Dynamic Chiropractic

CHIROPRACTIC (GENERAL)

Chiropractic and National Health Care Reform

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Chiropractic health care is low-cost, high-yield health care. An ever growing body of scientific and professional literature (Meade et al., 1990; Shekelle et al., 1991 a&b; Waagen, 1986) suggests that chiropractic care is clinically and cost effective for many of the health problems that have driven health care costs in America to their current crisis stage, especially musculoskeletal and stress-related conditions. The prestigious journal, Science, has estimated that for every dollar spent on chiropractic care, four dollars could be saved (British study, 1990). Funded solely by the chiropractic profession, the RAND Corporation recently assembled a panel of expert clinicians and researchers in medicine and chiropractic, who concluded that despite the unevenness of the available data, "support is consistent for the use of spinal manipulation as a treatment for patients with acute low back pain and an absence of other signs or symptoms of lower limb nerve root involvement." Lesser degrees of scientific scrutiny and support were available for other subcategories of back pain (Shekelle et al., 1991 a&b). Investigators in a retrospective but case-controlled comparison of chiropractic vs. medical care for workers' compensation claimants in Utah found that "cost for care was significantly more for medical claims, and compensation costs were 10-fold less for chiropractic claims" (Jarvis et al., 1991). Last year, the British Medical Journal reported a randomized clinical trial of manipulation vs. physiotherapy vs. medical care of 256 patient with back and neck pain (Koes, 1992). At one year follow-up, manipulation was more effective in relieving pain and restoring physical function than either physiotherapy or medical care. These results essentially replicate the 748 patient-controlled comparison of chiropractic care vs. physiotherapy reported by clinical epidemiologist Thomas Meade a year ago, which concluded that "chiropractic treatment was more effective than hospital outpatient management mainly for patients with chronic or severe back pain. ... The benefit of chiropractic treatment became more evident throughout the follow-up period. Secondary outcome measures also showed that chiropractic was more beneficial" (Meade et al., 1990).

We believe that this growing body of scientific evidence emphatically supports our contention that chiropractic care is a sensible first choice for patients with musculoskeletal disorders, particularly back pain. We appreciate the efforts of this committee in recent years to include language inclusive of chiropractic colleges in authorizations for further clinical/scientific research through the Agency for Health Care Policy & Research (AHCPR) and the Public Health Service. We are aware of several significant studies now under way or under consideration (e.g., at AHCPR) which will further our knowledge of how best to help our patients, and we urge this committee to maintain its vigilance in monitoring the progress of these studies. We are encouraged that the Congress, like the American people themselves, are increasingly supportive of the potential benefits of chiropractic and related alternative health care providers (Eisenberg et al., 1993). We note also that health care researchers have confirmed that our patients are especially appreciative of the quality and manner of care provided by doctors of chiropractic (Cherkin et al., 1989). We believe that the superior satisfaction reported by chiropractic patients is a strong additional argument in favor of the primary care capacity of the chiropractic physician.

Despite this progress in establishing the scientific basis of chiropractic care for musculoskeletal problems, the broader primary care role of chiropractic physicians, and the potential economic

advantages it could offer have scarcely been addressed by health care researchers and policymakers. For 98 years the chiropractic profession has emphasized the preventive role of the doctor. We have pioneered in the provision of health education in areas such as diet and nutrition, regular exercise, and the avoidance of unnecessary drugs. In the case of the elderly, chiropractors have emphasized outpatient care and the maintenance of those functional abilities (such as walking) which enable senior Americans to maintain their physical fitness, and to remain in their homes and in charge of their lives for longer periods. In so doing, our clinical services have helped our society to avoid extraordinary costs of nursing home placements. We have traditionally provided clinical care to underserved, rural Americans: not infrequently chiropractors have been the only doctors available in specific regions. We have, in fact, functioned as gatekeepers to the health care delivery system.

The credibility of chiropractors' potentially broad role in improving the health of the nation and in reducing health care costs to society continues to suffer from our century-long isolation from the centers of scholarship and clinical investigation which are so readily available to other health care providers, including universities, teaching hospitals, the Veterans Administration, and the National Institutes of Health. For the most part the progress made in improving standards of quality of care in chiropractic, such as the recently developed Mercy Guidelines (Mercy 1992) have come almost exclusively through the efforts of chiropractors and without the assistance of government, as is so often the case for other health care disciplines. Accordingly, we take this opportunity to request of Congress that a focused and deliberate program of capacity-building in chiropractic research and education be initiated. Innovative programs could originate in the AHCPR, the National Institute for Arthritis, Musculoskeletal, and Skin Diseases, the National Institute on Aging, the National Institute of Disability and Rehabilitation Research, the Veterans' Administration, the Armed Forces, and the Department of Education. These strategies should include:

1. Continued efforts to encourage significant growth in outcomes research of conservative methods of health care. Target groups should include patients with debilitating spinal and musculoskeletal disorders, stress-related conditions, the needs of the elderly, military personnel, veterans, and other underserved populations. The clinical talent at chiropractic institutions makes these institutions an obvious and most strategic place to invest dollars in outcome studies of conservative, cost effective care of a great many musculoskeletal health problems. Additionally, the efficiency of private chiropractic colleges could mean a greater savings for individual research projects. Overhead (indirect) costs for research at the largest medical research centers average about 40 percent, and can run as high as 70 percent. In contract, the indirect costs for clinical trials conducted at chiropractic colleges are often as low as 10 percent.

2. Innovative programs to encourage U.S. universities to establish and/or incorporate existing chiropractic colleges within their systems. Although U.S. chiropractic colleges enjoy federally recognized accreditation through the Council on Chiropractic Education, the continuing isolation of our institutions from universities severely restricts our ability to develop greater research and training capacity. Per capita support of the free-standing chiropractic schools would also aid in alleviating the exceptional tuition dependency which now limits the ability of our institutions to meet the challenges of health care reform. Federal funding for educational innovation and outcomes research would aid in breaking down a century of anti-chiropractic bias in the wider health science and health education communities. A federal investment in university-based chiropractic colleges would produce increased stability of the infrastructure of the schools by reducing dependence on tuition as the primary source of operating funds. This tactic alone would enable future chiropractic physicians to receive a better education and to incur less debt upon graduation.

3. Funding to provide doctoral (PhD) level training to doctors of chiropractic in the clinical sciences, particularly including clinical epidemiology and public health. These are the disciplines more strongly associated with the sorts of clinical investigations (effectiveness, economy) which could determine the potentially broad usefulness of chiropractic methods. There currently exist no DC/PhD programs in the United States, although physician-scientist (e.g., MD/PhD, DO/PhD) training is available in other health disciplines. To our knowledge, the only significant source of educational support for chiropractors who wish to pursue advanced training (e.g., the PhD) in the health sciences is the Foundation for Chiropractic Education & Research. The federal government has yet to make any investment in postdoctoral training of chiropractors.

4. Programs to encourage the National Institutes of Health to recruit doctors of chiropractic for fellowships with the NIH's intramural research programs. Relatedly, the Veterans Administration, which provides substantial research and training services for medical colleges throughout the nation, ought as well to make its facilities available to and encourage collaboration with colleges of chiropractic.

5. Programs to mandate access for chiropractic faculty and students to the teaching hospitals of the United States. Chiropractors, no less than doctors of medicine, osteopathy, dentistry, and podiatry, require the opportunity to observe patients with the diversity of illnesses to which humans are susceptible.

6. Demonstration projects to evaluate the competence of chiropractic physicians to serve as health care providers in the various branches of the armed forces. Although Congress and the executive have now approved the commissioning of doctors of chiropractic within the medical corps of the armed forces, the prospects of any chiropractor being so commissioned seem minimal until appropriations for implementation are forthcoming. Ironically, back pain and related musculoskeletal problems are among the most frequent reasons for disability and discharge among servicemen; chiropractors' ability to maintain our fighting forces in peak condition merits serious investigation.

7. Funding to further develop competency-based, problem-oriented education in chiropractic colleges. Modeled after the experimental program in medical education at Harvard University -- "New Pathways" -- the ADVANTAGE program now under way at the Los Angeles College of Chiropractic provides a model for innovative efforts in problem-based learning. Problem-based curricula with small group active learning tactics have been shown to significantly influence doctors' capacity for critical thinking, and encourages the adoption of life-long learning habits among doctors.

8. Funding to further the seminal efforts of the chiropractic profession to develop, refine, and implement standards of quality of care, such as the initial efforts of the Mercy Center Conference (Mercy, 1992). Procedures for creating data-based consensus guidelines for primary care providers are being developed by the AHCPR; the chiropractic profession should be included in this process and should be assisted in our efforts to improve standards for patient care.

Forty thousand doctors of chiropractic are positioned throughout the nation to provide quality health care to Americans. We are not specialists, rather we are primary care providers with special skills in dealing with the neuromusculoskeletal systems of the body. We are strategically placed to make significant contributions to health care reform: We emphasize prevention, maintenance of functional abilities, a holistic view of the individual patient, and we do so at lower cost per condition than comparable services from other providers.

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