

**TOO MANY DEATHS,
TOO MANY LEFT BEHIND:
A PEOPLE'S EXTERNAL REVIEW OF THE CDC**

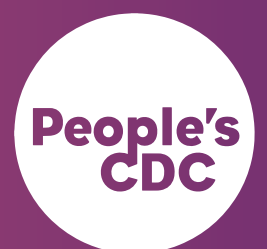


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Authors: Lara Jirmanus, MD, MPH, Rita Valenti, RN, Eiryn Griest Schwartzman, CHES, Sophia Simon-Ortiz, MPH, Lilly Havstad, PhD, Rob Wallace, PhD, Dana Ludwig, MD, MS, Theo Allen, Josh Garoon, PhD, Dannie Ritchie, MD, MPH, Molly Rose Kaufman, Samuel R Friedman, PhD, Mindy Thompson Fullilove, MD

Survey data for this report was collected in collaboration with Marked By Covid.

1. INTRODUCTION

1.1 Overview

In 2020, the first 100,000 deaths from COVID-19 shocked the nation. However, when U.S. COVID deaths surpassed the 1.1 million mark in January 2023,¹ rather than pausing to acknowledge the grave loss, President Biden moved to end the COVID-19 State of Emergency. The US population has suffered worse health consequences due to COVID-19 than comparable wealthy nations.² Even with the additional resources that the state of emergency provides, the poor U.S. government response has led to a nearly 3-year decline in average life expectancy, and much worse in low-income and communities of color.³ In 2022 alone, a year when many politicians and even some medical professionals had suggested the pandemic was over, more than 250,000 people in the United States died from COVID.¹ COVID remains the third leading cause of death in the United States since the pandemic began (see Figure 1.1).^{4,5} More than 1600 children have died from COVID-19,⁶ making COVID one of the top 10 causes of death in children since the beginning of the pandemic.⁷ More than 200,000 children have lost a caregiver to COVID.⁸ Meanwhile, as many as 16 million American workers are struggling with Long COVID,⁹ a chronic condition affecting as many as 1 in 5 people after COVID infection.^{10,11}

COVID-19 is the #3 cause of death in the U.S. thus far in 2022

Total deaths in the United States from COVID-19 and other leading causes, 2020-2022

Category	Total deaths (Jan.-Sept. 2022)	Total deaths (2021)	Total deaths (2020)
1 Heart disease	572,336	767,937	764,512
2 Cancer	454,176	604,358	599,607
3 COVID-19	234,434	475,059	343,566
4 Accidents	170,166	226,987	203,033
5 Stroke	123,215	162,769	159,248
6 Chronic respiratory	107,559	141,906	152,051
7 Alzheimer	87,866	119,442	134,271
8 Diabetes	74,716	103,197	101,355
9 Other respiratory	50,635	66,381	66,053
10 Renal failure	42,596	53,057	51,221

Notes: For 2022, the total death sum for each category is for January 1 - September 30, 2022, except deaths from accidents and suicides are from January - September 2021. Chronic respiratory is chronic lower respiratory disease.

Figure 1.1 Total deaths in the United States from COVID-19 and other leading causes, 2020-2022 ([Ortaliza et al 2022](#))

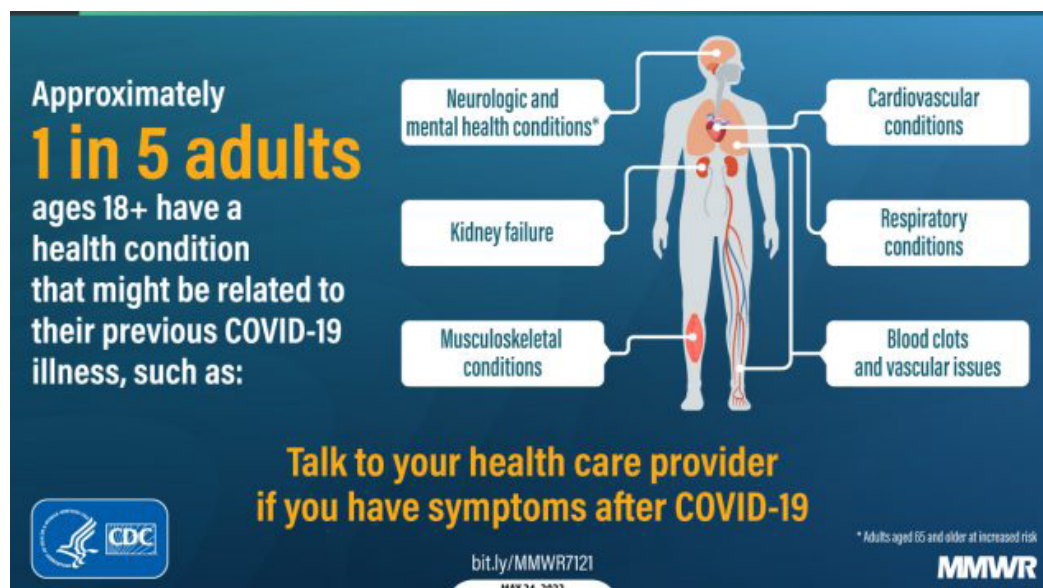


Figure 1.2 One in five adults have a health condition that may be related to their prior COVID-19 illness ([Bull-Otterson et al. 2022](#))

Amid this terrible pandemic, some public health professionals and community activists observed that the CDC was straying from its history of promoting evidence-based public health. We identified three major “red flags:”

1. **The CDC leadership downplays the serious threat COVID-19 continues to pose**, likening COVID to the flu¹² and creating [maps](#) that deemphasize the risk of COVID transmission instead of aiming to control and prevent disease.
2. **The CDC leadership has shifted recommendations following pressure from influential business interests¹³ and has aligned public health guidance with political agendas¹⁴ over scientific evidence** to create an atmosphere where workers and consumers are willing to put their lives and health at risk to work and shop in unsafe conditions.
3. **CDC guidance pushes individual choice over a population health approach to protect everyone.¹⁵ This approach devalues the lives of high-risk individuals (4 in 10 US adults¹⁶) by burdening them to protect themselves¹⁷** instead of encouraging everyone to protect each other. Encouraging the public to tolerate preventable deaths¹⁸ is unethical and is not a sound public health strategy.

In January 2022, we formed the [People’s CDC](#), a volunteer-run coalition of public health practitioners, scientists, health care providers, educators, advocates, and people from all across the country who are passionate about reducing the harmful impacts of COVID-19. As the People’s CDC, we also believe a well-informed public would agree we should not tolerate hundreds of thousands of preventable deaths each year from COVID-19. The CDC and elected leaders often have referenced the need to “meet people where they are,”¹⁹ when removing public health protections, but repeated polls have shown the U.S. public favors COVID-19 protections (e.g., mask mandates) when infection rates are high.^{20–23} Because of misleading messaging from the CDC, most people do not know

when COVID-19 transmission rates are high.²⁴ Those who do know are more likely to protect themselves by wearing masks (as a [CDC Morbidity and Mortality Weekly report \[MMWR\]](#) recently pointed out).²⁴ When we learned that the CDC was carrying out an internal review of its work, we decided to carry out a “People’s External Review of the CDC.” We surveyed nearly 500 health workers, community leaders, and public health researchers and practitioners. We asked them to evaluate the CDC’s performance in eight key areas of pandemic management. Our findings underscore the concerns that brought us to this investigation.

For the CDC to realize its vision of “equitably protecting health, safety and security,” the agency must return to fundamental principles of public health, including the interdependence of people and the precautionary principle. The concept of *interdependence*, the idea that no human being can survive completely on their own, but rather the idea that we are all dependent on one another, is a core public health concept. Interdependence is also critical to understanding the way a highly infectious airborne disease, like COVID-19, spreads; how collective action is essential to protect the vulnerable; and how protecting the vulnerable protects *everyone*.

Well before the COVID-19 pandemic, health policy and development experts warned of the importance of pandemic preparedness, instead of the panic-neglect cycle typical of pandemic response.^{25,26} However, even amid the COVID-19 pandemic, we experience the same typical pattern of panic when there is a serious threat and neglect when the threat subsides. Instead of oscillating between these extremes, we should create a pandemic preparedness plan to manage the COVID-19 pandemic, so it does not manage us, and to prepare for future pandemics.

1.2 Background

In April 2022, CDC Director Rochelle Walensky requested a [formal external review](#) of the CDC’s management of the COVID-19 pandemic.²⁷ In response, the People’s CDC launched a parallel independent survey of people and communities most impacted by COVID-19 and of public health experts. Survey responses were collated into an accompanying report, which provide a detailed critique of the CDC leadership’s COVID-19 response since January 2021, when the Biden Administration took the helm and Walensky’s tenure began. We specify our critique of the CDC *leadership* to acknowledge the work of the CDC scientists and policy experts and the numerous, well-researched, and rigorous reports they have written, many of which we cite, but upon which CDC public guidance

is not always based. We assessed the CDC’s pandemic management in eight key areas: disease control and prevention, ethics, equity and justice, scientific integrity, public health infrastructure, communication, inclusion, and addressing root causes.

In August 2022, the CDC released a [3-page outline about its formal external review](#),²⁸ announcing the review had been completed without sharing the document with the public. The outline stated the review aimed to “position the agency to better support the future of public health” and “equitably deliver CDC’s science and program activities to the American people.”²⁸ The outline concluded the CDC must improve its “accountability, collaboration, communication, and timeliness within CDC and with our customers.”²⁸ We appreciate that the CDC and CDC Director Walensky had reflected upon internal and some external critique; however, we find it problematic that the full CDC external review still has not been shared with the public. We are aware that other forces influence the CDC’s guidelines, especially the U.S. Department of Health and Human Services and the Biden Administration. Although we welcome prioritizing public health communication, partnerships, and development of a public health workforce, **the review failed to address the CDC’s central failure in its management of the COVID-19 pandemic. The CDC leadership failed to provide evidence-based guidance that prioritizes public health and equity over the profit of powerful corporations and political agendas.**^{14,29-31}

The United States is a dominant force internationally, and these policies have global repercussions. The United States continues to outpace other high-income countries in the numbers of deaths due to COVID-19.³² Instead of leading the world in COVID-19 deaths, the United States should be leading the world in protecting public health (see Figure 1.3).

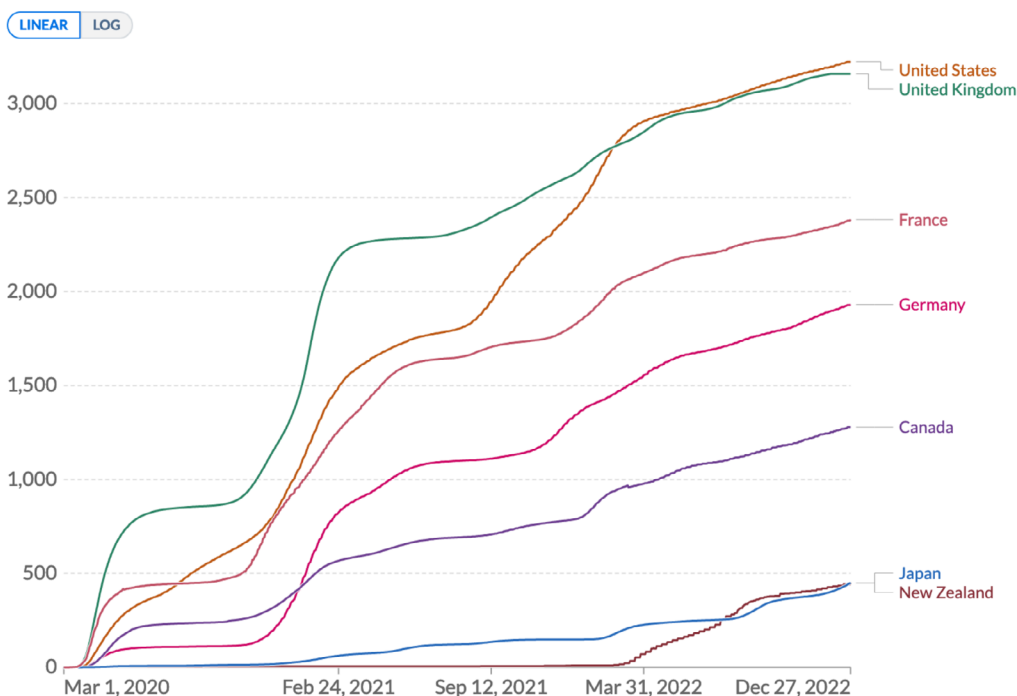


Figure 1.3 Cumulative confirmed COVID-19 deaths per million people from 2020-2022 show the United States outpaces many other high-income countries (Mathieu et al 2022)

Source: Johns Hopkins University CSSE COVID-19 Data

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Instead of referring to the U.S. public as people with rights or needs for health, the CDC repeatedly refers to its “[customers](#)” in its external review outline.²⁸ This language of people as customers reflects our core findings that, throughout the pandemic, CDC policies have failed to center the needs of communities that have been historically marginalized from thriving in society. These communities have less money to spend on health care; are less likely to have employment-based health insurance, paid leave, and other benefits; and have been more likely to be harmed by COVID. Instead, the CDC has prioritized big business interests, encouraging people to return to work and society to return to an imagined “normal” over protecting public health.^{31,33} Plans to end the COVID-19 state of emergency will only worsen health inequities,³⁴ which we have seen already with clinics turning away uninsured patients as federal COVID funding runs out.³⁵ These are our decision makers’ choices, not inevitable processes. This profit-over-people approach guarantees communities that have been most impacted by the pandemic will continue to suffer disproportionately, including COVID-bereaved people; people with Long COVID; immunocompromised, chronically-ill and disabled people; in-person workers, including health care workers; people who live in congregate facilities or who are incarcerated; older adults; and structurally marginalized and minoritized communities, including low-income communities, immigrants, and Black, Indigenous, and People of Color (BIPOC).^{36–44} We use condition-first⁴⁵ instead of person-first language, (e.g. “disabled,” instead of “people living with disability” at the recommendation of our disabled and disability-justice advocate coauthors and collaborators. It is furthermore unclear how creating “[a new equity office](#)” will be any more effective than the existing [CDC Office of Minority Health and Health Equity](#) at addressing these inequities.

We recognize the CDC does not act alone, that pandemic response must be coordinated at all levels, including the federal executive branch, state, and local authorities, and that the federalist system limits the CDC’s executive authority.^{46,47} The COVID pandemic has exposed and deepened socioeconomic inequities and strained the already weak U.S. public health infrastructure, disinvested in for decades.⁴⁸ A comprehensive pandemic response must include measures to strengthen public health infrastructure and address the root causes that create health inequity in the first place. We applaud the CDC for exploring the limits of its emergency powers to protect the public’s health during the pandemic and for issuing and defending sweeping guidelines, such as the federal eviction moratorium and federal mask mandates.^{46,47} Although public health infrastructure and addressing root causes of public health lie outside of the core purview of the CDC’s more narrow charge to develop and disseminate scientific guidance to prevent disease transmission, we believe these two areas are fundamental to pandemic management and include them in this critique. We hope this report can provide useful feedback to guide an evidence-based pandemic approach that aims above all to protect public health, prevent death and disability, and promote equity.

2. METHODS

The authors of this report developed the concept for the People’s External Review of the CDC through a modified Delphi process.⁴⁹ The Delphi approach is used often in the health sciences to gather expert judgements and use them to identify consensus through successive rounds of discussion.⁴⁹ For this review, a group of interdisciplinary medical and public health experts were surveyed to create a list of core pandemic management areas drawing from public health ethical and theoretical frameworks.^{50–52} Core themes were identified from the lists, and these were reviewed by the expert panel. After three rounds of consolidation and review, eight essential areas of pandemic management were identified: disease control and prevention, ethics, equity and justice, scientific integrity, public health infrastructure, communication, inclusion, and addressing root causes. These formed the basis for a survey, using a 5-point Likert scale ([see Appendix A](#)), and an opportunity for respondents to provide open-ended written suggestions. The survey emphasized that responses should address the performance of the U.S. CDC since January 2021, with regards to management of the COVID-19 pandemic specifically, and not to other functions of the CDC. The survey was translated into Spanish and shared, using convenience sampling techniques, with key stakeholders, including public health and health care practitioners and researchers, and individuals and other organizations from communities disproportionately impacted by the pandemic. We also partnered with [Marked by COVID](#), a national non-profit organization advocating for pandemic justice and remembrance, which disseminated the survey to their membership of COVID-bereaved individuals and families by sharing the link to the survey via email and social media.

In our study design, we aimed to embody an inclusive process, including representatives and highlighting perspectives from communities most impacted by COVID-19. We argue the CDC should similarly include better representation of communities impacted by the pandemic in the development of its pandemic policy. The survey was introduced to possible respondents via email with a survey link. The survey sample was limited to those able to access a survey via digital means. Respondents were offered the option to respond anonymously or consented to include their name, organization, or other identifiers in the report.

2.1 Analysis

Two authors independently read all qualitative text comments and organized them by topic area, identifying themes and recurring concerns raised by respondents, which informed the narrative component of the report. The two authors selected salient quotes to include in the report, which articulated recurrent themes and/or highlighted perspectives of individuals disproportionately impacted by the pandemic or with specialized professional knowledge.

A composite assessment of the CDC's performance in the eight key areas of pandemic management were scored from *strongly agree to strongly disagree* on a 5-point Likert scale. We summarized count data for survey responses in a stacked bar chart. Unsure responses were excluded. Descriptive statistics were summarized by a combination of information from the demographic fields solicited in the survey and by searching free text responses to open-ended questions, using keywords to identify data on occupation, affiliations and other descriptors. Two investigators completed and cross-validated respondent classification by profession and organizational affiliation.

One author facilitated a group of six coauthors who drafted the report, based upon the essential pandemic areas framework, and synthesized data from medical and public health literature, CDC MMWR reports, newspaper articles, white papers, and pandemic policy proposals from grassroots organizations.^{53,54} After a draft analysis and report was written, the authors invited the People's CDC membership and 50 survey respondents to review. Twenty-six people provided feedback, including experts in epidemiology, infectious disease, industrial hygiene, occupational health, public health nursing, and members from organizations disproportionately impacted by the pandemic, among others, including five who verified citations. One author then incorporated and responded to reviewer suggestions, in an internal peer-review process.

2.2 Limitations

A principal limitation of the study is that all respondent recruitment was via email or social media. Many of the communities most impacted by the pandemic may have less access to digital means of communication. People's CDC members made repeated attempts to share the survey with participants from rural and urban areas, reaching out to organizations and communities directly impacted by the pandemic. The brevity of our survey may also

have limited participants' ability to offer more nuanced feedback on specific aspects of performance in each of the pandemic areas. Although the survey included two spaces for free-text open responses, not all participants used this feature.

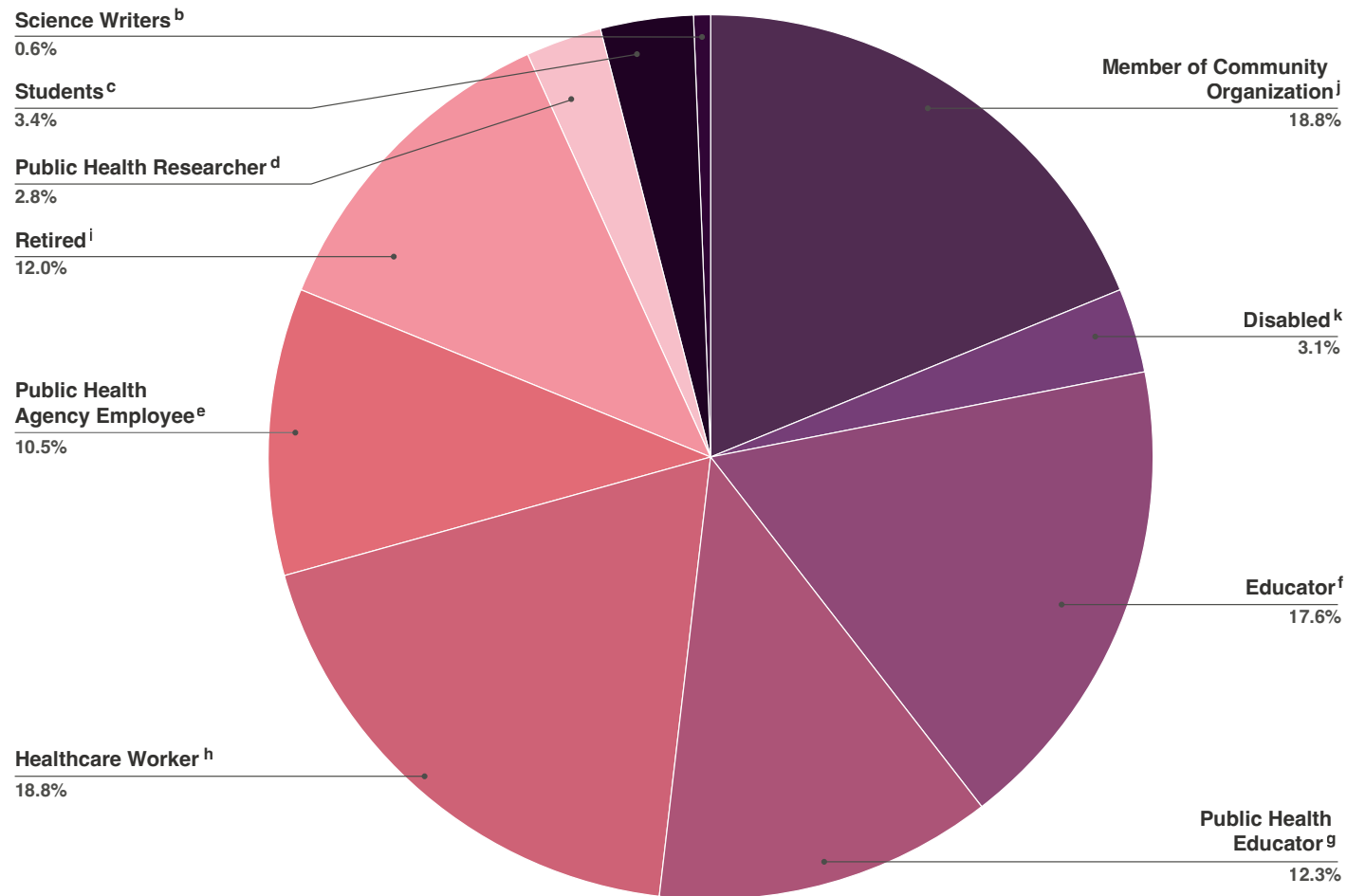
Respondent classification by profession and organizational affiliation was completed and cross-validated by two investigators, but vague or incomplete responses limited the accuracy of counts in these categories. The survey also solicited little demographic data, and did not require occupational data or data to assess whether respondents self-identified as being at high risk for serious illness due to COVID, in order to protect participant privacy. A better understanding of participant demographics also could have enriched the findings. Future research with a longer and more detailed survey instrument may help to elucidate some of these nuances.

Likert scale answer choices limit the scope of possible responses, and respondents may differ in their interpretation of differences between response levels. Likert scales are also subject to response bias, social desirability bias and demand characteristics. Response bias may have biased responses toward extremes of the Likert scale. Survey responses were not anonymous, which enabled investigators to request and attribute quotes to participants with their consent, although people could choose to respond anonymously. This may have contributed to bias due to social desirability and demand characteristics. Furthermore, perceptions that an external review of the CDC was intended to be critical, could have biased survey responses negatively.

2.3. Respondent Demographics and Survey Data

Four hundred and ninety-four individuals completed the survey from 152 organizations or institutions, including over 130 public health and medical professionals from 40 different U.S. states and territories. Three hundred and twenty-four individuals provided information on affiliation, employment, and/or area of expertise in the demographics section of the survey. The largest occupation categories included 97 educators, 61 healthcare workers, 61 members of community-based organizations, 40 public health educators and 34 public health agency employees. One hundred and seventy people did not provide any demographic information, as this was not a required field in the survey. Figure 2.3.1 below demonstrates categories of occupation/affiliation for the 324 respondents for whom occupational/affiliation data were available.

Figure 2.3.1. Occupation and Affiliations of Survey Respondents^a for People’s External Review of the CDC



- a. The People’s External Review collected responses from May to August 2022, via an online survey. Responses in this chart include 324 respondents for whom occupation/affiliation data were available.
- b. “Science writers” self-identify as journalists who write about public health or science-related topics.
- c. “Students” include self-identified students at university and/or graduate levels.
- d. “Public health researchers” include self-identified public health researchers and epidemiologists working in academic institutions or other organizations.
- e. “Public health agency employees” include epidemiologists and other workers at local or state public health government agencies, and retired agency employees.
- f. “Educators” include professors at universities, K–12 teachers and other educators, who teach in fields other than public health, including retired educators.
- g. “Public health educators” include university professors in public health fields, including retired public health educators.
- h. “Health care workers” include physicians, nurses and medical technicians, including retired healthcare workers.
- i. “Retired” includes individuals not otherwise classified who described themselves as retired.
- j. “Member of community organization” includes individuals who noted affiliation with a community based-organization.
- k. “Disabled” includes individuals who self-identified as “disabled” in questions about occupation/affiliation.

Four hundred and ninety-four respondents also answered the Likert survey questions. Unsure responses were excluded and ranged from 5-22 of the total 494 responses. Over 65% of all respondents disagreed or strongly disagreed that the CDC had met expectations in the eight areas of pandemic management (see Figure 3.2). This data can also be found in tabulated form for accessibility in [Supplemental Table A](#).

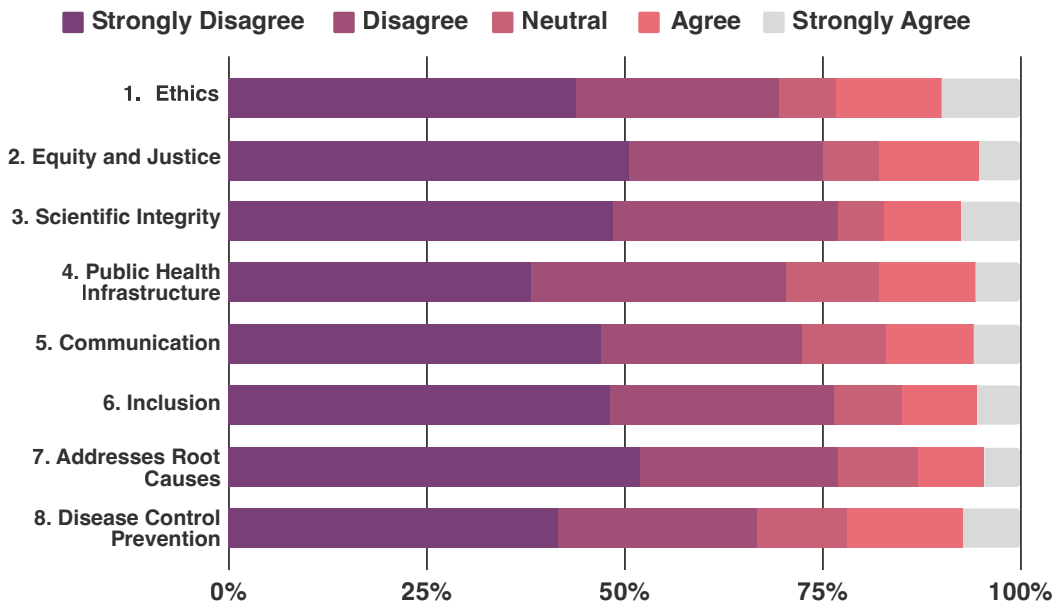


Figure 2.3.2. Survey Responses for People's External Review of the CDC Management of the COVID-19 Pandemic from January 2021 to August 2022

3. KEY FINDINGS: THE PEOPLE'S ASSESSMENT

In this section, we discuss our assessment of the eight key areas of pandemic management and survey results. Throughout the discussion, we include quotes from the qualitative portion of the survey to demonstrate respondents' concerns and perspectives on the CDC response to the pandemic since January 2021.

3.1. Disease Control and Prevention.

Collect and use high-quality data to promote a multifaceted approach to prevent and control disease transmission

Instead of acknowledging the very real public health threat the COVID pandemic continues to pose, the CDC has increasingly downplayed the risk of COVID-19, stating, “High levels of population immunity and availability of effective COVID-19 prevention and management tools have reduced the risk for medically significant illness and death.”¹⁵ However, over a year after COVID treatments and vaccines became available, COVID-19 remains the third leading cause of death in the United States.^{4,5} As of January 2023, an estimated 5% of the U.S. population report impairments in daily activities due to Long COVID.⁵⁵ The CDC's approach to rely on vaccines and treatments, rather than aiming to reduce COVID transmission, leaves high-risk individuals, such as older adults, immunocompromised and chronically-ill people permanently at risk of severe illness and death due to COVID-19. Survey respondents noted consistently that the CDC failed to emphasize a comprehensive, multilayered approach to primary prevention of illness, death, and disability from COVID. The strategy promotes increased transmission of disease and the emergence of new and potentially worse COVID variants, such as XBB and BQ subvariants,⁵⁶ which can already evade existing vaccines and COVID treatments and may ultimately prolong the pandemic.

“The CDC should be consistently noting the airborne nature of COVID-19 as top-line messaging, and guiding local and state health departments to likewise do this, with appropriate airborne mitigation that goes beyond masking to include air ventilation, air filtration, and UVGI... We have many tools for reducing airborne mitigation risk that the CDC and other Federal agencies are not emphasizing appropriately”

– Anonymous Public Health Policy Researcher, Illinois

The CDC should better **educate the public regarding airborne or aerosol transmission** of COVID. The SARS-CoV-2 virus, which causes COVID, can accumulate in the air when infected people exhale, talk, sneeze, or cough, especially in enclosed, poorly ventilated, indoor settings.^{57,58} **Layers of protection (i.e., use of masks, ventilation, testing, and vaccines in combination) are highly effective at decreasing COVID transmission rates.**⁵⁹ This approach can be visualized using a Swiss cheese model (see Figure 3.1.1). Ventilation can decrease COVID transmission by nearly 50%.⁶⁰ However, even in the best ventilation circumstances (e.g., outdoors), the risk of COVID transmission is not zero. For example, in crowded outdoor settings, COVID outbreaks can occur, such as the COVID outbreak at an outdoor concert in Puerto Rico in December 2021, where 2,000 people (about 2.5% of the roughly 80,000 who attended the event) contracted COVID-19.⁶¹

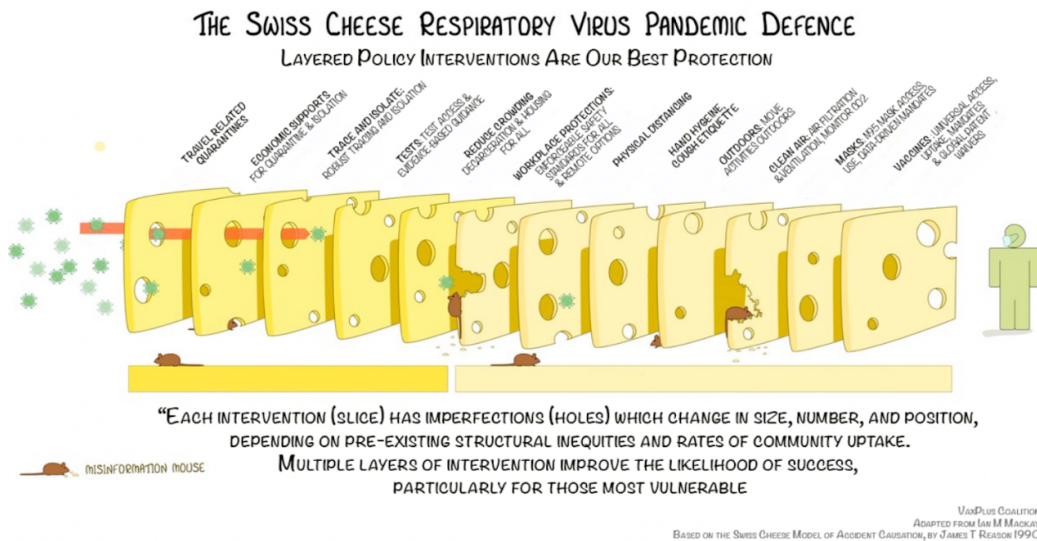


Figure 3.1.1. Layers of protection, using masks, ventilation, testing, vaccines and other methods together are highly effective at decreasing COVID transmission rates (adapted from MackayIM 2021 and Urgency of Equity 2022).

Masks and mask mandates reduce the risk of COVID transmission for individuals and in communities.^{60,62–64} Universal masking (i.e., masking by everyone) with high-quality N95 respirators is much more effective than one-way masking (i.e., by some and not others) to prevent COVID transmission.⁶⁵ However, the CDC frames mask wearing as a matter of preference rather than an evidence-based means to protect each other. Masks protect both the wearer and others around them, by filtering COVID virus exhaled by people who are infected and inhaled by uninfected people.⁶⁵ The dose of virus inhaled impacts the likelihood a person will become sick with COVID-19 and may impact the severity of illness as well.⁶⁶ For these reasons, universal masking is more effective at reducing COVID-19 exposure (see Figure 3.1.2).⁵⁷

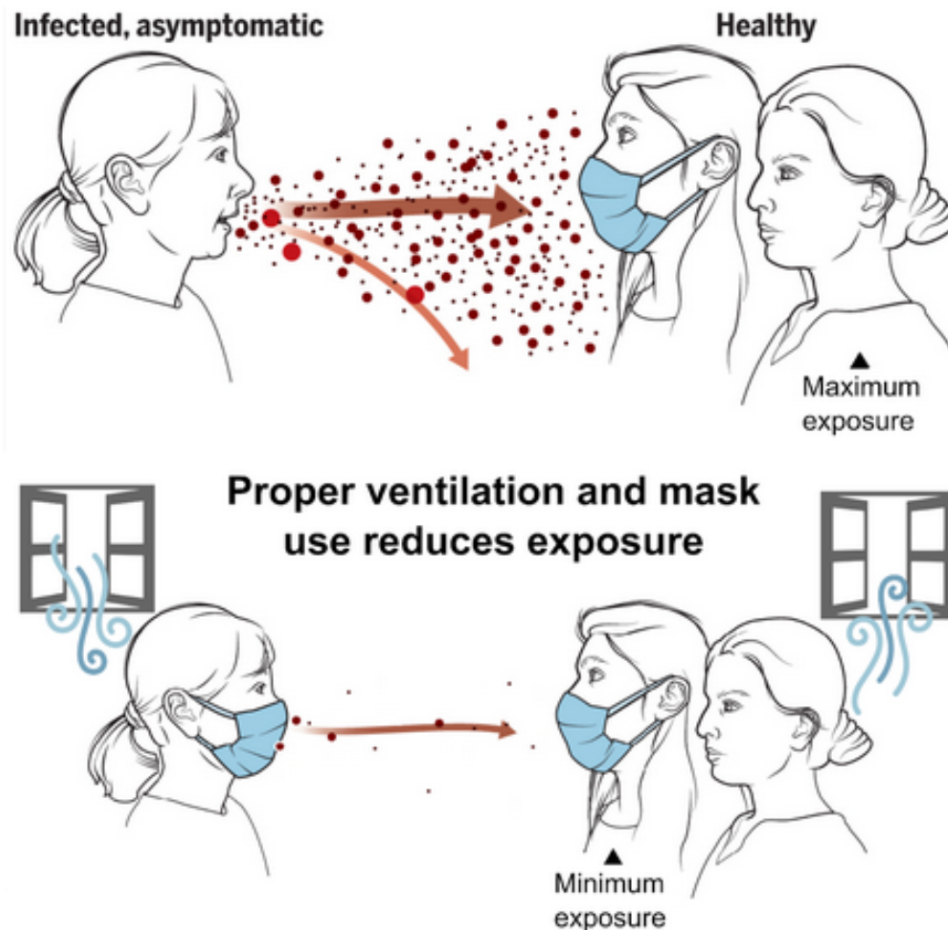


Figure 3.1.2. People are exposed to more virus particles when an infected person is not wearing a mask. Proper ventilation and mask use reduces the exposure (adapted from V. Altounian, [Urgency of Equity 2022](#))

GRAPHIC ADAPTED FROM V. ALTOUNIAN/SCIENCE

Furthermore, relying exclusively on individual acquisition and use of PPE for infection control is inconsistent with long-standing recommendations and regulations for hazard control. In particular, the National Institute for Occupational Safety and Health (NIOSH), which is part of the CDC, recommends the “hierarchy of controls” framework for layering hazard control measures, rather than exclusive use of a single intervention. As is shown in Figure 3.1.3 below, this framework emphasizes individual personal protective equipment (PPE) alone is the least effective approach and should be used in conjunction with broader measures.⁶⁷ In the context of aerosol/airborne pathogen control, the “engineering controls” component of this framework indicates indoor settings (e.g., workplaces) should prioritize improving indoor air quality by increasing ventilation and filtration in those spaces, which can be accomplished by several means, including natural ventilation (e.g., via doors and windows),⁶⁸ use of higher quality (MERV-13 standard or better) HVAC filters,⁶⁹ use of portable air cleaners with HEPA-grade filters,^{70,71} and possibly also Far-UVC germicidal radiation.⁷² However, the implementation of these engineering controls, while preferable to respirator use alone, requires time, funding, resources, and labor that have not yet been made widely available. For example, only 39% of U.S. K–12 public schools in a 2022 national survey reported using higher cost strategies (e.g., HVAC improvements, HEPA

filtration systems) to improve ventilation.⁷³ Guidance on indoor air quality improvements has already been made available by relevant organizations, including the American Society of Heating, Refrigerating and Air-Conditioning Engineers (ASHRAE), the American Industrial Hygienists Association (AIHA), and the American Conference of Governmental Industrial Hygienists (ACGIH).^{74,75} However, this guidance has not been incorporated yet into legally-binding regulations. Thus, universal respirator use is an important bulwark against indoor transmission until these measures are implemented consistently and equitably in indoor public and work spaces. Although we welcomed the mention of “high-quality masks” in the August 2022 CDC guidance, new recommendations failed to provide details or recommend public distribution of N95 respirators, which can be prohibitively expensive,⁷⁶ especially because the federal mask distribution program has ended.

“I am a disabled person who has been mostly housebound throughout the pandemic, and I live with a fellow immunocompromised person. We have both been exposed to COVID several times... We ration N95s, because they are expensive—the local businesses that supply free masks have said they were out of stock every single time I have called. I have had to postpone medical appointments during surges because many healthcare settings are not actually following COVID precautions, and I hardly ever socialize with friends and family. As tracing has ended and local transmission is harder to gauge, I feel less safe than ever.”

– Anonymous, New York

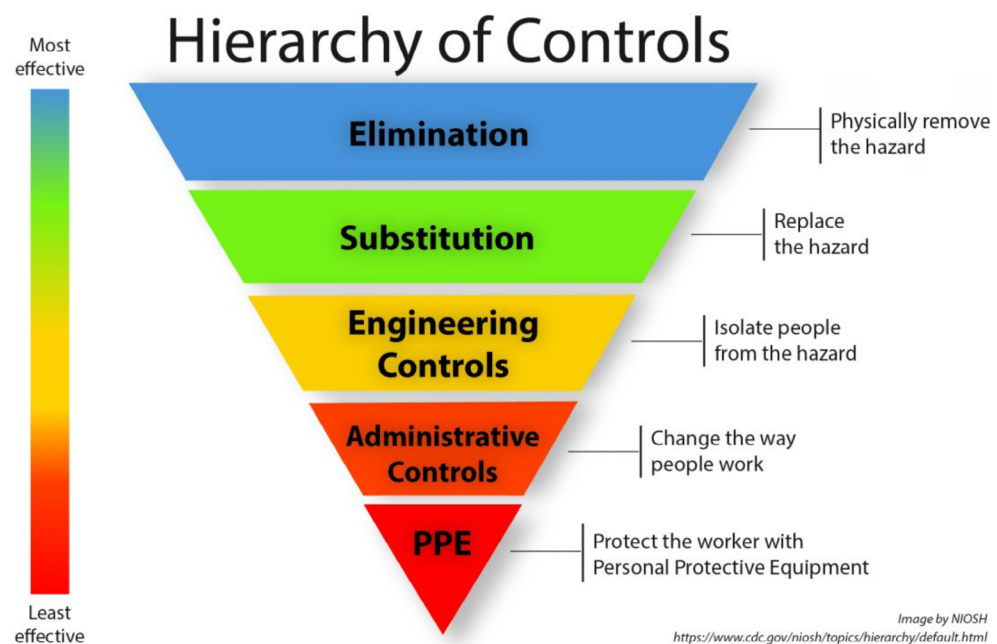


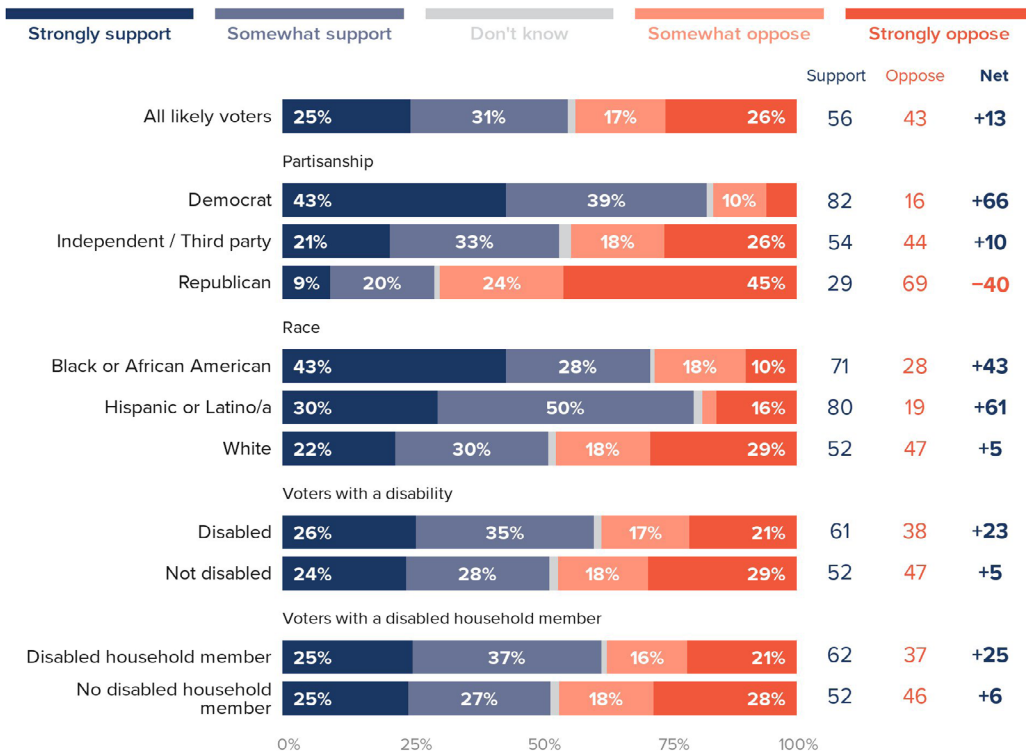
Figure 3.1.3. NIOSH hierarchy of controls, detailing five levels of controls “to remove or control hazards” (NIOSH, 2022) from top to bottom, in decreasing order of efficacy

The lack of a federal mask mandate makes it difficult for local officials to issue mask mandates, even when case rates are high enough that CDC guidelines support them.

For example, according to the Community Levels map, in July 2022, most U.S. counties should have enacted indoor mask mandates. However, when the CDC Community Levels map reaches a “high” COVID-19 community level, the CDC “recommends” individuals should wear masks indoors rather than recommending counties or states issue indoor and school mask requirements. Without a federal mask mandate, public health officials in Philadelphia and Los Angeles faced fierce opposition from business leaders when trying to implement local mask mandates, even to comply with the CDC indoor mask “recommendation” for “high” COVID community levels.^{77,78} Although CDC Director Walensky stated the hands-off approach defers responsibility to local policymakers,⁷⁹ in reality, local officials often cite the relaxation of CDC guidelines as the reason masks are no longer required.^{80,81} Public opinion continues to support requiring masks in indoor public spaces to prevent surges when COVID cases are high, as Figure 3.1.4 shows.^{22,82}

Voters Support Masks in Indoor Public Spaces

Do you support or oppose requiring that all individuals wear masks in public indoor spaces, like in grocery stores, restaurants, and retail shops, in order to combat another surge of coronavirus infections?



December 14–19, 2022 survey of 1,532 likely voters

DATA FOR PROGRESS

Figure 3.1.4. A December 2022 poll showed most U.S. voters supported masks in indoor public spaces to prevent COVID-19 surges ([Data For Progress, 2022](#)).

Preventing COVID-19 infections in schools is a [cornerstone of pandemic response](#). School outbreaks can seed infection in communities easily (see Figure 3.1.5).⁸³ But, even amidst a national pediatric bed crisis due to a surge in RSV and flu in Fall and Winter 2022,⁸⁴ CDC officials did not encourage people to wear masks to help prevent spread of respiratory viruses until December 2022 (see Figures 3.1.6a and 3.1.6b).^{85,86} Masks in schools have been linked to fewer COVID cases and student, teacher, and staff absences (see Figure 3.1.7).⁸⁷ Regular surveillance testing has been demonstrated to reduce COVID-19 transmission in schools,⁸⁸ but the CDC stopped recommending this in August 2022.^{15,89} Although public discourse has emphasized the importance of “returning to normal” above all else, this is difficult or impossible for the 200,000 U.S. children who lost a caregiver to COVID-19 during the pandemic—and the many more who live with adults at increased risk of severe illness from COVID-19. There is no robust empirical evidence showing masks interfere with student learning or cognitive development.⁹⁰ On the other hand, COVID-19 is a leading cause of death in children,⁷ and children can also develop Long COVID.^{7,91} Especially when COVID transmission rates are high, masks are much safer than catching COVID-19.

“I’m a psychologist working with kids and adolescents in public schools. Several of the kids I work with caught covid at school, brought it home to their parent or caregiver, and their parent/ caregiver consequently died. How does ensuring these situations continue to occur help the mental health of our country’s youth? What resources are you providing mental health professionals to help these students?”

– Anonymous Psychologist, New Jersey

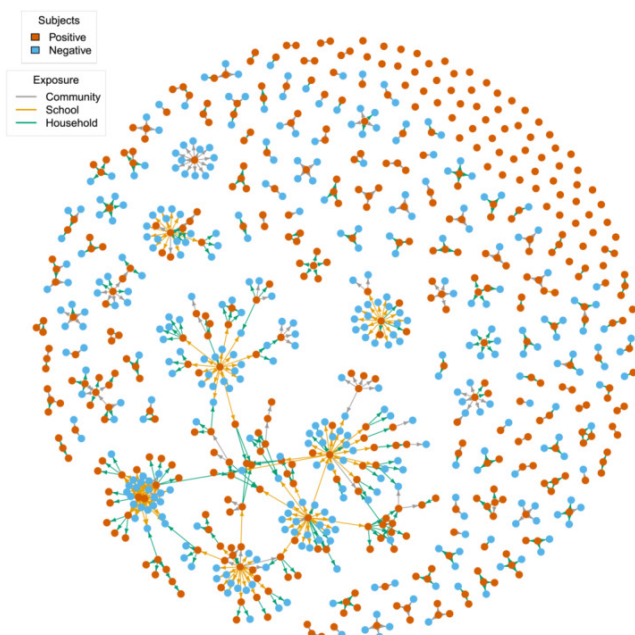


Figure 3.1.5. Infections acquired in school (connected with yellow lines) infect larger clusters (broader groups of people) and have longer chains of transmission (where one person infects another person who infects another) than infections acquired in the household (blue) and community (gray) ([Manica et al., 2022](#)).

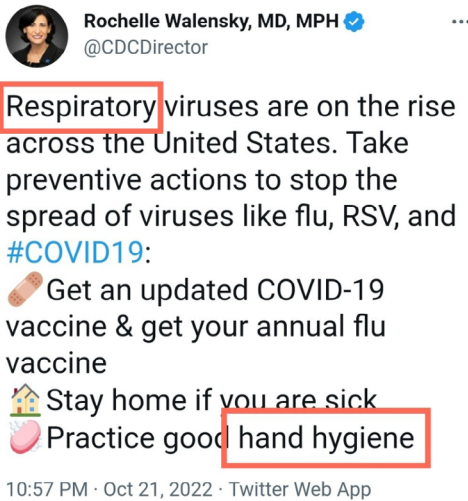


Figure 3.1.6a and b. Tweets from CDC Director Rochelle Walensky and the official CDC account fail to mention mask wearing as a way to protect against respiratory illnesses.

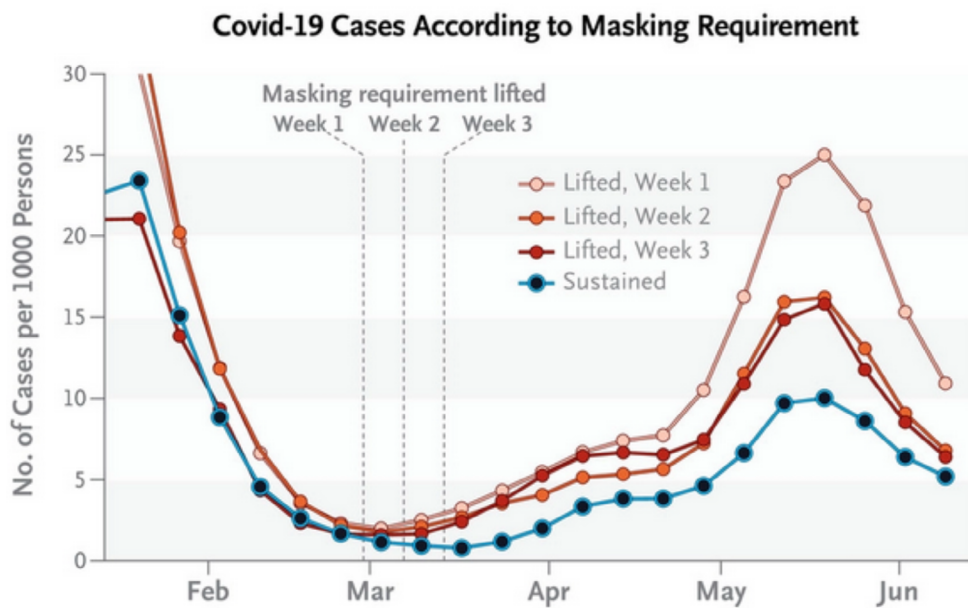


Figure 3.1.7. Schools in Massachusetts, which sustained the masking requirement through the end of the 2021 school year, had significantly fewer COVID-19 cases among students and staff than districts that lifted the mask requirement (Cowger et al., 2022).

Universal mask wearing on public transport is another important measure to prevent COVID transmission in spaces where people spend long periods together in close quarters. A CDC order to require universal mask wearing on public transport, including buses, trains and planes, ended when it was struck down by a Florida judge in April 2022.^{92,93} Although the Supreme Court ruled in September 2022 that the Transportation and Security Administration (TSA) had the authority to require masks on planes, trains, and other forms of transport,⁹⁴ the CDC has not publicly encouraged TSA to reinstate the mask mandate, and continues to only “recommend” mask wearing on public transportation. Mask mandates on public transport have remained popular. A November 2022 poll showed 57% of Americans continued to support mask mandates in airports (see Figure 3.1.8).²³ Mask mandates on transport are especially popular among Black and Hispanic respondents,²³ who are more likely to rely on public transport to commute to work (see Figure 3.1.9).⁹⁵

“I am an immunocompromised physician. I have been extremely disappointed that the CDC has reversed its position on the importance of masking, especially on public transportation (I got Covid in July 2022 after a flight, and tested positive for 35 days, despite prophylactic Evusheld and Paxlovid after infection). I am angry that the CDC has loosened quarantining/isolation protocols. I feel that the organization is corrupt, inept, or both.”

– Linda Parman, MD, Radiologist, Texas

29A. Support a Mask Mandate on Transportation — Airplanes

Would you support or oppose a policy that made it mandatory to wear masks in the following places?

	Gender			Race			Age				Income		
	Total	Male	Female	White	Black	Hispanic	18-29	30-44	45-64	65+	<50K	50-100K	100k +
Strongly support	35%	31%	40%	32%	55%	34%	33%	34%	38%	34%	42%	28%	32%
Somewhat support	22%	22%	22%	21%	16%	31%	30%	23%	17%	21%	21%	28%	21%
Somewhat oppose	11%	12%	10%	10%	8%	20%	15%	14%	8%	9%	8%	14%	13%
Strongly oppose	21%	26%	17%	27%	4%	12%	11%	15%	27%	29%	16%	26%	25%
Not sure	10%	9%	10%	10%	17%	3%	10%	14%	9%	6%	12%	4%	8%
Totals	99%	100%	99%	100%	100%	100%	99%	100%	99%	99%	99%	100%	99%
Unweighted N	(1,483)	(689)	(794)	(943)	(189)	(239)	(319)	(351)	(419)	(394)	(570)	(409)	(347)

The CDC’s September 2022 revised guidance for health care settings promoted COVID-19 transmission and placed vulnerable people with chronic diseases at risk. The new guidance said masks can be removed in health care settings when community transmission is no longer high.⁹⁶ However, community transmission levels are based on reported case data, which likely underestimate COVID-19 infections by as much as 30 times,^{97–99} because fewer people are testing for COVID and because the United States lacks a reporting system for home antigen tests. Even when community transmission rates are low, people with COVID seek care at clinics and hospitals, making them among the most likely places to encounter people with COVID-19. Contagion in healthcare settings is already a problem even in well-equipped U.S. academic medical centers.^{100,101} Because 40% of COVID cases are asymptomatic,¹⁰² it is insufficient to only require people with symptoms to mask. Without additional paid sick leave for COVID-19, employees also have an incentive not to test to avoid the recommended 5-day isolation period.¹⁰³ Failing to require masks in health care facilities, in nursing homes, and for home health care workers likely will place vulnerable people at risk for COVID exposure, including babies, immunocompromised and chronically-ill people, and older adults.

Figure 3.1.8. The Economist/YouGov poll of 1500 U.S. adult citizens, November 19-22, 2022, showed 57% of Americans support mask mandates on airplanes ([Economist/YouGov, 2022](#)).

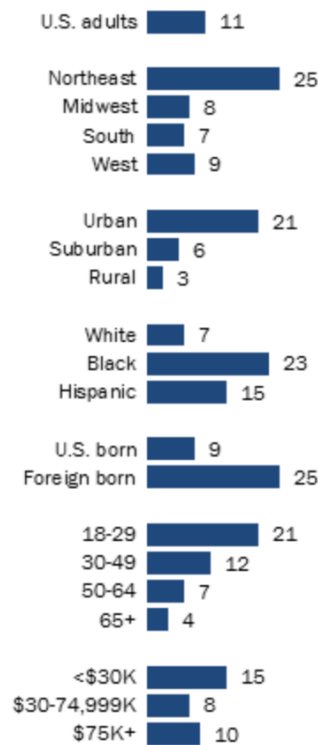


Figure 3.1.9. Percent of U.S. Adults who say they take public transportation (like a bus, subway or train) on a daily, almost daily or weekly basis ([Anderson, 2016](#)).

Note: Whites and blacks include only non-Hispanics. Hispanics are of any race.

Source: Survey conducted Nov. 24-Dec. 2015.

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Although reported case data underestimate COVID-19 infections, wastewater surveillance can detect SARS-CoV-2 shed by people with and without symptoms and can serve as an early warning that COVID-19 is spreading in a community.¹⁰⁴ Wastewater data were well-correlated with the rates of COVID-19 cases earlier in the pandemic.¹⁰⁵ However, as testing has decreased, some communities’ wastewater data suggest COVID-19 infection rates are much higher than reported, as Figure 3.1.10 from a California-based epidemiologist demonstrates below. The CDC should advocate for increased investment in wastewater surveillance across the United States. Ideally, the CDC and local public health authorities should use a combination of wastewater data and local community transmission (corrected for low rates of testing) to trigger public health mitigation measures, instead of using the problematic Community Levels map, which emphasizes hospitalizations rather than illness and Long COVID.

San Francisco Wastewater and Cases

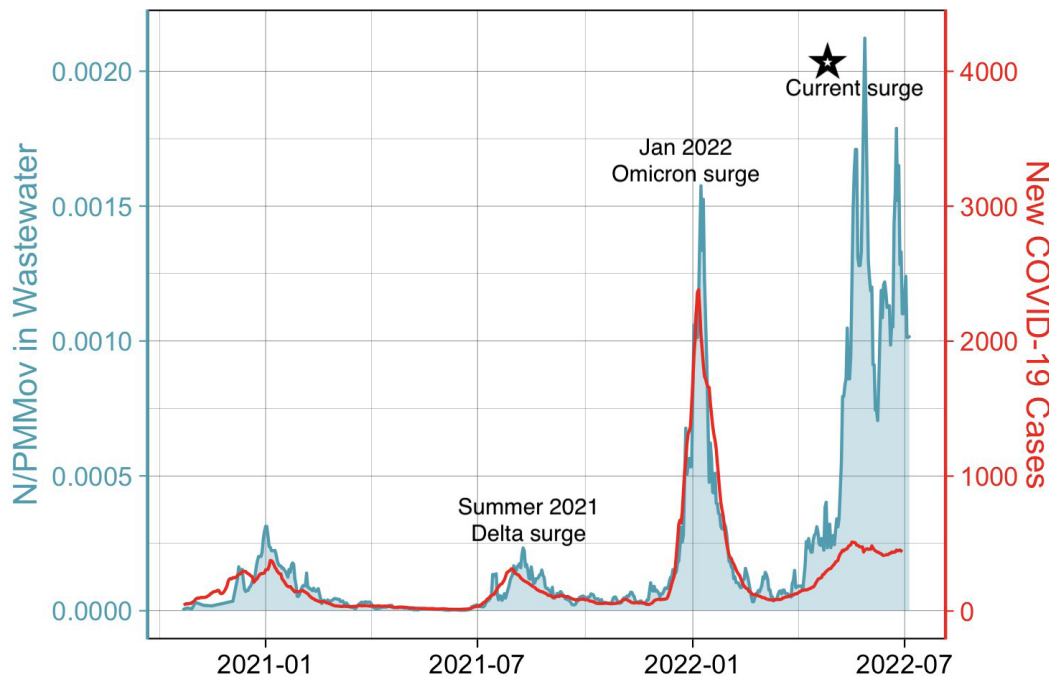


Figure 3.1.10. In this example from San Francisco, the concentration of SARS-CoV-2 in wastewater is in blue, and publicly reported cases are in red. Although cases looked much lower in July 2022 than January 2022, wastewater concentrations of SARS-CoV-2 were as high or higher than the January Omicron surge (Wolfe, 2022).

Prevention of COVID infection is especially important because SARS-CoV-2 mutates rapidly. Circulating Omicron variants have rendered monoclonal antibody treatments Sotrovimab and Bebtelovimab obsolete already.^{106,107} In late January 2023, the FDA announced that Evusheld, the prophylactic monoclonal antibody treatment containing tixagevimab and cilgavimab, offered to immunocompromised patients as additional protection, was no longer approved for use because it no longer protected against circulating COVID-19 variants.¹⁰⁸ Although vaccines prevent severe illness and death in most people, they are less effective at protecting older adults and immunocompromised people.^{41,109} For this reason, layered, nonpharmaceutical interventions are more reliable than relying on vaccines to reduce transmission and disease. Infants under 6 months

of age are ineligible for vaccination and were hospitalized at high rates, similar to people ages 65–74 during from December 2021 to August 2022.¹¹⁰ The CDC MMWR reports mentioned the importance of nonpharmaceutical interventions to protect immunocompromised individuals and infants,^{41,110} but CDC public health guidance does not emphasize such measures for the general public. As we lose increasing treatment options due to resistance, layered protections including masks and testing become more important to prevent infection.

I have an adult brother with Down Syndrome that contracted COVID this year (yes, even after 3 doses of vaccine). He was ventilated for months, had ARDS and sepsis, and contracted MRSA at the hospital. He survived but is still in recovery... To the CDC, he is just an “at risk individual.”

– Victoria Jent, MAS, Public Health Data Analyst, New York

Vaccines also provide only limited protection against Long COVID even for healthy, vaccinated adults and children.¹¹¹ Even after mild infections, COVID-19 can cause Long COVID, an umbrella term used to describe a constellation of conditions such as blood clots, heart attacks, strokes, brain fog and many others that can cause serious acute and long term syndromes.¹¹ The CDC defines Long COVID as “a range of new or ongoing symptoms that can last weeks or months after they are infected with the virus that causes COVID-19 and that can worsen with physical or mental activity.”¹¹² Repeated COVID infections can increase the risk of death, severe illness, and long-term sequelae in multiple organ systems due to COVID-19 (see Figure 3.1.11).¹¹³

“The vast majority of Americans do not know what Long COVID is or that everyone is at risk of developing it. This should be one of the top priorities of a public health agency aimed at preventing disease.”

– Lisa McCorkell, MPP, Co-Founder, Patient-Led Research Collaborative, California

Because one-way masking does not offer complete protection from COVID, babies, children, and some adults cannot mask effectively, and high-risk people cannot remain masked at all times, only collective efforts to reduce COVID transmission can keep us all safe.

“I have interstitial lung disease, so I’m high risk for hospitalization and/or death. Relaxing COVID mitigations puts me in even more

danger. I avoid indoor events and missed my high school friend’s wedding. I get my groceries delivered. I requested a mail-in ballot but never received it. I made my pastor mad when I wanted him to keep his mask on during his sermon and requested proper air filtration and ventilation. Relaxing COVID mitigations in public schools where vaccine rates are low makes me worry about my niece, who has already had COVID twice. Each time she catches it increases her risk of getting Long COVID... It’s irresponsible, reckless and negligent.”

– Anonymous, Chicago

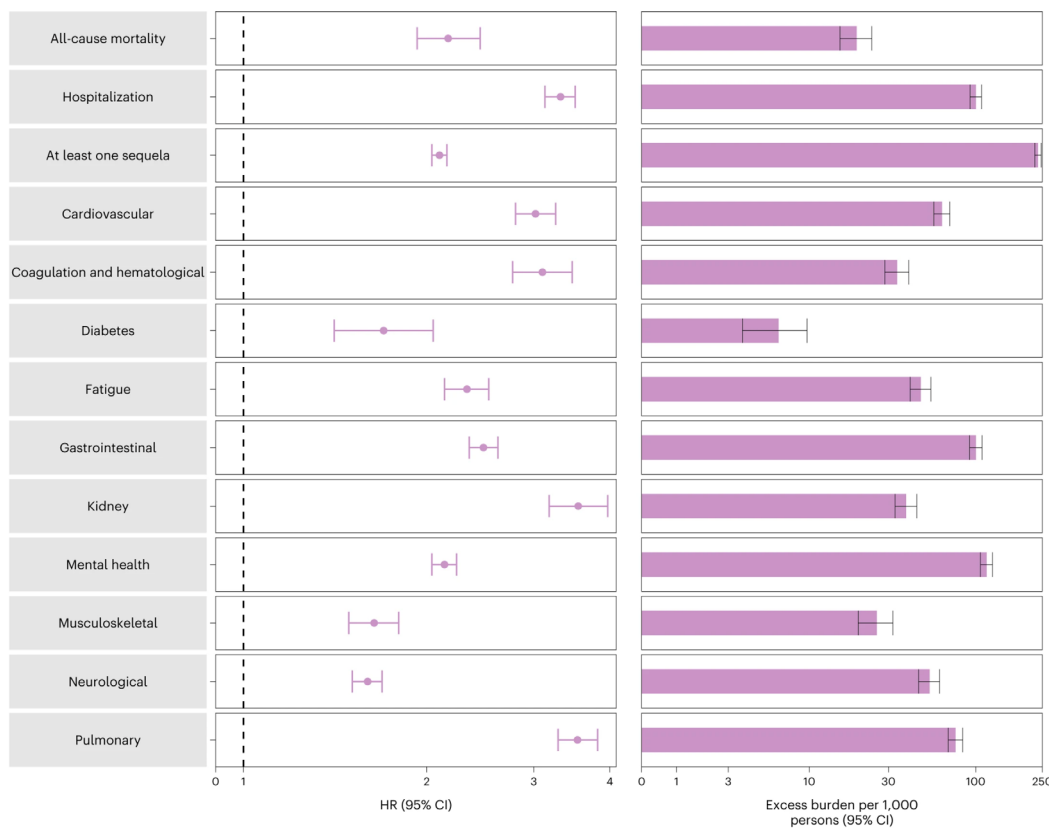


Figure 3.1.11. Risk and burden of sequelae in people with SARS-CoV-2 reinfection versus no reinfection shows repeated COVID-19 infection increases the risk of hospitalization, death, or Long COVID (Al Aly et al., 2022).

Recommendations for Control and Prevention of Disease:

- **The CDC should promote a comprehensive, layered public health strategy to reduce COVID transmission.** Such an approach should include targeted mask mandates to prevent surges, improved ventilation, workplace protections, public and free distribution of N95 respirators, and increased access to free testing, vaccines, and treatment.
- **The CDC should better educate the public that the SARS-CoV-2 virus, which causes COVID, is airborne,** meaning transmission happens through aerosols that can accumulate in the air when infected people exhale, talk, sneeze, or cough,

especially in enclosed, poorly ventilated, indoor settings.^{57,58}

- **The CDC should implement early warning systems to prevent COVID surges**, using local community transmission (corrected for low rates of testing) and wastewater data to trigger mitigation measures, instead of the Community Levels map, which emphasizes hospital capacity rather than sickness and Long COVID.
- **The CDC should advocate for increased funding and work with public, private, and community-based institutions to improve ventilation in public spaces**, including schools, workplaces, congregate living facilities, prisons, jails, and immigration detention centers, aiming for at least 6–12 air changes per hour (ACH) per guidelines of the American Conference of Governmental Industrial Hygienists (ACGIH) and the American Society of Heating, Refrigerating and Air-Conditioning Engineers (ASHRAE).⁷⁴
- **The CDC should broaden public messaging and education on the risks and prevalence of Long COVID**, its impacts, and how to seek help. This includes amplifying the CDC's findings, such as CDC reports showing at least 1 in 5 adults develop symptoms of Long COVID and children are twice as likely to develop serious heart and kidney problems after COVID infections.^{10,91}
- **The CDC should continue to require masks and pre-procedure/pre-admission testing** at all times in health care facilities and nursing homes, and recommend masks be required in all pharmacies as well.
- **The CDC should recommend that TSA to reinstate mask mandates** on public transportation, including airports, planes, buses, and trains, which most U.S. adults support.²³

3.2. Ethics.

Emphasize the equal value of all people's lives through policy decisions.

“I am a high-risk person with chronic illness who has feared for my life for most of the last 3 years. Now, CDC policies have completely left disabled people behind as if our lives are disposable because abled people don't want to wear masks. Abled people's convenience is not worth more than disabled people's lives.”

– Christine Mitchell, ScD, MDiv, Public Health Justice Collective, California

Above all, the CDC has privileged the interests of employers and the corporate sector and has prioritized keeping people in the workplace rather than protecting the lives and health of the U.S. public. The interdependence of people is a fundamental ethical principle at the core of public health.^{51,52} Although many of the eight key areas of pandemic management addressed in this report also are fundamental ethical principles, we address a few ethical concepts in depth in this section: (a) accountability and transparency, (b) respect for persons, and (c) interdependence, beneficence, and autonomy.

3.2.1. Accountability and Transparency

The CDC has veered from its duty to be **accountable and transparent** to the public by failing to base public recommendations on data regarding the risks of unmitigated COVID transmission. Although the CDC MMWR reports consistently demonstrate the efficacy of masks and mask mandates in preventing COVID transmission,^{60,62,63} CDC recommendations suggest mask wearing should be based on personal preference, rather than explicitly recommending mask and respirators as evidence-based protections to promote the common good and the health of the public.⁷⁹ **Because the CDC no longer recommends mask mandates explicitly, many institutions cite CDC guidelines as the principal reason not to mandate masks^{80,81}** in a circular system of reasoning that evades accountability at all levels.

‘As a freelancer who is not a member of a workers’ union, I have had to turn down many job opportunities... because the workplaces were “following CDC guidelines’.” ... Many people in charge of companies and organizations will avoid building comprehensive COVID safety infrastructure into their budgets if they aren’t required to do so... and it leads to high-risk folks being pushed out of workplaces, and society in general.’

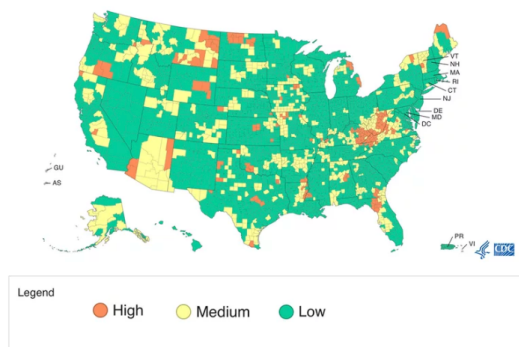
– Anonymous Freelance Artist, Minnesota

The CDC encourages the U.S. population to incur short- and long-term risks of COVID infection without their informed consent. CDC leadership and leading health experts increasingly have helped to shift public perception of COVID infection and transmission as normal and safe, which is not the case for millions of people in the United States. For example, in February 2022, the CDC changed the maps that trigger mitigation measures from the “Community Transmission” map to the “Community Levels” map based on the premise that COVID transmission is not problematic unless the health system is strained by COVID-19 hospitalizations.¹¹⁴ In the original “Community Transmission” map, risk levels were based on a combination of the number of new cases and the percentage of positive tests in the last 7 days. More than 100 new cases per 100,000 in the last 7 days was considered high.¹¹⁵ Now, the new Community Levels map considers anything less than

200 cases per 100,000 low. Furthermore, in the new map, high case numbers are not even sufficient to warn the public that the risk of COVID-19 is high as was the case with the old map. In the new map, case numbers greater than 200 also must be accompanied by high rates of new COVID-19 hospital admissions and/or percentage of hospitalized patients with COVID-19 to trigger a high community level.¹¹⁴ **The new map signals to the public that previously “high” rates of COVID-19 transmission are suddenly “low” risk.** It also communicates high rates of COVID transmission are fine unless the hospital system is strained, even though the risk of being infected with COVID-19 is related to the number of cases, not hospitalizations, in the community. As a result, **the Community Levels map essentially eliminates a leading indicator of virus spread (i.e., case numbers),** which could be used as an early warning to implement public health protections. **The new map builds a delay into the public health response, by basing public health guidance on a lagging indicator.** Because COVID-19 hospitalizations typically lag a week or more behind infections, by the time rates of COVID hospitalization rates rise, it is then too late to prevent many deaths.¹¹⁶ Lastly, the pastel color scheme of the new Community Levels map dampens the alarm, by using light orange at the highest level of risk, as opposed to the classic “green, yellow, red” to signal risk level in the original map. In effect, the new “Community Levels” map made the U.S. COVID risk level switch from high to low, and the map from red to green with the same data on the same day (see Figures 3.2.1 and 3.2.2 below). Ultimately, the decision to change metrics for masking recommendations took place without a clear public debate on the ethical tradeoffs of tolerating high rates of COVID transmission,¹¹⁷ equity considerations, or public input.

U.S. COVID-19 Community Levels by County Map

Maps, charts, and data provided by CDC, updates every Thursday by 8 pm ET
Updated: March 10, 2022



Level of Community Transmission of All Counties in US

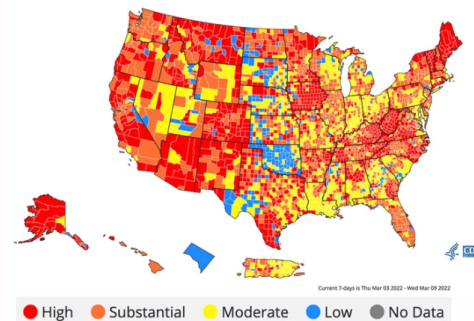


Figure 3.2.1. The new Community Levels map made the U.S. COVID risk level switch from red to green with the same data on the same day in early March 2022, shown beside the Community Transmission map, from March 2022 ([CDC via Stone and Simons-Duffin, 2022](#)).¹¹⁸

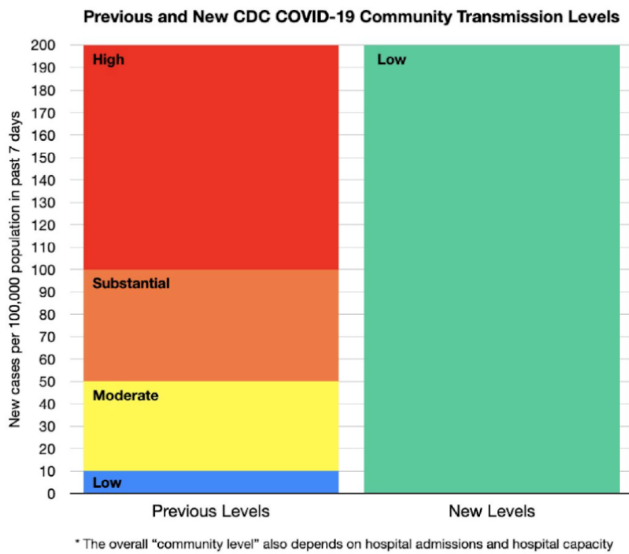


Figure 3.2.2. CDC guidelines prior to February 2022 categorized COVID-19 case rates > 50 cases per 100,000 substantial or high, but now fewer than 200 cases per 100,000 are considered low as long as the hospital metrics are low.

“De-emphasizing the map showing rates of COVID transmission and replacing it with Community Levels map is just one big mistake that is responsible for mis-educating the public and increasing health inequities between people of privilege and oppressed populations.”

– Jim Bloyd, DrPH, MPH, Collaborative for Health Equity Cook County, University of Illinois at Chicago School of Public Health

Furthermore, individual risk from COVID differs significantly based on health conditions, age, occupation, access to health insurance, paid sick leave, structural inequities such as race, *inter alia*. CDC communications rarely emphasize the risk of Long COVID despite CDC data suggesting Long COVID affects 1 in 5 of those infected with COVID regardless of severity of the initial infection.¹⁰ Framing mask wearing as an individual choice is dually problematic because many individuals do not have sufficient information to assess their own COVID risk and because asymptomatic, unmasked individuals can unknowingly transmit virus to others.

3.2.2. Respect for Persons

The ethical concept of respect for persons stipulates “individuals should be treated as autonomous agents, and second, that persons with diminished autonomy are entitled to protection.”¹¹⁹ CDC leadership has encouraged unmitigated spread of the virus without educating the U.S. public fully about the risks of this strategy. The strategy places the entire population at risk of repeated COVID infections, without providing sufficient protections to those who are at higher risk of severe disease (e.g., immunocompromised people), or

who have diminished autonomy to protect themselves (e.g., children, in-person workers, older adults living in nursing homes, people living in multigenerational households, or other congregate settings among others) with vaccines, masks, or other public health measures. CDC Director Walensky, however, appears to have considered and weighed the risks of unmitigated spread of COVID. When asked about the future of the pandemic in March 2022, Dr. Walensky stated, “We will have a coronavirus that will lead to death in some people every season that we will then tolerate in some way.”¹⁸ (See Figure 3.2.3).

Several of my older family members are disabled from chronic neurologic illness, after several years of contribution to society as physicians themselves, and I know firsthand that disability affects everyone, it’s just a matter of when. To create and sustain policy that has this much disregard for human life, means society as we know it is eroding. There is no modern democracy or even modern community the way the US is structured now, and these decrements are being promoted further for political gains of reelection.”

– Physician and Medical Director, Oregon



Figure 3.2.3. Quote by CDC Director Rochelle Walensky, from an interview with St. Louis Public Radio in March 2022 ([Fentem, 2022](#)).

“I think ultimately we’ll have good-level population immunity for variants that come our way, and even if surges come, the amplitude of those surges will be less,” Walensky said. “We’ll have a coronavirus that will lead to death in every season, that we will tolerate in some way.”



Figure 3.2.4. CDC COVID-19 Forecasts website predicts upcoming infections and deaths in the matter-of-fact tone of a weather forecast ([CDC, 2023](#)).



[< Back to COVID-19 Home](#)

Forecasts of COVID-19 Deaths

Updated Nov. 23, 2022 [Español](#) | [Other Languages](#)

Reported and forecasted new and total COVID-19 deaths as of November 21, 2022.

Rather than discussing these ethical dilemmas openly, the CDC characterized preventable deaths as inevitable in its “COVID-19 Forecasts,” which includes a section predicting upcoming infections and deaths in the matter-of-fact tone of a weather forecast (see Figure 3.2.4).¹²⁰ Thus, the CDC continues to encourage the U.S. public to accept the high rates of deaths in some groups (e.g., older adults, immunocompromised, chronically-ill and disabled people, people who are incarcerated or in congregate living facilities, low-income, BIPOC and immigrant communities), which have borne the brunt of the pandemic from the beginning (see Figure 3.2.5). **The decision to tolerate preventable deaths in disproportionately vulnerable groups, in exchange for the convenience of more able-bodied, younger, wealthy, and white individuals, is unethical and demonstrates a reckless disregard for the lives of communities disproportionately impacted by COVID.**

“As a person with an autoimmune disease, I am furious that I am seen as ‘collateral damage.’ Masking should be mandated indoors if in a medium or high level, not just recommended. Doctors’ offices should have mask mandates as well. How can I get my health needs attended to if I am afraid to go to my doctor because no one is masked except me???”

– Anonymous Teacher, New York

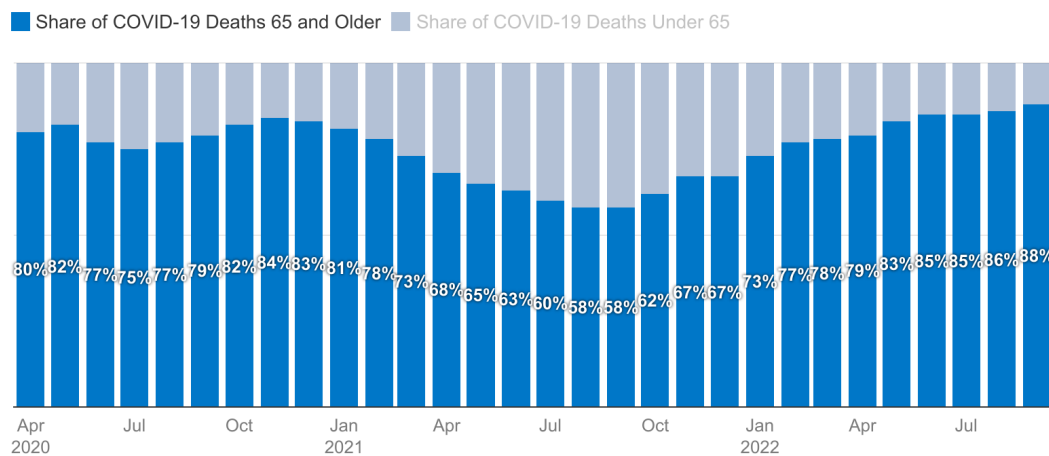


Figure 3.2.5. People 65 and older account for a much larger share of COVID-19 deaths than those under 65 (Freed et al., 2022)¹²¹

NOTE: KFF analysis of CDC Provisional COVID-19 Death Counts by Sex and Age, as of the week ending October 1, 2022.



3.2.3. Interdependence, Beneficence, and Autonomy

The public health ethical concept of **interdependence**, emphasizes “**each person affects and depends upon others.**”⁵¹ This principle is particularly relevant to the COVID pandemic, given that asymptomatic and mildly ill people can spread disease without knowing it. Humans are social animals, and much of the joy in our lives comes from social interaction.

Older adults, chronically ill and disabled people cannot isolate themselves permanently to avoid COVID infection; isolation harms both the vulnerable and those whose lives they enrich. For example, healthy, young adults often live with and/or depend upon older adults to care for children, who may contract COVID-19 in crowded classrooms and pass it to high-risk members of their households. We are all dependent on essential workers, which places them at increased risk of COVID-19. Narratives of vulnerability overemphasize the dependency of “vulnerable” populations, deemphasize our interdependencies,¹²² and promote resentment at calls to protect the vulnerable. On the other hand, a public health approach that centers interdependence would acknowledge that we all benefit when we protect one another.

The principle of **beneficence is understood as an obligation to “maximize possible benefits and minimize possible harms.”** Although we acknowledge the complexity of navigating ethical trade-offs amid the COVID pandemic, we find the CDC has emphasized individual “choice” over collective responsibility excessively, particularly regarding the debate around mask wearing. Instead, the CDC leadership should emphasize the scientific basis for universal mask wearing, promote the value of a community-care approach, encourage people to protect each other, and lead by example by wearing masks.

In March 2022, CDC Director Walensky dismissed mask wearing as an inconvenient, “scarlet letter” of the pandemic.¹²³ Her comment supported the false notion that mask mandates infringe upon bodily autonomy **more** than the unmitigated spread of COVID in public spaces does by placing people at risk of contracting COVID. In reality, during surges, wearing a high-quality respirator mask, such as an N95, in an indoor setting with unmasked people does not offer sufficient protection against COVID-19, because even high-quality masks can protect people for a limited period of time only.⁵⁷ **If we do not require masks during surges, then we require people to be subject to greater risks of exposure to COVID, which undermines their autonomy. This approach devalues the lives of the people most at risk of COVID complications and burdens them to protect themselves.** People should be able to choose to not be exposed to COVID, but people who have to spend prolonged periods of time in crowded, indoor spaces (e.g., schools or many workplaces) or who rely on public transportation, do not have this option. Although some basic needs can be met via curbside options, these are not universally available, and in-person workers and students cannot choose whether to go to work and school. Particularly during periods of high transmission, it is very difficult or impossible for most people to meet their basic needs without being exposed to the virus.

“I’m immunocompromised and I help aging parents with disabilities who live in the same city... Our ADA rights to access public services are being denied through the absence of protective public health measures... such as high-risk hours in which masks are at least strongly recommended. I asked my

county public health department for one high-risk hour per week at publicly funded places, like our public library. My request was denied and it sounded like the public health representative didn't even know what the ADA law entails.”

– Erica Hamilton, PhD, Disability Rights Advocate, Colorado

Recommendations for an Ethical Pandemic Response:

Accountability and Transparency

- **The CDC should inform the public of the true risk of COVID infection and illness to enable informed consent regarding COVID exposure** and provide transparent, evidence-based policy recommendations, providing detailed reasoning and opportunities for public comment regarding policy changes.

Respect for Persons

- **The CDC should promote public health policy that encourages equal respect for all persons**, and should incorporate the responsibilities of individuals to protect others, especially those with diminished autonomy or at highest risk of severe illness from COVID-19.

Beneficence

- **The CDC should promote community care and foster interdependence over individualism**, for the benefit of all rather than the most resourced, and encourage both those in power and the public to participate in our collective responsibility to protect each other and public health.

Autonomy

- **The CDC should protect people's autonomy by recommending policies that allow people to meet their basic needs and participate in society without exposure to COVID-19.** Such policies include requiring upgraded ventilation, masks and other layered protections in essential public spaces like schools, workplaces, healthcare, pharmacies, and public transportation; and providing accessible in-person and remote work and school options.

3.3. Equity and Justice.

Center policy decisions on the safety of disproportionately impacted people.

“The pandemic response has failed to promote policies that prioritize the most vulnerable groups and communities and has left the primary responsibility for staying safe up to each individual. We urgently need a collective, equity-centered response”

– Oni Blackstock, MD, MHS, Health Justice, New York

Although the CDC’s vision statement espouses a mission of “equitably protecting health, safety and security,”¹²⁴ the agency has done little to address the intersectional social and economic inequities at the root of COVID morbidity and mortality. As mentioned, death and illness from COVID have impacted socioeconomically marginalized populations disproportionately, including immunocompromised, chronically-ill, and disabled people; in-person workers, including health care workers; people who live in congregate facilities or who are incarcerated; older adults; and structurally marginalized and minoritized communities, including low-income communities, immigrants, and Black, Indigenous, and People of Color (BIPOC).^{36–44} We specifically chose the words “marginalized and [minoritized](#)” rather than “minorities” to name the fact that these groups have been disadvantaged not because of genetic or cultural differences but rather because they have experienced historic and ongoing racial, gender, sexual, age, and/or class discrimination by the political, economic, legal, educational, and medical institutions of the United States.¹²⁵

“CDC policies regarding nursing homes during the pandemic ... were slow, incomplete, too lax and resulted in the death of my husband and 15 others in his nursing home in July 2020. 52 of 58 patients were infected due to lax control over nursing homesThe CDC must act QUICKLY to END shared rooms in nursing homes –NOW! If you require healthy people to stay 6’ apart, then allow the MOST VULNERABLE to be jammed 2 and 3 to tiny rooms, this shows you think of older adults and infirm as totally expendable.”

– Maureen McKinney, Retired, Washington State

A recent provisional analysis from the CDC on the drastic drop in life expectancy from 2019–2021 shows some of these inequities in stark relief. Life expectancy between 2019 and 2021 declined by 6.6 years for the non-Hispanic American Indian/Alaskan Native population, compared with 3.2 years for the Hispanic population, 3.0 years for the non-Hispanic Black population, 2.4 years for the non-Hispanic white population, and 2.1 years for the non-Hispanic Asian population.³ In most populations, COVID-19 was the leading cause contributing to the negative change in life expectancy since 2019 (see Figure 3.3.1).³

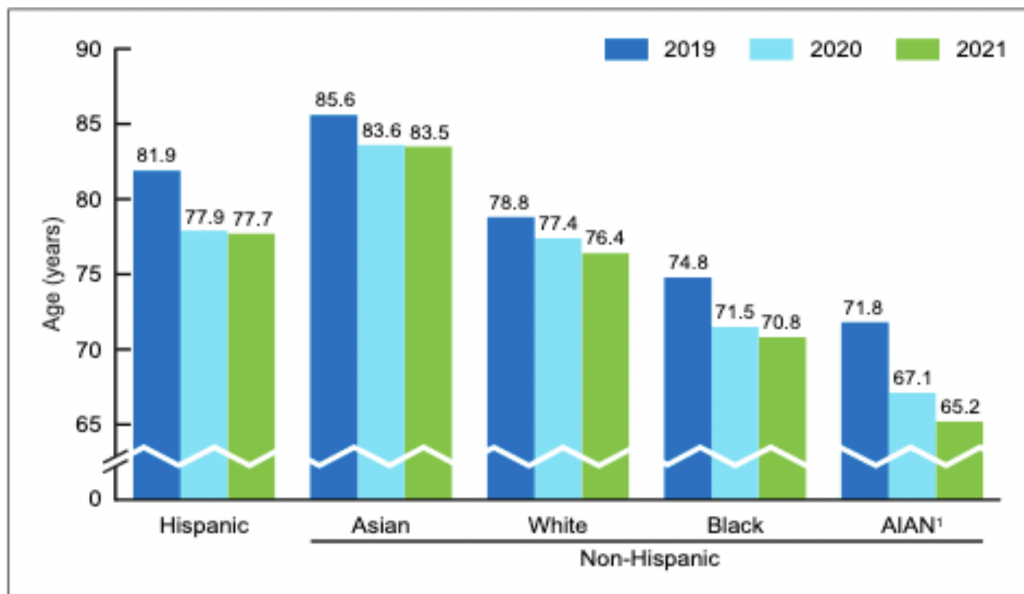


Figure 3.3.1. Life expectancy at birth, by Hispanic origin and race: United States, 2019–2021 shows a significant decline over the past 3 years (Arias et al., 2022).

¹American Indian or Alaska Native.
 NOTES: Estimates are based on provisional data for 2021. Provisional data are subject to change as additional data are received. Estimates for 2019 and 2020 are based on final data. Life tables by race and Hispanic origin are based on death rates that have been adjusted for race and Hispanic-origin misclassification on death certificates; see Technical Notes in this report.
 SOURCE: National Center for Health Statistics, National Vital Statistics System, Mortality.

Poor people of all colors and nationalities are disproportionately likely to have lost loved ones and caregivers. Children of racially minoritized groups are more likely to be among the over 200,000 U.S. children who lost a caregiver during the pandemic.^{8,126} As the Poor People’s Campaign demonstrated in their pandemic report, people living in poorer counties died at nearly 2 times the rate of people who lived in richer counties during the pandemic.¹²⁷ The CDC emphasizes vaccination over a comprehensive public health strategy, which would also include masks, testing, ventilation, and other measures to reduce viral transmission. However, increased deaths in low-income communities are not explained fully by vaccination rates,¹²⁷ suggesting a vaccine-only strategy for pandemic management is insufficient to protect communities facing increased health risks due to generations of systemic inequities, including lack of access to health care, workplace protections, paid sick leave, and affordable housing.

COVID inequities are rooted in societal and structural inequalities rather than differences in genetic disposition, as the Black Coalition Against COVID report noted in March 2022.³⁷

Vaccination rates remain lowest in the most socioeconomically vulnerable counties and low-income populations,^{128–130} and antiviral treatments for COVID have been dispensed disproportionately in wealthier, more socioeconomically advantaged communities.¹³¹

The COVID state of emergency measures give the federal government flexibility to waive or modify requirements in a range of public programs, including Medicare, Medicaid and CHIP.¹³² The emergency declarations increased access to health insurance, and provided federal funding for COVID vaccines, testing and treatment for people who lack health insurance.³⁴ An estimated 28 million Americans lack health insurance,¹³³ and many more are underinsured. Even with these emergency measures in place, historically and structurally marginalized communities have experienced disproportionate harm throughout the pandemic. If access to health insurance, free COVID testing and treatment, and other measures are discontinued as COVID-19 still remains a serious threat, these inequities will only worsen.

“Regarding the CDC’s actual guidelines: any policy that disproportionately harms the health of ethnic minorities and disabled persons is, definitely, eugenics. Changes to CDC guidelines in 2022 certainly reflect and support eugenics.”

– Asim Ali, PhD, Professor, University of Maryland

Occupational exposures to COVID-19 have been a central factor driving racial and ethnic inequities in COVID-19 infections and death throughout the pandemic. Black, Latinx, and Native American workers are more likely to work jobs that cannot be done remotely¹³⁴ and face greater risks of occupational exposure than whites.³⁹ Furthermore, Black and Latinx workers are more likely to work in high-risk occupations, like food prep, maintenance, and repair, and as store clerks and cashiers, with significant physical proximity and poor access to personal protective equipment (PPE) and other mitigation measures.¹³⁵ Enforcement of guidance from the federal Occupational Safety and Health Administration (OSHA), the CDC, and state agencies has been limited during the pandemic.¹³⁶ However, enforcement of workplace protections is critical to protecting frontline workers, who are at disproportionate risk of disability and death from COVID (see Figure 3.3.2).

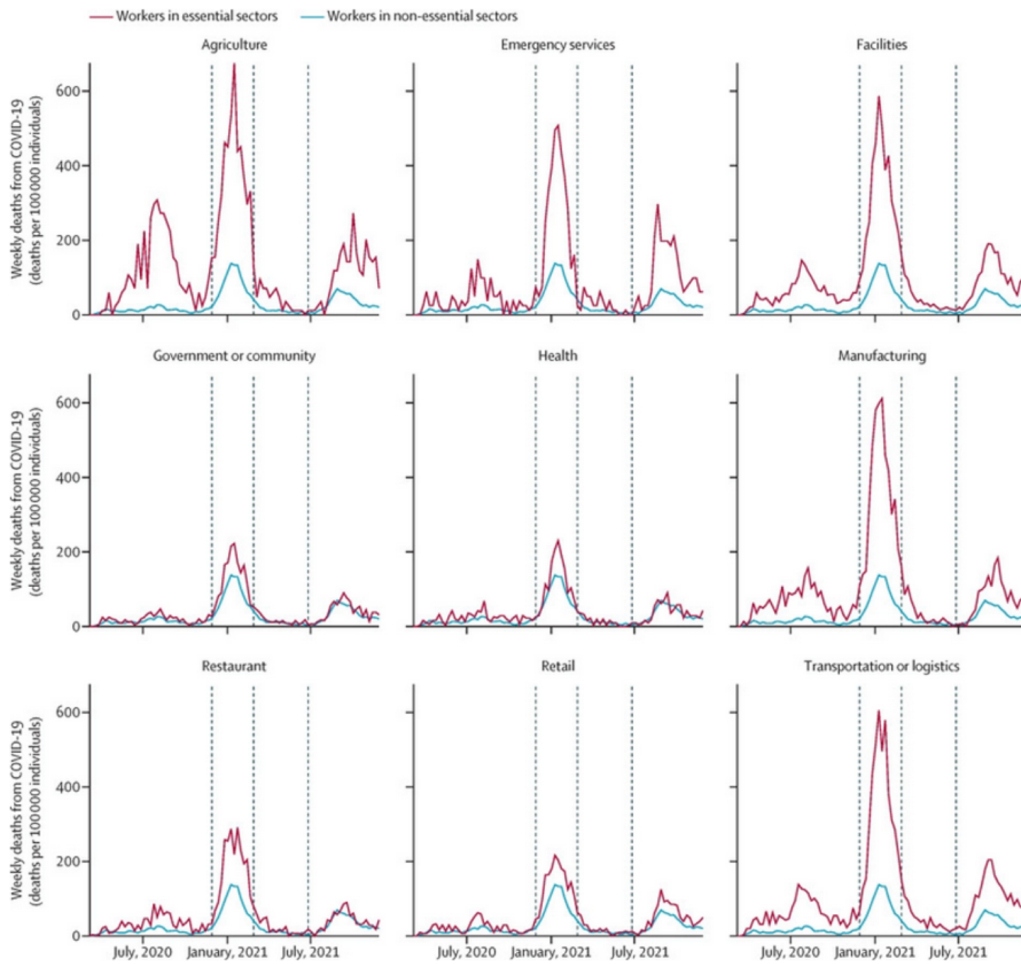


Figure 3.3.2. Per-capita COVID-19 mortality among Californians 18–65 years of age, by occupational sector, March 2020 through November 2021 (Chen et al., 2022)

The CDC has failed to emphasize the need for resource allocation sufficiently to rectify these and other health inequities. In May 2021, CDC Director Walensky tweeted, “Your health is in your hands. If you are unvaccinated, please get vaccinated as soon as you can to decrease your risk to #COVID19.”¹³⁷ However, health care facilities in counties with higher Black composition, rural areas, and the hardest hit urban areas were less likely to serve as COVID-19 vaccine administration locations in May 2021.¹²⁹ The federal government partnered with retail pharmacies to distribute COVID vaccines, tests, and treatments, but Black and Latinx neighborhoods in major U.S. cities are less likely to have pharmacies than white or diverse neighborhoods.¹³⁸ The CDC’s approach disproportionately burdens high-risk people with the responsibility of protecting themselves while they often lack the socioeconomic or structural resources to do so. Indeed, initiatives originating in structurally minoritized or marginalized communities have been successful in closing gaps in vaccination rates and increasing access to testing centers. Despite allocated CDC funding, these initiatives have been underfunded and have placed excess burden on organizations in impacted communities.³⁷ Amid messaging normalizing COVID infection and emphasizing individual responsibility to get tested, many testing sites and school surveillance testing programs have closed, which again limits access and promotes

high rates of COVID transmission in structurally marginalized communities. High rates of transmission in schools and workplaces where people must spend long hours puts them at risk of COVID-19 infection. Especially for immunocompromised, chronically ill or disabled people, these risks can be life threatening.

“As an immune compromised substitute teacher, I have been abandoned. I did not work in person all of last year and lost income. Cancer survivor, CHF, RA, asthma—all the risks and put my health and life on the line. My health insurance was canceled, so forced into Cobra for \$632 monthly ... I represent many subs who had COVID multiple times, long COVID, missed weeks and months of work, suffered brain damage. Lost income. Even after that, still no health coverage and no COVID sick pay.”

– Anonymous Substitute Teacher, Illinois

Immigrants also have disproportionately suffered from COVID.^{139,140} Immigrants represent 1 in 5 essential workers in the United States and are more likely than U.S. citizens to lack health insurance.^{141,142} Immigrants also suffered disproportionately from pandemic-related job losses¹⁴³ but were less likely to be eligible for pandemic relief financial supports.¹⁴¹ In the wake of the Trump Administration’s anti-immigrant policies, many immigrants continue to fear accessing health care, public benefits, and even COVID vaccines, due to concerns that it may impact their immigration status.^{142,144}

Research has demonstrated racial and ethnic disparities in rates of Long COVID as well. Reports also have suggested members of LGBTQ+ communities are disproportionately impacted by Long COVID.¹⁴⁵ A lack of race and ethnicity data, occupational data, and sexual and gender identity data has further made differences in COVID outcomes difficult to track in minoritized populations. As of September 2022, two states had no Long COVID care centers, and nine states had only one (counting virtual options, which are not accessible to all). Long COVID clinics typically are located in academic medical centers in large urban areas, making them inaccessible to most residents in the state.¹⁴⁶ Some Long COVID clinics require test results to demonstrate COVID history, which not all people can provide due to inequities in testing access. Long COVID can also cause prolonged disability, which currently impacts as much as 2.4% of the U.S. working population.¹⁴⁷ Because of underlying structural inequities, disability from Long COVID also places an unequal burden on communities disproportionately impacted by COVID. For example, a white-collar worker who can work from home, who has health insurance and ample paid sick leave, and who has a working spouse will be impacted much differently than a blue-collar worker, gig worker, or single parent who lacks adequate health care or adequate paid sick leave.

“I am high risk at this point being an essential worker that developed long COVID (POTS syndrome, small fiber/autonomic neuropathy). It feels very unsafe to go out when we are not requiring people to stay home when they are still testing positive with COVID. The 5-day rule makes no sense considering you are still contagious.”

– Brandy Bullock, Childcare Center owner, Michigan

Lastly, 3 years into the pandemic, although about 71% of the world population has been vaccinated against COVID-19, stark disparities remain.¹⁴⁸ In many low-income countries, less than 20% of the population has received at least one dose compared with high- and upper- to middle-income countries, where over 80% of the population has received at least one dose.¹⁴⁸ Increasing vaccination rates in low-income countries is a critical, basic step to control COVID transmission in the United States and around the world, because people travel between countries, and unmitigated spread promotes development of new variants. Although decisions about vaccine patents lie outside the CDC’s purview, the CDC should use its authority to advocate for broadening the 2022 Trade-Related Aspects of Intellectual Property Rights (TRIPS) waiver to include access to COVID therapeutics and diagnostics, in addition to COVID-19 vaccines. The CDC should also advocate for increased funding and technology transfer to build capacity for mRNA vaccine production in low-income countries. Such an approach could help to increase global production of COVID-19 vaccines, therapeutics, and diagnostics, enable low-income countries to be more self-sufficient, and more equitably prepare the planet for this and future pandemics.

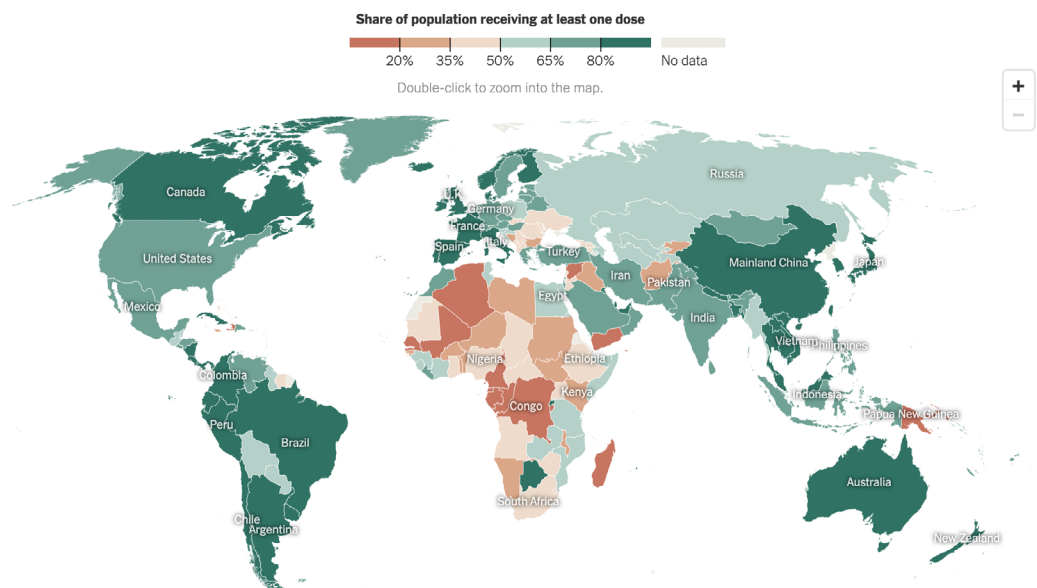


Figure 3.3.3. Map of COVID-19 vaccinations by country, share of population receiving at least one dose (Holder, 2023).

Recommendations for a More Equitable and Just Pandemic Response:

- **The CDC should partner with institutions and organizations in impacted communities to increase access to layered public health protections, COVID testing, vaccines, and treatment.** High-quality masks and respirators and COVID tests should be mailed to homes and distributed for free in public spaces, including schools, nursing homes and long-term care facilities, jails and prisons, shelters and other congregate living facilities, as well as community and faith-based organizations.
- **The CDC should publicly advocate for the COVID public health state of emergency measures which expanded access to health insurance, paid leave, SNAP benefits, improved ventilation, and COVID vaccines, testing and treatment to be made permanent and expanded upon,** in order to address inequities and build a resilient public health infrastructure for this and future pandemics.
- **The CDC should advocate for additional workplace protections,** including improved workplace safety, and universal ventilation standards, and adequate paid leave.
- The CDC should promote Long COVID equity **by advocating for increased research** funding and access to experimental treatments for Long COVID patients and for an accessible system for people living with Long COVID to obtain disability benefits.
- **The CDC should promote global pandemic equity** by advocating to broaden COVID-19 intellectual property rights waivers to include COVID-19 therapeutics and diagnostics, in addition to vaccines and should advocate for increased funding and technology transfer to increase vaccine production capacity in other countries.

3.4. Scientific Integrity.

Scientific Decision Making Free From Political Interference

“The CDC is the organization that many have looked to for clear, consistent, evidence-based guidance. At my university, our multi-hazard response plan for pandemic (pre-2020) always said to defer to the guidance and communication from the CDC . . . But this time, the communication was inconsistent and often seemed more politically driven than evidence-based The biggest issue I noticed was the politicization of public health.

The CDC should be nonpartisan and should safeguard the health of our nation, uniting us, rather than tearing us apart.”

– Marissa Brash, DrPH, EdD, MPH, CPH, Department Chair and Associate Professor, Azusa Pacific University, California

As one of the foremost public health agencies in the world, the CDC has an obligation to provide evidence-based guidance. The CDC’s MMWR reports provide evidence regarding the risks of COVID-19, and the efficacy of combined mitigation measures, like masks, testing, ventilation and isolating when sick to limit the spread of COVID-19. However, CDC leadership has shifted policy guidance away from its own scientific evidence in response to pressure from business¹³ and political interests.¹⁴ An April 2022 report by the U.S. Government Accountability Office further noted the CDC lacked policies and procedures to protect scientific decision making from political interference.¹⁴⁹

“As an organization led by political appointment, there is undue influence from the career politicians that appoint CDC leadership I do not believe there is adequate external review of this government organization by civilian boards.”

– Anonymous Former US Department of Health and Human Services Public Health Researcher, Hawai’i

Since the beginning of the pandemic, business interests have poured money into campaigns to legitimize attacks on pandemic mitigation measures (e.g., school closures and masks).^{29,30} The Biden Administration originally promised the U.S. public a comprehensive “Plan to Beat COVID-19.”¹⁵⁰ But, in mid-February 2022, a memo reportedly circulated in House and Senate Democratic campaigns from Impact Research, the well-known Democratic firm founded by John Anzalone, pollster for Biden’s 2020 presidential campaign. The memo recommended Democrats should: “Declare the crisis phase of COVID over and push for feeling and acting more normal. Recognize that people are ‘worn out’ and feeling real harm from the years-long restrictions and take their side. Acknowledge COVID still exists and likely will for a long time.”¹⁴ Poll data from the same period, however, showed that most Americans believed the pandemic was not under control and supported pandemic mitigation measures, including masking.^{20,151} On February 25th, the CDC lifted the federal school mask mandate and shifted its its map from community transmission rates to “Community Levels,” basing masking guidelines more on availability of hospital beds than on the rate of COVID in a community.¹⁵² These decisions to roll back COVID protection measures came only weeks after hospitals across the country were overwhelmed with COVID patients, in mid-January 2022.^{153–155} Biden’s March 1, 2022 State of the Union Address contained language strikingly similar to the policy memo.¹⁵⁶

The Title 42 order represents another critical example of public health guidance based upon political rather than scientific objectives. President Trump's advisor Stephen Miller had pushed for the order initially, which CDC Director Robert Redfield issued reportedly under pressure from The White House in spite of objections by CDC scientists.^{157,158} Under the order, people arriving at the U.S. border seeking asylum are automatically turned away without any hearing, under the false pretext that they threatened public health. Public health and medical experts condemned the policy as a thinly disguised attempt to restrict migration under the pretext of public health, particularly because immigrants are no more likely than other travelers to bring COVID-19 into the United States and because domestic transmission of COVID-19 was well established before the order went into effect.¹⁵⁹ Although the order was issued by the CDC during the Trump Administration, CDC Director Walensky extended it five times and only ended it in May 2022, at which point a federal judge reinstated the order. Over 1.7 million expulsions were carried out during President Biden's first 18 months in office under Title 42.¹⁶⁰

The CDC has modified its guidance repeatedly in response to pressure from influential business interests. Following industry pressure, notably including a letter from Delta Airlines CEO to CDC Director Walensky just before the guidance was updated,¹³ the CDC shortened the COVID isolation period from 10 days to 5 days, without a firm basis in evidence (see Figures 3.4.1a and b).^{31,161} Updated CDC guidelines for the 2022–2023 school year further entrenched this guidance by recommending children with COVID return to the classroom after only 5 days,¹⁵ despite evidence, including a CDC report showing viral transmission can persist up to 10 days with infection from the Omicron variant (see Figures 3.4.2 and Figure 3.4.3).^{162–165} Rather than minimizing the impact of COVID on communities, this change is likely to spur school outbreaks, as it permits students, teachers, and staff to return to class while still contagious.



Figure 3.4.1a. Delta CEO asked CDC to reduce COVID isolation period from 10 days to 5 days for vaccinated employees, shortly before the agency shifted its recommendation.



December 21, 2021

Rochelle P. Walensky, MD, MPH
Director
Centers for Disease Control and Prevention
1600 Clifton Road, NE
Atlanta, GA 30333

Dear Dr. Walensky:

We are writing on behalf of Delta Air Lines to the Centers for Disease Control and Prevention (CDC) to reconsider the current guideline for 10 days of isolation in fully vaccinated individuals who experience breakthrough COVID-19 infections.

This guidance was developed in 2020 when the pandemic was in a different phase without effective vaccines and treatments. At Delta, over 90% of our workforce are fully vaccinated, and those rates are increasing daily. Our employees represent an essential workforce to enable Americans who need to travel domestically and internationally. With the rapid spread of the Omicron variant, the 10-day isolation for those who are fully vaccinated may significantly impact our workforce and operations. Similar to healthcare, police, fire, and public transportation workforces, the Omicron surge may exacerbate shortages and create significant disruptions. Further, all airline personnel are required to mask at airports and on airplanes.

Current data suggest that Omicron is 25-50% more contagious, and likely less virulent and associated with more mild disease particularly among individuals who are fully vaccinated. Further, Omicron is associated with a shorter incubation period and infectious period among the fully vaccinated.

To address the potential impact of the current isolation policy safely, we propose a 5-day isolation from symptom onset for those who experience a breakthrough infection. Individuals would be able to end isolation with an appropriate testing protocol. As part of this policy change, we would be interested to partner with CDC and collect empirical data.

We look forward to continuing our partnership with the CDC to protect the health and safety of our people, customers and communities as the pandemic evolves.

All our very best,

Carlos del Rio, MD
Medical Advisor
Delta Air Lines

Henry Ting, MD
SVP and Chief Health Officer
Delta Air Lines

Ed Bastian
Chief Executive Officer
Delta Air Lines

Delta Air Lines, Inc., Post Office Box 20706, Atlanta, GA 30320-6001, U.S.A.

Figure 3.4.1b Letter from Delta CEO Ed Bastian urging Dr. Walensky to reduce COVID isolation period to 5 days ([Shepardson, 2021](#)).

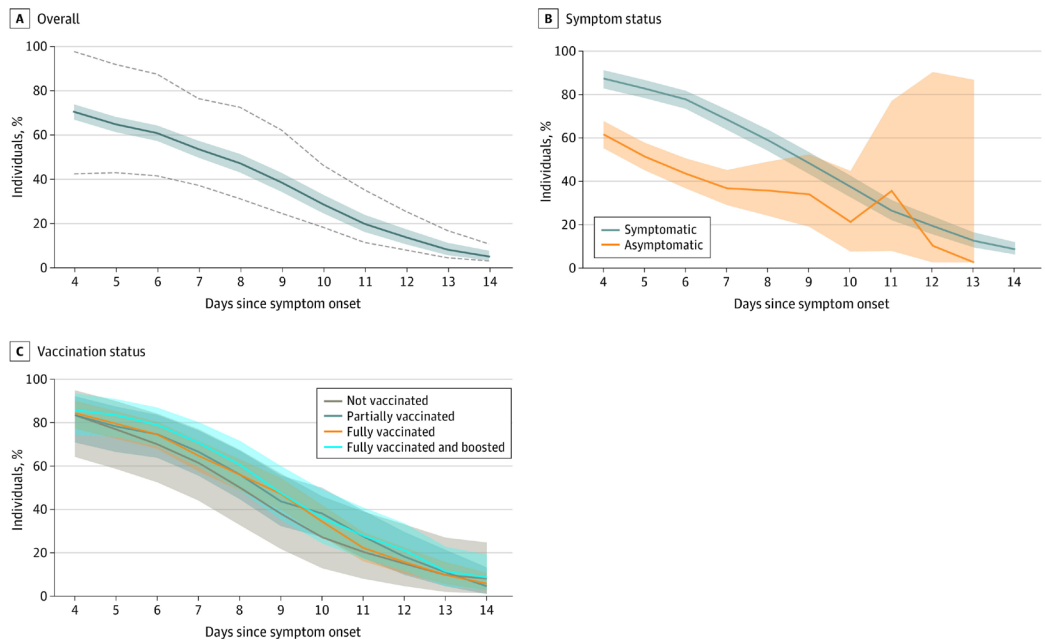


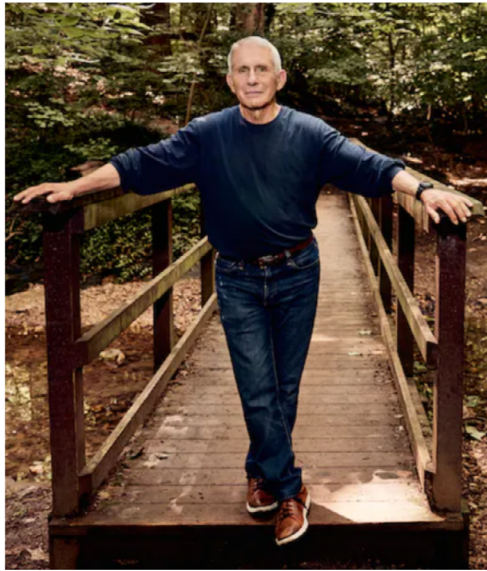
Figure 3.4.2. Rapid antigen diagnostic test positivity among 942 people with COVID-19 who underwent repeated testing during the Omicron BA.1 period by day of symptoms onset (if symptomatic) or day since initial positive test (if asymptomatic). 80% still tested positive on Day 5, and as many as 20% tested positive at 14 days (Marquez et al., 2022).

“I am in a high risk category & have isolated for 2+ yrs... I work with disabled children in their home and now imagine I could be exposed because there’s no masks, not adequate ventilation in most schools, little testing and kids going back to school while still positive unmasked... Also, once evidence is presented, the CDC never seems to shift course or correct its policies.”

– Donna DeMaria, Direct Support Professional, New York

In August 2022, the CDC published a new study showing COVID increases the risk for rare health problems in children, including blood clots, heart problems, and kidney failure, the same week as they announced plans to roll back school public health protections in the fall.^{91,166} Sources noted the policy changes reflected shifting public opinion toward the pandemic and increasing population immunity to COVID. However, a July 2022 poll showed over half of Americans still supported school mask mandates.²⁰ Furthermore, because the virus mutates rapidly, vaccines and infection do not produce durable immunity from infection.

The People’s CDC notes the double standard exposed during federal officials’ bouts with COVID. Before an in-person June 2022 interview with the chief medical advisor to the President, Dr. Anthony Fauci, a *Washington Post* reporter tested positive for COVID and was required to “test negative three days in a row and wear a mask, even outdoors”¹⁶⁷ during the interview (see Figure 3.4.3). Even President Biden took measures “above and beyond” CDC guidelines when he had COVID in July 2022, choosing to isolate until he tested negative.¹⁶⁸ CDC Director Walensky also worked remotely during a rebound COVID infection. Everyone should have access to such protections.³³



I am also aware that it would be a moral crime to transmit the coronavirus to Fauci. So when I got covid two weeks before our interview, I obsessively parsed the guidelines from the Centers for Disease Control and Prevention: As long as I waited 10 days after my first positive test, I could still meet Fauci in person, right? No, I was informed by Fauci, via a member of his communications team. I would need to test negative three days in a row and wear a mask, even outdoors.

The Washington Post
Democracy Dies in Darkness

Figure 3.4.3. Excerpt from article by Washington Post reporter Anna Peele regarding her visit with Anthony Fauci ([Peele 2022](#))

Instead of issuing evidence-based guidance, the CDC has shifted its COVID guidance to align with political and corporate interests.¹⁶⁹ Unfortunately, the CDC's guidance prioritizes returning to in-person work while jeopardizing lives and health. When asked about the difference between Biden's actions and CDC isolation guidance in July 2022, CDC Director Walensky said, "As we put forward our CDC guidance, we have to do so so they are relevant, feasible, followable by Americans, and that is Americans that live in urban jurisdictions and rural jurisdictions, that have less and less resources, that have, you know, work constraints and many other things."¹⁷⁰

As a leading scientific agency in the world charged with protecting the health of the U.S. public, the CDC should issue guidance based on science rather than assumptions regarding resource limitations and "work constraints" or corporate interests to keep the economy open. In some cases, policies failing to provide workers with adequate workplace protections are shaped by the CDC's own guidance. Instead, the CDC must lead the way to public health, issuing recommendations based on high-quality science alone. Policymakers and the public may prefer to ignore inconvenient truths regarding the short- and long-term risks of COVID, but the CDC should present these truths to the public nonetheless.

Recommendations to Safeguard Scientific Integrity:

The CDC should base public health guidance on up-to-date scientific evidence and reject corporate and political conflicts of interest in policy development and implementation. CDC guidance should be based on its high-quality MMWR data, reporting and peer-reviewed scientific evidence, instead of politicians' opinions regarding what the public will tolerate. Given appropriate information, the public can make their own decisions.

3.5. Public Health Infrastructure.

Build capacity for surveillance, community education, and dissemination of equipment and technical expertise necessary to prevent, respond to and control and eliminate this and future pandemics.

“Note that my recommendations are both to the CDC and to the executive branch and Congress to which CDC answers and on which it is dependent. The diversion of funding from non-COVID activities, both within the CDC and state and local health departments made clear that public health is way underfunded... That COVID surveillance was ... at the discretion of local/state DOHs was an enormous problem...pathogens do not respect state borders and...infection reporting should be both standard across states and be driven by science and not the politics of hiding (underreporting) cases.”

– David Perlman, MD, Infectious Disease Professor

We acknowledge much of the U.S. public health infrastructure exists beyond the scope of the CDC's power. Furthermore, even prior to the emergence of COVID-19, the U.S. public health system was fundamentally inadequate to prevent or control a pandemic, placing our nation at increased risk of poor health outcomes. A June 2022 report by the Commonwealth Fund noted the need for an overhaul of the U.S. public health system, citing insufficient central leadership and coordination, insufficient funding, lack of standardized expectations for health agencies, lack of systematic collaboration between the health care and public health systems, and a crisis of trust.¹⁷¹ We endorse this critique and note a lack of central leadership and standardization contributes to geographical inequities, as agencies in different states and territories have significantly different levels of funding. Furthermore, in the absence of consistent and centralized messaging from the CDC, and in the absence of sufficient regulatory power granted by legislatures and courts, state and local public health agencies have been left to enforce (or merely to suggest adherence to) public health regulations while facing personal harassment and threats.¹⁷²

The U.S. public health data system is a fragmented, federated data collection system in which individual states are not obliged to share data with the federal government, leaving important gaps in data from the most impacted communities, without guarantee of a racial or ethnic disaggregation of COVID-related data.¹⁷³ Lack of data on industry and occupation also inhibits capability to analyze workplace factors in assessing disease

risk.¹⁷⁴ With an increase in home testing and a decrease in COVID testing overall, experts estimate true COVID infection rates to be up to 30 times the rate of current reports.^{98,99} This makes further development of innovative data sources, such as wastewater data surveillance, essential to monitor spread of the virus. Similarly, poor central coordination and lack of funding have impeded public health scale surveillance genetic sequencing of SARS-CoV-2, which is important to track the spread of existing variants and identify new variants of concern.¹⁷⁵

“While this survey focuses on the CDC, I would like to acknowledge that the agency’s response to COVID-19 is part of a broader failure of the U.S. public health system at all levels. The CDC does not have authority in some key areas (such as requiring data reporting from state/local agencies, putting in place mandatory regulations, distributing health technologies, etc.); this lack of authority prevents the agency from collecting data and taking action in the manner that it should.”

– Betsy Ladyzhets, Independent Science/Health Journalist, New York

The U.S. health care and public health systems have long been criticized by public health advocates for spending more per capita than other high-income nations while seeing the lowest life expectancy and some of the worst health outcomes among the same group.¹⁷⁶ Of late, these disparities have widened, as the United States has seen its life expectancy decline in comparison to peer nations during the pandemic (see Figure 3.5.1).^{2,177} Despite the advances of the Affordable Care Act, 28 million Americans still lack health insurance,¹³³ and 25% report delaying care for serious illness due to cost.¹⁷⁸ The U.S. health system also has failed to invest in community-based public health resources (e.g., community health workers, public health nurses, other health educators). In contrast, Costa Rica, a middle-income country in the western hemisphere, has achieved a life expectancy of 79.9 years, higher than the United States, by geographically enrolling over 94% of its population into an integrated primary care system, with community health workers who visit families door to door.¹⁷⁹

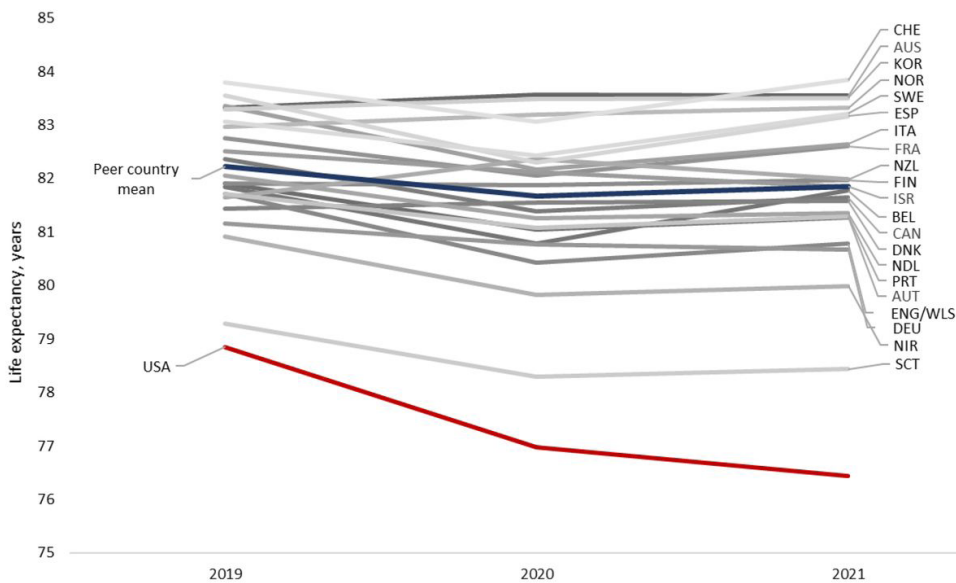


Figure 3.5.1. Life expectancy, 2019–2021, United States versus 21 peer countries, and peer country average. Life expectancy has declined compared to other peer nations during the pandemic (Masters et al., 2022).

Although U.S. government efforts to distribute high-quality respirators and rapid tests to the public were laudable, they were inadequate. Most Americans lack access to PCR testing with rapid results to allow people to quarantine or isolate in time to avoid exposing others. Furthermore, public health infrastructure must provide social, financial, and health care supports for people isolating with COVID. Aside from scant free tests mailed to households by the government, other free or subsidized rapid tests were only available to individuals with private insurance, many of which had to be purchased up front and then reimbursed later. The inequitable distribution and uptake of vaccines and boosters nationwide represents yet another reflection of a lack of investment in equitable, community-partnered, public health infrastructure.

“Mail free masks and tests to everyone. Make free PCR testing available nationwide without going through insurance companies. Fund updated vaccines. Dramatically increase the number of medical school seats. Reinstate mask mandates. Create workplace safety standards that include HEPA-quality ventilation.”

– Karyn Bishof, President and Founder of the COVID-19 Longhailer Advocacy Project, Florida

Although the National COVID-19 Response plan released in March 2022, and the American Rescue Plan allocated funding for improved ventilation in schools across the country, a CDC report found fewer than half of public schools had implemented ventilation upgrades, with inequities in particular in rural and mid-poverty schools (see Figure 3.5.2).⁷³ The lack of standardization in public health guidance, inadequate funding and infrastructure, and

ongoing messaging from the CDC and government health leaders normalizing COVID infections, signal schools in need are far less likely to receive necessary ventilation upgrades. Furthermore, without consistent enforcement of OSHA and CDC workplace safety guidance, workers in frontline occupations continue to face disproportionate risk of COVID-19.¹³⁵ Although we applaud the Biden Administration’s “Clean Air Buildings Challenge”¹⁸⁰ for raising awareness of the importance of ventilation in public settings, additional funding should be allocated to upgrade ventilation and improve ventilation standards in all workplaces and other public spaces where people spend significant periods of time. Federal, state, and local agencies should also have increased authority and capacity to enforce workplace safety standards.

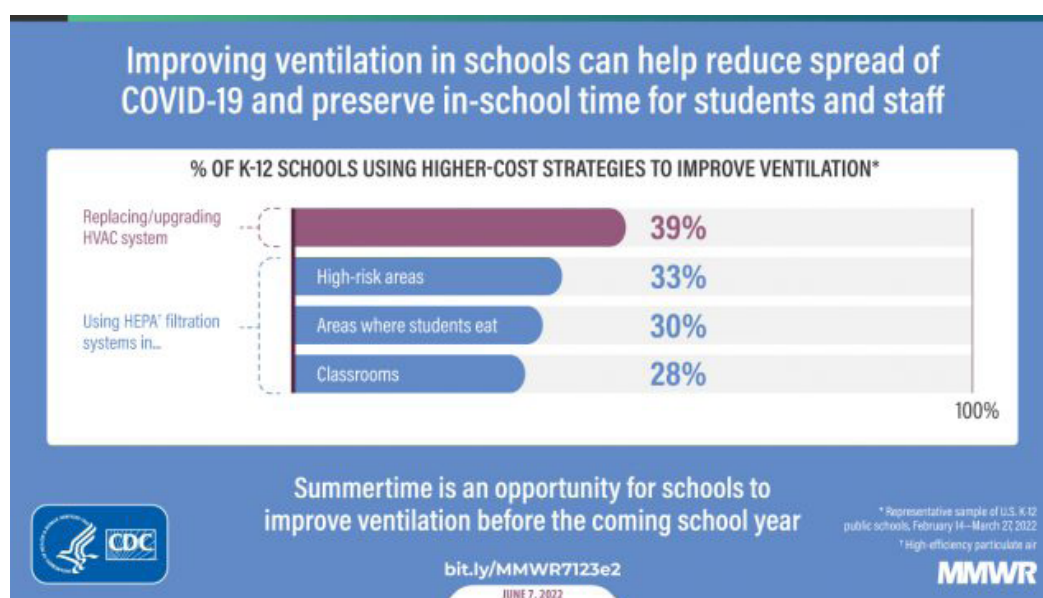


Figure 3.5.2. Improving ventilation can help reduce spread of COVID-19, but fewer than half of K-12 schools have upgraded ventilation ([Pampati et al., 2022](#)).

In sum, the CDC, and the state and local health departments and the legislatures funding them, has failed to build national and local capacity and public health infrastructure in partnership with impacted communities to respond to this and future pandemics.

Recommendations for Pandemic Public Health Infrastructure:

- **The CDC should work with state, territorial, and local authorities to develop a grassroots public health workforce**, including community health workers, in partnership with community organizations in impacted communities.
- **The CDC should advocate for increased funding and requirements for ventilation and UV technologies¹⁸¹** to improve indoor air quality in public spaces.
- **The CDC should facilitate improved coordination of the U.S. public health infrastructure and advocate for more equitable resource distribution.**
- **The CDC should streamline and improve national data collection**, including standardized collection of race, ethnicity, language, disability, occupational, sexual orientation, and gender identity data, to facilitate data sharing and analysis.

Increase viral sequencing and further develop wastewater data monitoring around the country.

3.6. Communication.

Build trust through evidence-based, accurate, effective, and accessible communication

“First CDC should communicate with the public and state long term and immediate goals explaining why and how they arrived at them. We can allow for modifying goals for a pandemic- but this must be explained to the public citing data and reasons. Also, demonstrate that the benefits are to the public first, not Big Pharma first.”

– Joyce Good, Retired Elementary School Teacher, Illinois

Public health communication should ideally employ frameworks and theoretical models emphasizing the interdependence of human beings, and acknowledge the centrality of structural factors in producing health inequity.^{52,182} To be most effective and accessible, communications strategies should be developed and implemented in partnership with trusted messengers and impacted communities. Public health leaders must also acknowledge the limitations of communications strategies alone to address structural factors, and simultaneously pressure institutions and employers to foster structural conditions that promote public health, such as workplace protections, improved ventilation, access to N95 respirators and adequate paid sick leave, as we discuss in the Public Health Infrastructure and Addressing Root Causes sections. Individualistic messaging, in particular, (e.g., “Your health is in your hands,”¹³⁷) disregards the importance of the structural factors underlying disproportionate rates of disability and death in structurally marginalized and minoritized populations.

I admin a COVID-19 advocacy Facebook group in SC that has ~30K members. We spent immense volunteer time translating ever-evolving pandemic policies released from the CDC for lay audiences. The public health communication efforts were a consistent sore spot. In addition, some of the statements did not reflect the current research...I have a child with special needs, am personally immunocompromised, and have a husband with

heart failure. So much of what was communicated by the CDC seemed ableist.”

– Anonymous Public Health Researcher, South Carolina

Public health communications should be evidence-based and accurate, helping the public to understand the true likelihood of infection and serious illness from COVID-19 and how to protect themselves and others around them. The CDC, however, increasingly has downplayed the risks of COVID transmission and disease severity and has emphasized vaccines above non-pharmaceutical protective measures, like masks, ventilation, and surveillance testing. The CDC's Community Levels map is misleading, suggesting the risk of getting COVID-19 is lower than it truly is. For example, in mid-July 2022, when much of the country was at a high level of COVID risk, hospitalizations were increasing, and the CDC Community Levels map recommended indoor masking, a minority of U.S. poll respondents were aware of high COVID transmission rates.²⁰ Although 70% reported they were likely to wear a mask if case numbers were increasing, only 45% believed cases were increasing in their area, and only 24% believed that hospitalizations were increasing.²⁰ A CDC MMWR analysis similarly demonstrated that 8 out of 10 people surveyed in June–July 2022 did not know when COVID spread was high in their community (Figure 3.6.1).²⁴ People who thought COVID rates were high were more likely to wear masks, avoid crowds, and travel.²⁴ **In other words, the CDC's approach to inform the public about the risk of COVID transmission has been so ineffective that even when cases are high and the CDC recommends masks, those willing to mask do not know they should.**

“Because of the CDCs botched messaging, I have friends who, upon receiving a “blazing positive” RAT on day 6 of a COVID infection, told me they were infectious but no longer contagious, citing the website and the Day 5 rule. Because of botched messaging, people who were extremely cautious (double masking with KN95s) as recently as the spring have given up their masks because they are no longer mandated and/or they have had COVID once and it “is much milder now.”

– Carrie Knight, Mother of 3, Virginia

“I am a single mother on significant immunosuppressants and the sole caretaker of my son. I live with a chronic autoimmune disease and am disabled ... I homeschool, and we used to find places in the community to go to supplement education and socialization. But now, there are no places in my community that are safe for my son and I to go to...We feel alienated.”

– Shea O'Neil, Disabled Parent, Florida

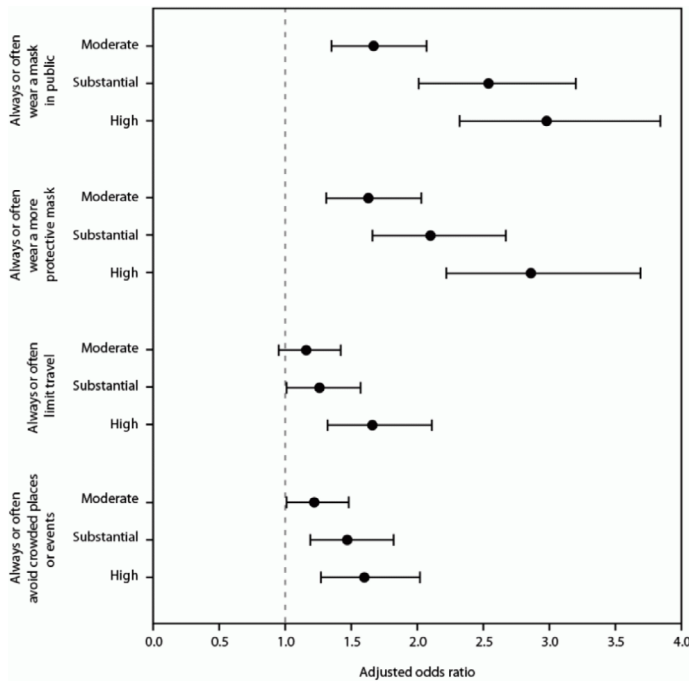


Figure 3.6.1. Adjusted odds ratios of participation in preventive behaviors by perceived level of local COVID-19 transmission among adults with recent positive SARS-CoV-2 test results – Illinois and Michigan, June 1-July 31, 2022 (Czeisler et al 2022)

A person’s risk of being exposed to COVID is related to the number of COVID cases in their community. However, the new Community Levels map, promoted as the public’s main source of COVID risk information, focuses more on hospitalizations (Figure 3.6.2). The public and the media can misinterpret this map easily as representing COVID cases. Even when interpreted correctly, the map directs focus away from transmission and normalizes COVID infections, hiding the increased risk people face when community transmission rates are high. As discussed in greater detail in section 3.2, the original Community Transmissions map set levels greater than 50 new cases per 100,000 as substantial or high, but the newer Community Levels map considers 200 cases per 100,000 low unless hospitalization rates are above a given rate. In addition, the Community Levels map changed the color scheme from very bold, distinct blue-to-red scheme to a muted pastel green-to-orange. Thus, when hospitals are at risk of being overwhelmed, the map shows only a pale orange, rather than the bright red typically used to signal a public health alert. As we noted earlier, true COVID rates likely underestimate cases by up to 30 times official case counts.^{97,98} When used as a decision and policy making tool, the Community Levels map enables unsafe choices that are unresponsive to the true risk of COVID.

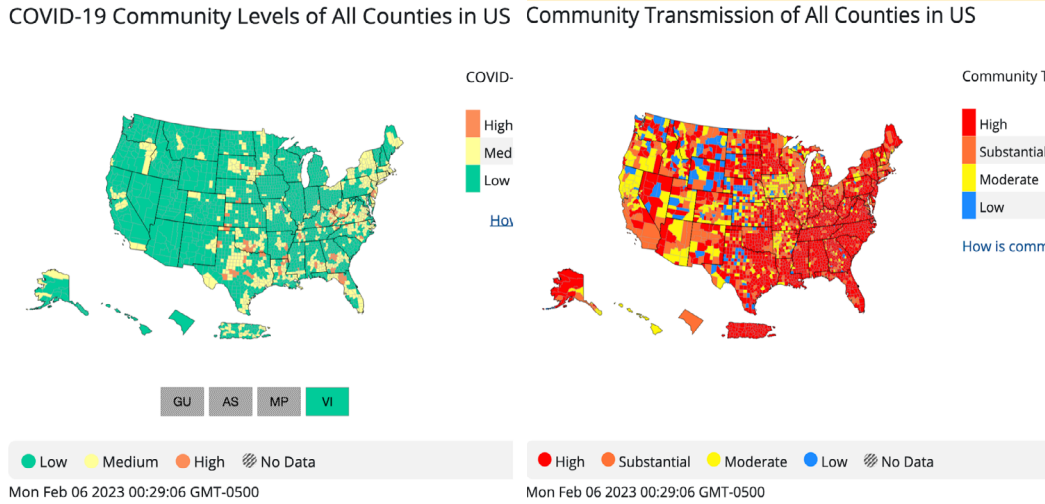


Figure 3.6.2. CDC Community Levels versus Community Transmission maps from February 6, 2023. (CDC COVID Data Tracker, 2023).

CDC officials often reference shifting public opinion as a reason for changes in COVID recommendations without acknowledging the role the agency plays in shaping those opinions. For example, in late February 2022, the CDC changed its map from the Community Transmission map to the “Community Levels” map and then used this logic to recommend that masks were no longer needed in most of the United States.^{114,183} As Figure 3.6.3 shows, data from a [March 2022 poll](#) demonstrated a prompt shift in public opinion immediately after the CDC changed its map and stopped recommending indoor masking; only then did the number of Americans who thought COVID was of little or no risk increase from 44% to 66%.²¹ Looking at the below poll data, it appears that when the CDC stopped recommending masks, employers stopped requiring them and people reported less concern about COVID risk (see Figure 3.6.3).

Percentage of Americans who...

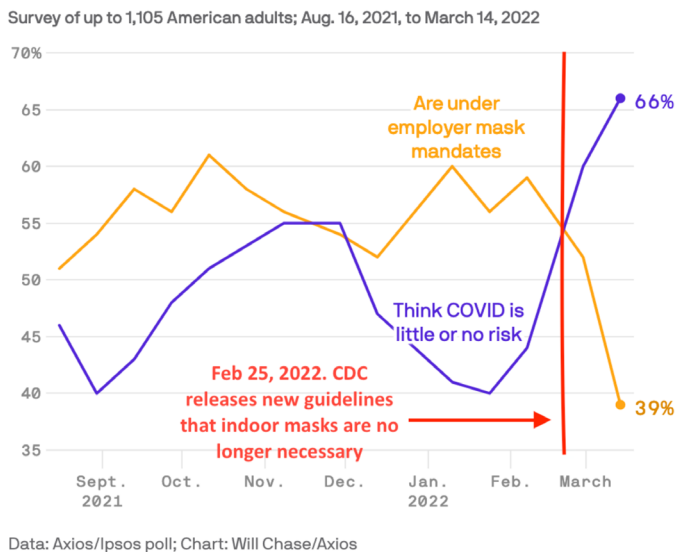


Figure 3.6.3. Data from a March 2022 poll demonstrated a prompt shift in public opinion immediately after the CDC changed its map and stopped recommending indoor masking (adapted from [Talev, 2022](#)).

CDC leadership has also shifted messaging to respond to media or governmental representations of public opinion, rather than actual poll data. For example, in March 2022, when CDC Director Walensky dismissed masks as an inconvenient, “scarlet letter” of the pandemic,¹²³ 3 in 4 people in the United States reported they would wear masks if infections increased where they live.²⁰ A July 2022 poll similarly showed 70% of Americans would wear a mask if infections increased in their area,²⁰ and a December 2022 poll demonstrated that 57% of U.S. voters still supported requiring masks indoors to prevent surges (see Figure 3.1.4).²²

An individual, one-size-fits-all communications strategy has proven ineffective at sharing pandemic guidance. CDC should instead develop a communications strategy in partnership with affected communities to develop tailored messaging to counter mis- and dis-information. The agency should host community dialogues to develop trust, listen to communities’ needs and respond to questions. The need to “**meet communities where they are**”¹⁹ should not be confused with the importance of basing COVID guidelines on scientific evidence, including airborne COVID transmission, COVID transmission rates, and the serious risks COVID infection poses to all, including young, healthy, vaccinated individuals.

“There needs to be more ‘shoulder to shoulder’ interaction within our communities with people representing public health... public health nurses on the ground who are known and trusted as the “county health nurse” who delivers health care to individuals, families, and communities to build that trust.”

– Pamela Guthman, DNP, RN, APHN, BC, University of Wisconsin-Eau Claire, College of Nursing and Health Sciences, Assistant Nursing Professor

The CDC downplayed the risk of severe illness in fully vaccinated individuals, starting in March 2021 when the agency prematurely communicated breakthrough COVID infections were rare and vaccinated people did not have to wear masks.¹⁸⁴ Although vaccines lower the risk of hospitalization and death, even fully vaccinated and boosted people can die from COVID-19.¹⁰⁹ Vaccinated and boosted people can also develop Long COVID.¹⁸⁵ Growing research has demonstrated that Long COVID can cause very serious health outcomes, including heart attacks and strokes, blood clots in the lungs, and cognitive and memory disturbances, even among fully vaccinated people (see Figure 3.6.4).^{185–188} Repeated infections increase the risk of developing Long COVID.^{113,189} for which there are few treatments available. Thus, primary prevention (i.e., preventing COVID infection in the first place) remains critically important, even for healthy, vaccinated adults and children.

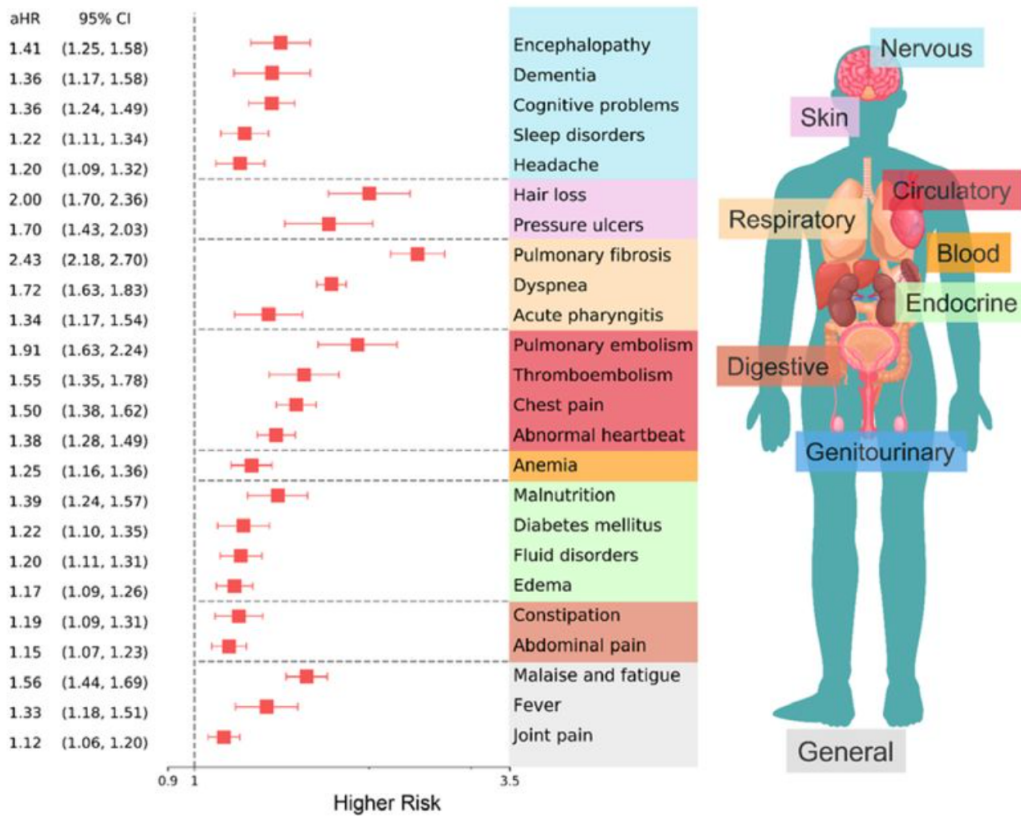


Figure 3.6.4. Long COVID affects organs throughout the body. Adjusted hazard ratios of incident Long COVID diagnoses from the INSIGHT cohort, March 2020 to November 2021 ([Zang et al., 2022](#))¹⁹⁰

“I went on a 6-hour airplane ride in July 2022. I bought my ticket before the mask mandate was repealed. Even though I wore an N95 mask and was 4x vaccinated, I still got Long COVID. These have been some of the hardest weeks of my life, I’m living with extreme exhaustion, headaches and brain fog, and sensitivity to light and noise. At first I was completely unable to function, now once a week, I can go out of the house for a half hour outing, and sit on a bench. I can’t focus enough to read more than a few pages at a time, can’t listen to music or watch tv, can’t make my own meals or do any chores. Being outside is hard, because my brain gets overwhelmed by the brightness of the sky and noise of traffic. It’s hard to describe how devastating and debilitating Long COVID is.

– Anonymous, Massachusetts

The CDC’s COVID communications assume a base audience of young, healthy, wealthy, and digitally savvy individuals with ample access to health care, vaccines, paid sick leave, masks, COVID tests, and treatment. This imagined “normal” population is advised to follow standard CDC guidelines, and “high-risk” individuals are advised to consult with their physicians.¹⁹¹ However, about 40% of U.S. adults (92.6 million people) are at

increased risk of developing serious illness from COVID (see Figure 3.6.5).¹⁶ Public health messaging for those at high risk of severe disease from COVID should not be deferred to 92.6 million individual conversations between patients and their physicians, not to mention the 1 in 4 Americans who do not have a primary care physician.¹⁹² Furthermore, because of rampant dis-information and mis-information regarding COVID transmission, infection risks, masks and other mitigation measures, and vaccine efficacy and safety, the CDC should have a strategy and budget dedicated to countering and acting as an effective antidote to widespread mis- and dis-information.

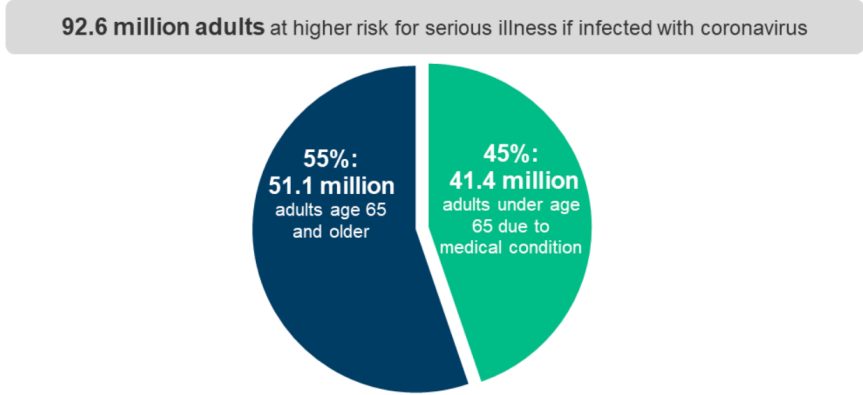


Figure 3.6.5. Over 90 million people of 246 million U.S. adults are at higher risk of serious illness if infected with COVID-19 (Koma et al., 2020).

NOTE: Data includes adults ages 18 and older; excludes adults living in nursing homes and other institutional settings.
SOURCE: KFF analysis of 2018 Behavioral Risk Factor Surveillance System.



Communications promoting individualism over community care assume individuals have the resources to assess their own risk and survive despite the health inequities that have marked the pandemic’s disparate health outcomes. In contrast to the CDC’s articulated strategy to address health equity,¹⁹³ CDC pandemic communications emphasize all Americans have “the tools” to protect themselves from COVID, regardless of the unequal distribution of risk and access to these tools. It is impossible for everyone to ascertain their risk, given disparities in access to health care, delays in diagnosis, delays in official CDC recognition of risk factors, health literacy, and limited knowledge of COVID-19 and Long COVID.

People who perceive themselves at lower risk of severe outcomes and/or Long COVID may unwittingly engage in risky behaviors, creating unsafe environments for people at high risk. The CDC’s risk communication frames the lives and health of high-risk people as disposable.¹⁹⁴ By disregarding these inequities, these communications uphold white supremacy, structural racism, ableism, ageism, and classism. The CDC’s communication strategy should instead promote the health of whole communities and population health, with a focus on the most impacted communities, because, in a pandemic, no one is safe until everyone is safe.

Recommendations for Pandemic Communications Strategy

- **The CDC should educate health care workers and the public on the serious risks COVID and Long COVID poses to all**, including young, healthy, vaccinated individuals.
- **The CDC should communicate local COVID risk to the public using community transmission rates and wastewater data** instead of the Community Levels map.
- **The CDC should “meet people where they are”¹⁹ by developing evidence-based, effective, and accessible communication strategies in partnership with affected communities.** Collaborate with diverse media personnel, trusted community organizations and messengers from impacted communities. The CDC should also collaborate with state and county health departments to ensure consistent national messaging and to design tailored messages for specific communities.
- **The CDC should disseminate updated information on emerging evidence about COVID in multiple languages and accessible formats** (including for disabled people and people who lack digital access).
- **The CDC should recognize communications strategies are limited by the structural context people face.** Combine communications with a structural strategy to implement institutional COVID protections in schools, workplaces, and other public spaces.

3.7. Inclusion:

Public health policy design and implementation in partnership with and demonstrating respect for all impacted communities

“The Centers for Disease Control and Prevention’s (CDC) ongoing failures have not gone unnoticed, in particular by the groundswell of people irrevocably harmed. Many pandemic victims have spent the last several years bringing attention to the need for a national pandemic overhaul to spare others from their pain, only to be ignored or dismissed by decision-makers, including CDC Director Rochelle Walensky.”

– Kristin Urquiza, MPA lost her dad to COVID in June 2020 & co-founded Marked By Covid, the grassroots network of COVID-bereaved individuals leading the national movement for pandemic justice and remembrance.

Public health policy and implementation should demonstrate respect for and prioritize the protection of all impacted communities; however, the CDC has emphasized vaccines and medical treatments above comprehensive public health measures to address the pandemic, promoting a society where high-risk individuals, and those in close contact with them, cannot meet their basic needs without risking COVID exposure and potentially life-threatening consequences.

“Because CDC did not require ventilation & filtration . . . did not set safety standards for schools... many schools remain unsafe for all and especially for the most vulnerable students & families, those with disabilities and other health conditions... Families like ours...were forced to leave school communities we loved because they were not safe enough... No family should have to make the choice between their long-term health and an in-person education in the school community they’ve been a part of for years.”

– Anonymous Parent and Educator, New York

Most visibly, in January 2022, the CDC director was criticized publicly for remarking it was “encouraging news” that over 75% of deaths among the vaccinated “occurred in people who had at least four comorbidities.”^{195,196} Although she later apologized, CDC policy has continued in this exclusive vein, centering the convenience of the healthy and able-bodied population to return to normal while burdening “high-risk” individuals to protect themselves.

An estimated, 6.2% of adults ages 18–64 are immunocompromised, according to the CDC,¹⁹⁷ and about 4 in 10 adults (92.6 million people) are at higher risk of developing serious illness if they become infected with COVID due to older age or health condition.¹⁶ CDC guidance for immunocompromised people and other individuals at risk for serious illness from COVID focuses on individual precautions, such as vaccination, individual masking, and avoiding poorly ventilated spaces; however, these precautions are inadequate when not implemented universally at an institutional and community level. For example, a July 2022 CDC MMWR report demonstrated that vaccination did not significantly mitigate the risk of intensive care unit admission or death for immunocompromised patients admitted to the hospital for COVID-19 (see Figure 3.7.1).⁴¹ Although the report authors even noted multilayered prevention measures, including nonpharmaceutical interventions (like wearing masks), can prevent hospitalization, the CDC has not advocated effectively for national implementation of this approach, even when the CDC’s own Community Levels map recommends it. Evusheld was an prophylactic treatment to prevent COVID-19 infection in immunocompromised people. However, when Evusheld lost its efficacy against circulating

variants in January 2023, the CDC advised people with weakened immune systems and their household members to create individual, and patently inadequate, “COVID-19 action plan[s]” to protect themselves.¹⁹⁸

Vaccination status*	No. (weighted %) [§]											
	Immunocompromised [¶]						Not immunocompromised**					
	ICU admission			Death			ICU admission			Death		
	Yes	No	aOR (95% CI)	Yes	No	aOR (95% CI)	Yes	No	aOR (95% CI)	Yes	No	aOR (95% CI)
Vaccinated	85 (25.0)	269 (75.0)	1.01 (0.64–1.58)	55 (16.5)	298 (83.5)	1.34 (0.71–2.51)	257 (18.7)	1,044 (81.3)	0.85 (0.60–1.12)	113 (9.5)	1,188 (90.5)	0.58 (0.39–0.86) ^{††}
Unvaccinated	129 (25.5)	351 (74.5)	Ref	66 (12.9)	413 (87.1)	Ref	1,121 (21.6)	3,771 (78.4)	Ref	488 (10.1)	4,409 (89.9)	Ref

Figure 3.7.1. Association of vaccination status with intensive care unit admission and in-hospital death among patients hospitalized for COVID-19, by immunocompromise status—COVID-NET, 10 states, March 1, 2021–February 28, 2022. (Singson et al., 2022).

“As a high risk immunocompromised adult that qualifies for Evusheld per your own {CDC} guidance, I have been denied. My state has no support for individuals like me who have their specialist in one city (which happens in rural communities) and the distribution of Evusheld is in another health care system... The immunocompromised high risk are not back to ‘normal’ and neither are those with long COVID or mourning lost loved ones. These victory laps are contributing to gaslighting and our continued segregation from society. This is morally and ethically against the best practices in public health. Include us in these conversations if our lives are of any value.”

– Anonymous Educator, Montana

Many people cannot completely avoid contact with others to give or receive necessary care and services. Many older adults, immunocompromised, chronically-ill and disabled people cannot isolate themselves from family members, school children, home care aides, and health care providers. Essential workers and low-income people inevitably face COVID exposure in the workplace due to few remote work options and minimal workplace protections. Students of all ages inevitably face COVID exposure at school and universities, which they can bring home to family members. People who are incarcerated or live in congregate settings and schoolchildren are permanently at risk given the long hours spent together in enclosed spaces. Given high rates of community transmission, it is nearly impossible for high-risk individuals to meet their basic needs without risking COVID exposure under current implementation of CDC guidelines.

The CDC’s pandemic response neglected to visibly include or partner with individuals, workers, or organizations from communities that have been impacted disproportionately by the COVID-19 pandemic. The agency’s approach, instead, burdened impacted

individuals to protect themselves using measures that are most effective when applied collectively rather than by individuals.

“People with disabilities need to be put in positions of authority, our community needs to be substantively engaged with throughout the policymaking process, and the CDC needs to use its platform to push back against federal, state, and local policies that discriminate against people with disabilities.”

– Colin Killick, MPP, Executive Director, Disability Policy Consortium, Massachusetts

Recommendations for an Inclusive Pandemic Strategy

- **The CDC should develop public health policy and communications in partnership with and featuring the leadership of groups disproportionately impacted by COVID** through the creation of a federal, state, and local COVID-19 advisory committees and by frequently meeting with community stakeholder groups and creating other accessible mechanisms for public participation. Inclusive policies should use layered prevention measures at the institutional level, rather than burdening individuals to protect themselves.
- **The CDC should advocate for occupational safety and health advisory boards to be integrated into public health agencies at local, state, and federal levels**, with representation from worker organizations, including labor unions and workers' centers, to codevelop workplace safety guidance and enforcement strategies.
- **The CDC should express support for** a federally-recognized Covid Memorial Day and permanent national Covid memorial to honor the over 1,120,000 people who have lost their lives to COVID-19 as of this writing, and to honor the wishes of COVID-bereaved families. Formal recognition of these tremendous losses should draw attention to the importance of redressing social inequities and building robust and equitable public health systems to avoid repeating such a tragedy in the future.

3.8. Addressing Root Causes.

Public health policy meaningfully addresses social and structural root causes of health outcomes, including economic and environmental injustices, and provides meaningful structures to promote health equity.

“As a family medicine physician, I worked closely with community-based organizations and community members working to serve their disproportionately impacted communities... I experienced leadership at ALL levels... continuously make decisions that reinforced... the pandemic disparities of our most-impacted communities... The answer is listening to the perspective and expertise of community, bring them to the table, and actually make them decision-makers. The most effective programs and outreach came from working with and following the lead of community.”

– Jenny Fish, MD, on behalf of Health Professionals for Equality and Community Empowerment (HPEACE), California

The CDC acknowledges structural racism must be addressed “as a root cause of racial and ethnic health inequities and a core element of our public health efforts.”¹⁹⁹ We recognize many of the root causes of health inequities lie beyond the CDC’s scope, but structural problems require structural solutions. However, the CDC has increasingly emphasized individual responsibility, rather than the importance of redressing health inequities via structural and institutional interventions. Individual recommendations to be vaccinated or to seek testing or treatment for COVID-19 inadequately address lack of access to health care, paid sick leave, transportation, and evidence-based health information to get vaccinated. Individual recommendations to stay home when sick are difficult to follow for workers who lack paid sick leave. Some workers are compelled to go to work with COVID,²⁰⁰ or must choose between taking a COVID test and running out of sick days.¹⁰³ For this reason, structural and institutional interventions, such as universal standards for ventilation in schools, workplaces, and other public spaces, universal workplace protections, and other means to facilitate access to COVID-19 protections, are essential to address inequities.

“Include representatives from the most impacted communities, including worker organizations, and a worker health and safety perspective to make decisions. Ensure that there are sufficient

resources to collect data – including demographics and occupation/industry - at the state and national level, as well as qualitative data as input for decisions.”

– Marcy Goldstein-Gelb, MS, Co-Executive Director, National Council for Occupational Safety and Health

The social, structural, and economic context that preceded the COVID-19 pandemic laid the groundwork for the disproportionate poor health outcomes and deaths experienced by the most marginalized populations. For example, a growing body of public health literature has described the disproportionate impact the pandemic has had on Black Americans and other people of color, who faced a triple threat preceding the pandemic: being more likely to work in essential occupations without remote work options, being more likely to have chronic medical conditions, and being less likely to have health insurance and access to health care (see Figure 3.8.1).^{201,202} Additional research has shown people from low-income backgrounds are more likely to live in crowded conditions or multigenerational homes, reside in communities with high rates of community transmission, and commute via public transport, placing them at higher risk for catching COVID and then spreading it to members of their household.^{95,203,204} The CDC recommends individuals at high-risk of severe disease of COVID should wear masks when community levels are medium or high, but avoiding infection from household members can be especially difficult for people who live in crowded, multigenerational households.

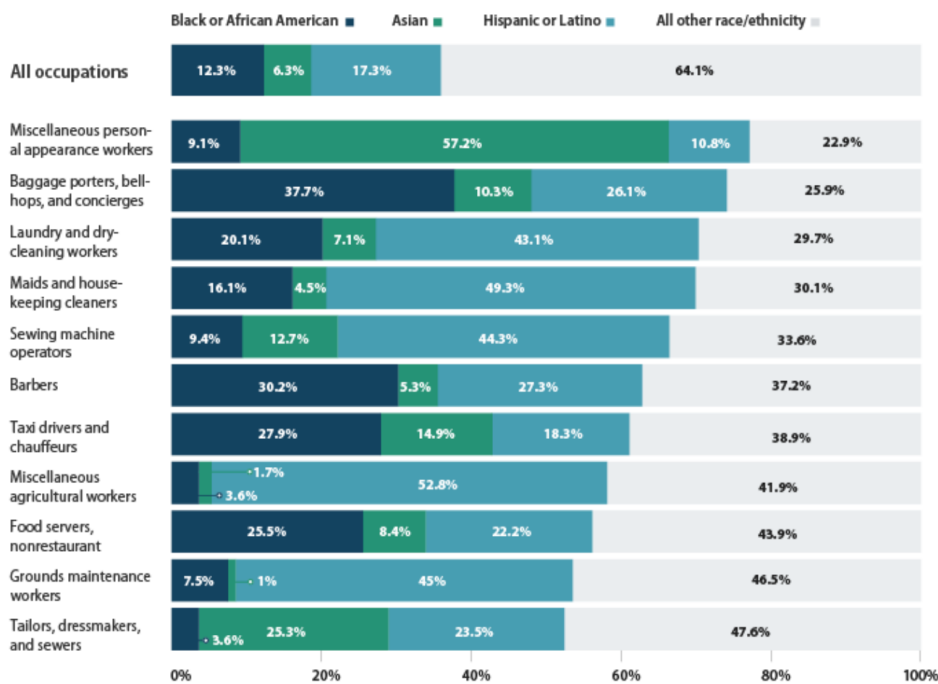


Figure 3.8.1. People of color remain overrepresented in some of the lowest-paying agricultural, domestic, and service vocations. Shares of total employed people by occupation, race and ethnicity, 2018 (Solomon et al, 2019).

Source: U.S. Bureau of Labor Statistics, "Labor Force Statistics from the Current Population Survey: Employed persons by detailed occupation, sex, race, and Hispanic or Latino ethnicity," available at <https://www.bls.gov/cps/cpsaat11.htm> (last accessed June 2019).



CDC efforts earlier in the pandemic (e.g., the eviction moratorium) leveraged the agency’s authority to target root causes of health inequities contributing to COVID disparities. Eviction moratoriums likely prevented thousands of COVID cases and deaths.²⁰⁵ However, as the CDC and other public health leaders signaled the end of the pandemic by downplaying the risk of COVID infections, pandemic social programs targeting food, housing insecurity, and unemployment also ended, placing many communities at increased risk of poverty. The end of the COVID-19 Public Health Emergency and associated other public programs will likely worsen these inequities. Supplemental Nutrition Assistance Programs (SNAP) will end remaining Emergency Allotments in March 2023,²⁰⁶ and 32 states plan to cut SNAP benefits, in what has been described as a “hunger cliff.”²⁰⁷ The employment-based health insurance system and the end of the COVID-19 Public Health Emergency puts an estimated 15 million people at risk of losing health insurance.²⁰⁸ BIPOC and low-income communities also have borne the brunt of COVID-related economic downturn, being more likely to have lost work and income due to the pandemic, more likely to have difficulty making rent and mortgage payments, and less likely to have paid sick leave.²⁰⁹ Low-wage workers also are the most likely to report missing work due to COVID-19, the least likely to have paid sick days, and the most likely to report food insecurity after missing work due to COVID-19 (see Figure 3.8.2a and 3.8.2b).²¹⁰ Meanwhile, economic inequality during the pandemic has increased. Billionaires’ wealth increased by \$1.5 trillion (50%) during the pandemic, while millions of Americans lost their lives and livelihoods (see Figure 3.8.3).²⁰⁹

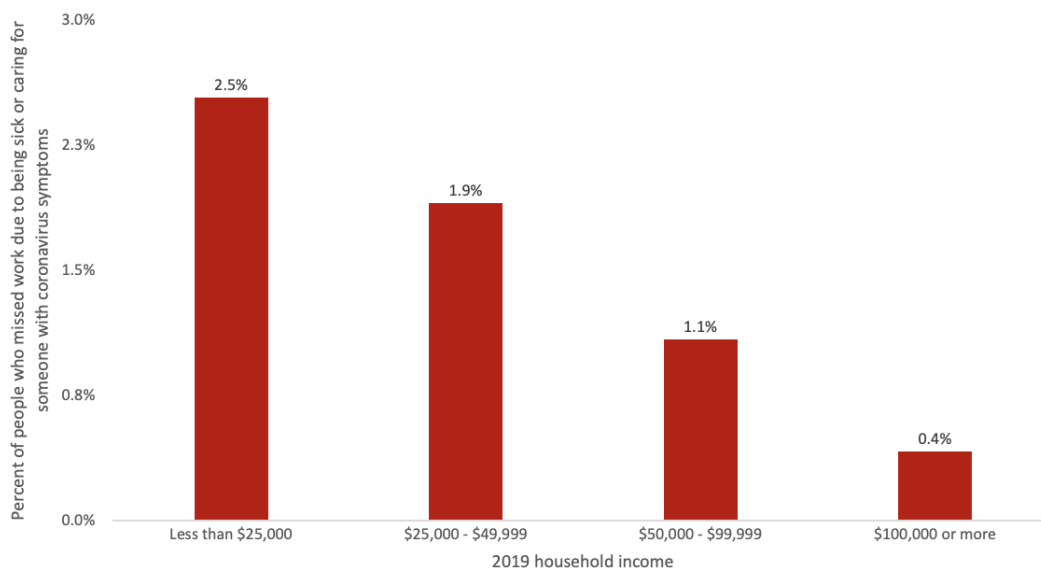


Figure 3.8.2a. Percentage of people who missed a whole week of work due to being sick with or caring for someone with COVID-19 symptoms, by household income, April 23-Dec 21, 2020 (Raifman et al., 2022).

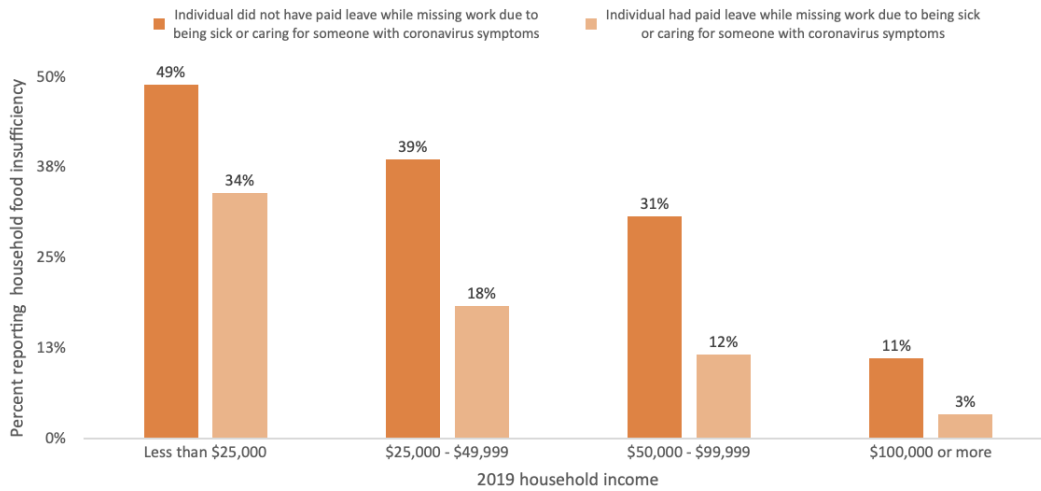


Figure 3.8.2b. Food insufficiency among people who missed a whole week of work due to being sick with or caring for someone with COVID-19 symptoms by household income and whether they had paid leave, April 23-Dec 21, 2020 (Raifman et al., 2022).

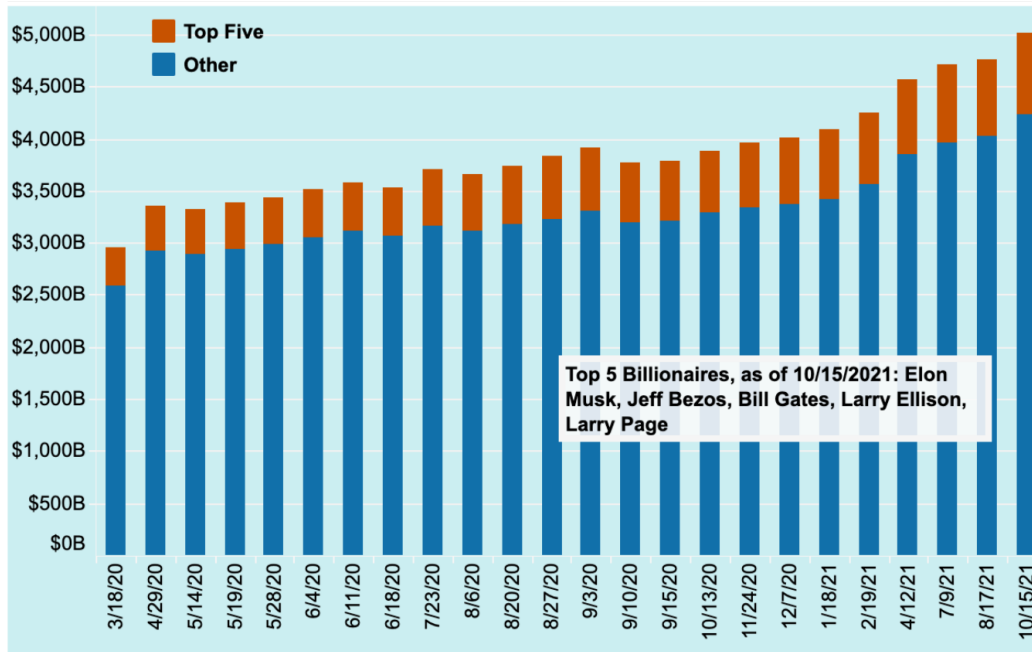


Figure 3.8.3. Total U.S. billionaire wealth, select dates in 2020 and 2021 shows billionaire wealth has increased more than 50% during the pandemic (Collins, 2022).

Source: Institute for Policy Studies and Americans for Tax Fairness

“Invest in upstream solutions that prevent harm from occurring. When communities experience harm, their risk exposure is not equally distributed.”

– Vinny Eng, Director of Policy and Advocacy, Safer Together, California

The United States has the highest incarceration rate in the world; therefore, U.S. prisons, jails, and immigration detention centers have contributed to COVID-19 infections.^{211,212} Incarcerated people are more likely to be infected and become seriously ill or die from COVID-19 than the general public.³⁸ Incarceration compounds the increased risk of COVID

morbidity and mortality in communities of color, because Black and Latinx members are 5 and 1.3 times as likely to be incarcerated than White Americans, respectively.²¹³ Decarceration has been shown to decrease the risk of COVID infection and should be further pursued as a public health and justice intervention.²¹⁴

Meanwhile, the pandemic response has compounded the impact of underlying inequities on COVID exposure by failing to rectify inequities in access to vaccinations, high-quality masks, testing, good air quality, paid sick leave, and treatment. Members of the most adversely impacted communities have continued to favor non-pharmaceutical public health protections. Numerous polls have demonstrated Black and Hispanic respondents are disproportionately more likely to report wearing masks and supporting mask requirements.^{22,82} However, the expense of regularly purchasing high-quality, well-fitting masks is burdensome and prohibitive for people already experiencing lost work and income. As mask mandates have been removed from schools and public transport, despite the fact that schools in communities of color are less likely to have quality ventilation,²¹⁵ and low-income, BIPOC workers are more likely to rely on public transportation,⁹⁵ structurally marginalized groups continue to face disproportionate risk for COVID-19-related morbidity and mortality.

A growing body of public health literature has demonstrated the fundamental impact of factors such as income, race, neighborhood, and other social determinants of health (SDOH) on health outcomes.^{216,217} The CDC describes SDOH as the conditions in which people are “born, grow, work, live and age and the wider set of forces and systems shaping the conditions of daily life.”²¹⁸ During the first year of the pandemic, the CDC directly intervened to address a socioeconomic rather than a medical need by issuing an eviction moratorium and, as a result, likely saved thousands of lives, as research later demonstrated.²⁰⁵ We applaud the CDC for its existing work to address SDOH²¹⁹, their recent delivery of much-needed resources to health departments to address COVID inequities at local, tribal, territorial, and regional levels,²²⁰ and urge the agency to further use its influence in partnership with marginalized and minoritized communities to advocate for broad-based policies and leverage all available powers to address socioeconomic inequities directly as a core aspect of its public health and equity agenda.

Recommendations to Address Root Causes of Health Inequities:

- **The CDC should partner with impacted communities and continue to leverage its authority and influence to enact and advocate for broader policies that directly address the social determinants of health**, including safe and affordable housing, universal health care, decarceration, improved workplace protections, living wages, and expanded paid leave and universal care infrastructure, such as childcare and increased support for family caregivers.
- **The CDC should publicly advocate for the COVID-19 Public Health Emergency measures to be made permanent and expanded upon**, including health

insurance, paid leave, food stamps, improved ventilation, and COVID vaccines, testing and treatment, in order to address inequities and build a resilient public health infrastructure for this and future pandemics.

“Capacity needs to be built at CDC to prepare for future emergencies along with powers to implement public health interventions, rather than continuing the panic-neglect cycle intrinsic to emergency preparedness.”

– Anonymous Safety Policy Specialist, Washington

4. CONCLUSION

In January 2023, White House COVID-19 response coordinator Ashish Jha warned that the U.S. health system would likely be dysfunctional due to COVID for years,²²¹ with hospitals and emergency rooms overwhelmed for 3–4 months each year. President Biden’s plan to end the COVID-19 Public Health Emergency without making the vital public health measures it provided permanent will only worsen the inequities³⁴ and high rates of morbidity and mortality, which have marked the COVID-19 pandemic in the United States. Instead, the CDC should publicly advocate for the COVID-19 Public Health Emergency measures which expanded access to health insurance, paid leave, food stamps, improved ventilation, and COVID vaccines, testing and treatment, among others to be made permanent and expanded upon in order to address inequities and build a resilient public health infrastructure for this and future pandemics.

In sum, although the CDC released many rigorous scientific reports during the pandemic, the agency’s leadership released guidance repeatedly that placed the interests of large corporations above the health and well-being of the public, which often contradicted its own science. CDC’s Community Levels map warns the public of surges after many people have been infected. The CDC’s emphasis on individual responsibility abandons population health and burdens the most impacted communities to protect themselves. Preventing highly transmissible disease is a group effort. Delegating responsibility of protection to individuals is ineffective and unethical, given the public may not have the necessary knowledge and resources to assess their own risk, and individualized protections are insufficient when applied too sparsely. Risk created at the structural level can only be addressed effectively at the structural level. The CDC must take responsibility to push for institutional protections that promote public health by decreasing disease transmission and should deliver communications that empower individuals and communities to promote health and safety for all.

If we fail to address the COVID-19 pandemic, we are accepting a worse quality of life overall, shorter life expectancy, and greater degree of suffering for huge numbers of people. Instead of this panic/neglect cycle of predictable and preventable death and disability, we urge the CDC, national and local public health departments, state and local school departments, and community and business leaders to embrace a community care strategy for COVID. The CDC pandemic strategy should value all lives, especially those disproportionately impacted through health inequity; actively promote a comprehensive, precautionary approach, determined without political or corporate influence; and

use evidence-based, layered prevention and mitigation measures to control disease transmission and a communications approach to make the strategy accessible and effective. CDC guidance and action in each area must center the people most harmed by, or otherwise still vulnerable to, the highest exposures to and worst outcomes of COVID-19.

We recognize a decision to value profit over people's lives and health is a feature rather than a flaw of U.S. capitalism, embraced by both political parties, and to which the CDC is not immune. However, we continue to urge the CDC leadership to live up to their organizational mission to protect the health of the U.S. population and the inextricably linked health of those around the world as well as the health of our economies. As we witness the growing numbers of COVID deaths and people disabled by Long COVID and emerging variants that can already evade existing vaccines and treatments, it becomes increasingly clear that a multifaceted, sustainable approach to the COVID pandemic is essential. The health of the U.S. economy is only as good as the people who do the work, and a plan to protect everyone, especially the most vulnerable, will be better in the long term, for people, for the economy, and for future generations.

Author Contributions

Lara Jirmanus: Conceptualization, Methodology, Formal Analysis, Project Administration, Writing–Original Draft, Review and Editing, Visualization; **Rita Valenti:** Conceptualization, Methodology, Writing–Original Draft, Review and Editing; **Eiryn Griest Schwartzman:** Conceptualization, Methodology, Formal Analysis, Writing–Original Draft, Review and Editing; **Sophia Simon-Ortiz:** Conceptualization, Writing–Original Draft, Review and Editing; **Lilly Havstad:** Conceptualization, Writing–Review and Editing; **Alanna Hirz:** Writing–Review and Editing; **Dana Ludwig:** Writing–Review and Editing; **Theo Allen:** Conceptualization, Writing–Review and Editing; **Josh Garoon:** Conceptualization; **Rob Wallace:** Conceptualization, Visualization; **Dannie Ritchie:** Writing-Review and Editing; **Molly Kaufman:** Funding Acquisition; **Samuel R. Friedman:** Conceptualization, Writing – Review and Editing; **Mindy Thompson Fullilove:** Conceptualization, Funding Acquisition, Writing–Review and Editing.

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APPENDIX A

People’s Review of the CDC COVID Pandemic Response Survey

People’s Review of the CDC COVID Pandemic Response

In parallel to the U.S. CDC’s own [internal review](#), we are organizing a People’s Review of the CDC, which will be informed by the communities most impacted by COVID, and a coalition of independent public health and health care practitioners and researchers.

To participate, please indicate your level of agreement with each statement below. Each statement addresses the performance of the U.S. CDC since January 2021, with regards to management of the COVID-19 pandemic specifically, and not to other functions of the CDC.

Individual responses will be kept confidential. Aggregated survey data will be used to create a report card* assessing the CDC’s performance in eight critical areas of public health, which we will disseminate to the media and public.

We welcome input from public health professionals working on equity, as well as the people most impacted by COVID-19 who are working on pandemic advocacy, including essential workers, people with disabilities and chronic illnesses, people who have lost loved ones, people who are incarcerated, people living in congregate facilities, low-income communities and immigrants, older adults and Black, Indigenous, and People of Color ([BIPOC](#)).

*Although the initial survey was intended to general a “report card,” authors elected to use a table with Likert scores to visualize the data to better represent responses.

Name: _____

Credentials (if applicable) e.g., PhD, MD, MPH: _____

Title/Position/Job: _____

Organization/Affiliation: _____

City: _____ USState/Territory: _____

I am answering this survey:

- As an individual
- On behalf of my organization

Note: Please, answer below survey items regarding the U.S. CDC management of the COVID-19 pandemic since January 2021.

1. Ethics: The CDC has made policy decisions that emphasize the value of all people’s lives.

- Strongly Agree Agree Neutral Disagree Strongly Disagree Unsure

2. Equity & Justice: The CDC has centered its policy decisions on the safety of disproportionately impacted people.*

* Includes essential workers, people with disabilities and chronic illnesses, people who are incarcerated, people living in congregate facilities, low-income communities and immigrants, older adults, and Black, Indigenous, and People of Color (www.thebipocproject.org).

- Strongly Agree Agree Neutral Disagree Strongly Disagree Unsure

3. Scientific Integrity: The CDC has made scientific policy decisions independently from political interference.

- Strongly Agree Agree Neutral Disagree Strongly Disagree Unsure

4. Public Health Infrastructure: The CDC has built capacity for surveillance, community education, and dissemination of resources and technical expertise necessary to combat this and future pandemics.

- Strongly Agree Agree Neutral Disagree Strongly Disagree Unsure

5. Communication: The CDC has built trust through evidence-based, accurate, effective and accessible communication.

- Strongly Agree Agree Neutral Disagree Strongly Disagree Unsure

6. Inclusion: The CDC has respectfully designed and implemented public health policy in partnership with all impacted communities.*

* Includes essential workers, people with disabilities and chronic illnesses, people who are incarcerated, people living in congregate facilities, low-income communities and immigrants, older adults, and Black, Indigenous, and People of Color (www.thebipocproject.org).

Strongly Agree Agree Neutral Disagree Strongly Disagree Unsure

7. Addresses Root Causes: The CDC's guidance and policies have meaningfully addressed the social, structural, economic and environmental injustices at the roots of public health.

Strongly Agree Agree Neutral Disagree Strongly Disagree Unsure

8. Disease Control and Prevention: The CDC has used high-quality data and promoted a comprehensive, precautionary approach with layered mitigation measures to control disease transmission.

Strongly Agree Agree Neutral Disagree Strongly Disagree Unsure

Recommendations:

If you have any recommendations for the U.S. CDC in any of the above categories, please list them here:

Comments:

If there is anything we have left out that you would like us to communicate, if you would like to explain your responses, or if you would like to share your lived experiences about being impacted by CDC policies (e.g., if you are high risk), please leave your comments here, and we may use them as a quote:

Attribution:

- You may use my name, affiliation, and quotes in your report card materials
- I prefer to remain anonymous
- I prefer not to be quoted

Endorsement:

- I would like to officially endorse the People's Review of the CDC on behalf of myself or my organization.

Thank you for participating in our survey! We value your time and contribution!

If you have any questions about this survey, or would like to help with our organizing efforts, please email us at info@peoplescdc.org.

The People's CDC is a collective of public health practitioners, scientists, health care workers, educators, advocates, and people from all walks of life working to reduce the harmful impacts of COVID-19. Our website is peoplescdc.org.

APPENDIX B

Supplemental Table A. Number of Respondents for the Eight Essential Areas of Pandemic Management by Likert Label for People’s External Review of the CDC Survey from January 2021 to August 2022

Category	Strongly disagree	Disagree	Neutral	Agree	Strongly agree	Total responses excluding 'unsure'
1. Ethics	215	125	35	65	49	489
2. Equity & justice	248	119	35	61	26	489
3. Scientific integrity	238	140	29	47	37	491
4. Public health infrastructure	184	154	56	58	28	480
5. Communication	231	125	53	54	29	492
6. Inclusion	227	134	40	45	26	472
7. Addresses root causes	250	120	49	40	22	481
8. Disease control and prevention	203	122	55	71	36	487

**People's
CDC**