A Proposal to the Public Health Council
From the Ad Hoc Finance Committee

Increased State Financing of Governmental Public Health
Wisconsin Department of Health and Family Services
Public Health Council

December 7, 2007

Public Health Council Ad Hoc Finance Committee
Julie Willems Van Dijk, chair
Bevan Baker
Carol Graham
Catherine Frey
Doug Nelson
David Ahrens

Authored by: Traici Brockman, MPH

DHFS staff support:
Jane Conner
Patricia Guhleman

Table of Contents

PURPOSE

In response to concern about inadequate financing of Wisconsin's public health system, the Public Health Council appointed an Ad Hoc Finance Committee to further examine and analyze the financing of public health in Wisconsin. The committee's charge included developing a proposal to increase state funding of state and local governmental public health entities. The charge acknowledged that the work of public health occurs in both governmental and private sector settings, but that such a comprehensive analysis would be beyond the scope of the current report. Thus, this report represents a first step in understanding the full public health financing system; its recommendations focus on improved financing for the governmental public health system. It is recommended that future analysis expand this work to study public health financing in non-governmental systems and offer further recommendations for improvement.

WISCONSIN'S HEALTH CRISIS

Many measures reflecting the basic health status of a community document Wisconsin's failure to adequately protect and promote the health of its residents. For example, Wisconsin's African American infant mortality rate was once ranked third best in the nation. A lack of attention, combined with inaction, has driven Wisconsin to the worst African American infant mortality rate among 40 reporting states; in Wisconsin, African American babies are three times more likely than white babies to die before they reach their first birthday.[1] Increasing rates of chronic diseases also place heavy financial burdens on the health care system and lead to increased disability and death for Wisconsin residents. The adult obesity rate has doubled since 1990, and more than half the adult population (60%) is classified as overweight or obese.[2] Accordingly, obesity can be linked to two of the top three causes of death in Wisconsin – heart disease and stroke. Alcohol abuse represents another chronic disease that not only has perilous effects on health but increases crime and decreases public safety. Wisconsin leads the nation in current drinking among high school students (49%), current drinking among adults (68%), binge drinking among adults (22%) and chronic heavy drinking among adults (8%).[3] This has led to an alcohol-related motor vehicle death rate, an alcohol dependence and abuse rate, and drinking and driving rates that all exceed the national average.[4]

Failure to fully implement the State Health Plan is one of the reasons these problems show little-to-no improvement and threaten to become even more burdensome. Wisconsin's State Health Plan, *Healthiest Wisconsin 2010: A Partnership Plan to Improve the Health of the Public*, was created as a guide to transform Wisconsin's public health system through focus on 11 major health priority areas. The plan includes an implementation guide that contains long-term objectives for addressing each health priority, and identified actions that can be taken to address education, social support, laws, policies, and behavior change – all essential to creating lasting improvement in health outcomes. The plan includes detailed short, medium, and long-term objectives expected to be met during the decade. The state health plan is a detailed, clearly defined strategy, grounded in science and based on the most current evidence-based practices to provide solutions to improving health outcomes in Wisconsin.

The State Health Plan provides direction for addressing many of Wisconsin's poor health outcomes but has not been fully implemented. The major impediment to full implementation of the plan is that minimal state resources are appropriated for implementation. Wisconsin invests miserably in public health. A 2007 report from the *Trust for America's Health* ranked the 50 states according to their respective state public health investments. Wisconsin ranked 47th. Compared to neighboring states in the upper Midwest, Wisconsin ranks last in public health investment, spending only one-quarter of the average of these states on funding public health.

Without adequate and sustained financing it is difficult to improve the public's health in the near and long term and impossible to implement the State Health Plan, which provides the guidelines to solve Wisconsin's major health crises. Experience demonstrates that dedicated and consistent financing of public health can reduce negative health-related behaviors and improve health outcomes. For example, dedicated and sustained funding for tobacco control efforts has

[1] Wisconsin Health Facts: Racial and Ethnic Disparities in Infant Mortality, Wisconsin Department of Health and Family Services, January 2006. http://dhfs.wisconsin.gov/healthybirths/pdf/InfantHealthFactSheet.pdf (Accessed 09/28/2007).
[2] The Importance of Nutrition and Physical Activity in the Prevention of Obesity and Other Chronic Diseases - A Joint Statement, Wisconsin Department of Health and Family Services. http://dhfs.wisconsin.gov/health/physicalactivity.pdf_files/JointStatement-Final.pdf (Accessed 11/16/2007).
[3] Impact of Alcohol and Illicit Drug Use in Wisconsin, University of Wisconsin Population Health Institute, October 2007.
[4] Impact of Alcohol and Illicit Drug Use in Wisconsin, University of Wisconsin Population Health Institute, October 2007.

led to significant decreases in youth cigarette smoking (12% of middle school youth smoked in 2000, compared to 5.8% in 2006; 38% of high school students smoked in 1999 compared to 20% in 2006); fewer establishments that sell tobacco products to minors; declines in per capita consumption of cigarettes (94.0 packs sold per capita in 1990 versus 71 packs per capita in 2006); and decreased smoking rates among pregnant women (23% in 1990 compared to 13% in 2005). Reductions in prenatal smoking affect not only the health of the women, but also generate significant health care cost savings and health benefits to the infant since maternal smoking contributes to costly low birth weight and preterm births.[5] These tobacco control successes are laudable; they were possible because a commitment was made to direct sufficient resources to target the problem using evidence-based solutions, and the funding remained consistent and sustained. The same types of success can be produced in other areas affecting the public's health with a similar commitment to provide sustainable resources.

IMPORTANCE OF PUBLIC HEALTH SERVICES

Public health's goal in Wisconsin is the improved health of the 5+ million residents of Wisconsin. "Public Health is defined as a system, a social enterprise, whose focus is on the population as a whole."[6] The public relies on this system to prevent injury, illness, and the spread of disease; create a healthful environment and protect against environmental hazards; promote healthy behaviors and mental health; respond to disasters and assist communities in recovery; and provide accessible, high-quality health services. When public health is under-resourced the ability to fulfill these functions is threatened and the results are a less healthy population and higher medical care costs.

The governmental sector is a critical part of the public health system. "Health officials are either directly elected or appointed by democratically elected officials."[7] The public expects that government will monitor the population's health, and intervene when necessary via laws, policies, and regulations; it expects that government will appropriate the necessary resources to carry out these functions. Under the state constitution state and local governments have primary responsibility for maintaining population health.[8] This responsibility is fulfilled by engaging in the activities that constitute monitoring the public's health. State and local policymakers must also make available sufficient and sustained resources that allow those activities to continue.

FINANCING GOVERNMENTAL PUBLIC HEALTH

National Comparisons

Compared with other states, Wisconsin's state investment in public health financing ranks very low. A report from the *Trust for America's Health* published in 2007 ranked the 50 states according to their state per capita investment in public health (2 states were excluded because of inability to obtain reliable data). For the 2004-2005 period Wisconsin ranked 47th; its public health spending amounted to only $6.24 per capita, which translates into a total investment of just over $34 million (Table 1, next page). It is important to note that this number includes all state GPR funds appropriated for public health activities – including state health department spending, pass-through to local health departments, and pass-through to community-based organizations.

[5] Wisconsin Department of Health and Family Services, Division of Public Health, Wisconsin Tobacco Prevention and Control Program Annual Report, 2006 Activities; April 2007.
[6] Wisconsin's State Health Plan, *Healthiest Wisconsin 2010*, p. 10.
[7] "The Future of the Public's Health in the 21st Century." *Institute of Medicine, 2003, p. 101.*
[8] "The Future of the Public's Health in the 21st Century." *Institute of Medicine, 2003, p. 102.*

Table 1: National Rankings of State Investment in Public Health FY2004-2005

State	Rank	Per Capita	Total
Hawaii	1	$123.10	$155,458,776
Wyoming	2	$ 89.65	$ 45,408,089
Georgia	3	$ 80.35	$ 709,400,466
Idaho	4	$ 74.28	$ 103,485,100
Alabama	5	$ 68.37	$ 309,750,247
California	6	$ 64.58	$2,318,112,000
Oklahoma	7	$ 64.34	$ 226,720,000
West Virginia	8	$ 63.28	$ 114,883,938
New Mexico	9	$ 63.05	$ 120,003,800
Vermont	10	$ 60.44	$ 37,555,659
Nebraska	11	$ 59.72	$ 104,344,393
Arkansas	12	$ 51.25	$ 141,082,698
Minnesota	13	$ 47.83	$ 243,993,000
Utah	14	$ 41.36	$ 98,805,900
South Carolina	15	$ 38.86	$ 163,119,348
Alaska	16	$ 37.29	$ 24,440,600
Rhode Island	17	$ 37.12	$ 40,109,206
Maryland	18	$ 36.01	$ 200,162,000
Delaware	19	$ 35.58	$ 29,542,100
Kentucky	20	$ 35.36	$ 146,613,334
Florida	21	$ 34.35	$ 597,539,043
Virginia	22	$ 33.61	$ 250,703,431
Tennessee	23	$ 31.15	$ 183,829,600
Washington	24	$ 29.97	$ 371,845,528
Pennsylvania	25	$ 29.27	$ 363,108,000
New Jersey	26	$ 28.81	$ 250,592,000
Michigan	27	$ 25.52	$ 258,028,300
Illinois	28	$ 24.42	$ 310,415,600
North Dakota	29	$ 23.25	$ 29,494,441
New Hampshire	30	$ 21.69	$ 28,186,104
Montana	31	$ 20.99	$ 19,459,374
Connecticut	32	$ 20.32	$ 71,185,754
South Dakota	33	$ 20.04	$ 15,449,514
Massachusetts	34	$ 19.67	$ 126,209,229
Arizona	35	$ 15.31	$ 87,947,400
Colorado	36	$ 14.93	$ 68,704,761
North Carolina	37	$ 13.62	$ 116,310,280
Texas	38	$ 13.59	$ 305,545,630
Kansas	39	$ 11.48	$ 31,396,513
Indiana	40	$ 11.29	$ 70,394,726
Ohio	41	$ 10.85	$ 124,279,084
Mississippi	42	$ 10.01	$ 29,062,469
Oregon	43	$ 9.07	$ 65,173,871
Missouri	44	$ 7.98	$ 45,943,007
Iowa	45	$ 7.88	$ 23,267,142
Maine	46	$ 7.04	$ 9,277,644
Wisconsin	**47**	**$ 6.24**	**$ 34,356,000**
Nevada	48	$ 3.76	$ 8,774,904

Source: Levi, J, Julianno, C, and Richardson, M. "Financing Public Health: Diminished Funding for Core Needs and State-by-State Variation in Support." *Journal of Public Health Management and Practice* 2007, 13(2) pg. 97-102.

Out of this $34 million only $13.4 million supports the governmental public health system in Wisconsin. The remaining $20.6 million supports non-governmental public health entities. Table 2 indicates how Wisconsin compares to other upper Midwest states in their investment in public health:

Table 2: Comparison of State GPR Expenditures in Public Health among Upper Midwest States, FY2004-2005

State	Rank	Per Capita	Total
Minnesota	13	$ 47.83	$ 243,993,000
Michigan	27	$ 25.52	$ 258,028,300
Illinois	28	$ 24.42	$ 310,415,600
Iowa	45	$ 7.88	$ 23,267,142
Wisconsin	**47**	**$ 6.24**	**$ 34,356,000**

Source: Levi, J, Julianno, C, and Richardson, M. "Financing Public Health: Diminished Funding for Core Needs and State-by-State Variation in Support." *Journal of Public Health Management and Practice* 2007, 13(2) pg. 97-102.

Structure of Financing Governmental Public Health

A mix of federal, state, and program revenues and a small amount of segregated appropriations finance governmental public health on the state level. At the local level public health programs are financed primarily by local tax levies along with a mix of federal, state, and program revenues. These financing structures often constrain local and state health departments by placing categorical restrictions by the funding source on the use of these funds. Very little of the revenues received by state or local government have flexible uses; therefore, these revenues cannot always be used for the most pressing problems of the community or state.

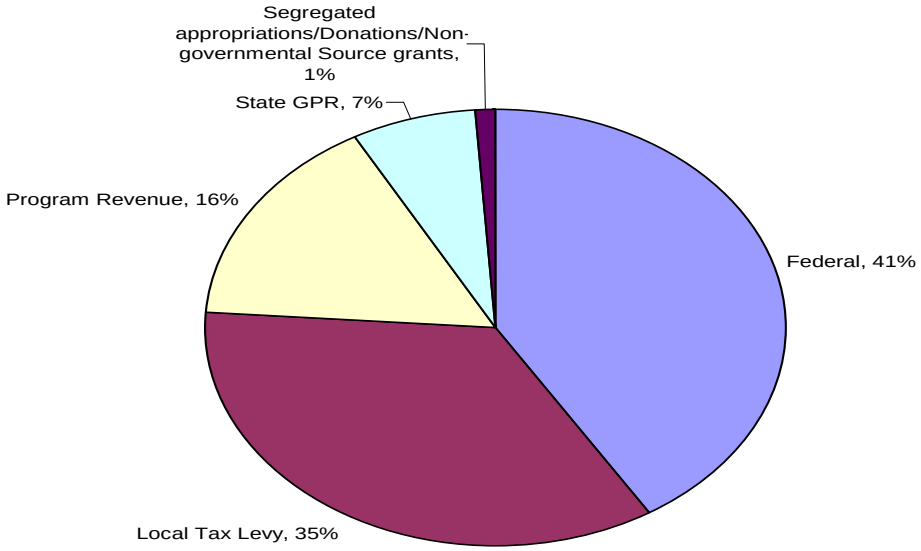
In Figure 1 (next page), federal funds (41%) refer to grant money received from the federal government. These funds are usually received by the state Division of Public Health, which retains approximately 20% for its operations. Much of federal funding is passed on to local partners, including local public health agencies (about 17%) and private community-based organizations (the remaining 63%). Federal funds are always for a specified purpose, such as the maternal and child health block grant, WIC funds, immunization grants, public health preparedness funds, and the prevention health block grant.

State funds (7%) are state general purpose revenue (GPR) granted to the state Division of Public Health, which retains about 12%; about 26% is passed to local health departments and 62% to private community-based organizations. Examples of this funding include monies for childhood lead poisoning prevention and the Wisconsin Well Woman cancer screening programs.

Program revenues (15%) are monies collected by state or local governments for services such as licensing, fees, certifications, and registrations. Donations are any monies received as gifts; and non-governmental source (NGS) grants are funds obtained through a competitive grant process from private foundations (for example, United Way and the Robert Wood Johnson Foundation).

In summary, governmental public health is financed by a mix of funds from different sources. Most of these funds carry categorical restrictions on their use, which may not allow health authorities to address the most pressing problems for the state or the local community. An examination of each of the funding sources referenced above and their contribution to financing Wisconsin's public health system in 2005 reveals some disturbing inequities.

Figure 1: Percent of Funding for Governmental Public Health in Wisconsin by Source – 2005



Source: Wisconsin Department of Health and Family Services, Bureau of Fiscal Services, SFY 2002-2005 Annual Expenditure Reports; Wisconsin Department of Health and Family Services, Division of Public Health, Bureau of Health Information and Policy, Wisconsin Local Health Department Surveys 2002-2005.

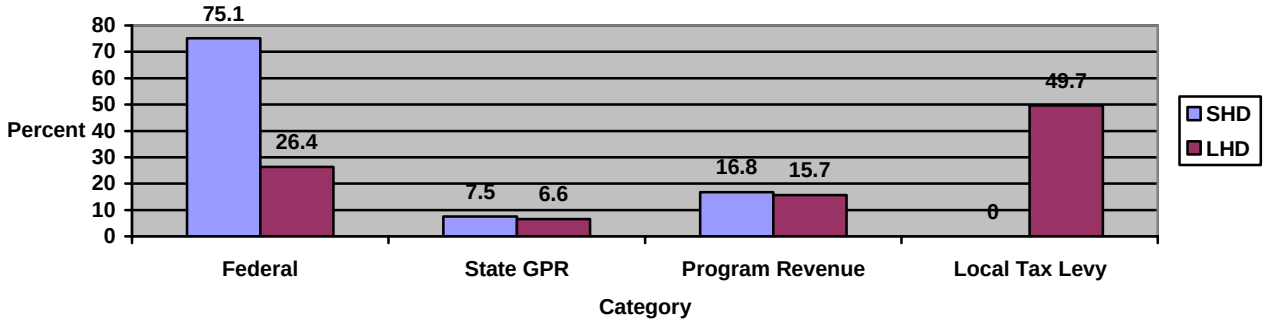
Data indicate that Wisconsin is heavily dependent on federal funding and local tax levy revenues to finance its governmental public health activities – these two sources contribute over three-quarters of all funding for governmental public health. State revenue contributes relatively little (7%) to support the public health responsibility for improved health outcomes for residents of the state.

Problems associated with being heavily reliant on federal funding and local taxes include:

- All federal revenue is categorical – if priorities and appropriations change at the federal level it will directly affect the ability of Wisconsin public health practitioners to focus on public health priorities.
- If significant decreases occur in federal funding, state and local public health agencies will need to drastically reduce the services they can provide to the state and individual communities.
- Because few of the dollars are derived from state sources, the state cannot define or implement its health priorities. If the state determines, for example, that ground water protection, diabetes prevention, and reductions in infant mortality are important, it has little revenue to direct to these priorities. The priorities that are deemed important at the federal level may not be what is most important for improving the health of Wisconsinites.
- Significant variation exists between counties' local tax bases; wealthier counties may have the ability to provide more and better programs and services than other counties, leading to increased disparities in service availability and delivery across the state.

Our analysis reveals that the state health department in Wisconsin has become dependent on federal revenue to finance 75% of its public health activities. Local health departments are dependent upon local tax levies for 50% of their funding and federal revenue for about 25% of their funding. In each case the state investment is minimal. In 2005, GPR contributed about 7.5% of state health department revenues and 6.6% of local health department revenues.

Figure 2: Sources of State and Local Health Department Revenues in Wisconsin – 2005



Source: Wisconsin Department of Health and Family Services, Bureau of Fiscal Services, SFY 2002-2005 Annual Expenditure Reports; Wisconsin Department of Health and Family Services, Division of Public Health, Bureau of Health Information and Policy, Wisconsin Local Health Department Surveys 2002-2005.

Analysis of trends in funding over the past five years does not indicate significant changes in total or per capita expenditures or the relative contributions of revenue from each funding source (see Appendix for more detail of funding in the past few years). In general, funding amounts have remained relatively flat and often when adjusted for inflation have decreased. (Table 3 displays per capita expenditures from each source of funding.) At the same time, greater demands are being placed upon governmental public health to perform services required by statute, respond to new and emerging threats, and make progress toward the goals of the State Health Plan. Without more and sustained resources it will be impossible for governmental public health to adequately and sufficiently accomplish these tasks.

Table 3: Per Capita Spending on Governmental Public Health by Source of Funding – 2005

Funding Source	Per Capita Spending	Total Expenditures
Federal	$14.36	$79,000,000
Local tax levy	$12.35	$67,900,000
State GPR	$6.24	$34,356,000

Source: Wisconsin Department of Health and Family Services, Bureau of Fiscal Services, SFY 2002-2005 Annual Expenditure Reports; Wisconsin Department of Health and Family Services, Division of Public Health, Bureau of Health Information and Policy, Wisconsin Local Health Department Surveys 2002-2005.

PROPOSED RECOMMENDATIONS

1. This committee recommends that the state increase its per capita investment in public health to $12.50. This would require an annual increase in funding of $33 million.
2. The committee further recommends that the funding be appropriated to the state health department but will be divided between both state and local governments; these entities can decide to use their funding to subcontract with private partners.
3. The committee recommends that the funds be used to implement evidenced-based approaches and strategies to address the health problems of obesity, alcohol abuse, and health disparities; some funding will also be available to address other health priorities of the state health plan.
4. The committee recommends that this new funding be generated via a $0.10 increase in the tobacco excise tax. Other options for funding would include a tax on alcohol and/or a tax on sugar-sweetened beverages.

Recommendation 1
An increase of the state's per capita investment to $12.50 is a starting point to better financing of governmental public health in Wisconsin because it will provide resources to improve the public's health. It will also produce equity among the three top funding sources in the state. This increase would move the state to a comparable investment to what local governments are spending on public health activities. It would also move the state closer to the federal government's

investment in Wisconsin's public health system. Holding other things equal, this increased investment would move Wisconsin's per capita investment ranking from 47th to 39th. It would also increase Wisconsin's investment to half the average investment of its upper Midwest neighbors.

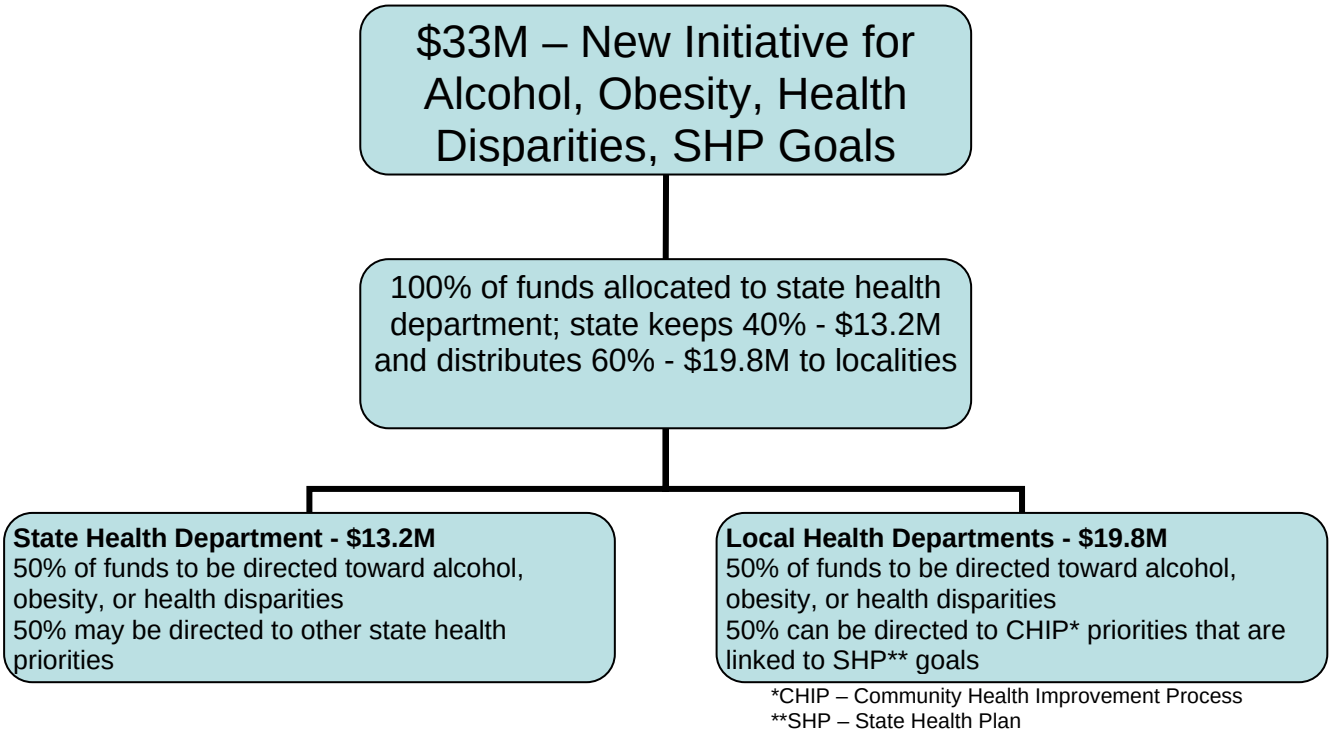
Recommendation 2

These new funds would be divided between state and local government. All funds would be directed to the state health department, which would retain 40% of the funds – approximately $13.2 million – and would distribute 60% - approximately $19.8 million - to local governments. This recognizes that both state and local governments have an important role in improving the public's health. The state health department will serve a leadership role in coordinating efforts to address Wisconsin's top health problems by disseminating best practices for the identified health problems and providing technical assistance to the localities. Distributing the greater percentage of funds to local governments recognizes that the most effective way to affect health issues is at a local level, where services and strategies connect with people.

State and local government would use these funds to address the increasing health problems of alcohol abuse, obesity, and health disparities. State and local health departments could also use some funds for addressing priorities from their community health plans, which are linked to state health plan goals. This approach assures that a significant portion of the new funds will be directed to three of Wisconsin's most pressing health issues, and incorporates enough flexibility to address other health priorities identified by the state health plan and local assessments.

Figure 3 describes how the money would be distributed between the two governmental institutions.

Figure 3: Description of New Funding Initiative and Priorities for Wisconsin Public Health



Under this model the state and local health departments would have discretionary authority regarding the use of this additional funding. Half of the funding would be designated for use in the areas of alcohol, obesity, and health disparities. Funds could be used to focus on one of those priorities or all three; however, at least half of the funding would have to address alcohol, obesity, or health disparities in some way. The other half of the funding would address the need to allow the state and localities to address other priorities within the state health plan that are identified through their community health plans if they so choose. They may also opt to direct 100% of their funds to alcohol, obesity, and health disparities.

Recommendation 3

While Wisconsin ranks well in a number of health outcomes there is indeed cause for alarm. Wisconsin is consistently dropping in national health rankings. The United Health Foundation annually publishes *America's Health Rankings,* a report based on a determinants-of-health model, which ranks the 50 states according to numerous health outcomes. When these rankings began in 1990 Wisconsin ranked 3rd, by 2000 that ranking had fallen to 8th. In 2006, Wisconsin was 10th and the recently released 2007 report shows Wisconsin has fallen another two spots to 12th.[9] Other analyses of Wisconsin show that although the state is often improving its health outcomes it is not improving as fast as other states or the national average; this causes Wisconsin to drop in national rankings despite making some improvement in health outcomes. A 2004 report from the Wisconsin Population Health Institute analyzed Wisconsin's ranking of all-cause mortality for persons under 75 years of age. Wisconsin ranked 16th but making improvements at its current pace was projected to drop to 18th by the year 2010.[10] Health outcomes consistently mentioned as areas that threaten the health of Wisconsin and will provide future challenges to maintaining a healthy state include health disparities, alcohol abuse (specifically binge drinking), and the increasing prevalence of obesity. Each of these issues was chosen as a priority on which to focus new funding because of the current intensity of the problems, the lasting burden they will place on the health care system, and their negative impact on the health of Wisconsin's people.

These funds will be targeted to implementation of evidence-based approaches and best practices to address the following pressing health priorities.

- ***Health Disparities***
  In Wisconsin, minorities, those with less income and education, and those in rural settings often have poorer health outcomes. Wisconsin's minority populations experience a disproportionate burden of many adverse health conditions and health outcomes. The *Health of Wisconsin Report Card* (July 2007) gave Wisconsin an overall health disparity grade of "D," and in many categories Wisconsin received a health disparity grade of "F." Wisconsin is failing to protect the health of many of its citizens, especially its minorities and those in the most vulnerable age groups. The infant mortality rate for the African-American population is more than three times the rate for the white population (17.6 deaths per 1,000 live births v. 5.1 deaths per 1,000 live births)[11]. The population referred to as children and young adults (ages 1-24) also shows disparity in mortality rates. African American and American Indian populations experience a child and young adult mortality rate of 66 deaths per 100,000 population compared to a rate of 39 per 100,000 for whites and 41 per 100,000 for Asians.[12] For adults aged 25-64, mortality rates are highest for those with high school or less education (459 per 100,000 compared to 188 per 100,000 for those who are college graduates) and African American and American Indian populations (624 per 100,000 and 592 per 100,000, respectively).[13] These disparities are differences in health outcomes due in part to inequality and indicate that many Wisconsinites are not experiencing optimal health outcomes.

[9] "America's Health Rankings 2007." United Health Foundation http://www.unitedhealthfoundation.org/media2007/shrmediakit/ahr2007.pdf (Accessed November 27, 2007).
[10] Kempf, AM, Peppard, PE, Kindig, DA, and Remington, PL. "How Fast Can Wisconsin become Healthier? A Framework for Setting State Objectives." http://www.pophealth.wisc.edu/UWPHI/publications/issue_briefs/issue_brief_v05n09.pdf (Accessed November 27, 2007).
[11] Booske, BC, Kempf, AM, Athens, JK, Kindig, DA, and Remington, PL. *Health of Wisconsin Report Card.* University of Wisconsin Population Health Institute, July 2007, p 4.
[12] Booske, BC, Kempf, AM, Athens, JK, Kindig, DA, and Remington, PL. *Health of Wisconsin Report Card.* University of Wisconsin Population Health Institute, July 2007, p 6.
[13] Booske, BC, Kempf, AM, Athens, JK, Kindig, DA, and Remington, PL. *Health of Wisconsin Report Card.* University of Wisconsin Population Health Institute, July 2007, p 8.

- ***Alcohol Abuse***
  A recent report, *Impact of Alcohol and Illicit Drug Use in Wisconsin* (October 2007) found that Wisconsin has the highest rates in the nation of current drinking among high school students (49%); current underage drinking (39%); current drinking among adults (68%); binge drinking among adults (22%); and chronic, heavy drinking among adults (8%). Such intense alcohol use and abuse leads to a number of alcohol-related consequences such as motor vehicle fatalities, cirrhosis of the liver and various cancers, hypertension and heart disease, and homicide and family violence. Alcohol and drug abuse resulted in the expenditure of nearly $190 million of public funds on hospitalizations and treatment for this problem.

- ***Obesity***
  Obesity is another health problem affecting Wisconsin with great intensity. According to 2005 data from the Centers for Disease Control and Prevention's (CDC) Behavioral Risk Factor Surveillance System (BRFSS), 60% of Wisconsin adults are overweight or obese (37% overweight and 24% obese). Also, in the CDC's ranking of states based on the percentage of adults that were overweight or obese, Wisconsin ranked 26th in 2004. Obesity contributes to a number of adverse health conditions such as hypertension, type 2 diabetes, some forms of cancer, coronary heart disease, and stroke. The economic burden of obesity is significant. State-level estimates of annual medical expenditures in Wisconsin attributable to obesity reported total expenditures of $1.5 billion; nearly half those costs were born by public programs, with Medicaid and Medicare incurring $626 million.[14] The 2006 and 2007 health ranking reports cited obesity as a continuing challenge for Wisconsin because of its increasing prevalence.

Recommendation 4
It is recommended that this new funding be generated from an increase in the tobacco excise tax. An increase in this tax has been supported by the Governor, the Legislature, the Public Health Council and other public health organizations. Analysis of cigarette consumption patterns after implementation of a tax increase shows that a $0.10 increase would be enough to generate the $33 million outlined in this proposal. Other options that could be considered to fund this initiative would be taxes on alcohol and/or sugar-sweetened beverages.

EXPECTATIONS AND ASSUMPTIONS

Coupled with this new funding would be expectations and accountability mechanisms for both the state and local governments that receive funds. The state Division of Public Health would act as a leader and disseminate best practices on preventing alcohol abuse, obesity, and health disparities as well as provide technical assistant to the localities, including readily accessible data related to the three health priorities to assist all parties in monitoring progress toward improvement. Local health departments would be expected to have already completed their community health plans and identified the priorities that are most pressing for the communities. These funds would not be available for them to complete the plans. Local governments could – and would be encouraged to – contract with private and community partners to help address the health problems discussed earlier. Also, accountability would be further ensured by using the state measures linked to the State Health Plan implementation guidelines. These guidelines should direct local activities. It would also be expected that local government should not see this new funding as a way to supplant current funding levels and decrease tax levy support for public health. The expectation would be for funding levels from all sources to remain at current or increased levels following this increase in state funding for public health. This would also be seen as a first step in improving the financing of governmental public health. Based on further public health financing analysis and experience through this initiative, it is expected that this funding will be sustained and increased over time as appropriate in order to maintain and improve the health of Wisconsin's people.

[14] "The Importance of Nutrition and Physical Activity in the Prevention of Obesity and Other Chronic Diseases – A Joint Statement." Wisconsin Department of Health and Family Services http://dhfs.wisconsin.gov/health/physicalactivity/pdf_files/JointStatement-Final.pdf (Accessed November 16, 2007).

Appendix

Table 1: Funding for Wisconsin State and Local Governmental Public Health Activities, 2001-2005

Year	Federal	Local Tax Levy	State GPR	Program Revenue	SA/Donation/NGS	Total
2002	$69,355,145	$61,542,132	$14,694,378	$33,343,604	$2,445,523	$181,380,783
2003	$76,420,640	$67,895,561	$14,300,223	$31,421,962	$2,363,996	$192,402,382
2004	$81,082,194	$67,780,839	$13,243,017	$29,613,514	$2,573,963	$194,293,527
2005	$78,956,387	$67,913,612	$13,369,064	$31,072,652	$2,379,241	$193,690,956

Source: Wisconsin Department of Health and Family Services, Bureau of Fiscal Services, SFY 2002-2005 Annual Expenditure Reports.
Wisconsin Department of Health and Family Services, Division of Public Health, Bureau of Health Information and Policy, Wisconsin Local Health Department Surveys 2002-2005.

Table 2: Percent of Wisconsin Governmental Public Health Funding by Source, 2001-2005

Year	Federal	Local Tax Levy	State GPR	Program Revenue	SA/Donation/NGS
2002	38.2%	33.9%	8.1%	18.4%	1.3%
2003	39.7%	35.3%	7.4%	16.3%	1.2%
2004	41.7%	34.9%	6.8%	15.2%	1.3%
2005	40.8%	35.1%	6.9%	16.0%	1.2%

Source: Wisconsin Department of Health and Family Services, Bureau of Fiscal Services, SFY 2002-2005 Annual Expenditure Reports.
Wisconsin Department of Health and Family Services, Division of Public Health, Bureau of Health Information and Policy, Wisconsin Local Health Department Surveys 2002-2005.

Table 3: Funding for Wisconsin State Health Department Public Health Activities, FY 2000-2001 – 2004-2005

FY	Federal	State GPR	Program Revenue	Segregated Appropriations	Total
2000-2001	$40,202,363	$6,712,278	$9,044,832	$370,400	$56,329,873
2001-2002	$44,827,115	$5,572,827	$11,378,300	$387,100	$62,165,343
2002-2003	$46,038,459	$5,607,491	$10,962,195	$393,300	$63,001,445
2003-2004	$46,914,932	$5,052,530	$9,434,653	$406,538	$61,808,653
2004-2005	$42,863,647	$4,297,842	$9,581,321	$325,663	$57,068,473

Source: Wisconsin Department of Health and Family Services, Bureau of Fiscal Services, SFY 2000-2005 Annual Expenditure Reports.

Table 4: Wisconsin State Health Department Public Health Activities: Percent of Funding by Source, FY 200-2001 – 2004-2005

FY	Federal	State GPR	Program Revenue	Segregated Appropriations
2000-2001	71.4%	11.9%	16.1%	0.7%
2001-2002	72.1%	9.0%	18.3%	0.6%
2002-2003	73.1%	8.9%	17.4%	0.6%
2003-2004	75.9%	8.2%	15.3%	0.7%
2004-2005	75.1%	7.5%	16.8%	0.6%

Source: Wisconsin Department of Health and Family Services, Bureau of Fiscal Services, SFY 2000-2005 Annual Expenditure Reports.

Table 5: Funding for Wisconsin Local Health Departments, 2001-2005

Year	Federal	State GPR	Program Revenue	Donation	NGS grants	Tax Levy	Total
2002	$24,528,030	$9,121,551	$21,965,304	$441,589	$1,616,834	$61,542,132	$119,215,440
2003	$30,382,181	$8,692,732	$20,459,767	$228,390	$1,742,306	$67,895,561	$129,400,937
2004	$34,167,262	$8,190,487	$20,178,861	$375,735	$1,791,690	$67,780,839	$132,484,874
2005	$36,092,740	$9,071,222	$21,491,331	$389,357	$1,664,221	$67,913,612	$136,622,483

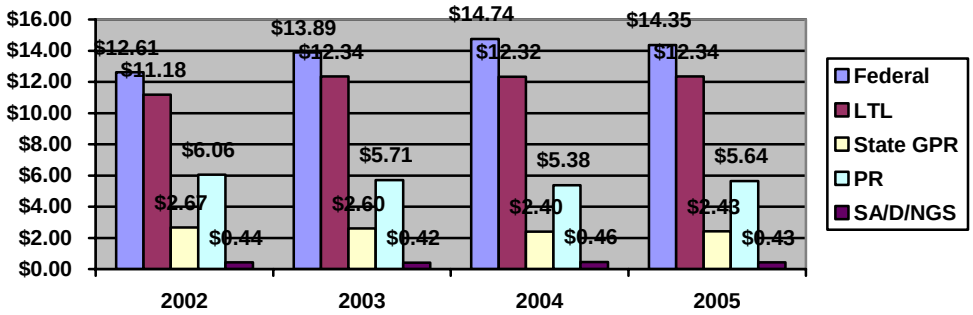
Source: Wisconsin Department of Health and Family Services, Division of Public Health, Bureau of Health Information and Policy, Wisconsin Local Health Department Surveys 2002-2005.

Table 6: Local Health Departments in Wisconsin: Percent of Funding by Source, 2001-2005

Year	Federal	State GPR	Program Revenue	Donation	NGS grants	Tax Levy
2002	20.6%	7.7%	18.4%	0.4%	1.4%	51.6%
2003	23.5%	6.7%	15.8%	0.2%	1.3%	52.5%
2004	25.8%	6.2%	15.2%	0.3%	1.4%	51.2%
2005	26.4%	6.6%	15.7%	0.3%	1.2%	49.7%

Source: Wisconsin Department of Health and Family Services, Division of Public Health, Bureau of Health Information and Policy, Wisconsin Local Health Department Surveys 2002-2005.

Figure 1: Per Capita Spending on Public Health by Source of Funds, Wisconsin, 2002-2005



Source: Wisconsin Department of Health and Family Services, Bureau of Fiscal Services, SFY 2002-2005 Annual Expenditure Reports. Wisconsin Department of Health and Family Services, Division of Public Health, Bureau of Health Information and Policy, Wisconsin Local Health Department Surveys 2002-2005.