Prepared Statement of Ranking Member Richard Burr

Examining Our COVID-19 Response: Improving Health Equity and Outcomes by Addressing Health Disparities

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Thank you to our witnesses for being here today to discuss ways to improve our pandemic response for those hit hardest by it, especially low-income, minority, and rural populations. This Committee has a long history of working together on health care issues that affect our seniors, our children, Americans with disabilities, and in supporting our hardest to reach communities. To our witnesses, thank you for your work during the pandemic, and for taking time away from your critical work to share your experiences with us today.

The disproportionate impact of COVID-19 on minority populations, people in rural areas, and others has revealed cracks in our health care system that persist despite efforts to improve care, including through community health centers and the National Health Service Corps, which seek to improve care for underserved communities. This pandemic has given us another perspective on these challenges and demonstrates a need to redouble our work to address the underlying problems facing these and other affected populations. Each response requires the ability to identify the problems local communities will face, strong leadership to recognize

the best solutions, and an ability to leverage the right approaches and technology to execute those changes.

With each emergency response, we learn about the ways each threat affects Americans differently and have adjusted our laws and plans accordingly. That is why we designed a response framework that is flexible – you never know quite how a new infectious disease or a natural disaster may impact us until it is on the ground and we are forced to respond. For example, during the last PAHPA reauthorization, Senator Casey and I included new advisory committees to identify the specific needs of our seniors and Americans with disabilities during emergencies. We also codified the Children's Preparedness Unit at the CDC to improve the availability of information for health care providers and families during the response to a public health threat.

We made changes to the PAHPA statute after the tragedies that occurred in Florida nursing homes during the 2017 hurricane season, allowing states to have better plans in place to protect their nursing home residents. Some states have done a good job of taking care of their nursing home residents during the COVID-19 response, and we can learn from the failures in New York and Pennsylvania about what not to do going forward.

We have also made changes to the PAHPA statute to improve the development of countermeasures to meet the needs of different populations, and

made sure we wrote it in a way that allowed maximum flexibility to respond to effected populations. During the response to swine flu, we realized that young children were coming into the hospital in need of a treatment. So, we worked quickly to get an emergency use authorization for flu antivirals, saving lives in real time. While we were working to treat children with swine flu, the science also showed us that some older Americans were ***less*** affected by the virus, because that generation was exposed to a similar strain of flu many years ago.

In contrast, most children appear to be less likely to experience serious illness from COVID, and older adults are at significantly higher risk. This virus has also compounded existing challenges that many communities—including rural, racial and ethnic minority, and low-income populations—face. These differences underscore the importance of maintaining flexibility as part of a public health response so that the state and local government can most effectively reach those in their communities most at risk for a particular public health threat.

The novel coronavirus has again shown us that we cannot fully anticipate the ways in which a threat will affect different communities across the country. We have utilized new technologies throughout the response to better understand just how the virus takes its toll and to do something about it. The FDA has provided greater flexibility in clinical trial design, working with drug developers to enhance enrollment in clinical trials in ways that reach more communities by deploying

remote technology that allows for patient monitoring without traveling to a major hospital. Manufacturers have gotten creative with targeting their trials to those who stand to benefit the most from a drug, with one developer creating mobile units to bring their COVID therapeutics directly to nursing homes as soon as they found an outbreak of the virus. Mobile health units have also been deployed to bring testing and vaccines to areas that need these countermeasures, and partnerships with historically black colleges and universities improved outreach to racial and ethnic minority populations on testing, participation in clinical trials, and providing information on vaccines and ways to prevent COVID-19.

Now, as we look toward the weeks and months ahead, this ingenuity needs to continue. Our response efforts must leverage technology to improve our surveillance capabilities and inform our public health decision making. And, our policies should encourage the incorporation of new technology, strategies, and partnerships to solve old problems and challenges.

I look forward to hearing your testimony on an issue with such a strong history in our Committee.

Thank you, Senator Murray.