



# The State of State-level Public Health Advocacy:

*Findings and Implications from a 50-state Scan*

Prepared for **The Network for Public Health Law**

Based on a 50-state Analysis Conducted by:

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## INTRODUCTION

Life expectancy in the United States was 76.4 years in 2021—the lowest point this measure has reached since the mid-1990s. In this important metric of overall health status, the United States has fallen further and further behind other developed countries, despite spending more on health care per person than other countries. The decline also is unevenly distributed, with the likelihood of an early death higher in the South and Midwest than the Northeast and West, according to a recent *Washington Post* analysis. The disparities in death rates, the authors note, “can be traced to decisions that local and state lawmakers made years ago on whether to implement cigarette taxes, invest in public health or tighten seat-belt regulations, among other measures.”<sup>1</sup>

Investments in public health funding reflect these inconsistencies. In Arizona, state public health funding was just \$15 per person in 2021. The good news was that this was up from \$8 per person a decade prior. The bad news? It was still among the lowest in the United States. Next door in New Mexico, state public health funding happened to be the highest in the country at \$159 per person in 2021, more than three times the 2011 level of \$51 per person. These funding and policy fluctuations contribute to a public health system that varies considerably and sometimes inexplicably, from year to year and from one jurisdiction to another.<sup>2</sup>

Despite these variations, some commonalities are evident across jurisdictions, no matter how public health is organized and funded in any given state. In general, public health has been **chronically underfunded** and has **faced serious challenges to its legal underpinnings**.<sup>3</sup> In part, this is because public health is **misunderstood** and **undervalued**. And the COVID-19 global pandemic—the event public health had been warning of and trying to prepare for since 1918—unleashed more **backlash** than support for public health functions designed to protect

This study and report adopt an inclusive definition of advocacy from Bolder Advocacy: “The term ‘**advocacy**’ encompasses a broad range of activities—including research, public education, lobbying, and voter education—that can **influence public policy**.”

<sup>1</sup> Weber R, Diamond D, Keating D. How Red-State Politics are Shaving Years Off American Lives. October 3, 2023. *The Washington Post* online edition. Accessed via [https://www.washingtonpost.com/health/interactive/2023/republican-politics-south-midwest-life-expectancy/?itid=lk\\_inline\\_manual\\_30](https://www.washingtonpost.com/health/interactive/2023/republican-politics-south-midwest-life-expectancy/?itid=lk_inline_manual_30).

<sup>2</sup> SHADAC analysis of per capita funding, 2011 and 2021, State Health Compare, SHADAC, University of Minnesota, [statehealthcompare.shadac.org](https://statehealthcompare.shadac.org). Accessed via <https://statehealthcompare.shadac.org/map/117/person-state-public-health-funding#a/4/154>

<sup>3</sup> Trust for America’s Health. 2022. *The Impact of Chronic Underfunding on America’s Public Health System: Trends, Risks, and Recommendations, 2022*. Issue Report from the Trust for America’s Health. Available from: <https://www.tfah.org/wp-content/uploads/2022/07/2022PublicHealthFundingFINAL.pdf>.

the public's health. These trends reflect another commonality: for a variety of reasons that have been compounding over decades, **advocacy** on behalf of the public's health and public health agencies has fallen short.

**What is the current state-level capacity for public health advocacy in the United States? How can it be strengthened?** To find out, a team of public health attorneys contracted by the Network for Public Health Law<sup>4</sup> researched specific markers of advocacy capacity and interviewed key respondents in 50 states and the District of Columbia between March and June 2023. Respondents included state and local health department representatives, elected officials, lobbyists, and partners in other sectors and organizations, although the specific type of respondent was different in each state. Regardless of their specific titles, current roles, or locations, all respondents represent voices from the field who are advocates for the health and well-being of everyone in their respective states.

**This report presents the findings and results of research and interviews covering all 50 states and the District of Columbia.**

Preliminary findings from the scan, reflecting research on 20 states, were shared at a Public Health Advocacy Convening in Atlanta, Georgia in April 2023 to provide guidance for discussions on strengthening advocacy capacity. The Convening followed publication of a feasibility study conducted by Frey Evaluation for the Network for Public Health Law, *Fighting for the Public's Health*.<sup>5</sup>

Although the interviews and desktop research covered consistent topics in each state, some caveats are in order. First, the scan findings should be viewed as a point-in-time snapshot, rather than a more comprehensive portrait. The timeline and resources did not allow for extensive interviews of multiple players in every state. The team members did not conduct independent research of political and funding trends over time, nor did we analyze factors such as public health funding trends in each state or media coverage of public health in every state.

In this report, we present findings from interviews and consider implications for various audiences inside and outside public health, including advocates, public health allies and partners, and funders. We hope these observations and ideas will spark both motivation and tangible support for public health advocacy. As one respondent observed,

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<sup>4</sup> Quang ("Q") Dang, JD, Manel Kappagoda, JD, MPH, Emma Waugh, MPH, and Leslie Zellers, JD are the team that prepared the 50-state scan for the Network for Public Health Law.

<sup>5</sup> The *Fighting for Public Health* feasibility study and report were funded by the Network for Public Health Law, Healthcare Georgia Foundation, and Montana Healthcare Foundation. The full report and an accompanying slide deck are available [here](#).

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*“This is worth the investment. **Public health is at a tipping point** because of COVID and the policy and cultural moment. It’s an important time to invest in public health advocacy. Otherwise, we run the risk of health and wellness deteriorating if public health isn’t the voice.”*

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The findings, each discussed in more detail below, are:

1. Public health has the **expertise and tools** to help all communities achieve health and well-being, but the **role and value of public health are often hidden and/or misunderstood**.
2. Members of the public health workforce and state/local public health leaders are **reluctant to rely on tools such as advocacy and lobbying that have served other sectors well**.
3. Public health measures in response to COVID have sparked ongoing **challenges to public health authority**, making advocacy even more difficult and essential.
4. **Health equity** is fundamental to public health and requires nuanced communication in some states/regions.
5. Many public health allies at the local and state levels remain **untapped resources** for protecting and promoting the public’s health, including supporting public health advocacy and lobbying efforts.
6. The **public health workforce** stepped up to protect all of us during COVID, despite not being at full strength going into the pandemic and being severely tested during the pandemic. COVID-related funding infusions are helpful but not sufficient unless sustained.

Following a discussion of these findings are **inter-related opportunities** to respond to them, including specific opportunities for funders. These opportunities include ways to:

- Elevate public health’s **value proposition**;
- Encourage **strategic deployment of advocacy and lobbying** on behalf of the public’s health;
- Counter **challenges to public health authority**;
- Fight for **health equity**, with or without the language of health equity;
- Tap the strengths, capabilities, and shared interests of **supportive allies**; and
- Support the **public health workforce**.

## FINDINGS

Finding #1: Public health has the **expertise and tools** to help all communities achieve health and well-being, but the **role and value of public health are often hidden and/or misunderstood**.

Here's what we heard:

Everything about public health seems difficult to communicate: its scope, its (often invisible) successes, its nuances, its underlying data and disciplines ... the list goes on. This, in turn, makes advocacy of all kinds more difficult. When we advocate for public health, what exactly should we be advocating *for*? Respondents noted that these communication challenges are distinct from the public health discipline of *health education*, which conveys specific information about how individuals, populations, and communities can be healthier by changing behaviors and policies.

Adding to the challenge are organized **disinformation** campaigns that foment mistrust and organizations actively hostile to public health and all governmental agencies, as opposed to indifferent or uninformed. It is worth noting that COVID-related disinformation and distrust of government come from all parts of the political spectrum and are affecting other issues as well, such as immunization uptake in general.

Some mistrust of public health and government—particularly from communities that include black, indigenous, and people of color, or BIPOC—is the result not of disinformation but rather of being harmed or poorly served by state and local public health before and during COVID.

Interview respondents had many suggestions for improving public health messages in ways that support effective advocacy and build trust among the general public.

In general, respondents believe that **topic- or issue-specific appeals** are more effective than more general pitches for public health infrastructure and funding. These open up alliances (e.g., with chronic disease organizations for diabetes prevention) and opportunities to appeal to interests of particular constituencies (Governors, bipartisan legislatures), as is believed to be the case with responses to the opioid epidemic or behavioral health issues.

Many respondents called for public health messaging designed to appeal to more **politically conservative** decision-makers, particularly more moderate Republicans. An example of a recent successful effort to communicate public health's value among Republican state legislators, led by a Republican governor, Eric Holcomb, took place in

Indiana, where the GOP-controlled legislature endorsed a 1,500-percent increase in state funding for local health departments that contribute a 20 percent match. Participating Indiana counties (over 90%) will share \$75 million in state funding this year and \$150 million next year—up from \$7 million directed to local health departments in prior years.<sup>6</sup>

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*“If given the right arguments, Republicans would support [residents of this (red) state].”*

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Suggestions for public health messaging included focusing on the implications of public health or related policies (e.g., Medicaid expansion) for a **healthy, productive workforce** or the community’s **economic vitality, returns on investment (ROI)**, and/or **regionally relevant** themes (e.g., the American Heart Association’s Heart Healthy Hunting campaign in Appalachia).

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*“Public health bills have to be workforce bills, not public health bills.”*

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Another way to improve public health’s visibility and value is to highlight its importance in **underserved rural areas**, where local health departments are often an important (if not only) source of health care, especially given the pace and extent of rural hospital closures. One state is using COVID and mpox funds to create a course for the public health workforce on how to build trust and counter misinformation and disinformation (i.e., deliberate misinformation).

Challenges specific to communicating about equity in general, racial equity in particular, and social determinants of health are described separately below.

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<sup>6</sup> For more about the Indiana messages and strategies, see Messerly M. *A red state boosted public health funding by 1,500 percent. This is how they did it.* Politico, 7/13/2023. Accessed via <https://www.politico.com/news/2023/07/13/red-state-public-health-funding-indiana-00105982>.

## Finding #2: Members of the public health workforce and state/local public health leaders are often **reluctant to rely on tools such as advocacy and lobbying that have served other sectors well.**

Here's what we heard:

The COVID-fueled backlash described above has discouraged an already skittish public health workforce to embrace the potential of stronger advocacy themselves and enlist lobbying from allies. Some members of the public health workforce (at all levels) misconstrue distinctions between broader advocacy and lobbying, some are constrained by state and local rules, training or temperament, and most are spread thin and not necessarily able to assume new training or responsibilities. Capacity among public health allies, who have more lobbying latitude than government employees, is also minimal in many places. However, respondents who were interviewed for this scan (some of whom were skilled public health professionals and lobbyists themselves) believe that public health cannot be strengthened and stabilized without lobbying. Indeed, lobbying is a necessary component of formulating and improving public policy. As one respondent put it,

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*“We [public health] care about how policy looks and affects people; lobbyists care about winning. Both are important.”*

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Several respondents noted that lobbying requires a constant presence and relationship-building, which in turn requires time and resources to cultivate these connections over time. Short and/or sporadic legislative sessions (e.g., 80 days every 2 years) make this even more difficult. As another respondent said,

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*“The [public health] organizations are the subject matter specialists, but **the paid lobbyists have the relationships, make the calls, and get things through.**”*

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Respondents described a variety of other challenges that impede effective lobbying on public health's behalf, including:

- **Lack of concrete training, guidance, and encouragement for the future public health workforce** (e.g., those pursuing undergraduate or graduate degrees in public health) and **current workforce**, especially on the



aspects of advocacy that are both allowable and needed (e.g., policy analysis and development, education and outreach to elected officials).

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*“The public health workforce **underestimates and undervalues** how much it can actually advocate.”*

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- **Need for greater resources for non-governmental organizations that could take on a lobbying portfolio more easily** than governmental public health, such as American Public Health Association (APHA) Affiliates, state associations of city and county health officials (SACCHOs), state Public Health Institutes (PHIs), and groups with shared purpose such as the American Heart Association (AHA), American Lung Association (ALA), and American Cancer Society (ACS). In some cases, these organizations have lobbyists on staff, others contract with lobbying firms. In many cases, their capacity is lean. Among the 52 APHA Affiliates, only 12 had registered lobbyists, according to the scan results. Another five Affiliates without registered lobbyists did have ties to other organizations (PHIs and local health department associations) with lobbying capacity, but this still means that two-thirds did not have access to registered lobbyists.
- **Confusion about the nuances of allowable funding for lobbying activities by non-profits**, such as whether funds generated from non-governmental sources such as an annual conference or individual donors can be used for lobbying within IRS limits and how to track and deploy these funds appropriately (i.e., accounting and fund management skills for 501(c)3s, 501(c)4s and 501(c)6s).

**Finding #3: Public health measures in response to COVID have sparked ongoing challenges to public health authority, making advocacy even more difficult and essential.**

Here’s what we learned:

Figures 1 and 2, below, summarize analyses conducted as part of the 50-state scan to determine which states had passed laws limiting public health authority, reallocating it, or strengthening public health between January 2021 and May 2022. Data sources for the figures are the Policy Surveillance Program database maintained by the Center for Public Health Law Research at Temple University’s School of Law<sup>7</sup> and the Network for

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<sup>7</sup> Policy Surveillance Program Database of State Legislation Addressing Public Health Emergency Authority. Accessed via <https://lawatlas.org/page/state-legislation-addressing-public-health-emergency-authority>

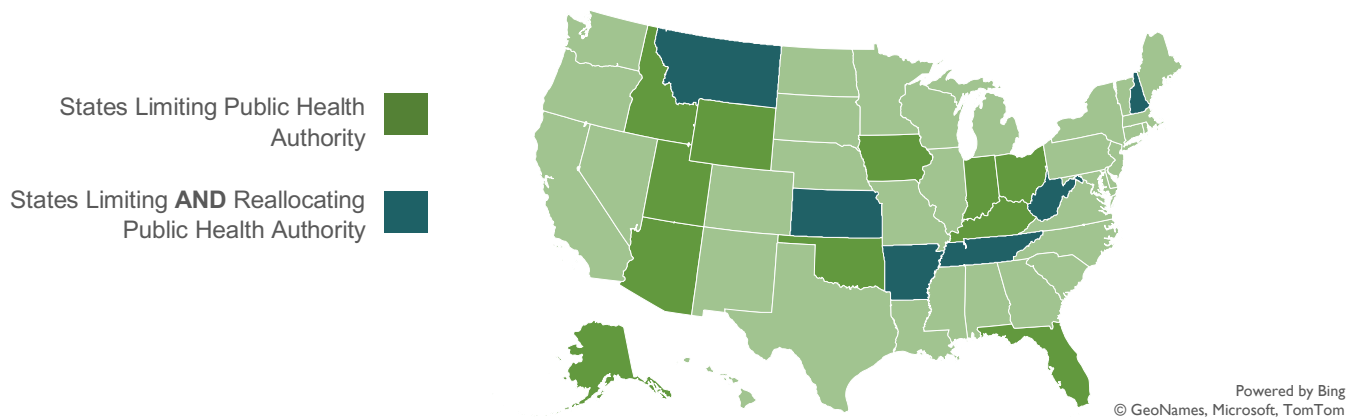
Public Health Law's *Summary of Enacted Laws and Pending Bills Limiting Public Health Authority: the Second Wave*.<sup>8</sup>

Figure 1 shows the 17 states whose legislatures passed laws limiting public health authority. Many more such bills were attempted but not passed—in several cases, due to gubernatorial vetoes [MI, LA, KY]. In many cases, these threats to public health are ongoing. Of note, attempts to counter them—whether effective or not—consumed significant resources within public health agencies and among allies and partners, such as state public health association affiliates.

Examples of laws that limited public health authority include prohibiting school districts and/or businesses from requiring masks or vaccines [OK, AL, IA, KS], prohibiting the Governor and/or state health officer from declaring or extending an emergency declaration [TN, ID, AZ], and an executive order prohibiting state agencies from requiring people to show proof of vaccination to enter public buildings [OK, IA].

In 6 of these 17 states, public health authority specifically was reallocated from the state health department to the legislature, Governor's Office, legislature, or another agency (e.g., a merged Health and Human Services agency with a leader appointed by the Governor [IA]).

Figure 1: States Passing Laws **Limiting** Public Health Authority (n=17) and **Reallocating** Public Health Authority to Legislature or Other Body (n=6 of the 17)

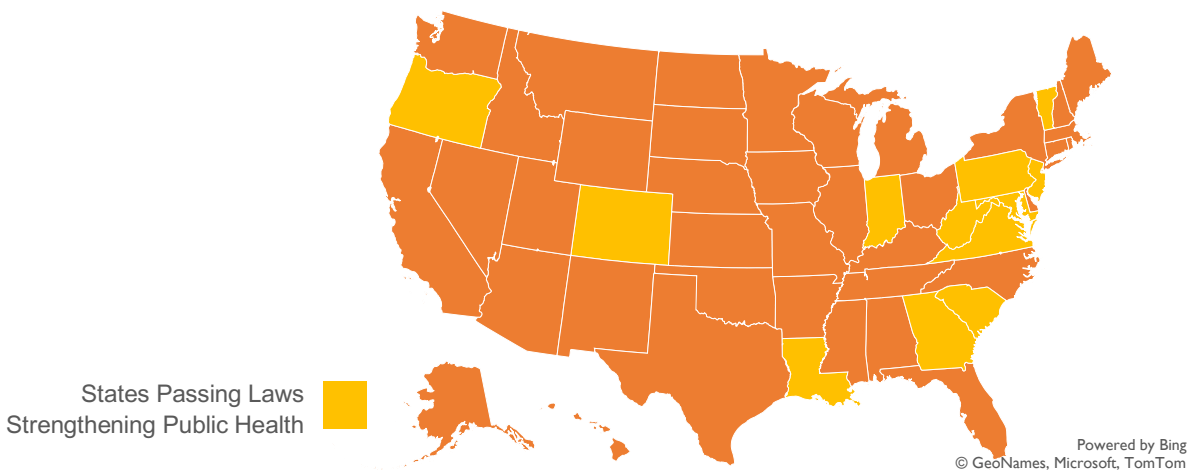


<sup>8</sup> Network for Public Health Law 50-state Survey: *Summary of Enacted Laws and Pending Bills Limiting Public Health Authority: the Second Wave*. Prepared in collaboration with Act for Public Health partners, including the Center for Public Health Law Research at Temple University and the Association for State and Territorial Health Officials. Accessed via <https://www.networkforphl.org/resources/50-state-survey-summary-of-bills-introduced-to-limit-public-health-authority/>

Attempts to limit or reallocate public health authority do not map neatly onto red, blue, or even purple state configurations or degrees of public health centralization/ decentralization. In part, this is because several of these states have politically divided legislative chambers and/or governors and legislatures with leaders from different parties. Even in very conservative red states, blue and purple pockets (typically larger cities and suburbs) are part of the mix [OK]; some blue states have red or reddening rural areas and corridors as well [CA]. Across the country, demographic changes and civic engagement from younger and more diverse voters and candidates for elected office may further alter the *status quo* [GA]. However, respondents also noted that demographic changes and civic engagement may not be enough to counter gerrymandering and other voter suppression efforts intensifying in multiple states and regions [AZ, ID, WI, OH].

In 12 states, laws were passed that have the effect of strengthening public health. This included two states [IN and WV] that also passed laws limiting or reallocating public health authority. Although 12 states appear to have strengthened public health authority to some degree by specifically protecting emergency preparedness powers, several of these positive changes are much narrower in scope and impact (e.g., allowing pharmacists and other health professionals to offer vaccinations [GA] or requiring the collection of race and ethnicity data for a statewide immunization registry [CA]) than those limiting or reallocating public health authority.

Figure 2: States Passing Laws Strengthening Public Health (n=12)



It is noteworthy that during 2021-22, 29 of 50 states passed laws limiting or strengthening public health authority. Make no mistake, public health is political!

## Finding #4: **Health equity** is fundamental to public health and requires nuanced communication in some states/regions.

Here's what we learned:

Most states (n=40) have an **office of health equity** or a similar body dedicated to tracking and addressing health equity gaps. Several others have policies or resources in place to perform a similar function (without a standalone office). As of August 2021, 12 states have **declared racism a public health crisis**,<sup>9</sup> in some states that have not done so, local jurisdictions have taken this step. In at least four states, equity analyses are part of the legislative review process.

In many states, the term “health equity” is a starting point for discussions about public health. Despite how central these concepts are to public health, they are not well received in some states, where they have the effect of shutting down conversations and discussions instead of jump-starting or deepening them. Even in a state with general support for health equity, a respondent noted resistance to extending this concept to immigrants and refugees, which state public health staff countered with op-eds focused on the economic benefits and productivity that immigrants contribute to the state. In another state, the term “health equity” was removed from the statewide Health Improvement Plan.

Respondents described many ways to talk about equity without using the actual word: access to care, fairness, rural and disadvantaged communities, vulnerable populations (older adults, rural populations, and low-income people), or specific race, income, and rural disparities. In several states, the **rural/urban divide** is an important (or even the most important) element in the equity conversation.

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*“... [Using the word ‘equity’] is not just a preference or pushback but could actually provoke state reaction.”*

*“While it is hard to deny the facts around racial disparities, the challenge is to figure out a way to discuss health equity without making it immediately toxic.”*

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<sup>9</sup> American Public Health Association. *Analysis: Declarations of Racism as a Public Health Crisis*. Accessed via <https://www.apha.org/Topics-and-Issues/Racial-Equity/Racism-Declarations>.

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*“[We’re a] long way off from talking about health equity. In most communities, [we’re] still just introducing the concept ... Community Health Centers in the state and the fight for Medicaid expansion all overlap with healthy equity, but ... Buzzwords and splashy DEI terms are not used.*”

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**Finding #5:** Many public health allies at the local and state levels remain **untapped resources** for protecting and promoting the public’s health, including supporting public health advocacy and lobbying efforts.

Here’s what we heard:

Although public health allies, as noted above, may themselves be stretched thin (especially in terms of lobbying capacity), this is not always the case. Some routinely join together for specific health issues and are connected to national organizations with related advocacy, communications, and messaging expertise.

In addition to those allies mentioned above (SACCHOs, state APHA and PHI affiliates, AHA, ALA, ACS affiliates), other allies mentioned during the scan include state-level Alzheimer’s Association chapters, health and hospital system advocacy organizations, Medicaid expansion coalitions, and groups advocating for the social determinants of health (transportation, education, housing), Tribal health organizations, rural health organizations/associations, and primary care associations, academia, justice and equity-related groups (environmental/climate justice, LGBTQIA and reproductive rights, voting rights, violence prevention, behavioral health).

Many respondents noted that **support for coordinating resources** across groups would be more useful in most places than creating new organizations for this purpose. However, some felt that new organizations and the flexibility they offer are needed, beyond a coordinating body. For example, some existing 501(c)3s would benefit from have the flexibility of a 501(c)4. Others might benefit from joining together a 501(c)3 and a 501(c)6 to create more latitude for lobbying.<sup>10</sup>

Whether new or knit together from existing networks, an organization, mechanism, or reliable forum is needed in most places for:

- **sharing advocacy models and lessons learned;**

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<sup>10</sup>For descriptions of these types of organizations, see Bolder Advocacy’s resource library: <https://bolderadvocacy.org/resource-library/types-of-organizations/>.

- collectively **expanding situational awareness or scans** to understand the landscape in a political jurisdiction (state and/or local);
- anticipating and **reacting more nimbly to sudden challenges**; and
- **nurturing evolving networks and coalitions** that are able to adapt to changing environments to advocate for policies and laws that protect and promote health.

**Finding #6:** The **public health workforce** stepped up to protect all of us during COVID, despite not being at full strength going into the pandemic and being severely tested during the pandemic. COVID-related funding infusions are helpful but not sufficient unless sustained.

Here's what we heard:

Even before the COVID pandemic, many respondents and others reported the public health workforce in most local and state agencies was considered to be inadequate to meet multiple public health needs.<sup>11</sup> Some federal infusions of COVID-specific funding helped public health agencies respond to the pandemic but did not address other ongoing and expanding demands: other infectious disease outbreaks; chronic diseases; emergencies such as wildfires, floods, and heat waves; injuries; and behavioral health issues including substance use and suicide. A related unintended consequence of COVID-specific funding was a misperception that because public health had received significant COVID funding (most of which was not flexible), additional funding is no longer needed. In most states, public health “revenue stagnation” or cuts are anticipated, rather than increases.

The 50-state scan hints at the toll across the country. In Mississippi, nearly half of the state health department positions (47 percent) were unfilled as of December 2022, twice the pre-pandemic vacancy rate.<sup>12</sup> In Colorado, half the local health department directors were reported to have resigned or been fired during COVID. In Illinois, one in five state health department staff left during the pandemic, particularly experienced

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<sup>11</sup>See, for example, the de Beaumont Foundation's analysis of what would be required to fully staff state and local health departments to deliver a minimum package of public health services: *Staffing Up: Workforce Levels Needed to Provide Basic Public Health Services*. Accessed via <https://debeaumont.org/staffing-up/>

<sup>12</sup>LaFraniere S. Why Mississippi, a COVID Hotspot, Left Millions in Pandemic Aid Unspent. *New York Times*, February 13, 2023. Accessed via <https://www.nytimes.com/2023/02/13/us/politics/covid-public-health-departments.html?searchResultPosition=1>

administrators.<sup>13</sup> **Among state health officers, only four pre-COVID leaders remained in place across all 50 states.** These losses represent decades of institutional knowledge and talent.

The turnover and vacancy rates reflect how difficult and demoralizing it has become to function in these roles. In several states, public health staff are reluctant to publicize data or programs that contradict their respective Governors' Offices, fearing retribution in terms of funding cuts and/or losing their positions and pensions. Even in states where public health is not under attack, some public health advocates shared they feel they must proceed with caution or “quiet advocacy.”

Advocacy in these circumstances is tricky, to say the least. Many respondents described the public health workforce in a defensive crouch—i.e., trying to protect remaining infrastructure and workforce rather than expand it. They also described fighting for the “least worst outcome,” or “blocking and tackling.” This defensive approach dovetails with more general public health workforce reluctance to engage in advocacy, perceptions about lobbying restrictions, and scarce bandwidth to pursue new tools and/or partnerships that could help.

## OPPORTUNITIES TO RESPOND

Advocacy was not public health's strong suit, at either state or local levels, before COVID. As the findings from interviews and state-by-state scans affirm, both COVID and the increasingly polarized political landscape have made it even harder to advocate for public health. The upshot? Yes, **the challenges surrounding public health advocacy are profound, yet many opportunities to strengthen it exist in every environment.**

These opportunities—bright spots, potential models, and other suggestions from respondents—are compiled here, grouped into categories that mirror the findings above. Some require action and concrete support from funders, allies, and advocates; some from public health practitioners and partners, and many from all of these entities. Collectively, these opportunities have the potential to alter the advocacy landscape across many states and jurisdictions.

One important caveat: in some states, infusions of funding or practices from other states and regions perceived to be politically different are not welcome and would

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<sup>13</sup>Rutecki J. *How a COVID-19 Exodus Affected Illinois Government Staffing, Salary Spending*. WTTW News, Chicago. April 21, 2023. Accessed via <https://news.wttw.com/2023/04/21/how-covid-19-exodus-affected-illinois-government-staffing-salary-spending>

undermine the cause. Instead, identifying models from nearby and/or politically similar states would carry more weight and feel more relevant.

## I. Elevate Public Health's Value Proposition

**Key opportunities** include:

- Engage local advocates and community members to **customize public health messages to local/state contexts** to increase understanding, trust, and support.
- Communications experts can help state and local public health use **consistent messaging and framing to highlight public health's contributions**.<sup>14</sup>

Specific opportunities for **funders** include:

- Support **customizing of consistent messages for local/state contexts** (including advocacy and lobbying for specific goals).
- Support development, dissemination, training, technical assistance related to **communications messages, framing, and tools**, as well as evaluation of their effectiveness.
- Convene state and local health officials, sponsor advocacy days, fund advocacy training, and other ongoing support for **building advocacy capacity and motivation**.

**What else?** Additional suggestions include:

- Create/support an **affinity group for advocates trying to communicate public health's value in red states**, including tools and resources that address ROI, workforce implications, rural/urban divides, and shared values.
- Identify **public health "brand ambassadors"** in each state (ideally from outside public health) to cultivate relationships with legislators and "translate" public health for them.
- Create **materials** and toolkits that can reinforce common themes and still be tailored/customized to local situations (such as the cost/benefit-ROI framing discussed above), using language understood outside public health (e.g., "non-medical drivers of health" vs. "social determinants"), reflecting shared values (protecting

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<sup>14</sup> See, for example, guidance from the Berkeley Media Studies Group (<https://www.bmsg.org/>), Public Health Communications Collaborative (<https://publichealthcollaborative.org/>), the de Beaumont Foundation's *Talking Health; A New Way to Communicate About Public Health* (<https://debeaumont.org/books/talking-health-a-new-way-to-communicate-about-public-health/>), and state-specific resources such as the Michigan Association of Local Public Health's compilation of media and advocacy resources (<https://www.malph.org/mi-manual-public-health-leaders/media-and-advocacy>)



children, safe neighborhoods, productive workforce) and addressing equity in ways that honor and advance the goal but use different terms.

- **Address misinformation** in every way possible, through specific training, learning how to challenge instances of misinformation, and supporting others who share this mission (e.g., journalists/local journalism).<sup>15</sup>
- Create a **public health caucus, commission (such as Indiana’s and Maryland’s), or committee (e.g., the Texas House Committee on Public Health)** through the state legislature, or if one already exists, identify allies and strengthen relationships.

## 2. Encourage Strategic Deployment of Advocacy and Lobbying on Behalf of the Public’s Health

**Key opportunities** include:

- Build capacity and motivation among the existing and future public health workforce to **deploy a full range of advocacy tools** more assertively.
- Include **advocacy skills** in core competencies, undergraduate and graduate public health curricula, and ongoing professional development (including performance expectations for different roles).
- Bolster/expand **lobbying capacity**.

Specific opportunities for **funders** include:

- Encourage grantees to engage in legitimate, allowed **advocacy** activities (i.e., walk them towards the advocacy/lobbying line instead of away from it).
- Help public health and its allies advance **advocacy and lobbying for specific goals** (which may differ according to local/state contexts).

**What else?** Additional suggestions include:

- Provide **resources for non-governmental organizations to hire more lobbyists** (moving beyond products, talking points, technical assistance, etc.) so that they can build relationships, defend against attacks on public health, and secure funding for ongoing investments and rebuilding.
  - Specifically, hire and support successful lobbyists from *outside* public health. They are more likely to have the relationships and access public health generally lacks and can deploy public health expertise, but don’t necessarily

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<sup>15</sup> A resource for addressing misinformation is the Public Health Communications Collaborative’s Misinformation Alerts website and notifications, available here: <https://publichealthcollaborative.org/misinformation-alerts/>

need to have it themselves. Respondents suggested lobbyists from adjacent sectors such as state cancer, lung, heart, and brain health associations; hospitals and medical associations; climate change; and social justice groups.

- Use the insights of experienced lobbyists to help determine the appropriate focus of public health advocacy in each state/region—i.e., issue-specific advocacy, rebuilding infrastructure, non-medical drivers of health, etc.
- While it is imperative to increase the number of **lobbyists**, it is also important to make public health professionals at all levels more knowledgeable about and comfortable with both advocacy and lobbying (and how they can support lobbyists with their expertise). This could include training and education for the current and future workforce through academic institutions as well as technical assistance customized to specific states and scenarios via an **Advocacy Academy**.
- Provide **technical assistance and translation of public budgeting and appropriations** to public health organizations and allies that helps them understand state and local governmental budgeting processes, track how public funds are spent, use existing analyses of state and local budgets to further public health advocacy, and demonstrate the return on investment that strong public health represents.
- **Arm lobbyists with compelling ROI or cost/benefit data** that shows policymakers how public health interventions (and legislation associated with them) affects their constituents.

### 3. Counter Challenges to Public Health Authority

**Key opportunities** include:

- Share examples of **successful resistance** to (and preparation for) challenges to public health authority.
- Understand/disseminate the **variety and scope of challenges** in other states to be more prepared for them.
- **Match countering/challenging responses to varied local conditions** (i.e., red /blue state categories are not definitive).
- Enlist **support of allies** to counter challenges.

Specific opportunities for **funders** include:

- Research, test, disseminate specific communications **messages/framing that resonate in different political environments**.

- Support efforts to **track the legislative and litigation attacks on public health authority**.<sup>16</sup>
- Develop or support **campaigns and ads to counter** anti-public health messaging by explaining what public health contributes to overall health and well-being.

**What else?** Additional suggestions include:

- **Monitor precedents and playbooks designed to limit public health effectiveness** so that these can be countered in the moment and elsewhere.

## 4. Fight for Health Equity, With or Without the Language of Health Equity

**Key opportunities** include:

- Share **multiple ways to express the concept of health equity** that can be adapted to different situations. In particular, amplify examples from red states passing progressive policies using “red speak,” e.g., economic framing, community loyalty, faith-based values.
- Explore and adopt messaging that affirms a commitment to health equity using **other concepts and language** (e.g., fairness, opportunity).

Specific opportunities for **funders** include:

- Support development/testing of how to **make a strong case for health equity** across different political environments (as part of broader messaging); share knowledge/tools for how to do so.
- Provide **general operating support** to give grantees flexibility with how they address health equity in their state or region.

**What else?** Additional suggestions include:

- Share effective strategies from projects that address health equity via collaborative partnerships, such as the CDC Foundation’s Strategies to Repair Equity and Transform Community Health (STRETCH) initiative.<sup>17</sup>

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<sup>16</sup> For example, Act for Public Health (<https://actforpublichealth.org>) is a collaborative of public health law organizations that provides tracking and analysis of efforts to limit public health authority. Partners include Public Health Law Watch; the Public Health Law Center at Mitchell Hamline School of Law; the Center for Public Health Law Research at Temple University’s Beasley School of Law; ChangeLab Solutions; and the Network for Public Health Law.

<sup>17</sup> For more details about the STRETCH Initiative, see <https://www.cdcfoundation.org/programs/stretch>.

## 5. Tap the Strengths, Capabilities, and Shared Interests of Supportive Allies

**Key opportunities** include:

- **Strengthen ties to allies** with the capacity and willingness to conduct **lobbying** on shared community health goals, such as state or regional hospital associations and chambers of commerce.
- Support **collaboration across existing health and health-related advocacy groups** to increase their impact.
- **Form new advocacy and lobbying coalitions or organizations**, where needed.

Specific opportunities for **funders** include:

- Provide general operating support for **coalitions and/or new organizations** (e.g., creating connections among 501(c)(3), 501(c)(4), and 501(c)(6) organizations and their funds)
- **Help states assess advocacy capacity within the state including local and regional** partners (e.g., fund more in-depth state-specific and/or regional scans).
- Share **examples of successful approaches** with potential for replication.

**What else?** Additional suggestions include:

- Seek, highlight, and engage **new or unheard voices**, such as youth, millennial donors, moderate Republicans, business/industry, Tribal representatives.

## 6. Support the Public Health Workforce

**Key opportunities** include:

- **Define and advocate for what full-strength public health offers communities** (e.g., coordinated prevention initiatives, health-promoting programs and policies, better health outcomes, better quality of life, increase in community economic potential and marketability).
- Rebuild public health infrastructure, workforce, and funding with **sustained investments**.

Specific opportunities for **funders** include:

- Continue to **document and advocate for what full-strength public health would entail and could offer** (including variations by state/region).

- **Use philanthropic leverage** to push for governmental funding of public health services.
- Provide **supplemental funding to state and local public health departments** while government funding is being rebuilt.

**What else?** Additional suggestions include:

- Systematically assess state and local public health funding, infrastructure, and workforce needs through **state commissions** and **reports with recommendations**. At least, these document the size and nature of the gap. At best, they have led to legislation to strengthen public health systems at the state and/or local levels (as was the case in Indiana) or bolster specific areas and initiatives such as behavioral health (as in Arizona, Ohio, Maryland, South Carolina, and many other states).

## CONCLUSION

Alarm bells have been ringing for decades about the fragile status of public health's infrastructure and the inadequate advocacy capacity available to muster ongoing support. These concerns are not new. What is new is a political backdrop of eroding trust in all public institutions, including public health; viral, potent, and persistent misinformation that has eroded hard-won gains against preventable disease; a lethal pandemic reminder of the life-and-death stakes for millions of people; and a political backlash challenging public health authority that is playing out in state legislatures, County commissions, City Councils, and school boards across the country. Yet, as this 50-state scan has documented, advocacy for the public's health is taking place to varying ways in varying degrees of robustness in all 50 states.

The word "advocate" comes to us from the Latin *advocare*: literally, **to add a voice**. As the report of the April 2023 National Convening to Strengthen Public Health Advocacy noted, advocacy for the public's health needs to take place in every possible venue, from street corners to faith organizations to boardrooms to legislative chambers. Coordinated, well-funded, and aligned efforts that add many voices alongside those of public health are crucial, but they need to be called forth. We hope this scan adds urgency and direction within public health and among its many allies to build a robust, equitable, nationwide system of advocacy for the public's health, in states and communities throughout the country, within the next decade.

## ACKNOWLEDGEMENTS

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<sup>18</sup> *Fighting for the Public’s Health: Ideas for Action from an April 2023 National Convening to Strengthen Public Health Advocacy*. Available via <https://www.networkforphl.org/news-insights/fighting-for-the-publics-health/>