

The United States confronts Ebola: Suasion, executive action, and fragmentation

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Abstract

The United States' experience with the Ebola virus in 2014 provides a window into US public health politics. First, the US provided a case study in the role of suasion and executive action in the management of public health in a fragmented multi-level system. The variable capacity of different parts of the US to respond to Ebola on the level of hospitals or state governments, and their different approaches, show the limitations of federal influence, the importance of knowledge and executive energy, and the diversity of both powerful actors and sources of power. Second, the politics of Ebola in the US is a case study in the politics of partisan blame attribution. The outbreak struck in the run-up to an election that was likely to be good for the Republican party, and the election dominated interest in and opinions of Ebola in both the media and public opinion. Democratic voters and media downplayed Ebola while Republican voters and media focused on the outbreak. The media was a key conduit for this strategic politicization, as shown in the quantity, timing, and framing of news about Ebola. Neither fragmentation nor partisanship appears to be going away, so understanding the politics of public health crises will remain important.

Introduction

The United States had little to fear from Ebola. When the 2014 Ebola outbreak in West Africa began to receive attention, American public health officials hastened to make reassuring statements, emphasizing the consensus that Ebola was transmitted primarily through intimate contact with bodily fluids of infectious victims and therefore primarily a risk to health care providers close to victims of the outbreak. The American public was in much more danger of getting sick or dying from a more banal illness, like the flu. The focus, U.S. public health leaders suggested, should be on Ebola as a global health threat that should be addressed in Africa (Fauci 2014, Frieden et al. 2014).

In retrospect, those public health officials were correct. In 2014-15, the United States had a total of eleven cases on its soil, four diagnosed in the country and seven of them evacuated from Africa after diagnosis. But at the same time, the political response to the Ebola outbreak in the United States was marked by a long string of news stories about incompetence and divergent government responses to the outbreak. The outbreak became a highly politicized topic which morphed into broader discussions of border security, immigration policy, and terrorism (SteelFisher, Blendon, and Lasala-Blanco 2015).

The combination of decentralized management of the outbreak with highly partisan public debate is typical of American politics. The Ebola experience of 2014 can be viewed as a case study in the politics of public health in the United States. Understanding the policy, and political, responses to the disease sheds light on the operation of public health, the political system, and the interaction of the two. It

underlines how powerful, and patterned, political forces shape public health action. In particular, it highlights how in a fragmented system responses tend to be driven by suasion- persuasive expertise- and executive action by presidents and governors rather than a coherent bureaucratic response.

Section One sketches the background of public health in the United States, which is a fragmented system in a fragmented country. Section Two argues that any public health action involves coordination of the federal government, state governments, public health agencies, and the American healthcare system. In each organization, there is a set of diverse actors who operate in a complex institutional landscape with no authoritative single source of regulation. The result is that action takes place through a mixture of executive initiative, forcing coordination within states or the federal government, and suasion between governments and the health system, relying on guidelines and expertise rather than hierarchical authority to shape responses.

Section Three turns from public health response to the politics that shaped policymakers' incentives and public perceptions. It argues that public opinion is affected by media outlet coverage of an event. Elites "cue" the public, especially partisans, with views about the importance and development of issues such as Ebola. We examine the role that media play in the politicization of the Ebola outbreak. We track the frequency and usage of stories related to Ebola in the six month period leading up the 2014 midterm elections on Fox News and MSNBC. We find that Fox News began covering the outbreak earlier, and produced stories more

frequently than MSNBC, until immediately after the midterm elections, at which point coverage waned on the network.

Section Four then turns to the public, the audience for both media and politicians. Political scientists routinely find that blame attribution and interest in a topic are more driven by pre-existing political views in the mass public than by close attention to the management of the outbreak. Ebola interest peaked in the run-up to the 4 November 2014 midterm election, when the opposition Republicans, who controlled the House of Representatives, had incentive to pin blame on the incumbent Democrats in an effort to gain majority control of the Senate. We show that in the month before the elections, Ebola became much more salient amongst Republican voters than Democratic voters. The politicization of the outbreak eventually involved President Obama, the federal government, and news media handling of Ebola and the beliefs about the likelihood of an outbreak striking the United States.

Taken together, these themes indicate that there needs to be greater awareness of the political dynamics at play for public health officials. Too many public health practitioners, who daily work on the front lines of federal, state, and local health departments, believe that they are immune from political machinations when they are not (Oliver 2006). As Lawrence Brown notes, “The public health community seldom acknowledges that its work is pervasively political, much less explores in depth how that political saturation shapes its professional life” (Brown 2010). But it is not enough to appreciate the role of politics. Some understanding of political dynamics, including public opinion, media effects, and the role of

intergovernmental relations is necessary to determine what kinds of actions are possible, plausible, or to be expected. Thus, for example, the “command and control” approach to outbreaks espoused by the WHO simply does not work in the United States, where authority is diffused, influence is often through expertise, executives of states and the federal government have great power and conflicting incentives, and both media and public tend to use polarizing political frames (World Health Organization 2000, Greer 2016). The mixture of suasion and executive action in the response to partisanship and elite cueing in public is not just predictable and unavoidable in the United States. It also shapes what is possible for public health policy.

I. Communicable disease control in a fragmented system

“Fragmentation” is one of the key words of American health policy studies (Okma and Marmor 2015, White 2009, Emanuel 2014). The United States has a fragmented political system, with an internally divided federal government, fifty states with constitutionally granted public health powers, which are also internally divided, and tens of thousands of local governments with varying emergency management and health responsibilities and capabilities.

System

There is little dispute that the American health care system is fragmented. Providers vary in scale, from large “systems” to small doctors’ practices, and their ownership

can be public, private, or non-profit. Many non-profit systems, even ones carrying residual religious connections, are every bit as focused on expansion, market share and margin as for-profit companies. Gaps in the provision of health care, as of 2014, were partially being filled by the Affordable Care Act, which provided public (Medicaid) insurance in some states or subsidized private insurance to the previously uninsured in all states (White 2013). The result is that the capacity of providers to invest in communicable disease is variable, and there is no guarantee that they will make investments or formulate effective policies. Nor is there a single, coherent, centre of power over provider behaviour, or shared set of strategic and operational goals among providers, or even a reliable way to coordinate patient movements in a given area with public health agencies. With a disease such as Ebola, which is substantially a healthcare-acquired infection, this diversity of providers is particularly important as they are key actors in its control or propagation.

States

In the basic American federal structure, core public health powers such as the power to quarantine are part of a broader “police power” that belongs to the states, not the federal government. Federal government’s coercive powers are enumerated and focused on interstate commerce and border protection (Katz and Rosenbaum 2010). The residual power to control citizens’ lives, including taking public health measures, belongs to states as part of their police power. The politics, laws, and capacity of the state you are in matter a great deal if you are caught up in an American public health emergency.

The fifty American states, which vary in size from the half million people of Wyoming to the 39 million people of California (the median state has a population of about five million), have major policy responsibilities and generally sophisticated and competent bureaucracies in interestingly diverse political systems. For example, they were quickly and successfully able to identify and monitor people exposed to Ebola (Stehling-Ariza et al. 2015). Their governors are high profile figures, often with national ambitions and media coverage. Governors also have no significant foreign policy roles, so they need not balance their interests in domestic affairs with a broader global health approach.

Lacking resources which are only available to the federal government, and frequently delegating public health work to local authorities, states are generally less invested in anticipating public health crises. Furthermore, federal public health agencies, such as the Centers for Disease Control (CDC) and the Federal Emergency Management Agency, are intended to operate in states when they face public health crises, lessening states need to invest in these agencies.

The federal government

The U.S. federal government has three kinds of relevant powers in relation to Ebola. One is its control over borders. The federal government can detain or otherwise regulate people who seek to cross US international borders. The second is through its power over interstate affairs, notably through the “commerce clause” allowing it to regulate interstate commerce, which justifies much public health regulation. The Commerce Clause effectively allowed the New Deal and the birth of the American

administrative state. It is therefore no accident that legal and political writings about the police power tailed off in the 1930s as the modern U.S. administrative state was born. The Commerce Clause also authorizes the federal government to take direct action regarding people seeking to cross state boundaries.

The third is its ability to spend its own money, for example by creating guidelines for personal protective equipment, funding research, or sustaining the thousands of experts who work at CDC. That spending power includes the basic mechanisms underpinning access to emergency health care. The federal government's extensive fiscal role means that it is a major influence on provider behaviour, through its policing of the non-profit tax exemption and through compliance required by participation in its giant health care programs such as Medicare and Medicaid.

There are three major loci of federal bureaucratic response to a problem like Ebola. One is the Department of Homeland Security (DHS). DHS was involved because of its border control function. It is also by law the principal department for major incidents, though the role of DHS in coordinating and responding to disease outbreaks is not as clear as its role in other kinds of incident (Kettl 2007, Morhard and Franco 2013). DHS was created in the aftermath of the September 11 attacks to improve coordination among a wide variety of US domestic security agencies, from counterterrorism to exotic biosecurity programs to border control to the Coast Guard to emergency management. Its relatively recent assembly out of often long-established agencies, and the rapidly changing security politics of the administrations of George W. Bush and Barack Obama all mean it lacks the

coherence of even a normal American cabinet-level department. Internal diversity, low morale, and poor coordination are among its most salient characteristics (Kettl 2007). For example, DHS has to answer to more than 90 congressional subcommittees and committees, and approximately thirty more task forces and similar congressional bodies (Markon 2014). Coordinating within DHS is a problem, and there are questions about its ability to contribute much, other than coordination, to the work of other departments in public health. The other salient characteristic of DHS is that it is much more focused on security, such as emergency management and bioterrorism preparedness, than on health *per se*. Security organizations and emergency managers have a style and staff that are quite distinct from public health (Fidler and Gostin 2008, Lakoff and Collier 2008, Botosaneanu et al. 2011).

The second, more prominent, centre of Ebola-related activity in the federal government is the Department of Health and Human Services (DHHS). Within DHHS, the centre of expertise and prestige is the CDC. CDC has been tremendously influential in public health over the decades since it began as a malaria control unit during World War Two, shaping basic public health concepts such as surveillance and carving out a connection with security agencies (Etheridge 1992, Fearnley 2010).

The third, most important center, is the executive- the White House. Major issues such as Ebola are coordinated at the federal level through White House advisors and the National Security Council (the principal venue for coordination on security issues, when it is working as intended, but also one focused on

international rather than domestic affairs). Departments and agencies are pulled in so many directions, by their missions, legacies, and particular constituencies that it takes conscious assertion of White House power to coordinate them (Sylves 2014). As with DHS, the role of the NSC is less clearly defined in public health incidents than in other kinds of emergencies.

Suasion and executive action

In such a diverse system, formal, hierarchical, governance is not the rule. The result is that much of the response to public health events such as Ebola is a mixture of suasion and executive action.

Suasion, in the United States and elsewhere, is a way to overcome fragmented governance arrangements by using non-hierarchical means such as offering assistance, writing guidelines, and financing networks of professionals. It compensates for the lack of top-down hierarchical governance in the US by diffusing agreements on how to work. It also often empowers the federal government, which, thanks to CDC, is rich in the kinds of resources and networks that are effective in suasion. For example, once the CDC released their recommendations for appropriate infection control procedures related to Ebola, it became the near-automatic resource for hospital administrators as they contemplated the threat of disease and their organizational response. CDC guidelines, even the ones without binding authority such as recommendations for disease management, enjoy a legitimacy that other guidelines do not. Finally, those resources, such as CDC laboratories and experts, and its emergency management personnel, can assist local actors. In

general, state and local authorities and health systems are highly responsive to CDC and will rarely contest its technical advice. In turn, if CDC advice is slow, changeable or contested, as it was during the Ebola outbreak, its effectiveness might rapidly diminish.

Unsurprisingly, in such a fragmented system, executives such as governors and the President have a major role when they want (Hess and Pfiffner 2012). The *Federalist Papers*, written by authors of the U.S. Constitution, accurately noted that there is always “energy in the executive” which tends to empower executives over time and in crises (Federalist 70). As in most political systems (Savoie 2010), the normal interagency coordination bureaucracy is slow and prone to failure, and so the executive develops techniques to act decisively, and force compliance, when the President really wants action. Likewise, in the states, governors and their offices tend to coordinate within their state governments and take decisive action. Executives, who are publicly visible and whom voters often hold accountable for conditions in their jurisdictions have both the opportunity to take on leading roles and the incentive to do so. Governors with ambition towards higher office can have extra incentive to provide visible leadership.¹ They might seek out conflict with the federal government, for example.

The result is an American pattern of executive energy within individual governments, directed by highly visible executives, and suasion based on authoritative knowledge. Executives can provide coordination and leadership, but also introduce conflict when they disagree and can have political incentive to accentuate their disagreements. Suasion is powerful when authoritative knowledge

is sought and valued, e.g. by health care providers unaccustomed to facing Ebola. Mixtures of authoritative expertise such as that of CDC, which enables suasion, and hierarchical authority, found in executives, drive U.S. public health responses.

II. Suasion and executive energy in Ebola response

The unlikely but horrifying event of an Ebola patient arriving unexpectedly was just what happened at the Texas Health Presbyterian Hospital (THPH) on September 26th, 2014. What followed shows the interaction of autonomous providers in a fragmented health care system, autonomous states in a federal system, and a fragmented federal government. Multiple players had the autonomy to make decisions, and not all of the decisions were viewed favourably in retrospect.

Thomas Duncan, a Liberian, was not the first person with Ebola in the United States, but the others had been medically evacuated from West Africa to specialist facilities. Duncan flew from Liberia to Dallas, Texas on 20 September. On 26 September he felt unwell and went to THPH's emergency department, which as a condition of participation in Medicare was obliged to at least "stabilize" him. There is some dispute between Duncan's family and THPH on whether Duncan told his providers that he had recently been in Liberia, but regardless he was stabilized without special protocol and sent home. Two days later, Duncan returned to THPH with much more acute symptoms, was diagnosed correctly and admitted. At this point, the CDC arrived in Dallas, but only in their capacity to advise THPH, not to

direct Duncan's treatment. After much treatment, Duncan died on October 8 at THPH.

Duncan's experience highlights the variable nature of preparation for Ebola in American hospitals. There was little preparation at THPH in the kinds of specific infection control measures required for Ebola and similar highly infectious viral haemorrhagic infections. The individual nature of infection disease control within hospitals, within the context of overlapping federal, state, and local health regulations is not surprising, and nor is the willingness of tertiary care hospitals to take on ambitious tasks such as treating an Ebola patient without previous experience. There is no system in Texas, or most states, to control hospitals' investments or autonomy. Decisions about, for example, their desire and capacity to treat very high-risk infectious diseases are left to the managers of competitive hospitals.

Within this fragmented and individualized system of care, it is unsurprising that two THPH nurses, Nina Pham and Amber Joy Vinson, were exposed to Ebola. A later report commissioned by Texas Health Resources concluded that "CDC and others were learning alongside the actual providers... it appears that there was a lack of effective and efficient collaboration prior to the event... The roles and responsibilities of all parties were not clearly outlined in advance" (Cortese et al. 2015). Subsequent legal action by Pham also claimed that THPH was simply unprepared to handle a disease like Ebola, with managers googling the relevant infection control protocols (Duncan's family settled a case against THPH)². None of this should really have been surprising in a fragmented system where CDC is largely

advisory, public health authorities have little legal authority or capacity to direct patients around the health care system, health systems are both diverse and often left to themselves, and ex-post regulation via lawsuits is common.

The Dallas events also left a number of political problems behind. The state of Texas had quarantined people associated with Duncan who had been caring for him or sharing living space before his admission, and then quarantined the two nurses Pham and Vinson. Vinson's case turned into a source of political dispute; she was in Cleveland, Ohio (cleared previously to travel by a CDC official) when it emerged that her colleague Pham had been exposed to Ebola. Texas officials declined to provide a private airplane, and she returned to Dallas on a commercial flight. After this emerged, local governments in Ohio and Texas closed schools and took other actions against people who had been on those flights with her. Meanwhile another THPH employee, a laboratory technician, went on a cruise, most of which the technician had to spend in quarantine on the ship after the potential Ebola exposure was discovered. Mexican officials, nevertheless, refused to allow the ship to dock in Cozumel.

Texas public health officials were criticized on the grounds that they appeared to lack clear policies or enforcement capabilities, and did not use their powers very forcefully (Walters and Root 2014). Republican Texas Governor and presidential candidate Rick Perry, who had actually gone on a trip to Europe during the events, took considerable criticism from Democrats. He responded by criticizing the federal government for inadequate border control, and set up a task force to reconsider the state's responses (Glueck 2014, Root 2014). Texan executive

inaction, overenthusiastic action such as school closures afterwards, and criticism of CDC's actions all marked Ebola as a political problem.

State responses

State governors, using their police powers, quickly began to mark out a robust role for themselves- perhaps with an eye to Perry's experience in Texas (Baker and Novack 2014). It was also an opportunity for Governors who were presumptive presidential candidates, such as Democratic Governor Andrew Cuomo of New York and Republican Governors Chris Christie of New Jersey and Bobby Jindal of Louisiana, to prevent the negative press associated with an outbreak and to court headlines by taking strong stances on mandatory quarantines (Jindal explicitly sought to dissuade tropical medicine specialists who might have been exposed from attending a conference in New Orleans)(Enserink 2014). Overall eighteen states had Ebola screening and monitoring policies which were more restrictive than the CDC's guidelines of voluntary isolation and monitoring of travellers exposed to Ebola (Prevention 2015b).

Whether a governor saw Ebola as an opportunity to make a national mark or simply a challenge to be managed, it is worth noting that a governor's calculus is simpler than a president's. Being seen to manage Ebola effectively in one state involves fewer trade-offs than trying to manage it globally. For example, the White House sought to promote engagement with West Africa in order to stop the outbreak at its source. The result was a dispute between a federal government, which did not want to dissuade efforts to help in the affected countries with punitive

policies such as quarantines and travel bans, and governors, who wanted to take visible action to protect their states, even at the risk of Ebola becoming endemic in West Africa³.

Christie and Governor Paul LePage of Maine both took decisive actions on quarantine policy and quickly entered a struggle with a nurse, Kaci Hickox, who had returned from treating Ebola patients in Africa on the day Christie and Cuomo announced quarantine policies. Christie ordered that she be quarantined against her will in a tent in Newark. She hired a lawyer, received media attention, and New Jersey relaxed the policy and let her go to her home in Maine on October 26th. Maine Governor LePage then sought to quarantine her in her house, sending state police to confine her at home (Alman 2014). The resulting footage of her riding a bicycle in defiance of the governor made national news (Roberts and Glenza 2014). On October 31 a Maine judge overturned the quarantine order.

Federal response

Like the governors, the President came under pressure to take visible action. Obama publicly intervened in the federal response with the appointment on October 17th, a bit less than two weeks before the upcoming midterm elections, of Ron Klain, a former chief of staff to Vice-Presidents Albert Gore and Joe Biden (Eilperin 2014). Ron Klain's appointment as Ebola "czar" was a powerful and predictable signal in Washington: the President was taking the issue seriously. Klain's appointment also reduced the pressure on the President's Homeland Security and National Security advisors, who were engaged with issues such as conflict in Syria and Iraq (Eilperin

2014). One account credits Klain for the new stricter, CDC protocol on PPE and the management of people exposed to Ebola, as well as smoothing the movement of contaminated materials and lobbying Congress for expenditure on Ebola-related work (Eilperin and Sun 2015).

Also predictably, Klain, like Obama, was a magnet for criticism. Most news reports mention that he was not a doctor and had a relatively low public profile, for which he was criticized by, especially, more Republican-leaning media (the *New York Daily News* ran the headline “Where the hell czar you?”). Klain and the White House argued that coordinating, rather than communications or medicine, was his task (Khimh 2014, Warren 2014).

The second major category of federal response focused on airport screenings and quarantines. From 11 October, passengers flying into the United States from countries with Ebola outbreaks were sent to one of five airports for additional screening. Passengers had to answer questions from DHS and have their temperature taken and checked for other Ebola symptoms. All passengers had to monitor their health and symptoms for three weeks and had to daily report their temperature and symptoms to their local health department. Each was given a thermometer and health log to document their temperature and other symptoms for the monitoring period, along with a cell phone with three weeks of unlimited talk and text services (Prevention 2015a).

CDC, which had been involved in Ebola before the Dallas events, had a team at THPH, and came under fire for insufficiently rigorous guidelines and inadequate assistance (Ambrose 2014). Director Frieden later said CDC should have

immediately become involved with infection control work on site, rather than only advising (Nutt, Phillip, and Achenbach 2014)⁴. CDC responded with new guidelines on infection control for Ebola, announced on October 20th, that included more stringent rules about personal protective equipment (Frieden 2014).

III. Media, elite cues, and Ebola

The policy decisions of, and conflicts between, political leaders already highlighted the importance of these elected politicians in a polarized political system. The media frame within which their actions were reported was also often shaped by partisan politics.

Public opinion researchers find that even politically engaged citizens organize their policy views to fit with “cues” from elites who share their partisanship. In this model, politically engaged citizens have coherent opinions because they take cues from political elites (Zaller 1992). This combination means that we can expect partisan elites to emphasize issues that catalyse their supporters’ objections to the other party. Partisanship will drive policy opinions much more often than the reverse.

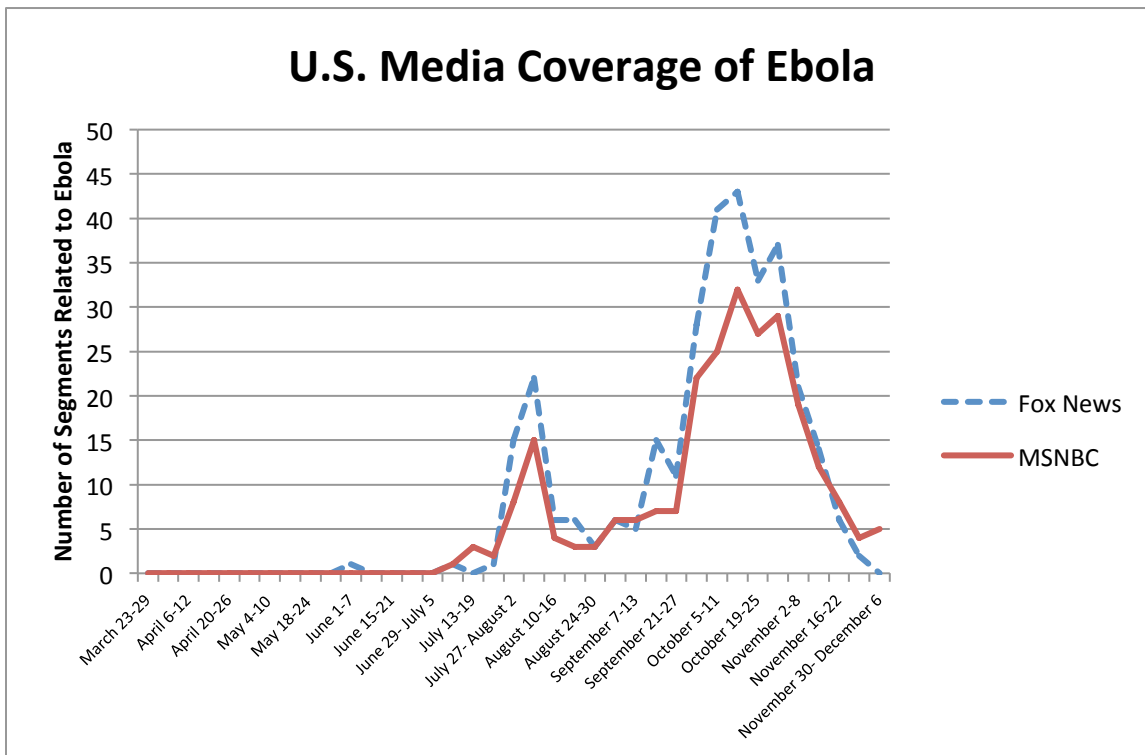
Over the past half century, party elites have become increasingly polarized and this polarization increasingly affects voters. These findings have been supported by analysis of roll call voting, examination of party platforms, survey experiments and polls (McCarty, Poole, and Rosenthal 2008, Green, Palmquist, and Schickler 2004, Iyengar and Westwood 2015, Iyengar, Sood, and Lelkes 2012, Ferguson 2015, Druckman, Peterson, and Slothuus 2013, Fiorina and Abrams 2008).

When an issue, such as Ebola, becomes the subject of elite cueing, we should expect partisans to fall in and perceive the issue in a partisan manner. We should not expect an issue such as Ebola to change minds, but we can expect it to become incorporated into voters' rationalizations of deeply held partisan beliefs.

This section examines the evidence related to differential coverage between traditionally conservative and liberal media in their duration and frequency of coverage of Ebola. During the time period of the Ebola outbreak, two of the highest rated cable news networks in the United States were Fox News and MSNBC (cable TV news has relatively few viewers, but they tend to be influential in politics). These two networks also provide an interesting case because of their differing ideological bents. Though the partisan symmetry is not perfect, Fox News is viewed as providing a more conservative slant on the news, while MSNBC is viewed as a more liberal counterpoint (Grossman and Hopkins 2016). Media and cable news viewership has been found to influence voting patterns among the American public (Martin and Yurukoglu 2014, DellaVigna and Kaplan 2006) and shapes the opinions of world events of viewers (Feldman et al. 2012, Prior 2013). Fox News, in particular, seems to have a big effect on conservative and Republican agendas and views (Skocpol and Williamson 2012, Grossman and Hopkins 2016).

To examine whether the news media for traditionally conservative outlets were more likely to cover the Ebola outbreak, we searched television transcripts from March 23 through December 6, 2014 for mention of the word 'Ebola'. By breaking down the number of segments on Fox News and MSNBC by weekly coverage, a clear divergence in the frequency of Ebola coverage emerges (Figure 1).

Figure 1: Ebola coverage on Fox and MSNBC. Source: Lexis-Nexis



Neither network had any mention of the word Ebola from March through May of 2014, when the disease was spreading through West Africa. The first mention of the word on any segment for either network was during the first week of June on Fox News, but was only used as a throw-away line for humour during the end of a segment related to events in Afghanistan. It was not until the end of July, when American aid workers began to be evacuated to American hospitals for treatment, that both networks began covering the outbreak regularly. Even when both networks were covering the Ebola outbreak, Fox News continually devoted more airtime to cover the disease. From the beginning of July to the end of November, Fox News had more stories about Ebola than MSNBC for all but six weeks. Of the six weeks where MSNBC devoted more coverage to the outbreak, half occurred following the midterm elections. Once the midterm elections were concluded, Fox News stopped devoting much air time to the outbreak, even as American citizens were diagnosed on United States soil. MSNBC was slower to lose interest after the election. Overall, Fox News averaged more than fourteen stories every week devoted to the Ebola outbreak, compared to eleven stories on MSNBC.

Republican elites' cueing behaviour could be expected to explain the partisan disparity in views about Ebola. It became a "Republican" issue, critical of President Obama. An analysis of a much larger corpus of U.S print publications echoes these conclusions. Between September 2014 and February 2015, Republicans were mentioned alongside Ebola twice as much or more than Democrats. This means that Ebola was a more popular topic amongst Republicans, or perhaps that Republicans

were more successful in being included in media coverage involving Ebola (Daku and Dionne 2015).

Coverage of the Ebola outbreak by Fox News was reinforced by the content of that coverage. Republican commentators and politicians further strategically politicized the Ebola outbreak by connecting fears of Ebola with the fears of international terrorism and immigration. For many conservative politicians and commentators, the politics of the Ebola outbreak during the lead-up to the midterm elections became a further demonstration of the weakness of American immigration and foreign policy. Eric Bolling, a Fox News commentator, commented that “we have a border that is so porous, Ebola or ISIS or Ebola on the backs of ISIS could come through our border”(Bradner 2014b).

Fox News explicitly connected Ebola with their coverage of the midterm elections. For example, as midterm election results were coming on November 4, 2014, Fox News correspondent Megyn Kelly explicitly linked Ebola to Democratic electoral fortunes when she commented on the New Hampshire Senate race between Democratic incumbent Jeanne Shaheen and challenger Scott Brown. She said, “Jeanne Shaheen was comfortably ahead until October 9th. On October 8th Thomas Duncan died of Ebola... And that is she wound up exploding in the month of October(Fox News Network 2014).”

Republican politicians also made the connection. Seven Republican senators wrote to President Obama asking him to impose a ban on travel from Ebola-affected countries⁵. Thom Tillis, Republican Senate candidate in North Carolina argued in a debate with Democratic incumbent Kay Hagan, “Ladies and gentlemen, we’ve got an

Ebola outbreak. We have bad actors that can come across the border. We need to seal the border”(Sullivan 2014). In interviews, Scott Brown, the Republican Senate candidate in New Hampshire, connected the spread of Ebola after Thomas Duncan’s death by saying that “if people are coming in from normal channels, can you imagine what they can do through our porous border. It’s so critically important to really use every tool, shut off every mechanism, for them and that disease and other potential diseases to come into our country” (Bradner 2014a). Representative Louie Gohmert, a Texas Republican, lampooned liberals when he said of border controls that “countries that recognize that they have an obligation to protect their people regardless of whether or not it’s politically correct have done just that...We used to have quarantines of serious diseases that would kill people. But this day in time, gee, we don’t want anybody to feel like they’re being left out” (Bradner 2014a). Beyond individual statements, there was an October spike in Republican campaign advertising calling the handling of Ebola a failure, for which Democratic politicians deserved blame, or showing images evoking public health threats such as people in haz-mat suits (Talev 2014).

IV. Ebola, partisanship, and blame in the 2014 elections

Ebola crystallized pre-existing partisanship, which was peaking immediately before November 2014 elections. Unsurprisingly, public opinion about Ebola was substantially predicted, and cued, by partisan beliefs.

Blame attribution and partisanship

The president's political party almost always suffers electoral defeat during midterm elections. Over the past seventy years, the political party of the president has on average lost nearly thirty combined seats in the House and Senate during a midterm election (Peters 2014). There are several reasons why the president's political party suffers electoral defeats in midterm elections, with two standing out: blame attribution and partisan cueing. Both suggest that an issue such as Ebola would turn into an opportunity for the opposition to the incumbent president to blame the president for presumed incompetence, which is exactly what happened.

The president is the most visible politician in the country and this visibility is a two-edged sword politically for the president's political party. It provides opportunity for policy advocacy and agenda shaping but it also inspires blame assignment by opposing partisans. During the midterm election season, opposition parties are able to campaign against presidential policy stances, controversies, and other events in their bid to gain more legislative seats.

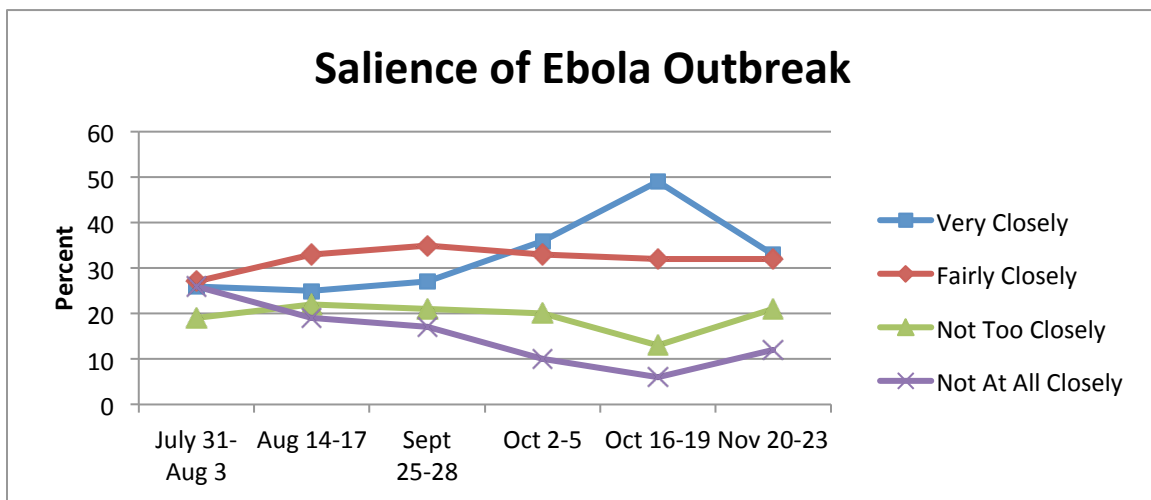
Party cues have been shown to be an important explanation of the development and shaping of policy preferences and have led to blame attribution. Individuals who identify themselves with a political party alter their own policy views to correspond with their identified political party (Miller and Shanks 1996). Party cues influence how voters view and blame politicians in the wake of government failure; voters with a stable party identification are more likely to blame officials of the opposite party (Malhotra and Kuo 2008). The party that does not hold the White House will try to maximize its legislative power by highlighting

failures of government performance and attributing them to the president's party (Lee 2009).

Salience of Ebola Outbreak

As the United States had its first experiences with Ebola, polling firms began tracking respondents' level of interest in the story. More than one-third of respondents reported that Ebola was a very important issue related to their vote for the midterm election (Preston 2014). At the end of July, the Pew Research Center found that respondents were just as likely to have very closely or fairly closely followed the Ebola outbreak as those respondents who did not follow the story at all. As the weeks progressed a marked shift occurred amongst Pew respondents. Throughout August and September 2014, the proportion of poll respondents who reported that they were following the Ebola outbreak "Very Closely" or "Fairly Closely" increased, while the percentage of respondents who did not follow the story decreased (Pew Research Center 2014). This trend continued through the end of October, while news reported actions such as the decision of a Texas community college to reject three Nigerian students on the grounds that they might carry Ebola (Jaschik 2014). The salience of the Ebola outbreak amongst the public was such that by the end of October, the Pew Research Center declared that the story was one of the most-followed events for the American public since 2010 (Motel 2014). Popular consciousness of Ebola reached its zenith during the period just leading up to the midterm elections in early November 2014 (Figure 2).

Figure 2: Salience of Ebola. Source Pew Research Center (Pew Research Center 2014)



Evidence that concern with Ebola was electorally driven includes the sharp decline in the number of respondents who followed the Ebola outbreak as soon as the election was past. Domestic Ebola events were still occurring, with the spread of the disease to New York City and the death of a Sierra Leonean physician in Nebraska occurring after the midterm elections, but the salience of the issue dropped sharply, along with media coverage.

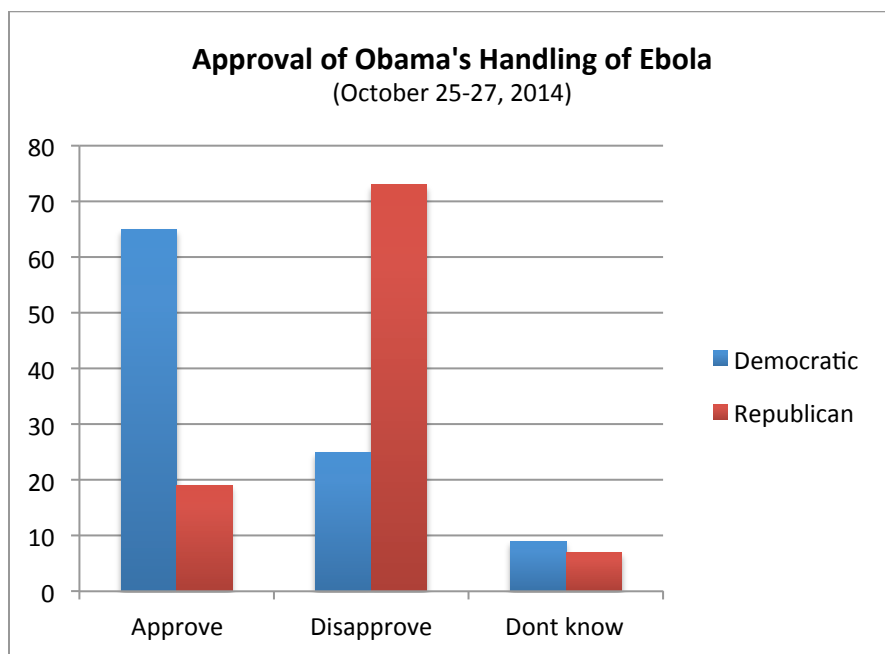
Politicization of the Ebola Outbreak and Response

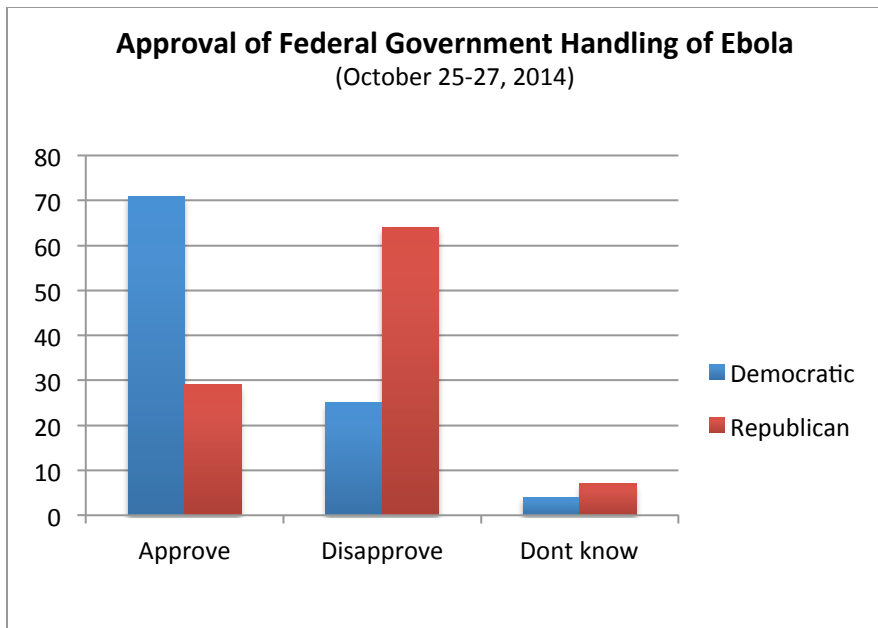
Public opinion surveys show both a high and highly politicized public view of Ebola (SteelFisher, Blendon, and Lasala-Blanco 2015). Nationally, there was voter support for both screening and quarantine interventions. A poll taken during the end of October found that sixty-nine per cent of respondents believed that the federal government should screen all foreign citizens entering the country for symptoms of Ebola and quarantine those showing symptoms. Additionally, thirty per cent of those who responded believed that no foreign citizen traveling from West Africa should even be allowed entry into the country (CNN/ORC 2014).

Polling indicates a clear politicization of views about interventions to control the Ebola outbreak. Republican respondents were nearly twice as likely to agree that the federal government should prevent entry into the United States for anyone, foreign or United States citizen, who had travelled from West Africa, than Democratic respondents (Fox News 2014b). Similar differences between Republican and Democratic respondents are evident in views of the policy option of banning all flights from West African countries (Fox News 2014b).

Views about the response of the Barack Obama and the federal government also reflected the growing politicization of the Ebola outbreak (Figure 3). By the end of October, public opinion had broadly turned against the view that the President and the federal government could adequately respond to the Ebola crisis. One-half of all respondents disapproved of the job Obama was doing to contain the Ebola outbreak (Fox News 2014a). Broken down by political ideology, Democrats were three times as likely to approve of Obama, compared to Republican respondents, with the inverse true for disapproval of his handling of Ebola.

Figure 3: Public Approval of Ebola Response. Source: Fox News (2014B)





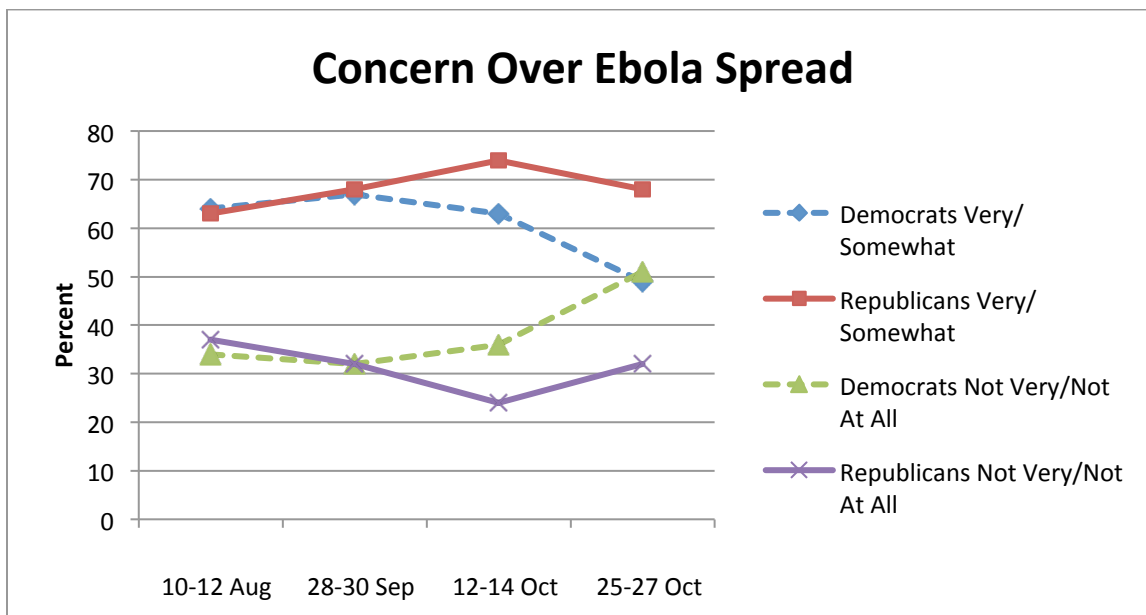
Views on the trustworthiness of the federal government, federal agencies, and media outlets also exhibit sharp divergence along partisan lines. Sixty-eight percent of Democratic and only fifty percent of Republican respondents trusted the information given by the CDC about containment and protection from the Ebola virus (Pew Research Center 2014). In other words, while there were grounds for criticism of CDC's response, guidelines, and communication, it seems that actual views of CDC's credibility among the public were driven by pre-existing partisanship.

Fifty-five per cent of Republicans, compared to forty per cent of Democrats, believed the federal government was not being completely honest with the American public. While most respondents believed that the news media had spent the right amount of time covering the Ebola outbreak (Hamel, Firth, and Brodie 2014), only half of Republican respondents trusted the news organizations covering

the outbreak, with three-quarters of Democratic respondents expressing trust in the media (Pew Research Center 2014).

The closer to the midterm elections, the more partisanship related to estimates of the likelihood of an Ebola outbreak striking the United States (Figure 4). From August to October 2014, there was little partisan difference in level of concern over an outbreak (Fox News 2014b). However, starting in October, Republicans became much more likely to be very or somewhat concerned about the spread of Ebola, in comparison with Democratic respondents (Fox News 2014b). In other words, just before an election, voters identified with the Republican Party became steadily more concerned about Ebola and voters identified with Democratic Party became less so. It seems that partisanship and cues from party elites were shaping views of the handling of Ebola for many in the public.

Figure 4: Concern about Ebola Source: Fox News (Fox News 2014b)



V. Conclusion

The United States' response to Ebola was neither command-and-control nor consensual, but rather a mixture of executive action, suasion, and political argument. We highlighted three themes, which help explain the response to Ebola in the United States. First, its fragmented health care system meant that the responses to the threat of Ebola on the ground would be highly variable, depending substantially on the particular health care organization and its infection control, legal, and media strategies. Additionally, American federalism meant that states would almost certainly have a major role. States are both responsible for much public health and a platform for their governors, who are major political figures. The federal government has inevitable internal coordination problems, and while CDC was present and active, broader coordination, including coordination of multiple erstwhile coordinators, awaited the intervention of the White House after media and political criticism.

Second, the Ebola issue predictably became politicized, as Republican elites identified an issue that interested their base just before an election, and made it a topic of prominent, negative, media and political discussion while Democratic elites and voters shied away from criticizing the federal executive's response. This contributed to a polarization of interest in the topic in the month before the election, with Republican identified voters more concerned, worried, and critical than Democrats. The disjunction between a partisan and Presidency-focused

understanding of accountability and blame and a far more diffuse capacity to act is a constant of American politics, and increases in importance as partisan polarization increases (Hacker and Pierson 2005). Third, conservative media highlighted the Ebola outbreak earlier and more frequently than liberal media. Media cued voters to the importance of Ebola which led to the instrumentalisation and politicization of the Ebola outbreak.

Our analysis highlights the need for public health officials to understand the logic of blame and partisanship in American politics. Politicization and blame attribution are constants of politics and should be expected. As the Ebola outbreak progressed through the political and media cycle, it began to take on new rhetorical forms. Politicians and media organizations began to conflate Ebola with broader concerns, including national security, immigration policy, and foreign policy. If there had been a Republican president in office, we can expect that Democratic political elites would have been highly critical and Democratic voters more disturbed by federal performance. Indeed, the political fallout from the Flint water crisis in 2015-16 indicates that both parties are apt to use public health disasters to serve their political ends. This is not all bad. The logic of democratic politics relies on harnessing opposition party incentives to expose and trumpet faults of the government in power (Hood 2010).

Similarly, our analysis also points to overconfidence in the idea that health care systems around the US were up to the task of managing Ebola whenever and wherever it occurred. Health providers in the United States lacked preparation and skill to effectively handle Ebola patients. Over the course of the Ebola outbreak, a

small handful of infectious disease ‘magnet’ hospitals handled all but two patients: the University of Nebraska Medical Center, Emory University Hospital, and the National Institutes of Health Clinical Center. Each of these hospitals had the clinical expertise and the physical space for biocontainment to handle the increased demands of Ebola patients. THPH and similar tertiary hospitals simply do not have the resources to adequately care for Ebola patients and to protect clinicians to the same degree as the hospitals which cared for Ebola patients (Bellevue hospital in New York City, a major centre for infectious disease for centuries, treated one patient successfully). There are a variety of reasons why people might advocate for the capacity to handle Ebola and similar diseases in every tertiary hospital, not least the impressive boost to expenditure on staff and equipment it would entail and the potential brand visibility of successfully handling cases. There was a much better case for communications to stress that an Ebola patient should be stabilized and transferred to a more appropriate clinical site as quickly as possible. In a fragmented system with no good way for public health officials to direct health care decisions, though, there is a high chance that ambitious tertiary care hospitals build their own capacity to manage highly infectious diseases. More capacity might be helpful (Klain 2016) but it will likely be unplanned and we will learn of its effectiveness in the next outbreak.

The Ebola experience is also suggestive with regard to the organization of the U.S. federal bureaucracy. Even if the strongest, and probably only powerful form of coordination in the federal government is the intervention of the President, the Ebola experience suggests that the U.S. federal bureaucracy could be more amenable

to coordination in public health emergencies. Both expertise and formal coordination for public health emergencies are spread across the CDC, HHS, the DHS, and the NSC. The latter two have little public health expertise, and it is not clear that framing public health emergencies as security issues or tasking emergency management bureaucracies with handling them produces better public health policy. Klain's own reflections on Ebola focused on how the lack of clear responsibilities dissipated public health expertise and slowed response. He called for a permanent public health emergency office on the grounds that there should be no need for a future czar for each disease (Klain 2016).

Finally, regardless of organizational issues, our analysis points to the importance of expertise, which underpins CDC's powers of suasion in a fragmented system with multiple incentives who have incentives to act. Authoritative knowledge, which CDC is usually presumed to have, is a powerful force to inform, standardize behaviour, and formulate appropriate responses. That means, of course, that CDC must be sure its knowledge is perceived to be authoritative- partly a challenge for its own scientific credibility in the eyes of public health practitioners, but also a challenge given partisan polarization of public views about any executive agency.

Our working title for this article was "Ebola in the United States: Well, what did you expect?" Public health policy that depends on suasion such as CDC guidelines, addressed to governments and providers alike, might frustrate those who believe that there is a one best way and want a hierarchical organization to do it. Likewise, energetic action by executives with whom one disagrees can be

frustrating (though federalism at least quarantines bad policy in one jurisdiction). Partisan media and public opinion can create or misdirect blame even when the system works well, and can make policy more difficult. Nonetheless, fragmentation, reliance on suasion and executive action to make policy, and an oppositional political system that finds fault for political reasons are at the core of American public health policymaking. We should not expect a different story in the next public health crisis.

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¹ Seventeen of the 43 Presidents had been governors, and governorships are high profile political positions whose occupants often have the means and ambition to run for President. Nine of the seventeen declared Republican primary contenders for the Presidential nomination in 2016 were or had been governors, as had one of the three Democrats.

² *Nina Pham v. Texas Health Resources, Inc.* Case DC-15-02252, District Court of Dallas County, Texas, filed 2 March 2015.

³ 'President Barack Obama's spokesman, Josh Earnest, made clear Monday that the White House was not thrilled that individual states had implemented quarantines viewed as unfair to returning healthcare workers, though he acknowledged the states' rights to set them. "We want to make sure that whatever policies are put in place in this country to protect the American public do not serve as a disincentive to

doctors and nurses from this country volunteering to travel to West Africa to treat Ebola patients," Earnest said.' (Wulforth and Morgan 2014)

⁴ See also the transcript of the House of Representatives Energy and Commerce Committee hearing "Examining the U.S. Public Health Response to the Ebola Outbreak", on 16 October 2014, at which Frieden and a representative of THPH testified.

⁵ Letter of October 17, 2014 from Senate Judiciary Committee Republicans, available at:

<http://www.grassley.senate.gov/sites/default/files/judiciary/upload/Immigration%20-%202010-17-14%20-%20Cease%20visas%20from%20Ebola%20countries%20-%20letter%20from%20GOP%20Judiciary%20members.pdf> Accessed 13 April 2016