The 13th COVID-19 wave and the further dismantling of US public health

Benjamin Mateus
13 September 2026

The United States has entered what the Pandemic Mitigation Collaborative (PMC), an independent modeling group led by Michael Hoerger of Tulane University, numbers as the 13th wave of the pandemic. The surge is being reported, where it is reported at all, as a routine item in a seasonal respiratory forecast alongside influenza and RSV. A disease that has killed more than 1.2 million Americans, and by excess mortality estimates upwards of 20 million people worldwide while disabling tens of millions more, is now described in the tones of a traffic and weather report.

The PMC estimates for September 7 put roughly one in 86 Americans, or 1.2 percent, actively infectious, with about 567,000 new infections a day and 3.69 million over the past week. A single week at this level produces between 900 and 1,600 excess deaths. The figures rest on wastewater surveillance, the last national measure of transmission still in effect which detects virus material shed into municipal sewage.

Transmission ran below the six-year median through spring and early summer before turning sharply upward in early August, leaving the population entering September with less recent infection-derived immunity than in comparable years. Outbreaks are underway in at least 33 states and territories, concentrated across the South, Southwest and Pacific Coast, with Texas the highest at one in 15 people actively infectious. The PMC counts only counties with observed data, citing South Carolina and Oklahoma as states where inadequate monitoring fails to register outbreaks.

Schools are opening into this rise under Centers for Disease Control and Prevention (CDC) guidance issued in March 2024 which directs infected people back to classrooms and workplaces once fever-free for 24 hours. There is no federal testing program in schools, no masking guidance and no ventilation requirement, and children bring the virus home into the crowded multigenerational households in which many working-class families live.

Each week of transmission at the present level produces between 185,000 and 740,000 new cases of Long COVID, by PMC's estimate. A feature in the September-October issue of the *Smithsonian* magazine reports that roughly 21 million American adults, more than 8 percent, have experienced Long COVID, with more than a million kept out of the workforce. Amy Proal of the PolyBio Research Foundation estimates the severe, disabling form affects about 2 percent of those infected. The Patient-Led Research Collaborative has catalogued more than 200 symptoms, led by post-exertional malaise, a collapse in function following exertion.

Michael Peluso and colleagues at the University of California, San Francisco found viral genetic material in patient tissue months and years after infection, with reservoirs in the gut and bone marrow, having expected to find none. About 90 drug trials are underway or completed worldwide, every one testing a drug developed for another condition. Nearly seven years on, the Food and Drug Administration (FDA) has approved no treatment for Long COVID, because drug companies will not fund development of remedies for a condition with no approved diagnostic and no reimbursement pathway.

A vaccine that works and who received it

On August 27, the FDA approved four updated COVID-19 vaccines targeting the XFG variant: Pfizer-BioNTech's Comirnaty, Moderna's Spikevax and mNexspike, and Novavax and Sanofi's Nuvaxovid. Each is approved for adults 65 and older, and for younger people only with a qualifying underlying condition. Blanket approval for the general adult population no longer exists. CDC surveillance places SW.2 as the most prevalent lineage at roughly 21 percent of sequenced cases, closely related to XFG, implying the current vaccines should offer adequate coverage despite the changing dominant strains of SARS-CoV-2.

A study by Ruth Link-Gelles and colleagues at the CDC's National Center for Immunization and Respiratory Diseases, published in *JAMA Network Open* on June 23, examined 85,725 emergency and urgent care visits and 26,073 hospitalizations across seven states. Adults without immune compromise who received the 2025-2026 vaccine were about 50 percent less likely to need emergency care and 55 percent less likely to be hospitalized.

Nonetheless, coverage remains low, and the cause is access rather than refusal. CDC survey data show 17.5 percent of adults had received the dose by February 22, down from 21 percent the season before. Child coverage stood at 9.7 percent, and vaccination among pregnant women at 11.1 percent. In the same season 43.9 percent of adults took an influenza vaccine against 16.1 percent for COVID-19, which rules out a general turn against vaccination. A cohort study found 39 percent of adults who said

they were willing to be vaccinated had still not received it by March, with non-vaccination tracking food insecurity, difficulty reaching health care and never having been offered the vaccine by a physician. While flu vaccines are oftentimes readily made available even at work, COVID-19 vaccines require individuals to seek them through their doctors or pharmacies.

That effectiveness study of the COVID-19 vaccines was to have appeared five months earlier in the government's own journal, in the March 19 issue of the CDC's *Morbidity and Mortality Weekly Report*, having passed agency scientific review and editorial approval. Jay Bhattacharya, director of the NIH and then also acting director of the CDC, pulled it, objecting to its test-negative design, an established method comparing vaccination rates among people testing positive against those testing negative. One week earlier the same journal had published an influenza vaccine study using that design. The manuscript was leaked and published by the newsletter *Inside Medicine* on April 27, reaching print in June in a journal the government does not control.

On August 14 the CDC changed the coding that translates numeric wastewater levels into the category labels the public sees, moving most levels one category downward, so that much of what had been High became Moderate. It gave no notice and no rationale, and applied the change retroactively, so that the archived record of every earlier wave now reads milder than it read at the time. In March the agency suppressed the measure of what the vaccine prevents. In August it altered the measure of how much virus is circulating.

On August 4 and 5, Robert Kadlec of the Department of Defense and NIH head Jay Bhattacharya signed a 10-year agreement transferring NIH funds to the Pentagon for the advanced development of medical countermeasures. Kadlec sought $1.9 billion, roughly a third of NIAID's (National Institute of Allergy and Infectious Diseases) budget; discussions now center on $700 million. Congress was not shown the deal. Representative Rosa DeLauro and Senator Patty Murray learned of it only after their staff pressed the agencies, and DeLauro says it would let the Pentagon strip funds from influenza, tuberculosis and HIV research to cover a shortfall caused by the war with Iran.

Militarizing the attack on vaccines

Senator Ron Johnson, a long-time opponent of COVID-19 vaccination, now chairs the Permanent Subcommittee on Investigations, whose first hearing of this Congress was titled "The Corruption of Science and Federal Health Agencies."

In an August 14 deposition reported by *Politico* and the *New York Times*, Army Lt. Col. Theresa Long testified that Secretary of War Pete Hegseth had detailed her as senior medical military adviser to Kennedy while she also reports to Hegseth. She is reviewing some 55,000 reports in the Vaccine Adverse Event Reporting System, an unverified database that accepts submissions from anyone and by design records events *following* vaccination rather than events *caused* by it, along with 2,544 death reports. Board-certified in aerospace medicine, Long has no specialized training in vaccines or viruses, according to the *Times*. She claimed personal knowledge of 28 vaccine-caused deaths and an 82 percent rate of pregnancy loss from vaccination, though studies of hundreds of thousands of women show no association with miscarriage, stillbirth or preterm birth.

Five months before the deposition, on March 9, the Department of War reported to Congress under Section 725 of the 2024 National Defense Authorization Act on 18 health conditions among active-duty service members from 2017 to 2024. The department indicated that infection rather than vaccination was harming its troops. In August Hegseth detailed an officer without expertise in vaccines to investigate the opposite proposition, using a database of unverified public submissions.

The vaccine works, and the government study proving it was suppressed. Transmission is rising, and the measurements were retroactively relabeled downward. Repeated infection is documented to cause lasting chronic disease, and the institute that would study it has deleted pandemic preparedness from its plan while transferring the work to the Pentagon.

These are not errors of judgment or failures of knowledge. They are the systematic defense of a policy that treats mass infection as cheaper than public health. Pathogens are an objective feature of modern social life and require a coordinated collective defense, which no economy subordinating human survival to private profit is willing to support any further.

Public health is a social right the working class must wrest from the ruling class. That requires rand-and-file committees of healthcare workers, educators, scientists and parents, independent of both capitalist parties, health research and provision placed under democratic working-class control, and the pharmaceutical monopolies must be taken out of private hands.