State funding inequities have placed residents served by local health departments (LHDs) across Southern California at an unfair disadvantage that contributes to persistent gaps in health outcomes and underinvestment in our communities. The principles below provide a framework to achieve more equitable allocations of California Department of Public Health (CDPH) resources across California.

1. Funding allocations should be determined by an algorithm that includes a simplified and streamlined definition of need.

Allocating resources based on need is the most transparent way to assess eligibility and streamline identification of the population to be served by the program. Having a complex allocation formula to determine distribution of funds to counties minimizes the essential assessment of need. We recommend that “need” be defined as the percentage of eligible individuals for the program accounting for disproportionate health outcomes experienced by racial and ethnic sub populations. Any additional factors considered in the methodology should be directly tied to the eligibility of the program in a streamlined, transparent formula. Examples include the Supplemental Nutrition Assistance Program Education Program (SNAP-ED) and combined Mental Health Services Act funding, which consider the percentage of eligible individuals, as well as the likelihood they will apply for these programs, when determining allocations. For Maternal, Child and Adolescent Health (MCAH) funding, we recommend a simple calculation of the percentage of projected Medi-Cal births per jurisdiction weighted by inequities in rates of low birth weight (LBW) or preterm births by race/ethnicity. By our calculations, this algorithm would significantly reduce the disproportionality in funding to Southern California and create more equitable allocation with other jurisdictions of similar size, due to the large number of Medi-Cal births occurring in such regions.

2. Funding allocations should not exacerbate existing distribution inequities, and disproportionate allocations should be redistributed based on need.

In order to correct historical inequities that exist in many State health funding programs, the State should ensure that allocations do not put any jurisdiction at an unfair disadvantage because of historical funding formulas or caps put into place to control spending. This has been an issue with Title XIX, where funding has been capped at pre-2017 levels and instituted an inequitable distribution in how this funding is allocated to many California jurisdictions. We recommend that existing disproportionate allocations should be reassessed to ensure that base funding is adjusted for those parts of the State that have historically received less funding than what they would receive if an equitable distribution algorithm was used.

3. A baseline allocation for all jurisdictions, or groups of jurisdictions, should be established to ensure the proportional needs are met statewide in an equitable fashion.

We recognize that some of the current funding disparities are the result of baseline funding for each jurisdiction previously constructed to ensure that smaller LHDs received important funding for services and operations. We support establishing a baseline amount that takes into consideration both the unique infrastructure needs of smaller LHDs, and county demographics including population size, poverty statistics, and inequities in health outcomes by race and ethnicity.

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1 Mental Health Services Act (MHSA) funding includes: MHSA Allocation, Behavioral Health Sub Account, Mental Health Sub Account Growth, Substance Abuse Mental Health Services Administration Projects for Assistance in Transition from Homelessness (SAMHSA-PATH), SAMHSA Mental Health Block Grant (SAMHSA-MHBG), 1991 Realignment (sales tax), 1991 Realignment (Vehicle License Fee), and 1991 Realignment (Vehicle License Fee Growth).
There should be transparency in funding allocations and methodologies.

All State funded allocations and health programs should be fully transparent with the State publicly sharing the following information in an easily accessible manner on their website:

a. Total funding available for each funding stream and program.

b. State funding allocation methodologies for all funding sources and programs.

c. Funding allocations for all health departments, including comparison against the allocation as a percentage of calculated program need based on eligibility.

d. The amount of funding that the State retains as an absolute amount and as a percentage of the total funding source, the funding methodology to determine these amounts, and a detailed description of how this funding is used.

e. Periodic reviews of allocations and methodologies to ensure needs are being met throughout the State.

The availability of other resources from non-State sources should not be assumed when allocating funding.

There have been cases where local health departments, often in large urban areas, do not receive a fair share of funding because the State assumes they have other sources available at the local, county or other level to fund these programs. Unless funding allocations are based solely on population size, eligibility for program services and health outcomes, there should be no consideration of the additional resources if these are used to address ‘unmet need’ related to the program goals.

The State should provide resources to regional LHD collaboratives for technical assistance on best and promising practices and peer-to-peer learning.

Given that many programs, including Title XIX, consider the ability to spend in making allocations, the State should provide funding for regional LHD collaboratives to provide technical assistance to local health departments on how to efficiently manage these programs through tracking and billing for all allowable activities in order to maximize spending. This would include customized local assessments to optimize qualifying activities for drawing down the match, when applicable. The funding for this technical assistance should come from the State, but the actual providers should be the regional LHD collaboratives who have the local programmatic expertise.

Once these right-sizing of allocations are made, and technical assistance is made available for proper management, local health departments should be accountable for spending down the funds.

We recognize that a pure need-based allocation does not take into account ability to spend, and that local health departments have an obligation to spend down money they receive. If changes are made to allocations to correct historical inequities and shift resources to where they are most needed, and local health departments receive the technical assistance they need to maximize spending, then local health departments should meet their responsibilities to spend down funding they receive from the State, within a reasonable, pre-determined percentage, or risk loss of funding that would then be redistributed to other jurisdictions, for the following year. This is not intended to re-institutionalize a funding inequity, but rather to serve as a temporary (one year) opportunity to receive additional technical assistance for fiscal management and to ensure full spend-downs the following year with a needs-based allocation.

For more information, please contact:

Tracy Delaney, PhD, Founding Executive Director
Public Health Alliance of Southern California
tdelaney@phi.org  |  (619) 722-340  |  http://PHASoCal.org