Testimony of Michael Fine M.D.

Speaking for himself

September 21, 2021

Mr. Chair and Members of the Committee,

It is a great honor to appear before you again today.

Before I delve into my strong support of the Rhode Island Department of Health's very long standing regulation and protocol for the testing and vaccination of health care workers against a number of communicable infectious diseases, and try to put where we stand vs a vis Covid-19 in Rhode Island today, I want to take minute to publicly honor my old colleagues from the Rhode Island Department of Health, each of whom is today asked to do the work of ten people, who have given their all for now almost eighteen months without complaint or pause. They have done a very great honor to their professions, to the calling profession of public health and to the great state of Rhode Island.

I also want to acknowledge the more than two hundred and fifty of our public health colleagues from forty-one states other than Rhode Island who have been fired, retired or felt they had to resign in the face of withering controversy about their work as they simply tried to do their jobs. We have a tradition of respecting the integrity of public health in Rhode Island, and it is a tradition that has served us well, enabling my colleagues and our over 100,000 health professionals to protect the health and safety of all Rhode Islanders but focusing on the needs of our public and their patients, by always putting patient care first.

I want to acknowledge in particular my colleague and friend Dr. Beata Nelken, who practices *by herself* on Broad Street in Central Falls, and who has worked tirelessly throughout the pandemic with no direct public support, caring for the kids of Central Falls and their families. *By herself* she has immunized about 5000 people in Central Falls, many of who are undocumented and have no other place to go for medical care. *By herself* she and her staff test over 100 people every day and provides pediatric care to fifteen to twenty kids a day. She pays for much of the testing she does out of her own pocket, and she often doesn't charge people who are undocumented and uninsured. She is a true Rhode Island hero, and I thought you would want to know about her work.

I want to first offer my strong support for the Department of Health's long-established responsibility to protect the health and safety of Rhode Islanders by preventing the spread of infectious diseases. For over one hundred years we have prevented that spread by a number of measures: vaccination, testing, contact tracing, isolation, quarantine, spraying for mosquitoes – and frequent but strategic public communications. Sometimes we have to close a classroom or a school for a few weeks. Sometimes it's a business or a beach. These processes, which take painstaking detective work and sometimes painful enforcement, have been amazingly effective. We've stopped tuberculosis, though we get a few imported cases every year. No one remembers the last human case of rabies. Rabies is an incurable

disease that remains endemic among wild animals in Rhode Island. We never got Ebola, which kills fifyy to seventy-five percent of the people who get it. No physician I know has ever seen a case of measles, which used to kill five hundred children a year in the US, the same number of children as have died from Covid-19. None of us have ever seen diphtheria, which used to kill fifteen thousand kids each year in the US when the population of the country was one hundred million less. It has a case fatality rate of 10-20 percent. That's right, diphtheria used to kill twenty percent of the kids under five who got it. I've never seen or even heard of a case because of good public health and effective vaccines, and effective vaccine policies.

The testing and immunization of health care workers to prevent tuberculosis, hepatitis, measles, mumps, diphtheria, pertussis, tetanus, varicella (chicken pox) ,Influenza and now Covid-19 has been part of the routine requirement for the licensure and regulation of health care workers for as long as any of us can remember. The specific regulations changed over the years, but the role and responsibility of the Rhode Island Department of Health in protecting the public – that's been there as long as the department has been there, and is integral, it seems to me, to the maintenance of a free society. Every state in the union requires vaccination on school entry. Many states have vaccine protocols for health worker testing and immunization, often tied to licensure, but they don't all require the same tests or vaccination. (Rhode Island's has long been the best!) As of August 20, 2021, twenty-four states had health care worker vaccination requirements for Covid-19.

But even more important than these protocols is the ethical basis of our health professions. Our job is un-self-interested advocacy. It is core to the integrity of the health professions that health professionals put their patients before themselves. You, and the public, need to trust health professionals to protect them. When I get vaccinated, I'm not focused on the risk to me. I'm focused only on the risk to you if I am not vaccinated. And that is exactly the way it should be.

Now let me talk for a few minutes about Covid-19, where we are, how we got here, and perhaps a little about what we need to beat this thing into the ground once and for all.

Ads everyone knows, Covid-19 is the disease caused by a virus called SARS-CoV-2, a new virus to human beings that crossed over to us sometime in 2019, very likely in China and then spread around the world, evolving as it spread.

It's difficult, and a little more dangerous than it might otherwise be because it was new to us, and, until about two years ago, no one was immune to it, which means we are all likely to get it eventually.

The good news is that it isn't a very dangerous infectious disease, as infectious diseases go – it killed about six of every thousand people who got it at first, and now kills about two of every thousand – about twice the rate of flu. The bad news is that it has become exceptionally infectious, and that it preys on the old and the sick, killing as many as ten percent of people over eighty who are hospitalized with it – and that it will kill some younger people and some kids, numbers that become meaningful when you realize there are many more kids and young adults than there are elders.

But it is also true that there is lots we don't know about Covid-19 and its population dynamics – we are learning every day. That's part of why you heard so much confusing information in the beginning, and why it is so terribly important that we be clear about what we know, what we don't know, and that we be as honest as we can about what is just a guess or a projection, so people know where they – and we stand.

As we discuss numbers, I want you to understand the three numbers are most important: hospitalization rate, covid mortality rate, and the community transmission rate.

That said, please understand that the mortality rate, which I'm going to spend most time on, is as of this week. When we compare countries and states, where we are today isn't as important as where we are at the end of the pandemic. There are surges and seasonal variation. One country might look great today. But might fall apart in six months with a new variant or because of some change in behavior or a failure to vaccinate. Even so, some countries have done twenty times better than the US. Which means that if we had done as well as them, we'd be mourning 35,000 Americans. Not 700,000.

I'm actually not going to talk about the community transmission rate in very much detail; although I think community transmission is of upmost importance and hasn't attracted the kind of focus it needs. Community transmission means how many people now have Covid-19 in Rhode Island, and how fast its spreading, remembering that each person who has the Delta variant is thought to infect eight other people- and some of us believe (a projection to be sure) that between 10000 and 20000 Rhode Islanders have Covid-19 today.

I'm not going to talk about our actual community transmission *number* much because it depends too much on how much testing we are or aren't doing, and who we are testing.

But please understand that community transmission itself predicts hospitalizations and deaths with a two-to-four-week lag. At our level of community transmission, we are seeing and should expect to see one to four deaths from Covid-19 a day, and that number of deaths will likely stay the same until the level of community transmission goes down, or perhaps, until a much larger number of people are vaccinated. Please understand that when we encourage more movement and more interaction at this level of community transmission, we are accepting the number of hospitalizations and deaths we have now. For a number of technical reasons, the vaccine won't make hospitalizations and deaths go away by itself. But if we used all the public health tools at our disposal and were able) to reduce community transmission to a low level, likely two to five new cases per 100,000 per day (20 to 50 new cases per day in Rhode Island as a whole) that by itself would be associated with few hospitalizations and much fewer deaths, which was what we had for a few weeks in July in both 2020 and 2021.

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The United States has the 21st highest death rate in the world, at about 2084 deaths per million population, or one death for every five hundred people. We've lost 694,000 Americans to Covid-19 – and are losing over two thousand people a day again, but that number is likely to shrink some, as new

positive cases are falling around the country, at least for the moment. For my money, the US Covid-19 response has been a dismal failure, a result of the extent of our political division and the extent to which we have allowed our politics and our obsession with commerce to intrude on the public health process. From where we stand today, many other nations – over a hundred and fifty other nations, in fact -- have done better than us, and some *way* better. Some of these nations like the South Korea and Japan are large, diverse and developed nations with accurate reporting and reliable data. Those nations are seeing deaths per million in the range of fifty to one-hundred-and-fifty, one tenth to one twentieth of ours. If our response was like theirs, we'd have thirty to seventy thousand dead, not almost 700,000. In Rhode Island, that means 140 to 280 dead, not over 2800. Singapore is at 10 deaths per million. Australia is at 46 deaths per million. All this could change tomorrow, but probably won't – those nations have done well during the whole pandemic and are now getting their people vaccinated. The US could put a man on the moon. We stopped Hitler. We developed this vaccine! Surely, we can and must do better as a nation.

Rhode Island started the pandemic with much greater than average risk of rapid disease spread. We have lots of old-old: 31,401 people over eighty-five at the start of the pandemic. We're ninth in the nation for people over eighty-five and 13th for people over sixty-five, with more than 11 percent of our population over sixty-five living in poverty. That's important because people over eighty-five are at the highest risk of death from the virus should they contract it. We've lost about 3 to 5 percent of the RI population over eighty to Covid – over 1600 of our 2800 deaths. And Israeli data suggests that people over eighty-five and those with chronic disease who are vaccinated and get Covid have the same chance of hospitalization and death as people who are unvaccinated, which is why reducing community transmission is so important. That and isolating them are the only way we can protect our elders.

We're densely populated: second in the nation, although we are not as densely populated as we once were, compared to other places: Central Falls is the 27th most densely populated incorporated place in the US. Parts of Providence and Pawtucket are also very densely populated. Population density is important because of the way infectious disease spreads, which always involves densely populated places. Public health as we know it *started* in Europe in the 1840s and 50s after outbreaks of cholera in densely populated places.

We have too many people living in poverty: we're the 32th poorest in the nation, 2nd poorest in New England. That's important because people living in poverty have to go out of their houses to work every day, and often work in close proximity to one another, providing an opportunity for disease to spread. People living in poverty can rarely work from home: they are our factory workers, our store clerks, our fast-food workers, our CNAs, our landscapers, and often our construction workers. The unacceptable overlap of race and poverty is well known -- too many people of color live in poverty, in densely populated housing, and suffer multiple risks for Covid-19.

Rhode Island is one of six states with no local health departments. Only about fifty percent of us have and use a primary care physician. We're 12th in the nation for the number of people who speak languages other than English at home, which makes public health communication more challenging.

All that said, here's how we've done so far as a state: we're 8th in the nation for deaths per million, with 2815 deaths as of yesterday and a rate of 2657 deaths per million. If we were a nation, we'd be tenth in the world for deaths per million. We've had forty-six deaths in September already so we'll likely have sixty to seventy-five deaths is September alone and a similar number in October and November. That's because our level of community transmission remains high, does not appear to be decreasing, and is unlikely to drop, given that school has just started and people will be moving indoors in the next month. We may also see more deaths because vaccine immunity, which most of us think lasts about 6 months, is likely to be less than it was until people over sixty-five get boosters, hopefully in the next month or so but likely too late to change the rate of transmission, hospitalizations and death, at least until about six or eight weeks from now.

We've had 11,421 Covid hospitalizations in Rhode Island since the start of the pandemic. Our current 14-day hospitalization rate is twenty-four per 100,000 people, an 8 percent increase in the last two weeks, in a four-way tie for 25th in the nation. I don't have good data that compares our cumulative hospitalization rate to that of other states. There *is* good data on child hospitalization rates, which climbed by about 10 percent over the last two weeks nationally. We've had 268 children hospitalized in Rhode Island. Our child hospitalization rate has remained stable through about two weeks ago, which is great given the jump up in the national rate. But data from Israel and the UK tell us that our child hospitalization should have dropped by two thirds. That shows just how infectious the delta variant is, as delta likely precluded the expected drop in child immunizations rates.

We're 7th in the nation for the number of cases – but I don't put much store in that number, because we've done more testing than most places in the US – although not nearly enough from my perspective. You do more testing; you find more cases. Our ranking has improved somewhat in the last month, but that's not because we are doing better. It's because other states, which have lagged in vaccination, have caught up with us and passed us. We the fifth most vaccinated state in the US, at about sixty-seven percent fully vaccinated, which is a very good thing – but we are used to being the best vaccinated state in the Union, in part because of your support of the Rhode Island Universal Purchase programs, which buys vaccine for every Rhode Islander and has stabilized vaccine supply and distribution for more than 20 years. The good news is that we may be able to start vaccinating children 5 to 12 in the next few months, and I believe the vaccination of kids will help us end this pandemic by the end of next spring. The bad news is that the contagiousness of the Delta variant means that we will likely need to get to ninety to ninety-five percent vaccinated before we can reliably bring the pandemic under control. The other bad news is that about vaccine eligible 140,000 Rhode Islanders remain unvaccinated, with 52 percent of Black Rhode Islanders and 48 percent of Latinx Rhode Islanders remaining unvaccinated, so the pandemic is likely to continue to prey most on people of color.

Can we do better? I believe we can but doing better involves a much deeper commitment to public health, and a change in our priorities, so we stop trading off lives for commerce. We need ten times the number of public health workers than we have. We need to involve our primary care practices much more deeply. We can support our businesses through this economically, but we can't get back the lives we lost. And are losing every day.

Thank you again for this opportunity, and for your interest and commitment to protecting the health and safety of all Rhode Islanders.

Respectfully submitted,

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