Flu season reveals U.S. hospital crisis

by Marcia Merry Baker

What makes this year's influenza "season" so severe in the United States? Not the currently prevalent type of microbe, Type A strain-Sydney variant, which is the predominant influenza now circling the globe. It is a nasty virus, but there have been worse. The relevant fact is that the U.S. hospital base, and health-care delivery system, have been so cut back in recent years by deregulation and privatization, that resources are overtaxed simply because of the predictable, annual arrival of the flu. The model for cutbacks in social services, Britain, is in even worse shape (see accompanying article, p. 7).

Granted, there is another contributing factor to the flu's fierce impact in the United States, which is its relatively early arrival. As of Jan. 10, the flu had broken out in 35 U.S. states, with the worst hit being in the west and south. Epidemiologists consider the outbreak early, because flu more commonly shows up in late January, or even as late as March. But though uncommon, today's flu epidemic is *not rare*.

Thus, the dramatic strains and overload now showing up in hospitals and public health systems result, not from an out-of-the-blue catastrophe, but from the drastic *reduction* in facilities and staffing that has occurred over the last 20 years of "managed care" and Health Maintenance Organizations, to the point that just a fairly normal flu season overtaxes the system. Because the normal length of a flu season is six to eight weeks, the worst may be yet to come.

On average, 30 million Americans get the flu each year, and 110,000 people need hospitalization and 20,000 deaths occur annually from flu-related illness (pneumonia, or complications of pre-existing conditions such as asthma, heart and lung disease, diabetes, AIDS, or sickle cell anemia). The elderly, the very young, and those with health impairments may need special medical care. The way to reduce the toll of illness and death, is to have *redundancy* in facilities, medical and public health staff, medications, and so on, in case of heavy requirements.

Now, instead of licensed hospital beds numbering in the range of four or five per 1,000 people—the rule of thumb (suited to local conditions) since the 1940s Hill Burton Act standards—there are less than two per 1,000 for most communities, or even no beds for hundreds of miles. This is true for the economic "bubble-belt" of Northern Virginia ("Silicon Valley East"), as well as for poorer and remote rural areas. The situation in the eastern states typifies the national picture:

Maryland: At least 12 hospitals of 26 in the Baltimore area and Washington's Maryland suburbs were on red alert as of Jan. 6, which means that they had no more critical-care beds and their in-patient operations were overwhelmed. Many hospitals were cancelling elective surgery and turning away non-emergency patients. There was the worry that the state's facilities would be "saturated" if the intensity of the flu epidemic persists. Dr. Rick Alcorta, head of the state Emergency Medical Resource Center, which tracks the status of hospitals, said, "If the trend continues the way it is now, within the next month we are going to have a great challenge to find beds to admit anybody in the state of Maryland."

Pennsylvania: At Temple University Hospital in Philadelphia, patients lined the halls on gurneys, waiting for rooms. As of Jan. 6, flu patients occupied half of the Lehigh Valley's 70 single-patient rooms.

Virginia: In hard-hit Northern Virginia, Inova-Fairfax Hospital took to having nurses treat patients in the hallways of the Emergency Room.

New York City: St. Luke's-Roosevelt Hospital in Manhattan as of Jan. 10 had to close its Emergency Room to ambulances.

Rhode Island and **Connecticut:** Many hospitals became swamped as of the first week of January, and began rescheduling all elective surgery in an attempt to free up beds.

No substitute for medical facilities

This shortage of hospital infrastructure was revealed in another way when, as of the second week in January, Federal health officials issued an advisory to all local physicians to stop relying so much on newly approved anti-viral flu medications (which at best only decrease the length of the illness by a day), and to instead diligently diagnose and hospitalize people where called for.

On Jan. 11, the Food and Drug Administration (FDA) said that some flu patients might have died because they did not get the more aggressive treatment they should have received, such as oxygen, intravenous fluids, and other intensive therapy. Diagnosis and treatment for bacterial infections that may be lurking in a flu patient are especially important.

Six months ago, two new anti-viral drugs received Federal approval. One is Relenza, made by Glaxo Wellcome, and the other, Tamiflu, by Hoffman-LaRoche. By early January, doctors had already written over 300,000 prescriptions for Relenza, and several hundreds of thousands for Tamiflu.

Dr. Heidi Jolson, head of the FDA anti-viral drug products division, cited several specific cases this year where death from flu of people who were given such medicines was considered avoidable. "These cases suggest that these products are being used in patients who are at higher risk of adverse outcomes," she said.