

UPGRADING PUBLIC HEALTH  
INFRASTRUCTURE: THE NEED TO  
PROTECT, REBUILD, AND STRENGTHEN  
STATE AND LOCAL PUBLIC HEALTH  
DEPARTMENTS

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HEARING

BEFORE THE  
SELECT SUBCOMMITTEE ON THE CORONAVIRUS  
CRISIS  
OF THE

COMMITTEE ON OVERSIGHT AND  
REFORM

HOUSE OF REPRESENTATIVES  
ONE HUNDRED SEVENTEENTH CONGRESS

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*Written opening statements and the written statements of the witnesses are available on the U.S. House of Representatives Document Repository at: docs.house.gov.*

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*Documents are available at: docs.house.gov.*



**UPGRADING PUBLIC HEALTH  
INFRASTRUCTURE: THE NEED TO  
PROTECT, REBUILD, AND STRENGTHEN  
STATE AND LOCAL PUBLIC HEALTH  
DEPARTMENTS**

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**Wednesday, September 29, 2021**

HOUSE OF REPRESENTATIVES  
COMMITTEE ON OVERSIGHT AND REFORM  
SELECT SUBCOMMITTEE ON THE CORONAVIRUS CRISIS  
*Washington, D.C.*

The subcommittee met, pursuant to notice, at 2:17 p.m., in room 2154, Rayburn House Office Building, and over Zoom; Hon. James E. Clyburn (chairman of the subcommittee) presiding.

Present: Representatives Clyburn, Waters, Velázquez, Foster, Krishnamoorthi, Scalise, Jordan, Green, and Miller-Meeks.

Chairman CLYBURN. Good afternoon. The committee will come to order.

Without objection, the chair is authorized to declare a recess of the committee at any time.

I now recognize myself for an opening statement.

For decades, state and local public health departments have been chronically underfunded and understaffed. Throughout the pandemic, we have seen firsthand how our under resourced public health system was ill-equipped for such a large-scale emergency, with limited disease monitoring and surveillance capabilities, testing and reporting deficiencies, and outdated technology hampering the response.

The response was also impacted by significant cuts in the public health work force over many years. As this chart reflects, in the past decade, at least 37,000 state and local public health jobs were eliminated, leaving a skeletal work force that was stretched thin even before the coronavirus first reached our shores.

This persistent underinvestment in our public health system hasn't just hampered our response to this pandemic. It also limits our ability to reduce and manage chronic illnesses, implement prevention and preparedness programs, and promote good health behaviors, which research has shown can reduce overall health spending.

It is clearly long past time we commit to investing sustainably in state and local public health departments.

While many of the challenges facing public health agencies are longstanding, since the start of the coronavirus pandemic, we have

observed a potentially even more dangerous trend: the reckless politicization of public health.

Since the pandemic began, public health officials have faced unprecedented levels of harassment, threats, and attacks from members of the public, particularly in response to their attempts to adopt proven mitigation measures, such as masks and social distancing guidelines, after they were recklessly politicized by the past President and his anti-science allies.

One local health official was repeatedly threatened for issuing public health orders by a man with ties to the far-right who was found with more than 130 firearms and explosive materials when police arrested him for stalking and threatening the official.

Another official's family home was surrounded by anti-science protesters who used bullhorns and sirens to amplify their hostile rants against her every Sunday for multiple weeks.

These are just a few of many similar stories. It is abhorrent that public health officials and their families have received death threats, had their homes vandalized, and faced other malicious attacks for following the science and taking steps to save American lives.

Alarming, this dangerous movement to politicize public health has extended to elected officials across the country.

At least 26 states have enacted laws during the pandemic permanently weakening public health authorities.

At least 16 states, including Ohio and Kansas, the home states of two of our witnesses here today, have passed laws limiting public health officials' authority to issue mask requirements or quarantine and isolation orders not just during the coronavirus pandemic, but in any future infectious disease outbreak.

Republican Governors like Florida Governor Ron DeSantis and Texas Governor Greg Abbott have also sidelined public health experts by issuing executive orders to prohibit localities from implementing commonsense protective measures.

Experts warn that these actions recklessly inject politics into public health decision-making, resulting in more cases and deaths from the coronavirus, undermining public health officials' ability to combat future disease outbreaks, and threatening any effort to improve the health of the American people.

Amid this dangerous movement to politicize public health, more than 300 state and local public health leaders have left their jobs during the pandemic, marking the largest exodus of public health officials in United States history.

Let me be clear. Any effort to undermine the longstanding authority of public health officials to keep Americans safe is shortsighted and dangerous. To do so for political purposes is simply unconscionable.

We must stand up for our public health leaders and reject attempts to sideline public health experts.

Fortunately, the Biden administration has taken bold action to protect, rebuild, and strengthen the Nation's public health infrastructure.

Using funding Democrats in Congress provided in the American Rescue Plan, the Biden administration is investing billions of dol-

lars to help states and localities expand their public health departments and prepare for future pandemics.

This includes investments in programs to teach and recruit students from historically Black colleges and universities and other minority-serving institutions to be the next generation of public health leaders.

I commend President Biden's historic efforts to revitalize our public health system. We must keep building on this progress to ensure our public health work force consistently receives the resources it needs over the long term.

I want to thank our witnesses for being with us here today. I look forward to learning more about the challenges you have experienced working on the front lines of the pandemic response and how we can better support and strengthen our state and local public health infrastructure.

I now yield to the ranking member for his opening statement.

Mr. SCALISE. Thank you, Mr. Chairman, for yielding and for holding today's hearing.

I want to welcome all of our witnesses today, but especially Dr. Kanter from the Louisiana Department of Health.

How are you doing, Dr. Kanter?

Louisiana has endured three brutally COVID waves, and, unfortunately, we were one of the first states to really feel the crush of the Delta variant.

But there are several things that Louisiana has done well, particularly as it relates to getting kids back in school.

We've had a number of hearings on that important issue, so many scientists, including Dr. Fauci, who testified that the science is very clear that all kids should be in school and, in fact, it hurts kids to keep them out of school. Not every school system has done that, but Louisiana has done that very well.

We were one of the first states to reopen schools for in-person learning, and I'm proud of that and hope that it can serve as a model for other states who still haven't gotten to that point.

It's important that we hear from local and state public health officials about their experiences and ways for the Federal Government to do a better job of confronting this latest outbreak. We have a lot of work to do, not only to overcome this pandemic, but to better prepare for others that might come.

That's why it's so hard to understand why the majority has not used the authority provided to the subcommittee to perform oversight into areas like the nursing home debacle in New York.

Former Governor Cuomo's "must admit" order, which went against the recommendation of the CDC, led to thousands of unnecessary deaths. He then engaged in a coverup of massive proportions.

And yet, this subcommittee never held a hearing to uncover the truth that Governor Cuomo hid from the thousands of victims and their families. They still want and deserve answers. We could get those answers.

On top of that, the subcommittee has ignored the question of where the coronavirus actually came from, and the Democrat majority does not want to investigate whether the United States fund-

ed research at the Wuhan lab in China that is the likely source of this virus.

Many medical experts have suggested that the virus absolutely did start in that lab in Wuhan and was genetically engineered, it was not a natural virus that was created from bats, transferred through animals to humans. We need to have a hearing on that question.

There are several big open questions about reports that the Biden administration interfered with the FDA, political interference that I would argue has created serious confusion on vaccine booster shots.

I know most people would agree that the public health messaging from the Biden administration has been disastrously unclear.

These are major public health mistakes that we should investigate, but the majority refuses to do so.

I'm very concerned with the path the Biden administration has taken to politicize the pandemic and try shaming and bullying Americans that don't think exactly the way that they do.

The vaccines are excellent. Proud to have been vaccinated. But vaccines are not enough. The Biden administration has failed to adequately develop more therapeutic options to protect Americans who fall ill. The fact that 2,000 people a day are still dying should be clear evidence of this epic failure.

I don't think vaccine mandates are the best way to accomplish our shared goal of ending this pandemic, and I'm very concerned about what mandates are doing right now to undermine staffing levels at hospitals, for healthcare, and for other frontline workers that are already facing burnout and staffing challenges.

We're already seeing the negative effects that these mandates are having in states that have imposed their own.

Dozens of state troopers are now quitting in the state of Massachusetts.

About 90 percent of San Diego police officers surveyed said they oppose COVID-19 vaccine mandates, and 65 percent of all San Diego police officers said they would consider quitting the police force if the city were to impose a mandate requirement.

In New York state, hospitals and nursing homes are bracing for mass staffing shortages that have been sparked by the state's vaccine mandate.

According to The New York Times, as of September 22, state data shows around 84 percent of New York's 450,000 hospital workers and 83 percent of its 145,000 nursing home employees have been fully vaccinated. That means that tens of thousands of people likely will not have gotten the shot by the September 27 deadline that New York set, risking their jobs and livelihoods.

One hospital, the Lewis County General Hospital in Lowville, New York, has announced that it is pausing maternity services because dozens of staff members quit rather than getting COVID-19 vaccines. The hospital is, quote, "unable to safely staff its maternity department and newborn nursery."

Other departments in the hospital are at risk as well if more workers don't want to get vaccinated and end up getting fired for that.



A hospital system in North Carolina announced just yesterday that about 175 employees were terminated because they didn't comply with the hospital's mandate.

Imagine, hospitals that are running short on staffing on employees to care for people are firing nurses who won't get vaccinated, firing them, making those hospitals less able to safely take care of patients. This is nuts.

Many fear that this will continue to happen all across the country if the Biden administration's vaccine mandate on healthcare workers and employers goes into effect.

Mr. Chairman, this committee should hold a hearing into the real-world implications that a big government mandate will have on our Nation's hospitals, our healthcare workers, and on our first responders. We're already seeing this play out in many states across this country.

Unfortunately, I'm not sure the Biden administration cares about those negative consequences or the public health implications of their counterproductive mandates. Their plan appears to be just shame and bully millions of Americans into submission.

Last week, the Secretary of Health and Human Services, our former colleague, Xavier Becerra, referred to the people who are hesitant about the vaccines as, quote, "flat earthers." This isn't one monolithic group of people. It represents every spectrum of our society, Black, White, Asian, Hispanic, all. We've seen different segments of our population that have expressed some hesitancy.

We should be encouraging people to get vaccinated, let's be clear about that, but we want more Americans to make their own decision to get vaccinated. This idea that you can just bully people and shame people is not working.

And the idea that they're going to continue doing it, leading to people getting fired, healthcare workers getting fired, when we need more healthcare workers, police officers getting fired, when we need our frontline first responders to keep our communities safe.

Trying to shame and bully people for their personal medical decisions is disgraceful, and it needs to stop. If you want to get vaccinated, it is safe, it's effective, it's free, and it's readily available. That should be the message that we all send.

I believe one way to give people more confidence and more of a feeling of control over their own decisions is to let them know that this is their decision. So let's give folks who are hesitant the reassurance that they are not going to be forced by the Federal Government to do something against their will or face termination from their jobs and their livelihoods.

Vaccines are not the only answer. Millions of Americans have contracted COVID-19, and they have the antibodies. Testing should be easy to use and widely available, and we should encourage the FDA to continue to work on finding therapeutics to treat COVID.

Maybe this isn't happening because President Biden still has failed to appoint a head of the FDA, nine months into his presidency. He's yet to even put a name forward to head the FDA, which some people have referred to as a rudderless ship on major, major health decisions that are not being made by the FDA.

Maybe we should have a hearing, Mr. Chairman, on why the President hasn't appointed a head of the FDA, nine months into a pandemic that was already in place.

We need a multipronged approach to fight back against the COVID-19 virus, not a one-size-fits-all solution that is forcing millions of Americans to lose their job or face termination.

With that, I look forward to hearing from our witnesses, and I yield back the balance of my time.

Chairman CLYBURN. I thank the ranking member for his statement, but I'm sure he's aware that vaccinations are nothing new. I've still got my polio scar. I still remember the little drop of serum on a lump of sugar. I'm very grateful for it, because we virtually eliminated polio from this country, and I think that these vaccinations are going to do the same thing in this country.

In fact, United Airlines, I'm sure you're aware, they mandated it and they're up to 97 percent. And I think that just because people don't know what's good for them, sometimes we have to encourage them along.

Mr. SCALISE. We know there's still breakthrough cases, too, Mr. Chairman. And as we continue to develop the science, as we continue to help people confront whatever their concerns are, this should be a question we direct people to go talk to their doctor about.

If they have valid questions or hesitations, clearly, shaming them and threatening them is not working because people are getting fired. They're losing their jobs. We're losing healthcare workers when we need more healthcare workers.

And so while government thinks it knows what's best for people, if people still make that choice, ultimately those of us that choose to get vaccinated have made that educated choice. If someone knowing the facts chooses not to, should it really be something that forces the termination from their career and their livelihoods?

Chairman CLYBURN. I agree, and I wish that all of our citizens had physicians that they could go to. And that's one of the things we're trying to do with some of the legislation that's before the floor now. You have a physician, I've got several, but we've got health insurance to pay for it.

So, if we can get health insurance to everybody, maybe they'll be able to consult their physicians.

Mr. SCALISE. We could have a hearing on that, too.

Chairman CLYBURN. With that, I'm pleased to welcome today's witnesses.

Dr. Jennifer Bacani McKenney serves as Wilson County Health Officer, as well as the Fredonia City Health Officer in Kansas. She's also the associate dean of the Office of Rural Medical Education at the University of Kansas Medical Center and serves on the board of directors for the Kansas Health Foundation. Dr. McKenney is a family physician practicing in her hometown of Fredonia.

Dr. Mysheika Roberts serves as the Health Commissioner of Columbus Public Health in Ohio where she leads an organization of more than 500 public health professionals. Dr. Roberts has spent 20 years working in public health, including at the CDC, where she

investigated disease outbreaks. She also serves as the chair-elect of the Big Cities Health Coalition, an organization of leaders from the country's largest metropolitan health departments.

Dr. Joseph Kanter serves as the state Health Officer and Medical Director of the Louisiana Department of Health where he consults on a variety of issues, including emergency preparedness, infection control, and health equity.

Prior to joining the Louisiana Department of Health, Dr. Kanter served as the Director of Health for the city of New Orleans and was the Health Director of the Healthcare for the Homeless Clinic.

Dr. Kanter is a practicing emergency physician and a clinical assistant professor of Medicine at the LSU Health Services Center and Tulane School of Medicine.

Dr. Beth Resnick is a senior scientist and assistant dean for the Public Health Practice at the Johns Hopkins School of Public Health. Her research and practice interests include assessing and improving the public health infrastructure, enhancing knowledge of potential health connections, and developing effective public health policies.

Prior to joining the Johns Hopkins faculty, Dr. Resnick worked at the National Association of County and City Health Officials where she provided technical assistance and support to the Nation's local health departments.

Thank you all for taking the time to testify today. I look forward to hearing from our witnesses on ways we can strengthen our public health infrastructure.

Now will the witnesses please rise and raise your right hands?

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

You may be seated.

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

Without objection, your written statements will be made part of the record.

Dr. McKenney, you are recognized for five minutes for your opening statement.

**STATEMENT OF JENNIFER BACANI MCKENNEY, HEALTH OFFICER, WILSON COUNTY HEALTH DEPARTMENT (KANSAS)**

Dr. MCKENNEY. Thank you. Good afternoon, Chairman Clyburn, Congressman Scalise, and members of the subcommittee. My name is Dr. Jennifer McKenney, and I've been the Local Health Officer for Wilson County in southeast Kansas since 2011.

I'm also a family physician in my hometown of Fredonia, Kansas, a community of 2,500 people, where I've been practicing medicine for the last 12 years with my 77-year-old father, who has served our community for 42 years. I am the mom of an 8-year-old son and a 10-year-old daughter.

I also serve as the president of the Kansas Academy of Family Physicians and as the associate dean for rural medical education for the University of Kansas School of Medicine.

I will be speaking on behalf of myself, someone on the front line, with multiple roles that give me a unique perspective on public health and healthcare.

In rural communities, we are feeling immense strain. My health department has four full-time employees and serves a county of about 9,000 people. Our team has worked days, nights, and weekends to detect COVID cases, do contact tracing, educate the public, and vaccinate, all the while still attempting to provide the high-quality services we have provided for years.

Unfortunately, we have now had turnover of three of our four employees employed at the start of the pandemic. We are in the process of hiring a new health department administrator, as the last two have resigned in the last six months.

There is no doubt we need national pipeline programs in place to support the training and retention of public health professionals. Otherwise, we will see continued attrition, and we'll be ill-prepared for the future.

In addition to staff shortages, our overall public health and medical resources are extremely limited. Recently, I had to call 40 hospitals in our region to find a bed for a critically ill COVID patient.

This is a common story these days, unfortunately, because public health guidance and recommendations are not being followed by many in our communities.

We rural healthcare workers have managed patients on ventilators without ICUs. We struggle for hours to get our patients the critical care they need while they struggle to breathe.

Never before have we seen how much our rural and urban communities are interconnected. Never before have we seen them so overwhelmed.

While the majority of the people in my community are supportive of my healthcare work, some individuals, the same ones we are working so hard to protect, distrust the government, as well as science and public health. Even though the virus is the enemy, their anger and frustrations are often directed toward public health officials like me.

Kansas has seen one of the highest rates of public health leadership turnover in the Nation. Many of my colleagues have experienced worse harassment than me by the general public and elected officials. But some have not been able to speak up for fear of retaliation, so I share some challenges during the pandemic to give a voice to those who are unable.

For example, after our public mask mandate hearing, a local sheriff's deputy asked if he could escort me to my car because he was worried about the angry people in the crowd who spoke up against masks.

And I've been a member of our local school board for the last six years and a former president. Despite presenting scientific evidence for masking in schools, our school board, like many others, still voted against keeping kids masked.

The same science that we teach children in schools is being ignored by those making decisions for them.

Because the Kansas state legislators passed legislation restricting public health powers during the pandemic, county commissioners, most of whom have no medical or public health training,

are now the ones who make COVID-related decisions as the Board of Health. They have been told that consulting with health officials is optional.

I, myself, was informed that my job would be opened up for applications last fall because I focused too much on health and science and not enough on business.

We need support, more support, from local, state, and Federal leaders. We are being asked to work longer and harder in a much more difficult and controversial work environment.

My colleagues and I have worked thousands of unpaid hours because we have promised to protect our friends, families, and neighbors. But this is not realistic for everyone in public health.

Funding needs to be sustained over time. It should support training for those with an interest in public health careers, and it must also provide these workers the tools they need to succeed.

Healthy communities are good for everyone. The COVID-19 pandemic has challenged the entire Nation. It has produced miraculously effective vaccines as well as producing resistance to time-proven public health strategies. We have seen heroic altruism, and we've seen extreme selfishness.

We need to do something now. With the support of this Congress, we can have the human capital and resources we need to point public health in the right direction for all communities.

Thank you so much for your attention. I'll be happy to answer any questions.

Chairman CLYBURN. Thank you, Dr. McKenney.

We will now hear from Dr. Roberts.

Dr. Roberts, you are recognized for five minutes.

**STATEMENT OF MYSHEIKA ROBERTS, HEALTH  
COMMISSIONER, COLUMBUS PUBLIC HEALTH (OHIO)**

Dr. ROBERTS. Thank you so much and good afternoon, Chairman Clyburn, Ranking Member Scalise, and members of the subcommittee. I am Dr. Mysheika Roberts, the Health Commissioner here at Columbus Public Health, which serves the cities of Columbus and Worthington in the great state of Ohio.

Over the past 20 months, my colleagues and I have worked tirelessly to keep our community safe during this once-in-a-lifetime pandemic. Local health departments like mine are the boots on the ground, tasked with bringing this pandemic to an end in partnership with our state and Federal partners.

The experience we bring to the table is unique. How public health is responding to this pandemic is no different than how we respond to other infectious diseases. While the scale is much larger, the work we do to mitigate and to protect the health is not new. Public health has been doing this work for nearly a century.

Public health is essential to a thriving community. We need support to be successful, not only during this pandemic, but the new normal that lies beyond. We must be allowed to do what we do best, which is to protect our community's health using every public health tool at our disposal.

After months of working really long hours on COVID-19 testing, tracing, and vaccinating to protect the health of our community, my staff is burned out, overworked, and underpaid. Some are leav-

ing the field entirely, unable to contribute any more to the work they once loved. Simply put, their tank is empty.

The pandemic has taken its toll on all Americans, but its impact on public health is often overlooked, undervalued, and left in the shadows.

Nearly all of my staff have been called to our COVID-19 response. Many of them have jobs that have nothing to do with the infectious disease containment and mitigation of COVID-19. Yet, they are now on the front lines of this pandemic.

Local health department staff are also combating unprecedented levels of disinformation that divides communities, it allows the virus to flourish, and it erodes the trust in the public health system.

Public health officials also have been physically threatened and politically scapegoated, causing them to leave when they are needed the most.

This is the largest health crisis of our lifetime, and it has created an unprecedented challenge for public health. We need the support of our lawmakers now more than ever.

Yet, lawmakers in many states are actively working against proven public health practices and our authority to protect the health and safety of the communities we serve.

Laws that challenge and undermine public health authority have been proposed in all 50 states, with 26 states passing laws that hinder our response to COVID-19—laws prohibiting mask mandates, banning the use of quarantine for those exposed to COVID-19, setting arbitrary time limits on emergency orders, and giving unilateral power to legislatures.

These are health decisions, not political ones. Local health officials make decisions based on science to protect the public's health, whether popular or not. Public health has been doing this work for nearly a century. It should be no different today.

As was mentioned, in the Ohio General Assembly they recently passed a law that undermines the science of infectious disease containment, which public health has long successfully practiced.

These things are not new or unique to COVID-19. I can only issue orders for those diagnosed with the disease, not for case contacts, which demonstrates the ignorance of the basic underlying science of infectious diseases. And sadly, this change was made despite the protests of hundreds of medical and public health experts.

Public health professionals are leaving the field due to fatigue, some early retirement, challenges to our public health authority, and harassment from the public. These vacancies, plus years of disinvestment in public health, have made our COVID response even more challenging.

According to NACCHO, local health departments began the pandemic with fewer dollars and people compared to a decade ago. At Columbus Public Health, our general fund per capita was \$24 in 2020 compared to an average in Ohio of \$37 per capita in 2018.

Budget reductions directly impact the people needed to do this work, which is critical to pulling out us of this pandemic and building a strong public health infrastructure.

We need your sustained, predictable, and robust investment in public health, not just disease-specific program lines to support the

infrastructure of our communities' needs. We must invest in public health to keep our communities thriving.

We must do more to recruit and retain a skilled work force. Local health departments are unable to be competitive in today's job market. Salaries often fall significantly short of the healthcare sector and make it difficult to attract graduates.

Public health needs a work force loan repayment program modeled after the National Health Services Corps to help recruit and retain talent.

Boom and bust funding cycles to tackle this crisis and others that will follow place Americans' lives at risk. Short-term solutions to the pandemic will not ensure long-term readiness of our Nation. But with your help, we can enhance our public health system and get through the pandemic, and be prepared for whatever comes next.

I thank you all for your time this afternoon, and I'm happy to answer any questions.

Chairman CLYBURN. Thank you very much, Dr. Roberts.

We now will hear from Dr. Kanter.

Dr. Kanter, you're recognized for five minutes.

**STATEMENT OF JOSEPH KANTER, STATE HEALTH OFFICER  
AND MEDICAL DIRECTOR, LOUISIANA DEPARTMENT OF  
HEALTH**

Dr. KANTER. Good afternoon, Chairman Clyburn, Ranking Member Scalise, members of the subcommittee. I serve as state Health Officer and Medical Director for the Louisiana Department of Health. I'm also a member of the Association of State and Territorial Health Officials, an organization which has provided crucial support and coordination throughout the pandemic.

On behalf of the Louisiana Department of Health and the state of Louisiana, we thank you for your attention and dedication to these pressing issues.

I must note that as I speak to you today, many communities in Louisiana continue to struggle in the aftermath of Hurricane Ida. We are appreciative of the Federal Government's continued partnership on this front as many families in the affected areas still need our help.

Yet, despite these struggles, the COVID-19 storm continues to rage even if it is not as immediately visible.

Hurricane Ida has taken the lives of 30 Louisianans. In that same time period, since Ida made landfall, our department has unfortunately reported an additional 1,541 new COVID-19 deaths.

Our fatality count, as high as it is, would undoubtedly be higher if not for the expertise, commitment, and selflessness of our public health work force. Under the leadership of Governor John Bel Edwards and Secretary Courtney Phillips, we have brought a science-and compassion-based approach to this crisis.

It often falls to our public health work force to operationalize the response, and this work force, a critical piece of our health infrastructure, is in danger of crumbling. Much like physical infrastructure, routine maintenance and sustained investment are needed to prevent collapse.

Let us be frank. Stress fractures in our human public health infrastructure have been visible for years. In many departments across the country, these fractures have become gaping holes. State and local health departments need help shoring up their work forces before they buckle under the weight of a now 19-month-long pandemic.

I do not in any way intend to discount the heroics of the clinical healthcare workers. As a practicing ER physician, I am one myself, and I can tell you, my colleagues in the clinical sphere have performed with true grit and honor. The Nation remains indebted and thankful.

But it is public health professionals who provide the bedrock of how we as a community and as a Nation respond to and ultimately overcome this pandemic.

My department, like others across the Nation, is staffed by high-performing health advocates who can handle the workload and weight of the moment. Like a clutch ballplayer in the playoffs, this is precisely what they're trained for.

However, as with any well-trained and valuable professional, they are sought after, and they have options. We need to be able to provide competitive salaries, opportunities for professional advancement, and the ability to surge resources when need arises. And to do this, we need greater flexibility in funding.

The emergency supplemental funding provided by Congress during the pandemic has been instrumental in our ability to mount an appropriate response, and we remain deeply thankful for the resources.

Unfortunately, the usual grants that provide the bulk of health department funding tend to be overly prescriptive and unnecessarily complicated.

More importantly, they are too short-lived. Departments like mine are built on a perpetual stream of short-term, high-maintenance grants. It's no way to do business. You can never build for the future if your funding is limited to the priorities of yesterday's appropriations.

To recruit and retain the work force that is needed to keep America healthy, our health departments need funding mechanisms that allow for strategic investment and longer-term planning, mechanisms like longer spending durations for routine grants, capacity-building grants, specific funding allocations for professional development, educational loan forgiveness programs for public health professionals, and incentive programs to recruit public health professionals who come from the communities they intend to serve.

The pandemic has showed us how interdependent we all are. Outbreak waves of the virus have spread across the country, bleeding from one state into another.

As state Health Officer of Louisiana, it matters a great deal to me that Texas, Arkansas, and Mississippi have strong health departments. Threats to the health of their constituents will quickly become threats to the health of mine.

There is a clear national interest, indeed, a national security interest, in bolstering all public health work forces.

Mr. Chairman, thank you for your time and attention. And to the subcommittee, I look forward to our continued partnership.



Chairman CLYBURN. Thank you very much, Dr. Kanter.  
Finally, we will hear from Dr. Resnick.  
Dr. Resnick, you are recognized for five minutes.

**STATEMENT OF BETH RESNICK, ASSISTANT DEAN FOR PRACTICE AND TRAINING, SENIOR SCIENTIST, BLOOMBERG SCHOOL OF PUBLIC HEALTH, JOHNS HOPKINS UNIVERSITY**

Ms. RESNICK. Thank you. Good afternoon, Chairman Clyburn, Ranking Member Scalise, and members of the subcommittee. Let me also thank the other panelists that are here with us today.

I am a senior scientist at the Johns Hopkins Bloomberg School of Public Health. I'm honored to come before this committee today.

Now, more than ever, the United States needs a robust public health system. My testimony today will address three urgent tasks. First, stop harassment and attacks against the public health work force. Next, protect the statutory authority of public health. And third, rebuild the public health system.

Stop harassment and attacks against the public health work force. It is the job of public health agencies to protect the health of their communities.

In a democracy, dialog is necessary. Disagreement is inevitable. But there is no place for attacks and harassment against public health workers.

We identified at least 1,500 incidents of attacks and harassment against workers in health departments across the country, and half of this local health department survey reported at least one incident of attack or harassment. From death threats to protests, intimidation, even shots fired at their homes, public health workers and their families continue to be the focus of attacks and harassment.

Public health officials joined their professions to save lives. Now, in the wake of these attacks and harassment, many are leaving just when we need them the most.

Since the pandemic began, over 300 state and local public health leaders have left their jobs, resulting in one in five Americans losing their public health leader. Therefore, we recommend two immediate actions to protect the public health work force.

First, CDC should establish a national reporting system for incidents of violence and harassment against state and local public health workers for performing their official duties.

Second, the Federal Government should provide legal protections for public health workers facing harassment and violence. The U.S. Department of Justice should support state and local prosecutors and law enforcement in their use of existing laws and other legal protections to prosecute those who threaten or commit violence against state and local public health workers.

Protect the statutory authority of public health. Public health emergency authority is an essential component of a well functioning government. Throughout our Nation's history, the use of public health authority, such as imposing quarantines, abating nuisances, and administering vaccines, has saved lives. Without public health powers, we would still have smallpox. We would still have polio.

Public health powers are not absolute. There must be checks and balances. But if we unilaterally disarm against public health threats, we put ourselves in peril.

Yet, state legislatures in over 20 states have passed at least one law to undermine public health authority. Imagine if a legislature passed a law prohibiting the fire department from using hoses.

Clearly, this makes no sense, yet such senselessness is exactly what is happening across the country as state legislatures work to strip emergency authority away from public health officials.

We need to fix this. Therefore, we recommend the Federal Government implement legal strategies and funding incentives to support effective public health authority at the state and local levels.

Rebuild the public health system. The pandemic arrived after a decade of neglect of state and local public health. Over 40,000 jobs eliminated, 15 to 20 percent of the total work force lost.

Such neglect has consequences. We are all now facing those consequences as our Nation struggles with our COVID response, hobbled by a paucity of data, inadequate testing, and contact tracing, struggling vaccine efforts, and insufficient outreach to marginalized communities.

We can never be this unprepared again. Therefore, we offer three recommendations for the Federal Government to rebuild the public health system.

First, guarantee multi-year funding for state and local public health infrastructure so that our improvements are sustainable and that funding reaches all state, tribal, and local public health agencies and their communities.

Next, sustain Federal investment in the work force. Build on the short-term Federal investments in the work force with sustained scholarships, loan repayment programs, and training to assure a diverse and prepared public health work force to protect communities across our Nation.

Third, modernize the public health data systems. Provide full funding to upgrade systems and technology for electronic data transmission and exchange across Federal, tribal, state, and local agencies.

In closing, nearly 700,000 Americans have lost their lives from COVID. To quote the late Baltimore Congressman Elijah Cummings, we are better than this. By stopping attacks and harassment against public health officials, protecting public health statutory authority, and assuring sustained funding to rebuild the public health infrastructure, we will be better than this.

Thank you for the testimony, and I look forward to your questions.

Chairman CLYBURN. Thank you very much, Dr. Resnick.

Each member will now have five minutes for questions.

The chair now recognizes himself for five minutes.

For decades, public health departments around the country have been underfunded. Overall, public spending for state and local public health departments has dropped more than 15 percent since 2010, with more than three-quarters of Americans living in states that spend less than \$100 per person annually on public health.

I am concerned that this figure to invest in public health is putting American lives in jeopardy and has hampered our country's ability to mount an effective response to the coronavirus.

Dr. Roberts, how has underfunding impacted your department's ability to provide core public health services in Columbus, Ohio, both over the long term and in response to this pandemic?

Dr. ROBERTS. Thank you for the question, Chair Clyburn. And you're absolutely right, public health funding is essential to a thriving community.

Our health department has an emergency response team that was sufficiently funded when it started in 2001, shortly after 9/11. But over the course of the last 20 years, that funding has dwindled down.

To put things in perspective to you, at one point in time that office staffed about 20 individuals. But by the time the pandemic hit in the spring of 2020, we had five individuals funded on our emergency preparedness grant.

That reduction in staffing left a hole in how we could adequately respond and gear up to this once-in-a-lifetime pandemic.

So funding, stable funding, is essential to a successful health department and to the response of a successful health department.

Chairman CLYBURN. Dr. Kanter, how about Louisiana?

Dr. KANTER. Thanks, Mr. Chair.

I feel very similar. The way that a lot of health departments are funding, certainly my health department, is the overwhelming majority of the operating revenue is coming from program-specific Federal grants, CDC grants, SAMHSA grants, HRSA grants that are tied very narrowly to a specific program and are oftentimes very short-lived. A couple years is a common duration.

And it's just very challenging to do anything substantial, anything long-term, anything that builds capacity when you're hamstrung with that.

We find that departments can do exactly what they're funded to do, which is what was important a year prior when that funding came down, but they can't do much to build for the future.

So in looking back through this pandemic, and I'm proud of how Louisiana responded and my department, but I don't feel well prepared for the next thing because the next thing is going to be a little bit different, and I don't anticipate having a lot of resources that have the type of flexibility that we're going to need to build what we have to build to do that.

Chairman CLYBURN. My district is largely rural, and I am concerned about the chronically underfunded public health departments that serve rural communities.

Dr. McKenney, why is it so important to ensure that public health departments have adequate funding?

Dr. MCKENNEY. Thank you for this great question.

Really, I would say that rural communities and urban communities are so intimately intertwined. So what happens in our rural communities affects urban communities and vice versa.

So when I talk about my small health department that only has four full-time employees, if we lose one, we lose two, I mean, really, we're not able to do the things that we need to do every day to take

care of moms and babies, to do routine childhood vaccinations, to take care of the public in general and do that type of education.

One lost employee is a huge hit on a health department the size of ours in our rural community.

So funding, stable funding, as we talked about, is such an important thing so that we can continue to plan for the future so that we know what we have to work with, so that we can actually stay open. We want to keep our doors open because every rural citizen deserves as much of the services and the public health education as any urban community, and we want to keep that going within every community.

Chairman CLYBURN. Well, thank you very much for that. I suspect that we won't be able to get another question in, in 15 seconds. So in the absence of the ranking member, the chair is pleased to recognize Dr. Miller-Meeks.

Mrs. MILLER-MEEKS. Thank you so much, Mr. Chair.

And I want to thank all of our witnesses here for their testimony. As a former Director of the Iowa Department of Public Health, I'm deeply appreciative for the work that all of you do. So not only a physician but a former Director.

And, in fact, I spoke on the floor of Congress in criticism of the latest COVID relief bill that passed because less than one half of 1 percent of the total \$1.9 trillion funding went to public health work force, and it could have gone to public health work force in non-competitive grants to local public health work force, of which in Iowa there are 101 local public health work forces, county departments, who did amazing work during the pandemic.

As we all know, the coronavirus crisis presented a unique and profound challenge for our healthcare communities. The impact of the economic lockdowns and school closures had on our economy and general well-being cannot be understated as well.

In fact, the World Health Organization found that government imposed lockdowns can have a profound impact on individuals, communities, and societies by bringing social and economic life to a near stop, and this is especially true for our already vulnerable groups.

Last April, I wrote an article about the impact that the lockdowns would have on excess deaths from cardiovascular events, from untreated cancers, undetected cancers, cancers that were not continuing on their treatment use, from increased drug use, addiction, and overdose, and from increased anxiety, depression, and, unfortunately, suicide.

The United Nations Children's Fund has estimated that these lockdowns the increased childhood poverty rate by 15 percent. Additionally, mental health problems are up 31 percent.

Drug use and addiction resulting in overdose have exploded. The San Francisco Chronicle relayed in January of this year, published that deaths in the 18-to 45-year-old age group by drug overdoses far exceeded deaths in that age group from COVID-19.

And children as young as nine have committed suicide.

How we have responded to reopening our economy and getting back to normal is also troublesome to me and presents a challenge for the healthcare sector specifically.

Dr. McKenney, Dr. Roberts, and Dr. Kanter, all three of you mentioned in your written testimony issues with turnover and the struggle to recruit and retain healthcare workers. Meanwhile, we see an administration pushing for vaccine mandates among these very populations.

These are the brave men and women who worked tirelessly, and many of you in your local departments have worked tirelessly over a year through the pandemic with no vaccine to care for our country.

This seems a little bit hypocritical to me that these healthcare professionals receive a vaccine after fighting this virus for 18 months and have the wherewithal and knowledge to understand and make an informed decision.

So I'd like to ask all of you, do you believe that we should be recognizing immunity as the broad base of immunity that we know in public health, which is immunity either acquired from an infection or from a vaccine?

So if you would each keep your answers brief. Do we acknowledge that and recognize that there is immunity? Should we be talking about immunity, and immunity, whether it's acquired through infection or natural immunity or acquired through vaccine?

Chairman CLYBURN. Dr. Resnick?

Ms. RESNICK. I'm not a virologist, but I do want to offer a statement, a quote from Dr. David Thomas, chief of the Hopkins Division of Infectious Diseases, who stated that, "I would advise persons previously infected to consider adding vaccination if they haven't already received it. SARs-CoV-2 infection can kill and produce long-term side effects that no one wants. Vaccination remains the best way to be protected without experiencing the risk of infection."

Mrs. MILLER-MEEKS. Well, I would say those recent studies that have come out from Israel do, in fact, highlight the broad based immunity of naturalized infection. No one is suggesting that people go out and get infected or have a COVID-19 party like chickenpox.

So, Dr. McKenney, yes or no?

Dr. MCKENNEY. Yes. I would be happy to answer.

In response to the Israel study, we are all very anxious to see more data come out in various studies.

With that, the risk of getting natural immunity, like you mentioned, is so high. We've seen the consequences of COVID. And so—

Mrs. MILLER-MEEKS. Again, I'm not asking about the risk.

Dr. MCKENNEY. Yes.

Mrs. MILLER-MEEKS. I'm asking, should we be talking about immunity as a broad based immunity like we do for any other infectious diseases? None of us want people to go out and deliberately get infected.

So thank you for that.

Dr. Roberts?

Dr. ROBERTS. Thank you for the question.

I would just add, as you mentioned before, that vaccine mandates are very common in the healthcare sector, and for many of those, we do allow a natural immunity as an option if they can prove that.

Mrs. MILLER-MEEKS. Thank you so much. And I, in fact, have a bill that asks that we mandate insurance coverage for testing for antibodies and T-cell antibodies so we can show proof of immunity.

And then, Dr. Kanter?

Dr. KANTER. Yes. Thanks, Rep. Miller-Meeks. I respect you as a colleague, both as a doc and a state health officer, a former Health Officer.

I agree. I think there needs to be more discussion. The data out there is somewhat inconclusive. The Maccabi data, I think, has some selection bias issues.

There's compelling data from Kentucky and Alabama that shows that natural protection from an infection is somewhat unpredictable. About a third of people that get natural infection might not mount an antibody response.

There are also other viruses that we still vaccinate people for after they have an infection, like varicella.

So I think it's complex. But I advise my patients who had COVID-19 infection that they get more protection if they go and get vaccinated after that.

Mrs. MILLER-MEEKS. So I think testing for the immune response would be a very valuable piece of information in that data.

So thank you, and I yield back my time.

Chairman CLYBURN. Thank you very much.

The chair now recognizes for five minutes, Ms. Waters.

Ms. WATERS. Thank you very much, Mr. Chairman. I'm very appreciative for you holding this hearing. I think it's so very important.

First, let me say, of course, I'm in Los Angeles County, and we have the Director of Los Angeles County Public Health, Dr. Barbara Ferrer, and she is absolutely wonderful. She works long hours. Not only is she managing that department, but she does public appearances. She responds to requests from legislators and others on town hall meetings, virtual meetings, on and on and on. And this department works very hard.

And I am always amazed that we have so many entities in L.A. County who are following the advice. I have been tested at least six or seven times for every event, public event that I've gone to. Those entities in L.A. County have required that you have recent testing. They're taking temperatures, and they're asking for proof of vaccination. They're following the leadership of Dr. Ferrer in L.A. County, and they're doing a good job.

But I know they're overworked. And without even talking about funding, it is just absolutely necessary that they have the staffing, that they have the funding that's needed to do the kind of work that they're doing and provide the kind of protection that they're providing.

Given that we have our health departments, our public health departments who are struggling because many of them, not only are they under attack, as has been testified to here today, they are basically dealing with these contradictions that I just don't understand.

And I want to ask any and all of our witnesses here today, how do we reconcile that we have so many people who are

unvaccinated? As I understand it, we have 70 million eligible Americans who remain unvaccinated.

And a recent CDC study found that unvaccinated people are 29 times more likely to be hospitalized with severe coronavirus. More than 97 percent of recent coronavirus deaths are among the unvaccinated persons.

Can you help me to understand how we could have our legislators or anybody else who believes that the unvaccinated personnel should be taking care of people who are very ill and being hospitalized because of the coronavirus?

Dr. Resnick, how does this work? Does that make good sense? I mean, how is it we could say that there are workers who should not be mandated to be vaccinated themselves who are taking care of unvaccinated people who are crowding our hospitals?

Ms. RESNICK. So, good question, Congresswoman. I might yield to my physicians to give more specific examples.

But I do know that the evidence has shown that vaccine mandates that are crafted well are effective in terms of having us well staffed and well protected. And, obviously, as we know, vaccination does remain the best way to be protected without experiencing risk of infection.

Ms. WATERS. And so, I don't know if it's proper for me to ask you, having stated what you've stated, that do you believe that mandating vaccinations throughout our society would help to defeat this coronavirus that we're confronted with, this pandemic?

Ms. RESNICK. So from a personal standpoint, I feel like it is a complicated question, and oftentimes individual communities have their own needs. But I think a key point of this hearing here is that we need a strong public health infrastructure to start.

So having better information, being able to start out ahead of the game, knowing what's going on, having testing and information and data, could help inform our decisions to then, first of all, get out ahead of it, hopefully; and, second of all, be able to make informed decisions that might be appropriate for each individual place. For example, a nursing home is going to be different than a bowling alley, different than a hospital.

Ms. WATERS. Dr. Roberts, what do you think about that? Should we have more mandates?

Dr. ROBERTS. Well, thank you for the question, Congresswoman Waters.

I would just add that we have had vaccine mandates in our country for many years. It is something common that kids have to be vaccinated to go to school. It is very common that healthcare workers have to be vaccinated against certain infectious diseases.

This is not new. Our response to this pandemic is no different than how public health has been working for the last 100 years.

I do think we need to educate our public and our healthcare work force about the vaccine. I've spent lots of time and effort educating our community, educating agencies about the safety and effectiveness of the vaccine.

But the final decision is up to the individual. And I think that vaccine mandates, again, have worked in the past. We know the vaccine is safe and effective.

And we know that individuals in the front lines, whether you are in public health, healthcare, or working in the front lines as a law enforcement officer, you are at increased risk to being exposed to this virus.

Ms. WATERS. Thank you. I yield back.

Chairman CLYBURN. Thank you very much.

The chair now recognizes Dr. Green for five minutes.

Mr. GREEN. Thank you, Mr. Chairman. I appreciate having the hearing. And of course Ranking Member Scalise.

I want to thank our witnesses for being here today.

During the last hearing, I just want to clarify some testimony that I provided. I think it was misunderstood by Mr. Raskin. I've spoken to Mr. Raskin, but I want to make sure that it's on the record.

When I spoke about natural immunity and the study out of Israel with a sample size of 700,000 people showing that natural immunity was 27 times better than the vaccine, I was not arguing that the vaccine was not effective. For people who are at risk for bad outcomes for COVID, the vaccine is a great choice.

So I want to make sure that's clear. And I did clarify. I caught Mr. Raskin offline and we spoke about it.

But I just want to make sure everybody understood what I was talking about was this natural immunity that is showing itself to be better than the vaccine. And yet, we're not considering natural immunity with vaccine mandates. And we're firing people, we're kicking people out of the military who might very well have a better answer than the vaccine.

So that was my point with the testimony last week. I wanted to clarify that. And thank you very much.

Chairman CLYBURN. Very good. Thank you.

Mr. GREEN. My biggest concern with our committee has been—and I think y'all have heard me say this many times—what we're not talking about.

And a quick example. I just flew back from Brazil. I went down to Brazil to meet with leadership down there, to talk to their military about joint military stuff, and all this as a part of my responsibilities on Foreign Affairs and as the ranking Republican on Western Hemisphere.

When I came back, I had to have a negative COVID test. Yet, thousands and thousands of migrants are coming across our southern border, they are not getting COVID tested, and our government is sending them all over the United States.

It's as if we're seeding COVID all over the country and we're not talking about that in this committee. We should talk about that in this committee. That's a big, big deal.

And of course the heavy-handed lockdowns, I'd love to spend some time talking on that. I think that those government officials created an unmitigated disaster with consequences that are going to be felt for years, small businesses forced into bankruptcies, unemployment.

As a physician, I'm very concerned about the long-term effects of delayed cancer screenings and preventative care.

I think most people here know that I had colon cancer. And I went to combat, too. I don't have survivor guilt from the war, but



I do have some survivor guilt from the cancer ward. And when you're sitting in a chemo chair getting chemo and you become friends with the person who comes every other Tuesday with you in the chair next to you and they die, you have to live with the question of, why wasn't it me that died?

Yet, here we are with all our lockdowns. There weren't cancer screenings for months. Thousands of undiagnosed cancers will kill Americans. We didn't consider the ratio. We won't look at the numbers. We won't talk about this.

And even today—I talked to my oncologist this week—30 percent below our pre-COVID levels of colon and breast cancer screening. We are still scaring people to death literally, because they're afraid to go get their cancer screening.

School closures forced millions of students to substitute screens for classrooms, and it has led to a massive setback in our educational progress for those students, not to mention the very well-documented toll on social isolation and mental health.

As an ER physician, I would see people all the time coming in with suicidal ideation, with suicidal attempts. And when it is a young person, it rips your heart out. Yet we're not talking about that.

In fact, while we know for a fact that there's been a 30 percent increase in ER visits for mental health issues amongst teenagers, and a 50 percent increase for women, the CDC hasn't released the suicide data for the last year.

Why? Well, we ought to know that in the midst of this pandemic. If we're going to balance out how many we lost to the virus, well, how many did we wind up harming, killing with the bad lockdowns?

I mean, we should look at that data. Why aren't we talking about those things?

I'm a clinician and I'm also an ER physician, so I think very practically.

I have so much more to talk about, Mr. Chairman, but I'm running out of time.

But I'm concerned about what we're not talking about in this committee. Last week I talked about the origins of the virus. We haven't yet talked about that.

I'm out of time, but I yield, and thank you.

Chairman CLYBURN. I assure the gentleman that the ranking member did talk about that, as you can imagine.

Mr. GREEN. I bet he did.

Chairman CLYBURN. The chair now recognizes Ms. Velázquez for five minutes.

Ms. VELÁZQUEZ. Thank you, Mr. Chairman, for this important hearing.

And I want to take this opportunity to thank all the witnesses.

Dr. Kanter, there continues to be a significant amount of misinformation regarding miracle cures for COVID. First, it was hydroxychloroquine, and now the miracle drug is the horse dewormer Ivermectin.

Dr. Kanter, how is this misinformation and junk science impacting people in your state?

Dr. KANTER. Thank you for the question, Representative Velázquez. And thanks for your work in this area, too.

It's been incredibly harmful. And there is a long history of snake oil and snake oil salesmen in this country. And it is not just for this, COVID, it's not just hydroxychloroquine and Ivermectin. Talk about an antacid like Pepcid. I've seen people talk about gargling hydrogen peroxide, and all types of other things that do nothing to help prevent or treat COVID.

I'll tell you, what I've seen clinically and what I've heard from other clinicians is patients coming in sick with COVID and shocked and angry that the Ivermectin they were taking didn't help them, or the hydroxychloroquine they were taking didn't help them, and realizing too late that what they were listening to was not accurate.

I think the essence here is we all wish that there was a silver bullet. I can't tell you how much I wish that there was a silver bullet that would be easy, one pill to make you immune. I wish that was true, and most doctors do. It's just not the case.

And while some of these medicines might not hurt the person immediately, the harm they cause is in giving a false sense of security when there are other things, like vaccination, that would really protect them more.

Ms. VELÁZQUEZ. Thank you.

There are people that know better. And when public officials do not immediately condemn the spread of misinformation or junk science, does it make your job harder to have the public follow public health guidance? And how does your agency try to combat misinformation?

Dr. KANTER. It does. It makes the job more harder. But more important than that, it hurts people.

I talk to a lot of individuals who have seen this misinformation on Facebook and social media, and believe it. And I would never fault anyone for that, because everything with COVID has been so fast paced and confusing, and that's understandable, and I have a lot of empathy for that.

It's hard to have empathy for people that know better and are trying to spread this because God knows why. But they are trying to spread it. And there are real people and real families that get hurt on the other end of it. That's tough to stomach.

Ms. VELÁZQUEZ. Thank you.

Dr. McKenney, I have been appalled by the hate and abuse experienced by public officials who are doing their best to protect us during this pandemic.

Can you please describe for us the backlash you faced when you advocated for the use of proven mitigation measures, such as masks?

Dr. MCKENNEY. Yes, absolutely. Thank you for this question.

For me, it has been a very personal experience. If you can imagine, I'm in my hometown where I grew up with all of these people, and I've been caring for them for over a decade.

And those same people, as you mentioned about the misinformation and everything, these same people are ones that do attack and ask for your termination or your resignation. And these are people I've known for my whole life.

So these are the things that truly hurt a community as a whole. It's not just the virus anymore, it's not just infection, it's not just physical health. But this leads to mental health problems, the misinformation, the problems when people are fighting in your community, when your community before the pandemic was so tight knit.

And so, absolutely, not just in rural communities, we all have communities, whether it is urban, or our church community, or whatever it is. But all the misinformation, all the attacks on people just trying to help other people have really broken our society apart in so many ways that are beyond the virus and beyond infection.

Ms. VELÁZQUEZ. Just the previous colleague was talking about mental health and how we need to study it.

Again, what toll have these threats and harassment had on you and your coworkers?

Dr. MCKENNEY. This is why we see people leaving public health now. It is not because we've been asking them to be vaccinated, truly. It's because every day they have to endure things like people lying to them about their close contacts or when their symptoms started.

It is truly the personal effect, the way they're putting their whole heart into everything that they're doing to help people, only to get other people to, again, lie or yell or attack or shame them in public for just trying to do their job. And that's such a strain and truly is a reason why we've seen so many people quit public health.

Ms. VELÁZQUEZ. Thank you for your service.

Mr. Chairman, I yield back.

Chairman CLYBURN. I thank the gentlelady for yielding back.

The chair now recognizes Mr. Jordan for five minutes.

Mr. JORDAN. Thank you, Mr. Chairman.

Dr. Resnick, in your testimony, your written testimony, you stress that public health emergency authority is essential, and the power of public health officials, state and local public health officials, in making decisions.

Should there be limits on the emergency powers of public health officials?

Ms. RESNICK. Yes. Thank you for the question, Congressman.

As I said in my testimony, yes, there should absolutely be checks and balances in thinking these things through.

Mr. JORDAN. Tell me what those checks and balances should be.

Ms. RESNICK. Well, actually, Lawrence Gostin, a law professor of global health at Georgetown University, has some criteria that he thinks we can think about for individual rights:

Is there scientific evidence that the policymaker makes sense?

Is the intervention the least restrictive possible to achieve our public health goal?

Are the measures used likely to gain the public's support and confidence?

Does the person have access to due process to challenge the intervention?

And is the measure arbitrary or discriminatory?

Mr. JORDAN. Those don't sound like checks and balances. Those sound like guidelines and just good common sense. Checks and balances means someone else has power, some other authority has

power to actually check and balance the decision made by the public health official.

What should those checks and balances be?

Ms. RESNICK. Well, again, I think, keeping these guidelines in mind—and you're right, these aren't checks and balances, they're guidelines—but thinking that through carefully before you even propose the intervention, and then, obviously, having to balance those risks. And, again, yes, the public health officials shouldn't make the decision—

Mr. JORDAN. Public health official makes an emergency decision, emergency authority, and says, "This is going to happen." What should be the—should there be a time limit on that?

Ms. RESNICK. So those are good questions. But when we think about the illness and the situation that we're facing, so if you have smallpox, you have some kind of very contagious disease, there should immediately be able to put that into place, yes.

Mr. JORDAN. So are you agreeing with me, there should be a time limit?

Ms. RESNICK. No. I think it depends on the circumstances. I don't think there could be a set—one set moment that—

Mr. JORDAN. Well, let's back up a second.

Who should be able to check the decision of the public health official?

Ms. RESNICK. So you have the local boards of health. You have the elected officials.

Mr. JORDAN. Well, now we're talking, yes. It seems to me it should be the elected officials. That's how our system works. People who put their names on the ballots should make decisions for the people they represent, not someone who's unelected.

So the checks should come from the elected body. And I'm asking what would be—for example, in the state of Ohio I know what our legislature did. They said, the public health order from the governor's office, from the state health director, there should be a time limit on how long that is in effect before the legislature—a limited amount of time they can take that decision.

But at some point the legislature gets to weigh in and say whether that's appropriate or not. Do you agree with that?

Ms. RESNICK. So, again, I think it depends on the circumstances. So, again, if you have a very contagious disease, no, I do not. But if it's a longer-term thing, yes.

Mr. JORDAN. You don't think the elected official should be able to overrule at some point the length of time of a public health decision emergency authority? A public health emergency authority decision, I should say. You don't think the elected official should be able to overrule that?

Ms. RESNICK. At some point, maybe. But I'm saying in an immediate emergency—

Mr. JORDAN. Maybe?

Ms. RESNICK [continuing]. in an immediate emergency where you have life and death.

Mr. JORDAN. I'm not arguing with that. I'm saying at some point—to your point, at some point—it seems to me at some point, of course, the elected officials can overrule that.

Ms. RESNICK. OK. I wouldn't disagree with that. But I guess the question is, at what time point and when that would be?

Mr. JORDAN. Yes.

Ms. RESNICK. Again, I think that would depend on the circumstances that you're facing, and there would be questions—

Mr. JORDAN. I think that depends on the decision the elected officials make, not the unelected official.

Ms. RESNICK. But would you think that you'd need public health guidance and information and knowledge to inform those decisions?

Mr. JORDAN. We take guidance, that's why we have hearings. We take testimony from people. That's why you're here today, we're getting information. Of course, that's always part of the process.

But in the end you don't get to decide, the public health official doesn't get to decide. The people whose names are on the ballot elected to the state legislature, they get to decide. That's how it works in our system.

Have public health officials ever been wrong, state and local public health officials ever been wrong on orders they do?

Ms. RESNICK. I don't know for sure. I'm sure there's been cases, yes.

Mr. JORDAN. How about the recent one in New York, the state and local public health officials who said we should put COVID-positive patients back in the nursing homes? It seems like that was probably wrong.

It would have been nice maybe if the legislature got to weigh in on that and change that decision. People's lives might have been saved. We've got all kinds of examples of where that's wrong. Of course, we need the check and balance of the elected officials to make these decisions.

Do you agree?

Ms. RESNICK. I also think there's emergency situations where they would have to act in immediacy.

Mr. JORDAN. No one disagrees with that. That's why the legislature gave them emergency authority for a limited amount of time. But at some point the elected officials get to weigh in.

I see I'm out of time. I yield back.

Chairman CLYBURN. I thank the gentleman for yielding back.

The chair now recognizes Mr. Foster for five minutes.

Mr. FOSTER. Thank you.

Maybe I'll start with just a simple question to Drs. Kanter, McKenney, and Roberts.

Do you have any doubt that if everyone in your state had been promptly vaccinated as soon as it became available then the ICUs and the rest of your medical system would not be under stress today?

Dr. KANTER. Thanks, Representative Foster.

I don't. I have absolutely no doubt that if that had happened, we would have averted the situation we did. And we're coming out from our Delta surge right now. It was the largest surge to date. And we stressed our hospitals absolutely to the brink. We avoided catastrophe, but we came awfully, awfully close.

Mr. FOSTER. And do you ever think about what the situation would be if in some parallel universe everyone had taken the vac-

cine as soon as it became available? It must kind of break your heart and contribute to the burnout.

Dr. McKENNEY?

Dr. MCKENNEY. Yes, I would agree. And thank you for asking. I agree with Dr. Kanter that I have no doubt that if we did come out and have everybody vaccinated from the beginning, then we would be in a much different place right now.

I don't even think we need an alternate universe. We saw that with polio and we saw that in history. And so, we have that luxury of being able to look back, and that is our research and that is our proof.

So I wish that that had been the case early on for all of us. A lot of lives would have been saved.

Mr. FOSTER. Dr. Roberts?

Dr. ROBERTS. I agree with my colleagues. I have no doubt whatsoever that we'd be in a very different position now had more of our community been vaccinated. Our hospitals are seeing rates comparable to what they saw in December 2020, which was before we even had a vaccine.

And so, this Delta surge, which is still ongoing in Ohio, is hitting our urban areas and our rural areas very hard. And with only about 52 percent of the state's population being vaccinated, I am very confident that if we had a higher vaccination rate we would not be experiencing what we are seeing now in our hospitals.

Mr. FOSTER. And so, when you hear our Republican colleague, the ranking member, state that, well, we know that there are breakthrough cases and therefore somehow it's OK if people remain unvaccinated, what's your reaction to that line of logic, that the vaccines aren't perfect, therefore people shouldn't have to take them?

Dr. ROBERTS. Well, first of all, nothing in life is perfect. The vaccines are very effective. And from talking to my hospital colleagues about our breakthrough cases, the vast majority of our breakthrough cases are found in our elderly population and those with underlying health conditions, which are the same population that have now been eligible for a third or a booster dose of a vaccine to give them that extra level of protection.

So I would say the vaccines are very effective. And for the average healthy adult and child, if they are vaccinated, they are six times less likely to be hospitalized and to die from a COVID-19 infection.

Mr. FOSTER. And as a scientist, I will be paying very careful attention to the experiment we are seeing in real time, where countries like Italy, I believe, which are implementing a nationwide vaccine mandate, to see if they see a different course of COVID than we will see in our country, where we believe it's a—some of us seem to believe it's a matter of individual choice to do something that puts your fellow American at risk.

Dr. Resnick, you emphasized modernizing electronic health data systems, which I think all of us were sort of shocked at how little information we had early in the pandemic, even elementary things like ICU occupancy, the number—the fraction of people sick with COVID, the testing reporting system.

I want to make two quick points.

First, the Congress has actually done something on this—and the Senate, of course, is sitting on it—which is to remove the Federal law against having a unique patient identifier. This is simply a system that patients can opt into to have a unique identifier for all the electronic health records. And we passed that unanimously through the U.S. House. For the last 25 years it's been illegal for the electronic health record systems to do that, to develop such a system.

And so, can you comment on if we had a rational way for a patient to have a health record where you could collect the testing status, the vaccination status, other relevant aspects in a single location, how that might have transformed the response?

Ms. RESNICK. Yes. So I think, obviously, these are complicated issues with privacy and other questions. But I think the key point is that they have to be interoperable so that people can share. And right now what we're facing is, as we saw with COVID, you can't even share information between state, local, tribal agencies.

And so, having an ability to do that—and, again, I'm not an expert on all the privacy rules, so I think you'd have to have lots of discussion around it—but the key point would be that you'd have to be able to share that information across governmental levels would be super important.

Mr. FOSTER. And so, yes. Israel, for example, has multiple competing providers, but they have a unique identifier so that you can pull in all of the health data for one patient when they opt into the system.

Anyway, so I urge everyone to continue thinking about putting pressure on the Senate to do the right thing and save tens of thousands American lives a year.

Thank you. I yield back.

Chairman CLYBURN. Thank you very much, Mr. Foster.

The chair now recognizes Mr. Krishnamoorthi for five minutes.

Mr. KRISHNAMOORTHY. Thank you Mr. Chair, for allowing me to participate virtually.

I've been reading these articles about threats to public health officials, and they are very startling. I just read an article detailing how in Kent County, Michigan, just last month, a man, a public health official, whose public health department issued a mask mandate, said that a woman driving more than 70 miles an hour tried to run him off the road twice in one night. He said someone also called him an expletive and then yelled, quote, "I hope someone abuses your kids and forces you to watch."

In another incident, this time in Colorado, in Jefferson County, Colorado, someone threw live fireworks into a tent of public health workers administering vaccines.

And then, in Ohio, someone actually went up to a former public health official's home and shot into their home, in a suburb that's not otherwise known for gun violence.

Dr. McKenney, let me start with you for a moment. You've seen this backlash, and you talked about it a little bit. I also saw that you told NBC News that it might have something to do with your race.

Can you talk to us a little bit about that? As an Asian American, I'd be curious about your observations there.

Dr. MCKENNEY. Yes. Thank you so much for asking.

I do believe that there is a lot more that has to do with race within the pandemic that we haven't talked about, and that might be the hate against Asians that we've seen out there.

It also might be the discrepancies in the care that people have gotten because of their various races or socioeconomic status.

So there is so much more to it, I think, than we have really even able to dive into at this point.

As a Filipino-American woman in a small town in Kansas, you can imagine I'm not exactly what everybody looks like here. My benefit is that I've grown up here, so they know me, and I've built trust over the years.

But even with that, you still hear the comments about how this an Asian or a Chinese disease, and you feel the fingers being pointed.

There's no denying that there have been racial issues throughout this entire pandemic. And it's so unfortunate, because, again, that is not what we're trying to fight. We don't need to be fighting each other. We need to be fighting this virus. And somewhere along the way people decided——

Mr. KRISHNAMOORTHY. May I jump in for a second?

Dr. MCKENNEY. Yes, please.

Mr. KRISHNAMOORTHY. Did any officials or public figures exacerbate that particular situation for you in the way that they talked about the public health threat?

Dr. MCKENNEY. I did not personally have anyone that was an elected official say that directly to me.

Mr. KRISHNAMOORTHY. OK.

I think that this is something that we have to tamp down, which is anti-Asian-American bias, and, of course, anti-Asian hate crimes. And, unfortunately, it's manifesting itself everywhere, including toward public health officials where you see a disproportionate number of people of Asian-American heritage represented.

Dr. Kanter, I understand that you recently spoke at an assembly where you were talking about the efficacy of mask wearing, and somebody said you were, quote, "complicit in genocide" for making people take these vaccines. So I guess you also talked about the effectiveness of vaccines.

How dangerous is it when people believe that public health officials such as yourself are complicit in, quote/unquote, "genocide"?

Dr. KANTER. Thanks. I appreciate the question. As the grandson of Holocaust survivors, that was a particularly stingy comment to make.

I just wish people would tone it down. And I think we can have a discussion about what the prudent public health response is. And there is room for that discussion without taking it to the level of personal attacks, without even assuming that people are doing things because they're trying to be a "tyrant," quote/unquote.

But there's been a lot of these high-level accusations, there's memes with Nazi imagery. And it just needs to be taken down, because the things that Dr. McKenney described are real and people are going to get hurt and the people that are trying——

Mr. KRISHNAMOORTHY. Let me just jump in and summarize. I think that the anti-Asian or anti-Semitic tropes that kind of are



coursing through social media generally and in the White supremacist movement are also being directed at public health officials now. And this is deeply dangerous. And we have to combat it wherever it rears its ugly head.

Thank you so much.

Chairman CLYBURN. I thank the gentleman.

And I thank all the witnesses here today.

Before we close—I don't see anybody else to be recognized—before we close, I would like to enter into the record letters the committee has received from the National Association of County and City Health Officials, American Public Health Association, Big Cities Health Coalition, and Network for Public Health Law, with respect to some of the challenges facing state and local public health officials.

I ask unanimous consent that these letters be entered into the official record. So ordered.

Chairman CLYBURN. In closing, I want to thank Dr. McKenney, Dr. Roberts, Dr. Kanter, and Dr. Resnick for testifying before the Select Subcommittee today. We appreciate your personal stories, your expertise, and your continued leadership in the face of multiple challenges.

I often quote Dr. Martin Luther King, Jr.'s statement issued at a healthcare conference back in 1966, and I quote: "Of all the forms of inequality, injustice in health is the most shocking and the most inhumane because it often results in physical death." End of quote.

Dr. King is often misquoted to have said "injustice in healthcare." And healthcare is obviously critically important for health. But he said, "Injustice in health is shocking and inhumane because it is often results in physical death."

State and local health departments do far more for the health of their communities than provide healthcare. They promote healthy lifestyles, conduct health education, stop the spread of disease, and so much more. Their services are particularly important for vulnerable communities who have long suffered health disparities and inequity.

The neglect of these public health agencies has caused injustice in health that has, particularly during the coronavirus pandemic, resulted in physical death of far too many Americans.

We must end this shocking and inhumane injustice by investing sustainably in state and local public health departments. We must revitalize the public health work force, which is facing high burn-out rates and rapid turnover. These investments will result in better health outcomes and can lead to less overall health spending.

Fortunately, the Biden administration is already making historic investments to upgrade our public health infrastructure, ensuring that state and local public health departments have the resources they need to combat the coronavirus, be better prepared for the next pandemic, and improve the overall health of the people in their communities.

I look forward to continuing to work with President Biden to rebuild and strengthen state and local public health departments and the entirety of our public health infrastructure moving forward.

As we heard today, longstanding public health funding and work force challenges are significant. But we are also facing more acute problems.

The unprecedented level of harassment, threats, and attacks against public health workers during the pandemic, fueled by an alarming anti-science movement, must be addressed head on. We cannot allow our public health officials to be subjected to such outrageous behavior simply for doing their jobs to keep Americans safe and healthy.

We must also reject attempts to undermine public health authorities for political purposes. Public health decisions must be made by experts based on the best available science, not politics.

Underinvestment in public health has consequences. Politicalization of public health has consequences. Attacking public health workers has consequences.

Nearly 700,000 Americans have now died from the coronavirus. To prevent this level of unjust physical death in the future we must protect, rebuild, and strengthen our public health infrastructure, starting with the state and local public health departments and the dedicated Americans who have devoted or will devote their careers to protecting the health of their communities.

I look forward to working with today's witnesses, my colleagues here in the Congress, and the Biden administration to do just that.

And with that, without objection, all members will have five legislative days within which to submit additional written questions for the witnesses to the chair, which will be forwarded to the witnesses for their response.

This hearing is adjourned.

[Whereupon, at 3:55 p.m., the subcommittee was adjourned.]

