

NATIONAL SUMMIT SERIES: SUMMIT 3

Strengthening Public Health Law, Governance and Finance to Support a Modern System

FEBRUARY 23, 2022

SUMMARY REPORT

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Introduction

Lights, Camera, Action: The Future of Public Health National Summit Series

A CDC Foundation summit series launched in December 2021 to explore and advance the future of public health with the theme of *Lights, Camera, Action: The Future of Public Health*. This national summit series not only presents a comprehensive and critical view of the current landscape of public health in the United States but—more importantly—it convenes public health workers and key stakeholders across disciplines and across the nation to collaboratively construct a harmonized, strategic and action-oriented approach to move the field forward following decades of underinvestment and two years of a devastating pandemic.

The theme of the summits—*Lights, Camera, Action*—provides a framework through which the field can transform itself to meet the present and future needs of public health in the United States.

- **Lights** are the guiding lights from recent research, recommendations and action plans from leading public health organizations. These exemplars in practice and policy showcase the nation's current gaps and identify solutions to rebuild public health infrastructure.
- **Camera** refers to framing public health through the lens of the pandemic and its impact on the public's trust in the field. Today, there is a need for the United States to refocus the camera to rebuild trust and transform public health. The camera also emphasizes the need for everything public health does and touches to be framed through an equity lens.
- **Action** represents the steps public health officials and partners can take to address the issues illuminated by the lights and captured through the camera lens. Public health officials at all levels of state, local and national governments have a role to play in shaping a public health system built for today's needs and tomorrow's challenges.

The *Lights, Camera, Action National Summit Series* is a collaboration of the CDC Foundation, the National Association of County and City Health Officials (NACCHO), Association of State and Territorial Health Officials (ASTHO) and Big Cities Health Coalition (BCHC). Support for the summits is generously provided by the United Health Foundation, the Robert Wood Johnson Foundation and the Pew Charitable Trusts.

The summit series grew out of a coalition of organizations brought together by the Bipartisan Policy Center to develop a five-year road map for public health leaders and elected officials. Their goal is to influence strategic investments and decision-making to build a more robust and sustainable public

health system. The reports that came out of that coalition, [Public Health Forward: Modernizing the U.S. Public Health System](#) and [The Future of Public Health: A synthesis report for the field](#), provided the foundation for these summits.

Many of the themes and suggestions that emerged from this summit reflect those in the *Public Health Forward* and *The Future of Public Health* reports while also adding details of individual and shared experiences of summit presenters and participants.

The four virtual convenings of the summit series are focused around key priority areas: (1) workforce development; (2) data and technology; (3), law, governance and finance; and (4) cross-sector partnerships and community engagement. The overarching objective of the summits is that together we can write a new script and produce a new future for public health in America.

This summary report provides an overview of the discussion in the third virtual convening held on February 23, 2022. In addition, a video recording of the third summit is available on the summit series website at www.futureofpublichealth.org, along with relevant resources for each summit and the series overall. Summary reports, scripts for action and video recordings of the first two summits are also posted on the website, and similar reports will be available following the other summits as well.

This report highlights key observations and themes for action identified by summit speakers and participants that stakeholders can use to guide their efforts to advance the future of public health in the United States.

Strengthening Public Health Law, Governance and Finance to Support a Modern System

The third of the four virtual convenings of the *Lights, Camera, Action: The Future of Public Health* summits focused on three topics essential to providing leadership in public health: governance, finance and law. While these three topics are presented in this report as distinct entities, they are in fact intricately interwoven to support the system of public health. Governance, finance and law, in turn, drive each other, define each other and serve as both facilitators and barriers to each other.

In her opening remarks, Judy Monroe, MD, president and CEO of the CDC Foundation, defined each of the three terms and introduced the relevant strengths and opportunities that would be the focus of the third summit:

“Governance provides the context—how public health functions in a jurisdiction.”

Governance of public health in the United States is difficult to discuss in broad strokes because it varies greatly from jurisdiction to jurisdiction, especially with respect to the degree of centralization. In some states, a more decentralized, or home rule, model is preferred, whereas in others governance is more top-down. Both approaches have their advantages and disadvantages. Governance also determines what gets financed and how.

“Financing supports the skilled workforce, the state-of-science laboratories, and the forward-leaning programs—in essence the mechanics of public health.”

The unprecedented influx of federal funds to state and local public health departments provides significant opportunities for the advancement of public health, but with it comes enormous complexity. The key challenge in financing public health in this moment is in finding, strategically assembling and determining how to deploy these resources to rebuild and ensure the future sustainability of public health.

“Public health law provides the legal guidance and authority required for healthy communities.”

The protection of public health has long been guaranteed through laws and policies that are deeply rooted in scientific evidence. Over the past two years especially, laws and policies have facilitated unprecedented efforts to protect the public’s health and stop the spread of the COVID-19 virus—for example, through CDC’s federal mask mandates for public transportation and the moratorium on evictions. These and many other exercises of public health authority have protected and saved countless lives throughout the pandemic, but they have also made public health more controversial.

As the COVID-19 pandemic shed new light on the role of public health law and policy in public life, it also sparked some challenges for the field. In some places existing public health authority is being questioned, and in others laws have been revised to restrict the practice of public health moving forward.

Throughout the third summit, presenters and attendees discussed successes and challenges in public health governance, finance and law as well as ways that strengthening these three domains can collectively support a modern system. Speakers acknowledged this moment is a turning point for public health in the United States. The renewed attention to the field creates a window of opportunity to fundamentally transform public health infrastructure for an equitable and sustainable future and to write a new script for the future of public health.

Following the summit plenary, invited breakout group sessions were held with decision makers around the country to strategize about how to transform these ideas into action. These breakout group sessions included six perspectives: 1) innovations in financing population health; 2) current federal opportunities in public health financing; 3) opportunities and challenges in the flow of federal funding through states to communities; 4) future public health leadership and infrastructure; 5) hot topics in law and what to do about them; and 6) equity in law and governance.

An Accelerating Action report will follow this event summary report with more details on actions to be taken by different stakeholders in the short, medium and long term. Check the [summit series’ website](#) for these and other resources for each summit.

The virtual summit produced several key themes for how to strengthen public health governance, finance and law to support a modern system. This report frames these topics through the summit series’ theme.

- **Lights:** Shining a spotlight on the essential role of governance, finance and law in public health will help the field practice good governance through clear, effective communications; navigate innovations in public health finance; and understand fundamentals of public health law and authority.
- **Camera:** Reframing and refocusing the camera on the functions of governance, finance and law in public health will enable the field to practice equitable and inclusive community engagement rooted in values, to transform the public health finance ecosystem for equity and justice, and to apply law as a tool for advancing health equity and racial justice.
- **Action:** After shining a spotlight on the roles of governance, finance and law in public health and reframing and refocusing the camera on the functions of each domain, the field can take action through deepening cross-sector and community partnerships to advance health equity, financing a sustainable future for public health and embedding law and advocacy into public health learning and practice.

Governance

Governance is the means through which public health applies its laws, policies and approaches for finance to protect health, center equity and promote well-being for all. As one of the plenary speakers explained, the COVID-19 pandemic has created a “wet cement” moment that provides the field with an opportunity to rethink how public health is governed.

*“We have weathered, are weathering multiple disasters at the same time, [but] disasters also offer what we can think of as these ‘wet cement’ moments, where systems and structures that previously seemed impervious to change actually become malleable and changeable. **And so in this wet cement moment we find ourselves in today, we have a once-in-a-generation opportunity to reimagine what should properly be governed as public and what should properly be governed as private....** So now is an incredible and critical opportunity to bring our health equity values, to bring our racial justice values to this conversation and bring more of the social determinants of health into the public realm so that they may appropriately be publicly governed.”*

AYSHA PAMUKCU, JD, POLICY FUND INITIATIVE OFFICER,
THE SAN FRANCISCO FOUNDATION

This third virtual convening highlighted the role of governance in public health at this point in history, refocused the camera on its potential impact across and between the different levels of government and produced a new script for action to strengthen public health governance to support a modern system.

The first poll taken during the third virtual convening attempted to pinpoint the present and future role of public health governance according to summit attendees. Participants were asked to choose which aspect of governance they would prioritize to strengthen the field of public health. Their response was a near tie in the two most popular choices: “clear, effective communications” (27 percent) and “equitable and inclusive community engagement” (26 percent).

POLL: Which aspect of governance would you prioritize to help strengthen the public health field? (Select one.)	% of total responses
Accountability	10%
Clear, effective communications	27%
Effectiveness and efficiency	14%
Equitable evaluation frameworks/tools	6%
Equitable and inclusive community engagement	26%
Responsiveness	5%
Transparency	10%
Other (Enter your priority in the chat.)	2%
Total	100%

At least five attendees expounded on this tie in the chat, stating they had trouble choosing between the top two options. Two others commented that accountability is also difficult to isolate from the other choices.

In fact, the issues of clear, effective communications and equitable and inclusive community engagement overlap significantly when it comes to public health governance. Good governance requires meaningful community engagement, and meaningful community engagement cannot be achieved without clear, effective communications.

GOVERNANCE

- **LIGHTS: Good Governance through Clear, Effective Communications**

CAMERA: Equitable and Inclusive Community Engagement Rooted in Values

ACTION: Deepening Cross-Sector and Community Partnerships to Advance Health Equity

Guiding Lights

LIGHTS: Good Governance through Clear, Effective Communications

The third virtual convening of the *Lights, Camera, Action National Summit Series* illuminated the need for good governance through clear, effective communications. Emphasizing communications about the positive aspects of public health governance will make it easier for the field to effectively govern public health in more challenging times. Accepting that public health is inherently political and embracing a values-based approach will further facilitate clear communications for effective public health governance.

Clear communications about good governance

Throughout the third summit, presenters and attendees discussed the need to improve public health communications in order to strengthen public support for the field and its work. Improving communications has been a recurring theme across all the summits. As Dr. Georges Benjamin, executive director of the American Public Health Association (APHA) stated in the [first summit](#), “we all in public health used to chuckle about the fact that even our family members didn’t know what we did.”

As participants have noted across all the summits, the traditional behind-the-scenes nature of public health’s work has presented some challenges during the COVID-19 pandemic. In the chat, attendees of this third virtual convening emphasized the role improved public health communications can play in highlighting all the positive aspects of public health governance. Communicating about public health’s successes in prevention and improvements to quality of life can help to ensure that the field maintains its authority to manage the threats to come.

- “Why don’t we hear about things we’ve investigated and prevented in the media? We pride ourselves on people not hearing when public health is not working, and that’s awful. No wonder people don’t give us money. We need to tell people what we’re doing and what we’re succeeding with.... If we don’t communicate, public health authority will be taken away.”
- “No one knows what we prevent. We also need to be clear when we talk about social determinants of health; we need to communicate our strategic vision well. We are talking about having a society where people feel good, not just lowering the cases of car accidents. Social determinants is about having a top-level vision of

a happy, hopeful, healthy society and all those deeper conditions. We have to convince people to appreciate the good life, not just prevent epidemics. How is what we're doing going to make people feel like the deck is stacked FOR them?"

One of the questions posed to the audience in the chat during the third summit asked participants for their suggestions on how to better communicate about the role of public health. Summit attendees provided a wealth of advice on what needs to be communicated and how. The recommendations from summit participants are sorted into themes in the table below.

Q: How do we communicate better about the role of public health?	
WHAT	Explain public health fundamentals
	Highlight public health's achievements
WHEN	Talk about public health in good times AND bad
HOW	Use plain language and storytelling
	Communicate uncertainty with transparency, consistency and humility
THROUGH WHAT MEANS	Establish two-way communication channels
	Seek assistance from communications and marketing experts
	Partner with schools
	Partner with trusted messengers

The idea of two-way communication channels was raised by several summit attendees who saw it as a way to combine the poll's top priorities of clear, effective communications and equitable and inclusive community engagement. A few participants suggested things in the chat like hosting public town-hall-style meetings, *"giving the public a chance to tell you what they are dealing with and hearing what you are doing for the community."* Another participant talked about a daily public health column in the local newspaper that emerged during COVID-19: *"there is no reason this cannot be used in the future to answer the public's questions and communicate our role."*

In one of the breakout groups, participants acknowledged listening is a fundamental skill public health needs to develop in order to improve its communications:

"Listening is the through line in this discussion. We talk about improving communication and messaging, but communication is a two-way street. We do a lot of talking at people and want to tell them what we know, but communication involves listening. So much of what I'm hearing around the answer to the question on governance and innovation was around partnerships and it is around communications: working together, communication and active listening."

At one point in the plenary, panelists were asked for their number-one tip for advancing public health practices to be more inclusive of diversity of thought and religious/cultural/political viewpoints for effective public health governance. Overwhelmingly, the response was: "listen."

"Listen. That is our number-one initiative that we're taking: being better listeners to community voices...really listening to what community issues are and then how can we jointly help solve those. But let the community voice drive what those solutions are; don't make any presumptions that we know what they are.... We need to...operate through humility and ask what the community needs. And just really listen."

ELKE SHAW-TULLOCH, MHS, PUBLIC HEALTH ADMINISTRATOR,
IDAHO DEPARTMENT OF HEALTH & WELFARE

Effective communications about complicated governance

Learning to listen more should help the field significantly improve its communications around governance issues that have the potential to be the most controversial. As the pandemic revealed, one of the biggest challenges to public health governance is the perceived conflict between collective well-being and individual liberties. This conflict creates challenges for both effective communications and inclusive community engagement.

Throughout this summit series, and especially in this third virtual convening, speakers and participants urged the field to consider more diversity of thought. While the field—with its shared vision of collective well-being—can sometimes seem like an echo chamber, the public it serves is most definitely not. As one attendee put it in the chat:

“Public health needs to be willing to speak to the public, to elected officials, to the business community. It must speak to communities adverse to public health.”

In a breakout group discussion on how to engage with those who disagree with public health’s vision of collective well-being, participants shared a variety of perspectives. These ranged from exasperation to charging ahead regardless to attempting to “bring in” those who disagree with the field:

- *“How do we push forward toward equity when some locales can’t even say the word ‘equity’ for fear of triggering backlash?”*
- *“Many people’s beliefs and values are more individually focused and are not aligned with the idea that health is not something that an individual can do alone. The mindset of rugged individualism is widespread and lauded. So taking a values-based approach may not work with that section of the population. Perhaps we press ahead and accept that this cohort will be a vocal opposition?”*
- *“What if we treated the conflicts that we have encountered between governmental public health and some of our elected leaders in ‘home rule’ jurisdictions and those who champion states’ rights as we treat working with diverse cultures and diverse communities? This approach encourages us to learn about what makes those policy makers and others tick and work to reach common ground. What if we thought about how to be accountable for the public health authorities that we have been granted through law or rules and regulations in ways that aren’t perceived as heavy government but helpful government?”*

There were multiple discussions about how to approach this challenge throughout the breakout group sessions, but ultimately—as with so many things in public health—what is needed is for the field to take a both/and approach. As APHA’s Dr. Georges Benjamin explained when this topic came up in the first virtual convening of this summit series, the key is acknowledging that public health functions in an inherently political environment, while at the same time striving to maintain “the respect and trust of all the people that provide us oversight including our elected officials, our bosses, as well as the public.” Such an approach can help to ensure good governance in challenging times.

Accepting the political nature of public health for clear, effective communications

A recurring theme throughout the entire summit—and the entire summit series—was the impossibility of ignoring the fact that public health is inherently political. The political nature of public health, and the field’s aversion to it, has serious implications for clear, effective public health communications.

“Public health has always been and always will be political because it’s public policy. It is not a technocratic domain. It is a public domain.”

JOSÉ MONTERO, MD, MHCDS, DIRECTOR, CENTER FOR STATE, TRIBAL, LOCAL AND TERRITORIAL SUPPORT, U.S. CENTERS FOR DISEASE CONTROL AND PREVENTION

One of the breakout group participants mentioned an article in *The Atlantic* from late 2021 by Ed Yong, [“How Public Health Took Part in Its Own Downfall,”](#) which poses that public health’s attempts to be apolitical all but guaranteed the field’s inability to address the intersecting crises of the global pandemic and centuries of systemic racism coming to a head in these past two years.

GOVERNANCE

LIGHTS: Good Governance through Clear, Effective Communications

- CAMERA: Equitable and Inclusive Community Engagement Rooted in Values

ACTION: Deepening Cross-Sector and Community Partnerships to Advance Health Equity

Guiding Lights

“As the 20th century progressed, the field moved away from the idea that social reforms were a necessary part of preventing disease and willingly silenced its own political voice. By swimming along with the changing currents of American ideology, it drowned many of the qualities that made it most effective. Public health’s attempts at being apolitical push it further toward irrelevance.”

Indeed, in a breakout group discussion, one of the participants at this third virtual convening explained that the field’s aversion to being political only makes room for others outside of public health to decide how the field is to be politicized.

“There has been a fear of being political (not partisan necessarily) in public health—defining ‘political’ here as having to do with the allocation of scarce resources. Sometimes we have been unwilling to advocate on behalf of a set of values and ideals, instead dithering with numbers around technocratic fixes rather than broad values-based solutions. The fear I have is that—in choosing not to advocate in a values-driven way—we are getting washed up in a larger wave that is politicizing us, independent of our own choices. There has to be a sense where we say, ‘Listen, what we do implies a redistribution of resources in society.’ And it implies that there are going to be people who are not happy with the fact that, sometimes, when we redistribute, it’s a little more zero-sum than some people like.... For as much as we have resisted being political—there is a lot that is politicizing us.”

Participants in the third virtual convening recommended public health should accept and embrace the field’s political nature, intentionally engage in more organized advocacy (more details below in the Law section) and reclaim its values-based approach to make the field’s communications more effective.

CAMERA: Equitable and Inclusive Community Engagement Rooted in Values

In addition to clear, effective communications, another priority from the poll on aspects of governance to strengthen the field of public health was equitable and inclusive community engagement. Adopting a values-based approach will not only facilitate clearer, more effective communications for public health but it will also help to reframe and refocus the way the field engages with the communities it serves.

Meaningful community engagement requires humility

Before discussing how the field can move forward in meaningful community engagement, it is necessary to clarify what is meant by the term “community.” In the context of this summit, when speakers and attendees used the word “community” they were most commonly referring to populations who experience the worst impacts of health inequities and who have historically been excluded from public health planning and decision-making. To rectify this historical exclusion, it will be necessary for public health to practice humility.

Humility in public health governance involves ceding power to partner organizations and community groups. This means challenging the hierarchy within the field itself, as one breakout group participant put it:

“It is critical that the local-state-federal public health partnership focus on collaboration as peers. We need to ensure that our strategy, communication and funding must support and capitalize on the expertise across the peer-to-peer-to-peer relationship.”

Humility also means treating community partners—and coworkers—as equal peers with autonomy over their own work.

“We need training and/or capacity building for governmental public health staff who need to learn how to ‘let go’ and let some of their partners work. We have had several requests for that recently.”

Additionally, humility means accepting that it is okay and desirable to seek help from others with different areas of expertise, rather than trying to be and do everything. As Aysha Pamukcu put it, a core competency for the future public health workforce should be *“to have the capacity to look outside our field and invite folks in.”*

As described above and below, the pandemic has demonstrated that engaging partners with expertise in civil rights, communications, finance and law will be essential for public health to practice good governance moving forward.

Moreover, with humility public health can approach the communities it wishes to serve with an asset-based approach—recognizing and valuing the strengths in a community that public health can lift up to address challenges as equal partners, rather than looking for weaknesses and problems that public health can tell them how to fix. As one of the plenary speakers put it, taking this approach will not only facilitate meaningful community engagement but will also help to demonstrate the field’s value:

“We have to recognize that historically marginalized communities are resourceful, organized and reflect a tremendous diversity of experience, perspectives and interests. Community members can bring a much-needed sense of urgency and high-level awareness about the stakes involved in any given issue. To tap into these assets—the expertise on the ground, we have to create platforms where people, as experts in their own right, can share their perspectives, experiences and ideas with practitioners and technical experts. And this is a key that we’re finding to provide clear value on the ground.”

CLAUDE JACOB, MPH, HEALTH DIRECTOR, SAN ANTONIO
METROPOLITAN HEALTH DISTRICT

For equitable and inclusive community engagement that is truly rooted in public health values, the field must dig deeper to understand the historical and structural forces that have created and perpetuated health inequities. In the United States, this work starts with recognizing that racism is deeply embedded in the nation’s governance structures—including public health.

Addressing structural racism is a precondition for equitable, inclusive public health governance

Good governance requires public health to acknowledge the larger historical and structural forces that have created the inequities that persist today. One of the polls taken during the third virtual convening asked participants to identify their top priority to make public health law more effective and equitable from a list of choices. The top choice (selected by 29 percent of respondents) was “addressing structural racism to advance health equity.” In the chat, summit attendees explained that addressing structural racism is a precondition to improving health equity through meaningful community engagement:

- *“We cannot begin to speak about ‘equitable’ unless we address structural racism!”*
- *“Addressing structural racism is necessary but must be done by engaging communities.”*

One of the plenary speakers described the necessity for the field to acknowledge structural racism in order to practice good governance:

*“Another way of measuring the strength of the process of governance is the strength of public discourse. Our ability to build that discourse on an infrastructure of facts, a shared understanding of basic science/medical facts but also stickier and thornier facts, such as the facts surrounding the racialization of the country—how resources move through certain communities and not others, why policies are readily accessible to some communities and not others. These realities are built on historical and systemic facts that are nonetheless hotly contested and fully disagreed upon. **Until we can really come to a common understanding of our racialized past and present, it’s going to completely stymie our ability to do good governance and to have the strong relationships and the trust that’s necessary to govern effectively.**”*

AYSHA PAMUKCU, JD, THE SAN FRANCISCO FOUNDATION

Any reference to structural racism in the United States—especially in the context of public health governance—must also acknowledge the long history of broken treaties and unkept promises to American Indians and Alaska Natives and its devastating impacts on those communities’ health and well-being.

“Although the treaties have long been signed, and although that is the law of the land as Supreme Court decisions have affirmed, years and years of underfunding the Indian Health Service, funding at between 30 and 50 percent of documented need, no funding for public health infrastructure or capacity in Indian country...many tribal communities, as a result, do not have running water. How do you adhere to the CDC’s number-one recommendation to prevent yourself from getting COVID, wash your hands all the time, if you don’t even have running water? Twenty-seven percent of tribal homes do not have running water. Many have no sanitation facilities.... Tribal communities don’t have appropriate housing.... These create very immediate challenges, not just for what we’re facing with COVID-19, but in the day-to-day lives of our people.”

STACY BOHLEN, MA, CEO, NATIONAL INDIAN HEALTH BOARD

Addressing structural racism for meaningful community engagement requires a broader understanding across public health of the historical and structural factors that have shaped the health of American Indian and Alaska Native populations, the fundamentals of tribal governance and how non-tribal public health can support and uplift tribal sovereignty (see the Law section below for more on tribal and territorial public health law).

“Get your own house in order first”—uprooting structural racism within public health

In breakout group sessions, participants discussed first steps in racial equity work. There was broad agreement that the work must start from within the field, especially in governmental public health:

- *“When we start to talk about the racial justice movement people zoom all the way out, like there is nothing in their scope to do. They go all the way out to changing federal law. But when we start with what we need to do differently with public health, one thing is to acknowledge the source of some of our really harmful practices. For one, the way social workers and public health have been trained, it’s a very white savior approach to the work. So that’s why child health and such gets the funding and public health in general doesn’t.... If we are going to talk about building a response, we need to see what needs to be changed internally so we can start to adopt impactful and meaningful equity strategies.”*
- *“First thing is this: truth, reconciliation and healing. People want to jump right to reconciliation and healing, and we haven’t told the truth. So, one of the first steps is telling the truth. **Truth-telling is necessary for the reckoning needed before repair and trust-building can happen.**”*

Participants recommended resources and frameworks for advancing internal racial equity work within public health organizations. Some cautioned against a “one size fits all” approach, while others acknowledged challenges to moving this work forward if leadership is not on board.

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*“One of the biggest barriers for health departments is not knowing where to start... The [report from the Institute for Healing Justice & Equity](#) on the jurisdictions that have used the [Government Alliance on Race & Equity](#) or [PolicyLink](#) framework within their organization as part of starting/building on racial equity work—is this an opportunity for recommending something to support agencies in the use of these racial equity frameworks? Also for promoting them throughout the entire enterprise. **Internal work is essential to being able to actually do something meaningful to support change in community. ‘Get your own house in order first.’**”*

Earning legitimacy for effective public health governance

While addressing structural racism internally is no small feat and will take time and commitment, the next step toward uprooting structural racism in public health is acknowledging historical harms (truth-telling) and working to overcome legacies of mistrust—earning legitimacy. One breakout group participant described their approach:

“We did our own research to understand what happened in the past... We wanted to understand that experience and how the demographics changed over time. Also what are the community residents’ thoughts about that change and other issues. It’s about values. Understanding the people that we are serving. That is where we started in terms of earning legitimacy and changing how the public views government.”

Some breakout group participants had an ambitious vision for the role public health can play in broader racial justice work:

“The evidence is there. We just have to agree this is where we want to put our money, time and focus. We have to agree to be uncomfortable and step in front of that. If we don’t, we’re going to be forced to—and that’s the space we’re in right now. As a field we’ve got the science and the data and the heart... We are the field that can connect science to truth and reconciliation work and why it matters to health outcomes. We have a responsibility there.”

Speakers acknowledged that this work requires accepting and even embracing comfort with discomfort and encouraged public health to embrace tension as a natural and healthy part of the process.

ACTION: Deepening Cross-Sector and Community Partnerships to Advance Health Equity

Once the field has lit its path to clear, effective communications and reframed and refocused its approach to community engagement by taking on the hard work of uprooting structural racism, public health can take action by applying these governance skills to advance health equity through cross-sector partnerships and meaningful community engagement.

Strategies for meaningful community engagement to advance health equity

Advancing health equity requires meaningful engagement with communities most impacted by health inequities. Throughout the third virtual convening, summit presenters and attendees provided examples of strategies and success stories in meaningful community engagement.

“Our work is to make sure that local governments have the capacity and tools to create policy solutions that are actually designed by the constituents whose voices have been most marginalized.... What I love so much about inviting in nonprofit leaders into the governance process is it challenges a lot of notions about what our proper roles are. It challenges the notion that governance is just for elected officials, policy is just for bureaucrats, public health is just for health departments. We know that isn't so, so we invite the community into the governance process as cocreators.... We're seeing that not only does this have a transformative effect on the policy created but actually on the policy and governance process itself.... We're transforming the way that policy is done, the way business as usual is conducted.”

AYSHA PAMUKCU, JD, THE SAN FRANCISCO FOUNDATION

In a breakout group discussion on success stories of meaningful community engagement, the moderator asked for specific first steps: *“When people say we engaged the community or we had meaningful connections with leaders, what is the thing you did that engaged the community meaningfully?”* The responses echoed the recommendations for improving public health communications: practice humility, listen and cocreate.

- *“I tend to start with advancing goals of those communities and not with public health. It's important we **go to the communities we serve with a blank slate. Start where they are.**”*
- *“We need to listen and not just talk. We need to learn how to ask the right questions so we get the feedback from the communities and they are able to track the issues we are raising. We need to accept what they say and then work with one or two of the topics (not tackle them all because we will underdeliver). The point is to do something together, and that will build the future engagement and credibility.”*
- *“Acknowledge first what level of participation we are looking for. Too often we're looking for input on something we've already decided on. We shouldn't mislead people into thinking they are coming to help us make a decision. This doesn't help to rebuild trust.... If we want to do this high end of engagement, then nothing we do has been decided, nothing that we present is done. Don't bring glossy things for them to react to. Actually engage them early and often in the decision-making. **Come empty-handed and early.**”*

In some breakout groups, participants shared examples of how they have implemented power-sharing with local communities through innovative governance processes such as participatory budgeting or through tech interfaces that facilitated two-way communication:

- *“We do participatory processes for budgeting and policy making. We create pools of public and private dollars. We bring together groups of citizens that have experienced disparities, we give them the data, access to subject matter experts and space to make decisions. We have done the process in jails, neighborhoods, schools, etc., and **we've expanded from participatory budgeting to participatory policy making.**”*
- *“In NYC, prior to the pandemic they spent two to three years refining a web-based solution, so at the touch of a button they could pull up partnerships they had in a particular ZIP code. This allowed them to mobilize partners a lot faster than they would have been able to otherwise and also have bidirectional communications that weren't dependent on tracking an email stream but were in a separate portal. When it came time for community partners to report back on what they were doing with the monies that had been rapidly released into the community it provided a streamlined way to report data back quickly. This was a **higher level of community engagement that really spoke to bidirectional information-sharing in real time.**”*

These systemic and structural approaches to community engagement will help to embed equitable and inclusive practices in public health governance. One of the plenary speakers also provided some examples of successful approaches to hardwiring equity into public health governance structures. The strategies she described included building a health equity section into the city's COVID-19 incident command structure from the beginning, at the same level as labs, legal, monitoring and surveillance. Additionally, engaging members of the most-affected communities proved integral to the health department's success:

“We created a community advisory board that was a part of the planning process in terms of maximizing the number of people who could remain safely housed, safely fed, who had their basic core needs met so they could safely comply with what we were asking them to do, in terms of isolation and quarantine. Without community advisory boards that were representative of the communities most affected, our response would have taken a very different trajectory.”

OXIRIS BARBOT, MD, SENIOR FELLOW FOR PUBLIC HEALTH AND SOCIAL JUSTICE, THE JPB FOUNDATION

Efforts to engage the most-impacted communities need to do more than check a box; they should create mutually beneficial partnerships and build capacity for future work. One plenary speaker described how a small-scale effort in Idaho to improve vaccination rates among its Latino/a/x population fostered relationships that allowed the initiative to scale statewide and bring in other community partners:

“One thing that came up in our work, that rose out of the pandemic, is looking at our Latinx population and how to reach out. It started with a task force in a localized area trying to address vaccination rates, but it quickly grew. Our state team started participating and getting to know the community members. That helped build trust, and they said, ‘Help us replicate this in other parts of the state and make connections,’ which was great. It helped not just in fostering that local relationship and building that trust but it also kick-started conversations and movements across the state to address the Latinx population. It even translated to community partners doing mobile vaccine clinics—helping them make connections and do door-to-door conversations to drive people to clinics, and then it grew and grew.”

ELKE SHAW-TULLOCH, MHS, IDAHO DEPARTMENT OF HEALTH & WELFARE

Policy design, too, requires meaningful community engagement. One breakout group participant provided an illustrative example of the value of equitable and inclusive community engagement through two different approaches to the same policy issue: one that was perceived as paternalistic and the other dignifying.

*“In policy design it’s important to make sure the design works and provides dignity to the community as well. With sugary drink taxes, for example, when a lot of these policies were designed it was, ‘let’s increase the price so price-sensitive folks will shift consumption.’ But for a lot of folks that don’t have a lot of means, when they hear that is the strategy it doesn’t feel right. When we brought community in from the beginning, we found it makes a lot more sense if we focus on raising revenues by taxing corporations and investing that into community-led norms change. That felt so much better for the community! It is putting community first and not just listening but **understanding the effects of policies we are putting into place: does it dignify people? Does it build power, consciousness, capacity or infrastructure for the next area we are going to work on?**”*

The need to engage affected communities in public health policy development was expressed by many of the summit attendees. For example, in the poll that asked summit participants to select their number-one priority to make public health law more effective and equitable, tied for second place was “engaging communities in public health policy development” with 26 percent of votes. This was also a key sentiment shared in response to one of the questions posed to attendees in the chat: *What are some opportunities highlighted in the summit that are ready for implementation?*

- “Better engagement with the public and communities before developing policy”
- “Enhancing community participation in making decisions and formulating policies”
- “Putting the public in public health law!”

Identifying and sharing best practices for engaging and uplifting historically disinvested and marginalized communities in public health governance, practice and decision-making will lay the groundwork for public health to build meaningful partnerships for advancing health equity.

Community engagement through cross-sector partnerships, even with uncomfortable partners

Inclusive community engagement will require public health to build deeper relationships with existing partners as well as learning to work with nontraditional partners. Despite all the devastation the pandemic has wreaked in communities across the country and the world, one of the silver linings is that it has provided opportunities for people in and outside of public health to expand their notion of what public health work is and who does it.

Cross-sector partnerships for improved public health governance

Breakout group participants explained how the COVID-19 pandemic has opened the door to new relationships, deepened existing relationships and hopefully established ongoing cross-sector partnerships, including with some unconventional partners. As the pandemic evolved, other governmental agencies began to see themselves in public health. Existing partnerships with faith communities, community-based organizations and even the military have been strengthened.

- *"I was struck by the way in which other city agencies came to see themselves as doing the work of public health. For example, **sanitation, transportation, housing—all got firsthand experience of how their sectors contribute to public health.** That's an opportunity for public health to continue to build bridges to diversify the way public health is done at the local level."*
- *"Health departments, in particular, learned to work with unlikely partners in ways that should be captured and built on for the future, not just pandemics. Two examples: **faith communities** (important in rural towns) became increasingly important during COVID-19. But now they're also beginning to work with public health in all sorts of other ways. The other example is the **National Guard**. Though they (the health department) have a strong history of working with the National Guard post-disasters and that sort of thing, they've learned to work with them differently through the pandemic and in positive ways that don't alarm communities, particularly ones that would be distrustful of anyone in a military uniform."*
- *"We did a little study during COVID-19 on how **community-based organizations** (CBOs) showed up in the response, and the things they did were an extension of local infrastructure. That has not been the way we think about CBOs. We've thought of them as service delivery folks and local advocates. But the ways they showed up in COVID-19...they weighed in at the state and local level to help policy makers understand why their programs and resources were falling short. So there is a different way that we can do things, and part of it is about taking some of those resources we are getting from the federal level and giving it to those orgs to cocreate and be our partners."*

One breakout group participant provided an example of how Boston worked with partners across multiple sectors to advance health equity through meaningful engagement with people experiencing homelessness:

"In Boston there was a significant increase in the homeless population and concentrations of homeless into what became referred to as an encampment. The mayor hired the former state public health commissioner to oversee the process. They did a tent-by-tent survey and interviewed every person: What do they need to feel comfortable leaving the encampment? They calculated the number of units needed to house people, and they housed them—some in short-term housing (renting hotels), some in longer-term housing, some went into substance use treatment or other healthcare facilities. So they successfully and peacefully contributed to the elimination of the encampment. As they're monitoring it, people are doing well. Didn't do it alone; it was led with a public health perspective but required people in social services, the business community, the city's sanitation department, public safety people.... This is a model example of not thinking of homelessness as a public safety issue or a criminal issue but as a public health issue, and then using public health tools in partnership with other sectors to stop the problem."

The notion of cross-pollination came up repeatedly during the third virtual convening—not only in terms of nontraditional partners seeing themselves in public health but public health seeing itself in nontraditional partners. Summit attendees noted that many people who study public health end up working in other sectors. Rather than lamenting this lost workforce potential, participants in one breakout group saw this as an opportunity for the field to expand its footprint.

Public health can build upon new and existing partnerships that grew during COVID-19 for a more collaborative approach to public health governance moving forward.

GOVERNANCE

LIGHTS: Good Governance through Clear, Effective Communications

CAMERA: Equitable and Inclusive Community Engagement Rooted in Values

ACTION: Deepening Cross-Sector and Community Partnerships to Advance Health Equity

• Guiding Lights

Strategies for strengthening partnerships between public health and business

Other partners that played a role in supporting public health during the COVID-19 pandemic were local, national and international businesses. During the plenary, speakers offered suggestions for how public health can build and deepen relationships with business partners. They provided examples like working together on public policy, cohosting events and presenting at each other's Chamber of Commerce or Health Commission meetings.

Summit attendees talked about how business partners small and large stepped up to support public health during the pandemic. Community stewardship and corporate social responsibility were highlighted as motivating factors for business and healthcare partners to engage with public health. And in rural areas, especially, participants described how larger companies set the tone for safe business practices during the pandemic.

- *"From the business perspective everything has been innovated the last two years. It has required an incredible amount of nimbleness.... There were instances in which businesses pivoted to a completely new product line because that was going to be helpful for the pandemic.... They weren't going to make money off of it; they just wanted to be good community stewards. That's not necessarily innovative—the idea that **business wants to be a good community partner**—but it was good to see innovation come into space in a way we haven't seen in modern times."*
- *"The national corporations and business leaders made the world of difference, especially in rural America. It was a partnership for public health that wasn't talked about too much, but what they did and how they did it and **how they created safe spaces for their customers became the role model for the small businesses in the community**. Without them there would not have been that opportunity. Sometimes in public health we forget that a lot of what we do takes place outside of government, and our nongovernmental partners can be quite the leaders when we need them."*

One plenary speaker described how partnerships between businesses and public health have evolved during the COVID-19 pandemic and emphasized that those relationships should be ongoing:

"Our businesses have taken action at the request of our public health leaders. That includes PPE production from people who don't make PPE—or didn't, until the first part of 2020.... Many of our business members began to use things differently or use people differently just like we are right now. And that was informed by public health and in partnership with public health. Finally, the policies we have used around our employees—whether it's testing, vaccination requirements, screening for COVID-19 or other policies implemented at an organizational level—have all been informed by public health and will continue to need to be so."

SCOTT HALL, JD, MBA, SENIOR VICE PRESIDENT FOR CIVIC AND COMMUNITY INITIATIVES,
THE GREATER KANSAS CITY CHAMBER OF COMMERCE

The wealth of new and existing cross-sector partnerships that have evolved during the pandemic is an asset the field must continue to invest in to ensure inclusive community engagement and good governance moving forward.

Guiding Lights

Aspirational guidelines for the future of public health

Fundamental to the work of strengthening public health governance, finance and law to support a modern system are several recent articulations of goals for the future of public health in the United States. Resources that inspired this national summit series include:

- [Public Health 3.0](#)
- [Public Health 3.0 After COVID-19—Reboot or Upgrade?](#)
- [10 Essential Public Health Services \(updated 2020\)](#)
- [Public Health Forward: Modernizing the U.S. Public Health System](#)
- [The Future of Public Health: A synthesis report for the field](#)

Recommended resources for strengthening public health governance

Throughout the third virtual convening and the breakout group discussions, presenters and participants recommended specific tools and resources to strengthen public health governance. A selection of participant-recommended resources is listed below by topic.

Addressing structural racism within an organization and externally:

- "A [report from the Institute for Healing Justice & Equity](#) on the jurisdictions that have used the [Government Alliance on Race & Equity](#) or [PolicyLink](#) framework within their organization as part of starting/building on racial equity work"
- "A practical tool is the [Government Alliance on Race & Equity toolkit](#). It includes questions like, who is community, and who should be contributing? Who is your policy, proposal or intervention intended to benefit, and who might it burden?"
- "Racial Equity Tools recently re-released their website with a robust search engine: <https://www.racialequitytools.org/>. It responds to inquiries to help you figure out what to do and then what to do next."
- "<http://healthequityguide.org>—includes case studies to illustrate use of the tools and strategies"

Identifying and addressing structural racism in the community:

- [Measuring Structural Racism: A guide for epidemiologists and other health researchers](#)
- [Racism Is a Public Health Crisis. Here's how to respond.](#)
- [Truth, Racial Healing & Transformation Implementation Guidebook](#)

Equitable and inclusive community engagement:

- "Morning Star Lodge, a Canadian Tribal org, has an entire research in public health institute/framework (<https://www.indigenoushealthlab.com/>) that centers their tribal values and ensures tribal elders and members are involved in setting up what questions get asked/determining who gets asked/being part of the meaning-making/making sense of the data. They are the owners of the data and what gets shared. It's such a paradigm shift!"
- The International Association for Public Participation's [Spectrum of Public Participation](#) describes five general modes of public participation in democratic decision-making on a continuum of increasing community influence.
- Tamarack Institute also has a [Spectrum of Community-Led Approaches to Change](#) that identifies four levels of community leadership: community owned, community driven, community shaped, community informed.

Finance

FINANCE

- **LIGHTS: Navigating Innovations in Public Health Finance**

CAMERA: Transforming the Public Health Finance Ecosystem for Equity and Justice

ACTION: “No Temporary Scaffolding”—Financing a Sustainable Future for Public Health

Guiding Lights

This third summit highlighted what an exciting time this is for finance in public health. The discussions also elevated how integral finance is to the success of public health governance and law. As the CDC Foundation’s Dr. Judy Monroe proposed in her opening comments for the plenary, the unprecedented federal funding can provide a launchpad for meaningful cross-sector partnerships to advance health equity:

“For the first time in decades, these resources provide public health the financial leverage to incentivize other sectors to together think creatively and strategically about how to braid and blend dollars to improve their community’s well-being.”

JUDY MONROE, MD, CDC FOUNDATION

“Thematically, there are three A’s... It’s about (1) leveraging the assets on the ground...(2) making sure we deputize supporters and stakeholders on the ground to be ambassadors of our work. But at the end of the day, it’s about (3) alignment, alignment, alignment. So that we don’t diverge our limited resources but that we converge, and we can be more responsive to the crises on the ground. We tend not to move at the speed of change as a discipline, yet our agility has been our best asset through this pandemic.”

CLAUDE JACOB, MPH, SAN ANTONIO METROPOLITAN HEALTH DISTRICT

LIGHTS: Navigating Innovations in Public Health Finance

This third virtual convening emphasized the essential role of finance in public health work, the creative potential in this current moment of unprecedented federal funding and ways that resources can be used strategically to ensure a sustainable, equitable and just future for public health.

Seeing the money in the system from all sources

Speakers and participants at the third virtual convening shed light on the variety of new sources of funding available to public health due to the federal government’s response to the pandemic. Some, like grants, were quite familiar to the field, whereas more innovative sources of funding for public health were less well known.

A poll taken during the summit listed a number of funding mechanisms and asked participants to select the one with which they are most familiar. The results showed respondents were most familiar with hospital community benefit (21 percent) and low-income housing tax credits

(21 percent). Possibly the most significant result of the poll, however, is the smaller share of respondents who were very familiar with more innovative funding mechanisms such as local wellness funds (10 percent), pay for success (aka social impact bonds) (4 percent) or New Market Tax Credits (1 percent).

POLL: Which of the following funding mechanisms are you most familiar with? (Select one.)	% of total responses
Community Development Financing Institutions	18%
Hospital community benefit	21%
Local wellness funds	10%
Low-income housing tax credits	21%
New Market Tax Credits	1%
Pay for success (aka social impact bonds)	4%
All the above	10%
Other (Enter your response in the chat.)	15%
Total	100%

As 15 percent of respondents selected “other,” it is worth noting that 53 out of 60 comments (88 percent) responding to this question in the chat mentioned grants. According to summit attendees, grants are by far the most common funding mechanism for public health work.

A few commenters noted that entire departments, like community outreach or information technology, are almost exclusively grant-funded. Other funding sources that were mentioned include specific grant sources such as notices of funding opportunities (NOFOs) and cooperative agreements (CoAGs), fee-for-service and the Tobacco Settlement Fund.

The unprecedented flow of funding to public health in the federal government’s response to COVID-19 presents an enormous opportunity for the field. Another poll question posed to summit attendees asked how ready they are to help others use new funding from the federal government’s response to COVID-19. More than half of respondents at the time of the summit (56 percent) had not yet developed a plan nor started working with others to utilize this funding. Less than 20 percent of respondents said they were already helping others use this new funding.

POLL: How ready are you to help others use the unprecedented federal funding that is now available through the American Rescue Plan Act and other sources? (Select one.)	% of total responses
Not on my radar	20%
Thinking about it	36%
Have a plan	8%
Ready to begin	17.5%
Already doing it	18.5%
Total	100%

Given the number of new and existing funding sources, one summit speaker proposed that a new role in public health departments may be needed to help the field navigate them all:

“Federal, state, local, NOFO money are all being poured in. This can be overwhelming for smaller local health departments and community-based organizations who may not have the capacity to match the money to their needs. We have considered funding navigators to help guide these agencies and organizations. We want to do things differently than ever—we have never had this much local money in this way. It is not forever, but we have the opportunity to change how decisions are made and who has input.”

KAREN MINYARD, PHD, DIRECTOR, GEORGIA HEALTH POLICY CENTER

There was, however, some pushback against this suggestion in the chat, where participants emphasized that reducing the complexity of funding should be the overarching goal:

*“Our inclination often seems to *add* complexity to funding versus trying to *reduce* complexity with funding. Few elected officials are rewarded for tinkering with an existing program/funding stream versus launching something new... Funding navigators solve a short-term problem. If we invest in these, do we just become the hospital billing department, where we value complexity, and we just accept complexity? We have to blow up the funding paradigm a bit and have more looseness and liberation.”*

However public health decides to move forward with seeing the money in the system from all sources and navigating this new funding environment, the next step is figuring out how to best deploy these funds.

Innovations in public health financing

Throughout the summit, presenters and attendees discussed creative approaches to public health financing, including braiding and blending funds across sectors. They also shared examples of innovative funding sources and other opportunities. The following table highlights some of these innovations according to the level of government.

Level of government	Funding innovation
Local	<p><i>“Approval of mergers among hospitals is also an opportunity to require community benefit agreements.”</i></p> <p><i>“In the systems that we work with, there was land that was no longer being used because of changes with COVID-19. The land was no longer considered strategic and could be donated or sold for community purposes, and that was gold. In many ways, the land was more valuable to communities than a financial investment.”</i></p>
State	<p><i>“Determination of Need in MA is a real helpful driver of community investment. Wish there were more of that across the country.”</i></p> <p><i>“We have seen states pressing greater investment in community health. States requiring as part of their managed care contracting, to require more community investments. I think there are also innovations in what is getting funded.”</i></p>
Federal	<p><i>“In behavioral health, feds require 20 percent set aside for prevention work. We were able to be innovative and put that money to upstream social determinants of health with community coalitions we had worked with across the state. Each coalition was offered a quarter of a million dollars to undertake a community project with their community and coalition partners. They are creating walking trails, community gardens, playgrounds, and they are also developing longer-range projects that are not just physically based.”</i></p>

One of the most promising funding approaches that was discussed during the summit was local wellness funds. Georgia Health Policy Center's Dr. Minyard described how this funding mechanism rose to the top in a study of financing innovations.

“Over the last seven years we've worked very closely with a number of sites. The Bridging for Health sites began to study various financing innovations, working with community development financial institutions (CDFIs), impact investing, pay for success, New Market Tax Credit, hospital community benefit and low-income housing tax credits. They looked at all of these different kinds of innovations and they all settled on building local wellness funds as an umbrella for other financing mechanisms: a way to put resources together in the community and then think about how to use those to support the work they wanted to do.”

KAREN MINYARD, PHD, GEORGIA HEALTH POLICY CENTER

Local wellness funds are one of many exciting innovations for financing the future of public health. But finding and learning about these financing innovations are only the first steps to implementing innovative approaches to public health financing.

Dismantling financial barriers and breaking through red tape

Once public health has seen the money in the system from all sources and learned about creative ways to finance public health work, the next step is figuring out how to exercise creativity in a complicated system. Applying innovative strategies in financing, such as braiding and blending funding streams across sectors, requires overcoming a number of barriers. Some of the most common barriers to creative financing mentioned in this summit were silos, lack of flexibility and politics.

As summit participants noted, most funding is not designed to encourage cross-sector partnerships:

“I want to acknowledge that our system is designed to do exactly what it does: allocating money in silos. There is no google.gov to find colleagues in HUD or other departments that we can collaborate with. It makes it hard to work together.”

Bureaucracy can preclude sustainability when public health cannot spend the money that is allocated to it. Moreover, as money makes its way through levels of bureaucracy, creativity becomes more elusive when more restrictions are added at each stage. Finally, politics can be another barrier to financial flows when ideology holds up funding that was supposed to trickle down to local health departments or community organizations.

Obstacles to funding flows

Bureaucracy	<i>“Some states have still not spent the truly emergency money because legislatures are so slow in allocating federal dollars. This can come back to hurt us when we ask for long-term investments.... Can the federal government develop a way to force moving money faster?”</i>
Lack of flexibility	<i>“As dollars flow from the state to local levels, additional restrictions are being placed decreasing the flexibility from just the federal restrictions, making braiding more difficult. There are some critical lessons, and we should be thinking about the programs that have had long-term success.”</i>
Politics	<i>“One thing we’ve seen is when funding is exclusively eligible for states and large local health departments, politics get in the way, and it leaves out small communities that might want access to a piece of that funding. For example, in one state the local health department was trying to support the state with some contact tracing, but the governor wasn’t interested.”</i> <i>“Some governors will not look at plans if COVID-19 is in the wording, and that means some local departments don’t get funding. It’s holding things up, and money sits at the state level. Things that Congress dictates don’t translate.”</i>

A recommendation to overcome these barriers that echoed across all the summits was bypassing the states, so that more funding goes directly to local agencies and organizations that are doing the work:

“A very tangible step that could occur is CDC more directly funding local entities, whether health departments or CBOs, versus going through states.”

Other suggestions included being explicit about funding flexibility and identifying and sharing best practices in streamlining and distributing funding effectively:

- *“Longer grant periods, with streams of funding that cover explicit leveling (community-based, local, state, federal) and allow for flexibility (unrestricted) and being explicit in funding structural interventions and covering operational/infrastructure/evaluation.”*
- *“It would be great if there were recommendations, such as from NACCHO, to various funding organizations like the CDC, based on the barriers preventing smaller agencies and organizations from accepting funds.”*
- *“In terms of potential next steps for CDC, one could be to identify specific jurisdictions—local, state, federal departments—that have gone through a strategic exercise to streamline their granting processes, funding criteria, etc., and share best practices.... Is there a landscape analysis that could help us identify what is working, to then be put into a report as a result of this summit? It would be helpful to copy what other local jurisdictions have successfully done.”*

This third virtual convening highlighted the opportunity in this moment for creativity in public health finance. Seeing the money in the system from all sources, understanding innovations in public health financing and dismantling financial barriers and breaking through red tape will enable the field to move forward with confidence to transform the public health finance ecosystem.

FINANCE

LIGHTS: Navigating Innovations in Public Health Finance

- CAMERA: Transforming the Public Health Finance Ecosystem for Equity and Justice

ACTION: “No Temporary Scaffolding”—Financing a Sustainable Future for Public Health

Guiding Lights

CAMERA: Transforming the Public Health Finance Ecosystem for Equity and Justice

In this third summit in the *Lights, Camera, Action* series, presenters and guests envisioned ways to reframe and refocus the public health finance ecosystem by aligning with other sectors and ensuring that funding is used to advance health equity and racial justice.

Align with other sectors to transform the public health finance ecosystem

Just as cross-sector partnerships are crucial to successful public health governance, they are equally essential in public health finance. Speakers and attendees at this third virtual convening discussed a shift in thinking in the world of public health finance toward a more holistic view of the entire funding ecosystem and shared strategies for moving in that direction. As a breakout group participant described:

*“For the notion of money whispering—stewardship—there is a growing recognition of the need to understand the difference of **funding services vs. funding the ecosystem** and capturing how funds flow and how you integrate them. Different governance and power structures involve community and relationships around the funding. I am seeing that a lot with foundations wanting community input much earlier than they used to, as well as engaging community in the decision-making.”*

Aligning across sectors to achieve this vision of a holistic finance ecosystem will require creativity and innovation. The first step is to find the right partners. In the breakout group sessions, participants discussed lessons learned in identifying appropriate partners. Their experiences boiled down to finding and demonstrating shared values:

- *“I have realized that it is important to be in relationship with the right folks that align with your values and turn down those that don’t.”*
- *“We found there was a lot of experience with harm with city government, planners, health partners. Rather than just asking priorities, we made an effort to act fast (e.g., housing repair to build trust).”*

Once shared values are identified and compatible partners are found, the next step requires a paradigm shift in power dynamics. As breakout group participants explained, the funder/grantee relationship is inherently imbalanced. As a recipient of funding from a variety of sources including government, philanthropy, health care and business partners—and as a provider of funding for community-based organizations—public health is familiar with both sides of this relationship. This knowledge should serve the field well in its endeavors to shift the relational power dynamics from transactional to transformational.

A transformational partnership embodies a holistic view of the ecosystem that equal partners—who mutually contribute to and benefit from the relationship—seek to change for the better. Breakout group participants encouraged public health to move away from transactional thinking on both the parts of the funder and the recipient so that partners can collectively envision and work toward a better future:

- *“It was helpful for the community development finance institutions and developers to stop treating the hospitals like a slot machine. When the community groups treated the hospitals as a partner in the ecosystem for transformative change, rather than transactional actions, that is where we saw good partnership—thinking of the gives and gets of the partnership over time.”*
- *“Future-casting: one of the ways I’ve been trying to influence change between public health and health care is to influence a perspective on what the future looks like, the ideal situation, and engaging with hospitals on the future state with their work on CHA/CHIPS. The first paradigm shift is moving from the reactive notion of whack-a-mole—throwing effort at discrete issues/problems—to assembling resources for future needs, the future we want to create.”*

Reframing and refocusing public health’s approach toward finance to incorporate deeper partnerships with communities and cross-sector partners will guide the field in transforming the finance ecosystem to one that can facilitate advances in health equity and racial justice.

Ensure funding is used to advance health equity and racial justice

As the COVID-19 pandemic has made all too clear, a wealth of resources in no way guarantees prosperity and well-being for all. Especially in this current frenzy of federal funding, public health must do all it can to ensure money is distributed equitably and that it is dedicated to equitable transformation. As with any transformation, the work must begin within the field itself. Presenters and participants of this third virtual convening also made clear the need for a paradigm shift in the way public health funding is designed and evaluated.

“It is very unprecedented, this federal funding opportunity. Not only to provide an opportunity to address the current pandemic and economic crisis but also to reimagine a more equitable approach to strengthen our systems, our practices, and really centering our communities so they can benefit and access critical resources.”

RITA CARREÓN, VICE PRESIDENT FOR HEALTH, UnidosUS

Invest in diversity and belonging and value the public health workforce

As with the field's necessary work in addressing structural racism, ensuring that the new funding is used to advance health equity and racial justice should begin within public health itself. This means—to the extent possible—investing some of the new funds in the public health workforce. And to the extent that this is not possible, the field should engage in more advocacy to ensure the contributions of public health workers are appropriately valued. A recurring theme across the breakout group sessions was taking care of the public health workforce, with a necessary but not sufficient demonstration of their value through substantial investment in salaries (a recurring theme across the entire summit series). As one summit three participant put it, there needs to be an “overhauling of how public health expertise is valued.”

Participants in the breakout group sessions also reflected on changes needed to strengthen and diversify the public health workforce. Some emphasized a focus on inclusion and belonging:

- *“I want to bring up a perspective on this concept of ‘us vs. them.’... Here we are poised in an incredible influx of resources to enhance the workforce in public health, and if we really want to engage the community, why don't we make public health look like the very communities that it's attempting to work with? If we miss this opportunity, we're going to continue this ‘us vs. them.’”*
- *“We have to think about employee retention. We have a belonging problem in public health. We need to be ensuring we're making space for people who are not traditionally in public health.”*

One breakout group participant suggested expanding beyond traditional skill sets to incorporate more expertise in public health departments around structural determinants of health and overcoming racism:

“There's a need to have special resources and expertise in health departments in order to sustain the advances we've made, having full-time public health people with expertise in housing or transportation—but also equity and overcoming racism in the community—as their job. I hope with these new funding opportunities we can think transformatively about creating a new notion of what kind of core people you have at a health department.”

Using some of the new funding to increase investment in salaries, expand the diversity of the workforce and foster inclusion and belonging will go a long way in preparing the field to succeed in achieving the transformation that is called for in this moment.

Disease-agnostic funding as the way forward

As noted above, not all of the new funding is available for investment in the public health workforce. In order for funding to be used to advance health equity within the workforce and in the field's work with communities, the standard model of disease-specific funding needs to be transformed. Flexibility in funding is essential to facilitate innovations in financing, such as braiding and blending

funding across sectors. Rochelle Walensky, MD, MPH, director of the U.S. Centers for Disease Control and Prevention, raised the issue of disease-agnostic funding in her remarks at the [first summit in this series](#), and it has been a recurring theme throughout all the summits:

*“We must provide stable resources that allow public health departments...adequate flexibility to respond to emerging threats and needs. And, **perhaps most critically, our funding has to be disease-agnostic.** It must be that the person you hire for ‘x’ disease can also work on ‘y’ disease. We must leverage skills in one area so that they can be used at any moment in time for another.”*

As attendees of the third virtual convening noted in the chat, the future of public health is in disease-agnostic funding:

- *“We’re trapped in categorical funding, usually disease-specific. We need to figure out ways to collaborate across funding so you could use money for diabetes to work in the same communities and tackle funding that may not be recognized here.”*
- *“Financing also directly impacts the work of listening—we need to support health departments to hire and retain staff, give them time and focus to build relationships and sustain them, which is not a disease-specific task. Unfortunately, traditional funding streams don’t support that. We need to ensure disease-agnostic funding streams to support these relationships.”*

One breakout group discussed the transformative potential of new disease-agnostic funding sources:

“CDC is going to release a \$3 billion NOFO on workforce with no limitations on what you can do with the money. It’s not a disease-specific fund—which is unheard of—and will last for years. This could be a transformative opportunity for health departments to hire people that haven’t been historically funded to do this kind of work. There also might be billions in infrastructure funds. Infrastructure could be thought of as key partnerships and working on key issues that are not about a disease or condition but are about what is needed to bring healthy conditions in communities.”

Ensuring funding is used to advance equity requires attention in the development, design, distribution and evaluation phases. To allow for meaningful input from multiple stakeholders, as well as meaningful outcomes, reasonable time lines must be built into funding opportunities. Moreover, funders need to recognize that the competitive nature of most funding only perpetuates and exacerbates inequities in access to resources.

- *“Ensure strategy for federal funding usage includes input from the local and state level. Invest in improving administrative preparedness with a focus on moving money quickly and equitably.”*
- *“Ensuring time lines make it possible to engage the community, having funding to have community members engage in the process—we need to be introspective. **What are we doing that’s creating a lack of community engagement in financing flows?**”*
- *“Federal funding is distributed on a competitive basis. The places best equipped to write grants are most likely to receive funding. **We need to rethink how we allocate funding so that the places most in need are most likely to get funding.**”*

Another concern raised during the summit was equitable funding for rural and tribal areas. This requires equity in terms of distribution according to the level of need, which, in the case of rural and tribal areas, often does not equate with population size.

- *“Since most federal and state agencies, not to mention foundations, are NOT in rural areas, with most or all of their staff living NOT in rural areas, how are rural residents supposed to TRUST that their concerns are heard, known and supported? Especially when rural communities see that funds tend to be allocated toward the large metro areas RATHER than to address the LARGE NEEDS (disparities, inequities, injustices) of public health in rural areas.”*
- *“We need to look at how other partners fulfill their roles in public health funding to ensure equity. The pandemic highlighted the struggle of many of the tribes, and for the first time ever the CDC provided equitable funding across the 534 tribes and public health authorities that usually don’t have access to public health funding or the tax system. This proves the CDC can get funding out to all the tribes for support.”*

- *“Herminia Frias very well describes the perplexity of countless system disparities, inequities and injustices in most rural areas, where almost every human service is on the knife’s edge—no food, no transportation, no communication, etc.—all on the edge of failure as systems. Yet rural areas are not funded at the level of this need.”*

In order to hold the field accountable for making public health financing more equitable and just, summit speakers and participants spoke to the need to rethink public health finance evaluation.

Better evaluation of public health financing

Finally, ensuring funding is equitable and just requires accountability. One element of accountability is evaluation.

*““In the 90s I went to the Carter Center for a meeting and sat next to a poet who said:
‘You need to appreciate the myth you are currently living in.
You know we are living in the economic myth.’”*

*I’ve thought about that ever since. Our conversation today is rooted in money. In terms of what we have to do in public health, we have to engage with people and appreciate from/with people what really matters. **I’m very concerned our metrics and decision-making are all tied up in this economic myth that is not a myth of health and well-being.** We have to rethink ourselves... If we are going to envision a better community, then we’ll have to think what those measures are. I don’t think we are measuring them, and **unless we have that focus our outcomes are going to be inequitable** because it’s about money/power, and we can’t ignore this conversation. This is not a time for incremental improvement.”*

MARISSA LEVINE, MD, MPH, FAAFP, PROFESSOR OF PUBLIC HEALTH PRACTICE, UNIVERSITY OF SOUTH FLORIDA

Evaluation should be reflected in public health financing as a key factor in determining what gets funded. Summit attendees shared their frustration that funding too often goes to ineffective programs—either because evaluation is not happening or the evaluation models and metrics are not measuring the right things.

- *“One of the times I was frustrated by the Build Back Better bill was the tripling of programs that do not work. I worry about these kinds of discussions because there’s little example of how [evaluation] has improved upstream.”*
- *“We have to be careful about what we mean when we say evaluation, because we only evaluate things we value—usually big things, like RCTs (randomized controlled trials). But a lot of evidence-based practices on the ground don’t have a lot of uptake because people don’t trust the systems. Some of the things that really move the needle are not necessarily the things we’re looking at. Our most effective interventions have a small-to-medium design size. Often logic models and evaluation metrics are set by funders, without conversation with service providers or those closest to the impact. We need to ask better questions (e.g., what the community wants vs. what the funder is asking for).”*

Breakout group participants provided suggestions for improving public health evaluation with a focus on equity, including redefining metrics and methods and allowing time for meaningful outcomes:

- *“A racial equity lens is just asking strategic, pointed questions as an analysis for our intentions and approach.”*
- *“We need to be more holistic and comfortable with qualitative research on impact. And be creative in how we define those impacts.”*
- *“Aligned metrics for cross-sector investment [for sustainability]. Aligned health equity metrics. Place-based metrics toward common outcomes.”*
- *“Short-term grant funding does not facilitate evaluation because we don’t have time to see results.”*

Reframing and refocusing public health finance toward a holistic ecosystem, rooted in partnerships with communities and other sectors, will position the field well to ensure the new federal funding sources are used to advance health equity and racial justice. While many of the new funding sources are only short term, however, the transformational goals of public health certainly are not. Part of the required transformation in public health finance at this moment is ensuring that the funding is used to support a sustainable future for the field.

FINANCE

LIGHTS: Navigating Innovations in Public Health Finance

CAMERA: Transforming the Public Health Finance Ecosystem for Equity and Justice

- ACTION: “No Temporary Scaffolding”—Financing a Sustainable Future for Public Health

Guiding Lights

ACTION: “No Temporary Scaffolding”—Financing a Sustainable Future for Public Health

Once the field has seen the way to navigate innovations in public health financing and reframed and refocused its approach to finance toward a more holistic ecosystem to advance health equity and racial justice, public health needs to take action to ensure these new funding sources and the transformations to public health governance, finance and law are sustainable.

Public health has always managed to do a lot with a little. But with the current unprecedented levels of investment in public health, the field has an opportunity to advocate for sustained funding for the long haul. Through stewardship and well-funded advocacy efforts, public health—and its funders—can be confident their investments are sound.

Stewardship for sustainability

With all this new funding, the field needs to ensure it is used to pave the way for a sustainable future for public health. A theme across all the summits in this series has been the unsustainability of the typical “feast or famine” pattern of public health funding. At this moment, when public health is in the spotlight and the money is pouring in, the field needs to take action to ensure it is on a sustainable path to protect the public’s health for the long haul.

“I heard the Chicago mayor give a talk at the U.S. Conference of Mayors. She said her motto for the pandemic was ‘no temporary scaffolding’—that she wanted to use funding to build structures that would really make a difference for her city. And I think that’s a pretty good motto for public health. How do you use funding to build something in the direction that people have been talking about today?”

JOSHUA SHARFSTEIN, MD, PROFESSOR OF THE PRACTICE IN HEALTH POLICY AND MANAGEMENT, JOHNS HOPKINS UNIVERSITY

Summit speakers and attendees proposed suggestions for ways to use new funding to build infrastructure that would provide a more stable foundation for the future of public health. One recommendation was investing in the **workforce** by hiring staff who understand finance:

“Having resources/grants to support a health economist at the local level would help us better explain the benefits of public health in a financial perspective.”

Presenters also explained that **capacity building for financial stewardship with community partners** is an investment in sustainability:

*“It’s super important to involve community leaders in the process as you set up and seek funding opportunities, provide support for fiscal administrative services and establish continuous and transparent communication.... One of the challenges we saw was this lack of access to state and federal funding to increase the familiarity of fiscal management and even improving the capacity of data collection and reporting back to federal agencies. A critical element here that we’re not talking about is **increasing the capacity of our CBOs that historically have not had access to federal funding in the past—it’s an opportunity to really focus on that equity lens.**”*

RITA CARREÓN, UnidosUS

Likewise, summit speakers emphasized that **investing in relationships themselves** is an investment in sustainability for public health:

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“Engagement with the community and working with neighborhood leaders at a very grassroots level has been critical and really cannot be underinvested in. Developing and supporting resident and community leaders so they can be at the table and part of the process are things we certainly have valued through our relationship and the work we’re investing in.... Managing and nurturing those relationships in and among partners is extremely important to foster a long-term relationship. That’s going to be necessary to support this work over a long-term period.”

KIMBERLY CUTCHER, EXECUTIVE DIRECTOR,
TOLEDO LOCAL INITIATIVES SUPPORT CORPORATION

With the massive amounts of funding pouring in from the federal government for public health at this moment, the field must ensure it is invested sustainably. To the extent the funding sources allow, investing in the workforce, in community partners’ capacity and in relationships themselves will help the field build the infrastructure it needs for a sustainable future.

Fund advocacy for solid infrastructure and sustained resources

Ideally the field would use the current influx of federal funding strategically to build (or rebuild) infrastructure that will sustain the future of public health. While some of the new funding is more flexible than in the past, the ability to invest in strategic infrastructure still eludes the field. Therefore greater advocacy is needed to ensure that all the recommendations that came out of this third virtual convening can be realized.

Reiterated throughout all of the summits was the call for a shift to more long-term funding for public health work. One of the breakout groups in this third summit pointed out that real change at the population level takes a generation to see. How can grant-funded public health be expected to succeed when it must constantly scrounge for funding in one- to two-year increments that demands results within that time period?

“As we think about this work, this kind of change takes time. This is not something we can solve in the short term. We need to look for little wins along the way that will change hearts and minds...[but we also] need to really think about the long game and what that means. It’s going to take at least a decades-long investment in change.”

Ultimately, sustainability in public health finance requires funding advocacy to make the case for doing good public health work founded in relationships with the communities it serves, which can only be built slowly over time as trust grows.

Guiding Lights

Recommended resources for strengthening public health finance

Presenters and participants in the third virtual summit also recommended specific tools and resources to strengthen public health finance. Participant-recommended resources include the following.

Innovations in public health finance:

- [Bridging for Health: Improving community health through innovations in financing](#)
- [Local Wellness Funds](#)—information and tools
- [Local Wellness Funds: Advancing the Practice](#)—learning cohort summaries
- [NACCHO public health finance innovations](#)
- [Georgia Health Policy Center Aligning in Crisis](#)—cross-sector alignment to advance health equity

Innovations in evaluation: [Better Evaluation](#)

Law

LAW

- **LIGHTS: Understanding Fundamentals of Public Health Law and Authority**

CAMERA: Law as a Tool for Advancing Health Equity and Racial Justice

ACTION: Embed Law and Advocacy into Public Health Learning and Practice

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This third virtual convening cast light upon the importance of law and policy in public health at this point in history, refocused the camera on its potential for advancing health equity and racial justice, and suggested actions including education and advocacy to strengthen public health law to support a modern system.

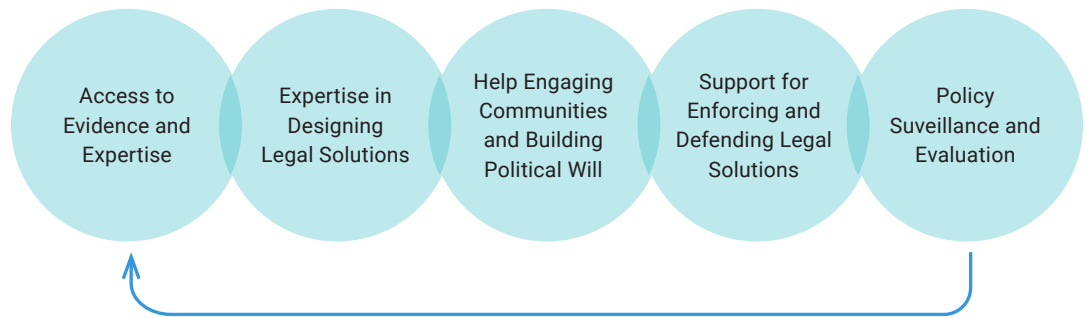
LIGHTS: Understanding Fundamentals of Public Health Law and Authority

The third summit in the *Lights, Camera, Action* series pointed out the essential role that law and policy play in every aspect of public health. Presenters described the fundamentals of public health law and the scope of public health authority. They emphasized the need for the field to understand the role of law in public health to ensure that laws and policies are effective in advancing public health's goals as well as to preserve the field's authority to protect public health in the future.

Fundamentals of public health law

Law and policy played tremendous roles in facilitating protection of the public's health during the COVID-19 pandemic. One of the most innovative examples is the CDC's federal moratorium on evictions, which protected countless lives by ensuring that people who were struggling financially due to the economic fallout of the pandemic could stay in their homes. While the policy was not perfect, it demonstrated how public health law can play a significant role in protecting the public's health, especially in times of emergency.

To highlight the fundamentals of public health law, speakers at this third virtual convening pointed to a 2016 article, "[Better Health Faster: The 5 Essential Public Health Law Services](#)," which was a collaboration by several of the summit presenters. The figure below encapsulates the five essential public health law services.



One summit speaker explained how essential a fundamental understanding of public health law is at every stage in the policy-making process:

“We will never have had more control over the whole process and over the outcome than that stage at which we are figuring out the initial policy ideas.... If people who design policies are not thinking about legal issues, they may not be ready with good evidence and strong rationales when their policies are challenged in court. If they’re not thinking about politics, they may design a legal intervention that can’t be passed or that is crippled by widespread resistance and noncompliance. If they are not thinking about implementation during the design and drafting and advocacy stages, they may fail to get the specific powers or the appropriation they need to actually implement the law effectively. And finally, if we don’t treat legal interventions like any other public health intervention and properly evaluate them in a timely way, we’ll never know if what we did worked or in fact whether what we did is actually causing harm. This is particularly important if we care about equity, because we know that so many neutral laws on the books, on paper, do not operate neutrally.”

SCOTT BURRIS, JD, PROFESSOR AND DIRECTOR, BEASLEY SCHOOL OF LAW CENTER FOR PUBLIC HEALTH LAW RESEARCH AND THE COLLEGE OF PUBLIC HEALTH, TEMPLE UNIVERSITY

Understanding the fundamentals of public health law will help ensure that the field is able to successfully design, pass and implement effective policies to advance health equity moving forward.

Scope and preservation of public health authority

In addition to the fundamental principles of law in public health, the field needs to understand the scope and limitations of its authority in order to preserve it. As one summit presenter explained, it is essential for public health to have a deep understanding of its authority long before it needs to exercise it:

“One of the most critical things I’ve learned in my years of public health leadership is the importance of knowing and understanding the authority of your office before you need to use it. So not only do we need to be intimately familiar with the laws that help us carry out the everyday public health responsibilities entrusted to health departments but we need to be especially familiar with those that are critical in emergencies.”

OXIRIS BARBOT, MD, THE JPB FOUNDATION

The complexity of public health’s legal authority has certainly been highlighted and challenged by the COVID-19 pandemic. Policies like mask mandates, limits to the size of indoor and outdoor gatherings and travel restrictions played essential roles in limiting the spread of the virus. But they also shined a spotlight on public health authority that had previously been unfamiliar to much of the public. Negative reactions to these policies have resulted in legislative and judicially imposed limitations on or rollbacks of public health’s authority to protect the public through law and policy.

The plenary session featured a panel session of public health leaders reflecting on their experiences in exercising public health authority. Speakers were asked to identify, “*what are some steps that we can take to strengthen or use public health law?*” The moderator also referred to comments in the chat that talked about “*building more muscle, more political muscle and more ability to use public health law.*” Panelists pushed back slightly against this notion of “muscle” in public health law, cautioning that any exercise of public health authority—to mandate mask-wearing, for example—subjects the field to risk that the authority will be taken away, as is indeed happening in some localities across the country.

“I too was very hesitant to use the muscular power of public health law... We have to appreciate that whatever we do, there will be a response, which is what we’re seeing now in terms of many state governments, for example, diminishing the authorities of public health leaders.... We have to consider public health legal practice as a series of stepwise actions. In a sense I like to think, as a leader, that if I had to mandate something it was a failure of sorts. Not that it shouldn’t be there if absolutely necessary in an emergency situation, but I knew if I used it, I could potentially lose it at a later time. And that’s what we’re seeing now. So we need to go in as public health leaders and practitioners with the idea that we have to do everything possible not to mandate.”

MARISSA LEVINE, MD, MPH, UNIVERSITY OF SOUTH FLORIDA

Preemption

One of the strategies being used to limit public health’s legal authority is preemption. A summit presenter explained the concept of preemption and how it has been used recently to block local communities’ efforts in advancing equity:

“Preemption is the concept that a higher level of government takes away or limits the power of a lower level of government to work on a particular issue. In itself, preemption is not inherently a good or a bad thing, but it is being used or it can be misused to do bad things. And research shows that, over the past decade, preemption has been used as a tool to thwart equity. For example, local governments are being prohibited from passing minimum wage laws, expanding access to affordable housing and even limiting broadband access. Through COVID-19 we know these were all foundational to our health and well-being.”

SARAH DE GUIA, JD, CEO, CHANGELAB SOLUTIONS

Public health officials and practitioners need to understand preemption and the tools the field can use to effectively combat the use of preemption in efforts to restrict public health authority.

The breakout group on hot topics in public health law had a robust discussion about challenges and potential opportunities related to preemption. Among their conclusions were developing the evidence base to make the case for or against preemption in specific circumstances and more investment in legal epidemiology:

- “There’s a [recent study published by Drexel](#) that actually models the impact of cases for jurisdictions that would have taken specific action with keeping restaurants closed but for state preemption. This study provides a clear, direct message that isn’t as hypothetical as other studies on the impact of preemption have been. We in the legal world should really think about having conversations with statisticians and public health modelers on how to craft these studies where we can directly model the ‘but for preemption, this would have happened’ impact.”
- “A lot of times the evidence is there for the thing that is being preempted already being shown as being healthy. So if you have a preemption on raising the minimum wage, we know that raising the minimum wage is good for health, and so on down the line. I think we can fight against figures. I know the Big Cities Health Coalition is trying to promote the data they have on local policy on preemption. If we could send one message it should be: NIH, fund legal epidemiology!”

Participants also discussed strategies to challenge preemption:

- “In thinking about how to martial resistance to preemption...something that [Local Solutions Support Center \(LSSC\)](#) does—and that has been quite effective in some states—is to try and build a coalition across issue domains so there is a mutual assistance pact at the state capitol, with environmental lobbyists supporting the lobbyists for minimum wage and so on.”

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- *“Strengthening home rule for cities is an additional strategy that may be useful for building strengths for local governments when it comes to preemption. For that, I would go to the recent National League of Cities publication [Principles of Home Rule for the 21st Century](#).”*

Ultimately, preemption is relevant to public health workers even if they are not lawyers because it has the capacity to constrain (or possibly support) public health’s work. Lawyers in the plenary and breakout groups urged their colleagues in public health to recognize this and learn more about how preemption can help or hinder progress in advancing health equity.

Tribal and territorial public health law

Another aspect of public health authority the field needs to understand better is tribal and territorial law as it relates to public health. As one summit speaker explained, it is essential for public health workers at every level of government to understand that each tribe is, in itself, a sovereign nation.

“Fundamentally, every discussion of tribes and our interactions with the various levels of government—state, local, national—must be built on the foundation of understanding tribes as sovereign nations, sovereign governments, with a nation-to-nation relationship that we have with the federal government. There is no inherent relationship between the tribes and state and local governments. That’s a very, very important and fundamental reality to understand when thinking about the role of law in tribal communities when it comes to public health.”

STACY BOHLEN, MA, NATIONAL INDIAN HEALTH BOARD

Stacy Bohlen went on to explain the federal trust obligations that underlie the federal government’s responsibility to tribal public health:

“There is also a trust responsibility that obligates the federal government to provide tribes with access to resources to handle emergencies such as global pandemics... Providing health care, including public health services, was promised by federal officials, certified by the United States Senate, in treaties, which are the supreme law of the land, and codified in federal law since the beginnings of this nation.”

She also shared some examples of innovations in tribal governance that emerged during the pandemic to ensure tribal sovereignty over public health through *“the growing sophistication of public health law at the tribal level.”* Some of the innovations she described included tribes restricting travel through their lands to limit the spread of COVID-19 from events like the Sturgis motorcycle rally or the reopening of tourism in national parks.

As public health workers learn about the scope of public health authority, it is essential they also learn about the role they can play in honoring and upholding tribal law and sovereignty when it comes to public health. This will help the field ensure that public health law is used to advance health equity and racial justice.

CAMERA: Law as a Tool for Advancing Health Equity and Racial Justice

Speakers and participants at the third summit shared ways the field can reframe and refocus its approach to law to see it as a tool for advancing health equity and racial justice.

The role of law in structural racism

The last poll taken during the third virtual convening asked summit attendees to prioritize approaches to making public health law more effective and equitable. The highest priority, according to poll respondents, was “addressing structural racism to advance health equity” (29 percent). Tied at 26 percent each for a close second priority were “evaluating the impact of laws on public health and health equity” and “engaging communities in public health policy development.” Only 8 percent

of respondents indicated that “educating public health practitioners about key legal concepts” should be the top priority. Only 9 percent selected “strengthening community well-being while respecting individual liberties” as their top priority.

While only a fraction of attendees commented in the chat in response to this question, nearly 30 percent of those who did (seven out of 24 comments) said they would prioritize all of the above (although that was not one of the provided options). Four commenters also agreed that evaluation should be included in all the options.

POLL: Which one of the following would you prioritize to make public health law more effective and equitable? (Select one.)	% of total responses
Educating public health practitioners about key legal concepts	8%
Evaluating the impact of laws on public health and health equity	26%
Addressing structural racism to advance health equity	29%
Engaging communities in public health policy development	26%
Strengthening community well-being while respecting individual liberties	9%
Other (enter your priority in the chat)	2%
Total	100%

“We need to make sure that individuals within the legal infrastructure understand the role that social and structural inequities play in how our laws are designed, implemented and enforced. Because inequities are not just avoidable and unnecessary, they’re unjust. Which means that we have to look at the role that systems and institutions play in creating and reinforcing them. When I talk about structural inequities, I’m talking about the ways that cultures, norms, policies, laws, institutions—they all interact in a discriminatory way that perpetuates and intensifies the subordination of certain groups, across many spheres of their lives.... Laws are really powerful tools to help us undo these types of structural inequities.”

SARAH DE GUIA, JD, CHANGELAB SOLUTIONS

Model laws and policies for advancing racial justice and health equity

Throughout the summit and breakout groups, participants discussed examples of laws and policies that can be used to advance racial justice and health equity by addressing the fundamental drivers of health inequities.

For example, while non-tribal public health absolutely must recognize and honor tribal sovereignty, it also needs to do everything it can to support tribes in their provision of public health for their communities. Ensuring policies are in place to guarantee federal obligations to tribes are honored and resources are distributed commensurate to the level of need—especially given the long history of the federal government’s failure to uphold these obligations—is a significant step public health can take in advancing health equity for tribal populations.

Breakout group discussions also highlighted a number of ways that law has been used to advance racial justice and health equity during the pandemic, including paid sick leave policies and changing or eliminating eligibility requirements for support programs and services. Other avenues for addressing the impacts of structural racism through public health law could include policies like reparations and guaranteed income.

“Ways in which law is used to advance equity include the growing number of state and local governments that are instituting paid sick leave policies—which are tied to structural discrimination and income inequality—to help rectify the current and historic exclusion of Black, indigenous and other communities of color from gaining and maintaining wealth. Also during COVID, we saw changes to policies and programs that shifted eligibility or eliminated certain kinds of requirements that made programs more accessible to food, to PPE, to other kinds of supports and services during the pandemic, which have raised the question of whether those requirements are still needed. We also need to explore the role that reparations and guaranteed income can play in redressing multigenerational impacts of slavery, racism and discrimination across BIPOC communities.”

In one breakout group participants called for a compendium of model laws and policies that could be adapted to address the fundamental drivers of health inequities in different settings. Different approaches have been taken in different states and localities, they reasoned, and having these examples as resources would facilitate the development, passage and implementation of such policies in other places.

Evaluation of the health impacts of laws

In addition to having model laws and policies, conducting more evaluation of the health impacts of law would also facilitate the effective use of public health law to advance health equity and racial justice in other places. The need for more and better evaluation was, indeed, a cross-cutting theme of this and all of the summits in this series.

Tied for second place in the poll on priorities to make public health law more effective and equitable was “evaluating the impact of laws on public health and health equity,” selected by 26 percent of respondents. Evaluation is relevant to governance, finance and law, and summit participants pointed out the need to strengthen evaluation across all three domains.

Summit participants especially recommended more evaluation of the health impacts of laws, saying they should be treated just like any other intervention. Throughout the plenary and breakout group discussions, participants called for evaluation of public health law design, implementation and enforcement in order to identify what works and what does not work to advance health equity.

Summit attendees also questioned whether the field has figured out how to evaluate the effectiveness of investments in racial justice, for example. Meaningful and constructive evaluation, they explained, requires not only identifying what went well and what did not but also determining and making course corrections toward a better outcome:

“Trying to hold our constituencies accountable to targeting particular metrics of inequity and actually gauge whether or not our interventions are working is important. Sometimes you get a rhetorical investment in racial justice that doesn’t necessarily map to a set of new interventions. Even if you get the new interventions, you don’t necessarily map to asking whether or not you have solved or helped to solve the problem you went after. If it didn’t work, how are you going to change and adjust? The better use of data is to ask whether or not our values argument turned into an intervention, which turned into a change on the ground. Being really concrete about using those metrics internally and holding ourselves accountable to them is really quite critical.”

Preemption as a barrier to health equity and racial justice

Evaluating the health impacts of laws could be particularly useful in identifying laws that—by design or coincidence—result in disparate effects for different populations. For example, one of the breakout groups discussed the underlying racial dynamics in some state uses of preemption. Others in that group also raised the issue of attempts to restrict civil rights, including access to voting, which can likely be linked to inequitable health outcomes in a given population.

- *“In thinking about how to martial resistance to preemption, [we need to] call out the racial or equity dimension of so many of these battles when, really, the battle is between the metropolitan area, which is very diverse (in representation and electives), and the state house, which is not diverse at all.”*

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- *“Another factor here that underlies all of this: there is an effort to dilute democratic participation, because differing incentives or ideologies between rural or urban areas or areas with a more diverse population will be exacerbated further as these efforts to dilute voting strengths and placing impediments to vote are moving forward.”*

It is important for public health to understand how preemption can serve as a barrier to health equity and racial justice so the field can develop strategies to counter such misuse of preemption.

Ensuring equitable enforcement of public health law

Just as law can be used as a tool to restrict certain populations' access to rights and services, the enforcement of law can also have disparate impacts on different populations. Throughout this third virtual convening, participants noted how enforcement, or lack thereof, of a public health law can create or exacerbate inequities between populations.

“What I learned about the role of law during a pandemic is the equity implications of enforcing the requirements under the laws that are available to us. The best example here [in New York City] is, when we first implemented mask orders in late March/early April, the decision was made—against public health advice—to have police enforce the mask mandate. And what ended up happening is that Black and Brown communities were disproportionately and more harshly regulated than other communities.... When this was brought to leadership's attention, there was a quick course correction to engage communities through more public health-informed approaches.... Equity considerations must always be at the center of the conversation when laws are being triggered and enforced, during emergencies and nonemergencies.”

OXIRIS BARBOT, MD, THE JPB FOUNDATION

Inequitable enforcement has long-term effects on communities of color—not only in terms of interactions with the criminal justice system but in the cumulative economic impacts of disproportionate imposition of fines—which serve as structural factors of health and wealth inequities:

“When we think about enforcement, the role enforcement can play—it can actually lead to furthering health inequities by, for example, increasing interactions with law enforcement, which we know will disadvantage BIPOC communities. But another way to think about this is when fines are levied, and when they continue to be levied over and over again—the impact that can have on low-income communities as well.”

SARAH DE GUIA, JD, CHANGLAB SOLUTIONS

As public health gains a deeper understanding of the role of law at all stages—design, implementation, enforcement and evaluation—in structural racism it will be better equipped to effectively apply law as a tool for advancing health equity and racial justice. In order to achieve this deeper understanding, the field needs to embed law and advocacy into every aspect of public health.

ACTION: Embed Law and Advocacy into Public Health Learning and Practice

Once the field has shined a light on the fundamentals of public health law and authority and reframed and refocused its approach to law as a tool for advancing health equity and racial justice, the field can take action by embedding law and advocacy into every aspect of public health learning and practice.

Integrate public health law into public health education and practice

One of the breakout group participants shared results from a forthcoming ChangeLab Solutions study illuminating the dearth of legal skills in public health education:

“ChangeLab Solutions reviewed the 190 schools and programs offering MPH degrees. We found that 110 (58 percent) offer a course that covers the law in some capacity (including health law, health care law, or public health law). Of those, 68 (36 percent) cover public health law specifically. Of these, 13 (7 percent) are required for all students for graduation.”

While only 8 percent of poll respondents said they would prioritize “educating practitioners about key legal concepts” to make public health law more effective and equitable, the discussions in this summit demonstrated how critical it is for everyone in public health to have a core understanding of how the law can support health equity or serve as a barrier to it.

“We urge public health to build lawyers and long-term thinking and education about law and human behavior far more deeply into the professional model. Consider it vaccination against future implementation failure. It might cause a little initial discomfort when you first get the shot, but it’ll provide a lifetime of protection against unforced errors and missed opportunities.”

SCOTT BURRIS, JD, TEMPLE UNIVERSITY

The fundamentals of public health law need to be embedded into the foundations of public health education. One summit attendee proposed more cross-pollination of law and public health in education by incorporating each into the other field’s curricula and introducing it earlier in programs/ careers for “people who are going to be the future holders of these roles.”

In addition to expanding education on public health law, legal expertise needs to be integrated into every area of public health practice. This could be achieved by hiring more people with law backgrounds in various roles such as policy positions. One summit attendee warned, however, that structures and systems need to be in place to foster the cross-pollination of law and public health, so that it does not all fall on the one attorney in the department. Another way to ensure that legal expertise is built into public health projects is to make it standard practice to include funding for legal expertise in budgets and grants.

Integrating law education and legal expertise into every aspect of public health learning and practice will help ensure that public health law can be most effective in advancing the goals of the field. Public health practitioners and lawyers, however, are not the only ones who need a deeper understanding of public health law and policy. The field must reclaim advocacy as an essential function of public health to ensure that all of the recommendations in this report can be realized.

Embrace and reclaim advocacy as an essential public health service

Another way the field must take action is by embracing advocacy as an essential function to guarantee an effective, equitable and sustainable future for public health. Engaging and educating elected officials on public health law is a necessity to build relationships so each understands what the other does and how they can support each other’s work. The field needs to understand the potential for advocacy that is permissible and not be afraid to exercise it in order to advance public health’s goals and vision.

Engage and educate elected officials on public health law

There were many calls for strengthening public health advocacy throughout the third virtual convening. A key element of public health advocacy involves engaging and educating elected officials on all aspects of the field’s work, including public health law. But during the plenary and in breakout groups, summit participants raised concerns that public health’s connections with lawmakers and elected officials are weak, if not nonexistent in many cases:

- *“While we figure out how to build more organized political power, every public health leader could begin by being sure they are on a first-name basis with their elected representatives.”*
- *“Another missing element: among prominent public policy makers, who is universally recognized as a champion of public health? Hard to name even one.”*

- “Judicial organizations, National Governors Association and National Conference of State Legislatures are more aware of public health law than they were a couple years ago. We have made connections, but we need to develop these relationships.”

While it was not one of the provided choices, in response to the poll that asked summit attendees to name their top priority in making public health law more effective and equitable a few people specifically commented that public health needs to take up the charge of educating elected officials on aspects of public health law:

- “Educating elected officials on public health law needs to be a new one.”
- “Educating judges in issues on enforcement and interpretation of the law.”
- “[We need] a tool that helps our elected officials use basic needs and SDoH (social determinants of health) as decision points.”

Ensuring elected officials are knowledgeable about and aware of the work public health is doing is essential to advancing health equity through public health law and policy. Relationships with legislators and executives are required for the kind of partnerships public health needs to succeed in its work.

Beyond building relationships with and educating elected officials on public health law and policy, the field needs to educate itself on the permissible scope of advocacy and let go of its fear of practicing it. Such advocacy may require a multifaceted approach that involves both investing in existing public health advocacy organizations and building something new, as one participant suggested in the chat: “[We need to] build a dedicated public health advocacy organization to develop our public health political muscles that were found lacking during COVID-19.”

Shed the fear of engaging in public health advocacy

In the plenary and breakout groups, a frequently cited reason for why public health has such limited relationships with lawmakers is a deeply instilled fear of engaging in advocacy:

*“In the area of workforce development and support, in my role as president of APHA, a lot of the state public health associations get requests all the time to do training with governmental public health workers on the difference between advocacy and lobbying. We seem to be hung up on that. Today we talked about getting to know our policy makers and developing those relationships. So part of actionable discussion needs to be shoring it up that **it’s really okay for governmental public health workers to get to know their policy makers—local, state or federal legislators. Talking to them about what they do and the needs.** It’s not lobbying if you’re not promoting a particular bill. Government agencies need to lighten up and use these good voices. If we’re going to come away from this summit saying relationships with those who govern matter, then we need to be comfortable developing those relationships.”*

**KAYE BENDER, PHD, RN, FAAN, PRESIDENT,
AMERICAN PUBLIC HEALTH ASSOCIATION**

Breakout group participants concurred that the field needs a better understanding of what kinds of advocacy are allowable and expressed their hopes that public health lawyers can facilitate that education. With a concrete grasp on the bounds of what is permissible, public health can strengthen its advocacy muscles and exercise them without fear.

- “We need to enlighten folks about the myriad of advocacy that is not lobbying, and how to get people engaged.”
- “That’s where I’d love my fellow lawyers to come in—lean into being the voice of enabling folks to act, and clearly understand the boundaries, rather than narrowing possibilities for action.”
- “The mistake we have made in public health is that we’ve gotten in our cubicles and our labs—and COVID has complicated this—but we need to come out. One of the recommendations in a couple different health equity guides is around joining local movements. Often the work is already being done and we can join in and use our resources in ways that we can walk right up to the lobbyist line, use what we have—which tends to be data—to support these local movements and to be voices to go in the decision makers offices on our behalf and theirs.”

In addition to advocating for policies to advance health equity, public health can also support tribes in their advocacy efforts:

“We’re just thankful that, if anything good came of COVID-19, it was to raise awareness about the plight of American Indians and Alaskan Natives. And to elevate the intolerable conditions to a point where others who are friends and allies share that outrage and intolerance and will work with us to change laws and change the future. Join us in our advocacy efforts. Tribes need help. We are only four percent of the population.... So be part of our advocacy efforts in states. And if you’ve got tribes inside of your borders, work with us, we want to work together.”

STACY BOHLEN, MA, NATIONAL INDIAN HEALTH BOARD

Many, if not all of the recommendations in this report will require advocacy to realize or sustain the transformations discussed in this third virtual convening for public health governance, finance and law. Appreciating and exercising the power of advocacy for public health will be essential if the field is to succeed in strengthening governance, finance and law for a modern public health system.

LAW

LIGHTS: Understanding Fundamentals of Public Health Law and Authority

CAMERA: Law as a Tool for Advancing Health Equity and Racial Justice

ACTION: Embed Law and Advocacy into Public Health Learning and Practice

● Guiding Lights

Guiding Lights

Recommended resources for strengthening public health law

Presenters and participants in the third virtual summit also recommended specific tools and resources to strengthen public health law. These include the following.

Fundamentals of public health law:

- [Better Health Faster: The 5 essential public health law services](#)
- The [Network for Public Health Law](#)
- Online trainings through the [Public Health Law Academy](#), developed by CDC and ChangeLab Solutions

Preemption and public health:

- Network for Public Health Law’s description of a recent [use of preemption to restrict public health authority during the pandemic](#)
- A [compendium of resources on preemption and public health](#) from ChangeLab Solutions
- “A [recent study published by Drexel](#) that actually models the impact of cases for jurisdictions that would have taken specific action with keeping restaurants closed but for state preemption.”
- National League of Cities’ [Principles of Home Rule for the 21st Century](#)

Advancing racial justice and health equity through law and policy:

- ChangeLab Solutions’ [A Blueprint for Changemakers: Achieving health equity through law & policy](#)
- [The Civil Rights of Health: A New Approach to Challenging Structural Inequality](#)
- [Healing Through Policy: Creating Pathways to Racial Justice](#) policy and practice briefs
- ChangeLab Solutions’ [Equitable Enforcement to Achieve Health Equity: An introductory guide for policymakers and practitioners](#).

Conclusion

The third virtual convening of the *Lights, Camera, Action: The Future of Public Health National Summit Series* brought together nearly 1,500 public health workers from across the United States to discuss strengthening public health governance, finance and law to support a modern system. Although governance, finance and law are addressed individually in this report, none of these domains stands alone. In fact, they are interdependent; strengthening and supporting a modern public health system requires synergy across all three domains.

LIGHTS

This third summit of the *Lights, Camera, Action* series highlighted good governance through clear, effective communications; navigating innovations in public health finance; and understanding fundamentals of public health law and authority.

CAMERA

The presenters and participants at this third virtual convening recommended the field reframe and refocus its approach to governance, toward equitable and inclusive community engagement; to finance, by transforming the public health finance ecosystem for equity and justice; and to law, by seeing it as a tool for advancing health equity and racial justice.

ACTION

Finally, attendees of the third summit were urged to take action through governance, by deepening cross-sector and community partnerships to advance health equity; through finance, by financing a sustainable future for public health; and through law, by embedding law and advocacy in public health learning and practice.

This summit honed in on the connection between these three domains in public health at this point in history, refocused the camera on their potential impact across and between the different levels of government, and produced a new script for action to strengthen each of these domains individually and collectively to support a modern public health system.

Taken together, these efforts will allow public health to strengthen governance, finance and law to support a modern system that will enable the field and its partners to face current and future public health threats and, together, produce a new future for public health.

Themes for Action

This summary report provides an overview of the feedback from the audience of the third *Lights, Camera, Action* summit, capturing a point in time of a very rich discussion with multiple partners. The following key themes emerged from the virtual convening as areas of potential action to strengthen governance, finance and law to support a modern public health system:

- **Public health communications**
 - Conduct an assessment of public health communications, identify best practices and areas for improvement and develop strategies for communicating about public health that will resonate in different circumstances and geographies.
 - Communicate about the positive accomplishments of public health and its contributions to improving quality of life in good times.
 - Elevate qualitative data in public health communications and evaluation.
 - Seek assistance from communications and marketing experts.
 - Establish and sustain two-way communication channels between public health and the communities it serves.
 - Train public health workers in the skill of listening to improve public health communications and governance.
 - Reclaim and embrace a values-based approach to public health communications.
- **Community engagement**
 - Institutionalize the practice of humility in the field of public health, particularly when it comes to community engagement.
 - Utilize an asset-based approach in community engagement.
 - Train public health workers in spectrums of community leadership to institutionalize power-sharing.
 - Challenge and transform power dynamics in community partnerships by sharing decision-making power.
 - Engage affected communities early in the public health policy development process.
- **Uproot structural racism in public health**
 - Tackle racial equity internally within public health agencies and organizations before taking on racial justice externally.
 - Embrace tension and discomfort as essential to the process of uprooting structural racism.
 - Systematically identify and acknowledge historical harms caused by public health at every level of governance and partner with the most-impacted communities to collectively determine how to repair and heal from those harms.
 - Develop standardized measures for structural racism to communicate and monitor the impacts of racism over time.
- **Innovations in finance**
 - Educate public health workers on new and existing funding opportunities.
 - Educate public health workers on innovative strategies to finance public health work.
 - Adopt a holistic view of the public health finance ecosystem to facilitate innovation and long-term impact.
 - Reduce barriers to funding innovations by increasing flexibility and duration of funding.
 - Make disease-agnostic funding the norm rather than the exception.

- Reduce barriers to distributing funding effectively by allocating more funding directly to local entities rather than through the states.
- Reconsider competitive grant processes to ensure funding is distributed equitably according to need.
- Invest in capacity building for financial stewardship with community partners.
- **Workforce development**
 - Invest in public health salaries.
 - Assess inclusion and belonging within the public health workforce and develop and standardize strategies and policies to improve both.
 - Expand beyond traditional public health skill sets in hiring, education and training to address structural determinants of health inequities.
- **Public health law**
 - Increase education and training on the fundamentals of public health law and authority—including tribal and territorial law and authority—for all public health workers.
 - Embed legal expertise into every area of public health practice.
 - Identify and share model laws and policies that can be adapted to address fundamental drivers of health inequities in different settings.
 - Standardize evaluation of the impacts of laws on public health and health equity to communicate and monitor changes over time.
- **Embrace advocacy**
 - Accept that public health is inherently political.
 - Normalize advocacy as an essential public health practice.
 - Fund advocacy for solid infrastructure and sustained resources for public health.
 - Engage and educate elected officials on public health law and practice.

For more detailed recommendations for the future of public health, the cohosts and partners of this national summit series urge readers to review the reports that came out of the Bipartisan Policy Institute's bipartisan coalition, [Public Health Forward: Modernizing the U.S. public health system](#) and [The Future of Public Health: A synthesis report for the field](#).

Summit Evaluation and Upcoming Virtual Convenings

The final poll conducted at the end of the plenary asked attendees how effective the summit was in meeting its objectives: “Elevate the connection between law, governance and finance in public health at this point in history and their impact/potential across and between the different levels of government” (96 percent selected “Effective” or “Very Effective”); “Offer tools, strategy and information to policy makers and public health officials to strengthen public health” (93 percent selected “Effective” or “Very Effective”); and “Strengthen relationships throughout the field of public health across different areas of focus and levels of government” (91 percent selected “Effective” or “Very Effective”).

Additionally, summit participants were asked whether they and their team will be able to take action based on the information from this summit over a range of time periods. Nearly two-thirds (63 percent) of respondents said they would be able to take action immediately or within two to six months.

The fourth and final summit was held on March 23, 2022, on the topic of *Catalyzing Cross-Sectoral Partnerships and Community Engagement*. The [summit website](#) includes recordings, summary reports, Accelerating Action reports and other details on all the virtual summits as that information becomes available.

The cohosts and partners look forward to convening with you virtually and learning from your contributions to the future summits as we plan together and write a new script for the future of public health.