

Editorial

Health Care Costs Are Rising: Myth or Magic?

No question... one of the bustlin' buzzwords on the political and socioeconomic scene is *health*. Who has not been deluged with the debates about health care, health costs, health maintenance organizations (HMOs), health reforms and health benefits? And, all of this seems to be promulgated by and cascading from the health experts in the National Institutes of Health (NIH) and from the Department of Health and Human Services (DHHS) and, beyond the beltway, the World Health Organization (WHO).

If you don't believe that there is all of this noise, then try the following exercise. We examined a recent and randomly chosen issue of America's leading medical journal¹ from cover to cover including even the advertisements, book reviews, Letters-to-the-Editor, and, of course, the major communications. In the approximately 150 pages, the designation *health* was encountered about 300 times ... almost twice per page. So, no argument, *health* is indeed a busy buzzword.

And, how is it used? What does it mean? Cited below from that *JAMA* issue are direct quotes and page numbers.¹ For emphasis *health* is underlined.

... Enact a payroll tax or impose some comparable assessment on employers/employees in workplaces that do not provide acceptable health insurance ... There is no known mechanism for enforcing an absolute ceiling on total health expenditures in our pluralistic system (p. 2700) ... The cost of health care is rising two to three times faster than inflation (p. 2706) ...

And so, is it health or medical insurance, health or medical expenditures, health or medical care which is the crux of the problem? In every one of the above instances, the statement would be more correct if the term *medical* replaced *health*.

Can we reduce the confusion and better resolve the problem by pinpointing *real* health care? We'll try with two simple experiments. As a starter, we ought not to forget that we are no better than our immune systems. When our coping mechanisms finally collapse, we

die. What is the before and after immunologic picture in a group subjected to 30 minutes of t'ai chi (n = 30) versus a controlled subset (n = 30)?² Lo and behold, only in the group performing t'ai chi was there a marked improvement in immunocompetence (T-lymphocytes). Here is a superb demonstration of health care in action with all of its simplicity and absence of costliness.

There are obviously other common sense lifestyle verifications. In the real world, it's generally agreed that the increasing older population easily become ill and that a significant segment of their problems is of an infectious nature. Professor Chandra from Johns Hopkins University studied the effect of RDA amounts of vitamins and trace elements versus placebo supplementation on coping mechanisms.³ Specifically, he examined the occurrence of infection-related illness at the beginning and at the end of a 12 month interval. Ninety-six independently living, healthy elderly individuals (not taking any medications) were randomly assigned to receive dietary fortification or placebo. The frequency of infection-related illness was ascertained. Only the subject in the supplemented group demonstrated superior immune response as measured by sophisticated indices (e.g. interleukin-2, etc.). Of particular note is the fact that illness due to infection could be markedly reduced. In actual numbers, the placebo group suffered 48 days; the supplemented subset only 23 ... a reduction of over 50%. Also, the antibiotic time was halved.

So, what is the problem? Darwin, many years ago and in context, put it this way, "It took me 20 years to see the problem ... once I saw the problem, the solution was obvious!" And, the problem seems to be one of semantic correctness.

Where do we go from here? Do we need more doctors, nurses, hospitals, CAT scans money? If not, then what do we need?

Here is a simple and inexpensive story about health, not medical, care (without physicians, nurses, hospitals, MRIs, etc.). A study of the effectiveness of an intervention program designed to favorably modify behaviors hypothesized to be related to the future developments of cancer was initiated among 1,105

children in 15 institutions in the New York City vicinity.⁴ Schools were assigned to either an intervention (experimental) or a nonintervention (control) program. Subjects in schools in the experimental subgroup received each year, from fourth through ninth grades, a teacher-delivered curriculum focusing on diet and prevention of cigarette smoking. After six years (by the ninth grade), the rate of initiation of cigarette smoking was significantly (actually 73%) lower among children in the experimental schools. And equally, if not more fascinating, there was also a striking increase in reported intake of total carbohydrates and a concomitant decline in total and saturated fats.

It's time to resolve the myth of this monstrous medical muddle. The first step is to recognize the smoke and mirrors, the semantic magic which has led to the notion that health and medical care, albeit interdependent, are not synonyms. This will allow the opportunity to price the costs of health (e.g. lectures to kids, simple vitamins to the elderly, etc.) versus the price tag for a high tech medical system with all of its extravagant gadgets.

Nonsense ... health care costs are not rising ... it's our biggest bargain!

References

1. JAMA, 1992: 268:2607-2754.
2. Xusenq S, Yugi X, Yunjian X: Determination of E-rosette-forming lymphocytes in aged subjects with Taichiquan exercise. *Int. J. Sports Med.* 1989: 10:217-219.
3. Chandra RK: Effect of vitamin and trace-element supplementation on immune responses and infection in elderly subjects. *Lancet* 1992: 340:1124-1127.
4. Walter HJ, Vaughan RD, Wynder EL: Primary prevention of cancer among children. Changes in cigarette smoking and diet after six years of intervention. *J. Nat. Cancer Inst.* 1989: 81:995-999.
E. Cheraskin, M.D., D.M.D.
Park Tower 904/906
2717 Highland Avenue South
Birmingham, Alabama 35205-1725

Lysine, Ascorbic Acid and Angina Pectoris

Recently this journal carried several astonishing reports from Dr. L. Pauling's Institute.¹⁻⁴ In these reports Dr. L. Pauling and M.

Rath summarized their findings that elevated levels of low density lipoprotein cholesterol is not the major factor in the cause of arteriosclerosis. Their evidence shows that the most important single factor in the genesis of cardiovascular disease is the elevated level of lipoprotein(a). This fraction is present in plaque and accumulates when its levels are too high in the blood. They suggest that lipoprotein(a) is a surrogate for ascorbic acid. When we lost the ability to make ascorbic acid about 40 million years ago we presented nature with a major problem called hypoascorbemia.

When ascorbic acid was no longer provided in food, we lost the main compound which maintained the integrity of the collagen tissues. The vessel walls lose their ability to retain fluid and we would all bleed to death, as we do with scurvy. Nature developed a substitute. This is lipoprotein(a). By increasing the amount in the blood this provided the support to the vessel wall which was no longer provided for by the ascorbic acid. This theory is comprehensive and unique, and it accounts for the multicausal nature of hardening of the arteries in which many other nutrients play a role, including niacin, Pyridoxine, antioxidants and the amino acid lysine.

Pauling⁵ further reported that a combination of high dose lysine and ascorbate restored to normal a man suffering from severe angina on effort sometime after three coronary bypass operations. Rath and Pauling⁴ discussed the role played by the essential amino acid lysine. In addition to many other properties including its anti-viral action, it is the most important natural inhibitor of plasmin induced proteolysis which is involved in the pathogenesis of arteriosclerosis. Thus when the intake of lysine is low there will be a greater tendency for the development of plaques. McBeath and Pauling⁶ described the second response to these two nutrients, and a third one appears in this issue.

When a single case report appears it is possible that it was a chance related event. The odds that the response was due to the combination depends upon the number of spontaneous recoveries of patients with similar disease. When two cases are found the odds become much better, and when there are three reports of a response it is highly unlikely that they were due to chance. One must as-

sume that there is a real therapeutic effect and that further exploration will demonstrate its efficacy for other members of the same class of diseased patients. We are certainly at this stage now. But there is more.

Following the original Pauling report I was asked to see a patient in December 1991 who suffered from excruciating pain due to shingles. He also had congestive heart failure. He had a heart valve replaced in 1985 and was then advised he should no longer travel by air. I started him on a comprehensive program which included lysine 1 g daily and ascorbic acid 6 g. He also took niacin, vitamin E and Coenzyme Q10. In two weeks the pain was nearly gone. But when I increased his lysine to 6 g daily there was a major improvement in his overall health. Last month, after 1-1/2 years, he was found physically fit to travel by air. He was very excited since until now he had been grounded and had to deny himself the world travel that he had been accustomed to.

I have no doubt that the combination of lysine and ascorbic acid is powerful and safe for restoring ailing cardiovascular systems to normal. It seems to me to be prudent for all cardiovascular patients, including those who are so ill they have to have chelation therapy, to start on this combination before if possible, certainly during and probably long after. I predict that these two nutrients may be very important in decreasing the need for cardiovascular surgery if they are started in time.

References

1. Rath M and Pauling L: Solution to the Puzzle of Human Cardiovascular Disease: Its Primary Cause is Ascorbate Deficiency Leading to the Deposition of Lipoprotein(a) and Fibrinogen/ Fibrin in the Vascular Wall. *Journal of Orthomolecular Medicine* 6: 125-134, 1991.
2. Pauling L and Rath M: An Orthomolecular Theory of Human Health and Disease. *Journal of Orthomolecular Medicine* 6:135-138, 1991.
3. Rath M and Pauling L: A Unified Theory of Human Cardiovascular Disease Leading the Way to the Abolition of This Disease as a Cause for Human Mortality. *Journal of Orthomolecular Medicine* 7: 5-15, 1992.
4. Rath M and Pauling L: Plasmin-Induced Proteolysis and the Role of Apoprotein(a), Lysine and Synthetic Lysine Analogs. *Journal of Orthomolecular Medicine* 7: 17-23, 1992.
5. Pauling L: Case Report: Lysine/Ascorbate Related Amelioration of Angina Pectoris. *Journal of*

Orthomolecular Medicine 6: 144-146, 1991.

6. McBeath M and Pauling L: A Case History: Lysine-Ascorbate-Related Amelioration of Angina Pectoris. *Journal of Orthomolecular Medicine* 8: 77-78, 1993.

The Discovery of Heparin

Professor L. B. Jaques is one of the earliest pioneer research scientists responsible for introducing heparin into surgery and medicine. His historical account in this issue relates the discoveries, the difficulties, and the errors that have been perpetuated by thoughtless writers who did not read or properly interpret the clinical data.

History in medicine is seldom discussed in medical schools. This is a pity, for physicians do not learn that the history of medicine is a history of conflict, and that the medicine of today represents the outcome of dozens of battles. If physicians knew this they would be more tolerant of new ideas, and this would be very important to millions of patients who suffer from the very long gap between discovery and its application. But Prof. Jaques not only was a pioneer, he was and still is one of the most knowledgeable scientists in this field.

Heparin is not one compound. It is a complex of many substances, and contrary to current belief it is effective even when taken by mouth. The idea that it works only when given by injection was based upon a major error. As you will read, this conclusion attributed to Astrup was not one made by Astrup. Jaques simply states the conclusion was invented by writers. This has cost us dearly.

The field is opening widely with the introduction of dextrans. These dextrans might be very helpful in treating AIDS as well as many other conditions including schizophrenia, but because of the belief these compounds are inactivated in the stomach the FDA would not permit the release of these compounds for testing. The Canadian equivalent, the HPB, slavishly followed the decision of the FDA. This is another example from many, which shows how dangerous are hasty conclusions not based upon reading the original work reported by scientists.

A. Hoffer, M.D., Ph.D.
#3A - 2727 Quadra Street
Victoria, B.C. V8T 4E5