

**WHEN POLITICS TRUMPS SCIENCE: HOW POLICYMAKING DURING COVID-19
FOLLOWED POLITICS RATHER THAN SCIENCE**

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ABSTRACT

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The COVID-19 Pandemic disrupted life around the world and tested each country's ability to mobilize its medical resources, scientific expertise, and political efficiency. The United States stood out among the international community for its inadequate response that seemed to be hampered by political partisanship and reluctance from the President himself to follow scientific evidence. As the American people inch toward herd immunity and the chance for "normal life" again, we must reflect on the COVID-19 Pandemic's mishandling. This paper aims to recount and describe how partisan politics marginalized the role of scientific judgment and empirical evidence in policymaking during the COVID-19 pandemic. Additionally, it aims to answer the question of how the Trump administration overruled the evidence-informed opinions of U.S. federal scientists during the policymaking process. This paper takes an analytical approach to describing how U.S. scientific authorities succumbed to political pressure and opposition when the country faced the greatest public health crisis in a century. This project will describe the influence of the Trump administration on COVID-19 policymaking. It will explore how the Trump administration convinced federal, state, and local policymakers to discount and disregard the evidence-based opinions of public health officials. In other words, I will collect and analyze new observations on the relationship between political and medical authorities. After conducting this analysis, this paper finds that the United States' highly politically polarized environment enabled the Trump administration to overcome evidence-based opinions from U.S. public health experts. These outsized influence politics played in the U.S. should inform future pandemic preparedness planning.

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Introduction

At the beginning of 2020, The United States appeared prepared to respond to future public health emergencies. The Global Health Security Index rated the United States the best-prepared country to encounter a public health emergency should one arise. The Index ranks countries according to their ability to respond to a public health emergency and its ability to treat “the sick and protect health workers,” (GHS Index 2019). Shortly after its publication, the novel Coronavirus would challenge the report’s claims and ultimately negate them.

Despite high expectations, the United States has demonstrated a weak response to the COVID-19 pandemic. As of March 2020, the US accounts for less than five percent of the world’s population (U.S. Census Bureau, 2021). At the same time, a quarter of worldwide COVID-19 cases are within its borders (Johns Hopkins Dashboard 2020). Out of the twenty countries with the direst COVID-19 situations, the US has the fourth-highest deaths per capita figure (Johns Hopkins Dashboard 2020).

However, facts and figures do not fully capture the degree to which America failed to respond to COVID-19. The US’s lackluster statistics could not communicate what personal stories and images have. A shortage of personal protective equipment left frontline healthcare workers defenseless (Emanuel 2020). Pictures showed nurses without proper PPE and makeshift hospitals quickly built for patients when hospitals were full (Alltucker 2020 and “The United States Leads” 2020). Moreover, stories of fighting between scientists and elected officials raised anxiety and uncertainty about the US’s situation. These stories added some details to the US’s quantifiably inadequate response. Strung together, these stories told the world that America’s public health workforce was depleted, its infrastructure beyond full capacity, and a house

divided. How could a country topping the world's list of nominal GDP fail on such a scale? (Silver 2020).

The gap between expectation and reality calls the actions of the US government into question. Although no country was sufficiently prepared for a global pandemic according to many, the United States failed, and it failed to a greater extent than it should have. While the pandemic is still going on, we need to reflect on the US COVID-19 response. We are now reflecting on not only the unprecedented public health emergency as a country but also the failure of federal leaders to respond adequately and prevent the crisis within America's borders. Times of national emergency call on elected officials to mobilize the nation's expertise and resources and implement effective policy to combat human suffering. In particular, the politicization of the pandemic deserves attention, especially regarding its handling by the U.S. Executive Branch. How did the Trump administration influence policymakers to marginalize the role of scientific expertise and evidence-informed opinion in Public Health Emergency decision-making?

The outsized influence of political actors on policymaking and citizens' perceptions of the COVID-19 pandemic deserve to be evaluated. The current literature on pandemic preparedness and response does not address the influence of political capability on mounting an effective pandemic response. This project aims to highlight the ability of the President's political objectives to severe public trust in empiricism, science, and their elected leaders. Further, this analysis seeks to call attention to the absence of standards for evidence-collection and inclusion in policy. It also proposes that U.S. government officials and the American public adopt a new understanding of public health as a national security issue that will become more important as the world becomes more globalized. By analyzing the mishandling of the COVID-19 pandemic

in the U.S., this paper will identify the ways by which the country's President convinced American citizens and government leaders to align COVID-era policies with political goals rather than community well-being. The final part of this paper examines the consequences of politicizing the pandemic and offers recommendations for handling the next disease outbreak in the US or abroad.

Methods

This paper takes an analytical approach to describing how U.S. scientific authorities succumbed to political pressure and opposition when the country faced the greatest public health crisis in a century. This project will describe the influence of the Trump administration on COVID-19 policymaking. It will explore how the Trump administration convinced federal, state, and local policymakers to discount and disregard the evidence-based opinions of public health officials. In other words, I will collect and analyze new observations on the relationship between political and medical authorities.

To achieve these objectives, I collected and surveyed secondary and primary qualitative data. To accurately recount the events occurring from January to September 2020, I compiled news articles from publications considered neutral and fact-based (Pryor 2020). I collected articles reporting events regarding the Trump Administration's approach to responding to COVID-19. News articles sourced most information about what occurred in the U.S. during 2020, and primary government documents sourced information regarding the activities, policies and communications of government officials and agencies. To inform my analysis, I searched for and collected peer-reviewed, journal articles discussing public health, politics, evidence-based

policymaking, government crisis response, public health communication, executive power during a health crisis, and many other topics.

I decided to first conduct a contextual analysis of the US leading up to the country's first case of COVID-19. After this, I constructed a timeline of events that detailed the federal government's policy response to the pandemic. Particularly, I examined the timeline to discern when prevailing evidence did or did not inform policies and communication at the federal level. I analyzed the timeline to make observations about the role of science in federal policymaking. This aimed to identify prevalent themes in how politics overpowered science in policy.

These components of analysis provide the most effective approach to answering my research question and objectives. Examining the role of scientific expertise and evidence in federal policy requires a description of politics, public health, and crisis policymaking in the U.S. prior to 2020. This context facilitates a thorough assessment of how the pandemic played out in the U.S. Constructing a timeline establishes who knew what when. The timeline also serves as an objective description free from hindsight bias that lead some to make unfair judgments on policymakers' decisions. The American public and its leaders, in 2021, now have a much better understanding of the coronavirus and its characteristics.

Part 1: A Configuration of Factors

Chapter 1: The State of Public Health in the U.S.

The state of the US public health infrastructure met the novel coronavirus unprepared and under-resourced. By design, the US decentralized system of government distributes public health

authority among the federal, state, and local governing bodies. The greatest amount of power to direct public health activities for the public's protection lies at the state and local level, as states determine what is in the best interest of their populations. The tenth amendment reserves police power to state governments. This tiered power system puts power in the hands of those closest to the community which they govern, and citizens often trust their local officials more than distant elected officials in Washington D.C. However, this style of governance gives rise to a public health system that differs greatly from state to state. States prioritize public health insofar as their governing officials, acting in the interest of their constituents, care to direct resources to the system. Only state governors may implement restrictions regarding public health such as quarantines and business closures.

Federal agencies within the executive branch have duties and roles within the country's public health infrastructure. Federal public health authorities exist within the executive branch under the Department of Health and Human Services (HHS). The President of the United States appoints the HHS Secretary, who wields considerable power over the department's activities. HHS includes eight U.S. Public Health-oriented agencies ("HHS Family" 2021). An evaluation of each agency and its structure is outside the scope of this paper. Still, a few HHS agencies wield considerable influence over the US effort to protect and promote public health.

Powers over citizens during a public health emergency (PHE) largely resides with the states. The federal government, however, maintains some power over public health insofar as it affects interstate commerce. The Public Health Service Act awards HHS the power to design and enforce measures to "prevent the introduction, transmission, and spread" of infectious diseases into the country (Public Health Service Act 1944). The federal government also, at any time, has

the responsibility to protect America's borders, and can evoke emergency powers if needed. In a PHE, the federal government coordinates the nation's response.

The Centers for Disease Control and Prevention exists within HHS and functions as the U.S.'s premier disease surveillance and prevention organization. The CDC functions as the country's premier disease control and prevention agency. The CDC's role in public health has grown over the years as SARS, H1N1, and Ebola knocked on the country's door. Now, individuals and governments look to the CDC for information about health and data regarding the health of America's population.

The Federal Drug Administration (FDA) and National Institutes of Health (NIH) represent two other notable organizations within HHS with respect to public health. Like the CDC, the FDA aims to promote sound public health strategies. However, the FDA's primary role lies in its regulation of medicines and medical technologies. The FDA oversees other consumer products such as tobacco and cosmetics, but its role in public health emergencies relates to its duty to deem drugs and vaccines safe and effective. The National Institutes of Health (NIH), another HHS agency, represent the leading organization for "conducting and supporting medical research" ("About the NIH" 2015). These agencies all operate under the supervision of the presidential administration occupying the White House. The president appoints the leaders of these organizations and, effectively, maintains some influence over their priorities.

Following the 2008 recession, public health agencies and departments at all levels of government suffered a divestment of funds. The great recession in 2008 led policymakers to prioritize nursing the economy back to health. This course of action caused a great divestment from public health. Since the recession, "at least 38,000 state and local public health jobs have disappeared," (Barry-Jester et al., 2020). Murthy et al finds that between 2002 and 2014,

“funding for public health as a share of overall health spending” declined from 3.18% to 2.65% (2017). A fragmented public health system under constant threat of divestment hinders pandemic preparedness.

The Trump administration further dismantled U.S. public health efforts and organizations from the beginning of his Presidency. By signing the Tax Cuts and Jobs Act in 2017, Trump cut \$750 million from the CDC’s Prevention and Public Health Fund (Tax Cuts and Jobs Act 2017). In May of 2018, the Trump administration removed Admiral Timothy Ziemer, the leader of the National Security Council’s global health security team (Yang, 2020). This removal impeded the US’s capacity to respond to the next pandemic since Ziemer had been charged to lead that effort in the event a pandemic befell the country. President Trump stood by his actions to divest from public health and pandemic response planning saying “I don’t like having thousands of people around when you don’t need them. When we need them, we can get them back very quickly,” (Friedersdorf 2020).

Despite hits to its funding and workforce, the CDC persisted in developing pandemic preparedness plans and expanding its disease surveillance overseas. The CDC took the lead in the aftermath of SARS, Ebola, and H1N1 to bolster the country’s preparation for the next novel disease. In 2011, the CDC published a National Public Health Preparedness Standards as a guide for state and local health departments in the event of a public health emergency (PHE) (“Public Health preparedness capabilities”, 2011). A review by Murthy et al. found that the US had made progress in state and local self-reported preparedness between 9/11 and 2016 (Murthy et al. 2017). Nevertheless, the report highlighted concerns of local and state health departments. Local and state officials reported their significant challenges to enhancing Public Health Emergency

Preparedness (PHEP): “lack of trained personnel, plans, and sustained resources” (Murthy et al., 2017).

Public health authorities at all levels assume greater responsibilities when a public health crisis begins looming. The executive branch, however, wields greater power over the country in times of crisis. The Secretary of Health and Human Services (HHS) may issue a public health emergency (PHE) under the Public Health Service Act (PHSA). This declaration enables the Secretary to assume powers he or she otherwise would not have.

Presidents may declare national emergencies under either the National Emergencies Act or the Stafford Disaster Relief and Emergency Assistance Act. The National Emergencies Act (NEA) of 1976 grants the President over one hundred additional powers. More importantly, Presidents may mobilize resources directly to states in an overwhelming emergency (Brennan Center 2020).

Chapter 2: The U.S. Political Climate

Public health activities depend on support from Congress which is charged with responding to problems through enacting legislation. The policymaking process, thus, represents an important dimension of the US’s public health capabilities. The legislative branch of government responds to the nation’s problems in a slow, deliberate manner.

An increasingly polarized political climate has hindered the productivity of the legislature and its ability to respond to the country’s greatest issues. The growing adherence to political ideology by Congressmembers has stifled its ability to implement policy favored by their

constituents. These constituents increasingly associate trust with those who adopt the same political ideology.

Partisanship has become a dominant heuristic for Americans outside of their decisions on the ballot. Since the election of Donald Trump in 2016, the US political climate has become more polarized (Abramowitz, 2010 and Iyengar et al. 2012).

Importantly, this polarization has emboldened political leaders to act as ideologues rather than pragmatic representatives of citizens' needs. This "elite polarization" drives the public to fall in line with their ideological separation, even when it is irrational. Druckman et al. defines elite polarization as "elected representatives and activists from the major parties have become more ideologically distinct from one another and more internally homogeneous" (Druckman et al., 2013, pg. 57). In particular, elite polarization affects how Americans form and develop opinions of the country's greatest issues by "stimulat[ing] partisan reasoning" which "generates decision making that relies more on partisan endorsements and less on substantive arguments" (Druckman et al., 2013 pg. 57).

The rise of social media platforms has ushered in an unprecedented information revolution that exacerbates the polarization of public opinion. The internet and social media platforms accelerated the spread of misinformation about all topics. "Fake news" flooded the online space making it difficult for some to distinguish what is true and what is not. Americans are increasingly placing an emphasis on the source of any news instead of the science, evidence, and facts of the story (Funk et al. 2017)

At the same time, the country has been experiencing another political trend: populism. Like many countries around the world, a wave of populism has caught many Americans who are growing increasingly frustrated with what they perceive as "the establishment." Populism

inherently sows distrust of elected officials and other bureaucrats who become, in the eyes of populist leaders, the “establishment” that is beholden to special interests.

This rise in populism is embodied in the surprising election of Donald Trump—a TV character with no formal political experience. Trump capitalized on the country’s frustration with inefficient, unresponsive governance and portrayed himself as an anti-establishment, anti-elite candidate fighting for the interests of regular, American folks. Trump demonized politicians to a great extent, but he villainized the “mainstream media” even more. He sowed doubt about reputable media outlets such as the New York Times and CNN. He fueled partisan-linked mistrust of the Democratic party, and that mistrust only grew after his election in 2016 (Funk 2020).

The combination of polarization and populism poses a grave threat to the policymaking process that has recently begun to call for more evidence inputs in the policymaking process.

Evidence-based policymaking (EBP) sought to bolster the country’s data collection and, subsequently, use empirical evidence to design policies best-suited to address important issues. This strategy is especially relevant to public health, as its successes and shortcomings can be measured and gathered as evidence. Evidence-based policymaking (EBP) grew out of an earlier movement that advocated using evidence to guide clinical decisions (Lancaster, 2020). During the 1990s, the Evidence-Based Medicine (EBM) movement became the paradigm for medical decision-making. The popularity of evidence-based decision-making (EBDM) spread to other sectors, especially policymaking. This ethos of EBDM permeated the health policy sector, as legislators and researchers saw a great advantage to this strategy for improving American citizens’ health.

EBP relies on the ability of science to communicate reliable findings to decision-makers. Successful evidence-based policies depend on the quality of evidence imparted by science and, even more so, policymakers' willingness to incorporate that evidence into legislation. In 2016, the U.S. Congress passed the Evidence-Based Policymaking Commission Act of 2016, which formally created a commission to "examine methods for increasing the availability and use of data that could be used to evaluate the effectiveness of government programs" (Evidence-Based Policymaking Commission Act 2016). The commission explained their findings in a 2017 report and ultimately recommended applying good scientific evidence to inform government decisions.

The commission's report led to the Evidence-Based Policymaking Act, passed by Congress in 2018. This legislative measure calls upon federal organizations to improve how they acquire and examine evidence. In effect, the Act requires federal agencies to create a position dedicated to evidence-based decision making, "establish an architecture for policy development and coordination of information across the federal executive branch," and "establish a framework and governing principles for the collection and use of data by the federal agencies," (Kane 2019 pg. 809). In sum, the law creates more space for "the public and nongovernmental experts to inform policy development and program operation at the federal level" (Kane 2019 pg. 809).

While EBP has produced beneficial rules and regulations, the idea that sound evidence will underpin most health policies is misguided. In reality, policymaking does not rely primarily upon, or even secondarily, data and research. According to Brownson, individuals mistakenly believe in the primacy of research evidence (Brownson 2009). They forget he postulates, the decisive influences on policymakers, such as their "values and competing sources of information,

including anecdotes and personal experience” (Brownson 2009 pg. 177). Unfortunately, the nature of politics tames the power of research evidence as “policies are often driven by ideology and biases rather than evidence” (Fishbeyn 2015 pg. 1).

Chapter 3: The Intersection of U.S. Science and Politics

Public health officials and centers work to surveil health threats to the American public and produce recommendations for courses of action. Policymakers, on the other hand, are in charge of allocating resources to public health efforts at any time. **Nevertheless, the ideal relationship between science experts and politicians is a symbiotic one.** The Federal Advisory Committee Act of 1972 established a permanent role for experts to impart their knowledge and offer their informed opinions to members of Congress.

Despite commitments from each domain, history shows that conflicts between public health and public policy are nothing new. A study by Choi (2005) finds that policymakers “operate on a different hierarchy of evidence than scientists” (Brownson 2009 pg. 180). Often, politicians rely on case studies and anecdotes to sway their fellow legislators (Stone 2012). Of course, EBP realizes that scientific evidence is not the only component worth considering when crafting legislation. However, no benchmark or standard exists to hold legislators accountable for legislation being at least somewhat grounded in evidence.

Relationships between science leaders and political leaders only enhance the EBPM process. Some public health agencies, however, have more political capital in DC compared to others. Although the CDC represents the nation’s central communicable disease control and prevention agency, it wields less political power in comparison to other agencies. The CDC’s

Atlanta location distances the agency and its staffers from policymakers on Capitol Hill and government officials in the White House. The Senate does not vet the nominee for CDC director, which keeps the distance between CDC and politics intact (“United States Government Policy and Supporting Positions” 2020). Other top health appointees who come before the Senate often make connections with policymakers in D.C. after their confirmation hearing.

The Senate confirmation process accords greater recognition to those who experience it and allows health officials to build relationships with decision-makers in Washington. Relationships represent the currency of the Capitol. Without the connections or political clout, the CDC director must depend on the HHS secretary to manage politics on behalf of public health. Consequently, the HHS secretary has the ability to leverage his or her political skills and connections to advance the CDC’s interests. The CDC may produce objective, scientific evidence that should underpin subsequent policy, but the ability to implement evidence-informed policies relies on more than adequate evidence. Implementing the best science and evidence is a political process. Moreover, the idea that science and politics are at opposite ends of a spectrum misses the mark.

Rather than viewing scientists and politicians as members of the same team, anti-establishment rhetoric espoused by some politicians has fostered a hostile environment for science. Public health organizations have felt the impact of this unfavorable view of science. “Rapid turnover among public health officials” have populated more and more positions with political appointees rather than public health professionals with experience and expertise (Halverson et al. 2017). Local and State health departments have reported a deterioration in the skillset of employees over the years (The Future of Public Health” 2002).

Part 2: Timeline

Chapter 1: Before COVID-19 Infected the U.S.

The emergence of an unidentified respiratory illness in Wuhan City, China in late 2019 drew attention from public health officials in the country and abroad. As Chinese health officials scrambled to contain the disease and mitigate its spread, epidemiologists around the globe paid attention to the outbreak as well. The Ebola and Zika outbreaks in 2014 and 2016, respectively, reminded governments and public health officials that a public health threat in one country posed a threat to all countries. Globalization had caused an uptick in international trade and travel which enabled the spread of infectious disease at a much higher rate than in previous decades. Thus, public health officials in the U.S. considered the Wuhan outbreak a situation worthy of its attention.

While the U.S. public health sector began devoting attention and resources to the Wuhan outbreak, U.S. politicians and media outlets were focused on an impending impeachment trial in Washington D.C. Infrequent headlines described a mysterious illness circulating in China and treated it as a distant situation deserving of mild concern and sympathy. In January, American news outlets inundated readers with news about domestic affairs. A pending impeachment trial occupied the nation's political conversation and drowned out the news emanating from China's Hubei province. The feud between Congress and President Trump did not distract other countries and the WHO from paying close attention to the outbreak. On January 9th, the WHO publicly described the illness circulating in Wuhan as a "mysterious coronavirus-related pneumonia" ("WHO Statement Regarding Cluster" 2020).

In the early stages of the Wuhan outbreak, the American public had too little information about the pathogen to consider this a formidable threat. The CDC communicated with Chinese officials to learn more about the outbreak. The agency ramped up surveillance efforts in China during the first week of January to gain information about this illness and its origin, severity, and transmissibility. This information would be crucial for decision makers to gauge the scope and nature of the threat posed to the United States.

Chinese researchers coordinated with the WHO to publish information about the illness and its characteristics. By January 13, China had announced the first death from the novel virus, Chinese scientists published COVID-19's genome, and other Asian countries had confirmed first exported cases (Qin and Hernandez 2020). This news garnered more attention from public health officials around the world, as the virus was no longer confined within China's borders. The news triggered further action from the CDC. The organization began screening passengers for illness at New York's JFK, LAX, and San Francisco International airport ("Public Health Screening 2020). One CDC official, Dr. Nancy Messonnier, held frequent conference calls with health care providers and members of the media to offer transparent communication about the novel coronavirus. On January 17th, Dr. Messonnier affirmed to listeners on the call that the "current risk from this virus to the general public is low," ("Transcript" 2020). Dr. Messonnier stated on the January 17th phone call that "some patients have been described as being seriously ill, while others have recovered" ("Transcript" 2020).

While the CDC was scaling up its response to the outbreak, America's attention remained fixed on the ongoing impeachment. Information about the virus, and expert judgments from public health officials, largely stayed within the CDC. The Executive Branch would not act decisively until doctors in Washington State confirmed the country's first 2019-nCoV case on

January 21. Two days before detecting the case in Washington State, the WHO confirmed “limited” human-to-human transmission (WHO Timeline 2020). After these developments, the CDC changed its tone. In another telebriefing, Dr. Messonnier relayed new information from Chinese health officials—the size of the outbreak in China had grown to 300, researchers hypothesized that older adults were most vulnerable to the infection, and human-to-human transmission had been reported (CDC January 21, 2020). However, the CDC did not yet know the speed and nature of the pathogen’s transmission.

The CDC increasingly highlighted the uncertainty and volatility of the coronavirus outbreak once thought to pose significant risk to those in China. It also emphasized that this situation was evolving each day, and that the US shouldn’t feel panic but shouldn’t feel immune to this threat. However, two days later on CNBC, President Donald Trump painted a contradictory picture of the situation for American viewers: “we have it totally under control,” (CNBC 2020). The President’s contradiction of the scientific consensus frustrated U.S. public health officials but soothed the American public.

The American people and media would pay greater attention to the novel coronavirus when news broke that Wuhan had entered a lockdown. The scope of the threat grew larger as, on January 24th, European scientists in France confirmed Europe’s first case of the coronavirus, and the U.S. announced its second confirmed case of the infection (Al Jazeera 2020).

By the end of January, public health officials recognized that containment of the novel virus was a foregone strategy. The outbreak had grown to a point that demanded Wuhan confine eleven million individuals to their homes for a city-wide quarantine (BBC 2020). The new developments regarding the Wuhan outbreak and its spread to other countries raised awareness outside of public health institutions. A few Congress members sought information on the

coronavirus, but their attention was limited. Meanwhile, Chinese President Xi Jinping voiced his concern about the rapid spread of coronavirus publicly (Hermesauto 2020).

As days passed, information about the outbreak and understanding of its growing risk compounded. Outside the country's top public health agency, former U.S. health officials began voicing concern about the US's course of inaction thus far. These individuals took to the New York Times, the Wall Street Journal, Washington Post, and other news outlets to implore the White House take more aggressive action against this threat. Reports from the New York Times indicate that pressure was mounting outside of the executive branch and inside the White House. The Medical Advisor for the Department of Veterans Affairs, Carter Mecher, sent emails claiming, "any way you cut it, this is going to be bad" (Lipton et al. 2020). HHS Secretary Alex Azar quietly asked Congress for more funds since the appropriated funds were quickly waning. The Infectious Disease Rapid Response Fund's \$105 million budget dwindled as more resources needed to be deployed. But directing funds to a weak public health system in the U.S. could only do so much to prepare for an outbreak spreading undetected around the world.

Those with expertise in and experience with global health, pandemics, and other health emergencies called on the U.S. to be more proactive. Policymakers failed to act early, which limited the country's policy options going forward. The U.S. squandered crucial preparation time that would force the country to enact more extreme measures, such as stay-at-home orders and other nonpharmaceutical interventions. By the end of January, the Trump Administration had launched the White House Coronavirus Task Force. Trump named Alex Azar to lead the committee and tapped the National Security Council to coordinate its efforts. The task force aimed to bolster existing efforts to monitor and contain the virus's spread. The White House announcement said the task force contained "subject matter experts from the White House and

several United States Government agencies, and [...] some of the Nation's foremost experts on infectious disease" ("Statement from the Press Secretary Regarding the President's Coronavirus Task Force" 2020). The original twelve members of the task force, hand-selected by President Trump, contained two top-ranking U.S. health officials and ten political appointees from other corners of the executive branch. Four members of the task force had no scientific expertise, but they curried favor with President Trump for their loyalty to his governance.

After designating personnel to champion the U.S. Coronavirus response, Trump enacted a symbolic and ineffective policy. In an executive order, President Trump implemented a travel ban on China hoping to curtail contact between uninfected Americans and potentially infected Wuhan residents (Proclamation 9984, 2020). Republican Congress members lauded the order, but public health officials did not believe this measure constituted a timely, evidence-based measure. In its global health emergency declaration, the WHO Emergency Committee specifically advised against "any travel or trade restriction based on the current information," (Nebehay 2020). Of course, recommendations handed down from the WHO cannot determine the politics of the U.S., its states, or its local communities.

However, American health officials echoed the WHO and did not believe this policy response represented an appropriate and effective measure. First, many considered Trump's travel "ban" a misnomer because it contained a significant exception: Americans in China could still return to the U.S. Those returning to the United States from China posed a greater threat to bring more of the coronavirus to the country. Second, experts alleged that this move "created a false sense of security" and "delayed other more effective" strategies to mitigate the spread of COVID-19 in the U.S. (Nowrasteh, 2020).

Pressure mounted specifically on HHS Secretary Alex Azar, who could no longer downplay the alarms being sounded by public health officials in America and abroad. After a month of warnings, Azar declared a Public Health Emergency on the last day of January. In his declaration, he admitted that a public health emergency "exists and has existed since January 27, 2020" (HHS Announcement 2020). Scientists properly raised concern about the trajectory of the coronavirus if more stringent measures were not taken. Experts made educated judgments and issued guidance to health care providers, international travelers, and the American public. An article published in *The Lancet* predicted that "independent, self-sustaining outbreaks [of 2019-nCoV] in major cities could become inevitable" (Wu et al., 2020). Privy to these journal articles, Dr. Messonnier relayed these increasing occasions of asymptomatic spread, and the WHO would shortly confirm these reports.

Chapter 2: The Coronavirus Demands Attention from Policymakers

The beginning of February saw U.S. policymakers begin to interact with public health officials and devise policies to protect their constituents against the unmitigated spread of the Coronavirus. As the novel coronavirus spread undetected, the CDC turned its attention to issuing guidance on exposure risk and developing diagnostic tests to trace the virus's path (CDC). Concurrently, policymakers paid more attention to the outbreak. In a letter to CDC Director Dr. Robert Redfield, forty-eight members of Congress urged more aggressive action and widespread testing (Kilmer et al. 2020). In an op-ed, former FDA Commissioner Scott Gottlieb and former director for medical and biodefense preparedness policy at the National Security Council Luciana Borio also did and wrote: "it is highly probable that dozens of other cases [of covid]

have gone undetected" (Borio & Gottlieb 2020). Like others, they emphasized the need for widespread testing to contain the spread of COVID.

Once his impeachment hearing in Congress concluded on February 5th, President Trump and his cabinet officials began ramping up efforts to respond to the growing disease outbreak. The U.S. had less than twelve confirmed COVID cases, but the country's insufficient testing capacity called the true amount of COVID-19 spread into question. The beginning of February also marked growing criticism from Democratic Congressmembers of their Republican counterparts for not taking the developing outbreak seriously enough. Senator Chris Murphy rebuked Republican politicians for underestimating the growing threat, and both Hawaii senators reprimanded the lack of coordination between the federal, state, and local governments (Werner & Abutaleb 2020). Senator Dianne Feinstein added to the growing political pressure by sending a letter to HHS Secretary Alex Azar. She knew that human-to-human spread was occurring and asked Azar about the personnel, medical equipment, coordination with state and local governments, as well as contact tracing efforts being deployed by HHS ("Feinstein Asks" 2020).

Members of Congress sought to engage with public health officials by starting to hear testimony from the nation's top infectious disease experts. The House Foreign [CH1] Affairs Committee heard testimony from Drs. Jennifer Nuzzo and Jennifer Bouey and the former White House Ebola response coordinator, Ron Klain. Dr. Nuzzo is an associate professor and senior scholar from the Center for Health Security at Johns Hopkins University, and Dr. Bouey is a senior policy researcher and Tang Chair in China Policy studies at the RAND corporation. Dr. Nuzzo presented key recommendations for the U.S. government to consider for its response to the growing biothreat. She admitted that, although many unknowns about the virus's trajectory

loom, there are “increasing signs” that containment was no longer an option (Nuzzo 2020). She echoed the WHO’s advice against relying on travel bans “to prevent the importation of the virus,” (Nuzzo 2020). Dr. Nuzzo directly warned lawmakers at the hearing that “no country, including the US, is fully prepared for significant infectious disease outbreaks,” (Nuzzo 2020).

Dr. Nuzzo stated her opposition to the President’s China Travel Ban. She doubted this order’s ability to protect the U.S. from importing the disease and characterized this policy as ineffective and distracting from other needed public health strategies and policies. She noted the importance of using this period to prepare for possible outcomes. For this, she recommended that health departments receive resources to “conduct surveillance,” hospitals gather resources to prepare for a possible “surge of patients,” and for federal health agencies begin facilitating “diagnostics, vaccines, and therapeutics,” (Nuzzo 2020).

The third witness, Ron Klain, offered a policy perspective for the hearing’s attendees. As the former leader of the White House Ebola response, he shared lessons learned from his work with disease outbreaks. Importantly, Klain emphasized that a “lack of knowledge does not counsel a lack of action,” (Klain 2020). He described how partisanship could derail any effective government response and urged caution against such politically charged attitudes surrounding the U.S. response. He said plainly, “saving lives, abroad and at home, turns on putting policies aside and allowing science, expertise, and sound decision making to govern our actions,” (Klain 2020). Klain’s recommendations included establishing sound coordination and leadership, deploying U.S. officials overseas to gather information on the virus, and making decisions based on “science and expertise” rather than “fear or politics” (Klain 2020). He cautioned: “one of the first casualties in an epidemic is rational thinking,” (Klain 2020). Like the two other witnesses, Klain opposed travel restrictions as an effective strategy for fighting the

virus. He warned that “banning travel to or from China altogether would impede the flow of medical assistance, expert investigation, or other key response functions” and “key supplies,” (Klain 2020). He advised that the Trump Administration “quickly assemble [...] an emergency funding package” to guard against delays “in responding to the coronavirus challenge” (Klain 2020). And, like Dr. Bouey, Klain emphasized the need to “watch for discrimination against people in our country of Chinese origin and ancestry,” (Klain 2020). He warned that this unwarranted and unethical discrimination “makes it harder to combat the disease,” (Klain 2020). This hearing supplied important warnings, recommendations, and information that decision-makers would need to consult before taking further actions.

Two days after this hearing, the Coronavirus Task force addressed questions from reports at a press briefing. The Task Force was tight-lipped and publicized the travel restrictions put in place and the administration’s approach to the pandemic. Meanwhile, other federal government organizations were expressing concern at the potential impact of undetected community spread and outbreaks in the US. The Federal Reserve expressed concern about the potential economic damage COVID-19 could cause (Schneider & Dunsmuir 2020). The State Department announced that it had shipped “nearly 18 tons of privately-donated personal protective equipment and other supplies” to China (Bauchner et al. 2020). The polarized political climate called on Republicans to follow President Trump’s lead in staying quiet and confident about the scope of the Coronavirus threat. Democratic leaders in the U.S. Senate took the opposite position. They voiced their frustration with the Trump Administration’s inaction and pressured him to request Emergency Funding to bolster the U.S. response (Press Release).

By mid-February, the characteristics of the virus were becoming clearer. An article in the *Lancet* studied the forty-one COVID patients hospitalized in Wuhan for the 2019-nCoV infection. Huang et al. identified common symptoms among this cohort: fever, cough, and fatigue. They established that: “The 2019-nCoV infection caused clusters of severe respiratory illness like severe acute respiratory syndrome coronavirus and was associated with ICU admission and high mortality. Major gaps in our knowledge of the origin, epidemiology, duration of human transmission, and clinical spectrum of disease need fulfilment” (Huang et al., 2020).

The U.S.’s attempts to develop a reliable diagnostic test progressed slowly and often proved unsuccessful. Private public health labs sought authorization from the FDA to create their own tests, but the FDA did not move to utilize private efforts. While specifics about the virus’s transmissibility had yet to be determined, the world witnessed the case count in South Korea jump from thirty-one to 201 in three days (Liévano 2020). Italy also reported its first case of local transmission (Reuters 2020). Another report from researchers at the UK Imperial College theorized that “about two-thirds of COVID-19 cases exported from mainland China have remained undetected worldwide” (Bhatia et al. 2020).

As the situation grew worse, Americans reacted to the uncertainty that faced the world. The US stock market plummeted on February 24th as the WHO warned the globe to prepare for a pandemic (Everett 2020). Finally, the White House formally asked Congress for \$1.25 billion in new emergency funds (Cook and Emma 2020). CDC Director Robert Redfield responded to worried Congress members assuring them that the CDC was being “aggressive” and identifying “potential cases early” (Michael 2020). The CDC, again, strengthened travel restrictions after the virus became more prominent in South Korea and Italy (Jernigan 2020). Trump took to

Twitter to communicate with his followers that the coronavirus “is very much under control in the USA,” (Trump 2020A) He complimented the hard work of the CDC and said that the stock market was “starting to look very good to me!” (Trump 2020B).

By February 25, containment was no longer an option for the U.S. response to COVID. In a telebriefing, Dr. Nancy Messonnier grimly told listeners on the call that “disruption to everyday life might be severe,” (CDC February 26, 2020). She also said that community spread was imminent. Additionally, the principal deputy director at the CDC Anne Schuchat said to reporters: “current global circumstances suggest it’s likely this virus will cause a pandemic” (Feuer 2020). The National Center for Medical Intelligence also signaled an impending pandemic when it “raised its warning level regarding coronavirus to WATCHCON 1” (Fink and Jamali 2020). Around this time, Carter Mecher, a senior medical adviser for the Department of Veteran Affairs, projected 1.7 million Americans could die from COVID-19 if the government continued its slow-paced response (“We Are Flying” 2020). Only twelve labs outside of the CDC had the capability to test individuals for the coronavirus (Soucheray 2020).

By late February, the CDC had changed its tune on the severity of the Coronavirus outbreak. The CDC published a risk assessment that warned that the threat posed by the coronavirus is “high, both globally and to the United States” (“Update: Public Health Response” 2020). President Trump suggested, that same day, that the coronavirus was “very well under control” in a speech (Oprysko 2020). Further, Trump ridiculed then-Senate-Minority Leader Chuck Schumer for thinking Trump should ask for more than the \$2.5 billion he had requested (Trump 2020C). The first case of confirmed community transmission occurred in the US on February 26th (“CDC Confirms” 2020). On the same day, Trump replaced Secretary Azar with Vice President Pence as the head of the White House Coronavirus Task Force. The next day, on

February 27th, CDC Director Robert Redfield reported to the Subcommittee on the US COVID response and the novel pathogen itself. He confirmed that the “potential global public health threat posed by this virus is high, but right now, the immediate risk to most Americans is low,” (“CDC Washington” 2020).

Federal PH officials started responding and saying things in line with Trump’s narrative. CDC Director Dr. Robert Redfield recounted the CDC’s missteps in developing a diagnostic test and the U.S. government’s actions toward protecting its citizens against COVID. He touted the travel restrictions and “enhanced illness screening and self-monitoring” implemented by the U.S. government (“CDC Washington” 2020). He highlighted the CDC’s travel restrictions and warnings.

March marked the beginning of the political sphere turning its full attention to the COVID-19 epidemic. Unfortunately, U.S. policymakers gave this growing issue attention once the virus had already arrived in the US and was spreading undetected. Mike Pence, the leader of the White House Coronavirus Task force at this point, said on March 2nd that the US was now focused on mitigation (Ehley 2020). Secretary Azar signaled a change of severity in the situation when he said at the same press briefing, “the degree of risk has the potential to change quickly,” (Ehley 2020).

Multiple problems warranting a policy response became clear as each day passed. One imminent problem was a questionable supply of medical resources. On March 3rd, the WHO warned of a “severe and increasing disruption” to the global medical supply chain (“WHO’s Director General’s Opening” 2020). Additionally, the U.S.’s testing capacity was still severely low. The CDC amended its testing criteria on March 4th and made tests available for those who received their doctor’s approval (Rabin and Thomas 2020).

Trump faced an increasingly serious disruption to American public and economic health. By the beginning of March, Trump began mobilizing resources and personnel to bolster the U.S.'s inadequate response. On March 6th, Trump signed a bill allocating \$8.3 billion in emergency funds to federal agencies (Coronavirus Preparedness and Response Supplemental Appropriations Act 2020). Meanwhile, the President tried to temper anxieties about the uncertainty of the disease outbreak. He tweeted out his version of the truth: “the fake news media is doing everything possible to make [the Trump Administration] look bad” in its approach to the Coronavirus outbreak (Trump 2020D). President Trump persisted in voicing misleading information about COVID-19 on Twitter by comparing it to the flu. In a tweet, he erroneously compared the Coronavirus to the seasonal flu (Trump 2020E).

The WHO contradicted President Trump’s ongoing narrative that the Coronavirus was totally under control when it declared the Coronavirus outbreak a pandemic (WHO 2020 March 11). The WHO made this announcement on March 11. Later that day, President Trump returned to another symbolic yet ineffective policy response: announcing a 30-day travel ban on most of Europe and signing an executive order to “increase the availability of respirators” (Brady 2020). The same day, the White House coronavirus task force announced 30-day mitigation strategies for New Rochelle, NY; Seattle, WSH; and Santa Clara, CA (Nir and McKinley 2020).

Dr. Anthony Fauci testified before the House Oversight and Reform Committee on March 11th. He estimated the mortality rate for COVID-19 would be ten times worse than the seasonal flu, which Trump had recently compared COVID-19 to on Twitter. Dr. Fauci was clear to his audience: “it’s going to get worse” (Forgey et al. 2020). Reality grew grimmer as the Stock Market plummeted on March 12. Further, The Department of Health and Human Services issued their COVID-19 response plan on March 13. The plan predicted that this pandemic would “last

18 months or longer and could include multiple waves,” (“U.S. Government COVID-19 Response Plan” 2020).

Chapter 3: The U.S. in Total War Against COVID-19

After the situation’s severity became clear, President Trump finally declared a national emergency on March 13. This freed up billions of dollars to bolster the federal COVID-19 response (Proclamation 2020). By mid-March, all states within the US had declared a state of emergency (Rutledge 2020). On March 15, the CDC issued guidance urging the cancellation of events hosting fifty or more people (“Get Your” 2020). This same day, the Federal Reserve cut interest rates to near zero (Torres and Miller 2020). The American public’s eyes turned to the federal government for guidance and information regarding this unprecedented pandemic and disruption to everyday life. At this point, the White House Coronavirus Task Force took center stage to explain developments each day.

The Task Force began holding daily press conferences to provide information about the virus and how the Trump Administration planned to enact policies aimed at mitigating the spread of the virus. Although Trump appointed Mike Pence leader of the Coronavirus Task Force, Trump designated himself as the U.S.’s minister of COVID-19 information. At these briefings, Trump chose to star in these press conferences which attracted millions of viewers each time they aired. Trump’s hijacking of these conferences enabled him to control the narrative of the pandemic and discredit those who offered contradictory opinions to a great extent. On March 19, President Trump began touting an antimalarial drug called Hydroxychloroquine as a proven treatment for COVID-19 (Facher 2020).

Trump also pitted state governors against each other in March, as he tasked governors with procuring personal protective equipment, ventilators, and other resources. Governors struggled to secure these resources as a disruption in the medical supply chain made this equipment scarce. Trump lashed out at multiple democratic governors who criticized the president's handling of the coronavirus. This feud launched attacks from both sides. Governor Cuomo accused the president of politicizing the pandemic; Trump called out Cuomo for not "doing more" for his state (Trump 2020F).

By the end of March, the economic impact of the nationwide started to materialize. More states began implementing statewide lockdown orders, and unemployment claims reached a record high of 6.6 million ("Unemployment" 2020). The U.S. led the world in confirmed cases of COVID-19.

The beginning of April saw a deepening of the rift between the Trump administration's approach to the pandemic and that of Science. On April 2nd, President Trump's son-in-law and advisor spoke out about the U.S. Strategic National Stockpile and said, "the notion of the federal stockpile was it's supposed to be our stockpile; it's not supposed to be state stockpiles that they then use," (Blake 2020). Donald Trump blamed state governments on Twitter saying: "Massive amounts of medical supplies, even hospitals and medical centers, are being delivered directly to states and hospitals by the Federal Government. Some have insatiable appetites & are never satisfied (politics?). Remember, we are a backup for them" (Trump 2020G).

A Pew poll published on April 2nd also revealed a partisan divide: 83% of Republicans rated Trump's handling of the pandemic as "excellent or good" while only 18% of Democrats said the same (Green & Tyson 2020). Further, risk perception of the COVID-19 pandemic

differed according to party identity: 78% Dems say “outbreak is a major threat” while only 52% of Repubs say the same (Green & Tyson 2020).

On April 2nd, Dr. Fauci made a grim prediction that the pandemic would “get worse before it gets better” and emphasized that nonpharmaceutical interventions were the country’s best bet until it develops a vaccine (Today Show 2020). The discovery of substantial asymptomatic and pre-symptomatic spread posed a challenge to mitigating the overwhelming spread of COVID-19 within the U.S. In response to this information about COVID-19’s transmissibility, the CDC began recommending Americans wear face masks (CDC Announcement April 3 2020). This guidance reversed previous messages from Dr. Anthony Fauci and other top officials who had told Americans wearing face masks was unnecessary (CDC 2020). The change in messaging received criticism from many including President Trump, who deemed the new guidance as “voluntary” (BBC 2020). He went on to say that he would not be following this advice.

Inadequate medical resources still crippled healthcare workers’ ability to treat the influx of patients rushing into their doors with COVID. The HHS inspector general, Christi Grimm, released a report surveying hospitals around the U.S. about the adequacy of medical supplies and other resources. After surveying U.S. hospitals in late March, the results found that there were “severe shortages of testing supplies and extended waits for test results limited hospitals’ ability to monitor the health of patients and staff” that “widespread shortages of PPE put staff and patients at risk” (“Hospital Experiences” 2020). Shortly after Grimm published the report, President Trump sharply criticized its empirical findings. According to the President, the inspector general’s report was “wrong” and “politically motivated,” (Subramaniam et al. 2020). Trump’s accusations of partisanship toward apolitical officials and institutions...

President Trump ramped up his control of the COVID-19 narrative in April. During the first week of April, President Trump took more time away from U.S. scientists and talked to the press at briefings and the American public on Twitter. Trump sidestepped Dr. Anthony Fauci and fielded a question about hydroxychloroquine's prospects as a treatment for the Coronavirus (Facher 2020). President Trump, "speaking on gut instinct," highlighted hydroxychloroquine and "authorized the US government to purchase and stockpile 29 million pills of hydroxychloroquine" (Saag 2020 pg. 2161).

Trump promoted this drug even though no medical consensus had yet to classify it as a proven, effective treatment for COVID-19. The American Heart Association, the American College of Cardiology, and the Heart Rhythm society qualified Trump's statements by issuing a joint statement clarifying that the anti-malarial drug could cause complications for those with cardiovascular disease (Roden et al., 2020). Trump intensified his opposition to Dr. Fauci when he retweeted a post on Twitter saying "#fireFauci" (Shepherd et al. 2020). On April 14, President Trump directed his administration to withhold American funds to the World Health Organization. Despite praising the organization on February 24th, Trump launched sharp criticisms of the WHO and characterized it as an accomplice to China. On April 16th, the administration released reopening guidelines for states across the country, but the president emphasized that each state's COVID-19 situation warranted different necessary measures.

The next day, Trump stoked outrage toward the Governor of Michigan's lockdown measures by tweeting, "LIBERATE MICHIGAN" (Mauger and LeBlanc 2020). The tweet incited Trump supporters to protest lockdown measures in Michigan, Virginia, Minnesota, and other places. Trump lent support to these protests and echoed their complaints about stringent lockdown measures in a press event at the White House (Mauger and LeBlanc 2020). Later,

CDC Director Robert Redfield would call the president's calls for liberation "not helpful" (Brito 2020).

At the end of April, Dr. Rick Bright released a statement that cited his unwillingness to promote an unproven treatment for COVID-19 as the reason for his dismissal. Bright led the CDC's efforts to develop a COVID vaccine, but Trump later removed from his position (Detrow 2020). Another CDC official, Nancy Messonnier, stated that COVID-19 might present a "significant disruption" to American lives. After this remark, Trump threatened to remove Messonnier from her position as director of the CDC's National Center for Immunization and Respiratory Diseases (Woodward 2020). The White House Coronavirus Task Force released reopening guidelines on April 16th, which proposed a phased approach to getting the American economy back on track.

President Trump extended his attacks on U.S. scientists to Dr. Robert Redfield. Dr. Redfield, the CDC director, told the Washington Post that "there's a possibility that the assault of the virus on our nation next winter will actually be even more difficult than the one we just went through" (Sun 2020). The day after the Post published the interview, President Trump rebuked Dr. Redfield's statements and claimed that his warning was "misquoted" (Tweet 2020H).

Chapter 4: Economy vs. Public Health

Trump spent much of May defending his administration's response to the virus and continuously claimed that the U.S. set the example for containing the Coronavirus. President Trump capitalized on the plateauing number of COVID-19 cases in May by erroneously advertising that COVID-19 cases were coming "way down" and that the pandemic was coming

to a close (Riotta 2020). Trump encouraged reopening from the beginning of May, despite caution from public health experts like Dr. Anthony Fauci. Trump pushed hard to reopen while continuing to espouse false claims about the virus, including those saying that children should not worry about getting infected with COVID-19 (Woodward 2020).

Trump's disregard for science reached new heights as he began calling for states to reopen their economies. Scientists were quick to denounce the President's calls. Trump encouraged reopening from the beginning of May, despite caution from public health experts like Dr. Anthony Fauci. Trump pushed hard to reopen while continuing to espouse false claims about the virus, including those saying that children should not worry about getting infected with COVID-19

On May 11, Twitter introduced another measure to curtail COVID-19 misinformation on its website. Their announcement said that the company would add labels to tweets containing “potentially harmful [or] misleading information related to COVID-19” (Roth and Pickles 2020). Twitter’s move to monitor misinformation more closely drew criticism from free-speech advocates who largely identified as Republican party voters. After Twitter added one of these labels to a tweet from President Trump, he accused the platform of “stifling free speech” (Trump 2020i).

Looking far ahead, the White House announced the creation of Operation Warp Speed (OWS) on May 15th. The program enlisted the help of the Department of Defense to deliver “safe and effective vaccine doses to the American people beginning January 2021,” (“From the Factory” 2020). A few days after this announcement, President Trump continued pushing for economic recovery by signing an executive order “directing federal agencies to remove regulatory barriers to economic activity as part of a coronavirus pandemic recovery effort”

(Executive Order 13924, 2020). The next day, the CDC published guidance for “implementing the Opening Up America Again Framework” (Dearen 2020). The Associated Press, however, learned shortly after this document’s release that the Trump Administration censored the report before its release. A CDC official told the AP that the original 17-page document contained a detailed set of guidelines for all sectors of the US economy. The official went on to explain that Trump administration officials suppressed specifics in that report, such as how far restaurants should space tables apart (Dearen 2020).

Trump responded to social media platforms flagging COVID-19 misinformation by enacting an executive order on May 28, 2020. The order condemns social media platforms for “engaging in selective censorship that is harming our national discourse” (Executive Order No. 13,925, 2020). Trump specifically charged Twitter for targeting posts “in a manner that clearly reflects political bias” (Executive Order No. 13,925, 2020).

The executive order aimed to weaken section 230 which protects social media platforms from being liable for information, misinformation, and disinformation that occurs on their platform. Trump’s order “seeks to increase federal regulations of online platforms who engage in “selective censorship” and limit the Section 230 liability protections available to those platforms. While the Executive Order specifically names Twitter, Facebook, Instagram, and YouTube, it applies to “any website or application that allows users to create and share content or engage in social networking, or any general search engine.” (David & Pierce 2020). President Trump relied on social media platforms, especially Twitter, to communicate directly to his followers. Moreover, he “lashes out at any effort by those companies to edit or comment on his posts.” (David & Pierce 2020).

May saw Trump push for governors to reopen their economies. In June, this attitude backfired on governors, mostly Republican, who decided to follow the President's political will.

The summer brought troubling spikes in COVID-19 cases across the south and southwest. Trump repeatedly attributed this dangerous rise in cases to a ramping up of COVID-19 testing in the U.S., but scientists and public health experts highlighted data contradicting this explanation (Ward 2020). Trump continued to ignore public health guidelines when he held a rally in Tulsa, Oklahoma on June 20th, which approximately 6,200 people attended. During this gathering, Trump falsely claimed that the pandemic was "fading away" (Wingrove 2020). During a press conference, one of Oklahoma's Health Department Directors, Dr. Bruce Dart, reported a surge in COVID-19 cases resulting from the rally (Carlisle 2020).

The sharp COVID-19 spikes in southern states called on governors to reverse their reopening plans. On the nation's Independence Day, Trump prompted further misunderstanding of the Coronavirus by saying that "99% of cases are totally harmless" (Associated Press 2020). Days later, Trump put his scientific illiteracy on display by claiming that the U.S. had the lowest mortality rate in the world (Gittleson 2020). This blatant falsehood contradicted the voices and opinions of scientists in America and around the world. His claims played to some Americans' suspicions that the number of deaths from COVID-19 was "grossly inflated" (Kenworthy et al. 2021 pg. 7).

President Trump exhibited his aversion to evidence-informed regulation on reopening the country again in July when the CDC and White House met to discuss guidance for school reopening. After Trump disapproved of the CDC's original guidelines, Vice President Mike Pence told reporters that the CDC would "be revising the guidelines," (Rasmussen and Jamieson 2020 pg. 901). CDC Director Robert Redfield offered contradictory information the next day by

saying that the CDC would not be revising its school reopening guidelines, but it would publish “additional reference documents” to “aid communities” (Rasmussen and Jamieson 2020 pg. 901). This exchange raised preexisting concerns that CDC guidelines were being influenced by the White House and were not being directed a-politically according to the best evidence available.

Fears of interference with science grew later that month when Trump boldly changed the COVID-19 data collection procedure by shifting responsibilities away from the CDC to HHS, an agency that reports directly to him. The president ordered hospitals to report COVID-19 data to an HHS database in Washington D.C. to consolidate information. The HHS Website posted on its website: “as of 15 July 2020, hospitals should no longer report the covid-19 information in this document to the National Healthcare Safety Network (NHSN) site” (“COVID-19 Guidance for Hospital Reporting” 2020). The change proceeded despite “more than 100 public health and patient advocacy groups [...] warned that the switch could degrade crucial data reporting” (Piller 2020 pg. 397). This change diverted information away from public view, which raised concern among scientists who had been studying the data published by the CDC. Importantly, this decision placed COVID-data collection under the supervision of a political, non-independent organization, whereas the CDC operates as an independent, apolitical one.

Indeed, on July 14, four former CDC directors published an editorial in the Washington Post charging Trump with politicizing science during the public health emergency. The prior data collection agency had been “the country’s source of infectious disease data for decades” (Dyer, 2020). While the summer saw horrific spikes in cases in states like Florida and Texas, Trump ignored the data to demand schools fully reopen come fall. Betsy DeVos, the head of the Department of Education, parroted his demands against many public health experts (Gaudio

2020). In a Washington Post piece, former CDC Director Tom Frieden criticized DeVos for focusing on reopening schools “quickly” rather than “safely,” (Frieden et al. 2020). The dispute regarding whether schools should reopen in August became another issue that divided the American public along party lines (Horowitz 2020).

Moving into the fall, Trump’s feuds with scientists were further exposed as several individuals commented on the president’s attempts to muzzle them. On 60 Minutes, Dr. Fauci confirmed that the White House had stopped him from appearing on media programs (Lapook 2020). Trump would later call the nation’s top infectious disease expert a “disaster” and retweet a tweet calling for Fauci’s termination (Shabad and Alba 2020). Trumps’ misinformation campaign also continued as he said the virus “affects virtually nobody” --even as the US surpassed 200,000 COVID deaths (Thrush 2020).

“A planned FDA EUA for plasma was initially blocked by senior government scientists who cited the lack of adequate efficacy data. President Trump then expressed concern that influences within the FDA were trying to delay COVID-19–related approvals until after the election to harm him politically. Immediately thereafter, the FDA reversed its decision on convalescent plasma and authorized an EUA for it, apparently without additional trial outcome data to justify this move (Avorn and Kesselheim 2020 pg 1284)”

During his campaign, Trump showed his most egregious ignorance toward public health guidelines by holding multiple in-person rallies attended by thousands. Trump retweeted a post from a user that claimed, “only 6 percent of [reported COVID-19] deaths were actually from COVID-19” (Aschwanden 2020). The Chief mortality statistician at CDC, Robert Anderson, responded to this claim by saying it was “a gross misinterpretation” of “how death certificates work” (Aschwanden 2020).

Trump's public pressure and influence on U.S. scientific institutions continued into September. He turned his efforts to the FDA who oversaw overseeing vaccine trials. His version of the vaccine rollout timeline diverted sharply from the versions voiced by FDA and CDC officials. Testifying before Congress, Dr. Redfield said that a vaccine would be available by mid-2021. Concurrently, Trump had been baselessly promising the American people that the vaccine would be available before election day. Shortly after Redfield's comments, Trump rebuked him and told reporters that Redfield was mistaken (Jaffe 2020).

Part 3: Analyzing the Role of Science in the U.S. COVID-19 Response

Chapter 1: Themes of the U.S. COVID-19 Response

Under the direction of the executive branch, the federal government made policy decisions in better alignment with Trump's political agenda rather than the best scientific judgment coming from U.S. public health institutions. US house of reps released report that cited forty-seven "instances in which government scientists had been sidelined or their recommendations altered" (Viglione 2020). While public health experts sounded alarms about the mysterious Wuhan outbreak, Trump and his allies focused on fighting an impeachment trial. The marginalization of science led to ineffective policy ill-equipped to address the country's challenges against the pandemic.

Pre-existing political climate fueled politicization of science and confusion as to what facts should be considered when devising policy solutions. Republican politicians benefited from preexisting polarization in American media and politics and anti-establishment attitudes to

advance their agendas at the expense of American public health. A polarized political climate enhanced the Trump administration's ability to reduce science's role in responding to COVID-19. Political polarization led Americans to ascribe to political elites' beliefs in the absence of a trusted source of information. At the beginning of the pandemic, many Americans felt uncertain and anxious about the duration of the coronavirus pandemic. This uncertainty increases Americans' reliance on media and "cues provided by political elites" (Cori et al. 2020). Not only was information about the pandemic scarce, but it was also constantly evolving. Evolving information spread across traditional and new media breeds confusion on what is true (Gollust, Nagler, and Fowler 2020). The scarcity of verified information about the virus left U.S. citizens to adopt their most trusted individuals and institutions' beliefs and opinions. Trump proclaimed himself as the only trustworthy source of information.

Trump's populist persona adapted to the pandemic by shifting anti-establishment attacks toward science and away from other politicians. Under a guise of concern for everyday Americans' interests, Trump undercut American trust in scientific experts and recommendations. Medical populism, a political style used in health emergencies to "pit the people against the establishment," worked to Trump's political advantage (Lasco & Curato, 2019). Trump characterized himself as an agent for the everyday American and painted those opposing his positions, primarily scientists, as elites recommending senseless policies.

Throughout the COVID-19 pandemic, the Trump administration enabled political allies and disabled the authority of those with opposing views. The public health emergency put more power and control in the executive branch's hands. Emergency declarations by the federal government granted more power to the executive branch and tasked the Trump administration with designating personnel to lead aspects of the response. Throughout his time in office, Trump

infamously appointed individuals to federal positions based on his most important criteria: loyalty. Trump appointed loyal, political allies in key leadership positions and set a tone that said it was okay to ignore recommendations that ran counter to his wishes. The U.S. Coronavirus response cast of leaders featured prominent Trump administration officials rather than individuals with public health expertise or experience. Trump first named HHS Secretary Alex Azar to lead the White House Coronavirus Task Force, but he later replaced Azar with Vice President Mike Pence. Trump also appointed Dr. Deborah Birx to two highly influential positions within the White House Coronavirus task force (Beaubien 2020). Birx, a public health veteran, abided by Trump's will by failing to push back on his erroneous comments and carrying out his desire to change the long-standing data collection procedures in the middle of the pandemic.

Once the pandemic reached the U.S. and demanded federal action, Trump enacted measures that ran counter to international and domestic scientific recommendations. His first decisive action came in an executive order banning travel from China. While he would later tout this decision as effective and timely, those with knowledge on effective pandemic responses disagreed. The WHO and experts providing Congressional testimony in February advised governments against travel restrictions. After the country had experienced unprecedented disruption to daily life, President Trump began calling for states to reopening against the judgment of U.S. health authorities. Later, Trump similarly put pressure on U.S. public schools to fully reopen; by this time, the COVID-19 death toll in the U.S. was approaching 200,000.

Trump put political allies in front of the American people to parrot his version of the situation. Communication, one of the cornerstones of the CDC's function in the U.S., was taken

over by Trump and Trump-approved spokespeople. Daily coronavirus press briefings starred President Trump, who used these events to espouse his version of the truth. Unlike the two previous administrations, the Trump White House sidelined the CDC and centered itself in COVID-19 press events. President Trump led nearly three-quarters of sixty-nine COVID-19 Press events (Desikan 2020). During the SARS outbreak under President George W. Bush, the CDC led all press events on the topic (Desikan 2020). Likewise, the Obama administration let the CDC lead thirty-two out of thirty-five H1N1 press events (Desikan 2020). The Trump White House, on the other hand, kept scientific authorities on the bench to keep reality out of its narrative that everything was under control. The public should hear from the President during an unprecedented health crisis, but not at the expense of hearing sound scientific judgment.

On the other hand, President Trump diminished the roles of those who followed science rather than his political agenda. CDC officials such as director Robert Redfield and principal deputy director Anne Schuchat did not appear “on the podium during White House Briefings by the coronavirus task force for more than a week” even though both had valuable experience responding to the 2009 H1N1 influenza epidemic (Sun 2020). Trump hindered the independence of the CDC by keeping a close eye on its publications and communications. On multiple occasions, Trump pressured the CDC to revise guidance that offered information that deviated from his pandemic narrative. The White House reserved the final say on the content of communications published by any federal scientific agencies (Shear and Haberman 2020). Interference with independent scientific institutions and attacks on scientific authorities resulted in policy decisions aligned with the Trump administration's political agenda rather than scientific consensus.

The Trump administration capitalized on its emergency powers to control the COVID-19 narrative. Trump utilized widespread uncertainty and political tactics to impose his own narrative while attacking that voiced by scientists and public health officials. Before COVID-19, Trump often accused political opponents of hypocrisy. Updating one's opinion in politics makes the candidate vulnerable to these attacks; revising one's scientific conclusion or judgment based on new information represents a respected value. Trump, however, disregarded any differences in conduct between the world of politics and that of science. Trump painted scientist's updates as hypocritical, which played to his base's disdain for scientific elites. Additionally, the rapidly evolving information environment exacerbated a "long-term decay in scientific trust among political conservatives (Gauchat 2012), further contributing to an asymmetric partisan response to scientific information" (Gollust, Nagler, and Fowler 2020). Villainizing evolving scientific opinion resonated with Republican politicians and their constituents. The public should hear from the president during an unprecedented health crisis, but not at the expense of hearing sound scientific judgment.

The Trump Administration demonstrated its desire to control the narrative even more when it imposed strict guidelines preventing journalists from reporting on the reality of COVID-19 within clinics and hospitals. Early in 2020, "a senior official in the Trump administration quietly reinforced a set of guidelines that prevented journalists from getting inside all but a handful of hospitals at the front line of the pandemic," (Maass 2020). The guidelines cited HIPAA to justify their restrictions on reporters. These measures to protect patient privacy existed before President Trump's arrival in D.C., but his administration quickly relaxed "a wide range of privacy restrictions on medical providers" except for guidelines restricting the public

from “seeing the ailing and the dying” (Maass 2020). Michael Kamber spoke on the importance of photography during a national crisis: “This is the greatest loss of life on the American continent in such a concentrated time, and we’re seeing almost no images that really convey the devastation and the death” (Maass 2020).

Trump’s efforts to control the pandemic narrative went beyond keeping experts tight-lipped during press events. When Trump could not step in front of scientists, he contradicted their opinions and attacked their credibility. His success in maintaining a chokehold on the COVID-19 narrative also stemmed from his ability to ensure his voice was the loudest. US communication during COVID was misaligned with what science was saying (Lopez 2020). He strengthened his brand as anti-establishment and his direct tweets and messages to the American people confused the public on what is true (Gollust, Nagler, and Fowler 2020). This happened with masks, hydroxychloroquine, and what the ‘real’ COVID numbers were. Trump’s most famous grievances were aimed at Dr. Anthony Fauci. News outlets highlighted differences between President Trump and Dr. Anthony Fauci, Director of the NIAID. Trump’s criticisms of Fauci grew as the President saw his approval ratings dip and those of Dr. Anthony Fauci soar. His attacks eroded trust between the American people and its government officials with knowledge on responding to infectious disease outbreaks.

Trump’s platform on social media was central to his ability to discredit dissenting views based on empirical fact. He gave COVID-19 misinformation a large platform as his tweets and retweets were broadcast to his tens of millions of followers on the site. His messages were amplified on social and traditional media particularly within the right-wing media ecosystem (Seeger & Sellnow, 2016). These platforms accelerated the spread of misinformation about the

virus and bolstered Trump's efforts to sow doubt about the pandemic. The COVID-19 pandemic arrived when American media had become fragmented and characterized as "fake" by the President himself. News outlets in the U.S. were seen as "ideologically-charged" echo chambers rather than trusted sources of information (Iyengar and Hahn 2009; Scacco and Muddiman 2020). According to Pew polling, only 49% of Americans believed the media accurately reported the pandemic (Funk et al., 2020). Nearly a quarter of Americans did not believe what the media was reporting at all (Funk et al., 2020). This communication stream shielded users and audiences from opposing views and reinforced their opposition to empirical facts.

Social media platforms disappointed those hoping that reason and better scientific judgment would prevail. Incentives on social media rewarded outrageous posts from famous figures more often than unknown scientists at the CDC.

Trump leveraged economic insecurity against the country and pitted people's lives against their livelihoods. Trump appealed to average Americans in economic distress by proposing a false dichotomy between mitigating the spread of COVID-19 and reviving the country's economic health. Beginning in April, Trump drew on his pro-business anti-elite rhetoric to make reopening a red-state-blue-state issue. Politicians on the right followed Trump's lead in pitting Americans' lives against their livelihoods. Trump ignored experts' rebuttals explaining that economic prosperity depends on a healthy workforce (Hunter, 2016). Trump didn't understand that "vitality and economic viability of any community" relies in great part on the country's population health and the quality of its health systems (Hunter, 2016 pg. 438). Trump wanted to get re-elected and wanted a strong economy, as it had been a cornerstone of his political platform. Instead of using political capital to pressure Congress to deliver economic

relief to the American people, Trump spent more time retweeting misinformation about COVID-19 and U.S. federal health officials.

The sixth theme was science's inability to fight back against political attacks. Skilled politicians excelled in a game in which they were familiar: politics. They fought hard to villainize scientific authority. On the other hand, science struggled to play politics while they tried to put forth judgments on how the U.S. should be responding. Science's inability to counter or discredit attacks from the White House furthered the Trump administration's ability to sideline them. Their lack of political capital hindered public health officials' ability to convince Americans of their legitimacy. Science issued harsh rebukes of the President's words and policy decisions, but their criticism fell flat with his large base of supporters. In their eyes, the truth came from the President. The Centers for Disease Control and Prevention, the nation's premier agency to fight disease outbreaks, did not stand a chance against Trump's political agenda. The CDC wields little political power within the executive branch compared to its peer agencies like the FDA or NIH. Former CDC Director Tom Frieden commented that "the agency has no experience with responding to this level of political attack" (Florko 2020).

Further, David Rosner, a co-director of the Columbia Center for the History and Ethics of Public Health, claimed that CDC culture "tend[s] to ignore politics" and, as a result, is "conducive to being manipulated" (Florko 2020). The agency's location in Atlanta distances it from policymakers in D.C. Moreover, the CDC Director position does not require Senate confirmation, unlike the FDA or NIH leaders. The senate confirmation process allows nominees to foster relationships with policymakers and build political capital within U.S. senators.

Voices across both the public and private sectors increasingly highlighted the White House's ignorance of scientific judgment. But these voices could not overpower Trump and his

loyal allies and supporters. Science was weak to begin with in terms of its personnel, workforce, and resources. Budget cuts under President Trump depleted weakened public health departments' capacity to respond to a disease outbreak, let alone a global pandemic. The absence of surveillance data further "crippled understanding" needed to mount an effective response to COVID in a few ways (Kirlin 2020).

Science also did not have a relationship with the American people like elected officials and, especially, the president. Few people had visited the CDC website or knew who Dr. Anthony Fauci was. Politicians were "mentioned more, relative to scientists, in newspapers" (Hart et al., 2020). On the other hand, President Trump had a strong relationship with his voters and an adversarial one with U.S. federal scientists. Trump established an anti-science tone and an unfriendly attitude toward science to begin with. This hostile environment exacerbated existing difficulties in engaging stakeholders outside of politics to inform policy decisions.

The last theme was the willingness of Trump's GOP colleagues to support his behavior and harmful rhetoric. Trump leveraged political capital to influence state-level policies enacted by state governors. Policy decisions undercut scientific consensus and aligned with Trump's political goals rather than scientific judgment. Trump's hands-off approach to the U.S. pandemic called on state governments to manage the health emergency without federal guidance. The lack of a national plan or recommendations for states left public health decisions up to state officials with their own political agendas. Proponents of States' rights typically argue that, rather than prescribing the best course of action for a state, states "can act as laboratories of learning, with the best ideas spreading horizontally to other states," (Huberfeld et al., 2020 pg. 952). However, Huberfeld finds that this theory does not play out. Shipan and Volden (2008) find that the

"diffusion of policies across states" occurs by "ideological mimicking" rather than by evidence and "policy results," (Huberfeld et al. 2020 pg. 952).

State governors bought into Trump's populist rhetoric and furthered his claims against science. The pandemic turned Trump's authoritarian tendencies style into a full-blown strategy. He exhibited zero tolerance for dissenting opinions emanating from "elites." Trump dismissed challenges to his interpretation of the facts. Maintaining favor among his base of constituents incentivized state governors to lean into Trump's political antics. Trump leveraged his position of power further by suggesting states who supported his approach to the coronavirus would enjoy greater assistance from the federal government.

States took political cues, which played a significant role in handling the pandemic within their own states. States differed in their responses to the pandemic in alignment with their party's collective attitude toward the pandemic. Republican-led states took cues from President Trump and decided to let politics guide their policy response. Rutkow (2014) confirms that Trump's approach influenced State Governors' decisions on when to declare a State of Emergency (Fowler et al. 2021).

The politically charged response to the COVID-19 pandemic saw a sharp divide between red and blue states regarding public health measures and restrictions. GOP governors "were far less likely to consider COVID-19 as a serious threat early on" while President Trump "downplay[ed] the severity of the pandemic" (Fowler et al. 2021). Red states were slower to close down or impose restrictions, while blue states accepted and implemented scientifically backed measures (Halpern 2020). While most states acted swiftly to slow the spread of COVID within their borders, others like Georgia shut down late. In Georgia's case, lockdown measures did not come down until April 2nd. (Halpern 2020). Adolph et al. determined that a governor's

political party identification represented the strongest predictor of “early adoption of social distancing policies--with Republican governors adopting and implementing more slowly.” (Erwin et al. 2020 pg 650).

Citizens in states whose governments sided more with Trump than scientific information were at a disadvantage no matter their will. Some populations suffered from or feared the virus to a greater extent due to the political identification of their governor. Politics infected the fair allocation of resources to states. States were fighting each other for emergency equipment, and they could not respond as strongly as the federal government who has way more money. State budgets are incapable of responding to an emergency on the scale of COVID-19 (Huberfeld et al. 2020). Trump leveraged political support against state governors by suggesting that "Democratic governors who did not speak well of [Trump]" would "not receive much help in terms of pandemic supplies" (Rupar 2020). Trump opted to offer aid to states in exchange for public statements thanking the President for his help. This behavior directly contradicted medical experts who believe allocation should depend on need. But the Trump administration succeeded in dismissing outside recommendations. Residents of blue states "with political governance that fosters the competent implementation of scientific knowledge" were disadvantaged by the President's inhumane instinct to put politics above fairness during a public health emergency.

President Trump reprimanded Democratic governors who spoke out against his handling of the pandemic and responded/warned these officials that their behavior would deter him from prioritizing that state in terms of medical supplies (Rupar 2020).

Certain states' political actions enabled them to acquire more PPE (Huberfeld et al. 2020). Differences in PPE distribution should not be made on political favorability. In theory, federalism supports the spread of good ideas from one state to another. The adoption of proven

policies to benefit state citizens depends on the state government's ideological leanings and politics (Shipan and Volden 2008). Moreover, this system furthered the already higher risk of vulnerable populations in red states. These individuals could least afford the economic hardship that accompanied the pandemic. Access to health should not be determined by the political leanings of one's state.

Another prominent consequence of partisan identity became a risk factor for risky health behaviors. Engaging in important health behaviors was associated with being a Democrat or leaning that way politically. Nearly seventy percent of Dems agree that “social distancing measures are helping a lot to slow the spread” compared to under fifty percent of Republicans (Funk et al., 2020). Voters who identify as Democrat “are more likely to support wearing face coverings and to trust the Centers for Disease Control and Prevention (CDC)” (Halpern 2020). Based on GPS data, Allcott et al. found that Democrats adhered to social distancing guidelines to a greater extent compared to Republicans (2020)

As new variants threaten the hard-fought progress of the US pandemic response, Democrats and Republicans exhibit differences in how they perceive these variants as a reason to continue behaving responsibly and according to public health guidelines. Over half of Democrats say “new coronavirus variants will cause a major setback for the country” while 40% of Republicans agree (Funk & Tyson 2021).

A Pew Report published in 2021 observes partisan differences, which have been prevalent during the duration of the pandemic, in individuals' plans to take or not take the COVID-19 vaccine (Funk & Tyson 2021). It finds Democrats are “27 percentage points more likely than Republicans to say they plan to get, or have already received, a coronavirus vaccine

(83% to 56%)” (Funk & Tyson 2021). And, disturbingly, the Pew report adds that “this gap is wider than those seen at multiple points in 2020” (Funk & Tyson 2021). Losing trust in science harms the entire country. The CDC used to be an internationally respected public health agency. In 2015, 70% of Americans viewed the CDC favorably. In March 2020, that percentage had dropped to forty-six (Piller 2020). Confidence in medical scientists grew among Democrats but stayed the same among Republicans from 2019 to 2020 (Funk et al. 2020).

We’re getting to a point where your party identification is a determinant of your belief in empiricism and reason. Six out of ten individuals who identify as Democrats look to scientific expertise for policy decisions; a third of individuals who identify as Republicans say the same (Funk et al. 2020). Further, Republicans are much less likely to “rate the performance of public health officials positively” than Democrats—44% vs 79% (Funk & Tyson 2021). This metric for measuring Republicans’ views on public health officials is “down 14 points since November, while views among Democrats have stayed about the same,” (Funk & Tyson 2021).

The United States’ mishandling of the COVID-19 pandemic stems from multiple factors. Trump does not deserve all of the blame, but he certainly exerted a strong, anti-science influence over the country’s policies and behavior. Dr. Robert Hahn published a study in the *International Journal of Health Services* estimating that Trump’s remarks about masking exacerbated the spread of the virus and served as a distal cause of 4,000 COVID-19-related deaths (Hahn 2021).

When we don’t follow evidence, we follow ideologies, and it becomes not about the best evidence but the best manipulation and infectious ideas that can garner a following. Political polarization during a pandemic could lead to individuals basing behavior and decisions on political leanings (Gollwitzer et al. 2020). Policy doesn’t only depend on scientific opinion and evidence, but it can’t ignore it.

CONCLUSION AND RECOMMENDATIONS

Pandemic preparedness depends not only on the degree of scientific expertise within a country's borders but also that country's political capacity to infuse policy with that expertise. This paper aimed to describe how U.S. partisan politics marginalized evidence-based policymaking during the COVID-19 pandemic. The coronavirus found the American public severely politically polarized. The timeline of events has presented the unprecedented marginalization of scientific authority and describes how the Trump administration discredited scientific judgment, censored public health guidance, and ultimately undermined the U.S.'s ability to respond effectively to the coronavirus. That political environment, strong anti-science rhetoric from Republican politicians, and the inability for science to push back against misinformation narrative facilitated Trump's ability to keep voices from the CDC or NIH quieter than those of his political allies. The Trump Administration's mismanagement of the COVID-19 pandemic exhibits the danger of politicizing science during a Public Health Emergency.

While the COVID-19 pandemic still rages, policymakers and public health officials must work toward ensuring this mishandling of a global pandemic does not happen again. Looking ahead, the demand for evidence-based policies must come from public pressure. Voters need to make clear that they want their representative to take public health seriously.

The United States must recognize that protecting human lives and livelihoods go hand in hand. President Trump and other Republicans exploited economic anguish caused by the pandemic without admitting that their early idleness necessitated extreme mitigation measures. Pandemics could incur up to \$6 trillion dollars in damage worldwide during the 21st century

(“The Neglected Dimension,” 2016). The U.S. needs to discontinue its divestment from public health agencies and support these institutions with greater funding. The U.S. must strengthen its public health infrastructure to protect communities from the next pandemic. Public health departments at the state and local levels lack the resources and personnel to achieve public health objectives during a pandemic. Brownson et al finds that support from state legislatures, adequate staff, and adequate funding represent the greatest determinants of effective public health policymaking (2007). Further, state legislatures should consider bolstering public health surveillance measures to better address disease outbreaks.

Politicians must support federal health agencies with public support and give them the autonomy to conduct research and communicate findings to elected officials and the American electorate. Elected officials must exhibit respect for public health officials and affirm their expertise. Politicians serve their constituents by advocating for their needs and interests; public health officials serve their communities by collected and evaluating evidence. Politicians fail to invest in public health preparedness due to weak political incentives. Healy and Malhotra find that voters do not “reward preparedness spending” and that, in the U.S., “the incumbent presidential party” does not receive political rewards for devoting more government funds to disaster preparedness” (2009 pg. 401 & 404)

President Trump’s hawkish approach to foreign threats did not extend to what he called the invisible enemy. Herein lies the moral of the U.S. COVID-19 response story: disease outbreaks threaten U.S. homeland security and should be taken seriously. Irrational policymaking cost human lives in times of crisis. Within a year, the coronavirus killed over half a million Americans, and many who did not succumb to the illness experienced economic anguish. During a global pandemic, letting feelings override facts incurs a toll on the country’s

population, homeland security, economic prosperity, and political stability. Gostin et al. expresses the urgency of pandemic preparedness well: “the scale of human and economic harm from pandemics compares with war, terrorism, and finance crises” (2016 pg. 1451).

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Biography

Catherine Holley was born in Waco, Texas, on December 16, 1998. She graduated from Vanguard College Preparatory School in Waco, Texas, before attending the University of Texas at Austin. She earned two degrees in Plan II and Health & Society and a minor in McCombs business foundations. During her undergraduate years, Catherine participated in Student Government, the University Panhellenic Council Executive Board, and two winning Student Body President and Vice president campaigns. This fall, Catherine will attend the LBJ School of Public affairs to earn her master's in public affairs. She plans to work on infusing equity in health policy at the state level in Texas.