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TESTIMONY BEFORE THE UNITED STATES CONGRESS

House Budget Committee

HEALTH & WEALTH INEQUALITY IN AMERICA

How COVID-19 Makes Clear the Need for Change

AVIK S. A. ROY

President, The Foundation for Research on Equal Opportunity

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Figure 1a. Black Unemployment Rate Minus White Unemployment Rate, 1972–2020

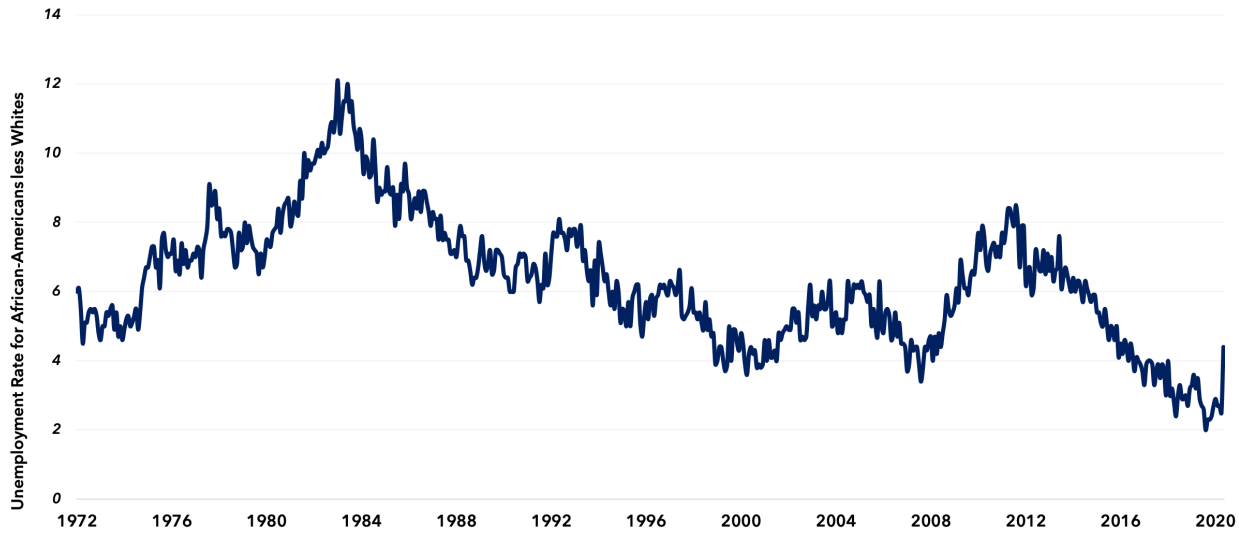
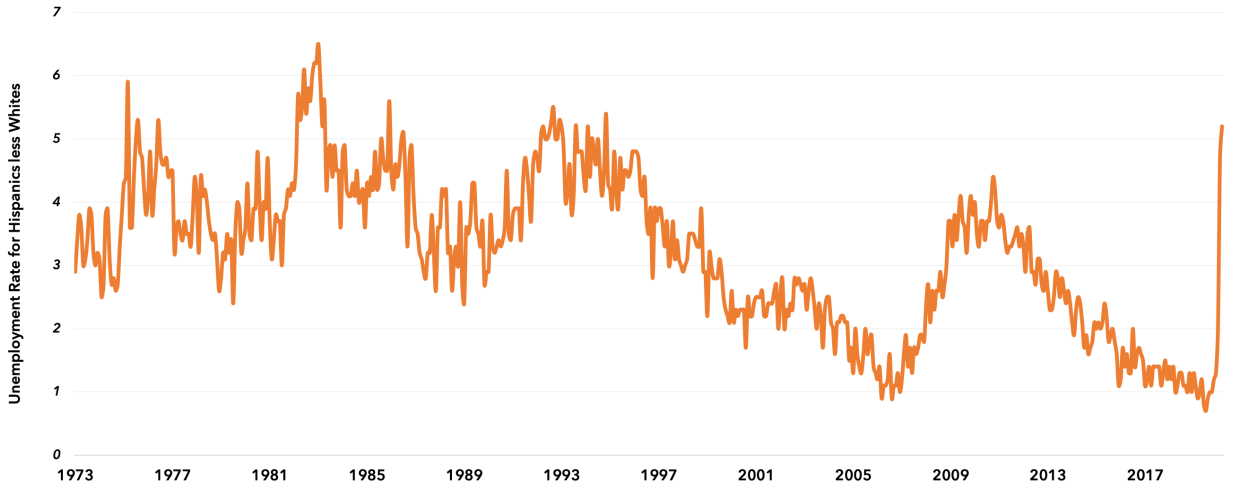


Figure 1b. Hispanic Unemployment Rate Minus White Unemployment Rate, 1973–2020



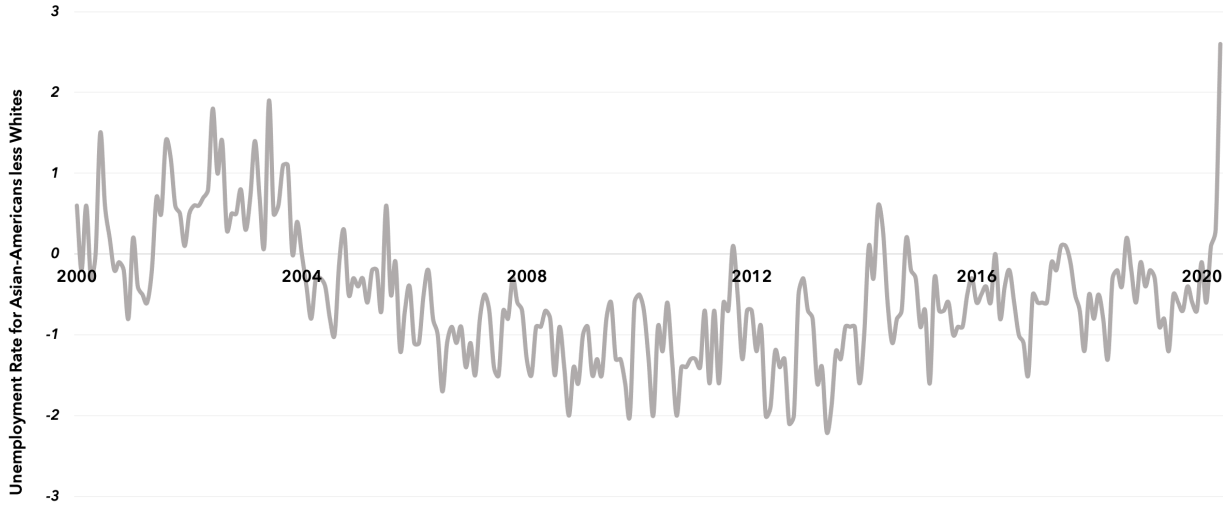
Lockdowns have widened the disparities between white vs. black and Hispanic unemployment. Hourly-wage workers, who are disproportionately non-white, were most harmed by economic lockdowns that forced small businesses to close. *(Source: Bureau of Labor Statistics; Graphics: A. Roy / FREOPP)*

INTRODUCTION

Prior to the COVID-19 pandemic, important measures of economic inequality were in decline. The overall unemployment rate reached a record low in the second half of 2019, and disparities between white and non-white unemployment also reached record lows during this period. Unfortunately, the economic lockdowns imposed by state and local governments have obliterated these gains.

Furthermore, extended lockdowns have led Congress to increase federal spending by trillions of dollars, further destabilizing the federal budget. The fiscal reckoning to come will disproportionately harm economically vulnerable Americans, by increasing unemployment through higher taxes, and by requiring reductions in federal spending that may harm those who most depend on government assistance.

Figure 2. Asian Unemployment Rate Minus White Unemployment Rate, 2000–2020



The disparity between the Asian and white unemployment rates has reached a record high. For most of the 21st century, Asians have enjoyed a lower unemployment rate than whites. That changed during the COVID-19 pandemic. *(Source: Bureau of Labor Statistics; Graphics: A. Roy / FREOPP)*

ECONOMIC LOCKDOWNS HAVE HARMED MINORITIES

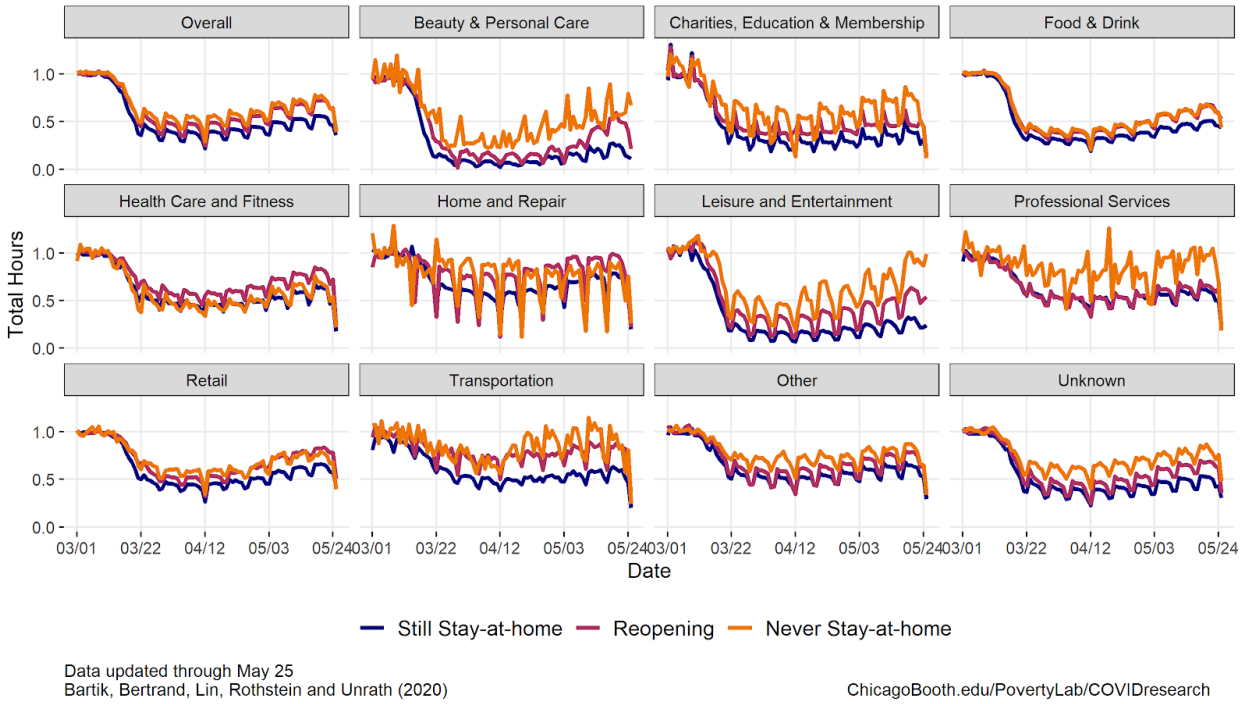
Prior to the pandemic, unemployment rates for all racial and ethnic groups reached record lows. In August of last year, black unemployment fell to 5.4 percent: the lowest rate ever recorded. The following month, Hispanic unemployment hit a record low of 3.9 percent. And in June of that year, Asian unemployment hit a record low of 2.1 percent.

The economic lockdowns have destroyed those gains. Today, the unemployment rates for whites, blacks, Hispanics, and Asians are 12.4, 16.8, 17.6, and 15.0 percent, respectively.

Notably, last fall, the disparities between white and black unemployment, and between white and Hispanic unemployment, also fell to record lows. Over the last five decades, the association is clear: a strong economy most benefits minorities, and a worsening economy most harms them.

For most of the 21st century, Asian-Americans have enjoyed a lower unemployment rate than whites. But since the lockdown, Asians have faced record unemployment.

Figure 3. Hourly Wage Reductions by Industry and Economic Lockdown Policies



Data updated through May 25
Bartik, Bertrand, Lin, Rothstein and Unrath (2020)
ChicagoBooth.edu/PovertyLab/COVIDresearch

Racial and ethnic minorities have been disproportionately harmed by economic lockdowns. Blue-shaded curves represent work reductions for those in lockdown states; red and orange curves represent reopening and open states, respectively. *(Source: A. Bartik et al., University of Chicago)*

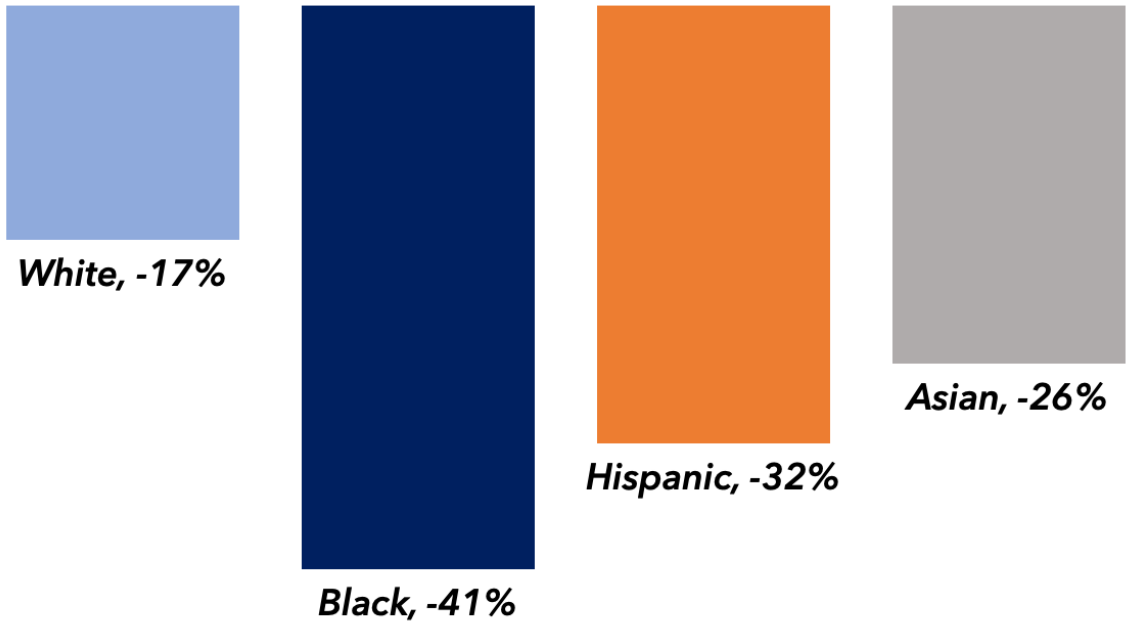
These disparities are in part caused by the fact that racial and ethnic minorities make up a disproportionate share of hourly wage earners; 25% are Hispanic, 15% are black, and 5% are Asian. In contrast, for the overall workforce, 17% are Hispanic, 13% are black, and 6% are Asian.[1] [2]

[1] M. Ross and N. Bateman, Meet the Low-Wage Workforce. The Brookings Institution. 2019 Nov: https://www.brookings.edu/wp-content/uploads/2019/11/201911_Brookings-Metro_low-wage-workforce_Ross-Bateman.pdf; accessed June 9, 2020.

[2] Bureau of Labor Statistics, Labor force characteristics by race and ethnicity, 2018. 2019 Oct: https://www.bls.gov/opub/reports/race-and-ethnicity/2018/home.htm; accessed June 9, 2020.

While many white workers are in white collar professions in which remote work is possible, blacks and Hispanics often work in hourly-wage jobs where in-person attendance is essential. Researchers at the University of Chicago's Rustandy Center for Social Sector Innovation have found that hourly-wage workers have seen their hours cut by 50 percent in states that have continued to lock down their economies. In states that have reopened their economies, by contrast, hourly work is recovering.[3] Racial and ethnic minorities, unfortunately, live in many states where lockdowns have continued.

Figure 4. Reduction in Small Business Activity, by Ownership, February–April 2020



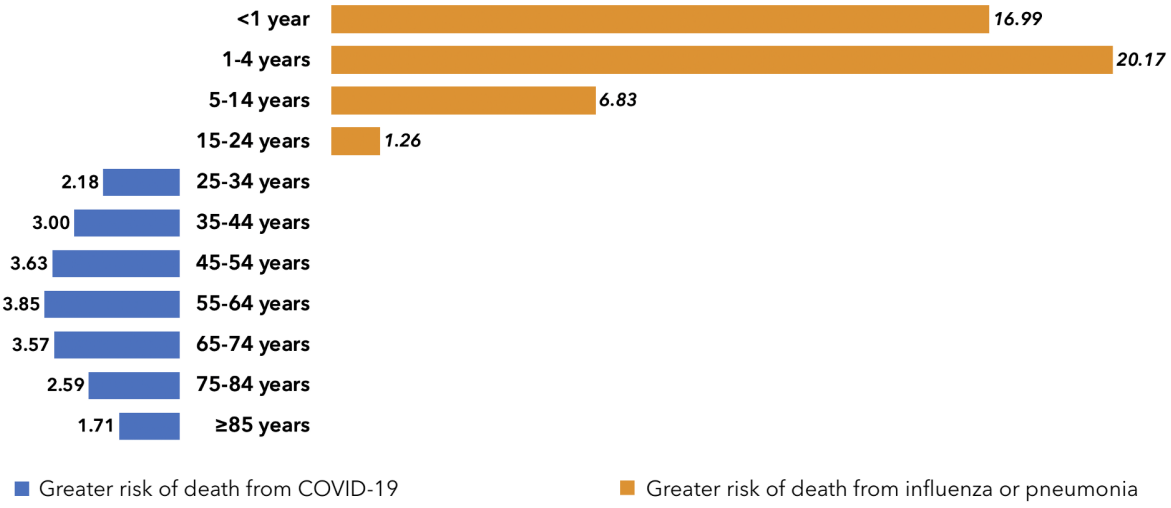
Minority-owned businesses have been disproportionately harmed by the COVID-19 lockdowns. In particular, businesses owned by African-Americans have seen substantial losses. *(Source: R. Fairlie, National Bureau of Economic Research)*

Small businesses have also been hammered by the policy response to COVID-19. A new working paper by Robert Fairlie of the University of California, Santa Cruz, estimates that "the number of active business owners in the United States plummeted by 3.3 million or 22 percent over the crucial two-month window from February to April 2020." Black-owned

[3] A. Bartik, M. Bertrand, F. Lin, J. Rothstein, & M. Unrath, Week 7 and 8: Labor Market Impacts of COVID-19 on Businesses: Update with Homebase Data Through May 23. University of Chicago: https://www.chicagobooth.edu/research/rustandy/blog/2020/week-7-labor-market-impacts-from-covid19; accessed June 3, 2020.

businesses fell 41 percent, Hispanic-owned businesses 32, percent, and Asian-owned businesses 26 percent. Immigrant-owned businesses dropped by 36 percent.[4]

Figure 5. Estimated Relative Risk of Death from Influenza vs. COVID-19
(Assuming 150,000 Total COVID-19 Deaths)



Those under aged 25 are at the lowest risk of death from COVID-19. A clear pattern emerges from what we know, in which those under aged 25 are at the lowest risk of death from COVID-19, relative to influenza or pneumonia. *(Source: A. Roy, FREOPP.org)*

LOCKDOWNS WIDEN EDUCATIONAL DISPARITIES

A necessary step to allow the nation to go back to work is to reopen K-12 schools, preschools, and child care centers. Beyond their mission of providing learning opportunities, K-12 schools, preschools and child care centers allow their parents to work.

Reopening the nation's education and child care programs is also important to ensure that American children continue to learn, and particularly to help children from lower-income families who often have fewer opportunities to learn outside of school. Researchers have found that differences in outside of school learning opportunities contribute to the academic achievement gap between rich and poor children.[5] The current situation is likely

[4] R. Fairlie, The Impact of Covid-19 on Small Business Owners: Evidence of Early-Stage Losses from the April 2020 Current Population Survey. National Bureau of Economic Research. 2020 Jun: https://www.nber.org/papers/w27309.pdf; accessed June 9, 2020.
[5] J. McCombs et al., Making Summer Count. RAND Corporation: 2011: https://www.rand.org/content/dam/rand/pubs/monographs/2011/RAND_MG1120.pdf; accessed June 19, 2020.

exacerbating this opportunity gap, particularly since poor children are less likely to have internet access at home.[6]

Widespread school closures have other negative consequences for the nation's children, and particularly those from low-socioeconomic backgrounds. For example, American schools provide food to more than half of the school aged population. Nearly 30 million children receive free or reduced-price lunch through the National School Lunch Program. (While most children will not go hungry without free or subsidized meals, children from the poorest families could be affected by the lack of regular access to these services.) Schools and child care centers also play a critical role in state child welfare systems and supporting children's health.

In addition, other student populations, including children with special needs and English language learners, suffer from school closures and the lack of specialized instruction outside of school.

Beyond these direct educational effects, widespread closures are having significant impacts on school systems. For example, dozens of private schools are closing due to the loss of revenue and families' inability to afford tuition after the pandemic. These closures may increase the burdens on traditional public school systems as private school students enroll in public schools. (A coalition of organizations that support choice in education estimated that public schooling costs will increase by $15 billion if 20 percent of private school students enroll in public schools.) Moreover, many states are projecting revenue shortfalls due to the pandemic and economic downturn.

American policymakers and school leaders have an opportunity to study and learn from international examples, particularly as several nations have already reopened and are operating their school systems. Schools in other countries are applying a range of tactics to protect public health, such as modifying school calendars and schedules, promoting social distancing, keeping windows open to improve ventilation, and checking students' temperatures.

The good news is that children and young adults are at extremely low risk of dying of COVID-19, as detailed in Figures 2 and 11.

State and local policymakers must quickly work to develop two distinct but aligned education systems: (1) a physical school system for in-person learning consistent with public health guidance, and (2) a virtual or distance learning that supports all children's options to learn at-home or outside of the traditional school setting. A forthcoming paper from the Foundation for Research on Equal Opportunity, co-authored by Dan Lips, Preston Cooper, and Avik Roy, among others, will explore these questions in detail.

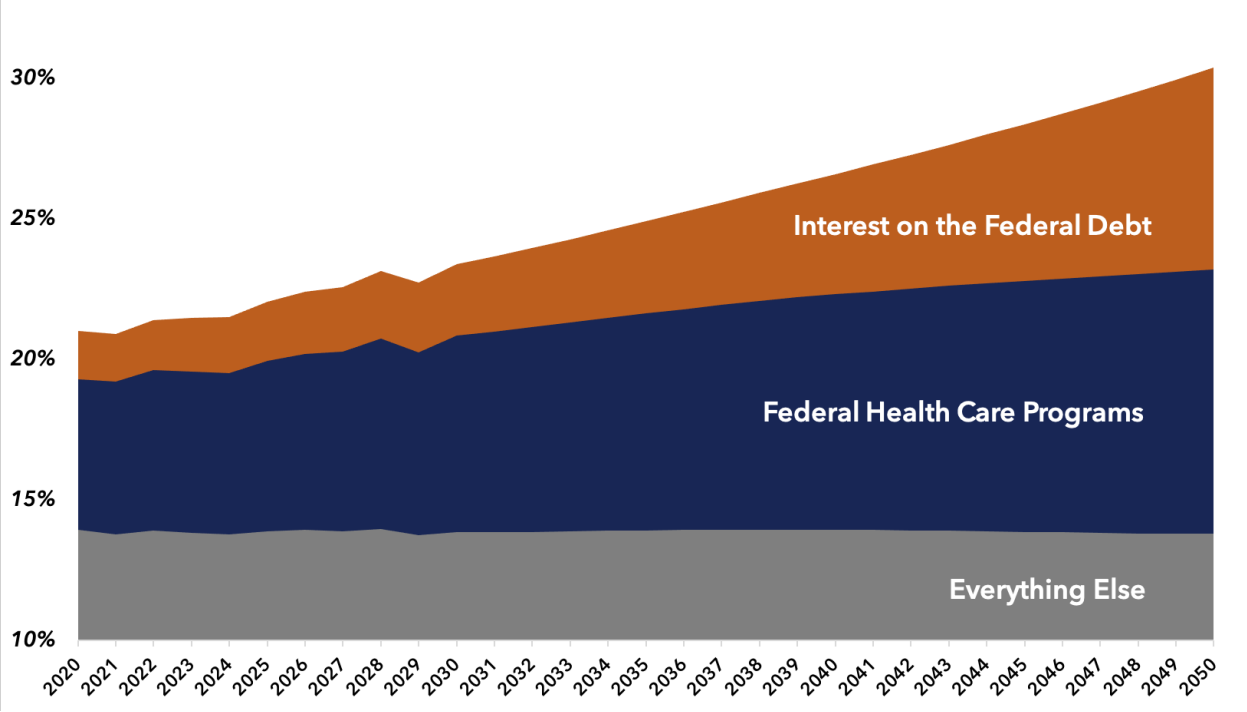
RISING FEDERAL DEBT HARMS LOW-INCOME AMERICANS

Congress has enacted several major pieces of legislation in order to compensate for economic lockdowns, most notably the Coronavirus Aid, Relief, and Economic Security Act

[6] National Center for Education Statistics. Table 218.70: Number and percentage distribution of 5- to 17-year-old students, by home internet access, poverty status, and locale: 2017. https://nces.ed.gov/programs/digest/d18/tables/dt18_218.70.asp?current=yes; accessed June 19, 2020.

of 2020. In total, these bills have increased the federal debt by over $2 trillion.[7] Continued lockdowns will increase pressure on Congress to enact further deficit-increasing legislation.

Figure 6. CBO: Long Term Budget Projections, 2020–2050



Medicare, Medicaid, and interest on the debt drive unsustainable federal spending. As a share of gross domestic product, growth in federal health care programs and interest on the debt drive all federal spending as a share of economic output. The trillions in COVID-19 economic relief passed by Congress further destabilize the federal budget. *(Source: Congressional Budget Office)*

Material increases in the federal debt further destabilize what is already a dangerous situation, in which federal health care entitlements like Medicare and Medicaid, along with interest payments, overwhelm the ability of the federal government to collect sufficient revenue. If demand for U.S. Treasury bonds declines on account of decreased U.S. creditworthiness, such that Congress must enact substantial austerity measures, it will be low-income Americans who will bear the greatest burden.

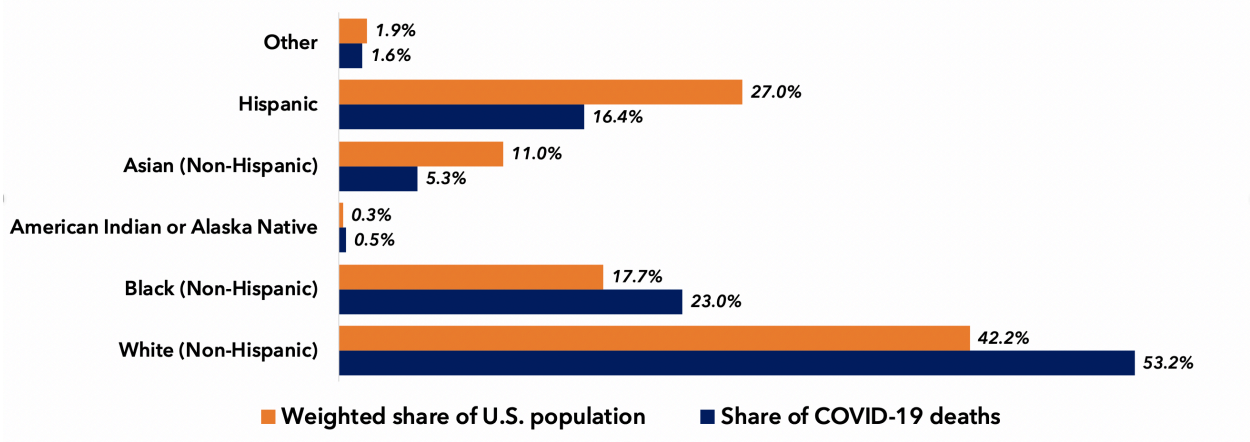
First, if Congress significantly raises taxes in order to reduce the debt, the resulting shrinkage of the economy will most harm economically vulnerable Americans, as shown above, through rising unemployment.

[7] Congressional Budget Office. H.R. 748, CARES Act, Pubic Law 116-136. 2020 Apr 16: https://www.cbo.gov/publication/56334; accessed June 20, 2020.

Second, reductions in federal spending will most harm those who most depend on that spending, such as Medicare and Medicaid beneficiaries.

Hence, it is essential that Congress consider ways to pay for the recent COVID-19 relief packages, and also avoid further destabilizations of the federal budget. One small contribution to that effort would be the enactment of the Prescription Drug Pricing Reduction Act reported by the Senate Finance Committee in the summer of 2019, which the Congressional Budget Office projects as reducing federal spending by $94 billion from 2021–2030.[8]

Figure 7. CDC: Share of COVID-19 Fatalities by Race & Ethnicity, vs. Geographically Weighted Share of U.S. Population



Racial and ethnic distribution of COVID-19 fatalities is mixed. Whites and blacks are both overrepresented in their share of COVID-19 deaths, relative to their geographically adjusted share of the U.S. population. In contrast, Asians and Hispanics are underrepresented in their share of COVID-19 fatalities. *(Source: Centers for Disease Control and Prevention)*

RACIAL DISPARITIES IN COVID-19 MORTALITY ARE MIXED

On a population level, both whites' and blacks' shares of COVID-19 deaths are higher than one would expect if deaths were evenly racially distributed. On the other hand, Asians' and Hispanics' shares of COVID-19 deaths are lower than one would expect. For example, whites represent 53 percent of all COVID-19 deaths, but only 42 percent of a geographically adjusted population. 23 percent of fatalities are among blacks, while blacks represent 18 percent of the geographically adjusted population.[9]

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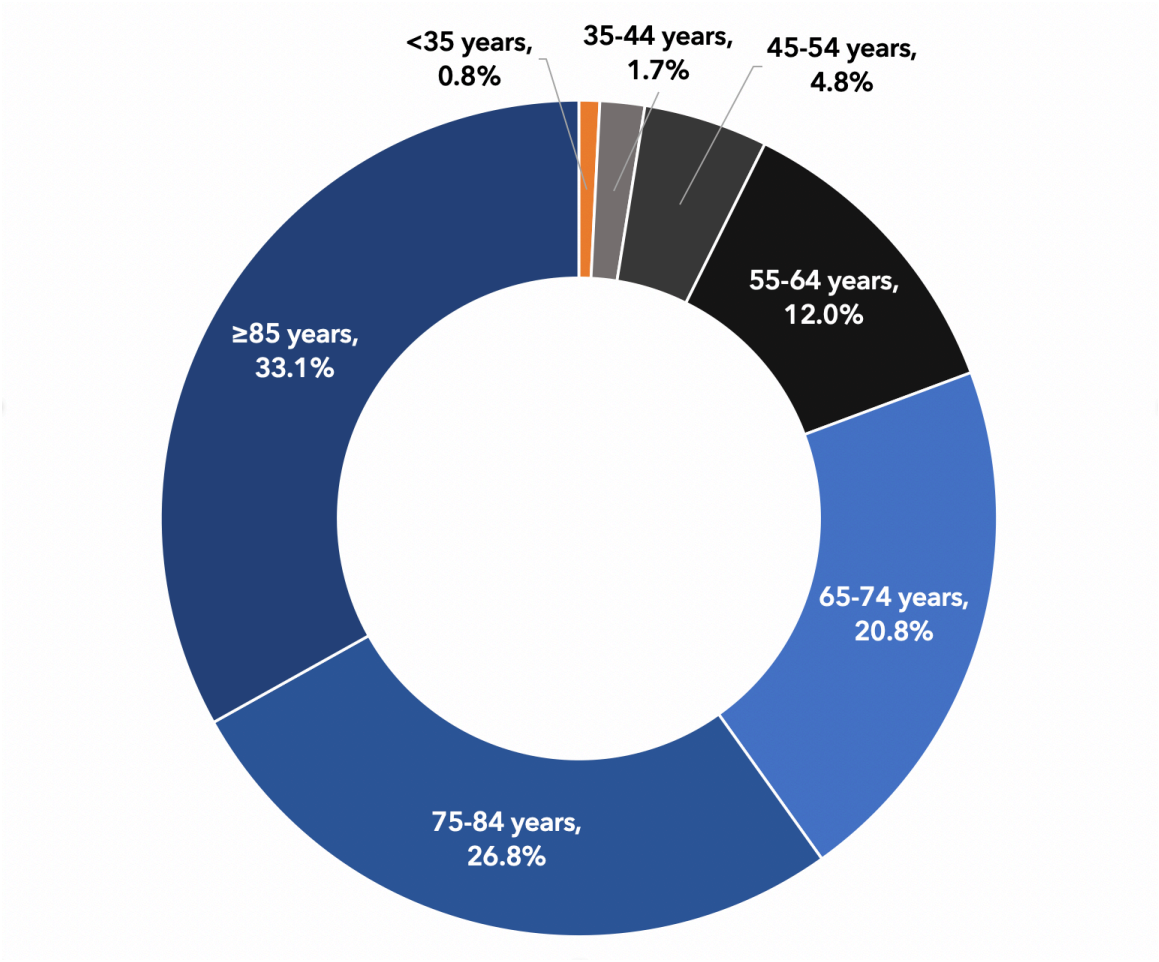
[8] Congressional Budget Office. Prescription Drug Pricing Reduction Act of 2019. 2019 Dec 6: https://www.finance.senate.gov/imo/media/doc/2020-03-13%20PDPRA-SFC%20CBO%20Table.pdf; accessed June 20, 2020.

[9] Centers for Disease Control and Prevention. Weekly Updates by Select Demographic and Geographic Characteristics. https://www.cdc.gov/nchs/nvss/vsrr/covid_weekly/; accessed June 3, 2020.

Figure 8. Share of COVID-19 Fatalities by Age Bracket



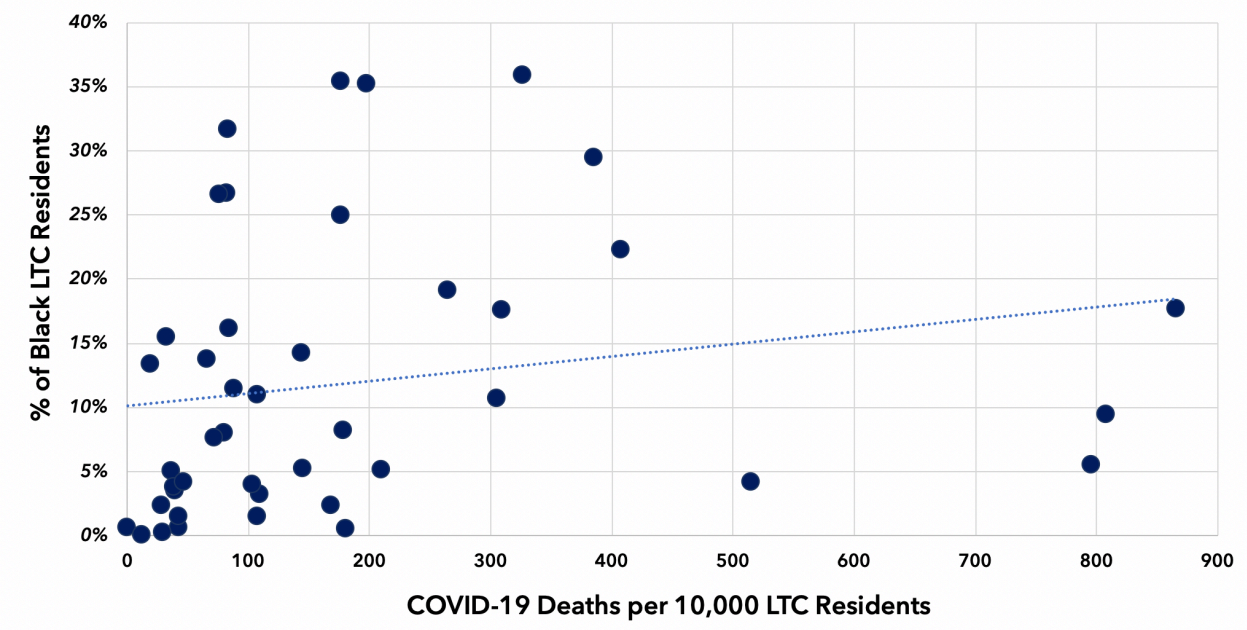
COVID-19 mortality is heavily skewed toward those over 65. 81 percent of all deaths from COVID-19 have occurred among those 65 and older. Those under 35 years of age represent 0.8 percent of deaths.. *(Sources: CDC, FREOPP analysis)*

(The Centers for Disease Control and Prevention geographically adjust racial and ethnic groups' shares of the U.S. population in order to take into account the fact that COVID-19 fatalities are concentrated in cities, where a higher percentage of the overall population is non-white.)

The most probable explanation for most of these differences is related to age. Serious illness and death from COVID-19 are highly concentrated among the elderly. 81 percent of all U.S. COVID-19 deaths have taken place among those aged 65 or older; by contrast, only 0.8 percent of U.S. COVID-19 deaths have taken place among U.S. residents younger than 35. This is important to account for, because while the median age of white Americans is 44, for Asians it is 37, and for Hispanics it is 30. In other words, the disparity in share of deaths

relative to whites, Hispanics, and Asians may turn out to be mostly explained by age differences, even though working-age adults represent a higher share of COVID-19 deaths among non-white racial and ethnic groups.

Figure 9. No Correlation Between Long-Term Care COVID-19 Fatality Rates and State-Level African-American LTC Resident Share



At the state level, there is no correlation between African-American race and mortality in nursing homes and assisted living facilities. States with high black population shares in nursing homes and assisted living facilities were not correlated to those with high levels of black mortality. The r^2–the probability of a linear correlation–was only 3.5%. *(Sources: Brown University, FREOPP analysis)*

The same explanation does not fully apply to blacks. The median age of African-Americans is 34—somewhere in between that of Hispanics and Asians—but blacks suffer from a disproportionate share of COVID-19 mortality.

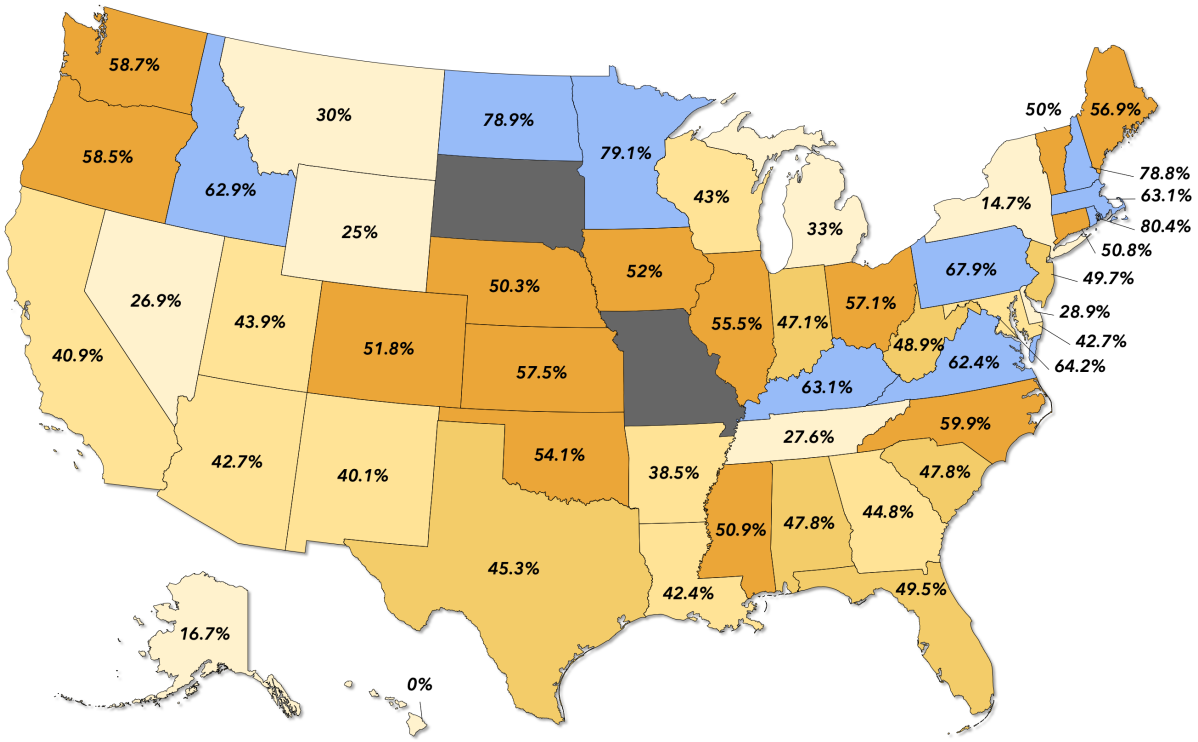
Further data from the CDC, breaking out racial and ethnic shares by age bracket, should help us learn more about these differences, though in our view that data is not yet mature enough for us to draw firm conclusions.

LTC FACILITIES: 43% OF COVID-19 DEATHS, BUT 0.6% OF THE POPULATION

Another source of racial disparities in COVID-19 health outcomes may come from nursing homes and assisted living facilities. Nursing homes, in particular, serve disproportionately

poor individuals, with a large number of Medicaid enrollees. Vulnerable seniors residing in such long-term care facilities represent 43 percent of U.S. COVID-19 fatalities, while residents of such facilities only account for 0.6 percent of the total U.S. population.[10]

Figure 10. COVID-19 Deaths in Long-Term Care Facilities as a Share of Total COVID-19 Deaths (as of June 19, 2020)



0.6% of Americans live in long-term care facilities that account for 42% of all COVID-19 deaths. In some states, this tragedy was compounded by policies that forced nursing homes to accept patients infected with the novel coronavirus SARS-CoV-2. *(Source: G. Girvan and A. Roy, FREOPP.org)*

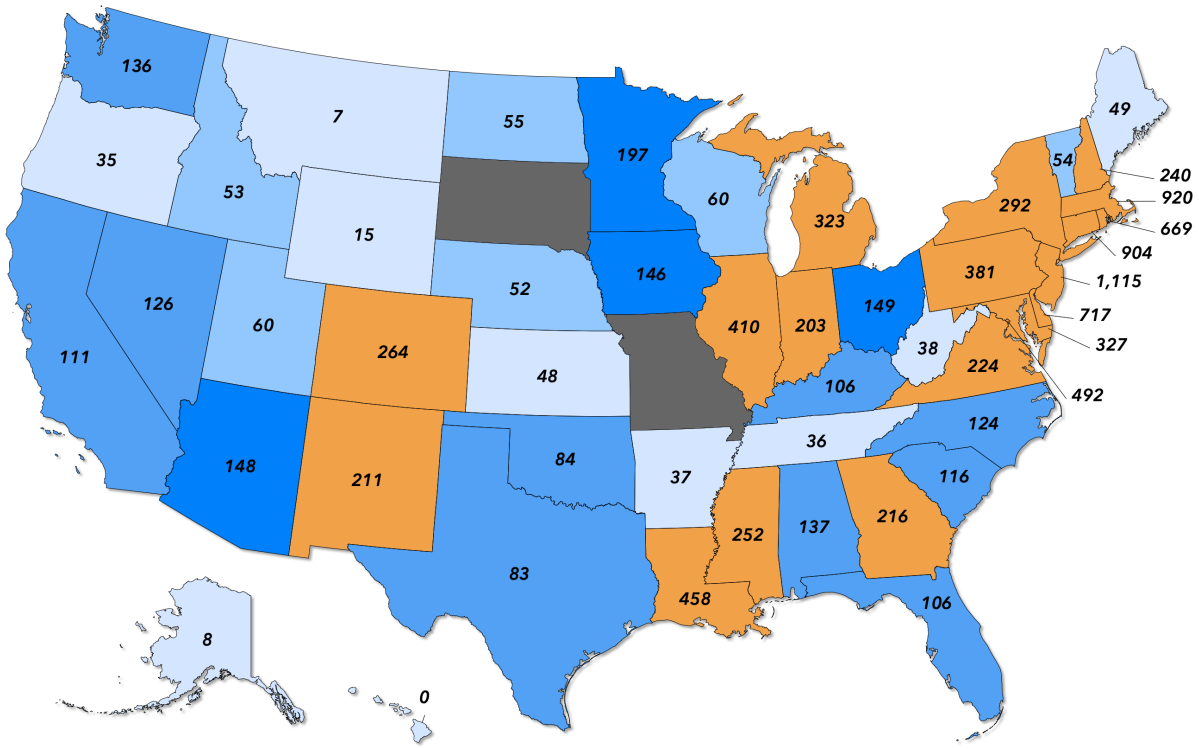
In part this is due to disastrous decisions taken by some state governors to force nursing homes to accept COVID-infected patients who had been discharged from a hospital, including New York, New Jersey, and Michigan.[11] This catastrophic policy helped spread

[10] G. Girvan and A. Roy, Nursing Homes & Assisted Living Facilities Account for 42% of COVID-19 Deaths. The Foundation for Research on Equal Opportunity. 2020 May 7: https://freopp.org/the-covid-19-nursing-home-crisis-by-the-numbers-3a47433c3f70?source=collection_home---1------0----------; accessed June 3, 2020.

[11] A. Roy, The Most Important Coronavirus Statistic: 42% of U.S. Deaths Are From 0.6% Of The Population. *Forbes*. 2020 May 26: https://www.forbes.com/sites/theapothecary/2020/05/26/nursing-homes-assisted-living-facilities-0-6-of-the-u-s-population-43-of-u-s-covid-19-deaths/#232a01f074cd; accessed June 3, 2020.

COVID-19 in long-term care facilities, leading to needless deaths and additional hospitalizations that we then asked our health care personnel to take on.

Figure 11. COVID-19 Deaths in Long-Term Care Facilities per 10,000 Long-Term Care Residents (as of June 19, 2020)



COVID-19 deaths in nursing home and assisted living facilities are concentrated in the Northeast. In New Jersey, more than one in ten long-term care facility residents have died of the novel coronavirus. *(Source: G. Girvan and A. Roy, FREOPP.org)*

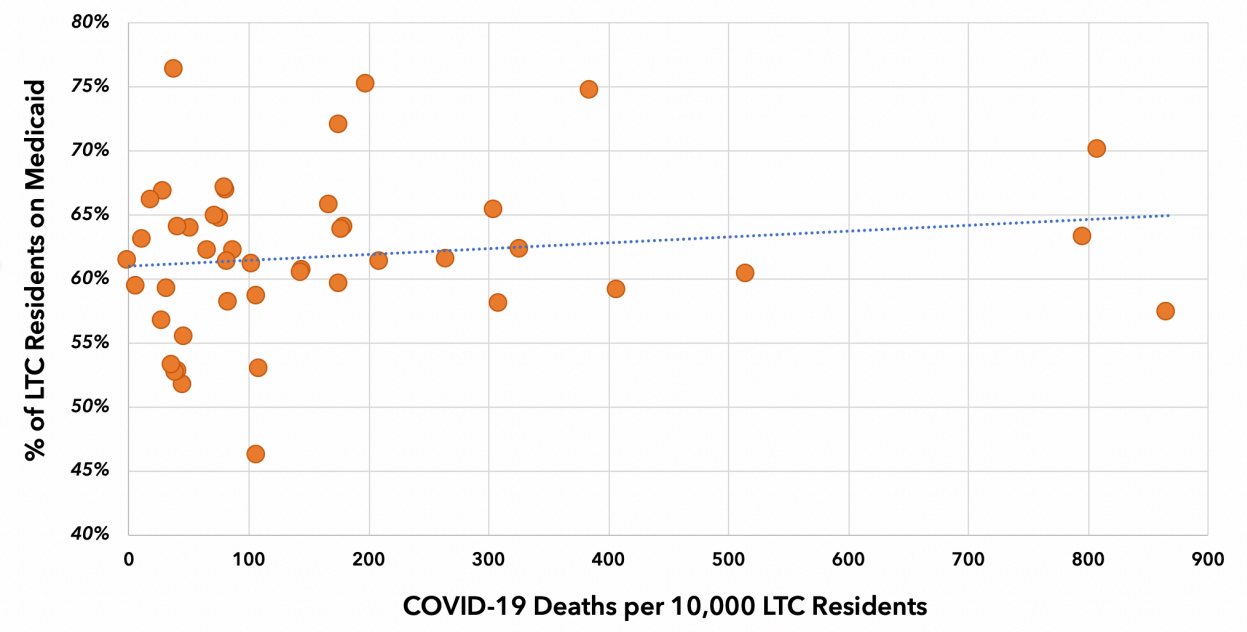
In order to examine racial disparities in COVID-19 deaths in nursing homes, Gregg Girvan and I looked at state-level long-term care facility mortality rates, and compared them to the percentage of blacks living in long-term care facilities, and also the relationship between nursing home mortality and Medicaid eligibility.

There was no correlation between black race and state-level long-term care fatalities. The r^2—the probability of a linear relationship between high black population and high long-term care death rates—was only 3.5 percent. Similarly, there was no correlation between states with high Medicaid enrollment and those with high COVID-19 mortality rates in their assisted living facilities; the probability of a linear correlation was only 2.3 percent.

This finding was surprising, because we would expect to see that nursing homes with a high volume of low-income patients would fare worse under COVID-19. We aim to investigate

this question further, at the county level, in order to determine if the correlations are stronger within states.

Figure 12. No Correlation Between Long-Term Care COVID-19 Fatality Rates and State-Level Medicaid LTC Resident Share



At the state level, there is no correlation between enrollment in Medicaid and COVID-19 mortality in nursing homes and assisted living facilities. States with high Medicaid enrollment in nursing homes and assisted living facilities were not correlated to those with high levels of COVID-19 mortality. The r^2—the probability of a linear correlation—was only 2.3%. *(Sources: Brown University, FREOPP analysis)*

One explanation for this finding could be that nursing home and assisted living facility residents are, as a group, vulnerable to the coronavirus pandemic, and that therefore African-American resident share is less impactful on overall long-term care mortality statistics.

ECONOMIC LOCKDOWNS IMPACT PUBLIC HEALTH

It is essential and urgent that states and localities do everything possible to responsibly reopen their economies.[12] We can do this by focusing on protecting high-risk populations,

[12] L. Chen, B. Kocher, A. Roy, & B. Wachter, A New Strategy for Bringing People Back to Work During COVID-19. The Foundation for Research on Equal Opportunity. 2020 Apr 14: https://freopp.org/a-new-strategy-for-bringing-people-back-to-work-during-covid-19-a912247f1ab5; accessed June 3, 2020.

like the elderly in nursing homes; reopening schools; and reopening workplaces where it is safe to do so, especially for low-risk workers.

Economic lockdowns do not merely have a financial impact on racial and ethnic minorities who lose their jobs or have their hours cut. Economic dislocation also worsens health outcomes in myriad ways, whether by deaths of despair, inability to access or afford physicians, or disruption in health insurance coverage.

Reopening the economy is not merely about livelihoods, but also about lives.

APPENDIX: REOPENING THE U.S. ECONOMY EVEN IF THE PANDEMIC ENDURES

Avik Roy, The Wall Street Journal, April 24, 2020

As the Covid-19 shutdown enters its second month, policy makers and commentators have emphasized that we're not yet out of the woods. Deaths and hospitalizations are continuing to rise, albeit more slowly than before. The flattening curves have encouraged some people to talk about reopening the economy, and others to rise in protest against ongoing restrictions, but most Americans remain cautious. We've been willing to endure the staggering economic damage because we're convinced that it's necessary for public health—and that the lockdowns won't last too long.

Indeed, a kind of conventional wisdom has emerged among public health officials and policy experts. We're told that life will go back to normal just as soon as we've reached a series of public health milestones: near-universal testing, the development of effective treatments, the emergence of herd immunity and, ultimately, approval of a vaccine.

But this conventional wisdom has a critical flaw. We've taken for granted that our ingenuity can solve almost any problem. But what if, in this case, it can't? What if we can't scale up coronavirus testing as quickly as we need to? What if it takes us six or 12 months, instead of three, to identify an effective treatment for Covid-19? What if those who recover from the disease fail to gain immunity and are therefore susceptible to getting reinfected? And what if it takes us years to develop a vaccine?

Once we start asking these questions, a terrible truth becomes clear: The scenario in which we meet all the public health milestones, and then return to our regularly scheduled economic programming, is highly optimistic. A more realistic scenario is that we will fail to reach one or more of the milestones. If that happens, do we prolong the economic shutdown for six months or longer? Do we impose a series of on-and-off stay-at-home orders that could go on for years?

The damage from a prolonged economic shutdown is difficult to contemplate. Tens of millions of Americans have already lost their jobs. Countless small businesses have closed—many for good. Two months ago, 20% unemployment seemed unthinkable. Two months from now, 20% unemployment might seem like the good old days.

Americans are optimistic by nature, and the public is right to hope for the best. But policy makers must prepare for the worst. And that means we must consider options for reopening the economy in a world in which we have not completely controlled the Covid-19 pandemic.

Time is of the essence. Every week matters. A 2016 study by the JPMorgan Chase Institute found that the median small business holds just 27 days' worth of cash in reserve. For restaurants, retail shops and construction firms, the buffer is even thinner.

The good news is that there are ways to get America back to work while we control the spread of SARS-CoV–2, the novel coronavirus that causes Covid-19. We need to escape from the false dichotomy which insists that the only way to improve public health is by shutting down the economy and the only way to improve the economy is by sacrificing public health.

How hard will it be to achieve the conventional public health milestones? Harder than it looks.

Consider testing. There are two principal kinds of tests: those that detect if a patient has developed antibodies to the virus and those that measure viral RNA levels in a patient's

nasal secretions. Both have significant technical limitations. Antibody tests often suffer from accuracy problems and can fail to detect an active infection. Viral RNA tests are highly accurate, but most versions must be administered in a clinical setting like a doctor's office or a hospital, making them difficult to scale up.

To match the modestly high level of coronavirus testing for which South Korea has been praised, the U.S. would need to administer 7 million tests a week. We'll be fortunate if we reach half that number by September.

There's good reason to be confident that we'll eventually find an effective treatment against Covid-19. According to the Milken Institute, there are more than 150 drugs being actively tested against the disease. Some of them are likely to work. But when will we know?

The first drug to get some positive buzz was hydroxychloroquine, but in the latest published clinical trial, more patients on the drug died relative to those taking a placebo. Over the past week, remdesivir, a failed Ebola drug, was generating excitement because of positive anecdotal data out of Chicago. On Thursday, however, the World Health Organization inadvertently posted preliminary findings from a larger, randomized study, in which patients on remdesivir actually fared worse than those on a placebo.

Gilead Sciences, remdesivir's manufacturer, insists that "trends in the data suggest a potential benefit." But if future studies produce similarly negative results, we may be waiting several more months to find an effective therapy.

We'd be less dependent on treatments if more Americans could become immune to SARS-CoV-2. Most people who recover from Covid-19 develop antibodies to the virus; epidemiologists hope that these antibodies will confer protection from future reinfection. If more people can gain immunity, the virus will have a harder time spreading, eventually dying out.

But what if antibodies don't confer immunity or if the protection doesn't last very long? This is a very real possibility, based on our experience with other coronaviruses, like the original SARS from 2003 and even the common cold.

The same issue may make it hard for biotech companies to develop an effective vaccine. Vaccines are hard enough to develop in normal circumstances. After decades of trying, we still don't have vaccines against HIV or hepatitis C. The fastest vaccine ever developed for a viral infection is the Ebola vaccine, which took five years. And yet many commentators talk about developing a SARS-CoV-2 vaccine within 12 to 18 months, as if it were a piece of cake.

For these reasons, it's essential for the U.S. to move rapidly away from an unrealistic checklist of public health milestones and to focus instead on the specific biology of the new coronavirus and specific evidence of how Covid-19 spreads. If we do that, we'll find that we have better options to reopen the economy than we once believed.

The starting point for a more realistic strategy is the key fact that not everyone is equally susceptible to hospitalization and death due to Covid-19. There is considerable evidence that younger people largely avoid the worst health outcomes. According to the Centers for Disease Control and Prevention, those over the age of 65 are 22 times more likely to die of Covid-19 than those under 55.

That is not to say that younger people are invulnerable. We've seen significant numbers of deaths among those of middle age and above who suffer from chronic diseases like high

blood pressure, cardiovascular disease, diabetes and kidney failure. Men appear to have nearly twice the fatality rate of women.

Still, the much lower incidence of death among younger people warrants a reconsideration of our one-size-fits-all approach to stay-at-home policies, especially outside the hard-hit tri-state region of New York, New Jersey and Connecticut.

To start, states and localities should work as quickly as possible to reopen pre-K and K-12 schools. Children have a very low risk of falling seriously ill due to Covid-19, and the majority can and should return to school this academic year. Switzerland, for example, is planning to reopen schools on May 11, based on research showing that school closures were among the least effective measures at reducing European Covid-19 cases.

Children who live with the elderly or other at-risk individuals should continue to stay home. Teachers and staff from vulnerable populations should stay home as well, with paid leave. School districts should immediately begin to develop virtual lesson plans for those who must remain home.

Similarly, we should reopen workplaces to healthy, non-elderly individuals who don't live with vulnerable people. At-risk individuals with jobs should continue to have opportunities to work from home or to receive paid medical leave.

And we should reopen businesses that may not be "essential" but can be safely operated while maintaining appropriate physical distance between workers and customers. We should offer a fixed-dollar per-worker tax credit to employers who test their employees, thereby giving businesses an incentive to scale up testing and increase consumer confidence.

Nursing homes are at especially high risk for Covid-19. Indeed, in many European countries, roughly half of all deaths due to Covid-19 have taken place in assisted living facilities. In the U.S., the share of nursing home deaths is lower. But, disastrously, New York state has forced nursing home operators to accept previously hospitalized Covid–19 patients, exacerbating the outbreak.

We must ensure that nursing homes get all the help that they need to protect their residents, including regular testing for residents and staff. Jails and prisons will also need additional resources to manage their most crowded facilities.

While we're reopening the schools and the economy to lower-risk individuals, and protecting the vulnerable, we should make sure that we're using modern public health techniques to help slow the spread of the virus. The most important of these is contact tracing.

Once someone tests positive for Covid-19, local officials should interview the patient to see who he or she has spent time with in previous weeks. The officials can then work backward to talk to those contacts—and their contacts, and so on—to ensure that those at risk get tested and treated.

In recent months, East Asian countries like Singapore, Taiwan and South Korea have deployed a much more sophisticated version of contact tracing, in which Bluetooth or GPS-enabled smartphones help officials automatically alert those who have recently been in close contact with an infected individual. U.S. companies are working on versions of the technology, including some with robust privacy protections.

A key virtue of contact tracing is that it can work in an environment where testing for SARS-CoV-2 is far from universal. Indeed, if we succeed in encouraging people to use

contact tracing apps in the U.S., we may be able to control the spread of Covid-19 with the modest levels of testing we already have.

On April 16, President Trump unveiled his plan for reopening the economy. It improves on the conventional wisdom by setting aside comprehensive testing, effective treatment and herd immunity as absolute prerequisites for action. Still, the Trump plan is overly cautious about reopening the economy and especially schools. The president's team recommends that schools only reopen in "states and regions with no evidence of a rebound" in infections and hospitalizations.

Reopening the schools is important for the welfare of children, especially those in low-income communities, but it's also important for their parents. Think of the pharmacist single mother who can't go to work because the schools are closed and her children would be left alone at home. We might even consider extending school into the summer, so that children and parents can make up for lost time, and camps and summer programs also should be released from lockdown restrictions.

There are more things that we can do to help improve our economy. We should expand the role of telemedicine for those who cannot see their physicians in person. We should accelerate highway construction projects while road traffic is meaningfully reduced. And we should do more to restore consumer confidence in air travel.

But most of all, we have to completely change our mind-set. Instead of thinking up creative ways to force people to stay home, we should think hard every day about how to bring more people back to work.

That doesn't mean the choices are easy. Minority communities are the ones most harmed by school closures, because they often lack the resources and opportunities to educate their children in other ways. At the same time, however, a larger share of African-Americans are at high risk from Covid-19, so under a partial reopening, more black children may need to stay home to protect their families.

Similarly, a faster reopening of workplaces will require vulnerable individuals of working age to remain home. While that may feel like an inequity, getting many more Americans back to work will have beneficial effects even for those who aren't among the first to return.

Reopening the economy is not merely about livelihoods, but also about lives. All of us can see the mounting mental and emotional toll of our ongoing lockdowns, and we've learned a great deal in recent years about how high unemployment increases deaths of despair. If we keep these urgent problems in mind—and not just infection rates and case fatality ratios—we may yet find our way out of this crisis.

Mr. Roy is president of the Foundation for Research on Equal Opportunity and the co-author (with Lanhee Chen, Bob Kocher and Bob Wachter) of the foundation's "A New Strategy for Bringing People Back to Work During Covid-19," from which this essay is partially adapted.