AMERICAN PUBLIC HEALTH ASSOCIATION
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Committee on Oversight and Reform
"Building Trust and Battling Barriers: The Urgent Need to Overcome Vaccine Hesitancy"
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Chairman Clyburn, Ranking Member Scalise and members of the subcommittee, thank you for the opportunity to address you today. I am Georges C. Benjamin, MD, executive director of the American Public Health Association in Washington, D.C. APHA is the nation's professional society of public health practitioners that champions the health of all people and all communities. We strengthen the public health profession, promote best practices, and share the latest public health research and information. We are the only organization that combines a nearly 150-year perspective with a broad-based member community that works to advance policy to improve the public's health. We have three overarching priorities: To achieve universal access to health care, achieve health equity and ensure an adequate public health infrastructure.

Our nation has undergone the greatest infectious public health threat in over 100 years. SARS-CoV-2, the virus that causes COVID-19, has infected over 33.4 million individuals, and taken more than 601,000 lives. This staggering amount of morbidity and mortality does not capture the full impact of this disease as we know a substantial number of people had asymptomatic or mild disease that we have not captured in these numbers. We also now know it has a significant chronic disease state known as "Long COVID," which is often disabling for those who have it regardless of the degree of severity in their initial illness. In addition, there are numerous noninfected people whose overall physical and mental health have been impacted by other disease states who had their care delayed and/or condition worsen during the pandemic. The full accounting to the health of our population is still being reconciled, but a recent study

published in the *Proceedings of the National Academy of Sciences* estimated that the U.S. population will experience "an overall reduction in life expectancy at birth of 1.13 years. The Black and Latino populations are estimated to experience declines in life expectancy at birth of 2.10 and 3.05 years, respectively, both of which are several times the 0.68-year reduction for Whites."[1] This is in line with an earlier report from the Centers for Disease Control and Prevention concluding that the provisional life expectancy for all Americans was reduced by 1 year in the period from January to June of 2020.[2] The reduction was 0.8 years for non-Hispanic White Americans, 2.7 years for non-Hispanic Black Americans and 1.9 years for Hispanic Americans. This same CDC report found that Black men had a reduction in life expectancy of 3 years and Hispanic men of 2.4 years (compared to a reduction of 0.8 year for non-Hispanic White men). Non-Hispanic Black females had a reduction of 2.3 years and Hispanic females of 1.1 years (compared to a reduction of 0.7 year for non-Hispanic White females). These are significant declines in life expectancy for all portions of our populations by all public health measures, and these declines will not be easy to reverse.

This pandemic would have been much worse had we not employed the science-based, effective public health tools utilized over the last 18 months to address this tragedy. These tools included a range of nonpharmacological interventions such as mask wearing, hand hygiene, physical distancing, crowd avoidance, stay at home orders and selected closures of businesses and other venues. Because this is a disease that you catch from other people, generally through the respiratory route, these interventions were highly effective but burdensome and were not practical for the long haul. We now have one public health intervention that is highly effective to both reduce both the morbidity and mortality from infection: COVID -19 vaccines.[3]

While we are aware of many evolving strains that could impact the degree of efficiency of the current vaccines, to date the vaccines still appear highly effective. We all applaud the effort to get the vaccine studied and approved expediently through the emergency use authorization process. This was done with full scientific transparency and rigor. Yet, having a

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[1] Racial and ethnic disparities in COVID-19's impact on life expectancy. PNAS February 2, 2021 118 (5). Available at: https://www.pnas.org/content/118/5/eiti0521118.

[2] Centers for Disease Control and Prevention. NVSS Vital Statistics Rapid Release. Provisional Life Expectancy Estimates for January through June, 2020. Feb. 2021. Available at: https://www.cdc.gov/nchs/data/vsrr/VSRR10-508.pdf

[3] Centers for Disease Control and Prevention: Benefits of Getting a COVID-19 Vaccine Available at: https://www.cdc.gov/coronavirus/2019-ncov/vaccines/vaccine-benefits.html.

safe and effective vaccine and getting that vaccine into the arms of a susceptible population are two entirely different matters.

The process of actually vaccinating people started off slowly but has accelerated to the point that as of June 27, 2021, according to CDC, we have administrated over 323 million of the 381 million doses available. This has resulted in 179 million (63%) people having received one dose and 153 million (54%) of the eligible population age 12 and older being fully vaccinated. Despite this encouraging progress, we are now seeing a dramatic slowing in the number of vaccines being delivered, as well as continued disparities when it comes to who is being vaccinated.

The Kaiser Family Foundation has been tracking the disparities in vaccination in rates for various ethnic groups. Their reports have shown the degree of disparities between African Americans, Hispanics, and Asians as compared to non-Hispanic Whites. While there has been some progress in narrowing the vaccination gaps over time, significant disparities remain. In most states, Black and Hispanic people continue to receive a smaller share of vaccinations than their share of the total population. Asian people generally have been vaccinated at rates that match their representation in the population, and, overall, non-Hispanic Whites have received a greater share of vaccinations. These disparities represent the impact of both vaccine hesitancy as well as structural barriers that disadvantage communities of color and other underserved populations. These disparities in vaccinations mirror the clinical disparities we already see in the prevalence of COVID-19 disease and the disparities in life expectancy.[4]

The Biden administration had set July 4, 2021 as the date they were hoping to get 70% of the U.S. adult population ages 18 and older vaccinated with at least one dose. While they will get close to this goal, they will not achieve it by this date. We know that there are disparities in different ethnic groups as well as age groups in when they will achieve this level of vaccine coverage.

We also are now seeing a profound difference in the level of vaccination between states /territories, where some states/territories are very successful in getting their populations vaccinated with others lagging far behind. Sixteen states have vaccinated over 60% of their

[4] Kaiser Family Foundation Report: Latest Data on COVID-19 Vaccinations by Race/Ethnicity. June 23, 2021. https://www.kff.org/coronavirus-covid-19/issue-brief/latest-data-on-covid-19-vaccinations-race-ethnicity/#

population with at least one dose of vaccine, 14 states between 50% - 59% and the rest under 50%. Five states remain under 40% for people getting their first dose of vaccine.

The populations at risk in these states also include more younger people and people who have strongly held doubts and views about the risks of COVID-19 that put them at higher risk for infection.[5] The combination of low vaccination rates coupled with low infection rates, which confirms a degree of immunity, also contribute to the risk in some communities. It is clear we still have work to do to achieve a level of immunity to protect our population.

These large variations in vaccination levels in states/territories are of concern because of the rapid spread of SARS-CoV-2 variants that are more infectious and potentially lethal than the wild type virus that initiated this pandemic. One current variant, the Delta type, is rapidly spreading around the world and in the United States and is on track to become the predominant circulating strain. The Delta variant appears to be 60% more infectious than the original wild type strain and possibly more virulent. While the current vaccines do work satisfactorily against it, they are not as protective for disease transmission as with the original strain. This strain is rapidly emerging as the strain most responsible for severe illness and deaths, especially in people who are unvaccinated regardless of age.

Vaccine Hesitancy

Enhancing vaccine confidence has been a significant challenge to getting shots in arms throughout the vaccination effort. The NAACP, in partnership with the COVID Collaborative, looked at the issue of vaccine hesitancy in African American and Latinx communities, finding in the fall of 2020 that "fewer than half of Black adults, 48 percent, say they probably or definitely would get a coronavirus vaccine if it were available for free – including just 18 percent who definitely would get vaccinated. Among Latinx adults, interviewed for comparison, far more likely would get vaccinated, 66 percent, including 31 percent definitely."[6] Other surveys have found similar results; however, vaccine reluctance can be addressed through a range of established public health measures, including using culturally appropriate information delivered

[5] COVID-19 Vaccination Coverage and Intent Among Adults Aged 18–39 Years — United States, March–May 2021, MMWR / June 25, 2021 / Vol. 70 / No. 25. Available at: https://www.cdc.gov/mmwr/volumes/70/wr/mm7025e2.htm?s_cid=mm7025e2_x.

[6] Coronavirus Vaccine Hesitancy in Black and Latinx Communities. The COVID Collaborative. Nov. 2020. Available at: https://www.covidcollaborative.us/content/vaccine-treatments/coronavirus-vaccine-hesitancy-in-black-and-latinx-communities.

by well-informed and trusted messengers. This strategy has been proven to increase knowledge and behavioral change for people with HIV/AIDS, to address maternal child health/infant mortality, violence prevention, tobacco reduction and substance misuse.

Most people are curious about the vaccine, do not know enough about it and are eager to know more before deciding to get vaccinated. A poll by Frank Luntz for the de Beaumont Foundation[7] found that using certain words and approaches will increase vaccine adoption:

1. Tailor your message to your audience because perceptions about vaccines differ by race, age, political party, and geography.
2. Discuss the benefits of the vaccine as well as the consequences of not taking it.
3. Avoid judgmental language when talking to people who have concerns. Find out and address what their specific concerns are.
4. Describe the vaccine development process, what the vaccine does and does not do, what safety and side effects mean for a vaccine recipient as well as the ongoing safety precautions that are in place to track potential complications.

Addressing misinformation with facts and avoiding repeating the falsehood, which can end up reinforcing the misinformation, are other important steps. Also, messages must be delivered by trusted messengers who are culturally competent and may include the individual's physician, nurse, a health department staff member, faith or other trusted community leader, community health workers, local pharmacists and other health care workers known to the community.

A March – May survey of individuals ages 18-39 showed that the major reasons for vaccine hesitancy remains concerns about safety and efficacy. This shows there is still significant work to do to address the concerns of this population.[8]

Structural Barriers

A lot of work has been done to address structural barriers since the vaccination effort began last fall. There has been a substantial increase in the supply of vaccine such that vaccine supply now exceeds demand in most areas of the country. We've also experienced increases in

[7] Poll: The Language of Vaccine Acceptance**.** The de Beaumont Foundation. Dec. 2020. Available at: https://debeaumont.org/news/2020/new-poll-reveals-effective-language-to-improve-covid-19-vaccine-acceptance/.

[8] COVID-19 Vaccination Coverage and Intent Among Adults Aged 18–39 Years — United States, March–May 2021, MMWR / June 25, 2021 / Vol. 70 / No. 25. Available at: https://www.cdc.gov/mmwr/volumes/70/wr/mm7025e2.htm?s_cid=mm7025e2_x.

the number of vaccinators, community-based locations of vaccinations sites, hours of vaccination availability and both appointments and walk-in capacity. A central vaccine portal to find available vaccine sites vaccines.gov is now in place. A range of transportation supports and partnerships exist to assist individuals who need transportation to and from their vaccination locations. While this is indeed progress in the vaccination system design and function, more will need to be done to achieve the levels of vaccinations needed to contain the pandemic.

Success Requires a New Strategy

We need to refocus our efforts on a new strategy — one that builds on the successful national strategy we have in place but strengthens our efforts in communities. What often happens is, we get close to the finish line in these kinds of public health programs, and then we get complacent and don't finish the job. The queues for getting vaccinated diminish, so we close down the mass vaccinations sites, stop having some of the evening or weekend hours and pull back the emphasis needed to complete the effort. In any public health program, the early adopters are always easier to reach than the dawdlers. We actually need to double down on efforts to reach the most vulnerable as the group we're trying to vaccinate now is much tougher to reach even when they're interested in getting vaccinated.

APHA is supportive of a four-step approach that we have recently endorsed that is community-driven.[9] This framework has four components:

- Identifying communities that are at lower than expected levels of vaccination.
- Exploring which challenges they have to coverage.
- Engaging local community-based stakeholders to design solutions.
- Customizing solutions and implementing, monitoring, and evaluating the impact.

This is a cyclical approach that requires remapping, reassessment and remodeling until adequate vaccination levels are achieved. This also means building community engagement for the long term because this is a disease we will be faced with for quite some time. One should anticipate that we may have intermittent outbreaks of COVID-19 for the next several years that will require testing, contact tracing, isolation and quarantine of individuals and possibly selective

[9] Surgo Ventures, Resolve to Save Lives (2021). COVID-19 Vaccine Precision Response Toolkit: An End-to-End Vaccination Improvement Framework to Improve COVID-19 Vaccine Uptake. Available at: https://surgoventures.org/resource-library/increasing-covid-19vaccine-uptake-a-four-step-framework-to-promote-access-acceptance-and-equity.

closures of venues much like we see with other endemic infectious outbreakes. The fact that the disease still rages in many parts of the world and the likelihood of adequate vaccination in these countries remains unlikely until late next year. This supports the need for a strong public health system in the United States to manage not only this pandemic but the other health threats and problems that challenge our nation.

A Strong, Well-Resourced Public Health System is Essential

We are grateful for the previous emergency supplemental funding approved by Congress to address the COVID-19 pandemic, including funding to strengthen the public health workforce, support the distribution and administration of vaccines, increase vaccine uptake and ensure greater equity and access to vaccines by those disproportionately affected by COVID-19, but we know more must be done.

A strong and well-funded public health infrastructure and workforce are essential to help ensure our public health system is equipped to play its vital role in vaccine distribution, administration and to increase uptake by ensuring everyone in the nation has equitable access to the vaccine and that the public understands the true benefits of getting vaccinated. Unfortunately, we have failed to adequately invest in our nation's public health infrastructure and workforce. In order to better ensure our public health infrastructure is adequately prepared for addressing the current pandemic, future pandemics, and other public health emergencies, we must seriously look at fixing our vastly underfunded public health system. APHA is calling on Congress to include Sen. Patty Murray's Public Health Infrastructure Saves Lives Act in the infrastructure and jobs legislation currently under development in Congress. This critical legislation would provide $4.5 billion in additional long-term annual mandatory funding for CDC and state, local, tribal and territorial public health agencies for core public health infrastructure activities.[10] This funding would support essential cross-cutting activities such as: disease surveillance, epidemiology, laboratory capacity, all-hazards preparedness and response, policy development and support, communications, community partnership development and organizational competencies. This funding is essential to ensuring our health departments have broad core

[10] Organization letter to House and Senate leaders supporting the inclusion of the Public Health Infrastructure Saves Lives Act in infrastructure and jobs legislation currently being developed in Congress. June 22, 2021. Available at: https://www.apha.org/-/media/Files/PDF/advocacy/letters/2021/210622_PHISLA_infrastructure_leaders.ashx.

capacity to not only respond to the current pandemic but to better respond to the many other public health challenges they face on a daily basis. For far too long, we have neglected our nation's public health infrastructure, and we must end the cycle of temporary infusions of funding during emergencies and provide a sustained and reliable funding mechanism to ensure we are better prepared to protect and improve the public's health, including our most vulnerable communities, from all threats.

Congress should also support efforts to recruit and retain a strong and qualified public health workforce at our nation's state and local health departments. We are calling on Congress to authorize and appropriate funding for a public health workforce loan repayment program.[11] Rep. Jason Crow has introduced the Public Health Workforce Loan Repayment Act of 2021, which is supported by APHA. Providing funding for this important program will help incentivize new and recent graduates to join the governmental public health workforce, encourage them to stay in these roles, and strengthen the public health workforce as a whole. The public health workforce is the backbone of our nation's governmental public health system at the county, city, state, and tribal levels. These dedicated professionals lead efforts to ensure the tracking and surveillance of infectious disease outbreaks, such as COVID-19, prepare for and respond to natural and man-made disasters, and ensure the safety of the air we breathe, the food we eat, and the water we drink. Health departments employ public health nurses, behavioral health staff, community health workers, environmental health workers, epidemiologists, health educators, health policy experts, nutritionists, laboratory workers and other health professionals who use their invaluable skills to achieve health equity and keep people in communities across the nation healthy and safe.

In addition, to ensure our states, cities, territories and tribes are better prepared for the next emergency, it is essential that Congress increase annual discretionary funding for programs within the Centers for Disease Control and Prevention and the Health Resources and Services Administration. Funding for these two agencies remains woefully inadequate to meet the many public health challenges faced by our nation. CDC is a key source of funding for many of our state, local, territorial and tribal programs that improve the health of our communities, including through CDC's Section 317 Immunization Program, which helps assure the implementation of

[11] Organization fact sheet supporting funding for a loan repayment program. Available at: https://www.apha.org/-/media/Files/PDF/advocacy/letters/2020/PH_workforce_loan_repayment.ashx.

effective and safe immunization practices to achieve high coverage, reduce disparities and support infrastructure for essential activities. CDC serves as the command center for the nation's public health defense system against emerging and reemerging infectious diseases. From playing a leading role in aiding in the surveillance, detection and mitigation of the COVID-19 pandemic in the U.S. and globally, to playing a lead role in the control of Ebola in West Africa and the Democratic Republic of the Congo to monitoring, investigating and helping to control the recent measles outbreaks in the U.S., to pandemic flu preparedness, CDC is the nation's – and the world's – expert resource and response center, coordinating communications and action and serving as the laboratory reference center. States, communities, and international partners rely on CDC for accurate information, direction, and resources to ensure they continue to be prepared for and able to respond to and recover from a crisis or outbreak.

Through strengthening the health workforce, supporting innovative programs and delivering quality health services to people who live in medically underserved areas or face barriers to needed care, HRSA helps to build healthy communities, a healthy workforce and healthy people. Some of the major programs carried out by HRSA include health workforce programs that provide support across the training continuum and offer scholarship and loan repayment programs to ensure a well-prepared, well-distributed and diverse workforce that is ready to meet the current and evolving needs of a growing and aging population, as well as primary health care programs that support almost 13,000 health center sites in every state and territory, improving access to comprehensive preventive and primary care for primarily low-income individuals or people living in areas with few health care providers.

We urge Congress to provide at least $10 billion for CDC and $9.2 billion for HRSA in FY 2022. Adequate and sustained funding of these two critical public health agencies, and other important federal health agencies, is essential to ensure our public health and health care systems and workforce are better prepared to address both COVID-19 and the next public health emergency.

I thank you for the opportunity to testify before you on this important issue. We look forward to working with Congress and the administration to prioritize efforts to ensure the nation has a strong and equitable public health system and the needed well-trained public health workforce to address the current pandemic and future public health emergencies. I look forward to answering any questions you may have.