

Narrow the Focus of the Centers for Disease Control and Prevention and Food and Drug Administration

Lack of Attention to Communicable Diseases and Duplicative Efforts Have Harmed the Nation's COVID-19 Response

By Michelle Minton*

The Centers for Disease Control and Prevention (CDC) and the Food and Drug Administration (FDA) may well have taken their eye off the ball by focusing too much of their budget and efforts on public health issues such as the risks association with flavored vaping products. This focus may have diverted the medical community's research, strategy, and preparedness goals toward those of interest to federal grant makers, including the National Institutes of Health, and away from acute threats to health, like infectious diseases. Congress should refocus these health agencies toward protecting the nation against genuine threats like infectious diseases.

Mission Creep Erodes Focus on Infectious Diseases. As its original name, the Communicable Disease Center implies, the initial purpose of the CDC was to assist the states in the control of infectious disease.¹ It arose out of federal efforts to control malaria, a mosquito-borne illness that posed a hazard to the World War II efforts in southern states. Since its establishment in 1946, however, the CDC's purview has gradually expanded. First, it grew to incorporate infectious diseases beyond malaria and later to include conditions and diseases not caused by the spread of dangerous pathogens, but by lifestyle factors, such as heart disease, cancer, and diabetes.

The amount of money allocated to the CDC has grown along with its ever-expanding portfolio of issues. Whereas in 1987 the agency received just under \$590 million in federal appropriations, today it spends around \$8 billion on all manner of topics, many of which are only tangentially linked to health.² In addition to infectious illnesses like malaria, HIV, and influenza, CDC also maintains projects on alcohol consumption, tobacco use, traffic accidents, sports injuries, domestic violence, and gun control.³ These things can impact an individual's health and wellness, of course, but they are far afield from the CDC's original purpose of preventing the spread of dangerous pathogens.

Duplicative Efforts. A strong case can be made for the value of spending taxpayer funds to monitor and minimize non-infectious health threats. Not only can this investment

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materially benefit the health of the public, but surveillance could result in better resource allocation, while research could increase the effectiveness of government policies, thereby decreasing financial burdens and increasing efficiency. To that end, the federal government already awards responsibility and a significant portion of its budget—nearly \$40 billion—to the National Institutes of Health (NIH).⁴ Individual Institutes within NIH already cover nearly all of the non-infectious disease projects taken up by the CDC.

The area in which the CDC has most significantly expanded its reach is in the category of “chronic diseases”—illnesses and conditions linked, at least in part, to lifestyle choices. Its National Center for Chronic Disease Prevention and Health Promotion, which focuses on heart disease, cancer, stroke, diabetes, arthritis, and oral disease, among other ailments, received nearly \$1.1 billion in funding in 2018.⁵ The Center’s activities include not only research, but also efforts to control behaviors identified as risk factors for these conditions, such as tobacco use, poor nutrition, and lack of physical activity. There is little question that these behaviors genuinely impact individual and population health, but it is questionable whether the CDC’s involvement provides a net benefit to public health.

According to a 2016 study by EconoStats, a project of the Statistical Assessment Service (formerly associated with George Mason University), the CDC’s Chronic Disease project shares its mission with at least 10 other agencies, mostly divisions of NIH, such as the National Heart, Lung, and Blood Institute, the National Cancer Institute, the National Institute of Neurological Disorders and Stroke, the National Institute on Alcohol Abuse and Alcoholism, and the National Institute of Diabetes and Digestive Kidney Disease.⁶ Except for the Institute on Alcohol Abuse and Alcoholism, the appropriations allocated to each of these Institutes is at least 50 percent greater than the \$1.1 billion budget for CDC’s entire Chronic Disease project. Thus, not only do the individual Institutes have far more resources, but also thanks to their specialization, a greater degree of expertise on these issues than CDC.

One might think that such overlap provides added benefit or, at least, that there is no harm in the CDC lending its resources and attention to issues already covered by other agencies. However, this duplicative and often contradictory work between agencies can create confusion, particularly in emergency situations.

For example, both the CDC and the Food and Drug Administration (FDA) maintain programs on tobacco use. Their differing perspectives and approaches came to a head in the summer of 2019 as clusters of a mysterious lung ailment seemingly linked to vaping began appearing around the country. Based on early information about the cases, it quickly became apparent that the majority of patients shared a history, not only of vaping per se, but of vaping illicit cannabis products.⁷ By September 2019 the FDA had issued a specific warning that the public should avoid from vaping THC products, particularly those purchased illegally.⁸ The CDC, however, maintained a broader warning that consumers should avoid e-cigarettes and all vaping.⁹ Then in January 2020 the CDC stepped back from this broader language and noted that illicit cannabis vaping, not e-cigarettes or vaping in general, appeared to be the main culprit.¹⁰ In the meantime, the months of conflicting advice from federal agencies led to misinformation among consumers.¹¹ It also created confusion

among policy makers, inciting several states, cities, tribal territories, and even other countries to temporarily or permanently ban electronic nicotine products—even though not a single commercial e-cigarette was implicated in the outbreak.¹²

Such duplicative efforts have the potential not only to create confusion, but to erode an agency's ability to execute its other functions. As we are unfortunately learning with the outbreak of the novel coronavirus, this is exactly what happened at the CDC. As it expanded its mission and diverted resources from infectious disease control toward controlling all manner of behaviors and factors related to chronic health, it undermined its own ability to effectively address its original core mission. There has been evidence of this fact for years.

Warning from Ebola Outbreak. The worst outbreak of Ebola in history began in early 2014 when the virus ravaged West African nations like Guinea, Sierra Leone, and Liberia, with more than 3,000 people dying of the disease by the end of the summer.¹³ At that time, the CDC was taking the outbreak seriously, activating its Emergency Operations Center and stepping up travel advisories to avoid nonessential travel to West Africa.¹⁴ Despite the growing gravity of the situation, then-CDC Director Thomas Frieden remained relatively unconcerned and confident in his agency's ability to keep the American public safe. "It is not a potential of Ebola spreading widely in the U.S.," he told reporters in conference call on July 31, 2014; "we have quarantine stations at all the major ports of entry."¹⁵

Thomas Duncan arrived in Dallas from Liberia on September 20, 2014, and a week later went to a local hospital emergency room with symptoms of Ebola. Even after he informed nurses that he had recently arrived from Liberia, he was sent home. It was not until three days later, when Duncan returned to the hospital, that he was quarantined and tested positive for Ebola.¹⁶ Even after testing positive, the response by government officials was slow and inadequate for individuals who had been living with Duncan, who were forced to remain isolated in the contaminated apartment.¹⁷ Two nurses who cared for Duncan subsequently tested positive for Ebola. Colleagues who cared for them argued that protocols were not in place to deal with the outbreak and that they lacked adequate protective equipment and had not been properly trained.¹⁸ One of the nurses who treated Duncan flew to Ohio before falling ill and testing positive there, after which the CDC announced that no one else involved in Duncan's care would be allowed to use public transportation and acknowledged that it had not been aggressive enough in containing the virus.¹⁹

In October, a CDC official commented that "we let our guard down a little bit. ... Now that we've seen this happen, we know now that we need to do more to make people feel prepared."²⁰ At the same time, Frieden, once confident in the nation's preparedness for Ebola, admitted that "stopping Ebola is hard."²¹ Perhaps in response to CDC's lackluster response to the outbreak, President Obama appointed Ron Klain, a former chief of staff to Vice President Joe Biden and former Vice President Al Gore, to take over coordinating the government's response to Ebola four days later.²²

Despite the CDC's acknowledgement that it needed to be more aggressive in containing deadly infectious diseases like Ebola, it appears to have done little since then to improve its

capacity to provide the information, training, and equipment necessary for the nation's health care system to act quickly and effectively in response to infectious disease threats. In March 2020, a survey by National Nurses United found that supply and staffing shortages, conflicting guidelines, and lack of information had left the U.S. "wildly unprepared" for the current outbreak of the novel coronavirus.²³ Moreover, Thomas Frieden told members of Congress in 2016 that the agency was looking into adding respirators to the Strategic National Stockpile (which managed by the CDC until 2018, when it was transferred to the Office of the Assistant Secretary for Preparedness and Response) because "when we do models of what could be a worst-case scenario, there is likely to be a shortage of ventilators that could be critically important."²⁴ It has become clear now that Frieden was correct, with an estimated 10 to 25 percent of coronavirus patients ultimately requiring assistance to breathe and too few available to meet such high demand.²⁵

Conclusion. Since 2014, the CDC has continued to dedicate time, energy, and funding toward issues that, while perhaps important, fall outside of its reason for existence. As a result, the CDC has devolved into an agency incapable of adequately addressing the serious threat posed by infectious disease, particularly novel diseases for which there is little information about risk, spread, and treatment. Lack of funding, the go-to excuse raised by CDC after repeated failures, will do little to improve the agency's capability in preparing for and responding to such incidents unless Congress forces the CDC to narrow its activities, redirects or eliminates funding for its non-infectious disease projects, and recommits its attention to the issue for which it was founded: infectious disease.

Notes

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² 1987 figure: www.gao.gov/assets/90/83314.pdf. \$8 billion in outlays data via President's 2021 budget, February 10, 2020, <https://www.whitehouse.gov/omb/budget>. <https://www.cato.org/blog/coronavirus-nih/cdc-funding>. Spencer Woody, "'Mission Creep' Leads to Costly Duplication and Ineffectiveness," National Taxpayers Union Foundation Blog, January 19, 2017, <https://www.ntu.org/foundation/detail/mission-creep-leads-to-costly-duplication-and-ineffectiveness>.

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⁴ Edwards, "Coronavirus and NIH/CDC Funding.

⁵ Centers for Disease Control and Prevention Fiscal Year 2019 Congressional Justification, FY 2019 Budget Detail Table, <https://www.cdc.gov/budget/documents/fy2019/fy-2019-detail-table.pdf>.

⁶ EconoStats, *Government Mission Creep: A Case Study of the Centers for Disease Control and Prevention*, December 2016, <https://www.yumpu.com/en/document/view/58041543/government-mission-creep>. The breakdown is as follows: National Heart, Lung, and Blood Institute, \$3 billion; National Cancer Institute, \$5.1 billion; National Institute of Neurological Disorders and Stroke, \$1.7 billion; National Institute on Alcohol Abuse and Alcoholism, \$460 million; and National Institute of Diabetes and Digestive Kidney Disease, \$2 billion. "HHS FY2016 Budget in Brief," U.S. Department of Health and Human Services, <https://www.hhs.gov/about/budget/budget-in-brief/nih/index.html>, updated February 2, 2015.

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