

Financing Local Public Health Services in Minnesota: Trends in Local Tax Levy Expenditures



Minnesota Public Health Research to Action Network

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State and local leaders in public health and health care have long called for adequate, stable and flexible funding for local public health services in Minnesota.^{1,2,3} A recent report by the Institute of Medicine underscores urgency around public health financing nationwide.⁴ Emerging research increasingly supports the central role of funding in the performance of public health departments as well as population health outcomes.

Amount and source of funding is important for health department performance and outcomes

Several published studies have reported a strong relationship between per capita local public health spending and performance of public health departments.^{5,6,7,8} Recent longitudinal studies have found strong associations between LHD per capita expenditures and health outcomes, including all-cause mortality.^{9,10} Local public health departments receive funding from multiple sources and the relative contributions from those sources can fluctuate from year to year.¹¹ In some studies, local funding (local tax levy) appears particularly important to performance.¹²

Current local health department expenditures and funding sources, Minnesota, 2011¹³

In 2011, well over half of total funding for local health departments (LHDs) in Minnesota (61 percent) came from locally generated funds which include reimbursements and fees for services, local tax levy, and other local sources. The local tax levy is the single largest source of funding for local public health services in Minnesota. In 2011, local tax levy allocated to Minnesota LHDs amounted to 30 percent of total LHD expenditures statewide. State and federal funds (other than reimbursements through Medicare and Medicaid) accounted for 16 percent and 22 percent of total LHD expenditures. State general funds comprising the Local Public Health (LPH) Block Grant have comprised six to seven percent of total LHD expenditures statewide, however these proportions are locally quite variable.

Flexible funding: A crucial consideration

The local tax levy and the Local Public Health Block Grant are the two sources of flexible funding for LHDs in Minnesota. Many critical public health responsibilities (e.g., those related to foodborne illness outbreaks, public health nuisance

At A Glance

The amount and type of funding is important to local health department (LHD) performance and outcomes.

Local tax levy is (1) the largest single source of funding for LHDs in Minnesota, (2) a crucial source of flexible funding for LHDs, and (3) associated with performance.

Many local public health responsibilities hinge on flexible funding (e.g., outbreak response, nuisance investigations, the sharing of infectious disease data with local health care providers, and health promotion activities).

When adjusted for inflation, Minnesota's per capita local tax levy increased nearly 16 percent during the 5-year period 2006-2010. Conversely, per capita local tax levy expenditures decreased 2.4 percent across Minnesota local health departments.

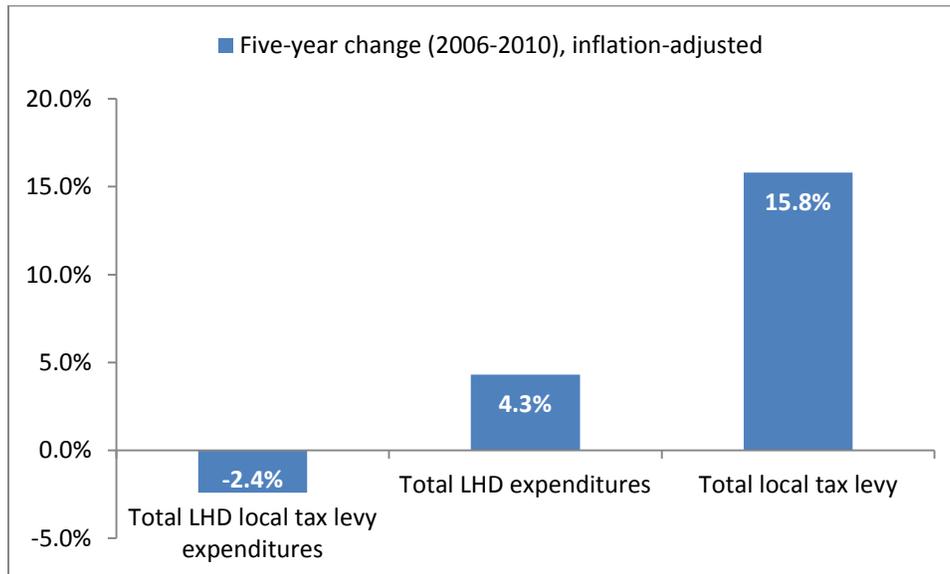
Findings raise important questions regarding local flexibility, state mandates, and capacity to provide crucial public health services.

investigations, the sharing of local infectious disease data with are health care providers and most health promotion and prevention activities) are not consistently supported by categorical grants, and typically are not eligible for reimbursements or fees.¹⁴ The proportion of flexible funding has decreased from 52 percent in 1972 to 37 percent in 2011. In 2002, flexible funding dipped to a low of 26 percent of total expenditures. After climbing to 41 percent of total expenditures in 2005, flexible funding remained stable until a decline to 35 percent of total expenditures in 2009 and 2010. Individual LHDs have a range of “flexible funding” from 4 percent to 74 percent with a median of 31 percent.¹⁵

Local tax levy support for Minnesota’s local health departments: A closer look¹⁶

Public health financing is a pressing issue for Minnesota, where per capita public health funding ranks among the lowest states nationwide (46th).¹⁷ Compared to the nation as a whole, Minnesota LHDs rely more heavily on funding from local and federal sources.¹⁸ Minnesota’s local tax levy represents the largest single source of funding for LHDs, and is a valuable source of flexible funding.¹⁹ This exploratory study led by the University of Minnesota School of Public Health examines a five year trend in local tax levy support of local public health departments in Minnesota. Findings are presented in Figure 1.

Figure 1. Total LHD Local Tax Levy Expenditures, Total LHD Expenditures, and Total Local Tax Levy in Minnesota, 2006-2010 (Per Capita).



	2006	2010	5-year change	Inflation-adjusted 5-year change
Total LHD local tax levy expenditures	\$ 16.55	\$ 17.48	5.6%	-2.4%
Total LHD expenditures*	\$ 50.98	\$ 57.63	13.0%	4.3%
Total local tax levy†	\$ 400.00	\$ 500.00	25.2%	15.8%

Between 2006-2010, Minnesota LHDs increased per capita expenditures of local tax levy funds by 5.6 percent. During this same period, the total per capita local tax levy generated statewide increased 25.2 percent. The disparate trend remains evident when adjusting for inflation (See Figure 1). Minnesota’s total local tax levy increased an inflation-adjusted 15.6 percent between 2006-2010. Conversely, inflation-adjusted LHD local tax levy expenditures *decreased* 2.4 percent.

During this time state general funds that comprise the Local Public Health Block Grant have remained stable, a trend that continued in 2011.²⁰ However, a \$47 million increase in other state funds appropriated as part of 2008 health reform legislation

* Source: Planning and Performance Measurement Reporting System, Minnesota Dept. of Health

† Source: Office of the State Auditor, Minnesota Dept. of Administration

partly offset the reduction in local tax levy expenditures. This increase in state funding for the Minnesota SHIP Initiative was not sustained, as funding was reduced to \$15 million for the 2012-2013 biennium.²¹

Questions for the future

As we continue monitoring trends in the amount and source of LHD expenditures, these exploratory²² findings raise several important questions.

It appears that local tax levy funding for LHDs has not kept pace with inflation, and that a recent per capita increase in the total local tax levy has not translated into a parallel increase in LHD local tax levy expenditures.

Does this mean that local tax levy funding for LHDs is not keeping pace with local tax levy funding for other local services?

Over the past several years, the State of Minnesota has reduced aid to local governments, which are facing enormous pressure to contain costs and manage budget deficits. In recent years, counties have increased local property taxes, while at the same time total county expenditures (adjusted for inflation) have declined.²³

To what extent does the current economic environment contribute to “competition” across government services for local tax levy dollars?

Minnesota’s decentralized public health system operates largely within a framework of voluntary guidelines developed through a longstanding state and local partnership (i.e., the State Community Health Services Advisory Committee).

Does having relatively few state public health mandates make it easier for local officials to direct scarce local resources toward those services mandated by the state—and away from public health services that are defined and prioritized locally?

If so, and if present trends continue,²⁴ how can Minnesota LHDs sustain capacity to provide critical services that are not mandated or supported by categorical grants or fees?

What implications do sizeable annual shifts in the amount and source of LHD funding have for ability to lead and manage a local health department?

About the Research to Action Network

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¹ Minnesota Medical Association Healthcare Reform Taskforce. (2005, March). Physicians plan for a healthy Minnesota: The MMA’s proposal for health care reform. *Minnesota Medicine*, Supplement 13-41.

² Minnesota Local Public Health Association. (2012). *Local public health in Minnesota*. Retrieved from http://www.lpha-mn.org/Advocacy/FactSheets/Local%20Public%20Health%20in%20MN_facts2012.pdf

³ Minnesota Department of Health, Office of Performance Improvement. (2011). *Building a solid foundation for health: A report on public health system development*. Retrieved from <http://archive.leg.state.mn.us/docs/2011/mandated/110181.pdf>

⁴ Institute of Medicine. (2012). *For the public’s health: Investing in a healthier future*. Washington, DC: The National Academies Press.

- ⁵ Bhandari M.W., Scutchfield F.D., Charnigo R., Ridell, M.C., & Mays, G.P. (2010). New data, same story? Revisiting studies on the relationship between of local public health systems characteristics to public health performance. *Journal of Public Health Management and Practice*, 16(2), 110-117.
- ⁶ Mays G.P., McHugh M.C., Shim K., Perry, N., Lenaway, D., Halverson, P.K., et al. (2006). Institutional and economic determinants of public health system performance. *American Journal of Public Health*, 96(3), 523-531.
- ⁷ Honoré P.A., Simoes E.J., Jones W.J., & Moonesinghe, R. (2004). Practices in public health finance: an investigation of jurisdiction funding patterns and performance. *Journal of Public Health Management and Practice*, 10(5), 444-450.
- ⁸ Minnesota Public Health Research to Action Network. (2011). *Factors Associated with Local Public Health Department Performance: Literature Review*. Retrieved from <http://www.health.state.mn.us/pbrn>
- ⁹ Erwin P.C., Greene S.B, Mays G.P., Ricketts, T.C., & Davis M.V. (2011). The association of changes in local health department resources with changes in state-level health outcomes. *American Journal of Public Health*, 101(4), 609-615.
- ¹⁰ Mays G.P., & Smith S.A. (2011). Evidence links increases in public health spending to declines in preventable deaths. *Health Affairs*, 30(8), 1-9.
- ¹¹ Riley W., Briggs J., & McCullough M. (2011). Estimating the financial resources needed for local public health departments in Minnesota: a multi-method approach. *Journal of Public Health Management and Practice*, 17(5), 413-420.
- ¹² Hyde J.K., & Shortell S.M. (2012). The structure and organization of local and state public health agencies in the U.S.: A systematic review. *American Journal of Preventive Medicine*, 42(5S1): S29-S41.
- ¹³ Local health departments report expenditure data annually to the Minnesota Department of Health through the Local Public Health Planning and Performance Measurement System (PPMRS): <http://www.health.state.mn.us/ppmrs/library/>
- ¹⁴ Minnesota Department of Health, Office of Performance Improvement. (2011). *Building a solid foundation for health: A report on public health system development*. Retrieved from <http://archive.leg.state.mn.us/docs/2011/mandated/110181.pdf>
- ¹⁵ Local health departments report expenditure data annually to the Minnesota Department of Health through the Local Public Health Planning and Performance Measurement System (PPMRS).
- ¹⁶ For a more complete description of study methods and findings go to: Riley W., Gearin, K.J., Parrotta C.D., et al. (In press). Tax levy financing for local public health: Fiscal allocation, fiscal effort and fiscal capacity. *American Journal of Preventive Medicine*, in press.
- ¹⁷ Trust for America's Health. (2012). *Investing in America's health*. Retrieved September 24, 2012 from <http://healthyamericans.org/report/94/>
- ¹⁸ National Association of County and City Health Officials. *Minnesota local health departments: Findings from the 2008 National Profile of Local Health Departments Study* [Data Set]. Retrieved from <http://profile-iq.naccho.org/>
- ¹⁹ Minnesota Department of Health, Office of Performance Improvement. (2011). *2010 Community Health Services system expenditure report*. Retrieved from http://www.health.state.mn.us/ppmrs/library/docs/2010_financial.pdf
- ²⁰ Minnesota Department of Health, Office of Performance Improvement. (2011). *2010 Community Health Services system expenditure report*. Retrieved from http://www.health.state.mn.us/ppmrs/library/docs/2010_financial.pdf
- ²¹ Two-year SHIP grants were awarded on July 1, 2009, to community health boards and tribal governments across the state to decrease obesity by increasing physical activity and improving nutrition and reduce tobacco use and exposure. All 53 community health boards and nine of 11 tribal governments in Minnesota received Statewide Health Improvement Program (SHIP) funds. Grants were awarded through a competitive process for statewide investments of \$20 million in 2010 and \$27 million in 2011. The first two years of SHIP ended in June 2011. Now funded for \$15 million over two years, a smaller version of SHIP supports 18 grantees, covering 51 counties and one tribe. For more information: Minnesota Department of Health, Office of Statewide Health Improvement Initiatives. (2012). *The Statewide Health Improvement Program*. Retrieved from <http://www.health.state.mn.us/divs/oshii/ship/docs/shipfactsheet.pdf>, & Minnesota Department of Health, Statewide Health Improvement Program. (2012). *The Minnesota Statewide Health Improvement Program: SHIP progress brief – Year 2*. Retrieved from http://www.health.state.mn.us/divs/oshii/docs/SHIP_yr2_brief.pdf
- ²² For purposes of comparing data from various sources, we assume that all local health department (LHD) expenditures reported in a given year reflect the full amount of local tax levy allocated to the LHD that year, and that any tax revenue levied in a given year is spent in that same year.
- ²³ Minnesota Office of the State Auditor. (2012). *Minnesota county finances report*. Retrieved September 24 2012 from <http://www.auditor.state.mn.us/default.aspx?page=20120420.000>
- ²⁴ Minnesota Department of Revenue. (2011). *2011 Minnesota tax incidence study*. Retrieved from http://www.revenue.state.mn.us/research_stats/research_reports/2011/2011_tax_incidence_study_links.pdf). In 2011, (the year following this study period), MN LHDs reported local tax levy expenditures equivalent to \$17.81 per capita. When inflation adjusted to 2010, this represents a 1 percent decrease from 2010 LHD tax levy expenditures. For a longer term perspective, the Office of the State Auditor presents total county expenditures by category (including public health) for the years 2011-2005 and 2006-2010 (*Minnesota county finances report*. Retrieved September 24 2012 from <http://www.auditor.state.mn.us/default.aspx?page=20120420.000>). Figures reported by the Office of the State Auditor have been adjusted for inflation. Figures reported in this brief have been adjusted for inflation and presented on a per capita basis to account for changes in population.