Debacle: Trump's Response to the COVID-19 Emergency

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Abstract Why did the United States, ranked as the world's best prepared country, fail so dramatically in its response to the COVID-19 pandemic? Part of the reason is the backdrop of a fragmented and largely market-driven health care system, part of the reason is a society marked by dramatic racial and economic inequality, but a key part of the reason is the structure of the public health system. The United States approach, which reflects the politics of American federalism, involves underinvestment and underpreparedness at every level of government except the federal. Effective response has to be led by the federal government. The complexity of the federal government is such that any effective federal response must be led by the White House. If the White House fails to lead, the federal government will fail to lead and the system as a whole will not be capable of effective public health response. That is exactly what happened in 2020.

In January 2020, a consortium led by the respected Johns Hopkins Center for Health Security produced its Global Health Security Ranking.[1] It evaluated the pandemic preparedness of almost every country. While critical of every country, it ranked the United States as the best prepared country to face a pandemic. President Donald Trump flourished the report's color-coded map at the February 26th press conference. At that same conference, he assured Americans that their risk "remains very low" and that he had taken "very good decisions."[2]

By June 2020, the United States stood out for one of the worst, if not the worst, pandemic response of any country. Its cases were high and rising, its population confused and embroiled in partisan struggles about masks and physical distancing, and its president, desperately trying to change the topic to economics and xenophobia, was holding rallies in pandemic hotspots. Citizens of the world's richest country, with supposedly the best

[1] https://www.ghsindex.org/

[2] https://www.npr.org/sections/health-shots/2020/02/26/809578063/trump-to-address-response-to-coronavirus

pandemic preparedness, were very reasonably banned from travel to Europe on the grounds that they would bring infection.

What happened?

This chapter explains the structures which made the United States so vulnerable to the virus and to Donald Trump's leadership. It focuses on fragmentation, inequality, and the disruptive president.

American public health: Fragmentation and federal leadership

Like everything in the United States public sector, communicable disease control is extremely fragmented. The United States has approximately 90,000 governments, of which approximately 18,000 have public health responsibilities. These latter range from mosquito control districts with a handful of staff to the state of California, with about 40 million inhabitants, to the federal government itself, with its approximately 4.5m civilian and 1.3m military employees. As the English constitutional theorist Walter Bagehot wrote long ago:

> "The English constitution, in a word, is framed on the principle of choosing a single sovereign authority, and making it good: the American, upon the principle of having many sovereign authorities, and hoping that their multitude may atone for their inferiority." (1)

Local governments in the United States are even more multitudinous and inferior today than they were in 1867. American local and state government is optimized to minimize its costs, even while enabling a wide variety of rent-seeking, such as licensing and professional monopolies far more restrictive than the EU permits (2). They compete to offer services to voters and business at the lowest possible price. Many of them are frankly predatory, using police as revenue-generators through techniques such as large fines for minor infractions (3).

There are virtues to this competitive system if the goal is to prevent excessive provision of public services (whatever that means outside a tendentious and formal economic model), though the whole logic is somewhat invalidated if their approach to balancing tax revenue and services is to escape the tradeoff by depending on predatory policing for revenue. But one thing is clear: the system is not set up for optimal local production of public goods. It is set up to provide public goods such as public health at the lowest level that allows society to function, and will often err on the side of providing too little. Public goods, in the United States even more than in other federal countries, are best and most sustainably produced by the federal government (4).

This dynamic is more important because so few parts of the United States health care system are actually built to provide public goods. As has been endlessly rehearsed by comparative studies, the United States health care system costs an enormous amount of money to produce outcomes that are average by international standards while leaving a large number of Americans with inadequate or no health insurance (the annual *Health at a Glance* publications of the Organisation for Economic Cooperation and Development are a damning portrayal of the US health care system compared to its peers, as are the

Commonwealth Fund's annual surveys). Private and nonprofit health care providers respond to regulatory mandates, lawsuits, and payment systems. These highly imperfect tools are only part of the toolkit for health policymakers in most systems, but in the United States they are most of the toolkit. The underlying problem for the United States health care system is simple enough to see in comparative perspective: there is no effective monopsony purchaser of health care and there is no price-setting mechanism. Every other OECD health system has these and the endlessly fascinating differences between system types such as Bismarckian and Beveridgean systems are secondary to that basic structural fact (5) (6). Combined with the lack of commitment to universal health care access, the result is a health care system focused on economic efficiency and revenue. Predictably enough, that focus meant that it lacked resilience in the pandemic, and that the pandemic threatened to leave key areas such as primary care seriously damaged by the lack of customers. That the United States faced a health care recession that threatened to devastate its rural and primary health care in the middle of a pandemic is a testament to the underlying perversities of its health policies and health care sector.

In such a system, some governments, even vile ones, will provide public health, whether as a service to citizen in urban areas such as New York (7) or as a service to businesses that require stable and cheap labor. But tax competition, balanced budget rules which make states viciously procyclical (8), weak and declining transparency and media, and anti-government politicians all ensure underinvestment in even the biggest, most capable, and most progressive states. Most state and local policymakers will understand their incentives correctly, roll the dice, underinvest, and assume that there will be no public health crisis for which they can be held accountable.

As a result, the dominant theme of the development of public health in the United States has always been the role of the federal government. The federal government has the expertise and powers of suasion and leadership that can mobilize the rest of the US's weak public health system, adding crucial expertise and making the whole more than the sum of its parts. And above all, it has money (9, 10).

Federal leadership has compelling advantages in the abstract (as we see in debates about what the EU, while respecting subsidiarity, can do better in public health) (11) (12). It enables specialism- CDC employs experts in almost any known disease, and can rapidly create expertise in new ones. Smaller countries, such as even big EU member states, have difficulty justifying such investment (the solution is to work with universities, but that creates other complexities). It is efficient- there is no reason for any other single US government to employ scientists interested in topics such as coronaviruses. CDC can maintain staff and research all over the world; the calculus for a polity of ten million people such as North Carolina, Michigan, or Sweden would be different, and we would absolutely not expect a small polity like Wyoming, Vermont, Rhode Island, Cyprus, Malta or Estonia to do things like run a large research station in Indonesia. Size enables specialization and division of labor, which can be very helpful.

In the particular context of US federalism, where other governments' tax competition and politics lead them to invest as little as possible in public health, federal leadership and resources are necessary to provide public health when there is a public health emergency (13) American local governments are, structurally, like people who are forced to build closely-packed houses out of flammable wood but enjoy a very good fire

department. The problem for them is that while the fire department can put out individual fires alone, in a real crisis everybody has to join the bucket brigade (14). The CDC can manage individual outbreaks well, but organizing a bucket brigade requires that everybody have buckets, strength, and leadership. Austerity policies driven by the Republican party since 2010 had been undermining the fire department as well as that bucket brigade. State and local government finances never left the austerity of the financial crisis, the result has been a decade of declining expenditure on public health and related services and a loss of around a fifty of public health jobs 2010-2020.

In short: the system was too dependent on a CDC that was dependent on competent federal leadership. The federal role depends on the ability to marshal the federal government. The United States executive branch is notoriously complex, filled with fiefdoms and agencies with their own political and legal accountabilities, and lines of authority on paper that have no relation to reality. To summarize a huge volume of research, the result is a system in which coordinated action is only possible if the White House wants it, whether through the established interagency mechanism of the National Security Council or an ad hoc "czar" (10). Trump's National Security Advisor John Bolton abolished the pandemic preparedness function of the NSC that Obama had created. As a result, there was little central capacity to respond to health emergencies by 2020. Powerful components of the US government, from CDC, to the military and emergency management, were never really coordinated.

Thus, for example, it was immediately obvious that the inability of the Food and Drug Administration and the CDC to agree on procedures for testing in the crucial months of March and April reflected a failure of the White House to demand coordination. Given the way the Trump administration operates, a failure of coordination was a reasonable expectation, but evidence immediately started to build up that Trump was actively hindering response. Early in the pandemic, he made it clear that he opposed testing because it increased the numbers of reported cases.[3] In June, he told a rally that "I said to my people, 'Slow the testing down,'"[4] and when his communications staff said he was joking, he reaffirmed it: "I don't kid...By having more tests we find more cases."[5] The US federal failure could well have been a sin of commission as well as the blatantly obvious sin of omission, omission to coordinate the federal bureaucracy in the way only the White House can do.

American public health politics: Partisanship and inequalities

What politics produced this public health system, in which the federal government rose up like a giant before the world despite its feet of clay at the local and state levels? The politics

[3] https://www.vox.com/2020/5/15/21259888/trump-coronavirus-testing-very-few-cases

[4] https://www.washingtonpost.com/nation/2020/06/21/coronavirus-live-updates-us/

[5] https://www.politico.com/news/2020/06/23/trump-joking-slowing-coronavirus-testing-335459

of public health in the United States reflects its institutions, discussed above, as well as the broader trends in its political economy and society that shape interests and party strategies.

There are two key relevant issues in the American political arena. The first is the extent of partisan polarization among elites and in the electorate. By any indicator, federal and state elected representatives of the two big political parties no longer overlap on many issues; the most-right-wing federal Democrat is to the left of the most left-wing Republican. American political parties, long known for ideological incoherence and transactional behavior, have achieved levels of legislative bloc voting and ideological decisionmaking that rival parties in European systems long known for their well-coordinated parliamentary blocks. Voters have taken the cue: to the extent that an American voter knows about politics, that voter is likely to be partisan and ideological. Voters who followed politics at all were more and more likely to have adopted coherent partisan views that reflected party elite politics (15). This polarization extended to the level of increasing reluctance to accept a child's decision to marry a partisan of the other party (16). It was also asymmetrical; Republicans are a much more socially coherent and self-consciously ideological party (17). One result has been that Americans disposed to magical thinking, conspiracy theory and superstition, have sorted into the Republican party (18). Donald Trump accelerated this polarizing trend with his skill at inserting himself into issues, making disparate news items, from weather to sports, into stories about him and his preferred issues.

It is a commonplace of electoral studies that partisanship rests on cleavages, and a commonplace of American electoral studies that the key American electoral cleavage is to do with race. White superiority, religious fundamentalism, and patriarchy form a "tryptych" of conservative beliefs that dominate the south and structure the Republican party as a whole (19). The United States shares with other societies shaped by slavery a particular kind of politics in which racial divisions are the key tool used to block cross-class racial coalitions (20). Combined with a partisan political media, notably the powerful role of the Murdoch-owned Fox News channel (21), the result is that partisanship predicts attention to and understanding to public health issues (10, 22). It should be no surprise that partisanship predicted compliance with social distancing, that refusal to take public health precautions correlated with refusal to accept science on other issues such as global heating (23), and that viewers of Murdoch's Fox News network, especially specific hosts, were less likely to take public health precautions (24).

Donald Trump: Denial and distraction

Donald Trump made extensive welfare chauvinist (25) claims during his campaign, seeming at time to claim the largely unoccupied American political space of an advocate for an ethnically exclusionary but generous welfare state. In practice, though, he had a strong preference for focusing his symbolic and programmatic politics on his core issues of xenophobia and racism, such as brutal border enforcement and massive restrictions on visas for legal immigrants.

In this he was not unlike other politicians of the populist radical right, whether entire parties or individual politicians who draw on that political repertoire such as Boris

Johnson (Falkenbach and Greer, forthcoming). It was entirely in character with the man, his political strategy, and his ethnonationalist party to simply declare victory over the virus and push to re-open the country without even masking or the pretense of physical distancing (e.g. holding a packed rally on June 23 in Phoenix, just when it was clear that Arizona's outbreak was completely out of control and its health systems about to collapse). Changing the topic to "LAW AND ORDER" (which he tweeted on May 31 and June 6), immigration policy, and a putatively reviving economy would at least allow him to excite his base voters and shape the agenda in a way beneficial to him.

Trump came into office at a time when the presidentialism of the US had created an extremely powerful and autonomous executive that legislators had, for a variety of reasons, little interest in checking (26, 27). The whole federal public health system depended on the leadership of the federal government; the federal government depended on the leadership of the White House; and the White House, unfortunately, depended on Donald Trump.

Daniel Drezner summarized the story of US public administration that led to this situation:

> "For decades, political architects in both major parties had worked at building the presidency into the most powerful position in the world. As polarization gripped Congress, the president was viewed as the last adult in the room. And then someone with the emotional maturity of a small child was elected to that office. Each of the guardrails checking presidential power had eroded before Trump was elected president. Under the 45th president, they have almost completely disappeared. As president, Donald Trump has acted like many toddlers: he is bad at building structures, but fantastic at making a complete mess of existing ones." (28)

There are, as noted above, deeper issues in American politics and more impressive evolution. Without the increasingly obvious shift from a white majority, undemocratic institutions such as the unrepresentative Senate and Electoral College, Republican jurists' decisions that exacerbate political inequality, the partisanship of Republican Senators, or the increasing focus on white identity of the Republican party, Donald Trump would not have been in office by March 2020. But there are accidents in history as well, and Trump's showmanship and strategy of ethnic outbidding might have been the necessary condition to take over a Republican party uncomfortably stretched between racist appeals and other electoral pitches.

Summary: Before the storm

As of January 2020, then, before storm, we could characterize public health politics in the United States as follows:

A fiercely competitive and often inept set of state and local governments were structurally inclined to underinvest in public health. Rather than change their overall incentives, the federal government built an impressive apparatus, especially CDC, to make up for their deficiencies. This was efficient and enabled American communicable disease control to run smoothly despite the meager resources state and local governments gave it. Federal leadership, normally through CDC, was the center of the system. Federal leadership,

however, is difficult given the difficulty of coordinating the federal government. Coordinating the federal government requires an effective White House or National Security Council.

If the White House is ineffective or uninterested in solving the problem, then the federal government will not lead. If the federal government will not lead, then the system overall does not function. In particular, no other actor, whether state or local, public or private, has the money and staff or scientific resources to replace an inept or malign federal government.

Debacle

Unfortunately, the president of the United States when COVID-19 hit was Donald Trump. COVID-19 and Donald Trump were both almost perfectly adapted to exploit the problems of American inequalities, American politics, and American public policy.

Inequalities

As sociologist Tressie Cottom succinctly put it in March, "wealth is the vector" (29). By late April, though, it was clear that pre-existing social, economic, racial and health inequalities would shape its effects on people and society. Once endemic in an area, COVID-19 quickly became a disaster for, poorer people and in particular people of color (30).

Morbidity and mortality were grotesquely disproportionate: by late June, CDC was reporting that Native Americans, Alaskan natives, and Blacks were approximately five times more likely to be hospitalized for COVID-19 than non-hispanic whites, and hispanics were four times more likely. Put another way, Blacks are 13% of the US population but as of the end of June 23% of the people who died of COVID-19 whose race was recorded were Black. Wisconsin is 6% Black but 27% of recorded deaths due to COVID-19 were Black people. Michigan is 14% Black, but 21% of the cases and 42% people whose deaths were attributed to COVID-19 were Black as of the end of May. Many of the states known for the worst health and other inequalities were not publishing data on COVID-19 that allowed us to understand the demographics of people with the disease and people who died from it. It is clear that much of the South had particularly bad outbreaks and mortality in black communities, e.g. in Georgia and Louisiana, but the states make it impossible to quantify the disparities. Some states, such as Georgia and Florida, were openly manipulating their statistics and presentations to minimize the scale of the outbreak.

The reasons were no surprise to inequalities researchers (30) (31). First, race predicted exposure via the job market and living conditions. People of color were more likely to work in low-wage service sector jobs that demanded contact with the public. Many of these were deemed "essential" and continued during lockdowns, such as supermarket clerks or bus drivers. Many of them worked in health care, where tasks such as cleaning rooms were obviously dangerous. The agricultural workforce, including people employed in the country's poorly regulated abbatoirs, is disproportionately Latino and highly exposed.

In terms of risk factors for becoming sicker (e.g. requiring hospitalization), the same inequalities were at work. Residential segregation meant that exposure to a variety of

contaminants was higher, which meant that risk factors such as asthma were much more prevalent among Blacks and Latinos. Thus, for example, the shocking outbreak among the Navajo Nation in spring 2020 was partly due to extended and mutually supportive intergenerational families- exacerbated by the widespread lack of clean water supplies that even a cursory reading of American history would lead an observer to expect. Residents of the poor and mostly Black town of Flint, Michigan, still did not all have safe drinking water, and many others had been cut off from water for unpaid bills, which made it hard to obey calls for constant handwashing. As the Black Lives Matter movement has communicated clearly, racism in American society simply puts more daily stress on people of color and that translates into greater susceptibility to a wide range of health problems (32). An uneventful interaction with police, for example, is much more stressful for Blacks than for whites.

Access to health care, then, is problematic. The United States has a long history of discrimination in health care provision that is by no means over . Nonwhite Americans are more likely to lack health insurance or stable health care providers. In rural areas, where health care infrastructure is increasingly poor, health systems lack capacity and are easily overwhelmed (e.g. with the early outbreak in majority-Black poor counties in southwestern Georgia). States that did not expand Medicaid have the worst health care access problems; they are also among the poorest, most unequal, and have large Black populations and highly racialized politics. A legacy of discrimination in health research also means many Blacks and other people of color have less trust in health care providers (33) (34) (35).

The result was predictable enough: by mid-June, 31% of Black Americans surveyed reported that they knew somebody who had died of the virus, as against only 9% of whites[6]. In the lived experience of many well-off American whites, COVID-19 was simply not their problem, but lockdown and the economic slowdown were. It is unsurprising that Republican leaders, including ones who had initially defied Trump and taken strong measures, sped to undo lockdown and "reopen" their states even when epidemiological, public health, and health care infrastructure data all suggested it was a bad idea (36). Scholars of public opinion will have an urgent and difficult research task working out how the burden of COVID-19 was understood by different voters, and how that fed into their views about appropriate responses.

Fragmentation

The simple axiom of American public health emergency management is that the system, to work, requires federal leadership and federal leadership, to work, requires White House leadership. If the White House refuses to lead, or cannot lead, then the federal government will not play the leading role written for it and state or local governments will have to figure it out as they go along. That is exactly what happened. The result was a federal COVID-19 plan that was quickly abandoned, the sidelining of CDC, a corrupt free-for-all in

[6] https://www.washingtonpost.com/health/almost-one-third-of-black-americans-know-someone-who-died-of-covid-19-survey-shows/2020/06/25/3ec1d4b2-b563-11ea-aca5-ebb63d27e1ff_story.html

personal protective and medical equipment markets, and failure to take advantage of the months that the March-April lockdowns bought. The federal government did not just fail to coordinate and show leadership; it actively interfered with the efforts of state and private actors to do basic tasks like buy equipment.

This left it up to states. States, in US public health law, have the crucial "police power" to regulate behavior. It is states that can order businesses to close or people to wear masks. But despite their often impressive professionalism, they are also structurally without relevant resources. Much of their public health is Mätzke's underfunded bucket brigade rather than the well funded federal fire brigade work. Many have gerrymandered electoral systems that mean that they have Republican legislative majorities despite large Democratic majorities in the popular vote (Wisconsin, Michigan). All, effectively, have balanced budget rules that mean they cannot run deficits; the result is that they are procyclical, and can neither spend to compensate for downturns nor even spend in a downturn. State budget planners, faced with unprecedented revenue declines, were hardly able to rapidly build public health capacity.

Almost mathematically, devolving a function to states creates more divergence (37) (38). Letting different jurisdictions do different things produces different outcomes, and to the extent that they must raise the revenue to do it, they will be more different still. By late March, governors and health systems began to realize that they would not have federal help, and began to suspect that the federal government was being used by the Trump White House for corrupt purposes (39). They responded by coordinating with each other (and areas of the federal government less affected by Trump, such as the military)- developing what amounted to small spontaneous confederacies.

In other words, the executive-federal system failed because the federal executive failed. The result is a complete failure to contain the virus, coupled with constant attempts to distract from the problem and corruption and incompetence in the response. Federalism produced a partial solution as under-resourced governors realized that they were on their own and began to exercise leadership. Federalism has a bad reputation in public health circles because it incentivizes egotism and makes coordination difficult, but in federations with dysfunctional executives, such as Brazil and the United States, it has allowed some public health leadership (26). Predictably enough, though, partisanship rather than epidemiology, population health, or other factors drove state political decisions (40).

On the brighter side, the United States quite unexpectedly got the right ideas in social policy. Social and economic policy such as unemployment insurance and payroll subsidies (kurzarbeit) to employers are crucial to keep both businesses and people afloat in crisis. A hastily passed series of economic and social measures did just that, with a mixture of subsidies to industries (e.g. airlines), enhanced unemployment insurance, and flat payments to Americans. There are significant data problems at the time of writing, but it appears that spring 2020 saw both the most dramatic job losses in the history of American economic statistics- and a double-digit drop in poverty. While many Americans understandably focused on the enormous sums of money handed out by the Trump administration with no oversight or criteria, the policies worked as a broad stimulus. Reducing poverty by a large margin in the context of an economic collapse on a scale known to no adult was impressive.

Partisanship

As many commentators had remarked, Trump was lucky in that most of the crises he faced were of his own making, and he could end them if he stopped making them. Regardless of the increasing the challenges the US faced, the agenda-dominating issues of Trump's first three years were largely problems he created and extinguished as he chose. COVID-19 and the global economic shutdown were different. They exposed his and his party's fundamental unseriousness about public health or disasters, an unseriousness that was easily predictable by looking at the priorities of its key donors and voters. In the biggest disasters of his term before COVID-19, the hurricanes of 2017, his administration mainly distinguished itself for effectively ignoring Puerto Rico, with thousands of deaths and a migratory outflow as a result (41).

When COVID-19 hit, Trump pursued a base-focused strategy that research on the polarization of American politics suggested would work. Trump said, and made it clear, that he had slowed down testing in order to reduce COVID-19 test numbers. This strange nominalism affected Republican policymakers in multiple state governments as well. They appeared to believe that policies to reduce positive COVID-19 tests would somehow be equivalent to having fewer sick people, that changing statistics on hospital usage would somehow affect hospitalizations (as in Florida), or that "reopening" strategies which forced laid-off employees back to work and off of unemployment insurance would obscure a nearly unprecedented depression. American voters today are stably and highly polarized by party, prone to motivated reasoning, and tend to interpret events in a manner that is both partisan (42) and myopic (43). It is nonetheless very hard to imagine that a pandemic which kills tens of thousands of people a month and double-digit unemployment in a country with a limited safety net, can be hidden by a redefinition of intensive care or the creation of administrative burdens on those who want tests.

Possible futures

As of late June 2020, the United States probably has the world's worst outbreak of COVID-19 and certainly has the worst outbreak in a rich country. Cases are rising in many of the states, and many major states have quite clearly and predictably lost control of the situation.

There is no reason to put much stock in the prediction of any analyst at this point. If there is a guideline, it is probably that an analyst who makes big predictions should not be trusted. The scale of the disease has no precedent in the last century of American history. The scale of the economic collapse has no precedent in the last 90 years of American history. The scale of the federal response has no precedent in the last 90 years of American history. The president arguably has no precedent in American history.

In terms of public health, the United States had by late June suffered as many casualties as its armed forces saw in World War I (116,500 casualties). It seems highly unlikely that the US will adopt any policy trajectory before 2021 that avoids massive casualties. In late June, it was seeing a bit less than 600 COVID-attributable deaths a day, but since deaths lag infection by about a month the rising number of cases and test

positivity rates suggest mortality will rise. In most countries, it is wise to avoid data about COVID attribution since it is subject to problems from limited testing and data problems and which will tend to be an undercount. It is better, for scientific purposes, to focus on "excess mortality" which is simply the difference between the number of deaths on a given day and the number of deaths on average on that day in years past. Excess mortality data is robust (it is hard to hide dead bodies) but tends to be slow. It shows that the United States had about 122,300 excess deaths by June 23rd and the epidemic was out of control in much of the country.

The United States is therefore very likely to experience at least one September 11th (2,977 deaths) per week, and a Vietnam war (c. 58,000 dead) every few months for the rest of 2020. We simply do not know how American voters, however polarized and partisan they may be, will respond to that, any more than we could have known the impact of the Vietnam war in its first few months.

Nor do we know which voters will face the consequences of the federal failure or will be seen to face those consequences. While wealth is the vector and inequality to predictor of suffering to date, if risky behavior continues to become a badge of identity among conservative white people, their behavior might change the profile of the epidemic considerably. A pandemic that looks like a problem for people of color in Detroit, New Orleans, and New York- the situation in late spring- will have very different valence in American politics to a pandemic that is striking conservative suburban or rural white populations precisely because of behavior such as unsafe churchgoing.

This means that the *duration* of the test matters greatly. Enormous exertions in March, April, and May appeared to damp down the epidemic, leading to hasty and ill-advised re-openings and a surge of infections in southern and southwestern states with particularly bad health inequalities, particularly bad population health, and Republican governors. What will several more such rolling waves of infection and crisis do? Will the federal government respond with anything like the level of support for individuals and businesses that it initially did (or with the same, impressively large, opportunities for executive branch corruption)? Will Republican politicians continue to take their lead from Donald Trump or will they begin to hedge their bets as they see him founder? For example, they could revert to their behavior of March and April. In those months they had no clear partisan message on public health measures and their federal representatives voted for stupefyingly large federal aid to sustain the economy. American state and local governments, many of them led by Republicans, are seeing enormous budget shortfalls now.

Major new federal economic assistance seems likely, but its direction will matter. What will it do for state and local governments? What will it do for precarious workers? Will it continue its generosity to the unemployed? When will American elites understand that the failure to contain the pandemic at all means that most of the live entertainment, bar, restaurant, travel, sports, higher education and other sectors will lose their economic viability unless given a long-term bailout of at least a year? And what will they do when they realize that? Interest rates on federal debt remain so low that the federal government could just keep these sectors in a medically induced coma for years. It could, but will it?

The federal government under Trump had, as of mid-June, placed all its bets on the technological solution of a vaccine. Having bungled essentially every element of pandemic response, the White House, in true American fashion, hoped that technology would help.

Operation Warp Speed is an effort to test and distribute a vaccine faster than has ever happened- by the end of 2020. There are a number of seriously alarming issues. The first is that it might not work and there might not be a valid Warp Speed vaccine by the end of the year, in which case the abandonment of other public health measures by the federal government will condemn Americans to a widely circulating disease and prolonged international isolation. The second is that the vaccine might work in some sense but might be dangerous. Until now, the fastest vaccine development had been the mumps vaccine, which took about four years. Vaccines can have unpredictable effects over time and people; they can interact with other issues to produce health problems in healthy people, they can have negative effects over time that short trials do not identify, and they can even make the illness worse for those who catch the virus. The purpose of clinical trials is to identify these problems- and send designers back to their labs if the problems cannot be remedied. That takes time; a side effect that takes time, or even infection, to arise might not be identified for a few years. A hasty trial could create public health problems on its own, and a hastily trialled vaccine that turned out later to have side effects could create serious public health problems once it was being widely distributed. These two major questions, which arise because of the haste with which the vaccine is being developed, will play into a third major issue, which is vaccine hesitancy. The United States, like much of the west, has problems of both vaccine hesitancy and a strange social movement opposed entirely to vaccines. Vaccine hesitancy might be especially high, and the opportunity for anti-vaccination groups especially big, if a vaccine is trialled or brought to market so quickly- still more since likely vaccines are made with synthetic biology techniques whose public acceptance is far from clear (44) (45). There might be tremendous reticence or backlash. Even well-informed and generally pro-vaccination people with understanding of the science and statistics might choose to avoid a vaccine that was being administered with far less trial data than usual. Fourth, if a questionable vaccine is being distributed (even in the context of an immense "trial"), there will be huge political and ethical questions about who is obliged to get the vaccine. If white-collar workers are allowed to continue working from home, isolated and unvaccinated, while service workers are obliged to get the vaccine and keep working, both fears and any real problems with the vaccine will produce a political brew of rare toxicity. Fifth and finally, a vaccine-focused strategy with no public health component- which is where much of the US is headed- depends on the United States being able to buy and distribute the vaccine. There is simply no guarantee that the US will be able to do that. If a Chinese or European or other company develops the vaccine, or even if it is manufactured outside the US, the United States might find it is not at the front of the queue to buy hundreds of millions of doses. The loud egotism of the Trump administration might have made such an outcome more likely, but the incentives to national selfishness and power politics in this case are so immense (46) as to actually make it less likely that Trumpian boorishness does extra damage. In short, it is hardly surprising that the Trump administration has found itself betting on an extraordinary and high-risk technological feat or even giving the project a gauche name from 1970s science fiction. It would also be surprising if it were to work.

Operation Warp Speed could change the development of the pandemic and its politics in many different ways, whether by saving us all or creating a new public health disaster, or it could simply fall by the wayside. There are too many imponderables to

predict. It is not clear whether there will be anything like a free and fair nationwide election in November 2020. It is not clear what the reaction of the militant white nationalist right or Donald Trump to a Democratic victory would be. It is not clear what Donald Trump or his party would do were either voters or institutional dysfunction to grant him a second term (the Republican party is re-using its 2016 platform for 2020). It is not clear what the responses of the many social movements aligned with the Democratic party would be to a second Trump administration either. We just do not know enough about the disease, the economy, the voters, or the political actors to predict the overall outcome by the end of 2020, let alone 2021. What we can say is that the comprehensive failure of the federal government caused cascading failures in the first half of 2020 which have led to the United States' lethal and unpredictable situation.

Lessons for others about the United States

Spare a thought for American citizens, finally. At each stage in this debacle, they have been let down. A system premised on federal leadership and good sense, which requires presidential leadership and good sense, was in the hands of Donald Trump. Trump's election reflected a series of failures by party elites and institutions that were supposed to block demagogues and ensure the will of the electorate and instead enabled a demagogue who had lost the popular vote by a large margin. In a country that had increasingly focused power and autonomy in the federal executive, elite failures led to a situation in which a system that requires a grown-up in the White House confronted an enormous crisis with a toddler in charge.

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