Public health: From politicization to a path forward

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INTRODUCTION

On April 18, 2022, US District Judge Kathryn Kimball Mizelle in Florida ruled that the federal mask mandate covering planes and other forms of transportation exceeded the statutory authority of the Centers for Disease Control and Prevention (CDC).1 Among other reasons, Judge Mizelle ruled that the CDC failed to justify the mandate order and did not follow proper rulemaking procedures.

Public health law scholars and practitioners have strongly criticized the opinion and are concerned about the consequences for public health if upheld on appeal.2 What cannot be missed about this ruling, however, is the public's reaction to it. Eventhough polls show that most people continue to support a mask mandate on public transportation,3 the ruling itself, announced in mid-flight on many airlines, led many to cheer and immediately remove their masks.

In this perspective, we examine how such a seemingly common-sense public health measure became so politically divisive and what public health professionals can learn from this journey. In addressing these issues, we also want to acknowledge that state and local public health officials have managed the pandemic with exceptional dedication and commitment to protecting the public's health, despite the many obstacles that they confronted.

THE CASE

By any reasonable interpretation of the Public Health Service Act of 1944 (PHSA),3 CDC has ample authority and scientific justification to sustain the mask mandate on appeal. For several reasons, the Florida opinion contravenes the PHSA’s plain language.

First, the PHSA specifically states that the CDC may take “other measures the Public Health Service deems necessary to protect the public’s health.” The mask mandate clearly meets this provision, especially since scientific evidence supports masks’ effectiveness (see, e.g., Ref. 4).

Second, Judge Mizelle’s opinion incorrectly defines sanitation as “active measures to clean something,” and concludes that “masks clean nothing.” This disregards the contemporaneous meaning of the PHSA’s term “sanitation.” A leading 1940s public health law text defined sanitation as “public hygiene,” stating that sanitary science embodies “the principles that aid in an understanding of the sources of infection and modes of transmission of disease.”5

Third, under the logic of this opinion, judges would usurp whether and how to mitigate an infectious disease outbreak rather than deferring to public health professionals. As such, the underlying issue in the case is less about masks than it is about the legitimacy of the CDC’s authority to protect the public’s health in future pandemics.6

THE POLITICIZATION OF PUBLIC HEALTH

Early in the pandemic, many public health leaders were unprepared for the political implications of becoming public figures tasked with leading communications and policy to mitigate a fast-changing, little-understood global pandemic.7 While there was initially much public unity on measures to contain the pandemic (flatten the curve!), that unity quickly fell apart as political leaders started giving messages about coronavirus disease 2019 (COVID-19) that conflicted with public health messages.

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This early politicization intersected with the scientific uncertainty around COVID-19, especially in understanding the disease (e.g., transmission routes via surfaces vs. droplets vs. airborne; importance of superspreading events). Guidance about it from the CDC and other public health leaders appropriately changed as more information was shared and data were analyzed. Unfortunately, the communication of uncertainty was not always clear, leaving the public confused about the disease’s trajectory, the feasibility of policies to mitigate the pandemic, and when it would end. All of this provided and enabled opportunities for misinformation and politicization to undermine the aims of public health.

The structure of public health—with Federal, State, and Local agencies often not aligned and accountable to different political leaders—also interfered with consistent and clear messaging to the public. In some cases, states competed with one another for resources. In other instances, the lack of coordination and structure sometimes led to conflicting messaging, unclear authority, and logistical challenges.

Decades of underfunding of public health also meant that public health leaders were struggling with limited staff and overwhelming workloads.7 At the same time, they needed to be spokespeople to the public and communicate uncertainty and nuance in what were often complex, changing situations. Underfunding and the fragmented structure of public health deprived health officers of unified data standards. The lack of data standards made it remarkably challenging to collect and combine data across regions to understand the full picture of COVID-19 transmission. These deficiencies further created openings for misinformation and politicization.

Finally, some of the measures initiated to keep the public safe relied on using public health’s powers to require all citizens to adopt certain personal behaviors (e.g., masking). These public-oriented protective actions, in combination with the length of time the pandemic has been in effect, collided with the strong thread of libertarianism that runs through American society. When combined with the other factors above, the politicization of public health became inevitable.

**RESULTS OF THE POLITICOIZATION**

By themselves, the factors unique to COVID-19, and the length of the pandemic itself, would have created serious political problems. However, the growth of social media and other tools of misinformation allowed groups generally opposed to governmental actions to turn their attention to public health. These groups mobilized to fight public health measures and often, public health leaders themselves. Examples abound, including contentious school board meetings, public health leaders personally threatened, and local sheriffs refusing to enforce government orders.8,9

The group that brought the lawsuit resulting in the Florida decision is only one example.

Equally significant, we have seen corresponding changes in trust of the public health system—positive ratings of the public health system declined from 43% to 34% from 2009 to 2021, and positive ratings of the CDC fell from 59% to 54% over the same period, according to a survey by the Robert Wood Johnson Foundation and Harvard School of Public Health.10 The low trust of the CDC was particularly pronounced among Republicans, with 27% of Republicans reporting trust in the CDC compared to 76% of Democrats. The loss of trust in the CDC reflects the political polarization of public health messages—potentially leading to differences in the health impacts of the pandemic.11,12

**WHERE TO GO FROM HERE**

There are tremendous learnings coming out of COVID-19—many of these lessons on the scientific side will have global benefits for improved medical interventions that are only beginning to be understood. As painful a journey as it has been, there can also be beneficial learnings for public health that can strengthen public health into the future. From the journey so far, we can say:

- Public health leaders need more training and experience in public communication: especially how to communicate uncertainty. In addition, public health leaders need a better understanding of how to deliver concise and accessible messages, particularly on social media platforms.
- The public health system in the United States must focus on improved internal communications, coordination, and alignment. Federal, state, and local public health professionals must work to give consistent messages that are clear and understandable to the public and available on a broad range of platforms that can reach all Americans.
- Public health and the rest of the health care system must reach beyond their own silos and build trust and partnerships. While trust in public health is low, trust in primary care and other medical professionals providing clinical care remains high. Yet, these professionals were often not called upon to participate in the public health messaging in response to the pandemic.
- Although many public health leaders appealed to the common good in their messages, it was harder for those messages to break through as the time of the pandemic lengthened and the resistance became entrenched. Mobilizing other, trusted community leaders, such as the faith community, to provide these messages could help reinforce and restore the cultural norm of a shared responsibility. This will require ongoing evaluation of new messaging and other strategies to rebuild the public’s trust in governmental public health.
- Public health officials need to be able to rely on law enforcement agencies to enforce their orders. In too many instances, the pandemic exposed law enforcement’s unwillingness to enforce the orders. Health officers’ need to build relationships between agencies, well in advance of a crisis situation. At a minimum, health officers should develop memoranda of understanding to ensure that the orders will be enforced.
- Although the pandemic has spurred growth and integration of public health data systems, these data investments have...
been short term. Long-term investments in data systems need to be made for these improvements to continue and to be sustained.

• Public health agencies at the state and local levels need more secure funding. Funding increased for public health once the pandemic was in full swing, but public health was playing catch-up rather than being prepared. To implement the lessons learned that we list here, public health agencies must be funded sufficiently to tackle future disease outbreaks.

• Finally, given the libertarianism so evident in America, public health orders must necessarily be as judicious, time limited, and most importantly, as targeted as possible. The measures taken in COVID-19 have often been taken without clear goal posts on when they would end and what circumstances they were most necessary for. There has been comparatively little backlash to masking in medical care settings because the public understood the reasons and importance behind that measure. There was also little push back at first to the measure on masking in public transit because the reasons were clear early in the pandemic. Clarity about the reasons for the measures and goal posts on when they will end are particularly important when faced with a longer-term emergency such as a multiyear pandemic. As we saw in the early days of the pandemic, people are often more willing to accept limitations on their activities for shorter, acute emergencies, but as an emergency continues, tolerance of these measures goes down.

CONCLUSION

Navigating the COVID-19 pandemic has sorely tested our public health leaders at every level of government. Despite the incredible technical challenges of dealing with a little-understood and fast-moving pandemic and the often-hostile political environment faced by too many, these leaders have been remarkable in their dedication and commitment to saving lives and doing all they could to make our communities safe. Too many of our public health leaders have been left to fight this battle without the resources and supports they need to be successful. Let us hope that the learnings from COVID-19 do not just end as we move from pandemic to endemic. We have an opportunity to learn, prepare, and do better for all of our futures. Let us not waste it.

CONFLICTS OF INTEREST

The authors declare no conflicts of interest.

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