



**Strengthening the Nation's Infrastructure for Infectious Diseases**  
Proposals to the U.S. Senate for the Economic Stimulus Bill  
from the Infectious Diseases Society of America

**Antimicrobial Resistance and Emerging Infections**

The Infectious Diseases Society of America (IDSA) urges the Senate to include in the stimulus package the following investments in the nation's public health infrastructure for infectious diseases. These three proposals emphasize the crises of antimicrobial resistance and emerging infections. An ongoing explosion of antibiotic-resistant infections is plaguing U.S. health, while resistance to influenza antivirals is cause for concern. More broadly, the nation is ill-equipped to adequately track and respond to emerging infections. Down-payments on a robust national capacity to prevent, monitor and control the spread of infectious diseases, these initial corrections to critical deficiencies will create jobs, promote cost-savings, and pave the way toward additional innovations and investments in the context of health reform.

**(1) IDSA urges an increase in two underfunded, cross-cutting budget lines at the Centers for Disease Control and Prevention (CDC) which address the crises of antimicrobial resistance and emerging infections:**

**CDC's Antimicrobial Resistance budget line + \$77 million**

Increasing the present, poorly-funded \$17 million antimicrobial resistance (AR) line will aid a range of programs through which CDC provides assistance to states, ensuring program continuity and allowing some expansion. States receive AR funds to improve laboratory detection and monitoring of AR infections and conduct laboratory research; conduct outbreak investigations on resistant pathogens; develop "best practices" guidelines for healthcare facilities and workers; and operate educational initiatives to improve the appropriate use of antibiotics in community, healthcare and agricultural settings, with the goal of reducing overuse which contributes to resistance. The AR line also funds extramural research awards; efforts to track and control resistance in food-borne bacteria and other needs. *Notably, an internal CDC professional judgment last year determined that a total of \$94 million was needed annually for this line.*

**Emerging Infectious Diseases (EI) + \$30 million**

Adding \$30 million to the Emerging Infectious Diseases (EI) budget line, which stands currently at \$130 million, will boost the agency's capacity to nimbly identify and respond to emerging infections. *Infectious diseases funding provided to CDC is highly disease-targeted, making it difficult to fund cross-cutting or emergent needs. Unique in its flexibility, the EI line supports dozens of research*

*and surveillance programs which must compete for funding from the EI line to address new and unpredictable needs, as well as needs that cannot be funded adequately by other mechanisms. For instance, anthrax research and global monitoring of dengue are partially reliant on this line. Fierce competition for this line limits program viability, effectiveness and growth.*

**(2) IDSA urges immediate investments in two CDC cooperative agreements that build state and local public health capacity to address infectious diseases:**

State and local public health departments are unable to maintain their capacity to adequately address emerging infectious disease threats in community and healthcare settings, including tracking specific organisms such as methicillin-resistant *Staphylococcus Aureus* (MRSA) which are becoming endemic in many settings, *Clostridium difficile* infections which are on the rise, and multidrug resistant strains of the so-called “gram negative” types of bacteria for which few treatments exist. Increases to the funding lines that support the Epidemiology and Laboratory Capacity (ELC) program and the Emerging Infections Program (EIP) will buttress these critical, under-resourced tools to aid state and local health agencies.

**Joint request for ELC and EIP + \$180 million**

**Epidemiology and Laboratory Capacity (ELC) program**

The Epidemiology and Laboratory Capacity (ELC) for Infectious Disease program builds health department and state laboratory infrastructure in all fifty states to ensure effective local response to infectious disease outbreaks, including antimicrobial resistance and new and emerging infectious diseases, and maintain adequate information systems. *Since its peak in 2002, ELC funds for building and maintaining core infectious disease infrastructure has declined by 30%; funding stood at \$46 million in FY08. The increased funding will go directly to health departments to purchase equipment and supplies and to hire and support personnel, partly ameliorating significant layoffs experienced during the current economic downturn.*

**Emerging Infections Programs (EIPs)**

The Emerging Infections Programs (EIPs) are ten collaborations of selected state or local health agencies working with academic institutions and CDC. Through focused collaboration, the EIPs go beyond the routine work supported by the ELC program to conduct in-depth surveillance that documents the entirety of the burden of an infectious pathogen in given geographic areas; they also develop and evaluate prevention strategies. Work by the EIPs was able to define the rapidly changing epidemiology and growing burden of MRSA for example. *This program is operating at maximum capacity with limited funding flexibility and assurance, with funds standing at only \$25 million in FY08. Increased funding would be used for improved information technology and additional epidemiological studies on emerging threats.*

**(3) IDSA urges increased investment in the National Healthcare Safety Network which tracks healthcare-associated infections (HAIs) in healthcare settings.**

**National Healthcare Safety Network + \$30 million**

Providing an added \$30 million directly to CDC for the National Healthcare Safety Network (NHSN) will allow needed expansions to this data system, which tracks healthcare-associated infections (HAI) including resistant hospital infections. Hospitals and other healthcare institutions report data to NHSN on incidents of healthcare-associated infections (HAIs), antimicrobial resistance and other adverse events. Until recently this was done wholly on a voluntary basis. *As a result of new state laws requiring institutions to report data to the NHSN, CDC has been unable to keep up with the data and related needs. Since April 2007, the volume of participating facilities has quadrupled from less than 500 to more than 2,100. Yet NHSN funding stood at only \$5 million in FY08. Increased funding will allow CDC to begin to improve the information technology framework through which institutions report data, articulate better standards for reporting, and improve national analysis of these patient safety problems. This will lead to the design of improved interventions and solutions. In sum, increased funding will allow this under-resourced system to begin to fulfill its potential as an important national tool in fighting HAIs including highly problematic resistant HAIs.*

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## **Strengthening the Nation's Infrastructure for Infectious Diseases**

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### **Tuberculosis and HIV/AIDS**

The Infectious Diseases Society of America (IDSA) and HIV Medicine Association (HIVMA) urge the Senate to include in the stimulus package the following investments in the nation's public health infrastructure for infectious diseases. The following proposals emphasize the crises of tuberculosis and HIV/AIDS. Down-payments on a robust national capacity to prevent, monitor and control the spread of infectious diseases, these initial corrections to critical deficiencies will create jobs, promote cost-savings, and pave the way toward additional innovations and investments in the context of health reform.

**IDSA strongly supports infectious diseases programs that are funded under the National Center for HIV/AIDS, Viral Hepatitis, STD and TB Prevention. The House stimulus bill allocates \$335 million in new funding for programs funded under the Center, but \$1 billion infusion of resources would ensure that the national response to HIV, tuberculosis, STDs and viral hepatitis is adequate. Specific funding recommendations for HIV and tuberculosis follow:**

#### **Tuberculosis funding at CDC**

**+ \$300 million**

In 2006, there were 13,767 cases of active TB reported in the United States. In addition to those with active TB, an estimated 10,000,000 to 15,000,000 people in the United States have latent TB infection. Treatment of multidrug-resistant TB (MDR-TB), a growing threat, is more than 100 times as costly as treatment of drug-susceptible TB, requiring intensive case management for its prolonged (18-24 months) and more toxic treatment course. In 2002 the Institute of Medicine estimated that \$528 million was needed in annual TB control expenditures to put the US on a path to TB elimination. Today, the CDC is providing only about \$140 million to address TB, most of it to state-level programs, and the effort to develop new medications and other TB tools is grossly underfunded at \$133 million from all US agencies. With an additional \$300 million for TB programs via CDC, including \$100 million for urgent TB research, the Congress could jump-start the US response to TB and produce significant cost-savings.

**Tuberculosis vaccine research at USAID + \$120 million**

An additional area in immediate need of additional funding is research for a TB vaccine through the U.S. Agency for International Development (USAID). The Lantos-Hyde Act authorized U.S. contributions to tuberculosis vaccine development programs, "which may include the Aeras Global TB Vaccine Foundation," however USAID is currently providing no funds for this purpose. The Aeras Global TB Vaccine Foundation, a public-private partnership, was launched in 2003 to develop an effective vaccine, and its manufacturing and research facility is located in Rockville, Maryland. Aeras has the broadest pipeline of promising TB vaccine candidates, with six in or near clinical trials. Aeras has accelerated the proof-of-concept testing of a new vaccine to 2009, rather than 2011, and it urgently needs funding to expand to larger clinical trials for this and other candidates. It is estimated that Phase III clinical trials will cost \$120 million per vaccine candidate. An immediate boost of \$120 million for TB vaccine research would put the world on course for a safe and effective vaccine by 2016.

**HIV prevention at CDC + \$550 million**

Every ten minutes there is another HIV infection in the U.S., with disproportionate impact on minority groups. Yet CDC's HIV prevention budget has declined 19% compared to inflation since 2002. With \$550 in additional funding for HIV prevention, beginning in 2009 with stimulus funding for the CDC and then maintained for the following three years, we can achieve a 50% reduction in both transmission rate and incidence by enhancing funding for routine HIV testing, surveillance and community-based prevention programs, among other activities. *Notably, an internal CDC professional judgment last year determined that an increase of \$877 million was needed annually for this line.*

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