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SUPPLY AND DEMAND:
THE CASE FOR COMMUNITY MEDICAL RESILIENCY

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Surge Capacity—or Lack Thereof

Events such as 9/11, Hurricane Katrina, and pandemic flu have led emergency response professionals to recognize the urgent need to plan for catastrophic medical events. How could the medical system deal with a large number of casualties—due to a nuclear detonation, massive earthquake, biological disease (intentional or novel), etc.—when the majority of hospitals operate at peak capacity normally and overcrowding is common during the normal flu season? Not since the Spanish Influenza of 1918 has the U.S. been pressed to manage the ill or injured on a national scale. Patients were cared for in public venues (arenas and concert halls) and even tents because the requisite hospital beds were not available. Half of all Americans were infected and reportedly 675,000 died, approximately half between the ages of 20-40.[1] Yet despite the knowledge that we have less medical capacity now on a per capita basis, policy makers and emergency planners still fail to adequately address the most important aspect of emergency management: the ability to provide care to citizens during a catastrophe.

Given that the supply of medical services has limitations, which can be quickly overwhelmed during a natural or manmade catastrophic incident, it is apparent that we must fundamentally evaluate our ability to reduce the demand side of the equation during these rare, but certain to occur events. Adequately reducing the demand for medical services will require development of "community medical resiliency."

From Resiliency to Community Medical Resiliency

There are numerous definitions of "community resiliency." Generally speaking, these all include the idea that resiliency exists when a community has improved its ability to cope during a disaster and recover to a pre-disaster state. In order to begin the process of developing

[1] Taubenberger JK, Morens DM. 1918 influenza: the mother of all pandemics. Emerg Infect Dis [serial on the Internet]. 2006 Jan [*accessed 9/15/10*]. Available from http://www.cdc.gov/ncidod/EID/vol12no01/05-0979.htm

community medical resiliency it must first be recognized that it is a specific subset of this concept. It is about having the knowledge to not be a demand on the health care system. The medical care of citizens has been the exclusive domain of the health care community with no expectation by the general public that they can provide for themselves after an incident. This limited perspective has led to the unreasonable expectation that during large scale medical events citizens must seek medical care via their traditional avenues such as Emergency Medical Services (EMS) and emergency departments. There has been little or no effort to provide the citizens with the basic education, expertise, or knowledge which could sustain themselves, their families and neighbors for even a short period of time during an emerging crisis.

Reducing the demand side of the equation will require a shift beyond the conventional concepts of community preparedness. Individuals will need to be educated to develop personal responsibility for their own healthcare and those within their family. Incentivizing community organizations to support the cultural shifts will in fact be much more effective then having "government" do it. Utilizing community organizations that have social standing, respect within the community and hold social leadership roles should enable acceleration of the cultural shifts required to develop basic medical resiliency quickly. The development of these incentive systems should be targeted at non-governmental organizations, business interests and individuals, while designed based upon the uniqueness of every community.

Longer term solutions will include encouraging the institutionalization of basic first aide and basic rescue training in local educational curriculums. This can follow the example of both fire prevention/safety and environmental topics (recycling, global warming, etc.). For example, would it be inappropriate to make Citizen Emergency Response Teams (CERT) training a prerequisite to graduating from high school?

Responsibility and Investment

The recently released National Security Strategy states, "We will emphasize individual and community preparedness and resilience through frequent engagement that provides clear and reliable risk and emergency information to the public. A key part of this effort is providing practical steps that all Americans can take to protect themselves, their families, and their neighbors."[2] This messaging, although laudable, has not yet manifested in any concrete Administration actions. A shift in policy will be required if we are to see significant changes at a local level. Local community planners and responders have longed believed that the majority of Federal funding should be utilized to make plans, buy equipment and train responders. Although some programs have continued to grow, such as CERT, it has been done with comparatively little funding. Yet without the ability of local citizens to step-up and support the emergency response, a large scale incident is likely to lack the needed response within the relatively short time required to save lives. It should be the responsibility of the local

[2] National Security Strategy of the United States 2010, pg. 19

governments to find more effective ways of spending scarce dollars across ever evolving communities to improve resiliency beyond paying for day-to-day resources and paper plans. The Federal system should work to support these efforts, but it is incumbent on the local officials to be responsible for the community's preparedness.

Recommendations

In a large scale event such as a nuclear detonation or a large earthquake, there will be thousands or even hundreds of thousands of injuries. The initial response will be a flood of emergency medical providers from anywhere and everywhere within a days drive. Although this will seem like the only answer, it will still not adequately address the victims of a truly catastrophic event. If it is assumed that we can not supply enough resources quickly enough then we must reduce the demand. People will have to be capable of taking care not only of themselves, but of each other. Being able to reduce the demand of the citizen's medical needs during a catastrophic event will ultimately function as a force multiplier and possibly decrease the morbidity and mortality of the event by several orders of magnitude. The only way, in the near term, to reduce the demand on medical resources in the aftermath of a catastrophic event is to support strategies that enable the citizen to manage for themselves for several days.

- The National Security Council official responsible for "resiliency" should develop a national strategy for all aspects of a community's resiliency, with a focus on medical issues.
- DHS/FEMA should shift current State and local grant funding priorities to reflect the need to develop individual and family preparedness with an emphasis on medical preparedness.
- Emergency managers, first responders, city managers, and other relevant planners have to include the public in their catastrophic event planning. This means accepting they have a vital role to play in not only preparedness, but also in response to an incident. This will require shifting priorities away from paper plans to develop public engagement and education through direct engagement with businesses, religious organizations, and secular groups.

Only through a national campaign of resiliency development can we hope to reduce demand on the medical system following a catastrophic event.

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