

# The Impact of Chronic Underfunding on America's Public Health System:

## TRENDS, RISKS, AND RECOMMENDATIONS 2024



## Acknowledgements

**Trust for America's Health (TFAH)** is a nonprofit, nonpartisan public health policy, research, and advocacy organization that promotes optimal health for every person and community, and works to make the prevention of illness and injury a national priority.

Any opinions, findings, conclusions, or recommendations expressed in this report are those of the authors and do not necessarily reflect the views of TFAH's funders.

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---

### REPORT AUTHORS

**Matt McKillop, MPP**

*Senior Health Policy Researcher and Analyst*

**Dara Alpert Lieberman, MPP**

*Director of Government Relations*

### REPORT CONTRIBUTORS

**Kevin McIntyre**

*Government Relations*

*Manager*

**Brandon Reavis, J.D.**

*Senior Government Relations*

*Manager*

**Cecelia Thomas, J.D.\***

*Senior Government Relations*

*Manager*

**Madison West**

*Government Relations*

*Manager*

\*Ms. Thomas was a member of the TFAH staff through July 2024.

### EXTERNAL REVIEWER

This report has benefited from the insights and expertise of the following external reviewer. Their review does not necessarily constitute an endorsement of the report's findings or recommendations by the reviewer or their organization. TFAH thanks the reviewer for their time and assistance.

**Erin Will Morton**

*Executive Director*

*Coalition for Health Funding*

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## Executive Summary

The U.S. public health system is a critical driver of progress in improving the nation's health, from reducing infant mortality and controlling infectious diseases to increasing life expectancy and promoting healthier lifestyles. However, for decades, chronic underfunding has limited the system's capacity to fully address the complex health challenges facing the nation today. Despite recent progress in improving data and disease detection systems and bolstering the public health workforce through temporary funding measures—such as those implemented during the COVID-19 pandemic—increased, sustained, and flexible investment is urgently needed to modernize public health infrastructure, strengthen emergency preparedness, promote health equity, and prevent the growing burden of chronic diseases and mental health conditions. By investing in public health, policymakers can build on past successes, ensure the system's continued effectiveness, and create a healthier, more resilient future for all U.S. residents.

Core federal public health funding, primarily allocated through the Centers for Disease Control and Prevention (CDC), has remained relatively flat over the past decade when adjusted for inflation. In addition, the siloed, disease-specific nature of public health funding streams has enabled little investment in cross-cutting capabilities. This has significantly limited CDC's ability to support critical programs and initiatives at the state, local, tribal, and territorial levels. Key areas impacted by insufficient funding include chronic disease prevention, infectious disease control, environmental health, and public health emergency preparedness. Many evidence-based programs have yet to reach all 50 states and U.S. territories due to resource constraints, hindering efforts to address the leading causes of death and drivers of healthcare costs.

The Prevention and Public Health Fund, established by the Affordable Care Act to provide a dedicated funding stream for prevention and public health activities, has been repeatedly cut and diverted to other purposes. This fund has supported crucial investments in every state, such as expanding vaccine access, building laboratory capacity, and preventing chronic diseases. Restoring and protecting this fund is essential

for supporting evidence-based interventions that promote health, reduce health disparities, and control healthcare costs.

State and local health departments face significant challenges in maintaining and strengthening public health infrastructure due to chronic underfunding. Workforce shortages, outdated technology and data systems, and limited surge capacity during crises are among the major issues confronting these agencies. The COVID-19 pandemic exacerbated these challenges, leading to high levels of burnout, turnover, and even threats and harassment against public health officials.

Recent initiatives, such as CDC's Public Health Data Modernization and Public Health Infrastructure Grant program, represent important steps forward in addressing these infrastructure gaps. These efforts aim to upgrade public health data and technology systems, enhance data analytics and visualization capabilities, and strengthen the foundational capabilities of health departments. However, these initiatives require sustained funding and long-term commitment to fully realize their potential in improving public health decision-making, outcomes, and equity.

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For too long, people have taken public health for granted. At its core, public health ensures our air and water are clean; our roads are safe; our schools, businesses, and restaurants are hygienic; and harmful substances and infectious diseases are kept out of communities. Public health enables us to be physically active, eat nutritious food, and prevent substance misuse. Everyone wants their community to be strong, healthy, and safe—this is what public health does for us each and every day. For all of these reasons, increased and sustained funding for the nation’s public health system is critical.

**Anand Parekh, M.D.**

*Chief Medical Advisor*

Bipartisan Policy Center

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## COMPREHENSIVE AND FLEXIBLE INVESTMENT: ESSENTIAL FOR EFFECTIVE PUBLIC HEALTH PREVENTION AND RESPONSE

Chronic diseases, which are largely preventable, are a major driver of the nation’s \$4.5 trillion annual healthcare expenditure.<sup>1</sup> They not only escalate healthcare costs but also impact economic growth, with conditions like heart disease and stroke costing more than \$100 billion in lost job productivity annually, according to the American Heart Association.<sup>2</sup>

Investment in a broad range of prevention activities is critical for maintaining public health, including community preparedness and resilience. This includes programs across CDC, other federal agencies, and at the state, local, tribal, and territorial levels.

With six in 10 U.S. adults living with a chronic disease<sup>3</sup> and the increasing frequency and severity of public health emergencies, such as extreme weather events and infectious disease outbreaks, the connection between a population’s underlying health and a community’s resilience during and after

a public health emergency becomes evident. People with chronic diseases or behavioral health conditions are at heightened risk of severe illness, complications, or mortality during infectious disease outbreaks<sup>4</sup> or natural disasters.<sup>5</sup> This emphasizes the importance of preventing chronic diseases and improving the overall health of communities to mitigate severe health impacts during emergencies.

An effective public health response requires experts from various disciplines, including maternal health, children’s health, older adult health, behavioral health, environmental health, and health equity. Investing in programs that address health disparities and prevent chronic disease, alongside flexible funding streams that enable health departments to meet the specific needs of the communities they serve, forms a critical foundation for the nation’s emergency preparedness and overall well-being.

To improve the health and well-being of all U.S. residents, reduce healthcare costs and health disparities, and protect the nation’s health security, this report recommends several key policy actions:

- 1. Strengthen the nation’s public health infrastructure:** Increase and sustain funding to modernize public health data systems, support local and state public health laboratories and epidemiology, and grow and diversify the public health workforce.
- 2. Enhance health security:** Boost funding for programs that fortify defenses against a wide range of threats, from infectious diseases to weather-related events. Support vaccine infrastructure and ensure healthcare system readiness.
- 3. Address health inequities and the social determinants of health:** Invest in programs and policies that target the root causes of health disparities, including the social and structural drivers of health.
- 4. Promote health and prevent chronic disease across the lifespan:** Allocate resources for evidence-based interventions that promote healthy behaviors and prevent chronic diseases at every stage of life.
- 5. Prioritize primary prevention of behavioral health concerns and deaths of despair:** Invest in comprehensive suicide and substance use disorder prevention programs, emphasizing early interventions and timely identification of individuals at risk.
- 6. Prepare for and mitigate the health impacts of climate change and environmental threats:** Increase funding to address the health consequences of climate change, extreme weather events, and other environmental health hazards.

**TABLE 1: Summary of Public Health Funding Recommendations**

This chart summarizes current funding (FY 2024) and TFAH-recommended funding levels for FY 2025 for CDC and the Administration for Strategic Preparedness and Response (ASPR) programs associated with the report’s recommendations.

Program/Division	FY 2024	FY 2025 (TFAH recommendation)
<b>CDC</b>		
Public Health Infrastructure and Capacity	\$350 million	\$1 billion
Public Health Data Modernization	\$175 million	\$340 million
Public Health Emergency Preparedness Cooperative Agreement	\$735 million	\$1 billion
Immunization Program	\$682 million	\$1.1 billion
Climate and Health Program	\$10 million	\$110 million
National Environmental Public Health Tracking Network	\$34 million	\$65 million
Social Determinants of Health	\$6 million	\$100 million
Division of Nutrition, Physical Activity, and Obesity	\$58 million	\$130 million
Racial and Ethnic Approaches to Community Health and Healthy Tribes	\$69 million	\$103 million
Division of Adolescent and School Health	\$57 million	\$100 million
Suicide Prevention	\$30 million	\$80 million
Adverse Childhood Experiences	\$9 million	\$33 million
Age-Friendly Public Health Systems	N/A	\$50 million
<b>Total CDC Program Level</b>	<b>\$9.2 billion</b>	<b>\$11.5 billion</b>
Agency for Toxic Substances and Disease Registry	\$82 million	\$100 million
<b>ASPR</b>		
Health Care Readiness & Recovery	\$305 million	\$500 million

Implementing these recommendations will require a paradigm shift in public health financing, moving away from reactive, crisis-driven funding and toward sustained, predictable investments in core infrastructure, programs, and capabilities. This shift is essential for building a public health system that is agile, resilient, and capable of addressing both ongoing and emerging health threats.

Moreover, rebuilding public trust and support for public health institutions and expertise will be critical for the success of these efforts. The politicization of public health measures during the COVID-19 pandemic, coupled with the spread of misinformation and disinformation, has led to increased skepticism and hostility toward public health officials and agencies. Addressing this erosion of trust will require investment in public health communications capacities, transparent and inclusive decision-making processes, effective communication with diverse audiences, and a commitment to advancing health equity.

By prioritizing stable, adequate funding for public health and engaging in meaningful partnerships with communities, policymakers can help build a public health system that is better equipped to promote health, prevent disease, and protect the well-being of all people in the United States. Investing in public health is not only a moral imperative but also a sound economic strategy, as it can reduce healthcare costs, increase productivity, and strengthen the nation's resilience to future health crises.

As the nation continues to grapple with the far-reaching consequences of the COVID-19 pandemic and faces a growing array of complex health challenges, the time for bold action and transformative change in public health is now. By heeding the recommendations outlined in this report and committing to a vision of a robust, equitable, and adequately resourced public health system, the United States can chart a path toward a healthier, more prosperous future for all its residents.

## PROGRESS IN STRENGTHENING PUBLIC HEALTH INFRASTRUCTURE: SOME ADVANCES MADE, MORE INVESTMENT NEEDED

A modern and robust infrastructure, including data and disease surveillance systems and a highly skilled workforce, is the underpinning of an effective public health system. Progress toward that goal has been made, but decades of underfunding have left too many health departments dependent on antiquated systems and insufficient staffing levels. Additional, sustained, and flexible investment is urgently needed.

Government investment in public health infrastructure typically follows a boom-and-bust cycle, funneling money into the public health system in response to emergencies but failing to do so on a consistent basis. Additionally, this emergency funding is often congressionally mandated to focus on specific response actions, rather than investing in the foundations of effective public health systems.

Recent federal actions that invest in programs to protect public health include the 2021 Infrastructure Investment and Jobs Act (also known as the Bipartisan Infrastructure Law, or “BIL”) and the 2022 Inflation Reduction Act (IRA). The Bipartisan Infrastructure Law provides hundreds of billions of dollars in new and critical funding sources to strengthen transportation infrastructure, including public transit, and to support programs aimed at reducing greenhouse gas emissions. It also supports programs to improve access to clean drinking water, replace lead service pipes, expand high-speed internet access, invest in clean energy and environmental remediation, and create communities that are more climate resilient.<sup>6</sup>

The Inflation Reduction Act includes a number of actions to make healthcare more accessible

and more affordable, including giving Medicare the authority to negotiate the price of some prescription drugs and creating an annual \$2,000 cap on out-of-pocket prescription costs for Part D enrollees starting in 2025. The act also extended subsidies to lower Affordable Care Act premiums, which were expanded under the American Rescue Plan Act and were due to expire at the end of 2022, through the end of 2025.<sup>7</sup>

### Sustained Progress Requires Increased Investment

CDC is the primary driver of public health infrastructure funding to states, local, tribal, and territorial health departments. By allocating funds across these different levels of government, CDC aims to ensure that public health systems are well-equipped to manage both routine needs and emergent health crises. These investments help to build and maintain a skilled public health workforce, enhance data collection and analysis capabilities, and strengthen the overall resilience of public health systems against future public health threats. Through these strategic allocations, CDC not only bolsters public health capacities locally but also enhances the nation’s ability to respond to public health challenges effectively and efficiently.

Through its various grant programs and cooperative agreements, CDC provides critical financial support to strengthen the foundation of the nation’s public health system. One such initiative is the Public Health Infrastructure Grant program, launched in 2022, which aims to enhance key capabilities across three crucial areas: workforce development,



foundational capabilities, and data modernization.<sup>8,9</sup> This program equips health departments of all sizes with the resources needed to attract, train, and retain skilled professionals; improve essential public health services; and upgrade data systems for better decision-making and response. By investing in these core components of public health infrastructure, CDC helps to build a more robust, resilient, and responsive network of public health agencies nationwide, ultimately improving the health and well-being of communities across the United States.

Through its Public Health Infrastructure Center and the Public Health Infrastructure Grant program, CDC awards 70 percent of the Public Health Infrastructure and Capacity appropriation to health departments to help them build their foundational capabilities, including information technology, communications, performance management, and accreditation. In fiscal year (FY) 2024, all 50 states, the District of Columbia, 47 large cities or counties, and eight territories or freely associated states received a combined total of \$245 million to support their unique infrastructure needs. Sixty-four recipients also received \$80 million in data modernization funding in FY 2024. As of January 2024, CDC had awarded a total of \$4.35 billion in grants, with \$4.01 billion going to health departments and \$340 million to national public health organizations for training, technical assistance, evaluation, and communications support. CDC expects to award approximately \$5 billion in public health infrastructure grants over the five-year program window, through November 2027.<sup>10</sup>

Public health infrastructure funding now appears to be entering the austere phase of a boom-and-bust

cycle. COVID-19 response funds were a significant but short-term source of public health investment over the past four years, including funding through the Coronavirus Aid, Relief, and Economic Security (CARES) Act of 2020 and the American Rescue Plan Act (ARPA) of 2021, which provided the largest single investment in public health infrastructure in recent years. However, such funding was temporary and has now been largely obligated, or, in some cases, rescinded by Congress.<sup>11</sup> The result is a serious financial cliff for CDC and many health departments, where federal assistance for specific programs or personnel is no longer available and program cuts have been made or are on the horizon.

While the Fiscal Responsibility Act (FRA), adopted in June 2023, was critically important because it prevented the United States from defaulting on its debt, it had two significant impacts on federal public health agencies. First, it rescinded pandemic response appropriations and funding from the American Rescue Plan Act that had been allocated to CDC, the Administration for Strategic Preparedness and Response, the Health Resources and Services Administration, the Defense Production Act Medical Supplies Enhancement, the National Institutes of Health, and the Food and Drug Administration. In total, the FRA rescinded approximately \$13.2 billion in emergency response funding, according to estimates from the Congressional Budget Office. Second, the FRA introduced new discretionary spending limits for two years, which affect the amount of appropriations made available for public health through regular appropriations. These funding cuts underscore the ongoing challenges faced by public health agencies in maintaining essential services and preparedness in the face of variable funding streams and competing priorities.<sup>12</sup>

## 1

# Public Health Funding Trends

Public health in the United States is a collaborative effort involving federal, state, local, tribal, and territorial agencies working together with the healthcare sector, community-based organizations, businesses, and other sectors to promote and protect the health of communities nationwide.

Funding for public health programs and services flows from various sources, with the federal government providing significant support through agencies such as the Centers for Disease Control and Prevention (CDC).

CDC awards more than 80 percent of its funds to states, tribes, territories, and local health departments, among other external partners, to support a wide array of programs. Other federal agencies, such as the Health Resources and Services Administration (HRSA), the Substance Abuse and Mental Health Services Administration (SAMHSA), and departments outside of the U.S. Department of Health and Human Services (HHS), such as the U.S. Department of Agriculture (USDA), are also a part of the public health funding landscape.

However, federal funding tells only part of the story. State and local funding for public health plays an important role in enabling health departments to meet the unique needs of the communities they serve. When state and local funding is robust and consistent, health departments can maintain vital services, retain skilled staff, and nimbly respond to emerging health threats. Conversely, when state and local budgets are strained, it can lead to program reductions, staffing shortages, and diminished capacity—leaving communities more vulnerable.

Throughout the COVID-19 pandemic, the critical importance of sustained, stable funding for public health preparedness and infrastructure was starkly illuminated. Chronic underfunding at all levels has contributed to long-standing challenges like workforce shortages, outdated data systems, and limited surge capacity during emergencies. Moving forward, strengthening the public health system will require strategic investments and long-term commitments from

federal, state, and local partners.

The following sections take a closer look at public health funding trends at the federal and state levels, including allocations to CDC and its key initiatives, the role of the Prevention and Public Health Fund, and the funding landscape for state and local health departments. By examining these funding streams and the programs they support, policymakers can better understand the current state of public health financing and identify opportunities to build a more resilient, equitable public health system for the future.

## Federal public health funding

The federal government allocates investments in public health programs across numerous agencies and initiatives. These programs, which represent core elements of the nation's public health system, aim to enhance health, prevent diseases and injuries, and prepare for potential disasters and major health emergencies. The majority of these funds are awarded to states, tribal nations, territories, and local health departments through CDC, which supports a wide range of activities, including immunization programs, infectious disease control, chronic disease prevention, environmental health, and public health emergency preparedness.

In addition to CDC, other agencies within HHS play critical roles in funding public health programs. For example, HRSA supports community health centers, maternal and child health programs, and health workforce development, while SAMHSA funds mental health and substance use prevention and treatment services. The Indian Health Service

provides healthcare services and public health programs for American Indian and Alaska Native populations.

Beyond HHS, several other federal departments contribute to public health funding. The USDA administers nutrition assistance programs, such as the Supplemental Nutrition Assistance Program (SNAP) and the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC), which play a vital role in promoting food security and healthy eating. The U.S. Department of Housing and Urban Development (HUD) supports programs

that address the social determinants of health, such as housing stability and lead abatement. The U.S. Department of Transportation funds initiatives to improve road safety and promote active transportation, while the U.S. Environmental Protection Agency (EPA) works to ensure clean air, water, and land, which are essential for public health.

These diverse federal funding streams reflect the complex and multifaceted nature of public health, which requires collaboration across sectors and levels of government. By investing in a broad range of programs and initiatives, the

federal government aims to create the conditions for optimal health and well-being for all U.S. residents, particularly those in underserved and marginalized communities. However, ensuring adequate and sustained funding for these critical public health programs remains an ongoing challenge, particularly in light of competing budget priorities and the boom-and-bust cycle of crisis-driven investments. Stable, predictable funding is essential for building and maintaining a robust public health infrastructure that can effectively prevent disease, promote health equity, and protect the nation's health over the long term.

## SAFEGUARDING PUBLIC HEALTH: THE CRITICAL ROLE OF THE PREVENTION FUND

As a nation, the United States spent \$4.5 trillion on health in 2022, but only 4.7 percent of that spending funded public health and prevention initiatives to promote health and prevent illness.<sup>13</sup> In this era of rising rates of chronic disease and increasing healthcare costs, investments in prevention are critical. The Prevention and Public Health Fund (Prevention Fund) is one of the nation's most significant sustained investments in disease prevention.

Since its inception in 2010 as a part of the Affordable Care Act, states and territories have received over \$12.3 billion from the Prevention Fund to address public health priorities, including immunizations, epidemiology, and laboratory capacity.<sup>14</sup> The Prevention Fund also supports the Preventive Health and Health Services Block Grant, which allows states to address their most relevant health concerns and backfill underfunded priorities.

The Prevention Fund represented 13 percent of CDC's budget in FY 2024.<sup>15</sup> While the majority of its investments fund CDC initiatives, the Prevention Fund also supports programs at the Administration for Community Living and SAMHSA. The Administration for Community Living receives Prevention Fund support for programs related to Alzheimer's disease prevention, falls prevention, and chronic disease self-management. SAMHSA uses Prevention Fund resources to support suicide prevention initiatives.

CDC's Tips from Former Smokers campaign is supported by the Prevention Fund. In 2024, the campaign released a new set of advertisements featuring individuals sharing their stories about

how cigarette smoking and smoking-related diseases have negatively impacted their lives. It is estimated that between 2012 and 2018, this campaign helped prevent about 129,000 early deaths and saved roughly \$7.3 billion in smoking-related healthcare costs.<sup>16</sup>

The Prevention Fund also works to prevent chronic disease. All 50 states receive funding for heart disease and chronic disease prevention. Another notable success is the Diabetes Prevention Program, which saves an estimated \$1,146 per participant in diabetes-related healthcare costs.<sup>17</sup>

Unfortunately, the Prevention Fund's history has been limited by its use as a funding offset. As first established by the Affordable Care Act, the Prevention Fund should have risen to \$2 billion by FY 2015. After multiple cuts, the Prevention Fund will not reach that number until FY 2030, a full 15 years later than intended. In total, the Prevention Fund has been cut by \$12.95 billion between FY 2013–2029 (see pages 16-17).

Threats to the Prevention Fund are still active. Legislation recently passed by the House of Representatives would cut an additional \$1.19 billion from the Prevention Fund over FY 2024–2029. Over 100 organizations joined a recent sign-on letter to U.S. House of Representatives leadership opposing these cuts.<sup>18</sup>

*This content is based on work originally published as a Coalition for Health Funding blog post in April 2024, authored by Kevin McIntyre, TFAH Government Relations Manager.*

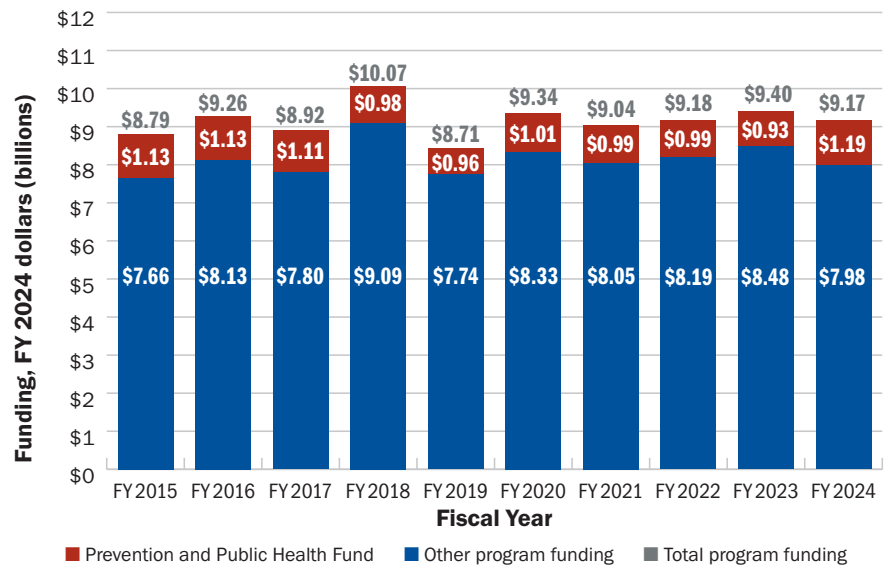
## CDC funding

CDC stands as the nation’s foremost public health agency. Its mission encompasses safeguarding U.S. residents from disease outbreaks, disasters, and contaminated food and water, as well as preventing and mitigating the leading causes of injury and death. To facilitate the achievement of its objectives, CDC collaborates with states, localities, tribes, and territories, as well as researchers, nonprofits, and other entities, in addressing threats and enhancing health within communities. In fact, CDC channels a significant portion of its program funding to these jurisdictions, recognizing the critical role they play in implementing public health programs and services.

However, the agency’s budget has not kept pace with the nation’s growing public health needs and emerging threats, including the rise in chronic diseases, weather-related emergencies, substance use disorders, and suicide. Years of eroding resources for public health emergency preparedness contributed to the country’s flat-footed response to the COVID-19 pandemic.<sup>19</sup> Funding for effective community prevention programs, such as obesity prevention, is insufficient to support every state adequately.<sup>20</sup> Despite the rapid growth in the older adult population,<sup>21</sup> funding to support the overall health and well-being of older adults remains scarce. Moreover, CDC, and by extension its state, local, tribal, and territorial partners, lack the flexible funding needed to respond to the underlying drivers of poor health and to adequately grow and support the cross-cutting, foundational capabilities that bolster comprehensive public health systems at all levels of government.<sup>22</sup>

The FY 2024 budget for CDC is \$9.2 billion, reflecting a \$4.5 million (less than 1 percent) increase from FY 2023

**FIGURE 1: CDC Program Funding, Adjusted for Inflation, FY 2015–2024**



Note: To accurately compare funding levels from FY 2015–2018 with those from FY 2019 onward, it is necessary to consider the transfer of funding for the Strategic National Stockpile from CDC to the Office of the Assistant Secretary for Preparedness and Response in FY 2019.

Funding levels are presented in FY 2024 dollars. TFAH has adjusted the data for inflation using the Bureau of Economic Analysis’s Gross Domestic Product price index.

Source: CDC Annual Operating Plans<sup>24</sup>

funding, or a 3 percent decrease in inflation-adjusted dollars.<sup>23</sup> Looking further back, CDC’s budget increased by just 4 percent over the past decade (FY 2015–2024), after adjusting for inflation. (See Figure 1.) This modest growth has not been commensurate with the increasing demands placed on the public health system, the rising costs of public health interventions, and the need to modernize public health infrastructure and data systems.

The chronic underfunding of CDC and the public health system has severe consequences for the nation’s health and preparedness. It limits the ability of public health agencies to invest in disease surveillance, laboratory capacity, workforce development, and innovative programs to address the root causes of poor health. It also hinders efforts to reduce health disparities and promote health equity, as underserved communities are often

the most impacted by public health budget cuts and resource limitations.

To build a more resilient and equitable public health system, it is essential to provide CDC and its partners with sustained, predictable funding that allows for long-term planning and investment in core capabilities. This includes not only increasing funding for specific programs and initiatives but also providing more flexible funding streams that enable public health agencies to respond to emerging threats, address the social determinants of health, and support cross-cutting functions such as data modernization and community engagement. By prioritizing stable, adequate funding for CDC and the broader public health system, policymakers can help ensure that all communities have access to the resources and services they need to protect and promote health.

CDC's FY 2024 Operating Plan outlines the agency's funding allocations for the fiscal year. It is largely based on the congressionally mandated budget and reflects the priorities set by Congress and the President, with minor adjustments to address specific public health needs.<sup>25</sup> The total CDC program level budget for FY 2024 is \$9.2 billion, which includes budget authority, Prevention and Public Health Fund (Prevention Fund) transfers, and Public Health Service (PHS) evaluation transfers.

The FY 2024 plan maintains stable funding for public health functions such as HIV/AIDS, viral hepatitis, sexually transmitted infections, and tuberculosis prevention, as well as steady support for global health programs. There was a slight increase in funding (\$9.5 million, 1 percent) for emerging and zoonotic infectious diseases.

Funding for injury prevention and control remained unchanged, maintaining but not growing support for various programs, including opioid overdose prevention, domestic violence, and firearm injury prevention research. Similarly, occupational safety and health funding remained stable, continuing support for research and health programs for workers.

Public health scientific services saw a decrease in budget authority funding but an increase in PHS evaluation transfer, suggesting a shift in how funds are categorized rather than a reduction in services. The PHS evaluation transfer is a mechanism that allows a portion of funds appropriated to certain programs within HHS to be used for evaluation purposes.<sup>26</sup> The use of it allows CDC to conduct critical evaluations and assessments of its programs and activities, without relying solely on its regular budget authority or other funding sources. This helps to ensure



that the agency can continue to monitor and improve the effectiveness and impact of its work, even in the face of budget constraints or changing priorities.

The public health preparedness and response budget received a small increase (\$5 million, less than 1 percent), with \$55 million allocated to the combined Response Ready Enterprise Data Integration (RREDI) platform and Center for Forecasting and Outbreak Analytics. This represents a consolidation of these two programs under a single budget line, potentially constraining the resources available for each program's full functionality. RREDI is a comprehensive data-integration and decision-making platform initially created for COVID-19 response, now expanded to address outbreaks like mpox, integrating data from more than 300 sources for use by over 4,500 users from federal, state, and local entities, as well as the private sector.<sup>27</sup> The Center for Forecasting and Outbreak Analytics, established in 2021, uses data, modeling, and analytics to

forecast and track disease outbreaks, providing crucial insights to guide public health decision-making and improve outbreak response at federal, state, and local levels.

There was a \$10 million reduction in the Infectious Diseases Rapid Response Reserve Fund, a dedicated funding source that allows the agency to quickly respond to emerging infectious disease threats and outbreaks, which could potentially impact rapid deployment capabilities for emerging health threats.

Overall, the FY 2024 Operating Plan reflects the funding levels and allocations set by Congress, which aim to support CDC's core public health functions while also directing resources to specific health threats through targeted increases in certain areas. The slight increase in overall program-level funding (+\$4.5 million), despite the decrease in direct budget authority (-\$321.3 million), indicates a reliance on transferred funds from other sources like the Prevention Fund and PHS evaluation transfer to maintain or slightly expand operations.

## THE LOOMING PUBLIC HEALTH FUNDING CLIFF: A CRISIS IN THE MAKING

As the United States emerges from the acute phase of the COVID-19 pandemic, a new crisis looms on the horizon for public health: a severe funding cliff that threatens to undo much of the progress made in strengthening the nation's public health infrastructure. The combination of expiring emergency funds and rescissions (i.e., cancellations or reductions of previously approved but unspent funding) mandated by the Fiscal Responsibility Act of 2023 poses a significant threat to critical public health programs and capabilities built up during the pandemic response. Below are the programs within CDC that face significant funding cliffs and rescissions.

### KEY AREAS FACING FUNDING CLIFFS:

#### 1. Advanced Molecular Detection (AMD):

The AMD program, crucial for identifying and tracking infectious disease threats, received a one-time supplemental appropriation of over \$1.7 billion in 2021. This funding dramatically expanded the nation's capacity for genomic sequencing and analysis. However, this supplemental funding ends in 2024, leaving the program with only its annual base appropriation of \$40 million<sup>28</sup>—a staggering reduction. This cliff threatens to reverse critical gains in pathogen detection and surveillance capabilities.

#### 2. Public Health Workforce:

CDC awarded \$3 billion to health departments nationwide to address chronic workforce shortages exacerbated by the pandemic.<sup>29</sup> This funding supported hundreds of new positions across state and local health departments. However, these are one-time funds, potentially leading to widespread layoffs and a return to pre-pandemic workforce levels that left the nation unprepared for COVID-19. In addition, \$176 million in funding—about half of its original budget—for the Public Health AmeriCorps program was rescinded as a result of the Fiscal Responsibility Act. The program has created pathways to public health careers for more than 4,700 future public health leaders, with a focus on service in underserved communities in rural, urban, and tribal areas.<sup>30,31</sup>

#### 3. Public Health Infrastructure:

As of January 2024, CDC had awarded \$4.35 billion in grants to strengthen public health infrastructure across 107 state, territorial, and local health departments.<sup>32</sup> Over \$3.8 billion of these funds, critical for modernizing public health systems and capabilities, are set to expire in FY 2027. Without sustained funding, health departments may struggle

to maintain the improvements made in data systems, laboratory capacity, and community partnerships.

#### 4. Center for Forecasting and Outbreak Analytics (CFA):

Established with one-time funding during the pandemic to enhance the nation's ability to use advanced data, models, and analytics to support public health decision-making, CFA is the only federal entity with the primary mission of providing infectious disease forecasts during a response. Congress provided base funding of \$50 million in FY 2023 and \$41 million in FY 2024, with a rescission of \$8.8 million.<sup>33</sup> These continued decreases will require CFA to pull back on investments in establishing capabilities at the state and local levels, particularly within Insight Net, a collaborative network of more than 100 partners established to enhance modeling and analytic capabilities across U.S. health departments. Experts estimate \$100 million per year would allow CFA to continue operating at its current levels.

#### 5. National Wastewater Surveillance System:

Over \$500 million in supplemental funding has been invested to build a nationwide wastewater surveillance system capable of detecting COVID-19 and other pathogens.<sup>34</sup> This funding expires soon, with only \$20 million proposed in the FY 2025 budget to maintain a much scaled-down version of the program. This represents a massive reduction in funding, threatening to dismantle much of the surveillance network built during the pandemic.

#### 6. Bridge Access Program:

CDC's Bridge Access Program, launched to ensure continued access to COVID-19 vaccines as they transitioned to the commercial market, is set to expire in August 2024.<sup>35</sup> This program provides

free COVID-19 vaccines to 25–30 million adults without health insurance and those whose insurance does not fully cover vaccine costs. It utilizes a network of local health providers, HRSA-supported health centers, select pharmacies, and community events to distribute vaccines. The program's expiration could leave millions of adults without access to free COVID-19 vaccines, potentially widening health disparities and reducing overall vaccination rates. This comes at a time when COVID-19 continues to circulate, and updated vaccines may be needed to address new variants. The administration has proposed a broader Vaccines for Adults program to enable uninsured adults to have access to recommended vaccines.

### **Rescissions from the Fiscal Responsibility Act:**

Compounding the problem of expiring funds, the Fiscal Responsibility Act of 2023 mandated significant rescissions of unspent COVID-19 emergency funds, many of which officials had planned to use to shore up underlying public health capacity. Some of these rescissions included:

- **Vaccine Programs:** Over \$945 million was cut from programs that help get vaccines to people, build vaccine equity, and encourage vaccination.
- **Disease Tracking:** About \$430 million was taken away from efforts to track how diseases emerge and change over time.
- **Global Health:** More than \$300 million was removed from CDC's work on health issues around the world.
- **Data and Forecasting:** Nearly \$18 million was cut from programs that help predict and understand disease outbreaks.

The combination of expiring supplemental funds and mandated rescissions threatens to recreate the cycle of boom-and-bust crisis funding that left the United States vulnerable to COVID-19. Key consequences include:

- 1. Workforce Reductions:** Many health departments may be forced to lay off staff hired with emergency funds, losing valuable expertise and capacity.
- 2. Technology Setbacks:** Investments in data modernization and surveillance systems may be difficult to maintain without sustained funding.
- 3. Reduced Preparedness:** The ability to quickly detect and respond to new disease threats may be compromised as programs like AMD and wastewater surveillance are scaled back.
- 4. Widening Health Disparities:** Many of the programs facing cuts were instrumental in addressing health inequities exposed by the pandemic. Their reduction may disproportionately impact under-resourced and marginalized communities.

Allowing these funding cliffs to occur without providing long-term funding alternatives risks undoing years of progress. Consistent, adequate funding is necessary to maintain a robust public health system capable of protecting the nation from future health threats. We must translate the lessons learned from the pandemic into sustained support for public health infrastructure, workforce, and programs—breaking the cycle of crisis-driven funding once and for all.

## Prevention and Public Health Fund

Of CDC's \$9.2 billion FY 2024 budget, \$1.2 billion (13 percent) came from the Prevention Fund,<sup>36</sup> a dedicated federal funding stream for public health and prevention activities established by the Affordable Care Act in 2010. Statutorily intended to "improve health and help restrain the rate of growth in private and public [sector] health care costs,"<sup>37</sup> the Prevention Fund supports "expanded and sustained national investment in prevention and public health programs."<sup>38</sup>

Over the past decade, the Prevention Fund has supported a variety of programs and initiatives, covering disease prevention, early detection, management of health conditions, and promotion of healthy lifestyles. It has also strengthened the nation's public health infrastructure, including workforce development, community transformation, and public health research.

In the context of CDC's FY 2024 budget, the Prevention Fund played a significant role in offsetting some of the cuts in the agency's budget authority. While CDC's direct budget authority decreased by \$321.3 million, the agency's Prevention Fund transfer increased by \$282.9 million, helping to mitigate the impact of the budget authority reduction on the agency's overall program-level funding. By providing a dedicated funding stream for prevention and public health activities, the Prevention Fund helps to ensure that critical programs can continue even in the face of budget constraints or shifts in funding sources.

Allocations from the Prevention Fund are directed to specific programs within CDC's budget, supplementing or replacing funds that would otherwise come from the agency's regular budget authority. In the agency's FY 2024 Operating Plan, several programs received substantial funding from the Prevention Fund. The Immunization Program, which promotes immunization efforts across the country, relied heavily on the Prevention Fund in FY 2024, receiving \$681.9 million, which accounted for all of its funding.

Similarly, tobacco-related programming received \$125.9 million from the Prevention Fund, representing more than half of its total funding. This dedicated funding stream supports CDC's ongoing efforts to prevent and reduce tobacco use, which remains the leading cause of preventable disease, disability, and death in the United States.<sup>39</sup> The Prevention Fund also provides critical support for programs addressing chronic diseases and environmental health issues. In FY 2024, heart disease and stroke programs received \$29.3 million from the Prevention Fund, fully offsetting a reduction in budget authority funding, while diabetes-related efforts received \$66.4 million, more than a full offset.

In FY 2024, childhood lead-poisoning prevention efforts, a critical component of environmental health programming, were allocated \$51 million from the Prevention Fund. This amount represented a \$34 million increase from the previous year, which effectively offset an equivalent reduction in the program's regular budget authority. This

funding is vital for CDC's efforts in identifying and preventing lead exposure, crucial to protecting children's health and development.

Finally, in FY 2024, the Preventive Health and Health Services Block Grant, which provides flexible funding to state and local health departments for a broad range of public health activities,<sup>40</sup> received \$160 million exclusively from the Prevention Fund. This block grant allows states and localities to tailor public health interventions to meet the unique needs of their communities, thereby strengthening the infrastructure of the nation's public health system.

Since its establishment in 2010, the Prevention Fund has significantly contributed to public health in the United States. Overall, it has been a key enabler in strengthening public health systems and enhancing health outcomes across the country, demonstrating the value of sustained investment in health prevention and public health infrastructure. As a dedicated source of funding for prevention and public health activities, the Prevention Fund has supported CDC and its partners in implementing and expanding a range of programs and initiatives based on evidence. These efforts have sought to improve health outcomes through increased vaccination rates, decreased smoking prevalence, and better chronic disease management, among other public health advancements.<sup>41</sup> The Prevention Fund has also been instrumental in enhancing the U.S. public health infrastructure by supporting



investments in surveillance systems, epidemiology and laboratory capacity, and the public health workforce. This funding has helped to modernize critical health systems and improve the nation’s readiness and response to health crises. Additionally, by providing flexible funding through the Preventive Health and Health Services Block Grant, the Prevention Fund has empowered state and local health departments to address their unique public health needs. This flexibility has enabled tailored responses to local health challenges, helping communities build resilience against emerging threats and better manage their public health programs.

While the Prevention Fund has demonstrated its value in supporting

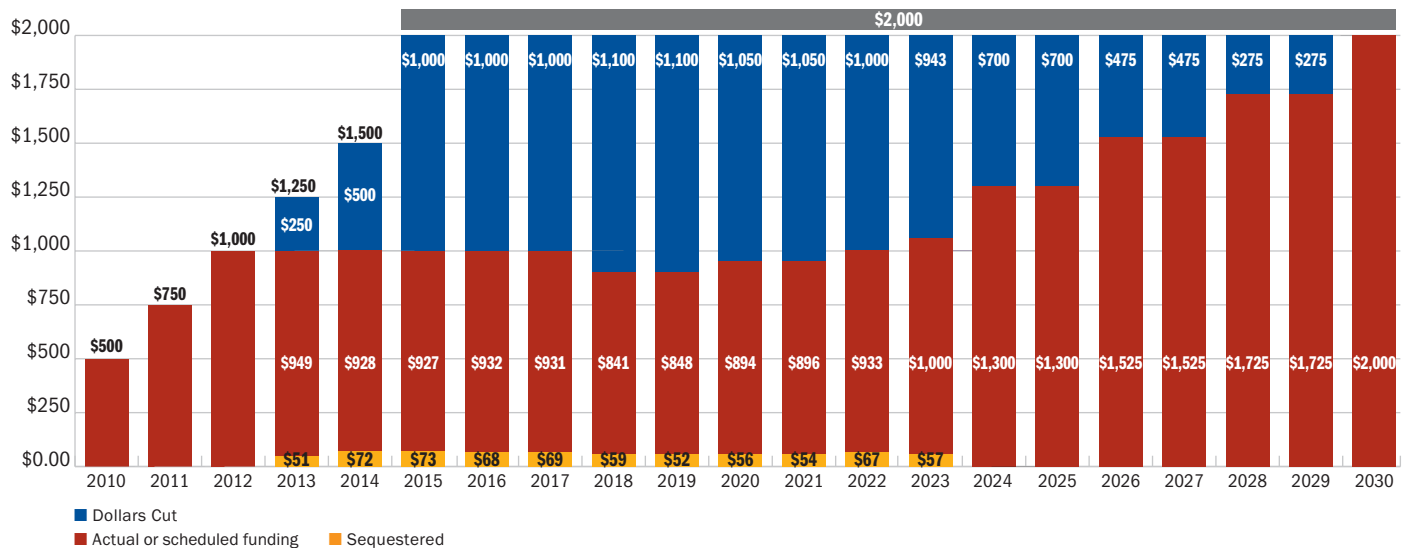
critical public health programs, it has nevertheless faced challenges since its inception. Efforts to divert Prevention Fund funds to other purposes and budget cuts have threatened the stability and effectiveness of this dedicated funding stream. To the detriment of the nation’s health, starting in FY 2013, the Prevention Fund has been repeatedly used for other purposes. There is a growing gap between the funds that were originally enacted and actual or scheduled funding. (See Figure 2.) In all, the fund is on pace to lose \$12.95 billion—about a third—of its originally allocated \$33 billion from FY 2013–2029.

As policymakers and public health leaders work to strengthen the U.S.

public health infrastructure and respond to ongoing and emerging challenges, the Prevention Fund will remain an indispensable tool for supporting effective, evidence-based public health interventions. CDC’s FY 2024 Operating Plan provides a clear illustration of the tangible impact that the Prevention Fund can have on critical public health programs, emphasizing the importance of sustained investment in prevention and public health capacity. Maintaining strong support for the Prevention Fund is essential to enabling CDC and its partners to continue their vital work in promoting health, preventing disease, and protecting communities from emerging threats.

**FIGURE 2: Historical Reductions in Prevention Fund Allocations, FY 2010–2030**

**Yearly Funding Trends for the Prevention and Public Health Fund**



Note: The Affordable Care Act initially set the allocations (represented by blue, red, and gold bars), whereas the Bipartisan Budget Act of 2018 (current law) introduced subsequent reductions (illustrated by blue bars). While CDC receives the majority of distributions from the Prevention Fund, remaining funds are allocated to SAMHSA and the Administration for Community Living.

Source: CDC Annual Operating Plans<sup>42</sup>

## Funding for key CDC initiatives

CDC plays a critical role in protecting and promoting the health of the nation by supporting a wide range of public health programs and initiatives. These efforts encompass both cross-cutting aspects of public health, such as public health laboratories and surveillance systems, as well as issue-specific priorities, including emergency preparedness and response, chronic and infectious disease prevention, and substance use disorder and suicide prevention. Central to CDC's mission is addressing the persistent health disparities that exist in communities across the country.

One of CDC's top priorities is strengthening America's capacity to prevent, detect, and respond to public health emergencies, such as infectious disease outbreaks, natural disasters, and bioterrorism threats. The agency's Public Health Emergency Preparedness (PHEP) cooperative agreement provides critical funding and technical assistance to state, local, and territorial health departments to enhance their preparedness capabilities and build resilience against emerging threats. However, despite the increasing frequency and complexity of public health emergencies, funding for the PHEP program has fallen over the past two decades, limiting the ability of health departments to maintain and expand their preparedness efforts.

CDC's chronic disease prevention programs support evidence-based interventions, public education campaigns, and partnerships with healthcare providers and community organizations to promote healthy behaviors and reduce the burden of chronic diseases. However, funding limitations have restricted the reach

and impact of these programs, with many states and localities lacking the resources to fully implement comprehensive chronic disease prevention strategies.

CDC also prioritizes efforts to address the crises of substance use disorders and suicide, which have devastating consequences for individuals, families, and communities nationwide. The agency's programs support a range of prevention services, as well as surveillance and research activities, to better understand and address these complex public health issues. However, the scale of the alcohol, drug, and suicide epidemics requires a significant expansion of these efforts, which is hindered by insufficient funding and competing public health priorities.

Across all of these program areas, CDC places a strong emphasis on advancing health equity and reducing health disparities. The agency recognizes that social, economic, and environmental factors play a significant role in shaping health outcomes and that certain communities, including low-income, rural, and those predominantly comprising people of color, face disproportionate barriers to health and well-being. To address these disparities, CDC works to integrate equity considerations into all of its programs and initiatives, support targeted interventions for underserved populations, and build partnerships with diverse stakeholders to promote health for all.

Despite the critical importance of these public health priorities, CDC's budgets for many of these initiatives have failed to keep pace with inflation, population growth, or the growing

scope and complexity of public health challenges. This chronic underfunding has limited the agency's ability to fully support all states, territories, tribes, and localities in their efforts to prevent and control diseases, prepare for emergencies, and promote health equity. As the United States continues to grapple with the impacts of the COVID-19 pandemic and faces an array of ongoing and emerging public health threats, it is imperative that policymakers and public health leaders work to strengthen and sustain funding for these vital CDC programs and initiatives. Only by investing in a robust, responsive, and equitable public health system can the country ensure that all communities have the resources and support they need to achieve optimal health and well-being.

## Public health emergency preparedness and response

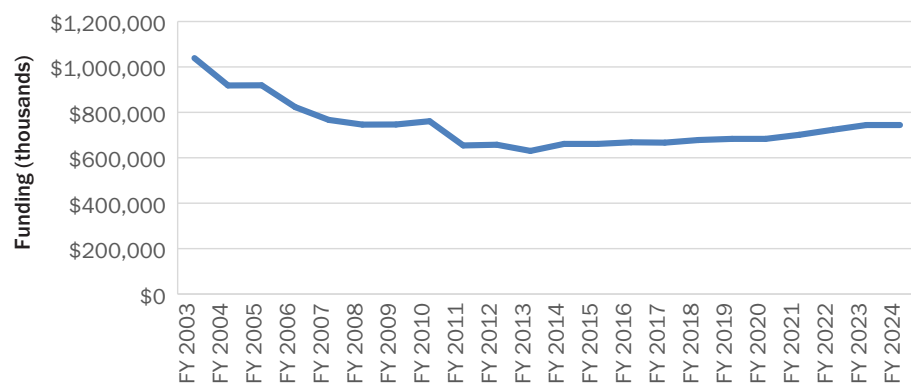
The COVID-19 pandemic exposed significant vulnerabilities in America's public health emergency preparedness and response capabilities, largely due to chronic underfunding and neglect of the nation's public health infrastructure. The primary federal programs supporting state, local, tribal, and territorial public health emergency preparedness and response—the PHEP cooperative agreement and the Health Care Readiness and Recovery program, which includes the Hospital Preparedness Program (HPP)—have seen substantial funding cuts over the past two decades, limiting the ability of health departments and healthcare systems to effectively prevent, detect, and respond to emergencies.

Administered by CDC, the PHEP cooperative agreement was established in 2002 to enhance the preparedness and response capacity of state, local, tribal, and territorial public health departments in the aftermath of the September 11 terrorist attacks and subsequent anthrax attacks.<sup>43,44</sup> The program provides funding and technical assistance to support the development and maintenance of emergency preparedness and response infrastructure, including surveillance systems, laboratory capacity, trained personnel, and partnerships between public health departments and emergency management agencies, healthcare organizations, and community-based organizations. Nearly 6,000 preparedness staff across state, local, and territorial health departments are supported in part or whole through PHEP funding,<sup>45</sup> creating the backbone of the nation’s public

health preparedness workforce.<sup>46</sup> PHEP funding has been critical to building the Laboratory Response Network—a system of labs that can quickly detect and respond to public health threats. It has also increased the country’s ability to track and understand how diseases spread. Additionally, this funding supports the distribution of vital medical supplies and treatments, such as vaccines and medications, during health emergencies.

Despite its critical role, PHEP funding has been cut by hundreds of millions of dollars over the past two decades. (See Figure 3.) In FY 2024, PHEP received flat funding, following a \$20 million increase in FY 2023. The current funding level (\$735 million) falls far short of the \$1 billion recommended by TFAH and other public health groups to build nationwide readiness for health emergencies.

**FIGURE 3: PHEP Funding Slowly Recovers, Yet Requires Further Investment**  
**CDC funding for state and local preparedness and response, FY 2003–2024**



Note: Data from FY 2003–2015 represent “state and local preparedness and response capability,” including specific increases in FY 2003 for smallpox preparedness and in FY 2004 for the Cities Readiness Initiative and U.S. Postal Service costs. Data from FY 2016–2024 combine funding totals from the PHEP cooperative agreement and the Academic Centers for Public Health Preparedness. A shift in the reporting practices within CDC’s annual operating plans has necessitated these differences.

Source: CDC Annual Operating Plans<sup>47</sup>

Similarly, Health Care Readiness and Recovery programs, administered by the Administration for Strategic Preparedness and Response (ASPR) at HHS, have seen their funding cut from \$515 million in FY 2003 to \$305 million in FY 2024—a nearly two-thirds reduction after adjusting for inflation.<sup>48</sup> Within this line, the HPP serves as the foundation for nationwide healthcare readiness by providing funding, technical assistance, and guidance to healthcare organizations to enhance their preparedness and response capabilities and to encourage collaboration with public health departments and other community partners.<sup>49</sup>

The HPP has been instrumental in strengthening the ability of healthcare systems to respond to public health emergencies and maintain essential services during crises.<sup>50,51</sup> Through the HPP, healthcare coalitions have been established across the country, fostering collaboration and resource-sharing among hospitals, public health departments, and emergency management agencies. These coalitions have been crucial in coordinating medical surge capacity, managing and distributing medical supplies, and ensuring the continuity of care during emergencies. For example, Regional Medical Response System, the lead agency for one of Oklahoma's six health care coalitions, coordinated a timely and successful response to the 18 tornadoes that hit central Oklahoma in April 2023, including relocating nursing home residents within hours after a tornado destroyed their facility.<sup>52</sup>

The erosion of PHEP and HPP funding over time increased the vulnerability of the United States ahead of the COVID-19 pandemic. Understaffed health departments were forced to respond to

a 21st-century pandemic with outdated tools and limited resources,<sup>53,54</sup> while healthcare systems struggled with insufficient surge capacity, inadequate supplies of personal protective equipment, and lack of training for high-consequence infectious diseases.<sup>55,56,57,58</sup>

During public health emergencies that exceed existing capacity and countermeasures, supplemental funding may be required. The most common approach is for Congress to pass a supplemental appropriation, as it did during the initial stages of the COVID-19 pandemic. However, emergency supplemental funding can create additional challenges, such as restrictions on how funds can be used (e.g., COVID-19-related supplemental funding could not easily be repurposed for mpox vaccination clinics, even when the two outbreaks overlapped), short-term funding that hinders workforce retention, and a boom-and-bust cycle that contributes to an unstable public health infrastructure.

Other mechanisms, such as the Infectious Diseases Rapid Response Reserve Fund<sup>59</sup> and the Public Health Emergency Rapid Response Fund, can potentially accelerate the availability of resources during emergencies. However, these funds are limited in size and scope and are not intended to replace adequate annual funding for public health agencies at all levels of government.

The Biden-Harris Administration's FY 2025 budget request included mandatory funding for pandemic preparedness across federal agencies. Within that request, \$6.1 billion in mandatory funds for CDC would go to modernize and build laboratory capacity, strengthen public health data

systems, enhance disease surveillance, and support the evaluation of vaccine and medical countermeasure safety and effectiveness.<sup>60</sup> If approved, this funding would represent a significant investment in bolstering the U.S. public health infrastructure and enhancing its capacity to respond to existing and emerging health threats.

By prioritizing sustained investment in public health emergency preparedness and response, policymakers can help build a more resilient and agile public health system capable of protecting the health and well-being of all U.S. residents in the face of future crises.

### **Promoting health at the community level**

The conditions in which people are born, live, work, play, and age significantly impact their health and well-being.<sup>61,62,63</sup> Social determinants of health—such as economic opportunity, accessible transportation, robust physical infrastructure, educational access, affordable and nutritious food, stable housing, and public safety—all contribute to wellness and life expectancy.<sup>64,65</sup> Despite the profound influence of these factors on a community's health outcomes,<sup>66</sup> many places still struggle to make healthy options easily accessible for people. Moreover, funding specifically targeted at addressing social determinants of health by CDC remains limited compared with the large-scale need to alter these conditions.

Improving social determinants of health and the overall health of population groups requires collaboration among governmental and nongovernmental organizations, as well as community members. Public health leaders play a critical role

by initiating and informing policy interventions, convening multisector stakeholders, and providing actionable data. For example, community partnerships have developed and advocated for increasing the number of healthy food retailers in low-income neighborhoods; engaged in Complete Streets planning to address the safety needs of pedestrians, bicyclists, and transit riders of all ages and abilities;<sup>67</sup> and launched multimedia education campaigns to reduce tobacco use.

The National Diabetes Prevention Program is another model for promoting health at the community level. This evidence-based lifestyle change program, led by CDC, aims to prevent or delay type 2 diabetes among adults with prediabetes.<sup>68</sup> By partnering with public and private organizations to offer structured sessions that focus on healthy eating, physical activity, and stress management, the program has demonstrated significant success in improving health outcomes and reducing healthcare costs. Trained lifestyle coaches work with participants to set goals, track progress, and provide ongoing support, resulting in an estimated savings of \$1,146 per participant in diabetes-related healthcare costs.<sup>69</sup>

Two complementary efforts include the Appalachian Diabetes Control and Translation Project<sup>70</sup> and the Native Diabetes Wellness Program.<sup>71</sup> Millions of people in Appalachia suffer from poor health outcomes, including elevated rates of type 2 diabetes, due to a complex interplay of socioeconomic, geographical, and cultural factors.<sup>72</sup> Similarly, Native Americans exhibit the highest prevalence of type 2 diabetes among all racial groups in the United States,<sup>73</sup> a phenomenon rooted

in centuries of colonization, forced relocation, and cultural assimilation. Both projects utilize regional coalitions and community resources to deliver culturally appropriate education and lifestyle interventions to communities disproportionately impacted by diabetes. However, insufficient funding limits the reach of these programs.

Health disparities account for an estimated \$320 billion in annual healthcare spending, which could grow to \$1 trillion or more by 2040 if not addressed.<sup>74</sup> Two key CDC programs that specifically focus on racial and ethnic populations at elevated risk of preventable illness, injury, and death—Racial and Ethnic Approaches to Community Health (REACH) and Healthy Tribes—are underfunded and depend on limited resources. Both programs have a solid track record of advancing culturally appropriate, evidence-informed, and effective interventions for populations that experience disproportionate burdens of chronic disease. Congress should appropriately fund both programs to match the scale of the problem.

Community prevention efforts can effectively address a wide variety of negative health outcomes, such as chronic disease, substance misuse, injury, and violence.<sup>75,76</sup> By extension, this investment can also help reduce preventable healthcare spending, producing a substantial return on investment.<sup>77</sup> For example, school-based substance misuse screenings, brief interventions, and referrals to treatment programs have produced returns on investment as high as \$20 for every \$1 spent.<sup>78</sup> Tobacco-control mass-media campaigns have demonstrated impressive returns,<sup>79</sup> and CDC's Tips from Former Smokers campaign,

funded by the Prevention Fund, resulted in hundreds of thousands of lifetime quits, preventing early deaths and smoking-related healthcare costs.<sup>80</sup>

While CDC's existing programs have proved effective in addressing several nonmedical factors of health, it was not until FY 2021 that the agency specifically received funds (\$3 million) for strategies that focus on the social determinants of health.<sup>81</sup> The \$22 million that CDC received from FY 2022 to FY 2024 to address social determinants of health<sup>82</sup> have continued to build momentum for innovative work, but that amount needs to grow to fully address the scope of the issue and allow CDC to fund the implementation of plans to address these issues in communities. To build the evidence base for future work in this area, CDC evaluated existing multisector coalitions that are working to advance health equity through solutions centered on the social determinants of health. In a first-year evaluation, CDC found that of 42 community partnerships evaluated, 90 percent of them contributed to community changes that promote healthy living.<sup>83</sup>

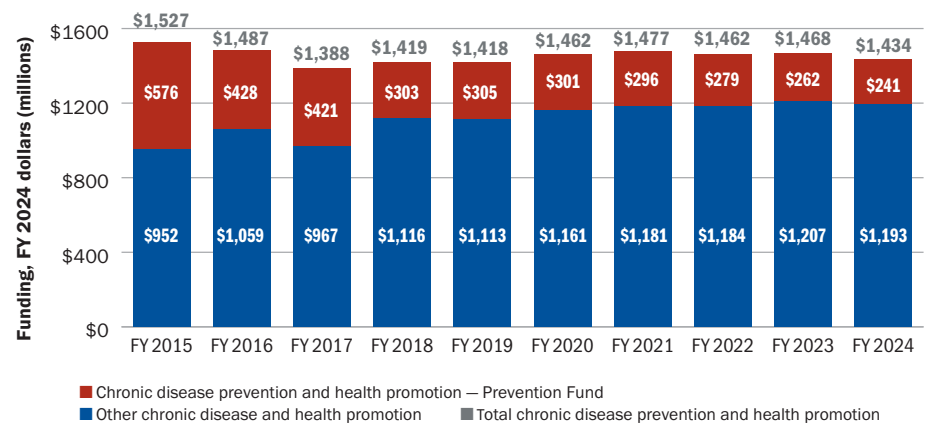
By prioritizing investment in community-level health promotion and addressing the social determinants of health, policymakers can help create the conditions for all people to live healthier lives, reduce health disparities, build more equitable and resilient communities, and reduce future healthcare spending. This will require a sustained commitment to funding, a focus on community engagement and leadership, and a willingness to work across sectors and agencies to develop innovative solutions to complex challenges.

## Chronic disease prevention

Chronic diseases are a significant burden on the health and well-being of U.S. residents, with roughly 60 percent of adults living with one or more chronic conditions, such as heart disease, diabetes, cancer, obesity, and asthma.<sup>84</sup> These conditions are responsible for seven in 10 deaths each year in the United States<sup>85</sup> and, along with mental health conditions,

account for the vast majority of the country’s health spending.<sup>86</sup> Despite the enormous impact of chronic diseases, CDC is on track to spend only \$1.4 billion on chronic disease prevention and health promotion in FY 2024, a level that has remained roughly the same in recent years and is below the FY 2015 level after adjusting for inflation. (See Figure 4.)

**FIGURE 4: CDC’s Current Chronic Disease Funding Lags Behind FY 2015 Level**  
Chronic disease funding, adjusted for inflation, FY 2015–2024



Note: Funding levels are presented in FY 2024 dollars. Data have been adjusted for inflation using the Bureau of Economic Analysis’s Gross Domestic Product price index.

Source: CDC Annual Operating Plans<sup>87</sup>

Insufficient funding limits the reach and effectiveness of evidence-based programs designed to prevent and manage chronic diseases. For example, CDC’s State Physical Activity and Nutrition (SPAN) program—which provides strategies to improve nutrition and encourage physical activity in early care, education, and community settings—only has enough funding to support programs in 17 states in FY 2024.<sup>88</sup> Expanding SPAN to all 50 states would require an estimated additional \$1.2 million per state, a relatively small investment compared with the \$170 billion in obesity-related healthcare costs the United States spends annually.<sup>89</sup>

While genetic risk factors contribute to the development and progression of chronic diseases, behavioral factors such as smoking, alcohol consumption, poor nutrition, and lack of physical activity play a significant role.<sup>90</sup> Sedentary lifestyle alone contributes to an estimated 10 percent of premature deaths,<sup>91</sup> is a major risk factor for severe COVID-19,<sup>92</sup> and costs the healthcare system tens of billions of dollars annually.<sup>93</sup> Importantly, these behavioral risk factors are tied to social, economic, and environmental conditions, highlighting the need for prevention efforts that address the underlying determinants of health and

promote healthful behaviors through improved access to healthy foods and physical-activity-friendly environments.

The burden of chronic diseases is not distributed equally, with historically marginalized and under-resourced communities experiencing disproportionate impacts. Factors such as poverty, limited access to healthcare, discrimination, and environmental inequities, including disproportionate exposure to pollutants, lack of green spaces, and limited access to healthy food options, contribute to higher rates of chronic conditions like diabetes, heart disease, and obesity in these populations. For example, Black and Hispanic adults are more likely to have diabetes compared with their white counterparts,<sup>94,95</sup> and low-income neighborhoods often lack access to healthy food options and safe spaces for physical activity. These disparities are rooted in systemic inequalities and social determinants of health, which have been perpetuated by a long history of discriminatory policies and practices. Addressing these underlying issues requires a concerted effort to dismantle structural barriers, invest in community-led solutions, and prioritize health equity in all aspects of decision-making. Public health agencies play a critical role in this work by collecting and analyzing data to identify disparities, engaging communities in the development and implementation of interventions, and advocating for policies that promote fair opportunities for health. Additional resources are needed to continue advancing health equity.

To effectively reduce healthcare expenditures related to treating chronic diseases, increased investment in proven prevention programs is essential. CDC's chronic disease prevention and health-promotion activities focus on four key areas: (1) measuring disease prevalence



and risk factors to inform targeted interventions, (2) making environmental improvements that facilitate healthy choices, (3) strengthening prevention services within healthcare systems to integrate routine screening and early interventions, and (4) creating connections between clinical services and community programs that support comprehensive disease prevention and management strategies.<sup>96</sup>

CDC has several cost-effective, evidence-based prevention and control programs ready for community implementation.<sup>97</sup> The National Breast and Cervical Cancer Early Detection Program has served more than 6 million women since 1991, identifying over 75,000 invasive breast cancers, 5,000 invasive cervical cancers, and 240,000 precancerous cervical lesions.<sup>98</sup> The Tips from Former Smokers campaign, aimed at encouraging smoking cessation, helped 1 million smokers successfully quit between 2012 and 2018, prevented an estimated 129,000 early deaths, and saved roughly \$7.3 billion in smoking-related healthcare costs. The Million Hearts initiative prevented an estimated 135,000 cardiac events from 2012 to 2016, averting \$5.6 billion in medical costs.<sup>99</sup> These achievements demonstrate the significant impact of CDC's work in promoting healthier

lifestyles and reducing the burden of chronic diseases in the United States.

In CDC's FY 2024 Operating Plan, the Chronic Disease Prevention and Health Promotion budget was allocated \$1.4 billion, a slight increase of \$3.5 million from the FY 2023 level. The majority of the funding is directed toward cancer prevention and control, heart disease and stroke, and tobacco-control and prevention efforts. While some programs addressing health disparities and social determinants of health receive comparatively smaller allocations, they play a vital role in promoting health equity and tackling the root causes of chronic diseases.

To effectively address the growing burden of chronic diseases and reduce health disparities, policymakers must prioritize sustained investment in comprehensive, community-based prevention and health-promotion programs. By addressing the root causes of chronic diseases, promoting healthy behaviors, and ensuring equitable access to preventive services and resources, the country can improve the health and well-being of all U.S. residents while reducing the staggering costs associated with these largely preventable conditions.

## Substance misuse and suicide prevention

The United States continues to face drug overdose and mental health crises that claim the lives of tens of thousands of U.S. residents each year. Provisional CDC data released in May 2024 predicted more than 107,000 overdose deaths in the 12-month period ending in December 2023,<sup>100</sup> with most deaths attributed to illicit synthetic drugs like fentanyl and methamphetamine.<sup>101</sup> American Indian/Alaska Native (AI/AN) and Black individuals have been disproportionately affected by the recent spike in drug overdose deaths, with the highest rates in 2022 among the non-Hispanic AI/AN population (65.2 deaths per 100,000 residents) and the non-Hispanic Black population (47.5 deaths per 100,000 residents).<sup>102</sup>

These alarming trends can be attributed to a combination of factors, including the proliferation of highly potent synthetic opioids, the impact of the COVID-19 pandemic on mental health and substance use, and the persistent disparities in access to prevention, treatment, and recovery services. The widespread availability of illicitly manufactured fentanyl, often mixed with other drugs without an individual's knowledge, has dramatically increased the risk of overdose. The social and economic crises precipitated by the pandemic, including extensive social isolation, coupled with barriers to behavioral health treatment and racial disparities in access to treatment options, have also put individuals in need of mental health or other services at particular risk.<sup>103</sup> Furthermore, long-standing structural inequities, such as poverty, discrimination, and a lack of access to healthcare, have

contributed to the disproportionate impact of these crises on AI/AN and Black communities, which often face barriers to accessing culturally appropriate and evidence-based prevention and treatment services.

Concurrent with the drug overdose crisis, the number of suicides in the United States reached a record high of nearly 49,500 in 2022.<sup>104</sup> The suicide rate also rose to its highest level since 1941. While the suicide rate increased for both males and females, the total number of suicides among males (39,255) was nearly four times that of females (10,194). Suicide rates generally declined for younger age groups but increased for older age groups. The highest suicide rate was among non-Hispanic AI/AN individuals at 26.7 per 100,000.

CDC employs a comprehensive strategy to address these challenges, focusing on integrated research, policy, education, and community-based initiatives. It enhances understanding and response through robust surveillance and data-collection systems, which track trends in drug overdose and suicide. Additionally, the agency conducts research to identify risk and protective factors, informs guidelines for opioid prescriptions and suicide prevention, and supports state, local, and tribal programs with funding and technical assistance. Promoting safe and supportive school environments, positive youth development programs, and policies and practices that support LGBTQ+ students can further contribute to reducing substance misuse and suicide. And public education

campaigns play critical roles in raising awareness about the dangers of substance misuse and the importance of mental health support. These campaigns often focus on topics such as the life-saving role of naloxone in reversing opioid overdoses, strategies for preventing overdoses, and reducing the stigma surrounding substance use treatment to encourage more individuals to seek help.

To help reverse these alarming trends and promote positive outcomes, CDC also focuses on the prevention of adverse childhood experiences (ACEs). ACEs are potentially traumatic events that occur in childhood, such as experiencing abuse, witnessing domestic violence, or growing up with family substance misuse, which can have long-lasting effects on health and well-being. An estimated 64 percent of adults report having experienced at least one ACE,<sup>105</sup> and investing in programs that address ACEs could significantly reduce adult depression cases, among other benefits. Funding for CDC's ACEs prevention work has increased slightly from \$4 million in FY 2020, its first year of funding, to \$9 million in FY 2024.

While suicide is a complex issue with multiple contributing factors, it is important to recognize that suicidal crises are often temporary and characterized by a brief period of acute risk.<sup>106</sup> Research has shown that many suicide attempts are impulsive acts, with the time between the decision to act and the attempt itself sometimes being as short as a few minutes to a few hours. This narrow window of heightened vulnerability underscores the critical



importance of immediate intervention and support for individuals in crisis. People who survive suicide attempts often go on to lead fulfilling lives, with the majority not dying by suicide at a later date.<sup>107</sup> This highlights the potential for recovery and the need for accessible, effective mental health services and support systems that can help individuals navigate challenging times and build resilience.

The establishment of the 988 Suicide and Crisis Lifeline in July 2022 represents a significant step toward a comprehensive crisis-response system. This service, an expanded and rebranded update of its predecessor, the National Suicide Prevention Lifeline, provides a shorter, easier-to-remember number for accessing immediate crisis support. Since its launch in July 2022, the 988 Lifeline has seen substantial growth in usage. In its first two years of operation, counselors have answered more than 10 million calls, texts, and chats from people experiencing mental health or substance use crises. The service has expanded significantly, with a 51 percent increase in texts answered in the past 12 months compared to the year before.<sup>108</sup> The average speed to answer has also improved dramatically, decreasing from 2 minutes and 39 seconds to just 41 seconds.<sup>109</sup> The 988 Lifeline has expanded its services to better support populations at risk of suicide, adding Spanish text and chat services, specialized support for LGBTQ+ youth and young adults, and video-phone service for deaf and hard-of-hearing individuals. These enhancements were made possible by nearly \$1 billion in investments from SAMHSA, as well

as state funding. As the 988 Lifeline continues to evolve and expand, it will serve as a vital component of a broader vision for behavioral health crisis response, ensuring that anyone, anywhere, at any time has someone to talk to, someone who will respond, and a safe place to turn for help.

Substance misuse, overdose, and suicide share common risk and protective factors. Addressing them requires socially focused efforts, such as strengthening economic support for families, early intervention to reduce harm when children are mistreated, and supporting safe and inclusive schools.

CDC supports efforts to address these issues through a prevention-focused approach that translates research into practical actions. By emphasizing the role of public health departments in addressing social determinants of health, as well as shared risk and protective factors, CDC aims to create sustainable population-level and community health improvements. This approach effectively complements the individual and treatment-focused services provided by SAMHSA and other agencies, ensuring a holistic strategy that spans prevention, treatment, and recovery.

CDC's FY 2024 budget dedicates \$30 million to suicide prevention, with no change from FY 2023. CDC funding for opioid overdose prevention and surveillance increased from \$125 million in FY 2017 to nearly \$506 million in FY 2024.

Despite these efforts, gaps remain in addressing the underlying causes of substance misuse and suicide,

particularly among communities of color and other populations at higher risk. Policymakers must prioritize sustained investments in comprehensive, community-based prevention strategies that address social determinants of health, promote resilience, and ensure equitable access to mental health and substance use disorder services. By focusing on upstream prevention and early intervention, the country can work toward reducing the devastating impact of substance misuse and suicide on individuals, families, and communities across the nation.

### **CDC Program Funding to States, FY 2023**

More than 80 percent of the funding that CDC receives annually is directed to states, localities, tribes, territories, and other external partners to support related health programming in their communities. Major priorities include funding for childhood vaccination (e.g., Hepatitis B, MMR, DTaP) programs; prevention of serious infectious diseases such as HIV/AIDS, tuberculosis, and various sexually transmitted infections; and chronic disease prevention. Table 2 shows CDC program funding awarded to states across major budget categories in FY 2023. In total, CDC awarded \$14.9 billion. The data provide a comprehensive picture of how CDC distributes program funding to support state public health efforts aligned with national priorities. While the funding is substantial overall, gaps remain in key areas. Sustained, predictable funding will be critical for states to make progress on a range of public health challenges moving forward.

**TABLE 2: CDC PROGRAM FUNDING TO STATES, FY 2023**

State	Agency for Toxic Substances and Disease Registry (ATSDR)	Birth Defects, Developmental Disabilities, Disability and Health	CDC-Wide Activities and Program Support	Childhood Obesity Demonstration Project	Chronic Disease Prevention and Health Promotion	Emerging and Zoonotic Infectious Diseases	Environmental Health	Health Reform - Toxic Substances & Environmental Public Health	HIV/AIDS, Viral Hepatitis, STI and TB Prevention
Alabama		\$7,588,429	\$11,971,854		\$16,042,737	\$2,425,998	\$716,861		\$14,320,217
Alaska	\$586,596	\$491,000	\$4,742,200		\$20,745,139	\$1,044,066	\$464,963		\$2,798,183
Arizona	\$390,000	\$1,689,998	\$19,400,526		\$21,133,658	\$1,945,627	\$2,147,185		\$12,966,092
Arkansas	\$454,400	\$1,766,000	\$8,480,959		\$12,427,059	\$1,088,139			\$6,414,453
California	\$2,249,999	\$2,113,155	\$84,490,700	\$345,000	\$37,953,203	\$14,096,456	\$4,823,919		\$120,904,936
Colorado	\$2,730,180	\$1,726,308	\$14,814,291		\$16,192,053	\$7,551,987	\$3,098,876		\$11,132,196
Connecticut	\$533,882		\$9,237,613		\$9,343,861	\$6,242,153	\$2,183,754		\$6,764,120
Delaware			\$6,769,143		\$7,215,292	\$501,515	\$1,115,095		\$2,676,334
D.C.	\$383,712	\$21,917,130	\$39,376,576		\$21,605,988	\$10,080,301	\$1,672,073		\$39,755,868
Florida	\$492,070	\$1,939,639	\$33,322,917		\$16,422,374	\$4,674,582	\$2,339,168		\$71,136,105
Georgia	\$484,751	\$5,332,961	\$88,678,548	\$50,000	\$81,032,636	\$10,620,013	\$2,763,732		\$58,172,492
Hawaii		\$166,000	\$11,252,988		\$8,592,519	\$1,780,722	\$642,273		\$3,146,480
Idaho	\$300,000	\$166,000	\$4,452,897		\$5,899,800	\$567,641	\$512,000		\$2,219,566
Illinois	\$1,933,184	\$6,491,399	\$26,432,042	\$330,000	\$37,347,548	\$3,413,558	\$3,410,892		\$31,072,002
Indiana		\$1,642,811	\$14,685,993		\$10,745,945	\$1,345,042	\$1,930,217		\$13,006,002
Iowa		\$1,861,000	\$7,676,742		\$10,715,379	\$3,927,662	\$2,016,359		\$2,984,790
Kansas		\$429,907	\$9,003,332		\$11,246,038	\$1,271,078	\$1,261,885		\$2,771,734
Kentucky		\$160,000	\$12,548,198		\$12,752,085	\$1,547,092	\$2,050,504		\$7,201,013
Louisiana	\$312,998	\$165,998	\$14,169,889		\$13,626,499	\$2,900,050	\$1,323,694		\$18,993,726
Maine		\$166,000	\$6,804,681		\$7,769,974	\$1,660,741	\$2,031,000		\$2,320,042
Maryland		\$4,865,053	\$73,671,126	\$150,000	\$28,315,016	\$20,836,627	\$3,027,425		\$28,417,169
Massachusetts	\$2,739,275	\$3,356,608	\$42,076,609	\$307,000	\$20,449,573	\$8,437,598	\$3,210,792		\$15,588,341
Michigan	\$2,722,500	\$2,096,152	\$28,064,153		\$28,162,434	\$4,791,484	\$8,914,197		\$19,926,057
Minnesota	\$485,586	\$3,149,514	\$25,417,542		\$22,215,241	\$11,061,505	\$3,402,859		\$8,600,184
Mississippi			\$10,924,890		\$14,485,895	\$344,094	\$671,265		\$11,735,096
Missouri	\$584,355	\$2,137,726	\$19,652,107	\$300,000	\$16,406,048	\$1,580,144	\$2,399,372		\$13,408,020
Montana	\$357,131	\$897,500	\$5,901,297		\$10,957,166	\$972,000	\$1,013,325	\$2,999,999	\$1,862,069
Nebraska		\$166,000	\$7,408,097	\$300,000	\$8,188,396	\$1,567,974	\$1,136,113		\$2,862,108
Nevada		\$836,099	\$7,472,107		\$11,451,346	\$1,290,347	\$1,214,421		\$8,076,877
New Hampshire	\$407,372	\$738,500	\$5,837,550		\$8,651,439	\$1,443,077	\$2,496,526		\$1,891,113
New Jersey	\$2,734,622	\$1,916,001	\$15,231,534		\$12,430,689	\$1,798,400	\$2,379,488		\$27,915,915
New Mexico	\$547,083	\$166,000	\$10,544,693		\$14,918,267	\$2,412,252	\$1,884,273		\$2,979,273
New York	\$2,641,248	\$9,864,176	\$54,152,337		\$34,953,226	\$12,461,808	\$5,173,247		\$100,856,691
North Carolina	\$2,606,637	\$4,263,752	\$32,836,201		\$23,202,946	\$6,517,786	\$2,118,166		\$22,425,842
North Dakota		\$166,000	\$4,081,939		\$7,591,831	\$1,005,105			\$2,123,503
Ohio	\$472,500	\$1,058,143	\$28,272,755		\$16,632,206	\$6,254,698	\$1,982,280		\$17,682,480
Oklahoma		\$160,000	\$13,974,927		\$14,382,139	\$701,608	\$515,000		\$7,603,726
Oregon	\$646,130	\$1,126,738	\$10,888,411		\$17,992,782	\$2,877,694	\$1,758,037		\$7,473,591
Pennsylvania	\$499,819	\$959,569	\$38,785,446		\$18,870,226	\$6,015,769	\$2,706,736		\$28,476,181
Rhode Island	\$467,030	\$416,000	\$10,497,138	\$300,000	\$10,682,020	\$1,670,814	\$2,273,738		\$2,331,210
South Carolina		\$1,411,000	\$18,123,246		\$18,466,255	\$1,781,536	\$1,150,000		\$13,332,575
South Dakota			\$3,784,739		\$11,267,090	\$1,283,492	\$498,955		\$1,628,067
Tennessee	\$573,019	\$4,935,078	\$16,044,539		\$15,489,532	\$4,375,972	\$1,338,763		\$17,593,832
Texas	\$445,000	\$3,573,922	\$56,879,864		\$27,101,834	\$4,131,190	\$3,037,674		\$69,048,370
Utah	\$300,000	\$3,484,838	\$15,522,150		\$13,296,126	\$5,948,439	\$2,485,583		\$2,792,141
Vermont		\$166,000	\$3,607,395		\$8,210,485	\$1,133,987	\$1,933,306		\$1,812,193
Virginia	\$295,498	\$1,973,752	\$45,656,097		\$24,528,923	\$6,035,571	\$4,408,099		\$16,883,600
Washington	\$436,447	\$691,000	\$43,668,414		\$20,740,342	\$9,239,545	\$2,277,333		\$14,541,594
West Virginia		\$744,971	\$5,117,681		\$11,367,702	\$987,408	\$664,491		\$2,670,999
Wisconsin	\$688,484	\$2,295,247	\$16,766,266		\$16,748,545	\$7,788,463	\$3,103,547		\$5,424,463
Wyoming		\$166,000	\$3,669,734		\$5,370,829	\$803,201	\$833,775		\$1,822,100
<b>United States</b>	<b>\$31,501,508</b>	<b>\$113,595,074</b>	<b>\$1,102,843,073</b>	<b>\$2,082,000</b>	<b>\$892,336,336</b>	<b>\$216,234,011</b>	<b>\$106,513,236</b>	<b>\$2,999,999</b>	<b>\$910,541,731</b>

**TABLE 2: CDC PROGRAM FUNDING TO STATES, FY 2023**

State	Immunization and Respiratory Diseases	Injury Prevention and Control	Occupational Safety and Health	Public Health Preparedness and Response	Public Health Scientific Services (PHSS)	Public Health Social Services Emergency Fund (PHSEF)	Vaccines for Children	World Trade Center Health Programs (WTC)	Total State Funding
Alabama	\$4,403,090	\$6,836,435	\$1,850,000	\$9,785,870	\$835,309	\$82,270,134	\$79,287,867		\$238,334,801
Alaska	\$2,561,775	\$5,560,431	\$99,352	\$5,210,000	\$1,494,737	\$20,395,964	\$12,220,922		\$78,415,328
Arizona	\$8,605,077	\$15,547,691	\$639,956	\$13,007,079	\$1,410,149	\$101,469,498	\$112,521,081		\$312,873,617
Arkansas	\$3,361,534	\$4,715,788		\$6,986,193	\$996,903	\$48,501,675	\$49,692,842		\$144,885,945
California	\$32,898,276	\$36,202,658	\$9,270,681	\$66,434,088	\$5,855,552	\$478,698,668	\$544,077,381		\$1,440,414,672
Colorado	\$6,482,476	\$12,316,616	\$5,002,675	\$11,079,633	\$1,819,775	\$77,514,065	\$62,770,185		\$234,231,316
Connecticut	\$6,916,507	\$12,949,228	\$2,240,487	\$8,123,961	\$1,498,898	\$49,505,572	\$44,758,922		\$160,298,958
Delaware	\$2,205,131	\$4,656,727		\$5,426,073	\$642,368	\$22,328,003	\$14,190,821		\$67,726,502
D.C.	\$11,508,376	\$20,794,417	\$1,167,600	\$9,070,295	\$5,943,636	\$18,405,216	\$13,965,717		\$115,646,905
Florida	\$12,349,620	\$22,901,655	\$3,779,377	\$32,992,280	\$2,929,708	\$260,466,975	\$331,756,625		\$797,503,095
Georgia	\$21,222,580	\$38,174,752	\$690,625	\$18,431,023	\$18,538,836	\$140,743,535	\$176,539,452		\$661,475,936
Hawaii	\$2,784,257	\$3,630,835		\$5,567,141	\$1,651,353	\$38,419,849	\$19,098,893		\$96,733,310
Idaho	\$2,795,326	\$3,103,498		\$5,742,299	\$840,549	\$30,704,314	\$24,633,210		\$81,937,100
Illinois	\$21,187,317	\$19,348,284	\$4,599,278	\$28,122,647	\$2,918,007	\$168,938,556	\$147,408,670		\$502,953,384
Indiana	\$4,520,156	\$12,645,965	\$150,000	\$12,101,913	\$1,361,657	\$89,849,432	\$96,382,752		\$260,367,885
Iowa	\$4,710,535	\$6,663,821	\$4,734,819	\$6,873,572	\$487,442	\$45,706,977	\$43,328,772		\$141,687,870
Kansas	\$3,607,950	\$7,819,504	\$76,000	\$7,154,030	\$933,669	\$43,863,519	\$33,402,524		\$122,841,170
Kentucky	\$3,647,330	\$11,234,164	\$3,637,091	\$8,733,185	\$580,391	\$68,366,734	\$64,874,465		\$197,332,252
Louisiana	\$2,204,982	\$14,770,138	\$658,508	\$9,083,163	\$1,441,567	\$131,153,913	\$92,094,150		\$302,899,275
Maine	\$3,073,015	\$8,862,101		\$5,210,000	\$675,858	\$26,160,781	\$16,681,299		\$81,415,492
Maryland	\$15,844,011	\$15,034,481	\$9,393,691	\$14,480,777	\$15,418,516	\$289,231,285	\$94,513,387	\$499,489	\$613,698,053
Massachusetts	\$6,642,765	\$16,288,885	\$3,575,795	\$13,927,467	\$1,047,021	\$94,390,701	\$86,147,185	\$260,266	\$318,445,881
Michigan	\$10,785,722	\$20,095,654	\$2,833,147	\$17,051,164	\$1,533,094	\$125,832,573	\$104,463,733		\$377,272,064
Minnesota	\$8,797,351	\$11,324,197	\$3,464,985	\$12,231,559	\$1,218,084	\$74,850,362	\$54,555,719		\$240,774,688
Mississippi	\$3,097,223	\$3,979,172		\$6,888,671	\$488,868	\$49,233,896	\$48,313,534		\$150,162,604
Missouri	\$5,322,993	\$11,276,940	\$3,418,479	\$11,155,537	\$792,697	\$80,711,366	\$75,212,349		\$244,358,133
Montana	\$1,680,068	\$5,116,031	\$288,220	\$5,510,000	\$311,717	\$22,582,018	\$10,582,514		\$71,031,055
Nebraska	\$2,689,150	\$5,689,890	\$2,667,183	\$5,807,091	\$603,084	\$34,863,705	\$27,043,741		\$100,992,532
Nevada	\$3,194,775	\$7,225,451		\$7,675,437	\$773,997	\$50,235,479	\$44,168,389		\$143,614,725
New Hampshire	\$1,932,322	\$4,327,171	\$283,077	\$5,370,707	\$277,673	\$24,417,758	\$12,670,698		\$70,744,983
New Jersey	\$7,504,430	\$11,008,084	\$1,112,760	\$16,927,878	\$1,050,990	\$117,393,566	\$104,895,901	\$1,000,000	\$325,300,258
New Mexico	\$4,596,992	\$7,257,762	\$1,481,660	\$6,958,927	\$375,666	\$37,416,410	\$36,909,939		\$128,449,197
New York	\$21,988,230	\$21,905,714	\$5,237,945	\$40,222,710	\$5,662,860	\$283,091,984	\$308,961,624	\$21,894,633	\$929,068,433
North Carolina	\$8,485,691	\$16,866,560	\$3,063,114	\$15,601,710	\$1,074,356	\$137,279,686	\$160,999,025		\$437,341,472
North Dakota	\$2,099,747	\$2,437,682		\$5,210,000	\$588,553	\$17,329,280	\$8,947,057		\$51,580,697
Ohio	\$11,724,614	\$24,042,161	\$3,437,022	\$18,328,130	\$1,165,543	\$145,440,442	\$151,346,877		\$427,839,851
Oklahoma	\$3,129,547	\$8,145,858	\$50,000	\$8,008,571	\$532,150	\$66,789,061	\$71,352,307		\$195,344,894
Oregon	\$6,589,090	\$9,283,888	\$1,867,457	\$8,466,536	\$720,505	\$62,742,205	\$42,418,510		\$174,851,574
Pennsylvania	\$13,877,093	\$23,454,387	\$3,050,069	\$20,019,413	\$1,480,281	\$173,479,346	\$152,227,305		\$483,901,640
Rhode Island	\$2,408,786	\$7,948,187		\$5,710,743	\$264,535	\$23,314,099	\$17,117,284		\$85,401,584
South Carolina	\$2,648,002	\$7,179,645		\$10,499,488	\$626,428	\$72,679,857	\$81,451,027		\$229,349,059
South Dakota	\$1,589,186	\$3,466,195		\$5,493,952	\$249,624	\$21,616,767	\$11,269,283		\$62,147,350
Tennessee	\$9,374,786	\$13,590,769	\$828,503	\$12,032,654	\$790,440	\$102,415,166	\$108,523,680		\$307,906,733
Texas	\$24,281,710	\$17,336,088	\$4,304,181	\$43,765,264	\$3,485,290	\$402,352,407	\$616,936,504		\$1,276,679,298
Utah	\$3,174,925	\$6,283,180	\$2,795,060	\$7,233,853	\$406,478	\$40,530,031	\$30,349,934		\$134,602,738
Vermont	\$2,051,661	\$5,680,290		\$5,497,162	\$225,977	\$15,955,192	\$8,062,458		\$54,336,106
Virginia	\$5,790,496	\$13,382,743	\$1,008,542	\$17,614,956	\$8,177,810	\$185,729,488	\$94,078,705		\$425,564,280
Washington	\$11,932,306	\$15,587,269	\$4,621,091	\$13,364,241	\$1,118,692	\$95,258,508	\$96,084,099		\$329,560,881
West Virginia	\$1,097,287	\$7,399,418	\$508,000	\$5,504,439	\$336,381	\$31,380,117	\$24,946,455		\$92,725,349
Wisconsin	\$4,429,634	\$12,077,838	\$2,810,511	\$12,412,034	\$648,515	\$84,660,795	\$52,420,129		\$222,274,471
Wyoming	\$1,453,522	\$2,957,506		\$5,205,186	\$219,996	\$17,331,013	\$6,053,226		\$45,886,088
<b>United States</b>	<b>\$371,259,425</b>	<b>\$606,383,804</b>	<b>\$100,696,941</b>	<b>\$659,310,702</b>	<b>\$104,522,185</b>	<b>\$4,923,997,943</b>	<b>\$4,722,709,124</b>	<b>\$23,654,388</b>	<b>\$14,891,181,480</b>

Note: The U.S. total reflects grants and cooperative agreements awarded to all 50 states and the District of Columbia. It does not include funding allocated to territories, localities, or tribes to ensure comparability.

Source: CDC Grant Funding Profiles<sup>110</sup>

## Broader federal funding landscape

While CDC serves as the primary federal public health agency, its efforts are supported and complemented by several other federal agencies within and outside HHS. These agencies work collaboratively, enabling a broad approach to the health challenges facing the nation.

### Health Resources and Services Administration

**HRSA** plays a critical role in improving access to healthcare services for people who are geographically isolated or economically or medically vulnerable. This agency's efforts in health workforce education and training, health systems enhancements, and increasing patient access to healthcare help bolster public health capabilities across the country. In FY 2024, HRSA's funding level of \$8.9 billion represents a decrease of \$577 million from the previous year's \$9.5 billion.<sup>111</sup>

### Substance Abuse and Mental Health Services Administration

**SAMHSA** advances the nation's behavioral health. Its programs prioritize treatment and recovery approaches for individuals with mental and substance use disorders. As public health challenges like the opioid epidemic and mental health crises increase, the importance of SAMHSA's work has become increasingly prominent. The funding for FY 2024, \$7.45 billion, was a \$70 million decrease from FY 2023.<sup>112</sup>

### Food and Drug Administration (FDA)

The **FDA** ensures the safety of food and drugs, which directly impacts public health. Its regulatory roles include overseeing the manufacture and distribution of drugs, biological products, medical devices, cosmetics, and tobacco products, and ensuring food safety and security. The FDA's total FY 2024 budget authority is \$3.6 billion, slightly below what it was in FY 2023.<sup>113</sup>

### Agencies Outside HHS

Beyond HHS, many federal departments are assisting in promoting health by addressing social determinants of health, such as access to safe housing, adequate nutrition, and clean air and water.

- **USDA** manages nutritional programs that affect public health through food security, such as SNAP, WIC, and school lunch programs.
- **EPA** plays a critical role in protecting human health and the environment. It regulates air quality, water quality, and chemical safety, areas that have significant public health implications.
- **HUD** contributes significantly to public health through its housing policies and programs, which have profound impacts on community health outcomes. In addition to its efforts to improve housing conditions and reduce homelessness, HUD also addresses environmental health hazards within homes, such as lead exposure and poor air quality.

## State and Local Public Health Funding

The United States public health system is a complex network of federal, state, local, tribal, and territorial agencies that work together to protect and promote the health of the nation. At the federal level, agencies provide leadership, guidance, and funding to support public health initiatives nationwide. These agencies set national health priorities, conduct research, and develop evidence-based guidelines and policies.

State and territorial health agencies play a dual role: they serve as a link between federal agencies and local health departments, while also working directly on the front lines alongside local agencies. They are responsible for allocating federal funds, implementing statewide and territory-wide policies and programs, and providing technical assistance and support to local agencies. Additionally, state health departments may be actively involved in community-level interventions and programs. Tribal health departments work in concert with federal and state agencies but operate under the sovereignty of their respective tribes, tailoring public health initiatives to meet the cultural and specific needs of their communities. Local health departments, which are typically county or city-based, are on the front lines, directly serving their communities through a variety of programs and services. When it is operating effectively, this multi-tiered structure allows for a coordinated approach to public health, with each level playing a distinct yet interconnected role. The structure leverages centralized resources and expertise while enabling local, tribal, and territorial flexibility and adaptability.

Within this system, state, local, tribal, and territorial health agencies work to promote and protect the health and well-being of the communities they serve. These agencies are responsible for a wide range of essential public health functions, including disease surveillance, health education, immunization programs, environmental health services, and emergency preparedness and response. They collaborate with community partners, healthcare providers, and other stakeholders to assess and address the unique health needs of their populations, with a focus on preventing chronic diseases, reducing health disparities, and promoting health equity. By implementing evidence-based interventions, developing and enforcing public health policies, and providing critical services to those in need, state and local health agencies play a vital role in ensuring that all individuals have the opportunity to live healthy lives.

Federal funding is critical to the capacity and effectiveness of state and local health departments. These agencies rely heavily on federal grants and cooperative agreements to support a wide range of programs and services. When federal funding is inadequate, inconsistent, or subject to budget cuts, it can undermine the ability of state and local health departments to maintain essential services, respond to emergencies, and address emerging health threats. Insufficient federal support can lead to staff layoffs, program reductions, and diminished capacity to serve under-resourced populations, ultimately weakening the nation's public health infrastructure

and leaving communities more susceptible to health risks. Conversely, robust and sustained federal investment in state and local public health enables these agencies to build and maintain a skilled workforce, modernize data systems, and implement innovative strategies to promote health and health equity.

In addition to federal and state funding, state and local health departments also derive substantial portions of their budgets from their own revenue streams, such as state taxes, local levies, fees, and third-party reimbursements. The level of funding that states and localities allocate to public health can have a significant impact on the capacity and effectiveness of their health departments. When state and local funding is robust and consistent, health departments are better equipped to meet the needs of their communities and they gain flexibility to address specific priorities that may not be fully covered by federal programs. However, when state and local budgets are strained or public health funding is deprioritized, it can lead to reduced services, understaffing, and a limited ability to address emerging health challenges. This can be particularly detrimental during times of crisis, such as the COVID-19 pandemic, when health departments are called upon to mount a rapid and comprehensive

response. Ultimately, a strong and resilient public health system requires a combination of adequate and sustained funding from both federal and state/local sources.

In recent years, federal sources were the primary funders for several key state health agency programs and services, including the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC), chronic and infectious disease prevention and control initiatives, and public health emergency preparedness and response activities.<sup>114</sup> In contrast, state sources played a larger role in funding injury prevention programs, environmental health services, administrative functions, and quality-improvement efforts within state health agencies. This breakdown highlights the important interplay between federal and state funding in supporting a wide range of public health activities.

Zooming in on funding supported by states' own revenues (i.e., state-generated revenue from taxes, fees, third-party reimbursements, etc.), at least 37 states and the District of Columbia either maintained or increased their public health funding in FY 2023, as indicated in Table 3. Nonetheless, at least 11 states reduced their funding, potentially compromising their services and preparedness for critical situations. (Data were not available for two states.)

**TABLE 3: STATE PUBLIC HEALTH FUNDING HELD STABLE OR INCREASED IN AT LEAST 37 STATES AND DC**  
Funding by state FY 2022 to 2023

State	FY 2023 Funding	Change from prior year
Alabama	\$263,287,972	▲
Alaska	\$64,418,952	▼
Arizona	\$207,373,903	▲
Arkansas	\$136,766,941	▼
California	\$3,285,985,000	▼
Colorado	\$431,843,503	▲
Connecticut	\$148,028,800	▲
Delaware	\$51,492,300	▲
District of Columbia	\$283,955,264	▲
Florida	\$494,027,569	▲
Georgia	\$379,950,092	▲
Hawaii	\$108,761,695	▲
Idaho	\$85,779,300	▼
Illinois	\$544,606,900	▲
Indiana	\$103,590,532	▼
Iowa	\$119,222,212	▲
Kansas	\$93,325,089	▲
Kentucky	\$181,031,172	▲
Louisiana	\$133,585,366	▲
Maine	\$62,150,861	▲
Maryland	\$1,170,828,542	▼
Massachusetts	\$900,614,572	▲
Michigan	\$388,926,200	▼
Minnesota	\$456,390,188	▲
Mississippi	\$50,314,251	▲
Missouri	\$41,211,456	▲
Montana	\$21,292,874	▲
Nebraska	\$88,166,806	▲
Nevada	Not reported	Not reported
New Hampshire	\$33,319,186	▲
New Jersey	\$398,799,000	▲
New Mexico	\$496,109,500	▲
New York	\$1,966,367,471	▲
North Carolina	\$177,645,131	▲
North Dakota	\$56,283,518	↔
Ohio	\$349,346,148	▼
Oklahoma	\$267,563,211	▲
Oregon	\$771,415,283	▲
Pennsylvania	\$230,521,100	▲
Rhode Island	\$69,133,504	▼
South Carolina	\$152,741,314	▲
South Dakota	\$36,970,122	▲
Tennessee	\$511,633,400	▲
Texas	\$505,712,378	▼
Utah	\$118,077,900	▲
Vermont	\$39,949,928	▲
Virginia	\$408,737,966	▲
Washington	\$539,708,566	▲
West Virginia	Not reported	Not reported
Wisconsin	\$113,264,800	▼
Wyoming	\$19,452,254	▲

Note: Caution should be exercised when comparing across states due to variations in organizational responsibilities, budgeting practices, and fiscal structures that can affect public health funding data. For FY 2023, Nevada and West Virginia did not submit their public health funding data to TFAH. To understand the nuances and methodology behind the data collection, including TFAH's specific criteria for defining "public health funding," refer to the "Appendix B: Methodology" section of TFAH's 2024 Ready or Not report.<sup>115</sup>

Source: TFAH analysis of states' public health funding data.

In 2024, state and local public health departments are navigating a complex landscape, including significant fiscal cliffs created by the end or rescission of COVID-19 response funding.

State and local agencies often face significant challenges in maintaining and strengthening public health infrastructure, including the fundamental resources, systems, and capabilities needed to effectively deliver essential services and protect population health. This includes a skilled and sufficient workforce, up-to-date data and information systems, adequate laboratory capacity, and strong organizational and communication networks. Chronic underfunding, particularly during periods between public health emergencies, has led to workforce shortages, outdated technology and data systems, and limited surge capacity during crises.

With respect to workforce capacity, state and local public health agencies often struggle with recruitment and retention. This has had serious consequences, as 76 percent of local health departments report that inadequate staffing levels hindered the effectiveness, scale, or quality of their COVID-19 response—the largest reported obstacle by a significant margin.<sup>116</sup> The pandemic has exacerbated these challenges, leading to high levels of burnout, turnover, and even threats and harassment against public health officials.<sup>117,118,119,120,121,122</sup> Experts estimate that state and local health departments need to increase their workforce by nearly 80 percent, equating to an additional 26,000 full-time equivalent positions at the state level and 54,000 full-time equivalent positions at the local level.<sup>123</sup>

## PRESIDENTIAL ADVISORS CALL FOR STRENGTHENING THE PUBLIC HEALTH WORKFORCE

A May 2023 report by the President’s Council of Advisors on Science and Technology<sup>124</sup> focused on rebuilding the U.S. public health system after the COVID-19 pandemic and emphasized the importance of investing in the public health workforce to achieve health equity. Key recommendations included:

- Establishing a common lexicon and standardized classification system for the public health workforce to enable better data collection, resource allocation, and workforce development.
- Expanding recruitment, retention, and training efforts for public health careers through an all-of-government campaign, including direct hiring authority, loan repayment and forgiveness options, and personnel exchanges between federal, state, tribal, and territorial health officials, as well as the private sector.
- Supporting community health workers with sustainable career pathways and fostering a national community of practice focused on scientifically informed, community-engaged practices for health equity.



These are concerning circumstances, but there are reasons for hope. First, in recent years, several states, including Colorado, Georgia, Oklahoma, Oregon, and Utah, enacted laws to protect public health workers from harassment or threats of violence, thus strengthening and adding to the legal protections that exist in at least 35 states and the District of Columbia.<sup>125</sup> Additionally, the \$7.4 billion included in the American Rescue Plan Act to hire and train public health workers was a positive step.<sup>126,127</sup> Another positive development was the adoption of the Public Health Workforce Loan Repayment Program as part of the Consolidated Appropriations Act of 2023, which allows the establishment of a federal loan repayment program to support recruitment and retention.<sup>128</sup> However, these loan repayment incentives must be funded by Congress to be implemented.

Another bright spot in the area of public health infrastructure has been notable efforts in recent years to address the challenges related to outdated technology and data systems. The COVID-19 pandemic has highlighted the critical importance of having modern, interoperable, and secure data infrastructure to support real-time decision-making, disease surveillance, and response coordination. In 2019, CDC invested first-time dollars in Public Health Data Modernization, a multiyear effort to upgrade public health data systems and technology at the federal, state, and local levels.<sup>129</sup> Data modernization aims to improve data quality, timeliness, and accessibility; enhance data analytics and visualization capabilities; and strengthen data security and privacy protections. In addition to annual funding, the Coronavirus Aid, Relief,

and Economic Security (CARES) Act and the American Rescue Plan Act provided significant funding to support public health data-modernization efforts, including grants to state and local health departments for technology upgrades and data-integration projects.

CDC's updated Public Health Data Strategy for 2024–2025<sup>130</sup> and its 2023 Lookback Report<sup>131</sup> demonstrate significant progress in modernizing public health data systems and lay out a roadmap for continued improvement. The strategy's focus on accelerating the adoption of electronic case reporting (eCR), connecting public health to health IT systems, expanding core data sources, and prioritizing data to address health disparities aligns with the pressing need to enhance public health infrastructure and reduce health inequities. The 2023 achievements—such as the increased implementation of eCR in healthcare facilities, including in critical-access hospitals in rural areas, and the launch of the Respiratory Virus Data Channel, a tool on CDC's website that provides up-to-date data visualizations and findings for COVID-19, influenza, and respiratory syncytial virus—highlight the potential of modern data systems to improve real-time disease surveillance, outbreak response, and public communication. As state and local health departments work to leverage these advancements, sustained federal funding and technical assistance will be critical to ensure equitable access to these tools and build long-term capacity for data modernization.

Perhaps most significantly, CDC is administering the groundbreaking Public Health Infrastructure Grant program in partnership with three national organizations: the Association

of State and Territorial Health Officials, the National Network of Public Health Institutes, and the Public Health Accreditation Board.<sup>132</sup> The five-year grant program is intended to help state, local, and territorial public health agencies build the size and diversity of their workforce, modernize their data systems, and enhance their capabilities.<sup>133</sup>

The Public Health Infrastructure Grant represents a major opportunity for state and local health departments to address longstanding infrastructure gaps and build the foundational capabilities needed to deliver essential public health services and respond to emerging health threats. By providing flexible funding and technical assistance across a broad range of infrastructure areas, the program can support health departments in developing a more skilled and diverse workforce, implementing modern data systems, and strengthening community partnerships and engagement. Importantly, the program's emphasis on equity and accountability can help ensure that infrastructure investments are targeted to address health disparities and improve outcomes for underserved communities. As the program continues its implementation, it will be critical for CDC and its partners to provide ongoing guidance and support to grantees, share best practices and lessons learned, and evaluate the impact of infrastructure investments on public health capacity and performance. With sustained funding and effective implementation, the Public Health Infrastructure Grant program has the potential to meaningfully improve the U.S. public health system and better position state and local health departments to protect and promote the health of all communities.

## Recommended Policy Actions

To improve the health and well-being of all U.S. residents, reduce healthcare costs and health disparities, and protect the nation's health, economic, and national security, TFAH recommends that Congress and the Administration take the following actions.

### Modernize and Strengthen Public Health Systems in Every Community

**Protect and increase overall funding for CDC and public health to save lives nationwide.** TFAH supports providing sustained, predictable annual appropriations for CDC of at least \$11.5 billion in FY 2025. More than 80 percent of CDC funding is allocated to state, local, territorial, and tribal health departments, among other external partners, to implement evidence-based public health and prevention programs. Many proven, evidence-based public health and prevention programs, including programs aimed at preventing the leading causes of death and drivers of healthcare costs, have yet to reach all 50 states due to underfunding. Similarly, state, local, tribal, and territorial lawmakers should prioritize public health funding to ensure workforce retention and avoid the boom-and-bust cycle of public health support.

**Ensure continuous improvement of public health infrastructure systems.** The nation's public health system is built on an infrastructure that is insufficient due to chronic underfunding. TFAH supports sustained funding for the people and systems needed to provide essential services. Public health experts estimate an increase of \$4.5 billion per year is necessary to enable health departments to develop foundational capabilities of public health.<sup>134</sup> Sustained and predictable funding to build critical infrastructure, as proposed in the Public Health Infrastructure Saves Lives Act, would ensure more effective emergency responses, faster disease detection, and continuous progress toward preventing chronic conditions. In the meantime, Congress should provide at least \$1 billion in annual investment in CDC's **Public Health Infrastructure** program, which is already yielding important progress in strengthening the foundations of public health. Together with

investments in workforce and data, these grants will lead to more effective responses to emerging threats and improved health outcomes.

**Invest in sustained public health data modernization to detect and contain outbreaks and emerging threats.** TFAH and partners recommend that Congress provide at least \$340 million in FY 2025 for **Public Health Data Modernization** at CDC to modernize and sustain the data infrastructure at CDC and at state, local, tribal, and territorial health departments. This initiative enables real-time and actionable data to improve responses to epidemics and to improve the effectiveness of related programs. Investments to date are already yielding benefits, such as faster case reporting and reduced staff hours needed. The Data: Elemental to Health campaign estimates that at least \$7.84 billion is needed over five years to strengthen public health data systems at the state and local levels.<sup>135</sup> Congress should also support next-generation disease detection and forecasting through CDC's **Advanced Molecular Detection** program, **National Wastewater Surveillance System**, and the **Center for Forecasting and Outbreak Analytics**. These programs face significant reductions in services without increased base appropriations.

**Fund CDC to support state and local public health laboratories and epidemiology.** Congress should increase funding to strengthen the **Epidemiology and Laboratory Capacity Program** across the country. Currently, funding for the Epidemiology and Laboratory Capacity grant meets fewer than half the needs of laboratories and health department epidemiologists nationwide, with little funding allocated for cross-cutting systems and workforce.<sup>136</sup>

**Bolster recruitment and retention of the public health workforce.** Congress can support recruitment and retention of a well-trained and sufficient public health workforce by funding HRSA's **Public Health Workforce Loan Repayment Program** and CDC's **Public Health Workforce Development** program. While emergency supplemental funding can help with short-term staffing needs for discrete response requirements, it cannot be used to recruit and retain the workforce in the long term. Funding for CDC's workforce line should include an additional \$100 million to continue the **Public Health AmeriCorps program**, which faces

a funding cliff that will effectively end the initiative. Public Health AmeriCorps has successfully recruited and trained future public health leaders to address health needs in underserved communities.

**Restore the Prevention and Public Health Fund and reject further cuts.** The Prevention Fund has made critical investments in every state, such as expanding vaccine access through CDC's Immunization Program, building laboratory capacity, and preventing chronic disease.<sup>137</sup> In addition to representing around 10 percent of CDC's budget each year, the Prevention Fund supports prevention

programs at the Administration for Community Living and SAMHSA. Despite funding critical work, the Prevention Fund has already been cut by \$12.95 billion from FY 2013 through FY 2029.

**Enact full-year appropriations bills.** Continuing resolutions, short-term funding, government shutdowns, and across-the-board cuts are all deeply harmful to public health. They do not allow for efficient, effective use of taxpayer dollars, or for the hiring and retention of skilled workers. Congress should pass full-year appropriations for HHS and other federal agencies.

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## Invest in the Nation's Health Security

**Strengthen the Public Health Emergency Preparedness (PHEP) program.** PHEP is the main federal program that supports domestic health security across the country for all types of natural disasters, biological threats, and man-made events. Congress should continue to restore funding to CDC's PHEP cooperative agreement program to \$1 billion in FY 2025 to ensure states, tribes, territories, and localities have the core capabilities necessary to respond to an escalating number and severity of emergencies. Increased funding would deploy epidemiologists in additional jurisdictions, advance laboratory capacity in states to keep up with current technologies and threats, and improve medical countermeasures as well as planning and response capabilities.

**Ready the healthcare system for disasters.** Congress should provide at least \$500 million to the **Health Care Readiness and Recovery program**, administered by the Administration for

Strategic Preparedness and Response (ASPR), the primary federal source of funding to help the healthcare delivery system prepare for and respond to disasters. Appropriations for this line, which includes Hospital Preparedness Program funding for 50 states as well as territories and cities, have been cut drastically from \$515 million in FY 2003 to \$305 million in FY 2024. The HPP supports multiple approaches to develop healthcare-system readiness, but limited funding has prevented some regions from fully developing this capacity. Among its outcomes, increased funding would expand readiness for cyber threats to the health system, address major gaps in preparedness, and build special pathogen-preparedness capacity across the United States.

**Support the vaccine infrastructure to reduce preventable infectious diseases.** Every year, the United States spends an estimated \$26.5 billion to treat four major vaccine-

preventable diseases among adults ages 50 and older.<sup>138</sup> Congress should increase support for immunization infrastructure, outbreak prevention, and outbreak response by appropriating at least \$1.1 billion in FY 2025 for the **National Immunization Program**. CDC's National Immunization Program supports state and local immunization programs that increase vaccine rates (including among underserved populations), respond to outbreaks, educate the public and providers, conduct surveillance, improve vaccine confidence, establish partnerships, and improve information systems.

**Prevent the threat of antimicrobial-resistant infections.** More than 2.8 million antimicrobial infections occur and more than 35,000 people die each year in the United States from infections that are resistant to drugs like antibiotics.<sup>139</sup> Congress should increase funding for innovative methods of preventing, detecting,

and containing outbreaks supported by the **Antimicrobial Resistance Solutions Initiative (ARSI)** at CDC. Through ARSI, CDC is investing in prevention measures in every state to strengthen lab capacity, track infections across healthcare systems, detect new threats, disrupt pathogens, coordinate prevention strategies, and educate healthcare providers on appropriate antibiotic use. As a result of recent investments, CDC launched a U.S.-based antimicrobial resistance lab network to detect resistant pathogens and prevent infections.<sup>140</sup>

**Create a Health Defense Operations budget designation to meet the challenges of public health emergencies.** The surge of short-term, time-limited funding in COVID-19 supplemental appropriations legislation was important for America's significant response needs, but it is not a sustainable source of funding to finance this country's preparedness requirements. Furthermore, thousands of competing priorities in the non-defense discretionary budget category continue to impede annual discretionary appropriations,

making it nearly impossible to invest in medium- to long-term pandemic prevention. Congress should create a **Health Defense Operations budget designation** to exempt specific health defense programs central to pandemic preparedness from the annual discretionary budget allocations and ensure these critical activities receive sustainable resources necessary to secure Americans' health and economic and national security.<sup>141</sup>

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## Address Health Disparities and Root Causes of Disease

**Advance health equity by addressing community-wide social determinants of health.** Nonmedical factors, such as housing, employment, transportation, food security, and education have a major influence on individual and community health.<sup>142</sup> Indeed, these factors are estimated to contribute as much as 80 to 90 percent toward a person's health outcomes, while traditional healthcare only accounts for 10 to 20 percent.<sup>143</sup> For FY 2025, TFAH urges Congress to fund CDC's **Social Determinants of Health** program at \$100 million to invest in addressing conditions that affect the health and livelihoods of communities and prevent disease.<sup>144</sup> The funding would support local, state, and tribal efforts to coordinate multisectoral partnerships to identify and address the most pressing nonmedical factors influencing health in their communities and make healthy choices the easy choice.

**Direct funding to community-led initiatives to reduce health disparities.** Congress should appropriate at least

\$102.5 million for CDC's **Racial and Ethnic Approaches to Community Health (REACH)** and **Healthy Tribes** programs in FY 2025. Within this total, TFAH recommends including at least \$75.5 million for the REACH grant program to allow it to scale up so that all eligible and approved but currently unfunded communities can be funded. The REACH program explicitly focuses on improving chronic disease outcomes and health equity for specific racial and ethnic groups in communities with high incidence rates for such diseases. REACH grantees successfully partnered with trusted community leaders to decrease rates of smoking, reduce obesity, increase fruit and vegetable consumption, and improve healthy behaviors. In addition, Congress should allocate \$27 million for Healthy Tribes to expand the three programs under this funding line: Good Health and Wellness in Indian Country, Tribal Epidemiology Centers for Public Health Infrastructure, and Tribal Practices for Wellness in Indian Country. Healthy Tribes initiatives

provide tribal leaders with resources, technical assistance, and evidence-based policies so that each grantee can then create chronic disease prevention programs that center tribal history, traditions, and beliefs.

**Focus funding on populations at elevated risk due to the impact of structural racism, poverty, systemic discrimination, and disinvestment.** Communities disadvantaged by systemic discrimination, including those living with health disparities as part of systemic marginalization, must be a priority for funding and investment. Federal health agencies should consider disease burden and social context when determining grant-making eligibility criteria and enable capacity-building funding so the communities with the greatest need can access and benefit from competitive grants. Congress and federal agencies should ensure funding is reaching under-resourced, marginalized, and disproportionately impacted communities.

## Promote Health and Prevent Chronic Diseases Across the Lifespan

**Significantly increase investments in chronic disease prevention.** Six in 10 adults in the United States live with a chronic disease,<sup>145</sup> and just over one in three young adults ages 17 to 24 exceed the weight limits to serve in the U.S. military.<sup>146</sup> Chronic diseases are the leading causes of death and disability and, along with mental health conditions, account for an estimated 90 percent of the nation's \$4.5 trillion annual health costs.<sup>147</sup> Many of these conditions could be prevented or managed with cost-effective community interventions and patient support. Congress should counteract years of underfunding of CDC's **National Center for Chronic Disease Prevention and Health Promotion**. Under current funding, CDC cannot provide adequate resources to all eligible states or communities, including states that already have high rates of disease.

**Expand obesity prevention to all states through CDC's Division of Nutrition, Physical Activity and Obesity.** Congress should allocate at least \$130 million in FY 2025 to **CDC's Division of Nutrition, Physical Activity and Obesity** to allow CDC to continue building out key programs, including extending the State Physical Activity and Nutrition program (SPAN) program to all 50 states, U.S. territories, and tribal communities. SPAN enables states to implement evidence-based strategies to improve overall health and prevent the

obesity epidemic, but it currently only supports 17 out of 50 eligible states.<sup>148</sup> SPAN grantees focus their efforts on increasing breastfeeding support, disseminating food-service guidelines, promoting community physical-activity access strategies, and integrating both nutrition and physical activity standards into statewide early care and education systems. This funding level would also enable CDC's Active People, Healthy Nation to provide technical assistance to small, rural, and underfunded communities to access active transportation grant funding from the Bipartisan Infrastructure Law.

**Support Age-Friendly Public Health Systems.** Congress should provide at least \$50 million for CDC to build state, local, tribal, and territorial public health department capacity to promote the health of older adults. Age-Friendly Public Health System interventions can optimize the well-being of adults ages 65 or over, prolong their independence, and reduce their use of expensive healthcare services. Public health's role in improving health across the lifespan is being recognized, leading to a growing number of collaborations between the public health and aging-services sectors. Increased funding is needed to ensure public health capacity and capability to address the unique needs of older adults, such as social isolation and loneliness, and access to healthy food and transportation.

## Invest in Primary Prevention of Behavioral Health Concerns and Deaths of Despair

**Expand Comprehensive Suicide Prevention to all states.** According to CDC data, the number of suicides—over 49,000 deaths—increased in 2022 to historic peak levels after slight declines in 2019 and 2020.<sup>149,150</sup> The highest age-adjusted suicide rate in 2022 was for American Indian and Alaska Native (AI/AN) people, and rates for men in all age groups over 34 increased from 2021 to 2022, with significant increases for those ages 45–54 and 55–64.<sup>151</sup> Congress should appropriate at least \$80 million for CDC’s **Comprehensive Suicide Prevention** program, which funds states, territories, and tribes to implement comprehensive suicide-prevention plans using multisector partnerships and data to inform prevention efforts with the goal of reducing suicide by 20 percent by 2025.<sup>152</sup> The Comprehensive Suicide Prevention program also aims for a 10 percent reduction in suicide and suicide attempts among populations that are disproportionately affected by suicide, including veterans and rural communities.

**Increase resources to prevent and mitigate Adverse Childhood Experiences (ACEs).** ACEs, such as child abuse and neglect, can have profound lifetime impacts on behavioral and physical health. A 2021 review found an association between ACEs and the development and severity of substance use disorder.<sup>153</sup> Prevention of ACEs can have significant benefits: CDC estimates that the prevention of ACEs could avoid 21 million cases of depression and up to 1.9 million cases of heart disease among adults.<sup>154</sup> CDC research also shows that creating and sustaining safe, stable, nurturing relationships and environments for all children

and families can prevent ACEs and help children reach their full health and life potential. Congress should provide at least \$33 million in FY 2025 to expand CDC’s **Adverse Childhood Experiences** prevention program to up to 30 new states, territories, tribes, and localities to implement prevention strategies in their communities. CDC takes a comprehensive public health approach to preventing ACEs by building the evidence base through research and evaluation, supporting data innovation, identifying strategies, and improving capacity and awareness to prevent ACEs across the country.

**Expand school-based services to reduce risk among youth.** Congress should increase funding for CDC’s **Division of Adolescent and School Health** (DASH) program to \$100 million in FY 2025. DASH funds local education agencies to implement school-based programs and practices designed to improve health education, increase access to health services, and institute strategies to improve school connectedness and parent engagement.<sup>155</sup> In an action guide released in December 2023, for

example, DASH outlined strategies to promote mindfulness and build relationships and social skills among students.<sup>156</sup> DASH programs reduce risk behaviors, among other positive outcomes, for less than \$10 per student.<sup>157,158</sup> In fact, studies released in January and February 2022 found that these programs resulted in significant decreases in sexual risk behaviors, violent experiences, and substance use.<sup>159,160</sup> DASH programs currently reach approximately 2 million—or around 7 percent—of the nearly 30 million middle and high school students as of fall 2022.<sup>161,162</sup> An increase in DASH funding to \$100 million would allow these programs to expand to all 50 states and 75 of the largest local education agencies, reach 25 percent of all students, and help equip more children and adolescents with protective factors that will enable them to become healthy adults. Findings that CDC released in February 2023, showing increasing levels of poor mental health for nearly all groups of youth, underscore the importance of this work.<sup>163</sup>



## Prepare for and Prevent the Health Impacts of Environmental Threats

**Prepare for and mitigate the health impacts of climate change, extreme weather, and other environmental health threats.** Congress should increase overall funding for CDC's **National Center for Environmental Health** and other federal agencies that protect against environmental health risks. Programs that protect people from threats such as lead, toxic chemicals, extreme heat, and flooding need support to reach communities at highest risk. These programs include:

- **Environmental Health Tracking.** Congress should increase funding to \$65 million to extend CDC's **National Environmental Public Health Tracking Network** to every state. The network helps states collect key data around environmental health threats and target interventions to save lives. Through the network, states monitor water quality from wells used for drinking water, check levels of mercury in popular fishing areas, measure air quality from wildfires, and track the impact of smoke from wood-burning stoves. The program has an estimated return on investment of \$1.44 for every dollar invested in healthcare costs alone.<sup>164</sup> The network also partners with the Climate and Health Program and National Oceanic and Atmospheric Administration on the Heat and Health Tracker, a national resource that provides local heat and health information so communities can better prepare for and respond to extreme heat events.



- **Climate and Health Program.** The administration and Congress should increase funding to \$110 million to expand CDC's **Climate and Health Program** to improve climate readiness in every state, large city, tribe, and territory. Due to funding limitations, only 13 entities (including state health departments, local health departments, and academic institutions) are grantees of CDC's Climate and Health Program through the Climate-Ready States and Cities Initiative.<sup>165</sup> This initiative provides these communities with assistance to implement CDC's Building Resilience Against Climate Effects (BRACE) framework. The BRACE framework can help jurisdictions identify likely climate impacts, potential health impacts, and high-risk populations and locations, and it can create and

implement adaptation plans. This level of funding would allow CDC to reach all states and territories, and to offer more scientific and epidemiological studies and resources on climate change and related health outcomes. Additionally, CDC would be better equipped to evaluate the grantees' work in order to identify and share best practices with communities nationwide.

- **Support infrastructure to respond to environmental disasters.** Congress should provide at least \$100 million in funding for the **Agency for Toxic Substances and Disease Registry (ATSDR)**. ATSDR's expertise and ability to respond around the clock have been critical in supporting responses to events like the East Palestine, Ohio, train derailment, Canadian wildfire

smoke, and contamination from per- and polyfluoroalkyl substances (PFAS). ATSDR supports the ATSDR Partnership to Promote Local Efforts to Reduce Environmental Exposure (APPLETREE) cooperative agreement, which expands the environmental health capacity in state health departments, allowing them to do critical work to identify if and how people are exposed to hazardous substances and make recommendations to prevent and address those exposures.

- **Coordinate efforts to address the impact of climate change on health through the HHS Office of Climate Change and Health Equity.** Congress should allocate \$5 million for HHS's **Office of Climate Change and Health Equity** (OCCHE) to support its mission of serving as a hub for climate and health policy in pursuit of equitable health outcomes. OCCHE coordinates and aligns agency-wide programs to develop climate and health resilience for disproportionately affected populations, climate actions to reduce health disparities, and health-sector resilience and environmental harm reduction. To date, OCCHE has not received appropriations from Congress, creating challenges such as a lack of staffing stability and difficulty engaging in long-term planning. Dedicated congressional funding would allow OCCHE to coordinate and align agency-wide programs

to develop climate and health resilience for disproportionately affected populations.

- **National Asthma Control Program.** Congress should increase funding to \$40 million for the **National Asthma Control Program**. About 26 million Americans have asthma, including one in 10 school-aged children.<sup>166</sup> Asthma is a leading chronic illness among children and adolescents in the United States and one of the leading causes of school absenteeism. It disproportionately affects low-income populations, communities of color, and children living in metropolitan areas, leading to more emergency department visits, hospitalizations, and deaths in these groups compared with the general population.<sup>167</sup> It is responsible for approximately \$50 billion annually in healthcare costs, \$3 billion in missed school and workdays, and \$29 billion from mortality.<sup>168</sup> The program currently supports 25 state, territorial, and local health departments in their efforts to reduce asthma morbidity and mortality.<sup>169</sup> These grantees work to improve asthma surveillance, provide asthma self-management education, and promote policies to reduce environmental asthma triggers. While the program has made significant strides, many jurisdictions remain unfunded. Expanding the program's reach could potentially improve asthma outcomes for many more U.S. residents.



# Closing Thoughts

While many of the initiatives described in this report represent important steps forward, sustained funding and long-term commitment will be essential to fully realize the potential of modern data systems, a larger public health workforce, and programs designed to address the social determinants of health and health equity. Moreover, there are troubling signs that the historical boom-and-bust pattern of only investing in public health during emergencies may continue. The Fiscal Responsibility Act (FRA) of 2023 rescinded unobligated COVID-19 supplemental funding from several public health agencies and programs, including the Public Health and Social Services Emergency Fund, CDC, and others.<sup>170</sup> This reduced support for public health workforce recruitment, training, and retention programs and decreased funding for state and local health departments.

The FRA's funding rescissions underscore the urgent need for a paradigm shift in public health financing, moving away from reactive, crisis-driven funding and toward sustained, predictable investments in core infrastructure and capabilities. Without this shift, the progress made through initiatives like Public Health Data Modernization and the Public Health Infrastructure Grant risks being undermined, leaving state and local health departments once again underprepared and under-resourced to address the next public health emergency.

Compounding these financial challenges is the growing erosion of public trust in public health institutions and expertise.<sup>171</sup> The politicization of public health measures during the COVID-19 pandemic, coupled with the spread of misinformation and

disinformation, has led to increased skepticism and hostility toward public health officials and agencies. This loss of trust not only undermines the effectiveness of public health interventions but also contributes to the burnout and attrition of the public health workforce.

Furthermore, in the wake of the pandemic, many states have considered or adopted legislation or regulatory measures to limit the authority of public health agencies.<sup>172,173</sup> These efforts threaten to hamstring the ability of public health officials to respond quickly and effectively to future emergencies.

Rebuilding public trust and support for public health will require a concerted effort by public health leaders, policymakers, and community partners to engage in transparent,

inclusive decision-making processes, communicate effectively with diverse audiences, and demonstrate the value and impact of public health interventions. This must be accompanied by a commitment to addressing the root causes of health inequities and ensuring that public health measures are implemented in a fair and equitable manner.

Investments in public health systems are investments in prevention and a healthier America. By investing in the foundational capabilities of public health infrastructure, engaging in meaningful community partnerships, and committing to equity, the United States can continue to build a public health system that is better equipped to meet the challenges of the 21st century and safeguard the health of all its residents.

## Endnotes

- 1 Centers for Disease Control and Prevention. “Fast Facts: Health and Economic Costs of Chronic Diseases.” May 15, 2024. [https://www.cdc.gov/chronic-disease/data-research/facts-stats/?CDC\\_AAref\\_Val=https://www.cdc.gov/chronicdisease/about/costs/](https://www.cdc.gov/chronic-disease/data-research/facts-stats/?CDC_AAref_Val=https://www.cdc.gov/chronicdisease/about/costs/). Accessed July 5, 2024.
- 2 Benjamin, Emelia J., Salim S. Virani, Clifton W. Callaway, et al. “Heart Disease and Stroke Statistics—2018 Update: A Report from the American Heart Association.” *Circulation*, 137(12): e67–e492, 2018. <https://www.ahajournals.org/doi/10.1161/CIR.0000000000000558>. Accessed July 5, 2024.
- 3 Centers for Disease Control and Prevention. “Chronic Disease.” <https://www.cdc.gov/chronic-disease/index.html>. Accessed July 5, 2024.
- 4 Centers for Disease Control and Prevention. “Underlying Medical Conditions Associated with Higher Risk for Severe COVID-19: Information for Healthcare Professionals.” Updated April 12, 2024. <https://www.cdc.gov/coronavirus/2019-ncov/hcp/clinical-care/underlyingconditions.html>. Accessed July 5, 2024.
- 5 Tomio, Jun, and Hajime Sato. “Emergency and Disaster Preparedness for Chronically Ill Patients: A Review of Recommendations.” *Open Access Emergency Medicine*, 6: 69-79, 2014. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4753992/>. Accessed July 5, 2024.
- 6 The White House. “Fact Sheet: The Bipartisan Infrastructure Deal.” November 6, 2021. <https://www.whitehouse.gov/briefing-room/statements-releases/2021/11/06/fact-sheet-the-bipartisan-infrastructure-deal/>. Accessed July 5, 2024.
- 7 Kirchhoff, Suzanne M. “Selected Health Provisions of the Inflation Reduction Act.” *Congressional Research Service, In Focus*, September 1, 2022. <https://crsreports.congress.gov/product/pdf/IF/IF12203>. Accessed July 5, 2024.
- 8 Centers for Disease Control and Prevention. “CDC-RFA-OE22-2203: Strengthening U.S. Public Health Infrastructure, Workforce, and Data Systems.” Grants.gov, August 15, 2022. <https://www.grants.gov/search-results-detail/340034>. Accessed July 5, 2024.
- 9 Centers for Disease Control and Prevention. “Public Health Infrastructure Grant.” March 14, 2024. [https://www.cdc.gov/infrastructure-phig/about/?CDC\\_AAref\\_Val=https://www.cdc.gov/infrastructure/phig/program-overview.html](https://www.cdc.gov/infrastructure-phig/about/?CDC_AAref_Val=https://www.cdc.gov/infrastructure/phig/program-overview.html). Accessed July 5, 2024.
- 10 Ibid.
- 11 Sekar, Kavya. “Public Health Funding and the Fiscal Responsibility Act of 2023.” *Congressional Research Service, Insight*, July 31, 2023. [chrome-extension://efaidnbmnmbpcjpcglclefindmkaj/https://crsreports.congress.gov/product/pdf/IN/IN12208](https://www.crsreports.congress.gov/product/pdf/IN/IN12208). Accessed July 5, 2024.
- 12 Ibid.
- 13 Centers for Medicare & Medicaid Services. “National Health Expenditure Data: Historical.” Updated December 13, 2023. <https://www.cms.gov/data-research/statistics-trends-and-reports/national-health-expenditure-data/historical>. Accessed July 5, 2024.
- 14 Trust for America’s Health. “The Prevention and Public Health Fund: Preventing Disease and Reducing Long-Term Health Costs.” September 2023. [https://www.tfah.org/wp-content/uploads/2023/09/PPHF\\_Backgrounder\\_September2023.pdf](https://www.tfah.org/wp-content/uploads/2023/09/PPHF_Backgrounder_September2023.pdf). Accessed July 5, 2024.
- 15 Centers for Disease Control and Prevention. “FY 2024 CDC Operating Plan.” <https://www.cdc.gov/budget/documents/fy2024/FY-2024-CDC-Operating-Plan.pdf>. Accessed July 5, 2024.
- 16 Centers for Disease Control and Prevention. “Tips Impact and Results.” Updated February 5, 2024. <https://www.cdc.gov/tobacco/campaign/tips/about/impact/campaign-impact-results.html>. Accessed July 5, 2024.
- 17 National Diabetes Prevention Program Coverage Toolkit. “Cost & Value.” May 3, 2024. <https://coveragetoolkit.org/cost-value-elements/>. Accessed July 5, 2024.
- 18 Trust for America’s Health. “Prevention and Public Health Fund Sign-On.” February 5, 2024. <https://www.tfah.org/wp-content/uploads/2024/02/PPHF-Sign-On-2-5-24.pdf>. Accessed July 5, 2024.
- 19 Trust for America’s Health. “What We Are Learning from COVID-19 About Being Prepared for a Public Health Emergency.” May 2020. <https://www.tfah.org/report-details/covid-19-policy-response-brief/>. Accessed July 5, 2024.
- 20 Trust for America’s Health. “The State of Obesity 2021: Better Policies for a Healthier America.” September 2021. <https://www.tfah.org/report-details/state-of-obesity-2021/>. Accessed July 5, 2024.
- 21 Mather, Mark, and Paola Scommegna. “Fact Sheet: Aging in the United States.” *Population Reference Bureau*, January 9, 2024. <https://www.prb.org/aging-united-states-fact-sheet/>. Accessed July 5, 2024.
- 22 DeSalvo, Karen, Anand Parekh, G. William Hoagland, et al. “Developing a Financing System to Support Public Health Infrastructure.” *American Journal of Public Health*, 109(10): 1358-1361, 2019. <https://ajph.aphapublications.org/doi/10.2105/AJPH.2019.305214>. Accessed July 5, 2024.
- 23 Centers for Disease Control and Prevention. “FY 2024 CDC Operating Plan.” <https://www.cdc.gov/budget/documents/fy2024/FY-2024-CDC-Operating-Plan.pdf>. Accessed July 5, 2024.
- 24 Centers for Disease Control and Prevention. “Operating Plans.” Updated May 15, 2024. <https://www.cdc.gov/budget/operating-plans/index.html>. Accessed July 5, 2024.
- 25 Centers for Disease Control and Prevention. “FY 2024 CDC Operating Plan.” <https://www.cdc.gov/budget/documents/fy2024/FY-2024-CDC-Operating-Plan.pdf>. Accessed July 5, 2024.
- 26 Congressional Research Service. “Public Health Service Agencies: Overview and Funding (FY2015-FY2017).” May 19, 2016. <https://crsreports.congress.gov/product/pdf/R/R44505>. Accessed July 5, 2024.
- 27 Centers for Disease Control and Prevention. “Pandemic All-Hazards Preparedness Act Reauthorization.” Congressional testimony, May 4, 2023. <https://www.cdc.gov/washington/testimony/2023/t20230504.htm>. Accessed July 5, 2024.
- 28 Trust for America’s Health. Direct communication with Centers for Disease Control and Prevention staff, June 3, 2024.
- 29 Centers for Disease Control and Prevention. “CDC Awards More Than \$3 Billion to Improve U.S. Public Health Workforce and Infrastructure.” Press release: November 29, 2022. <https://www.cdc.gov/media/releases/2022/p1129-cdc-infrastructure.html>. Accessed July 5, 2024.
- 30 Centers for Disease Control and Prevention. “Public Health AmeriCorps.” June 21, 2024. <https://www.cdc.gov/workforce/php/about/public-health-ameri-corps.html>. Accessed July 5, 2024.
- 31 AmeriCorps. “Public Health AmeriCorps.” <https://americorps.gov/serve/ameri-corps/ameri-corps-state-national/public-health-ameri-corps>. Accessed July 5, 2024.
- 32 Big Cities Health Coalition. “Public Health Works: The Power of Public Health Infrastructure Funding.” March 2024. [https://www.bigcitieshealth.org/wp-content/uploads/2024/03/BCHC\\_Infrastructure\\_PHBackground\\_2024\\_digital.pdf](https://www.bigcitieshealth.org/wp-content/uploads/2024/03/BCHC_Infrastructure_PHBackground_2024_digital.pdf). Accessed July 5, 2024.
- 33 Trust for America’s Health. Direct communication with Centers for Disease Control and Prevention staff, June 26, 2024.
- 34 Trust for America’s Health. Direct communication with Centers for Disease Control and Prevention staff, June 3, 2024.
- 35 Centers for Disease Control and Prevention. “CDC’s Bridge Access Program.” Updated May 10, 2024. <https://www.cdc.gov/vaccines/programs/bridge/index.html>. Accessed July 5, 2024.
- 36 Centers for Disease Control and Prevention. “FY 2024 CDC Operating Plan.” <https://www.cdc.gov/budget/documents/fy2024/FY-2024-CDC-Operating-Plan.pdf>. Accessed July 5, 2024.

- 37 Centers for Disease Control and Prevention. "Prevention and Public Health Fund." Updated June 22, 2021. <https://www.cdc.gov/funding/pphf/index.html>. Accessed July 5, 2024.
- 38 Prevention and Public Health Fund, 2006. 42 USC §300u-11(a). <https://www.govinfo.gov/app/details/USCODE-2010-title42/USCODE-2010-title42-chap6A-subchapXV-sec300u-11>. Accessed July 5, 2024.
- 39 Centers for Disease Control and Prevention. "National Tobacco Control Program Funding." Last reviewed November 2, 2023. <https://www.cdc.gov/tobacco/php/tobacco-control-programs/program-funding.html>. Accessed July 5, 2024.
- 40 Centers for Disease Control and Prevention. "Preventive Health and Health Services Block Grant." May 15, 2024. <https://www.cdc.gov/phhsblockgrant/index.htm>. Accessed July 5, 2024.
- 41 Trust for America's Health. "The Prevention and Public Health Fund: Preventing Disease and Reducing Long-Term Health Costs." *PPHF Background*, September 2023. [https://www.tfah.org/wp-content/uploads/2023/09/PPHF\\_Background\\_September2023.pdf](https://www.tfah.org/wp-content/uploads/2023/09/PPHF_Background_September2023.pdf). Accessed July 5, 2024.
- 42 Centers for Disease Control and Prevention. "Operating Plans." Updated May 15, 2024. <https://www.cdc.gov/budget/operating-plans/index.html>. Accessed July 5, 2024.
- 43 Centers for Disease Control and Prevention. "Public Health Emergency Preparedness Program and Guidance." February 12, 2024. <https://www.cdc.gov/readiness/php/phep/index.html>. Accessed July 5, 2024.
- 44 Sutton, Jill. "Public Health Emergency Preparedness (PHEP) Funding Program Marks 20 Years." *APHL Blog*, September 21, 2022. <https://www.aphlblog.org/public-health-emergency-preparedness-phep-funding-program-marks-20-years/>. Accessed July 5, 2024.
- 45 Centers for Disease Control and Prevention. "Emergency Preparedness Funding." May 30, 2024. <https://www.cdc.gov/readiness/php/data-research/emergency-preparedness-funding-map.html>. Accessed July 5, 2024.
- 46 Trust for America's Health. Direct communication with Centers for Disease Control and Prevention staff, June 7, 2024.
- 47 Centers for Disease Control and Prevention. "Operating Plans." Updated May 15, 2024. <https://www.cdc.gov/budget/operating-plans/index.html>. Accessed July 5, 2024.
- 48 Watson, Crystal R., Matthew Watson, and Tara Kirk Sell. "Public Health Preparedness Funding: Key Programs and Trends From 2001 to 2017." *American Journal of Public Health*, 107(S2): S165-S167, 2017. <https://ajph.aphapublications.org/doi/10.2105/AJPH.2017.303963>. Accessed July 5, 2024.
- 49 Administration for Strategic Preparedness and Response. "Hospital Preparedness Program (HPP)." <https://aspr.hhs.gov/HealthCareReadiness/HPP/Pages/default.aspx>. Accessed July 5, 2024.
- 50 Administration for Strategic Preparedness and Response. "Health Care Readiness in Action: Stories from the Field." <https://www.phe.gov/Preparedness/planning/hpp/events/Pages/default.aspx>. Accessed July 5, 2024.
- 51 Administration for Strategic Preparedness and Response. "Use of Hospital Preparedness Program Funds: COVID-19 Preparedness and Response." <https://aspr.hhs.gov/HealthCareReadiness/HPP/Pages/Use-of-Hospital-Preparedness-Program-Funds.aspx>. Accessed July 5, 2024.
- 52 Administration for Strategic Preparedness and Response. "Oklahoma Health Care Coalition Coordinates with Key Response Partners to Relocate Nursing Home Patients After Central Oklahoma Tornadoes." April 2023. <https://aspr.hhs.gov/HealthCareReadiness/StoriesfromtheField/Pages/Stories/OK-HCC-Coordinates-Nursing-Home-Relocation.aspx>. Accessed July 5, 2024.
- 53 Kliff, Sarah, and Margot Sanger-Katz. "Bottleneck for U.S. Coronavirus Response: The Fax Machine." *The New York Times*, July 13, 2020. <https://www.nytimes.com/2020/07/13/upshot/coronavirus-response-fax-machines.html>. Accessed July 5, 2024.
- 54 Hamilton, Janet J., Kathryn Turner, and Meredith Lichtenstein Cone. "Responding to the Pandemic: Challenges with Public Health Surveillance Systems and Development of a COVID-19 National Surveillance Case Definition to Support Case-Based Morbidity Surveillance During the Early Response." *Journal of Public Health Management and Practice*, 27(Supplement): S80-S86, January/February 2021. [https://journals.lww.com/jphmp/Fulltext/2021/01001/Responding\\_to\\_the\\_Pandemic\\_Challenges\\_With\\_Public.14.aspx](https://journals.lww.com/jphmp/Fulltext/2021/01001/Responding_to_the_Pandemic_Challenges_With_Public.14.aspx). Accessed July 5, 2024.
- 55 Branswell, Helen. "A Severe Flu Season Is Stretching Hospitals Thin. That Is a Very Bad Omen." *STAT*, January 15, 2018. <https://www.statnews.com/2018/01/15/flu-hospital-pandemics/>. Accessed July 5, 2024.
- 56 Shammas, Brittany, Ariana Eunjung Cha, Ben Guarino, and Jacqueline Dupree. "Record Numbers of COVID-19 Patients Push Hospitals and Staffs to the Limit." *The Washington Post*, December 16, 2020. <https://www.washingtonpost.com/health/2020/12/16/hospitals-covid-overwhelmed/>. Accessed July 5, 2024.
- 57 Popescu, Saskia, and Rebecca Leach. "Identifying Gaps in Frontline Healthcare Facility High-Consequence Infectious Disease Preparedness." *Health Security*, 17(2), April 26, 2019. <https://www.liebertpub.com/doi/10.1089/hs.2018.0098>. Accessed July 5, 2024.
- 58 National Academies of Sciences, Engineering, and Medicine. "2. Perspectives on the Nation's Capacity to Respond to Threats to Health, Safety, and Security." In: *Engaging the Private-Sector Health Care System in Building Capacity to Respond to Threats to the Public's Health and National Security*. Washington, DC: National Academies Press, March 2018. <https://nap.nationalacademies.org/read/25203/chapter/3>. Accessed July 5, 2024.
- 59 Infectious Diseases Rapid Response Reserve Fund, 2020. 42 USC 247d-4a. <https://uscode.house.gov/view.xhtml?req=granuleid:USC-prelim-title42-section247d-4a&num=0&edition=prelim#sourcecredit>. Accessed July 5, 2024.
- 60 U.S. Department of Health and Human Services. "FY 2025 Budget in Brief." <https://www.hhs.gov/sites/default/files/fy-2025-budget-in-brief.pdf>. Accessed July 5, 2024.
- 61 Dorans, Kirsten S., Elissa H. Wilker, Wenyuan Li, et al. "Residential Proximity to Major Roads, Exposure to Fine Particulate Matter, and Coronary Artery Calcium: The Framingham Heart Study." *Arteriosclerosis, Thrombosis, and Vascular Biology*, 36(8): 1679-1685, 2016. <https://www.ahajournals.org/doi/10.1161/ATVBAHA.116.307141>. Accessed July 5, 2024.
- 62 Navathe, Amol S., Feiran Zhong, Victor J. Lei, et al. "Hospital Readmission and Social Risk Factors Identified from Physician Notes." *Health Services Research*, 53(2): 1110-1136, April 2018. <https://www.ncbi.nlm.nih.gov/pubmed/28295260>. Accessed July 5, 2024.
- 63 Singh, Gopal K., Gem P. Daus, Michelle Allender, et al. "Social Determinants of Health in the United States: Addressing Major Health Inequality Trends for the Nation, 1935-2016." *International Journal of MCH and AIDS*, 6(2): 139-164, 2017. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5777389/>. Accessed July 5, 2024.
- 64 MacIntyre, Sally, and Anne Ellaway. "Ecological Approaches: Rediscovering the Role of the Physical and Social Environment." In: Berkman, Lisa, and Kawachi, Ichiro (eds.). *Social Epidemiology*. New York: Oxford University Press, 2000: 332-348. <https://academic.oup.com/book/55060/chapter-abstract/422873189?redirectedFrom=fulltext>. Accessed July 5, 2024.
- 65 Committee on Valuing Community-Based, Non-Clinical Prevention. "2. Community-Based Prevention." In: *An Integrated Framework for Assessing the Value of Community-Based Prevention Programs; Board on Population Health and Public Health Practice; Institute of Medicine*. Washington, DC: National Academies Press, 2012. <https://www.ncbi.nlm.nih.gov/books/NBK206935/>. Accessed July 5, 2024.
- 66 Magnan, Sanne. "Social Determinants of Health 101 for Health Care: Five Plus Five." *National Academy of Medicine*, October 9, 2017. <https://nam.edu/social-determinants-of-health-101-for-health-care-five-plus-five/>. Accessed July 5, 2024.

- 67 Smart Growth America. "Complete Streets." <https://smartgrowthamerica.org/what-are-complete-streets/>. Accessed July 5, 2024.
- 68 Centers for Disease Control and Prevention. "National Diabetes Prevention Program." [https://www.cdc.gov/diabetes-prevention/?CDC\\_AAref\\_Val=https://www.cdc.gov/diabetes/prevention/index.html](https://www.cdc.gov/diabetes-prevention/?CDC_AAref_Val=https://www.cdc.gov/diabetes/prevention/index.html). Accessed July 5, 2024.
- 69 National Diabetes Prevention Program Coverage Toolkit. "Cost & Value." May 3, 2024. <https://coveragetoolkit.org/cost-value-elements/>. Accessed July 5, 2024.
- 70 Centers for Disease Control and Prevention. "Improving Health in Appalachia." May 15, 2024. <https://www.cdc.gov/diabetes/health-equity/improving-health-appalachia.html>. Accessed July 5, 2024.
- 71 Centers for Disease Control and Prevention. "Native Diabetes Wellness Program." [https://www.cdc.gov/diabetes-ndwp/?CDC\\_AAref\\_Val=https://www.cdc.gov/diabetes/ndwp/index.html](https://www.cdc.gov/diabetes-ndwp/?CDC_AAref_Val=https://www.cdc.gov/diabetes/ndwp/index.html). Accessed July 5, 2024.
- 72 Appalachian Regional Commission. "Creating a Culture of Health in Appalachia: Mortality." 2021. [https://www.arc.gov/wp-content/uploads/2021/02/Health\\_Disparities\\_in\\_Appalachia\\_Mortality\\_Domain.pdf](https://www.arc.gov/wp-content/uploads/2021/02/Health_Disparities_in_Appalachia_Mortality_Domain.pdf). Accessed July 5, 2024.
- 73 Centers for Disease Control and Prevention. "Vital Signs: Native Americans with Diabetes." November 15, 2018. <https://archive.cdc.gov/#/details?url=https://www.cdc.gov/vitalsigns/aian-diabetes/index.html>. Accessed July 5, 2024.
- 74 Davis, Andy, Neal Batra, Asif Dhar, et al. "US Health Care Can't Afford Health Inequities." *Deloitte Insights*, June 22, 2022. <https://www2.deloitte.com/us/en/insights/industry/health-care/economic-cost-of-health-disparities.html>. Accessed July 5, 2024.
- 75 Centers for Disease Control and Prevention. "Hi-5 Health Impact in 5 Years." May 11, 2017. <https://stacks.cdc.gov/view/cdc/48459>. Accessed July 5, 2024.
- 76 The New York Academy of Medicine and Trust for America's Health. "A Compendium of Proven Community-Based Prevention Programs." 2013. <https://www.tfah.org/report-details/a-compendium-of-proven-community-based-prevention-programs/>. Accessed July 5, 2024.
- 77 Masters, Rebecca, Elspeth Anwar, Brendan Collins, et al. "Return on Investment of Public Health Interventions: A Systemic Review." *Journal of Epidemiology and Community Health*, 71(8): 827-834. <https://jech.bmj.com/content/71/8/827>. Accessed July 5, 2024.
- 78 Minnesota Management and Budget. "Substance Use Disorder Findings." <https://mn.gov/mmb/results-first/substance-use-disorder/>. Accessed July 5, 2024.
- 79 Community Preventive Services Task Force. "Reducing Tobacco Use and Secondhand Smoke Exposure: Mass-Reach Health Communication Interventions." 2015. [chrome-extension://efaidnbnmnnibpcajpccglcfeindmkaj/https://www.thecommunityguide.org/media/pdf/SET\\_Tobacco\\_MassReach.pdf](chrome-extension://efaidnbnmnnibpcajpccglcfeindmkaj/https://www.thecommunityguide.org/media/pdf/SET_Tobacco_MassReach.pdf). Accessed July 5, 2024.
- 80 Sundar S. Shrestha, Kevin Davis, Nathan Mann, et al. "Cost Effectiveness of the Tips from Former Smokers Campaign—United States, 2012–2018." *American Journal of Preventive Medicine*, 60(3): 406-410, March 2021. <https://pubmed.ncbi.nlm.nih.gov/33455819/>. Accessed July 5, 2024.
- 81 Centers for Disease Control and Prevention. "FY 2021 Operating Plan." <https://www.cdc.gov/budget/documents/fy2021/FY-2021-CDC-Operating-Plan.pdf>. Accessed July 5, 2024.
- 82 Centers for Disease Control and Prevention. "Operating Plans." Updated May 15, 2024. <https://www.cdc.gov/budget/operating-plans/index.html>. Accessed July 5, 2024.
- 83 Centers for Disease Control and Prevention. "Advancing Health Equity in Chronic Disease Prevention and Management: Getting Further Faster." Updated December 21, 2023. <https://www.cdc.gov/health-equity-chronic-disease/sdoh-and-chronic-disease/nccdp-hps-programs-to-address-social-determinants-of-health/getting-further-faster.htm>. Accessed July 5, 2024.
- 84 Centers for Disease Control and Prevention. "About Chronic Diseases." May 15, 2024. [https://www.cdc.gov/chronic-disease/about/?CDC\\_AAref\\_Val=https://www.cdc.gov/chronicdisease/about/index.htm](https://www.cdc.gov/chronic-disease/about/?CDC_AAref_Val=https://www.cdc.gov/chronicdisease/about/index.htm). Accessed July 5, 2024.
- 85 Raghupathi, Wullianallur, and Viju Raghupathi. "An Empirical Study of Chronic Diseases in the United States: A Visual Analytics Approach to Public Health." *International Journal of Environmental Research and Public Health*, 15(3): 431, 2018. <https://www.mdpi.com/1660-4601/15/3/431>. Accessed July 5, 2024.
- 86 Centers for Disease Control and Prevention. "Fast Facts: Health and Economic Costs of Chronic Diseases." May 15, 2024. [https://www.cdc.gov/chronic-disease/data-research/facts-stats/?CDC\\_AAref\\_Val=https://www.cdc.gov/chronicdisease/about/costs/](https://www.cdc.gov/chronic-disease/data-research/facts-stats/?CDC_AAref_Val=https://www.cdc.gov/chronicdisease/about/costs/). Accessed July 5, 2024.
- 87 Centers for Disease Control and Prevention. "Operating Plans." Updated May 15, 2024. <https://www.cdc.gov/budget/operating-plans/index.html>. Accessed July 5, 2024.
- 88 Centers for Disease Control and Prevention. "State Physical Activity and Nutrition (SPAN)." January 5, 2024. <https://www.cdc.gov/span/php/about/index.html>. Accessed July 5, 2024.
- 89 Ward, Zachary J., Sara N. Bleich, Michael W. Long, et al. "Association of Body Mass Index with Health Care Expenditures in the United States by Age and Sex." *PLOS ONE*, 16(3): e0247307, March 2021. <https://journals.plos.org/plosone/article?id=10.1371/journal.pone.0247307>. Accessed July 5, 2024.
- 90 Centers for Disease Control and Prevention. "About Chronic Diseases." May 15, 2024. [https://www.cdc.gov/chronic-disease/about/?CDC\\_AAref\\_Val=https://www.cdc.gov/chronicdisease/about/index.htm](https://www.cdc.gov/chronic-disease/about/?CDC_AAref_Val=https://www.cdc.gov/chronicdisease/about/index.htm). Accessed July 5, 2024.
- 91 Chakradhar, Shraddha. "More Than 15% of U.S. Adults Are Physically Inactive, New CDC Data Show." *STAT*, January 16, 2020. <https://www.statnews.com/2020/01/16/physical-inactivity-us-adults-cdc-data/>. Accessed July 5, 2024.
- 92 Sallis, Robert, Deborah Rohm Young, Sara Y. Tartof, et al. "Physical Inactivity Is Associated with a Higher Risk for Severe COVID-19 Outcomes: A Study In 48,440 Adult Patients." *British Journal of Sports Medicine*, 55(19): 1099-1105, 2021. <https://pubmed.ncbi.nlm.nih.gov/33849909/>. Accessed July 5, 2024.
- 93 Chakradhar, Shraddha. "More Than 15% of U.S. Adults Are Physically Inactive, New CDC Data Show." *STAT*, January 16, 2020. <https://www.statnews.com/2020/01/16/physical-inactivity-us-adults-cdc-data/>. Accessed July 5, 2024.
- 94 Gaskin, Darrell J., Roland J. Thorpe Jr., Emma E. McGinty, et al. "Disparities in Diabetes: The Nexus of Race, Poverty, and Place." *American Journal of Public Health*, 104(11): 2147-2155, 2014. <https://pubmed.ncbi.nlm.nih.gov/24228660/>. Accessed July 5, 2024.
- 95 Osborn, Brandon, Brittany N. Morey, John Billimek, and Annie Ro. "Food Insecurity and Type 2 Diabetes Among Latinos: Examining Neighborhood Cohesion as a Protective Factor." *Journal of Racial and Ethnic Health Disparities*, 10: 2061-2070, 2023. <https://doi.org/10.1007/s40615-022-01386-4>. Accessed July 5, 2024.
- 96 Centers for Disease Control and Prevention. "National Center for Chronic Disease Prevention and Health Promotion: About Us." May 15, 2024. <https://www.cdc.gov/chronicdisease/center/index.htm>. Accessed July 5, 2024.
- 97 Centers for Disease Control and Prevention. "Chronic Disease." <https://www.cdc.gov/chronic-disease/index.html>. Accessed July 5, 2024.
- 98 Centers for Disease Control and Prevention. "Our Impact on Chronic Diseases and Risk Behaviors." May 15, 2024. <https://www.cdc.gov/nccdp/impact/index.html>. Accessed July 5, 2024.
- 99 Ibid.

- 100 Centers for Disease Control and Prevention. “National Vital Statistics System: Provisional Drug Overdose Death Counts.” National Center for Health Statistics. Updated June 12, 2024. <https://www.cdc.gov/nchs/nvss/vsrr/drug-overdose-data.htm>. Accessed July 5, 2024.
- 101 Office of National Drug Control Policy. “Dr. Rahul Gupta Releases Statement on CDC’s New Overdose Death Data Showing a Full Year of Flattening Overdose Deaths.” Press release: July 12, 2023. <https://www.whitehouse.gov/ondcp/briefing-room/2023/07/12/dr-rahul-gupta-releases-statement-on-cdcs-new-overdose-death-data-showing-a-full-year-of-flattening-overdose-deaths/>. Accessed July 5, 2024.
- 102 Spencer, Merianne R., Matthew F. Garnett, and Arialdi M. Miniño. “Drug Overdose Deaths in the United States, 2002–2022.” *NCHS Data Brief*, 491, December 21, 2023. <https://stacks.cdc.gov/view/cdc/135849>. Accessed July 5, 2024.
- 103 Trust for America’s Health and Well Being Trust. “Pain in the Nation 2022: U.S. Experienced Highest Ever Combined Rates of Deaths Due to Alcohol, Drugs, and Suicide During the First Year of the COVID-19 Pandemic.” May 2022. <https://www.tfah.org/report-details/pain-in-the-nation-2022/>. Accessed July 5, 2024.
- 104 Trust for America’s Health. “Pain in the Nation 2024: The Epidemics of Alcohol, Drug, and Suicide Deaths.” July 2024. <https://www.tfah.org/report-details/pain-in-the-nation-2024/>. Accessed August 1, 2024.
- 105 Centers for Disease Control and Prevention. “About Adverse Childhood Experiences.” April 9, 2024. <https://www.cdc.gov/aces/about/index.html>. Accessed July 5, 2024.
- 106 Harvard T.H. Chan School of Public Health. “Duration of Suicidal Crises.” <https://www.hsph.harvard.edu/means-matter/means-matter/duration/>. Accessed July 5, 2024.
- 107 Harvard T.H. Chan School of Public Health. “Attempters’ Longterm Survival.” <https://www.hsph.harvard.edu/means-matter/means-matter/survival/>. Accessed July 5, 2024.
- 108 Substance Abuse and Mental Health Services Administration. “Now in Its Second Year, 988 Lifeline Continues to Help Millions of People” <https://www.hhs.gov/about/news/2024/07/16/second-year-988-lifeline-continues-help-millions-people.html>. Accessed July 29, 2024.
- 109 Ibid.
- 110 Centers for Disease Control and Prevention. “Grant Funding Profiles.” Updated May 28, 2024. <https://www.cdc.gov/fundingprofiles/index.htm>. Accessed July 5, 2024.
- 111 Association of State and Territorial Health Officials. “Summary of FY24 Labor, Health and Human Services, Education, and Related Agencies Appropriations Bill.” March 21, 2024. <https://www.astho.org/advocacy/federal-government-affairs/leg-alerts/2024/summary-of-fy24-labor-health-and-human-services-education-and-related-agencies-appropriations-bill/>. Accessed July 5, 2024.
- 112 Ibid.
- 113 U.S. Food and Drug Administration. “FY 2024 Operating Plan Narrative.” <https://www.fda.gov/media/177540/download>. Accessed July 5, 2024.
- 114 Association of State and Territorial Health Officials. “Profile of State and Territorial Public Health.” 2022. <https://astho.shinyapps.io/profile/>. Accessed July 5, 2024.
- 115 Trust for America’s Health. “Ready or Not 2024: Protecting the Public’s Health from Diseases, Disasters and Bioterrorism.” March 14, 2024. <https://www.tfah.org/report-details/ready-or-not-2024/>. Accessed July 5, 2024.
- 116 National Association of County and City Health Officials. “2020 Forces of Change: The COVID-19 Edition.” April 28, 2022. <https://www.naccho.org/uploads/downloadable-resources/2020-Forces-of-Change-The-COVID-19-Edition.pdf>. Accessed July 5, 2024.
- 117 Bryant-Genevier, Jonathan, Carol Y. Rao, Barbara Lopes-Cardozo, et al. “Symptoms of Depression, Anxiety, Post-Traumatic Stress Disorder, and Suicidal Ideation Among State, Tribal, Local, and Territorial Public Health Workers During the COVID-19 Pandemic—United States, March–April 2021.” *Morbidity and Mortality Weekly Report*, 70: 947-952, July 2, 2021. [https://www.cdc.gov/mmwr/volumes/70/wr/mm7026e1.htm?s\\_cid=mm7026e1\\_w](https://www.cdc.gov/mmwr/volumes/70/wr/mm7026e1.htm?s_cid=mm7026e1_w). Accessed July 5, 2024.
- 118 De Beaumont Foundation and the Association of State and Territorial Health Officials. “The Impact of the COVID-19 Pandemic: Rising Stress and Burnout in Public Health: Results of a National Survey of the Public Health Workforce.” March 2022. [https://debeaumont.org/wp-content/uploads/dlm\\_uploads/2022/03/Stress-and-Burnout-Brief\\_final.pdf](https://debeaumont.org/wp-content/uploads/dlm_uploads/2022/03/Stress-and-Burnout-Brief_final.pdf). Accessed July 5, 2024.
- 119 National Association of County and City Health Officials. “2020 Forces of Change: The COVID-19 Edition.” April 28, 2022. <https://www.naccho.org/uploads/downloadable-resources/2020-Forces-of-Change-The-COVID-19-Edition.pdf>. Accessed July 5, 2024.
- 120 National Association of County and City Health Officials. “NACCHO Research: Harassment Targeting Local Public Health Associated With Dire Outcomes on an Already Stretched Workforce.” *NacchoVoice*, November 22, 2022. <https://www.naccho.org/blog/articles/naccho-research-harassment-targeting-local-public-health-associated-with-dire-outcomes-on-an-already-stretched-workforce>. Accessed July 5, 2024.
- 121 McCall, Timothy C., Aaron A. Alford, Margaret C. Cunningham, et al. “The Role of Harassment in the Mental Well-Being of Local Public Health Professionals and Its Relationship with an Intent to Leave Their Organization During the COVID-19 Pandemic.” *Journal of Public Health Management and Practice*, 29(Supplement 1): S45-S47, January/February 2023. <https://pubmed.ncbi.nlm.nih.gov/36223508/>. Accessed July 5, 2024.
- 122 Royster, Jordan, Jack A. Meyer, Margaret C. Cunningham, et al. “Local Public Health Under Threat: Harassment Faced by Local Health Department Leaders During the COVID-19 Pandemic.” *Public Health in Practice*, 7: 100468, June 2024. <https://www.sciencedirect.com/science/article/pii/S266653522400053?via%3Dihub>. Accessed July 5, 2024.
- 123 De Beaumont. “Staffing Up: Workforce Levels Needed to Provide Basic Public Health for all Americans.” October 7, 2021. <https://debeaumont.org/news/2021/staffing-up-research-brief/>. Accessed July 5, 2024.
- 124 President’s Council of Advisors on Science and Technology. “Report to the President: Supporting the U.S. Public Health Workforce.” May 2023. [https://www.whitehouse.gov/wp-content/uploads/2023/04/PCAST\\_Public-Health-Report\\_May2023.pdf](https://www.whitehouse.gov/wp-content/uploads/2023/04/PCAST_Public-Health-Report_May2023.pdf). Accessed July 5, 2024.
- 125 Association of State and Territorial Health Officials. “COVID-19 Pandemic Further Strains Public Health Workforce.” 2022. <https://www.astho.org/globalassets/pdf/legislative-prospectus-series/2022-public-health-workforce.pdf>. Accessed July 5, 2024.
- 126 Association of State and Territorial Health Officials. “ASTHO Applauds President Biden’s Historic Public Health Workforce Expansion.” Press release: May 13, 2021. <https://www.astho.org/communications/newsroom/2021/astho-applauds-president-bidens-historic-public-health-workforce-expansion/>. Accessed July 5, 2024.
- 127 National Association of County and City Health Officials. “NACCHO Applauds Biden Administration Plan to Bolster Public Health Workforce.” Press release: May 13, 2021. <https://www.naccho.org/blog/articles/naccho-applauds-biden-administration-plan-to-bolster-public-health-workforce>. Accessed July 5, 2024.

- 128 National Association of County and City Health Officials. “NACCHO Lauds Passage of Public Health Workforce Loan Repayment Program Included in End-of-Year Legislation.” Press release: December 23, 2022. <https://www.naccho.org/blog/articles/naccho-lauds-passage-of-public-health-workforce-loan-repayment-program-included-in-end-of-year-legislation>. Accessed July 5, 2024.
- 129 Centers for Disease Control and Prevention. “Data Modernization Initiative.” Updated April 23, 2024. <https://www.cdc.gov/surveillance/data-modernization/index.html>. Accessed July 5, 2024.
- 130 Centers for Disease Control and Prevention. “The Public Health Data Strategy.” Updated April 11, 2024. <https://www.cdc.gov/ophdst/public-health-data-strategy/index.html>. Accessed July 5, 2024.
- 131 Layden, Jennifer. “2023 Year-End Lookback Report: From Insights to Impact.” Centers for Disease Control and Prevention, Office of Public Health Data, Surveillance, and Technology, 2023. <https://www.cdc.gov/ophdst/public-health-data-strategy/phds-lookback-report-508.pdf>. Accessed July 5, 2024.
- 132 Centers for Disease Control and Prevention. “Public Health Infrastructure Grant Program.” <https://www.cdc.gov/infrastructure/index.html>. Accessed July 5, 2024.
- 133 Centers for Disease Control and Prevention. “Public Health Infrastructure Grant.” March 14, 2024. <https://www.cdc.gov/infrastructure-phig/about/index.html>. Accessed July 5, 2024.
- 134 DeSalvo, Karen, Anand Parekh, G. William Hoagland, et al. “Developing a Financing System to Support Public Health Infrastructure.” *American Journal of Public Health*, 109(10): 1358-1361, 2019. <https://ajph.aphapublications.org/doi/10.2105/AJPH.2019.305214>. Accessed July 5, 2024.
- 135 Data: Elemental to Health. “Modernize Public Health Data: A Call to Congress.” [https://cdn.ymaws.com/www.cste.org/resource/resmgr/data\\_health/DMI\\_Costs\\_One\\_Pager\\_FINAL\\_08.pdf](https://cdn.ymaws.com/www.cste.org/resource/resmgr/data_health/DMI_Costs_One_Pager_FINAL_08.pdf). Accessed July 5, 2024.
- 136 Association of State and Territorial Health Officials. “FY25 Governmental Public Health Appropriations Book.” April 2024. <https://www.astho.org/globalassets/pdf/astho-appropriations-book.pdf>. Accessed July 5, 2024.
- 137 For more information, see: Trust for America’s Health. “Prevention and Public Health Fund Detailed Information.” <https://www.tfah.org/report-details/prevention-and-public-health-fund-detailed-information/>. Accessed July 5, 2024.
- 138 McLaughlin, John M., Justin J. McGinnis, Litjen Tan, et al. “Estimated Human and Economic Burden of Four Major Adult Vaccine-Preventable Diseases in the United States, 2013.” *The Journal of Primary Prevention*, 36(4): 259-273, June 2, 2015. <https://link.springer.com/article/10.1007/s10935-015-0394-3>. Accessed July 5, 2024.
- 139 Centers for Disease Control and Prevention. “About Antimicrobial Resistance.” April 22, 2024. [https://www.cdc.gov/antimicrobial-resistance/about/?CDC\\_AAref\\_Val=https://www.cdc.gov/drugresistance/about.html](https://www.cdc.gov/antimicrobial-resistance/about/?CDC_AAref_Val=https://www.cdc.gov/drugresistance/about.html). Accessed July 5, 2024.
- 140 Sievert, Dawn. “Going global: CDC launches novel antimicrobial resistance tracking network in 50 countries.” *Centers for Disease Control and Prevention*. Updated March 16, 2023. <https://archive.cdc.gov/#/details?url=https://www.cdc.gov/ncezid/what-we-do/2022-highlights/antimicrobial-resistance.html>. Accessed July 5, 2024.
- 141 Resolve to Save Lives. “Epidemics Don’t Have To Happen: But Every Day, Millions of Lives and Livelihoods Are at Risk Because Outbreaks Aren’t Detected, Reported and Controlled in Time.” <https://resolvetosavelives.org/prevent-epidemics>. Accessed July 5, 2024.
- 142 Taylor, Lauren A., Caitlin E. Coyle, Chima Ndumele, et al. “Leveraging the Social Determinants of Health: What Works?” *Yale Global Health Leadership Institute and Blue Cross and Blue Shield Foundation of Massachusetts*, June 29, 2015. <https://www.bluecrossmafoundation.org/publication/leveraging-social-determinants-health-what-works>. Accessed July 5, 2024.
- 143 Magnan, Sanne. “Social Determinants of Health 101 for Health Care: Five Plus Five.” *National Academy of Medicine*, October 9, 2017. <https://nam.edu/social-determinants-of-health-101-for-health-care-five-plus-five/>. Accessed July 5, 2024.
- 144 Office of Management and Budget. “Summary of the President’s Discretionary Funding Request.” April 9, 2021. <https://www.whitehouse.gov/wp-content/uploads/2021/04/FY2022-Discretionary-Request.pdf>. Accessed July 5, 2024.
- 145 Centers for Disease Control and Prevention. “Chronic Disease.” <https://www.cdc.gov/chronic-disease/index.html>. Accessed July 5, 2024.
- 146 Centers for Disease Control and Prevention. “Unfit to Service Obesity and Physical Inactivity Are Impacting National Security.” July 2022. <https://www.cdc.gov/physicalactivity/downloads/unfit-to-serve-062322-508.pdf>. Accessed July 5, 2024.
- 147 Centers for Disease Control and Prevention. “Fast Facts: Health and Economic Costs of Chronic Diseases.” May 15, 2024. [https://www.cdc.gov/chronic-disease/data-research/facts-stats/?CDC\\_AAref\\_Val=https://www.cdc.gov/chronicdisease/about/costs/](https://www.cdc.gov/chronic-disease/data-research/facts-stats/?CDC_AAref_Val=https://www.cdc.gov/chronicdisease/about/costs/). Accessed July 5, 2024.
- 148 Centers for Disease Control and Prevention. “State Physical Activity and Nutrition (SPAN).” Updated January 5, 2024. <https://www.cdc.gov/span/php/about/index.html>. Accessed July 5, 2024.
- 149 Trust for America’s Health. “Pain in the Nation 2024: The Epidemics of Alcohol, Drug, and Suicide Deaths.” July 2024. <https://www.tfah.org/report-details/pain-in-the-nation-2024/>. Accessed August 1, 2024.
- 150 Curtin, Sally C., Matthew F. Garnett, and Farida B. Ahmad. “Provisional Estimates of Suicide by Demographic Characteristics: United States, 2022.” *Vital Statistics Rapid Release*, 34, November 2023. <https://stacks.cdc.gov/view/cdc/135466>. Accessed July 5, 2024.
- 151 Ibid.
- 152 Centers for Disease Control and Prevention. “Comprehensive Suicide Prevention.” January 16, 2024. [https://www.cdc.gov/suicide/programs/csp.html?CDC\\_AAref\\_Val=https://www.cdc.gov/suicide/programs/csp/index.html](https://www.cdc.gov/suicide/programs/csp.html?CDC_AAref_Val=https://www.cdc.gov/suicide/programs/csp/index.html). Accessed July 5, 2024.
- 153 Leza, Leire, Sandra Siria, José J. López-Goñi, and Javier Fernández-Montalvo. “Adverse Childhood Experiences (ACEs) and Substance Use Disorder (SUD): A Scoping Review.” *Drug and Alcohol Dependence*, 221: 108563, April 1, 2021. <https://pubmed.ncbi.nlm.nih.gov/33561668/>. Accessed July 5, 2024.
- 154 Centers for Disease Control and Prevention. “About Adverse Childhood Experiences.” April 9, 2024. <https://www.cdc.gov/violenceprevention/aces/fastfact.html>. Accessed July 5, 2024.
- 155 Parental engagement—in which parents and school staff work jointly to improve the health and development of students—can reduce the risk of unhealthy behaviors like drug use. See: Centers for Disease Control and Prevention. “Parental Engagement in Schools.” Updated August 7, 2018. [https://www.cdc.gov/healthyyouth/protective/parent\\_engagement.htm](https://www.cdc.gov/healthyyouth/protective/parent_engagement.htm). Accessed July 5, 2024.
- 156 Centers for Disease Control and Prevention. “Promoting Mental Health and Well-Being in Schools: An Action Guide for School and District Leaders.” Updated March 22, 2024. <https://www.cdc.gov/healthyyouth/mental-health-action-guide/index.html>. Accessed July 5, 2024.

- 157 Centers for Disease Control and Prevention. "Success Stories: What's Working in Schools." Updated August 8, 2022. <https://www.cdc.gov/healthyouth/stories/index.htm>. Accessed July 5, 2024.
- 158 Centers for Disease Control and Prevention. "About the Division of Adolescent and School Health." June 4, 2024. <https://www.cdc.gov/nccdphp/divisions-offices/about-the-division-of-adolescent-and-school-health.html>. Accessed July 5, 2024.
- 159 Robin, Leah, Zachary Timpe, Nicolas A. Suarez, et al. "Local Education Agency Impact on School Environments to Reduce Health Risk Behaviors and Experiences Among High School Students." *Journal of Adolescent Health*, 70(2): 313-321, February 2022. <https://www.sciencedirect.com/science/article/abs/pii/S1054139X21004006>. Accessed July 5, 2024.
- 160 Kaczkowski, Wojciech, Jingjing Li, Adina C. Cooper, and Leah Robin. "Examining the Relationship Between LGBTQ-Supportive School Health Policies and Practices and Psychosocial Health Outcomes of Lesbian, Gay, Bisexual, and Heterosexual Students." *LGBT Health*, 9(1), January 2022. <https://www.liebertpub.com/doi/10.1089/lgbt.2021.0133>. Accessed July 5, 2024.
- 161 Centers for Disease Control and Prevention. "About the Division of Adolescent and School Health." Updated February 7, 2024. <https://www.cdc.gov/healthyouth/about/index.htm>. Accessed July 5, 2024.
- 162 U.S. Census Bureau. "School Enrollment: CPS Table: 2022." <https://www2.census.gov/programs-surveys/demo/tables/school-enrollment/2022/2022-cps/Tab02-01-2022.xlsx>. Accessed July 5, 2024.
- 163 Centers for Disease Control and Prevention. "Youth Risk Behavior Survey Data Summary & Trends Report: 2011–2021." Division of Adolescent and School Health, February 13, 2023. chrome-extension://efaidnbmnnnibpcjpcglclefindmkaj/[https://www.cdc.gov/healthyouth/data/yrbs/pdf/YRBS\\_Data-Summary-Trends\\_Report2023\\_508.pdf](https://www.cdc.gov/healthyouth/data/yrbs/pdf/YRBS_Data-Summary-Trends_Report2023_508.pdf). Accessed July 5, 2024.
- 164 U.S. Department of Health and Human Services. "Department of Health and Human Services: Fiscal Year 2013. Centers for Disease Control and Prevention: Justification of Estimates for Appropriations Committees." <https://www.documentcloud.org/documents/20985475-fy-2013-cdc-congressional-justification>. Accessed July 5, 2024.
- 165 Centers for Disease Control and Prevention. "Climate-Ready States & Cities Initiative Grant Recipients." Updated April 17, 2024. [https://www.cdc.gov/climate-health/php/climate\\_ready/grant-recipients.html](https://www.cdc.gov/climate-health/php/climate_ready/grant-recipients.html). Accessed July 5, 2024.
- 166 Allergy and Asthma Network. "Asthma Statistics." <https://allergyasthmanetwork.org/what-is-asthma/asthma-statistics/>. Accessed July 5, 2024.
- 167 Centers for Disease Control and Prevention. "Asthma." Updated August 18, 2022. <https://www.cdc.gov/healthyschools/asthma/index.htm>. Accessed July 5, 2024.
- 168 Nurmagambetov, Tursynbek, Robin Kuwahara, and Paul Garbe. "The Economic Burden of Asthma in the United States, 2008-2013." *Annals of the American Thoracic Society*, 15(3): 348-356, March 2018. <https://pubmed.ncbi.nlm.nih.gov/29323930/>. Accessed July 5, 2024.
- 169 Centers for Disease Control and Prevention. "Asthma." Updated August 18, 2022. <https://www.cdc.gov/healthyschools/asthma/index.htm>. Accessed July 5, 2024.
- 170 Sekar, Kavya. "Public Health Funding and the Fiscal Responsibility Act of 2023." *Congressional Research Service*, July 31, 2023. chrome-extension://efaidnbmnnnibpcjpcglclefindmkaj/<https://crsreports.congress.gov/product/pdf/IN/IN12208>. Accessed July 5, 2024.
- 171 SteelFisher, Gillian K., Mary G. Findling, Hannah L. Caporello, et al. "Trust in US Federal, State, and Local Public Health Agencies During COVID-19: Responses and Policy Implications." *Health Affairs*, 42(3): 328-337, March 2023. <https://www.healthaffairs.org/doi/10.1377/hlthaff.2022.01204>. Accessed July 5, 2024.
- 172 The Network for Public Health Law. "Summary of Enacted Laws and Pending Bills Limiting Public Health Authority: The Second Wave." Updated April 22, 2022. [https://www.networkforphl.org/wp-content/uploads/2022/04/50\\_State-Survey-Summary-of-Enacted-Laws-and-Pending-Bills-Limiting-Public-Health-Authority-1.pdf](https://www.networkforphl.org/wp-content/uploads/2022/04/50_State-Survey-Summary-of-Enacted-Laws-and-Pending-Bills-Limiting-Public-Health-Authority-1.pdf). Accessed July 5, 2024.
- 173 Weber, Lauren, and Joel Achenback. "Covid Backlash Hobbles Public Health and Future Pandemic Response." *The Washington Post*, March 8, 2023. <https://www.washingtonpost.com/health/2023/03/08/covid-public-health-backlash/>. Accessed July 5, 2024.



1730 M Street, NW, Suite 900  
Washington, DC 20036  
(t) 202-223-9870  
(f) 202-223-9871