Wartime Measures

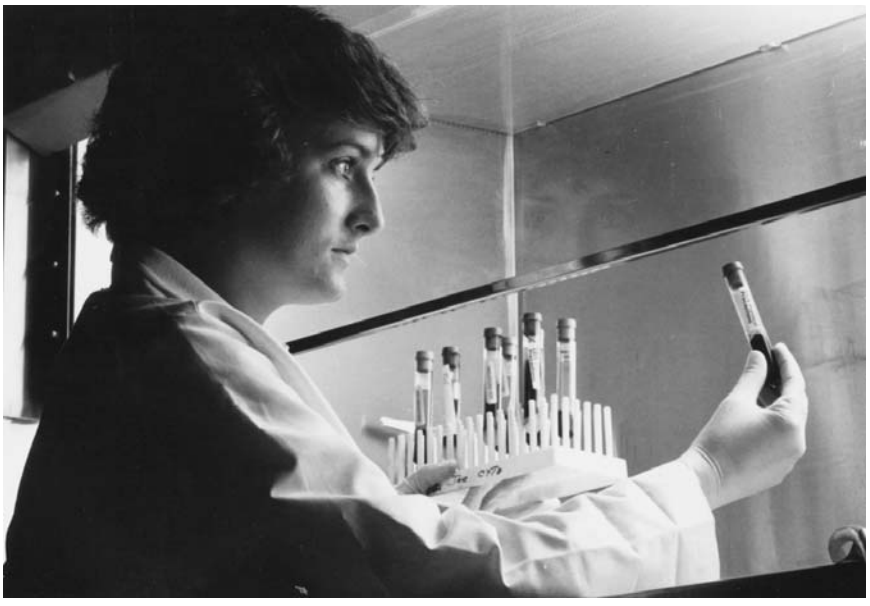
Reopen Closed Hospitals, Our National Assets

by Marcia Merry Baker

Four important public hospitals stand closed and vacant within a stretch of 50 miles, from Washington, through Arlington and Leesburg out to the northern Virginia city of Winchester. They include (pictured below) the famous District of Columbia General Hospital, the 194-year-old top-flight community facility, where Washington postal workers lined up for anthrax treatment, though Congress had closed it in May; the seven-story former Frederick County hospital in Winchester, strategically located with capacity for over 400 licensed beds, but closed in the 1990s; and in Leesburg, the former hospital facility for Loudoun County, with a capacity for 112 beds, but standing empty since 1997, except for a clinic. This hospital, like Frederick County's, stood on a route which was part of the "outer perimeter" defense lines of Washington.

The HMO-privatization policy which closed them is suicidal for the nation. The community hospital is the vanguard of public health and defense against germ warfare or natural diseases and catastrophe. A crash program can restore the now decrepit U.S. hospital system, beginning with a rapid county-by-county survey, and then proceeding with resources to re-open closed hospitals, operate interim facilities, and build new capacity to quickly provide the required ratio of beds per 1,000 population.

Besides numbers, all the specific functions of full-service hospitals must be brought up to standard. The American Hospital Association's (AHA) Nov. 1 report summarizes the needs of its 4,900 member hospitals to get up to required levels in eight areas: communications, disease surveillance, reporting and laboratory identification, personal protective equipment, facility, dedicated decontamination facilities, medical/surgical and pharmaceutical supplies, training and drills, and mental health resources. The total cost of the package is about $11.3 billion, and the AHA is working with members of Congress to design some sort of legislation to make these resources available, in the form of a grant program for hospitals. Dr. Jim Bentley, the AHA's senior vice president of strategic planning, said their working assumption is that in any terrorism or major disaster incident, hospitals are going to be on



their own for 24 to 48 hours, in terms of resources, so the assessment estimates are based on that contingency.

The current hospital deficit is the direct result of the last 30 years of HMO-era deregulation of hospitals, during which time the United States went from some 7,000 community hospitals in the 1970s, down to under 5,000 today. The average ratio of beds-per-1,000 persons went from close to 5 in the 1970s, down to under 3 today. In many counties and urban areas, it is 0.5 or nothing. The Department of Veterans Affairs could provide 3,300 beds on short notice, but spread out across 130 VA centers. The Veterans' and military base hospitals have been severely cut back as well, over the last 20 years. The prestigious Walter Reed Army Medical Center, for example, was designed to treat 1,260 patients; it now has 240 beds, with 400 more in storage for which there are no staff or equipment.

It is now estimated that the United States has an immediate shortage of 126,000 registered hospital nurses. By simple linear projection to 2020, it is estimated that the nurse workforce will be 20% lower than what is needed. Shortages in other hospital staff, including anesthesiologists, pharmacists, X-ray technicians, among others, are now growing. A national mobilization is required.

This "de-structuring" followed a period of deliberate build up of the U.S. hospital system from 1947 to the early 1970s, mandated by the 1946 Hospital Survey and Construction Act—called "Hill-Burton" after its bipartisan co-sponsors. After the war, the Hill-Burton Act mandated that *every county* must have a community hospital, and ratios of beds must be available in the range of 4-5 per 1,000 persons. This was accomplished by the 1970s (while Jim Crow practices of separate white and black hospitals were done away with); then, thrown away in the 1980s and 1990s, when nearly 1,000 hospitals were closed by the takeover of "shareholder values."

Rebuilding Local Public Health

City and county public health departments, the backbone for detection and response to a biological attack or disease outbreak, are unprepared for such events in large parts of the country. The number of public health workers per 100,000 people nationwide today is about 156 (Federal, state, and local), when in the 1970s it was over 200. In the Midwest and parts of the South, the ratio is only 80 health workers per 100,000. Many counties have only a single nurse. Some have no computers, no statewide communication system, and certainly no "disease detectives."

Public health testing laboratories, like the one shown above, have been cut back, or farmed out. Few have staff on call 24 hours a day, seven days a week. Public health veterinarians, critical for surveillance of disease transmitted from animals to humans, such as bubonic plague, are almost non-existent. According to Dr. Tom Milne, Executive Director of the National Association of County and City Health Officials (NACCHO), 180 out of 3,000 counties nationwide,

have no presence of any kind of state or local public health center.

Right now, the capacities of state labs are not even based on the population density of a region, and have been taxed to the breaking point. The Executive Director of the American Public Health Association, Mohammed N. Akhter, MD, said in October, that "the demands to investigate these latest anthrax cases are rapidly outpacing our ability to act." At various labs, some 1,200 environmental samples were being tested per day for possible anthrax. Dr. Akhter was blunt: "If they [terrorists] use a contagious agent like smallpox, we will not have isolation facilities to quarantine people. *If there's a major attack that would require more than 500 beds, no community has that number of extra beds available"* (emphasis added).

Even Federally, the Atlanta-based Centers for Disease Control and Prevention (CDC) is sited in 55-year-old facilities meant to be replaced 40 years ago. In October, an electricity outage from old wiring delayed CDC anthrax sample analysis by hours. The CDC was overtaxed even by the small outbreak of West Nile virus cases. It needs to be put on war footing, with expansion of both lab capacity and specialists.

Dangerous Concentration Of Food Processing

A public health threat has been created over the past 30 years, by the increasing "free" (rigged) trade cartelization in the food supply business, bringing both huge volumes of imports through more than 100 ports of entry, and also a pattern of "factory farms," and concentrations of food processing. The photo (p. 64) shows a giant Iowa corn sweetener plant run by Archer Daniels Midland (ADM), the world's largest soybean and corn processor, operating mega-factories. Pathogens can easily enter the extended food chain "naturally," and be dispersed rapidly over wide areas, instead of being confined regionally. There have been recalls, for example, of millions of pounds of meat product contaminated by *E. coli* bacteria; and listeria has been found in dairy foods. The potential impact of bioterrorism is amplified by such a system.

Huge factory-farms of hog, cattle, dairy, and poultry operations make any livestock disease outbreak—or veterinary terrorism, into an automatic catastrophe. The latest estimates of concentration of meat processing are: Five firms account for over 80% of all beef processed in the United States (IBP, ConAgra, Excel/Cargill, Farmland National, and Packerland); six firms account for over 80% of the pork (Smithfield, IBP, ConAgra, Excel/Cargill, Farmland Industries, and Hormel). The same situation prevails in diary and cereals.

As a national sanitation defense measure, localization of farming and food processing can be restored through the restoration of traditional farm product parity pricing, and related anti-trust executive action.

To Win War On Terror, Shut Down Dope, Inc.

by Jeffrey Steinberg

In response to the Sept. 11 irregular warfare attacks against the World Trade Center and the Pentagon, President George W. Bush declared war against international terrorism—all international terrorism. The overwhelming majority of nations of the world—led, from day one, by Russia—endorsed the President's declaration of war, and vowed to collaborate in the campaign to rid the planet of the scourge of terrorism.

Some 60 days into the war, and 30 days into American and British military operations inside Afghanistan, the entire venture may be running aground. Within the Muslim world, there is growing fear that a protracted Anglo-American military operation against the Taliban regime and Osama bin Laden's al-Qaeda organization, will trigger a backlash against moderate Arab governments. The "breakaway ally" regime of Ariel Sharon in Israel is threatening military action against a range of regional targets—from the Palestinian Authority, to the Hezbollah inside Lebanon, to Syria, Iraq, and even Saudi Arabia. Any such action by Israel, particularly in the context of the ongoing U.S. and British military actions in Afghanistan, would detonate the "Clash of Civilizations" demanded by such lunatic geopoliticians as Samuel Huntington, Zbigniew Brzezinski, Bernard Lewis, and Henry Kissinger.

Such events would constitute a decisive defeat of the war against terrorism, and would engulf the entire planet in decades of brutality and chaos—far more lethal than the hideous attacks of Sept. 11 and the ongoing biological warfare attacks against the United States.

To prevent this ruinous turn of events, it is imperative that the Bush Administration abandon its present course of action, and launch a genuine war against terrorism that proceeds from an entirely different set of axioms. These axioms have been stated and restated by Lyndon LaRouche since the moment the Sept. 11 attacks began.

An Enemy Within

In a live radio interview with Salt Lake City talk show host Jack Stockwell, which began just moments after the first hijacked plane crashed into the Trade Center tower, LaRouche predicted that there would be a media-led stampede to blame the irregular warfare assault on Osama bin Laden—even though it was transparently clear that bin Laden could not have carried out such a sophisticated military-precision attack. LaRouche never ruled out that assets from the Afghansi mujahideen apparatus were employed in the Sept. 11 attacks. He insisted that the control over the attacks—and