



# Local Public Health Funding in Michigan: An Evergreen Need, Even in Our “New Normal”

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## Introduction

Public health protects us all. Broader than healthcare access or affordable coverage alone, public health is central not only to the health of individuals but also the health of their communities. Public health encompasses infectious disease control, environmental safety, health behavior change, quality food and water in addition to social determinants of health, or non-medical factors influenced by the conditions in which people are born, work, age and live. Broadly, public health prevents disease from occurring in the first place; promotes physical, social and environmental health; and protects entire communities through sound policy and programs.

In Michigan, the Department of Health and Human Services (MDHHS) has a core role in the delivery of public health services. Other departments, such as the Michigan Department of Agriculture and Rural Development (MDARD) and the Michigan Department of Energy, Great Lakes and Environment (EGLE) also regulate and provide public health services, including ones related to food- and environment-related safety, respectively. In 2022, just 1.2 percent (\$812.6 million) of the total state budget (1.6 percent General Fund/General Purpose, or \$183.5 million) was devoted to public health through MDHHS funding.<sup>1</sup> State funding for public health is thinly spread across a wide array of services that prevent, monitor and control infectious disease spread; address social determinants of health; support a number of family, maternal and children’s health services; and prepare local and state entities for emergency responses, such as COVID-19.

Despite ranking highly on measures of clinical care, like access to care and quality of care, Michigan falls short on measures of health outcomes. Greater investment in policies and programs that support health outcomes outside of clinical care is needed to influence communities’ overall health. Increased public health funding, especially targeted at the local level and to local health departments (LHDs), will support the delivery of essential public health services and improve health outcomes overall.

In addition, a strategic focus on upstream health factors and social determinants of health can help reduce existing racial health disparities in Michigan. Such disparities are not inevitable and the actions of the Michigan Coronavirus Racial Disparities Task Force provide a useful case study in how taking key actions, including greater investment in local infrastructure and capacity, can address long-standing health equity barriers. A worthwhile, forward-looking investment, greater state spending on public health will contribute to a healthier future for all Michiganders.

## The Impact of COVID and Moving Toward a “New Normal”

Over the past few years, COVID has dominated conversations about public health and the policies that promote it. Communities and leaders, including public health practitioners and LHDs, have learned how best to respond and in many cases, have come together to do so effectively and saved thousands of lives in Michigan.<sup>2</sup> There are 45 LHDs across Michigan and each of them had to pivot many of their regular activities to combat the virus and address its impact in their community.<sup>3</sup> LHDs’ actions to shift resources like funding, staffing and programming away from other services and *toward* COVID prevention and response makes clear that “normal” activities – that is, outside of an active global pandemic – encompass so much more than those exclusively related to COVID.

**“ Proactive public health policies do not simply ensure someone who gets sick can be treated in a clinical setting; instead, they additionally look to solve the underlying issues that erode health and safety, using trends in population data and solutions that reach whole communities and collectively improve the social determinants of health. ”**

Unfortunately, over the course of the pandemic, “public health” and related terminology have, to some degree, become buzzwords. This shift has left it open to misrepresentation and has often resulted in its being equated with policies that control the spread of COVID – and nothing else. We have seen the consequences in Michigan, as limited LHD funding, which supports the delivery of essential services well beyond COVID activities, was recently put in jeopardy regarding mask mandates.<sup>4</sup>

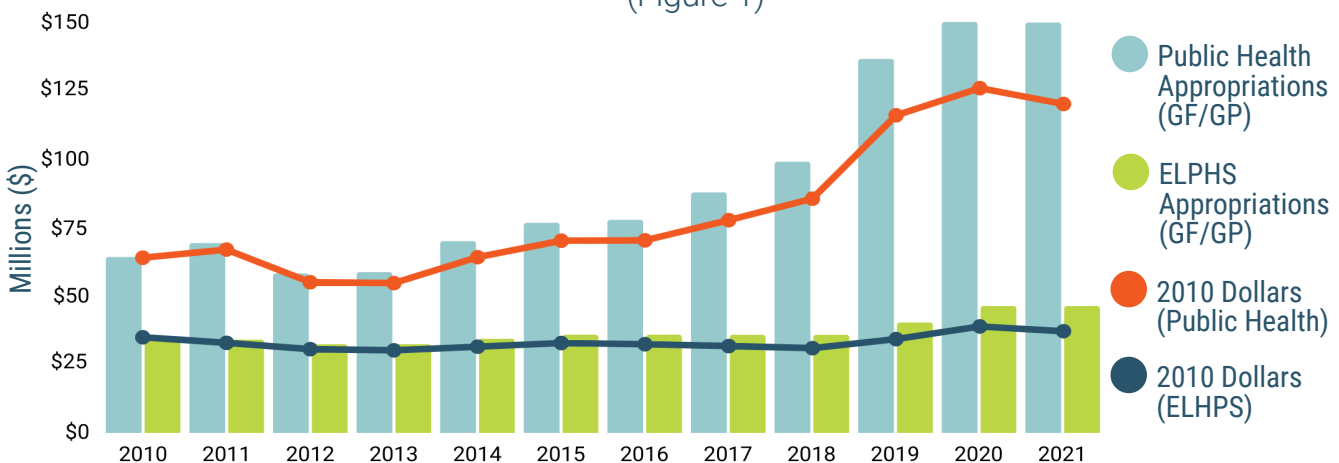
LHDs are required to provide Essential Local Public Health Services (ELPHS), which is core public health programming across seven different areas.<sup>5</sup> In addition, LHDs connect families to affordable healthcare, prevent foodborne illness and collect and analyze local health data, among other activities.<sup>6</sup> Over the last decade, Michigan has not substantially invested in local public health systems. Increased public health funding, for LHDs and community-based partners in particular, is necessary to continue all of these activities as we navigate a new budget year and move toward a “new normal,” two years after the pandemic was declared.

Our “new normal” must be prepared for future public health needs while also intentionally addressing systemic racism and health disparities through targeted programming and strategic policymaking. Proactive public health policies do not simply ensure someone who gets sick can be treated in a clinical setting; instead, they additionally look to solve the underlying issues that erode health and safety, using trends in population data and solutions that reach whole communities and collectively improve the social determinants of health. Greater investment in local public health through LHDs is one tangible way to ensure our “new normal” prioritizes prevention, innovative policies and community health programs that promote safety and wellbeing across Michigan.

## Public Health Funding Through the Michigan Department of Health and Human Services

Budget decisions on public health within MDHHS support community public health services and health policy as well as family, maternal and children’s health services. Over the last decade, gross public health funding within this department has remained at about \$600 million per fiscal year.<sup>7</sup> Across this same time frame, there have been increases in state spending for key state and local health functions like laboratory services, epidemiology and some local health services; there has also been investment in both child and adolescent health services and prenatal care outreach and support.<sup>8</sup> From 2010 to 2021, GF/GP funding for public health within MDHHS has increased by 88% when adjusted for inflation, driven largely by significant increases in recent years (see Figure 1). Notably, in 2022, public health received an additional boost of \$26.5 million gross (\$23.2 million GF/GP) in one-time appropriations.<sup>9</sup> Still, despite more recent robust investment, Michigan’s per-capita spending on public health is low when compared with other states.

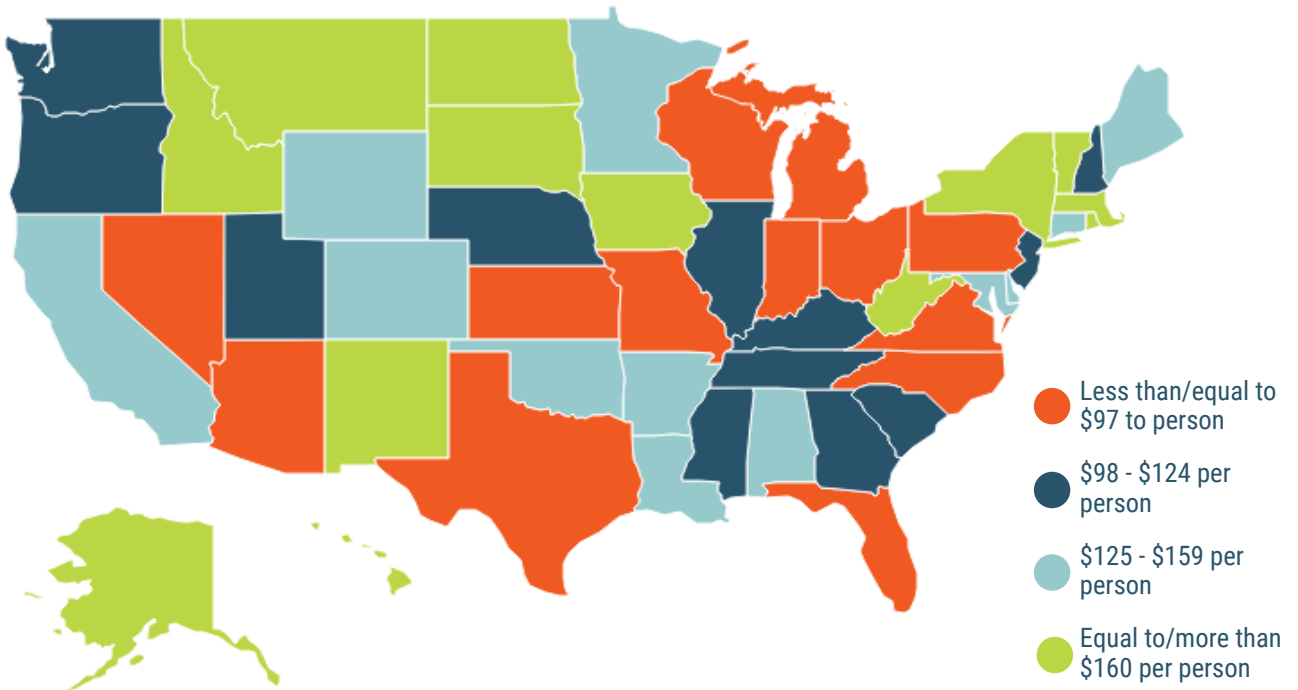
**Aside from boosts in 2019 and 2020, Essential Local Public Health Services (ELPHS) funding has remained fairly flat despite consistent increases in overall public health funding**  
(Figure 1)



Source: Michigan League for Public Policy analysis of House Fiscal Agency Community Health Archives using Consumer Price Index Retroactive Series (2010=100). Accessed March 16, 2022.

Currently, much of Michigan’s total public health funding comes from federal dollars. For more than the past decade, over half of Michigan’s annual public health funding (within MDHHS) has come from federal sources, while approximately one quarter comes from the state’s general fund.<sup>10</sup> Limited state investment results in lower per-capita spending on public health: \$83 per person in Michigan, below the national average of \$116, which ranks the state 40th in the nation (see Figure 2). Federal funding is critical and important to protect, but without sufficient state spending, Michigan is left sensitive to changes in federal funding—including influxes that can support one-time investments—and less able to flexibly provide sufficient and sustainable state resources to address public health concerns as they arise.

**Michigan ranks 40th for per-capita public health funding, at \$83, which is below the national average of \$116 (Figure 2)**



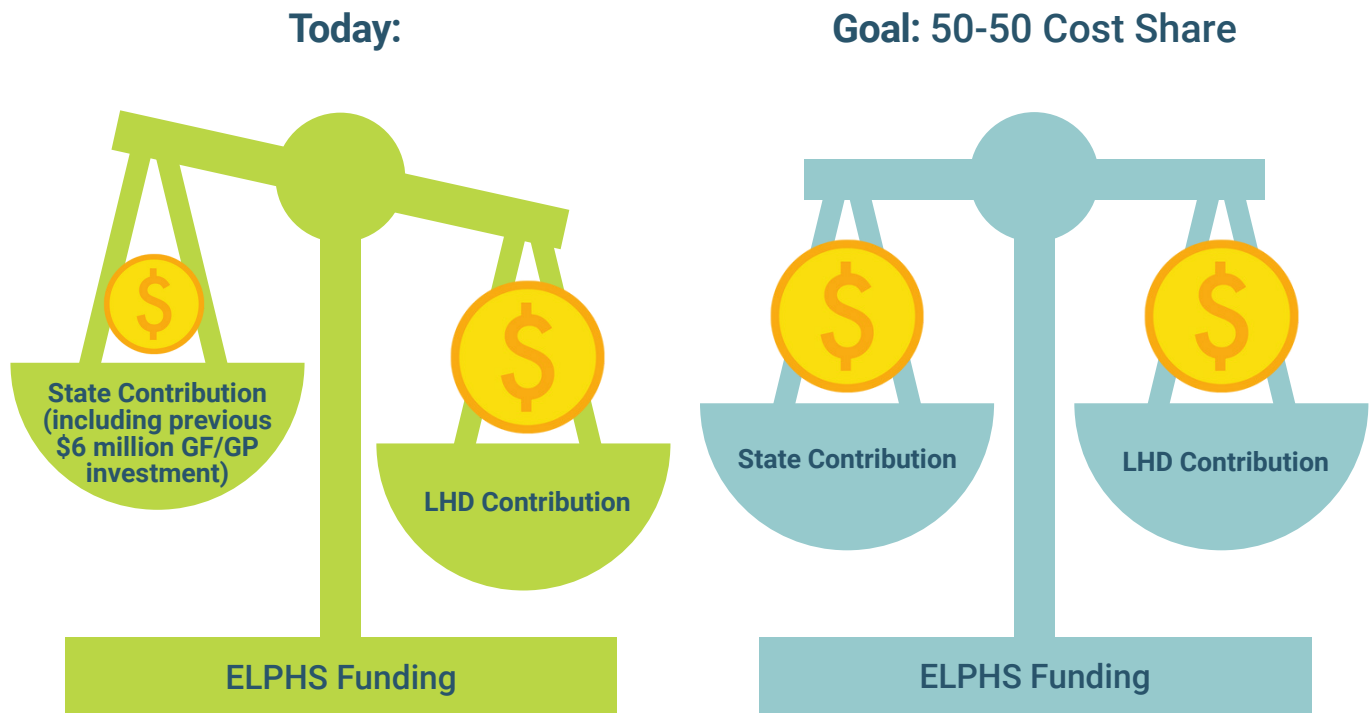
Source: America’s Health Rankings. “Public Health Funding: Edition Year 2021.” Accessed March 16, 2022. Trust for America’s Health, Centers for Disease Control and Prevention and Health Resources and Services Administration, 2019-2020. Retrieved from [americashealthrankings.org](http://americashealthrankings.org). Note: \$97 per person = 25th percentile; \$124 per person = 50th percentile; and \$160 per person = 75th percentile. Public health funding includes state dollars dedicated to public health and federal dollars directed to states by the CDC and HRSA. District of Columbia not included in chart or state rankings. D.C.’s per-capita public health spending is \$874.

**“LHDs receive funding from a variety of sources, such as local units of government, private funding, grants and fees, yet state funding is critical to financing the essential services that LHDs provide. Just \$2.2 million of investment above 2010 funding levels for ELPHS is minimal considering that overall public health spending has increased more substantially over the last decade.”**

The increases in state public health funding over the past decade have had a more limited reach at the local level because there has been significantly less investment targeted to LHDs over the same time frame. Despite boosts in 2019 and 2020, ELPHS funding, which is distributed across all 45 LHDs to provide seven core public health services, was relatively stagnant, including flat funding of \$35.7 million from 2015 to 2018, even as overall public health investment increased (see Figure 1). While ELPHS funding saw an \$11 million nominal increase in GF/GP funding from 2010 to 2021, when adjusted for inflation, this results in only a 6% increase and is equal to an investment of just \$2.2 million above 2010 funding levels. Although LHDs receive funding from a variety of sources, such as local units of government, private funding, grants and fees, this funding from the state is critical to financing the essential services that LHDs provide.<sup>11</sup> The investment in state-funded ELPHS is minimal considering that overall public health spending has increased more substantially over the last decade.

In addition, per the Michigan Public Health Code, the money that LHDs spend on ELPHS should be reimbursed by the state at a 50 percent match.<sup>12</sup> However, a 2019 internal review by the Essential Local Public Health Services Funding Committee of the Public Health Advisory Council found that the state has not been meeting this 50-50 cost-sharing requirement. The analysis found that to meet this statutory requirement, the state would need to contribute an additional \$36 million to ELPHS.<sup>13</sup> Although ELPHS funding increased by \$6 million in 2020, LHDs have continued to go without tens of millions of additional state dollars that they are entitled to, which would support the delivery of ELPHS across Michigan.<sup>14</sup> The limited general fund investment coupled with the lack of adequate state matching funds for ELPHS means that more support is needed to ensure that LHDs are equipped to provide necessary services, programming and care to Michigan residents.

**Despite a \$6 million investment in Essential Local Public Health Services in 2020, the state is not adequately matching Local Health Departments for their essential services.**



What's more, targeting greater investment from the state level toward LHDs' services would provide a bang for our buck. Research has demonstrated that LHD spending is some of the most effective public health spending. It is linked to the delivery of essential services, stronger public health system performance and reduced deaths overall.<sup>15,16</sup> Michigan can better support public health across the entire state by increasing the amount of state funding that LHDs receive, which could finance not only the delivery of essential services but also children's healthcare services and initiatives that address the root causes of health disparities and focus on social determinants of health.

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## The Impact of Greater Investment on Children’s Health and Community Health Outcomes

Children are among the most impacted by public health funding, particularly at the local level. Childhood lead poisoning prevention and a variety of family, maternal and children’s health services rely on local public health funding.<sup>17</sup> These services and others are delivered in partnership with LHDs and protect our youngest Michiganders from preventable disease or worse health outcomes. For example, LHDs provide required childhood immunizations, often at free or reduced cost; provide nutritious food and formula to eligible families and young children by conducting the majority of Women, Infants, and Children (WIC) programs across Michigan; and participate in the Children’s Special Health Care Services (CSHCS) program, which is for children age 20 years or under and some adults with special healthcare needs (there are over 2,500 diagnoses that are eligible for CSHCS coverage).<sup>18</sup>

### Local Health Departments provide:

Childhood vaccinations  
(free/reduced cost)



Women, Infants, and Children  
(WIC) programming



Children’s Special Health Care  
Services (CSHCS) programming

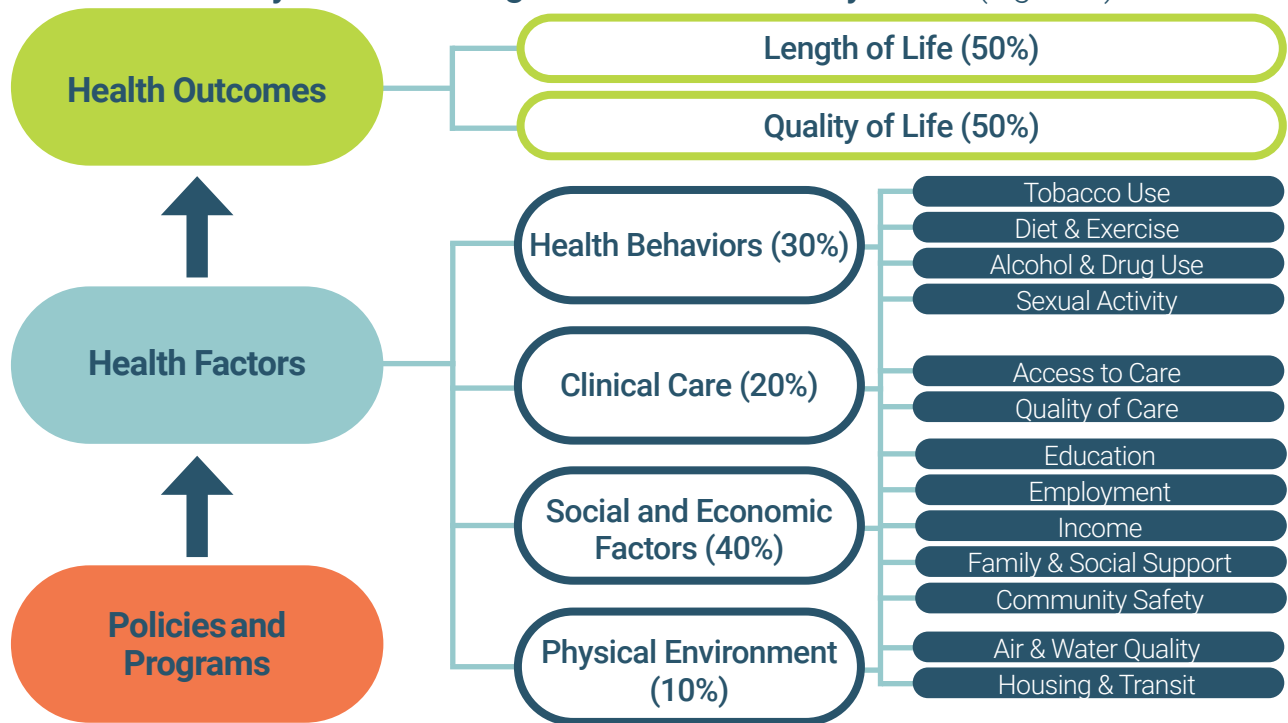


The CSHCS program in particular has seen enrollment increases that have put pressure on LHDs. From 2012 to 2018, program caseloads increased by 32 percent, from 35,431 to 46,816 in annual enrollment.<sup>19</sup> For those enrolled in CSHCS, LHDs assist with renewals, arrange transportation, create plans for care and help clients with issues they may face in receiving care. A higher caseload puts a strain on LHDs as the demand for these services increases, as does the costs for providing them, which falls to LHDs. In January 2022, the CSHCS program expanded to include adults with sickle cell disease and cover the treatment cost for a subset of eligible enrollees; however, no additional funding for LHDs was provided.<sup>20</sup> Increased LHD funding would allow for local programming like CSHCS to not only hire more staff, but to also do more outreach and enrollment, coordinate care and ensure equitable and comprehensive access to healthcare services through LHDs across Michigan.

In addition to supporting children and other specific populations, funding dedicated to local public health efforts, including targeted programs or interventions, can have health impacts across communities as a whole. There is a measurable benefit to broadening what is treated as “healthcare” to address social determinants of health – or “upstream” societal factors that impact “downstream” health outcomes – as opposed to simply the receipt of medical care. Unfortunately, current data and health rankings demonstrate this is an area of need for Michigan. To have an impact on health outcomes and health equity, more attention on, and investment in, upstream factors is required.<sup>21</sup>

The County Health Rankings model demonstrates that policies and programs influence a variety of health factors, all of which ultimately affect and improve a community’s health outcomes.<sup>22</sup> The model (see Figure 3) makes clear that 80 percent of the health factors that contribute to health outcomes are outside of clinical care (defined as access to care and quality of care). Health behaviors, for example, make up 30 percent of health factors and are influenced by socioeconomic factors (e.g., diet and exercise are influenced by the availability of healthy food or infrastructure that allows for safe walking or biking, respectively). Critically, half of the factors that impact health are attributed to social and economic factors in addition to the physical environment. Examining data on health outcomes in Michigan reveals strength in clinical care outcomes but a need to focus on the other 80 percent of health factors that influence communities’ health.

County Health Rankings Model of Community Health (Figure 3)



Source: County Health Rankings Model from the University of Wisconsin Population Health Institute, 2014.

America’s Health Rankings provides an assessment of public health on a state-by-state basis across a wide array of health-related measures. Based on these 2021 findings, Michigan ranks 13th in the nation on clinical care measures and rates highly on measures of access to care and quality of care (8th and 18th, respectively). Outcomes like a high percentage of adults having a dedicated healthcare provider and a low percentage of adults having avoided care due to cost are incorporated into this ranking. However, Michigan falls to 40th in the nation on measures of health outcomes. Outcomes related to physical health, behavioral health, chronic conditions and mortality are incorporated into this ranking.<sup>23</sup>

Although Michigan may be doing well on clinical care factors that influence an estimated 20 percent of health outcomes, the state is neglecting other changeable health factors, like social determinants of health, by not investing in policies and programs that support health factors outside of clinical care. The impact of this decision making is measurably worse health outcomes for Michigan communities and residents. An alternative approach would include supporting and investing in policies, programs, or environmental changes that can affect communities’ health, particularly at a local level, by influencing individual behaviors as well as focusing on upstream factors like employment and community safety, among others. Increased public health funding at the local level can result in innovative, tailored interventions, more staff to facilitate programming and better partnerships among stakeholders like local health departments and community-based organizations. In addition, it can create a greater capacity to evaluate interventions’ effectiveness and sustainability and ultimately, lead to improved health among Michiganders.

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## Neglecting Upstream Health Factors Results in Downstream Racial Health Disparities

Captured in these America's Health Rankings data is also a measure of residential segregation between Black and white residents, which ranks Michigan among one of the most residentially segregated states in the country. To this day, a history of geographic and economic segregation in addition to institutional racism that limits access to resources continues to impact the racial and economic makeup of Michigan's communities.<sup>24</sup> One result is that Black or African American children and Hispanic or Latinx children in Michigan are disproportionately more likely to live in high-poverty areas.<sup>25</sup> Concentrated poverty pushes well-resourced institutions and services farther from reach, which includes higher-paying jobs, healthy food, better-funded schools, and physical environments free from environmental hazards and built for community safety. Notably, per the County Health Rankings model, these are the same types of social and economic factors outside of clinical care that affect health outcomes.

**“ Concentrated poverty pushes well-resourced institutions and services farther from reach, which includes higher-paying jobs, healthy food, better-funded schools, and physical environments free from environmental hazards and built for community safety. ”**

In fact, one health outcome measured by America's Health Rankings is premature death (years lost before age 75 per 100,000 population). The racial groups with the largest disparities in premature death in Michigan include Black residents and Native American/Alaskan Native residents, when compared with non-Hispanic white residents.<sup>26</sup> These racial disparities for premature death in Michigan are an example of how both racial and economic segregation and less access to beneficial social and economic health factors have led to measurably worse health for communities of color in the state – particularly Black communities. A lack of attention to social, economic and environmental health factors has contributed to the racial disparities that exist today, but improving community-wide health factors can make progress toward health equity in Michigan. For example, the case study included in this report describes the work of the Michigan Coronavirus Racial Disparities Task Force and exemplifies how such attention can dramatically reduce racial health disparities in the span of one year.

**“ Racial health disparities are not universal and need not be inevitabilities; community-specific, health equity-focused public health programming must be better equipped and can be most successful at the local level. ”**

Racial health disparities are not universal and need not be inevitabilities; community-specific, health equity-focused public health programming must be better equipped and can be most successful at the local level. Robust, intentional investment is needed to address upstream factors of health, and this funding can support LHDs, nonprofits and institutions that provide programming and conduct public health interventions that impact factors outside of clinical care. Without this investment, racial health disparities in Michigan will continue to be inadequately addressed for future generations.

## Conclusion

To better protect communities across Michigan, public health services – especially those at the local level and delivered through LHDs – need more state funding. Compared with other states, Michigan's per-person public health spending is low, and LHDs must be better equipped to provide essential, local services and programming that goes well beyond COVID-related care. Increasing state funding for LHDs will have an impact on programs that support children, including the CSHCS program, and can also help address the myriad of upstream health factors aside from clinical care that ultimately influence downstream health outcomes. A greater focus on, and investment in, policies and programs that support social determinants of health, health behaviors and the physical environment will also help reduce racial health disparities in Michigan. Some of the most effective public health spending flows through local entities, and providing greater state resources for LHDs will better prevent disease, promote health and protect us all.

## Case Study in Focusing on Social Determinants of Health and Local Partnerships: Michigan Coronavirus Racial Disparities Task Force<sup>27</sup>

In 2020 through June 2021, Michigan experienced three waves of COVID; overall, the pandemic has disproportionately impacted racial and ethnic minorities in Michigan in terms of cases and deaths. The first wave (between March and June 2020) was especially concerning, given that early data showed that while 14 percent of the state's population is Black, 40 percent of COVID deaths were Black Michiganders – the highest death rate among all racial groups.

In April 2020, Governor Gretchen Whitmer established the first-of-its-kind Michigan Coronavirus Racial Disparities Task Force to address racial health disparities related to the COVID pandemic. The Task Force, chaired by Lieutenant Governor Garlin Gilchrist, is composed of state officials, legislators, community organizations, universities and health advocacy groups. There also continue to be opportunities for public participation. In February 2022, the Task Force released a report providing data and background information, key action steps that it has implemented and recommendations to continue to reduce racial health disparities, with a focus on impacting social determinants of health.

The Task Force has made progress on reducing racial health disparities that are a result of the COVID pandemic. For example, death rates among Black Michiganders were reduced from 15.6 per million in the first wave to 4.5 per million in the third wave, which occurred one year apart. The Task Force has identified effective strategies related to many of the root causes of health disparities. Through the lens of the **County Health Rankings model (Figure 3)**, these are solutions that affect **upstream health factors** and can improve **health outcomes**.

### Policies and programs that:

- Target systemic racism in healthcare system, which contributes to disparities;
- Reduce the rate of Michiganders who are uninsured;
- Provide extended support for new parents with low incomes; and
- Are guided by the findings from race equity impact assessments, which help develop strategies and actions to **improve health outcomes**, particularly for marginalized groups.

### Strategic investment in the infrastructure that impact **health factors like clinical care, social and economic factors, the environment and health behaviors**.

- Meeting marginalized communities where they are, including local testing and vaccination sites to limit travel, with culturally and linguistically appropriate services to be more accessible to residents.
- Building capacity with community leaders and organizations at the local level by directing state resources to local testing sites and hiring and training community-based staff.
- Investing in targeted and appropriate messaging driven by (and tailored to) impacted communities, to build trust, meet local needs and promote healthy behaviors related to COVID such as testing, mitigation strategies and vaccination.

### Improved data collection and analysis to better **track trends** in health disparities and **measure progress** toward improved health outcomes.

The report notes that MDHHS is developing a targeted social determinants of health strategy that may include local stakeholders like health departments and community partners. One tangible step toward aligning state-level goals of the Task Force and operations of LHDs, consistent with the League's policy recommendation outlined in this budget brief, is to provide them the necessary resources to advance health equity at the community level, which includes increasing the amount of MDHHS funding that flows to local entities like LHDs.



## End Notes

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