Health Equity Principles for State and Local Leaders in Responding to, Reopening, and Recovering from COVID-19

Overview

COVID-19 has unleashed a dual threat to health equity in the United States: a pandemic that has sickened millions and killed tens of thousands and counting, and an economic downturn that has resulted in tens of millions of people losing jobs—the highest numbers since the Great Depression. The COVID pandemic underscores that:

- Our health is inextricably linked to that of our neighbors, family members, child- and adult-care providers, co-workers, school teachers, delivery service people, grocery store clerks, factory workers, and first responders, among others;

- Our current health care, public health, and economic systems do not adequately or equitably protect our well-being as a nation; and

- Every community is experiencing harm, though certain groups are suffering disproportionately, including people of color, workers with low incomes, and people living in places that were already struggling financially before the economic downturn.

For communities and their residents to recover fully and fairly, state and local leaders should consider the following **health equity principles** in designing and implementing their responses. These principles are not a detailed public health guide for responding to the pandemic or reopening the economy, but rather a compass that continually points leaders toward an equitable and lasting recovery.

Collect, analyze, and report data disaggregated by age, race, ethnicity, gender, disability, neighborhood, and other sociodemographic characteristics.

Pandemics and economic recessions exacerbate disparities that ultimately hurt us all. Therefore, state and local leaders cannot design equitable response and recovery strategies without monitoring COVID's impacts among socially and economically marginalized groups.[1] Data disaggregation should follow best practices and extend not only to public health data on COVID cases, hospitalizations, and fatalities, but also to: measures of access

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"Health equity means that everyone has a fair and just opportunity to be as healthy as possible. This requires removing obstacles to health such as poverty, discrimination, and their consequences, including powerlessness and lack of access to good jobs with fair pay, quality education and housing, safe environments, and health care."

What Is Health Equity? And What Difference Does a Definition Make?
Robert Wood Johnson Foundation, 2017

Health Equity Principles

1. Collect, analyze and report disaggregated data.

2. Include those who are most affected in decisions, and benchmark progress based on their outcomes.

3. Establish and empower teams dedicated to racial equity.

4. Proactively fill policy gaps while advocating for more federal support.

5. Invest in public health, health care and social infrastructure.

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1   People of color (African-Americans, Latinos, Asian Americans, American Indians, Alaska Natives, and Native Hawaiians and other Pacific Islanders), women, people living in congregate settings such as nursing homes and jails, people with physical and intellectual disabilities, LGBTQ people, immigrants, and people with limited English proficiency.

to testing, treatment, personal protective equipment (PPE), and safe places to isolate when sick; receipt of social and economic supports; and the downstream consequences of COVID on well-being, ranging from housing instability to food insecurity. Geographic identifiers would allow leaders and the public to understand the interplay between place and social factors, as counties with large black populations account for more than half of all COVID deaths, and rural communities and post-industrial cities generally fare worse in economic downturns. Legal mandates for data disaggregation are proliferating, but 11 states are still not reporting COVID deaths by race; 16 are not reporting by gender; and 26 are not reporting based on congregate living status (e.g., nursing homes, jails). Only three are reporting testing data by race and ethnicity. While states and cities can do more, the federal government should also support data disaggregation through funding and national standards.

2 Include in decision-making the people most affected by health and economic challenges, and benchmark progress based on their outcomes.

Our communities are stronger, more stable, and more prosperous when every person, including the most disadvantaged residents, is healthy and financially secure. Throughout the response and recovery, state and local leaders should ask: *Are we making sure that people facing the greatest risks have access to PPE, testing and treatment, stable housing, and a way to support their families? And, are we creating ways for residents— particularly those hardest hit—to meaningfully participate in and shape the government's recovery strategy?*

Accordingly, policymakers should create space for leaders from these communities to be at decision-making tables and should regularly consult with community-based organizations that can identify barriers to accessing health and social services, lift up grassroots solutions, and disseminate public health guidance in culturally and linguistically appropriate ways. For example, they could recommend trusted, accessible locations for new testing sites and advise on how to diversify the pool of contact tracers, who will be crucial to tamping down the spread of infection in reopened communities. They could also collaborate with government leaders to ensure that all people who are infected with coronavirus (or exposed to someone infected) have a safe, secure, and acceptable place to isolate or quarantine for 14 days. Key partners could include community health centers, small business associations, community organizing groups, and workers' rights organizations, among others. Ultimately, state and local leaders should measure the success of their response based not only on total death counts and aggregate economic impacts but also on the health and social outcomes of the most marginalized.

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3 **Establish and empower teams dedicated to promoting racial equity in response and recovery efforts.**

Race or ethnicity should not determine anyone's opportunity for good health or social well-being, but, as COVID has shown, we are far from this goal. People of color are more likely to be front-line workers, to live in dense or overcrowded housing, to lack health insurance, and to experience chronic diseases linked to unhealthy environments and structural racism. Therefore, state and local leaders should empower dedicated teams to address COVID-related racial disparities, as several leaders, Republican and Democrat, have already done. To be effective, these entities should: include leaders of color from community, corporate, academic, and philanthropic sectors; be integrated as key members of the broader public health and economic recovery efforts; and be accountable to the public. These teams should foster collaboration between state, local, and tribal governments to assist Native communities; anticipate and mitigate negative consequences of current response strategies, such as bias in enforcement of public health guidelines; address racial discrimination within the health care system; and ensure access to tailored mental health services for people of color and immigrants who are experiencing added trauma, stigma, and fear. Ultimately, resources matter. State and local leaders must ensure that critical health and social supports are distributed fairly, proportionate to need, and free of undue restrictions to meet the needs of all groups, including black, Latino, Asian, and Indigenous communities.

4 **Proactively identify and address existing policy gaps while advocating for further federal support.**

The Congressional response to COVID has been historic in its scope and speed, but significant gaps remain. Additional federal resources are needed for a broad range of health and social services, along with fiscal relief for states and communities facing historically large budget deficits due to COVID. Despite these challenges, state and local leaders must still find ways to take targeted policy actions. The following questions can help guide their response.

Who is left out?
Inclusion of all populations will strengthen the public health response and lessen the pandemic's economic fallout for all of society, but federal actions to date have not included all who have been severely harmed by the pandemic. As a result, many states and communities have sought to fill gaps in eviction protections and paid sick and caregiving leave. Others are extending support to undocumented immigrants and mixed-status families through public-private partnerships, faith-based charities, and community-led mutual aid systems. Vital health care providers, including safety net hospitals and Indian Health Service facilities, have also been disadvantaged and need targeted support.

Will protections last long enough?
Many programs, such as expanded Medicaid funding, are tied to the federal declaration of a public health emergency, which will likely end before the economic crisis does. Other

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policies, like enhanced unemployment insurance and mortgage relief, are set to expire on arbitrary dates. And still others, such as stimulus checks, were one-time payments. Instead, policy extensions should be tied to the extent of COVID infection in a state or community (or its anticipated spread) and/or to broader economic measures such as unemployment. This is particularly important as communities will likely experience reopenings and closings over the next six to 12 months as COVID reemerges.

Have programs that meet urgent needs been fully and fairly implemented?
All existing federal resources should be used in a time of great need. For example, additional states should adopt provisions that would allow families with school-age children to receive added Supplemental Nutrition Assistance Program (SNAP) benefits, and more communities need innovative solutions to provide meals to young children who relied on schools or child care providers for breakfast and lunch. States should also revise eligibility, enrollment, and recertification processes that deter Medicaid use by children, pregnant women, and lawfully residing immigrants.

5   **Invest in strengthening public health, health care, and social infrastructure to foster resilience.**

Health, public health, and social infrastructure are critical for recovery and for our survival of the next pandemic, severe weather event, or economic downturn. A comprehensive public health system is the first line of defense for rural, tribal, and urban communities. While a sizable federal reinvestment in public health is needed, states and communities must also reverse steady cuts to the public health workforce and laboratory and data systems. Everyone in this country should have paid sick and family leave to care for themselves and loved ones; comprehensive health insurance to ensure access to care when sick and to protect against medical debt; and jobs and social supports that enable families to meet their basic needs and invest in the future. As millions are projected to lose employer-sponsored health insurance, Medicaid expansion becomes increasingly vital for its proven ability to boost health, reduce disparities, and provide a strong return on investment. In the longer term, policies such as earned income tax credits and wage increases for low-wage workers can help secure economic opportunity and health for all. Finally, states and communities should invest in affordable, accessible high-speed internet, which is crucial to ensuring that everyone—not just the most privileged among us—is informed, connected to schools and jobs, and engaged civically.

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Conclusion

These principles can guide our nation toward an equitable response and recovery and help sow the seeds of long-term, transformative change. States and cities have begun imagining and, in some cases, advancing toward this vision, putting a down payment on a fair and just future in which health equity is a reality. Returning to the ways things were is not an option.