’ in California

departments that possess data and GIS systems and skilled staff are able to collect, analyze, interpret, and disseminate useful equity related data to influence and create policy and systems change. Departments with dedicated staff to advance equity are best positioned to prevent disproportionate impacts of health, economic and other emergencies in the future. Moreover, even when an LHD has equity and/or climate change staff, limited capacity overall may lead to this staff being diverted to assist with other roles, as is happening during the COVID-19 pandemic.

A BOLD VISION

for Funding Robust and Resilient Local Health Departments

We cannot turn our public health system on and off during times of emergency, just like you can't buy fire insurance once your house is burning. We need a more sustainable model moving forward. We are facing a unique moment and can make the bold choice now to create robust and resilient local health departments. COVID-19 demonstrates the real risks a pandemic has to public safety, our economy, and national security, and the serious impacts on our most vulnerable populations already experiencing the most significant health inequities. It is time we decide to do everything we can to protect our entire population from these grave risks.

We need to invest in our local health departments so they can support all residents in times of crisis and advance a vision of health for all. Our local health departments should be able to act proactively to the likely resurgence of COVID-19, as well as future public health emergencies related to infectious disease outbreaks, climate change, natural disasters and other events. We should seize this opportunity to create a comprehensive public health system that is prepared for the future and works daily to not just ameliorate threats, but work to eliminate health inequities and create healthy communities that allow everyone to live to their full potential.



We cannot turn our public health system on and off during times of emergency, just like you can't buy fire insurance once your house is burning. We need a more sustainable model moving forward.

A CALL TO ACTION

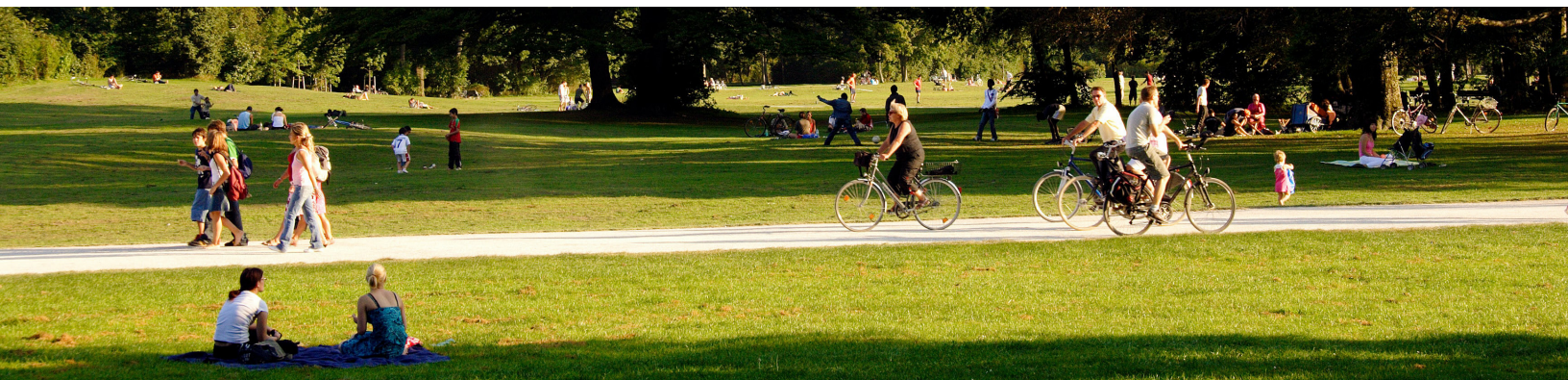
Strategies for Investing in Our Local Health Departments

To create robust and resilient local health departments, we need a call to action to rebuild and strengthen them in the following ways:

- **Significantly Increase Funding for Local Health Departments in Local, State and Federal Budgets.** Simply put, we need more funding from local, regional, state and federal sources to be dedicated to local health departments. This funding should be flexible and allow for the hiring of critical staff, purchasing new and modernizing existing equipment and facilities, acquiring critical supplies, developing plans and strategies for addressing important public health challenges and emergencies, and partnering with community-based organizations to advance health equity. In addition, COVID-19 has resulted in LHDs taking on and responding to the immediate needs necessary to respond to the pandemic, and funding needs to be provided for back funding and loan forgiveness for costs incurred while responding to this crisis. Finally, this funding should maintain and enhance funding for dedicated equity and climate change staff at the local level.

“We have not given health departments the funds to modernize and create a prevention focus across sectors, diseases and health conditions. Health departments across the country are battling 21st century health threats and need appropriate resources to win those battles. The COVID-19 crisis demonstrates this reality in the starkest of terms.”

— Trust for America’s Health⁵⁴



“We need to make sure public health early warning systems are sensitive enough to detect local microclusters of potential COVID-19, rapidly isolate infected individuals, and appropriately quarantine their identified contacts. This requires a comprehensive technology infrastructure for real-time data surveillance at the local level to monitor emergency department volume, as well as hospital admissions and deaths ...Robust data streams that include race and ethnicity are critical for us... and set in motion aggressive ongoing responses centered on equity. Collecting data on race and ethnicity is an imperative—it should be viewed as essential as monitoring ventilator supply.”

— Oxiris Barbot, *Health Affairs*⁵⁵

There are four important strategies for investing in our local health departments:

- » **Increase Non-Categorical Funding:** LHDs need flexible funding to allow them to develop a cross-cutting workforce that can be trained in multiple skills and functions. Less than 5% of current LHD funding is flexible, which limits ability to hire staff trained in multiple disciplines and pivot as public health emergencies arise. By investing in a more flexible public health infrastructure, we can ensure LHDs have the resources they need to respond to a range of issues and threats, including health equity and climate change, in a more sustainable way.
- » **Provide Greater Allowances Within Categorical Funding:** Loosening the requirements on many categorical funding streams will allow greater flexibility. In the absence of a significant infusion of new funding, this will allow LHDs to be more innovative in how they use their funding to address important public health issues.
- » **Enhance Categorical Funding for High-Need Positions:** There are high demand functions, such as epidemiologists and public health nurses, that require sophisticated skill sets and certifications. Enhanced funding should be provided to LHDs to ensure adequate staffing, training and retention of workers with these technical capabilities.
- » **Sustain Funding:** LHDs need long term funding to be able to address everyday public health threats and more proactively prepare themselves for future emergencies. It is common for LHDs to receive one-time infusions of funding for public health emergencies such as COVID-19, but these temporary solutions only address current needs. Longer term, more sustainable funding is necessary to ensure LHDs have the staffing, infrastructure and resources they need for all situations.
- **Fund Dedicated Health Equity/Racial Justice Staff or Teams:** Systemic racism and historical inequities pose grave threats to our society. We need to acknowledge the root causes of recent events, along with historical and structural disinvestments in low income communities of color, and make intentional efforts to address these inequities. Racism is a public health crisis, and California’s local health departments have been leaders in advancing health equity by collecting disaggregated data at the local level, advancing policy changes, and developing targeted interventions to close the race life expectancy gap. This work has become increasingly hard to do with diminishing resources, and most LHDs do not have dedicated staff working on health equity or racial justice issues. Our local health departments need this dedicated staffing to ensure they can work to improve community conditions and ensure everyone has the

opportunities and resources they need to lead a healthy life.

- **Fund Dedicated Staff or Teams to Work on Addressing Climate Change and Health:** Most local health departments do not have dedicated staff to work on climate change, despite the far-reaching health and economic impacts of recent climate events. Extreme heat, floods, wildfires, and droughts have already caused thousands of deaths and displaced tens of thousands of people across California. *The Lancet* has called climate change the “biggest global health threat of the 21st century.”⁴⁹ As climate change exacerbates the potency of extreme weather events, we

must invest dedicated staffing or teams within our local health departments to increase resilience to climate impacts.

- **Invest in Prevention and the Social Determinants of Health.** While there are many immediate needs for emergency response, local health departments also need funding for prevention of chronic disease and improving community conditions, which can also support responses to infectious disease outbreaks and emergencies. Social and economic factors such as access to safe and affordable housing, good-paying jobs, quality educational opportunities, healthy food and convenient transportation options

What are the Social Determinants of Health?

People’s health is shaped dramatically by “non-health” policies and community characteristics, such as housing, education, economic, neighborhood and social factors. These community conditions, also called the “social determinants of health,” are depicted in the graphic here.



have a greater impact on health than genetics. The data show that those most at risk of COVID-19 are the same people with elevated risk of developing chronic conditions due to the impact of racism, poverty and systemic discrimination and disinvestment. One's ZIP code is often a better predictor of health than one's genetic code, and neighborhoods just a few miles away can have vastly different life expectancies and community conditions. Our investments in local health departments should be made with the social determinants of health in mind, and allow LHDs to work on addressing them in their core work.

- **Enhance Data Platforms to Provide Real-Time Disease Surveillance and Facilitate Data Sharing:** LHDs need funding to modernize and upgrade their data collection and reporting systems. These are important to conduct real-time disease surveillance, detect the spread of COVID-19, collect various data points, and monitor public health threats. These systems should be integrated within LHDs and across other agencies at the local, regional, State and federal level to facilitate greater data sharing. They should have the ability to collect and disaggregate demographic data, including race/ethnicity, income, geography, and the social determinants of health, to address health equity concerns. Staff also need support in understanding and being able to link the data to the historical and current contexts that lead to racial inequities. There are also many examples of LHDs unable to access data from divisions within their own department, such as being unable to obtain mortality data, as well as across other agencies at the local, state and federal level, such as barriers to accessing Section 8 housing data. To address this, investments should also be made in developing data sharing agreements and other legal documentation that addresses privacy and confidentiality issues while also providing the information LHDs need to make informed decisions.

- **Ensure Equitable Allocation of Resources to Local Health Departments.** Many complex funding methodologies are not transparent, and there exist inequities in how LHDs are funded. The majority of LHD funding comes from the federal and state levels and goes through a formula allocation in which the needs of all LHDs in the state are considered. We need to ensure that funding is allocated equitably and based on need. The Alliance developed [Principles for Funding Equity](#)⁵⁰ outlining a process for how funding should be allocated to LHDs that could be used as guidance for equitable future allocations of public health funding to LHDs (see Figure 3).
- **Make Investments in Communities Most Impacted by Health Inequities.** While LHDs themselves need greater funding flexibility to build up their health equity work, investments should also be made directly in communities themselves to address longstanding health inequities, community conditions and structural racism. COVID-19 has had the greatest impact on low-income communities and communities of color, and our recovery efforts will need to put these communities front and center. Investing in our communities goes hand in hand with investing in our local health departments. We will build a stronger, more equitable and resilient public health system if we eliminate structural barriers to optimal health.

Any resources made available for COVID-19 recovery and investing in public health should dedicate a portion of funding for investments in the communities most impacted by COVID-19 and that will be most vulnerable to future threats. For example, the California Climate Investment Program has a legislative requirement that at least 35% of all grant funding must go to projects within and benefitting disadvantaged and low-income communities.⁵¹ These investments could also incentivize and encourage partnerships between LHDs and community-based organizations to work together on addressing health equity. These investments are necessary and complementary to investments made in our local health departments.

- **Expand Eligibility for Local Health Departments to Apply for Grant Funding from Non-Health Local, State and Federal Agencies, Philanthropy, and Other Sources.**

Local health departments are eligible to apply for grants from many non-health sources, but the list could be expanded at all levels. At the federal level, there are a variety of grant opportunities available to advance public health initiatives related to prevention and the social determinants of health. At the state level, LHDs can apply to the California Transportation Commission's **Active Transportation Program** grants to promote walking, bicycling, and Safe Routes to School, but there are many other grant programs, including most of the California Climate Investment programs, where they are not eligible or are only identified as recommended partners in project implementation, without funding attached for their participation.

On the foundation side, LHDs are eligible for grants to advance their health equity work, but many foundations limit their grantmaking to nongovernmental organizations. When LHDs receive this kind of grant funding, they are often able to bridge silos, bring in multisector partners, and pass through the funding to community-based organizations that are led by those who are most negatively impacted by health inequities. More grant programs should expand eligibility to include LHDs, allow funding to be used for their participation in multi-sector projects, and encourage greater community and multi-sector collaboration and a Health in All Policies Approach to grant-funded programming.

- **Support Innovative Partnerships and Investment Strategies with the Health Care, Community Development and Other Sectors.** Traditional funding sources alone will not provide sufficient funding for LHDs to carry out their routine work, let alone in a public health emergency. There are innovative financing strategies being implemented across the United States that supplement the resources available to LHDs. This includes strategies like blending funding with sources from other sectors like health care and community development, creating

a Wellness Fund, developing an Accountable Communities for Health model, exploring anchor institution strategies, and partnering with community development financing institutions and other sectors to leverage funding sources. The Alliance has created a comprehensive **research report**⁵² outlining these innovative community investment strategies, which provides more information on best practices and recommendations for greater implementation and inclusion of LHDs in these investment efforts.

- **Ensure Existing Health Care Funding Streams Include Investments in Prevention and Local Health Departments:** Given that we spend an estimated \$3.6 trillion annually on health care, but less than 3% of that is spent on public health, there is a significant opportunity to leverage our health care expenditures to invest in local health departments. The health care sector should expand their investments in local health departments through their existing funding streams. This is especially important because LHDs provide many basic health care services covered by Medi-Cal and Medicare, often with little to no reimbursement. Many LHDs do not have the billing infrastructure set up to properly account for and be reimbursed for all the services they provide under Medi-Cal. They also lack the capacity to track all the state and federal policy changes that impact their work, including the complex Medicaid waiver processes. There needs to be greater collaboration between the health care and public health sector, and incentive mechanisms need to be put in place to ensure this happens in a meaningful way. For example, California's CalAIM⁵³ proposal could include stronger incentives for Medi-Cal managed care plans to contract with LHDs to provide basic health care services and to advise on the development of population health management plans, enhanced care management and in lieu of services. State and federal health care policies could provide clearer guidance on how LHDs can access health care funding for their needs, and how they can get health plans in particular to pay for their specific needs.

CONCLUSION

The COVID-19 pandemic has made clear that our local health departments are at a critical juncture. This is the time for us to be rallying around a call to action to invest in our local health departments to ensure our well-being at all times. As our elected officials wrestle with budget decisions, it is essential to recognize that the choices made today will have lasting implications on the public's health and our ability to advance healthier, equitable communities tomorrow. We must support a comprehensive public health system to protect our society from the threat we currently face with COVID-19, as well as take steps to prevent the disproportionate impacts of the next public health threat before it occurs. Funding robust and resilient local health departments will protect our residents most impacted by health inequities and keep everyone safe and healthy. When we invest in local health departments, we are investing in a future where everyone can live to their full potential, where people have stability and security in their work, homes, schools, and environment to enjoy life, and where we come together to help each other and ensure no one is left behind.



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ABOUT THE ALLIANCE

The Public Health Alliance of Southern California (Alliance) is a coalition of local health departments in Southern California. Collectively our members have statutory responsibility for the health of nearly 50% of California's population. Our vision is "vibrant and activated communities achieving health, justice, and opportunities for all" and our mission is to "mobilize the transformative power of local public health for enduring health equity." For more information about the Alliance, please visit <http://PHASoCal.org/>

The Alliance is fiscally administered by the Public Health Institute.

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