

Withdrawal/Redaction Sheet

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DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
001. resume	re: Joseph Pizzorno (partial) (2 pages)	03/02/1999	P6/b(6)
002. letter	Stefano Maddalena to President Clinton re: phone number and address (partial) (1 page)	11/10/1998	P6/b(6)

COLLECTION:

Clinton Presidential Records
Domestic Policy Council
Devorah Adler
OA/Box Number: 20472

FOLDER TITLE:

Alternative Medicine [Folder 5]

2012-0463-S

rc710

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]
- P4 Release would disclose trade secrets or confidential commercial or financial information [(a)(4) of the PRA]
- P5 Release would disclose confidential advice between the President and his advisors, or between such advisors [(a)(5) of the PRA]
- P6 Release would constitute a clearly unwarranted invasion of personal privacy [(a)(6) of the PRA]

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.

Freedom of Information Act - [5 U.S.C. 552(b)]

- b(1) National security classified information [(b)(1) of the FOIA]
- b(2) Release would disclose internal personnel rules and practices of an agency [(b)(2) of the FOIA]
- b(3) Release would violate a Federal statute [(b)(3) of the FOIA]
- b(4) Release would disclose trade secrets or confidential or financial information [(b)(4) of the FOIA]
- b(6) Release would constitute a clearly unwarranted invasion of personal privacy [(b)(6) of the FOIA]
- b(7) Release would disclose information compiled for law enforcement purposes [(b)(7) of the FOIA]
- b(8) Release would disclose information concerning the regulation of financial institutions [(b)(8) of the FOIA]
- b(9) Release would disclose geological or geophysical information concerning wells [(b)(9) of the FOIA]

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Prue

Joseph E. Pizzorno, Jr., N.D.

P6(b)(6) [001]
Office (425) 602-3003; 602-3196 fax
Home P6(b)(6)
Internet president@bastyr.edu

A leader in the field of natural medicine, Dr. Pizzorno is a practical visionary. His uniting the healing traditions of natural medicine with the rigors of the scientific method has resulted in major advances. Co-founder and founding president of Bastyr University, he has lead Bastyr to become the first ever accredited, multidisciplinary university of natural medicine in the United States (and the English-speaking world) and set the standard of educational excellence for institutions of natural medicine throughout the world. Under his leadership, Bastyr University was one of the first institutions chosen as an National Institutes of Health Office of Alternative Medicine Center for Alternative Medicine Research. As senior editor and co-author of the internationally-acclaimed *A Textbook of Natural Medicine* and member of several editorial boards, he has helped define the standard of care for natural medicine, establish the importance of critical thinking in scientific evaluating the validity of natural medicine, and pushed forward the frontiers of our understanding of healing. As lecturer, best-selling co-author of the *Encyclopedia of Natural Medicine* (400,000 copies, six languages), researcher and expert spokesman, he has introduced and taught credible natural medicine to medical and lay audiences throughout the United States, South Pacific and Europe.

An expert in natural medicine (and licensed as a naturopathic physician and, previously, as a midwife), he actively works with the media (over 100 national media interviews a year) and county, state and federal legislatures and regulatory agencies to establish the appropriate role for natural medicine in health care. Dr. Pizzorno presented the role of naturopathic medicine in health care to First Lady Hillary Clinton's Health Care Reform Taskforce, was appointed to the U.S. Congress's Office of Technology Assessment's Advisory Panel on the Safety and Efficacy of Dietary Supplements, and has provided expert advice to the U.S. Federal Trade Commission. Dr. Pizzorno is Senior Medical Advisor for the *Journal Alternative & Complementary Therapies*.

In January 1996, Dr. Pizzorno debated natural medicine on national radio (CBS) and television (Good Morning America) programs, was the featured personality in the February 1996 issue of *Natural Health Magazine*, in May appointed to the King County Board of Health, the first natural medicine practitioner to be appointed to such a position (reappointed to a three year term in December), and, in June, appointed to the ad hoc advisory committee for the NIH Office of Dietary Supplements. In September, the American Association of Naturopathic Physicians Honored Dr. Pizzorno as the first recipient of the Benedict Lust Award (founder in 1896 of the naturopathic profession) and in October the *Seattle* magazine recognized him as one of the city's top 20 national intellectual leaders. His newest book, *Total Wellness*, was released by Prima last year.

In 1997, a few of Dr. Pizzorno speaking engagements include: the Ecological Farming conference in Monterey, the World President's Organization in Key Largo, the American College for the Advancement of Medicine in Tampa, the National Council of State Nursing Boards annual convention in Chicago, the Washington State Teamsters Welfare Trust, the International Spa & Fitness Association annual conference in Banff, and the annual meeting of the American Public Health Association in Indianapolis. New editions of the textbook *Natural Medicine* (Churchill-Livingstone) and *The Encyclopedia of Natural Medicine* (Prima) will be released in 1998.

Education **N.D. with Scholastic Honors** (Doctor of Naturopathic Medicine), 1975
National College of Naturopathic Medicine
Portland, OR

B.S. with Distinction, Chemistry, 1969
Harvey Mudd College
Claremont, CA

Certificate in Organizational and Group Leadership, 1993
Leadership Institute of Seattle (LIOS), Summer Institute

Licensure **Licensed Naturopathic Physician**, 1975-present
Washington State

Licensed Midwife, 1981-1989
Washington State

Basic Sciences Certificate, 1974
Nevada State Healing Arts Board

Awards and Honors

Recognized as one of the top 20 national intellectual leaders from Seattle
Seattle Magazine (1996)

First recipient of the **Benedict Lust Award** (founder in 1896 of the naturopathic profession)

Awarded at the 1996 American Association of Naturopathic Physicians Convention

President's Award for His Vision and Leadership in Naturopathic Medical Education and His Many Contributions to the Advancement of the Profession, 1988

Awarded at the 1988 American Association of Naturopathic Physicians Convention

Award for Central Role in the Development and Federal Recognition of the Council on Naturopathic Medical Education, 1987

Awarded at the 1987 American Association of Naturopathic Physicians Convention

Naturopathic Physician of the Year, 1981

Awarded at the 1981 Northwest Naturopathic Physicians Convention

Recognized in the Marquis *Who's Who* (several), 1989-present

Employment

Academic

President, Co-Founder, 1978-present

Faculty, Naturopathic Philosophy, Physical Diagnosis, Clinical Diagnosis, Environmental Health, Nutrition, Integrative Therapeutics (a course which integrates herbal, nutritional, exercise, physical medicine, psychological, Chinese medicine, and homeopathic therapies), Advanced Case Analysis, Clinical Applications, Clinic physician

Bastyr University
Seattle, WA

Part-time Faculty, Environmental Public Health, 1978-84
Seattle Central Community College
Seattle, WA

Adjunct Faculty, Alternative Medicine, Spring 1978
Evergreen State College
Olympia, WA

Research **Member, Human Subjects Review Committee**, 1980-1987

Research Faculty, 1983-87
Bastyr College
Seattle, WA

Research Technologist, 1971-75

Department of Rheumatology
School of Medicine
University of Washington
Seattle, WA

Health Care **Private Practice, 1975-81**
Specializing in natural childbirth and family practice of naturopathic medicine
Seattle, WA

Public Affairs Activities **Member, Board of Health, 1996-present**
Seattle/King County, Washington

Member, Ad Hoc Advisory Committee, 1996
NIH Office of Dietary Supplements
Bethesda, MD

Member, Alternative Health Care Advisory Committee, 1995-1996
Blue Cross of Washington and Alaska
Montlake Terrace, WA

Member, Advisory Council 1995-1997
NIH Office of Alternative Medicine Center for Complementary and Alternative
Medicine Research in Asthma and Allergy
University of California, Davis
Davis, CA

Member, Advisory Panel on the Safety and Efficacy of Dietary Supplements, 1993-94
Office of Technology Assessment
United States Congress
Washington, D.C.

Member, Advisory Board, 1994
New Health Network (A consumer health advocacy organization)
Boulder, CO

Expert Consultant, 1993 1994
U.S. Federal Trade Commission,

Expert Witness, 1993
Role of Naturopathic Medicine in Health Care Reform, Presented to First Lady Hillary
Clinton's Health Care Reform Taskforce
Washington, D.C.

Legislative Witness
Florida, Minnesota, Nebraska, Washington

Professional Activities **Member, Advisory Board, 1996-present**
HealthWorld OnLine
Downey, CA

Member, Board of Advisors, 1996-present
HerbalGram
Dallas, TX

Member, Board of Directors, 1996-present
American Herbal Pharmacopoeia
Santa Cruz, CA

Member, Advisory Council, 1993
Phytochemistry Research Institute
Weber State University
Ogden, UT

Consultant, 1990

National Chinese Research Institute
Taiwan

Founding Member Board of Directors, 1978-87

President, 1985-87, Vice-President, 1987-89; Secretary, 1978-85
Council on Naturopathic Medical Education (the U.S. Department of Education-recognized accrediting agency for programs in naturopathic medicine)
Portland, OR

Founding Member Board of Directors, 1985

Member, Board of Directors, 1985-1994
American Association of Naturopathic Physicians
Seattle, WA

Vice President, 1977-78

Member, 1975-present; Secretary, 1976-77; Chair, Education Committee, 1976
Washington Association of Naturopathic Physicians
Seattle, WA

Member, Education Advisory Committee, 1980-1991

Seattle Midwifery School
Seattle, WA

President, Cofounder, Member Board of Directors, 1978-1987

Federation of Naturopathic Colleges
Seattle, WA

President, 1979-81

United Trust for Naturopathic Medicine
Boise, ID

Member, 1977-1981

National Association of Naturopathic Physicians
Boise, ID

Member, 1980-85

Northwest Academy of Preventive Medicine
Bellevue, WA

Secretary, Board of Directors, 1976-78

National College of Naturopathic Medicine
Portland, OR

Featured Speaker Multiple conferences in the U.S. and around the world. The following is a listing of 1997 speaking engagements and a few prior highlights.
The Committee of Sustainable Agriculture, Monterey, CA (1997): *The relationship between Health, Diet, and Organically-Grown Foods*
Evergreen Hospital Community Forum, Kirkland, WA (1997): Total Wellness: Medicine
World President's Organization, Key Largo, FL (1997): *Seven Steps to Total Wellness*
American College for the Advancement of Medicine, Tampa, FL (1997): *Herbal Support for Immune Modulation*
Washington Self-Insurers Association Annual Conference, Seattle, WA (1997): *Current and Future Trends in Natural Medicine*
National Council of State Nursing Boards Annual Convention, Chicago, IL (1997): *Naturopathic Physicians as an Authorized Provider Working with Nurses*
Health Care Reform
EarthSave Foundation, Seattle, WA (1997): *The Scientific Basis of Natural Medicine*
St. Joseph's Medical Center, Tacoma, WA (1997): *Integrated Medicine*
International Spa & Fitness Association annual convention, Banff, Canada (1997):
Keynote: *The Current State of the Science in Detoxification*

Ontario Association of Naturopathic Doctors, Toronto, Canada (1997): *Rediscovering our Roots: Detoxification and its Clinical Applications*
 American Public Health Association annual conference, Indianapolis, IN (1997): *Natural Medicine Conceptualization of Health and Disease*
 University of Washington, School of Medicine, Medical History and Ethics Class (1997): *Naturopathic Medicine*
 Tsu Chi Institute for Complementary and Alternative Medicine, Vancouver, Canada (1997): Keynote: *Critical Review of the Alternative Medicine Therapies and Theories in Multiple Sclerosis*
 American College for the Advancement of Medicine (April 1997)
 Washington State Nursing Commission, Olympia, WA (1996): *Integration of Nurses into a Natural Medicine Practice*
 Functional Medicine Symposium, Vancouver, BC (1996): *Workshop on Clinical Application of Nutrition into a Medical Practice*
 Great Lakes Association of Clinical Medicine, Chicago, IL (1996): *Role of Phytonutrients in Free Radical Neutralization*
 International Conference on Clinical Botanical Medicine, Auckland, New Zealand (1996): *Current Research Status of Botanicals Used to Enhance Immune System Function and Practical Experience with Botanical Treatments for HIV-Infected and AIDS Patients*
 U.S. Office of Dietary Supplements, San Francisco, CA (1996): *Scientific Basis and Appropriate Clinical Applications of Nutritional Supplements and Botanical Medicines*
 American College for the Advancement of Medicine, Orlando, FL (1996): *Botanical Medicines for Cardiovascular Disease*
 Rosenthal Center for Alternative & Complementary Therapies/Columbia University College of Physicians and Surgeons, New York, NY (1996): *Botanical Medicine: Traditional Ethnomedical Use and Modern Clinical Practice*
 Churchill Livingstone World Conference on Complementary Therapies in Medicine, Washington, DC (1996): *Role of Natural Medicine in Health Care Reform*
 National Institutes of Health, Office of Alternative Medicine, National Conference on Integration of Alternative Medicine Education in Medical Schools, Bethesda, MD (1996): *Naturopathic Medicine and Medical Education*
 Second Annual International Congress on Alternative and Complementary Medicine, Washington, DC (1996): *Allergy and Immunity*
 Grand Rounds: Children's Hospital (1994), Swedish Hospital (1995), Overlake Hospital (1995): *Natural medicine*
 American Academy of Environmental Medicine, October 1995: *Botanical Medicines for Detoxification*
 International Spa Association, September 1995: *The Politics of Alternative Medicine: Working Within the System*
 Joint AIDS and Complementary Committee, Great Britain's Parliament, 1991: *Bastyr University Healing AIDS Research Project*
 Chinese Medicine Conference, Taipei, Taiwan, November, 1990: *Current State of Alternative Medicine in the United States*
 Natural Foods Expos: Anaheim, Baltimore, Philadelphia, Washington, D.C., multiple appearances, multiple topics

Media Activities

National Live Debate

Television and Radio

Featured personality

Good Morning America (1996), CBS Radio (1996)

Over 100 national media interviews and appearances a year
 Today Show, Good Morning America, National Public Radio, New York Times, etc.

Seattle Magazine (1996)
 Natural Health Magazine (1996)
 Northwest Computers Users (magazine)
 The Vitamin Supplement (magazine)

Editorial Responsibilities

Associate Editor, 1998 publication date
 Textbook of Complementary and Alternative Medicine
 Wayne B. Jonas and Jeff Levin, Editors

Williams and Williams
Baltimore, MD

Advisory Board, 1996-present
Natural Health Magazine
Brookline Village, MA

Senior Medical Advisor, 1994-present
Alternative & Complementary Therapies
Mary Ann Liebert, Inc. Publishers
New York, NY

Editorial Board, 1994-present
Journal of Alternative & Complementary Medicine
Mary Ann Liebert, Inc. Publishers
New York, NY

Editorial Advisory Board, 1995-present
Nutrition Science News
New Hope Communications
Boulder, CO

International Advisory Board, 1993-present
Complementary Therapies in Medicine
Churchill Livingstone Journals
Edinburgh, UK

Editorial Board, 1993
Alternative Medicine: The Definitive Guide
Future Medicine Publishing
Puyallup, WA

Co-Author/Editor, 1993
Naturopathic Medicine: Contributions to Health Care Reform, Presented to First Lady
Hillary Clinton's Health Care Reform Taskforce
American Association of Naturopathic Physicians
Seattle, WA

Editorial Board, 1992-1996
Health News & Review
Keats Publishing
New Canaan, CT

Senior Editor, 1992-93
Natural Foods Education Program (A 30-lesson training program for health food store
employees; utilized by 1,600 stores throughout the United States)
Bastyr College Publications
Seattle, WA

Executive Editorial Board, 1988-1992
Journal of Naturopathic Medicine
Greenwich, CN

Medical Advisory Board, 1987-present
Let's Live Magazine
Los Angeles, CA

Editor, 1979-81
Journal of the John Bastyr College of Naturopathic Medicine
Seattle, WA

Editorial Advisory Board, 1977-78
Journal of Natural Medicine
Boise, ID

Publications Pizzorno JE: *Total Wellness*.

Prima, Rocklin, CA, 1996

Murray MT and Pizzorno JE: *Encyclopedia of Natural Medicine*.

MacDonald Optima, World rights and Prima, US, 1990 (Best seller - 400,000 copies)

Translations: Greek, Hebrew, Italian, Russian, Spanish, and Yugoslavian (50,000 copies)
2nd edition 1998; 946 pages; 2,500 research citations

Pizzorno JE and Murray MT: *A Textbook of Natural Medicine*.

John Bastyr College Publications, Seattle, WA, 1985-present (Updated quarterly)

Two volumes. 200 chapters

New edition, Churchill-Livingstone, 1998 publication date

Monthly Research Review Column, 1993

Choices

Seattle, WA

Bi-Monthly Column, 1993-94 (with Lara Pizzorno)

Veggie Life

Concord, CA

Bimonthly Column, 1991-1992

Vegetarian Times

Oak Park, IL

Pizzorno JE: The naturopathic physician. *Miami Medicine*, 65:25-26, 1994

Barrie SA, Wright JV and Pizzorno JE: Effects of garlic oil on platelet aggregation, serum lipids and blood pressure in humans. *Journal of Orthomolecular Medicine*, Fall, 1986

Barrie SA, Wright JV, Pizzorno JE, Kutter B, and Barron PC: Comparative absorption of zinc picolinate, zinc citrate and zinc gluconate in humans. *Agents and Actions*, 21:223-8, 1987

Pizzorno JE: Phytolacca Decandra. *Journal of Natural Medicine*, 1:26-7, 1977

Simkin PA and Pizzorno JE: Transsynovial Exchange of Small Molecules. *Journal of Applied Physiology*, 36:5, 1974

Personal Born in P6/(b)(6) married to Lara Udell Pizzorno and has two children, Raven (nineteen) and Galen (eight). His hobbies include microcomputers and science fiction. He is athletic and especially enjoys basketball, cycling, snorkeling, SCUBA diving, white water kayaking, hiking, and ultimate Frisbee.

C O V E R

S H E E T



FAX

To: DeVorah

Fax #: 456-5557

Subject:

Date: March 12, 1999

Pages: 7, including this cover sheet.

COMMENTS:

From the desk of...

Steven Ottenstein
White House Liaison
Department of Health and Human
Services/Office of the White House Liaison
200 Independence Avenue, SW
Washington, DC 20201

(202) 690-6625
Fax: (202) 401-1948

for an individual (except in an individual's capacity as an employer or a health care provider), until legislation is enacted specifically approving the standard.

TITLE VI—NATIONAL CENTER FOR COMPLEMENTARY AND ALTERNATIVE MEDICINE

ESTABLISHMENT OF NATIONAL CENTER FOR COMPLEMENTARY AND ALTERNATIVE MEDICINE

SEC. 601. IN GENERAL.—Title IV of the Public Health Service Act (42 U.S.C. 281 et seq.) is amended—

- (1) by striking section 404E; and
- (2) in part E, by adding at the end the following:

"Subpart 5—National Center for Complementary and Alternative Medicine

"SEC. 485D. PURPOSE OF CENTER.

"(a) IN GENERAL.—The general purposes of the National Center for Complementary and Alternative Medicine (in this subpart referred to as the 'Center') are the conduct and support of basic and applied research (including both intramural and extramural research), research training, the dissemination of health information, and other programs with respect to identifying, investigating, and validating complementary and alternative treatment, diagnostic and prevention modalities, disciplines and systems. The Center shall be headed by a director, who shall be appointed by the Secretary. The Director of the Center shall report directly to the Director of NIH.

"(b) ADVISORY COUNCIL.—The Secretary shall establish an advisory council for the Center in accordance with section 406, except that at least half of the members of the advisory council who are not ex officio members shall include practitioners licensed in one or more of the major systems with which the Center is concerned, and at least 3 individuals representing the interests of individual consumers of complementary and alternative medicine.

"(c) COMPLEMENT TO CONVENTIONAL MEDICINE.—In carrying out subsection (a), the Director of the Center shall, as appropriate, study the integration of alternative treatment, diagnostic and prevention systems, modalities, and disciplines with the practice of conventional medicine as a complement to such medicine and into health care delivery systems in the United States.

"(d) APPROPRIATE SCIENTIFIC EXPERTISE AND COORDINATION WITH INSTITUTES AND FEDERAL AGENCIES.—The Director of the Center, after consultation with the advisory council for the Center and the division of research grants, shall ensure that scientists with appropriate expertise in research on complementary and alternative medicine are incorporated into the review, oversight, and management processes of all research projects and other activities funded by the Center. In carrying out this subsection, the Director of the Center, as necessary, may establish review groups with appropriate scientific expertise. The Director of the Center shall coordinate efforts with other Institutes and Federal agencies to ensure appropriate scientific input and management.

"(e) EVALUATION OF VARIOUS DISCIPLINES AND SYSTEMS.—In carrying out subsection (a), the Director of the Center shall identify and evaluate alternative and complementary medical treatment, diagnostic and prevention modalities in each of the disciplines and systems with which the Center is concerned, including each discipline and system in which accreditation, national certification, or a State license is available.

"(f) ENSURING HIGH QUALITY, RIGOROUS SCIENTIFIC REVIEW.—In order to ensure high quality, rigorous scientific review of complementary and alternative, diagnostic and prevention modalities, disciplines and systems, the Director of the Center shall conduct or support the following activities:

- "(1) Outcomes research and investigations.
- "(2) Epidemiological studies.
- "(3) Health services research.
- "(4) Basic science research.
- "(5) Clinical trials.
- "(6) Other appropriate research and investigational activities.

The Director of NIH, in coordination with the Director of the Center, shall designate specific personnel in each Institute to serve as full-time liaisons with the Center in facilitating appropriate coordination and scientific input.

"(g) DATA SYSTEM; INFORMATION CLEARINGHOUSE.—

"(1) DATA SYSTEM.—The Director of the Center shall establish a bibliographic system for the collection, storage, and retrieval of worldwide research relating to complementary and alternative treatment, diagnostic and prevention modalities, disciplines and systems. Such a system shall be regularly updated and publicly accessible.

"(2) CLEARINGHOUSE.—The Director of the Center shall establish an information clearinghouse to facilitate and enhance, through the effective dissemination of information, knowledge and understanding of alternative medical treatment, diagnostic and prevention practices by health professionals, patients, industry, and the public.

"(h) RESEARCH CENTERS.—The Director of the Center, after consultation with the advisory council for the Center, shall provide support for the development and operation of multipurpose centers to conduct research and other activities described in subsection (a) with respect to complementary and alternative treatment, diagnostic and prevention modalities, disciplines and systems. The provision of support for the development and operation of such centers shall include accredited complementary and alternative medicine research and education facilities.

"(i) AVAILABILITY OF RESOURCES.—After consultation with the Director of the Center, the Director of NIH shall ensure that resources of the National Institutes of Health, including laboratory and clinical facilities, fellowships (including research training fellowship and junior and senior clinical fellowships), and other resources are sufficiently available to enable the Center to appropriately and effectively carry out its duties as described in subsection (a). The Director of NIH, in coordination with the Director of the Center, shall designate specific personnel in each Institute to

serve as full-time liaisons with the Center in facilitating appropriate coordination and scientific input.

"(j) **AVAILABILITY OF APPROPRIATIONS.**—Amounts appropriated to carry out this section for fiscal year 1999 are available for obligation through September 30, 2001. Amounts appropriated to carry out this section for fiscal year 2000 are available for obligation through September 30, 2001.

"(k) **TECHNICAL AND CONFORMING AMENDMENT.**—Section 401(b)(2) of the Public Health Service Act (42 U.S.C. 281(b)(2)) is amended by adding at the end the following:

"(F) The National Center for Complementary and Alternative Medicine."

TITLE VII—MISCELLANEOUS PROVISIONS

RATES OF PAY FOR PUBLIC BROADCASTING AND NATIONAL PUBLIC RADIO

SEC. 701. Section 396(k)(9) of Title 47, United States Code, is amended by striking "at an annual rate of pay which exceeds the rate of basic pay in effect from time to time for level 1 of the Executive Schedule under 5312 of title 5, United States Code" and inserting "in excess of reasonable compensation as determined pursuant to Section 4958 of the Internal Revenue Code for services that the officer or employee renders to organization" after "compensated."

SEC. 702. The amount of the DSH allotment for the State of Minnesota for fiscal year 1999, specified in the table under section 1923(f)(2) of the Social Security Act (as amended by section 4721(a)(1) of Public Law 105-33) is deemed to be \$33,000,000.

SEC. 703. The amount of the DSH allotment for the State of New Mexico for fiscal year 1999, specified in the table under section 1923(f)(2) of the Social Security Act (as amended by section 4721(a)(1) of Public Law 105-33) is deemed to be \$9,000,000.

SEC. 704. Notwithstanding section 1923(f)(2) of the Social Security Act (42 U.S.C. 1396r-4(f)(2)) (as amended by section 4721(a)(1) of the Balanced Budget Act of 1997 (Public Law 105-33; 111 Stat. 511), the amount of the DSH allotment for Wyoming for fiscal year 1999 is deemed to be \$95,000.

SEC. 705. **EXTENSION OF CERTAIN ADJUDICATION PROVISIONS.**—The Foreign Operations, Export Financing, and Related Programs Appropriations Act, 1990 (Public Law 101-167) is amended—

(1) in section 599D (8 U.S.C. 1157 note)—

(A) in subsection (b)(3), by striking "1997 and 1998" and inserting "1997, 1998, and 1999"; and

(B) in subsection (e), by striking "October 1, 1998" each place it appears and inserting "October 1, 1999"; and

(2) in section 599E (8 U.S.C. 1255 note) in subsection (b)(2), by striking "September 30, 1998" and inserting "September 30, 1999".

SEC. 706. (a) Section 2104(c) of the Social Security Act (42 U.S.C. 1397dd(c)) is amended by adding at the end the following new paragraph:

"(4) **ADDITIONAL ALLOTMENT.**—

"(A) **IN GENERAL.**—In addition to the allotment under paragraph (1), the Secretary shall allot each common-

wealth and territory described in paragraph (3) the applicable percentage specified in paragraph (2) of the amount appropriated under subparagraph (B).

"(B) **APPROPRIATIONS.**—For purposes of providing allotments pursuant to subparagraph (A), there is appropriated, out of any money in the Treasury not otherwise appropriated \$32,000,000 for fiscal year 1999."

(b) Section 2104(b)(1) of such Act (42 U.S.C. 1397dd(b)(1)) is amended by inserting "(determined without regard to paragraph (4) thereof)" after "subsection (c)".

SEC. 707. **DETERMINATION OF NUMBER OF CHILDREN AND STATE COST FACTORS FOR FISCAL YEARS 1998 AND 1999 FOR PURPOSES OF STATE CHILDREN'S HEALTH INSURANCE PROGRAM (SCHIP).**—Notwithstanding any other provision of law, for purposes of determining the product under section 2104(b)(1)(A) of the Social Security Act (42 U.S.C. 1397dd(b)(1)(A)) for a State for each of fiscal years 1998 and 1999—

(1) the number of children under clause (i) of such section shall be the number of low-income children specified for the State in Column B of the table on pages 48101-48102 of the Federal Register published on September 12, 1997, adjusted by the Census Bureau as necessary to treat children as being without health insurance if they have access to health care funded by the Indian Health Service but do not have health insurance; and

(2) the State cost factor under clause (ii) of such section shall be the State cost factor specified for the State in Column C of such table.

SEC. 708. (a) **EXTENSION OF DEADLINE FOR SUBMISSION OF REPORT BY COMMISSION TO ASSESS THE ORGANIZATION OF THE FEDERAL GOVERNMENT TO COMBAT THE PROLIFERATION OF WEAPONS OF MASS DESTRUCTION.**—Section 712(c)(1) of the Combating Proliferation of Weapons of Mass Destruction Act of 1996 (subtitle A of title VII of Public Law 104-293; 110 Stat. 3470; 50 U.S.C. 2351 note) is amended by striking out "the date of the enactment of this Act" and inserting in lieu thereof "January 18, 1998".

(b) **MEMBERSHIP OF COMMISSION.**—Section 711 of that Act is amended—

(1) in the matter preceding subsection (b)(1), by striking out "eight members" and inserting in lieu thereof "twelve members, none of whom may, during the period of their service on the Commission, be an officer or employee of any department, agency, or other establishment of the Executive Branch (other than the Commission), and";

(2) in subsection (b)(2), by striking out "one" and inserting in lieu thereof "three";

(3) in subsection (b)(4), by striking out "one" and inserting in lieu thereof "three"; and

(4) in subsection (e), by striking out "the date on which all members of the Commission have been appointed" and inserting in lieu thereof "the date of enactment of an Act making appropriations for the Departments of Labor, Health and Human Services, and Education, and related agencies, for the fiscal year ending September 30, 1999".



Mantel

CHARTER

NATIONAL ADVISORY COUNCIL FOR COMPLEMENTARY AND ALTERNATIVE MEDICINE

PURPOSE

The Secretary of Health and Human Services (Secretary) is mandated under section 301 of the Public Health Service (PHS) Act, as amended (42 U.S.C. 241) to support and encourage research, studies, and related activities in the health fields. This mandate is fulfilled in part by the mechanism of research grants-in-aid awarded by the research institutes and centers of the National Institutes of Health (NIH). In addition, the Secretary is authorized under Section 487 of the PHS Act, as amended (42 U.S.C. 288), to support research training through National Research Service Awards. The National Advisory Council for Complementary and Alternative Medicine (Council) shall advise, assist, consult with, and make recommendations to the Secretary and the Director of the National Center for Complementary and Alternative Medicine, also referred to as "Center") on matters related to the activities carried out by and through the Center and the policies respecting these activities.

AUTHORITY

42 U.S.C. 284a, _____; sections 406, 485D(b) of the PHS Act, as amended. This Council is governed by the provisions of Public Law 92-463, as amended (5 U.S.C. Appendix 2), which sets forth standards for the formation and use of advisory committees.

FUNCTION

The Council shall advise the Secretary; the Assistant Secretary for Health; the Director, NIH; and the Director, NCCAM on matters relating to the conduct and support of research training, health information dissemination, and other programs with respect to complementary and alternative medicine treatment modalities.

The Council may recommend to the Secretary acceptance, in accordance with section 231 of the PHS Act, as amended, acceptance of conditional gifts for study, investigation, or research respecting complementary and alternative medicine treatment modalities and for the acquisition of grounds, or for the construction, equipping, and/or maintenance of facilities for the Center.

The Council (1) may, on the basis of material provided, make recommendations to the Director, NCCAM, respecting research conducted at the Center; (2) may review applications for grants and cooperative agreements for research and training and recommend for approval applications for projects which show promise of making valuable contributions to human knowledge; (3) may review any grant, contract, or cooperative agreement proposed to be made or entered into by the Center; (4) may collect, by correspondence or by personal investigation, information as to studies which

are being carried on in the United States or any other country with respect to complementary and alternative medicine and, with the approval of the Director, NCCAM, make available this information through appropriate publications for the benefit of public and private health entities, health professions personnel and scientists, and for the information of the general public; and (5) may seek advice from special consultants, assemble ad hoc working groups, appoint subcommittees and convene workshops and conferences.

STRUCTURE

The Council shall consist of eighteen members appointed by the Secretary; five nonvoting ex officio members: the Secretary; the Director, NIH; the Director, NCCAM; the Chief Medical Director of the Department of Veterans Affairs; the Assistant Secretary of Defense for Health Affairs (or their designees) and any additional officers or employees of the United States as the Secretary determines necessary for the Council to effectively carry out its functions.

Of the 18 appointed members, 12 shall be selected from among the leading representatives of the health and scientific disciplines (including not less than 2 individuals who are leaders in the fields of public health and the behavioral or social sciences) relevant to the activities of the Center, particularly representatives of the health and scientific disciplines in the area of complementary and alternative medicine. Nine of the twelve shall include practitioners licensed in one or more of the major systems with which the Center is involved.

Six of the members shall be appointed by the Secretary from the general public and shall include leaders in the fields of public policy, law, health policy, economics, and management. Three of the six shall represent the interests of individual consumers of complementary and alternative medicine. A quorum for the conduct of business by the full Council shall consist of a majority of currently appointed members. A quorum for each subcommittee shall be three members.

Members shall be invited to serve for overlapping four-year terms, except that any member appointed to fill a vacancy for an unexpired term shall be appointed for the remainder of that term. A member may serve after the expiration of that member's term for 180 days after the date of the expiration. Terms of more than two years are contingent upon the renewal of the Council's charter by appropriate action prior to its expiration. A member who has been appointed for a term of four years may not be reappointed to an Advisory Council before two years from the date of expiration of that term of office. If a vacancy occurs among the appointed members, the Secretary shall make an appointment to fill the vacancy within 90 days from the date the vacancy occurs.

The Chair of the Council shall be selected by the Secretary from among the appointed members, except that the Secretary may select the Director, NCCAM, to be the Chair. The term of office of the Chair shall be two years.

As necessary, standing and ad hoc subcommittees, composed of members of the parent committee, may be established to perform functions within the Council's jurisdiction. The Department Committee Management Officer shall be notified upon the establishment of each standing subcommittee and shall be given information on its name membership, function, and estimated frequency of meetings.

Upon approval by the Chair, the advice of a subcommittee shall be considered the advice of the Committee.

A member of one subcommittee may serve as a voting member of other subcommittees when that member's expertise is required. However, that member shall not be counted in determining the presence of a quorum.

Management and support services shall be provided by the Office of the Director, NCCAM.

MEETINGS

Meetings shall be held not less than three times each fiscal year at the call of the Chair with the advance approval of a government official or upon the request of the Director, NCCAM. A government official shall approve the agenda and shall be present at all meetings of the full Council or of any subcommittee.

Meetings shall be open to the public except as determined otherwise by the Secretary; notice of all meetings shall be given to the public.

Meetings shall be conducted and records of the proceedings kept, as required by applicable laws and departmental regulations.

COMPENSATION

Members shall be paid at the rate of \$150 per day, plus per diem and travel expenses as authorized by section 5703, Title 5 U.S.C., as amended, for persons in the government service employed intermittently. Members who are officers or employees of the United States shall not receive compensation for service on the Council.

ANNUAL COST ESTIMATE

Estimated annual cost for operating the Council, including compensation and travel expenses for members but excluding staff support is \$91,896. Estimate of annual person-years of staff support required is 0.5 at an estimated annual cost of \$39,518.

REPORTS

The Council may prepare for inclusion in the biennial report prepared by the Director, NIH, under section 403 of the PHS Act, as amended, (1) comments regarding the activities of the Council in the fiscal years for which the report is prepared; (2) comments on the progress of the Center in meeting its objectives; and

(3) recommendations respecting the future directions and program policy emphasis of the Center. The Council may prepare any additional reports as it may determine appropriate.

In addition, an annual report shall be prepared no later than December 31 for submission to the Secretary through the Assistant Secretary for Health and the Director, NIH, which shall contain, as a minimum, the Council's functions, a list of members and their business addresses, the dates and places of meetings, and a summary of the Council's activities and recommendations during the year. A copy of the report shall be provided to the Department Committee Management Officer.

TERMINATION DATE

Unless renewed by appropriate action prior to its expiration, the Charter for the National Advisory Council for Complementary and Alternative Medicine will expire two years from the date of approval.

APPROVED:

JAN 28 1999

Date



Secretary

1-28-99
Charter Filing Date

C O V E R

S H E E T



FAX

To: *Devorah Adler*

Fax #: *456-5557*

Subject: *See attached*

Date: *3/30/99*

Pages: *17*, including this cover sheet

COMMENTS:

Devorah,
Attached is a copy of the slate for The National
Advisory Council for Complementary and Alternative Medicine,
and also copies of letters that were
received by The White House and
HHS regarding this Committee.

Steven

From the desk of...

Marie Absher
Political Personnel Specialist
Office of the White House Liaison
Department of Health and Human Services
200 Independence Ave SW, Room 610E
Washington, DC 20201

(202) 690-6625
Fax: (202) 401-1948



MEMORANDUM TO THE SECRETARY
THROUGH: COS _____

FROM: Steven L. Ottenstein
White House Liaison/Secretary's Advisory Committee Office Director

SUBJECT: National Advisory Council for Complementary and Alternative Medicine

BACKGROUND

The National Advisory Council for Complementary and Alternative Medicine advises the Secretary; the Director, National Institutes of Health; and the Director, National Center for Complementary and Alternative Medicine on matters relating to the conduct and support of research training, health information dissemination, and other programs with respect to complementary and alternative medicine treatment modalities.

ISSUE

Attached are recommendations for appointment of 18 members to the newly established National Advisory Council for Complementary and Alternative Medicine. These appointments include four members for one-year terms, five members for two-year terms, five members for three-year terms, and four members for four-year terms. If the slate is adopted, the Council will have four minority representatives one of which is a female and five women out of eighteen members.

Retiring Members

Not Applicable (newly established)

Chair Nomincc

William Harlan, M.D., Acting Director, National Center for Complementary and Alternative Medicine, National Institutes of Health, Bethesda, Maryland

Dr. Harlan received his M.D. degree in 1955 from the Medical College of Virginia. Prior to his NIH tenure, he has held several prestigious positions including Professor of Medicine and Director of the Robert Wood Johnson Clinical Scholars Program, Duke University Medical Center; and Professor of Medicine and Associate Dean at the University of Michigan Medical School. Dr. Harlan's NIH career includes appointments as the Director of the Division of Epidemiology and Clinical Trials, NHLBI, and Associate Director for Disease Prevention, Office of the Director, NIH. In addition, he has provided oversight for numerous offices in the Office of the Director, NIH, including the former Office of the Alternative Medicine.

Nominees

1. Dana J. Lawrence, Director, Department of Publications and Editorial Review, National College of Chiropractic, Lombard, Illinois

Mr. Lawrence has more than 17 years teaching and administrative experience in chiropractic education. He also has expertise as a biomedical editor, writer, and textbook consultant. In the past, Mr. Lawrence served as a grant reviewer for HRSA and the Health Care for Rural Areas Grant Program. He served as a consultant to HCFA's Manipulation Coding Panel in 1996. Mr. Lawrence has over 60 peer-reviewed publications. Manipulation is among the therapies the National Center for Complementary and Alternative Medicine has been specifically mandated to investigate. The addition of Mr. Lawrence to the Council is essential to the success of the Center and the Council.

2. Raymond H. Murray, M.D., Professor Emeritus, Department of Medicine, College of Human Medicine, Michigan State University, East Lansing, Michigan

Dr. Murray is a cardiologist who has an extensive academic and clinical background. He has published extensively in cardiopulmonary issues as well as broader topics involving physicians and health care. He has recently published several articles about the growing interest in alternative medicine. Dr. Murray serves as Governor of the Michigan Chapter of the American College of Physicians. His extensive background in cardiology and academia, as well as his knowledge of the issues facing health care professionals in understanding and appropriately integrating complementary and alternative health care practices, make him an ideal candidate for the Council.

3. Karen N. Olness, M.D., Professor, Department of Pediatrics, School of Medicine, Case Western Reserve University, Cleveland, Ohio

Dr. Olness is also Professor of Pediatrics at Case Western Reserve University. She has extensive clinical, academic, and research experience. Her work in child health using biofeedback, hypnosis, imagery, and other mind/body techniques is extensive. She has successfully competed for NIH grants and conducted research on the neurodevelopmental status of HIV + Ugandan infants. The National Center for Complementary and Alternative Medicine has a particular interest in investigating complementary and alternative medical approaches in pediatrics, and her membership on the Council will be valuable.

4. Harry G. Preuss, M.D., Professor of Medicine and Pathology, Department of Medicine and Pathology, Medical Center, Georgetown University, Washington, DC

Dr. Preuss is a clinician, educator, and researcher who currently holds the position of Professor of Medicine and Pathology at Georgetown University School of Medicine. He serves on numerous editorial boards including "Clinical Nephrology" and "Geriatric Nephrology and Urology" and is the editor of "The Clinical Practice of Nephrology." Additionally, Dr. Preuss has edited four books addressing acid-base balance, renal metabolism, and renal evaluation via laboratory procedures. His scientific expertise includes, nutrition, hypertension, nephrology, and general internal medicine.

5. Alexander G. Schauss, Ph.D., Director, Life Science Division, American Institute for Biomedical Research, Inc., Tacoma, Washington

Dr. Schauss holds dual appointments as Associate Professor of Behavioral Sciences and Program Coordinator, Institute for Professional Studies and Continuing Education, National College of Naturopathic Medicine, Portland, Oregon, and Associate Professor of Research and Research Director, Southwest College of Naturopathic Medicine and Health Sciences and the Southwest College Research Institute, Scottsdale, Arizona. Additionally, Dr. Schauss is the former Executive Director of Citizens for Health Education, a non-profit, consumer education and research organization whose primary focus is on economic cost analysis of alternative health care modalities. Dr. Schauss has over 70 publications and is an expert in nutritional supplements.

6. Marilyn J. Schlitz, Ph.D., Director of Research, Department of Research, Institute of Noetic Sciences, Sausalito, California

Dr. Schlitz serves as principal investigator on a program of research focusing on extended survival of metastatic breast cancer at the Geraldine Brush Cancer Research Institute. As Director of Research at the Institute of Noetic Sciences, Dr. Schlitz is responsible for developing and overseeing research in three principal program areas: emerging world views, inner mechanisms of the healing response, and extended human abilities. She served on the Breast Cancer Research Program Peer Review panel of the US Army Medical Research and Material Command in 1995-1996. Since 1994, Dr. Schlitz has also served as the Director of the Esalen Center for Theory and Research Working Group, "Direct Mental and Healing Interactions on Living Systems." Dr. Schlitz's research expertise in complementary and alternative medicine will be beneficial to the Council.

7. Gilbert Ramirez, Dr.P.H., Vice Chair/Associate Professor, Department of Public Health and Preventive Medicine, University of North Texas Health Science Center, Fort Worth, Texas

Dr. Rameriz is the former Co-Director of the Cochrane Center at San Antonio. In this position he had responsibility for the collection and evaluation of controlled trials. Within Cochrane Collaboration there is a Complementary Medicine Field Group that will be collecting and evaluating randomized controlled trials in complementary and alternative medicine. Dr. Rameriz is a statistician who has assisted in meta-analyses of several alternative treatments. He is a former Director of the Center for Cross-Cultural Research at Southwest Texas State University School of Health Professionals. With this background, Dr. Rameriz would be a valuable asset to the Council.

8. Robert E. Windom, M.D., Health Care Consultant, Sarasota, Florida

Dr. Windom also serves as a Senior Advisor for the Florida Department of Health and has a history of extensive participation and noteworthy contributions to the areas of health promotion and disease prevention. Prior to this appointment, Dr. Windom served as the Assistant Secretary for Health, DHHS. In this role he was responsible for numerous innovative and scientifically critical initiatives, including the establishment of the Federal Coordinating Committee on the HIV Epidemic and a

National AIDS Program Office in the Public Health Service. He is a member of several prestigious medical societies including the American Heart Association and the American Medical Association and has been the recipient of numerous awards and honors, including the Helen Hayes Award for his commitment in the "Fight Against AIDS".

9. Herbert Pardes, M.D., Vice President/Dean Health Sciences/Medicine, Department of Psychiatry, College of Physicians and Surgeons, Columbia University, New York, New York

Dr. Pardes is a distinguished scientist in the area of mental health sciences and psychiatry. In addition to serving as the Lawrence C. Kolb Professor and Chairman, he also holds the dual titles of Vice President for Health Sciences and Dean of the Faculty of Medicine, Department of Psychiatry, College of Physicians and Surgeons, Columbia University. He has served both as a member and chair on advisory committees at DHHS, NIH, numerous research and teaching universities, and private foundations. Additionally, Dr. Pardes currently serves as a member of several well-respected and prestigious societies, editorial boards, and he has an extensive publication record. Dr. Pardes is the recipient of numerous honors and awards for his contributions to mental health. His membership on the Council will no doubt be a positive one.

10. William L. Haskell, Ph.D., Professor, Department of Medicine/Cardiovascular, School of Medicine, Stanford University, Palo Alto, California

Dr. Haskell, Deputy Director, Stanford Center for Research in Disease Prevention, is a distinguished scientist in the area of cardiovascular medicine and disease prevention. He has contributed to the scientific research arena by both his numerous memberships in professional organizations and participation in scientific advisory groups and panels. Dr. Haskell's extensive publication record in refereed journals demonstrates his interest and awareness of current investigations in the area of physical activity and cardiovascular disease. His tenure as a member of the Council will augment the contributions to the area of complimentary medicine.

11. Tae H. Oh, Ph.D., Professor, Department of Anatomy and Neurobiology, School of Medicine, University of Maryland, Baltimore, Maryland

Dr. Oh, currently Professor of Anatomy and Neurobiology, possesses expertise in neuroscience as well as molecular biology and cellular biology. His major research interests include: (1) CNS regeneration and degeneration; (2) reactive astrogliosis in injured CNS; (3) neuroepithelial progenitor cell differentiation; and (4) neuroprotective agents from natural products. Dr. Oh has been and continues to be involved in numerous professional and academic activities in neurobiology. He has served as a consultant and member in several NIH study sections, as an editor for scientific journals, participated in numerous university activities, and national and international scientific convocations. His publications demonstrate his awareness and contributions to the intellectual advancement of this scientific area.

12. Sheila M. Katz, M.D., Ph.D., Special Assistant to the President and CEO, Office of the President, Allegheny University of Health Sciences, Philadelphia, Pennsylvania

Dr. Katz has obtained broad based experience in academic medicine, health policy, and public health, serving at highly prestigious institutions with ten years experience in senior leadership roles. Her experience in the health science environment at the university level as Dean has demonstrated her management capabilities in financial management, organizational strategy, and leadership development and mentoring. Dr. Katz is also a board certified pathologist, and Professor of Pathology and Laboratory Medicine and has received research funding for her investigations in pathology, transplantation, and immunology. Additionally, she has over 100 publications and is nationally recognized for her discovery of the cause of Legionnaire's disease.

13. Richard H. Grimm, M.D., Ph.D., Director, Department of Internal Medicine, Berman Center for Outcomes and Clinical Research, Hennepin County Medical Center, Minneapolis Medical Research Foundation, Minneapolis, Minnesota

Dr. Grimm is Director of the Berman Center for Outcomes in Clinical Research, Minneapolis Medical Research Foundation, Hennepin County Center. In addition to this appointment, he also serves as Professor, Cardiovascular Division, Internal Medicine, University of Minnesota, and Professor, Division of Epidemiology, School of Public Health, University of Minnesota. Dr. Grimm is a well recognized and highly distinguished scientist in the areas of hypertension, preventive cardiology, and epidemiology. His membership in professional societies and participation in numerous workshops indicate his scientific interest, awareness, and continued involvement in his chosen area of study. Dr. Grimm has an extensive publication record in refereed journals highlighting his involvement in current clinical research.

14. Lawrence E. Sullivan, Ph.D., Director, Center for the Study of World Religions, Harvard University, Cambridge, Massachusetts

Dr. Sullivan's curriculum vitae identifies him as an individual whose current and past studies - utilizing multicultural, multidisciplinary, and multireligious methodology - has contributed to important concepts of spirituality, religion, social welfare, and health. He is the recipient of many academic, government, and nongovernment honors and awards. Dr. Sullivan has demonstrated a willingness to identify the role of spirituality and religion and life forces by his teaching, administrative positions he has held, his numerous publications, and participation in scientific, social, and medical convocations worldwide. His Council membership should be a fruitful one resulting in positive contributions to this area of medicine and health care.

15. Diane C. Manley, Massage Therapist, New Bern, North Carolina

Ms. Manley's personal life experience indicates an individual with the inner strength needed to achieve stated goals. Her aspiration to seek health care for herself and subsequently to become a certified provider of massage therapy speaks to her willingness to apply this method into the armamentarium for

health care provision. Ms. Manley's expertise as a massage therapist and her humanitarian concern and caring spirit for the well-being of her clients will add a much needed dimension to the composition of Council membership.

16. Konrad Kail, N.D., Naturopathic Physician, Naturopathic Family Care, Inc., Phoenix, Arizona

Dr. Kail is a naturopathic physician who has a distinguished history of active contribution and participation in this area of medical care. His many publications provide much needed information that can be used in the inclusion of Council health care considerations. Currently Dr. Kail is the owner-operator of a Naturopathic family care practice which is holistic in nature, emphasizing natural and non-invasive therapies. He currently serves on the Editorial Board of "Alternative Medicine Digest" and was consultant to the health food industry. Dr. Kail's involvement in committee deliberations will undoubtedly be an asset.

17. Charlotte R. Kerr, R.N., M.P.H., Acupuncturist/Senior Faculty Member, Center for Traditional Acupuncture, Columbia, Maryland

Sister Charlotte Kerr's nursing training and additional graduate degrees in public health and Traditional Chinese Medicine indicate an individual concerned with health care. She has sought additional information from ancillary sources such as theology and ecology to be considered in the healing process. Sister Charlotte Kerr's personal and professional focus has been to bring to the public and the medical community new and transforming ways of looking at health and healing, and to bring together Western and complementary and alternative medicine therapies. Her participation in health care and well-being activities as well as her experience will provide an extremely valuable contribution to the Council in its deliberations.

18. Everett R. Rhoades, M.D., Associate Dean for Community Affairs, University of Oklahoma School of Medicine, Oklahoma City, Oklahoma

Dr. Rhoades is the former Director of the Indian Health Service. He has extensive expertise in infectious diseases, public health issues, and internal medicine. Dr. Rhoades has been very active in the Kiowa Tribe of Oklahoma and through personal experience has an understanding of the cultural issues involved with Native Americans and healing. Dr. Rhoades has received numerous awards and honors for his exemplary service within the Public Health Service, civic organizations, and the academic and Indian community.

RECOMMENDATION

I recommend that you approve the appointment of these nominees.

APPROVED _____ DISAPPROVED _____ DATE _____

United States Senate

WASHINGTON, DC 20510-3002

ENVIRONMENT AND PUBLIC WORKS
INTELLIGENCE

HELSINKI COMMISSION

February 16, 1999

Donna E. Shalala, Ph.D.
Secretary
Department of Health and Human Services
200 Independence Ave, S.W.
Washington, D.C. 20201

Dear Secretary Shalala:

I am writing to recommend Mr. Barry W. Turner for appointment to the Center for Complementary and Alternative Medicine Advisory Council. Mr. Turner has over 20 years of experience in research, sales, marketing, and management of pharmaceutical products. In addition, he has successfully worked with and managed diverse groups of scientists, engineers, managers and individuals. As you can see from Mr. Turner's resume, his extensive background in the field of complementary medicines make him a strong candidate for the Advisory Council.

As you know, the Center for Complementary and Alternative Medicine Advisory Council is charged with the responsibility of conducting and supporting the basic and applied research, research training, the dissemination of health information, and other programs with respect to identifying, investigating, and validating complementary and alternative treatment, diagnostic and prevention modalities, disciplines and systems. Currently, Mr. Turner serves as the Vice President of Global Complementary Medicines at Warner-Lambert where he is responsible for leading Warner-Lambert into the phytomedicine/non-prescription healthcare business with the launching of Ginkgo Biloba and Saw Palmetto under the Quanterra brand. He also seeks out small companies selling the most attractive extracts and active ingredients to develop joint ventures for global distribution and sales and continues working towards expansion of clinically tested and approved European extracts into the U.S. marketplace. In addition, Mr. Turner focuses on educating consumers to the legitimate therapeutic need for complementary medicines, stressing that they do not replace the need for prescription medicines but that they do provide the opportunity for supplementing existing medicines.

From 1994 through 1998, Mr. Turner served as the President of Warner-Lambert Consumer Healthcare Canada where he was responsible for a \$100 million line of business supported by 65 sales and marketing staff. He was also responsible for an affiliate wide service center (400 administrative and manufacturing staff) which supported Canada's pharmaceutical, confectionery, and shaving products division. From 1991 through 1994, Mr. Turner served as Vice President of Marketing and General Manager of Warner Wellcome

REPLY TO:

608 HART SENATE OFFICE BUILDING
WASHINGTON, DC 20510-3002
(202) 226-4744

E-mail: Frank.Lautenberg@leutenberg.senate.gov
Internet: www.senate.gov -encl@sen.gov

One New York Center 14th Floor
New York, NY 07102-5257
(201) 945-3030

WASHINGTON COMMISSION
208 WHITE HOUSE PLAZA
SUITE 18-19
WASHINGTON, DC 20501
(202) 757-3331

PRINTED ON RECYCLED PAPER

Turner
February 16, 1999
Page 2

where he was responsible for the formation of Warner-Lambert's joint venture with Glaxo and Burroughs Wellcome in Canada. In addition to his daily professional responsibilities, Mr. Turner has been a Board Member and Executive Committee Member of the Non Prescription Drug Manufacturers' Association and a Board Member of Advertising Standards Canada.

Mr. Turner is quite accomplished in his field. I hope you will give his application serious consideration. Thank you for your attention to this matter.

Sincerely,

A handwritten signature in black ink, reading "Frank R. Landenberg". The signature is written in a cursive style with a large, stylized "F" and "L".

THE WHITE HOUSE
WASHINGTON

January 19, 1998

Mr. Stefano Maddalena
631 East 11 Street, Apt. 6
New York, New York 10009

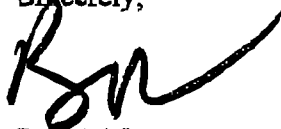
Dear Mr. Maddalena:

The President has forwarded to me your letter recommending Professor Michael C. Cohen for the Advisory Council on Complementary and Alternative Medicine Policy. I appreciate his willingness to serve.

You speak highly of Professor Cohen and I have carefully noted your insights. Since the Council is appointed by the Secretary of Health and Human Services, I have forwarded your letter to the appropriate staff members at the Department. Professor Cohen's candidacy is sure to be given every consideration.

On behalf of the President and Vice President, we welcome your views and thank you again for your personal recommendation.

Sincerely,



Bob J. Nash
Assistant to the President and
Director of Presidential Personnel

BN:hm:ss

cc: Steven Ottenstein
Heather Marabeti
Systems

11-20-98

DM

Personnel / R. Vane

November 10, 1998

President William Jefferson Clinton
The White House
1600 Pennsylvania Avenue
Washington, D.C. 20500
(202) 456-1414

DEC 3 1998
11-20-98

White House Commission on Complementary and Alternative Medicine Policy

Dear President Clinton:

I am writing to recommend Professor Michael H. Cohen to the White House Commission on Complementary and Alternative Medicine Policy.

I first became aware of Professor Cohen's scholarly work in the regulation of complementary and alternative medicine while studying as a PhD Student at the Institute of Health Law, School of Law, University of Neuchâtel, Switzerland. I was impressed with the depth and scope of Professor Cohen's analysis. At that time, the Swiss government had commissioned me to study the regulatory scheme for complementary care in Europe. I was completing a multi-volume work entitled, The Legal Status of Complementary Medicines in Europe – A Comparative Legal Analysis, published by Stämpfli Verlag, Bern (December 1998). Professor Cohen's work provided an excellent summary of U.S. law and served as a bridge between U.S. and European regulation.

Professor Cohen's book, Complementary and Alternative Medicine: Legal Boundaries and Regulatory Perspectives, published by Johns Hopkins University Press, is an outstanding map for the European community and other global constituencies regarding U.S. law and policy in complementary and alternative medicine. Given the mandate and interest in these issues in Europe, Professor Cohen's book provides an insightful and penetrating focus for comparative analysis and for legislative proposals arising out of this analysis.

Recently I had the opportunity to meet Professor Cohen personally, in a visit to Professor William Sage at Columbia Law School. I also had the opportunity to discuss European developments and legislative proposals with Professor Cohen. I was impressed with Professor Cohen's warmth, intelligence, and dedication to this work, as well as with his skillfulness in bridging cultural and regulatory models. I believe he has already made, and will continue to make, a genuine contribution to the development of complementary and alternative medicine in his country, as well as internationally.

I hope you find this recommendation helpful, and I invite you to contact me if you have any questions regarding this letter.

Withdrawal/Redaction Marker

Clinton Library

DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
002. letter	Stefano Maddalena to President Clinton re: phone number and address (partial) (1 page)	11/10/1998	P6/b(6)

COLLECTION:

Clinton Presidential Records
Domestic Policy Council
Devorah Adler
OA/Box Number: 20472

FOLDER TITLE:

Alternative Medicine [Folder 5]

2012-0463-S

rc710

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]
- P4 Release would disclose trade secrets or confidential commercial or financial information [(a)(4) of the PRA]
- P5 Release would disclose confidential advice between the President and his advisors, or between such advisors [(a)(5) of the PRA]
- P6 Release would constitute a clearly unwarranted invasion of personal privacy [(a)(6) of the PRA]

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.

Freedom of Information Act - [5 U.S.C. 552(b)]

- b(1) National security classified information [(b)(1) of the FOIA]
- b(2) Release would disclose internal personnel rules and practices of an agency [(b)(2) of the FOIA]
- b(3) Release would violate a Federal statute [(b)(3) of the FOIA]
- b(4) Release would disclose trade secrets or confidential or financial information [(b)(4) of the FOIA]
- b(6) Release would constitute a clearly unwarranted invasion of personal privacy [(b)(6) of the FOIA]
- b(7) Release would disclose information compiled for law enforcement purposes [(b)(7) of the FOIA]
- b(8) Release would disclose information concerning the regulation of financial institutions [(b)(8) of the FOIA]
- b(9) Release would disclose geological or geophysical information concerning wells [(b)(9) of the FOIA]

Truly yours,

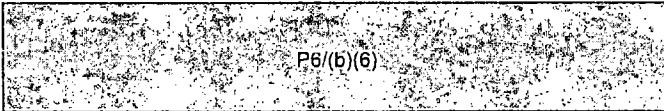


Stefano Maddalena

JsD in law at the University of Neuchâtel, Switzerland

PhD in law at the University of Neuchâtel, Switzerland

Visiting scholar at the school of law, University of Columbia, New York



[002]

email: smadda007@aol.com

Copies to:

The Honorable Tom Harkin
U.S. Senate
Washington, D.C. 20510
(202) 224-3254

The Honorable Dan Burton
U.S. House of Representatives
Washington, D.C. 20515
(202) 225-2276

The Honorable Peter DeFazio
U.S. House of Representatives
Washington, D.C. 20515
(202) 225-6416

THE WHITE HOUSE
WASHINGTON

January 19, 1998

Dr. Brian M. Berman
Kernan Hospital Mansion
220 Kernan Drive
Baltimore, Maryland 21207-6697

Dear Dr. Berman:

The President has forwarded to me your letter expressing an interest in serving on the Advisory Council on Complementary and Alternative Medicine Policy. I appreciate your willingness to serve.

Since the Council is appointed by the Secretary of Health and Human Services, I have forwarded your impressive resume to the appropriate staff members at the Department. Your candidacy is sure to be given every consideration.

On behalf of the President and Vice President, thank you for your offer of service.

Sincerely,



Bob J. Nash
Assistant to the President and
Director of Presidential Personnel

BN:hm:ss

cc: Steven Ottenstein
Heather Marabeti
Systems



B. NASSI

UNIVERSITY OF MARYLAND
SCHOOL OF MEDICINE

~~is/for/~~
~~for/~~
~~for/~~

COMPLEMENTARY MEDICINE PROGRAM

November 24, 1998

The Honorable William Clinton
The White House
1600 Pennsylvania Avenue
Washington, D.C. 20500

Dear President Clinton:

I am writing to express my interest in serving on the White House Commission on Complementary and Alternative Medicine that was recently announced. I have been integrally involved with the complementary medicine movement in the United States and continue to pursue opportunities that will enable my contribution in advancing this field. My clinical experience and in-depth knowledge of the scientific literature lead me to believe that many alternative medicine systems and practices have the potential to enhance the delivery of health care.

I am a family physician, board certified in pain management and family medicine with extensive training in complementary therapies such as acupuncture, homeopathy and manipulation which I have integrated into my clinical practice over the past 17 years. I received my medical training at the Royal College of Surgeons in Dublin, Ireland, residency at the University of Maryland, and have trained extensively in acupuncture at UCLA, the London School of Traditional Chinese Acupuncture, and homeopathy at the Royal London Homeopathic Hospital.

Presently, I am an Associate Professor of Family Medicine and Director of the Complementary Medicine Program (which I founded in 1991) at the University of Maryland School of Medicine. The program is dedicated to rigorous research into the safety and efficacy of complementary and alternative therapies. I also serve as Principal Investigator (P.I.) of a National Institutes of Health (NIH) Center for Alternative Medicine Pain Research Evaluation (CAMPRE) grant to research the safety and efficacy of complementary and alternative therapies for the treatment of chronic musculoskeletal pain disorders. I am also the P.I. or co-P.I. for numerous other studies investigating alternative therapies for pain-related problems, including two NIH grants for the study of acupuncture in the treatment of osteoarthritis and post-operative dental pain. Additionally, I am the Field Coordinator for Complementary Medicine for the Cochrane Collaboration, an international network of researchers dedicated to the conduct, maintenance and dissemination of up-to-date reviews of all health care interventions.

Patient Appointments:
University Physicians Clinic
James L. Karian Hospital
2200 Kerman Drive
Baltimore, Maryland 21207-6697
410 448-6723
FAX: 410 448-1875

Academic Research & Education Office:
Kerman Hospital Extension
2200 Kerman Drive
Baltimore, Maryland 21207-6697
410 448-6871
FAX: 410 448-6875
TDD: 410 328-9600

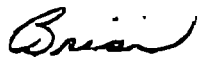
The Honorable William Clinton
1600 Pennsylvania Avenue
November 24, 1998

On the national level, I have been extensively involved with the movement to evaluate complementary and alternative medicine. In 1992, I chaired the initial ad hoc advisory board for the newly established NIH Office of Alternative Medicine as well as the editorial board for the 350-page report to the NIH, *Alternative Medicine: Expanding Medical Horizons*, which summarizes alternative medicine systems and practices in the U.S. In this past year, I completed 2 full terms of service on the NIH Office of Alternative Medicine Advisory Board. Additionally, I have presented on clinical research in complementary medicine at numerous the NIH conferences, most notably a Consensus Development Conference on Acupuncture in November, 1997, as well as at the NIH Pain Consortium the same year. I am a founding member of the American Academy of Medical Acupuncturists and am currently serving on the Task Force on Complementary Medicine for the Arthritis Foundation.

In addition to my academic responsibilities at the University of Maryland, I hold a number of editorial posts, including the *British Homeopathic Journal*, *Acupuncture in Medicine*, and *Complementary Therapies in Medicine*, to name a few, and I have an extensive list of publications, which are detailed on the enclosed C.V.

My interest in the field of complementary and alternative medicine springs directly from my vocation as a family physician. My desire to help the many patients I know in my own practice who suffer from chronic, debilitating diseases that my conventional training falls short in helping has pushed me to look for new answers. At the same time, I am keenly aware of the mass of confusing claims and information that is out there on an overwhelming hodge-podge of complementary therapies. If my experience in evaluating these can be of service to the commission and help throw light on the potential or the drawbacks of complementary medicine, I would be delighted to be involved.

Sincerely,



Brian M. Berman, M.D.
Associate Professor and
Director

Enclosure

cc: The Honorable Senator Tom Harkin
The Honorable Senator Barbara A. Mikulski

THE WHITE HOUSE
WASHINGTON

January 27, 1999

Senator Barbara Mikulski
Hart Senate Office Building
United States Senate
Washington, DC 20510

Dear Senator Mikulski:

The President has forwarded to me your letter recommending Sister Charlotte Kerr to the Advisory Council on Complementary and Alternative Medicine Policy. I appreciate her willingness to serve.

You speak highly of Sister Kerr and I have carefully noted your insights. Since the Council is appointed by the Secretary of Health and Human Services, I have forwarded your letter and Sister Kerr's impressive resume to Secretary Shalala. Sister Kerr's candidacy is sure to be given every consideration.

On behalf of the President and Vice President, thank you for your letter and your continued support.

Sincerely,



Bob J. Nash
Assistant to the President and
Director of Presidential Personnel

BN:hm:mv

cc: Secretary Donna Shalala
Steven Ottenstein
Heather Marabeti
Systems

BARBARA A. MIKULSKI
MARYLAND

COMMITTEE

APPROPRIATIONS

LABOR AND HUMAN RESOURCES

United States Senate
WASHINGTON, DC 20510-2003

CC: Bob Nash
SUITE 709

HART SENATE OFFICE BUILDING

WASHINGTON, DC 20510-2003

(202) 224-4844

TTY: (202) 224-5223

January 13, 1999

The Honorable William Jefferson Clinton,
President
The White House
1600 Pennsylvania Avenue, NW
Washington, DC 20500

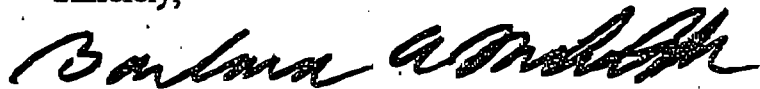
Dear President Clinton:

I am writing to inform you of my enthusiastic support of the nomination of Sister Charlotte Kerr to the National Advisory Council on Complementary and Alternative Medicine, called for in the Fiscal Year 1999 Omnibus Consolidated and Emergency Supplemental Appropriations bill. As you know, I am very interested in complementary and alternative medicine and have sponsored legislation in this area as well as helped to establish the Center for Complementary and Alternative Medicine at the National Institutes of Health (NIH) and this advisory council.

Sister Charlotte Kerr has been in health care for more than thirty years. Her background includes experience as a primary care nurse practitioner, assistant professor of nursing at the University of Maryland School of Nursing, consultant in public health, and senior faculty member of the Traditional Acupuncture Institute. Since 1977, she has been a practicing acupuncturist at the Centre. As her CV indicates, she serves on numerous boards and advisory committees. I think you will find that, based on her experience as a licensed practitioner of complementary medicine, as well as her other health care background and activities, Sister Charlotte would contribute greatly to the Advisory Council.

I urge you to do all you can to ensure that Sister Charlotte's nomination receives every possible consideration. Thank you for your attention to this issue.

Sincerely,



Barbara A. Mikulski
United States Senator

BAM:rr

Enclosure

*You're not on Charlotte
in Baltimore at Nash*

WORLD TRADE CENTER, SUITE 251
201 E. PRATT STREET
BALTIMORE, MD 21202-4800
(410) 952-6810

80 WEST STREET, SUITE 202
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Calendar No. 539

105TH CONGRESS }
2d Session }

SENATE

{ REPORT
105-300 }

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

SEPTEMBER 8 (legislative day, AUGUST 31), 1998.—Ordered to be printed

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

REPORT

[To accompany S. 2440]

The Committee on Appropriations reports the bill (S. 2440) 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

7:30-8:00
812-8380

CDC to aid the development of a nutrition and obesity.

ch.—The Committee recognizes the problem of child abuse and neglect that the NIH, under the leadership of its component organizations, cooperative efforts on child abuse and neglect urges the continuation of the implementation of the recommendations. The working group to hold a neglect to assess the state-of-the-art for a research agenda in this area that NIH be prepared to report on its progress in this area at the fiscal year

documents submitted to the Committee. \$350,000,000 will be allocated to the fiscal year 1999. As noted elsewhere, the Committee believes that the projected increase in the number of Americans who will be stricken with Alzheimer's disease warrants special priority, encourages that additional funds be requested for the National Institute on Neurological Disorders and Stroke, and the Department of Health to launch an Alzheimer's study. Given the potentially ruinous effects of Alzheimer's on the Medicare and Medicaid programs, that the Health Care Financing Administration has a stake in the effort. The Committee is to develop a plan for undertaking research on its progress during the fiscal year.

The Committee encourages the Director of Women's Health to enter into research in Complementary and Alternative Medicine to conduct a study to validate gender comparisons and analyses in research. The study should utilize the information from the task force on the NIH women's study in the 21st century. The IOM study should report and seek to determine the consequences of gender studies in both Federal and State studies to address how to accomplish these developments and have implications for research, clinical medical education, health services

—The Committee has recommended

ch.—The Committee recognizes that the death for Americans from age 44 and the loss of work productivity. The Committee has urged the NIH to develop a coordination of research on burn care research with the appropriate agencies including NIGMS, NINDS, NIAMS, and the National Center for Rehabilitation

Research. This collaborative effort should focus on the goal of realizing the opportunities presented by basic science research by applying that knowledge to clinical research in trauma and burn care in order to significantly ameliorate the enormous impact of injury on both the patient and society.

Center for Complementary and Alternative Medicine.—The Committee strongly supports the work of the Office of Alternative Medicine [OAM] and has included \$50,000,000 to support its activities to investigate, evaluate, and validate alternative therapies. The Committee directed NIH to establish this office in 1991 with the intent of assuring that alternative therapies be rigorously reviewed to provide consumers reliable information. However, it is now clear that without greater authority and independence—including the initiation of research projects and development of its own peer review panels—alternative therapies will not be adequately reviewed and inefficiencies will remain. Currently, scarce time and resources are wasted because the Office must work through an Institute in order to carry out research projects. To address these shortcomings, the Committee has included bill language creating a Center for Complementary and Alternative Medicine [CCAM].

The Committee expects that support for the centers supported by CCAM will be expanded significantly. The Committee directs CCAM to undertake field investigations and a program for the collection 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 Center 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.

The Committee notes the growing popularity of natural medicines and the relative paucity of research focusing on these promising treatments. This research gap creates consumer safety issues and prevents the Nation from realizing the full potential of natural medicines. The Committee, therefore, strongly encourages NIH, working through its Center for Complementary and Alternative Medicine, to increase funding support for the development and evaluation of natural medicines. The Committee is aware of a collaborative effort by the National Center for the Development of Natural Products [NCDNP] at the University of Mississippi, Georgetown University's Center for Drug Development Science [CDDS], and the presentation health system in South Dakota to identify and develop natural products with potentially efficacious

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.

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

Results of a Follow-up National Survey

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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.

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.

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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-

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, ¹⁷ %	Survey, %
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.

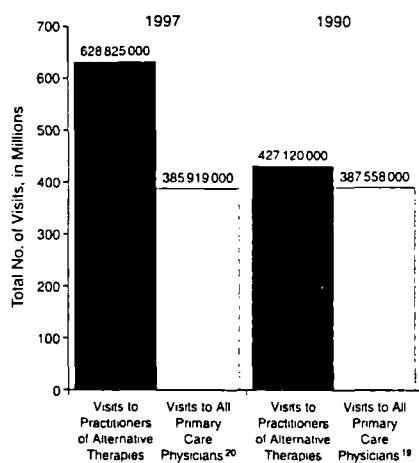
†Estimate based on 1997 population estimate of 198 million.

‡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.

alternative 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	5.3	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 others†	...	...	...	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≤.05; ¶P≤.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-

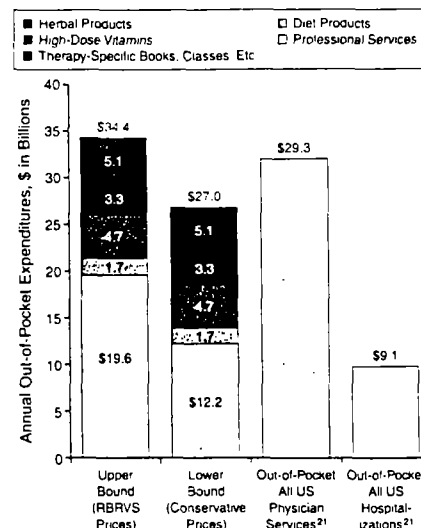


Figure 2.—Estimated annual out-of-pocket expenditures for alternative therapies vs conventional medical services, United States, 1997. Data are from the Health Care Financing Administration, United States.²¹ RBRVS indicates Resource-Based Relative Value Scale.

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^{21,27} 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.

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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 Mittelman, 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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DEPARTMENT OF AGRICULTURE
OFFICE OF THE SECRETARY
WASHINGTON, D.C. 20250

JAN 20 1999

Mr. Christopher C. Jennings
Office of Policy Development
Domestic Policy Council
Room 216, Old Executive Office Building
Washington, D.C. 20502

Dear Chris:

Enclosed is the concept paper on a White Conference on Food, Nutrition and Health developed after our December meeting. The initial meeting held in my office on December, 14, 1998, with the Department of Health and Human Services and the Department of Agriculture officials was instrumental in formulating a joint departmental response.

I will call your office this evening to see if we can arrange a meeting at a mutually convenient time to discuss whether and how to proceed. Best personal regards.

Sincerely,

A handwritten signature in cursive script, reading "Eileen Kennedy".

EILEEN KENNEDY, D.Sc.
Deputy Under Secretary
Research, Education, and Economics

Enclosure

White House Conference on Food, Nutrition and Health

Introduction

Improved nutrition has been the cornerstone upon which all modern societies and economies were built. The United States has made dramatic progress in improving diets and nutritional status of Americans. The 1969 White House Conference on Food, Nutrition and Health was a seminal event that reaffirmed the U.S. commitment to proper nutrition for all Americans. A number of specific actions emerged from the 1969 White House Conference which have led to improved diets and enhanced nutritional status; several of the key nutrition interventions, which formed part of the U.S. safety net, including the food stamp program, food labeling, and school lunch programs, trace their roots to this conference. The initial links between diet, nutrition and health emerged from research proposed as part of the follow-up agenda of the 1969 White House Conference. Given these gains and given the newer knowledge of the complexity of nutrition, including its role in chronic disease prevention, it is time to reevaluate the nutrition agenda to provide a vision for policy, interventions and research that will guide us into the 21st Century.

White House Conference on Food, Nutrition and Health

The overarching theme for a White House Conference will be "Nutrition as the Key to Better Health." There are two interconnected goals for the Conference: to emphasize the role of nutrition in health promotion/ disease prevention and to accentuate the need for a high-quality food supply. The links between improved diet, nutrition and enhanced health are clearer than ever before. Indeed there are a number of government-led initiatives that highlight these links, including Healthy People 2010, Dietary Guidelines for Americans, and the Surgeon General's Report on Dietary Fat. An emphasis on the preventive aspects of nutrition offer the greatest potential for improving public health. The development of an optimal food supply can be critical to the improvement of health. A 1999 White House Conference on Food, Nutrition and Health will provide the opportunity to assess the gains that have been made since the 1969 White House Conference and, more importantly, to identify how to build on successes to ensure more effective links between nutrition and health.

Joint Activities of DHHS and USDA

An initial meeting of DHHS and USDA officials was held on December 14, 1998, at USDA. This group would form the nexus of a steering committee to facilitate interaction with the White House as well as external groups. In order for the agenda to be manageable, it was agreed that the conference needed to be focused on Nutrition as the Key to Better Health. A number of subthemes clearly emerged; these include the role of agriculture in providing a healthful food supply, nutrition promotion/nutrition education, the role of the consumer and of communities in achieving improved nutrition, nutrition interventions as a vehicle for reducing health care costs, and policies and programs needed to address the nutritional concerns of underserved populations. It was agreed that a series of regional satellite meetings preceding the White House Conference

could serve to underscore some of the issues noted above, could receive input from a broad cross-section of the American public, and could focus on important scientific research opportunities for the future.

A preliminary timetable was discussed as follows:

- | | |
|---------------------------|---|
| January 1999: | joint DHHS/USDA transmittal of concept paper on a White House Conference on Food, Nutrition and Health to the White House. |
| January 1999: | finalize representatives on interagency steering committee; begin to develop an agenda for the White House Conference, with input from outside organizations, which will be refined through the regional/satellite conferences. |
| February - March 1999: | finalize plans for regional/satellite conferences as a prelude to WH Conference. |
| April - September 1999: | six regional/satellite conferences to be held throughout the U.S.; utilize satellite downlink capabilities to ensure participation of Washington-based officials. |
| October - November 1999: | synthesize input received from regional sessions. |
| December 1999/early 2000: | White House Conference on Food, Nutrition and Health to be held in Washington, D.C.; regions of the U.S. will be linked to conference by satellite hookup. |

Summary

The structure proposed would allow broad "buy-in" from a range of organizations and institutions without creating the expectation that a vast number of people would actually participate in the White House Conference. The recommendations and deliberations of the conference would provide a clear vision of actionable next steps to improve diet and nutrition in America.



National Institutes of Health
Office of Disease Prevention

FAX Cover Sheet

Date:

1/11/99

To:

Chris Jennings

FAX No. 202/456-5557

Number of pages (including cover sheet): 10

From:

William R. Harlan, M.D.
Associate Director for Disease Prevention
National Institutes of Health
Building 31, Room 5B41
31 Center Drive, MSC 2182
Bethesda, Maryland 20892-2182
Phone: (301) 496-1508
Fax: (301) 480-7660

Message:



DEPARTMENT OF HEALTH & HUMAN SERVICES

Public Health Service

National Institutes of Health
Bethesda, Maryland 20892

January 11, 1999

NOTE TO CHRIS JENNINGS

I have attached the background on the "White House Commission on Complementary and Alternative Medicine Policy," and some other NIH responses to Senate and House directives and questions. These are in draft, but provide information that may be useful to you.

The materials for conversion of the "Office of Alternative Medicine" in the OD to the "National Center for Complementary and Alternative Medicine" have been sent to the Secretary (on January 8, 1999) and we hope for expeditious handling.

A second piece is the legislative language for a White House Conference on Nutrition, Food and Health. The attached letter to the Surgeon General provides the language and the current status of its development. Also, an outline of the timetable for the meetings is included. The draft statement regarding the purposes is being revised and we expect to have it completed in the next week. The language regarding the conference was in the appropriations bill in the section for the Office of Dietary Supplements -- but with no earmarked funds.

If I can help further, please call.

William R. Harlan, M.D.
Associate Director for Disease
Prevention

Attachments



DEPARTMENT OF HEALTH & HUMAN SERVICES

Public Health Service

National Institutes of Health
Bethesda, Maryland 20892

December 18, 1998

TO: David Satcher, M.D.
Surgeon General

FROM: Associate Director for Disease Prevention, OD, NIH

SUBJECT: White House Conference on Nutrition, Food and Health

I am writing to provide background and to review the current status of plans for a White House Conference on Nutrition, Food and Health. The academic nutrition community has championed for several years the development of such a White House Conference that would be held 30 years after a similar, very effective conference on the issue of hunger. The general themes of the proposed conference would be the positive contributions of nutrition to health and the major advances and challenges in developing healthy and safe foods. The Senate Appropriations Bill for the current year included language in the NIH section that:

"encourages the (NIH) 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."

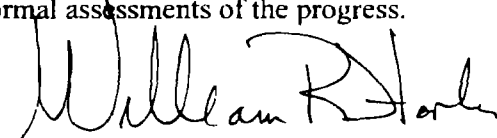
There have been initial meetings between the non-governmental advocates for a conference and governmental groups from NIH and the Department of Agriculture. A small group of governmental and non-governmental scientists met on December 1, 1998, with Chris Jennings, the White House domestic advisor. He suggested the preparation of a brief outline by the NIH and Department of Agriculture and representatives have met to discuss plans. The non-governmental groups will remain active in the planning, but the leadership will come from the government. At a meeting on December 14, NIH representatives (Bill Harlan, Paul Coates and Bernadette Marriott) met with USDA representatives (Eileen Kennedy, Floyd Horn, Dorothy Caldwell, and Rajen Anand) and Linda Meyers from ODPHP and the Surgeon General's office, they developed a tentative plan for several regional satellite meetings followed by a White House Conference, probably in February or March 2000. The goal will be to have the final conference after presentation of several major reports, such as Healthy People 2010, Dietary Guidelines for Americans, and the Surgeon General's Report on Dietary Fat. This would allow for an orderly progression to the White House Conference.

There is considerable work to be done. The next steps are: to develop a one-page brief of the conference activities; to propose that the Interagency Coordinating Committee on Human

Page 2 - David Satcher, M.D.

Nutrition Research provide oversight; to enlist NIH Institutes and other agencies, such as ODPHP, CDC, HRSA and FDA in planning; and to address development of financial support as no monies were committed for the activities.

Dr. Paul Coates, Deputy Director of the NIH Division of Nutrition Research Coordination will be leading the planning and development of these activities for NIH. He has worked closely with the DHHS agencies in many nutritional endeavors and he will have the assistance of several of us at NIH. I would expect to provide further information as planning proceeds and Linda Meyers is engaged in the process and can provide informal assessments of the progress.



William R. Harlan, M.D.

cc: Dr. Harold Varmus
Dr. Ruth Kirschstein
Dr. Paul Coates
Dr. Bernadette Marriott

Senate Report accompanying the FY 99 Labor, HHS, and Education bills.

S266 Alternative therapies -- The Committee directed NIH to establish this office [OAM] in 1991 with the intent of assuring that alternative therapies be rigorously reviewed to provide consumers reliable information. However, it is now clear that without greater authority and independence -- including the initiation of research projects and development of its own peer review panels -- alternative therapies will not be adequately reviewed and inefficiencies will remain. Currently, scarce time and resources are wasted because the Office must work through an Institute in order to carry out research projects. To address these shortcomings, the Committee has included bill language creating a [National] Center for Complementary and Alternative Medicine.

Pertinent language from the Senate bill to elevate the Office of Alternative Medicine (OAM) to the status of a national center has been incorporated into the Omnibus Appropriations Bill (H.R. 4328, P.L. 105-277, 11 Stat. 2681), which was enacted on October 21, 1998. The newly established National Center for Complementary and Alternative Medicine (NCCAM) will continue the previous OAM mandate to promote quality science, rigorous and relevant research, and open and objective inquiry into which complementary and alternative medicine (CAM) practices work, which do not, and why. The NCCAM's overriding goal will be to provide the American public with reliable information about CAM practices. In implementing this goal, the NCCAM will continue to work with other NIH Institutes/Centers and with other federal agencies to ensure appropriate scientific input and management of CAM research programs.

S267 Evaluation of outcome data on alternative therapies -- The Committee expects that support for the centers supported by [N]CCAM will be expanded significantly. The Committee directs [N]CCAM to undertake field investigations and a program for the evaluation of outcome data on promising alternative therapies, including new clinical trials of herbal natural products and other CAM therapies. The Committee also expects [N]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 Center has only eight FTE's while other NIH entities with comparable budgets have considerably larger professional staffs. Therefore, the Committee expects that the [N]CCAM will be provided sufficient FTE's.

Goals for the National Center for Complementary and Alternative Medicine (NCCAM) for the next five years include: an increase in the number of investigator-initiated and research center grants; further development and maintenance of comprehensive bibliographic database(s) of complementary and alternative medicine (CAM) research; an assessment of CAM practices using field investigations; and a coordinated, comprehensive research training program for investigators interested in CAM. These goals will be pursued in collaboration with other Institutes and Centers and in partnership with other agencies, including CDC and AHCPR.

NCCAM will expand its Research Centers to include new areas of interest and to increase the quality of research in the centers. The level of support for each center will be increased and each center will assume more responsibility for designing new programs and for enhanced support of training and career development activities. The CAM Research Centers will focus on: cancer, cardiovascular disease; HIV/AIDS; pediatrics; musculoskeletal disorders (with an emphasis on rheumatoid and osteoarthritis); neurological disorders and stroke; substance abuse; and problems associated with aging. In addition, NCCAM is planning new clinical trials of natural herbal products and other promising CAM therapies.

In response to the enhanced scope of responsibilities and activities for the NCCAM, a revised organization and staffing plan is being developed, subject to approval by the Secretary, DHHS.

S268 Federal policy on alternative therapies -- 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.

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Promoting rigorous scientific research to determining the efficacy of promising natural products remains a priority for NCCAM. Grant applications for complementary and alternative medicine (CAM) research projects are evaluated through established scientific peer review procedures, following the same process as applications for all research projects supported by NIH. The Center Director, after consultation with the Advisory Council for the Center, and with the Center for Scientific Review, will ensure that scientists with appropriate expertise in research on complementary and alternative medicine, are incorporated into the review, oversight and management processes of all research projects and other activities funded by the Center.

House Report accompanying the FY 99 Labor, HHS and Education bills.

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National Institutes of Health
Office of Disease Prevention

FAX Cover Sheet

Date:

1/11/99

To:

Chris Jennings

FAX No.

202/456-5557

Number of pages (including cover sheet):

10

From:

William R. Harlan, M.D.

Associate Director for Disease Prevention

National Institutes of Health

Building 31, Room 5B41

31 Center Drive, MSC 2182

Bethesda, Maryland 20892-2182

Phone: (301) 496-1508

Fax: (301) 480-7660

Message:



DEPARTMENT OF HEALTH & HUMAN SERVICES

Public Health Service

National Institutes of Health
Bethesda, Maryland 20892

January 11, 1999

NOTE TO CHRIS JENNINGS

I have attached the background on the "White House Commission on Complementary and Alternative Medicine Policy," and some other NIH responses to Senate and House directives and questions. These are in draft, but provide information that may be useful to you.

The materials for conversion of the "Office of Alternative Medicine" in the OD to the "National Center for Complementary and Alternative Medicine" have been sent to the Secretary (on January 8, 1999) and we hope for expeditious handling.

A second piece is the legislative language for a White House Conference on Nutrition, Food and Health. The attached letter to the Surgeon General provides the language and the current status of its development. Also, an outline of the timetable for the meetings is included. The draft statement regarding the purposes is being revised and we expect to have it completed in the next week. The language regarding the conference was in the appropriations bill in the section for the Office of Dietary Supplements -- but with no earmarked funds.

If I can help further, please call.

A handwritten signature in dark ink, appearing to read "Bill", is positioned above the typed name.

William R. Harlan, M.D.
Associate Director for Disease
Prevention

Attachments



DEPARTMENT OF HEALTH & HUMAN SERVICES

Public Health Service

National Institutes of Health
Bethesda, Maryland 20892

December 18, 1998

TO: David Satcher, M.D.
Surgeon General

FROM: Associate Director for Disease Prevention, OD, NIH

SUBJECT: White House Conference on Nutrition, Food and Health

I am writing to provide background and to review the current status of plans for a White House Conference on Nutrition, Food and Health. The academic nutrition community has championed for several years the development of such a White House Conference that would be held 30 years after a similar, very effective conference on the issue of hunger. The general themes of the proposed conference would be the positive contributions of nutrition to health and the major advances and challenges in developing healthy and safe foods. The Senate Appropriations Bill for the current year included language in the NIH section that:

"encourages the (NIH) 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."

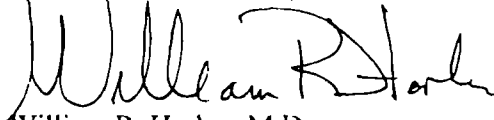
There have been initial meetings between the non-governmental advocates for a conference and governmental groups from NIH and the Department of Agriculture. A small group of governmental and non-governmental scientists met on December 1, 1998, with Chris Jennings, the White House domestic advisor. He suggested the preparation of a brief outline by the NIH and Department of Agriculture and representatives have met to discuss plans. The non-governmental groups will remain active in the planning, but the leadership will come from the government. At a meeting on December 14, NIH representatives (Bill Harlan, Paul Coates and Bernadette Marriott) met with USDA representatives (Eileen Kennedy, Floyd Horn, Dorothy Caldwell, and Rajen Anand) and Linda Meyers from ODPHP and the Surgeon General's office, they developed a tentative plan for several regional satellite meetings followed by a White House Conference, probably in February or March 2000. The goal will be to have the final conference after presentation of several major reports, such as Healthy People 2010, Dietary Guidelines for Americans, and the Surgeon General's Report on Dietary Fat. This would allow for an orderly progression to the White House Conference.

There is considerable work to be done. The next steps are: to develop a one-page brief of the conference activities; to propose that the Interagency Coordinating Committee on Human

Page 2 - David Satcher, M.D.

Nutrition Research provide oversight; to enlist NIH Institutes and other agencies, such as ODPHP, CDC, HRSA and FDA in planning; and to address development of financial support as no monies were committed for the activities.

Dr. Paul Coates, Deputy Director of the NIH Division of Nutrition Research Coordination will be leading the planning and development of these activities for NIH. He has worked closely with the DHHS agencies in many nutritional endeavors and he will have the assistance of several of us at NIH. I would expect to provide further information as planning proceeds and Linda Meyers is engaged in the process and can provide informal assessments of the progress.



William R. Harlan, M.D.

cc: Dr. Harold Varmus
Dr. Ruth Kirschstein
Dr. Paul Coates
Dr. Bernadette Marriott

Senate Report accompanying the FY 99 Labor, HHS, and Education bills.

S266 Alternative therapies -- The Committee directed NIH to establish this office [OAM] in 1991 with the intent of assuring that alternative therapies be rigorously reviewed to provide consumers reliable information. However, it is now clear that without greater authority and independence -- including the initiation of research projects and development of its own peer review panels -- alternative therapies will not be adequately reviewed and inefficiencies will remain. Currently, scarce time and resources are wasted because the Office must work through an Institute in order to carry out research projects. To address these shortcomings, the Committee has included bill language creating a [National] Center for Complementary and Alternative Medicine.

Pertinent language from the Senate bill to elevate the Office of Alternative Medicine (OAM) to the status of a national center has been incorporated into the Omnibus Appropriations Bill (H.R. 4328, P.L. 105-277, 11 Stat. 2681), which was enacted on October 21, 1998. The newly established National Center for Complementary and Alternative Medicine (NCCAM) will continue the previous OAM mandate to promote quality science, rigorous and relevant research, and open and objective inquiry into which complementary and alternative medicine (CAM) practices work, which do not, and why. The NCCAM's overriding goal will be to provide the American public with reliable information about CAM practices. In implementing this goal, the NCCAM will continue to work with other NIH Institutes/Centers and with other federal agencies to ensure appropriate scientific input and management of CAM research programs.

S267 Evaluation of outcome data on alternative therapies -- The Committee expects that support for the centers supported by [N]CCAM will be expanded significantly. The Committee directs [N]CCAM to undertake field investigations and a program for the evaluation of outcome data on promising alternative therapies, including new clinical trials of herbal natural products and other CAM therapies. The Committee also expects [N]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 Center has only eight FTE's while other NIH entities with comparable budgets have considerably larger professional staffs. Therefore, the Committee expects that the [N]CCAM will be provided sufficient FTE's.

Goals for the National Center for Complementary and Alternative Medicine (NCCAM) for the next five years include: an increase in the number of investigator-initiated and research center grants; further development and maintenance of comprehensive bibliographic database(s) of complementary and alternative medicine (CAM) research; an assessment of CAM practices using field investigations; and a coordinated, comprehensive research training program for investigators interested in CAM. These goals will be pursued in collaboration with other Institutes and Centers and in partnership with other agencies, including CDC and AHCPR.

NCCAM will expand its Research Centers to include new areas of interest and to increase the quality of research in the centers. The level of support for each center will be increased and each center will assume more responsibility for designing new programs and for enhanced support of training and career development activities. The CAM Research Centers will focus on: cancer, cardiovascular disease; HIV/AIDS; pediatrics; musculoskeletal disorders (with an emphasis on rheumatoid and osteoarthritis); neurological disorders and stroke; substance abuse; and problems associated with aging. In addition, NCCAM is planning new clinical trials of natural herbal products and other promising CAM therapies.

In response to the enhanced scope of responsibilities and activities for the NCCAM, a revised organization and staffing plan is being developed, subject to approval by the Secretary, DHHS.

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Presidential Commission on Complementary and Alternative Medicine Policy (CCAM)

Tuesday, March 30, 1999

11:00 am

- Legislative Authority for CCAM
- Charter for CCAM
- Membership for CCAM (Number of Members)
- Appointment Process for CCAM
- Management and Administrative Support for CCAM
- Legislative Authority for Secretary's Advisory Council for Complementary and Alternative Medicine
- Charter for Secretarial Council
- Membership/Status of Slate for Secretarial Council
- Next Steps

Mitchell Goldstein

Calendar No. 539

105TH CONGRESS }
2d Session }

SENATE

{ REPORT
105-300 }

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

SEPTEMBER 8 (legislative day, AUGUST 31), 1998.—Ordered to be printed

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

REPORT

[To accompany S. 2440]

The Committee on Appropriations reports the bill (S. 2440) 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

the development of a obesity.

Committee recognizes the of child abuse and ne- IH, under the leadership component organizations efforts on child abuse and the continuation of the of the recommendations. working group to hold a assess the state-of-the-art a research agenda in this be prepared to report on is area at the fiscal year

submitted to the Commit- 00,000 will be allocated to year 1999. As noted else- lies that the projected in- o will be stricken with Alz- rsons—warrants special pri- rages that additional funds the National Institute on al Disorders and Stroke, and th to launch an Alzheimer's e potentially ruinous efforts Medicare and Medicaid pro- e Health Care Financing Ad- take in the effort. The Com- velop a plan for undertaking on its progress during the fis-

Committee encourages the Direc- Women's Health to enter into ine to conduct a study to vali- comparisons and analyses in should utilize the information sk force on the NIH women's entury. The IOM study should nd seek to determine the con- r studies in both Federal and how to accomplish these de- nlications for research, clini- cal education, health services

Committee has recommended

The Committee recognizes that or Americans from age 44 and work productivity. The Com- IH to develop a coordination care research with the appro- g NIGMS, NINDS, NIAMS, onal Center for Rehabilitation

Research. This collaborative effort should focus on the goal of realizing the opportunities presented by basic science research by applying that knowledge to clinical research in trauma and burn care in order to significantly ameliorate the enormous impact of injury on both the patient and society.

Center for Complementary and Alternative Medicine.—The Committee strongly supports the work of the Office of Alternative Medicine [OAM] and has included \$50,000,000 to support its activities to investigate, evaluate, and validate alternative therapies. The Committee directed NIH to establish this office in 1991 with the intent of assuring that alternative therapies be rigorously reviewed to provide consumers reliable information. However, it is now clear that without greater authority and independence—including the initiation of research projects and development of its own peer review panels—alternative therapies will not be adequately reviewed and inefficiencies will remain. Currently, scarce time and resources are wasted because the Office must work through an Institute in order to carry out research projects. To address these shortcomings, the Committee has included bill language creating a Center for Complementary and Alternative Medicine [CCAM].

The Committee expects that support for the centers supported by CCAM will be expanded significantly. The Committee directs CCAM to undertake field investigations and a program for the collection 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 Center 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.

The Committee notes the growing popularity of natural medicines and the relative paucity of research focusing on these promising treatments. This research gap creates consumer safety issues and prevents the Nation from realizing the full potential of natural medicines. The Committee, therefore, strongly encourages NIH, working through its Center for Complementary and Alternative Medicine, to increase funding support for the development and evaluation of natural medicines. The Committee is aware of a collaborative effort by the National Center for the Development of Natural Products [NCDNP] at the University of Mississippi, Georgetown University's Center for Drug Development Science [CDDS], and the presentation health system in South Dakota to identify and develop natural products with potentially efficacious

medical uses, perform the clinical testing of these products, and evaluate the data to determine their safety and efficacy. Full and fair consideration should be given to the project described above.

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. The Committee understands that behavioral science is an area of exceptional promise for understanding and ameliorating some of the Nation's most serious health concerns, many of which are due to behavior, and commends OBSSR for its efforts to increase the visibility of behavioral science at NIH. The Committee recognizes that OBSSR's budget is extremely limited, and urges the Director to examine OBSSR's budget in order to increase the number of cross-NIH behavioral research and training initiatives.

The Committee recognizes that stress contributes to a host of medical conditions confronted by health care practitioners, and current pharmaceutical and surgical approaches cannot adequately treat stress-related illnesses. Mind/body approaches, particularly those of the relaxation response and those related to utilizing the beliefs of the patients, have been used successfully to treat these disorders. The Committee is aware that the Mind/Body Medical In-

stitute at the Harvard Medical School on mind/body interactions and the Committee is encouraged by the and cost benefits of mind/body approaches OBSSR to establish pil more visible the benefits of scientific base; and to teach a these approaches. The Committee to establish 10 mind/body centers the Committee prior to the status of the establishment.

Peer review reorganization.—The NIH is in the process of research grant proposals. The integration of systems of NIA considerably more neuroscience opportunity for NIH to significant infrastructure. Because of health implications of NIH continue to monitor this reorganizing the changes by September.

Hepatitis C [HCV].—The C Hepatitis C Consensus Development new research recommendation most particularly NIDDK, NIAAA. The Committee urges to continuing and expanding the research plan for address Committee requests that the the plan to assure the new training respond most effectively to the needs as detailed in the Consensus the liver and biliary strategic.

Grant opportunities.—The Committee encourages the efforts of the NIH to apply specifically its weekly electronic opportunities. The Committee encourages components that make funds available agreements to supplement the listserve with a weekly listserv to the full document. In addition such availability in the Federal Government's component pages. The Committee prove the flow to all potential as well as in isolated communities western Pacific, and rural America Register to arrive in a timely to apply for grant programs.

Brain molecular anatomy project.—The brain molecular anatomy project by NIMH and NINDS, which identifies the genes that direct brain development in the brain, and develop

17 March 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 50 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 and Training:

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 components be standardized within the curricula for medical public health schools?
3. What can be done to encourage continuing education of CAM among practicing physicians and other conventional health care providers?

Research:

1. How can support for increased research by the private sector be encouraged for self-care remedies such as vitamin and herbal products that are not easily patented?
2. How can coordination among federal agencies be encouraged to address the diversity of research needs in CAM?
3. What can be done to stimulate innovative research of CAM practices by the private and public sector, both in the field and in the lab?
4. 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?

Delivery of Integrated Health Care:

1. How should public health programs assess whether alternative therapies or products that demonstrate effectiveness are covered or subsidized by government health programs?
2. What should and can be done to further the integration of effective CAM therapies into mainstream medical practices?

Oversight:

1. Are additional steps needed to ensure that consumers have appropriate access to promising CAM therapies and products?
2. How should we determine what is effective or safe for self-care or for use under the direction 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 10-12 knowledgeable and prominent representatives with expertise in health care practice and/or CAM from the public and private sectors in the following measure:

- 2-3 CAM practitioners
- 2-3 conventional medical practitioners
- 2-3 researchers of CAM or conventional sciences
- 2 health policy analysts
- 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 April 15, 1999. It would conclude its work and provide its recommendations to the President and Congress by May 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.

for an individual (except in an individual's capacity as an employer or a health care provider), until legislation is enacted specifically approving the standard.

TITLE VI—NATIONAL CENTER FOR COMPLEMENTARY AND ALTERNATIVE MEDICINE

ESTABLISHMENT OF NATIONAL CENTER FOR COMPLEMENTARY AND ALTERNATIVE MEDICINE

SEC. 601. IN GENERAL.—Title IV of the Public Health Service Act (42 U.S.C. 281 et seq.) is amended—

- (1) by striking section 404E; and
- (2) in part E, by adding at the end the following:

“Subpart 5—National Center for Complementary and Alternative Medicine

“SEC. 485D. PURPOSE OF CENTER.

“(a) IN GENERAL.—The general purposes of the National Center for Complementary and Alternative Medicine (in this subpart referred to as the ‘Center’) are the conduct and support of basic and applied research (including both intramural and extramural research), research training, the dissemination of health information, and other programs with respect to identifying, investigating, and validating complementary and alternative treatment, diagnostic and prevention modalities, disciplines and systems. The Center shall be headed by a director, who shall be appointed by the Secretary. The Director of the Center shall report directly to the Director of NIH.

“(b) ADVISORY COUNCIL.—The Secretary shall establish an advisory council for the Center in accordance with section 406, except that at least half of the members of the advisory council who are not ex officio members shall include practitioners licensed in one or more of the major systems with which the Center is concerned, and at least 3 individuals representing the interests of individual consumers of complementary and alternative medicine.

“(c) COMPLEMENT TO CONVENTIONAL MEDICINE.—In carrying out subsection (a), the Director of the Center shall, as appropriate, study the integration of alternative treatment, diagnostic and prevention systems, modalities, and disciplines with the practice of conventional medicine as a complement to such medicine and into health care delivery systems in the United States.

“(d) APPROPRIATE SCIENTIFIC EXPERTISE AND COORDINATION WITH INSTITUTES AND FEDERAL AGENCIES.—The Director of the Center, after consultation with the advisory council for the Center and the division of research grants, shall ensure that scientists with appropriate expertise in research on complementary and alternative medicine are incorporated into the review, oversight, and management processes of all research projects and other activities funded by the Center. In carrying out this subsection, the Director of the Center, as necessary, may establish review groups with appropriate scientific expertise. The Director of the Center shall coordinate efforts with other Institutes and Federal agencies to ensure appropriate scientific input and management.

“(e) EVALUATION OF VARIOUS DISCIPLINES AND SYSTEMS.—In carrying out subsection (a), the Director of the Center shall identify and evaluate alternative and complementary medical treatment, diagnostic and prevention modalities in each of the disciplines and systems with which the Center is concerned, including each discipline and system in which accreditation, national certification, or a State license is available.

“(f) ENSURING HIGH QUALITY, RIGOROUS SCIENTIFIC REVIEW.—In order to ensure high quality, rigorous scientific review of complementary and alternative, diagnostic and prevention modalities, disciplines and systems, the Director of the Center shall conduct or support the following activities:

- “(1) Outcomes research and investigations.
- “(2) Epidemiological studies.
- “(3) Health services research.
- “(4) Basic science research.
- “(5) Clinical trials.

“(6) Other appropriate research and investigational activities.

The Director of NIH, in coordination with the Director of the Center, shall designate specific personnel in each Institute to serve as full-time liaisons with the Center in facilitating appropriate coordination and scientific input.

“(g) DATA SYSTEM; INFORMATION CLEARINGHOUSE.—

“(1) DATA SYSTEM.—The Director of the Center shall establish a bibliographic system for the collection, storage, and retrieval of worldwide research relating to complementary and alternative treatment, diagnostic and prevention modalities, disciplines and systems. Such a system shall be regularly updated and publicly accessible.

“(2) CLEARINGHOUSE.—The Director of the Center shall establish an information clearinghouse to facilitate and enhance, through the effective dissemination of information, knowledge and understanding of alternative medical treatment, diagnostic and prevention practices by health professionals, patients, industry, and the public.

“(h) RESEARCH CENTERS.—The Director of the Center, after consultation with the advisory council for the Center, shall provide support for the development and operation of multipurpose centers to conduct research and other activities described in subsection (a) with respect to complementary and alternative treatment, diagnostic and prevention modalities, disciplines and systems. The provision of support for the development and operation of such centers shall include accredited complementary and alternative medicine research and education facilities.

“(i) AVAILABILITY OF RESOURCES.—After consultation with the Director of the Center, the Director of NIH shall ensure that resources of the National Institutes of Health, including laboratory and clinical facilities, fellowships (including research training fellowship and junior and senior clinical fellowships), and other resources are sufficiently available to enable the Center to appropriately and effectively carry out its duties as described in subsection (a). The Director of NIH, in coordination with the Director of the Center, shall designate specific personnel in each Institute to

serve as full-time liaisons with the Center in facilitating appropriate coordination and scientific input.

"(j) AVAILABILITY OF APPROPRIATIONS.—Amounts appropriated to carry out this section for fiscal year 1999 are available for obligation through September 30, 2001. Amounts appropriated to carry out this section for fiscal year 2000 are available for obligation through September 30, 2001.

"(k) TECHNICAL AND CONFORMING AMENDMENT.—Section 401(b)(2) of the Public Health Service Act (42 U.S.C. 281(b)(2)) is amended by adding at the end the following:

"(F) The National Center for Complementary and Alternative Medicine."

TITLE VII—MISCELLANEOUS PROVISIONS

RATES OF PAY FOR PUBLIC BROADCASTING AND NATIONAL PUBLIC RADIO

SEC. 701. Section 396(k)(9) of Title 47, United States Code, is amended by striking "at an annual rate of pay which exceeds the rate of basic pay in effect from time to time for level I of the Executive Schedule under 5312 of title 5, United States Code" and inserting "in excess of reasonable compensation as determined pursuant to Section 4958 of the Internal Revenue Code for services that the officer or employee renders to organization" after "compensated."

SEC. 702. The amount of the DSH allotment for the State of Minnesota for fiscal year 1999, specified in the table under section 1923(f)(2) of the Social Security Act (as amended by section 4721(a)(1) of Public Law 105-33) is deemed to be \$33,000,000.

SEC. 703. The amount of the DSH allotment for the State of New Mexico for fiscal year 1999, specified in the table under section 1923(f)(2) of the Social Security Act (as amended by section 4721(a)(1) of Public Law 105-33) is deemed to be \$9,000,000.

SEC. 704. Notwithstanding section 1923(f)(2) of the Social Security Act (42 U.S.C. 1396r-4(f)(2)) (as amended by section 4721(a)(1) of the Balanced Budget Act of 1997 (Public Law 105-33; 111 Stat. 511), the amount of the DSH allotment for Wyoming for fiscal year 1999 is deemed to be \$95,000.

SEC. 705. EXTENSION OF CERTAIN ADJUDICATION PROVISIONS.—The Foreign Operations, Export Financing, and Related Programs Appropriations Act, 1990 (Public Law 101-167) is amended—

(1) in section 599D (8 U.S.C. 1157 note)—

(A) in subsection (b)(3), by striking "1997 and 1998" and inserting "1997, 1998, and 1999"; and

(B) in subsection (e), by striking "October 1, 1998" each place it appears and inserting "October 1, 1999"; and

(2) in section 599E (8 U.S.C. 1255 note) in subsection (b)(2), by striking "September 30, 1998" and inserting "September 30, 1999".

SEC. 706. (a) Section 2104(c) of the Social Security Act (42 U.S.C. 1397dd(c)) is amended by adding at the end the following new paragraph:

"(4) ADDITIONAL ALLOTMENT.—

"(A) IN GENERAL.—In addition to the allotment under paragraph (1), the Secretary shall allot each common-

wealth and territory described in paragraph (3) the applicable percentage specified in paragraph (2) of the amount appropriated under subparagraph (B).

"(B) APPROPRIATIONS.—For purposes of providing allotments pursuant to subparagraph (A), there is appropriated, out of any money in the Treasury not otherwise appropriated \$32,000,000 for fiscal year 1999."

(b) Section 2104(b)(1) of such Act (42 U.S.C. 1397dd(b)(1)) is amended by inserting "(determined without regard to paragraph (4) thereof)" after "subsection (c)".

SEC. 707. DETERMINATION OF NUMBER OF CHILDREN AND STATE COST FACTORS FOR FISCAL YEARS 1998 AND 1999 FOR PURPOSES OF STATE CHILDREN'S HEALTH INSURANCE PROGRAM (SCHIP).—Notwithstanding any other provision of law, for purposes of determining the product under section 2104(b)(1)(A) of the Social Security Act (42 U.S.C. 1397dd(b)(1)(A)) for a State for each of fiscal years 1998 and 1999—

(1) the number of children under clause (i) of such section shall be the number of low-income children specified for the State in Column B of the table on pages 48101-48102 of the Federal Register published on September 12, 1997, adjusted by the Census Bureau as necessary to treat children as being without health insurance if they have access to health care funded by the Indian Health Service but do not have health insurance; and

(2) the State cost factor under clause (ii) of such section shall be the State cost factor specified for the State in Column C of such table.

SEC. 708. (a) EXTENSION OF DEADLINE FOR SUBMISSION OF REPORT BY COMMISSION TO ASSESS THE ORGANIZATION OF THE FEDERAL GOVERNMENT TO COMBAT THE PROLIFERATION OF WEAPONS OF MASS DESTRUCTION.—Section 712(c)(1) of the Combating Proliferation of Weapons of Mass Destruction Act of 1996 (subtitle A of title VII of Public Law 104-293; 110 Stat. 3470; 50 U.S.C. 2351 note) is amended by striking out "the date of the enactment of this Act" and inserting in lieu thereof "January 18, 1998".

(b) MEMBERSHIP OF COMMISSION.—Section 711 of that Act is amended—

(1) in the matter preceding subsection (b)(1), by striking out "eight members" and inserting in lieu thereof "twelve members, none of whom may, during the period of their service on the Commission, be an officer or employee of any department, agency, or other establishment of the Executive Branch (other than the Commission), and";

(2) in subsection (b)(2), by striking out "one" and inserting in lieu thereof "three";

(3) in subsection (b)(4), by striking out "one" and inserting in lieu thereof "three"; and

(4) in subsection (e), by striking out "the date on which all members of the Commission have been appointed" and inserting in lieu thereof "the date of enactment of an Act making appropriations for the Departments of Labor, Health and Human Services, and Education, and related agencies, for the fiscal year ending September 30, 1999, regardless of whether all the

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CHARTER

NATIONAL ADVISORY COUNCIL FOR COMPLEMENTARY AND ALTERNATIVE MEDICINE

PURPOSE

The Secretary of Health and Human Services (Secretary) is mandated under section 301 of the Public Health Service (PHS) Act, as amended (42 U.S.C. 241) to support and encourage research, studies, and related activities in the health fields. This mandate is fulfilled in part by the mechanism of research grants-in-aid awarded by the research institutes and centers of the National Institutes of Health (NIH). In addition, the Secretary is authorized under Section 487 of the PHS Act, as amended (42 U.S.C. 288), to support research training through National Research Service Awards. The National Advisory Council for Complementary and Alternative Medicine (Council) shall advise, assist, consult with, and make recommendations to the Secretary and the Director of the National Center for Complementary and Alternative Medicine, also referred to as "Center") on matters related to the activities carried out by and through the Center and the policies respecting these activities.

AUTHORITY

42 U.S.C. 284a, _____; sections 406, 485D(b) of the PHS Act, as amended. This Council is governed by the provisions of Public Law 92-463, as amended (5 U.S.C. Appendix 2), which sets forth standards for the formation and use of advisory committees.

FUNCTION

The Council shall advise the Secretary; the Assistant Secretary for Health; the Director, NIH; and the Director, NCCAM on matters relating to the conduct and support of research training, health information dissemination, and other programs with respect to complementary and alternative medicine treatment modalities.

The Council may recommend to the Secretary acceptance, in accordance with section 231 of the PHS Act, as amended, acceptance of conditional gifts for study, investigation, or research respecting complementary and alternative medicine treatment modalities and for the acquisition of grounds, or for the construction, equipping, and/or maintenance of facilities for the Center.

The Council (1) may, on the basis of material provided, make recommendations to the Director, NCCAM, respecting research conducted at the Center; (2) may review applications for grants and cooperative agreements for research and training and recommend for approval applications for projects which show promise of making valuable contributions to human knowledge; (3) may review any grant, contract, or cooperative agreement proposed to be made or entered into by the Center; (4) may collect, by correspondence or by personal investigation, information as to studies which

are being carried on in the United States or any other country with respect to complementary and alternative medicine and, with the approval of the Director, NCCAM, make available this information through appropriate publications for the benefit of public and private health entities, health professions personnel and scientists, and for the information of the general public; and (5) may seek advice from special consultants, assemble ad hoc working groups, appoint subcommittees and convene workshops and conferences.

STRUCTURE

The Council shall consist of eighteen members appointed by the Secretary; five nonvoting ex officio members: the Secretary; the Director, NIH; the Director, NCCAM; the Chief Medical Director of the Department of Veterans Affairs; the Assistant Secretary of Defense for Health Affairs (or their designees) and any additional officers or employees of the United States as the Secretary determines necessary for the Council to effectively carry out its functions.

Of the 18 appointed members, 12 shall be selected from among the leading representatives of the health and scientific disciplines (including not less than 2 individuals who are leaders in the fields of public health and the behavioral or social sciences) relevant to the activities of the Center, particularly representatives of the health and scientific disciplines in the area of complementary and alternative medicine. Nine of the twelve shall include practitioners licensed in one or more of the major systems with which the Center is involved.

Six of the members shall be appointed by the Secretary from the general public and shall include leaders in the fields of public policy, law, health policy, economics, and management. Three of the six shall represent the interests of individual consumers of complementary and alternative medicine. A quorum for the conduct of business by the full Council shall consist of a majority of currently appointed members. A quorum for each subcommittee shall be three members.

Members shall be invited to serve for overlapping four-year terms, except that any member appointed to fill a vacancy for an unexpired term shall be appointed for the remainder of that term. A member may serve after the expiration of that member's term for 180 days after the date of the expiration. Terms of more than two years are contingent upon the renewal of the Council's charter by appropriate action prior to its expiration. A member who has been appointed for a term of four years may not be reappointed to an Advisory Council before two years from the date of expiration of that term of office. If a vacancy occurs among the appointed members, the Secretary shall make an appointment to fill the vacancy within 90 days from the date the vacancy occurs.

The Chair of the Council shall be selected by the Secretary from among the appointed members, except that the Secretary may select the Director, NCCAM, to be the Chair. The term of office of the Chair shall be two years.

As necessary, standing and ad hoc subcommittees, composed of members of the parent committee, may be established to perform functions within the Council's jurisdiction. The Department Committee Management Officer shall be notified upon the establishment of each standing subcommittee and shall be given information on its name membership, function, and estimated frequency of meetings.

Upon approval by the Chair, the advice of a subcommittee shall be considered the advice of the Committee.

A member of one subcommittee may serve as a voting member of other subcommittees when that member's expertise is required. However, that member shall not be counted in determining the presence of a quorum.

Management and support services shall be provided by the Office of the Director, NCCAM.

MEETINGS

Meetings shall be held not less than three times each fiscal year at the call of the Chair with the advance approval of a government official or upon the request of the Director, NCCAM. A government official shall approve the agenda and shall be present at all meetings of the full Council or of any subcommittee.

Meetings shall be open to the public except as determined otherwise by the Secretary; notice of all meetings shall be given to the public.

Meetings shall be conducted and records of the proceedings kept, as required by applicable laws and departmental regulations.

COMPENSATION

Members shall be paid at the rate of \$150 per day, plus per diem and travel expenses as authorized by section 5703, Title 5 U.S.C., as amended, for persons in the government service employed intermittently. Members who are officers or employees of the United States shall not receive compensation for service on the Council.

ANNUAL COST ESTIMATE

Estimated annual cost for operating the Council, including compensation and travel expenses for members but excluding staff support is \$91,896. Estimate of annual person-years of staff support required is 0.5 at an estimated annual cost of \$39,518.

REPORTS

The Council may prepare for inclusion in the biennial report prepared by the Director, NIH, under section 403 of the PHS Act, as amended, (1) comments regarding the activities of the Council in the fiscal years for which the report is prepared; (2) comments on the progress of the Center in meeting its objectives; and

(3) recommendations respecting the future directions and program policy emphasis of the Center. The Council may prepare any additional reports as it may determine appropriate.

In addition, an annual report shall be prepared no later than December 31 for submission to the Secretary through the Assistant Secretary for Health and the Director, NIH, which shall contain, as a minimum, the Council's functions, a list of members and their business addresses, the dates and places of meetings, and a summary of the Council's activities and recommendations during the year. A copy of the report shall be provided to the Department Committee Management Officer.

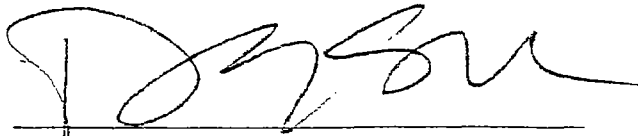
TERMINATION DATE

Unless renewed by appropriate action prior to its expiration, the Charter for the National Advisory Council for Complementary and Alternative Medicine will expire two years from the date of approval.

APPROVED:

JAN 28 1999

Date


Secretary

Charter Filing Date

1-28-99

PRESIDENT'S COMMISSION ON COMPLEMENTARY AND ALTERNATIVE MEDICINE

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