Chairman Roy Blunt Opening Statement
Senate Committee on Appropriations Subcommittee on Labor, Health and Human Services, Education, and Related Agencies

Hearing Titled "Department of Health and Human Services' Coronavirus Response: A Review of Efforts to Date and Next Steps"

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(As prepared for delivery)

Good morning. I want to thank our witnesses for appearing before the Subcommittee today to provide an update on COVID-19.

This continues to be an incredibly challenging time for our country. COVID-19 has killed 195,961Americans and 6.6 million have tested positive. It has rapidly swept across the globe and even countries that thought their cases were contained are facing new outbreaks.

COVID-19 is a new disease and even after nine months, relatively little is known about it, or even coronaviruses generally. This has hindered our public health response. Trying to find the answers has been like building the plane while flying it.

That comment is not to exonerate this Administration's handling of the response. Can justified criticisms be leveled? Yes.

But history allows us to look at past events to put current ones into perspective. For this history lesson, we only need to remember back six years to 2014 when West Africa faced the largest Ebola outbreak the world had ever seen.

Unlike COVID-19, Ebola is a disease that has been around since the mid-1970s. It is a disease that, scientifically, we knew a lot more about in 2014 than we do COVID-19 in 2020.

But even the kindest recollections of our public health response to Ebola would call it flawed. As the threat of an Ebola patient flying to the US was a growing reality, the Obama Administration refused to consider closing borders.

When CDC began implementing infection control guidelines, critics said they were too complicated and too hard to follow. Health care worker unions stated that their members had inadequate training and protective equipment. Public health experts said the CDC director should be more upfront about the unknowns and uncertainties of the disease.

Members of Congress used words like "cryptic" and "misleading" to describe the information that was provided to them by the Administration.

And when a case finally was found in the United States at a Dallas hospital, the CDC director blamed the hospital for a "breach in protocol" that led to the infection of two nurses.

Yet, when one of those nurses wanted to board a commercial flight while running a fever, she was allowed to with the CDC's consent.

This lesson is to illustrate a simple reality: public health is hard. And it is especially difficult for a disease we are still learning about as we fight it in pandemic form. Those in charge of the response are never going to get everything right and it will always be easier for talking heads or other experts to criticize those making the tough decisions.

But we should have learned, and more importantly implemented, more than we did from Ebola and H1N1. For example, the top two lessons learned from the Ebola outbreak in West Africa according to the World Health Organization were: (1) research at the heart of the response; and (2) test results turned around quickly.

Neither this Administration nor the last prioritized medical research. Would we have had a better response if there was more money during the early 2000s for medical research? We'll never know. But I do know that NIH turned its attention from other coronavirus outbreaks like MERS or SARS when funding became tight. And like Ebola, we all know the importance of rapid testing for coronavirus. It can make or break a response. We need to ask ourselves why CDC wasn't more prepared.

As someone who has chaired the LHHS Subcommittee for nearly six years, I have tried to refocus our efforts on medical research and preparedness. Over the past five years, in a bipartisan manner, the Subcommittee has been able to increase funding in the annual appropriations bills for the National Institutes of Health by nearly 40 percent. CDC funding has increased 21 percent. And preparedness funding is up 44 percent.

I believe the Appropriations Committee's job is to ensure funding is prioritized to the most important activities. If everything is a priority, then nothing is a priority. In the past five years, I think we have proven that medical research, public health, and preparedness are the priorities, and have done so in a bipartisan manner.

And because we had done so, we were more ready for an unknown pandemic. This is illustrated by how quickly medical research pushed several vaccine candidates into late-stage development only six months after we discovered the disease in this country.

There are now 238 FDA emergency use authorizations for diagnostic and antigen tests on the market, and every day we get closer to an affordable, reliable, rapid test that can be deployed anywhere to be taken at any time.

In a few years, when someone gives a history lesson about the COVID-19 response, there will be criticism. And it will be significant.

But I know there are things both sides agree to. This includes a further investment in testing – so it can be as widespread as possible – more resources for our vaccine candidates to finish their trials, manufacture the vaccine, and for CDC to distribute it through a vetted, well thought through plan.

We also know that parents are struggling to return to work without many schools or child care facilities open. Child care programs operated on razor thin margins prior to the pandemic. Now, with additional costs and decreased enrollments, and social distancing, many child care programs are being stretched beyond their breaking point. More investment is needed to help child care providers safely stay open or re-open, and to provide safe, high-quality child care so their parents can return to work.

I know if we focus on COVID-19 related funding, we can reach an agreement with the other side.

I want to once again thank the witnesses for appearing today. I look forward to your testimonies and appreciate your thoughtful dialogue with us. Thank you.