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US COVID-19 LESSONS

US public health after covid-19: learning from the failures of the hollow state and racial capitalism

Justin Feldman and **Mary Bassett** describe how diminished political will to use government powers for service provision hampered the US response to the covid-19 pandemic and what needs to change

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The US response to the covid-19 pandemic failed in its central task of protecting life. When the government's public health emergency declaration ended on 11 May 2023, more than 1.1 million people in the US had died, the covid-19 death rate was higher than in comparable wealthy nations,[1] and gaping racial and ethnic inequalities in mortality remained.[2] In public health circles, chronic underfunding of public health agencies is often used to explain the shortcomings of the US covid-19 pandemic response.[3] If only health departments had larger budgets, these arguments go, government could have expanded efforts to prevent SARS-CoV-2 transmission, promote vaccination, and deliver early treatment to medically vulnerable people.

The budgetary concerns are warranted. Only 1% of the country's total health spending is devoted to public health activities.[4] State public health spending was flat in the decade following the 2008-09 recession[5] despite growing needs, including rising maternal mortality[6] and stagnant or declining life expectancy.[7] However, the challenges facing government public health go beyond budgetary constraints. Although starving health department budgets is harmful, it is a symptom of the more fundamental problem of political divestment from state capacity and state directed projects of social transformation.

The pandemic has revealed that US federal politics can support high levels of spending in response to a major crisis. The CARES Act, a $2.2tn pandemic response bill passed by US Congress in March of 2020, was the largest spending bill in the country's history, and the American Rescue Plan Act (ARPA), passed by Congress in March 2021, provided $350bn in fiscal support to state, local, and tribal governments. Unfortunately, unprecedented spending was not accompanied by parallel efforts to address fundamental deficiencies in government capacity—staff, skills, experience, and facilities.

Reflecting on global trends of the past half century, political analysts refer to the diminished role of government in planning and service provision as "the hollowing of the state."[8] The pandemic response broke with previous commitments to fiscal austerity, but this change was not accompanied by a proportionate expansion of the planning, coordinating, and service delivery functions of government. As a consequence, the state remained hollow, even if a much higher level of funding was available for a few years. In this article, part of a BMJ series on lessons from covid-19 for the US (https://bmj.com/collections/us-covid-series), we consider how racism and other factors contributed to the development and maintenance of the hollow state and identify opportunities for change that could improve responses to other public health crises.

Historical context

By international standards, the US historically has assumed low levels of public intervention in the provision of services, which notably includes its lack of a national health system. Even so, numerous political efforts have been underway, particularly since the 1990s, to further privatize public services. Examples exist in education (eg, government funding of privately owned schools through charter and voucher systems),[9] health insurance (eg, delivering Medicaid and Medicare through private corporations),[10] and even emergency services (eg, private equity ownership of local fire and paramedic services).[11] This "privatization of everything" generally undermines the quality of services.[12]

The trend toward privatization is just one aspect of the hollowing of the state, however. A second is the erosion of the state's role in economic redistribution, which has included a substantial decline in the proportion of total taxes paid by the wealthiest 0.01% of households between 1950 and 2018.[13] A third aspect is the political abandonment of the state as a tool of major social transformation aimed at rectifying injustices and improving lives. The New Deal (1933-38) created federal regulatory and social welfare infrastructures and the Great Society (1964-68) expanded civil rights protections and healthcare while seeking to eliminate poverty. No initiatives of similar ambition have been pursued since the 1970s, however, and by his 1996 State of the Union speech, President Bill Clinton could confidently declare that "the era of big government is over." A circumscribed role for government became an increasingly dominant view within both major political parties as well as for various thinktanks, industry associations, and political donors.[14]

Racial capitalism—the strategic deployment of racism by governing elites with the intention of reproducing class privilege—has driven these historical trends in three key ways. First, racism served as an important tool to undermine political support for redistributive and transformative government initiatives. An example is the attacks on social welfare programs in

the 1970s and 1980s, during which politicians appealed to white resentment by conjuring implicitly Black images of "young bucks" and "welfare queens" who were undeserving recipients of government aid.[15] Second, when state capacity remained, politicians wielded it in increasingly punitive ways in an effort to appease resentments and fears about Black people. This ranged from imposing onerous requirements for receipt of government aid to the large scale expansion of incarceration between the 1980s and 2000s.[16]

Finally, the hollowing of the state exacerbated racial inequities in the US across many areas of life, including income, health, healthcare, and employment. Black people in the US, who have historically been over-represented as public sector workers and as consumers of public services such as Medicaid, have borne a disproportionate burden of these changes. For example, the transition to privately administered Medicaid programs in the US state of Texas at the turn of the century resulted in a substantial increase in Black infant mortality and preterm birth rates, worsening racial inequality in these outcomes.[17]

Hollow pandemic response

The US response to the covid-19 pandemic reflected these key features of the hollow state. The circumscribed role of the state is apparent in the federal government's failure to try to create a comprehensive national plan for non-pharmaceutical interventions. Privatization was another theme that appeared throughout the response, including a heavy reliance on the private sector for functions ranging from public policy development to vaccine distribution. Additionally, limited state resources were used for punitive ends, with state and local governments spending several times more federal ARPA funding on police, prisons, and courts than on the public health system.[18]

That state and local governments were granted wide latitude over how to spend billions of dollars in pandemic funding, reflects the fragmented nature of the federal pandemic response. State and local governments were not required to pursue particular public health strategies to receive funding, and although some aid was specifically intended for public health purposes, most was not.[19] This approach put federal health officials in a weak position: they were often left to rely on diplomacy, rather than law, to encourage action. Other federal interventions, such as issuing occupational health regulations to control SARS-CoV-2 transmission and creating a federal public health response force of 100 000 workers, appeared in a White House plan that Joe Biden's administration released on his first day in office in 2021.[20] Few of these measures were ever pursued, however, and some were blocked by courts.

Although public health leaders and scientists may have limited ability to intervene in major congressional deliberations, we see two domains—the use of management consulting firms and the investigator driven model of US health research policy—as strategic areas that are relatively more amenable to our intervention as decision makers who can directly effect change within the public sector, citizens who can use our voices to influence political choices, and leaders who can establish norms for our field.

Use of management consultants

A key example of the hollowed state during the US pandemic response was government use of management consulting firms. Management consulting is an industry that purports to identify operational challenges, recommend solutions, and guide implementation of new programs. Critics have argued that employing public sector consulting firms such as McKinsey and Company, Boston Consulting Group, or Deloitte undermines state capacity.[21] By one count, at least 25 states paid management consulting companies to aid their pandemic response, as well as many US federal agencies and local governments.[22] One factor that likely made contracting these firms an enticing option at the local level was inadequate federal guidance, which was rooted in the failure of the Trump administration to provide leadership over the pandemic response.[23] The leadership vacuum proved lucrative, with consulting companies collectively earning hundreds of millions of dollars.[24] Their roles ranged from coordinating vaccine distribution programs to contact tracing, to developing post-lockdown reopening plans, and proposing the organizational restructuring of health departments.

Lack of transparency makes it difficult to determine the exact role of management consultants in the US pandemic response, let alone evaluate their performance. Some contracts prohibited sharing details of the work performed,[25] and firms were often insulated from the public records laws that would apply to a health department. The small number of investigative news articles about the role of these firms in the US pandemic response focused on consultants' lack of public health expertise,[22] unclear or ineffective interventions,[24] or their use in ways that circumvented the authority of health departments.[26]

Outside of the pandemic, consulting firms' misdeeds have sometimes taken years to come to light. Most notably, McKinsey advised several drug manufacturers, including Purdue Pharma, on "turbocharging" opioid sales amid a rising opioid epidemic while also advising Food and Drug Administration regulators.[27] This work began in 2004 but was not uncovered by journalists until 2019. Given the parlous economic state of the US journalism industry, numerous barriers to information access, and the media's waning interest in covid-19,[28] the role of these firms in the pandemic response is unlikely to face the level of scrutiny that is warranted.

While health departments certainly do not have a perfect track record, they offer numerous benefits that management consultants do not: expertise and experience in public health response, legal mechanisms for accountability and transparency, and a workforce that is motivated by the principles of public health, which also has a codified set of professional ethics.[29] Many health departments around the US have prioritized racial health equity initiatives in recent years.[30] But it is difficult to imagine a company such as McKinsey, which in 2018 proposed reductions in food and medical provisions to detained migrants as part of a $20m contract with US Immigration and Customs Enforcement,[31] substantively contributing to racial justice efforts. Health leaders can use their decision making powers within government and their voices as citizens to push against public spending on contracts with management consulting companies, while advocating that those funds be used toward expanding in-house expertise instead.

Public health research: funded publicly, pursued privately

The US has a system of health research that is largely publicly funded but privately directed by scientists at (predominantly private) universities. More than 80% of the US National Institutes of Health's (NIH) annual budget funds these scientists through grants.[32] Although NIH civil servants set broad thematic priorities, scientists pursue specific research questions that are shaped by their individual interests, judgment, and ambition. Furthermore, assessed expertise may become self-rewarding and a strategy of minor innovation on previous work most likely to maximize funding.[33] The foundation for this system was laid after the second world war. It represented the triumph of a model of the scientist as someone

who worked on "subjects of their own choice dictated by their curiosity for exploration of the unknown."[34] This model succeeded over visions that conceptualized science as a collective enterprise conducted mostly in government run facilities where social needs were more likely to factor when identifying research questions of public importance.[34]

When the covid-19 pandemic struck, this system was ill suited to serve public needs. It did not respond rapidly or prioritize research questions relevant to high stakes policy deliberations. In 2020, a mere 2% of NIH's external grant funding went to covid-19 research, and only a handful of these grants were related to disease transmission or nonpharmaceutical interventions.[35] Furthermore, US research policy had, by the time of the pandemic, produced generations of public health scientists with little experience in public health practice. While there are notable exceptions of academic engagement with health departments,[36] little has changed since a 1988 Institute of Medicine report identified the separate silos of academic public health and government agencies as a problem.[37] This long entrenched division of labor between research and practice, a result of the dominant "individual scientist as innovator" model, was not conducive to effectively mobilizing the thousands of US academic researchers to help with the major public health crisis.

One model for research that stands in contrast to this usual approach is Operation Warp Speed, the federal initiative to develop and produce covid-19 vaccines that was launched in May 2020. Although Operation Warp Speed was reliant on the private sector, the government took a heavily interventionist and coordinating role, setting an ambitious goal, deciding which projects to fund, assisting with vaccine development, ensuring the availability of manufacturing capacity, and sharing technology with researchers.[38] This effort supported the rapid development of multiple successful vaccines and highlighted the success of government scientists in developing groundbreaking techniques, what some have called the under-recognized "entrepreneurial state."[39] This notably included Moderna's vaccine, the production of which used a molecular stabilizing technique developed by the NIH Vaccine Research Center.

Nonetheless, the opportunity was lost to rethink how government might partner with the private sector to ensure public benefit of publicly funded scientific innovation. Concerns are growing that government's failure to assert ownership and control over the products that it helped develop will exacerbate inequities of vaccine access both in the US and in low income countries.[40]

Way forward

The US experience of the covid-19 pandemic has revealed that the mere existence of acute social need is not sufficient to bring about fundamental political change. History, however, has shown that state-led transformative projects that improve living conditions and rectify injustices can be achieved when social movements exert pressure. This was true for such pivotal public health developments as the construction of sanitation systems in mid-19th century England, which came about as a concession to organized workers amid more radical and redistributive visions for public health.[40] More recently, US teachers have successfully organized to prevent further school privatization in many states[41]; these campaigns have been strengthened through their alliances with other community organizations, unified by shared principles that often center on racial justice.[42] In addition, international examples including Vietnam, Kerala state in India, and Rwanda, each of which has built or maintained robust public health systems despite lacking the economic resources of high income countries,[21] show that declines of state capacity are not inevitable in the 21st century, but rather are political choices.

The political challenges to building a robust public health system in the US are formidable, and the task is far too large for the public health workforce to take on alone. Covid-19 will be followed by other pandemics, and the growing impact of climate change is likely to make crises more frequent. While underfunding is a ready target for advocacy, these broader challenges to rebuild the hollowed state offer opportunities for new alliances. Health workers have important roles in setting policy and educating the public about the causes of the seemingly intractable problems of governance that undermine the people's health. A focus on limiting the entrenchment of management consultants and protecting the network of government run public health surveillance and laboratories offers a starting point.

Key messages

- The US response to the covid-19 pandemic was hampered by long term policy trends favoring privatization, limited government, and a punitive role for state programs
- Racism against Black people has long undermined political support for state functions that are critical to protecting public health and promoting health equity
- Lack of government leadership led to widespread use of management consultants to guide public health response with limited accountability
- The investigator driven model of public health research has sidelined social needs and separated researchers and those working in public agencies
- Reduced reliance on consultants and improved resources for government run research and surveillance would help ensure better response to future crises

Contributors and sources: MTB was the New York state health commissioner during the omicron surge of 2021-22. This experience gave rise to many of the concerns regarding government public health capacity explored in this article. JMF researches health equity, policing, structural racism, and the political economy of the US covid-19 pandemic response. JMF wrote the first draft. Both authors contributed to, read, and approved the final version.

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