Author's response to reviews

Title: CAM practitioners in the Australian health workforce: an underutilized resource

Authors:

Sandra Grace (sandra.grace@scu.edu.au)

Version: 2 Date: 29 August 2012

Author's response to reviews: see over
Dear Executive Editor,

Thank you for the opportunity to revise my Debate paper entitled CAM practitioners in the Australian health workforce: An underutilized resource. I have addressed all reviewers’ comments in the revised paper (see highlighted text).

Response to reviewers:

Reviewer 1

- Do patients have to pay extra money for CAM services provided by the CAM practitioners? What is the vision? That CAM provided by CAM practitioners is reimbursed?

I thank the reviewer for suggesting the inclusion of cost-benefit analysis in the paper. The vision is that inclusion of some CAM services could reduce the cost of government subsidised health services. The following paragraphs have been inserted on pages 11 and 12:

Cost-benefit. In Australia most CAM services are provided at the patient’s expense and arguments for government subsidy turns on cost-benefit analysis. In Australia, as elsewhere, there has been some optimism that the use of CAM with its focus on low cost lifestyle management and health maintenance might reduce future medical costs [58]. It is clear that there is a need for rigorous research in this area and that there are methodological difficulties to be overcome [59, 60].
Studies of the costs of specific CAM occupations for specific conditions compared to Western medical treatment have shown inconsistent results [61]. Using cost per quality adjusted life years, additional costs of CAM care have been shown to be wholly or partly offset by reductions in the cost of conventional care [62]. Systematic reviews by White and Ernst [63] and Canter, Coon and Ernst [59] showed that spinal manipulation and acupuncture actually increased the costs to clients when compared to other treatments approved for use by the National Health Service in the UK, although in estimates of cost per quality adjusted life year they compared favourably. In 1998, the Swiss government commissioned an extensive study of CAM treatments including homoeopathy, traditional Chinese medicine, herbal medicine and anthroposophic medicine to determine if they were effective and cost-effective. The results of the study were responsible for the reinstatement of the Swiss government’s health insurance program to support CAM [64,65]. Sarnat and Winterstein [66] in the US found promising clinical and cost saving results when they investigated primary care physicians who integrated non-pharmaceutical/non-surgical approaches with allopathic medicine. Cost-effectiveness of this sort strengthens the case for the inclusion of CAM services in government-subsidised programs.

- **An educational aspects with regard to CAM practitioners, collaboration models etc would be very important in this context.**

I have revised the section on page 8 *Exclusion from national registration* to address inconsistencies in education standards more fully (see Reviewer 3 first dot point below).

In addition, I appreciate the opportunity to discuss interprofessional education in this context and have added the following text at the end of New Models of Delivery on p10-11:

Models of care where medical practitioners are gatekeepers of patient care rely in part on the knowledge and attitudes of the referring medical practitioners to establish health care teams. Educating medical practitioners about CAM has been advocated by the Australian Medical Association [33], as it has by the US Institute of Medicine’s Academy of Science Committee on the Use of CAM [50] and by similar
bodies in other countries, as a vital strategy to enable competent advice about CAM to be given by medical practitioners and to ensure competent referrals. CAM education for medical practitioners has been poorly endorsed in Australian medical education [51].

Collaborative models of health care delivery may be encouraged by interprofessional learning strategies which could foster such competencies in learners as teamwork, leadership, and the ability to identify shared goals in patient care [52-53], especially when it is introduced in the early years of training [54, 55]. Logistical and resource constraints, including the paucity of appropriately skilled educators, have been identified as inhibiting the implementation of interprofessional learning, as have diverse learning styles and levels of motivation in students [56, 57]. In Australia, examples of interprofessional education are isolated. It appears that it currently exists only on the margins of health professional curricula and practice.

- In large part the debate remains on a surface level. For the reader it would be interesting to develop scenarios raising new questions.

My intention was to discuss the most immediately achievable strategies in this paper. However, I have added further points to the section Strategies for making better use of the CAM workforce on page 15 to provoke consideration of other innovative strategies.

Other collaborations: Other innovative strategies include developing a role for CAM practitioners in Australia’s Medicare Local health reform initiative. Medicare Local is a nation-wide network of primary health care organisations established to coordinate primary health care delivery directed to local care needs and service gaps. They will drive improvements in primary health care and ensure that services are better tailored to meet the needs of local communities. One of their key roles involves supporting local primary care providers, such as general medical practitioners, practice nurses and allied health providers, to adopt and meet quality standards.
Collaborations could also be developed in Australia’s General Practitioner Super Clinic program, which is establishing multidisciplinary primary care health services and education and training placements in multidisciplinary care settings and also targets the health needs and priorities of their local community.

- Furthermore a broader view across the Australian borders would be important in such a debate article. The integration of CAM is a relevant question in many European countries as well as in the US and Canada. So it might be helpful to see which strategies are developed by other countries and to transfer these strategies to Australia.

I have added the following text in the section Strategies for making better use of the CAM workforce on page 15 which now refers to one of the international examples suggested by the reviewer.

- Further CAM education programs for medical practitioners. Australian universities have been slow to embrace CAM education programs for medical practitioners, unlike their counterparts in the UK, Europe, US and Cuba. In the Cuban model medical practitioners are trained to practise CAM themselves [70]. It is likely that the reach of most Australian programs will be to educate medical practitioners to be informed advisers, not to practise CAM.

I have also inserted the following text in the section Promoting CAM research on pages 14 and 15 which includes reference to the other international example suggested by the reviewer.

- Fostering collaborations with international groups like CAMbrella, a network of European research institutes in CAM, could contribute to our understanding of the current status of CAM in Australia and promote future research activities [69].

Reviewer 2

- The article strongly advocates for great inclusion of CM practitioners but doesn’t really discuss the potential negative outcomes of this. This is alluded to in the section recommending greater education for CM practitioners, lack of regulation or standardised education. But there may be other negatives for patients, the professions etc.
I have included a new section on pages 12 and 13 which canvasses some of the potentially negative consequences of greater utilisation of the CAM workforce:

*Potential disadvantages of greater utilisation of the existing and future CAM workforce include:*

- **Delayed diagnosis.** Greater utilisation of CAM practitioners by government agencies and medical and other health practitioners could promote CAM practitioners’ primary contact role in health care. Concerns have been raised about the competence of some CAM practitioners to adequately fulfil this role [67]. For patients, this could mean an incorrect or delayed diagnosis, less than optimal health outcomes, and a waste of money and time,

- **The most likely model of care** which integrates medical and CAM practitioners to be taken up places the general medical practitioner as the gatekeeper for patient care. For CAM practitioners this represents a loss of autonomy and potentially a compromise of their treatment approach [67].

- **Greater utilisation potentially means more multidisciplinary teams and communication between healthcare providers.** What problems do you see with this and how might they be overcome? e.g. different philosophies, technical terms, education, funding models.

I have inserted the following paragraphs on pages 10 and 11 in the section *New Models of Delivery* to expand the discussion on potential difficulties associated with multidisciplinary teams and interprofessional communication.

Models of care where medical practitioners are gatekeepers of patient care rely in part on the knowledge and attitudes of the referring medical practitioners to establish health care teams. Educating medical practitioners about CAM has been advocated by the Australian Medical Association [33], as it has by the US Institute of Medicine’s Academy of Science Committee on the Use of CAM [50] and by similar bodies in other countries, as a vital strategy to enable competent advice about CAM to be given by medical practitioners and to ensure competent referrals. CAM education
for medical practitioners has been poorly endorsed in Australian medical education [51].

Collaborative models of health care delivery may be encouraged by interprofessional learning strategies which could foster such competencies in learners as teamwork, leadership, and the ability to identify shared goals in patient care [52-53], especially when it is introduced in the early years of training [54, 55]. Logistical and resource constraints, including the paucity of appropriately skilled educators, have been identified as inhibiting the implementation of interprofessional learning, as have diverse learning styles and levels of motivation in students [56, 57]. In Australia, examples of interprofessional education are isolated. It appears that it currently exists only on the margins of health professional curricula and practice.

- The article would benefit from addressing some of the perceived and actual barriers to greater utilisation and integration of CM practitioners. e.g. the Friends of Science in Medicine debate in Australia and similar campaigns in the UK and US - what drives them? They sway professional opinion but why do they occur?

In the first paragraph of the Discussion on page 5 I have made reference to entrenched rivalries between mainstream medicine and CAM:

There are long histories of territorial rivalries, power struggles, and, within current evidence-based medicine, disagreements over what constitutes legitimate evidence [20].

This sentence is followed on page 6 with more explicit reference to some of the perceived and actual barriers to greater utilisation and integration of CM practitioners:

Failure to recognise the potential contribution of CAM to primary health care, and in some cases overt hostility to it, still exist within the medical profession [21,22]. A recent example is the Friends of Science in Medicine whose mission is to remove CAM courses from universities on the grounds that the pseudoscience they teach is not worthy of inclusion in higher education curricula [23].
Nurse practitioners have been used by GPs to fill some of the gaps proposed by the author as suitable for CM practitioners - some discussion about this, the limitations of nurse practitioners and strengths of CM practitioners for some specific areas would be useful. Maybe exploring how the nurse-practitioner-GP relationship works or doesn't work will help formulate a strategy forward.

I agree with the author that reference to nurse practitioners is a useful model for consideration and have included a paragraph on page 14 in the section Redesigning roles of CAM practitioners. A fuller discussion of the relationships between nurse practitioners and GPs and comparisons with CAM practitioners and GPS is beyond the scope of this paper.

The CAM practitioner role could be legislated in a similar fashion to that of nurse practitioners who conduct autonomous and collaborative nursing practice in an advanced and extended clinical role. Nurse practitioners’ tasks include prescribing medication, ordering diagnostic investigations, and referral to other health care practitioners. CAM practitioners already provide a valuable service in both community and private settings, Their particular strengths would be their focus on lifestyle medicine, health promotion, chronic disease management, and referral to other health practitioners. Ordering diagnostic investigations could transform the practices of many CAM practitioners who currently depend on medical practitioners who may not support the rationale for their requests. However, it is likely that there would be legislative barriers and pockets of strong opposition from other health professions to overcome, as there have been for nurse practitioners [68].

Reviewer 3

- In my opinion, the issue of lack of nationally agreed curricula and standards for the non-registered CAM practitioners is a major hurdle and any consideration of better utilisation of these groups is really not possible until this is addressed. Sufficient weight has not been given to this issue.

I would argue that there is a nationally agreed curricula for some CAM (see Health Training Package HLT07 which was developed and modified over the past 10 years with extensive consultation of CAM educators in the private and VET sectors). Nationally accredited curricula include naturopathy, herbal medicine, nutrition, homoeopathy, massage practice and remedial massage. The issue is, as the reviewer suggests, that not all CAM practitioners
have nationally agreed curricula and those that have been developed are inconsistently delivered which undermines any attempt to ensure quality of health care. Most of the nationally agreed curricula are for courses with an AQF level 5 or below (i.e. Advanced Diploma, Diploma and Certificate IV level).

I have revised the section on page 8 *Exclusion from national registration* to address the inconsistent education standards more fully. The revised text on page 8 also includes reference to attempts within naturopathic groups to address these issues as a prelude to obtaining registration:

Little has changed since the Australian government’s Expert Committee on Complementary Medicines in the Health System [9] reported that “educational standards amongst Australian trained complementary medicine practitioners are extremely variable, and neither the public nor other healthcare practitioners have a reliable way of assessing who is sufficiently or appropriately qualified for safe, competent practice” (p. 24). Inconsistent educational standards for non-registered CAM practitioners is a major barrier to better utilisation of these groups. The development of a national curriculum by the Australian National Training Authority in the Health Training Package HLT07 represents a genuine attempt by the Australian government to develop uniform curricula for some CAM occupations [40]. However, lack of resources to monitor compliance with training requirements has undermined the process. Other interest groups have emerged including the Australian Register of Naturopaths and Herbalists which aims to establish minimum standards of education in accordance with government requirements for the regulation of health practitioners [41].

- **The paper may benefit by considering registered and non-registered practitioners separately.**

I have separated discussion of registered and non-registered practitioners in both i) Number of CAM practitioners on page 1, and ii) Work practices of CAM practitioners on page 4. In these sections the first paragraph discusses registered practitioners; the second paragraph discusses non-registered practitioners. The first paragraph of ii) Work practices of CAM practitioners is a new addition:
The limited data available from the Chiropractic and Osteopathic Registration Boards suggests strong similarities between the professions: 61.5% of registered chiropractors and 67.6% of registered osteopaths are between 26 and 45 years of age; 35.6% of registered chiropractors and 31.3% of registered osteopaths are female; and the majority of practitioners practise in NSW and Victoria (60.2% of chiropractors and 80.2% of osteopaths) [14,15].

Yours sincerely,

Dr Sandra Grace
Senior Lecturer
School of Health & Human Sciences
Room 22.12
Southern Cross University
PO Box 157
Lismore NSW 2480
Telephone: 61-2-6626 9258
Fax: 61-2-6620 3307
Email: sandra.grace@scu.edu.au

Adjunct Research Associate
The Education for Practice Institute
Charles Sturt University