JAMA Health Forum™

Insights

What Federalism Means for the US Response to Coronavirus Disease 2019

Sarah H. Gordon, PhD, MS; Nicole Huberfeld, JD; David K. Jones, PhD

Author affiliations and article information are listed at the end of this article.

The rapid spread of novel coronavirus disease 2019 (COVID-19) across the United States has been met with a decentralized and piecemeal response led primarily by governors, mayors, and local health departments. This disjointed response is no accident. Federalism, or the division of power between a national government and states, is a fundamental feature of US public health authority.[1] In this pandemic, US public health federalism assures that the coronavirus response depends on zip code. A global pandemic has no respect for geographic boundaries, laying bare the weaknesses of federalism in the face of a crisis.

Cited benefits of federalism include the flexibility to customize responses to the unique characteristics of a local population, maintain state budgets, and test new policies.[2,3] Some states have responded to the lack of national leadership by forging their own paths by independently acquiring essential equipment or collaborating with neighboring states to reopen their economies. Such efforts are necessary but not a sufficient replacement for a nationally coordinated effort. When our collective fate relies on speed, efficiency, and unity, federalist ideals fall flat. Divided governance creates unnecessary challenges for residents of states that are slow to act or to take up federal policies.

While the Trump administration's coronavirus response has aggravated the pandemic with uneven assistance to states, funding and supply delays, inconsistent messaging, and insufficient testing, the federal government is limited in its ability to mandate a centralized course of action. This is by design; the COVID-19 response is divided among more than 2000 state, local, and tribal public health departments. The Department of Health and Human Services, Federal Emergency Management Agency, and the Centers for Disease Control and Prevention (CDC) have limited authority to direct local officials to take united action.[1,4]

When asked about eastern and western states' coordinated response to the pandemic, President Trump asserted that the authority of the president is "total…[States] can't do anything without the approval of the president of the United States." This is not accurate. The power of quarantine rests primarily with state and local authorities, with substantial variation among jurisdictions.[5] Under the Public Health Service Act, the Surgeon General, with the permission of the Secretary of the Department of Health and Human Services, has authority to prevent the spread of disease between states and from other countries. However, the responsibility for other public health functions lies with the CDC, a subdivision of the Department of Health and Human Services that is tasked with hard science, data collection, and surveillance. The CDC's experts generally have no means to enforce public health measures. As a result, each state is separately responsible for responding to a public health event.

Once the federal government declares a national emergency, state disaster declarations trigger specific, short-term powers, such as stay-at-home orders, and enable the drawdown of federal funding. Resulting state variations have implications reaching beyond infection rates. Lax stay-at-home orders in one area may foil much stricter measures in a neighboring region. For example, Salt Lake City, Utah, mayor Erin Mendenhall issued a stay-at-home order weeks before Utah governor Gary Herbert issued a milder statewide decree, delaying prevention efforts in the state's most populous city. These differences are even starker in states where residents cross borders for health care, such as New Hampshire and Massachusetts.

The COVID-19 pandemic also intensifies and reveals longstanding inequitable distribution of power and resources, already evidenced by disparate rates of treatment and morbidity for African American patients. Historically, state flexibility in health policymaking has meant that certain communities, such as poor African American families in the deep South, have fewer resources over the long term and suffer entrenched health disparities. As a result, they experience higher rates of asthma and other comorbidities that may exacerbate the severity of COVID-19. As hospitals develop triage plans, racial/ethnic minority patients may be deprioritized for life-saving treatment because of disproportionate burdens of preexisting comorbidities. Moreover, the economic outcome in places such as the Mississippi delta will be extensive, where the most common job is retail cashier, Medicaid eligibility thresholds are extremely low, and health care facilities were already struggling.[6]

Our public health federalism is questionably adequate under the best of circumstances—divided governance and policymaking result in predictably disparate health outcomes that vary by zip code. During an emergency, when the health of the nation depends on acting with coordination and cooperation, the failures of federalism come into sharp relief, forcing us to reconsider one of the most deeply held American beliefs: that decisions made closer to home are inherently better.

While it is possible for a federalist public health system to respond adequately to a pandemic, this would require developing a set of robust federal guidelines for pandemic response that prevent the wide variation that has occurred during the coronavirus outbreak. First, federal standards for local stay-at-home orders could be derived from data-driven thresholds for case numbers, transmission rates (as determined by the CDC), and the status of bordering states, which together would trigger states to enact protections supported by federal funding. Second, the distribution of medical supplies and equipment should be systematized with clear, data-driven allocation guidelines. Informed by the CDC, the Federal Emergency Management Agency could establish a simple application portal that states use to request supplies, an action that would facilitate mapping disaster need and response more efficiently.

Third, epidemic data collection should be standardized. Uniform data collection across states would enable authorities to move quickly and make consistent choices as the country moves into the reopening phase. Coronavirus outcomes should be tracked by race/ethnicity and household income to identify and target resources to areas exhibiting health disparities. Data standards could be operationalized by the CDC through predicating distribution of public health funds on state collection of specific data fields. Lawmakers have called for such a provision in the next coronavirus relief bill. Lastly, support for underresourced hospitals, particularly in rural areas, is sorely needed. While direct infusions of funding may be a short-term solution, expansion of Medicaid eligibility under the Affordable Care Act is an existing, more durable option that is associated with lower rates of hospital closures in rural areas.[7]

These recommendations retain federalist flexibility by allowing states to take actions beyond a federally established minimum standard. Moreover, most do not require congressional action. However, implementing these changes will require enhanced coordination and cooperation between and within government agencies at all levels.

Coronavirus disease 2019 challenges the assumption that poor health care for some will not affect the many. In the long term, implementing robust national guidelines for state-level pandemic response and providing a uniform baseline level of health care access will not only improve equity but also help to ensure that the nation's health is protected.

ARTICLE INFORMATION

Correction: This article was corrected on May 15, 2020, to edit the title from "...the US Coronavirus Disease 2019 Response" to "...the US Response to Coronavirus Disease 2019" for the sake of clarity.

Corresponding Author: Sarah H. Gordon, PhD, MS, Department of Health Law, Policy and Management, Boston University School of Public Health, 715 Albany St, Boston, MA 02118 (gordonsh@bu.edu).

Author Affiliations: Department of Health Law, Policy and Management, Boston University School of Public Health, Boston, Massachusetts.

Conflict of Interest Disclosures: None reported.

REFERENCES

1. Mariner WM, Annas GJ, Huberfeld N, Ulrich MJ. *Public Health Law*. Carolina Academic Press; 2019; 18-20;63-194.

2. Holohan J, Weil A, Wiener JM, eds. *Federalism and Health Policy*. Urban Institute Press; 2003.

3. Gluck AR, Huberfeld N. What is federalism in healthcare for? *Stanford Law Rev*. 2018;70(6):1689-1803.

4. Centers for Disease Control and Prevention. Health department governance: public health professionals gateway. Updated October 23, 2018. Accessed April 13, 2020. https://www.cdc.gov/publichealthgateway/sitesgovernance/index.html

5. Gostin LO, Wiley LF. Governmental public health powers during the COVID-19 pandemic: stay-at-home orders, business closures, and travel restrictions. *JAMA*. 2020. Published online April 2, 2020. doi:10.1001/jama.2020.5460

6. Jones DK. Political participation in the least healthy place in America: examining the political determinants of health in the Mississippi delta. *J Health Polit Policy Law*. 2019;44(3):505-531. doi:10.1215/03616878-7367048

7. Lindrooth RC, Perraillon MC, Hardy RY, Tung GJ. Understanding the relationship between Medicaid expansions and hospital closures. *Health Aff (Millwood)*. 2018;37(1):111-120. doi:10.1377/hlthaff.2017.0976