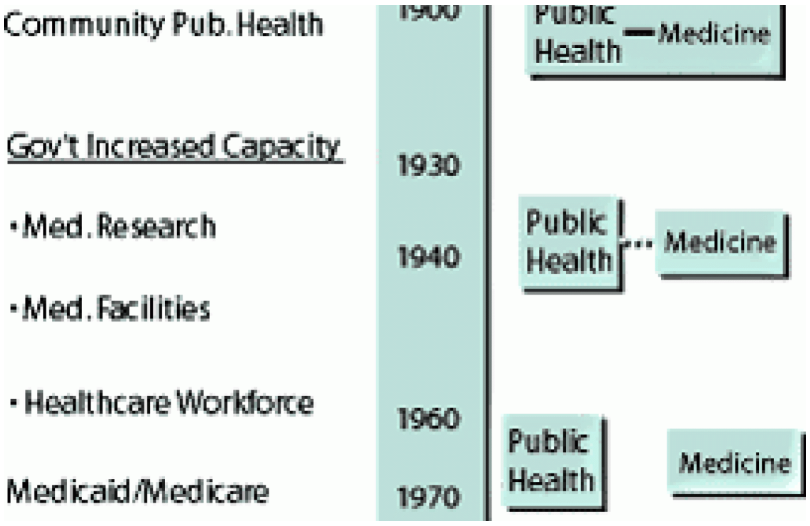
Dynamic Chiropractic



CHIROPRACTIC (GENERAL)

That Was Then, This Is Now - Chiropractic Health Care, Public Health, and the Health Care System

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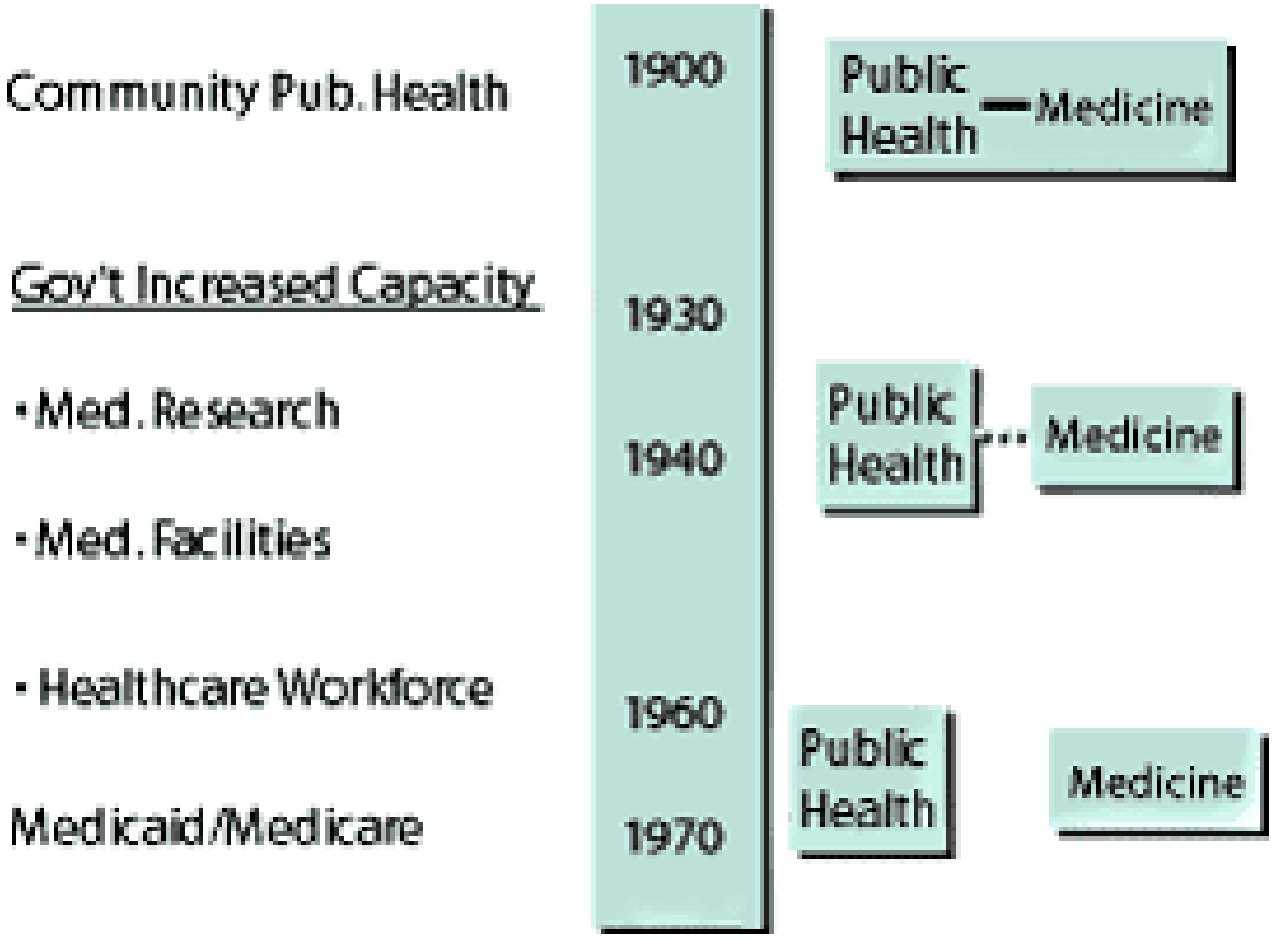
Chiropractic health care emphasizes the inherent recuperative power of the body to heal itself, and includes diagnosis, appropriate case management, and promoting total health.[1] By working in cooperation with other health care practitioners, doctors of chiropractic successfully integrate a balanced understanding of high-technology care with a conservative natural approach to holistic health care. Yet, during many key health policy and planning discussions at the local, state and federal levels, chiropractic health care providers still represent a largely unrecognized and untapped health care workforce resource in this nation's health care system and public health needs. How might we, as individual practitioners and as a profession, most effectively change that? How might we best position ourselves for the opportunities and challenges currently before us?

To fully understand where we are now, it's helpful to compare from where we've come. The following timeline briefly summarizes some of the health policy milestones in the development of the health care system and public health.

In the early part of the 20th century, the prevalence of infectious disease was the most important health problem. That early period was characterized by a closely connected and supportive relationship between the practice of medicine and public health in implementing the key public health strategies of the day: quarantine; sanitary reform; safe water systems; pasteurization; and personal hygiene.

The health policy approach during the period surrounding WWII can essentially be summed up as "more is better." Bolstered by a strong economy and national optimism, policies and resources were directed toward building the infrastructure and capacity of the health care system. Support was expanded for medical research that linked to the government's public health responsibilities, e.g., the National Cancer Institute, established in 1937, the forerunner of the Centers for Disease Control and Prevention (CDC) established in the 1940s, etc. Under the Hill-Burton Act of 1946,

public resources were targeted toward constructing more, and better hospital facilities.



During the first half of the 20th century, the discovery and improvement of a broad array of effective pharmacological agents, and diagnostic and therapeutic procedures further strengthened the technologically-oriented biomedical paradigm. The major causes of death and disability were increasingly shifting away from communicable disease to chronic disease. Interestingly, this technological evolution of biomedicine, coupled with changes in the social health burden and health policy priorities, had the added effect of increasingly separating the function and culture of medicine from that of public health.[2]

The next several decades (1960s through 1980s) were marked by major transitions in health care policy, the impact of which continues to shape today's evolving health care system. The direct role of the government up to that time had been largely confined to general public health activities, such as ensuring food and water safety. The government also assumed responsibility for directly providing health services to certain underserved populations outside of the private sector, (e.g., care for Native Americans through the Indian Health Service Act.) Health policies allowed the government to indirectly shape the health care system by building the capacity (mainly facilities) of what had become a largely privatized medical industry. Capacity-building policy efforts during the latter half of the century also emphasized greater production of the health care workforce to meet the assumed societal need, e.g., National Health Service Corps; Health Professional Educational Assistance Act; and the Nurse Training Act of the 1960s; and the Comprehensive Health Manpower Training Act of 1971. With the passage of Medicare and Medicaid legislation in the mid-1960s, the government, as a major purchaser of services, further financed the privatized medical industrial complex that it had helped to build. By the end of the century, public health and privatized medicine had diverged into two distinct sectors, characterized more by their differences than by

their commonality.[2]

So, in light of the above discourse, what lessons can we apply to chiropractic health care?

Perhaps the most obvious is that "public health" is not synonymous with "medicine," nor are public health activities the sole purview of medicine. Perhaps more to the point, chiropractors that assume the professional responsibility for providing essential public health services within their chiropractic practices are not "practicing medicine."

Patients and purchasers of health care seek the best value for their health care dollars. The chiropractic health care profession can increase its value to individual patients and to society by providing fundamental public health services such as screening (e.g., for hypertension and diabetes), allowing for prompt referral and timely intervention in cases of identified medical need. The value of chiropractic health care is enhanced when chiropractic practice includes public health services such as prevention and health promotion (e.g., smoking cessation; weight management; stress reduction; exercise; and other lifestyle interventions).

In addition to improving the delivery of public health services within their practices, chiropractic health care professionals can, and should, engage in the dialogue and activities of the larger public health arena. At the local and state levels, doctors of chiropractic are increasingly volunteering and being invited to contribute to public health planning and policy development. Active participation by DCs in national organizations such as the American Public Health Association (APHA) provides highly visible and effective opportunities for interacting with public health workers; health care providers; educators; administrators; policymakers; and research scientists. The APHA Chiropractic Health Care section (APHA-CHC) offers continuing education credits for DCs attending the annual APHA meeting sessions.

For the past 30 years, attempts to increase the health workforce capacity in medically underserved areas (e.g., through federal National Health Service Corps and statewide Area Health Education Centers) have met with less-than-optimal success. To what extent might doctors of chiropractic help to address continuing problems of health professional shortages? Can DCs meaningfully improve access to health care for underserved populations? Further, are "capacity-building" policies, such as student loan repayment programs for service to underserved populations, relevant to chiropractic healthcare delivery?

Interestingly, part of the answer rests in the position stated earlier: Doctors of chiropractic can unequivocally demonstrate added value to the health care they deliver by documenting that they provide essential public health services such as screening, prevention, and health promotion to their patients and to the larger community. As the principle legitimate profession emphasizing a natural, holistic, noninvasive, conservative, and wellness-oriented approach to health care, chiropractic is well positioned to assume a key leadership role in public health. If not us, then who? And what better time to assume it than now?

Further information on APHA membership and chiropractic CE for license renewal can be found at the APHA-CHC website: www.apha.org/sections/sectwww.htm.

References

1. Association of Chiropractic Colleges. Issues in chiropractic: *The ACC Chiropractic Paradigm.* Position Paper #1. July 1996.
2. Lasker RD, and the Committee on Medicine and Public Health. M*edicine & Public Health: The Power of Collaboration*, New York Academy of Medicine, 1997. Monograph on World Wide Web: http://www.nyam.org/pubhlth.

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