Reality Hits: The Nation Needs A Public Health System

by Edward Spannaus

After decades in which the public health system of the United States has been systematically and intentionally dismantled in the name of "efficiency" and "shareholder values," the events of Sept. 11 appear to have shocked many policymakers into an emerging realization of the insanity of this destructive path. Congressional hearings on emergency preparedness and bioterrorism are now almost a daily occurrence, and warnings about the breakdown of the nation's public health infrastructure are being taken seriously for the first time in many years.

Consequently, we are now seeing the beginnings of a recognition, in Congress and in other policymaking circles, that "public health" is not just something for the poor. The systematic destruction of the nation's public health and overall health-care system, through budget cuts, privatization, and the domination of health maintenance organizations (HMOs) and other forms of "managed care," have left the nation unnecessarily and terribly vulnerable to any biological or chemical attack—not to mention to the rising rates of illness and disease which accompany an economic collapse such as that which the nation and the world were already undergoing prior to the events of Sept. 11.

LaRouche's Campaign Against HMOs

The groundwork for this public reawakening on the importance of the public health infrastructure, has been laid by the campaign that Lyndon LaRouche and *EIR* have led for a number of years, against the managed-care or HMO system, and to restore the system typified by the 1946 Hill-Burton Act; that law mandated a national standard for hospital facilities necessary to assure access to health care for all citizens—regardless of where they live, or their ability to pay—as well as special Federal programs to attack and treat dangerous diseases.

LaRouche's opposition to the HMO system goes back to 1973, when the first HMO provisions were enacted by Congress; at that time, LaRouche denounced this as an austerity program that would condemn large sections of the American population to the status of "useless eaters."

In April 2000, LaRouche launched a campaign to ban HMOs altogether—on the grounds that their existence is contrary to the intent expressed in the U.S. Constitution to defend the general welfare of the population.

"The problem is, the HMO law is evil, intrinsically evil!" LaRouche declared. "The only thing that will solve the problem is to cancel the HMO law; repeal it. End the existence of HMOs. Go back to the system we had earlier, a system under the Hill-Burton legislation, which is the postwar system, under which we *improved* health care. . . .

". . . [T]he purpose from the beginning, in 1973 when that bill was passed, the *purpose was to cut the health care of the population*. That was its purpose, by privatizing it under shareholder value rules."

No Preparedness, No Capacity

The beginnings of a new "paradigm shift" in the thinking about public health, are evident in the flurry of hearings on bioterrorism and related matters in Congress, and in other public debate, since Sept. 11:

- At a Senate hearing of the Health, Education and Labor Committee on Oct. 9, Dr. Mohammad N. Akhter, executive director of the American Public Health Association, warned

The national "anti-terror" crusade could not avoid throwing light on what honest political activists and medical professionals have long known: the "managed care revolutionaries" made billions while destroying public health readiness and closing absolutely essential hospitals, like D.C. General in Washington.

of the dire lack of preparedness for any biological attack. His testimony was reflected in an op-ed he wrote for the *Washington Post* on Oct. 10, in which he declared that the public health systems of both the District of Columbia, and the nation as a whole, are "woefully unprepared" to do anything about a bioterrorism attack, and that hospitals would be flooded with patients in such an event. Dr. Akhter pointed out that there is a greatly reduced number of beds in these facilities, which he attributed in part to "the privatization movement to downsize hospitals."

• In an Oct. 5 ABC-TV "Nightline" broadcast of a "town meeting" in D.C. that same day, the role of privatizing medical care was also cited as a major problem in the lack of preparedness. This was raised by Col. Randy Larsen, formerly of the National War College, who has helped develop some of the exercises which tested preparedness for a biological attack. Larsen noted that private hospitals are not willing to participate in such planning and training, because their purpose is to make a profit.

"In this nation, we made a decision that we wanted to have your medical care in the private sector," Larsen said, noting that he agreed with that. "The problem is, they have to make a profit. Today, 30% of those hospitals are in the red. Fifty percent of the teaching institutions are in the red. When we asked the CEOs of those institutions, 'We need you to do exercises, planning and training,' they can't afford to do that."

• A closely related point was made during an Oct. 11 hearing of the House Intelligence Subcommittee on Terrorism and Homeland Security, when a leading expert on biological defense and biological warfare cited managed care—the HMO system—as the cause for the lack of hospital capacity in the United States to deal with any bioterrorist incident.

Col. Edward Eitzen, who is now the commander of the U.S. Army Medical Research Institute of Infectious Disease at Fort Detrick, Maryland, said that there are three major areas in which to bolster the nation's preparedness for bioterrorism—1) a strong public health system, with excellent real-time surveillance systems to rapidly detect an outbreak, state-of-the-art laboratories to tell us what disease agent we are facing, and strong research programs to develop new countermeasures; 2) educational programs to make biological first responders—emergency and primary care physicians, nurses, public health personnel, and clinical laboratory technicians—aware of the clinical symptoms, initial treatment, laboratory procedures, and reporting mechanisms that they need to know to detect and manage an outbreak; and 3) adequate capacity in the health-care system.

Eitzen said that we must "make sure that we have adequate capacity in the health care system to be able to treat the casualties," adding: "This is not now present for a large-scale attack, because our hospitals have been running kind of lean and mean in the last few years, with the advent of managed care."

• Dr. Jonathan Tucker, of the Monterey Institute of International Studies, identified the importance of the nation's

D.C. General Chief Surgeon: Reopen The Hospital

In a letter to the Washington, D.C. City Council, Dr. Bernard Anderson, former Chief of Surgery at D.C. General Hospital, says that the capital's public health preparedness and disaster readiness demand the reopening of D.C. General Hospital (DCGH). Dr. Anderson, Professor of Surgery at Howard University, writes, "We are not currently ready for . . . a potential disaster emanating from a major biological, chemical, nuclear, physical-natural or unnatural event." He calls for disaster preparedness training of all medical students and post-graduates; for an increase in both the number and the state of readiness of Level I trauma centers; their ready accessibility to and from "potential target areas" of disasters; and that they be expandable in functional and physical capacity up to four to five times their regular capacity.

"More of the public's money must be budgeted to the health care system, as private compensation cannot be expected to cover the operational costs of such entities. . . . Such money should go, preferably, to the public hospitals and teaching hospitals and to university hospitals that have a high investment in education, research and training. Of note is the fact that the recently killed DCGH met most of these essential efforts.

"DCGH was a vibrant Level I trauma center that handled at any one time either the largest number, or second-largest number of trauma victims in the city. It was staffed in the emergency room by a dedicated team of surgeons that were in the hospital 24 hours per day. . . . These surgeons were integrated in the staff with the other surgeons from Howard and Georgetown University clinical faculty who met and exceeded all the qualifications and operational requirements of the American College of Surgeons Committee on Trauma for a Level I trauma center. The facility was dedicated to deliver the highest level of care to the trauma victim available anywhere in the world. . . .

"Additionally DCGH was one of three centers in the city with equipment, trained staff, and capability to function as a mass casualty/terrorism/decontamination center with the capability of responding to nuclear, chemical, and biological misadventures.

"Surely the decision to close DCGH without providing for the services it rendered faithfully to its natural service community, and was capable of rendering to the wider community, was a reckless and callous act that considerably increased the exposure and vulnerability of all persons in the city. . . .

"While 'Humpty Dumpty' can usually not be put together again, the many reasons to reconstitute DCGH on the same site for the public good, safety, and access for all the people of the city, are overwhelming. The steeply inverse morbidity/mortality ratio experienced on the Sept. 11 disaster should not be relied upon to preserve the veneer of being ready and being capable. We dodged a bullet this time. Now honorable ladies and gentlemen and leaders of the community, let us do the right thing so that we may be in a truly optimal state of readiness to serve the best interests of the city."

public health system to deal with the threats of both emerging diseases, and of potential bioterrorist incidents. "Back in the 1950s and '60s, publicly supported community hospitals and public health laboratories supported an effective early warning network for detecting and containing epidemics," Dr. Tucker stated.

- The lack of preparedness of the U.S. public health system was also discussed extensively at a hearing of the Oversight and Investigations Subcommittee of the House Energy and Commerce Committee on Oct. 10. But Rep. Greg Ganske (R-Iowa) was the first to delve into the actual reasons for this, beyond just the obvious lack of funding. Ganske said that "under the HMO model of health care, in this country, we have wrung out of the health care system any redundancy, in the quest for efficiency," and he noted that, because of the HMO-run constricting of the health system, there is no capacity in the health care system to handle the surge resulting from an epidemic or a terrorist attack.

The Fight For D.C. General Hospital

At the beginning of this year, the LaRouche movement identified crucial importance for the entire nation, of the fight to save the District of Columbia General Hospital. D.C. General, with a 200-year history, was the last public hospital in Washington, D.C., and contained top-flight treatment and teaching facilities—and a state-of-the-art decontamination center—all of which were dismantled over the Spring and Summer of this year.

Now, in light of the Sept. 11 attacks, there is renewed attention of the need to restore D.C. General, if the nation's capital were to have any capacity to deal with a large-scale medical emergency. Had a hijacked plane crashed into the Capitol on Sept. 11, the District's nearby hospitals, whose emergency rooms are already overflowing, would have had no capacity to deal with the crisis. (As it was, those injured at the Pentagon were mostly taken to the closest hospitals, in Arlington and Alexandria, Virginia.) Robert Malson, the

president of the D.C. Hospital Association, recently asked, "Does it make sense not to have D.C. General's trauma center at a locale 19 blocks from the U.S. Capitol?"

LaRouche himself said recently, that those who opposed the efforts to keep D.C. General open have now been "proven terribly, terribly wrong."

"The point is, now the Control Board is ended, the issue of D.C. General Hospital is back in the lap of Congress," LaRouche said, referring to the termination of the Financial Control Board whose charter ended on Sept. 30. Its five-year dictatorship over the District of Columbia, included shutting down D.C. General in violation of its Congressional mandate. "We have a national emergency, which includes a national medical emergency, which includes the D.C. area. The only sane thing to do now, is to totally reconstitute D.C. General Hospital."

But that was not the approach taken by District of Columbia officials at an oversight hearing on emergency preparedness held by the D.C. Council on Oct. 5. The issue of D.C. General was only raised by D.C. Hospital Association president Malson (representing private hospitals), who presented it in the following terms, including citing the role of the HMO system:

"Our nation's hospitals no longer have the 'surge capacity' required for large-scale casualties, mainly due to the advent of managed care and a major shortage of health-care workers—particularly nurses, radiology and laboratory technicians, and pharmacists," Malson testified. "In the meantime, one of the city's leading trauma centers, D.C. General Hospital, located 19 blocks from the U.S. Capitol, was closed earlier this year, seriously crippling our trauma and decontamination capacity. I urge the Council, the Mayor, and the Federal government to review the feasibility of reinstating a wider range of emergency services available to those who live and work near the U.S. Capitol and the Supreme Court."

That night, on the ABC-TV "Nightline" town meeting, host Ted Koppel asked D.C. Mayor Anthony Williams about the closing of D.C. General. "Mr. Mayor, people outside the District of Columbia do not know, but D.C. General, one of your biggest hospitals, just closed down," Koppel said. "So you have fewer beds now than you did a year ago."

Williams sidestepped the question, instead saying that the District has a good system for monitoring the utilization of hospitals, in which the D.C. Hospital Association has taken the lead. And, despite all the warnings that were made about the danger of shutting down D.C. General in case of any public health emergency, Williams glibly continued: "But this is a good story of where you are building your system for normal times, you're not building your systems for spikes and emergencies, and that's where we have, as I said earlier, a lot of work to do in terms of investment. One of the things we're looking at is what role D.C. General can play in terms of providing backup space."

Of course, without restoring D.C. General, it can't provide much more than beds and empty space, since its surgery, laboratory facilities, and other essential back-up components have been dismantled.

'A Reckless And Callous Act'

The folly of closing D.C. General is shown in the letter to the D.C. Council (see box), from the former head of the Department of Surgery at D.C. General, Dr. Bernard Anderson. Dr. Anderson notes that D.C. General was a "vibrant Level I trauma center" and that it was one of only three centers in Washington, D.C. with the capability and equipment to function as a mass-casualty and decontamination center in the event of a nuclear, chemical, or biological attack.

"Surely the decision to close DCGH without providing for the services it rendered faithfully to its natural service community, and was capable of rendering to the wider community, was a reckless and callous act that considerably increased the exposure and vulnerability of all persons in the city," Dr. Anderson wrote.

Meanwhile, the death toll arising from the dismantling of D.C. General Hospital has reached at least 47, according to LaRouche activist Lynne Speed, a leader of the Coalition To Save/Restore D.C. General Hospital. Most of the cases involved victims of gunshot wounds or other trauma, who had to be transported to more distant hospitals because D.C. General was no longer accepting ambulance arrivals. Since Aug. 26, ambulances have been permitted to bring some patients to the stripped-down emergency room (actually just a clinic) on the site of D.C. General, but a number of these have died because there are no surgical, laboratory, and other essential services necessary to quickly treat emergently injured or ill patients.

Senate Is Warned That Public Health Is Unready

by Linda Everett

Two recent Senate hearings, focussed on the country's capability to respond to a biological or chemical terrorist incident, uniformly presented a chilling warning—that the United States is, on every level of its public health infrastructure, woefully unprepared for such a terrorist event. On the Federal level—states and localities are in worse shape—a newly released study by the General Accounting Office (GAO, the Congressional research body) found that the government's plan for responding to the public health and medical consequences of a bioterrorist attack is a collection of poorly coordi-