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The Foundation *for* Research *on* Equal Opportunity

TESTIMONY BEFORE THE UNITED STATES CONGRESS

House Committee on Oversight & Reform

NO WORKER LEFT BEHIND

Bringing All Americans Back to Work While the Pandemic Endures

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June 10, 2020

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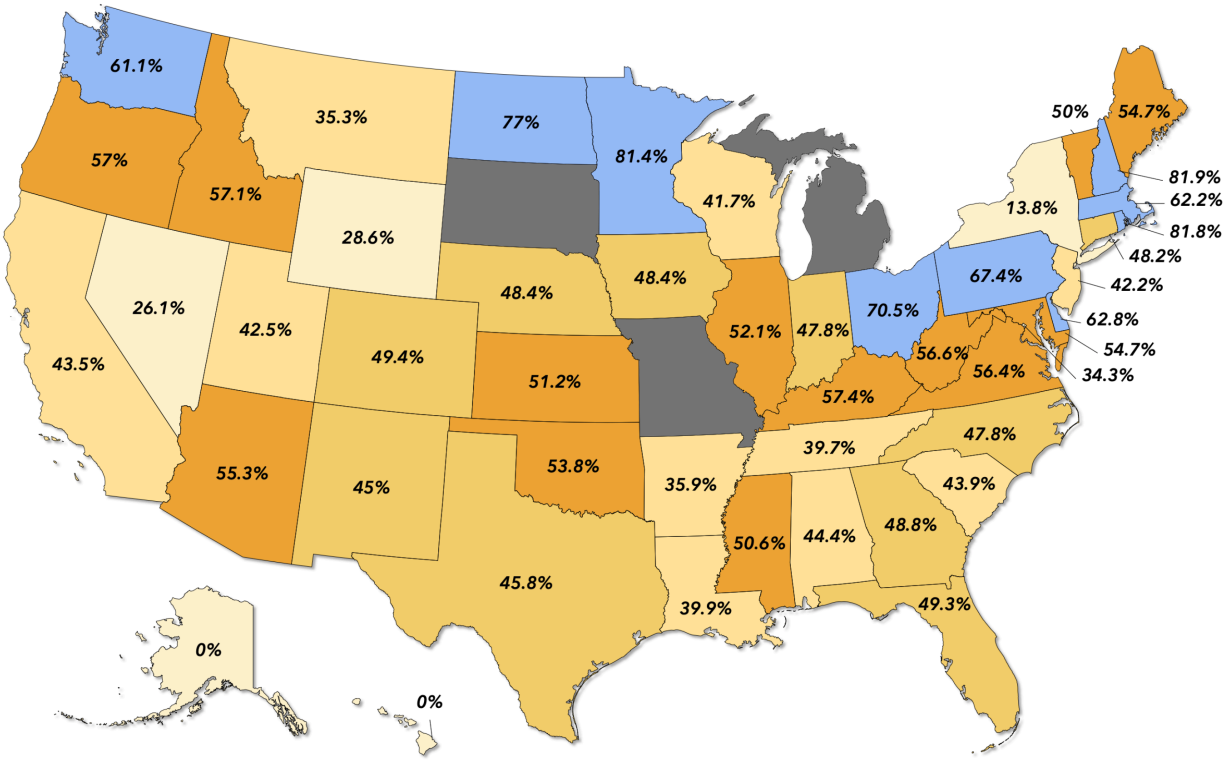
INTRODUCTION

Since March, 43 million U.S. residents have filed for unemployment benefits. Some of these workers have been deemed "essential"—but others have not. State and local governments have, by definition and by law, left tens of millions of workers behind.

All Americans are grateful for the risks that hospital staff and other first responders have taken to care for those who have fallen ill. As of June 9, of the 100,000 Americans who have died of COVID-19, the Centers for Disease Control and Prevention count 379 deaths among health care personnel.[1] Each of these deaths is tragic.

Figure 1. COVID-19 Deaths in Long-Term Care Facilities as a Share of Total COVID-19 Deaths (as of June 1, 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)*

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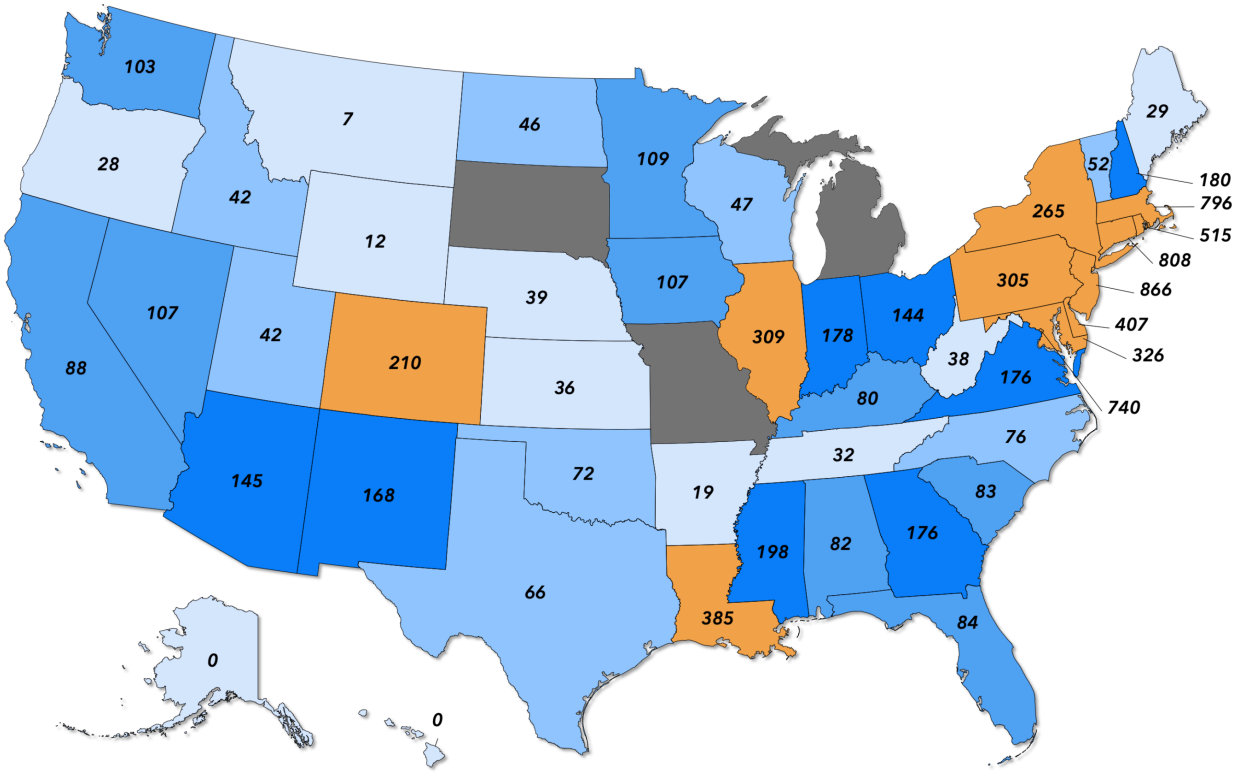
[1] Centers for Disease Control and Prevention, COVID-19: Cases in the U.S. 2020 Jun 9: https://www.cdc.gov/coronavirus/2019-ncov/cases-updates/cases-in-us.html; accessed June 9, 2020.

But it is also tragic that more than 40,000 vulnerable seniors have died of COVID-19 in nursing homes and assisted living facilities. Indeed, residents of long-term care facilities only represent 0.6% of the U.S. population, but they represent 42% of the deaths from COVID-19.

Figure 2. COVID-19 Deaths in Long-Term Care Facilities per 10,000 Long-Term Care Residents (as of June 1, 2020)



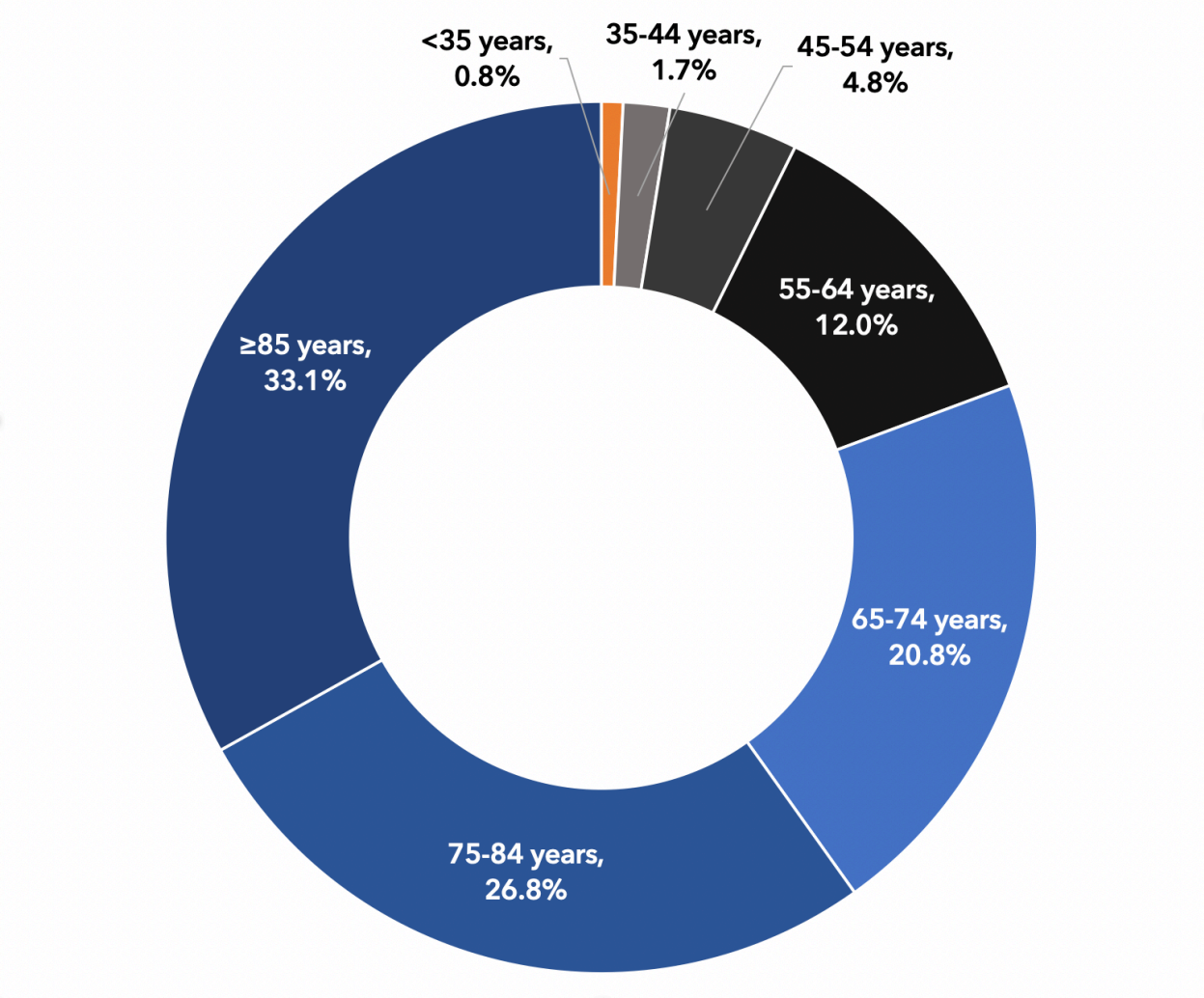
COVID-19 deaths in nursing home and assisted living facilities are concentrated in the Northeast. In New Jersey, nearly one in ten long-term care facility residents have died of the novel coronavirus. *(Source: G. Girvan and A. Roy, FREOPP.org)*

In New York, New Jersey, and Michigan, among other states, government officials forced nursing homes to accept patients with active COVID-19 infections who were being discharged from hospitals.[2] This catastrophic policy helped spread 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.

[2] 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 9, 2020.

The best way to protect our first responders is to move away from one-size-fits-all economic lockdowns, and focus our attention on those who are truly at risk for illness and death from COVID-19. This focus has the additional virtue of enabling us to leave fewer workers behind.

Figure 3. 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)*

WHO IS AT RISK FOR DEATH FROM COVID-19?

There are several key categories of high-risk individuals to whom we must be most concerned:

- *Residents of long-term care facilities.* As noted above, vulnerable seniors who live in nursing homes and assisted living facilities represent 0.6% of the U.S. population and 42% of its COVID-19 fatalities.
- *Americans over 65.* Elderly Americans represent 81% of all deaths from COVID-19. Those under 35, by contrast, represent only 0.8% of all COVID-19 fatalities.[3]
- *Middle-aged and older Americans with underlying cardiovascular or metabolic disease.* In some studies, over 90 percent of those dying of COVID-19 have an underlying chronic cardiovascular or metabolic disease, such as diabetes, heart disease, high blood pressure, or obesity.
- *Americans living in dense urban environments where the pandemic is already severe.* In particular, the stretch of the East Coast from Virginia to New Hampshire has been hard hit.

In *A New Strategy for Bringing People Back to Work During COVID-19*, a paper published by The Foundation for Research on Equal Opportunity in April, I and my co-authors provide a detailed roadmap for protecting these vulnerable populations while reopening the economy for those for whom the risk of severe illness or death is very low.[4]

For example, we recommend a surge of testing, tracing, and personal protective equipment in long-term care facilities and other places where at-risk or elderly populations congregate. At the same time, we recommend reopening schools and most workplaces, with certain precautions, because children and working-age adults are at low risk of severe illness from the novel coronavirus.

ECONOMIC LOCKDOWNS HAVE WORSENED RACIAL DISPARITIES

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.

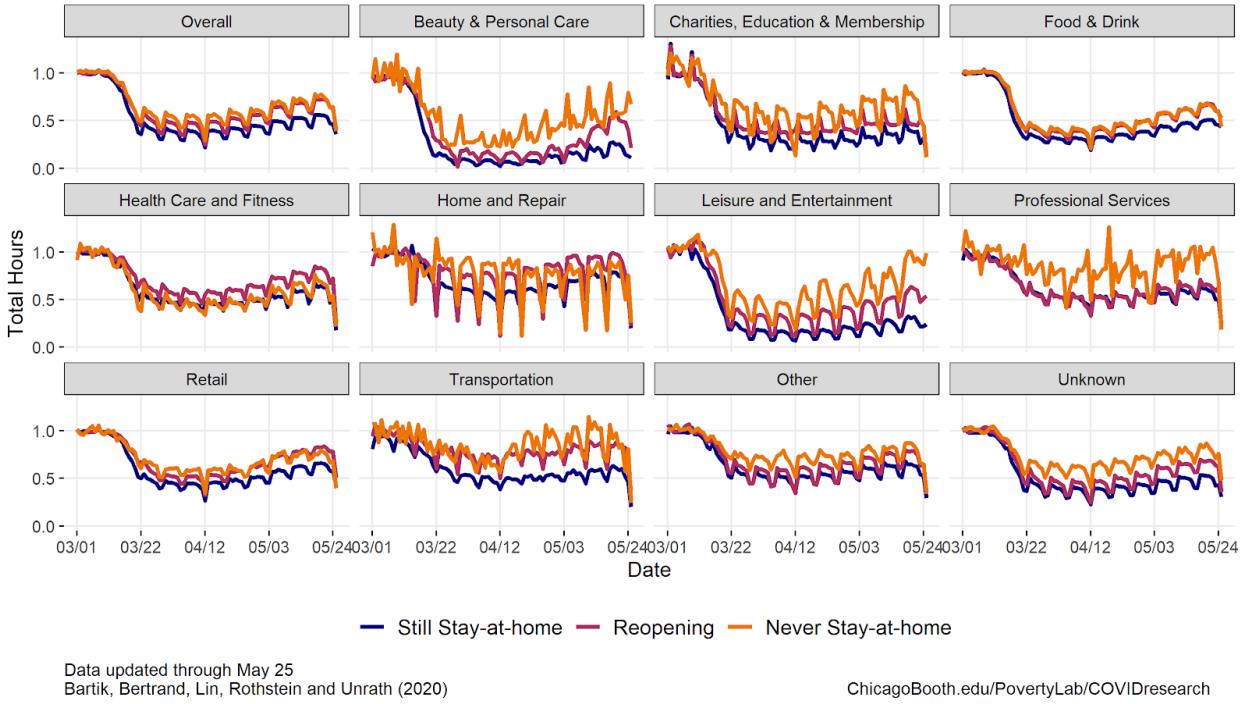
These disparities are in part caused by the fact that racial and ethnic minorities make up a disproportionate share of hourly wage earners; 25% are Hispanic, 15% are black, and 5% are

[3] 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 9, 2020.

[4] 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 9, 2020.

Asian. In contrast, for the overall workforce, 17% are Hispanic, 13% are black, and 6% are Asian.[5] [6]

Figure 4. Hourly Wage Reductions by Industry and Economic Lockdown Policies



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)*

This matters because hourly-wage workers have been badly damaged by the economic lockdowns. 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.

[5] 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.

[6] 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.

Figure 5a. Black Unemployment Rate Minus White Unemployment Rate, 1972–2020

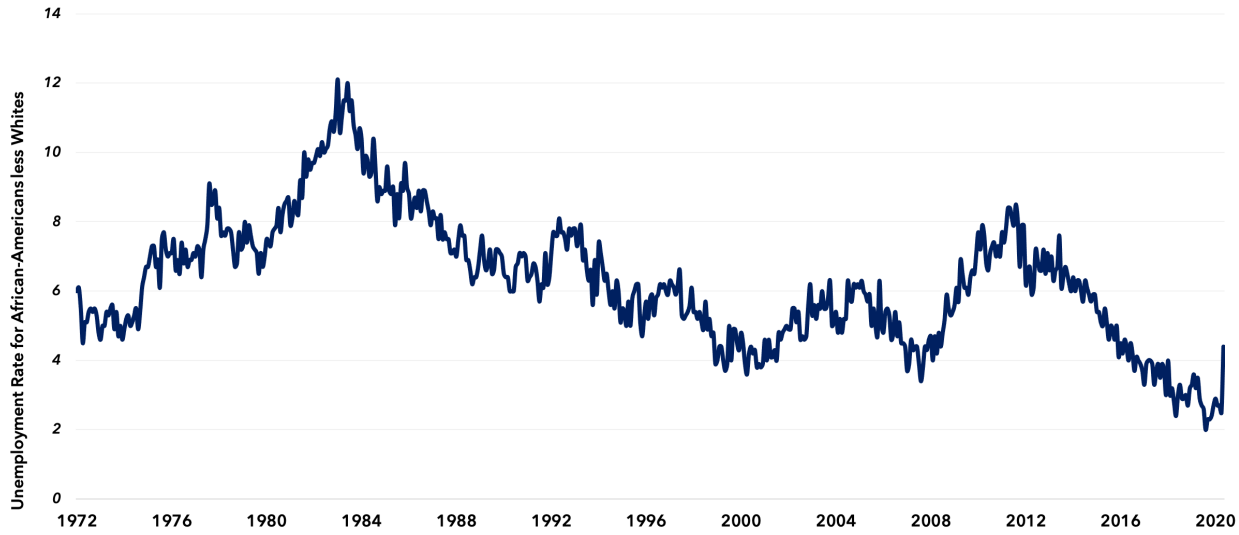
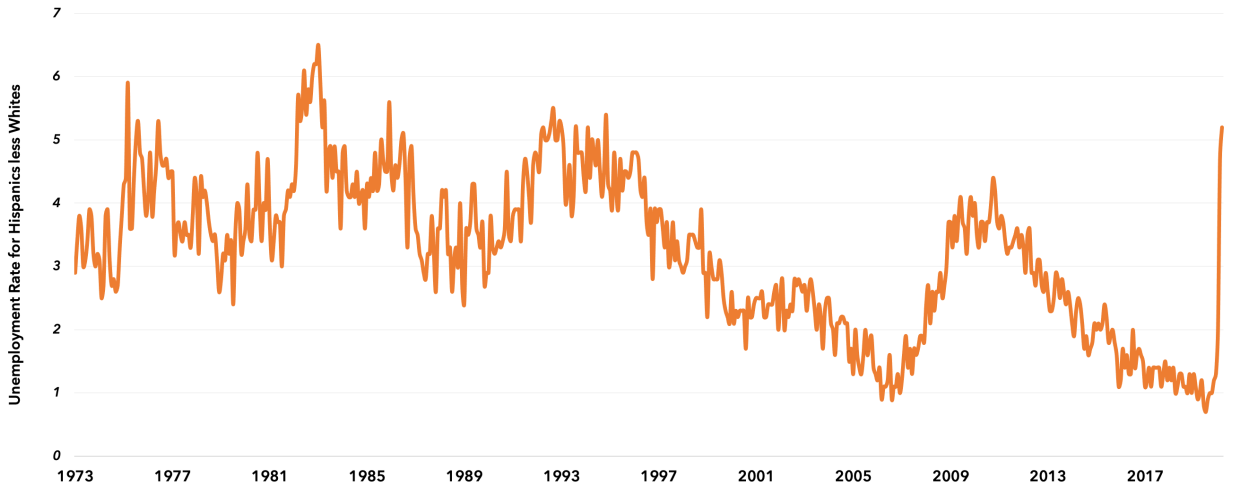


Figure 5b. Hispanic Unemployment Rate Minus White Unemployment Rate, 1973–2020

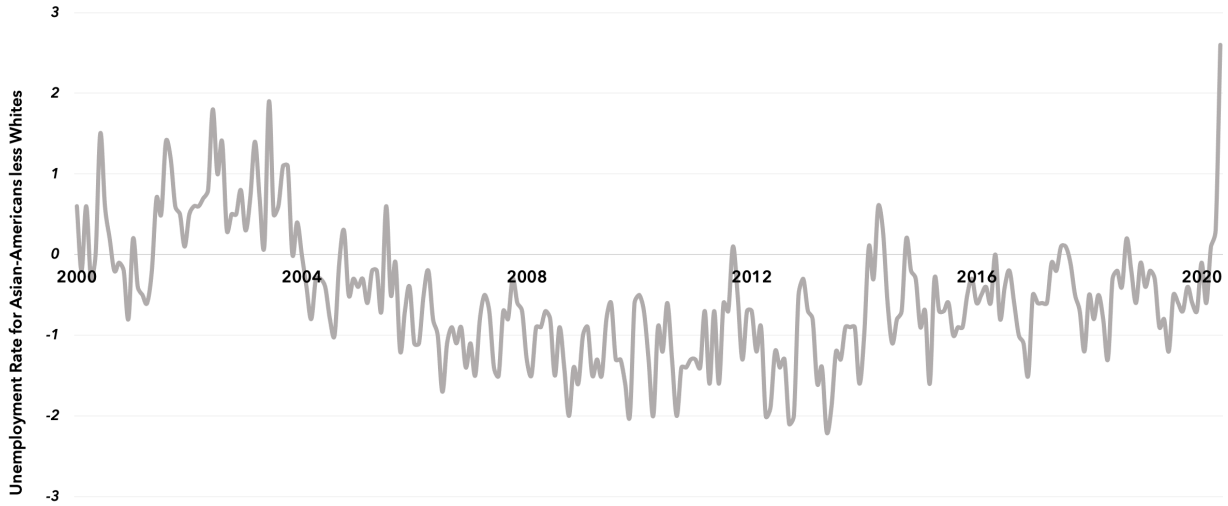


Lockdowns have dramatically increased black and Hispanic unemployment. Hourly-wage workers, who are disproportionately non-white, were most harmed by economic lockdowns that forced small businesses to close. *(Source: Bureau of Labor Statistics; Graphics: A. Roy / FREOPP)*

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.[7] Racial and ethnic minorities, unfortunately, live in many states where lockdowns have continued.

Figure 6. 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)*

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 businesses fell 41 percent, Hispanic-owned businesses 32, percent, and Asian-owned businesses 26 percent. Immigrant-owned businesses dropped by 36 percent.[8]

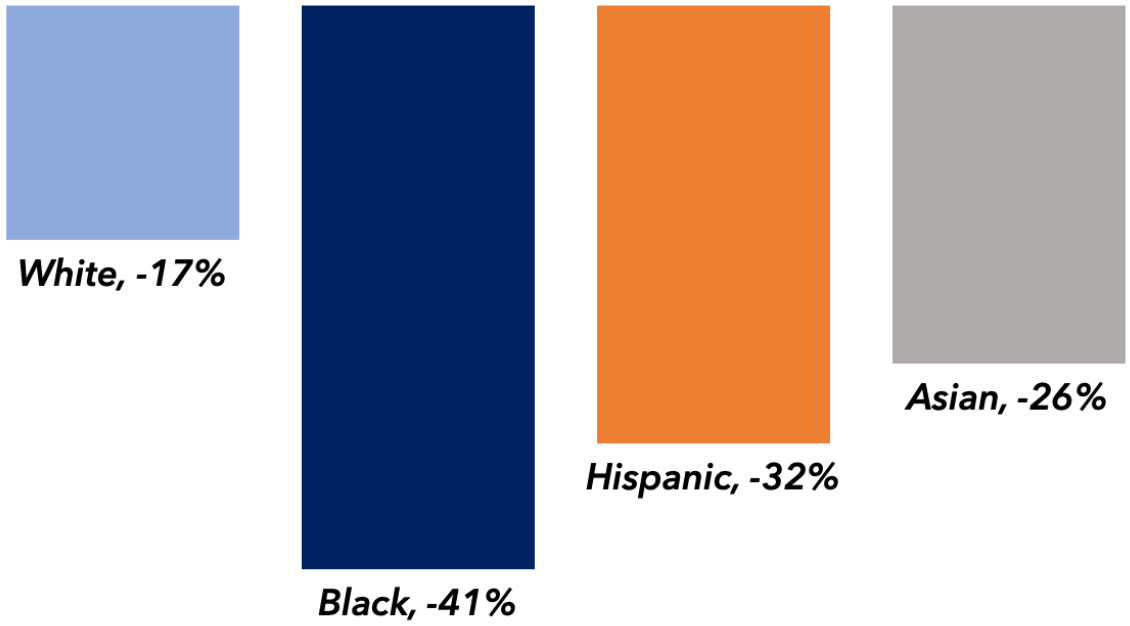
None of this is to minimize the damaging effects of economic lockdowns on white Americans. Indeed, economically vulnerable people of all races and ethnicities have

[7] 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 9, 2020.

[8] 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.

struggled during the lockdown. Most Americans consider their own jobs to be essential—to them and those they support.

Figure 7. 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)*

Health care workers have not been spared from layoffs. Indeed, the lockdowns have dramatically reduced utilization of hospitals and other health care services, leading tens of thousands of such workers to receive layoffs, furloughs, and reduced pay.

POLICY SOLUTIONS

Appended to this brief is a summary of FREOPP's proposal to safely reopen the economy in ways that helps all workers while concentrating our attention on those most at risk for severe illness and death from COVID-19.[9]

Rep. Carolyn Maloney, Chair of the House Oversight & Reform Committee, has introduced a bill, the Pandemic Heroes Compensation Act of 2020, that would establish a "COVID-19

[9] A. Roy, Reopening the U.S. Economy Even if the Pandemic Endures. The Wall Street Journal. 2020 Apr 24: https://www.wsj.com/articles/reopening-the-u-s-economy-even-if-the-pandemic-endures-11587740529; accessed June 9, 2020.

compensation fund" of unlimited size to benefit those who any state or local government has deemed "essential." The bill would require federal taxpayers to pay both economic and noneconomic damages for any harm that beneficiaries' attorneys can demonstrate.

Congress has already spent more than $3 trillion in order to mitigate the damage caused by economic lockdowns. At this point, a major concern is that further federal spending will incentivize states to keep their economies closed, even though a prudent reopening is warranted. The specific form of relief described in the Pandemic Heroes Compensation Act may largely accrue to trial lawyers, and the Act would provide federal compensation to people who may have experienced harm due to poor state policy, such as forcing nursing homes to accept COVID-19 patients. A more defined and targeted approach would be better suited to addressing gaps in CARES Act funding.

Furthermore, we should lift stay-at-home orders for most non-elderly individuals, reopen safe but "non-essential" businesses, rescind mandatory discharges of COVID-19 patients to nursing homes, and prioritize testing in long-term care facilities. Ultimately, the most sustainable way to help first responders is to protect those most at risk from COVID-19, and to let low-risk individuals return to school and work.

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Reopening the U.S. Economy

Even if the Pandemic Endures

It's not true 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. **By Avik Roy**

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?

What if it takes us years to develop a vaccine for Covid-19?

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

Please turn to the next page

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.

Inside

EDITOR AT LARGE

GERARD BAKER

The Unique Catastrophe Unfolding In New York City

The terrible death toll is difficult to explain just by the fact that 'a lot of people live here.'

IT ISN'T AN EXAGGERATION to state that the coronavirus crisis in the U.S. is, in many ways, a New York public health crisis. This is not in any way to belittle the suffering across the nation, but it is hard to overstate the disproportionate role that the Empire State has played in America's current woes.

According to the latest estimates by the University of Washington's Institute for Health Metrics and Evaluation, by August, 67,000 Americans will have perished from this pandemic. The number of deaths in New York is expected to be over 23,000—more than a third of the national total, in a state with less than 6% of the U.S. population.

New York City alone—a city of eight million—currently accounts for between 50% and 60% of Covid-19 deaths in the state and for perhaps a quarter of national fatalities. On current trends, the likely final death toll in the city may be above 15,000. (The latest data are fuzzy since New York City is counting thousands of people who died outside hospitals who weren't diagnosed with Covid-19.)

But even allowing for some margin of error, the numbers amount to one death in New York City for every 500 people. Not—remember—one death for every 500 people with Covid-19 but one death for every 500 *residents of the city*. Think about that. That might be a handful of parents or grandparents at your average high school, or one or two co-workers on your office floor.

Not only is this multiples higher than other major population centers in the U.S., it is way more than any comparable city in the world. London, with a similar population, has recorded a little over 4,000 deaths, about a third of New York's tally.

If New York City didn't exist, the likely number of total deaths in the U.S. from this virus would be about one for every 7,000 Americans. This would make it about as lethal as the average annual influenza, as critics of the policy response to the crisis have said. In American terms, it can be said that it is New York alone that makes this pandemic...a pandemic.

New York subway passengers wearing protective masks on Monday.

This might change, and of course the total number of deaths everywhere so far has probably been held down by the social-distancing measures in place across the country. But whichever way you look at it, New York is (miserably) unique.

There is much hand-wringing by state and city officials and others that all this is some sort of act of God, an unavoidable catastrophe as a result of the particular characteristics of New York, driven mainly by high population density. There is clearly much to this. But it's unlikely to be the whole explanation. Density alone doesn't seem to account for the scale of the differential between New York's fatality rates and those of other cities. New York has twice the density of London but three times the deaths, and the differential is even higher for cities such as San Francisco and Los Angeles.

Deaths have occurred disproportionately in poorer areas, where the incidence of long untreated morbidities such as heart disease and diabetes have contributed significantly. But the same is true in all other cities.

The high dependence on mass transit also seems to be a factor. In other major cities, car commutes are much more common.

As Joel Kotkin, a scholar of cities at Chapman University in California, says, it may be the lethal convergence of all three factors. "If you put together density, levels of poverty and reliance on a mass-transit system, you have a hat trick," he told me.

But even that may not explain the extent of New York's unique catastrophe. Around the world, the highest death rates have occurred where hospital systems were overwhelmed in the early stages of the crisis. This is especially true in northern Italy. Anecdotally, at least, it seems that the same happened in New York: Large numbers of sick people never got to hospitals, arrived too late or, in the impossible circumstances that medical personnel were confronted with, were given ineffective treatment.

Policy may bear some responsibility too. It's fair to ask if the city's mayor and the state's governor were slower to respond to the spread of the virus than officials elsewhere.

It will be a while before we get a proper understanding of what went so tragically wrong—for New York and, by extension, the U.S. But we will probably have to do better than, "A lot of people live here."

HOLLY PICKETT/BLOOMBERG NEWS

A Realistic Plan for Going Back to Work

Continued from the prior page

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.

People wait in line for help with unemployment benefits in Las Vegas, March 19.

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.

All of us can see the mounting mental and emotional toll of ongoing lockdowns.

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.

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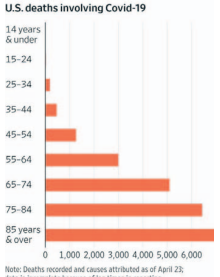
Age Discrimination

The novel coronavirus has hit the elderly the hardest

U.S. deaths involving Covid-19



Note: Deaths recorded and causes attributed as of April 23; data is incomplete because of lag times in reporting.
Source: National Center for Health Statistics