

THE BROOKINGS INSTITUTION

WEBINAR

A ROADMAP FOR REOPENING AMERICA -
HOW TO SAVE LIVES AND LIVELIHOODS

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P R O C E E D I N G S

MR. 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 even is part of a larger Brookings project. Last week we published 22 short papers that addressed 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 16th we will be publishing another 22 papers on reopening the world. They will look at the non-U.S. experience and teaching other 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 appreciated the opportunity to join you all on 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 eliminate the fact that we are on a different trajectory that it appears to be now. So, with that caveat, I do want to offer some thoughts on what we may, very well, expect in the coming days.

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 are capable of testing for what is a completely new virus. It 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 roll out the testing capacity, but also train staff, etc., 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 -- 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 were 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 the 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 over 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 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.

We talked about flattening the curve -- 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, in 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 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 a political issue.

The reason why I, as an epidemiologist, am interesting in testing is because it's the

process by which we identify cases.

In order to understand if the case numbers that are being reported represents 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 tests results are reported so that we can 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 it 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 for 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 COVID-19 Testing Insights Initiative, where we're trying to not only, rather, been 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 test compared to any other country, we have also conducted more tests per capita than many other countries, although 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 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% 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 into, 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 lock downs, 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-ditch effort to stop 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-base 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.

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.

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 three-quarters of all deaths that have been reported. Nursing homes account for possibly more than a third 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 the Latino populations are over-represented 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 then, 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 that best to prevent it.

It's also important to recognize that when we talk about pandemics -- and this is the hallmark of pandemics -- is that they tend to kill or harm in three ways. And so, when we think about what the effects of this COVID-19 are going to be, we have to think of it in 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 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 affects 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 a third category, which is harms that are associated with the economic tolls. And one of the things that 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 up-tick in the number of suicides that was thought to be related to the global economic downturn. The economic tolls of this pandemic are really

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

In terms of how this will play out in the next few months, there are few variables that are sort of up to us.

The 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 more in Sweden versus a little over 84 hundred 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 totally, about 12% of the reported cases in Sweden have died, versus under 3% 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 when 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 are 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're 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 tested 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 sizable outbreak associated with some of the nightclubs and bars that reopened.

And so, what this tells us is that always have to be on the alert. Even if we've had success, we always have to be ready to respond to a surge of new cases as we begin to lift restrictions, otherwise we could find ourselves right back where we started, where we have 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.

That is what is in our future, unfortunately, for the long-term until a vaccine comes, or perhaps some other medical product -- 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, really, to my last point, which is that going forward, what I'm most worried about are the health systems.

And I just want to remind everybody that 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 how systems everywhere are weak, including here in the U.S. -- given the fact that we were unable to accommodate the surge in patients from COVID-19 -- but in many other 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 that 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 health care 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.

We do really have to worry about other health systems as much as the pandemic exposes the fact that we are all vulnerable, and may encourage, you know, every country for themselves type approaches, we will not be safe as a globe until every country is capable of keeping COVID-19 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 is 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.

MR. 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.

MR. 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 to 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'm John Allen, 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 are very difficult times.

Between COVID-19, a severe recession, 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 a 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 (pause). Thank you very much.

Turning to today's discussion, put simply, the Brookings Reopening of America in the world effort represents our premier contribution at this moment to this crisis. It's as deep as it is wide, but 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 grip with the long-term implications of COVID-19 and the difficult of the economic recovery.

These issues are central to saving many lives and the livelihoods of our people, or 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, it will be a very brief introduction, but I am very honored to be with them today.

The first is Molly Kinder who is 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 Economy 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 Studies program.

Colleagues, it's great to see you and welcome to the panel this afternoon, and ladies and gentlemen, as a final reminder, we are live and obviously on the record, and we will be turning to Q & 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.

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 with 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 through the panel, please.

MS. KINDER: Sure, thanks John, and thanks so much for having me in this great discussion. My research has really focused on the essential workers; the millions of workers who've carried on working throughout this pandemic.

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 don't have the protective equipment they need.

So, as recently as early May a survey showed that upwards of two-thirds of frontline health workers had insufficient PPE. Some really fascinating survey data out of Berkley showed highly uneven basic safeguards amongst frontline workers across industries, and often, terribly inadequate standards.

And we see that workers are frustrated. They are demanding more. The spike with workers in 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 delivery 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 half months ago, that weren't really a risk as much to themselves, suddenly posed a real risk to their safety.

They use words at me like "petrified" and "terrified" of the risk. Most importantly, the workers I interviewed felt most concerned 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 couple with that was frustration. A lot of workers really felt that their employer simply weren't doing enough to keep them safe, especially in the health sector; lots of frustration about inadequate access to PPE, being asked to prolonged use of PPE well past when it's safe.

And really, what was striking to me was some workers 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.

MR. ALLEN: Molly, thank you. Look, we are 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 thought on this.

MR. 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 marks, 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 p.m.

So, it's very different 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 the 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 too, and we will have to see how Americans and others react to the news.

If there's an uptake 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.

MR. ALLEN: David, thank you, 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?

MR. 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 p.m. -- I worry about these essential workers that Molly highlights, because I think at times, we think that people oftentimes have the ability to stay in, that people have the ability to social distance. But my research highlights that social distancing is a privilege and I think adhering to curfews is the same way.

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 in 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 the curfew. And I think that's an unintended consequence of a curfew that we need to think about.

I think, in short, are we ready to reopen? No, I don't think so. And I think oftentimes it's not a catch-all; it's not necessarily a one thing fits all.

As I know, being from Tennessee, is that they're dealing with different pressures and different sort of issues that 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, one 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 the 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 are 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 worry 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 sorts 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 the rules for our democracy. I think it's highly problematic for everyone in this particular moment, that it almost seems to be the Wild, Wild West in some regard, in the ways that these sorts 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 196 countries, that the United States ranked Number 1 in finances, but 175th 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 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.

MR. ALLEN: Rashawn, thank you very much. Your voice, as I said at the beginning, is very powerful in 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?

MR. WEST: Ross, you're muted.

MR. 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 is wide variation in how ready different parts of the United States are to detect, to respond, 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've all experienced are, for our economy, for our society, and even for our 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, Vietnam, 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 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, in 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.

MR. 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 that we look forward to your additional comments later, on this very issue. Finally, Bill Galston.

MR. 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 -- 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 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've 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 in 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.

The 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 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 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 the death toll in nursing homes is anywhere from 25 to 28 thousand, out of the 105,000 total, and this is not just the patients, but also the people working in them.

This problem is so clear and present, we've got to deal with it upfront. We can't be business as usual when it comes to those spots.

Secondly, multigenerational 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 multigenerational families, which has imposed special vulnerabilities on the elderly, and special responsibilities on their children and grandchildren. We better think very hard about that.

And a final point, epidemiologists around the world have pointed out, 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 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 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.

MR. 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 our 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 (audio skip) page of that newspaper.

While the newspaper and others are entreating us to remember the lives of all of those that have been lost as individuals, it also encourages us to curb the continual loss of lives as we go forward.

105,000 dead, many more ill. We've got a long way to go, as Dr. Nuzzo said, until 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 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 research. And then, we'll go to individual questions after this, please. And, Bill, let's come right back to you.

MR. GALSTON: Wow (laughter), 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 workplace standards.

Workers should not be forced by economic necessity to return to unsafe workplaces; period, full stop, and I feel that very strongly.

Number 2, workers who are sick should not have to choose between coming to work sick 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 has 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. They ought to be given 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.

MR. 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.

MR. 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 we look a lot at what's going on within the economy, and I think it's quite unusual a moment. Where in the past we have sometimes been reluctant to bailout banks because they caused a big problem in 2008/2009, or to discourage people from working because we thought that with incentives they'd go to work, this is just extraordinary and different. Where we have, in the interest of public health, instructed businesses to shut down, factories to close, workers to stay home, ballgames and theaters and movie theaters 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 we'll 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.

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

MR. HAMMOND: Sure. So, the question is, how do we curb the continual loss of

American lives. And fundamentally, to curb the loss of American lives from COVID-19 we have to control the 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 are costly to our economy, but they are 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 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 contact tracing, what you'd 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 change 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 at.

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.

MR. ALLEN: Thank you, Ross, we'll come back to you in a moment to have you elaborate a bit more on the TRACE model because it has 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?

MR. RAY: Obviously, I'm thinking about dealing with racial disparities and 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, 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 focused on everyone else.

I think when it comes to black Americans in particular, there is one key stat that 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 black peoples' behavior, and even their blood, and some other sorts 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% 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 become a good place to look.

So, I mean, I've written about why this gap exists, and what we can do to reduce it, but I think what's key is that people really have to understand the 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 (phonetic), had a very fascinating piece in fix (phonetic) gov (phonetic) -- 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, 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 know that blacks are more than 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 of weeks, people know this -- but it should unnerve us all. And while COVID-19 is an equal opportunity disease, our healthcare systems 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 stops necessarily taking the color-blind 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.

MR. ALLEN: I will also ask you, Rashawn, when you come back, 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 everyone 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?

MS. KINDER: Sure, 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.

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 are disproportionately the folks who have been laid off from jobs -- when restaurants, and movie theaters, and nail salons, and shopping centers shut -- it's those workers who lost their jobs.

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.

The first is this point that Rashawn has done so much great work on, is the fact that there are much higher prevalence of these underlying health conditions that Bill discusses, 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 it, and Rashawn has shown all of the different structural inequities that lead lower income and workers of color to be more prone to die of this disease.

The second 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, 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 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, was this issue of multigenerational housing. And that's a term that we might use, but 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 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 I heard these really horrible stories of these grandmothers -- Yvette has seven people in her household, she's the sole provider for and they all live together -- and the length 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 link to that is childcare, and I know I think it was Bill who mentioned childcare. Lower wage workers can't afford the backup plans, 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 of inequity.

I think, unfortunately, as we reopen so many workers can 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 in equity.

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 this 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, cannot work.

No matter what we do at safety, some of those at highest risk, it's just too much of a risk for them.

And there has 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 are 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.

MR. ALLEN: Thank you, Molly. Look, I'm going to use the power of the moderator to pull five minutes off the Q&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 to 'til about 2-0; so about 3:20, and so let me start with David, if I may

Reopening the county if, of course, a crucial part of revitalizing the society. 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. At the same time, there remains crucial needs to continue social distancing 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 not about individual workers, but the policymakers and the leaders.

How do we balance these demands to find the equilibrium between safeguarding peoples' lives, and ensuring their livelihoods? Thank you, David.

MR. WESSEL: You're right, John. There is a tradeoff. We're 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 talked about, testing and 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 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 has 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.

MR. ALLEN: 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?

MR. HAMMOND: Great question, thanks John. I think it's certainly likely that different regions or communities will want to tailor their containment policies to contacts 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's trying to devise a containment policy has to grapple with all of those factors that are not well understood, and certainly matter for how well containment can work.

In addition to those, 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, the three things I have mentioned several times so far, enough capacity for testing and contact tracing, a smart strategy to use those 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 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 if 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.

MR. 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.

MR. HAMMOND: Thanks.

MR. 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 at www.brookings.edu. So, please visit that site. It's great work, Ross, and we're all benefiting from it. So, thank you.

MR. HAMMOND: Thanks.

MR. 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 the policymakers and decision makers on ways the United States can systematically approach the remedy of this tragic situation.

MR. RAY: Yeah, General Allen, as you know -- I mean, look, racially equitable

healthcare access and equality 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, gender, age, and other factors relating 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 lack data on race to know about COVID-19 is the same way 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 you 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 a 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% 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 color-blind perspective. And I assert that we need to take a health equity approach to COVID-19.

And when it comes to prisons, which is 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.

About 20% of Ohio's COVID-19 cases are in prison. When it comes to Arkansas, about 40% 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-19 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-19 that we're seeing in prison was matched in the general population? What we would

see is about 700,000 more people who'll have COVID, and about 50,000 more people die from COVID. And I these are some of the disparities that we're seeing.

So, we need to ramp up the PPP funding. I think the conversation on prisons is continuing. In fact, one of me and Molly's Rubenstein fellow cohort-mate, Annalies 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. It's that we think about some of the forms of the 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.

MR. ALLEN: Rashawn, thank you. Reimagining 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 you've studied it -- of low-income workers. Indeed, millions have filed for unemployment benefits; this, 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?

MS. KINDER: Yes, absolutely. I think that the response so far has been very mixed. So, there's been some good news -- and David highlighted a little bit of this.

In the Cares Act, Congress extended unemployment insurance in a few really important ways.

It expanded the types of workers who are eligible, to those like gig workers who previously haven't really benefited from unemployment insurance. It extended for a longer time, so through 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 are some challenges that were already raised. One, is that millions of workers

who filed for unemployment and have the right to it, have still not received it. In fact, Bloomberg did a story today that upwards of a third 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'll 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 an hour, \$11 an hour; they're really struggling to pay the bills too.

And talk is cheap. Everyone has heralded these workers. Our legislators have heralded 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 are starting to roll it back.

So, I see this as a major weakness. We are not standing with those workers who are disproportionate -- especially those lower wage essential workers -- are disproportionately black and workers of color.

Their lives matter, their safety matters, their work matters, and I think this is a huge deficit that the federal government should respond to.

MR. ALLEN: Thank you, Molly. Very, very well put. 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, a keen observer of leadership. 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.

In your essay, Bill, in the reopening project, you talked about the need for restoring public confidence. Can you describe the tangible ways that you think that leaders who are observing this even 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, (audio skip) hold them accountable, these leaders?

MR. GALSTON: Well, John, we've reached the moment that I dreaded since this event was announced because you've spent all of your adult life in positions of leadership and for me the figure might be something like 10%. 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 has to be in touch with realities that people on the frontlines at the grass roots 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 old time classic of this, of course, was Winston Churchill who promised his people 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 shuck 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.

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 the 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. The old 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 preserve 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 old time classic here is Lincoln's Gettysburg Address, 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.

MR. 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 notability 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 times for questions.

Let me do one thing, though, and ask every one of the panelists, 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 --

MS. KINDER: Yeah.

MR. ALLEN: So good. Say it again.

MS. KINDER: Put equity at the heart and safety first.

MR. ALLEN: Rashawn, please.

MR. 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 --

MR. ALLEN: There you go --

MR. RAY: Where you bring the key actors to the table to help you make decisions that you don't know the answer to, because as we know from Shirley Chisholm, if you're not at the table, you're on the menu and someone is eating you for lunch (laughter). And for too long, the most marginalized among us have been on the menu, and that needs to change.

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

MR. 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.

MR. ALLEN: Terrific, thank you. David, please?

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

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

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

MR. 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 (audio skip).

It's really making a difference and it's reflected in the product that we've just put out on the reopening of America and the world. And to the audience that tuned in today, thank you for joining us.

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.

Well, 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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