NACCHO
National Association of County & City Health Officials

07-03

STATEMENT OF POLICY

TUBERCULOSIS PREVENTION, CONTROL, AND ELIMINATION

Policy

The National Association of County and City Health Officials (NACCHO) strongly supports increasing categorical federal, state, and local funding for state and local health department programs to control active tuberculosis (TB) disease[1] and prevent spread through detection and treatment of latent tuberculosis infection (LTBI).[2] This should include reimbursement from the federal government to local health departments for services provided to individuals with communicable diseases of public health significance.[3] NACCHO also encourages the adoption of federal and state guidelines and policies that improve access and reduce financial barriers to screening, testing, and treatment for active TB disease and latent TB infection. Such investments can lead to immediate benefits, accelerate declines in cases, yield long-term cost savings, and advance the goal of TB elimination in the United States.

Justification

Tuberculosis remains a leading cause of preventable infectious disease deaths worldwide, [4,5] and the rising global emergence of multi-drug resistant tuberculosis (MDR-TB) and extensively drug resistant tuberculosis (XDR-TB) increase public health workload and pose public health challenges, particularly with the growing potential for importation and subsequent spread of these infections.[6] Domestically, TB continues to disproportionately affect vulnerable populations and requires strong public health infrastructure to maintain adequate elimination and control measures. Underlying risk factors for TB such as diabetes and renal disease are also rapidly on the rise and contribute to the threat of TB resurgence. Furthermore, TB is a disease for which there is no effective vaccine but is curable and preventable.

In the United States, eliminating TB and strengthening domestic capacity to combat drug resistant TB are national public health goals.[5] Effective prevention and control efforts have been responsible for a marked and sustained decrease in the number of TB cases reported between the early 1990s and 2020.[7] TB cases rose during 2021 and 2022, but remained lower compared to pre-pandemic levels; however, concerns about pandemic-related disruptions persist. Furthermore, ongoing research into novel interventions and treatments has yielded effective new options, such as better laboratory tests and short-course treatment regimens for TB infections. However, since 2013, after two decades of annual declines, incidence of TB in the United States has leveled.[8]

U.S. immigration law mandates a medical examination including screening for communicable diseases of public health significance for persons applying to immigrate as permanent residents and those designated as refugees or asylees. Local health departments are frequently responsible for follow up of individuals identified as having a class B condition, including inactive or noninfectious TB. This follow up can be time intensive,

exacerbated by challenges and special considerations such as an unreliable current address, not having a phone number listed such that a home visit is necessary, as well as needs for translation services and time to build trust with communities who may be hesitant to engage with governmental agencies. If an individual is found to have active TB disease, isolation, contact investigations, and supervision or directly observed therapy are additional commitments that take time and money. As such, federal support for TB evaluation and treatment is critical. Reflecting the wide range of activities LHDs conduct related to screening, follow up and treatment of refugees, asylees and immigrants with potentially communicable diseases, reimbursement for these activities is inconsistent nationwide. In some states, mechanisms for reimbursement exist, including leveraging insurance coverage for TB care or civil surgeon evaluations, or possible state-level funding, but local health departments across the country are tasked with following up on certain cases and there is no established, consistent process for reimbursement. Insurance reimbursement for TB care or civil surgeon evaluations is possible in some states, but this places additional financial burdens on local health departments, as it requires additional FTE to navigate the complex health insurance system.

To achieve TB elimination, public health and community stakeholders must intensify efforts to interrupt TB transmission and increase their focus on detecting and treating TB infection.[8] Eliminating the reservoir of disease is key because as many as 85% to 90% of U.S. TB cases may originate from reactivation of infection.[9] Success in achieving elimination will depend on a number of factors including adequately resourcing state and local health departments to maintain core public health activities (e.g., TB surveillance and contact investigations) while increasing targeted testing and treatment for TB infection by primary care providers.[10] Clinical guidelines that encourage treatment of latent TB infection; effective engagement of and support for community-based providers; and policies that ensure universal access and reduce financial barriers to screening, testing, and treating TB infection in primary care, will also be key. These efforts are labor- and resource-intensive, requiring funding and the recruitment, training, and retention of highly skilled health care workers. However, their benefits are clear. Past resurgences in TB cases have been directly attributed to decreases in funding for TB control and infrastructure and have taken billions of dollars to correct.[11]

Appropriately treating TB also prevents the emergence of costly and lethal drug-resistant strains. Drug-resistant *M. tuberculosis* poses substantial obstacles to TB care and prevention, including higher toxicity drugs, longer treatment regimens, and prolonged social isolation while patients are infectious. An analysis of outcomes for 135 patients with MDR-TB or XDR-TB in the United States during 2005-2007 demonstrated that 78% of patients completed treatment and that mortality was comparable to that for U.S. patients with drug-susceptible TB.[12] However, these favorable outcomes came at a high cost: in 2020 the direct costs were estimated to be $182,186 for a patient with MDR-TB and $567,708 for a patient with XDR-TB, compared to $20,211 for a patient with drug-susceptible TB.[13] A large portion of those costs are born by the public health departments that provide intensive clinical and case management services and directly observed therapy for the duration of treatment, which frequently lasts 18-24 months for a patient with drug-resistant TB. Preventing MDR/XDR TB in the U.S. will require a robust U.S. public health infrastructure to rapidly diagnose and appropriately care for these patients.

To achieve TB elimination, it is critical that we strengthen local capacity to implement prevention and control activities and treat TB infections. Increased funding of TB control programs at the state and local level, along with public health policies that improve access to testing and treatment, are essential to protecting the community from a disease that is largely treatable and preventable. Along with incentives for state and local health departments to use new, innovative control and treatment modalities, these will ensure progress toward TB elimination and a world free of the scourge of this deadly disease.

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[2] World Health Organization. Global tuberculosis report, 2024. Retrieved January 17, 2025, from https://iris.who.int/bitstream/handle/10665/379339/9789240101531-eng.pdf?sequence=1[3]

[3]Centers for Disease Control and Prevention, U.S. Department of Health and Human Services. (2016). Final Rule 42 CFR Part 34: Medical Examination of Aliens – Revisions to Medical Screening Process. Retrieved December 5, 2018 from: https://www.federalregister.gov/documents/2016/01/26/2016-01418/medical-examination-of-aliens-revisions-to-medical-screening-process.

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[5] The White House. (2022). https://obamawhitehouse.archives.gov/sites/default/files/microsites/ostp/national_action_plan_for_tuberculosis_20151204_final.pdf Fact Sheet: President Biden raises record level of funding for Global Health through Global Fund Seventh Replenishment. Retrieved January 10, 2025 from https://www.whitehouse.gov/briefing-room/statements-releases/2022/09/21/fact-sheet-president-biden-raises-record-level-funding-for-global-health-through-global-fund-seventh-replenishment/

[6] Centers for Disease Control and Prevention. (2023). About Drug-Resistant Tuberculosis Disease. Retrieved January 12, 2025 fromhttps://www.cdc.gov/tb/about/drug-resistant.html

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[9] Centers for Disease Control and Prevention. (2023). Tuberculosis — United States, 2023., *Morbidity and Mortality Weekly Report (MMWR)*, March 28, 2024 / 73(12);265-70. Retrieved October 31, 2024, from https://www.cdc.gov/mmwr/volumes/73/wr/mm7312a4.htm?s_cid=mm7312a4_w.

[10] Shiau, R., Holmen, J., & Chitnis, A. S. (2021). Public Health Expenditures and Clinical and Social Complexity of Tuberculosis Cases–Alameda County, California, July-December 2017. *Journal of Public Health Management and Practice*, *28*(2), 188–198. https://doi.org/10.1097/phh.0000000000001356

[11] Centers for Disease Control and Prevention. (2024). Core Curriculum on Tuberculosis: What the Clinician Should Know. Retrieved January 17, 2025, from https://www.cdc.gov/tb/hcp/education/core-curriculum-on-tuberculosis.html[12] Marks SM, Flood J, Seaworth B, Hirsch-Moverman Y, Armstrong L, Mase S, et al. Treatment practices, outcomes, and costs of multidrug-resistant and extensively drug-resistant tuberculosis, United States, 2005-2007. *Emerging Infectious Diseases Journal*. 2014;5:812-20.

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Record of Action

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