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Examining Political Polarization on COVID-19 Response in the United States: A Case Study

By

Nheissa Isidor

MPH

Hubert Department of Global Health

_____

Julia Smith-Easley, MPH, CHES
Committee Chair

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By

Nheissa Isidor
Bachelor of Arts in International Studies
University of Florida
2020

Thesis Committee Chair: Julia Smith-Easley, MPH, CHES

An abstract of
A thesis submitted to the Faculty of the
Rollins School of Public Health of Emory University
in partial fulfillment of the requirements for the degree of
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2022

Abstract
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Background:
Political polarization in the United States has increased over the years. These partisanship differences play a significant role in public health policy in the United States, especially in issues regarding quick and effective response. Despite the need for political consensus in times of crisis, there is a growing amount of evidence that the COVID-19 response in the United States has been politically polarized. The lack of political consensus has severe consequences on the livelihood and well-being of the American people.

Purpose: The purpose of this thesis is to explore the role of political polarization on public health policy through the lens of the COVID-19 pandemic response in the United States. Through a documentary case on study polarization on social distancing measures, this thesis aims to identify the drivers of existing political barriers that hinder the transformative change needed in public health today.

Methods: A literature review and a case study were chosen as the methodological approaches to examine the role of political interference in the COVID-19 response in the United States. The sequential synthesis of these approaches resulted in the development of recommendations to establish political coherence in public health policy for the future.

Results: The role of political polarization on social distancing measures were examined through two separate analysis: one examining political polarization on social distancing orders across all fifty states and another on the effect of partisanship on public perceptions regarding stay-at-home orders in Pennsylvania. These analyses suggested that the political interference in the COVID-19 response in the United States remains a major roadblock not only to the necessary full compliance with social distancing measures but to the transformative change needed in the field of public health, especially as polarization increases over time.

Discussion: Partisan differences impose a major threat to public health because it holds implications on public health policies and campaigns designed to increase compliance to COVID-19 related measures. Recognizing that politics and public health will remain intertwined, public health advocates must develop a constructive approach to navigating a dysfunctional political system when interacting with governmental officials.

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Chapter 1: Introduction

1.1 Introduction and Rationale

1.1.1 Origins of SARS-CoV-2

The origins of the coronavirus disease 2019, also known as COVID-19 or SARS-CoV-2, trace back to a seafood market, Huanan Seafood Wholesale Market in Wuhan, China. A mysterious outbreak of severe pneumonia characterized by various symptoms, such as fever, cough, and fatigue was reported to have impacted 66% of the market's staff and many of its consumers (Wu et al., 2020). On January 1st, 2020, after an epidemiological alert from Chinese health authorities to shut down the market, this zoonotic disease spread rampantly through numerous provinces in China and abroad, igniting one of the deadliest pandemics in history. Scientists from the Wuhan Institute of Virology and the McLellan laboratory quickly identified and studied the SARS-CoV-2 infection from the early patient samples. After the continuous concerns raised by the scientists from the Wuhan Institute of Virology from clinical findings, The World Health Organization (WHO) declared the SARS-CoV-2 outbreak as a Public Health Emergency of International Concern on January 30th, 2020. Subsequently, countries worldwide were urged by the WHO to implement social distancing and quarantine measures to reduce the spread of COVID-19. Despite early fragmented efforts to stop the spread of the virus, SARS-CoV-2 resulted in more than 5 million cases and more than 500,000 deaths worldwide by May of 2020 (Carvalho et al., 2021; Hiscott et al., 2020).

1.1.2 Early Global Response

Similar to previous pandemics, the rapid transmission and detrimental effects of COVID-19 exemplified that pandemics cannot be solely managed on a national level. As a result, this crisis spiraled into a global scientific response with the primary goal to discover its virology,

transmission, and immunopathogenesis. These efforts consisted of collaborations among policymakers, members of the scientific community, and public and private funders to facilitate an integrated response. On every continent, alliances, networks, and consortia have emerged to share their interdisciplinary knowledge and to support initiatives and multidisciplinary projects addressing the detection, treatment, and prevention of SARS-CoV2 infections (Hiscott et al., 2020).

Before the pandemic was declared, many countries joined forces to coordinate a rapid response against the pandemic. As the pandemic spread throughout the world, countries took drastic measures to prioritize the health of their citizens. The early lockdown and strict enforcement of social distancing were used as effective strategies to limit the spread of the virus in countries worldwide. Proceeding the implementation of social distancing measures, many countries also began to reinforce personal hygiene and protective masks as additional measures to minimize the transmission of the virus. Consequently, these early pandemic responses negatively impacted the economic growth of countries worldwide, including the United States

1.1.3 Early Pandemic Response in the United States

On January 21, 2020, the first case of COVID -19 was confirmed in the United States. The White House Coronavirus Task Force was established shortly after. However, the government took little to no action in preparing for an effective response in the following weeks. Even after the WHO's pandemic announcement in March 2020, mixed messages from federal and state officials further confused the public (Hiscott et al., 2020; Rutledge, 2020). Additionally, they didn't assemble the necessary amount of medical supplies for health facilities. As a result, hospitals began to experience medical supply shortages, both testing and personal protective equipment, which put the lives of the frontline medical staff at risk. To rapidly address

the lack of medical supplies, governors were left to purchase supplies from the international market. The delays in announcing the lockdown and the varying social distancing reinforcement among states further exacerbated the transmission of the coronavirus. By the end of March 2020, cases of COVID-19 were reported in all 50 states (Hiscott et al., 2020).

In mid-March, as the cases multiplied at a rapid pace, businesses, travel industries, restaurants, retail shops, and institutions were all closed abruptly. Millions of Americans were ordered to stay home to minimize the transmission of the virus. Similar to many countries worldwide, this lockdown caused millions of people to be out of work and to file for unemployment in the following weeks. Because of the country's lack of efforts in drafting a COVID-19 response strategy immediately after numerous warnings from China and the World's Health Organization, its health system was not mobilized in time to respond to the overwhelming number of cases in March (Hiscott et al., 2020). Unfortunately, the pandemic highlighted the disastrous impact of structural inequalities and pandemic politics on the livelihood and well-being of the American people.

1.2 Problem Statement

Political polarization in the United States has increased over the years. Political polarization can be defined as a reflection of "political convictions by the public or ruling elites, or both, into two distinct camps, in which people are included to support Democratic or the Republican parties' policies and candidates for elective office," (Nivola, 2016). This political distance among partisans roots back to the 1960s, when conservative Southern Democrats reinforced "tribalism" by protecting the long-standing beliefs and ideals of their political party, of which some members of the Democratic party were drifting away from at the time (Bhaiji, 2021). Despite the warnings from political scientists to be more "responsible" with their

decision-making in the following years, government officials from the main political parties disregarded these concerns and instead continued to systematize their loyalty to their beliefs and political "tribe". This political polarization is mirrored in the field of public health since both fields are in fact intersected through public policy. These political differences in partisanship play a significant role in public health policy in the U.S., especially in issues regarding quick and effective response (Bhaiji, 2021). These attitudes can have severe consequences on the livelihood and well-being of the American people.

The COVID-19 pandemic response by the U.S. government is a prominent example of the dysfunction that can result from political polarization. The United States endured one of the worst outbreaks of COVID-19, with approximately 80.1 million confirmed cases in the country and counting as of May 2022 (Bhaiji, 2021; "COVID Data Tracker", 2020). With the total number of COVID-19-related deaths worldwide amounting to 6 million people, the United States has the highest number of deaths and covers about 16% of those deaths (Kerr et al., 2021; "WHO Coronavirus (COVID-19) Dashboard", 2022). Aside from pharmaceutical treatments, scholars have increasingly emphasized the role of social science and the impact of non-pharmaceutical interventions, such as mask mandates and social distancing, when evaluating the pandemic evolution in this country (Kerr et al., 2021). Reflecting on the inadequate response from one of the most powerful nations in this world, the effectiveness of these interventions does not only depend on the scientific knowledge and advancements of COVID-19 but also on the degree to which people adhere to these interventions at both local and national scales (Kerr et al., 2021). As a result, the lack of political consensus can manipulate public perceptions of COVID-19 policy interventions and approaches, which may worsen the severity of the pandemic on the population.

These partisanship differences and tribalistic attitudes are reflected in various early strategies and approaches conducted under the Trump administration. The leadership of former President Donald Trump further highlights the deficient political commitment and unclear goals for crisis response. In the beginning stages of the pandemic, these dysfunctional institutional dynamics handicapped the federal COVID-19 response with ideological resistance (Carter and May, 2020). The Executive Branch's inability or unwillingness to acknowledge the emerging coronavirus threat and articulate a strategic vision for the response led to an overwhelming number of preventable deaths, economic loss, and other sociocultural damages (Carter and May, 2020). The strategic plans of public health professionals, who are well-equipped to carry the actions to tackle this outbreak, were often dismissed, especially when they directly challenged the status quo and the organizational structure of the country's economic system (Kerr et al., 2021). As the WHO's Director-General, Tedros Ghebreyesus, warned, increasing political polarization presents a direct threat not only to the management of the pandemic but also to the future of public health (Kerr et al., 2021; "COVID-19 Virtual Press Conference", 2020). If not addressed, the grave implications of polarization will continue to profoundly shape the future of public health in the US in the post-COVID-19 era "with the content, scope, and funding of public health policies and institutions likely to change dramatically as power shifts between political leaders," (Findling, 2022).

1.3 Purpose Statement

The purpose of this special studies project is to explore the role of political polarization on public health through the lens of the COVID-19 pandemic response in the United States. Through the examination of the Executive Branch's strategies and approaches in crafting a federal COVID-19 response from January 2020 to June 2020, this project describes how and

why the U.S. government responded the way it has. A documentary case study on social distancing measures further addresses how political influences can shape public health policy. The exploration of the role of politics on public health policy aims to identify the drivers of existing political barriers that hinder the transformative change needed in public health today.

1.4 Research Questions

Does political polarization influence public health policy?

What are the implications of political interference in public health?

1.5 Significance

To truly understand the impact of the COVID-19 response, we must dissect our limited understanding of how political polarization has become a barrier to public health. The sociopolitical barriers that hinder public health as a public good to operate at its full potential must be addressed. By illuminating these political influences and identifying transcending setbacks, we can better design a public health system that is less vulnerable to political interference. The findings from the case study will contribute to the existing body of work on political polarization in public health. More broadly, this project will amplify the necessity to fill in this gap in knowledge by providing recommendations for better public health policy-making in the future.

1.6 Definitions of Terms

Containment – a public health strategy that entails identifying cases of covid-19 through testing, placing infected individuals in isolation, tracking who infected persons might have been in contact with and potentially quarantining those who came into contact with infection so that the disease doesn't continue to spread.

Democratic Party - one of the two major contemporary political parties of the United States. The platform of the Democratic Party of the United States is generally based on American liberalism. Democrats believe that the economy should work for everyone, health care is a right, our diversity is our strength, and democracy is worth defending.

Elite - small groups of persons who exercise disproportionate power and influence.

Executive Branch – a governmental branch responsible for carrying out and enforcing laws. It includes the president, vice president, the Cabinet, executive departments, independent agencies, and other boards, commissions, and committees.

Grey Literature - information produced on all levels of government, academia, business, and industry in electronic and print formats not controlled by commercial publishing (ex. conference papers/proceedings, discussion forums, tweets, working papers etc.).

Partisan - a firm adherent to a party, faction, cause, or person.

Political Polarization - a reflection of "political convictions by the public or ruling elites, or both, into two distinct camps, in which people are included to support Democratic or the Republican parties' policies and candidates for elective office.

Populism - political approach that strives to appeal to ordinary people who feel that their concerns are disregarded by established elite groups.

Republican Party - one of the two major contemporary political parties of the United States. It is often referred to as the Grand Old Party or the "GOP". Their platform is centered on stimulating economic growth for all Americans, protecting constitutionally guaranteed freedoms, ensuring the integrity of our elections, and maintaining our national security

Right wing - part of a political or social organization advocating a conservative or reactionary position.

Social Distancing - a public health practice that aims to prevent sick people from coming in close contact with healthy people in order to reduce opportunities for disease transmission.

Swing states - also known as battleground states, states that have split support for Democratic and Republican candidates in US presidential elections. They could potentially be won by either candidate.

Tribalism - the state or fact of being organized in a tribe or tribes. It is also used to describe situations where people are overly loyal to their own group.

1.7 Abbreviations

CDC - Centers for Disease Control and Prevention

CNBC – Consumer News and Business Channel

MERS-CoV - Middle East Respiratory Syndrome

SARS - Severe Acute Respiratory Syndrome

SARS-CoV-2 - Severe Acute Respiratory Syndrome Coronavirus 2

WHO - World Health Organization

Chapter 2: Literature Review

"That's our message; unity at national level, no politicizing, no need to use COVID to score

political points, no need. You have many other ways to prove yourselves. This is not the one to

use for politics. It's like playing with fire so more than ever before national unity is important if

we care about our people, if we care about our citizens. Please work across party lines, across

ideology, across beliefs, across any differences for that matter. We need to behave. That's how

we can defeat this virus."

- Dr. Tedros Ghebreyesus, Director-General at WHO's COVID-19

Virtual Press Conference on April 8, 2020

2.1 Incoherence of Federal Government During the Pandemic

The COVID-19 pandemic has drastically amplified a public health, socioeconomic and political crisis worldwide. Since many countries experienced this pandemic at different stages, it is crucial to understand how and why governments responded the way they have to explore if their response was effective and comprehensive. There is a long-established disconnect between political scholars, public health scientists, and health professionals in the United States. Scholars emphasized this point by stating that, "there is a real risk that political scientists and economists will publish analyses that try to attribute morbidity and mortality to policy and politics without understanding the serious and highly political limitations on data about COVID-19 infections and attributable mortality," (Greer et al., 2020). Meanwhile, public health professionals often recycle political theories that are too complex to apply, or they may overlook social and political contexts, which can sometimes omit interdisciplinary factors (Greer et al., 2020). For instance, social and economic policy must be implemented in the planning process of a crisis response. It is often overlooked and not discussed enough in the recovery process of a crisis emergency.

During the early months of the pandemic, the U.S government emphasized the significance of compliance through mitigation measures, including social distancing. However, public compliance does not only require trust and communication, but it also requires pre-existing policies that can sustain the economy without people starving (Greer et al., 2020). A pandemic response that prioritizes politics as a serious focus must also be addressed to create sustainable interventions in policymaking and public health. Additionally, state capacity must be examined thoroughly as it also impacts all aspects of emergency response. In other words, infrastructure, systems, and administration should be assessed when understanding a country's state capacity because it can often not be properly used in emergency crises. Though it is too early to thoroughly assess the effects of political decisions during an ongoing pandemic, distinguishing the purpose behind those decisions, as well as their setbacks across governing levels, can shape our understanding of the political polarization of public health and it can pinpoint better effective tactics for future public health interventions (Greer et al., 2020).

2.2 Early Warning Signs of Novel Outbreak

Throughout the years, the common phrase, "*it's not about if, but when,"* has made recurrent headlines. However, its warning notion continues to be ignored. There have been numerous warning signs of a potential outbreak or pandemic. One of history's deadliest pandemics, the Black Death - also remembered as the Bubonic Plague - pioneered a shift in early medieval medicine and shaped the origins of public health through various factors, including the rise of surgery and the emergence of advisory health boards (Vanneste, 2010). Throughout the 21st century, periodic outbreaks and epidemics have impacted numerous regions around the world. Some examples include the 2003 Severe Acute Respiratory Syndrome (SARS) in Asia, the 2003 avian influenza (H5N1; bird flu) outbreak primarily in Asia and Africa, the 2009 H1N1

influenza in North America, the 2012 Middle East Respiratory Syndrome (MERS-CoV) Coronavirus originating from the Middle East, the 2014-2016 Ebola virus outbreak in West Africa and the recent 2016 Zika virus epidemic in South America (Hiscott et al., 2020). With the repeated nature of pandemics and outbreaks in the past years, their impact on scientific and medical advancements should have contributed to minimizing the fatal outcomes of COVID-19. However, despite the messages from political and scientific leaders, the prioritization of strategic pandemic preparedness plans and international cooperation hasn't been sustained over the years (Hiscott et al., 2020).

Similar to previous administrations, the Trump administration was completely aware of the high possibility and imminent plausibility of a pandemic occurring. Before the emergence of the COVID-19, several Trump administration officials expressed strong concerns about the lack of federal efforts in the country's public health infrastructure (Goodman and Schulkin, 2020). Although some measures were implemented for pandemic readiness, the Trump administration has ironically dismantled others since 2017, which later compromised the U.S. COVID-19 response (Goodman and Schulkin, 2020).

As presented in Figure 1, Figure 2, and Figure 3, this timeline provides chronological information about select moments and major COVID-19 response initiatives from the United States and countries around the world.

Figure 1. COVID-19 Timeline From December 2019 to February 2020

Late 2019

December 12, 2019
A cluster of patients in Wuhan, Hubei Providence, China begin to experience shortness of breath and fever.

December 31, 2019
The World Health Organization China Country Office is informed of a number cases of pneumonia of unknown etiology (unknown cause) detected in Wuhan, Hubei Province. All cases connected to the Huanan Seafood Wholesale Market in Wuhan.

Early 2020

January 2, 2020
The World Health Organization activates its incident management system across the three levels of WHO (country office, regional office, and headquarters).

January 5, 2020
Chinese public health official share the genetic sequence of the unknown pneumonia virus (Wuhan-Hu-1) through an online database.

January 5, 2020
CDC's National Center for Immunization and Respiratory Diseases (NCIRD) activates a Center Level Response for novel pneumonia of unknown etiology.

January 7, 2020
Chinese authorities identify and isolate a novel coronavirus as the causative agent of the outbreak

January 7, 2020
CDC establishes a 2019-nCoV Incident Management Structure to guide the response. It follows previously established MERS-CoV preparedness plans for developing tests and managing cases.
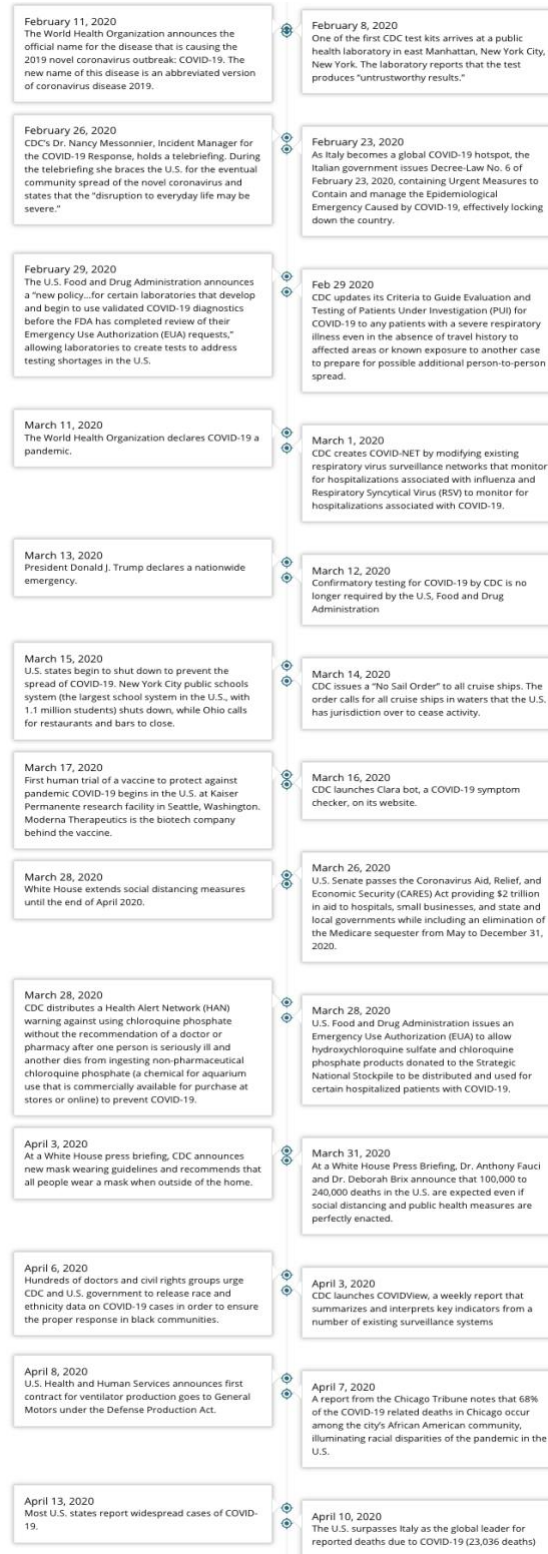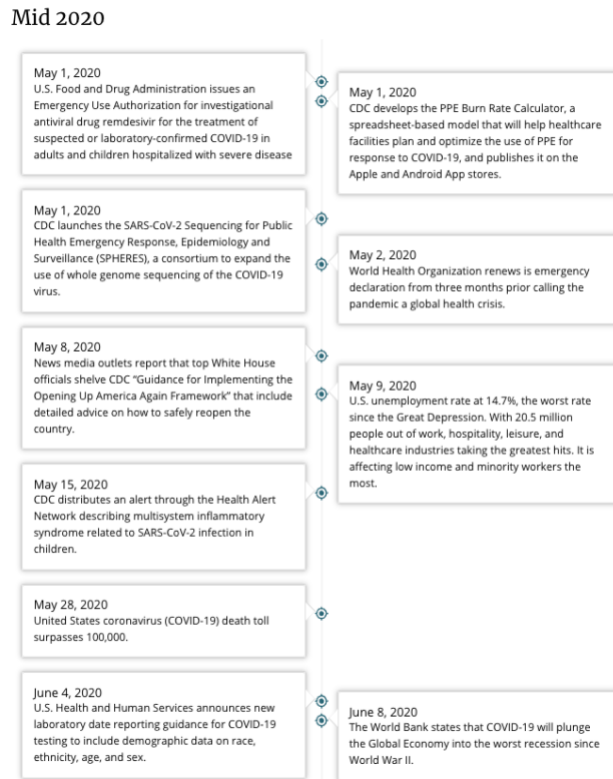
January 10, 2020
CDC publishes information about the novel coronavirus on its website.

January 13, 2020
The Thailand Ministry of Public Health confirms the first imported case of lab-confirmed novel coronavirus from China.

January 15, 2020
The Japanese Ministry of Health, Labor and Welfare reports an imported case of laboratory-confirmed novel coronavirus.

January 17, 2020
CDC begins screening passengers on direct and connecting flights from Wuhan, China at San Francisco, California, New York City, New York, and Los Angeles, California and plans to expand screening to other major airports.

January 17, 2020
CDC deploys a team to Washington state to assist with contact tracing efforts in response to the first reported case of 2019-nCOV in the U.S.

January 20, 2020
CDC confirms the first U.S. laboratory-confirmed case of COVID-19 in the U.S. from samples taken on January 18 in Washington state.

January 21, 2020
CDC transitions from a Center-led Incident Management Structure to an Agency-wide Structure and activates its Emergency Response System

January 21, 2020
CDC artists Alissa Eckert and Dan Higgins create "an identity" for the novel coronavirus by designing the iconic red and white virus image.

January 22, 2020
The World Health Organization International Health Regulation Emergency Committee meets. The Emergency Committee decides to not declare the novel coronavirus a Public Health Emergency of International Concern. The Committee decides instead to monitor the situation and reconvene in 10 days to re-discuss.

January 22, 2020
The World Health Organization confirms human-to-human spread of the novel coronavirus.

January 29, 2020
The White House Coronavirus Task Force is established with U.S. Health and Human Services Secretary, Alex Azar, as the head of the Task Force.

January 27, 2020
The United States Food and Drug Administration announces that it will take "critical actions to advance development of novel coronavirus medical countermeasures" with interagency partners, including CDC.

January 31, 2020
U.S. Secretary of Health and Human Services, Alex Azar, declares the SARS-CoV-2 virus a public health emergency and the White House 2019 Novel Coronavirus Task Force announces the implementation of new travel policies to be effective at 5:00 PM EST on February 2, 2020.

January 31, 2020
The World Health Organization International Health Regulation Emergency Committee reconvenes and declares the coronavirus outbreak a Public Health Emergency of International Concern.

February 4, 2020
The U.S. Food and Drug Administration approves the Emergency Use Authorization (EUA) PACK for the CDC developed SARS-CoV-2 diagnostic test. CDC distributes 200 test kits through its Influenza Reagent Resource program to laboratories across the U.S.

February 3, 2020
CDC submits an Emergency Use Authorization (EUA) PACK to the U.S. Food and Drug Administration to expedite approval for the CDC developed SARS-CoV-2 diagnostic test.

Note. From "*CDC Museum COVID-19 Timeline*", by Centers of Disease Control and Prevention, 2022, (https://www.cdc.gov/museum/timeline/covid19.html).

Figure 2. COVID-19 Timeline From February 2020 to April 2020

February 11, 2020
The World Health Organization announces the official name for the disease that is causing the 2019 novel coronavirus outbreak: COVID-19. The new name of this disease is an abbreviated version of coronavirus disease 2019.

February 8, 2020
One of the first CDC test kits arrives at a public health laboratory in east Manhattan, New York City, New York. The laboratory reports that the test produces "untrustworthy results."

February 26, 2020
CDC's Dr. Nancy Messonnier, Incident Manager for the COVID-19 Response, holds a telebriefing. During the telebriefing she braces the U.S. for the eventual community spread of the novel coronavirus and states that the "disruption to everyday life may be severe."

February 23, 2020
As Italy becomes a global COVID-19 hotspot, the Italian government issues Decree-Law No. 6 of February 23, 2020, containing Urgent Measures to Contain and manage the Epidemiological Emergency Caused by COVID-19, effectively locking down the country.

February 29, 2020
The U.S. Food and Drug Administration announces a "new policy...for certain laboratories that develop and begin to use validated COVID-19 diagnostics before the FDA has completed review of their Emergency Use Authorization (EUA) requests," allowing laboratories to create tests to address testing shortages in the U.S.

Feb 29 2020
CDC updates its Criteria to Guide Evaluation and Testing of Patients Under Investigation (PUI) for COVID-19 to any patients with a severe respiratory illness even in the absence of travel history to affected areas or known exposure to another case to prepare for possible additional person-to-person spread.

March 11, 2020
The World Health Organization declares COVID-19 a pandemic.

March 1, 2020
CDC creates COVID-NET by modifying existing respiratory virus surveillance networks that monitor for hospitalizations associated with influenza and Respiratory Syncytical Virus (RSV) to monitor for hospitalizations associated with COVID-19.

March 13, 2020
President Donald J. Trump declares a nationwide emergency.

March 12, 2020
Confirmatory testing for COVID-19 by CDC is no longer required by the U.S. Food and Drug Administration

March 15, 2020
U.S. states begin to shut down to prevent the spread of COVID-19. New York City public schools system (the largest school system in the U.S., with 1.1 million students) shuts down, while Ohio calls for restaurants and bars to close.

March 14, 2020
CDC issues a "No Sail Order" to all cruise ships. The order calls for all cruise ships in waters that the U.S. has jurisdiction over to cease activity.

March 17, 2020
First human trial of a vaccine to protect against pandemic COVID-19 begins in the U.S. at Kaiser Permanente research facility in Seattle, Washington. Moderna Therapeutics is the biotech company behind the vaccine.

March 16, 2020
CDC launches Clara bot, a COVID-19 symptom checker, on its website.

March 28, 2020
White House extends social distancing measures until the end of April 2020.

March 26, 2020
U.S. Senate passes the Coronavirus Aid, Relief, and Economic Security (CARES) Act providing $2 trillion in aid to hospitals, small businesses, and state and local governments while including an elimination of the Medicare sequester from May to December 31, 2020.

March 28, 2020
CDC distributes a Health Alert Network (HAN) warning against using chloroquine phosphate without the recommendation of a doctor or pharmacy after one person is seriously ill and another dies from ingesting non-pharmaceutical chloroquine phosphate (a chemical for aquarium use that is commercially available for purchase at stores or online) to prevent COVID-19.

March 28, 2020
U.S. Food and Drug Administration issues an Emergency Use Authorization (EUA) to allow hydroxychloroquine sulfate and chloroquine phosphate products donated to the Strategic National Stockpile to be distributed and used for certain hospitalized patients with COVID-19.

April 3, 2020
At a White House press briefing, CDC announces new mask wearing guidelines and recommends that all people wear a mask when outside of the home.

March 31, 2020
At a White House Press Briefing, Dr. Anthony Fauci and Dr. Deborah Brix announce that 100,000 to 240,000 deaths in the U.S. are expected even if social distancing and public health measures are perfectly enacted.

April 6, 2020
Hundreds of doctors and civil rights groups urge CDC and U.S. government to release race and ethnicity data on COVID-19 cases in order to ensure the proper response in black communities.

April 3, 2020
CDC launches COVIDView, a weekly report that summarizes and interprets key indicators from a number of existing surveillance systems

April 8, 2020
U.S. Health and Human Services announces first contract for ventilator production goes to General Motors under the Defense Production Act.

April 7, 2020
A report from the Chicago Tribune notes that 68% of the COVID-19 related deaths in Chicago occur among the city's African American community, illuminating racial disparities of the pandemic in the U.S.

April 13, 2020
Most U.S. states report widespread cases of COVID-19.

April 10, 2020
The U.S. surpasses Italy as the global leader for reported deaths due to COVID-19 (23,036 deaths)

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Figure 3. **COVID-19 Timeline from May 2020 to June 2020**

Mid 2020

May 1, 2020
U.S. Food and Drug Administration issues an Emergency Use Authorization for investigational antiviral drug remdesivir for the treatment of suspected or laboratory-confirmed COVID-19 in adults and children hospitalized with severe disease

May 1, 2020
CDC develops the PPE Burn Rate Calculator, a spreadsheet-based model that will help healthcare facilities plan and optimize the use of PPE for response to COVID-19, and publishes it on the Apple and Android App stores.

May 1, 2020
CDC launches the SARS-CoV-2 Sequencing for Public Health Emergency Response, Epidemiology and Surveillance (SPHERES), a consortium to expand the use of whole genome sequencing of the COVID-19 virus.

May 2, 2020
World Health Organization renews is emergency declaration from three months prior calling the pandemic a global health crisis.

May 8, 2020
News media outlets report that top White House officials shelve CDC "Guidance for Implementing the Opening Up America Again Framework" that include detailed advice on how to safely reopen the country.

May 9, 2020
U.S. unemployment rate at 14.7%, the worst rate since the Great Depression. With 20.5 million people out of work, hospitality, leisure, and healthcare industries taking the greatest hits. It is affecting low income and minority workers the most.

May 15, 2020
CDC distributes an alert through the Health Alert Network describing multisystem inflammatory syndrome related to SARS-CoV-2 infection in children.

May 28, 2020
United States coronavirus (COVID-19) death toll surpasses 100,000.

June 4, 2020
U.S. Health and Human Services announces new laboratory date reporting guidance for COVID-19 testing to include demographic data on race, ethnicity, age, and sex.

June 8, 2020
The World Bank states that COVID-19 will plunge the Global Economy into the worst recession since World War II.

2.3 Trump's Presidential Leadership and Expertise

In times of crisis in the United States, it is the duty of the president as the leading figure to prepare and protect the public by implementing the necessary steps to overcome troubled times. In the past, presidents who experienced a crisis have heavily relied on the expertise and guidance from their executive branch to navigate these tough situations (Rutledge, 2020). Such interactions with a small group of advisors can often influence presidential decisions. During a crisis, decision-making often consists of interactions between political and bureaucratic leaders to come up with a collective solution. As a result, the way in which presidents manage a group of advisors has tremendous consequences on decision-making during a crisis. To further examine the decision-making of the 45th President of the United States, Donald Trump, his management of the Executive Branch and his advisors have to be analyzed as it has been unique to American history (Rutledge, 2020). Before even launching his campaign, Trump had been vocal about his hostility toward the administrative state. Through his consistent and problematic use of Twitter, he has disparaged the federal bureaucracy by spreading conspiracy theories about the government's motive for business interests, regulation, targeted individuals, and more (Rutledge, 2020). Additionally, Trump's vibrant hostility and skepticism have tainted the value of expertise within the federal bureaucracy. His disposition and management of the administrative state during his term entailed serious ramifications for the federal response to the COVID-19 pandemic (Rutledge, 2020).

The early responses to the COVID-19 pandemic from the Trump Administration displayed a constant pattern of discounting public health experts and displaying right-wing populist views. For instance, in mid-January 2020, the WHO began publishing reports on the COVID-19 outbreak in China and the guidelines for testing. Despite the warning from his

advisors and experts worldwide, Trump downplayed the threat of the outbreak. During a CNBC segment, "Squawk Box" with Joe Kernen, Kernen asked Trump whether there was a concern for a possible pandemic, especially after the CDC identified the first case of coronavirus in Washington State (source). He responded to his question by saying, "No. Not at all. And-- we're-- we have it totally under control. It's one person coming in from China, and we have it under control. It's—going to be just fine," (Rutledge, 2020). Although it was unclear at the time to issue a global health emergency, Trump's response was more certain and optimistic than the WHO's statements, which inferred the potential for the outbreak to become an emergency overtime ("WHO Director-General's statement on the advice of the IHR Emergency Committee on Novel Coronavirus", 2020; Rutledge, 2020). During the same month, his economic advisor, Peter Navarro, began to share memos about the health and financial consequences that could result from the outbreak. He warned the White House that the virus had the potential to kill half a million Americans and could cost the government almost 6 trillion dollars (Rutledge, 2020). These cautionary memos were all ignored by Trump. Meanwhile, Alex Azar, the secretary for the Department of Health and Human Services, also warned Trump of the possibility of a pandemic, but Trump ignored his warning by telling his administration that Azar was being an alarmist (Rutledge, 2020).

The following month, despite the increasing rates of transmission outside of China, Trump continued to downplay the threat of the virus on numerous standard outlets and/or Twitter by ensuring the public that the virus is "under control" in this country and how the government is doing a "good job" monitoring the cases. However, with the conflicting statements from top experts released to the media, a culture of fear perpetuated by Trump emerged to control the messages released to the public. It began at a White House Briefing in late February, when Dr.

Nancy Messonnier, the Director of the National Center for Immunization and Respiratory Diseases at the Centers for Disease Control and Prevention (CDC), warned the American public to expect severe disruptions to their every-day lives and emphasized the need for the government to act quickly and aggressively (Rutledge, 2020). Shortly after, she did not appear again at the following White House briefings and there were speculations of Messonnier being "silenced" after Trump expressed the desire to fire her following her statement. As a result, Trump's closest advisors did not contrast his statements regarding the low risks of the virus. Instead, they remained careful about public messaging during the remainder of the month. Dr. Anthony Fauci, the Director of the National Institute of Allergy and Infectious Diseases and the Chief Medical Advisor to the President, even addressed the public warning from experts on NBC's Today Show, by stating, "there's no need to change anything that you're doing on a day-to-day basis. Right now, the risk is still low," (Rutledge, 2020). Hence, many experts, even those in the field of public health, coordinated their measures for crisis response while being careful not to contradict Trump's messages. On the contrary, the WHO classified the global risk for COVID-19 from high to very high (Rutledge, 2020) by the end of February.

Despite various initial warnings from the public health experts, intelligence agencies, the economic council, and the CDC, Trump objected to all of the strategic plans that required an aggressive and "containment" response. Furthermore, he was extremely slow in approving and acting on policy responses. A firm example of this action is the delayed issue of a travel ban on China done on January 31st, despite the fact that Wuhan was declared the epicenter weeks prior (Rutledge, 2020). The European travel ban came about six weeks later, long after the virus ravaged European countries. He continued to downplay the threat of the coronavirus by telling the public to "calm down" and dismissed the public health community of expertise and the

obvious increasing number of cases globally. Trump's dismissal further demonstrated his hostility toward expertise and his administration as the country's delayed response barely executed the recommendations proposed in the early stages of the pandemic.

Following the WHO's declaration of the pandemic and the large spike in cases in mid-March, Trump began to rebut his month-long of downplaying the spread of the virus by inferring that he felt that it would turn into a pandemic before it was declared a pandemic (Rutledge, 2020). Finally, on March 16, 2020, Trump began to carry out significant measures to slow down the spread of coronavirus in the United States by encouraging state governments to implement social distancing measures. However, Trump did not cease to ignore the expertise of his advisors and staff. He would continue to disregard science and fervently share misleading information about the virus, primarily on social media. Ironically, he began to show impatience with social distancing as well. Contrary to the WHO's recommendations and the CDC's guidance regarding social distancing, Trump shared on Fox News on March 24 that the virus will potentially be gone by Easter and churches would be packed all over the country (Rutledge, 2020). However, Dr. Mike Ryan of the WHO's Health Emergencies Program addressed Trump's claim by urging the public to be patient and cautious in ending the shutdown. Perhaps due to the realization that the Easter goal would not be met, Trump angrily blamed the scientific community in early April 2020. He tweeted, "The WHO really blew it. For some reason, funded largely by the United States, yet very China-centric. We will be giving that a good look," (Rutledge, 2020). The WHO's Director-General, Tedros Adhanom Ghebreyesus, responded by asking Trump to refrain from politicizing the virus and instead, shift the focus of political parties to save the people. Shortly after Ghebreyesus's statement, Trump instructed his administration to stop funding the World Health Organization in the midst of the global pandemic (Rutledge, 2020).

The government shutdown rapidly generated economic decline, as Alex Azar had warned back in January. With unemployment rates increasing, Trump supporters and allies began to push for the reopening of businesses in order to tackle the economic crisis and to increase his chances at reelection later that year (Kumar, 2020). Trump started to push states to open the economy and even encouraged protests in several states where Democratic Governors had been slower to open their states. The pressure to reopen states led to various Congressional hearings, in which Dr. Fauci's presence was requested. Unsurprisingly, another instance of Trump's polarization motives was reflected when he denied Fauci from appearing and testifying while the Democratic-controlled House (Rutledge, 2020). Instead, Fauci was allowed to testify before the Republican-controlled Senate. Fauci warned that the reopening would trigger more outbreaks which would set the country back even more on the road to economic recovery. Trump was very critical of Fauci following his testimony by arguing that his answers were acceptable and that Fauci "likes to play both sides of the equation," (Rutledge, 2020). The clash between Dr. Fauci and Trump did not end there. Trump and his secretary of State Mike Pompeo have aggressively pushed the narrative that the virus was made in a lab in China, a claim that Dr. Fauci repeatedly discredited as false during proceeding interviews. Despite being issued by the CDC, the reopening guidelines have been the subject of "political modification and according to reports have been watered down by the Trump Administration," (Rutledge, 2020). Unfortunately, during four months from February 2020 to May 2020, the United States had approximately 100,783 American COVID-19-related deaths ("National Data: Deaths", 2022).

The United States has the capacity, resources, expertise, and strategies to respond to a pandemic effectively. However, when reflecting on the polarization of public health, Trump's presidential leadership reflected a series of failures in decision-making, communication,

collaboration, implementation, and control. The lack of trust and utilization of expertise on

pandemic response, slow-decision-making, and misleading communication on mitigation

measures overpowered the value of federal leadership and most importantly, the significance of

public health leadership (Kapucu and Maynihan, 2021). As documented above, Trump has been

an agent of disruption toward the bureaucracy throughout the COVID-19 response. Trump's

disposition toward the executive branch has led to normalizing the dismissal of expertise and the

mass departures of civil servants. This poor executive leadership and the lack of coordinated

action at the federal level have caused similar setbacks among emergency management agencies

and health institutions at state and local levels (Kapucu and Maynihan, 2021). Conflicting

perspectives and methods arose among state and local governments due to incoherence at the

federal level (Kapucu and Maynihan, 2021). As some undermined trust in government and

federal institutions, many shared similar views with Trump, which made them vulnerable to the

transmission of viruses. These adopted beliefs ranged from the exaggerated risks associated with

the pandemic to public health measures challenging American liberty, which persists to this day

(Kapucu and Maynihan, 2021). Unfortunately, the pandemic has demonstrated the disastrous

impacts of poor executive leadership "in establishing consistency and national consensus in

response to a pandemic health crisis," (Kapucu and Maynihan, 2021).

Chapter 3: Methods

3.1 Research Design

This chapter describes the methodological approaches used to answer the main research question on analyzing the role of political polarization on public health through the lens of the coronavirus pandemic. The methodological components used for this paper include a literature review and a case study. The literature review was conducted to examine the role of political interference in the COVID-19 response in the United States. Meanwhile, a case study was also conducted through a review of publicly available documents on the adaptation of social distancing measures across various U.S. states in March 2020. Lastly, the sequential synthesis of these approaches resulted in the development of recommendations to establish political coherence in public health policy for the future. In conclusion, the chapter will briefly discuss the limitations of each methodological approach.

3.2 Literature Review

The literature search was conducted to identify existing studies that answer the questions: How has the political polarization affected the U.S. response to COVID-19? Three electronic databases or search engines were utilized to retrieve these studies: Google Scholar, Political Polarization Database, and JSTOR. The following terms or keywords used when searching in each search engine include: Political Polarization ("Polarization" OR "Politics" OR "Pandemic Politics" OR "Political Views" "Political Opinions" OR "Political Parties" OR "Party Polarization" OR "Partisanship" OR "Tribalism" OR "Republican" OR "Democracy" OR "Elite Polarization" OR "Mass Polarization"), COVID-19 ("Coronavirus" OR "Coronavirus Disease 2019" OR "SARS-CoV-2"), Trump ("Trump" OR "President Trump" OR "Donald Trump" OR "President' OR "Trump Administration" OR "Presidential Term"), USA ("USA" OR "The U.S."

OR " United States), and lastly, Response ("Response" OR "Preparedness and Response" OR

"Measures" OR "Crisis Response" OR "Pandemic Response" OR " COVID-19 response" OR

"Pandemic Readiness" OR "Pandemic Management"). Additional articles were retrieved from

the reference lists of all retrieved articles and peer-reviewed articles focusing on the U.S.'s

COVID-19 response under the Trump Administration. Moreover, the literature review also

contains grey literature to expand available evidence for this review.

3.2.1 Inclusion Criteria

During the literature review, the following criteria for inclusion were used to identify

relevant articles, documents, and reports: date of publication, geographic location, the scope of

focus, and language of publication. As a result, these criteria were applied as follows: 1) the

articles were published between 2017 to 2022, 2) the geographic location discussed in the

articles was in the United States, 3) the scope of focus relied solely on the role of politics on the

COVID-19 pandemic response, 4) they were published in English.

3.2.2 Exclusion Criteria

Articles, reports, and documents were excluded if: 1) they were not published during and

after Trump's presidential term (ex. between 2017-2022), 2) the geographic location discussed in

the article was outside of the United States, and 3) their scope of focus covered the role of

politics in topics unrelated to COVID-19 response or failed to analyze public policy during the

coronavirus pandemic.

3.2.3 Limitations of Literature Review

The timing of the data collection for my review is a limitation to the available data on the

effects of political affairs on COVID-19 response. Amid a pandemic, literature on this topic is

constantly evolving; hence, it is too early to evaluate the implications of political decisions

issued during this time. The results may be skewed or biased based on the word choice chosen for the terms or key terms used during the search strategy.

3.3 Case Study

The case study was used to elaborate on "how" and "why" the U.S. response to the COVID-19 pandemic in early 2020 was driven by political interests. It allows for the understanding of a complex social phenomenon without removing the real-life context that shapes the phenomena. Overall, this case study explores the role of partisan politics on social distancing measures through two separate analyses: one examining political polarization on social distancing orders across all fifty states and another on the effect of partisanship on public perceptions regarding stay-at-home orders in Pennsylvania. The unit of analysis for this case study is social distancing measures in the United States in 2020.

Chapter 4: Case Study Results

4.1 Political Polarization on Social Distancing Orders Across State Governments

From the observation of the universal effectiveness of social distancing in Asia and Europe, the WHO and CDC have recognized social distancing as an effective way to address the rapid spread of the emerging coronavirus. To understand the effectiveness of this social distancing policy, it is crucial to look into the gaps among the states that did not issue statewide social distancing orders. In a paper by Painter and Qiu (2020), geolocation tracking data was collected to analyze the state-level policies on social distancing. The results from this research concluded that political beliefs served as a main limitation for public adherence to these orders (Painter and Qiu, 2020).

From this study, social distancing was measured as the percentage of people who stay at home for the entire day relative to a census block group from smartphone location data from February and most of March 2020. Additional data on county-level demographics, voting results per county, and government-sanctioned orders were collected. The comprehensive datasets provided insights into the effects of partisanship on public adherence to social distancing policies using a difference-in-difference framework (Painter and Qiu, 2020). When analyzing the differential responses to state policies issued, it was found that compared to Democratic counties, Republic counties were less likely to respond to social distancing orders. Moreover, when examining the possible effect of the political affiliation of the governor announcing the orders on public compliance, results showed that the "aligned" counties were those in compliance and with the same political affiliation as the governor, whereas the "misaligned" counties have conflicting political identities and were less likely to comply (Painter and Qiu, 2020). The results further suggested that the difference in compliance to social distancing orders among these counties was

"due to how credible residents find government officials and not an information transmission channel," (Painter and Qiu, 2020). In other words, Republican and Democrat leaders are likely to rely on bipartisan support to ensure compliance for effective mitigation of the virus. Furthermore, Painter and Qiu (2020) concluded that "Republican and politically-misaligned Democratic counties responded significantly less to social distancing policies." Accordingly, the study concluded that political polarization serves as a major roadblock in implementing life-saving measures, such as social distancing measures in moments of crisis.

In another study based on state-level social distancing measures, Adolph et al. (2021) assessed the variation of social distancing measures enacted by states from first reported case of transmission in the U.S. on February 26th, 2020 through March 23rd, 2020. Five social distancing measures were included in this study: restrictions on gatherings, school closures, restaurants restrictions, non-essential business closures, and stay-at-home orders (Adolph et al., 2021). Data on the implementation date across all fifty states were collected to assess if the effect on social behavior was immediate and to predict the timing of governors' actions, especially if any delays occurred (Adolph et al., 2021). Figure 4 displays the timing of the adaptations of all five social distancing measures across all states over four weeks.

Figure 4. **The Diffusion of Five Social Distancing Measures Across States in March 2020**
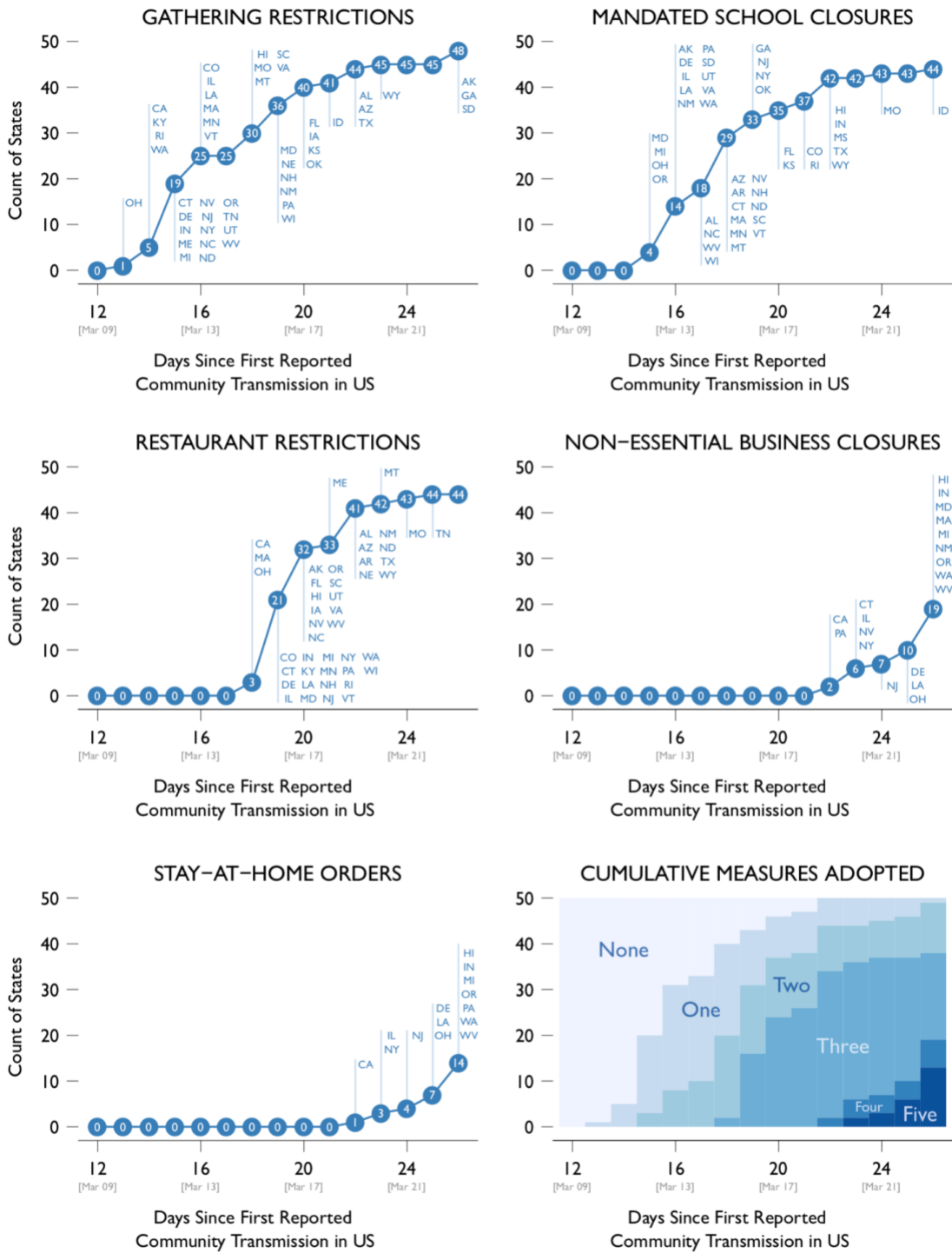
Before March 10th, 2020, no state enacted social distancing measures; however, by the end of the study period, all states had implemented at least one of the five measures (Adolph et al., 2021). Using an event history analysis and Wei-Lin-Weissfeld marginal model, common factors affecting the implementation of social distancing across states were examined. These factors included "pooling the five social distancing measures, stratifying baseline hazards across the five policy types to allow for varying underlying tendencies to adopt some policies more quickly than others, and clustering standard errors by state," (Adolph et al., 2021). To further analyze state-level responses variations based on social economic and political differences, five covariates were included in the model, which involves: the number of confirmed cases of COVID-19 in the state, the gross state product per capita, the presence of a Republican Governor, the percent of voters choosing Trump in 2016 and the percentage of neighboring states enacting each social distancing measure (Adolph et al., 2021). Alternative explanatory factors were also added to these covariates. Figure 5 and Figure 6 demonstrated the results of the baseline model.

Figure 5. **Relative Probability of Adopting Additional Social Distancing Measures**
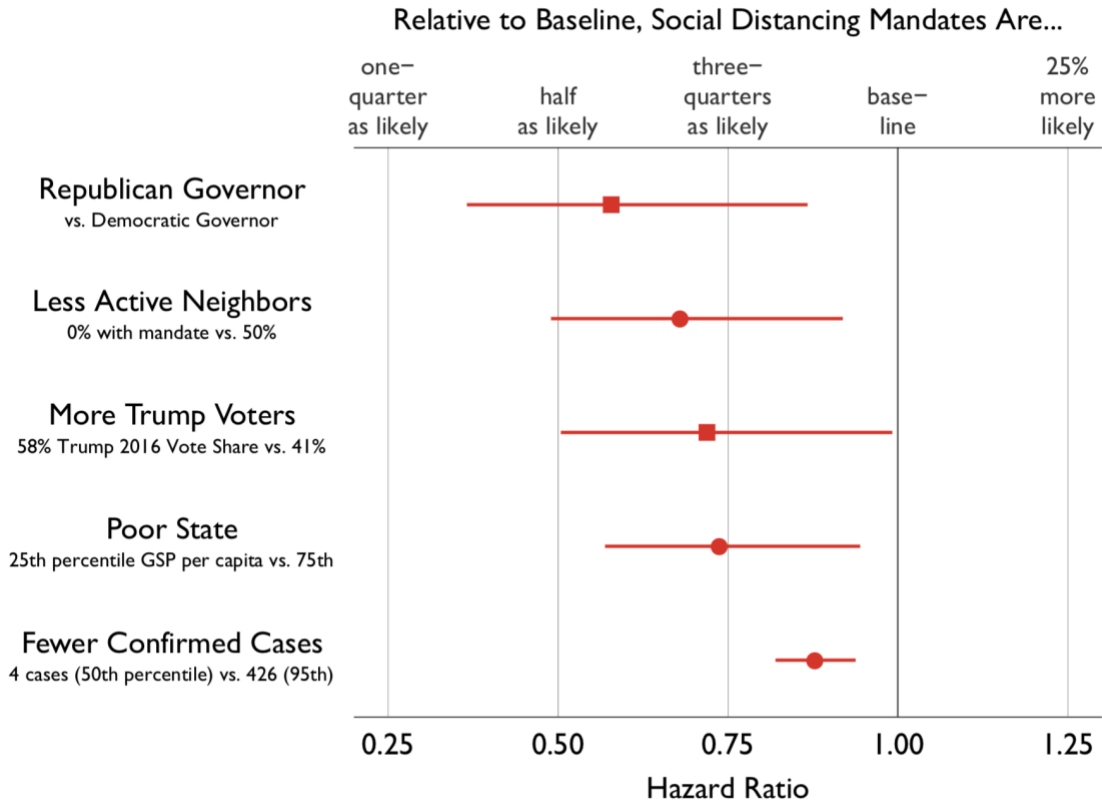
Note. From "*Pandemic Politics: Timing State-Level Social Distancing Responses to COVID-19*" by Adolph et al., 2021. This figure shows the estimated hazard ratios obtained from the Wei-Lin-Weissfeld marginal model on all social distancing policies.

Figure 6. **Expected Delay in Adopting Additional Social Distancing Measures**
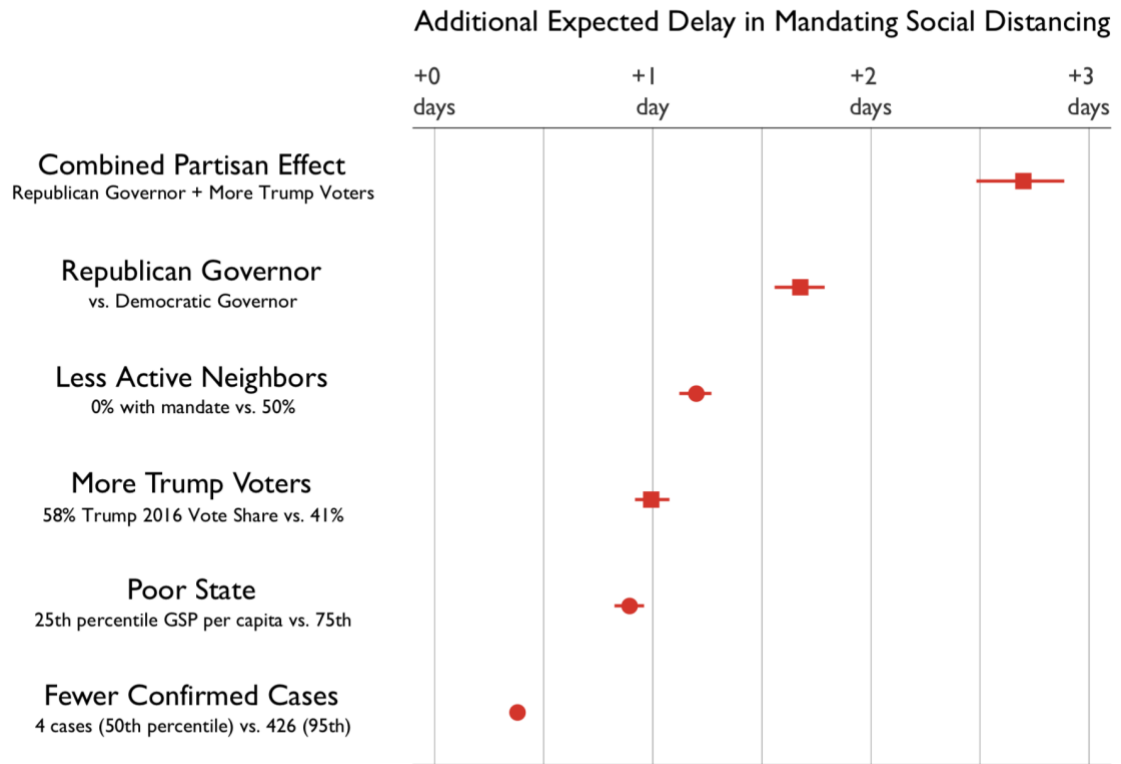
Note. From "*Pandemic Politics: Timing State-Level Social Distancing Responses to COVID-19*" by Adolph et al., 2021. This figure shows the estimated marginal effects of the average delay that each factor would present in each state.

In conclusion, the results from the figures above show "how the degree to which each factor – such as governors' partisanship, the presence of Trump voters, or actions by neighboring states – reduces the chance a state acts to impose a new social distancing mandate on a given date," (Adolph et al., 2021). In addition, the study found that Republican-leaning states are slower to adopt social distancing policies. In other words, in a state where rates of COVID-19 infections are doubling in a matter of days, the delay caused by Republican partisanship can be

associated with a drastic rise in COVID-19 cases. The study results further indicate the total

number of confirmed COVID-19 cases in a state had only a small impact on the implementation

of social distancing. The results also showed that poorer states were less likely to adopt social

distancing policies. As seen in Louisiana, the adoption of social distancing was slow despite

having a Democratic governor and experiencing a confirmed outbreak (Adolph et al., 2021). Due

to limited economic resources, poorer states were most likely to experience social distancing

delays (Adolph et al., 2021). Lastly, the authors found that governors from neighborhood states

were likely to implement a similar social distancing policy seen in their peer governor's state

(Adolph et al., 2021).

4.2 Effect of Political Polarization on Public Perceptions in a Swing State

Note. Taken From "*Pennsylvania"* by Thompson and Miller, 2021. Image on the left is the flag

of Pennsylvania and the other on the right is the map of the State of Pennsylvania.

(https://www.britannica.com/place/Pennsylvania-state)

Pennsylvania, officially the Commonwealth of Pennsylvania, is one of the fifty states in

the United States. It is also one of the original 13 American colonies. Located on the east coast,

Pennsylvania is also classified as a Middle Atlantic State. Its population is approximately 12.8

million people (Milligan, 2020). The rectangular-shaped state is bounded by neighboring states

of Maryland, New Jersey, Delaware, West Virginia, Ohio, and New York (Thompson and

Miller, 2021). Its capital, Harrisburg, lies in the foothills of the Appalachian Mountains. Under

the constitution of 1968, Pennsylvania's executive branch "consists of the governor, lieutenant

governor, attorney general, auditor general, state treasurer, and governor's cabinet," (Thompson

and Miller, 2021) As a swing state, Pennsylvania has a long history of being consequential in

presidential elections since it holds 20 electoral votes that are crucial for presidential elections.

The political breakdown of its population is as follows: " Republican 38%, Democrat 48%,

Minor party or no party: 14%" (Milligan, 2020). Although primarily Democratic among its

major cities, the political demographics of the state are constantly changing. Below, Figure 7

displays a timeline of the governors' political actions in its COVID-19 response in the early

months of 2020.

Figure 7. **Political Responses to COVID-19 Timeline**
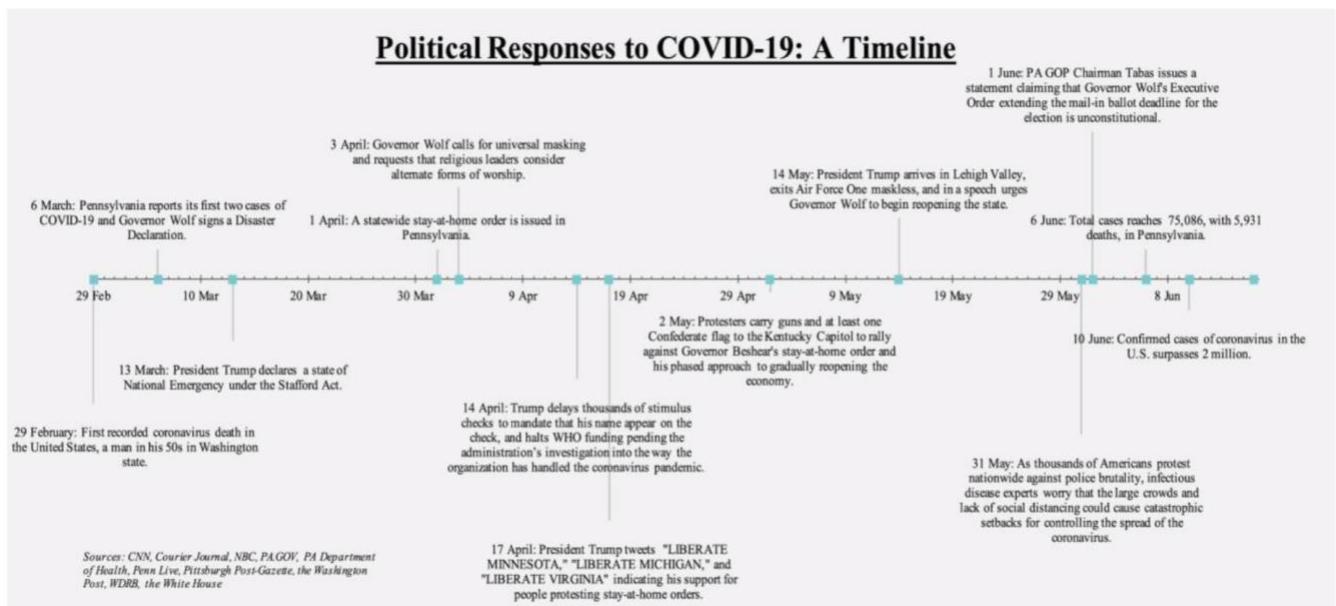
During the early months of 2020, social distancing became a primary strategy for reducing the spread of COVID-19 in the United States as well as in other countries. At this scale, the enactment of these early measures represented a dramatic expansion of governmental authority; however, the effectiveness of these policies played a significant role in how the American public supported and complied with them. Throughout the pandemic, physical congregation and mobility fell tremendously across the country until May and June once the hospital capacity surges began to diminish (Bhanot and Hopkins, 2020). During this time frame, research began to show significant evidence of polarization among reactions to these emerging policies. For example, "at-home orders and business closures in state capitals including Lansing, Michigan and Harrisburg, Pennsylvania…Meanwhile, multiple studies found that individuals in more Democratic areas were more likely to engage in social distancing, even accounting for demographic factors such as population density," (Bhanot and Hopkins, 2020).

There are numerous possible explanations for the resistance documented against social distancing guidelines. One possible driver of resistance includes antipathy toward elite institutions and individuals, including "public health experts, government officials, and/or the media." This antipathy, specifically among Americans, may be driven by "reactance", known in psychology as the human tendency to push against constraints on freedom. This resistance to guidelines promoted by the "elites" can become a barrier for policymakers, especially in crafting a pandemic response that requires the expertise of public health professionals. Another driver of resistance is anti-intellectualism, which is critical in understanding American politics. According

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to recent research, it is found that "Republicans, in particular, are increasingly skeptical of political and intellectual elites," as demonstrated by former President Trump's actions throughout the COVID-19 (Bhanot and Hopkins, 202). In addition, research inferred that "Americans may view scientists and their messaging through a partisan lens," (Bhanot and Hopkins, 2020). The last driver of resistance may strictly be the partisan divide and their parties' reactions to scientific messaging. In other words, many Americans often receive different messages from the major parties, which further impacts their behavior in adhering to these measures.

Bhanot and Hopkins (2020) from the University of Pennsylvania conducted a two-part study to assess partisan polarization and resistance to social distancing in spring 2020, with the first study occurring in April and the second study occurring in May-June. This two-part study provides descriptive and experimental evidence from online surveys with embedded experiments among 2000 residents of Pennsylvania, a pivotal swing state (refer to Figure 5 for a timeline of political responses to COVID-19 in Pennsylvania). Results from the first study completed in April concluded that elite authority on stay-at-home orders did not "diminish support for key pandemic control policies across the political spectrum," but instead increased support slightly for these measures as displayed in Figure 8 (Bhanot and Hopkins, 2020).

***Figure 8.* Impact of Elite Urging on Support for Social Distancing, Full Sample (Study 1:
April 2020)**
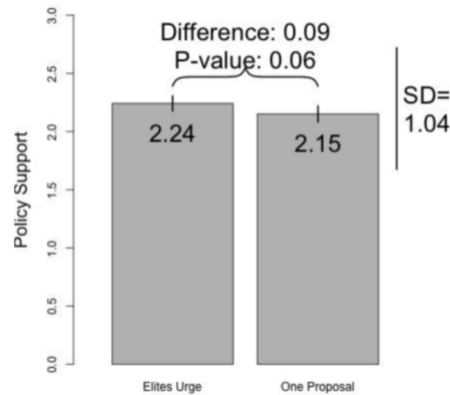
Note. From "*Partisan Polarization and Resistance to Elite Messages: Results from a Survey
Experiment on Social Distancing*" by Syon Bhanot and Daniel J. Hopkins, 2020. This figure
shows the results of an experiment to assess the impact of social distancing messaging from
elites. "There is no evidence that elite framing reduced support for stay-at-home policies; if
anything, the point estimates suggest that framing these policies as having elite support made
people more likely to back them," (Bhanot and Hopkins, 2020).

On the contrary, in the following months, while attitudes grew more polarized, the results
from the second study indicated that all of the elite groups generated the same response. As
stated, survey respondents "continued to not penalize policies when they were described as
supported by public health experts in particular. This stood in contrast to more negative views on
the same policies when they were presented as supported by government officials," as
demonstrated in Figure 9 (Bhanot and Hopkins, 2020).

Figure 9. **The Impact of Attributing Policy Using Benchmarks to "Government Officials,"**
"Public Health Experts," or "Some." (Study 2: May-June 2020)
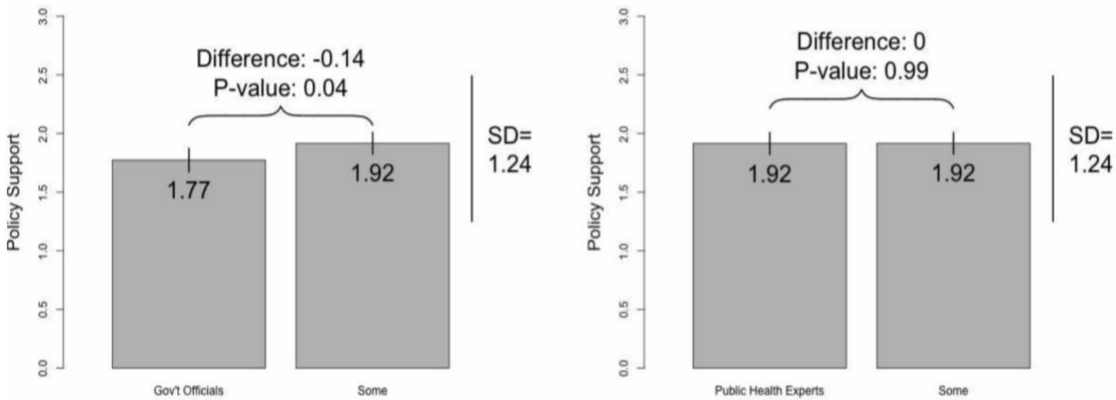
Note. From "*Partisan Polarization and Resistance to Elite Messages: Results from a Survey*
Experiment on Social Distancing" by Syon Bhanot and Daniel J. Hopkins, 2020. This figure

shows the results of an experiment to look into differences among the "elite" groups such

governmental officials and public health experts. "The left side of Figure 2 illustrates the

difference between attributing the strict benchmarking policy to government officials versus a

more generic alternative. Here, attributing the policy to government officials actually reduces

support by 0.14 (p=0.04) relative to the control condition. By contrast, attributing the policy to

public health experts has virtually no effect on levels of support (p=0.99)," (Bhanot and Hopkins,

2020).

In recent years, research has suggested the possibility for some Americans to reject

policies advocated by representations of those elite institutions and individuals. However, the

results from this two-part study not only highlighted the impact of Americans' perceptions on the

feasibility of these policies, but it critically emphasized the role of public opinion about the

policies, especially with partisanship differences being at the forefront. Although the first study

did not provide any evidence of backlash to policies advocated by elite groups, it is imperative to

continue to assess partisan gaps throughout the pandemic when examining the adherence to

COVID-19 recommendations from public health professionals and governmental officials

(Bhanot and Hopkins, 2020). As COVID-19 spread in the following months and as political

polarization became more evident in the U.S. pandemic response, the findings in the second part

of the study indicated that "invoking government officials as advocates of strict policies around

COVID-19 reduces enthusiasm for these policies amongst citizens of both parties," (Bhanot and

Hopkins, 2020). This lack of enthusiasm is likely to be associated with the resistance to social

distancing measures among population groups. Hence, the point of view bolstered by

Pennsylvania residents inferred "that public health experts, and not government officials, are

better positioned to advocate for collectively beneficial public policies during public health

crises," (Bhanot and Hopkins, 2020). As a result, especially in polarized times, policies,

recommendations, and strategies for public health crises in the future would be more effective

for public adherence if public health professionals remained the primary advocacy group for

these measures, rather than policymakers or governmental officials.

Implementing social distancing policies was critical to reducing the rates of transmission

of an emerging infectious disease like the coronavirus 2019. Although the federal government

and international institutions issued recommendations for social distancing measures, the

decision to implement and adopt these measures was left up to each state. This decision imposed

various economic consequences as some states faced higher potential costs from these

recommended policies. However, social distancing remained a dominant tool to reduce the

probability of contact between infected and non-infected people (Adolph et al., 2021). As a

result, the delay in implementing these necessary measures based on partisan differences in various states contributed to public health implications, such as a high number of COVID-19 deaths among vulnerable populations. Research on the impact of political polarization on the U.S. response across governing levels is helpful for policymakers in crafting better strategies and responses in challenging times.

Chapter 5: Discussion

During the early months of the pandemic, social distancing was a vital mitigation measure to address the rapid spread of the novel coronavirus. The analysis in the case study provided evidence of political polarization in the implementation of social distancing orders and discussed the effect of polarization on compliance with these mitigation measures. While identifying the political drivers that are influencing these public health measures, the results from the case study suggest that the political interference in the COVID-19 response in the United States remains a major roadblock not only to the necessary full compliance with social distancing measures but to the transformative change needed in the field of public health, especially as polarization increases over time. The following section describes the public health implications of political polarization concluded from the main three findings and provides recommendations for public health policymaking in the future:

I. **Bipartisan support is essential in maximizing the effectiveness of COVID-19 policies, such as social distancing orders.** Researchers have indicated that Republican and politically misaligned Democratic counties are less likely to adhere to mitigation measures (Painter and Qiu, 2020; Adolph et al., 2021). Trends among counties across the country have shown that differences in compliance with social distancing measures is likely due to trust in the credibility of government leaders issuing government orders. Bipartisan support can serve as a major factor in ensuring effective mitigation measures. For example, research has shown that Democratic residents are more likely to adhere to state-level orders or policies issued by a Democratic governor and vice versa among Republicans. However, partisan differences impose a major threat to public health because it holds implications on public health policies and campaigns designed to increase compliance to COVID-19

related measures. Some direct consequences of non-compliance fueled by political differences can include an increasing number of COVID-19 cases and deaths among states and subsequent economic costs of a presentable COVID-19 surge.

A. *Recommendations*

1. Bipartisan consensus strengthens the likelihood of effectively managing the pandemic through timely enactment of policies and ensures higher public compliance with these policies. Future research should address how to effectively bridge the partisan divide on the COVID-19 pandemic response. (Kerr et al., 2021).

2. Governmental leaders must integrate the recommendations and expertise of public health professionals with public policy to reflect coherence in implementing public health responses throughout their states.

II. **Political polarization affects public perceptions of public health policies.** As demonstrated in the study in Pennsylvania (Bhanot and Hopkins, 2020), public perception of policies tend to be more negative when supported by government officials and less likely to be penalized when supported by public health experts. This resistance to social distancing guidelines promoted by the "elites" can become a barrier for policymakers, especially in crafting a pandemic response that requires the expertise of public health professionals. Public health professionals should be aware of the resistance based on partisanship occurring in public health policies, especially if they require compliance. The implications of this finding demonstrate the need for public health policies to be drafted and fully supported by public health experts instead of political leaders as a primary advocacy group.

A. *Recommendations*

1. Reestablishing trust in public health institutions and experts should be prioritized in order for public health problems to be addressed seamlessly.

2. Recognizing that politics and public health will remain intertwined, public health advocates and institutions must develop a constructive approach when navigating a dysfunctional political system when interacting with governmental officials. Expanding the public health workforce across the federal sectors and implementing reforms on the dynamics of appointed roles will provide structural opportunities to help integrate politicians as part of the solution to public health problems.

3. Implementing structural independence of public health institutions, such as the CDC, in which the CDC Director has complete independence of his or her decisions during a 10-year term, similarly to the FBI Director. This will help ensure that public health recommendations from the CDC are not procumbent to modifications from cabinet members or the White House. This will also help address the lack of trust caused by the lack of perception of independence among public health institutions.

III. **State capacity is an underestimated factor in assessing political drivers in the COVID-19 measures.** Research has indicated that poorer states were less likely to adopt social distancing measures (Adolph et al., 2021). Despite the political affiliation of the governor, trends of slow or delayed adoption of social distancing policies were found among poorer states due to the limited availability of economic resources, human capital, and infrastructure for crisis response. This is a crucial implication for policymakers and

public health experts to consider when understanding the timing of a governor's decision. A state's inability to implement social distancing measures effectively due to its weak capacity can worsen the health and wellbeing of marginalized populations, especially when poorer states tend to have vulnerable populations and more fragile health systems (Adolph et al., 2021).

A. *Recommendations*

1. Further research should examine the role of local governments in implementing early mitigation measures in order to detect additional drivers of resistance.

2. Federal, state, and local governments should invest in tools and resources such as data modernization, resource accessibility, workforce capacity, and cumulative and adequate funding to help strengthen capacity and readiness for future public health resources

5.1 Case Study Limitations

One major limitation of this case study is that some of the information used was found in grey literature, which can make it difficult to assess any bias or subjectivity in those sources. Due to limited evidence of political polarization on early social distancing across various states, the results of the case study may provide little basis for generalization or may not necessarily be representative of the whole population. In addition, the timing of the publication of the sources used can also be a limitation because there may be some inconsistencies in the data provided.

5.2 Conclusion

In conclusion, despite the need for political consensus in times of crisis, there is a growing evidence that the COVID-19 response in the United States has been politically polarized. As public health professionals and advocates of systematic change, we must examine the effect of political factors shaping the strategies and approaches of the Executive Branch and other government officials. By discussing the impact of the political differences in public health incentives, we can better address the existing barriers that hinder our public health infrastructure.

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