LaRouche Says, Treat Anthrax Attack As 'Wartime' Emergency

by Marcia Merry Baker

All the while the anthrax attack has grown (to involve Congress, the postal system, the White House, as well as the media and New York mayoral offices), and instances of exposure, infection, and death increased, two points have come to stand out clearly. Both were predictable given the abandonment of a "general welfare" approach to public health since the 1970s.

First, the U.S. public health and medical infrastructure has been allowed to become so eroded over 30 years of health maintenance organization (HMO) deregulation, that the broken-down health care system itself is now part of the crisis. The second, "cultural problem" related to this, is that the many expert agencies involved—such as medical, military, investigatory, law enforcement—are acting as the gang that can't think straight.

Appropriate Action

U.S. Democratic 2004 Presidential pre-candidate Lyndon LaRouche stressed on Oct. 25 that what is required is to see the anthrax terrorism as an act of warfare against the United States, and accordingly, to declare a wartime medical emergency, and take the appropriate actions: Open up any and all the institutions needed, including hospitals, laboratories, emergency facilities; deploy the Atlanta-based Centers for Disease Control (CDC), epidemiologists, and public health experts to take all necessary action to test and define areas of exposure and infection; use relevant antibiotics; regularize testing as an early warning program; look for specifics of other biological threats. In other words, mobilize as in war.

In particular, LaRouche pointed out, you have to focus on poorer people, whose greater health problems and poorer health care make them most susceptible. LaRouche pointed to the immeidate testing and treatment for Capitol Hill staff after an anthrax letter was sent to the offices of Senate Majority Leader Tom Daschle (D-S.D.), and that this kind of follow-up was not pursued as general policy. It was not pursued in the case of the District of Columbia local community and postal workers in mid-October.

Washington: What Did, And Didn't Happen

On Oct. 15, it was made known that Daschle's Capitol Hill office had received a letter confirmed to be carrying anthrax. The letter was sent for analysis to the Army specialist laboratories at Fort Detrick, Maryland for further, refined testing. On Capitol Hill, steps were taken right away for individual screening and precautionary treatment of staff; for environmental testing to establish the location of any "hot spots;" and for defining the perimeter of the area of potential presence of infective agents. Buildings were shut down for a long recess. As of ten days later, some 400 people had been given 60-day doses of antibiotic; of those, 28 had shown confirmed exposure.

However, days went by before there were similar actions taken along the "backtracking" route of the letter's postal trail, most particularly at the Brentwood Road Post Office, where workers had been exposed. Four workers there were stricken with inhaled anthrax; two died.

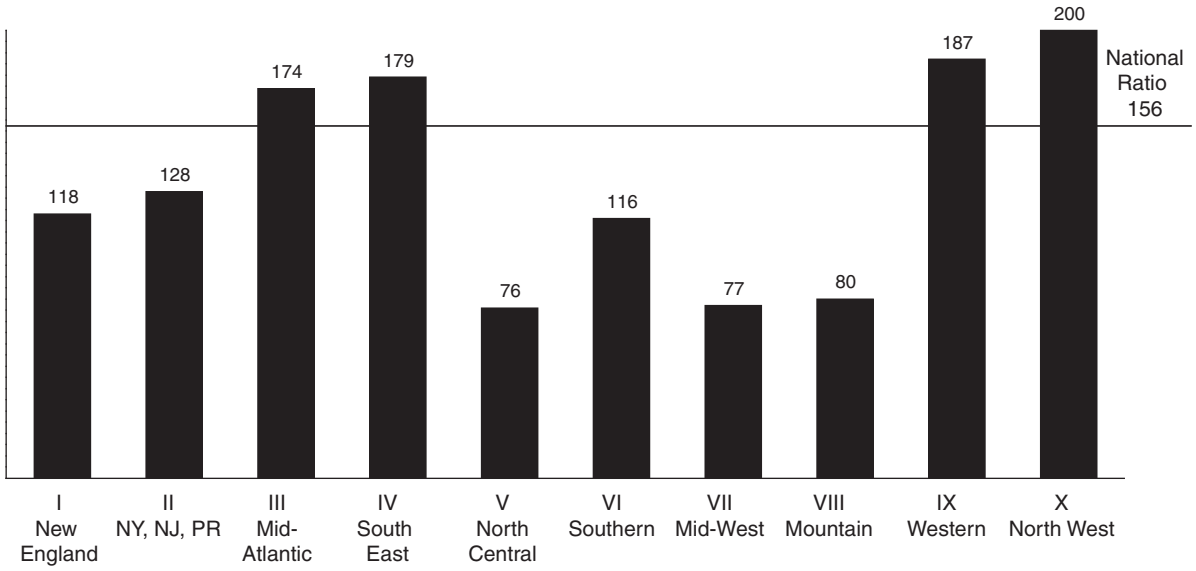
This lapse of command-decision was not the result of need to await test results on the Daschle letter. It was established relatively quickly that the strain involved was "common" (i.e., was not antibiotic resistant, or did not have other bio-engineered traits), but *it was imputable, under a military readiness approach,* that the powdery form of the anthrax in the letter, might be highly dispersible through the air. Therefore, aggressive precaution would have dictated rapid backtracking through the postal system—testing, treating, and analyzing at likely points along the way; most importantly; the feeder station to the Senate building, Brentwood Road Northeast. This was not done.

Instead, the CDC said on Oct. 18, that there was no significant danger at the Brentwood Post Office; other agencies

FIGURE 1

U.S. Ratios Of Public Health Workers Vary, By Region, 1999

(Number per 100,000 Population)



collaborated in this baseless public reassurance, ranging from the District of Columbia Department of Health, to the Army, the FBI, and Bush Cabinet officials.

On Oct. 22, fully one week after the public notification of the Daschle letter, the spokesmen for the CDC and other agencies apologetically admitted their error in delay. They even said that there had been been a delay in their being informed that the two Brentwood postal workers had been hospitalized with extreme flu-like symptoms in the days following the Oct. 15 Daschle letter incident. These two workers died from pulmonary (inhaled) anthrax; two others have been in serious condition with the same infection.

It was not until Oct. 21, that the public health order was given for Brentwood and other postal employees and post office users, to report to D.C. General Hospital for precautionary antibiotics; and for the environmental testing of 36 postal stations in the District. However, the 5,600 postal workers and others were not being given careful follow-up. CDC officials staffing the location, at first began screening and testing, then abandoned it for the mass dispensing of a ten-day supply of the antibiotic Cipro.

Physicians, including Dr. Bernard Anderson, the former head of surgery at (now closed) D.C. General Hospital, point out that the proper way to proceed, would instead be to try to focus on those individuals who were likely exposed to known areas of contamination; start them on the full antibiotic treatment (60 days), and if they later test negative, stop the treatment. This takes staffing, lab back-up, and commitment.

The CDC defended all that happened the week of Oct. 15 by saying that their "science was evolving." They defended their judgment, by saying that they had wrongly oriented to presuming danger of infection only in direct association with the contaminated letter in a restricted area, not with significant airborne sources.

In fact, it has been subsequently reported that the final test results show that the dry anthrax substance inside the letter was remarkably refined, concentrated, non-electrostatic, and in other ways "weaponized" for maximum transmissibility and potency. In terms of leads on the perpetrator, this sophisticated character of the anthrax powder raises questions of domestic complicity in the terrorism. In terms of public health, this episode, and the deaths, demonstrate that a medical wartime approach is the only realistic response—not just for anthrax, but for any bio-threat.

Public Health Infrastructure Degraded

Even beyond the evil cunning of the anthrax attack, is the reality that the U.S. public health system is so badly atrophied, it doesn't take much to overload it. In Washington, laboratories can't handle the testing, hospitals are strained, and any "routine" occurrences—e.g., seasonal flu epidemic, or a large-scale accident—could overwhelm the whole medical infrastructure system. This end result—not necessarily mass kill—is one of the top objectives of bioterrorism, as was always stressed by the famous Soviet program Biopreparat.

On Oct. 23, LaRouche commented, "I am not yet able to determine whether the anthrax cases are action from the original set of conspirators [of the Sept. 11 attacks in New York and on the Pentagon], or, what appears to be a copy-cat of lesser technical capability. So far, this problem has not yet

assumed the form of an epidemic; I would be worried by the technical possibility of a return of the 'Spanish flu' epidemic, or some other horrors; but in any case, panic is the worst danger of all.

"Instead of panicking, we must act to force through a rapid rebuilding of those health-care and related national defenses which have been torn down since the Nixon Administration's ramming through the overturn of the Hill-Burton law with HMO legislation."

Since that Federal law authorizing HMOs was enacted in 1973, all the critical U.S. public health ratios have declined: manpower, diagnostics, laboratories, hospital beds, vaccine stockpiles, to the point of becoming a clear and present danger. This was the direct result of the switch-over from public infrastructure standards, to health care *deregulation,* in which so-called "market"-based decision-making provided spectacular rates of profiteering to "managed care" companies, pharmaceutical houses, and financial interests.

The public and lawmakers stood by and let it happen. Some of the same leaders of the shutdown process are now holding Federal office, calling for billions in Federal monies to revive health infrastructure. Homeland Security Director Tom Ridge drastically cut Pennsylvania medical programs for the poor while he was Governor there. Secretary of Health and Human Services Tommy J. Thompson pioneered imposing sweeping cuts in state welfare, health, and medical services in Wisconsin, when he was Governor there.

Even if billions in Federal spending on public health were authorized tomorrow, the political reality is that on the state and local level, there are multimillion-dollar cuts being made in medical and health services, because governments are trying to "adjust" to the economic collapse now under way (see *Documentation*). A national "Chapter 11 bankruptcy-style" approach is required to ensure that vital economic functions are kept going—services, businesses, agriculture, transportation, and health care. Unpayable debts need to be frozen, while an infrastructure build-up—in the case of health care, "soft" infrastructure—revives the economy.

Health Infrastructure Decline

Over the past 30 years, some 1,000 U.S. hospitals have been closed down; still more have had their bed-count reduced, dropping the national ratio of beds per thousand persons from about five in the 1970s, down to less than three; and in many counties down to one or none. The world-famous 1946 Hospital Construction Act ("Hill-Burton") had mandated a ratio of between 4.5 and 5 beds per 1,000, but this was scrapped in the 1970s.

Besides hospitals, all the other parts of our national "soft" infrastructure for public health, have been undermined.

Workforce: The ratio of U.S. public health workers to population dropped drastically from the 1970s to the 1990s. In

Budget Cuts Threaten Argentine Institute

The Argentine government's insane "zero deficit" plan, mandated by the International Monetary Fund, threatens the state-funded Malbrán National Microbiology Institute, the nation's premier scientific agency which is known throughout Ibero-America for its excellence in medical and microbiology research. Founded in 1916, Malbrán treats 7,000 patients annually for diseases such as tuberculosis, Chagas, hantavirus, dengue, meningitis, and polio. It also specializes in the production of vaccines, and in the study and treatment of congenital birth defects and high-risk pregnancies.

Between 1998 and 2001, the Institute's budget was cut by 12.5%, and under President Fernando de la Rúa, it is slated to undergo another 21% cut in 2002. This, despite the fact that the Institute has been recently called upon to analyze, for possible anthrax contamination, more than 1,000 letters sent into the country—which it can only do by diverting financial resources from other Institute departments.

In an interview with *EIR,* Dr. Sergio Angel, Vice President of the Institute's Professional Association (APROINM), said that this means that "people won't die of anthrax, but of other diseases," because there are no funds for treatment. APROINM President Graciela Davel said that with the Institute's reduced budget, "50% of the 13,000 TB patients nationwise will die, because they won't receive medication. . . . We aren't prepared to handle any bioterrorism emergency, because [the government] hasn't really complied with the full budget."

Dr. Angel told *EIR* that Finance Minister Domingo Cavallo has allocated "zero pesos" for purchase of supplies in the fourth quarter of this year. For 2002, the Finance Ministry plans to allocate only $2.6 billion to the Institute, whereas the budget for TB treatment *alone* is $2.2 billion. Doctors, and even patients and their families, are donating personal funds to pay for supplies. Contract personnel (doctors, technicians, administrators) will have to be fired, as the monthly budget for that category has been cut from $130,000, to $10,000.

Dr. Pablo Barbero, who heads the Institute's Human Genetics Center, said that the lack of funds threatens the Institute's ability to maintain sanitary standards, protect ongoing experiments, and preserve biological strains being studied.—*Cynthia Rush*

the early 1970s, there was one public health worker employed (state, county, Federal combined—from nursing, to clerks, to epidemiologists, etc.) for every 457 persons; in 1999, this had fallen to one worker per 635 persons.

Moreover, the jobs of many in today's public health field now involve home care and primary care, not necessarily "front-line" disease-related functions, which have been scaled back severely.

There is also a wide disparity in the ratios of public health staff per population, depending on the part of the country. **Figure 1** shows this variation across country in the ten health districts (which are set by the Department of Health and Human Services). As of 1999, the national ratio was 158 workers per 100,000 population. But, according to *The Public Health Workforce, Enumeration 2000,* many states are way below this ratio, e.g., the North Central region (Illinois, Minnesota, Indiana, Michigan, Ohio, and Wisconsin) has 76 workers per 100,000! For the Midwest (Nebraska, Iowa, Kansas, and Missouri), there are 77 per 100,000 population. The highest ratio is in the Northwest (Washington, Oregon, Idaho, and Alaska), with 200 workers per 100,000 population.

Vaccines: U.S. vaccine output capacity, and stockpiles, fell below minimum security levels years ago, both for seasonal influenza, tetanus, and similar "routine" illnesses, as well as for exotic diseases. In 1985, a report called "Vaccine Supply And Innovation" came out from the National Institutes of Medicine and the Academy of Sciences, warning that the supply of vaccine in the United States was "precarious" and the situation "a threat to the public's health." The report said that steps were "urgently" needed to assure that supply stockpiles, production, and development remained adequate. This did not occur.

Now, Ridge has called for production of 300 million doses of smallpox vaccine as a precaution against bio-terrorism. The government stockpile is below 15 million doses, of uncertain condition. It will take through Summer 2002, at best, to produce another 54 million doses. How to produce the remainder is now under negotiation. The Gilmore Commission, the anti-terror preparedness group set up a few years ago, is expected to issue a call for a Federal government vaccine factory.

The danger posed by the marginal state of U.S. vaccines is now shown by the bio-preparedness recommendation, that the general population in New York City, Washington, D.C., and elsewhere get flu shots this Fall, because any case of anthrax poisoning would then be less likely to be confused with influenza. This means millions more doses of flu vaccine are required.

D.C. General Hospital

The case of the status of the 195-year-old District of Columbia General Hospital makes the point about what is wrong, and what is required nationally. This Summer, the capital's top-flight—and only public—hospital was shut down, over the objections of the D.C. City Council, the population, and the international community, led by the Lyndon LaRouche 2004 Presidential campaign. The reason given was "fiscal" necessity, by the decision by a Congressionally imposed Financial Control Board.

But all of a sudden, on Oct. 21, the hospital came back on the TV screens because of the anthrax crisis. Part of D.C. General was re-opened at that time, because thousands of postal workers and others had to be screened for exposure. *The necessity of a full-service hospital* has thus been made dramatically clear. Even so, D.C. General's high-quality microbiology laboratory, trauma unit, and other divisions, remain closed.

States Cut Public Health, Medical Infrastructure

by Mary Jane Freeman

South Carolina: The only state health laboratory capable of analyzing suspicious letters and packages for South Carolina, North Carolina, and Georgia, may have its budget cut or frozen, just when usage has increased markedly, *The State* reported on Oct. 23. State budget officials plan to impose 4% across-the-board cuts by Oct. 31, which will include a $10 million cut in the health department's spending. All agree that the lab and law enforcement *should be* spared any cuts—but by law, they cannot be. The state faces at least a $310 million revenue shortfall.

Connecticut: A Nov. 13 special session of the legislature has been called, to deal with a $300 million revenue shortfall which will require budget cuts. A proposed $14 million cut in new mental health programs is likely, the online *Hartford Courant* reported on Oct. 24.

Florida: The legislature is in special session, wrangling over how to plug a $1.3 billion revenue shortfall, Sun-Sentinel.com reported on Oct. 24. The House plan would cut 7% across the board including $5 million for dental care, hearing tests, and eyeglasses for the poor and disabled adults; $22 million in prescription help for the elderly; and $14 million in juvenile substance abuse programs. Jack Levine, president of the Center for Florida's Children, said, "Many of our basic prevention services are severely at risk. We are in for a terrible ride if we go along with these cuts."

Illinois: Nearly 100,000 state workers, retirees, and their dependents may face delays in payment on health insurance claims, to help stave off up to $110 million of the state's expected $450 million revenue shortfall, the Oct. 24 *St. Louis Post-Dispatch* reported.

Indiana: The state has a two-year revenue deficit of almost $1 billion, which will translate into an additional 5% cut in the state's Medicaid budget.