The Coronavirus Pandemic: Public Health and American Values

Currents in Contemporary Bioethics

Mark A. Rothstein

In 2004, the year after the SARS epidemic in Asia and Canada, I wrote an article in which I considered whether the United States would be able to replicate the large-scale quarantine and isolation strategies effectively implemented by the countries hardest-hit by SARS. I called it "Are Traditional Public Health Strategies Consistent with Contemporary American Values?"[1] Although I cautioned against overreliance on social distancing measures, I questioned whether there would be adequate levels of compliance with quarantine in a society grounded on libertarianism, as distinguished from the more collective or communitarian societies of Canada, China, Hong Kong, Singapore, Taiwan, and Vietnam. More generally, I wondered whether the United States had the social solidarity to respond to a major public health threat. Now, 16 years later, we face a challenge much greater than SARS, and it seems appropriate to reexamine American values during the coronavirus pandemic and beyond.

Public Health Preparedness and Response

In the first two decades of this century, the world experienced several international disease outbreaks, including SARS (2003), H1N1 (2009), MERS (2012), Ebola (2014), and Zika (2016). The United States was fortunate in avoiding the worst outcomes from any of these diseases, but the possible catastrophic consequences of a public health crisis for any country, including the United States, became clear. American experts warned that a new and lethal epidemic was just a matter of time.[2] There were countless meetings, simulations,[3] warnings,[4] reports,[5] and plans.[6] Yet, on December 31, 2019, when China informed the WHO of a novel coronavirus outbreak,[7] the U.S. was woefully unprepared and unable to respond quickly to this deadly and fast-moving pathogen.

One reason for the poor response is that the U.S. has been reducing public health funding at the federal, state, and local levels for decades.[8] As a result, there was a severe shortage of ventilators and personal protective equipment, including gloves, gowns, masks, and face shields.[9] The country also lacked surge capacity, especially hospital beds and ICU beds.[10] This should not have come as a surprise. The existence of a substantial number of unused hospital rooms and equipment runs counter to the business model of most hospitals, which typically strive to maintain occupancy rates of at least 85 percent.[11] When the need for tens of thousands of additional hospital beds became clear in several epicenters of COVID-19, state and local public health officials scrambled to convert hotels, dormitories, convention centers, and other facilities into makeshift hospitals.[12] The retrofitting process cost valuable time, and the substitute facilities and supplies often were inadequate.

The most cataclysmic failure of the public health response was the inability to provide coronavirus test kits throughout the country in a timely manner to diagnose disease in individuals and to control the spread of infection.[13] The CDC rejected German designed tests used by the WHO; instead, it attempted to develop its own more accurate test.[14] Unfortunately, the new test kits developed by the CDC and distributed to state public health laboratories gave inconclusive results and were unus-

About This Column

Mark A. Rothstein serves as the section editor for *Currents in Contemporary Ethics*. Professor Rothstein is the Herbert F. Boehl Chair of Law and Medicine and the Director of the Institute for Bioethics, Health Policy and Law at the University of Louisville School of Medicine in Kentucky. (mark.rothstein@louisville.edu)

Mark A. Rothstein, J.D., *is the Herbert F. Boehl Chair of Law and Medicine, Director, Institute for Bioethics, Health Policy and Law, University of Louisville School of Medicine.*

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able.[15] Without a backup plan, by mid-February, the only coronavirus testing facility in the country was at the CDC's headquarters in Atlanta, and it processed a mere 100 tests a day.[16] Meanwhile, federal government officials repeatedly assured the public that large-scale testing was imminent and that anyone who wanted a test could get one.[17] Despite such assurances, symptomatic people had to wait in lines for hours to be tested,[18] and in many places, even in April, an acute shortage of test kits caused continued rationing, with testing limited to individuals with severe symptoms.[19] Immediate, widespread testing, however, is essential to identify asymptomatic individuals who harbor the infection, identify their contacts, direct them to self-quarantine, and prevent additional transmission.[20]

Until late spring 2020, the relatively small number of protests and disconcerting actions embracing American rugged individualism were overshadowed by more community-oriented behavior reflecting the reality of significant individual and group peril. Economic, social, and political pressures opposing social distancing increased as the period of economic inactivity dragged on and the quest to "reopen" the country took on a partisan political dimension, even attracting extremist groups.

Federalism and Fragmentation

The U.S. response to COVID-19 cannot be fully appreciated without understanding the respective public health responsibilities of the federal and state governments. During colonial times, public health, including quarantine, was a matter for the colonies, and therefore when the Constitution was drafted, public health was not one of the enumerated powers granted to the new federal government and was reserved to the states. Consequently, the U.S. is one of the few nations without a national public health agency.[21] The authority of the CDC is limited to controlling international and interstate health threats, as well as performing research, developing training programs, collecting and analyzing public health data, providing laboratory services, recommending best practices, and the like. State governments and, in some states, county or local governments are responsible for all aspects of public health, including quarantine and isolation. This delegation of public health authority is uneven, and many counties lack the necessary funding or expertise; a few lack the political commitment to have *any* public health agency.[22]

Public health authority is not only divided vertically among federal, state, local, and tribal governments, it is also divided horizontally. Thus, at the state and local level, various public health functions are allocated to public health departments, hospital authorities, first responders, law enforcement agencies, sanitation departments, and other entities. Nationally, public health is the responsibility of 3,000 agencies.[23] Even under the best of working arrangements, inter-government and inter-agency cooperation may be difficult in a public health emergency.

The federal government's constitutional inability to mandate state public health measures does not diminish the importance of the federal role in developing and coordinating a national public health strategy with the states.[24] In early 2020, however, relationships were severely strained between the federal government and many states, which resulted in conflicting policies and fragmentation of efforts. While the federal government was minimizing the threat and severity of a coronavirus outbreak, states began to act, and 33 states declared a public health emergency before the federal government changed course and declared a state of emergency on March 13, 2020.[25] In allocating federal funds appropriated by Congress, states whose governor spoke kindly of the president received generous funding, whereas states with governors who were more critical received less consideration.[26] A lack of federal coordination in purchasing personal protective equipment caused states to compete with each other to purchase essential items, thereby driving up the prices and contributing to further shortages.[27] Fragmentation of efforts led to needless delays, gaps, redundancies, and inconsistencies.

Rugged Individualism

In my 2004 article, a central issue I considered was whether Americans would obey a quarantine.[28] As background, in Toronto during the SARS outbreak, there were about 30,000 individuals in quarantine, but in only 27 cases were quarantine orders required.[29] Canada is known for social solidarity, but in the United States, rugged individualism, self-reliance, nonconformity, and independence are highly valued. Americans are also skeptical of government and not reluctant to assert their rights in protests and in court. Widespread disobedience with public health directives or time-consuming litigation would threaten the ability of quarantine to reach the 90 percent compliance rate needed for maximum effectiveness.[30] Although China used a *cordon sanitaire* (an area quarantine in which nobody may enter or leave) in part of Hebei province and in parts of Beijing to fight SARS,[31] the notion that such draconian measures might be ordered, let alone tolerated, in the U.S. seemed inconceivable.

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COVID-19 changed everything. In early 2020, China far surpassed its prior level of coercive measures in ordering a *cordon sanitaire* for the entire Hubei province and the sheltering in place of 60 million residents.[32] In the U.S., every state has declared a public health emergency, including some or all of the following provisions: quarantining travelers entering the state, ordering sheltering in place, closing schools and nonessential businesses, maintaining a social distance of at least six feet, prohibiting groups from congregating, requiring individuals to wear masks in public, and directing individuals with possible coronavirus exposure to self-quarantine for 14 days.[33] The "lockdown" of more than 245 million Americans represents the largest and most aggressive social distancing measure ever imposed in the United States.[34]

Social distancing attempts to "flatten the curve," delaying the peak onset of cases so they do not overwhelm the health care system.[35] These measures succeeded in reducing transmission of the virus,[36] but the morbidity and mortality totals were still overwhelming, and the economic and emotional effects were devastating. Social distancing measures would have been more successful if every state had adopted them in a timely manner, but some states from the Midwest and South lagged behind, perhaps awaiting stronger leadership from the White House.[37]

Despite many people viewing the social distancing measures as onerous and unduly prescriptive, initially there was a high rate of compliance.[38] There were three main categories of miscreants. First were the hoarders. Initially, the primary goods hoarded were toilet paper, hand sanitizer, disinfectant wipes, and certain food staples.[39] More troubling was the hoarding of medicines by physicians. Despite a lack of FDA approval or research studies, President Trump touted chloroquine and hydroxychloroquine at press conferences as being "very effective" and possibly "the biggest game changer in the history of medicine."[40] A number of uninfected physicians followed the president's endorsement by prescribing the drugs for themselves and family members to stockpile,[41] resulting in an acute shortage of a drug essential for patients with lupus or rheumatoid arthritis.[42]

Although public health depends on social cohesion, the U.S. has a long history of partisan politics interfering with public health, dating back at least to the 1918 influenza pandemic. More recently, in 2009, political party affiliation was highly correlated with the likelihood of an individual accepting or refusing vaccination against H1N1 influenza.

Second, disparate groups disobeyed social distancing and other public health measures.[43] For example, some college students on spring break ignored public health directives and continued partying on beaches in Florida;[44] the failure to cancel the Mardi Gras celebration was a leading cause of a major outbreak in New Orleans;[45] and some churches refused to cancel in-person Easter services, thereby placing the attendees and all of their contacts at risk.[46]

Third, and perhaps most offensive, President Trump's repeatedly calling the coronavirus the "Chinese virus"[47] predictably contributed to numerous acts of anti-Asian xenophobia and harassment.[48] According to one study, 30 percent of Americans reported witnessing COVID-19 bias against Asians.[49] Similar behavior targeting Asians took place in 2003 during the SARS outbreak,[50] against Mexicans in 2009 during the H1N1 outbreak,[51]and against Africans in 2014 during the Ebola outbreak.[52]

Finally, a few words about American health care providers. Because of the extreme danger and the independent spirit of Americans, some experts worried that many American health care providers might not report to work in a pandemic.[53] These fears proved to be greatly misplaced. Despite frequently inadequate personal protective equipment and long hours under exceedingly difficult conditions, American physicians, nurses, first responders, and allied health professionals came to work day after day at tremendous personal risk.[54] They earned the nation's deepest gratitude and respect.

Until late spring 2020, the relatively small number of protests and disconcerting actions embracing American rugged individualism were overshadowed by more community-oriented behavior reflecting the reality of significant individual and group peril.[55] Economic, social, and political pressures opposing social distancing increased as the period of economic inactivity dragged on and the quest to "reopen" the country took on a partisan political dimension, even attracting extremist groups.[56]

Partisanship

During the early days of the coronavirus pandemic, the American people performed substantially better than many public officials, and a major reason for the inadequate governmental response was partisanship. Although public health depends on social cohesion, the U.S. has a long history of partisan politics interfering with public health, dating back at least to the 1918 influenza pandemic.[57] More recently, in 2009, political party affiliation was highly correlated with the likelihood of an individual accepting or refusing vaccination against H1N1 influenza.[58]

The COVID-19 pandemic arose at a time of unprecedented partisan

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polarization, in an election year, and shortly after the impeachment trial of the president. Disparities were first apparent in the level of concern by members of different political parties. Republicans thought Democrats were overestimating the risk and using the threat of a coronavirus outbreak as another way to criticize President Trump. Fox News reinforced this view. "If you were a Fox News watcher, you weren't *supposed* to be worried about the virus."[59] It was not until President Trump declared a national state of emergency that Republicans and conservative media commentators recognized COVID-19 as a serious threat to public health.[60]

The partisan divide was more than a difference in attitude. Initially, COVID-19 disproportionately affected urban areas, including New York, Seattle, New Orleans, Detroit, Chicago, and Los Angeles, which meant that Democratic-voting areas had many more cases than Republican-voting areas. In a study of the first 102,000 cases, 77 percent of the cases were from counties that voted for Hillary Clinton in 2016, and only 19 percent were from counties that voted for Donald Trump.[61] As the pandemic spread in rural areas, the gap decreased, but partisanship did not.

The greatest partisan issue has become the rate of and conditions for "reopening" the economy and scaling back on social distancing measures as the first wave of the pandemic wanes. The dispute will certainly heighten as the presidential campaign unfolds.[62] At heart is a fundamental divergence of political philosophy. "A lockdown runs counter to the spirit of rugged individualism that takes on near-mythic proportion in America, particularly among libertarian-minded conservatives."[63] If political considerations overtake science and policy decisions increasingly divide along party lines, the country's ability to address the difficult challenges of a pandemic will be seriously undermined.

The Future

In the midst of an unprecedented pandemic, it is extremely venturesome to predict how, if at all, American society will change after the pandemic ends. Will the United States be able to lessen some of the vitriolic and destructive partisanship? Will a greater sense of common purpose lead to a society less divided by income, more tolerant of minorities, and more sympathetic to the plight of its most vulnerable members? Will the country exhibit less hubris with regard to its scientific and technological prowess? Will the United States reassume a leadership role in global health? These and other grand societal issues are beyond the scope of this commentary, but the following three matters should be among the top priorities of policy makers and the public.

First, the public health system needs a complete overhaul, including significant increases in funding and meaningful coordination of federal, state, local, and tribal public health entities. Public health leaders at all levels should be experts insulated from partisan political pressure. Federal funding should ensure adequate surge capacity in hospitals and vast stockpiles of ventilators, personal protective equipment, medications, and essential supplies. According to Donna Shalala, who served as Secretary of HHS during the Clinton Administration: "Every time I said 'public health infrastructure,' to Congress, their eyes glazed over. So I blame both parties for not paying attention."[64]

Second, Congress should enact legislation providing for paid sick leave as a matter of public health necessity. Individuals who are ill, but who lack paid sick leave, often feel financially compelled to work, thereby exposing coworkers and the public to illness. Federal and state legislation also should be enacted to provide income support to individuals in quarantine as well as protecting them from adverse actions, such as discharge from employment, eviction from housing, and repossession of autos. Legislation also should grant immunity from arrest, deportation, or other legal jeopardy to encourage individuals to enter quarantine.[65]

Third, Congress should enact legislation providing for universal access to health care. The method of funding such a measure is less important than having coverage in place. People lacking health insurance and regular heath care suffer from more serious illnesses, and they are more difficult to treat. They are also more likely to acquire and transmit infections that threaten population health. A humane, inclusive approach to health care access will benefit all of society.

Note

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