ISSUE REPORT

Investing In America's Health:

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

Trust for America's Health
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ACKNOWLEDGEMENTS

TRUST FOR AMERICA'S HEALTH IS A NON-PROFIT, NON-PARTISAN ORGANIZATION DEDICATED TO SAVING LIVES BY PROTECTING THE HEALTH OF EVERY COMMUNITY AND WORKING TO MAKE DISEASE PREVENTION A NATIONAL PRIORITY.

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Introduction

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

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

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

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

In this report, the Trust for America's Health (TFAH) examines public health funding and key health facts in states around the country.

- **Inadequate Federal Funding:** Federal funding for public health has remained at a relatively flat and insufficient level for years. The budget for CDC has decreased from a high of $7.31 billion in 2005 to $6.13 billion in 2012.[2] Spending through CDC averaged to only $19.54 per person in FY 2012. And the amount of federal funding spent to prevent disease and improve health in communities ranged significantly from state to state, with a per capita low of $13.72 in Indiana to a high of $53.07 in Alaska.
- **Cuts in State and Local Funding:** At the state and local levels, public health budgets have been cut at drastic rates in recent years. According to a TFAH analysis, 29 states decreased their public health budgets from FY 2010-11 to FY 2011-12. Budgets in 23 states decreased for two or more years in a row, and budgets in 14 states decreased for three or more years in a row. In FY 2011-12, the median state funding for public health was $27.40 per capita, ranging from a high of $154.99 in Hawaii to a low of $3.28 in Nevada. From FY 2008 to FY 2012, the median per capita state spending decreased from $33.71 to $27.40. This represents a cut of more than $1.15 billion, based on the total states' budgets from those years, which would be $1.9 billion adjusted for inflation.

According to a survey by the Association of State and Territorial Health Officials (ASTHO), 48 state health agencies (SHAs) reported experiencing budget cuts since 2008.[3] According to the Center on Budget and Policy Priorities (CBPP), states have experienced overall budgetary shortfalls of $540 billion combined from FY 2009 to FY 2012, and 31 states have projected or closed budget gaps totaling $55 billion in FY 2013.[4, 5]

State and local health departments have cut more than 45,700 jobs across the country since 2008.[6] During 2011, 57 percent of all local health departments reduced or eliminated at least one program.[7]

- **Wide Variation in Health Statistics by State:** There are major differences in disease rates and other health factors in states around the country. For instance, only 6.7 percent of adults in Colorado and Utah have diabetes compared to 12.3 percent in Mississippi, and less than 12 percent of adults in Utah are current smokers while almost 30 percent report smoking in Kentucky.
- **Wide Variation in Health Statistics by County:** There are also major differences in disease rates and health factors within each state. County Health Rankings, published by the Robert Wood Johnson Foundation (RWJF) and University of Wisconsin Popu-

lation Health Institute, provide county-level data on a number of key health factors for nearly every county in the country. The rankings assess health behaviors (tobacco use, diet, alcohol use, etc.), clinical care (access to and quality of care), social and economic factors (education, employment, income, etc.) and physical environment (environmental quality and the built environment). The Rankings highlight the healthiest and least healthy counties in every state and identify factors that influence health, outside of the doctor's office. The rankings do not currently include budget data by county.

Public health departments have the unique role and responsibility as chief health strategist for communities — working to improve health in their schools, workplaces and neighborhoods. This involves identifying the top health problems and developing strategies for how to address them. To be effective, public health officials must have the capabilities to define the scope of health problems, set goals to improve health and recruit whoever can help make change happen.

In 2013, the public health field faces a sea change: a reforming health system, massive budget cuts, an increased focus on accountability and the growing adoption of electronic health records (EHRs) are creating new challenges and opportunities.

Historically, the exact services and programs that public health departments provide can be different depending on where you are in the country. The structures, budgets and sets of responsibilities can vary significantly based on the state and county.

Two recent projects have stressed that to adapt to the changes they face and to meet modern needs, public health departments at the federal, state and local level must have a stronger focus on their unique and most effective capabilities. Both the IOMs *For the Public's Health: Investing in a Healthier Future* report and a group of thought-leaders who comprised the Transforming Public Health project, funded by the Robert Wood Johnson Foundation (RWJF) and convened by RESOLVE, identified foundational capabilities for public health.[8, 9]

But, federal public health programs as currently structured, do not actively promote a set of baseline, consistent capabilities that every community across the country should meet. There is little strategic rationale for the way public health is funded in America, including for the differences in funding for different places around the country. Federal funding is based on a mixture of population-based formula grant programs (often based on disease rates or other incidence formulas) and a series of competitive grants — where some states receive funding and others do not. Because of insufficient funding for CDC, many states submit competitive grants that are "approved but unfunded" because of limited funds. In most cases, there is no official strategy for targeting or coordinating these funds. Also, state and local funding varies dramatically, largely due to the different structures of a state's public health department. Some departments are centralized, while others are decentralized where responsibilities rest more on local departments than at the state level. However, states and localities also place different priorities on public health, which also accounts for differences in funding. The state-by-state comparisons included in this report's budget analysis do not include county or city revenues that are generated to support local health departments, which are also quite variable.

This report examines some key disease rates in combination with health spending to help further the discussion about what the right amount of public health funding should be in order to have a real impact on reducing disease rates nationally.

Overall, the report concludes that a sustained and sufficient level of investment in prevention is essential to improving health in the United States and that differences in disease rates will not be changed unless an adequate level of funding is provided to support public health departments and disease prevention efforts.

WHERE YOU LIVE SHOULD NOT DETERMINE HOW HEALTHY YOU ARE

Where you live, learn, work and play make a big difference in how healthy you are.

A range of factors, like education, employment, income, family and social support, community safety, and the physical environment, impact our health.

In many communities, healthy choices are easy choices for their residents. In these communities, there are plenty of gyms, safe places to jog and community recreation centers with high-quality swimming pools and sports fields. The children play and exercise in well-maintained parks and have access to affordable nutritious foods. But in many other American communities, there are obstacles to healthy living:

- Parks and playgrounds are littered, broken or unsafe.
- School meals are low in nutritional value, school vending machines sell junk food, and students don't get regular physical education classes.
- There are few places to get out and exercise — some communities don't even have sidewalks for walking.
- Access to fruit and vegetables is limited because there are no supermarkets.
- Dilapidated housing, crumbling schools, abandoned factories, and freeway noise and fumes cause illness and injury.

The poor overall conditions cause higher levels of obesity and chronic disease, including diabetes, heart disease and cancer, leading to higher health care costs.

One major factor in the health of a community is whether or not they have a strong public health system. Public health departments can help improve the health of communities, since they are responsible for finding ways to address the systemic reasons why some communities are healthier than others and for developing policies and programs to remove obstacles that get in the way of making healthy choices possible.

FOUNDATIONAL CAPABILITIES FOR PUBLIC HEALTH

In their April 2012 report, *For the Public's Health: Investing in a Healthier Future,* the IOM called for increased focus and prioritization among governmental public health agencies at all levels. They identified a set of foundational capabilities that included:[10]

- Information systems and resources;
- Health planning;
- Partnership development and community mobilization;
- Policy development analysis and decision support;
- Communication; and
- Public health research, evaluation and quality improvement.

Following the IOM report, a group of leading public health thought leaders also participated in the Transforming Public Health project, funded by the Robert Wood Johnson Foundation and convened by RESOLVE to develop guidance for public health officials and policymakers to prioritize vital public health functions in a shifting political landscape.[11]

They summarized the foundational capabilities of public health as:

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

The project also identified a set of additional important issues for public health departments to consider, which include:

- Maintaining a culture of continuous quality improvement;
- Improving coordination across all levels of government to foster synergy and efficiency;
- Building a better-and cross-trained workforce, more versatile and well equipped to hand a range of public health needs;
- Bolstering research, capitalizing on improved technology to access and analyze data, to better demonstrating the value of public health and prevention services and programs; and
- Ensuring sufficient, stable and sustainable funding for public health, including leveraging resources from non-traditional sources that also have an interest in improving health, such as across government agencies and from the health care sector, private industry, non-profit fundraising and community development.

The project stressed that "prioritizing is the only way to be able to take on new challenges in a time of declining resources," and it is essential to be successful in the future, public health should focus on:[12]

- Ensuring what is being done is being done well and as efficiency as possible;
- Coordinating across all levels of the governmental public health system and other government agencies and jurisdictions to maximize impact; and
- Cultivating and/or training a workforce that can deliver foundational capabilities when implementing programs.

PUBLIC HEALTH ACCREDITATION

The Public Health Accreditation Board (PHAB), created in 2007, has launched a voluntary public health accreditation program for state and local public health departments.[13] This accreditation process is a major effort to improve and standardize core capabilities of health departments.

The PHAB administers the national public health department accreditation program for public health departments operated by Tribes, states, local jurisdictions and territories,[14] and in March, 2013, PHAB announced the first round of public health departments to achieve accreditation status. PHAB accreditations include domains (groups of standards that pertain to a broad group of public health services), standards (the required level of achievement that a health department is expected to meet), and measures (evaluation tools for meeting standards).

There are 12 domains. The first 10 domains address the 10 Essential Public Health Services; domain 11 addresses management and administration, and domain 12 addresses governance.[15]

The 12 domains include:

Domain 1: Conduct and disseminate assessments focused on population health status and public health issues facing the community.

Domain 2: Investigate health problems and environmental public health hazards to protect the community.

Domain 3: Inform and educate about public health issues and function.

Domain 4: Engage with the community to identify and address health problems.

Domain 5: Develop public health policies and plans.

Domain 6: Enforce Public Health Laws.

Domain 7: Promote strategies to improve access to health care services.

Domain 8: Maintain a competent public health workforce.

Domain 9: Evaluate and continuously improve health department processes, programs and interventions.

Domain 10: Contribute to and apply the evidence base of public health.

Domain 11: Maintain administrative and management capacity.

Domain 12: Maintain capacity to engage the public health governing entity.

Standard 5.4 focuses specifically on preparedness and requires that public health departments maintain an all hazards emergency operations plan. In order to become accredited, a health department must:[16]

- Participate in the process for the development and maintenance of an All Hazards Emergency Operations Plan (EOP);
- Adopt and maintain a public health emergency operations plan (EOP); and
- Provide consultation and/or technical assistance to Tribal and local health departments in the state regarding evidence-based and/or promising practices/templates in EOP development and testing.

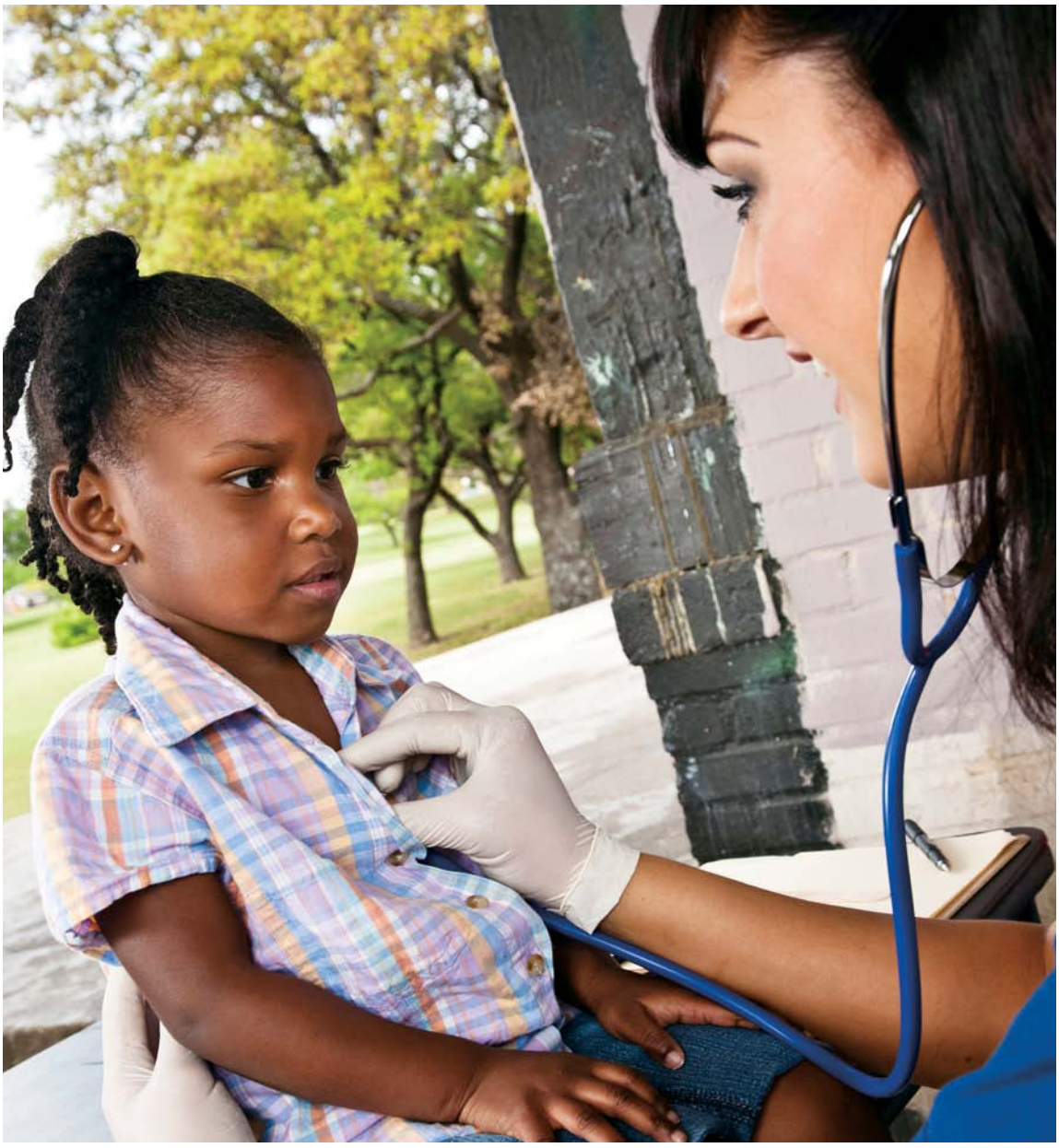
SECTION 1

Funding for Public Health

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

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

TFAH analyzes federal and state funding for public health based on the most complete financial data currently available. There is a significant delay from the time when a President proposes a fiscal year budget to when appropriations legislation is signed into law to the time when the funds are disbursed. TFAH uses FY 2012 data for this analysis, which is the budget year for which the data is most complete and accurate.



A. FEDERAL INVESTMENT IN PUBLIC HEALTH

Federal Funding for States from the U.S. Centers for Disease Control and Prevention

Summary of CDC Dollars — FY 2012			
State	**CDC Total (All Categories)**	**CDC Per Capita Total**	**CDC Per Capita Ranking**
Alaska	$38,819,934	$53.07	1
Vermont	$21,110,207	$33.72	2
New Mexico	$70,250,361	$33.68	3
Delaware	$30,280,612	$33.02	4
Rhode Island	$31,960,614	$30.43	5
North Dakota	$21,055,124	$30.09	6
Maine	$39,946,126	$30.05	7
Montana	$29,819,454	$29.67	8
South Dakota	$24,396,747	$29.28	9
Wyoming	$15,695,996	$27.23	10
Mississippi	$74,978,923	$25.12	11
West Virginia	$46,508,068	$25.07	12
New York	$463,529,133	$23.69	13
Maryland	$138,402,431	$23.52	14
Hawaii	$32,221,612	$23.14	15
Washington	$158,136,461	$22.93	16
Nebraska	$42,124,937	$22.70	17
Louisiana	$103,141,587	$22.41	18
Oklahoma	$84,813,374	$22.23	19
Arkansas	$65,243,850	$22.12	20
Idaho	$34,903,102	$21.87	21
New Hampshire	$28,650,897	$21.69	22
Georgia	$212,478,247	$21.42	23
South Carolina	$100,755,655	$21.33	24
Nevada	$58,779,217	$21.31	25
Massachusetts	$139,390,305	$20.97	26
Iowa	$63,417,878	$20.63	27
Texas	$520,769,662	$19.98	28
Illinois	$257,152,778	$19.97	29
Oregon	$76,661,012	$19.66	30
NATIONAL AVERAGE $19.54			
Alabama	$93,514,221	$19.39	31
Utah	$55,357,071	$19.39	31
Colorado	$99,074,398	$19.10	33
Arizona	$122,062,646	$18.63	34
Connecticut	$66,704,650	$18.58	35
North Carolina	$175,697,917	$18.02	36
California	$684,468,876	$17.99	37
Kansas	$51,502,609	$17.85	38
Minnesota	$95,782,348	$17.81	39
Kentucky	$77,279,238	$17.64	40
Michigan	$169,498,728	$17.15	41
Tennessee	$110,507,394	$17.12	42
Missouri	$101,819,630	$16.91	43
New Jersey	$144,925,215	$16.35	44
Florida	$314,363,404	$16.27	45
Wisconsin	$90,650,154	$15.83	46
Pennsylvania	$196,649,136	$15.41	47
Ohio	$163,520,990	$14.16	48
Virginia	$115,110,759	$14.06	49
Indiana	$89,666,444	$13.72	50
D.C.*	$91,209,376	N/A	N/A
U.S. TOTAL**	**$6,134,759,508**	**$19.54**	**NA**

*D.C. was not included in the per capita rankings because it receives different funding levels than the 50 states.

**Total includes monies only for Washington, D.C.and U.S.

Federal public health spending through CDC averaged only $19.54 per person in FY 2012. And the amount of federal funding spent to prevent disease and improve health in communities ranged significantly from state to state, with a per capita low of $13.72 in Indiana to a high of $53.07 in Alaska.

Approximately 75 percent of CDC's budget is distributed to states, localities, and other public and private partners to support services and programs. Most of the federal funding from CDC is distributed by categories. Some of CDC's funding is based on the number of people in a state or on a need-based formula for priority programs. Other funds are based on competi-

tive grants. States can apply to CDC for funding for specific program areas. Often in these cases, not all states that apply for funds receive them because there are insufficient funds appropriated to allow all states to receive grants.

Public health funding from CDC has been flat in recent years. After converting each year into 2012 dollars, CDC funding shows 2005 as the peak of distribution during the past seven years. CDC distributed $7.31 billion in 2005, decreased significantly to $5.76 billion in 2007, and in 2008 the amount remained flat at $5.71 billion. A slight increase can be seen in 2009 and 2010 at $6.32 billion and $6.58 billion respectively. Funds started decreasing in 2011 to $6.45 billion, and continue to decrease in 2012 to $6.13 billion.

Federal Funding for States from the Health Resources and Services Administration

Summary of HRSA Dollars — FY 2012			
State	**HRSA Total (All Programs)**	**HRSA Per Capita Total (All Programs)**	**HRSA Per Capita Ranking**
Alaska	$56,461,159	$77.19	1
Montana	$55,181,295	$54.90	2
Hawaii	$62,127,665	$44.62	3
New Mexico	$80,009,615	$38.36	4
Rhode Island	$37,297,028	$35.51	5
Maine	$45,380,118	$34.14	6
Massachusetts	$219,790,597	$33.07	7
New York	$627,145,827	$32.05	8
Delaware	$29,129,117	$31.76	9
Vermont	$19,844,591	$31.70	10
Louisiana	$145,622,675	$31.64	11
Mississippi	$94,179,895	$31.55	12
West Virginia	$58,368,017	$31.46	13
Colorado	$152,988,731	$29.49	14
South Dakota	$24,378,784	$29.25	15
Washington	$192,609,665	$27.93	16
South Carolina	$130,932,399	$27.72	17
Idaho	$44,021,110	$27.59	18
Arkansas	$81,210,483	$27.54	19
Maryland	$161,031,336	$27.37	20
Alabama	$131,090,954	$27.19	21
Connecticut	$97,261,394	$27.09	22
Tennessee	$158,423,179	$24.54	23
North Dakota	$16,858,024	$24.10	24
Kentucky	$104,359,297	$23.82	25
Oregon	$92,805,051	$23.80	26
New Hampshire	$30,921,347	$23.41	27
Illinois	$299,168,473	$23.24	28
NATIONAL AVERAGE $23.18			
California	$874,584,956	$22.99	29
Florida	$439,720,852	$22.76	30
Missouri	$136,094,279	$22.60	31
Pennsylvania	$282,517,924	$22.13	32
Kansas	$62,425,080	$21.63	33
Georgia	$212,867,975	$21.46	34
Nebraska	$39,334,468	$21.20	35
New Jersey	$185,392,672	$20.91	36
Oklahoma	$77,847,908	$20.41	37
Iowa	$62,004,278	$20.17	38
North Carolina	$183,948,138	$18.86	39
Michigan	$179,270,438	$18.14	40
Virginia	$147,363,454	$18.00	41
Texas	$467,406,983	$17.94	42
Minnesota	$94,261,831	$17.52	43
Wyoming	$10,096,330	$17.52	43
Arizona	$114,612,133	$17.49	45
Utah	$49,388,525	$17.30	46
Ohio	$195,435,475	$16.93	47
Wisconsin	$90,930,864	$15.88	48
Indiana	$88,306,262	$13.51	49
Nevada	$34,330,501	$12.44	50
D.C.*	$125,424,928	N/A	N/A
U.S. TOTAL**	**$7,276,739,152.0**	**$23.18**	**N/A**

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

** The U.S. total reflects HRSA grants to all 50 states and D.C.

Health Resources and Services Administration (HRSA) grants to states averaged out to only $23.18 per person in FY 2012. And the amount of funding spent for key health program areas ranged significantly from state to state, with a per capita low of $12.44 in Nevada to a high of $77.19 in Alaska.

Information on the amount of federal funding each state receives for a range of public health programs is available online at www.healthyamericans.org along with key health facts for each state. The online State Data pages contain funding information on programs from CDC, HRSA and the Office of the Assistant Secretary for Preparedness and Response (ASPR). A full list of the funding by category is available in Appendices E-F; and a list of key health statistics by state is available in Appendices B-D. Notes on data and methodology are available in Appendix A.

HRSA distributes approximately 90 percent of its funding in grants to states and territories, public and private health care providers, health professions training programs and other organizations.[17] HRSA's funding is not distributed on a strictly per capita basis. The bulk of HRSA funds are in its two largest programs, the community and migrant health centers and the Ryan White Act HIV programs, and these dollars are awarded on a competitive basis and/or based on disease burden.

WHAT ARE THE FEDERAL GOVERNMENT'S PUBLIC HEALTH OBLIGATIONS?

In partnerships with states and localities, the federal government has an obligation to:

- Ensure the capacity of all levels of government to provide essential public health services;
- Act when health threats may span many states, regions, or the whole country;
- Act where the solution may be beyond the jurisdiction of individual states;
- Act to assist the states when they do not have the expertise or resources to mount an effective response in a public health emergency such as a natural disaster, bioterrorism, or an emerging disease;
- Facilitate the formulation of public health goals in collaboration with state and local governments and other relevant stakeholders;
- Be transparent and accountable for public health investments; and
- Disseminate innovation and best practices from state and local public health.

Source: Trust for America's Health. *Public Health Leadership Initiative an Action Plan for Healthy People in Healthy Communities in the 21st Century.*[18]

NATIONAL PREVENTION STRATEGY AND PREVENTION FUND

The Affordable Care Act (ACA) included a number of new federally-supported public health and prevention measures, aimed at improving the health of Americans, including:

- A new focus on cost containment and improving health within the health care system;
- A major expansion of the number of Americans and types of preventive services covered by insurance;
- The creation of a National Prevention Strategy and Plan to find more ways across the federal government to support better health;
- A new Prevention and Public Health Fund to provide $12.5 billion in mandatory appropriations over 10 years to local communities to improve health and reduce illness rates, which included Community Transformation Grants (CTGs) to allow local communities to tackle their most serious problems, including obesity and tobacco, using evidence-based prevention programs tied to strict performance measures; and
- New community engagement and reporting requirements for nonprofit hospitals' community benefit programs.

THE PREVENTION AND PUBLIC HEALTH FUND

Prevention saves lives, reduces health care costs, and makes the country a healthier, more productive place. More than half of Americans live with at least one serious preventable health condition, like diabetes or heart disease, which forces taxpayers to spend billions of dollars a year on health care. And, today's children are in danger of becoming the first generation in American history to live shorter, less healthy lives than their parents. The Prevention and Public Health Fund enables communities around the country to invest in proven strategies to improve health. That's why the Fund has the support of 783 national, state and local organizations.

Combating the leading causes of chronic diseases will improve the health of Americans and reduce health care costs over the long term. The Fund will be used for programs at the local, state and federal level to reduce the rates of obesity, heart disease and stroke, and tobacco use by five percent within five years.

Communities across the country often face increased health and safety threats without the resources to combat them. The Fund supports community-driven prevention efforts to reduce tobacco use, increase physical activity, improve nutrition, expand mental health and injury prevention programs and improve prevention activities.

Patients need to be able to act on their doctor's orders outside of the doctor's office. The Fund supports services and programs that allow health to be improved in our schools, neighborhoods and workplaces by making healthier choices easier choices.

Businesses benefit by having a productive, healthy workforce. Investing in the health of Americans improves the bottom line of businesses by lowering health care costs, reducing absenteeism, increasing academic achievement and improving productivity.

Public health emergencies demand a public response. The Fund enables state and local health officials to respond to emergencies that put citizens' lives and health at stake — including natural disasters, terrorist attacks, infectious diseases, and unsafe food, air and water.

Job-training and opportunities are supported to ensure the future workforce can respond to the health and safety challenges of the 21st century. The Fund provides training and financial assistance for workers, and invests in up-to-date equipment and technology, needed to protect communities from disease outbreaks and other health threats.

Every community has unique challenges. The Fund provides financial support directly to states and communities and gives them flexibility to address their most pressing health challenges.

Flexibility must come with accountability when taxpayer dollars are at stake. The Fund invests in prevention programs that are proven and effective. Oversight and evaluation is a key component of every Fund-sponsored program, and strict performance measures ensure accountability.

COMMUNITY TRANSFORMATION GRANTS: PROMOTING PROVEN STRATEGIES TO FIGHT CHRONIC DISEASES

CTGs, one major initiative funded under the Prevention and Public Health Fund, are targeted at addressing the leading causes of chronic diseases to improve the health of Americans and reduce health care costs over the long term. The investments being made are critical to make sure people can take personal responsibility for their health care outside of the doctor's office and allow individual communities to address their greatest health needs. CTGs will benefit more than one in three Americans, approximately 145 million people.

Why are CTGs Needed:

- Chronic diseases are responsible for 7 of 10 deaths among Americans each year, and treatment for people with chronic conditions account for more than 75 percent of the more than $2 trillion spent on annual U.S. medical care costs.
- Unhealthy Americans cost communities, taxpayers, and businesses in health care costs and productivity loss, and lower academic achievement for kids and young adults.
- While individuals must take personal responsibility for their health, they must have the support of their communities so that they do not face obstacles to healthy living.

What CTGs do:

- CTGs allow communities to design specific interventions that meet the most pressing needs of their populations.
- CTGs invest in proven, effective community-based interventions, and focus on addressing the leading causes of chronic disease, such as tobacco use, obesity, poor nutrition and health disparities.
- Within five years, CTG grantees are required to meet strict performance measures, including reducing death and disability due to tobacco use by five percent, the rate of obesity by five percent through nutrition and physical activity interventions, and death and disability due to heart disease and stroke by five percent.

Why CTGs Work:

- CTGs are required to base their efforts on proven, evidence-based approaches and must meet measurable, achievable outcomes to continue receiving federal dollars.
- CTGs are developed and administered by community members working together at the local level, not Washington bureaucrats who may not understand the specific community needs.

THE NATIONAL PREVENTION, HEALTH PROMOTION, AND PUBLIC HEALTH COUNCIL; THE ADVISORY GROUP ON PREVENTION, HEALTH PROMOTION, AND INTEGRATIVE AND PUBLIC HEALTH: AND THE NATIONAL PREVENTION STRATEGY

The ACA established a National Prevention, Health Promotion, and Public Health Council and an Advisory Group on Prevention, Health Promotion, and Integrative and Public Health, designed to provide coordination and leadership among 17 executive departments and agencies at the Federal level on prevention, wellness and health promotion practices through the public health system.

The Council, chaired by the Surgeon General, was created by Executive Order in June 2010.

The role of the council is to ensure federal health and prevention efforts are coordinated, aligned and championed; and to encourage partnerships to benefit all Americans among all levels of government, the private sector, philanthropic organizations, educational organizations, community and faith-based organizations. The role of the Advisory Group is to offer recommendations to the members of the Council and advise them on effective, evidence-based prevention and health-promotion activities.

In June 2011, the Council released the National Prevention Strategy — a guide for the country to achieve, in the most effective way, improved health and well-being. The Strategy identified four Strategic Directions: 1) create, sustain and recognize communities that promote health and wellness through prevention; 2) ensure prevention-focused health care and community prevention efforts are available, integrated, and mutually reinforcing; 3) support people in making healthy choices; and 4) eliminate health disparities to improve the quality of life for all Americans. It also specified seven evidence-based priorities: 1) tobacco free living; 2) preventing drug abuse and excessive alcohol abuse; 3) healthy eating; 4) active living; 5) injury and violence free living; 6) reproductive and sexual health; and 7) mental and emotional well-being.

In June 2012, the Council released the National Prevention Council Action Plan, which builds from the vision, goal, recommendations, and actions of the landmark National Prevention Strategy. The Action Plan identifies commitments shared across all 17 departments and unique department actions being taken to further each of the Strategic Directions and Priorities of the National Prevention Strategy. The Council identified three shared commitments across the federal government: 1) identifying opportunities to consider prevention and health; 2) increasing tobacco-free environments; and 3) increasing access to healthy and affordable food.

Why The National Prevention Strategy Matters:

- Numerous factors outside the health care system — including housing, education, transportation, the availability of quality affordable food, and conditions in the workplace and the environment — often play a large role in public health so working across agencies to identify and develop reforms can have a major impact in improving the health of all Americans.
- If every federal agency focuses increased attention on prevention and health promotion, benefits will flow to the public's health and will help each agency fulfill its mission.

B. STATE INVESTMENT IN PUBLIC HEALTH

State Funding for Public Health

State Public Health Budgets			
State	**FY 2011-2012**	**FY 11-12 Per Capita**	**Per Capita Ranking**
Hawaii[2]	$215,793,131	$154.99	1
D.C.	$65,927,000	$104.26	2
Idaho	$143,890,100	$90.17	3
West Virginia	$160,589,232	$86.55	4
Alaska[2]	$59,261,100	$81.02	5
New York	$1,468,595,515	$75.04	6
Alabama	$358,728,139	$74.39	7
California	$2,512,158,000	$66.04	8
Wyoming	$33,852,718	$58.73	9
Massachusetts	$361,079,843	$54.33	10
Arkansas	$150,180,308	$50.92	11
North Dakota[3]	$34,013,780	$48.62	12
Rhode Island	$49,390,630	$47.03	13
New Mexico	$97,144,500	$46.58	14
Kentucky	$191,695,800	$43.76	15
Tennessee	$275,073,200	$42.61	16
Washington[3]	$289,049,500	$41.91	17
Vermont	$26,084,071	$41.67	18
Delaware[2]	$38,153,700	$41.60	19
Nebraska	$72,690,976	$39.18	20
Oklahoma[1]	$148,623,000	$38.96	21
Virginia[3]	$299,156,071	$36.55	22
Colorado	$180,719,799	$34.84	23
Maryland[2]	$175,461,490	$29.82	24
South Dakota[4]	$23,735,633	$28.48	25
MEDIAN $27.40			
Utah	$78,246,700	$27.40	26
New Jersey	$229,203,000	$25.86	27
Connecticut[2]	$88,191,904	$24.56	28
Illinois	$297,253,500	$23.09	29
Maine[2]	$29,708,338	$22.35	30
Florida[2]	$382,052,729	$19.78	31
Montana	$19,552,494	$19.45	32
South Carolina	$90,947,879	$19.25	33
Texas	$478,338,289	$18.36	34
Iowa	$53,688,501	$17.46	35
Indiana	$113,929,495	$17.43	36
Michigan[3]	$172,041,800	$17.41	37
Georgia	$168,715,698	$17.01	38
Louisiana	$70,778,560	$15.38	39
Minnesota[2, 4]	$77,456,000	$14.40	40
Ohio	$166,257,009	$14.40	40
Kansas[4]	$41,479,143	$14.37	42
Pennsylvania[2]	$181,961,000	$14.26	43
North Carolina[2]	$138,126,056	$14.16	44
New Hampshire	$17,794,601	$13.47	45
Oregon	$52,141,850	$13.37	46
Wisconsin	$75,042,700	$13.10	47
Mississippi[2]	$26,521,920	$8.89	48
Arizona	$49,756,500	$7.59	49
Missouri	$36,592,175	$6.08	50
Nevada	$9,042,262	$3.28	51

Notes:

1 May contain some social service programs, but not Medicaid or CHIP.

2 General funds only.

3 Budget data taken from appropriations legislation.

4 State did not respond to the data check TFAH coordinated with ASTHO that was sent out October 26, 2012. States were given until November 16, 2012 to confirm or correct the information. The states that did not reply by that date were assumed to be in accordance with the findings.

According to TFAH's analysis of state funding, 29 states decreased their public health budgets from FY 2010-11 to FY 2011-12, 23 states decreased budgets for a second year in a row, and of those 14 decreased for three years in a row. In FY 2011-12, the median state funding for public health was $27.40 per capita, ranging from a high of $154.99 in Hawaii to a low of $3.28 in Nevada. From FY 2008 to FY 2012, the median per capita state spending decreased from $33.71 to $27.40.

The majority of funding for public health comes from the state and local levels, although estimates of the percentages vary. in 2000, according to one analysis, state and local spending was 2.5 times the federal level, accounting for 70 percent of all public health spending.[19] According to one analysis in 2000, combined state and local public health spending was $44.29 per person while federal spending was $17.77 per capita. Dramatic cuts to state and local funding since 2008 mean this ratio is likely to change significantly.

Every state allocates and reports its budget in different ways. States also vary widely in the budget details they provide. This makes comparisons across states difficult. For this analysis, TFAH examined state budgets and appropriations bills for the agency, department, or division in charge of public health services for FY 2010-11 and FY 2011-12, using a definition as consistent as possible across the two years, based on how each state reports data. TFAH defined "public health services" broadly, including most state-level health funding.

Public health funding is discretionary spending in most states and, therefore, is at high risk for significant cuts during economic downturns. While few states allocate funds directly for public health preparedness, state and local funding is essential for supporting public health infrastructure and core capacities of health departments. The ways some states report their budgets, for instance, by including federal funding in the totals or including public health dollars within health care spending totals, make it very difficult to determine public health as a separate item.

WHAT ARE STATE AND LOCAL GOVERNMENTS PUBLIC HEALTH OBLIGATIONS?

States and localities have an obligation to:

- Fulfill core public health functions such as diagnosing and investigating health threats, informing and educating the public, mobilizing community partnerships, protecting against natural and human-made disasters, and enforcing state health laws;
- Provide relevant information on the community's health and the availability of essential public health services. This information should be integrated with reporting from local hospitals and health care providers to show how well public concerns and health threats are being addressed. These reports should also be publicly available and utilized by public health departments to work collaboratively with hospitals, physicians, and others with a role in public health to set health goals;
- Work collaboratively with the multiple stakeholders who influence public health at the community level in designing appropriate programs and interventions that address key health problems and improve the health of the region; and
- Deal with complex, poorly understood problems by acting as "policy laboratories." States and localities are closer to the people and to the problems causing ill health.

Trust for America's Health. *Public Health Leadership Initiative an Action Plan for Healthy People in Healthy Communities in the 21st Century.*[20]

C. LOCAL INVESTMENT IN PUBLIC HEALTH

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

A July 2011 study published in the journal *Health Affairs* found that increased spending by local public health departments can save lives currently lost to preventable illnesses.[22] Researchers Glen P. Mays and Sharla A. Smith mapped spending by local public health agencies from 1993-2005 with preventable mortality rates in each agency's respective jurisdiction. The report found:

- On average, local public health spending rose from $34.68 per capita in 1993 to $40.84 per capita in 2005 — an increase of more than 17 percent.
- For each 10 percent increase in local public health spending, there were significant decreases in infant deaths (6.9 percent drop), deaths from cardiovascular disease (3.2 percent drop), deaths from diabetes (1.4 percent drop), and deaths from cancer (1.1 percent drop).
- The 3.2 percent decrease in cardiovascular disease mortality cited above required local health agencies to spend, on average, an additional $312,274 each year. In contrast, achieving the same reduction in deaths from cardiovascular disease by focusing on treatment and other traditional healthcare approaches would require an additional 27 primary care physicians in the average metropolitan community. To put this comparison in perspective, the median salary for a single primary care physician was $202,392 in 2010 as a result, 27 primary care physicians would cost nearly $5.5 million, or more than 27 times the public health investment.[23]

According to a 2008 study by researchers at the University of Arkansas for Medical Sciences, while local public health spending reached $29.57 per capita for the median community in 2005, funding ranged from an average of $8 per person in the lowest 20 percent of communities to nearly $102 per person in the top 20 percent of communities.[24] The spending in the top 20 percent was 13 times more than the lowest 20 percent. They found that communities in the top quintile of public health spending were likely to operate as decentralized units of government.

In addition, the researchers found that communities with higher rates of medical spending and resources and more physicians per capita spent less on public health, and conversely communities with lower rates of medical spending and resources and numbers of physician spent more on public health. The authors provide possible reasons for this, including: communities that spend a lot on medical care may not have additional resources for public health; communities with low rates of health insurance may rely more strongly on public health services for their needs; and communities with good preventive services may offset the need for medical care.[25]

A recent study conducted by the National Association of County and City Health Officials (NACCHO) found significant cuts to programs, workforce and budgets at LHDs around the country. Since 2008, LHDs have lost a total of 34,400 jobs due to layoffs and attrition.[26] Combined state and local public health job losses total 45,700 since 2008.[27] LHDs continue to struggle with budget cuts. In July, 2011 nearly half of LHDs reported reduced budgets, which is in addition to 44 percent that reported lower budgets in November 2010.[28] In addition, more than 50 percent of LHDs expect cuts to their budgets in the upcoming fiscal year.

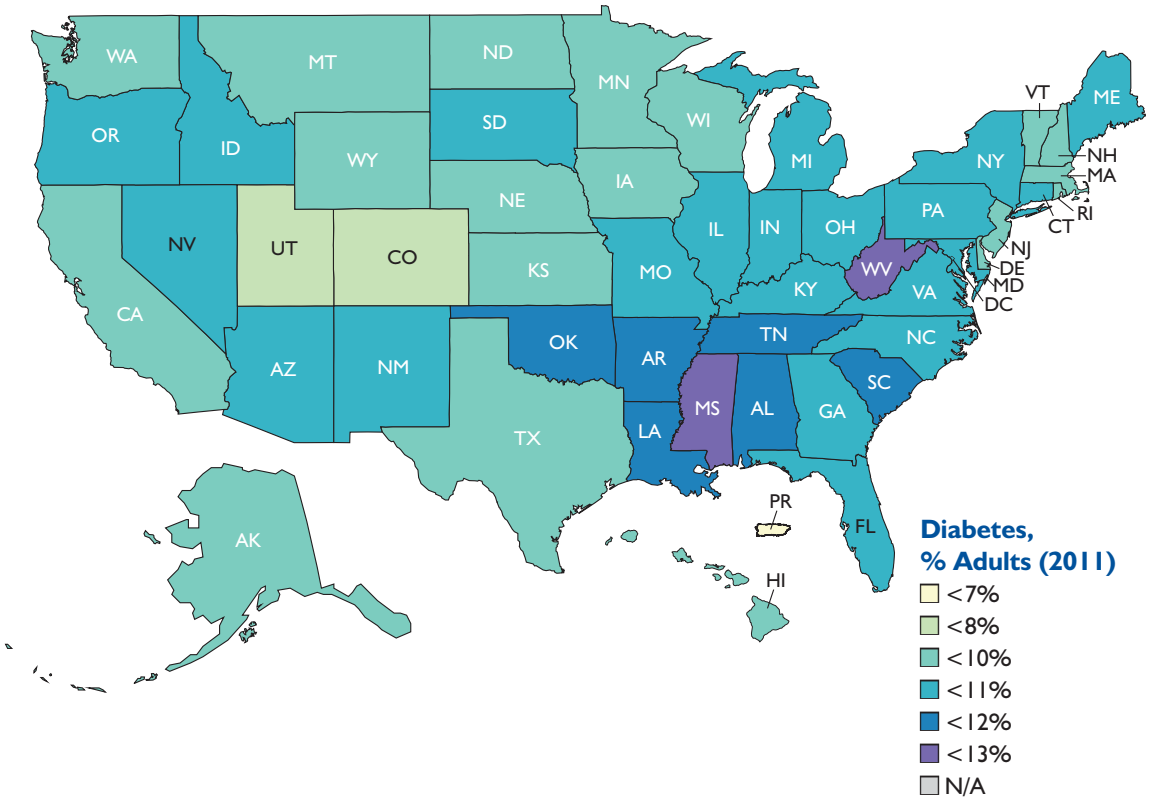
Key Health Facts

SECTION 2

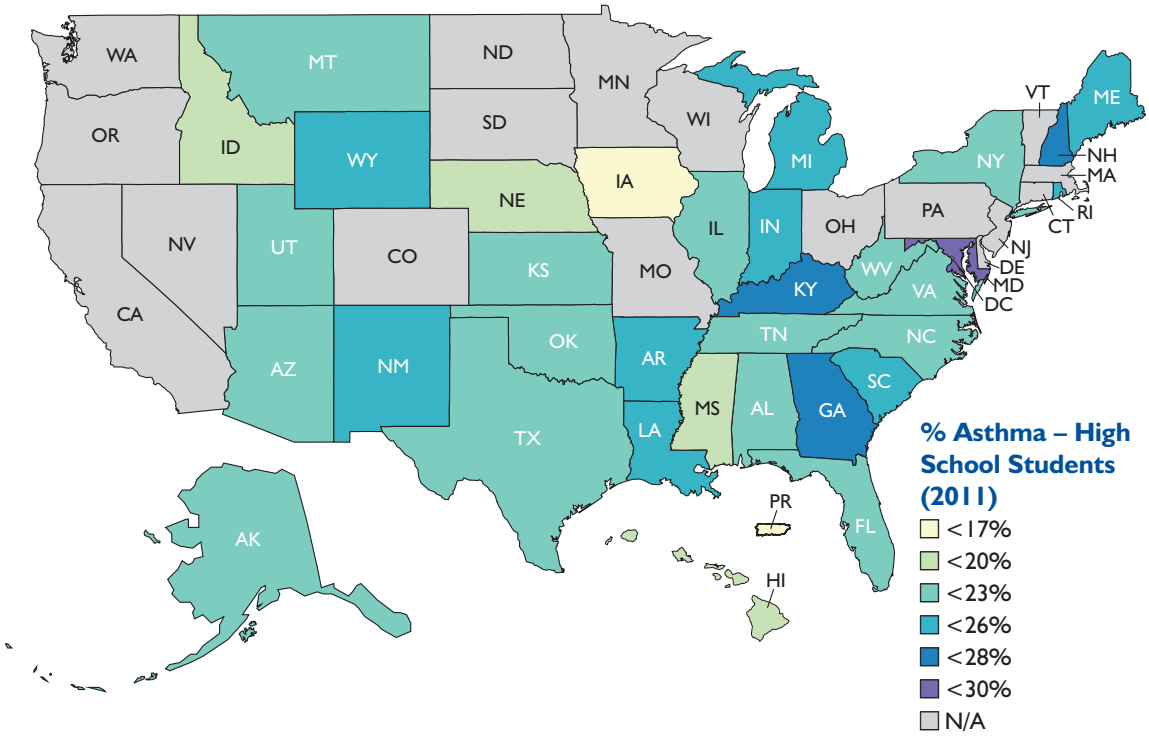
The following are a series of maps demonstrating differences in disease rates for a number of key indicators on a state-by-state basis.

ADULT HEALTH INDICATORS	U.S. Total	State with Highest/ Worst	State with Lowest/ Best
% Uninsured, All Ages (2011)	15.7%	Texas (23.8%)	Massachusetts (3.4%)
Adult Physical Inactivity Rate (2011)	N/A	Mississippi (36.0%)	Colordao (16.5%)
AIDS Cum Cases 13 and Older (2010)	1,119,652	New York (199,176)	North Dakota (180)
Alzheimer's Estimated Cases among 65+ (2025)	6,479,700	California (660,000)	Alaska (7,700)
Asthma (2010)	13.5%	Hawaii (17.6%)	Tennessee (9.3%)
Percent Exclusive Breastfeeding at 6 Months, (Births 2009)	16.3%	Mississippi (7.6%)	Colorado (26.6%)
Cancer Estimated New Cases (2012)	1,638,910	California (165,810)	Wyoming (2,650)
Chlamydia Rates per 100,000 Population (2011)	457.6	D.C. (1094.4)	New Hampshire (228.6)
Diabetes (2011)	N/A	Mississippi (12.3%)	CO and UT (6.7%)
Fruits and Vegetables (2011)	N/A	West Virginia (7.9%)	D.C. (25.6%)
Human West Nile Virus Cases (2012)	5,387	Texas (1,739)	AK and HI (0)
Hypertension (2011)	N/A	Alabama (40.0%)	Utah (22.9%)
Obesity (2011)	N/A	Mississippi (34.9%)	Colorado (20.7%)
Pneumococcal Vaccination Rates 65 and Over (2011)	70.0%	Illinois (62.5%)	Oregon (76.0%)
Poverty (2011)	15.9%	Mississippi (22.6%)	New Hampshire (8.8%)
Seasonal Flu Vaccination Rates 65 and Over (2011)	61.3%	Alaska (51.8%)	IA and LA (70.2%)
Syphilis Rates per 100,000 Population (2011)	4.5	D.C. (27.4)	SD and WY (0.0)
Tobacco Use -Current Smokers (2011)	21.2%	Kentucky (29.0%)	Utah (11.8%)
Tuberculosis Number of Cases (2011)	10,528	California (2,323)	Wyoming (4)
CHILD HEALTH INDICATORS			
% Uninsured, Under 18 (2011)	9.4%	Nevada (21.0%)	Massachusetts (2.5%)
AIDS Cumulative Cases, Under Age 13 (2010)	9,475	New York (2,437)	ND and WY (2)
Asthma High School Students (2011)	N/A	Maryland (28.7%)	Iowa (16.0%)
Fruit Indicator High School Students (2011)	N/A	Kentucky (23.0%)	New York (36.8%)
Vegetable Indicator High School Students (2011)	N/A	Indiana (9.0%)	West Virginia (18.7%)
% of Kids 19 to 35 Months w/out All Immunizations (2011)	26.4%	Wyoming (36.8%)	North Dakota (16.5%)
Infant Mortality - Per 1,000 Live Births (2009 Final Data)	6.4	Mississippi (10.1)	Minnesota (4.6)
% Low Birthweight Babies (2011 Final Data)	8.1	Mississippi (11.8%)	Alaska (6.0%)
Obese High School Students (2010)	N/A	Alabama (17.0%)	Colorado (7.3%)
Overweight or Obese 10 to 17 Year Olds (2007)	N/A	Mississippi (44.4%)	MN and UT (23.1%)
Pre-Term Births % of live births (2011 Preliminary Data)	11.7%	Mississippi (16.9%)	Vermont (8.8%)
Tobacco: Current Smokers High School Students (2011)	N/A	Kentucky (24.1%)	Utah (5.9%)

PERCENT OF ADULTS WITH DIABETES

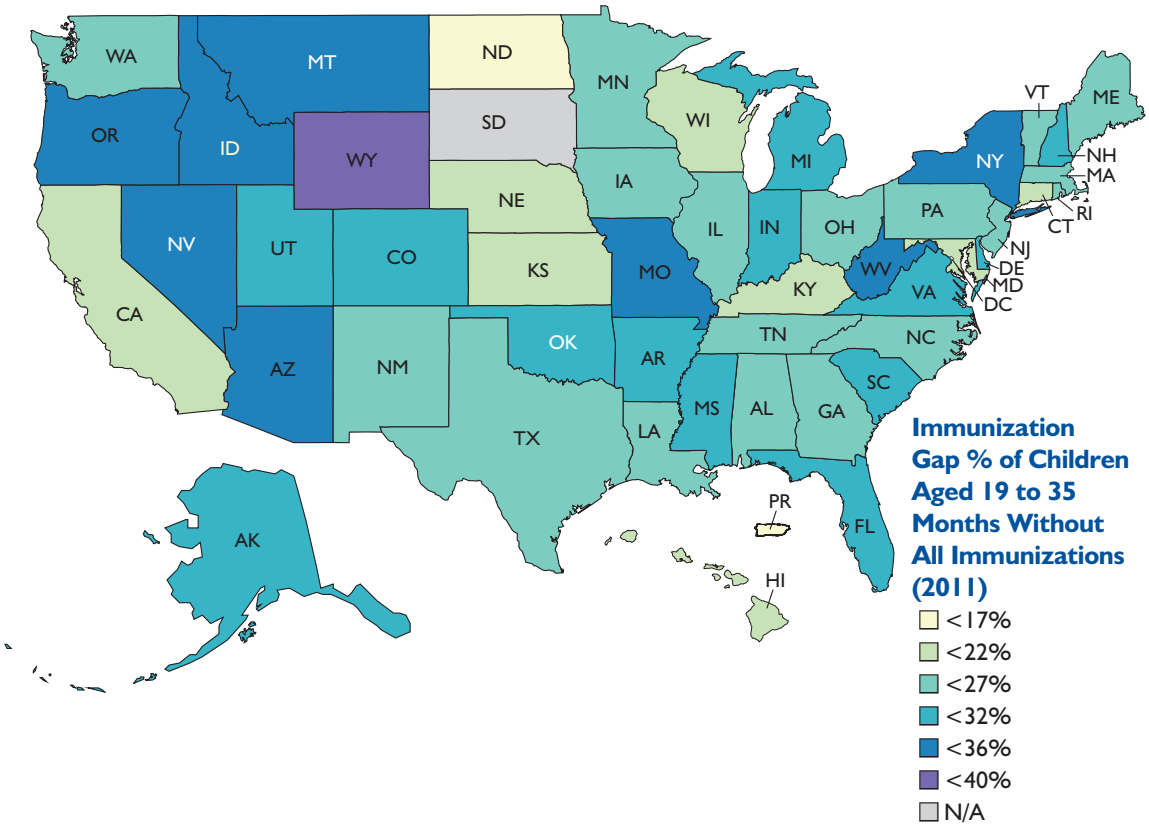


PERCENT OF HIGH SCHOOL STUDENTS WITH ASTHMA



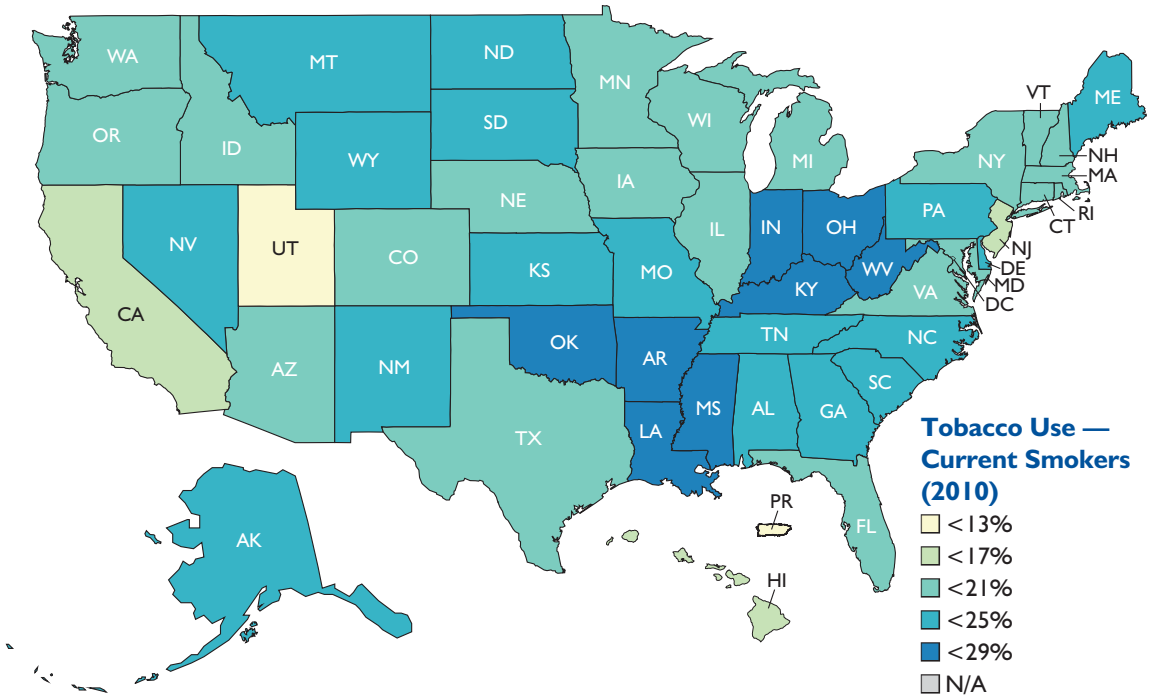
Asthma 2011 High School Students data come from the Youth Risk Behavior Surveillance System, Comprehensive Results 2011, percent responding "ever been told" they have asthma. National Center for Chronic Disease Prevention & Health Promotion, Centers for Disease Control and Prevention. Available at: http://www.cdc.gov/mmwr/pdf/ss/ss6104.pdf (accessed January 14, 2013).

IMMUNIZATION GAP AMONG CHILDREN AGES 19 TO 35 MONTHS



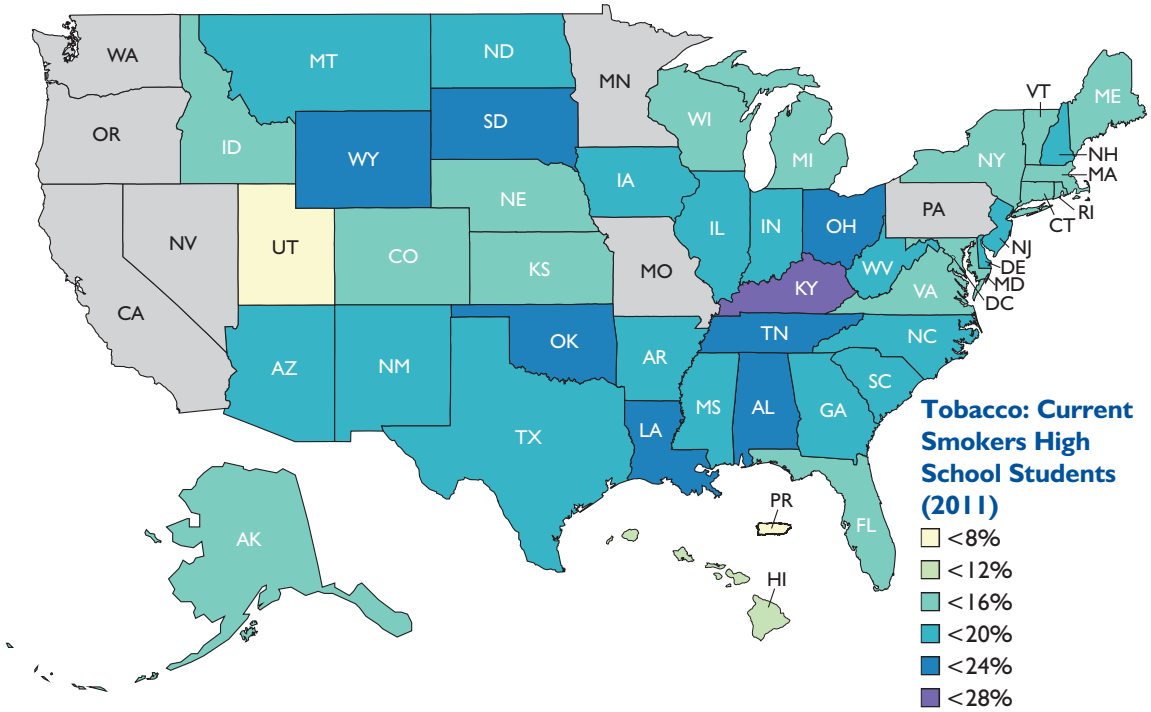
Immunization Gap: Children Aged 19 to 35 Months without All Immunizations 2011 data come from Estimated Vaccination Coverage with Individual Vaccines and Selected Vaccination Series Among Children 19–35 Months of Age by State and Local Area U.S., National Immunization Survey, 2011 (accessed January 15, 2013). TFAH used the data for the **4:3:1:3:3:1:4** series which is the CDC-recommended series for children aged 19–35 months. The 4:3:1:3:3:1:4 series is used to evaluate progress toward one of the Healthy People 2020 objectives, which aims to achieve greater than 80% coverage with the series among children ages 19–35 months.

PERCENT OF CURRENT ADULT SMOKERS



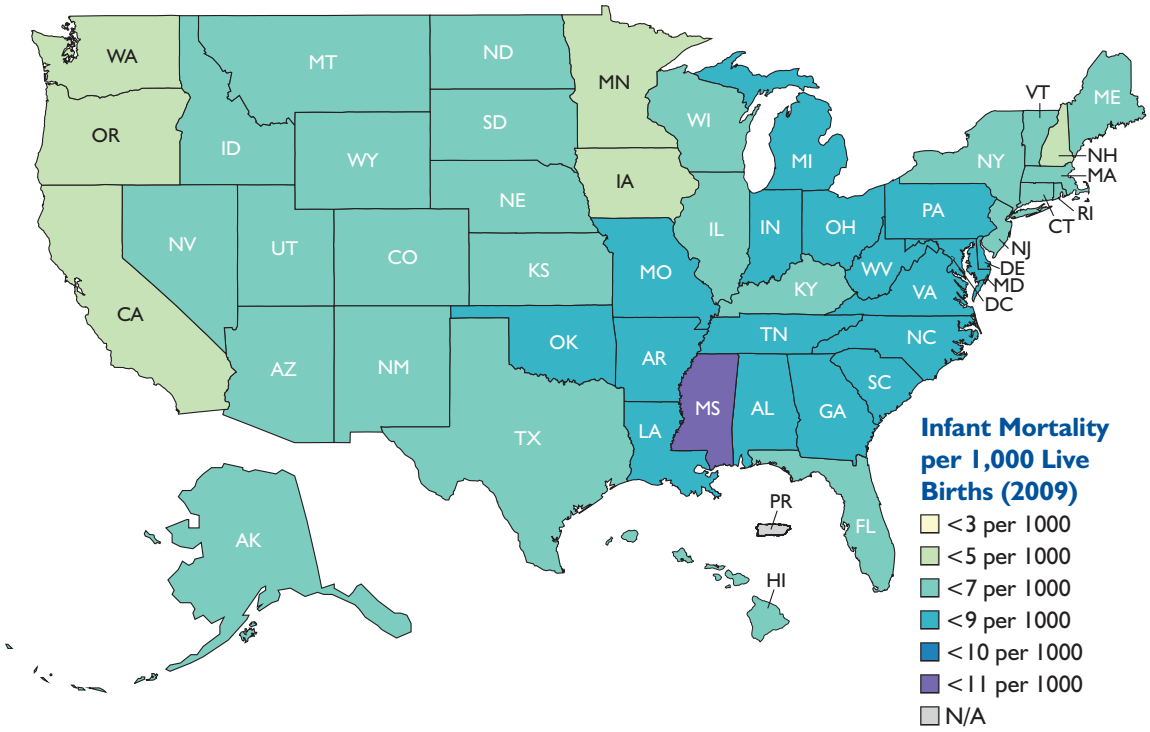
Tobacco Use - Current Smokers 2011 data come from the BRFSS Prevalence Data 2011, percent responding they are current smokers. National Center for Chronic Disease Prevention & Health Promotion, Centers for Disease Control and Prevention. Available at BRFSS Data.

PERCENT OF HIGH SCHOOL STUDENT SMOKERS



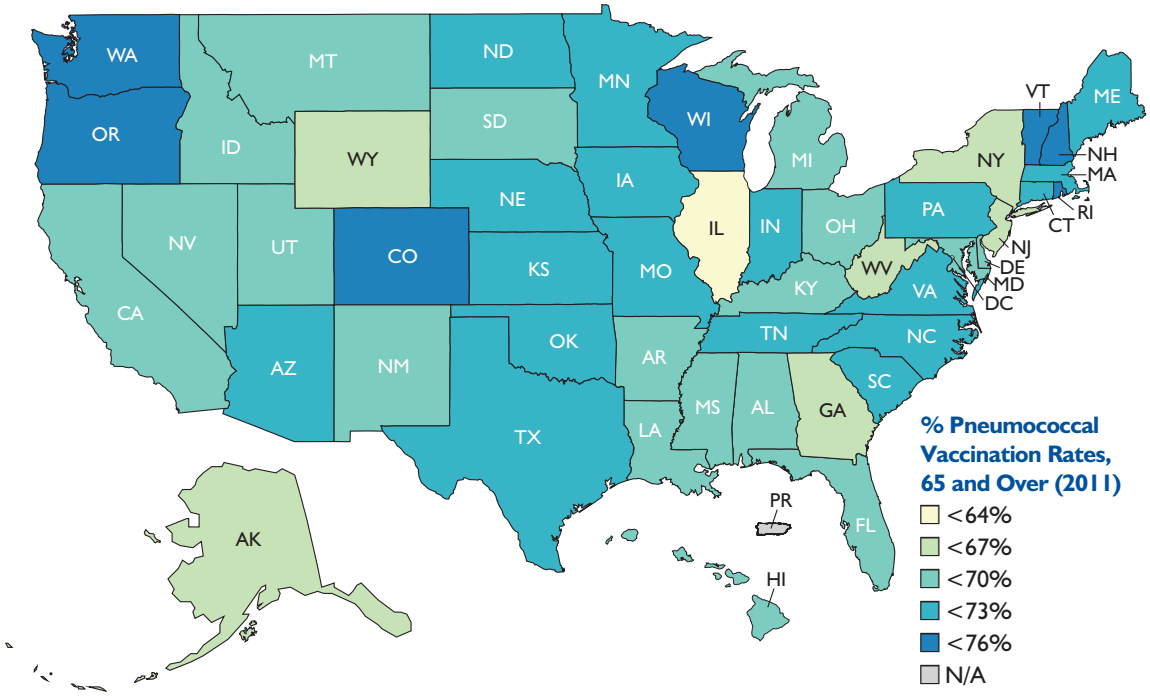
Tobacco: Current Smokers High School Students 2011 data come from the Youth Risk Behavior Surveillance System, Comprehensive Results 2011, percent of "students who smoked cigarettes on one or more of the past 30 days." National Center for Chronic Disease Prevention & Health Promotion, Centers for Disease Control and Prevention. Available athttp://www.cdc.gov/mmwr/pdf/ss/ss6104.pdf (accessed January 14, 2013).

INFANT MORTALITY PER 1,000 LIVE BIRTHS



Infant Mortality per 1,000 Live Births 2009 data come from the National Center for Health Statistics, National Vital Statistics Report, Deaths: Final Data for 2009 (accessed January 15, 2013).Low Birthweight Babies 2011 data come from the National Center for Health Statistics, National Vital Statistics Report, Births: Preliminary Data for 2011, State-specific Detailed Tables for 2011, Table I-4 (accessed January 15, 2013).

PNEUMOCOCCAL VACCINATION RATES, 65 AND OVER



Pneumococcal Vaccination Rates 65 and Over 2011 data come from the BRFSS Prevalence Data 2011. National Center for Chronic Disease Prevention & Health Promotion, Centers for Disease Control and Prevention. Available at BRFSS Data.

Recommendations

SECTION 3

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

In tough economic times, it is more important than ever to invest in the health of Americans. Improving the health of Americans is essential for reducing health care costs and increasing productivity to help the economy get back on track for the long term.

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

In addition to shoring up the core ongoing funds for public health, we need to ensure the Prevention Fund is used to build upon and expand — not supplant — existing efforts. If we do not keep the foundation of support intact, we will never advance in the fight to prevent diseases, curb the obesity epidemic or reduce smoking rates.

TFAH recommends that funding for public health must:

A. Be increased to a sufficient level so that federal, state and local health departments can meet their responsibilities for protecting the health and safety of Americans.

- Sufficient, stable funding is needed to support essential baseline functions consistently across the country, such as being able to carry out the foundational capabilities articulated by the IOM and Transforming Public Health reports; and
- Funds should be used as efficiently as possible to maximize effectiveness in lowering disease rates and accountability and transparency for how funds are used must be a cornerstone of public health funding.

B. Be considered strategically in an era of reforming health systems and increased Health Information Technology (HIT), including evaluating potential new financing models and developing partnerships within and beyond the health sector.

A. INCREASE CORE FUNDING FOR PUBLIC HEALTH AT THE FEDERAL, STATE AND LOCAL LEVELS

The country needs to redouble its commitment to sufficient, stable funding for public health. Investing in prevention is the most common sense, effective way to improve health and lower disease rates, which, in turn, helps contain health care costs. However, a number of independent evaluations have found that for decades, funding for public health and prevention has not kept pace with the responsibilities and requirements of health departments. Funding should be rationalized to support a consistent baseline of capabilities for every community across the nation, so where you live doesn't determine how healthy you are — or how at risk you are — for health problems.

- **All Americans should be protected by a set of public health services. For that to be accomplished, these services must be fully funded.**

Through the ACA, as a nation, we have established a minimum set of health benefits that all Americans deserve through health coverage. Since so much of what impacts health happens beyond the doctor's office where people live, learn, work and play, it is important to make sure all Americans are afforded a minimum set of public health services. An established set of minimum or baseline services could then also be equated with costs to maintain these services on a per capita basis, which would then help standardize funding for public health. Ensuring a consistent baseline set of foundational capabilities, such as those identified by the IOM and the Transforming Public Health projects, should become a primary focus of federal, state and local funding, even if it means restructuring some categorical funding streams. Funding

must also be maintained at a level to guarantee these capabilities can be effectively maintained and delivered.

- **Funding should be increased for CTGs, so that all Americans benefit.** Because of limited funding, only 40 percent of Americans benefit from the health and cost savings generated in communities that receive these grants. Congress should double the current investment and expand the number of CTGs awarded, so the program can be scaled so every community across the country can benefit.
- **Public health departments should only pay for direct services when they cannot be paid for by insurance.** Some public health departments provide direct services in their communities along with other preventive programs. However, the ACA will expand the number of individuals with coverage and expand what services are covered by many insurance providers. Public health departments should reassess their roles in the direct provision of medical services (including the option of becoming a Federally Qualified Health Center), to ensure that they do not use their public health budgets to pay for services that could be billed to insurers or could be paid for through health center dollars.

- **Accountability for achieving and maintaining foundational capabilities must be a cornerstone of public health funding.** The public deserves to know how effectively their tax dollars are being used to improve health. Accreditation, continuous quality improvement and transparency are some of the important ways to help demonstrate that these capabilities are being met and maintained. For instance, the Public Health Accreditation Board (PHAB) has a voluntary accreditation process where governmental public health departments can begin to demonstrate core competencies and accountability. In the future, accreditation could also potentially be used as an important mechanism for states and localities to more easily and effectively demonstrate that they have met the capabilities required for federal funding opportunities.

B. CONSIDER NEW FINANCING MODELS OR CHANGES IN A REFORMING HEALTH SYSTEM

As the health system is in the process of evaluating and implementing a series of reforms, it provides an opportunity to explore new funding models to provide sufficient support for basic capabilities as well as ways to break down traditional silos so that public health is partnering with the health care system and other sectors to achieve maximum results for improving health and reducing health costs.

- **There are a number of proposals for new potential funding models for public health that should be evaluated, including:**
  - **Examining a new model that would increase flexibility for state and local health departments that demonstrate core capabilities.** This potential option for stabilizing funding would assess the feasibility of moving away from CDC's existing model of funding that includes a series of categorical grants and move toward core capacity grants, based on the core capabilities of a modern system that are agreed upon by the federal and state departments of health, and are evaluated by strict performance measures. Currently, for instance, grants for epidemiological, laboratory and surveillance support are administered separately and are also divided from grants for diseases or conditions they are working to prevent or control. Grants stressing flexibility and accountability should be structured to help all states reach and maintain the foundational capabilities defined by the IOM report and Transforming Public Health project; and
  - **Evaluating a possible model of shared federal-state responsibility for maintenance of programs and funding.** Currently, funding for public health differs dramatically for every state, based on a combination of categorical federal funds and discretionary allocations from state and local governments, and there is no rational model for ensuring base-level support for public health. A 2008 analysis by NYAM found that approximately 60 percent of public health funding is federal, and 40 percent is a blend of state and local funds, although the exact amounts are variable by state. According to ASTHO, federal funds are the largest source of state health agency revenue (approximately 45 percent in FY 2009), around 60 percent of which goes to local health departments and community-based organizations. It is worth examining the potential of a system for public health that sets a basic standard that every state must meet while also providing flexibility based on the states decisions, needs and governmental structure. Medicaid provides

one example for how the federal government and states can work together to set basic eligibility and benefit standards. This model allows for flexibility in implementation as long as certain standards are met and provides special incentives for states that embrace new program elements by increasing the federal match. Such a system would have to 1) set standards for federal matches for state and local public health funding; 2) establish a maintenance of effort standard at the current levels of state and local public health funding — so that existing funding structures would be the baseline for every given state as they are with Medicaid and so states are not hit with new unfunded mandates; and 3) standardize federal match levels based on priorities, such as an 80-20 split for basic capacities; a 60-40 split for priority program areas; and a 50-50 split for other categorical efforts. New federal requirements would need to start with an initial 100 percent federal commitment that could be brought down into the existing splits over time. This system could be managed within CDC's existing structure or through a restructured federal public health system.

- **Public health departments and health care providers should work toward improved integration to help achieve maximum results for improving health and containing costs.** As health systems are developing reforms, they should be encouraged to incorporate community-based prevention and public health into their systems. Investing in prevention as part of these overall models can help providers more easily and effectively reach their goals of healthier communities and lower health care costs. Incentives and mandates should be explored to encourage this integration, including developing models for sharing savings achieved through prevention. Integrating prevention and public health with the larger health care system can be implemented in a variety of ways, including through coordination with health care providers and existing public health programs and departments. And, public health departments must adapt to work with new entities and financing mechanisms in the reformed health system, such as by working with Accountable Care Organizations (ACOs) or within new capitalized care structures and global health budgets, to help improve health beyond the doctor's office.
  - ACOs should expand to include ways to improve health beyond the doctor's office, such as through following an Accountable Care Community (ACC) model. ACCs, which expands on the idea of the ACO to coordinate care inside and outside the doctor's office, work across a range of sectors, including employers, housing, transportation, education and Chambers of Commerce, and work together with health care providers and public health officials to find ways to improve health while also achieving other critical goals. ACCs are based on the recognition that different sectors interact with public health. For example, being healthy is important to being productive at work; stable and safe housing impacts community members' health; and a quality education helps improve health and economic prospects. As with the ACOs, a comprehensive approach works to improve the overall health of individuals and can result in health care savings. The range of organizations involved can then benefit from these shared cost savings, and everyone benefits by having a healthy and more productive community. ACC models leverage the resources and capabilities of all of the partners and share the cost savings achieved by lower health care costs.
  - If global budgets are adopted, they should invest in community-based prevention programs. States and organizations with global budgets have a strong incentive to identify and invest in strategies to improve the health of the community they serve. To be as strategic as possible, global budgets should include investments in community-based prevention. Including community prevention directly in global health models can help improve health and bring down overall costs, which, in turn, would provide more resources to reinvest in the health care system.
- **Public health departments should develop strategic, common-sense partnerships with a wide range of groups within the community.** Public health departments play a central role as chief health strategists for communities, but cannot reach goals to improve their community's health on their own. To be effective in improving health in neighborhoods, workplaces and schools, strategies must involve a series of synergistic partnerships. Healthy neighborhoods, healthy schools and healthy workplaces must be accessible to all Americans. Integrated and strategic joint investments in prevention strategies in our country's and communities education, transportation and other policy arenas are critical to ensuring healthy choices are available and to yielding joint benefits.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APPENDIX A: NOTES ON DATA AND METHODOLOGY

The sources for the funds and indicators come from a variety of publicly available sources. In some cases, fiscal years for funding may vary depending on availability of data, and year of health indicators may vary slightly as well.

Funding References

CDC Funds for State and Local Health Departments, Universities, & Other Public and Private Agencies FY 2012 data were all provided by the U.S. Centers for Disease Control and Prevention's Financial Management Office. The total (all categories) was also provided by the CDC; it includes program areas not highlighted here. CDC Per Capita Total FY 2012 calculated by TFAH by dividing CDC provided total by July 1, 2012 U.S. Census Bureau population estimates. CDC Per Capita Ranking based on TFAH calculated per capita totals.

HRSA Health Professions, HIV/AIDS, Maternal & Child Health, and Primary Health Care FY 2012 funding data come from HRSA's Geospatial Data Warehouse, State Profile Report (accessed February 2012.) The total HRSA dollar amount also came from this source. HRSA key program area totals, however, were calculated by TFAH using Microsoft Excel. **HRSA Per Capita Total** FY 2012 calculated by TFAH by dividing HRSA Total dollars by July 1, 2012 U.S. Census Bureau population estimates. **HRSA Per Capita Ranking** based on TFAH calculated per capita totals.

ASPR Hospital Preparedness Program FY 2012 funding from U.S. Department of Health and Human Services: Office of the Assistant Secretary for Preparedness and Response Office of Preparedness and Emergency Operations Division of National Healthcare Preparedness Programs. "Hospital Preparedness Program (HPP) Budget Period 1 (Fiscal Year 2012) Funding." (accessed December 17, 2012).

State Public Health Budget Methodology TFAH conducted an analysis of state spending on public health for the last budget cycle, fiscal year 2011-2012. For those states that only report their budgets in biennium cycles, the 2011-2013 period (or the 2010-2012 and 2011-2012 for Virginia and Wyoming respectively) was used, and the percent change was calculated from the last biennium, 2009-2011 (or 2008-2010 and 2009-2010 for Virginia and Wyoming respectively).

This analysis was conducted from September to October of 2012 using publicly available budget documents through state government web sites. Based on what was made publicly available, budget documents used included either executive budget document that listed actual expenditures, estimated expenditures, or final appropriations; appropriations bills enacted by the state's legislature; or documents from legislative analysis offices.

"Public health" is defined to broadly include all health spending with the exception of Medicaid, CHIP, or comparable health coverage programs for low-income residents. Federal funds, mental health funds, addiction or substance abuse-related funds, WIC funds, services related to developmental disabilities or severely disabled persons, and state-sponsored pharmaceutical programs also were not included in order to make the state-by-state comparison more accurate since many states receive federal money for these particular programs. In a few cases, state budget documents did not allow these programs, or other similar human services, to be disaggregated; these exceptions are noted. For most states, all state funding, regardless of general revenue or other state funds (e.g. dedicated revenue, fee revenue, etc.), was used. In some cases, only general revenue funds were used in order to separate out federal funds; these exceptions are also noted.

Because each state allocates and reports its budget in a unique way, comparisons across states are difficult. This methodology may include programs that, in some cases, the state may consider a public health function, but the methodology used was selected to maximize the ability to be consistent across states. As a result, there may be programs or items states may wish to be considered "public health" that may not be included in order to maintain the comparative value of the data.

Finally, to improve the comparability of the budget data between FY 2010-2011 and FY 2011-2012 (or between biennium), TFAH adjusted the FY 2011-2012 numbers for inflation (using a 0.9764 conversion factor based on the U.S. Dept. of Labor Bureau of Labor Statistics; Consumer Price Index Inflation Calculator at http://www.bls.gov/cpi/).

After compiling the results from this online review of state budget documents, TFAH coordinated with the Association of State and Territorial Health Officials (ASTHO) to confirm the findings with each state health official. ASTHO sent out emails on October 26, 2012 and state health officials were asked to confirm or correct the data with TFAH staff by November 9, 2012. ASTHO followed up via email with those state health officials who did not respond by the November 9, 2012 deadline and were given until November 16, 2012 to respond. The states that did not reply by that date were assumed to be in accordance with the findings.

Population Facts

U.S. Total Population estimates come from the U.S. Census Bureau 2012, National and State Population Estimates, Resident Population Data, released December 2012 (accessed January 16, 2013).

Poverty Rate 2011 estimates from the U.S. Census Bureau 2011, Number and Percentage of People in Poverty in the Past 12 Months by State: 2010 and 2011. (accessed December 18, 2012).

Total Number of U.S. Uninsured, All Ages estimates come from the U.S. Census Bureau, Current Population Survey, Table HI06. Health Insurance Coverage Status by State for All People: 2011. (accessed December 17, 2012).

Total Number of Uninsured, under 18 estimates come from the U.S. Census Bureau. Current Population Survey, Table HI05: Health Insurance Coverage Status and Type of Coverage by State and Age for All People: 2011 (December 17, 2012).

Adult Health Indicator References

Adult Physical Inactivity Rate 2011 data come from the BRFSS Prevalence Data 2008-2011, percent responding "did not engage in any physical activity". National Center for Chronic Disease Prevention & Health Promotion, Centers for Disease Control and Prevention. Available at BRFSS Data.

AIDS Cumulative Cases Aged 13 and Older 2010 Yr End data come from the U.S. Centers for Disease Control and Prevention, National Center for HIV, STD, and TB Prevention, Table 20, HIV Surveillance Report: AIDS diagnoses, by area of residence, 2010 and cumulative—United States (accessed December 17, 2012).

Alzheimer's Estimated Cases among 65+ (2025) data come from the Alzheimer's Association report Alzheimer's Disease Facts and Figures 2012 (December 17, 2012).

Asthma 2010 data come from the BRFSS Prevalence Data 2010, percent responding "ever been told" they have asthma. National Center for Chronic Disease Prevention & Health Promotion, Centers for Disease Control and Prevention. Available at BRFSS Data.

Breast Feeding Report Card 2009 data come from "Breastfeeding Report Card, United States: Outcome Indicators." CDC National Immunization Survey, Provisional Data, 2009 births. (accessed December 17, 2012).

Cancer Estimated New Cases 2012 data come from the American Cancer Society's Cancer Facts and Figures 2012 (accessed December 17, 2012).

Chlamydia Rates per 100,000 Population (2011) data come from the Division of STD Prevention, National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention, U.S. Centers for Disease Control and Prevention Sexually Transmitted Disease Surveillance, 2011 (accessed December 17, 2012).

Diabetes 2011 data come from the BRFSS Prevalence Data 2011, percent responding "ever been told" they have diabetes. National Center for Chronic Disease Prevention & Health Promotion, Centers for Disease Control and Prevention. Available at BRFSS Data.

Fruit and Vegetable Intake 2011 data come from the BRFSS Prevalence Data 2011, percent who consume fruit and vegetables 5+ times daily. Available at BRFSS Data.

Human West Nile Virus Cases 2012 data come from the 2012 West Nile Virus Human Infections in the United States (accessed December 17, 2012).

Hypertension 2011 data come from the BRFSS Prevalence Data 2011, percent responding "ever been told" they have high blood pressure. Hypertension data is collected only on odd-numbered years. National Center for Chronic Disease Prevention & Health Promotion, Centers for Disease Control and Prevention. Available at BRFSS Data.

Obesity 2011 data were calculated by contractors using self-reported height and weight measure from the BRFSS Prevalence Data 2011. National Center for Chronic Disease Prevention & Health Promotion, Centers for Disease Control and Prevention. Available at BRFSS Data. Obesity was defined as having a BMI greater than or equal to 30.

Pneumococcal Vaccination Rates 65 and Over 2011 data come from the BRFSS Prevalence Data 2011. National Center for Chronic Disease Prevention & Health Promotion, Centers for Disease Control and Prevention. Available at BRFSS Data.

Seasonal Flu Vaccination Rates 65 and Over 2011 data come from the BRFSS Prevalence Data 2011. National Center for Chronic Disease Prevention & Health Promotion, Centers for Disease Control and Prevention. Available at BRFSS Data.

Syphilis Rates per 100,000 Population (2011) data come from the Division of STD Prevention, National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention, U.S. Centers for Disease Control and Prevention Sexually Transmitted Disease Surveillance, 2011 (accessed December 17, 2012).

Tobacco Use — Current Smokers 2011 data come from the BRFSS Prevalence Data 2011, percent responding they are current smokers. National Center for Chronic Disease Prevention & Health Promotion, Centers for Disease Control and Prevention. Available at BRFSS Data.

Tuberculosis (TB) Number of Cases 2011 data come from "Reported Tuberculosis in the United States, 2011," U.S. Centers for Disease Control and Prevention (accessed December 17, 2012).

Child and Adolescent Health Facts

AIDS Cumulative Cases Children Under 13 2010 Yr End data come from the U.S. Centers for Disease Control and Prevention, National Center for HIV, STD, and TB Prevention, Table 20, HIV Surveillance Report: AIDS diagnoses, by area of residence, 2010 and cumulative—United States (accessed December 17, 2012).

Asthma 2011 High School Students data come from the Youth Risk Behavior Surveillance System, Comprehensive Results 2011, percent responding "ever been told" they have asthma. National Center for Chronic Disease Prevention & Health Promotion, Centers for Disease Control and Prevention. Available at: http://www.cdc.gov/mmwr/pdf/ss/ss6104.pdf (accessed January 14, 2013).

Fruit and Vegetable Behavioral Indicators Students data come from the Youth Risk Behavior Surveillance System, Comprehensive Results 2011, percent responding "ate fruit or drank 100% fruit juices two or more times/day" and "ate vegetables three or more times/day" in the past seven days. National Center for Chronic Disease Prevention & Health Promotion, Centers for Disease Control and Prevention. Available at: http://www.cdc.gov/mmwr/pdf/ss/ss6104.pdf (accessed January 14, 2013).

Immunization Gap: Children Aged 19 to 35 Months without All Immunizations 2011 data come from Estimated Vaccination Coverage with Individual Vaccines and Selected Vaccination Series Among Children 19-35 Months of Age by State and Local Area U.S., National Immunization Survey, 2011 (accessed January 15, 2013). TFAH used the data for the **4:3:1:3:3:1:4 series** which is the CDC-recommended series for children aged 19--35 months. The 4:3:1:3:3:1:4 series is used to evaluate progress toward one of the Healthy People 2020 objectives, which aims to achieve greater than 80% coverage with the series among children ages 19--35 months.

Infant Mortality per 1,000 Live Births 2009 data come from the National Center for Health Statistics, National Vital Statistics Report, Deaths: Final Data for 2009 (accessed January 15, 2013).

Low Birthweight Babies 2011 data come from the National Center for Health Statistics, National Vital Statistics Report, Births: Preliminary Data for 2011, State-specific Detailed Tables for 2011, Table I-4 (accessed January 15, 2013).

Obese High School Students 2011 data come from the Youth Risk Behavior Surveillance System, Comprehensive Results 2011. National Center for Chronic Disease Prevention & Health Promotion, Centers for Disease Control and Prevention. Available at http://www.cdc.gov/mmwr/pdf/ss/ss6104.pdf.

Obese 10 to 17 Year Olds 2007 data come from the National Survey of Children's Health, 2007. Child and Adolescent Health Measurement Initiative. *2007 National Survey of Children's Health,* Data Resource Center for Child and Adolescent Health website. Available at http://www.nschdata.org/Content/Default.aspx (accessed July 6, 2009).

Pre-Term Births as Percent of Live Births 2011 data come from the National Center for Health Statistics, National Vital Statistics Report, Births: Preliminary Data for 2011, Table I-3 (accessed January 15, 2013).

Tobacco: Current Smokers High School Students 2011 data come from the Youth Risk Behavior Surveillance System, Comprehensive Results 2011, percent of "students who smoked cigarettes on one or more of the past 30 days." National Center for Chronic Disease Prevention & Health Promotion, Centers for Disease Control and Prevention. Available at http://www.cdc.gov/mmwr/pdf/ss/ss6104.pdf (accessed January 14, 2013).

Other Public Health Indicators

Health Professions Shortage Areas: Primary Care, Mental Health, Dental Care FY 2012 data come from HRSA's Geospatial Data Warehouse, State Profile Report (accessed January 17, 2013).

Projected Supply vs. Demand for RNs (2010) data comes from the National Center for Health Workforce Analysis in the Bureau of Health Professions, Health Resources and Services Administration paper "What Is Behind HRSA's Projected Supply, Demand and Shortage of Registered Nurses?" Washington, D.C.: September 2004.

APPENDIX B: STATE-BY-STATE ADULT HEALTH INDICATORS

Adult Health Indicators											
State	2012 Census Population Estimates	% Uninsured, All Ages (2011)	Adult Physical Inactivity Rate 2011 (95% Conf Interval)	AIDS Cumulative Cases Aged 13 and Older – 2010 Yr End	Alzheimer's Estimated Cases among 65+ (2025)	Asthma Prevalence 2010	Percent Exclusive Breastfeeding at 6 Months– from Births 2009 ^	Cancer Estimated New Cases - 2012	Chlamydia Rates per 100,000 Population (2011)	Diabetes 2011 Percentage (95% Conf Interval)	
Alabama	4,822,023	13.0%	32.6% (+/- 1.6)	10,195	110,000	11.8%	9.1%	26,440	619.8	11.8% (+/- 0.9)	
Alaska	731,449	18.2%	22.0% (+/- 2.0)	763	7,700	14.4%	21.0%	3,640	808.0	7.9% (+/- 1.4)	
Arizona	6,553,255	17.3%	24.2% (+/- 2.2)	12,709	130,000	14.8%	19.6%	31,990	457.6	9.5% (+/- 1.3)	
Arkansas	2,949,131	17.5%	30.9% (+/- 2.1)	4,582	76,000	13.6%	10.6%	16,120	550.5	11.2% (+/- 1.2)	
California	38,041,430	19.7%	19.1% (+/- 0.9)	164,707	660,000	12.6%	21.7%	165,810	447.7	8.9% (+/- 0.6)	
Colorado	5,187,582	15.7%	16.5% (+/- 1.0)	10,166	110,000	14.7%	26.6%	22,820	433.7	6.7% (+/- 0.6)	
Connecticut	3,590,347	8.6%	25.3% (+/- 1.6)	16,400	76,000	15.3%	12.6%	21,530	381.9	9.3% (+/- 0.9)	
Delaware	917,092	10.0%	27.0% (+/- 1.9)	4,242	16,000	15.1%	13.1%	5,340	502.0	9.7% (+/- 1.1)	
D.C.	632,323	8.4%	19.8% (+/- 1.8)	20,917	10,000	15.5%	14.8%	2,980	1,094.4	9.1% (+/- 1.1)	
Florida	19,317,568	19.8%	26.9% (+/- 1.3)	122,793	590,000	13.8%	19.2%	117,580	404.4	10.4% (+/- 0.8)	
Georgia	9,919,945	19.2%	26.8% (+/- 1.4)	39,250	160,000	11.5%	12.9%	48,130	561.6	10.1% (+/- 0.7)	
Hawaii	1,392,313	7.8%	21.3% (+/- 1.5)	3,332	34,000	17.6%	20.7%	6,610	441.2	8.4% (+/- 0.8)	
Idaho	1,595,728	16.9%	21.4% (+/- 1.7)	747	38,000	13.6%	23.2%	7,720	299.8	9.4% (+/- 1.0)	
Illinois	12,875,255	14.7%	25.2% (+/- 1.7)	39,823	240,000	13.6%	13.6%	65,750	506.1	9.7% (+/- 1.1)	
Indiana	6,537,334	12.0%	29.3% (+/- 1.4)	9,802	130,000	14.2%	13.8%	35,060	428.8	10.2% (+/- 0.8)	
Iowa	3,074,186	10.0%	25.9% (+/- 1.3)	2,082	77,000	11.6%	15.6%	17,010	351.4	8.2% (+/- 0.7)	
Kansas	2,885,905	13.5%	26.8% (+/- 0.8)	3,343	62,000	13.2%	17.4%	14,090	371.5	9.5% (+/- 0.5)	
Kentucky	4,380,415	14.4%	29.4% (+/- 1.5)	5,685	97,000	14.9%	9.6%	25,160	383.2	10.8% (+/- 0.8)	
Louisiana	4,601,893	20.8%	33.8% (+/- 1.5)	21,381	100,000	11.6%	9.6%	23,480	697.4	11.8% (+/- 0.9)	
Maine	1,329,192	10.0%	23.0% (+/- 1.0)	1,308	28,000	15.7%	15.2%	8,990	232.9	9.6% (+/- 0.6)	
Maryland	5,884,563	13.8%	26.1% (+/- 1.4)	37,129	100,000	12.4%	15.0%	31,000	471.3	9.4% (+/- 0.8)	
Massachusetts	6,646,144	3.4%	23.5% (+/- 1.0)	23,037	140,000	15.3%	16.5%	38,470	347.7	8.0% (+/- 0.5)	
Michigan	9,883,360	12.5%	23.6% (+/- 1.2)	17,512	190,000	15.8%	17.9%	57,790	501.5	10.0% (+/- 0.8)	
Minnesota	5,379,139	9.2%	21.8% (+/- 1.0)	5,867	110,000	10.9%	16.1%	28,060	318.7	7.3% (+/- 0.6)	
Mississippi	2,984,926	16.2%	36.0% (+/- 1.5)	8,191	65,000	11.6%	7.6%	15,190	715.0	12.3% (+/- 0.8)	
Missouri	6,021,988	14.9%	28.5% (+/- 1.6)	13,028	130,000	14.2%	16.2%	33,440	465.6	10.2% (+/- 1.0)	
Montana	1,005,141	18.3%	24.4% (+/- 1.3)	500	29,000	12.9%	12.5%	5,550	344.2	7.9% (+/- 0.7)	
Nebraska	1,855,525	12.3%	26.3% (+/- 0.8)	1,831	44,000	12.2%	20.2%	9,030	371.2	8.4% (+/- 0.5)	
Nevada	2,758,931	22.6%	24.1% (+/- 2.2)	7,004	42,000	14.5%	11.7%	13,780	389.1	10.4% (+/- 1.6)	
New Hampshire	1,320,718	12.5%	22.5% (+/- 1.5)	1,254	26,000	15.0%	24.7%	8,350	228.6	8.7% (+/- 0.8)	
New Jersey	8,864,590	15.4%	26.4% (+/- 1.1)	55,440	170,000	13.3%	16.1%	50,650	298.1	8.8% (+/- 0.6)	
New Mexico	2,085,538	19.6%	25.3% (+/- 1.3)	3,096	43,000	14.6%	22.8%	9,640	552.4	10.0% (+/- 0.8)	
New York	19,570,261	12.2%	26.2% (+/- 1.4)	199,176	350,000	14.7%	15.3%	109,440	530.3	10.4% (+/- 0.9)	
North Carolina	9,752,073	16.3%	26.7% (+/- 1.4)	20,578	210,000	12.6%	15.3%	51,860	574.9	10.8% (+/- 0.8)	
North Dakota	699,628	9.1%	27.0% (+/- 1.6)	180	20,000	10.6%	15.4%	3,510	363.5	8.3% (+/- 0.8)	
Ohio	11,544,225	13.7%	27.0% (+/- 1.3)	18,358	250,000	13.8%	11.0%	66,560	456.4	10.0% (+/- 0.8)	
Oklahoma	3,814,820	16.9%	31.2% (+/- 1.4)	5,681	96,000	14.2%	10.4%	19,210	389.1	11.1% (+/- 0.8)	
Oregon	3,899,353	13.8%	19.7% (+/- 1.5)	6,929	110,000	16.2%	26.3%	21,370	356.1	9.3% (+/- 0.9)	
Pennsylvania	12,763,536	10.8%	26.3% (+/- 1.2)	39,162	280,000	13.8%	14.1%	78,340	416.3	9.5% (+/- 0.7)	
Rhode Island	1,050,292	12.0%	26.2% (+/- 1.5)	2,969	24,000	16.7%	16.9%	6,310	393.9	8.4% (+/- 0.8)	
South Carolina	4,723,723	19.0%	27.2% (+/- 1.3)	16,422	100,000	12.9%	13.3%	26,570	625.5	12.0% (+/- 0.8)	
South Dakota	833,354	13.0%	26.9% (+/- 2.0)	332	21,000	11.6%	22.1%	4,430	418.7	9.5% (+/- 1.1)	
Tennessee	6,456,243	13.3%	35.2% (+/- 2.7)	15,089	140,000	9.3%	13.9%	35,610	490.1	11.2% (+/- 1.5)	
Texas	26,059,203	23.8%	27.2% (+/- 1.3)	82,258	470,000	12.8%	13.7%	110,470	496.6	10.2% (+/- 0.8)	
Utah	2,855,287	14.6%	18.9% (+/- 1.0)	2,607	50,000	14.3%	24.8%	10,620	256.4	6.7% (+/- 0.5)	
Vermont	626,011	8.6%	21.0% (+/- 1.3)	512	13,000	17.2%	23.3%	4,060	237.0	7.7% (+/- 0.7)	
Virginia	8,185,867	13.4%	25.0% (+/- 1.0)	20,373	160,000	12.9%	15.8%	41,380	453.9	10.4% (+/- 1.1)	
Washington	6,897,012	14.5%	21.9% (+/- 1.2)	13,484	150,000	15.8%	19.9%	35,790	346.2	8.9% (+/- 0.7)	
West Virginia	1,855,413	14.9%	35.1% (+/- 1.6)	1,837	50,000	10.7%	9.1%	11,610	231.8	12.1% (+/- 1.0)	
Wisconsin	5,726,398	10.4%	22.6% (+/- 1.8)	5,309	130,000	12.8%	16.9%	31,920	432.9	8.4% (+/- 1.0)	
Wyoming	576,412	17.8%	25.3% (+/- 1.6)	280	15,000	14.7%	20.5%	2,650	371.2	8.2% (+/- 1.0)	
U.S. Total	**313,914,040**	**15.7**	**N/A**	**1,119,652**	**6,479,700**	**13.5%**	**16.3%**	**1,638,910**	**457.6**	**N/A**	

Notes ^ The AAP Section on Breastfeeding, American Academy of Family Physicians, World Health Organization, United Nations Children's Fund, and many other health organizations recommend exclusive breastfeeding for the first 6 months of life.

State	Fruits and Vegetables (5 or more times a day) 2011 (95% Conf Interval)	Human West Nile Virus Cases 2012 (as of December 11, 2012)	Hypertension 2011 (95% Conf Interval)	Obesity 2011 Percentage (95% Conf Interval)	Pneumococcal Vaccination Rates 65 and Over 2011	Poverty 2011	Seasonal Flu Vaccination Rates 65 and Over 2011	Syphilis Rates per 100,000 Population (2011)	Tobacco Use – Current Smokers 2011	Tuberculosis Number of Cases – 2011
Alabama	12.5% (+/- 1.1)	51	40.0% (+/- 1.6)	32.0% (+/- 1.5)	68.3%	19.0%	62.6%	4.8	24.3%	161
Alaska	18.9% (+/- 1.9)	0	29.4% (+/- 2.1)	27.4% (+/- 2.2)	66.2%	10.5%	51.8%	0.7	22.9%	67
Arizona	21.4% (+/- 2.0)	125	28.0% (+/- 2.0)	24.7% (+/- 2.1)	71.3%	19.0%	57.9%	4.3	19.2%	255
Arkansas	13.5% (+/- 1.7)	63	35.7% (+/- 2.1)	30.9% (+/- 2.2)	68.5%	19.5%	57.3%	6.2	27.0%	85
California	24.4% (+/- 0.9)	451	27.8% (+/- 0.9)	23.8% (+/- 0.9)	68.1%	16.6%	57.2%	6.6	13.7%	2,323
Colorado	19.0% (+/- 1.0)	131	24.9% (+/- 1.0)	20.7% (+/- 1.1)	75.8%	13.5%	65.9%	2.6	18.3%	70
Connecticut	20.8% (+/- 1.4)	21	29.7% (+/- 1.5)	24.5% (+/- 1.5)	71.0%	10.9%	60.2%	1.8	17.1%	83
Delaware	12.9% (+/- 1.4)	9	34.6% (+/- 1.9)	28.8% (+/- 1.9)	69.2%	11.9%	63.4%	3.0	21.8%	21
D.C.	25.6% (+/- 2.1)	8	29.9% (+/- 2.0)	23.7% (+/- 1.9)	63.3%	18.7%	56.7%	27.4	20.8%	56
Florida	18.4% (+/- 1.1)	65	34.2% (+/- 1.3)	26.6% (+/- 1.3)	69.8%	17.0%	57.6%	6.7	19.3%	754
Georgia	15.4% (+/- 1.1)	78	32.3% (+/- 1.3)	28.0% (+/- 1.4)	66.5%	19.1%	55.2%	7.0	21.2%	347
Hawaii	19.7% (+/- 1.4)	0	28.7% (+/- 1.5)	21.8% (+/- 1.5)	67.7%	12.0%	64.7%	1.0	16.8%	123
Idaho	17.4% (+/- 1.5)	17	29.4% (+/- 1.7)	27.0% (+/- 1.8)	68.0%	16.5%	56.3%	0.8	17.2%	12
Illinois	18.3% (+/- 1.6)	282	31.0% (+/- 1.8)	27.1% (+/- 1.8)	62.5%	15.0%	54.7%	6.9	20.9%	359
Indiana	15.0% (+/- 1.1)	75	32.7% (+/- 1.3)	30.8% (+/- 1.4)	70.5%	16.0%	60.6%	2.7	25.6%	100
Iowa	13.5% (+/- 1.0)	31	29.9% (+/- 1.3)	29.0% (+/- 1.4)	70.9%	12.8%	70.2%	0.7	20.4%	40
Kansas	13.3% (+/- 0.6)	45	30.8% (+/- 0.8)	29.6% (+/- 0.9)	70.8%	13.8%	67.6%	0.8	22.0%	36
Kentucky	10.6% (+/- 1.0)	6	37.9% (+/- 1.5)	30.4% (+/- 1.5)	70.0%	19.1%	64.2%	3.0	29.0%	71
Louisiana	8.2% (+/- 0.9)	335	38.3% (+/- 1.4)	33.4% (+/- 1.5)	69.1%	20.4%	70.2%	9.9	25.7%	167
Maine	19.5% (+/- 0.9)	1	32.2% (+/- 1.0)	27.8% (+/- 1.1)	72.7%	14.1%	61.6%	0.9	22.8%	9
Maryland	16.6% (+/- 1.2)	46	31.3% (+/- 1.4)	28.3% (+/- 1.4)	69.9%	10.1%	62.8%	7.8	19.1%	233
Massachusetts	18.8% (+/- 0.9)	30	29.2% (+/- 1.0)	22.7% (+/- 1.0)	72.2%	11.6%	66.9%	4.1	18.2%	196
Michigan	17.8% (+/- 1.1)	202	34.2% (+/- 1.3)	31.3% (+/- 1.3)	67.1%	17.5%	58.0%	2.9	23.3%	170
Minnesota	15.2% (+/- 0.8)	70	26.3% (+/- 1.0)	25.7% (+/- 1.1)	74.2%	11.9%	63.6%	2.6	19.1%	137
Mississippi	10.3% (+/- 0.9)	249	39.2% (+/- 1.4)	34.9% (+/- 1.4)	69.0%	22.6%	65.4%	6.4	26.0%	91
Missouri	14.2% (+/- 1.3)	20	34.3% (+/- 1.6)	30.3% (+/- 1.7)	71.7%	15.8%	63.1%	2.3	25.0%	98
Montana	16.0% (+/- 1.1)	6	30.1% (+/- 1.3)	24.6% (+/- 1.4)	69.6%	14.8%	55.9%	0.7	22.1%	8
Nebraska	14.6% (+/- 0.7)	186	28.5% (+/- 0.8)	28.4% (+/- 0.8)	70.3%	13.1%	61.8%	0.5	20.0%	23
Nevada	18.7% (+/- 2.0)	8	30.9% (+/- 2.2)	24.5% (+/- 2.1)	68.9%	15.9%	53.7%	5.0	22.9%	95
New Hampshire	22.5% (+/- 1.5)	1	30.6% (+/- 1.5)	26.2% (+/- 1.5)	73.1%	8.8%	57.4%	1.4	19.4%	11
New Jersey	16.6% (+/- 0.9)	46	30.6% (+/- 1.1)	23.7% (+/- 1.1)	65.6%	10.4%	61.3%	2.6	16.8%	331
New Mexico	18.8% (+/- 1.1)	46	28.5% (+/- 1.2)	26.3% (+/- 1.3)	69.2%	21.5%	58.8%	3.4	21.5%	49
New York	19.9% (+/- 1.3)	107	30.6% (+/- 1.4)	24.5% (+/- 1.4)	65.2%	16.0%	60.0%	5.6	18.1%	910
North Carolina	14.1% (+/- 1.0)	6	32.4% (+/- 1.3)	29.1% (+/- 1.5)	72.1%	17.9%	66.6%	4.5	21.8%	244
North Dakota	13.7% (+/- 1.2)	89	28.9% (+/- 1.5)	27.8% (+/- 1.6)	70.1%	12.2%	58.0%	0.1	21.9%	7
Ohio	14.6% (+/- 1.0)	121	32.7% (+/- 1.3)	29.6% (+/- 1.4)	69.9%	16.4%	61.4%	3.8	25.1%	145
Oklahoma	9.8% (+/- 0.9)	187	35.5% (+/- 1.4)	31.1% (+/- 1.4)	72.8%	17.2%	62.4%	2.2	26.1%	94
Oregon	22.3% (+/- 1.4)	3	29.8% (+/- 1.5)	26.7% (+/- 1.6)	76.0%	17.5%	54.2%	2.5	19.7%	74
Pennsylvania	16.4% (+/- 1.0)	50	31.4% (+/- 1.2)	28.6% (+/- 1.3)	73.0%	13.8%	62.6%	2.9	22.4%	260
Rhode Island	19.8% (+/- 1.4)	4	33.0% (+/- 1.5)	25.4% (+/- 1.6)	73.1%	14.7%	56.6%	4.4	20.0%	27
South Carolina	12.5% (+/- 0.9)	29	36.4% (+/- 1.3)	30.8% (+/- 1.3)	70.1%	18.9%	65.2%	4.8	23.1%	140
South Dakota	11.0% (+/- 1.2)	203	30.9% (+/- 1.9)	28.1% (+/- 1.9)	67.1%	13.9%	68.3%	0.0	23.0%	15
Tennessee	10.6% (+/- 1.9)	32	38.6% (+/- 2.6)	29.2% (+/- 2.5)	70.4%	18.3%	67.7%	4.4	23.0%	156
Texas	17.1% (+/- 1.1)	1,739	31.3% (+/- 1.3)	30.4% (+/- 1.4)	70.4%	18.5%	59.1%	4.6	19.2%	1,325
Utah	19.2% (+/- 1.0)	5	22.9% (+/- 0.9)	24.4% (+/- 1.1)	70.0%	13.5%	56.9%	0.5	11.8%	34
Vermont	22.7% (+/- 1.3)	3	29.3% (+/- 1.4)	25.4% (+/- 1.4)	74.3%	11.5%	65.4%	1.4	19.1%	8
Virginia	15.9% (+/- 1.3)	29	31.2% (+/- 1.6)	29.2% (+/- 1.7)	72.0%	11.5%	63.3%	2.7	20.9%	221
Washington	17.5% (+/- 1.0)	4	30.1% (+/- 1.2)	26.5% (+/- 1.2)	74.0%	13.9%	60.7%	4.9	17.5%	200
West Virginia	7.9% (+/- 0.9)	9	37.1% (+/- 1.6)	32.4% (+/- 1.6)	64.4%	18.6%	68.5%	0.2	28.6%	13
Wisconsin	16.1% (+/- 1.5)	56	28.9% (+/- 1.8)	27.7% (+/- 2.0)	74.0%	13.1%	56.5%	1.1	20.9%	70
Wyoming	17.4% (+/- 1.4)	7	28.7% (+/- 1.6)	25.0% (+/- 1.6)	66.5%	11.3%	54.5%	0.0	23.0%	4
U.S. Total	**N/A**	**5,387**	**N/A**	**N/A**	**70.0%**	**15.9%**	**61.3%**	**4.5**	**21.2%**	**10,528**

APPENDIX C: STATE-BY-STATE CHILD AND ADOLESCENT HEALTH INDICATORS

Child/Adolescent Health Indicators								
State	2012 Census Population Estimates	% Uninsured, under 18 (2011)	AIDS Cumulative Cases Under Age 13 - 2010 Yr End	Asthma - 2011 High School Students (95% Conf Interval)	Fruit Indicator High School Students - 2011 (95% Conf Interval)	Vegetable Indicator High School Students - 2011 (95% Conf Interval)	Immunization Gap, % of Children Aged 19 to 35 Months Without All Immunizations - 2011	
Alabama	4,822,023	7.3%	78	20.2% (+/- 2.6)	29.2% (+/- 4.1)	14.2% (+/- 2.1)	26.7% (+/- 5.9)	
Alaska	731,449	10.7%	7	22.1% (+/- 3.0)	32.0% (+/- 3.7)	15.1% (+/- 2.4)	31.0% (+/- 7.0)	
Arizona	6,553,255	13.5%	47	21.7% (+/- 2.5)	N/A	N/A	34.9% (+/- 8.8)	
Arkansas	2,949,131	8.1%	38	23.4% (+/- 2.4)	25.8% (+/- 3.7)	12.4% (+/- 2.0)	28.5% (+/- 7.1)	
California	38,041,430	10.8%	703	N/A	N/A	N/A	22.0% (+/- 4.9)	
Colorado	5,187,582	10.4%	32	N/A	N/A	N/A	29.7% (+/- 8.5)	
Connecticut	3,590,347	5.3%	188	N/A	35.2% (+/- 2.6)	11.1% (+/- 2.1)	21.0% (+/- 5.0)	
Delaware	917,092	6.4%	27	N/A	30.3% (+/- 2.1)	N/A	31.4% (+/- 7.0)	
D.C.	632,323	4.3%	190	N/A	N/A	N/A	23.7% (+/- 5.8)	
Florida	19,317,568	13.0%	1,570	21.7% (+/- 1.2)	34.8% (+/- 1.5)	14.9% (+/- 0.8)	28.4% (+/- 6.2)	
Georgia	9,919,945	10.9%	252	26.8% (+/- 2.8)	30.8% (+/- 2.8)	13.3% (+/- 1.8)	20.5% (+/- 5.6)	
Hawaii	1,392,313	4.1%	17	N/A	25.5% (+/- 2.1)	13.9% (+/- 1.8)	21.5% (+/- 6.9)	
Idaho	1,595,728	11.3%	3	19.7% (+/- 2.2)	28.8% (+/- 2.7)	13.5% (+/- 2.5)	33.1% (+/- 7.7)	
Illinois	12,875,255	6.2%	290	20.7% (+/- 1.7)	31.5% (+/- 3.0)	11.4% (+/- 1.7)	28.2% (+/- 5.2)	
Indiana	6,537,334	5.6%	57	23.7% (+/- 2.9)	24.6% (+/- 1.9)	9.0% (+/- 1.2)	29.9% (+/- 6.3)	
Iowa	3,074,186	4.9%	14	16.0% (+/- 2.8)	30.9% (+/- 3.9)	13.2% (+/- 2.4)	22.9% (+/- 6.4)	
Kansas	2,885,905	9.4%	16	22.6% (+/- 2.6)	26.1% (+/- 2.6)	12.4% (+/- 1.7)	20.3% (+/- 6.1)	
Kentucky	4,380,415	4.6%	38	26.7% (+/- 2.8)	23.0% (+/- 2.5)	12.3% (+/- 2.9)	19.4% (+/- 6.5)	
Louisiana	4,601,893	11.6%	135	23.9% (+/- 6.6)	23.8% (+/- 4.4)	11.7% (+/- 1.9)	23.5% (+/- 6.0)	
Maine	1,329,192	6.3%	9	26.0% (+/- 1.4)	30.8% (+/- 2.1)	N/A	23.4% (+/- 5.6)	
Maryland	5,884,563	10.0%	338	28.7% (+/- 2.7)	34.7% (+/- 2.6)	15.3% (+/- 1.7)	22.0% (+/- 5.4)	
Massachusetts	6,646,144	2.5%	231	N/A	N/A	N/A	23.1% (+/- 7.3)	
Michigan	9,883,360	5.4%	118	24.6% (+/- 1.9)	31.2% (+/- 3.5)	12.6% (+/- 1.7)	28.2% (+/- 7.4)	
Minnesota	5,379,139	6.4%	29	N/A	N/A	N/A	25.1% (+/- 6.9)	
Mississippi	2,984,926	9.0%	58	20.0% (+/- 1.9)	32.3% (+/- 4.1)	16.6% (+/- 1.6)	28.7% (+/- 7.3)	
Missouri	6,021,988	11.5%	63	N/A	N/A	N/A	32.1% (+/- 6.0)	
Montana	1,005,141	12.3%	3	20.3% (+/- 1.2)	26.9% (+/- 1.6)	11.9% 9+/- 1.2)	33.2% (+/- 8.6)	
Nebraska	1,855,525	8.2%	13	19.2% (+/- 1.7)	26.9% (+/- 1.6)	N/A	17.4% (+/- 5.6)	
Nevada	2,758,931	21.0%	29	N/A	N/A	12.2% (+/- 1.2)	34.0% (+/- 8.5)	
New Hampshire	1,320,718	7.4%	10	26.1% (+/- 2.4)	33.9% (+/- 2.7)	15.5% (+/- 2.3)	27.4% (+/- 7.1)	
New Jersey	8,864,590	9.4%	811	N/A	30.6% (+/- 3.3)	13.1% (+/- 2.1)	26.1% (+/- 5.6)	
New Mexico	2,085,538	9.9%	9	24.9% (+/- 1.8)	31.2% (+/- 1.5)	18.1% (+/- 1.5)	24.4% (+/- 6.0)	
New York	19,570,261	6.6%	2,437	21.3% (+/- 1.0)	36.8% (+/- 2.1)	N/A	34.9% (+/- 5.1)	
North Carolina	9,752,073	9.3%	133	22.8% (+/- 1.7)	30.1% (+/- 2.8)	13.3% (+/- 2.0)	26.7% (+/- 7.7)	
North Dakota	699,628	4.7%	2	N/A	28.7% (+/- 2.3)	10.8% (+/- 2.2)	16.5% (+/- 6.4)	
Ohio	11,544,225	8.7%	150	N/A	26.7% (+/- 3.5)	11.2% (+/- 2.1)	23.6% (+/- 8.3)	
Oklahoma	3,814,820	6.4%	27	22.1% (+/- 2.2)	28.2% (+/- 3.3)	14.1% (+/- 2.6)	27.3% (+/- 6.4)	
Oregon	3,899,353	7.4%	19	N/A	N/A	N/A	34.8% (+/- 8.1)	
Pennsylvania	12,763,536	7.6%	378	N/A	N/A	N/A	27.0% (+/- 4.9)	
Rhode Island	1,050,292	5.8%	28	25.3% (+/- 1.8)	34.1% (+/- 2.7)	14.1% (+/- 1.4)	23.3% (+/- 5.8)	
South Carolina	4,723,723	13.3%	117	23.5% (+/- 2.8)	25.6% (+/- 3.7)	11.7% (+/- 2.0)	30.2% (+/- 7.0)	
South Dakota	833,354	7.5%	6	N/A	25.9% (+/- 2.4)	11.3% (+/- 1.7)	N/A	
Tennessee	6,456,243	5.9%	61	20.7% (+/- 2.1)	28.7% (+/- 2.9)	13.2% (+/- 1.3)	26.7% (+/- 6.4)	
Texas	26,059,203	15.4%	398	21.4% (+/- 2.2)	29.9% (+/- 2.0)	10.7% (+/- 1.5)	25.1% (+/- 3.9)	
Utah	2,855,287	10.7%	20	20.7% (+/- 1.8)	31.7% (+/- 2.8)	15.3% (+/- 2.6)	29.7% (+/- 6.7)	
Vermont	626,011	4.0%	6	N/A	36.1% (+/- 2.7)	16.9% (+/- 1.0)	26.6% (+/- 6.2)	
Virginia	8,185,867	5.9%	188	22.0% (+/- 3.6)	30.2% (+/- 3.0)	12.0% (+/- 2.7)	27.8% (+/- 6.9)	
Washington	6,897,012	8.8%	34	N/A	N/A	N/A	24.7% (+/- 6.0)	
West Virginia	1,855,413	9.7%	11	22.7% (+/- 2.7)	33.0% (+/- 4.9)	18.7% (+/- 5.1)	33.0% (+/- 5.9)	
Wisconsin	5,726,398	5.8%	34	N/A	32.9% (+/- 2.4)	12.7% (+/- 1.9)	20.8% (+/- 6.5)	
Wyoming	576,412	10.0%	2	25.3% (+/- 1.8)	29.8% (+/- 1.9)	17.5% (+/- 1.6)	36.8% (+/- 9.7)	
U.S. Total	**313,914,040**	**9.4%**	**9,475**	**N/A**	**N/A**	**N/A**	**26.4% (+/- 1.2)**	

	State	Infant Mortality - Per 1,000 Live Births 2009 Final Data	% Low Birthweight Babies - 2011 Preliminary Data	Obese - 2010 High School Students (95% Conf Interval)	Obese: % of 10 to 17 Year Olds (2009)	Pre-Term Births % of live births 2011 Preliminary Data	Tobacco: Current Smokers High School Students 2011 (95% Conf Interval)
	Alabama	8.3	9.9%	17.0% (+/- 3.9)	36.1% (+/- 4.6)	14.9%	22.9% (+/- 3.6)
	Alaska	6.8	6.0%	11.5% (+/- 2.0)	33.9% (+/- 4.4)	10.4%	14.1% (+/- 3.8)
	Arizona	6.0	7.0%	10.9% (+/- 1.9)	30.6% (+/- 4.9)	12.1%	17.4% (+/- 2.8)
	Arkansas	7.7	9.1%	15.2% (+/- 2.1)	37.5% (+/- 4.2)	13.2%	18.2% (+/- 3.2)
	California	4.9	6.8%	N/A	30.5% (+/- 6.4)	9.8%	N/A
	Colorado	6.3	8.7%	7.3% (+/- 2.4)	27.2% (+/- 5.1)	10.3%	15.7% (+/- 3.1)
	Connecticut	5.5	7.7%	12.5% (+/- 2.7)	25.7% (+/- 3.7)	10.1%	15.9% (+/- 3.0)
	Delaware	7.9	8.4%	12.2% (+/- 1.5)	33.2% (+/- 4.1)	11.2%	18.3% (+/- 2.2)
	D.C.	9.9	10.5%	N/A	35.4% (+/- 4.8)	13.7%	N/A
	Florida	6.9	8.7%	11.5% (+/- 2.3)	33.1% (+/- 6.1)	13.0%	14.3% (+/- 1.5)
	Georgia	7.4	9.4%	15.0% (+/- 2.3)	37.3% (+/- 5.6)	13.2%	17.0% (+/- 3.0)
	Hawaii	6.1	8.2%	13.2% (+/- 2.4)	28.5% (+/- 4.1)	12.3%	10.1% (+/- 1.9)
	Idaho	5.4	6.1%	9.2% (+/- 1.6)	27.5% (+/- 3.9)	10.2%	14.3% (+/- 3.6)
	Illinois	6.9	8.2%	11.6% (+/- 1.7)	34.9% (+/- 4.1)	12.1%	17.5% (+/- 2.4)
	Indiana	7.8	8.1%	14.7% (+/- 1.8)	29.9% (+/- 4.3)	11.6%	18.1% (+/- 2.3)
	Iowa	4.6	6.5%	13.2% (+/- 3.2)	26.5% (+/- 4.3)	11.1%	18.1% (+/- 2.8)
	Kansas	7.0	7.2%	10.2% (+/- 1.5)	31.1% (+/- 4.2)	11.2%	14.4% (+/- 2.6)
	Kentucky	6.9	9.1%	16.5% (+/- 2.5)	37.1% (+/- 4.1)	13.4%	24.1% (+/- 3.3)
	Louisiana	8.7	10.9%	16.1% (+/- 2.6)	35.9% (+/- 4.6)	15.6%	21.8% (+/- 4.4)
	Maine	5.6	6.7%	11.5% (+/- 1.4)	28.2% (+/- 3.8)	9.6%	15.2% (+/- 1.3)
	Maryland	7.3	8.9%	12.0% (+/- 1.7)	28.8% (+/- 4.2)	12.5%	12.5% (+/- 3.5)
	Massachusetts	5.1	7.6%	9.9% (+/- 1.8)	30.0% (+/- 4.6)	10.5%	14.0% (+/- 1.9)
	Michigan	7.5	8.3%	12.1% (+/- 1.6)	30.6% (+/- 4.3)	12.0%	14.0% (+/- 2.8)
	Minnesota	4.6	6.4%	N/A	23.1% (+/- 4.0)	9.9%	N/A
	Mississippi	10.1	11.8%	15.8% (+/- 2.2)	44.4% (+/- 4.3)	16.9%	17.9% (+/- 3.0)
	Missouri	7.2	7.9%	N/A	31.0% (+/- 4.1)	11.6%	N/A
	Montana	5.9	7.2%	8.5% (+/- 1.1)	25.6% (+/- 3.7)	10.8%	16.5% (+/- 2.2)
	Nebraska	5.4	6.6%	11.6% (+/- 1.2)	31.5% (+/- 4.6)	10.6%	15.0% (+/- 1.8)
	Nevada	5.9	8.2%	N/A	34.2% (+/- 5.4)	13.2%	N/A
	New Hampshire	4.9	7.1%	12.1% (+/- 1.7)	29.4% (+/- 3.9)	9.5%	19.8% (+/- 3.8)
	New Jersey	5.1	8.5%	11.0% (+/- 2.0)	31.0% (+/- 4.5)	11.7%	16.1% (+/- 3.2)
	New Mexico	5.3	8.8%	12.8% (+/- 2.1)	32.7% (+/- 5.0)	11.8%	19.9% (+/- 2.4)
	New York	5.3	8.1%	11.0% (+/- 1.3)	32.9% (+/- 4.4)	10.9%	12.5% (+/- 1.9)
	North Carolina	7.9	9.0%	12.9% (+/- 3.2)	33.5% (+/- 4.5)	12.6%	17.7% (+/- 3.0)
	North Dakota	6.1	6.7%	11.0% (+/- 1.7)	25.7% (+/- 3.3)	9.9%	19.4% (+/- 3.0)
	Ohio	7.7	8.6%	14.7% (+/- 3.1)	33.3% (+/- 4.7)	12.0%	21.1% (+/- 5.5)
	Oklahoma	7.9	8.5%	16.7% (+/- 3.0)	29.5% (+/- 4.1)	13.2%	22.7% (+/- 3.8)
	Oregon	4.8	6.1%	N/A	24.3% (+/- 3.9)	9.1%	N/A
	Pennsylvania	7.2	8.2%	N/A	29.7% (+/- 4.8)	11.0%	N/A
	Rhode Island	6.2	7.4%	10.8% (+/- 2.3)	30.1% (+/- 4.2)	10.4%	11.4% (+/- 2.7)
	South Carolina	7.1	9.9%	13.3% (+/- 3.0)	33.7% (+/- 4.2)	14.1%	19.1% (+/- 3.2)
	South Dakota	6.7	6.3%	9.8% (+/- 2.0)	28.4% (+/- 3.9)	11.2%	23.1% (+/- 6.7)
	Tennessee	8.0	9.0%	15.2% (+/- 1.6)	36.5% (+/- 4.3)	12.8%	21.6% (+/- 3.4)
	Texas	6.0	8.5%	15.6% (+/- 2.0)	32.2% (+/- 5.6)	12.8%	17.4% (+/- 2.0)
	Utah	5.3	6.9%	8.6% (+/- 1.7)	23.1% (+/- 4.2)	10.9%	5.9% (+/- 1.2)
	Vermont	6.2	6.7%	9.9% (+/- 2.0)	26.7% (+/- 4.5)	8.8%	13.3% (+/- 1.3)
	Virginia	7.2	8.0%	11.1% (+/- 2.5)	31.0% (+/- 4.2)	11.2%	15.0% (+/- 4.1)
	Washington	4.9	6.1%	N/A	29.5% (+/- 5.0)	9.8%	N/A
	West Virginia	7.8	9.6%	14.6% (+/- 2.4)	35.5% (+/- 3.9)	12.7%	19.1% (+/- 3.3)
	Wisconsin	6.1	7.2%	10.4% (+/- 1.6)	27.9% (+/- 3.8)	10.4%	14.6% (+/- 2.2)
	Wyoming	6.0	8.1%	11.1% (+/- 1.4)	25.7% (+/- 4.0)	10.2%	22.0% (+/- 3.0)
	U.S. Total	**6.4**	**8.1%**	**N/A**	**NA**	**11.7%**	**N/A**

APPENDIX D: STATE-BY-STATE OTHER PUBLIC HEALTH INDICATORS

Other Public Health Indicators						
State	2012 Census Population Estimates	Health Professions Service Areas Primary Care (As of 12/31/12)	Health Professions Service Areas Mental Health (As of 12/31/12)	Health Professions Service Areas Dental Care (As of 12/31/12)	Nursing Shortage Estimates (2010)	ASPR Hospital Preparedness Program Funding by State 2012
Alabama	4,822,023	80	52	61	-200	$5,422,089
Alaska	731,449	79	54	49	-2,300	$1,231,384
Arizona	6,553,255	141	94	154	-12,500	$7,082,390
Arkansas	2,949,131	80	42	42	-2,700	$3,502,762
California	38,041,430	516	319	334	-47,600	$28,752,455
Colorado	5,187,582	106	55	78	-10,900	$5,678,980
Connecticut	3,590,347	37	29	37	-11,100	$4,180,544
Delaware	917,092	9	10	6	-1,300	$1,424,677
D.C.	632,323	14	8	10	-3,000	$1,119,644
Florida	19,317,568	252	145	216	-32,700	$19,861,267
Georgia	9,919,945	186	86	146	-16,400	$10,476,179
Hawaii	1,392,313	26	30	21	-4,500	$1,900,815
Idaho	1,595,728	69	30	63	-800	$2,114,269
Illinois	12,875,255	226	127	159	-9,300	$10,936,885
Indiana	6,537,334	104	57	46	-8,200	$7,176,908
Iowa	3,074,186	118	65	119	-3,400	$3,637,084
Kansas	2,885,905	162	67	136	-1,000	$3,438,092
Kentucky	4,380,415	127	107	85	1,200	$4,968,606
Louisiana	4,601,893	118	106	100	100	$5,168,389
Maine	1,329,192	63	49	73	-2,500	$1,867,923
Maryland	5,884,563	51	48	40	-7,000	$6,445,505
Massachusetts	6,646,144	67	60	63	-16,100	$7,242,636
Michigan	9,883,360	214	142	157	-3,100	$10,678,003
Minnesota	5,379,139	108	56	112	-4,400	$5,961,891
Mississippi	2,984,926	107	40	108	-500	$3,555,672
Missouri	6,021,988	193	66	146	-12,900	$6,667,295
Montana	1,005,141	98	65	70	-500	$1,518,883
Nebraska	1,855,525	103	74	73	-2,400	$2,380,735
Nevada	2,758,931	66	26	41	-4,100	$3,280,981
New Hampshire	1,320,718	24	18	21	-3,300	$1,855,678
New Jersey	8,864,590	23	23	23	-19,600	$9,553,742
New Mexico	2,085,538	92	58	72	-3,100	$2,620,507
New York	19,570,261	178	132	120	-21,500	$12,036,626
North Carolina	9,752,073	118	83	127	-8,100	$10,319,477
North Dakota	699,628	81	50	34	-900	$1,192,623
Ohio	11,544,225	122	90	118	-12,100	$12,380,094
Oklahoma	3,814,820	169	105	93	-500	$4,363,077
Oregon	3,899,353	104	63	85	-5,300	$4,445,174
Pennsylvania	12,763,536	155	115	153	-21,100	$13,580,693
Rhode Island	1,050,292	11	12	15	-3,000	$1,583,915
South Carolina	4,723,723	96	46	79	-5,200	$5,263,121
South Dakota	833,354	84	50	54	-200	$1,338,429
Tennessee	6,456,243	99	58	134	-18,500	$7,035,110
Texas	26,059,203	355	327	229	-41,900	$26,394,469
Utah	2,855,287	59	34	48	-1,500	$3,346,201
Vermont	626,011	30	23	24	-600	$1,144,377
Virginia	8,185,867	103	70	93	-11,000	$8,739,318
Washington	6,897,012	147	112	108	-8,800	$7,424,816
West Virginia	1,855,413	94	76	84	700	$2,408,182
Wisconsin	5,726,398	102	110	74	500	$6,356,361
Wyoming	576,412	38	16	23	-1,200	$1,080,412
U.S. Total	**313,914,040**	**5,852**	**3,815**	**4,591**	**-405,800**	**$322,135,345**

APPENDIX E: STATE-BY-STATE FUNDING CHART — HRSA

FY 2012 HRSA Grants to States by Key Program Area (Selected Programs)							
State	Primary Health Care	Health Professions	Maternal & Child Health	HIV/AIDS	HRSA Total (All Programs)	HRSA Per Capita Total (All Programs)	HRSA Per Capita Ranking
Alabama	$54,878,416	$21,827,381	$21,765,363	$31,438,052	$131,090,954	$27.19	21
Alaska	$43,887,495	$1,660,895	$4,301,527	$2,225,062	$56,461,159	$77.19	1
Arizona	$53,570,002	$9,199,649	$22,221,053	$26,577,625	$114,612,133	$17.49	45
Arkansas	$40,590,217	$8,785,580	$17,954,249	$10,943,485	$81,210,483	$27.54	19
California	$421,417,543	$66,239,859	$77,652,355	$301,588,259	$874,584,956	$22.99	29
Colorado	$90,343,153	$11,382,511	$18,514,906	$28,479,487	$152,988,731	$29.49	14
Connecticut	$41,555,656	$6,633,969	$17,790,091	$30,906,820	$97,261,394	$27.09	22
Delaware	$10,258,766	$3,541,910	$7,744,211	$7,154,230	$29,129,117	$31.76	9
D.C.	$13,630,241	$20,709,667	$26,792,244	$63,545,863	$125,424,928	N/A*	N/A*
Florida	$147,748,861	$24,030,952	$26,925,294	$238,200,290	$439,720,852	$22.76	30
Georgia	$68,552,651	$17,549,110	$27,923,648	$94,362,663	$212,867,975	$21.46	34
Hawaii	$39,856,511	$5,839,680	$10,539,539	$4,022,102	$62,127,665	$44.62	3
Idaho	$32,348,903	$1,284,800	$5,183,563	$3,251,530	$44,021,110	$27.59	18
Illinois	$122,228,954	$35,170,734	$46,533,745	$89,931,200	$299,168,473	$23.24	28
Indiana	$35,266,491	$6,386,073	$27,577,596	$16,733,909	$88,306,262	$13.51	49
Iowa	$29,971,196	$5,484,440	$17,092,703	$5,499,939	$62,004,278	$20.17	38
Kansas	$38,861,487	$4,300,709	$11,086,826	$4,962,237	$62,425,080	$21.63	33
Kentucky	$53,615,799	$6,446,887	$22,749,855	$16,508,134	$104,359,297	$23.82	25
Louisiana	$50,323,441	$13,921,809	$27,583,014	$49,685,379	$145,622,675	$31.64	11
Maine	$23,404,143	$3,782,762	$12,299,475	$2,975,021	$45,380,118	$34.14	6
Maryland	$53,227,748	$6,683,541	$23,559,437	$75,147,860	$161,031,336	$27.37	20
Massachusetts	$97,817,509	$33,136,326	$37,484,935	$49,421,805	$219,790,597	$33.07	7
Michigan	$80,260,580	$25,456,652	$34,145,372	$32,010,450	$179,270,438	$18.14	40
Minnesota	$38,255,838	$10,895,602	$23,702,693	$15,120,118	$94,261,831	$17.52	43
Mississippi	$58,733,457	$2,108,906	$12,844,379	$17,754,949	$94,179,895	$31.55	12
Missouri	$62,095,023	$18,205,846	$19,770,289	$29,234,212	$136,094,279	$22.60	31
Montana	$37,933,758	$3,002,075	$7,940,828	$2,085,046	$55,181,295	$54.90	2
Nebraska	$15,685,280	$5,403,875	$10,210,607	$5,288,517	$39,334,468	$21.20	35
Nevada	$10,269,387	$2,342,515	$4,266,986	$15,823,313	$34,330,501	$12.44	50
New Hampshire	$16,892,360	$1,993,572	$7,628,820	$2,463,947	$30,921,347	$23.41	27
New Jersey	$60,084,681	$7,280,112	$28,213,213	$88,532,621	$185,392,672	$20.91	36
New Mexico	$55,571,281	$5,417,591	$11,093,264	$5,815,220	$80,009,615	$38.36	4
New York	$185,186,279	$32,871,160	$58,869,784	$345,707,462	$627,145,827	$32.05	8
North Carolina	$80,857,731	$13,947,880	$28,616,555	$57,046,751	$183,948,138	$18.86	39
North Dakota	$4,253,478	$3,689,361	$3,878,244	$755,423	$16,858,024	$24.10	24
Ohio	$81,811,169	$38,280,386	$37,166,606	$34,353,418	$195,435,475	$16.93	47
Oklahoma	$38,843,331	$3,961,209	$22,233,482	$10,831,690	$77,847,908	$20.41	37
Oregon	$58,066,369	$3,427,455	$15,793,302	$12,911,623	$92,805,051	$23.80	26
Pennsylvania	$80,478,551	$58,328,250	$50,149,365	$86,431,181	$282,517,924	$22.13	32
Rhode Island	$21,168,775	$2,221,619	$7,653,393	$5,963,241	$37,297,028	$35.51	5
South Carolina	$71,307,812	$4,850,504	$18,878,577	$33,457,377	$130,932,399	$27.72	17
South Dakota	$11,774,088	$2,000,049	$5,736,502	$1,620,845	$24,378,784	$29.25	15
Tennessee	$67,444,390	$22,146,370	$27,240,673	$38,533,370	$158,423,179	$24.54	23
Texas	$211,680,164	$44,322,219	$55,251,591	$151,713,150	$467,406,983	$17.94	42
Utah	$20,116,163	$6,591,346	$14,754,409	$6,295,377	$49,388,525	$17.30	46
Vermont	$10,663,456	$1,795,940	$5,230,890	$1,472,862	$19,844,591	$31.70	10
Virginia	$66,553,677	$10,489,543	$24,630,589	$41,879,914	$147,363,454	$18.00	41
Washington	$88,263,177	$16,601,191	$21,031,753	$62,171,689	$192,609,665	$27.93	16
West Virginia	$35,555,481	$4,017,806	$11,686,170	$3,704,012	$58,368,017	$31.46	13
Wisconsin	$40,879,102	$14,189,785	$19,948,853	$13,505,425	$90,930,864	$15.88	48
Wyoming	$5,090,504	$1,017,567.00	$1,983,158	$970,238	$10,096,330	$17.52	43
U.S. TOTAL	**$3,179,130,525**	**$680,855,630**	**$1,101,825,976**	**$2,277,014,393**	**$7,402,164,080****	**23.18****	**N/A***

*D.C. was not included in the per capita rankings because total funding for D.C. includes funds for a number of national organizations.
**The US total reflects HRSA grants to all states and D.C.

APPENDIX F: STATE-BY-STATE FUNDING CHART — CDC

CDC FUNDING BY STATE										
State	Agency for Toxic Substances and Disease Registry (ATSDR)	Birth Defects and Developmental Disabilities	Chronic Disease Prevention	Cross-Cutting Public Health	Environmental Health	Infectious Diseases	Injury Prevention and Control	Occupational Safety & Health	Occupational Safety & Health	
Alabama	$0	$2,192,024	$9,741,416	$130,064	$215,945	$14,098,601	$534,004	$1,334,758	$1,334,758	
Alaska	$260,250	$1,031,933	$12,838,325	$250,000	$0	$3,700,871	$613,402	$73,147	$73,147	
Arizona	$233,040	$1,723,933	$7,970,459	$250,000	$143,949	$16,331,684	$895,474	$1,598,855	$1,598,855	
Arkansas	$226,787	$1,795,918	$7,915,362	$0	$90,000	$7,232,456	$321,020	$0	$0	
California	$655,364	$3,144,586	$26,479,403	$1,696,585	$4,325,785	$132,434,890	$7,515,074	$2,963,105	$2,963,105	
Colorado	$281,013	$3,392,442	$12,177,425	$634,026	$375,000	$18,527,908	$2,611,900	$2,030,306	$2,030,306	
Connecticut	$431,189	$240,374	$5,318,647	$180,000	$467,500	$15,322,592	$408,938	$236,271	$236,271	
Delaware	$0	$482,289	$3,656,789	$0	$0	$4,173,794	$306,504	$0	$0	
D.C.	$2,197,510	$6,504,838	$12,164,348	$3,727,027	$1,157,197	$31,571,578	$1,540,969	$153,635	$153,635	
Florida	$443,878	$706,597	$12,189,565	$129,000	$736,308	$62,165,379	$2,902,068	$1,505,151	$1,505,151	
Georgia	$485,661	$930,909	$21,637,892	$3,380,931	$767,176	$39,200,280	$3,308,098	$152,611	$152,611	
Hawaii	$0	$233,747	$3,854,613	$84,271	$585,514	$6,106,069	$295,481	$0	$0	
Idaho	$219,879	$137,801	$5,013,920	$0	$0	$3,648,301	$155,377	$0	$0	
Illinois	$645,192	$5,657,102	$13,453,186	$368,294	$698,295	$42,094,689	$2,989,132	$1,848,291	$1,848,291	
Indiana	$0	$237,802	$5,373,810	$250,000	$366,616	$11,396,038	$730,140	$81,663	$81,663	
Iowa	$0	$2,435,190	$7,631,027	$185,000	$206,407	$6,311,436	$1,187,910	$2,611,234	$2,611,234	
Kansas	$0	$93,750	$7,165,624	$310,000	$35,957	$6,342,145	$858,325	$0	$0	
Kentucky	$0	$346,824	$8,919,876	$100,000	$425,000	$8,801,695	$1,346,120	$696,959	$696,959	
Louisiana	$268,100	$410,403	$7,631,960	$1,801,146	$630,000	$17,993,463	$661,398	$57,956	$57,956	
Maine	$0	$153,949	$6,601,538	$310,000	$635,032	$4,758,323	$153,092	$0	$0	
Maryland	$0	$3,880,985	$14,089,959	$290,501	$2,417,366	$32,196,085	$3,833,183	$1,374,429	$1,374,429	
Massachusetts	$402,895	$2,239,815	$12,871,995	$290,146	$1,285,525	$23,746,399	$1,646,999	$4,693,810	$4,693,810	
Michigan	$415,276	$1,843,639	$22,366,651	$920,715	$1,216,609	$23,812,415	$4,617,203	$2,012,835	$2,012,835	
Minnesota	$436,860	$770,524	$13,522,933	$150,083	$1,582,990	$15,216,907	$1,293,128	$1,733,450	$1,733,450	
Mississippi	$0	$451,815	$9,122,528	$162,047	$522,241	$11,080,909	$341,584	$0	$0	
Missouri	$331,895	$1,182,710	$9,866,365	$0	$548,771	$13,924,055	$1,508,389	$0	$0	
Montana	$2,325,280	$554,998	$6,727,431	$50,000	$379,612	$3,349,511	$366,255	$102,983	$102,983	
Nebraska	$0	$192,682	$8,562,476	$70,000	$165,710	$4,889,725	$505,180	$0	$0	
Nevada	$0	$649,254	$5,848,681	$0	$10,000	$6,511,492	$239,949	$0	$0	
New Hampshire	$299,659	$873,736	$5,682,264	$247,676	$586,317	$3,749,983	$148,392	$0	$0	
New Jersey	$524,292	$7,111,696	$7,837,916	$0	$369,680	$38,021,629	$1,352,716	$0	$0	
New Mexico	$1,000,000	$130,144	$6,677,254	$81,849	$539,420	$7,475,812	$398,917	$209,730	$209,730	
New York	$872,102	$5,340,261	$27,190,337	$1,792,965	$2,732,799	$130,854,338	$7,263,941	$1,707,885	$1,707,885	
North Carolina	$263,712	$3,807,153	$15,898,820	$31,426	$748,076	$21,978,357	$4,394,735	$1,170,685	$1,170,685	
North Dakota	$0	$496,279	$4,587,871	$60,190	$2,851	$3,091,811	$289,525	$0	$0	
Ohio	$615,592	$730,781	$10,897,294	$54,329	$526,174	$22,420,087	$3,408,513	$1,673,767	$1,673,767	
Oklahoma	$0	$627,750	$7,181,901	$93,040	$306,272	$8,043,776	$930,579	$72,184	$72,184	
Oregon	$482,166	$632,058	$8,839,915	$50,000	$1,122,574	$12,913,479	$1,364,156	$1,173,986	$1,173,986	
Pennsylvania	$455,685	$1,419,288	$11,415,151	$0	$424,946	$38,282,491	$3,421,450	$1,771,495	$1,771,495	
Rhode Island	$0	$855,738	$5,162,772	$25,000	$973,879	$5,141,252	$937,236	$0	$0	
South Carolina	$30,000	$2,719,810	$11,601,978	$52,894	$62,270	$15,420,297	$691,211	$0	$0	
South Dakota	$0	$138,972	$5,650,030	$8,778	$0	$3,378,375	$219,443	$0	$0	
Tennessee	$205,360	$1,614,220	$4,535,979	$0	$350,001	$19,227,896	$930,851	$169,483	$169,483	
Texas	$341,070	$1,091,352	$16,332,815	$142,250	$492,057	$76,662,341	$3,936,859	$1,340,876	$1,340,876	
Utah	$217,145	$2,059,360	$9,356,395	$54,140	$421,187	$6,257,043	$1,351,098	$1,378,243	$1,378,243	
Vermont	$0	$150,000	$3,373,513	$170,000	$575,476	$3,775,951	$73,108	$0	$0	
Virginia	$366,912	$476,274	$9,857,051	$1,961,028	$646,933	$22,428,655	$2,485,524	$449,759	$449,759	
Washington	$536,552	$243,602	$16,068,145	$50,000	$2,170,910	$18,605,710	$1,706,875	$1,298,555	$1,298,555	
West Virginia	$0	$0	$9,509,466	$58,950	$397,000	$4,677,983	$1,053,664	$359,335	$359,335	
Wisconsin	$591,383	$1,146,720	$8,268,075	$231,500	$818,705	$10,777,390	$1,201,705	$538,020	$538,020	
Wyoming	$0	$141,924	$2,487,994	$175,000	$0	$3,224,327	$59,293	$0	$0	
U.S. TOTAL	**$17,051,699**	**$75,425,951**	**$509,127,140**	**$21,060,851**	**$34,258,032**	**$1,063,348,673**	**$81,306,087**	**$38,575,452**	**$38,575,452**	

	State	PHPF/Other ACA Funds	Preventive Health and Health Services	Public Health and Social Services Emergency Fund	Public Health Preparedness & Emergency Response	Vaccines for Children	World Trade Center Health Program	CDC Total (All Categories)	CDC Per Capita 2012	CDC Per Capita Ranking
	Alabama	$1,849,398	$1,192,738	$0	$9,459,860	$52,765,413	$0	$93,514,221	$19.39	31
	Alaska	$4,157,356	$257,635	$0	$4,393,150	$11,243,865	$0	$38,819,934	$53.07	1
	Arizona	$4,546,139	$930,839	$25,000	$12,157,881	$75,265,393	$0	$122,062,646	$18.63	34
	Arkansas	$1,609,163	$673,866	$0	$6,740,140	$38,639,138	$0	$65,243,850	$22.12	20
	California	$73,726,133	$5,307,140	$18,295	$63,715,237	$362,487,279	$0	$684,468,876	$17.99	37
	Colorado	$8,219,394	$945,845	$25,233	$10,046,756	$39,807,150	$0	$99,074,398	$19.10	33
	Connecticut	$3,907,230	$1,080,712	$30,353	$7,910,139	$31,020,780	$149,925	$66,704,650	$18.58	35
	Delaware	$7,915,348	$144,334	$12,591	$4,409,756	$9,179,207	$0	$30,280,612	$33.02	4
	D.C.	$12,390,203	$565,434	$8,268	$9,007,273	$10,071,171	$149,925	$91,209,376	$144.24	N/A
	Florida	$10,706,454	$2,353,463	$15,914	$29,447,714	$191,061,913	$0	$314,363,404	$16.27	45
	Georgia	$11,639,224	$2,738,403	$16,260	$17,263,669	$110,957,133	$0	$212,478,247	$21.42	23
	Hawaii	$1,822,801	$578,664	$25,495	$4,918,135	$13,716,822	$0	$32,221,612	$23.14	15
	Idaho	$1,428,385	$285,302	$13,716	$5,075,426	$18,924,995	$0	$34,903,102	$21.87	21
	Illinois	$26,027,372	$1,815,543	$40,158	$27,765,615	$133,749,909	$0	$257,152,778	$19.97	29
	Indiana	$5,815,669	$1,179,398	$16,090	$11,789,922	$52,429,296	$0	$89,666,444	$13.72	50
	Iowa	$10,604,788	$821,982	$34,097	$7,166,458	$24,222,349	$0	$63,417,878	$20.63	27
	Kansas	$4,489,834	$706,029	$15,698	$7,026,471	$24,458,776	$0	$51,502,609	$17.85	38
	Kentucky	$3,625,811	$1,009,785	$8,690	$8,880,214	$43,118,264	$0	$77,279,238	$17.64	40
	Louisiana	$4,867,697	$2,140,320	$22,541	$9,394,886	$57,261,717	$0	$103,141,587	$22.41	18
	Maine	$10,326,865	$658,506	$25,446	$4,785,322	$11,538,053	$0	$39,946,126	$30.05	7
	Maryland	$11,466,282	$1,415,949	$30,604	$15,150,806	$52,256,282	$0	$138,402,431	$23.52	14
	Massachusetts	$22,073,956	$2,019,981	$30,282	$14,485,903	$53,602,599	$0	$139,390,305	$20.97	26
	Michigan	$9,324,756	$2,936,577	$1,110,463	$17,182,074	$81,739,515	$0	$169,498,728	$17.15	41
	Minnesota	$13,988,891	$2,066,852	$25,759	$11,894,656	$33,099,315	$0	$95,782,348	$17.81	39
	Mississippi	$4,463,459	$1,078,494	$12,114	$6,760,196	$40,983,536	$0	$74,978,923	$25.12	11
	Missouri	$5,656,047	$2,055,979	$20,343	$11,365,070	$55,360,006	$0	$101,819,630	$16.91	43
	Montana	$3,393,837	$698,577	$15,631	$4,301,218	$7,554,121	$0	$29,819,454	$29.67	8
	Nebraska	$3,772,159	$1,420,833	$17,061	$5,577,004	$16,952,107	$0	$42,124,937	$22.70	17
	Nevada	$7,040,676	$433,937	$7,379	$6,973,184	$31,064,665	$0	$58,779,217	$21.31	25
	New Hampshire	$2,262,252	$1,044,862	$14,927	$5,027,392	$8,713,437	$0	$28,650,897	$21.69	22
	New Jersey	$3,511,714	$2,166,732	$30,066	$16,195,847	$65,995,028	$1,807,899	$144,925,215	$16.35	44
	New Mexico	$11,230,472	$1,242,728	$22,897	$6,848,172	$34,392,966	$0	$70,250,361	$33.68	3
	New York	$29,056,631	$5,302,704	$371,092	$39,281,130	$197,975,096	$13,787,852	$463,529,133	$23.69	13
	North Carolina	$11,665,577	$2,079,075	$15,980	$16,413,342	$97,230,979	$0	$175,697,917	$18.02	36
	North Dakota	$2,671,792	$326,483	$21,190	$4,106,390	$5,400,742	$0	$21,055,124	$30.09	6
	Ohio	$8,277,518	$3,496,551	$23,855	$18,793,103	$92,603,426	$0	$163,520,990	$14.16	48
	Oklahoma	$4,701,680	$914,024	$8,757	$8,173,184	$53,760,227	$0	$84,813,374	$22.23	19
	Oregon	$10,901,745	$784,043	$23,778	$8,234,517	$30,138,595	$0	$76,661,012	$19.66	30
	Pennsylvania	$8,898,934	$3,597,270	$1,120,893	$20,208,337	$105,633,196	$0	$196,649,136	$15.41	47
	Rhode Island	$2,731,948	$352,843	$32,267	$4,572,316	$11,175,363	$0	$31,960,614	$30.43	5
	South Carolina	$8,970,185	$935,133	$30,427	$9,759,459	$50,481,991	$0	$100,755,655	$21.33	24
	South Dakota	$1,527,999	$176,627	$16,989	$4,084,764	$9,194,770	$0	$24,396,747	$29.28	9
	Tennessee	$3,470,607	$1,235,680	$52,113	$11,195,905	$67,519,299	$0	$110,507,394	$17.12	42
	Texas	$20,470,572	$3,201,419	$845,674	$37,933,496	$357,708,881	$0	$520,769,662	$19.98	28
	Utah	$6,171,636	$725,349	$70,823	$6,843,571	$20,451,081	$0	$55,357,071	$19.39	31
	Vermont	$2,827,603	$203,664	$33,682	$4,059,802	$5,867,408	$0	$21,110,207	$33.72	2
	Virginia	$6,011,254	$1,760,160	$55,590	$16,300,344	$52,161,350	$149,925	$115,110,759	$14.06	49
	Washington	$18,326,266	$795,955	$867,427	$13,150,991	$84,315,473	$0	$158,136,461	$22.93	16
	West Virginia	$4,386,332	$665,282	$31,948	$5,433,358	$19,934,750	$0	$46,508,068	$25.07	12
	Wisconsin	$11,576,325	$1,466,116	$1,141,676	$11,613,465	$41,279,074	$0	$90,650,154	$15.83	46
	Wyoming	$694,124	$170,753	$45,035	$4,064,476	$4,633,070	$0	$15,695,996	$27.23	10
	U.S. TOTAL	**$471,468,493**	**$72,156,570**	**$6,500,567**	**$627,337,496**	**$3,101,096,971**	**$16,045,526**	**$6,134,759,508**	**$19.54**	

Endnotes

1 Institute of Medicine. *The Future of the Public's Health in the 21st Century.* Washington, D.C, 2003. U.S. Centers for Disease Control and Prevention. *Public Health's Infrastructure — A Status Report.* Atlanta, Georgia, 2001. Trust for America's Health. *Blueprint for a Healthier America: Modernizing the Federal Public Health System to Focus on Prevention and Preparedness.* 2008.

2 Adjusted for inflation.

3 Association of State and Territorial Health Officials. Budget Cuts Continue to Affect the Health of Americans: Update August 2012. http://www.astho.org/Research/Data-and-Analysis/ASTHO-Budget-Cuts-Impact-Research-Brief-Update-(August-2012)/ (accessed December 3, 2012).

4 Oliff P, Mai C, Palacios V. *States Continue to Feel Recession's Impact.* Washington, D.C.: Center on Budget and Policy Priorities, 2012. http://www.cbpp.org/cms/index.cfm?fa=view&id=711 (accessed November 9, 2012

5 Oliff P, Mai C, Palacios V. *States Continue to Feel Recession's Impact.* Washington, D.C.: Center on Budget and Policy Priorities, 2012. http://www.cbpp.org/cms/index.cfm?fa=view&id=711 (accessed November 9, 2012

6 Association of State and Territorial Health Officials. *Budget Cuts Continue to Affect the Health of Americans: Update August 2012.* http://www.astho.org/Research/Data-and-Analysis/ASTHO-Budget-Cuts-Impact-Research-Brief-Update-(August-2012)/ (accessed December 3, 2012).

7 National Association of County and City Health Officials. *Local Health Department Job Losses and Program Cuts: Findings from January 2012 Survey.* Washington, D.C.: NACCHO, 2012. http://www.naccho.org/topics/infrastructure/lhdbudget/upload/Overview-Report-Final-Revised.pdf (accessed November 9, 2012).

8 Institute of Medicine. *For the Public's Health: Investing in a Healthier Future.* April 2012.

9 RESOLVE. "Transforming Public Health: Emerging Concepts for Decision Making in a Changing Public Health World." 2012.

10 Institute of Medicine. *For the Public's Health: Investing in a Healthier Future.* April 2012.

11 RESOLVE. "Transforming Public Health: Emerging Concepts for Decision Making in a Changing Public Health World." 2012.

12 RESOLVE. "Transforming Public Health: Emerging Concepts for Decision Making in a Changing Public Health World." 2012.

13 Welcome to the Public Health Accreditation Board. In *Public Health Accreditation Board.* http://www.phaboard.org/ (accessed November 9, 2012).

14 Public Health Accreditation Board. *Standards and Measures.* Alexandria, VA: Public Health Accreditation Board, 2011.

15 Ibid.

16 Ibid.

17 Health Resources and Services Administration. "About HRSA." U.S. Department of Health and Human Services. http://www.hrsa.gov/about/default.htm. (accessed January 23, 2008).

18 Trust for America's Health. *Public Health Leadership Initiative An Action Plan for Healthy People in Healthy Communities in the 21st Century.* Washington, D.C.: Trust for America's Health, March 22, 2006. http://healthyamericans.org/policy/files/ActionPlan.pdf The "Action Plan" has been signed onto by a range of public health experts, including Rachel Block, United Hospital Fund; Dr. Georges Benjamin, American Public Health Association; Dr. Jo Ivey Boufford, New York University Wagner; Shannon Brownlee, New America Foundation; Maureen Byrnes, Human Rights Fund (formerly with The Pew Charitable Trusts); Dr. Lawrence Deyton, Veterans Health Administration; Dr. Jonathan Fielding, Los Angeles County Department of Health Services; Dr. David Fleming, The Bill & Melinda Gates Foundation; Dr. C. Earl Fox, University of Miami; Dr. Lawrence Gostin, Georgetown Law Center; Dr. Peggy Hamburg, NTI; Dr. James J. James, American Medical Association; Dr. James Marks, Robert Wood Johnson Foundation; Dr. Dennis O'Leary, Joint Commission on Accreditation of Healthcare Organizations; Dr. Alonzo Plough, The California Endowment; Dr. Kathleen Toomey, Emory University; Dr. Kenneth Warner, University of Michigan.

19 Frist B. "Public Health and National Security: The Critical Role of Increased Federal Support." *Health Affairs* 21, no. 6 (November/December 2002): 117-130.

20 Trust for America's Health. *Public Health Leadership Initiative,* 2006.

21 Meyer J. and Weiselberg L. "County and City Health Departments: The Need for Sustainable Funding and the Potential Effect of Health Care Reform on their Operations." Health Management Associates, A Report for the Robert Wood Johnson Foundation and the National Association of County & City Health Officials. December 2009.

22 http://content.healthaffairs.org/content/early/2011/07/19/hlthaff.2011.0196.full.pdf+html

23 http://www.mgma.com/physcomp/

24 Mays GP and Smith SA. "Geographic Variation in Public Health Spending," 2009.

25 Ibid.

26 Ibid.

27 *Budget Cuts Continue to Affect the Health of Americans: Update November 2011.* Washington, D.C.: Association of State and Territorial Health Officials, November 2011.

28 Ibid.

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