

Journal of Complementary and Integrative Medicine

Volume 4, Issue 1

2007

Article 5

How Do Private CAM Therapies Affect Integrative Health Care Settings in a Publicly Funded Health Care System?

Daniel Hollenberg*

*Centre for International Health, University of Toronto; Department of Sociology & Health,
Aging and Society, McMaster University, hollend@mcmaster.ca

Copyright ©2007 The Berkeley Electronic Press. All rights reserved.

How Do Private CAM Therapies Affect Integrative Health Care Settings in a Publicly Funded Health Care System?

Daniel Hollenberg

Abstract

“Integrative health care” (IHC), combining various aspects of Western biomedicine and complementary/alternative medicine (CAM), is a relatively new development in health care systems. IHC is recognized internationally, yet the occurrence of private CAM therapies and their various effects on IHC settings has not extensively been analyzed. This paper presents findings from a larger study of three IHC settings in Canada conducted between 2002 and 2003. The main research question addressed here is: How have private CAM therapies affected IHC settings combining CAM and biomedicine in a publicly funded health care system? Drawing on ethnography, 38 in-depth interviews are drawn upon, including those with 15 biomedical and eight CAM practitioners, 13 patients and two health care managers. Ethnographic observation and document analysis was conducted at each site. Findings illustrated that patients could not consistently afford unfunded CAM treatments, resulting in the premature termination of an integrative care plan. CAM practitioners from the private sector could not uniformly attend group rounds, resulting in disrupted care co-ordination. Certain biomedical institutions viewed CAM as a commodity from which to generate revenue and lower budgetary deficits. This study argues that the unfunded nature of CAM therapies in public health systems, although CAM has therapeutic value, does not contribute to an equitable partnership when attempting to integrate biomedicine and CAM. Future analyses of IHC need to take into account the complexities of health system context that continues to shape IHC.

KEYWORDS: CAM, integrative medicine, complementary/alternative, private/public health care

INTRODUCTION AND BACKGROUND

The term “integrative health care” (IHC) is now used widely in many different areas of health care, including within biomedical health sciences and the health policy and international health fields, and most recently, within the broad field of complementary/alternative medicine (CAM). In both biomedical and CAM communities, attention appears to have partially shifted away from separating therapeutic modalities into categories such as “biomedical” or “alternative”, to focus on merging diverse modalities into a “new” integrative health system. This integration of diverse health care modalities combining various combinations of biomedicine, complementary/alternative medicine and traditional medicine has been recognized internationally, as indicated by medical conferences around the world focussing on the topic of integration. Certain health policy documents, such as those released by Health Canada (Advisory Group on Complementary and Alternative Health Care, 2001) and the World Health Organization (2002) also focus on outlining specific strategies to establish integrative health care settings and systems. There are many variations of IHC (e.g., “collaborative practice”; “interprofessional care”; “*integrated*” and “*integrative*” medicine) and not all forms necessarily combine biomedicine and CAM (e.g., see Hornby and Atkins, 2000; Way et al., 2000; Rees and Weil, 2000; Bell et al., 2002; Caspi, 2001; Maizes and Caspi, 1999). Where CAM is concerned, the most basic concept refers to biomedical and CAM practitioners of different backgrounds and training working collaboratively together for the benefit of the patient, and an expanded concept of “wellness” (Schroeder and Likkell, 1999; Boon et al., 2004).

This paper addresses one aspect of the health system context and one form of IHC, namely, how payment for CAM health services, and particularly their private nature and lack of funding in publicly funded health systems, is affecting IHC settings combining biomedicine and CAM. It is perhaps obvious that the majority of CAM is paid for privately by patients in nearly all Western health care systems where CAM is offered. To date, the ramifications of this process for patients, practitioners and care models, however, have not extensively been addressed. The everyday effect of private CAM modalities in public health settings has been overlooked in the sociological analysis of CAM.

The private nature and significant billion-dollar revenue generated by CAM (e.g., 42.5 billion USD in 1998) has been commonly noted in nearly every demographic CAM survey. At first glance, private income from CAM could only be seen as beneficial for IHC endeavors, particularly in private health care systems. In publicly funded health care systems, private CAM revenue could also be seen as aiding a public system overburdened by its social health expenses. Yet, the effects of private CAM revenue are complex, with multiple effects depending on each health care system. Directing specific attention to this issue,

particularly in light of increasing numbers of new health care settings combining CAM and biomedicine with a clear market interest in mind, can provide significant policy-related information on IHC.

Different types of integrative clinical environments or “settings” (e.g., clinics; hospitals) have emerged recently in most industrialized countries, and with various types and numbers of modalities, practitioners, treatment styles, and patterns of professional interaction. At least five years ago, in the United States there were an estimated 100 settings combining aspects of biomedicine and CAM in various forms (Mark Hoch, personal communication, May 16, 2002). This number can only now be seen to have substantially increased. Yet, to date, the nature of the health care systems in which forms of IHC are occurring has not extensively been analyzed. The health system context is crucially important in shaping, enabling and/or disabling forms of IHC that will occur. For example, national health policy, the history and current status of health professions, political patterns of the state and health economics all influence how IHC is developing today.

Although there are an increasing number of descriptive reports (e.g., Faass, 2001), there are few analytical studies examining the nature of IHC settings where CAM is concerned, and particularly, the effects of private therapies in these new settings. Related studies of solo CAM practitioners working in departments in publicly funded hospitals in Israel, such as those conducted by Shuval and colleagues, examined collaborative patterns of interaction between biomedical and CAM practitioners (Shuval et al., 2002; Mizrachi and Shuval, 2005; Mizrachi et al., 2005). The studies found a wide variety of CAM practitioners (e.g., in the fields of Chinese medicine; homeopathy; chiropractic; herbal medicine) in various hospital departments. Yet, only a small minority were employed full time in a formal hospital position, or with a regular salary; and CAM practitioners were generally not included in departmental clinical conferences or hospital rounds. In Israel, CAM practitioners included in publicly funded biomedical hospitals made uniformly less than biomedical practitioners. Similar analysis must be undertaken in actual IHC settings with multiple numbers of biomedical and CAM practitioners, to examine the effects of private CAM therapies in IHC settings. Such is the focus of this study.

CAM, PRIVATIZATION AND THE CANADIAN HEALTH CARE SYSTEM

Canada’s health care system is based on the principles of universal access to care, according to which patients have “free” access to biomedical health care providers and services such as family physicians, specialists and hospital care. Canada, however, has had a particular type of welfare state, a “liberal welfare state”, from which its health care system is derived. In such a system, although

clearly providing for important health care services moreso than in certain other countries, only modest universal health care transfers and public insurance plans have been developed. This is in comparison with other countries such as Sweden and Austria with social democratic states and more comprehensive biomedical health care plans (Esping-Anderson, 1989). In short, although Canada is classified as having a national health service or “Beveridge-type” health care system (Angus, 1998) with universal coverage for residents and financed by national general taxes, Canadians only have “universal” access to certain health services. Nearly two-thirds of Canadians are thus left paying out of pocket, and must purchase additional private health care insurance for additional biomedical health care services or products (Canada Life and Health Insurance Association, 2001 and 2006). These include, among others, the majority of pharmaceutical drugs (unless admitted to hospital), and fees for paramedical professions (e.g., dentists; physical therapists).

Further, up to 73 per cent of Canadians are also using many other health care practices such as non-biomedical or CAM therapies that fall outside of Western biomedicine and universal health care coverage (Ramsay et al., 1999). A minority of CAM therapies are covered by additional private insurance plans, or partially subsidized by government (e.g., chiropractic), although even these are becoming fast de-listed for the private sector (Boon and Verhoef, 2001). Thus, the majority of CAM services are paid for without reimbursement by the patient, as CAM in Canada has traditionally existed only in the private or “unfunded” health care sector. While certain CAM professions are regulated by some provincial governments (e.g., acupuncture in British Columbia, Ontario and Québec; midwifery in Ontario), other equally-important CAM professions such as naturopathy are not, and with the exception of chiropractic and midwifery, neither regulated nor unregulated CAM professions receive any public government funding to provide patient services.

Overall, the ongoing de-listing of paramedical professions such as physiotherapy, and the recent cancellation of partial provincial coverage for chiropractic in Ontario, suggests that CAM in Canada will continue to exist solely in the private sector. Although never a part of nationally funded health care, CAM practices involved in IHC initiatives in Canada will likely remain as a private service paid for by the patient/client. To-date, only biomedical services practiced in IHC settings are funded by public health care insurance in Canada, such as consultations with physicians and diagnostic tests. The increasing trend to privatize *both* CAM and biomedical services, however, may now be on the rise. These trends to further rationalize, bureaucratize, and privatize can be attributed to global forces driving the Canadian health care system. Analysts are suggesting that the world has now shifted from a state of “monopoly” to “global” capitalism, characterized by a “rolling-back effect” of all welfare states’ provision for

publicly-funded social and health services. The state is “loosening” its resistance to “big business” interests in privatizing and rationalizing health care and other social services, including those such as CAM that already contribute significant private revenue (Teepel, 2000).

METHODS

The findings presented here on the effects of unfunded CAM therapies on IHC settings are part of a larger ethnography of three IHC sites in Canada conducted between 2002 and 2003 (see Hollenberg, 2006). The occurrence of private CAM therapies was having an immediate and widespread effect on Canadian IHC settings and thus, analysis focussed first on these effects. The main research questions related to private therapies were: How does payment for private health services affect patients in IHC settings? How does the unfunded nature of CAM health services affect CAM practitioners and IHC care models? In this study, the private fiscal nature of CAM had significant effects in three related areas: patients’ use of therapies; practitioners’ experiences (biomedical and CAM); and policy in biomedical institutions (hospitals).

As IHC settings consist of complex patterns of social interaction amongst “social actors”, an ethnographic design was considered as most appropriate for the study. Similar to case studies, ethnographies can be viewed as a strategy for doing research that involves an investigation of a particular phenomenon within its real life context, using multiple sources of information (Robson, 1993: 146). Ethnographies are particularly suited for the exploration and analysis of complex context-dependent social processes, such as IHC. Data was collected using in-depth semi-structured interviews with patients, practitioners, and administrators of the sites; ethnographic observation; and document analysis.

Three different research sites were chosen for the study: an independent and free-standing IHC centre; a tertiary IHC clinic in a hospital; and a proposed IHC initiative in an ambulatory care centre. Ethics approval was obtained before commencing research. In the larger case study noted above, a total of 50 in-depth interviews were conducted, which included those interviews with biomedical and CAM practitioners, patients, health care managers and stakeholders. Selected excerpts are presented here solely from biomedical and CAM practitioners (15 biomedical; 8 CAM) and patients (13), in addition to two health care managers (total interviews=38). Hand-written notes were taken during the interview, and the full text of all interviews was transcribed into a computer file. Ethnographic observations were also recorded by hand at each research site throughout the duration of the research: these observations pertained mainly to the physical layout of the setting, and group activities such as meetings or rounds. Documents such as promotional material and minutes of meetings were collected and

analyzed. Data was compared from three different sources (interviews, observations, and documents) to maximize comprehensiveness and diversity, and to cross-validate information (Robson, 1993: 383).

RESEARCH SITES

Site 1 is a free-standing IHC centre in a large urban Canadian city. The centre's main mission is to provide an integrated, complementary cancer care programme for people with cancer and their families by encouraging a holistic healing approach to cancer care. The centre consists of five general physicians and eight complementary/alternative practitioners. The CAM practitioners include a massage therapist, a doctor of traditional Chinese medicine (TCM), a registered nutritional consultant, a naturopathic doctor, two homeopathic practitioners, a holistic counsellor, and an integrative body work counsellor.

Site 2 is a tertiary multi-disciplinary pain management centre established as part of a large hospital, located in a separate, large, urban Canadian city. The centre's mission is to provide a wide range of effective care for complex pain conditions. The centre has biomedical, paramedical and CAM practitioners, both located within the centre and in other hospital departments that include: 13 biomedical practitioners (including three neurologists, four anaesthetists, four psychiatrists and one intern); eight paramedical practitioners (including one registered nurse, five dentists and two physiotherapists); and three CAM practitioners (three TCM practitioners). The centre offers a wide range of therapeutic options, such as: various pharmacologically-active agents for preventing pain, including a range of analgesics, narcotic-based drugs (e.g., morphine) and injections (e.g., Botox, used as an analgesic); physiotherapy, including mobilization and manipulation of soft tissues; biofeedback; hypnosis; and psychiatric and lifestyle counselling. Acupuncture is also provided in a related clinic area, as part of the centre.

Site 3 is a proposed traditional Chinese medicine clinic to be integrated into an ambulatory care centre, also located in a large urban Canadian city. Although at the time of research Site 3 did not yet have any practitioners or patients, the initiative plans to have five TCM practitioners, several general physicians, and several other types of CAM practitioners. Treatment was anticipated to focus on women's health issues. As such, the range of therapies would primarily be TCM-based (acupuncture; massage; herbs), with a combination of selected biomedical and other CAM therapies. Interviews for Site 3 were conducted mainly with health care managers, stakeholders and advisors.

RESULTS

PATIENT EXPERIENCES WITH PRIVATE CAM THERAPIES IN IHC SETTINGS

At all three IHC sites, patients were required or were anticipated to pay out-of-pocket for CAM modalities. For example, at Site 1, patients were required to pay for all complementary medicines such as herbs and supplements, physical treatments, and for consultations with CAM practitioners. Certain CAM treatments, such as supplements, were subsidized by the Centre's global health budget, which resulted in a lower cost to patients than other CAM therapies. There was no subsidization, however, for any treatment or consultation provided by CAM practitioners, which also included other types of physical medicines such as TCM herbs. A separate "in-house" (and unpublished) survey of 100 randomly selected patients at Site 1 found that one-third could not afford seeing a private CAM practitioner due to financial constraints. In contrast, the biomedical services at Site 1 were covered by public health insurance, such as consultations with physicians. Although the majority of new pharmaceutical drugs were also paid for by the patient without reimbursement, different from CAM, a minority of drugs were subsidized by patients' health care plans.

At Site 2, patients were also required to pay for all CAM therapies. Eight out of 10 patients interviewed at Site 2 indicated difficulty in affording private CAM treatments. They struggled most to pay for pain-relieving analgesic injections such as Botox (a new "alternative" drug used as an analgesic as opposed to a cosmetic technique) and private acupuncture treatments. For example, one 50-year-old female patient at Site 2 suffering from chronic lower pelvic and lower back pain since 1993, described her experience of being a single mother trying to cope with the costs of the private treatments she was receiving. Having spent approximately \$5,000 on non-reimbursed treatments (which included those at Site 2), she conveyed her distress at trying to afford private health care costs and other financial commitments such as her son's university tuition fees. She was also frustrated by her time-consuming struggle with private health care insurance companies when attempting to cover her out-of-pocket costs. When asked if she was suffering a financial burden she replied:

Yes, I am, definitely. My son's in college so--it's \$13,000 for him this past year. Now I find that my Botox isn't covered. Now Dr. G. just told me today I could try my insurance company because they might pay for it because, you know, it's something I need. But I was disappointed with my insurance company, actually, because Dr. G. wrote a letter and they just came back with a 'no.'

When asked how she was surviving financially, this patient responded:

Well...I'm trying to do the best I can. I'm okay for now because I haven't really been off work for a long time. But then it's going to start changing and I don't know how that's going to work. And that bothers me in a lot of ways, you know. And finding out that I'm not covered in Botox, that even made it a little worse.

When asked if she anticipated having to terminate any of the private CAM treatments, she replied:

I may have to, yes. It just depends. You know, what am I going to do if I need more? Like I've got two vials, and [the doctor] wants me to have three more. And now where am I going to get it paid for, you know?

A second woman of similar age suffering from chronic neck and shoulder pain since 1996 described her problems paying for private CAM treatments. Although at the time of research this patient was employed, when asked what her main reasons were for stopping acupuncture, she replied, "I spent about \$300 a month that isn't covered by my benefits, so that's why I don't go to acupuncture any more." When asked if she thought acupuncture should be covered under hospital insurance, she emphatically stated:

I do not think you [should] have to pay. I think you should not pay for it. I think that it's a medically proven effective way of curing chronic pain and alleviating chronic pain, and there are a significant number in the population that would subscribe to that, would believe in that; not just people from China, but other people too. And it's safe, and I think that it should be covered.

A third female patient at Site 2 suffering from a chronic pain condition due to fibromyalgia following two consecutive car accidents reflects the experiences of the two patients cited above. When asked how she was able to afford the private CAM treatments she was receiving, she replied:

Well, I wasn't able to actually afford to pay for Botox, that's why I had so much pain for so long, until Dr. G. was

nice enough to call me and said that there was a demonstration that he had for other doctors. And when he does that to teach them how to do the injections, the company provides the Botox for free. So he used me as, you know, the person to do that. So that helped me.

This patient was only able to receive the alternative drug treatment by participating in a company-sponsored demonstration. This patient also described a lengthy struggle with her work-based insurance company to pay for the private treatments she was receiving:

For a long time, actually, I paid from my pocket because they didn't cover it. Now I got to the point I can't any more because I haven't been able to work for two years now...My insurance company, just for no reason, stopped all my treatments regardless from physio to acupuncture to any other things that I've done.

Fortunately for this patient, she had just won a legal battle with her insurance company to cover all prescribed private treatments, as her insurance company had finally validated her illness as "real." At Site 3, it was also anticipated that patients would pay for all TCM treatments including acupuncture, herbs and massage.

The primary consequence of patients having to pay for unfunded CAM practices and modalities in IHC settings (whether "holistic" or "alternative drug") was that many patients could not afford CAM treatments, and ultimately stopped receiving them or seeking them out. This resulted in a disrupted IHC plan that involved the premature termination of an integrative form of care. Of the 13 patients interviewed for this study, 10 indicated unemployment and low financial income as the main reasons for terminating their CAM treatments (such as described by the two patients, above). As Clarke argues, unemployment and low income are two key aspects affecting health and contributing to socioeconomic status, in addition to gender, race/ethnicity, and education (Clarke, 2000).

EXPERIENCES OF CAM PRACTITIONERS WITH PRIVATE AND PUBLIC HEALTH CARE: FORMALIZED AND "HALLWAY" ROUNDS

The fact that CAM practitioners operated in the private health care sector in Canada also had a significant impact on the organization of clinical care in IHC settings. As CAM practitioners were essentially private entrepreneurs in a public system, they had various commitments that prevented them from attending group

rounds with biomedical practitioners. These commitments involved, among others, scheduled appointments with patients and teaching responsibilities. For example, at both Sites 1 and 2, CAM practitioners had appointments with patients at hours that prevented them from uniformly attending group rounds and meetings. At Site 2, TCM practitioners also had teaching responsibilities that often coincided or conflicted with rounds. As one of these practitioners commented, “So after my class, usually if I don’t have a meeting, if my time is free, I will go.” A second practitioner, commenting on whether or not he is able to attend group rounds, stated:

It depends on my schedule and teaching. So pretty much every week, if I’m busy I just don’t go. This semester I’m teaching Wednesday till 1:00 p.m. which conflicts with the rounds, so I just don’t go. It’s unfortunate.

Several practitioners commented on the private nature of their practices. For example, one CAM practitioner at Site 1 stated:

The way the Centre is set up, CAM practitioners are really small, independent businesses, so we are not on staff. *We are not paid staff. So we essentially rent our rooms and run our practices.* [emphasis added]

A second CAM practitioner at Site 1 explained why she was unable and unwilling to attend doctors’ meetings, arguing that her need to make a living took priority over voluntarily attending rounds:

One of the reasons is sometimes financial. I can’t afford to spend an extra hour of time sitting there when I can be doing something else. *The doctors get paid doing it, I don’t.* I lose an hour or so, so I don’t bother. [emphasis added]

In order to cope with not being able to attend formal group rounds or meetings, CAM practitioners developed a style of clinical communication with other practitioners that could be called “hallway rounds.” Hallway rounds refers to the communication of clinically relevant information outside of formally-designated meeting times or locations, where clinical information is communicated in an informal, verbal, and sometimes rushed manner in places such as hallways, corridors, or doorways of offices. One could argue that this is a new and largely unnoticed pattern of professional interaction that has yet to be

documented in detail, nor analyzed in terms of its effects on clinical care. Describing this experience, one CAM practitioner explained:

If there is a problem during one of my treatments of a patient that I wanted to check with, with the doctor, then I would just *hustle down the hall* and see if one of the doctors was free. If there were some suspect signs and symptoms, I would try to double-check with them. [emphasis added]

Physicians at Site 1 were well-aware of this type of “hallway round”, as one physician commented:

We wait for the [CAM practitioners]. We don't have any formal referral system. If the [CAM] practitioner needs to meet with one of the doctors to discuss the case, they're more than welcome to meet with us any time they want, *to catch us in the hall*, or meet with us to find out more about the case. [emphasis added]

When asked if it would be beneficial if CAM practitioners were paid to attend doctors' meetings, one CAM practitioner stated:

I think it would be very beneficial because there's...a lot of things that we can discuss, more in terms of alternative therapies, approaches, things that I've done more investigations on and they haven't done that. Things that we're taught in naturopathic school, little things they [doctors] don't know about.

THE COMMODIFICATION OF CAM IN BIOMEDICAL INSTITUTIONS

In addition to disrupting the co-ordination, implementation and integration of clinical care amongst patients and practitioners in IHC settings, private CAM therapies in Canada also had an impact on the health care institutional context. That is, certain forms of CAM were being viewed by particular health care institutions intent on the integration of health care services as a commodity from which to generate revenue, increase profit, and ultimately lower deficits in institutional health budgets. As noted earlier, the generation of significant CAM revenue could be beneficial for a beleaguered public system with little funds for

investing in CAM, and could also provide a much needed start-up fund for new IHC initiatives.

Yet, in the context of the proposed Site 3, complementary medicines, in this case TCM, appeared to become commodities rather than therapies. In the attempt to create an integrative TCM clinic within Site 3, TCM was viewed at the senior level of fiscal management as an “untapped resource” with a potential for profit, as part of a business-oriented health care venture. The therapeutic goal of IHC was completely overlooked in the face of bottom-line profit, to further aid biomedical services. An interview with a senior financial manager revealed a corporate philosophical orientation, the main goal being to commodify TCM. Conceptualizing this initiative, the manager began by stating:

I mean, to me, first and foremost, this is a business opportunity for the organization to get into business with a partner, a business which should be able to accomplish a number of objectives, one of which is to make a bottom-line profit, which can then be reinvested in other priorities. So I think the driving factors are an unmet demand, potentially a marketing opportunity in terms of a unique sort of a position in the marketplace.

As this financial advisor explained, health care, in his view, is a business opportunity that requires expert market knowledge outside of health care:

For this to be successful, it needs more than just a health care provider. You don't just hang up your shingle and the flocks come to you. There's going to be required marketing savvy and those types of things, and so clearly understanding what those issues are.

As noted at Site 3, traditional Chinese medicine was simply another revenue stream that could be used to aid *biomedical* health care initiatives. This financial advisor further went on to state:

So the goal out of this is to be able to create a revenue stream that can help move us forward with the health care system, and I can use that money to reinvest in other health care initiatives.

Curiously, this individual did not view TCM as necessarily effective for treating health conditions. When asked why, then, he would be interested in including

TCM, he revealed that the “bottom line” was that if patients believed in a certain health care product, he was prepared to sell it. As he stated:

This is a public hospital, but it is a private corporation. It happens to have a board of directors. It’s a not-for-profit organization, but that doesn’t mean it doesn’t need to make a profit in order to reinvest in itself. *So I guess my view is, if there are customers who believe in this product and wish to buy this product, then we should be prepared to sell this product to those customers.* [emphasis added]

Supporting the senior financial manager’s views of the Site 3 initiative, there was also information to suggest that the implementation of a revenue-generating CAM service, TCM or otherwise, would aid in the institution’s deficit situation. When asked if the initiative would be a sanctioned form of private health care that could help to lower the hospital’s deficit, another senior financial advisor responded:

Well, it might. It certainly might. I think in any health care business right now, we’re always looking for other ways to increase our revenue and other ways to not always rely on our Ministry of Health for our dollars every day. *We’re looking for other ways to make money.* [emphasis added]

DISCUSSION AND CONCLUSION

The maintenance of CAM health services as private and therefore unfunded in Canada has led to decreased patient access to CAM services in IHC settings, and to the premature termination of “integrative” care. Marginalized patients experiencing a disadvantaged socioeconomic status, whether they experience low income or unemployment, cannot afford private treatments, unless they are fortunate to successfully negotiate with private insurance corporations through claims, or to participate in therapeutic demonstrations. Public health care insurance in Canada, because it is based exclusively on supporting biomedical care, excludes CAM services and, ironically, excludes poorer patients from CAM—just as poorer patients were excluded from biomedical care *before* Medicare. Patients also struggle with payments for private services due to their inability to work as a result of their chronic illness, a vicious circle when attempting to access health care services.

The health care insurance system in Canada, by relegating CAM practitioners to the private sector, also disrupts integrative clinical care by

restricting activities of CAM practitioners, and restricting patient flow in IHC sites. Just as patients had to terminate an integrative care plan due to their inability to afford private treatments, CAM practitioners could not afford to work towards integration in a system where CAM is not funded—even with income from their private practice, which although thought to be high, is substantially lower than biomedical practitioners (Shuval et. al, 2002). The fact that CAM practitioners could not attend group meetings can thus be viewed as a significant challenge to the development of integrative care models. For example, if CAM practitioners are unable to discuss clinically relevant information regarding patients in a focussed and detailed manner with other practitioners, including doctors, then the co-ordination of care between practitioners of multiple healing paradigms is either not allowed to develop, or is doomed ultimately to decline. Clinically, this could result in potential side effects between modalities, and ultimately a lack of coordination would result in a reduced level of care and effectiveness for patients. Kailin (2001, p. 46) has also termed this process as a “dominating integration pattern,” which “distorts” and diminishes the clinical benefits of CAM, and may lead to patient harm. The development of “hallway rounds” seemed to be the norm, and physicians, probably overconfident, seemed very comfortable and even assured that they were receiving adequate clinical information from the CAM practitioners regarding mutual patients that they shared. One question, however, the level of “integrative care” that was really being achieved through this style of interaction.

Further, the increased commodification of health care now extends to CAM practices, which are being viewed by biomedical institutions such as hospitals as revenue-generating devices. New health care services, in terms of their potential for hospital revenue, are now essentially in the same category as new hospital retail initiatives such as clothing or fast food chains. As Grinspun (2000: 25) argues, management in North American hospitals has shifted over the last decade from a cure-care paradigm, to a business paradigm. Hospitals have been reconceptualized as “financially competitive enterprises” by using a number of management, and marketing strategies from the corporate world, such as bottom line goals instead of health outcomes analysis. The marketing of CAM services in the private sector, such as acupuncture, reflects the post-Fordist concept of “program management”, where hospitals are managed as a portfolio of a business (also called Strategic Business Units), and where each “unit” produces a product or service for a particular group of patients (Grinspun, 2000: 30-31). Hospitals in the United States are clearly reflecting this trend, with over half of HMOs now offering CAM services (Baer, 2004). The potentially positive benefits of CAM-generated revenue (such as for start-up funds for new IHC clinics) are overlooked for biomedical profit. In fact, it could be argued that integrative sites provide yet another way for biomedical services to capitalize on

and appropriate the choice of CAM treatments by patients, thus marginalizing CAM and keeping it in the private sector (see Hollenberg, 2006).

In Canada's public health care system, maintaining CAM in the private and therefore unfunded sector in particular appears to convey a clear message to those interested in combining biomedicine with CAM: patients and CAM practitioners, while perhaps benefiting early on from multi-disciplinary care, will in the end "lose out" to a focus on biomedical care and profit. It remains possible that for-profit CAM revenue could benefit IHC initiatives. Patients, however, will always struggle to pay for private treatments.

This research further suggests that in a publicly funded biomedical health care system, the exclusion of CAM from public funds when the goal at the policy level is to merge biomedicine and CAM together, does not support the ideal of integrative care. To biomedically-oriented health care managers, private-based CAM may only appear as an incentive to increase profit. Yet, because patients and CAM practitioners are ultimately excluded, this kind of integration is hidden within a neo-liberal individualistic agenda that, ironically, goes against the ideal of "universal access to care." Although there appears no easy solution to adding even more health services such as CAM to the "public pool," for IHC in Canada or elsewhere to be truly equitable, attempts must be made to address the "inequality of IHC."

REFERENCES

- Advisory Group on Complementary and Alternative Health Care. Towards an integrative health system. In: Perspectives on Complementary and Alternative Health Care: A Collection of Papers Prepared for Health Canada. Ottawa: Health Canada Publications, 2001:IV.C5-IV.52.
- Angus DE. Health care costs: Canada in perspective. In: Coburn D, D'Arcy C, Torrance G, eds. Health and Canadian Society. Toronto: University of Toronto Press, 1998:23-42.
- Baer, H. A. Toward an integrative medicine: Merging alternative therapies with biomedicine. Walnut Creek, CA, USA: AltaMira Press, 2004.
- Bell IR, Caspi O, Schwartz GER, Grant KL, Gaudet TW, Rychener D, Maizes V, Weil. A. Integrative medicine and systemic outcomes research: Issues in the emergence of new model for primary health care. Archives of Internal Medicine I 2002;162:133-140.

- Boon H, Verhoef MJ. Complementary and alternative medicine: A Canadian perspective. In: Ernst E, ed. *The Desktop Guide to Complementary and Alternative medicine: An Evidence-based Approach*. Edinburgh, London: Mosby, 2001:362-373.
- Boon H, Verhoef M, O'Hara D, Findlay B, Majid N. Integrative health care: Arriving at a working definition. *Alternative Therapies in Health and Medicine* 2004;10(5):48-56.
- Canada Life and Health Insurance Association. The role of supplementary health insurance in Canada's health system. Submission to the Senate Standing Commission on Social Affairs, Science and Technology. Available from: www.clhia.ca/submissions/2001/Supp_Health_Ins/SSC.PDF. 2001.
- Canada Life and Health Insurance Association. Facts and figures by province. Available from: www.clhia.ca/e5.htm. 2006.
- Caspi O. Integrated medicine: orthodox meets alternative. *British Medical Journal* 2001;322:168.
- Clarke, J. N. *Health, illness, and medicine in Canada* (2nd edition). Don Mills, Ontario, Canada: Oxford University Press, 2000.
- Esping-Anderson G. The three political economies of the welfare state. *Canadian Review of Sociology and Anthropology* 1989;26(1):10-36.
- Faass N, ed. *Integrating Complementary Medicine into Health Systems*. San Francisco, California: Aspen Publications, 2001.
- Grinspun D. Taking care of the bottom line: Shifting paradigms in hospital management. In: Gustafson D. ed. *Care and Consequences: The Impact of Health Care Reform*. Halifax: Fernwood Publishing, 2000.
- Hollenberg D. Uncharted ground: Patterns of professional interaction among complementary/alternative and biomedical practitioners in integrative health care settings. *Social Science & Medicine* 2006;62(3): 731-744.
- Hornby S, Atkins J. *Collaborative Care: Interprofessional, Interagency and Interpersonal*. Oxford: Blackwell Science Ltd., 2000.

- Kailin, D. C. Initial strategies. In: Faass N. ed. Integrating complementary medicine into health systems (pp. 44–58). Gaithersburg, MD, USA: Aspen Publishers, 2001.
- Lincoln YS, Guba EG. Naturalistic Inquiry. London: Sage Publications, 1985.
- Maizes V, Caspi O. The principles and challenges of integrative medicine: More than a combination of traditional and alternative therapies. *Western Journal of Medicine* 1999;171: 148-149.
- Mizrachi N, Shuval JT. Between formal and enacted policy: Changing the contours of boundaries. *Social Science and Medicine* 2005;60: 1649-1660.
- Mizrachi N, Shuval JT, Gross S. Boundary at work: Alternative medicine in biomedical settings. *Sociology of Health & Illness* 2005;27(1): 20-43.
- Ramsay C, Walker M, Alexander J. Alternative Medicine in Canada: Use and Public Attitudes: Public Policy Sources Number 21. Vancouver: The Fraser Institute, 1999.
- Rees L, Weil A. Integrated medicine imbues orthodox medicine with the values of complementary medicine. *British Medical Journal* 2001;322:119-120.
- Robson C. Real World Research: A Resource for Social Scientists and Practitioner-Researchers. Oxford, U.K. and Cambridge, USA: Blackwell, 1993.
- Schroeder CA, Likkell J. Integrative health care: The revolution is upon us. *Public Health Nursing* 1999;16(4):233-234.
- Shuval JT, Mizrachi N, Smetannikov E. Entering the well-guarded fortress: Alternative practitioners in hospital settings. *Social Science and Medicine* 2002;55:1745-1755.
- Teeple G. Globalization and the Decline of Social Reform: Into the Twenty-First Century. Aurora, Ontario: Garamond Press, 2000.
- Way D, Jones L, Busing N. Implementation Strategies: “Collaboration in Primary Care – Family Doctors and Nurse Practitioners Delivering Shared Care.” Toronto, Ontario: Ontario College of Family Physicians, 2000.

Hollenberg: Effects of Private CAM Therapies on Integrative Health Care

World Health Organization. Traditional Medicine Strategy 2002-2005.
Document. Geneva, 2000.