



Profile of the complementary and alternative medicine workforce across Australia, New Zealand, Canada, United States and United Kingdom

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Summary

Background: Despite the expressed demand for complementary and alternative medicine (CAM) services in developed countries, little is known about the CAM workforce in terms of supply and composition.

Objective: To describe the CAM workforce across five developed countries to better inform health workforce and health services planning, and per chance, inform debate on future public health and primary care policy.

Methods: Data from the Australian, New Zealand, Canadian, UK and US Censuses of population were interrogated for information pertaining to the size and characteristics of the CAM workforce. This was supplemented by other population-level workforce data where available.

Results: The quality and availability of population-level data on the CAM workforce vary substantially across nations. Of the nine CAM disciplines explored, massage therapy consistently comprised the largest portion of the CAM workforce, followed closely by chiropractic. Disciplines in shortest supply were homoeopathy in Australia, traditional Chinese medicine in New Zealand, and naturopathy in the US. Across the broader CAM workforce, practitioners were typically female, aged ≥ 40 years, worked within a primary care setting, held a vocational or higher education level qualification, worked full-time, and earned $< \$1000$ gross per week.

Conclusions: This work has helped shape current understandings of the CAM workforce. In doing so, it will help to inform the training and continuing education needs of the evolving CAM workforce, and further, ensure the provision of a competent CAM workforce to service the needs of consumers. Addressing the many limitations of existing data sources will assist in meeting these needs.

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Introduction

Complementary and alternative medicine (CAM) represents a diverse range of health-related therapies and interven-

tions that are largely considered to be outside the realm of Western medicine. Consumer interest in complementary and alternative medicines and CAM services has increased over the past decade. Recent data indicate that a large proportion of the population of developed countries,¹ including Australia (52–69% of those surveyed),^{2,3} Canada (59–60%),⁴ the United States (62%),⁵ Singapore (76%)⁶ and Japan (50%),⁷

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have used CAM at least once over a twelve-month period. Over the same period of time, close to twelve percent of Canadian adults,⁸ sixteen percent of US adults,⁹ twenty-six percent of English adults,¹⁰ and twenty-three¹¹ to forty-four percent of Australians³ had consulted a CAM practitioner, with massage being the most commonly used service.

Even though a comparatively greater proportion of the population of developed countries visit Western medical practitioners (i.e. >77%) than CAM practitioners,^{12,13} there is surprisingly little difference in the total number and cost of visits between groups, at least in Australia. For instance, in 2005, Australian adults made an estimated 69.2 million visits to CAM practitioners, at an estimated cost of AU\$1.73 billion. In the same year, there were approximately 68.9 million consultations with Western medical practitioners, at a total cost of AU\$1.6 billion.³ In the US, the out-of-pocket costs for CAM services are far less than Western medical care. In 2007, US adults made 354.2 million visits to CAM practitioners, at an estimated out-of-pocket cost of US\$11.9 billion¹⁴; the out-of-pocket cost of Western physician services in the same year was \$US46.8 billion.¹⁵ These data provide clear evidence of expressed demand for CAM services in developed countries, which is not too dissimilar from the expressed demand for Western medical services.

There are several explanations for the increasing use of complementary medicines and CAM services across the globe.^{2,9} Earlier studies have suggested that consumer dissatisfaction with Western medicine may be a leading reason for CAM use¹; however, more recent reports indicate that an aspiration for active health-care participation, greater disease chronicity and severity, holistic health-care beliefs, and an increase in health-awareness behaviour are more likely to be associated with CAM use.^{16–18} These transformations in consumer attitude and health behaviour have paralleled changes in the way many CAM specialties practice.¹⁹ This suggests that complementary medicines and CAM services are addressing unmet needs in health care.

Despite the increasing demand and need for CAM services in developed countries, little is known about the CAM workforce in terms of supply and composition; and apart from a few workforce surveys, which are hampered by narrow scope, limited data, poor response rates, and/or moderate-sized convenience samples,^{20–23} little has been published in the public domain. Without knowledge of the composition of the CAM workforce, it is difficult to (1) understand the diversity and characteristics of the CAM workforce, (2) meet the training and continuing education needs of the evolving CAM workforce, and (3) ensure the provision of a competent CAM workforce to service the needs of consumers. In recognising these concerns, this article describes the CAM workforce across five developed countries in order to better inform health workforce and health services planning, and perchance, inform debate on future public health and primary care policy.

Methods

Geographical regions were limited to organisation for economic cooperation and development (OECD) countries as the increasing demand for CAM is largely reported in these developed nations. Of these countries, only those that provided publicly accessible census data on the CAM workforce

were considered. Five countries were selected: Australia, New Zealand, Canada, United Kingdom and the United States.

The CAM workforce was defined as any health service not considered a core component of Western medicine, nursing or allied health,²⁴ and delivered in any industry of employment. This included, but was not limited to, system-based therapies (e.g. naturopathy, herbal medicine, traditional Chinese medicine [TCM], acupuncture, homoeopathy) and manipulative therapies (e.g. chiropractic, osteopathy and massage therapy). Diagnostic techniques (e.g. iridology, kinesiology) were excluded.

Census data were acquired by request where possible (e.g. Australia and New Zealand), and where requests for data were not feasible or cost-prohibitive (e.g. UK, US and Canada), data were sourced from the websites of each census administrator. Data from the 2006 Australian Bureau of Statistics Census of Population and Housing, 2006 Statistics New Zealand Census of Population and Dwellings, 2006 Statistics Canada Census of Population, 2001 UK Office for National Statistics Census, and the 2000 US Census Bureau Census of Population and Housing were interrogated for information pertaining to the size of the CAM workforce, as well as key characteristics of the workforce, such as age, sex, primary discipline, highest level of education attained, industry of employment, hours worked per week, and gross weekly income. These five population censuses were selected as they employed similar study methods, used comparable survey items, and provided high-quality data that were highly representative of each national population (Table 1). Where possible, census information was supplemented by workforce data reported by other pertinent sources where the publication date closely approximated the census date of the selected country. While more recent censuses have been conducted across four of the five selected countries (i.e. Australia, Canada, UK and US), detailed occupation data were not publicly available from any of these censuses during the conduct of the project.

Available data were analysed descriptively using frequencies and percentages. Workforce populations were converted to patient-provider ratios to allow for international comparisons. General/family practitioner population data were included as a point of reference only.

Results

Quality of CAM workforce data

The Australian and New Zealand Census of population provided the most comprehensive population-level data on the CAM workforce; although, data were only available for seven distinct CAM disciplines (Table 1). The Canadian Census of population provided data for most fields of interest, but only for chiropractors and general practitioners. Data for all other CAM occupations were reported in aggregate form with other non-CAM occupations and were not useful for occupation-specific workforce planning. US population census data were limited, with data available for only few fields of interest for chiropractors and massage therapists; data for most fields had to be sourced from workforce surveys. Data for all other occupations were reported in aggregate form

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