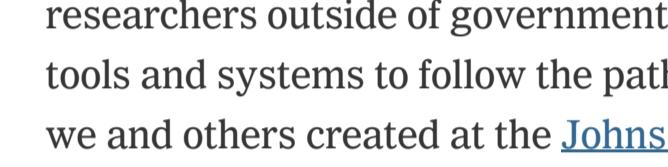
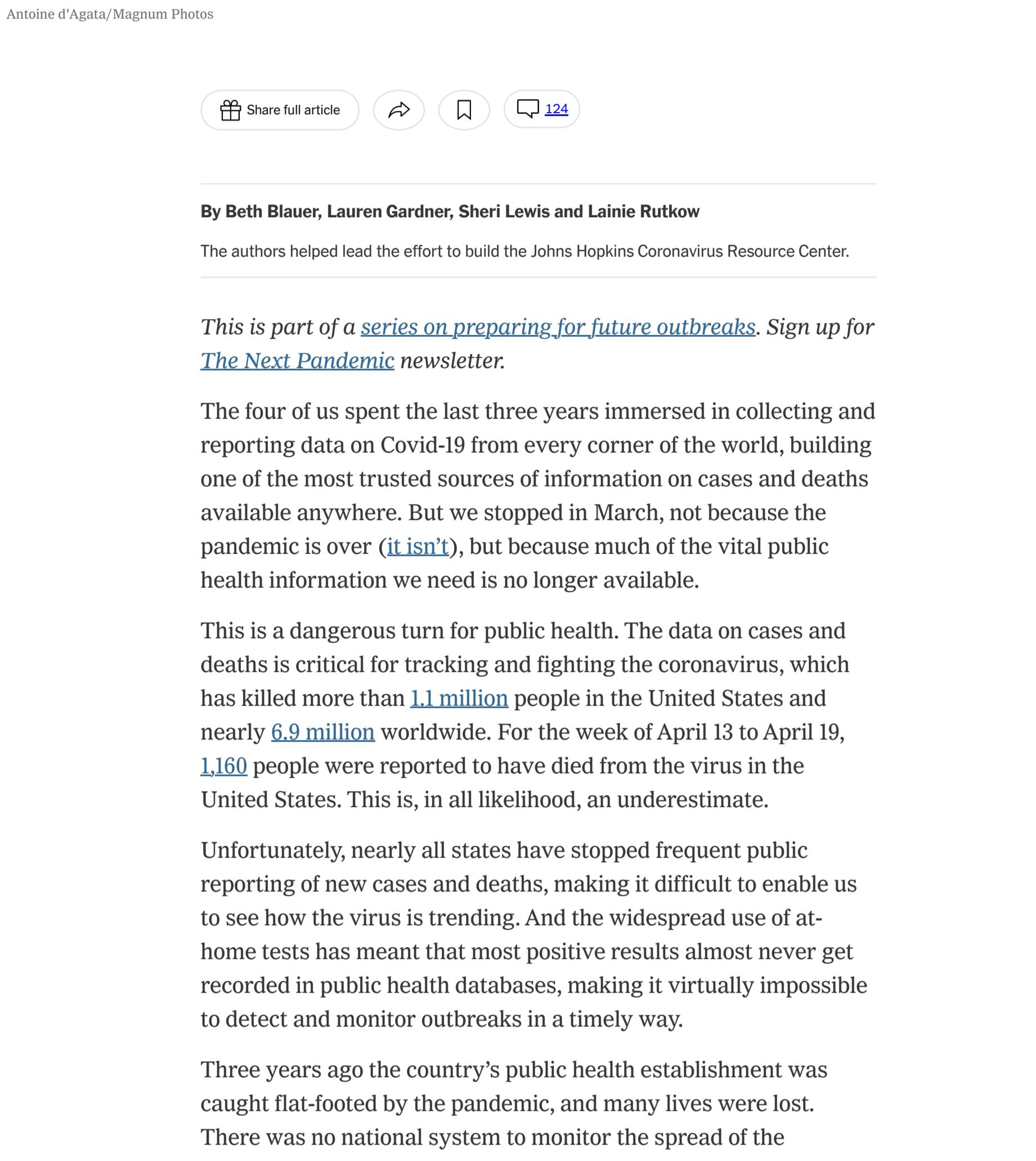


A white glove lies on a dark, textured surface, possibly asphalt or concrete. The glove is positioned with the fingers slightly spread. The background is a dark, textured wall.

A 3x6 grid of 18 images showing various gloves (white, blue, black) on a dark, textured surface. The images are arranged in three rows and six columns. Each image shows a single glove, either white, blue, or black, placed on a dark, textured surface. The gloves are shown from different angles and perspectives, including top-down views and side-on views.

A small, white, fossilized skull specimen, likely a rodent or insectivore, viewed from above. It has a rounded braincase, a prominent nasal opening, and short, thick upper teeth.



In the early days of the pandemic, state and local governments made the right decision to share Covid data publicly through reports to the C.D.C. These local reports

through reports to the C.D.C. These local reports, published daily on online dashboards that detailed cases, hospitalizations and deaths, became the primary sources for our reporting at Johns Hopkins.

publish nearly real-time information as the pandemic spread. But almost as soon as local and state governments amassed the capacities to keep the public informed, we began to see across-the-board declines in the quality and availability of the information they were sharing. Understaffed local health departments had difficulty sustaining testing and data collection efforts; in the second year of the pandemic, many began to focus on the distribution of vaccines. Politicized rhetoric about vaccines also drove decisions in some parts of the country to end data reporting. As of this spring, only seven states continued to publish data on cases and deaths more than once a week.

The seven-day averages of cases and deaths still reported weekly by the C.D.C. is valuable but of limited use for spotting and reacting to trends. As testing data has declined and the public health emergency is about to end, hospitalization data collected and reported by the U.S. Department of Health and Human Services is the best information available, but it is insufficient to fully track and understand the pandemic because hospitalizations lag several weeks beyond infections.

levels should be continuing to build the virus-tracking capacity that was hastily created as the Covid crisis grew. There is still much more to do to fix the hodgepodge of antiquated, disconnected surveillance data systems that exist across governments. This is important not only for the next pandemic — and there will be one — but also to help the public health community understand and address other threats that kill people every day: infectious diseases, drug addiction, gun violence, obesity and poverty.

network of comprehensive public health data that helps local authorities stay ahead of the next virus and deploy resources to the most at-risk areas. Uniform data standards combined with prompt collection and analysis of that data and timely reporting of the information enables public health officials to focus on flare-ups and reduce the need for sweeping, polarizing and economically damaging mandates, like closing schools and businesses.

Diversify skills and collaborate. The United States needs to invest in developing a new generation of public health professionals steeped in three areas: systems thinking to plan across multiple disciplines, data management to improve information flow, and effective communication to counter misinformation. As we worked to track the virus and response, we collaborated daily with a broad range of experts including data scientists, engineers,

epidemiologists, experts in law and policy, communications strategists and more. All these skills are needed to produce accurate information that creates public trust. To accomplish this governments, universities and professional societies must collaborate to create the demand, develop the talent, continue to innovate and hold one another accountable.

Without a plan to collect data from at-home testing, we haven't been able to count the results. The federal government also never invested enough in building genomic sequencing capacity to determine the genetic makeup of the virus and keep pace with the emergence of new mutations. This left a huge gap in our understanding of changing conditions. And in many instances, already strained health care providers were further stressed during the pandemic by the time-consuming frustrations of relaying data using archaic technology.

Let's learn the lessons of the pandemic. Decades of chronic underfunding of public health agencies must be reversed. Outdated disease surveillance systems, data sharing networks and laboratories must be modernized, and that requires significant investment.

To help, Congress must continue to finance the C.D.C.'s multiyear billion-dollar-plus [Data Modernization Initiative](#) to create a public health data and surveillance system that can move at least as fast as the disease it's tracking and bring together all levels of government.

We can't afford to neglect our public health systems any longer. Panic is not the way we should respond to our next health crisis.

We should be ready to take on what comes.

Beth Blauer, Lauren Gardner, Sheri Lewis and Lainie Rutkow helped lead the effort to build the Johns Hopkins Coronavirus Resource Center.

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