Political Polarization, Power and Public Health: What Should Organizations Know

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Abstract

This paper presents challenges public health officials (PHOs) experience in decision making around the SARS-CoV-2 pandemic. The paper presents two challenges, political polarization and

power in workplaces, that have direct and substantial outcomes for organizations and employees. We argue that organizations are making decisions about the safety of employees and the future of work based on recommendations from PHOs, and these recommendations are warped by political polarization and power processes. Developing a nuanced and complex understanding of this process can allow us to build more streamlined, autonomous, and ultimately, more safety conscious decision-making processes for PHOS and our organizations. We conclude the paper outlining best practices for PHOs, organizations relying on PHOs to make workplace decisions, and future research recommendations.

Keywords: worker health, organizational decision making, public health officials, power, political polarization

Introduction

Throughout the United States, we are witnessing a variety of public health, political, and organizational responses to the SARS-CoV-2 pandemic. To be certain, there is no one effective response that meets all geographical and municipal considerations. Decisions must be made at the state and local levels, with careful attention given to available resources and current challenges. Nevertheless, it is increasingly obvious that political responses—particularly partisan, polarized political responses—to SARS-CoV-2 are complicating the decisions and communication strategies of public health officials (PHOs), and subsequently, the decisions and communication strategies of organizations concerned with the health and safety of their employees and workspaces. This position paper will outline the complex relationship between PHOs and organizations and discuss various pressures PHOs are experiencing as they are making recommendations that impact organizations and the future of work. Further, this paper speaks to organizational need for accurate health related information and barriers that undermine that communication.

One example of political response in tension with public health response can be observed in the differences between the state of Washington and the state of New York (Duhigg, 2020). Washington's governor, Jay Inslee, directed residents' attention to public health experts, while New York's governor, Andrew Cuomo, decided to head up SARS-CoV-2 pandemic communication efforts for New York residents himself. Duhigg (2020) purported this difference in approach is, in part, responsible for the different health outcomes of these states. Yet, both New York and Washington are blue states with Democratic governors. More striking differences can be seen between Republicans and Democrats. For instance, in Pew Research surveys conducted in March and May 2020 (Jurkowitz & Mitchell, 2020; Mitchell & Oliphant, 2020)

found that participants were divided on issues of how serious the pandemic is, how well the media is covering the pandemic, how the pandemic started and how it will end, all along partisan lines. Republicans were more likely to believe the media were exaggerating the dangers of SARS-CoV-2. Democrats were more likely to believe that the media were reporting well on the pandemic. Also, Republican-led states were some of the first states to reopen, and red states are further along in reopening phases than blue states.

The tensions between political and public health responses pose a specific challenge to organizations and businesses. Organizations rely on PHOs to make decisions about policies and practices that impact the health, safety, and economic stability of employees, but much of this information is disseminated by political officials. In this position paper, we adopt the following definition of PHOs presented by Regidor and colleagues (2007): "individuals employed by local, regional or state, and national or federal health departments or government health agencies, who have attained their position in an open competition or by contract through a public examination based on professional merit." This definition excludes political appointments and elected officials. Using this definition allows us to consider how issues of political polarization and other power-laden pressures impact the PHOs who may appear to be structurally protected from such pressures.

PHOs operate in a space that is impacted by several factors. Gollust, Baum, and Jacobsen (2008) found that PHOs experience the following political issues at work: public health agenda-setting, political pressures, political conflicts with best practices, and the scope of public health practice. Broadly, the distribution and exercise of power can impact health policy and systems. At times of crisis, marked by the need for quick response and a lack of data, these political and power-laden issues have a chance of impacting the crisis response and communication processes

for which PHOs are responsible. This can impact workplaces in direct and critical ways as organizations rely on PHOs to deliver timely, accurate and objective information. When power associated with political pressure challenge PHO's autonomy and erode trust in PHOs, organizations and their workers suffer the consequences of misinformation too.

The purpose of this position paper is to foster understanding of the safety, science, and partisanship issues PHOs must navigate in response to the SARS-CoV-2 pandemic. Ultimately, the tension between partisanship and public health has direct and substantial outcomes for organizations working to make well-informed health and safety decisions for their employees and workspaces based on public health recommendations. To that end, we will delve into the nature of partisanship and further describe the nature of partisanship in relation to public health response to and communication about SARS-CoV-2. Additionally, we will discuss the best practices in public health response and communication developed by experts, as well as the power dynamics inherent in public health's relationship with the government. In our discussion of current implications resulting from the tension between PHOs and politics, we provide recommendations for PHOs, organizations relying on PHOs to make workplace decisions, and policy recommendations. To begin, we will first define what we mean by partisanship.

Relevant Body of Work

Political polarization

Partisanship, or the strong allegiance to one's political party based on affect or ideology, is a prerequisite for political polarization. One must strongly associate themselves with a political group in order to be partisan. This can be done in one of two ways. Affective partisanship relies on the emotional benefits one receives from being a member of a group of like-minded individuals (Sunstein, 2009). Sunstein (2009) goes on to describe that when like-minded

individuals group together, they are more likely to become more entrenched, or extreme, in those like-minded views, and less likely to entertain the views of non-group members. This movement toward the extreme is what defines polarization. Ideological partisanship operates similarly, but the focus is on the fundamental ideas and issues of the political party. As Abramowitz (2010) writes, ideological polarization is not a matter of Democrats and Republicans not liking each other because they are members of different groups, but because these groups differ fundamentally about the important issues within our society, and subsequently, the best approach for handling such issues. In fact, scholars argue that as Democrats and Republicans continue to polarize, important societal issues in the U.S. will become increasingly more difficult to address through the political process (Abramowitz, 2010; McCarty, Poole & Rosenthal, 2008). Sunstein (2009) writes that the further polarization progresses, the less likely individuals will be moved by the words or actions of others.

We can see the effects of polarization in a variety of political issues and policy topics. These issues do not exist in a cultural silo – they impact organizational policies and behaviors of organizational members. In recent years, we've witnessed polarization in marriage equality, reproductive health rights, and the impeachment proceedings of President Trump. Political polarization is increasing substantially and has been doing so since the 1970s (McCarty, Poole & Rosenthal, 2008). Yet, this is not the first time the United States has been so politically polarized. While common sense may direct us to think that public health—especially in the midst of a global pandemic—would be a bipartisan issue or immune from this polarization, this is not the first time that polarization has impacted public health measures in the face of pandemics and epidemics.

Historical incidents of political polarization & public health

There are several historical examples of political partisanship and polarization impacting public health efforts across the globe. One such example—which has recently found itself reintroduced in current news media covering SARS-Cov-2—are the Cholera Riots. The Cholera Riots occurred across several countries, including Russia, Great Britain, France, Italy, and the United States in the early 1830s (Burrell & Gill, 2005; Cohn, 2017; Kolbert, 2020). Cholera is a food and water-borne disease that causes significant diarrhea and dehydration often resulting in death. This was especially true in the 1830s, with few ways to effectively control or treat the bacteria that causes cholera. As Cohn (2017) described, there is no reason to believe that word of the riots in these nations reached one another. Instead, the Cholera Riots were focused on and exacerbated by political and socio-economic struggles in each nation. These riots were formulated around the idea that elites—officials, politicians, medical professionals, and others—were, at best, misinforming the population about the disease and allowing poor individuals to die to lessen population concerns and resources needed to maintain the social welfare of the poorest amongst these societies. At their worst, particularly in the Liverpool riots of 1832, officials and medical professionals were accused of willfully murdering patients to sell their corpses for medical and/or scientific study. As individuals moved to protest public health and safety measures taking place in these countries, protestors were met with heavy-handed response; many were injured and incarcerated, some were shot, and in four instances, the military were mobilized against protestors (Cohn, 2017). This, in turn, escalated the protests and resulted in significant property damage, the destruction of the town Donetsk, and even the assault of medical professionals in dozens of locations. Many protests ended after public health and safety measures were ended and clergy from multiple denominations pleaded directly with parishioners and in the news media for calm (Burrell & Gill, 2005).

A more recent, and directly relevant, example can be found in the anti-mask movement and protests in San Francisco during the 1918-1919 Influenza Pandemic (Bristow, 2020). The pandemic hit the West Coast in mid-October 1918, and by the end of January 1919, political feuds broke out around the public health and safety measures (e.g., bans on large social gatherings, calls for social distancing, and requirements to wear masks in public) enacted in San Francisco. While these political feuds over public health and safety measures could be found in several cities in the United States during 1918 and 1919, San Francisco had some of the largest protests. According to Bristow (2020), on January 25, 1919, almost two thousand protestors assembled in San Francisco to convene the Anti-Mask League. The political pressure placed on politicians and officials by the Anti-Mask League resulted in rescinding public health measures aimed at controlling the spread of the virus, including the mandate to wear masks in public. Subsequently, San Francisco fared worse than most cities in the United States during the influenza pandemic (Influenza Archive, n.d.).

Finally, an example of the intersection of political polarization and public health that occurred in many of our lifetimes involves the 1980s AIDS crisis. Piot and colleagues (2007) argued that, “the response to AIDS is probably the most striking contemporary example of how intertwined politics, policy, and public health are” (p. 1934). AIDS was first identified in 1981, and formally named by the CDC in 1982. First thought to affect only gay men, by 1983, medical professionals knew that the disorder could affect anyone and was transmitted by blood (in the case of blood transfusions) or sexual activity (including heterosexual partners) (Avert, 2019). The White House Press Corp – namely Lester Kinsolving – repeatedly and fruitlessly asked President Reagan’s press secretary, Larry Speakes, if the President would address the growing AIDS crisis during the years of 1982-1984 (Lopez, 2016). Speakes proceeded to treat the line of

questioning as a joke each time it was brought up, going so far as to question Kinsolving's sexuality. President Regan finally commented on the growing AIDS crisis in 1987, by which time nearly 23,000 Americans had died from the disease (Gibson, 2015). The White House Administration's refusal to even mention the AIDS crisis—much less address it in any meaningful way at the federal level—for nearly five years was the result of the disease being highly stigmatized. The first reports of the disease involved populations (i.e., gay men and intravenous drug users) engaged in behaviors that contradicted the Republican party's socially conservative, "family values" platform. Even when Reagan did choose to address the growing AIDS crisis in 1987, he attributed it to poor moral choices, stating, "After all, when it comes to preventing AIDS, don't medicine and morality teach the same lessons?" (Gibson, 2015). This means the advancements in AIDS treatment and public health messaging during 1981-1989 were markedly local and grassroots in nature. AIDS would not be addressed as a public health crisis at the federal level until the Bush administration and only received substantive federal support during the Clinton administration (Avert, 2019). The years-long delay in federal response to AIDS limited the public health response and communication endeavors of state and local public health agencies, which, in turn, impacted businesses, schools, and community organizations across the country. These examples demonstrate how political polarization has a long history of shaping public health policy and responses. It is worth examining if current widespread public access to the most up to date science research mitigates the impact of political polarization on health.

Public health best practices and the effects of political polarization

These historical examples can be difficult to reconcile with our current experience of the SARS-CoV-2 pandemic. Many of us are unaware of the ways in which political polarization can

interfere with public health initiatives. In fact, many public health officials, medical experts, scientists and scholars of crisis and disaster would argue that we are very knowledgeable about infectious diseases and much more likely to come together and help one another in times of significant strife. For instance, Solnit (2009) has written about how everyday citizens, often with little-to-no assistance from local or federal officials, have come together to help one another during disasters such as the Mexico City Earthquake, 9/11, and even in the aftermath of Hurricane Katrina. Yet, pandemics can elicit different psychological responses to crisis, last longer than the initial response to other types of disasters and have given rise to more opportunities for political polarization than other recent crises (Fisher, 2020).

The Centers for Disease Control and Prevention (CDC) has issued guidelines that outline best practices used in communication around a public health crisis. In the Field Epidemiology Manual (2019), CDC cautions that the 24-hour news and media environment impacts ways in which public health authorities disseminate the message to the media and the public. The best practices include the understanding of the public's risk perception and how those perceptions may impact communication and the role trust and credibility play in persuasion. Effective messages during outbreak responses should start with empathy, detail what is and is not known about the threat (transparency), preview potential timelines, explain public health plans including both dilemmas that exist and factors that lead to decisions. Furthermore, the messages have to cater to news outlets and be clear and succinct.

The crisis response evolves in four stages referred to as the CERC lifecycle (CERC, 2019). First, in the preparation stage, the messages are drafted and communication and response plans are created. The second phase, labeled the initial phase, occurs in the beginning of the crisis. Here crisis communicators should express empathy, explain risk, promote action, and

describe response efforts. In the maintenance phase of crisis response, crisis communicators should continue explaining the risk, provide background information, and address rumors. Finally, the resolution phase includes motivating the audience to stay vigilant, revise the plan, and discuss the lessons learned. All the decisions throughout the phases have the potential of being impacted by scientific considerations, political partisanship, and understanding of risk and safety.

In the response to SARS-Cov-2, we have several indications of polarized political interference with public health response and communication. Initially, President Trump publicly denied the risk of SARS-CoV-2 to the United States. Additionally, the administration chose to develop and administer their own tests, instead of accepting offers of already-developed tests from the World Health Organization (WHO) and other nations. The CDC-developed test roll-out was botched, and it is now believed that the tests, in fact, were contaminated (Willman, 2020). Other polarizing events included the reluctance of the President to issue a federal shelter in place order and, subsequently, Republican governors were also slow to issue state shelter in place mandates. Due to the massive shortages of needed medications, ventilators and personal protective equipment, the states were forced to bid against one another for equipment on the private market. President Trump also encouraged early reopening of states in press briefings, and many Republican governors moved on this request to end shelter in place orders, opening states before meeting the benchmarks provided by the White House Administration. As of July 2020, the nation is seeing significant increases in COVID-19 cases, hospitalizations and ICU bed utilization, especially in Republican-led states. Finally, there has been the spread of misinformation (e.g. masks are not effective in stopping the transmission of SARS-CoV-2 to others; COVID-19 is nothing more than a cold or flu-like illness), conspiracy theories (e.g. the

virus was created in a lab in Wuhan, China, and either intentionally or accidentally released; states are over-reporting COVID-19 cases and deaths to receive federal monies), mockery of and refusal to engage in public health practices, and censoring of the CDC's COVID-19 communications. One major takeaway from these events is that political officials—at the federal, state and local levels—have much more power than we may expect over PHOs and public health decision-making, despite not being experts in public health. In order to delve further into the political and policy power dynamics PHOs must navigate, we will first introduce power and the roles it plays in organizational decision making.

Power

Discussions about organizational decision-making are incomplete without understanding of the concept of power and how it functions on all levels of decision-making. Power is addressed in several different subfields (communication, sociology, anthropology and others) and has a range of definitions. Traditional, or functionalist, approaches view power as a tangible force that can be acquired, lost, and "exerted" over others (Morgan, 1986). This early model of power was introduced by French and Raven (1959) and can be exerted in five ways: a) power based on the ability to reward; b) power of coercion; c) referent power that comes with the recipient's desire to impress the superior; d) expert power of knowledge; and e) legitimate power that comes with a social or hierarchical position. This view sees power as something that is rooted in influence and relationality. In this view power is structural, it is about having access to resources, having access to knowledge, and is built strategically. This view of power is criticized for having an almost exclusively managerial focus centering on outcomes.

Contemporary definitions of power complicate the functionalist conceptualization. For example, the interpretive definition of power shifts the focus from power "over" others to power

exercised "through" everyday gestures, actions, and discourse. This view envisions power that is held through "discursive closures," or intentional conversational moves those in power make to limit what concerns are deemed legitimate and who gets to raise concerns (Deetz, 1992). Here phrases like "you are saying this because you are a woman," or "this is a matter of opinion," have the power to delegitimize an inquiry before it even begins. Critical approaches to understanding power in organizations are based on the works of Karl Marx (e.g., 1967) and view organizations not as rational or efficient, but as machines of control. In this view, the workers are unaware of the conditions of control they are experiencing and are complicit in creating and reproducing the systems of power. Foucault (1976) added to this theorizing with his work on "bio-power," the process through which the body is controlled by the speed of the assembly line. The modern worker experiences this control through surveillance and omnipresence of mobile technology. For example, we are disciplined to respond to email notifications and other pings of our phones no matter where we are. This conceptualization of power provides us with useful concepts to understand the ways power and political polarization impact PHOs' decision making process.

Contemporary theorizing on power focuses on control, identity, and discipline to explain how power functions in organizations (Barker, 1993; Thompkins & Cheney, 1985). Concretive control is a concept that shifts the locus of control onto fellow workers, who comply because they identify with the goals of the organization. For example, in a study of teams Baker (1993) found that when teams were given an opportunity to develop and reinforced their own rules and norms for everyday work practices, they developed much more rigid and demanding rules than those any manager developed.

The emphasis on organizational power and control opens the opportunities for resistance. In the face of control by the organization, workers can create individual and communal acts of resistance. Scott (1990) describes “hidden transcripts” of resistance that include complaining to peers, sabotaging work events, quietly disobeying policy, “borrowing” work supplies and others. These moment to moment micro-political actions allow the workers to release steam and allows for ongoing renegotiation of power relations. Overt communal acts of resistance can take the form of union organizing and strikes. Micro and macro acts of resistance are a part of power relations at work. Existing research has not connected issues of political polarization and power, yet PHOs are navigating both of those areas in forming their response to SARS-CoV-2. In order to understand ways power impacts PHOs, we now discuss the ways power has been studied in public health.

Power in the realm of public health

Public health officials do not work in a vacuum sealed from the influences of the outside world. The examples of the AIDS crisis, Cholera riots, and Liverpool riots previously discussed serve as examples of this phenomena. It is noteworthy that public health work is supported financially by state and federal funding. The presence of this funding not only impacts public health policy, but also what issues are deemed appropriate for consideration in the scope of public health. These arguments are fundamentally political and often are determined across party lines where conservative perspectives favor a more narrow definition of public health topics paired with limited government involvement, and the liberal perspective favors a hands-on government approach to a broad range of issues (Gostin & Bloche, 2003).

Thorough theoretical examination of the political nature of public policy work has been focused on ethical issues in public health practice. These examinations focused on the ethics of

individual autonomy, resource allocation, and privacy issues among others. Further, there have been studies that empirically examined the day-to-day ethical dilemmas and tensions public health officials experience due to the political environment. Some of these studies framed the questions of political influences as an ethical issue, thus making it harder to distinguish the role power plays in PHO's decision making.

Notably, the calls for thorough examination of power and politics in public health are ongoing (Gomez, 2016; Parker & Garcia, 2019; Storeng & Mishra, 2014). Specifically, there are calls for research that connects political science (including political polarization) and public health to develop more nuanced understanding of the ways issues of power impact PHO's practices and decisions (Gomez, 2016). Additionally, there are calls for examining impacts of politics and policy on SARS-CoV-2 pandemic response.

Current Implications

This position paper argues that it is vital to create more complex understandings of the decision-making processes around safety, science, and partisanship PHOs must navigate in response to the SARS-CoV-2 pandemic. We want to offer recommendations for research and practice that can allow PHOs to function in more autonomous ways and for organizations to feel more confident in relying on PHO's recommendations.

Policy recommendations

In this position paper we have outlined the effects of political polarization on public health policy on the macro level and discussed the way power functions on the everyday, micro level. This creates the conditions for PHOs to be unable to make decisions or implement response and communication plans that are evidence-based and grounded in science. To ameliorate these issues, we offer the following policy recommendations.

First, we recommend a re-envisioning and restructuring of public health as an autonomous entity that is protected from political changes. While it may be not possible to remove public health from power structures, we recommend changes in federal and state policy that allow for more autonomy and better safeguards to the changing winds of politics. Second, we recognize that it may be challenging to separate public health from politics. Thus, we recommend for both PHOs and organizations to have rigorous crisis response and communication plans. Many global health crises have been predicted before they occurred, and having both communication and response plans at the ready—instead of needing to create response and communication plans during the health crisis—could allow public health policy makers to have some buffer against the political pressures they experience in health crises.

Recommendations for PHOs

Our first recommendation for PHOs, and public health organizations more broadly, involves educating PHOs and others of the existing power dynamics impacting public health. For instance, in the field of mass communication, researchers have demonstrated through media literacy educational efforts that awareness of the effects (e.g., hostile media effect, third-person media effect, credibility and legitimacy of news sources, etc.) media can have on individuals is one of the most direct and effective ways to reduce the strength of said effects (Vraga et al, 2009). We argue that educating PHOs and others on power dynamics and the appropriate means of managing such issues within public health organizations would be highly beneficial for everyone, including business and communication organizations.

Additionally, we recommend that PHOs and public health agencies work to develop and maintain positive relationships with community partners and regional industries well before the pre-event phase of any health crisis. While many public health organizations have developed

relationships with first responders, local hospitals and clinics, and perhaps even media organizations, extending the relationships to include other non-profit organizations and corporate entities in their region would be highly beneficial. Currently, many corporate organizations seeking information on how to best protect their employees and stakeholders must rely on political officials, and news coverage of said politicians, to act as intermediaries for this information. Building relationships with community partners where direct communication can occur on a frequent basis would ameliorate some of those issues, and also work to build organizational and community resiliency, where PHOs and community organizations can work together in public health response and communications (Houston et al, 2015).

Recommendations for organizations

Our recommendations for organizations also focus on education and planning. First, we recommend that organizational leaders understand how power is created maintained and reproduced in a workplace. It is a common practice for organizations to conduct training for leadership teams and employees on a variety of topics ranging from team work digital workplaces to D&I. We recommend that the development of training is informed by scholarship about ways power functions. For example, this paper discussed the concept of “discursive closures.” Training on this and other ways conflict suppression is a part of everyday talk will allow for more opportunities where issues of power and polarization are disrupted, ultimately making for safer work environments.

Second, we recommend for organizations to create crisis plans that are reflective of organizational values. For example, the grocery store H-E-B was praised for its steady and focused crisis response. The chain has a long history of crisis preparedness that includes dedicated year-round staff and ongoing evaluation and retooling of crisis plans. This history is

directly informed by the company value of taking care Texas communities. The first example of H-E-B's preparedness involved their longstanding relationships with national and international counterparts, which allowed them to connect with Chinese grocers and suppliers in January. H-E-B also had an influenza pandemic plan in place, and within a matter of weeks ran scenarios to determine how their plan could be updated to address the SARS-CoV-2 pandemic. This allowed H-E-B to be one of the first corporations to deploy social distancing and disinfecting measures, increase employee pay and sick leave, and manage their supply chain and stocked inventory. We recommend that organizations take a similar approach of considering how values inform crisis preparedness. Finally, we recommend that organizations develop crisis plans by seeking active input from all organizational levels of participation. It is well known that the executive teams and frontline staff may have different experiences. Thus, participation from all levels of staff will make for more inclusive, robust, and adaptable crisis plans. This plan should also allow for flexible work accommodations (including what is work, who does work, where is it done, etc.).

Overall, we recommend that organizations reconceptualize the understanding of the role all workers play. SARS-CoV-2 had demonstrated that all workers are functionally safety workers. Regardless of the profession or occupation all workers can contribute to or derail safety processes in any organization. We recommend that training and supervision practices in workplaces focus on helping the workers understand their roles in safety management. In turn, this allows organizations to develop a culture of communal care.

Recommendations for research

In addition to professional recommendations for public health agencies, businesses and organizations, we also have recommendations for future scholarly research into this area. For instance, we believe there is a need for more academic research into the intersections of political

polarization and power, as they relate to public health and in broader contexts. Additionally, scholars have called for more research into the impacts of power and politics in public health. We second this call. In fact, we are engaging in this research, starting with developing a nuanced understanding of the ways in which political polarization and power dynamics impact the daily activities of PHOs and public health agencies in the United States.

Conclusion

In this position paper we briefly introduced some of the ways political influences and power dynamics can impact public health response and communication plans. The issues navigated by PHOs during the SARS-CoV-2 pandemic have a direct and substantial impact on businesses and organizations attempting to make decisions that are in the best interest of their employees and stakeholders. Additionally, we provided examples of past pandemics where political polarization and power dynamics did not result in the best health outcomes for communities, and we have made recommendations for PHOs, business and organizations, as well as for policy changes. It is our hope that engaging in these recommendations can help to alleviate some of the challenges recently witnessed during the SARS-CoV-2 pandemic.

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