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What Health Experts Want Now That the COVID-19 Public Health Emergency Is Over

Most Americans have already been treating COVID-19 as a non-crisis for months, as cases have declined thanks to immunity from vaccines and infections and the virus has changed to become less virulent.

The federal government's pandemic response will now reflect that waning urgency. On May 11, the public-health emergency and national emergency surrounding COVID-19 will officially expire. That means that many emergency measures put in place—through additional funding, relaxed insurance coverage policies, and free testing and treatments—will end.

Even though we all may be ready to put the pandemic behind us, health experts hope we can maintain as many of the positive changes triggered by the health emergencies as possible.

What we lose when the COVID-19 emergencies end

The public-health and national emergencies mobilized an unprecedented amount of federal funding that had a direct impact on individual health. People enrolled in Medicaid received continued coverage regardless of their changing eligibility year to year during the pandemic, and hospitals were reimbursed at higher than normal rates for the intensive medical care that Medicare COVID-19 patients required. The government also provided free COVID-19 rapid tests—an important tool for controlling viral spread—and free antiviral treatments through its Test to Treat program, which helped reduce the time that people were contagious.

These efforts weren't perfect. Testing—especially the at-home kind—wasn't possible until the end of 2020, almost a year into the pandemic, and not everyone who needed it could access the Test to Treat program at pharmacies because of transportation and other issues. Still, such measures were essential for containing COVID-19, and working out challenges will be important to ensure they will be even more effective in future responses.

Beyond the individual-level services that the health emergencies made possible, community, state, and national programs kept the public informed with near real-time data about where cases were increasing—something that hadn't been done before, even with conditions like flu. That helped states to direct resources such as testing and treatments to those communities and alert people if their risk of getting infected was high. But most of these surveillance systems are also going away.

Lessons learned?

All of these are part of Public Health 101: sound practices that form the foundation for controlling a fast-spreading disease like COVID-19. And, for a brief moment, these fundamental strategies demonstrated their effectiveness, not just in theory, but in practice. "We lived through an historic moment, mobilized massive amounts of support, and put in place a massive amount of flexibilities and provisions to ensure that the public systems we rely on were as resilient as possible," says Jen Kates, director of global health & HIV policy at the nonprofit KFF. "We know they didn't work in all places, but we saw things that we normally don't have: coverage of more things, access to telehealth, and increased payments to hospitals. Now we're going back to the regular system."

Not every pandemic measure is necessary in non-emergency times, but public-health experts now see some of these changes as indispensable. One is a robust telehealth system covered by insurers so more people can access care if even if they can't physically see a health-care professional. (Telehealth services will continue to be reimbursed for Medicare beneficiaries through December 2024, thanks to legislation that extended the coverage period.) Another is maintaining a strong research community working on next-generation vaccines and treatments that could be more effective and more quickly distributed when—not if—another pandemic strikes.

"If things were to get significantly worse again"—whether with COVID-19 or another infectious disease—"all the flexibilities that had been in place during the public-health emergency will not be in place," Kates says. "And that could present challenges."

Hopefully, the U.S.'s response to the next outbreak will be more streamlined, given the experience the country now has. The public is now more educated about how their behaviors can control the spread of a virus, through high-quality masking, regular testing, and isolation when symptomatic. And legislators have seen firsthand how funding for vaccines and treatments can pay off. The job ahead is to ingrain those expectations and behaviors into the nation's health care system by directing funding toward continued innovation in treatments; tracking potential new health threats through systems like monitoring wastewater; and building a response network of people, innovation, and supplies nimble enough to detect new infectious threats and respond to them quickly.

The end of the health emergencies will return the U.S. to its pre-pandemic, public health status quo, with state and local health departments struggling to provide services from basic preventive care to protection against new infectious diseases. COVID-19 has taught us that that's no longer good enough. "New health threats are on the horizon. The time to invest resources in preparedness is now, not when the next pathogen starts to spread," said Dr. Carlos del Rio, president of the Infectious Diseases Society of America and executive associate dean at Emory University School of Medicine & Grady Health System, in a statement. "A well-funded infrastructure for public health, research, and health care, and a workforce trained in infectious diseases and biopreparedness, is needed to protect the American people."

Making permanent as many of the temporary measures enabled by the public-health emergency as possible is one road toward such preparedness, and one way to ensure that the sacrifices made during COVID-19—in lost lives and lost opportunities—weren't in vain. *Story by Alice Park • MSN/TIME*