Prologue

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I COVID-19 AND HEALTH EQUITY

In 2020, the United States experienced a 1.5-year decrease in life expectancy due primarily to the COVID-19 pandemic, the largest decline since World War II.[1] But the toll of the pandemic has not been equal. Rather, it has exposed how our standard pre-pandemic policies and practices were inadequate to meet the needs of many Americans – particularly for people of color and marginalized communities. For Black Americans, life expectancy dropped 2.9 years in the same period, and in the Latinx community, life expectancy fell by a full three years.[2] That Black and Latinx families are more likely to live in more crowded households or multigenerational homes, or hold essential jobs with higher risks of exposure, accounts for some of these disparities. Similarly, Asian/Asian Americans, Native Hawaiians, and Pacific Islanders, those living outside metropolitan areas, and individuals with certain disabilities have experienced staggeringly high rates of COVID-19 infection, hospitalization, and mortality.

COVID-19 is therefore much more than a public health emergency. It is also a convergence of crises. Hospital workforces have long failed to reflect the diversity of the communities they serve, which has contributed to worse health outcomes for people of color. As COVID-19 spread, rural hospitals shuttered. And when vaccines became available, the public and private sectors did not distribute doses equitably or accessibly. Prior to the pandemic, structurally marginalized communities already struggled to access nutritious food, stable and high-quality housing, childcare, health insurance, transportation, and reliable Internet. The pandemic exacerbated these challenges, making it all the more difficult to adhere to public health guidelines around social distancing and quarantine. The inequities that existed before the pandemic were exploited by COVID-19.

[1] Jane Greenhalgh, U.S. Life Expectancy Fell by 1.5 Years in 2020, the Biggest Drop since WWII, NPR (July 21, 2021), www.npr.org/sections/coronavirus-live-updates/2021/07/21/1018590263/u-s-life-expectancy-fell-1-5-years-2020-biggest-drop-since-ww-ii-covid.

[2] Id.

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II CLOSING COVID-19 EQUITY GAPS: A VIEW FROM THE FRONT LINES

COVID-19 presented several distinct challenges over time, and I was privileged to advise both the state of Connecticut and the Biden-Harris Administration. In the early months of the pandemic, testing and tracing were key – as was getting accurate data on how COVID-19 was impacting different communities. After vaccines became available, work shifted to the profound challenges of ensuring equitable access to vaccines and gaining the trust of individuals reluctant to take them. The pressing issues of the day became partnering with community leaders and others to meet people where they were, leading conversations with respectful understanding and providing accurate information. We developed solutions based on unique collaborative initiatives. Our collective efforts helped close the equity gap in vaccination and offer lessons for the future.

Data drives health care and policy. However, getting accurate data on COVID-19 was an early challenge. In an August 2020 paper I co-authored with my Yale colleague Cary Gross and others, we were among the first to show that COVID-19 mortality data stratified by race and ethnicity was largely unavailable in state reporting. We also found that when data were available and adjusted for age, the disparities were severe. For example, we found that the risk of dying from COVID-19 was significantly higher for the Black population than for the White population in twenty-two states (along with New York City). An absence of reliable data makes it harder to develop government policies and appropriately target needed resources.

In the early months of the pandemic testing and tracing were core priorities. In Connecticut, where I served on Governor Ned Lamont's Reopen Connecticut Advisory Committee as co-chair of the community subcommittee, protecting people in congregate settings – such as long-term care facilities, carceral settings, homeless shelters, and shared housing – as well as essential workers was a priority. Contact tracing, while effective, proved to have its own difficulties. It is not enough to develop and deploy a successful program; it must be successful in all communities. We focused on ensuring that people had the right economic and basic needs supports, including food, housing (in those cases where separating and isolating from others in a home was not possible), and childcare, to properly quarantine or isolate as necessary. Months later, once vaccines became available, ensuring equitable access and building trust through community partnership became the next major health equity goal across the country.

The Biden-Harris Administration aimed to provide equitable access across the continuum of COVID-19 life-saving resources. I was privileged to serve as co-chair of the Transition COVID-19 Advisory Board and later as Senior Advisor to the White House COVID-19 Response Team and Chair of the Presidential COVID-19 Health Equity Task Force in the Department of Health and Human Services. To reach the hardest-hit and highest-risk individuals, four direct federal vaccine allocation

programs were launched in the first three weeks of the Administration. The four programs – Community Health Center Partnerships, the Retail Pharmacy Program, Community Vaccination Centers, and Mobile Vaccination Sites – complemented the work that states were doing and centered equity as a key priority, keeping considerations such as location and extended hours in mind. Further, metrics such as the Centers for Disease Control and Prevention's social vulnerability index were used to help target these resources to communities. And the Administration always centralized the need to work closely with community and faith-based organizations to be most effective in connecting with their clients and members. Federal vaccination centers were barred from inquiring about citizenship and made sure that everyone knew vaccines were free to them. Pharmacy partners were engaged to ensure they were reaching hard-to-reach populations. Collaborations were key, including with community-based organizations, local public health departments, faith-based communities, and others. The Administration partnered with churches, schools, and even barber shops to reach people where they were. Throughout, the approach was guided by an understanding that both the message and the messenger matter. Messages must be tailored to their audience, and messengers must be trusted and trustworthy within a given community.

The Biden-Harris Administration put this understanding into practice through several necessary programs, in addition to the ones already mentioned. I had the opportunity to co-chair the National Public Education Campaign for COVID-19, which included the COVID-19 Community Corps. Starting with approximately 6,000 members before growing substantially, it comprised community leaders and others across the country who came together to get accurate information from Administration officials about vaccines and other pandemic matters on a regular basis. I was also honored to host a series of stakeholder roundtables, organized across multiple agencies and offices in the White House and the Department of Health and Human Services. These roundtables opened clear lines of communication about the pandemic, including about testing and vaccines, with a wide range of constituencies. They were intimate and off the record, and represented a space designed to elevate the wisdom of those with lived experience. Participants told Administration officials what they needed, while offering feedback on which Administration strategies were and were not effective, helping inform next steps. The Administration listened and acted on what they heard.

But bringing vaccines to communities and building confidence that the vaccines were safe and effective was just the beginning. The close relationships we built through dialogue helped us tackle a core problem: getting individuals who were willing to receive the vaccine but unable to access it a path to vaccination. The next issue was addressing structural barriers to vaccination. Through ongoing dialogue with our partners, we learned that people were facing a series of challenges – some did not have access to transportation or childcare, while others did not have paid time off from work. The Administration introduced policies and

initiatives that addressed each of these problems – such as giving tax credits to businesses to make sure people got paid time off, supporting the provision of childcare, and encouraging rideshare companies to provide free rides. These solutions came from public–private collaborations. It was essential to ensure that accurate information was always being shared in a respectful way and to engage with community and local public health leaders. Taken together, this collaborative work paid off. By September 2021, we consistently saw that there were no longer gaps by race and ethnicity in adult vaccination rates.

Throughout the pandemic, what set effective interventions apart and really made a difference from prior moments in the health equity space was the presence of political will, stemming from the very top. The personal commitment of President Biden and Vice President Harris to both understand what was needed to close equity gaps in the pandemic and to act on that understanding was transformational.

III THE PANDEMIC'S LEGACY AND LESSONS FOR THE FUTURE

The pandemic has caused incalculable grief, stress, and other mental health challenges. More than 100,000 children have lost caregivers to the pandemic. Black, Brown, and LGBTQIA+ communities have reported skyrocketing rates of anxiety and depression. So, too, have older adults, for whom social isolation and loneliness increases the risk of cognitive dysfunction, heart disease, and mortality. COVID-19 also drove a significant spike in opioid overdoses. Even as mental health worsened in the country, stay-at-home orders and the widespread job-related loss of insurance made it harder for individuals to access behavioral health services. Meanwhile, people of color were more likely than their White counterparts to be essential workers, putting themselves and their families at increased risk.

The disproportionate burden of COVID-19 morbidity and mortality have resulted in a "grief gap" among communities of color and other marginalized populations. A broad lens is necessary to center equity across the groups the pandemic most affects: people living with disabilities, those who are involved with the justice system, cherished elders, rural neighbors, mixed-status families, LGBTQIA+ people, Black and Brown people, Indigenous people, Asian/Asian Americans, Native Hawaiians, Pacific Islander people, and those struggling on the margins of the economy.

The pandemic's lesson is that while high-quality health care is essential, health equity goes beyond health care. It includes housing stability, food and nutrition security, and ensuring equitable access to technology. People need pathways to educational and economic opportunities. The prominence of COVID-19 in the public consciousness has made us aware of its uneven toll on communities of color and other marginalized groups, but there has never been a time in which these communities have not suffered disproportionate burdens of death and disease. To

advance health equity, we must urgently address both the historical and contemporary underpinnings of these realities.

Systemic problems require systemic solutions. An effective pandemic response is reliant on people's trust in science and is grounded in meaningful community engagement.

Misinformation, conflicted messaging, and the politicization of science have undermined the pillars of effective response. Therefore, we must also strive toward a new post-pandemic reality, a reality that puts science, reliable communication, community health, and racial/ethnic and social equity at the forefront.

In this rebuilding, we must also remember that although communities are experts in their own needs, we can no longer allow them to shoulder the burdens of establishing health equity alone. We must work toward sustained investment in community-led solutions. The pandemic gave us an opportunity to disrupt patterns of harm and improve inequitable systems and practices.

Looking forward, there are concrete steps that we can take to learn from the pandemic. The final report of the Presidential COVID-19 Health Equity Task Force, which I chaired, lays out fifty-five prioritized recommendations, with five toplines. First, we must invest in community-led solutions to address health equity. Second, we need a data ecosystem that promotes equity-driven decision-making. Third, we must increase accountability for health equity outcomes. Fourth, investing in a diverse and representative health care workforce and increasing equitable access to high-quality health care for all is essential. Finally, leading and coordinating implementation of the COVID-19 Health Equity Task Force's recommendations should take place from a permanent health equity infrastructure in the White House.

We have a once-in-a-generation opportunity for transformational change. But we must acknowledge that advancing health equity will take multisectoral commitment, collaboration, and intention. The legacy of the pandemic is an invitation for us all to envision a new world, one in which the government, the private sector, community leaders, and philanthropists collaborate to achieve health justice.