Commentary

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The Public Health Funding Paradox: How Funding the Problem and Solution Impedes Public Health Progress

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Deeply entrenched health inequities are well documented across the United States. These inequities are being laid bare by the coronavirus disease 2019 (COVID-19) pandemic and the protests of police violence against Black people in the United States, including the extrajudicial killings of George Floyd and Breonna Taylor. Health inequities stem in large part from government policies and practices that distribute power and resources—such as housing, law enforcement, education, employment, environmental amenities, and health services—inequitably. Simultaneously, our government-funded public health agencies are tasked with eliminating the resulting health inequities and improving population health. Thus, public health finds itself in a paradox: the government and taxpayers are subsidizing both policies that cause health inequities and the work by public health agencies to address them.

Examples of the Public Health Funding Paradox

We highlight 2 divergent ways in which government policies are distributing resources: (1) the government spends substantial amounts of money on policies that have been shown to harm health, and (2) policy-driven deprivation of critical resources causes harm to population health. Although we narrow our analysis to a spending/deprivation binary, poor and marginalized communities are often simultaneously experiencing spending on both harm and deprivation.

Spending on Harm

Although the murders of George Floyd, Breonna Taylor, and many others by police are clear examples of government spending on systems that perpetuate harm, the broader systems of criminal justice and immigration enforcement also exemplify spending on harm. When the costs of policing and courts are combined with the costs of operating prisons, jails, parole, and probation, the annual cost of these systems is estimated to be more than $181 billion per year.[1] Including the expenditures on both the criminal justice and immigration enforcement systems during the 30-year period from 1983 to 2012, the United States spent an estimated $3.4 trillion more on the justice system than it would have had its funding levels been capped at the 1982 level (inflation-adjusted).[2] Research finds that imprisonment is an ineffective long-term intervention for violence prevention,[3] and without increases in incarceration, life expectancy from 1981 to 2007 would have extended by almost 2 additional years.[4]

Policing, sentencing, and incarceration disproportionately target poor people and communities of color and have deleterious effects on health. Police violence and incarceration cause both direct and indirect physical and mental harm. For direct harm, 6295 men were killed by police from 2012 to 2018[5]; from 2001 to 2014, boys and men aged 15-34 were treated in hospital emergency departments for injuries caused by police at a similar rate to pedestrians injured by motor vehicles.[6] People who have been incarcerated are more likely than those who have not to have negative health effects such as death from accidents, substance use, HIV, liver disease, and liver cancer.[7] For every year of incarceration, life expectancy decreases by an estimated 2 years, even when controlling for demographic and offense-related factors.[8] The current pandemic also reveals the harm caused by

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incarceration: as of May 18, 2020, seven of the 10 largest COVID-19 outbreak clusters were in jails, prisons, or detention centers.[9]

The negative effects also ripple across families and communities: young adults with an incarcerated father were more likely to report being diagnosed with high cholesterol, asthma, migraine, depression, posttraumatic stress disorder, and anxiety than young adults without an incarcerated father.[10]

The billions of dollars that fund immigration law enforcement have been shown to cause poor health among immigrants and have spillover effects into broader society.[11] The budget for Enforcement and Removal Operations—the agency that leads detention and deportation of immigrants—had a total budget authority of $7.45 billion in fiscal year 2018 to support enforcement activities.[12] These enforcement actions include large workplace raids, home raids, and the surveillance and profiling of immigrant and/or racial/ethnic minority communities.

After a raid in 2008 that detained nearly 400 Latino workers in an Iowa town, Latina mothers (regardless of citizenship status) had lower birth-weight infants compared with before the raid; the infants of non-Hispanic White mothers showed no change in birth weight.[13] The stress caused by the immigration enforcement system can contribute to increases in systolic blood pressure, increases in body mass index, and decreases in health care use, as well as activate chronic stress processes that lead to poor health for those who experience it.[14-16] For every 2 deportations in the United States, an estimated 1 child who is a US citizen has poorer health as a result of the removal of a primary caregiver or financial provider.[17]

Depriving of Health: Underfunding Marginalized Communities

Federal spending on programs (beyond health care) that are known to improve health for people with low or moderate incomes has been projected to decrease through 2029.[18] Federal budgets continue to propose shifting massive costs to states. These costs affect strained states and municipalities to the point where they are cutting the very public sector spending known to improve population health.[19] The COVID-19 pandemic will exacerbate the struggles of states to fund critical public services. Even with federal relief funds and state reserves, states will face an estimated $510 billion budget gap, and without further federal support, most states will make cuts to education and health care—cuts that will delay recovery and undermine public health.[20]

An example of population health being devastated by government financial deprivation was the 2014 water crisis in Flint, Michigan. Flint had been struggling financially for years after General Motors left the city; the automotive company employed 80 000 Flint residents in 1978 and 8000 by 2006. Then, from fiscal years 2006 through 2012, Flint lost a cumulative 46% in its 3 largest sources of revenue: property taxes, income taxes, and state shared revenue (which itself declined by 61%, from $20 million to $7.9 million).[21] By siphoning shared revenue from municipalities, state officials further compounded Flint's financial distress, which the state then used to justify the imposition of 5 emergency managers from 2011 to 2015.[22] Emergency managers are unelected officials who impose austerity measures to balance city budgets. These emergency managers imposed cuts onto a community that already had one of the highest unemployment rates in the state (23.3% in 2010) and where 34.9% of residents lived below the federal poverty level in 2009.[22] The decision to change the water source was made by an emergency manager—who was not a Flint resident or accountable to Flint's predominantly Black residents—claiming it would save the government $5 million.[23] The decision was approved by the governor's office. The consequences and costs have been enormous: from the exposure of thousands of children to lead poisoning to the deaths of 12 people from Legionnaires disease.[24] The health damages of the Flint water crisis have already cost taxpayers more than $1 billion.[25]

The overburdened network of national, state, and local public health agencies in the United States must attend to traditional public health services (outbreak response, immunizations, disease surveillance, and disease prevention programs) while also addressing the national opioid epidemic, growing rates of chronic diseases, and racial/ethnic health disparities. But as illustrated previously, public health agencies are also responsible for improving the health of communities that have been harmed by immigration enforcement, criminal justice systems, and chronic disinvestment. Although public health increasingly recognizes the outsized role the government plays in funding policies and practices that can harm health, it is increasingly less equipped with the funding, governance structure, and resources it needs to address those harms, given budget cuts at all levels of the public health system. Of the $3.36 trillion spent annually on health care in the United States, only 3% goes to public health.[26] The COVID-19 pandemic has exposed this underfunding and presents an opportunity to overcome this funding paradox.

Overcoming the Funding Paradox With a Fundamental Causes Approach

First, we need to restructure our own government-funded public health agencies to focus on key foundational drivers of health and well-being rather than disease categories. Currently, public health agencies in the United States—for example, the National Institutes of Health and the Centers for Disease Control and Prevention—are structured on specific diseases or whether a health issue is chronic or infectious. However, the latest epidemiologic research shows that social inequities are a fundamental cause of poor health.[27]

Recognizing that health is not an end but a means by which all people can live unencumbered and full lives suggests orienting the work of public health to address the fundamental causes that create barriers to health and well-being.[28] A fundamental causes approach demands "dismantling the systems that initiate and sustain inequities in a broad range of societal institutions that are the drivers of inequities in health."[29] How would our evidence and public health solutions shift if we had a National Institute of Anti-racist Institutions? It could force public health researchers and professionals to shift their focus from the individual and the disease to the structural drivers of health.

The need for this shift is evidenced by the racial/ethnic disparities in COVID-19 outcomes.[30] The same factors that make Black people in the United States more susceptible than White people to a range of health issues (eg, structural racism that increases the likelihood of chronic stress, low-wage jobs, excess pollution, lack of health care access) have made Black people more susceptible than White people to the complications of COVID-19.[30] But the public health workforce is not organized or equipped to create structural changes to our economic system, criminal justice system, or political system to shift the fundamental causes of these health inequities. With the current pandemic and protests against racial injustice, voters and politicians are giving unprecedented attention to public health and racial/ethnic health inequities. Sustained advocacy efforts should focus on reforms that create systemic change to government funding.

Second, we need to enhance collaborations between public health professionals and government agencies responsible for housing, education, public safety, and other foundational drivers of health. As recommended by the Health in All Policies movement, we should be "improving the health of all people by incorporating health considerations into decision-making across sectors and policy areas."[31] As a first step, public health professionals should ensure that public debates related to defunding the police, criminal justice reform, public benefits, or other foundational drivers of health are framed as health issues. It is essential to actively pursue resident input in these processes—potentially by collaborating with community organizers—to center the experiences of people who are most severely affected by harmful public policies. With the COVID-19 pandemic, non–public health sectors are calling on public health officials for advice on infection control. Continuing this level of collaboration across sectors is crucial.

Third, resolving this paradox requires the mobilization of public health professionals to advocate for policies that support health. This mobilization can begin with how we train public health professionals—both formal students and continuing education for professionals—to build coalitions, create an advocacy strategy, or use advocacy tools (eg, fact sheets, op-ed pieces, relationship building). For example, Public Health Awakened connects public health professionals to mobilize on behalf of health-promoting strategies such as Health Instead of Punishment, family-friendly immigration reform, and reforming the criminal justice system.[32] By becoming organized, the voice of public health–minded voters and constituents can be powerful and spur a tipping point toward health-oriented public policies.

If public health is serious about reducing health inequities and improving overall population health, we will need to adopt a foundational causes approach and use data, people, and power to collectively overcome the public health funding paradox.

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