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*Health Promot Pract* 2006; 7; 280  
DOI: 10.1177/1524839906289583

The online version of this article can be found at:  
<http://hpp.sagepub.com/cgi/content/abstract/7/3/280>

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## ***State Health Policy Makers: What's the Message and Who's Listening?***

Ellen Jones, MS, CHES  
Marshall Kreuter, PhD  
Sharon Pritchett, MPH  
Rose Marie Matulionis, MSPH  
Neil Hann, MPH, CHES

*This article is based on a white paper commissioned by the Directors of Health Promotion and Education, a national organization representing state health agency directors and practitioners in health promotion and education initiatives. The work reflects an assessment of current understanding of how state-level policy makers receive and use information related to health promotion and chronic disease prevention. Although health education practitioners are routinely encouraged to use policy and environmental change strategies, a systematic approach to communication with policy leaders is not readily available. This work describes the current knowledge of the relationship and offers recommendations for research and practice.*

**Keywords:** *health promotion; health policy; health education; chronic disease; decision makers*

**Health Promotion Practice**  
July 2006 Vol. 7, No. 3, 280-286  
DOI: 10.1177/1524839906289583  
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### ► **HOW STATE-LEVEL POLICY MAKERS RECEIVE AND USE INFORMATION**

Progress toward the Healthy People objectives during the next several decades will depend on a combined effort of federal, state, and local programs. In addition, evidence-based interventions must be combined with personal responsibility and policy and environmental approaches to public health. The obesity epidemic is case in point. There is no single federal policy that will reduce the rapid rise in childhood and adult obesity. Similarly, community interventions that are not complemented by environments that promote physical activity and healthy eating will fall short. In this context, it has become increasingly important that state and local public health practitioners become adept at communicating with state-level policy makers.

The goals of communication with state level policy makers are to

- improve legislators' perception of public health and health promotion as worthy of their support,
- understand motivating factors for state and local policy leaders,
- make the case for evidence-based programs, and

- integrate state and local efforts to improve health.

### ***Understanding Differences***

Communication requires contact, and meaningful, sustained communication requires a relationship. Establishing contact leading to a relationship with legislators begins with an understanding of a fundamental reality: No two state legislatures are the same!

Results from a 2004 report by the National Conference of State Legislatures (NCSL) indicates that, across the states, issues about balance of power, organizational structure, and even time dedicated to governing are more dissimilar than similar. Thus, just as health promotion practitioners must tailor programs to the characteristics and circumstances of a given place and population, so too must they select communication strategies with legislators based on unique circumstances that exist in their respective state legislative bodies. Examining variability across several basic factors, the NCSL has grouped the 50 state legislatures into three major categories based on time spent in session, compensation, and staff support: Red, White, and Blue (see Figure 1).

One of the key points to learn from the figure is that being a legislator

Red States		White States		Blue States	
Time	80%	Time	70%	Time	54%
Comp	\$68,599	Comp	\$35,326	Comp	\$15,984
Staff	8.9	Staff	3.1	Staff	1.2
AK	NJ	AL	KY	OR	GA
CA	NY	AZ	LA	SC	ID
FL	OH	AR	MD	TN	IN
IL	PA	CO	MN	TX	KS
MA	WI	CT	MO	VA	ME
MI		DE	NE	WA	MS
		HI	NC		NV
		IA	OK		NM
					VT
					WY

**FIGURE 1 National Conference of State Legislatures Breakdown of States by Category (2004)**

NOTE: Time = Estimated proportion of a full-time job spent on legislative work including time in session, constituent service, interim committee work, and election campaigns. Comp = Estimated annual compensation of an average legislator including salary, per diem, and any other unvouchered expense payments. Staff = Ratio of total legislative staff to number of legislators.

goes beyond the work she or he does in the state house attending legislative sessions, reviewing and acting on the governor’s proposed budget, and voting on proposed laws. It also includes spending substantial time assisting constituents, studying state issues during the interim, and campaigning for election. Decisions about how and when to interact with a legislator should take into account these elements throughout the year, whether legislators are in the state house or in their home district.

**Do Decision Makers Find Health Information Useful?**

A recent report titled *Health Policy-Makers’ Perceptions of Their Use of Evidence: A Systematic Review of Evidence* (Innvær, Vist, Trommald,

**The Authors**

*Ellen Jones, MS, CHES, is a health promotion, chronic disease, and health policy consultant in Madison, Mississippi.*

*Marshall Kreuter, PhD, is a professor with the Institute of Public Health, Georgia State University in Atlanta, Georgia.*

*Sharon Pritchett recently received her MPH from the Institute of Public Health at Georgia State University in Atlanta, Georgia.*

*Neil Hann, MPH, CHES, is chief of Community Development Service, Oklahoma State Department of Health, in Oklahoma City, Oklahoma.*

*Rosemarie Matulionis, MSPH, is the executive director of the Association of State Directors of Health Promotion and Education in Washington, D.C.*

& Oxman, 2002) searched through more than 2,000 articles that included interviews with policy makers from several countries and all levels of government to determine what policy makers say they find helpful or not when using health information to make decisions. The most commonly mentioned barriers to the use of research evidence in policy making were absence of personal contact between researchers and policy makers; lack of timeliness or relevance of research; mutual mistrust, including perceived political naivety of scientists and scientific naivety of policy-makers; power and budget struggles; poor quality of research; and political instability or high turnover of policy-making staff.

Innvær et al. (2002) advised those wishing to influence policy to

have personal and close two-way communication with decision-makers; provide decision-makers with a brief summary of their research with clear policy recommendations; ensure that their research is perceived as timely, relevant and of high quality; include effectiveness data; argue that the results of their research are relevant to current policy and demands from the community. (p. 244)

Similar conclusions were also found in research focusing solely on the United States. To better understand how state legislators receive, use, and perceive the usefulness of health information, Sorian and Baugh (2002) conducted a national telephone survey of nearly 292 policy makers from across the country; the sample included legislators from health related committees (n = 97), legislative staff who focused on health (n = 97), and managers of state health agencies (n = 98). Respondents’ characteristics were representative of state governments as a whole.

Sorian and Baugh (2002) found three points especially salient: (a) that public health and policy information must be framed such that it is relevant to current debates at the state level; (b) although researchers and health professionals may be focused on long-term solutions to systemic problems, what legislators want is information about the news “in the paper today”; and (c) it is critical to layer information so that the most easily read information will be used immediately—policy

makers and staff can read additional information in greater detail once they get the overview.

Overall, respondents said they never get to more than one third (35%) of all information. They said they were likely to skim about 53% of what they receive and actually read only 27% of the information in detail. Critical factors in making the cut in terms of their decision to read were “relevancy” and “easy to read.” When asked what makes information relevant, 67% of legislators surveyed said relevance to current debates, and 25% said impact on real people. Respondents were least likely to read material that was long, full of jargon, too detailed, or seen as biased. Popular formats included bulleted points and simple graphs. Journals were least likely to be used by legislators and more likely to be used by state agency heads. Few respondents were likely to attend meetings and conferences to get information to make policy decisions. In general, policy makers are overwhelmed with information. More than one fourth (27%) said they already have too much information or do not want any more.

The extent to which legislators trust the sources of information was an important factor in their decision to use the health data and information they receive. Most said they trusted some sources more than others. Professional associations such as the Association of State and Territorial Health Officers (ASTHO) and the NCSL ranked high on the trust scale. The conclusions overwhelmingly confirmed the importance of relationships with policy makers in addition to the presentation of the evidence. The implications for practice include the need to understand that persuasive information

may be enhanced when integrated with messages about “what’s in the paper today.” Clearly, a tie-in to issues that are relevant to state legislative debates, public concerns, and high priority issues for state agencies will improve the overall interest in health promotion issues.

### ▶ THE LINK BETWEEN INFORMATION AND POLICY DECISIONS

Gottlieb and her colleagues (Gottlieb et al., 2003) carried out a three-state research study to ascertain state legislators’ intentions to support or oppose tobacco-control legislation and determine how such intentions are influenced by legislators’ demographic characteristics, their knowledge of and attitudes toward tobacco control, and their perception of and contact with lobbyists on tobacco-related issues. Interviews were completed with 84% (444 of 529) of all state legislators who were serving in North Carolina, Texas, and Vermont at the time of the interviews in May and October 1994. These states were chosen to represent a spectrum of tobacco-control laws, dependence on tobacco income, demographic composition, and health status measures. A data set was established that included information on legislators’ intentions related to tobacco prevention and control initiatives. In addition, the data set contained information on constituent demographics, campaign contributions, and voting record on tobacco-related legislation. Gottlieb et al. (2003) found the following:

- Most legislators believe tobacco is addictive, although there were differences among the states: 82% from Vermont, 70% from Texas,

and 56% from North Carolina believe that people who smoke cigarettes do so mainly because they are addicted to nicotine.

- 79% from Vermont, 65% from Texas, and 42% from North Carolina agreed with the statement that environmental tobacco smoke can cause lung cancer in nonsmokers.
- More than 75% of legislators stated that they would support measures to enforce laws preventing tobacco sales to youth. The enforcement mechanisms described included unannounced annual inspections of all merchants, merchant education programs, and a fine of \$100 for failure to comply with the law.
- 75% of the legislators did not believe that smoking in indoor public places was a personal right.
- Overall, 3 to 4 times more legislators said they could be persuaded on tobacco issues by medical society and nonprofit health lobbyists than said they could be persuaded by tobacco lobbyists.

Legislators reported less contact with medical society lobbyists than tobacco lobbyists about tobacco issues. Overall, 58% of legislators reported any face-to-face contact with medical society lobbyists, 72% with nonprofit health lobbyists, and 72% with tobacco lobbyists during the 1993–94 legislative session. When asked to evaluate the amount of contact with lobbyists on tobacco-related issues, 26% stated that they had too little contact.

### ▶ THE IMPORTANCE OF VOTER PREFERENCE

Gerber and Lewis (2004) studied the link between voter preferences, district heterogeneity, and legislator

behavior in Los Angeles County, California. Essentially, *district homogeneity* implies that collectively the majority of voters in a given district hold common views on political issues; in a heterogeneous district, the case is just the opposite. The study concluded that in homogeneous districts, the median voting preferences of district residents is a good predictor of the legislator behavior (voting). Conversely, in heterogeneous districts (where the political views of voters are less consistent) the voting behaviors of legislators are more likely to reflect their personal political biases even though the median voting preference of those in the district favor a position that is the opposite of the legislator's.

This finding has implications for undertaking strategic efforts within legislative voting districts. Specifically, such efforts might use local evidence of health promotion effectiveness and frame that evidence in the context of how those programs yield direct local benefits in terms of quality of life and, in some instances, cost savings. Findings from district-level surveys showing that a large portion of residents see public health and health promotion as a high priority offer evidence that legislators will have difficulty ignoring.

In their book, *Republic On Trial: The Case for Representative Democracy*, Alan Rosenthal and his coauthors (Rosenthal, Loomis, Hibbing, & Kurtz, 2003) reinforced the importance of the views held by constituents. They pointed out that the legislative process, consistent with the reality of democracy in action, is necessarily complex and manifests uncertainty, competing interests, confusion, bargaining, compromise, and conflict. However, constituents hold an important key for legislators as

they grapple with those complexities: "Legislators pay close attention to their constituents' views because they are products of their communities and think in similar ways, they want to do good for their districts and most want to be reelected to office" (p. 85). The examples of successful programs within their states (and specifically within legislative districts in their respective states) give state and local health educators an ideal and relevant entrée for enhancing communication with legislators and engaging them in the development and support of public health programs that will make a difference in their "backyards."

#### ► PERCEPTIONS OF STATE POLICY LEADERS

The following quotes and narratives were made by legislators from West Virginia, Mississippi, and Georgia during unstructured interviews and discussions carried out by the authors in 2005. Quotes are taken from a white paper commissioned by the Directors of Health Promotion and Education (DHPE), available at [www.dhpe.org/CommunicatingHealthPromotionEffectiveness](http://www.dhpe.org/CommunicatingHealthPromotionEffectiveness) to SHADecisionMak

Keep in mind that most of us pay serious attention to three factors: (1) votes, (2) money, and (3) media. To stay in office, we must have votes and must respect the views, interests and values of those who elected us. We have to run campaigns and we need support for that. Also we don't easily forget those who provided support for a priority issue we were pushing for—it's called reciprocity. Media is critical because it equals exposure—it helps bring attention to an important issue or debate, and us as well.

Those early session briefings are very helpful.

In West Virginia, at the beginning of each year's legislative session, leading academic economists from the University of West Virginia provide an assessment of West Virginia's economy. Legislators are unanimous in their support of a "health of the state" briefing to give them perspective. We were told by two key legislative leaders that next year (2006) they hope to add a similar, unbiased briefing on the State of West Virginia's Health. This is consistent with the annual health status briefing for Massachusetts conducted by staff from Harvard University's School of Public Health.

Constituents matter—if they want it, I listen.

Pay attention to the current debates—during any given year there are a few topics or issues that are clearly legislative and budget priorities we must all grapple with—that is what we are referring to when we use the term 'current debates.' So if the current debate is over Medicaid, tie your health promotion issue to that! In a similar vein, one legislator said; "Don't get sideways with other health constituents." He explained that public health should present a common, consistent message and implying that if diabetes is seen as competing with immunization or environmental health "it just looks bad."

#### ► PERCEPTIONS FROM THE FIELD

Health educators working in public health and research have a

unique opportunity to educate policy leaders about the needs in the population and the efficacy of health education interventions. Although many practitioners are not formally taught these communication skills, many have developed close relationships with health policy leaders at the state and local levels. Where such relationships exist, health education becomes a tool to promote health through policy interventions.

Understanding the relationship between state health agencies and health policy leaders is extremely important. Tom Sims, director of Health Education at the West Virginia Department of Health, sums it up this way:

Those who work in health departments find themselves in a technical field that exists in a political environment. Certain topics are more volatile than others, such as tobacco, gun control, and actions that affect commerce. An example of the latter is health advocacy around the content and placing of snack and soda vending machines. (personal communication)

The relationships should transcend any individual issue so that public health professionals are a resource in a myriad of health policy debates.

Communication advisors have helped practitioners with strategies that recognize that the long-range goals for healthy communities must be compatible with short term goals of policy leaders. The relationships between practitioners, researchers, and policy leaders are important at all levels. In Sims experience, "The importance of mid-level management in public health should not be underestimated. The tenure of commissioners and state health directors is often not very long, but

many of us in the ranks have more than twenty years working for the organization."

Donna Nichols, senior prevention policy analyst with the Texas Department of State Health Services, described essential services this way:

The biggest job of any health practitioner working with health policy leaders is to understand their issues from the policy leader's perspective, anticipating their questions and being ready with answers that provide a balanced point of view. Providing evidence of health promotion effectiveness alone rarely changes the minds of health policy makers. The message must be communicated in real time by a trusted messenger or constituent and with the understanding that there is a return on investment. (personal communication)

In addition to forming and nurturing relationships with health policy leaders and their staff, practitioners and researchers must appreciate the roles that many of these key leaders play. "Elected officials must balance more priorities than most of us can count," says David Hoffman, director of the Bureau of Chronic Disease Services at the New York State Department of Health.

We, as public health professionals, have a responsibility to distill our knowledge, findings and suggestions into bite sized pieces. We must then prioritize—from a public health perspective—knowing that final decisions are made in the context of local politics, this year's budget, and in reaction to stories of the people we all serve. Part of our job is to be prepared to answer the tough questions before they are

asked, and sometimes help policy-makers see the real questions. (personal communication)

Insight from Dick Welch, Minnesota Department of Health (1987-1996) and a member of the Minnesota House of Representatives (1977-1985) highlights the challenge of providing timely and relevant information.

Most elected policy makers like to be able to solve problems with good public policy. . . . The voices heard and faces seen by policy makers are most effective when they include people they know and respect, including those of us who have first hand experience with the consequences and burden of the health problem. (personal communication)

### *Understanding Challenges*

"In the past, a dominant factor slowing investments that address the non-medical determinants of health was lack of consensus on what could be done to change factors such as behavioral choices, social conditions, and the physical environment" (McGinnis, 2002, p. 84). Currently, it seems a major challenge is to effectively communicate what is known to decision makers and to have this translate into policy or to sustained support for public health programs.

Two major bodies of theory in literature address this: First, that those who produce research and those who produce policy have inherently different values, priorities, and notions of themselves than the other. Second, the utilization of knowledge can mean several different things: Research can be applied in a variety of ways, including informing policy or literal

execution of recommendations (Innvær et al., 2002). The result of this is a continual dance between policy makers and those trying to convey their messages, with both groups believing they are supporting rational choices beneficial to society.

Increasing the amount of evidence of public health effectiveness is one solution with its own set of problems. Although commonly accepted guidelines for systematic reviews of evidence have grown during the past decade and databases or clearinghouses of information have expanded their availability to the public, the lack of research on programs which meet this criteria, lack of reviewers or funding to maintain regular updates, and the few numbers of longitudinal studies contribute to a large gap in information (Kindig et al., 2003). State health leaders can help fill this gap by sharing evidence from programs in their own states with each other and with policy makers and by encouraging researchers to include policy implications with their findings.

As mentioned in the previous example, McGinnis (2002) referred to a "diffusion of responsibility for health" that must be addressed in communication with state policy makers. First, there are an array of health determinants that must be addressed by evidence from nontraditional health fields such as economics and organic and social sciences (Lavis, 2002). Next, there are many people believed to be responsible for maintaining health, from the individuals to their health care and insurance providers, as well as policy creation and enforcement at local, state, and national levels. Messages to policy makers must delineate their role of responsibility

and be inclusive of the larger effects of their decisions in seemingly non-health-related policies.

### ► **RECOMMENDATIONS FOR PRACTICE**

Health promotion practitioners are in a unique situation in terms of their ability to communicate with state and local leaders whose decisions influence health policy. Through voluntary organizations, state and local boards of health, coalitions, university partners, and communities, practitioners come in contact with health policy leaders at all levels. The following recommendations are made for practitioners:

1. Talk about the general evidence of the effectiveness of health promotion: Associations whose state members must communicate with policy makers should add a feature to their Web sites that provides a sampling of evidence documenting the effectiveness of health promotion (as illustrated in this report). The Web site should be created in an easy-to-access and understandable format that is reviewed and updated biennially. With easy access to that information, all requests for information about effectiveness can be addressed in a concise and timely manner.
2. Present local (state-by-state) evidence of the effectiveness of health promotion: State practitioners need to take steps to strategically give greater emphasis to existing state-level evidence of the benefits of health promotion. "Evidence" takes on special relevance when it is a local example and when the effects of that

- example are framed in terms of its direct impact on one's local community, family, or constituents. In effect, such examples send the message that "health promotion works and it is working in our own backyard!" "Furthermore, our residents support and value [this program]; here are the tangible benefits it generated." (Tom Sims, personal communication)
3. Establish an ongoing academic partnership: Although local success stories have universal appeal, they are especially relevant in the 78% of all states where legislators spend 70% or less time on the job. For these legislators, a greater effort is needed to establish relationships with legislators who spend most of their time "at home." Although available in virtually all states, local success stories appear to be an underutilized resource. To maximize and strengthen this resource, we encourage state leaders to explore the possibility of a collaborative effort involving the respective state health agencies and selected Prevention Research Centers (PRCs). Together with state-based researchers, practitioners can frame messages effectively.
  4. Help legislators understand the difference between evidence and likely impact: State policy leaders are keenly aware of pressing public health issues in the communities they serve. Levels of effectiveness must be evaluated in real-life terms; that is, when an intervention has met with success at the local level and is successfully mobilizing community action, it is more likely to be viewed as successful. Many local interventions are based on promising practices

- and on interventions based on research in other communities.
5. Keep your finger on the pulse: Public health practitioners must become more astute at keeping their “finger on the pulse” of relevant health issues in their respective states. Evidence we reviewed repeatedly pointed to relevance of current debates as a critical factor in health policy. Understanding this will serve the health educator in at least two ways. First, it broadens health educators’ understanding of important health issues facing policy makers. These may be issues traditionally outside the purview of public health education units. By understanding these pressing issues, health educators can better frame their own issues. Second, opportunities to expand current discussion so that they include the benefits of health promotion and education may be identified. By “tagging on” to current debates, educators make health promotion issues more relevant.
  6. Maintain sustained leadership as part of a team: Whatever strategy is undertaken by health education and chronic disease prevention researchers and practitioners to enhance the credibility and effectiveness of health promotion with legislative leaders,

care should be taken in the way that effort is framed; that is, it should be seen as a planned activity that clearly complements the ongoing efforts of your state health department and other health advocacy groups such as the American Public Health Association (APHA), the Society for Public Health Education (SOPHE), and the Coalition of National Health Education Organizations (CNHEO).

Furthermore, while undertaking such an effort, state and local health promotion advocates must remain mindful that communicating with state and local policy makers is an ongoing effort. Agency heads and elected officials change frequently, the relevancy of health issues is fluid, and partners whose mission involves state and local advocacy are not static. DHPE voting members should be committed to the principle that an integral part of their job is to seek to maintain on-going communication with individuals and groups that influence health policy at the state level.

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