

**Helene D. Gayle, MD, MPH**  
President & Chief Executive Officer  
The Chicago Community Trust

**House Rules Subcommittee on Legislative and Budget Process**  
Wednesday, January 19, 2022

As we enter the third year of the COVID pandemic, I would like to thank Chairman Morelle and the members of the subcommittee on Legislative and Budget Process for the opportunity to brief you on the importance of planning for the *next* pandemic. We know the emergence of the next crisis is a matter of when, not if. We must prepare by devoting resources to preventing the devastating health and economic consequences we see today.

My name is Helene Gayle. I am the president and CEO of The Chicago Community Trust, a community foundation focused on the most pressing needs of the Chicago region. I come to this role after almost 40 years of public health and global and local economic development at the Centers for Disease Control and Prevention, the Bill and Melinda Gates Foundation, and the international humanitarian organization CARE. During the current pandemic, I served as the co-chair of the National Academies of Science, Engineering & Medicine's Committee on Equitable Allocation of Vaccine for the Novel Coronavirus, which released a framework of recommendations for distributing the COVID19 vaccines equitably. I also served on a Council on Foreign Relations Task Force to Improve Pandemic Preparedness by drawing lessons from COVID-19. In addition, the Chicago Community Trust has been at the forefront of the pandemic response in Chicago, leading philanthropic efforts to respond to the COVID 19 crisis, and more recently on efforts to ensure that the recovery from the pandemic is equitable and inclusive and does not leave those disproportionately harmed by the crisis farther behind.

Since March 2020, COVID-19 has infected at least 307 million people around the world, killing nearly 5.5 million. In the United States, 60 million people have contracted COVID and over 800,000 have died. Sadly, with the recent surge of the Omicron variant, these numbers continue to grow. Beyond the health consequences, the pandemic has triggered an economic collapse. Today, employment remains below pre-pandemic levels, and millions still do not have enough to eat, are behind on rent payments, and struggle to meet household expenses.

COVID-19 has also exacerbated preexisting disparities. Low-wage workers are less likely to have paid sick leave or savings to pay for food, housing, and health care. Black, Latinx, and other people of color are more likely to be frontline workers, live in overcrowded housing, suffer from chronic diseases, and struggle to access testing, treatment, and vaccines.

While the health and economic consequences of COVID-19 have been unlike anything we've seen in recent memory, it may not be a once-in-a-generation pandemic. Future pandemic threats are inevitable and predictable. More than forty new infectious diseases in humans have emerged in the past few decades, including SARS (2003), H5N1 flu (2007), the H1N1 flu (2009), MERS (2012), the Ebola virus in West Africa (2013–16), and Zika in the Americas (2015–16) before COVID-19.

I am pleased to provide testimony and be in conversation with the Chair and members of the House Rules Committee on this consequential matter. We must take the lessons from prior global pandemics, and those of the current crisis to better prepare the U.S. and invigorate our leadership in preparation for the next pandemic that is sure to come.

*In my testimony, I offer 5 key points and accompanying recommendations for how I think we can be better prepared for future pandemics and prevent the disproportionate burden borne by the most vulnerable and under-resourced communities, here and abroad.*

1. Pandemics play on the social fault lines and will always disproportionately impact the most vulnerable. Our preparation must be equal to the task.
2. We must work with communities that are most impacted, establishing links to organizations and people who are trusted.
3. A pandemic knows no geographic and political boundaries. A go-it-alone approach is ineffective and counter-productive to preventing and addressing a global pandemic.
4. The fall-out from a pandemic can, as we have seen, be as devastating—if not more so—than an act of war or terrorism. Yet, pandemic preparedness is under-funded as compared to the investments we make in military readiness.
5. Maintaining public health infrastructure, including a well-trained and robust workforce, surveillance systems, laboratory systems, and information systems are all key lessons we should have learned from the HIV/AIDS pandemic, Ebola, SARS, etc.

*Below, I provide more detail on each of these points and clear examples of where we can do better in preparation for the next pandemic, even as we learn from and navigate our way through the current one.*

### **1. Pandemics play on social fault lines and will always impact the most vulnerable in our societies.**

COVID19 has highlighted how the social determinants of health and the underlying root causes that make one vulnerable to poor health along with lack of information (or disinformation) further amplify social inequity.

During this pandemic, infection and mortality rates have been highest among nursing home residents and Black, Indigenous, and Latinx communities. The virus causes the most severe illnesses in people with preexisting medical conditions such as high blood pressure, diabetes, obesity, and cardiovascular diseases. These underlying conditions are more prevalent among vulnerable groups with inadequate access to nutrition, health care, and a clean environment. The economic fallout also remains prevalent among Black adults, Latino adults, and other people of color who struggle getting enough food, paying rent, or covering household expenses. These disproportionate impacts reflect long-standing inequities in education, employment, housing, and health care that the current crisis has exacerbated. Black, Latinx, and other people of color are

more likely to be frontline workers, live in overcrowded housing, suffer from chronic diseases, and struggle to access testing, treatment, and vaccines. Low-wage workers are less likely to have paid sick leave or savings to pay for food, housing, and health care.

Pandemic preparedness means focusing on how we provide for economic stability and resiliency, not just in the face of a crisis, but in normal times. This requires us to think about how we address root causes and the social determinants of health, like decent, safe affordable housing, and the social supports we provide to individuals and families over the long term, like paid sick and family leave; living wages; affordable, accessible high-speed internet; and comprehensive, affordable insurance.

For example, it became clear early during this pandemic that families did not have enough savings to weather the disruption to their income that came from the loss of employment during stay-at-home orders. Many families quickly faced food insecurity or fell behind on rent payments. Unfortunately, our social safety net currently centers around very specific needs, and there are many hurdles to qualifying for assistance, often preventing families with limited resources from navigating a complex system to access support. When the pandemic struck, what many families urgently needed—and we were able to provide through our Covid Relief funding in Chicago and the federal government provided through Economic Impact Payments—was cash. This unrestricted support was a significant departure from how the federal government offers other social supports through programs like Temporary Assistance to Needy Families or supplemental nutrition assistance. The pandemic required us to trust in families to know their own needs and how to best direct resources to support their families through a pandemic.

Pandemic preparedness can and should include a reimagining of how we deliver social and economic supports to allow for resiliency in good times and in crisis. We might think about how we provide affordable housing to act as an investment in pandemic preparedness by ensuring that individuals and families have a decent, safe place to live when a crisis strikes. Or how guaranteed paid sick and family leave would have allowed individuals to care for children or family members without worrying about loss of income. We know resources like housing and paid leave have important implications for an array of health outcomes, whether heart disease, asthma or weathering a COVID storm.

## **2. We must work with communities that are most impacted, establishing links to organizations and people who are trusted.**

An important lesson we learned during COVID, as we have during other crises, is that to address the public health needs of people, we must work with the communities that are most impacted, who often have less access to services and less faith in medical systems that have failed them in the past. It is critical that public health institutions develop relationships with trusted messengers— organizations and people—in order to deliver lifesaving measures like vaccines. The people and organizations that are based in community, and have been there in good times and during crises, are more often better equipped than the government, scientists, or the news media to provide resources, information and support to residents grappling with impact of a pandemic.

As The Chicago Community Trust has been involved in getting the word out and supporting vaccination efforts across the Chicagoland area, we wanted to understand the status, intentions, and characteristics among both vaccinated and unvaccinated residents. We partnered with local public health partners and researchers to conduct a survey to better understand the issues surrounding the vaccine.

While nearly all unvaccinated respondents know where they can go to get a vaccine or info about scheduling a vaccine appointment, many unvaccinated respondents worried about getting sick or experiencing side effects from the vaccine. Two-thirds of the unvaccinated respondents would prefer to have more time to wait and see if the vaccine works. Most unvaccinated respondents believed the vaccine was developed too quickly compared to other vaccines, and only about a quarter agreed that the vaccine was safe or effective. Many unvaccinated respondents reported trusting their doctor or healthcare provider, but overall, this group was not very trusting of other sources of information about the COVID-19 vaccine, such as the CDC, scientists, religious leaders, news media, or government officials.

We must develop messaging that describes how the vaccine testing and production process was safely compressed into a shorter timeframe while still validating and supporting people who want more time to wait and see. For them, we can focus on other risk-reduction behaviors like masks and testing. Finally, we must talk to the community about who they *do* trust when it comes to information about COVID-19 and vaccines.

### **3. Pandemics do not know geographic and political boundaries. A go-it-alone approach is ineffective and counter-productive to preventing and addressing a global pandemic.**

Given modern increases in global trade, easy travel, and rapid urbanization, infectious diseases easily cross borders. Diseases that may once have died out in rural communities now reach crowded cities—almost 5.5 billion people live in urbanized areas—that act as incubators for outbreaks. And as we have seen with COVID, these diseases are transmissible before people exhibit symptoms and can spread without the knowledge of the infected person. The resulting deaths, illness, and public health restrictions reduce the size of labor forces, lead to absenteeism, and reduce productivity. And treatment and mitigation measures to stop the spread of the virus strain already burdened health-care systems.

While preparing for future pandemics at home and strengthening our own health safety net are immediate priorities, we cannot afford to ignore global health security vulnerabilities. There are no boundaries to global pandemics, and attempts to isolate populations (e.g., by closing boundaries) are not only ineffective but are counterproductive as they lead to lack of cooperation that is critical for addressing global pandemics.

We must provide international assistance to address the impact of the current pandemic and adopt measures to improve pandemic preparedness and response in the future. These commitments are not a matter of charity but a strategic investment in U.S. and global health security. The United States should approach foreign aid to fight COVID-19 the same way it has treated AIDS Relief and other global health programs: as strategic health diplomacy and an investment in U.S. foreign policy, national security, and economic interests.

#### **4. Pandemic preparedness is as important but under-funded, as compared to the investments we make in military readiness.**

Knowing that future pandemics are a very real threat, the federal government must commit to investing in prevention, detection, and response to protect vulnerable populations from future infectious disease outbreaks. However, our current priorities are clear in the federal budget, which allocated \$750 billion to the U.S. military in fiscal year 2020, but only \$547 million to prepare for global health security threats like COVID. The reality is that pandemic diseases like COVID-19 pose risks to Americans on a level comparable to or beyond international terrorism.

When COVID arrived in the U.S., lack of adequate preparedness funding made us reactive, forcing the government to rely on supplementary appropriations for pandemic response. Having now witnessed firsthand the devastating health and economic consequences of a pandemic like COVID, we must proactively appropriate funds for a comprehensive health security budget which would include increased funding for the pandemic preparedness programs, projects, and activities of relevant U.S. agencies, including the CDC, the National Institutes of Health, the Food and Drug Administration (FDA), the State Department, and USAID.

Important components of the nation's health security budget would include increased funding for state and local hospitals, scientific research on emerging diseases, epidemiological surveillance, the Strategic National Stockpile, vulnerable countries around the world, WHO, and other essential multilateral agencies.

As part of increased preparedness funding, we must also commit to improving living conditions and removing barriers to health in good times. Strengthening the U.S. health and social safety net will lead to better, more equitable outcomes during future pandemics and recessions. This will require sizable investments from all levels of government and parts of the federal budget. But like many other developed countries, we can ensure that our residents have paid sick and family leave; living wages; affordable, accessible, high-speed internet; and comprehensive, affordable health insurance. And when the next pandemic does arrive, emergency health, economic, and social supports should be available to all residents regardless of work or immigration status. Such supports should automatically trigger based on predefined criteria and continue for the duration of the pandemic or related recession.

#### **5. Maintaining public health infrastructure, including a well-trained and robust workforce, surveillance systems, laboratory systems, and information systems are all key lessons we should have learned from the HIV/AIDS pandemic, Ebola, SARS etc.**

The public health workforce is estimated to have shrunk dramatically leading up to the pandemic, by approximately 56,000, primarily due to funding issues. According to the Public Health Workforce Interest and Needs Survey, a large proportion of workers are considering leaving their job in the next year, in part due to inadequate pay. State health officials estimate that 25 percent of their workforce were eligible for retirement just last year. This is more concerning than ever as we hear about fatigue and burnout setting in amongst health care workers right as cases spike from the Omicron variant's spread.

Inadequate public health funding has devastating health consequences. The Trust for America's Health estimates that the United States spends an estimated \$3.6 trillion annually on health care, less than 3 percent of that amount is directed toward public health and prevention. The proportion of total health spending on public health has been decreasing since 2000 and falling in inflation-adjusted terms since the Great Recession.

The budget for the Hospital Preparedness Program—the single source of federal funding to help regional healthcare systems prepare for emergencies funded through the Office of the Assistant Secretary for Preparedness and Response in the U.S. Department of Health and Human Services—was \$275.5 million in FY 2020, slightly more than half of what it was in FY 2004 at \$515 million.

These are just a few examples of how a decline in funding in the years leading up to the pandemic led to the United States being caught flat-footed when citizens needed a robust public health infrastructure more than ever.

The inevitability and health and economic consequences of future pandemics make investments in preventive measures both sensible and cost effective. We must commit to better preparation and increased funding for future pandemics to prevent the disproportionate impact on the most vulnerable and under-resourced communities, here and abroad.