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State Contexts for a Public Health Emergency: The Divergence of Politics and Administration in COVID-19 Vaccination Rates

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Abstract: Amid the array of challenges prompted by the COVID-19 pandemic, the policy response of governments proved vital. Different states in the U.S. pursued varied policy approaches that demonstrated distinct divergences in impact. Particularly, contrasting state contexts produced markedly assorted frameworks for the delivery of public health services, which indicate potential effects for COVID-19 policy implementation. Using the rates of COVID-19 vaccination as a measure of policy execution, the purpose of this study is to examine the political and administrative influences contributing to differences in COVID-19 public health policy outcomes among the states in the U.S. Ordinary least squares (OLS) regression models included data sources of nationally representative information pertaining to state public health attributes of politics and administration during the height of the pandemic and vaccine campaign. The findings suggest that state political leadership and fiscal capacity display significant associations with COVID-19 vaccination disparities, while other administrative indicators did not. The results signal important policy implications for the politics–administration dynamic within the COVID-19 pandemic and offer further understanding toward the roles of federalism and governance in future public health emergencies.

Keywords: politics and administration; COVID-19; public health; public policy; federalism



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1. Introduction

In the midst and aftermath of the COVID-19 pandemic, government leadership and support represented critical efforts toward mitigation and prevention. The urgent and extraordinary circumstances unquestionably strained existing public health systems beyond expected limits, exacting a necessity for efficient and effective policy outcomes. In the U.S., the immensity of this challenge intensified the inherent successes and shortcomings of federalism as public officials at all levels of government balanced policy options and directives with available resources and capabilities [1,2]. The division of powers provides a full spectrum of state contexts in health emergency situations [3,4]. Notably, divergences in politics and administration among the states may have yielded dissimilarities in results [5,6], especially relating to the key policy pursuit of COVID-19 vaccinations [7–9].

The purpose of this study is to examine the political and administrative influences contributing to differences in COVID-19 public health policy outcomes among the different states in the U.S. Specifically, in the framework of federalism, what is the impact of state political and administrative contexts on COVID-19 vaccination rates? Focusing on COVID-19 vaccinations as a measure of policy execution, this research incorporates four hypotheses to address the overall effect of politics–administration on the pandemic outcomes of American states. Primarily, political contexts entail social and cultural governing dispositions that may motivate state persuasions toward both public health policy and administration, including political party leadership and objectives of executive and legislative actors [10–16]. However, administrative contexts encompass the institutional arrangements and governance designs of implementing agencies, involving aspects of decentralization,

independence, and financial aptitude in state public health services [17–24]. Utilizing indicators for these state features of politics and administration, this study offers a uniquely comprehensive view of the potential impacts on public health policy during the height of the COVID-19 pandemic and vaccination campaign [25]. The findings suggest that state political leadership and fiscal capacity display significant associations with vaccination rates, while other administrative factors did not.

Prior research has explored issues of COVID-19 policy implementation [26–28], including the political implications and policy outcomes of state selection in mask mandates and lockdowns [29–32]. However, volatile attributes of American federalism exhibited during the pandemic encourage further consideration in this area [33,34], particularly toward the core policy goal of vaccination. Well recorded is the expanded federal role in public health due to COVID-19 [35–37] and in the pivotal development and free distribution of vaccines [38]. Yet, states were responsible for the coordination of vaccines, the determination of critical populations, and the support and monitoring of vaccine allocation in communities [39]. This study observes that imperative facet, adding to this gap of understanding with a dual vantage point that comprises both political and administrative effects in COVID-19 public health policy in states within the U.S. during this emergency event.

From a theoretical perspective, policy outcomes epitomize the broader conceptual linkage of the politics and administration relationship. Foundational work in the field suggests that the separational ‘dichotomy’ generally serves as an abstract distinction of influence among executive and legislative roles [40,41]. Within this normative premise, the bridging element of policy represents an area of complementarity between politicians and administrators in the intersect of application toward addressing public interests [42,43], particularly magnified by the overlapping operations and demands of contemporary federalism and governance [44,45]. In other words, aside from the larger philosophical debate, public policy best signifies the authentic synchronization of political and administrative enterprise in governmental functionality toward implementation [46]. This study aims to add to the continued evolution of the politics–administration nexus within the overarching theme of federalism and the related repercussions revealed through variant public health policy results in extreme situations of service complexity and civic need.

The organization of this study is as follows: First, a review of the literature describes federalism and politics–administration for public health policy in the states within the U.S., which informs the theoretical expectations. Next, a description of methods identifies the research approach, followed by data analysis and interpretation of the findings. Finally, a concluding discussion addresses implications and recommendations for future research.

2. Federalism and Politics–Administration in Public Health Policy

The American federal system demarcates powers held by the national and fifty state governments, which crafts a multipart arrangement of intergovernmental relationships and balancing tensions in governance [47,48]. Within this assembly, interactions and internal policies exemplify vast mixtures in political formulation, spurred by geographical, ideological, and cultural peculiarities [49]. Federalism impacts government management and, in turn, policy outputs by dictating the manner of networks and interfaces among entities, demonstrated in patterns of traditional top-down policy diffusion and more novel groupings of localized and interdependent configurations [50]. Such conditions stimulate policy learning and innovation, as the states regularly assume the role of ‘laboratories’ in experimenting with policy alternatives [51,52]. Yet, the division of powers and patently exclusive political contexts of the states create a fracturing of public policy, which is most apparent in specialized areas, such as healthcare, and in times of crises [53].

In public health, the federal structure acts as a mode of devolution in which the administration of massive national health platforms, such as Medicaid and the Patient Protection and Affordable Care Act (ACA), rests with the states, creating an assortment of programmatic identities typically reliant upon state resources and political inclinations [54]. Such fragmentation inevitably warrants inconsistency that, while beneficial for policy invention,

may limit the propensity for uniform remedies to widespread problems [55]. Amid the challenges of the COVID-19 pandemic, existing imbalances in healthcare governance coupled with leadership gaps and partisan disputes generated a factionalized and partitioned approach, establishing concurrently divergent, and in some cases contradictory, public health policy responses [2,5,7,16]. Noticeably, the ever-expanding disconnect between the federal and state governments in this policy arena was deepened, leaving states and localities in control by default [1,35].

A federal system fosters allotments of authority and action among governments, with coordinating relationships between elected officials, implementing agencies, and constituents [56,57]. The nature, composition, and application of government all impact institutional character and layout, which lend to special aspects of autonomy, originality, and dissemination [58,59], principally in areas such as public policy [60,61] and revealed both during and after the COVID-19 pandemic [17,62,63]. Each state cultivates discrete relationships in the devise and delivery of public health policy, resulting in interspersed responsibilities and obligations [64] that may prompt deviating outputs. Of particular interest, during the COVID-19 pandemic, wide variation existed among states in the percentage of fully vaccinated persons, with the highest rate in Rhode Island (80.5 percent) and the lowest in Alabama (50.2 percent) [38]. Thus, within a broader setting of federalism, this study distinctively seeks to advance understanding of the political-administrative dynamic in states within the U.S. that produced such disparate policy outcomes.

2.1. Theoretical Expectations

2.1.1. State Political Contexts in Public Health

Political factors guide an array of government properties evident at the state and local levels, including structures, policy, and efficacy [65–68]. In the COVID-19 pandemic, state political orientations, expressive of partisan divides and state-local disagreement, assumed a stake in policy decisions and reactions. For instance, the political stance of governors may have been persuasive in state policies toward mask mandates [29], and such policies met public resistance in conservative-leaning states [31]. As a result, policies fluctuated, and the actions taken within individual states and among local governments exposed pre-existent tensions and politically motivated catalysts, contributing to differences in outcomes such as mortality rates [69]. Backlashes against executive orders and bureaucratic policymaking fueled dissensions between state legislatures and governors as well as intrastate political nuances and compliance pushback from local governments [13,27]. Such divisions among the states, overlaying elements of partisan discrepancy, conflicts and distrust, and newly strained intergovernmental relationships, convey a potency of political factors in public health policy during the COVID-19 emergency.

The influence of state agencies in policy decisions and formation appears more expansive within the executive branch, classically with governors, as opposed to the more fractured political interests embodied within state legislatures and local governments [11,70]. In this way, the impetus for policy aligns with the public choice theory of the political economy, alleging that public officials will habitually act in self-interest by endorsing policies that are most amenable to their own organizations, political expediencies, and constituents [14], which shapes the temperament of the policymaking process and the character of the policy approach [15]. Of interest, Democrat governors depict a higher amenability to state health policy adoption and implementation [71,72], possibly associated with higher levels of COVID-19 vaccination rates [69]. Based on the above, Hypothesis 1 posits the following:

Hypothesis 1: *A state with a Democrat governor is positively associated with COVID-19 vaccination rates.*

In situations of a divided government, where competing political parties split control of the governorship and state legislature, the prospect for policy compromise may be more

limited and may prolong the timeframe for action [73,74]. In public health policy, this effect is often accentuated, predictably at the state level where executive responsibility in healthcare is commonly more concentrated and centralized [54]. During the pandemic, policies for infection mitigation, such as wearing a mask, necessitated concerted efforts from both state executive and legislative actors [26,30], which potentially amplified political leanings in COVID-19 vaccination policies [8]. As such, Hypothesis 2 posits the following:

Hypothesis 2: *A state with a divided government is negatively associated with COVID-19 vaccination rates.*

2.1.2. State Administrative Contexts in Public Health

In the U.S., state public health governance structures refer to the organizational relationships among state and local units in the delivery of public health services [64,75]. For state policies, the institutional interactions between state officials/agencies and local governments may yield improved cooperation and coordination in implementation and sponsorship [18,61]. However, internal state structures vary in degrees of centralization, which prescribes interorganizational affiliations among state agencies and local entities [4,75]. For example, the institutional location within state government may portend more control over policy implementation by those public health agencies afforded greater independence in operation [22,70]. Recent research suggests that decentralized structures may increase cooperative ventures among officials, aiding collaborative policymaking and joint outcomes in public health [3,76] and interlocal sustainability [77].

Assessing the impact of COVID-19, propositions for improved public health systems include decentralized tactics, such as community-based health initiatives for enhanced partnership and communication among organizations [28,62]. Decentralized public health configurations proved to be effective during the pandemic, as states and localities filled in the gaps of implementation from federal directives [26]. In contrast, internationally, strongly centralized approaches were less effective in public health objectives and impeded the ability of local entities to handle rapidly evolving conditions [78,79]. However, some states within the U.S. with higher levels of local government autonomy witnessed fewer independent actions taken by local officials in addressing COVID-19 issues [9], while such states were also more likely to experience pre-emption and increased centralization of policy directives by state governors during the pandemic [32]. Based on the above arguments, Hypothesis 3 posits the following:

Hypothesis 3: *A state with decentralized public health governance structures is positively associated with COVID-19 vaccination rates.*

Existing research of local immunization rates and programs among U.S. health departments distinguishes several factors that may enrich the efficacy of service and policy delivery, including organizational leadership and alignment, resources, political relationships, community partnerships, credibility, and cultural competency [23]. The capacity attributes of states, including rural orientations that may be symptomatic of lower socioeconomic status and healthcare employment per capita, signal associations with state systems for medical countermeasures and distribution during public health emergencies [21,80]. This lends itself to the aspect of state administrative capacity, comprising components of public health workforce and financial disposition, which may anticipate the ability of states to administer effectual services and outcomes for all populations [81–83], particularly in severe public health conditions [17]. Thus, accounting for the inherent capacity contrasts of the states within the U.S., Hypothesis 4 posits the following:

Hypothesis 4: *A state with greater administrative capacity is positively associated with COVID-19 vaccination rates.*

3. Materials and Methods

3.1. Data and Sources

This study used multiple datasets from the Association of State and Territorial Health Officials (ASTHO) [64], Kaiser Family Foundation (KFF) [38,84], National Conference of State Legislatures (NCSL) [85], U.S. Bureau of Economic Analysis (BEA) [86], and the U.S. Centers for Disease Control and Prevention (CDC) [87]. These data sources included nationally representative information pertaining to state vaccination rates and public health characteristics of politics and administration during the height of the pandemic and vaccine campaign [25], with data collection occurring between 14 December 2020 and 24 February 2022. The data include all fifty states within the U.S. ($N = 50$), excluding the District of Columbia.

3.2. Models and Variables

Table 1 displays the variables, measures, and expected effects of state contexts on vaccination rate. The dependent variable is the total percentage rate of state residents designated as fully vaccinated, receiving two doses of a COVID-19 vaccine [87], which is a function of state political contexts, state administrative contexts of state public health governance and state administrative capacity, and state socioeconomic factors. Three models were used to assess the effects of state political and administrative contexts on the dependent variable. Model 1 incorporates state political contexts and controls, Model 2 integrates state public health administrative contexts and controls, and Model 3 is a comprehensive model with all variables.

Table 1. Variables, measures, and expected effects of state contexts on vaccination rate.

Variables	Measure	Effect	Data Sources
Dependent Variable			
Percentage of the population fully vaccinated	The percentage of state residents who received two doses of a COVID-19 vaccine (2022)		U.S. Centers for Disease Control and Prevention (CDC)
Independent Variables			
Political Contexts			
Democrat governor	(1) A state with a Democrat governor; (0) a state without a Democrat governor (2021)	+	National Conference of State Legislatures (NCSL)
Divided government	(1) A state with a split between the party affiliation of the governor and the state legislature majority; (0) a state without divided government (2021)	−	National Conference of State Legislatures (NCSL)
Administrative Contexts			
Decentralized public health governance (state–local)	The relationship between state and local public health departments (decentralized) (1) a state with decentralized governance; (0) a state without decentralized governance (2021)	+	Association of State and Territorial Health Officials (ASTHO)
State public health personnel	Public health workforce capacity per 10,000 (2021)	+	Association of State and Territorial Health Officials (ASTHO)
State fiscal capacity	State GDP (per capita) (2021)	+	U.S. Bureau of Economic Analysis (BEA)
Controls			
State population	Total state population (log) (2021)	−	Kaiser Family Foundation (KFF)
Race/ethnicity	Non-white (%) (2021)	−	Kaiser Family Foundation (KFF)

State political contexts are composed of a Democrat governor and divided government. A highly divided government complicates consensus, possibly hindering opportunities for effective policy execution, and states with majority Democrat support and governors tended to experience higher vaccination compliance [8]. A Democrat governor and divided government are dichotomous measures to designate states with Democrat governors coded as '1' and divided state governments coded as '1', otherwise coded as '0'.

State administrative contexts encompass state public health governance and the extent of the state's capacity to design and implement public health initiatives. The former portrays the relationship and alignment between state and local public health agencies. The states employ alterable configurations for public health governance that range in degrees of centralization [64], or concentrated state control and authority, which may affect service delivery and policy outcomes. A dummy variable designates states with decentralized public health governance coded as '1', otherwise coded as '0'. Moreover, state administrative capacity, represented by personnel and fiscal dimensions, may determine the extent of agency resources available to dispense health services [17], such as vaccines. Two variables for state administrative capacity, state public health workforce capacity per 10,000 and state per capita Gross Domestic Product (GDP), are considered in the models.

In addition, the total state population and the percentage non-white population are included in the models to control for state socioeconomic factors. The size of the population can result in an increase in public demands, and the problem severity may affect the circulation and equity of health services. Specifically, during the pandemic, COVID-19 vaccination rates and deaths differed substantially by race/ethnicity [69,81,88].

3.3. Estimation Strategy and Limitations

Ordinary least squares (OLS) regression models with robust standard errors for unbiased OLS coefficients under heteroscedasticity were utilized. Diagnostics to address multicollinearity found no issues of correlation among the independent variables. However, this study is a preliminary study with a small sample size ($N = 50$) and many explanatory variables, resulting in fewer degrees of freedom. The cross-sectional study design did not permit researchers to control for systematic differences resulting from varied state histories toward existing public health problems and contingencies, such as obesity rates, education levels, etc. The measure used for COVID-19 vaccination rates was limited by those vaccines that required two doses, which represented the predominant mode of vaccines administered [38,87] and does not account for single-dose vaccines. The purpose of this study was to examine political and administrative influences contributing to differences in public health policy outcomes among the states within the U.S. specific to vaccination rates during the crucial distribution period of the COVID-19 pandemic, as designated by the national government [25]. This limits datasets and data collection to this timeframe and is not representative of changes or progressions in the status of such indicators that may have previously or subsequently transpired.

4. Results

4.1. State Political Contexts

The models in Table 2 contain the robust OLS regression estimators of the percentage of the population who were fully vaccinated in states within the U.S. Democrat governors were significantly associated with higher vaccination rates, as shown in Models 1 and 3. This finding is congruent with Hypothesis 1 and prior research of the political effects on state health policy and implementation during the pandemic [26,29,31,36], and expresses the influences of political leadership in COVID-19 policy and adherence among states within the U.S. [1,2,7,30,80]. However, a divided government was not statistically related with the dependent variable, which opposes Hypothesis 2 and other extant studies [65,73,74].

Table 2. Contexts for the percentage of population fully vaccinated in states within the U.S.

Variables	Model 1	Model 2	Model 3
Political Contexts			
Democrat governor	0.154 ** (0.015)		0.133 ** (0.020)
Divided government	0.027 (0.017)		0.026 (0.015)
Administrative Contexts			
Decentralized public health governance (state–local)		–0.022 (0.025)	–0.018 (0.019)
State public health personnel		0.038 * (0.017)	0.006 (0.013)
State fiscal capacity (state GDP)		0.296 ** (0.047)	0.132 * (0.049)
Controls			
State population	0.002 (0.008)	0.018 (0.017)	0.006 (0.013)
Race/ethnicity	–0.053 (0.047)	–0.092 (0.098)	–0.084 (0.059)
Constant	0.515 ** (0.118)	–2.995 ** (0.495)	–0.995 (0.589)
F-value	28.76	15.36	31.93
R-squared	0.682	0.356	0.730

* $p < 0.05$, ** $p < 0.01$, Robust standard errors, $N = 50$.

The findings provide additional corroboration for the role of political contexts in state policy effects during the COVID-19 crisis and offer supplemental clarification of the politics–administration dynamic in state differences for vaccination rates. Previous studies suggest that, while adequate frameworks and alliances for emergency public health contingencies were instituted by federal and state organizations in reaction to the pandemic, political fracturing, exacerbated by partisan misrepresentations, financial missteps, and leadership deficiencies, ultimately undermined the viability of coordinated policy execution [4,35]. Hence, extenuating national circumstances and politicking negated pre-existing protocols, damaged intergovernmental relationships and citizen trust, and created a vacuum of policy responsibility that devolved to the states [63]. In this way, state political leadership assumed a principal setting for COVID-19 policies and subsequent outcomes [5]. This key finding contributes to further understanding of the effects for state COVID-19 vaccination disparities in aspects of public health policy and federalism.

4.2. State Administrative Contexts

For state administrative contexts, the findings in Models 2 and 3 suggest that state public health governance structures with decentralized relationships between state and local agencies did not influence COVID-19 vaccination rates. This result is not in accordance with prior studies on the positive impacts of decentralized organizational arrangements for collaborative policymaking and outcomes [3,62,77–79], and is also contrary to research denoting the effects of agency configuration in health administration [22–24].

Although inconsistent with Hypothesis 3, the discrepant effects of structural governance could be credited to the unprecedented and urgent nature of the COVID-19 pandemic that may have obscured existing public health protocols [28,33]. In other words, because of the extraordinary and unparalleled circumstances, the intended operation of prevailing systems was compromised and compounded by emergency necessities, political stalemates,

and rapidly evolving conditions [6,21]. Furthermore, during the time of the pandemic, many state governors assumed the lead on public health policy [13,32], issuing over 4000 executive orders related to COVID-19 between 2020 and 2021 [89], which ostensibly may have added to the diminishing faculty and relevance of preceding configurations for administration and correspondingly intensified the influence of politics.

Examining the impact of state administrative capacity, the findings show that the public health workforce per 10,000 state residents and state per capita real GDP were associated with vaccination rates in Model 2, excluding state political contexts, which aligns with Hypothesis 4. However, in the comprehensive Model 3, only the state GDP was statistically significant. Potentially, this may be ascribed to more collaborative substitutes for the public health workforce during the pandemic, including nonprofits and private contractors as well as other public actors [9,19,27,51]. The positive effect of the state GDP supports previous extrapolations of the financial component in COVID-19 vaccination campaigns [82], which is reflective of the extraordinarily high percentage of GDP devoted to state healthcare expenditures during the vaccine campaign timeframe [90] and suggests that the financial standing and resources of states may have contributed to the available policy approaches and resulting outcomes for vaccination adherence.

To control for state socioeconomic factors, the models included the total state population and the percentage non-white population. The total state population did not affect the dependent variable. Likewise, the percentage non-white population did not show a statistically significant association with state vaccination rates, which counters earlier research that documents this connection [81,84,87,88].

5. Discussion and Implications

The purpose of this study was to examine the political and administrative influences contributing to differences in COVID-19 public health policy outcomes among the states within the U.S. Specifically, in the framework of federalism, what is the impact of state political and administrative contexts on COVID-19 vaccination rates? The findings display traits related to state political leadership, namely the party affiliation of governors, along with the fiscal capacity of the state GDP exhibiting significant associations with COVID-19 vaccination rates, while other indicators of administrative design and aptitude did not. The results provoke a broader discussion of the proper roles ascribed to politics and administration in effectual policy execution and the consequent positions of governments within federal systems for future public health emergencies.

In countering COVID-19, the national government activated emergency public health procedures. However, delays in action and coordination among officials and agencies affected applications [63]. Here, the scheme of federalism fittingly delegated remaining assignments to the states, which resulted in a deviation of policy approaches reflective of the political temperaments in individual states [10,27,37,54]. Ultimately, based on the findings of this research, the politics-administration nexus signaled an overarching predominance of political persuasion in the vaccination policy outcomes of states, which seemingly rendered existing administrative structures and conventions immaterial. These interpretations are consistent with assertions from extant studies that suggest politics held a disproportionate locus of influence in the reaction and subsequent activities of governments toward the mitigation of COVID-19 through public policy, not just in the United States but worldwide [34,76,91]. Moving forward, this supposition is both revealing and disconcerting for public health, as even the most diligent and proactive protocols set forth by administrative agencies in preparation for extraordinary health events may be displaced by the prevailing political sentiments of the moment.

What is more, the findings raise additional questions for the politics-administration relationship in public health crises and the necessity of aligning tasks within federalism for the coordination of equitable policy outcomes. Debatably, politics symbolize the formal arbiter for administration in a representative democracy, subject to the voting preferences of the citizenry and bound by the authorizations and oversight of elected officials in policy

implementation [40]. Conversely, the assumption of expertise places administrators in a presumably better position to address specific policy contingencies, such as public health, creating opportunities for politics–administration synchronization in outputs that will be most beneficial to the overall public interest [4,42,51,56]. Modern iterations of the politics–administration dichotomy suggest a continuum model that coalesces roles of political and administrative actors for enhanced collaborative interactions and leadership [44]. Yet, the politicization of major policy functions, such as healthcare, may limit the aptitude afforded to administrators to operate accordingly [1,45,46]. As current research shows, social behaviors and attitudes typify fragmented political dispositions toward the issues of COVID-19 and vaccines among state populations and communities, demonstrating an impact on the administrative campaigns and policy efforts toward vaccination [16,81,92,93]. Relatedly, the findings of this study portend serious considerations for the cooperative link of politics–administration in producing universal policy outcomes at the state level when facing massive public health predicaments on a scale of federalism.

In general, states with Republican party leadership, such as the governor and state legislature majority, have been averse to increased expenditure toward healthcare programs and policies as opposed to their Democrat-led counterparts [94], which is particularly accentuated by the differences in large-scale public health initiatives such as Medicaid expansion [95,96]. Compatibly, states with Democrat leadership portray more centralized administrative structures for healthcare agencies [64] that signify a potentially strengthened span of political presence and oversight in directing public health policy procedures [97]. In 2020, moving into the pandemic, states with Democrat governors [39] and Democrat majorities in the state legislature demonstrated higher health spending per capita [98], indicating a pre-existent difference in the allocation of financial and administrative resources toward public health services. Moreover, following the COVID-19 emergency, Democrat-led states consistently display higher rankings for the performance of health systems in comparison to states of Republican leadership [99]. Yet, as the findings of this study show no impact of a divided state government on vaccination rates, there is a consideration for the unique environment of state dynamics that may persuade political decisions to be more narrowed and expedient of individual state needs and nuances [49,97,100]. This may not necessarily be beneficial in addressing wide-ranging public health emergency situations that compel uniform policy strategies and effects.

As an example, the results of this research indicate that fiscal capacity, represented by the state GDP, may have been instrumental in vaccination rates, which suggests that economic disparities among the states may have obstructed the ability to attain equivalent outcomes. The state GDP is a function of economic policy that prefigures the political orientation and administrative organization of state systems. The national government sustained the financial volume to spearhead vaccine development and distribution, while state governments typically did not maintain adequate assets for such endeavors [39]. Historically, state governments have required a balancing of revenues and expenditures and have been prohibited from raising deficits [101], which could negatively constrict a state's flexibility in reaction to a COVID-type incident. As witnessed in the pandemic, such instances of federalism require a reciprocation of corresponding resources to obtain comparable results, which the states did not possess. During the COVID-19 emergency, the national government dramatically increased health spending from USD 13 billion in 2019 to USD 135 billion in 2020, while state and local governments augmented their health expenditures by only 9 percent from USD 93 billion to USD 102 billion [102]. In particular, the former spent over USD 30 billion on vaccine development and distribution [38]. For the states, health spending is reflective of GDP, as the proportion of available resources dictates the allocation of financial and administrative support designated to healthcare services and systems [90]. This represents the policy link and paradigm of politics–administration in public health, as the decisions to apportion funding for health platforms, such as vaccination campaigns, ultimately reside with state political leadership. Hence, to ameliorate such policy discrepancies as beheld among the states for vaccination rates, the findings of this

study propose evidence for an expanded role of national governments in confronting COVID-level public health situations with a compatibly more localized duty for state-level governments and entities. As such, administrative and political officials in federal systems may seek more coordinated and anticipatory policy frameworks that designate appropriate best practices for each, with the objective to mitigate impediments prior to emergency events. This may likewise address operations most suited to centralized and decentralized structures that are conducive to consistent and equitable policy effects, while in consideration of pre-existing economic and capacity disparities among levels of government that may catalyze escalated political segmentation and influence within federal configurations.

Certainly, there is a need for further research. Enhanced understanding is required to distinguish those factors that produced such incongruent COVID-19 vaccination policy results in the states within the U.S. and globally. This is markedly emphasized by the observed disparities in public health equity, including the COVID-19 vaccination and mortality rates of minority populations [84,93,103]. Future researchers may want to discern state financial support allocated toward public health policy alternatives for vulnerable or marginalized individuals, which could influence people's decisions to stay at home without getting vaccinated, possibly affecting vaccination rates and compliance. Additionally, exploring various indicators related to state fiscal capacity could be valuable for future studies. Outside of this study, several restrictive factors may have affected the policy leadership and support of governments during the pandemic, involving institutional limitations and internal dynamics, the scope of policy persuasion, and the range of interventions available to state and local policymakers [47,57]. These constructs relate to Peterson's [104] focus on the categories of public policy, such as developmental versus redistributive policies for the proper division of work among the federal, state, and local governments. Future researchers may want to review alternating responsibilities in federal systems for prior public health issues and examine viable functions assigned to each level of government. Of note is further investigation into the appropriate roles for politics and administration in public health policy, identifying areas of overlap and the potential for strengthened complementarity in collaborative governance, and explicitly how such dynamics may be harnessed to promote innovations of improved protocols and uniformity in outcomes for population health and large-scale vaccination campaigns.

6. Conclusions

The COVID-19 crisis epitomized an unprecedented public health episode of mammoth proportions. Within this predicament, the federal and state governments experienced exceptional challenges in the provision of safeguards and services. Existing models were defied, and novel problems were uncovered. A variety of unimagined exigencies tested preconceptions of federalism and public health policy. Overall, the system functioned suitably, and, in time, the U.S. found its way out of the pandemic. However, questions remain as to the lessons learned from this occurrence and how well governments and public health agencies will be prepared for such an event in the future. The intention of this research was to seek supplemental exploration of the influences affecting the COVID-19 policy outcomes of the different states. While the findings suggest that state political and economic contexts played a part in COVID-19 vaccination rates, there is still more to discover. Continuing to gain further knowledge of how the politics-administration partnership can be utilized optimally in future public health emergencies may assist in obtaining more ideal outcomes for governments, policy, and the public.

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