# The Bias Against Preventative Healthcare

By Peter Leighton

Listening to the ongoing debate about healthcare reform and witnessing the financial morass that we find ourselves in because of our healthcare system, it strikes me as odd that very few stakeholders are even looking at *why* the system is failing us. Without even questioning the basis of our healthcare system, legislators and the media seem hell-bent on defending or supporting a system that is clearly designed to feed a for-profit economic market.

Hold on everybody…isn't the healthcare system supposed to support and enhance the health of the population? Isn't the goal to reduce sickness and lower the costs to everyone, both patients and government? If this is the overriding goal of healthcare, then perhaps it is time to review our current system in the light of day, and hold the system up to the goals we aspire. It's time to recognize that the emperor is wearing no clothes.

I for one am not so naive to believe that the American healthcare system can be transformed and corrected overnight. There are way too many stakeholders with deep economic interest in keeping the system just the way it is, or better yet, continue to slide the system towards their self-serving interests. But in a true democracy, when the light of truth illuminates the injustices of the many, the chemistry of change begins. Yet in order for change to occur it is critical that the facts be told and that each individual recognize their responsibility and their power. For too long Americans have been numbed into acquiescence by our affluence and dumbed into indifference by our legislative complexity.

Our healthcare system is failing because the current system is designed to support disease, not prevent it. The real questions are *why is there a bias against preventative*

*healthcare* and *where does it come from*. The answers are found if, as with most investigations, we follow the money. But first, a historical perspective on health care and medicine in general.

## Mainstream vs. Traditional Medicine


There are two basic types of medical training: Allopathic and Osteopathic. Mainstream medical schools offering graduates MD degrees are Allopathic. Medical schools offering a DO degree are Osteopathic.

Osteopathic doctors are legally and professionally equivalent to medical doctors. The important difference between the two types of schools is that osteopathic medical schools have a holistic perspective on the practice of medicine based on a belief in treating the "whole patient" (mind-body-spirit) and the primacy of the musculoskeletal system in human health and the utility of osteopathic manipulative treatment.

Allopathic healthcare is symptom focused, primarily looking at resolution of dysfunction. Often the forms of treatment are technologically based and/or invasive such as surgery or drugs. While this form of medicine is often highly effective, especially for emergency or critical situations, because it is symptom based, one system might well be treated at the expense of another system.

As much as “mainstream” allopathic medicine has tried to subordinate osteopathic medicine, these “whole patient” doctors have refined a public image of being superior caregivers that has been very well received by American consumers. It is an image drawn from a distinctive medical philosophy crafted in the early nineteenth century, and observed by alternative or “traditional” practitioners of all stripes ever since.

## “Drugless Healing”

Osteopathic doctors are practitioners of "natural healing," meaning they use remedies and procedures that support and stimulate the healing power of nature, the innate tendency of the body to react to illness and work to restore itself to equilibrium and wholeness.

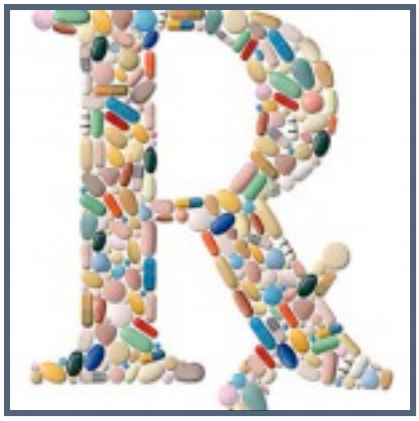
What this means is that the doctor or physician tends to look at the whole person when making treatment judgments, taking great pains to figure out how one symptom or body system affects another. Conceptually based upon Chinese medicine and the Meridian System, this kind of medicine is really the more traditional form of health care, and focuses on maintaining health before it reaches the point of dysfunction.

As the counter-culture movement of the 1960's gained strength, more people began returning towards a more natural way of life and healing. What was being called "alternative medicine" began snowballing throughout the 1970's and 1980's, culminating in 1992 in the establishment by Congress of the Office of Alternative Medicine (OAM) at the National Institutes of Health.

Conversely, Western allopathic medicine, with enormous economic interests supporting it, is designed to treat disease instead of preventing it. Not really a healthcare system, we should call it what it is — a disease care system. A true healthcare system would mitigate the causes of poor health and promote & encourage preventative lifestyles. Unfortunately, about 95 percent of public healthcare spending goes toward sick care and only 5 percent on prevention of illness or to public health.

As noted, one of the tools used by allopathic medicine and central to the current "healthcare" system is the use of medications. Sadly, prescription drugs don't treat diseases; rather they mask the symptoms of our stressed-out, calorie-rich, toxic lifestyles. The pharmaceutical industry is a multi-trillion dollar machine that lines the pockets of many vested interests from Wall Street to K Street. Perpetuating a faulty "disease care" system, Big Pharma and their cronies are making out like bandits. It's no wonder so many Americans are dying from prescription medications, as they are not getting better, just masking the symptoms with medications.

## Big Pharma



Big Pharma has earned its nickname because of the tremendous amount of money it genera tes. Pharmaceutical manufacturers rank among the nation's most profitable industries (profit as a percentage of revenue), with profits of 15.8% compared to 5.7% for all Fortune 500 firms, including the oil companies.

While drugs are not the only problem with our "healthcare" system, prescription drugs are 10% of national healthcare spending and by far the fastest growing portion at +9%. From 1997-2007, the number of prescriptions in the U.S. increased 72% to over 3.8 billion prescriptions that while the nation's population only grew 11%. Per capita, the average number of prescriptions is over 12.6, and retail prices of these drugs increased more than 2.5 times the rate of

inflation. HHS projects U.S. prescription drug spending to reach $516 billion by 2017. With more than 40% of the U.S. population now on prescription drugs, the drug content in human urine is now so high that trace amounts of antidepressant drugs can be found in public water supplies.

One way Big Pharma has grown so big is by convincing us that we are sick. The incredible amount of money the pharmaceutical industry spends on direct-to-consumer (DTC) advertising has mushroomed, as have their profits. In 1997 a paltry $1 billion was spent on DTC advertising; in 2005 that number exceeded $4 billion. And that certainly makes sense from their perspective considering that there is a definitive and positive correlation between advertising spending and prescriptions written for those drugs. A GAO reviewed study found sales increases of $2 for every $1 spent on DTC advertising, and another study found $4.20 in sales generated from every DTC ad dollar spent. Yet DTC is overshadowed by what Big Pharma spends on promotions to physicians, which was $3 billion more than DTC advertising in 2005, according to the GAO.

It seems that with all of their incomprehensible profit, Big Pharma is a massive marketing machine, convincing us that we are ill and pushing the doctors to promote their chemical cures. The pharmaceutical industry will vigorously defend their profits with the argument that research and development costs a lot, yet the facts don't support them. Big Pharma spends almost twice as much on promotion of its products than it does on research & development. According to "The Cost of Pushi ng Pills: A New Estimate of Pharmaceutical Promotion Expenditures in the United States," as a percentage of domestic sales in 2004, the pharmaceutical industry spent 24.4% on promotion and only 13.4% for R&D.

The lack of R&D funding is negatively impacting the market through a lack of innovation. It may surprise you to know that only a handful of truly important drugs have been brought to market in recent years, and they were based mostly on taxpayer-funded research at academic institutions, small biotechnology companies, or the National Institutes of Health (NIH). What passes as "new" drugs are not new at all but merely variations of existing drugs already on the market. This lucrative strategy involves producing something very similar to a top-selling drug. For instance, we now have six cholesterol-lowering statins on the market, each a variation of the first.

Of the 78 drugs approved by the FDA in 2002, only 17 contained new active ingredients, and the FDA classified only 7 of these as improvements over older drugs. The other 71 drugs were deemed no better than drugs already on the market.

## Putting Government to Work

Furthermore, Big Pharma feeds off the government through its dependence upon patent grants and FDA approvals, both of which offer the pharmaceutical industry exclusive monopolies. And the types of drugs they are securing monopolies to, are significantly driven by lifestyle concerns as opposed to disease conditions — unless you consider restless leg syndrome, nail fungus and erectile dysfunction life threatening diseases. But they are conditions that drive revenue.

Beginning in 1980, Congress enacted a series of laws designed to speed the commercialization of tax-supported basic research into useful new products. Technology transfer, as it is known, is supposed to also help drive American-owned technology into world markets. One of these laws, the Bayh-Dole Act, enabled universities and small businesses to patent discoveries emanating from research sponsored by the National Institutes of Health, the major distributor of tax dollars for medical research, and then to grant exclusive licenses to drug companies. Until then, taxpayer-financed discoveries were in the public domain, available to any company that wanted to use them. But now universities, where most NIH-sponsored work is carried out, can patent and license their discoveries, and charge royalties. Similar legislation permitted the NIH itself to enter into deals with drug companies that would directly transfer NIH discoveries to companies. These laws essentially made the U.S. government, and taxpayer dollars, an exclusive research & discovery mechanism of Big Pharma, so these companies no longer have to rely on their own research for new drugs. In fact, they increasingly rely on academia, small biotech startup companies, and the NIH for research and instead plow more money into promotion and advertising.

It didn't take long for these under-funded academic research facilities and non-profit medical schools and teaching hospitals to become enthusiastic "partners" with the drug companies. As the entrepreneurial spirit grew during the 1990s, medical school faculty entered into other lucrative financial arrangements with drug companies, as did their parent institutions.

In spite of their dependence upon taxpayer-funded research, tax benefits and government supported market monopoly, Big Pharma has another incredible asset in the form of secrecy. The FDA is not allowed to reveal any of the research data the drug companies provide. So the only clinical research results the public hears about are those Big Pharma choose to make public, which tend to be the favorable ones.

And still, in the face of a deck stacked in their favor, the pharmaceutical industry is increasingly hit with government investigations and civil and criminal lawsuits. The barrage of charges includes illegally overcharging Medicaid and Medicare, paying kickbacks to doctors, engaging in anticompetitive practices, colluding with generic

companies to keep generic drugs off the market, illegally promoting drugs for unapproved uses, engaging in misleading direct-to-consumer advertising, and, of course, covering up evidence.

A study conducted by *USA Today* found that more than half of the "experts" hired to advise the FDA on the safety and effectiveness of drugs have financial ties to the pharmaceutical companies that will be impacted by those decisions. While federal law prohibits FDA from using experts with such conflicts, FDA has waived the restrictions more than 800 times since 1998.

## Drugs Kill

Although some adverse drug reactions are not very serious, each year more than 2 million people in the United States are hospitalized or injured, including more than 100,000 fatalities. In fact, according to the Journal of American Medical Association, adverse drug reactions are one of the leading causes of death in the United States.

Every day more than 4,000 people have adverse drug reactions so serious that they need to be admitted to a hospital. What's more, over 2,000 patients a day suffer an adverse event caused by drugs once they are admitted.

From 1998 through 2005, reported serious adverse drug events to the FDA increased 2.6-fold, and fatal adverse drug events increased 2.7-fold. The numbers reported have increased 4 times faster than the total number of outpatient prescriptions during the period. A few sobering facts about FDA approved drugs:

- During the period from 1998-2005, the painkillers oxycodone and fentanyl caused at least 9000 deaths; The antipsychotic medication risperidone (Risperdal®) was responsible for at least 1093 deaths; The antipsychotic Clozapine caused at least 3277 deaths; Interferon-beta, a drug that helps regulate the immune system, and two immune-affecting drugs, Infliximab and Etanercept, were each responsible for over 1000 deaths.

- Based on five years of data on 3,876 heart bypass patients from around the world, the death rate among the 1,072 patients given Bayer AG's anti-bleeding drug aprotinin (Trasylol®) was nearly 21%, two-thirds higher than the mortality rate among surgery patients not given anti-bleeding drugs. Bayer failed to reveal to U.S. regulators the results of this large study.

- In clinical trials by Merck, the cholesterol lowering drugs Zetia® and Vytorin® were found to not be effective at preventing heart attacks, and in fact caused fatty plaques to grow almost twice as fast as in the control.

- A prostate study gave 28 men a one-year course of finasteride (Proscar®), the standard drug for benign prostate problems. The other 25 were given nothing. When the year was up, researchers gave each man a second biopsy. Nearly 30% of the men taking Proscar® developed prostate tumors. Yet tumors were found in only one of the 25 men taking nothing.

Recent analysis found that the makers of antidepressants like Prozac® and Paxil® never published the results of about a third of the drug trials that they conducted to win government approval, misleading doctors and consumers about the drugs' true effectiveness. The fact is, when all data is considered the drugs outperform placebos, but by a modest margin. Furthermore, there are some herbal dietary supplements that have demonstrated comparable efficacy without significant side effects. What are some of these side effects?

SSRIs cause hyperprolactinimemia, which results in erectile disfunction, increased breast cancer, autoimmune conditions such as lupus, etc. Children and young people treated with SSRI or SNRI more frequently exhibit suicidal thoughts and suicidal behavior as well as hostile behavior than comparable patients treated with a placebo. Another study shows an increased occurrence of malformation in children born by mothers who had used an SSRI antidepressant during early pregnancy.

Even OTC medications which seem harmless, medications long regulated and approved by the FDA, kill more people than any dietary supplement ever has. In any given year, Tylenol® (acetaminophen) is responsible for more than 14,000 unintentional overdoses, with about 100 of those cases resulting in death. In one large clinical trial, subjects taking acetaminophen every six hours for one week saw over 1/3 experiencing serious liver damage.

Every year NSAID's are responsible for an estimated 7,600 deaths and 76,000 hospitalizations in America. NSAID use has been linked to "leaky gut" syndrome and intestinal damage by a host of studies. For instance, in a large group of arthritis patients with a history of NSAID use, it was found that 70% had intestinal erosion, and 25% had severe, large lesions. Ibuprofen (Advil®, Midol®, Motrin®, Nuprin®, Pamprin®), naproxen (Aleve®, Naprosyn®, Anaprox®), and indomethacin had the worst adverse effects. In those with a history of heart problems, NSAID use increased the risk of hospital admission over 10 fold. NSAIDs taken by pregnant women increase the risk of miscarriage by 80%. Between 8-20% of adult asthmatics experience bronchospasm following ingestion of aspirin and other non-steroidal anti-inflammatory drugs (NSAIDs). Termed aspirin-induced asthma, this reaction is potentially fatal.

As a point of comparison, between 1993 and 1998, the FDA reported only 2,621 "adverse reactions," including 184 fatalities for well over 3,000 different dietary supplements.

## The Power of Plants

The challenge faced by natural therapeutics, or nutraceuticals, is that they are complex compounds with a host of variability. In other words, pharmaceuticals are usually single small molecules that are created synthetically so as to be laser focused on its structures, actions, mechanistic responses, etc. Plant based phytonutrients present so much variability, whether by species, genus, crop geography, seasonality, harvesting methods, processing methods, etc. And that's just the plant. When you start to consider that in a particular plant extract there may be hundreds of molecules, representing millions of variable interactions, you can see why allopathic medicine favors a new chemical entity that they can create and manipulate.

As modern scientific tools have progressed, however, we are able to learn more about theses phytonutrients and the mechanistic actions of their involvement in a wide array of biological processes. We know that many of these compounds are involved in activation of antioxidant defenses, signal transduction pathways, cell survival-associated gene expression, cell proliferation and differentiation and preservation of mitochondrial integrity. Furthermore, many of these compounds exert anti-inflammatory actions through inhibition of oxidative stress-induced transcription factors (e.g., NF-kappaB, AP-1), cytotoxic cytokines and cyclooxygenase-2. According to proceedings from the *Third International Conference on Mechanism of Action of Nutraceuticals*, these phytonutrients play a crucial role in the protection against the pathologies of numerous age-related or chronic diseases.

Demonstrating the therapeutic benefits of foods by scientific means remains a challenge, particularly when compared with standards applied for assessing pharmaceutical agents. The real challenge lies not in proving whether foods, and their phytonutrients, have health benefits, but in defining what these benefits are and developing the methods to expose them by scientific means.

The practice of medicine — both past and present-often involves the prescription of specific foods (almost always plants) or their potent phytochemicals, to treat a wide spectrum of illnesses.

Many epidemiologic studies, including both cohort and case-control, have shown protective effects of plant-based diets on cardiovascular disease (CVD) and cancer, just

to name a few diseases. These studies strongly suggest that plant foods also have preventive potential and that their consumption is lower in those who subsequently develop disease. This has fueled the research into, and discovery of, many unique phytochemicals, bioactive compounds found in plants.

## Cardiovascular Disease: Pharmaceuticals versus Phytonutrients

As just one example of a phytonutrient capable of outperforming a pharmaceutical, we can look at garlic. There are now well over 2,200 credible scientific papers that have studied garlic and its phytochemicals, including its chemistry, pharmacology, and clinical applications. After 70 centuries of human use, research on garlic is beginning to provide the hard data that supports anecdotal therapeutic and preventative health uses.

Studies show that garlic may decrease the progression of cardiovascular disease, which is associated with several factors, including raised serum total cholesterol (TC), raised low density lipoprotein (LDL), and increased LDL oxidation (free radical damage), reduced high density lipoprotein (HDL), increased platelet aggregation, hypertension, and smoking. Garlic seems to help decrease LDL and TC levels while raising good cholesterol (HDL), decreasing platelet aggregation (helps the blood flow more easily), and decreasing blood pressure. Recently, garlic was also found to decrease two other markers of cardiovascular disease, homocysteine and C-reactive protein.

Normally, the body's natural HDL prevents the build-up of nanoplaques through hindering the docking of LDL (Low-Density Lipoprotein, i.e. "bad cholesterol") to its receptor sites in blood vessels or existing plaques. Therefore, high concentrations of LDL and low concentrations of HDL are high risk factors for the development of atherosclerotic plaques. Studies show that garlic reduces LDL-induced nanoplaque formation by 15%. In fact, existing nanoplaques are dissolved by up to 25% within minutes after the introduction of garlic. And garlic has been shown to reduce calcification of the cholesterol docking sites in the arteries by up to 50%.

In 37 randomized clinical trials, garlic supplements compared with placebo, consistently led to small, statistically significant reductions in total cholesterol. Statistically significant reductions in low-density lipoprotein levels (LDL) and in triglycerides were also found. In one double blind, placebo controlled clinical study published in *American Journal of Medicine*, serum TC levels in garlic supplement treatment subjects were lowered by 15 points vs. 2 points for placebo; Low-density lipoprotein cholesterol (LDL-C) was reduced by 11% by garlic treatment and 3% by placebo. Overall, treatment with standardized

garlic supplements produced a significantly greater reduction in serum TC and LDL-C than placebo, and the garlic formulation was well tolerated without any odor problems.

Ten small randomized trials showed promising effects of various garlic supplements on platelet aggregation and mixed effects on plasma viscosity and fibrinolytic activity.

Two double-blind trials in participants with atherosclerotic lower extremity disease evaluated whether garlic increased pain-free walking distance at 12 to 16 weeks compared with placebo. In one trial, pain-free walking increased by approximately 40 meters with garlic supplements compared with approximately 30 meters with placebo. In the other trial, the maximum walking distance increased 114% among persons randomized to a combination treatment of garlic oil macerate/soya lecithin/hawthorn oil/wheat germ oil compared with those randomized to placebo.

Garlic may also reduce blood pressure. Numerous studies have reported that garlic is associated with reduced systolic and diastolic blood pressure. The one small trial that directly compared a standardized garlic supplement with an active antihypertensive drug found no differences in blood pressure between groups, meaning that the garlic worked as well as the drug.

In summary, numerous bioactive compounds appear to have beneficial health effects, and there is sufficient evidence to recommend consuming food sources rich in bioactive compounds. From a rational perspective, this translates to recommending a diet rich in a variety of fruits, vegetables, whole grains, legumes, oils, and nuts. From a practical perspective, since most people do not consume anywhere near the basic recommended daily allowance of phytonutrients, dietary supplementation becomes an important tool in preventative health and a viable therapeutic option.

Yet despite all the increasing data that supports the benefits and functionality of natural bioactive phytonutrients in a preventative modality, it is the FDA and other vested interests that continue to limit their viability in the marketplace.

## The FDA’s Role in Keeping You Sick


Starting in the 1960’s, and culminating with legislative changes in 1994, a popular uprising against systemic “sick care” and a belief in “wellness” and self-care options took root in America. One of the key tools of the wellness platform has been dietary supplements.

According to the FDA, a dietary supplement is a product taken by mouth that contains a "dietary ingredient" intended to supplement the diet. The "dietary ingredients" in these products may include: vitamins, minerals, herbs

or other botanicals, amino acids, and substances such as enzymes, organ tissues, glandulars, and metabolites. Dietary supplements can also be extracts or concentrates, and may be found in many forms such as tablets, capsules, softgels, gelcaps, liquids, or powders. They can also be in other forms, such as a bar, but if they are, information on their label must not represent the product as a conventional food or a sole item of a meal or diet.

Whatever their form may be, the Dietary Supplement Health and Education Act (DSHEA) of 1994 places dietary supplements in a special category under the general umbrella of "foods," not drugs, and requires that every product be labeled a dietary supplement.

A common myth abounds that dietary supplements are not regulated by the FDA and hence are unsafe, unproven and unwise. The fact is that dietary supplements are regulated by the FDA as a distinctly different modality from both food regulation on the one hand and pharmaceutical regulation on the other. With the passing of the popular DSHEA in 1994, the dietary supplement industry receives specific guidance for manufacturing, labeling, and selling dietary supplements.

Under the Dietary Supplement Health and Education Act of 1994 (DSHEA), the dietary supplement manufacturer is responsible for ensuring that a dietary supplement is safe before it is marketed. FDA is responsible for taking action against any unsafe dietary supplement product after it reaches the market. Since the FDA recognizes through DSHEA that there are health benefits in the distinct constituents within foods, and since these constituents have a long history of common use within foods, there is an assumption of overall safety. The logic follows that if it is common to eat vegetables, and the constituents in those vegetables are demonstrated to have specific health benefits, these components are assumed safe and shall not be required to provide the same level of qualification than is required of a new chemical entity marketed as a pharmaceutical therapeutic. Conversely, the FDA does not allow the marketing of those constituents to claim any therapeutic benefit.

Dietary supplement “claims” are regulated by both the Food and Drug Administration and the Federal Trade Commission. Claims that can be used on food and dietary supplement labels fall into three categories: nutrient content claims, health claims, and structure/function claims.

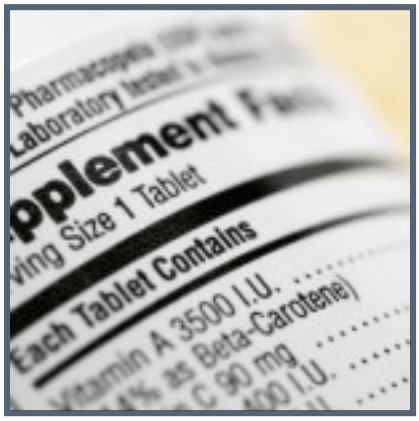
**Nutrient Content claims** describe the level (or lack) of a particular nutrient contained in a product. FDA regulations spell out which nutrient content claims are allowed and under what circumstances they can be used. There are eleven core terms: "free," "low," "lean," "extra lean," "high," "good source," "reduced," "less," "light," "fewer," and "more."

**Health claims** describe a relationship between a food, food component, or dietary constituent, and reducing the risk of a disease or health-related condition. For example:

An approved Calcium and Osteoporosis (21 CFR 101.72) claim would be “Regular exercise and a healthy diet with enough calcium helps teens and young adult white and Asian women maintain good bone health and may reduce their high risk of osteoporosis later in life.” FDA authorizes these types of health claims based on an extensive review of the scientific literature, generally as a result of the submission of a health claim petition, using the *significant scientific agreement* standard to determine that the nutrient/disease relationship is well established.

As you may have surmised, the awkward and overly qualified “claim” is anything but straight forward and definitive, regardless of the strength of the science behind it. Furthermore, the FDA’s standard of SSA (significant scientific agreement) is a nebulous and unqualified criterion, which is usually only met by the time the issue no longer has relevance. For instance, it wasn’t until 1993 that the FDA felt there was Significant Scientific Agreement and approved the claim that calcium reduces the risk of osteoporosis, in spite of the preponderance of data that had been published for over 40 years!

Legally, health claims must meet the Significant Scientific Agreement standard, which imposes a burden of showing to the FDA’s satisfaction that the claims are supported by published studies and opinions from qualified professionals. Recognizing that the results of randomized, double blind clinical studies are the best supporting data, however (here is the Catch-22), the FDA may consider a substance a drug if it has been the subject of published clinical trials. In fact, the FDA will block foods containing approved drugs or biologics from the food market. Thus, while tests must be conducted to support health claims, if those tests are clinical trials (the ideal type of test), they may cause the ingredients to be categorized as drugs and subject to more onerous safety regulations or removal from the market.




To make matters more confusing, the FDA provides for the use of **qualified health claims** when there is emerging evidence for a relationship between a food, food constituent, or dietary supplement and reduced risk of a disease or health-related condition. FDA uses its enforcement discretion for qualified health claims after evaluating and ranking the quality and strength of the totality of the scientific evidence. You can imagine that if it takes the FDA over forty years of mounting data to approve a “no-brainer” calcium claim, they likely are not on the leading edge of any real emerging evidence.

But the real sweet spot for dietary supplements are **Structure/Function claims**. Statements that address a role of a specific substance in maintaining normal healthy structures or functions of the body are considered to be structure/function claims. Structure/function claims may not explicitly or implicitly link the relationship to a disease

or health related condition. If a dietary supplement label includes such a claim, it must state in a boxed disclaimer that FDA has not evaluated the claim. The disclaimer must also state that the dietary supplement product is not intended to "diagnose, treat, cure or prevent any disease," because only a drug can legally make such a claim.

## How Do You Spell Irony

Today the market for dietary supplements and natural health products is over $100 billion. Yet the irony is that many of the consumers of these products are the ones who need them the least. Generally speaking, consumers of health & wellness products are better educated, more affluent and consume a better diet than most Americans. They are the ones that can afford better health insurance, seek better care, and because of their lifestyle behaviors, are less likely to suffer the scourge of our “Malnutrition of Affluence”.

So when the FDA creates a constant barrage of hurdles, manipulates the rules of engagement, and denies clear and overwhelming facts that consumers should have access to, it should certainly make you wonder who the FDA is trying to protect.

It is slowly becoming clear that what most of us assumed to be the best, most advanced healthcare system, vetted and supported by our own government, is in fact an economic system that enriches those stakeholders who have hitched their wagon to its mighty engine. The trail of money that supports our current “healthcare” system is spread wide to ensure its very survival. Yet this system of care is not living up to its original intent, it is not providing real healthcare, but in fact this system is bankrupting our nation economically and morally.