

eases. This alone would “prove” that the U.S. economy is failing, not succeeding as President Bush would have it. Whereas in 1980, the number of deaths per 100,000 persons was about 42, the rate today is over 52, even excluding deaths from HIV/AIDS, which are significant. These figures were quoted in a 400-page report on health trends, published in 2003 by the Institute of Medicine: *Microbial Threats to Health; Emergence, Detection and Response*. One chapter is titled, “A Case in Point: Influenza—We Are Unprepared.”

Therefore, the protection given to the population by the annual influenza inoculation program is vital. Of the total world’s flu shot supply of 290 million doses annually in recent years, the United States has used about 80 million. During this time, the annual rate of U.S. flu cases was 20-40 millions, or 10-20% of the population, with about 200,000 hospitalizations, and a death toll of 35,000-40,000 people.

For a variety of factors, the Centers for Disease Control (CDC) has even advised recently that it would be optimum for the United States to administer 185 million flu shots annually. One of these factors is that America’s hospitals now cannot cope with a peak flu season, as documented in the figures given below.

Thus, two sets of actions are imperative: The first is targeted inoculation and stand-by treatment infrastructure. Centralized action is urgent to implement the tightest possible re-call, and re-assignment of as many as possible of the 40-plus million flu doses coming from Aventis Pasteur, the other supplier company besides Chiron; and the 1-2 million FluMist supplies coming from MedImmune; along with what can be arranged from Canada and other sources. Assembling additional supplies requires international coop-

eration—including creating groundwork for a long-overdue collaboration in a worldwide effort to mitigate flu and other illnesses. At maximum, only some 20 million—perhaps far fewer—shots from Aventis Pasteur may be possible to redirect.

The categories of targeted recipients are clear, and guidelines exist from the CDC, including chronically ill, the elderly, healthcare workers, etc. Nationally, the institutions exist—CDC, Health and Human Services (HHS) Department, the 6,000-strong Public Health Service Corps—to collaborate to carry through plans, through a network including 3,000 county health departments, city agencies, thousands of public hospitals, private physician practices, etc., to make the best of a bad situation.

Similarly, facilities and staff must be lined up in readiness to treat what can be expected to be a heavy peak period of flu hospitalizations. The U.S. hospital base is so eroded that in recent years, it could not handle both flu patients, and the regular caseload of surgeries, auto accidents, and other cases. There were extreme trade-offs. Therefore, what’s needed is to make ready stand-by facilities, and staff. Re-open facilities such as hospitals wings currently empty; public hospitals recently closed, as in Washington, D.C.; alternate suitable buildings in the area, etc.

The institutions exist to carry this through if Federal policy leadership is given—including, the professional nurses and physicians associations, the American Hospital Association, the HHS, CDC, and related agencies, and all the state and local-level associations. The much-touted new Homeland Security government-liaison communications hardware and software can be activated to deal with preparations for coping with flu cases.

LaRouche: ‘We Need A Crash Program. . .’

On Oct. 6, following the previous day’s announcement by British-based Chiron Corporation that it had cancelled its intended supplies of 48 million flu shots to the United States for the 2004 season, Lyndon LaRouche gave a pre-scheduled international webcast in Washington, D.C. A group of medical students, participating from the University of Maryland Medical School in Baltimore, asked for his comment.

Q: Mr. LaRouche, going into yesterday, we were already very concerned about the impending flu epidemic, and there were questions as to how we could most efficiently vaccinate the population. Yesterday, a story broke indicating that

almost instantaneously, 50% of the supply of serum was wiped out, because of a manufacturing problem. It does seem to us that the other shoe suddenly dropped. Our question is, can this be considered a problem of healthcare, or is it a problem of infrastructure? Either way, what do you do about it, when the flu season is immediately upon us?

LaRouche: The question is two. First of all, what should you do? And secondly, how effective can you be?

What you should do, you’re going to have to do anyway. This constitutes the basis for defining an international health emergency. This means that we have to have a crash program approach to deal with this problem. This also means a restructuring of the implementation of our healthcare policy.

What are our problems? First of all, we don’t have hospitals. Why don’t we have them? Because we destroyed them. Take the D.C. General Hospital, for example. It was destroyed. The best resource for the defense of the citizens of this area against infectious disease and other problems, was

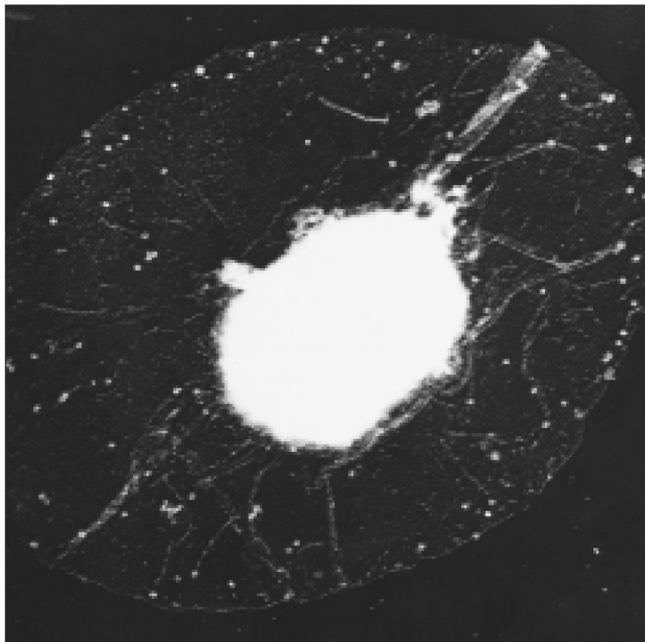
Restore a Hospital-Beds Adequacy Standard

The second broad policy action required is to reverse the HMO-era takedown of the U.S. hospital and public health system. The sudden influenza vaccine crisis clarifies the need to reverse the 1970s-onward shift away from the public health principle expressed in the 1946 landmark law, known as the Hill-Burton Act (named for Senators Lister Hill, D-Alabama; and Harold Burton, R-Ohio). That “Hospital Survey and Construction Act” mandated that Federal and local efforts would see to it that all Americans would have access to local hospital facilities on a standard, modern ratio of 4-5.5 beds per thousand people, everywhere—town and country alike.

From the 1940s through 1970, the same “Hill-Burton” principle prevailed for needed vaccinations, as well as diagnostic and other facilities. Public health programs and applied R&D all but eliminated polio and tuberculosis. Pertussis (whooping cough) declined from a peak of 156,000 cases in 1947 to 14,800 in 1960; diphtheria declined from 18,700 cases in 1945, to 900 in 1960. The use of the insecticide DDT, begun in the 1940s, was on the way to eliminating malaria and other mosquito-borne disease.

Then came the shift. On Dec. 29, 1973, President Richard Nixon signed into law the bi-partisan Health Maintenance Organization and Resources Development Act, which ushered in the era of deregulation of healthcare delivery, to the point where over 2,000 hospitals have shut down since. Likewise, core public health functions have been drastically reduced. For example, in the Gulf Coast/Delta state of Louisiana, many parishes have no mosquito abatement program at all, in the face of dengue fever, West Nile virus, and malaria.

The propaganda pushed onto the public and lawmakers was that “competition” by HMOs, and privateer hospital chains



Red blood cell of a chicken with influenza virus (the white, woolly spots); chicken eggs have been used for decades to produce flu vaccines, making it a long and complicated process, which may be shortened if new production technologies can be mobilized.

such as Columbia/HCA, would be good for you, by bringing prices down, etc. Among many other deliberate lies, was the promotion of the idea that vaccines themselves are harmful.

Behind this shift—including funding anti-science hokum about vaccines—stands the network of private financial interests, best called synarchist, controlling all kinds of services and commodities, including energy, food, minerals, insurance,

destroyed—in a swindle, a financial swindle. A rip-off, which my “friends” at the Washington Post had something to do with. And if somebody dies in your family, you should get them to pay for it. Because that’s what happened.

We have gone away from a policy of having reserves. We used to have all kinds of reserves, medical reserves. It was something which we insisted upon, from the experience of World War II, for example. We learned a lot of lessons from World War II about this kind of problem.

We destroyed it! So, therefore, we have to say, “First of all, this was a mistake. To put the human race at risk in this way, was a mistake! We have to adopt a policy of correcting that mistake, by reversing the policies which led to that mistake.”

Now, that means, on another level, you treat it like a military emergency. You have all the relevant institutions tasked to come up with an approach to this and, whatever it takes, do the job. Whatever it takes. I don’t know what the full

resources are; but obviously, it has to be treated as an emergency, and we can not accept, in order to balance the budget, etc., etc.: “We have a problem, it’s going to take more time.” It’s not acceptable. Whatever we have to do, is what is acceptable. And if we can’t do it, at least let’s kill ourselves, in a sense, trying to do what should be done. And let’s minimize the damage, if we can’t absolutely prevent it. But we have to be considerate. We have to take it on.

Look what we’ve destroyed, look what we’ve done! Look what we’ve done since 1973, since the HMO law was put in. We have destroyed essential parts of the medical defense system of the United States. And we’re killing people by that! What we’re doing with HMO policy; the way they regulate physicians. A physician can’t spend too much time talking to a patient. How else is a physician going to practice preventive healthcare, if he can’t talk to a patient in order to diagnose what the patient’s problems may be, as opposed to what a specific, authorized-category disease is?