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Think Globally, Respond Locally: Smarter Health Coordination Models

Tom Cotter, MPH

Health Response Alliance

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#IAEM25

Case for Change

Core Problem

- Disasters are growing in frequency and scale in the U.S. and globally
- Public health capacity is declining, leaving gaps in preparedness and response
- Current health emergency systems remain largely government-only, with no standard way to integrate NGO or corporate partners

Impact

- Delayed restoration of essential health services during major disasters
- Critical gaps and overlaps in medical care and supply chains
- Underuse of private-sector logistics, innovation, and global NGO reach

Opportunity

- Create an integrated, cluster-style health response system
- Combine government authority with NGO agility and private-sector scale
- Deliver faster, more equitable, and more cost-efficient outcomes for both U.S. and international emergencies

Why Now?

01

Escalating Disaster Burden

- U.S. averages over 20 billion-dollar disasters per year (NOAA 2024)
- Global disasters affect >300 million people annually (UNDRR)
- Climate-driven health impacts rising on every continent

02

Public Health Systems Under Strain

- U.S. public health workforce down ~20% over the past decade
- Similar gaps documented in Europe, Asia, and Latin America
- Fragile health systems raise cross-border disease and supply chain risks

03

Expanding NGO and Corporate Capacity

- International NGOs and private firms contribute tens of billions of dollars annually to humanitarian health response
- Global supply chains can surge resources rapidly if integrated

04

Lessons from Recent Events

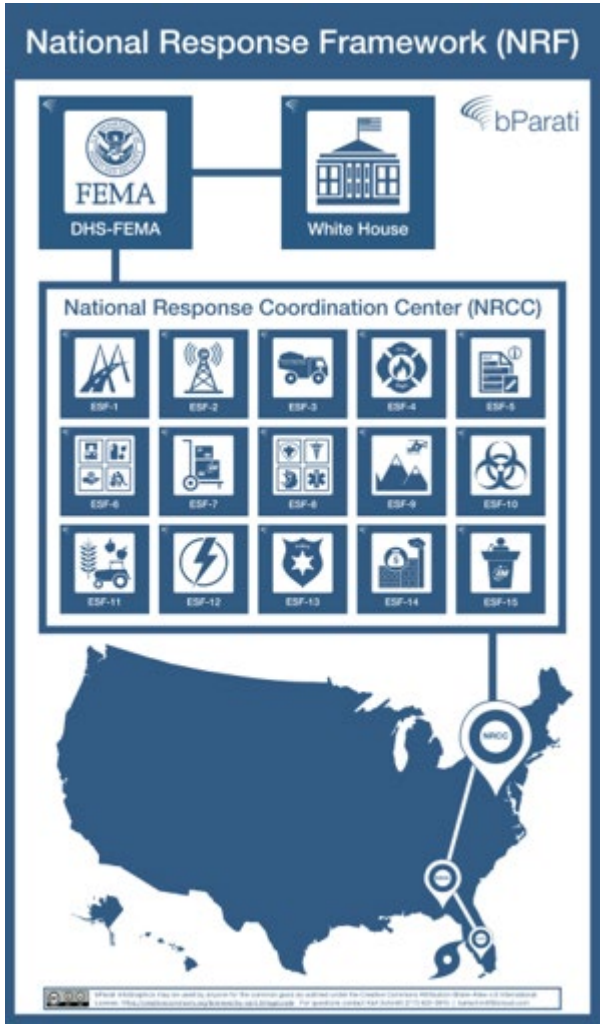
- COVID-19: fragmented public-private coordination delayed vaccine distribution worldwide
- Maui wildfires and U.S. hurricanes: heavy reliance on NGOs for medical care with limited early visibility of clinic status
- Cyclone Freddy and Türkiye–Syria earthquakes: demonstrated the value of cluster-style NGO and private-sector integration

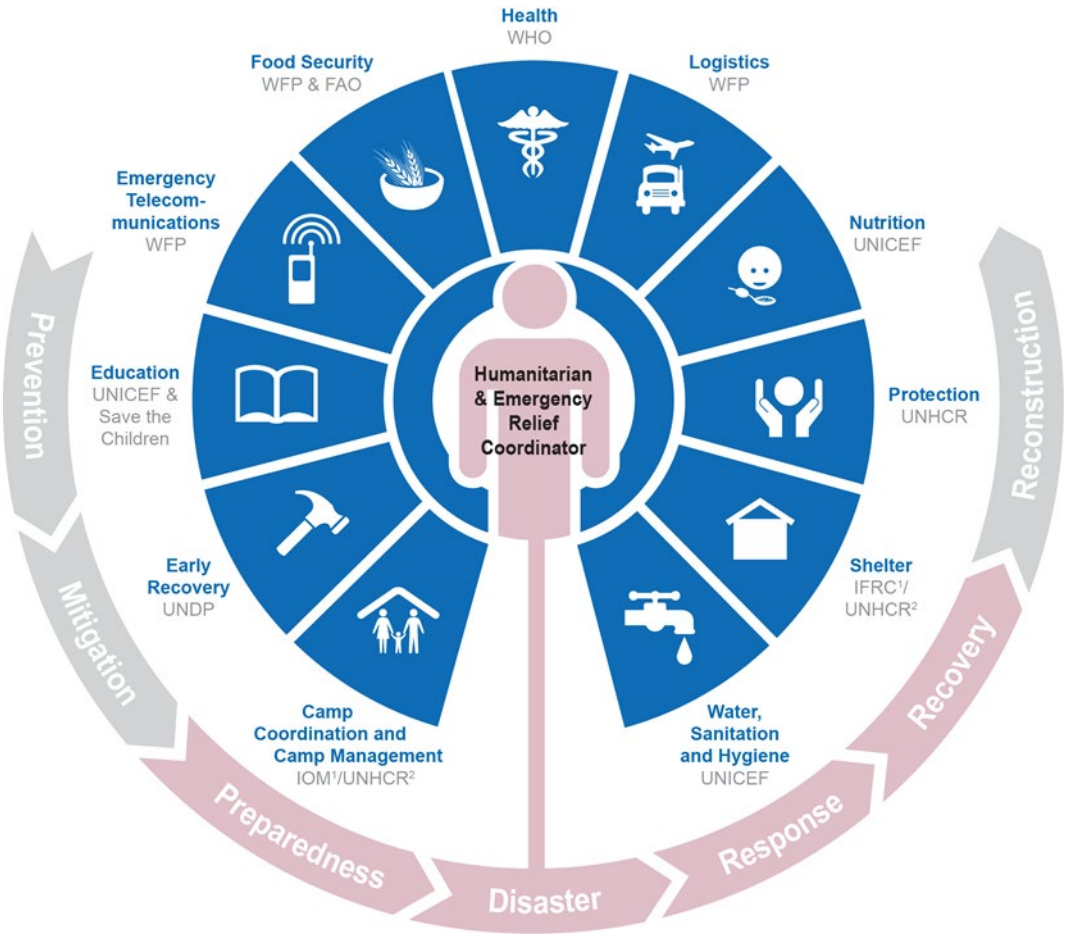
05

Opportunity for Transformation

- Heightened global awareness of climate-health risks
- Chance to build a model that strengthens both U.S. resilience and international cooperation before the next large-scale emergency

UN vs. US Emergency Coordination Systems





Structural Comparison

Feature	UN Cluster System	U.S. ESF/NIMS
Governance	Ministry of Health/national authority led with UN support, with structured NGO participation	Government-led (federal/state), hierarchical
Health Leadership	WHO leads Health Cluster globally; integrates epidemiology, clinical care, supply chain, and surveillance	ASPR leads ESF-8; relies on ad hoc state-federal coordination
Participation	NGOs and health agencies have defined roles in planning and technical groups	NGOs typically not involved in formal structure (except ARC)
Coordination Tools	Health Cluster meetings, 3/4W mapping	ICS/NIMS planning and incident command
Donor Interface	Built-in health humanitarian funding and pooled mechanisms	Limited donor integration

Gaps in Gov't Only Health Response

Other Emergency Support Functions integrate private sector well

- Energy: utilities, fuel suppliers, power companies embedded in planning and operations
- Transportation: airlines, railroads, freight carriers in joint logistics and evacuation planning
- Public Works: engineering firms and construction contractors pre-vetted and on standby
- Communications: telecom and technology providers in core coordination and restoration plans

Public Health and Medical Response

- No comparable standing mechanism for NGO or corporate partner integration
- Engagement often ad hoc, dependent on personal contacts or emergency declarations
- No standardized seat or national reporting platform for NGOs, private clinics, or pharmaceutical supply chains

Operational consequences

- Slower mobilization of NGO medical teams, private logistics, and supply chains
- Lack of unified 3W/4W/5W-style reporting to reveal gaps and overlaps in real time
- Missed opportunities to leverage private resources, data, and innovation at the scale seen in energy, transportation, or communications sectors

Partner-Integrated Health Response Globally

Global Reach of Cluster-Style Models

- ~29 countries and regions with active Health Clusters or Sectors coordinating government, NGOs, and private actors in emergencies
- Cluster approach used in over 60 countries for sectoral coordination (including health) in disasters beyond refugee settings

Examples of Integrated Systems

- Yemen, Uganda, Cameroon, Pakistan: Health Clusters or equivalent EOC structures routinely embed national and international NGOs, UN agencies, and private partners in emergency planning and response
- Similar partner integration documented across Asia, Africa, and Latin America

Contrast with U.S. Public Health and Medical Response

- No standing mechanism for NGO or corporate partner integration in centralized health emergency leadership
- Engagement of external partners mostly ad hoc
- No standard 3W/4W/5W-style reporting for non-governmental orgs

Key Takeaway

- Most disaster-prone regions worldwide standardize NGO and private-sector participation in health emergencies
- U.S. remains an outlier with a government-only model, limiting speed, coverage, and innovation during large-scale health crises

US Case Studies

- **COVID-19**
  - Private pharmacies and clinics critical to vaccine distribution and testing
  - Lack of unified reporting and coordination delayed equitable access and created duplication
  - GAO: >200 coordination-related recommendations still pending as of 2024
- **Major Wildfires (e.g., Maui 2023)**
  - NGOs and private clinics delivered >25 tons of medical supplies and 1,100+ mobile clinic visits
  - Coordination gaps: limited early data on open/closed health facilities, delayed integration of outside medical teams, vulnerable populations underserved

What's in it for Them?

Strategic and operational

- Influence through formal seats
- Unified reporting and shared situational awareness (4Ws)
- Shared logistics and pooled procurement
- Joint contingency planning and stockpiling

Financial and resource

- Access to pooled funding and rapid financing
- Ability to combine philanthropic, commercial, and NGO
- resources

Reputation and risk

- Donor and investor visibility
- ESG alignment and brand reputation
- Faster restoration of health infrastructure and workforce

Funding gap relevance

- Directing resources to highest-impact gaps during tight
- public budgets

Why Bother?

$100B

Peak Philanthropy

Corporate giving in peak years.

$5B

Annual Disaster Funding

Dedicated funds for disaster response.

$49.4B

2024 Global Need

Humanitarian requirement for the year.

50%

Current Funding Level

Portion of global need currently met.

Critical Supplies

Medicines, cold-chain, generators, transport fleets, temporary clinics.

Rapid Workforce Surge

Specialized personnel deployed within hours to days.

Local Reach

Ability to access and serve underserved populations.

External Partnerships: Return on Investment

Faster Service Restoration

- Integrated NGO and corporate partners can cut time to reopen primary care, pharmacies, and vaccine cold chain by 30–40% in U.S. and international pilots

Economic Efficiency

- Every dollar invested in preparedness and coordination saves an estimated 4–15 dollars in disaster response and recovery (World Bank, WHO)
- Reduces duplication of services and waste of supplies across borders

Improved Health Outcomes

- Lower mortality and morbidity through rapid deployment and coordinated WASH interventions
- Fewer secondary outbreaks (cholera, measles, respiratory illness) in refugee or evacuation settings

Equity and Accountability

- Reduces service gaps in rural, low-income, and migrant populations at home and abroad
- Global reporting enables transparent tracking for donors and governments

Private and Philanthropic Leverage

- Clear legal frameworks and roles unlock sustained investment and in-kind support from multinational corporations
- Enhances corporate ESG performance and builds trust for long-term partnerships

What this Looks like in Practice

- Health Clusters coordinate hundreds of NGOs and private partners using 3W/4W/5W reporting to map hospital functionality, synchronize vaccination campaigns, and integrate surveillance.

- Central, transparent data environments allow real-time gap analysis that is essential when government resources are limited and quick decisions are vital.

Preparedness in the Cluster System

Global Level

Policy, surge coordination, donor and corporate engagement.

Regional Level

Cross-border planning and regional business links.

National Level

Ministry alignment, NGO integration, and private supply chains.

Subnational and Local Levels

Coordination cells near affected populations and infrastructure.

Central to effective preparedness across all levels are these core elements:

Risk Analysis & Planning

Risk analysis, contingency plans, and simulations.

Pre-positioned Supplies

Medical and logistics supplies pre-positioned for rapid deployment.

Standardized Reporting & Training

Standardized 3W/4W/5W reporting and comprehensive training programs.

Cluster Approach Adaptation or Hybridization

Public Health Working Groups

Establish groups mirroring Health Cluster structures, providing NGOs and private-sector actors structured technical roles under ESF-8.

Standard Health Mapping

Implement a single shared reporting platform (3W/4W/5W) to collect data from all partners, identifying gaps and overlaps in health response.

Formal Technical Seats

Assign defined leadership roles for private-sector logistics, supply chains, and NGOs in areas like community or mental health.

Cross-Border Collaboration

Build international interoperability to effectively respond to disease outbreaks and medical supply-chain disruptions across borders.

Institutionalized Preparedness

Adopt year-round planning and joint exercises, modeled on best cluster practices and international incident response systems.

Focus on Scarce Resources

Prioritize transparent reporting and pooled funding mechanisms to compensate for reduced or delayed government allocations and maximize impact.

Roadmap to an Integrated Partnerships Model

Identify Partners

- Map NGOs and private-sector actors active in recent health or disaster responses
- Use recent incidents and state plans to find those supplying staff, logistics, or funding

Assess Needs & Capabilities

- Match priority health needs (surge care, cold-chain, WASH) to non-governmental and private capacities
- Use **3W/4W/5W reporting** (Who–What–Where–When–for Whom/Why) to spot gaps and overlaps

Develop & Train on 4W Reporting

- Co-design or adapt 4W forms
- Train all partners and run drills to ensure consistent, timely reporting and data verification

Address Legal & Regulatory Issues

- Clarify **licensure reciprocity**, **liability waivers**, and other emergency powers that affect volunteers, corporate teams, and donated goods
- Build these requirements into MOUs and activation plans

Formalize & Exercise

- Vet partners for reliability and capability
- Integrate them into contingency planning and joint simulations to test roles, reporting, and legal compliance

Activate & Update

- When disasters occur, deploy vetted partners and log all activities in the shared reporting platform
- Continuously refine partner data, agreements, and lessons learned

Thank you!

Tom Cotter, MPH
tcotter@healthresponsealliance.org

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