LaRouche: Reverse the Policy That Created the Flu Crisis

by Linda Everett and Marcia Merry Baker

After half of U.S. flu vaccination stocks were suddenly cancelled in mid-October because of contamination at the source of supply in England, a chaotic scramble was on across the United States for scarce flu shots—not only for the elderly, the young, and the chronically ill, but for front-line civil defense staff such as nurses and doctors, hospital and healthcare workers, firefighters, police, emergency team-members, rescue squads, and the military. Between November, when the influenza season is likely to hit, and January, another scramble will be on—for scarce hospital beds, scarce medical staff, and all kinds of workers who become sick and scarce on the job. There will be thousands of avoidable deaths.

So much for homeland security, and the Bush-Cheney Administration's much-hyped "Bio-Defense" drills for bioterrorism, small pox, anthrax, plague, etc. The mob scenes at the few flu-shot distribution sites make the point: Today's situation is an each-against-all mess.

President Bush did a two-step on the flu, when asked about it at the Oct. 13 election debate. He called on healthy people to patriotically forego a shot: "I'm not having a flu shot this year." And he diverted attention from the fact that his Administration relied on only two suppliers for an intended 100 million doses, one of which companies "outsourced" 48 million doses to a production facility known to be risky, and then cancelled altogether. Bush issued his sound-bite proudly: "We won't allow contaminated medications into the country."

Senator Kerry properly shifted to the larger issue: "Our public health system is in trouble."

Lyndon LaRouche spelled out the physical economic dimensions of the trouble at his Oct. 6 webcast in Washington, D.C., just hours after the mass flu shot cancellation announcement, when he was questioned by Maryland medical students (see box, p. 6). LaRouche stressed treating the immediate situation as a medical emergency and getting the "relevant institutions tasked to come up with an approach to this, and whatever it takes, do the job." Overall, he called for reversing *the policies that created the flu crisis* in the first place.

The Oct. 6 announcement which triggered the panic, and its relevant particulars—even the Enronomics characterizing the global pharmaceutical cartel and Chiron, the California-based supplier company—are not right now the focus point for decision-making about what responsible government should do immediately.

The most urgent points for consideration are: first, how the current public health emergency should be dealt with; and secondly, how the *thinking and practices must be stopped* which, over the past four decades, took down America's excellent public health system, and made the United States vulnerable to all kinds of microbial and other health threats, from reliance on unreliable pharmaceutical cartel companies, to allowing the spread of West Nile virus.

We provide here some of the key parameters and principles concerning the build-up, and then the takedown, of the U.S. public health system. Animations of the processes involved—for example, of the provision, then removal, of desired ratios of community hospital facilities per population, can be seen at www.larouchepac.com.

Deal With the Crisis

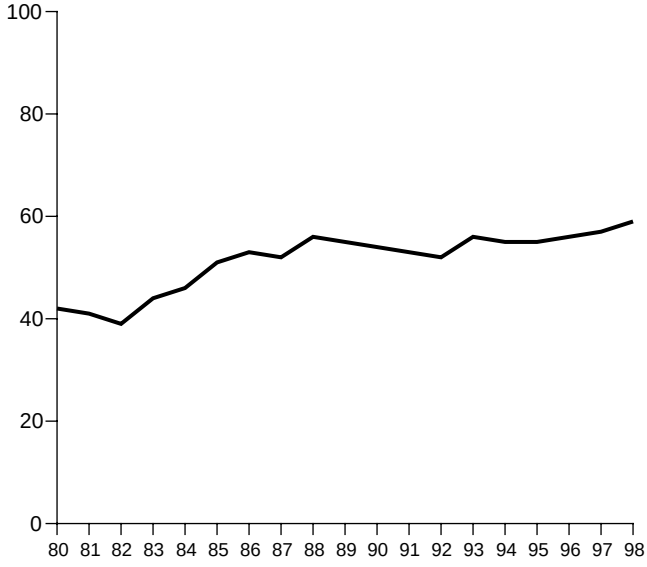
First, consider the context; then the specifics of what to do become clear. To begin with, the American population is not robust. Look at today's soaring rates of obesity, depression,

From two dozen flu vaccine manufacturers 30 years ago, one, French (!) supplier now stands between the United States and a killer flu epidemic. The nation is also short of DTAP vaccines (diptheria, tetanus and pertussis or whooping cough, being given to a National Guardsman here); and those for adenovirus now epidemic at military bases; as well as chicken pox, MMR, pneumococcal disease, and others.

FIGURE 1

U.S. Death Rate Rising From Infectious Disease (Excluding AIDS/HIV), 1980-98

(Crude Death Rate Per 100,000)



Source: In *Microbial Threats to Health; Emergence, Detection and Response* (Washington, D.C.: Institute of Medicine, March 2003), reprinted with permission from Pinner, R.W., Roy, K., Shoemake, H., "Mortality from Infectious Diseases in United States, 1993-1998" (unpublished manuscript, 2002).

and childhood asthma, besides the millions of cases of non-managed conditions such as diabetes, due to lack of insurance and access to medical care. These add to, and interact with, the expected disease rates connected with the population's age profile and associated disease likelihood. And due to lack of public transportation, the United States has a relatively high rate of impairment, besides mortality, from vehicular accidents.

Figure 1 shows a fundamental marker of ill health in the United States—the rising rate of death from infectious dis-

Chiron's Vaccine Plant: Blair's Sweetheart Deal?

An emerging scandal surrounds the Administration's approval for half of all the United States' 2004/2005 flu vaccine to come from a known risky plant in Britain. Particularly under scrutiny is the involvement of Lord Paul Rudd Drayson, top moneybags to Prime Minister Tony Blair and the Labour Party.

The record, from press and corporate accounts: In June 2003, a U.S. Food and Drug Administration (FDA) delegation visited the vaccine-making facility in Speke, Liverpool, for a sanitation inspection; the FDA then gave approval to California-based Chiron Corp. for a mega-order for the 2004/2005 U.S. flu season, to be produced at the Liverpool plant despite its record of contamination problems, and frequent changes of ownership in the past, with attendant under-investment in upkeep.

At the time of the FDA 2003 visit, Chiron did not even own the plant! The then-owner, Lord Drayson, is notorious for having made a windfall of £32 million from the Blair government granting PowderJect a mega-contract for smallpox vaccine supplies, soon after a secret meeting at Downing Street in December 2001. Blair's Health Minister Lord Hunt misled Parliament to think this was the only means to vaccine. (During this same period, 2001-2002, Vice President Dick Cheney's top staffer I. Lewis Libby, was nicknamed "Germ-Boy" at the White House, for insisting on universal smallpox inoculation.) In an earlier episode, Drayson was faulted by the National Audit Office for donating £50,000 to the Labour Party, during the time the Blair government was awarding a TB vaccine contract; it went to PowderJect. In late Spring 2004, Drayson gave a whopping £505,000 to the Labour Party.

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 *targetted 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 cooperation—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 targetted 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*

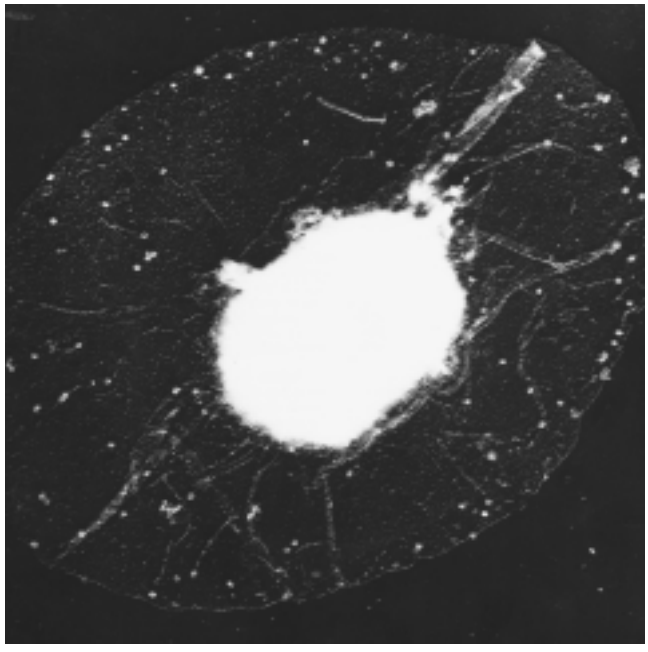
Restore a Hospital-Beds Adequacy Standard

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; diptheria 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 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.



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.

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?

etc., through cartels and companies such as Enron. In the realm of chemicals, pharmaceuticals, and seedstocks, consolidation of control over supplies has reached an extreme stage.

The *Wall Street Journal* spoke explicitly on behalf of the Synarchist cartels, in an Oct. 12 editorial, "Healthcare Showdown," claiming, "Healthcare is a scarce good like any other and can't escape the laws of economics. As such it will be 'rationed' one way or another. The only question is whether that is done through prices and individual choice, or through the brute political force of government."

It is time to defeat any form of this thinking and control. What is required is a shift back to the traditional American System form of general-welfare healthcare policy, restoring a delivery system of adequate ratios of hospitals, drug supplies, staff, public health services, etc. based on both private and non-profit collaboration, as worked for decades before the neo-conservative, free-trade disaster.

In particular, measures to ensure adequate supplies of flu vaccine—and other needed public health vaccines of all kinds—in the near-future, include the once-traditional *regulatory* government procedures: commissioning a number of suppliers; becoming either the upfront bulk-purchaser for redistribution through private and public channels, or buyer-of-last resort of unused quantities; granting tax benefits for producers and researchers of priority vaccines; partnering with private operations for research and production, etc.

Cartels Threaten Public Health

On Oct. 5, Chiron Corp., the Emeryville, California-based supplier of nearly half (48 million doses) of the United States' anticipated influenza vaccine supply for this season (and for 2003), announced that its total shipment of vaccine was cancelled, its Liverpool, England plant de-licensed, because of contamination issues. The British Medicines and Healthcare Products Regulatory Agency suspended Chiron's license to sell vaccine for three months, and cancelled all of its vaccine while it investigated its facility for contamination.

In August, Chiron had told the U.S. Food and Drug Administration (FDA) that delivery of some shipments of its vaccine, Fluvirin, would be delayed because some lots were contaminated with *Serratia marcescens* bacterium, which can cause severe, even fatal infections in humans. When U.S. regulators inspected Chiron's manufacturing plant in Liverpool in 2003, they found evidence of contamination problems then.

Since the October announcement, followed quickly by emergency Congressional hearings on the crisis, charges have erupted that the FDA knew as early as September 2004 that *all* the 48 million doses were endangered. On Oct. 11, Lester M. Crawford of the FDA denied this. On Oct. 13, it was made known that a grand jury has been convened to investigate the circumstances and timing of the Chiron cancellation. Lost in the banter of "who knew what, when" crisscrossing the Atlantic, are two larger issues regarding vaccines.

First, it was knowable and manifest that the globalized, cartelized pharmaceutical industry is a menace to public health, Chiron's English facility in particular. Secondly, squadrons of Administration top health officials also knew that an influenza pandemic is "overdue"—they have stated so publicly—yet they accepted a reliance on a risky set-up of only two sources for this season's flu vaccine supplies.

Could Avian Flu Cause A New Pandemic?

Influenza originally from birds has killed 30 of the 42 people infected with it in Southeast Asia over the last year. This particular flu virus has been mainly transmitted from birds to humans; but recently, in Thailand, there is a probable case of human-to-human transmission, which has experts quite worried about a new flu pandemic.

The concern about a new pandemic is justified, based on several scientific considerations. First, this avian flu virus has shown a very high lethality in people who contract it, and this may be due to a very limited human immune system resistance to the virus. Second, there is no vaccine currently available that can protect the human population from this virus. And lastly, if the virus does acquire the ability to spread from person to person, effectively jumping the species barrier, it will be very difficult to contain.

1997 Epidemic Warning

Influenza viruses that infect people come from two groups, A and B, and are further categorized into subtypes based on the surface antigens *hemagglutinin* (H) and *neuraminidase* (N). The current avian flu now spreading in Asia is influenza A, subtype H5N1, which originally came from ducks and geese in China.

The 1997 Hong Kong outbreak of avian flu that killed six people was the first time this subtype H5N1 was found to be able to infect humans. The H5N1 flu virus is present in a large number of ducks and geese in southern China; most of these birds do not display any symptoms of illness, and the disease is not lethal. But when this same H5N1 virus was transmitted to chickens, the infection was found very often to be lethal.

The 1997 Hong Kong outbreak of avian flu was contained by a massive quarantine and slaughter of all poultry

Consider the simple fact that the CDC itself has recommended that 185 million vaccinations would be the optimum way to minimize flu in the U.S. population; but vaccine production is wholly at the discretion of private pharmaceutical companies. It was they who decided that only 100 million doses, based on "market demand," not the medical needs of the population, were to be produced.

Not only infectious disease experts, but even the government's own General Accountability Office (GAO), issued warnings in 2003 and 2004, that the potential exists for a world-wide virulent influenza outbreak imminently, perhaps *this year*—a pandemic that would far exceed our immunization, public health, and hospital infrastructure capability. But no action has been taken accordingly.

As of mid-October, about half of local health departments in the United States had no flu vaccine, according to a survey of 150 local health departments by the National Association of County and City Health Officials. County and city health departments and medical professionals in many states had ordered vaccine exclusively with Chiron. Those regions include the nation's capital—Virginia, Maryland, and the District of Columbia all depended on Chiron for vaccine.

This year's shortage is the fifth time in six years that the United States has experienced disruption in availability of flu vaccine. Yet, the Federal government has had no remedial plan, other than "market" rationing. The CDC issued a hastily revised set of guidelines for who should get vaccinated, and called for voluntary re-distribution of the Fluzone vaccine produced by Aventis Pasteur. This recourse to "voluntary" action by the top health officials, was defended on Oct. 11 in Congressional testimony and national broadcasts by Antony Fauci, Director for Infectious Diseases at the National Institutes of Health, using *Wall Street Journal* double-speak. Fauci said things may be a "bit random" around the country, in the "redistribution phenomena."

The CDC's original priority target population amounts to 100 million *in toto*, which of course, is not possible to immunize now. In mid-October, there were an estimated 22 million remaining Fluzone dosages at various stages of distribution around the country. Otherwise, some 1-2 million doses of the inhalable FluMist exist, but are appropriate for use only by healthy adults under 49 years of age, because a live-virus formulation is used.

The vast majority of Aventis' vaccine is in private hands—like supermarkets. That list is proprietary; Aventis won't disclose their names. CDC chief Dr. Julie Gerberding wants a "voluntary" redistribution of vaccine because a government action would be "too disruptive."

Gerberding said Oct. 12 that she was "sorry" for the situation, and called on healthy adults to forego vaccination. She termed them, "health heroes."

Administration Knew About Chiron

The oft-heard Wall Street term for the disappearance of flu vaccine suppliers and supplies, is "fragility in the vaccine industry"—the words of Dr. Fauci on Oct. 13 to paper over the Administration's responsibility. Fauci spoke of needing to "incentivize" drug companies to make vaccines. In reality, the government has a role to play to guarantee needed medications; but it has abdicated under deregulation, and some cartel companies have made out like bandits, while shortages have become the norm. Simply based on the record from press accounts, and Chiron's corporate reports, there are strong grounds to question the Administration's actions.

Chiron: Chiron Corporation, a global biotech company, was founded in 1981, is headquartered in Emeryville, California, and operates vaccine-producing facilities in Canada, Italy, Germany, and India as well as the U.S.A. and England.

In 2003, Chiron acquired the PowderJect Pharmaceuticals plant in Liverpool, U.K. for nearly $1 billion, despite that facility's record of contamination problems. Operations at this plant were intended by its new owners to produce enough of its Fluviron, for half of the U.S. flu vaccination supply for the 2004-05 influenza season. Before PowderJect had acquired the plant in September 2000, the plant had been owned by Celltech, which earlier that year had been ordered by British health authorities to withdraw an oral polio vaccine because of concerns about contamination *in that factory.* It was well known that the succession of owners had long under-invested in the Liverpool plant, according to A.G. Edwards analyst

in the province. The problem now facing Asia, is that the natural reservoir of the virus in the ducks and geese, has allowed the virus to mutate into an increasingly pathogenic form that can infect mammals.

In an experimental study published in May 2004, researchers in China isolated 21 different H5N1 virus types from apparently healthy ducks over the period 1999-2002, and then analyzed their ability to infect mice. What they found was that over this period, the H5N1 virus progressively gained the ability to more easily infect mice, and cause increasingly damaging and lethal disease in them.

How the virus is genetically reassorting itself to be able to infect mammals, or if it is picking up genes from another flu virus in another mammal, such as the pig, is not yet known. If this H5N1 virus does acquire the ability to infect humans, and spread from person to person, it could represent a threat equaled only by the 1918-19 flu pandemic known as the "Spanish Flu," that killed, not hundreds of thousands as in normal flu seasons, but 20 million people.

—Colin Lowry

TABLE 1

Dividends and Stock Buy-Backs as Percent of Research and Development

Company	Percent
Pfizer	210%
Merck	143
GlaxoSmithKline	122
Abbot Laboratories	107
Bristol-Myers Squibb	93.4
Johnson & Johnson	89.8
Eli Lilly	67.7
Wyeth	56.7
Schering-Plough	43.3

Sources: Banc of America Securities, *USA Today.*

Alexander Hittle. Nevertheless, during June 2003, U.S. FDA authorities visited Liverpool to inspect the site, shortly before Chiron completed its purchase of it, and subsequently extended the okay to Chiron for the mega-order for vaccine for 2004-05.

Chiron's governing board members are not neophytes. They have top-level interconnections with the most long-standing and largest bio-chemical cartel companies of the last two centuries, especially with Novartis AG, the mega-company formed from the merger a few years ago of Sandoz and Ciba-Geigy, Swiss companies active during the Hitler era. Chiron's Chief Financial Officer, Raymund Breu, is a Member of the Executive Committee of Novartis; Pierre E. Douaze, head of Novartis Healthcare, and Paul L. Herrling, head of Corporate Research, Novartis International AG, are also Chiron board members.

The other supplier of flu vaccine to the United States is Aventis Pasteur, headquartered in Lyon, France.

Forty years ago, there were dozens of U.S. vaccine makers. In the 1960s, childhood vaccines were produced by 26 different manufacturers. By 2002, there were only 12, and at that, they could not produce the needed doses to protect children against basic but dangerous childhood diseases (measles, mumps, rubella or MMR). Acute shortages have arisen, including for pertussis, invasive pneumococcal disease, Dtap (diptheria, tetanus, and pertussis or whooping cough), and chicken pox (varicella).

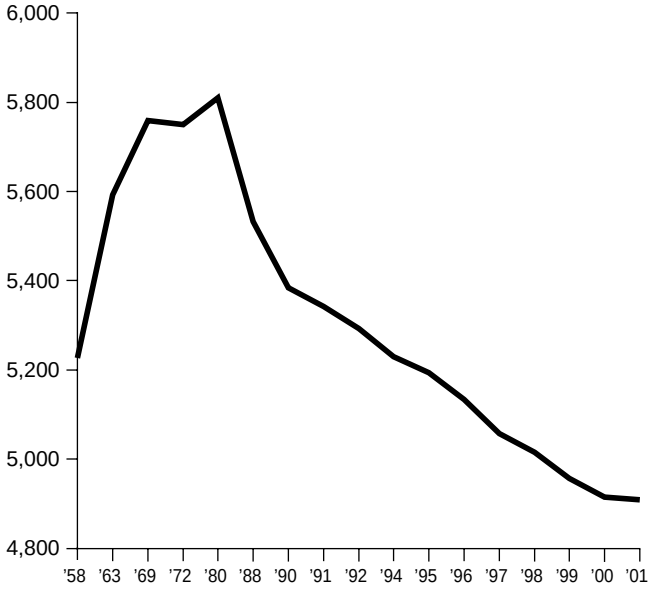
Moreover, hospitals' drug needs are frequently not met. The American Association of Health System Pharmacists (mostly hospital druggists), say shortages include everything from treatment for hemophilia, snakebites, emphysema, and hepatitis C virus, to certain surgical anesthetics, injectible antibiotics and steroids for premature infants.

The catch-all phrase cited as the cause is, "manufacturing problems." What this reflects overall, is that drug

FIGURE 2a

Number of Community Hospitals Declined Nationally During HMO Era

(Number of Hospitals)

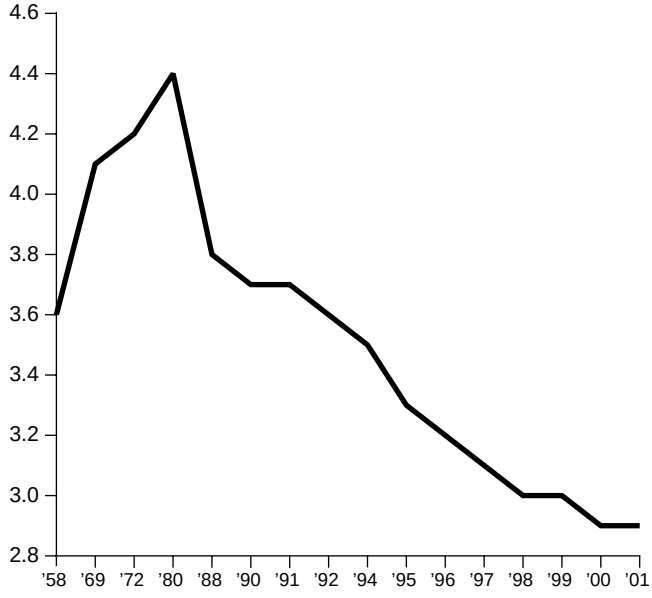


Source: U.S. Statistical Abstracts; *EIR.*

FIGURE 2b

Community Hospital Beds per 1,000 Persons Declined During HMO Era

(Number of Beds)

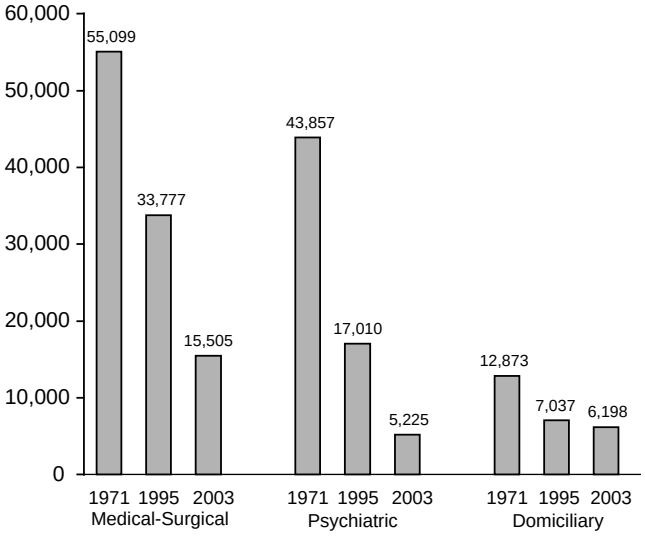


Source: U.S. Statistical Abstracts; *EIR.*

FIGURE 3

Decline in VA Medical Care Infrastructure, Loss of Beds, 1971-2003

(Staffed, Operating Beds)

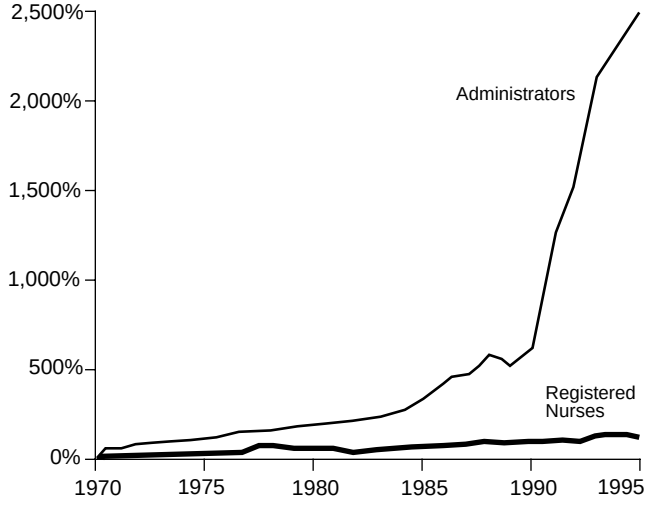


Source: U.S. Department of Veterans Affairs.

FIGURE 4

Growth of Registered Nurses and Healthcare Administrators, 1970-96

(Percent Growth Since 1970)



Source: Bureau of Labor Statistics and Himmelstein/Woolhandler/Lewontin Analysis of CPS data.

companies at large have turned to seeking billions of profits from blockbuster drugs, like Viagra. Vaccine producers have mostly exited the market altogether. At the same time, there is the pressure to perform for Wall Street. **Table 1** shows the ratio of corporate outlays for stock buybacks and dividends, as compared with research and development.

Drug companies also claim the threat of malpractice suits drove them from childhood vaccine production. Families charged that children suffered from faulty vaccines, or ones that contained mercury (but a Federal program that helps with the costs of any vaccine-related catastrophic injuries exposes the drug companies' claims).

The Wall Street factor was further aided by the Bayh-Dole Act (1980), giving drug companies exclusive licensing rights to discoveries arising from Federally sponsored drug research programs. Other legislation followed that and quickly turned production of critical medicines into a looting process by pharmaceutical companies.

Takedown of Hospitals

Over the HMO era of deregulated healthcare, the number of community hospitals, and the hospital bed ratio, of licensed beds per thousand people, have fallen markedly in the United States. **Figures 2a-b** show these trends clearly. In 1950, the average ratio of beds per thousand people for the nation stood at 3.35. As of 1970, the national average reached the Hill-Burton standard of 4.4 beds per thousand. But today, the ratio has fallen to below 3 beds per thousand, which is below the 1940s national average which gave rise to the post-World War II remedial hospital-building program in the first place! The United States is fast going backward to conditions prevailing pre-World War II, when appendicitis, maternal child-birth deaths, and accidents claimed lives for no other reason than the absence of hospitals.

Another important part of the hospital base of the nation, is that of the Department of Veterans Affairs. **Figure 3** shows how the number of staffed, operating beds in VA medical facilities have been reduced from 1971 to the present, in all three categories of operation: medical-surgical, psychiatric, and domiciliary. These numbers are heading for another sharp drop, if the closures and downsizing mandated by the Bush-Cheney Administration go through, including huge VA facilities from Waco, Texas, to Pittsburgh, Pennsylvania. These cuts are mandated despite the waves of returning wounded from Iraq and Afghanistan.

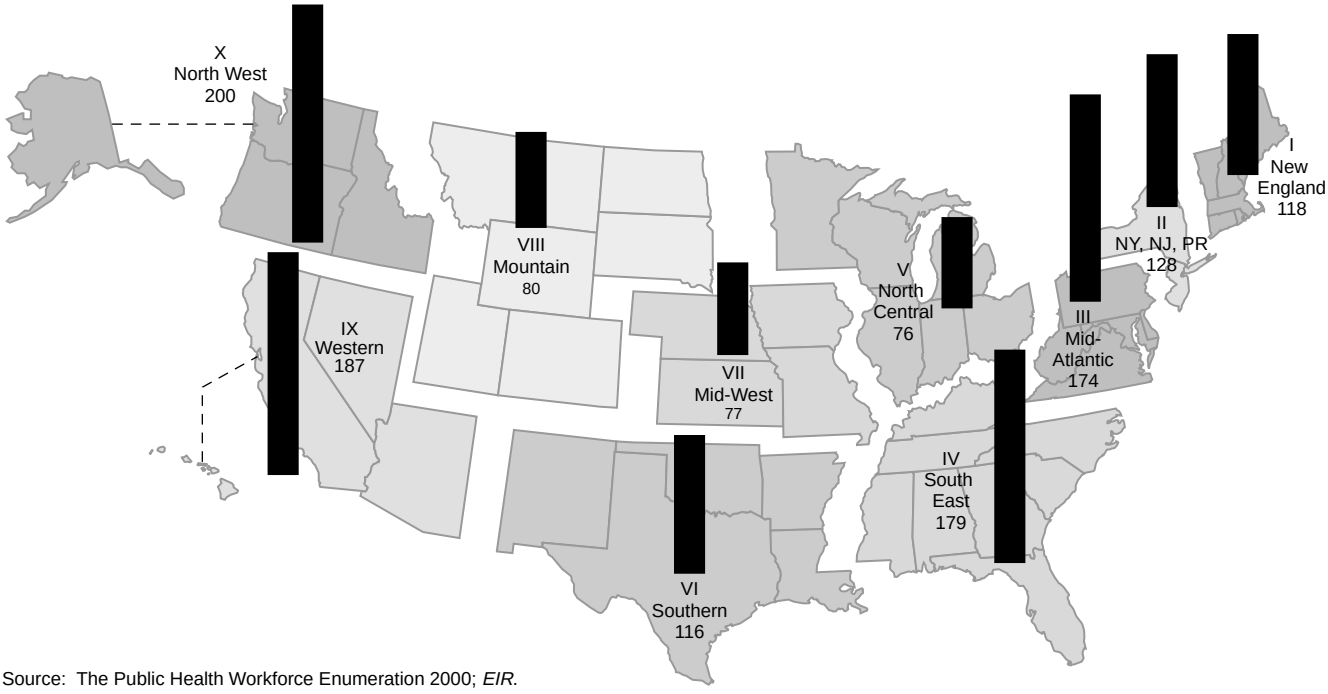
There is no way this reduced combined hospital base can handle a heavy influenza season, which is now guaranteed for the coming Winter, barring a miracle-mild strain of flu. Only a coordinated mobilization to re-open and restore facilities—for example, D.C. General Hospital in the nation's capital, wrongfully shut in 2000—can expand the base short-term.

Figure 4 illustrates the related problem of staffing,

FIGURE 5

Public Health Workers per 100,000 Population, in 10 Federal Health Districts, 1999

(Number per 100,000 Population)

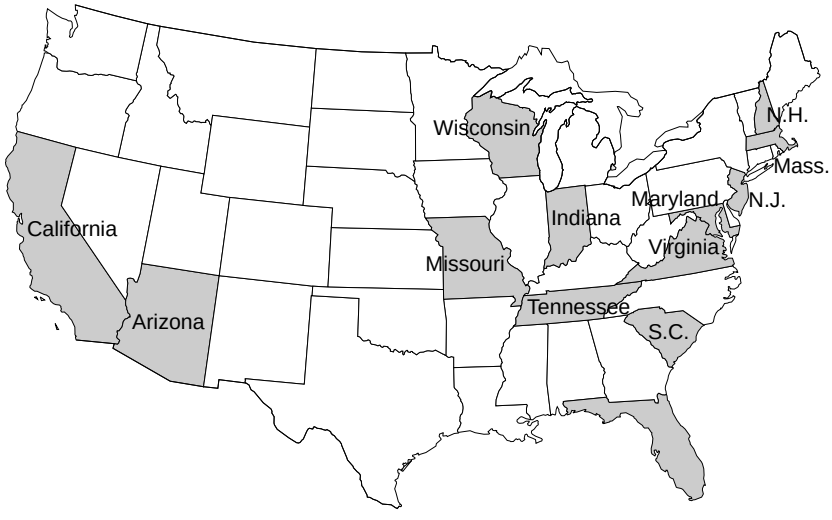


Source: The Public Health Workforce Enumeration 2000; *EIR*.

Over the past 25 years—and especially the last two years—there has been a major scale-back in the United States, in the ratios of public health workers, hospital beds, staff and facilities (equipment, quarantine facilities, etc.) per population. The graph shows one aspect of this—the wide disparity in the number of public health workers (all kinds—epidemiologists, county nurses, technicians, etc.) per 100,000 people, in the ten health districts, which are set by the Department of Health and Human Services.

FIGURE 6

Only 13 of 37 States Have Plans for Pandemic Influenza, 2003



Source: www.HEALTHYAMERICANS.ORG, "Ready or Not? Protecting the Public's Health in the Age of Bioterrorism," December 2003;

which must be solved on a contingency basis. During the 1970-95 years of the HMO era, the number of health system administrators grew far more than registered nurses!

Public Health System Needs To Be Rebuilt

Our public health system relies on many functions in addition to the central role played by hospitals—disease surveillance systems, epidemiologists, laboratories, nurses, technicians, and other staff. All of these capabilities have been downsized relative to tasks required of all kinds—from vector control (vermin, mosquitoes), to sanitation, and inoculations. Indicative of the problem is that an ongoing enumeration of the staffing at all levels is not kept. According to a survey by the Association of State

and Territorial Health Officials (ASTHO) taken less than a year ago, 57% of states report lack of personnel as a major problem.

In the early 1970s, there was one public health worker for every 457 persons; in 1999, this had fallen to one public health worker for 635 persons. The ratio is now down below one worker for 580 persons.

Figure 5 shows the geographic disparity of the presence of public health workers, according to the 10 Federal administrative health regions. Nationally overall, there were 156 public health workers per 100,000 people in 1999, but this varies widely. The Northwest states had the highest, with 200 staff per 100,000 population. Many states fell as low as 76 workers per 100,000 (in the North-Central region, this included Illinois, Michigan, Minnesota, Indiana, Ohio, and Wisconsin).

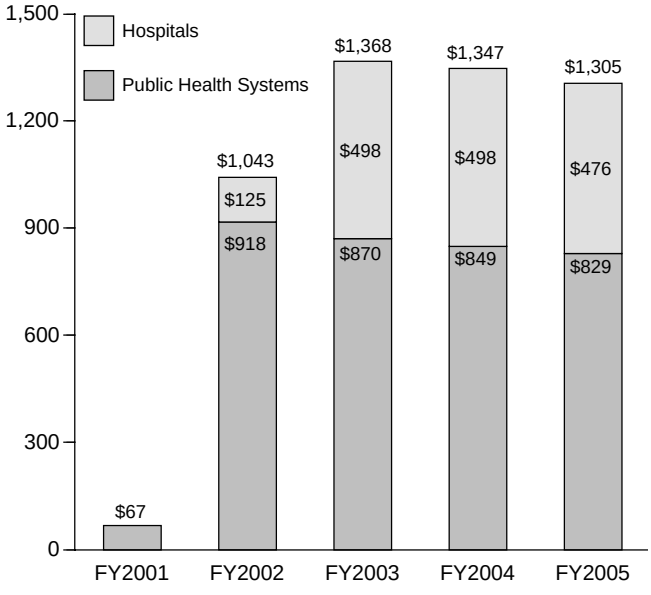
Map onto this, the potential patterns of the unfolding incidence of influenza this year, along with the pattern of the drastically reduced hospital base, and the problem of lack of logistics to handle health needs becomes clear. **Figure 6** gives a summary indication of lack of preparedness. Only 13 states have a plan in place for handling an influenza pandemic. This was one of 10 points on a preparedness survey scoring all 50 states, mapped by the Trust for America's Health (www.healthyamericans.org) in December 2003. The report stated, "The scores indicate that, despite the surge in Federal funds [Homeland Security], states are only modestly more prepared to respond to health emergencies than they were prior to 9/11. Overall, the preparedness effort has been severely compromised by the impact of state budget crises" and related factors. The report gives funding figures for all 50 states, showing drops in expenditures.

Figure 7 shows the figures with which the Bush-Cheney Administration tries to cover up the states' crises, by pointing to the Federal money *promised* to states and hospitals for health infrastructure, but overall not enough, and not delivered! As of May 2004, the Federal government had not advanced any at all of the pledged FY2004 monies, and had announced its intention to divert pledged monies for FY2003 and even FY2002!

FIGURE 7

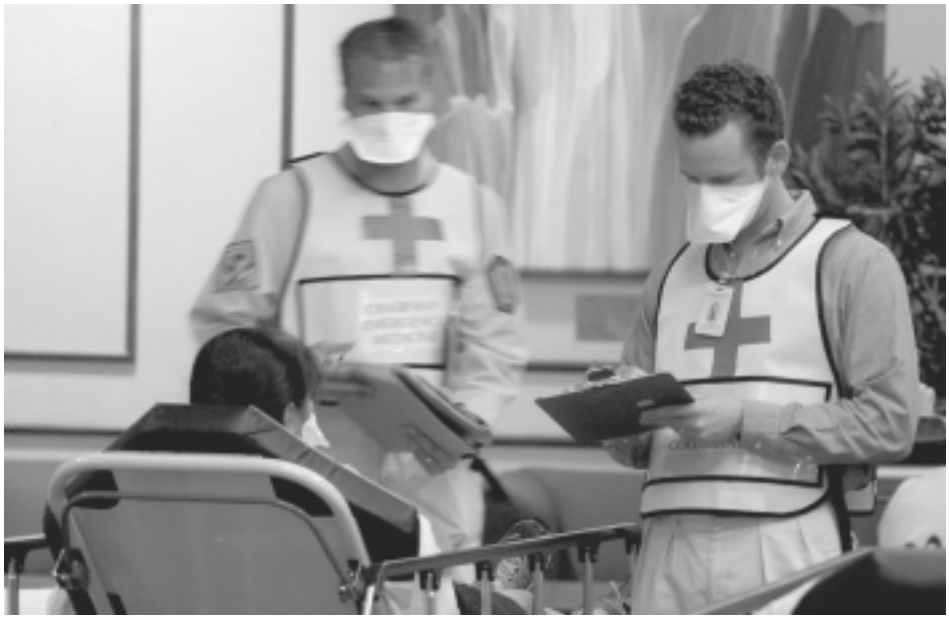
Federal Bioterrorism Funding for Public Health, FY2001-05

($ Millions)



Source: Alliance for Health Reform, *States and Dollars*, July 2004.

Looks okay, but. . . . The Federal funds authorized for hospitals and public health have been diverted. None had been appropriated for Fiscal 2004, and the Administration is still trying to divert some of the FY2003 and even FY2002 funds!



Emergency exercises have been run against smallpox, anthrax, and a-b-c warfare attack; but the public health infrastructure for dealing with common and new epidemics is sorely lacking, and most states have no plan for a serious influenza epidemic even now.