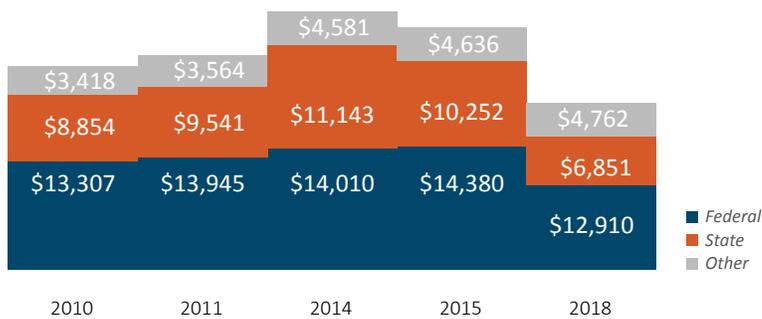


# State Health Agency Expenditures: 2010-2018

State health agencies (SHAs) provide a variety of health programs and services at the individual level through clinical services such as health screenings and administration of the women, infants, and children (WIC) nutrition program, and at the population level through programs such as infectious disease control and prevention, emergency preparedness, laboratory services, and the regulation, inspection, and licensing of health facilities. Funding for these programs comes primarily from federal and state government sources, but also from fees and fines collected by the agency, payment for clinical services, tobacco settlement funds, and private grants. ASTHO’s Profile of State and Territorial Health collected data on funding for fiscal years 2010-2011, 2014-2015, and 2018. These data show that overall funding for SHAs was lower in 2018 than 2010. Funding for some key programs, including all-hazard emergency preparedness and response and infectious disease programs, followed the same pattern. These decreases in funding jeopardize SHAs’ ability to respond to both new public health issues, such as COVID-19, and longstanding public health issues, such as heart disease and tobacco use.

*Total, federal, and state expenditures are all lower in 2018 than 2010.*

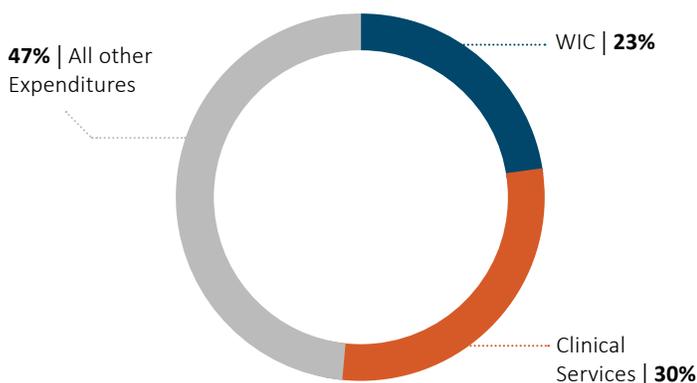


*In millions (\$)*

- **Federal funds:** Includes all federal grants, contracts, cooperative agreements, and federal Medicare and Medicaid reimbursement for direct clinical services.
- **State funds:** Includes all revenues received from the state (general and other funds) as well as state Medicare and Medicaid reimbursements for direct clinical services.
- **Other:** Includes tobacco settlement funds, fees and fines, payment for clinical services (except Medicare and Medicaid), private donations or grants, and funding from local governments.

Total and state expenditures were greater in 2014 than 2010, but lower in 2015 than 2014. Expenditures from other sources were largest in 2018. Federal expenditures were relatively similar in 2010, 2011, 2014, and 2015, but were lower in 2018.

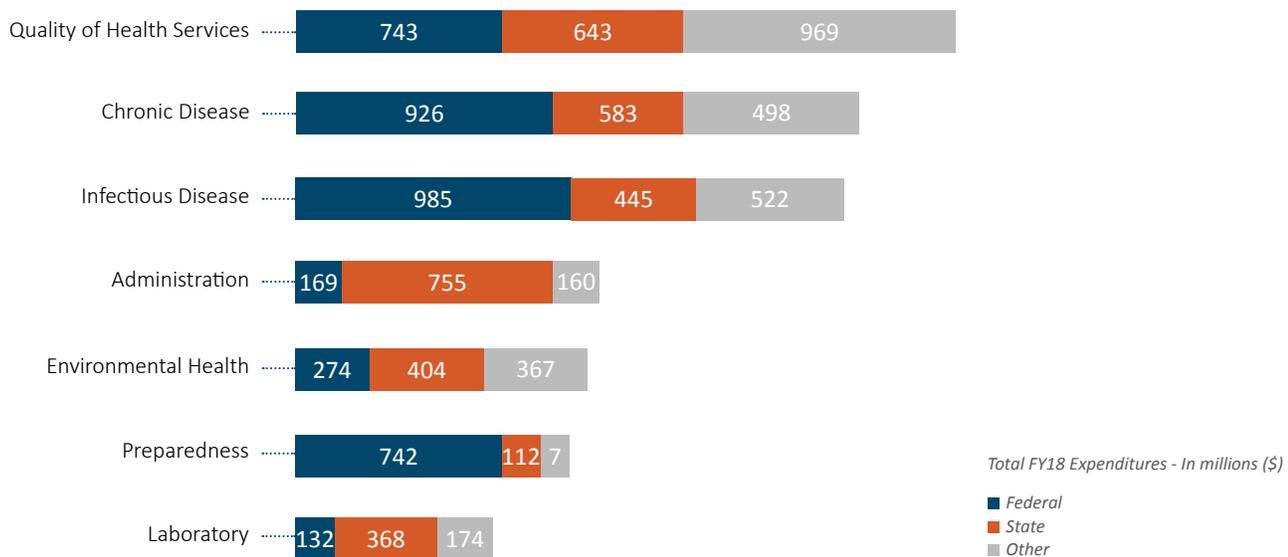
*Clinical services and WIC comprise more than half of all 2018 SHA expenditures.*



- **WIC:** Women, infants, and children nutrition program, including vouchers and education.
- **Clinical Services:** Programs that provide healthcare-related services to individuals, such as maternal and child health programs, oral health, sex education, treatment for infectious diseases, and clinical preventive services for substance misuse.

Federal funding contributes nearly 90% of WIC expenditures, while clinical services are supported by federal (45% of total), state (36%), and other (19%) funding sources.

Sources of funding vary among SHA programs.



**Quality of health services:** Includes regulation, inspection, and licensing of health-care related facilities; institution compliance audits; and equipment quality.

**Chronic disease:** Includes prevention and screening for chronic diseases, substance misuse, and mental health conditions (excludes treatment).

**Infectious disease:** Includes immunizations and vaccine management, as well as chronic disease prevention, screening, and control activities (excludes treatment).

**Administration:** Includes costs for the executive office; communications; legal affairs; human resources; and IT.

**Environmental health:** Includes regulatory programs for food, water, air, and lead; vector control; and veterinary public health.

**Preparedness:** Includes disaster preparedness programs; bioterrorism; and disaster response.

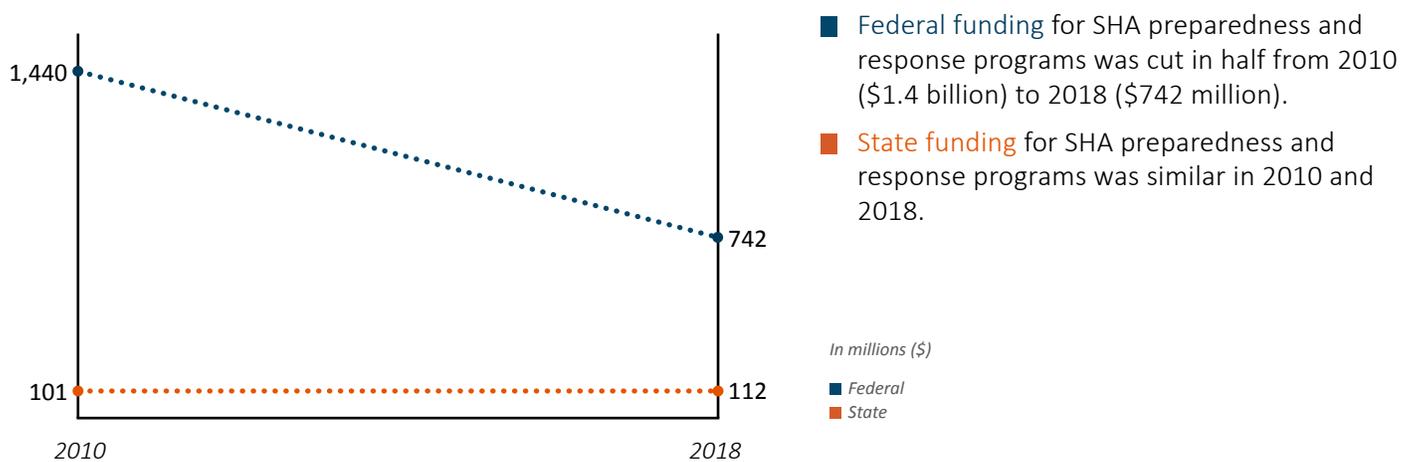
**Laboratory:** Includes chemistry and microbiology labs and all costs associated with state labs, such as administration and supplies.

Quality of health services is the largest of these six programs and administration, with total expenditures of \$2.4 billion. Chronic disease and infectious disease are the next largest, with total expenditures of about \$2 billion each.

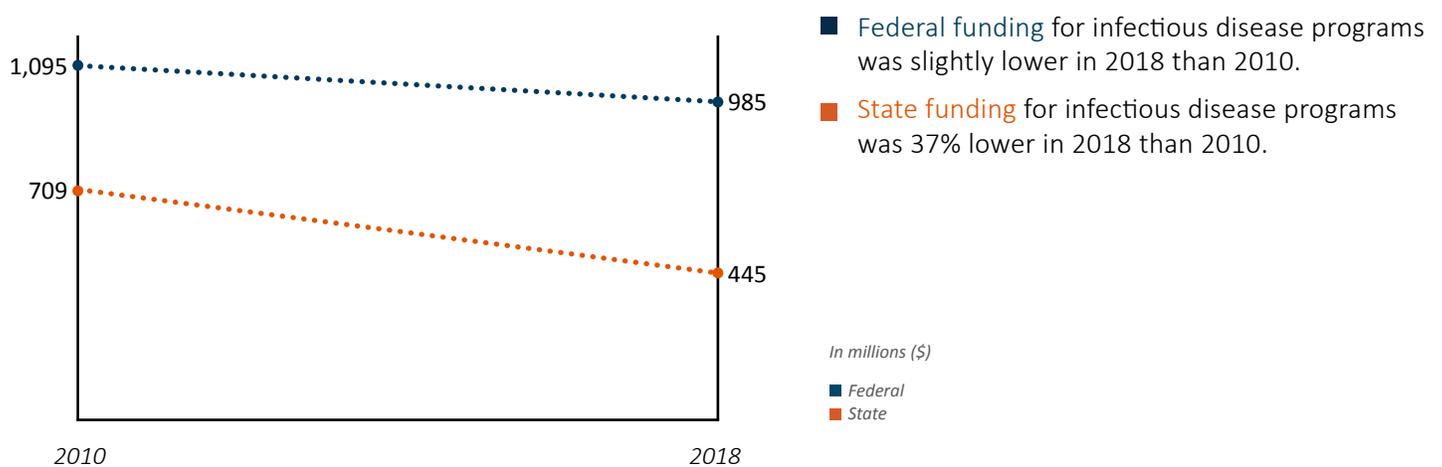
The largest amounts of **federal funding** supported infectious disease (\$985 million), chronic disease (\$926 million), quality of health services (\$743 million), and emergency preparedness (\$742 million) programs. The largest amounts of **state funding** went to administrative services (\$755 million), quality of health services (\$643 million), and chronic disease programs (\$583 million). The largest amounts of funding from **other sources** went to quality of health services (\$969 million), infectious disease (\$522 million), and chronic disease (\$498 million) programs.

The data below compare levels of **federal** and **state** expenditures on programs related to all-hazards preparedness and response, infectious disease, and quality of health services in 2010 and 2018. Each of these program areas is highly relevant to the COVID-19 pandemic response by SHAs. All figures are shown in millions of dollars (\$M).

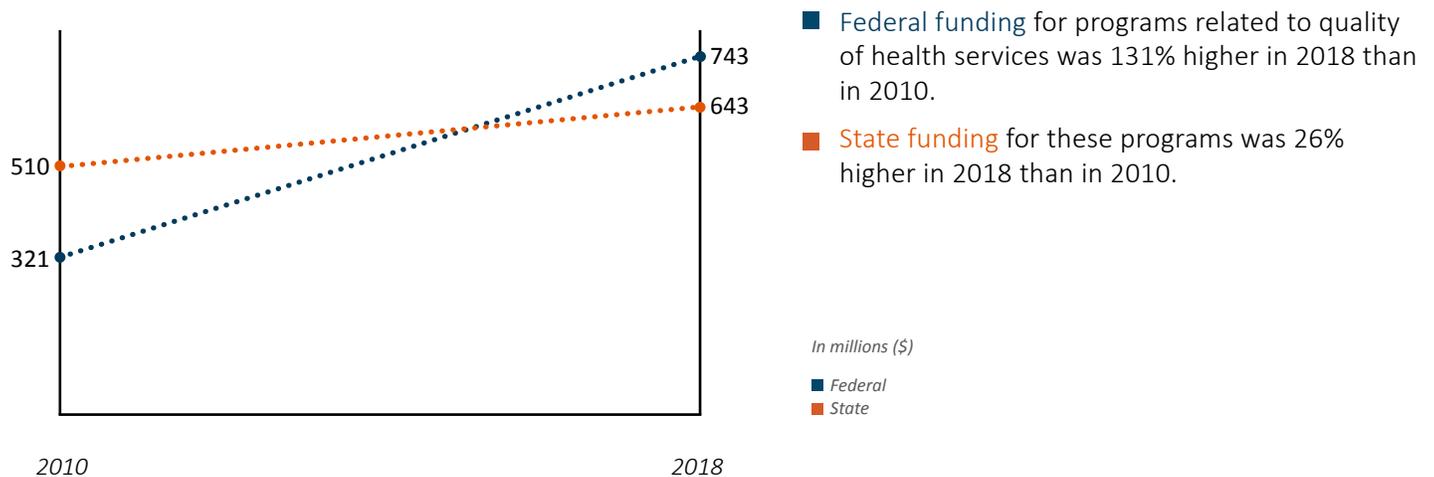
*Federal funding for SHA all-hazards preparedness and response programs declined dramatically between 2010 and 2018.*



*State funding for infectious disease programs decreased by more than one-third between 2010 and 2018.*



Federal funding for programs related to quality of health services more than doubled between 2010 and 2018.



## Study Methodology

The ASTHO Profile of State and Territorial Public Health (Profile) is a survey completed periodically every two to three years since 2007 by all state health agencies, Washington, D.C., U.S. territories, and freely associated states. The Profile presents comprehensive data to document changes over time in public health agency activities, structure, financial resources, and workforce.

## Limitations

The finance data displayed in this brief are expenditures, not revenue, to serve as a proxy for overall funding. These data are reported as-is and although they were reviewed and verified, they have not been validated against external data sources. Because this survey has not been administered annually, data are not available for every year. In addition, the inconsistent survey periodicity may have caused short-term influxes in funding (e.g., emergency supplemental) to be missed. All dollar amounts in this document are as reported and have not been adjusted to account for inflation.

ASTHO's definitions for program areas have evolved over time, so there may be differences in SHA reporting for different fiscal years. In the 2019 Profile survey, certain programs provided by only a few SHAs were omitted from expenditure totals, allowing program areas to increase comparability among SHAs. These programs were not omitted from total SHA expenditures.

SHAs do not all use the same program area categories in their financial systems. Consequently, it is difficult for some SHAs to accurately map their expenditures to the Profile's program areas. Some SHAs that are part of larger umbrella agencies cannot always distinguish expenditures on behalf of the SHA from expenditures on behalf of other agencies under their umbrella.

Information about Profile methodology and the limitations of the data, including details on missing data and estimates of data points, is available in the technical notes documentation [here](#).

Profile data can be found on ASTHO's website at [www.astho.org/profile](http://www.astho.org/profile). For additional information about the ASTHO Profile Survey, contact [profile@astho.org](mailto:profile@astho.org).

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