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Editorial Comment: Temporal Trends in Preparedness Capacity

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Editorial Comment: Temporal Trends in Preparedness Capacity

Abstract

In view of the critical role local health departments (LHDs) play among agencies responsible for responding to natural and man-made emergencies, Bevc et al. examined the LHDs' emergency preparedness and capacity. They compared LHDs in North Carolina with those across the country for preparedness along eight domains. Significant declines in emergency preparedness were noted from 2010 to 2012 for five out of eight domains, raising questions about our national priority concerning this important function of public health agencies. These findings have numerous implications, some of which are covered in this commentary.

Emergency preparedness and response capabilities of local health departments (LHDs) have been increasingly of critical significance in the years following the terrorist attacks of 2001. Subsequent disasters, such as the H1N1 influenza outbreak that was declared a “pandemic” by the World Health Organization in June 2009, highlight the importance of LHDs’ capacity to work closely with external partners to plan for, respond to, and recover from public health emergencies. In response to these threats, CDC’s Public Health Emergency Response (PHER) Grant for 2009 and 2010 led to short term increases in emergency preparedness funding for many LHDs. Even so, the 2010 Profile of LHDs study showed that PHER and ARRA funding collectively accounted for just three percent of overall revenue for LHDs. Reduced capacity is perhaps attributable to the impact of recession on broader public health budget reductions. Federal dollars are the most common source of preparedness funding for LHDs. About 59 percent of LHDs rely exclusively on federal funding to carry out their preparedness activities (Shah et al., 2011). In the words of philosopher, essayist, poet and novelist George Santayana (1863-1952), “those who do not remember the past are condemned to repeat it.” Unfortunately, the public health policy makers have historically shown a very short-term memory concerning needs for sustaining emergency response capacity, particularly when major disasters do not occur for a year or two. This decline in funds might also be indicative of a general disinvestment in PH. In addition to large scale disasters or pandemics, LHDs frequently respond to other events such as foodborne illness and infectious disease outbreaks; these events receive little attention. Were these other important events kept in view, the need for a robust preparedness and response program and a trained workforce would have been abundantly clear, and funding for such capacity may have been a top priority. In the absence of major disasters, policy makers perhaps just hope for the best. Stephen Kings’ quote in *Different Seasons* serves as a good reminder here: “there's no harm in hoping for the best as long as you're prepared for the worst.” The important findings from the study by Bevc and colleagues show that preparing for the worst is perhaps not a priority, as their findings reveal significant reduction in capacity of LHDs over the three years period beginning 2010. Bevc et al., examined eight domains of emergency preparedness that included “surveillance & investigation”, “plans & protocols” “workforce & volunteers”, “communication, information dissemination”, “the incident command domain”, “emergency events & exercises”, and “corrective action activities”. LHDs’ capacity was found to have declined in five out of these eight domains.

In addition to the repercussions of reduced LHD capacity highlighted by Bevc and colleagues, there are additional public health implications. The declined capacity must also be viewed within the context of increased extreme weather events (e.g., hurricanes, tornados, flooding, and heat waves) that have disproportionate adverse effects on the elderly, disabled and other subpopulations, including increased risks of adverse physical and mental consequences, suffering, illness and death (Adams et al., 2011). These subpopulations often experience restricted mobility, reduced sensory awareness, poor physical and mental health, coexistence of multiple chronic conditions, and disruption of routine treatment during emergencies (CDC, 2012; Tomio, Sato & Mizumura, 2010). Given this, studies on emergency preparedness should also examine the capacity and inclination of LHDs to take population-specific actions to understand and address the needs of vulnerable subpopulations such as disabled and elderly before and during disasters. LHDs represent a crucial component of the public health practice at the grass-roots level (Leep and Shah, 2012). What is not known well is what proportion of LHDs segment the jurisdiction population according to age,

race/ethnicity, or socio-economic status, and when LHDs conduct theoretically- and empirically-informed assessments of the needs and capacities of these groups and the organizations that serve them. It is also not well known if LHDs use these assessments to plan for specific strategies to address their needs. Given the recent developments in use of information and communication technologies (ICTs) in public health and dwindling budgets of LHDs, it is imperative to also investigate if and how LHDs plan for addressing the needs and limitations of at-risk sub-populations during disasters.

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