PREPARING FOR THE NEXT PANDEMIC: LESSONS LEARNED AND THE PATH FORWARD

HEARING

BEFORE THE

SELECT SUBCOMMITTEE ON THE CORONAVIRUS PANDEMIC

OF THE

COMMITTEE ON OVERSIGHT AND ACCOUNTABILITY

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PREPARING FOR THE NEXT PANDEMIC: LESSONS LEARNED AND THE PATH FORWARD

Thursday, November 14, 2024

U.S. HOUSE OF REPRESENTATIVES
COMMITTEE ON OVERSIGHT AND ACCOUNTABILITY
SELECT SUBCOMMITTEE ON THE CORONAVIRUS PANDEMIC
Washington, D.C.

The Subcommittee met, pursuant to notice, at 11:30 a.m., in room 2154, Rayburn House Office Building, Hon. Brad R. Wenstrup (Chairman of the Subcommittee) presiding.

Present: Representatives Wenstrup, Miller-Meeks, Lesko, Cloud, Joyce, Greene, McCormick, Ruiz, Dingell, Mfume, Ross, Garcia, Bera, and Tokuda.

Dr. WENSTRUP. Good morning. The Select Subcommittee on the Coronavirus Pandemic will come to order.

I want to welcome everyone here today.

Without objection, the Chair may declare a recess at any time.

I now recognize myself for the purpose of making an opening statement.

I would like to thank the witnesses for their testimony at the Select Subcommittee's final hearing.

The COVID–19 pandemic stands as one of the most devastating crises in our Nation's history. It claimed the lives of millions of Americans, disrupted livelihoods, and took a profound physical, emotional, and economic toll on families and communities across the country.

Sadly, this likely will not be the last pandemic. There will be others that test our Nation's preparedness and resiliency in the future. So, we're here today to look at the lessons learned from the COVID–19 pandemic in order to prepare for and hopefully prevent the next one.

In the last 2 years, the Select Subcommittee has sent 118 investigative letters, conducted 38 transcribed interviews, held 25 hearings, and reviewed nearly 1 million pages of documents. The work of the Select Subcommittee revealed serious flaws in the government's response to the pandemic, underscoring the need for reforms.

We saw inconsistent, contradictory guidance from the CDC that sowed confusion and diminished trust. Students were out of the classroom and told to attend school remotely even when the science

had started to clearly demonstrate it was safe for them to be back in the classroom.

We saw Americans pressured to receive a vaccine they were assured that would make them a dead-end for the virus and prevent reinfection and transmission—something that was known to be false based on vaccine trials.

And at the NIH, there was a glaring lack of oversight over Federal grants that posed risk to public health and national security, and millions in taxpayer dollars funded risky gain-of-function research in China. We found nefarious behavior by several federally funded actors—actions that betray the trust of the American citizens.

We must learn from these errors, take the lessons to heart, and make fundamental changes. We must establish clearly defined roles, with an overarching structure that empowers agencies to act swiftly and effectively in mitigating the spread of novel viruses, as an example.

It is essential for institutions such as NIAID and CDC to execute their assigned missions, functions, and tasks and not stray out of their respective lanes. For example, NIAID is entrusted with vaccine development, while the CDC is tasked with controlling and containing the spread of diseases. Throughout the pandemic, NIAID encroached into CDC's lane by advising on matters pertaining to containing the spread, creating confusion among the American people.

Poor decisions made by Federal agencies shattered trust in our public-health institutions and left Americans questioning the very leadership that was supposed to protect them.

Decisions made out of lack of knowledge and data is one thing, but poor decisions must be corrected. To be successful in the next pandemic, our Federal public-health institutions must be accountable to the people again. To be successful, our health organizations must do what they are supposed to do—protect Americans. Stronger oversight, better accountability, and improved structure within our agencies are essential.

Congress must consider a dedicated authority to oversee agency practices, ensuring that agencies act solely within their areas of statutory responsibilities and subject-matter expertise and insisting that public-health decisions are transparent, consistent, and credible.

Let today's hearing be a step toward lasting reforms that will protect future generations from similar crises. I want to thank you, and I look forward to a strong on-topic discussion today.

I would now like to recognize Ranking Member Ruiz for the purpose of making an opening statement.

Dr. RUIZ. Thank you, Mr. Chairman.

When COVID–19 hit our shores in the early months of 2020, our Nation began one of the most challenging chapters in its history. We entered a period marked by uncertainty, fear, and a staggering loss of life.

And in those initial months, we, as Members of Congress and as a Nation, overcame our differences and came together to protect and provide relief through the Families First Coronavirus Response

Act and the CARES Act for the American people in the face of this novel threat.

Since that time, thanks to the life-saving impact of vaccines and the tireless work of our Nation's scientists and public-health officials, we have turned the page on the darkest days of the COVID–19 pandemic.

But during that same period, we have also seen an unsettling rise in mistrust for our Nation's public-health officials and misinformation and disinformation about the very interventions that saved us.

As we began the 118th Congress, we had a rare opportunity to take a serious, constructive look at these problems and develop forward-looking solutions to safeguard Americans from current and future threats. And when I became Ranking Member, I stood ready to work with any Member on either side of the aisle who would join me in this objective.

But instead of taking steps forward to prevent and prepare our Nation for future pandemics, this Select Subcommittee has spent 2 years fanning the flames of people's mistrust in public health and taking advantage of their fears. And under the Republicans' leadership, the Select Subcommittee pursued vendettas against our Nation's scientists and public-health officials for partisan gain.

But whether it was allegations that Dr. Fauci caused and covered up the origins of the COVID–19 pandemic or that our Nation's public-health officials sought to keep schools and businesses closed, more than half a million pages of documents, more than 30 transcribed interviews, and nearly two dozen hearings failed to turn up evidence to substantiate these extreme and baseless claims.

And while the Select Subcommittee's probes did reveal discrete issues of misconduct that must be taken seriously, including by Dr. Peter Daszak and Dr. David Morens, we must ask ourselves whether our efforts over the past 2 years have fulfilled the objective of constructively improving our Nation's ability to prevent and prepare for the future pandemics on the issues that matter most and that would have the most significant impact in those future pandemics.

Look, since day one, I have said that the Select Subcommittee's mission must be collaborating to develop the forward-looking solutions that leave our Nation better prepared for future novel viruses.

I have wanted to examine how we close pathways for novel viruses to emerge, be they in nature or in a lab; or to focus on how we can strengthen our schools so that they can be better prepared to maintain safe, in-person learning during future pandemics; to look at how we can build on progress in strengthening infection prevention and control in nursing homes to keep our seniors safe and save lives; to explore how we can lay the groundwork for the rapid development of future vaccines and therapeutics for novel viruses when they inevitably emerge.

And we could've done all these important things, things that have a high impact, significant ability to curb the deaths of the next pandemic or possibly even prevent them—and I've asked for more over the past 2 years—but we didn't. We didn't.

And while we haven't yet come together to tackle these serious challenges—challenges facing Republicans and Democrats alike—I have always looked for opportunities to do so.

So, as we begin today's hearing, I want to acknowledge that I welcome its focus, that I wish that we spent more time pursuing this subject with more experts, and I hope that we can commit to a forward-looking discussion about the road ahead. Because, even after 2 years, I still believe that there is a lot more to do, and it's not too late to come together and do the work of saving future lives.

Thank you, and I yield back.

Dr. WENSTRUP. Our witnesses today are:

Dr. Lawrence Tabak. Dr. Tabak is the Principal Deputy Director of the National Institutes of Health and served as Acting Director of the NIH from December 2021 to November 2023.

Dr. Henry Walke. Dr. Walke is the Director of the Office of Readiness and Response at the Centers for Disease Control and Prevention.

Dr. Hilary Marston. Dr. Marston is the Chief Medical Officer at the U.S. Food and Drug Administration and was a senior advisor on the White House COVID–19 Response Team.

Pursuant to Committee on Oversight and Accountability rule 9(g), the witnesses will please stand and raise their right hands.

Do you solemnly swear or affirm that the testimony that you are about to give is the truth, the whole truth, and nothing but the truth, so help you God?

Thank you.

Let the record show that the witnesses all answered in the affirmative.

The Select Subcommittee certainly appreciates you all for being here today, and we look forward to your testimony.

Let me remind the witnesses that we have read your written statements and they will appear in full in the hearing record. Please limit your oral statements to 5 minutes.

As a reminder, please press the button on the microphone in front of you so that it is on and the Members can hear you. When you begin to speak, the light in front of you will turn green. After 4 minutes, the light will turn yellow. When the red light comes on, your 5 minutes has expired and we would ask that you please wrap up.

I now recognize Dr. Tabak to give an opening statement.

STATEMENT OF LAWRENCE TABAK, DDS, PH.D.
PRINCIPAL DEPUTY DIRECTOR
NATIONAL INSTITUTES OF HEALTH

Dr. TABAK. Thank you, Chairman Wenstrup, Ranking Member Ruiz, and distinguished Members of the Subcommittee.

I appreciate the opportunity to be here today to discuss the critical role NIH plays in supporting research necessary for preventing infectious-disease outbreaks and preparing for the next public-health threat. We are here today because of our shared belief that taking stock of the lessons learned during the recent pandemic needs to happen sooner rather than later.

While far too many lives were lost, we are proud of the research communities and brave research volunteers who participated in NIH-supported research that delivered a vaccine, diagnostic tests for home use, and a treatment, all in under a year—three remarkable feats.

It is fair to say that many thousands of additional people would've died were it not for the public's investment in NIH-supported research. But more work is needed to prepare for future threats, and it is essential to leverage what we've learned from the COVID–19 pandemic.

To maximize our readiness for future pandemics, NIH must better coordinate its key assets, such as research and trial networks, as well as standardize platforms to rapidly evaluate the efficacy of diagnostic tests.

To ensure that we can evaluate the broadest range of potential interventions, meaningful collaboration across the USG, industry, academia, and the public must be forged now. Plans must be put into place to assess potential interventions for their value to all communities of our Nation.

It is not currently feasible to characterize and develop countermeasures for all circulating viruses around the globe. Therefore, the NIH, led by the National Institute of Allergy and Infectious Diseases, has developed a pandemic preparedness plan that prioritizes development of medical countermeasures for representative viruses from each of nine virus families.

The knowledge gained will not only provide ready potential prevention and treatment strategies for the many different viral variants that could emerge but also the framework for a rapid research and product-development response to other viruses within each family in the event of an outbreak.

In addition, by standardizing reagents, models, and data outputs, NIH's coordinated research networks would be able to more easily share results and collaborate quickly to enhance research efforts.

We must also continue to invest in the development of methods for detecting transmission of virus that can be deployed in communities equitably and rapidly across the country. NIH is now applying the so-called RADx approach to address a range of health problems, including technologies to reduce the spread of HIV, and developing emergency diagnostics for emerging threats such as avian flu and then the seasonal flu.

Finally, NIH knows that we cannot tackle emerging infectious diseases on our own, and we are working in partnerships with others to tackle emerging threats across the globe.

One example is Marburg virus disease, a severe and often fatal illness in humans clinically very similar to Ebola virus disease. Currently, there are no FDA-approved therapeutics or vaccines available. In September of this year, Rwanda reported cases around their country.

NIH is working with HHS counterparts and international partners to support research through the ongoing outbreak. NIAID has supported research on candidate therapeutics and vaccines for the disease and has helped make these candidates available in Rwanda to enable patient treatment and vaccination of contacts and healthcare workers.

NIH remains committed to supporting these efforts and more to advance pandemic preparedness and enhance the international research capacity to respond to infectious disease.

Continued success in NIH pandemic preparedness and biodefense efforts is contingent upon sustained congressional support. The President's budget request includes $20 billion in mandatory funding for the Public Health and Social Services Fund, of which $2.69 billion will support NIH's work.

We appreciate your attention and support for these efforts. NIH will continue to meet the public-health emergency needs by advancing high-priority research of these threats.

I thank you for your attention and welcome your questions.

Dr. WENSTRUP. Thank you, Doctor.

I now recognize Dr. Walke.

And if I mispronounced your name earlier, I apologize.

Dr. WALKE. That's OK.

Dr. WENSTRUP. Dr. Walke, you can give an opening statement, please.

STATEMENT OF HENRY WALKE, M.D., MPH
DIRECTOR OF THE OFFICE OF READINESS AND RESPONSE
CENTERS FOR DISEASE CONTROL AND PREVENTION

Dr. WALKE. Thank you. Chairman Wenstrup, Ranking Member Ruiz, and distinguished Members of the Subcommittee, it's an honor to be here today.

I'm Henry Walke, the Director of CDC's Office of Readiness and Response, and I'm here today to discuss how CDC is working every day to protect our health security and save lives by putting science into action to help people and communities prevent, detect, and respond to health threats at home and abroad.

We're seeing more infectious-disease threats than ever before, including emerging pathogens like avian influenza; viral hemorrhagic fevers like Ebola and Marburg; mpox; and Oropouche a new illness linked with birth defects.

At the same time, many of the leading causes of death and the largest drivers of healthcare costs for Americans are noninfectious diseases such as heart disease, stroke, overdose, and suicide. CDC works in coordination with state and local health departments around the country to provide communities with effective strategies to combat all of these threats. With about 80 percent of our domestic funds going directly to state and local partners, we dedicate ourselves to partnering with communities to protect Americans.

We are also in over 60 countries around the world, increasing laboratory capacity and building work force expertise so we can identify and stop pathogens at their source, protecting Americans at home. The relationships CDC builds in other countries means the first call ministries of health make when a health threat arises is often to CDC. It's a matter of national security that we maintain our world-class expertise to be the first to respond.

The COVID–19 response showed a number of important successes, but it also exposed challenges and gaps that need to be filled. CDC, in conjunction with outside stakeholders, conducted an extensive review of our processes and organizational structure to document lessons learned and identify corrective actions. As this

Committee has heard before, the report identified a number of areas for improvement, including streamlining communication, sharing data faster, and promoting partnerships.

CDC has implemented over 160 key actions to drive accountability. These changes are seen every day in how CDC operates.

Starting last respiratory season, CDC now has a public dashboard displaying COVID–19, flu, and RSV information all in one place.

CDC recently made the first-of-its-kind awards with five private-sector clinical laboratory companies that provide a warm base of support for rapid and efficient distribution of diagnostics.

And we're getting data out faster with the launch of the 1CDP data platform that leverages data reported to CDC from thousands of sources to programs across the entire agency and shares it back in an action-oriented format for Federal, state, and local partners.

I'm proud of the work we have done, but I have been at CDC long enough now to know that we can't do it alone. One of the core themes identified in moving forward with an effort to improve and modernize the agency was that CDC needed to bolster our core capabilities of data analytics, laboratory capacity, public-health work force, and domestic and global readiness and response.

Strengthening these core functions would allow CDC to be nimble enough to address any health challenge, but we need the necessary funding and authority from Congress if we want to make the type of lasting change needed to respond to the next pandemic—or, better yet, to prevent it.

Unfortunately, public-health funding is boosted when there is a crisis, but much of that funding is allowed to lapse during peacetime. We've seen this with H1N1, Ebola, Zika, and now COVID–19.

These resources let us create incredible tools that can be used in an emergency but also support situational awareness for other pathogens—for example, our national wastewater system that gives us an early look at how diseases are progressing; or the RREDI platform that supports a response-ready agency to use data to make decisions near-real-time; or our Center for Forecasting Outbreak Analytics that can now show us when and where an emerging threat may go, helping communities best target limited resources; and, more broadly, continuing to modernize our public-health data capabilities.

Without increased and sustained resources, these capabilities, which were all largely built with one-time emergency funds, are at risk of going away. Without authorities that let us surge and sustain our work force for the next emerging threat, we'll be back where we started before COVID.

The CDC works every day to achieve our mission of protecting your communities from health threats. But we can't be the national-security asset Americans deserve without bipartisan support. I look forward to speaking with you today on the ways that we can enhance our collaboration to protect health and improve lives.

And I'm happy to answer your questions.

Dr. WENSTRUP. Thank you.

I now recognize Dr. Marston to give an opening statement.

STATEMENT OF HILARY MARSTON, M.D., MPH
CHIEF MEDICAL OFFICER
U.S. FOOD AND DRUG ADMINISTRATION

Dr. MARSTON. Thank you so much.

Chair Wenstrup, Ranking Member Ruiz, and Members of the Subcommittee, thank you for the opportunity to discuss the FDA's pandemic preparedness efforts.

Recent events, whether the COVID–19 pandemic, the presence of highly pathogenic avian influenza in dairy cattle, or the emergency-induced supply chain disruptions that we're seeing with Hurricanes Helene and Milton, have all underscored the need to continue to optimize our Nation's preparedness and response capabilities.

We know the profound impact that public-health emergencies and our ability to respond to them have on American lives. This can range from how global supply chains affect access to foods and medical products to the value and importance of vaccines, therapeutics, and diagnostics to address those public-health threats, reduce suffering, and ultimately save lives.

The additional authorities and funding requested in the Fiscal Year 2025 President's budget are necessary to address future public-health threats effectively.

Specifically for FDA, our public-health preparedness priorities are: one, providing greater transparency into supply chains; two, fostering medical countermeasure development; and three, ensuring operational readiness and surge capacity within the agency.

So, first, supply chains. We need greater transparency into supply chains to help ensure access to critical medical products. Supply chains are subject to a range of market forces that are well beyond FDA's scope. For example, generic drugs, particularly generic sterile injectables, are most vulnerable to shortage. We know this. But that's due to market dynamics, including competition, investment needs, and uncertain demand—all dynamics beyond the FDA's scope.

FDA has worked within its current authorities to find ways to prevent and mitigate medical product shortages. Since the COVID–19 pandemic, we've worked with manufacturers to successfully mitigate or prevent 586 drug, biologic, and medical-device shortages. We rely on notifications from manufacturers to help prevent supply disruptions, and we've identified changes that could help the agency better mitigate or prevent shortages.

Specifically, FDA seeks authorities to require FDA notification when there's increased demand for a product; require manufacturers to report sources of active pharmaceutical ingredients and the extent of manufacturer reliance on them; require labeling to include the original manufacturer and supply chain information; and require manufacturers to notify FDA about interruptions or discontinuances in medical-device manufacturing outside of public-health emergencies.

Second, the COVID–19 pandemic underscored the importance of fostering medical countermeasure development as a preparedness measure.

Throughout the COVID–19 response, FDA's scientists and employees worked around the clock trying to provide guidance to man-

ufacturers and researchers, minimizing the time between clinical development, manufacturing, scale-up, and regulatory review. This is how FDA was able to help make critical medical countermeasures, especially COVID–19 vaccines, available as quickly as possible based on our stringent scientific and regulatory standards.

We're leveraging the lessons learned from the COVID–19 response in our everyday reviews, including reviews of platform technologies and improving communications with manufacturers.

Third, ensuring operational readiness and surge capacity is critical in emergencies.

During the COVID–19 pandemic, we saw FDA staff pulled away from other work to focus on pandemic work for 3 years, leading to backlogs and fatigue. Creating a specialized program to defend against emerging pathogens and other threats would leave the FDA best positioned to respond to future emergencies and focus experienced staff to work quickly on medical countermeasure development.

Critical investments are also needed to increase FDA's inspectorate work force capacity to conduct oversight of those products.

The key lessons learned and proposals I'll discuss today will bridge key gaps to enable a robust and timely response to future emergencies. They'll help enhance early detection; provide safe, effective, and accessible medical products; and maintain health system capacity.

We look forward to continuing to work with Congress to improve public-health preparedness. Thank you for the opportunity to testify. I look forward to your questions.

Dr. WENSTRUP. Thank you.

I now recognize myself for questions, but I do want to take a moment to thank you all again for being here.

And I would tell you, I appreciate your constructive reforms that you talk about, actions that have been taken since the pandemic response, the idea of solutions, and honest self-reflection that we all need to undergo if we are going to do better in the future. And I do hope that there can be robust work with Congress and the agencies and our Federal Government to do better.

One of the things that we wanted to look at is the grant process. And we looked into that, and there seem to be, from Dr. Fauci's testimony, several flaws that I think we can correct. And we can correct them together for sure, improving the process. But part of that process is holding those that get grants accountable for their own responsibilities.

So, Dr. Tabak, this past May, HHS immediately suspended and proposed debarment for both EcoHealth and Dr. Daszak. And, just following up, our understanding is that this process remains ongoing at this time?

Dr. TABAK. That's correct.

Dr. WENSTRUP. And does NIH still support the debarment of EcoHealth and Dr. Daszak?

Dr. TABAK. We do. And we have provided all necessary documents to the Department.

Dr. WENSTRUP. Thank you.

At the time HHS announced the suspension, EcoHealth had three active grants with NIH. These grants had moneys already outlaid and obligated.

Does the suspension stop future funding on these grants even if the money has already been obligated but not outlaid?

Dr. TABAK. If the activity occurred before the suspension, we are, by law, obligated to reimburse them on a case-by-case basis. Any activities after the suspension are not reimbursable.

Dr. WENSTRUP. Did NIH make any efforts to claw back already-outlaid funds, or just realized you couldn't?

Dr. TABAK. This has not occurred. This is—going forward from the suspension, they are not allowed to get additional funds.

Dr. WENSTRUP. OK. Thank you.

One final question for you. Dr. Daszak has routinely said that the regulations did not require that he provide NIH with lab notebooks from the Wuhan Institute of Virology. Last year, NIH put out a new rule regarding this issue.

So, just to clarify, when NIH asked for these lab notebooks, was Dr. Daszak required to produce them?

Dr. TABAK. He was indeed.

Dr. WENSTRUP. Thank you.

Dr. Walke, the Select Subcommittee went to Southeast Asia, Cambodia and Laos in particular, some of us, to get firsthand experience on how we work with these countries to protect the United States. And, quite frankly, I find it, as we discussed yesterday, a good form of diplomacy for the United States. But while we were there, we had meetings with CDC employees that were in-country.

Now, you worked in global health. Do you think having U.S. Government personnel in countries to try to prevent pandemics from reaching our shores has a large return on investment? And, briefly, why?

Dr. WALKE. Thank you for the question.

Absolutely. CDC has over 60 country offices spread around the world. We have CDC staff embedded in ministries of health to work on surveillance or data collection, laboratory capability, and trying to help improve their work force.

So, when there is a cluster of illness anywhere in the world, our staff can work closely with ministries of health to detect that outbreak and then to try to rapidly control the outbreak at its source so that it actually maintains—that outbreak is maintained actually within the country or the region and never makes it to the U.S.

So, it's a national-security asset to have these global health relationships.

Dr. WENSTRUP. Yes, I appreciate that. And I got to see that firsthand and receive praise to the United States for our efforts in that area. And it does reduce the potential for a pandemic to reach our shores, or an epidemic.

The CDC issued hundreds of guidelines during the pandemic. The Federal and state governments took these guidelines a step further and imposed mandates. We had mask mandates, vaccine mandates, vaccine passports. These types of mandates blocked individuals from seeking personalized medical advice from their doctors very often.

Do you think in future pandemics ensuring the sanctity of the doctor-patient relationship is vital?

Your microphone, please.

Dr. WALKE. Thank you. Thanks again for the question.

The COVID vaccine saves millions of lives. Related to the need for continued vaccine—I'm sorry, sir. I forgot your question. I apologize.

Dr. WENSTRUP. I said, do you think in a future pandemic ensuring the sanctity of the doctor-patient relationship is vital?

Dr. WALKE. I——

Dr. WENSTRUP. I think that, with mandates, we eliminated too much of the discussion that a patient can have with their doctor to talk about—yes, the vaccine saved millions of lives; I'm convinced of that. But there were things it couldn't do. And patients wanted to know that.

So, I just wanted your take on maintaining that doctor-patient relationship.

Dr. WALKE. Yes. No medical intervention, including vaccines, is risk-free, so it's very important for the patient or the person receiving that medical intervention, a vaccine for example, to have that strong relationship with their provider so they have the medical advice that they need. Some of these patients, for example, have underlying diseases or may have some complication related to the medical intervention.

So, CDC makes recommendations for the population, for large communities—for communities at large, but maintaining that relationship between the provider and the patient helps interpret those recommendations for the individual.

Dr. WENSTRUP. Thank you, Doctor.

Dr. Marston, in your written testimony, you emphasize the need for greater transparency within the medical-product supply chain—the supply chain issue is very important to me—to help prevent and mitigate drug shortages. The COVID–19 pandemic underscored just how fragile the supply chain is, as unprecedented demand led to severe shortages.

Can you outline specific steps the FDA can take and maybe has started to take to strengthen supply chain resilience and prevent drug shortages during future public-health crises?

Dr. MARSTON. Well, first, I want to say I appreciate the question, because these shortages are incredibly painful for communities across the country. They are not a new problem, but they certainly were laid bare during the COVID–19 pandemic.

Also, it's important to recognize what's causing these shortages. And the primary causes of the shortages, the long-term causes, are these weaknesses in the markets, right?

These generic sterile injectables in particular, not everybody can make them. They need to be sterile; that's an important thing. You know this as a physician. They can't be made everywhere. And they require additional upkeep of those lines, additional care, the ability to have buffer stocks. All of these things cost money, and unfortunately the profit margins are very razor-thin.

That is quite clearly beyond the mission of the FDA, but it is something where we are often trying to work on the fallout from those issues. So, one of the things that we've been doing is trying

to partner across government for solutions that can address those market-based issues.

But for the FDA in particular, there are some things that we can do to improve our ability to provide and mitigate shortages.

First, we really need to be able to know when there is a rise in demand that these companies can't keep up with. So, currently, they are required to tell us if a line goes down and they can't keep up with supply. But if there's a spike in demand, for example, as we saw with the children's analgesics a couple of years ago, they don't need to tell us about that. So that sets us back in our ability to mitigate.

Second, they don't need to specify their reliance on different manufacturers for active pharmaceutical ingredients. They don't need to put those things on their label. So, we have proposals that would address both of those and require that.

And, third, medical-device manufacturers actually aren't required to tell us about any supply disruptions outside of a public-health emergency. So, if a tornado takes out your factory, which unfortunately is a painfully real example, you're not required to tell the FDA. We might call you, we might see it in the news, but it's not a requirement. So that's, again, something that we want to address.

Dr. WENSTRUP. Well, I don't know if you had previously read my next question, but it sounds like it. Because an idea we have had is to stand up a manufacturing reserve corps, in essence, to have trusted companies with capabilities ready to make things like masks, hand sanitizer, gowns, or vaccines, all that in place.

So how can the FDA improve its coordination with manufacturers and healthcare providers to anticipate and meet surges in demand? And how can Congress help with that as well?

Dr. MARSTON. So, maintaining those open lines of communication is one of our lessons learned from the pandemic, that, early and often, those communications are really what's needed to make us most effective.

In terms of manufacturers, our small-but-mighty drug-shortages staff is in close touch with manufacturers of some of these critical medical products, understanding their capabilities to make these products and be able to respond particularly for critical medical products should a supply disruption occur.

As I mentioned, generic sterile injectables, particularly drugs like penicillin, these are things that are difficult to make, right? Not everybody can make them. So, it would be important to make sure that those manufacturers are qualified and have good processes in place, don't have an issue with cross-contamination, for example, which could end up in quite a bit of damage.

Dr. WENSTRUP. Thank you.

I now recognize the Ranking Member, Dr. Ruiz from California, for 5 minutes of questions—or as you see fit.

Dr. RUIZ. Thank you.

As the Select Subcommittee gathers today, our Nation faces a pivotal moment when it comes to the future of pandemic prevention and preparedness.

Thanks to the tireless work of the agencies and the individuals in those agencies sitting before us over the past 4 years, our Nation

overcame the darkest days of the COVID–19 pandemic and has taken meaningful strides to strengthen our public-health infrastructure going forward.

But the possibility of a future pandemic remains very real. Even today, we are facing emerging viruses like H5N1 which will continue to require investments of time and resources to contain. So, we must keep our foot on the gas even if it might be tempting to let up.

Dr. Walke, let me begin with you. I understand an essential component of fortifying CDC's readiness for future outbreaks is providing the agency with expanded authority for robust public-health data collection.

Why is this reform so important? And what other reforms should Congress consider going forward to ensure your agency is best positioned to respond to emerging viruses?

Dr. WALKE. Thank you for the question.

Early in the pandemic, as the virus was changing—first we had the wild type, then Alpha, Beta, Delta, and then Omicron—we had difficulty trying to understand where transmission was happening. It was difficult to integrate our laboratory data with our hospital data with our case-based information in a way that we could actually create dashboards and make quick decisions on what to do. Some of our jurisdictions were even faxing information in around case reports.

With sustained investment from Congress, we made incredible progress in pulling together that information and creating those systems so we could create that interoperability between all those various systems. But in order to keep going forward, we're going to need sustained investment in our data platforms.

We have a large number of jurisdictions now who, still, healthcare providers are entering information in manually, actually, to report case reports. We've made incredible strides in electronic case reporting, moving from 187 healthcare facilities before COVID now to over 45,000 healthcare facilities who are able to quickly give us information around case reports. So, we need to continue that investment and actually improve it.

We need authorities, though, as well. Early in the pandemic, early in an outbreak, before an emergency, a public-health emergency is declared, we have to collect information very quickly to understand what's happening, as in COVID, and we need those policy changes to enable us to collect the information that's needed to make decisions.

As well, that's a core capability related to data, but I'll stop there.

Dr. RUIZ. Thank you.

Dr. Marston, one of the great success stories of the pandemic was the effective and efficient manner in which scientists and the FDA brought a safe and effective COVID–19 vaccine to the market and distributed throughout our Nation.

What lessons did FDA identify from its work on the COVID–19 vaccine? And how can Congress help to ensure these best practices remain in place for emerging public-health threats going forward?

Dr. MARSTON. Thanks so much for that question and for your kind words about the work of the professionals at the FDA.

Couldn't agree more with you. I joined the FDA in 2022, so I was an observer of that work. But, really, a tremendous effort.

A couple of lessons that we learned.

No. 1, continued transparency. We have made sure that our advisory committees are airing the data that they're seeing, that we're putting out summaries of our views, of our own analysis of the data that's provided by manufacturers. We do our own analysis, right? We don't just take things that are given to us. Our professionals look into the data themselves.

Second, we have certainly learned a lesson and we have taken this lesson across the FDA for various medical countermeasures: the importance of telescoping to industry what our expectations are going to be, what sort of information that they're going to need to provide to us. So, we do that in the form of guidance, and we've done it in vaccines several times, therapeutics, and diagnostics.

Third is this issue of surge capacity. Our folks are incredibly dedicated, and they worked around the clock. As I mentioned, that's led to backlogs, it's led to fatigue. If we had a cadre of folks who were experts in medical countermeasures, during, quote/unquote, "peacetime" they could work on those preparedness medical countermeasure development issues and during a response could jump into action. That would be tremendously helpful for the organization.

Dr. RUIZ. Thank you.

Let me conclude with you, Dr. Tabak. While the Select Subcommittee's efforts did not ultimately shed light on the origins of the novel coronavirus, they did underscore the importance of addressing pathways for potential pandemics both in nature and in labs.

How can we balance the need for continued essential research to identify and get ahead of future viruses with the imperative that research take place safely and in a manner that is transparent to American taxpayers?

Dr. TABAK. Well, as you point out, we do need to take the appropriate steps to ensure that any research of this type is done in a safe and efficient manner, but I think we do need to continue the long-term investment in basic discovery. Because without the fundamental knowledge of, for example, the different viral families for which we have less information, we would be working blind should one of those escape to be a new emergent pathogen.

We also have to continue to build on the infrastructure that we have in place to ensure that we are ready for the next pandemic. And that includes things like, you know, pathogen surveillance and genomic sequencing and informatics and structural biology so that we have better understanding of what potential targets might be.

And then, finally, we have to maintain a flexible domestic and global clinical-trial network infrastructure so that we can rapidly deploy potential countermeasures and test them for their efficacy.

Dr. RUIZ. And what would the ramifications be of cutting funding to NIH for this and other essential research as a knee-jerk reaction to the possibility that the novel coronavirus emerged from a lab incident?

Dr. TABAK. The need for basic discovery is essential. We need to understand who the pathogens are. We need to understand how

the pathogens transmit. We need to understand what their mechanisms of action are; what type of disease, what type of pathology they cause. And we need to support the key infrastructure that is essential going forward if we are to successfully defeat any emergent pathogen.

Dr. RUIZ. OK.

And I'm pretty confident that our own labs could attain that level of security. The question is, how do we work with adversarial countries to ensure that they're not—that they're up to code and they're transparent?

Dr. TABAK. As you know, international collaboration and research is essential. And the pandemic underscored that. But, unfortunately, when there are instances of noncooperation, we have to, you know, call that out and hopefully work, you know, through both diplomatic and other channels to try and bring those organizations into, you know, a more favorable compliance.

Dr. RUIZ. Thank you.

Dr. Walke, you mentioned earlier that having investments in personnel in other countries is very important to be able to monitor any emerging virus.

In your opinion, do we have—have we mapped the high-risk animal-to-human potential transmission locations? Are we in the right places?

Dr. WALKE. Thank you for the question.

Related to emerging threats, there's a lot of work being done, both within CDC and public-health agencies, as well as the academic world, around where the next emerging threat might be. There's a number of issues here related to deforestation, for example, and population movements. But we do have staff actually in most of these areas—for example, in South America or in Africa—where we're seeing some of these emerging threats.

We also place our staff where there's a large burden of disease—for example, HIV or malaria or tuberculosis. So, there's a number of different criteria when we make decisions about where to put our staff.

But, as you have said, it's incredibly important to actually have that face-to-face people on the ground working side-by-side with ministries of health, because when something happens actually, they then work with our staff and ask for technical assistance and we're actually able to have that partnership.

Dr. RUIZ. In what other ways, in addition to technical assistance, are we building the host countries' capacity to identify any emerging viruses and to better respond to those emerging viruses, to contain it there?

Dr. WALKE. In a similar way that we're trying to build capacity in this country in data and analytics and laboratory capacity, that trained public-health work force. And for global response, we do similar things, actually, in other countries.

We embed within the laboratories and try to make sure that they have the validated assays available. We work with their data systems to make sure they can connect with each other. We actually train their field epidemiologists so that they know how to go out and collect the information to understand the transmission of these——

Dr. RUIZ. OK.

Dr. WALKE [continuing]. Of these pathogens.

Dr. RUIZ. Well, I really appreciate all of you—thank you—all of you individually for your tireless work for our government, for the American people. Thank you for your work during the pandemic, and thank you for being here.

I yield back.

Dr. WENSTRUP. I now recognize the Chairman of the Full Committee, Mr. Comer from Kentucky.

Mr. COMER. Thank you.

Dr. Tabak, is Dr. David Morens still employed by the NIH?

Dr. TABAK. He is still an employee.

Mr. COMER. When you testified this summer, I asked you a series of questions about some of Dr. Morens' actions. The first was if the NIH FOIA Office teaches employees how to avoid FOIA. You said, and I quote, "I certainly hope not."

Are you aware one of your former FOIA officers invoked the Fifth Amendment when asked about this issue?

Dr. TABAK. I have learned that in the lay press, yes.

Mr. COMER. I then asked if Dr. Morens' deleting emails and using his personal email to hide his relationship with EcoHealth was consistent with NIH policy, and you said no.

Do you stand by that?

Dr. TABAK. Absolutely.

Mr. COMER. I then asked if Dr. Morens' sharing internal NIH deliberations or helping EcoHealth craft responses was consistent with NIH policy. You said, quote, "If those actions occurred, they would not be consistent."

Do you stand by that?

Dr. TABAK. Yes, sir, I do.

Mr. COMER. If I show you proof of those actions, will you take more employment action against Dr. Morens?

Dr. TABAK. Sir, we are taking the actions necessary in all cases——

Mr. COMER. OK.

On the screen, in an email chain, it shows an internal NIH email about a draft letter from Dr. Fauci to Senators Graham and Paul. Dr. Morens forwarded this first to his Gmail and then to Dr. Daszak.

Does sharing that draft letter violate NIH policy?

Dr. TABAK. Yes, of course.

Mr. COMER. The next email is the NIH informing Dr. Morens that the National Security Council will be leading the communications on the WHO origins report. Dr. Morens forwarded this first to his Gmail and then to Dr. Daszak.

Does sharing this internal deliberation violate NIH policy?

Dr. TABAK. Yes, it does.

Mr. COMER. The next email is Dr. Daszak soliciting Dr. Morens' help in responding to NIH. Dr. Morens responded with his edits to the letter.

But let's not take Dr. Morens' word for it. The attachment includes comments and track-changes done by Dr. Morens.

Sir, does an NIH employee editing a grantee's oversight response to NIH violate NIH policy?

Dr. TABAK. It absolutely is inappropriate.

Mr. COMER. Have you read Dr. Morens' transcript of his interview before the Select Subcommittee?

Dr. TABAK. I have not.

Mr. COMER. Well, I'd like to share you with a few examples of his testimony.

Dr. Morens was asked if he ever deleted an official record from his NIH account, and he answered, "No."

On January 21, 2022, Dr. Morens wrote, and I quote, "Twice in the past, including a month or so ago, I deleted everything with EHA people from my entire Outlook," end quote.

Then, on August 1, 2022, Dr. Morens wrote, and I quote, "Hopefully no problems with the emails that came to me at my NIH address. I deleted them quickly," end quote.

Did Dr. Morens lie to Congress?

Dr. TABAK. Sir, I don't know if he successfully deleted the emails or not. If he's a Capstone employee, he would not be able to delete the emails. It goes out of his——

Mr. COMER. Well, he thought he deleted them.

Dr. TABAK. Well, he may have that thought that, but if he's a Capstone employee——

Mr. COMER. So——

Dr. TABAK [continuing]. It would remain in the record.

Mr. COMER [continuing]. It looks to me like he lied to Congress. And that's a felony.

Dr. TABAK. Well, again, I——

Mr. COMER. Dr. Morens was asked if he provided any advice to Dr. Daszak on how to respond to NIH oversight requests, and he said, "No."

As we discussed and you saw earlier, Dr. Morens personally edited a letter for Dr. Daszak that was directly related to NIH oversight of EcoHealth, the company at the center of the entire COVID pandemic.

Did Dr. Morens lie to Congress?

Dr. TABAK. Again, those types of actions would be completely inappropriate.

Mr. COMER. "Yes." The answer is "yes." The evidence is on the screen.

There's evidence that Dr. Morens violated numerous NIH policies and lied to Congress multiple times. Dr. Tabak, will you fire Dr. Morens?

Dr. TABAK. As you know, we don't discuss specific personnel matters, but we are following all of our procedures to the letter.

Mr. COMER. Well, this appears to me the perfect example of bureaucratic overreach, the type of bureaucratic overreach I think the American people sent a loud message to Washington that they're fed up with. And they want the bureaucracies dismantled.

And one thing where I think we have bipartisan agreement is that there were a lot of mistakes made during the COVID pandemic. That's what the purpose of this Select Committee is for, and I think this Committee has been very effective in getting the truth to the American people.

I look forward to working with the incoming Trump administration to get rid of waste, fraud, abuse, and mismanagement in the

government and get rid of Federal employees that stand in the way of trying to bring transparency and efficiency to the Federal Government.

Thank you, Chairman Wenstrup. Thank you for the great work you've done on this Select Committee.

And I yield back.

Dr. WENSTRUP. Thank you.

I now recognize Dr. Bera from California.

Dr. BERA. Thank you, Mr. Chairman.

You know, the title of this is "Lessons Learned and the Path Forward." And there were a lot of lessons learned, and there's a lot that we should be thinking about.

And this is an area that I've spent my six terms in Congress thinking about, pre-pandemic. You know, my staff would, early on, often wonder, like, why are you spending so much time thinking about this? I'd say, "Go watch 'Contagion.'" And then, unfortunately, you know, we lived it. That wasn't the hope.

You know, post-Ebola, we put in some things in place, you know, in terms of having someone who was in charge of pandemic preparedness at the NSC looking around, programs like the PREDICT program that, you know, would be out there. And I visited those folks in Sierra Leone to see what we were doing to try to have early warning systems and do disease surveillance.

A lot of that was dismantled in the first Trump Administration, and we sounded the alarms that it would make us vulnerable. I'm glad that we've put some of that back.

You know, early in the winter of 2020, we sounded the alarms when we saw what was going on. We had the first hearing in Congress about this novel coronavirus and understood it was something different.

We've now spent the better part of 4 years talking about COVID origins. I don't think we will ever get to the bottom of that, because the evidence was probably destroyed. And, you know, it was unfortunate we weren't able to get to the hot zone immediately in early 2020.

I would urge us, as Congress and the country, to just accept both as plausible theories, so we can—you know, if it is a lab leak, let's actually raise lab standards. Let's have the ability—if folks are doing gain-of-function research and other research that is absolutely necessary for preparedness, let's make sure they're adhering to the highest of lab standards.

We also know that viruses occur naturally and there are naturally occurring pathogens. We should do everything we can to, you know, try to prepare for that, and I think it's time for us to move on.

You know, we have to better understand, with a novel virus and a pandemic and a very fluid situation where new information was coming in, how we get that information, how do we communicate it to the public. Because what we knew in March 2020 was very different than what we knew in October 2020.

And, again, in a fluid situation where people are scared, we should spend time thinking about how we allow the scientists to be the scientists, how we allow the politicians to be the politicians, but not have the politicians try to be the scientists and the scientists

try to be the politicians. How do we work together to communicate that, again, to a scared public.

You know, Dr. Marston, you talked about the critical vulnerabilities in our supply chain. Those clearly were exposed. We, as Congress, should do everything we can, with the rest of the world, to address those critical shortages, think about what that looks like, and, you know, fairly quickly, where it makes sense, on APIs, on protective equipment, et cetera, you know, make sure we've got adequate stockpiles but we've also got the reserve capacity to flex up very quickly.

Early on, I was involved in lots of conversations that talked about various strategies of—you know, we knew older patients were more vulnerable. You know, perhaps this did not seem to be impacting younger folks as quickly as possible, given the devastation we were seeing in New York. We made broad decisions which I think made sense at that juncture, but as we gained more information, we should've fed that back into strategies.

You know, I totally understand why in the spring of 2020 we closed schools. Was that the right decision in the fall of 2020? You know, we've got a perfect ability to—different states did different things. We should go back and learn from that and feed that into the future so, if we're faced with the same dilemma, we have that information.

I still have plenty of questions about why, as this virus evolved—you know, it came up through the East Coast, through Italy, into New York, devastated New York. We had the first naturally occurring case at my home institution, UC Davis, but it didn't rip through California. You know, I would've expected to see really bad results in Japan—densely populated area, they're a little bit more open, an older population. Why did the virus impact different countries differently? It didn't rip through India, which, you know, we were incredibly worried about.

I would hope that we, in an objective way, as a scientific community, taking politics out of this, could go back and try to understand the epidemiology. Was it that Japanese culture is a mask-wearing culture, et cetera.

So, you know, there are plenty of questions that still remain outstanding. If we could allow the scientists and the academics to address those things, I would hope that we, as Congress, could fund those studies, understand it, not to prosecute anyone or anything else but to actually better prepare ourselves as a country and the world.

You know, our public-health systems I knew had atrophied. We had very bad disease surveillance systems. Obviously, we've stood up wastewater surveillance and other measures. We could do better, though, to protect our public.

And it is not just naturally occurring pathogens. The Chairman and I sit on the Intelligence Committee and we talk about, you know, the vulnerabilities of bad actors, of bio threats, et cetera. We ought to, as a Congress, in a nonpartisan way, learn from the past but better prepare ourselves for the future.

There were real successes as well. You know, I never would've expected that we would get a vaccine—several vaccines that were safe and efficacious within 12 months. We did it. Some of that was

because of prior investments in research at the NIH and elsewhere. Can we get that from 12 months to 3 months?

Can we—the FDA successfully streamlined processes to get biotherapeutics to market. What are lessons learned there? Can we take some of those and actually use them to develop those therapeutics and countermeasures fairly quickly?

I'm out of time. I can go on and on. But I would hope, as we look forward, we actually do a real, objective analysis without trying to point—we got things right, and we got things wrong. Let's actually learn from that, and let's better prepare for the future.

Thank you, Mr. Chairman.

Dr. WENSTRUP. You know, I thank you, Dr. Bera. I'm going to have to take a second to comment on your comment. Because I agree with you tremendously. Yes, part of what we are doing here—we had to look back. We can't look forward if we don't look back and see how we can do things better. And I think you just gave a very constructive approach to what can be done in the future. And that's greatly appreciated. And I want people to hear that.

This Committee is doing a lot of things. Sometimes there's things people don't like, and sometimes there's things people do like. But, nonetheless, it's, what are we doing going forward?

And so, this has been an after-action review. Lessons learned. And that's how you create the path forward. And I think you touched on many of those things. And I thank you for taking your time today to reflect on that.

I now recognize Dr. Miller-Meeks from Iowa for 5 minutes of questions.

Dr. MILLER-MEEKS. Well, thank you very much, Chairman Wenstrup.

And thank you to witnesses for testifying before the Select Subcommittee today.

And I am going to dovetail a little bit on what my colleagues just said.

Today being the last scheduled hearing for the Select Subcommittee, this is my fourth year on this Select Subcommittee. I would like to take a moment to thank Dr. Wenstrup and his staff for their incredible leadership throughout this Congress on investigating and evaluating the Federal Government's response to the COVID–19 pandemic.

Under his direction, we have held key agencies and witnesses accountable for their actions made during the pandemic, fulfilling the Oversight and Accountability Committee's mission to provide a check and balance on the role and power of Washington, and a voice to the people it serves.

I'm really proud of the work that we have done, and I look forward to another productive hearing. And, most importantly, the majority of us on this Committee understood that our mission was, in fact, to prepare for the next pandemic. And so, what has been brought up by Dr. Wenstrup and Dr. Bera is precisely that. I spent 24 years in the military, as well as a practicing nurse, doctor, former director of the Iowa Department of Public Health. And, if we don't look back on what we did and do an after-action report,

we don't know how to buildupon what has gone before, what our errors were.

Dr. Walke, you are the director of the Office of the Readiness and Response at the CDC where you support the agency's effort to improve performance for public health emergencies. And, as you likely know, as I just stated, I was the director of the Department of Public Health, and I was a practicing physician prior—before, after, and then prior to coming to Congress.

And I thank Dr. Bera for his comments about origins. Yes, we spent a lot of time on origins. But, even in 2020 as a freshman Congressperson when the media and social media was trying to portray this as a witch hunt, and it was useless, my comments in 2021 are the same as they are today. It was necessary to investigate origins because that's how we prepare for the next pandemic.

We need to discuss immediate disclosure, which the Chinese Community Party did not do and are required to do under international law. We need to discuss lab safety, what type of laboratory research occurs and what lab environments, and that it's in the correct lab environment. And, No. 3, we need to discuss the ethics of certain types of research, i.e., gain-of-function research. So that's why those were important issues.

And, you know, my next question is going along this line on how people were treated who engaged in conversations, not conformity of thought. During the COVID–19 pandemic, I administered vaccines to Iowans in all 24 counties in my district but never supported any sort of vaccine mandate or vaccine passport. And that's because I'm a physician first.

I was and still am critical of the CDC's messaging surrounding vaccines during the pandemic, largely because it inserted itself between the doctor-patient relationship, and it discouraged patients from asking questions. It downplayed and, in fact, refuted that there was infection-acquired immunity and herd immunity. People were labeled as antivaxxers, radicals, and called other demeaning terms simply for questioning whether novel vaccines that had not been FDA approved were right for them; or if they needed to be vaccinated if they'd already had proven disease and immunity; or if, because of their age—and we saw two of the expert—vaccine experts at the FDA resign over the FDA's position.

So, as a result, we have seen increased rate of vaccine hesitancy, which could have a detrimental impact on public health, especially as we're entering flu season. In most of my district, for example, rates of vaccine hesitancy are already at 15 percent. And, as a state senator in 2019 and 2020, I can tell you there were numerous bills entered and discussed about prohibiting vaccines.

So, do you believe that the CDC's, I'll call it forceful, to be diplomatic, guidance on COVID–19 vaccines, and lack of detailed information on possible adverse outcomes, like when they downplayed that there was myocarditis in young men, that it's contributed to the increasing rates of vaccine hesitancy?

Dr. WALKE. Thank you for the question. COVID vaccines have really undergone the most rigorous safety monitoring of any vaccine in history. And there are——

Dr. MILLER-MEEKS. I'm sorry. Please don't do that. Please don't do that. I'm asking you, how is the CDC going to overcome increas-

ing vaccine hesitancy? And talking to people about the most rigorous scientific protocol for COVID–19 vaccines is not going to end that hesitancy. They have people they talk to in their community. They have young people who have myocarditis. We have people who were kicked out of the military because they declined to get a vaccine when they didn't need it. I even was advised, even though I had strong antibodies, to get the booster. And I'm a physician and asking the physician, "Why in the world would you recommend this when you just tested my antibodies?" The purpose of vaccines is to confer immunity.

So, what is the CDC doing on vaccine hesitancy? Have you worked with outside stakeholders and providers? And how are you going to meaningfully reduce vaccine hesitancy?

Dr. WALKE. We are working with a number of different external groups to try to improve trust and try to overcome vaccine hesitancy.

Vaccines are incredibly effective and the best defense. We also believe that CDC makes recommendations for the general public. But that relationship between the provider and the patient is incredibly important to interpret that recommendation from a public health agency——

Dr. MILLER-MEEKS. I would wholeheartedly agree, which is what the CDC should have done and how they should have messaged during the vaccine, to leave that between the doctor and patient.

With that, I yield back. Thank you.

Dr. WENSTRUP. I now recognize Mr. Mfume from Maryland for 5 minutes of questions.

Mr. MFUME. Thank you very much, Mr. Chairman. I want to thank you and the Ranking Member for leading us through these last 2 years of this Subcommittee. And I think it's fair to say that Members on both sides of the aisle have had an opportunity to express themselves but also an opportunity to listen to and, at different points, appreciate the positions of other Members of this Committee that may not be in line with ours.

I want to thank, in particular, the Ranking Member for leading us toward a minority report, which as we know submitted and carried the best thinking, the thoughts, and the position of those of us on this side of the aisle. And just both of you for the way you have worked together and the example that you have put forward.

I always talk about real time when I get a chance to speak here on this Committee. Because COVID was real time. And there was no playbook. There were no real guidelines. And we learned, and we made mistakes in real time.

The one thing that I do want to preface of my remarks is that we must never, ever, ever forget the millions of people who died here and all over this globe as a result of this pandemic. We don't talk about them that much as we get further and further away. But we cannot do an autopsy of what we went through without mentioning the fact that so many lives, so many families were and still are affected by this.

So, we have a special calling, I think, to find in a bipartisan way those things that will help us in future years as we look back on this. And it is important, in many respects, since we are no longer in real time of a disease, that we do that autopsy, do it the right

way, and make sure that this Congress, at least, leaves behind at the conclusion of the Select Subcommittee, a path and a way forward, and a number of suggestions and other things that will help us well into the future.

Now, I think it's, for me at least, always important to make sure that there is a public record established, and sometimes it means through redundancy.

So, I want to speak directly to you, Dr. Walke, Dr. Tabak, maybe Dr. Marston, and be a little redundant here. But redundancy is important because, if, in fact, in your positions and if, in fact, with the expertise that you bear, that you say what you said prior to this meeting over the last several years, but that you say it one more time.

So, Dr. Marston, Dr. Walke, give me, please, what you believe is the way that we can, in this Nation, persuade the public that approved vaccines are safe and effective while taking into considerations the things that come up after the issuance of those vaccines that call attention to special groups or special circumstance that then ought to be rolled into how we move forward. Either or both of you if you could.

Dr. WALKE. Thank you for the question. Related to mistrust around vaccines, a Federal agency like CDC can make recommendations for vaccines and through—and with our other agencies create the scientific base so that they are the best defense against hospitalizations and death.

But I remember when I was in the emergency operation center in 2000 watching the deaths climb. And then, when vaccines became available, I saw the rates go down. And it was tremendous. It was magnificent. But then the distrust and the miscommunication around vaccines started, and we saw those death rates plateau.

A Federal agency can only do so much. It requires healthcare providers. And that relationship, it requires communities, leaders in the communities, and various different types of leaders actually to trust in leaders——

Mr. MFUME. Well, let me interrupt you here. I'm also trying to get to what happens when there are new developments after the issuance of a vaccine? The gentlewoman from Iowa spoke about enlargement of the heart syndrome and how that was believed to be affecting certain groups. When those types of information come forward, how do you evolve then your presentation of the evidence or of the vaccine? Because, if not, there's going to be continue to be a great deal of mistrust.

Dr. WALKE. I'll start. Again, we have these adverse events, surveillance systems in place to detect any adverse event. And then we have other systems in place to try to see if there is a cause, if myocarditis was related or not. And, once we have that type of information, we try to push that out in various ways, including the scientific publications but also through, again, various state and local leaders to try to engage with their communities.

Mr. MFUME. Is that what we did?

Dr. WALKE. That is what—we had a multiprong approach to try to communicate the risk related to vaccines. But, again, I think we have a—there is a number of different communities in our country,

and we need to do better, I believe, at trying to reach those communities to talk to them about what are some of the issues they have with vaccine.

Mr. MFUME. Dr. Tabak——

Dr. WENSTRUP. If we can, your time has expired, but I do want to let Dr. Marston reply as well. I think it was a very important question that you asked, and I would like to give you opportunity to reply.

Dr. MARSTON. Thank you, Mr. Chairman, I would be glad to. So, the truth of the matter is that we worked quite closely with the CDC on these matters. And the most important lesson, I think, that we have learned is to show our work and explain our work.

For example, when we see a safety signal in something like VAERS, we're going to look in our multiple systems to see if that actually is something that is plausibly related to the vaccine. Where then, we then have multiple cases, taking those analyses and put them into the published literature, we also present them at advisory committees.

I think one of the things that we are also looking at is that that's not good enough, right? So that reaches a certain group of people. The people who are regularly reading the medical literature, for example. We need to take it a step further, right, and communicate those things on multiple levels so that they're easy to understand.

So, one of the things that we've been doing is working with the clinician community, trying to make sure that they're armed digestible information that they can then relate at their patients. Because, you know, people might not be listening to the Federal Government, the public health agencies. I hope that they will. But we also want to make sure that we're meeting people where they are. And, if that's with their local clinician with their physician, with their nurse, we want to give those people the info they need.

Mr. MFUME. Thank you. Thank you for the extra time, Mr. Chairman.

Dr. WENSTRUP. I now recognize Mrs. Lesko from Arizona for 5 minutes of questions.

Mrs. LESKO. Thank you, Mr. Chairman. Before I ask questions, I want to say thank you to the Chairman Wenstrup. Both he and I are ending our careers in Congress, and so I really appreciate all the work that you've done. I think this has been a very important Committee, and thank you for inviting me on it.

I also want to thank the other Members, including the Ranking Member, Dr. Ruiz. It's been an honor serving with all of you.

Now, I'm going to get to my question.

Dr. Tabak, I want to followup on what Chairman Comer asked about and Dr. Morens. It does appear to me from previous testimony and questions that our staff—that he violated rules, whether that's FOIAs. He was trying to get around FOIAs. It appears that he was trying to help EcoAlliance, EcoHealth Alliance I should say. And why can't you fire him? I don't understand why it hasn't happened already.

Dr. TABAK. We are following our process.

Mrs. LESKO. What is the process? How long does it take to fire somebody?

Dr. TABAK. We follow our process.

Mrs. LESKO. What is the process?

Dr. TABAK. The individual is accorded the opportunity to be present their side of the facts.

Mrs. LESKO. Right.

Dr. TABAK. An individual is then charged with making a decision as to what should occur. Again, this is hypothetical, of course, in terms of—I can't discuss any specific case.

Once that decision is provided to the individual staff member, he or she is allowed to appeal that decision, and then that goes to a second official for a final adjudication. So, we're following our process, and that's what we're doing.

Mrs. LESKO. Has this process been started?

Dr. TABAK. I'm not allowed to discuss any specifics of the process. Over——

Mrs. LESKO. Well, I hope you understand, sir, why, you know, myself and the American public just don't—they think this is not a good policy because.

For instance, in a regular company or business, if somebody violated the rules, you just get fired. Right? And so that's why I think some of the actions that are being taken with the next Administration are probably happening because the American public just don't understand why somebody who seems to have clearly violated things, you know, the answer is just, "We're following the process."

But my next question is actually for all of you in the little over 2 minutes I have. The Americans have decreased trust, less trust in the Federal health agencies after COVID. And I want to know from each of you if you or your agencies believe that you played a role in that, and if so how are you going to change it?

Dr. TABAK. Well, since I have my mic on, I'll start. Of course, this was a very fluid situation, as you, of course, appreciate from your work on this Committee. And we understand that we have to do a much, much better job of being more transparent, of doing better communication, of getting into communities, working with trusted partners in communities. You just can't so-call parachute and expect people to benefit from your wisdom. You have to have a real conversation with them in a transparent manner.

Dr. WALKE. I would agree with Dr. Tabak. Trust is critical for a public health agency. There is a number of—the pandemic was moving quickly. The virus was changing rapidly. We were putting out a lot of guidance almost weekly. And it became very difficult, even, to find the information that was needed on our CDC.gov website. We have made changes. We try to be a lot more transparent. We have streamlined, actually, our website by about 60 percent. We tried to move to make it more plain language so it's more accessible to the American public. So, we acknowledge that there are challenges here, and we are responding to them.

Dr. MARSTON. Yes, I would agree as well. I think one of the things that we've been working on is how to work in concert with individuals who are in other settings, clinical settings, the individuals right before us right now, people who also have the ear of the American people, and trying to make sure that we're putting out information that is both high quality, up to our scientific standards, and digestible.

Mrs. LESKO. Well, thank you all for your answers. I would say that it is important to be more transparent—and that was goes back to my question about Dr. Morens, I mean, just saying procedures. Now maybe there's legal consequences. But that's like not a very transparent answer in my view.

Also, I want to suggest to all of you, hopefully, you've heard it before from me is that government mandates—that backfired. I mean, I don't think there should be government mandates at all. I don't think they should be suggested because people don't trust the government. And so that made people less trustful of the government in my view. And so, with that, I yield back.

Dr. WENSTRUP. I now recognize Mr. Garcia from California for 5 minutes of questions.

Mr. Robert Garcia of California. Thank you to our witnesses. I want to thank the Chairman and the Ranking Member of the Subcommittee for all of their work. And, obviously, oftentimes Members on this body and Committee disagree. I think it's important to recognize we lost 1.3 million Americans due to the pandemic, our single largest loss of life event that we've had in the modern era. There's over 3,000 people in my own city of Long Beach died while I was the mayor right before I got to Congress. Horrific experience to see what the pandemic did for cities and communities across the country and, of course, the world.

I want to note a couple of things as this is our closing. This Committee, I think, one is—I'm hoping that there's two critical changes that I think are really important on the Federal level, bills that I've been working on. I want to note this for all of you. I am very concerned that still the Department of Health and Human Services does not have the same emergency buying power the Department of Defense has.

When we went through the pandemic, much of the purchasing of PPE and testing went through DOD because they have emergency power to purchase in bulk and purchase and kind of cut the red tape. That power does not exist for Health and Human Services, where I personally and many others believe is where those purchases and where that direction should be coming. It should be coming HHS, not from DOD. At least it should have the same purchasing power. So that's something that we're working on. We have a bill on that.

The second issue I want to note for Members of the Committee is we have to get to a point where we fully fund the CDC's National Wastewater Surveillance System. I can't express how important this is in preventing future pandemics. This is woefully underfunded. And we have a huge opportunity to allow and provide the CDC the resources they need to ensure that we are using this incredible resource now and being able to track viruses and pandemics to the future, and they were funding this at its full level, and not actually cutting the CDC and this program. So those are things that are very concerning to me.

And I want to say one other thing which I think is important, my last opportunity. Dr. Tabak, I know you're with the NIH. And I just wanted you to just briefly mention what the NIH's responsibility is to prevent pandemics that this Committee is working on?

Dr. TABAK. So, we support and conduct the research that informs the actions of my colleagues on this panel. We do long-term basic discovery to learn about viruses. We develop key infrastructure so that we can be responsive in identifying newly emergent organisms. We set up appropriate model systems to test the efficacy of potential countermeasures. We have a GMP manufacturing facility. And——

Mr. GARCIA. And, Doctor, I would be correct to assume that this is a completely nonpartisan organization. The work is essential to our Nation's security and preparedness. I have met folks that I have worked with at the NIH and immense respect for the scientists, doctors, workers that are there. Would you agree it's a completely nonpartisan type of work.

Dr. TABAK. Yes, we certainly are not.

Mr. GARCIA. Then I want to just leave us a final thought. I'm very, very concerned that someone that can be entrusted with Nation's health—RFK, Jr.—has recently said, and I quote, that he plans to have a big role in the administration as it relates to health, and has just days ago pledged to gut the NIH, firing hundreds of scientists and researchers on day one.

[Chart shown.]

Mr. GARCIA. And I am going to show—this is from ABC News—the headline that just appeared a few days ago. If we're talking about pandemic preparedness—and with all due respect to the Committee and the work—the fact that we're considering to bring somebody on with no scientific or medical credentials, who has falsely claimed for decades that vaccines cause autism, who has quite frankly said just outrageous comments about science and medicine, that this person would come in to gut the NIH, I think is shameful. I think it's shameful.

And, Ms. Greene, you can clap all you want. But it is shameful; it's dangerous. And, if this Committee is about pandemic prevention, we should be very concerned as a country that RFK, Jr. could be put in charge of health when he is a vaccine denier and has caused great harm to the American public.

I want to say just, finally, that I'm very concerned that someone that wants to gut the NIH, HHS, and other services could be put in charge of health, of any kind, in this country.

So, I want to thank you, sir, for your service at the NIH and for all of the witnesses that are here.

And, with that I yield back.

Dr. WENSTRUP. I now recognize Mr. Cloud from Texas for 5 minutes of questions.

Mr. CLOUD. Thank you, Chairman, and thank you all for being here to discuss the lessons learned throughout the COVID pandemic. Together you all represent the bulk of the government's response to COVID, or you represent the agencies that were bulk of the response. And the American people are very concerned about the government's response, you know. There was a lot of understanding in the first couple of weeks that this was novel, and we had to figure it out. But, once the outbreak kept going, we saw attempts to cover up failures. We saw blatantly politicized policymaking. We saw Americans getting deceptive advice while their civil liberties were being trampled on. Federal public health agen-

cies promoted school closures that caused long-term learning loss and mental health problems. Forced mask mandates on toddlers in the face of all scientific evidence to the contrary. Threatening Americans with the loss of their livelihood. Their businesses were closed if they declined new—any experimental vaccine. Along with many, many, many other grievances that the people would have in the response that we had.

Now, we got together on Tuesday just so the Chairman can let us know that this hearing was going to happen, and someone asked the question and said, "What do you think the lessons learned are going to be in the testimony?" And I kind of jokingly replied, "Well, I'm guessing like every other agency that makes a mistake or has failures in the Federal Government, they'll probably come and same, 'Well, we need more money and more authorities.'" And that's by and large what the testimony was today. And I'm not saying those discussions don't need to happen at some point. I mean, it would be very suitable for the Appropriations Committee. But what we didn't see was an answer to these questions that remain outstanding for the American people. And, in an effort to rebuild trust, it's very important that we answer these questions.

Dr. Tabak, I wanted ask you one of the things that we—that came up in much of our testimony—Dr. Fauci and Dr. Collins both indicated to this Committee that, even though their signatures appear on every grant, basically the process is that you have people researching the grants, right, at a lower level, and basically they put it before a committee or a peer-review committee that receives a priority score. Then it goes to an advisory council. And then it goes to—at the time it was Dr. Fauci, for example, when we were talking about the NIH grant.

Now, this is one of many cases. I've seen this in agency after agency after agency. These are supposed to be multiple levers of accountability. And what happens is Dr. Fauci, for example, said, "Well, yes, my name's on it, but, you know, I don't have time to read every grant." And that's kind of understandable. Well, then who is responsible for it? Well, it's this Committee. Well, this Committee votes on it. Like block grants to the tune of even sometimes a hundred grants at the same time. They don't actually read it either.

And so, we end up having these supposed multiple layers of accountability that turn into multiple layers of plausible deniability. So, nobody ends up being held to account. And so, when we're talking about lessons learned, these are the kind of systemic things within agencies that I would like to hear: What are we doing to fix these things? What are we doing to make sure that we don't tread on people's civil rights again? What are we doing to make sure that we don't threaten the licenses of medical professionals who are experts in the field that might have a different view?

These are the kind of things that I'm wondering, how are we going to make sure that the government stays in check so that we can begin to restore the trust in the American people?

Can you speak to the grants system, and has anything been done about that? Because I brought this up in several Committee hearings since then.

Dr. TABAK. So, again, you described the way grants are reviewed.

Mr. CLOUD. That's my point, though. My point is that needs to change. So, you know, we brought this up in a number of Committee hearings how broke this process is. Are you doing anything to fix those things? Are you doing anything to fix these other—before you come in and ask is for money, we still have a guy who committed perjury before Congress who is still there. Now I understand some of that's statutory, and maybe we can work together to streamline that process. So, I'm not putting that on you.

But, when it comes to like we're going to ask the American people to fund some of these ideas you have, right, I am concerned about the government having more data I will say. But what can we do in—I mean, feel free any of you jump in, to fix these systemic problems so we can—before we go ask the American people to fund this, what are we doing to fix the issues that tread on their rights, that took their jobs, that failed their businesses, that took their medical license, all these sorts of things.

Dr. WALKE. Thank you. I would just start and say that we have reflected and looked at our internal processes and made a number of operational changes, including related to revamping our communication. I talked about trying to clean up our website and make it more accessible. We've improved our test development process and had better partnerships with the private sector. We actually have mechanisms in place now where the H5N1, we are trying to work with other partners, with private industries and develop new tests for H5N1 and for Oropouche.

We've refined our guidance processes in the way we're sharing with external partners and trying to make standardized across all of CDC and internal to CDC. When we deployed staff all around the Nation, we had difficulty with the way we did that. So, we have actually changed the way we actually are deploying our staff. And so, all of our staff are moving toward operational readiness, readiness to respond. So, we have made a number of changes at CDC.

Mr. CLOUD. My time is up.

Dr. WENSTRUP. I will allow anyone else to answer that.

Dr. TABAK. Again, the changes we have made are to enhance our oversight of the awarded grants. Because where we ran it into difficulties was the failure to catch certain things along the way with the application that we, you know, talked a lot about in these hearings. And so, we do have now more fail-safe signals within our system to prevent oversight of not having a progress report done in a timely manner, making sure that it's reviewed in a timely manner, and ensuring that we can't refund the grant if all the progress reports haven't been received and reviewed and signed off on. Those are the types of things that we've done.

Dr. MARSTON. Sure. We've certainly taken a look at number of our practices throughout the pandemic. We've been building on what's worked and moving away from things that are maybe not as effective.

So, for example, trying to make sure that we are as transparent as we can be in our reviews, putting our work out. But then building on that and not just putting out a memo that's, you know, digestible to a certain portion of population, but actually taking that a step further and doing that actually in concert with our colleagues at the CDC.

Second, Emergency-Use Authorizations. Now everybody knows about EUAs. But, coming into the pandemic, they had really been used for Zika and Ebola diagnostics for the most part. So, we learned a lot about Emergency-Use Authorizations, and the importance of communicating early and often with manufacturers and putting out our thinking in advance so they weren't guessing about what we would need to see.

And then, third, as I said, supply chain. We have learned lessons about the gaps that we have in our understanding of where products are coming from and the vulnerability that that creates for the healthcare system.

Dr. WENSTRUP. If I can just add to that. I think it's important for discussion. I think it's in line with what Mr. Cloud was saying. You know, in some ways, through testimony from people involved, you know it would be like me signing a prescription I haven't read. That's a problem. That's a problem. The buck has to stop somewhere. And these are things that I think we really need to fix.

I now recognize Ms. Tokuda from Hawaii for 5 minutes of questions.

Ms. TOKUDA. Thank you, Mr. Chairman.

You know, during the pandemic, medical countermeasures like diagnostics, vaccines, and therapeutics were essential for responding to COVID–19 and saving lives. Research and investment into developing these medical countermeasures even before COVID–19 hit our shores, quite frankly, gave our public health workers the critical tools they needed to keep pace with the virus.

So, with that in mind, I'd like to discuss efforts by your agencies to lay the groundwork for rapid medical countermeasure development for if and when, quite frankly, the next pandemic strikes.

Dr. Tabak or Dr. Walke, what kind of research are you folks doing investing to prepare in the next generation of medical countermeasures for future novel viruses? And, quite honestly, are we already behind the curve due to cuts and misinformation that were experienced during the previous administration? Are there concerns about public acceptance of these countermeasures when they need to be executed as a result of a lot of the disinformation that we've also seen?

Dr. TABAK. Perhaps I'll start. So, the first step is you have to identify the offending pathogen, and you have to invest in representative viruses from nine different viral families in order to cover the landscape of viruses that are circulating the globe. And, once you do that and learn as much as possible about them and understand their lifestyle, you can begin to think about where you can intervene through so-called countermeasures. So that's a big part of what NIH does. We develop model systems so that potential countermeasures can be rapidly developed. And then, of course, we stand up clinical trial networks to ultimately see if there is efficacy of proposed countermeasures in humans. But let me turn it to my colleague now.

Dr. WALKE. A couple of comments. CDC's role in medical countermeasure development is more on the back end after actually have medical countermeasures through clinical trials, and then they're introduced to the public. We do a lot of work on vaccine effectiveness, real-world vaccine effectiveness around the Nation.

And so, we stood up those networks quickly to try to understand the effectiveness in various populations related to the vaccine. And we do similar work actually with other medical countermeasures.

Ms. TOKUDA. Now very briefly because I have limited time here. Knowing that what we know now as a result of going through the COVID pandemic, do you feel that we are on track in terms of really understanding those potential offending pathogens and where we need to be—when, quite frankly, that next pandemic could strike, are we prepared to be able to execute with fidelity to the public that would be accepting of these countermeasures as well? Just say yes or no if, right now, are we prepared for what will come next given our current capacity?

Dr. TABAK. We're better prepared.

Dr. WALKE. We're more prepared than we were. Absolutely.

Ms. TOKUDA. OK. So, we're more prepared right now. I will tell you I am very concerned, as Representative Garcia mentioned, that the incoming administration is already proposing to streamline NIH, including restructuring the agency's budget and bypassing its intense peer-review system, all critical to really create these countermeasures that we are talking about that will save lives. I'm very concerned that any attempt to overhaul our Federal agencies in this matter will result in the loss of our best and brightest scientists, and threaten the quality and integrity of our agencies' research and ability to execute to a public that needs to hear from the very best and brightest in our country.

Dr. Tabak, how important are sustained Federal Investments, not funding cuts, but sustained Federal investments and public trust in science and scientists to your agencies' work in preparing for future health threats. Just a brief response.

Dr. TABAK. History has shown that the sustained investment is what attracts people to biomedical research and keeps them into the biomedical research work force.

Ms. TOKUDA. Thank you.

And, Dr. Marston, how would funding cuts, coupled with anti-science and anti-vaccine sentiment affect FDA's work in responding to future health emergencies?

Dr. MARSTON. Well, I think that one of the things that we've seen through the course of the pandemic is how stretched that we were pulling from every corner of the FDA. Funding cuts will result in exacerbation of that.

Ms. TOKUDA. Thank you. So honestly we need quite a bit more resources and capacity to really combat what will ultimately be on the horizon for us.

And, while I've appreciated the forward-looking focus of this hearing, I must point out that the incoming administration poses a serious threat to undo all of the progress that our witnesses have discussed with us today.

Under the false pretense of making America healthy again, President-elect Trump and RFK, Jr., have committed to an extreme agenda that promises to hamstring our Federal health agencies and the essential work to keep Americans safe. We cannot let that happen. And I urge my House Republican colleagues who have spoken in favor of public health and pandemic readiness today to

stand against the dangerous agenda and support critically needed investments, not cuts, in pandemic preparedness.

Thank you, Mr. Chairman, I yield back.

Dr. WENSTRUP. I now recognize Dr. Joyce from Pennsylvania for 5 minutes of questions.

Dr. JOYCE. Thank you, Chairman Wenstrup, and Dr. Ruiz, Ranking Member, for convening this important hearing and to our witnesses for testifying.

During this Committee's investigation of the Federal response to the COVID–19 pandemic, it has become abundantly clear that throughout the pandemic, many decisions and many statements made by public health officials were not based on science. When Federal officials manipulate or ignore data in order to fit a narrative, it fractures the trust between the American people and our public health leaders, and it hinders our response to developing an adequate ability to address potential future pandemics. And the trust, we all recognize from this investigation, from these hearings, has been fractured.

During the rollout of the COVID–19 vaccine, then CDC Director Dr. Rochelle Walensky reported that according to data vaccinated individuals both did not carry the virus and that they did not get sick. This is not consistent with what clinical trials and real-world data showed, which is that, while the vaccines can be somewhat effective, vaccinated individuals still carry the virus, and vaccinated individuals still can become sick, and vaccinated individuals can still transmit the COVID–19 virus.

Dr. Marston, in order to prevent misleading statements, such as the ones that were made by Dr. Walensky, how can the FDA more effectively communicate the conclusions of clinical data used to approve new vaccines?

Dr. MARSTON. Well, I appreciate your question. And, first, I'd like to say these vaccines—no medical intervention is perfect. And I think it's been said to this Committee before that drinking too much water can cause water toxicity, right? And we just have to recognize that. That being said, these vaccines——

Dr. JOYCE. We're not talking about water and water toxicity. We're talking misinformation.

Dr. MARSTON. So, I think each medical intervention needs to be taken one by one. Look at the benefits of those and the risks of those. So, the benefits of these vaccines are very important, right? We believe that there would have been an additional 3.2 million deaths had the vaccine not been rolled out. Incredibly important, hospitalizations on top of that.

We also need to recognize and be transparent about the risks that are there. So, for example, we discussed some of the work that we do trying to put out our analyses of risks that we're seeing in our various data bases, putting those into the public literature, the published literature; we have done that on a series of recent cases.

For example, in the New England Journal, in the CDC's MMWR. So, we try to make sure that we're putting out that information in our latest thinking on a regular basis.

Dr. JOYCE. So, you talk about that collaboration.

Dr. Walke, are the CDC and the FDA regularly communicating and sharing information in order to ensure that CDC vaccine guid-

ance is consistent with the scientific evidence and the clinical data that the FDA is using to review and approve new vaccines?

Dr. WALKE. CDC and FDA have a close working collaboration.

Dr. JOYCE. How often does that occur?

Dr. WALKE. We're a large organization, and so we different——

Dr. JOYCE. Is it daily? Is it weekly? Is it twice a week? You talk about a close collaboration. I just need to know, as a Member of Congress, how close is that collaboration?

Dr. WALKE. During the COVID response——

Dr. JOYCE. How close is it now? We're talking about being prepared. How close is that collaboration?

Dr. WALKE. It's very close.

Dr. JOYCE. Again, timeline. We need that information.

Dr. WALKE. On a weekly basis.

Dr. JOYCE. And these are weekly meetings? Is there face-to-face meetings that you hold on a regular weekly basis?

Dr. WALKE. At various levels of our organizations, we do meet on a regular basis.

Dr. JOYCE. I find "regular" to be a really broad reaching term. And, by failing to effectively communicate the clinical data and the results behind the COVID–19 vaccines, the CDC and the FDA have contributed to growing vaccine hesitancy among the American people, including from routine childhood vaccinations. The culpability lies within your agencies. And the responsible stewardship of Federal funds is critical to the American trust in public institutions. And, unfortunately, the NIH and the NIAD have completely failed to exercise effective oversight of EcoHealth Alliance when they receive grant funding for research of novel coronavirus, which was conducted at the Wuhan Institute of Virology.

Dr. Tabak, how is the NIH improving oversight of grant funding to ensure the failure seen like the EcoHealth Alliance would never happen again?

Dr. TABAK. We have restated the requirement that subawardees, which was an example of Wuhan Institute of Virology, are required to provide all data in a timely manner. We have made it clear to our staff that progress reports need to be reviewed in a timely manner and have put so-called red flags in our automated systems to ensure that a grant can't be renewed if there's an outstanding that has not been reviewed or re——

Dr. JOYCE. Please define defining manner——

Dr. TABAK. Say it again?

Dr. JOYCE. Please define what is in a timely fashion? You've said that twice to me. What is a timely fashion? A response before the computer puts up a red flag.

Dr. TABAK. The timing for this is—when you are coming to the conclusion of a year's period of funding, you are supposed to provide a progress report. And I believe the window is 2 months. I would have to get back to you.

Dr. JOYCE. Please get back to us. Because you're saying, at the end of a year, you're given an additional 60 days to be considered providing timely information?

Dr. TABAK. That's correct because it allows you assemble all the——

Dr. JOYCE. What happens if they don't?

Dr. TABAK. And that's the point. Now——

Dr. JOYCE. Indeed, it is the point. What happens if that is not provided?

Dr. TABAK. Then they are contacted. We try and find out what is the hang-up. And, if they don't provide it, then they cannot get the next amount of funding.

Dr. JOYCE. I think it's clear in the aftermath of our Federal COVID–19 response, you need to do a lot of work. There's significant work to be done to repair the trust between the American people and our public health infrastructure. And, in order to earn that trust, public health officials must learn from these large mistakes. And it is my hope that the work of this Subcommittee will help identify a path forward when responding to the next public health emergency. My time has expired.

Mr. Chairman, I thank you, and I yield back.

Dr. WENSTRUP. I now recognize Ms. Ross from North Carolina for 5 minutes of questions.

Ms. ROSS. Thank you, Mr. Chairman, and the Ranking Member.

And thank you so much to our witnesses for joining us today. Your agencies' tireless work over the past 4 years allowed us to overcome the COVID–19 pandemic and its devastating impacts on the health and the economy of our Nation. I would like to discuss these efforts a bit—in a bit more detail so that we can continue to identify essential lessons for ongoing work of pandemic prevention and preparedness.

I'm not going to ask Dr. Tabak about the NIH's work on the vaccine because I think that's been covered. But I would like to again remind everybody that, according to one estimate, the COVID–19 vaccine has saved more than 3 million lives and prevented more than 18.5 million hospitalizations.

But I would like to turn to Dr. Marston about how the FDA has continued work to review and approve updated COVID–19 vaccines to help keep Americans safe from new variants as they go about their day-do-day lives.

Dr. MARSTON. Thanks so much for the question. We have been working in concert with the CDC and their surveillance system to understand the viral evolution and its potential impact on vaccine related immunity. We have, on a regular basis, had our advisory committee meet and look at that information, advising us on what the composition of an additional vaccine should be. We have seen in repeated studies that those booster immunizations are important and that they are saving lives.

One study in Denmark, for example, showed that individuals who had gotten a boost at the time of the XBB variant had one quarter the rate of hospitalizations of those who did not. Very important public health intervention.

Ms. ROSS. Thank you very much. And, moving to the CDC, we know that the CDC played an essential role in the rollout of the COVID–19 vaccine, which got hundreds of millions of shots in arms and amounted to the largest vaccination campaign in our Nation's history. Of course, we need to encourage people get those boosters now too. So, if you haven't gotten your booster, please get your booster before the holidays.

But Dr. Walke, how did the CDC work on the COVID–19 campaign and use that campaign to reach into communities to allow us to reopen as quickly as possible?

Dr. WALKE. Thank you for the question. Eighty percent of CDC's funding from Congress on the domestic side goes out to states to build state and local infrastructure and preparedness. Those states actually do a risk assessment and try to identify those populations that are at greatest risk when there is an emerging threat. They also do a number of different exercises to try to distribute that last mile of medical countermeasures. And so, we activate it. There are state and local relationships and that infrastructure to try to distribute the COVID vaccine. We also do a lot of work, as I've talked about before, related to vaccine effectiveness. And that was another key role, real-world effectiveness, that CDC played.

We did see that it was difficult to reach some populations more than others. And so, understanding where those communities at greatest risk were, who are being affected, who were hard to reach, really that relationship between local and state health departments with CDC was invaluable to try to identify those pockets where vaccine was not being distributed and then to quickly try to rectify that situation.

Ms. ROSS. Thank you for that. And I clearly saw that in my home state of North Carolina. And now, of course, we have Dr. Cohen at the CDC.

I also want to express how grateful I am for the CDC's efforts to take lessons learned during the pandemic through the Moving Forward Initiative and use them to inform future-oriented policies that will leave the country better prepared for the next pandemic.

To ensure and continue these critical preparedness efforts, Congress must act to provide additional support to our public health infrastructure. While public health emergencies can trigger critical supplemental funding for agencies, the funding structure is not conducive to preventing future pandemics.

For example, CDC jump-started an innovative wastewater surveillance program during the pandemic through the use of emergency supplemental funds. Once this funding dries up, the agency will no longer have the resources to continue this program. We must ensure that tools like this are fixtures of our public health strategy rather than waiting for emergent situations to implement them.

Another key area that the CDC has focused on is improving our disease testing infrastructure. To enhance these efforts, Congress must act to improve the supply of medical laboratory personnel, a profession that played an indispensable role during the worse days of the pandemic and is currently facing a serious work force shortage.

I proudly introduced, and Dr. Bera has joined me in it, the Medical Laboratory Personnel Shortage Relief Act of 2024, which would do just that. It's clear that Congress can take steps to complement the tremendous efforts made by our public health agencies to ensure that we're ready for the next pandemic.

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

Dr. WENSTRUP. Thank you.

I now recognize Ms. Greene from Georgia for 5 minutes of questions.

Ms. GREENE. Thank you, Mr. Chairman. This Committee hearing today is titled "Preparing for the Next Pandemic: Lessons Learned and the Path Forward."

I think one of the greatest lessons that has been learned here is the government and its powerful agencies should never use the American people's hard-earned tax dollars to create viruses that can be unleashed on the world like COVID–19 was. This led to killing millions of people all over the world.

COVID–19 was funded using the gain of function in a bio lab in China, and then it was lied about. Dr. Fauci lied to the American people, abusing his power and position and role, very powerful role paid for by the American tax people. He lied, and many, many people died. Not only that, schools were shut down. People's jobs were shut down. Employment was ended. Small businesses were shut down. Life as everyone knew it was shut down. This caused violations of people's First Amendment rights, freedom of speech, freedom of religion. People couldn't even go to the beach.

Then suicides hit record highs. And the saddest thing is there were record suicide rates seen among children and a mental health crisis released on Americans like never before.

Now there's massive delays in education and loss of learning. What was absolutely repulsive is the forced masking requirements of children. Children were not at risk of being hospitalized or dying from COVID–19, yet children became one of the worst victims of the malpractice and abuse of power by your agencies and by people in charge in many cities, states, and the government. It was absolutely horrendous.

But then there were doctors that came out with treatments using ivermectin, zinc, vitamin D, and it was labeled horse paste. And those doctors were attacked and criticized and called conspiracy theorists. Yet, while those doctors were actually saving lives, these other patients were being forced into the hospital, put on respirators, and were actually dying.

My own personal doctor never lost one single patient by prescribing ivermectin and this other protocol. As a matter of fact, he saved people's lives. Thank God he did that.

The CDC even changed the definition of "vaccine." The FDA approved an experimental vaccine through a rushed approval process that suppressed trials and data that showed that vaccines didn't work and had side effects that even caused death.

Fifteen pages of known side effects the FDA wanted sealed for 75 years. What were they hiding and lying about to the American people? Well, we know now.

Vaccines have been mandated on the population in order to work, go to school, and live as functioning citizens in the United States. Yet people who reported vaccine injuries and deaths on the VAERS system were ignored; they were mocked; they were called conspiracy theorists; and they were canceled on social media when they tried to tell about the horrifying things that were happening to them or their family members.

The White House even accused the unvaccinated of killing people, calling it a pandemic of the unvaccinated. And they said we'll bring a winter of death for yourselves, families, and hospitals.

But guess what? Vaccines didn't work. And those that were vaccinated, boosted, continued to catch COVID. Our own President, President Biden even tested positive for COVID–19 after this summer's Presidential debate. That is unbelievable. And I can tell you, when you talk about vaccine hesitancy, as one sitting before you that never took the COVID vaccine, nor will I take it—thank God—I'm so glad I didn't take it—yes, this vaccine hesitancy has risen to new heights. And I can tell you right now, I'll stand here and represent all the Americans that do not ever want to be forced to take another vaccine that the government is telling us to take after they created a deadly virus. I can tell you right now, I'll also represent all the Americans that never want their children to be forced to be vaccinated.

Currently, right now, the CDC is recommending the children as young as 6 months have two doses of the Moderna COVID–19 vaccine or three doses of the Pfizer COVID–19 vaccine. So, vaccine manufacturers continue to make billions and billions of dollars on a vaccine that doesn't work being forced on children, innocent children that don't even need it because they aren't at risk of being hospitalized or dying from this vaccine.

Not only that, vaccines need to be investigated further. The rise of autism, learning disabilities, neurological problems, and so much more that children are suffering from today absolutely is being forced upon these children and their families because of these vaccines.

This Committee should have investigated the vaccines, and it was a failure to not do so. This has literally been a war on the American people's health, the world's health, but also a war on our children's health. It's a war that has been waged on them by our government, Big Pharma, who's making all the money.

Preparing for the next pandemic is actually recognizing that the last pandemic resulted in crimes against humanity. People that perpetuated and continue to perpetuate these crimes need to be prosecuted. And that needs to be starting in the next administration. And I'm pretty sure our next Attorney General will do that. And I look forward to seeing that happen.

Mr. Chairman, I yield back the remainder of my time.

Dr. WENSTRUP. I now recognize Dr. McCormick from Georgia for 5 minutes of questions.

Dr. MCCORMICK. Thank you, Mr. Chair. May I say it's been a pleasure working with you on this Committee, as well as in Congress. I wish you all the best in your new endeavors.

When this pandemic began, I wasn't in Congress. As a matter of fact, when this pandemic ended, I still wasn't in Congress. I was serving in the emergency department in the Atlanta suburbs as an ER doc doing night shifts the entire pandemic.

From beginning to end, we learned some things. And I am going to ask you in a very concise way to state what you learned during this pandemic. Because we come to an end. And really this whole Committee has been about what we learned. I hope we have learned some valuable lessons, and we can admit humbly where we

made mistakes. I know doctors made a lot of mistakes in treating patients.

So, very briefly, Dr. Walke, what did the CDC learn? And make that in 30 seconds, if you can, just an overview. What really did you learn that you did wrong?

Dr. WALKE. Thank you for the question.

We learned a number of things through COVID. We learned that, as the virus changed, we needed to also put out a lot of different guidance. And, unfortunately, our guidance was more technical than—the public actually had difficulty understanding. And so, we've actually made some changes to try to streamline that guidance and make it more understandable for the American public.

Dr. MCCORMICK. Would you say that you could've admitted maybe to making some mistakes in interpreting the data and the science?

Dr. WALKE. You know, the COVID pandemic——

Dr. MCCORMICK. I hope you'll say the right answer, because it's going to be really important to the follow-on conversation.

Dr. WALKE. The COVID pandemic happened over multiple years. We certainly made mistakes during that time.

Dr. MCCORMICK. Thank you.

Dr. WALKE. We quickly tried to rectify those mistakes, and we learned and tried to get better throughout the response. And we continue to do so. We revamped our communication, as I've said. We've improved our test development process. We've refined our guidance——

Dr. MCCORMICK. Didn't want to know what you did better; I want to know what you did wrong. Because that's how we learn, right? I understand what you did better because we admit to our mistakes.

How about the NIH, Mr. Tabak? What did the NIH learn that we did wrong?

Dr. TABAK. We didn't take hold of all of our clinical-trial networks early on in the pandemic. And, as a result, a number of underpowered trials were conducted, and that sort of siphoned away the capacity to do the larger trials that were ultimately necessary. That was one thing.

A second thing is, we learned that we needed to forge relationships with industry much sooner to make sure that we could take advantage of all of their knowledge as we, you know, considered different potential countermeasures.

Dr. MCCORMICK. OK. Thank you, both of you.

You know, as an ER doc who basically got exposed to a deadly virus, saw patients who were sick, watched patients die, watched the science evolve, and watched my fellow physicians get criticized the whole time by people who were not treating people, that hurt me a lot. And I think it really decreased the credibility of people who call themselves scientists, who didn't even have science at the time; they had guesses. And they were guessing and outmaneuvering the physicians who were treating the patients and doing their very best.

I'll tell you a few things that I learned as somebody who lived through this from the physician/treatment side.

First of all, the CDC gave blanket recommendations that were not scientific at times, quite frankly. Because we didn't have science; we didn't know. But they still gave recommendations that superseded what doctors could do. And it made people either not trust their doctors or not trust the CDC. You had to choose sides then. That's wrong. It became—instead of scientific, it became politically driven, in my opinion.

I also think that we fell very short in accountability and transparency at the NIH. I think the way we do our grant system, and the way that we're trying to come up with the right answers according to who protects NIH rather than who protects the people, in my opinion, based on the relevant evidence that we've received while we're here.

But, mostly, as in any crisis—doesn't matter if it's banking, housing, climate change, or disease—we should be hesitant to turn to government for the answers. Bureaucrats and politicians are not experts and should never be allowed to infringe upon our inalienable rights of life, liberty, and the pursuit of happiness.

Even when it's scary, we have the right to self-determine. We, as Americans, must always protect freedom, whether that be in our protecting of ourselves, which has consequences of possibly income or travel, or also allowing people to pursue education, transportation, or the best interests of their business even if that requires risking their own health or income. That is America. That is the promise, not of security, but of opportunity that exists nowhere else in the world.

Your discussion should be with your doctor, not intruded upon by the government that thinks they know better than both the doctor and the patient.

We saw how easy it is for the government to take away our rights, to make our lives miserable, if we don't comply, so that, as Dr. Fauci said, "We lose our ideological bullshit," quote, in order to get the favor of a government that is ruling instead of serving. That's what I've learned.

Instead of turning to government for the answers, we allow people to determine with their healthcare professionals what is best. And, by the way, we may not agree, and that's OK. The government should never determine who's right and wrong. Science, experience, and treatments determine what ends up being right and wrong, and it's a learning process that should never be intruded by the government.

With that, sir, I yield. God bless you. Thank you for this Committee. And let's go forth and do great things.

Dr. WENSTRUP. I thank the gentleman. I am reminded of a Teddy Roosevelt quote. He said, "It's not the critic who counts but the man in the arena." Thank you for being in the arena during this difficult time for our country and the world.

I'd now like to yield to Ranking Member Ruiz for a closing statement if he would like one.

Dr. RUIZ. Thank you.

I, too, want to pause and remember the millions of people who died due to the pandemic and their families who mourn, including some of the Members that sit up on this dais who lost their families, members in the audience, perhaps even our expert witnesses

and staff who are here. It is very important that we keep front and center and remember them always.

When the COVID–19 pandemic hit, it gripped our Nation with uncertainty. We knew little about this novel virus, about the way it spread, the danger it posed, and the damage it would inflict on our communities. But it was during this time of significant uncertainty when one thing became increasingly clear: Our Nation was not where it needed to be when it came to pandemic preparedness and response.

But with rapid and sustained deployment of COVID–19 vaccines and therapeutics and robust public health investments in the American Rescue Plan, we left the darkest days of the pandemic behind us.

This is thanks in large part to the dedicated and hardworking members of our Nation's health agencies. I want to offer my thanks again to our witnesses here today representing some of those agencies and sharing with us the tireless work they are doing to prevent and prepare for the next pandemic.

I want to make it very clear to the scientists, who never wanted to delve into politics, who went pre-med and not political science; I want to send a message to the lab technicians that work in your agencies; I want to send a message to the administrators who, day-in and day-out, want to do the right thing for the mission that your agencies pose; I want to say thank you. You are not the enemy, and you should never be demonized. Your work is valuable. Your work is appreciated. And your work is what is keeping our country safe.

And there will be help, and there will be recognition of that work, and there will be a positive way forward from this. So hang tight, buckle up, believe in your work. Know you that are appreciated by millions of people in this country, regardless of the demonizations and the disinformation that's out there and the misinformation that's out there. You're doing good work. So, I want to thank you.

And know that—keep your integrity, keep your character, and do the right thing. We have seen and investigated individuals here that veered from doing the right thing, and that is not acceptable. So, what you're doing in doing the right thing, being transparent and open, is what's going to help us through to the next pandemic.

So—and that is why—this is thanks, what we've been able to accomplish, in large part to the dedicated and hardworking members of our Nation's health agencies. And I want to offer my thanks again to our witnesses here today representing some of those agencies and sharing with us the tireless work that they are doing to prevent and prepare for the next pandemic.

Last Congress, Democrats led the House in taking meaningful steps toward bolstering our pandemic preparedness and response capabilities with passage of the Consolidated Appropriations Act of 2023.

Included in this law were bipartisan provisions from the PREVENT Pandemics Act, which made several significant reforms to help ensure we are better prepared when a future pandemic strikes. These reforms acted to advance our Nation's biosafety and biosecurity, revitalize our public-health work force, prevent undue

foreign influence in biomedical research, and enhance our Strategic National Stockpile.

We didn't focus on these during these last 2 years. We didn't really have a conversation about the positive work that has resulted from that—from these laws from last Congress and how they're being implemented. We didn't dive into the positive things that we learned from the lessons learned.

So, I just really want to highlight them there, that there is a whole other section of actual work that's being done. And there still needs to be oversight, there still needs to be collaboration, there still needs to be a discussion of all those changes so that we can make sure it moves in that right direction and, in fact, that we keep them, given all the recent threats that we've heard today.

Because, ultimately, these policies have charted the course of a more efficient, streamlined pandemic response for the future, and they have shown what we can do when we come together constructively to protect Americans' health and save lives. And we must work to continue these efforts to strengthen our supply chains, develop new vaccines, and stay on the cutting edge with advanced therapeutics.

As an emergency physician and a public health expert, developing forward-looking solutions that help our Nation better prevent and prepare for future public-health crises continues to be my top priority.

So, I hope that today's hearing serves as a reminder of the important work that our Federal health agencies do for the American public—it's imperfect, but it's important, and the results have shown for itself, since we are no longer in the throes of this pandemic—and that Congress will continue to support this work, rather than manufacturing distrust or throwing conspiratorial accusations in our safety systems and public health as a whole.

And before I end, I know we'll have another session, but I'm going to take advantage here and thank this hell of a guy, Miles Lichtman, the director on the Democratic staff team, Alicia Yass, Dani Walker, and Joseph Romero, who have done incredible work, who I'm extremely proud of, who have only made me a better person and a better leader and have done extremely, extremely important work for the American people. And I want to thank you all individually.

And I also want to thank the Republican staff. I have seen firsthand the dedication during some of our travels and work that we've done. I know your heart's in the right place. Thank you.

I yield back.

Dr. WENSTRUP. Thank you, Dr. Ruiz.

In closing, I'd like to thank our panelists once again for your important and insightful testimony here today. I thought this was a very good hearing.

I would like to thank you, Dr. Walke, Dr. Marston, Dr. Tabak, for coming here today to testify at this final hearing of the Select Subcommittee on the Coronavirus Pandemic. We greatly appreciate your insight, and hope that we all will continue to work on improving our future pandemic response and that we continue to learn from our past shortcomings.

I had several reasons for not running for office again. Amongst them, when I was given this responsibility, was, I wanted it to be seen that I am not here on a political purpose or a political mission. I'm a physician. Truth matters. Lessons learned matters. All of those things come into play. Nothing about chairing this Subcommittee had political gain for me. But I did want to serve the American people and be able to take this after-action review and get our lessons learned.

Unfortunately, throughout some of this, some things became political, unfortunately. Some people had self-interests over that of all of mankind. And we discovered that, and we worked our way through that.

And we will have a product for the American people to absorb and for we as a government to absorb on how we can go about doing our business and how we can protect the American people more and save lives and be the leader in the world when it comes to being able to respond appropriately so that others may benefit from mistakes we made, that we may benefit from mistakes we made, and, also, it's a time to applaud some of the things we did right, which are many, through this whole process.

I want to thank also staff on both sides. Thank you. Thank you all. There's been a lot of hard work put in this in the last 2 years.

Some things we found, not so good. Some things we found, very good. And we should build on those things. We should build on those things.

Politics has no place in taking care of people. That's the bottom line. To me, we can do better, and we're going to propose to do better, and try to create the environment where we can do better.

The next pandemic will happen, maybe not in our lifetime, but let's be better prepared. There's a lot of logistics. America can lead the way. We can lead the way. We've got too many good people to not lead the way.

So, there's been a lot of reflection today, and, you know, I want to go down the line, starting with you, Dr. Tabak, and ask that each of you will commit in the next 2 weeks, if you would, to provide this Select Subcommittee your top two lessons learned through this and how we can work together to overcome these issues.

You're nodding your head?

Dr. TABAK. Yes, absolutely, sir.

Dr. WENSTRUP. Thank you.

Dr. WALKE. Happy to do so, and thank you.

Dr. WENSTRUP. Thank you.

Dr. MARSTON. I didn't realize we were going to get homework, but yes. Thank you.

Dr. WENSTRUP. Oh, we always have homework.

Dr. WENSTRUP. Anyway. But, you know, while today was the last hearing of this Select Subcommittee, our work is not yet complete. The Select Subcommittee on the Coronavirus Pandemic will be releasing its final report in the coming weeks, and in this report we can continue our commitment to transparency. We'll release our findings on the investigations that we have so thoroughly examined during the past 2 years.

In addition to our findings, we'll include recommendations for future pandemics based on the lessons learned. It would be irrespon-

sible for us not to do that. It's not enough to highlight what went wrong, or terribly wrong, but if we do not work to find ways to fix it for the future and have a better process, then we have wasted our time. And I don't think any one of us here—people that run for office, people that serve the American people, you do not want to waste your time.

I look forward to releasing our final report. Hope that our work, which has been extensive, as you know, will be used to prevent, predict, prepare, and protect us from the future pandemic, which were my words at the very beginning.

Thank you all.

With that, and without objection, all Members will have 5 legislative days within which to submit materials and to submit additional written questions for the witnesses, which will be forwarded to the witnesses for their response.

Dr. WENSTRUP. If there is no further business, without objection, the Select Subcommittee stands adjourned.

[Whereupon, at 1:50 p.m., the Subcommittee was adjourned.]