When Thomas Eric Duncan was sickened with what turned out to be Ebola that he had contracted in Liberia, he did what most people with illnesses do—he sought out local medical care. That was a mistake—in Dallas anyway. It turned out that Texas Health Presbyterian Hospital was by its own admission unprepared to deal with a patient infected with a deadly virus from another continent. From the start the hospital fumbled things: releasing Duncan after he was admitted to the emergency room on Sept. 25 with a fever and other Ebola symptoms and failing to adopt adequate precautions for his caretakers, including two nurses who were infected with the disease. Duncan eventually died, but thankfully one of the nurses is now Ebola-free (and even got to hug President Obama at the White House on Friday).

When Dr. Craig Spencer exhibited a low-grade fever in New York City on Thursday, the response was very different. Spencer, a volunteer M.D. with Doctors Without Borders who had helped treat Ebola patients in Guinea, followed the right procedures. He notified authorities from his apartment...
that he was feeling ill and was quickly transferred by trained paramedics fully encased in protective suits to an isolation ward at Bellevue Hospital Center. Bellevue's isolation ward was constructed in the 1990s to manage tuberculosis patients and is one of eight hospitals in New York State that were declared “Ebola-ready” by Gov. Andrew Cuomo’s office.

The widely varying responses between New York and Dallas tell us a lot about the nation’s uneven preparedness for a deadly disease outbreak. So far, with Ebola, we seem to dodging the contagion bullet, but mainly because the virus is not easily transmitted. Yet what if this had been a more infectious kind of virus? What kind of a nationwide contagion might we be facing now, all because of a few missteps in Dallas, or if New York City hadn’t had proactive measures in place to deal with its first Ebola victim?

All this points up an important issue that is getting too little attention in the current crisis. The federal government has been taking a beating for its handling of Ebola’s arrival on U.S. shores, and on the whole, there has been much to gripe about. But all the media outrage over missteps by the Centers for Disease Control and Prevention and partisan sniping over travel bans—controversially, the governors of New York and New Jersey have both issued a 21-day quarantine for any travelers who had contact with Ebola patients in West Africa—is ignoring the elephant in the room: managing a major disease outbreak depends more on local capabilities then federal ones.

The alarms that should be ringing around the country should not be centered on Washington. Instead, they should be going off in the nation’s state capitals and city halls to which falls the task of mobilizing a response to infectious diseases and preventing their spread. New York state spends six times per capita more on public health than Texas, and the difference that kind of investment makes is now on prominent display. Reversing the longstanding neglect of public health infrastructure requires mobilizing a bottom-up effort involving every state and community as well as civil society. The federal government can support this, but cannot be a substitute for it.

For much of our history, Americans understood safeguarding public health to be an essential responsibility of government, like providing for the national defense. But unlike waging wars, public health has always been handled primarily at the local and state levels where it could directly engage with and draw support from the populace.

During World War II, one-quarter of the nation’s population were members of the Red Cross, most of whom received some basic first-aid training at the 4,000 chapters that operated around the country. In 1947, when there was an outbreak of smallpox in New York City, the city’s Health Department officials jumped into action. In a civic response that involved private physicians,
pharmacists and volunteer workers in factories, union halls and police precincts, more than 5 million New Yorkers were vaccinated for small pox in just two weeks.

It is nearly inconceivable that that kind of mobilization effort could be mustered today. And after the 1947 outbreak was brought under control, New York City’s health commissioner singled out the media for thanks “for giving so generously of their space and time to bring necessary information to the public.” What are the chances of that happening in 2014?

It is likely we will be able to plod our way through this outbreak of Ebola. Even though there is currently no vaccine, this virus can spread for now only through direct contact with bodily fluids or items recently contaminated by bodily fluids, as opposed to being airborne. Beyond the two nurses involved with his care, the dozens of people who had direct contact with Duncan—who died in an isolation ward at the Texas Health Presbyterian Hospital on Oct. 6th—have not developed symptoms. This should reassure New Yorkers who are now dealing with their first Ebola victim, and the wider public, that the danger of widespread contagion within the United States from Ebola is remote.

But we might not be so fortunate next time around—and with infectious diseases, dangerous outbreaks are only a question of time. Once jittery nerves have settled—likely after the midterm election when stoking fear for political gain has run its course—we need to take four steps that can strengthen our societal resilience in the face of deadly diseases.

First, we need to seize this moment to conduct aggressive training on managing infectious diseases. This should include not just health-care professionals, but the general public. Perhaps the donors and public relations firms who are now flooding our airwaves with polarizing and misleading political advertisements might instead devote a small portion of their resources and energies to putting together public service announcements for an understandably anxious and poorly informed public. We also need to tap the power of social-media tools. While authoritative messages communicated by responsible officials will always be important, so too are the community-level efforts of civil society. We need to do a better job of empowering people with the information and measures they can take to make themselves and others safe.

Second, we must bolster the budgets for public health at the state and local levels. Thanks to budget cuts, federal funding support for state and local hospital preparedness for emergency outbreaks has fallen by 42 percent since 2001, according to a 2013 report by the Trust for America’s Health and the Robert Wood Johnson Foundation. Many cities have not made up the shortfall. Last year, while New York spent $116.21 per capita, the median level of state funding
across the United States was a paltry $27.49 per person, down by 10 percent since 2009. Missouri, for example, cut its budget by 64 percent from its 2009 level, spending just $5.86 per Missourian in 2013—or roughly the cost of a coffee and pastry—for the public health infrastructure their citizens are dependent on when disease strikes.

Third, we must embrace and actively support efforts by the World Health Organization and non-profit organizations such as Doctors Without Borders, which play an indispensable role in combating disease outbreaks at their source.

In our globalized world, travel bans and national borders will never protect us from the danger of microbes. When new diseases emerge, they require early and aggressive public health actions overseas and local actions at home such as are on display in New York City. We must insist that our elected officials treat this outbreak as a real wake-up call. Starving public health budgets is a deadly gambit.

Stephen E. Flynn is a former advisor to the Department of Homeland Security who is professor of political science and director of the Center for Resilience Studies at Northeastern University.

Additional credits:

* Lead image by Getty.*