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Mass casualty event scenarios and political shifts: 2020 election outcomes and the U.S. COVID-19 pandemic

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ABSTRACT

COVID-19 models indicate a mass casualty event may potentially occur in the United States. Among numerous social and economic changes, the potential to reshape the political landscape exists. The theoretical perspective of politics-administration dichotomy is used to examine the rhetoric, power, and authority of public health messages during the pandemic. This study considers political shifts using state-level data on population, historical voter turnout, and projected COVID-19 cases number coupled with national-level data on voter participation by age group and COVID-19 fatality rates. Developing a formula to calculate these data, we project the extent to which the number of voters from each party could diminish. The analysis shows the potential for significant political changes due to the disproportionate loss of older voters in key swing states in the months leading to the 2020 presidential election.

KEYWORDS

COVID-19; elections; mass casualty event; politics-administration dichotomy

The COVID-19 pandemic holds the potential to reshape the political, economic, and social systems in the U.S. The political landscape stands to be significantly altered should a mass casualty event occur particularly for a sustained amount of time. This research note considers the potential for a large shift in the electorate due to a potentially catastrophic mass casualty situation.

Political concerns over the economy have at times led to divergent policy positions from those advocated by health experts including the critical need to minimize person to person contact (e.g., lock-down, shelter). Political rhetoric has added to this divergence with different political leaders sending different messages and challenging the dichotomy of politics-administration. For instance, President Trump at times has pushed to shorten the length of sheltering measures to minimize the associated economic loss (Mohsin, 2020; O'Reilly, 2020). Alternatively, New York Governor Andrew Cuomo has been urgently working to secure and deploy resources as the state he leads has the largest number of COVID-19 cases in the nation (Torres, 2020). There exists a politically motivated disparity between the responses of some elected officials and administrators attempting to provide unbiased health information. This paper examines the political outcomes of COVID-19 from a demographic perspective.

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Covid-19

The potential for a sustained mass casualty situation on the scale of the COVID-19 outbreak is a rare occurrence. Few events in the modern history of the United States or the world have the same potential to fundamentally alter society as the COVID-19 pandemic. Mattox, et al. (2013) defines a mass casualty event as one that overwhelms hospital resources due to the number or severity of casualties. Models currently project that COVID-19 cases could reach levels that would exceed hospital capacity across much of the U.S. (COVID ACT NOW, 2020). As of April 3, 2020, over 245,000 people in the United States have tested positive for the COVID-19 virus (Johns Hopkins University & Medicine, 2020). The States of New York and Washington are experiencing shortages in hospital capacity. Evidence from other nations such as Italy, Spain, and parts of South Korea and China show that the massive number of affected individuals can easily overwhelm available hospital resources (Horowitz, 2020; Liu & Tsoi, 2020; Poggioli, 2020). Drastic control measures are necessary to attempt to control the number of cases and fatalities (COVID ACT NOW, 2020).

The medical community is still working to learn about COVID-19 including its symptoms, treatment, and spread of the infection. There is currently not a vaccine or specific treatment for the virus, yet several are under development (Gallagher, 2020). COVID-19 tends to be more fatal in older individuals, those with compromised immune systems, and those who have other serious underlying medical conditions (CDC, 2020). According to the Centers for Disease Control and Prevention (CDC), "8 out of 10 deaths reported in the United States have been in adults 65 years old and older" with those above the age of 85 at even greater risk (CDC, 2020). Over 52 million people in the United States are over the age of 65 or about 16% of the population (U.S. Census Bureau, 2019).

Not all cases of COVID-19 are severe as many affected individuals have mild symptoms or are asymptomatic (Rothe et al., 2020). These individuals may still spread the virus leading to additional complexities for combating its spread. Typical treatment for severe cases requires the patient to be placed on a ventilator often in an Intensive Care Unit (ICU) of a hospital (CDC, 2020; Wunsch et al., 2013). In the U.S., there are 6,146 hospitals with a total of approximately 925,000 hospital beds with 97,776 designated as ICUs (American Hospital Association, 2020). Not all beds are considered "staffed" and this number includes all intensive care beds regardless of their more specific designation (e.g., burn care, cardiac). The nation has access to approximately 62,000 full feature ventilators and another 98,000 more basic models (Cha, 2020; Johns Hopkins Center for Public Health, 2020). The Centers for Disease Control maintains an additional stockpile of approximately 8,900 ventilators while some states also maintain stockpiles of ventilators (Johns Hopkins Center for Public Health, 2020). Modeling for influenza outbreaks conducted by the CDC in 2017 focused on regionally specific needs that require the deployment of national stockpiles. The underlying assumption of the models are that stockpiles would be deployed to high need areas in the event of an influenza outbreak. The report notes the number of ventilators "to suffice for a moderate (1957- and 1968-like) pandemic, in which hospitalization rates roughly triple, they would fall far short in a severe (1918-like) pandemic" (Huang et al., 2017, para. 29).

As health resources are limited, decisions on how and which patients to treat poses a difficult choice for healthcare providers. In the United States, these decisions are made at the local level often by hospital-based ethics committees comprised of healthcare professionals and others (e.g., social workers, clergy) (Pfeiffer, 2020). Age and preexisting health conditions are common considerations (Pfeiffer, 2020). Thus, individuals who are older in life are at a disadvantage in situations where choices must be made about which patients are allocated health resources.

Mass casualty events

There are historical examples of global pandemics resulting in mass causalities. The AIDS epidemic (1981-present), Plague of Justinian (Beginning in 541 AD), and the Black Death (1348–1351) serve as examples of epidemics with death tolls well into the millions of individuals (Brainerd & Siegler, 2003). Influenza routinely claims the lives of thousands of people per year with some years being particularly severe (e.g., 1957, 1968, 2009) (Jordan, n.d.). The most serious influenza events have the potential to be classified as a pandemic if certain criteria are met, as outlined by the World Health Organization (WHO) (World Health Organization, 2020). The most recent global influenza pandemic occurred in 1918 with the spread of the H1N1 influenza strain. The pandemic claimed the lives of an estimated 50 million people worldwide and 675,000 people in the United States (Jordan, n.d.). Since this pandemic occurred over a century ago, sound data was not collected as it might be today (Brainerd & Siegler, 2003). However, experts believe that the influenza strain was indiscriminate in that it was often fatal even to those in good health (Crosby, 1989).

The most salient mass casualty scenario for many in the United States would have occurred on September 11, 2001 (Quillen, 2002). While most in the United States were not directly impacted in terms of injury or death, hospitals in the regions directly affected by the terrorist attacks that occurred that day were overwhelmed for a time due to the large influx of victims. Health systems may be overwhelmed by natural disasters or other mass casualty events, but these tend to subside in a matter of days, at least in terms of demand for emergency response and intensive care. The widespread and enduring nature of the COVID-19 outbreak has the potential to overwhelm the healthcare system on a nationwide basis for a sustained amount of time, possibly weeks or months. The nationwide scope of the situation negates any benefit potentially derived from the movement of patients and resources to different regions. In other words, medical staff, resources (e.g., ventilators, personal protective equipment), and patients cannot be redeployed if much of the nation is struggling to meet similar healthcare demands. Additionally, the worldwide nature of a pandemic lessens the ability of other nations to provide assistance beyond their own borders. The ability to respond to a pandemic requires a concerted effort between healthcare providers as well as actors at multiple levels of government due to the federal system of government.

Administration and politics

Within this crisis, the tension between a politically driven desire for certain outcomes and advice of health experts exists. Since Wilson's (1887) *The Study of Administration*

was published, the politics-administration dichotomy has been a theoretical lens used to examine the separation of politics from administration. During the COVID19 pandemic, members of the White House Corona Virus Task Force attempt to provide evidence-based information in a political setting, blurring the separation of politics and administration. The theory of politics-administration dichotomy constructs the boundaries and relationships between elected leaders and professional administrators whose goal is to provide facts over value-driven concepts to the public (Rolandi, 2020).

Recommendations regarding public health information from the Centers for Disease Control (CDC) and Dr. Anthony Fauci, a leading scientist and director of the National Institute of Allergy and Infectious Disease, should be free of politics; however, political leaders have controlled much of the conversation. While Dr. Fauci has a long history of public service, providing expert knowledge and serving as "a top public health advisor in six presidential administrations- across both sides of the aisle," politics have impacted the message regarding public health during this pandemic (Rolandi, 2020). For example, the White House has tightened "control of coronavirus messaging by government health officials and scientists;" and, "Dr. Fauci has told associates that the White House had instructed him not to say anything else without clearance" (Shear & Haberman, 2020). Typically, the CDC leads the country in times of medical outbreaks; however, the "recent absence from the national stage has led to fears that the agency's objective, science-based approach is being ignored, especially as Trump signals that he hopes to relax restrictions on social gatherings by Easter to help revive the economy" (Greenfieldboyce, 2020).

The political rhetoric has at times emphasized a need to "get back to work" in hopes of minimizing the economic impact (O'Reilly, 2020). The rhetoric surrounding COVID-19 certainly illustrates the government using politics and expansive authority in governing, which challenges the traditional politics-administration dichotomy. It is also imperative to recognize the use of authority, reason, and discretion and how the consequences of the use influence society, democracy, and the existing power structures of government (Sementelli, 2007). This political desire runs against the advice provided by the aims of government actors concerned with the loss of life. Additionally, this approach to governing minimizes concern for the well-being of citizens' health and leads to a moral dilemma of how to govern during a crisis. Given that the virus tends to affect the elderly more than the young, a policy that favors economic activity at the expense of action to reduce the person to person contact will disproportionately harm the elderly. Approaches such as these void the normative perspective of good governance, which tends to be guided by instilling moral values in decision making and incorporating an ethic of care in serving the public. Scott explains that after crises, such as Hurricane Katrina, "we have watched ideologically-inspired dreams of conquest, power, and fame," which have greatly impacted public service and administration (Scott, 2008, p.118). This approach further illustrates the blurring of the politics-administration dichotomy, where we experience priority placed on political agendas rather than governing with compassion, ethics and morals. Perhaps, Gilligan's approach to incorporate justice and ethics in public decision making and articulating these ideas to the public may lead to good governance (Gilligan, 1983).

U.S. political landscape

The COVID-19 pandemic could have a particularly direct effect on the U.S. presidential election scheduled for November 3, 2020. All members of the U.S. Congress, one-third of Senators, and numerous state and local elected officials are up for election at this time. Given the gravity of the pandemic situation, it is likely to have a profound impact on the election (e.g., Cillizza, 2020).

This research note models the potential effects of the COVID-19 virus on the political landscape of the U.S. past election projections have not accounted for the vast loss of life that is currently being projected as part of the COVID-19 response modeling (COVID ACT NOW, 2020). Should these dire projections hold, the political shifts in the nation could be dramatic based on the change in demographics alone.

Several states play an outsized role in determining the outcomes of the U.S. Presidential election. Since most states are predictable in their support of the candidate of a political party, a strong performance in the swing, or battleground states, is necessary for a candidate to gain the needed electoral votes to prevail. Florida, Ohio, Nevada, Colorado, North Carolina, Virginia, Iowa, New Hampshire, and Wisconsin were considered swing states in the 2016 election (Mahtesian, 2016). Donald Trump carried all of these except Virginia, Colorado, Nevada, and New Hampshire. Other states proved to be exceptionally close in the 2016 presidential race including Pennsylvania and Michigan (Meko, Lu, & Gamio, 2016). In 2016, Trump won the election with 306 electoral votes to Hillary Clinton's 232 (New York Times, 2017).

Political effects of COVID-19

COVID-19 has been shown to affect different demographics to a greater degree than others. Individuals with underlying health issues or advanced age tend to have a more difficult time coping with the disease. Affected individuals over the age of 65 have significantly higher fatality rates with individuals over 85 having the highest fatality rate based on the age ranges provided by the CDC (CDC, 2020). It should be noted that the fatality rates in the U.S. data are based primarily on a population that contracted the virus at a time when healthcare capacity was high. As the number of cases increases, the availability of healthcare resources diminishes and thus a higher fatality rate occurs. Italy, China, and Iran have resorted to rationing healthcare resources such as ventilators (Cha, 2020).

Certain demographics have a strong tendency to vote for one of the two major political parties more than others. According to the Pew Research Center, when data from the 2016 U.S. Presidential election was analyzed, the Republican candidate (Donald Trump) had an advantage with voters fifty and older, while the Democratic candidate (Hillary Clinton) had an advantage with voters under 49 years of age (Pew Research Center, 2018). Voting differences based on other demographics such race and gender were also noted.

Older Americans tend to vote more than younger ones. A Pew Research Center (2018) poll on the 2016 presidential election found that individuals age 65 or older made up 27% of voters while those aged 18–29 made up 13%. U.S. Census (2019) data indicate that these two groups of Americans are roughly equal in terms of the

population yet this difference in voter participation gives older Americans a disproportionately large influence in elections. The loss of a significant number of older individuals could reshape U.S. politics. This could be particularly true in the U.S. presidential election as critical swing states were won by Trump with very narrow margins including Michigan (10,704 votes), Wisconsin (22,748 votes), and Pennsylvania (44,292 votes) (Meko et al., 2016; New York Times, 2017).

Data

Data for this project came from several sources. All information on state populations, including state populations broken down by age groups, came from the U.S. Census Bureau (2019). It is important to examine this topic using state-level data because the age breakdown of each state varies widely. For example, people 65 years or older comprise 21% of the population in Florida and Maine, but only 11% of the total population in Utah.

Information on the percentages of voters in the 2016 presidential election, broken down across age groups, as well as information on the percentages of individuals in the various age groups who voted either Republican or Democrat, came from Gallup Inc. (Pew Research Center, 2018). While the use of national-level data is a limitation, the strength of age as a predictor of political affiliation has been shown to be relatively consistent across the nation, as opposed to being a phenomenon limited to one state or specific geographic region of the country. Additional work by Gallup supports these findings. A survey taken over the course of 18 months in 2013 and 2014, sampled over 267,000 randomly selected U.S. adults. It found that younger individuals (18 to mid-40s) tend to identify more as Democrats. For individuals age 65 and up, more people identify as Republican or lean Republican (Newport, 2014).

Data on the percentages of deaths from COVID-19 in the United States, by age groupings, came from the CDC (2020). Detailed data on COVID-19 related deaths in the United States, is not yet available at the state level. As a result, national data were used for this analysis.

Finally, data on projected fatalities based on predicted outcome models for different thresholds of intervention to stop the spread of the COVID-19 virus was collected from the website COVID ACT NOW (2020). The website is described as being "created by a team of data scientists, engineers, and designers in partnership with epidemiologists, public health officials, and political leaders to help understand how the COVID-19 pandemic will affect their region" (https://covidactnow.org/about). The site provides a state level estimate of the potential for loss of life (predicted outcomes after three months) based on four levels of government response: limited action, three months of social distancing, three months of shelter in place, and three months of lockdown. As of March 27, 2020, four states were taking limited action, 24 were enforcing social distancing, and 22 states were in a shelter in place. No states were practicing a full lock down, described as a Wuhan (China) style response, and thus we did not consider this action in the analysis even as it is modeled by the website to be the most effective in limiting loss of life. Please also note that the COVIDActNow.org website only provides projection data for each state's current, and any more restrictive, COVID-19 governmental response plans.

Accordingly, if a state, at the time this manuscript was drafted, had an active shelter-in-place order, the website did not provide predictions on the number of deaths that might occur if that state were to take only limited action or if it were to have only a social distancing order in place. Given that the state has already moved beyond these less restrictive responses, it is reasonably unlikely that any predictions modeled after them would become a reality.

Methods

The first task of combining this data was to find age categories that could be calculated and used across all sources. Some data, such as state population information, could be calculated using any number of age groupings because the data was broken down in a very detailed manner. Other sources reported data using pre-set age categories only (see Gallup Inc. data on voting behavior as an example of this). As a result, the following age categories allowed for the use of data across all sources: 18–49 years, 50–64 years, 65+ years. From Gallup data, we know that the youngest age group had a 45% share of the electorate in the 2016 presidential election, while the middle age group had a 29% share, and the oldest age group had a 27% share of voters. Further, we can calculate from the Gallup data that the youngest age group voted 53% Democrat and 36% Republican (with the remainder voting for a candidate of a third party), the middle age group voted 45% Democrat, and 51% Republican, and the oldest age group voted 44% Democrat and 53% Republican, in the 2016 presidential election.

We also know from the data examined, that of the COVID-19 related deaths reported to the CDC at the time of their published report, roughly 4% were deaths from the 18 to 49-year-old age group, 16% were deaths from the 50 to 64-year-old age group, and 80% were deaths of people over the age of 65. It is important to note that this breakdown does not represent all people infected by COVID-19, but instead is the age breakdown for only those people who have died from the novel coronavirus. As mentioned previously, all patients measured in the CDC report became ill before hospital resources were overwhelmed. As medical resources become more limited, and difficult decisions must be made about the distribution of equipment, such as ventilators, elderly patients will likely be at a further disadvantage in fighting this illness.

Analytical approach

The statistical software SPSS, version 26, was used to complete this analysis. While the computations were not complex, basic math, in fact, SPSS was chosen because it allows for a reviewable, and editable, syntax record. To complete this analysis, first, the researchers had to compute the number of people in each age group (groups 1–3, with 1 being the youngest group, and 3 the oldest), in every state in the United States. Then the age groups were weighted by the percentage of the electorate that they represented in the 2016 presidential election. Using this weighted measure and the political affiliation breakdowns from the Gallup Inc. data, the numbers of Democratic and Republican voters were estimated for every state simultaneously. Table 1 illustrates this data.

Table 1. Background data on state populations.

	State	State population in each age group	Weighted state population*	Estimated number of Democratic voters in 2018	Estimated number of Republican voters in 2018
Age group 1 (18–49 years)	Colorado	2,533,246	1,089,296	577,327	392,146
	Florida	8,395,604	3,610,110	1,913,358	1,299,639
	Iowa	1,277,284	549,232	291,093	197,724
	Michigan	4,048,144	1,740,702	922,572	626,653
	Minnesota	2,307,728	992,323	525,931	357,236
	Nevada	1,288,216	553,933	293,584	199,416
	New Hampshire	538,505	231,557	122,725	83,361
	North Carolina	4,273,587	1,837,642	973,950	661,551
	Ohio	4,728,756	2,033,365	1,077,683	732,011
	Pennsylvania	5,151,620	2,215,197	1,174,054	797,471
	Virginia	704,548	1,524,404	807,934	548,786
	Wisconsin	2,343,291	1,007,615	534,036	362,741
Age group 2 (50–64 years)	Colorado	1,052,814	305,316	137,392	155,711
	Florida	4,248,078	1,231,943	554,374	628,291
	Iowa	606,463	175,874	79,143	89,696
	Michigan	2,062,791	598,209	269,194	305,087
	Minnesota	1,108,896	321,580	144,711	164,006
	Nevada	570,170	165,349	74,407	84,328
	New Hampshire	312,831	90,721	40,824	46,268
	North Carolina	2,022,663	586,572	263,958	299,152
	Ohio	2,363,577	685,437	308,447	349,573
	Pennsylvania	2,664,560	772,722	347,725	394,088
	Virginia	1,671,396	484,705	218,117	247,199
	Wisconsin	1,205,635	349,634	157,335	178,313
Age group 3 (65+ years)	Colorado	808,229	218,222	96,018	115,658
	Florida	4,358,071	1,176,679	517,739	623,640
	Iowa	539,830	145,754	64,132	77,250
	Michigan	1,716,604	463,483	203,933	245,646
	Minnesota	889,802	240,247	105,708	127,331
	Nevada	476,181	128,569	56,570	68,142
	New Hampshire	245,645	66,324	29,183	35,152
	North Carolina	1,689,265	456,102	200685	241,734
	Ohio	1,995,022	538,656	237,009	285,488
	Pennsylvania	2,335,630	630,620	277,473	334,229
	Virginia	1,315,401	355,158	156,270	188,234
	Wisconsin	985,473	266,078	117,074	141,021

*Note that state populations were weighted by the percentage each age group represented in the 2016 presidential election. Age groups 1–3 represented 45, 29, and 27% of the 2016 electorate, respectively.

Data was then pulled from the COVID ACT NOW (2020) website, which provided the projected number of fatalities, in each state, under each of three conditions (limited action, social distancing, and shelter-in-place). Once the fatality projections were added to the data set, CDC data on the percentage of deaths in each age category was used to divide the projected fatality numbers into the three age categories. Once this was done, researchers could see the number of projected deaths due to COVID-19, in each age category, if a state were to take limited or no formal action, exercise social distancing, and shelter-in-place, respectively. Please note that, due to the data available from the COVIDActNow.org website, the work contained in this research only includes examinations at or above each state's current COVID-19 response condition. In other words, if a state has a social distancing order in place, this paper considers what will happen if that social distancing order remains, and what will happen if a shelter-in-place order is implemented. It does not, however, consider what would happen if that state chooses to

Table 2. Background data from CovidActNow.org.

	State	Estimated deaths by age group if social distancing	Estimated deaths by age group if sheltering in place
Age group 1 (18–49 years)	Colorado	–	3,520
	Florida	12,800	360
	Iowa	1,840	40
	Michigan	–	5,960
	Minnesota	–	3,320
	Nevada	1,880	80
	New Hampshire	–	800
	North Carolina	–	6,280
	Ohio	6,960	280
	Pennsylvania	7,600	400
	Virginia	5,160	80
	Wisconsin	–	3,520
Age group 2 (50–64 years)	Colorado	–	14,080
	Florida	51,200	1,440
	Iowa	7,360	160
	Michigan	–	23,840
	Minnesota	–	13,280
	Nevada	7,520	320
	New Hampshire	–	3,200
	North Carolina	–	25,120
	Ohio	27,840	1,120
	Pennsylvania	30,400	1,600
	Virginia	20,640	320
	Wisconsin	–	14,080
Age group 3 (65+ years)	Colorado	–	70,400
	Florida	256,000	7,200
	Iowa	36,800	800
	Michigan	–	119,200
	Minnesota	–	66,400
	Nevada	37,600	1,600
	New Hampshire	–	16,000
	North Carolina	–	125,600
	Ohio	139,200	5,600
	Pennsylvania	152,000	8,000
	Virginia	103,200	1,600
	Wisconsin	–	70,400

"–" indicates that the state has already moved beyond this level of COVID-19 preparedness. The COVIDActNow.org website only provides prediction numbers for each states' current, and more progressive, intervention levels. Therefore, no data are available for what would happen with only a social distancing order, if a state already has a shelter-in-place order active. No state listed here is doing less than social distancing at the time this paper was written.

take limited or no action, because it has already moved beyond that response level. Table 2 illustrates the data used from the COVID Act Now website.

Following the computation of potential fatalities at each age level, and for each state response, the projected fatalities were subtracted from the weighted (by the percentage of the electorate that they represented in the 2016 election) number of people in each age category. This created new variables, which illustrate the number of people that would be left in each age category, in every state, after COVID-19. These were run separately for each possible governmental response, as the projected number of fatalities for each, vary widely. These revised age categories, were then broken into Democratic and Republican voters, using Gallup Poll percentages, and a difference was calculated between the estimated number of Republican and Democratic voters before COVID-19 (weighted by their share of the electorate at the state level), and the estimated numbers

Table 3. Changes in the numbers of Democratic and Republican voters by state and age category.

	Swing states	Republican voter change, social distance	Democratic voter change, social distance	Republican voter change, shelter in place	Democratic voter change, shelter in place
Age group 1 (18–49 years)	Colorado	–	–	−1,267	−1,866
	Florida	−4,608	−6,784	−130	−191
	Iowa	−662	−975	−14	−21
	Michigan	–	–	−2,146	−3,159
	Minnesota	–	–	−1,195	−1,760
	Nevada	−677	−996	−29	−42
	New Hampshire	–	–	−288	−424
	North Carolina	–	–	−2,261	−3,328
	Ohio	−2,506	−3,689	−101	−148
	Pennsylvania	−2,736	−4,028	−144	−212
	Virginia	−1,858	−2,735	−29	−42
	Wisconsin	–	–	−1,267	−1,866
Age group 2 (50–64 years)	Colorado	–	–	−7,181	−6,336
	Florida	−26,112	−23,040	−734	−648
	Iowa	−3,754	−3,312	−82	−72
	Michigan	–	–	−12,158	−10,728
	Minnesota	–	–	−6,773	−5976
	Nevada	−3,835	−3,384	−163	−144
	New Hampshire	–	–	−1,632	−1440
	North Carolina	–	–	−12,811	−11,304
	Ohio	−14,198	−12,528	−571	−504
	Pennsylvania	−15,504	−13,680	−816	−720
	Virginia	−10,526	−9,288	−163	−144
	Wisconsin	–	–	−7,181	−6,336
Age group 3 (65+ years)	Colorado	–	–	−37,312	−30,976
	Florida	−135,680	−112,640	−3,816	−3,168
	Iowa	−19,504	−16,192	−424	−352
	Michigan	–	–	−63,176	−52,448
	Minnesota	–	–	−35,192	−29,216
	Nevada	−19,928	−16,544	−848	−704
	New Hampshire	–	–	−8,480	−7,040
	North Carolina	–	–	−66,568	−55,264
	Ohio	−73,776	−61,248	−2,968	−2,464
	Pennsylvania	−80,560	−66,880	−4,240	−3,520
	Virginia	−54,696	−45,408	−848	−704
	Wisconsin	–	–	−37,312	−30,976

"–" Indicates that the state was already sheltering in place at the time this article was written. Accordingly, numbers were not analyzed for a lesser response. Every state here has at least a social distancing order in place.

of Republican and Democratic voters that will remain in each state and age grouping, if their state takes only limited action, orders social distancing, or issues a shelter-in-place order.

Results

Table 3 illustrates the results of this study.

Note that the table only contains information on "swing" states in the most recent U.S. presidential election. Because these states primarily use a winner-takes-all approach to the distribution of their electoral college votes, winning them can swing an election for a candidate.

In looking at Table 3, we can see that in the youngest age grouping, Democratic voters tend to be lost in higher numbers than Republican voters. This is because people in this age category are more likely to vote Democratic. Given this, the differences in

human losses between voters of each party, are low enough, in most cases, that they are not likely to rise to the level of altering an election. Many differences concern fewer than 100 people, with the largest difference representing approximately 2,000 more Democratic voters lost to COVID-19, when compared to Republican voter losses. This possibility exists in Florida if the state or federal government does not issue a shelter-in-place order.

Findings for the youngest age category do not hold true when examining those 65 years of age or older. Recall that individuals in this age group are more likely to vote Republican, which explains why Republican voters in this category are projected to be lost in greater numbers than Democratic voters. In looking at Table 3, if the Commonwealth of Pennsylvania continues to use only social distancing to combat the latest coronavirus, they could potentially lose over 13,000 more Republican than Democratic voters, in the 65+ age category. Even with a shelter-in-place order in effect, states such as Michigan and North Carolina could see significantly greater losses of Republican voters in this age group. These results suggest that when considering nothing other than the loss of life due to COVID-19, the demographic shifts alone, could be enough to alter the political landscape of the United States.

As an example, if the results of the calculations noted in Table 3 were applied to the outcomes of the 2016 presidential election, a significant narrowing of the results in the closest contests would occur. For instance, Pennsylvania is implementing a social distancing action showing a projection of 190,000 adult fatalities including across the three age categories 18–49 (7,600), 50–64 (30,400), and 65+ (152,000). After accounting for voter participation, the calculations show that among age group one, 953 more Democratic voters than Republicans voters would lose their lives. In age group two, 1,824 more Republicans than Democrats would potentially perish while in age group three 13,680 more Republicans would potentially perish. Cumulatively, 14,551 more Republicans than Democrats would perish under these projections, a significant change given that Trump carried the Commonwealth by 44,292 votes. Michigan is also implementing a social distancing action and projections show that the estimated loss of life is lower than in Pennsylvania. However, Trump carried the state by 10,704 votes with the narrowest margin in the nation. The calculations suggest that 11,145 more Republicans than Democrats would potentially perish, suggesting that Michigan would be more difficult for Republicans to maintain their narrow win in 2016 for future elections.

Discussion

Beyond the personal tragedy with every loss of life, these projections show the potential for profound effects on society. A dramatic change in the U.S. political landscape is just one of any number of effects upon society that may be caused by the COVID-19 pandemic and a mass casualty event. Numerous factors can impact an election, however, in American history, we have rarely seen an event with the potential to reshape the political landscape of the nation in a matter of months. Ultimately, these political changes could have a significant impact on policies including those related to healthcare, immigration, the environment, education, gun control, and other issues.

This situation furthers a question about the role of governance. Theoretically, governing approaches should lead with an ethic of care and justice, minimizing individuals' class, race, age, citizenship status, and political party affiliation in an effort to make public decisions that are good for all (Gilligan, 1983). The use of authority and partisanship should be minimized in order for public information to be filtered in an ethical and moral manner. This approach to governance may lead to public policy decisions with less harsh divisions between groups of citizens and achieve good governance. As discussed in terms of costs for economic damage versus the loss of life for not implementing sheltering directives, other considerations in pandemic response exhibit a political bent. For instance, those most likely to consider the COVID-19 outbreak to be a "major threat to the health of the U.S. population" matter are Democrats (Green & Tyson, 2020). In numerous categories, Democrats also favor additional restrictions to combat the issue. While the number of Republicans concerned about the virus is rising (Badger & Quealy, 2020), they are more likely to view the President's response to the pandemic more favorably (Green & Tyson, 2020; Scanlan, 2020). Holding the view that the virus is not a threat or severe may lead more Republicans to engage in unsafe behavior such as congregating in larger groups of people and taking fewer health precautions. This could lead to additional illness or fatalities among this demographic. Conversely, the current COVID-19 pandemic is taking a greater toll on urban areas in states that tend to be democratic strongholds (e.g., Washington, California, New York). However, projections show that the virus will spread to more rural areas in the coming weeks. Many rural areas lack access to the same level of health resources as other areas of the nation. For instance, 71 of the 254 counties in Texas do not have a hospital (Texas Organization of Rural & Community Hospitals, 2019).

Limitations and future research

As with all studies this research carries limitations. In order to forecast future results, several assumptions are inherent. First, we are living in a critical time as we collectively face one of the most trying events in the history of the nation. Given the enormity of the event, the breadth of potential outcomes will almost certainly yield a different result than the conclusions offered in this research. However, we are certain that large shifts in society will occur due to the event and research must move quickly to understand these changes. For instance, the COVID-19 pandemic will be at the top of people's minds as they go to the polls or possibly use mail-in ballots for the first time to continue to practice a reduction in large scale gatherings. The data cannot reflect the number of actual voters or their intentions. Secondly, we assume similar levels of voting as the last presidential election. Turnout may vary greatly as more people see the need to become involved in the political process or decrease as more people decide to stay home. Third, the data has some inherent issues that should be noted. CDC data is not currently available for fatality rates for each state. Most states have only experienced a few deaths and thus the size of the sample would not be appropriate to use. As more data is collected and analyzed, more robust models may be considered. A national-level measure for political affiliation is not ideal as while age represents the significant variance in political affiliation, there exists a state by state or regional consideration that the

data do not reflect. As data on the level of fatalities is still being compiled, it is too early to fully grasp the true fatality rate as there are numerous considerations that are yet to be determined. Governments are still working to limit a person to person contact, hospitals are seeking additional capacity, and scientists are working to rapidly develop treatments and a vaccine. These factors will certainly impact the loss of life experienced during the pandemic. Data projections, including the Covid Act Now website, have received criticism. Given the high levels of uncertainty, this is not surprising, yet it should be noted that much of the overall criticism of various data sources often reflects a political bent (e.g., Osburn, 2020).

From a theoretical perspective, this divergence of interests over expertise calls into question the meaning of governance and challenges the politics-administration dichotomy. For instance, Scott (2008) provides a lens for understanding both the idealistic nature of the political system and the often-stark realities inherent to administration and public service. In this case, the political system is exerting pressure to maintain control and authority of the message the public is receiving, rather than allowing facts to supersede values or partisanship.

Future research should build on this work to better understand how mass casualty events impact the social, economic, and political aspects of society. As more data and information becomes available, future studies should revisit and expand on the matters considered in this work. Additional political considerations will no doubt stem from the COVID-19 pandemic. High levels of fatalities, even if well below the COVID ACT NOW (2020) projections, could lead older voters to change their minds about supporting the Republican Party if someone they knew died due to the pandemic.

Conclusion

The political landscape is very complex. Economic factors, the perception of leadership at multiple levels of government, and numerous other factors ultimately contribute to specific election outcomes. Other tragic events have caused political shifts in the past but the potential scale of the COVID-19 pandemic has the potential to reshape U.S. politics due to a tragic loss of life. Most nations have rarely been confronted with such a monumental task of preserving lives. We hope this note serves only as a scenario, not a road map.

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