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Robert Wood Johnson Foundation

Attachment—Additional Questions for the Record

Energy and Commerce Subcommittee on Health

Hearing on
"Road to Recovery: Ramping Up COVID-19 Vaccines, Testing, and Medical Supply Chain"

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The Honorable Frank Pallone, Jr. (D-NJ)

The pandemic has laid bare vast disparities amongst our most vulnerable populations, as well as highlighted severely under resourced state and local public health departments. You commented in your testimony that both our public health system was underfunded prior to the pandemic and that we cannot accept these deficiencies as status quo while moving on to address the next crisis. Will you please describe how a lack of core baseline public health funding impacts the ability of local public health departments to plan and carry out their mission?

We often think of health in terms of healthcare, and with good reason: high quality, affordable healthcare is an essential component in how well and how long we live. It should not be reserved only for those wealthy enough to afford or fortunate enough to access it, yet nearly 30 million people in the United States were uninsured prior to the pandemic and millions of job losses over the past year have exacerbated these trends. Achieving universal healthcare coverage in the United States is long overdue.

Nevertheless, access to and quality of clinical care only accounts for approximately 20 percent of a person's overall health picture, with the other 80 percent dependent upon social and economic factors, health behaviors, and the physical environment. That is where public health comes in. As the American Public Health Association explains, whereas doctors treat those who are hurt or sick, those who work in public health "try to prevent people from getting sick or injured in the first place." So much of what affects our health happens outside the doctor's office, such as whether our air and water are clean, if we have enough healthy food to eat and opportunities for physical activity, and if the homes where we live and buildings where we work are safe and secure. Public health has a hand in all of those elements, and others, of daily life.

As we have seen over the past year, public health also plays a critical role responding to emerging threats and diseases. That includes monitoring and collecting data on where outbreaks are occurring and who is being affected; crafting and explaining guidance for how people can

keep themselves, their families, and their communities safe; and ensuring vaccination efforts to prevent infection are efficiently and equitably managed.

Nevertheless, investments in public health in the United States are woefully lacking. Healthcare spending in the United States reached $3.6 trillion in 2018, yet public health funding accounted for less than three percent of that total. Even more troublingly, public health funding at all levels has declined dramatically over the past several years, including a 50 percent decline in the CDC's public health and preparedness response budget over the past 10 years and a 33 percent decline in state and local public health funding since 2003.

During the COVID-19 crisis, we have seen the consequences of this underinvestment. To take one salient example, it is essential that we collect Covid-19 vaccine data by race and ethnicity to ensure that shots are being administered to those populations and communities that have been hit the hardest by the pandemic. Yet race and ethnicity is known for only about half of all those who have received at least one dose, a direct result of underfunded and antiquated public health reporting systems. Gaps can only be addressed sufficiently if they are identified sufficiently.

The American Rescue Plan Act includes $160 billion in additional public health spending that will bolster vaccine administration, improve testing and contact tracing efforts, and help modernize public health data systems. It also provides $7.6 billion to expand the state, local and territorial public health workforce. These significant investments will help frontline public health workers address the immediate challenges presented by the pandemic as well as manage long-term needs and future outbreaks.

However, it is essential that we not treat these investments in public health as a one-off. The trend in the United States is to invest in public health during and immediately after a crisis, and then revert to an underfunded status quo once an immediate threat has passed. For us to ensure that we can effectively manage future outbreaks, as well as the daily public health needs of more than 300 million people, that trend must end with this pandemic.

Community vaccination sites are a critical part of the American Rescue Plan that has been proposed by the Biden Administration. Specifically, a $20 billion investment has been included to help set up these sites, some of which will be able to vaccinate thousands of individuals per day when we have adequate supply. What are the important logistical steps that will need to go into preparing these sites and using them to get more vaccines into arms?

After a slow start, the Covid-19 vaccination effort has picked up considerably. To date, we have successfully administered more than 109 million shots, with more than 20 percent of our nation partially vaccinated and more than 10 percent fully vaccinated. Over the past week, we have averaged well over two million shots administered per day. The increased pace of vaccination, combined with rates of new cases that are at considerably lower levels compared to just a few months ago, give me hope that we may finally be turning a corner against this devastating virus.

Yet the benefits of vaccination are not being shared equally. As we have seen since the start of this pandemic, Black and brown communities have suffered the highest case, hospitalization, and death rates. Given those trends, as well as the fact people of color make up a significant proportion of frontline workers who have among the highest risks of exposure are, it is both a practical and moral imperative that people of color be at the front of the vaccine line. Yet per CDC data, of those who have received at least one vaccine dose, 65 percent of recipients are White, compared with 9 percent Hispanic, 7 percent Black, 5 percent Asian, and 2 percent American Indian or Alaska Native.

Those trends are deeply troubling. As I remarked in my testimony before the subcommittee last month, "vaccines are only as effective as people's ability to obtain them and willingness to access them." I explained how, during my time at the Chicago Department of Public Health during the H1n1 crisis in 2009, we made it a priority to bring vaccines directly to neighborhoods that had the biggest needs and the least access to ensure that priority populations were not being left behind.

I am hopeful that the funding in the American Rescue Plan Act devoted to setting up community vaccination sites will go a long way toward ensuring that the next phase of the vaccination rollout is both swift *and* equitable. These funds will scale up federally run centers and complement ongoing state, local, tribal and territorial efforts. More than 750 additional community health centers are going to receive vaccine doses, for a total of 950 sites, while pharmacy sites and pop-up clinics are doubling. In the not too distant future, we can also expect both a national vaccine website and a 1-800 number for people to call, which will hopefully make it easier for people to secure appointments and can reach destinations easily.

Most people across all races and ethnicities want to be vaccinated, but they are having trouble navigating a very complicated system. Principles to follow for this next phase should include:

- Locating sites in easily accessible and trusted places.
- Offering appointments before and after hours, and on weekends, for those who cannot take time off of work to get vaccinated
- Ensuring systems for making appointments are accessible to low literacy, non-English speaking individuals
- Providing phone and walk-in registration for those who do not have Internet access.
- Collaborating with trusted community voices and existing grassroots efforts to address people's questions and concerns and help people navigate the registration process.

During a public health emergency, one of the most important roles of the federal government is to provide clear, consistent, and fact-based communication. The CDC has played a key role in federal messaging during this pandemic by publishing guidelines that all Americans can utilize to improve safety for themselves and others. Why is it so important that our federal agencies are communicating a clear and consistent message throughout the COVID-19 pandemic?

Whenever a new threat like Covid-19 emerges, what we do not know in the beginning far outweighs what we do know. That changes over time, as more information becomes known. As such, recommendations for how people can keep themselves, their families, and their communities safe evolve as well.

We have seen that play out during Covid-19. Perhaps the most salient example is masks. At the start of the pandemic, the CDC did not recommend universal mask wearing. This was partly due to lack of supply, in particular with respect to N95 masks, and the immediate need to ensure that frontline healthcare workers with the highest degree of exposure had enough supply to keep them safe. It was also partly due to lack of evidence, as we did not know early on whether universal mask-wearing would be a successful deterrent to this new threat. Over time, of course, research has shown that universal mask wearing is an exceptionally effective response, which led CDC to change its recommendations to encourage all people in the United States to wear masks in public.

Unfortunately, for much of the pandemic, the CDC and other public health agencies were sidelined. When the CDCs guidance on masks changed, agency leaders were not permitted to explain to the American people why the guidance changed. As a result, mask wearing became a

political litmus test rather than a public health imperative. In some places, state and local leaders followed public health guidance and adopted mask mandates. In others, however, state and local leaders followed political winds by either not mandating masks at all or lifting mandates far too quickly. We still have not fully recovered from the politicization of the pandemic, and thousands of lives have been consequently and needlessly lost.

A situation like this shows why it is so critical for public health to take the lead on a response to a new threat and why policymakers at all levels must follow the public health roadmap for both better health outcomes and economic recovery. The CDC is arguably the most renowned public health institution in the world; I am deeply proud to have worked there. I am heartened that CDC has become significantly more visible during the response in recent months, but we are still paying the price for how long it took us to reach this point.

How do you think CDC's approach to communication throughout the last year has impacted the public's willingness to be tested for COVID-19 and participate in local contact tracing efforts?

Contact tracing is a critical component of public health. At its core, the goal is to ensure that one case of a disease or virus does not lead to a widespread outbreak. Public health agencies do so by tracking persons who test positive, reaching out to that person's close contacts, and encouraging those contacts to be tested and quarantine/isolate following a confirmed exposure. In most public health emergencies, CDC establishes and promotes guidance related to testing and contact tracing, guidance that is followed by state, local, tribal and territorial health agencies and healthcare providers.

Unfortunately, contact-tracing efforts in the United States in response to Covid-19 have been rendered less effective by a variety of factors, including:

- Rapid increases in caseloads that made following each individual case difficult, if not impossible, in most parts of the country.
- A lack of funding for state and local public health departments to implement facets of contact tracing plans, such as hiring investigators and interviewers.
- Hesitancy on the part of contacts to speak with contact tracers, particularly those in communities of color and immigrants who have suffered past or current mistreatment from medical and/or public health systems.
- Millions of workers lacking paid sick and family medical leave, meaning that a 14-day quarantine period could cost a person his or her job and the ability to put food on the table or pay rent.
- A dearth of reliable and accessible testing, particularly early in the pandemic and significant delays in receiving results.

These barriers to successful testing and contact tracing programs were exacerbated by CDC not being permitted to assume its typically prominent public platform for much of the past year to explain its guidance on contact tracing and other matters. As a result, confusion on contact tracing often reigned among public health agencies, healthcare providers and the public, leading to inconsistent approaches being implemented in various parts of the country.

Despite the difficulties with respect to testing and contact tracing efforts, it remains essential for us to track the virus—even as new cases decline, particularly in light of new variants that may be more transmissible and lethal. I am hopeful that the public health funding in the American Rescue Plan Act, a stronger commitment to genomic sequencing, and a continued decline in the numbers of new cases will all make it easier for CDC and other public health agencies to more effectively and efficiently track the spread of the virus in the coming months.

In what ways do you think CDC is succeeding in their approach to communicating about the COVID-19 vaccine and in what ways do you think they can improve?

I have full confidence in Dr. Rochelle Walensky and the thousands of devoted public servants at the CDC to help lead us out of this crisis. I am pleased that CDC has been permitted to communicate more consistently with the public in recent months. Dr. Walensky's regular opportunities to brief the media and the public have been critically important, and those opportunities will continue to be essential over time.

The fact that we have three highly safe and effective vaccines against Covid-19 just over a year after this new virus was identified is an astounding scientific achievement. President Biden has directed that states make all adults in the United States eligible for vaccines by May 1. Majorities of people across all races and ethnicities want to be vaccinated. As supply increases and accessibility improves, tens of millions of additional people in the United States will likely be vaccinated in the coming months.

CDC must use that time to continue regularly reporting vaccine administration data and help encourage and enable states to report that data by race, ethnicity, occupation, and neighborhood. The CDC should also continue its efforts to support and partner with existing community-based and grassroots efforts to understand people's concerns and help move those on the fence from vaccine hesitancy to vaccine confidence.

The Robert Wood Johnson Foundation is pleased to do its part to assist with these kinds of efforts to help build trust and confidence in the safety and effectiveness of the COVID-19 vaccines and increase COVID-19 vaccinations in communities most affected by the pandemic. Our Foundation has provided grant support for several such projects, including:

- Center for Strategic and International Studies Panel on Vaccine Confidence and Misinformation
- Ensuring Equity: State Strategies for Monitoring COVID-19 Vaccination Rates by Race and Other Priority Populations
- Ensuring Access to the COVID-19 Vaccine for Adult Medicaid Enrollees: A Roadmap for States
- Anticipating COVID-19 Vaccination Challenges through Flu Vaccination Patterns

Recently, CDC issued interim guidance for what fully vaccinated individuals can do, which will allow those individuals to see and hold loved ones, engage safely with others in small groups, and begin a return to the joys of daily life we have all missed over the past year. I am hopeful that CDC will be able to update that guidance regularly in the coming months. CDC's initial guidance was delayed, and while I understand and appreciate the fact that the science on which this guidance is based is constantly evolving, tens of millions of additional people will be turning to this guidance in the not-too-distant future as supply and accessibility increase. My hope is that updates to this guidance, such as travel protocols and recommendations for those fully vaccinated, will soon be forthcoming.

The Honorable Michael C. Burgess, M.D. (R-TX)

The CDC's Advisory Committee on Immunization Practices (ACIP) made its vaccine prioritization recommendations to assist jurisdictions in decision making on how to allocate the limited doses of available vaccines. The ACIP recommendations identify non-health care frontline essential workers should be vaccinated during jurisdiction's phase 1b. Should individuals who work in vaccine,

therapeutic, or related medical countermeasure industry, who are essential to the production of vaccines be prioritized during phase 1b?

The Advisory Committee on Immunization Practices (ACIP) is an independent advisory group that makes recommendations to the CDC—and in turn, to states—on who should receive vaccinations. ACIP is composed of scientists, infectious disease experts, and medical organizations. As a former member of ACIP, I can state with full confidence and firsthand experience that the committee's operations are built on transparency and research, with no political agenda.

As such, while the ACIP recommendations do not carry the force of law, states typically adhere to them. When the Pfizer and Moderna COVID-19 vaccines were approved for emergency use, ACIP issued recommendations that took into account risk of both exposure and severe disease or death. They started with frontline healthcare workers and people who live in long-term nursing care, followed by those over age 75 and essential workers. The phased approach was also designed to promote an equitable rollout.

Unfortunately, ACIP's guidance was largely abandoned in short order. Before supply increased or accessibility improved, many states quickly opened up vaccine eligibility to anyone over age 65 after healthcare workers and long-term care residents and workers. In doing so, there has been less focus on vaccinating essential workers, despite their high risk of exposure and the fact that a significant proportion of those workers are people of color. States should work to ensure that frontline and essential workers are at the front of the line.

The current vaccine distribution chain only involves one distributor. Have there been capacity issues with distribution that could be solved by involving more private distribution companies? Are there certain areas, for example rural, that are more difficult to reach under the existing distribution channels?

Issues of inequity have long plagued people living in rural America — from a lack of broadband access to food insecurity to underfunded schools. These economic and geographic barriers to opportunity have been exacerbated during the pandemic, with rural communities experiencing disproportionate rates of cases due to a generally older population and higher rates of underlying medical conditions.

These inequities have extended to the vaccine rollout. In rural counties in the center of the country, a shortage of pharmacies is hampering the distribution of COVID-19 vaccines, potentially extending the pandemic in these communities. The American Rescue Plan's additional funding to increase the number of community health centers and double the number of pharmacy and pop-up clinics, which will include mobile units, will benefit rural communities as well. A recent poll finds that upwards of 40 percent of people living in rural areas would choose not to be vaccinated, which is concerning. Increasing access to the vaccine in rural parts of the country should go hand-in-hand with efforts to increase confidence in the vaccine as well.

The Honorable Gus Bilirakis (R-FL)

Obesity has proved to be a major risk factor in the COVID-19 pandemic and past pandemics, such as the H1N1 pandemic in 2019. Over 40% of Americans have obesity, and that number is projected to continue to grow. In addition to hampering our public health preparedness, obesity leads to chronic diseases that account for nearly $500 billion in direct medical costs and over $1 trillion in lost productivity. Doesn't that indicate we need to put all resources to bear, from intensive behavioral counseling, to anti-obesity medications, to bariatric surgery,

to help those with obesity and improve our ability to respond to future public health threats?

Obesity is linked to increased risk for serious health conditions, including heart disease, diabetes, and certain types of cancer. In the U.S., childhood obesity—which impacts roughly one in seven youth ages 10-17—is estimated to cost $14 billion annually in direct health expenses. As a result, since 2007, the Robert Wood Johnson Foundation has pledged a total investment of more than $1 billion to address childhood obesity and help ensure that all children in the United States grow up at a healthy weight.

Obesity is a significant underlying condition with respect to Covid-19. Obesity increases the risk for severe illness from COVID-19 among people of any age, including kids. Moreover, people with obesity tend to become sicker, are more likely to be hospitalized, and are even more likely to die if they get sick with COVID-19.

One of the underlying causes of obesity is a lack of access to healthy foods. Prior to Covid-19, millions of families were living in poverty, with hunger, in unsafe homes and without health care. School closures, jobs losses, and wage reductions during the pandemic have exacerbated these trends. Feeding America estimates that 45 million people, including 15 million children, experienced food insecurity in 2020, with 42 million (and 13 million children) projected to experience food insecurity in 2021. Again, significant racial disparities exist; approximately 21 percent of Blacks individuals may experience food insecurity in 2021, compared to 11 of white individuals.

Congress and USDA have taken important legislative and regulatory steps to address food insecurity over the past year, including a 15 percent increase in SNAP benefits and free school meals for all students. However, those provisions are currently slated to expire on September 30, 2021. Per our recent policy brief, RWJF believes that Congress should permanently increase SNAP benefits. Moreover, we should work to ensure that students—particularly where schools remain closed—do not lose access to nutritious school meals that improve their health.