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COMMENTARY

Indiana's Public Health Investment Holds Insights For Other States

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ABSTRACT Indiana has a business-friendly environment, but historical underinvestment in public health has yielded poor health outcomes. In 2023, when trust in governmental public health was strained nationwide, Indiana increased public health spending by 1,500 percent. In this article, we explain how Indiana achieved this unprecedented legislative victory for public health, describing the context, approach, and lessons learned. Specifically, an Indiana University report linking economic vitality and overall health sparked the creation of a governor's commission charged with exploring ways to address Indiana's shortcomings. Working with the Indiana Department of Health, the commission developed multisectoral coalitions and business and government partnerships, and it maintained consistent and coordinated communication with policy makers. Lessons learned included the value of uncoupling public health from partisan narratives, appointing diverse commission membership with strategically selected cochairs, involving local leaders, and ensuring local decision-making control. We believe that Indiana's approach holds insights for other states interested in strengthening public health funding in the current era.

Charles Winslow, an early pioneer of public health, defined it as “the science and art of preventing disease, prolonging life and promoting health through the organized efforts and informed choices of society, organizations, public and private communities, and individuals.”¹ Although public health has been the primary contributor to improvements in overall life expectancy in both the twentieth century² and the early twenty-first century,³ policy makers in the US have historically underfunded public health, especially compared with the medical care delivery system that public health is designed to complement.

Until recently, Indiana was no exception. For several decades, Indiana ranked low in per capita public health investments⁴ and had poor overall health outcomes, including high smoking rates,

infant and maternal mortality, and rates of chronic health conditions.⁵ Indiana has a decentralized public health structure generally composed of small local health departments that experience significant staffing and budgetary constraints. Similar to many other states, during the COVID-19 pandemic, the historical underinvestment in public health further strained the Indiana public health infrastructure and its workforce.⁶ These occurrences make it all the more remarkable that the Indiana Republican legislature appropriated \$225 million in new biennium public health funding in 2023 for fiscal years 2024 and 2025,⁷ even as trust in governmental health agencies was low among political conservatives.⁸

In this article, we explain how Indiana achieved this unprecedented legislative victory for public health. Prompted by a state university

review of Indiana's public health infrastructure⁹ and organized by the state health department, the effort relied on tried-and-true public health methods that included multisectoral coalitions, business and civic government partnerships, and coordinated communication with policy makers. We discuss the findings of the report that proved to be critical to the process, the ensuing approach to building legislative support for unprecedented new funding, and the lessons learned that might hold insights for other states interested in strengthening public health funding in the current challenging era.

Indiana Public Health System Review

In 2020, the Richard M. Fairbanks Foundation, a respected local philanthropic organization, funded a report assessing the Indiana public health system, conducted by Indiana University's Richard M. Fairbanks School of Public Health.⁹ Released in December 2020, the report comprehensively analyzed the availability of public health services across Indiana counties and made recommendations for how the state could address key deficiencies. Relying on key-informant interviews with dozens of public health experts from across the state and other data analyses, the report compared Indiana on important metrics with the US overall, with neighboring states, and with a comparable set of states selected for their similarities to Indiana in political and structural characteristics. These metrics included per capita public health funding and population health metrics such as disease burden, premature mortality, and health behaviors (for example, smoking).

The five key findings of the report helped frame major issues, established a shared knowledge base among stakeholders, and tied population health to other important state goals. First, the report found that many state stakeholders, including business leaders and some policy makers, were unable to differentiate between the role of public health in preventing illness and protecting populations and the role of the medical care system in treating illness and injury one patient at a time. Second, the report showed how Indiana's communities receive less public health funding compared with the US overall, neighboring states, and comparable states, which likely contributes to Indiana's poor health outcomes.

Third, the report showed that all Indiana local health departments, regardless of size, predominantly rely on local funds (for example, county property taxes and user fees) to support approximately 70 percent of public health activities and

services within their jurisdictions. This contrasts with US norms, where state-level funds more predominantly support the provision of local public health services. Critically, every Indiana county is subject to a constitutional property tax cap and a limited tax base, creating a need for prioritization, given the limited funds. Relying on local funds has resulted in significant variability in the provision of essential public health services from one county to the next, which was the report's fourth key finding. In fact, some areas provided fewer than half of all recommended services.

Fifth, the report found that failure to address population health in Indiana will likely impede the state's economic growth. Indiana has historically prided itself on maintaining a business-friendly environment, but many policy makers had not previously recognized the inextricable link between population health and long-term business success.

To address the findings presented, the report recommended the creation of a statewide task force with broad representation from major constituency groups. The report also provided a foundation for subsequent efforts to gather legislative support and ultimately transform the state's public health system.

The Approach

On August 18, 2021, Gov. Eric J. Holcomb issued an executive order establishing the Governor's Public Health Commission, funded through a grant from the Richard M. Fairbanks Foundation and department appropriations. The broad membership included leaders from business, health, and academia and locally elected officials, appointed in consultation with the state health commissioner (Kristina Box), who served as the commission's secretary. Two cochairs were appointed whose complementary skills and credibility proved critical to the commission's success. One of the cochairs was a seasoned prominent former legislator with significant budgetary appropriation experience who was also known for being historically skeptical of expanding public funding. The second cochair was a national public health leader who had previously served as Indiana's state health commissioner. A list of members and their position titles is in the online appendix.¹⁰

The activities of the Governor's Public Health Commission included monthly public meetings, seven listening tours across the state, and the crafting of a proposal for structural and operational interventions to ensure the statewide availability of foundational public health services. The governor consistently showed strong

support for the work of the commission and highlighted the importance of public health in his State of the State Address, in other speeches, and in meetings with stakeholders. The Governor's Public Health Commission was supported by approximately one dozen staff members at the Indiana Department of Health, who organized public meeting agendas, lined up subject-matter experts, and provided additional data as requested. The staff performed these tasks above their regular duties or had their workloads temporarily rebalanced. A contracted consulting firm provided project management, research, and technical assistance. The commission used a socio-ecological model of health to help demonstrate the interrelatedness of various partners and systems and their impact on an individual's health outcomes and on population health.

MONTHLY PUBLIC MEETINGS The first meeting of the Governor's Public Health Commission focused on the findings and recommendations of the report described above, which set the stage for the commission's subsequent work. It also served as an opportunity to educate members on foundational public health concepts. Other meetings covered such topics as governance, infrastructure, and services; public health funding; data and information integration; public health and clinical workforces; child and adolescent health; and emergency preparedness.

All Governor's Public Health Commission meetings were open to the public and held at the Indiana State Library, with the option to participate via live stream. An electronic public comment form was created to allow people not physically present to provide feedback to the commission on relevant topics. Comments received were synthesized and read into the record. Presentation materials were posted to the commission's website, and recordings of each meeting were later posted online. The cochairs actively engaged all members of the commission with questions and discussion. Attendance at the meetings was very high for publicly appointed groups, with nearly 100 percent attendance among commission members for the duration of the commission. After each meeting, a press release was issued to highlight the key points and to ensure transparency and ongoing awareness.

LISTENING TOUR In addition to the monthly meetings, the Governor's Public Health Commission conducted seven in-person listening sessions across the state in various urban and rural locations. These sessions began with a brief introduction to the commission's purpose, its mandate, and major public health achievements over the course of the past century. Commission members also introduced themselves and offered brief remarks. Stakeholder input (up to

The Governor's Public Health Commission worked diligently to demonstrate the linkage between investment in public health and long-term economic security.

three minutes of oral testimony per person) was solicited to help commission members understand public perceptions about the state of public health, potential recommendations, and general concerns. As expected, many attendees expressed concerns about the pandemic response and generally negative views of public health authority related to mask and vaccine mandates. Importantly, the commission members and Indiana Department of Health staff did not engage or interact beyond asking probing questions and then thanking participants, which helped ensure orderly hearings.

Given the findings of the Indiana public health system review, a secondary purpose of these meetings was to clearly differentiate public health as a complement to clinical care delivery. Distinctions were made between clinical care, such as a physician visit for a checkup, and population-based interventions, such as trauma and injury prevention programs to increase helmet use. In addition, the Governor's Public Health Commission stressed how strengthening public health benefits all residents of the state, not just a particular group, as was originally perceived by many stakeholders. Participation in each listening session was enhanced by intentionally inviting local business and community leaders, including hospital leadership, chamber of commerce members, county commissioners, state legislators, educators from K-12 and higher education institutions, leaders of other municipal corporations, local health department leadership, and leaders of other community-based organizations.

As the commission worked on finalizing its recommendations, members had access to summaries of the listening sessions, which allowed them to include language or approaches that

An important lesson that proved indispensable was the deliberate uncoupling of the benefits of public health from partisan narratives.

incorporated community feedback. For example, data privacy had not been identified as a recommendation until it was mentioned several times during listening sessions.

BUSINESS AND CIVIC PARTNERSHIPS As part of its early messaging, the Governor's Public Health Commission worked diligently to demonstrate the linkage between investment in public health and long-term economic security. Indiana Department of Health and commission leaders met with dozens of organizations to help them understand this linkage, and thus the commission's urgency. Working with chambers of commerce, the commission established a further link between the high cost of health care in the state, the lack of health coverage, and a perennial focus on crisis care in lieu of prevention.

Working with county commissioners, mayors, and community-based organizations, the commission further established how insufficient access to public health and preventive services attenuated the ability to attract new businesses because of poor population health, lower worker productivity, increased sick leave, and higher employee health costs, all of which affect business competitiveness. For example, data showing decreased life expectancy in the cohort ages 25–64 highlighted a hollowing out of a key working-class age group. The effect on businesses resonated strongly with stakeholders and underscored the imperative nature of investing in public health to stem the tide of preventable deaths.

COORDINATED COMMUNICATIONS Critical to the success of the commission's approach was consistent and coordinated communication about how deficiencies in public health service availability adversely affected individuals and communities. This communication relied on empirical data to undergird important points and was accompanied by relevant vignettes to help capture the attention of key stakeholders. For exam-

ple, the Indiana Department of Health detailed the number of underserved people who relied on various local health department services. The department further shared anecdotes of how local health departments collaborated; how local health administrators took extra steps to solve problems; and instances when the state needed to assist, as requested by local health departments, in the provision of needed services.

Senior leaders at the Indiana Department of Health were in constant communication with state legislators, county commissioner groups, and other stakeholders, keeping each abreast of topics important to their respective constituencies. Department staff drafted postmeeting updates with short but salient points for all legislators, focusing on information they could share with constituents. These notes, which were typically a couple of sentences long, were what the Indiana Department of Health staff and the Governor's Public Health Commission cochairs considered most relevant to legislators. Leaders from the department and the commission met with key legislative leaders representing public health committees in the Senate and House more frequently to provide more in-depth updates. The department also held more than thirty meetings with various stakeholder groups, including trade associations (for example, medical societies and health groups) and local public health directors and their staffs, to provide specific updates, answer questions, and resolve issues raised.

The governor's office also played an important role in bidirectional communication, coordinating with the Indiana Department of Health, the Governor's Public Health Commission, and others. Governor Holcomb encouraged naysayers to keep an open mind, engage with the commission in earnest, and consider the benefits to all state residents of having a robust public health system in place. Overall, these open, consistent, and transparent communications were frequently cited by stakeholders as very helpful, which allowed for updates on progress and potential solutions.

PUBLIC HEALTH DAY AT THE CAPITOL During the 2023 legislative session, Indiana Department of Health staff organized a Public Health Day that took place at the state capitol to draw attention to the work of the Governor's Public Health Commission. This event was attended by thousands of grassroots supporters, who filled the atrium and several gallery levels throughout the day. Activities included speeches by the governor, the commission cochairs, and business and health leaders. Supporters also distributed blue and gold t-shirts, representing the agency colors of the Indiana Department of Health, in

support of public health. Messages throughout the day reinforced how improvements to public health benefit all residents of Indiana.

COUNTY AND STAKEHOLDER ENGAGEMENT Engaging with county officials was important throughout the entire process. County health officers and local elected officials (county commissioners and a mayor) were represented on the Governor's Public Health Commission. Importantly, counties in Indiana differ significantly with respect to life expectancy (exhibit 1), population size, and historical public health funding. There was a need to be as inclusive as possible when engaging with county stakeholders to ensure buy-in and representation from multiple perspectives regarding public health.

On August 1, 2022, the Governor's Public Health Commission issued its report to the governor.¹¹ After the release of the commission's

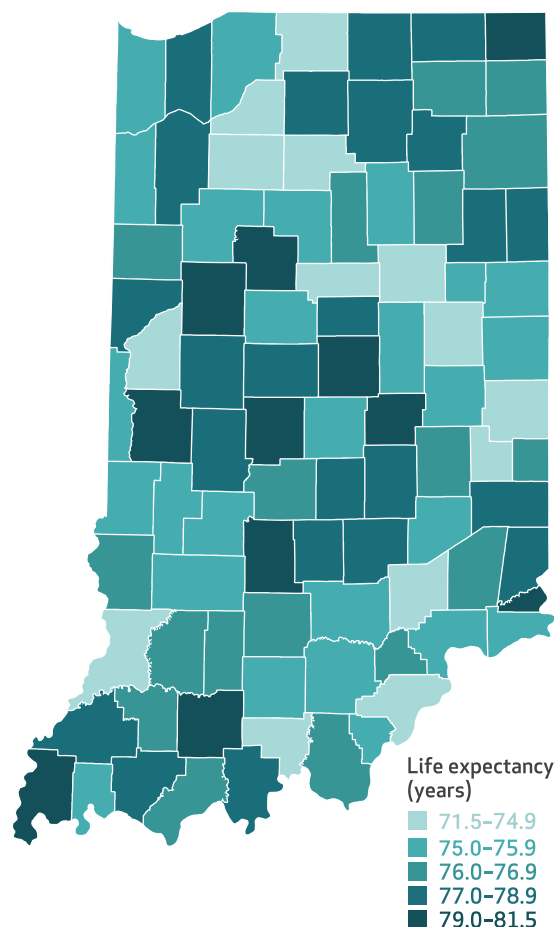
recommendations, the Indiana Department of Health convened the Core Services Leadership Committee to discuss the core public health services that should be performed at the county level, as well as applicable key performance indicators. Importantly, the committee included several local health department administrators and county health officers. Updates regarding the committee's deliberations were regularly shared with all local health departments for feedback, which, in turn, created opportunities for bidirectional information sharing and refinement of the ad hoc committee's recommendations to the Indiana Department of Health with regard to how to implement the commission's findings.

The commission's work included engagement and communication with legislators during the legislative session. In addition, during this time, the Indiana Department of Health and Governor's Public Health Commission leadership simultaneously worked closely with many stakeholder groups from the health care, business, and manufacturing sectors, including the Association of Indiana Counties and Indiana County Commissioners.

The legislation implementing the commission's nonfinancial recommendations, Senate Enrolled Act 4, passed with strong bipartisan support and was signed into law on May 4, 2023. Separately, the budget bill (House Enrolled Act 1001) established a new funding formula for local health departments and appropriated \$225 million in new biennium public health funding for fiscal years 2024 and 2025 with no new state taxes. The Indiana Department of Health began implementing the commission's recommendations by launching the Health First Indiana program to signify a new era for Indiana's public health system.¹²

EXHIBIT 1

Life expectancy in Indiana counties, 2018–20



SOURCE University of Wisconsin Population Health Institute. County Health Rankings and Roadmaps, Indiana [Internet]. Madison (WI): The Institute; c 2024 [cited 2024 Apr 26]. Available from: https://www.countyhealthrankings.org/health-data/indiana?measure=Life+Expectancy*&year=2022

Lessons Learned

There are several lessons learned that we believe could be helpful in future discussions about ways to strengthen investments in public health, especially in other states. First, convincingly showing the link between the health of the population and future economic vitality aligned stakeholders. Although those who work in public health have come to accept this link as common knowledge, it was surprising to see how few others intrinsically perceived this connection.

Second, the inclusive composition of the Governor's Public Health Commission with strategically selected cochairs—one with legislative experience, the other with public health expertise—was critical to the commission's success. The cochair with previous state legislative

The health of the population and the economic vitality of the community are universal goals that should be shared by leaders in every US state.

experience originally had reservations but committed to the process. Seeing the evidence, hearing the stories of citizens struggling to receive needed services, and recognizing the value of public health transformed the skeptical cochair into a key advocate for the legislative victory. The other cochair, who was respected for her public health expertise, helped ensure that all relevant information was considered. Including locally elected officials and experts at the Indiana Department of Health strengthened stakeholders' and legislators' understanding of the health, technical, and political issues, which was necessary to effect change. Of note, all Governor's Public Health Commission members signed the commission's recommendations, demonstrating unity in their endorsement.

The process was further enhanced by the transparent and accessible nature of commission operations, with open meetings, a statewide listening tour, and all materials made available publicly ahead of or soon after each meeting. The listening tour's bidirectional information sharing instilled credibility in the process and encouraged further engagement, especially from local leaders and key partners. Working with locally elected officials was critical for galvanizing grassroots support.

An important lesson that proved indispensable was the deliberate uncoupling of the benefits of public health from partisan narratives. Heightened political polarization during the pandemic created a challenging environment for public health leaders and their messages.¹³ A conscious effort was made to avoid using terms that unintentionally elicit partisan narratives and impede meaningful discourse. Instead, the Governor's Public Health Commission focused on broad public health goals (for example, every-

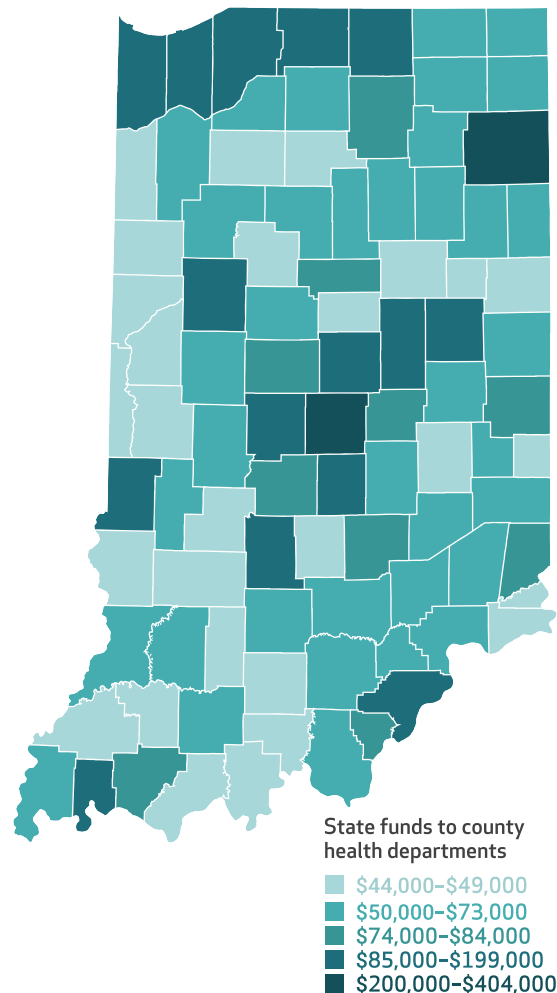
one deserves access to essential services and a healthy life), the local benefits of a stronger public health infrastructure (for example, attractiveness to business and positive effects for everyone), and more robust investments in prevention (for example, fewer deaths, greater wellness, and productivity). The broader focus reframed the discussion around what was possible, rather than what was wrong now or in the past. A 2010 report by the Robert Wood Johnson Foundation highlighting effective ways to talk about the social determinants of health with people of varying political views was very helpful.¹⁴ The commission's experience suggests that the health promotion and prevention messaging that public health has delivered for decades was not inaccurate but was, perhaps, limited in its delivery.

Another takeaway was the importance of the locally authored university report that assessed the Indiana public health system.⁹ The knowledge gaps among stakeholders identified by the report influenced what the Governor's Public Health Commission focused on, and how. Using data from neighboring and comparable states was helpful, given that previous critiques of the state's public health system typically focused on comparisons with exemplar states that did not share Indiana's political and demographic characteristics or values. The link drawn by the report between health outcomes and the state's economic development goals was also very important. Ultimately, the report fostered a shared understanding of the multidimensional challenge among stakeholders and is an example of what academic health departments can accomplish when schools of public health and state and local health departments form partnerships.¹⁵

Last, given county leaders' concerns that increased state public health funding would effectively cede control of local decisions to the state, the Governor's Public Health Commission, at the urging of one of the cochairs, recommended a voluntary opt-in approach to Health First Indiana funding at the county level, with shared match requirements (exhibit 2 shows funding levels by county in 2023, before Health First Indiana was implemented). Such a matching approach was previously used successfully in Indiana to fund county road improvements. Counties that opted in (eighty-six of ninety-two counties did so) to receive state funding were required to contribute a 20 percent match, but they maintain independent control over how to provide the required core public health services. Counties can leverage and scale existing programs within their communities, create new grant-funded programs, or expand services in partnerships with counties around them. The funding to the coun-

EXHIBIT 2

State funds provided to Indiana county health departments in 2023, before the implementation of Health First Indiana



SOURCE Local public health budgets, state of Indiana, 2023. See Health First Indiana. Health First Indiana in your community [Internet]. Indianapolis (IN): Indiana Department of Health; [cited 2024 Apr 11]. Available from: <https://www.in.gov/healthfirstindiana/your-community-info/>. **NOTE** Health First Indiana is a statewide public health initiative that began after the Governor's Public Health Commission issued its report in 2023.

ties is based on a statutory formula that considers population size, social vulnerability, and life expectancy for the county. Counties can periodically revisit the decision to accept state funds and must submit annual budgets, a report of how the funds were used, and their performance on statewide key performance indicators and, eventually, local key performance indicators.

Implementation, Preliminary Evaluation, And Expectations

To assist with the implementation of Health First Indiana, the Indiana Department of Health de-

veloped a county health scorecard with metrics and ratings for seven health measures.¹⁶ Counties can use these data to develop their budgets and plan where they should focus initiatives. In the first year of funding (2024), evaluation is focused on building capacity, which includes either hiring or partnering with local and state organizations to provide the required core public health services. Some counties will hire new employees or upgrade part-time employees to full time; others will convert contractors to employee status. In addition, counties are required to develop local key performance indicators. The Indiana Department of Health's goal is for local health departments to ensure local provision of core public services, including with local civic and business partnerships. Local health departments need not provide all services directly, but, through partnerships, they can ensure access to core services within their community. This may shift the role of the local health department to being more of a convener and focal point within the community network, rather than exclusively a direct provider of services.

The legislature generally expects to continue funding Health First Indiana efforts past the first two-year budget cycle. The Indiana Department of Health meets regularly with local health departments, community organizations, and local and state elected officials to share ideas and answer questions. The Governor's Public Health Commission disbanded after issuing its recommendations in 2023, but stakeholders and individual commission members continue to be engaged. In February 2024, the Indiana Department of Health hosted the second Public Health Day, during which the Indiana Chamber of Commerce (representing more than 4,000 businesses) and the Indiana Hospital Association (representing more than 170 hospitals) announced a pledge to support state and local efforts to address obesity, tobacco cessation, and infant and maternal mortality. A delegation from Maryland attended Public Health Day to learn about how Indiana's experience might inform Maryland's efforts to strengthen its public health system.

Conclusion

Overall, Indiana's experience showed how academic institutions, state and local government officials, business and community leaders, hospital leaders, health leaders, and other stakeholders can work together in pursuit of shared goals. Doing so was enabled by tactics long used in public health endeavors, including multisectoral coalitions and partnerships, forums for the meaningful exchange of ideas, and coordinated

communication with policy makers. The health of the population and the economic vitality of the community are universal goals that should be shared by leaders in every US state.

Despite the differences from one state to the next with respect to public health funding, infrastructure, or policies, the foundational public health capabilities and services are universally required for any system to function even at a basic level. All states could benefit from addressing the known deficiencies in the nation's public

health system. We hope that sharing Indiana's contemporary experience gaining support for public health might be helpful to others interested in strengthening the health of all. Ultimately, although we are optimistic about Indiana's progress, we note that despite the new investments in public health, Indiana's per capita investments still lag the US average. Nevertheless, Indiana now has an opportunity to show policy makers and constituents what investments in public health can yield. ■

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