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LOOKING BACK BEFORE MOVING FORWARD:

ASSESSING CDC'S FAILURES IN FULFILLING ITS MISSION

WEDNESDAY, JUNE 7, 2023

House of Representatives,

Subcommittee on Oversight and Investigations,

Committee on Energy and Commerce,

Washington, D.C.

The subcommittee met, pursuant to call, at 10:31 a.m. in Room 2322, Rayburn House Office Building, Hon. Morgan Griffith [chairman of the subcommittee] presiding.

Present: Representatives Griffith, Burgess, Guthrie, Duncan, Palmer, Lesko, Armstrong, Cammack, Rodgers (ex officio); Castor, DeGette, Tonko, Ruiz, Peters, and Pallone (ex officio).

Also present: Representative Miller-Meeks.

Staff Present: Sean Brebbia, Chief Counsel; Lauren Eriksen, Clerk; Tara Hupman, Chief Counsel; Peter Kielty, General Counsel; Emily King, Member Services Director; Chris Krepich, Press Secretary; Molly Lolli, Counsel; Gavin Proffitt, Professional Staff Member; John Strom, Counsel; Joanne Thomas, Counsel; Austin Flack, Minority Junior Professional Staff Member; Waverly Gordon, Minority Deputy Staff Director and General Counsel; Liz Johns, Minority GAO Detailee; Will McAuliffe, Minority Chief Counsel, Oversight and Investigations; Constance O'Connor, Minority Senior Counsel; Christina Parisi, Minority Professional Staff Member; Harry Samuels, Minority Oversight Counsel; Andrew Souvall, Minority Director of Communications, Outreach, and Member Services; and Caroline Wood, Minority Research Analyst.

*Mr. Griffith. The Subcommittee on Oversight and Investigations will now come to order.

The chair now recognizes himself for a five-minute opening statement.

Welcome to today's hearing to look back and to take stock of the recent performance of the Centers for Disease Control and Prevention, or the CDC. I speak for many of my colleagues when I say that the COVID-19 pandemic revealed that we did not have the CDC that we thought we had.

Before I continue my remarks, I want to be clear. The COVID-19 pandemic was an immense challenge for public health agencies, health care providers, every level of government, and the American people. There were always going to be mistakes made, and we need to avoid the distortions of hindsight.

I also believe there are many hard-working, talented doctors and public health experts working at CDC who want to do their part to keep Americans safe. One of my biggest frustrations, however, with the CDC is that, when you look at all of the talent, all of the scientific knowledge, technical resources, and immense funding that we have put into the agency, the end product is somehow less than the sum of its parts.

It is reasonable for the American people to expect CDC

to use the best available science when preparing guidance and recommendations. All too often during the pandemic the CDC appeared to work backwards. The agency seemed to first decide its preferred policy outcome, whether that was universal masking, vaccine mandates, shutting down businesses, or school closures. Once the policy was decided, then the agency sought out data supporting that policy decision. Data that could undermine CDC's preferred outcome was either ignored or discounted in many cases, particularly if the data came from outside of the CDC itself.

As we saw during the COVID-19 pandemic, the CDC's recommendations carry great weight. There is perhaps no better example of this than the process creating CDC's school reopening guidance. The damage wrought by school closures has been enormous, and well documented and, fairly, I do not believe that my kids' education has recovered yet from these closures, even as we speak.

The single biggest factor determining whether schools were in person or remote was the political power of public school teacher unions. At a time when parents and school systems were desperate for accurate public health guidance, the CDC allowed the group most opposed to reopening to directly edit its finalized guidance. CDC director Dr. Walensky was even forced to state on national television that

her school reopening statements many took as a CDC position -- that she made them and they were given in a personal capacity, not as the CDC director. As best I can tell, this was the only time that she spoke in a personal capacity on an issue related to CDC guidance while she was agency director.

In addition, when the Department of Labor issued its nationwide vaccine mandate for companies with 100 or more employees in November of 2021, it cited CDC science and guidance more than 80 times to justify the mandate. At the time the mandate was issued, there was a growing body of evidence, largely ignored by the CDC, indicating that vaccines did not stop the transmission of the disease. Thankfully, the Supreme Court struck down this mandate after only two months, ruling that it was unconstitutional.

The CMS vaccine mandate for health care providers, which only ended on May 1st of this year, also relied heavily on the CDC, citing the agency over 50 times. Thousands of health care workers who were heralded as heroes during the early months of the pandemic lost their jobs, in part because of CDC's reluctance to admit the limitations of the COVID-19 vaccines, and failure to acknowledge that natural immunity can provide protection.

The problems at CDC that led to the failures we saw during the COVID-19 pandemic are not new. The CDC made

mistakes during its response to Ebola and Zika and other smaller, localized events. What differentiates the mistakes made during COVID-19 was the scale of the emergency and the impact of those failures on the American people.

It is appropriate that CDC's failures during COVID-19 prompted the agency to conduct an internal review: the first step is admitting you have a problem. This review has now led to a reorganization that appears on its face to be extensive, but there is no way for us to tell without more information from the CDC. As a part of the reorganization, CDC has asked Congress for extensive legal authorities that would require state and local governments, pharmacies, hospitals, and other health care providers to report to the CDC health-related information. This has huge implications for privacy and for data security.

In May this committee wrote to Director Walensky requesting information and documents related to the review and the reorganization. Congress needs this information to understand and independently assess the CDC's reorganization. Congress is constitutionally entitled to this information. We did, however, receive -- we did receive a four-page letter last night that mostly reflects what is already posted on the CDC website. It was not sufficient, however, and I hope the CDC will provide the complete documentation that we have

requested in our letter, and that they will get that to us in short order.

In closing, until we get full cooperation, the CDC's request for new legal authorities cannot and will not move forward.

In today's hearing, we will hear from witnesses who will help us explore what reforms are appropriate and necessary at the CDC.

[The prepared statement of Mr. Griffith follows:]

**********COMMITTEE INSERT**********

*Mr. Griffith. And with that, I yield back and now recognize the gentlelady from Florida, the ranking member, Ms. Castor, for her five-minute opening statement.

*Ms. Castor. Well, thank you, Mr. Chairman. Good morning. Thank you to the witnesses for being here.

In the five months since the start of the Republican majority here in the House, this subcommittee has held several hearings that seem geared more toward undermining public health and the professionals working to protect our neighbors than constructive oversight and improvements to public health partnerships. This is concerning for many reasons. It irresponsibly ignores the lessons from the COVID-19 pandemic, which took the lives of over 1 million Americans, and diminishes the importance of a strong public health network across America.

The pandemic exposed weaknesses and inefficiencies in our existing infrastructure that put us at a disadvantage to adequately respond from the start.

We also saw firsthand how the COVID-19 crisis was further fueled by then-President Trump's early insistence that the virus was not serious, a message that contradicted what health officials were seeing on the ground. During a critical period we lost time that we couldn't afford in getting a handle on the size and the scope of the deadly

pandemic.

Disinformation also ran rampant. In my home state of Florida, Governor DeSantis and his administration spread disinformation often, and vilified scientists who were recommending ways to protect everyone from the deadly virus. The state withheld and censored data on nursing home infections and deaths, overall mortality data, and other valuable information. This caused confusion at the local, state, and Federal level. And unlike many other states, many more Floridians died after the vaccine was widely available, due to misinformation.

So how can public health officials combat a pandemic if political leaders are actively undermining their efforts to protect and inform the public? These are the sort of historical facts that cannot be ignored when we assess the government response to COVID-19 and set priorities moving forward.

Federal health agencies are our first line of defense against the next threat, and we need to take an honest, holistic look at their responses to public health challenges. For example, in recent hearings with leaders of the Federal health agencies, they have told us that preparedness needs to be a centerpiece of future plans. Even today we are using our knowledge from COVID-19 to monitor and respond to impacts

as cases tick back up.

Everyone acknowledges that improvements are needed. The CDC took initiative to conduct an internal review, and is pursuing a moving forward plan aimed at making the agency more resilient and accountable to the American people. If you are a critic of the CDC for its response to COVID-19, this should be a welcome development. I certainly look forward to hearing more as this reorganization continues, and I appreciated the bipartisan visit to CDC headquarters in Atlanta last year, where we discussed needed improvements.

In addition to the descriptions of the improvement process on CDC's website, CDC has also provided a letter that I would like to include in the record describing in more detail just how thoughtful and extensive their efforts have been.

Hundreds of employees have participated, and they have provided feedback, they have been briefed. In short, CDC continues to apply the hard lessons learned, and we must support that effort.

I also want to take this opportunity to thank outgoing CDC director Dr. Walensky for her tireless work under incredibly challenging conditions. She inherited a terrible situation. When she took office there were nearly 100,000 COVID-19 hospitalizations per week, and 25,000 deaths per

week. We are now under 10,000 new hospitalizations per week and 500 deaths per week. Schools reopened safely under her watch. Despite politicization and misinformation, Americans got vaccinated. I thank her and the dedicated public servants at CDC who work hard every day to keep us healthy.

Last month CDC Director Walensky testified before the Health Subcommittee and further detailed the reorganization initiative, saying it aims to eliminate bureaucratic reporting layers, break down silos in the agency, promote foundational public health capabilities, and improve accountability at CDC.

But the CDC cannot do it alone. The Congress must step into its role to improve the nation's public health. That includes investing in data modernization we need at the local level, improving CDC's ability to collect and act upon timely and complete health data. We will not be successful if Republicans in Congress continue to target public health for large budget cuts. I am deeply disappointed that House Republicans insisted upon rescinding funds for public health efforts in exchange for not destroying the U.S. economy last week. This rescission of funds only worsens the challenges we face in protecting the health and safety of our neighbors. These are not the challenges my colleagues claim they want to solve. They cannot have it both ways.

The Biden Administration and Democrats in Congress, however, will remain focused on providing public health institutions the necessary support and resources they need to be more prepared and responsive to public health challenges.

[The prepared statement of Ms. Castor follows:]

**********COMMITTEE INSERT**********

*Ms. Castor. Thank you, and I yield back my time.

*Mr. Griffith. The gentlelady yields back. I now recognize Mr. Guthrie for a five-minute opening statement. He is Chair Rodgers's designee this morning.

*Mr. Guthrie. Thank you, Chair, for yielding. I appreciate everyone for being here today.

In today's hearing we will focus on understanding the scope of what is wrong at the CDC so that we can begin to fix it. This is not about villainizing the CDC; it is about accountability, accountability for children kept out of school who are dealing with mental, social, and emotional health issues; small business owners who watch their life's work dry up; for people who lost their jobs because of vaccine mandates.

The CDC's response to the COVID-19 pandemic created a crisis in confidence in the agency. The pandemic made it overwhelmingly clear that the CDC has serious foundational problems in the roots, in many cases spanning multiple administrations.

From the start of the pandemic, it was clear how challenging the novel coronavirus would be to contain, which was made even more difficult because of how unprepared CDC was to respond to the emerging threat. No doubt that a virus as transmissible as SARS-CoV-2 was always going to be

difficult. But in the earliest days of the pandemic the CDC's faulty test kits set us back. Without testing, we cannot effectively slow the spread of the virus when cases amounted to just a few numbers.

People also counted on the CDC to provide timely and clear guidance based on the best available science to keep themselves and their loved ones safe. Yet, time and again, CDC's guidance failed to meet this expectation, and instead consistently issued guidance that lacked clarity and the best available science.

More consequentially, CDC's guidance reflected the agency's preferred policy outcomes or political considerations. At its worst, CDC released guidance that was influenced by teachers' unions, and was a significant signal to states that they weren't fully confident in the schools' ability to return to school safely, despite earlier versions of the guidance suggesting otherwise. Our children are paying a terrible price academically, physically, and emotionally for the CDC's shortcomings.

Bad science and CDC guidance, when used to justify mandates, destroyed lives.

CDC public communications on COVID-19 vaccines were just as bad. Simply put, CDC over-promised when it should have known better. CDC's leadership told the public that vaccines

prevented transmission, while the agency was streaming reports of breakthrough infections among the vaccinated. CDC downplayed the existence of adverse events while it was receiving reports of post-vaccination myocarditis in young men.

The CDC's decades of experience running mass vaccination programs should have prepared it to manage the administration of COVID-19 vaccines. The CDC knows only 30 to 40 percent of people get an annual flu shot. That vaccine hesitancy did not just begin with the COVID-19 vaccine.

It is going to be a long road to rebuild the trust, and the agency cannot go it alone. Many of CDC's COVID-19 failures have their roots in longstanding problems at the agency. The CDC needs to address its failures with openness and, frankly, humility. I am deeply worried that CDC's insular, academic culture will prevent it from learning the right lessons.

Outgoing Director Walensky launched a reorganization at CDC. Whether it survives her departure is unclear. Whether the reorganization would address CDC's foundational problems is also unclear.

This committee intends on conducting oversight to ensure the agency gets back on track. The CDC still hasn't provided this committee with the information needed to independently

assess the reorganization. As Chairman Griffith noted in a conclusory letter sent to us the night before, a hearing isn't sufficient. But I do look forward to obtaining more details from the agency about this restructuring plan in the coming weeks.

I will close by noting that Congress is not without blame for the current state of CDC. CDC has never been authorized -- Congress has never, in a single voice, told the CDC what its mission is and is not. This must be fixed. This committee's majority is committed to working on CDC reform.

Today's hearing, Dr. Miller-Meeks and our ongoing oversight of CDC's -- Dr. Miller-Meeks's request for information and our ongoing oversight of CDC's reorganization are the first steps towards getting the agency back on track. In addition to this work I look forward to our Health legislative hearing next week to reauthorize immediate preparedness and response programs.

It is critical we come together to assure the American people the Federal Government is equipped for the immediate response for all types of public health hazards, such as a pandemic or a chemical, nuclear, radiological, biological, or cyber attack.

[The prepared statement of Mr. Guthrie follows:]

**********COMMITTEE INSERT**********

*Mr. Guthrie. Thank you to our witnesses. I look forward to your testimony, and I yield back.

*Mr. Griffith. The gentleman yields back. I now recognize the ranking member of the full committee, Mr. Pallone, for his five-minute opening statement.

*Mr. Pallone. Thank you, Mr. Chairman. Let's call this hearing what it is, an opportunity for committee Republicans to criticize the work of the Centers for Disease Control and Prevention during the COVID-19 pandemic without them being here.

CDC Director Walensky testified before this subcommittee in February, along with leaders of the other key public health agencies. She then testified before the Health Subcommittee last month. And while I appreciate the witnesses for being here and look forward to their testimony, if Republicans were really interested in conducting oversight of the CDC, they would have invited the CDC to be here today.

Now, the COVID-19 pandemic was an unprecedented challenge for the nation. From the outset there was uncertainty and confusion, and a total lack of leadership.

If we are going to take a look back, let's start by going back to the beginning of the pandemic and looking right at the top: then-President Donald Trump. We all remember him repeatedly casting doubt about the dangers of COVID-19

right from the start. In January of 2020 Trump said that it was "one person coming in from China, and we have it under control, it is going to be just fine.'' He praised the efforts of the Chinese Government, saying, "It will all work out well. In particular on behalf of the American people, I want to thank President Xi.'' At the end of February 2020 he said that cases would "be down to close to zero,'' and that "one day it is like a miracle, it will all disappear like magic.''

He publicly promoted hydro -- what is it -- hydroxychloroquine as a treatment. I remember that. Maybe the Republicans have forgotten that one. He asked whether disinfectant could be injected. He pondered whether UV light inside the body would cure people. Then, in June, when the virus was killing hundreds of people every day, he said, and I quote, "It is fading away, and the numbers are starting to get very good.'' He admitted that -- he quoted again, "said to my people, 'slow the testing down, please, slow the testing down'.''

Now, that is just a small sample of the anti-science misinformation that President Trump spread during the first years of the pandemic. This misinformation seriously undercut our public health institutions, including the CDC, who were doing difficult work under impossible circumstances

with President Trump.

And certainly, there are lessons to be learned, and CDC has acknowledged the need for reforms. It is implementing over 100 recommendations that were developed based on the feedback of hundreds of CDC staffers, and is also recognizing to be more efficient and responsive when facing future threats.

Last month, the -- Director Walensky further detailed the CDC's plans during her appearance before the Health Subcommittee. She said the agency is moving forward initiatives, aims to "eliminate bureaucratic reporting layers, break down silos in the agency, promote foundational public health capabilities, and improve accountability at CDC.'' And we certainly look forward to hearing more from CDC as it continues that process.

Now, the committee, I have to say, is also in the process of reauthorizing the Pandemic and All-Hazards Preparedness Act, the first opportunity to review PAHPA since COVID-19. It is clear that CDC needs additional authorities, including public health data authority, to be better prepared for the future.

We also need to strengthen our drug and medical device supply chains, which have known vulnerabilities that would be exacerbated by another pandemic.

But unfortunately, it seems the Republican majority is not interested in these approaches to better prepare for the next pandemic, but instead is focused on tearing down public health institutions, and that is extremely disappointing. We should be working together to strengthen our nation's health agencies for the future, and enable them to institute reforms that will improve future pandemic response. So I am hoping we will be able to do that in the future.

But it is clear that that is not the Republicans' goal right now. So I don't know what else to say. I mean, I certainly don't -- I certainly want to hear from this panel, but the CDC should be here, and the idea that there were problems with the CDC, you know, just go back and look at what your President was doing that first year. I mean, I was listening to all this nonsense while he was President and supposedly dealing with this crisis, and all he did was make things worse. And I think a lot of people died and -- because of the fact that he misinformed everybody about what was going on.

[The prepared statement of Mr. Pallone follows:]

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*Mr. Pallone. So with that --

*Ms. DeGette. Will the gentleman yield?

*Mr. Pallone. Yes, sure.

*Ms. DeGette. Thank you for yielding. I just want to also add the lack of cohesive leadership from the top, from the White House, added to pre-existing issues at the CDC that were longstanding. And this committee, in a bipartisan way, has explored those for many years, and that led to the chaos.

So we do need to move forward, but blaming it on the current CDC is just wrong.

Thank you, Mr. Ranking Member, and I yield back.

*Mr. Pallone. Thank you, and I yield back, Mr. Chairman.

*Mr. Griffith. I thank the gentleman for yielding back, and in response to his question about the CDC being here, we will get to the CDC in due time. But they need to answer our written requests for documents and information in something other than just a thin, cursory statement and response, a superficial response, before we bring them in there -- in here for a detailed oversight hearing.

Today we are going to gather information. We are going to go forward and get the information that we can today and then, when we bring in the CDC, they will have the stage all to themselves to explain it to us. But first they have got

to cooperate with this subcommittee and its jurisdiction.

That being said --

*Ms. Castor. Mr. Chairman, I did have a unanimous consent request for --

*Mr. Griffith. You did, and we will get to that at the end of the hearing.

*Ms. Castor. Okay, thank you.

*Mr. Griffith. Yes. Not ignoring you, just putting it to the end where we do that.

All right, I want to thank our witnesses for being here today and taking time to testify before the subcommittee.

You all will have an opportunity to give an opening statement, followed by a round of questions from our members.

Our witnesses today are Mary Denigan-Macauley, director of public health, U.S. Government Accountability Office -- we are going to have to get you a permanent seat here, you give great testimony and we appreciate you coming in today to talk yet again about issues, but today's issues focused on the CDC.

We also have Charity Dean, CEO and founder of the Public Health Company; Tracy Beth Hoeg, epidemiologist, Department of Epidemiology and Biostatistics, University of California, San Francisco; and Georges C. Benjamin, executive director of American Public Health Association.

We appreciate you all being here today, and I look forward to hearing from you all.

As you are aware, this subcommittee is holding a oversight hearing, and when doing so has the practice of taking our testimony under oath. Does anyone have an objection to -- any of our witnesses have an objection to taking the testimony under oath?

Seeing no objections, we will proceed.

The chair would also advise you that you are entitled to be advised by counsel, pursuant to House rules. Do you have a desire to be advised by counsel during your testimony today?

Seeing that no one has requested that, if you all would, please rise and raise your right hand.

[Witnesses sworn.]

*Mr. Griffith. Seeing the witnesses all answered in the affirmative, you are now sworn in, and under oath, and subject to the penalties set forth in title 18, section 1001 of the United States Code.

With that, we will now recognize Mary Denigan-Macauley for her five-minute opening statement.

*Dr. Denigan-Macauley. Thank you.

TESTIMONY OF MARY DENIGAN-MACAULEY, PHD, DIRECTOR OF PUBLIC HEALTH, U.S. GOVERNMENT ACCOUNTABILITY OFFICE; CHARITY DEAN, MD, MPH & TM, CEO AND FOUNDER, THE PUBLIC HEALTH COMPANY; TRACE BETH HOEG, MD, PHD, EPIDEMOIOLOGIST, DEPARTMENT OF EPIDEMIOLOGY AND BIOSTATISTICS, UNIVERSITY OF CALIFORNIA, SAN FRANCISCO; AND GEORGES C. BENJAMIN, MD, EXECUTIVE DIRECTOR, AMERICAN PUBLIC HEALTH ASSOCIATION

TESTIMONY OF MARY DENIGAN-MACAULEY

*Dr. Denigan-Macauley. Chairs Griffith, Guthrie, Ranking Members Castor and Pallone, and members of the subcommittee, thank you for the opportunity to discuss the Centers for Disease Control and Prevention reform efforts.

In January 2022, we determined that HHS's leadership and coordination of our nation's preparedness for and response to public health emergencies is in need of transformation, placing it on GAO's high-risk list. We made this determination based on a body of work that found persistent deficiencies for more than a decade in HHS's ability to perform its leadership role. These deficiencies, including those at the CDC, hindered the nation's response to the COVID-19 pandemic and to a variety of past emergencies.

In April we reported that CDC intends to undergo

programmatic, scientific, and operational improvements to better support the agency's public health response during emergencies and in peace time. We met with CDC to get more information about the reform efforts and to share GAO's leading practices for successful agency reform.

These leading practices state that, while transformation to improve performance is no easy task, and that it can take time to fully implement, agencies can successfully change when careful consideration is given to capacity, capabilities, and essential change management practices such as the involvement of key stakeholders. We developed questions that Congress, CDC, and others can use to assess agencies' proposals for and implementation of reform efforts.

For example, what is CDC trying to achieve with its proposed reforms, and who or which agencies should achieve them? Public health preparedness, as we all have seen, is not a capability held just at the CDC. It takes a whole-of-nation approach.

To that end, how did CDC develop the proposed reforms, and what factors were considered? For example, to what extent did the agency consult with Congress; state, local, tribal, and territorial jurisdictions; public health and private laboratories?

How will the reforms address identified concerns,

including GAO's concerns about clearly identifying roles and responsibilities; improving the completeness and consistency of data; ensuring clear and consistent communication; enhancing transparency and accountability; and understanding key partners' capabilities and their limitations?

Further, what practices did CDC put in place to ensure the proposed reforms will succeed? For example, is there a dedicated implementation team that has the capacity?

Do they have the staffing, the resources, and the authorities needed to manage the reform process?

Has CDC developed a plan with key milestones and deliverables to track their progress?

What considerations are given to the workforce? For example, to what extent has CDC conducted strategic workforce planning to determine whether it will have the needed resources and capacity, including the right people with the right skills to carry out the reforms now and in the future?

CDC has acknowledged failures, and launched a review to help the agency know what it needs to change. For example, CDC says that it needs to share science and data faster; it needs to translate science into practical policy; it needs to prioritize communications for the American public; it needs to develop a workforce ready to respond to future threats; and it needs to promote partnerships. But CDC has not

detailed answers to the questions I posed for how it will carry out these reforms.

These leading practices, importantly, along with sustained leadership commitment, are essential to helping ensure the country is better prepared for future public health emergencies. Leadership commitment is critical for initiating and sustaining progress and making the types of management and operational improvements required to narrow or remove it from a high-risk area.

With Dr. Walensky leaving her post at the end of this month, it raises additional questions about leadership commitment for these reforms, going forward. We encourage the next director to engage with stakeholders to develop detailed, transparent, and accountable reform plans that close identified gaps, and to work with Congress doing so, for is not a question of if, but when the next public health emergency will occur. CDC has an opportunity now to learn from past mistakes so that it is better prepared for the future.

Mr. Chairman, and Ranking Member, and distinguished members of the subcommittee, this concludes my prepared statement. I look forward to any questions you may have.

[The prepared statement of Ms. Denigan-Macauley follows:]

**********COMMITTEE INSERT**********

*Mr. Griffith. I thank the lady for yielding back, and now recognize Dr. Charity Dean for her five-minute opening statement.

TESTIMONY OF CHARITY DEAN

*Dr. Dean. Thank you. Is my microphone on?

Chairs McMorris Rodgers and Griffith, Ranking Members Pallone and Castor, and distinguished members of this committee, thank you for the invitation to be here today.

I believe that, in order to prepare for future disease threats, we have a duty to conduct a rigorous assessment of our COVID-19 response. Even if it is painful, this thorough inventory then becomes a gift, a clear roadmap of what we must do now to meet future threats with strength, and that is something I have dedicated my life to: building system solutions to protect all Americans from public health threats.

My experience as a local and state public health official has given me a unique vantage point which I have shared in other forums, including in Michael Lewis's "The Premonition,'' as well as in "Lessons From the COVID War,'' an investigative report of which I am a co-author.

The COVID-19 response was a massive systems failure across the whole of the U.S. public health system, including the CDC. I want to be clear. Our humans didn't fail, our systems failed. Our humans and our public servants gave it their all. This core failure was due to a lack of an

intelligence and operational infrastructure capable of meeting the moment. Containment of biological threats, which must always be the first objective, is not possible without these twin capabilities. They would have enabled the United States to convert disparate, scattered data into reliable intelligence across both public and private sectors, enabling fast, unified, front-line decisions. Intelligence makes the invisible visible.

I served as the local health officer for Santa Barbara County when the Disneyland measles outbreak struck in 2014. I received a panicked phone call that a toddler in a busy daycare center had a rash spreading down from their forehead. Their cousin had visited Disneyland just a few weeks before. Soon there were two cases in young children, and exposures across three adjoining counties, and a suspicious cluster in two other states. With measles, every hour matters. When a kiddo first develops the classic rash, they have already been contagious for four days, so we are four days behind. It is a race against time.

Around-the-clock flurry of phone calls, emails, fax machines ensued with my tribe of local health officers, which now included more than five other states. My wall was covered in sticky notes with connecting locations and suspects and large exposure venues. We formed an ad hoc

intelligence infrastructure, using tools essentially from the 1970s. The outbreak ultimately spread to seven states, Mexico, and Canada before we contained it.

A college meningococcal outbreak had similar lessons. On a Saturday afternoon in 2013 I received a phone call alerting me to a college kid with what appeared to be meningococcal disease, a bacterial blood infection that goes to the brain and spreads fast among students. I immediately attempted to form an intelligence picture: How many kids were infected? Which dorm rooms? Which sports teams?

Operating without much of a playbook of intelligence, I implemented a range of broad temporary measures all at once: canceled parties, sports, gave antibiotics. I enlisted the university, ERs, local businesses to find cases. We found more. By contrast, the CDC wanted to implement one mitigation measure at a time, like a controlled academic study. At the end of one long conference call with them I was told I was alone in my decisions and response.

The truth is, trust is the currency of public health. It is earned with honesty and transparency. It has little to do with government titles. To quote Braveheart, "Men don't follow titles; they follow courage.'' Together with the university and community, we contained that outbreak. A few years later, CDC guidance was published with our approach as

a model.

I am not going to dwell on the COVID-19 story, as much ink has been spilled on that. Suffice it to say, I was the number-two doctor for the State of California. I experienced the same phenomenon yet again. We were all flying blind, relying on an antiquated public health system built on disconnected local nodes that are siloed from each other to meet a fast-moving 21st century biological threat. To quote Edwards Deming, "A bad system beats a good person every time.’‘

In September 2020 I founded the Public Health Company out of a deep conviction that a new intelligence capability must exist built, on transparency and accountability. I believe that the core technology for this capability had to come not from government, but from the innovation made possible by the private sector, with its advances in artificial intelligence and data streaming. Nearly three years later we have now built from scratch commercial-grade software. Our company is venture-capital-backed, and we are honored to be supported by BARDA Ventures within ASPR.

In closing, I want to emphasize my belief that the United States is still capable of solving hard problems. Solutions will require innovation, courage, and bold leadership. I am deeply grateful to every committee member

here for your tireless efforts to that end. Thank you.

[The prepared statement of Dr. Dean follows:]

**********COMMITTEE INSERT**********

*Mr. Griffith. Thank you. I now recognize Dr. Hoeg for her five minutes.

TESTIMONY OF TRACY BETH HOEG

*Dr. Hoeg. All right, good morning. Thank you for the invitation to be here. My name is Tracy Beth Hoeg. I am a practicing MD and PhD epidemiologist currently in the department of epidemiology and biostatistics at the University of California, San Francisco. And I am also affiliated with the University of Southern Denmark.

I am a Danish-American dual citizen, and moved back to the U.S. from Denmark in 2015. I have co-authored 14 scientific publications related to the epidemiology and medical evidence during the COVID-19 pandemic, 13 where I was first or senior author. My own research and publication experiences during the pandemic led me to numerous eye-opening and disappointing revelations about the CDC.

One of the most important questions, if not the most important question as we look back on the pandemic, is why, under the CDC's guidance, K through 12 schools in the United States remained closed to in-person learning longer than any other high-income nations, with around a fifth of U.S. students out of in-person learning for an entire year.

In the fall of 2020 I was the senior author of a landmark study published in the CDC's journal, MMWR, on COVID-19 transmission in schools. My co-authors and I

expected the findings of our study would be used to swiftly re-open the schools in early 2021, as our peer nations had done many months earlier. In line with research from Europe and our own country, we found remarkably limited transmission between students and none to teachers and staff during a time of high community disease prevalence among greater than 5,000 students and staff over a 14-week period.

However, shortly after our studies publication, the CDC, under Rochelle Walensky, in spite of the scientific data, doubled down on the need for closures at high community transmission levels and the unproven need for six feet of distance in screening testing. When the school reopening guidelines were released, over 90 percent of the country was in the high transmission level, meaning the CDC recommended virtual learning for secondary schools that did not have access to screening testing programs and hybrid learning, with six feet of distancing for elementary students. This would keep as many as 90 percent of students in the U.S. out of either full-time school or any in-person learning.

I thought the current Administration, like Europe, believed in a progressive ideology which valued the education of the most vulnerable and disadvantaged in our society. So why were they putting up so many unproven barriers in their guidelines when it came to getting children back in the

classrooms?

And why did they not consult us, the authors of the study published on this very topic in their own journal? We could have told them we did not have a screening testing program, and greater than 90 percent of elementary students in our study were less than 6 feet apart, and children ate lunch without masks indoors.

In fact, out of desperation to communicate with the CDC, we rapidly released a pre-print outlining the simple circumstances under which the schools in our study stayed open. I eventually learned what was happening, that the CDC was consulting with the leaders of the U.S.'s two largest teachers unions over text messages up to the day before about exactly how the school reopening guidelines should be worded. It was not that I felt teachers should not be consulted, but that the science and anticipated harms of continued school closures were being ignored when they should have been the utmost priority.

My second experience involved the downplaying and lack of sense of urgency about post-vaccination myocarditis in young people, especially males, which I have published two harm benefit analyses on and one additional publication. Briefly, the CDC's unwillingness to properly communicate and address this adverse effect among young, healthy people,

especially those who had already been infected with COVID-19 for whom the benefit of vaccination was entirely unclear, demonstrated a greater commitment to partisanship than the health of our nation's youth.

My third example has to do with concerning publication bias within the CDC's journal, MMWR, when they refused in 2021 to publish a follow-up study that I and my co-author did, looking at a study that was published in fall of 2021, which was a brief, 2-week study which found a barely significant association between school mask mandates and a lower rise in pediatric cases in counties. When we expanded the study out to six weeks and included the remaining counties that had reopened the schools, we failed to find any significant association between the pediatric -- between the school mask mandates and pediatric cases, and MMWR refused to publish the follow-up publication, which any journal should have readily published, considering that we found a reversal of the original findings.

We did go on to get this published in the highly respected Journal of Infection, and one should bear in mind that what we found, the lack of correlation, was consistent with the highest evidence at the time, from randomized studies, that wearing masks in the community probably makes little to no difference in the outcome of laboratory-

confirmed influenza or SARS-CoV-2.

There is a desperate need for more scientific rigor within the CDC and MMWR and a transparent review process, including external peer review, to restore integrity of the Journal. Whatever our political beliefs, we should all be deeply concerned about a national public health agency that chooses to publish, promote, and develop guidelines around politically favorable policies instead of the highest quality evidence. Thank you.

[The prepared statement of Dr. Hoeg follows:]

**********COMMITTEE INSERT**********

*Mr. Griffith. I appreciate it, thank you. Now I recognize Dr. Georges Benjamin for his five minutes of opening statement.

TESTIMONY OF GEORGES C. BENJAMIN

*Dr. Benjamin. Thank you, Mr. Chairman and Ranking Member Castor and members of the subcommittee. Thank you very much for allowing me to spend some time with you today. I am Georges Benjamin. I am the executive director at the American Public Health Association. I am in my 21st year. What that means is I am old, and it also means that I have had a chance over not only the 20 years of being at APHA, but also the many years of practicing public health in this community, both in D.C. and Maryland, in interacting with the with the CDC in a variety of roles.

I have had the opportunity to advise both the agency and the Department of Health and Human Services, both in administrations -- both the Republican and Democratic administrations. I have had a chance to support their efforts, and I have a chance -- have had an opportunity to yell at them when I think they are not on track.

I think that one of the things we have to be very careful about is the retrospective scope, which I think is a very, very powerful tool. It is a powerful tool because it allows you to go back and look at what happened in the past, and you want to be careful that you don't -- you remember what decisions you made, and what you knew when you made

those decisions going forward. And I know we all know that, and I just wanted to say that.

I also think that it is important that we understand that the politicization that has happened for public health is very destructive, and people die because of that destructive nature. The misinformation and disinformation that has occurred at a variety of levels has resulted in people, I believe, dying prematurely. And so we, as a collective, both of us doing policy, those of us on the advocacy world, those of us doing science need to do a better job to bring that to an end as quickly as we possibly can.

We live in a very, very rapidly changing health environment. COVID is transitioning to something else. We will figure out what that is when it tells us what it is about to do. We have been wrong on almost every single assumption that we have made with COVID, and I suspect we are still going to learn some things.

But just to remind you that we still have an obesity epidemic, we still have an opioid epidemic, we still have an epidemic of firearms and premature death from injury from firearms, we have the opportunity to finally get our hands around HIV AIDS, to finally get the opportunity to stamp out Hepatitis C. We have a growing STD epidemic, and I remind you we now have the return of babies with syphilis, which we

used to think was very, very uncommon. And we have the return of vaccine-preventable diseases.

Dr. Dean's experience in southern California is just the tip of the iceberg of what we should expect as we look at what is going forward with vaccines and vaccine hesitancy in our country.

My point is that we need a very, very strong CDC if we are serious about that. It is the only agency within the Department of Health and Human Services that does what it does. It has historically done it very, very well. That does not mean that they are perfect. It does not mean that they are not perfect, or that they are perfect. They are not.

So going forward, let's talk about what they need. They need data. Public health is fundamentally a data-driven science. Without data, we can't make data-driven decisions. And we need to end the practice of being data archeologists.

We need a health information technology system. The fact is that I can get food right now on my phone in DoorDash in this room, but I can't get my EKG. We need to fix that.

We need to strengthen the public health workforce. We have a huge vacancy level in public health, even though -- thank you very much -- the funding that you have given under the Recovery Act certainly has gone to help public health,

but we still have lots of vacancies, and we need to fix those.

We need -- CDC needs budget flexibility. Their budget is extremely rigid, and they are unable to do a lot of the things that I was able to do as a state and local health officer.

Clearly, public health needs adequate and sustainable funding. This yo yo funding has to end, where we put in a lot of money in when something bad happens, often it comes a little late, not quite enough, and then we take it away too quickly. And you can't build a system like that. In fact, none of you would tolerate that for the Department of Defense.

And CDC needs external supports. You have heard from, I think, every one of these witnesses how important it is to have this as part of a system.

And we need to finally, once and for all, build a sound public health system in our country.

With that, I will stop and thank you very much, Mr. Chairman and Ranking Member.

[The prepared statement of Dr. Benjamin follows:]

**********COMMITTEE INSERT**********

*Mr. Griffith. Thank you very much. I appreciate your testimony. I appreciate all the witnesses' testimony. I will now begin the question-and-answer portion of our hearing, and I will recognize myself for five minutes.

Dr. Benjamin, I would agree that making this issue into the -- into a political football will not help us. It will distract us from our job. It is true early on President Trump made statements that turned out to be in error. It is also true that then-candidate Biden made statements that turned out to be in error. What we need to do is to get answers from the CDC, so we can figure out what went wrong, what went right, and what we can do to move forward appropriately.

Dr. Denigan-Macauley, I heard in your opening statement that, just like this committee, you are having a hard time getting answers out of the CDC. Is that correct, yes or no?

*Dr. Denigan-Macauley. Yes.

*Mr. Griffith. And do you feel that the lack of being able to get these answers has impaired your ability to give us an assessment of whether or not this reorganization is going to help solve problems or not?

*Dr. Denigan-Macauley. We do need more information.

*Mr. Griffith. All right, and I appreciate that, and I agree with you. All of us need more information if we are

going to try to make this not a political football, but something where we are just trying to get to the facts, as Jack Webb would have said many years ago, "Just the facts.'‘

All right, Dr. Hoeg, I got to tell you, I appreciate your testimony, very concerned. And as I said in my opening statement, I don't think my kids have yet recovered. The schools in my district were scared that if they didn't follow the CDC guidelines they would be sued. I talked to a number of them, and that is what I was told behind the scenes: "Well, we don't know that -- we think we can do it, but if we do it our lawyers tell us we are in jeopardy.'‘ And so they kept them -- they closed them, and then they kept them closed for longer out of fear of reopening because the CDC guidelines about reopening came out, and they did not reflect, as you said, science.

Did they -- I mean, they clearly ignored your studies. They clearly wouldn't publish your peer-reviewed paper in their flagship journal, "The Morbidity and Mortality Weekly Report.'‘ To your knowledge, did they -- to any extent did they consider the science, the studies, the reports that were out there showing that, among school-aged children, social distancing and transmission rates were fairly low, if existing at all?

*Dr. Hoeg. So we had data very early on from Europe

from already June of 2020 that -- comparing Finland to Sweden -- that reopening or having schools closed did not have any impact on community transmission of the disease. And we had similar investigation from the Centers of Global Education and Development that they found, similarly, with all of the countries that reopened their schools, which was most of Europe in the spring of 2020, that there was no correlation between opening and increase in community disease spread.

And so I think that we really -- you know, the CDC really failed for quite a long time to look at the data coming out of Europe, which, you know, not only considered the very low transmission that we were seeing in schools, but also considered the effects, the long-term effects and the collateral damage of keeping the schools closed.

And many private schools were open. I was the advisor for a large diocese in Sacramento, where we reopened the schools actually based on the data out of Europe in the fall of 2020. And we were able to keep them open the entire year, and had a very successful year. And it is very sad that schools, especially public schools, especially inner city schools, defaulted to the CDC for their guidance, when the CDC was really -- you know, they were -- well, we know that they -- now -- that they were basing, at least in February of 2021, their guidelines on the teachers' unions, what the

teachers unions wanted, rather than the science that had been accumulating for months out of Europe and our own country, also from our own daycares.

And so it is really tragic, what happened to American children. And I do view it as a result of politicization and schools relying on the CDC and defaulting to them, and it hurt our nation's children.

*Mr. Griffith. And it wasn't just the inner cities. It was also the rural schools and everywhere that you have any disadvantaged children, because what I have done for my kids is we have brought in tutors, and they are catching up. I don't think they will ever get fully recovered for that lost year, but they are catching up. But most families can't afford to bring in tutors one or two times a week to try to get that -- particularly in our family, math -- to get that math skill back to where it ought to be if they had been in the classroom. Would you agree with that? Yes or no, because I am running out of time.

*Dr. Hoeg. Yes, I agree with that, yes.

*Mr. Griffith. All right. And because I am running out of time, I am just going to make this next one simple. It is not just the learning. It is also the mental health, is it not?

*Dr. Hoeg. Absolutely.

*Mr. Griffith. The socialization, the lack of socialization. And for kids that are already in trauma, not having that security of going to see their friends at school, not being able to have interaction with their teachers who love them -- teachers are great -- is a mental health crisis in and of itself, is it not, yes or no?

*Dr. Hoeg. Absolutely.

*Mr. Griffith. I have to yield back. I yield back and now recognize Ms. Castor, the ranking member, for five minutes of questions.

*Ms. Castor. Well, thank you, Mr. Chairman. I think everyone agrees with Dr. Benjamin. We need a strong CDC. And as we transition out of the public health emergency, we have just got to make sure that our public health partnerships across the country have the tools necessary to protect our neighbors and ensure they are healthy and well.

And I think I see a common thread in what a lot of you are saying: we need to have the most accurate, thorough, and timely data to inform the guidance. We need to be able to detect disease in real time, stamping out problems before they grow.

I know the GAO, one of your top recommendations, data are critical to inform the response to a public health emergency. However, the data HHS relied on during COVID-19

were incomplete and inconsistent, highlighting longstanding concerns there. Public health data are collected by thousands of disparate health departments, health care providers and laboratories, as well as multiple agencies.

But Dr. Benjamin, as you state in your testimony, you watched in horror as rural communities, hospitals, skilled nursing centers tried to send data via fax machine. It is completely outdated. So the Congress responded, and we provided some emergency authorities to CDC and some funds to modernize.

But now, as the public health emergency expires, those emergency authorities expire. That is why I have reintroduced the Improving Data and Public Health Act with Congresswoman Lauren Underwood to promote data-sharing and modernization, to better identify, monitor, and respond to public health emergencies.

So how would -- Dr. Benjamin, talk to us about the outdated nature of data gathering across the country, and how a more modern system would improve the result?

*Dr. Benjamin. You know, the -- thank you very much. The truth of the matter is that when I was the deputy health officer in Maryland in the mid-1990s, we were sending information by fax machine, and we are still doing it. And the problem with that is that the person that fills it out

fills it out by pen and ink, they put it in the machine, it goes off to another place, and then you suddenly realize the data set is incomplete. Now you have got to go back and track and find the person who filled out the data. And we have just far too much of that.

And, you know, look, Congress did invest after 9/11 and the anthrax letters funding for public health. The problem was obsolescence kicked in. We didn't keep the funding up.

We were just talking a little earlier that, you know, college today is a -- used to be a one-computer experience. Now it is a two or three-computer experience for your kids, just because the technology changes so quickly. And we have not done that, we have not built a data information technology highway. We don't have a single patient identifier. We don't know that Dr. George Benjamin in one system is the same George Benjamin in another data system.

I know there are concerns about patient privacy and the data being misused, but the bank gets your data, other systems get your data. The proof of concept we had during COVID was that it worked. And I think you have heard from all of us that the importance of -- how important that data is.

*Ms. Castor. So you can de-identify personal identification of people, but it is important to collect all

sorts of information on age and health disparities. Isn't that right?

*Dr. Benjamin. Yes, most of the time -- and we can divide it up in many ways, but most of the time what CDC needs is to know whether it is going up, down, and whether or not the numbers are not duplicative. And so there are systems that can do that. And you can -- the box can make that happen for you. We have -- the data systems are ready to do it. This is not new technology.

*Ms. Castor. But it is not standardized. So --

*Dr. Benjamin. It is not even standardized.

*Ms. Castor. So that is a very significant problem. Talk about that a little bit.

*Dr. Benjamin. Yes, the fact that just the data that comes from one hospital to another hospital from a health department, you may not be all sitting in the same data set. Those of you who have looked at your lab tests when you have gone to the doctor, you will know that sometimes they are not the same. They don't get reported in the same way. And that is a problem, particularly when you are using electronic systems which use, you know, zeros and ones, the system will misinterpret what it is getting.

*Ms. Castor. So where would you rank improving data reporting and giving CDC the authority to standardize things

across the country in our toolbox as we move to improve the CDC?

*Dr. Benjamin. I think it is a tool, that is number one. I think from a functional perspective I have another issue. But for -- in terms of data, data is at the top of my list.

*Ms. Castor. Thank you very much. I yield back.

*Mr. Griffith. The gentlelady yields back. The chair now recognizes the chairwoman of the full committee, Mrs. McMorris Rodgers.

You are now recognized.

*The Chair. Thank you. Thank you, Mr. Chairman. Before I begin I need to respond to what the ranking member said in his opening statement.

I am extremely disappointed that he and others on this committee have decided to make this hearing political about the former President, about scoring political points, not about serious reforms.

If you want to look at bad decisions, the number-one mistake was blindly following Dr. Fauci, who was so focused on COVID-19 that he refused to think about every other aspect of public health to the detriment of our children, our economy, our country.

We have already had CDC Director Walensky in front of

this committee, even in the last five months. And then Ranking Member Pallone did not -- did in the last -- we have had her more in front of the committee this Congress than in the last Congress, when the Democrats were setting the agenda, and refusing to have her come up here and talk about monkeypox or COVID.

We on this -- we celebrate this committee. This is a serious committee that does the hard work necessary to legislate. And we have shown that by moving complicated legislation on privacy and reducing health care costs, when we come together, we can do the hard work necessary to legislate.

Why should examining existing agencies be any different? CDC has never been authorized, never. And now CDC has broken the trust of the American people.

To be an effective public health agency, the American people must be able to trust and understand what is coming out of CDC, and why.

Like the chairman said, I had numerous conversations with Dr. Walensky during COVID, and I was impressing upon her that, at the local level, the school districts, my communities believe there should be a different approach to COVID, to the mask, to lockdowns of our schools, our kids being locked down in schools. And yet -- and she said, "Oh,

Cathy, these are guidelines. These are not mandates. These are guidelines.'' Well, at the local level, they were mandates. And she said they shouldn't even be at the state level. Washington State was locked down until the spring of 2021.

Unlike CDC's closed-door Moving Forward initiative, this hearing is the start of our effort to focus on public and a transparent process to understand what Congress should be doing to make needed reforms, because that is our role as the elected representatives of the people. That is our constitutional responsibility. And it includes authorizing the committee or the agency giving direction and guardrails.

I am not interested in blindly following CDC and saying that, yes, they need more money, they need more authority, and we are just going to say yes to that. The American people rely on us to know how to make decisions or to know how decisions are made. They are relying on us to know how decisions are made, how decisions are made at the CDC, how the priorities are set. The American people are relying on us to ensure that it is a transparent process. And certainly, before we give them more authority and money we, as the elected representatives of the people, need to ensure that we are fulfilling that responsibility.

So I hope that this committee and all the members of

this committee that I greatly respect and admire will come together. Let's do our job. Let's improve CDC, and let's make sure that the tone is not one that is about scoring political points. Okay?

Yes, and we do have a disagreement over the data, and the amount of data that we should just be handing over to CDC. So under CDC they are requesting right now sweeping legal authority to require state and local governments, as well as hospitals, pharmacies, doctor's offices to report health information to them if requested. In my opinion, this is dramatically changing the current Federal-state public health relationship, and I am deeply troubled by CDC's inability to articulate any limitations on how they would or would not use this authority.

We know that people were being tracked during COVID-19. We know that. And we are working on a privacy legislation right now because we believe that individuals -- I think that there is a shared belief among Republicans and Democrats that individuals need to own their personal data, and we need to have privacy protections in place.

There is a lot more to do on this issue. There is a lot more questions to ask of CDC. My plea to my colleagues on the other side of the aisle is let's do this together. We are the elected representatives of the people.

I yield back.

*Mr. Griffith. The gentlelady yields back. The chair now recognizes Representative Pallone, the ranking member of the full committee, for five minutes for questions.

*Mr. Pallone. Thank you, Chairman. You know I respect all of you on the other side of the aisle, but I am so frustrated because I really don't know how we proceed here anymore.

The ranking member criticized Dr. Fauci, who I greatly respect and think was one of the best things we had during the COVID crisis, okay?

Chairman Griffith said that President Trump's statements were in error, but the President doesn't admit his errors. Many of his supporters continue to insist that COVID was a conspiracy, vaccines shouldn't be taken, masks shouldn't be worn, schools shouldn't have been closed in certain circumstances. I don't know how we can make improvements at the CDC when we fundamentally disagree on almost everything that happened during the COVID crisis.

We -- you know, we talk about data -- and I am going to ask you questions, Dr. Benjamin, about the data -- but the bottom line is that we look at the same data and come to totally different conclusions about what to do. So I don't know where we are going here. I mean, I love you on the

other side of the aisle, but I really don't know how we proceed when we have such disagreements over fundamentally what happened during the COVID crisis, and how to deal with it in a new way. I just don't see it.

I -- you know, I am an advocate for vaccines. I think everyone should take the vaccines. I think that COVID was real. I think masks should have been worn in many circumstances. I think some schools should have been closed. I don't -- I just don't know.

And I, you know, the -- Chairwoman Rodgers, it is just so frustrating because I don't know how we can proceed with such a disagreement on everything, even though we look at the same facts.

But in any case, let me ask a question. Everything that the CDC does depends on good data. It needs to have accurate, timely health data from state and local partners to determine an appropriate response to health crisis. It informs the guidance that CDC will put out to support state and local health care institutions so the data has great value for the CDC and health officials across the nation.

But at the same time, through reauthorization of the Pandemic and All-hazards Preparedness Act, Congress has the opportunity to support sensible reforms and further ensure that our nation's public health agencies, including CDC, have

the necessary authority and resources to respond to future threats.

So let me start out with Dr. Benjamin. I have two questions, if you can do them both in this -- whatever time is remaining here. How would better data enable CDC to keep up with persistent health threats the nation faces?

And secondly, would giving our health institutions like CDC and FDA broader authority to address issues like drug shortages and data transparency help our pandemic response abilities?

Those are separate questions, but you have got two minutes.

*Dr. Benjamin. Yes, speed and efficiency. We missed opioids when we had, you know, thousands and thousands of doses of opioids going into communities, and nobody paying attention because the data wasn't timely. You heard the measles story.

I am sitting at home during COVID, head of the Public Health Association. My phone rings, and the health officer in Milwaukee, Wisconsin calls me to tell me that she has seen a disproportionate number of African American men dying of COVID. That is how I found out there was a disparity occurring. I assumed it was occurring, but it was the first evidence that I had, was a phone call to my home from a

member of the American Public Health Association who wanted me to fix it at, you know, 9:00 at night. And that should not happen. And CDC was struggling to get that kind of disparity data. So time and efficiency -- speed and efficiency are the two things you get.

*Mr. Pallone. And what about the authorities? I mentioned about the -- giving CDC and FDA broad authority to address drug shortages and data transparency.

*Dr. Benjamin. No, I think it is essential, and I understand there is a difference of opinion there, but I think we can do it. I think we can sit in the room, we can figure out how to do that in a way that protects patient confidentiality, increases speed.

Look, we give the banks a whole lot of latitude, and they have a lot of information on us. Google has a lot of information on us. You know, the social media companies have a lot of information on us. And I know you are struggling with that, as well, but I don't see why you can't come up with a way to do this. Maybe ask for a study. You know, put the, you know, the authority in the law when you reauthorize the law, but require some kind of study in order to understand how best to implement that before it gets implemented. I don't know, but I --

*Mr. Pallone. Well, you are a lot more optimistic than

I am at this point, I got to be honest with you about our ability to come together and address some of these concerns. But hope springs eternal.

*Dr. Benjamin. We don't have a choice. And I am just going to, you know, to argue here today we have to solve this. We cannot wait. People are dying, literally, while this is happening because we don't have the numbers, we don't have the data.

And I think we -- I can see a solution here. And I can tell you that there are many of us who will be eager to sit down with you to try to figure that one out.

*Mr. Pallone. Thank you. Thank you so much. I yield back.

*Mr. Griffith. The gentleman yields back. I now recognize Dr. Burgess of Texas for his five minutes of questioning.

*Mr. Burgess. Thank you, Mr. Chairman. Boy, I wish we had had Dr. Dean and Dr. Hoeg at the office of attending physician a few years ago.

We had a microcosm here, if you will, in the United States Capitol. The House of Representatives was required to mask before we could go into the Capitol, and sit on the floor masked, and the United States Senate was not. Well, wait a minute, COVID -- what is the population that is more

likely to be stricken by COVID? It is the older individuals, which -- and I don't want to cast aspersions on the United States Senate, but they are generally older than your average House person. So what was magical about the Rotunda that made the virus -- took away all its potency by going from the House to the Senate? It made no sense, and the population -- people saw this. And that is what was so frustrating over and over again.

Look, I want to share with you. In 2005, during the first bird flu, my first term on this committee, I was asked to go to Geneva and visit the World Health Organization, which I did. And my takeaway from that visit at the World Health Organization is that, if it was not for the CDC, the World Health Organization would not be worth anything. It was the embedded people from the CDC at the World Health Organization that gave it its value. That is why it is particularly painful to be here today, recognizing the CDC has lost all kinds of credibility.

It is not -- Mr. Pallone, it is not us fighting that caused them to lose their credibility. It was them not having the simple humility to come before the American people and say, "We have never seen this before. This is what we think today. And you know, what we told you last week, something that was a little different, we have learned

something along the way.'' They would not do that. And that was just -- it just decimated any credibility that people had -- that the CDC might have had with the American people.

Now, look. In 2016 there was Zika crisis, and the Zika crisis was going to affect the Olympics, and the CDC badly mishandled the testing then. I have got an article, Mr. Chairman, from The Washington Post. I am going to ask unanimous consent to put it into the record after I finish. But this article talks about how the CDC sidelined an effective laboratory test, and the test that the CDC recommended be used failed about a third of the time and there was a more reliable test.

Look, we had all kinds of young people, athletes going down to Brazil during the height of Zika. These are the people who would be at risk for the sequelae of a Zika infection. And unfortunately, the CDC was way behind on this on the testing. Why is that important? Because in February of 2020 the CDC badly mishandled the test for the coronavirus, for COVID-19. And we were a month behind. The United States was a month behind countries like South Korea and Japan that had the laboratory-developed test that was necessary to detect.

I mean, measles is a problem, I agree with you, and I am so grateful you brought that to the committee's attention.

You got four days of infectivity that is in the community before you realized it was there. COVID-19, it was two weeks, we think. We don't really even know. But that period of infectivity after exposure, two weeks, and we were a month behind in getting a reliable test.

I spoke to Dr. Burke several times during the COVID problem, and I got to tell you one of my great frustrations -- we knew we had a problem with testing after we finally got the testing up and running a month late. Then we just didn't have enough. And the President would go on television and -- or the Vice President would say, "Everyone who wants a test is going to get a test,'' and LabCorp would say, "How?'' But we all knew that people wanted testing. We actually had a lot of testing capacity, capacity that was probably paid for by NIH grants that sat in hospitals and research labs across the country, and it was on the sidelines and wasn't used.

So Ms. Dean, let me ask you. Does the CDC currently have the authority to tap into that network of hospital and research lab equipment to use it at a time of a national crisis?

[No response.]

*Mr. Burgess. Dr. Dean, yes, you are the one who has probably had the most experience with this.

*Dr. Dean. I am not able to comment on the current

authorities the CDC has, what they can or can't do regarding laboratory testing. But I will share that in California I was a co-chair of the testing task force in March, and we had to stand it up fast to solve that problem. And it was remarkable to see the private sector voluntarily participate.

*Mr. Burgess. Yes.

*Dr. Dean. Machines, humans, everyone was in it together, public, private. And that is what I saw work.

*Mr. Burgess. Well, Mr. Chairman, I see my time has expired. I have got a number of other questions I will submit for the record.

[The information follows:]

**********COMMITTEE INSERT**********

*Mr. Burgess. And I look forward to your written responses. Thank you.

*Mr. Griffith. I thank the gentleman for yielding back. I now recognize Ms. DeGette of Colorado for her five minutes of questions.

*Ms. DeGette. Thank you so much, Mr. Chairman.

You know, I have to associate myself with Dr. Burgess's timeline here, because he is absolutely right. In the late aughts -- I have been on this subcommittee for 27 years, and I have either been the chair or the ranking member a number of years. And the CDC has been an agency that, for all those 27 years, we have been wringing our hands about how we can improve and bring into the 21st century.

And Dr. Burgess is right. When we had the avian flu hearings, we thought that we had solved some of these fundamental systemic problems at the agency. We were pretty smug.

But then, as he said, we had Zika in 2016, and then in 2020 -- well, first of all, let me say December 4th, 2019 this subcommittee had a hearing. And in that hearing we asked -- we were doing a hearing about CDC and about pandemic preparedness. And we asked the experts, including Dr. Fauci, "What is your worst nightmare?'' This was December 2019. And Dr. Fauci said his worst nightmare would have been an

international pandemic. And lo, it came to be only a few months later.

And the problem was the CDC, as an agency, still had not updated its data collection, its communications with the states, its organization to the point where it could deal with an international pandemic. Dr. Redfield was the head of the CDC at that time, and Dr. Burgess is absolutely right, the CDC could not even complete the fundamental efforts of developing a COVID test because the test samples at what is supposed to be the preeminent agency in the world were contaminated.

So I think we can sit here and emote all we want, and finger point about about the schools and everything else, and much of that I agree with. But I think that the usefulness of this committee, Madam Chair and Mr. Chair, is if we start to think about what kinds of reforms we can really make, and how we can be partners in that.

So Dr. Walensky, before she -- and she saw this, too -- this subcommittee had a trip down to Atlanta to look at the CDC, and we met with Dr. Walensky, and she was brought in, and she saw these issues, too. So before she announced her departure she had a number of changes that she suggested in the Moving Forward initiative. And I am just going to state what some of those initiatives are, because I think they are

worth us and the CDC exploring them: standing up new internal systems, processes, and policies to enhance bidirectional communication and accountability; establishing clear outcomes and timeframes for deliverables and bidirectional engagement for core capabilities and agency-wide initiatives; implement new government structure -- governance structures to ensure accountability closely tied to funding decisions; share scientific findings and data faster and better translate; share scientific findings and data better -- or no, promote results-based partnerships; develop a workforce prepared for future emergencies.

These are broad goals, but I would like to ask the panel, do any of you disagree with these as broad goals? First I will ask you, Dr. Denigan-Macauley. Yes or no, do you disagree with these as broad goals?

*Dr. Denigan-Macauley. We do not disagree.

*Ms. DeGette. And what about you, Dr. Dean?

*Dr. Dean. I do not disagree.

*Ms. DeGette. And what about you, Dr. Hoeg?

*Dr. Hoeg. I don't disagree.

*Ms. DeGette. And what about you, Dr. Benjamin?

*Dr. Benjamin. I agree with those goals.

*Ms. DeGette. Thank you. I think so, too.

They also -- she also talks about a list of new

authorities that Congress should provide: public health and regulatory authorities, e.g. mandatory data reporting, paperwork reduction, action exemptions, et cetera -- I know we all love fax machines, but maybe we should look at paperwork reduction; human resources authorities, e.g. hazard pay, overtime pay, direct hire authority, hiring authority exemption, et cetera; and other operational authorities.

And then she suggests a bunch of other next steps: appointing a seasoned executive to implement the vision -- and we are really hoping that President Biden's new nominee will do exactly that -- and then some other things I don't have time to mention.

Look, we need to fix this agency, and so let's just do it because the next pandemic is right around the corner. And if we don't have our public health ducks in order, if we are still sitting around bickering about should the schools have been closed or should there have been mask mandates, then we are going to really lose in the next round.

And I yield back.

*Mr. Griffith. I thank the gentlelady. I now recognize Mr. Palmer of Alabama for his five minutes of questioning.

*Mr. Palmer. Thank you, Mr. Chairman, and I agree with my distinguished colleague from Colorado that we do need to follow the evidence.

I speak to a lot of young people, and I tell them smart people learn from their mistakes but brilliant people learn from other people's mistakes. This is one of those learning opportunities. And I think mistakes were made, and I think trying to somehow convince us that mistakes were not made is not helpful.

I think if you look at the evidence, say for instance from Sweden, and how they went about things, it clearly indicates that we did enormous harm with the policies that we enacted with school-aged children. And it makes me wonder how much interaction was taking place, how much discussion was taking place. It reminds me of politics a lot. You know, you make up your mind what you believe is right, and you dig in, and it doesn't matter what the evidence shows, you just stick with it, and that kind of makes me sick to even think about it on the political side about where we are today.

But the thing that I want to get into is how we went about this decision-making on the mask. And I talk to a lot of people in medicine, and it was pretty evident to me that a lot of people realized the masks were marginally effective, yet we were -- we had situations where we weren't -- we were forcing kids, toddlers to wear a mask. We saw things where parents were removed from airline flights because they

couldn't get their toddler to keep the mask on. I mean, this was unbelievably disruptive.

So that said, it is a learning experience. It is a learning opportunity. And what has happened is we have talked a little bit about how much the CDC's reputation has been damaged, how much other institutions, government institutions' reputations have been damaged. And I think the way you overcome that is you get back to real science, you get back to real medicine, you get back to respecting people's personal rights, which I think this was -- the heavy-handedness of government came to bear on people. And like I say, we are still suffering the consequences of it, not the least of which is the enormous amount of debt we have inflicted on coming generations of this country.

Dr. Hoeg, in your testimony you outlined your concerns with the CDC making the decision to keep schools closed based on the whims of teachers' union leaders, particularly Randi Weingarten. This is part of what I am talking about. This wasn't science, was it?

*Dr. Hoeg. I mean, it didn't feel like -- I mean -- and I can see looking back that the CDC was not looking at the science. I mean, they were not looking at the data that was coming out of Europe. They were not looking at the data from our study. They were not consulting us. I -- they were not

consulting similar, you know, experts in this subject in the United States who had published a study with similar findings from North Carolina.

And so, to us it felt like politics. It felt like a tragedy. It felt like, you know, why are decisions being made based on, you know, just asking one group of people, rather than also consulting the scientists and, you know, the relevant science around this topic? So I --

*Mr. Palmer. Well, what you are saying is you can't cherry-pick the data. And it is not just on the COVID virus and other biological issues like that, it is across the board in science right now. It has become so politicized, and both sides are guilty. I will admit that, to a certain extent, both sides are guilty of cherry-picking the data. And at the end of the day, who suffers?

*Dr. Hoeg. We all do. I mean, we all suffer if they cherry-pick the data.

And the masking is another perfect example of that, because the data that was published in their journal, you know, was clearly not in line with the randomized, higher-quality data that we had. And the fact that they would not publish a study that was a more robust data set follow-up to their initial study that didn't find a significant association between masking and reduced cases just speaks

very strongly to the political bias and the cherry-picking of data within the CDC's flagship journal, MMWR. It is a huge problem.

*Mr. Palmer. Well, this is -- gets into the issue then of transparency and accountability, and it is something, again, that I try to confront on a number of issues related to science.

And Dr. Denigan-Macauley, your written testimony -- you said when agencies need to quickly disseminate funding and information during a public health emergency, transparency and accountability are especially critical to help ensure that these programs have integrity, that they build public trust. But we found deficiencies in this area prior to and during the COVID pandemic. Just what -- how do you -- what do you say about that? How do you address this issue of these deficiencies?

*Dr. Denigan-Macauley. Yes, absolutely, and I actually think it is a way forward for the committee, as well, is go on the data, go on the science, and be very transparent and accountable about how decisions are made. We said that with therapeutics. Hydroxychloroquine was mentioned. You know, if you are transparent on how the decisions were made, it will be much easier for everyone going forward. And it is guidance, and that way everyone can make their decisions to

the best of their knowledge, based on the information.

*Mr. Palmer. Well, I appreciate all the witnesses being here -- Mr. Chairman, for you holding this hearing. I just hope this is a learning opportunity for us, and I yield back.

*Mr. Griffith. The gentleman yields back, and I now recognize Mr. Armstrong for his five minutes of questions.

*Mr. Armstrong. I am going to talk a little bit about data, but I am going to do it in a little different way.

Sunday morning, April 18th, 2021 was the first time I knew we had a problem, and we had a real problem. And I did -- there was a hearing, and people got in an interesting conversation. But the head of the CDC was on a Sunday morning show on CNN and said, "This is a public health issue. It has nothing -- it is not a civil liberties issue. This has nothing to do with civil liberties.''

This committee has been working on comprehensive privacy legislation, and the focus on the extent to which Americans' sensitive information is in the hands of third parties, particularly data brokers and purchasers of that data. In a recent subcommittee hearing we learned how seemingly de-identified data can easily re-identify individuals. While our focus has largely been on private actors' use of this data, I have been equally concerned about the government's purchase and use of this data.

In March, FTC Chair Kahn testified before the IDC subcommittee that, "A lot of people have concerns about data collection by the government. I would argue that we should be more concerned about government's collection and use of this data compared to private actors.'` Republican members of this committee sent a letter to CDC Director Walensky in May of 2022 inquiring about the CDC's $420,000 purchase of Americans' location data to monitor COVID lockdown compliance.

Mr. Chair, I will seek unanimous consent to enter that into the record.

The company the CDC bought this data from has a checkered history, if I am being polite, of misusing location data. They have sold two years of de-aggregated data, device-specific location data, to the Illinois State Government which, guess what, turns out wasn't de-identified. And they were selling ads in real time to women who were sitting in an abortion clinic. That is who the CDC contracted with.

This CDC data request details a list of 21 different potential uses for cases for that data, covering location information, points of interest. The CDC request specifically sought data to track people who were attending places of worship during quarantine.

CDC's response to the committee was that this -- that it has the authority under 42 USC 241, which is a vague authorization to research diseases. And I want to repeat that: the CDC cited general research statute as justifying purchasing location data about Americans exercising their First Amendment right.

The CDC's response to the committee's letter also dedicated an entire paragraph describing how this aggregated and anonymous data population [sic]. Again, we had hearings in this subcommittee last month describing that is a fallacy, and multiple studies since 2013 showed that less than 5 points of data are enough to re-identify 90 percent of individuals. And individuals can really be identified particularly when they are going to Mass in a place like Beulah, North Dakota that has under 4,000 citizens.

If we are going to legislate on data privacy, and we are going to continue to get asked to provide more and more data, I think it is our duty to address government access to what the Supreme Court has referred to as the time-stamped data that provides an intimate window into a person's life revealing familial, political, professional, religious, and sexual associations.

I don't know -- there is a lot of debate about Dr. Fauci. I am not a doctor. I never went to medical school.

I have no idea. But you know what I know he is not an expert on? Civil liberties. And when people continue to ask us for this stuff, and they say that this is -- that civil liberties have no place in an emergency, my response to them would be that is when they matter the most. Every single -- I don't care if it is a 15-day emergency order, I don't care if it is a 2-year emergency order.

Civil liberties matter the most when the government is trying to clamp down on them. And when we have the head of the CDC on a Sunday morning show acknowledging that he didn't care about civil liberties while he was pontificating out to be the expert on this -- because I have a lot of constituents that cared about their civil liberties. I have people who couldn't send their kids to school. Whether that decision was right or not, that is an infringement on their civil liberties. I have people that were worried about whether they were getting tracked to church during quarantine.

And so if we want to have -- if we want to fix this data conversation, and we want to be able to track whatever the new disease is and how we do this, the first thing we have to do is figure out how we protect this and keep people from having their -- identified by a government that really, really is trying to help, but people don't trust them. And it doesn't help when the head of the CDC, who knows nothing

about civil liberties, is opining on them on Sunday morning, April 18th, 2021.

And with that, I yield back.

*Mr. Griffith. Will the gentleman yield for a question?

I would assume you are not a -- as you told us, you are not a doctor, but I would let the committee know that you are trained as an attorney who did some work in civil liberties. Is that not correct?

*Mr. Armstrong. I have written quite a few briefs on the Fourth Amendment, yes.

*Mr. Griffith. There you go. All right. I yield now to -- for five minutes to Mr. -- Dr. Ruiz from California for his five minutes of questioning.

*Mr. Ruiz. Thank you. So the esteemed chair had lots to say about making this partisan, but one of the Republican members sent a letter to CDC in a purely partisan fashion. Those responses have not been shared with the minority, and we specifically asked committee staff that responses be shared, and we were told that the letter was the act of an individual member, not the committee. However, today you present a desire to work together and infer that somehow Democrats are making this political. So --

*Mr. Griffith. Will the gentleman yield?

*Mr. Ruiz. Yes.

*Mr. Griffith. Are you referring to the response we got last night?

*Mr. Ruiz. I am referring to this letter dated April 5th, 2023.

*Mr. Griffith. And the response we received last night? I am happy to share with you I was unaware you had not been shared with. We will make sure you get that response.

*Mr. Ruiz. We will work with staff to make sure the staff -- it is a different letter?

*Mr. Griffith. It is a different letter, all right.

*Mr. Ruiz. So do you want to mention which letter it was?

*Voice. [Inaudible.]

*Mr. Griffith. Oh, okay. I don't know anything about that, so I apologize.

*Mr. Ruiz. Well, we will --

*Mr. Griffith. But anything that I have, you are more than welcome to have.

*Mr. Ruiz. Okay.

*Mr. Griffith. All right.

*Mr. Ruiz. Thank you.

*Mr. Griffith. And I will -- we will give you some extra time. Oh, you stopped the clock. Okay, good. I didn't want to eat up your time with that.

*Mr. Ruiz. All right, thank you.

*Mr. Griffith. Thank you, Dr. Ruiz. I yield back, thank you.

*Mr. Ruiz. So the suggestion here is that the letter should have been -- well, we should have started with sending an oversight letter from the committee that both Republicans and Democratic committee staff would have access to the responses. And so, if you want to do the good oversight together, we are absolutely willing to do that. That is not the approach that the committee and the staff have said that has been taken.

So I ask unanimous consent to add the letter dated April 5th, 2023 into the record. I appreciate it.

So now, CDC. CDC cannot fulfill its mission to equitably protect Americans from disease and death without a foundation of trust between the agency, health care providers, and the public. And during the pandemic we saw the confusion and damage caused by policy-makers promoting fake treatments or undermining scientific evidence like the importance of masking.

There was a lot of conspiratorial accusations that were not founded with any conclusive evidence. This type of misinformation and disinformation and partisan weighing in on, you know, masks and social distancing, and whether the

virus was a hoax or not is the misinformation -- and sometimes intentionally -- disinformation, which I cannot emphasize enough is not the same as a difference in opinion.

This type undermines the efforts of health care providers, CDC, and other public health institution. It manufactures distrust, in fact. The public hears conflicting advice, and can become unsure of who to listen to for reliable information. This is a manufactured distrust that harms CDC and other public health entities' ability to be trusted and effective messengers both for physicians, who look to them for guidance, as well as the general public who now isn't sure who to listen to.

Dr. Benjamin, how did we get here? How did early attacks on the integrity of our public health agencies degrade Americans' long-term trust in our institutions?

*Dr. Benjamin. You know, we had a failure of leadership during the COVID pandemic. We didn't function as a collective at a national level to respond to that emergency.

By the way, we still don't do that real well.

And I think that we under-communicated to the American people, we didn't respond quickly to the amount of misinformation and disinformation that was out there. We, you know, as you know, both of us are emergency docs, so we know how things happen in an emergency. And it is always

difficult to address some of these things in an emergency condition. But we have got to do a much better job of partnerships, engagement of people, and addressing the false things that are out there.

And I have got to tell you, there is a leadership vacuum here that has to be filled. And I am very concerned that I still see it coming.

*Mr. Ruiz. You know, I think that there is a misguided prioritization of how to deal with lessons learned in this pandemic. There seems to be a lot of -- and I say this wholeheartedly in the concern for our country moving forward -- there is a lot of emphasis in trying to prove some intentional, nefarious scheme from Dr. Fauci and Dr. Collins that somehow suppressed information that the virus was created in a lab and leaked from a lab, and now there is some kind of web of cover-ups, and without any conclusive evidence, with multiple statements from our public health leaders, that is not true.

And we are missing the opportunity to focus on things that will actually prevent a pandemic and help us prepare for a pandemic. Nobody in the next pandemic is going to be remembering whether or not this alleged accusation is true or not. They are going to want to stay safe, and they are going to want to make sure that we have learned so that we can go

through a pandemic resilient, and not have to close schools, or not have to undergo some of the more extreme measures we had to take because we weren't prepared.

And so that is my warning in general, and that is -- I am hoping that we can move from this partisan narrative to more concrete solutions. And with that I yield back.

*Mr. Griffith. I thank the gentleman for yielding back. And clearing up the question, it appears that the letter was from Dr. Mariannette Miller-Meeks. I was not privy to it until you gave it to me, either. And we will move forward with that, and it certainly is already public, so we can deal with that at the appropriate time.

I now recognize Mrs. Lesko, vice chair of this subcommittee, for her five minutes of questioning.

*Mrs. Lesko. Well, thank you, Mr. Chairman, and thank you for all of you being here today.

I -- you know, I don't know if you have ever read the riveting deposition by Dr. Fauci in a lawsuit, but this is where this question is coming from. In a deposition in November 2022, Dr. Anthony Fauci was questioned about an email exchange he shared with former HHS Secretary Sylvia Burwell in February of 2020. She asked him in the email, "I am traveling to'' -- it is a redacted location. "Folks are suggesting I take a mask through the airport. Is that

something I should do?'' And Dr. Fauci responded to Ms. Burwell saying that masks don't protect -- don't protect -- uninfected people from acquiring infection. He recommended not wearing a mask.

And I remember being in the Homeland Security Committee at the beginning of this whole thing, and they -- you know, the health care workers were wearing masks, and then the government official said, "No, you shouldn't wear masks.'' Like, the standard people shouldn't wear masks. And it went back -- it seemed like it went back and forth, and it was very confusing to the American public.

So my question is, why do you think -- I guess this is to Ms. Dean and -- or Ms. Hoeg. Why do you think Dr. Fauci would tell a personal friend not to wear a mask, and then later -- I mean, it was shortly later after that he said, "Everybody, everybody should be mandated to wear a mask''?

*Dr. Dean. I can't speak to what Dr. Fauci was thinking, or really comment on his statement.

I will say that in the U.S., because there are about 3,000 local nodes of local health officers who have the authority to give recommendations, issue mandates, and then 50 state health officers, that what we really have is a patchwork quilt. So it is never a surprise in the United States when different places are giving different

recommendations.

That is part of the problem that I think we need to fix with a coordinated intelligence capability, operational capability. It led to a lot of confusion during COVID, including different and conflicting mask mandates in different parts of the U.S. with different officials speaking to them.

*Dr. Hoeg. And I guess I would add to that that the evidence that we had going into the COVID-19 pandemic for influenza-like illness had failed to find in randomized studies that masks prevented transmission in the community setting or the hospital setting. And so in the summer of 2020 -- and I think you said 2022, but I think you meant 2020 --

*Mrs. Lesko. Oh, okay, sorry.

*Dr. Hoeg. That was when Dr. Fauci --

*Mrs. Lesko. Thanks for correcting.

*Dr. Hoeg. We didn't have good evidence showing that masks worked. And so, you know, it was really up to us to generate good data to find out was it going to -- were masks going to be effective against COVID-19, surgical and N-95 masks. The United States did not run randomized studies in our country to get the answer to that.

And so really, we then had a Cochrane review that

reviewed the data of the randomized studies that had been done during the COVID-19 pandemic. They didn't find that masks were effective at preventing COVID-19 transmission. They failed to find that in the randomized studies. However, the United States continued to recommend masking of children down to age two, which they actually still do today under certain circumstances. So we act like we are talking about things in the past. CDC is still recommending children down to the ages of two mask under certain circumstances of high disease burden.

And so I think that he said that because that is what he felt the data showed at the time, and that -- in my understanding of the data, would -- is -- was an accurate representation of what we knew, that masks were not effective, from the data that we had.

*Mrs. Lesko. Yes. I think, you know, part of the reason that we are asking about this is -- in fact, most of the reason -- is we don't want to repeat the problems that we had before.

And, you know, I am also on the select subcommittee investigating COVID and its effects. And one of the things I think we talked about there was the closing of schools for our children, and how far behind they are. And Ms. Hoeg, I don't know if I had a chance to ask you questions last time,

but in Sweden, if I remember right, they didn't close the schools at all. They didn't close the schools at all.

*Dr. Hoeg. They didn't close the public --

*Mrs. Lesko. And none of the kids died, right? None of the kids died. Is that accurate? From COVID.

*Dr. Hoeg. So from their --

*Mrs. Lesko. Yes.

*Dr. Hoeg. -- initial report, there were no children that died.

*Mrs. Lesko. Yes.

*Dr. Hoeg. I actually don't have the latest data --

*Mrs. Lesko. Yes, right.

*Dr. Hoeg. I apologize, but -- yes. And -- but they did not close the primary schools, and then they have had very brief closures of the secondary schools. And their excess mortality -- I mean, they -- their excess mortality has been none to, you know, negative.

*Mrs. Lesko. Yes.

*Dr. Hoeg. I mean, they have done -- probably one of the best countries in the world during the pandemic, if not the best.

*Mrs. Lesko. So, Ms. Macauley, do you think that the CDC in the future could look to what other countries did? If this happens again, which, eventually, it will happen again,

do you think that they should look to what other countries did? Because some other countries didn't do all these mandates, and closing schools, and things like that, and they didn't seem to have a problem. Do you think that is a good thing for the CDC to do?

*Dr. Denigan-Macauley. Yes.

*Mrs. Lesko. Sorry, I ran out of time.

*Dr. Denigan-Macauley. We have always encouraged to look at all lessons learned, and to revise plans as needed.

*Mrs. Lesko. Thank you.

*Dr. Denigan-Macauley. Domestic or international.

*Mrs. Lesko. Thank you. Thank you, Mr. --

*Mr. Griffith. The gentlelady yields back. I now recognize Mr. Tonko of New York for his five minutes of questioning.

*Mr. Tonko. Thank you Mr. Chair, and I would think that deaths is one -- happens to be one measurement, but permanent damage or damage of any kind to the respiratory system and cardio systems might also be another calculation that we should pay attention to.

Public trust in our health agencies can be quickly eroded by political interference in public health decisions. We saw this during the pandemic: politically-motivated efforts to downplay the dangers of COVID-19 by then-President

Donald Trump are well documented. Reports showed that during the early stages of the pandemic the Trump White House interfered with CDC efforts to carry out media briefings that would have provided science-based information to the public. I am a big believer in relying on science, and I think we have rejected it in many, many occasions on the Hill. And rampant misinformation also impeded public health officials' efforts to get critical information out to the public.

So, Dr. Benjamin, how does low public trust in health care institutions impede our ability to effectively respond to what was a public health emergency, if not continues to be?

*Dr. Benjamin. Yes, it creates an environment when you have low public trust that people won't do what generally is recognized by experts. And we saw that in, you know, vaccine uptake, we saw that in people taking medications that have been clearly proven not to be effective, like hydroxychloroquine. We saw that in people using all kinds of things that they would go to the Internet and find and use.

So it is a real problem, and it is persistent. And we are now seeing it bleed into routine childhood vaccinations, uptake in other adult vaccinations. So it is a big problem.

*Mr. Tonko. So the damage can spread. I don't ever remember in my many years a public health crisis becoming so

politically charged, and I think that is a difficult dynamic to introduce.

How does the spread of misinformation about, for instance, the safety of vaccines worsen the risk posed by an infectious disease like COVID-19?

*Dr. Benjamin. Well, it means that people won't get vaccinated or do other protective things, and then they get infected and they infect other people.

You know, in the spring of 2020, early part of the pandemic, we already had anti-vaccine groups handing out fliers, going into communities and telling those communities don't get tested when the vaccine is available. We didn't have a vaccine yet, but before we even had a vaccine --

*Mr. Tonko. Right.

*Dr. Benjamin. -- don't get the vaccine, and all the bad things that they hypothesized would happen if you got it. So they were already working against good public health.

*Mr. Tonko. Yes, and that just creates a weak environment, and especially as it relates to our children, because they are not many times making those decisions.

GAO has issued several recommendations to immunize HHS's operating divisions from political influence, including by developing policies and training staff in reporting bias. HHS has agreed with these recommendations, and is in the

process of implementing them.

So, Dr. Benjamin, how do efforts to reduce political interference or -- excuse me, yes, how do efforts to reduce political interference strengthen CDC and improve public confidence in health institutions?

*Dr. Benjamin. Well, quite frankly, the current Administration stopped screwing around with your website, telling them what to say, interfering with their public presentations and, all in all, followed the science. And that has dramatically changed the way the agency has been able to function and engage with the public, and engage with other partners. That was a terrible mistake that was previously done. And that will help CDC recover the trust of the American people.

*Mr. Tonko. Right. Well, science-based and evidence-based data and anecdotes should be what guide us.

Dr. Denigan-Macauley, GAO's latest high-risk report mentions the importance of HHS building a skilled health workforce. I would argue that persistent political interference with the work of health care professionals would be counterproductive to achieving that goal. Why is strengthening the health care workforce a key component to public health emergency preparedness?

*Dr. Denigan-Macauley. It is absolutely essential. No

matter how many systems you build, or -- you have to have the people to be able to run it. I mean, obviously, we are getting artificial intelligence, and we are getting smarter and being able to do things without staff. But that is not where we are. And as we have said on this committee, or on this board right here today, on your panel, it takes the whole of nation. It is patchwork. And the -- it is from -- at the local level, tribal, territorial. It is everyone.

*Mr. Tonko. Okay. Well, my time has now been exhausted. But I would say it is important for us to pay attention to and listen to science, so that we can do the appropriate policy.

*Mr. Griffith. I thank the gentleman for yielding back, and now recognize Mrs. Cammack of Florida for her five minutes of questioning.

*Mrs. Cammack. I have a microphone that won't cooperate with me, so I will adjust. I will start with you, Dr. Dean.

I am going through your testimony for a second time, and there is a couple of things that have just stuck out to me, talking about the failures of the CDC to listen to those on the front lines. This is something that seems to happen, whether it is COVID, whether it is Ebola. It doesn't seem to matter what crisis we are facing down, it seems that the bureaucrats in Washington are greatly removed from those on

the front lines, be it EMS, our public health safety officials. Can you elaborate on what you have seen?

And if you had to give me in three bullet points what CDC needs to do to turn this around, to be more forward-facing and actually start listening to people on the ground who are dealing with it rather than operating from computer screens up here in Washington, D.C., that would be much appreciated.

*Dr. Dean. Thank you for the question. I would highlight this is a systems problem. I never blame the humans. The public servants are my heroes, but we are all operating in a broken system. On the front lines you have to make decisions in the fog of war, often times without the data that you want.

If I were to bullet point the three things, it would be, number one, the CDC reform that they are attempting to do that is deeply discussed by this committee. As part of that, looking at not just the infrastructure, but the culture. In academic research, institute culture is very much needed. We rely on that for the kind of information retrospective that we use on the front lines, but it is different than front-lines response.

So I would say bullet two would be an intelligence infrastructure, real-time data shared with all the nodes on

the front lines so we can make decisions.

And number three, an operational infrastructure. We already do this. We call each other and ask for help. We back each other up. Let's formalize that into a structure, where someone really is coming to save us when we need it.

Those would be my three.

*Mrs. Cammack. And as a follow-up to that, we are concerned about Federal authority that undermines the mayors, the governors, and other local elected officials that are on the front lines. If the Federal Government can demand data, and there is no need to work cooperatively with the states and local governments, what kind of data, then, do we need to be pinpointing that is going to be beneficial for the state and local responders?

*Dr. Dean. On the front lines, as a local health officer, we already call each other. We share information. We are calling firefighters and EMS. I am calling my colleagues in other states. So that kind of intelligence-sharing is happening right now.

*Mrs. Cammack. Is it everything, though, from predictive data, or is it more of, hey, this is the PPE that we have in stock, and we are moving things around? What --

*Dr. Dean. It is all of it. It is all of it. Because what we are trying to do is gain situational awareness.

So when talking about data-sharing, the point I would make is it is really important that it doesn't just go to one place where it is held, that it is immediately shared out to everyone on the front lines. And this is far beyond public health. My colleagues in EMS, those that run supply chain, we all need that real-time, situational awareness. We live in a data-rich but intelligence-poor system in the U.S. And let's fix that.

*Mrs. Cammack. I like the way you phrased that, thank you.

Okay, Dr. -- I am going to mess this up.

*Dr. Hoeg. Hoeg.

*Mrs. Cammack. Hoeg, got it, okay.

Many of the COVID-19 mandates, particularly the national mandates, have done tremendous harm to our country: people who have lost their jobs, communities' -- children's development was impaired. There is truly an extensive list of the harms that have been created, many of which were not science-based. National mandates undermine the public's trust in public health because it is not something that the Federal Government has done or done well. It is inconsistent, quite frankly, with our constitutional system.

The national COVID-19 mandates were made worse by the fact that they were put in place, despite conflicting

scientific evidence. Now, in your testimony you noted that the CDC often cherry-picks what scientific data they find relevant. For example, the mask mandate that was implemented here on the -- on Capitol Hill for members and staff was based on a peer-reviewed study that had failed peer review, and had been tested on a sample size that was not an American population. So if that is happening here on Capitol Hill, how can we be sure that the decisions at the highest level of government are not based on incomplete, conflicting science like what we saw during the pandemic?

*Dr. Hoeg. Yeah, thanks for that question. So I guess I would say, you know, we -- just to get to the vaccine issue first, I mean, we have talked about this distrust in public health and vaccine hesitancy. And I am actually concerned that a lot of that came from making extrapolations from the initial data, and sort of telling the American people that these vaccines were going to be stopping infection, all infection. We really only knew about the 94 to 95 percent efficacy against symptomatic infection from the initial trials. We didn't know how long it would last. We didn't know if it was going to prevent transmission.

And so -- and then, you know, the mandates were sort of instituted -- based on, like, incomplete data. And then people ended up losing their jobs because they felt

uncomfortable taking the vaccine. They didn't feel like they had enough information. And that has been devastating.

And then we find out, you know, as we gather more data, the vaccines were not effective at preventing transmission, especially not long term, maybe a few-month period that they can decrease infection risk, but they don't decrease transmission risk. And so I feel like people lost trust because they were told that, for sure, that the vaccines did something, and then we found out that that wasn't true, and they were coerced to get a vaccine. And so that has fueled some distrust.

And I know I am, like, running out of time here, but I wanted to get to that point. I am sorry I didn't answer --

*Mrs. Cammack. No, I appreciate that. And thank you for the chairman's grace, and --

*Mr. Griffith. Yes, the gentlelady yields back time.

*Mrs. Cammack. -- time, thank you.

*Mr. Griffith. I now recognize Mr. Peters for his six minutes or so.

[Laughter.]

*Mr. Griffith. For his five minutes of questioning.

*Mr. Peters. All right, thank you very much, Mr. Chairman. I do appreciate you having this hearing. I think anything like this deserves an after-action report. And we

ought to be looking, honestly, at what we got right and what we got wrong, and we should not expect that we would have gotten everything right.

I would just say, on behalf of President Trump, Project Warp Speed was great. I think getting a vaccine in a year is something that is -- deserves a lot of credit, and is something we can replicate for other things here, too. On the other hand, you know, suggesting on TV that you inject bleach, that probably wasn't a good idea.

And there was -- now there is politics around vaccines that the very people who did all the work to do vaccines don't even want to admit that they took the vaccine, because that has become politicized. So we could use some help across the board of getting really honest after-action on vaccines.

And I would say about Dr. Hoeg, yes, it didn't transmit -- it didn't prevent transmission, but we prevented people from dying, in general, which was really the objective, I think, as we started. And I think that is good.

I do agree with you that schools -- school closures was wrong. It was a -- it was -- kind of ended up being a disaster, I think, going into it. We didn't know that. But once we had vaccines that would keep teachers alive, we should have gotten those schools back open again. You have

made a very serious charge that I am not going to adjudicate here that it was the teachers unions that drove that decision, but I think that CDC should answer for that. How did that factor in? I think we should understand that, because we don't want it to be politicized. We want it to be factual going forward.

On that topic, though, something that I have been trying to talk about forever since the beginning of this is the terrible data system that we have here. On -- you know, I am not an advocate of having a national health system like England, but they have the same data on every patient. And we don't. We have different hospitals in different states collecting and reporting different data. And we are asked, as policymakers, to make policy judgments based on, basically, a lot of guesswork. There is a lot of holes in that data. And I am going to ask the epidemiologist something about that in a second.

But if -- you know, we heard rumors that it was type O blood that had an effect, or vitamin D. I mean, great, that might be true, we had no way to really figure that out without data.

And then looking backwards, you know, learning loss, mask efficacy, community spread around schools. I don't know that we have the data that we need for that, even,

tragically, now that this is -- at least this phase of it has passed us by.

So, Dr. Hoeg, what would you advise us, as Members of Congress, to ask for from the CDC or DHS or the Department of Health in terms of data? What do we need to concentrate on, and what do we need to have before us, what do we need to be collecting that we are not doing now?

*Dr. Hoeg. Yes. I mean, in terms of looking back, I mean, we should -- you know, I want to say that I am concerned about the role that the teachers unions played, just so -- I think we do need more --

*Mr. Peters. Like --

*Dr. Hoeg. -- on that.

*Mr. Peters. So, well, let's take that up.

*Dr. Hoeg. In terms of the data, I think that we have a problem that we have not -- we don't have a culture here of running high-quality randomized trials of the efficacy of different interventions, like, promptly, so that we can get real answers about how well things work, like masks, like school closures.

Even for -- currently, the bivalent booster -- and the boosters, we didn't have large-enough randomized trials in young people. So I think that we need to have a culture where we quickly are able to run randomized studies to get

real answers, because right now with the MMWR, as we saw over and over again, they are publishing observational studies which have very low-quality data. I mean, they are publishing, you know, studies about --

*Mr. Peters. Let us take a step back from that, though, because I am going to run out of time. What is it we should be collecting? What should we be getting from patients that we need to make judgments about?

*Dr. Hoeg. So, I mean, I think that I would bring up just one of my studies in terms of, you know, what data we should be collecting is we do need accurate death rates, actually, from -- is one of the studies that we did showing that, you know, the CDC was repeatedly reporting inaccurate data based on the COVID-19 tracker, which doesn't use death certificates, over-estimating the death rates, the true death rates in children. And so I think that that is one of the things, is we need to have a better data system that is reliable, so that we know that the data that we are getting is accurately representing --

*Mr. Peters. I am going to run out of time, and I ask -- invite any of you, if you have thoughts about that, to let us know in writing how you would improve Federal data.

I would just say this, though, on -- you know, look. I feel a little bit like I am getting two sides of a message.

One is that we should have really good information, but the other is we have to act based on the information we had. And at the time I think we had these vaccines, I think it was very prudent to require the military to get them, people over 18, and to ask teachers to do that, too. And so I am not going to fault anyone for that.

I hope we learn from this experience so that we do it better when we face it again. But I really do appreciate your thoughts, and I yield back.

*Mr. Griffith. I thank the gentleman for yielding back, and now recognize Ms. Miller-Meeks for her five minutes of questioning as a waive-on.

*Mrs. Miller-Meeks. Thank you very much, Mr. Chair, and I want to thank all of our witnesses who are here today.

As many of you know, I am a physician and a former director of the Department of Public Health. And so I take public health very seriously, and I recognize the important role. And for me, the CDC, prior to the pandemic, was the premier institution. But I also recognize the important role of state health departments and local public health agencies in keeping Americans safe.

In April of this year I released a CDC RFI, request for information, to hundreds of stakeholders requesting feedback on how to sensibly and effectively reform America's top

communicable diseases agency. And I want to address and clarify some comments made by Representative Dr. Ruiz.

First, this was an RFI that my office sent publicly to stakeholders and constituents to seek feedback and input on CDC reform as a result of the CDC's many failures. This was not a letter sent to the CDC, though I would also welcome their feedback and input. And in fact, to this end, I met privately with Dr. Walensky and a staff member.

It sounds like there are many opportunities for improvement based upon the discussion today, and I thank you for that. And I welcome additional conversations with Dr. Ruiz and his staff as to constructive and thoughtful ways to reform the CDC.

Not surprisingly, public trust in the CDC is at an all-time low, and health experts across the nation have presented many suggestions on how to rebuild that trust.

During the pandemic, much of the CDC's guidance did not appear to emanate from data and scientific evidence, and they certainly weren't able to incorporate real-world evidence that was occurring, and data and research occurring in other countries. Rather, the data seemed to come from political interests, such as the clear coordination between the CDC and the American Federation of Teachers Unions on school closures, despite clear evidence that children did not

transmit the virus, and they were not super spreader organizations. And we, in fact, opened our schools in Iowa in April of 2020.

To the CDC's credit, however, they recognized the declining public trust, which led Dr. Walensky to launching the Moving Forward initiative. This effort included reorganization and potential requests for new authorities from Congress. As part of the initiative, CDC acknowledges that the agency faces significant structural and systematic operational challenges. One of those was just discussed, and that is data. And it indicates a central goal to create new internal processes, systems, and governance to empower leaders, align incentives, and hold CDC accountable.

Dr. Hoeg, in your written testimony you highlight the confusing and backward school closure guidance, stating that the recommendation to keep schools shut down was unthinkable. And I asked Dr. Walensky in testimony if she had contacted the State of Iowa or the State of Iowa's department of education for their experiences with opening schools. Can you detail what you believe the science behind Dr. Walensky's school closure recommendations -- why it was so flawed, and what guidance reforms the Moving Forward initiative should include?

*Dr. Hoeg. Yes. So we had data at the time of the --

that -- the winter of 2021, the February of 2021 guidance from, essentially, all over the world of schools reopening safely, successfully. And I think most of the world recognized that schools should be open by default, and that closing schools is an emergency measure.

And so also in our own country we had private schools, public schools in many states, often depending on political affiliation, that were already open, had data. It wasn't just my Wisconsin study, it was the diocese, very diverse diocese that I am medical advisor for, that we had successfully reopened with very simple, straightforward mitigation strategies, that -- there was a total lack of sort of commitment and creativity and willingness to get these kids back into school and then, you know, figure out, you know, how to make it as safe as possible.

And so I do think it is unthinkable what happened, the way the data were ignored from, really, all over the world in our own country about how schools could be reopened safely, considering the enormous damage from prolonged school closures that we all knew was coming, and we see the effects of now.

*Mrs. Miller-Meeks. Thank you. As a first-term congressman, my first markup hearing on Education and Labor Committee brought up school closures, the rate of youth

suicide, the rate of mental health and depression and anxiety, and what that has done. So not only the learning loss, but the obesity, the physical effects, and also the tremendous mental effects that closing schools had on our children and a generation that may be lost and difficult to recover. So thank you so much for your testimony.

Thank you for, despite all of the pushback -- I have been part of that -- that you were willing to continue to publish and to make known your findings. Thank you.

I yield back, Mr. Chair.

*Mr. Griffith. The gentlelady yields back. I now recognize Ms. Castor for a unanimous consent request.

*Ms. Castor. Thank you, Mr. Chairman.

I would like to ask unanimous consent to submit for the record just some context regarding the Dr. Fauci February 2020 email in the early days of the pandemic response regarding his mask suggestions.

As we all know, the understanding about the effectiveness of masks and guidance about wearing them evolved during the pandemic, as did Dr. Fauci's position on their use.

So I will ask a UC.

*Mr. Griffith. The gentlelady has requested unanimous consent. We would also -- during this hearing we have had

unanimous consent requests both from Ms. Castor, but also Dr. Burgess, Mr. Armstrong, and Mr. Ruiz -- Dr. Ruiz, excuse me. And have I missed any? I think that has got all of them, but -- and also any documents that have been included in the staff hearing documents list. Any objection to any of those documents being submitted to the record?

Hearing none, the documents are --

*Ms. Castor. Thank you.

*Mr. Griffith. -- agreed to be put in as a part of the record.

[The information follows:]

**********COMMITTEE INSERT**********

*Mr. Griffith. Seeing that there are no further members wishing to ask questions, I would like to thank our witnesses again for being here today. Thank you. This has been very informative.

In pursuance of the committee rules, I remind members they have 10 business days to submit additional questions for the record, and I have already got a few, so I will be sending those along.

[The information follows:]

**********COMMITTEE INSERT**********

*Mr. Griffith. And I ask that witnesses submit their response within 10 business days upon receipt of those questions.

Without objection, the subcommittee is adjourned.

[Whereupon, at 12:37 p.m., the subcommittee was adjourned.]