

Withdrawal/Redaction Sheet

Clinton Library

DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
001. schedule	Schedule for Hillary Rodham Clinton [partial, page 1 in full] (7 pages)	09/14/1999	b(7)(E), b(6)
002. memo	Neera Tanden and Stephen Metcalf to Mrs. Clinton re: Briefing [partial] (1 page)	09/14/1999	b(6)
003. memo	Marc Lapidus to the First Lady re: political (1 page)	09/14/1999	Personal Misfile
004. fax	re: political (7 pages)	09/13/1999	Personal Misfile
005. memo	Marc Lapidus to the First Lady re: political (1 page)	09/14/1999	Personal Misfile
006. memo	Gabrielle Fialkoff to the First Lady re: political (1 page)	09/13/1999	Personal Misfile
007. memo	Gabrielle Fialkoff to the First Lady re: political (1 page)	09/13/1999	Personal Misfile
008. list	re: political (2 pages)	09/14/1999	Personal Misfile
009. schedule	Schedule for Hillary Rodham Clinton [partial] (2 pages)	09/13/1999	b(6)
010. list	re: Commission on Complementary and Alternative Medicine (2 pages)	n.d.	b(6)
011. list	re: possible commission members (2 pages)	n.d.	b(6)

COLLECTION:

Clinton Presidential Records
Domestic Policy Council
Ann O'Leary
OA/Box Number: 19581

FOLDER TITLE:

Alternative Medicine

2013-0436-S

rc1287

RESTRICTION CODES

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C. Closed in accordance with restrictions contained in donor's deed of gift.

PRM. Personal record misfile defined in accordance with 44 U.S.C. 2201(3).

RR. Document will be reviewed upon request.

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**SCHEDULE FOR HILLARY RODHAM CLINTON
TUESDAY, SEPTEMBER 14, 1999**

PAGE 2

8:00 am

CONFERENCE CALL

Call: 1-800-403-2015 code:125 451

PARTICIPANTS:

(b)(6)

[001]

8:35 am

DEPART

(b)(6)

EN ROUTE Hillary 2000 Headquarters
[drive time: 20 minutes]

(b)(7)g

8:55 am

ARRIVE Hillary 2000 Headquarters

9:00 am-

PRIVATE MEETING

9:45 am

HRC Office
Hillary 2000 Headquarters
450 7th Avenue
Suite 804
New York, New York 10123
Phone: 212/239-2000
Fax: 212/563-5249
CLOSED PRESS

PARTICIPANTS:

(b)(6)

9:50 am

DEPART Hillary 2000 Headquarters
EN ROUTE 163-13 Depot Road, Flushing
[drive time: 40 minutes]

**SCHEDULE FOR HILLARY RODHAM CLINTON
TUESDAY, SEPTEMBER 14, 1999**

PAGE 3

(b)(7)e

10:30 am ARRIVE 163-13 Depot Road

10:35 am- PRIVATE MEETING

**11:35 am Assemblyman Brian McLaughlin's District Office
163-13 Depot Road
Flushing, New York 11358
Phone: 718/762-6575
Fax: 718/762-0917
CLOSED PRESS**

PARTICIPANTS:

**HRC
Assemblyman Brian McLaughlin
Mark Lapidus**

**11:40 am DEPART 163-13 Depot Road
EN ROUTE 34 Middle Neck Road, Great Neck
[drive time: 15 minutes]**

(b)(7)e

11:55 am ARRIVE 34 Middle Neck Road, Great Neck

GREETERS:

**Robert Rosengarten, Mayor of Great Neck
Lee Seeman, Program Manager, Great Neck Chamber
of Commerce
Tom DiNapoli, State Assemblyman and Nassau County
Democratic Chair**

12:00 pm-

LUNCH

1:00 pm

**Bruce's Bakery
34 Middle Neck Road
Great Neck, New York 11021
OPEN PRESS**

PARTICIPANTS: 100 patrons expected

**SCHEDULE FOR HILLARY RODHAM CLINTON
TUESDAY, SEPTEMBER 14, 1999**

PAGE 4

1:05 pm **DEPART** 34 Middle Neck Road
 EN ROUTE 80 Grace Avenue
 [drive time: 5 minutes]

(b)(6)

1:10 pm **ARRIVE** 80 Grace Avenue

GREETERS:

Barbara Reiss, Executive Director
Mary Ann Rettino, Program Coordinator, Adult Day
Care

PROCEED BRIEFLY TO HOLD

1:15 pm- **VISIT TO THE GREAT NECK SENIOR CITIZENS' CENTER**

2:45 pm All Purpose Room
Great Neck Senior Citizens' Center
80 Grace Avenue
Great Neck, New York 11201
Hold: Executive Director's Office
Phone: 516/487-0025
Fax: 516/487-4738
OPEN PRESS

FORMAT:

-Barbara Reiss introduces HRC.

-HRC makes remarks.

-HRC takes Q&A.

PARTICIPANTS: 100 senior citizens

2:50 pm- **PRIVATE MEETING**

3:20 pm Executive Director's Office
Great Neck Senior Citizens' Center
80 Grace Avenue
Great Neck, New York 11201
Hold: Executive Director's Office
Phone: 516/487-0025
Fax: 516/487-4738
CLOSED PRESS

**SCHEDULE FOR HILLARY RODHAM CLINTON
TUESDAY, SEPTEMBER 14, 1999**

PAGE 5

PARTICIPANTS:

HRC
Heskel Elias
Janet Elias

CONTACT: Heskel Elias 718/268-5850

3:25 pm-

PRESS AVAILABILITY

3:45 pm

Room 6
Great Neck Senior Citizens' Center
80 Grace Avenue
Great Neck, New York 11201
Hold: Executive Director's Office
Phone: 516/487-0025
Fax: 516/487-4738

3:50 pm

DEPART 80 Grace Avenue, Great Neck
EN ROUTE 834 Fifth Avenue
[drive time: 40 minutes]

(b)(7)e

4:30 pm

ARRIVE 834 Fifth Avenue

4:30 pm-

DOWN TIME

4:55 pm

4:55 pm

DEPART 834 Fifth Avenue
EN ROUTE 817 Fifth Avenue
[drive/walk time: 5 minutes]

(b)(7)e

5:00 pm

ARRIVE 817 Fifth Avenue

GREETERS:

John Catsimatidis
Margo Catsimatidis

**SCHEDULE FOR HILLARY RODHAM CLINTON
TUESDAY, SEPTEMBER 14, 1999**

PAGE 6

5:00 pm- **HILLARY 2000 FUNDRAISER**
6:30 pm Catsimatidis Residence
817 Fifth Avenue
New York, New York 10021
Phone: 212/826-9865
Fax: 212/421-2475
CLOSED PRESS

FORMAT:

- HRC does a photo receiving line with guests.
- John and Margo Catsimatidis introduce HRC.
- HRC makes remarks.
- HRC has the option of taking Q&A before she departs.

PARTICIPANTS: 50 guests expected.

6:30 pm **DEPART** 817 Fifth Avenue
EN ROUTE West 23rd Street and Hudson River
[drive time: 25 minutes]

(b)(7)e

6:55 pm **ARRIVE** West 23rd Street and Hudson River

GREETERS: Larry and Klara Silverstein

7:00 pm- **HILLARY 2000 FUNDRAISER CRUISE**
9:00 pm Silverstein Boat
Chelsea Piers
Phone: 917/544-1029
Fax: 954/261-4637
CLOSED PRESS

FORMAT:

- Boat sets sail.
- HRC does a photo receiving line with guests.
- Larry and Klara Silverstein introduce HRC.

**SCHEDULE FOR HILLARY RODHAM CLINTON
TUESDAY, SEPTEMBER 14, 1999**

PAGE 7

-HRC makes remarks.

-HRC has the option of taking Q&A.

-Boat docks and HRC departs.

PARTICIPANTS: 50-70 guests

CONTACT: Anne Tobin 212/551-7333

9:05 pm

DEPART West 23rd Street and Hudson River

(b)(7)e

(b)(7)e

9:25 pm

ARRIVE 834 Fifth Avenue

RON

(b)(7)e

WEATHER FORECAST FOR NEW YORK, NEW YORK: Partly sunny. High 81.
Low 67.

WEATHER FORECAST FOR FLUSHING AND GREAT NECK, NEW YORK: Partly
sunny. High 76. Low 64.

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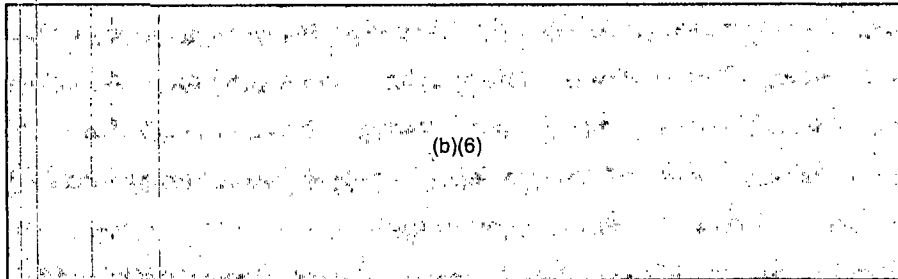
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MEMROANDUM TO MRS. CLINTON

From: Neera Tanden
Stephen Metcalf

Re: Briefing for September 14th, 1999

The following is your briefing for tomorrow's events:



Meeting with Assemblyman Brian McLaughlin

- Memorandum on Brian McLaughlin
- Biographical Sketch of Brian McLaughlin

Lunch with Thomas P. DiNapoli

- Biographical Sketch of Assemblyman Thomas P. DiNapoli
- Names, Addresses and Numbers for Great Neck Lunch

Listening Session at Great Neck Senior Center

- Briefing
- President Clinton's Plan to Modernize and Strengthen Medicare
- Article, New York Times: Debate on Elderly Focuses on Women
- Remarks by the President and Mrs. Clinton on Women and Medicare

Fundraising Events

To be forwarded by Gabrielle Fialkoff tomorrow morning.

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Brian M. McLaughlin

Brian M. McLaughlin, a leading figure in New York City's labor movement for more than two decades, was born in the Inwood section of Manhattan on April 30, 1952.

Mr. McLaughlin, a graduate of Brentwood High School on Long Island, became a journeyman electrician in 1977, following in the footsteps of his father and grandfather. While working in the electrical industry, he continued his education, receiving a Bachelor of Science Degree from Empire State College of the State University of New York and Master's Degree in Industrial Labor Relations from the New York Institute of Technology.

In June of 1995, Mr. McLaughlin was unanimously elected President of the New York City Central Labor Council, AFL-CIO, an umbrella organization of public and private sector unions in New York City with a combined membership of more than 1.5 million working men and women. He is only the third President in the Council's four-decade existence.

Since he has become president, the Central Labor Council has worked to revitalize New York's labor movement at the grassroots level through organizing, public education, and political action. A new Organizing Institute to transform union members into highly skilled organizers has been established in collaboration with the Harry Van Arsdale, Jr. School of Labor Studies at Empire State College of the State University of New York. More than 100,000 new members have been added to the Central Labor Council during his tenure through new organizing and reaffiliation. Under Mr. McLaughlin's leadership, the Central Labor Council has dramatically increased its advocacy and grassroots political education efforts on city issues that affect working families and given resources and strategic assistance to several local unions engaged in critical collective bargaining negotiations and strikes, including commercial building workers, health care employees, and public employees.

In the trade union movement, Mr. McLaughlin previously served as Assistant to the President of the Central Labor Council, where he regularly organized New York City's Labor Day Parade. He has also served as Special Assistant to the Business Manager of Local 3 of the International Brotherhood of Electrical Workers, AFL-CIO, and the Business Representative for Local Union #3's Street Lighting Division. For six years, Mr. McLaughlin was Pension Director of the electrical industry, where he was responsible for securing pension benefits for 3,000 retirees.

For his work as a trade unionist and community activist, Mr. McLaughlin has received the Hubert H. Humphrey Humanitarian Award of the Association of Teachers of Social Studies/UFT, the John E. Lawe Labor Leaders' Award of the New York Chapter Arthritis Foundation, United Jewish Appeal Federation of New York, the George Meany Service Award of the Lower East Side Democratic Club, the Ellis Island Medal of Honor of the National Ethnic Coalition of Organization Foundation, Inc.; and has been honored

by the Civil Service Merit Council, the State of Israel Bonds program, the Santiago Inglesias Educational Society, the Louis Howard Latimer Association, the Catholic Council of Electrical Workers, the Jewish Welfare Club, the American Cancer Society, the New York Branch of the NAACP, the National Council of Young Israel's, and the Coney Island Chamber of Commerce.

In 1992, Mr. McLaughlin was elected to the New York State Assembly by the residents of the 25th Assembly District, which is made up of portions of the New York City neighborhoods of Flushing and Whitestone-one of the most ethnically, culturally, and economically diverse legislative districts in the country. In the Legislature, Assemblyman McLaughlin has been a leading advocate for tough crime laws and safe streets, where he has been honored by the New York State District Attorney's Association for his leadership on criminal justice issues. Praised by the New York Times for "his progressive views and strong community involvement," he is the author of more than a dozen state laws, including measures toughening crime laws, preserving the quality of life of residential neighborhoods, improving health care in his community, and helping Holocaust survivors qualify for state assistance. He also chairs the Subcommittee on Community Reinvestment of the Assembly's Standing Committee on Banks, which monitors discriminatory lending practices in the banking industry.

McLaughlin has been a Board member of United Way of Greater New York, a member of the Board of Directors of the Queens Overall Economic Development Corporation, a Board member of the New York City Council on Economic Education, a member of Queens Community Board 8, an officer of the Electchester Athletic Association, a Democratic District Leader, an Advisory Committee member of the Flushing Beacon Center, a member of the Board of Directors of the Queens Women's Center, an Advisory Council member of the New York State Labor-Religion Coalition, and a member of the Advisory Board of the New York State School of Industrial and Labor Relations at Cornell University.

Mr. McLaughlin has four children, Brian P., an apprentice electrician; Kelly, a college student; and Robert and Cassie, both high school students. He and his wife Eva live in Flushing.

THOMAS P. DINAPOLI

16th Assembly District (Part of Nassau County)

Now in his seventh term in the Assembly, Thomas P. DiNapoli, a Democrat, represents a district in northwestern Nassau County on Long Island.

Assemblyman DiNapoli serves as Chairman of the Standing Committee on Local Governments and the Assembly Task Force on Long Island Sound. He also Co-Chairs the Legislative Commission on Water Resource Needs of New York State and Long Island. He is a member of the Standing Committees on Education, Environmental Conservation, Veterans' Affairs and Ways and Means.

Since his election in 1986, Assemblyman DiNapoli has earned a reputation as one of the Assembly's leading voices on environmental issues. In 1993, Tom worked with an array of Long Island environmental, governmental and business leaders to craft the landmark "Long Island Pine Barrens Protection Act". For the past ten years, Assemblyman DiNapoli has been the Co-Chair of the Legislative Commission on Water Resource Needs of New York State and Long Island. He has championed efforts to restore the Long Island Sound and numerous measures to ensure the quality of our state's drinking water and protect surface and groundwater resources throughout the State. In 1998 he sponsored the law establishing Community Preservation Funds for Long Island's five east-end towns. This significant initiative will generate about \$110 million for land acquisition over the next decade. Tom has been active in addressing the public health implications of pesticides. He is the sponsor of the Neighbor Notification bill, a measure that would ensure greater public awareness of residential pesticide use. He has also sponsored the "Oil Spill Prevention and Contingency Act" to safeguard our waterways from petroleum spills.

Education issues are also a high priority for Assemblyman DiNapoli. In 1972, at the age of 18, Tom became the youngest person in New York State to hold public office when he was elected as a Trustee of the Mineola Board of Education. This election prompted then-Governor Nelson Rockefeller to approve legislation clarifying the right of 18 to 21 year-olds to hold elective office in New York State. He served on the school board for ten years, including two terms as President. In the Assembly, Tom has sponsored bills to provide for increased availability of absentee ballots for school elections, the sharing of administrative services between school districts and a single voting day for Long Island's school-budget votes.

Assemblyman DiNapoli has taken the lead on health care issues. He has sponsored laws to prohibit so-called "drive-through" mastectomy surgery by ensuring that decisions regarding length of hospital stay be left to doctor and patient, and to provide coverage for second opinions for all cancer patients.

In 1998, Assemblyman DiNapoli sponsored "Kieran's Law", which sets up a child care registry enabling parents to access information on caregivers who come to your home to take care of your children. This groundbreaking legislation will reassure parents that the caregiver hired does not have a criminal record, helping to eliminate some of the worrying associated with leaving a child at home.

In the 1995-96 legislative session, Tom DiNapoli served as President of the New York Conference of Italian-American State Legislators. This bipartisan organization encourages the development of an agenda on behalf of Italian-Americans throughout New York State. The goal of the Conference is to fight ethnic discrimination, to support maximum educational achievement for all students and to promote economic ties between New York State and Italy. The highlight each year is a weekend conference that brings together Italian-Americans from across the state to exchange ideas and address issues of concern.

A lifelong resident of the Town of North Hempstead, Tom DiNapoli grew up in Albertson and graduated from Mineola High School. He holds a Master's degree in Human Resources Management from the New School for Social Research and a Bachelor's degree (magna cum laude) in History from Hofstra University.

Prior to his election, Tom worked as a manager in the telecommunications industry. He also served as Legislative Assistant to Assemblyman Angelo Orazio in 1977 and as District Representative to Congressman Robert Mrazek from 1983 to 1985.

Tom has been active in local community affairs. He has served as President of the Board of Big Brothers and Big Sisters of Nassau County and as a Board Member of the Herricks Community Life Center. He remains a member of the Great Neck United Community Fund Board, the Sierra Club, the Great Neck Chamber of Commerce, Cellini Lodge - Sons of Italy and St. Aloysius Church in Great Neck. A former President of the Reform Democratic Association of Great Neck, Tom DiNapoli was a candidate for North Hempstead Town Council in 1975 and for Town Supervisor in 1982.

Assemblyman DiNapoli resides in the Village of Thomaston. He is the son of Nicholas and the late Adeline DiNapoli and the brother of James DiNapoli.

Names, Addresses and Numbers for lunch in Great Neck, September 14, 1999

Thomas DiNapoli, Nassau Cnty. Dem. Chairman, Assemblyman, 16th AD

Robert Rosegarten, Mayor of Great Neck

Lee Seeman, State Committee Person, Chamber of Commerce Program Manager

May Newburger, Town of North Hempstead Supervisor

Doreen Banks, Town of North Hempstead Town Council

Tony D'Urso, Town of North Hempstead Town Council

Ann Galante, Town of North Hempstead Receiver of Taxes

Lisanne Altmann, Nassau County Leg. (10th LD)

September 13, 1999

LISTENING EVENT AT THE GREAT NECK SENIOR CENTER

Date: September 14th, 1999
Time: 1:10 pm to 2:40 pm
Location: Great Neck Senior Citizens Center
80 Grace Avenue
Great Neck, New York
From: Neera Tanden
Stephen Metcalf

I. PURPOSE

To discuss issues of concern to seniors, including Medicare, prescription drugs, Social Security, long-term care, as well as other issues.

II. BACKGROUND

Overview

You will be part of a listening session on senior issues. You will open the listening session with brief remarks that touch upon senior issues, but will focus in particular on Medicare. You will use New York State Medicare statistics and discuss the Republican tax plan. You will then open the listening session and hear from the audience of senior citizens.

The President's Plan

Medicare is expected to become insolvent in 2015, nearly 20 years before Social Security. The President has therefore dedicated over \$300 billion of the non-Social Security budget surpluses over the next ten years to keeping Medicare solvent for the next twenty-five years. The Republican plan spends the entire surplus on a tax cut, leaving not a single penny for extending Medicare's solvency.

The President's plan includes a long-overdue prescription drug benefit. The President's proposal would give all beneficiaries the option to access affordable prescription drug coverage. It provides special benefits protections to low-income beneficiaries.

Medicare Benefits and Women

--At birth, an American woman's life expectancy is 79.1, six years longer than a man's.

--Women make up more than two-thirds of the nursing home population and two-thirds of the users of home health-care services.

--Most Medicare beneficiaries are women. 59 percent of Americans over 65 receiving benefits are women; 71 percent over 85; and 83 percent over age 100.

--Total spending on prescription drugs for women on Medicare is \$1,210, nearly 20 percent more than men.

--Nearly 7 in 10 of the Medicare beneficiaries living below the poverty line are women.

--17 percent of women on Medicare have incomes below the Federal poverty level (\$7,740 per year as of 1996).

--According to the Older Women's League, women spend a larger portion of their income on healthcare than men --22 percent, as compared to only 17 percent for men.

Medicare and Prescription Drugs

--There are thirteen million Medicare beneficiaries without prescription drug coverage.

--The value of Medicare Managed Care drug benefits is declining.

--The percentage of plans with limits of less than \$1000 has risen from 35 percent in 1998, to almost 60 percent in 2000.

--Only about 25 percent of the Medicare population has any significant prescription drug benefit, and this is likely to come from retiree health plans. Fewer and fewer firms are offering such plans --down more than 25 percent since 1994.

Medicare and New York State

--There are 2.7 million Medicare beneficiaries in New York State. Well over half --1.6 million -- are women. It is estimated that roughly two million New Yorkers have no significant prescription drug benefit.

--There are 310,000 Medicare beneficiaries age 85 and older in New York State.

--The number of all seniors --not just beneficiaries --in New York State is estimated to grow to 3.3 million by 2025 --a 38 percent increase. This growth rate is 4 times the general rate of projected population growth in New York State.

--Medicare beneficiaries seeking prescription drug benefits often turn to managed care. In 1999, nearly 250,000 New York Medicare beneficiaries had no managed care option. Another 350,000 had only one option for managed care.

--The President's prescription drug proposal gives all beneficiaries the option to access affordable prescription drug coverage. It provides special protections to low-income beneficiaries. Those below 135 percent of poverty (\$11,500 for a single person, \$15000 for a

couple) would pay no premiums or cost sharing, and those with incomes up to 150 percent of poverty (\$12,300 for a single person, \$16,500 for a couple) would pay a reduced minimum. At least half a million beneficiaries in New York would be able to participate in the Medicare prescription drug option without paying premiums or cost sharing. There were 436,000 Medicare beneficiaries in New York State below 120 percent of the poverty level in New York in 1998.

Local Issues of Concern

There are two local issues of particular concern. First is transportation, as Long Island has a poor bus system, making the elderly over-dependent on expensive cabs. (Long Island's public transportation system is in marked contrast to New York City's, which is heavily traveled by senior citizens.) In addition, support for social services and nutrition programs are an issue of concern to the local area, and the whole of New York State, as many seniors are very dependent on such aid. The Great Neck Senior Center helps administer such programs locally (see below).

Barbara Reiss, the Center's Executive Director, says that the issues of most pressing concern to the Center's members are the high cost of prescription drugs, the high cost of assisted living, home care and extended care.

NOTE: On April 28, 1999 you telephoned the Great Neck Chamber of Commerce, Great Neck Village Plaza and The Great Neck Millennium Committee to inform them that Great Neck had been chosen by the White House as an official "Millennium Community."

The Great Neck Senior Center

Started as a "Golden Age Club" in 1954, the Great Neck Senior Center evolved into a multi-purpose Senior Center. Its current mission is to "improve the quality of life for our older adults; to provide education, recreation, socialization and supportive services so they can remain independent as long as possible." In a typical week, about 750 people use the Center.

A significant portion of the population served by the Center is Jewish (perhaps a Happy New Year wish?) The Center includes an art room for painting and sculpture, and the offers lectures in art history, health, exercise, current events, poetry and creative writing, as well as four different dancing classes.

Health screenings, free flu inoculations and health lectures are an important part of the Center. The Center is linked to a network of counseling, bereavement and caretaker's groups in Nassau County. The Nassau County Department of Senior Citizen Affairs sponsors a five-day-a-week Nutrition Program providing a balanced hot lunch and transportation program that brings members to and from the Center door-to-door. The Center's Social Model Special Needs Day Care Program services the functionally disabled.

One of the Center's primary goals is to maintain and/or improve the quality of older adults' lives by keeping them in their own homes and offering supportive services to their families and caretakers. Often that caretaker is often a senior who is also in need of supportive services.

A special group within the Center, "New Options", is made up of three hundred members who go to trips to the theatre in New York City and Long Island, as well as various museums and other cultural institutions.

III. PARTICIPANTS

--Barbara Reiss, Executive Director, Great Neck Senior Center, will greet you

IV. SEQUENCE OF EVENTS

--Barbara Reiss, Executive Director of the Center, delivers welcoming remarks, and introduces you.

--You deliver remarks from podium.

--You listen to audience members and take questions.

--You work the room and depart.

V. PRESS PLAN

--Open Press.

THE WHITE HOUSE

Office of the Press Secretary

For Immediate Release

June 29, 1999

PRESIDENT CLINTON'S PLAN TO MODERNIZE AND STRENGTHEN
MEDICARE FOR THE 21st CENTURY

June 29, 1999

Today, President Clinton will unveil his plan to modernize and strengthen the Medicare program to prepare it for the health, demographic, and financing challenges it faces in the 21st Century. This historic initiative would: (1) make Medicare more competitive and efficient; (2) modernize and reform Medicare's benefits, including the provision of a long-overdue prescription drug benefit and cost sharing protections for preventive benefits; and (3) make an unprecedented long-term financing commitment to the program that would extend the life of the Medicare Trust Fund until 2027. The President will call on the Congress to work with him to reach a bipartisan consensus on important reforms this year.

MAKING MEDICARE MORE COMPETITIVE AND EFFICIENT. Since taking office, President Clinton has worked to implement Medicare reforms that, coupled with the strong economy and the Administration's aggressive anti-fraud and abuse enforcement efforts, have saved hundreds of billions of dollars and helped to extend the life of the Medicare trust fund from 1999 through 2015. Building on this success, the plan he unveils today:

- Gives traditional Medicare new private sector purchasing and quality improvement tools. The President's proposal would make the traditional fee-for-service program more competitive through the use of market-oriented purchasing and quality improvement tools to improve care and constrain costs. It would provide new or broader authority for competitive pricing, incentives for beneficiaries to use physicians who provide high quality care at reasonable costs, coordinating care for beneficiaries with chronic illnesses, and other best-practice private sector purchasing mechanisms. Savings: \$25 billion over 10 years.

- Extends competition to Medicare managed care plans by establishing a "Competitive Defined Benefit" while maintaining a viable traditional program. The Competitive Defined Benefit (CDB) proposal would, for the first time, inject true price competition among managed care plans in Medicare. Plans would be paid for covering Medicare's defined benefits, including a new subsidized drug benefit, and would compete by offering lower cost and higher quality. Price competition would make it easier for beneficiaries to make informed choices about their plan options and would, over time, save money for both beneficiaries and the program. The CDB would do so by providing beneficiaries with 75 cents of every dollar of savings that result from choosing lower cost plans. Beneficiaries opting to stay in the traditional fee-for-service program would be able to do so without an increase in premiums. Savings: \$8 billion over 10 years, starting in 2003.

- Constrains out-year program growth, but more moderately than the BBA 1997. To ensure that program growth does not significantly increase after most of the Medicare provisions of the BBA expire in 2003, the proposal includes out-year policies that protect against a return to unsustainable growth rates, but are more modest than those included in the BBA of 1997. This proposal would reduce average annual Medicare spending growth from 4.9 percent to 4.3 percent per beneficiary between

2002 and 2009. Savings: \$39 billion over 10 years (including interactions and premium offsets).

- Takes administrative and legislative action to smooth out the Balanced Budget Act (BBA) of 1997 provider payment reductions. The proposal includes a provider set-aside designed to smooth out provisions in the BBA that may be affecting Medicare beneficiaries' access to quality services. The Administration will work with Congress, outside groups, and experts to identify real access problems and the appropriate policy solutions. The plan also includes a number of administrative actions that are designed to moderate the impact of the BBA 1997 on some health care providers' ability to deliver quality services to beneficiaries. Cost: \$7.5 billion over 10 years.

MODERNIZING MEDICARE'S BENEFITS. The current Medicare benefit package does not include all the services needed to treat health problems facing the elderly and people with disabilities. The President's plan would take strong new steps to ensure that Medicare beneficiaries have access to affordable prescription drug and preventive services that have become essential elements of high-quality medicine. It also addresses excess utilization and waste associated with first-dollar coverage of clinical lab services and reforms the current Medigap market. Finally, it integrates the President's Medicare Buy-In proposal to provide an affordable coverage option for vulnerable Americans between the ages of 55 and 65. His plan:

- Establishes a new voluntary Medicare "Part D" prescription drug benefit that is affordable and available to all beneficiaries. The historic outpatient prescription drug benefit would:
 - Have no deductible and pay for half of the beneficiary's drug costs from the first prescription filled each year up to \$5,000 in spending (\$2,500 in Medicare payments) when fully phased-in by 2008.
 - Ensure beneficiaries a discount similar to that offered by many employer sponsored plans (estimated to be, on average, over 10 percent) for each prescription purchased - even after the \$5,000 limit is reached.
 - Cost about \$24 per month beginning in 2002 (when the benefit starts at a \$2,000 cap) and \$44 per month when fully phased-in by 2008. (This is one-half to one-third of the typical cost of private Medigap premiums.)
 - Ensure that beneficiaries with incomes below 135 percent of poverty (\$11,000/\$17,000 single/couples) would not pay premiums or cost sharing. Those with incomes between 135 and 150 percent of poverty would receive premium assistance as well.
 - Provide financial incentives for employers to retain their retiree health coverage if they provide a prescription drug benefit to retirees that was at least equivalent to the new Medicare outpatient drug benefit. This approach would save money for the program because the subsidy given would be generous enough for employers to maintain coverage yet lower than the Medicare subsidies for traditional participants.

Most Medicare beneficiaries will choose this new prescription drug option because of its attractiveness and affordability. Because older and disabled Americans rely so heavily on medications, about 31 million beneficiaries would benefit from this coverage each year. Cost: \$118 billion over 10 years, beginning in 2002.

- Eliminates all cost sharing for all preventive benefits in Medicare and institutes a major health promotion education campaign. This

proposal would cost \$3 billion over 10 years and would:

- Eliminate existing copayments and the deductible for every preventive service covered by Medicare, including colorectal cancer screening, bone mass measurements, pelvic exams, prostate cancer screening, diabetes self management benefits, and mammographies.

- Initiate a three-year demonstration project to provide cost-effective smoking cessation services to Medicare beneficiaries.

- Launch a new, nationwide health promotion education campaign targeted to all Americans over the age of 50.

- Rationalizes cost sharing. To help pay for the new prescription drug and preventive benefits, the President's plan would save \$11 billion over 10 years by rationalizing the current cost sharing requirements for Medicare by:

- Adding a 20 percent copayment for clinical laboratory services. The modest lab copayment would help prevent overuse, reduce fraud, and has been advocated by the Medicare Payment Advisory Commission.

- Indexing the Part B deductible for inflation. The Part B deductible index would guard against the program assuming a growing amount of Part B costs because, over time, inflation decreases the amount of the deductible in real terms. Compared to average annual Part B per capita costs, the deductible has fallen from 43 percent in 1967 to about 3 percent in 1999, according to CBO.

- Reforms Medigap. The President's plan would reform private insurance policies that supplement Medicare (Medigap) by: (1) working with the National Association of Insurance Commissioners to add a new lower-cost option with low copayments and to revise existing plans to conform with the President's proposals to strengthen Medicare; (2) directing the Secretary of HHS to determine the feasibility and advisability of reforms to improve supplemental cost sharing in Medicare, including a Medigap-like plan offered by the traditional Medicare program and steps to make it easier for beneficiaries to compare the cost and quality of private Medigap options; (3) providing easier access to Medigap if a beneficiary is in an HMO that withdraws from Medicare; and (4) expand the initial six month open enrollment period in Medigap to include individuals with disabilities and end stage renal disease (ESRD).

- Includes the President's Medicare Buy-In proposal. The plan includes the President's proposal to offer any American between the ages of 62-65 the choice to buy into the Medicare program for approximately \$300 per month if they agree to pay a small risk adjusted payment once they become eligible for traditional Medicare at age 65. Displaced workers between 55-62 who had involuntarily lost their jobs and insurance could buy in at a slightly higher premium (approximately \$400). And retirees over age 55 who had been promised health care in their retirement years would be provided access to "COBRA" continuation coverage if their old firm reneged on their commitment. The \$1.4 billion cost is offset in the President's FY 2000 budget.

STRENGTHENING MEDICARE'S FINANCING FOR THE 21ST CENTURY. The Medicare plan the President is proposing would strengthen the program and make it more competitive and efficient. However, no amount of policy-sound savings would be enough to handle the doubling of the elderly population from almost 40 million today to 80 million over the next three decades. Every respected expert recognizes that additional financing will be necessary to maintain basic services and quality for any length of time. The President believes that the baby boom generation should not pass along its inevitable Medicare financing crisis to its children. That is

why he has proposed that a significant portion of the surplus be dedicated to strengthening the program. Specifically, his plan:

- Extends the life of the Trust Fund until at least 2027. Dedicating 15 percent of the surplus (\$794 billion over 15 years) to Medicare not only ensures the financial health of the Trust Fund through at least 2027, but it also eliminates the need for future excessive cuts and radical restructuring that would be inevitable in the absence of these resources.
- Responsibly finances the new prescription drug benefit through savings and a modest amount from the surplus. The new drug benefit would cost about \$118 billion over 10 years. It would be fully financed by:
 - Savings from competition and efficiency. About 60 percent of the \$118 billion Federal cost of the new Medicare prescription drug benefit would be offset through these savings.
 - Dedicating a small fraction of the surplus. About 40 percent, or \$45.5 billion, of the surplus allocated to Medicare would be used to help finance the benefit. To put this amount in context, it is:
 - Less than one eighth of the amount of the surplus dedicated for Medicare (2 percent of the entire surplus); and
 - Less than the reduction in the Medicare baseline spending between January and June, 1999.

Policy experts advising the Congress (MedPAC, CBO, and the Medicare Trustees) have consistently underscored their belief that much of the recent decline in Medicare spending beyond initial projections is due to our success in combating fraud and waste. Reinvesting the savings that can be reasonably attributed to our anti-fraud and waste activities into a new prescription drug benefit is completely consistent with the past actions of the Congress and the Administration utilizing such savings for programmatic improvements.

PRESIDENT'S PLAN TO STRENGTHEN AND MODERNIZE MEDICARE FOR THE 21st CENTURY

- Goals for Reform:
 - Make Medicare More Competitive and Efficient
 - Modernize Medicare's Benefits
 - Strengthen Medicare's Financing for the 21st Century

PRESIDENT'S PROPOSAL

(Dollars in Billions, Trustees' Baseline)

00-04 00-09

COMPETITION & EFFICIENCY

Medicare Modernization	-5	-25
Competition	-0	-8
Provider Savings	-4	-39*
Provider Set-Aside	+4	+7.5
Total	-5	-64.5

MODERNIZING BENEFITS

Prescription Drug Benefit	+29	+118
Cost Sharing Changes	-2	-8
Total	+27	+110

DEDICATING FINANCING

Contribution to Solvency	-28	-328.5**
Surplus for Drug Benefit	-22	-45.5
Surplus Allocation	-50	-374

* Includes \$5.7 billion in interactions/premium offset

** Does not count toward package

- Reduces Medicare spending by \$72 billion over 10 years. About half of these savings come from innovative proposals to adopt successful private sector tools and competition. As a result of these policies, Medicare growth per beneficiary from 2003 to 2009 would slow from 4.9 percent to 4.3 percent.

- Adds an optional prescription drug benefit. This benefit would cost \$118 billion over 10 years. This cost is only about 5 percent of total Medicare spending in 2009.

- Over 60 percent of the costs are offset by the proposal's savings.

- The remaining \$45.5 billion would come from the Medicare allocation of the surplus. This amount is one-eighth of the \$374 billion over 10 years dedicated to Medicare, and less than 2 percent of the overall surplus.

- Extends the life of the Medicare trust fund for a quarter of a century, to at least 2027. The President's plan would dedicate 15 percent of the surplus to strengthen Medicare. This amount, when combined with the offset for the drug benefit and Part A savings, would extend the life of the Medicare Trust Fund for a quarter century, through at least 2027. This is the best prognosis for Medicare since the program was created.

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LEXIS®-NEXIS® Political Universe

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September 13, 1999, Monday, Late Edition - Final

SECTION: Section A; Page 1; Column 3; National Desk

LENGTH: 1333 words

HEADLINE: THE DEBATE ON AID FOR THE ELDERLY FOCUSES ON WOMEN

BYLINE: By ROBIN TONER

DATELINE: WASHINGTON, Sept. 12

BODY:

It is not an accident that Flo, a feisty sixty-something woman, is the star of the pharmaceutical industry's latest advertising campaign in the battle over adding **prescription drug** coverage to **Medicare**.

Nor is it a coincidence that the White House held an event not long ago to focus on **Medicare** as a women's issue. Or that the Democratic women of the Senate formed a working group last year to examine what the various proposals to restructure Social Security would mean to women. Or that the Older Women's League, an advocacy group, issued a report on Mother's Day this year titled, "The Face of **Medicare** Is a Woman You Know."

All of this reflects a basic demographic and political reality that increasingly colors the debate over restructuring **Medicare** and Social Security: old age is largely a country of women.

Women not only tend to live longer; they also are more economically insecure, have more chronic health conditions and, as a result, eventually become more dependent on those basic safety-net programs, health policy analysts say. Politically, that means they are becoming a prime audience -- and target and symbol -- in the great struggles over entitlements. Some defenders of these programs say that highlighting this vulnerable population -- as opposed to the image of the more affluent retirees -- is not only good policy but could be a potent political appeal.

"Women perceive it as a twofold issue: One, they're more likely to have all the problems of old age because they're likely to live longer," said Celinda Lake, a Democratic pollster. "And second, whatever caregiving responsibilities exist, women expect to fall squarely on their shoulders."

Bill McInturff, a Republican pollster who also works for the pharmaceutical industry, said, "When you do focus groups, women say, 'Look, I'm going to live longer. I could outlive my income.' Women just presume there's a higher chance they'll need a Government safety net more than men."

The demographics are clear: At birth, the American woman's life expectancy is 79.1, six years longer than a man's. Women account for 54 percent of the **Medicare** beneficiaries from age of 65 to 74, and

61 percent of the **Medicare** population from 75 to 84, according to the Henry J. Kaiser Family Foundation, a health research group. They account for 71 percent of the 85-and-over **Medicare** population. Reflecting this skew, women make up more than two-thirds of the nursing home population and two-thirds of the users of home health-care services.

Older women also have higher poverty rates than their male counterparts: 17 percent of the women on **Medicare** have incomes below the Federal poverty level (\$7,740 a year in 1996), compared with 11 percent of the men on **Medicare**, according to a report by the Older Women's League. Nearly 7 in 10 of the **Medicare** beneficiaries living below the poverty line are women, that report said.

"The good news is we live longer than men, and the bad news is that we live longer than men," said Judith L. Lichtman, president of the National Partnership for Women and Families, a liberal advocacy group for such causes as expanded family leave.

Ann F. Lewis, a Presidential counselor, said, "When you start talking about the fact that women live longer, are paid less, are far less likely to have pensions with their work, and far more likely to carry the responsibility for caregiving in our families, every woman in the audience starts to nod."

Ms. Lichtman and other advocates say women's groups have long recognized that "aging is a women's issue," because of women's work patterns, caregiving responsibilities, economic status and longevity. But in the last few years, as Social Security and **Medicare** appeared headed for overhauls, advocates say these groups have organized to insure that women's interests are protected.

"The reason you're hearing more about this now is the programs that women and men, but especially women, rely on for old age, Social Security and **Medicare**, are under new strains," said Joan Entmacher of the National Women's Law Center, an advocacy group that focuses on women's legal rights.

Senator Barbara A. Mikulski, Democrat of Maryland, said the Democratic women in the Senate began meeting on the issue a year ago, when Social Security restructuring appeared imminent and the debate over privatizing the program was taking off. Any major restructuring is now considered unlikely until after the 2000 election. A few months ago, the Democratic women produced a checklist of necessary ingredients for any Social Security overhaul, including preserving the program as a guaranteed benefit with protection against inflation.

"Others wanted to talk about macroeconomics," Ms. Mikulski said. "We wanted to talk about it at the macaroni-and-cheese level."

There is a clear political rationale for presenting Social Security and **Medicare** as women's issues, just as liberal advocates a decade ago tried to cast welfare and poverty as children's issues. Preserving and improving expensive entitlement programs for frail and economically vulnerable widows is much more appealing than doing so for affluent retirees.

"It puts a human face on it," Ms. Mikulski said of the focus on women. "And I believe a far more realistic face. We're not talking about the gilded golf cart here."

While Democrats and their sympathetic advocacy groups have been hitting this issue particularly hard, the focus on women is bipartisan. Representative Nancy L. Johnson, a Connecticut Republican who is a senior woman on the House Ways and Means Committee, contends that Republicans have

"been the lead party" in trying to protect older women's economic security through such measures as tax credits for caregivers and the purchase of long-term care insurance. "I think part of my job is to educate them about what we're doing and why we're doing it," Mrs. Johnson said.

In the near term, these demographic undercurrents are strong in the struggle over whether to add **prescription drug** coverage to **Medicare**, as proposed by the Clinton Administration this year. The Administration and the Older Women's League contend that this coverage gap is a particular hardship for older women, who spend a greater share of their income on health care than men, 22 percent compared with 17 percent.

Republican leaders, for their part, contend that they will focus on the needy in the debate over assistance for **prescription drugs**.

The drug industry, which fears that a major new Government benefit will lead to price controls, is sounding alarms in the person of Flo, who warns that "the White House plan puts bureaucrats in charge of our medicines."

The campaign presents Flo -- "an actress, but her story and concerns are real," according to campaign literature -- as being in the two-thirds of the **Medicare** population that has private drug coverage and plays to worries of people in this group that their insurance will be replaced by a less-generous and more-intrusive Government plan.

The advertisements say they are produced by Citizens for Better **Medicare**, a coalition of business, drug industry and some patients groups, but a spokesman for the group said they were primarily paid for by the pharmaceutical industry. The Pharmaceutical Research and Manufacturers of American have taken the lead in this campaign.

Some advocates of new **prescription drug** benefits have reacted angrily to the Flo advertisements. "The Flo campaign is really outrageous," said Representative Rosa DeLauro, Democrat of Connecticut. Deborah Briceland-Betts, executive director of the Older Women's League, said her organization had mounted an anti-Flo campaign: "The message is Flo is a fake, and she doesn't represent the majority of older women in America who are trying to figure out how to cover the costs of drugs."

The struggle over Flo is a symbol of what is to come, advocates on both sides agree. "We're all talking to women on these issues," said Ms. Lichtman. "They are, we are."

GRAPHIC: Graph: "AT A GLANCE: Health Care Among Older Women"

More women get **medicare**, and they are poorer than men. Women make up a larger and larger percentage of **Medicare** recipients as age increases. Women recipients are poorer, with about twice the percentage as men living on incomes below \$10,000 a year. Graph compares percentages of men and of women receiving **Medicare** and those living on incomes below \$10,000. Figures are compiled according to the following age groupings: 65-74, 75-84, and 85 and up. (Source: **Medicare** Current Beneficiary Survey, 1996; the Henry J. Kaiser Foundation)(pg. A14)

LANGUAGE: ENGLISH

LOAD-DATE: September 13, 1999

THE WHITE HOUSE
Office of the Press Secretary

For Immediate Release

July 27, 1999

REMARKS BY THE PRESIDENT
AND THE FIRST LADY
ON WOMEN AND MEDICARE

Presidential Hall

10:24 A.M. EDT

MRS. CLINTON: Thank you very much. And I want to thank Secretary Shalala, who has been a strong voice and strong force on behalf of issues that affect how we live and what kind of country we are.

I want to thank all of you for being here, as we come together to talk about one of most important challenges our nation faces today -- saving and preserving Medicare. I want to acknowledge the many people here who have done so much over the years to help us meet our obligations to each other and to the next generation -- members of the Older Women's League, the American Association of University Women, and those of you who represent women's and seniors' groups and Medicare advocates from one end of our country to the other.

We've come here today because our nation is engaged in a critical debate about America's future. We're living in a time of great prosperity and blessings, and of almost unparalleled opportunities for progress for all of our citizens. And we should all take pride in what we have been able to accomplish together over the last six and a half years. But the question before us now is how do we take advantage of this historic opportunity to take on some of the tough challenges our nation faces? How do we strengthen, rather than weaken, our fundamental commitments not only to our parents and our grandparents, but to future generations as well?

And that brings me to an issue that touches all of us, the urgent need to protect and preserve Medicare. Unless we act now, current projections say the Medicare trust fund will be insolvent in the year 2015, which is not very long at all. While this is a major concern for all of us, we're here today to spotlight those who have the greatest stake in a strong and healthy Medicare program, and that is America's women.

As the Henry Kaiser Family Foundation and OWL have reminded us again and again, women simply live longer than men. Now, we hope that is one gender gap that will eventually be closed, but it is the fact. And it is the fact as we project out into the 21st century. Now, that means we have more years to cherish our mothers and our grandmothers, but it also means that they and we are more likely to suffer from multiple and chronic illnesses and have greater long-term care needs. Four out of five of America's elderly women are widowed and almost half live out their days alone. And, not surprisingly, elderly women are much more likely to be poor. Nearly 7 in 10 Medicare beneficiaries living in poverty are women.

For all these reasons, supported by new data that the President will talk about in a few minutes, women rely more on Medicare than men and are, therefore, more vulnerable to changes in Medicare policies.

Over the past six and a half years, and as recently as a few weeks ago, I've spoken with women around the country about their concerns about the future: Women living alone who worry about who's going to care for them when they can no longer live independently; women with limited incomes who are struggling to pay for their prescription drugs, who don't think they can afford to get regular check-ups or get screening tests for osteoporosis, or breast cancer; women who, in their 60s and their 70s, are taking care of their aging or disabled parents, and who rely on Medicare to help them meet their family responsibilities.

I'm sure each of us here today has a story to tell. And we have with us just one example of a devoted daughter: Mary Lee DiSpirito, whose mother came to live with her in Virginia after her father died. As her mother became increasingly frail, Mary Lee had to stop working to care for her mother full-time. Like so many elderly women today, Mary Lee's mother suffered from multiple health problems. And while she had Medicare, and even a Medigap policy, it did not cover prescription drugs.

Because her mother's sole source of income was a monthly \$800 Social Security check, Mary Lee and her family paid \$4,500 a year in out-of-pocket expenses for prescription drugs -- an amount that would have -- if her mother had been alone, without a devoted daughter and family -- would have depleted half of her mother's yearly income. Mary Lee's mother passed away last November. But her valiant efforts to care for her mother, often under very difficult circumstances, are a vivid reminder of why we must act now to protect and preserve Medicare. I'd like to ask Mary Lee to stand up, because she is emblematic, and symbolic, of women throughout our country. (Applause.)

We owe Mary Lee and all of us the commitment that goes not only to our parents and our grandparents, but to those of us in this generation who are the caretakers who will soon begin to age, may become disabled or chronically ill ourselves. And we owe it to our children and eventually our children's children -- because if we don't invest in our nation's priorities and dedicate the necessary funds to save and modernize Medicare, countless women, like Mary Lee and all of us, and her mother and ours, will be at even greater risk than they are today.

If we don't save and modernize Medicare, then women will continue to struggle to pay for out-patient prescription drugs, and the problem will only get worse as medical advances increasingly rely on drug treatments that even today are beyond the means of most ordinary citizens. If we don't save and modernize Medicare, then women will continue to skip regular screenings and check-ups that would enhance the quality of their lives and reduce Medicare's long-term costs.

And perhaps most importantly, if we don't take advantage of this time of prosperity that we have worked so hard to achieve, then we will look back at our generation as having missed a unique opportunity to make responsible decisions and we will instead have run the risk of becoming a great burden to our own children that none of us ever wanted to be.

That's why I believe that to meet these critical challenges we must take a responsible and balanced approach to tax cuts. Only then will we be able to meet our obligations to America's elderly and disabled, and extend the life of the trust fund for the next quarter

century. Only then will we be able to modernize the benefit package to include prescription drugs and preventive care, and support the teaching hospitals that are so critical to serving America's poor and elderly. And only then will we be able to sustain and expand the investments we are making now in our schools, in our environment, in our cities and our country that are so critical to our future prosperity.

So, as we continue to debate these critical issues, not only in the halls of Congress, but around our kitchen tables -- let's not forget the human dimension of what we stand for and we fight for, and what we are seeking to protect and support. Sometimes these debates have a way of making our eyes glaze over as hundreds of billions of dollars are talked about. So let's remember to keep a human face on this debate. (Applause.)

And I want to introduce someone who will add to our understanding and make sure we keep that human dimension, just as Mary Lee has, someone who knows firsthand the challenges of caring for an aging mother at a time when her own daughter had not even yet left home. She knows what's at stake for women in this debate over the future of Medicare. She also represents millions of women who would benefit if we act now to strengthen and modernize Medicare. So it is my great pleasure to introduce Judith Cato. (Applause.)

* * * * *

THE PRESIDENT: Well, I must say that Judith did such a good job, there's hardly anything left to say. (Laughter.) Thank you very much for being here, and we welcome your daughter here.

I want to thank Secretary Shalala, and acknowledge the presence in the audience of Deborah Briceland Betts, the Executive Director of the Older Women's League; the people here from the Henry Kaiser Family Foundation, and the other representatives of women's groups, senior women's groups, and Medicare advocates. Hillary and Secretary Shalala and I are delighted to welcome you to the White House today, and we thank you for your interest in this critical issue.

We are here to discuss what I have repeatedly called a high-class problem: the American people are living longer, especially women. And it is a high-class problem because we have this surplus today, and a projected surplus for several years into the future, which will enable us to deal with the challenge of people living longer and spending more money on Medicare, and then the retirement of the baby boomers, which will put additional pressure on Medicare and on Social Security.

It is a high-class problem, but we don't want it to turn into a nightmare because we walked away from it when we could have dealt with it and we had the money to deal with it -- when we had the time to deal with it, and we knew good and well we ought to deal with it. So, again I say I thank you for being here, and I hope today we can get out some information which will persuade the American people and members of the Congress that the approach I have recommended for the future is the right one.

For 34 years now, Medicare has protected the health of our seniors -- it has enriched the lives of the disabled, it has eased the financial burdens on families as they cared for their loved ones. For millions of American women, in particular, Medicare has been the lifeline to a dignified retirement.

As the report released today by the Older Women's League so clearly tells us, a strong and modern Medicare system is absolutely

vital to the health and future of America's women. First it is critical because the majority of beneficiaries quite simply are women. Listen to this: 20 of the 34 million Americans currently enrolled in Medicare are women. I think we've got a chart that says that. But look here: 41 million -- 41 percent of the people in this country on Medicare over 65 are men; 59 percent are women.

And, of course, as time goes on, the percentages get better or worse, depending on the perspective. (Laughter.) Twenty-nine percent of the people over 85 are men, 71 percent are women; 17 percent of people over 100 are men, 83 percent are women. You may think those numbers are insubstantial, but Americans over 80 are the fastest growing population group in the United States, and I'm sure that most of us hope to be among them some day. So this is very important.

Second, without Medicare the doors to hospitals and doctor's offices to basic medical treatment and good health would actually be closed to millions of older women. Throughout their lives, women's incomes have always lagged behind those of men, a gap underscored in retirement through smaller pensions and Social Security checks. So even as they must make ends meet on smaller incomes, women must meet greater health care needs. Nearly three-fourths of older women have two or more chronic illnesses, compared to just 65 percent of older men. For these women, Medicare has truly meant the difference between a healthy retirement and one clouded by uncertainty, untreated illness and poverty.

Now, as you have just heard, the clock is ticking on Medicare's ability to meet the needs of our seniors in the next century. People living longer than ever, the retirement of the baby boom approaching, the Medicare trust fund will become insolvent by 2015. Now, you may think that's a good ways away, but let me tell you, when I took office, Medicare was supposed to become insolvent this year. And we took a lot of very strong steps to stop it from happening.

But we have taken all the easy steps, and some that, arguably, have gone too far. Everywhere I go, people say, you know, the therapy services have been cut back too much, or the inner-city hospitals with big teaching loads or the teaching hospitals generally -- not just in the big urban centers -- everywhere I go, people talk to me about this. So it should be obvious to everyone, there are no longer any easy ways to lengthen the life of the Medicare trust fund -- just as people are living longer and accessing it more. So that is problem one.

Problem two is that Medicare's benefits have not changed significantly since 1965, although the world of modern medicine has changed dramatically. There are some who really believe we can afford to put off this until later. I disagree. To them I say, listen to Judith Cato's story. Like millions of women in the same situation, affording prescription drugs for herself is right around the corner, and for her mother is today.

The typical 65-year-old woman retiring this year can expect to live to be 84. That's 19 more years of retirement. But if we don't act soon, the Medicare trust fund will expire in 16 years. Over the past six and a half years, we have managed to transform an economy burdened by an unconscionable deficit of \$290 billion to an economy that today is the picture of fiscal health, with a surplus of \$99 billion and a large projected surplus over the next decade. We've done this by balancing the budget, cutting unnecessary spending, expanding our investments in education and training, expanding our trade abroad; all of it bringing interest rates down and getting investment up and giving us a remarkable period of economic growth -- the longest peacetime expansion in our history; nearly 19 million new jobs and the lowest minority unemployment

and the highest home ownership ever recorded.

The question is, what are we doing to do with this? We know what one plan is -- you have talked about it. The majority in Congress say, well, let's approve a big tax cut now and worry about Medicare and extending the life of the Social Security trust fund, scheduled to run out of money in a little more than 30 years -- let's worry about that later.

One of my bright staff members said, it's kind of like a family sitting around the kitchen table saying, you know, we have always wanted to plan a really fancy vacation to Europe -- let's just do it and blow the works, and when we get home, we'll figure out whether we can pay the mortgage, the car payment and send the kids to college. (Laughter.)

You're laughing, but you know, it's not just a question of the size of the tax cut. Why are we even discussing it before we decide what it takes to save and strengthen Medicare, and what it takes to save Social Security, and what we have to invest in the education of our children, the defense of our nation, the protection of our environment. Why don't we ask ourselves what it is we have to do before we ask ourselves what it is we would like to do?

Now, so what do I think we have to do? Here's what I think we should do. I think, first of all, my plan would secure Medicare by dedicating over \$320 billion of our budget surplus for 10 years, to extend the life of the trust fund from 2015 to 2027. That would be the longest projected life we've had on the trust fund in many years. But we have not been this financially healthy in many years, nor have we faced the challenge of so many people retiring and living so long ever before. So we need to know it's going to be all right for a good while.

Secondly, we will introduce more modern mechanisms of competition to improve quality, but to control costs as well as we can, as private sector innovations have done. We will give seniors the chance to choose between lower-cost Medicare managed-care plans and the traditional program, but we will not support changes that would force them to move from one to the other.

I also believe it's important to modernize benefits and, over the long run, the economical thing to do. Over the last 30 years, a medical revolution has transformed health care, and in many cases prescription drugs now supplant what used to be routinely dealt with with surgeries. They have lengthened and improved the quality of life.

As the Older Women's League study shows, women have borne the greatest cost of this pharmaceutical revolution. According to the next chart, women spend \$1,200 a year on prescription drugs, on average -- about 20 percent more than men. Now, as you have already heard, our plan will help seniors to afford the prescription drugs that have become essential to modern medicine. The plan is completely voluntary, but available to all Medicare beneficiaries.

This is a challenge, I might add, not just for poor women. It is also a challenge for middle-class women as well. Look at the next chart. Half of all middle-class women -- that is, for seniors, those who make at least \$12,700 a year or, with couples, \$17,000 a year -- have no prescription drug coverage at all. So among those who have no coverage, a quarter are below the poverty line, a quarter are between 100 and 150 percent of poverty, half are over 150 percent of the poverty line -- although, if your drug bills are big enough, it doesn't take long to get down below the poverty line again.

Women who have tried to buy extra coverage through private Medigap policies have to cope with escalating premiums as they get older. That's one of the great ironies of these Medigap policies that -- I keep hearing about, you know, we don't really need this because of Medigap. They get more and more and more expensive as you get older and older and older and less and less and less able to come up with the money to pay for them.

Now, I think anybody that says we don't need to do this is out of touch with people's real lives and out of date. I'd also like to point out that our plan would eliminate the last barrier between seniors and preventive screenings -- tests for breast cancer, colon cancer, prostate cancer, diabetes and osteoporosis -- that can help save their lives. For too many seniors on fixed incomes, especially low-income women, the cost of the modest co-payment is prohibitive. Last year, for example -- listen to this -- just one in seven women took advantage of the mammograms covered by Medicare.

So what we want to do is to eliminate the deductible and the co-payments for the preventive screenings -- (applause) -- and we pay for it by introducing a modest co-pay on lab tests that are frequently overused, ones that have been identified, and by indexing to inflation the modest Part B premium, which will be much less burdensome because it's more broadly spread in a smaller amount of money. But the people who need these preventive screenings, this will save lives.

Consider the irony of this. Every condition I just outlined, we pay for the doctor benefits, we pay for the hospital benefits, but we don't want to let people get the preventive screenings that will keep them from spending that money in the first place -- keep them healthy and keep them alive. This is a good thing to do.

Now, this is a good plan. It is a responsible plan. And it is important that we deal with the Medicare challenge now, while we have the funds and the prosperity to do so. I have proposed to dedicate the Social Security portion of the surplus to Social Security, but also to lengthen the life of the trust fund by taking the interest savings we'll have, because this will allow us to pay the debt down, and putting it into the Social Security trust fund, so it will last longer. So we'll have at least over 50 years of life on the Social Security trust fund. (Applause.)

And as I said, I proposed to put over \$320 million in Medicare. There's not a single expert on this program who believes that we can stabilize the fund and lengthen the life of it and deal with the coming demographic challenges without more money. No one who has looked into this believes it. And I think this is very, very important, because if the tax cut being pushed by the congressional majority, which includes vast benefits for people in my income group and higher -- who have done quite well in the stock market, thank you very much -- (laughter) -- and are not clamoring for it, and are worried that it will destabilize the economy -- even today, there are stories in the paper that if we have a big tax cut, with the economy growing as fast as it is, it might stimulate inflation, which would cause increases in interest rates, which would take away all the economic benefits of the tax cuts in higher interest rates.

So I say to you, I do not believe that is the wise thing to do. I think first we should say, let's save Social Security and Medicare; let's add this responsible prescription drug benefit; let's decide the commitments that we ought to make -- to give our children good education, to keep our streets safe, to biomedical research, to national defense, to the environment -- and then let's decide what we can afford in a tax cut. Let's do first things first.

In addition, another benefit of my plan not present in any other one is that if my proposal were to pass the Congress, in about 15 years we would actually be out of debt as a nation, for the first time since 1835. (Applause.)

Now, the significance of that for older Americans is quite important. Why? Because if we are out of debt, it means we will have long-term prosperity, lower interest rates -- which means lower costs for business borrowing, more investment, more jobs, higher incomes, and for families, lower home mortgages, car payments, credit card payments and college loan payments. That amounts to a very big tax cut over 10 or 15 years, getting this country out of debt, making us less vulnerable to the vagaries of the international financial system, securing the long-term economic stability for the young people here in the audience and throughout our country.

Believe it or not, we can do all that and still have a fairly sizable tax cut. I propose to let people use it for retirement savings, for long-term care, for child care. But the point I want to make today is not so much what we spend it on, but how much it can be, and in what order we are doing this. We did not get to this moment of prosperity by figuring out how to eat our cake, and then looking around for the vegetables. (Laughter.) That's not how we got here. We got here -- and a lot of members of Congress lost their jobs over it because we took the tough decisions in 1993 to get the deficit down, to bring interest rates down, and to do it without having to give up on obligations to education and to our other important national priorities.

So here we are with this opportunity of a lifetime to deal with this, and I think we ought to do it. Now, I regret that, as all of you know, the congressional majority appears to have a different philosophy. Look what happened -- last week, in the House of Representatives, they passed an irresponsible tax bill that would spend our surplus, it wouldn't devote a dime -- not a dime -- not one dime to extending the solvency of Medicare. And interestingly enough, these tax cuts are worded so that they won't go into full effect until the year 2010, just when the baby boomers start to retire. And in the second 10 years, they'll cost way over twice as much as they did in the first 10 years.

Now -- so the whole impact of them will hit us right between the eyes as the baby boomers retire, Medicare nears insolvency, Social Security starts to show strains.

This week, the Senate is going to take up a similar bill. They also, I might say, as all the analysis -- I don't know if you've had -- I don't want to take time today to do this, but if you haven't seen the analysis of the bills, you ought to, because they're standing up there saying if we don't give this money back to you -- "they" -- i.e., me and my allies in Congress -- will spend it on "their" friends.

Well, Judith is my friend. (Laughter and applause.) It sounds so great: "we want to give it back to you, they're going to spend it on their friends." We want to spend it on saving Social Security and Medicare, educating our children, paying down the national debt and getting us out of debt, to help our friends, the American people.

They tickle me, you know, these guys. They were fighting the patients' bill of rights several days ago and they said, oh, these Democrats, all they do is stand up and tell stories, we're talking about something besides stories. Well, I don't know about you, but the older I get the more it seems to me like life is just a collection of stories.

(Laughter.) And people are pretty important -- a lot more important than statistics.

And I'm telling you, I've been at this business a long time. This country may never have an opportunity like this. And they're spending it on their friends. (Laughter and applause.) And, ironically, their friends are better off under our plan because the stock market has more than tripled -- their friends have done very well under our plan. We have had an economic policy that has been non-discriminatory, benefitting Republicans and Democrats, alike. (Laughter.)

Look, today I want you to read the papers today. They point out that the Congress, the majority, has begun resorting now to accounting gimmicks, because they've approved such a big tax cut they can't meet the fundamental obligations of government without beginning, right now, to spend the surplus. And they don't want to acknowledge that, so they've resorted to accounting gimmicks to disguise the fact that they're dipping into the surplus. They can't live within the budget limits we set in 1997 -- I told you, we all know we cut Medicare too much in '97; we're going to have to fix it. A lot of you know it. A lot of you deal with these programs and these health care providers.

But they want to give the illusion they're living within the budget limits, nothing has to be done, and they can have this tax cut. I'm telling you what's going to happen. If this tax cut were to become law, it would mean huge cuts in education, huge cuts in the environment, huge cuts in medical research, huge cuts in health care, and huge cuts in national defense -- or, if they didn't do that, we would see -- balloon the deficit again, just like we did in the 12 years before I took office, when the national debt quadrupled.

We tried it that way; it didn't work very well. Why are we going down the same road we tried before, when we have a road that we have tried for six and a half years that has brought us to this point? Why would we reverse course instead of building on what we've done and going beyond it? It is a big mistake, and it's wrong. It's not just wrong for the seniors. It's not just wrong for the women of this country. It's wrong for all Americans. It is not the right thing to do.

Now, it also -- it will take away the single best opportunity any of us will ever have in our lifetimes to save Social Security for the baby boomers, to save and strengthen Medicare, and to get us out of debt for the first time since 1835 -- to give the young people in this room a chance at a generation of prosperity. And I don't believe any thinking person, once they understand what the real numbers are -- let's get out of the rhetoric here, who's going to give it to whose friends and all that. What are the numbers? This is an arithmetic problem.

You know, I told people when I got elected President -- I'd come from a state with fairly straightforward values and ways of doing things, and I thought we ought to have a radical new idea in Washington -- we'd bring basic arithmetic back to the budget. (Laughter.) And basic arithmetic has worked pretty well. This doesn't add up.

And so I ask you to help me send the word to the Congress that let's do first things first. Let's fix Medicare. The women of America especially need it. (Applause.)

You know, we have to work together. Every time we get in one of these fights people throw their hands up. But there's normally a process that goes on here. When we were doing welfare reform I vetoed two bills because it took away the mandate of health care and nutrition

for children. We finally got a welfare reform that I thought was right, it carried by big majorities in both parties, in both Houses -- we have the lowest welfare rolls in 30 years. And we did it in an election year.

Then the next year we did the Balanced Budget Act and it has worked superbly. The only problem with it is that the Medicare cuts were too burdensome on certain groups, and we're trying to fix that. But I can tell you that if this tax cut passes there will be breathtaking cuts in every area of our national life that you would believe is important, over and above what it would do to totally rob us of any chance to stabilize and improve Medicare and save it for the baby boom generation.

We have big tests as a country: How are we going to deal with the aging of America? How are we going to give all of our kids a world-class education, especially since more and more of them come from families whose first language is not English? Those of us who expect to be alive in 20 years, or hope to be, better hope we do a good job of educating those kids.

How are we going to deal with all these other challenges? How are we going to bring economic opportunity to people who still haven't felt it? How are we going to stabilize the economy so that we'll still be growing even better 10, 15, 20 years from now? These are big challenges. But they are high-class problems in the sense that nations rarely get these opportunities. Once in a lifetime you get a chance to stand up with your country in good shape, bring people together, look down the road and say, yes, these are big challenges and we're going to check them off -- one, two, three, four -- because we have the money and the vision to deal with them.

So my appeal today is that we not get into a big fight, we just go back to basic arithmetic. These tax bills the majority is pushing could not get the support of their own members if we had a chart up on the wall that says, here is what we have to spend just to stay where we are today in education, defense, the environment, medical research; here's what every expert says it takes to stabilize Medicare; here is the interest savings you ought to be putting into the Social Security trust fund; here is what we have to do to fix health care. They agree we have to do some more for veterans care. They agree with these things -- the numbers don't add up. We cannot take the vacation without paying the home mortgage, the car payment, and the college loan bill. We can't do it. We can't eat the cake until the vegetables and the soup are out of the way. And we cannot defy the basic laws of arithmetic.

And contrary to some of the debate, we cannot forget the stories. This is about how millions upon millions upon millions of Americans will live. Will they live in dignity and health, or will they live in want and insecurity, imposing unconscionable burdens on their children, and limiting their children's ability to raise their grandchildren?

Or will we use this moment to build a more prosperous, more just, more decent society? This is about way more than drugs and trips to the doctor. This is about what kind of people we are and whether we can look beyond today to the tomorrow we all want for all of us.

Thank you. (Applause.)

END

11:06 A.M. EDT

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DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
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006. memo	Gabrielle Fialkoff to the First Lady re: political (1 page)	09/13/1999	Personal Misfile
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COLLECTION:

Clinton Presidential Records
Domestic Policy Council
Ann O'Leary
OA/Box Number: 19581

FOLDER TITLE:

Alternative Medicine

2013-0436-S

rc1287

RESTRICTION CODES

Presidential Records Act - [44 U.S.C. 2204(a)]

- P1 National Security Classified Information [(a)(1) of the PRA]
- P2 Relating to the appointment to Federal office [(a)(2) of the PRA]
- P3 Release would violate a Federal statute [(a)(3) of the PRA]
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008. list	re: political (2 pages)	09/14/1999	Personal Misfile
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SCHEDULE FOR HILLARY RODHAM CLINTON
MONDAY, SEPTEMBER 13, 1999

FINAL

WASHINGTON, DC / NEW YORK, NEW YORK

LEAD ADVANCE: JUSTIN KRONHOLM
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PRESS ADVANCE: ALLISON CHADWICK
917/865-4736 CELL PHONE

SITE ADVANCE: BASIL SMIKLE
518/339-0552 CELL PHONE

SITE ADVANCE: KEVIN PARKER
518/339-0550 CELL PHONE

SITE ADVANCE: PETE SELFRIDGE
518/339-0553 CELL PHONE

SITE ADVANCE: MELISSA ROCHESTER
202/365-7522 CELL PHONE
212/490-2938 HOME

SCHEDULER: EVAN RYAN
202/456-6751 PHONE
202/456-5340 FAX
202/483-0383 HOME
WHCA PAGER #4223

PREV RON The White House

2:30 pm DEPART South Portico
EN ROUTE Andrews Air Force Base
[drive time: 20 minutes]

2:50 pm ARRIVE Andrews Air Force Base

3:00 pm WHEELS UP Andrews Air Force Base
EN ROUTE LaGuardia International Airport
[flight time: 50 minutes]

3:50 pm WHEELS DOWN LaGuardia International Airport

4:00 pm DEPART LaGuardia International Airport
EN ROUTE Hillary 2000 Headquarters
[drive time: 40 minutes]

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009. schedule	Schedule for Hillary Rodham Clinton [partial] (2 pages)	09/13/1999	b(6)

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Domestic Policy Council
Ann O'Leary
OA/Box Number: 19581

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2013-0436-S

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SCHEDULE FOR HILLARY RODHAM CLINTON
MONDAY, SEPTEMBER 13, 1999

PAGE 2

4:40 pm **ARRIVE** Hillary 2000 Headquarters

GREETERS: Samara Rifkin

4:45 pm- **MEET & GREET with volunteers**

5:15 pm Hillary 2000 Headquarters
450 7th Avenue
Suite 804
New York, New York 10123
Phone: 212/239-2000
Fax: 212/563-5249
CLOSED PRESS

5:20 pm- **PRIVATE MEETING**

5:30 pm HRC Office
Hillary 2000 Headquarters
450 7th Avenue
Suite 804
New York, New York 10123
Phone: 212/239-2000
Fax: 212/563-5249
CLOSED PRESS

PARTICIPANTS:

(b)(6)

[009]

5:30 pm- **OFFICE TIME**

5:45 pm

5:50 pm **DEPART** Hillary 2000 Headquarters

EN ROUTE 82 Greene Street

[drive time: 20 minutes]

6:10 pm **ARRIVE** 82 Greene Street

GREETERS:

Eve Ensler
Susan Davidson
James Phillips
David Stone

**SCHEDULE FOR HILLARY RODHAM CLINTON
MONDAY, SEPTEMBER 13, 1999**

PAGE 3

6:15 pm-
8:15 pm

HILLARY 2000 FUNDRAISER

Residence of Susan Davidson and James Phillips
82 Greene Street
Apartment 5-F
New York, New York 10012
Phone: 212/219-3428
Fax: 212/219-3471
CLOSED PRESS

FORMAT:

- HRC does a photo-receiving line with guests.
- Patti LuPone and Phoebe Snow perform.
- Eve Ensler makes brief remarks and introduces HRC.
- HRC makes remarks, and has the option of taking Q&A.
- HRC departs.

PARTICIPANTS: approximately 70 guests expected.

8:20 pm

DEPART 82 Greene Street

(b)(6)

8:40 pm

ARRIVE 834 Fifth Avenue

RON

(b)(6)

WEATHER FORECAST FOR WASHINGTON, DC: Mostly sunny and warm.
High 82. Low 60.

WEATHER FORECAST FOR NEW YORK, NEW YORK: Sunny and warm. High
82. Low 66.

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**PRESIDENT'S COMMISSION ON
COMPLEMENTARY AND ALTERNATIVE
MEDICINE**

September 1999
Office of Presidential Personnel

CAM PRACTITIONERS

James Gordon *MD, Harvard*
District of Columbia *Psychiatrist*
Director, Center for Mind-Body Medicine, DC
Sponsor: Senator Harkin

Dr. Kabat-Zinn
Boston, MA
Executive Director, Center for Mindfulness in Medicine, Health Care, and Society, UMASS
Sponsor: Dr. Harlan

Sister Charlotte Kerr
Columbia, MD
Acupuncturist, Traditional Acupuncture Institute
Sponsor: Senator Barbara Mikulski

Kevin Kunz
Albuquerque, NM
Reflexology Research Project

Laura Patton, MD -
Seattle, WA
Clinical Director, Alternative Services, Washington University Medical Center

Joseph Pizzorno, Jr., N.D.
Bothell, WA
President, Bastyr University
Sponsor: Senator Harkin

Adam Perlman, MD
Director of Integrative Medicine for the Saint Barnabas Health Care System

Guy Riekeman
Davenport, IA
President, Palmer College of Chiropractic
Sponsor: Senator Harkin

Eliot Tokar *(Think about)*
Howard Beach, NY
Burlington Vermont Tibetan Resettlement Project
Trained in Eastern medicine
Sponsors: Senator Charles Schumer; Senator Patrick Leahy; Senator James Jeffords

HEALTH POLICY ANALYSTS

Michael H. Cohen, Esq.
Costa Mesa, CA
Author, Guest Lecturer, UCLA School of Medicine
Sponsor: Dr. Harlan

~~Michael Cohen~~
Washington, DC
Special Assistant to the President for Education
Domestic Policy Council, White House

Joseph M. Kaczmarczyk
Gaithersburg, MD *LHS*
Senior Advisor on Integrative Medicine and Alternative Health Practices
Health Resources and Services Administration
US Public Health Service

Jennifer Klein
Washington, DC
former Special Assistant to President for Domestic Policy, White House

~~Shelly McLane~~
Senior Public Policy Analyst *disabled*
National Association of Protection and Advocacy Systems

Marc S. Micozzi, M.D., Ph.D.
Philadelphia, PA *over-extended*
Executive Director of the College of Physicians of Philadelphia
Sponsor: Senator Harkin

Jay Moskowitz
Winston-Salem, NC *far more even*
Senior Associate Dean
Wake Forest University School of Medicine

William Roper, M.D., M.P.H.
Chapel Hill, NC
Dean and Professor of Health Policy and Administration, UNC
Sponsor: Senator Harkin

Ann Scheppach *no*
Senior Advisor to the Deputy Commissioner of the SSA

RESEARCHERS OF CAM OR CONVENTIONAL SCIENCES

□ Linda Aiken, PhD

Philadelphia, PA *mm*

Director of the Center for Health Outcomes and Policy Research and
Professor of Nursing and Sociology at the University of Pennsylvania

Wesley Alles, PhD

Palo Alto, CA

Senior Research Scientist, Stanford University

Brian Martin Berman, M.D.

Baltimore, MD *Center*

Associate Professor and Director, Complementary Medicine Program, University of Maryland
Sponsor: Senator Harkin

Arthur Caplan

Philadelphia, PA *researched not rep in ethics* *Harlan*

Director, Center for Bioethics and Trustee Professor of Bioethics, University of Pennsylvania

James Dalen, MD

Tucson, AZ

Vice President for Health Sciences

Dean, College of Medicine

University of Arizona

David Eisenberg, MD

Boston, MA

Assistant Professor of Medicine, Harvard University

Sponsor: Senator Harkin

William Leas Haskell

Portola Valley, CA

Director, Complementary and Alternative Medicine Program, Stanford University

Sponsor: Dr. Harlan

Fredi Kronenberg, PhD.

New York, NY

Associate Professor of Clinical Physiology and Rehabilitation Medicine, Columbia University

Sponsor: Senator Harkin

Robert McCaleb

Boulder, CO

President and Founder, Herb Research Foundation

Sponsor: Senator Harkin

RESEARCHERS (Continued)

Roger Nelson

Princeton, NJ

Experimental Psychologist, Director of Princeton Engineering Anomalies Research Laboratory

Marilyn Jean Schlitz, PhD

Sausalito, CA

Senior Scientist, Geraldine Brush Cancer Research Institute

California Pacific Medical Center

Richard Campbell Strohman

Berkeley, CA

Emeritus Professor of Molecular and Cell Biology, UC-Berkeley

Sponsor: Senator Harkin

David Spiegel, MD

Professor, Stanford University

Brian Strom, MD

Chair and Professor of Biostatistics and Epidemiology

Professor of Medicine, Professor of Pharmacology

Director of the Center for Clinical Epidemiology and Biostatistics

University of Pennsylvania School of Medicine

CONVENTIONAL PRACTITIONERS

Hugh F. Hill, III, M.D.

Bethesda, MD

Attending Physician/Clinical Instructor, Johns Hopkins Bayview Hospital

Sponsor: Presidential Personnel

Robert A. Nash, MD

President, Creative Medical Institute

Sponsor: Rep. Owen Pickett

Dean Ornish, M.D.

Sausalito, CA

Clinical Professor of Medicine and Attending Physician

University of California, San Francisco

Sponsor: Senator Harkin

GENERAL

(Including Academic, Consumer, Business, Health Care Companies, Public)

Wade Aubrey, MD

San Francisco, CA

National Medical Consultant Blue Cross Blue Shield Association and

Associate Professor of Medicine at University of California at San Francisco

Eric Bauman

Van Nuys, CA

Consultant and Managing Partner

Consultants in Nursing Services Administration

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former Congressman, IA

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CEO and Founder of Tom's of Maine

Leading manufacturer of CAM products

Ian Coulter

Los Angeles, CA

Professor of Dentistry, UCLA

George Devries

San Diego, CA

Chairman and CEO, American Specialty Health Plans

Sponsor: Senator Harkin; Rep. Frank Pallone (D-NJ)

Tracy Williams Gaudet, MD

Tucson, AZ

Executive Director, Program in Integrative Medicine

University of Arizona Health Sciences Center

Dr. Harley Goldberg

Of San Francisco, CA

Regional Coordinator of CAM for

Northern California Kaiser Permanente Medical Care Program

GENERAL (Continued)

Stephen Gorin, PhD

Canterbury, NH

Executive Director of the NH Chapter of the National Association of Social Workers

Professor of Social Work, Plymouth State College, Plymouth, NH

Samuel Gorovitz, PhD

Syracuse, NY

Professor of Philosophy and Public Administration

Syracuse University

Ellen Hughes, MD, PhD

San Francisco, CA

Associate Clinical Professor of medicine, Division of General Internal Medicine, University of California at San Francisco

Wayne Jonas

Bethesda, MD

Director, Office of Alternative Medicine

National Center for Complementary and Alternative Medicine

NIH

Sponsor: HHS, NIH

Michael Leitzes

Yardley, PA

President, Healthcare Management Consulting Services

John C. "Jack" Lewin, M.D.

San Francisco, CA

Executive Vice President and Chief Executive Officer of California Medical Association

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George Lundberg, MD

Chicago, IL

Professor at Northwestern and Harvard

Carolene Marks

San Francisco, CA

Board Member, National Foundation for Alternative Medicine

Breast cancer survivor with CAM experience

Letter from Dianne Feinstein

Letter from Nancy Pelosi

GENERAL (Continued)

Albert Martin, PhD
San Francisco, CA
Senior Vice President and Corporate Medical Director
Blue Shield of California

Cynthia Mulrow
San Antonio, TX
Professor of Medicine and Section Chief, General Internal Medicine
Audie Murphy VA Hospital, TX

Gilbert Ramirez, PhD
Fort Worth, TX
Associate Professor and Vice Chairman, Department of Public Health and Preventive Medicine
University of North Texas Health Science Center

Barry Turner
New Jersey
Former President of Warner-Lambert Consumer Healthcare Canada
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M. Jean Watson, PhD
Boulder, CO
Professor of Nursing, former Dean of School of Nursing
Founder and Director, Center for Human Caring
University of Colorado

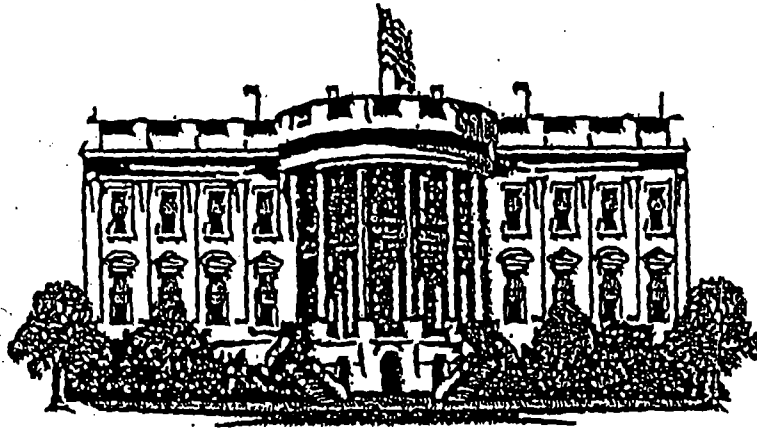
Andrew Weil
Tucson, AZ
Director, Program in Integrative Medicine of the College of Medicine, University of Arizona

John Weeks
Seattle, WA
Publisher-Editor, The Integrator for the Business of Alternative Medicine

Robert Windom
Senior Advisor, Florida Department of Health
Former A.S. of HHS (Reagan)
Sponsor: Senator Bob Graham

James Winn, MD
Executive Vice President of the Federation of State Medical Boards

THE WHITE HOUSE



Christopher C. Jennings
Deputy Assistant to the President for Health Policy
216 Old Executive Office Building
Washington, DC 20502
phone: (202) 456-5560
fax: (202) 456-5557

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DRAFT

EXECUTIVE ORDER

(Executive Order Number)

WHITE HOUSE COMMISSION ON COMPLEMENTARY AND ALTERNATIVE MEDICINE POLICY

By the authority vested in me as President by the Constitution and the laws of the United States of America, and in order to establish, in accordance with the provisions of the Federal Advisory Committee Act, as amended (5 U.S.C. Appendix 2), the White House Commission on Complementary and Alternative Medicine Policy, it is hereby ordered as follows:

Section 1. Establishment. There is established the White House Commission on Complementary and Alternative Medicine Policy ("Commission"). The Commission shall consist of not more than 12 members, including the chair, appointed by the President from knowledgeable representatives in health care practice, and complementary and alternative medicine.

Section 2. Function. The Commission shall report to the President and the Congress regarding legislative and administrative recommendations to assure that public policy maximizes the benefits to Americans of appropriate use of complementary and alternative medicine (CAM). The recommendations shall address the education and training of health care practitioners; coordinated research to increase knowledge about complementary and alternative medicine practices and products; reliable and useful information for health professionals that can be made readily accessible and understandable to the general public; and guidance for appropriate access and delivery of complementary and alternative medicine.

Section 3. Administration. The Department of Health and Human Services shall provide the Commission with administrative services, facilities, staff, and other support services necessary for the performance of its functions. Funds for the operation of the Commission shall

DRAFT

be provided by the Department of Health and Human Services.

(a) The heads of executive agencies shall, to the extent permitted by law, provide the Commission such information and assistance as it may require for the purpose of carrying out its functions.

(b) Each member of the Commission shall be compensated at a rate equal to the daily equivalent of the annual rate of basic pay prescribed for Level IV of the Executive Schedule under section 5315 of title 5, United States Code, for each day during which the member is engaged in the performance of the duties of the Commission. Members shall be allowed travel expenses, including per diem in lieu of subsistence, at rates authorized for employees under subchapter I of Chapter 57 of Title 5, United States Code, while away from their homes or regular places of business in the performance of services for the Commission.

© Notwithstanding any other Executive Order, the functions of the President under the Federal Advisory Committee Act, as amended, which are applicable to the Commission, except that of reporting to the Congress, shall be performed by the Secretary of Health and Human Services in accordance with guidelines issued by the Administrator of General Services.

(d) The Commission shall terminate 2 years from the date of this order unless extended by the President prior to such date. OR

The Commission shall terminate 30 days after submitting its report.

WILLIAM J. CLINTON

THE WHITE HOUSE,

(Date)

January 8, 1998

MEMORANDUM FOR HILLARY RODHAM CLINTON

FROM: Jennifer Klein, Chris Jennings, Nicole Rabner
SUBJECT: Meeting with Senator Harkin

On Monday, you will be meeting with Senator Harkin at his request to discuss his proposal to examine and promote alternative medicine by forming a White House Commission on Integrated Health Care. In the Congress, Senator Harkin has championed efforts to evaluate the use of alternative medicine. In 1992, he created the Office of Alternative Medicine at the NIH, but has long felt that, nonetheless, the NIH has not given the issue appropriate attention. The last budget signed by the President included, due to Senator Harkin's efforts, a significant increase for the NIH office -- from \$20 million to \$50 million. In addition, Senator Harkin secured \$1 million in the last budget to fund a commission should the President decide to appoint one.

Establishing a commission, as you know, has disadvantages, particularly the extraordinary length of time often taken to appoint members and for any actual work to get done. According to his staff, Senator Harkin may be open to other ways to achieve his goals. We are trying to reach the Acting Director of the NIH Office of Alternative Medicine before Monday's meeting to explore what if anything we might suggest in lieu of a commission. One alternative meeting may be to host a high level meeting to give the issue visibility and momentum.

Attached please find the Senator's proposal for this commission, as well as a recent articles on the subject of alternative medicine.

Meeting Participants

The First Lady
Senator Harkin
Peter Reinecke, Senator Harkin's office
Sabrina Corlette, Senator Harkin's office
Melanne Verveer
Chris Jennings
Jennifer Klein
Nicole Rabner

FROM SENATOR HARKIN

Proposal for a Commission on Integrated Health Care: Developing A National Plan

Background

Wide-spread use: According to the November 1998 issue of the *Journal of the American Medical Association (JAMA)*, 85 million American adults (42% of the population) now use complementary and alternative medical (CAM) products and practices. There are substantially more visits each year to alternative medicine practitioners than to conventional primary care physicians. The public's out-of-pocket expenses for these CAM products and services is equal to that paid out-of-pocket for physician services and is three times that paid out-of-pocket for hospital expenses.

A Women's Health Issue: Increasing numbers of women (48.9% in 1997) are turning to CAM products and practices for a variety of conditions and illnesses, including breast cancer, menstrual problems, endometriosis, nerve-related conditions, and pregnancy and labor management. Over the next 16 years, each year nearly 1 million American women will turn 50. The average age for menopause is 51. Hormone replacement therapies constitute the most prescribed drugs in America today and often are marketed as panaceas for conditions associated with aging such as osteoporosis and heart disease, in addition to the full range of menopausal complaints. Women are seeking natural, less invasive and holistic alternatives to synthetic drugs — alternatives that may reduce symptoms, improve well-being, and prevent and treat chronic illness. However, there is little or nothing known about the safety and effectiveness of many of these products and practices on pre-and menopausal women.

Similarly, little is known about alternative treatments for endometriosis, even though up to 20% of American women of childbearing age are diagnosed every year with this painful disease. While studies have shown some efficacy with conventional drugs, all of them have side-effects that make them unsuitable for long-term use. Subsequently, women are turning to untested alternative treatments and products to treat this condition.

Women often are the primary caretakers for the health of their entire family, making decisions about diet and illness prevention, such as vitamins and other food supplements, and for treatment of minor aches and pains. And these women increasingly desire to take charge of their own -- and their family's -- health care practices. For example, the vast majority, approximately two-thirds, of homeopathic patients and purchasers of homeopathic products are women.

Integrated Medicine: Over 95% of those who use CAM products and practices do so in conjunction with conventional medicine — not in place of it. Americans are looking for health care services to complement conventional medicine when its side effects, costs, and effectiveness are inadequate or unacceptable. However, only a minority of patients disclose CAM use to their doctor and few doctors ask about CAM use or have the expertise to advise on the benefits and risks of these practices. In late 1997, *JAMA* noted the "increasingly critical" need to determine how to integrate CAM practices into clinical practice to improve patient care.

There is credible research showing the effectiveness of various CAM practices concerning many common conditions such as heart disease, depression, asthma, addictions and pain management. As research on CAM opens up new treatment options, the health care community has attempted to respond to the public's interest in CAM. Nearly 70% of American medical schools now offer CAM electives, and several are already incorporating required lectures and seminars into their core curricula. And managed care organizations and insurance companies are beginning to grapple with how to offer CAM benefits, and hospitals throughout the nation are opening "integrative care centers."

Statement of Need

National health and science policy must catch up with the changing values and needs of the American people. The movement toward integrated medicine promises a more comprehensive, and more responsive health care system. Evidence suggests that this approach may be far more cost-effective as well.

The Federal government needs to develop a national plan to address the integration of complementary and alternative treatments into mainstream health care. To that end, the Congress provided funding for a White House Commission on Integrated Health Care. The Commission is charged with developing a federal strategy for the integration of CAM into our health care system. In particular, the Commission would evaluate current CAM therapies; assess the prospects of a holistic or integrated approach for improving the health of Americans; address issues of regulation and safety; and establish guidelines for the integration of this approach and these therapies into all aspects of health care, including patient care, research, professional training and health education. Under the leadership of the White House, this Commission would seek input from all relevant constituencies, with a special focus on women's health, in the development of this plan.

Goals

The White House Commission's National Plan for Integrated Health Care would address the following:

- Determining priorities for integrated health care in the areas of practice, research and policy. These should include:
 - Surveillance and monitoring of potential adverse effects from CAM use
 - Adequate CAM education and training of health care providers
 - Accountability of emerging CAM products and practices
 - Consumer access to alternative medicine products and practices
 - Priorities for funding research on integrated health care, with a special emphasis on women's health research
 - Criteria for the provision of integrated health care benefits
 - Areas for frontier and anomalous sciences that are of interest to the public, including family wellness and women's health issues

— Use of traditional and indigenous medical practices in conjunction with conventional medicine

- Identifying what information on integrated health care should be collected, summarized and made easily accessible to the public
- Establishing appropriate and adequate research priorities, particularly in the area of women's health
- Developing guidance in making integrated health care services safe and effective, including how to monitor the possible adverse effects of these practices and products, and how to establish standards of training, credentialing, licensing and monitoring of service quality
- Establishing guidance to assure reasonable access and appropriate benefits to integrated health care services
- Reviewing the impact of integrated health care services on special populations, including the disadvantaged, elderly, veterans, children, women and minority populations

Consensus

Under the leadership of the White House, the Commission may seek the input and participation of a number of organizations, including, but not limited to, the following:

Association of American Medical Colleges
Association of Health Insurers of America
American Board of Medical Specialties
Agency of Health Care Policy and Research
Agency of International Development
Bureau of Primary Health Care
Bureau of Health Professionals
Centers for Disease Control and Prevention
Complementary and Alternative Medicine Consortium
Department of Health and Human Services
Office of Women's Health
Department of Defense
Department of Education
Food and Drug Administration
Federation of State Medical Boards
Government Reform and Oversight Committee
Health Care Financing Administration
Health Resources and Services Administration
Institute of Medicine
National Academy of Sciences

National Institutes of Health
National Library of Medicine
Office of Alternative Medicine
Office of Women's Health Research
Professional Health Care Associations
Veterans' Affairs
The World Bank

Membership

Under the leadership of the White House, the Commission would be composed of 10-15 knowledgeable and prominent citizens of the country with knowledge of and expertise in health care practice and policies and be drawn from both the public and private sectors.

The Chair should be a respected member of the health care establishment with experience in all aspects of medicine and health care and with an openness to innovative alternative practices and an ability to balance a wide diversity of views.

Timeline and Resources

The Commission would convene for a 12 to 15-month period. It would be allotted sufficient resources and a coordinating staff to support the Commission, solicit expert advice, collect relevant background information and obtain public input.

PAGE 1
LEVEL 1 - 5 OF 6 STORIES

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November 11, 1998, Wednesday, Final Edition

SECTION: A SECTION; Pg. A01

LENGTH: 1381 words

HEADLINE: Widening the Medical Mainstream; More Americans Using 'Alternative' Therapies

BYLINE: Susan Okie, Washington Post Staff Writer

BODY:

The number of Americans who are using "alternative" treatments such as herbal supplements, massage therapy and megavitamins is increasing dramatically and visits to alternative practitioners have become more common than visits to the family doctor, according to a new survey released yesterday.

At the same time, scientific attempts to evaluate the effectiveness of such therapies are starting to separate those that work from those that don't. For example, studies also released yesterday by a major medical journal found that burning a Chinese herb next to the toe of a pregnant woman can often make her breech baby turn head-down, but that another herb commonly sold as a weight-loss aid is useless.

The studies were among a half-dozen published today in the Journal of the American Medical Association (JAMA) in a special issue dedicated to alternative medicine. It marked the first such effort by a mainstream U.S. medical journal and was an attempt to meet doctors' need for high-quality scientific information on treatments that more and more patients are trying, the editor said. Altogether, the American Medical Association this week planned to publish a total 80 reports about alternative medical therapies in JAMA and other journals.

"It is the beginning of the beginning of acceptance of some forms of 1998 alternative medicine into mainstream medicine in the United States," said George Lundberg, the editor of JAMA. "Acceptance the good, old-fashioned way -- by merit."

An estimated 83 million American adults -- more than four out of 10 -- used some form of alternative medical treatment last year, according to the new survey by a Harvard research team. They reported that visits to practitioners of alternative therapies, from herbal medicines to "energy healing," have increased 47 percent since 1990, propelled chiefly by middle-aged, health-conscious baby boomers. Half of the people between age 35 and 49 reported of using at least one of the surveyed treatments last year. The majority of users said they were turning to the therapies to prevent future illnesses rather than to treat current ones.

Jeff Sherman, 46, a real estate developer from McLean, said he has used acupuncture and homeopathy to relieve headaches and dizziness. He said many of his friends also have tried various alternative therapies.

"I think we're all of the age, and we know enough about medicine, that we're willing to consider that perhaps Western medicine doesn't have the only answer," he said.

The Harvard team, led by David M. Eisenberg, questioned 2,055 randomly selected adults about their use last year of 16 alternative therapies and compared the results to a similar survey conducted by the same team in 1990. In addition to herbal medicine and "energy healing," therapies included in the survey were relaxation techniques, massage therapy, chiropractic, spiritual healing, megavitamins, self-help, imagery, homeopathy, hypnosis, biofeedback, acupuncture, folk remedies and various diets. The researchers tried to be more specific in a number of these areas. For example, when asked about vitamins, the surveyors specifically said they meant something other than regular daily vitamins or vitamins prescribed by a doctor.

The researchers found that Americans' use of alternative therapies increased by 25 percent during the seven-year period and that expenditures for practitioners' services increased by 45 percent. They estimated that Americans spent \$ 27 billion, most of it not reimbursed by insurance companies, on alternative treatments last year. Among the fastest-growing therapies were herbal remedies, massage, megavitamins, relaxation techniques and "spiritual healing."

"The fact that nearly 50 percent more people visit alternative medicine practitioners now than in 1990 is astounding," said Sen. Tom Harkin (D-Iowa), who sponsored legislation that created the Office of Alternative Medicine at the National Institutes of Health in 1991. "Consumers need and deserve better information on what works and what doesn't."

Last month, President Clinton signed a law upgrading the office to the National Center for Complementary and Alternative Medicine and increasing its

annual budget from \$ 20 million to \$ 50 million.

Only about 40 percent of people who use alternative therapies tell their doctors, the survey found. And as many as 15 million people who take prescription drugs also are using herbs or high-dose vitamins, raising concerns about possible side effects from combining treatments, Eisenberg said. "We raise the question of whether these 15 million adults are at risk for drug-herb or drug-vitamin interactions," he said.

The six studies tested various alternative therapies using a classic research design, the randomized clinical trial in which one group of patients receives a treatment and another group receives a placebo. In most of them, doctors and patients didn't know who was receiving what. Some of the results were surprising.

For instance, one study found that moxibustion, a traditional Chinese therapy in which an herb, *Artemisia vulgaris*, was burned next to an "acupuncture point" on the toe, proved safe and effective for stimulating fetuses in the wombs of pregnant women to turn over from a breech (feet-first) position to a head-first position, which is safer for delivery, said Francesco Cardini, an Italian gynecologist who conducted the study in China.

After two weeks, breech fetuses had turned over in 75 percent of the 130 women who received moxibustion daily or twice a day but in only 48 percent of 130 women who didn't get the treatment, he said. He said the therapy, which is painless, increases fetal movement, perhaps by changing nerve stimulation to the uterus.

"This treatment is quite strange for us, but it is easy, cheap, safe and can be done at home," said Cardini. "If it fails to attain the result, another therapy can be done later."

In another study, a stretching regimen based on yoga was found to help relieve hand pain and weakness produced by carpal tunnel syndrome, which is caused by compression of a nerve at the wrist. And a third study found that a mixture of traditional Chinese herbs helped alleviate symptoms -- such as abdominal pain, constipation or diarrhea -- in people with irritable bowel syndrome.

But spinal manipulation by chiropractors was not shown to relieve tension headaches. An herb, *Garcinia cambogia*, commonly found in supplements marketed to dieters was no more effective than a placebo for promoting weight loss. And acupuncture turned out to be no better than a placebo for pain caused by nerve damage in people with AIDS.

Lundberg said a study that finds that an alternative therapy, such as traditional Chinese herbs, is effective for a particular problem shouldn't be viewed as a blanket endorsement. "It is not proper to make a giant leap from one study to immediately say, 'That means Chinese herbs are okay from anybody's closet, for anything,' " he said at a Washington news conference where the research was released.

Some medical experts also have expressed concern that herbal products, which do not have to meet any official government purity or manufacturing standards, may carry dangerous impurities.

Gary Kaplan, a family practitioner and chronic pain specialist who runs an integrative medicine clinic in Arlington, applauded the studies. Kaplan said he and other practitioners at his clinic use a variety of treatments including manipulation, acupuncture, guided imagery, biofeedback, nutritional counseling and homeopathy. "I'm very pleased to see this stuff being studied," he said. "What's going on is really something of a quiet revolution in medicine. We're going to see an expanded concept of health and illness."

Alternative Treatments

Visits to practitioners of alter-native medicine have grown rapidly in the past seven years.

Total number of visits:

Alternative therapies

1990: 427 million

1997: 629 million

Primary care physicians

1990: 388 million

1997: 386 million

SOURCE: Journal of the American Medical Association

GRAPHIC: CH

LANGUAGE: ENGLISH

LOAD-DATE: November 11, 1998

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November 10, 1998, Tuesday, Final Edition

SECTION: OP-ED; Pg. A21

LENGTH: 766 words

HEADLINE: Another Kind Of Medicine

BYLINE: Daniel S. Greenberg

BODY:

Congress has given the orthodox medical establishment \$ 50 million to sort out the claims, mysteries and realities of "alternative medicine." That's the term for a melange of potions and treatments that includes massage and acupuncture, as well as shark's cartilage for cancer and St. John's Wort, a low-octane anti-depressant for sale without prescription.

Unfortunately, the congressional generosity is misbegotten, since the money was entrusted to the National Institutes of Health, where the management rates alternative medicine as synonymous with quack medicine. With lesser sums previously imposed on it by Congress, \$ 20 million last year, the guardians of medical orthodoxy at NIH have been pawing at alternative medicine since 1993, with little to show for their efforts. In fact, squabbles still persist about the definition of alternative medicine, with some proponents preferring to call it "complementary medicine," while others have recently shown interest in calling it "integrative medicine," sometimes in combination with the other terms.

It's important to look at it, the proponents argue, since Americans by the scores of millions are gulping strange potions beyond the reach of the Food and Drug Administration and subjecting themselves to procedures foreign to traditional medical practice. According to a recent issue of the Journal of the American Medical Association (JAMA) that was devoted to alternative medicine, Americans made 629 million visits to "alternative medicine practitioners" in 1997, "thereby exceeding total visits to all U.S. primary care physicians." The alternative healers are said to have taken in \$ 21.2 billion; \$ 12.2 billion of that sum was out of pocket -- which probably signifies a mixture of confidence and desperation among their clients.

The expressed concern in the ranks of orthodox medicine is that reliance on

the alternatives might delay or interfere with effective treatments for serious ailments. There's also worry about fraud in the grand snake-oil tradition and well-intentioned but harmful incompetence. A mainstream scientist is quoted in the JAMA issue as saying, "Why don't we form a center at Harvard for the scientific study of astrology?" Various alternative camps respond that these concerns reflect the turf insecurities of organized medicine, now intensified by the income-cutting rigors of managed care.

The directed purpose of the NIH program is to subject alternative treatments to the same type of scientific examination that supposedly ensures the safety and efficacy of mainstream medicine. The moving force behind this effort is Sen. Tom Harkin (D-Iowa), who forced money upon NIH in 1992 for what eventually became a low-level Office of Alternative Medicine. Hostile to this mandate, the NIH management entombed the office in bureaucratic snarls, to the point where the founding director quit in disgust after two years. His successor, Wayne B. Jonas, a medical officer on detail from the U.S. Army, fared better during a three-year stint. Jonas made progress toward getting mainstream scientists and physicians to recognize that whatever their attitude toward alternative medicine, scores of millions of Americans are indulging in it and therefore it is desirable to identify what works and what doesn't. Harkin struck again this year, elevating the office to the more independent rank of a center in the NIH organizational structure, and raising the budget to \$ 50 million, despite NIH's preference for holding the money level.

In a swan song article in JAMA, Jonas touched on several characteristics that may account for the popularity of alternative medicine. Based on reports of patient surveys, he notes that the "time spent with each patient by an alternative medicine practitioner usually exceeds that spent by the average conventional physician, and patients are often more satisfied with their interactions with unorthodox than orthodox medical practitioners." He points out that conventional treatments gone awry "are a major cause of death and hospitalization" -- a failing openly acknowledged by orthodox medicine.

The need to study alternative medicine is beyond dispute. But NIH, a stronghold of medical orthodoxy, has amply demonstrated over six years that it's not the place to do it. The new center would be better off as an independent agency, safely insulated from the tender care of the elite skeptics at the National Institutes of Health.

The writer is a visiting scholar in the history of science, medicine and technology at Johns Hopkins University.

GRAPHIC: ILL,JOHN OVERMYER
LANGUAGE: ENGLISH
LOAD-DATE: November 10, 1998

Trends in Alternative Medicine Use in the United States, 1990-1997

Results of a Follow-up National Survey

David M. Eisenberg, MD; Roger B. Davis, ScD; Susan L. Ettner, PhD; Scott Appel, MS; Sonja Wilkey; Maria Van Rompay; Ronald C. Kessler, PhD

Context.—A prior national survey documented the high prevalence and costs of alternative medicine use in the United States in 1990.

Objective.—To document trends in alternative medicine use in the United States between 1990 and 1997.

Design.—Nationally representative random household telephone surveys using comparable key questions were conducted in 1991 and 1997 measuring utilization in 1990 and 1997, respectively.

Participants.—A total of 1539 adults in 1991 and 2055 in 1997.

Main Outcomes Measures.—Prevalence, estimated costs, and disclosure of alternative therapies to physicians.

Results.—Use of at least 1 of 16 alternative therapies during the previous year increased from 33.8% in 1990 to 42.1% in 1997 ($P \leq .001$). The therapies increasing the most included herbal medicine, massage, megavitamins, self-help groups, folk remedies, energy healing, and homeopathy. The probability of users visiting an alternative medicine practitioner increased from 36.3% to 46.3% ($P = .002$). In both surveys alternative therapies were used most frequently for chronic conditions, including back problems, anxiety, depression, and headaches. There was no significant change in disclosure rates between the 2 survey years; 39.8% of alternative therapies were disclosed to physicians in 1990 vs 38.5% in 1997. The percentage of users paying entirely out-of-pocket for services provided by alternative medicine practitioners did not change significantly between 1990 (64.0%) and 1997 (58.3%) ($P = .36$). Extrapolations to the US population suggest a 47.3% increase in total visits to alternative medicine practitioners, from 427 million in 1990 to 629 million in 1997, thereby exceeding total visits to all US primary care physicians. An estimated 15 million adults in 1997 took prescription medications concurrently with herbal remedies and/or high-dose vitamins (18.4% of all prescription-users). Estimated expenditures for alternative medicine professional services increased 45.2% between 1990 and 1997 and were conservatively estimated at \$21.2 billion in 1997, with at least \$12.2 billion paid out-of-pocket. This exceeds the 1997 out-of-pocket expenditures for all US hospitalizations. Total 1997 out-of-pocket expenditures relating to alternative therapies were conservatively estimated at \$27.0 billion, which is comparable with the projected 1997 out-of-pocket expenditures for all US physician services.

Conclusions.—Alternative medicine use and expenditures increased substantially between 1990 and 1997, attributable primarily to an increase in the proportion of the population seeking alternative therapies, rather than increased visits per patient.

native medicine prevalence, costs, and patterns of use¹ demonstrated that alternative medicine has a substantial presence in the US health care system. Data from a survey in 1994² and a public opinion poll in 1997³ confirmed the extensive use of alternative medical therapies in the United States. An increasing number of US insurers and managed care organizations now offer alternative medicine programs and benefits.⁴ The majority of US medical schools now offer courses on alternative medicine.⁵

National surveys performed outside the United States suggest that alternative medicine is popular throughout the industrialized world.⁶ The percentage of the population who used alternative therapies during the prior 12 months has been estimated to be 10% in Denmark (1987),⁷ 33% in Finland (1982),⁸ and 49% in Australia (1993).⁹ Public opinion polls and consumers' association surveys suggest high prevalence rates throughout Europe and the United Kingdom.¹⁰⁻¹³ The percentage of the Canadian population who saw an alternative therapy practitioner during the previous 12 months has been estimated at 15% (1995).¹⁴ The wide range of utilization rates can be explained, in part, by the disparity in definitions of alternative therapy and the selection of therapies assessed.

The presumption is that alternative medicine use in the United States has increased at a considerable pace in recent years. The purpose of this follow-up national survey was to investigate this presumption and document trends in alternative medicine prevalence, costs, disclosure of use to physicians, and correlates of use since 1990.

JAMA. 1998;280:1569-1575

From the Center for Alternative Medicine Research and Education, Department of Medicine, Beth Israel Deaconess Medical Center (Drs Eisenberg and Davis, Mr Appel, and Mss Wilkey and Van Rompay), and the Department of Health Care Policy, Harvard Medical School (Drs Ettner and Kessler), Boston, Mass.

Reprints: David M. Eisenberg, MD, Center for Alternative Medicine Research and Education, Beth Israel Deaconess Medical Center, 330 Brookline Ave, Boston, MA 02215.

ALTERNATIVE medical therapies, functionally defined as interventions neither taught widely in medical schools nor generally available in US hospitals,¹ have attracted increased national attention from the media, the medical community, governmental agencies, and the public. A 1990 national survey of alter-

METHODS

Sample

We conducted parallel nationally representative telephone surveys in 1991 and 1997. Survey methods were approved by the Beth Israel Deaconess Institutional Review Board, Boston, Mass.

Both surveys used random-digit dialing to select households and random selection of 1 household resident, aged 18 years or older, as the respondent. Eligibility was limited to English speakers in whom cognitive or physical impairment did not prevent completion of the interview. We asked respondents about their use of alternative therapies during the prior 12 months. We consider the results of the 1991 survey, fielded between January and March of that year, representative of 1990, and the results of the 1997 survey, fielded between November 1997 and February 1998, representative of 1997.

The sampling scheme was designed with a target sample of 1500 in 1990 and 2000 in 1997. The latter sample size was chosen to provide power in excess of 80% to detect an increase from 34% to 39% in the proportion of adults who used at least 1 form of alternative therapy during the prior 12 months. The actual numbers of completed interviews were 1539 in 1990 (67% response rate) and 2055 in 1997 (60% weighted response rate). A secular trend in lower survey response required us to offer a \$20 financial incentive for participation in the 1997 survey to maintain a response rate near the one achieved in 1990. No financial incentive was used in the 1990 survey.

The data in each survey were separately weighted to adjust for geographic variation in cooperation (eg, by region of country and urbanicity) and for household variation in probability of selection (ie, the inverse relationship between size of household and probability of selection because only 1 interview was completed in each sample household). The data were then weighted in parallel on sociodemographic variables to adjust for aggregate discrepancies between the sample distributions and population distributions provided by the US Census Bureau. This last stage of weighting was based on the 1997 Current Population Survey data¹⁵ and was done in parallel across the 2 surveys to remove any between-survey discrepancies of weighted sociodemographic distributions.

Of the initial sample of 9750 telephone numbers in 1997, 26% were nonworking, 17% were not assigned to households, and 9% were unavailable (ie, despite 6 attempted follow-up contacts). We declared 481 households ineligible because respondents did not speak English or because of cognitive or physical incapacity. Among the remaining 4167 eligible respondents, 1720 (41.3%) completed the interview on initial request. Attempts were then made to convert a random subsample of 1066 refusers by offering them an increased stipend (\$50). A total of 335 (31.4%) of the 1066 contacted were converted in this manner. Extrapolating this

conversion rate to all of the refusers and weighting the data for the undersampling of initial refusers, we obtained a 60% ($41.3\% + [31.4\% \times (100\% - 41.3\%)]$) weighted overall response rate among eligible respondents.

Interview

In both years, the interview was presented as a survey conducted about the health care practices of Americans by investigators from Harvard Medical School. No mention was made of alternative or complementary therapies. The substantive questions began by asking about perceived health, health worries, days spent in bed, and functional impairment due to health problems. We then asked respondents about their interactions with a *medical doctor*, defined as "a medical doctor (MD) or a doctor of osteopathic medicine (DO), not a chiropractor or other nonmedical doctor." The term *medical doctor* was used throughout the remainder of the interview.

To document trends we explored the following: (1) Respondents in both surveys were presented with a list of common medical conditions and asked if they had experienced each of these conditions during the previous 12 months. (2) Respondents who reported more than 3 conditions were asked to identify their 3 most bothersome or serious medical conditions and were then asked about seeing a medical doctor for these principal medical conditions and about the perceived quality of these interactions. (3) Respondents were asked about their lifetime and past 12-month use of 16 alternative therapies and whether each of these therapies was used for each of the principal medical conditions. The 1997 survey also asked about use for a representative sample of other medical conditions and expanded the list of therapies beyond the original 16 assessed in 1990. (4) We distinguished between use under the supervision of a practitioner of alternative therapy and use without such supervision. Respondents who reported supervised use were asked about their number of visits in the past 12 months to practitioners of each therapy. (5) All users of alternative therapies in 1997 who acknowledged seeing a medical doctor during the past year were then asked if they had discussed their use of each therapy with a medical doctor and, if not, why not.

Prior use of 16 targeted therapies was explored using a computer-assisted interview transcript, which included the following clarifications in both 1990 and 1997: When asking about high-dose vitamin or megavitamin therapies, interviewers made clear that the survey sought information on vitamins not including a daily vitamin or vitamin pre-

scribed by a doctor. Prayer or spiritual healing by others was asked about separately from prayer or spiritual practice for individual health concern. Commercial diet programs were described as "the kind you have to pay for, but not including trying to lose or gain weight on your own." A lifestyle diet included examples like vegetarianism or macrobiotics. Questions regarding energy healing included examples of magnets, energy-emitting machines, or the "laying on of hands," and use of relaxation techniques was explained using the examples of meditation or the relaxation response. The remaining 9 therapies were asked about without interviewer clarification.

The 1997 survey was longer (average, 30 minutes) than the 1990 survey (average, 25 minutes) because we sought to explore a number of areas in more depth. All the important questions in the 1990 survey were repeated in 1997. These replicated questions are the focus of the current report. One major change in the 1997 survey involved replicated questions: respondents who reported using more than 3 alternative therapies were asked in-depth questions (eg, use of a practitioner of alternative therapies, number of visits, out-of-pocket expenses, reasons for use) for all such therapies in 1990 but only for a random sample of 3 such therapies in 1997. This was required because of expansion in both the number of alternative therapies we assessed in 1997 and questions about each therapy. The 1997 data were weighted to adjust for this sampling in making comparisons with the 1990 data.

Insurance Coverage

For each therapy for which respondents said they used services of an alternative medicine practitioner, we asked whether insurance helped pay for any of the costs of the therapy and whether the respondent paid any of the costs out-of-pocket. Based on the answers to these questions, we calculated the proportion of users of each therapy who had complete, partial, or no insurance coverage for that therapy. We also calculated the overall frequency of insurance coverage by weighting the insurance frequencies within each therapy by the proportion of all user therapies accounted for by that therapy.

Construction of Cost Measures

The total cost of visits to alternative medicine practitioners was calculated by multiplying the number of visits for each therapy by a per-visit price and adding the prices of the following therapies: relaxation techniques, herbal medicine, massage therapy, chiropractic care, megavitamins, self-help groups, imagery techniques, commercial diet, folk rem-

edies, lifestyle diet, energy healing, homeopathy, hypnosis, biofeedback, and acupuncture. Out-of-pocket costs were constructed for each therapy by multiplying each user's visits by the full price of the visit if the user had no insurance coverage, by 0.2 if the user had partial insurance coverage, and by zero if insurance paid the full price of the visit. The assumption of a 20% coinsurance rate among users with partial insurance coverage should yield a conservative estimate of out-of-pocket costs, because it ignores deductibles and benefit caps and assumes that insurance benefits for alternative therapy are similar to medical coverage.

We calculated costs based on per-visit prices chosen from typical prices paid for such services by private insurers using a Resource-Based Relative Value Scale (RBRVS)¹⁶ system in selected states. We then recalculated costs using a second set of prices chosen partly to reflect empirical data on the out-of-pocket costs paid by the respondents, but primarily to represent conservative estimates of the per-visit cost of alternative therapies. Total costs based on this second set of prices should represent a lower bound on true expenditures.

Out-of-pocket costs of herbs, megavitamin supplements, and commercial diet products were calculated by multiplying the total population of users by the average out-of-pocket expenditures reported by respondents who used each of these products. In 1997, each respondent who used an alternative therapy was also asked, "Did you spend any additional money on things like books, classes, equipment, or any other items related to [the alternative therapy] in the past 12 months?" Out-of-pocket expenditures on these other items were calculated following the same procedures used for herbs, megavitamins, and commercial diet products. Out-of-pocket expenditures on herbs, megavitamins, commercial diet products, and related items were based on actual dollar amounts reported, so changes between 1990 and 1997 include inflation. To isolate the increase in the cost of practitioner visits between 1990 and 1997 solely because of the increase in the use of alternative therapies, we calculated 1990 practitioner costs using 1997 prices. The differences between the 1990 and 1997 costs of practitioner services reported are understated because they do not take into account inflation, estimated at 44% by the medical component of the Consumer Price Index.¹⁷

Statistical Analysis

Analyses reported herein consist of computation of prevalence and mean estimates and comparisons of these esti-

mates through the years. As the data in both surveys are weighted, the Taylor series method was used to compute significance tests using SUDAAN software.¹⁸ χ^2 Tests of independence were used for comparing proportions, while *t* tests were used for continuous measures. Extrapolations of survey estimates to the total population were based on the assumption that there were 180 million adults living in the US household population in 1990 and 198 million in 1997.¹⁵

RESULTS

Characteristics of Respondents

The characteristics of the subjects we interviewed are shown in Table 1. The sociodemographic characteristics of the survey sample are similar to the population distributions published by the US Bureau of the Census.¹⁵

Patterns of Use

Use of alternative therapies in 1997 was not confined to any narrow segment of society. Rates of use ranged from 32% to 54% in the wide range of sociodemographic groups examined. Use was more common among women (48.9%) than men (37.8%) ($P = .001$) and less common among African Americans (33.1%) than members of other racial groups (44.5%) ($P = .004$). People aged 35 to 49 years reported higher rates of use (50.1%) than people either older (39.1%) ($P = .001$) or younger (41.8%) ($P = .003$). Use was higher among those who had some college education (50.6%) than with no college education (36.4%) ($P = .001$) and more common among people with annual incomes above \$50 000 (48.1%) than with lower incomes (42.6%) ($P = .03$). Use was more common among those in the West (50.1%) than elsewhere in the United States (42.1%) ($P = .004$). With the exception of observed sex differences in 1997, these patterns are consistent with those identified in 1990.

Population prevalence estimates of alternative medicine use in 1990 and 1997 are shown in Table 2. The 1990 survey estimated that 33.8% of the US adult population (60 million people) used at least 1 of the 16 alternative therapies listed, while the 1997 survey estimated that this proportion increased significantly to 42.1% (83 million people). A comparison of specific therapies in the first column shows increases in 15 of the 16 therapies; 10 of these were statistically significant ($P \leq .05$). The largest increases were in the use of herbal medicine, massage, megavitamins, self-help groups, folk remedies, energy healing, and homeopathy. Summing Table 2 (first column) data shows a 65% increase in

Table 1.—Characteristics of the 1997 (N = 2055) and 1990 (N = 1539) Subjects Interviewed Compared With the US Population*

Characteristic	1997 US		1990
	Survey, %	Bureau of the Census, %	
Sex			
Female	52	52	48
Male	48	48	52
Age, y			
18-24	10	13	16
25-34	22	20	23
35-49	33	32	27
≥50	35	35	34
Race/ethnicity			
White	77	73	82
African American	8	12	9
Hispanic	10	11	6
Asian	1	4	1
Other	4	1	2
Education			
<High school	14	18	24
High school graduate	37	34	35
College or more	49	48	40
Annual income, \$			
<20 000	27	33	30
20 000-49 999	45	41	53
≥50 000	27	26	18
Region			
Northeast	21	19	22
North central	24	24	32
South	35	35	26
West	20	22	19

*Due to rounding, percentages do not always total 100.

total number of therapies used, from 577 therapies per 1000 population in 1990 to 953 per 1000 in 1997.

Several categories of alternative therapy warrant clarification about the actual modalities used. Three quarters of respondents who acknowledged use of relaxation techniques said they used meditation. Among those who reported using energy healing, the most frequently cited technique involved the use of magnets. Other modalities common to this category included Therapeutic Touch, Reiki, and energy healing by religious groups. The use of self-prayer, in contrast to spiritual or energy healing performed by others, was investigated in terms of prevalence of use but not in terms of costs, referral patterns, or insurance reimbursement. All analyses in this article exclude data involving self-prayer.

Table 2 (second column) shows that a significantly higher proportion of alternative therapy users saw an alternative medicine practitioner in 1997 (46.3%, equivalent to 39 million people) than in 1990 (36.3%, equivalent to 22 million people). Of the 15 therapies for which the question was asked, the proportion of users who saw a practitioner increased for 11. However, even in 1997 there were only 5 therapies in which a majority of users consulted a practi-

Table 2.—Comparison of Prevalence and Frequency of Use of Alternative Therapies Among Adult Respondents, 1997 vs 1990*

Type of Therapy	Used In Past 12 mo, %		Saw a Practitioner In Past 12 mo, %		Mean No. of Visits per User in Past 12 mo		No. of Visits per 1000 Population		Estimated Total No. of Visits in 1997 (In Thousands)†	Total Visits, %‡§
	1997	1990	1997	1990	1997	1990	1997	1990		
Relaxation techniques	16.3¶	13.1	15.3	9.0	20.9	18.6	521.2	219.3	103 203	16.4
Herbal medicine	12.1**	2.5	15.1	10.2	2.9	8.1	53.0	20.7	10 491	1.7
Massage	11.1**	6.9	61.6#	41.4	8.4	14.8	574.4	422.8	113 723	18.1
Chiropractic	11.0	10.1	89.9**	71.1	9.8	12.6	969.1¶	904.8	191 886	30.5
Spiritual healing by others¶	7.0#	4.2	...	9.2	...	14.2	...	54.9	...	...
Megavitamins	5.5**	2.4	23.7	11.8	8.6	12.6	112.1	35.7	22 196	3.5
Self-help group	4.8**	2.3	44.4	38.3	18.9	20.5	402.8	180.6	79 754	12.7
Imagery	4.5	4.2	23.1	15.1	11.0	14.2	114.3	90.1	22 640	3.6
Commercial diet	4.4	3.9	43.2	24.0	7.3	20.7	138.8	193.8	27 474	4.4
Folk remedies	4.2**	0.2	6.2	0.0	1.0	...	2.6	...	516	0.1
Lifestyle diet	4.0	3.6	8.0	12.5	2.8	8.1	9.0	36.5	1774	0.3
Energy healing	3.8**	1.3	26.3	32.2	20.2#	8.3	201.9¶	34.7	39 972	6.4
Homeopathy	3.4**	0.7	16.5	31.7	1.6	6.1	9.0	13.5	1777	0.3
Hypnosis	1.2	0.9	62.7	51.8	2.8	2.6	21.1	12.1	4171	0.7
Biofeedback	1.0	1.0	54.3	20.8	3.6	6.4	19.5	13.3	3871	0.6
Acupuncture	1.0¶	0.4	87.6	91.3	3.1	38.4	27.2	140.2	5377	0.9
≥1 of 16 alternative therapies	42.1**	33.8	46.3#	36.3	16.3	19.2	3176.0	2373.0	628 825	...
SE	1.2	1.4	1.9	2.5	1.8	4.5	378.7	599.7	74 997	...
Self-prayer¶	35.1**	25.2	...	...	...	...	...	...	...	...

*Percentages are of those who used that type of therapy. Ellipses indicate data not applicable.

†Estimate based on 1997 population estimate of 198 million.

‡Percentage of total visits of the 16 therapies (ie, excluding self-prayer).

§Because of rounding, percentages do not total 100.

¶Respondents who received spiritual healing by others were not asked for details of visits in 1997, nor were those who used self-prayer in either year.

¶P≤.05; #P≤.01; **P≤.001.

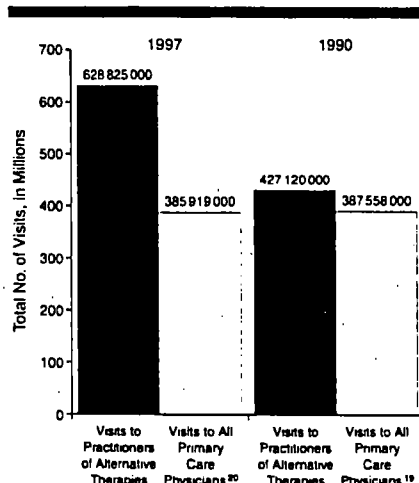


Figure 1.—Trends in annual visits to practitioners of alternative therapies vs visits to primary care physicians, United States, 1997 vs 1990. Data are from the National Ambulatory Medical Care Survey from 1996²⁰ and 1990.¹⁹

tioner: massage, chiropractic, hypnosis, biofeedback, and acupuncture. Unsupervised use (ie, a form of expanded self-care) remains the usual method of use for all other alternative therapies.

Table 2 (third column) reveals no consistent change in the average number of visits among respondents who consulted practitioners of alternative therapy between 1990 (19.2%) and 1997 (16.3%). However, because of the increase in the proportion of people using these therapies, the total number of visits increased substantially from 1990 to 1997. This

47.3% increase in total visits is largely because of increases in visits for relaxation therapy, massage, chiropractic, self-help, and energy healing. The visits to practitioners of alternative therapy in 1997 exceeded the projected number of visits to all primary care physicians in the United States by an estimated 243 million (Figure 1).^{19,20} Visits to chiropractors and massage therapists accounted for nearly half of all visits to practitioners of alternative therapies.

Prevalence estimates for selected additional therapies assessed in 1997 but not 1990 include: aromatherapy (5.6%), neural therapy (1.7%), naturopathy (0.7%), and chelation therapy (0.13%) (data not shown). Comparisons of total visits and costs for 1990 and 1997 were performed without inclusion of these data. Prevalence estimates for the simultaneous use of prescription medications with herbs, with high-dose vitamins, or with both were obtained. Among the 44% of adults who said they regularly take prescription medications, nearly 1 (18.4%) in 5 reported the concurrent use of at least 1 herbal product, a high-dose vitamin, or both.

Table 3 summarizes results regarding use of alternative therapies for the most commonly reported principal medical conditions in either survey. In each year, a majority of respondents reported 1 or more principal medical conditions. The list of conditions was expanded in 1997 (37 conditions) compared with 1990 (24 conditions). Significant increases in the proportion using alternative therapies

for principal condition(s) (second column) occurred for back problems, allergies, arthritis, and digestive problems. The highest condition-specific rates of alternative therapy use in 1997 were for neck (57.0%) and back (47.6%) problems. The proportion of respondents with 1 or more medical conditions who reported use of an alternative therapy for at least 1 of those conditions increased significantly from 22.9% in 1990 to 33.7% in 1997 ($P \leq .001$). The weighted condition-specific proportion who saw an alternative medicine practitioner for a given condition also increased significantly from 6.8% in 1990 to 11.4% in 1997 ($P \leq .001$).

Table 3 also summarizes the probability that individuals who saw a medical doctor for a particular condition also used an alternative therapy (fourth column) or also saw a practitioner of alternative therapy (fifth column) for that same condition during the same year. A generally increasing pattern of alternative medicine use can be seen across the range of conditions studied. In 1990, an estimated 1 (19.9%) in 5 individuals seeing a medical doctor for a principal condition also used an alternative therapy. This percentage increased to nearly 1 (31.8%) in 3 in 1997 ($P \leq .001$). The percentage who saw a medical doctor and also sought the services of an alternative practitioner increased significantly from 8.3% in 1990 to 13.7% in 1997 ($P \leq .01$). In both 1990 and 1997, chiropractic, relaxation techniques, and massage therapy were among the al-

Table 3.—Comparison of Use of Alternative Therapies for the Most Frequently Reported Principal Medical Conditions, 1997 vs 1990

Condition	Percentage Reporting Condition		Used Alternative Therapy for Condition in Past 12 mo, %		Saw Alternative Practitioner for Condition in Past 12 mo, %		Saw Medical Doctor and Used Alternative Therapy for Condition in Past 12 mo, %		Saw Medical Doctor and Alternative Practitioner for Condition in Past 12 mo, %		Therapies Most Commonly Used in 1997
	1997	1990	1997	1990	1997	1990	1997	1990	1997	1990	
Back problems	24.0#	19.9	47.6#	35.9	30.1#	19.5	58.8**	36.1	39.1#	23.0	Chiropractic, massage
Allergies	20.7#	16.0	16.6#	8.7	4.2	3.3	28.0#	15.7	6.4	5.0	Herbal, relaxation
Fatigue*	16.7	...	27.0	...	6.3	...	51.6	...	13.1	...	Relaxation, massage
Arthritis	16.6	15.9	26.7#	17.5	10.0	7.6	38.5#	23.8	15.9	13.8	Relaxation, chiropractic
Headaches	12.9	13.2	32.2	26.5	13.3#	6.3	42.0	31.8	20.0	12.1	Relaxation, chiropractic
Neck problems*	12.1	...	57.0	...	37.5	...	66.6	...	47.5	...	Chiropractic, massage
High blood pressure	10.9	11.0	11.7	11.0	0.9	2.9	11.9	11.6	1.1	3.5	Megavitamins, relaxation
Sprains or strains	10.8	13.4	23.6	22.3	10.3	9.6	29.4	24.7	15.9	13.6	Chiropractic, relaxation
Insomnia	9.3#	13.6	26.4	20.4	7.6	4.0	48.4	19.8	13.3	10.9	Relaxation, herbal
Lung problems	8.7	7.3	13.2	8.8	2.5	0.5	17.9	11.1	3.4	0.6	Relaxation, spiritual healing, herbal
Skin problems	8.6	8.0	6.7	6.0	2.2	1.6	6.8	6.9	0.0	2.5	Imagery, energy healing
Digestive problems	8.2	10.1	27.3#	13.2	9.7#	3.6	34.1#	15.3	10.7	5.8	Relaxation, herbal
Depression†	5.6	8.4	40.9	20.2	15.6	7.0	40.9	35.2	26.9	14.0	Relaxation, spiritual healing
Anxiety‡	5.5	9.5	42.7	27.9	11.6	6.5	42.7	45.4	21.0	10.4	Relaxation, spiritual healing
Weighted average across all conditions§	...	...	28.2**	19.1	11.4**	6.8	31.8**	19.9	13.7#	8.3	...
People with ≥1 condition	77.8#	81.5	33.7**	22.9	15.3**	6.9	...	...	...	...	...

*Not included as a separate question in 1990 survey. Ellipses indicate data not applicable.

†The 1997 question asked about severe depression, which is not directly comparable with the 1990 question that asked about depression.

‡The 1997 question asked about anxiety attacks, which is not directly comparable with the 1990 question that asked about anxiety.

§The weighted averages are calculated based on all 37 conditions studied in 1997 and all 24 conditions studied in 1990, ie, condition is unit of analysis.

||This row shows percentage of respondents who reported 1 or more principal medical conditions, along with the percentage of these respondents who reported use of therapy or practitioners for at least 1 of these conditions, ie, person is the unit of analysis.

#P≤.05; #P≤.01; **P<.001.

ternative therapies used most commonly to treat principal medical conditions.

As in 1990, 96% of 1997 respondents who saw a practitioner of alternative therapy for a principal condition also saw a medical doctor during the prior 12 months, and only a minority of alternative therapies used were discussed with a medical doctor. Among the 618 respondents in 1997 who used 1 or more alternative therapies and had a medical doctor, only 377 (38.5%) of the 979 therapies used were discussed with the respondent's medical doctor. This is not significantly different from the 353 (39.8%) of the 886 therapies discussed by the comparable group of respondents (n = 501) in the 1990 survey. Given that most alternative therapy is used without the supervision of an alternative practitioner, a substantial portion of alternative therapy use for principal medical conditions (46.0% in 1997 and 51.3% in 1990) was done without input from either a medical doctor or practitioner of alternative therapy.

Payment for Alternative Therapy

Data on insurance coverage of expenditures for alternative therapy services are shown in Table 4. The majority of people who saw alternative therapy practitioners paid all the costs out-of-pocket in both 1990 (64.0%) and 1997 (58.3%). None of the changes in insurance coverage between 1990 and 1997 were statistically significant, probably due in part to small sample sizes.

Using conservative assumptions about the fees charged by practitioners of alternative therapies and assuming no changes in visit prices, Americans spent an estimated \$14.6 billion on visits to these practitioners in 1990 and \$21.2 billion in 1997 (Table 5). Using less conservative (RVRBS) price figures, the amount spent on services of practitioners of alternative therapies was estimated at \$22.6 billion in 1990 and \$32.7 billion in 1997. Regardless of which set of prices is used, total expenditures for practitioners of alternative therapies are estimated to have increased by approximately 45% between 1990 and 1997 exclusive of inflation.

Estimated out-of-pocket expenditures for high-dose vitamins increased from \$0.9 billion in 1990 to \$3.3 billion in 1997. Smaller increases were observed for commercial diet products (\$1.3 billion vs \$1.7 billion). Unlike the 1990 survey, the 1997 survey included questions about expenditures for herbal products (\$5.1 billion) and respondents' alternative therapy-specific books, classes, or equipment (\$4.7 billion).

The estimated total out-of-pocket component of the alternative medicine market in 1997 is shown in Figure 2. Projected out-of-pocket expenditures for all hospitalizations in 1997 in the United States totaled \$9.1 billion, while projected out-of-pocket expenses for all US physician services in the same year were \$29.3 billion.²¹ This compares to a conservatively estimated \$12.2 billion in out-of-

pocket payments to alternative medicine practitioners for the 15 therapies studied. Adding the estimates of \$5.1 billion for herbal therapies, \$3.3 billion for megavitamins, \$1.7 billion for diet products, and \$4.7 billion on alternative therapy-specific books, classes, and equipment, the total out-of-pocket expenditures for alternative medicine are conservatively estimated to be \$27.0 billion. Using the average per-visit prices derived from an RBRVS system¹⁶ rather than our conservative estimates (Table 5), the estimated total out-of-pocket expense is approximately \$34.4 billion, which is comparable with the projected 1997 out-of-pocket expenditures for all physician services.²¹ These estimates exclude out-of-pocket expenditures associated with therapies unique to the 1997 survey (eg, naturopathy, aromatherapy, neural therapy, and chelation therapy).

COMMENT

The results of our study are limited by the restriction of the sampling frame to people who speak English and have telephones and by the low response rate. The decrease in overall response rate from 67% in 1990 to 60% in 1997 is consistent with secular trends for US telephone interviews in recent years.²² It is difficult to know what, if any, bias was introduced or whether trend estimates are biased by the fact that financial incentives were used in 1997 but not 1990. Furthermore, we have no data on the accuracy of self-

Table 4.—Insurance Coverage of Alternative Medicine Services in the United States, 1997 vs 1990*

Type of Therapy	Percentage of Users of Services					
	Coverage, 1997			Coverage, 1990		
	Complete	Partial	None	Complete	Partial	None
Relaxation techniques	28.8	6.6	64.7	5.1	25.9	68.7
Herbal medicine	8.6	11.2	80.2	30.7	15.5	53.8
Massage	11.8	16.7	71.5	19.1	18.3	62.6
Chiropractic	17.6	38.1	44.3	11.5	32.8	55.9
Spiritual healing by other†	...	...	...	0.0	0.0	100.0
Megavitamins	2.7	53.3	44.0	0.0	100.0	0.0
Self-help group	11.7	36.9	51.5	2.8	17.4	79.8
Imagery	51.5	3.5	45.0	16.1	0.0	83.9
Commercial diet	5.0	40.1	54.9	0.0	5.1	94.9
Folk remedies	0.0	0.0	100.0	...	...	...
Lifestyle diet	0.0	44.9	55.1	62.3	0.0	37.7
Energy healing	30.8	8.2	61.1	0.0	19.1	80.9
Homeopathy	0.0	0.0	100.0	0.0	24.7	75.3
Hypnosis	5.1	0.0	94.9	7.0	0.0	93.0
Biofeedback	30.5	43.7	26.0	14.1	19.9	66.0
Acupuncture	0.0	40.7	59.3	21.6	23.0	55.4
Weighted average across all therapies	15.3	26.4	58.3	12.3	23.7	64.0

*Data are percentage of users of alternative therapies provided by practitioners. Ellipses indicate data not applicable.
†Reimbursement patterns not explored in 1997.

Table 5.—National Projections of Expenditures for Alternative Therapies in the United States, 1997 vs 1990*

Category of Expenditure	1997 (Billions of Dollars)		1990 (Billions of Dollars)		Change (%), 1997 vs 1990 (Billions of Dollars)	
	Conservative (SE)	RBRVS (SE)	Conservative (SE)	RBRVS (SE)	Conservative	RBRVS
Total expenditures on professional services for 15 alternative therapies†	21.2 (2.4)	32.7 (3.8)	14.6 (4.0)	22.6 (6.1)	6.6 (45.2)	10.1 (44.7)
Out-of-pocket expenditures						
Professional services, 15 therapies†‡	12.2 (1.7)	19.6 (3.3)	7.2 (1.3)	11.0 (2.1)	5.0 (69.4)§	8.6 (78.2)§
Megavitamins	3.3 (0.4)		0.9 (0.3)		2.4 (266.7)¶	
Commercial diet products	1.7 (0.3)		1.3 (0.3)		0.4 (30.8)	
Subtotal of out-of-pocket expenditures assessed in 1997 and 1990†	17.2	24.6	9.4	13.2	7.8 (83.0)	11.4 (86.4)
Out-of-pocket expenditures assessed only in 1997						
Herbal medicine	5.1 (0.5)		...		...	
Therapy-specific books, classes, and equipment	4.7 (0.8)		...		...	
Total out-of-pocket expenditures for alternative therapies in 1997†	27.0	34.4	...	...	...	...

*The 1990 and 1997 cost measures are based on 1990 and 1997 population estimates, respectively (180 million vs 198 million). Both used 1997 per-visit price estimates as follows (conservative price estimate is followed by Resource-Based Relative Value Scale [RBRVS] estimate for each therapy): relaxation techniques (\$20, \$50), herbal medicine (\$40, \$60), massage therapy (\$40, \$60), chiropractic care (\$40, \$65), megavitamins (\$40, \$50), self-help groups (\$20, \$20), imagery techniques (\$45, \$50), commercial diet (\$20, \$20), folk remedies (\$20, \$50), lifestyle diet (\$20, \$60), energy healing (\$40, \$50), homeopathy (\$45, \$60), hypnosis (\$60, \$80), biofeedback (\$60, \$80), and acupuncture (\$40, \$60). (Price estimates for spiritual healing by others were not included because respondents reporting use were not asked for details of professional visits). Ellipses indicate data not applicable.

†These figures reflect the range in out-of-pocket expenditures for conservative vs RBRVS-derived visit prices.

‡Assumes a 20% copayment for users with partial insurance coverage.

§P<0.05; ¶P<0.001.

reports concerning recollections of number of visits and amounts spent on books, classes, relevant equipment, herbs, or supplements. To the extent possible, we adjusted by weighting data on sociodemographic variables associated with alternative therapy use (eg, income, education, age, region). It is conceivable that the estimated prevalence and costs of alternative therapy use would have been lower if it were possible to correct for those limitations.

Within the context of these limitations, the results of these 2 surveys suggest that the prevalence and expenditures associated with alternative medical therapies in the United States have increased substantially from 1990 to 1997. This increase appears to be primarily due to increases in the prevalence of use and in the frequency with which users of alternative therapy sought professional services. In 1997, an estimated 4 in 10 Americans used at least 1 alternative therapy as com-

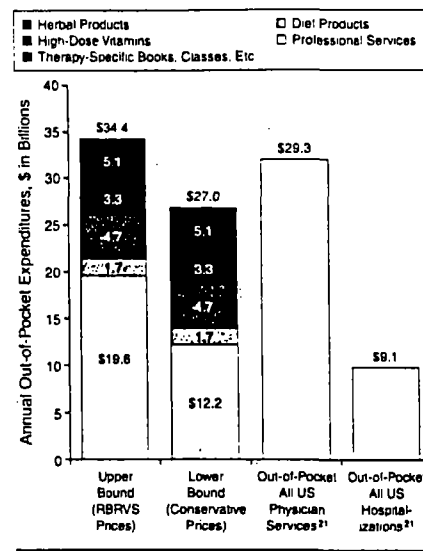


Figure 2.—Estimated annual out-of-pocket expenditures for alternative therapies vs conventional medical services, United States, 1997. Data are from the Health Care Financing Administration, United States.²¹ RBRVS indicates Resource-Based Relative Value Scale.

pared with 3 in 10 in 1990. For adults aged 35 to 49 years in 1997, it is estimated that 1 of every 2 persons used at least 1 alternative therapy. Overall prevalence of use increased by 25%, total visits by an estimated 47%, and expenditures on services provided by practitioners of alternative therapies by an estimated 45% exclusive of inflation. Moreover, the use of alternative therapies is distributed widely across all sociodemographic groups.

It is possible to arrange the 16 principal therapies common to the 1990 and 1997 surveys along a spectrum that varies from "more alternative" to "less alternative" in relationship to existing medical school curricula, clinical training, and practice. Arguably, therapies such as biofeedback, hypnosis, guided imagery, relaxation techniques that involve elicitation of the relaxation response (<1% of the sample), lifestyle diet, and (possibly) vitamin therapy can be considered as representative of the more conventional (ie, less alternative) side of the spectrum. Visits associated with these 6 categories accounted for less than 10% of total visits to alternative medicine practitioners; the remainder were associated with the more alternative therapies.

In light of the observed 380% increase in the use of herbal remedies and the 130% increase in high-dose vitamin use, it is not surprising to find that nearly 1 in 5 individuals taking prescription medications also was taking herbs, high-dose vitamin supplements, or both. Extrapolations to the total US population suggest that an estimated 15 million adults are at risk for potential adverse interac-

tions involving prescription medications and herbs or high-dose vitamin supplements. This figure includes nearly 3 million adults aged 65 years or older. Adverse interactions of this nature, including alterations of drug bioavailability or efficacy, are known to occur^{23,27} and are more likely among individuals with chronic medical illness, especially those with liver or kidney abnormalities. No adequate mechanism currently is in place to collect relevant surveillance data to document the extent to which the potential for drug-herb and drug-vitamin interaction is real or imaginary.

The magnitude of the demand for alternative therapy is noteworthy, in light of the relatively low rates of insurance coverage for these services. Unlike hospitalizations and physician services, alternative therapies are only infrequently included in insurance benefits. Even when alternative therapies are covered, they tend to have high deductibles and co-payments and tend to be subject to stringent limits on the number of visits or total dollar coverage. Because the demand for health care (and presumably alternative therapies) is sensitive to how much patients must pay out-of-pocket,²⁸ current use is likely to underrepresent utilization patterns if insurance coverage for alternative therapies increases in the future.

In 1990, a full third of respondents who used alternative therapy did not use it for any principal medical condition.¹ From these data, we inferred that a substantial amount of alternative therapy was used for health promotion or disease prevention. In 1997, 42% of all alternative therapies used were exclusively attributed to treatment of existing illness, whereas 58% were used, at least in part, to "prevent future illness from occurring or to maintain health and vitality."

Despite the dramatic increases in use and expenditures associated with alternative medical care, the extent to which patients disclose their use of alternative therapies to their physicians remains low. Less than 40% of the alternative therapies used were disclosed to a physician in both 1990 and 1997. It would be overly simplistic to blame either the patient or their physician for this inadequacy in patient-physician communication. The current status quo, which can be described as "don't ask and don't tell," needs to be abandoned.²⁹ Professional strategies for responsible dialogue in this area need to be further developed and refined.

Data from this survey, reflective of the US population, are representative of a predominantly white population. Even if we were to combine data sets from the 1990 and 1997 surveys, we would not

have a sufficiently large database to provide precise estimates of the patterns of alternative therapy use among African Americans, Hispanic Americans, Asian Americans, or other minority groups. Parallel surveys, modified to include therapies unique to minority populations and translated when appropriate, should be conducted using necessary sampling strategies. Only then can we compare patterns across ethnic groups and prioritize research agendas for individual populations. As alternative medicine is introduced by third-party payers as an attractive insurance product, it would be unfair for individuals without health insurance and those with less expendable income to be excluded from useful alternative medical services or consultation (eg, professional advice on use or avoidance of alternative therapies).

In conclusion, our survey confirms that alternative medicine use and expenditures have increased dramatically from 1990 to 1997. In light of these observations, we suggest that federal agencies, private corporations, foundations, and academic institutions adopt a more proactive posture concerning the implementation of clinical and basic science research, the development of relevant educational curricula, credentialing and referral guidelines, improved quality control of dietary supplements, and the establishment of postmarket surveillance of drug-herb (and drug-supplement) interactions.

This study was supported in part by National Institutes of Health grant U24 AR43441, Bethesda, Md, the John E. Fetzer Institute, Kalamazoo, Mich, The American Society of Actuaries, Schaumburg, Ill, the Friends of Beth Israel Deaconess Medical Center, and the Kenneth J. Germeshausen Foundation, Boston, Mass, and the J. E. and Z. B. Butler Foundation, New York, NY.

The authors thank the staff of DataStat, Inc, Ann Arbor, Mich, for their assistance with telephone data collection, Linda Bedell-Logan for assistance with RBRVS data analyses, Dan Cherkin, PhD, Murray Mittleman, MD, Ted Kaptchuk, OMD, and Thomas Delbanco, MD, for their review of the manuscript, and Debora Lane, Marcia Rich, and Robb Scholten for their technical assistance.

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Harkin staff mtg 3/1/89

Commission wd not dev. research priorities - rather, The NIH Center Advisory Bd wd do this.

↑ consumer conf - weeding out quacks, devel. rec for standards, etc.

Research rec: priv sector not carrying weight - products that aren't patentable
who can make claims about a product - address issue

inappropriate claims / penalties - fines

if that respect comes some level of responsibility - getting rid of quacks helps
the perception of industry

request of Harkin / Daschle - putting together what they're doing
what HHS is doing overall re: CAM
COC working group - ~~Nov~~ Nov
HRSA, Bureau of Primary Health Care.
appointments (?)
w/ Rich Tarplin
Roger McIlwain
Inventory department-wide

NIH wants to be involved in structure development. → Harkin
reps from HOPA, HHS.

design of Commission - it'd be transferred or admin function.
admin & advisory - more resources / invested in
w/ HHS app't.

Meeting w/ Harkins staff
3/1/99

- Sabrina Corlette

Draft March 1, 1999

***Proposal for Commission on Complementary and Alternative Medicine:
Developing a National Plan***

THE CHARGE TO THE COMMISSION

The Commission will report to the President and the Congress legislative and administrative recommendations to assure that public policy maximizes the benefits to Americans of appropriate use of complementary and alternative medicine (CAM). These recommendations should address the education and training of health care practitioners; coordinated research to increase knowledge about CAM practices and products; reliable and useful information for health professionals that can be made readily accessible and understandable to the general public; and guidance for appropriate access and delivery of CAM.

BACKGROUND

In November 1998, the *Journal of the American Medical Association* reported that 83 million Americans now use some form of complementary and alternative therapy. That represents a nearly 50 percent increase from 1990 in the number of visits to complementary and alternative medicine (CAM) practitioners. These visits totaled 629 million in 1997, exceeding total visits to all primary care physicians. Americans are digging into their pocketbooks for this care. Nearly 60 percent of alternative health care was paid for out-of-pocket--an estimated \$12 billion.

With this rapid rise in the use of CAM therapies by the public has come a number of other changes. Over the last decade nearly all U.S. medical schools have incorporated some form of training in unconventional medical therapies. Many private insurers have begun to offer coverage for CAM therapies. The number and quality of research studies evaluating CAM therapies has increased significantly.

While the government has acted to substantially increase its support for CAM research by establishing and funding the new National Center for Complementary and Alternative Medicine at the National Institutes of Health (NIH), many other areas of public policy have not kept pace. Public policy regarding training, credentialing, access, quality and consumer education, among others, must be evaluated and updated to meet the challenges and opportunities presented by complementary and alternative medicine.

The Commission will review and make recommendations in each of these areas. While the Commission will be charged with reviewing ways to increase support for CAM research, it will not set the nation's research agenda. This function remains the clear responsibility and role of the National Center for Complementary and Alternative Medicine at the NIH.

FOCUS AREAS FOR THE COMMISSION

Education, Training and Credentialing:

1. Should those being trained in CAM practices, such as acupuncture and homeopathy, be eligible for the full range of federal education assistance (loans, grants....)?
2. How should CAM be better integrated into the curricula and field training of medical, public health, and other health professional schools?
3. What can be done to encourage continuing education of CAM among practicing physicians and other conventional health care professionals?
4. Are existing licensing and accreditation standards for CAM fields appropriate?
typically state level - some states none

Research:

1. How can private sector support be increased for research on CAM practices and products, particularly self-care remedies such as vitamin and herbal products that are not easily patented? Are additional federal incentives required?
Orphan drug model
2. How can greater coordination among federal agencies be encouraged to address the diversity of research needs in CAM?
3. What can be done to expand the current research environment so that frontier claims and practices that lie outside conventional scientific conceptions are adequately and appropriately addressed?
e.g. prayer

Delivery of Integrated Health Care:

1. What criteria should be used to determine whether CAM therapies or products that demonstrate effectiveness are covered or subsidized by government health programs and private health plans?
identify reasonable criteria
2. What should and can be done to further the integration of effective CAM therapies and approaches with mainstream/traditional medical practices?
ed, info

Oversight: (combine?)

1. What can be done to ensure that consumers have appropriate access to promising CAM therapies and products?
how go about to supply these things?
2. Are there adequate guidelines for the use of CAM whether in self-care or under the guidance of a health care provider?

3. Should a federally-sponsored entity be established to coordinate CAM-related activities and discussions among federal agencies?

Public Information:

1. How can useful, reliable and updated information about CAM products and practices be made more accessible to the public and to health professionals?

COMMISSION MEMBERSHIP

The White House will identify and appoint 12-15 knowledgeable and prominent representatives with expertise in health care practice and/or CAM from the public and private sectors in the following measure:

4-6 CAM and conventional practitioners

2 research experts

2 health policy experts

2 business/health management experts

2-3 consumers/patient representatives

The Chair should be a respected health care professional with broad-based health care and public policy experience, who reflects an openness to innovative alternative practice and an ability to balance a wide diversity of views.

Additionally, a number of ex officio representatives will be identified from federal agencies to provide technical assistance and expertise. ←

An executive staff will be established to organize and support the Commission, and will include detailees from federal agencies.

TIME LINE and FUNDING

The Commission would be named and begin its work by May 15, 1999. It would conclude its work and provide its recommendations to the President and Congress by June 1, 2000. It would be funded by the \$1,000,000 provided through the National Center for Complementary and Alternative Medicine in the Fiscal Year 1999 Labor, HHS Appropriations Act.

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TOM HARKIN
IOWA

(202) 224-3254
TTY (202) 224-4633
Tom.Harkin@Harkin.Senate.Gov

United States Senate

WASHINGTON, DC 20510-1502

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320 6TH ST.
110 FEDERAL BLDG.
SIOUX CITY, IA 51101
(712) 252-1550

TOM HARKIN
IOWA(202) 224-3254
TTY (202) 224-4533
Tom_Harkin@Harkin.Senate.Gov

United States Senate

WASHINGTON, DC 20510-1502

COMMITTEES:
AGRICULTURE
APPROPRIATIONS
SMALL BUSINESS
LABOR AND HUMAN
RESOURCES

September 17, 1998

Ms. Patti Solis-Doyle
Director of Scheduling
for the First Lady
The White House

Dear Patti:

I recently met with Jennifer Klein to discuss a proposal for a White House Commission on Integrated Health Care. As you may know, this proposal is, in part, a result of a recent conversation between the First Lady and Senator Harkin at Camp David regarding alternative and complementary medicine. Senator Harkin would like to meet with the First Lady to discuss the idea. The Senator and the First Lady share a mutual interest and concern in this issue.

Please contact me (224-9369) or Senator Harkin's scheduler, Carrie Nelson, at 224-3254, when you get a chance to discuss this further, and hopefully to arrange a convenient meeting time. Thanks for looking into this for Senator Harkin.

Sincerely,

Peter Reinecke
Legislative Director for
Tom Harkin, U.S. Senator

cc: Jennifer Klein

150 FIRST AVENUE, NE
SUITE 370
CEDAR RAPIDS, IA 52407-4884
(319) 385-4504210 WALNUT ST.
733 FEDERAL BLDG.
DES MOINES, IA 50309
(515) 284-4574131 E. 4TH ST.
3148 FEDERAL BLDG.
DAVENPORT, IA 52801
(319) 322-1338350 WEST 6TH ST.
315 FEDERAL BLDG.
DUBUQUE, IA 52001
(319) 582-2130320 6TH ST.
110 FEDERAL BLDG.
SIOUX CITY, IA 51101
(712) 252-1550

Proposal for a White House Commission on Integrated Health Care: Developing A National Plan

BACKGROUND

Widespread and Increasing Use: The *New England Journal of Medicine* reported that, in 1990 alone, an estimated one in three Americans visited an alternative health care practitioner, constituting nearly 425 million visits, more than to all conventional primary care physicians. It is estimated that 85 million American adults (42% of the population) now use complementary and alternative medical (CAM) products and practices, usually in conjunction with more conventional care. Harvard University reported that the public's out-of-pocket expenses for these CAM products and services is equal to that paid out-of-pocket for physician services and is three times that paid out-of-pocket for hospital expenses. In 1990, those costs equaled more than \$14 billion, of which at least \$10 billion were not reimbursed to patients by medical insurances.

The NIH reports that more than 50% of conventional physicians in the U.S. use or refer patients for alternative treatments, while in Europe and Australia, up to 70% of health care patients make regular use of CAM practices. The groundswell of public demand for CAM therapies has greatly fueled the interest of conventional medical practitioners, with 80% of medical students in the U.S. reporting a desire for more structured training in CAM practices.

A Women's Health Issue: Increasingly, women are turning to CAM products and practices for a variety of conditions and illnesses, including breast cancer, fibroids, menstrual-related problems, endometriosis, nerve-related conditions, and pregnancy and labor management. The *Journal of the American Medical Association* (JAMA) recently reported that the four top treatment categories for CAM users are chiropractic (16%); lifestyle diet (8%); exercise/movement (7%), and relaxation (7%). Nearly 50% of these CAM users are women.

Health issues for women are multiple and diverse; most have profound effects on both the mind and the body. Some of these impact all women, regardless of health status, simply through the process of aging. For example, over the next 16 years, each year nearly 1 million American women will turn 50. The average age for menopause is 51. Accordingly, hormone replacement therapies constitute the most prescribed drugs in America today and often are marketed as panaceas for conditions associated with aging such as osteoporosis and heart disease, in addition to the full range of menopausal complaints. Increasingly, older women are seeking out natural products and mind-body treatments as alternatives to synthetic drugs. Yet very little is known about the effectiveness of these products and practices on pre- and menopausal women.

Similarly, little is known about alternative treatments for endometriosis, even though up to 20% of American women of childbearing age are diagnosed every year with this painful disease. Current treatment strategies are ineffective in eliminating the disease, which can affect

a woman's whole existence--her ability to work and to reproduce, as well as her relationships with her mate, her child, and everyone around her. Studies have shown some efficacy with drugs, but all of them have side-effects that make them unsuitable for long-term use. Subsequently, women are turning to alternative treatments and products, about which very little is known.

Women often are the primary caretakers for the health of their entire family, making decisions about diet and illness prevention, such as vitamins and other food supplements, and for treatment of minor aches and pains. The vast majority, approximately two-thirds, of homeopathic patients and purchasers of homeopathic products are women. Meanwhile, 20% of Americans on prescription medications are also taking herbal or high dose vitamins, but little or no guidance and oversight is available to monitor interactions or unseen risks.

Need for Integrated Health Care: Over 95% of those who use CAM products and practices do so in conjunction with conventional medicine — not in place of it. Patients who use alternative medicine are not alternative patients; they use it to supplement or support, rather than to supplant, conventional medicine. In late 1997, *JAMA* noted the “increasingly critical” need to determine how to integrate CAM practices into clinical practice to improve patient care.

There is credible research showing the effectiveness of various CAM practices concerning many common conditions such as heart disease, depression, asthma, addictions and in pain management. As alternative medicine research opens up additional options for managing clinical conditions, the health care community's responsiveness to public interest in CAM practices has also increased. Nearly 70 American medical schools now offer CAM electives, and several are already incorporating required lectures and seminars into their core curricula. There are more than 15,000 acupuncturists in the U.S., of whom some 5,000 are physicians. Even managed care organizations and insurance companies are beginning to grapple with how to offer CAM benefits, and hospitals throughout the nation are opening “integrative care centers.”

STATEMENT OF NEED

Clearly, science and policy must catch up with the changing values and needs of the American people. The movement toward integrated medicine promises a more comprehensive, more effective, and more responsive health care system. Evidence also suggests that this approach may be far more cost-effective as well.

A national plan for addressing the two main vulnerabilities of integrated health care—research evidence and regulatory oversight—is crucial for the safety and benefit of the American public. Such a plan should include, but not be dictated by, a wide range of governmental, scientific, medical, private and public groups. It must be grounded in the ethical principles of autonomy and beneficence, use science as a guide, and be responsive to consumer needs.

A White House Commission on Integrated Health Care is needed to examine the changes that are underway: to evaluate the state-of-the-art of complementary and alternative therapies; assess the promise of a holistic or integrated approach for improving the health of Americans; address issues of regulation and safety; and establish guidelines for the integration of this approach and these therapies into all aspects of health care, including patient care, research, professional training and health education. Under the leadership of the White House, this Commission would seek input from all relevant constituencies, with a special focus on women's health, in the development of this plan.

GOALS

The White House Commission's National Plan for Integrated Health Care would address the following:

- Determining priorities for integrated health care in the areas of practice, research and policy. These should include:
 - Surveillance and monitoring of the effects from CAM use
 - Adequate CAM education and training of health care providers
 - Accountability of emerging medicine products and practices
 - Access to alternative medicine products and practices
 - Priorities for funding research on integrated health care, with a special emphasis on women's health research
 - Criteria for the provision of integrated health care benefits
 - Areas for frontier sciences that are of interest to the public
 - Use of traditional and indigenous medical practices in conjunction with conventional medicine
- Identifying what information on integrated health care should be collected, summarized and made easily accessible to the public
- Establishing appropriate and adequate research priorities, particularly in the area of women's health
- Developing guidance in making integrated health care services safe and effective, including how to monitor the possible adverse effects of these practices and products, and how to establish standards of training, credentialing, licensing and monitoring of service quality
- Establishing guidance to assure reasonable access and appropriate benefits to integrated health care services

- Reviewing the impact of integrated health care services on special populations, including the disadvantaged, elderly, veterans, children, women and minority populations

CONSENSUS

Under the leadership of the White House, the Commission may seek the input and participation of a number of organizations, as follows (including, but not limited to):

Association of American Medical Colleges
 Association of Health Insurers of America
 American Board of Medical Specialties
 Agency of Health Care Policy and Research
 Agency of International Development
 Bureau of Primary Health Care
 Bureau of Health Professionals
 Centers for Disease Control and Prevention
 Complementary and Alternative Medicine Consortium
 Department of Health and Human Services
 Office of Women's Health
 Department of Defense
 Department of Education
 Food and Drug Administration
 Federation of State Medical Boards
 Government Reform and Oversight Committee
 Health Care Financing Administration
 Health Resources and Services Administration
 Institute of Medicine
 National Academy of Sciences
 National Institutes of Health
 National Library of Medicine
 Office of Alternative Medicine
 Office of Women's Health Research
 Professional Health Care Associations
 Veterans' Affairs
 The World Bank

MEMBERSHIP

Under the leadership of the White House, the Commission would be composed of 15-20 knowledgeable and prominent citizens of the country with expertise in health care practice, policy, scientific and public communities and be drawn from both the public and private sectors.

The Chair should be a respected member of the health care establishment with experience in all aspects of medicine and health care and with an openness to innovative alternative practices and an ability to balance a wide diversity of views. This individual must be skilled in balancing diverse points of view and gifted at making the White House Commission's recommendations intelligible and useful to the general public and the health care community. The Chair would work in close collaboration with the White House on all aspects of the Commission's work.

TIMELINE AND RESOURCES

The Commission would be convened for a 2-year period. It would be allotted sufficient resources and a coordinating staff to support the Commission, solicit expert advice, collect relevant background information and obtain public input on all areas.

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[COMMITTEE PRINT]

NOTICE: This is a draft for use of the Committee and its staff only, in preparation for markup.

Calendar No. 000

105TH CONGRESS }
2d Session }

SENATE

{ REPORT
{ 105-000

DEPARTMENTS OF LABOR, HEALTH AND HUMAN SERVICES, AND EDUCATION AND RELATED AGENCIES APPROPRIATION BILL, 1999

SEPTEMBER 00 (legislative day, JULY 00), 1998.—Ordered to be printed

Mr. SPECTER, from the Committee on Appropriations,
submitted the following

REPORT

[To accompany S. 0000]

The Committee on Appropriations reports the bill (S. 0000) making appropriations for Departments of Labor, Health and Human Services, and Education and related agencies for the fiscal year ending September 30, 1999, and for other purposes, reports favorably thereon and recommends that the bill do pass.

Amount of budget authority

Total bill as reported to Senate	\$287,592,472,000
Amount of adjusted appropriations, 1998	262,257,417,000
Budget estimates, 1999	286,606,839,000
The bill as reported to the Senate:	
Over the adjusted appropriations for 1998	+ 25,335,055,000
Over the budget estimates for 1999	+ 985,633,000

lection and evaluation of outcome data on promising alternative therapies, including new clinical trials of herbal natural products and other CAM therapies. The Committee also expects CCAM to continue and expand its work with CDC on field investigations and with AHCPR on literature reviews. Finally, the Committee continues to be concerned with the lack of adequate staff resources dedicated to this Center. The Committee notes that this Office has only eight FTE's while other NIH entities with comparable budgets have considerably larger professional staffs. Therefore, the Committee expects that the CCAM will be provided sufficient FTE's.

The Committee believes that Federal policy in a number of areas is failing to keep up with the increased use of complementary and alternative therapies. An amount of \$1,000,000 has been provided to support the establishment and operation of a White House Commission on Complementary and Alternative Medicine Policy to study and make recommendations to the Congress on appropriate policies regarding research, training, insurance coverage, licensing, and other pressing issues in this area.

Office of Dietary Supplements.—The Committee continues to strongly support the important work of this Office. Use of dietary supplements has increased significantly among Americans who want to improve their health and prevent disease. There is a great need for additional research to better inform consumers of the health benefits of supplements. The President's Commission on Dietary Supplements recently recommended that ODS be funded at its fully authorized level to meet this need. The Committee has included \$2,000,000 in additional funds for the Office to expand its efforts and to develop a botanical research centers initiative with major research institutions across the Nation.

The Committee also notes that 1999 marks the 30th anniversary of the landmark White House Conference on Food, Nutrition, and Health which lead to many major advancements in nutrition and health policy. The Committee encourages the Institute to plan and convene a conference to develop human nutrition policy recommendations for the next century. This conference should be developed in cooperation with the Agriculture Department and ensure full and appropriate private sector involvement.

Training.—The Committee received the Director's response to the 1994 National Academy of Sciences recommendations on training needs for health research. The Committee appreciates NIH's decision to increase stipends as recommended, but is concerned that the NAS recommendations for increasing the number of awards in behavioral science, health services research, oral health, and nursing research were not included in this decision. The Academy articulated compelling national needs for increased training in these areas and its recommendations were developed with every awareness of the cost implications. Given the importance of a stable supply of high-quality scientists in the areas specified in the NAS report, the Committee urges NIH to revisit the NAS recommendations. The Committee would like to receive a report on NIH's system for considering the NAS recommendations and establishing training policies in general.

Office of Behavioral and Social Sciences.—The Committee has included \$12,853,000 for the Office of Behavioral and Social Sciences.

TOM HARKIN
IOWA

(202) 224-3254
TTY (202) 224-4833

COMMITTEES:
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RESOURCES

United States Senate

WASHINGTON, DC 20510-1502

FAX COVER SHEET

TO: Katy Button

FR: Sabrina Corlette

Number of Pages to Follow: 1

COMMENTS:

If there is a transmittal error, please call:

(202) 224-3254

FAX: (202) 228-2923

THANK YOU

210 WALNUT ST.
733 FEDERAL BLDG.
DES MOINES, IA 50309
(515) 284-4574

360 WEST 8TH ST.
315 FEDERAL BLDG.
DUBUQUE, IA 52001
(319) 582-2130

BOX 74884
CEDAR RAPIDS, IA 52407-4884
(319) 365-4504

131 E. 4TH ST.
3146 FEDERAL BLDG.
DAVENPORT, IA 52801
(319) 322-1338

320 8TH ST.
110 FEDERAL BLDG.
SIOUX CITY, IA 51101
(712) 252-1550

Memo

To: Katy Button
Fr: Sabrina Corlette *SC*
Re: Senator Harkin and alternative medicine
Da: July 24, 1998

To Sen & Co.
Call

*sent to
Patti*

Hi Katy. Could you run this by Melanne and Mrs. Clinton? Thanks!

While at Camp David together a few weeks ago, Senator Harkin and Mrs. Clinton spoke about their interest in complementary and alternative medicine (CAM) and her acquaintance with Dr. Jim Gordon.

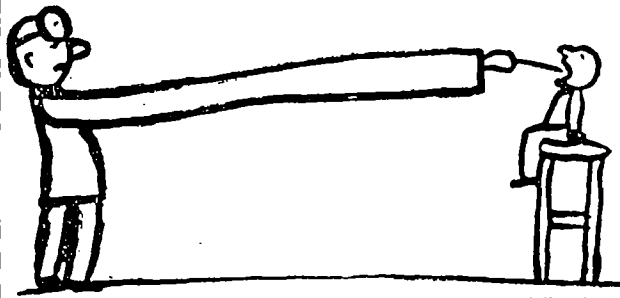
Sometime in November, Harvard University researchers will publish in JAMA a comprehensive study of the use of CAM in the United States. Their results will show that the use of CAM is growing rapidly, particularly among women.

For example, the study will show that in 1990, 34% of Americans used CAM. In 1996, 42% of Americans use CAM. In 1996, there were 50% more visits to CAM providers than to conventional primary care doctors. In addition, out-of-pocket spending on CAM currently equals spending for conventional medicine.

However, the Federal government has done little or nothing to address this issue, whether through research, training, safety and effectiveness review, or information dissemination. Senator Harkin would like to discuss this with Mrs. Clinton, including the possibility of a White House Commission to coordinate activities at the Federal level.

He'd like to sit down with her sometime before the August break or in early September, whichever time best suits her schedule.

If you could call me at 224-4538 to discuss this, that would be great. Or you could contact Senator Harkin's scheduler, Carrie Nelson, at 224-3254 to set up a time. Thanks. I miss you guys!



Daniel S. Greenberg

Another Kind Of Medicine

Congress has given the orthodox medical establishment \$50 million to sort out the claims, mysteries and realities of "alternative medicine." That's the term for a melange of potions and treatments that includes massage and acupuncture, as well as shark's cartilage for cancer and St. John's Wort, a low-octane anti-depressant for sale without prescription.

Unfortunately, the congressional generosity is misbegotten, since the money was entrusted to the National Institutes of Health, where the management rates alternative medicine as synonymous with quack medicine. With lesser sums previously imposed on it by Congress, \$20 million last year, the guardians of medical orthodoxy at NIH have been pawing at alternative medicine since 1993, with little to show for their efforts. In fact, squabbles still persist about the definition of alternative medicine, with some proponents preferring to call it "complementary medicine," while others have recently shown interest in calling it "integrative medicine," sometimes in combination with the other terms.

It's important to look at it, the proponents argue, since Americans by the scores of millions are gulping strange potions beyond the reach of the Food and Drug Administration and subjecting themselves to procedures foreign to traditional medical practice. According to a recent issue of the Journal of the American Medical Association (JAMA) that was devoted to alternative medicine, Americans made 629 million visits to "alternative medicine practitioners" in 1997, "thereby exceeding total visits to all U.S. primary care physicians." The alternative healers are said to have taken in \$21.2 billion; \$12.2 billion of that sum was out of pocket—which probably signifies a mixture of confidence and desperation among their clients.

The expressed concern in the ranks of orthodox medicine is that reliance on the alternatives might delay or interfere with effective treatments for serious ailments. There's also worry about fraud in the grand snake-oil tradition and well-intentioned but harmful incompetence. A mainstream scientist is quoted in the JAMA issue as saying, "Why don't we form a center at Harvard for the scientific study of astrology?" Various alternative camps respond that these concerns reflect the turf insecurities of organized medicine, now intensified by the income-cutting rigors of managed care.

The directed purpose of the NIH program is to subject alternative treatments to the same type of scientific examination that supposedly ensures the safety and efficacy of mainstream medicine. The moving force behind this effort is Sen. Tom Harkin (D-Iowa), who forced money upon NIH in 1992 for what eventually became a low-level Office of Alternative Medicine. Hostile to this mandate, the NIH management entombed the office in bureaucratic snarls, to the point where the founding director quit in disgust after two years. His successor, Wayne B. Jonas, a medical officer on detail from the U.S. Army, fared better during a three-year stint. Jonas made progress toward getting mainstream scientists and physicians to recognize that whatever their attitude toward alternative medicine, scores of millions of Americans are indulging in it and therefore it is desirable to identify what works and what doesn't. Harkin struck again this year, elevating the office to the more independent rank of a center in the NIH organizational structure, and raising the budget to \$50 million, despite NIH's preference for holding the money level.

In a swan song article in JAMA, Jonas touched on several characteristics that may account for the popularity of alternative medicine. Based on reports of patient surveys, he notes that the "time spent with each patient by an alternative medicine practitioner usually exceeds that spent by the average conventional physician, and patients are often more satisfied with their interactions with unorthodox than orthodox medical practitioners." He points out that conventional treatments gone awry "are a major cause of death and hospitalization"—a failing openly acknowledged by orthodox medicine.

The need to study alternative medicine is beyond dispute. But NIH, a stronghold of medical orthodoxy, amply demonstrated over six years that it's not the : to do it. The new center would be better off as an

Washington Post
11/98

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A Proposal for a White House Commission on Integrated Health Care

Background:

Over the last 25 years, Americans have been participating in a vast, rapidly growing, and largely unorganized popular health movement. They are turning to therapies that are alternative to, or other than, those learned by physicians in medical schools, and to approaches which complement conventional Western medicine. Though many in this movement make use of particular therapies in symptomatic treatment – the herb echinacea to forestall a cold, a chiropractic adjustment for a stiff neck – there is a strong desire for a new kind of integrative medicine which includes the best of complementary and alternative as well as conventional therapies, a medicine which understands the needs, perspectives, and whole lives of patients and makes them full partners in their own care.

People have become part of this movement for several reasons. First and foremost, they have begun to look outside of conventional medical practice because the treatment of chronic illness is (in contrast to its capacity to deal with trauma or surgical and medical emergencies) inadequate or fraught with side effects that can be almost as distressing as the illness. (For example, a recent study in the *Journal of the American Medical Association* showed that conventional treatment, *properly administered*, is now one of the leading causes of death and is responsible for over 10% of the hospitalizations in the US.) In addition, many who are fatigued, depressed, and feel unwell, but have no easily diagnosable condition are also looking for healing approaches – like acupuncture, mind-body therapies and nutrition – which appear tailored to enhancing health, rather than treating illness. Finally, an aging population is reaching out to find any and all means to stay well and prevent illness. Ninety-five percent of all those who use complementary and alternative therapies do so in conjunction with conventional treatment, but few are able to find both in the same practitioner or practice.

Americans are also looking for more caring relationships, as well as more effective treatment. In a time when managed care has made many physicians less attentive, as well as more hurried and harried, patients want more respect, more kindness and more time. They believe – often with some justification – that those who offer a holistic approach or who use alternative therapies are more likely to stand against the tide of assembly-line medicine, to pay more attention to them as whole people with lives as well as lab values.

A study published in the *New England Journal of Medicine* (in 1993) indicated that 34% of American adults had used complementary and alternative therapies in 1990. In 1997 the figures were at 42%, and at over 50% among women. At present, Americans make substantially more visits each year to alternative medicine practitioners than to conventional primary care physicians. The public's out-of-pocket expense for products and services is equal to that paid out-of-pocket for conventional physicians' services, and it is three times the amount they pay out-of-pocket for hospital expenses.

This public interest has been matched by a significant and rapidly growing response in the professional community and the health care industry. Seventy American medical schools now offer electives in complementary and alternative medicine, and several are already incorporating required lectures and seminars into their core curricula. In 1970 there were virtually no non-Asian acupuncturists in the US; today, there are more than 15,000, of whom some 5,000 are physicians. Twenty million Americans use chiropractors each year and a number of bright college graduates are choosing to become chiropractors, acupuncturists, naturopaths, or Chinese medical doctors, rather than MDs. Meanwhile, every major managed care organization and insurance company is grappling with how to "cover" alternative medicine (and therefore attract new subscribers); hospitals in every part of the country are hurrying to open "integrative care centers;" and the natural food, supplement and herbal businesses are booming.

Though most of the surveys indicate that primary users of complementary medicine are adult, white, and middle or upper-middle class, there is every reason to believe that larger numbers of people with less income would use these therapies if they were covered by insurance. In addition, it is clear that the number of poor people already using these approaches is

underestimated in the surveys; the overall percentages are likely to be significantly higher than 42% for many of those who do not have telephones: migrant workers, as well as recent immigrants from Latin America, Asia and Africa for whom the therapies that we call complementary and alternative are both the traditional and the primary sources of health care.

This movement is immensely hopeful. It is, however, only minimally integrated into our health care system, with potential and real adverse effects. One in five Americans uses herbal formulations or vitamins in high doses in combination with conventional drugs, and neither their physicians nor the public know if they are being harmed. Research on complementary and alternative therapies is in its infancy and is grossly underfunded. Licensing of non-physician practitioners varies greatly from state to state and is often arbitrary. Procedures for feedback about adverse effects of alternative therapies are as haphazard as provision of information about their benefits.

Finally, it is interesting to note that the use of these therapies – and passionate advocacy on their behalf – is distributed among people of every political persuasion, in the general public as well as in Congress. Progressive Democrats, moderate Republicans and arch conservatives all use these therapies. And the vast majority agree that there should be easier access to them, greater insurance coverage for them, more research into and more readily available knowledge about them, more informed regulation of them, and better integration with conventional medicine.

It is no longer a question of whether complementary and alternative medical approaches will become part of health care, but of how this process of integration will proceed. In the past, changes in medicine and health care have followed particular discoveries (the introduction of antibiotics), the rise of powerful interest groups (the AMA in the latter part of the 19th century), the passage of wide-reaching new legislation (Medicare and Medicaid), or market forces (the creation of managed care organizations). The movement toward an integrated medicine is larger, less coherent and insistently populist. It holds out the promise of a health care that is far more comprehensive, more effective and more responsive to people's human needs. There is already some evidence to suggest that this approach may be far more cost-effective as well.

A White House Commission on Integrative Medicine would examine the changes that are underway; evaluate the state of the art of complementary and alternative therapies; assess the promise of a holistic or integrated approach for improving the health of Americans; deal with issues of regulation and safety; and establish guidelines for the integration of this approach and these therapies into all aspects of health care, including patient care, research, professional training and health education. It is entirely likely that such a Commission would not only provide guidelines for integration, but a new model for what all health care should be.

The Tasks of the Commission:

Specifically the Commission would

- Address the public's need for a system of integrated health care that is responsive to their needs and reflects their concerns
- Formulate strategies for gathering and evaluating information about complementary and alternative therapies and the role they can play in an integrated health care
- Develop research agendas and priorities for the government and help guide private efforts in the study of the most promising therapies
- Provide guidelines for the safe use of natural products and of new therapies, and for the ongoing reporting of both adverse effects and benefits
- Establish criteria for training, credentialing, licensing, and monitoring integrated health care professionals
- Develop models for offering health benefits in federal and private programs
- Develop guidelines for the integration of education about integrative health care and its various perspectives and practices in all programs of health professional education
- Develop a blueprint for distributing responsibility for all aspects of integrative health care among the various federal agencies
- Suggest mechanisms of on-going coordination among federal agencies and between federal agencies, professional groups and the general public
- Offer guidance in the development of proposals for funding model integrative health programs for people with specific illnesses (e.g. cancer) and for special populations which so far have the least access to these areas of care: the poor, minorities, veterans, and children

(See diagram for visual image of these tasks)

The Commission

Membership:

The Commission would be composed of 15-20 people who are committed to the creation of a system of health care that is responsive to the public's diverse needs, respectful, effective, and integrative. Members will include those who have been leaders in creating an integrative medicine, as well as those who have been working within the medical establishment (as researchers, clinicians and administrators) to enlarge its perspective; visionaries in the area of health policy, as well as citizen advocates who grapple each day with the medical system; representatives of the business community concerned with their employees' health; and ordinary men and women who are struggling to create their own programs of integrative health care.

The Chair of the Commission would be a leader in creating an integrative medicine and articulating its scope and importance – someone thoroughly grounded in the practice of complementary and alternative as well as conventional medicine. This person must be skilled in balancing diverse points of view and gifted at making the Commission's recommendations intelligible and useful to the general public and the health care community. The Chair would work in close collaboration with the White House on all aspects of the Commission's work.

Timetable, Staffing and Budget:

The Commission would be convened for a two-year period. It would have a coordinating staff to support its work in collecting background information, soliciting expert and public testimony, holding hearings, and assembling work groups on particular topics. Estimated personnel: seven. Estimated cost: \$5 million.

Developing a National Plan for Integrated Health Care

