The Cure to

"The Sorry State of American Health"

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January 1, 2009

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Executive Summary: The Cure to "The Sorry State of American Health"

The title quoted above, from the cover story of the December 1, 2008 issue of *Time*, says it all: our nation's health care system is not meeting the needs of its citizens.

The key questions confronting health care policy decision makers at the outset of the Obama administration are: What are the challenges presented by our health care system, as currently structured? What cost- and outcome-effective health care options can widen the bandwidth of available services for the general population? How do we overcome the obstacles to the incorporation of those services into the existing system?

The structure of the health care system that services our Nation today is the result of the collective decisions made by our predecessors in this society over the last four generations. Unfortunately, for a variety of reasons, the system that has evolved over this period of time is, for a large and increasing number of American citizens, now seen as part of the problem, from the standpoint of both the bandwidth of services available and the outcome of those services.

The American health care system is currently beset by a daunting series of challenges, relating to both the current and projected costs of our health care system, and the inadequate outcomes obtained from that system. If left unaddressed, these challenges both present a direct threat to the long term adequacy of the currently approved proposals, and threaten the long term fiscal stability of our economic system.

Additionally, several significant systemic factors inhibit our ability to effectively implement meaningful changes, and must be overcome before these changes can be successfully applied.

They are: 1.) the monetization of scientific research; 2.) medical education system shortfalls; 3.) FDA bias/conflicts of interest; 4.) the impediment of state level regulation; 5.) rejection of complementary and alternative health care by the health care insurance industry; and 6.) public health education deficiencies.

The confluence of circumstances in the health care arena present the Obama-Biden administration with an unprecedented opportunity to not simply reform our current system, but transform it into a model for the entire planet. A more fully integrative approach, emphasizing the best aspects of both conventional medicine and holistic health, holds the bright promise of creating a health care system which is truly accessible and affordable for all.

To create a truly world class health care system in the United States, and address our pressing health care needs, we recommend a series of bold actions be taken ASAP by the Obama administration to both widen the bandwidth of access to cost- and outcome-effective health care service options for the American people and overcome the systemic obstacles to implementation of these actions.

Preface

The eyes of the world are once again upon this nation. The beacon of hope for true and lasting change is held in the promise of the new man the People have chosen to lead us into the future.

Zig Ziglar once said: "If standard of living is your major objective, quality of life almost never improves, but if quality of life is your number one objective, your standard of living almost always improves."

There is nothing that defines the quality of human life more than one's state of health. Not power, or fortune, or possessions, neither social position nor security against foreign enemies. None of these aspects of life can be fully achieved, much less enjoyed, without health.

In contrast to the widespread public perception of our health care system as a world leader in quality, the World Health Organization has ranked the US #72 on "Level of Health" (between Argentina-71 and Bhutan-73) and #37 (between Costa Rica-36 and Slovenia-38) on "Overall Health System Performance"[i].

For the first time in history, this government has the opportunity to set a precedent and create a transformative model for true health care, not just a more efficient way of financing and delivering disease management. President-elect Obama is quoted as saying:

"When you see what the health care crisis is doing to our families, to our economy, to our country, you realize that caution is what's costly. Inaction is what's risky. Doing nothing is what's impossible when it comes to health care in America. It's time to act. This isn't a problem of money, this is a problem of will.

"We have to ask what we can do to provide more Americans with preventative care, which would mean fewer doctor's visits and less cost down the road."

The following document lays out a comprehensive strategy, a vision of a true health care system that provides quality of life for every American, young and old, rich or poor.

"America can no longer afford inaction. That's not who we are - and that's not the story of our nation's improbable progress." - Barack Obama.

The Cure to "The Sorry State of American Health"

The cover story of the December 1, 2008 issue of *Time* says it all: our nation's health care system is not meeting the needs of its citizens.

The key questions confronting health care policy decision makers at the outset of the Obama administration are:

- What are the challenges presented by our health care system, as currently structured?

- What cost- and outcome-effective health care options can widen the bandwidth of available services for the general population?

- How do we overcome the obstacles to incorporation of these services into the existing system?

Background

The structure of the health care system that services our Nation today is the result of the collective decisions made by our predecessors in this society over the last four generations. Unfortunately, for a variety of reasons, the system that has evolved over this period of time is, for a large and increasing number of American citizens, now seen as part of the problem, from the standpoint of both the bandwidth of services available and the outcome of those services.

If the status quo remains, we now know that by the year 2017 one out of every five dollars of our gross domestic product will be spent on health care. The Congressional Research Service has identified health care spending as the single greatest threat to our nation's long term economic well being.

The health care web page on the Obama-Biden Transition web site states that the proposed health care plan "ensures patient choice of doctor and care without government interference. . . The Obama-Biden plan will promote public health. It will require coverage of preventive services. . ."

However, the confluence of circumstances in the health care arena present the Obama-Biden administration with an unprecedented opportunity to not simply reform our current system, but transform it into a model for the entire planet. A more fully integrative approach, emphasizing the best aspects of both conventional medicine and holistic health, holds the bright promise of creating a health care system which is truly accessible and affordable for all.

Challenges Presented By the Current System

The American health care system is currently beset by a daunting series of challenges, relating to both the current and projected costs of our health care system, and the outcomes obtained from that system. If left unaddressed, these challenges present a direct threat to the long term adequacy of the currently approved proposals:

Cost - "The United States spent a per capita average of $2,668 on outpatient care in 2004 — **three-and-a-half times the OECD average**."[ii]

Cost - According to a Harvard University study, **medical bills are now the leading cause of personal bankruptcy in the US**.[iii]

Cost - "**A couple retiring this year will need about $225,000 in savings to cover medical costs in retirement**, according to a [recent] study released. . . by Fidelity Investments. The figure, calculated for a couple age 65, is up 4.7% from the $215,000 estimate for 2007. . ."[iv]

Cost - "Over the next few decades, the nation's fiscal outlook will be shaped largely by demographics and health care costs. As the baby boom generation retires, federal spending on retirement and health programs such as Social Security, Medicare, and Medicaid will grow dramatically. A range of other federal fiscal commitments, some explicit and some representing implicit public expectations, also bind the nation's fiscal future. Absent policy change, **a growing imbalance between expected federal spending and tax revenues will mean escalating and ultimately unsustainable federal deficits and debt**."[v]

Cost - "**GAO's simulations lead to an overarching conclusion: current fiscal policy is unsustainable over the long term**. Absent reform of federal retirement and health programs for the elderly--including Social Security, Medicare, and Medicaid--federal budgetary flexibility will become increasingly constrained. Assuming no changes to projected benefits or revenues, spending on these entitlements will drive increasingly large, persistent, and ultimately unsustainable federal deficits and debt as the baby boom generation retires."[vi]

Outcome- "The paradox is that **the costliest health system in the world performs so poorly**. We waste one-third of every health care dollar on insurance bureaucracy and profits while two million people go bankrupt annually and we leave 45 million

uninsured" - Dr. Quentin Young, national coordinator of Physicians for a National Health Program.

Outcome - "**The United States has below-average life expectancy and mortality rates**. The United States has the third-highest rate of deaths from medical errors" among OECD countries reporting.[vii]

Outcome - "In 2004, **the 10 leading causes of death** were (in rank order) Diseases of heart; Malignant neoplasms; Cerebrovascular diseases; Chronic lower respiratory diseases; Accidents (unintentional injuries); Diabetes mellitus; Alzheimer's disease; Influenza and pneumonia; Nephritis, nephrotic syndrome and nephrosis; and Septicemia."[viii] Many studies have concluded that **eight out of the preceding ten could be substantially prevented through diet and lifestyle intervention**.

Outcome - Among Americans age 20 and older, **142.0 million are overweight or obese**.[ix] 23.6 million people—7.8 percent of the population—have diabetes.[x] The total direct and indirect annual cost of diabetes management efforts in the US is $174 billion. Nearly 87 percent of adults 40 years and older are either at risk for type 2 diabetes or heart disease (61.1 %) or have been diagnosed with one of these diseases (25.8%).[xi] **This presages a veritable explosion in the numbers of citizens diagnosed with diabetes in the future.**

Outcome - A study published in the December 2005 Journal of the American College of Nutrition examined Department of Agriculture records from 1950 through 1999 to determine changes in the nutrient status of the US Produce supply. The study found that, depending on the type of produce and nutrient examined, **the nutrient value of our food supply has declined from between 6% and 38%**[xii]. The authors conclude this has occurred due to the overuse of available farmland, and growing techniques more suited to mass marketing than to producing truly healthy food.

Outcome - According to a 2006 survey commissioned by the Council for Responsible Nutrition (CRN)[xiii], nearly six Americans in 10 (58 percent) acknowledge that they do not eat a balanced diet on a regular basis. Although 81 percent of those asked said that eating a balanced diet was important, **only 20 percent say they eat a balanced diet every day**.

Outcome – According to the 2007 survey "Stress in America," conducted by the American Psychological Association (APA), Americans are living in "A National Pressure Cooker[xiv]." Nearly half the respondents reported that stress has a negative impact on their emotional well-being (49 percent) and physical health (46 percent). Three-quarters (77 percent) experienced physical symptoms during the month prior to the survey as a result of stress. Nearly as many (73 percent) experienced psychological symptoms in the previous month. The American Institute of Stress estimates that stress-related ailments cost companies about $300 billion a year in increased absenteeism, tardiness, reduced productivity, and the loss of talented workers. The APA has concluded that "extended reactions to stress can alter the body's immune system in ways

that are associated with. . . conditions such as frailty, functional decline, cardiovascular disease, osteoporosis, inflammatory arthritis, type 2 diabetes, and certain cancers[xv]." **The combination of our society's dietary influences, lifestyle factors, social conditioning, and toxic influences has imposed a cumulative stress load so great that millions of our citizens are teetering on the brink of ill health, overwhelming our health care system's ability to meaningfully respond.**

Outcome – It has been estimated that, as a species, **mankind has been exposed to more new chemical influences in the last fifty years than in its entire prior histor**y. The US Environmental Protection Agency reports that our society has created over 500,000 toxic chemicals which require special safety handling. This number increases by approximately 5,000 annually. At the same time, emerging research has disclosed that the swarm of electronic devices our society surrounds itself with has a definite and detrimental impact on our collective state of health[xvi]. Despite this, **our health care system devotes almost no resources to developing and implementing preventive health strategies to deal with these dangerous and pervasive problems**.

These data, and much more like them, confront our nation and its leaders with an unpleasant reality: **we no longer have a health care system in this country, but a disease management system, increasingly driven by the financial interests of the medical/pharmaceutical/insurance complex and processed food industry.** Absent change, the consensus among government and independent health care experts is that the size and estimated fiscal demands of the Baby Boomer population cohort will overwhelm the ability of our current health care and financial systems to meet the needs of our citizens.

"Increasingly, there is clear evidence that the major chronic conditions that account for so much of the morbidity and mortality in the United States, and the enormous direct and indirect costs associated with them, in large part are preventable - and that to a considerable degree they stem from, and are exacerbated by, individual behaviors ... As Americans see healthcare expenditures continue to increase, **it is important to focus on strategies that reduce the prevalence and cost of preventable disease**." - U.S. Dept. of Health and Human Services - *Prevention Makes Common Cents*

Complementary and Alternative Health Care: Widening the Bandwidth of Available Options - A Solution Already Embraced By the American Public

While we pay due respect to the scientific advances which have revolutionized conventional medicine over the last several decades, we know that the recent revelations about its significant limitations also deserve our collective close attention. Simply put, **our society now knows that we cannot merely prescribe our way to good health.**

At the same time, it is apparent that **an ever increasing body of holistic health knowledge exists which predates and, in many respects, transcends the framework of conventional medicine**. This body of knowledge, combined with those of other

peoples around the planet, **holds tremendous value in terms of their collective ability to improve the health of America's citizens.**

As the cost of conventional medical care continues to soar, these time-proven therapies and modalities hold the promise of transforming our health care system, its effect on our economy, and our society at large.

The 2002 White House Commission on Complementary and Alternative Medicine (CAM) Policy has explicitly stated: ***"Each person has the right to choose freely among safe and effective care or approaches, as well as among qualified practitioners who are accountable for their claims and actions and responsive to the person's needs."*** (Emphasis added.)

The Commission further states *"The input of informed consumers and other members of the public must be incorporated in setting priorities for health care and health care research and in reaching policy decisions, including those related to CAM, within the public and private sectors."* (Emphasis added.)

"**I can't think of any major city where these kinds of services are not offered now.** In some states or geographic areas it may be more difficult to find, but it's not absent. There are small and single practices everywhere, as well as major institutions like the Cleveland Clinic or the Mayo Clinic. **The demand has been almost entirely consumer driven.**"
- Kenneth R. Pelletier, PhD, MD, Clinical Professor of Medicine at the University of Maryland School of Medicine (UMMC) and the University of Arizona School of Medicine, a medical and business consultant to the U.S. Department of Health and Human Services, the World Health Organization (WHO), the Washington Business Group on Health, and numerous major corporations.

The last survey article on complementary and alternative health care in the *Journal of the American Medical Association*[xvii] recognized that **complementary and alternative health care is the fastest growing segment of the health care industry**, with over 83 million Americans spending over $34 billion[xviii] on CAM annually. It should be noted that the majority of consumer spending on complementary and alternative healthcare is out-of-pocket. Despite this, **the number of visits to complementary and alternative health care practitioners in 2002 exceeded those to primary care physicians by over 200 million**.

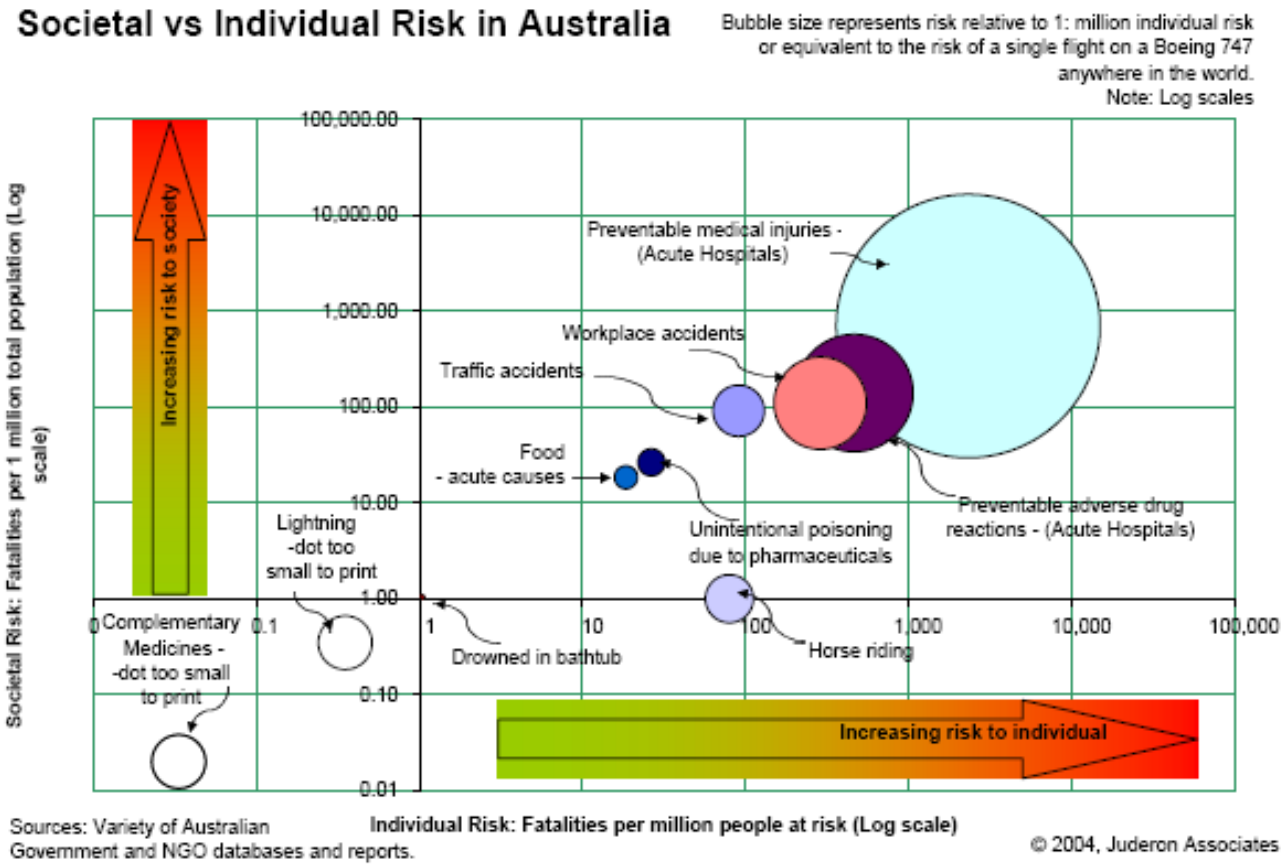
This rapidly growing embrace of complementary and alternative health care has coincided with a veritable explosion of the population of such practitioners in every state in the nation. The vast majority of these practitioners are not licensed by the states in which they reside.

This, in turn, has caused the conventional health care professions to sound the alarm, on the basis of safety, as to the lack of professional qualifications of these practitioners. Their concerns are unfounded.

Although the Food and Drug Administration steadfastly refuses to conduct similar studies in this country, risk management assessments in other Western countries have yielded the results in Figures 1 and 2 below.

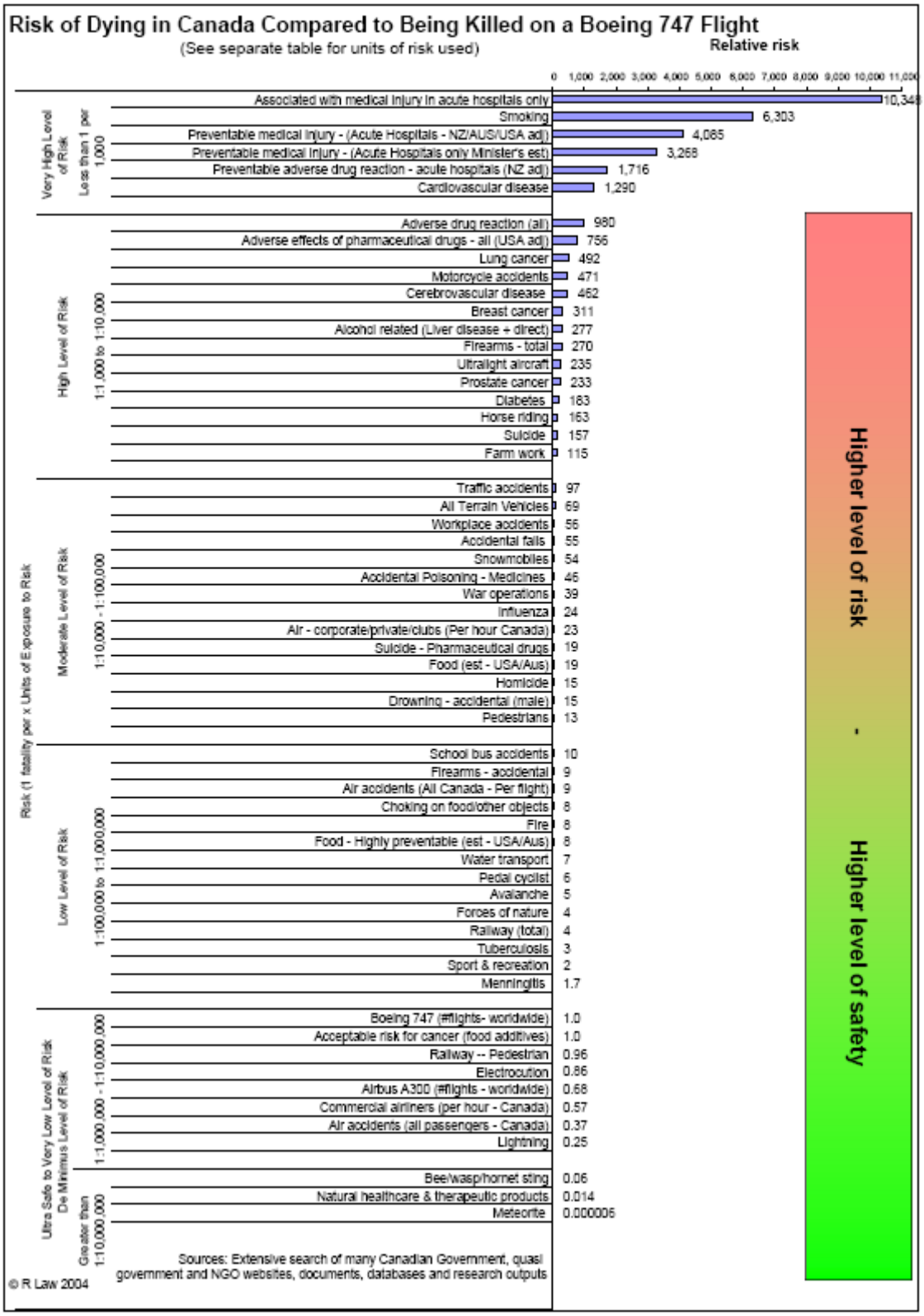
Figure 1, published in Australia, is a logarithmic scale depiction of the risks of various human activities relative to the 1 in a million odds of dying in a crash on a single flight of a Boeing 747 anywhere in the world. The larger the circle depicted, and the closer to the upper right corner of the chart, the greater the risk in relation to the datum event. Figure 2, published in Canada, depicts the same type of information using the same risk datum point (i.e., a single Boeing 747 flight), only in bar chart form.

Figure 1.



In other words, ***a person is significantly less likely to die from administration of complementary and alternative medicines than from a lightning strike.***

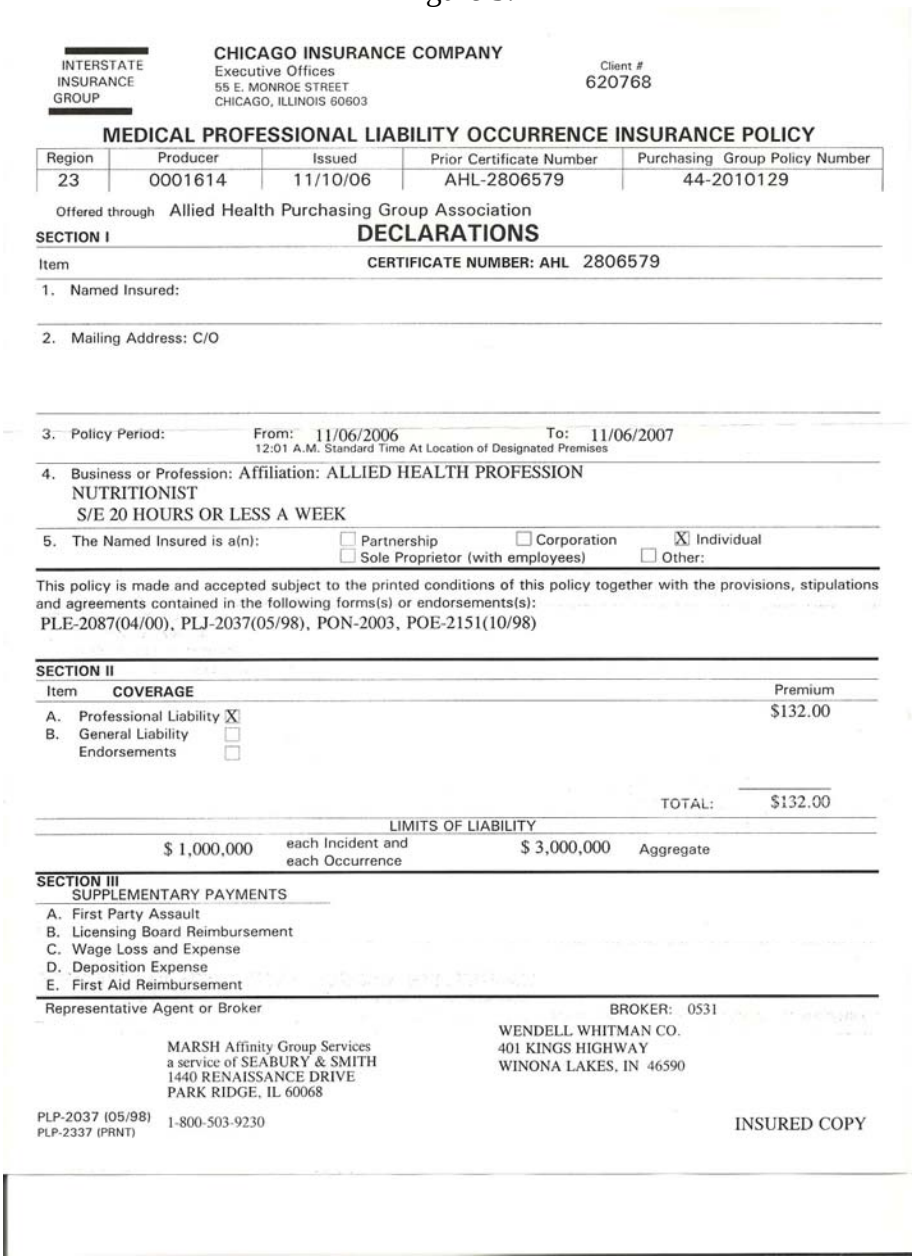
Figure 2.



In other words, ***the only thing that is less likely to cause death from natural healthcare and therapeutic products is being struck by a meteorite.***

For those who insist that US-generated data is the only acceptable metric of safety, the US insurance industry has already weighed in on the side of safety of complementary and alternative health care. As Figure 3 below clearly shows, and in contrast to the sometimes six figure premiums conventional health care practitioners must pay for malpractice insurance, a part time nutritionist can obtain significant lifetime liability insurance coverage for a small fraction of the annual cost conventional health care practitioners are assessed.

Figure 3.



INTERSTATE INSURANCE GROUP

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Client # 620768

MEDICAL PROFESSIONAL LIABILITY OCCURRENCE INSURANCE POLICY

Region	Producer	Issued	Prior Certificate Number	Purchasing Group Policy Number
23	0001614	11/10/06	AHL-2806579	44-2010129

Offered through Allied Health Purchasing Group Association

SECTION I **DECLARATIONS**

Item **CERTIFICATE NUMBER: AHL** 2806579

1. Named Insured:

2. Mailing Address: C/O

3. Policy Period: From: 11/06/2006 To: 11/06/2007
12:01 A.M. Standard Time At Location of Designated Premises

4. Business or Profession: Affiliation: ALLIED HEALTH PROFESSION
NUTRITIONIST
S/E 20 HOURS OR LESS A WEEK

5. The Named Insured is a(n): ☐ Partnership ☐ Corporation ☒ Individual ☐ Sole Proprietor (with employees) ☐ Other:

This policy is made and accepted subject to the printed conditions of this policy together with the provisions, stipulations and agreements contained in the following forms(s) or endorsements(s):
PLE-2087(04/00), PLJ-2037(05/98), PON-2003, POE-2151(10/98)

SECTION II

Item	COVERAGE	Premium
A.	Professional Liability X	$132.00
B.	General Liability ☐	
	Endorsements ☐	
	TOTAL:	$132.00

LIMITS OF LIABILITY

$ 1,000,000 each Incident and each Occurrence $ 3,000,000 Aggregate

SECTION III
SUPPLEMENTARY PAYMENTS
A. First Party Assault
B. Licensing Board Reimbursement
C. Wage Loss and Expense
D. Deposition Expense
E. First Aid Reimbursement

Representative Agent or Broker BROKER: 0531

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PARK RIDGE, IL 60068

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Critics of complementary and alternative health care also cite the current lack of meaningful interface between conventional medicine and the complementary and alternative health care community as an insurmountable obstacle to integration with conventional health care. However, several states have already begun this integration process.

The states of California (SB 577), Florida (Governor's Proclamation), Idaho (Title 54), Louisiana (Act No. 334), Minnesota (Law 146A), Oklahoma (Law 59-480), and Rhode Island (Law 23-74-1) have all taken various forms of legislative or executive branch action to allow better accessibility to and public visibility of complementary and alternative health care in their respective states. **An innovative concept in this arena involves the enactment of a legal "safe harbor" for complementary and alternative health care providers** which exempts them from the requirements of the medical practice acts in those states, provided they avoid prohibited conduct spelled out by state governments and offer professional disclosures helpful to the consumer**.** In the state of Minnesota, the first to enact such "safe harbor" legislation, there were only 84 complaints in the first seven years after its law was enacted, and less than half of those complaints were actionable. There was so little investigation and enforcement activity during the first four years that the governor of Minnesota tried to eliminate the appropriation for the office governing alternative practice in order to save the state money. His efforts were unsuccessful, but the state's record provides evidence that allowing these modalities to be practiced in the open does not present a threat to public safety. Advocacy groups in several other states are also pursuing enactment of such legislation.

Another legislative alternative which permits greater public visibility of and accessibility to complementary and alternative health care is state-level enactment of so-called **"title acts." These acts clearly define what education, training and certification requirements permit the use of specific titles for complementary and alternative health care practitioners.** Examples of these include enacted bills in California, Idaho and Minnesota, which both allow for exclusive use of titles for some practitioners but include exemptions for other practitioners to protect their right to practice in the public domain.

Such title acts, acting in concert with the previously cited "safe harbor" legislation, can serve as a bridge to permit forward looking insurance carriers to simultaneously offer coverage of such services while insulating themselves against increased liability. However, they stop short of the state-mandated restrictions imposed by traditional exclusionary licensure or registration acts. In doing so, they present a practical, middle-ground solution to the problem surfaced by the White House CAM Commission regarding the conflicting outcomes of licensure: **"For many CAM providers, licensure presents a tension between the desire to increase standardization of CAM education, training, and practices across states and the desire to keep CAM practice flexible, non-standardized, and linked to subjective, interpersonal and intuitive aspects of care."**

There is potential for huge systemic health care cost savings by embracing complementary and alternative health care as an integral part of our health care system. For example, the final report of a 2006 Lewin Group study, commissioned by the Dietary Supplement Education Alliance (DSEA), shows that over the period 2008-2012, **appropriate use of select dietary supplements would improve the health of key populations and save the nation more than $24 billion in healthcare cost avoidance**[xix].

To cite just one example from this study, appropriate use of calcium with vitamin D for the Medicare population shows potential avoidance of approximately 776,000 hospitalizations for hip fractures over five years, as well as avoidance of stays in skilled nursing facilities for some proportion of patients. The five-year (2008-2012) estimated net cost associated with avoidable hospitalization for hip fracture is approximately $16.1 billion.

This study examined only four nutrients; existing data indicates that much larger savings could potentially accrue by large scale employment of natural products as an adjunct to conventional medicine.

Additionally, a recent pilot study, conducted by a major state level health care insurance carrier[xx], employed complementary and alternative practitioners (chiropractors) as primary care providers for a large test group. **Medical insurance claims from the group dropped by 50% over two years, and in excess of 70% over the remainder of the study**. Also, "clinical and cost utilization based on 70,274 member-months over a 7-year period demonstrated decreases of 60.2% in-hospital admissions, 59.0% hospital days, 62.0% outpatient surgeries and procedures, and 85% pharmaceutical costs when compared with conventional medicine IPA performance for the same health maintenance organization product in the same geography and time frame[xxi]."

Finally, although the medical/pharmaceutical/insurance complex continues to assert that complementary and alternative health care is of limited utility and not cost effective, the American consumer maintains that it is a good value for the health care dollars expended.[xxii]

These are all indications of the growing recognition and acceptance by the American public, and a growing segment of the health care industry, that conventional medical modalities are but one aspect of total health and wellness care. As the cost of conventional medical treatment continues to soar, the American public is clamoring for less costly solutions that increasingly do *not* involve drugs.

Given the huge projected cost increases associated with maintenance of the status quo, it is not an understatement to assert that **large scale incorporation of complementary and alternative health care at the primary (wellness and prevention) level holds the potential to take full advantage of a vast, untapped resource of wellness expertise that can exert a transformative effect on how health care is delivered in the United States.**

At the same time, **it offers our government and the citizens it serves an opportunity to directly combat *the* most direct threat to our future economic well being: unrestrained cost growth in our current health care system.**

The American people already understand this situation, and its impact on both their health and financial well being. In millions of cases, and with the help of a veritable army of competent, well trained complementary and alternative health care practitioners, they are taking the care of their health, and that of their families, back into their own hands, as they find the solutions offered by the conventional health care system to be ineffective, from both an outcome and cost standpoint.

Given this growing clamor for change, the incoming Obama administration would be well advised to adopt bold measures to more aggressively contain costs, while delivering more effective and safe treatment options, such as those above, to the public.

Obstacles to Change

Unfortunately, several significant systemic factors inhibit our nation's ability to effectively implement such changes, and must be overcome before they can be applied:

Monetization of scientific research. From sources as diverse as JAMA[xxiii], Discover magazine[xxiv], and the Life Extension Foundation[xxv], the alarm is being sounded concerning the inappropriate influence of "advocacy science," i.e., science pursued strictly to advance financial gain. **In 1965, 60% of US scientific research was conducted in government laboratories. By 2006, 65% was conducted by private companies**[xxvi].

The primary impetus to this change was enactment of the 1980 University and Small Business Patent Procedures Act (P.L. 96-517, Patent and Trademark Act Amendments of 1980) otherwise known as the Bayh-Dole Act. By lifting the restrictions on researchers owning and profiting from their discoveries, it was hoped that the resulting greater and more varied research would stimulate wider advances in every field of science.

Although that has indeed occurred, **an unintended byproduct has been the development of a culture of "science for sale."** Now, in virtually every field of science, health care included, research consultants can parlay the "halo effect" of their advanced academic credentials to lend credence to their corporate sponsors' claims concerning their proffered products and services.

Conversely, these same consultants can be employed to structure research which questions the effectiveness of a competitor's products and services. This is a prevalent use of "advocacy science" in the health care system, especially by pharmaceutical companies who wish to discredit a particular natural product or service.

Finally, **there exist no uniform standards, inside the government or out, to require disclosure of the financial ties between a health care researcher and the company underwriting his/her research**. Numerous examples exist of studies published in peer-reviewed journals where this information was deliberately omitted. The scale of this problem was the genesis of the critical JAMA article "The Influence of Money on Medical Science," written by the JAMA managing editor (see note xxi. in End Notes).

Medical education system shortfalls. While the US medical education system is generally recognized as among the best in the world, it is lacking in the areas of mandatory education of new physicians in complementary and alternative health care and nutrition. A 2007 survey of the mandatory curricula of the nation's top 25 medical schools, as rated in 2006 by US News and World Report, disclosed the following:

MANDATORY NUTRITION AND CAM TRAINING AT TOP US MEDICAL SCHOOLS

MEDICAL SCHOOL	NUTRITION TRAINING*	CAM TRAINING*
1. Harvard University (MA)	2 Semester Hours	None Listed
2. Johns Hopkins University (MD)	None Listed	None Listed
3. University of Pennsylvania	One four week combined course	None Listed
4. University of California–San Francisco	One combined course	One combined course
4. Washington University in St. Louis (MO)	One week combined course	None Listed
6. Duke University (NC)	None Listed	None Listed
7. Stanford University (CA)	None Listed	None Listed
7. University of Washington	One two week course	None Listed
9. Yale University (CT)	None Listed	None Listed
10. Baylor College of Medicine (TX)	One six week combined course	None Listed
11. Columbia U. College of Physicians and Surgeons (NY)	Award winning 4 year program	None Listed
11. University of California–Los Angeles (Geffen)	One combined course	None Listed
11. University of Michigan–Ann Arbor	None Listed	None Listed
14. University of California–San Diego	One combined course	None Listed
15. Cornell University (Weill) (NY)	5 clock hours	3 clock hours
16. University of Pittsburgh	8 clock hours	2 clock hours
17. University of Chicago (Pritzker)	20 clock hours	None Listed
17. Vanderbilt University (TN)	None Listed	None Listed
19. U. of Texas Southwestern Medical Center–Dallas	None Listed	None Listed
20. Northwestern University (Feinberg)	One combined course	8 clock hours

(IL)		(est.)
20. University of North Carolina–Chapel Hill	One combined course	None Listed
22. Case Western Reserve University (OH)	12 week course	None Listed
22. Mayo Medical School (MN)	None Listed	None Listed
22. University of Alabama–Birmingham	50 clock hour course	None Listed
25. University of Virginia	None Listed	None Listed
UT Health Sciences Center – San Antonio	One conference	None Listed
UT Health Sciences Center - Houston	None Listed	None Listed

*The term "combined course" indicates that the nutrition and/or complementary care training was combined with another subject area, e.g., nutrition with gastroenterology. No subject-specific breakout of the course content was offered in the curricula. Sources: online course catalogs for each school listed.

The data reveal that **only 8% of these schools offer *any* training in complementary care, and less than one third offer meaningful training in nutrition** (i.e., information over and above that offered to the general public).

The practical result of this lack of education is reflected in the November 1998 article "Battling Quackery" from the Archives of Internal Medicine. Referring to sources of the medical establishment's skeptical attitude toward micronutrient supplementation, the authors cite "uncritical acceptance of news of toxicity. . . the angry, scornful tone used in discussions of micronutrient supplementation in the leading textbooks of medicine; and by ignoring evidence for possible efficacy of a micronutrient supplement. . ."[xxvii] Small wonder that the medical community continues to display a skeptical collective attitude toward complementary and alternative health care.

FDA bias/conflict of interest. In the early 1970s, the maverick US Senator William Proxmire (D – WI) exposed the "revolving door," and its resultant ethical conflicts, which then existed between the Defense Department and the defense/aerospace industry. His efforts spurred defense personnel and acquisition reforms that remain effective to this day.

In contrast, no such legal firewalls exist between the FDA and the medical/pharmaceutical/insurance complex. **The vast majority of FDA decision makers have either worked for drug companies in the past or are likely to work for drug companies in the future.**

Many of these decision makers hold significant financial positions with companies over whose products they exercise approval authority[xxviii]. As the recent series of spectacular revelations about the adverse side effects of new drugs graphically portrays, it is an obvious and potentially deadly conflict of interest. Although the FDA has recently instituted some reforms, the fact remains that **a researcher can still sit on an approval panel for a drug in which he has up to a $50,000 personal financial interest. These restrictions may be waived at the discretion of senior FDA decision makers.**

This same problem of split allegiance also affects FDA decision maker attitudes concerning complementary and alternative health care. **As a result of their collective background, generated in large part by the medical education system referenced above, the institutional bias of FDA decision makers runs very deep**. Rather than allow an unbiased, head-to-head comparison of pharmaceutical and complementary medicine, the FDA permits researchers employed by drug companies to publish studies with known design flaws, so long as they are able to either advance the interests of a pharmaceutical company or disparage a competitor in the field of complementary and alternative health care[xxix]. A compelling case can be made that this institutional bias within the FDA is intensified due to the additional influence of personal financial interests.

As a result, the FDA, with the help of its advocates in the pharmaceutical industry, has been able to use the scientific method to unfairly and inaccurately disparage complementary and alternative health care, to the detriment of both the government and the general public[xxx]. The revelations of **numerous instances of data and study parameter manipulation, and the repeated attempts at FDA rule making to restrict public access to complementary and alternative health care**, point to a concerted effort on the part of FDA decision makers to effectively eliminate complementary and alternative health care as a meaningful component of the US health care system. This attitude is most clearly displayed by the FDA delegation to the Codex Alimentarius Commission, where FDA representatives consistently advocate an unabashed pro-pharmaceutical industry position.

The impediment of state level regulation. Since every state has the authority to manage and regulate the actions of its health care practitioners, the focus of attention of many health care professional organizations (i.e., the AMA, the American Dietetic Association, the American Massage Therapy Association, the American Association of Naturopathic Physicians, and their state level affiliates) has increasingly shifted to the state level. **Passage of exclusionary licensing laws at the state level has proven to be an effective tool for these organizations to effectively shut out their unlicensed complementary and alternative health care competition.**

Relying on the mantra of "protect the public," and preying on the concerns of largely uninformed legislators, they have achieved mixed success. For example, the American Dietetic Association now has exclusionary licensure over the practice of dietetics and nutrition in 30 states; practicing nutritional counseling without a license in these states is now a crime punishable, in some cases, by arrest, imprisonment and heavy fines.

In contrast, **the stated rationale for licensing, "to protect the public," has proven to be a chimera.** For example, the most heavily licensed profession in our health care system, physician, generates tens of thousands of unintended deaths per year[xxxi]. In contrast, advocates of exclusionary licensing must hunt for isolated instances of harm on the part of unlicensed complementary and alternative practitioners, and inaccurately portray them as the norm, to attempt to justify their position. Recent information also

clearly demonstrates that these **efforts at licensing proliferation would result in an increasing burden for cash-strapped state governments**[xxxii].

In reality, the motive for all these efforts is largely financial, i.e., to advance the economic interests of these groups at the expense of their competition. For example, the American Dietetic Association's web site lists numerous corporate sponsors among the processed food industry as contributing significant financial support to the ADA[xxxiii]. It is not surprising, therefore, that its dietary guideline recommendations substantially reflect the financial interests of its corporate benefactors.

Rejection of complementary and alternative health care by the health care insurance industry. Although the health care insurance industry generally touts the inclusion of complementary and alternative health care as a covered treatment in most health care insurance plans, the fine print reveals that these treatment modalities (typically, only acupuncture, chiropractic and massage) are much less accessible within those plans than is conventional medical care.

Two overriding considerations impact this situation. First, when pressed to more widely implement the previously mentioned insurance carrier-sponsored pilot study on using CAM practitioners as primary care providers, the carrier declined, citing the lost revenue from decreased medical services utilization, and the resulting need to lower their premiums, as the reasons. *In other words,* ***the insurance industry makes more money from disease management than from preventive services.***

Second, in evaluating the cost and treatment effectiveness of complementary and alternative health care, **the industry uses essentially the same criteria (and biases) as the FDA (see above), essentially shutting out most complementary and alternative health care from their menu of covered services. This deprives the American business community from access to the full spectrum of effective wellness and preventive health care services.** For example, although between 70% and 90% of corporate employee hospital visits are for stress-related ailments,[xxxiv] virtually no insurance-related resources are made available to the insured to combat this major contributing factor to poor health.

Public health education deficiencies. Because of the previously cited factors, public education concerning the cost and treatment effectiveness of complementary and alternative health care is very limited, and of limited effectiveness.

This is especially true of childhood health education. Combined with the overlay of corporate influence on our nation's dietary guidelines, it is not surprising that we face the childhood obesity challenges we do, with little useful dietary information offered to counter this growing trend.

Additionally, despite the veritable explosion of available information on the Internet concerning complementary and alternative health care, the general public has been socially conditioned to only seek medical advice at the stage of disease management, and to ignore information that may prevent disease altogether.

A recent study published in JAMA reveals that **editors working for the mainstream media (MSM) routinely fail to report that pharmaceutical companies fund the health care studies they're writing about.** This study shows strong media bias in favor of simply trusting the conclusions of studies funded by drug companies rather than asking intelligent, skeptical questions about them. It is an open question what influence, if any, the prevalence of drug advertising in a given media organ has on editorial decision making in this arena.

Creating A World Class Health Care System - Recommendations

In order to create a truly world class health care system in the United States, we recommend the following actions be implemented ASAP by the Obama administration:

1.) **Goal: Clearly define for the public the correlation between consumption of certain foods, and the relation of lifestyle factors, to the incidence of the leading causes of death in this country.**

Recommendation: Re-craft the nation's dietary and lifestyle guidelines, independent of the influence of Big Food and Big Pharma. Convene a panel of leading independent health care experts, with substantial emphasis on the field of complementary and alternative health care, to report to the Secretaries of Health and Human Services and Agriculture their results and recommendations for action.

2.) **Goal: Provide incentives for farmers to more strategically employ farmland and fully fertilize their crops so that the nutrient shortfalls previously identified are closed, thereby not only improving dietary nutrient values but also reducing healthcare costs as a result of improving Americans' diets.**

Recommendation: Convene a Department of Agriculture commission to create a set of tasks to accomplish this goal, and provide the Secretary of Agriculture a report, with recommendations on how to implement them.

3.) **Goal: Create incentives for cities and states to make complementary and alternative health care services more visible, accessible and affordable to the average citizen, thus helping to reduce the city and state health care cost burden.**

Recommendation: This may include, but not be limited to, making federal funding assistance for state health care programs contingent upon the passage of "safe harbor" and/or title legislation to increase the visibility and accessibility of complementary and alternative practitioners, and rescinding of state laws which limit current access and drive up costs. Examples of such restrictive laws include:

a. Exclusionary licensing laws that confer sole ownership of a field of complementary and alternative health care to a single community;

b. Laws which prohibit or restrict currently licensed health care professionals from practicing complementary and alternative medicine;

c. Laws which bar complementary and alternative health care professions from meaningful participation in state health policy decisions.

4.) **Goal: Separate the definitional framework of drugs, and complementary and alternative health care products and foods.**

Recommendation: Revise the Food, Drug and Cosmetics Act to separately define the category of synthetic chemicals with therapeutic or curative properties, and intended for prescription use only, as drugs, and all natural substances, regardless of their therapeutic or curative properties, as foods or dietary supplements.

5.) **Goal: Broaden public access to information regarding health claims for foods and natural products, allowing American consumers to make more intelligent and informed choices about their consumption of foods and natural products.**

Recommendation: Further revise the Food, Drug and Cosmetics Act to allow a broader definition of health care claims to be applied to natural products made generally available to the public. A suggested starting point would be the language contained in Rep. Ron Paul's HR 2117.

6.) **Goal: Better synchronize the actions of public officials in the international arena with the overall objectives of our health care system.**

Recommendation: Require FDA officials to use the broader definitions recommended above as a national position in the ongoing CODEX negotiations.

7.) **Goal: Develop a national strategy for effective stress management in our society, providing both improved health and reduced healthcare costs.**

Recommendation: Convene a panel of experts, with substantial emphasis on the field of complementary and alternative health care, to create a set of guidelines and develop a comprehensive strategy for managing all aspects of the major categories of stress in our society. The panel should also include expertise from the arenas of public health, environmental health and quality, and labor, to provide maximum cross-disciplinary input for creating usable solutions. The panel will present its results to the Secretaries of Health and Human Services and Labor, and the Director of the Environmental Protection Agency, with recommendations for immediate implementation.

8.) **Goal: Develop a national strategy for dealing with toxic exposure in our society.**

Recommendation: Create a task force, composed of leading experts in the complementary and alternative health care, environmental quality, occupational health and safety, and labor communities to craft a comprehensive strategy for dealing with the chemical, biological, radiological and electronic threats to public health. The strategy should include identification of specific threats, identification of professional communities and resources best suited to counter the threats, and creation of a public education strategy to bring the threats and resources to the American public's attention. Responsibility for implementation should be divided among the appropriate executive branch agencies. The task force should present its report to the Secretaries of Health and Human Services and Labor, and the Director of the Environmental Protection Agency, for immediate implementation

7.) **Goal: Better educate families on self help measures they can take to improve the health of all family members.**

Recommendation: Create new incentives for states to develop health care education programs which more heavily emphasize the value of complementary and alternative health care in this context.

8.) **Goal: Correct the systemic abuses created by the unintended effects of P.L. 96-517 by enacting into law a new set of financial disclosure requirements, with substantial criminal and financial penalties for non-compliance, governing the publishing of scientific research.**

Recommendation: Specifically, require full disclosure of a study author's financial connections to a research topic before such research can be used as a basis for establishing a federally approved health claim for a drug, food or natural product. Require the FDA to include this financial disclosure information in all public statements concerning such research, and also apply the above mentioned penalties for non-compliance to the conduct of FDA employees.

9.) **Goal: Strengthen FDA conflict of interest guidelines.**

Recommendation: Enact a set of laws that mirror those currently in effect in other segments of the federal executive branch to protect the government and the public against the influence of conflicts of interest within the FDA. The laws should specify strict new limits on:

a. The ability of FDA employees to exercise regulatory authority over pharmaceutical or food companies, for whom they have worked or will work, immediately before or after government service.

b. The ability of government-paid researchers or consultants to participate in the approval process of drugs or food products in which they have any direct financial interest.

c. The ability of FDA decision makers to determine the validity of health claims for drugs, foods or natural products without taking into account the financial interests of the researchers in the outcome of the research being used to make the decision.

10.) **Goal: At the federal level, make complementary and alternative health care more accessible and affordable to the public.**

Recommendation: Convene a committee, which reports to the Secretary of Health and Human Services, to identify opportunities for incorporating more complementary and alternative health care services into existing health care insurance plans. The committee will make recommendations to the Secretary on how to work with the insurance industry to best incorporate those modalities that hold the most promise for reducing consumer costs.

11.) **Goal: Improve public health education on complementary and alternative health care.**

Recommendation: Begin a campaign to educate and empower the public with useful and effective information on complementary and alternative health care, with emphasis on self care and childhood education as an additional means of preventing the ten leading causes of death.

12.) **<u>Goal</u>: Improve public awareness of the influence of money on our health care system.**

<u>Recommendation</u>: Use the persuasive powers of the executive branch public information system to sensitize the media to the importance of reporting on the financial aspects of health care research, to include emphasis on potential conflicts of interest in the reporting of health care-related studies.

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End Notes

[i] http://www.photius.com/rankings/world_health_performance_ranks.html
[ii] Peterson, C. and Burton, R., *CRS Report for Congress: U.S. Health Care Spending: Comparison with Other OECD Countries*, September 17, 2007.
[iii] http://www.consumeraffairs.com/news04/2005/bankruptcy_study.html
[iv] http://www.usatoday.com/money/perfi/retirement/2008-03-05-retirement-health-care_N.htm
[v] http://www.gao.gov/special.pubs/longterm/
[vi] http://www.gao.gov/special.pubs/longterm/challenge.html
[vii] Peterson and Burton.
[viii] Heron, M. Ph. D., *National Vital Statistics Reports, Volume 56, Number 5, Deaths: Leading Causes for 2004*, November 20, 2007.
[ix] http://www.americanheart.org/downloadable/heart/1197994908531FS16OVR08.pdf
[x] http://diabetes.niddk.nih.gov/dm/pubs/statistics/#allages
[xi] http://professional.diabetes.org/ResourcesForProfessionals.aspx?typ=17&cid=60396
[xii] Davis, D. PhD, FACN, Epp, M. PhD and Riordan, H. MD, *Changes in USDA Food Composition Data for 43 Garden Crops, 1950 to 1999*, Journal of the American College of Nutrition, Vol. 23, No. 6, 669–682 (2004)
[xiii] http://www.crnusa.org/PR06_CRN_NutritionSurvey071306.html
[xiv] American Psychological Association, *Stress in America*, October 24, 2007, p. 3.
[xv] http://www.apahelpcenter.org/articles/article.php?id=105
[xvi] Khurana V. PhD, FRACS, *Mobile Phones and Brain Tumours – A Public Health Concern*, © 2008, G. Khurana – All Rights Reserved, download from www.brain-surgery.us.
[xvii] Eisenberg, D. MD; Davis, R. ScD; Ettner, S. PhD; Appel, S. MS; Wilkey, S. ; Van Rompay, M.; Kessler, R. PhD *Trends in Alternative Medicine Use in the United States, 1990-1997*, JAMA, November 11, 1998—Vol 280, No. 18
[xviii] MacLennan AH, Wilson DH, Taylor AW: *The escalating cost and prevalence of alternative medicine.* Preventive Medicine 2002, 35:166-173.
[xix] DaVanzo, J. PhD, MSW, Freeman, J. MA, *Effect of Selected Dietary Supplements on Health Care Reduction – Study Update*, The Lewin Group, June 5, 2007
[xx] Sarnat, R. MD, Winterstein, J. DC, Cambron, J. DC, PhD. *Clinical Utilization and Cost Outcomes From an Integrative Medicine Independent Physician Association: An Additional 3-Year Update*, Journal of Manipulative and Physiological Therapeutics, May 2007, pgs. 263-269.
[xxi] Sarnat, R. MD, Winterstein, J. DC, Cambron, J. DC, PhD. *Clinical Utilization and Cost Outcomes From an Integrative Medicine Independent Physician Association: An Additional 3-Year Update*, Journal of Manipulative and Physiological Therapeutics, May 2007, pg. 263.
[xxii] White AR, Resch KL, Ernst E, *Methods of economic evaluation in complementary medicine.* Forsch Komplementarmed 1996, 3:196-203.
[xxiii] DeAngelis, C. MD, MPH, *The Influence of Money on Medical Science*, (Reprinted) JAMA, Published online August 7, 2006
[xxiv] Washburn, J., *Science Under Siege,* Discover, p. 66-73, October 2007.
[xxv] Faloon, W., *Dietary Supplements Attacked by the Media,* Life Extension Magazine, June 2006.
[xxvi] Washburn, p. 66.
[xxvii] Goodwin, J. MD: and Tangum M. MD, *Battling Quackery*, ARCH INTERN MED/VOL 158, Nov. 9, 1998, p. 2187.
[xxviii] http://www.forbes.com/2005/02/24/cx_mh_0224fda.html
[xxix] Faloon, p. 1.
[xxx] Ibid. pgs. 1, 2, 4, 9.
[xxxi] Null, G. PhD, Dean, C. MD ND, Feldman, M. MD, Rasio, D. MD, Smith, D. PhD, *Death By Medicine*, Life Extension Institute, October 2003.
[xxxii] Ltr from David L. Lakey, MD, Commissioner Texas Department of State Health Services, to Rep. Patrick Rose, October 24, 2007, p. 2.
[xxxiii] http://www.eatright.org/cps/rde/xchg/ada/hs.xsl/home_10575_ENU_HTML.htm
[xxxiv] Chessher, M. *Cubicle Karma,* Southwest Airlines *Spirit* Magazine, October 2005, pg. 66.