

The Whole Picture

Integrated Management of Chronic Conditions in New Zealand

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Biomedicine

1. Focus on disease and treatment, where treatment is related to specific problems
2. Research based
3. Public and private funding
4. Strong and influential professional organisations
5. International, historical and organisational traditions
6. Increasingly multi-practitioner business
7. Role in secondary/tertiary care hospitals.

Complementary and Alternative Medicine

1. Focus on holistic situation of client, where the care can be as important as the final outcome
2. Application based
3. Private funding
4. Tend to act as individual practitioners, separate modalities
5. Indigenous, tradition of innovation
6. Small businesses, often only one-person practitioner business.

The Issue

Why is it that we are considering bringing these two traditions together NOW?

...and How?

There is a burgeoning interest in CAM in New Zealand and worldwide. According to the 2002/03 New Zealand Health Survey, nearly one in four adults (23.4%) had seen a CAM practitioner in the previous 12 month period.

The most popular being:

- massage therapist (9.1%)
- chiropractor (6.1%)
- osteopath (4.9%)
- homeopath/naturopath (4.5%).

(MACCAH, 2004: 67-68)

The majority of these people visited a CAM practitioner for three reasons:

- disability/long-term illness/chronic condition (32.5%)
- short-term illness or temporary condition (28.3%)
- injury or poisoning (23.9%).

(MACCAH, 2004:68)

There were two main reasons given for choosing a CAM practitioner for assistance:

- to provide help with conditions that other health care providers were unable to treat (50.7%)
- and referred by friend/relative (29.2%)

Lesser reasons were:

- offered specialist services (12.5%)
- referred by doctor (12.0%).

(MACCAH, 2004:69)

We are on the brink of a paradigm shift: a change in the way that New Zealanders, see health:

1. To be kept well, rather than to be made better when we are sick.
2. To be kept at “peak performance”, regardless of age, gender, ethnicity, social class, location. None of these factors should be an excuse for poor health.
3. To have access to all means of keeping well, and of getting better.
4. To do this, appropriate information should be available on all preventative and curative health practices, along with public funding for appropriate practices (those that are safe, efficacious and cost-effective).
5. Furthermore, all health professionals should be familiar with each other’s expertise so that the public can be given appropriate referrals and monitoring.

Terms of Reference

- Provide information and advice to the Minister on complementary and alternative health care
- Provide advice on the need, or otherwise, to regulate complementary and alternative health care practitioners in order to protect consumers who use complementary and alternative health care
- Provide advice on consumer information needs and, in particular, advice on the benefits, risks and costs of complementary and alternative therapies
- Review overseas evidence-based research, identify priorities for the development of New Zealand evidence-based research on the safety and efficacy of specific complementary and alternative therapies and support the development of guidelines
- Provide advice on whether, and how, specified complementary and alternative health practitioners should be integrated into the mainstream system
- Provide advice on how complementary and alternative health care can improve outcomes in the priority areas signalled in the New Zealand Health Strategy.

Members of MACCAH

Prof. Peggy Koopman-Boyden (Chair)

David Holden

Rhys Jones

Melva Martin

James McNeill

Janine Randle

Maika Kinahoi-Veikune

Marilyn Wright

Tim Ewer (Committee Advisor)

Natasha McMillan (Secretariat)

During MACCAH's three years it published:

- 2002. *Terminology in Complementary and Alternative Health.*
- 2003. *Complementary and Alternative Medicine: Current Policies and Policy Issues in New Zealand and Selected Countries.* A Discussion Document 2003.
- 2003. *Complementary and Alternative Medicine: Current Policies and Policy Issues in New Zealand and Selected Countries.* Submission Booklet.
- 2004. *Advice to the Minister of Health.*

All of MACCAH's publications are on its website:
www.newhealth.govt.nz/maccach

Complementary and Alternative Health Care in New Zealand

Advice to the Minister of Health from the Ministerial
Advisory Committee on Complementary and Alternative
Health

June 2004

www.newhealth.govt.nz/maccah

Guiding Principles of MACCAH

- A holistic concept of health combining the WHO definition of health and 'Whare tapa wha', the four-sided house concept of health developed by Professor Mason Durie:

Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity (WHO, 1948).

"Whare tapa wha" incorporates "taha wairua," a spiritual focus; "taha hinengaro," mental focus; "taha tinana," physical focus; and "taha whanau," extended family (Mason Durie, 1998).

- Recognition that health care may involve the maintenance of health and well being, the prevention of treatment of illness, disease or injury and/or relief from the effect of illness, disease injury or treatment
- Patient satisfaction is an important health outcome (together with any reduction in symptoms)
- Participation and shared responsibility by both patients and practitioners
- Balancing health consumers' needs for health care options with those of safety and efficacy
- Maximisation of public health gains within the constraints of limited health resources
- Reduction of disparities both in access to effective health care and in health outcomes
- Acknowledgement of the special relationship between Māori and the Crown under the Treaty of Waitangi
- Recognition of the growing ethnic diversity within New Zealand and implications for the demand and provision of health care.
- Consistency with the goals of the New Zealand Health Strategy.

(MACCAH, 2004: 4)

What do we mean by integration?

The World Health Organization defines integrated care as:

A concept bringing together inputs, delivery, management and organisation of services related to diagnosis, treatment, care rehabilitation and health promotion. Integration is a means to improve the service in relation to access, quality, user satisfaction and efficiency.

(Grone and Garcia-Barbaero, 2001)

What do we mean by integration?

To bring together:

- Different understandings about health, illness and the purpose of treatment
- Different perspectives on whether it is possible to combine the two into a single 'whole' system of health care, and indeed whether it is desirable
- Whether it is possible for CAM and biomedicine practitioners to participate equally given biomedical practitioner dominance in the current health care setting.

(MACCAH, 2004: 43-44)

MACCAH's Recommendations re Integration

10. Where there is evidence of safety, efficacy and cost effectiveness, specified CAM modalities should be considered for public funding.
11. Health care education and training bodies should be encouraged to include elements of CAM and biomedicine in each other's curriculum. A national curriculum committee should be established to develop policy on this.
12. Research should be undertaken to establish best practice for the integration of the approved CAM modalities with biomedicine.
13. District Health Boards should be provided with guidance on the appropriateness of integration initiatives.
14. The Ministry of Health should encourage the District Health Boards to establish pilot studies to identify the practicalities, costs, benefits and health outcomes that would accompany CAM and biomedical practitioners working together.

The Benefits of Integration

- Transparent referral systems, sharing of information, better communication and better understanding between biomedical and CAM practitioners working with the same patient
- More equitable access to proven CAM therapies across population groups and geographical locations
- The holistic health models of CAM can complement biomedicine in areas such as chronic conditions or where radical changes in lifestyles need to be maintained and supported by a therapist.

The Drawbacks of Integration

- The risk that there will be a focus on providing a limited number of therapies that are accepted in an integrated system
- Integration of specified practitioners may lead either to an oversupply of primary health practitioners, or to discontinuation of a practice, thereby reducing consumer options
- The burden of continuing education required for both CAM therapies and biomedical therapies could become excessive.

(MACCAH, 2004: 45)

Factors that might Facilitate Integration

- Consumer demand for CAM practitioners
- Where CAM and biomedical practitioners are already referring patients to each other
- Where biomedical professional groups are already developing policies on CAM
- CAM professional groups are providing policies on referral
- Medical schools are providing information on CAM
- Moves within CAM education to provide a basic level of biomedical understanding (e.g. in anatomy, physiology, first aid, emergency procedures)
- Stronger forms of regulation are being developed, along with the promotion of practitioners who belong to these groups
- The Ministry of Health's CAM database provides more evidence-based information on specific CAM modalities.

(MACCAH, 2004:47)

Factors that might Obstruct Integration

- Professional resistance to CAM integration by CAM or biomedical practitioners unwilling to refer patients to other forms of treatment
- The practicalities of the additional demands involved with continuing education about other forms of health care in order to make appropriate referrals.

(MACCAH, 2004:48)

Chairing MACCAH and Integration

1. Different paradigm
2. Different language
3. Terminology
4. Different research culture
5. Huge range of health systems, modalities and practices in CAM
6. Huge range in function and status of CAM professional organisations
7. Huge diversity in training/education of CAM practitioners
8. CAM largely small business/private practice with little research capacity
9. CAM little involvement in NZ policy regulation or wider policy context.

Where to Next?

Recommendation 18:

The Minister of Health should develop a framework (or unit) to coordinate the existing expertise and build a CAM capacity to better evaluate the safety and efficacy of CAM in the interests of further integration of biomedicine and CAM.

(MACCAH, 2004:63)

To integrate the systems we must be sure that:

- We have controlled the level of risk through various levels of regulations (Recommendation 1)
- Practitioners (both biomedical and CAM) who practice one of more CAM modalities have training appropriate to the risk of each CAM modality (Recommendation 4)
- Consumers have ongoing access to evidence-based information on the efficacy and safety of CAM therapies (Recommendation 5)
- Recognition should be given to the relevance and importance of research at different levels of evidence for the efficacy and safety of CAM (Recommendation 9).

The hardest part will be to suspend judgement of our own personal views and interests.

The focus must be: What is in the best interests of the consumer patient and the country's health care system?

Finally, we must at all costs, protect the ability to initiate new ideas with respect to better health.

The integration of CAM and biomedicine could be a groundbreaking development in New Zealand.