Politics Spread COVID: Developing a Public Health Response

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The circumstances leading to one million American deaths from COVID-19 are familiar to health educators: The pandemic was politicized from the outset; public health professionals were pushed aside and sometimes attacked; in many areas, compliance with public health recommendations was low, and vaccine uptake was much less than required to meet the threat; the public health community tied itself in knots trying to figure out how to cut through the plethora of misinformation; people in marginalized populations died in vastly disproportionate numbers in spite of years of preparation to prevent just that outcome. Cumulative mortality is equivalent to some of the "worst case" scenarios put forth by U.S. public health experts at the beginning of the pandemic even though we've worked so hard to prepare for this type of global pandemic, so what went wrong? Profound changes in American politics have led to a relationship between public health and swaths of society that is quite unlike what previously was assumed in the dominant models of public health; it was believed that public health experts would be treated as and listened to as the experts they are in the field. As the politicization of the pandemic and subsequent deaths show, these assumptions are no longer valid and we cannot assure the health of the public as we are required to do. The assumptions that we have operated under for so long in public health now must be deconstructed and revisited in order to move forward and prevent unnecessary future deaths. To do this, we must better understand the influence of American politics and we must more effectively engage in politics at all levels.

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By now, the circumstances leading to one million American deaths from COVID-19 are familiar: The pandemic was politicized from the outset; public health professionals were pushed aside and sometimes attacked; in many areas, compliance with public health recommendations was low, and vaccine uptake was much less than required to meet the threat; the public health community tied itself in knots trying to figure out how to cut through the plethora of misinformation; people in marginalized populations died in vastly disproportionate numbers in spite of years of preparation to prevent just that outcome. It was not just a few unfortunate failures in an otherwise excellent response; the United States leads the world in total COVID mortality (Statista, 2022). Public health professionals worked so hard for so long to be ready for this moment. How did things go so wrong?

Public health values the autonomy of persons and that includes the right to decline public health advice (Coalition for National Health Education Organizations [CNHEO], 2020). But there are times when a health

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threat is so serious it constitutes an existential crisis. In that case, public health becomes part of our nation's emergency preparedness system and can require near universal compliance from the public to avoid a mass casualty event. The legal basis for this is codified in State Public Health Codes. But during the COVID pandemic, public health found itself battling governors, legislatures, courts, and even school boards to the point where experts ultimately were unable to communicate what was required to a sufficient number of people.

This happened at least in part because of profound changes in American politics that mean the relationship between public health and the rest of society is now unlike what is assumed in the dominant models of public health, such as those offered by the Public Health Accreditation Board (PHAB) or the National Commission for Health Education Credentialing, Inc. (NCHEC). These models identify major domains of public health competency. It is assumed that, if public health carries out the functions contained in the domains, health will be better as a result: *If public health offers health education correctly, then the public will change their behavior accordingly and avoid preventable disease. If public health issues lawful emergency orders, elected officials will support the orders and then the public will comply, preventing the transmission of disease.* As the politicization of the pandemic and subsequent deaths show, these assumptions are no longer valid and, under such circumstances, we cannot assure the health of the public as we are required to do. The assumptions that we have operated on for so long in public health now must be deconstructed and revisited as we continue to face not only surges in COVID but also future pandemics and other mass casualty events. As advocacy leaders in the public health education arena who have helped grow the advocacy skills of the next generation, we realize that we have stopped short of teaching our professionals to truly dig into the complexity of the politics that are keeping us from successfully doing our jobs.

Therefore, we are calling on the public health community to engage in an active and inclusive dialog about how to develop the capability to grapple with the political dysfunction that has resulted in so much needless illness and death. We are not claiming to know how to address political dysfunction ourselves; we are certain we do not. However, we have faith that our community does contain that knowledge and that we must begin seeking a way forward together.

WHY THIS IS HAPPENING NOW?

The field of political science offers explanations for societal failures—such as the inability to respond effectively to a pandemic—and the specialized field of rhetoric analyzes how abuses of political discourse contribute to them. Demagogy is a style of political discourse that arises when politicians are primarily concerned about attaining power by mobilizing supporters and have little regard for the public policy consequences of what they say and do (Hahl et al., 2018). We think we can discern three characteristics of demagogy present in American politics now which impede the ability of public health to perform its role:

1. **The rise of social media**. Social media is a perfect vessel for demagogic communication because social media algorithms show participants ever more extreme versions of ideas they are predisposed to hold. Because of this, inaccurate information spreads faster than accurate information on many types of social media platforms. Research shows that political actors deliberately use social media to cultivate outrageous falsehoods that appear to strengthen their own positions without regard to the consequences (Garmani & Biller-Andorno, 2021). In such an environment, public health communication flounders.
2. **The vilification of others**. Political scientists say another crucial feature of demagogy is a political culture that includes the purposeful vilification of others. The scapegoating of minorities is a familiar example of this, but it also takes the form of attacks against people who can be said to be elites (Roberts-Miller, 2022). During the pandemic, local public health leaders in some jurisdictions were characterized as deceitful outsiders. Without the trust of the public, health leaders cannot expect to communicate successfully.
3. **The elimination of other power centers**. A key feature of democracy is the presence of multiple centers of power, permitting consensus about policy questions to emerge through rich negotiations. As demagogy advances, it eliminates rival power centers stifling political discourse. This process is happening now with respect to public health, as some states move to curtail its powers and reduce the role of public health officials. In some states, these efforts are being funded by dark monied private interests—elected leaders are using their campaign war chests against the agencies they are responsible for supervising (Roberts-Miller, 2022).

Ultimately, elected leaders are responsible for the health of the public, and public health is the tool leaders use to protect health. Therefore, when elected leaders undermine public health and willfully engage in activities that encourage the spread of disease, we are dealing

with a profound political failure and a sincere danger to our public's health.

IMPACT ON PUBLIC HEALTH

These changes in politics, described above, mean that public health simply could not perform many essential functions during the COVID pandemic. Critical tools used by public health during the pandemic included encouraging masking and social distancing, contact tracing and case investigation, and emergency orders including closure and vaccination orders. However, many political leaders undermined the use of these tools.

Motallebi et al. (2022) reported a significant association between country-wide mask mandates and lower COVID death rates in a longitudinal study that included 44 countries and over one billion people. However, in many U.S. states, governments refused to enforce mask mandates, which led to higher rates of infection and death. In spite of this, many political leaders spoke out against masking (Boucher, 2021). Furthermore, Fetzer and Graeber (2021) found that proper contact tracing led to a 63% reduction in the spread of COVID and 66% reduction in deaths, but many state governments were slow in their support or completely unwilling to invest the resources to provide proper local support for those needing to establish fast and effective tracing protocols. For example, in Indiana, leaders decided originally that all contact tracing would be run through a centralized state system. However, the system was under-prepared, leading to vast delays in tracing time and leaving local leaders, in organizations like universities, to set up their own outside tracing protocols to best prevent viral spread. While contact tracing has been used for many outbreaks, Ebola, for example, most state and federal governments did little to support this effort at community levels and they seemed woefully unprepared or unwilling to establish the necessary protocols in the face of COVID. This left local health departments, hospitals, and universities scrambling to find ways to do this work with little to no funding or structural support. Finally, impacting public health's ability to perform its basic functions was the refusal by some states to back state or federal executive orders. Though scientific data consistently documented vaccines as effective, safe, and the best weapon to protect against death from COVID when used in combination with masking, social distancing, and contact tracing, some political leaders demonized vaccines and 12 states[1] still banned vaccine mandates (Mitchell, 2022). The result of public health not being able to do its basic functions led to higher infections, public health worker burn out, and lack of adequate medical staffing. Subsequently, we have seen a mass exodus of those working in public health either to other jobs or to early retirements.

Public health must regain its ability to protect the public, and to do so it must develop a new capability—the ability to grapple successfully with political dysfunction. This capability is not just another form of advocacy. Whereas it may start with advocacy, it is clear that current advocacy alone has been ineffective in times such as these. This new capability may include some combination of electoral strategies, legal strategies and even direct political action to compel elected leaders to carry out their responsibilities under the law. We cannot allow lifesaving public health strategies to be dismissed or sabotaged by policymakers when the greater good and population health is at risk.

OPTIONS FOR ACTION

Public employees have long told themselves it is inappropriate to move beyond the role of advocacy into more direct forms of political engagement, but when politicians block improvements in human welfare, our work has often required this elevated level of commitment. With this in mind, there are an array of strategies for combating dysfunction, many of which are familiar and have been used often in the history of public health.

In an effort to lay out examples of options for a dialog about what public health must do now, we offer a simple framework. In it, potential forms of political engagement are arranged in order of increasing complexity and difficulty from those that are extensions of the kinds of advocacy public health does now, to engagement that gets at the root causes of the current crisis. For ease of comprehension, we group the levels of engagement into those that are primary, secondary, and tertiary, deliberately using the same language used for the familiar public health levels of prevention. This is shown below in Table 1.

Actions at the primary level of engagement are the kind of activities we do now such as enacting new programs or proposing new regulations. We are not suggesting that politicians must approve everything public health wants, but that disagreements are about what is best for community health. Ideally, this work should be done on issues where social justice and politics intersect, laying a foundation for more fundamental change in the future. Two examples could include

Long term and residential care—COVID has further highlighted long neglected risks to vulnerable populations within communities. COVID spread quickly through assisted living facilities, placing both the

TABLE 1
Levels of Engagement

Levels of engagement	*Explanation*	*Goal of engagement*	*Example*
Primary	Assumes political system functioning normally. Politicians may not agree with public health, but take it seriously.	Winning conventional public policy battles.	Progress in topical areas such as protecting vulnerable people (seniors, vulnerable adults, front-line workers); letter writing campaigns; community organization.
Secondary	Includes reforms (regulatory, legal, judicial) necessary to make politics work better.	Actions to address social changes described above that have made public health ineffective.	Regulation of social media. Campaign finance reform. Electoral reform (e.g., gerrymandering and voter suppression).
Tertiary	Public engagement is necessitated by continuing deterioration of democratic government.	Apply pressure on, or hold accountable, politicians whose behavior drives disease.	Enforcement of gross negligence standards. Class action suits. Labor action.

residents and workers in danger. Residents themselves, but especially workers, were often victims of anti-public health demagogy and sometimes failed to mask, socially distance or get vaccinated when opportunities arose. Continued advocacy regarding the needs of vulnerable populations within communities can be a way to funnel resources to the groups most needing them through direct back channels like local health departments or nonprofit organizations without needing to immediately address the political systems creating the disparities.

Worker's rights and health—Workers considered "essential" were placed in situations of greater risk from the start of the pandemic, many working long and stressful hours directly engaging with COVID-positive individuals. Even when putting themselves in positions to protect and offer services to others, these same workers were sometimes bullied, harassed, and even threatened for their health and safety roles. Fighting for workers' rights as a part of public health efforts should again be pushed to the forefront of efforts.

Actions at the secondary and tertiary levels are directed at the root causes of the current crisis. They aim to address the political changes mentioned above that have created barriers to the success of public health. Actions at the secondary level would include activities like regulating social media, restoring campaign finance reform or strengthening public health law. They also could include work to protect democracy which, in the United States, must mean reducing gerrymandering and ensuring the right for all to vote:

Constrain social media echo chambers—As mentioned above, social media can undermine speech by driving people toward extreme views and spreading false information more effectively than accurate information. Management of the toxic impacts of social media needs to move beyond content policing and tweaking algorithms to the reconstruction of platforms themselves to break up echo chambers. For example, social media platforms could be regulated like hospitals—with licensure dependent on attaining publicly determined goals such as the average diversity of contacts for users or aggregate levels of political literacy—leaving the method for achieving the goals up to the firms themselves.

Renewal of fairness standards in streaming and broadcasting—At the beginning of the era of radio and television broadcasting, licenses had strict requirements for balanced public information sharing. However, few people access information via broadcasts now and most use streaming and online sources. It is time to explore ways that fairness standards can and should be applied to the online environment, helping to diversify the information provided to the public.

Return to limits and transparency in political funding—Since the Supreme Court ruled against the Federal Election Commission in the Citizens United lawsuit in 2010, it has become even easier for wealthy corporations and individuals to influence political and social outcomes in the United States by secretly funding political action committees. Incredibly, elected officials are using Political Action Committee (PAC) dollars to campaign against public health law—the very public health system they are responsible for overseeing (Bredderman, 2021). It is time for public health to fight for the good of the people through encouraging both transparency and financial limits on campaign contributions.

Strengthening democracy—The majority favors security and health and yet often are unable to translate

their values into consistent policies through the ballot. In many countries, foreign interference in elections in favor of extremist politicians is a recurring threat. In the United States, the gerrymandering of voting districts and voter requirements that amount to voter suppression resulted in many states having anti-public health policies during COVID in spite of the public's preferences. Red legislatures across the country have openly drafted and passed policies clearly designed to limit access to the ballot box for individuals who do not traditionally vote in their favor.

Actions at the tertiary level can be used to apply pressure on politicians to enact policies to strengthen democracy like those described above. They can also be aimed at politicians engaging in demagogy to hamper or remove them so the policy process can move forward. This could include enforcing gross negligence standards for elected officials, class action lawsuits against those who knowingly threaten health, actions by labor, or political actions to galvanize the public:

Enforcement of gross negligence standards—Often, efforts to remove politicians from office are about political disagreements—for example, pro-life voters trying to remove a pro-choice politician. Otherwise, politicians are rarely removed except for the most egregious of crimes like theft, sexual abuse, treason, etc. While decision-makers should be protected from inadvertent consequences of well-intended decisions, deliberately engaging in activities that kill one's constituents, like encouraging the spread of disease, ought to be disqualifying for public office. Public health must advocate for requirements for leadership that include placing the health of the public foremost, ahead of engaging in dangerous stunts aimed at getting re-elected.

Class action lawsuits—Another way to hold politicians accountable could be class action lawsuits. Though authors are not interested in punishing individuals for what already happened, we do want to restore the ability of public health to protect people. It is easy to show that politicians who encouraged activity that spread COVID were thoroughly briefed by their public health agencies on the consequences of their actions. For this reason, lawsuits should be an option for consideration.

Direct political action—Public health requires a foundation in democracy. To legitimately carry out the will of the people, public health officials must report to elected leaders who put the health of the public ahead of private interests. However, this is not currently happening. In the political crisis faced by the United States and other countries, governance has failed. It is incumbent upon the public health community to restore legitimacy to the governance of the people's health and this may require going beyond the traditional advisory roles of public health to direct action.

Labor actions especially in the health sector—Given the chaos COVID caused in workplaces—especially health and public health–it is surprising that there have been few labor actions related to it. In the American Journal of Public Health (Wright, 2016), Michael Wright called for "a much closer relationship between unions and public health practitioners" citing the historical role of politically active unions in improving community health for all.

The actions described in this section are examples of what the capability to grapple with political dysfunction might look like. Going further, the capabilities of the public health system depend on the competencies of the workforce. Public health certification and accreditation programs exist to a large extent to communicate to political leaders that the workforce is meeting its responsibilities. However, as we have shown that there will inevitably be times when political leaders attack public health for doing its job. How should we think about professional competencies in this context? We are calling for a change in professional competencies, guidelines in professional preparation programs, and both program accreditation and certification to meet the professional development and continuing education needs of the public health workforce as they increase their advocacy capabilities. Even though the field of health education recently has placed greater emphasis on advocacy skills overall, the call here is for even greater emphasis and a more thorough undertaking of how to effectively influence politics as skills to be developed in all current and upcoming public health professionals. At a minimum, we can say that for us to make progress, it is going to take us engaging as we have not done in recent history. For exhausted public health workers, and people in similarly disrupted professions like education and clinical nursing, this type of engagement may seem overwhelming, but the stakes are too high to fail to engage in this work. . .lives can and will be lost due to inaction.

CONCLUSION

Before concluding our appeal, we want to address a couple of potential criticisms. One potential criticism is that we are advocating censorship. To be clear, we are not saying that the mere expression of disagreement with public health caused a million deaths, nor are we saying such disagreement should be suppressed. Our argument is that the entire environment within which political discourse is occurring has changed and that public health needs new strengths if it is to cope with this new environment. As

it now stands, the voice of public health cannot be heard over the din of social media echo chambers and the vilification directed at public servants and we cannot assure the public their health is protected.

Another potential criticism is that we discount the possibility that giving too much power to public health also risks harm to the public. For example, an excessively draconian response to a pandemic like COVID might cause more harm than the disease itself would alone. In fact, we share this concern. We believe an inclusive dialogue about the future of public health should strike a balance between public health and other public interests seriously.

Finally, we want to say that we are not blaming specific individuals for America's excessive COVID deaths. We think this sad chapter should be put behind us. But we do believe the COVID pandemic has made it clear we, as a nation, are unprepared for the inevitable next mass casualty event. We need to put aside strategies created during a time of carbon paper and rotary dial landlines. The terms of engagement are being determined by well-funded, tech-savvy activists. We need tools that are appropriate to the tasks before us.

We have the resources needed to hold an inclusive dialog about how to grapple with political dysfunction. Public health has an embarrassment of intellectual riches in its vibrant leadership (National Association of County and City Health Officers [NACCHO], Association of State and Territorial Health Officers [ASTHO], American Public Health Association [APHA], Society for Public Health Education [SOPHE], Robert Wood Johnson [RWJ], Trust for America's Health [TFAH], etc.)[2] who have the means to do this. To maximize our strength and wisdom, an inclusive dialog should encompass all roles in public health. Furthermore, it must be obvious that the crisis we have described here affects many sectors, not solely health, including education, environmental health, labor, clinical nursing, etc. who are traditional partners in community health. Public health has pushed itself through many profound changes in the past and we can do it again.

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Notes

1. Arizona, Arkansas, Georgia, Florida, Indiana, Montana, New Hampshire, North Dakota, Oklahoma, Tennessee, Texas, and Utah.
2. National Association of County and City Health Officials, Association of State and Territorial Health Officials, American Public Health Association, Society of Public Health Educators, Robert Wood Johnson Foundation, Trust for America's Health.

REFERENCES

Boucher, D. (2021, April 21). *Michigan GOP leader shares misinformation on masks that suggests suing employers*. Detroit Free Press. https://www.freep.com/story/news/politics/2021/04/27/michigan-gop-leader-misinformation-mask-effectiveness/4860259001/

Bredderman, W. (2021, November 23). Anti-vax leader turned lockdown rage into money maker. *The Daily Beast*. https://www.thedailybeast.com/michigan-anti-vax-leader-ron-armstrong-turned-lockdown-rage-into-money-maker

Coalition for National Health Education Organizations. (2020). *Code of ethics for the health education profession* [Document]. https://drive.google.com/file/d/1tMlqPXW3ruG9FQoAXHkf6VdEKqGibEmP/view

Fetzer, T., & Graeber, T. (2021). Measuring the scientific effect of contact tracing: Evidence from a natural experiment. *Proceedings of the National Academy of Sciences*, *118*(33), Article e2100814118. https://doi.org/10.1073/pnas.2100814118

Garmani, F., & Biller-Andorno, N. (2021). The anti-vaccination infodemic on social media: A behavioral analysis. *PLOS ONE*, *16*(3), Article e0247642. https://doi.org/10.1371/journal.pone.0247642

Hahl, O., Kim, M., & Sivan, E. (2018). The authentic appeal of the lying demagogue: Proclaiming the deeper truth about political legitimacy. *American Sociological Review*, *83*(1), 1–33.

Mitchell, H. (2022, October 12). *12 states banning COVID-19 vaccine mandates and how they affect healthcare workers*. https://www.beckershospitalreview.com/workforce/11-states-banning-covid-19-vaccine-mandates-how-it-affects-healthcare-workers.html

Motallebi, S., Cheung, R. C. Y., Mohit, B., Shahabi, S., Tabriz, A. A., & Moattari, S. (2022). Modeling COVID-19 mortality across 44 countries: Face coverings may reduce death. *American Journal of Preventive Medicine*, *62*(4), 483–491. https://doi.org/10.1016/j.amepre.2021.09.019

Roberts-Miller, P. (2022). *Characteristics of demagoguery*. https://www.patriciarobertsmiller.com/characteristics-of-demagoguery/

Statista. (2022). *Number of novel coronavirus (COVID-19) deaths worldwide as of June 27,2022, by country*. https://www.statista.com/statistics/1093256/novel-coronavirus-2019ncov-deaths-worldwide-by-country/

Wright, M. J. (2016). The decline of American unions is a threat to public health. *American Journal of Public Health*, *106*, 968–969. https://doi.org/10.2105/AJPH.2016.303217