"Lessons from the West African Ebola Response:

How to Save Lives and Protect our Nation

During the Novel Coronavirus Epidemic of 2020"

Testimony before the

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By

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Chairman Bera, Ranking Member Yoho, other members of the Subcommittee:

Thank you for inviting me to participate in this hearing today. I want to commend the Subcommittee for moving quickly to gather information and educate the public about the novel coronavirus epidemic that originated in Wuhan, China, and has now spread to countries around the world, including our own. It is a privilege to be able to present my perspective on this, and to answer your questions about the emerging US response.

Before I begin my substantive presentation, I want to make two preliminary points.

First, as frustrating as it may be, it is important to understand that what we know about this epidemic and the virus that causes it remains uncertain and preliminary. We know much less about coronavirus today than we did about Ebola in 2014. Scientists in the US and around the world are working at unprecedented speed to improve our understanding about the virus and its spread; new papers are being published every day, literally. Nonetheless, there are critical questions about the virus, how quickly it spreads, how infectious it might be, how lethal it will be – and others –for which we still do not know the answers, and that (once learned) will have huge impacts on our response. Part of this is due to a lack of full transparency and cooperation by the Chinese government, which hopefully will improve. But part of this is simply due to the fact that it takes time for science to learn key facts about a novel virus. As someone who has coordinated the policymaking and implementation of a response to an epidemic, I know that these information gaps are vexing: many decisions cannot wait, and have to be made on the best information available. But it is important that we understand this limitation, understand that policy choices will have to change as our fact base changes, and that we be careful not to make definitive or declarative pronouncements when the science does not justify such statements.

Simply put, at present, we do not know how serious this epidemic will become, how many people – in China, in the US, and elsewhere – will contract the virus, how many will die, and how grave the threat is to our own country. Such a lack of knowledge does not counsel a lack of action, indeed, perhaps it counsels just the opposite. But it does advise modesty in the forcefulness of our conclusions, and awareness of the need to make changes in policy choices as we gain more information.

Second, a point about partisanship and the response. I am an outspoken political partisan – that is well known. But I come here today in the same way that I approached my tenure as White House Ebola Response Coordinator: putting partisanship and politics aside. The coronavirus will not ask any person's partisan affiliation before infecting them. There is no Democratic or Republican approach to fighting infectious disease; only sound and unsound measures.

To reinforce this point: what we did during the Obama administration's Ebola response relied heavily on lessons learned and expertise acquired during the Bush administration's efforts to fight AIDS and malaria in Africa. Key players in the Ebola response were veterans of both

Democratic and Republican administrations. President Obama's emergency funding package passed this House with strong, bipartisan support; our implementation of it domestically involved work with state and local officials from both parties, and the input of Members of Congress of all political and ideological camps. Saving lives, abroad and at home, turns on putting politics aside and allowing science, expertise, and sound decision making to govern our actions.

With these two preliminary points made, I want to move on to the subject of my testimony today: how the lessons we learned during the Ebola response in 2014-15 should shape how our government – in the Executive and Legislative branches – approaches the threat now posed by the novel coronavirus.

To be clear, the Ebola response was not without its own problems and mistakes. Particularly early on, the danger to Africa and the world was underestimated; early signs of progress in containing the disease in the Spring of 2014 led to a false sense of security. The fact that no Ebola outbreak prior to 2014 had ever involved more than 500 cases of the disease also led to a false confidence that a large-scale epidemic was unlikely. Early initiatives in West Africa lacked a full understanding of the complexities of implementation there and cultural and religious barriers to some aspects of the response. And confusion and a lack of preparation led to missteps when the first case of Ebola arrived in Dallas, Texas, in late September, 2014.

But ultimately, the US got the response organized; quickly adapted and improved its approach; and made adjustments to what responders were doing in Africa and here at home. President Obama mustered an all-of-government response to the challenge, authorized the first-ever deployment of US troops to combat an epidemic ("Operation United Assistance"), appointed me to lead a team of dedicated and talented professionals at the White House to coordinate this effort, implemented novel and innovative policies on travel screening and monitoring, and worked with Congress to enact a $5.4 billion emergency package to fight the disease abroad and improve our preparedness at home and around the world for future such epidemic threats.

In the end, the epidemic in West Africa was tragic: an official death toll of over 11,000, with the real count likely higher. But the backdrop for this loss of life must be considered. In September of 2014, experts forecast that the death toll could be over 1 million people; thus, the response succeeded in helping to reduce the projected loss of life by as much as 98%. America's actions – as part of a global response, with Africans playing the largest part, deserving the greatest credit, and suffering the harshest losses to its health care workers – saved hundreds of thousands of lives. It was a great humanitarian achievement.

Here at home, after the initial missteps in Dallas, no one contracted Ebola on US soil, and Americans evacuated for medical care in the US were successfully treated and released, with only a lone fatality. Once implemented, our monitoring system successfully insured no domestic transmission of the disease, routed suspected cases to prepared medical facilities

before those patients could be infectious, and enabled ample time for successful testing and response.

The ongoing legacy of this response is likewise enormous. With Congress' support, we implemented a national four-tiered network of hospitals and medical facilities that remain prepared to this day to identify and isolate cases of dangerous infectious disease, and to provide treatment to those who are infected – nothing like this existed in 2014 when the Ebola epidemic began, as many earlier investments made after the anthrax attacks in 2001 had been allowed to dissipate. The capacity to test for and promptly identify diseases like Ebola grew from three laboratories in the US in September 2014 to almost 100 by the end of that year. We developed rapid diagnostics that ended the risky practice of having patients wait days to learn if they were sick and/or infectious. Vaccines against Ebola were tested and developed, and as a result of that work, an effective vaccine now exists and is being used in the field. New therapeutics were developed that helped reduce the mortality rate of Ebola dramatically.

It is no wonder that this effort – without in any way minimizing the devastation in West Africa – is seen today as a huge success. Tom Friedman wrote last year that that West African Ebola response was:

> "[President Obama's] most significant foreign policy achievement, for which he got little credit precisely because it worked — demonstrat[ing] that without America as quarterback, important things that save lives and advance freedom at reasonable costs often don't happen."

From mid-October 2014 to mid-February 2015, I was proud to lead the team at the White House that coordinated this response. We saw the weekly new case count in West Africa drop from about 1,000 a week to fewer than five a week, at which point the President announced the end of Operation United Assistance and began the withdrawal of US troops serving in that mission.

This was a truly global response, with tremendous contributions by government officials, NGOs, and volunteers from around the world, with a particularly close partnership with our allies in the United Kingdom and France. With regard to the US part of this global effort, special thanks should go to the men and women on the frontlines. This includes members of the 101st Airborne (who constituted the bulk of Operation United Assistance), and also, civilian responders -- via US AID DART teams and CDC employees deployed to the region, and contractors who supported them. It includes the men and women of the US Public Health Service who staffed the Monrovia Medical Unit in Liberia. It includes career Ambassadors and other diplomats who served in all three effected countries with skill and played such a large role in the response. It includes the doctors, nurses and other health care workers – many of them volunteers -- who served in Ebola treatment units, hospitals, and other facilities – treating the sick under extreme conditions. It includes the scientists of the NIH and the CDC who pioneered new diagnostics, therapeutics, and vaccines. The US response put over 10,000

people – soldiers and civilians, government workers and NGO teams, contractors and volunteers – on the ground in West Africa in 2014-2015. It was a gargantuan undertaking, and a story in which all Americans should take pride.

To make that effort effective, and to match it with preparation and protection here at home, it took talented teams in Washington, in Atlanta at the CDC, and in government agencies and private health care facilities around the country. Public servants of all ranks and all levels worked around the clock. And as I mentioned before, Congress acted swiftly and on a bipartisan basis to approve most of the Obama administration's request for $6 billion in aid, less than five weeks after it was sent to Capitol Hill.

I would be remiss if I did not say that, of course, President Obama, too, deserves credit for this success. He weathered sharp criticism for his actions during the Ebola response, and had to ignore pressures to put aside the advice he was getting from top scientists and medical experts. He made difficult decisions about the actions we took abroad and at home. He communicated openly and directly with the American people, and chaired repeated meetings of the National Security Council as the response took shape. He used every tool at his disposal – from his bully-pulpit (to destigmatize survivors by publicly hugging Ebola patient Nina Pham in the Oval Office after her discharge from the hospital), to authorizing the massive deployment to West Africa, to personally engaging numerous world leaders to activate their resources and support for the response, to urging Congressional leaders to approve his emergency spending package, and much more: he did so much to achieve these results.

The challenge we face from the novel coronavirus that began in China late last year contains many similarities, but also, many differences from the challenge posed by the Ebola epidemic in West Africa in 2014-15. It would be a mistake to simply repeat what we did at that time, given those many differences. But likewise, it would also be a mistake to ignore the lessons that can be learned from that response, given the similarities. And hence, I am grateful for the opportunity to talk about the lessons I think are most applicable from this experience, to be applied in the current circumstance.

Among the many possible lessons that should be employed now, there are seven in particular that I would like to call out today. I will do so briefly, but I am happy to go into more depth on any of them in response to your questions or any subsequent follow-up from the Subcommittee.

***First, in a complex, rapidly evolving scenario like the one we are seeing, there is no substitute for White House coordination and leadership*.** There should be a single official inside the National Security Council at the White House, supported by an appropriate team, working on this full-time, overseeing our response.

This does NOT mean that we need a "Coronavirus Czar" to serve the same role that I played during the Ebola epidemic. At the end of my tenure as Ebola Response Coordinator, I said, in fact, there should never be another specific "Disease Czar" at the White House. Instead, I

recommended to President Obama that he create a permanent "Pandemic Preparedness and Response Directorate" inside the NSC, led by a Deputy National Security Adviser-level appointee with direct access to the President as needed, to oversee ongoing work to prepare for future infectious disease threats, and to coordinate a response when such threats arrive.

President Obama accepted this recommendation, and set up such a unit in 2015. President Trump continued with the structure, and named Admiral Tim Ziemer – a respected long-time public servant – to fill this post. If Admiral Ziemer were still in place, I believe that America would be much better positioned to respond to the coronavirus threat today.

But unfortunately, in July of 2018, when John Bolton took over as head of the NSC, he disbanded this unit, and Admiral Ziemer was reassigned to US AID. As a result, there has been no special unit at the NSC to oversee preparedness for epidemics, or the current response. In addition, the Trump administration has dismantled the Homeland Security Advisor structure that Presidents Bush and Obama used to deal with complex transnational threats, further undermining our preparedness for events like these.

The administration's recent decision to create a "Task Force" to oversee the response, led by Secretary Alex Azar, is a valuable step, but an insufficient one. This is not a criticism of Sec. Azar, who I believe is playing a critical role in the response, and brings great experience and judgment to this effort. But a response to a challenge like this one requires action from a number of federal agencies outside of Sec. Azar's authority: Homeland Security, State, US AID, Transportation, DOD – and probably also Labor, Commerce and Justice. Given the nature of Cabinet government, the fundamentals of bureaucratic behavior, and the realities of competing demands on a Cabinet secretary's time, no single Cabinet agency head can lead such a response. There are global implications as well: in dealing with other nations as the world shapes and implements the response, a single point of coordination inside the White House both emphasizes the response's importance to the President, and facilitates high-level government-to-government cooperation.

For these reasons, and many more, an effective response to a challenge like coronavirus should be led by a full-time, high-level appointee at the White House. Ideally that decision would be made by the Executive Branch, but another avenue to achieve this structure would be for Congress to move ahead on the Global Health Security Act (HR 2166), introduced by Reps. Connolly and Chabot, as that bill would create much of this apparatus by statute.

Second, the US must "lean forward" to fight this epidemic overseas, using all of the tools and leverage that it can commit to the effort. Unlike West Africa in 2014, China in 2020 probably does not need, and would not accept, thousands of US responders on the ground treating patients, testing new approaches, conducting research, providing infrastructure, and helping bring the disease under control. This is a huge difference.

But that should not get us off our toes, or have us sitting back and believing that our only sphere of action is the homeland. Dr. Tony Fauci of NIH has publicly urged the deployment of

medical researchers and investigators to China, and key administration leaders – at State and the White House – should apply pressure to encourage the most open access possible. Nations less advanced or well-resourced than China may experience significant coronavirus outbreaks and require more direct forms of US assistance, akin to what we provided during the 2014 Ebola epidemic, albeit on a smaller scale. We should send CDC experts wherever they would be helpful, and task US AID to determine where DART teams and other assistance could be usefully deployed. Likewise, we should bolster preparedness in low-income countries now – before the disease spreads further – to avoid spread in places where local containment efforts might fail. Our diplomats should be empowered and engaged around the globe, and our government must press WHO – with stronger leadership today under Dr. Tedros Adhanom Ghebreyesu than it had during the 2014 Ebola epidemic – to do the right thing.

This is a global challenge, and America must provide global leadership. There is no room for isolationism or withdrawal. The best way to keep Americans safe is to contain and combat the virus overseas. We should do this not only because it is generous or humanitarian – though it would be generous and humanitarian, both great American traits – but because it will make America safer and reduce the risk of a larger outbreak here.

***Third, the administration must ensure that science and expertise guide our actions, not fear or politics*.** One of the first casualties in an epidemic is rational thinking, replaced by fear, bias and poor decision-making. We saw this in 2014 with calls for needless travel bans and baseless quarantine restrictions; President Obama was right to reject these misguided calls, and to implement travel and monitoring policies based on the scientific advice he got from the nation's leading experts.

Travel warnings and advisories make sense in the face of the coronavirus; telling people not to take trips to China right now, except in special or compelling cases, is wise. That is quite different from banning people – including, for example, Americans in China, or family members of Americans – from coming back home, or going for essential purposes. Congress should press the administration for the science behind recently announced quarantines and exclusions of non-US persons from travel to the US; also, it should inquire as to the effectiveness of the measures being implemented. Banning travel to or from China altogether would impede the flow of medical assistance, expert investigation, or other key response functions; in addition, key supplies – including supplies critical to our own health care system – come from China.

More generally, there will be many policy decisions to be made in the days and weeks ahead. Science, medicine and expertise should guide them. The American people are lucky to have the world's leading experts on infectious disease working in their government, led by men and women like Tony Fauci at NIH and Anne Schuchat at CDC. They have served Democratic and Republican administrations, and helped Presidents with a wide variety of political perspectives save lives and protect our nation. This expertise should be paramount in decision making at all levels of government.

Fourth, the administration should quickly assemble, and transmit to Congress, an emergency funding package to ensure that there are no delays in responding to the coronavirus challenge. Fighting the coronavirus overseas and at home will cost money. HHS (and its units like ASPR, BARDA, NIH and CDC), US AID, DHS, and other agencies will have costs. State and local governments will feel a pinch from monitoring contacts of those who have the virus, and tracking and monitoring individuals who have been in effected countries. Hospitals treating patients with the virus may need assistance. Research and deployment of new therapeutics and vaccines needs government support, and funding for private-public partnerships. The list of needs goes on.

While Congress responded quickly to a funding request from the Obama administration for Ebola, even that short delay had some impact on our response. The delay of months in approving funding for the Zika response was quite consequential. Most importantly, Congress is unlikely to even begin considering these funding needs until the administration makes a request.

The Trump Administration has tools that we lacked in 2014, most importantly – and to the Congress' credit – it has a new Emergency Fund on which the Administration can (and has) drawn. But I expect that this will not be adequate, and it would be wise for the administration to begin putting together a Supplemental Funding request immediately.

Fifth, Congress must do its own work in dealing with the novel coronavirus. The burden of action does not rest entirely with the Executive Branch; Congress too must do its part.

This starts with the point I made above: once the administration makes an emergency funding request, Congress should act on it without delay. Of course, Congress should not rubberstamp the request: any proposal to use public funds should get scrutiny and review. But prompt action must drive this process, and divisions between parties or chambers should not result in delay. Indeed, Congress might want to begin now – given the expertise of many in this body – preparing for such a request even before it is made, and contemplating the likely funding needs.

But Congress' role does not end with acting on the emergency funding question; there are a number of other elements of the response that demand Congressional attention. Hearings like today's are important, to help ascertain how the response is going and where it needs to be improved. Congress wisely funded the Public Health Emergency Fund last year – but did so only on a limited basis. Adding to that funding, and funding an additional emergency fund specific to the development of therapeutics and vaccines via public-private partnerships, should be considered.

Additionally, as I wrote in the Post with Dr. Syra Madad in December – before the coronavirus hit -- Congress is overdue to renew the funding for the network of "Ebola and Special Pathogens Hospitals." This network was created during the Ebola epidemic in 2014, and funding for it expires in May of 2020. Pending legislation would fund only the 10 most advanced such

facilities, and would end federal funding for the 60 other hospitals that screen, test, and provide initial treatment for these cases. Allowing this funding to expire in May would be a huge mistake; funding for these specialized facilities should be renewed, and the network should be strengthened with greater help for frontline facilities, EMS responders, and other touch points in our medical system that are least prepared and most exposed. .

Sixth, both the Executive Branch and the Congress should take this as a wake-up call to finish the work we need to do on pandemic preparedness and readiness. Recently, America marked the 100th anniversary of the single largest mortality event in our history: the Spanish Flu epidemic of 1918-19. More Americans died from this epidemic than from World War I, World War II, the Korean War, and the Vietnam War - -combined. While, on the one hand, science has made great strides since 1918, on the other hand, increased global travel, human incursion on animal habitats, and the stresses of climate change have raised the risk that we will face such a "great pandemic" once again.

At present, it seems very unlikely that the coronavirus poses such a threat to the United States – but we cannot know for certain. Moreover, even if this current epidemic is not "the big one" that is coming, it is a reminder that this danger lurks, and our preparedness for it is lacking. As Dr. Ashish Jha of the Harvard Global Health Institute often says, "Of all the things that can kill millions of Americans quickly and unexpectedly, an epidemic is probably the most likely … and the one in which we invest the least to prevent."

The Global Health Security Agenda, legislation such as HR 2166, Blue Ribbon Commission reports, table top exercises, proposals from members of this Subcommittee – and my own extensive writing over the past five years – have set forth detailed agendas of what we need to do to prepared for this event. These bipartisan calls for action have largely been ignored. The current public focus on infectious disease generated by the coronavirus should spur us into action. The time to act on this agenda is now. If we wait until the catastrophic pandemic arrives, it will be too late.

Seventh, we need to be on the watch for discrimination against people in our country of Chinese origin and ancestry, and speak out strongly against any such fear-driven racism. The coronavirus strikes humans – not people of any particular ethnicity or race. Chinese-Americans or Chinese people in America are no more likely to get the disease, carry the disease, or transmit the disease, than any other group of people.

Yet we have already seen signs that such people are the targets of discriminatory fear – with some already being hassled, threatened with expulsion from schools and other mistreatment. As fears of the coronavirus accelerate, so too will these incidents. This kind of discrimination not only is wrong, but also makes it harder to combat the disease. If some members of the Chinese-American community feel that they are likely to face hostility, they are less likely to work closely with authorities, and less likely to heed advice of public health experts.

It is incumbent on every person in authority in this nation to speak out against such racism, and to ensure that this does not become part of our civic life during the coronavirus epidemic. Americans need to pull together to fight a disease, not pull apart to fight one another.

In closing, I want to thank, again, the Subcommittee for holding this hearing, and for inviting me to participate. I stand ready to answer your questions about any of these points, or any other aspects of the response.

America has the tools, the talent, and the expertise to combat the coronavirus, both abroad and at home. The question now is whether our leaders, in the Executive Branch and the Congress, will deploy them effectively; act promptly and wisely; rely on expertise – not bias and fear; organize and implement our response appropriately; and allow science and medicine to be our touchstone. For the sake of people around the world, and for the sake of the American people, let us work to see that it is so.