THE BROOKINGS INSTITUTION
BROOKINGS CAFETERIA PODCAST

A ROADMAP FOR REOPENING AMERICA

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P R O C E E D I N G S

DEWS: Welcome to the Brookings Cafeteria, the podcast about ideas and the experts who have them. I'm Fred Dews. The coronavirus pandemic has plunged the economy into a condition not seen since the Great Depression. And has had dramatic effects on government, business, and families. Now, as states consider reopening their communities, questions remain as how best to safeguard lives and livelihoods against both the pandemic and its impact on the economy, governance, and social well-being.

Brookings has launched a comprehensive effort to answer such questions with experts from within and outside the institution. The first volume of essays, *Reopening America, How to Save Lives and Livelihoods* provides context and ways forward on reopening, recovery, and renewal across the United States. This week Brookings hosted a virtual event to complement the launch of this publication.

In this episode, I present a replay of that event, which began with keynote remarks from Dr. Jennifer Nuzzo of Johns Hopkins Bloomberg School of Public Health. A discussion from an expert panel followed, including Brookings experts Bill Galston, Ross Hammond, Molly Kinder, Rashawn Ray, and David Wessel. Brookings President John R. Allen moderated the discussion.

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And now, here's a *Roadmap for Reopening America, How to Save Lives and Livelihoods*.

WEST: Thank you for joining us today. I'm Darrell West, vice president of governance studies at the Brookings Institution. So, this is the latest in a series of webinars that Brookings has been holding on a variety of topics. Our goal is to address important issues and to offer our

thoughts on how to deal with those subjects. Our topic today is reopening America. And we want to discuss how to reopen in ways that both saves lives and livelihoods. One without the other is incomplete.

We have to reopen in a way that protects peoples' health, rebuilds the economy, and promotes social wellbeing. This event is part of a larger Brookings project. Last week we published 22 short papers that address reopening in regard to healthcare, education, workforce issues, and technology innovation, among other topics. Those papers are available free online at brookings.edu.

On June 16, we will be publishing another 22 papers on reopening the world. They will look at the non-U.S. experience and detail the lessons learned from South Korea, Germany, France, the United Kingdom, China, Russia, and many other places. To help us understand the current situation, I'm pleased to welcome a distinguished expert. Dr. Jennifer Nuzzo is an associate professor in the Department of Environmental Health and Engineering and also the Department of Epidemiology at the John Hopkins Bloomberg School of Public Health. She is also a senior scholar at the University Center for Health Security. She is one of our country's leading authorities on infectious diseases and in her remarks today, she will provide a status report on COVID-19. Over to you, Jennifer.

DR. NUZZO: Thank you so much. I appreciate the kind introduction and really greatly appreciate the opportunity to join you all in this important discussion. My remarks today are going to be centered around two parts. A look at sort of where I think we are with respect to the global pandemic of COVID-19 and then where we might be headed. Recognizing, of course, that this is a highly dynamic situation. Our understanding of this virus is continually evolving and we may learn new things in the days and weeks that come that could illuminate the fact that we're on

a different trajectory than it appears to be now. So, just with that caveat, I do want to offer some thoughts on what we may very well expect in the coming days.

So, where we are today is that there are more than 6.3 million cases of COVID-19 being reported across the globe. There is a small point of light in this, which is the fact that as of today, 188 countries have reported COVID-19. And while it is not good that COVID-19 is in 188 countries, I think it's important to point out the fact that 188 countries of capable of testing for what is a completely new virus is an important success and one worth recognizing. Many of the countries that are today reporting cases were not previously capable of doing the kinds of tests required to report cases. And for this rapid expansion in surveillance, I believe the WHO, the World Health Organization, deserves a tremendous amount of credit for both being able to rollout the testing capacity, but also train staff, et cetera, so that we can get a global picture of where COVID-19 is and where it may not be.

To put the pace of this pandemic though because, of course, now I'm getting to the bad news. To put the pace of this pandemic into perspective, I gave a talk five days ago. And as of five days ago, there we 600,000 fewer cases being reported across the globe. So, that is a very worrisome trajectory. The United States has now for quite some time and still accounts for the most cases reported across the globe. As of today, we're over 1.8 million cases being reported in the U.S., and also the greatest numbers of deaths. We just very recently passed a quite deadly milestone of 100,000 deaths. Today it's over 105,000. So, just to give you a sense of how quickly this situation is evolving.

Across the U.S., the total number of new cases that are occurring each day has, in fact, slowed as of, you know, the last month or so, which is clearly good news. But we are very much not out of the woods yet. There are increasing signs that the epidemics that were occurring in

certain parts of the U.S., for instance, for a long time three states, New York, New Jersey, and Massachusetts accounted for about half of all of the cases being reported in the U.S. That dynamic has changed and now many more cases are accounting for most of the—many more states are accounting for most of the cases that are being reported in the U.S.

What we're seeing as of today, is that there are many parts of the U.S. where the case numbers are headed in the wrong direction. Meaning the occurrence of new cases is growing and not staying flat or—we talked about flattening the curve—in actually as of today, 16 states have for the last two weeks seen increasing growth in new cases occurring each day. So, that is obviously quite a worrisome trajectory.

These states are largely in the Midwest and the southeastern part of the U.S. And the occurrence of these cases is often happening in communities that are smaller than say cities like New York, so, less population dense. And that means that the total numbers that are occurring are small, probably not large enough to make the nightly news. Nonetheless, these cases are also occurring in places where there may be much more limited healthcare resources. And so, I'm actually deeply worried about these places because even a small continued growth in cases could have quite deadly consequences if, you know, there are insufficient healthcare resources in order to meet even a small increase in the number of severely ill patients. So, this is very much something that we should pay attention to.

It's become increasingly clear that in order to understand and compare case numbers, we also have to understand testing. And so why testing? Why do we talk so much about testing? You've probably heard it on the news a lot. It's become, for reasons I don't fully understand, a bit of political issue. The reason why I, as an epidemiologist, am interested in testing is because it's the process by which we identify cases. So, in order to understand if the case numbers that are

being reported represent something close to reality, we have to understand how likely it is that someone who is infected can get tested, is tested, and that those test results are reported so that we can count them—count that person among the total reported cases.

It's become clear in many parts of the world, but certainly here in the United States, that testing has been constrained for quite some time, which has greatly limited our ability to identify infections. And has also limited our ability to take action to find out who is infected so that they can be isolated so they can't transmit their infection onto others to do the next steps of trying to interrupt the spread of disease. So, testing is very important both from a making sure we know that the case numbers that we're seeing are close to what is actually occurring and that it's not an undercount. And also to make sure that we are taking the next steps that are aimed at preventing further spread of this virus.

We at Johns Hopkins recently launched something called the testing—the COVID-19 Testing Insights Initiative where we're trying to not only we—rather infamously mapping global COVID-19 cases, but we are now also trying to analyze and understand trends in testing both here in the United States. And one of the things that we found is that first of all, just comparing the U.S. to other countries, though the U.S. has conducted the greatest number of cases,—sorry, greatest number of tests compared to any other country, we have also conducted more tests per capita than many other countries. Although not—we are not the top in terms of tests per capita.

That does not necessarily mean we have done enough testing. In fact, one of the metrics that we look very closely at on our site is positivity. So, the percentage of tests that are coming back positive. And the reason why this is important is because if positivity is too high, it suggests that we're not casting a wide enough net to find infections. It means that we're probably only testing the sickest of the sick and the people who are, you know, maybe have milder symptoms

may not likely be included among those tested. So, ideally, positivity should be low.

The World Health Organization has recommended that countries that are thinking about reopening, thinking about lifting restrictions, that they achieve a positivity of 5 percent or lower and maintain that for 14 days. And when we looked across the United States to see whether U.S. states have met that criterion, what we found is that most haven't. And so as of today, 26 states including many of the states, I mean, every single state at this point is in some process of reopening, yet 26 U.S. states have positivities that is considered too high.

And so that makes us worry that not only are we not doing enough testing, but that we are missing cases. We are not including them in our case numbers that we're supposed to be looking at. And that we are missing those opportunities to interrupt infection. And I am very much worried about the potential for these undetected cases to continue to spread silently until perhaps they find their way into somebody who gets sick enough to show up at a hospital.

It's important to just recognize that—and I don't think that this has been made quite clear, or maybe clear enough, the measures that we are implementing right now with social distancing, the lockdowns, all of the various measures are aimed at reducing the likelihood that we will come in contact with each other. Those did not cure the virus. They did not make the virus go away. They were simply a pause button. Put in place, frankly, as a last-ditched effort to stop a very rapidly accelerating case numbers here in the U.S. to buy time to try to put in the more targeted public health measures, the things like testing and isolation and contact tracing. Those are the things that we need to do to actually try to interrupt the spread of the virus. The social distancing measures will only have an impact so long as they're maintained. And as soon as we release them, the case numbers can grow again unless we have these more targeted case-based interventions of testing, tracing, and isolating.

So, that brings us to what should we expect going forward? And what should we see in the weeks to months ahead? So, I just wanted to comment briefly on projections that you may have seen in terms of what the impact of this pandemic will be. There are a lot of models that are out there that make predictions or projections as to the number of hospitalizations that we may see or the number of deaths. One model from a group called IHME is the one that has been relied upon by the White House Coronavirus Task Force. It has made projections. And it's probably famous for being the one that's being used, but also having lower estimates than some of the other models.

I personally think that models are best used to ask questions rather than to tell us specific numbers. I will just say that many of the models have been converging and even the group at IHME has had to revise their model. And they adjusted upward their projections of the numbers of deaths that may occur in the United States. In part because case numbers in the U.S. weren't slowing as quickly as they initially anticipated. And also because they had assumed that states would keep the measures, the social distancing and the other restrictions in place until the beginning of August. And clearly, that hasn't happened.

In terms of also just kind of thinking about what the ultimate projections will be in terms of impacts, it's important to recognize that the impacts of this pandemic have not been shared equally among us. And so people over the age of 65 represent 3/4 of all deaths that have been reported. Nursing homes account for possibly more than 1/3 of the total deaths that have been reported in the United States. And we know that certain racial and ethnic groups like African Americans and Latino populations are overrepresented in both the case numbers and the hospitalizations and deaths.

So, there are huge disparities in who has been affected by this pandemic. And these are

things that we need to better understand so that we can prevent these impacts from happening. And, unfortunately, particularly when it comes to racial and ethnic disparities, not every state is reporting data on this, which really hinders our ability to understand what this is due to and how best to prevent it.

It's also important to recognize that when we talk about pandemics, and this is a hallmark of pandemics, is that they tend to kill or harm in three ways. So, when we think about what the effects of this COVID-19 are going to be, we have to think of it three categories. One, who is directly affected by the virus? So, people who are infected get severe illness and die. The second group is those who are affected by interruptions to health services. And this happens all the time in pandemic and epidemic scenarios. That the chaos and the pressures from the pandemic itself mean that certain health services that are aimed at prevention or even treatment are put on hold. And you've probably heard about, you know, cancer patients who have been for a long time unable to get treatment, people who have routine and preventative health services delayed. Even hearing reports about children who have not been able to get routine childhood vaccines on the regular schedule due to interruptions in services. And so we have to account for the health effects that are in this other category due to the interruption of healthcare and health services delivery as we know it.

And then, finally, we also have to think of the third category, which is harms that are associated with the economic tolls. And one of the things I'm deeply worried about is the mental health impacts of this pandemic. We know that this pandemic can affect in multiple ways, but in particular, the economic tolls of this pandemic and the potential mental health impacts of that. After 2008, there was a very noticeable uptick in number of suicides that was thought to be related to the global economic downturn. And the economic tolls of this pandemic are really

extraordinary and in many ways unprecedented. So, we do have to be worried about the health effects associated with those economic consequences as well.

In terms of how this will play out in the next few months, there are a few variables that are sort of up to us. And one is how will governments respond? And whether governments will continue to promote social distancing and whether they will continue to have certain restrictions aimed at trying to reduce or slow the spread of COVID-19. And just to see how this can have an impact, I like to compare Sweden versus Norway. These are two somewhat similar countries. They both got started with their epidemic around the same time. But Sweden has taken a very controversial approach in that it has not largely put in the same level of restrictions that many other countries have put in.

And to date, there are about close to 40,000 COVID-19 cases reported in Sweden versus a little over 8,400 in Norway. And even when we standardize it by the population, Sweden has been much harder hit in terms of number of cases per capita. Also, the trajectory of Sweden's epidemic is continuing to climb, whereas Norway has plateaued. And in total, about 12 percent of the reported cases in Sweden have died versus under 3 percent in Norway. So, social policies can have an impact on the trajectory of the pandemic. And what we choose to do going forward will also have an impact.

I mentioned before the case-based measures. The targeted interventions, looking at trying to find the people who are infected and figuring out who they may have exposed and hopefully making sure that no one who is infected can go on to infect others by either isolating them home if they're sick, or staying at home under monitoring if they are exposed, but we don't yet know they're sick. That process of identifying those people is called contact tracing. And we keep them at home because they're not yet sick, we call that quarantine.

Those measures will be really important in trying to interrupt the transmission. And yet we know many governments including states here in the U.S. don't have the resources to even do the appropriate level of testing to identify infected people, or the appropriate resources in order to conduct contact tracing, which is an extraordinarily resource intensive endeavor. And so for places that are going to do it, they're going to have to hire a lot more people and train more people and they really need to get to work because it is not an easy thing to stand up overnight.

I mentioned that the social distancing measures are a pause button and they are not a cure. And just to give an example of this, South Korea has been really made famous in many respects, but in particular, in the context of COVID-19 for its very effective response, particularly testing. They have testing a lot of their population before many other countries did. But also in terms of isolating sick patients and doing contact tracing. And so they at one point was the single largest epidemic outside of China, while China was still the first, but South Korea flattened its curve. It brought down the occurrence of new cases in quite an effective way.

However, they recently began to release some of these restrictions and they saw a cluster of new cases. They went out and did a lot of testing and found a fairly sizeable outbreak associated with some of the, you know, night clubs and bars that reopened. And so, what this tells us is that we always have to be on the alert. Even if we've had success, we always have to be ready to respond to a surge in new cases as we begin to lift restrictions. Otherwise, we could find ourselves right back where we started where we have had rapidly accelerating case growth and are once again worried about health systems becoming overwhelmed. So, this will have to be maintained. This vigilance and these case-based interventions will have to be maintained so long as the virus is circulating, and so long as we don't have immunity from some other source like a vaccine.

So, that is what is in our future, unfortunately, for the long term until a vaccine comes or, perhaps, some other medical—a therapeutic that potentially could make people less likely to become severely ill. But the research and development timelines that we're looking at are quite long. So, we should expect to see these interventions have to last for a long time.

Which brings me to really my last point. Which is that going forward, what I'm most worried about are the health system. And I just want to remind everybody that we are all sitting—we have been sitting at home. We put these restrictions in place largely out of concern that the case numbers were accelerating so quickly that they would overwhelm our health systems here in the United States. But when I think about health systems in other countries, first of all we know health systems everywhere, including here in the U.S., given the fact that we're unable to accommodate the surge in patients from COVID-19. But in many other parts of the country—parts of the world, they have many fewer resources to bring to this. And so, thinking about how acutely concerned we were about U.S. health systems being overwhelmed and that we would have shortages of essential health resources like critical care beds and access to ventilators. And then I think about the fact the U.S. has 85 times more ventilators per capita than a country like Kenya.

So, thinking about the impacts of this in other countries that have fewer healthcare resources to bring to bear, is a deeply worrisome prospect. Particularly given the fact that the primary tool that we have at our disposal right now in order to control the spread of COVID-19. Sitting in our homes is not something that I think will be easily implemented in other countries where there isn't, you know, a several trillion-dollar stimulus package in the works to enable people to replace some of their income. You know, where you're asking people who have to choose between becoming sick or potentially going out and earning a living to protect their

families.

And so, we do really have to worry about other health system. As much as a pandemic exposes the fact that we are all vulnerable and may encourage countries to—you know, every country for themselves-type approaches, we will not be safe as a globe until every country is capable of keeping COVID case numbers from growing out of control And yet, many, many countries still lack the resources to be able to do that. So, as much as there's a temptation to look inward, we also have to continue to look outward. So, I'll end my remarks there and thank you so much for your attention.

WEST: Thank you very much, Jennifer. That was a terrific talk. It was very informative. And we appreciate you taking the time to join us because we know you are in hot demand.

Now, I want to introduce the President of the Brookings Institution, John Allen. John will moderate a panel of Brookings experts. Over to you, John.

ALLEN: Darrell, thank you. Dr. Nuzzo, thank you very much. I want to sincerely express our gratitude as an institution for a terrific assessment of the current environment with respect to COVID-19 and the fight that we're all waging, stay healthy, and to get past this pandemic. You've really set the conditions and the stage very well today for our conversation. And I want to thank you and thank all of your colleagues for what you do every single day to keep us safe in this world.

And, Darrell, thank you. Thank you for the introduction. Thank you for organizing this panel. But also for your leadership and support of this project, the reopening of America and the world. We couldn't have done it without you, and I want to thank you for that.

So, ladies and gentlemen, as noted, I am John Allen. And I'm the president of the Brookings Institution. And it is our great privilege to have you with us today for this panel.

Before we get started, I wanted to address something head-on. These are not ordinary times. They're very difficult times between COVID-19, a severe recession, and the outrage stemming from the killings of George Floyd and Ahmaud Arbery, and the other recent incidents. This moment has exposed for all of us to see the fault lines of our society in the inequality gap. And most certainly, the persistence of systemic racism in America today.

Yesterday, at Brookings I led a moment of silence for the institution. And I know in this panel today, many of the issues that have generated the pain across America will come up in our discussion. So, before we start the panel today, I would ask you to join me to reflect for moment in a moment of silence the deaths of those black men and women of our population, our American citizens who've been harassed, who've been assaulted and who've been killed simply for the color of their skin. Please join me in a moment of silent reflection.

Thank you very much. Now, turning to today's discussion, put simply, the Brookings Reopening of America and the World effort represents our premiere contribution at this moment to this crisis. It's as deep as it is wide and we're very proud of all of the excellent analysis and the hard work that went into its production and its launch. In the coming months, Brookings will also contribute a substantial effort looking at a blueprint for long term recovery and renewal of our societies as we come to grips with the long-term implications of COVID-19 and the difficulties of the economic recovery.

These issues are central to saving many lives and the livelihoods of our people, of our population, and in the world. And we hope that we find, that you find, that this was as useful for your local communities as it was for us to produce for the general population. But most importantly, we hope that you remain safe and well throughout these challenging times. For today, however, we have five leading experts from within the Brookings Institution who were

major contributors to the reopening effort. And, sadly, I don't have enough time to spend the time I should on their backgrounds, so I'll be a very brief introduction, but I'm very honored to be with them today.

And the first is Molly Kinder who's a David M. Rubenstein fellow in the Metropolitan Policy program. And Rashawn Ray, also a David M. Rubenstein fellow with our Governance Studies program. Ross Hammond who's a senior fellow and the director of our Center on Social Dynamics and Policy and Economic Studies program. David Wessel, a senior fellow and director of the Hutchins Center on Fiscal and Monetary Policy in the Economic Studies program. And last, but certainly not least, Bill Galston, senior fellow and Ezra K. Zilkha chair in our Governance Study program.

Colleagues, it's great to see you. And welcome to the panel this afternoon. So, with that—and ladies and gentlemen, as a final reminder, we are live and obviously on the record. And we'll be turning to Q and A following our discussion in a few moments. And you can submit questions by emailing them to events@brookings.edu. That's events@brookings.edu or via Twitter using #covidreopening, #covidreopening. Indeed, some of you have already submitted some questions and we're very grateful for those. And time allowing, we'll get to as many as we can.

So, let's get started. The first question is for the whole panel. Beginning first with Georgia, regional reopenings have commenced across the country. As Dr. Nuzzo said, we've seen some mixed successes. Even Washington, D.C. has started phase 1 beginning last Friday. So, here's the question, are we genuinely ready to reopen? And recognizing the inevitability of the reopening efforts, what do you think are the lessons learned from our COVID experience so far, as well as responses that we have seen and studied from overseas? And, Molly, let me start with you, if we can. And we'll just go straight through the panel, please.

KINDER: Sure, thanks, John. And thanks so much for having me in this great discussion. My research is really focused on the essential workers. The millions of workers who've carried on working throughout this pandemic. And when we look at their experience, it really serves as a cautionary tale for reopening, to bringing more workers back to their jobs. And this is really revealed both in the data and the experiences of those workers.

When we look at the numbers, just the sheer number of deaths amongst essential workers. Whether transit workers, nursing home workers, grocery workers, it really is astonishing, and we see outbreaks. The meat packing industry for instance. It's really been shocking and unacceptable the extent to which essential workers are perishing from this pandemic. And when we look at some of the survey data, it reveals that workers are really—they don't have the protective equipment they need.

So, as recently as early May, a survey showed that upwards of 2/3 of frontline health workers had insufficient PPE. Some really fascinating survey data out of Berkeley showed highly uneven basic safeguards amongst frontline workers across industries, and often terribly inadequate standards. And we see that workers are frustrated. They're demanding more. The spike in workers with protests and walkouts, urgent letters from doctors and nurses pleading the federal government to do more in PPE.

But for me, what's really hit home is not even just the numbers. It's the stories from the workers themselves who are putting themselves and their families at risk as they work. I've had the great privilege of interviewing about two dozen essential workers since the start of the pandemic from grocery cashiers to nurses, gig workers delivering groceries and meals, hospital workers, cooks, and cleaners in nursing homes.

And I would describe the two strongest emotions I've heard are both fear and frustration.

Fear because they genuinely believe that the jobs that they were doing two and a half months ago that weren't really a risk as much to themselves suddenly pose a real risk to their safety. They use words with me like petrified and terrified of the risks. Most importantly, the workers I interviewed felt most concern, not about their own safety, but the safety of their families. Because this is something you bring home to the people you live with. And it came up pretty frequently that some of these workers lived with family members with underlying health conditions. And it was making them petrified that they were going to come home and cause harm to their family.

And then coupled with that was frustration. A lot of workers really felt that their employers simply weren't doing enough to keep them safe. Especially is the health sector, lots of frustration around inadequate access to PPE, being asked to prolong use of PPE well past when it's safe. And really what was striking to me was some workers I interviewed had no access to PPE from their employers. Whether home health workers who were taking care of our society's most vulnerable, or many of the gig workers got nothing at all from their employers.

So, I really think these last two and a half months are a cautionary tale. I don't feel that the federal government has really done enough to ensure that we have enforceable standards in workplaces, and that we had sufficient supplies of the lifesaving protective equipment that we need.

ALLEN: Molly, thank you. Look, we're all very grateful for the research you've done in this regard. You have really highlighted the role of the essential workers to all of us, but you've also highlighted the casualties that they have endured in bringing those essential roles to us all. Thank you very much for that research.

David, let me go to you, please, if you have some thoughts on this.

WESSEL: Sure. I think the short answer to your question is we don't really know whether it's safe to reopen. We are running a grand experiment. I'm concerned that we're not ready because we didn't adequately provide testing and we didn't adequately instruct people on what they're supposed to be doing. It seems like chaos and cacophony.

But I'm also struck, as you mentioned in your introductory remarks, John, about what a jarring moment this is. As you pointed out, we're in phase 1 of reopening in the District. Yet today, we face a curfew at 7:00 p.m. So, it's very difficult for me to separate how we reopen the economy as we try and conquer COVID, at the same time when so much unrest is going on in the cities and how difficult a moment is in our country. And so, the conversation we have today is even more complicated and difficult than the one we would have had just a couple of weeks ago.

So, my short answer is we're not ready, but I think that largely this will be determined not by government policy but what people choose to do. The evidence is that in many communities, people started to self-quarantine even before the governments asked them to. And we will have to see how Americans and others react to the news. If there's an uptick in the virus, will people be afraid to go out again? Or will they think of themselves as invincible and just get tired of sitting at home and participating in Zoom meetings or playing board games with their kids?

ALLEN: David, thank you. And you've highlighted the complexity of the moment. It is as difficult as it can be in the context of a pandemic. But when you add in the difficulties we're facing socially right now, it's almost more complex than we can imagine.

Rashawn, if I could ask you next to join us. You have been a very powerful voice to this point. Especially helping us all to understand the issues of inequality and how it has struck our underprivileged and underserved and vulnerable segments of the population. Could I ask you to

come in on this, please?

RAY: Yeah, well, General Allen, thank you. I just want to echo what we just heard from Molly and David. I think their statements really capture what's happening. And as I think about curfews and even in Washington, D.C., the fact that this curfew is going to be going into effect at 7:00 p.m., I worry about these essential workers that Molly highlights. Because I think at times we think that people oftentimes simply have the ability to stay in. That people have the ability to social distance. What my research highlights is social distancing is a privilege.

And I think adhering to curfews is the same way. And I think about the combination of social distancing violations like we're seeing in New York City, where 80 to 90 percent of the sanctions given out and arrests are for our own black and Latinos who live in the city. Individuals who are oftentimes working as essential workers where they can no longer use public transit during a curfew. And I think that's an unintended consequence of a curfew that we need to think about.

I mean, I think in short, are we ready to reopen? No, I don't so. And I think oftentimes, it's not a catchall. It's not necessarily a one thing fit all. As I know being from Tennessee, is that they're dealing with different pressures and different sort of issues than we might be dealing with in Washington, D.C. or where my children were born, which was in Oakland, California. I think these are all playing out in different dynamics. So, location matters.

Even within a specific location, place matters. So, we have to look at zip code. One thing that we know a zip code is highly correlated with people's social class and their racial background. So, in that regard, once side of the city, say in Washington, D.C., the western side of the city might actually be far more prepared than the eastern side of the city. And we all know the way race and class plays out there.

I worry about a few specific things as well. I worry about health capacity. So, not just healthcare access, but I also worry about healthcare quality, which I'll say something about later. But then I also worry about our infrastructure capacity. I worry about schools. I worry about public transit. I sit on a school board and one of the discussions we were having were all of the changes that the school was going to have to make. They're going to have to purchase a whole bunch of equipment that's going to cost a lot of money. They're going to have to purchase new places for kids to wash their hands, to try to get water. They're changing around things. And they're purchasing all this PPE. To Molly's point, I'm worried about the ways that we're implementing these PPE rules and guidelines without properly training people to do it. So, as the spouse of a person who's a healthcare provider, I hear my wife talking about these sort of things all the time.

I think the final point is this. I also worry about how during this moment, we seem to be setting new rules for our democracy. And I think it's highly problematic for everyone in this particular moment that it almost seems to be the wild, wild west in some regards in the ways that these sort of policies are being laid out. And I think it comes down to a comprehensive analysis on pandemic response and preparedness that Johns Hopkins led. That study found of 195 countries, that the United States ranked number one in finances, but 175 out of 195 when it came to healthcare access. I think that speaks to what we're talking about. And the report noted that there is no evidence that the United States is engaged in an exercise to identify a list of gaps in best practices.

And oftentimes, these gaps and lack of best practices collide on the bodies of our most vulnerable and oppressed citizens. Whether that'd be by race, blacks, Latinos, and also by income. So, I think what we have to do in reopening is to really reimagine ourselves. Reimagine

what it looks like. And as a person who studies racial and social inequality, I hope that in this moment we can reimagine a country where racism and inequality do not determine how much healthcare access people have and how long they live and whether or not their lives matter during a pandemic.

ALLEN: Rashawn, thank you very much. Your voice, as I said at the beginning, is very powerful on these matters. Helping us to understand the facets of the inequality that you've pointed out so powerfully for us. So, thank you for that.

Let me go to Ross. Ross Hammond, you've done a lot of work statistically on these matters. What are your thoughts please? Ross, you're muted.

HAMMOND: Thank you very much. Of course, from an epidemiological perspective as we heard Dr. Nuzzo speak to, reopening risks renewed spread of the epidemic. And I think there's a wide variation in how ready different parts of the United States are to detect, to respond to, and to control that kind of renewed spread that is likely to occur as we release lockdown and other social distancing measures.

From our response so far, we can see here in the United States how costly the mass shutdowns that we have all experienced are for our economy, for our society, and even for your health. Even when they are effective in controlling the spread of COVID-19. But from the responses of those overseas, we can see alternative measures we might consider here for controlling the spread of disease. We heard South Korea mentioned, but there are many other countries that have done a great job in using these alternative strategies. Australia, New Zealand, Viet Nam, Taiwan. There's a long list actually of such places. The question then becomes what would it take to use those strategies here in the United States? That's a subject that I've done a lot of research on that I hope we will talk more about later.

One thing I want to just highlight here in this moment of renewed attention to inequality here in the U.S. is that almost all of these measures rely fundamentally on asking people who have COVID-19 who are contagious to self-isolate, to be in quarantine. And for some of America, that's relatively easy to do. But for some, it's really not easy to do. And a critical policy point will actually be to facilitate those who need to stay home doing so. And I think we've so far not done a great job of discussing how important that is or what we need to do specifically to make that possible.

ALLEN: Thank you, Ross. And again, you point to the complexity and how many different countries have handled it, but also the complexity in the home. And this is going to be an area we look forward to your additional comments later on this very issue.

Finally, Bill Galston.

GALSTON: Thanks, John. I came in with a long list and as my colleagues spoke, I started checking off items that they had discussed much better than I could. So, let me just tell you very briefly what I have left.

To your first, you know, to the framing of the question. I agree with just about everybody. We're not ready. We're not as ready as we should be. We're not as ready as we could have been. But we have to face facts. We are reopening. And so, the (inaudible) question is how to do so as safely, carefully, and prudently as possible.

I've been spending a lot of time looking around the world as Ross and others have and here are a few things that I have learned. Some of them good news, some of them not such good news. First, a couple of pieces of good news. Number one, a number of European countries have reopened their public schools. Some for as long as six weeks already. And these countries have not experienced the infection spike that might have been expected and that some predicted. And

that's really important because schools are going to be a really important choke point for the reopening of the economy and normal social life. Put simply, if parents can't send their kids to school, most of them are going to have to stay at home with their kids. Especially women, but not only women. And so, this is an important piece of good news.

A second piece of good news is that, and this is intuitive rather than counterintuitive, it is a lot safer to reopen outdoors activities than indoor activities. And so, for all you golf players, you're in luck. But in general, it's—I think it's pretty safe to reopen public parks, national parks, monuments, and things of that sort. Obviously, we can't behave just the way we behaved before. But for Americans looking for a respite, you know, from sheltering in place, I think that is going to be a first resort, not a last resort.

Now, for a few pieces of bad news. First, countries around the world regardless of their strategies, have done a very poor job of ministering to the special vulnerabilities of the elderly. This is true as we heard from Dr. Nuzzo in the United States where, you know, the death toll in nursing homes is anywhere from 25,000 to 28,000 out of the 105,000 total. And this is not just the patients, but also the people working in them. You know, this is—this problem is so clear and present, we've got to deal with it up front. We can't be business as usual when it comes to those spots.

Secondly, multi-generational households, right? We've learned from Italy, you know, what's characteristic of Italy is not just that it has a very old population by global standards, but also that Italians are more likely than just about any country on earth to live in multi-generational families, which has imposed special vulnerabilities on the elderly and special responsibilities on their children and grandchildren. We'd better think very hard about that.

And a final point, epidemiologists around the world have pointed out, you know, both

anecdotally and statistically that there are certain underlying health conditions that are especially likely to lead to the severity of COVID-19 and to death from COVID-19. Among the leading ones, asthma, heart disease, obesity, and diabetes. Those are the big four. And as we open up everything, including our workplaces, we ought to create some sort of diagnostic and sorting mechanisms so that, you know, so that workers with one or more of these underlying conditions, which are not evenly distributed on racial and ethnic grounds, as Rashawn and others have pointed out, that they can be—that they can be given special treatment and if necessary, exemption from the workplace as long as the COVID-19 pandemic rages.

So, that's what I've gleaned so far, but more to come.

ALLEN: Bill, thank you. And you've touched on a lot of the complexities and you've given us a lot to think about. Especially on the health conditions, which are indicators of vulnerabilities. So, thank you for that.

Let me ask a second question for all of the panelists this afternoon. On Sunday, the 24th of May, the *New York Times* paid a very powerful tribute to the lives lost to COVID-19. I think we've all seen the lead page of that newspaper. While the newspaper and while others are entreating us to remember the lives of all of those that have lost as individuals, it also urges us to curb the continual loss of lives as we go forward. One hundred five thousand dead, many more ill. We've got a long a way to go before, as Dr. Nuzzo said, we're going to get around the containment and the movement towards a therapeutic or a vaccine. So, we have to take steps on our own.

Now, in the context of this question, let me ask each of you, in view of the specialness of your research, to give your thoughts, please, on what are the primary challenges that we face in ensuring that this country can move towards reopening? Again, within the context of your

search. And then we'll go to individual questions after this, please. And, Bill, let's come right back to you.

GALSTON: Wow, caught me by surprise. Well, I work hard on various social policy issues and let me just give you a handful of points that stand out to me. You know, what do we need to do? Number one, we need specific, enforceable workplace safety standards. We don't have them. OSHA has been largely asleep at the wheel. And we need a national effort, which may be legislative, probably should be as a matter of fact, for specific and enforceable workforce—workplace standards. Workers should not be forced by economic necessity to return to unsafe workplaces, period, full stop. But I feel that very strongly.

Number two, workers who are sick should not have to choose between coming to work sick and, you know, and being able to support their families. We need a program of paid sick leave and it ought to be universal. Again, period, full stop.

Third, in order for parts of our economy like restaurants to reopen, we're going to need rapid results on the spot testing at the threshold of those establishments for workers and potential customers. I can tell you I am not going to die for a sit-down meal out of my home. And as I read the survey research, most Americans aren't willing to do so either. But if you tell me that a test has been administered on the spot with results in 10 minutes, which is how long you usually stand on a restaurant line anyway, and everybody in the establishment is tested negative, I think I'd probably be willing to take that chance, but not otherwise.

We obviously have starved our system of public health for 30 years. We need to rebuild it. And two measures which we need, but I'm afraid we're not going to get, are first of all, contact tracing. As Dr. Nuzzo emphasized, it is very resource and personnel intensive. It can be experienced as intrusive. I'd like to see it, but I don't think we're going to get it except in selected

spots that are really committed to it like Massachusetts, which is pretty far ahead of the rest of the nation.

Finally, Asian nations have experienced a lot of success with mandatory quarantines. Once again, I think a lot of Americans are going to bridle for reasons good and bad, understandable and not so understandable about that kind of measure. But at the very least, we ought to offer people voluntary quarantine options making use of structures such as our mostly empty hotels in this country. And there are many of them. In order to give them a place to go because they want to do the right thing. They don't want to infect the rest of their families. And they ought to have an option. And this is particularly true for people who are living packed together in very dense quarters. If we don't give them an option, they won't have one.

ALLEN: Great comments, Bill. Thank you very much. A good complex answer. Thank you. David, in the Hutchins Center, what are you all thinking in terms of the research and what it shows?

WESSEL: Well, I'm thinking I'd rather go before Bill Galston than after Bill Galston the next time. That was such a terrific list. I think that we look a lot at what's going on with the economy. And I think it's quite unusual moment where in the past we have sometimes been reluctant to bail out banks because they caused a big problem in 2008 and 2009. Or to discourage people from working because we thought that without—with incentives they'd go to work. This is just extraordinary and different. Where we have, in the interests of public health, instructed businesses to shut down, factories to close, workers to stay home, ballgames and theatres and movie theatres to be suspended.

And I think it's very important as we gradually reopen whether we're ready or not we are, that we not move too quickly to withdraw this support from the economy. Or we will have not

only an uptick in the coronavirus, but will have what some economists call the W-shaped recovery. Where things will get better for a while and then they'll get worse. So, economically, the most important thing is not to end the support for the economy prematurely because the implications will be devastating.

ALLEN: Thank you, David. Ross, what are your thoughts, please, based on your research?

HAMMOND: Sure. Well, so the question is how do we curve the continual loss off American lives? And fundamentally, to curve the loss of American lives from COVID-19, we have to control spread of the epidemic. There's no way around that and in the absence of a vaccine or herd immunity, we will have to have some kind of containment policy. Now, the question is what should that policy look like? And we've seen that the policies we've used so far of closing workplaces, of closing schools, of asking everyone to stay home, are very costly. They're costly to our economy, but they're also increasingly costly to our health and to the fabric of our society.

And our work is really about what alternatives are out there. I'm more optimistic than I think Bill is about the possibility of adopting some of these successful strategies that are not just in Asia, but also in places like New Zealand and Australia that have a certain resemblance to the United States where widespread testing and contact tracing has worked. And I think in order to deploy those kinds of strategies for the next phase here, we really need to emphasize three things.

The first is there has to be enough capacity. We have to have enough tests. We have to have enough capacity to do contact tracing. The second is we have to have a coordinated plan to use those resources, which will inevitably be constrained. We'll never have all the tests we want. We'll never have all the capacity we want. So, we have to have a plan to use it efficiently and in

a very focused targeted clever way. And the third, which I alluded to earlier, is that fundamentally, when you conclude this chain of testing and contract tracing, what you would like is to identify people who may be contagious to others and to isolate them through quarantine, through asking them to stay home when they're sick as we do with other respiratory diseases like flu. And so we need an investment in how to make that more likely to actually happen for most Americans. And our work trying to model these what if questions, what would it take to actually deploy these strategies in the U.S. underline the importance of adherence to quarantine. If too few people self-quarantine when they're asked, none of these strategies have a chance of working.

And I believe that actually all three of those things are within reach. They will require further investment to realize them. But I don't think we're that far off from where we might need to be. I don't think these are crazy ideas. And I think given the alternatives, renewed epidemic spread, mass social distancing, further damage to our economy, such investments make all the sense in the world. And they can't possibly cost as much as we've endured so far. And I think this is an important avenue for policymakers throughout our country to pursue as quickly as they possibly can.

ALLEN: Thank you, Ross. We'll come to you in a moment to have you elaborate a bit more on the TRACE model because it's been very, very helpful in the formulation of policy. Rashawn, please, can you give us a sense of how your research has indicated how we get after this?

RAY: Yeah, I mean, so obviously, I mean, I'm thinking about dealing with racial disparities in healthcare access. I think that becomes one of the main challenges because if we focus—and we've heard from our other colleagues, Bill mentioned the elderly. I mean, we could

also talk about the prison population. But oftentimes, when we center the most vulnerable, then all of a sudden we know that we are also focusing on everyone else. I think when it comes to black Americans in particular, there is one key stat that's came out of this that should be troubling to us all. That's the fact that black people are six times more likely than whites to be turned away from testing and treatment once they go to hospitals.

So, even after we've dealt with healthcare access, we see the healthcare quality is a problem. And so while a lot of people are talking about, you know, black people's behavior or even their blood, and some other sort of things that don't necessarily come to fruition in actual research, nationally we know that black people are about three times more likely to die from COVID-19. And in some cities and states across the United States, represent about 80 percent of all the people who have died from COVID-19. We also know that Latinos have been disproportionately hit by COVID-19. I think Chicago and Illinois becomes a good place to look.

So, I mean, I've written about this gap exists and what we can do to reduce it. But I think what's key is that people really have to understand that structural conditions of our neighborhoods oftentimes undergird preexisting health conditions that impact people and actually increase the likelihood of minorities being exposed, contracting, and dying from COVID-19.

I think the other thing, of course, we know is that black people, as Molly's research highlights, and Latinos are more likely to be part of the essential workforce. Being a low wage worker increases the barriers to social distancing as I mentioned earlier. And some of our colleagues, Makada Henry-Nickie, and John Hudak had a very fascinating piece in *FixGov*, actually a couple of pieces, highlighting what's happening in Detroit. And as we know, Michigan has been hit extremely hard.

And, honestly, when it comes to the upcoming election, one thing that I really worry about and that I've noted is the way that COVID-19 might literally be killing off stable black voting blocks in battleground states, in Michigan, Wisconsin, Pennsylvania, Ohio, and North Carolina. And I think that's something that people haven't really been highlighting and talking about what it even looks like to lead up to a presidential election. I think we also noted blacks are more likely to live in densely populated areas. They lack healthy food options and places to engage in physical activity.

And then, I think, one of the main things is this. I think that race and racial inequality and hopefully, after what we've seen over the past couple weeks, people know this, but it should unnerve us all and while COVID-19 is an equal opportunity disease, our healthcare system is far from it. And currently we are dealing with two pandemics. We're dealing with COVID-19. But we are also dealing with the United States' original sin, which is racism and structural racism. And it's high time that the United States stop necessarily taking the colorblind approach to this pandemic, and instead give us the opportunity to correct some of these racial health disparities by implementing a reopening plan that actually centers health equity. And I'll say a little bit more about that later.

ALLEN: I would also ask you, Rashawn, when you come back too. You touched on it just briefly. I don't think we've heard enough about what's going on in the prisons. And in the context of mass incarceration, we should concern every one of us. I'd love to hear a little bit more about that when we come back to you for the next question.

And, Molly, of course, your great work again on essential employees. Could you give us a little bit from your specific research, please?

KINDER: Sure. So, like Rashawn, I'm really concerned about the big equity questions as

we reopen. And as we have had workers these past three months working through this. And inequity, by that I mean both race, but also income. And there's a really stunning statistic. When we talk about reopening the economy and putting more workers back in the job, this is disproportionately going to impact low wage workers. And that's because low wage workers are six times less likely to be able to telework and work from home presumably in front of a computer than high income workers. They're disproportionately the folks who have been laid off from jobs. When restaurants and movie theatres and nail salons and shopping centers shut, it's those workers who lost their job. And when they go back to their jobs, those jobs have a lot of face-to-face contact. They're not like this moment where I'm sitting here by myself on my computer. So, the nature of that work is high risk.

But there are three factors that came up all the time in my interviews with low wage workers who were disproportionately workers of color, the folks I interviewed. And these anecdotal experiences are all backed up in the data. And the first is this point that Rashawn has done so much great work on is the fact that there is much higher prevalence of these underlying health conditions that Bill discussed that are the most prone to kill people who get the disease. Whether that's asthma or diabetes. Over and over I heard from the workers I interviewed that they have those underlying health concerns or someone in their household does. And that was some of the biggest concern was not just the worker who might have diabetes and is worried about going to her job, but her granddaughter who lives with her. So, there was real concern about—and, Rashawn has shown all the different structural inequities that lead lower income and workers of color to be more prone to die of this disease.

The second was—is one that's not being talked about very much, but again came up frequently. The workers I interviewed were predominantly in cities in the mid-Atlantic. From

Richmond to Baltimore to Philadelphia and D.C. And many of those workers with the lowest wages don't have access to a car to get to work. And one worker, Yvette Betty (phonetic), who's a home health worker in Philadelphia described how she feels getting on public transit at this time. She said getting on a public bus during a pandemic is like getting on the bus with a loaded shotgun and not knowing who on that bus is going to set it off. I talked to another home health worker in Philadelphia who takes five transfers to get to work for a job that pays her $9.00 an hour. It takes her almost three hours to get to work and she's risking her life. While I have access to a car, so, I'm going to try to avoid public transit for the time being.

The other issue that came up, and Bill mentioned it as well as I think Rashawn, was this issue of multi-generational housing. And that's a term that we might use, but like just to put it bluntly, low wage workers cannot afford to live alone. That's the way we should be thinking about this. Sabrina Hopps (phonetic) is a housekeeper in an ICU in an acute care facility in D.C. And she explained to me her low wages, she makes about $14.00 an hour in a very expensive city. She can't afford rent on her own. So, she lives with her daughter, her son, and her granddaughter. And her son is a cancer survivor. She has diabetes. So, there's all sorts of health risks. She said, look, if you raise my wages, I could live apart. And, you know, really horrible stories of these, you know, grandmothers with—Yvette has seven people in her household. She's the sole provider for it and they all live together. And the lengths she goes when she gets home to scrub herself down and try not to pass on this disease. It's really terrifying.

The other thing we linked to that is childcare. And I know, I think it was Bill who mentioned childcare. Lower wage workers can't afford the backup plans. The paying for a nanny when schools are shut. They're going to have to turn to family members, which is going to further increase the risk of disease transmission amongst lower income and communities of

color.

So, I think this raises to me all sorts of terrifying questions around equity. I think unfortunately as we reopen, so many workers could potentially be put in an agonizing decision. Do I try to keep myself healthy, try to protect my kids from this virus? Or do we survive financially? And I think a lot has to be done to build inequity.

And what I was going to say was very similar to Bill. Something that I wrote about with my colleague Martha Ross in our essay for the series is how do we think about expanding the safety net so those who are at most risk and those who have family members they live with can not work? No matter what we do with safety, some of those at highest risk it's just too much of a risk for them. And there have been some important steps taken. In fact, the State of Texas has issued guidance to say that not only those with those high-risk categories who are workers, but anyone who lives with other members in those high-risk categories are eligible for unemployment.

But there's still barriers. Even if you're eligible, can people get that letter from their doctor? Do they even know about it? The system has been really frustrating. So, I think these equity considerations are extremely important.

ALLEN: Thank you, Molly. Look, I'm going to use the power of the moderator to pull five minutes off the Q and A because I think the value of this conversation and the individual presentations and the benefit that we can all harvest from your incredible research, all of your research, is very important to the audience that has tuned in today. So, what I'd like to do is I'll ask everyone to be as brief as you can. We're going to go until about 2-0, so about 15—about 3:20.

And so, let me start with David if I may. Reopening the country is, of course, a, you

know, crucial part of revitalizing this society. And the United States like the rest of the world, took an enormous economic downturn. The likes of which we haven't seen in many respects since the Great Depression. And at the same time, there remains crucial needs to continue social distancing measures to encourage people to maintain good hygiene.

So, David, how can we as policymakers or how can policymakers and leaders balance these two demands? We're talking about not the individual workers, but the policymakers and the leaders. How do we balance these demands to find the equilibrium between safeguarding people's lives and ensuring their livelihoods? Thank you, David.

WESSEL: You're right, John. There is a trade-off. We are not going to all stay home until we have a vaccine. And I hope we're not all going to go back and resume the lives we had before COVID-19. So, somewhere in the middle, we have to find a way to safely reopen. And I think that requires in addition to the sorts of things that Ross talks about, testing, social distancing, it requires some trust in our leaders that they're giving us sound advice, scientifically based, not aiming at the next election.

Second, I think we have to be careful to, as I said earlier, sustain the support for the economy for businesses and workers who we've forced to the sidelines. And importantly, we have to make sure that the system is working so they actually get the aid that Congress has offered them. Shocking numbers of people are not able to get the unemployment insurance benefits to which they're entitled because their states have inadequate computer systems or have had deliberate policies to discourage people. Shortcomings of the food distribution system have made it hard for people to get food whose kids might have gotten free or reduced lunch. And so, there's all sorts of things in the administration of the benefits we have to care about.

And third, as you said earlier, COVID-19 has exposed for everybody to see some of the

inequities in our society. And the police violence and what followed has reinforced that. So, at the same time that we're addressing these short-term problems, it is important to figure out as we reopen the economy, how do we address these long-term problems that have been simmering but unaddressed for far too long?

ALLEN: Thank you, David. Thanks very much. Ross, let me come to you if I could, please. You've done some tremendous work on something that has been created called the TRACE model. Which offers policymakers very powerful analytical tools to create and assess their containment policies. In your research thus far, what have you found to be the most effective policies? Is there a one-size that seems to fit all model? Or do different regions or different communities require different variants of that model?

HAMMOND: Great question. Thanks, John. I think it's certainly likely that different regions or communities will want to tailor their containment policies to context because they have different starting points, different resources, and different demographics. I also think that there will be variants in the strategies that different communities use because we're in a situation of such high uncertainty about COVID-19 itself. As Dr. Nuzzo reminded us at the beginning, there's lots of unsettled science. We don't know just how many people actually show no symptoms when they have COVID-19. We don't know how contagious people without symptoms might really be. We don't know why so few kids are getting COVID-19.

And actually, I read the science as being quite unsettled still about who's really at risk. We hear a lot about people of a certain age category being at highest risk. But there's a lot of evidence that has to do with underlying conditions and the ways in which it depends on those underlying conditions are quite complicated and I think far from settled.

So, given all that uncertainty, a policymaker who is trying to devise a containment policy

has to grapple with all of those factors that are not well understood and that certainly matter for how well containment can work. In addition to those, if you went—if you as a policymaker go to actually implement a policy based on testing and tracing, you have to think about not only how many tests are needed specifically, but how accurate those tests need to be. Who you give them to? How much contact tracing capacity you need? How many people do you need to hire and how do you need to train them to do that work? And how all of those answers probably depend on these things that I just listed that are so uncertain.

So, TRACE was actually a model that we designed to help policymakers grapple with that uncertainty and answer those very difficult questions in designing their own containment efforts. For those of you who are interested in looking at it, it's at www.brookings.edu/trace, T-R-A-C-E. The good news from the work we've done with TRACE so far is that we actually found quite a few policies that are robust to that uncertainty. That is they work even in the very worst-case scenarios that we looked at. And we actually looked at over several million different scenarios, over 10,000 different combinations of policies across a huge range of uncertainty about the underlying epidemiology.

And we think these reliable policy options will work for most places. And those policy options need three things. Three things I have mentioned several times so far. Enough capacity for testing and contact tracing, a smart strategy to use supplies. And we actually find that the way in which most testing is going on right now, which is to give priority to people with symptoms, is not the most effective way to use limited testing supplies. We actually advocate a set of different and slightly more complex strategies involving contact tracing, which you can read more about at our website on the Brookings website. And three, this idea that adherence is so central to success with any of these policies and supporting Americans in being able to self-isolate when

they need to.

And I want to stress that given the right mix of ingredients, our TRACE model shows that we can really, as Americans, aim not just to flatten the curve by pushing cases off into the future, which was very important and necessary and timely effort, but to actually really suppress COVID-19. To have a system whereby we can detect and promptly respond to small outbreaks as they occur. To keep explosive growth from occurring, and to do that indefinitely. Because as Dr. Nuzzo reminded us, it may be some time before a vaccine comes along. And the strategies that TRACE puts forward can be deployed indefinitely to contain COVID-19 even while almost all of us go back to work and to school and to our daily lives in ways that are important to the fabric of our society.

ALLEN: Ross, listen, on behalf of your colleagues at Brookings and many policymakers and leaders who have either used TRACE or will use TRACE, I want to thank you for that research.

HAMMOND: Thanks.

ALLEN: It is making a huge difference. And for those in the audience today, just as Ross just did, I invite you to go to the website, which is /trace@www.brookings.edu. So, please visit that site and it's great work, Ross, and we're all benefiting from it. So, thank you.

HAMMOND: Thanks.

ALLEN: Rashawn, you have written extensively on how COVID-19 has affected the lives of black Americans and the black community. According to your work, you found that in every state where there are racial data statistics, black Americans are more likely to contract the disease and tragically, die from it as well. In our newly released report, you specifically point to the lack of access to quality healthcare as one of the reasons for that disparity.

So, as the country continues its recovery efforts, what would you recommend to policymakers and decisionmakers on ways that the United States can systematically approach the remedy of this tragic situation?

RAY: Yeah, General Allen, as you know, I mean, look, racially equitable healthcare access and quality is what we need moving forward. I mean, we have to get to capacity where we have the data to properly analyze what's going on as it relates to race, place, gender, age, and other factors related to preexisting health conditions, in order to paint an appropriate picture for what's going on. And I think tragically at this moment, the same way that we lack data on race to know about COVID-19, it's the same that we lack data on police violence. And I think it's one of the reasons why we're seeing these two pandemics and what's happening in our streets across the country.

I think in order to do it, I think there are a few things we could do. One big thing that I've been pushing, and we've seen this what I'm about to say adopted in New York by Governor Cuomo and Congressman Jeffries, which is to really leverage black churches in this moment. My research has overwhelmingly shown and some of this work I've done with Dr. Abigail Sewell as well as Dr. Keon Gilbert that black churches become key trustee sites. That people who attend black protestant churches are more likely to trust healthcare physicians. They are also more likely to utilize healthcare.

Well, why would that be? Well, you instantly deal with a network issue. So, part of the thing that we know is that black people are less likely to access healthcare. They are also less likely to get high quality healthcare. Well, when have a network node, say like a black church, all of a sudden throughout that network people say these are the physicians to go to in our neighborhood. These are the places to seek treatment. Don't go to that place, go to this place.

It's the same logic we use based on which restaurant has the best food or which park has the best sort of playground for kids to play in, that black people do this same sort of process at churches. Latinos do as well. This has been implemented in the State of New York where they've allocated specific funding for churches to do testing and triage. I think that's something very important. We need to ramp this up.

We also need to work with local organizations and key trustees in neighborhoods to ensure that black people are included in clinical trials. That those clinical trials are implemented equitably. And in many regards, this really aligns with President Obama's promise zones that he was trying to push when he was in office. I think there are also a couple of additional things though. Because I think that's the big one dealing with testing.

I think the other part is we need to ensure equity as it relates to PPP funding. One of the things we know from the first and second round, is that black, Latino, and women-owned small businesses were rejected from that funding. About 95 percent of them. When we have these businesses in neighborhoods where they already lack infrastructure, and then you further devoid them of opportunities to leverage their businesses and maintain their businesses and keep people employed, this was yet again a missed opportunity by the United States to create some equity. And we did the exact opposite.

So, I think the big framework is that when we've approached COVID-19, we've approached it from a colorblind perspective. And I assert that we need to take a health equity approach to COVID-19. And when it comes to prisons, which are something you asked me about. And we had an event a few weeks ago, Reverend Jesse Jackson gave opening remarks. I wrote a piece in *Newsweek* with Reverend Jesse Jackson and Dr. Todd Yeary from Rainbow/PUSH. And one of the things that we highlighted in that piece are the disparities that

we're seeing when it comes to incarceration. That about 20 percent of Ohio's COVID cases are in prisons. When it comes to Arkansas, about 40 percent of the state. And when it comes to right here in Washington, D.C., the D.C. jail, the D.C. Department of Corrections, has a COVID rate that is 14 times higher than the D.C. population that is not in that jail.

I mean, when we think about that, these disparities are so outlandish. I mean, it is difficult for us to even map them. And one of the things that I did was some analysis to look at what would it mean if the rate of COVID that we're seeing in prison was matched in the general population? What we would see is about 700,000 more people that have COVID and about 50,000 more people die from COVID. And I think these are some of the disparities that we're seeing.

So, we need ramp up the PPP funding. I think the conversation on prisons is continuing. In fact, one of me and Molly's Rubenstein fellow cohort mates, Annelies Goger, is having an event on Friday. Senator Cory Booker is going to be here to give some remarks about how we think about prisons, how we think about helping people get access to work after prisons. And I think this is part of what it means to reimagine America. Is that we think about some of the forms of inequalities that we simply accepted as not given facts. But instead things that we can actually change. And I think it starts with empowering people in local communities.

ALLEN: Rashawn, thank you. Reimaging America, that's the challenge and that's the key. Molly, let me ask you if I could, while COVID-19 has affected the lives of all Americans, every American, it's especially affected the lives as you have mapped it and as you've studied it of low-income workers. Indeed, millions have filed for unemployment benefits just as the Congress is deliberating on a second stimulus package. Molly, do you think that these efforts are enough? And if not, what are the ways that the federal government can offer meaningful

economic relief in these challenging times to this essential strata of our population that keeps us going?

KINDER: Yes, absolutely. I think the response so far has been very mixed. So, there has been some good news and David highlighted a little of this. So, in the CARES Act, Congress extended unemployment insurance in a few really important ways. It expanded the types of workers who were eligible to those like gig workers who previously haven't really benefitted from unemployment insurance. It extended for a longer time. So, through the end of the end of the year. And importantly, they added an additional $600 a week as sort of extra compensation.

And I think all of those measures are really important. But there were some challenges that were already raised. One, is that millions of workers who filed for unemployment and rightfully have the right to it, have still not received it. In fact, Bloomberg had a story today that upwards of 1/3 of workers who filed claims haven't got their money.

The second is that it's limited. So, those extra $600 a week are set to expire at the end of July. All of this unemployment could expire at the end of the year when we still expect to have a lot of unemployment. So, those benefits should be extended not on some arbitrary deadline because of politics, but based on the economic conditions.

The other thing I'd just say is that it's not only the workers who are unemployed that the federal government should provide relief to, it's also those essential workers who've carried on working. By one estimate by *New America*, there are 13 million essential workers who earn less than $15 an hour, so, less than a living wage. And I've interviewed a lot of those workers making $9.00 an hour, $11.00 an hour. They're really struggling to pay the bills too. And talk is cheap. Everyone has heralded these workers. Our legislators have herald them, the administration. And while there's been some motions, nothing yet has been passed to give hazard pay to raise the

wages particularly of the lower wage workers. And even some of the employers who provided it are starting to roll it back.

So, I see this as a major weakness. We are not standing with those workers who are—especially those lower wage essential workers are disproportionately black and workers of color. So, we need—their lives matter. Their safety matters. Their work matters. And I think this is a huge deficit that the federal government should respond to.

ALLEN: Thank you, Molly. Very, very, well put. Hope we're listening. Let me come to Bill Galston, finally. Bill, you've been a keen observer over the years and certainly during these last several months of crisis, crisis at various levels, a keen observer of leadership. Now, you've written about it, you talk about it frequently. And leadership during a time like this is magnified in crises such as a global pandemic or what we're seeing in the streets today. Your essay, Bill, in the reopening project, you talk about the need for restoring public confidence. Can you describe the tangible ways that you think that leaders who are observing this event today or who are going to read our work or just think about this, what leaders can do to turn around an absence of confidence? And how we as citizens can support them or (inaudible) hold them accountable these leaders?

GALSTON: Well, John, we've reached the moment that I've dreaded since this event was announced because, you know, you've spent all of your adult life in positions of leadership and for me the figure might be something like 10 percent. But for what it's worth, here is my five-part manual for leaders to restore public confidence in times like this.

Point one, from which all else follows. Clear, consistent, and credible communication. You're allowed to change your mind, but not too often and you'd better explain why. And what you say—what you say has to be in touch with realities that people on the frontlines, at the

grassroots can touch and feel and see for themselves. There's no way they're going to believe the sky is green if they can see for themselves that it's blue.

Point number two. Tell the unvarnished truth no matter how tough the circumstances are. The all-time classic of this, of course, was Winston Churchill who promised his people at the, you know, at the moment of maximum peril, nothing except blood, toil, tears, and sweat.

Point three. Take responsibility for what happens on your watch. The bad stuff as well as the good stuff. That means you don't shy away from doing the hard part of the job and chuck it off on subordinates. You do it yourself. You model that and number two, you take responsibility for the bad things that happen on your watch. You know, let me quote briefly from a piece of paper that Dwight Eisenhower prepared on the eve of the Normandy Invasion. He literally prepared two envelopes.

One for success and one for failure. And here's the failure message that he never had to deliver, and I quote, "Our landings have failed to gain a satisfactory foothold and I have withdrawn the troops who did all that bravery and devotion to duty could do. If any blame or fault attaches to this attempt, it is mine alone." And I actually looked at the original piece of paper and the words, mine alone are underlined in thick ink.

Point four. When there's fear, address it head-on, while at the same time doing your best to create a horizon of hope. You know, the all-time classic here is FDR's first inaugural, the only thing we have to fear is fear itself. That's not always true. Right now, we have fear to fear, but we also have an invisible virus to fear. But at the same time, reassure people that we will persevere to a successful conclusion even if we don't know how long and hard the path is going to be.

And finally. Put current difficulties in a larger frame of ennobling public purposes, right? We don't just need to rescue America or recover America, we need to renew America. This

should be framed as an opportunity to build it back better. The all-time classic here is Lincoln's Gettysburg Address. You know, a charnel house of human slaughter.

But Lincoln said we here highly resolve that these dead shall not have died in vain. That this nation under God shall have a new birth of freedom. Well, we need a rebirth of something and we need it desperately. And leadership to restore public confidence means providing that framework of not only rescue, but renewal.

ALLEN: Bill, I'm sitting here transfixed listening to you. That was fantastic. And I hope everybody was paying attention to that and taking notes. And the nobility of Eisenhower's soaring words of accepting responsibility in failure is something that a lot of people ought to be paying attention to now. And heroic leadership is desperately needed in this country today. Heroic leadership and noble conversation, nobility.

Look, I have failed our audience. We don't have enough time for questions. Let me do one thing though and ask every one of the panelists in the time we have left, which is just a couple of minutes. What one thing—what one thing would you suggest to leaders and policymakers to try to deliver our people of America safely to the other end of this crisis? What one thing? Let me start with you, Molly, please. And let me just add, you may have already said it --

KINDER: Yeah.

ALLEN:—so good, say it again.

KINDER: Put equity at the heart and safety first.

ALLEN: Rashawn, please.

RAY: Yeah, I ditto what Molly said. I think the one thing I failed to leave off is in states and local jurisdictions around the country, create a racial equity task force --

ALLEN: There you go.

RAY:—where you bring the key actors to the table to help you make decisions that you don't know the answers to. Because as we know from Shirley Chisholm, if you're not at the table, you're on the menu and someone's eating you for lunch. And for too long, those marginalized among us have been on the menu, and that needs to change.

ALLEN: Thank you, Rashawn. Ross, your thoughts, please. One thing.

HAMMOND: Develop and deploy a coherent strategy to contain the epidemic and be transparent about why you're doing it, how it will work, so you build confidence in the populous that it will work.

ALLEN: Terrific, thank you. David, please.

WESSEL: Remind us what we have in common rather than to emphasize what pulls us apart.

ALLEN: Thank you. And, Bill, one thing.

GASTON: Tell America specifically what it means to build it back better.

ALLEN: Great, thank you. Well, for my colleagues on the panel, I can't thank you enough. Not just for being on the panel today, but for the quality, the depth, and the passion. It's really making a difference. And it's reflected in the product that we've just put out on Reopening of America and the World. And to the audience that tuned in today, thank you for joining us.

Your Brookings Institution is trying to make a difference and trying to help everyone to come through this pandemic whole. But also to try to imagine and envisage a better world at the far end of this crisis.

So, thank you for joining us today. Thank you to the panel members. And that concludes our session. Please be safe and please be well.

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Until next time, I'm Fred Dews.

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