

# THE CHIROPRACTIC REPORT

An international review of professional and research issues, published bimonthly.

By David Chapman-Smith, LL.B. (Hons), Toronto.

July 1987 Vol. 1 No. 5

## Australian Report Recommends Funding for Chiropractic

### Introduction

1. Government funding for chiropractic services was established in several countries during the 1970s, including Canada, Denmark, Switzerland, and the United States. This was largely on the basis of public demand. There was recognition that the chiropractic profession had stood the test of time, but little investigation.

2. The most thorough investigation of chiropractic – its origins, its present day standards of education and practice, and the emerging scientific evidence of effectiveness and inter-disciplinary cooperation – came in 1978/79. A New Zealand Commission of Inquiry, which conducted investigations in New Zealand, Australia, the United States, Canada, and England, found that chiropractic was a mature and effective health care profession and recommended government funding for chiropractic services.<sup>1</sup>

3. Now comes the latest report, from an Australian Federal Government Committee, considering the international research evidence up to 1986 and finding:

- Over 90% of chiropractic practice in Australia is “for musculo-skeletal problems and headache”.
- For these categories of complaint, comprising the great majority of chiropractic practice, chiropractic is well accepted by the Australian public, proven effective, cost-effective, and “an attractive proposition” for government funding.

- There should be government funding for chiropractic, with appointments of chiropractors in public hospitals and/or community health centres across Australia.

- “The poor relationship between chiropractic and orthodox medicine tends to work against the health interests of Australians and there is a need for orthodox medicine to come to terms with the fact that chiropractic is accepted by the public and is here to stay.”<sup>2</sup>

4. The report of the Australian Medicare Benefits Review Committee (MBRC) is of significance to all chiropractors because of its findings on chiropractic, its comment on other health professions, and its analysis of the principles relevant to third party funding of health care.

### MBRC – Background

5. Australia has federal and state

governments (like the U.S.A.) and a government health care system funded by both levels of government (like Canada).

Government funding for health services is recent, having first been established in 1975. Current funding is for medical services, dental services in the field of oral surgery performed in a hospital, and some optometry services. There are no benefits for chiropractic care.

6. The MBRC was established in July 1984 by the Federal Minister for Health. It was asked to review the government funded system, and “to consider requests for extending the scope of the Medicare arrangements to provide benefits for certain paramedical services”.

7. Australia, which has modern legislation governing the practice of chiropractic in all states, has approximately 1,750 chiropractors. They are represented by the Australian Chiropractors Association (principally those chiropractors trained in the United States and more recently the School of Chiropractic at the Philip Institute of Technology, Melbourne, Australia) and the United Chiropractors Association (those chiropractors trained in Australian colleges with less influence from chiropractic in North America – the most important of which has become the Sydney College of Chiropractic, which is affiliated with the University of New South Wales). The ACA and the UCA established a National Committee for its presentations to the MBRC.

8. The MBRC delivered its first report, on medical aspects of the government plan, in November 1985.<sup>3</sup> Its second report, dated June 1986, deals with funding for all other health care professions – including chiropractic, dentistry, optometry, osteopathy, and physiotherapy.

The initial membership of the MBRC comprised a judge, as chairperson, and four MDs including two senior officials of the Australian Medical Association. Because questions were raised concerning bias, the medical members of the MBRC withdrew following the first report. For the second report, considering funding for chiropractic and other health professions, the MBRC comprised Judge Robyn Layton, Chairperson, and two PhDs (Dr. Brian Shea, former Chairman of the South Australian Health Commission, and Dr. John Deeble, Director, Australian Institute of Health).

### Professional notes:

#### New U.S. Statistics on LBP and Chiropractic

‘Description Epidemiology of Low-Back Pain and Its Related Medical Care in the United States’, Deyo R, Spine (1987 12(3)264-268. PNI

1 in 3 Americans with an episode of back pain lasting more than 2 weeks consults a chiropractor. Complete statistics on professionals consulted are family physician (59%), orthopaedist (37%), chiropractor (31%), physical therapist (16%), osteopath (14%), internist (8%) and rheumatologist (2.5%).

There are “important racial, regional and educational differences in the use of various types of practitioners”. Thus there is similar use of MDs by white (59%) and black (58%) patients – but not for chiropractors, white (39%) and black (14%), or osteopaths, white (17%) and black (5%). Those with more education are more likely to choose a chiropractor. Patients with only elementary education prefer general medical practitioners (74%) to chiropractors (33%), but the difference is much less with a college education – MD (48%) and chiropractor (37%).

These are some of the findings of Dr. Richard Deyo of the University of Texas, who has degrees in medicine and public health, in his recent analysis of the largest U.S. survey to include back pain epidemiology which has yet been reported”. This was the second National Health and Nutritional Examination Survey performed between 1976 and 1980. Deyo’s sample includes 10,404 adults. Other points of interest:

continued on insert page 1.

9. The procedure adopted by the MBRC was receiving submissions from the various professional associations and other interested parties, then holding interviews in the form of public hearings.

In summary, the procedure was as thorough as possible given the very wide scope of the committee's deliberations, but superficial in comparison with a judicial procedure such as that of the New Zealand Commission. (When it came to chiropractic the MBRC accepted the New Zealand findings, acknowledging that NZCI's status as "the most comprehensive and detailed independent examination of chiropractic ever undertaken in any country.")

However the findings of the Australian MBRC represent the most thorough government inquiry into the funding of health care, including chiropractic services, during the 1980s.

#### Government Funding – Principles

10. The MBRC, after considering the international evidence from past studies, provides an excellent review of the criteria relevant to government funding for health care.<sup>4</sup> In summary, these are:

##### A. First Stage Criteria

i **Effectiveness.** (Clinical and scientific evidence must demonstrate "a reasonable ability to promote and maintain the health of people, or to beneficially alter the natural course or symptomatic effects of defined conditions".)

ii **Social acceptability.** (Over a reasonable period of time and across a reasonable proportion of all subsections of society.)

iii **Cost efficiency.** (Firstly the cost relative to the benefits provided, and secondly the cost in comparison to other health services of approximately equal effectiveness – where there are competing services the least costly alternative should be preferred.)

iv **Established standards of practice.** (Evidenced by statutory regulation, or appropriate and adequate education, training, and self-regulation.)

These first stage criteria must be satisfied for public funding. If these "essential minimum criteria" have been met, there should then be consideration of a further five criteria, compliance with which is important, but not essential.

##### B. Second Stage Criteria

i **Need.** (Either a general need i.e. "need of a significant proportion of the population"; or a special need. The MBRC expressly uses 'need', to be proven by current utilization rates, in preference to the concept 'demand'.)

ii **Unmet or inadequately met needs.** (i.e. The need identified under (i) above is not adequately met by services already funded.)

iii **Relationship with other professions.** (The extent to which the profession to be newly funded can be appropriately coordinated with other funded services.)

iv **Scope for cost saving.**

v **Availability.** (This involves two concepts. Firstly, a sufficient number of practitioners spread geographically to "reasonably satisfy" the inadequately met needs in question. Secondly, ability to do this without stripping existing publicly funded services of their personnel.)

#### Chiropractic – Findings

11. The MBRC reports on chiropractic in Chapter 10.<sup>2</sup> On the basis of independent survey evidence it accepts that over 90% of chiropractic practice in Australia relates to 'Type M' problems – "disorders whose symptoms are mainly local pain either of spinal origin or in closely related areas such as headaches."

This great majority of chiropractic practice is found to satisfy all the essential criteria for government funding, making funding "an attractive proposition". (For the balance, 'Type O', see para. 12 below.) with respect to specific criteria:

##### Effectiveness

After considering the clinical and research evidence, and analyzing the growing body of chiropractic and interdisciplinary clinical trials, the MBRC concludes, "sufficient material was placed before us to satisfy us that the services provided by chiropractic... are effective."

##### Social Acceptability

"We consider that there is little need to comment on this criterion. A modality with the usage rate as high as chiropractic and one that is steadily growing (it has a reported annual growth of 4.1%) has obviously 'stood the test of time'. It is also recognised by private health insurers and, in our view, is clearly socially acceptable."

(The most recent Australian Health Survey (1983) ranked chiropractic fourth in demand. In health consultations during 2 weeks prior to interview per 1,000 population, consultation with a chiropractor (12) was fourth after MD/specialist (174), dentist (49), chemist (26), and higher than physiotherapist (9), optician (5), community nurse (4), naturopathy/herbalist (4), and podiatrist (2).)<sup>5</sup>

##### Cost Efficiency

"Chiropractic services appear to be cost efficient."

"The popularity of chiropractic may stem partly from its effectiveness, and partly from

#### Cranial Adjustment

1. Who is the new Executive Vice-President of the American Chiropractic Association?
2. Alan Breen D.C. is a prominent chiropractic researcher in which country?
3. A 'chonkavash' is a bone-setter, or bone-smith, in which country?
4. How many Americans with low back pain lasting 2 weeks or more consult a chiropractor – 1 in 3, 1 in 4, 1 in 5?
5. How many English general medical practitioners refer patients to chiropractors or osteopaths for manipulation – 10%, 25%, 40%, or 50%?
6. Name the former dean of the Canadian Memorial Chiropractic College who wrote 'Neurodynamics of the Vertebral Subluxation' and has retired to Florida?
7. Give the name and country of the chiropractic college which last month graduated its first class?
8. In 1920 Sofus Larsen D.C., a Palmer graduate, opened the first chiropractic clinic in which country?
9. A South African who studied chiropractic at National is Dean of the School of Chiropractic, PIT, Melbourne, Australia – his name?
10. Does Jim Parker D.C. drive a Rolls Royce?

- Answers
1. Ronald L Harris D.C. of Ocala, Florida.
  2. England.
  3. Hungary.
  4. 1 in 3 – see Deyo article, this issue.
  5. 50% – see Anderson article, this issue.
  6. Earl Homewood D.C.
  7. French Institute of Chiropractic, Paris, France.
  8. Denmark – in Copenhagen.
  9. Andres Kleyhans D.C.
  10. He used to – the gift of grateful chiropractors – but no more.

the non-invasive drug-free nature of its treatments which have the added advantage of being comparatively rapid in their results."

"Average charges for chiropractic services are similar to those of other health professionals. Because chiropractors generate few additional costs in drug utilisation, hospitalisation or referral to specialist providers, overall treatment costs are almost certainly lower than those of traditional medical practice. For the treatment of musculo-skeletal conditions, in which we regard effectiveness as well-established, we also accept that chiropractic services are cost effective.

#### Standards of Practice

The MBRC reviews the two accredited educational programs in Australia, the statutory regulation in each state, the roles of the two national associations, and concludes that chiropractic "has the infra-structure and ability to ensure that satisfactory standards of practice can be achieved."

• "In the United States back pain is the second leading symptom that prompts visits to physicians. (The leading symptom is that of the cold)".

Deyo did this survey because "back pain prevalence data for the U.S. are sparse" and yet low back pain has "an enormous impact on the health care system".

• A number of studies have shown that 80-85% of the population in western society has an incapacitating attack of back pain at some stage during life. Deyo reports that 6.8% of the U.S. adult population is suffering from an episode of back pain lasting more than 2 weeks at any given time.

• Among all those reporting back pain in the survey there was an equal distribution as to duration - 33% acute (less than 1 month), 33% sub-acute (1-5 months) and 33% chronic (6 months or more).

• Deyo concludes that "these data suggest an agenda for further therapeutic and epidemiologic research. For example the high rates of use of chiropractic care indicate a major need for more and better data on the therapeutic efficacy of spinal manipulation."

#### England - 50% of GPs refer to Chiropractic and Osteopathy

'General Practitioners and Alternative Medicine', Anderson E & Anderson P, J Royal College Gen. Practitioners, (February 1987) 37:52-55. PN2

There have been a number of recent studies in England, referred to in this the latest, investigating the attitudes of general medical practitioners (GPs) towards 'alternative medicine' and their working relationship with alternative practitioners.

'Alternative medicine' is principally manipulation, acupuncture, homeopathy, hypnotherapy. (The fact that 'manipulation' is described as 'alternative medicine' says a lot about how little spinal manipulation is understood or used by the medical profession at large. See following item on Jayson's new text.)

The researchers, one of whom is a GP, sent a questionnaire to 274 GPs in Oxfordshire. There was an "unusually high response rate" (81%) indicating "a high level of interest in alternative medicine" and findings are:

(a) The 'alternative medicine' of highest interest by far was manipulation.

(b) 89% had discussed manipulation with patients during the previous year, 50% had made referrals to an alternative practitioner. (Practitioners are not identified, but in England will have been osteopaths and chiropractors.)

(c) Some GPs had practised manipulation "without training or attendance at classes". 5% had received training (unspecified), and 25% "would like training" in manipulation.

(d) The authors advise fellow GPs "that all doctors who wish to practise alternative medicine should have adequate and recognized training." More conclusions follow. They ask that existing registers of chiropractors and osteopaths be widely available for both MDs and members of the public. As GPs are referring patients this frequently they conclude that alternative practitioners should receive reimbursement under the state health service, and they acknowledge that the medical profession has a

duty to the public to assess the benefits and harms of alternative practices.

The British Medical Association, which has come under increasing fire for its recent report showing a closed mind to alternative approaches to health care, is criticized again. Its report is challenged as being unhelpful to the many general practitioners who refer to chiropractors, osteopaths, and others.

#### Spondylolisthesis - Not a Contraindication

'A Comparison of the Effectiveness of Spinal Manipulative Therapy for Low Back Pain Patients with and without Spondylolisthesis', Mierau, Cassidy, McGregor and Kirkaldy-Willis (April, 1987) JMPT 10(2):49-55. PN3

Some medical specialists debate the wisdom of chiropractic adjustment for back pain where there is clear radiographic evidence of spondylolisthesis.

Here is a recent paper from chiropractic and medical authors finding that "lumbar spondylolisthesis is not a contraindication to prudent manipulation applied to the lumbosacral spine. Specific high-velocity, low-amplitude manipulation to the dysfunctional joints in side posture is the technique of choice".

The authors conclude that "prone lumbar manipulations can be harmful" and make the point that "the manipulation is directed at correcting joint dysfunction above and below the defect and not affecting the level of the defect or slip".

This is a further product of the Saskatoon research led by Drs. Kirkaldy-Willis MD and Cassidy DC. Among the large number of patients referred to the University Hospital with low back pain during the trial period a small group of 25 had lumbar spondylolisthesis. Average duration of disability was 10.5 years. Disability was Grade 4 ("constant severe low back and/or leg pain and unable to work or go about their daily activities"). 80% (20/25) returned to normal function and minimal or no pain after 2 weeks of daily chiropractic adjustments.

The results were "not significantly different" from those patients without lumbar spondylolisthesis, and the authors observe that results might be even better when patients are seen at the primary contact level.

#### Non-Specific Low Back Pain - A Valuable New Review

'Recognizing Specific Characteristics of Non-specific Low Back Pain' Bernard and Kirkaldy-Willis (April, 1987) Clinial Orthopaedics 217:266-280. PN4

Bernard, an MD from Columbus, Georgia, and Kirkaldy-Willis an orthopaedic surgeon from Saskatoon, Canada, review 12 years of experience (1972-1984) in the treatment of 1,293 patients for low back pain in a hospital setting and come up with some exciting findings for chiropractic. The main purpose of this study is "to draw attention to some of the lesser-known causes of low back pain whose clinical presentation frequently mimic other well-known lesions." Points are:

1. There is an excellent general discussion of causes of low back pain, differentiating between those well-known to medicine and causing *radicular* pain (eg. herniated disc, stenosis, and spondylolisthesis) and those lesser-known and causing *referred* pain (eg. posterior joint syndrome, sacroiliac joint syndrome, and various muscle syndromes).

2. These lesser-known causes are found to be more prevalent, but "frequently overlooked" because they "do not demonstrate abnormalities radiographically". The single most frequent syndromes in this hospital population are posterior joint syndrome (22.1%) and sacroiliac joint syndrome (22.6%).

3. Co-existing lesions occur in 1 of 3 (33.5%) patients. An example given is bulging disc and spondylolisthesis and sacroiliac joint syndrome. Here the authors say there should be manipulation for the sacroiliac joint syndrome first, and only after therapeutic failure with manipulation should other better-known syndromes be accepted as the cause of the problem.

4. Manipulation is identified as the general treatment of choice for the lesser-known but most common causes of referred pain - posterior joint syndrome and sacroiliac joint syndrome - *whether these are the sole lesion or found in conjunction with other nerve root compression syndromes*. The reported success rate, where diagnosis and treatment has been performed by chiropractors, on the hospital team is:

(a) 95% where there is a sole lesion; and

(b) 65% with the presence of additional nerve root compression syndromes.

In summary, an excellent and well-illustrated review, together with compelling evidence of the effectiveness of chiropractic diagnosis and treatment with what are found to be the most common causes of low back and leg pain in a hospital population of patients.

#### Ultrasound - State of the Art

'Mechanisms Involved in Therapeutic Ultrasound' Dyson M, Physiotherapy (March 1987) 73(3):116-120. PN5

Dr. Mary Dyson is a basic scientist with a Ph.D for work on wound healing, and has many publications on ultrasound in biology and medicine. This, her latest, explores what is known concerning the physiological, psychological, and physical mechanisms involved in therapeutic ultrasound.

The article also outlines problems that can be encountered in ultrasound treatment, and how they can easily be avoided. There is explanation of why the applicator must be moved throughout treatment - in the absence of movement reflected waves of ultrasound (reflected from an interface between two materials with different acoustic properties such as soft tissue and bone) become super-imposed on following waves to create *standing waves* which can create severe damage to the endothelium of vessels and clot formation, and various other effects. Standing wave formation is avoided not only through constant movement of the applicator but also by using the lowest intensity and highest frequency required for the desired therapeutic effect.

However Dyson's conclusion is that "although much is known about therapeutic ultrasound, far more remains to be discovered." "The optimum treatment regimes of soft connective tissue injuries" have not been determined and "comparisons need to be made at the clinical level of the effects of different treatment parameters, in particular of the effect of treatment at different stages in the repair process."

## Where is Chiropractic, Where is Spinal Manipulation?

'The Lumbar Spine and Back Pain' (1987) Ed. by Jayson M.I.V., Churchill Livingstone, London and New York (3rd Ed). PN6

This new edition of Jayson's text is greatly expanded. As Dr. Allan Dixon, consultant physician, Royal National Hospital for Rheumatic Diseases, Bath, U.K. says in his introduction "since the first edition of this book was planned 10 years ago much has changed in the field of the lumbar spine and back pain."

Chapters are contributed by leading experts worldwide on subjects that include basic disciplines (epidemiology, pathology, neurology, and biomechanics), diagnostic studies (measurement of spinal movements, radiological investigation, CT scanning, and NMR) and treatment (from surgery and chemonucleolysis to back schools and psychology).

Although international experts have been found for all these subjects the whole field of spinal manipulation is dealt with briefly and quite inadequately in the context of a general chapter entitled 'Conservative Treatment of Back Pain' which places greatest emphasis on exercise. The authors are Robert Swezey, Medical Director, Arthritis and Back Pain Center, Santa Monica; and Clinical Professor of Medicine, UCLA California, and Philip Clements, an Associate Professor at UCLA who also works at the Santa Monica Center. Neither seem to have any significant training or experience in the field of spinal manipulation, let alone an understanding of chiropractic and the recent literature.

They are prepared to make the amazing statement that "the reports of the efficacy of manipulation in the treatment of low back pain show either no efficacy or at best a slightly accelerated rate of recovery during the first few weeks." Compare that, for example, with the findings of Bernard and Kirkaldy-Willis referred to in this Report. (Similar findings, relating to a 6 year period, were published by Kirkaldy-Willis in his text 'Managing Low Back Pain' back in 1983.)

One is confident that the authors have never been exposed to chiropractic or any skilled form of manipulation when they write "it is the sound and fury of manipulation that attracts and repels, and in general has relegated its practises to the lay practitioner or paraprofessional... the fury is in the uncontrolled thrust, its potential for harm, and in the lack of scientific justification for its use... Obviously, at the time of this writing the need for manipulation as such in the management of low back pain is not great."

Accordingly, while there is much of excellent value in Jayson's new text, do not read it for reality on chiropractic or spinal manipulation.

## Dr. Mennell Launches Multi-Disciplinary Research Foundation

The new Physical Medicine Research Foundation is worth thinking about because it is attracting heavy international attention and funding for the first time to research into approaches to treating musculo-skeletal problems without surgery or medication,

and because it has the express aim of awarding research funds to those pursuing multi-disciplinary research.

The driving force behind the Foundation is Dr. John Mennell who chairs an International Multi-disciplinary Board with a number of chiropractic members - Drs. Rick Hunter and Paul Bishop of Vancouver, Dr. Ron Gitelman of Toronto, Dr. David Cassidy of Saskatoon, and Dr. Scott Haldeman of Los Angeles. Early months have seen endorsements from the Duke of Edinburgh, Bob Hope, and many leaders in industry and finance. The government of Canada has already made a grant of \$50,000 for the PMRF to establish a resource library and database.

Executive Director is Mr. Marc White, a massage therapist, and Foundation President is Dr. John Yates, who has his Ph.D in physiology. Foundation officers have currently been established in Canada, United States, and the United Kingdom. At the Foundation's inaugural symposium in August, 1986 at the University of British Columbia in Vancouver, Dr. Mennell addressed a large gathering of health professionals, including many chiropractors, in these terms:

"It has been a prime object throughout my career to promote togetherness rather than separateness in the field of physical and rehabilitation medicine. Too often it is the suffering public which is the victim of the lack of cooperation, communication, and education between health care practitioners. It is time for family physicians, orthopaedic surgeons, physiatrists, sports medicine physicians, physiotherapists, chiropractors, osteopaths, acupuncturists, psychologists, and massage therapists to work together for the betterment of humankind."

The main objectives of the Foundation are:

1. Establishing an international resource centre for all interested health care professionals.
2. Generating research funds to be awarded to academic institutions and researchers pursuing multi-disciplinary research in the field of physical and rehabilitation medicine. (Co-chairmen of the Research Committee, which establishes research and funding priorities, are Dr. Mennell and Dr. Rick Hunter dc.)

The Australian MBRC's report discussed in the lead article of this Report shows that research is of more than clinical importance - chiropractic was found worthy of public funding but osteopathy not, and a major factor was that chiropractic could show significant research into effectiveness and cost-effectiveness.

Most chiropractors today make some financial

commitment to research each year. You will rightly wish to continue as a first priority with established chiropractic research foundations and colleges.\* However you may wish also to lend support to a foundation supporting a natural and multi-disciplinary approach to health care, and one which appears to have the leadership backing and influence to attract far greater funds for research than any purely chiropractic organization could hope for.

Inquiries: North America: Mr. Marc White, Executive Director, PMRF, Suite 215, 207 West Hastings Street, Vancouver, B.C. V6B 1H7, Canada, (604) 684-4148; United Kingdom: Dr. Richard Ellis, National Secretary, Wessex Rehabilitation Association, Odstock Hospital, Salisbury, Wilts, SP2 8BJ.

## \* Chiropractic Research organizations:

Individual chiropractic colleges.

Foundation for Chiropractic Education and Research (FCER). Executive Director Mr. Brian E. Cartier, 1701 Clarendon Blvd., Arlington, Virginia 22209, U.S.A. (703) 276-7445.

Chiropractic Foundation for Spinal Research (CFSR) Chairman, Dr. G. Dan Redhead, Winnipeg General P.O. 638, Winnipeg, Manitoba, R3C 2K3, Canada (204) 324-5325.

Pacific Consortium for Chiropractic Research, 1081 Alameda De Las Pulgas, P.O. Box 74, Belmont, California 94002, U.S.A. Contact: Paul H. Lehman, Director of Public Affairs, California Chiropractic Association and California Chiropractic Foundation (916) 457-5202.

## International Multi-Disciplinary Board, PMRF:

John Mennell M.A., M.B., Cert.P.M., B.Ch., D.M.R.&E., (Chairman)

John Barnes, PT

Paul Bishop, D.C., M.Sc.

J. David Cassidy, D.C., M.Sc.(Orth.), FCCS

Edward Corboy, M.D.

Patricia Dryden, Reg.M.T.

Richard M. Ellis, M.A., M.B., B.Chir., MRCP, FRCS, M.D.

Gil Faclier, M.D., FRCP

Donald Fraser, M.D., CCFP, FCFP

Brian Gibson, Reg.M.T., M.D., FRCP

Ronald Gitelman, D.C., FCCS(C)

Chan Gunn, M.D., Cert.P.M., LMCC, FICAE, FAAA

Scott Haldeman, D.C., M.D., FRCP, FCCS, FAAN

Warren Howe, M.D., FACSM, FAAFP

Rick Hunter, D.C.

W.H. Kirkaldy-Willis, M.D., FRCS

Stephen Levin, B.S., M.D., FACS

Wilbur Lowry, B.A., M.D., C.M., FBMA, FRCGP,

M.B.E., O.St.J. of Jerusalem

John Oldham, R.P.T., MCPA

William Parsons, B.A., M.D., FRCP

Jack Richman, M.D., CCBOM, DOHS, CCFP

Martin Shoemaker, Ph.D., A.B.P.P.

Wesley Sime, M.Sc., MPH., PhD

William Tucker, C.V.O., M.B.E., T.D., M.A.,

M.B., B. Chir., FRCS, MRCS, LRCP

Elizabeth Whynot, M.D., CFP

## Conference on Internal Disorders

The First International Conference on Chiropractic Diagnosis and Treatment of Internal Disorders is to be held January 7-9, 1988 at the Airport Marriott Hotel at St. Louis, Missouri.

There has been a call for scientific papers from committee chairman Dr. Robert Wiehe of West Plains, Missouri who says "the chiropractic profession is placing too little emphasis on this aspect of chiropractic practice - we need to know what is going on throughout the profession in relation to the diagnosis and management of internal diseases.

Should you wish to submit a paper for presentation and publication, or join the organizing committee contact: Robert J. Wiehe, D.C., P.O. Box 586, West Plains, Missouri, 65775 U.S.A. (417) 256-5099 or Michael Cessna, D.C., 504 North 13th St., Rogers, Arkansas 72756, U.S.A. (501) 636-1178.

12. In its review of the 'Second Stage Criteria' for funding, none of which represented difficulty for chiropractic, the MBRC makes pointed comment on the traditional antipathy of the medical profession to chiropractic. Comments are:

- "...the continuing schism between the two professions does little to help improve the health of the many Australians who might benefit from a joint chiropractic/medical approach to their problems."
- "The poor relationship between chiropractic and orthodox medicine tends to work against the health interests of Australians and there is a need for orthodox medicine to come to terms with the fact that chiropractic is accepted by the public and is here to stay."
- (Recommending funding for chiropractic in hospitals and other public institutions.) "We are aware of the very considerable organizational and professional obstacles... Orthodox practitioners and, indeed, some chiropractors may initially find the experience an uneasy one, but we consider the differences that currently exist to be unreasonable and efforts should be made to bridge the gap."

13. There are two important areas in which the MBRC's findings are adverse to chiropractic. In both the Committee's conclusions are plainly unfair and open to easy rebuttal.

14. Firstly, the MBRC holds that because a small part of chiropractic practice relates to "Type O" problems, defined as visceral disorders such as hypertension and peptic ulcers, there is "a major obstacle to public funding for chiropractic services in general." This is because:

- i. There is "insufficient material... to determine effectiveness" for Type O treatments, and
- ii. Because "administratively it is impossible to publicly fund only part of the work performed by a practitioner."

Obvious responses include:

(a) It is true that there is limited evidence of effectiveness of chiropractic adjustment, and other forms of spinal manipulation, for Type O conditions. However there is significant evidence, more than for many funded medical treatments, and furthermore many funded medical manipulators use spinal manipulations for Type O conditions. (See the March 1987 (Vol. 1 No. 3) issue of this Report.)

(b) To find that the public has a legitimate need for 95% of a health care profession's services, then obstruct access to that 95% of services in the present circumstances, is plainly unjust. If indeed it was "administratively impossible" to fund only some services then logic suggests all services should here be funded. That is actually what happens in other countries (eg. Canada, and Denmark). It is also what happens under private insurance and other third party payment arrangements for chiropractic internationally, including in Australia.

(c) However it is both amazing and wrong to suggest that it is administratively impossible, or even difficult, to fund a part only of the work of a practitioner or profession. This already happens in Australia with dental surgeons. It is what was recommended by the New Zealand Commission of Inquiry.<sup>6</sup> It is what happens in the United States under Medicare. (Payment for chiropractic services where there is evidence of subluxation, or vertebral joint dysfunction, on x-ray). All that would be necessary in Australia, if the MBRC's recommendation of no funding for Type O treatments was to be followed, would be documentation requiring the treating chiropractor to list the patient's chief presenting complaint - if it was a Type M complaint as defined the government plan would meet the costs. There could be ready verification through random checks with patients as currently occur in all government funded schemes.

(d) There are further arguments against the whole approach based on conditions. One is that this is an unreal way of viewing

most health care encounters. It places emphasis on crisis treatment and makes no allowance for health promotion and prevention of ill health - concepts that are increasingly viewed by governments as a vital element of primary health care, and that are an aspect of presently funded medical services. Secondly, from a purely chiropractic point of view, it is inappropriate to be viewing chiropractic treatment as a response to specific conditions. A chiropractor may treat a 'patient with cancer', thereby relieving pain and assisting physiological response, but does not treat 'the patient's cancer'.

15. The MBRC has a second argument against fee-for-service benefits of chiropractic. This is that where, as - it is said - with chiropractic, "treatment is mainly concerned with the relief of pain, which clearly has subjective qualities, treatment norms could be difficult if not impossible to establish. Costs would be difficult to estimate and control." Thus "the most suitable way for chiropractic services to be supported in the public domain would be for their provision on a salaried or a sessional basis through public hospitals and community health centres."

16. This is equally simple to rebut. Most treatment can be described in one sense as "mainly concerned with the relief of pain." This is probably more accurate of physiotherapy and even dentistry and general medical practice than chiropractic. Chiropractic is mainly for the restoration of correct function, with present relief of pain being only one consideration.

It is not "difficult or impossible to establish treatment norms", which is done throughout the world by chiropractic associations, regulatory boards, and third party payors. As to the observation "cost would be difficult to estimate and control", cost can be controlled quite simply and absolutely. The most basic approach, seen wherever there is government funding for health services, is the setting of monetary limits per procedure, per symptom complex, or per patient. Thus, for example, the Canadian provinces generally fund treatment from a licensed chiropractor for all services but at specific rates per procedure with an annual maximum figure per person or family.

17. Having regard to the MBRC's established criteria for government funding, and their finding that chiropractic meets all the essential criteria, the very thin arguments recommending only institutional funding as opposed to fee-for-service funding can be seen as bending to political expediency rather than standing firm on principle.

## PAPER ORDERING SERVICE

(Photocopy, complete, and forward with payment).

Subscribers may order any paper/item referred to in main article (just quote the reference number) or the professional notes (quote PN1, PN5, etc.) at a cost of:

1 article - \$8.00 (US, Can, Aust, NZ - your currency) £4 or US\$8 (Europe and elsewhere); each additional article - add \$2.00 or £1.

Name \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State/Province \_\_\_\_\_ Postal Code/Zip \_\_\_\_\_

Issue of The Chiropractic Report (month and year) \_\_\_\_\_

Reference No(s) \_\_\_\_\_ PN No(s) \_\_\_\_\_

PLEASE CHECK ONE

Visa  Card Number \_\_\_\_\_

Master Card  Exp. Date \_\_\_\_\_

Check/Cheque Enclosed

Payable to: The Chiropractic Report  
P.O. Box 244, Station "S",  
Toronto, Ontario M5M 4L7 Canada

## Other Disciplines – Funding for Spinal Manipulation Medicine

18. The Australian Association of Musculo-skeletal Medicine claimed to represent medical specialist in the field of manipulation, and asked for a new specialist rating and fee for AAMM members.

The MBRC refused this request, saying it did "not accept the proposal that recognition of spinal manipulation as a medical specialty for Medicare benefits purposes can be justified... on the grounds of possession of certain qualifications when the (AAMM) seeks to deny the extension of benefits to services rendered by non medical practitioners holding the same qualifications."<sup>3</sup>

### Osteopathy

19. Whereas chiropractic satisfied the criteria for public funding, the MBRC came to an opposite conclusion on osteopathy after reviewing the evidence presented by the two professional associations representing Australia's approximately 300 osteopaths.

The criteria had not been met "as to the effectiveness of osteopathic services nor their cost efficiency" and the MBRC found it had "too little data available... on many issues under consideration to enable public funding to be contemplated at this stage."<sup>7</sup>

### Physiotherapy

The Australian Physiotherapy Association, which represented the physiotherapy profession, reported 70% of all registered physiotherapists were APA members. Membership in 1985 totalled 5,400, of which 1,200 (22%) were in private practice. Existing public funding covers many physiotherapy services in public hospitals and community health programs, but no private practice of physiotherapy.

The MBRC accepted that physiotherapy practice in general, including the treatment of orthopaedic and spinal problems by spinal manipulation, satisfied the essential criteria for funding but, as with chiropractic, did not recommend any fee-for-service funding. Physiotherapy fell within this general funding recommendation:

## SUBSCRIPTION AND ORDER FORM

Annual Subscription (6 bi-monthly issues): US — US\$52.  
Canada — Can\$52. Australia — A\$60. NZ — NZ\$60.  
Europe and elsewhere — £28 or US\$52.

• Special subscription rate for members of ACA, ICA, Austr CA, CCA, ECU, NZCA, UCA:

US — US\$38. Canada — Can\$38. Australia — A\$45.  
NZ — NZ\$45. Europe and elsewhere — £20 or US\$38.

PLEASE PRINT CLEARLY

Name \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State/Province \_\_\_\_\_ Postal Code/Zip \_\_\_\_\_

Country \_\_\_\_\_ Tel. No. ( ) \_\_\_\_\_

ACA  ICA  Austr CA  CCA  ECU  NZCA   
UCA  (CHECK AS APPROPRIATE)

PLEASE CHECK ONE

Visa \_\_\_\_\_ Card Number \_\_\_\_\_

Master Card \_\_\_\_\_

Check/Cheque Enclosed \_\_\_\_\_ Exp. Date \_\_\_\_\_

Payable to:

The Chiropractic Report  
P.O. Box 244, Station "S" Toronto, Ontario M5M 4L7 Canada

"That an amount of \$20 million annually be offered to the states/territories on a per capita basis for extension of services under the community health program in the modalities of dietetics, occupational therapy, podiatry, physiotherapy, and speech pathology."<sup>8</sup>

### Natural Therapy

21. The case for funding for natural therapy, or naturopathy, was put forward by the Australian Natural Therapists Association, claiming to represent 700 members nationally. Unlike chiropractic and osteopathy, there is no legislation regulating education and practice in naturopathy in Australia.

MBRC members were "unable to satisfy ourselves that... naturopathy's standards of practice, effectiveness, and cost efficiency matched our criteria" for funding.<sup>9</sup>

### Conclusion

22. This report from Australia confirms once more that funding for health care involves both principle and politics, and that success is ultimately a political matter.

On evidence described by the MBRC as "well-researched and comprehensive" chiropractic is found to satisfy all the criteria for fee-for-service funding — it is found to be highly acceptable to the public, well regulated under appropriate legislation, effective, and cost-efficient. Furthermore an independent patient survey confirmed that "69% of patients surveyed were seeing their medical practitioner less often, so that some medical costs were clearly reduced by chiropractic."

23. Chiropractic was the only profession outside dentistry, medicine, and optometry to receive an independent new recommendation for funding. However this was limited to funding of chiropractors in hospitals and community health centres — the Committee found pretexts to avoid the cost of funding private chiropractic services.

24. The maturity of the modern chiropractic profession has been demonstrated in yet another country, and the Australian profession deserves applause for its efforts. Now it is necessary to generate political will.

## References

1. 'Chiropractic in New Zealand', Report of Commission of Inquiry (1979), P D Hasselberg, Government Printer, Wellington, NZ.
2. Second Report (June 1986), Medicare Benefits Review Committee, C J Thompson, Commonwealth Government Printer, Canberra, Australia, Chapt. 10 (Chiropractic).
3. First Report (November 1985), MBRC, Canberra Publishing & Printing, Fyshwick, ACT, Australia, Chapt. 12 (Spinal manipulation by medical practitioners).
4. Ref 2 supra, Chapt. 5.
5. Ref 2 supra, 76.
6. Ref 1 supra, 312 — Recommendation 14.
7. Ref 2 supra, Chapt. 21.
8. Ref 2 supra, Chapt. 22.
9. Ref 2 supra, Chapt. 17.

**Multiple Subscriptions.** You may photocopy The Chiropractic Report for patients. However, in response to many requests, multiple subscriptions will now be available, allowing present subscribers to order direct mail subscriptions for other health professionals, decision-makers, patients — anyone except other doctors of chiropractic. Rates (each order): US-US\$20. Canada-Can\$20. Australia-A\$25. NZ-NZ\$25. Europe and elsewhere-£10 or US\$20. Complete order form at left with your name, address, etc. Attach name, mailing address and occupation of person(s) for whom you are ordering.

**Multiple Copies.** Subscribers may order extra copies of each issue, cost \$1 (50p) each, minimum order number of 10 (cost of airmail post included in this price).