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Online Event

"A Conversation with Congressman Tom Cole"

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FEATURING:
Congressman Tom Cole,
U.S. House of Representatives (R-OK)

CSIS EXPERT:
J. Stephen Morrison,
Senior Vice President and Director, Global Health Policy Center, CSIS

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J. Stephen Morrison: Good morning, or afternoon, or evening depending on where you are. I'm J. Stephen Morrison. I'm a senior vice president here at the Center for Strategic and International Studies, CSIS, where I direct our global health work. We're delighted today to have join us for a one-hour conversation Congressman Tom Cole, Republican of Oklahoma, serving in his ninth term. Welcome, Tom. Thank you so much for being with us.

Representative Tom Cole: Good to be here, Stephen. Thanks for having me.

J. Stephen Morrison: I'm going to offer a few words of thanks to help put us together and say a few words of introduction of Congressman Cole, and then we're going to move into our conversation. And we will – we will attempt to incorporate some remarks or comments that come in from you. So please feel free to do that. I want to offer special thanks to Josh Grogis, Sabrina Parker, and Sarah Corley from Congressman Cole's staff who kindly helped us pull this together, and from our staff at CSIS, Clifton Jones and Amith Mandavilli. Thanks to them all.

Congressman Cole comes to us a longstanding leading on health security, both at home and abroad. We'll hear more about that role in a moment. He is also a member, has been since 2018, of the CSIS Commission on Strengthening America's Health Security, which we are going to extend through the fall of 2022. And we're delighted that he has agreed to stay with us for that duration. We'll also be sitting down soon, in the next few days, to do a podcast with him. So, keep your ears open for that. He is a former chair and current ranking member on the Appropriations Subcommittee on Labor, HHS, Education, and related agencies, a key position in determining U.S. approaches on health security. Ranking member also of the full Rules Committee, and deputy whip of the Republican Conference.

He's used this leadership position to enormous benefit for Americans at home and abroad in our approaches on global health security. Last year the House and Senate moved through the Pandemic and All Hazards Preparedness and Advancing Innovation Act, PAHPA, which went to the president's desk and was signed into law. He has been instrumental in creating a $100 million infectious disease rapid response reserve fund at CDC, which has proved in this current period to be an invaluable tool for us. He has advocated across the years a bipartisan approach to preparedness and arguing in favor of incremental – steady incremental increases, often beyond the administration's requests, for research and development by NIH, for programmatic support to CDC, and support to the strategic national stockpile – all critical elements of our architecture for preparedness.

We'll hear more. He's been a harsh critic during this Covid-19 outbreak of China's behavior. We'll hear a bit about that. He's also been a defender – if reform-minded – around the WHO. We'll talk about that. One of the things that has come across very vividly is his emphasis to Americans on the need for individual responsibility in responding to this COVID threat. He, just to quote, "for life to return for normal, every single one of us must commit to take precautions." Oklahoma, his home state, is a red zone at the moment. We'll discuss a bit of that. And he has – he plays a very important and unique role in leadership on Native American populations. He is a member of the Chickasaw nation. In the CARES Act, we'll hear a bit more about that, and about the special provisions to bring support, funding to the Indian

Health Service, food and nutrition, housing and energy assistance, and economic relief.

So, with that, introduction, Congressman, thank you so much for being with us. We have a lot of ground to cover here today. I want to ask you to begin by talking about the United States and the continued challenges around bringing testing across states and local municipalities. You've been looking at this problem and thinking about how do we go from where we are today to the next stage? We've heard there was just a study just recently released by Ashish Jha from Brown saying we need to go from where we are today, 800,000 to 1,000,000 tests, to a higher level of 4 million and beyond, at that. But we need to do it in an integrated and systematic way. So, tell us, what are your thoughts on that? Thank you.

Rep. Tom Cole: Well, I couldn't agree more with the conclusion. The challenge is, you know, to some extent, is our own federal system and our own traditions of local independence and local initiatives. Those are by and large strengths inside our system. And they allow us to manage a continental nation of 330-odd million people of every race, every ethnicity, every opinion on the political scale. So, I'm not one to want to tear it down. But I do recognize when you're dealing with a national pandemic – international pandemic, it obviously doesn't recognize any kind of borders. And to some degree, you're at the mercy of the sophistication of the public health system in your particular state. And frankly, you are also subject to the cultures of those states. And some of them are better at responding than others.

I do think, first and foremost, you have to have a national plan. I don't think anybody envisioned anything quite like this, any more than anybody envisioned 9/11. And while we have bits and pieces of things in place, we didn't have anywhere near what we needed in terms of just, you know, raw testing capability, in terms of lab capacity in our public institutions. We were a little slower than I would have liked at mobilizing the private resources that are available, which are vast in this country. And I actually think that that's probably been the greatest success of this response. But it was later coming, and we see it more around the vaccine area than we do perhaps have seen it in the testing area.

So, I guess I would start with that. But obviously we, in my view, need a 9/11-type commission to look at this. You know, a 9/11 type commission really did generate a lot of useful change. And I think it's actually one of the reasons why we haven't had another 9/11 is some of the adaptations we made after the great shock to our system. And we ought to do the same thing here. And if anything, this has been more damaging – more damaging economically, more damaging certainly in terms of loss of life. It's going to be with us a lot longer. So, you know, again, I would be a strong advocate. And thank you for what CSIS is already doing in that regard in terms of providing first-class thinking about what do we need to do legislatively, how do we need to respond administratively.

So, we clearly need a lot more in the way of supply chain capability inside the United States. I think we need to probably give the president more power than presidents have in this regard. The real response is driven by governors, quite frankly, following guidance from CDC, following presidential jawboning, if you will. But if we're going to have the ability to have national testing, you're going to have to have more authority concentrated some place in the federal government.

J. Stephen Morrison: I see. Yes. Well, on the testing side, I mean, we are seeing – I do believe we are on the edge of seeing very promising technologies – saliva tests, antigen tests, being able to do screening and assurance testing on a mass scale. So, we are approaching a moment where this kind of scaled national approach with a national plan becomes much more feasible. But we've really – our system is so disaggregated in a way – I mean, we have 3,000 public health jurisdictions – they tend to be, as you point out, very variable. They tend to be often understaffed or underfinanced. And so, figuring out the laboratory capacity and how does that connect to the health providers once you get these tests, it's a complicated web that needs to be woven together. And a national commission could really kind of carry that forward.

Now, when the 9/11 Commission came about, it – people look at that – look retrospectively at that from 18 years ago and think: OK, it had very strong leadership. It had Governor Kean. It had former Congressman Lee Hamilton. It had strong leadership with Phil Zelikow as the secretary. It had – it had a subpoena authority. And it managed itself and preserved its bipartisanship and its credibility throughout that process, and it controlled its messaging and the way that it – and there's much to be learned from that. But I do think today we're a very divided country. So, there has been, I think, four bills put forward in Congress, a couple of them on a bipartisan basis, for a commission of this kind. But just tell us, let's say we get into next year, whether it is a Trump presidency or a Biden presidency, whether the Senate is controlled by Democrats or Republicans, what's your thoughts on how to move this idea forward for a national commission?

Rep. Tom Cole: Well, I think it actually becomes easier next year in some ways, because obviously we're in a political year right now, and I think there's great sensitivity. Would a commission like this be casting blame? And that's not the purpose. And you have to laud the Bush administration for being willing – being willing to run that kind of risk, if you will, because there were parts of the report, and some of the findings and hearings, that were highly charged politically.

But to their credit, they were willing to go through the fire a little bit so that we could understand what happened and make the appropriate preparations. That, to me, gets – and remember, this was happening in 2001. So, it was maybe a little bit easier than it would have been had the attack come in 2003. And so, we'll have that same vantage point next year. And hopefully about the time we should be doing this is about the time vaccines will become widely available to the American public. I think that takes a lot of the political worry out of this.

But a lot of it will depend on who's on that commission and what's the spirit in which they approach this. You know, if it's full of partisans of one side or the other – one trying to defend, the other trying to attack – and we've seen a lot of that on the pandemic. I mean, it's inevitably a political issue and a political year – I get that. But you know, we don't need a commission looking at it that that. Again, it's a real test to our democracy. But, you know, again, we've has these things before in American history, whether it was commissions looking at Pearl Harbor or commissions looking at 9/11. So, it's just a fundamental feature of our democracy. But, you know, they quite often generate lessons learned that really have enduring value. So, I'm willing to run the risk to go through it. And I think there are plenty of people on both sides of the aisle that believe that way. Congress in particular.

Congress has had an interest here – and I'm not being critical of the Trump administration, or the Obama administration, or anybody else. But you could see it in the bipartisan support for things like NIH and CDC. And that was, by the way, a long time ago. I mean, the late '90s to early 2000s the NIH was doubled in size. That was driven largely by Congress, not by the administration, either Clinton or Bush. They weren't – they weren't calling for that. But Congress has been interested in biomedical research and biomedical defense for a long time. And there's actually a very strong bipartisan tradition.

You were kind enough to mention the infectious disease rapid response fund. I have some good news for you, my good friend Rosa DeLauro, who was very supportive, she was the ranking member, she's now currently the chairman of the Labor-H Subcommittee. Actually, increased that up to $300 million and, again, was very helpful to me getting established. It actually was an institutional thing. I put it in a bill, and we had a hard time convincing the Senate. It took us a couple years. And again, not because they were critical.

One of them just made the point, well, look, there'll always have health-care emergencies, and so they'll always use it all up. And I said, no, this is a fund set aside for a genuine emergency. And fortunately, I remember the first year talking to Dr. Redfield. And we only had $50 million. And I said: Dr. Redfield, please don't spend it all. You know, just please let me convince them, because the provisions allow you to roll over the money. So the idea was to start with $50 million. If we didn't have a problem, great. We'd roll over the $50 million and put another $50 million in, so we could build this up over time.

And unfortunately, that first year we had an Ebola problem and they spent about 30 – or, 20 million (dollars) of it, I think. But they rolled over $30 million. And so, that kind of helped. But anyway, again, this has been – the effort in Congress has been bipartisan. I think the effort to look at Covid-19 can be bipartisan as well, particularly on the other side of the election, regardless of – I mean, if it's President Trump he'll never be running again. So hopefully people can take that. If it's President Biden, well, it happened on President Trump's watch. And Biden's historically been pretty good in these areas in terms of particularly NIH funding. So maybe he'll be interested in looking at this too.

But it just needs to not become a means to scapegoat anybody in this process. We were overtaken by a great biomedical disaster. We did some things I think we can judge now very well. We did other things not as well as we could've or should've. And that needs to be looked at that way. And recognizing people did the best they thought they could do with the information they had, which was fragmentary and evolving at the time. I don't think anybody deliberately, you know, did anything wrong. We just need to do things better.

J. Stephen Morrison: Thank you. One thing I just want to point out, in the course of our – in our report issued last November on ending the cycle of crisis and complacency in U.S. approaches to health security, which you're a part of that commission, we included a recommendation that that – that that emergency fund be expanded to $250 million. And we were thrilled to see it go to 300 (million dollars). And your leadership and Congresswoman Rosa DeLauro's, and others was integral to making that happen.

There's a lot of discussion today around the integrity – preserving the integrity and the scientific capacity and respect for the CDC, for FDA, for NIH, but also paying attention to what's the strategic national stockpile need to look like in this period? We have been testifying in the Senate with Senator Johnson's committee responsible for this, Government Affairs. And I just wanted to ask you, are you worried about the sort of integrity and respect that FDA and CDC require in order to preserve the trust and confidence of the American people?

Rep. Tom Cole: I do worry about that. You know, partly, look, one of the things we're going to have to really understand is why we didn't do better on the testing front at CDC right off the bat. I mean, clearly, we had some problems, we had some testing failures, and we probably had some conceptual failures in the sense that we were testing too narrowly in terms of the population, what we'd be looking at. And again, I don't say that with any criticism. I admire the CDC. I worked well with Dr. Frieden. I worked well with Dr. Redfield. They're both really fine, fine people – who have been the two directors during my tenure on the Labor-H Committee. I've visited the institute and visited Atlanta on multiple occasions. Not a finer group of people in the world, not a better facility, you know, on public health in the world. But we needed to get off to a little better start than we did.

I do worry that – you know, we've had some instances where information, you know, may well have been shaded to, you know, present a particular line. That's a mistake. It just needs to be everything on the table that any professional would want to know. And then let the professionals beyond the CDC have access to that information. FDA, I worry there. Actually, I think FDA has done an extraordinary job in all this. You know, Operation Warp Speed, which I think we will look back on as – in the way that we look back on the Manhattan Project now, as something that was unprecedented. I've actually had NIH scientists use that term to describe what's going on there.

You know, but we have – the FDA has been integral in that in terms of some of the things it's gotten rid of in terms of its regulations, some of the unprecedented efforts that it's made to see that drugs are tested – or, vaccines are tested – and drugs. Therapeutics as well. You know, and rapidly deployed without jeopardizing safety. But there's been people that have raised questions about that. And again, we're in a political season. I get that. But it's not helpful to discourage people from using vaccines. You either have confidence in the CDC and the FDA, or you don't. I have high confidence in both and the career professionals there. And I think it's incumbent upon public officials to reinforce the credibility of public health-care professionals.

They have a lot of it there. I mean, you can look at any polling data you want to and, believe me, they rank a lot better than the political figures that are questioning their professionalism and their credibility. But it still matters that we reinforce from the public platform what public health officials have to say. And, you know, that's in everybody's interests. It just protects the American people. But if there's confusion, or there's doubt. Or, well, this administration's controlling that entity, so it's not providing you with the accurate information, or it's rushing through a vaccine for political reasons, not the reasons that – look, we have every reason to want to get a vaccine as quickly as possible. We have thousands of people dying every month. We have trillions of dollars' worth of economic damage. Why wouldn't we want to get there fast? So I don't have to look at somebody and say:

You're rushing this for political reasons. I know why they're rushing it. They're rushing it to save lives. They're rushing it to protect the economy. We need to make sure it's safe. And the political advantage, you know, will follow where it will. It'll either work or not. But the bigger political risk actually would be to do something too quick and have it backfire, have a situation where you had a vaccine that made people sick, or you approved the drugs that had some awful counter-reaction. So, you know, it's a delicate balance but, again, we have a role to play as public officials in protecting the credibility of the institutions that are serving the interests of the American people.

J. Stephen Morrison: Thank you. And I'm delighted to hear you say that, because there is a lot of fear and concern right now. And we see it manifest. Yesterday's Washington Post editorial page, I think it was six former FDA commissioners in a very strongly worded statement expressing their acute concern – their alarm at political interference in the operations of FDA, and appealing for exactly what you're calling for, which is respect of the institution, patience, respect of the scientists, and allow them to go ahead and do their job.

We've seen a similar pattern around CDC, a pattern of repeated sort of interventions that have distorted some of the reporting and some of the guidance and created ongoing controversy around a number of issues. And former CDC directors from across Republican and Democratic administrations putting their names on very strongly worded statements. And those have, I think, registered. And also, we're seeing the Pew Research Survey results that just came out last week, the Kaiser Family Foundation, which is showing enormous public doubt about this process of putting forward.

So, if we come up with a safe and effective vaccine, which I believe we will, or vaccines, as we enter 2021, we can't afford a situation where half our population really is so untrusting, doesn't really want to embrace. If we're going to get to herd immunity, we've got to have a trusting public that believes in the authority – what the authorities are telling them. So, I'm delighted to hear you say that.

Another issue that's terribly important is that of social disparities, in the way different communities are experiencing this. And that – we've seen shocking data around the impact on the Native American communities, on the Black and Latinx communities. Can you just – and those – I think everyone's been shocked at seeing that and understanding why that is so, but also thinking ahead – and this is something the commission could address – how to redress those disparities, and guarantee that in the future we do not see that happening. Your thoughts on that? I know you've been a leader in this area. And so, I'd like to hear a little more from you around what more needs to be done.

Rep. Tom Cole: Well, there's no question that these health disparities really reflect the underlying social inequities. I mean, that's just the fact that these populations are underserved on a regular basis. If you look at them in terms of any kind of health-care data you want, average life expectancy, they would still rank badly. It wasn't like oh my gosh, they're uniquely vulnerable to this. They've been vulnerable to a lot of things for a lot of years. This really brings it home, though. And it's dramatic. But it's shrining a light on inequities that already exist.

There's lots of things we could do. Obviously, health care is an area that is

incredibly complex and highly charged politically. But, you know, some of the things we've done in recent years that have helped – you know, I look at community health centers, which in my own state – when I came into office, we only had five. We have over 60 now. They serve underserved populations in vulnerable areas. You know, we have dramatically expanded the money for them. It used to be about one and a half billion (dollars) appropriated in discretionary funds. We expanded that. I didn't vote for Obamacare, but it expanded that for a five-year period, with mandatory funding up to $5-6 billion, in that kind of range. So pretty dramatic. And every year since that five years has passed, Congress has chosen to renew and continue to move it forward, because we all see the value here. So, you're going to have to do that.

The second, you know, we have a real disparity of health-care providers. I represent a district that's very rural. Rural America, whether it's red, whether it's Black, whether it's White, is, you know, dramatically underserved. And part of this, frankly, is where the practitioners want to go and live. If you spend much time on Indian reservations, the first thing – particularly poor Indian reservations – there's no private housing. So, where do you live? And if you've come there and your social, you know, sort of options in terms of everything from education, to culture, to entertainment are much more limited than they would be someplace else. So, you get a lot of – you know, Indian Health Service is chronically understaffed. And we got an awful lot of young people, God bless them, that go out to reservations for a period of time to, you know, help discharge their debt, and to provide a really needed public service. Those are great programs, but we need to do a lot more to train indigenous health-care providers, or to train, you know, health-care workers in the African American, Latino communities, because those are the people most likely to actually, number one, want to serve that population, number two, want to live where that population lives, in many cases.

We do a lot of work in Oklahoma in two areas. One, Oklahoma State University has an excellent program to recruit medical students from small town Oklahoma, so that they're much more likely to want to go back to small town Oklahoma than Tulsa or Oklahoma City. And they actually come in with that mission. We're going to – we hope that you will – obviously, you're an American. You can live where you want; you can pursue what you want. But we want you to think seriously about providing areas like your home communities with adequate health care.

The Cherokee Nation is now in partnership with Oklahoma State creating its own medical school in Tahlequah to train indigenous health-care workers. They have a very sophisticated health-care system. They're the largest tribe in the country. They're a successful tribe economically. They placed – they don't just take the money from the Indian Health Service. They take a considerable portion of their own resources and invest that on top of that. And they're building – and this is a point of some chagrin with me as a Chickasaw. We had the largest Indian-built hospital in the world, but the Cherokees are going to pass us next year. But it's going to be a great facility, and well-staffed and, you know, provide. So, there are ways to begin to address these things.

Long term, you're going to have to think of ways to make sure that Latinos, and African Americans, and Native Americans, and other disadvantaged populations get, you know, adequate and continuous health care. So much of the susceptibility of these populations is because of underlying health conditions that preceded

coronavirus and made them more vulnerable. We all know if you have another condition – and, again, these are populations that are afflicted with a variety of chronic illnesses at a higher percentage than the national population. So, you know, your day-to-day care's has got to get a lot better.

And again, we've done some things to try and respond. I think you'll see more of this in the distribution of a vaccine. I mean, clearly, we've got certain populations where it's going to – it's, number one, harder to distribute but, number two, maybe the need is even greater. And I hope that's taken into account as we work through the appropriate distribution of vaccines, as we get them out there.

You mentioned again, not to ramble on here too much, but on the Native American front, an interesting study by the American – or, the Indian Health Board, a national survey. And if every Indian tribe were a state in the union, the five states with the highest infection rate would all be Native Americans. You know, I think Mississippi Choctaws, their infection rate – and they're a fairly affluent, very sophisticated tribe. Been to their reservation. And their infection rate's more than double New York City. So, you know, we really have some pockets. This population is – New Mexico, I saw a set of numbers, Native Americans are about 11 percent of the population there. They're well over a third, pushing up to a half, of the fatalities.

So clearly very – and, obviously, we have very similar and striking statistics where African Americans are concerned, and disturbing statistics for Latinos. So, I don't want to just single out Native Americans. It's just a population I'm very familiar with. And again, a lot of things we can do to make sure there's adequate health care, and then at the point of crisis we recognize there's going to be special areas, special vulnerabilities, just like we understand nursing homes now. I mean, 40 percent of deaths are from about 0.6 percent of the population. So, we've learned a lot, and we need to now apply that to strategies going forward to protect especially vulnerable populations.

J. Stephen Morrison: Let me take – pivot to the question that you raised around vaccines. Operation Warp Speed, as you point out, it's a – it's a very special historic enterprise. It looks a little bit like the Manhattan Project. It's got lots of resources, over $11 billion, and lots of authority. It brings together Moncef Slaoui, an industry – an iconic industry leader. It brings together General Perna, and quite a number of folks drawn from DOD on the logistics side, and the Army Materiel Command. It brings in BARDA from HHS on the funding the field trials, NIH, CDC on the immunization programs. Nancy Messonnier is very integral to this.

Now, we're approaching that moment, as you referenced, as we get into the new year when it's likely we're going to have – we now have four of the vaccines being developed by industry in partnership with the U.S. in phase three human trials. There are different types of vaccines, different models, but they're looking promising. And as we get into the new year, we're going to begin introducing these to – in the first phase, to priority populations. We haven't yet settled on what those priority populations will be. We're also going to face some very major logistical challenges in terms of reaching those populations and handling these very fragile – some of them may require deep freezer capacity, the messenger RNA vaccines and the like.

What are your thoughts around prioritizing populations in the first phase? And what are your thoughts about – you know, what are you worrying about in terms of the logistical – the logistical and distributional obstacles that we may face?

Rep. Tom Cole: That's a great question, and a lot of different aspects to it. You know, look, you either trust the people making the decisions or you don't. And I broadly trust them. My own thinking would be obviously you're going to start with health-care workers first. They're the most exposed part of the population. And just as we would protect our soldiers in battle, you know, because we know they're fighting for all of us, we're going to protect our health-care workers who are fighting for all of us in their own unique kind of battle.

Then I think you look – to me, the next population, particularly institutionalized populations like nursing homes and honestly like prisons. You know, we've had a lot of outbreaks in the penal system. That's an ideal breeding ground. A lot of people might not want to put them up near the top, but I think you have to because they're a governmental responsibility. So institutionalized populations. You would think also in some cases of, you know, folks that might be in mental health facilities, in any institutional setting I think I would prioritize.

I honestly, and it'll be highly charged, but I would look at these racial disparities as well. I think you have to take them into account. And fortunately, I think we will have enough vaccines available in sufficient quantity that this isn't a question of keeping one group waiting, or whatever. But I do think you're going to need to make a special effort. And again, some of these folks are in very hard to reach locations. You know, I think particularly of migrant farm workers. That's a mobile population working in remote areas.

You think obviously of Indian reservations, which are very unserved, very remote. You know, you travel much of the Navajo Nation, it's a long way between any place in the Navajo Nation. And some of the great reservations in the Midwest and Southwest are all like that. And then, you know, again, you're going to look broadly at seniors in every population because their mortality rate is so much higher than younger people.

So, you know, again, I'll trust the experts to make decisions and wrestle through. I just – I think what politicians need to avoid doing is politicizing the decision, because it's going to be pretty easy to score political points by championing some community that you decide has been left out or underserved. At the same time, you have an obligation to speak up if you think an injustice is going on. But broadly speaking, I would hope we recognize you have to distribute these in some sort of systematic way. You want to do it in ways that everybody can agree on.

Maybe the easiest thing again, health-care workers first, highly vulnerable populations second. And you can determine that in a variety of ways. Age, which works for every group, you know, institutions, which include every group. But also, recognition you're going to have to work harder maybe in the inner cities and particularly populations – a lot of this spread too is, you know, families that live in intergenerational settings. That makes it much tougher, when you've got, you know, multiple – or multiple family units in close places.

That's the other thing I would look at. Where do we have crowded conditions?

Those populations are going to be more vulnerable, just by definition. If you live in a high-rise apartment, the way I do when I'm in D.C., I'm a lot more vulnerable there than I am in my individual family home back in Oklahoma. I'm just exposed to more people – whether it's the elevator, or the lobby. Although they've shut down the gym and the coffee machine. So, they've made it pretty miserable to live there. But they're doing the right thing, but I sure –

J. Stephen Morrison: What is your – what do you – when you look out over 2021, and under the best of scenarios in terms of verifying that we have safe and effective vaccines, mobilizing the machinery to get them out to the populations that deserve to be in the first phase, what are you imagining unfolding over the course of the year? And how are you – when your constituents come and say: What can I expect – when can I expect to see a rising percentage of our population in Oklahoma receive these vaccines, so that we begin to approach heard immunity?

Rep. Tom Cole: You know, Dr. Fauci recently made a statement that he thought by the spring, April or May, that a vaccine would be available essentially to every American that wanted it. And I hope he's right about that. Again, I have great faith in him, so I have no reason to doubt him. But he'd be the first one to tell you, you know, if you listen to him very – he's very nuanced when he's talking. And very wisely says: This is my best, you know, estimate today. You know, tomorrow it could be different; there could be some new factors. So, but I think that's true.

What worries me the most actually is the fact that as we get the vaccine available, we'll too quickly want to discard masks, forget about social distancing, and do I really need to wash my hands 12 times a day – you know, do that sort of stuff. And we'll get rid of the really basic stuff that we need to do too quickly, because the vaccine itself, you know, we don't know at this stage, but there are very few vaccines that are 100 percent effective. And 50 percent would be very good. I mean, this is more likely to be like a flu vaccine than something with a higher percentage. So, we're going to have to keep a lot of the things in place that people were slow to adapt and would love to discard longer than we would want to.

We were having a discussion about this with the House physician, because all this is impacting the House of Representatives and Congress in the way it operates. I mean, how many staff can you have in the office? How do we vote? Do we clean the chamber between votes? Can sit on the floor anymore and do 30 amendment votes at two-minute intervals. And so, we were trying to figure out how long would this last. And we were having a very good discussion with the House attending physician – the Capitol Attending Physician Dr. Monahan. He said: I think this is going to last two to four years.

I mean, don't think you're coming back to normal next year. And I think what's true for us as an institution is true for American society in general. There are some things that we're not going to come back to, "normal." Frankly, some things that will never get back to normal. There will be some enduring changes out of this. You can already see it in the economy when you look at winners and losers. There are winners to this point. If you're in big tech, if you're in Amazon, pretty good year. You're hiring people. If you're in homebuilding, they're way up: 25 percent new home starts as people rethink how they want to live, what kind of space they need – if they're going to work from home what kind of space they need, if distance learning is going to become part of their child's permanent future.

They don't – so I wouldn't think these other things – but so, again, my biggest concern will be – I think the vaccine will arrive quickly, but it's not going to end the coronavirus. It's going to be with us. It's embedded in the community for a long time. We're going to have to take a lot of precaution. And some of those precautions, frankly, will probably help us avoid – or, not just deal with this pandemic, but maybe help us and offer some measure of protection against any future one.

But, you know, I get fascinated by things like I saw some company marketing disinfectant you like – sort of like when you walk through the security screen at the airport. You walk through a disinfectant screen. It takes about three seconds and, you know, you're sort of protected. And they were marketing this for football stadiums and for gaming facilities, for places that are going to have high crowds. We're going to have to do some different kinds of things going forward. And so, I think it will take an adjustment over several years. But the vaccine portion will be the quickest. And some of these other changes, again, are going to prove more enduring than we like, and then we'll see some new things as well.

J. Stephen Morrison: Well, one – you know, we are seeing right now a kind of fatigue among Americans. We're seeing declining mask use. Obviously, masks became unfortunately or tragically sort of politicized in many ways. And we're seeing less social distancing and vigilance. And we have out of the Institute for Health Metrics and Evaluation, the IHME, Chris Murray's shop at the University of Washington, a projection that as winter – as the seasonality changes and we enter winter, temperatures drop, people are indoors, that there's going to a turbo-charged surge. And there's some pretty dire projections in terms of what will happen in the rise of daily cases, and daily deaths, and projections that we – November, December, January are going to be very, very rough in the midst of this surge.

My question to you is: If we are entering the new year with that happening at the same time that we're having these very promising developments around the vaccine, how do we get the American public to reconfirm the commitment to those kind of personal individual practices that you've been advocating, in terms of mask wearing, social distancing, personal hygiene in that period?

Rep. Tom Cole: Americans are generally speaking better at solving problems than managing them. And unfortunately, this is a – so we're – you know, we'll get to the vaccine quicker than we've gotten to social acceptance of things that we know work, and that other countries have demonstrated. Countries that have been much more uniform in following these things, you know, Japan, Taiwan, South Korea, Australia, New Zealand, Canada. Look at where their death rates are.

And these are first-world countries that we can trust their public health statistics. There's a lot of statistics out there. there are some societies that aren't transparent that I just – I'm sorry, I'm not believing what's coming out of the country. There are other societies that try to give you the best information they can, they just simply don't have sophisticated public health-care systems that have the reach that you have in Europe and the advanced countries in Asia and the United States.

So, you know, I think we just have to keep preaching the lesson, and hopefully we'll

do that in a uniform way on the public front. Again, I think that gets easier after November, strangely enough. And I'm sad to say that, but that people will question – be less prone to question one another's motives. And I also think – again, there's a – it's not just a federal responsibility. Look, the gubernatorial responses have varied around the country. And I actually don't say that critically because, again, I think the federal system, while it has some challenges, is one of our great strengths.

But it does give us – let's go back and look honestly at state by state response and see what's worked. You know, and there are – we have multiple different models out there, for good or ill. And I'm not trying to be critical of anybody. We in Oklahoma, for instance, our initial experience was not nearly as bad as the rest of the country. You know, we were not New York City. We were not the West Coast. As I used to joke, maybe it's actually good to live in flyover country. You know, we were probably better off, but you can correlate international airports and disease spread pretty closely with one another. We don't have an international airport in Oklahoma. You fly to someplace else. You fly out of or into the United States there.

So those kinds of states, you know, sort of avoided a lot initially maybe of what was happening in New York City, which, of course, is one of the prime travel destinations in the world for all kinds of populations. So, I think we probably kidded ourselves that we were doing a better job. We're also, again, a very rural state. So social distancing is a lot easier, you know, in Wewoka, Oklahoma than it is in New York City. That's just – it's easier on the economy, it's a more normal part of who we are.

But now I think we've seen where we've come up short. You know, we're now having too much response – although I talked to Dr. Birx about this, or I was on a call and she was – I didn't talk to her because somebody else posed the question. But I had the benefit of listening to her. And she made the point: The Midwestern states – she says, you know, one of the reasons why the – why the infection rate is higher in the Midwest or these rural states is because people are taught you don't go to the doctor until you're really sick. And so when you show up you're much more likely – and they tend to show with more symptoms. They wait longer to go get tested.

And it just shows – I mean, different cultures respond in different ways. It's not – you know, I remember growing up in that kind of household. You know, hey, going to the doctor's expensive. You don't go unless you're really, really sick. You don't just go to see if you're OK. To some degree we're going to have to change that, and we're going to have to provide – not just going back to the doctor, but this gets back to the testing culture. We've got to provide testing that fits the lifestyle of American communities. It's too hard to change – it's easier to get tests to match them than it is to change them to match the test.

So you know, it's no mystery in America, you know, if you build a better mousetrap – the simpler you make it, the cheaper you make it, the more likely it is to get used and the more successful you're going to be. We need to harness that. That's one of

our strengths, at least the mass distribution of all kinds of valuable products. And it'll do the same here. But we're going to have to make it easier. And I think we are, by the way. It's getting a lot better. I know the distance between being tested three months ago and being tested today, you know, it's already better in the places that I go in and out of, where I have to be tested.

J. Stephen Morrison: Mmm hmm. Yeah. Thank you.

In the time that remains, I'd like to ask you a question, first of all around – to get back to Congress and appropriations. The deliberation on should there be a new kind of account created. I know there's been deliberations around looking at the contingency operations accounts that were used for funding Afghanistan, Iraq. Is this a – is this something that we're going to give very serious consideration to, and it's something that you think will emerge as a tool, as a mechanism for dealing with the next several years of the – of the pandemic and its aftermath?

Rep. Tom Cole: Well, I hope we do. I floated the idea a number of months ago to the administration, and I was not successful, to say, you know, we were operating under, you know, a budget cap agreement that was forged two years ago, with no idea that we'd be facing this. And I said, why don't we – you can leave the caps in place for everything – but set up a series of health-related accounts – health-care accounts. And I would include NIH, CDC, strategic stockpile, obviously, infectious disease fund.

But I would also include, like, FDA, which is not part of our budget. My good friend Chairman DeLauro pointed out, what about the food chain? I said, well, that's a great idea. So, we were actually busy having discussions back and forth. And that these areas out to be immune to caps, that the federal government needed to be able to appropriate what it needed to do. So, you know, I think these kind of caps can be extremely useful, and I hope we think through how to provide one here.

The second thing that we need to do, you know, most legislators – and I will tell you, I had no idea until I was chair of Labor-H. I did not know that 60 percent of the public health budget for the state of Oklahoma was provided for the Center of Disease Control. And it's on average about 50 percent for every state in the country. And the poorer and more rural you are, the higher the percentage is. It's not all that robustly funded an agency in many ways. It's about an $8-9 billion agency. And yet, it's providing half the public health budget for the basic sort of stuff for every state in the country.

That's ridiculous. And if we're going to do that, we need a much, you know, different kind of account. We probably need an account that supplements public health budgets, or some sort of matching account where – I'm almost loath to go there, because I'm too afraid the poorer the state, the less likely they are to do the match, and then you're creating problems for a population that's already challenged. Whereas richer states I think would do that easily. But there needs to be, again, some sort of fund set up that we make sure there's adequate public health, you know, facilities, laboratories, protecting every single state in the country.

We're sort of doing it through CDC, but it's pretty haphazard. And we're sucking a lot of resources away from CDC that ought to be coming from somebody else. But

more broadly, they're just out of a single department. We all have an interest in public health, not just the Center for Disease Control. They shouldn't be doing what they do on a national and international basis, and simultaneously funding half the public health-care budgets of the states in the country. That's a ridiculous – you know, God bless them for their efficiency, because they do a remarkable job, but that's too much burden on an $8-9 billion budget. So, I would very much – and we could do that on a per capital population basis. There's a variety of ways to do this, to have a basic fund that sets a floor for every state in the country.

J. Stephen Morrison: Thank you. I want to ask you about the international domain and U.S. leadership in the international domain. There's a couple of big issues there. You know, the global health security agenda has been an instrument in building capacity in low-income countries that are vulnerable. That was – that came about around the same time as Ebola. It got turbo charged with the supplemental. But there's a question of sustaining that as a way of building defenses and preparedness in those countries that are very vulnerable.

There's also the issue of the vaccine facility, to bring vaccines to low and middle-income countries that may really struggle to get that. And we have the COVAX facility led by CEPI and Gavi, Gavi playing the procurement and distribution role. U.S. has chosen not to be part of the COVAX facility. The door is still open. That can be changed. Congress can play a role there. And related to that is a question of WHO reform. Obviously, the president has chosen to terminate membership in WHO. That has been a controversial issue. We need to be thinking about what is the future of attempting to reconnect with WHO under what basis. We have the Independent Panel on Preparedness and Response that's underway, an international group, which is charged with looking at these issues. And the U.S. has supported that panel.

Tell us your thoughts around what the U.S. leadership role should be in the international domain, particularly with reference to low and lower-middle income countries in this next phase.

Rep. Tom Cole: Well, I start with a belief that – you know, I'm a big believer in enlightened self-interest. I think some of the best things we've done in the country – you know, whether it's PEPFAR or whether it's NATO – they're very different types of efforts, obviously. But the reality is, helping others to help yourself is pretty smart. And where disease is concerned, there is no border that will protect you. So, we need to be engaged globally on the health-care front. I actually toured yesterday – or, excuse me – Monday, I think, a biomedical facility in Maryland where they manufacture a whole variety of products. But two of the most interesting are things that, number one, are rapidly test – you can use them routinely, but they have surge capacity. So, we would never have this testing problem if we built these type of things and grouped them in appropriate places.

The other thing is that a smaller test, they argue, you could spread all over the world that could test unique things that we would – we would, you know, pick it up. Look, as I said, this is actually – you know, we had Ebola in Africa. We had one guy get to Dallas that was carrying the disease. You want to fight Ebola in West Africa or west Dallas? I know where I would pick. So, we need to be very aggressive. And a lot of the countries don't have much health-care infrastructure. It's not that they're not fine, but strengthening their infrastructure strengthens our

protection. It's just that simple. I mean, we live in a world where disease can move with extraordinary speed.

I had a good friend of mine, a guy named Kyle Harper, who's a brilliant Roman historian, published a book a couple years ago called –

J. Stephen Morrison: Yes, I recall that.

Rep. Tom Cole: You know, the end of – or, "The Fate of Rome." And it's on climate change and disease in the Roman Empire. And he made the obvious point, but important, hey, you know, once you have secure borders and all of a sudden you can cross the Mediterranean easily, disease start moving a lot more rapidly inside the Roman Empire. In the past, that had not been possible. We've created that on steroids in the 21st century globe in terms of how people and disease can move. So, the idea that we can just be good here and not worry about the rest of the world is a mistake.

And I would also tell you, I remember talking to my good friend, Ambassador Mark Green, who I served in Congress with. He was talking about his experience in East Africa as an ambassador. And at the nadir of Bush's popularity in America, he could go to any city in East Africa and there'd be standing lines cheering him eight people deep because of what the United States through enlightened self-interest did to fight AIDS, you know, in the Bush administration. Which Dr. Birx was part of that.

So, this is good politics. It's good diplomacy. It's good protection for the American people. And it's cheap. It's a lot cheaper to do this than it is to send a combat brigade team any place in the world. And the people that are coming are usually a lot more welcome than a combat brigade team is when you send it. So, look, I'm a big believer that we need to be active in all these international health groups. I agree with the president that WHO's performance on coronavirus was not what it should have been. I put a lot of blame on the Chinese there. I put a lot of blame on the leadership.

But that doesn't mean you give up on the institution or you disengage. We have to find other ways to hold people accountable. And we do spend a lot more money than a lot of other people that are pretty biased with their remarks. But you also have to recognize we have the ability to do that. You know, I do believe the Biblical injunction that to whom much is given much is expected. We've been given a lot. There's capabilities that we have in this country. Everything from resources, to scientific capability, technical expertise, that no other people can emulate.

So, you know, we do have a little bit of responsibility here. And, yes, our first responsibility is to look after our own people, but it's not going to hurt us to help other people – quite the opposite. And as a matter of fact, you know, we're having our – and I am very sharply critical of the Chinese performance here. But long term, this is actually one of the areas we should find a way to cooperate with one another. We have a vested interest in this. They have 1.3 billion people. We have 330 million people. Believe me, if there's a major disease outbreak we're both highly mobile societies. It's very likely to happen to both of us. And this is not an area that we need to compete with one another. It's really an area where we need to cooperate with one another. And we can.

So again, just broadly speaking, I want us to be more engaged internationally. I want us to be welcome and testing all over the world, so when we catch something we can isolate it someplace. I think that's one of the great Chinese failures, quite frankly, is that they're too closed to society. And it hurt them, and it ultimately hurt the rest of the world. They should have been inviting every expert in the world to come into China the moment they had this problem, and to help them solve it. And the fact that they didn't and I think, you know, were not open and honest with everybody, hurt them, and it certainly hurt the rest of the world. It certainly hurt the United States.

And frankly, the more open your society is, and we're about as open as any of them, the more vulnerable you're going to be. So, you have a vested interest, again, in partnerships, relationships, advanced warning, helping people stop something inside their country before it gets to our country. And how is that not smart politics? And how is that not the right thing to do both for us and other countries? How does that not yield great benefits ultimately to the United States diplomatically, economically, politically, obviously and most importantly, in terms of our health-care security? So, it's a no-brainer argument.

And there's no such thing as a biomedical nationalist. You know, I'm sorry, we live in the same biosphere. And it's going to throw stuff at us from all kinds of angles and all kinds of time. You are much more likely to die, we know now, in a pandemic from a terrorist attack. So, you better have the defense every bit as robust in the biosphere as you do in the traditional military sense.

J. Stephen Morrison: Thank you. We do have a problem on the vaccine side, which is, you know, the wealthy, powerful – most wealthy and most powerful countries in the world have locked up about 4 billion doses in those that are in 10 – those 10 that are in phase three field trials – those 10 vaccine candidates. Four in phase three here in the U.S., four in China, two in Europe. And there's great question around the low and lower-middle income countries. Will there be an adequate – will they be forced into a long delay, and a frustrating delay in that process in which they remain highly vulnerable and the disease is able to continue to transmit in those societies, while the wealthier countries are attempting to go through two rounds of vaccination that gets them to herd immunity of 70 percent of the population, and the like.

And the COVAX facility is one solution to that, with Gavi. And there's been some big commitments. The British made a half a billion commitment this week in Prime Minister Boris Johnson's speech to the U.N. General Assembly. We've had – we are hearing about some other commitments. It's still going to be a struggle, I believe. And I just wanted to ask you, are you worried that we're facing a high risk of a situation where there will be this huge disparity between the wealthiest countries – Europe, North America, Japan – versus those that are really kind of on the sidelines waiting to see what happens?

Rep. Tom Cole: Yeah, I do worry about that. And, you know, I worry about it in a couple of ways. First of all, it's very unfair to people who happen to be living and born in poorer societies. That's just – I expect the Europeans, and the Japanese, and the Chinese, and the Russians to pay their fair share. I understand it's a little bit different in Bangladesh. It's a little bit different in sub-Saharan Africa. And so we have to recognize that and act accordingly.

Second, you know, we have our own economic interest in these places. So, it's not good for us if these countries are suffering from a health-care crisis that's easily preventable. These are trading partners, in some cases allies, in all cases part of a global community that our prosperity depends on. So, to me, this is, again, enlightened self-interest. And it's cheap. Again, when we're talking about vaccines we're not talking – that's the cheapest part of the problem that we've dealt with because of coronavirus. The real cost has been, you know, obviously needing to help people that are unemployed through no fault of their own, sustain the airline industry. That's real money. The cost of vaccine production and the search for the vaccines is cheap compared to the economic dislocation that's come out of this kind of pandemic.

So, I would look at that the same way on a global scale. And again, if humanity is not safe everywhere, ultimately, it's not safe anywhere. The idea that we can cordon off part of the world and we'll be fine and, you know, we'll get around to help you when we can – it's in our interest to help those countries as quickly as possible. And we recognize if we're providing the resources the United States is going to look after its own people, just as other countries are going to look after their own. But you know, we shouldn't stop there. We should be thinking about – because, again, our long-term security depends on other people's health and wellbeing as well.

If we just approach it that way, we'll find the wherewithal to do it. And again, compare that to the cost of the Iraq or Afghan wars, it's miniscule. You know, it's the use of military power, you know, that is far more expensive than the expenditure of resources on, you know, aid, certainly on health care where, again, disease transmission is ultimately a danger to everybody. And if you look at it that way, we'll build up the global infrastructure working with other countries.

It doesn't need to just be an American initiative because, again, look, the death rate in the U.K. per million is higher than it is here. You know, Italy is comparable. France is comparable. Belgium is higher. Sweden is higher. Those are all first-world countries with great health-care systems. So, they have every bit as much of an interest as we do in cooperating in this area. And they have the wherewithal – both the technical abilities, you know, great scientists, great pharmaceutical companies on their own right, but also enough resources that on what's an important but still comparatively cheap endeavor.

Again, I would argue this is a hell of a lot cheaper than infrastructure – than building dams and roads. I'm all for buildings dams and roads, but this is not that expensive when you multiply it out across a $9 billion global population to make sure that we get quick and adequate vaccine development. And again, we know we can do things. Like, look what we've done on polio. Look what we did with smallpox. There are lots of things we can do that are on a mass scale that are comparatively cheap and, again would improve human life all over the planet enormously, would rebound to the credit of the United States, and would make our own people safer.

J. Stephen Morrison: Thank you. Thank you so much. We're getting to the close of our hour. I want to thank you so much for this conversation today and for – and for your membership and contribution to the CSIS Commission on Strengthening America's Health

Security. We're very in your debt for that.

And I want to just close by asking you to tell us what gives you the greatest hope, looking ahead?

Rep. Tom Cole.: You know, I'll take Project Warp Speed. You know, I think we're on the cusp of something that's unprecedented in human history. I'm told – I was talking to Dr. Collins about this. I was actually going through it. Now, if I say this is this true, is this accurate, Dr. Collins? Head of the NIH, as you know, wonderful great man, I think. I always call him the best politician in Washington, D.C., because he got appointed by both President Obama and President Trump. Now you show me anybody else who's got the credibility to get that done.

But we were talking about vaccine development and how excited he was. And, you know, clearly this is the fastest in human history. And we argue about is it going to come before the election or after the election. That's irrelevant. It's coming faster than any vaccine has come in human history. And it'll be distributed more rapidly than any vaccine in human history. That shows you what we're capable of doing when we put what the government does well, with what our best researchers do well, with what our, you know, pharmaceutical industries do well. And the – Dr. Collins when we were talking was almost giddy. He said, we're getting things done in a year or two that normally take 10 or 20. And we are cooperating in ways that are unprecedented.

Now, at the beginning of this, we had some of the smartest people in the world thinking about this. Now we have all the smartest people in the world that know anything about it thinking about this. And we have placed essentially unlimited resources in the hands of the people that can come up with a solution. And we've removed as many barriers as are prudent in terms of letting them collaborate and move quickly. And we've taken the financial risk out of this. No private company could afford to start manufacturing vaccine before it's been approved by the FDA. Can't run that risk. We've said, hey, we've got four or five promising lines here, we think they're going to make it, we're going to start building – you know, manufacturing the vaccine right now so when they are approved, we're ready to go.

We save a year worth of time, at 25,000 lives a month, I think that's kind of worth it. At trillions of dollars this is cheap. I mean, yeah, we will, "waste money" in the pursuit of the vaccine. But when you see how much quicker we'll be able to get on top of the problem – not completely solve it but get on top of it – the investment is miniscule in terms of what it's going to save you. So, when I see that much human talent, and I see us working that well together, and I see – you know, I look at AstraZeneca. They're in the race. That's a British company with great British science in Oxford. But it's American money that has allowed them to compete. And that makes me feel good.

The United States has – that's a promising line. This isn't Americans only. You got a good idea? Come here. We're going to help you. We're going to work with you. Now, we need to make sure Americans get their appropriate share of this. But you know, so I see this as a great human endeavor. And I likened it earlier to the Manhattan Project. But look at the difference, the Manhattan Project was the right thing to do, but it was an act of destruction that was going to ultimately cost lives. It was the search for a weapon. This is the search for a cure that's going to save

millions of lives. It's going to make the world better.

And the United States has played an unprecedented and leading role in this. And you know, in a highly charged time, you know, a divided Congress has come up with the resources, put it in the hands of an administration that, you know, is controversial to parts of the American public, said: Go do it. Get it done. We got your back. And we've done it. Or, we're on the cusp of doing it. Now, we'll have all kinds of problems and distribution problems.

But again, when I look at that and I can see us still capable of doing something that is unprecedented in human history – unprecedented. Fastest disease – vaccine, I'm told – a major vaccine took four years to develop. We didn't get the genetic code on this thing until mid-January of this year. And here we are very close to having tens of millions of vaccines, I hope and with great confidence believe, you know, by the end of this year or early next year. That's pretty amazing.

So, a people – and by that I mean species – that can do that and a country that can play a leading role in that, you know, is a pretty remarkable species and a pretty amazing country. So, I remain optimistic about humanity in general and about the United States of America in particular.

J. Stephen Morrison: Thank you so much, Congressman. That's a very eloquent, powerful, and inspiring close to our conversation today. And I just want to thank you on behalf of all of us here for taking the time, and for your extended leadership in so many different ways over the last two decades in Congress. We're very much in your debt. So, I know that we're keeping you from other important appointments. We've run a little bit overtime. I apologize for that. But it's been well worth it. And thank you so much.

Rep. Tom Cole: Stephen, thank you very much. Appreciate it.