NAVIGATING FEDERAL UNCERTAINTY FROM THE FRONT LINES
A CONVERSATION WITH DANIEL EDNEY, M.D., FACP, FASAM

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Q: Could you start by describing the Mississippi State Department of Health—its mission, priorities, and the degree to which federal funding supports your ability to carry out that work?

The Mississippi State Department of Health is celebrating 150 years of public health in Mississippi starting in January of next year. The mission of the department is to protect and advance the health, well-being, and safety of everyone in Mississippi—with no exceptions. That's all 2.9 million of us. We're one of the very few entities that touches every life, every day. We emphasize the importance of public health as a core function of government to remind our elected officials that what we do is critically important in serving the people of Mississippi.

When I took office four years ago, we were about 80 percent funded by federal dollars, which was very dangerous. That's an exceedingly high ratio of federal to state funding. We're a small state, so our budget runs about $500 million or so a year. Four years ago, 80 percent of that was federal. Now it's about 65 percent. But that's not from federal cuts; that's from the state doing better. We have the ability to generate revenue as a centralized agency, so we were actually generating more revenue ourselves than we received through the state appropriation. My goal is to get us down to 55 percent of our budget being federally funded through improved efforts on the state side.

Q: Looking back at the period from early 2025 through today, what has this period looked like from where you sit in Jackson?

All of our federal partners are extremely important. In my four years as state health officer, the federal relationship has been largely unidirectional. It has involved very heavy-handed directives coming from Atlanta and Washington rather than cooperative efforts. The best example was the DOGE cuts. We lost $230 million. Those funds weren't budgeted. Their loss didn't slam our budget, but it slammed our work.

The so-called COVID rescissions were done very impulsively and irrationally, with no thought given to what the impact would be. No one ever asked us, "What are you doing with these funds?" We were doing what we were supposed to be doing: preparing for the next pandemic and rebuilding our infrastructure, which the recent pandemic decimated. A big part of that preparation was the data modernization that we're all working on and simply having a better-prepared public health system so it can respond better than we did the last time.

That just pulled the rug out from under us. It made as much sense as building half of your house and then shutting down construction without having any walls or a roof. It was an utter waste of money because there was so much we had begun investing in that we couldn't finish.

That was not partnership. I'm of the mind that the public health agenda of the state of Mississippi is better determined by Mississippians than by federal project officers. The more discretion the states on the front lines are given, and the closer we can get to communities as we make these important decisions, the more effectively and efficiently the money will be used. Then give us some opportunity to braid and blend funding.

Q: Beyond the dollar amounts in grant awards, federal health agencies provide technical assistance, scientific guidance, laboratory services, data infrastructure, and subject matter expertise that states rely on to do their work. Have you experienced changes in that dimension of the partnership? What does it look like when a familiar federal contact or source of expertise is no longer available?

Relationships matter. The best time to develop a relationship is before the crisis happens. When you have that relationship, it makes working through a crisis easier—rather than talking on the phone for the first time with people you've never spoken to before.

We're very grateful for our federal partnerships, and some do a better job than others. HRSA is an outstanding partner with us on rural health issues. The folks at EPA Region 4 know us; we talk to them all the time. There aren't that many state or territorial health officials, so I think CDC leadership should know every one of us.

We don't have the ability to do Biosafety Level 4 laboratory testing. With all of the crazy, rare bugs, the states don't have enough volume to do that on a day-to-day basis in our public health laboratories. We need CDC's expertise and laboratory testing, especially for unusual or challenging outbreaks, like the measles outbreaks in Texas, Utah, and South Carolina.

We need CDC's epidemiologic expertise. We need that technical expertise on hantavirus. We don't deal with that in Mississippi, but I had to be prepared in case there had been travelers involved. We can't defend Mississippi against Ebola by ourselves. It takes partnerships with CDC, but CDC can't be on the front lines in Jackson, Mississippi, so we have to work together.

It hurts public health in Mississippi when we can't immediately pivot to our federal experts for help when we need it. A great example was the blackout period during the transition between presidential administrations. We were disconnected from the federal government, and I just thought, "Well, Lord, I hope nothing happens where we need CDC during this."

Q: In August 2025, MSDH declared a public health emergency over Mississippi's infant mortality rate—the highest the state had recorded in more than a decade. Addressing that crisis depends in part on federal support from agencies such as CDC and HRSA. What has this period of federal uncertainty meant for that work specifically?

The emergency was based on an explosion in African American infant mortality. It was a drastic jump that was so worrisome on top of an already bad number. I brought together everyone throughout the agency to understand whether they were doing anything related to infant mortality and what investments we were making in maternal health.

We reconstructed our home-visitation program into a new model using community health workers. Our experts were telling us that safe-sleep issues were killing way too many of our babies, especially in the high-risk, low-income homes that were most affected. We got cribs and Pack 'n Plays to our high-risk homes, along with teaching families and grandparents about safe sleep. We had federal funding available to help us.

Later, one of my team members said, "Well, we used to give out cribs."

I said, "Well, why did we stop?"

She said, "The federal grant went away."

I just shook my head. It brought home to me that we need to determine the public health policies and programs that Mississippi needs, and then we will use every federal, state-appropriated, and discretionary dollar we can to make them happen. But we cannot base our programs on whether federal funding is available. Now, if federal funds go away, the cribs aren't going away. These changes are making an impact. They're teaching us a lesson.

Q: Much of Mississippi's federal public health funding flows through your department to local health departments and community organizations. When federal funding is disrupted at the state level, how does that affect the partners downstream who depend on MSDH as an intermediary?

I shared with our congressional delegation that the folks who were hit the hardest by the DOGE rescissions were community-based partners. It really hurt the trust we had built with partners because we had contracts and subgrants in place related to all this funding that was rescinded.

We had work orders, and millions of dollars were going out to community-based organizations with relatively small budgets that had applied for and received awards and had begun their work. Then we had to issue stop-work orders because the federal funds were pulled. Now nobody wants to enter into contracts with us because they don't know whether the money will be rescinded.

It was not catastrophic, but it negatively affected our work and severely affected our partnerships. It decimated our community health worker efforts, which we're slowly rebuilding with Rural Health Transformation grant funds. The smarter thing would have been to leave those initial grants alone and let them mature so the work that had already started could be completed.

Q: As ASTHO's President-Elect, you hear from state health officers across the country. Are there patterns you're seeing in how this period has played out across states?

We've all been trying to work through these changes together, just in our different ways. The blue states had challenges and were knocked back on their heels, but their funding got turned back on. The red states are used to more funding challenges, especially my colleagues in the Southeast, but we have a different attitude about it.

We all work in the same political climate, but we do it successfully. When we go to the Capitol, we're appreciated, respected, and listened to. It doesn't mean they give us everything we ask for, but they voice their appreciation frequently, and that goes a long way.

The most important thing I have to defend is not our funding, but trust in public health. And we've been very successful with that. We navigated the pandemic without losing trust or abusing public health authority, and we were seen as trusted subject matter experts by our elected officials and the community at large. That has made it easier to request funding for specific issues.

Q: The President's FY 2027 budget proposes significant reductions to CDC and other federal public health programs. What would those cuts mean in practice—for your department, the communities you serve, and communities across the country?

It was counterintuitive to me that an administration that's trying to make us healthy again would eliminate the Prevention and Public Health Fund or eliminate the Office on Smoking and Health at CDC.

No one has asked us at the state level, "If you need to trim 15 percent from the budget, what would be the wisest way to do it, and how would it affect the community?" I'm not opposed to some thoughtful reorganization, but I think what has also been extremely expensive is the drastic reduction in the federal workforce without a whole lot of planning, thought, or preparation. Those of us who are used to managing large workforces know that workforce adjustments need to be done thoughtfully.

I suspect there will be cuts. I can't predict which of the proposed cuts will be honored, but I'm very worried about any cuts to the Title V Maternal and Child Health Services Block Grant. We have the investment in our federally qualified health centers through HRSA. The WIC program is absolutely necessary, so cutting WIC across the board in a less-than-thoughtful manner is going to hurt women, infants, and children, which I don't think any of us in the United States wants to do.

I think our HIV funding is at risk, right as we are making historic improvements in reducing the incidence and prevalence of HIV and bringing the largest number of people into care that I think we ever have.

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Q: What would you most want members of Congress—and the public—to understand about what federal public health investment makes possible and what is genuinely at risk right now?

When I talk to our congressional delegation, I share that CDC is our closest federal partner. We also have a lot of work in the HRSA space and some work with SAMHSA, but mostly CDC. Then I remind them that 80 percent of CDC's funding flows out to states and localities.

I know there was a lot of appetite to punish CDC. Having endured the pandemic, first as a practitioner at the bedside and then coming to the State Department of Health right in the middle of it, I know there are things that could have been done better. But everybody's heart was in the right place.

You cannot decimate CDC and then think it's going to work well. It is an extremely important federal agency that has now been decapitated and is just floundering. When CDC is hurting, that hurts public health in Mississippi.

The stability in public health has occurred because state and local agencies have held it together. The folks at CDC are doing the best they can in this situation. We love and respect them, and we need them. What I've been communicating to our federal delegation is the importance of CDC and the good work it does for Mississippians. It is the best example for us in terms of our federal partners.

If I'm getting direct funding from Congress without CDC, I can keep doing a lot of what we do, but I can't keep doing everything we do. Also, a lot of people don't understand how many different federal partners we work with every day. For us to keep the water safe in this state, we have to have EPA. For us to keep the milk supply and dairy products safe and to manage the WIC program, we have to have USDA.

Q: Is there anything we have not discussed that you think is important for readers—especially policymakers—to understand about this moment for state public health agencies?

How do you survive challenging budget times? I knew we had to do better at generating revenue ourselves. I knew the area where we were getting practically no funding was the private sector—and who in the world wants to donate to a state agency?

I was able to get the legislature to enact a trust for public health in Mississippi and have it funded in a blended fashion. There are appropriated tax dollars, discretionary public health dollars, and private donations beginning to come into the trust. It's a true endowment that earns interest and can't be used for any other purpose. We work only off the interest. That gave me a different revenue stream.

I love the thought that, even after I'm long gone, some of the work we've instituted during this time will still be working to save moms and babies.

The pendulum is swinging, and it's going to swing back. In our state, funding is going to be more stable than I think our federal funding will be. Rather than just preaching doom and gloom about it all, I think it's best that we respond to where we are in the current climate. Keep advocating for the importance of our work. Demonstrate excellence. As we demonstrate excellence and good stewardship, the funding will come.

And, you know, I think we're going to have some lean times for a few years, but then I think the pendulum will come back, and that'll be okay. It's just going to be the role of all of us who are currently state health officials to navigate the waters. We can do it, though. It'll be all right.

This interview was conducted in June 2026 and has been lightly edited for length and clarity.