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America 2021: Building a bridge to normalcy

To America's leaders, innovators, and changemakers: even as the COVID-19 pandemic continues, a return to a normal existence is in sight. Getting the endgame right could save thousands of lives.

by Matt Craven, Tom Latkovic, and Jordan VanLare

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We hope that 2021 will see the United States gain a decisive upper hand in its fight against COVID-19. The country is currently engaged in an unprecedented race to vaccinate as many people as possible while using public-health measures to minimize deaths in the short term. The situation is dire—more people died in the United States from COVID-19 in January 2021 than died in the last two years from the flu.[1] Even as we work through the challenges of this ongoing tragedy, we argue that it is reasonable to hope that the first half of 2021 can be a bridge to what we term "normalcy"—when many aspects of social and economic life can resume without fear of excess mortality (when overall mortality exceeds its long-term average). The great news is that vaccines appear effective—seeing "shots go into arms" is heartening. The less great news is that new challenges are emerging by the day, including more contagious strains of the virus and a slow start to vaccine rollout.

America's leaders, innovators, and changemakers can take steps to ensure that the bridge we're building is safe, sound, and gets us where we need to be. In this memo, we condense the recent history of COVID-19 into five must-see charts and, based on that history, set out six considerations for our nation's bridge builders.

The past ten months in five charts

The COVID-19 crisis has confounded expectations again and again. Sometimes it seems as if the only safe view is hindsight. Here's a summary of the most critical insights gained during 2020.

1. Containment policy only works if it leads to changes in personal behavior

Public policy can set the tone, but it only works with the consent of the governed. Containment of COVID-19 is about millions of individual decisions. In the United States, stringent policies about testing, tracing, and mask wearing have correlated only loosely with changes in epidemiology (Exhibit 1).[2] This is not because testing, tracing, and mask wearing don't help, but because public consent has been limited.[3] Citizens' behaviors are based on public sentiment; people modulate their actions in line with those around them.

Let's be clear, the United States has proven that containment can work in a wide range of settings. Safeguarding can work, including at schools, warehouses, factories, and airlines.[4] In all these settings, where human activity is to some degree routine and predictable, essential activities can operate relatively safely. Other settings where the United States has not found consistently safe models of interaction—household interaction, social gatherings, and work settings where safeguards are not followed[5]—appear to account disproportionately for transmission.

2. Mortality is driven by protecting (or not) those most at risk

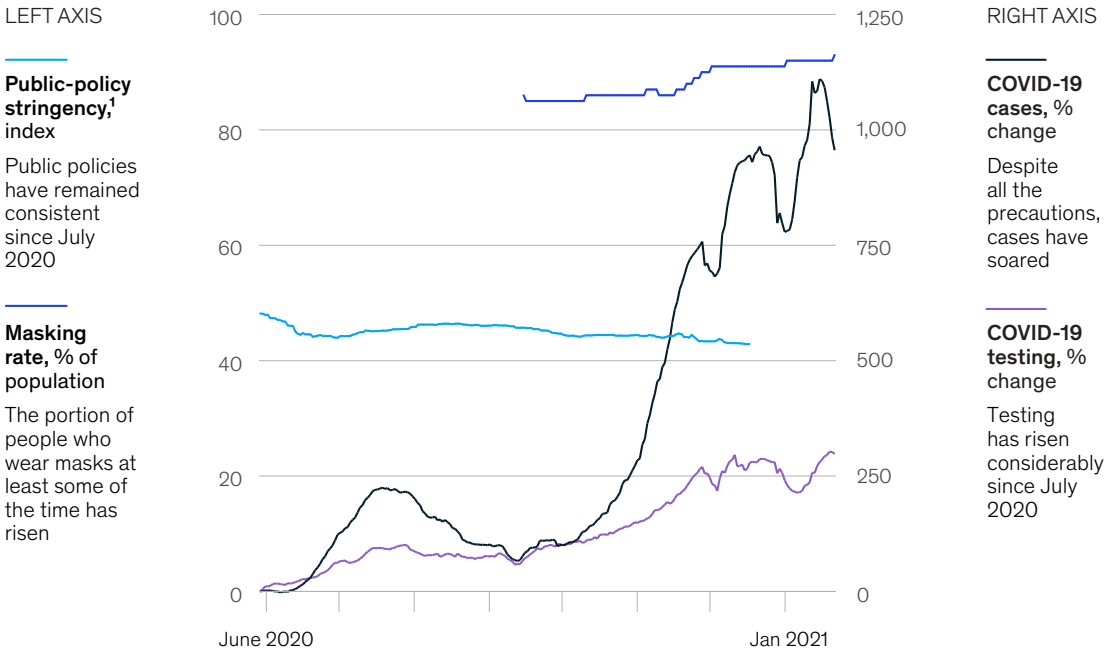
COVID-19 is much tougher on older people. A person over 75 is 1,000 times more likely to die from COVID-19 than a 15-year-old (Exhibit 2).[6]

[1] "Past seasons estimated influenza disease burden," CDC, October 1, 2020, cdc.gov.
[2] COVIDcast Survey, Carnegie Mellon University and Delphi Group, January 2021, delphi.cmu.edu; *Community vulnerability to COVID-19: Explore the U.S. data*, Surgo Ventures, January 2021, surgoventures.org; "The COVID tracking project," The Atlantic Monthly Group, February 2021, covidtracking.com; "COVID-19 United States Cases," John Hopkins Coronavirus Resource Center, 2021, coronavirus.jhu.edu; "Coronavirus government response tracker," Blavatnik School of Government, 2020, bsg.ox.ac.uk.
[3] Jessica Becker et al., "Americans' COVID-19 stress, coping, and adherence to CDC guidelines," *Journal of General Internal Medicine*, May 2020, Volume 35, Number 8, pp. 2296–2303, link.springer.com.
[4] "Public attitudes, behaviors, and beliefs related to COVID-19, stay-at-home orders, nonessential business closures, and public health guidance," CDC, May 2020, cdc.gov; "Updated interim guidance for airlines and airline crew: Coronavirus disease 2019," CDC, March 2020, cdc.gov; "Operating schools during COVID-19," CDC, February 2021, cdc.gov; Katherine Auger et al., "Association between statewide school closure and COVID-19 incidence and mortality in the US," JAMA Network, September 2020, jamanetwork.com.
[5] Julia Ries, "The 7 most common places COVID-19 is spreading right now," *Huffington Post*, December 23, 2020, huffpost.com.
[6] "COVID data tracker," CDC, 2021, covid.cdc.gov; "Estimated disease burden of COVID-19," CDC, January 2021, cdc.gov.

Exhibit 1

COVID-19 cases have grown despite stringent policies and increases in masking and testing.

US public-health measures and cases, July 2020–January 2021



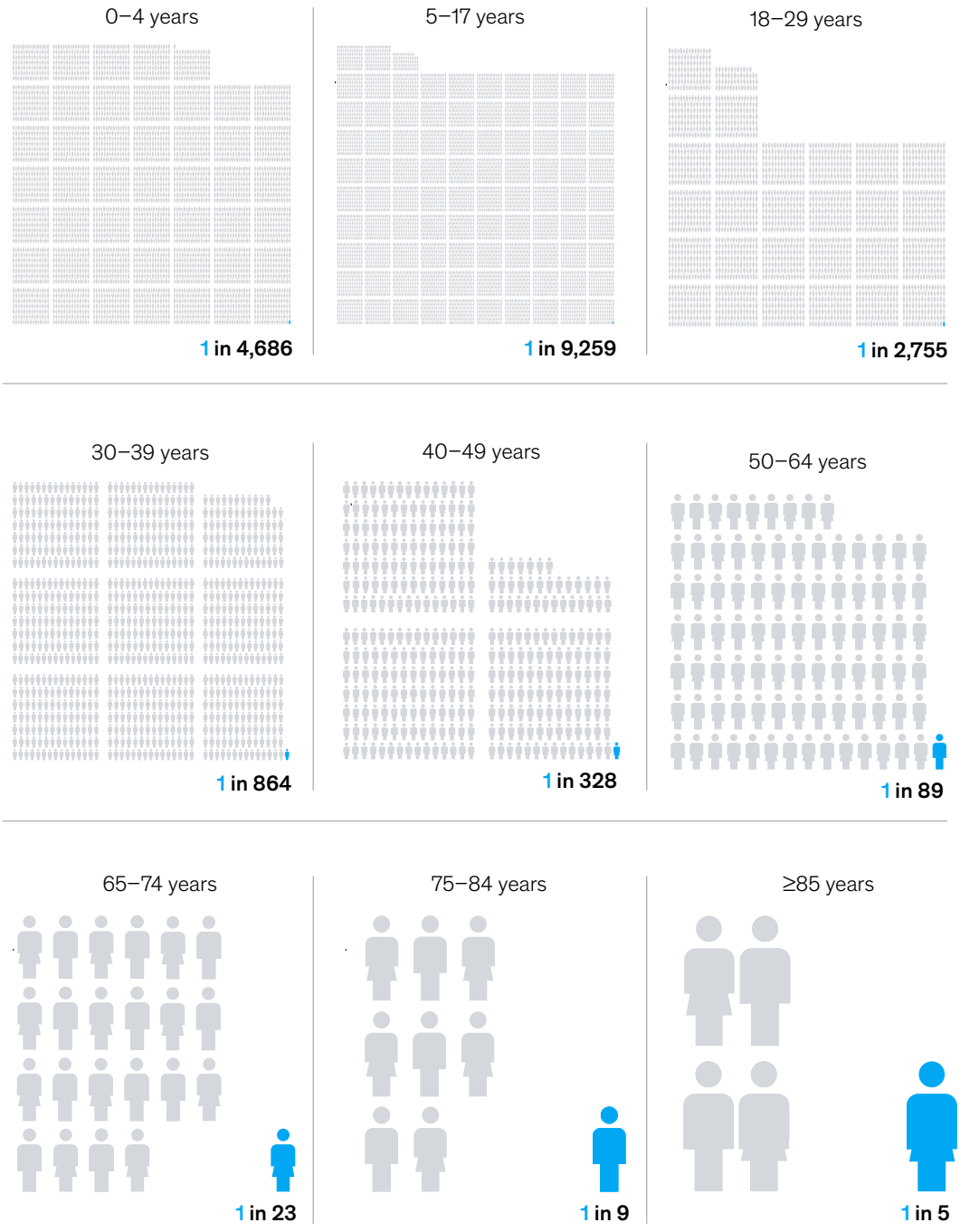
[1]McKinsey's COVID-19 Public Policy Tracker, which monitors restrictions in more than 15 settings and assigns a weighted score based on stringency of measures.
Source: CMU Delphi Group's COVIDcast survey, accessed through precisionforcoviddata.org; COVID Tracking Project; JHU COVID-19 tracker; McKinsey COVID-19 Public Sector Analytics's Public Policy Tracker

In the United States, stringent policies about testing, tracing, and mask wearing have correlated only loosely with changes in epidemiology.

Exhibit 2

Older people are much more likely to die if they contract COVID-19.

Chances that a person who catches COVID-19 will die, by age group (cumulative data through January 20, 2021)



Source: Centers for Disease Control and Prevention

The implication is clear: protect the most vulnerable. Vaccines are one important tool, but until they are widely deployed, we should consider protecting those at high risk from the rest of society. In the early days of the outbreak, proactively isolating older people was considered cruel and unreasonable. The arrival of safe, effective vaccines has changed the calculus by making the pain of isolation a time-bound problem. Economic supports for older people in isolation may help sustain them as we build the bridge.

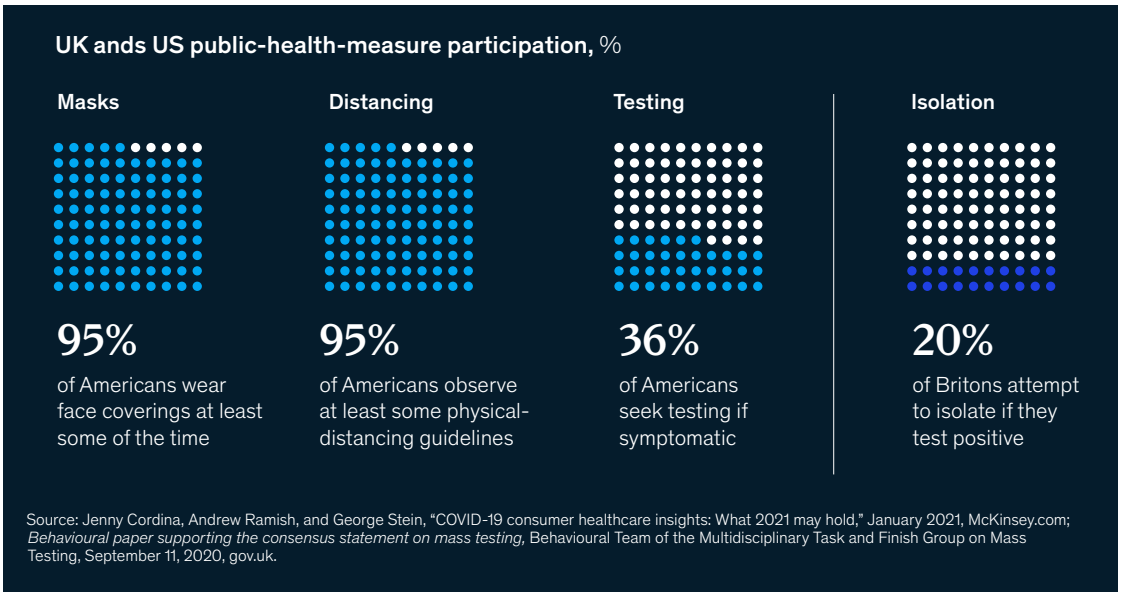
3. Simple and sustainable is often better than striving for perfection

Americans are weary.[7] Most want to comply with public policies, but they are worn out and confused.[8] Today, some states are effectively in a form of lockdown, but high percentages of the population are not fully complying with guidance (Exhibit 3). Shifting policies don't help; while they often reflect the best new science, they are hard for people to grasp, and in some cases undermine credibility.

The more that people believe a practice or guideline is both useful and doable, the more likely they are to comply.[9] A guideline that is 70 percent effective and is followed by 80 percent of people would probably produce better outcomes than a 90 percent effective guideline that only 10 percent of people follow.

Exhibit 3

Significant portions of UK and US populations are not in compliance with main public-health protocols.



Source: Jenny Cordina, Andrew Ramish, and George Stein, "COVID-19 consumer healthcare insights: What 2021 may hold," January 2021, McKinsey.com; *Behavioural paper supporting the consensus statement on mass testing,* Behavioural Team of the Multidisciplinary Task and Finish Group on Mass Testing, September 11, 2020, gov.uk.

[7] "YouGov COVID-19 behaviour changes tracker: Avoiding crowded public places," YouGov, March 17, 2020, yougov.co.uk.
[8] Yasmeen Abutaleb, Josh Dawsey, Jeff Stein, and John Wagner, "Trump weighs restarting economy despite warnings from U.S. public health officials," *Washington Post*, March 23, 2020, washingtonpost.com.
[9] Sonia Laszlo, Natalia Mishagina, and Erin Strumpf, "The importance of new social norms in a COVID-19 outbreak," Policy Options Politiques, March 31, 2020, policyoptions.irpp.org.

4. The public sector can catalyze private-sector innovation

When government and the private sector fully exploit their distinct resources and capabilities, breakthrough innovation is possible. The clearest example has been the successful vaccine development of Operation Warp Speed[10]—the collaboration between the federal government and the pharmaceutical industry on SARS-CoV-2 vaccine development. The collaboration helped speed one vaccine to market, after a federal investment of about $10 billion and nine months (Exhibit 4).

At the local level, public/private collaboration has had mixed success. Many safeguarding efforts have scaled well, and have, in general, allowed many forms of economic activity to resume while decreasing risk. And few jurisdictions can point to successful contact-tracing operations, for example, or consistent testing at scale across public and private stakeholders.

5. COVID-19 is a public-health crisis—and much more

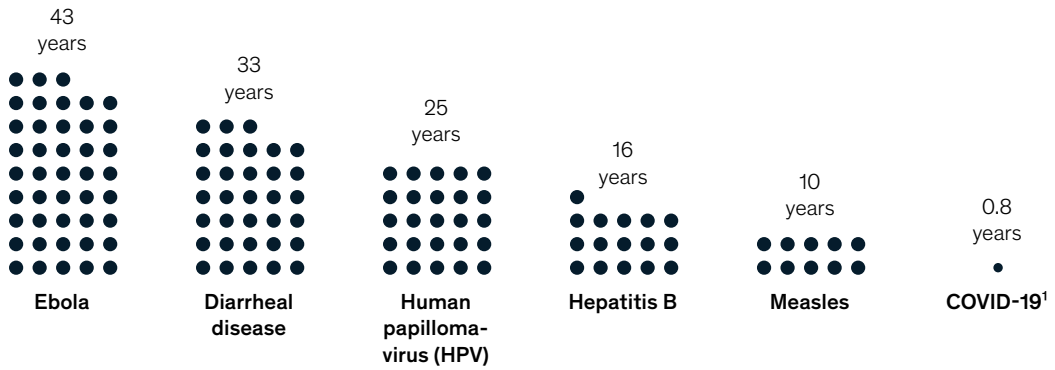
Make no mistake: COVID-19 is first and foremost an infectious disease. The death toll in the United States is now over 460,000,[11] and broader effects on health are substantial (Exhibit 5). But many of the interventions we are using to prevent the direct impact of COVID-19 have caused substantial secondary harm, including unemployment,[12] learning loss,[13] and increases in substance-use disorders.[14] The bridge to normalcy needs to be a time when we address not only the underlying issue of SARS-CoV-2 transmission, but also the restoration of our economy and the secondary effects of COVID-19.

Addressing the secondary effects of COVID-19 requires dealing first with the underlying disease. But as we do so, we should recognize that many citizens need help with many aspects of their lives.

Exhibit 4

COVID-19-vaccine development and approval has taken a fraction of the usual time.

Vaccination innovation,[1] time from infectious agent identification to vaccine license in US



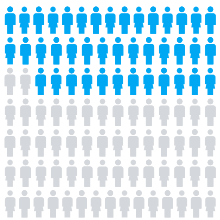
[1]COVID-19 vaccines have received Emergency Use Approval; they have not yet received Biologic License Application approval.
Source: Bernadeta Dadonaite, Max Roser, and Samantha Vanderslott, "Vaccination," Our World in Data, December 2019, ourworldindata.org; "COVID-19 vaccines," US Food & Drug Administration, February 5, 2021, fda.gov.

[10] Arthur Herman, "Why Operation Warp Speed worked," *Wall Street Journal*, February 1, 2021, wsj.com.
[11] "COVID data tracker," CDC, 2021, covid.cdc.gov; "Estimated disease burden of COVID-19," CDC, January 2021, cdc.gov.
[12] "Effects of COVID-19 pandemic on the employment situation news release and data," US Bureau of Labor Statistics, 2021, bls.gov; Elise Gould and Melat Kassa, *Young workers hit hard by the COVID-19 economy*, Economic Policy Institute, October 14, 2020, epi.org.
[13] Emma Dorn, Bryan Hancock, Jimmy Sarakatsannis, and Ellen Viruleg, "COVID-19 and learning loss—disparities grow and students need help," December 8, 2020, McKinsey.com.
[14] "COVID-19's far reaching impact on global drug abuse," UN News, June 25, 2020, news.un.org.

Exhibit 5

Adults are delaying or avoiding medical care because of COVID-19-related concerns.

Hospital care



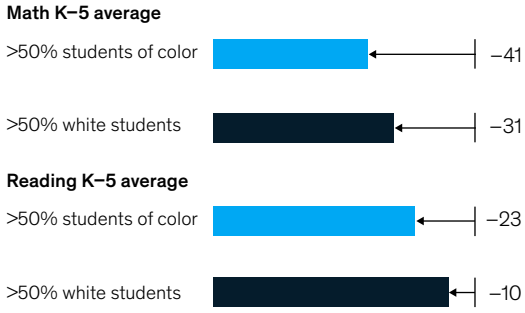
41%
of adults have deferred care as a result of the pandemic, potentially costing the health system

$125–$200
billion, and greater morbidity and mortality

Source: Mark É. Czeisler et al., "Delay or avoidance of medical care because of COVID-19-related concerns – United States, June 2020," Centers for Disease Control and Prevention, September 11, 2020, cdc.gov; Erica Hutchins Coe, Kana Enomoto, Patrick Finn, John Stenson, and Kyle Weber, "Understanding the hidden costs of COVID-19's potential impact on US healthcare," September 2020, McKinsey.com.

Learning loss among K–5 is considerable, and worse for students of color.

Learning loss at schools in the 2019–20 year, % less than historical scores[1]



[1]Percent of an "average" year of learning gained by students in 2019–20 school year, where 100 = historical matched scores over previous 3 years. Source: Curriculum Associates

Police departments in cities around the country are seeing a rapid rise in domestic-abuse cases.

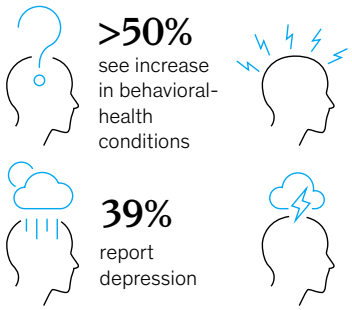
Domestic-abuse cases by city, % increase over average since COVID-19 pandemic began

At one hospital in Boston, domestic-abuse cases in 8 weeks in 2020 exceeded the total of 2018 and 2019 combined.

Source: Brad Boserup, Adel Elkbuli, and Mark McKenney, "Alarming trends in US domestic violence during the COVID-19 pandemic," *American Journal of Emergency Medicine*, April 2020, Volume 38, Number 12, pp. 2753–55, ajemjournal.com; Babina Gosangi et al., "Exacerbation of physical intimate partner violence during COVID-19 pandemic," *Radiology*, January 2021, Volume 298, Number 1, pp. E38–E45, pubs.rsna.org; Jeffrey Kluger, "Domestic violence is a pandemic within the COVID-19 pandemic," *TIME*, February 3, 2021, time.com.

Anxiety and depression have more than doubled during COVID-19 ...

US citizen behavioral-health conditions, %[1]



>50%
see increase in behavioral-health conditions

39%
report psychological distress

39%
report depression

>40%
report anxiety

... and in the postpandemic year, a further 10% of the US could be affected.[2]

>35 million Americans will experience behavioral-health conditions postpandemic including

1.6 million directly affected by severe illness or loss

this could result in

$100–$140 billion of additional healthcare spending in the first 12 months after the onset of the COVID-19 pandemic

[1]Jagdish Khubchandani et al., "Post-lockdown depression and anxiety in the USA during the COVID-19 pandemic," *Journal of Public Health*, January 2021, academic.oup.com.
[2]A. Analysis does not include Tricare, individual market, or uninsured populations. B. Analysis includes claims data from the Medicare FFS Limited Data Set from the Centers for Medicare and Medicaid Services, anonymized Medicaid data, and IBM's Truven MarketScan Commercial Database. Any analysis, interpretation, or conclusion based on these data is solely that of the authors and not International Business Machines Corporation. C. Accounts for reduction in spend for people losing employment and not getting Medicaid coverage. Erica Hutchins Coe, Kana Enomoto, Patrick Finn, John Stenson, and Kyle Weber, "Understanding the hidden costs of COVID-19's potential impact on US healthcare," September 2020, McKinsey.com.

Potential priorities for public- and private-sector leaders

What do those historical lessons mean for the bridge to normalcy? We see six opportunities; for each, we highlight potential imperatives and actions for America's leaders across sectors.

1. Define the endgame, set expectations, boost morale

Crossing the bridge to normalcy will require additional sacrifice from everyone. More clearly defining the end point we are trying to reach, estimating when it might occur, and determining how each person (and institution) can help achieve it could create hope, strengthen resolve, and maybe even improve national solidarity.

The most vexing and important issue for public-sector leaders is to define the specific conditions or reality that constitute a return to normalcy (see sidebar, "Three landings"). People want to know the conditions that will allow them to attend a large wedding without face coverings and hug friends without fear. Can that happen only when a city or state achieves a high level of herd immunity with close to zero cases? Could it happen with some ongoing transmission, so long as we expect a level of mortality similar to other infectious diseases such as the flu (Exhibit 6)? Or could it happen if and when every resident has full access to an effective vaccine?

Private-sector leaders can reinforce messages from government leaders, but also set institutional aspirations that, if achieved, would increase the odds of societal success (for example, where appropriate and legal, a target for vaccine adoption among employees[15]). Private-sector leaders also have an opportunity to link societal success to business objectives, and cross the bridge to normalcy together.

2. Triple down on vaccine adoption

The most likely bridge to normalcy is built by achieving high vaccine adoption. But as we highlighted in December 2020, the United States is unlikely to achieve this objective on its current path.

[15] Alexia Elejalde-Ruiz, "McDonald's to pay employees to get vaccinated," *Chicago Tribune*, February 2, 2021, chicagotribune.com.

Three landings

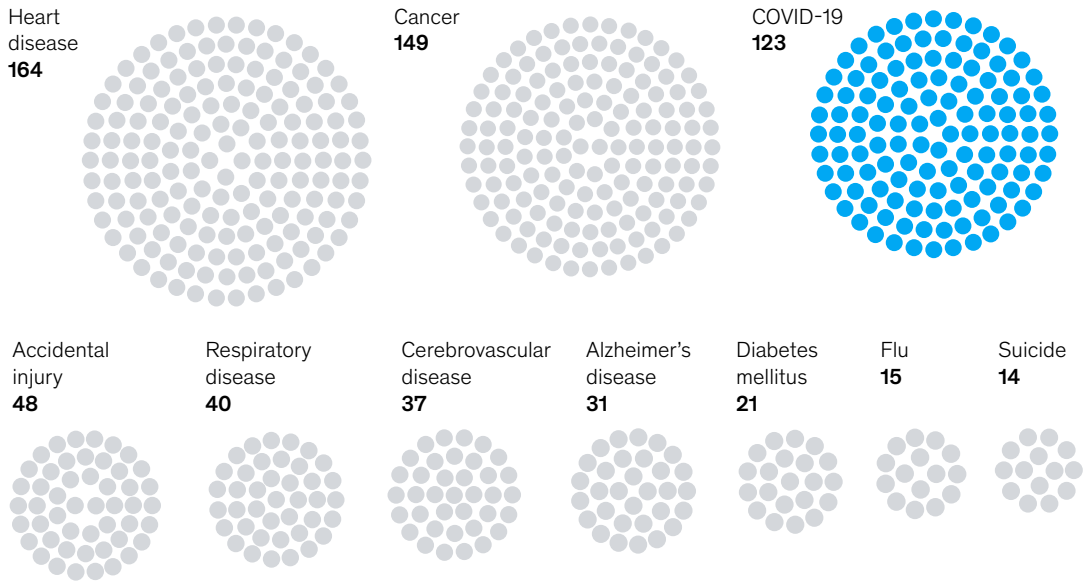
We see three significant milestones in the continuing fight against COVID-19. One such marker could come in our process—for example, when all high-risk individuals (or all Americans) have had the opportunity to receive a safe, effective vaccine. Another is based on epidemiology: once new cases or hospitalizations have fallen below a defined threshold, normalcy might be reached. A third might come from the wider public-health effort; as a society, we might say that once overall mortality is not measurably higher than the long-term average, or once COVID-19 mortality falls below that of influenza or other respiratory diseases, then we've achieved what's necessary to feel confident about returning to normal activities. Note that each of these milestones comes before new cases reach zero.

Once a milestone is defined, government leaders have an opportunity to design and communicate the metrics that best indicate success. It could be powerful to align around just the handful of measures that matter most to achieving normalcy (see number 3 below). With the endgame defined, it is easier for governments to explain and justify the actions for each individual and institution to "do their part" in the overall journey. And it is easier to get people on board with a national effort that requires personal inconvenience if the endpoint is well understood, rather than seeming an endless slog.

Exhibit 6

COVID-19 was a leading cause of death in 2020. In 2021 and beyond, it may more closely resemble flu.

Top ten causes of death in the US,[1] number per 100,000 people



[1]COVID-19 deaths based on Jan 2020–Jan 2021 data, remainder of data points based on 2018 data.
Source: Centers for Disease Control and Prevention

The past six weeks have illustrated the substantial challenges associated with distributing and administering vaccines at an unprecedented scale, including confusion, wastage, and the relatively slow administration of available doses.[16] Public- and private-sector leaders alike are attempting to navigate a series of objectives in tension: equity, speed, fairness, convenience, cost, and so on. While it is too early to declare best practices, themes are beginning to emerge. Public-sector leaders who appear to be performing better seem to be doing at least three things well: delegating when possible, effectively supporting those they delegate to, and simplifying as much as possible.

While operational challenges with distribution and administration are real and should be addressed, the much more problematic issue is vaccine adoption. We observe at least five challenges to at-scale COVID-19 vaccine adoption: historical analogues consistently demonstrate the challenges of public-health-initiative adoption in the United States; about 50 to 70 percent of Americans, including those in at-risk segments, convey uncertainty toward COVID-19 vaccination; the drivers of vaccine uncertainty are complex; many of the most credible influencers, physicians, and nurses are uncertain; and mis- and disinformation exists and could increase.[17]

[16] Katie Thomas, "U.S. Covid vaccine supply: How to make sense of those confusing numbers," *New York Times*, January 28, 2021, nytimes.com; Jonathan Drew and Zeke Miller, "US boosting vaccine deliveries amid complaints of shortages," Associated Press, January 26, 2021, apnews.com; Caroline Chen, Ryan Gabrielson, and Mollie Simon, "How many vaccine shots go to waste? Several states aren't counting," Propublica, January 21, 2021, propublica.org; Rachana Pradhan, "Delicate Covid vaccines slow rollout—leading to shots given out of turn or, worse, wasted," Kaiser Family Foundation, January 21, 2021, khn.org.

[17] Tara Azimi, Michael Conway, Tom Latkovic, and Adam Sabow, "COVID-19 vaccines meet 100 million uncertain Americans," December 18, 2020, McKinsey.com.

These concerns have, unfortunately, already started to reveal themselves in practice. Multiple states have cited that as many as 50 percent of workers in nursing homes have refused vaccination.[18]

Driving rapid large-scale vaccine adoption will require much stronger conviction among patients and influencers, ensuring that vaccination is costless (or even compensated, as some are considering[19]) for consumers, and is highly convenient. Many employers are already stepping up to the plate.[20] Delivering conviction, convenience, and costlessness will require four major shifts in the actions of stakeholders across sectors:

— Public and private sectors could come together to launch an unprecedented campaign to support vaccine adoption at scale.

— Government can consider ways to develop and innovate the infrastructure further to support vaccine adoption.

— Healthcare providers and payers can put vaccination at the top of their agendas.

— Employers can support employees in their quest to get vaccinated.

3. Prioritize the containment tactics with the highest ROI

The accumulated evidence over the past ten months tells us that our success or failure is mostly due to the behavior of individual Americans—as employees, family members, business owners, pastors, and more. To be sure, other factors are involved. But individual choices matter most. The government and private-sector leaders have a critical role to support individuals. But it does not matter very much how many tests are available if only one-third of people with COVID-19 symptoms even attempt to get tested, and less than 30 percent of those testing positive isolate fully.[21] It doesn't matter how many contact tracers are hired if contacts don't quarantine. As such, an effective containment strategy is one that leads to widespread adoption of the behaviors that are most likely to reduce spread.

The good news is that, as we observed in April 2020, many of the most valuable interventions are comparatively "low cost" and don't fully restrict economic nor social activity. A combination of such approaches, even if each is individually imperfect, can be effective.

Two things changed over the past several months: the change in seasons accelerated transmission during the fall, and compliance with social distancing eroded. And throughout the year, a limited fraction of the population has complied with guidance around testing, isolation, and quarantine.[22]

As such, both government and private-sector leaders have an opportunity to refocus their efforts and messaging to encourage adoption of the most basic and effective behaviors recommended by public-health experts—get a test if you might have COVID-19, isolate yourself if you are positive, quarantine if you are a contact. We also observe an opportunity to better direct physical-distancing guidance to measures that have been successful in other countries—for example, forming pods or bubbles.

Government and private-sector leaders can play a significant role in enabling public adoption of this guidance, by offering paid time off, housing supports, employer-led testing and contact tracing, and so on.

[18] Kevin Barry, "More than half of Ohio's nursing home staff refusing vaccine as first round is nearly over," News 5 Cleveland, January 5, 2021, news5cleveland.com; Bryan Anderson, "Most N.C. nursing home workers are refusing COVID vaccine," Associated Press, January 5, 2021, apnews.com; Lou Michel, "Covid-19 vaccinations refused by one-third of nursing home workers in New York," *Buffalo News*, January 19, 2021, buffalonews.com; Rick Rouan, "DeWine says 60% of nursing home workers not electing to get vaccine," *Columbus Dispatch*, December 31, 2020, dispatch.com.

[19] Uri Berliner, "Should the government pay people to get vaccinated? Some economists think so," NPR, January 13, 2021, npr.org.

[20] Kenneth Terrell, "These companies are paying employees to get vaccinated," AARP, February 2, 2021, aarp.org.

[21] COVIDcast Survey, Carnegie Mellon University and Delphi Group, January 2021, delphi.cmu.edu; Colleen McClain and Lee Rainie, "The challenges of contact tracing as U.S. battles COVID-19," Pew Research Center, October 30, 2020, pewresearch.org.

[22] "YouGov COVID-19 behaviour changes tracker: Avoiding crowded public places," YouGov, March 17, 2020, yougov.co.uk; COVIDcast Survey, Carnegie Mellon University and Delphi Group, January 2021, delphi.cmu.edu.

We need to be prepared for the possibility that COVID-19 remains endemic to society.

4. Go all out to protect those at risk

Even with improved containment, lives will still be at risk from COVID-19 during the bridge period. Every day, the disease claims thousands of Americans, most of them elderly. Making vaccines available to at-risk populations is the highest priority, but leaders can also consider time-limited measures to isolate those at risk until vaccines take effect. This should be done with compassion—many older Americans have endured too much isolation already. We need to support older people and those in poor health through another several months of isolation.

Public-sector leaders can help in several ways, none more important than being clear about the risk. Leaders can better use existing data to identify those at greater risk of exposure and severe morbidity and mortality based on their occupation, residence, and lifestyle. Government can direct support strategies at these groups to cover social and economic needs in isolation as well as safeguarding approaches.

Private-sector leaders have critical roles, especially to protect their employees who are either at risk personally or live or care for those at higher risk. Ideally, employers would allow these individuals to avoid higher-risk settings, by working from home when possible or through other accommodations such as a temporary change in responsibilities. Where some individuals whose age or medical history puts them at higher risk still need to come to work, companies could provide them with surgical or N95 masks, which afford greater protection compared with the cloth face coverings many people wear.

5. Create a 'black swan' team to plan for unexpected downside scenarios

The arrival of effective vaccines has significantly reduced the range of uncertainty around pandemic outcomes. However, there may still be significant twists to the story. In the past six weeks, for example, the recognition of multiple new variants of SARS-CoV-2 has forced leaders in many parts of the world to adapt their approaches.[23] Most leaders' attention should likely be focused on the issues described above. But it may be worth creating a "black swan" team to plan in parallel for outlier events, especially those that are known even if they are unlikely possibilities. What if the duration of immunity proves to be shorter than expected? What if a significant safety issue arises with one of the vaccines? What if an unrelated infectious-disease spillover event unleashes simultaneous pandemics of different diseases?

None of these is the most likely outcome, but none is impossible given the position in which we find ourselves as a society. It's better to be prepared for the worst than to be surprised yet again.

6. Prepare for the other side of the bridge

History is replete with examples of countries that won wars but were not prepared to win the peace. To avoid repeating these mistakes, public- and private-sector leaders have the opportunity to prepare now for the transition to a post-COVID-19 version of normalcy. At minimum, we need to be prepared for the possibility, perhaps likelihood, that COVID-19 remains endemic to society. We must also recognize the possibility that new pandemics will emerge.

[23] Lawrence Wright, "Can the COVID-19 vaccine beat the proliferation of new virus mutations?" *New Yorker*, January 21, 2021, newyorker.com.

Simply returning to the same disease-fighting protocols and infrastructure that we used before the pandemic won't be adequate. We have the potential to establish a next-generation disease surveillance and testing infrastructure, including wider access to genomic sequencing; 21st-century data management and analysis; and closer integration between health delivery and public-health capabilities.

Private-sector leaders have a huge role to play in creating and delivering improved public health. First, employers have an opportunity to create and sustain safe working environments and can even more strongly encourage adoption of public-health measures like vaccination. Second, employers can build stronger linkages to public-health departments and healthcare providers. Finally, private-sector innovation, products, and services are likely to play a significant role in next-generation public health.

We've all heard the jokes about misbegotten proposals for a so-called bridge to nowhere. What we outline above is a bridge to everywhere. The next several months will determine when our collective future arrives, and in what form. America's leaders have an opportunity, even an obligation, to get this right. We hope that the ideas set out in this memo prove useful as they survey and engineer the way forward.

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