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Communicable Disease Prevention and Control by Local Health Departments (Health Services -- Public Health)

[LFB 2021-23 Budget Summary: Page 279, #2]

CURRENT LAW

Wisconsin's public health system relies on local health departments (LHDs) to prevent and control the spread of communicable diseases, with support and coordination from state and federal agencies. Wisconsin has 97 LHDs, organized at the city, county, multi-county partnership, or tribal level. They receive funding from several sources, including local levies, state grants that primarily target specific health issues or programs, and federal grants including grants from the Centers for Disease Control and Prevention (CDC).

In recent years, the Department of Health Services (DHS) has allocated approximately $5.2 million in GPR funding and $30.3 million in federal grant funding per year to LHDs through consolidated contracts. This funding comprises approximately two dozen distinct programs offering a wide range of services, including maternal and child health, immunization, nutrition and education services under the women, infants and children (WIC) supplemental food program, lead poisoning prevention, and reproductive health.

However, local levies are the primary source of funding for LHDs. In 2013, the last year for which DHS collected survey information, LHDs reported local tax levy-supported expenditures totaling approximately $78.3 million. In addition, LHD budgets often include significant grants from non-governmental sources, as well as direct charitable contributions and revenue from fees for services.

2017 Wisconsin Act 59 (the 2017-19 biennial budget act) established the state's first GPR-funded grant program that explicitly supports LHD efforts to prevent, trace, and mitigate the spread of communicable diseases, and provided $500,000 GPR annually, beginning in 2017-18, to fund grants under the program. LHDs may use this grant funding for a variety of activities, including

testing for and tracking disease activity, contact tracing, staff development and training, improving communication among health care professionals, public education and outreach, and other infection control measures. DHS allocates approximately half of the total funding as a flat grant of $2,500 to each LHD (97 x $2,500 = $242,500), and awards the remaining funds ($257,500) in proportion to the population in each LHD's jurisdiction. The median annual grant award LHDs receive is approximately $4,000.

Independent of this grant funding and contracts related to other fund sources, current law mandates that every LHD provide the following core services: (a) surveillance and investigation of communicable disease; (b) communicable disease control, including vaccination and outbreak response; (c) interventions to prevent chronic disease and injury; (d) coordinated emergency response; (e) guidance and promotion of practices that support public health; (f) identification and control of health hazards; (g) policy coordination and information assessing the health of their communities; (h) leadership and competent organization; and (i) public health nursing services applied to the preceding requirements. Wisconsin LHDs spend considerably more than their state communicable disease grant amount to meet the first two requirements by supporting this function with local levy and federal funds from the CDC.

The requirements related to communicable diseases apply to approximately 100 different diseases, including food-borne illnesses, sexually-transmitted infections, diseases spread by mosquitos, ticks, and other vectors, influenza, and many others. Diseases of particular concern must be reported to the DHS Division of Public Health, and in some cases the CDC. The state publishes data on around 30 of these, ranging from those that affect fewer than 50 Wisconsinites each year, such as malaria, mumps, and meningitis, to diseases that infect thousands, such as Lyme disease and hepatitis C.

DISCUSSION POINTS

1. Over the past decade and prior to the COVID-19 pandemic, local, state and federal public health spending has generally remained flat or declined, which has limited state and local public health agencies' ability to prevent the spread of communicable diseases. In an April, 2021, article published in *Health Affairs*, the authors researched state and local spending trends in eight categories of public health activity from 2008 through 2018. The authors concluded that the mean and median per capita population-weighted state spending for public health was $80.40 and $62.37, respectively in 2008, but had decreased to $75.83 and $54.28 in 2018. The authors found that per capita mean spending for the control of communicable diseases increased slightly during this period, from $8.73 in 2008 to $9.32 in 2018.

2. LHD staffing levels have followed similar trends, generally decreasing or remaining flat over the past decade. A nationwide study conducted by the National Association of County and City Health Officials indicates that staffing for LHDs decreased by 16% from 2008 to 2019. Public health nurses, which fill key roles for communicable disease control and prevention by conducting testing and providing immunizations, among other services, accounted for most of the staffing decreases during this period.

3. Most of the federal funding related to communicable diseases LHDs receive is provided through CDC grants for public health emergency preparedness (PHEP) and immunizations and vaccines for children. Wisconsin's awards under both these programs have remained roughly flat over the last decade. In 2019, Wisconsin received $11.3 million from PHEP and DHS distributed $5.2 million of this grant to LHDs, allocating the remainder to support public health activities at the state level. Wisconsin's 2019 immunizations award was $7.5 million, of which DHS distributed $1.5 million to LHDs.

4. Several of the federal acts passed in response to the COVID-19 pandemic provided one-time supplements to the PHEP grant and the CDC's epidemiology and laboratory capacity for infectious diseases (ELC) grant. The three large federal response acts passed in 2020 provided a total of $161.1 million to the state in supplements to these two grants. From that amount, DHS has distributed $88.8 million to LHDs. Both federal response acts passed in 2021, the Coronavirus Response and Relief Supplemental Appropriations Act and the American Rescue Plan Act, also provided supplements to the ELC grant. The CDC has allocated $510.5 million to Wisconsin from these acts to date, and it is anticipated that DHS will make further distributions to LHDs. These funds support measures LHDs have taken in response to the COVID-19 pandemic, including testing, hiring and training many new contact tracers to alert people to exposure to the virus and provide guidance to limit its spread, and administering vaccinations. Despite the one-time increase in federal funding, DHS indicates that LHDs have had to reduce or terminate some efforts to prevent and control other communicable diseases, as well as other public health work, to meet the demands of the COVID-19 response.

5. In recent years, the CDC has distributed one-time supplemental funding for state and local health departments to respond to several major communicable disease outbreaks, including Zika, Ebola, and H1N1. Increasing reliance on these grant supplements, which states received after the outbreaks became known, shifts the public health system away from proactive and sustained spending on communicable disease control and prevention. Increasing the ongoing GPR grant would enable LHDs to focus on preventing epidemics and building capacity to mobilize quickly when diseases begin to spread.

6. Some evidence suggests these trends in spending and staffing have had negative impacts on public health outcomes. Wisconsin LHDs and national research, including the article previously cited in *Health Affairs* and articles published in the *Milbank Quarterly* in June, 2020, and *Kaiser Health News* in July, 2020, report that currently available resources are insufficient to deliver the needed level of service, including communicable disease prevention and emergency preparedness.

7. Further, life expectancy has declined and mortality increased for some demographic groups, particularly in connection to the opioid epidemic. The opioid epidemic suggests a need for funding to address broader weaknesses in public health capacity. Opioids, however, also pose threats in the area of communicable diseases: infections such as HIV and hepatitis C can be spread by shared needles and syringes, and controlling outbreaks among injection drug users is a key public health concern. The COVID-19 pandemic has also brought to light weaknesses in the public health system.

8. Aside from historical trends, the primary argument in favor of increasing state support for local communicable disease prevention and control is based on the demonstrated connection

between public health spending and health outcomes. Analysis published in *Health Affairs* in August, 2011, on differences in public health spending and outcomes across jurisdictions finds that a 10% increase in public health spending can be expected to reduce mortality rates from preventable causes, such as heart disease and infant mortality, by 1% to 7%. In Wisconsin, this corresponds to an expected 18 lives saved per year per $1 million in increased public health spending.

9. Investment in public health can create significant cost savings, primarily because public health interventions tend to prevent disease at a lower cost than treatment would require. A systematic review of various public health interventions at the local level published in the August, 2017, issue of the *Journal of Epidemiology and Community Health* found them to typically achieve a return of $4 for every $1 invested. A separate study in the October, 2020, issue of *Health Economics* focusing only on savings to Medicaid in one state found that every $1 invested in LHDs yielded an average reduction of $3 in Medicaid benefits costs. In Wisconsin, after considering the federal share of Medicaid expenditures, this would still suggest a net GPR savings from increased investment in public health.

10. Finally, population growth, rising numbers of elderly residents, and increasing responsibilities of LHDs are trends that would support increasing public support for LHDs.

11. Assembly Bill 68/Senate Bill 111 would provide an additional $5,000,000 GPR annually to increase, from $500,000 GPR to $5,500,000, the funding DHS provides to LHDs as a means of increasing state support for services LHDs provide to prevent and control communicable diseases.

12. The bill contains no statutory changes to the current program. However, current law requires DHS to determine an appropriate formula for allocating the $500,000 in annual grant funding among the LHDs, with the requirement that at least some base level of funding is provided to each LHD and that the remainder is distributed in consideration of population size, target populations, risk factors, and the size of the service area. DHS has not determined the formula the agency would use if additional funding is budgeted for the program. As discussed above, the current formula provides approximately half of the funding as a flat base payment and allocates the remainder in proportion to the total population of each LHD's jurisdiction. Under the current methodology and funding level most of the state funding is provided to LHDs with jurisdictions with fewer than 65,000 residents.

13. Although LHDs would continue to rely on funds from local levies to prevent and control communicable diseases, increasing state support for these activities would improve the consistency of available funding across jurisdictions. Outbreaks in one part of the state quickly affect others, making this consistency in capacity particularly valuable in the area of communicable diseases.

14. This paper presents several funding options the Committee could consider if it wishes to increase state support to LHDs to prevent and control the spread of communicable diseases, including adopting the Governor's recommended funding increase of $5,000,000 GPR per year (Alternative 1), increasing the program by $2,500,000 GPR annually (Alternative 3), and increasing the program by $1,000,000 annually (Alternative 5).

15. Alternatively, in light of the availability of one-time federal funds to assist LHDs in preventing and controlling communicable diseases, the Committee could increase funding for the

grant program by $5,000,000 (Alternative 2), $2,500,000 (Alternative 4), or $1,000,000 (Alternative 6) beginning in 2022-23, rather than 2021-22, which would reduce the amount of GPR required in the 2021-23 biennium to support the program but establish a base funding level increase for the program for the 2023-25 biennium.

16. Finally, given the significant amount of recent federal funding provided to LHDs in the state, the Committee could decide not to provide additional state support in 2021-23.

ALTERNATIVES

1. Provide $5,000,000 annually to increase, from $500,000 to $5,500,000, GPR grant funding DHS provides to local public health departments to prevent and control communicable diseases.

ALT 1	Change to Base
GPR	$10,000,000

2. Provide $5,000,000 in 2022-23 to increase, from $500,000 to $5,500,000, GPR grant funding DHS provides to local public health departments to prevent and control communicable diseases.

ALT 2	Change to Base
GPR	$5,000,000

3. Provide $2,500,000 annually to increase, from $500,000 to $3,000,000, GPR grant funding DHS provides to local public health departments to prevent and control communicable diseases.

ALT 3	Change to Base
GPR	$5,000,000

4. Provide $2,500,000 in 2022-23 to increase, from $500,000 to $3,000,000, GPR grant funding DHS provides to local public health departments to prevent and control communicable diseases.

ALT 4	Change to Base
GPR	$2,500,000

5. Provide $1,000,000 annually to increase, from $500,000 to $1,500,000, GPR grant funding DHS provides to local public health departments to prevent and control communicable diseases.

ALT 5	Change to Base
GPR	$2,000,000

6. Provide $1,000,000 in 2022-23 to increase, from $500,000 to $1,500,000, GPR grant funding DHS provides to local public health departments to prevent and control communicable diseases.

ALT 6	Change to Base
GPR	$1,000,000

7. Take no action.

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