Discussion Draft

National Plan to Advance Integrated Health Care

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Executive Summary
National Plan to Advance Integrated Health Care

We have prepared the following *National Plan to Advance Integrated Health Care,* in order to help focus the health care debate in the coming millennium. As representatives of consumers and practitioners, educational institutions and industry, we are dedicated to promoting national policies that will facilitate research, appropriate standards for professions as well as products, and increased consumer access to complementary and alternative therapies. We believe that a coordinated national effort, initiated at the highest levels of the federal government, is needed to ensure that the American public benefits from advancements in the science and understanding of all health care systems, disciplines and modalities.

The public health is best served by removing barriers to access, either via legislation, regulation, peer pressure, administrative law, or other means. The public will be well served by the objective and open examination of all health care systems, disciplines, and modalities, and the restoration of health care decision-making authority to consumers. In addition to eliminating barriers to access, we believe research must be done by as many public and private agencies as possible; integrated-care pilot projects must be developed to observe and analyze results; training and practice standards must be identified or developed for individual disciplines; open lines of communication must be maintained between policy makers, practitioners and patients; and the right to make their own health care decisions must be guaranteed for all Americans.

Our goal is for Americans to have equal access to all qualified practitioner types and for practitioners to have an equal opportunity to participate in all federal programs, and should they so chose, to participate in an integrated health care system free from bias and discrimination. We hope to help create a health care environment in which practitioners can practice in good conscience, with the well being of patients foremost in their minds and without fear of censure or recrimination for the use of complementary and alternative therapies. Consumers need to have confidence in the quality and safety of the products and therapies available to them; and confidence in the abilities and expertise of the practitioners they choose to see. For all of this to occur, the following issues need to be addressed in a coordinated manner:

I. Increased Research

Opportunities must be created to fund research for appropriate scientific and evidence-based models and databases for complementary and alternative medicine (CAM) and integrated health care (IHC).

II. Accountability and Education

Standards of accountability and education in CAM systems and disciplines must be recognized, researched and addressed. These standards must be further developed for those in emerging professions, for practitioners incorporating CAM therapies in conventional practices, and for licensed practitioners in established professions

III. Under served and Special Needs Populations

Greater access to CAM can benefit the American public at large, and can particularly benefit certain special needs populations.

IV. Regulation and Access to CAM Products and Devices

Opportunities *must* be created and barriers to access removed so that practitioners have more freedom to use and integrate CAM therapies into their practices, and so that consumers have access to the full range of health promotion and disease treatment approaches.

V. Federal Benefits Discrimination Against CAM

CAM providers and therapies should be included in all federal health care initiatives as a matter of policy. This would result in a dramatic increase in individuals' health care freedom, individuals' access to a broader array of therapies, significant cost savings, improved health, and a more egalitarian health care system.

VI. Clinical Practice, Quality of Care, Delivery Systems

The diversity of treatment options for patients *must* be increased; in addition, we must ensure that the practitioners have met educational and/or credentialing criteria and that adequate consumer protections are in place. A combination of solid practitioner training, appropriate standards of practice, increased research, and consumer education will result in better, safer, more equitable health care for all Americans.

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We would like to emphasize that if only *one* of the proposed policy changes we have proposed was enacted — a new and focused federal effort on disease prevention — millions of Americans could experience longer, healthier lives. The 10 leading causes of death, which affect 82 percent of all Americans, are highly preventable yet not easily addressed if we limit ourselves to conventional therapies. As such, we believe there is a moral imperative to create a health care environment in which the full range of therapies and full complement of practitioners is accessible to every American; and in which research concentrates not just on disease but on disease prevention. Without these changes, health care costs will continue to skyrocket; a two-tiered system of health care will become firmly entrenched; and the health and quality of life for millions of Americans will suffer from a system of inequality mandated and maintained by federal policies.

The following report elaborates on these proposals. It is designed to spur national debate and to focus attention on the very timely need to revamp our national health care policies, and on the costs of failing to do so. It is our hope that policy makers as well as stakeholders will respond by joining together in taking the steps necessary to move this discussion forward.

National Plan to Advance Integrated Health Care

I. RESEARCH ISSUES AND GOALS

Goal Statement: Opportunities must be created to fund research for appropriate scientific and evidence-based models and databases, and to assess public health and economic impact for Complementary and Alternative Medicine (CAM) and Integrated Health Care (IHC). The new NIH Center for Complementary and Alternative Medicine (NCCAM), with its increased funding and broader research mission, should be structured to participate as fully as possible (both directly and collaboratively with other agencies) in a comprehensive CAM research agenda.

Background: The NIH research mandate, which supports primarily large-scale controlled clinical trials of single therapeutic agents in placebo-controlled designs (and some basic sciences research) has generally been inadequate to measure the efficacy and value of CAM. With the creation of the new NCCAM, we expect the following issues will be addressed:

- Most CAM systems and modalities involve the use of multiple agents and rely to some undetermined extent on synergistic therapeutic interactions. Single-agent research does not adequately evaluate the effectiveness of multifactoral, integrated treatment plans.
- Placebo-controlled research poses an ethical problem for many CAM providers because its structure requires withholding a treatment believed to be effective from an ill patient.
- A major strength of many CAM systems is the ability to individualize treatment plans to accommodate each patient's unique presentation of health and illness. Health outcomes using these systems cannot be measured by the current NIH mandate and model.
- CAM systems of diagnosis, treatment, prevention and case management impact safety and efficacy, and direct the use of substances, methods and individualization of care. Systems must be studied, as well as substances and methods, and the effects on pathology and health status must be analyzed.
- Integrated Health Care (IHC) systems are developing; the effect of these systems on health and cost of delivery does not currently fall within the NIH operation, except under the new NCCAM.

Many of these research issues also exist in conventional medicine. Due to CAM systems approaches, however, they become essential priorities for validating effectiveness of CAM methods and systems.

A. Many appropriate and effective models are available to do credible research into CAM efficacy, cost effectiveness and safety. Outcomes and health services research needs to be done on public impact, costs, standards and effectiveness of CAM and Integrated Health Care (IHC).

1. Clinical epidemiological studies can be done to collect and analyze data on utilization patterns within CAM services.
2. Outcomes research includes a variety of possible targets and structures:
   a) Western diagnosis- and symptom-related clinical outcomes (verified by objective laboratory and assessment tools) can be evaluated and compared to CAM treatment methods. (Non-western diagnostic and wellness approaches may be addressed in future strategic planning.)
   b) Quality of life and wellness measures can be obtained prior to and subsequent to treatment. Functionality and patient/provider perceptions of functionality should be measured, as should health performance indicators (Healthy People 2010 initiative).

c) Cost comparison outcomes across certain diagnoses or health conditions can be measured and then correlated with measures of effectiveness and patient satisfaction.
d) Systems of case management must be correlated with measures of clinical effectiveness and patient satisfaction.
e) Clinical results in integrated care models can be compared to those from conventional and alternative providers working in non-integrated settings.

3. Randomized clinical trials can and should be done in the accepted NIH model to test the individual efficacy of single agents on specific conditions. They should be one part of a multifaceted research agenda.
4. Basic science research should be funded to a much greater extent to do *in vitro* and bench research on mechanisms of action.
5. Systematic literature reviews summarizing research already published in the peer-reviewed literature should be funded. CAM and IHC research and practice literature must be collected, organized, evaluated and made accessible to the scientific community at large and to the public.
6. Meta analyses can be done to evaluate groups of randomized clinical trials; such major overviews of past research can be of critical importance in choosing directions for future research and in guiding the development of education and policy.
7. Demonstration and pilot projects often provide ideal environments in which to perform some of the research described above; they can be efficiently structured to collect data assessing clinical outcomes, patient satisfaction, cost effectiveness, provider skills and competence. Many IHCs and health systems are currently piloting diverse CAM initiatives without necessary funds for proper study design, both for prospective and retrospective analysis. Federal support can rapidly enhance data gathering from these current integration sites.
8. The success of CAM interventions in diminishing the need for, or use of, conventional medications or procedures can be readily tracked, particularly in pilot or demonstration project settings, or in existing integrated care settings. (Three studies — Landmark 1997, Alternare/Group Health Cooperative-Premera Blue Cross 1997, and Stanford/ASHP 1998 — all found that a significant percentage of CAM users [30% to 62%] believe that CAM has diminished use of conventional services [office calls and/or prescription drugs]. Perception of diminished use of conventional services was highest in the most controlled environment. This significant pattern of perceptions demands analysis, particularly in a time when health costs are once again soaring.)
9. Federal agencies can work with insurers and HMOs to analyze "add-on versus replacement" data for CAM interventions. This requires analysis of both patient perceptions and of claims data for significant populations, preferably both retrospectively and prospectively.
10. There needs to be a new emphasis on disease prevention research, and bench science needs to be translated into outcomes. The present system rewards physicians for treatment, not prevention, yet the ten leading causes of death, affecting 82% of all Americans, are highly preventable.

B. There are many federal agencies in addition to the new Center for Complementary and Alternative Medicine where research such as that described above can and should be funded:

1. Clinical Epidemiological Research (including Meta Analyses)
   a) Centers for Disease Control and Prevention (CDCP)
   b) Practice Investigation Unit
   c) CDCP Surveys of Health Trends and Practices
   d) CDCP Practice Based Research Network
2. Outcomes Assessment, Including Cost Effectiveness
   a) Agency for Health Care Policy and Research (AHCPR)
   b) CAM and IHC funding for Evidence-Based Practice Centers
   c) AHCPR: Program on CAM effectiveness
   d) AHCPR-IOM (Institute of Medicine)

e) Outcomes and Effectiveness Research
f) Technology Assessment Guidelines
g) CDCP Field Investigation Activities and Surveys of Health Trends and Practices
h) Practice Effects and Safety Surveillance Research
i) Health Care Financing Administration
j) CAM and IHC Benefits

3. Randomized Clinical Trials and Basic Science Research
   a) NIH-NCCAM:
      - *supporting centers of CAM research*
      - *supporting clinical research development*
      - *supporting research training for CAM -licensed and medical researchers*
   b) NIH Centers and Institutes:
      - *supporting clinical trials in their areas*
4. Basic Science Research
   - National Institutes of General Medical Science (NIGMS)
5. Systematic Literature Reviews of CAM and IHC Research
   a) Obtaining Literature
      - *National Library of Medicine (MEDLINE)*
      - *National Center of Complementary and Alternative Medicine*
      - *Worldwide database of CAM and IHC research and practice*
   b) Evaluating Literature
      - *Agency for Health Care Policy and Research*
      - *Cochrane Collaboration*
      - *IHC Services Task Force Report (e.g., US Preventive Services Task Force for Prevention) with shared representation among CAM and conventional providers*
6. Demonstration and Pilot Projects
   a) Health Resources and Services Administration (HRSA): Bureau of Primary Health Care
      - *Education demonstration project: IHC/CAM residency exchange program involving CAM and conventional medical schools*
      - *Demonstration projects for minority and under served*
   b) Department of Defense Demonstration and Grant Programs
      - *Chiropractic Demonstration Project*
      - *Breast Cancer CAM Grants*
   c) State and County Health Department Project
      - *King County Natural Medicine Clinic*
      - *Community health centers and integrated health care projects*
   d) Veterans Administration
      - *Demonstration Project for Veterans*
   e) AHCPR
      - *Multi center clinical demonstration projects using combined CAM and IHC delivery systems*

C. Barriers to funding such research include:

1. In general, authorizing legislation for federal agencies is not inclusive of CAM fields or IHC.
2. Rules and regulations do not include CAM fields, nor do they identify pathways for integration; independent funding approval may be needed for CAM/conventional and IHC collaboration.
3. The management of a complex, multi-agency plan such as the one proposed herein may be very unwieldy unless coordinated at a higher level.
4. Current research infrastructure is completely dominated by conventional medicine; there is a considerable risk of having CAM systems and disciplines conventionalized or co-opted if forced

to operate solely on territory which is already ruled by a huge, powerful, biased vested interest. (NIH-NCCAM is an example. Stephen Barrett - a famed "quack buster" who is unalterably opposed to advancing alternative medicine - was placed on the scientific review panel for the only Center grant renewal application from a CAM credentialed Center!)

5. Licensed, credentialed CAM providers need to be adequately represented on Advisory Board and Scientific Review Panels, as mandated for the new NIH-NCCAM.
6. Investigational New Drug (IND) applications are required for nonpharmaceutical research (clinical trials). This process for low- or no-toxicity CAM products is prohibitive and unnecessary.
7. Pre and post-doctoral research fellowship qualifications do not specify CAM providers in list of authorized degrees.
8. Requiring the CAM professions to interface with the huge, complex governmental research bureaucracy as though these professions had well-developed and well-resourced institutional infrastructures for such purposes belies reality.
9. Implementing these research goals may require a broader mission than some agencies currently subscribe to (or perhaps are legislatively authorized for).

D. Action Steps

1. Establish an office on CAM and IHC at the Department of Health and Human Services with authority to coordinate and direct all federal CAM activities.
2. Establish a commission on CAM and Integrated Health Care, as mandated in the NCCAM bill language.
3. Establish a nondiscrimination policy affecting all funding at the federal level, requiring even-handed treatment of all systems, disciplines and modalities.
4. Research legislation and rules which control the listed agencies, and propose amendments and rule changes as necessary to support inclusion of CAM and IHC.
5. Ensure that licensed CAM providers from all CAM fields, and credentialed IHC proponents, are represented on Advisory Boards and Scientific Review Panels at NIH-NCCAM and other agencies as appropriate, including Office on CAM and IHC at HHS.
6. Fund basic sciences and clinical trials research centers at CAM institutions to help support the necessary development of a research infrastructure.
7. Establish pre- and post-doctoral research fellowships in CAM institutions.
8. Support CAM and conventional research collaborations.
9. Establish "Blue Ribbon" Panels to direct the Office and Congress (see above) on CAM and IHC policy and legislative requirements and to increase communication and education and collaboration among legislators, regulators, federal agency personnel, third party payers; CAM educators, licensed CAM providers, researchers and practitioners; and conventionally trained Integrated Health Care proponents. It is essential that the make-up of all such panels be cross-disciplinary.
10. Direct the federal commission to identify the most effective use of federal dollars to support and enhance CAM research opportunities currently underway or intended in the not-for-profit and for-profit hospital, HMO, insurance, IHC, and CAM provider networks.

E. Priorities

1. Provide funding support for development and operation of individual or consortium research centers funded by NIH-NCCAM, to include accredited complementary and alternative medicine research and education facilities.
2. Fund outcomes research (see above).
3. Fund demonstration project via HRSA on education and cross-disciplinary training involving CAM colleges and conventional medical schools, as well as projects to

increase CAM access for minority and under served populations.

4. Fund collaborative CAN/conventional residency exchange programs and residential programs in CAM institutions.
5. Fund research on institutional, provider and patient outcomes, including co-management team outcomes.
6. AHCPR: Establish a competitive bid process to support and research a dozen clinics in the U.S. in various sectors, selection to be made with IHC and CAM accredited institutions. Produce data and reports, including longitudinal data. Needs five years funding minimum.
7. Encourage research in disease prevention.

II. ACCOUNTABILITY AND EDUCATION

Goal Statement: The established standards of accountability and education in CAM systems and disciplines must be recognized, researched and addressed. Further standard development must be supported for emerging professions, for practitioners incorporating CAM therapies in conventional practices, and for licensed practitioners in established professions.

Background: Recent estimates of CAM use in the United States range from 40% of the populace (Astin, J**:** Why patients use alternative medicine; JAMA, May 20, 1998;279:15481553) to as high as 69% (Stanford University/American Specialty Health Plan national consumer survey, reported 9/18/98). A growing number of community health centers, private clinics and hospitals are slowly integrating CAM with existing services. Such a high level of use demands a responsible evaluation of public accountability in the education of CAM providers and the use of CAM systems and modalities. Such an evaluation must be made in the context of knowledge about emerging professions, including understanding recognizable stages and markers of development. The goal must be to recognize, articulate and help strengthen the education and standards of emerging and established CAM professions in order to improve public accountability in research, clinical practice, and developing integration models. (Significant differences exist in scope of practice from jurisdiction to jurisdiction, making delivery of covered services more problematic, particularly for national purchasers.) Many CAM standards have already been well developed. These standards must be integrated into mainstream delivery systems to insure accountable access.

Broad state practice acts for medical doctors are outdated in today's health care environment. Safety and efficacy in health care are at least partially dependent on credentialing providers in an accountable way to the highest available education and training standards to support scope of practice in various disciplines. The broad practice act ironically may put the consumer at increased risk of ineffective, costly or hazardous practices by MDs who are poorly trained in CAM systems or modalities and have not had their competency in those disciplines or modalities assessed before practicing. High standards have been developed and sanctioned and are being used by public agencies for many CAM providers, but the standards are not applied to M.D.s and other conventionally trained providers.

A. Differentiate Among CAM Systems, Modalities And Disciplines; Identify Providers

1. ***Systems/Disciplines***
   a) Anthroposophical Medicine
   b) Ayurvedic Medicine
   c) Chiropractic Medicine
   d) Homeopathic Medicine
   e) Midwifery
   f) Naturopathic Medicine
   g) Oriental Medicine/Traditional Chinese Medicine
   h) Tibetan Medicine
   i) Traditional and indigenous health care systems
2. ***Modalities***
   a) Acupuncture
   b) Botanical Medicine
   c) Chelation
   d) Health Psychology
   e) Hydrotherapy
   f) Lifestyle and Wellness Counseling (including dietary changes and exercise planning)

g) Massage
h) Natural Hygiene
i) Nutritional Medicine
j) Physical Medicine (i.e., Physiotherapy, Physical Therapy, and Manipulation)
k) Spiritual Healing

3. ***Providers using at least one of the systems/disciplines and modalities shown above:***

Licensed

a) Acupuncturists (CA, LAc)
b) Chiropractors (DC)
c) Massage therapists (LMP, LMT)
d) Medical doctors (MD)
e) Midwives (LM)
f) Naturopathic doctors (ND)
g) Nurses/ Nurse Practitioners (RN, NP)
h) Nutritionists, Registered Dieticians
i) Osteopathic doctors (DO)
j) Others

Other professional credentialing (may be progressing toward licensure in some states)

a) Certified nutritionists (CNS)
b) Oriental medical doctors (OMD)
c) Professional homeopaths
d) Professional hygienists

Unregulated (although some non governmental certifications may be available)

a) Bodywork specialists (Feldenkrais, Rolfers, etc.)
b) Fitness/Spa professionals and personal trainers
c) Herbalists
d) Hydrotherapists
e) Lay homeopaths
f) Lay midwives
g) Lifestyle counselors/health advisors
h) Spiritual healers
i) Tibetan/Ayurvedic/Yunani practitioners
j) Yoga, Tai Chi, Qi Gong instructors

B. Identify and evaluate types of public accountability for CAM education and clinical practice in use today: regulation, recognition, or other activities which address public accountability issues.

1. Accreditation of colleges, curricula and programs
2. Board exams for national certification
3. Board exams for state licensure
4. Continuing education
5. Disciplinary guidelines
6. Educational standards
7. Licensure and scope of practice
8. Peer review
9. Practice guidelines
10. Research
11. Quality improvement and quality assurance plans

C. Articulate patterns of emerging professions which may need to be understood and nurtured through transitional phases in public accountability.

1. Report on the general process, criteria and steps involved in a profession's emergence; know the history and stages of emergence which today's well-established professions passed through.
2. Report on status today of all emergent and emerging CAM professions with respect to categories shown above; fund projects for strengthening key standards where necessary.
3. Recommend public agency support to assist in nurturing, accrediting, and facilitating emerging professions as they establish standards for public accountability.

D. Address Conventional Provider Access Issues for CAM

1. Presence or lack of standardized or accredited education for conventional providers using CAM modalities and disciplines should be addressed.
   a) Articulate and support standards of credentialed CAM training (where available) for non-CAM providers.
   b) Articulate CAM, conventional and IHC resources for cross-training; support the development of such resources, and fund and replicate existing credentialed training programs.
   c) Articulate standards of professional accreditation, continuing education, credentialing for reimbursement, and licensure models as they relate to non CAM providers and their scope of practice in CAM modalities and disciplines.
2. Address safety and efficacy issues which the current situation may give rise to.

E. Facilitate Integration of Standards into Mainstream Health Care Systems

1. Identify and describe integration models now in use; disseminate this information. Three such models are integration within single provider (i.e., naturopathic physicians); co-management team; cross-referral and cooperation between institutions and networks.
2. Assess effectiveness of integration and delivery of CAM activities into mainstream systems and into conventional medicine (see Research section above).
3. Support interprofessional association and accreditation (CAM and conventional) coordination.
4. Identify standards gaps and fund consensus projects to recommend improvements.
5. Fund National Congress for CAM and IHC leadership to define consensus recommendations for credentialing standards in White Paper for federal and state guidance.

F. Action Steps

1. Research and report on emerging and established accountability standards in health care professions; summarize and compare standards in CAM and non-CAM fields.
2. Identify pathways and provide funding for the inclusion of existing CAM standards into established health care systems.
3. Fund joint conferencing -- use existing federal agencies and CAM and conventional organizations to coordinate joint offerings in key areas of mutual interest (education, regulation, standards, research).
4. HRSA: Bureau of Primary Care and Bureau of Health Professions
5. Approve professionally accredited CAM colleges and professions as eligible for grants, for residency and for cross-disciplinary programs.
6. Fund Blue Ribbon Panel to investigate issues related to non-CAM providers using CAM methods and make recommendations to Commission (see above) on Action Steps.

G. Priorities

1. Hold joint interagency meetings with NIH, FDA, and HHS.
2. HRSA Bureau of Health Professions and Bureau of Primary Care: approve accredited CAM colleges and professions for grant eligibility.

3. Fund National Congress on Standards/Accountability/Practice/Education/ Reimbursement Systems/Research with Blue Ribbon task force representing accredited colleges of licensed alternative health professions, national associations for licensed CAM professions, and emerging professions. Include organizations and task forces involved with standard setting in CAM education from within conventional medical education.

III. ADDRESS CAM NEEDS IN UNDER SERVED AND SPECIAL NEEDS POPULATIONS

Goal Statement: Greater access to CAM can benefit the American public at large, and can particularly benefit certain special needs populations.

Background: Certain under served or special needs populations now have very limited (or no) access to CAM providers, and therapeutic agents and products used by CAM providers have not previously been covered by Medicare/Medicaid or third party payers. Low income, veterans, tribal people, rural areas, the underinsured, and the disabled are among those groups which could benefit by having greater access and more diversity in health care options. Evaluation of CAM and IHC access is needed to facilitate delivery in these special populations.

A. Identify special needs which CAM providers can help meet:

1. National health shortage areas (HSAs)
2. Public Health Service positions
3. State and county health needs in special populations
4. Community education and support for lifestyle factors
5. Respect for and working with traditional medicines and providers in special populations

B. Identify barriers to implementation.

1. National Health Corps Program includes licensed acupuncturists but does not provide inclusion for licensed CAM providers to fill health care gaps in under served areas. Outreach programs are needed but not funded.
2. Public Health Service authorizing legislation and regulations do not name CAM providers.
3. State and County Health Department boards have no mandate to include CAM representatives.
4. Medicare and Medicaid services and reimbursement for products (Rx) are mostly unavailable, and many government entities use the Medicare authorization language for their own guidelines.
5. Veterans Administration has no mandate to cover CAM and IHC.

C. Action Steps

1. Include licensed CAM professions in Medicare/Medicaid regulations.
2. Include licensed CAM professions and IHC experts in Public Health facilities, State and County Health Boards and clinics, and National Health Corps Programs.
3. Authorize CAM participation in a funded Veterans Administration Demonstration Project.
4. Health Resources and Services Administration
   a) Bureau of Primary Health Care Services funding for a demonstration project for under served and minority populations receiving CAM services
   b) Bureau of Health Professions funding for a CAM Residency Training Program in under served/special populations
5. Facilitate the integration of co-management teams into state and county health department clinics (with training) using successful models such as the King County Natural Medicine Clinic. Fund training programs (Level 1-4) in CAM disciplines for health care providers in these clinics and systems.
6. Fund conference on methods for utilizing CAM health care in under served or special needs population.
7. Allow HMOs and provider groups which accept risk on capitated Medicare or Medicaid clients to utilize CAM providers and therapies and to implement integrated health services.
8. Create dialog and fund pilot project bringing CAM providers and traditional healers (Native

American, Hawaiian, etc.) to a common strategy for their populations.

D. Priorities

1. Revise statutes and regulations to provide access to National Health Corps Program for CAM providers.
2. Allow access to licensed CAM professions in Medicare/Medicaid and other federal health care programs.
3. Fund pilot projects to facilitate the development of integrated care services for under served populations, including co-management training in community health centers.

IV. REGULATION AND ACCESS TO CAM PRODUCTS AND SERVICES

Goal Statement: Opportunities must be created and barriers to access removed so that practitioners have more freedom to use and integrate complementary and alternative therapies (CAM) into their practices, and so that consumers have access to the full range of health promotion and disease treatment approaches.

Background: The general public is turning in ever-increasing numbers to CAM, yet the present system of laws and regulations does not easily accommodate development of integrated health care practices or emerging professions; nor does it allow for advancements in health care to easily reach the public, regardless of whether that care is alternative or conventional. Restrictions on access to information for consumers is analogous to antitrust in business (refer, for example, to the recently proposed and highly inappropriate FDA regulations regarding the use of health-related information on natural products).

A. There is a widespread belief that CAM therapies and an increased emphasis on prevention would result in significant cost savings to both individuals and the federal government. A number of small studies have supported this belief, but much larger ones need to be done.

B. Increased access to such therapies would foster the increasing desire of the public to take responsibility for their own health and health care, a movement that, by itself, will lower costs and improve health.

C. Many patients want and deserve both increased access and more information about the options available to them.

D. CAM therapies, as a rule, are safer and less toxic than allopathic therapies so they can often be tried first, thereby reducing or even eliminating the need for more expensive, invasive and toxic procedures.

E. There is a growing science base in support of the safety and efficacy of CAM therapies, and an increasing willingness to accept the science and experience of consumers and practitioners in other countries who have had decades, even centuries of experience with CAM therapies, thereby reducing or even eliminating the need to duplicate research.

F. Barriers to increased access include:

1. One of the barriers is opposition to CAM by pharmaceutical companies because of the perceived competition from such practices.
2. The Federation of State Medical Boards, and its members believe that increased access will open the door to quackery, exposing vulnerable patients to unnecessary risks and even life-threatening therapies, or failure to use conventional treatments. FSMB members would benefit from guidance in understanding CAM; in properly integrating CAM therapies and practitioners into conventional practices; and in the off-label uses of drugs.
3. There is a perception that CAM presents an economic threat to the allopathic medical industry.
4. Patient-driven health care is a new idea that requires education and changing attitudes among third-party payers, policy makers and mainstream providers.
5. The medical community tends to be unwilling to relinquish control/authority.
6. Competition and rivalries within the CAM community undermine the ability to effect change. Diverse agendas dilute efforts to achieve major changes in the health care environment.
7. Poor science and demagoguery undermine the credibility of valid CAM therapies and make substantiation more difficult.

8. The CAM science base is incomplete and conflicting, primarily because of limited research funding and the ineffectiveness of the Office of Alternative Medicine. It should be noted that CAM research is being measured against a 75-year history of conventional research which was overwhelmingly funded by the Federal Government and pharmaceutical houses, not by the practitioners themselves. The additional funding provided to the new NCCAM should help to remedy this situation, but it will take time.
9. It's difficult to organize and maintain a grassroots effort in support of federal legislation because systemic change is required. Systemic change is difficult to simplify and package; lacks emotional appeal; is expensive to address; and takes a long time to achieve.
10. Insurance coverage of CAM therapies and systems is generally lacking, which is creating a two-tiered system of limited access. Only the best educated or wealthiest Americans now have access to a wide range of therapies. Creation and acceptance of insurance codes is an important step in facilitating this equal access.
11. Lack of access to credentialing, and contracting for CAM providers by plans, creates artificial barriers to what should be a comprehensive, patient-focused health care system.
12. Among policy makers there is a lack of understanding of CAM, which creates barriers to integration.
13. As in any area, there tends to be a reluctance to change the status quo. The American people and especially the American Government want the United States to have the best health care system in the world. Changes in that system are perceived as a negative commentary on the medical community.

G. Action Steps

1. Amend administrative laws at the state level to eliminate the unconstitutional,
2. undemocratic behavior of licensing boards, which continue to harass and censure practitioners for the use of CAM products and therapies.
3. Promote insurance equality for CAM providers and therapies.
4. Change federal laws and regulations so as to create a regulatory system that allows access to non-FDA approved therapies by consumers, within certain guidelines, to prevent the growth of an unregulated black market in CAM therapies, and to eliminate the two-tiered system of access promoted by the present system.
5. Establish a system to collect and disseminate information about promising CAM therapies.
6. Promote and fund research on CAM by as many public and private agencies as possible. (See Section I)
7. Support, as a matter of national policy, the standards of practice inherent in state licensing laws.
8. Support funding by AHCPR for CAM practice guideline projects involving the CAM professions.

H. Priorities

1. Eliminate the regulatory, administrative and legal barriers to access for both providers and consumers.
2. Maintain open lines of communication between policy makers, practitioners and patients.
3. Guarantee the right of all Americans to make their own health care decisions, regardless of race, sex, education, income or eligibility for Medicare.
4. Eliminate the barriers to access and information caused by the present drug-approval process and eliminate FDA constraints on the dissemination of truthful, scientific information about natural medicine products such as dietary supplements. The FDA should be relieved of its responsibility to ensure the efficacy of CAM products that are safe.

V. FEDERAL BENEFITS DISCRIMINATION AGAINST CAM

Goal Statement: CAM providers and therapies should be included in all federal health care initiatives as a matter of policy. Agencies which may be affected include the Health Care Financing Administration (Medicare and Medicaid), Congress and Federal Agencies (Federal Employee Health Plans), the Department of Defense, the Veterans Administration, the Indian Health Service, the Substance Abuse and Mental Health Agency, the Food and Drug Administration, the National Institutes of Health, the Health Resources and Services Administration, the Substance Abuse and Mental Health Services Administration, the Agency for Toxic Substances and Disease Registry, the Agency for Health Care Policy and Research, the Public Health Service, the Centers for Disease Control and Prevention, and the Office of Public Health and Science.

Background: The inclusion of CAM in the many health care programs and research initiatives of the Federal Government would result in the widespread and rapid incorporation of CAM therapies in the health care of millions of Americans, resulting in a dramatic increase in health care freedom, individual access to a broader array of therapies, significant cost savings, improved health, and a more egalitarian health care system.

A. There is a tremendous need to reduce health care costs, both on the part of individuals and the Federal Government. The incorporation of CAM therapies and an increasing focus on prevention would result in savings of billions of dollars almost immediately. Diabetes alone consumes nearly 30% of the Medicare budget and it has been demonstrated that a combination of patient education and nutritional approaches could dramatically decrease the costs of patient care. (See Appendix A.)

B. Patients and their families want access to a wider range of therapies and providers. (See attached articles, Appendix B.)

C. Practitioners want to be able to offer a wider range of therapies to their patients than they are currently allowed or reimbursed for.

D. Many licensed providers are not allowed to fully participate in federal health insurance programs (acupuncturists, naturopathic doctors).

E. There is an increasing desire on the part of consumers for freedom and individual choice in health care.

F. Barriers

1. There is often a lack of understanding on the part of policy makers about CAM products and services in general; therefore, they are reluctant to increase access by providing coverage of such products and services in federal health care programs.
2. CAM is perceived as an "add-on" to existing coverage and, therefore, seen as costing the federal government more money instead of the opposite. (See Appendix A.)
3. Not all CAM therapies have been researched via the Western scientific method so there is a perception that the therapies are unproved and therefore should not be covered or provided in federal insurance programs.
4. Providers and insurers are afraid that more choice will cause costs to skyrocket.
5. The biomedical model is geared to using a medical doctor as gatekeeper. This gatekeeper has limited knowledge of CAM therapies and is unlikely to either refer or coordinate health care services with CAM providers.

6. The strength of the conventional medical community's desire to protect its turf slows or severely limits the incorporation of CAM products and therapies.
7. The FDA has an institutional bias against CAM. It is not designed to accommodate nonpatentable substances or a holistic approach to health care. Nevertheless, it has complete authority over the use of drugs, devices and foods, and the dissemination of information about drugs, devices and foods. This has resulted in a bottleneck for the dissemination of scientific information, and a roadblock in the advancement of health care for the American public.

G. Action Steps

1. Pass legislation to prohibit discrimination against CAM providers, products and services in all appropriate federal programs and initiatives.
2. Request a GAO report and mandate research on the cost savings possible through the incorporation of CAM products and services.
3. Create an Office of CAM at the Department of Health and Human Services, Office of Public Health and Safety to oversee and direct the incorporation of CAM in all federal health care programs and initiatives.

H. Priorities

1. Eliminate federal discrimination against CAM products, therapies and practitioners.
2. Educate policy makers about the safety, efficacy and cost savings possible through CAM products and therapies.
3. Develop methods to incorporate CAM providers, products and therapies in the existing health care system.
4. Provide CAM therapies and products in all of the appropriate federal health care programs and initiatives.

VI. CLINICAL PRACTICE, QUALITY OF CARE, AND DELIVERY SYSTEMS

Goal Statement: To increase the diversity of treatment options for patients while, at the same time, insuring that the practitioners have met educational and/or credentialing criteria and that adequate consumer protections are in place.

Background: CAM practitioners and therapies cannot be integrated with the conventional medical setting without first laying the groundwork. This runs the gamut from standard-setting and credentialing to fostering changes in the attitudes, perceptions and understanding of CAM by state licensing boards and state attorneys general.

A. At present, there is considerable variation in the quality of care, level of education, availability of credentialing and reliable science to support CAM therapies and evaluate CAM practitioners. This means there is no clear or simple way for consumers to evaluate either the practitioners or the therapies.

B. Emerging professions present unique challenges, most notably that of credentialing, which should be developed and monitored by the professions themselves. The Federal Government, however, can and should provide grants to help support the development of uniform standards; policy initiatives can provide support for the expansion of state licensure which provides public oversight.

C. The failure to integrate CAM into the existing health care system is resulting in a lack of patient care coordination. While it appears that the medical community would like to become the gatekeeper, that approach may not be the most fair or effective.

D. The integration of CAM into clinical settings is also a women's issue because:

1. Women are affected disproportionately by chronic conditions.
2. Women are interested in self-care and prevention.
3. Women make the majority of health care decisions in the U.S. for themselves and their families.
4. Women are the largest consumers of health care in the U.S.
5. Women are the major beneficiaries of CAM therapies.

E. Barriers

1. Lack of insurance reimbursement, due to several factors, is hampering the incorporation of CAM.
   a) Lack of FDA approval
   b) Lack of credentialing/licensing of practitioners
   c) Incomplete science base for some therapies
2. Internecine warfare among practitioner types is slowing the credentialing and licensing processes, as well as the incorporation of CAM into clinical settings.
3. The policies and scope of practice guidelines enforced by medical licensing boards do not permit the incorporation of CAM services in standard medical practices.
4. Reprisals, censure and harassment prevent progress in this direction.
5. Potential turf and control issues resulting from the interaction between CAM practitioners, conventional practitioners and those in emerging professions could slow or prevent true integration.

F. Action Steps

1. The National Commission for Quality Assurance, the accreditation body, must be encouraged to work appropriately with emerging professions to establish credentialing procedures, educational

requirements, and supportable standards of practice. It will need to work closely with experienced professionals in each field to develop quality measures for CAM. NCQA should be brought into the loop as soon as possible.

2. A nationwide study should be funded to examine the impact of licensure on costs, health care practices, consumer protection, standards and credentials.

G. Priorities

1. The licensing boards, HMO boards, hospital boards -- all of the enforcement bodies now in place to regulate the practice of medicine -- will need to be restructured to allow for the incorporation of CAM.
2. Emerging professions will have to set standards of education, scope of practice guidelines, and continuing education requirements, as well as monitor compliance. Resources are needed to help these processes develop and mature.
3. It will be important to educate practitioners, policy makers and patients about CAM to encourage its acceptance and use.

Overall Priorities

1. Pass legislation that prohibits discrimination in participation and funding in all appropriate federal programs. Patients must have equal access to all licensed or accredited provider types, and providers must have equal opportunity to participate in federal programs.

2. Establish an office at the assistant secretary level at the U.S. Department of Health and Human Services to:

a) coordinate and direct all federal CAM activities;
b) open structured and ongoing communication pathways among legislators, regulators, the research community and CAM providers, researchers, educators and organizational representatives;
c) increase and coordinate federally-funded research

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