

Federalism Is an Asset: How to Activate It to Build a National Pandemic Testing Program

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The U.S. is designed to be centralized and decentralized at the same time, which is exactly the structure we need right now to fight COVID-19. The ideological battles between conservatives and liberals always assume “either/or”—it is either the federal government or the states/localities that we need to steer policy, when actually it is both/and. U.S. special operations forces (under General Stanley McChrystal) successfully defeated the networked threat of al Qaeda in Iraq using a structure that was both centralized and decentralized. COVID-19 is also a networked threat. Response to the pandemic needs both a centralized authority for information gathering/dissemination, oversight of national production, and surge capacity, and a distributed capacity for execution that can respond quickly and flexibly to local circumstance. Distributed structures are of critical importance for resilience. In fighting COVID, we need distributed structures, anchored at the local level (county, metropolitan, municipal, tribal, and/or regional, depending on state and territorial public health structures), to ensure that we have as many different nodes of testing, tracing, treatment, and isolation as possible. A state-led and tribally or locally administered approach to a national testing, contact tracing, and supported isolation program (TTSI) will make for easier integration with existing equal protection and civil liberties safeguards and allow more local control, empowerment, and participation in ways that can actually advantage minorities and allow for widespread citizen engagement. This is critical at a time of widespread feelings of helplessness.

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01 Introduction

“If you’ve seen one state public health system, you’ve seen one state public health system.”

— **Public Health Official in Illinois**

As of April 7, 95% of Americans, or some 306 million people, were under stay-at-home orders or advisories ([Secon and Woodward 2020](#)). While some states have begun to reopen, it continues to be the case that there is no clear timetable for the progress and conclusion of this collective isolation, and no nationally shared strategy for addressing the pandemic. The White House routinely redirects responsibility to states and governors—cities cry out for more tests; states ask the federal government for help; the federal government tells states it’s their job (see [Eilperin et al. 2020](#)); states respond back that they don’t have the authority to generate the needed changes in the testing supply chain. In the absence of coordination, states have begun to compete ([Whalen et al. 2020](#)) with each other for ventilators, testing supplies (both PCR and serological), and personal protective equipment, driving prices up in a time when we instead need to drive prices down as part of scaling. The broad public perception is that our federal system is failing as responsibility and authority seem not to align, leading to a societal inability to mobilize for an effective response to COVID-19.

In fact, our federal structure—simultaneously centralized and decentralized—is an asset. But we need to understand that structure in order to mobilize it. Each tier of our system—federal, state and territorial, regional (via interstate compacts), tribal, county, metropolitan, and municipal—has a role to play. The conditions for the success of each tier depend on leaders in the other tiers fulfilling their own responsibilities. Our complex, interdependent system is highly resilient, provided that all tiers fulfill their assigned roles and that we design organizational structures for coordination and cooperation across the tiers.

Introduction

The policy landscape is converging around the view that in order to control COVID-19 while also reopening the economy and keeping it open, we will need to massively scale up our ability to test for presence of the virus, including in contexts of community spread, and trace the contacts of those who are COVID-positive. While policy analysts continue to debate the exact magnitude of testing we need (5 million tests a day vs. 5 million a week), it is highly likely that the country will need to administer millions of COVID-19 PCR diagnostic tests each day.⁵ That prospect has seemed daunting to some, yet it does not need to be. If we attend to the distinct role in pandemic response to be played by each tier of our federalized system, we can activate that system as an asset that can simultaneously achieve scale and flexibility—and build resilience for future pandemics and disasters.

⁵ The level of testing needed ranges from an estimate of 5 to 7 million tests a day from Ashish Jha at the Harvard Chan School of Public Health Center for Global Health (Jha, Tsai, and Jacobson 2020), to 2 million a day from the Rockefeller Foundation’s 2020 “National COVID-19 Testing Action Plan,” to 5 million a day from the “Roadmap to Pandemic Resilience” (Allen et al. 2020b).

02 Quick Review of Federalism

General Concepts

Tomes have been written on U.S. federalism, and many of its key features have been much debated, but five of its features are particularly important for understanding our current moment. The drafters of the Constitution self-consciously **tiered responsibilities and authorities**, recognizing that different kinds of functionality should be handled either nationally and centrally, or at a more local level closer to the diversity of facts on the ground. They thought explicitly about the joints connecting the whole federal system and charged the national government with **maintenance of harmony and proper intercourse among the states**. They considered the legislative branch, not the executive branch, to be the first branch of government. While power has swung to the executive over the course of our history, and particularly over the course of the twentieth century from the Great Depression onward, it is nonetheless the case that the structure of our Constitution and federal system depend in important ways on the **primacy of the legislature** (Allen 2020). Modernized federalism, a child of twentieth-century jurisprudence, introduces two additional key elements of particular relevance to us now: the role of the U.S. government in guaranteeing **equal protection of the laws** for all, thereby requiring all states to adhere to protection of constitutional rights, and the recognition that in the context of demographic diversity, **devolution of power**, where possible, provides an avenue to empowering minority subpopulations (Gerken 2020).

Recent Supreme Court jurisprudence has imposed limits on the ability of the federal government to compel the states to act. The Court, for instance, has prohibited commandeering, whereby the federal government compels state officials to act. The Court has also limited the federal government's ability to condition federal funding on state action. The federal government can nonetheless engage state governments in support of a whole-government response to an issue. The dominant approach is

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“cooperative federalism” in which states are given the opportunity to develop policy in particular areas (e.g., environmental regulation) against a backdrop in which the federal government, in the absence of state action, would itself directly regulate the actions of individuals and civil society organizations. This pathway gives states the opportunity to tailor a broad policy framework designed in broad terms by the national government to the specific needs of their state. This is the right approach to federalism for this crisis because it permits quicker, more rapidly scalable action.

In other parts of the world, the pandemic has been most easily controlled in population units smaller in scale than a massive nation state such as the U.S. China controlled the pandemic by locking down Wuhan specifically. Singapore, Hong Kong, Taiwan, Iceland, New Zealand, and Australia have been able to draw on properties of their island status and smaller populations to fend off the virus. Iceland, with a population of just over 300,000, has tested 10% of its population; the small town of Vò, Italy, tested everybody. The network properties of virus transmission mean that controls aligned to the existing networked structure of social life perform better than those disconnected from those networked structures. A case study is the contrast between Singapore, which failed to control the virus within its migrant community, and South Korea, which has moved swiftly at key points to control spread within specific communities and social networks (Mokhtar 2020). The best way of aligning COVID-19 response to the properties of disease transmission is to lodge authority for key public health decisions at the level of state and local authorities who are best positioned to understand and respond to the dynamics of community spread.

Simultaneously, however, those state and local authorities need conditions for success. The island nations combine an ability to make policy at levels closely tied to social network structures with the ability to achieve full coordination of a national economy to support that policy. Because of our tiered structure, public health authorities at the state and local level are without one of the tools they need—economic

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coordination at the national level. For this, they need leadership and support from the upper tier of the federal government.

Our tiered structure is valuable because it modularizes our society and makes it possible to deploy policy programs on smaller scales. Contact tracing and privacy is a clear example of both the benefits of a tiered federal system and of the dependence of those benefits on actors within the system performing their proper roles. A localized system of tracing and testing offers better privacy and civil liberties protections, but it also requires support from federal legislation and agencies to oversee the program. If contact tracing programs that depend on highly sensitive data are anchored at the local level, rather than flowing into nationally centralized databases, they don't pose the same degree of threat to civil liberties or introduce the same capacity for governmental surveillance and control. (There would, however, be a need for cross-state communication in a fashion similar to what occurs for traffic violations.) While that tiering of our federal structure and situating of policy authority at lower levels provides resilience and protection, success also requires support from the upper tiers of the system. Protocols for data systems should be designed at the federal level. When it comes to scale in technology, bigger, better-funded, and better-staffed organizations have clear advantages, but only if they design with local input and include mechanisms for mutual accountability.⁶

Citizens should expect the federal government to set goals and targets, and identify best practices for public health. They should expect their state, territorial, tribal, county, metropolitan, and municipal governments to develop and share pandemic response implementation plans.⁷ Those pandemic implementation plans should include strategies for management of health care for the ill, provision of

⁶ Cf. [CDC's 2005 "Policy on Releasing and Sharing Data"](#); and [HHS's 2014, "A 10-Year Vision for an Interoperable Health IT System."](#)

⁷ The jurisdictional unit that should create a pandemic plan can really get quite local. See the fine examples from Eastport, Maine, and Ajo, Arizona, as described by [Deborah Fallows in The Atlantic](#).

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support to those ordered into or voluntarily in isolation, and administration of massive scale pandemic testing, tracing, and supported isolation programs (TTSI). At the same time, however, citizens should also expect the federal government to secure the conditions of success for state and local actors.

Coordination among the tiers requires effective organizational structures. The best structures will be networked and distributed.

The Value of Networked and Distributed Structures

The U.S. public health system is massive, fragmented, and diverse.⁸ As one public health official from Illinois said, contemplating the current crisis, “If you’ve seen one state public health system, you’ve seen one state public health system.” State public health agencies work with tribal, county, metropolitan, and municipal health agencies as well as, in some cases, with regional health collaborations. Federal public health agencies work with all of the above as well as with tribal health agencies. In the context of an event such as a pandemic, state and federal health agencies also work in coordination with state and federal emergency management agencies. The entire state-, tribal-, and local-level public health apparatus finds itself working with all of the Department of Health and Human Services, CDC, and FEMA. Importantly, the federal agencies both work in support of and through states, and also work directly with affected populations, particularly under-resourced communities, as in the Ryan White HIV-AIDS initiative run by the Health Resources and Services Administration (HRSA). The HRSA is “the primary federal agency for improving health care to people who are geographically isolated, economically or medically vulnerable.” The federal government also provides direct care through veterans hospitals, Indian health services, and federally qualified health centers.⁹

⁸ For a list of accredited state and county health departments, see “[National Voluntary Accreditation for Public Health Departments](#)” (CDC 2020).

⁹ For the benefit of that safety net strategy, see, again, Deborah Fallows (2020) on Eastport, ME, and Ajo, Arizona. In each case the local pandemic plan was the result of work done by a federally qualified health center.

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The Value of Networked and Distributed Structures

Success in activating all tiers depends on distributed organizational structures that support successful flows of information both vertically and horizontally and that support cross-agency co-development of “decision support for government leaders at a local, metropolitan, region or state-level” (Fussell, Keister, and Pellegrini 2020). An organizational form known as a “fusion cell” (from the U.S. Special Operations as led by General Stanley McChrystal in the fight against the networked threat of al Qaeda in Iraq) may provide an illustrative model for interagency/intergovernmental cooperation, though additional experimentation around coordination models and best practices should also be encouraged.

In this example, using both this organizational form and the “team of teams” model, some 2,000 people came together every day on a common call to share information and under the centralized authority of McChrystal to ensure that they had “shared consciousness” and a general plan. Then they split into teams that were empowered to make decisions on their own, adapting to circumstance through “empowered execution.” In the context of the pandemic, the general plan around which “shared consciousness” forms needs to be a fully integrated policy roadmap that integrates health, economic, civil liberties, justice, and education policy at a minimum.

As with the military example, response to the pandemic needs a centralized authority for information gathering/dissemination, oversight of national production, and surge capacity, but it also needs a distributed capacity for execution that can respond quickly and flexibly to local circumstance. That distributed capacity needs nodes that bring together the several and not perfectly overlapping jurisdictions that characterize the health space within any given state. To succeed, those nodes should also connect the relevant network of health decision-makers to those working in the other substantive policy domains needed for an integrated solution to the crisis. Where an incident command system brings together all the portfolios within a specific jurisdiction, a fusion cell networks that jurisdictional structure with the other jurisdictional structures with which it overlaps and seeks to achieve “shared consciousness”

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across the overlapping jurisdictions around a set of shared and integrated set of policy goals.

Federal, state, tribal, county, metropolitan, and municipal governments, and hospital systems might all have multidisciplinary incident command structures, but in the pandemic response, they should replace bilateral communications among those independent incident command structures with a fusion cell. For instance, rather than having chains of communication from state to counties, states to cities, federal health agency to tribal health authorities, federal health agency to state public health offices, and so on, each state might link all these communications together in a daily call using a fusion cell structure. Those who staff the fusion cell would surface the data needs of decision-makers, elicit the relevant data, and provide access to it across the fusion cell. State and federal incident command systems would need to align policy goals for the fusion cells. Local level fusion cell participants would be empowered to implement shared policy goals emanating from aligned state and federal incident command systems.

An excellent example of the relevant kind of coordination is already available in the collaboration between the City of Tyler, Texas, Smith County, and the Northeast Texas Public Health District. Instead of having independent operations centers for a crisis as had been the case in the past, in this crisis, for the first time they have a joint operations center where municipal, county, and health district teams think and plan together. This partnership has permitted the county and district health officials to build out a contact-tracing strategy using personnel redeployed from the municipal level, for instance fire and police personnel and restaurant inspectors. The organizational innovation has permitted a marriage of public health expertise with municipal resource capacity. Without calling their structure a “fusion cell,” these local leaders have innovated in the organizational direction described above to make contact tracing possible in their community.

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Distributed organizational structures of this kind are resilient. When Paul Baran, a RAND Corporation researcher, was asked in 1964 to come up with a communications system that would withstand a nuclear attack, he looked at centralized, decentralized, and distributed networks (think of a fishing net) and concluded that only distributed network would do, because it is the only structure that can withstand the removal of many nodes and still survive. Distributed networks also often have the widest reach across the country, as we can see by comparing the distributed road system to the decentralized airline hub system, which leaves many places without air travel.

As testing and tracing expand across the country, much of the work of responding to the pandemic will be at a local level, even if policy frameworks and goals are set at a higher point in the system. We need distributed systems to ensure that we have as many different nodes as possible for testing, tracing, treating, and isolating, both to break the challenge of scale into manageable pieces and to allow for local empowerment, innovation, and participation. Depending on local power structures, distributing authority can allow for widespread citizen engagement, which is critical at a time of widespread feelings of helplessness. In other circumstances, local control can remove checks on deep local discrimination, which is why any response must engage local, state, and federal authorities together.

With all that said, however, effective response to the COVID crisis cannot be completely distributed. It requires more centralized communication and harmonization of action, which depends on one or more central hubs. Crisis communications systems typically have one information hub to collect and disseminate all information, but are structured in a sufficiently decentralized way such that not all members of the network receive all communications. Ideally the CDC would provide that central information hub, but university websites such as the Johns Hopkins Coronavirus Resource Center have become valuable information sources, as have various state authorities. The challenge is to centralize as much as possible in some areas while maintaining distributed structures in others.

03 The Responsibilities of Each Tier

Overview

When we focus on the resources of federalism relevant to the context of a pandemic and on distributed organizational structures, a picture for how the different parts of our federal system should be activated and coordinated comes into focus. The picture we offer here is compatible with the underlying legal structure of the distribution of public health authorities across levels of the system (Gostin et al. 2020; Allen et al. 2020a). We don't discuss legal authorities around quarantine orders and other key public health decisions; instead, we focus on responsibilities and authorities related to mobilization of the economy for treatment, support for those in quarantine and isolation, and disease mitigation and control. With that focus, we can see clear roles compatible with existing authorities for all tiers: federal, state and territorial, regional (via interstate compacts), and tribal and metropolitan/county/municipal. The key components of those roles are as follows.

The federal government should:

1. Provide surge capacity in support of health infrastructure;
2. Establish a Pandemic Testing Supply Board to organize the testing supply chain;
3. Provide scientific and policy guidance to states from the Department of Health and Human Services and CDC, supported by the National Academy of Sciences;
4. Conduct national "disease surveillance," for monitoring disease outbreaks and trajectories;
5. Maintain liquidity and fiscal viability in the system as a whole; and
6. Maintain safety net testing and contact tracing programs in communities that are not being effectively served by their state, tribal, and local governments.

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Overview

State governments should:

1. Activate state and national public health infrastructure surge capacity;
2. Establish design principles for county-level social distancing, travel restriction, and pandemic testing programs, fully integrating alignment with public health standards and ethics,¹⁰ equal protection standards, due process, non-discrimination standards, civil liberties, privacy protections, and labor protection standards;¹¹
3. Backstop access to personnel and supply resources for all counties to administer testing programs to target levels;
4. Work to coordinate efforts between counties;
5. Coordinate with neighboring states, especially when it is common for individuals to live in one state but work in another; and
6. Provide universal, free access to testing and subsequently necessary medical treatment for COVID-positive individuals without insurance.

Tribal authorities and county, metropolitan, municipal, and regional authorities should:

1. Deploy public health surge capacity in support of treatment of the ill and provision of support to the isolated;
2. Design and administer pandemic testing programs for their communities in accordance with public health standards, equal protection standards, due process, non-discrimination standards, civil liberties, privacy protection standards, and labor protection standards; and
3. Record and report pandemic relevant data upward to state and national public health laboratories in support of ongoing disease surveillance.

¹⁰ See [Public Health Leadership Society's 2002 "Principles of the Ethical Practice of Public Health."](#)

¹¹ These design principles, in other words, should deliver to localities parameters for their choices that are in alignment with the pertinent legal structures; localities would not themselves answer the complex legal questions involved in this space, but rather would make a set of implementation choices within frameworks developed by the state. Ideally, the American Law Institute would develop a "model law" that states could use to develop their own basic framework for a testing program.

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The Federal Role

The Federal Role

One job of the federal government is to maintain harmony and proper intercourse among the states. Instead, today disharmony reigns, as states compete for the supplies and personnel necessary to meet the exigencies of the moment (Whalen et al. 2020).

As argued in an earlier white paper (Weyl et al. 2020), the economic impacts of COVID-19 can be usefully partitioned into two categories: composition effects and scale effects. Composition effects refer to collapses in the demand for certain goods and services even as demand for others is sharply rising, while scale effects refer to the aggregate size of the economy with respect to employment and output. These different categories of effects require different policy responses: redeployment at scale to deal with composition effects, and social support and financing to deal with scale effects. However, our overriding goal should be clear: to maximize the speed and aggressiveness of compositional transitions to minimize the necessity of scaling down.

Surge Capacity

The intensity of the need for accelerated compositional shifts has generated fierce market competition among states for the personnel and supplies needed to fight the pandemic. The market alone cannot provide the rapid and massive redeployment of workers and capital, in part because the risks are great and the profits small. Ventilators, for instance, cannot be permitted to be sold at market clearing prices, which would enable affluent individuals to store them privately in case of future need. Such items need to be rationed and allocated in a manner consistent with norms of equitable access to lifesaving treatments. Masks, testing kits, sanitizers, and other goods in high demand also need to be rationed instead of being sold at market clearing prices to the highest bidders. A system in which states are

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competitors for scarce emergency goods on an unusually compressed time scale runs the risk of failing to deliver the compositional shifts necessary to fight COVID-19 successfully. It also runs the risk of fracturing the federal structure (in a manner similar to the tariff war that preceded the Constitutional Convention).

There are additional features of disharmony. The finances of state and local governments are already under extreme strain as revenues fall and expenditures rise, but most jurisdictions below the federal level cannot quickly or easily issue debt (or, in some cases, cannot do so at all), which leads to liquidity problems.

The federal government, then, has three jobs to do to maintain harmony and proper intercourse among the states: (1) temporarily control the supply chain for the resources needed to fight the pandemic; (2) backstop state and local government fiscal health; and (3) centralize and disseminate scientific understanding.

On all three fronts, the federal government is responsible, in essence, for enabling the federal system as a whole to activate and deploy surge capacity efficiently across the whole of the system. Our standing military, for instance, provides surge capacity needed for national defense, such that it can be activated to any state that needs it, even though states also have their own contingents of National Guard reserves. While the states individually maintain some surge capacity, the efficacy of national surge capacity depends on our ability to tap into resources (supplies, personnel, and capital) across states in a coordinated fashion in order to allocate resources where they are most needed, and to fill gaps in those resources with federal backstops. (cf. Jones and Rosenthal 2020).

While the full range of pandemic response includes providing surge capacity to the healthcare system

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specifically in the provision of care to patients, another element of needed surge capacity is the ability to massively scale up the level of diagnostic testing for the virus.

Here we currently see an especially intense need for federally activated coordination. The market has not so far supplied the necessary scale of test production. This is the basic, classic problem of coordination and planning that almost always afflicts complicated supply chains that need to be set up rapidly. In those situations, the same story is reported by almost every link in the testing architecture, from the final mile in cities and states back through the laboratories that process tests, the machine manufacturers, the factories producing RNA reagents, etc. Each player faults the other links in the chain for lacking either the relevant supply or demand to scale up, and each argues that they have heard from others that further supply is impossible or further demand is not forthcoming. Technologists argue that there is little point in producing tools for contact tracing given the lack of testing capacity, while test producers claim no one will want tests. As recently as early April, test producers reported that messages from the national government and public health community indicated that levels of testing only slightly above those at present (in the hundreds of thousands per day) would be sufficient to satisfy national goals and that, in this sense, “the testing phase of the pandemic [was] coming to a close.”

Such systemic finger-pointing, lack of common understanding, and disintegration are the classic hallmarks of the coordination failures that occur in complex, interdependent systems that need to rapidly change to serve a new demand. In virtually every successful historical example of such rapid coordination, a central authority has set goals and ensured each that part of the chain meets the interlocking goals required for that chain to succeed. This authority must have clarity on the levels and kinds of output required at each level to reach desired targets and induce all parts of the chain to act in conformity with this plan, in order to prevent failure in one part of the chain from sowing systemic distrust. This complex interconnecting system can be removed from many other parts of the mobilization, such as

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vaccinations, the supply of treatments and treatment equipment to hospitals, etc. This removal is in fact desirable as it allows great scope for innovation and experimentation. Only the parts that must be tightly coupled to achieve confidence need be managed by the same central authority, and such centralized management will be necessary only for the length of the crisis, as in wartime.

In wartime, the federal government must coordinate the national economy in order to deliver to generals in the field the resources of person-power and materiel that the generals need. So too in this context, the federal government must deliver those resources—but now to the governors, mayors, and tribal and local public health officials.

The federal government should develop an overall pandemic strategy in relation to which states and territories, and tribal and local leaders will coordinate their plans. In addition to mobilizing national economic resources effectively, the federal government should mobilize and disseminate national scientific resources in support of the success of governors, mayors, and tribal and local public health officials. To support the federal government in succeeding in this role, states need to share aggregate, anonymized data from their testing programs with the Department of Health and Human Services, and federal agencies, for instance the CDC, for purposes of disease surveillance.

Who should take responsibility for these functions? Congress or the president? This is another place where the answer is both/and. While the president has the responsibility for executing a war as commander-in-chief, and for executing a national pandemic strategy, the president shares power with Congress in setting a pandemic strategy. Indeed, Congress' authority to declare war, and in that regard to establish overarching strategic objectives for the nation, even with regard to matters of national security, underscores the scope of Congress' powers also in the context of a pandemic. Here too Congress can and should assert its powers as the first branch to establish overarching strategic objectives and to

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appropriate funds in support of them, assigning to the president the execution of the strategy.

Interstate Compacts and Pandemic Testing Board

Beyond this wartime model, there is another way of thinking about the federal role: the constitutional provision by which Congress can establish an interstate compact to carry out regional infrastructure projects with powers delegated from Congress. The Port Authority, an interstate compact linking New York and New Jersey, is a good example. States routinely coordinate as a policy matter, as they are currently doing through newly created regional coalitions. But the interstate compacts clause allows states to take on powers that would otherwise be within the ambit of the federal government. Compacts can be authorized before they are created or after they are proposed, and Congress can appropriate money to fund their activities. Via an interstate compact, Congress can set strategy, the president approves by signing the bill, and the responsibility of execution falls upon governors (Hansmann and Sitaraman 2020).

To realize its power and activate the federal system in support of the states and harmonization of their actions, Congress should establish a Pandemic Testing Board (PTB), akin to the War Production Board that the United States created during World War II. The purpose of the board would be to solve the supply chain problems and to massively scale up the production and deployment of testing. The PTB would work closely with the Department of Health and Human Services, and particularly its agency the CDC, as advised by the National Academy of Sciences, to establish target testing levels for the country as well as guidance to states on how to set their own targets.

Congress should allow the states, via an interstate compact, to create that Pandemic Testing Board, empower it to produce and deploy tests, and fully fund its activities. The board would be made up of

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nine members, from business, labor, academia, and government, and would be appointed by a bipartisan pair of governors who would chair the interstate compact. The board would have the power to coordinate production of tests and any testing materials—including to direct factories to produce essential materials—and to work with the states to develop strategies to deploy those tests. To ensure there aren't conflicts of interest and that taxpayers are protected, Congress would put ethics rules and oversight into its authorization of the compact as well. An alternative would be for Congress to establish the board as a federal agency, with the decision about which path to take depending on whether the governors or the president are in the moment of the crisis the better executors' of the national will as expressed by Congress.

Safety Net

In addition to providing surge capacity to complement state efforts and coordinating supply chains via the establishment of a Pandemic Testing Board through an interstate compact, the federal government also has the responsibility to define what is a minimum acceptable “floor” for COVID-19 testing. States have approached health care reform and expanded access to health care efforts unevenly. A recent example is the continued refusal by fourteen states to adopt Medicaid expansion as offered by the Affordable Care Act. Infectious diseases, unfortunately, do not recognize state boundaries. A significant portion of the population lives in one state and works in or frequently travels to another state. While states can require people coming from high-risk states with insufficient infection control to be tested and quarantined until the test results return (Hansmann and Sitaraman 2020), they cannot close their borders to residents of other states. Consequently, it is the responsibility of the federal government to ensure that the choices made by one state do not threaten public health in another state. Under the coercion doctrine found in constitutional jurisprudence, most notably in *National Federation of Independent Business v. Sebelius*, the federal government cannot directly compel the states to act nor

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use its spending power to de facto compel states to act. Furthermore, forcing states to engage in COVID-testing when they are reluctant to do so would undermine the benefits of federalism, as would the federal government assuming control of all testing programs across the country.

To facilitate state autonomy and achieve the benefits of federalism while preserving minimum public health, the federal government will need to create or define a minimally acceptable COVID-testing program to complement state efforts. The virtue of a system with a federally managed minimum but an emphasis on state leadership whenever possible is that it allows for the experimentation we value in our federalist system. This model is similar to the approach taken to build the health insurance exchanges mandated by the Affordable Care Act. States were given the option to build their own marketplaces or to use a federally designed platform. The federal government would run the marketplace for any state that refused or did not feel capable of administering its own exchange. As of 2020, thirteen states operated their own marketplaces, six states used the federal platform for their marketplaces, and thirty-two states allowed the federal government to run their exchanges.

The minimally acceptable COVID-testing program could include certain benchmarks, such as testing certain percentages of urban and rural populations. States that can meet or improve upon these minimum requirements will receive federal funding to help support their efforts. The federal government should deploy additional resources in states that refuse or cannot meet these minimum requirements. These resources could take the form of increased testing for the public through the Veterans Health Administration. The federal government could also utilize the federally qualified health centers, which already provide primary care to underserved populations, to add testing capacity.

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The State Role

The State Role

Most public health authorities lie with the states in regard to issuing social distancing orders, internal travel restrictions, and quarantine and isolation orders (Gostin et al. 2020). As with our discussion of the federal government, these are not our concern here. Here we focus instead on the states' and territories' responsibility for the mobilization of surge capacity. It is important to understand the framework within which states and territories do this work.

The jurisprudence flowing from the Fourteenth Amendment has established the federal government as a bulwark of civil rights and civil liberties against state actions that might undermine them. Consequently, state governments now exercise their powers and authorities very much constrained by the requirement to deliver equal protection of the laws in relation to all the rights encoded in the Constitution. As legal scholar Heather Gerken points out, "Ours is not your father's federalism. Today's federalism is sheared of sovereignty. Despite the best efforts of its conservative majority, the Supreme Court has failed to curb federal power. As a result, states cannot shield their discrimination from national norms, as they did during the days of Jim Crow" (Gerken 2020, p. 228).

This feature of our federal system, interestingly, means that all state policies must be designed in relation to requirements of the equal protection clause. This makes state-level policy-making a valuable asset for experimenting with policy decisions to find those that best align with protection of civil rights and civil liberties.

Gerken also highlights a second feature of modernized federalism, namely the fact that the plethora of jurisdictions can be a resource for empowerment and equality. People who are members of minority populations within a national population can nonetheless exercise majoritarian power within more

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The Responsibilities of Each Tier

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local jurisdictions, acquiring autonomy and deploying power to shape policy in ways that maximally recognize the distinctive features of their experience and perspective. As Gerken points out, this flexibility to federalism and its provision of opportunities for empowerment provides an additional route to justice. Policy can be adjusted to place and context by local decision-making and thereby more fully empower a diverse population in equitable ways. In such a policy-making context, local decision makers can be given design principles and then asked to deliver the version of a policy for their context that best meets the objectives of these design principles.

A key element of pandemic policy is the development of diagnostic testing and contact tracing regimes (Watson et al. 2020). These trigger significant concerns about civil liberties, civil rights, and justice. As states design frameworks for diagnostic testing and contact tracing programs that will be administered by tribal and local health departments, they must do so in full accord with the existing requirements for protections of all civil rights and liberties. Testing programs must be designed to anticipate and prohibit potentially discriminatory effects, to maximize privacy protections, to support labor protections including health accommodations, and to provide universal access to testing and any subsequent necessary treatment. States can and should experiment with how best to develop and implement effective testing and tracing programs consistent with non-discrimination and equal protection requirements, learning from one another in the process.

A model COVID-testing program law should be developed to assist states in their decision-making. This model law would be similar to the Model State Emergency Health Powers Act in that it would serve as guidance and inspiration for states. That model law should harness the power of federalism and incorporate clear guidance about how to adhere to public health standards, equal protection standards, due process, non-discrimination standards, civil liberties, privacy protections, and labor protection standards. Accompanying materials could also include guidance for counties looking to

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implement COVID-testing programs. The American Law Institute would be the ideal entity for developing such a model law.

The Role of Tribal, County, Metropolitan, and Municipal Jurisdictions

As states develop the framework and design principles for local testing programs, they should do so with the goal of devolving as much power as possible to the public and civil society authorities that are as closely linked as possible to the individuals participating in the testing program. To the maximum extent possible, testing and tracing programs, especially social supports for those under quarantine and isolation, should be administered at levels of government, or even civil society, maximally close to those they serve. One reason to prefer such devolution is to ensure that testing programs are administered and adapted by those in whom there is the most trust. Surveys of trust routinely reveal that Americans report higher levels of trust in their local rather than their federal representatives (McCarthy 2018; Pew Research Center 2019). A second reason to prefer devolution is that needs will vary across jurisdictions and significant scope for experimentation and learning should be allowed.

That said, allowing diversity in policy could well require significant controls of mobility across local jurisdictions, so that laxer jurisdictions do not spread infection to stricter ones. The problem of horizontal externalities is a core problem in federalism and one that's been litigated often—for example, in the Dormant Commerce Clause. There's also a substantial danger that some states will attempt to free-ride off of the states who do a better job and will impose externalities on others. This is one of the thorniest subjects to be addressed in the development of a model law for state-level testing programs. The federal role in establishing a minimal performance threshold is key to keeping the diversity within bounds that don't undermine the collective effort as a whole.

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The Role of Tribal, County, Metropolitan, and Municipal Jurisdictions

The nation's public health system has long operated with a structure that devolves power to local authorities, ranging from tribal jurisdictions to counties to metropolitan areas to regional consortia. State-by-state decisions will be needed to determine the correct jurisdictional authority in each state to run a diagnostic testing and contact-tracing program for the state's communities. The goal, however, should be to turn the country into so many Icelands, units whose scale is such that comprehensive diagnostic testing programs can be accomplished within each identified jurisdiction. Of course, local leadership is widely variable across the country in terms of resource base and effectiveness. Overlapping jurisdiction is already practiced in other areas of public health to address this issue. For example, Massachusetts empowers both the state Department of Public Health and local boards of health "to conduct surveillance activities necessary for the investigation, control and prevention of diseases dangerous to the public health" (105 Mass. Code Regs. 300.190). To ensure that there is sufficient testing everywhere, states and/or federal authorities may need to run testing programs directly in some locations. Public health departments in rural areas or lower-income communities may not have the infrastructure, resources, or expertise to lead their testing programs. Just as the federal government should establish the minimum standards necessary for states to meet (see above), states should provide guidance to local leadership on their minimally acceptable programs. States are better situated to provide this guidance than the federal government, because they know the unique challenges present. For example, New York State may create different requirements for denser municipalities, where infection can spread very quickly through a large number of people, than for more sparsely populated rural areas. In cases where local leadership is entirely missing, states should deploy their departments of public health to work with local providers to ensure testing.

We are well aware of the worry that situating testing and tracing programs at the local level will entrench regional inequalities or undermine the importance of shared national experience in a democracy in a moment of crisis. We are also aware that local communities have shown historically that they

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have as much capacity for acting tyrannically as do state or federal institutions. Leaving to local governments to decide how to enact tracing could leave too much room for discretion, or could blur or muddy the lines of political accountability. But these are extraordinary times, in which we must act as quickly as we can on the best information we can gather and the best safeguards we can design.

States should audit and hold local programs to account; they also have a responsibility to support surge capacity in those counties with fewer resources. An incentive for funding equalization is the simple fact that in a pandemic, the weak link will bring us all down. States will be naturally incentivized to want every local jurisdiction to succeed at test administration. This provides an opportunity to reverse the disinvestment in county-level public health of recent decades (McKillopp and Ilakkuvan 2019).

With all the pieces of the federal structure activated, mediated by state policy frameworks, the nation's tribal authorities and local governments should be able to deliver pandemic testing programs tailored to their context, but structured around design principles informed by national guidance.

04 Massively Scaled-Up Local Programs for Testing and Contact Tracing

Therapeutic Testing Plus Contact Tracing

The public health profession has made long-standing use of the tools of diagnostic testing and contact tracing to fight infectious disease. Existing public health programs throughout the country are equipped with knowledge of how to run such programs. In these programs, those who are symptomatic or who have a reasonable suspicion of COVID-19 exposure are tested, in order to connect them to necessary treatment. Then their contacts are traced and quarantined.

The Johns Hopkins Center for Health Security has recently sketched the components of a scaled-up testing and tracing program. As they put it, “contact tracing approaches will need to be adapted to jurisdictions based on existing public health infrastructure” (Watson et al. 2020, p. 12). Scaling up should be managed by “state and territorial public health departments” and “local and tribal health departments should be involved to coordinate contact tracing activities in their jurisdictions.” Pointing to the importance of something like the fusion cell model, they write, “Incorporation of mayors, community leaders, and faith leaders into planning and discussions will maximize the ability of jurisdictions to successfully support contact tracing at the community level” (Id). The goal is a “multi-agency and multi-sectoral coordinated approach” (Ibid p. 9). With the goal of tracing every diagnosed case of COVID-19 in the US, and basing their estimates of the work force needed on contact tracing programs for COVID-19 in other countries, the Johns Hopkins team recommends that we “at least start by adding an extra 100,000 contact tracers across the United States” (Ibid p. 8). These contact tracers would move among hot spots.

The Johns Hopkins report, written in collaboration with the Association of State and Territorial Health Officials, makes a compelling case that it is possible to run a massively scaled-up, manual traditional <https://ethics.harvard.edu/federalism-asset>

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contact tracing program in the U.S. However, the report does not provide epidemiological models to guide the level of testing needed to find all diagnosable cases. The report adheres to the therapeutic public health methodology of limiting testing to those who are symptomatic or who have good reason to believe they have been exposed via community spread. For the contacts of those who have tested positive, they recommend not diagnostic tests but quarantine. They also recommend widespread serological testing in order to assess rates of prevalence (p. 3). The numerical analyses of the quantity of contact tracing needed are rough estimates that derive from existing caseloads and general awareness of the shortfalls in diagnostic testing in the U.S. Consequently, the testing and contact tracing program that they outline may or may not suffice to control the disease. It will surely help to mitigate it but whether it would suffice to replace social distancing is unclear.

Consequently, there is still a need to describe what a massively scaled up testing program would look like, one that would generate more cases to trace than our current testing regime generates. To give ourselves a sense of the range of possibilities, the sketch that follows lays out elements of an approach that could be used for a program of nearly universal testing, should we find that that is the only way of controlling the disease.

Universal Testing Plus Contact Tracing

How would jurisdictions administer universal testing and contact tracing programs should that turn be what we need to control the disease without relying on collective stay-at-home orders? First we discuss the general concepts on which such a program should be built; then we offer a rough sketch of how to organize the mechanics of such a program, using a hypothetical Jones County as our unit of

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administration for the purposes of this sketch. This is not because we are specifically recommending a county-level program. We agree with the Johns Hopkins report that each state should make determinations about the appropriate jurisdictional level at which a contact tracing and testing program should be administered. Rather, we describe a hypothetical county program to demonstrate the kinds of questions that would emerge if one tried to design and build a universal testing program administered at the local level. We offer the sketch as a spur to thought, not as a formal policy recommendation. Each state, working with its local health departments, would need to design a testing program that aligns with the specific features of its own context.

General Concepts

Local level pandemic testing programs can be built with a similar structure to drug testing programs, drawing on the state's public authority to license, as it does with driving, but with a clear focus on the objectives of providing health care to the tested individual and of protecting the health of the broader community. Employers, schools, and public-assistance programs all have a reasonable basis on which to require tests, and the state could mandate this.

Currently, 56% of American employers use drug testing programs in both pre-employment and random testing contexts (Wylie 2018). Employees or prospective employees can visit any number of available and certified drug testing facilities; often urgent care facilities play this role. A "medical recording officer" at the facility reports the result of the test to the employer. In this regard, the medical recording officer functions much like any other public authority responsible for licensing.

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In addition to this use of drug testing by employers, states have also pushed aggressively for drug testing for those receiving public assistance.¹² This was blocked in a 2003 Michigan Court of Appeals case. *Marchwinski v. Howard* ruled that such tests were not allowable and “that subjecting every welfare applicant in Michigan to a drug test without reason to believe that drugs were being used, was unconstitutional.”¹³ Between 2011 and 2014, however, twelve states passed legislation requiring drug testing, having designed programs that complied with the standard set in *Marchwinski*.¹⁴

There are important differences between drug testing and COVID-19 testing. Although the legal landscape is changing rapidly, drug testing can reveal behavior connected to illegal narcotics activities and generates stigmatizing associations between the individual tested and illegal activity. Nor is drug testing typically used to connect people to health care (though perhaps it should be). COVID-19 testing, in contrast, has the goal of ensuring that all who need treatment for COVID-19 receive it and that those who are infectious without being symptomatic do not pass the virus on to others. The consequence of

¹² The National Conference of State Legislatures reports, “Substance abuse issues have long been part of public assistance policy discussions. States have proposed drug testing of applicants and recipients of public welfare benefits since federal welfare reform in 1996. The federal rules permit drug testing as part of the Temporary Assistance for Needy Families block grant. In recent years, nearly all states have proposed some form of drug testing or screening for applicants. In 2009, over 20 states proposed legislation that would require drug testing as a condition of eligibility for public assistance programs. In 2010 at least 12 states had similar proposals. None of these proposals became law because most of the legislation was focused on “suspicionless” or “random” drug testing, which is at odds with a 2003 Michigan Court of Appeals case. *Marchwinski v. Howard* ruled that subjecting every welfare applicant in Michigan to a drug test without reason to believe that drugs were being used, was unconstitutional” (<https://www.ncsl.org/research/human-services/drug-testing-and-public-assistance.aspx>).

¹³ [The National Conference of State Legislatures 2017 report, “Drug Testing for Welfare Recipients and Public Assistance.”](#)

¹⁴ The National Conference of State Legislatures reports, “The proposals gained momentum beginning in the 2011 session. Three states passed legislation in 2011, four states enacted laws in 2012, two states passed legislation in 2013, and three states passed legislation in 2014, bringing the total number of states to twelve. In 2013, Kansas enacted legislation to require drug testing for applicants and recipients suspected of using controlled substances. In 2012, Utah passed legislation requiring applicants to complete a written questionnaire screening for drug use and Georgia passed legislation requiring drug tests for all applicants for Temporary Assistance for Needy Families. Tennessee approved a bill to require the department to develop a plan for substance abuse testing for all applicants and Oklahoma passed a measure requiring all applicants for TANF to be screened for illegal drug use.”

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testing positive for COVID-19 is not a no-hire decision or loss of employment. Indeed, this needs to be written into legislation for the program. It is instead a recommendation to seek treatment and/or isolate for a recommended period (in all likelihood 14 to 28 days), with job protection guarantees. This is not meant to suggest that problems of stigma or abdications of societal responsibility will not arise for COVID-19 as they have for other diseases. Indeed, these are problems that we should anticipate and seek to ward off (Brandt and Botelho 2020). Nonetheless, the policy objectives for COVID-19 testing should be plainly directed at allocation of access to health resources. Tests should be designed to be an opportunity for connection to care, not a form of surveillance. While testing for illegal narcotics is also typically justified on health and safety grounds, in the case of illegal narcotics, it is the community that is being protected. In the case of COVID-19 testing, it is both the individual and the community that are being protected. An important part of any COVID-19 testing program will be the provision of adequate health resources to all. The resources of solidarity necessary to fight a pandemic in a democracy depend on materially meaningful social contract commitments (Cammatt and Lieberman 2020).

In relation to the contrast between drug testing and COVID-19 testing, it is important to note that the Appeals Court basis for invalidating any effort to connect broad drug testing to provision of public benefits does not pertain in the case of COVID-19. The argument in the former case is that the state cannot require drug tests of public benefits recipients “without reason to believe that drugs were being used.” But with COVID-19, the point of testing is precisely that we have good reason to believe that any one of us might in fact be carriers of the virus, even if we do not display symptoms.

Similarly, local contact tracing programs have long been in existence, particularly in relation to HIV, tuberculosis, measles, and syphilis. A particularly good example is the HIV testing and tracing program based in each of New York’s boroughs. Grouped under the title New York Knows, these programs involve community organizations as partners in recruiting people to be tested and in conducting contact

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tracing subsequent to positive tests. They have set the goal of ensuring that every borough resident has an HIV test. Importantly, the motivation for contact tracing programs of these kinds is the duty we all bear to warn others of their imminent danger, if and when we learn of it and if we have it within our power to warn them.

The next important question is what a COVID-19 testing program would look like if constructed out of these pre-existing policy tools.

Specific Mechanics for a Hypothetical County-Level Universal Testing Program

Here we sketch a possible approach to the specific mechanics of a county-level pandemic testing program in our hypothetical Jones County. We address the what, why, who, when, and “what else.”

What

In Jones county, when disease prevalence is above a threshold established by public health authorities or the reproduction number for the virus in the county is greater than 1, a person wishing to enter a work site and school must show a PCR or serological test showing either a recent negative result or antibody-based immunity (contingent on stable scientific knowledge about the relation between antibodies and immunity). Any test result—whether positive or negative—would be necessary for receipt of public benefits, subject to all the provisos below concerning the availability, affordability, and reliability of tests and a robust set of privacy and civil liberties protections. All work, school, and public places (e.g., shopping malls, theaters, etc.) are required to have operating thermal scanners in use at entrances during periods when pandemic testing programs are in effect. When disease prevalence is below the threshold, no such requirement may be imposed. Any effort to require proof of testing when no such program is authorized by the county is subject to civil and/or criminal penalty. Those who are registered for the testing program receive a testing card, much like a driver’s license but with a magnetic strip for

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encoded information; this card records their test status and is readable in the locations where sharing of test results is required. Those who prefer to carry their credential on their phone are able to opt into an app-based version of the credential that also provides privacy-protective contact tracing and warning services to users.

Tests are free to those without insurance and are offered at urgent care sites, doctors' offices, and other state-licensed testing sites. All sites receive reimbursement from state funds for the tests given to the uninsured. As an example of a state-licensed testing site, in Massachusetts, State Farm offices are able to renew drivers' license applications. Community organizations can apply to serve as testing sites, as in the New York Knows HIV-testing program. Jones County actively recruits community organizations to support testing of homeless populations and other vulnerable communities that are not well provisioned with urgent care sites, doctor's offices, or state-licensed testing sites.

Positive tests result in the individual being referred to medical care and a recommendation to isolate either at home or in a treatment facility. Isolation is monitored by a human isolation monitor or electronically, depending on caseloads. A first violation of isolation results in a warning. A second violation results in a fine. Existing models for successful monitoring range from the purely voluntary as in a 2004 Iowa measles outbreak to programs with penalties, as in the program used in Taiwan in the 2003 SARS outbreak.¹⁵

¹⁵ In the 2003 measles outbreak in Iowa, isolation and quarantine were voluntary; health department officials monitored the individuals in isolation or quarantine with unannounced daily visits and/or phone calls (CDC 2004). In the 2003 SARS outbreak in Taiwan, the protocol was as follows: "Persons under quarantine were required to stay where they were quarantined; take their temperature two to three times a day; seek medical attention promptly if they had fever (>100.4° F [>38° C]), cough, shortness of breath, or other respiratory symptoms; cover their nose and mouth with tissue paper when coughing or sneezing; and wear surgical masks when around other persons and outside the quarantine site. They were not allowed to use public transportation, visit hospitalized patients, or visit crowded public places. Persons under Level A quarantine could leave the quarantine site only for activities deemed necessary by local health authorities; meals were delivered. Persons under Level B quarantine were allowed to leave the quarantine site to seek medical attention, exercise in an open area, purchase meals, dispose of garbage, and perform other activities deemed necessary by local health authorities. All outdoor trips were recorded to facilitate possible future investigations. Failure to comply with quarantine regulations, submitting incomplete SARS inaccurate contact information, or providing inaccurate contact information was punishable by fines of U.S. \$1,765—\$8,824 and incarceration of <= 2 years" (CDC 2003).

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Why

The Jones County pandemic testing program offers universal access to COVID-19 testing and universal access to care for those who are COVID-positive and requires a high level of participation in order to connect infected individuals to appropriate care and supports and to reduce transmission of this highly infectious disease in the community. The goals of the pandemic testing program are that everyone should have access to the tests and care they need so that: (1) Jones County can secure a stable public health situation, (2) Jones County can get its economy running again and keep it running, and (3) people can be connected to opportunity, health, and a sense of safety. To succeed, Jones County strives to do this justly, fairly, and freely.

Who

During the period when a pandemic testing program is in effect, exemptions are available to those who can certify adherence to ongoing, extensive social distancing. Jones County's Department of Children and Family Protective Services prioritizes assessment of exemptions during time periods when a pandemic testing program is in effect. Those who are exempt receive an exemption card, which must be reactivated on a monthly basis.

Those who choose not to pursue an exemption and are therefore required to participate in the pandemic testing program must register at their chosen testing site, providing either employment, school, or social service agency registration number. Participants will be equipped with their COVID record ID. Registering for testing will involve setting a regular appointment slot.

Personnel at the testing sites include test administrators, medical record officers, manual contact tracers,

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and isolation monitors. Medical record officers use data systems to automatically report results to schools, workplaces, and social service agencies. Personnel in each of these locations are assigned responsibility to audit receipt of testing results on a weekly basis, and are responsible for reporting audit results to Jones County and the state. Manual contact tracers are assigned to each testing location and follow up on any positive test, unless the relevant individual is participating in a digital contact tracing program that has reached an adoption rate of at least 75% within Jones County. Surge personnel to staff these testing sites are provided to Jones County through state and federal health reserves (affiliated with the National Guard at the state level and the Department of Health and Human Services at the national level).

When

Tests are required with rates of frequency that depend on the prevalence of the virus within the community. In contexts of high prevalence, residents in Jones County expect a testing rate of once a week per individual; in contexts of moderate prevalence, residents expect a testing rate of once every two weeks; in contexts of low but still meaningful prevalence, residents expect a testing rate of once every month. Those individuals who frequent socially dense locations within the county or parts of the community with greater exposure are likely to be identified by contact tracing programs as requiring tests with above-average frequency. Testing rates should be closely monitored for appropriateness of testing levels, with a view to non-discrimination standards. Employers and schools are required to make time accommodations for testing.

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What Else

Public Gatherings

As long as virus prevalence in Jones County is low, places of public association are open on the same terms as prior to the pandemic. When prevalence is moderate, places of public association can be open with extra space among tables, thermal scanners at entrances, and audited hygiene standards. When prevalence is high, places of public association can be open if they are willing to accept and check pandemic virus tests result cards in a process roughly equivalent to the ID checks required at the entrances to many office buildings in large cities. When prevalence exceeds the top threshold, or the reproduction number rises above 1, such locations must close. Workplaces and schools can, however, stay open, if they require virus test cards for entrance and use thermal scanners at entrances.

Travel

Jones County sets travel guidelines that also track prevalence levels and are established by county health commissioners, in relation to a framework worked out by the state Department of Public Health and in accordance with the constitutional requirement to keep borders open, albeit with controlled terms of entry.

Data

All COVID-19 testing medical recording officers in Jones County use the same data system, which rolls up to county level, state level, and then national level. This has been built by the U.S. Department of Health and Human Services on top of the ILINETs system for influenza. The system used to report

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individualized data to workplaces, schools, and social service agencies is segregated from the data systems used to aggregate data for upward reporting to the county, state, and federal levels. Jones County disseminates information about prevalence levels to all businesses, schools, and social service organizations on a daily basis, as well as in routine news reports. This permits the public to hold authorities accountable for the removal of the testing program when the triggers that justify it no longer obtain.

Expiration

All of these policies of a pandemic testing program will expire in the event of the emergence of a vaccine or of therapeutics that reduce the severity of the disease and make community spread tolerable. The policies can be held in reserve, though, for use in a future pandemic.

Coordination

The leading public health official for Jones County and municipal leaders with adjacent portfolios participate in a daily statewide fusion cell call, with other county teams and with representatives from the State Budget Office and State Departments of Health, Transportation, Labor, Education, and Criminal Justice, and from tribal jurisdictions in the state, as well as a representative from the US Department of Health and Human Services and FEMA.

Upshot of the Hypothetical

This hypothetical example is not intended as a policy recommendation nor as a policy blueprint. Instead, it serves to demonstrate the kinds of questions that would require attention in any effort to make

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widespread testing a basic part of disease control and pandemic resilience. One of the challenging features of attempting to sketch a program of this kind is that the varying characteristics of different diseases require developing programs that are specific to the infection at issue. COVID-19 has a degree of infectiousness and ability to transmit through asymptomatic carriers that distinguishes it from other infectious diseases. A COVID-19 testing program will be different in kind from programs for other infectious diseases for this reason. In pandemic preparation, one cannot design a single testing program that will work for all diseases and jurisdictions. Instead municipalities and health officials will always need a fresh design that takes into account epidemiological features of the situation they face and their own community context. This reinforces the importance of having distributed and decentralized organizational structures capable of undertaking this tailoring rapidly.

05 Conclusion

Activating all tiers of our federal system and ensuring their successful coordination across levels requires networked, distributed systems of communication. We can achieve this, but to do so we need to elevate our ambitions. While many think that our decentralized federalist system is a liability, in fact its flexibility, modularity, and potential for well-structured forms of support across its several tiers are assets. They provide the resources that make it possible to navigate crises and emergencies, even of surprising, novel varieties, in ways that are protective of freedom, equality, justice, and constitutional democracy. And this is the goal: to defeat COVID 19—saving lives, securing our public health infrastructure, and mobilizing a healthy economy—in ways that align with the protection of liberty and justice and build long-term pandemic resilience.

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