

**Testimony of the Infectious Diseases Society of America (IDSA)  
on the Fiscal Year 2024 Department of Health and Human Services (HHS) Budget  
Prepared for the U.S. House Subcommittee on Labor, Health and Human Services,  
Education, and Labor Appropriations  
Submitted by Carlos del Rio, MD, FIDSA, IDSA President, on March 23, 2023**

On behalf of the Infectious Diseases Society of America (IDSA), which represents more than 12,000 physicians, scientists, public health practitioners and other clinicians specializing in infectious diseases prevention, care, research and education, I urge the Subcommittee to provide robust FY2024 funding for public health and biomedical research activities that save lives, contain health care costs and promote economic growth. **IDSA asks the Subcommittee to provide \$50 million for the Bio-preparedness Workforce Pilot Program at the Health Resources and Services Administration (HRSA), \$400 million for the Antibiotic Resistance Solutions Initiative (ARSI) at the Centers for Disease Control and Prevention (CDC), \$7.060 billion for the National Institute of Allergy and Infectious Diseases (NIAID), \$330 million for the Biomedical Advanced Research and Development Authority (BARDA) Broad Spectrum Antimicrobials and CARB-X programs.**

**HEALTH RESOURCES and SERVICES ADMINISTRATION  
Bio-preparedness Workforce Pilot Program**

IDSA urges you to include \$50 million in FY2024 to launch the new Bio-preparedness Workforce Pilot Program. Authorized in the Consolidated Appropriations Act, 2023 (Division FF, Chapter 3 – Sec. 2221(h)), within the Public Health Loan Repayment Program, the Pilot Program complements the Public Health Loan Repayment Program by ensuring the public health workforce has strong ID partners in community health care settings by incentivizing more health care professionals to enter the field of infectious diseases (ID) and work in underserved areas.

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Nearly 80% of U.S. counties nationwide do not have a single ID physician. The distribution of ID physicians is geographically skewed with rural Americans being less likely to have access to ID physicians. In 2022, only 56% of ID training programs filled their positions, while most other medical specialties 90% or more of their training programs. An average medical student educational debt of more than \$250,000 drives many physicians away from ID—the fifth lowest paid medical specialty, even below general internal medicine—and toward more lucrative specialties. Similar shortages persist among other ID experts, including clinical laboratory staff, infection preventionists, nurses and physician assistants—all of whom would be eligible for the Pilot.

Despite the deep gaps in the ID workforce, no federal programs offered loan repayment for providing ID care or conducting emergency preparedness activities in health care facilities prior to the establishment of the Pilot. This program fills a discreet but critical need without duplication of federal resources. The Pilot Program is intended to encourage early career health care professionals to enter the field of ID and expand access to ID care, targeting where it is needed the most. Funding in FY2024 will help ensure the U.S. has the workforce with the experience and expertise necessary to improve preparedness for future public health emergencies, limiting deaths and disruption, ensure that we have ID health professional experts to address infectious diseases such as HIV and viral hepatitis, and meet ID needs associated with cancer chemotherapy, organ transplants, opioid use, and other complex care.

\$50 million for the pilot program will provide up to \$50,000 in loan repayment to as many as 1,000 infectious diseases (ID) professionals who work in health professional shortage areas, federal health facility such as VA clinics, Ryan White HIV/AIDS Program clinics or tribal health facilities.

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Importantly, this funding will impact the decisions of medical students, residents and other trainees in this year's recruitment processes.

\$50 million in FY2024 will help secure the resources necessary for the pilot to more equitably distribute and increase the size of the ID workforce in the upcoming appropriations cycle and will allow us to further leverage the investments the Committee has made to end the HIV epidemic, improve pandemic preparedness, eliminate viral hepatitis, control sexually transmitted infections, and combat antimicrobial resistance.

### **CENTERS FOR DISEASE CONTROL AND PREVENTION** **[Antibiotic Resistance Solutions Initiative \(ARSI\)](#)**

**We urge \$400 million in funding for the Antibiotic Resistance Solutions Initiative in FY2024,** the cornerstone of the nation's efforts to detect, prevent, and respond to AMR. Rates of antimicrobial-resistant infections and deaths in U.S. hospitals rose 15% in 2020 due to the COVID-19 pandemic, wiping out progress made in 2012-2017. At least 35,000 people die of resistant infections in the U.S. every year. The burden of resistance is likely much higher, but our surveillance is unable to capture the full picture and the pandemic worsened data gaps. Antibiotic resistance accounts for direct health-care costs of at least \$20 billion. Infections are a primary or associated cause of death in [50% of patients with cancer](#), as AMR can make these infections difficult or impossible to treat. AMR has a [disproportionate impact](#) on certain communities due to variance in risk of exposure, susceptibility to infection or treatment received. Rates of several serious antibiotic-resistant infections, including community-associated methicillin-resistant *Staphylococcus aureus* (MRSA) infections, are higher incidence in Black populations. [Globally](#), resistant infections directly caused 1.27 million deaths in 2019 and played a role in 4.95 million deaths. If we do not act now, antibiotic-resistant infections will be the leading cause of death by 2050 and could cost the world \$100 trillion.

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Recommended funding would expand antibiotic stewardship across the continuum of care; double state and local grant awards; expand the AR Laboratory Network globally and domestically to strengthen the identification, tracking and containment of deadly pathogens; support AMR research and epicenters; and increase public and health care professional education and awareness. The program is also a critical building block of CDC's public health infrastructure that directly supports broader agency activities, including foodborne illness pathogen detection, global AMR prevention and surveillance, and responses to sexually transmitted infections and health care-associated infections..

### **ASSISTANT SECRETARY FOR PREPAREDNESS AND RESPONSE (ASPR) Biomedical Advanced Research and Development Authority (BARDA)**

The BARDA [Broad Spectrum Antimicrobials program](#) and [CARB-X](#) leverage public/private partnerships to develop products that directly support the government-wide National Action Plan for Combating Antibiotic-Resistant Bacteria and have been successful in developing new FDA-approved antimicrobials. Despite this progress, the pipeline of new antimicrobials development is insufficient to meet patient needs, and \$330 million in funding is needed to accelerate basic and applied research for developing new products. Additional funding will help prevent a post-antibiotic era in which we lose many modern medical advances that depend upon the availability of antibiotics.

### **NATIONAL INSTITUTES OF HEALTH [National Institute of Allergy and Infectious Diseases \(NIAID\)](#)**

\$7.060 billion for NIAID, including \$608 million for AMR research, would allow NIAID to address AMR while conducting its broader role in supporting infectious diseases research, including emerging infectious diseases, HIV, TB and influenza. Increased FY2024 funding would strengthen investment

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in the biomedical research workforce, including training and efforts to support early-career physician-scientists and promote diversity, and update the national clinical trials infrastructure to include community hospitals and enable access for underserved populations. With regard to AMR specifically, increased funding would support research on mechanisms of resistance, therapeutics, vaccines and diagnostics; development of a clinical trials network to reduce barriers to research on emerging and difficult-to-treat resistant infections; and support for training more physician scientists.

In 2022, only 56% of ID physician training programs filled their slots, leaving us with an inadequate pipeline of ID physician-scientists necessary to lead clinical trials and additional research to strengthen our prevention and responses to ID threats. NIAID should use funding to provide additional K, T, and F awards, and Early Investigator Awards, and research opportunities for community-based ID physicians to enhance recruitment, training and diversity of the research workforce.

### **CONCLUSION**

Thank you for the opportunity to submit this statement. The nation's infectious diseases physicians and scientists rely on strong federal partnerships to keep Americans healthy and urge you to support these efforts. Please forward any questions to Lisa Cox at [lcox@idsociety.org](mailto:lcox@idsociety.org) or (202) 669-4826.