Pandemic Politics: Assessing the Response to COVID-19 in the United States

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ABSTRACT

In January 2020, the Centers for Disease Control and Prevention (CDC) identified the first case of travel-related acquisition of the novel coronavirus (SARS-CoV-2) in the United States. By May 2020, the U.S. had accumulated more cases and deaths from COVID-19 than any other country in the world—a title that has been retained for the duration of the pandemic. The management of the COVID-19 pandemic in the U.S. was plagued by an alarming lack of federal support and the absence of a centralized planning mechanism. Evidence suggests that effective action by the 2020 Administration to combat coronavirus had the potential to realign U.S. progress on the pandemic with that of other industrialized nations and could have prevented up to 40% of deaths. Therefore, this project retroactively assesses how the policies, actions, and recommendations implemented by the 2020 White House Administration contributed to the U.S. response effort based on data from released former White House and Congressional documents, media reporting, World Health Organization (WHO), CDC, and Federal Drug Administration (FDA) reports, as well as data from scientific literature and COVID-19 surveillance reports. The execution of the U.S. COVID-19 response highlighted the ways in which political rhetoric and subversive action on multiple policy levels can detrimentally affect human health on a catastrophic scale. Subsequently, the knowledge derived from this synthesis serves to inform efforts to rebuild the reputation and capacity of public health response efforts in the U.S.

Keywords: COVID-19, SARS-CoV-2, United States, Politics, Pandemic Response

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In December 2019, reports emerged of pneumonia-like clusters of unknown etiology out of Wuhan, Hubei Province of China. By January 9, 2020, with 59 reported cases, the World Health Organization (WHO, 2020) announced that the illness is tied to the emergence of a novel coronavirus. Eleven days later, the Centers for Disease Control and Prevention (CDC) identified the first U.S. case of what is now widely known as COVID-19 in Washington state (WHO, 2020). On March 13, 2020, U.S. President Donald Trump declared a national emergency, releasing much-needed federal funding to address the emerging threat and spurring a wave of local and state mandated lockdown orders (AJMC, 2021). Despite this, cases and deaths in the U.S. continued to skyrocket. To date, the U.S. has seen over 27 million cases and nearly 500,000 deaths —higher than any other country in the world (JHU, 2021).

Public Health Governance

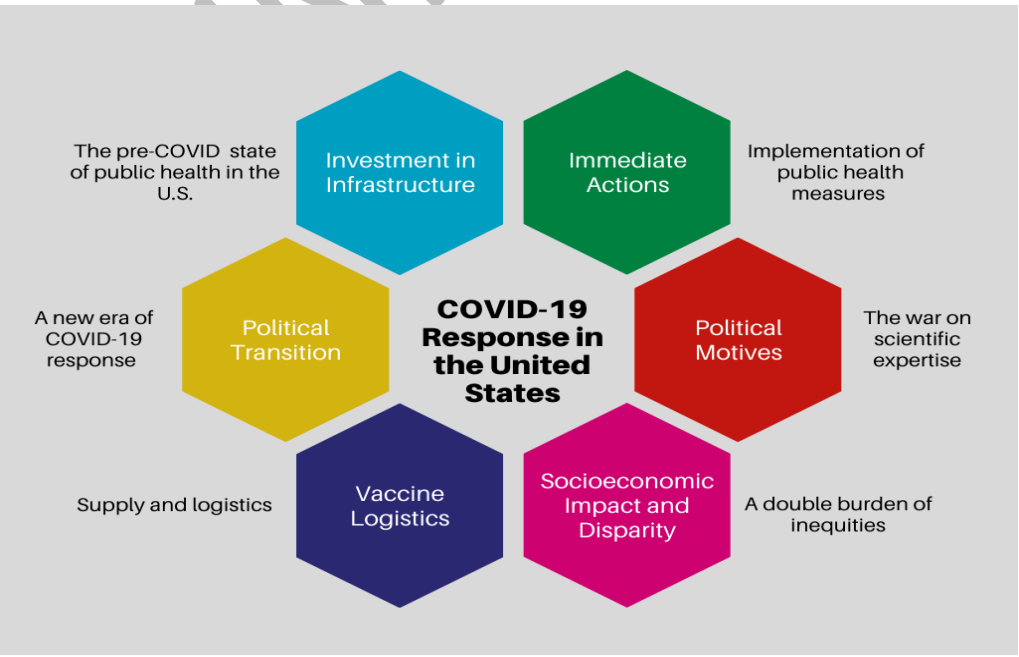
Of utmost relevance to understanding the United States' response is acknowledging the federalist system of public health governance (Haffajee & Mello, 2020). With a marked decentralization of jurisdiction surrounding the promotion of health, states retain primary responsibility in assuring such (Leider et al., 2018). However, in the event of a public health emergency, as was declared for COVID-19, the federal government maintains the power to aid in the expansion of services that protect human life and to enact a range of sweeping executive powers that restrict certain actions for the immediate and greater good (Haffajee & Mello, 2020). While the latter remains controversial amid concerns surrounding balances and abuses of power, it was an alarming lack of federally directed and unified action that defined the U.S. response to the novel coronavirus.

Grounds for Assessment

The COVID-19 response illuminated, in a distressing light, the depth of faults in the structure and funding of public health infrastructure in the United States. Furthermore, it revealed the true extent to which political discretions affect the function and nature of health. From Administration precedents to immediate and long-term actions following onset, this paper will serve as an evaluation assessing how the multi-system policies, actions and recommendations implemented by the 2020 White House Administration adversely affected the U.S. response. Topic areas to be addressed include: investment in infrastructure, immediate actions, political motives, socioeconomic impact and disparity, vaccine logistics, and political transition (see Figure 1). The knowledge derived from this synthesis will serve to inform efforts to rebuild the reputation and capacity of public health response efforts in the U.S.

Figure 1

Topic Areas for Assessing the U.S. COVID-19 Response



DATA COLLECTION

Sources for this analysis include released former White House and Congressional documents; WHO, CDC, and Food and Drug Administration (FDA) reports; as well as data from scientific literature, COVID-19 surveillance reports, and media reporting. Scientific literature was identified by keyword search of Google Scholar and PubMed databases using terms "U.S. COVID-19 Response", "U.S. COVID-19", "Trump COVID-19", "U.S. Public Health", "U.S. Public Health Infrastructure", and "U.S. Pandemic Response". Commentaries or letters to the editor published in journals and relevant to COVID-19 or public health under the 2020 Administration were included. Sources on the U.S. COVID-19 response were limited to those published after January 1, 2020. Sources pertaining to public health infrastructure were expanded to those published after January 1, 1980. CDC, WHO, and FDA documents were included if they were (a) specific to COVID-19 or (b) related to public health monetary/resource allocation and were obtained via CDC.gov, WHO.int, and FDA.gov, respectively. Data from the 2020 Administration's COVID-19 or public health funding documents and press releases were retrieved via the archived Trump White House webpage (trumpwhitehouse.archives.gov) and Congressional reports on COVID-19 were found via House.gov. Finally, media reports were identified using Google search and used as a premise for validating timelines for key response actions and statements under the 2020 Administration. Additional sources were identified via manual search of reference lists.

FINDINGS

In total, 52 sources were identified and included in this analysis, broken down as such: Public Health Infrastructure (13), Immediate Actions (10), Political Motives (10),

Socioeconomic Impact and Disparity (8), Vaccine Logistics (8), and Political Transition (3). The results derived for each section are summarized below.

Investment in Infrastructure

A 1988 report by the Institute of Medicine (IOM, 1988) was the first to formally expose the shortcomings of the American public health infrastructure. Key findings pointed to a lack of perceived importance of preventive efforts, as well as a general disarray surrounding the public health landscape. Of special interest, two main factors affecting the implementation of health activities were identified. First, level and availability of scientific knowledge (IOM, 1988). Second, and keenly relevant to the discussion moving forward, the influence and content of public opinion (IOM, 1988). The report specifically identified the inescapability of the relationship between American politics and public health commitments. In the context of the COVID-19 response, I will later evaluate the effects of inseparable political rhetoric on the second factor of public opinion related to health.

In the following years, several other assessments were released intending to call attention to the dire state of public health infrastructure in the U.S. A 2005 report entitled "*The Public Health Infrastructure and Our Nation's Health*" found that public health remained systematically underfunded, with more continuing to be spent on personal health services over population level initiatives (Baker et al., 2005). In addition, it was proposed that dwindling workforce and vastly varying local, county, and state-level capacities rendered the U.S. system unprepared for a well-coordinated response to emerging threats (Baker et al., 2005).

Under the Obama Administration, the implementation of the Affordable Care Act (ACA) was partially aimed at renewing emphasis on public health funding (Maani & Galea, 2020).

However, these funds were soon diverted to append Medicare needs or cut entirely via sequestration in 2012 (Maani & Galea, 2020). Reductions included $13 million to address emerging and zoonotic infectious diseases, $18 million for global health, $98 million for public health preparedness and response, and $35 million for cross-cutting activities and program support (CDC, 2013).

However, in 2014 amongst the Ebola outbreak in West Africa, Congress rebounded with a $600 million award and creation of a Global Health Security Agenda to help prevent infectious disease epidemics through a multinational effort (Sun, 2018). In recognition of the lack of coordination between responding agencies and the necessity of collaboration with global partners, the Obama Administration erected new infrastructure for pandemic response including the creation of command groups within the National Security Council (NSC) and the Department of Homeland Security (DHS) (Garrett, 2020).

In 2018, in addition to cutting the Complex Crises Fund ($30 million), the Trump White House cut $15 billion from the CDC, NSC, DHS, and the Department of Health and Human Services (HHS) (Garrett, 2020). This led to the CDC reducing efforts to prevent global outbreaks by 80%, due to lack of necessary funding (Heeb & Sheth, 2020). The Trump Administration also shut down the global health security unit intended to bolster future response efforts (Garrett, 2020). One year prior to onset, the CDC epidemiologist working within China's disease control agency departed and, rather than install a replacement, the Administration eliminated the role entirely ("Timeline of Trump's Coronavirus Response," 2021). In 2019, a simulation performed by HHS determined that there were "insufficient funding sources designated for the federal government to use in response to an influenza pandemic" (HHS, 2020, p. 1). Even in light of the alarm bells, no actions were taken to remediate the situation.

Eleven days after the WHO declaration of COVID-19 as a public health emergency, a Trump budget proposed a 16% cut to the CDC and 40% cut to the WHO, key coordinating agencies of the U.S. (CDC) and global response (WHO) (Devi, 2020). Based on expert opinion, in the midst of the COVID-19 pandemic the U.S. was short by approximately $4.5 billion in funds necessary to maintain minimum public health capabilities (Maani & Galea, 2020). Amongst national catastrophe, political appointees at the Trump White House continued to sideline much needed funding for health agencies – one example of which included removing $300 million from CDC's budget for creation of an HHS "Defeat Despair" campaign, without any consultation from CDC experts (Union of Concerned Scientists, 2020).

What remains clear is that the structure and funding of public health in the U.S. has been historically and systematically frayed. While the actions of prior governing administrations and foundational precedents of underfunding cannot be ignored, drastic and unprecedented attempts by the 2016-2020 White House Administration to undermine the stability of preparedness infrastructure must be acknowledged.

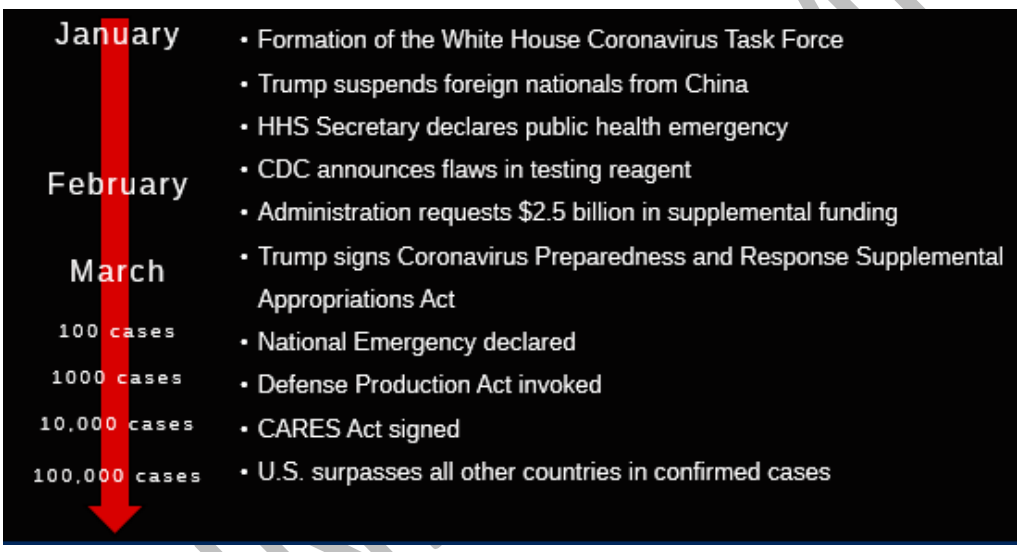
Immediate Action

On January 5, 2020, the WHO first acknowledged the existence of pneumonia of unknown etiology in Wuhan City, China (WHO, 2020). On January 21, 2020, the first case was identified in the U.S. and screening was initiated at five airports followed shortly after by the formation of the White House Coronavirus Task Force (Wallach & Myers, 2020). When asked about his concern that the novel coronavirus could reach pandemic levels, President Trump stated "No, not at all. And—we're—we totally have it under control…It's going to be just fine." (Rutledge, 2020) – a statement incongruent with the more cautious guidance coming from the WHO. By January 30, the WHO had officially declared the novel coronavirus as a public health

emergency of international concern (PHEIC) and one day later Trump issued a travel ban on foreign nationals coming from mainland China (Wallach & Myers, 2020; WHO, 2020). A summary of key events in the U.S. response from January 2020 through March 2020 is outlined in Figure 2.

Figure 2

Timeline of Key Events in the Early Coronavirus Response



Upon release of the viral genome, the WHO sent thousands of diagnostic tests to laboratories across the globe in early February (Wallach & Myers, 2020). Despite this, precedent determined that the CDC would develop their own tests to use domestically. As of early March 2020, over 100 Americans were infected, CDC tests were shown to be flawed due to failing reagents, and poorly constructed testing criteria ensured inadequate surveillance capabilities in the early response (Rabin et al., 2020).

At the time, Trump falsely touted “Anybody right now, and yesterday, anybody that needs a test gets a test. They’re there. And the tests are beautiful…. the tests are all perfect like

the letter was perfect.", as well as reiterated several times "Just stay calm. It will go away." ("Timeline of Trump's Coronavirus Response," 2021). At the same time, Dr. Anthony Fauci, Director of the National Institute of Allergy and Infectious Diseases (NIAID) and member of the Coronavirus Task Force, spoke before Congress expressing that the system was failing ("Timeline of Trump's Coronavirus Response," 2021). This would be one of many clashes between Trump and scientific experts over the COVID-19 response.

On March 13, 2020, with over 2,000 cases in the U.S., Trump declared a national emergency, freeing up essential funding to aid in response (Mangan & Wilkie, 2020). By March 26, 2020, the U.S. had surpassed all other countries in confirmed cases ("Timeline of Trump's Coronavirus Response," 2021). On the same day that President Trump declared a "Light at the end of the tunnel", the U.S. had lost 10,000 lives to COVID-19 ("Timeline of Trump's Coronavirus Response," 2021).

Between March 1 - May 31, 2020, 42 states issued mandatory stay at home orders (Moreland, 2020). However, upon expiration of these orders conflict began to emerge between political entities and scientific experts surrounding lifting restrictions prematurely. An overarching theme for the continuation of the U.S. response to COVID-19 from here on would be the pitting of economics against evidence-based action – an argument rooted deeply in the false assumption of an incongruence between health and wealth and a message further enflamed by partisan rhetoric.

Political Motives

On October 2, 2020, the United States House of Representatives Select Subcommittee on the Coronavirus Crisis (Subcommittee) released a staff analysis document outlining a minimum

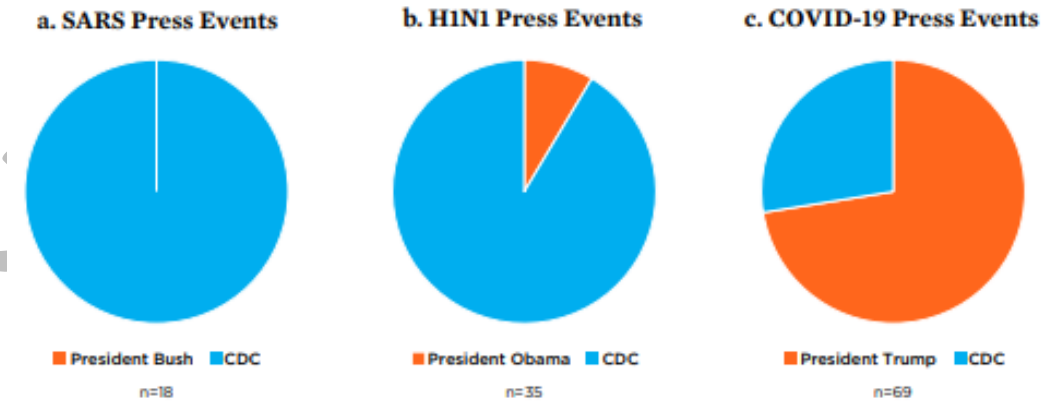
of 47 different instances of political interference by the Trump administration which served to directly degrade the quality of the U.S. pandemic response. The first clash between Trump and scientific experts documented in the analysis was on February 25, 2020 when Dr. Nancy Messonnier, Director of the CDC's Center for Immunization and Respiratory Diseases, spoke candidly of the potential for the novel coronavirus to substantially impact American life and was met with threats of being fired and an almost immediate walk-back of her comments by then-Secretary of HHS Alex Azar (Select Subcommittee on the Coronavirus Crisis, 2020). Dr. Rick Bright, a Whistleblower and the former Director of the Biomedical Advanced Research and Development Authority was demoted from his position and eventually resigned after being openly critical about shortcomings in the Administration's response (Rutledge, 2020). The exit or burnout of leading experts within or adjacent to the Administration was a theme that continued throughout Trump's tenure.

In April, already impatient with the impacts of COVID-19, Trump declared the virus threat would be eliminated by Easter – April 12, 2020 (Rutledge, 2020). This claim was unsubstantiated by the CDC or WHO. Trump responded by tweeting to his followers "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). This was met by the WHO's Director pleading that "the focus of all political parties should be to save their people", not politicize COVID-19 (Rutledge, 2020). On April 14, 2020, the Administration halted all U.S. funding for the WHO (Rutledge, 2020). By May 29, Trump had announced the U.S. would be entirely severing its relationship with the leading global response partner – a relationship formerly upheld since 1948 (Gostin et al., 2020).

In its entirety, the U.S. response was characterized by an unprecedented sidelining of science and factual expertise. Beginning in the very early days of COVID-19 in the U.S., the Administration ordered that all federal scientists' communications intended for the public be cleared by the White House before dissemination, restricted top-level experts from appearing independently across various media platforms, and barred HHS expertise from entering the room during crucial White House COVID-19 meetings (Desikan et al., 2020). Despite COVID-19 amassing far more cases in the U.S. than its predecessors SARS and H1N1, CDC-led briefings on the crisis were significantly reduced (Desikan et al., 2020). Figures 3 and 4 below from Desikan et al. (2020) on behalf of the Center for Science and Democracy, Union of Concerned Scientists illustrate the distribution of presidential and CDC-led briefings on major health events for the past three Administrations, as well as the timing of decline in briefings as the COVID-19 pandemic progressed.

Figure 3

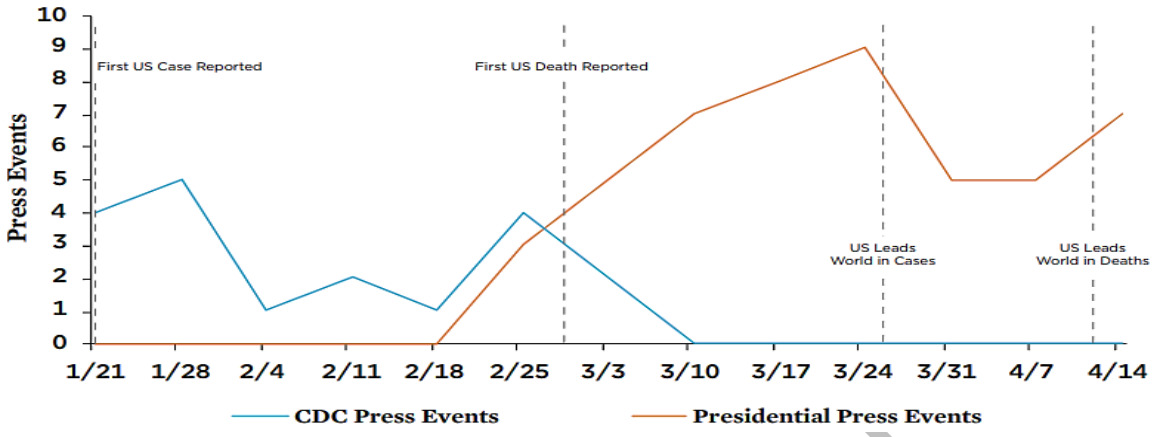
Distribution of Presidential vs. Expert-Led Briefings Over Three Administrations



Note. During 2020, the Trump Administration held nearly 3x as many briefings on COVID-19 as the CDC, a major reversal as compared to previous Administrations (Desikan et al., 2020).

Figure 4

Decline in Expert-Led Briefings on COVID-19



Note. The decline in expert-led briefings on COVID-19 was initiated soon after the first case was reported in the U.S. By March 2020, CDC briefings on the crisis were non-existent.

In the midst of the testing crisis of March and early April 2020, the Subcommittee reported that the Administration deliberately abandoned a national testing strategy in favor of using the opportunity to place blame on governors in Democrat-led states (Select Subcommittee on the Coronavirus Crisis, 2020). Several other instances of partisan-fueled malfeasance occurred as follows:

- In May 2020, after pushing for states to reopen prematurely, the Council of Economic Advisors published a projections chart grossly misrepresenting the forecast for deaths from coronavirus and the White House altered CDC guidance on faith gatherings (Select Subcommittee on the Coronavirus Crisis, 2020).
- In July, Trump installed multiple political appointees to positions at the FDA typically filled by nonpartisan civil servants (Select Subcommittee on the Coronavirus Crisis, 2020).

- In August, Trump elevated Dr. Scott Atlas, a radiology specialist with no background in epidemiology nor infectious disease, to the position of adviser to the Administration (Cook, 2020). Atlas was previously well-known for his echoing of Trump's push for reopening and downplaying of the virus (Cook, 2020).
- In September, the Administration attempted to delay and retroactively modify results published in the CDC's premier publication *Morbidity and Mortality Weekly Report* (MMWR) (Viglione, 2020).

These represent only a fraction of the efforts to manipulate and infuse partisan rhetoric into the U.S. response. Not only did these actions spark outrage among the scientific community, but they also took a severe toll on the already weakened credibility of public health institutions in the eyes of the public. Moving forward similar efforts to apply political pressure to the scientific landscape were seen in regard to treatments and eventually the approval of a vaccine for COVID-19 (Viglione, 2020).

As described in *The Death of Expertise* by political scientist Tom Nichols (2017):

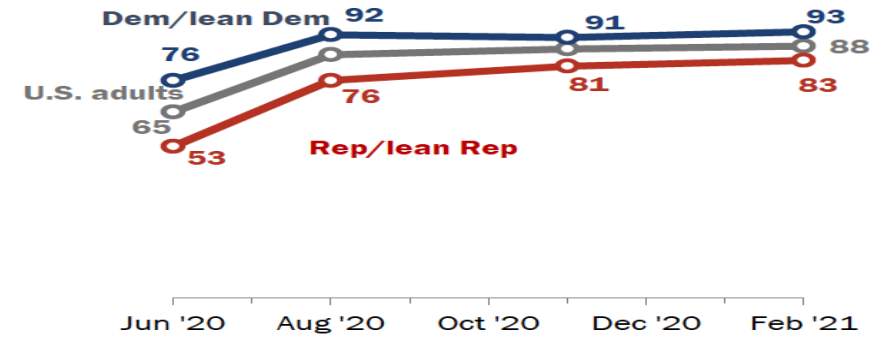
> This rejection of science and of expertise [has] become [a] demonstration of political loyalty. That's the part I didn't expect — that there would be an entire political movement, led by the president of the United States, to basically disavow science.

The dismantling of trust in science on partisan lines was initiated long before the start of the COVID-19 pandemic. A study published in the Lancet Commissions suggested that the seeds for this political shift and weakening of the government's role in health were sown decades before Trump's ascent (Woolhandler et al., 2021). Concordantly, the backlash of Trump's base against what he defined to be the liberal extremist mindset have largely defined public opinion related to

coronavirus. According to the Commission, approximately 40% of U.S. deaths may have been averted had the nation's death rate mirrored the average of other G7 nations (Woolhandler et al., 2021). As a comparison, fellow G7 nation France is ranked fourth in world for COVID-19 cases, but still maintains 6x fewer cases than the U.S. and a similarly lower rate of deaths (JHU, 2021). Although systemic issues related to the U.S. health care system should be accounted for in interpreting this figure, the unprecedented misalignment of the 2020 Administration's political rhetoric with scientific recommendations such as social distancing and mask wearing must be considered when evaluating the nation's catastrophic COVID-19 mortality count. In further support of the influence of political rhetoric on public behavior and opinion, Gollwitzer et al. (2020) confirmed that partisan differences in social distancing practices were associated with high infection and fatality rates in counties that were predominantly pro-Trump. Figure 5 and 6 below from the Pew Research Center (2021) illustrate the differences in mask-wearing behavior and view of various response officials by political affiliation.

Figure 5

Partisan Differences in Mask-Wearing Behavior

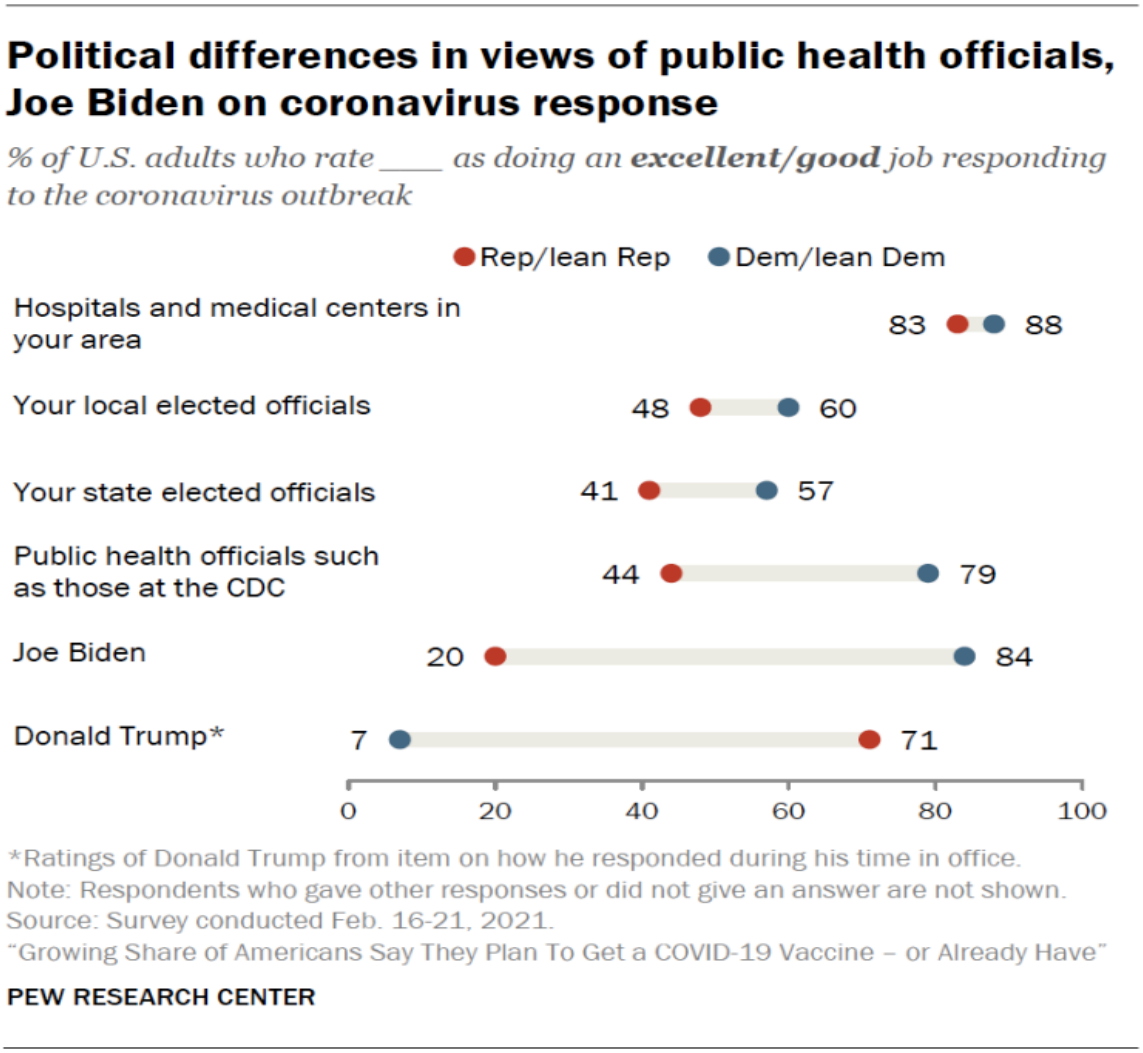


Note: Respondents who gave other responses or did not give an answer are not shown.
Source: Survey conducted Feb. 16-21, 2021.
"Growing Share of Americans Say They Plan To Get a COVID-19 Vaccine – or Already Have"

PEW RESEARCH CENTER

Figure 6

Partisan Differences in Views of Various Officials on Coronavirus Response



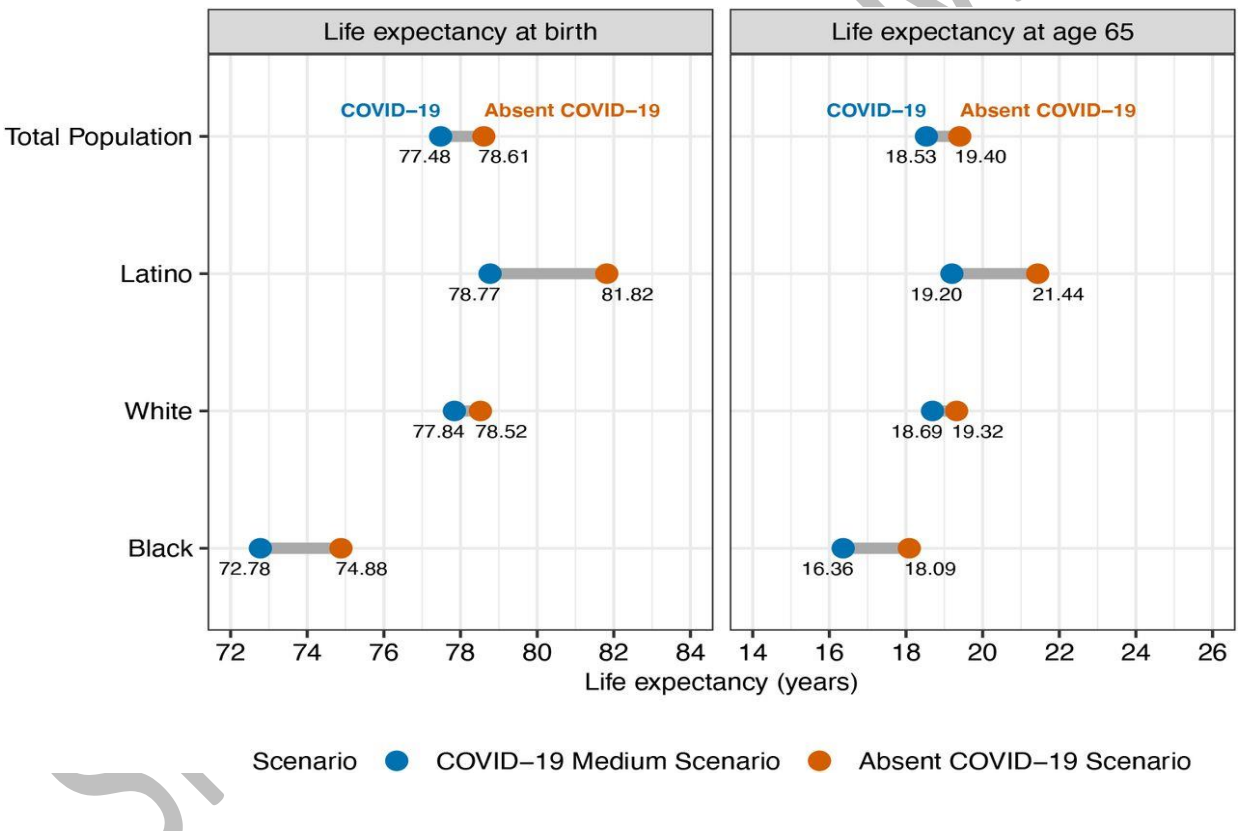
Socioeconomic Impact and Disparities

The onset of COVID-19 in the U.S. illuminated and exacerbated the extent of racial and socioeconomic disparities in health. Even prior to the pandemic, the U.S. was facing a rise in excess deaths, a widening gap in life expectancy as compared to other industrialized nations, and a general decline in overall health (Woolhandler et al., 2021). However, COVID-19 is projected

to increase the Black-White gap in life expectancy by at least 39%, in addition to reducing the Latino longevity advantage over White populations by over 70% (Andrasfay & Goldman, 2020). Figure 7 from Andrasfay and Goldman (2020) illustrates the reduction in life expectancy for each group based on the medium scenario projections provided by the Institute for Health Metrics and Evaluation as of October 9, 2020.

Figure 7

Projected Changes in Life Expectancy with the Presence and Absence of COVID-19



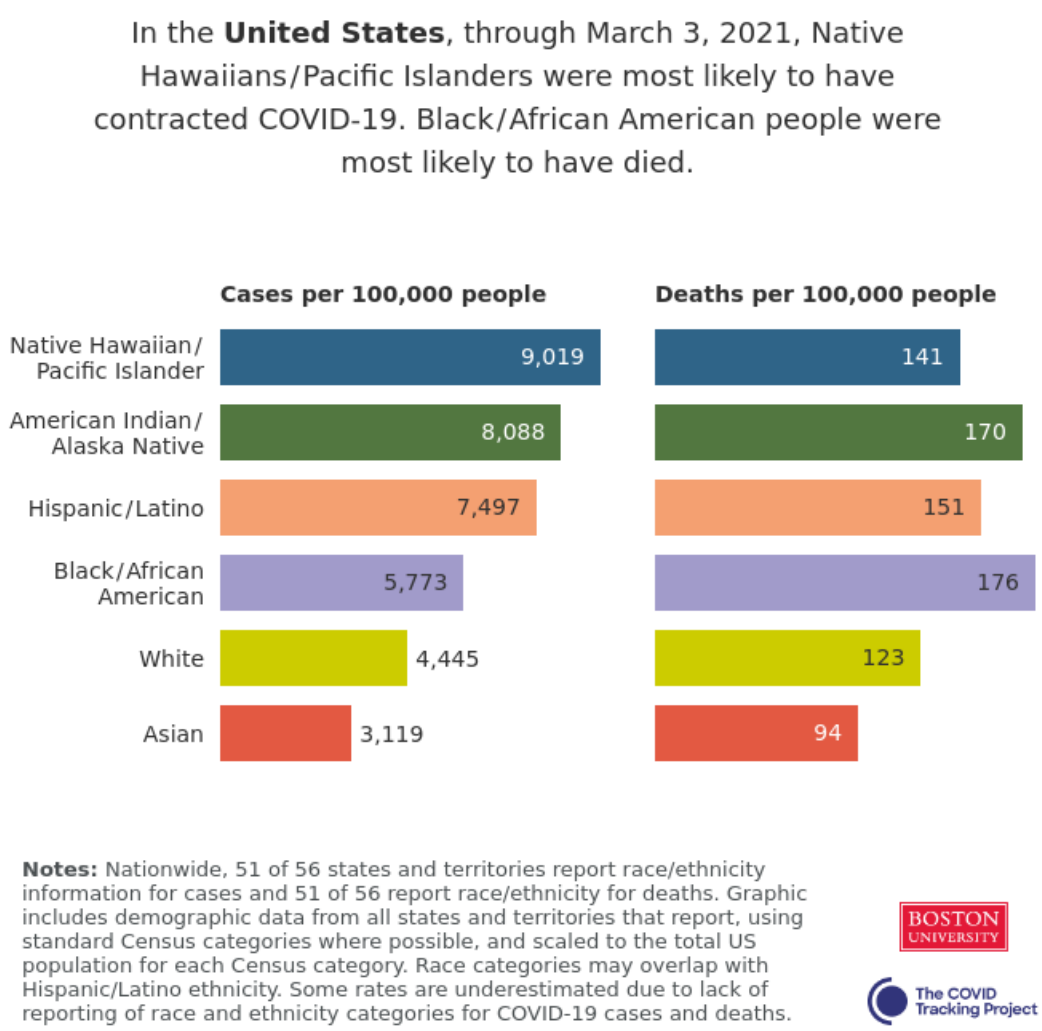
Trump's platform of race-bait political rhetoric and weakening of federal roles in health has led to a worsening of income and place-based disparities (Woolhandler et al., 2021). During his tenure, he implemented wide ranging cuts to social programs such as Medicaid; sensationalized the adoption of anti-immigrant policies using denigratingly racist language; and

in the midst of COVID-19, fueled anti-Asian sentiment by repeatedly referring to COVID-19 using terms such as the "Chinese virus" or "Kung Flu" (Woolhandler et al., 2020). On a more foundational level, the early Administration rollbacks of the ACA resulted in a decline in health care coverage for Latinx and Native peoples of over 1.6% (Woolhandler et al., 2020) – an effect only further exacerbated during COVID-19. Additionally, the influence of anti-immigrant sentiment has had a demonstrable impact on care-seeking attitudes related to management of chronic diseases that put one at an increased risk of poor outcomes from COVID-19 (Woolhandler et al., 2020). On the basis of the Administration's ruthless immigration policies, deportation of detained migrants continued in the midst of COVID-19 and it is reported that by November 2020, more than 7,000 individuals had contracted the virus at these facilities (Human Rights Watch, 2021).

For decades, Black Americans have shouldered the highest unemployment rate of all racial groups in the U.S., followed by Latinx individuals (Bureau of Labor Statistics (BLS), 2019). Of those employed, Blacks and Latinx populations also make up the most significant portion of service occupations (BLS, 2019) – ones in which they may be routinely exposed to COVID-19 through their designations as essential workers, and subsequently less able to step down from employment for risk of further economic hardship. While early relief packages passed by Congress provided short-term alleviation to these inequities, they also excluded certain facets of the workforce, including immigrants (Human Rights Watch, 2021). For years, experts in the field of public health have recognized the depths of social inequality and its capability for creating catastrophic health outcomes for minority populations. Yet, under the Trump Administration these dire warnings went unheeded. Figure 8, from The COVID Tracking Project (2021), illustrates the dire disparities between cases and mortality from COVID-19.

Figure 8

Distribution of Cases vs Deaths by Race/Ethnicity



The failure to implement a national testing strategy in favor of political gains left marginalized communities without access to crucial services. Despite briefly discussing the dedication of funds to community health centers aimed at reaching underserved communities in the CARES Act, Trump's response was largely aimed at ensuring minority votes rather than minority health (Vasquez, 2020). Amidst the testing crisis, Trump expressed on several

occasions that “We have got the greatest testing program anywhere in the world” and to “Slow the testing down, please,” while people of color continued dying at disproportionate rates from COVID-19 (Forgey, 2020). When asked about the disparities in rates of COVID-19 infection in Black Americans, Surgeon General Jerome Adams suggested it was more-so a matter of personal irresponsibility than systemic inequality, stating “We need you to understand, especially in communities of color. We need you to step up and stop the spread so that we can protect those who are most vulnerable” (Bunn, 2020).

In June, amid mounting pressure to do so, the Administration released guidelines requiring states to report demographic data on COVID-19 numbers (Weiland & Mandavilli, 2020). HHS asserted that this data would provide crucial insight and assistance with contact tracing and resource allocation (Weiland & Mandavilli, 2020). However, this directive gave states another two months until they were required to do so and left many questioning the integrity of the data that were eventually provided after an updated directive indicated states should bypass the CDC and report their data directly to HHS (Weiland & Mandavilli, 2020).

A thorough evaluation of the U.S. response disparities must consider all dimensions of policy inequity. A recent study in *JAMA* found that race itself was not entirely indicative of higher levels of COVID-19 incidence and mortality (Liao & De Maio, 2021). In areas where income inequality was high, race had a weaker correlation with incidence and mortality (Liao & De Maio, 2021). Therefore, the impact of social policies relating to workplace, minimum wage, federal relief, etc. and the systemic, often race-based inequities perpetuated through them may have proven just as important to addressing COVID-19 in the U.S. as direct health policy. Notably, counties in states that had opted in to expanded Medicaid under the ACA had an average of 32% lower infection rates (Liao & De Maio, 2021). This was not found to be

associated with state-level politics (Liao & De Maio, 2021), which may in fact be a result of the reduction in public association of Medicaid expansion with the Obama Administration and the ACA (Ollove, 2019) –remnant proof of the effects of partisanship on health.

Vaccine Logistics

On September 16, 2020, the Trump Administration released their COVID-19 vaccine distribution strategy to the public (HHS Press Office, 2020). The plan outlined four key tasks for successful implementation:

- Engagement with various state, tribal, territorial, local stakeholders as well as the public to effectively communicate information about the vaccine to promote uptake.
- Immediate distribution of vaccine following Emergency Use Authorization (EUA) by the FDA using a transparent phased methodology.
- Ensure safe administration and availability of all supplies necessary.
- Monitor distribution, administration, and other data on the outcomes of vaccination program.

After months of mounting rhetoric touting a vaccine before the November 2020 election, the first EUA was granted for the Pfizer-BioNTech COVID-19 vaccine on December 11, 2020 (FDA, 2020). Seven days later, the Moderna COVID-19 vaccine was also approved for an EUA (FDA, 2020). Both vaccines validated the application of messenger RNA (mRNA) technology and utilized a two-dose series to achieve efficacy of over 90%.

The Trump Administration made a promise of vaccinating 20 million Americans by the end of 2020. Days into 2021, little over four million had received a dose (Patel, 2021). It became increasingly apparent that states, while being provided guidance, were not receiving the logistical

support necessary from the Federal government to fulfill the Administration's promise. On January 12, 2021, the Operation Warp Speed released new guidance aimed at speeding up the pace of vaccinations (Simmons-Duffin & Huang, 2021). Deviating from CDC recommendations, the Administration called on states to immediately expand eligibility to those 65 and older or with underlying conditions (HHS, 2021). Most notably, the new recommendations also noted that vaccine allocation to states would be partially based on the pace of vaccine administration reported (HHS, 2021). Finally, the Administration announced they would immediately be releasing all vaccine doses from the strategic national stockpile (SNS), rather than withholding second dose amounts (HHS, 2021). In turn, states prepared to receive substantial increases in supply to address issues. However, days after the announcement it was revealed that the release had already taken place the week prior – there were no reserve doses left to distribute to states (Ingram, 2021). Despite this drastic miscalculation, officials continued to emphasize that the rollout was "flawless" on the part of the federal government and instead stated that state management was causing the backlog (Simmons-Duffin & Huang, 2021). On January 19, 2021, one day before the Trump Administration vacated the White House, the U.S. death toll from COVID-19 topped 400,000 and vaccinations remained short of 20 million (Geller & Har, 2021).

Political Transition

On his first full day in office, the Biden Administration released a 200-page comprehensive national strategy for addressing COVID-19. In addition to scaling up COVID-19 mitigation efforts, the plan specifically addressed restoring trust, addressing disparities, and strengthening preparedness infrastructure against future threats (The Biden Administration, 2021). The Administration made a commitment to strengthening global health partnerships by vowing to rejoin the WHO, join the COVAX global vaccine initiative, and launch a National

Center for Epidemic Forecasting and Outbreak Analytics (The Biden Administration, 2021). As part of his election platform, Biden promised Americans 100 million vaccinations by his 100th day in office. By January 27, 2021, the Administration had announced plans to increase vaccine supply by 50% through acquisition of 200 million more doses (AJMC, 2021). On February 1st, the U.S. reached a historic milestone with more individuals vaccinated (26.5 million) than had been infected (26.3 million) (AJMC, 2021). In March, Biden announced the country was on track to have vaccines available to every U.S. adult by May 2021 (AJMC, 2021). On March 19th, 2021, Biden's 68th day in office, the U.S. reported 100 million COVID-19 vaccinations administered (AJMC, 2021).

Perhaps the most drastic reversal in the U.S. COVID-19 response under the Biden Administration was a re-alignment with scientific recommendations and reemergence of experts to the forefront. Dr. Anthony Fauci was appointed as the White House's Chief Medical Adviser, Dr. Marcella Nunez-Smith was chosen to spearhead the newly created COVID-19 Health Equity Task Force, and Dr. David Kessler, former head of the FDA, was charged with overseeing the vaccination program. Additionally, publicly broadcasted scientific briefings from these experts resumed one week after the Biden Administration took office. As is the nature of infectious diseases, the political transition itself did not result in an immediate stifling of the virus. On February 22, 2021, under the Biden Administration, the U.S. crossed 500,000 deaths from COVID-19 (Hollingsworth & Weber, 2021). However, from the transition the U.S. has seen a new age of pandemic response – one guided by science and rooted in transparency.

In the context of politics, the Biden Administration has rejected the partisan rhetoric previously instilled by the former Administration. However, the lasting effects of the 2020 Administration's messaging have had direct consequences on vaccine attitudes. A 2018 study

found that conservative political ideology was associated with a reduced likelihood of expressing pro-vaccination beliefs (Baumgaertner et al., 2018). Concurrently, a Cornell University study revealed that media mentions of Donald Trump himself accounted for nearly 38% of the misinformation surrounding COVID-19 (Evanega et al., 2020). At this stage in the vaccination rollout, the U.S. is beginning to see the effects of this partisan divide, with polling from the Pew Research Center (2021) indicating that Democrats are 27% more likely than Republicans to get or to have already gotten the COVID-19 vaccine.

CONCLUSION: THE PATH FORWARD

In its entirety, the U.S. response was an alarming representation of the influence of politics on public health. With over 500,000 lives lost to COVID-19, this paper asserts that the acknowledgement of the exacerbation of the pandemic by the 2020 White House Administration is crucial to ensuring a preventable catastrophe of this magnitude is never again allowed to occur. Through healthcare, budget allocations, as well as social policy, the Trump Administration systematically weakened U.S. public health systems. Through political rhetoric, the Administration directly influenced the spread of COVID-19 by way of deterring crucial preventive measures such as mask wearing and social distancing and denigrating trust in public health officials.

This review relied on a variety of scientific literature, government documents, surveillance sources, and media reporting to inform conclusions. The scope of this review is potentially limited by the data and documents available at the time of writing, which is an inherent limitation when assessing policy. Additionally, it should be emphasized that methods did not involve rigorous statistical analysis or experimentation. Therefore, the results of this review should not be extrapolated as causal. Lastly, due to the ongoing nature of the COVID-19

pandemic, it is likely that true estimates of the case and death burden in the U.S. in 2020 will not be available until beyond the scope of the crisis. In spite of these limitations, the information synthesized here serves as a crucial attestation to the effects of multi-level policy and political rhetoric on the U.S. COVID-19 response in 2020. As such, the conclusions provided here are essential to guiding the rehabilitation of public health in the U.S.

As the U.S. begins to navigate out of the pandemic, the lasting effects of the Trump Administration's actions continue to threaten the nation's ability to achieve wide-scale vaccination coverage. In addition, the reestablishment of public trust in major institutions of scientific expertise including the CDC, FDA, and WHO, will likely take years if not decades. Moving forward, each aspect of the 2020 response effort serves to inform the future of public health infrastructure. The following are recommendations for action and topics for future study based on the findings of this assessment:

- Acknowledge and invest in preparedness efforts for emerging epidemic threats.
- Evaluate the resiliency of our healthcare system to handle disruptive health events.
- Define a national system of public health governance.
- Invest in the formation or continuation of global health partnerships.
- Create a systematic process for identifying, documenting, evaluating, and addressing disparities in health.
- Cultivate working partnerships between local, state, and community health organizations.

The COVID-19 response illuminated the ways in which the current ambiguity around structures of governance in public health is unacceptable. While the presidency of Donald Trump was invariably unprecedented, we must ensure that our public health systems are never again left

so exposed to the variance of political motivations. Institutions of scientific expertise must be allowed the funding and coordination necessary to ensure independent functioning and subsequently, to uphold the health of the nation. Current trends in budget allocations under the Biden Administration are promising, but in order to truly build back the reputation of public health, action must be taken to assure these changes persist.

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