



AMERICAN PUBLIC HEALTH ASSOCIATION
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**House Committee on Ways and Means, Subcommittee on Health
“The Path Forward On COVID-19 Immunizations”
Friday, February 26, 2021**

Chairman Doggett, Ranking Member Nunes and members of the subcommittee, thank you for the opportunity to address you today. I am Georges C. Benjamin, MD, executive director of the American Public Health Association in Washington, D.C. APHA champions the health of all people and all communities. We strengthen the public health profession, promote best practices, and share the latest public health research and information. We are the only organization that combines a nearly 150-year perspective, a broad-based member community and the ability to influence policy to improve the public’s health.

Our nation has undergone the greatest infectious public health threat in over 100 years. SARS-CoV-2, the virus that causes COVID-19, has infected over 28 million individuals and cost the lives of over a half million people. This death toll over a single year is more than the death toll of the six years of WWII combined. It is a staggering amount of mortality that does not yet have a full accounting when we include the number of noninfected people whose overall physical and mental health have been impacted. We do know, however, about the magnitude of the toll this disease has taken on life expectancy in our nation. Just last week, the Centers for Disease Control and Prevention reported that the provisional life expectancy for all Americans was reduced by 1 year in the period from January to June of 2020.¹ The reduction was 0.8 years for non-Hispanic White Americans, 2.7 years for non-Hispanic Black Americans and 1.9 years for Hispanic Americans. This same CDC report found that Black men had a reduction in life expectancy of 3 years and Hispanic men of 2.4 years (compared to a reduction of 0.8 year for non-Hispanic White men). Non-Hispanic Black females had a reduction of 2.3 years and Hispanic females of 1.1 years (compared to a reduction of 0.7 year for non-Hispanic White females). These are big declines in life expectancy for all portions of our populations by all public health measures, and these declines will not be easy to reverse.

Nevertheless, we do have effective public health and medical tools to address this tragedy. These tools include a range of nonpharmacological interventions such as wearing a mask, hand hygiene, physical distancing and avoiding large crowds. Because this is a disease that you catch from other people, generally through the respiratory route, these interventions are

¹ Centers for Disease Control and Prevention. NVSS Vital Statistics Rapid Release. Provisional Life Expectancy Estimates for January through June, 2020. Feb. 2021. Available at: <https://www.cdc.gov/nchs/data/vsrr/VSRR10-508.pdf>

highly effective but burdensome, and not practical for the long haul. We do have one intervention that is highly effective and has been recommended by CDC to reduce the morbidity and mortality from infection:² vaccines.

The nation participated in a bold national effort to produce a new type of vaccine using a platform known as mRNA that had been under scientific study for over 20 years. Using the mRNA platform, scientists around the world have produced, in record time, an mRNA-based vaccine that is both safe and effective in protecting people from the current strains of the SARS-CoV-2 virus. While we are aware of many evolving strains that could impact the degree of efficiency of the current vaccines, to date the vaccines still appear highly effective. We all applaud the effort in getting the vaccine studied and approved expediently through the emergency use authorization process. This was done with full scientific transparency and rigor. Yet, having a safe and effective vaccine and getting that vaccine into the arms of a susceptible population are two entirely different matters.

The process to actually vaccinate people started off slowly but has begun to pick up speed, and as of Feb. 23, 2021, according to the CDC, we have administered over 64 million of the 75.2 million doses available. This has resulted in 43.6 million people having received one dose and 18.8 million receiving the full two doses. Despite this encouraging progress, we are seeing troubling trends in disparities when it comes to who is being vaccinated, particularly in communities of color and among seniors. These disparities mirror those we saw in the early days of PCR testing for SARS-CoV-2 and raise concerns for exacerbations in the clinical disparities we already see in the prevalence of COVID-19 disease³ and additional disparities in life expectancy.

A recent report by the Kaiser Family Foundation found significant disparities in vaccination in African Americans, Hispanics, Native Americans and Asians when compared to non-Hispanic Whites in the 16 states reviewed.⁴ These disparities represent the impact of both vaccine hesitancy as well as structural barriers that disadvantage communities of color and other underserved populations.

Vaccine Hesitancy

Vaccine concerns have been identified as an important barrier to getting people vaccinated. The NAACP in partnership with the COVID Collaborative looked at the issue of vaccine hesitancy in African American and Latinx communities and in the fall of 2020 found that “fewer than half of Black adults, 48 percent, say they probably or definitely would get a coronavirus vaccine if it were available for free – including just 18 percent who definitely would get vaccinated. Among Latinx adults, interviewed for comparison, far more likely would get vaccinated, 66 percent, including 31 percent definitely.”⁵ Other surveys have found similar results; however, vaccine reluctance can be addressed through a range of established public

² Centers for Disease Control and Prevention: Benefits of Getting a COVID-19 Vaccine

Available at: <https://www.cdc.gov/coronavirus/2019-ncov/vaccines/vaccine-benefits.html>

³ Kaiser Family Foundation Report: COVID-19 Racial Disparities in Testing, Infection, Hospitalization, and Death: Analysis of Epic Patient Data. Sept. 16, 2020. Available at: <https://www.kff.org/coronavirus-covid-19/issue-brief/covid-19-racial-disparities-testing-infection-hospitalization-death-analysis-epic-patient-data/>

⁴ Kaiser Family Foundation report: Early State Vaccination Data Raise Warning Flags for Racial Equity. Jan. 21, 2021. Available at: <https://www.kff.org/policy-watch/early-state-vaccination-data-raise-warning-flags-racial-equity/>

⁵ Coronavirus Vaccine Hesitancy in Black and Latinx Communities. The COVID Collaborative. Nov. 2020. Available at: <https://www.covidcollaborative.us/content/vaccine-treatments/coronavirus-vaccine-hesitancy-in-black-and-latinx-communities>.

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

Most people are curious about the vaccine, do not know enough about it and are eager to know more before deciding to get vaccinated. A recent poll by Frank Luntz for the de Beaumont Foundation⁶ found that using certain words and approaches will increase vaccine adoption:

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

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

Structural Barriers

Significant structural barriers continue to unfairly disadvantage underserved populations, and that holds true in terms of COVID-19 vaccination. For example:

- Getting an appointment to be vaccinated is more difficult for people who don't have access to a computer, Wi-Fi, or broadband services.
- Currently appointments are not well-coordinated, do not have a single point of entry and are often hard to find.
- Limited numbers of telephone-based appointment systems, language barriers and the limited number of available appointments are barriers that can widen existing disparities in vaccine access.
- Jobs that require specific shift hours can make it difficult to access the appropriate system to schedule an appointment before all of the slots are gone for the day.
- The location of the vaccination site can also prove to be a significant barrier if access requires the use of a car or if the vaccination site is located in an area that is unreachable by public transportation.

Creating an organized, single point of entry for each state or political jurisdiction as appropriate that avoids duplicate appointment systems is ideal, and we should work to create them. Vaccine appointments also need to be provided over extended hours and on weekends to accommodate those with non-traditional work schedules. Follow-up appointments and reminder systems should be used to ensure people are both aware of the need for a second dose and to

⁶ Poll: The Language of Vaccine Acceptance. The de Beaumont Foundation. Dec. 2020. Available at: <https://debeaumont.org/news/2020/new-poll-reveals-effective-language-to-improve-covid-19-vaccine-acceptance/>

expedite the second appointment. Follow-up appointments should be scheduled at the conclusion of the initial vaccination whenever possible.

The importance of a stable and adequate supply of vaccine is essential for vaccination planners working to ensure equitable access to vaccines. Yet despite a substantial increase in vaccine supply, the shortage continues to be a major problem in many communities and remains a major barrier to effective planning, scheduling and vaccine delivery. The Biden administration should be supported in their efforts to increase vaccine supply.

Equitable vaccine distribution within states has been reported to be an issue, and the term “vaccine redlining” has been coined to illustrate the view that vaccine is preferentially going into communities of affluence over the underserved and communities with high COVID impact. The vaccine distribution situation has improved somewhat as vaccine supply has increased, but it will be critical to ensure that as we achieve/develop a stable, reliable supply line, we assure equal access to vaccines for underserved populations and those who are at highest risk for COVID-19.

Vaccine tourism is a growing issue in many communities. People jump the line by going to different states or communities to be vaccinated ahead of the resident population. In some regions where the tradeoff is of people being vaccinated where they work versus where they live or where regional lines cross political boundaries this may not be an issue because the exchanges cancel each other out. But in other instances, it is unacceptable when individuals use their influence and get vaccinated ahead of a designated priority group or get vaccinated and in effect “crowd out” access to vaccine for the communities that are hardest hit.

Using pharmacies that are located within the community will help with access; however, the sites with adequate vaccine are often not in communities of greatest need. I am aware that some pharmacy chains are proactively contacting established customers to get them in for vaccination and reaching out into hard hit communities of need with pop-up clinics and providing transportation to vaccination appointments. Federally qualified community health centers are an important element to solving this problem. These centers are located in the community and have the trust of these communities that is needed to address the hesitancy issues. Additional programs that provide transportation to and from vaccination sites or bring vaccines to a specific community are also needed.

As we roll out the national vaccination program and vaccine availability to the broad public increases, we need to ensure we address the many essential workers who have not yet been fully engaged. These include teachers, grocery store cashiers, meat packers, sanitary workers and others whose jobs are essential to keeping our society open. Health care providers have also had some issues in getting vaccinated; for example, primary care providers and dentists who are not linked to hospitals have reported having trouble getting themselves and their staff vaccinated. Ensuring their coverage and access needs to be a higher priority as well. We need to make sure we have enough trained individuals to give vaccinations. An all-hands-on-deck approach to use all of available vaccinators will likely allow us to mobilize enough qualified people for peak vaccination duty. Retired health workers with skills to vaccinate are ready and able to be engaged in this effort.

A Strong, Well-Resourced Public Health System is Essential

We are grateful for previous emergency supplemental funding approved by Congress to address the COVID-19 pandemic, including funding to support the distribution and administration of vaccines, but we know more must be done. We strongly support the additional funding proposed by the Biden administration and contained in the American Rescue Plan Act of

2021 currently before Congress. This legislation would provide essential additional funding for strengthening the public health workforce, including \$7.6 billion to hire contact tracers, public health nurses, epidemiologists, community health workers and other essential workers to help address COVID-19. The legislation would also provide \$20 billion to bolster the nation's vaccine distribution and administration efforts, including for state, local, tribal and territorial public health departments. It would also provide \$50 billion for improving our testing, contact tracing and other actions to prevent the spread of COVID-19, among many other important provisions. Congress should pass this legislation immediately and send it to President Biden for his signature.

A strong public health infrastructure and workforce are essential to help ensure our public health system is equipped to play its vital role in vaccine distribution and administration. Unfortunately, we have failed to adequately invest in our nation's public health infrastructure and workforce. In order to better ensure our public health infrastructure is adequately prepared for addressing the current pandemic, future pandemics and other public health emergencies, we must seriously look at fixing our vastly underfunded public health system. APHA is calling on Congress to provide \$4.5 billion in additional long-term annual mandatory funding for CDC and state, local, tribal and territorial public health agencies for core public health infrastructure activities.⁷ This funding would support essential activities such as: disease surveillance, epidemiology, laboratory capacity, all-hazards preparedness and response, policy development and support, communications, community partnership development and organizational competencies. This funding is critical to ensuring our state and local health departments have broad core capacity to not only respond to the current pandemic but to better respond to the many other public health challenges they face on a daily basis. For far too long, we have neglected our nation's public health infrastructure, and we must end the cycle of temporary infusions of funding during emergencies and provide a sustained and reliable funding mechanism to ensure we are better prepared to protect and improve the public's health, including our most vulnerable communities, from all threats.

Congress should also authorize and appropriate funding for a public health workforce loan repayment program.⁸ Providing funding for this important program will help incentivize new and recent graduates to join the governmental public health workforce, encourage them to stay in these roles, and strengthen the public health workforce as a whole. The public health workforce is the backbone of our nation's governmental public health system at the county, city, state and tribal levels. These skilled professionals deliver critical public health programs and services. They lead efforts to ensure the tracking and surveillance of infectious disease outbreaks, such as COVID-19, prepare for and respond to natural and man-made disasters, and ensure the safety of the air we breathe, the food we eat, and the water we drink. Health departments employ public health nurses, behavioral health staff, community health workers, environmental health workers, epidemiologists, health educators, health policy experts, nutritionists, laboratory workers and other health professionals who use their invaluable skills to achieve health equity and keep people in communities across the nation healthy and safe.

⁷ Organization letter urging a significant, long-term investment in public health infrastructure in future legislation to speed the response to the COVID-19 pandemic. Feb. 12, 2021. Available at: https://www.apha.org/-/media/Files/PDF/advocacy/letters/2021/210212_PH_Infrastructure_funding.ashx.

⁸ Organization letter to House leaders in support of including public health workforce loan repayment legislation in the next COVID-19 legislative package. June 26, 2020. Available at: https://www.apha.org/-/media/Files/PDF/advocacy/letters/2020/200626_PH_workforce_House.ashx

APHA also supports the proposal to launch a Public Health Job Corps, and to add 100,000 new workers to our field. This Corps should engage new individuals in the effort to end the pandemic and in the long term to support healthy behaviors in a culturally and community-relevant manner. These workers will be based in local communities and can help with efforts around vaccination and contact tracing for COVID-19. They also, hopefully, can become trusted community voices for health in these communities. This Corps would make a valuable contribution to building a sustainable and diverse public health workforce in the U.S.

In addition, to ensure our states, cities, territories and tribes are better prepared for the next emergency, it is essential that Congress increase annual discretionary funding for programs within the Centers for Disease Control and Prevention and the Health Resources and Services Administration. Funding for these two agencies remains woefully inadequate to meet the many public health challenges faced by our nation. CDC is a key source of funding for many of our state, local, territorial and tribal programs that improve the health of our communities. CDC serves as the command center for the nation's public health defense system against emerging and reemerging infectious diseases. From playing a leading role in aiding in the surveillance, detection and mitigation of the COVID-19 pandemic in the U.S. and globally, to playing a lead role in the control of Ebola in West Africa and the Democratic Republic of the Congo to monitoring, investigating and helping to control the recent measles outbreaks in the U.S., to pandemic flu preparedness, CDC is the nation's – and the world's – expert resource and response center, coordinating communications and action and serving as the laboratory reference center. States, communities and international partners rely on CDC accurate information, direction and resources to ensure they continue to be prepared for and able to respond to and recover from a crisis or outbreak.

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

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

We also support the enactment of legislation that directly targets existing disparities and promotes health equity. This would include legislation that provides support and coordination at the federal level for addressing the social determinants of health that underlie many existing racial and ethnic health disparities. We also need legislation that addresses these disparities directly through promoting equity in health care access, workforce representation, data collection and other areas. Existing legislation that would help further these efforts includes the Health Equity and Accountability Act (introduced in the last Congress as H.R. 6637) and H.R. 379, the Improving Social Determinants of Health Act of 2021.

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