



# THE THIRD ERA OF MEDICINE



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A FUNCTIONAL APPROACH TO RESTORE THE HEALTH OF AMERICA

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**T**he American health care paradigm is outdated and directly opposes the health-generating solutions required to reverse the proliferation of chronic disease and the resulting health care economic crisis.

Using a revolutionary approach to restore and create health, an elite force of Functional Medicine providers have fashioned the tools and the practical foundation from which to transform health care and affordably reverse the declining health of the American public.

After more than a decade of clinical application and refinement by some of the nation's most distinguished medical minds, a single obstacle stands between this invaluable technology and the American public - now desperate for the fruits of Functional Medicine.

The obstacle lies in the flawed design of the American health care marketplace that has disrupted the ordinarily self-correcting relationship between supply and demand. Specifically, the problem can be traced to the deceptively rigid rules of the third party payer system. The system appears to prohibit physicians who practice Functional Medicine to devote the time and apply the diagnostic and therapeutic technologies required to fulfill the promise of Functional Medicine for their patients while maintaining the financial viability of their practices.

This problem has been solved by the work of health care pioneers who comprise the lost sibling of the Functional Medicine movement – America's private physicians.

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## *The Root Cause of America's Health Care Dysfunction*

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The origins of the dysfunction in the American health care system are revealed by a high-level view of the recent history of medicine in the United States. What has been called the “first era of medicine” delivered victory in the epic fight against infectious disease. By the mid-twentieth century, immunizations, antibiotics, and improved public health produced a long-awaited breakthrough and ushered modern society into the second era of medicine.

Since this time, both the structure and the focus of the health care system have dramatically changed. A seismic shift in the structure of the system was brought about by the formation of Medicare in 1965 and the ensuing dawn of managed care. The country took deliberate steps to replace the longstanding non-profit business principles of American health care with a for-profit model that would be driven by the insurance industry.

The focus of American health care also changed. The efforts and resources of the health care system were redirected in the pursuit of antidotes and cures to suppress the next great threats to human health – cardiovascular disease, cancer, diabetes and other diseases that plague the modern population. As cures for these maladies have proven to be profoundly illusive, the focus of the second era has gradually shifted to a more modest, yet profitable objective. Most of the diseases in the crosshairs of the second era have been labeled as “chronic,” and the goal is now to “manage” these chronic diseases through the tireless suppression of their many symptoms.

The fruits of the second era have been a vast array of technologies, pharmaceuticals, and health services that serve to extend the lives of patients living under the burden of chronic disease, but do little

if anything to prevent or reverse it. The second era has spawned a massive sick-care industry that has proven to be an insatiable drain on the U.S. economy and a significant threat to the ability of American companies to compete in the global economy.

Today, the fuel that drives the engine of commerce in the American health care system is disease – not health. This must change.

### ***Trapped in the Oscillating Structure of the Second Era***

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While the need for change is obvious, the nation is trapped in the seemingly infinite oscillating cycle of reacting to disease. The fires in the economic furnace of the reactive second era of medicine are stoked by diagnosis and treatment... of disease... of symptoms of disease... of risk factors for disease (e.g. cholesterol)... and ultimately, of the downstream effects of the interventions and treatments themselves.

Medications are prescribed to manage the ill effects of other medications – signaling certain defeat in man’s vain attempt to bend the laws of nature to conform to a toxic and sedentary lifestyle. The third era will mark the end of this futile struggle when medicine and nature harmonize to accelerate the creation and restoration of health.

While the pressing need for this change is evident, it appears that history and economics have conspired to arrest the nation’s ability to advance its thinking and the application of its resources to the third era of medicine.

The fundamental problem is born from an inability to part with the orientation that produced victory in the first era of medicine. Battling for generations with infectious disease deeply rooted the notion that all health problems can be cured with the appropriate intervention (magic bullet). Therefore, health care system resources and innovation should be applied to the search, at any expense, for the magic cures to the population’s multiplying ills.

Financial and emotional marriage to this magic bullet thinking has pushed the health care industry and most of its providers to ignore common sense and an overwhelming body of evidence confirming the progressive and interconnected nature of disease in order to preserve the magic bullet paradigm of the first era.

The first era calls providers fundamentally to focus their attention on “what?” What is the diagnosis? And what is the intervention?

Current clinical understanding begs for a reorientation to the question of “why?” that preoccupies the growing ranks of Functional Medicine providers. Why has this patient’s health deteriorated? As these providers have demonstrated in recent years, the answer to this question generally reveals a health restorative (and often surprisingly economical) solution.

Yet, the system resists, dismissing common sense and mountains of evidence to cling desperately to the familiar and entrenched first era paradigm. The most troubling example is seen in the system’s blind perpetuation of its acute care orientation and its clumsy efforts to engineer acute scenarios to rationalize medical interventions.

***“In a time of drastic change, it is the learners who inherit the future. The learned usually find themselves equipped to live in a world that no longer exists.”***

ERIC HOFFER

The resulting approach to addressing cardiovascular risk is arguably the most tragic byproduct of the first era legacy. Recognizing fully that roughly half of patients with cardiovascular disease will learn of their disease through sudden death, it is a costly and immeasurable human tragedy that the system has conditioned most patients, and in many respects requires providers, to wait for pronounced symptoms of disease in order to engage in treatment.

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Looking up the stream of cardiovascular event risk to diabetes exposes possibly the most overt example of the system's irrational attachment to first era, acute care thinking. In the light of undisputed evidence that diabetes is a condition that develops progressively and measurably over the course of many years, the system leads patients and providers to wait for advanced disease (creating a seemingly acute scenario) before acknowledging and attempting to address the problem.

***To preserve the first era paradigm, the system refuses to embrace three key realities:***

1. Diabetes is in fact an escalating progression of systemic destruction set in motion by a well-understood clinical imbalance;
2. The imbalance and the resulting damage can be economically detected and measured very early in its progression; and
3. The destructive sequence can be inexpensively halted and reversed when addressed early in its progression.

Instead, diabetes is labeled as a “disease.” It is characterized as “chronic,” suggesting to patients that it cannot be reversed. And the early indications of its progression are labeled benignly as “pre” disease. Incredibly, while a diagnosis of diabetes is sufficient for insurance carriers to pay for nutritional and dietary counseling, a diagnosis of pre-diabetes often is not.

As a result, patients and providers are led to dismiss a lethal and costly health risk throughout the enormous window of time in which it can be easily and economically addressed – waiting instead to render an acute diagnosis and intervene in the dangerous and costly late stages of the progression.

Further magnifying the problem is the system's failure to anticipate or acknowledge the linkage among related health problems. As one of countless examples, despite the fact that insulin resistance (“pre” diabetes) decreases blood flow to the heart, the conditions of diabetes and hypertension are regarded as discrete diagnoses. Atherosclerosis, erectile dysfunction, peripheral arterial disease, macular degeneration, microvascular dementia, and the assortment of other vascular and inflammatory diagnoses all flowing from the same wellspring of

clinical imbalance are all advertised and treated as discrete “diseases” ... comorbidities... confounding variables to be reduced and treated independent of one another by disconnected specialists.

Every magic bullet needs a target. So the bullet makers embrace the granulation of disease into a heap of targetable diagnoses and invest billions fixating providers and their patients on symptoms rather than their causes – “what” rather than “why.”



Color Illustrator: Kelly Ishikawa

When applied to chronic conditions such as diabetes and cardiovascular disease, the most malignant artifacts of the first era paradigm may be the very notions of disease and diagnosis

### ***The Urgency and Challenge to Restore Health and Function***

Despite the mandate of managed care early in the second era to control costs, U.S. health care cost inflation has outpaced the growth of the annual GDP since 1970. Without bending the historical U.S. health care inflation curve, within approximately 30 years, the government's Medicare and Medicaid costs will exceed 100% of its revenues at today's taxation level. Nevertheless, the ever-evolving landscape of the U.S. health care system offers few signs of hope for the dawn of the third era of medicine.

Rather than challenging the tyranny of the diagnosis as exhorted by the father of the Functional Medicine movement, Jeffrey Bland, Ph.D., the system is advancing the paradigm in the opposite direction by migrating from ICD-9 to ICD-10 coding - multiplying the diagnostic spectrum from an already overwhelming 12,000 diseases to well over 150,000 possible diagnoses.

***“Infinitely varied in its effects, nature is simple only in its causes, and its economy consists in producing a great number of phenomena, often very complicated, by means of a small number of general laws.”***

PIERRE LAPLACE (1749-1827)

Rather than accepting the interconnected nature of health disruptions, the system clings blindly to the concept of comorbidities to conform to the specialized and organ-system oriented structure of the medical profession.

Cementing the system's attachment to the idea of discrete conditions physicians will continue to function in the silos of their subspecialties – disconnected and uncompensated for collaborating with colleagues in other specialties on the cases of shared patients.

As modern science continues to deepen in its understanding of how to create health, and in doing so, eradicate disease, it appears that the system's “standards of care” will continue to diverge evermore dramatically from optimal care. And the astonishing 10-20 year lag time between the proof and the implementation of health care innovation in mainstream medicine will continue to grow.

### ***Addressing the Root Cause to Advance the Third Era***

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The system's inability to evolve despite the avalanche of supporting evidence and the magnitude of the health care-driven economic crisis seems inexplicable and entirely inconsistent with the American culture of innovation and entrepreneurship.

The system's paralysis derives from the convergence of two pre-existing conditions.

First is the fact that the economic driver of the health care industry is disease. The only thing less profitable than health is sudden death. The management of chronic disease, on the other hand, equates to recurring revenue and substantial profit for most of the health care industry.

Second is an imperfection in the free marketplace for health care brought about by the third party payer system.

In most any other sector of the U.S. economy, the fundamental conflict between the desires and motivations of suppliers and consumers would be naturally resolved by the free market. In this case however, the U.S. market is unable to adjust to accommodate consumer demand because of the unnatural way in which health care is purchased.

In short, health care consumers desire health. Health care suppliers provide symptom abatement and disease management instead. And gradually, for patients and providers, the distinction between health and non-sickness has blurred.

While the pros and cons of the third party payer system remains a subject of spirited debate, four specific culprits are obstructing the third era of medicine.

First, the payer system is diagnosis-driven and therefore fundamentally reactive. For services to be paid for, those services must generally be justified by a corresponding diagnosis. The creation and stewardship of health, on the other hand, is a fundamentally proactive process.

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This is a very difficult if not impossible problem for Functional Medicine providers to resolve while subject to the apparent constraints of the payer system.

Second, at the primary care level, where the opportunity is greatest to affordably restore and create health, the payer system has imposed a business model on providers that is heavily driven by transaction (visit) volume. To the extent that there is any supposed virtue in this incentive system, it is rooted in the illusion of efficiency.

Motivated by the nation's physician shortage, the aging of the Baby Boomer population, and most recently the provisions of health care reform legislation, the system is pushing providers to squeeze more patient volume through their already overcrowded practices. Faster visits focusing on one problem at a time creates an assembly line for diagnoses, prescriptions, and specialist referrals. For most primary care providers, the speed of the treadmill dictates the financial viability of the practice.

The accelerating pace of care delivery works in direct opposition to the creation of health. While the third era of medicine promises to reverse health care inflation by reducing the burden of disease, the process begins by increasing – not decreasing the amount of time that primary care providers are able to spend with their patients.

The third obstructive culprit is the information vacuum created by the payer system. Consumers (and many providers) have little if any awareness of the actual price of specific health services, and they have no meaningful information about the quality care and its wide variance between providers and facilities. As a result, consumers have been bred by the system to have no sensitivity to price and blindly assume uniform quality across providers. Even worse, the information vacuum has suffocated the population's engagement in its own health care.

The irony is striking. In a society known around the world for its excellence at buying things, the productive, market-perfecting engine of American consumerism is completely missing in its largest industry.

The final culprit is the misuse of insurance to pay for preventive care. Insurance was created to enable people to avoid financial ruin in the face of certain defined and costly risks. The unlikely financial risks associated with house fires, floods, auto accidents and other catastrophes are mitigated by the relatively small investment in insurance.

Nowhere outside of health care is insurance used to pay for prevention. Fire extinguishers, roof maintenance, brake pads, and countless other preventive measure are valued, bought and paid for by, and at the discretion of, the consumer – not the insurance company. Why? Because prevention is not an insurable risk. 100% of drivers need brakes and air in their tires. So they pay for these things themselves. And the magnitude of their investment in prevention reflects their individual sensitivity to the risks they are seeking to mitigate.

Health care is the only sector in the American economy in which insurance is used to pay for prevention. This practice serves to accomplish four things:

1. It creates an unnecessary intermediary (the payer) between the provider and the patient that drives up the cost of prevention to pay for the overhead of the payer itself and the administration of an unnecessarily complex payment process.
2. It limits the scope and availability of preventive services to consumers by empowering the payer to dictate the preventive products and services for which it will and will not pay.
3. It kills the culture of personal responsibility and stewardship of health by obscuring the economics of health and disease at the individual level and by removing the immediate financial consequences of reckless living. For the vast majority of Americans, the payer system attenuates the financial rewards for creating health and the consequences of destroying it. Individual responsibility has been supplanted by a general sense of pre-paid entitlement.
4. It forces the commoditization of health services (including prevention) by creating a uniform

method of classifying and valuing the work of physicians irrespective of their skill level and often, the actual time invested with patients. Health services such as prevention, which vary widely in quality based on the knowledge and skills of the physician, are defined by CPT (current procedural terminology) codes and assigned a value that generally derives from the RVU (relative value unit) value measure used by Medicare.

The universal application of this classification and valuation construct to health care and preventive services devalues, demotivates, and financially handicaps physicians who wish to provide exceptional service. And it conditions consumers to view the stewardship of their health as a commodity service.

While not always apparent to consumers, the motivations of the payer are frequently at odds with the needs and desires of the individual patient. Payers are motivated to optimize their own costs (not their client's health) in providing health care to the population at large. They are led by this incentive to view and govern the marketplace for health care and prevention through the lens of the "average" patient taking into account the dynamics of the marketplace for health insurance.

Because most of the working population is insured by employer sponsored health plans, and these employers routinely shop and change insurance carriers to manage their own costs, carriers are conflicted by the long-term nature of an investment in prevention. There is no certainty at all that the carrier will ever reap the downstream return from an investment in prevention because the insured patient will have likely moved on through their employer to the roster of another insurance carrier before the investment yields a return in the form of cost savings.

Many critics of the health insurance industry question the existence of any incentive to reduce health care costs among for-profit commercial carriers. Their argument is that the primary driver of their profits is actually the return on the massive sums of money being held at any given time by the carriers before it is paid out in the form of health claims.

Magnifying the misalignment of incentives between the payer system and consumers is the fact that irrespective of the actual profit drivers for commercial carriers, the payer system itself lives under a mandate to minimize the cost of care for the insured population as a whole – not at the individual level. Fundamentally, when the cost of a preventive screening multiplied by the likely utilization of that screening exceeds the historical health claims cost associated with treating the disease in question, the screening is not paid for. Worse, the marketplace for that screening (and therefore the screening's availability), no matter how valuable to certain individuals, is destroyed.

As is widely understood in medicine, the "average" patient does not exist, and therefore, the population perspective in defining the marketplace for health care and prevention is flawed. This fundamental conflict and the system's ability to suppress consumer demand is in part responsible for the astonishing lag time in the adoption of new innovations in mainstream medicine.

The roots of the payer system run so deeply into the psyches of American patients and many health care providers that the "standards of care" defined by the system are commonly mistaken for optimal care.

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### ***Restoring the Health of the System (and the Population)***

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Humans want to be healthy. And because healthy people incur fewer health claims, the *real* payers for health care: employers, the government, and consumers, all desire health – not disease management. The power of this desire, coupled with the urgency of the health care economic crisis, creates a robust foundation of market demand for an economical approach to creating health.

Functional Medicine, while not yet widely known as such to the public, is an individualized health care approach that has clearly demonstrated its capacity to create and restore health and improve function. By design, it overcomes the harmful biases of the payer system and corrects the distortions of population medicine.

Its fundamental orientation to identifying and addressing the etiology of dysfunction to restore health while eliminating the symptoms of disease has proven not only effective for patients, but also intuitive to the media and the public.

The leaders of the movement have crafted and refined a curriculum and education delivery channels that are sufficient to develop the supply of providers of Functional Medicine. Meanwhile, physicians across the country are, in growing numbers, confronting the ethical dilemma of dispensing poor care in high volume at a hazardous pace as opposed to delivering good, personalized care to a responsible number of patients.

The stage is set for the third era of medicine, and therefore, the widespread adoption of Functional Medicine.

To transform American health care and the health of the population, the Functional Medicine movement needs only to liberate itself from its phantom oppressor – the restrictions of the payer system as they are perceived by its providers. The movement must teach its physicians how to deliver Functional Medicine while operating compliantly within the payer system.

Fifteen years of courageous work and hard fought battles by America's private physicians have paved the way for the proliferation of Functional Medicine and for its providers to reap the personal and professional rewards of a thriving practice without sacrificing the quality of the care they deliver.

The private medical movement has led to the creation of what are now well-established business models that enable physicians to deliver uncompromising, individualized care to patients without assuming the business risk and stigma of divorcing from the payer system. Using the same “fee for non-covered service” business model as the majority of “concierge” doctors, physicians who wish to practice Functional Medicine can right-size their patient panels and create the time they need to practice properly.

Under this model, patients may enjoy the ability to use their insurance to pay for services covered by

their insurance carriers or Medicare and pay their physician privately for the services not covered by their policies. The most common structure for the patient relationship with this type of practice is an annual membership or retainer.

This model of practice invites physicians to be creative and thoughtful in the design of their service to patients. The membership commitment from patients enables physicians to understand with precise accuracy exactly how many patients they have, and it encourages proactive outreach to those members throughout the year without concern over the patient's willingness to pay for each encounter.

### ***Why Functional Medicine Providers Should Not Divorce the Payer System***

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While physicians have every right to opt out of Medicare and not participate in the payer system, and many choose to exercise that right, for two reasons, it is initially important for Functional Medicine physicians to learn to live and thrive within the payer system.

First, if traditional physicians perceive that in order to practice Functional Medicine they must abandon the payer system, it creates unnecessary barriers to acceptance. A perceived requirement to separate from the payer system in order to practice Functional Medicine magnifies the business risk for any physician. Additionally, it reinforces any perception of a fringe stigma associated with Functional Medicine.

Conversely, if Functional Medicine providers are seen operating compliantly and profitably within the payer system, self-interest and the desire to practice better medicine will converge to accelerate the migration of traditional physicians to Functional Medicine.

Second, because of the misplaced psychological dependence of the American public on the payer system to administer the health care marketplace and validate the care itself, separation from the system creates an unnecessary barrier to the mainstream consumer acceptance of Functional Medicine.

A large segment, if not the great majority, of U.S. health care consumers view medical care provided

outside of the payer system as purely elective or questionable and in either case, unnecessary. Functional Medicine does not fall into either of these categories, and recognizing this consumer perception, its early providers should participate in the payer system if for no other reason than to project legitimacy to the marketplace.

## ***Conclusions***

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The Functional Medicine movement should capitalize on the achievements of private physicians in establishing the liberty of physicians to design their practices to best serve their patients and be compensated for services not covered by insurance. In doing so, the movement should actively engage the private physician community of some 4,400 U.S. doctors to teach them to responsibly provide Functional Medicine to their own patients.

This respected group of physician innovators offers strategic value to the movement in two ways. First, private physicians are the likely early adopters of Functional Medicine – motivated by their intense, market-driven desire to bring unique value and better medicine to their patients.

Second, private physicians tend to attract business leaders and other people of influence as patients. As purveyors of Functional Medicine, private physicians could play a powerful role in fueling the rapid adoption of Functional Medicine by accelerating its exposure to the most influential segment of the population.

## ***Acknowledgements***

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Any wisdom in this writing flows from their lips, books, and PowerPoint slides. My contribution was merely to synthesize their thoughts and present their insights in such a way as to poke the sleeping giant of American health care and spark a collaboration between the siblings that will change the system.

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## ***About the Author***

*Tom Blue is the Executive Director of the American Academy of Private Physicians, the national professional association for private (“conciierge”) physicians. He is also the Co-founder of n1Health, a firm that invests actively in the formation and development of private physician run medical practices that are dedicated to advancing the third era of medicine.*