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COVID-19: We've Been Here Before—How Past Disasters Have Shaped Policy

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We are living through an exceptional time in human history. Already, the COVID-19 virus has spread across the world, infecting more than a one million people, changing public life entirely in the span of a few weeks and shuttering many economies. Our nation's response to the virus includes a fresh look at how we conduct public health and emergency preparedness. Past disasters illustrate the potentially lasting effects of this new openness to policy changes, reinforcing the necessity of getting our COVID-19 policy response right. In this blog post, we'll dive into three prior disasters and highlight how they influenced our society in lasting ways.

The 1918 Flu Pandemic

Since the outbreak of COVID-19 and the resulting stay-at-home and shelter-in-place orders, many have drawn similarities between this current viral outbreak and the 1918 flu pandemic. When the deadly strain of flu virus hit the U.S. in the Spring of 1918, eugenics continued to influence public health policies and the general way of thinking. It was commonly believed that natural degeneracy and a chosen lack of morality and cleanliness led poor and working people to develop "dirty" diseases such as cholera and typhus. Remember, this was the same time that papers ran stories vilifying Mary Mallon, a working-class Irish immigrant and an asymptomatic carrier of typhus who infected many people throughout the early 1900s. Many public health measures consisted of practices designed to contain the spread of disease, often resulting in containing it to the poor and sparing the elites. However, the lack of understanding of flu transmission meant that it killed rich and poor alike, totaling between 50 and 100 million people globally. While certain cities implemented quarantine measures, they were often spottily applied across the country. That, coupled with the fact that the flu was not yet a reportable disease, helped the virus spread and made preventive measures nearly impossible.

The 1918 tragedy illustrated the necessity of data collection in combatting disease and increased the importance of epidemiology. Though epidemiology was used before the outbreak—exemplified by a private family hiring George Soper to root out Mary Mallon—there was no national disease tracking or reporting system. Not until 1925 were all states participating in such a system, created in response to the failure to contain and track the 1918 flu pandemic. Periodic standardized health surveys began first in Hagerstown, Maryland, in 1921, and the rest of the country followed, with U.S. residents receiving the first national health survey in 1935. Moreover, countries throughout the world began to realize the importance of maintaining public health by providing healthcare to their citizens. Russia created the People's Healthcare Commissariat in 1918, the world's first governing body overseeing all public health in the country. A year later, the United Kingdom established the Ministry of Health. While other countries had moved forward and continued to progress towards national insurance—such as the UK National Insurance Act of 1911 that was expanded through the 1920s—the U.S. continued to gravitate towards employer-sponsored health plans.

The 9/11 Terror Attacks

More recently, most of us experienced first-hand the aftermath following the September 11 attacks in 2001. Policymakers responded rapidly to the 9/11 attacks in a variety of ways, impacting the way Americans live even today—almost 20 years later. A quick health policy decision early in the 9/11 response was the Disaster Relief Medicaid Program, created by New York City, state governments, and the Bush Administration, which temporarily expanded Medicaid coverage to four months for all low-income people within the disaster area and created a new, easier one-page application. When the program closed enrollment in January of 2002, nearly 350,000 had gained Medicaid coverage, bolstering the health coverage safety network to vulnerable New Yorkers.

The 9/11 attacks also impacted policy within the Strategic National Stockpile (SNS), managed by the U.S. Department of Health and Human Services' Assistant Secretary for Preparedness and Response. When responding to 9/11, the SNS deployed its newly-created 12-hour Push Package, a response that delivers a broad array of supplies to meet any disaster needs, delivered to any location within 12 hours of the decision to deploy. The development and deployment of Push Packages continues to be a part of the SNS response, though perhaps less important than in previous disasters.

Of course, 9/11 brought broader policy changes to American privacy and security, most notably via the USA Patriot Act, combining the U.S. Customs Services and Immigration and Naturalization Services into the U.S. Immigration and Customs Enforcement (ICE), and creating the Transportation Security Administration (TSA). The USA Patriot Act was passed a quick 45 days after the 9/11 attacks and drastically expanded national security surveillance, with repercussions lasting until today. In 2015, Congress passed the USA Freedom Act, which curtailed certain provisions of the Patriot Act in response to concerns of bulk collection of private information. The consolidation of two agencies into what is now known as ICE has also had lasting impacts on our society—annual deportations increased from roughly 200,000 between 1999 and 2001 to nearly 400,000 between 2009 and 2010. Finally, most Americans are well-acquainted with how air travel has changed in the post-9/11 world—long lines at TSA checkpoints, removal of shoes and limited amounts of liquids brought on board are enduring policies implemented after 9/11.

Hurricane Katrina

The policy response to Hurricane Katrina has also garnered much attention, specifically the Bush Administration's rejection of a temporary Medicaid expansion, as well as the new powers and guidance given to the Federal Emergency Management Administration (FEMA). The states hardest hit by Hurricane Katrina had some of the highest rates of uninsured individuals—with even more becoming uninsured after businesses closed. Unlike 9/11, the Bush Administration rejected Congress' bipartisan legislation that would have suspended Medicaid eligibility requirements and offered additional months of coverage to those affected. However, HHS did release a new model Medicaid waiver that allowed states to provide up to five months of Medicaid and CHIP to certain individuals and their families, with 15 states eventually using these "Katrina waivers." However, because they retained previous categories of eligibility, many individuals remained ineligible.

Katrina also led to the Post-Katrina Emergency Management Reform Act, which gave FEMA clear guidance on its mission, priorities and authority. This act also created: a National Disaster Recovery Framework, Incident Management Assistance teams to provide full-time rapid response, Regional Emergency Communications Coordination Working Groups, National Business Emergency Operations Center, and the Office of Disability Integration and Coordination to provide assistance and guidance for equal access to emergency programs and services. In addition, Katrina represented the first time the SNS was used to deal with a natural disaster, deploying a 12-hour Push Package, as with 9/11. However, following Katrina also marked the first time that rapid purchasing was needed for supplies that were not a part of the SNS. This once-novel action of rapid purchasing is now a commonplace SNS response to disasters and stands to remain so for some time.

Disasters create new policy openness and can temporarily close political divides, but the resulting policy actions can have lasting impacts. The bandwidth of policymakers and advocates is already stretched thin during emergencies, yet we must remain vigilant to ensure that this new policy openness results in evidence-based policies that are fair, equitable and advance the health of our nation. The COVID crisis has signaled a critical need to address issues of equity, preparedness, medical supply chain and stronger linkages between public health and quality health coverage for all. Let's not waste the moment.

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