LOS ANGELES COUNTY
COMMISSION ON HIV

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PUBLIC POLICY COMMITTEE
Virtual Meeting
Monday, March 1, 2021
1:00PM-3:00PM (PST)

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Public Comments will open at the time referenced on the meeting agenda. For those who wish to provide live public comment, you may do so by joining the WebEx meeting through your computer or smartphone and typing PUBLIC COMMENT in the Chat box. For those calling into the meeting via telephone, you will not be able to provide live public comment. However, you may provide written public comments or materials by email to hivcomm@lachiv.org. Please include the agenda item and meeting date in your correspondence. All correspondence and materials received shall become part of the official record.

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LOS ANGELES COUNTY
COMMISSION ON HIV

AGENDA FOR THE VIRTUAL MEETING OF THE LOS ANGELES COUNTY COMMISSION ON HIV

PUBLIC POLICY COMMITTEE

MONDAY, MARCH 1, 2021 | 1:00 PM – 3:00 PM

To Join by Computer: https://tinyurl.com/1nuc22qm
Link is for non committee members only

To Join by Phone: 1-415-655-0001
Access code: 145 398 8799

Public Policy Committee Members:			
Katja Nelson, MPP *Co-Chair*	Lee Kochems, MA *Co-Chair*	*(Alasdair Burton, Alternate)*	Jerry D. Gates, PhD
Eduardo Martinez	Nestor Kamurigi	Ricky Rosales	Martin Sattah, MD
Tony Spears (Alternate)			
QUORUM: 5			

AGENDA POSTED: February 25, 2021

ATTENTION: Any person who seeks support or endorsement from the Commission on any official action may be subject to the provisions of Los Angeles County Code, Chapter 2.160 relating to lobbyists. Violation of the lobbyist ordinance may result in a fine and other penalties. For information, call (213) 974-1093.

ACCOMMODATIONS: Interpretation services for the hearing impaired and translation services for languages other than English are available free of charge with at least 72 hours notice before the meeting date. To arrange for these services, please contact the Commission Office at (213) 738-2816 or via email at HIVComm@lachiv.org.

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SUPPORTING DOCUMENTATION can be obtained at the Commission on HIV Website at: http://hiv.lacounty.gov. The Commission Offices are located in Metroplex Wilshire, one building west of the southwest corner of Wilshire and Normandie. Validated parking is available in the parking lot behind Metroplex, just south of Wilshire, on the west side of Normandie.

NOTES on AGENDA SCHEDULING, TIMING, POSTED and ACTUAL TIMES, TIME ALLOTMENTS, and AGENDA ORDER: Because time allotments for discussions and decision-making regarding business before the Commission's standing committees cannot always be predicted precisely, posted times for items on the meeting agenda may vary significantly from either the actual time devoted to the item or the actual, ultimate order in which it was addressed on the agenda. Likewise, stakeholders may propose adjusting the order of various items at the commencement of the committee meeting (Approval of the Agenda), or times may be adjusted and/or modified, at the co-chairs' discretion, during the course of the meeting.

If a stakeholder is interested in joining the meeting to keep abreast of or participate in consideration of a specific agenda item, the Commission suggests that the stakeholder plan on attending the full meeting in case the agenda order is modified or timing of the items is altered. All Commission committees make every effort to place items that they are aware involve external stakeholders at the top of the agenda in order to address and resolve those issues more quickly and release visiting participants from the obligation of staying for the full meeting.

External stakeholders who would like to participate in the deliberation of discussion of an a posted agenda item, but who may only be able to attend for a short time during a limited window of opportunity, may call the Commission's Executive Director in advance of the meeting to see if the scheduled agenda order can be adjusted accordingly. Commission leadership and staff will make every effort to accommodate reasonable scheduling and timing requests - from members or other stakeholders - within the limitations and requirements of other possible constraints.

Call to Order, Introductions and Check-in, Conflict of Interest Statements 1:00 PM – 1:05 PM

I. ADMINISTRATIVE MATTERS 1:05 PM – 1:08 PM

1. Approval of Agenda **MOTION #1**

2. Approval of Meeting Minutes **MOTION #2**

II. PUBLIC COMMENT 1:08 PM – 1:10 PM

3. Opportunity for members of the public to address the Commission on items of interest that are within the jurisdiction of the Commission.

III. COMMITTEE NEW BUSINESS ITEMS 1:10 PM – 1:15 PM

4. Opportunity for Commission members to recommend new business items for the full body or a committee level discussion on non-agendized Matters not posted on the agenda, to be discussed and (if requested) placed on the agenda for action at a future meeting, or matters requiring immediate action because of an emergency situation, or where the need to take action arose subsequent to the posting of the agenda.

IV. REPORTS

5. Executive Director/Staff Report 1:15 PM – 1:25 PM
a. Committee and Caucus Updates

6. Co-Chair Report 1:25 PM – 2:00 PM
a. 2021 Workplan
b. Act Now Against Meth (ANAM) Update
c. 2021 Policy Priorities **MOTION #3**

V. DISCUSSION ITEMS

7. Legislative Docket 2:00 PM – 2:10 PM

8. State Policy & Budget Update 2:10 PM – 2:20 PM

9. Federal Policy Update 2:20 PM – 2:30 PM

10. County Policy Update 2:30 PM – 2:50 PM
a. Transgender Wellness and Equity Fund Letter of Support

VI. NEXT STEPS 2:50 PM – 2:55 PM

11. Task/Assignments Recap

12. Agenda development for the next meeting

VII. ANNOUNCEMENTS 2:55 PM – 3:00 PM

13. Opportunity for members of the public and the committee to make announcements

VIII. ADJOURNMENT 3:00 PM

14. Adjournment for the meeting of March 1, 2021

PROPOSED MOTIONS	
MOTION #1	**Approve the Agenda Order as presented or revised.**
MOTION #2	**Approve the Public Policy Committee minutes, as presented or revised.**
MOTION #3	**Approve Public Policy 2021 Policy Priorities as presented or revised.**

LOS ANGELES COUNTY
COMMISSION ON HIV

COMMISSION MEMBER "CONFLICTS-OF-INTEREST"

Updated 2/17/21

The following list identifies "conflicts-of-interest" for Commission members who represent agencies with Part A/B –and/or CDC HIV Prevention-funded service contracts with the County of Los Angeles. According to Ryan White legislation, HRSA guidance and Commission policy, Commission members are required to state their "conflicts-of-interest" prior to priority- and allocation-setting and other fiscal matters concerning the local HIV continuum of care, and to recuse themselves from discussions involving specific service categories for which their organizations have service contracts.

COMMISSION MEMBERS		ORGANIZATION	SERVICE CATEGORIES
ALVAREZ	**Miguel**	No Affiliation	No Ryan White or prevention contracts
ALVIZO	**Everardo**	Long Beach Health & Human Services	Ambulatory Outpatient Medical (AOM)
			Benefits Specialty
			Biomedical HIV Prevention
			Medical Care Coordination (MCC)
			HIV and STD Prevention
			HIV Testing Social & Sexual Networks
BALLESTEROS	**Al**	JWCH, INC.	HIV Testing Storefront
			HIV Testing & Syphilis Screening, Diagnosis, & inked Referral…(CSV)
			STD Screening, Diagnosis, and Treatment
			Health Education/Risk Reduction (HERR)
			Mental Health
			Oral Healthcare Services
			Transitional Case Management
			Ambulatory Outpatient Medical (AOM)
			Benefits Specialty
			Biomedical HIV Prevention
			Medical Care Coordination (MCC)
			Transportation Services
BURTON	**Alasdair**	No Affiliation	No Ryan White or prevention contracts
CAMPBELL	**Danielle**	UCLA/MLKCH	Oral Health Care Services
			Medical Care Coordination (MCC)
			Ambulatory Outpatient Medical (AOM)
			Transportation Services

COMMISSION MEMBERS		ORGANIZATION	SERVICE CATEGORIES
CATALDO	**Raquel**	Tarzana Treatment Center	Ambulatory Outpatient Medical (AOM)
			Benefits Specialty
			Case Management, Home-Based
			HIV Testing Storefront
			STD Screening, Diagnosis and Treatment
			Health Education/Risk Reduction
			Biomedical HIV Prevention
			Medical Care Coordination (MCC)
			Mental Health
			Substance Abuse, Transitional Housing (meth)
			Transitional Case Management-Jails
			Transportation Services
COFFEY	**Pamela**	Unaffiliated consumer	No Ryan White or prevention contracts
DANIELS	**Michele**	Unaffiliated consumer	No Ryan White or prevention contracts
DARLING-PALACIOS	**Frankie**	Los Angeles LGBT Center	Ambulatory Outpatient Medical (AOM)
			HIV Testing Storefront
			HIV Testing Social & Sexual Networks
			STD Screening, Diagnosis and Treatment
			Health Education/Risk Reduction
			Biomedical HIV Prevention
			Medical Care Coordination (MCC)
			Promoting Healthcare Engagement Among Vulnerable Populations
			Transportation Services
DAVIES	**Erika**	City of Pasadena	HIV Testing Storefront
			HIV Testing & Sexual Networks
DONNELLY	**Kevin**	Unaffiliated consumer	No Ryan White or prevention contracts

COMMISSION MEMBERS		ORGANIZATION	SERVICE CATEGORIES
FULLER	**Luckie**	Los Angeles LGBT Center	Ambulatory Outpatient Medical (AOM)
			HIV Testng Storefront
			HIV Testing Social & Sexual Networks
			STD Screening, Diagnosis and Treatment
			Health Education/Risk Reduction
			Biomedical HIV Prevention
			Medical Care Coordination (MCC)
			Promoting Healthcare Engagement Among Vulnerable Populations
			Transportation Services
GATES	**Jerry**	AETC	Part F Grantee
GONZALEZ	**Felipe**	Unaffiliated consumer	No Ryan White or Prevention Contracts
GORDON	**Bridget**	Unaffiliated consumer	No Ryan White or prevention contracts
GRANADOS	**Grissel**	Children's Hospital Los Angeles	Ambulatory Outpatient Medical (AOM)
			HIV Testing Storefront
			STD Screening, Diagnosis and Treatment
			Biomedical HIV Prevention
			Medical Care Coordination (MCC)
			Transitional Case Management-Youth
			Promoting Healthcare Engagement Among Vulnerable Populations
GREEN	**Joseph**	Unaffiliated consumer	No Ryan White or prevention contracts
GREEN	**Thomas**	APAIT (aka Special Services for Groups)	HIV Testing Storefront
			Mental Health
			Transportation Services
HACK	**Damontae**	Unaffiliated consumer	No Ryan White or prevention contracts
HALFMAN	**Karl**	California Department of Public Health, Office of AIDS	Part B Grantee
JOHNSON	**Diamante**	Unaffiliated consumer	No Ryan White or prevention contracts
KAMURIGI	**Nestor**	No Affiliation	No Ryan White or prevention contracts
KOCHEMS	**Lee**	Unaffiliated consumer	No Ryan White or prevention contracts
KING	**William**	W. King Health Care Group	No Ryan White or prevention contracts
LEE	**David**	Charles R. Drew University of Medicine and Science	HIV Testing Storefront
			HIV Testing Social & Sexual Networks

COMMISSION MEMBERS		ORGANIZATION	SERVICE CATEGORIES
MARTINEZ	**Eduardo**	AIDS Healthcare Foundation	Ambulatory Outpatient Medical (AOM)
			Benefits Specialty
			Medical Care Coordination (MCC)
			Mental Health
			Oral Healthcare Services
			STD Screening, Diagnosis and Treatment
			HIV Testing Storefront
			HIV Testing Social & Sexual Networks
			Sexual Health Express Clinics (SHEx-C)
			Transportation Services
			Medical Subspecialty
			HIV and STD Prevention Services in Long Beach
MILLS	**Anthony**	Southern CA Men's Medical Group	Biomedical HIV Prevention
			Ambulatory Outpatient Medical (AOM)
			Medical Care Coordination (MCC)
			Promoting Healthcare Engagement Among Vulnerable Populations
			Sexual Health Express Clinics (SHEx-C)
			Transportation Services
MORENO	**Carlos**	Children's Hospital, Los Angeles	Ambulatory Outpatient Medical (AOM)
			HIV Testing Storefront
			STD Screening, Diagnosis and Treatment
			Biomedical HIV Prevention
			Medical Care Coordination (MCC)
			Transitional Case Management - Youth
			Promoting Healthcare Engagement Among Vulnerable Populations
MURRAY	**Derek**	City of West Hollywood	No Ryan White or prevention contracts
NASH	**Paul**	University of Southern California	Biomedical HIV Prevention
			Oral Healthcare Services

COMMISSION MEMBERS		ORGANIZATION	SERVICE CATEGORIES
NELSON	**Katja**	APLA Health & Wellness	Case Management, Home-Based
			Benefits Specialty
			HIV Testing Storefront
			HIV Testing Social & Sexual Networks
			STD Screening, Diagnosis and Treatment
			Sexual Health Express Clinics (SHEx-C)
			Health Education/Risk Reduction
			Health Education/Risk Reduction, Native American
			Biomedical HIV Prevention
			Oral Healthcare Services
			Ambulatory Outpatient Medical (AOM)
			Medical Care Coordination (MCC)
			HIV and STD Prevention Services in Long Beach
			Transportation Services
			Nutrition Support
PERÉZ	**Mario**	Los Angeles County, Department of Public Health, Division of HIV and STD Programs	Ryan White/CDC Grantee
PRECIADO	**Juan**	Northeast Valley Health Corporation	Ambulatory Outpatient Medical (AOM)
			Benefits Specialty
			Medical Care Coordination (MCC)
			Oral Healthcare Services
			Mental Health
			Biomedical HIV Prevention
			STD Screening, Diagnosis and Treatment
			Transportation Services
RAY	**Joshua**	Unaffiliated consumer	No Ryan White or prevention contracts
ROSALES	**Ricky**	City of Los Angeles AIDS Coordinator	No Ryan White or prevention contracts
SATTAH	**Martin**	Rand Schrader Clinic LA County Department of Health Services	Ambulatory Outpatient Medical (AOM)
			Medical Care Coordination (MCC)

COMMISSION MEMBERS		ORGANIZATION	SERVICE CATEGORIES
SAN AGUSTIN	**Harold**	JWCH, INC.	HIV Testing Storefront
			HIV Testing & Syphilis Screening, Diagnosis, & inked Referral…(CSV)
			STD Screening, Diagnosis and Treatment
			Health Education/Risk Reduction
			Mental Health
			Oral Healthcare Services
			Transitional Case Management
			Ambulatory Outpatient Medical (AOM)
			Benefits Specialty
			Biomedical HIV Prevention
			Medical Care Coordination (MCC)
			Transportation Services
SPENCER	**LaShonda**	Oasis Clinic (Charles R. Drew University/Drew CARES)	HIV Testing Storefront
			HIV Testing Social & Sexual Networks
SPEARS	**Tony**	Capitol Drugs	No Ryan White or prevention contracts
STALTER	**Kevin**	Unaffiliated consumer	No Ryan White or prevention contracts
ULLOA	**Maribel**	HOPWA-City of Los Angeles	No Ryan White or prevention contracts
VALERO	**Justin**	California State University, San Bernardino	No Ryan White or prevention contracts
VELAZQUEZ	**Guadalupe**	Unaffiliated consumer	No Ryan White or prevention contracts
WALKER	**Kayla**	No Affiliation	No Ryan White or prevention contracts
WALKER	**Ernest**	Men's Health Foundation	Biomedical HIV Prevention
			Ambulatory Outpatient Medical (AOM)
			Medical Care Coordination (MCC)
			Promoting Healthcare Engagement Among Vulnerable Populations
			Sexual Health Express Clinics (SHEx-C)
			Transportation Services
WILSON	**Amiya**	Unique Women's Coalition	No Ryan White or prevention contracts

LOS ANGELES COUNTY
COMMISSION ON HIV

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Presence at virtual meetings is recorded based on the attendance roll call. Only members of the Commission on HIV are accorded voting privileges and must verbally acknowledge their attendance in order to vote.
Approved meeting minutes are available on the Commission's website; meeting recordings are available upon request.

PUBLIC POLICY COMMITTEE
MEETING MINUTES

January 4, 2021

The Public Policy Committee acts in accordance with the role of the Commission on HIV, as dictated by Los Angeles County Code 3.29.090. Consistent with Commission Bylaws Article VI, Section 2, no Ryan White resources are used to support Public Policy Committee activities.

MEMBERS PRESENT	MEMBERS ABSENT	PUBLIC	COMM STAFF/ CONSULTANTS
Lee Kochems, MA, *Co-Chair*	Eduardo Martinez *(Alt.)*	Leopoldo Cabral	Cheryl Barrit, MPIA
Katja Nelson, MPP, *Co-Chair*	Ricky Rosales	Michaé De La Cuadra	Carolyn Echols-Watson, MPA
Pamela Coffey/Alasdair Burton	Tony Spears *(Alt.)*	Kevin Donnelly	Jane Nachazel
Jerry D. Gates, PhD		Jennifer Gjurashaj	Sonja Wright, MS, Lac
Bridget Gordon		Lambert Talley	
Nestor Kamurigi *(Alt.)*			**DPH/DHSP STAFF**
Martin Sattah, MD			None

*Some participants may not have been captured electronically. Attendance can be corrected by emailing the Commission.

CONTENTS OF COMMITTEE PACKET

1) **Cover Page**: Public Policy Committee Virtual Meeting, *1/4/2021*
2) **Agenda**: Public Policy Committee Agenda, *1/4/2021*
3) **Minutes**: Public Policy Committee Meeting Minutes, *12/7/2020*
4) **Statement**: Diane Feinstein, *12/29/2020*
5) **Recommendation**: Ending the HIV Epidemic Regional Meeting: Taking Strategic Action to Address Substance Use in California, *December 2020*
6) **Priorities**: 2020 Policy Priorities, *6/11/2020*
7) **Bill**: Assembly Bill 2218, Transgender Wellness and Equity Fund, *9/26/2020*
8) **Memorandum**: State Legislative Agenda for the 2021-22 Session, *12/22/2020*
9) **Memorandum**: Washington – Passage of the Fifth COVID-19 Relief Bill and Federal Fiscal Year 2021 Appropriations (H.R. 133, as amended), *12/28/2020*
10) **Fact Sheet**: Telehealth and COVID-19, *December 2020*
11) **Memorandum**: HHS Threat to CA Over Weldon Amendment, *12/17/2020*

CALL TO ORDER, INTRODUCTIONS AND CHECK-IN, CONFLICT OF INTEREST STATEMENTS:

- Ms. Nelson welcomed all and called the meeting to order at 1:07 pm.
- Attendees checked in with many wishing all a good 2021 and welcoming the new administration.
- Mr. Kochems attended from his mother's house in Cleveland. His stay there will be extended for a month or two. The foot of snow has melted and everything is green. COVID-19 rates in Ohio have been stable.
- Mr. Burton just received the second of two doses in the AstraZeneca COVID-19 vaccine trial. He did not know whether he was in the vaccine or the placebo arm of the trial, but has had no side effects to date. At today's appointment, he was

advised that any trial participants who become eligible for any approved COVID-19 vaccine should call in and they will be told whether they are receiving vaccine or the placebo. They can then decide next steps with their physician.

- Nestor announced he recently married. He just received his new identification yesterday to officially change his name from form Rogel to Kamurigi. Everyone offered congratulations.
- Dr. Sattah was trying to stay positive and thankful for all we have – especially the vaccine. He hoped the administration would distribute it efficiently in the next few months as he expected it would be a big turning point in the pandemic.
- Mr. Donnelly said it was good to know we're all working to make this a better world for everyone. While people may speak of "going back to normal," he hoped we would not go back to normal because normal wasn't working – but to do better.

I. ADMINISTRATIVE MATTERS

1. APPROVAL OF AGENDA
MOTION #1: Approve the Agenda Order, as presented **(*Passed by Consensus*)**.

2. APPROVAL OF MEETING MINUTES
MOTION #2: Approve the 12/7/2020 Public Policy Committee Meeting Minutes, as presented **(*Passed by Consensus*)**.

II. PUBLIC COMMENT

3. OPPORTUNITY FOR PUBLIC TO ADDRESS COMMISSION ON ITEMS OF INTEREST WITHIN COMMISSION JURISDICTION: There were no comments.

III. COMMITTEE NEW BUSINESS ITEMS

4. OPPORTUNITY FOR COMMISSIONERS TO RECOMMEND ITEMS FOR FUTTURE AGENDAS, OR ITEMS REQUIRING IMMEDIATE ACTION DUE TO AN EMERGENCY, OR IF NEED FOR ACTION AROSE AFTER POSTING AGENDA: There were no items.

IV. REPORTS

5. EXECUTIVE DIRECTOR/STAFF REPORT

- Ms. Barrit acknowledged we are seeing a great surge in COVID-19 cases which is taxing the capacity of our hospitals. As public health advocates and Los Angeles County (LAC) employees, we are asking everyone to do what they can to minimize the risk of transmission. Staff will continue to work from home and meetings will remain virtual for at least the first quarter.
- LAC employees continue Disaster Service Workers (DSW) work. Department of Public Health (DPH) staff continue contact tracing and were gearing up for mass vaccination clinics but, so far, Commission staff had not been deployed.
- The Executive Office has been stern in prohibiting Commission staff from going into the office at all due to the notable increase in cases, e.g., Ms. Barrit had to reschedule an appointment to discuss installation of plexiglass.
- Federally Qualified Health Centers (FQHCs) were also working hard and starting to plan community vaccination clinics with LAC. To date, the federal government has been releasing vaccines to local governments, but has not necessarily released funds for staffing. Consequently, Community Health Clinics (CHCs) providing vaccination clinics may be self-funding operational costs. That is something to consider in reviewing our safety net in 2021.

a. Committee and Caucus Updates

- The Commission meeting will be 1/14/2021. The County Counsel has been invited to provide the Commission's usual annual update on the Brown Act. DHSP was also invited to offer an update on the final Ending the HIV Epidemic (EHE) Plan submitted to the Centers for Disease Control and Prevention (CDC) and the Health Resources and Services Administration (HRSA). It was not yet on the DHSP website, but should be posted prior to the meeting for review.
- Commission staff have referred to DHSP reports of access challenges for the new Emergency Financial Assistance launched at the end of 2020. Mario Pérez, MPH, Director, DHSP with offer an EFA update as part of his regular report. Anyone experiencing any barriers should advise the Commission or DHSP staff. Issues were being tracked.
- Ms. Barrit was working on the Commission's Annual Report and hoped to have a draft for the January Commission.
- Staff were working on developing 2021 Work Plans for all Committees and Caucuses.
- Mr. Donnelly asked about the Oath of Office. Ms. Barrit replied terms end in June so generally it is given in July.
- Ms. Nelson asked if the Commission would be kept up to date on vaccine distribution. Ms. Barrit replied that Franklin Pratt, MD, MPHTM, Vaccine Preventable Disease Control, DPH, was invited to report at the Commission meeting on COVID-19 and HIV, specifically including vaccine information such as drug interactions and overall safety.

- ➲ Ms. Nelson will share her perspective on FQHC issues during Dr. Pratt's Q/A.

6. CO-CHAIR REPORT

a. Co-Chair Nominations/Elections

- Ms. Nelson was nominated and accepted at the December 2020 meeting. She nominated Mr. Kochems. He noted the Public Policy Committee has been supporting diversity and empowerment. He and Ms. Nelson would support anyone interested who felt they needed more experience, but he was willing to serve if no one else chose to run.

MOTION #3: Elect Lee Kochems, MA and Katja Nelson, MPP as the 2021 Public Policy Committee Co-Chairs **(*Passed by Consensus*)**.

b. Act Now Against Meth (ANAM) Update

- Ms. Nelson noted this has been added as a standing item. Staff were in contact with Richard Zaldivar for any updates.
- The packet includes a 12/29/2020 *Los Angeles Times* op-ed on the issue from Diane Feinstein as well as a report from the Center for HIV Identification, Prevention, and Treatment Services (CHIPTS) which addresses substance use overall.
- Ms. Echols-Watson was working on scheduling several key Substance Abuse and Prevention Control (SAPC) staff to attend the next Planning, Priorities and Allocations (PP&A) Committee for updates on prevention and treatment. SAPC has a meth task force with an arm each for prevention and for treatment. PP&A meets the third Tuesday at 1:00 pm.
- ➲ Anyone with suggestions may forward them to staff.

c. Review of Policy Priorities

- Ms. Nelson noted the prior four years focused on protection, but the Biden administration bodes well for growth.
- Ms. Barrit commented that the legislative cycle is two years. If there are 2021-2022 gaps, this would be the time to bring those to the Board's attention. The cycle's agenda was in the packet.
- Mr. Kochems suggested adding an item pertinent to priority COVID-19 needs, e.g., many PLWH are in the health field, 50% are over age 50, and/or have multiple co-morbidities. Consequently, they should be considered as care develops.
- Likewise, advances made in the context of COVID-19 should carry over into HIV care, e.g., telehealth, vaccine research.
- Regarding vaccine studies incorporating PLWH, Mr. Burton noted Phases I and II are safety studies so no one with other conditions is accepted. Phase III studies do accept PLWH, but PLWH must volunteer to achieve representation. Mr. Kochems related that PLWH were not initially accepted, but advocacy opened the Phase III studies to PLWH.
- Mr. Kochems suggested attaching the Black African American Community (BAAC) Task Force recommendations, but Ms. Barrit noted many pertained to DHSP contracting issues. Instead, she suggested adding, "All policy directives and priorities will be coming from an anti-racist perspective."
- ➲ Develop draft item on COVID-19 including access to care; and application of COVID advances to HIV, e.g., like use of telehealth, breakdown of barriers like renewal of Medi-Cal without resubmission, and a renewed focus on vaccine research. Call attention to areas that have suffered from lack of focus such as Sexually Transmitted Infections (STIs).
- ➲ Develop item on racism, including social justice, social equity, inclusion, and empowerment at the local, state, and federal level. Reach out for input to the BAAC Task Force. It was in the process of developing specific recommendations per Committee. Add, "All policy directives and priorities will be coming from an anti-racist perspective."
- ➲ Develop item on aging issues with its themes of data collection, expansion of prevention and care services with integrated care, and workforce development.
- ➲ Incorporate attention to women, the transgender population, and the indigenous population.
- ➲ Staff will draft updated 2021 Policy Priorities and disseminate for review to Co-Chairs, get feedback, then send back out to full Committee, get feedback, and finally forward to Executive Committee.

V. PRESENTATION

7. TRANSGENDER WELLNESS FUND (AB 2218): Michaé De La Cuadra

- Michaé De La Cuadra, Manager, Policy and Community Engagement, TransLatina Coalition, presented with a PowerPoint on the bill which was in the packet. A 2018 Trans Policy Agenda comprehensive report included a survey regarding policy priorities of over 200 transgender people statewide. Some 40 recommendations resulted including additional allocations. The remainder of 2018 was focused on developing an approach for moving forward.
- In 2019, the Coalition began to develop a bill and related budget proposals. Initial proposals were met with concern about the lack of data to support a budget proposal, e.g., population size. Groups from across the state were brought together to address those issues – growing from an initial three members to over twenty.

- A bill number was assigned in In February 2020 sparking a focus on language and strategy. With the global pandemic, the approach shifted to advocacy for attaining emergency health services resources for an increasingly impacted population. The language in the bill is purposely vague to ensure it could be used for holistic services like hormones, mental health, and housing, and arts and wellness programming – not just strictly medical health. That created some pushback.
- Even so, it passed the legislature and, after more advocacy, Governor Gavin Newsom signed it on 9/26/2020. Pushback often included the need to focus solely on COVID-19, but advocacy emphasized that health services do relate to COVID-19.
- While the bill was passed, the Appropriations Committee removed the $15 million identified in it so it is now an empty fund. Assemblymember Miguel Santiago, who sponsored the bill, has committed to help with the budget request. The budget is finalized in June so advocacy has begun for the $15 million. The effort to pass the bill was intentionally led by trans identified people or trans led organizations so there were few allied groups. For this effort, there will be a space for general meetings which were expected to start shortly. Allies will be welcome to participate in those activities.
- Bill co-authors include Assemblymembers Wendy Carrillo and Blanca Rubio, and Senator Scott Wiener. Holly Mitchell has also been very supportive and they met with all the Supervisors' staffs with those for Barger, Kuehl, and Solis most helpful. They hoped to identify physical space to expand services, e.g., case management, re-entry, work force development, anti-violence support, drop in center with daily food distribution and clothes, legal help, and peer navigation.
- Mr. Kochems noted the bill was on the Legislative Docket as a support.

➲ Michaé De La Cuadra will forward any support letters, et cetera, and meeting information to staff.

➲ Initiate AB 2218 Funding Work Group to develop HIV-specific letter to Board of Supervisors (Board) to support funding. It will include encouragement to share the letter with others. Members will include a Public Policy Co-Chair and Michaé De La Cuadra with members of the Transgender Caucus, especially Frankie Darling-Palacios, invited.

VI. DISCUSSION ITEMS

8. **LEGISLATIVE DOCKET**: Ms. Nelson noted that the Docket was beginning to be developed.
9. **STATE POLICY AND BUDGET UPDATE**: The vaccination priority committee was meeting virtually on Wednesdays and was open to the public.
10. **FEDERAL POLICY UPDATE**: There were no additional items.
11. **COUNTY POLICY UPDATE**: The Quarterly STD Report from November reflected a decline in Sexually Transmitted Disease (STD) cases, but that is due to reduced capacity because of staff shifts to COVID-19 work. Congenital syphilis, however, was up 120%. Only four of seven STD clinics were open in order to shift staff to hospital support.

VII. NEXT STEPS

12. **TASK/ASSIGNMENTS RECAP**: There was no additional discussion.
13. **AGENDA DEVELOPMENT FOR NEXT MEETING**: There was no additional discussion.

VIII. ANNOUNCEMENTS

14. **OPPORTUNITY FOR PUBLIC AND COMMITTEE TO MAKE ANNOUNCEMENTS**: There were no announcements.

IX. ADJOURNMENT

15. **ADJOURNMENT**: The meeting adjourned at 3:12 pm.

LOS ANGELES COUNTY COMMISSION ON HIV

2021 WORK PLAN – PUBLIC POLICY

Draft 03/01/2021

Committee Name: **PUBLIC POLICY COMMITTEE (PPC)**	Co-Chairs: Katja Nelson, Lee Kochems
Committee Adoption Date:	Revision Dates:

Committee Responsibilities:

1. Advocating public policy issues at every level of government to End of the HIV Epidemic (EHE).
2. Initiating policy initiatives in accordance with HIV service and prevention priorities.
3. Providing education and access to public policy arenas for Commission members, consumers, providers, and the public.
4. Facilitate Commission communication between government and legislative officials.
5. Recommend administrative policies and legislative actions to support prevention and HIV care services.
6. Advocating specific public policy matters to the appropriate County departments, interests, and bodies.
7. Research and implement public policy activities that support prevention and HIV care services.
8. Advancing Commission initiatives that support prevention and HIV care services.
9. Other duties as assigned by the Commission or the Board of Supervisors

Purpose of Work Plan: To focus and prioritize key activities for COH Committees and subgroups for 2021

Prioritization Criteria: Select activities that 1) represent the core functions of the COH; 2) advance goals to Ending the HIV Epidemic (EHE); 3) align with COH staff and member capacities and time commitment; and 4) Advance State and local government prevention and HIV care services.

To focus and prioritize key activities for COH Committees and subgroups for 2021.

Prioritization Criteria: Select activities that 1) represent the core functions of the COH and Committee; 2) advance the goals of the Comprehensive HIV Plan & Ending the HIV Epidemic (EHE) Plan; and 3) align with COH staff and member capacities and time commitment.

#	TASK/ACTIVITY	DESCRIPTION	TARGET COMPLETION DATE	STATUS/NOTES/OTHER COMMITTEES INVOLVED
1	Review Policy Priorities for 2021	Committee discussion on policy priorities for 2021. Update accordingly.	*04/2021*	
2	Develop 2021 Legislative Docket	Review legislation aligned with COH Policy Priorities, develop docket, and discuss legislative position for each bill.	*5/2021*	

LOS ANGELES COUNTY COMMISSION ON HIV

2021 WORK PLAN – PUBLIC POLICY
Draft 03/01/2021

#	TASK/ACTIVITY	DESCRIPTION	TARGET COMPLETION DATE	STATUS/NOTES/OTHER COMMITTEES INVOLVED
3	*Monitor and track the federal Ending the HIV Epidemic: A Plan for America; Getting to Zero: California's Integrated HIV Surveillance Prevention and Care Plan; Ending the Epidemic in Los Angeles County plan; Los Angeles County HIV Comprehensive Plan for 2017-2021. (Statewide HIV, STD, Hep C initiative)*	*Monitor updates, potential funding, and Presidential Advisory Council on HIV/AIDS' (PACHA) efforts. Coordinate and track advocacy efforts for End the Epidemics efforts. This includes funding request for HIV, STDs, and Hep C.*	*Ongoing*	
4	Track County's response to the STD local epidemic and STD motion	*Work with the Executive Committee on the preparation and follow-up of a letter to Board of Supervisor regarding the urgent need to address STD/STI in Los Angeles County.*	*Ongoing*	*Letter was already drafted pre-pandemic but was put on hold because of COVID-19. Committee action may be dependent on status of COVID response and recovery efforts.*
5	*Assess State actions regarding AB 2218*	*Monitor State budget for funding allocations to the Transgender Wellness Fund*	*06/2021*	
6	*Assess and monitor federal, state, and local government policies and budgets that impact HIV, STD, STIs, Hep C and other sexual health issues.*	*Review government actions that impact funding and implementation of sexual health and HIV services.*	*06/2021*	
7	*Align PPC efforts with Black/African American Community (BAAC) Task Force, Women Caucus, Aging Task Force, Consumer Caucus, Prevention Workgroup and Transgender Caucus recommendations.*	*Ensure policy efforts prioritize recommendations*	*Ongoing*	
8	*Monitor County and City support for safe consumption sites*	*Coordinate with the City of LA AIDS Coordinator's Office and Substance Abuse Prevention and Control (SAPC)*	*Ongoing*	*SAPC presented Meth TF, Needle Exchange and Wellbeing Center Programs*

DRAFT (3/1/2021)

LOS ANGELES COUNTY
COMMISSION ON HIV

3530 Wilshire Boulevard, Suite 1140 • Los Angeles, CA 90010 • TEL (213) 738-2816 • FAX (213) 637-4748
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PUBLIC POLICY COMMITTEE (PPC)
2021 POLICY PRIORITIES

HIV has been raging in communities across the world for almost 40 years and with advancements in biomedical interventions, research and vaccines, the time for the HIV cure is now. With a renewed sense of optimism and urgency, the PPC remains steadfast in its commitment to universal health care, eradication of racism in all forms, and unfettered access to care and supportive services to ensure that all people living with HIV and communities most impacted by HIV and STDs, live, full, productive lives.

The COVID-19 global pandemic has demonstrated that with political will, funding, and most important of all, urgency, rapid and safe vaccine development is possible. The COVID-19 global pandemic is severely impacting the delivery of HIV prevention and care services. The PPC is compelled to encourage and support innovative efforts to reduce bureaucracy, increase funding and enhance HIV prevention and care service. This effort is to address negative impacts pre-COVID service levels, as well exceed the quantity and quality of HIV and prevention services.

The PPC recommends the Commission on HIV endorse the prioritization of the following issues. PPC will identify support legislation, local policies, procedures, and regulations that address Commission priorities in calendar year 2021: (Issues are in no particular order.)

Racism

a. Health equity, the elimination of barriers and addressing of social determinants of health such as: implicit bias; access to care; education; social stigma, (i.e. homophobia, transphobia and misogyny); housing; mental health; substance abuse; and income/wealth gaps.
b. Reduce and eliminate the disproportionate impact of HIV/AIDS and STIs in the Black/African American community. To include the identification of and rooting out of systemic and systematic racism as it affects Black/African American communities.

Housing

a. Improve systems, strategies and proposals that expand affordable housing, as well as prioritize
housing opportunities for people living with, affected by, or at risk of transmission of HIV/AIDS.

b. Improve systems, strategies, and proposals that prevent homelessness for people living with, affected by, or at risk of contracting HIV/AIDS.
c. Promote Family housing and emergency financial assistance as a strategy to maintain housing.

Mental Health

a. Mental health services for people living with, affected by, or at risk of contracting HIV/AIDS.

Sexual Health

a. Access to prevention, care and treatment and bio-medical intervention (such as PrEP and PEP) services. Promote the distribution of services to people at risk for acquiring HIV and people living with HIV/AIDS.
b. Comprehensive HIV/STD counseling, testing, education, outreach, research, harm reduction services including syringe exchange, and social marketing programs.
c. Maximize HIV prevention to reduce and eliminate syphilis and gonorrhea cases, among young MSM (YMSM), African American MSM, Latino MSM, transgender persons and women of color.
d. Advance and enhance routine HIV testing and expanded linkage to care.
e. Maintain and expand funding for access and availability of HIV, STD, and viral hepatitis services.
f. Promote women centered prevention services to include domestic violence and family planning services for women living with and at high risk of acquiring HIV/AIDS.
g. Preserve full funding and accessibility to Pre-Exposure Prophylaxis Assistance Program (PrEP-AP).

Substance Abuse

a. Advocate for substance abuse services to PLWHA.
b. Advocate for services and programs associated with methamphetamine use and HIV transmission.

Consumers

a. Advocate and encourage the empowerment and engagement of People Living with HIV/AIDS (PLWHA) and those at risk of acquiring HIV. This includes young MSM (YMSM), African American MSM, Latino MSM, transgender persons and women of color, transgender and the aging.

Aging

a. Create and expand medical and supportive services for PLWHA ages 50 and over.

Women

a. Create and expand medical and supportive services for women living with HIV/AIDS. This includes services such as family housing, transportation, mental health, childcare and substance abuse.

Transgender

a. Create and expand medical and supportive services for transgender PLWHA.
b. Promote and maintain funding for the Transgender Wellness Fund created by the passage of AB2218.

General Health Care

a. Provide access to and continuity of care for PLWHA focusing on communities at highest risk for the acquisition and transmission of HIV disease.
b. Fund and expand eligibility for Medicaid, Medicare, and HIV/AIDS programs and health insurance coverage for individuals with pre-existing conditions.
c. Increase and enhance compatibility and effectiveness between RWP, Medicaid, Medicare, and other health systems. This includes restructuring funding criteria to **not** disincentives contractors from referring clients to other contractors.
d. Expand access to and reduction of barriers (including costs) for HIV/AIDS, STD, and viral hepatitis prevention and treatment medications.
e. Preserve full funding and accessibility to the AIDS Drug Assistance Program (ADAP), Office of AIDS Health Insurance Premium Payment (OA-HIPP) Assistance, Employer Based Health Insurance Premium Payment (EB-HIPP), and Medigap.

Service Delivery

a. Enhance the accountability of healthcare service deliverables. This would include a coordinated effort between federal, state, and local governments.
b. Incorporate COVID strategies to reduce administrative barriers, increase access to health services and encourage the development of an HIV vaccine mirroring the COVID 19 vaccine process.

Criminalization

a. Eliminate discrimination against or the criminalization of people living with or at risk of HIV/AIDS.

Data

a. Use data, without risking personal privacy and health, with the intention of improving health outcomes and eliminating health disparities among PLWHA.

b. Promote distribution of resources in accordance with the HIV burden within Los Angeles County.

The Public Policy Committee acts in accordance with the role of the Commission on HIV, as dictated by Los Angeles County Code 3.29.090. Consistent with Commission Bylaws Article VI, Section 2, no Ryan White resources are used to support Public Policy Committee activities.

LOS ANGELES COUNTY COMMISSION ON HIV

DRAFT - 2021-2022 Legislative Docket

3/1/2021

POSITIONS: SUPPORT | OPPOSE | SUPPORT w/AMENDMENTS | OPPOSE unless AMENDED | WATCH | County bills noted w/asterisk

BILL	TITLE	DESCRIPTION / COMMENTS	RECOMMENDED POSITION	STATUS
AB 4 (Arambula)	Medi-Cal: eligibility	The bill would extend eligibility for full scope Medi-Cal benefits to anyone regardless of age, and who is otherwise eligible for those benefits but for their immigration status. http://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=202120220AB4	Support	11-JAN-21 Referred to Committee on Health
AB 15 (Chiu)	COVID-19 relief: tenancy: Tenant Stabilization Act of 2021	This bill would extend the definition of "COVID-19 rental debt" as unpaid rent or any other unpaid financial obligation of a tenant that came due between March 1, 2020, and December 31, 2021. The bill would also extend the repeal date of the act to January 1, 2026. The bill would make other conforming changes to align with these extended dates. By extending the repeal date of the act, the bill would expand the crime of perjury and create a state-mandated local program. https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=202120220AB15		11-JAN-21 Referred to Committee on Housing and Community Development
AB 16 (Chiu)	Tenancies: COVID-19 Tenant, Small Landlord, and Affordable Housing Provider Stabilization Act of 2021	This bill would establish the Tenant, Small Landlord, and Affordable Housing Provider Stabilization Program. https://leginfo.legislature.ca.gov/faces/billStatusClient.xhtml?bill_id=202120220AB16		13-JAN-21 Re-referred to Com. on Housing and Community Development

BILL	TITLE	DESCRIPTION / COMMENTS	RECOMMENDED POSITION	STATUS
AB 19 (Santiago)	Unemployment insurance compensation: COVID-19 pandemic: temporary benefits	This bill would require the Employment Development Department to provide, until July 1, 2022, following the termination of assistance pursuant to Pandemic Unemployment Assistance (PUA) and Pandemic Emergency Unemployment Compensation (PEUC) or any other federal or state supplemental unemployment compensation payments for unemployment due to the COVID-19 pandemic, in addition to an individual's weekly benefit amount as otherwise provided for by existing unemployment compensation law, unemployment compensation benefits equivalent to the terminated federal or state supplemental unemployment compensation payments for the remainder of the duration of time the individual is unemployed due to the COVID-19 pandemic, notwithstanding the weekly benefit cap. https://leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill_id=202120220AB19		11-JAN-21 Referred to Com. on Insurance
AB 32 (Aguiar-Curry)	Telehealth	The bill would authorize a provider to enroll or recertify an individual in Medi-Cal programs through telehealth and other forms of virtual communication. http://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=202120220AB32	Support	16-FEB-21 Re-referred to Committee on Health
AB 65 (Low)	Low. California Universal Basic Income Program	This bill would declare the intent of the Legislature to enact legislation to create a California Universal Basic Income Program, with the intention of ensuring economic security for all Californians. https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=202120220AB65		08-DEC-20 From printer. May be heard in committee January 7.
AB 71 (Luz Rivas)	Homelessness funding: Bring California Home Act	This bill, for taxable years beginning on or after January 1, 2022, would include a taxpayer's global low-taxed income in their gross income for purposes of the Personal Income Tax Law, in modified conformity with the above-described federal provisions. The bill would exempt any standard, criterion, procedure, determination, rule, notice, or guideline established or issued by the Franchise Tax Board to implement its provisions from the rulemaking provisions of the Administrative Procedure Act. https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=202120220AB71		15-JAN-21 Re-referred to Coms. on Revenue & Tax and Housing & Community Development
AB 77 (Petrie-Norris)	Substance use disorder treatment services	This bill would declare the intent of the Legislature to enact Jarrod's Law, a licensure program for inpatient and outpatient programs providing substance use disorder treatment services, under the administration of the department. https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=202120220AB77		08-DEC-20 From printer. May be heard in committee January 7.

BILL	TITLE	DESCRIPTION / COMMENTS	RECOMMENDED POSITION	STATUS
AB 218 (Ward)	Change of gender and sex identifier	This bill would recast these provisions relating to new birth certificates to provide for a change in gender and sex identifier and to specify that a person who was issued a birth certificate by this state, rather than a person born in this state, may obtain a new birth certificate. https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=202120220AB218		28-JAN-21 Referred to Coms. on JUD. and HEALTH.
AB 245 (Chiu)	Educational equity: student records: name and gender changes	This bill would require a campus of the University of California, California State University, or California Community Colleges to update a former student's records to include the student's updated legal name or gender if the institution receives government-issued documentation, as described, from the student demonstrating that the former student's legal name or gender has been changed. https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=202120220AB245		28-JAN-21 Referred to Com. on HIGHER ED.
AB 328 (Chiu)	Reentry Housing Program	This bill would establish the Reentry Housing Program. The bill would require the Department of Housing and Community Development to, on or before July 1, 2022, take specified actions to, upon appropriation by the Legislature, provide grants to counties and continuums of care, as defined, for evidence-based housing and housing-based services interventions to allow people with recent histories of incarceration to exit homelessness and remain stably housed. https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=202120220AB328		12-FEB-21 Referred to Com. On Housing & Community Development
AB 369 (Kamlager)	Medi-Cal: street medicine and utilization controls	This bill would require the department to implement a program of presumptive eligibility for individuals experiencing homelessness, under which an individual would receive full-scope Medi-Cal benefits without a share of cost. https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=202120220AB369		12-FEB-21 Referred to Com. on HEALTH.
AB 453 (Cristina Garcia)	Sexual battery: nonconsensual condom removal	This bill would additionally provide that a person commits a sexual battery who causes contact between a penis, from which a condom has been removed, and the intimate part of another who did not verbally consent to the condom being removed. https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=202120220AB453		18-FEB-21 Referred to Com. On JUD.

BILL	TITLE	DESCRIPTION / COMMENTS	RECOMMENDED POSITION	STATUS
AB 789 (Low)	Health care facilities	This bill would require a primary care services in an outpatient department of a health facility or a primary care clinic, as specified, to offer a patient receiving health services a hepatitis B screening test and a hepatitis C screening test, as specified. The bill would also require the practitioner to offer the patient follow up health care or refer the patient to a health care provider who can provide follow up health care if the screening test is positive or reactive, as specified. https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=202120220AB789		25-FEB-21 Referred to Com. On HEALTH.
AB 1344 (Arambula)	State Department of Public Health: needle and syringe exchange services	This bill would expressly exempt needle and syringe exchange services application submissions, authorizations, and operations from review under the California Environmental Quality Act. Further, the bill would provide that the services provided by an entity authorized to provide those needle and syringe exchange services, and any foreseeable and reasonable consequences of providing those services, do not constitute a public nuisance under specified existing law. https://leginfo.legislature.ca.gov/faces/billStatusClient.xhtml?bill_id=202120220AB1344		22-FEB-21 Read first time.
AB 1400 (Kalra)	Guaranteed Health Care for All	This bill, the California Guaranteed Health Care for All Act, would create the California Guaranteed Health Care for All program, or CalCare, to provide comprehensive universal single-payer health care coverage and a health care cost control system for the benefit of all residents of the state. https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=202120220AB1400		22-FEB-21 Read first time.
AB 1407 (Burke)	Health care: discrimination	This bill would state the intent of the Legislature to enact legislation that would address discrimination in health care. https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=202120220AB1407		22-FEB-21 Read first time.
AB 2218 (Santiago) (Formerly)	Transgender Wellness and Equity Fund	This law establishes the Transgender Wellness and Equity Fund to organizations serving people that identify as transgender, gender nonconforming, or intersex (TGI), to create or fund TGI-specific housing programs and partnerships with hospitals, health care clinics, and other medical providers to provide TGI-focused health care, as defined, and related education programs for health care providers.	In Support of Transgender Wellness Fund	26-SEP-20 Approved by the Governor
SB 17 (Pan)	Public health crisis: racism	This bill would state the intent of the Legislature to enact legislation to require the department to address racism as a public health crisis. https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=202120220SB17		28-JAN-21 Referred to Committee on Rules

BILL	TITLE	DESCRIPTION / COMMENTS	RECOMMENDED POSITION	STATUS
SB 56 (Durazo)	Medi-Cal: eligibility	This bill would, subject to an appropriation by the Legislature, and effective July 1, 2022, extend eligibility for full-scope Medi-Cal benefits to individuals who are 65 years of age or older, and who are otherwise eligible for those benefits but for their immigration status. http://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=202120220SB56	Support	17-FEB-21 Set for hearing March 10
SB 57 (Wiener)	Controlled Substances: Overdose Prevention Program	This bill would, until January 1, 2027, authorize the City and County of San Francisco, the County of Los Angeles, and the City of Oakland to approve entities to operate overdose prevention programs for persons that satisfy specified requirements, including, among other things, providing a hygienic space supervised by trained staff where people who use drugs can consume preobtained drugs, providing sterile consumption supplies, and providing access or referrals to substance use disorder treatment. http://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=202120220SB57	Support	28-JAN-21 Referral to Committee on Judiciary rescinded due to the ongoing health and safety risks of the COVID-19 virus.
SB 110 (Weiner)	Substance use disorder services: contingency management services	This bill will expand substance use disorder services to include contingency management services, as specified, subject to utilization controls. http://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=202120220SB110		28-JAN-21 Referred to Committee on Health
SB 221 (Wiener)	Health care coverage: timely access to care	The bill would require both a health care service plan and a health insurer to ensure that appointments with nonphysician mental health and substance use disorder providers are subject to the timely access requirements. The bill would additionally require a health care service plan or a health insurer to ensure that an enrollee or insured that is undergoing a course of treatment for an ongoing mental health or substance use disorder condition is able to get a follow up appointment with a nonphysician mental health care or substance use disorder provider within 10 business days of the prior appointment. By imposing new requirements on health care service plans, the willful violation of which would be a crime, the bill would impose a state-mandated local program. https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=202120220SB221		28-JAN-21 Referred to Com. On HEALTH.

BILL	TITLE	DESCRIPTION / COMMENTS	RECOMMENDED POSITION	STATUS
SB 258 (Laird)	Aging	The bill would revise this definition "greatest social need" to include human immunodeficiency virus (HIV) status as a specified noneconomic factor. http://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=202120220SB258		3-FEB-21 Referred to Committee on Human Services
SB 306 (Pan)	Sexually transmitted disease: testing	This bill would require a health care provider to include "expedited partner therapy" on a prescription if the practitioner is unable to obtain the name of a patient's sexual partner. https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=202120220SB306		5-FEB-21 From printer. May be acted upon on or after March 7
SB 316 (Eggman)	Medi-Cal: federally qualified health centers and rural health clinics	This bill would authorize reimbursement for a maximum of 2 visits taking place on the same day at a single location if after the first visit the patient suffers illness or injury requiring additional diagnosis or treatment, or if the patient has a medical visit and a mental health visit or a dental visit, as defined. https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=202120220SB316		25-FEB-21 Set for hearing March 10.
SB 464 (Hurtado)	California Food Assistance Program: eligibility	This bill, commencing January 1, 2023, would instead make a noncitizen applicant eligible for the California Food Assistance Program if the noncitizen satisfies all eligibility criteria for participation in the CalFresh program except any requirements related to immigration status. https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=202120220SB464		25-FEB-21 Referred to Com. on HUMAN S.
SB 803 (Beall) (Formerly)	Mental health services: peer support specialist certification	This law requires the department, by July 1, 2022, to establish statewide requirements for counties to use in developing certification programs for the certification of peer support specialists.	Requires funding to implement. The State has proposed $4.7 million for 22-23 fiscal year. LAC is in support of the proposal.	25-SEP-20 Approved by the Governor

SB 306 (Pan)
STD Coverage + Care Act

Purpose

Authored by Senator Richard Pan - a practicing physician and Chair of the Senate Health Committee – SB 306: STD Coverage and Care Act – provides a comprehensive approach to addressing California's STD public health crisis during the COVID-19 pandemic and beyond. The bill aims to strengthen California's public health infrastructure and expand access to STD coverage and care to improve health outcomes and create a more equitable health system. The measure is sponsored by APLA Health, Black Women for Wellness Action Project, Essential Access Health, Fresno Barrios Unidos, Los Angeles LGBT Center, and the San Francisco AIDS Foundation.

Background

Stark Statistics

New data released by the Centers for Disease Control and Prevention (CDC) estimates that 1 in 5 people in the U.S. have an STD. The COVID-19 pandemic has exacerbated STD rates in California and across the country that were already skyrocketing to crisis levels prior to the public health emergency. According to the latest data available, in 2018, nearly 68 million STD infections were reported nationwide with rates of syphilis, chlamydia, or gonorrhea up 40% since 2013. California also had the second highest syphilis rates in the nation in 2018. While 90 percent of all male syphilis cases in 2013 were among bisexual and gay men, the epidemic has spread among women. Between 2008 and 2018, the syphilis rate among women of reproductive age increased by 743 percent. In 2018, more than 329 babies were born with congenital syphilis in California and there were 20 stillbirths associated with the disease. More than 100 babies were born with congenital syphilis in Los Angeles County alone in 2020 during the COVID-19 pandemic.

Untreated STDs Can Lead to Serious Long-Term Health Consequences

Signs that the STD epidemic has been neglected for far too long have already manifested in alarming ways. The CDC confirmed in 2020 that a new, antibiotic-resistant strain of gonorrhea began to spread across the country amidst the COVID-19 crisis. The California Department of Public Health (CDPH) also issued an alert in December of 2020 about the rising number of disseminated gonococcal infections, a severe complication of untreated gonorrhea that spreads across the body through the bloodstream.

The CDC estimates that untreated STDs cause at least 24,000 women in the U.S. each year to become infertile. The number of cancers related to Human Papilloma Virus (HPV) infections in men dramatically increased in 2016. Untreated syphilis can also lead to negative maternal

child health outcomes, including infant death. The CDC estimates that of the pregnant women who acquire syphilis up to four years before delivery, 80% will transmit the infection to the fetus, and 40% may result in stillbirth or death. STDs also increase both the transmission and acquisition of HIV.

Health Inequities Persist

Although our STD public health crisis is effecting communities across the state, California youth, Black, Indigenous and people of color, and gay, bisexual, and transgender people are disproportionately impacted. Statewide data indicate over half of all STDs in the state are experienced among California youth ages 15 – 24 years old. Currently, African Americans are 500% more likely to contract gonorrhea and chlamydia than their white counterparts. These disparities are expected to worsen during the COVID-19 pandemic. Studies conducted by the CDC suggest a range of factors linked to social determinants of health likely contribute to STD rate disparities, including inequitable access to safe, culturally competent, quality health, mental health and substance use treatment services, as well as high rates of incarceration, lack of access to economic mobility and education opportunities, adequate housing, racial segregation, and racism.

The Cost of Inaction

In a recently released report, the CDC estimated that new infections acquired in 2018 totaled nearly $16 billion in direct lifetime medical costs nationwide. Chlamydia, gonorrhea and syphilis combined accounted for more than $1 billion of the total cost. Sexually acquired HIV and HPV were the costliest due to lifetime treatment for HIV at $13.7 billion and treatment for HPV-related cancers at $755 million.

Approximately $1 billion is spent annually in California on health costs associated with STDs.

The Solution

The scope of the STD epidemic requires a bold response. California must take a comprehensive and robust approach to strengthening our public health infrastructure and expanding access to STD coverage and care to communities most impacted by the STD crisis. SB 306 will help address the STD epidemic and improve health outcomes by reducing barriers to STD services and treatment by:

- Expanding access to STD services and treatment for low-income and uninsured patients through the Family PACT program and provider network
- Increase prevention through innovative strategies like home testing + expansion of health professionals that conduct rapid testing in the community
- Revise current law to support the delivery and increased utilization of Expedited Partner Therapy (EPT), an evidence-based and effective STD prevention practice
- Update state law to require congenital syphilis testing during the third trimester of pregnancy

Contact

Please direct inquiries about this policy proposal to:

- Sylvia Castillo, 626.587.9646 / scastillo@essentialaccess.org
- Kathy Mossburg, 916.444.3108 / kmossburg@mvmstrategy.com

From:	Diana Rubio
Subject:	Sacramento – Pursuit of County Co-Sponsorship of State Budget Proposal Related to Peer Support Program - 2/11/21
Date:	Thursday, February 11, 2021 8:00:38 AM

Sacramento – Pursuit of County Co-Sponsorship of State Budget Proposal Related to Peer Support Program

Executive Summary

This report contains a pursuit of County position on the following State budget proposal:

- **Co-sponsor State Budget Proposal on Medi-Cal Peer Support.** A coalition of behavioral health organizations is pursuing a State budget proposal for $4.7 million in State funding in Fiscal Year (FY) 2021-22 to begin the implementation of the Medi-Cal Peer Support Specialist Certification Program, as created by County co-sponsored SB 803 (Chapter 150, Statutes of 2020). Therefore, unless otherwise directed by the Board, consistent with existing policy, **the Sacramento Advocates will co-sponsor the budget proposal to provide $4.7 million in State funding to begin the Peer Support Specialist Certification Program.**

Pursuit of County Co-Sponsorship of a State Budget Proposal

MEDI-CAL PEER SUPPORT SPECIALIST CERTIFICATION PROGRAM

Background

- County co-sponsored SB 803 (Chapter 150, Statutes of 2020), established the Medi-Cal Peer Support Specialist Certification Program to include peer support specialists as Medi-Cal billable providers and to add peer support services as a Medi-Cal reimbursable service.
- Peers support specialists use their lived experience with mental illness and/or substance use disorder (SUD) and recovery, bolstered by specialized training, to deliver valuable support services in a behavioral health setting.
- The Federal Center for Medicare & Medicaid Services (CMS) recognizes peer support services as an evidence-based mental health model of care and as an important component in a state's delivery of effective behavioral health treatment.
- Prior to the enactment of SB 803, California was one of only two states that had not established a peer support specialist certification program.

State Proposal

- This proposal would provide $4.7 million in State funding in FY 2021-22 for start-up costs to the State to: 1) contract with counties to develop and implement the Medi-Cal Peer Support Specialist Certification Program; 2) add peer support specialists as a Medi-Cal billable provider; and 3) add peer support services as a Medi-Cal covered benefit.
- These funds may be provided by State General Fund or Mental Health Services Act Administrative funds and would be matched by Federal Medicaid funds.
- This proposal is co-sponsored by the California Association of Mental Health Peer Run Organizations, County Behavioral Health Directors Association of California, and the Steinberg

Institute.

County Impact

- According to the Department of Mental Health (DMH), peers help to improve treatment outcomes and to facilitate the integration of health, mental health, and SUD treatment services.
- DMH reports that a peer certification program would establish standardized training, practice guidelines, and clinical supervision requirements for peer and family support specialists that would meet the standards set by CMS.
- This would professionalize the peer support specialists and enable the State to draw down additional Federal funding for these services.

Support and Opposition

- Support and opposition to this proposal is unknown at this time.

Recommendation

- This office and the Department of Mental Health support this budget proposal.
- Therefore, unless otherwise directed by the Board, consistent with existing Board-approved policy to support proposals to fund the training of mental health professionals, including certified peer counselors, **the Sacramento Advocates will co-sponsor the budget proposal to provide $4.7 million in State funding to begin the Peer Support Specialist Certification Program.**

Thank you,

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Help! What Do All These Executive Orders Mean to Us?

Folks, we have a new president--and with that, we have a whole lot of new executive orders. If you got a little lost in the flurry of papers coming out of the White House, you are not alone. We are here to help break down what these orders are and which ones affect women and people of trans experience living with HIV.

You may be asking yourself, "What exactly is an executive order?"

The president is the head of the executive branch of government, including all the administrative agencies, like the Department of Health and Human Services. Because the president oversees "executing the laws"-- i.e., putting what Congress passes into action—they are also able to explain to the employees of the executive branch how they think laws should be interpreted or applied.

Executive orders are the written directives that provide the president's interpretation of the law to these employees.

Because these employees then put that interpretation into action, it has concrete effects for our daily lives.

Now that you know what an executive order is, let's get into what the newest ones from President Biden are.

Executive Order	**What it does and what is its purpose**	**How this affects women living with HIV**
Executive Order on Advancing Racial Equity and Support for Underserved Communities Through the Federal Government	The purpose is to advance equity across the federal government; a main component of this is revoking a Trump-era executive order which banned federal contractors from engaging in diversity and inclusion training.	This revokes prior executive orders which made it so that many organizations which rely on government funding, such as nonprofits, universities, employers, community-based organizations, and AIDS service organizations, would have to choose between receiving necessary funding and training employees to provide informed service and combat racism. It made necessary programs less accessible and welcoming for BIPOC and LGBTQ+ communities because of the lack of informed training for employees. Removing this order was an important first step in working towards equity.
Executive Order on Ensuring a Lawful and Accurate Enumeration and Apportionment Pursuant to the Decennial Census	This executive order aims to ensure that the census count accurately counts every person in the country, as required by the Constitution. It revokes a Trump-era executive order which aimed to exclude undocumented immigrants from the census to the maximum amount feasible.	An accurate census count is essential for determining how funds are distributed to states and localities and it also impacts an area's representation in Congress. These funds are for programs we rely on every day for food, health care, and housing, like Medicaid, Medicare, the Supplemental Nutrition Assistance Program (SNAP), and public housing. This will ensure immigrants living with HIV who responded to the census are counted and that their communities get the political power and resources that they deserve.
Executive Order on Preventing and Combating Discrimination on the Basis of Gender Identity or Sexual Orientation	This order instructs federal agencies to prioritize enforcing the Supreme Court's Bostock decision which prohibited employment discrimination based upon gender identity or sexual orientation.	The administration is taking discrimination against LGBTQ+ folks seriously and ensuring the *Bostock* decision is enforced in virtually all federal programs, like public accommodations, education employment and housing. This is especially important for people of trans experience, who face significant barriers to employment, housing, and health services, which may increase vulnerability to acquiring HIV.
Executive Order on Ensuring an Equitable Pandemic Response and Recovery	This EO creates the COVID-19 Health Equity Task Force, tasked with addressingCOVID-19's impact on Black, Indigenous and other communities of color as well as other underserved populations.	The Task Force provides for the express inclusion of people with lived experience and will recommend how to best allocate COVID-19 resources; disburse funds in a manner that advances equity; and deliver effective, culturally aligned communication, messaging, and outreach to communities of color and other underserved populations. These communities are also the ones most

		impacted by the HIV epidemic, so this prioritization and focus will help women living with HIV who simultaneously more at risk for acquiring COVID-19.
Executive Order on Protecting Worker Health and Safety	This order aims to reduce the risks workers face for acquiring COVID-19 while on the job by issuing revised guidance for employers and, if necessary, issuing new OSHA standards.	Protecting essential workers will inevitably protect women living with HIV as well. Women living with HIV may be essential workers themselves, in which case these new guidelines and standards will help keep them safer as they enter their workplaces. Safer workplaces will also benefit people living with HIV who have to access places where these workers are, like grocery stores and health care settings.
Executive Order on Supporting the Reopening and Continuing Operation of Schools and Early Childhood Education Providers	This order aims to support high-quality education for all children and the safe reopening of schools for in-person learning by providing guidance for states, schools, and child care providers to use in deciding whether and how to reopen as well as developing a way for schools to share lessons learned and best practices. It also directs the creation of a report on disparate impacts of COVID-19 on students and ways to address it as well as finding ways to increase connectivity for students lacking reliable internet	Many women living with HIV and people of trans experience living with HIV are parents and need safe places to send their children where they will not contract COVID-19. This guidance can help increase confidence that sending children back into group learning environments is being done in a way that is consistent with the best available scientific data and public health research. Further, being unable to send children to school or have access to childcare can negatively impact a person financially and can be an additional stressor, especially if wireless connectivity is an issue for at home learning. Finding solutions to these problems, which disproportionately impact BIPOC communities, is essential, so it is fantastic that the administration is prioritizing it.
Executive Order on Enabling All Qualified Americans to Serve Their Country in Uniform	This order revokes a Trump-era ban and will allow people of trans experience to serve openly in the military.	The prior ban was arbitrary, discriminatory and perpetuated stigmatizing notions of people of trans experience and non-binary people. It is a good sign that the new president is including and centering transgender folks in his initial actions and, as advocates, we must encourage him to continue to do so in all other areas of his policy agenda.
Executive Order on Strengthening Medicaid and the Affordable Care Act	This executive order permits HHS to open HealthCare.gov for a "Special Enrollment Period," from February 15, 2021 – May 15, 2021, meaning that people have additional opportunities to sign up for health care coverage. The order directs federal agencies to reconsider rules and policies that limit access to health care and consider actions that will	The ACA significantly expanded access to care for women living with HIV but faced a concerted attack during the Trump era. This executive order begins the process of unwinding that damage and improving access to care even further. Especially of concern is access to care for those who live in states whose elected leaders have not expanded Medicaid, people who live in rural areas, and lifting the federal ban on abortion coverage. Ideally, this review will also demonstrate the need for a publicly funded coverage option as an alternative to

	protect and strengthen that access.	the private insurance market, which is driven by profit and private interests instead of public health.

President Biden took other important steps as well, which were not styled as executive orders but were either memorandums to agency officials or proclamations.

In one such memorandum, President Biden froze the implementation of Trump-era regulations pending his review. This halts the SUNSET Rule, which would have required the Department of Health and Human Services to reassess the economic impacts of its regulations every ten years. If the regulation was not reviewed, it would "sunset" or cease to have any enforcement power.

This was an extremely time consuming, wasteful, and burdensome regulation that would have impacted programs like Ryan White. During this regulatory freeze period, advocates should encourage the Biden administration to reject the SUNSET Rule.

President Biden revoked the global gag rule, which prevented international non-profits that provide abortion counseling or referrals from receiving U.S. funding, and directed HHS to review a similar rule that is used in the United States, referred to as the domestic gag rule or the Title X rule.

It also directed the Secretary of State to reestablish the flow of funds to United Nations Population Fund, which supports reproductive rights for all and widely available sexual and reproductive health services.

President Biden also withdrew the anti-choice and anti-LGBT Geneva Consensus Declaration. These steps are crucial in ensuring comprehensive access to health care for all people, including abortion care.

It is essential that HHS rescind the Title X Rule and, to ensure the global gag rule is not put into place by future administrations, Congress must pass the Global Health, Empowerment and Rights (HER) Act.

President Biden also extended the pause on federal student loan payments. Student loan debt disproportionately burdens BIPOC and low-income communities who are also disproportionately impacted by HIV epidemic. Although more can be done to address this inequity, a pause on payments during the coronavirus pandemic is an important first step.

Finally, President Biden issued a proclamation Preserving and Fortifying Deferred Action for Childhood Arrivals (DACA). The Trump administration had led a concerted effort for the past four years to undermine the DACA program and had stopped accepting DACA applications. President Biden will now allow the program to begin accepting applications again so DACA recipients and DACA eligible individuals can receive all the benefits they are entitled to under the program.

In his first several days in office, President Biden has taken many important steps to roll back harmful policies championed by the Trump Administration. We hope that as this administration moves forward into implementing its own policies, it takes a racial and gender justice approach to its work.

Public policy and health in the Trump era

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Executive summary

This report by the *Lancet* Commission on Public Policy and Health in the Trump Era assesses the repercussions of President Donald Trump's health-related policies and examines the failures and social schisms that enabled his election. Trump exploited low and middle-income white people's anger over their deteriorating life prospects to mobilise racial animus and xenophobia and enlist their support for policies that benefit high-income people and corporations and threaten health. His signature legislative achievement, a trillion-dollar tax cut for corporations and high-income individuals, opened a budget hole that he used to justify cutting food subsidies and health care. His appeals to racism, nativism, and religious bigotry have emboldened white nationalists and vigilantes, and encouraged police violence and, at the end of his term in office, insurrection. He chose judges for US courts who are dismissive of affirmative action and reproductive, labour, civil, and voting rights; ordered the mass detention of immigrants in hazardous conditions; and promulgated regulations that reduce access to abortion and contraception in the USA and globally. Although his effort to repeal the Affordable Care Act failed, he weakened its coverage and increased the number of uninsured people by 2·3 million, even before the mass dislocation of the COVID-19 pandemic, and has accelerated the privatisation of government health programmes. Trump's hostility to environmental regulations has already worsened pollution—resulting in more than 22 000 extra deaths in 2019 alone—hastened global warming, and despoiled national monuments and lands sacred to Native people. Disdain for science and cuts to global health programmes and public health agencies have impeded the response to the COVID-19 pandemic, causing tens of thousands of unnecessary deaths, and imperil advances against HIV and other diseases. And Trump's bellicose trade, defence, and foreign policies have led to economic disruption and threaten an upswing in armed conflict.

Although Trump's actions were singularly damaging, many of them represent an aggressive acceleration of neoliberal policies that date back 40 years. These policies reversed New Deal and civil rights-era advances in economic and racial equality. Subsequently, inequality widened, with many people in the USA being denied the benefits of economic growth. US life expectancy, which was similar to other high-income nations' in 1980, trailed the G7 average by 3·4 years in 2018 (equivalent to 461 000 excess US deaths in that year alone). The so-called war on drugs initiated by President Richard Nixon widened racial inequities and led to the mass incarceration of Black, Latinx, and Indigenous people. Overdose deaths soared, spurred by drug firms' profit-driven promotion of opioids and the spread of despair in long-afflicted communities of colour and among working-class white people. Market-oriented health policies shifted medical resources toward high-income people, burdened the middle class with unaffordable out-of-pocket costs and deployed public money to stimulate the corporate takeover of vital health resources.

The Commission applauds President Joe Biden and Vice President Kamala Harris for rejoining WHO and the Paris Climate Agreement, and for other steps they have taken to rescind some of President Trump's health-harming executive actions. But the new administration and Congress must go beyond simply repairing Trump's damage. They must initiate thoroughgoing reforms to reverse widening economic inequality and the neoliberal policy drift that pre-dated Trump, and redress long-standing racism—root problems that harm health and have fomented threats to US democracy. Additionally, forceful action is needed to forestall environmental disaster and strengthen public health infrastructure.

Reducing economic inequality will require raising taxes on the wealthy and using the proceeds to strengthen social, education, nutrition, and health programmes. Those programmes should avoid segregating the poor, and instead encompass all people in the USA to bolster the solidarity that is key to securing broad and continuing popular support. Government should stop funnelling expenditures through private firms whose profit-seeking boosts costs and distorts priorities. Hence, a single payer health-care reform offers the fairest, most effective, and most efficient route to universal health coverage.

Censure of Trump's virulent brand of racism is imperative but insufficient. US leaders must embrace emphatically anti-racist politics and programmes to dismantle the centuries-old structures that reproduce racial inequity in health and all other spheres. Ending mass incarceration and reforming the execrable policing and criminal justice systems that oppress communities of colour and fill prisons are essential for racial justice. Additional steps must include vigorous enforcement of voting and civil rights; large new investments in educational equity, the Indian Health Service, and minority-serving health and educational institutions; and compensation for wealth denied to and confiscated from communities of colour in the past.

Finally, the president and the Congress must mobilise massive resources to avert climate catastrophe, address

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Key messages

During his time in office President Trump:

- Politicised and repudiated science, leaving the USA unprepared and exposed to the COVID-19 pandemic
- Eviscerated environmental regulation, hastening global warming
- Incited racial, nativist, and religious hatred, provoking vigilante and police violence
- Denied refuge to migrants fleeing violence and oppression, and abused immigrant detainees
- Undermined health coverage
- Weakened food assistance programmes
- Curtailed reproductive rights
- Undermined global cooperation for health, and triggered trade wars
- Shifted resources from social programmes to military spending and tax windfalls for corporations and the wealthy
- Subverted democracy both nationally and internationally

Although the Trump administration policies posed a uniquely urgent threat to health, damaging neoliberal policies predated and abetted his ascendance:

- Life expectancy in the USA has lagged behind other wealthy nations since 1980 and began falling in 2014
- The chronically high mortality of Native Americans started rising in 1999, while yawning disparities between Black and white people persisted and progress on racial equity in other domains (eg, education, housing, income and policing) halted or reversed
- Substance abuse deaths greatly increased
- Income and wealth inequality widened
- Incarceration increased four-fold, initiated by President Nixon's racially motivated war on drugs and compounded by harsh laws enacted under Presidents Reagan and Clinton
- Welfare eligibility restrictions implemented by President Clinton removed benefits from millions
- Deindustrialisation spurred by trade agreements that favoured corporate interests over labour protections reduced economic opportunity in many regions of the USA, damaging health and increasing receptivity to racist and xenophobic appeals
- Market-based reforms commercialised and bureaucratised medical care, raised costs, and shifted care toward high-income US residents
- Despite the Affordable Care Act, nearly 30 million people in the USA remained uninsured and many more were covered but still unable to afford care
- Funding cuts reduced the front-line public health workforce by 20%

The Biden administration must cancel Trump's actions and also address the health-damaging structural problems that were present before Trump's presidency:

- Raise taxes on high-income people and use the proceeds to bolster social, educational, and health programmes, and address urgent environmental problems
- Mobilise against the structural racism and police violence that shorten the lives of people of colour
- Replace means-tested programmes such as Medicaid that segregate low-income people, with unified programmes such as national health insurance that serve all US residents, aligning the interests of the middle class and the poor in maintaining excellence
- Reclaim the US Government's role in delivering health and social services, and stop channelling public funds through private firms whose profit-seeking skews priorities
- Redirect public investments from militarism, corporate subsidies, and distorted medical priorities to domestic and global fairness, environmental protection, and neglected public health and social interventions
- Reinvigorate US democracy by reforming campaign financing, reinforcing voting, immigration, and labour rights, and restoring oversight of presidential prerogatives

the calamities caused by COVID-19, and attenuate global inequality. The 3·4% of GDP the USA currently spends on troops and armaments should be reduced to the 1·4% average of other G-7 nations, with the savings redeployed to address urgent health, social, and environmental problems at home; reinvigorate the scientific efforts that are vital to global progress; and fund the four-times increase in foreign aid needed to reach the level recommended by the UN.

COVID-19's facile breach of national boundaries is a reminder of the vulnerability of even the most powerful nations in an interconnected world, and the folly of contempt for science, facts, and equity. In years past, the USA deployed its economic power and scientific prowess in important, although imperfect, efforts to advance global health. It must rejoin the global community in a spirit of collaboration, rejecting the notion that others must fail in order for the USA to succeed.

Introduction

President Trump's time in office brought misfortune to the USA and the planet. In 2020 alone he expedited the spread of COVID-19 in the USA, deserted the WHO when the world needed it most, and responded to largely peaceful protests against racist policing by inflaming hatred and unleashing military force and vigilante violence that he subsequently mobilised for insurrection.

Trump's appalling response to 2020's crises culminated a presidential term suffused with health-damaging policies and pronouncements. The *Lancet* Commission on Public Policy and Health in the Trump Era, launched in April, 2017, soon after Trump's inauguration, was tasked with chronicling repercussions of the administration's actions and charting policies for a healthy future (panel 1).[1] We did not know then what the consequences of President Trump's era would be.

In publishing our Commission report after President Biden's inauguration, we have three objectives. First, to catalogue, albeit incompletely, the Trump administration's health-related policies and actions. Second, to reckon with the social, economic, and political failings that preceded and enabled the election of President Trump. Finally, to inform and suggest new policy directions in health-related domains for the incoming administration and Congress. Our recommendations are intended not just to reverse Trump's injurious actions but to recognise a generational failure to implement the measures needed for a healthy population.

Accelerating the decline of health in the USA

At the time of Trump's inauguration in January, 2017, the health of the US population was already on a downward trajectory. Average life expectancy in the US had declined from 78·9 years to 78·7 years between 2014 and 2018,[2,3] a period that included the first 3-year decline in longevity since World War 1 and the 1918 flu pandemic. Progress

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Panel 1: Description of the Commission

The *Lancet* Commission on Public Policy and Health in the Trump Era was formed following the publication of the *Lancet* Series on US health and health care. The Commission was comprised of 33 Commissioners from the US, the UK, and Canada working in medical, public health and law schools, universities, Indigenous communities, clinical settings, public health agencies, unions, and legislative bodies. 12 commission members self-identified as people of colour (one declined to self-identify) and 13 as women. The Commissioners' disciplines and expertise included clinical medicine, public health, epidemiology, medical care policy, community medicine, economics, nutrition, law, and politics.

The Commission aims to:

- Identify major health-related policy actions in the Trump era (2017–20), and evaluate emerging data on their effects
- Delineate long-term deficiencies in US politics, social policies, and population health that enabled the emergence of a populist, anti-democratic leader who marshalled racism, sexism, and xenophobia
- Explore the health effects of neoliberal policies that have favoured public-sector austerity, privatisation of health services, and subsidies to corporations
- Recommend to the next US administration alternative and more salutary policies

The Commission held an initial meeting in Atlanta, GA, USA, on Nov 5, 2017, to identify priority policy areas, develop a work plan, and allocate responsibilities for sections of the Commission. Commissioners distributed and discussed preliminary section outlines and modelling results electronically and at two subsequent Commission meetings at Boston University (Boston, MA, USA) on May 7, 2018, and Roosevelt House, Hunter College, City University of New York (New York, NY, USA) on Feb 9, 2019.

The Commission used data from original analyses, published studies, legal documents, news reports, and government websites.

on health stalled amid the longest-running economic expansion (between June, 2009, and March, 2020) in US history, an almost unprecedented decoupling of population health from GDP growth. The COVID-19 pandemic has further compromised longevity.

The lag in life expectancy since 2014 has resulted from past societal problems. Death rates, which fell rapidly through the 1960s and 1970s, started plateauing around 1980, a trend unique to the USA (figure 1).[4]

Throughout history, stagnating longevity has signalled grave societal problems, as has occurred in England since 2010[5] and in the years leading to the collapse of the Union of Soviet Socialist Republics.[6] For much of US history, income and wealth were distributed more equally than in most of Europe.[7] However, since

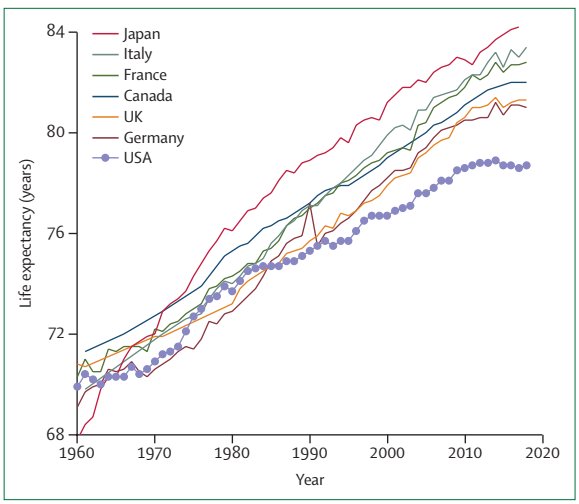

Figure 1: **Life expectancy at birth in the USA and other G7 countries (1960–2018)**

the 1980s, the disparity between social and economic classes has widened as high-paid manufacturing jobs disappeared after trade liberalisation, unions were stifled, and tax and social policies increasingly favoured the wealthy. Despite a booming stock market and low unemployment, many people living in the USA were forced into precarious jobs that offered low pay and insufficient benefits. This widening income inequality has, widened inequalities in health.[8]

Impoverishment has political and health consequences. As British economist John Maynard Keynes noted (cautioning against imposing World War 1 reparation payments on the German populace): "men will not always die quietly...in their distress [they] may overturn the remnants of organisation, and submerge civilization itself".[9] In the US context, presidential candidate Donald Trump stirred up the underlying racial animus of US society to deflect attention from policies that abet billionaires' accretion of wealth and power. His racist, anti-immigrant, and nationalist appeals found resonance in some middle-income and low-income white communities seeking scapegoats for their declining life prospects, even as they retained some privileges denied to people of colour.

Although Trump's ascent to the presidency was propelled by racism, nativism, and fear of privation, his policies constituted an intensified attack on the health and wellbeing of people in the USA and elsewhere. His signature legislative achievement, a trillion-dollar tax cut for the wealthy, opened a budget hole that served as justification for cuts to food and housing subsidies that prevent malnutrition and homelessness for millions of people in the USA; the number of homeless school-children increased by 150 000 in the first year of Trump's presidency.[10]

Trump's mismanagement of the COVID-19 pandemic—compounded by his efforts to dismantle the USA's already weakened public health infrastructure and the

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Panel 2: COVID-19 in the USA: chronically underfunded public health, inadequate disaster preparedness, and uncoordinated response

Pre-existing problems help to explain the slow and disjointed response to the COVID-19 pandemic by the US Government:

- Between 2002 and 2019, the share of US health spending devoted to public health fell from 3·21% to 2·45%[11] (approximately half the share of spending in Canada or the UK). Meanwhile, funding of the Public Health Emergency Preparedness programme (the main source of federal support for state and local public health emergency capacity) fell by one-third.[12] As a consequence of funding shortfalls, state and local public health agencies lost 50 000 positions, a 20% decrease in the front-line workforce for fighting epidemics.[13]
- Since 2003, the resources, independence, and scientific authority of the Centers for Disease Control and Prevention (CDC) have been progressively compromised, initially by the introduction of a corporate model[14] and the departure of experienced agency scientists and, during the past decade, by a 10% budget decrease (inflation-adjusted).[15] A hiring freeze in 2017 left hundreds of CDC positions for researchers and officials vacant.[16] In 2018, the Trump administration transferred the already partially depleted Strategic National Stockpile of drugs and medical supplies from the CDC to the Office of an Assistant Secretary in the Department of Health and Human Services.[17]
- The public health emergency-response capacity of other federal agencies has also been eroded. In 2018 the White House eliminated the National Security Council Directorate for Global Health Security and Biodefense, which had been created in 2014 to coordinate responses to Ebola virus and other global disasters. Moreover, nearly half of all scientific leadership positions in federal agencies were vacant by 2019.[18]
- Access to medical care, never fully adequate in the USA, contracted further during the Trump administration. One million health-care workers and many immigrant workers at high risk of coronavirus exposure were uninsured at the beginning of the COVID-19 pandemic in February, 2020.[19]
- In 2017 the Trump administration halted the nearly completed effort by the Occupational Safety and Health Administration to develop airborne infection control standards for workplaces to be issued in October 2017.[21]

These problems have been exacerbated by the COVID-19 pandemic because:

- Inadequately coordinated federal leadership resulted in delayed or inconsistent guidelines for state and local action.
- Reliance on market forces to supply equipment for preventing and treating COVID-19 left states and hospitals to compete with one another, and sometimes with the federal government itself, to buy personal protective equipment and ventilators.
- The Trump administration rejected WHO testing kits while waiting for US tests to be produced, which impeded testing. Other bottlenecks (eg, insufficient capacity to administer and analyse diagnostic tests) further slowed the response.
- Public health authorities were discredited by senior administration officials, which led to disregard for scientific expertise, misleading public communication, official (ie, President Trump and the US Food and Drug Administration) endorsement of therapies without evidence of efficacy, promotion of unproven theories about COVID-19, and President Trump's refusal to wear a mask, practise physical distancing, or avoid mass meetings.
- In an unprecedented expression of distrust, many states did not follow CDC's recommendations and instead joined multi-state coalitions to make policy for reopening the economy and schools.
- Many people lost their health coverage because of pandemic-related job losses.

These problems, and the structural inequities described elsewhere in this Commission report, have caused COVID-19's toll of death and misery to fall most heavily on people of colour, workers in low-paid jobs where physical distancing is challenging, people who are incarcerated, and nursing home residents and others in frail health.

To recuperate the CDC's authority and prestige, Congress must shield the agency from political interference and fund it and other public health efforts at levels commensurate with the threats posed by infectious agents, social inequality,[21] the opioid epidemic, and environmental degradation.

Affordable Care Act's (ACA) coverage expansions—has caused tens of thousands of unnecessary deaths. His elimination of the National Security Council's global health security team, and a 2017 hiring freeze that left almost 700 positions at the Centers for Disease Control and Prevention (CDC) unfilled, compromised preparedness (panel 2).[11–21] The number of people without health insurance had increased by 2·3 million during Trump's presidency, even before pandemic-driven losses of employment-based coverage increased the number of uninsured people by millions.[22]

Trump entrusted stewardship of the Environmental Protection Agency (EPA) to administrators who deny human-driven global warming and have devoted their careers to blocking regulation of the fossil fuel industry, with cataclysmic implications for the health of the planet. The EPA's reversal of emissions regulations portends increased deaths from air pollution, vector-borne infectious diseases, malnutrition, natural disasters, and global conflict.[23] Foes of LGBTQ rights, abortion, and even birth control were appointed to key health policy positions and have used those perches to roll back access to health care,

education, and family planning services. Militarised immigration enforcement has harmed the health and development of thousands of children and intimidated immigrant communities, discouraging them from using health and nutrition services. White nationalists were close advisers to President Trump and he advanced their agenda by backing efforts to suppress the voting rights of minority groups and affirmative action, entrusting civil rights enforcement to its foes (eg, Attorney General Jeff Sessions), banning residents of Muslim-majority countries from entering the USA, packing the federal judiciary with opponents of civil, voting, and reproductive rights, and focusing his 2020 election strategy on racist fear-mongering.

Many of President Trump's policies have yet to extract their full toll of ill-health. Some of the damage, as in the case of climate change, will last generations.

The Trump era in historical context

The disturbing truth is that many of President Trump's policies do not represent a radical break with the past but have merely accelerated the decades-long trend of lagging life expectancy that reflects deep and long-standing flaws in US economic, health, and social policy. These flaws are not only evident in faltering longevity—and the especially sluggish progress in reducing deaths amenable to health care[24]—but also in the widening gaps in mortality across social class and geography and the chronically high mortality of Black and Indigenous people.

Trump gained from the public dissatisfaction with the status quo, while his electoral opponents (in both the primary and general elections of 2016) offered little break from the failures of past administrations. Focusing narrowly on Trump's policies and rhetoric, while ignoring the failings that precipitated his election, risks obscuring the causes and remedies for the long-term downward trajectory of health in the USA.

Two waves of progressive legislation—President Franklin D Roosevelt's (in office 1933–45) New Deal in the 1930s and President Lyndon Johnson's (in office 1963–69) Great Society and civil rights measures in the 1960s—strengthened social and labour protections, redistributed income and other resources downward to those who need it most, curbed corporate abuses, and, in the Johnson era, initiated large-scale government health programmes and extended social and political rights to African American people and other minority groups. Between 1961 and 1969, the number of people in the USA living in poverty decreased from 40 million to 24 million, US hospitals were desegregated, infant mortality (ie, number of deaths in the first year of life per 1000 live-births) fell by 17%, and the mortality ratio between Black and white infants decreased. In the former slave states in the south of the USA, the number of African American people elected as state legislators increased from three in 1965 to 176 in 1985.[25] Even under President Richard Nixon (in office 1969–74), whose so-called war on drugs initiated mass incarceration, societal progress was made—eg, the US Supreme Court legalised abortion and Congress established the EPA and the Occupational Safety and Health Administration, providing landmark environmental and occupational health protections

The expansion of the welfare state, civil rights, and environmental regulation during the 1960s and 1970s substantially improved population health.[26] However, faced with economic stagnation and mounting inflation, President Jimmy Carter (in office 1977–81) pushed to reduce government deficits through spending cuts, and backed away from ambitions to expand social programmes.

In 1980, the election of President Ronald Reagan (in office 1981–89) signalled the end of the New Deal and civil rights order and a decisive adoption of neoliberal policies that eroded and privatised social programmes, reduced taxes on high-income individuals and corporations, weakened labour and environmental protections, and intensified the war on drugs. Even as productivity grew, the rewards flowed to corporation owners, wages plateaued, job security became increasingly precarious, and US longevity began to lag.

Although President Bill Clinton (in office 1993–2001) rejected many harmful environmental policies and efforts to impose conservative social values that were promoted during the Reagan and Bush (in office 1989–93) eras, he embraced key aspects of the neoliberal, pro-corporate agenda: pushing through the North American Free Trade Agreement (1994) and an updated General Agreement on Tariffs and Trade (leading to the establishment of the World Trade Organization in 1995) that dropped trade protections and weakened unions; deregulating banks and telecommunications firms; imposing time limits and other restrictions on welfare benefits and nutrition assistance; and passing a racially charged tough on crime bill (officially called the Violent Crime Control and Law Enforcement Act of 1994). Stock prices rose rapidly, income and wealth inequalities widened, and prisons filled up with people of colour.[27] Many people in the USA suffered the negative effects of globalisation and were left without adequate government supports.

President Barack Obama (in office 2009–17) made expanding health coverage a key component of his 2008 presidential campaign. But the 2010 ACA owed more to neoliberal tenets than to the progressive precepts of the Roosevelt era. Although the reform expanded coverage, it left nearly 30 million uninsured and the new public dollars it offered were funnelled through private insurers whose exorbitant overhead and profits drain funds before they reach the clinic. Meanwhile, a growing number of people in the USA were underinsured—ie, covered but still unable to afford health care, as rising co-payments and deductibles obstruct care for all but high-income individuals, who consume a growing share of national health expenditures.[28]

Panel 3: A century of exploitation and neglect in Puerto Rico

The plight of Puerto Rico's 3·1 million residents (an additional 5·6 million Puerto Ricans live on the US mainland) arises from the confluence of neocolonialism, neoliberalism, and racism.

In 1898, a year after Spain granted Puerto Rico autonomy after nearly 400 years of oppressive military rule, the USA annexed the island following the Spanish–American War. One year later the US devalued the local currency, enabling mainland firms to buy much of the arable land and industry at steep discounts. In 1917, to bolster the pool of military conscripts, the US granted Puerto Ricans citizenship but not voting rights. Thirty-five years later Puerto Ricans were allowed restricted self-governance under direct congressional rule, a situation that persists.

In the 1970s, Congress offered tax breaks to pharmaceutical and apparel factories relocating to Puerto Rico but phased them out in the 1990s after a backlash from other businesses. Half of the island's manufacturing jobs soon disappeared, its gross domestic product plummeted, and its government began a cycle of borrowing funds at increasingly prohibitive interest rates.

Traditionally, Puerto Rico considered health care a human right and its strong, regionalised system of free public clinics and hospitals focused on preventive care. In the 1970s, private providers entered the market and selected patients who were relatively healthy or wealthy, leaving the patients who were sick, poor, or older to the public sector. The result was underfunding of the public system, low salaries for its personnel, and care-rationing. This situation elicited calls for reform and, in 1992, islanders elected a physician as governor who promised to fix a health-care system in crisis. However, instead of boosting the public sector's funding, his government, in line with neoliberal orthodoxy, sold most of the public hospitals and medical centres to private investors and used public funds to purchase care through for-profit insurers. The privatised system was more fragmented, inadequate, and costly than the public system it replaced, forcing the government further into debt. Subsequently, the newly dominant for-profit health plans, citing inadequate reimbursement, began to cut, delay, and deny care; underpaid doctors fled the island—more than one-third left over a decade.

The US' unfair treatment of its colonial territories in health-care financing exacerbated the economic uncertainty and austerity imposed on Puerto Ricans. Medicare payment rates for seniors' care (aged ≥ 65 years) are approximately half of mainland levels. Federal funding for the island's Medicaid programme is far lower than for states,[29] resulting in a less extensive programme with greatly reduced benefits for the 43% of island residents living in poverty, a poverty rate that is twice that of the poorest US state. The chronic underfunding of health care helped deepen the island's debt crisis that forced the government to default on debts and file for bankruptcy in 2017.[30] To oversee debt restructuring Congress established a fiscal oversight board run mostly by Wall Street executives.

In 2017, Hurricane Maria struck, causing 4645 deaths on the island (70-fold higher than originally estimated) and devastating communication, electrical, water, transportation, agricultural, and health-care systems. The Trump administration's inept and insufficient response reflected the president's disregard for the facts, people of colour, and the island's predicament. Despite catastrophic damage, the oversight board proposed harsh fiscal austerity, mandating deep cuts to health care, pensions, and education, including a 56% cut imposed on the public university system.[31] It also forced the island to raise sales taxes higher than in any US state, earmark the revenues to repay bondholders, cut taxes on multinational firms, and privatise government-owned industries. The Trump administration's unremitting hostility toward Puerto Ricans was also reflected in its 2019 proposal to cut "excessive and unnecessary"[32] food assistance for more than 1 million Puerto Ricans,[32] and Trump's threat to block disaster relief for floods in the US Midwest if the package also included funding for the hurricane recovery in Puerto Rico,[33] a position he reversed just before the 2020 election—apparently to gain favour among Puerto Rican voters in Florida.

Puerto Rico's high poverty rates, older population (due to an exodus of young people, including health professionals), and underfunded health-care system made it vulnerable to COVID-19. Realising the epidemic's threat, and that federal help would not come, the local government and private citizens took aggressive preventive measures (eg, imposing a lockdown in March, 2020, earlier than elsewhere in the USA) that initially kept cases and deaths low. However, cases spiked in July and August, 2020, as the island reopened to tourists.

Solving the societal challenge in Puerto Rico will require major political changes. Obtaining statehood, a step favoured by one of the island's major political parties (the New Progressive Party), would help ameliorate federal funding inequities. Other parties favour a renegotiated US Commonwealth status or independence. To be effective, political solutions must end draconian austerity and privatisation efforts and reject racist attitudes that blame Puerto Ricans for the results of 120 years of exploitation and neglect by a colonial power.

Moreover, the ACA's provider-payment strategies reinforced decades of market-oriented reforms that made profitability the fundamental measure of performance, drove the commodification of care, and increasingly vested control in investor-owned conglomerates. Commercial interests have, for decades, promoted a health-care paradigm overly reliant on biomedical interventions, particularly pharmaceuticals, at the expense of holistic approaches to care and attention to social determinants of health.

The actions of the Trump administration have had a profound negative effect on US society. An emboldened

plutocracy, under guise of deregulation and austerity, has augmented its wealth and power by re-regulating markets to their advantage and adjusting government budgets for their own gain. Under this type of governance, wealthy firms and families receive generous government transfers (eg, large farm subsidies have gone to the wealthiest agricultural firms and farming families), an increasing proportion of the US population feels abandoned by the government (eg, millions denied welfare and nutrition support), rural and inner-city populations face local hospital closures, urban dwellers are displaced by rising housing prices, job opportunities have disappeared in the deindustrialised Midwest, US citizens in Puerto Rico have been consigned to neocolonial status (ie, ruled by the US Federal Government, but denied representation in Congress, or the right to vote in the presidential election) and neglected in the aftermath of Hurricane Maria in 2017 (panel 3),[29–33] and treaties with Native Americans have been abrogated and their lands are despoiled.

The social divides of racism and xenophobia affect health, directly, through structural and interpersonal discrimination and, indirectly, as political stakeholders exploit them to diminish the social solidarity required for a communitarian approach to health and health care. Trump's adoption of white supremacist appeals to incite low-income white people to blame their plight on low-income people of colour is singularly harmful and tragic. He gained his largest electoral margins in 2016 in counties with the worst economic and mortality trends[34] and proceeded as president to dismantle social and environmental protections that would benefit those communities.

Section 1: The missing Americans

COVID-19 and life expectancy declines in perspective

The global COVID-19 pandemic has had a disproportionate effect on the USA, with more than 26 million diagnosed cases and over 450 000 deaths as of early February, 2021, about 40% of which could have been averted had the US death rate mirrored the weighted average of the other G7 nations.[35]

Many of the cases and deaths were avoidable. Instead of galvanising the US populace to fight the pandemic, President Trump publicly dismissed its threat (despite privately acknowledging it),[36] discouraged action as infection spread, and eschewed international cooperation. His refusal to develop a national strategy worsened shortages of personal protective equipment and diagnostic tests. President Trump politicised mask-wearing and school reopenings and convened indoor events attended by thousands, where masks were discouraged and physical distancing was impossible.

The COVID-19 pandemic is one of many US health failures. The fact that COVID-19 affects Black, Indigenous, and Latinx people disproportionately has reinforced long-standing health inequities driven by racially patterned disparities in housing,[37] wealth, employment, and social and political rights.

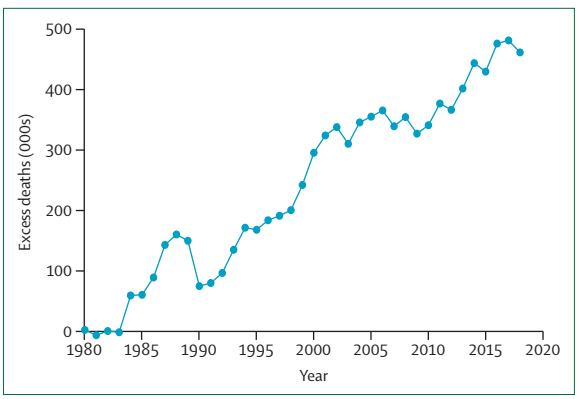

Figure 2: **Excess deaths each year in the USA relative to other G7 countries average (1980–2018)**

Declining US longevity between 2014 and 2017, and the minimal uptick in longevity in 2018, attracted substantial media attention. However, a focus on these recent trends risks obscuring how far the USA lags behind other high-income nations (figure 1), and how long these cross-national gaps have been in the making. Life expectancy in the USA was average among high-income nations in 1980, by 1995, it was 2·2 years shorter than the average of other G7 countries, and by 2018, the gap had widened to 3·4 years.[4]

The extent of difference can also be quantified as the number of missing Americans—ie, the number of US residents who would still be alive if age-specific mortality rates in the USA had remained equal to the average of the other six G7 nations. By this measure, in 2018 alone, 461 000 Americans went missing, an annual figure that has been increasing since 1980 (figure 2, appendix pp 2–3).[38] Most of the US mortality excess is among people younger than 65 years. If US death rates were equivalent to those of other G7 nations, two of five deaths before age 65 years would have been averted. To put this number in context, the number of missing Americans each year is more than the total number of COVID-19 deaths in the USA in all of 2020.

See Online for appendix

Even before the COVID-19 pandemic, the crisis of premature mortality in the USA affected most demographic groups (figure 3), with the exception of Asian American and older Hispanic people whose lower than average mortality rates are thought to reflect a so-called healthy immigrant effect (ie, the health advantage of people who are able to endure the rigors of migration) and the avoidance of unhealthy behaviours. Black, Native American and Alaska Native people were the demographic groups most affected by premature mortality—eg, death rates for Black people in the USA at ages 25–29 years are 4-times higher than the average of the other G7 nations and, for Native American and Alaska Native people deaths rates at ages 25–29 years are 7-times higher than this average. However, mortality

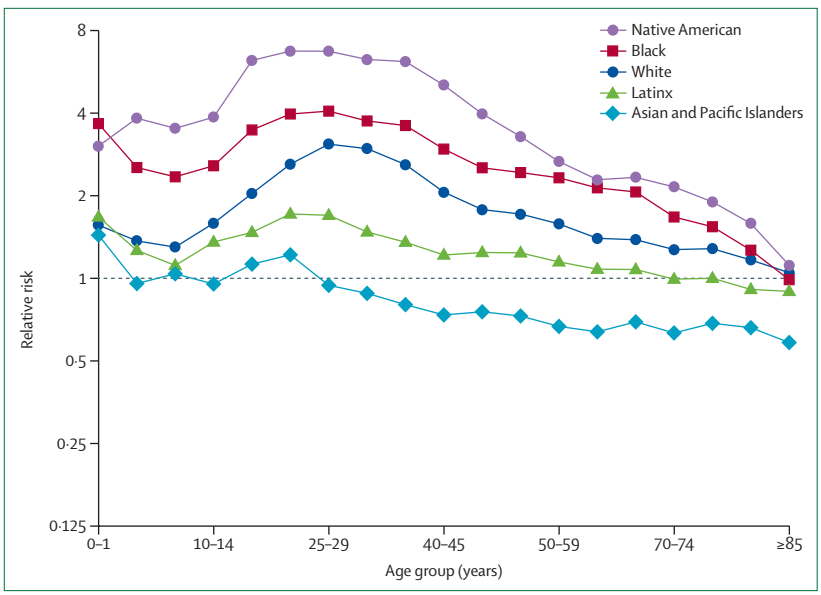

Figure 3: **Excess mortality in the USA relative to other G7 countries by age and race (2017)**

rates are also high for white people of all ages and for Hispanic people younger than 70 years.

Deaths of despair and structural racism

What explains the poor health statistics of the US population? Analyses of cause-specific mortality have found increases in fatal substance use and death by suicide since 1999—conditions that economists Anne Case and Angus Deaton labelled "deaths of despair".[39] Their initial report highlighted an epidemic of such deaths among middle-aged (aged 45–54 years) white US residents with low amounts of formal education.

However, studies have found concerning mortality trends for every racial and ethnic group,[40–42] and increases due to a broad spectrum of chronic conditions. Midlife (aged 25–64 years) mortality among Native Americans has risen steadily since 1999, whereas midlife mortality increases among non-Hispanic white people commenced around 2010, for Hispanic people in 2011, for non-Hispanic Black people in 2014, and for Asian and Pacific Islanders in 2015.[40] Before the COVID-19 pandemic, midlife mortality for Native American and Alaska Native people was 59% higher and for non-Hispanic Black people was 42% higher than for non-Hispanic white people. Black women are 3·2 times more likely than white women to have a pregnancy-related death, similarly, Native American and Alaska Native women are 2·3 times more likely.[43]

COVID-19 has increased the longevity gap between Black and white people by more than 50%.[44] Overall age standardised COVID-19 mortality rates for people of colour are 1·2 times to 3·6 times higher than for non-Hispanic white people. But disparities are far greater in younger age groups (eg, a 2·4–9·0 times difference among people aged 35–44 years) underscoring the importance of residential crowding and employment in low-status jobs that preclude physical distancing. Overall, in the USA, Black and Latinx people have incurred more total years of potential life lost than white people because of COVID-19, although the white population is three to four times larger.[45]

White people had a relatively early increase in opioid overdose deaths, partly because of their preferential access to prescription opioids.[46,47] Pharmaceutical company marketing practices initially targeted insured (predominantly white) patients. Lax federal regulation of opioids, and the racist perception that white people were less addiction-prone than Black people, further fuelled the epidemic.[48] Yet fatal overdoses now are increasing fastest among middle-aged (45–64 years) Black men and, in several big cities, overdoses claim mainly Black lives.[49] This racial crossover could have arisen, in part, from the substantially higher incarceration of Black men in the USA, which puts them at risk for post-incarceration overdose deaths precipitated by lowered physiological tolerance on release from prison and exposure to ultra-potent fentanyl in street markets.[50,51]

The "deaths of despair"[39] formulation was an important contribution, locating the root causes of rising mortality in a changing society—ie, deindustrialisation and declines in unionisation that shrunk opportunities for white people who did not have a higher (ie, post-high school) education.[52,53] However, although the media and many policy makers have focused on epidemic despair among working-class white people, despair is not exclusively, or even mainly, a white problem; the endemic excess mortality of Black and Native American and Alaska Native communities is arguably also due to despair.

Two decades before Case and Deaton's description of deaths of despair,[39] William Julius Wilson, a leading African American sociologist, noted the link between the loss of manufacturing jobs in Black communities in urban areas and many negative health and social effects.[54] However, the consequences of privation and economic dislocation rarely featured in popular or academic explanations of epidemics of crack cocaine, heroin, and HIV that were prevalent in Black and Native American and Alaska Native communities.[55] Instead, these epidemics and endemic alcoholism and violence were blamed on individuals' pathology, cultural inadequacies, and criminal tendencies, pathologies more appropriately viewed as the consequences of trauma and despair rooted in the USA's history of land expropriation, genocide, and slavery.

Paradoxically, some privileges available to white people have contributed to adverse health outcomes. Their preferential access to opioid prescriptions helped drive the opioid epidemic. Similarly, the rate of death by suicide among white men is linked to their high rate of gun ownership, which has been encouraged by political

and gun marketing messages about the need to defend themselves against others, messages that have also forestalled gun control. These appeals carry a subtext of the need of white men to defend their status in the racial hierarchy.[56] White people have also reaped benefit and harm from federal highway and housing policies that subsidised white suburban development and car ownership at the expense of public transportation and walkable urban spaces, pushing up rates of motor vehicle injury, obesity, and diabetes.

Growing disparities by socioeconomic status and geography

Lagging life expectancy in the USA has coincided with growing income-based and education-based mortality gaps among adults. These inequalities in mortality mirror widening economic inequality, with rising incomes for the wealthiest decile of the population (and huge gains for the very rich), but stagnant real incomes for the bottom 50%. By 2014, the life expectancy of the wealthiest 1% of men was 15 years longer than that of the poorest 1%; the difference for women was 10 years.[57] Between 2000 and 2014, adult life expectancy increased by over 2 years for people in the top half of the income distribution, while the lower half of the income distribution had little or no improvement, and mortality increased among low-income white women.[48,52,58]

Geographical disparities in health have also grown and differences in life expectancy between the poorest and richest US counties have increased since 1980,[58–60] driven partly by a widening urban–rural health divide.[61] Even in urban areas, mortality rates have greatly declined in some cities but not others and location is of major importance for low-income populations. Mortality differences between US cities are driven by differences among their poorest residents,[58] suggesting that deficiencies in local policy and environmental conditions, particularly residential segregation,[62] harm the poor more than the affluent.

Economic opportunity and health

Economic opportunity affects risk behaviours and health outcomes. In US counties that lost manufacturing jobs in the 2000s because of trade liberalisation, middle-aged male mortality worsened, marriage rates declined, and out-of-wedlock births rose as few men were able to find long-term employment.[53,63] Life expectancy fell in areas most affected by deindustrialisation,[64] with rising opioid overdose deaths (which have been linked to auto plant closures)[65] being a big contributing factor. Decreasing incomes and the growth of incarceration have also combined to exacerbate this problem.[66] Declining life expectancy in rural areas between 2009 and 2014[61] coincided with losses in economic opportunity, similar to the losses of manufacturing jobs in urban areas in the 1970s and 1980s that triggered epidemics of drug use and violence in Black communities.

However, not all regions with falling economic opportunity show these trends, which suggests the importance of local policy factors. For instance, suicide rates among adults who do not have a college education fell in states that ameliorated poverty by increasing their minimum wage and Earned Income Tax Credit (ie, income supplements available to some low-income workers).[67] Since the 1970s, life expectancy has stagnated in states implementing conservative policies, whereas it has improved in states that implement relatively liberal policies. Had all states followed the liberal states' longevity trends, US life expectancy would have been approximately 2·5 years longer in 2014—ie, about the same as other high-income nations.[68] Similarly, a cross-national comparison suggests that the weaker provisions for income support for people who are unemployed, ill, or older accounts for much of the lagging longevity in the USA.[69]

The regulatory state in the USA is also weaker than in many peer nations. Although regulation and taxation greatly reduced US motor vehicle and smoking-related mortality in the 1960s–90s, failure to regulate firearms, obesity-inducing foods, and prescription opioids fuels the epidemics of violence, diabetes, and overdoses that have contributed to the USA's excess mortality rate over the past few decades.[58,70–73]

Health and politics—a negative feedback loop?

Many of the adverse health and social trends preceded and presaged President Trump's election. His county-level vote share in 2016 was closely correlated with mortality trends.[34] Counties in which more than 60% of people voted for Trump had higher life expectancy in 1980 than those counties in which more than 60% of people voted for Clinton. However, by 2014, the Trump counties lagged more than 2 years behind counties that had voted for Clinton (Bor J, unpublished; figure 4).

The neoliberal policies that inflicted economic hardship and worsened health also helped precipitate the rightward

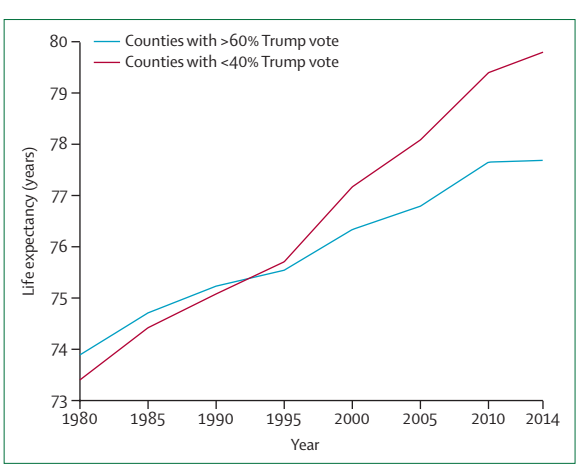

Figure 4: **Trends in life expectancy in counties that voted predominantly for or against Donald Trump in the 2016 election**
Data from Commission analysis of county-level voting and mortality trends.

For **county-level voting trends** see http://uselectionatlas.org

political shift that enabled Trump's election, what might be labelled a politics of despair. Among white-majority congressional districts, those suffering job losses linked to trade liberalisation with China were more likely to elect conservative Republicans to Congress and see an increase in the Republican vote share in the 2016 election.[74] These patterns have historical precedent.[75] Cities with high mortality rates in late-Weimar Germany also bore the greatest burden of economic dislocation due to austerity policies and subsequently became the growth centres of the Nazi Party between the 1930 and 1933 elections.[76] In the UK, austerity measures[77] and increasing deaths of despair[78] were linked to support for Brexit.

By contrast, job losses in majority non-white districts led voters to choose more liberal Democrats.[74] The divergent responses of white and non-white voters to economic distress signals the power of diversionary racist and nativist appeals. Such appeals, which have animated the backlash of white people against the welfare state since Nixon, became even more explicit under Trump. Low-income white people suffering the fallout of decades of austerity and neoliberal policies have often voted for austerity, swayed by their misperception that progressive economic policies mainly benefit people of colour.[79]

Ironically, the ascendance of right-wing populism and Trump's weakening of the US Government's role in protecting health are likely to exacerbate the income and place-based health disparities that harm many of his voters. A negative feedback loop—with low-income white people helping to stifle demands for vital public investments—risks inflicting additional and long-lasting damage to their health and wellbeing.

Responding to the Trump administration's health-harming policies, some state and local governments have stepped in to protect their residents, but have done so unevenly. Some have attempted to maintain environmental and health insurance regulations, fund health insurance expansions, and protect immigrants. However, other local authorities have done the opposite by imposing work requirements on Medicaid enrollees, restricting access to abortion and contraception, and collaborating with federal agencies in apprehending and detaining immigrants.

This geographical policy divergence continues a trend of devolution of responsibility for regulation and social service provision from federal to state and local levels. States and cities that are considered to be relatively liberal spend more on welfare and education when compared with conservative regions, investments that have been linked to improved health[69] and reduced mortality from coronary heart disease and suicide.[80] Conservative states and cities have cut taxes, social programmes, and regulations, often to attract corporate investment. Moreover, efforts in Republican-controlled states to consolidate political power through gerrymandering and obstructing minority voting[81] threaten to perpetuate underinvestment in public goods, racial inequities, and geographical health divides.[82]

If there is not a major reversal of federal policy, the drivers of US health stagnation are likely to persist. The increasing precarity of work in the so-called gig economy (ie, an economy based on short-term freelance work rather than permanent jobs) and job losses associated with automation, further threaten economic security. Persistent wealth gaps and other manifestations of structural racism will continue to privilege white people. Mortality trends will continue to favour cities where resurgent tax bases enable stronger public health and social programmes, which will widen existing geographical health disparities. Environmental degradation of rural areas exploited as corporate dumping grounds for agricultural and extraction-industry pollutants will harm health for generations. Finally, as seen with the unprecedented wildfires in the west of the USA in 2020, climate change will increasingly threaten cities, suburbs, and rural areas, with the poorest locales least able to adapt. Continuing down this road would lead to continued decline in health, widening health inequalities, and ever more missing Americans.

To repair health deficits in the USA, we must redistribute wealth and income through taxation, fortify social programmes and regulation, remediate the structural racism that afflicts Black, Latinx, and Indigenous people, and heal US democracy by eliminating obstructions to voting.

Section 2: White supremacy and the history of racism in the USA

> "Our nation was born in genocide when it embraced the doctrine that the original American, the Indian, was an inferior race. Even before there were large numbers of Negroes on our shores, the scar of racial hatred had already disfigured colonial society."
>
> *Martin Luther King Jr*[83]

The scar of racial hatred that came from the wounds of genocide and slavery, and extended through the exploitation of immigrant labour, remains a cardinal feature of US society. Centuries of systemic racism have produced obvious racial inequities in premature death.

The intersecting epidemics of COVID-19 and police brutality in 2020 disproportionately killed people of colour. Hospitalisation rates for COVID-19 are 4 to 5 times higher among Black, Native American and Alaska Native, and Latinx people than among European Americans,[84] largely because of residential crowding and employment as low-paid, front-line essential workers. Disregard for implementing appropriate infection control measures at high-risk worksites (eg, nursing homes) and penal institutions has compounded these inequities. COVID-19 incidence is 5 times higher in prisons (exceeding 65% in several prisons)[85] than in the non-incarcerated population of the USA and jail-acquired infections have accelerated community spread.[86] At current rates, 96 of every 100 000 Black male infants will eventually be killed

by the police, a rate 2·5 times higher than that for white men; Native American and Alaska Native and Latinx male individuals are also at an elevated risk, as are American Indian and Alaska Native women.[87]

Along with harming the health of people of colour, the psychological imprint of racism deforms societal values and policy to the detriment of all people living in the USA.[88] Cynical politicians, who have long fuelled racial enmity, undermined social solidarity, and weakened support for health and social programmes, set the context for the election of President Trump.

Racism before and during the Trump administration

White supremacy and the long history of separate and unequal

Health disparities in the USA began with the colonisation of the Americas by Europeans, who exterminated Native American people for the purposes of expropriating their land and enslaved millions of African people to generate wealth. Both the institution of slavery and open warfare on Native American nations ended by the conclusion of the 19th century. However, white supremacy (the ideology of the superiority of white people of European ancestry and the wielding of state and institutional power to subordinate people of colour) persists in society. Nowadays, racism continues to shape the social and structural conditions that are the substrates for health inequities—eg, racial segregation in housing, education, and health care; mass incarceration; and the widening wealth gap between white people and people of colour.[89]

The social and physical marginalisation of Native American people and their displacement from tribal land was implemented through the establishment of Indian reservations, boarding schools, and health services.[90,91] Treaties between the USA and tribal nations (a government-to-government relationship) obligate the US Federal Government to provide health care for tribal citizens as partial compensation for the seizure of their land and resources. Although the federal government created the Indian Health Service (IHS) in 1955 to provide services to Native Americans living on or near reservations and to Alaska Natives, congressional appropriations for the IHS have been perpetually inadequate to meet the needs of these populations.

Similar to how treaties did not end the deprivation of Native Americans, the surrender of the Confederate States of America in 1865 did not end the subordination of Black Americans. Liberation of Black people advanced during the brief Reconstruction period after the American Civil War (1861–65). However, subsequently, former Confederate states reversed most of these gains by enacting Jim Crow laws that enforced racial segregation, causing Black people to be subjected to mob violence, including lynchings from the Ku Klux Klan and other domestic terrorists.

White supremacist resistance to the emancipation of Black people after the Civil War also laid the foundation for the current racialised mass incarceration. In 1865, the 13th Amendment to the US Constitution abolished involuntary servitude except as a punishment for crime. Former slave-owners, facing the loss of their workforce, weaponised this clause to implement a modified form of slavery. Vagrancy statutes made it a crime to be unemployed, forcing many newly emancipated Black labourers to return to their former owners under contract, or be incarcerated and leased-out for labour, a practice known as convict leasing. Convict leasing established a precedent for modern-day prison labour practices; firms, including for-profit prisons, still profit from the labour of inmates paid far less than minimum wage and are exempt from labour protections.[92,93]

Similarly, the militarisation of local policing, now a major source of racial conflict, dates back to slavery and the Jim Crow laws. Slave patrols, organised to apprehend and inflict extrajudicial summary punishment on runaway slaves, constituted much of the early policing in the southern states of the USA. In the period after the Civil War, when most municipal policemen in the northern states did not carry guns, southern police were equipped with firearms to suppress the resistance of Black people to Jim Crow laws and of Native Americans to the expropriation of their lands.[94]

Medical science after the Civil War was also tainted by white supremacy. The eugenics movement, which began in the late 1800s and persisted until World War 2, promoted pseudo-scientific assertions of inherent white superiority. Despite eugenics being discredited, it contributed to a medical culture that continues to view race as a genetic rather than a social construct.[95] This legacy includes widely accepted practices such as routinely adjusting normal values for spirometry by race, which originates from Thomas Jefferson's discussion of enslaved peoples' deficient lung function and a later researcher's documentation of the lower than average lung volumes of Black people. Both men were slave-owners who attributed the differences to innate inferiority rather than oppressive work and living conditions.[96]

20th-century setbacks and progress

Racist policies in the USA were hardly limited to the southern states. President Roosevelt's Social Security Act of 1935—a pillar of the New Deal—excluded farm labourers and domestic workers (most of whom were Black) from ageing and unemployment insurance.[97] Roosevelt also ordered the mass internment of more than 110 000 Japanese Americans during World War 2, a sanction that German Americans and Italian Americans were spared. The 1946 Hill–Burton Act, which provided federal funds to remedy a shortage of hospitals, included a separate-but-equal provision that allowed hospitals to maintain racially segregated facilities[98]—a provision included to appease the southern Democrats who were supportive of social programmes that benefited white people but insistent on maintaining Jim Crow laws of segregation. Segregated hospitals also perpetuated a

segregated heath workforce,[99] excluding Black physicians from practicing at facilities that were predominantly caring for white patients, including in many hospitals outside of the southern states.

Segregation was also prevalent in medical societies and medical education. Until the mid-20th century the American Medical Association (AMA) effectively barred Black physicians from membership,[100] a prerequisite for gaining hospital-admitting privileges in some regions. Almost all Black physicians were educated at Howard University College of Medicine (Washington, DC) and Meharry Medical College (Nashville, TN), two historically Black institutions. Johns Hopkins University (Baltimore, MD) graduated its first Black medical students in 1967.[101]

The mass mobilisation of the civil rights movement during the 1950s and 1960s brought changes in society and medicine. The 1964 Civil Rights Act and 1965 amendments to the Social Security Act (which established Medicare and Medicaid) barred segregated hospitals from receiving payments from public insurance programmes. Medical schools initiated affirmative action programmes, altering their outreach and admissions practices to increase diversity. Consequently, the number of Black, Native American and Alaska Native, and Latinx medical students matriculating at US medical schools tripled from 2·9% in 1968 to 8·6% in 1971.[102]

The health of Black people improved following enactment of these civil rights laws and policies, especially in Jim Crow states.[103] Yet, the design of Medicare and Medicaid was tarnished by racism. The US Federal Government took sole responsibility for Medicare, a relatively generous programme for older people, whose initial beneficiaries were mostly white, as relatively few African Americans were living long enough to qualify. Administration of Medicaid, the programme for low-income people, who were disproportionately Black, was delegated to state governments, many of them overtly racist, resulting in stringent eligibility and payment policies that restricted access to care.

The white backlash

Extension of political rights and social programmes to Black people triggered a white backlash against public programmes that were, inaccurately, portrayed by politicians as benefiting primarily Black people and immigrants.[97] The influential 1965 Moynihan report[104] that blamed Black poverty on the alleged pathologies of Black families provided intellectual justification for the backlash.

The backlash gained momentum with President Nixon's 1971 war on drugs that villainised Black communities and initiated a sharp upturn in incarceration. As Nixon's chief domestic policy aide later averred, the war on drugs was driven by racist intent: "Nixon…had two enemies: the anti-war left and black people…We knew we couldn't make it illegal to be either against the war or black, but by getting the public to associate the hippies with marijuana and black people with heroin, and then criminalising both heavily, we could disrupt those communities. We could arrest their leaders, raid their homes, break up their meetings, and vilify them night after night on the evening news. Did we know we were lying about the drugs? Of course we did".[105]

A decade later, President Reagan's fabrication and rhetorical vilification of a so-called welfare queen—a fictional lazy and undeserving Black woman whose welfare payments were, he implied, stolen from hard-working white people—helped him to his position in the White House. Reagan's dismantling of social programmes harmed low-income US residents of all races but disproportionately affected people of colour. Disparities between Black and white premature death and infant mortality rates, which had narrowed between 1966 and 1980 began to widen in the 1980s, as the social safety net of public programmes and institutions available to support poorer US residents' health and other needs eroded.[106] The incarceration rate doubled during Reagan's term in office, driven by new laws mandating long sentences for many federal crimes, especially for offences involving the use of marijuana and crack cocaine, offences particularly concentrated in African American communities.[107–109]

The 1994 Violent Crime Control and Enforcement Act, authored by then Senator Joe Biden and signed into law by President Clinton (both of whom later expressed some regrets about the law), gave further impetus to mass incarceration. More than 2·2 million people are currently imprisoned in the USA[110,111]—a rate unsurpassed by any other nation. The USA, with 4·5% of the world's population, has 22% of its prisoners. Relative to non-Latinx white people, the incarceration rate is 80% higher for Latinx people (even excluding immigration detention), 323% higher for African Americans, and about 250% higher for Native American and Alaska Native people.[110–112] More than 20% of all African American men, and nearly 60% of African American men without a high school diploma, experience incarceration by age 34 years, a rate five times higher than the rates of non-Latinx white people with similar educational attainment.[113]

Although politicians cited public-safety concerns to justify draconian punishments, evidence to suggest that incarceration reduces crime rates or rehabilitates offenders is scarce.[114] However, it does worsen health problems such as smoking, cardiovascular disease, serious mental illness, and premature death—particularly from drug overdose or suicide.[115] For people exiting jails and prisons, the re-entry process contributes to excess mortality, often due to drug overdose, especially in the 2 weeks following release.[50] Stigma, itself a major determinant of poor health, follows former prisoners as they seek work and re-assimilation into the community, and nearly half of former prisoners report discrimination in health-care settings because of their criminal records.[116] Mass incarceration also harms prisoners' partners,

families, and communities by impoverishing them and disrupting social and family structures.[115]

The white backlash also targeted affirmative action. In 1978, the US Supreme Court ruled in favour of a white student who accused the University of California (Davis, CA) medical school of reverse discrimination for denying him admission while admitting Black and Latinx students with lower grades and admission-test scores. During the following decade the number of under-represented minority students enrolled in US medical schools stagnated, until universities renewed a campaign to diversify their student bodies in 1990. Conservative forces (funded by billionaires including Richard Mellon Scaife and Rupert Murdoch) resisted the campaign with many anti-affirmative-action lawsuits and ballot initiatives. The consideration of race in official state activities (including university admissions) were consequently outlawed in California (1996) and Washington state (1998). Medical school admissions of under-represented minority students promptly fell.[117]

On the health-care financing front, the Reagan administration launched a shift to market-oriented policies that continues nowadays, policies that have redistributed medical resources in favour of affluent and white people. Over the past four decades, health expenditures for high-income communities have grown much more rapidly than for low-income communities.[28] Safety-net hospitals (ie, those that serve people who are uninsured, poor, and communities of colour) have struggled financially and some rural and inner-city areas have lost hospitals and maternity services.[118]

The Obama years (2009–16)

The election of President Obama inspired hope that the USA would confront its legacies of racism and re-expand social programmes. Indeed, Obama increased enforcement of pre-existing civil rights laws and passed the ACA, boosted public spending on health, and narrowed some racial disparities. However, despite the ACA's offer of generous federal funding to cover the costs of expanding Medicaid eligibility, nine southern states with large Black populations continue to refuse the Medicaid expansion, accounting for 90% of all people denied coverage by such refusals.[119]

Moreover, even in states that expanded Medicaid, people of colour are largely consigned to second-class coverage. 74% of non-Latinx white people have private insurance that pays doctors and hospitals higher fees than Medicaid, bestowing preferential access to care,[120] whereas only 56% of Black, 52% of Latinx, and 46% of Native American and Alaska Native people have private insurance (Himmelstein DU, unpublished). As a consequence, the use of physician, hospital, and other care (as measured by total expenditures for their care) remains skewed in favour of non-Hispanic white people (figure 5).

Funding of the IHS also remained inadequate. Mandated to serve the 2·2 million members of the 574 federally recognised tribes, the IHS budget in the 2017 fiscal year, appropriated by Congress in the final year of the Obama administration, was US$5·0 billion. This budget amounted to less than US$3000 per person served by the IHS, approximately one quarter of the average per-capita health spending in the USA (although some patients of those served by the IHS receive care elsewhere as well, somewhat biasing this comparison). In 2019, The Tribal Budget Workgroup estimated that an additional US$2·7 billion would be needed to meet minimal operating needs of the IHS and US$37·6 billion would be required in 2021 to fund operations and investments to address the high health needs and disease burden of tribal populations.[121]

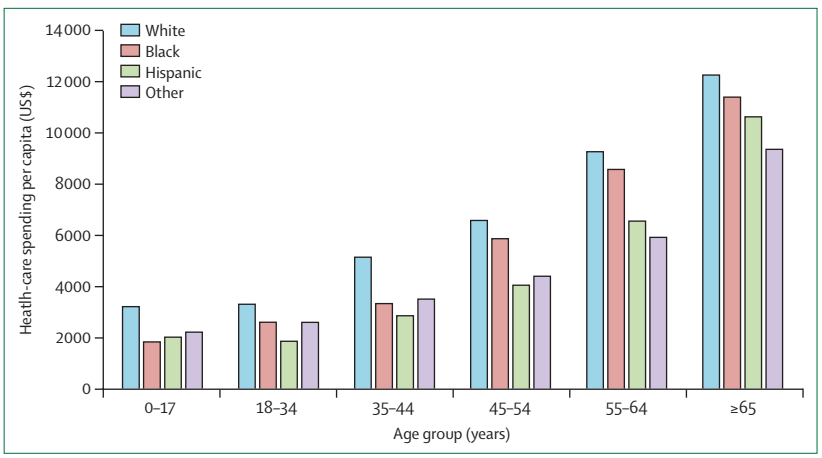

Figure 5: **Per-capita utilisation of care of white, Black, and Hispanic people, and other racial groups (2015–18)**
Data in US dollars per year.

Under the Obama administration, the number of federal prisoners was reduced for the first time in 40 years partly because of the introduction of a clemency initiative and new laws and executive actions that reduce sentences for drug offences.[122] However, extrajudicial murders of unarmed Black men and adolescents continued, worsening the mental health of nearby Black communities[123] and triggering protests. The acquittal of an armed civilian for killing Trayvon Martin in Florida led to the development of the Black Lives Matter movement in 2013, and the 2014 police murders of Michael Brown in Missouri and Eric Garner in New York triggered angry demonstrations against deeply entrenched systems of police brutality.

The structural racism and class-based inequities of US society continued to affect medicine and health during the Obama years. Black and Latinx employees are markedly over-represented among low-paid health-care workers, however, they, along with Native American and Alaska Native people, remain markedly underrepresented in the health-care professions (figure 6). In 1978, 54 of 15 923 (1 in 300) students matriculating at US medical schools were Native American and Alaska Native, a number that fell to 53 in 2014, despite an expansion of medical school enrolment.[127] The number of Black men enrolled in medical schools also fell during this period

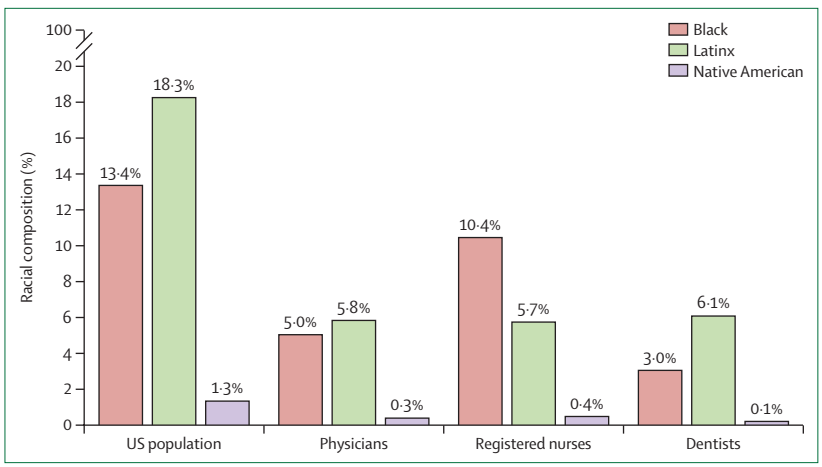

Figure 6: **Racial composition of US population and selected health professions**
Data from K Grumbach, prepared from population data (2018) from the US Census Bureau,[124] physician data (2018) from the Association of American Medical Colleges,[125] and data on dentists and nurses (2011–15, averaged) from the Health Resources and Services Administration.[126]

and class privilege remained a way into the medical profession. More than half of medical students come from families in the top quintile of household income.[128]

The Trump years (2017–20)

The political rise of President Trump was fuelled by his promotion of so-called birtherism—the claim that President Obama was born in Kenya and was therefore ineligible to be president—and the allegation that Obama was Muslim. After assuming office, Trump's rhetoric, which previously included broad hints of racism, escalated to blatantly racist pronouncements, and the affront of his rhetoric was matched by the destructiveness of his policies. In implementing cuts to social programmes (eg, imposing work requirements that restrict eligibility for Medicaid and food assistance) he frequently invoked stereotypes of freeloading people of colour.[129] His profane condemnation of Black athletes protesting police violence, sympathetic portrayals of neo-Nazis and other white nationalists, and vocal support for unregulated gun ownership energise and incite his white conservative base. In counties that hosted Trump campaign rallies in 2016, hate crimes motivated by race were double the rate by comparison with non-host counties.[130] Additionally, the anti-immigrant policies enforced by the Trump administration were promoted using explicitly racist language—eg, characterising Mexican people as rapists and Muslim people as terrorists. To deflect attention from his mishandling of the COVID-19 pandemic, Trump deployed anti-Asian racism, referring to severe acute respiratory coronavirus 2 as the "kung flu"[131] and the "Chinese virus"[132] and blaming Chinese influence for his withdrawal of the USA from the WHO.

The USA's legacy of racism is also evident in other actions by President Trump. In 2017, his reinstatement of the Dakota Access Pipeline and reopening of the Bears Ears National Monument in rural Utah to fossil fuel extraction threaten to defile American Indian lands, water supplies, and sacred sites, actions that repeat the history of US territorial expropriations. In the same year, he denied federal aid to Puerto Rico following Hurricane Maria, despite giving copious aid to Texas and Florida after those states were struck by hurricanes, a decision that cost many lives (panel 3). His dismissive approach to the COVID-19 pandemic as disproportionately affecting Black, Latinx, and Indigenous communities is reminiscent of the USA's failure to intervene with quarantines and vaccines to mitigate smallpox outbreaks among emancipated Black people after the Civil War.[100] In 2020, in response to burgeoning nationwide protests following the police killings of George Floyd in Minnesota, Breonna Taylor in Kentucky, and Rayshard Brooks in Georgia, Trump denigrated the Black Lives Matter protesters, threatened them with violence in an incendiary tweet[133] plagiarised from southern segregationists of the 1960s, and cast himself as a law and order president (despite his own lawlessness), a stance widely perceived to be a caricature of President Nixon.

Even before his repressive response to the anti-police brutality demonstrations, Trump had reversed several Obama-initiated criminal justice reforms—eg, by expanding the use of the death penalty (particularly for drug-related cases),[134] ending the federal oversight of local police forces implicated in civil rights abuses,[135] and reinstating private for-profit federal prisons (and expanding the role of for-profit prisons in immigrant detention) despite their record of abhorrent conditions.[136] However, Trump's support for the 2018 First Step Act—a bipartisan bill that shortened sentences for some federal crimes and increased educational and vocational services for inmates and former inmates—constituted one of the few positive aspects of his domestic policy agenda. He announced a Second Step Act that would reduce barriers to employment for some individuals with criminal records, although this bill has not been passed yet.

Trump's attacks on civil rights have reanimated anti-affirmative action groups, led by Edward Blum, the founder of Students for Fair Admissions.[137] Blum was the plaintiff in the 2013 US Supreme Court ruling that rescinded federal oversight of voting rights in states with long histories of suppressing the Black vote. Turning his attention to affirmative action, Blum recruited a white student to mount a new legal challenge to such practices, which the US Supreme Court turned back by a single vote. Undeterred, Blum organised similar lawsuits against several leading US universities. The Trump administration sided with Blum's ongoing lawsuits, rescinded Obama-era guidelines encouraging schools to consider race and ethnicity in admissions, and compelled the School of Medicine at Texas Tech University (Lubbock, TX) to agree to not consider race or ethnicity in admissions decisions or mention race in

recruiting materials. Crucially, Trump's appointees to the US Supreme Court seem likely to tip the court's balance in favour of conservatism and completely outlaw affirmative action.

President Trump's efforts to roll back the ACA and Medicaid also harm people of colour. Between 2017 and 2018, before the COVID-19 pandemic, the health insurance coverage rate decreased by 1·6 percentage points for Latinx people (equivalent to an extra 1·5 million uninsured) and by 2·8 percentage points for Native American and Alaska Native people, while remaining stable for non-Latinx white people (Gaffney A, unpublished).[138] The number of people who lost health insurance rapidly increased during the COVID-19 pandemic as millions of US residents lost jobs and, consequently, employer-sponsored health-care coverage. Preliminary data show that twice as many Black people as white people lost health-care coverage between June and August, 2020.[139]

A new direction

To achieve health equity, the Biden administration must embark on a process of truth and reconciliation that explicitly acknowledges the roots of inequity in the USA's history of systemic racism. There is a direct line that connects the historical events of genocide and slavery to the modern-day toll of shortened lives extracted from Native American and Black people in the USA.

First, the new administration's policy agenda must adopt an explicitly anti-racist framework. It should commit to compensate Indigenous, African American, and Puerto Rican people for the wealth and education confiscated from (or denied to) those groups in the past. In health care, such compensation should rapidly close the deficits in medical resources by prioritising capital investments in IHS facilities and those serving Puerto Rico, and Black and Latinx communities. Academic medicine must also do its part by committing to training and promoting Black, Latinx, and Indigenous health-care professionals needed to achieve a workforce representative of the whole US population. As an incentive, the US Department of Health and Human Services should require institutions receiving federal health grants and contracts to show progress in this realm—eg, by incorporating medical schools' Social Mission Score (which includes measures of diversity) in National Institutes of Health (NIH) and Centers for Medicare and Medicaid Services review criteria.[140] Similarly, hospitals should be required to target their investments and workforce development programmes to historically marginalised communities.

Second, annual appropriations for the IHS must immediately rise to amounts that are commensurate with need. While moving to enact a truly universal, single-payer Medicare for All programme, the federal government should offer additional incentives for all states to accept the ACA's Medicaid expansion. We also recommend the establishment of a law-enforcement violence prevention unit and a National Center on Anti-Racism and Health within the CDC, as Senator Elizabeth Warren has proposed. The Center should collaborate with educators, researchers, and practitioners to challenge the conventions of race-based medicine and advance understanding of race as a social construct.[141]

Finally, the new administration must introduce measures to address the social and environmental conditions that cause and exacerbate health inequities. These measures should include policing and sentencing reforms (ie, alternatives to incarceration) that will rapidly reduce prison and jail populations by 75% or more (ie, to rates prevalent in the USA before the war on drugs and in Europe today).

Section 3: The assault on immigrants

Anti-immigrant rhetoric was central to the election of President Trump and remained a defining feature of his presidency. At the beginning of his 2016 campaign, he denigrated immigrants from Mexico as rapists, drug dealers, criminals, invaders, parasites, and terrorists and encouraged his followers to embrace this dehumanising perspective. The consequences have sometimes been lethal, as in the case of a mass shooting of Latinx shoppers at a Texas Walmart store in August, 2019, one of the deadliest hate crimes in US history. The shooter, who told police he had targeted Mexican people, had posted a manifesto parroting President Trump's anti-immigrant rhetoric.

On assuming office, President Trump moved quickly to implement draconian enforcement of existing immigration laws and promulgate new anti-immigrant policies (President Biden has reversed many of Trump's actions on immigration and ordered review of others). During the first year of Trump's presidency the number of immigrants under detention increased 40%.[142] By July, 2019, Immigration and Customs Enforcement (ICE) was detaining an average of 55 000 people daily, more than ever before.[143] For-profit prison firms, notorious for their mistreatment of detainees, have been the biggest beneficiaries of these policies.[144]

Trump's actions escalated the injustices on immigrants. However, they built on a long history of scapegoating and harassment of immigrants in the USA. In 2016, the Obama administration deported more than 450 000 immigrants, although it focused deportation efforts on those with criminal records and afforded special protections to several immigrant groups—eg, allowing some undocumented immigrant parents of a US citizen or permanent resident child to remain in the USA for three years, expanding the Deferred Action for Childhood Arrivals (DACA) programme, and deferring immigration enforcement actions against undocumented immigrants from several countries afflicted by natural disasters.

The Trump administration's anti-immigrant policies spanned every stage of the immigration process, from

	Immigration entry to the USA	Immigration integration within the USA	Immigration detention and deportation
Trump administration policies	Refugee bans on some Muslim and African countries, deterring asylum seekers (eg, restricting entry for women facing intimate partner violence, denial of parole, family separations, Remain in Mexico policy)	Attempted termination of special immigration status programmes (eg, DACA, TPS), extreme vetting programmes, delays to H-1B visa programme, Public Charge (ie, reliant on tax-funded programmes)	Everyone as an enforcement priority (eg, ended prosecutorial discretion), increased detention quotas, expanded rates of indefinite detention
Recommended policy changes	Ensure timely and fair processing of asylum applications, revoke executive orders and policies that discriminate on the basis of religion and national origin	Revoke Public Charge rule and assure immigrants' access to health care and nutrition services, end state and local police cooperation with federal immigration enforcement, allow all immigrants to obtain driver's licences, enforce fair labour standards regardless of immigration status, adopt sensitive location policies to prevent immigration enforcement near health-care facilities, schools, places of worship, and courthouses	Minimise immigration detention by pursuing alternatives, end detention and separation of children from their families, reunite separated children with parents, codify in law and enforce current standards for detention facilities and develop higher standards going forward, establish independent medical and mental health oversight boards for detention facilities, terminate detention facility contracts when evaluations show inadequate conditions
Potential actions by health-care facilities and clinicians	Provide medical and psychological evaluations of individuals seeking asylum	Connect immigrants with legal rights and community advocacy groups, ally with broad coalitions addressing immigration and other social determinants of health, avoid recording immigration status in medical records, prepare for interactions with immigration enforcement officers, implement trauma-informed care, inform families that all children are entitled to a free public education and that immigrants are eligible for free COVID-19 vaccination	Provide independent medical review and letters of support to individuals in detention, participate in protests of violations of detainees' human rights, including the right to medical care

DACA=Deferred Action for Childhood Arrivals. TPS=Temporary Protected Status. H-1B=a visa available to temporary workers with special skills or qualifications.

Table 1: **Trump administration immigration policies and recommendations for policy makers and clinicians**

entry and integration within the US, to detention and deportation (table 1). Just 7 days after his inauguration, President Trump issued an executive order entitled Protecting the Nation from Foreign Terrorist Entry into the US,[145] which he termed a Muslim ban. This ban, which is redolent of the Chinese Exclusion Act that outlawed immigration from China and, later, other Asian nations until 1943,[146] prohibited travellers from seven Muslim-majority countries (Iran, Iraq, Libya, Somalia, Syria, Sudan, and Yemen) from entering the USA. He subsequently extended the policy, banning immigration from six additional countries (Myanmar, Eritrea, Kyrgyzstan, Nigeria, Sudan, and Tanzania). At the time that President Biden rescinded the immigration ban on Jan 20, 2021, it applied to nearly one-quarter of the population of the African continent. Trump also progressively lowered the quota of refugees admitted to the USA. Consequently, fewer refugees have been resettled than at any time since 1980 and the USA is no longer the world's top country for refugee admissions.[147] In 2020, the Trump administration exploited the COVID-19 pandemic to expand its ban on immigrants entering the USA, using the justification of protecting public health to deny entry, despite the USA having the most cases in the world.

The Trump administration's numerous efforts to deny entry to asylum seekers triggered many legal challenges. Officials sought to deny asylum to applicants fleeing domestic violence[148] and to deny parole to asylum seekers at low flight-risk (under previous administrations, such migrants would have qualified for release while their case was being processed).[149] Trump's so-called Return to Mexico policy moved asylum seekers awaiting court dates to often-dangerous border towns in northern Mexico, where their safety, and even lives, were endangered.[150] Children as young as 4 months, whose families were seeking asylum, have been separated from their parents.[151] An official audit estimated that at least 3000 children were forcibly separated from their parents and detained before the president's zero-tolerance policy was supposedly ended in June, 2018, amid much criticism.[152] However, evidence presented in court suggested that separations of children from their parents continued after that date and that the number of separated children is probably higher than the government acknowledged.[153]

President Trump's attempted termination of special programmes, such as the DACA and Temporary Protected Status (TPS), also attracted criticism. DACA has allowed some young adults who were brought to the USA as children to remain in the country and pursue education and work. Similarly, TPS afforded such protection to immigrants from some nations that were made unsafe by natural disasters or, less commonly, armed conflict. Trump's proposed changes threatened nearly 1 million immigrants nationwide.[154] Thousands of immigrants with DACA and TPS (and millions of other immigrants) serve as front-line workers in health care, food production and distribution, and other essential industries, exposing themselves to the risk of COVID-19 infection during the pandemic.

Additional policy changes implemented by President Trump threaten the immigration status of migrants with permanent resident status (so-called green card holders) or with valid visas. The administration changed the rules used to assess whether an immigrant is likely to become a public charge (ie, reliant on tax-funded programmes). The new rules would make many families who use

publicly funded services ineligible for re-entering the USA or upgrading their immigration status, curtailing immigrants' participation in health-related programmes such as Medicaid and the Supplemental Nutrition Assistance Program (SNAP).[155] Immigrants' fear and confusion in response to the public charge rule are likely to hamper efforts in identifying and isolating people with COVID-19.

Migrants seeking entry to the USA increasingly find their way barred and those already residing in the country face mounting risks of deportation. The Obama administration's emphasis on deporting individuals with criminal convictions gave way to a policy of deporting persons irrespective of criminal activity, including green card holders and even US military veterans who commit minor infractions.[156] Based on these rules, virtually every non-US citizen could be subject to detention and removal.

The rapid expansion of immigration detention, often in abysmal conditions, has had detrimental health effects, including promoting the spread of diseases such as mumps and measles.[157] As of September, 2019, at least seven children had died of influenza or other illnesses while in immigration custody.[158] Yet the Trump administration rebuffed efforts by medical groups to provide influenza vaccinations to detainees and also resisted urgent calls to release detainees from facilities that have COVID-19 outbreaks. Although lawsuits have forced some facilities to release immigration detainees to reduce the spread of COVID-19, the Trump administration vigorously defended its efforts to detain as many immigrants as possible.

Health effects

Some initial studies have identified associations between President Trump's election and reductions in health-seeking behaviours and worsening health for immigrants and their families, especially among Latinx populations irrespective of immigration status.[159,160] For instance, a cohort analysis of nearly 25 000 deliveries in Texas found that Latinx mothers had delayed their first prenatal visit and received fewer prenatal visits after a rise in anti-immigration rhetoric.[161] These studies add to previous evidence that links exclusionary immigration policies mandating aggressive enforcement and deportation to poor health outcomes,[162] including worsened cardiovascular risk factors, inflammation,[163] anxiety and sleep problems,[164] and pre-term births.[165] Conversely, policies conferring legal protection against deportation for immigrants, like DACA, were associated with improved mental health.[166] The COVID-19 pandemic's disproportionate effect on Latinx people highlights the importance of assuring that immigrants feel safe when seeking medical advice and care.

Long-term health harms will also be caused by the separation of children from parents at the US–Mexico border, which violated both long-standing medical guidelines and the UN Convention on the Rights of the Child (UNCRC). The core principles of the UNCRC include non-discrimination, devotion to the best interests of the child, the right to life, and respect for the views of the child, all of which have been violated at the border by ICE and other agencies. Detained children are at an increased risk for developmental delays, poor psychological adjustment, depression, anxiety, post-traumatic stress disorder, and other behavioural problems.[167] Numerous US medical and scientific groups have issued statements protesting family separations and noting the negative consequences for children's brain development and mental health, including a declaration by the American Academy of Pediatrics that "children…should never be detained, nor…separated from a parent"[168] unless a family court determines that it is in the best interest of the child. Pushback from the medical community has also included demonstrations, notably a protest by hundreds of health-care professionals against the Trump administration's immigration policies during a visit by Melania Trump to Boston Medical Center (Boston, MA, USA).

Practical steps to protect immigrants

Clinicians and public health professionals have worked to support migrant families and ensure that immigration status does not obstruct care. These efforts have included: partnering with legal organisations to do medical and psychological evaluations for asylum seekers, embedding immigration legal-navigators in clinical care settings, ensuring that hospitals are protected from on-site immigration enforcement to the fullest extent permitted by law,[169] and avoiding recording immigration status in medical records when such information is not essential for care.[170]

For more on **how clinicians can shield immigrant patients** see http://doctorsforimmigrants.com/

We have noted our recommendations of steps needed to reverse the harmful effects of the Trump administration policies on immigrants and their communities (table 1). The Hippocratic Oath commits physicians to serve all patients irrespective of where they come from. During this crucial time when immigrants are particularly being ostracised and face substantial adverse health consequences (which have been exacerbated by the COVID-19 pandemic), health professionals have a duty to use their skills and privilege to ensure that immigrant patients receive the best care possible.

Section 4: The modern opioid epidemic

Drug overdose is the leading cause of death for US people younger than 50 years.[171] Although opioid overdose was largely responsible for the declining life expectancy among white people (at least before the COVID-19 pandemic),[172] Black US residents had the sharpest increase in opioid overdose deaths between 2012 and 2018.[173] Since the emergence of COVID-19, 40 of 50 states have reported increases in overdose deaths,[174] which could be attributable to decreased access to treatment and harm reduction services, relapses because of pandemic-related

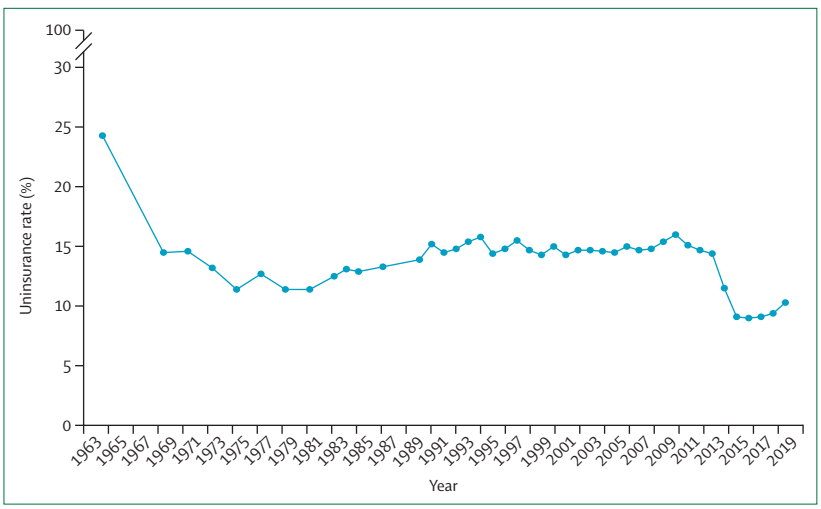

Figure 7: **Percent of US residents without health insurance (1963–2019)**
Data from Commission analysis of data from the Council of Economic Advisors[193] and the National Health Interview.[194]

economic stress and social isolation, and increased variability in the purity of drugs in illicit drug markets.[175]

During the Obama administration, the federal government's approach to substance use disorders began shifting from punishment toward treatment. This shift followed increased media attention on overdose deaths among white US residents. The change in attitude greatly contrasts with the decades-long war on drugs, when racialised images of drug users fostered the criminalisation of drug use and mass incarceration (mostly of Black and Latinx men). President Trump's Opioid and Drug Abuse Commission of 2017, the 21st Century Cures Act of 2016, the 2018 NIH Helping to End Addiction Long-term (HEAL) initiative, and Melania Trump's 2018 Be Best campaign have all focused on enhancing treatment.

Unfortunately, this treatment-oriented response has been applied unevenly and inequitably. Legislators from districts where opioid-related deaths among white constituents were rising often supported expanded treatment, whereas similar increases in mortality among Black constituents were less likely to trigger such support.[176] Harm reduction measures, such as syringe exchange and medically supervised overdose prevention sites, remain illegal in most states. Moreover, pregnant women who use drugs (whose numbers are rising)[177] are increasingly subjected to punitive measures such as criminal prosecution or child abuse reporting, contrary to the advice of major medical and public health organisations.[178,179] Such policies deter women from attending prenatal care visits or engaging in treatment,[180] which can worsen maternal and infant health outcomes.

The situation has been scarcely helped by Melania Trump's widely publicised Be Best campaign. Her public awareness campaign focused on withdrawal syndrome in newborn babies and failed to differentiate between infants exposed to prescribed maternal medications and those exposed to illicit drugs. Most infants with opioid withdrawal were exposed to drugs (eg, buprenorphine) prescribed for their mothers to treat opioid use disorder, a situation in which newborn baby withdrawal is both expected and readily treatable.[181] Yet, rather than highlighting the benefits of treatment, media reports of Melania Trump's high-profile visits to hospitals often featured disturbing images of infants with newborn baby opioid withdrawal syndrome, which could stigmatise treatment with medications and discourage pregnant women from seeking it. Such stigmatisation is redolent of the prenatal cocaine exposure theories (commonly known as the crack baby scare) of the 1980s and 1990s. During that time, preliminary research findings[182] (later recognised as being exaggerated and inaccurate)[183] suggested that cocaine-exposed infants had irreparable damage, breeding fear, and stigmatisation of low-income children and mothers of colour.

Since 2016, other federal initiatives have sought to expand access to medications to treat opioid use disorder and bring new medications and delivery devices to market by streamlining the approval process and augmenting funding for public–private partnerships to develop them. These approaches, while likely to enrich drug firms, risk omitting important social components of treatment and bypassing communities of colour.

Buprenorphine and methadone reduce non-prescribed opioid use and overdose deaths,[184,185] but will not end the overdose epidemic unless reforms to health financing, augmented prevention efforts, and attention to the social roots of drug use are also made. Access to medication treatment remains difficult and racially disparate. Patients must often pay for buprenorphine out-of-pocket and white non-Latinx patients with opioid use disorder are 3–4 times more likely than Black patients to receive buprenorphine.[186,187] Additionally, insufficient resources are available for harm reduction services that reduce the lethality of substance use, reduce the stigma associated with substance use and treatment, outreach to marginalised communities, and mitigate the concentrated poverty and hopelessness that breed drug use.[188]

The pharmaceutical industry has obstructed efforts to shift public funding to these essential social and public health needs or assure that medication-based therapies are affordable. That industry has virtually unchecked power to set drug prices in the USA, and inordinate influence on drug research and regulation, including US Food and Drug Administration (FDA) approvals of opioids.[189] Public research funding (notably the NIH HEAL initiative) emphasises the development of patentable new technologies for the treatment of pain and opioid use disorder; the resulting products will surely be unaffordable to many who need them. Groups that are marginalised by race, gender, sexual orientation, or socioeconomic status are rarely mentioned in opioid legislation.[190]

Bold changes are urgently needed and marginalised groups, patients, and affected communities must be afforded a role in designing and implementing them.

Policy makers should immediately lower barriers to treatment by decriminalising drug use, removing current restrictions that prohibit pharmacies from dispensing methadone and require a special certification for clinicians seeking to prescribe buprenorphine or methadone, allowing supervised injection facilities, and encouraging the distribution of clean injection equipment and naloxone. To guide medical interventions, research should separate out the long-term effects of in utero opioid exposure from co-existing risks such as maternal alcohol and tobacco use and social deprivation.[191] In the longer term, research and policy should prioritise addressing social determinants of drug use and health and promote relevant health and social services, without putting emphasis on expensive new technologies.

Section 5: Slowing the progress toward UHC

In 2014, one year before Donald Trump announced his presidential run, the major provisions of the ACA were implemented. By the time of his inauguration in January, 2017, 20 million US residents had newly enrolled in health coverage, although 28 million remained uninsured.[192]

Against this backdrop, President Trump's health financing policies—engineered to reduce health coverage—seem to be an aberration, a detour from the path toward greater health protection. Yet, the truth is more complicated. Despite Trump's policies being vastly different from previous administrations', they continued neoliberal traditions of deregulation, privatisation, and austerity (for low-income communities) that originated in the 1980s.

Health-care financing before the Trump era

After a half century of failed efforts to enact national health insurance, the 1965 passage of Medicare (for older US residents) and Medicaid (for some low-income US residents), cut the uninsurance rate by approximately half (figure 7).[193,194] Despite hope that additional reforms would complete the transition to UHC, President Reagan's election in 1980 dashed these hopes (panel 4). Reagan's health policies prefigured President Trump's push to privatise Medicare and Medicaid (panel 5),[195–202] cut services for low-income communities, and deregulate insurers and medical providers. The mix of austerity and pro-market policies was advertised as a cure for medical inflation. Yet, US health spending rose during Reagan's presidency and began diverging from that of other high-income nations (figure 8).[4]

The defeat of President Clinton's effort to expand coverage in 1994 stifled progress until President Obama's election in 2008. After fierce debate in Congress, the Democrats passed the ACA. The law halved the number of uninsured people (figure 7), mostly by expanding the Medicaid programme (a provision made optional for states by a US Supreme Court decision in 2012). It mandated that large employers (ie, ≥50 employees) offer coverage and that most uninsured individuals purchase it, created new insurance marketplaces where uninsured individuals could purchase federally subsidised private

Panel 4: **The evolution of US health policy**

In 1948, President Truman's plan for national health insurance (NHI) was defeated in part because of a campaign led by the American Medical Association. This defeat caused the Truman administration to narrow the scope of its proposal, advocating instead for a public insurance plan for older US adults, which became known as Medicare. It was eventually signed into law by President Johnson in 1965 (together with Medicaid, a joint federal–state programme for some people with low incomes). Medicare and Medicaid reduced the ranks of uninsured people, forced hospitals to end overt racial segregation, and increased health equity. However, many people remained uncovered.

In the early 1970s, NHI bills similar to Truman's—and to Medicare for All reforms that are currently under discussion—gained wide support. In response, President Nixon proposed a hybrid alternative built on private insurance, but the Watergate scandal derailed the reform debate. The push for NHI faded under President Carter, and ended with President Reagan's election in 1980.

Reagan's health policies prefigured President Trump's. Similar to Trump, Reagan embraced austerity for Medicaid, eliminating coverage for at least 500 000 people. Between 1981 and 1988, US longevity began to lag and uninsurance rates increased.

Reagan also presaged Trump's efforts to privatise Medicare and Medicaid. As California's governor, Reagan pioneered subcontracting Medicaid to private managed-care firms, offering them capitation payments and the right to keep funds not spent on care. As president, Reagan expanded this Medicaid payment strategy to other states and initiated a similar programme for Medicare. These taxpayer-funded programmes now account for the majority of private health insurers' revenues.

Reagan also initiated a neoliberal approach to health-care infrastructure, ending federal restrictions on hospital expansion and thereby fuelling cost growth. Eliminating analogous state-level certificate-of-need requirements was on Trump's agenda.

Popular demands for universal coverage re-emerged with President Clinton's election in 1992. His reform proposal closely resembled Nixon's public–private model, abandoning the Democrats' long-standing advocacy for NHI. However, the proposal was defeated, a testament to the rightward shift of both major parties.

Health reform returned to the national agenda with the 2008 election. Similar to Clinton, President Obama proposed a hybrid plan that echoed Nixon's. Despite this heterodox lineage, however, when the Affordable Care Act passed in 2010, Republican congressional opposition was unanimous.

Panel 5: Medicare Advantage—privatising publicly financed coverage

The federal Medicare programme covers older US residents (aged >64 years), some people who are disabled, and people with end-stage renal disease. Initially, the programme paid providers directly. However, in 1982, it began offering older people the option of enrolling in private managed-care plans, with Medicare paying the premiums. The private plans, initially called Medicare Health Maintenance Organizations and now known as Medicare Advantage plans, currently enrol 36% of Medicare beneficiaries. In 2019, private insurers derived US$371·4 billion from Medicare,[195] 28·8% of their total revenues.

Fraud and scandal related to the capitated programme was reported from the outset. In the 1980s, the operator of Florida's largest Medicare HMO collected US$781 million from Medicare to cover 197 000 enrollees but neglected to pay doctors and hospitals for their care;[196] the operator then absconded to Spain.[197]

Other private plans reaped profits legally by selecting relatively healthy, low-cost older enrollees, and pushing high-cost patients to transfer to fully public traditional-style Medicare.[198]

Although plans are prohibited from explicitly excluding unprofitable enrollees, they use subtle legal methods that accomplish the same thing.[199] After the government began using enrollees' diagnoses to risk-adjust the capitation premiums, plans began circumventing risk adjustment by recruiting minimally symptomatic older enrollees who require little care but carry particular diagnoses (eg, arthritis) that boost the capitation payments[200] and upcoding (ie, labelling patients with diagnoses that would otherwise be ignored but increase the capitation rates).[201]

These strategies have allowed private insurers to collect far more from the government (US$24 billion annually according to Medicare's official oversight commission)[199] than Medicare Advantage enrollees would have cost if covered by traditional fully public Medicare. Most of the excess payment goes for plans' overhead and profits, estimated at US$1360 to US$1608 annually per enrollee. However, the private plans use a fraction of the overpayments to offer extra benefits like gym memberships, allowing Medicare Advantage plans to outcompete traditional Medicare, despite raising Medicare's costs and restricting enrollees' choice of doctors and hospitals.

coverage, and required insurers to cover a package of essential health benefits and to stop denying coverage to people with pre-existing medical conditions. Finally, the ACA mandated so-called value-based payment reforms for Medicare, and a provision that went largely unnoticed by the media and public imposed a 3·8% surtax on the investment income of high-income US taxpayers. Not surprisingly, the ACA was not well-received by high-income conservatives, despite improving access to care[203] and saving lives.[204]

However, large gaps in coverage and access persisted.[205] 28 million remained uninsured at the time of Trump's election, resulting in an estimated 37 000 premature deaths in 2017.[206] Moreover, the law failed to stem the growing trend of underinsurance (ie, coverage with such high cost sharing that enrollees still cannot afford care).[207] In 2016, more than one-third of adults under the age of 65 years (including 25% of those with insurance) reported problems with medical bills or medical debt and a similar proportion went without needed medical care because of cost.[208] Meanwhile, bankruptcies stemming in whole or in part from illness remained common after the introduction of the ACA.[209]

Trump capitalised, albeit dishonestly, on the dissatisfaction concerning these persistent problems. He vowed to repeal the ACA and promised—atypically for a Republican—to protect Medicaid and Medicare[210] and to fight price gouging by the unpopular pharmaceutical industry. In other words, despite disparaging Obama's ACA, he posed as a health-care populist. Unfortunately, Trump's vow to protect Medicaid and Medicare proved to be a sham and his promise to take on the pharmaceutical industry produced few results. His threat to repeal the ACA, however, was serious and nearly effective (ie, the House of Representatives in Congress passed repeal legislation, but it failed in the Senate).

The battle against the ACA

The debate over repealing the ACA was ongoing before President Trump's inauguration. Republicans had repeatedly introduced repeal bills during President Obama's time in office but the assurance of a presidential veto rendered them purely symbolic. However, the American Health Care Act (AHCA) that the Republicans introduced in March, 2017, posed a real threat to health-care coverage. That bill would have cut federal Medicaid spending by US$839 billion over a decade,[211] slashed subsidies to low-income individuals for the purchase of private insurance, and weakened protections for people with pre-existing conditions. The Congressional Budget Office (CBO) estimated that passage of the bill would nearly double the number of uninsured people.[211] The funds freed up by these cuts were to be redirected to cover the cost of tax breaks for corporations and the elimination of the ACA's surtax on high-income individuals, granting them a US$172 billion windfall.[211]

The AHCA passed the House of Representatives in May, 2017. However, the companion bill was narrowly defeated in the Senate after the last-minute defection of a few Republican senators. This defection was driven by the bills' unpopularity (one poll found that only 17% of US people supported it)[212] and a surge of grassroots opposition; in a dramatic moment, disabled activists were hauled out of Republican congressional offices in their wheelchairs.

Subsequently, Republicans mostly stopped trying to overhaul the health-care system with a single sweeping piece of legislation. However, Trump was deterred rather than defeated. He resorted to executive actions and small legislative steps that gradually weakened the ACA and advanced a market-based vision.

Weakening the regulation of private insurance

On Jan 20, 2017—the day President Trump took office—he issued the first of several executive orders and actions on health-care financing (table 2).[213] The order stated his intention to disregard parts of the ACA until it was no longer law and looked ahead to a "free and open market in…health-care services and health insurance".[214] In the same year, his administration abruptly stopped funding

for advertising that encouraged enrolment in ACA plans.

Since 2017, Trump has subjected the ACA to unrelenting—and often factually inaccurate—rhetorical attacks. From January, 2017, to April, 2019, he made 662 misleading or outright false statements about health care in the USA,[215] nearly half of which were related to the stability or repeal of the ACA. He shortened the duration of the ACA insurance enrolment periods for 2017–18, and slashed funding for so-called navigators (agencies that help individuals navigate the ACA's complex enrolment process).[216]

To undermine the ACA's requirements that private insurers cover essential benefits and enrol applicants regardless of their health conditions, the Trump administration expanded loopholes that made some insurance plans exempt from those rules. These exempt plans (table 2) charge lower premiums but provide paltry coverage (eg, excluding maternity care). They mostly attract healthy enrollees who are anticipated to need little care, raising concern that they would take such enrollees away from the ACA marketplace, destabilising its risk pool.[217] The administration also tried to end payments that compensate ACA marketplace insurers for the cost-sharing subsidies they must offer low-income enrollees (a move blocked by the courts). Meanwhile, the Republican-controlled Congress eliminated the ACA's penalty for being uninsured, part of legislation that also provided new tax benefits for high-income individuals and corporations, including pharmaceutical firms.

These attacks on the ACA have had smaller effects than many people had feared. The ending of the individual mandate and broadened availability of substandard, exempt insurance have not drawn many enrollees away from the ACA marketplaces, probably because subsidies continue to make marketplace premiums attractive. Yet, these deregulatory actions reveal Trump's underlying agenda, which was to complete the transformation of health care into a market commodity available to those who can afford it, not a universal service financed by the community. Unfortunately, Trump's efforts to undermine Medicaid have been consequential.

Weakening Medicaid

In March, 2017, administration officials sent a letter to the nation's governors urging them to adopt changes to Medicaid that previous administrations had prohibited. These changes included the imposition of new out-of-pocket costs on low-income enrollees, and a requirement that many adult enrollees work at least 80 h a month or actively seek work.

Many states subsequently applied for and received waivers allowing them to adopt these changes. However, work requirements were blocked by the courts.[218] In Arkansas, the only state that implemented them before the courts stepped in, the new rules created widespread confusion and bureaucratic barriers for low-income beneficiaries, almost all of whom should have remained eligible for Medicaid.[219] About 18 000 people were forced out of coverage but employment rates didn't increase.[220]

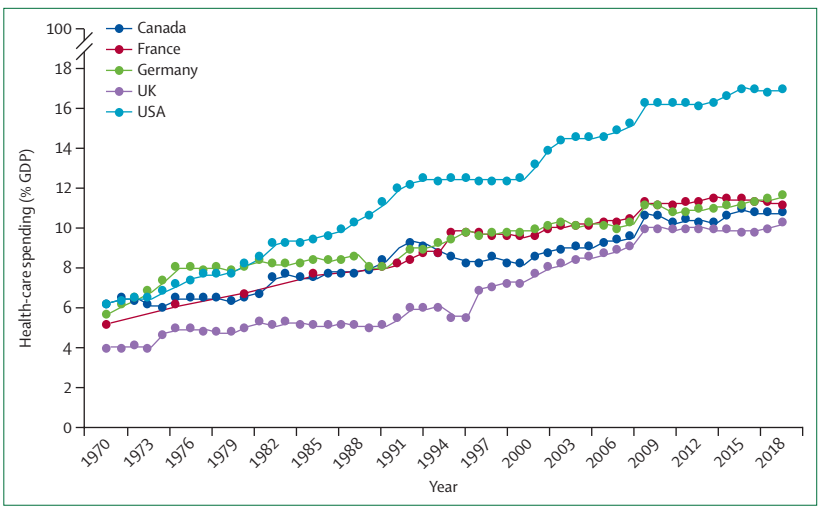

Figure 8: **Health-care spending in five wealthy nations (1970–2018)**
Data from Organisation for Economic Co-operation and Development.[4]

Before the COVID-19 pandemic the Trump administration had proposed US$920 billion in Medicaid cuts over the next decade[221] and was poised to require burdensome checks to verify eligibility for Medicaid[222] and tighten standards that have allowed some older, employed people with disabilities to receive Medicaid.[223] It was hoping to replace the open-ended federal funding commitment with restricted block grants for some states.[224]

During Trump's first 3 years in office, the number of US residents without coverage rose by 2·3 million, mostly because of a reduction in Medicaid coverage.[225] The coverage trend for children (aged <19 years) was especially worrisome as an additional 726 000 of them became uninsured.[225] Before the COVID-19 pandemic the CBO predicted a steady rise in uninsured US people to 35 million in 2027.[226] However, their estimate didn't account for the millions who lost jobs and employment-related coverage because of the pandemic, although the precise extent of the coverage losses is currently unknown.

Even more people will lose coverage if the US Supreme Court overturns the ACA. In its 2012 decision, the court upheld most of the law, reasoning that Congress' constitutional authority to levy taxes allowed it to impose penalties for failure to purchase insurance. However, after Congress reduced the penalty to US$0, a federal court in Texas ruled that the entire ACA was unconstitutional. The case is now under appeal at the US Supreme Court, with Trump's Justice Department having weighed in to support the Texas court's ruling.

The conservative health-care financing vision

President Trump's long-term plans for health-care reform were explained in a little-noticed October, 2017, white paper that advocated "choice and competition in health-care markets",[227] rhetorical cover for deregulation

	Order or action	Key provisions	Effects
Jan 20, 2017	Executive Order Minimizing the Economic Burden of the Patient Protection and ACA	Announces Trump's intention to repeal the ACA; instructs government agencies to avoid implementing ACA provisions (within the confines of the law) and work toward a free and open market in health-care insurance and services	ACA repeal efforts (failed); efforts to rollback provisions of the ACA and implement market-based reforms
Oct 12, 2017	Presidential Executive Order Promoting Healthcare Choice and Competition Across the United States	Expand use of tax-advantaged HRAs, including for non-group coverage; loosens ACA rules that had restricted two types of plans exempt from the ACA's coverage rules: (1) AHPs, which allow employer associations to offer exempt insurance, and (2) STLDI, previously limited to <3 months but now allowed for up to 3 years	Lax federal rule on AHPs and STLDI is issued in August, 2018; AHP expansion challenged and invalidated in federal court, and is currently under appeal; STLDI expansion likely to increase enrolment in such plans by 1·4 million (some states banned STLDI, limiting its effect)
Oct 12, 2017	Ending CSRPs	CSRPs are subsidies (along with premium subsidies) paid to insurers to reduce out-of-pocket costs for low-income people purchasing ACA marketplace plans; after a court ruling that Congress had not explicitly appropriated funding for CSRP, the Obama administration continued the payments pending appeal; the Trump administration abruptly ended the payments in 2017	Many people feared that ending CSRPs would damage the ACA marketplaces; paradoxically, the ACA plans' affordability to low-income enrollees improved, because insurers increased their premiums, triggering automatic increases in premium subsidies. Only high-income people purchasing unsubsidised insurance on the ACA marketplaces faced higher costs, as did the federal treasury, which will bear additional costs of nearly US$200 billion over a decade, according to a 2017 CBO estimate[212]
April 1, 2019	2020 Medicare Advantage and Part D Rate Announcement and Final Call Letter Fact Sheet	Allowed Medicare Advantage plans, but not traditional Medicare, to offer incentives for enrolment; increased Medicare Advantage payments rates by 5·62% (1·02% above the rate increase calculated previously); similar increases were granted in two previous years (2017 and 2018)	Gave private Medicare Advantage plans a competitive edge over publicly administered Medicare; increased overpayments to Medicare Advantage plans
June 24, 2019	Executive Order on Improving Price and Quality Transparency in American Healthcare to Put Patients First	Announces plans to increase price transparency to encourage patients to shop for health-care services via: (1) requiring hospitals to publicly post both charges and negotiated payment rates for selective services, (2) consideration of a rule to inform consumers of their possible out-of-pocket costs to patients, and (3) expand use of high-deductible health plans, and use of HSAs, by increasing the amount of HSA funds that can be rolled over to the following year, and permitting funds to be used for direct primary care (also known as concierge care) and health-care-sharing religious ministries	Rule released on Nov 15, 2019, requires hospitals to make public all charges and negotiated payments, for at least 300 selected services; on Nov 15, 2019, the administration released a proposed rule that would require insurers to provide information about cost-sharing to enrollees
Oct 3, 2019	Executive Order on Protecting and Improving Medicare for Our Nation's Seniors	Contends that Medicare for All could cause the failure of the Medicare programme; calls for so-called value-based payment methodologies within Medicare; calls for more plan choices for older enrollees via: (1) expanded use of medical savings accounts, (2) permitting Medicare Advantage plans to pay beneficiaries cash rebates, (3) ensuring that traditional Medicare has no advantages over Medicare Advantage, and (4) exploring ways to make traditional Medicare payments resemble those of commercial insurers and Medicare Advantage plans; calls for relaxing network adequacy requirements for Medicare Advantage plans and pre-emption of state laws restricting hospital expansions; calls for reducing barrier to licensing of non-US-trained physicians, participation of non-physician providers, and reducing payment differences between physician and non-physician providers; revocation of unnecessary barriers to private contracts between Medicare beneficiaries and providers; calls for allowing older enrollees to easily opt out of Medicare coverage for inpatient care; calls for market-based pricing of services in traditional Medicare	Intended to weaken traditional Medicare and accelerate the privatisation of coverage for older enrollees; likely to increase costs for older people and taxpayers in the long-term
Nov 12, 2019	Proposed Rule: Medicaid Fiscal Accountability Regulation	Bans federal Medicaid match of funds states collect from taxes on health-care providers and insurers	Would reduce federal Medicaid spending by US$28·3 billion and total (federal and state) Medicaid spending by US$44·0 billion annually
Sept 13, 2020	Executive Order on Lowering Drug Prices by Putting America First	Declares that Medicare will pay no more for certain prescription drugs than OECD nations with comparable GDP per capita, calls for HHS secretary to develop model programmes to implement (and study) this approach for select high-cost drugs	International index pricing would reduce drug prices; however, executive order has no immediate effect and will face court challenges; in December, 2019, Trump promised to veto an index pricing bill

ACA=Affordable Care Act. AHP=Association Health Plan. CBO=Congressional Budget Office. CSRP=cost-sharing reduction payments. GDP=gross domestic product. HRA=Health Reimbursement Accounts. HSA=health savings accounts. HHS=US Department of Health and Human Services. OECD=Organisation for Economic Co-operation and Development. STLDI=Short-term Limited Duration Insurance.

Table 2: **Examples of executive orders and actions on health-care financing during the Trump era**

and commercialisation. It called for the government to expand the supply of doctors, hospitals, and other providers by deregulating them (eg, relaxing professional licensing standards). It also called for deregulating private insurance, on the premise that the USA's exorbitant health-care costs are caused by state and federal (ie, ACA) requirements that force insurers to provide excessively generous benefits, a claim that would surprise the 41 million US residents who are underinsured.[228] To remedy the profligate use of care it would cut benefit packages, raise deductibles, and encourage patients to shop for lower-cost providers.

Over the past 4 years, the Trump administration gradually advanced its market-based agenda, including

efforts to divert funds from the Veterans Health Administration (VA) to purchase private care for veterans[229] and, most prominently, by pushing forward the creeping privatisation of Medicare that started with the Reagan administration (panel 5),[230] mirroring strategies to undermine the UK National Health Service that begun under Margaret Thatcher in the 1980s.[231] Ultimately, many Republicans hope to replace Medicare's current uniform guarantee of benefits with a voucher that older enrollees could use to shop among private insurance plans,[232] with affluent older people able to supplement the voucher and purchase more generous coverage and preferential access to care.

Trump's promise to restrict the power of pharmaceutical companies proved empty. His 2017 tax cut law yielded a US$7 billion windfall to just four pharmaceutical firms in 2018 alone,[233] which they have deployed for stock buybacks.[234] Trump released many executive orders on drug pricing, including several in July and September, 2020. However, they have had little effect. Meanwhile, pharmaceutical regulation by the FDA, already weakened by the 21st Century CURES Act passed in 2016, has faltered under Trump. FDA enforcement actions, such as safety warnings about medications or devices, have been greatly reduced.[235] During the COVID-19 pandemic, Trump promoted hydroxychloroquine as a miracle cure and the FDA issued (and subsequently revoked) an emergency use authorisation endorsing its use. Subsequently, the FDA promoted the efficacy of convalescent plasma, despite a paucity of evidence, and suggested its readiness to approve a vaccine even before phase 3 trials had been completed. Therefore, despite his populist, anti-drug company rhetoric, Trump's administration pursued a deregulatory, pro-corporate, and politicised pharmaceutical agenda at the expense of science.

Damaging as Trump's policies have been, they are not an aberration but an aggressive acceleration of decades-old trends toward deregulation and market-based reforms that have favoured large organisations and increased costs. Encouraged by the shift to value-based purchasing mandated by the ACA, massive health-care systems have bought up independent hospitals and physician practices and used their monopoly power to leverage higher fees.[236] Following major mergers, hospitals' profits have risen, the availability of primary care and other services has fallen, promised quality improvements have failed to materialise, and the experiences of patients have worsened.[237]

Investor-owned firms now employ tens of thousands of physicians and have increased for-profit hospitals' market share by 8 percentage points in the past 15 years.[238] Most US outpatient haemodialysis centres,[239] nursing homes,[240] inpatient psychiatric facilities, health maintenance organisations, and even hospices[241] are now for-profit.

The evidence on the clinical and cost implications of investor ownership is worrisome. Mortality rates in for-profit dialysis facilities are higher than in non-profit facilities, with the differences implying that for-profit ownership is associated with up to 3800 excess deaths annually in the USA[242] Studies also suggest that the quality of care is inferior at for-profit nursing homes[243,244] and home care agencies,[245] and that for-profit hospices avoid unprofitable patients.[246] Venture capital and private equity firms have pushed dermatologists they employ to boost revenues by promoting cosmetic procedures,[247] implemented billing practices that saddle emergency patients with surprise bills,[248] and closed urban hospitals sitting on valuable real estate.[249] For-profit hospitals have higher costs than both public and non-profit hospitals[250] and often select services on the basis of profitability, resulting in loss of emergency services and harm to communities.[251]

An alternative vision

The Biden administration should take a different approach. Within the framework of the current financing system, reforms could recover lost progress for Medicaid enrollees, close the gaps in Medicare's benefits package, and reverse the costly privatisation of Medicare and the VA. These incremental steps, although beneficial, would leave tens of millions of US residents uninsured (or greatly underinsured) and many other problems unaddressed.

During his campaign, President Biden proposed lowering the eligibility age for Medicare from 65 years to 60 years, increasing subsidies for the purchase of insurance, and offering for sale a Medicare-like public plan (a so-called public option) that would compete with private insurers. This approach could expand health insurance coverage. However, many people covered by Medicare or private insurance would still face onerous co-pays (ie, an out-of-pocket payment required for each service) and deductibles, and millions of people would remain uninsured. Additionally, such a multi-payer reform would retain private insurers, whose own high overhead (ie, their profits and administrative costs), along with the billing-related tasks they impose on doctors, hospitals, and other providers, drive up health-care administrative costs, which totalled US$812 billion in 2017.[252] In the absence of savings on administration that could offset the costs of increased coverage, a coverage expansion would cause US health-care spending, which is already twice the Organisation for Economic Co-operation and Development per-capita average, to rise further.[253]

Instead, we recommend a single-payer reform—often referred to as Medicare for All—that would cover all residents under a single, federally financed plan providing comprehensive coverage. It should depart from Medicare's current payment strategies by excluding private managed-care plans, adopting a drug-benefit programme modelled on the VA's version,[254] and paying hospitals lump-sum operating budgets rather than on a

per-patient basis. Funding for new buildings and major equipment should be allocated separately, rather than being derived from hospitals' surplus operating revenues. This step would minimise incentives for hospitals to focus on profitable patients and services and enable region-wide health planning. It would also allow remediation of inequities that have left IHS hospitals,[121] and those serving Black and Latinx patients,[255] with poor facilities and equipment.

Medicare for All faces major political obstacles, notably fierce opposition from pharmaceutical, health insurance, and for-profit hospital firms. However, the programme is gaining popular support, is backed by the majority of Democrats in Congress and the USA's largest nurses union, and was endorsed by the American College of Physicians (which has 163 000 members) in January, 2020.[256] By contrast to other health reform proposals, it could simplify the financing system, which would reduce expenditures on medical billing and administration by US$626 billion annually.[252] Based on such savings, 20 of 22 economic analyses,[257] a health policy guidance published in *The Lancet*,[258] and an estimate by the official Congressional Budget Office[259] have projected that single-payer reform would reduce overall health-care spending, even as it achieved universal coverage.

Such reform could also reverse the harmful shift toward the commercialisation of care that began in earnest in the 1980s. Most importantly, it could inaugurate a new era of respect for the human right to health and health care.

Section 6: Food, nutrition, and public health

The importance of food to health is self-evident: people must eat to live and must eat healthily to maximise longevity. Even before the onset of the COVID-19 pandemic, the public health burden of current US food production and consumption systems was clear. Nearly 11% of US residents were food insecure,[260] more than 42% of adults[261] and 19% of youth were obese,[262] and approximately 17% were affected by foodborne illness every year, causing 128 000 hospitalisations and 3000 deaths.[263]

The COVID-19 pandemic revealed systemic flaws in a food system that fails to protect against hunger and diet-influenced non-communicable diseases. It also exposes the conditions that made people who are living on low-incomes, disenfranchised, discriminated-against, and chronically ill the most vulnerable to harm from COVID-19. It particularly revealed the plight of formerly invisible workers on farms and in meatpacking plants, forced by presidential invocation of the 1950 Defense Production Act to work under crowded conditions that put them at high risk of contracting illness. Despite food banks being overwhelmed by demands from people who were newly unemployed and destitute, farmers destroyed food that could not be sold. Billions of dollars in government relief efforts were delayed, not always targeted to those most in need, and inadequate to meet demands.[264,265]

Before the Trump era

The USA has a long history of enacting policies aimed at addressing hunger, obesity, and foodborne illness, but these policies have never been coordinated. Instead, they evolved during the 20th century in response to specific crises as they arose and their regulatory authority was assigned to whichever agency seemed most appropriate at the time. The US Government Accountability Office has called for better coordination of food safety oversight for more than 40 years.[266]

Hunger policies

During the Great Depression of the 1930s, vast numbers of US residents lacked money to buy food and farmers could not sell the food they produced; the government responded by initiating food relief programmes. During World War 2, nearly half of military recruits were rejected from service because of malnutrition. By the 1960s, the government had established permanent food assistance programmes, among them food stamps (now known as SNAP) and school meals. As these schemes grew in enrolment and cost, they increasingly raised fiscal concerns and fears of inducing dependency.[154,267]

In the 1990s, President Clinton's election campaign included a promise to "end welfare as we know it".[268] Following his election, he followed through on that promise when Congress passed the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA).[269] Along with placing time restrictions on cash welfare benefits, PRWORA made some categories of immigrants ineligible for public benefits (including food stamps), banned the use of food stamps by people convicted of drug felonies, and introduced work requirements for food assistance for some able-bodied adults. These requirements were considered so damaging to the low-income population that three assistant secretaries of the US Department of Health and Human Services resigned in protest.[270]

Because clinical signs of nutrient deficiency rarely occur, even among low-income US residents, health authorities instead focus on the risk of malnutrition, which is determined using categorical measures of food security. These measures track closely with poverty—eg, food insecurity peaked at nearly 15% of the US population following the 2008 recession.[270] Participation in SNAP also increased sharply and peaked at 52 million people in 2013 but declined as the economy improved to 43 million by November, 2016, when President Trump was elected. As a result of Trump's actions, SNAP participation declined to 36·9 million by February, 2020,[271] but the economic dislocation caused by the COVID-19 pandemic reversed that trend.

Obesity policies

During most of the 20th century, obesity affected approximately 15% of the US population; however, from the early 1980s onwards, the percentage more than doubled for adults and tripled for children.[272] Since the early 2000s, obesity prevalence has stabilised among children but has continued to increase among adults, particularly among Latinx, Black, and low-income people.[260]

Obesity increases the risk of type 2 diabetes, heart disease, stroke, several cancers, and other conditions (including severe COVID-19) and is associated with substantial mortality from these conditions, high medical-care costs, and reduced productivity.[273] The Obama administration (led by Michelle Obama) campaigned to reduce childhood obesity by improving food access, school food, food and menu labelling, and by restricting food marketing to children. Her Let's Move! campaign encountered relentless opposition from industry groups who derided it as a so-called nanny-state intervention, but it nonetheless logged some notable achievements.[274] Whether these measures were responsible for the current stabilisation of childhood obesity rates is unknown but successful obesity prevention policies generally include a combination of efforts to ensure access to healthy foods, promote physical activity, and provide adequate income, education, and preventive health care.

Food safety policies

Food safety emerged as a policy issue in 1906 following publication of Upton Sinclair's *The Jungle*.[275] Congress responded to the book's revelations of filthy conditions in the meatpacking industry by passing two food safety laws and assigning their oversight to two different US Department of Agriculture (USDA) agencies, one of which eventually split-off to become the FDA. This move left the USDA mainly responsible for the safety of meat and poultry products (10–20% of the food supply) and the FDA in charge of the remaining 80–90%. However, because of its USDA origins, funding for the FDA and the USDA comes from congressional agriculture appropriations committees. These committees keep the FDA chronically underfunded, despite its substantial food safety responsibility.[276]

In the mid-1990s, the USDA required meat and poultry producers to establish pathogen reduction plans. Subsequently, illnesses from beef sources declined. Under the Obama administration, the FDA proposed similar rules for foods under its jurisdiction, extending them to farms and production facilities. Congress passed the Food Safety Modernization Act in 2011 and the FDA has continued to finalise its rules and guidance for implementation.[277] Despite these efforts, multistate outbreaks of illness from contaminated poultry, eggs, and produce continue to increase.[278]

Widespread outbreaks of COVID-19 among US meatpacking workers exposed the inadequacies of current worker-safety measures, despite guidelines for operating such plants and personal measures to prevent viral transmission. Food safety continues to be a high-risk issue demanding more effective coordination of oversight, enforcement of regulations, and response to outbreaks.[279]

Trump-era policies

In every domain of food and nutrition policy, the Trump administration consistently supported corporate rather than public health interests, with no policy domain too insignificant to be ignored. Among its many actions, the Trump administration weakened standards for organic foods, permitted the speeding up of poultry slaughter lines, used farm-support funds for prisons, allowed finely textured beef (known as pink slime) to be labelled as ground beef, permitted delays in complying with menu-labelling regulations, held back on issuing warning letters to companies violating labelling regulations, and blocked a UN panel (known as the WHO Independent High-Level Commission on NCDs) from endorsing soda taxes as a strategy to combat obesity. Beyond such small measures, the administration's actions are likely to cause the most lasting damage in three food areas: the USDA's research programme, SNAP, and school meals.

Destruction of the ERS

The Economic Research Service (ERS) of the USDA is a relatively small and formerly obscure agency of approximately 200 economists and scientists who do non-partisan research on food and nutrition policy. In August, 2018, the USDA announced that it would relocate the ERS out of Washington, DC, ostensibly to ease recruitment, save money on real estate, bring the agency closer to stakeholders, and enable closer alignment with USDA policy initiatives.[280] None of these reasons held up to public scrutiny. Instead, the move appeared to be an attempt to silence scientists whose research produced results incompatible with the Trump administration's agenda—ie, by documenting the benefits of SNAP and school meal programmes or the less nutritious quality of meals consumed outside the home. The proposal immediately elicited congressional protests, hearings, requests for delays, and legal challenges. While these were pending, the USDA announced that it was moving the ERS to Kansas City, MO. Nearly 70% of the scientific staff chose to resign rather than move, encouraging one USDA official to exult that this action had "drained the swamp",[281] referring to non-partisan scientists within ERS whose studies produced results inconvenient to the administration's agenda. The damage has been done and it is unlikely that the research capacity of this unit will recover.

Weakening SNAP

SNAP is by far the largest anti-hunger programme in the USA and a vital component of the safety net for

low-income US residents.[282] In December, 2019, SNAP provided 37·2 million US adults and children with an average benefit of US$126 per month per person at a total cost of US$55·6 billion in benefits and US$4·7 billion in administrative expenses. Following the onset of the COVID-19 pandemic, Congress gave states more flexibility in enrolling applicants and participation quickly increased to 43 million adults and children, along with an increase in the average benefit to US$181 per month per person.[283]

SNAP is demonstrably effective in reducing hunger and food insecurity. The programme ranks third only to Social Security and the Earned Income Tax Credit in its ability to lift low-income US residents out of poverty.[284] SNAP reduces the well-documented effects of food insecurity on health. Research strongly associates food insecurity with poor dietary choices, obesity, and chronic diseases—mainly type 2 diabetes and heart disease for which obesity is a risk factor—along with poor health status and reduced quality of life. Adults on SNAP tend to have fewer illnesses, miss less work, need fewer physician visits, and be less psychologically distressed. Older adults on SNAP are better able to live independently, need less medical care and hospitalisation, and are more likely to comply with medication regimes.[285] Children in food-secure families have fewer infections and better overall health and the benefits of their SNAP participation continue into adulthood. Overall, SNAP participation and food security are linked to reduced health-care expenditures.

SNAP could do more to promote public health. Public health advocates, for example, have suggested making sugar-sweetened beverages ineligible for purchase with the programme's debit cards and have called for the release of data on SNAP purchases.[286] The Trump administration supported retailers in opposing the release of such data.[287]

Despite its evident value to public health, SNAP was a prime target for programme cuts by the Trump administration. For instance, the administration tightened work requirements for continued participation in SNAP. Although programme rules already required able-bodied adults without dependents to work, some states granted waivers to that requirement. When Congress failed to include obligatory work requirements in the 2018 US Farm Bill, the Trump administration blocked states from granting such waivers,[288] a step that the courts temporarily blocked early in the COVID-19 pandemic.

Another Trump-era rule change prohibits states from automatically enrolling families in food assistance programmes once they qualify for cash assistance.[289] More than 3 million participants could lose SNAP benefits[290] and officials told reporters that 300 000 children could lose eligibility for school meals. The rule was expected to save about US$2 billion per year.[291] Additionally, in 2018, the Trump administration proposed the elimination of outreach to potential participants and the partial replacement of SNAP benefits at grocery stores with so-called harvest boxes of surplus farm commodities. Indeed, in response to COVID-19 the USDA initiated a Farmer to Families Food Box programme in August, 2020, that partnered with distributors to provide US$6 billion in produce, dairy, and meat products to food banks and other non-profit organisations.[292] This programme has raised questions about its contracting processes, lack of accountability, and failure to provide what was promised.[293] The Trump administration also discouraged immigrants' use of SNAP and other social services through its changes to the public charge immigration rule, despite opposition to such changes from virtually every US medical and public health association.

Rolling back school meal standards

In the USA, federal school breakfast and lunch programmes feed 30 million low-income children daily at an annual cost of approximately US$18 billion.[294] Michelle Obama's Let's Move! campaign, which began in February, 2010, advocated for improvement in the nutritional quality of school meals. Later that year, Congress passed the Healthy Hunger-Free Kids Act, which authorised improvements in nutritional standards for school meals and child nutrition programmes. These standards were opposed by food companies selling sugary drinks and snack foods in schools and by the School Nutrition Association, which represents school food-service personnel but receives much of its funding from companies that sell food products to schools. With some compromises, the campaign succeeded in requiring more offerings of fruits, vegetables, and whole grains and reducing foods high in undesirable nutrients.[295]

Under the Trump administration, food-industry groups' counterattacks undermined these advances. Despite much evidence to the contrary,[296] the Trump administration argued that children were rejecting the healthier meals, thereby increasing plate waste. On this basis, Trump's USDA reversed several of the improvements and gave schools permission to ignore how school meals affect children's health.[297] Early in 2020, the USDA announced further weakening of nutrition standards.[298]

The COVID-19 pandemic showed how school meals account for substantial proportions of the energy and nutrient intake of many low-income children. Out-of-school children were suddenly at high risk of hunger. The USDA permitted schools to provide free meals to children and families during this pandemic, most schools did so, and the CDC issued guidance about how to do so safely.

The Trump administration extended emergency school feeding to June, 2021, but without permanent institution of universal child feeding programmes, school meals, SNAP, and other important social welfare programmes will remain as targets for closing budget shortfalls.

A change in direction

To address long-standing shortcomings in food and nutrition policy and repair the damage caused by President Trump's actions, the Biden administration should improve food safety by enforcing existing rules

and regulations, which will require frequent inspections of farms and food processing facilities, making the rules consistent for all foods, and rationalising the entire food safety system by combining and coordinating the oversight functions of the USDA and FDA. It should also ensure adequate food-purchase ability for low-income residents, regardless of immigration status, by increasing benefits, promoting outreach, and undertaking pilot studies of ways to encourage healthy food purchases (eg, vegetables). A rational school-food policy would make school meals available to all children regardless of income or immigration status, equip schools to cook (not merely reheat) food, establish food-based rather than nutrient-based standards for school meals, and ensure that standards are met for all school meals and snacks.

Clinicians should advise caregivers to enrol children in school meal programmes and work with local school districts to ensure that all eligible children are served. They should inform low-income patients about eligibility for SNAP participation, prescribe SNAP for food-insecure patients regardless of immigration status and connect low-income patients with other sources of food assistance in their communities. Hospitals and clinics should consider hosting farmers' markets and ensure that vendors accept SNAP benefits.

If we had to pick only one nutrition-relevant reform, it would be income support for low-income families.

Section 7: The environment, workplace, and global climate

President Trump and his administration aggressively rolled back regulations that protect the environment, safeguard the health of US workers, and mitigate climate change. He portrayed such regulations as unnecessary burdens on industry and brakes on economic growth, and viewed dismantling them as an opportunity to provide relief to business, particularly the fossil fuel industry. His actions greatly contrasted to efforts in most other high-income countries.

One analysis identified 104 environmental rules and regulations that the Trump administration targeted for rollback (table 3).[299] As of July 2020, 84 of these rollbacks had been completed, and 20 were still in progress, although President Biden has moved to reverse many of these actions. Trump's most far-reaching policy rollback would weaken the 1969 National Environmental Policy Act, bedrock legislation that establishes the national framework for protecting the US' environment. 29 of the rollbacks relax air pollution and air emissions standards. Another 20 rollbacks lift restrictions on extraction and drilling for fossil fuels, such as cancelling a requirement that oil and gas companies must report methane emissions at fracking operations and along pipelines, and directing federal agencies to stop using an Obama-era calculation of the social cost of carbon emissions. Nine pertain to water pollution and eight relax protective standards for toxic chemicals, such as stopping enforcement of a 2015 rule prohibiting the use of hydrofluorocarbons in appliances, and blocking a ban on the neurotoxic insecticide, chlorpyrifos.

Occupational health rollbacks included the termination of a silicosis prevention programme, the weakening of health and safety standards for miners, and a proposal to allow new industrial uses of asbestos.[300]

State and local governments, along with advocates such as the Natural Resources Defense Council, have filed more than 100 lawsuits challenging the Trump administration's rollbacks. Many of these challenges have been successful and have slowed the pace of deregulation.

Trump's promotion of corporate interests over health protections was exemplified early into his presidency by his selection of Scott Pruitt as administrator of the EPA. Pruitt's previous campaign for election as attorney general of Oklahoma had been generously funded by the fossil fuel industry and, after his election to that position, he repeatedly sued the EPA. During his tenure at the EPA (which ended in July 2018 while there were at least 14 separate federal investigations into his conduct) Pruitt directed reversals of myriads of environmental regulations.[301]

The Trump administration pursued an aggressive campaign against the scientific foundations of environmental and occupational health policy, advancing a proposal deceptively titled Strengthening Transparency in Regulatory Science. This proposal, developed by the tobacco, fossil fuel, and chemical lobbies, mandates that the EPA base environmental regulations exclusively on research whose underlying data are fully accessible to the public and the affected industries. Clinical and epidemiological studies that do not publicly disclose the names, addresses, and medical histories of all human participants would be excluded from consideration; however, most are bound by law and regulation to maintain confidentiality. Environmental policy would cease to be informed by medical science. One leading researcher described the rule (which was finalised on Jan 6, 2021, the day of the storming of the US Capitol) as "a direct assault on epidemiology".[302]

Starting in March, 2020, the Trump administration used the COVID-19 pandemic as a pretext for further deregulation, suspending all enforcement of air and water rules and implementing additional rollbacks in a brazen attempt to lock in lax standards before a potential change in administration.[303] Fuel efficiency standards for automobiles were weakened, restrictions on mercury emissions from coal-fired power plants lifted, and the requirement that federal agencies consider climate change in assessing environmental effects of highways, pipelines, and other major infrastructure projects set aside. In April, 2020, the EPA announced that the timeline for regulatory review of potentially hazardous chemicals under the Toxic Substance Control Act would be accelerated and the length of public and scientific comment periods shortened. As of December, 2020, the EPA was doing accelerated evaluations of 13 chemicals, including 1,3-butadiene, ethylene

	US Agency	Status of rollback
Air pollution and air emissions		
Withdrew requirement for oil and gas companies to provide information on methane emissions at their existing operations	EPA	Complete
Replaced the Obama-era Clean Power Plan with a version that allows states to set their own standards for emissions from coal and gas-fired power plants	Executive Order; EPA	Complete
Rescinded California's right to set its own tougher standards for emissions from cars and light trucks	EPA	Complete
Enabled power plants to avoid emission regulations through revision of a permitting programme	EPA	Complete
Weakened guidelines aimed at reducing air pollution in national parks and wilderness areas	EPA	Complete
Reduced oversight of some state plans for reducing haze in national parks through replacement of regional haze federal implementation plans with state implementation plans	EPA	Complete
Reversed regulation aimed at prevention of methane releases on public lands during oil and gas operations	Department of Interior	Complete
Lifted measures limiting emission of several toxic pollutants from major industrial polluters	EPA	Complete
Proposed the elimination of rules aimed at the reduction of hydrofluorocarbons leaking from air-conditioning and refrigeration systems	EPA	Complete*
Revoked a rule requiring state and regional authorities to track tailpipe emissions from vehicles travelling on federal highways	Department of Transportation	Complete
Modified rules on community pollution monitoring by crude oil refineries	EPA	Complete
Halted calculation of the social cost of carbon in estimating the economic advantages of reducing CO_2 emissions	Executive Order	Complete
Revoked a guideline that federal agencies consider the effects of federal actions on climate	Executive Order; CEQ	Complete
Removed a ban on use of a gasoline blend containing 15% ethanol during the summer to reduce smog	EPA	Complete
Extended state and EPA deadlines for developing and approving plans to reduce methane emissions from landfills	EPA	Complete
Rescinded the Federal Sustainability Plan, a sweeping effort to cut the federal government's emissions of greenhouse gases by 40% over 10 years	Executive Order	Complete
Proposed weakening fuel-economy standards for light trucks and cars	EPA; Department of Transportation	Complete
Weakened a rule restricting mercury emissions from coal-fired power plants	EPA	Complete
Loosened air pollution regulations on plants that burn waste coal for electricity	EPA	Complete
Announced intent to withdraw from the UNFCCC Paris Climate Agreement in November 2020	Executive Order	Complete
Proposed removing a federal requirement that oil and gas companies detect and fix methane gas leaks at their facilities	EPA	Complete
Proposed revoking restrictions requiring capture of CO_2 emissions from new coal-fired power plants	EPA	Pending
Proposed revising CO_2 emissions standards for power plants that are new, modified, or reconstructed	Executive Order; EPA	Pending
Proposed revoking requirements that Texas and other states follow emission rules for power plant start-ups, shutdowns, and malfunctions in addition to an overall review of these regulations	EPA	Complete
Proposed restricting communities and individuals from challenging pollution permits issued by the EPA that are up for comment by a panel of agency judges	EPA	Pending
Focused efforts on limiting buffer zones for pesticide application meant to reduce human exposure.	EPA	Complete
Postponed issuing a rule restricting aircraft greenhouse gas emissions.	EPA	Pending*
Toxic chemical and occupational hazards		
Rejected a proposed ban on chlorpyrifos, a neurotoxic pesticide associated with developmental disabilities in children	EPA	Completed
Scaled back a law requiring safety assessments of toxic chemicals such as dry-cleaning solvents	EPA	Completed
Revoked a rule requiring trains hauling flammable liquids such as gasoline and ethanol to upgrade their braking systems	Department of Transportation	Completed
Excluded copper filter cake from the definition of hazardous waste	EPA	Completed
Ended an OSHA programme to prevent silicosis	Department of Labor	Completed
Proposed revoking most requirements of a rule designed to improve safety at work sites that use hazardous chemicals	EPA	Complete
Proposed allowing the rail transport of highly flammable, liquid natural gas	Department of Transportation	Complete
Announced an intention to reassess a rule reducing exposure to coal dust in mines	Department of Labor	Pending

Data from Popovich et al.[299] EPA=Environmental Protection Agency. CEQ=Council on Environmental Quality. OSHA=Occupational Safety and Health Administration. UNFCCC=UN Framework Convention on Climate Change. *Rescinded or weakened and then partially reinstated by court order.

Table 3: **Rules on air pollution, air emissions, toxic chemicals, and occupational hazards targeted by the Trump administration**

dibromide, 1,1,2-trichloroethane, tris(2-chloroethyl) phosphate, all of which pose threats to human health and the environment.[304]

Trump's claim that such deregulation benefits the economy contradicts a large body of evidence showing that pollution control measures typically generate large positive returns on investment, with most of the benefits accruing from the prevention of pollution-related illnesses and productivity losses.[305]

Health consequences of the Trump administration's environmental and occupational rollbacks

Evidence is already accumulating that the Trump administration's weakening of environmental and occupational

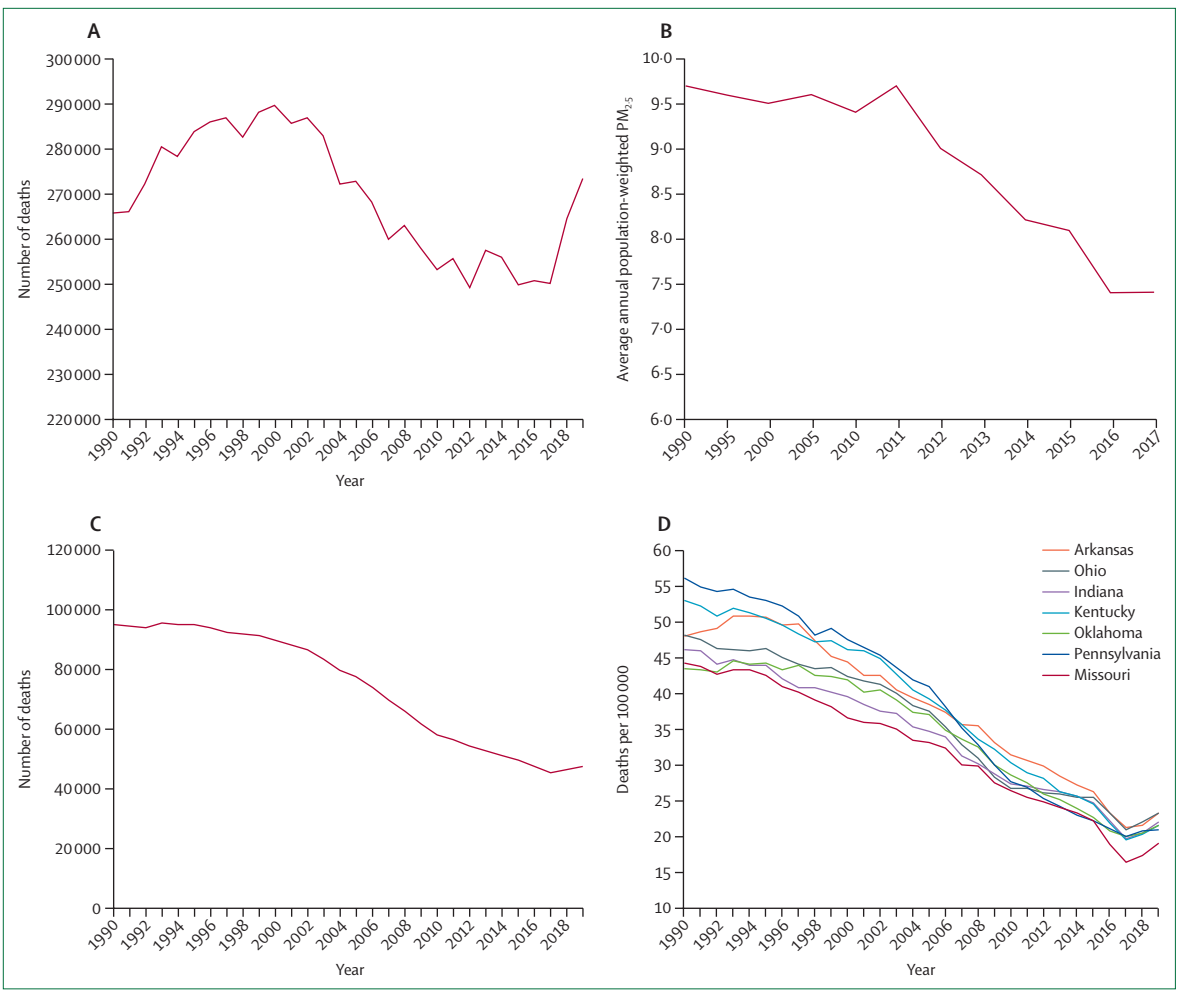

Figure 9: **Air pollution and health effects in the USA (1990–2019)**
(A) Deaths attributable to environmental and occupational risk factors. (B) Annual population-weighted mean $PM_{2·5}$ air pollution levels. (C) Deaths per 100 000 people attributable to ambient air pollution by year. (D) Annual deaths per 100 000 people attributable to $PM_{2·5}$ air pollution levels.

standards is increasing disease and death in the USA, especially among children, older people, and workers. Between 2016 and 2019, the annual number of environmentally and occupationally related deaths increased by more than 22 000, reversing 15 years of steady progress (figure 9A).[306,307]

The Trump administration's abrupt halt to control of fine particulate matter ($PM_{2·5}$) air pollution was probably a major driver of this mortality increase (figures 9B and 9C).[308] Air pollution concentrations in several heavily industrialised states have increased since 2016 after having declined steadily for the preceding 47 years since President Nixon signed the Clean Air Act into law in 1970. $PM_{2·5}$ pollution is closely linked to premature birth, asthma and pneumonia among children, heart disease, stroke, chronic obstructive pulmonary disease, lung cancer, and diabetes among adults.[307]

The sharpest increases since 2016 in deaths due to $PM_{2·5}$ air pollution have occurred in Midwestern and southern states that are major centres of coal mining, oil drilling, and natural gas extraction and have weak state-based environmental protections (figure 9D, appendix p 3).

The Trump administration's regulatory rollbacks have increased disease, injury, and death among workers in the USA. Its weakening of mine health and safety standards and mine enforcement programmes has led to increased injury deaths among workers employed in mining, quarrying, and oil and gas extraction (figure 10A)[309] and increased mortality from coal workers' pneumoconiosis (figure 10B). Despite rising deaths from work-related silicosis, the administration terminated a silicosis prevention programme launched during the Obama era.

The Trump administration's disregard for workers' health has been particularly evident during the COVID-19 pandemic. Despite receiving nearly 18 000 complaints from workers regarding COVID-19-related hazards in workplaces

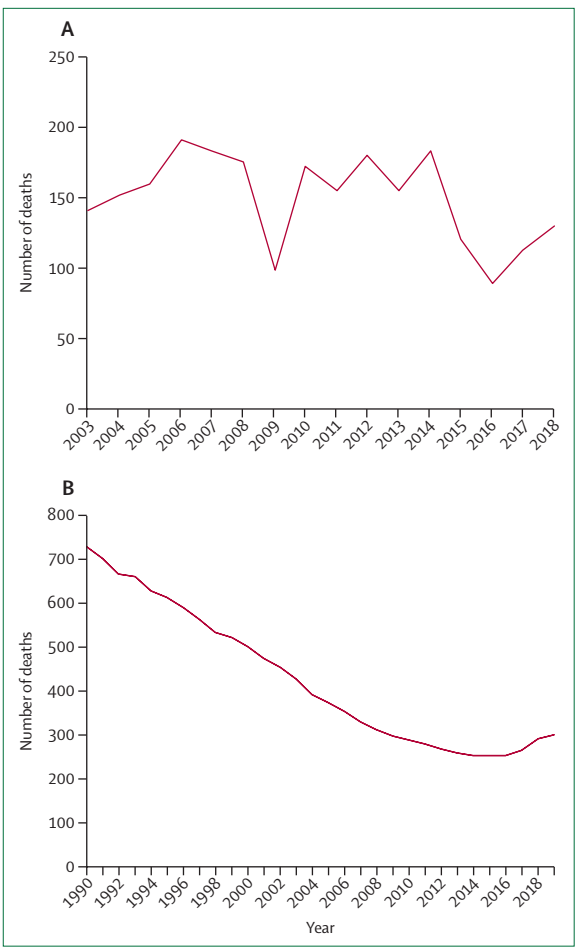

Figure 10: **US fatalities from occupational injuries**
(A) Fatal occupational injuries in mining, quarrying, and oil and gas extraction (2003–18). (B) Deaths from coal workers' pneumoconiosis (1990–2019). Data from Occupational Safety and Health Administration[309] and Institute for Health Metrics and Evaluation.[306]

(as of July 4, 2020), the Occupational Safety and Health Administration had (as of Sept 15, 2020) taken action against only one employer.[310] The government's anaemic and incompetent efforts to ramp up the supply of personal protective equipment and its non-existent oversight of infection control practices contributed to the COVID-19-related deaths of 2921 health-care workers as of Dec 26, 2020.[311] In April, 2020, President Trump designated meat processing plants as essential infrastructure, which compelled the industry's workers (many of them immigrants) to return to their jobs, despite clear documentation that employers were not assuring workers opportunities to maintain personal hygiene and physical distancing. As of mid-September, 2020, 42 606 meat-packing workers had been infected with COVID-19 and 203 had died.[312]

Ironically, the negative effects of the Trump administration's environmental and occupational rollbacks have taken their largest toll in states whose voters heavily supported President Trump in the 2016 election. By contrast, comparatively progressive states that have maintained robust state-level protections have lessened the effect the rollbacks have had on health (figure 11).

The adverse health effects of the Trump administration's deregulatory actions are concentrated in the states and demographic groups most affected by rollbacks in health insurance coverage. Therefore, these harms are compounding one another and are widening disparities in health by race, social class, and geography.

Climate

President Trump's climate denialism will probably be his most enduring environmental legacy. The Trump administration's encouragement of coal, oil, and gas combustion, and its weakening of emissions standards, are accelerating the release of greenhouse gases such as CO_2 and methane, which will remain in the atmosphere for decades. The global warming caused by release of these gases will increase the frequency of heatwaves, coastal flooding, violent storms and wildfires, and expand the ranges of vector-borne diseases such as dengue virus, Zika virus, and West Nile virus. Deteriorating air quality will increase global mortality from respiratory and cardiovascular conditions (eg, acute myocardial infarction, stroke, chronic obstructive pulmonary disease, and lung cancer).[305] Some parts of the world could become uninhabitable because of heat, humidity, and pollution, whereas others will suffer shortages of food and water. One review estimates that weakened environmental protections could lead to an additional 80 000 deaths over the next decade and exacerbate respiratory problems in more than 1 million people in the USA.[313] The growing frequency of climate-driven migration and conflict will threaten global security.

In November, 2019, despite widespread domestic and international opposition, President Trump announced that he would withdraw the USA from the Paris Agreement; withdrawal was formally completed on Nov 4, 2020, but reversed by President Biden on Jan 20, 2021. The Paris Agreement is part of the UN Framework Convention on Climate Change and commits 195 countries to take steps to prevent and mitigate global warming. Although the Trump administration had committed to upholding its obligations under the agreement until November, 2020, it had already withdrawn US$2 billion of the USA's promised US$3 billion contribution to the Green Climate Fund, which supports climate resiliency in low-income countries.[313]

The Trump administration claimed that its withdrawal from the Paris Agreement was motivated by its belief that constraining emissions would cost jobs in the USA and that withdrawal would regenerate the US coal industry and have a minimal effect on global warming. However, analysis of the administration's decision suggests other motivations. For example, numerous senior administration figures had close financial ties to the fossil fuel industry; withdrawal appeals to the supporters of President Trump in regions where fossil fuel production

is, or was, a major source of jobs; and it resonates with Trump's America First approach, his animosity for international cooperation, and his deep personal dislike of anything accomplished by President Obama.[314]

Projections of the consequences of the USA's withdrawal are, inevitably, imprecise. US emissions of greenhouse gases were expected to decline despite withdrawal from the Paris Agreement because of an ongoing shift to renewable energy sources that is driven by personal choice, tax rebates in the more progressive states, and the economic reality that it is now cheaper in many parts of the USA to produce heat and electricity from wind and solar power than from fossil fuels. However, the pace of reduction would probably slow from the anticipated rate of 26–28% (by 2025) to 15–18%.[315] Any slowing of progress is worrisome given the vast amount of evidence suggesting that the earth is nearing a so-called tipping point, after which a combination of factors will create malignant feedback loops and unstoppable global warming.[316]

Trump's environmental policies also affected the global response to climate change. Global environmental leadership has now passed, in effect, from the USA to the European Union and China. Additionally, the stance of the USA encouraged climate-damaging policies in other nations. For instance, in Brazil, President Jair Bolsonaro is adopting policies that hasten destruction of the Amazon rainforest and will accelerate climate change.

US federal funding cuts threaten global climate monitoring programmes. Examples include loss of funding for the Global Environmental Facility, which brings together 183 countries, civil-society organisations, and the private sector to tackle major environmental problems, and cuts to the National Aeronautics and Space Administration and the National Oceanic and Atmospheric Administration. Federal funding reductions threaten the leading role of US scientists, who have contributed a substantial share of the world's research on climate change.[317]

The federal government is, of course, only one locus of power within the USA. Shortly after the Trump administration announced withdrawal from the Paris Agreement, the governors of New York, California, and Washington state created the US Climate Alliance, which was subsequently joined by 21 other states and Puerto Rico. These states, which collectively produce 25% of US carbon emissions, have committed to reducing greenhouse-gas emissions by 26–28% from 2005 amounts,[318] and to meeting or exceeding the targets of the federal Clean Power Plan (introduced by the Obama administration), thus meeting the targets to which the USA had committed under the Paris Agreement.

Although government actions have been uneven, the emergence of a remarkable social movement on climate change gives reason for optimism. Young people in the USA and worldwide, witnessing the devastating 2020 wildfires in Australia and the west of the USA, floods in Europe and Asia, and drought in Africa, are calling for change. The reach of this movement is underscored by the September, 2019, Youth Climate Strike, which involved 6 million people in more than 150 countries. Gradually their voices are being heard, even in regions of the USA that are traditionally resistant to such messages (eg, in southeastern states where dread of hurricane season is mounting).

Re-joining the Paris Agreement, as President Biden has done, was the top priority for US environmental policy, but that action must be followed by meaningful change. With its vast scientific resources, the USA has unique capacity to document the consequences of global climate change for human and planetary health. Action will be needed to reinstate and strengthen safeguards that protect the air, water, and US workplaces, to re-establish monitoring systems and enforcement programmes that have been

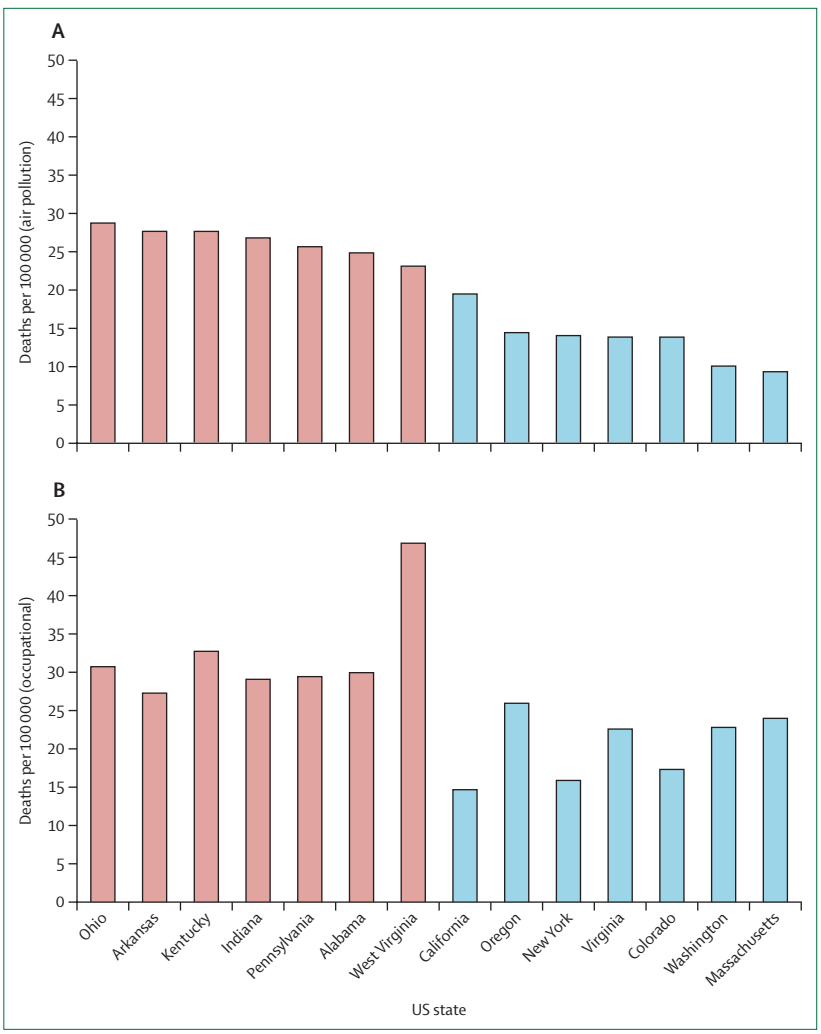

Figure 11: **Deaths per 100 000 people attributable to air pollution and occupational diseases by state (2019)**
(A) Deaths attributable to air pollution. (B) Deaths attributable to occupational diseases. Red bars represent states that voted Republican in the 2016 election and blue bars represent states that voted Democratic in the 2016 election. Data from Institute for Health Metrics and Evaluation.[306]

dismantled, and to re-open access to information that has been blocked and resume the open communication of scientific data. The Trump administration rolled back decades of progress on environmental policy. The message for the Biden administration is simple: do the opposite.

Section 8: Reproductive rights under threat

The right to safely bear a child without coercion and policing during pregnancy or to decide not to bear a child, has never been fully realised in the USA. Past legal and policy advances remain tenuous and subject to reversal and infant and maternal mortality rates remain disturbingly high—eg, OECD 2020 Health Statistics reported 5·8 deaths per 1000 livebirths and 17·4 deaths per 100 000 pregnancies in the USA.[4] Discrimination and financial constraints have particularly infringed on the reproductive freedom of people of colour, people on low incomes, LGBTQ people, those with disabilities, teenagers, and rural dwellers, but the rights of all are at risk.

We focus on abortion because it remains the locus of attacks on reproductive freedom in the USA. Historically, most women seeking abortions turned to herbal remedies and commercial preparations to restore menses, often provided by untrained midwives.[319] Early opposition to abortion came from the newly created AMA, whose campaign to ban abortion, initiated in 1857, grew partly from a desire to solidify white male-physician power in the sphere of medical practice.[320] At that time, the early anti-abortion movement fed on fear that immigrants, Catholics, and Black people would overwhelm native-born Protestant people and aimed to enforce childbirth among white native-born Protestant women.[319] By the end of the 19th century, most states in the USA had criminalised abortion, although it remained commonplace.

Activists' struggles to overturn states' abortion bans culminated in the US Supreme Court's 1973 *Roe v Wade* decision that legalised abortion nationwide. Subsequently, religious conservatives advocated against abortion as part of an agenda to deny to women the right to control childbearing, including the denial of access to contraception.

The anti-abortion movement's tactics have included lobbying, public rallies, shaming patients visiting abortion clinics, and, in some cases, threatening and committing acts of violence—including several murders—against physicians and other clinic staff. These efforts have resulted in the closure of hundreds of clinics that provided abortion care.

Many groups (including the AMA) have rallied against such attacks and restrictions and advocated for the extension of abortion access. Notably, the ACA mandated that private insurance plans cover contraceptives and several states have provided state funding for abortion care, required private insurance plans to cover abortion, or allowed qualified non-physician practitioners to do abortions.[321]

Intensifying threats to reproductive rights

President Trump, who had previously vocalised that he was pro-choice, reversed his position before launching his 2016 presidential campaign. His selection of Mike Pence (a notorious abortion opponent) as his vice-presidential running mate and his promise to appoint anti-abortion judges to the US courts, confirmed his anti-abortion sentiment to conservative voters. As of December, 2020, Trump had seated three (of nine) US Supreme Court justices and more than 200 other federal judges.[322]

The US Supreme court plays a central role in the battle over reproductive rights. In the *Roe v Wade* case, the court ruled that the US Constitution protects a pregnant woman's right to decide whether or not to terminate a pregnancy. However, the promise of that decision was soon undercut. In 1976 (and every year since), Congress passed the Hyde Amendment banning the use of Medicaid funds to pay for most abortion care, a ban that was expanded to all federal health programmes over the next 22 years, effectively barring funding for abortions for federal employees, Peace Corps workers, federal prisoners, military families, and those reliant on the IHS, among others. The US Supreme Court upheld this restriction, reasoning that the government could use its funds to favour childbirth—perhaps the court's only decision explicitly upholding the government's power to use its resources to discourage the exercise of a constitutional right.

Restrictions on access to abortion were tightened after a 1992 US Supreme Court decision holding that state anti-abortion laws were constitutionally permissible unless they placed a substantial obstacle to a woman seeking an abortion. As of July, 2020, 26 state legislatures have implemented laws requiring abortion patients to make two trips to a clinician—usually one visit to receive information designed to discourage abortion and a second for the actual procedure or medication.[323] Similarly, several states have passed laws (some of which are currently enjoined by the courts) outlawing abortions after the first trimester (or earlier in some states), banning the method used for most second-trimester abortions, restricting private insurance coverage for abortion, requiring that abortions after a particular gestational period be done in a hospital, requiring that abortions (even medication abortions) be done by a physician, or requiring parental consent (or a court waiver) for those under the age of 18 years.

Trump's shift of the US Supreme Court's makeup threatens to further constrain reproductive rights. Abortion access got a temporary reprieve in June, 2020, when Chief Justice Roberts sided with the court's four liberal justices to overturn a Louisiana anti-abortion law (known as the Unsafe Abortion Act or Louisiana Act 620). However, Roberts' opinion was founded on his reluctance to defy a precedent his court had set just four years earlier (over his dissent) and he made clear his

willingness to approve future anti-abortion laws. Subsequently, the court ruled that the administration had the authority to issue rules allowing employers (and universities) with religious or moral objections to disregard the ACA's requirement that their insurance plans cover contraception.

Administrative rule-making

In March, 2017, the Trump administration adopted a policy barring unaccompanied immigrant minors in its care or custody from getting abortions, a policy which was enjoined by the courts, and then abandoned by the administration. Furthermore, it issued a rule (which is currently vacated) broadening the right of providers with moral or religious objections to refuse to provide or refer patients to health-care services and information, potentially even in emergency situations.[324]

The administration also implemented a rule governing Title X, the federally funded family-planning programme, that is decimating access to contraception and other services for low-income people. The rule (which remains in effect, except in Maryland, while under court challenge), prohibits clinics receiving Title X funds from referring a patient for abortion care. Another proposed federal rule would require private insurers offering coverage under the ACA to send enrollees a separate bill for the portion of the premium that covers abortion care.[325]

Such restrictions threaten patients' health. State funding for medically necessary abortions has been associated with reductions in severe maternal morbidity.[326] Conversely, clinic closures and new abortion restrictions have precipitated decreased use of medication abortions, increased wait times and second-trimester procedures (despite a drop in the total number of abortions), lengthened travel distances, and have exacerbated racial disparities, all of which could increase maternal risk of morbidity and mortality.[327–329] Those denied abortion because their pregnancy is slightly over their state's gestational age cutoff suffer immediate mental health declines[330] and long-term increases in poverty[331] compared with those whose pregnancy is slightly under the gestational-age cutoff who received abortions. 200 000 Google searches per month in 2017 sought information on self-induced abortion, suggesting that the use of abortion-inducing pills bought online and through underground networks is substantial.[332]

Abortion currently remains legal in every state, although anti-abortion politicians in several states temporarily suspended abortions as COVID-19 hospitalisations surged, by deeming abortion a non-essential service, despite objections from the American College of Obstetricians and Gynecologists.[333] Even though more than 860 000 people secure abortion care annually in the USA, restrictions on abortion increasingly deny many others the right to make the life-changing decision about whether to have a child. As the US Supreme Court noted in its 1992 decision, such denials restrict the ability of women to participate equally economically and socially in US society. Reproductive freedom is increasingly out of reach for many who reside in states controlled by conservative legislatures, including large parts of the US Midwest and south. Many independent abortion clinics are struggling financially and their closure would worsen abortion access.

Activists, litigators, lawmakers, and health-care professionals have worked hard to maintain and expand access to abortion and mitigate the harms that originate from existing restrictions. Defending individuals' rights to control their reproduction is imperative for public health, equity, and democracy.

The Biden administration must immediately revoke the myriad rules that impede reproductive freedom within the USA and abroad, and the Hyde Amendment's restrictions on funding for abortion care from the federal budget, restore funding for reproductive services, and appoint judges committed to protecting reproductive rights.

Section 9: Globalising harm

International relations, involving US engagement with both other countries and global institutions, gave President Trump a platform to pursue policies that enrich his family and other wealthy US residents, and advertise his divisive, racist, and nationalistic agenda to his supporters. Since the beginning of his campaign, he has made clear that global collaboration was not a priority, nor was the use of foreign policy to support peace and human development. The COVID-19 pandemic has provided further evidence of the global harm inflicted by Trump's policies.

We discuss six main components of the policies implemented by the Trump administration, which have profound effects on global health. We characterise these components—rejection of science, neoliberalism, militarism, threats to reproductive rights, racism, and isolationism—in an effort to capture aspects of these policies that affect global health. President Trump's absence of policy coherence coupled with the capricious nature of his pronouncements means that the terms used here should be interpreted broadly, as guides to understanding his policies rather than as elements of a well-defined ideology.

Rejection of science

Trump's rejection of medical and climate science and his contempt for facts constituted a particularly pernicious aspect of his policies. In 2020, he claimed that COVID-19 is a hoax, refused to order or comply with evidence-based public health measures such as wearing masks and practising physical distancing, and promoted dangerous (bleach injection) and unproven (hydroxychloroquine) therapies. Moreover, his promotion of hydroxychloroquine compromised its availability to treat conditions for which it is effective, such as lupus and malaria.

Neoliberalism

The Trump administration represents the culmination of more than three decades of neoliberal policies seeking to privatise many public services and deregulate corporations to maximise profits. Trump's brand of neoliberalism particularly favours individual enrichment (often on the basis of personal and political connections) over public goods and seeks to reduce the size and scope of US Government services and terminate US support for health abroad. For example, the administration repeatedly proposed cuts in funding for the CDC, which plays a central role in fighting epidemics, both domestically and internationally, although Congress resisted most of the proposed cuts.

Trump's pro-corporate agenda was epitomised by his appointment of Alex Azar (a former Eli Lilly executive) to head the US Department of Health and Human Services, a signal to the pharmaceutical and other industries that their price gouging and anti-competitive behaviours would escape regulation. As discussed, President Trump's well-publicised promises to reduce drug prices yielded no results. Instead, he supported large corporations. For example, in 2018, the administration threatened sanctions against Ecuador for promoting breastfeeding, which might cut into the market of US manufacturers of infant formula.[334] Azar celebrated Gilead's donation of 2·4 million bottles of emtricitabine and tenofovir (Truvada) to prevent HIV transmission in 200 000 patients, which was met by scorn from activists who labelled Gilead's actions a publicity stunt aimed at slowing the market entry of a generic competitor and promoting the firm's new drug.[335] After preliminary data showed that remdesivir shortened COVID-19 hospitalisations, Trump made a deal with Gilead to secure 90% of the world's supply of the drug for the USA in August and September, 2020. The deal will pay Gilead approximately US$3100 per 5-day course of treatment, for a drug that costs approximately US$10 to manufacture and the development of which was partly funded by government grants.[336] Similarly, the US Government has given US$10 billion to firms (eg, Moderna, Sanofi, GlaxoSmithKline) developing COVID-19 vaccines, without placing restrictions on the prices they can charge.

Militarism

Despite applying the neoliberal doctrine of reducing government funding to health programmes, President Trump expanded government's immigration enforcement, militarised domestic policing, augmented the defence budget, and reversed the previous US renunciation of the use of land mines and cluster bombs, weapons banned by 164 other nations.[337] These actions exemplify the effect of Trump's health harming affinity for militarism.

US foreign policy too often destabilises regimes, encouraging armed conflicts that damage health and health-related infrastructure, and displace millions of people. Nowhere is this clearer than in Yemen where US support of the Saudi-led bombing has caused widespread malnutrition[338] and a cholera outbreak.[339] Despite almost 250 000 deaths and a large toll of disease and disability, President Trump vetoed a uniquely bipartisan set of resolutions passed by both the US House of Representatives and Senate that sought to curtail US support of the war (President Biden announced an end to US support for the Saudi-led bombing on February 4, 2021). The US economic sanctions imposed on Venezuela, and military posturing meant to support the right-wing leader Juan Guaidó, have caused food and medication shortages and as many as 40 000 deaths.[340] Trump's strong support for the Benjamin Netanyahu government in Israel has encouraged increased repression of Palestinians in the West Bank and Gaza.[341] Additionally, the Trump administration has cut US contributions (from US$350 million in 2017 to US$60 million in 2018) to the UN Relief and Works Agency that provides health and education assistance to Palestinians.[342]

Threats to reproductive rights

President Trump's efforts to win the support of domestic evangelical Christian voters through reinforcement of anti-abortion policies in foreign aid programmes reflect his damaging effect on reproductive rights. He reinstated and expanded the so-called Mexico City policy[343] (now called Protecting Life in Global Health Assistance). The early 1984 version of this policy, which bans US funding for non-governmental organisations (NGOs) that provide abortion or that counsel or refer women for abortion (except in very narrowly defined circumstances), only applied to NGOs that were not based in the USA. The 2017 version expanded the policy to also include NGOs based in the USA.[344] The earlier version cut off funding for groups such as the International Planned Parenthood Federation (based in the UK) and was associated with increased unintended pregnancies[345] and abortions in sub-Saharan Africa.[346] One study reviewing the early effects of the 2017 policy suggests that it has harmed women's health, although the authors note that stakeholders' reluctance to go against US authorities might have dampened the reporting of deleterious effects.[347] President Biden revoked the Mexico City policy in January, 2021.

Racism

President Trump's description of Haiti and some African nations as "shithole countries" led the UN and the African Union to label his comments as racist.[348] Racism also underlies many of his other statements, such as comments to other world leaders that refugees threaten European culture,[349] and his administration's maltreatment of refugees, especially children (discussed in section 3). Additionally, President Trump's continued and expanded executive order, now revoked, that banned people from Muslim-majority countries from entering

the USA, which eventually applied to much of Africa, threatened to dampen collaboration among low-income countries and international collaboration through many US universities.

Finally, Trump sought to deflect attention from the failure of his COVID-19 response by blaming and vilifying China, a step that has led to attacks on Asian American people, and obstructing international cooperation and shared learning that could enable control of the ongoing pandemic.

Isolationism

President Trump's isolationist America First doctrine resulted in withdrawal from international initiatives such as the Paris Agreement on climate change (discussed in section 7). Trump's isolationist view extended to people living in the USA (primarily health-care professionals) who offered assistance to other countries. This view was promoted in August, 2014 (ie, even before he assumed the presidency) as shown when he tweeted, "the US cannot allow EBOLA infected people back. People that go to far away places to help out are great—but must suffer the consequences".[350] The Trump administration also reduced participation in the response to the global AIDS epidemic, an important collaborative global health effort and a cornerstone of US aid-related diplomacy since 2003. President Trump's fiscal year 2021 budget proposal called for cutting US$1·52 billion from the US President's Emergency Plan for AIDS Relief and US$902 million from funding for the Global Fund to Fight AIDS, Tuberculosis and Malaria.[351] In an era with newly available tools to end the AIDS pandemic, such cuts threaten to set collaborative global efforts back for decades and slow progress. Additionally, Trump's 2021 budget proposal sought to cut funding for global health and disease control by one-third, cuts that would affect the CDC, the US Agency for International Development, WHO, and the Pan-American Health Organization (PAHO),[352] threatening PAHO with collapse.[353] At a crucial point in the COVID-19 pandemic, Trump announced that the USA would withdraw funding from WHO, undermining global health efforts in controlling the virus.

The rapid spread of COVID-19 infection is a reminder of the vulnerability of even the most powerful nations in an interconnected world and the importance of competent and compassionate leadership. In the past, the USA has played an important, albeit imperfect, role on the global health stage and its economic dominance assures that US politics are influential. The Biden administration must recognise that progress is not a zero-sum game and accept the responsibility of the USA to re-join global efforts to create an improved and peaceful world for everyone.

Section 10: Mobilising for change

Despite the turbulence of the Trump era, burgeoning movements advocating for a just and healthy society and a transformed cultural zeitgeist give reason for hope for the future.

Important signs of those movements emerged before Trump's election—Occupy Wall Street (2011) that decried wealth inequality, Black Lives Matter (founded 2013), the Dreamer movement that advocates for immigrants' rights (which coalesced in 2010 when Congress failed to pass the Dream Act), protests for Native American sovereignty and water protection at Standing Rock Reservation (from April, 2016, to February, 2017), and widespread movements against global warming and for LGBTQ rights and Medicare for All.

In January, 2017, the massive Women's Marches that took place the day after Trump's inauguration gave promise of resistance to his agenda. In the same year, resistance again was shown by the million people who participated in the March for Science, which called for leaders to make evidence-based policies, a demand that was emphasised by the 6 million youth climate strikers who protested throughout 2019.[354]

Resistance turned to incipient revolt in the spring and summer of 2020. The triggering event—a video of a white policeman calmly murdering George Floyd, a Black man, while other officers looked on—shocked a previously inattentive white population and a Black population in the USA who were familiar with such scenes. Frustration built from four centuries of racist oppression, four decades of retrogressive policies and practices, and four months of COVID-19-related lockdowns and the virus' inequitable toll, resulted in widespread unrest. Suddenly, tens of millions, Black and white, showed their anger in protests on a scale not witnessed in the USA since the 1960s or 1930s.[355]

In response, President Trump, similar to President Nixon in the 1960s, pinned his electoral hopes on mobilising white panic and backlash and promising to deploy repressive military force to restore law and order. Nixon's response signalled the end of an era of social progress. Trump's response seems more likely to herald an era of intensified struggle and social advance.

Past advances—ie, during Reconstruction, the New Deal, and the civil rights era—emerged from conflict, agitation, and struggle. Social, health, and legal protections that US residents now take for granted were won, not given. The success of recent movements will be measured by whether they initiate a new era of progress, not just the ending of the Trump era.

Health-care scholars and practitioners can support efforts to redress inequities by documenting health injustices. However, analysis must be coupled with action. Health-care professionals alone cannot transform the policy environment but can lend expertise, voice, cultural capital, and their presence in public protests with others to bolster movements for change.

We highlight three factors that are crucial to the effectiveness of efforts to achieve political and social

change:[356] the roles of framing, coalition building, and strategies for action. We hope to spark reflection on how health-care workers can advance health, equity and democracy in an era when these ideals are imperilled.

Framing

Successful activism needs more than good ideas, it needs to strike the right rhetorical chords through framing—ie, the imagery, motifs, metaphors, and stories that mobilise "typically unconscious structures called 'frames'".[357] Health-based frames often amplify social justice messages in other domains, an approach consonant with the Health in All Policies framework.

Advocacy for reproductive rights in the 1970s offers one example of how health-based frames can promote social justice issues. Activists pushed four simultaneous arguments for the legalisation of abortion.[358] One argument emphasised the autonomy of physicians and the sanctity of the doctor-patient relationship. A second cited a constitutional precedent affirming a so-called zone of privacy in marriage. A third argument centred around equality, noting that affluent but not poor women could access safe abortion, often by travelling overseas. Finally, an explicitly feminist rationale portrayed abortion as a woman's decision and right. Although all four frames circulated in the public sphere, the courts focused mostly on the two conservative arguments (ie, sanctity of the doctor-patient relationship and the right to privacy), which contributed to the US Supreme Court's decision legalising abortion in the *Roe v Wade* case. Nonetheless, the equality and feminist frames resonated in the broader cultural milieu, at a time of social turbulence and increasing receptivity to novel critiques of class and gender inequality. On the issue of abortion, the salience of particular frames depended heavily on the audience—ie, judges, legislators, or the public.

Timing also matters in determining whether a frame gains traction. In 1971, an era when private coverage carried minimal out-of-pocket costs, the nascent movement for national health insurance focused on covering the roughly 20 million people who were uninsured. Nowadays, with 30 million people still uninsured, the resurgent advocacy for Medicare for All often highlights problems afflicting insured US residents, such as surprise bills and medical bankruptcy.

Many framing dilemmas persist. For instance, some criminal justice reform advocates focus on the racism that is suffusing US laws, policing, and sentencing. Others appeal to fiscal conservatism, citing the ballooning cost of imprisoning 2 million people. Both appear to be mobilising public support, as shown by the passage of the federal First Step Act (discussed in section 2), a Florida ballot initiative to restore voting rights to most ex-prisoners, and California's and President Biden's decisions to end the use of for-profit prisons. Health professionals have framed mass incarceration and police violence as public health hazards, in accord with the tenets of the Health in All Policies framework that highlights the health consequences of policy choices in non-health domains, such as transportation and land-use zoning policies.

Although a common goal can be presented through different frames, rhetorical differences within a protest movement often reflect divergent goals. Some anti-police brutality activists call for the abolition of police departments in their current form and a rethinking of public safety systems, pointing to police departments' origins in the armed militias that suppressed Native Americans and people who were enslaved. In their view, policing the boundaries of white privilege is a cardinal feature of US law enforcement, which inevitably breeds racialised police violence. Others advocate for defunding of the police—ie, shifting some current police funding to social and mental-health services (demands shared by police abolitionists)—and community control reforms that would shift the power to hire, fire, and prosecute officers to directly elected civilian councils. The least militant frame promotes police reform implemented through changes in police training and culture. The long-term outcomes of the movement against police violence remain unknown; however, public sympathy for anti-racism protesters is high. Despite Trump's efforts to mobilise a backlash, approximately 64% of US adults supported the racial justice protests.[355]

Coalition building

Movements are often strengthened by building coalitions across sectors. In the Trump era, health workers' political involvement helped bolster social movements by informing, reassuring, and expanding the coalitions' bases.

For example, the push for gun control gained traction following a mass shooting in 1999 at a school in Columbine, Colorado. After one subsequent school shooting, many health-care professionals joined the March for Our Lives (2018), a series of student-led demonstrations and teach-ins for gun control.[359] In response to a position paper by the American College of Physicians,[360] the politically powerful US National Rifle Association posted a mocking tweet: "someone should tell self-important anti-gun doctors to stay in their lane".[361] Trauma surgeons and other health-care workers responded with a social media barrage, posting gruesome images and stories about gunshot injuries and more than 40 000 health-care providers signed a petition declaring "this is our lane".[362]

Students studying to be health-care professionals have been particularly prominent in social activism. For example, in 2014, in protest of police killings of unarmed Black men, medical students inspired by the Black Lives Matter movement formed White Coats for Black Lives, which organised (using social media) well-publicised so-called die-ins on international Human Rights Day at more than 80 US medical schools.[363] Medical

students, unions, and community allies also protested at the 2019 national meeting of the AMA, demanding that the association rescind its long-standing policy opposing single-payer health-care reform. Although not ultimately successful, a resolution to rescind the policy lost by a surprisingly narrow (47% *vs* 53%) margin.

Organisations have also taken action; medical societies including the American Academy of Pediatrics have issued statements condemning the separation of migrant children from their families. Medical journals (including many owned by medical societies) have welcomed research on immigrant health, racial disparities, firearms deaths, and particularly access to health care, with the intention of promoting evidence-based policy changes. Many medical groups, including Doctors for America, mobilised to lobby for passage and implementation of the ACA. Medicare for All has long been advocated by Physicians for a National Health Program, nurses unions, and, in January, 2020, the American College of Physicians.

Health workers' participation in coalitions also helps expand resources and offer vital protection. When the Lakota people of Standing Rock, ND, camped out in icy weather to block construction of the Dakota Access Pipeline, health workers provided supplies and on-site medical care, echoing the efforts of physicians and nurses who provided a medical presence hoping to protect activists who were under violent attack during the civil rights movement.[364]

Coalitions are also bolstered by inclusivity but social movements have sometimes failed to involve low-income and minority constituencies most harmed by policy shortcomings. However, there are signs that inclusivity is increasing. Disability rights organisations have mobilised important activism for Medicare for All and the ACA. The SisterSong Collective, led by women of colour, advocates the centring of Black women's issues and leadership in reproductive justice campaigns.[365]

Strategies and tactics

Health activists have also used various strategies and tactics to boost movements for social change. For instance, in the 1960s and 1970s, the Black Panther Party highlighted the inadequate health care and systemic health inequities imposed on African Americans by opening 13 free clinics and providing free breakfasts for children, as part of a broader strategy to end racist violence.[366]

In December, 2019, inspired by the Close the Camps campaign against immigrant detention, health-care workers organised a so-called white coat demonstration (which included the president of the California Medical Association) and civil disobedience to protest the Trump administration's refusal to vaccinate people in detention (or allow volunteer clinicians to do so), even after several detained children died from influenza.

The Black Panther clinics, and physicians' public offer to vaccinate detainees as part of advocating for more humane treatment, are examples of prefigurative politics—ie, modelling a better world through direct action.

Medical activists have also highlighted the life and death consequences of injustice. To advocate for drug price regulation, the Right Care Alliance organised health professionals and grieving parents to deliver the ashes of a young diabetic who died because he couldn't afford insulin to executives of pharmaceutical company Sanofi. Widespread protests against Trump's changes to the public charge immigration rules (described in section 3 and section 6) have featured health experts' warnings of the risks to child health.

Nowadays, activists work in a transformed media ecology. In the past, social movements reached the public through the print and broadcast media. For example, after the first Gay Pride march in 1970 in New York received wide press coverage, marches spread to cities across the world the following year. In the past decade, social media has allowed organisers to bypass traditional outlets and accelerate the spread of movements. For instance, the 2017 Women's March protesting Trump's misogyny and racism was organised mainly via social media; the effort drew 3 million demonstrators in the USA and an additional 4 million worldwide, with only a few months' lead time. The #MeToo movement is another striking example of major movements during the Trump Era. In 2006, activist Tarana Burke coined the term Me Too to highlight the pervasiveness of sexual violence. On Oct 15, 2017, actress and activist Alyssa Milano developed the hashtag #MeToo and encouraged women to tweet personal stories of sexual predation. Within 24 h, that hashtag was used by more than 4·7 million people in 12 million posts.[367] Another striking and reverberative example is Black Lives Matter, which also originated as a hashtag.

Looking ahead

President Trump's violation of democratic norms, incitement of racial, religious, and xenophobic hatred, attacks on environmental regulation and reproductive rights, and efforts to undermine health and social programmes could have a silver lining. His actions aroused activist energies and political engagement that are transforming US politics.

In 1977, activists and scholars Frances Fox Piven and Richard Cloward argued that sudden disruption to the status quo—whether by popular protests or changing electoral realignment—often cause big positive changes in public opinion and, subsequently, public policy.[368] Historically, eras of enlightened health and social policy change have often followed difficult periods. The confluence in 2020 of a viral pandemic, economic stagnation, racist murders, and climate disaster (all aggravated by

	Obama era	Trump era	Examples of relevant Trump actions
SDG 1 No Poverty: end poverty in all its forms everywhere	Little effect	Very negative	Undermined health insurance, cut housing aid, changed public charge rule to discourage immigrants' use of public benefits, constrained disaster aid for Puerto Rico
SDG 2 Zero Hunger: end hunger, achieve food security and improved nutrition, and promote sustainable agriculture	Somewhat positive	Very negative	Cut food assistance and imposed barriers to participation, relaxed school lunch nutrition standards and meat safety standards, proposed cuts to sustainable agriculture and conservation programmes
SDG 3 Good health and well-being: ensure healthy lives and promote wellbeing for all at all ages	Somewhat negative	Very negative	Blocked gun-control measures, increased funding to address opioid overdose epidemic
SDG 4 Quality education: ensure inclusive and equitable quality education	Little effect	Very negative	Revoked guidelines encouraging diversity in educational institutions, backed anti-affirmative action lawsuits, proposed US$66·6 billion cut in federal education funding
SDG 5 Gender equality: achieve gender equality and empower all women and girls	Little effect	Very negative	Appointed judges and officials who are hostile to reproductive rights, gag rules and other denials of funding for reproductive health, relaxed rules for schools' sexual harassment and assault policies, exempted health providers from providing or referring patients for abortion services
SDG 6 Clean water and sanitation—ensure availability and sustainable management of water and sanitation for all	Somewhat positive	Somewhat negative	Exempted non-navigable waterways from Clean Water Act, approved of the Dakota Access Pipeline that threatens the Missouri River
SDG 7 Affordable and clean energy: ensure access to affordable, reliable, sustainable, and modern energy for all	Very positive	Very negative	Gutted environmental regulations and encouraged coal burning, rescinded Clean Fuel grant programme, imposed tariffs on solar panels that raised solar power costs
SDG 8 Decent work and economic growth: promote sustained, inclusive, and sustainable economic growth, full and productive employment and decent work for all	Somewhat positive	Little effect	Continued economic and employment growth until COVID-19 crisis, trade wars, environmental deregulation, relaxed regulation of financial institutions and fiduciaries
SDG 9 Industry, innovation, and infrastructure: build resilient infrastructure, promote inclusive and sustainable industrialisation and foster innovation	Little effect	Very negative	Deregulated occupational and chemical hazards, obstructed funding for Puerto Rico hurricane and earthquake recovery, undermined disaster preparedness
SDG 10 Reduce inequality: reduce inequality within and among countries	Little effect	Very negative	Cut social, nutrition and medical programmes for the poor, so-called Muslim ban, tax windfalls for wealthy, failed to enforce civil rights and fair housing standards, encouraged voting rights restrictions, weakened protections for LGBTQ people
SDG 11 Sustainable cities and communities: make cities and human settlements inclusive, safe, resilient, and sustainable	Little effect	Very negative	Aggressively enforced exclusion, deportation, and incarceration of immigrants, including crackdowns on sanctuary cities or states, failed to act on threat of global warming, weakened CDC and state and local public health departments
SDG 12 Responsible consumption and production: ensure sustainable consumption and production patterns	Little effect	Very negative	Weakened auto fuel economy standards, eviscerated key food and agriculture research programmes, excluded key epidemiologic research from environmental regulatory decisions
SDG 13 Climate action: take urgent action to combat climate change and its impacts	Somewhat positive	Very negative	Withdrew from Paris Agreement, reversed environmental regulations
SDG 14 Life below water: conserve and sustainably use the oceans, seas, and marine resources for sustainable development	Little effect	Very negative	Expanded off-shore drilling for oil and gas, removed protections from marine national monuments, removed annual catch limits on numerous fish species
SDG 15 Life on land: protect, restore, and promote sustainable use of terrestrial ecosystems, sustainably manage forests, combat desertification, and halt and reverse land degradation and halt biodiversity loss	Somewhat positive	Very negative	Allowed mining and fossil fuel extraction in National Monuments, weakened endangered species and migratory bird protections
SDG 16 Peace, justice, and strong institutions: promote peaceful and inclusive societies for sustainable development, provide access to justice for all and build effective, accountable and inclusive institutions at all levels	Little effect	Very negative	Expanded military, including ending land mine ban; revoked requirement to report civilian casualties from US airstrikes, imposed bellicose foreign and trade policies, ended federal oversight of violent and discriminatory policing, encouraged racism and bigotry, reduced incarceration
SDG 17 Partnerships for the goals: strengthen the means of implementation and revitalise the global partnership for sustainable development	Somewhat positive	Somewhat negative	Cut foreign aid and global health spending

Evaluations represent consensus of Commission members. CDC=Centers for Disease Control Prevention. SDG=Sustainable Development Goal.

Table 4: **The effect of Trump-era versus Obama-era actions on the SDGs**

For the **complete list of Trump-era regulatory actions** see https://www.brookings.edu/interactives/tracking-deregulation-in-the-trump-era/

Trump and authoritarian leaders elsewhere) might yet presage a period of social progress.

Movements for social justice are, along with scientific advances and exemplary medical care, key to health improvement. It is incumbent on health-care professionals to offer their expertise and support to all such health-enhancing efforts.

Conclusion

During the Trump era the USA was led by a president whose disdain for science and manipulation of hatred jeopardise the health of the world and its people. President Trump's denunciations of the status quo ante and promises to return the USA to greatness, camouflaged policies that enriched people who were

***Panel 6*: Commission recommendations**

Recommendations for immediate executive action

- Implement a nationwide, science-led response to the COVID-19 pandemic*
- Enforce civil rights, voting rights, and fair-housing laws
- Include medical institutions' progress on diversity in grant or contract review criteria for US National Institutes for Health, US Centers for Disease Control (CDC), and other federal agencies
- Reinvigorate Justice Department oversight of discriminatory policing and end transfers of surplus military equipment to police departments
- Recommit to the Paris Climate Agreement* and reinstate occupational and environmental protections and funding
- Curtail federal prosecutions of substance use and pardon people previously convicted for such use
- Ban for-profit prisons and immigration detention facilities
- Revoke Trump's anti-immigrant executive orders* and policies and assure humane treatment of migrants and people fleeing persecution
- Deliver fully adequate disaster aid to Puerto Rico
- Align US foreign and trade policy with measures to promote the Sustainable Development Goals
- Abolish regulations that treat sexual-health services differently from other health services
- Reverse the Justice Department's support for lawsuits seeking to overturn the Affordable Care Act

Recommendations for legislative action

- Compensate Native Americans, Native Hawaiians, Puerto Ricans and African Americans for the wealth denied to and confiscated from those groups in the past
- Implement the Green New Deal, end subsidies and tax breaks for fossil fuels, and ban coal mining and single-use plastics
- Repeal the 2017 tax cuts on corporations and the wealthy, implement new taxes on assets, and increase taxes on capital gains and high earnings
- Increase public expenditures for social programmes, currently 18·7% of gross domestic product (GDP), to 24·2% (the average of other G7 nations), and repeal time limits and immigration restrictions on welfare and nutrition programmes
- Cut defence spending from the current 3·4% of GDP to 1·4% (the average of other G7 nations) and increase foreign development aid from 0·18% at present to the UN target of 0·7%
- Comply with long unmet obligations under treaties between the governments of the US and American Indian Nations, including boosting the funding of the Indian Health Service to levels commensurate with need
- Implement single-payer national health insurance and regulate drug prices
- Double federal public health spending, and reverse funding cuts to the CDC and global health programmes
- Guarantee shelter and increase funding for public and subsidised housing
- Prioritise funding for substance use treatment integrated with harm reduction and social services
- Make free school meals universal and implement policies to improve their nutritional quality
- Raise the minimum wage and strengthen labour protections
- Enact immigration reforms based on an inclusive vision of national identity, including: a realistic path for those seeking to immigrate; a roadmap to citizenship for undocumented individuals;† and human rights protections for detainees and other vulnerable migrants
- Restrict gun sales
- Eliminate patents, trade agreement restrictions, and treaties that impede global access to vital generic drugs
- Implement criminal justice reform through community control of the police, ending cash bail, shifting funds for public safety to mental health and social intervention, and ending special legal immunity for police
- Upgrade Puerto Rico's status to assure equal treatment to US states
- Protect democracy by implementing campaign finance reform, easing voter registration, and facilitating voting

*Action taken by President Biden in January, 2021. †Legislative proposal introduced by President Biden in January, 2021.

already very wealthy and gave corporations licence to degrade the environment for financial gain. He halted progress in almost every domain (table 4), undermined care for low-income people and the middle class, weakened pandemic preparedness; withheld food and shelter from those in need, and persecuted those who were vulnerable and oppressed.

Unfortunately, Trump's politics and policies are not an isolated US aberration.

Authoritarian agendas are spreading worldwide, as politicians mobilise people unsettled by their declining prospects to go against those below them in racial, religious, or social hierarchies. Leaders with agendas similar to Trump's already hold sway in many places—eg, Turkey, India, Hungary, the Philippines, and Brazil. In many other countries such leaders are gaining influence.

Trump's election was enabled by the failures of his predecessors. A four-decade long drift toward neo-liberal policies bolstered corporate prerogatives, privatised government services, reinforced racism, and imposed public austerity. The rich got much richer while their taxes were halved. Workers' earnings stagnated, welfare programmes shrank, prison populations greatly increased, and millions were priced out of health care even as government payments enriched medical investors.

GDP grew but longevity lagged, a sign of profound social dysfunction.

The path away from Trump's politics of anger and despair cannot lead through past policies. President Biden must act for the people, not for the wealthy and the corporations they control. Resources to combat climate change, raise living standards, drop financial barriers to higher education and medical care, meet global aid responsibilities, and empower oppressed communities within the USA must come from taxes on the rich, and deep cuts in military spending (panel 6). For health care, overreliance on the private sector raises costs and distorts priorities, government must be a doer, not just a funder—eg, directly providing health coverage and engaging in drug development rather than paying private firms to carry out such functions.

The suffering and dislocation inflicted by COVID-19 has exposed the frailty of the US social and medical order, and the interconnectedness of society. A new politics is needed, whose appeal rests on a vision of shared prosperity and a kind society. Health-care workers have much to contribute in formulating and advancing that vision, and our patients, communities, and planet have much to gain from it.

Contributors

All Commissioners participated in the conception and design of the report and approved the final draft. SW and DUH oversaw the project and they integrated and edited all sections, in collaboration with KG. MTB and MM helped obtain funding. DB provided administrative oversight and support. The following Commissioners and advisers led the drafting of individual sections of the report: section 1 (JB, AV, SG, HH, and MTB), section 2 (ZB, AMc, LT, MB, SLD, KG, and MTB), section 3 (AS, SA, and DS), section 4 (HH and DS), section 5 (AG and DM, with assistance from AMc, DS, SLD, and RM), section 6 (MN), section 7 (PJL, SF, JSM, and MM), section 8 (LP, JSM, and SLD), section 9 (JSM and MM), section 10 (MC, DB, JEM, and AS), panel 2 (Prof Alfredo Morabia and the Editors of the *American Journal of Public Health—AJPH*), and panel 3 (OC, with assistance from MN). JB, AV, AG, RM, SLD, GG, DUH, and SW did quantitative analyses that appear in section 1 and section 5, and in stand-alone manuscripts published separately from the Commission. JB did the analysis of the county level voting and mortality trends in figure 4. Additional Commission stand-alone analyses have addressed human rights protections for immigrants (LT, AS, and MM), and Puerto Rico (OC and MN), and outcomes in investor-owned versus non-profit health facilities (SLD, RM, and GG). ML participated in the Commission's initial discussions while affiliated with National Nurses United, he subsequently left the Commission because of a competing obligation and rejoined it after that obligation ended. All Commission members read, suggested revisions to, and approved the final version of the report.

Declaration of interests

KG is a member of the Board of Canopy Health, a limited Knox-Keene licensed health plan in California, serving as one of 3 University of California San Francisco board members for this health plan for which UCSF is a principal equity shareholder. KG is also a member of Physicians for a National Health Program, an organisation advocating for a single payer health plan in the USA. AG is a leader of Physicians for a National Health Program, a non-profit organisation that favours expanding insurance through a single payer programme, AG is not paid by this organisation but some travel has been reimbursed. AV reports grants from Robert Wood Johnson Foundation, grants from National Institutes of Health, grants from Center for Financial Security (University of Wisconsin), grants from Commonwealth of Kentucky, outside the submitted work. All other authors declare no competing interests.

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The ACT NOW: END AIDS Coalition and AIDS United
Recommendations for the Biden-Harris Administration

With all eyes on public health as 2020 comes to a close while the COVID-19 pandemic rages, the people of the United States face multiple threats to wellbeing as we await the next presidential administration in 2021. In response to ongoing pressure from HIV and reproductive justice communities for a comprehensive federal initiative to stop the spread of HIV domestically, in 2019 the United States Department of Health and Human Services adopted *Ending the HIV Epidemic: A Plan for America (EHE).* Across the country, public health leaders recognized EHE as an opportunity for progress among the communities most impacted by HIV in this nation. However, the COVID-19 pandemic and several of the incumbent administration's Executive Orders and policies have damaged health outcomes and violated the rights of communities already disproportionately impacted by HIV, and contradicted or delayed EHE efforts. The health and well-being of Black, Indigenous, Latinx, people of color, transgender, low-income, uninsured, and underinsured individuals across the United States requires their direct leadership in EHE efforts and federal safeguards that create equitable access to care for all Americans.

The next administration must elevate EHE and honor the work HIV leaders have put into the initiative thus far, while assuring that community is truly at the center of the next federal strategy. The 2020 World AIDS Day statement from Biden-Harris leaves us hopeful that together, the HIV community and incoming administration can create a robust plan to end the HIV epidemic in all communities across this country by 2025. The biomedical outcomes laid out in the nation's current EHE initiative can only be achieved through the simultaneous prioritization and protection of the health and rights of people living with HIV (PLHIV) and vulnerable to the virus. The EHE Initiative creates a framework to end HIV in this country; its next iteration needs to work in compliment to advocacy for universal health coverage, racial health equity, housing assistance, food security, and must address all social determinants of health.

We caution the Biden-Harris administration from simply recycling and supplanting EHE with a resurrection of the National HIV/AIDS Strategy (NHAS) that was admirably led by the Obama-Biden administration. NHAS provided a strong federal framework and foundation for where the nation needs to go to truly achieve an end to the epidemic. But the incoming administration must seize this opportunity to put forth an even bolder plan, backed by evidence and science-based policy, and in close collaboration with impacted communities in its development and implementation.

The ACT NOW: END AIDS (ANEA) Coalition represents community-based organizations, health departments, government, and community leaders invested in elevating community solutions to ending the HIV epidemic in the United States. In solidarity with the communities ANEA and AIDS United represent, we share the following recommendations to the incoming Biden-Harris Administration. Together, we can create a health system that protects individuals equitably regardless of race, gender, sexuality, migrant status, geography, economic status, or individual behavior.

Immediate action needed:

1. Restore trust in public health:

The inept and highly politicized COVID-19 response of the Trump administration circulated mixed messages and false statements about the virus, significantly hampering the ability of government agencies and health care providers to effectively disseminate best practices for containing COVID-19 and save lives. This mixed messaging, paired with a lack of a nationally coordinated response plan, have damaged public trust in health care, public health, and clinical research. As a step toward restoring trust, the US must offer health guidance that is clear, consistent, and science-based to both slow the spread of COVID-19 and address the roadblocks to EHE that have resulted as a consequence of the pandemic.

Trust is critical to actualizing biomedical prevention and treatment options for HIV (HIV-testing, pre and post-exposure prophylaxis [PrEP and PEP], and treatment-as-prevention)—whose service-delivery options have experienced significant interruptions due to COVID-19. Creating innovative messaging for biomedical HIV prevention, treatment options, and anti-stigma campaigns, such as Undetectable Equals Untransmittable (U=U), has become increasingly challenging due to the decline in public health credibility across the US. Conversely, when leaders like Demetre Daskalakis and Rochelle Walenksy are chosen for high-level positions like their newest roles at the Centers for Disease Control and Prevention (CDC), because of their pre-existing and tangible commitments to the HIV community, messaging about HIV prevention and treatment goes further and trust in public health institutions begins to increase.

Healthcare mistrust is higher in communities of color due to the compounding impacts of racial discrimination, over policing and excessive incarceration, and the US history of medical malfeasance against these communities. Thus practices like Molecular HIV Surveillance (MHS), a key feature of the "Respond" EHE pillar, create additional mistrust among HIV communities. MHS is the collection and use of people's biological data to track and prevent new HIV transmissions in clusters. There is no evidence that these data, when paired with recency assays, won't be used to criminalize PLHIV. ANEA urges federal leaders to immediately create HIV surveillance and research safeguards, such as those laid out in AIDS United's Public Policy Council June 2020 MHS Position Statement, to prevent the unintended consequences of MHS, and restore community trust in future plans to end HIV.

2. Address the barriers to ending HIV during the COVID-19 pandemic:
According to a survey by NASTAD in August 2020[1], more than 90 percent of health department staff in jurisdictions within the federal EHE plan report being detailed to the COVID-19 response. Hospital and clinic closures have made HIV testing, labs, and screening for PrEP increasingly difficult across the country. Due to the pandemic, an already aging infectious disease workforce had to shift their attention entirely to caring for COVID-19 patients, leaving people with HIV with fewer options for care. As these service disruptions and closures continue, and social distancing regulations ease, an increase to HIV and sexually transmitted infection (STI) incidence is estimated across the nation.

According to a survey done by the National Coalition of STD Directors[2], sixty percent of sexual health screening clinics report having to reduce hours or shut down altogether sometime due to COVID-19. The report highlights that the recent decline in reported STIs (many of which can be asymptomatic) is likely due to decreases in routine STI/HIV screening, and/or the inability to access programs. To prepare for the potential of a rise in STI and HIV rates, the recommendations detailed below for HIV also must be incorporated into the STI National Strategic Plan. Additionally, federal leaders should release public guidance that echos the creativity from health departments like the New York City Department of Health's *Safer Sex and COVID-19* guide that offers harm reduction strategies for both STIs and COVID-19 .

3. Secure/restore funding for innovative HIV programs and research:
COVID-19 care is straining many state and city budgets, jeopardizing resources that fund HIV prevention, care, and research. National Institutes of Health (NIH) coordinated HIV research networks, which have been well-developed through years of bipartisan funding, have been increasingly leveraged for its expertise and infrastructure in the COVID-19 epidemic. Many HIV researchers doing critical research on novel HIV therapies, vaccines, and cures have been pulled into COVID-19 research, possibly slowing the pipeline of HIV therapies. The extra cost of adapting to telehealth and the delivery delays experienced by HIV-drug-research labs have put additional financial strains on HIV-research. HIV research remains a wise government investment, yielding significant cross-benefits in the development of therapeutics and other biomedical interventions for addressing HCV, tuberculosis, cancer and now COVID-19. Yet, despite the historical scientific gains, HIV research continues to be flat-funded with small increases in the past two fiscal cycles. A significant increase in resources is needed for the National Institute of Allergy and Infectious Diseases (NIAID) and the Office of AIDS Research (OAR) to truly reach a vaccine and a cure for HIV.

Funding increases across all National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention centers commensurate with the actual scopes of each epidemic and their sydnemic

[1] https://www.nastad.org/sites/default/files/resources/docs/nastad_covid_rfi.pdf
[2] https://www.ncsddc.org/resource/covid-19-and-the-state-of-the-std-field/

effects are critical to getting the nation on track to end HIV by 2025. Federal programs like HUD's Housing Opportunities for People with AIDS (HOPWA) and the CDC's Division of Viral Hepatitis have been chronically underfunded as waitlists for their life-saving services get longer. As individuals continue to lose jobs and health insurance due the pandemic, the strain on state-run Ryan White Care programs continues to grow. The FY2020 Coronavirus Aid, Relief and Economic Security (CARES Act) provided one-time funding to the current Ryan White HIV/AIDS Programs (RWHAP) who received $90 million for the COVID-19 related health service needs of their clients. While the pandemic remains uncontrolled, there is an immediate need for additional emergency funding to RWHAP, cities, and states across the nation.

4. Uphold the human rights of key communities impacted by HIV/AIDS:
The previous administration expanded an unprecedented and often unilateral assault on the rights of historically marginalized and HIV-vulnerable communities in the U.S., including sex workers, people who use drugs (PWUD), people of trans experience, immigrants, Black people and other people of color. Through a series of harmful legislation, executive orders (EOs), as well as hateful and stigmatizing rhetoric - the rights of these communities have been dangerously eroded in the past four years, threatening these communities with violence and complicating their livelihoods and health. These policies only make it impossible for the administration and public health workers to engage these communities to end the epidemic. The Biden-Harris administration must take critical steps to directly restore and uphold the human rights of these communities impacted by HIV in its first 100 days.

Specifically, the incoming administration must immediately repeal and end several harmful and contradictory EOs that have complicated healthcare access, expanded punitive strategies that criminalize, and perpetuate stigma. These include orders that have disallowed any legal recourse for stigmatized communities that experience discrimination in the healthcare system (1557 waiver), to pronouncements that barred the participation of impacted communities in our nation's armed forces simply due to their HIV status and/or transgender identity. Ending these policies are key to meeting the vision of "unity" that the incoming administration seeks across a fractured nation, by centering those who have historically and increasingly been pushed to the margins.

In addition to immediately ending harmful policies, the Biden-Harris administration must demonstrate support by subsequently increasing funding and resources for these communities. Increased funding to engage people-who-use-drugs and sex workers, two communities often neglected in ending the epidemic plans, is necessary to prevent new HIV transmissions. A way for the new administration to demonstrate its commitment to diverse communities is by lifting the federal funding ban on the purchase of sterile syringes, which are instrumental in preventing both HIV and viral hepatitis. This could lead to truly disruptively innovative strategies to end the HIV epidemic among communities who inject drugs. Additionally, decriminalizing and

destigmitazing sex work by removing punitive laws that target sex workers and securing funding for HIV prevention and treatment options specific to the sex woker community would signal that the wellbeing of all individuals impacted by HIV is of importance to the incoming presidential administration.

5. Integrate the emerging innovations to telemedicine into federal efforts to end HIV:
The telemedicine options for healthcare introduced by COVID-19 have not only improved appointment retention across the country but have also benefited community engagement, HIV prevention, and treatment widely. The creation of accessible, virtual community engagement through the distribution of mutual aid funds for basic technological and other needs (tablets, phones, WiFi hotspots, and grocery gift-cards) have increased participation in meetings focused on receiving community input on ending the epidemic plans. This elevated accessibility and re-distribution of resources must continue beyond the COVID-19 pandemic in order to keep key communities at the center of public health strategies.

Innovations to PrEP, treatment, and other prevention options must be taken further by the incoming administration. Widespread access to 90-day supplies of HIV treatment or prevention medications have increased adherence across the nation, and in some states (WA, CO, CA) barriers to PrEP/PEP initiation have been removed by allowing for direct pharmacist prescriptions. In New York City, the promotion and access to on-demand PrEP (health clinics immediately starting people at risk for HIV on PrEP before all relevant laboratory tests return) has proven to be a safe model for increasing the uptake of PrEP via walk-in clinics. Streamlining funding and creating federal plans for the use of long-acting HIV treatment options such as intravaginal rings, injectable drugs, implants, and antibodies provides more options to individuals and can bring the U.S. closer to ending the HIV epidemic.

The COVID-19 pandemic has also shown us how profoundly beneficial telemedicine can be towards ending the overdose epidemic. The removal of arbitrary barriers to medication assisted treatment for opioid-use disorders has helped many people living with substance use disorders get access to previously unobtainable treatment. To mitigate the increase in overdose events since COVID-19, federal leaders must continue to augment naloxone distribution (including take-home naloxone) and advocate for access to medication-assisted treatment (MAT) for all people who want to stop using drugs.

6. Build directly upon the creativity of the intersectional HIV community:
The HIV community has advanced innovative messaging and stigma reduction strategies, like U=U, that can help the U.S achieve its ending epidemic goals. Innovative harm reduction strategies, such as medication-assisted treatment and Safer Drug Consumption Spaces (SCS), have proven to reduce or cease injection drug use, greatly reducing the risk of HIV transmission. Strategies like these that push the envelope on traditional HIV prevention further, have been

underfunded and undervalued in the current federal EHE strategy. The Biden-Harris administration must invest in the creativity of the communities most impacted by HIV to bring these innovations to scale in the current under resourced settings.

HIV leaders belong to intersecting movements and understand that any policy that advances the wellbeing of the individuals marginalized in the US is also a policy that can help end HIV. There are a number of critical community centered approaches to address the human-rights disparities currently occurring in communities marginalized across the nation. A few important examples of both practical and legislative recommendations to end HIV and the correlating inequities that fuel every domestic public health crisis in this nation are: 1. We the People; A Black Plan to End HIV 2. The National Latinx Health Policy Agenda 3. The Movement for Black Lives Policy Platform 4. The Sex Workers Outreach Program USA- Advocacy Agenda 2020-2022 5. American Disabled for Attendant Programs Housing Platform. To successfully end the epidemic, the incoming administration's federal HIV response must integrate key concepts from these diverse guiding documents written directly *by-and-for* communities marginalized by HIV.

A new administration, a renewed opportunity for community leadership:

As it stands, EHE funding requires the engagement of key communities throughout its four pillars. However, until clear pathways for community leadership are integrated into all aspects of a federal HIV strategy, this call will remain symbolic at best. We offer the following policy recommendations to the Biden-Harris transition team as opportunities to augment resources and create a safer environment for community-leadership throughout the nation's HIV response.

Policy Recommendations:

To truly achieve any ending the epidemic goals, the Biden-Harris Administration and the 117th Congress must:

1. **Undo Trump Era Executive Orders and Rules Detrimental to Ending the HIV Epidemic.**
    a. Undo Trump's final rule on section 1557 of the ACA
    b. Repeal the ban against racial and gender justice trainings for federal workers
    c. Repeal the attacks on LGBTQ communities
    d. Repeal the harmful executive orders on migrant communities
    e. Repeal global and domestic restrictions to sexual and reproductive healthcare and information
    f. End the ban on open services by transgender and PLHIV in the military
2. **Ensure Broad and Equitable Access to Effective HIV Care and Treatment.**
    a. Enhance the Ryan White HIV/AIDS Program for the communities most impacted by HIV and continue to fund access to essential services (transportation, food and nutrition, linguistic services, case management, housing services, etc.) for program recipients

b. Adopt national strategies to eliminate viral hepatitis, STIs, and TB
c. Eliminate the 29-month waiting period before SSDI recipients can obtain Medicare benefits

3. **Prevent New HIV Transmissions.**
   a. Fund community-based HIV service organizations to provide COVID-19 testing, to increase local usage of ASO/CBOs and to potentially increase HIV testing among people who are traditionally missed by testing efforts
   b. Work with Congress to fully repeal the ban on federal funding for sterile syringes and other materials needed to reduce the risk of HIV transmission in injection drug use.
   c. Fund and scale up PrEP, PEP, and treatment-as-prevention services and messaging for priority HIV populations
   d. Eliminate mandatory and discretionary abstinence-only-until-marriage (AOUM) and sexual risk avoidance (SRA) programs in public schools
4. **Address Social and Structural Barriers to Effective HIV Prevention and Care.**
   a. Pass the Anti-Racism in Public Health Act to address structural racism in health care
   b. Extend the federal eviction moratorium until the COVID-19 pandemic is under control
   c. Support and pass legislation to end HIV criminalization via the REPEAL (Repeal Existing Policies that Encourage and Allow Legal) HIV Discrimination Act
   d. Decriminalize sex work
      i. Pass the Safe Sex Workers Study Act to investigate the harms done by FOSTA/SESTA
      ii. Prevent the EARN It Act from passing
      iii. Prevent the PROTECT Act from passing
   e. Create and review, with community input, the uses of HIV molecular surveillance; create and publish guidelines restricting the access to said data from local, state, and federal policing and law enforcement agencies; and research its efficacy in helping to reduce transmissions
   f. Eliminate eligibility restrictions to accessing HUD programs related to drug use or drug-related convictions
   g. Support the Mainstreaming Addiction Treatment Act and remove regulatory hurdles to access to medication assisted treatment, the gold standard of care for opioid-use disorder
5. **Maintain U.S. Leadership in Lifesaving Research.**
   a. Make sustained multi-year increases for HIV/AIDS research funding to meet the annual Professional Judgement Budget target from OAR at the NIH
6. **Support the Meaningful Involvement of People Living with and Vulnerable to HIV.**
   a. Center the communities most impacted by the HIV epidemic in EHE leadership and decision-making
   b. Include people living with HIV directly in the Biden-Harris administration and in the broader federal government

Conclusion:

ANEA and AIDS United lay out a comprehensive way to end the U.S. HIV epidemic by 2025 through community solutions in our policy paper: *Ending the HIV Epidemic in the United States: A Roadmap for Federal Action.* Originally published in 2018, in 2020 ANEA updated the Executive Summary to reflect the new challenges posed by the COVID-19 pandemic and the emerging opportunities to act in favor of Black lives and racial justice. Both the complete 2018 Roadmap and the 2020 Executive Summary can be found at www.anea.org/the-roadmap. We welcome the opportunity to integrate key concepts from this transition document and our Roadmap into a Biden-Harris federal plan to end the HIV epidemic.

Together, we can end the structural disparities that fuel the HIV and COVID-19 epidemics such as poverty, antiblack racism, homelessness, transphobia, xenophobia, increased policing, and economic inequality.

Sincerely,

ACT NOW: END AIDS

AIDS United

Disclaimer: The content of this statement may not express the views of all members of the Act Now: End AIDS coalition or our government partners.

For questions about this document please email anea@treatmentactiongroup.org.