

Chapter 6: Access and Delivery

In Town Hall meetings across the country during the past two years, people voiced a number of concerns about access of the public to Complementary and Alternative Medicine (CAM) practitioners and products. Issues raised include access to qualified CAM practitioners, state regulation of CAM practitioners, integration of CAM and conventional health care, collaboration between CAM and conventional practitioners, and the cost of CAM services. Many people who testified, including those who have only limited access to "basic health care", expressed a desire for increased access to safe and effective CAM, along with conventional services.

As is true for conventional health care, many factors influence access to CAM services and their delivery. The distribution and availability of local providers, regulation and credentialing of providers, policies concerning coverage and reimbursement, and characteristics of the health care delivery system all affect the quality and availability of care and consumer satisfaction. Equally important, access is limited by income, since most CAM practices and products are not covered under public or private health insurance programs. As with conventional care, access to CAM is more problematic for rural, uninsured, underinsured, and other special populations. The issue of access is further compounded by lack of scientific evidence regarding safety and effectiveness of many CAM practices and products.

A better understanding of how the public uses CAM is needed in order to determine what can be done to improve access to safe and effective CAM within the context of other public health and medical needs. In addition, more information is needed on what constitutes "appropriate access" to CAM services.

Most CAM practices have developed independently of the conventional health care system and are not uniformly regulated by the states or the Federal government. A variety of market mechanisms and other arrangements have developed to pay for these services, including out-of-pocket payments, discounted fees, insurance reimbursement, and donated services. Where the public has had access to CAM services it has often been with little assurance of safety, quality, or efficacy. Moreover, because most consumers have had to pay for CAM services directly, access often has been limited to those with higher discretionary income.¹ An overview of insurance coverage and reimbursement for CAM is presented in Chapter 7.

As interest in CAM grows and as CAM increasingly enters the mainstream of American health care, mechanisms that worked in the past to help ensure safety and quality may no longer be adequate. For example, if CAM practices become eligible for reimbursement through the health insurance system, issues that now confront the conventional health care system - including safety, fraud, and

practitioner malpractice or incompetence - will need to be addressed for CAM. In addition, if private health insurance reimbursement for CAM services increases, questions of equity arise for beneficiaries of Federal - and state- sponsored health care programs, the underinsured, and uninsured.

Some people believe that existing practice structures have worked well for those who use CAM and that no further action is required. But market demand for CAM is already reshaping the dynamics of health care delivery, requiring that some issues be addressed. For example, insurers and managed care plans are offering CAM options more frequently, and integrated medical clinics and private practices are spreading. As more evidence is published on the safety and effectiveness of CAM practices, they are more likely to be incorporated into health care treatment protocols.

Now is the time to look at policy options for the future and to design strategies for addressing potential issues of access and safety. Beyond these basic concerns, protecting the public, maintaining free competition in the provision of CAM services, and maintaining the consumer's freedom to choose appropriate health professionals are issues to be considered when developing strategies and policies. Moreover, the need to maintain CAM styles of practice, rather than allowing them to be subsumed into the conventional medical model, also must be considered when addressing these issues.

If approached with both imagination and caution, the policy planning process could not only address these issues more effectively, but also a broader set of health issues affecting the nation, such as whether access to safe and effective CAM services can:

- Benefit vulnerable populations including those with chronic diseases, the terminally ill, and other populations with special needs;
- Lower health care costs and possibly increase access to conventional health care services for some segments of the population, such as the chronically and terminally ill; and,
- Help solve issues of equity and quality that do not set up a zero-sum struggle over limited resources.

The present state of evidence concerning the safety and effectiveness of various CAM practices precludes any final assessment of their contributions to and limitations in addressing these broader health issues. The process of gathering evidence is on-going, however, and as evidence increases concerning ways that various CAM approaches do or do not affect health, processes of living and dying, and costs for other care, access to and delivery of some CAM practices and services are likely to become more pressing public policy issues.

Meanwhile, public interest in CAM, and the market dynamics that have evolved in response to it, have brought issues of access to the forefront. Policy-makers

should begin to address these issues and examine the implications of different kinds of policy for consumers and practitioners, for clinics, hospitals and other organizational settings where health care is now delivered, and for the system as a whole.

CAM Practitioners and Public Safety

The public has expressed interest in maintaining easy access to CAM practitioners and in having sufficient information about them to make informed choices. Perceptions of the relative importance of being able to take responsibility for one's own health and health decisions, yet be protected from incompetent practitioners, underlie differences in consumers' response to possible state or Federal regulation of CAM. Public sentiment on the need for and degree of regulation ranges, with some calling for more regulation of CAM, to others who are opposed to any regulation. The Commission recognizes that Americans want to be able to choose from both conventional and CAM practices and that they want assurances that practitioners are qualified.

CAM practitioners have raised additional issues that are important to the public because they affect freedom of access to CAM providers. Some health care practitioners, both CAM and conventional, are concerned about liability and prosecution if the services they provide are not commonly accepted within conventional medical practice. Another concern of some CAM professionals is that they are licensed to practice in some states but not others, and that even where licensed, their scope of practice may vary across the country.

While some CAM professions endorse licensure requirements in order to participate fully in the health care delivery system, several people testified that licensure is not feasible for some categories of CAM practitioners, such as Native American and other traditional healers. Some CAM practitioners consider their disciplines to be educational (Alexander Technique) or spiritual (Reiki) and have expressed concerns about being licensed as health professionals. Some conventional health care practitioners who incorporate CAM modalities into their practices want to broaden the scope of practice laws to allow these modalities to be used.

Establishing legal authority to practice requires states to establish standards of practice, including training, education and continuing education requirements, as well as scope of practice. Some CAM professionals believe that to reorganize CAM on the conventional professional model, with the kind of licensure, registration, or exemption procedures that this implies, will damage the fundamental character of much of CAM. Some believe that in the past, legislation to "protect the public" was often used to restrict competition in the provision of services.

Five important issues of access and delivery concern both the public and practitioners:

- Protecting the public from the inappropriate practice of health care,
- Providing opportunities for appropriately trained and qualified health practitioners to offer the full range of services in which they are trained and competent,
- Maintaining competition in the provision of CAM and other health services,
- Preserving CAM styles and traditions that have been valued by both practitioners and consumers, and
- Determining the extent of the public's choice among health care modalities.

If addressed separately, these concerns can lead to very different public policies, and state legislation that affects access to CAM practices varies in its emphasis on these concerns. Therefore, when developing strategies to address problems of access to CAM practitioners, all of these criteria should be considered.

Evaluating State Approaches

Legislative and regulatory policies that affect conventional and CAM practitioners fall largely under the aegis of state governments, primarily through regulation of practice. In recent years, a few states have passed legislation and enacted regulations that affect access to CAM practitioners. These regulations provide a natural experiment for solutions to access and delivery of CAM. If properly documented and evaluated, these ventures could provide information that may guide other states and the Federal government in future policy development.

Minnesota provides almost unlimited freedom to practice. Unlicensed practitioners must inform clients of their education, experience, and intended treatments, as well as possible side effects or known risks of the treatments. Clients must sign an informed consent statement acknowledging the practitioner is unlicensed, that complaints may be filed with the Minnesota Department of Health if treatment is unsatisfactory, and that they have the right to seek licensed care at any time. Requirements for practice are minimal, but practitioners are not exempted from liability for untoward outcomes. Licensed health professionals also may provide CAM services, as long as their provision of the services is consistent with regulations governing their licensure. In short, the Minnesota law preserves maximum freedom for CAM practitioners and consumers and relies primarily upon informed consent for protection of health care consumers.

In contrast, Washington provides licensure, registration, or exemption for various categories of CAM professionals, based on their education and the extent to which their profession prepares practitioners to assume responsibility for the total health care of clients. Regulations delineate standards of practice, the scope of practice allowable, education and training requirements for licensure, registration,

or exemption, and required professional oversight. Four CAM professional groups (naturopathic physicians, acupuncturists, massage therapists, and chiropractors) are licensed and regulated.

The emphasis in Minnesota is placed on granting all CAM professionals the freedom to practice with minimal restrictions, while holding them accountable for outcomes. The Washington law emphasizes licensure as the route to protecting consumers and the practice rights of some CAM professionals. The Minnesota law preserves the range of CAM practices without distinguishing among them, whereas the Washington law requires CAM practitioners to fit into a professional model in order to receive the rights and responsibilities granted conventional health care professions.

Other states vary considerably in their regulatory approaches to licensure and scope of practice. For example, chiropractors are licensed in all states, while acupuncturists, massage therapists, and naturopathic physicians are licensed in 40, 30, and 11 states, respectively. (Table 1 shows the distribution of CAM specialties by state.) These variations affect access to and delivery of CAM by limiting practitioners' ability to practice lawfully and to obtain malpractice insurance. On the Federal level, several bills have been introduced into recent sessions of Congress that could affect access to CAM, including some that allow greater latitude for unconventional treatments. Any Federal legislation drafted in the future should consider the experience states are acquiring through their various legislative initiatives.

A number of factors should be studied when evaluating state models of creating access and delivery and protecting the public. Health services research should document how different legal frameworks affect access to CAM and how this different access affects health outcomes. Other issues to be considered include how state regulations affect the supply and distribution of various CAM practices and practitioners over time, as well as competition and costs of services. Also important are the effects of different regulatory models on the safety of the population, problems that may arise from use of different models, and the impact on conventional health care practitioners. Changes in the amount of time and quality of interaction with consumers of CAM services might also be assessed through periodic surveys. As evidence becomes available about the impact each regulatory model is having, the lessons learned can help inform choices that other states and the Federal government will be making.

Authority to practice has real impact on access to and delivery of services. The Department of Health and Human Services should gather and assess information about effects of these laws on the public's health as well as on access to CAM and CAM practitioners.

Recommendation 18: The Department of Health and Human Services should evaluate current barriers to consumer access to safe and effective CAM practices and to qualified practitioners and should develop strategies for removing those barriers in order to increase access and to ensure accountability.

Actions

- 18.1 The Department of Health and Human Services should assist the states in evaluating the impact of legislation enacted by various states on access to CAM practices and on public safety.
- 18.2 The Department of Health and Human Services and other appropriate Federal agencies should use health care workforce data, data from national surveys on use of CAM, regional public health reports on CAM activities and other studies to identify current and future health care needs and the relevance of safe and effective CAM services for helping address these needs.

Regulatory Frameworks

States, in exercising their authority over health care practitioners, should consider where a regulatory infrastructure for CAM practitioners might be necessary in order to promote quality of care and patient safety. The primary mechanisms used by states to regulate health care practitioners are:

- Mandatory Licensure, which prohibits the practice of a profession without a license. Licensure denotes a high degree of professional development, including consensus within the profession concerning standards of education, training, and practice, and the ability to self-regulate.
- Title Licensure, which permits anyone to practice the modality, but allows only those granted a license to use the title. A demonstrable level of skill or training normally is required for title licensure.
- Registration, which is granted in some states to professionals such as dietitians and pharmacists upon completion of required training and exams, is in other states simply a requirement that a provider register his or her name, address, and training with a designated state agency. This type of registration prohibits non-registered individuals from practicing and gives the agency authority to receive consumer complaints and revoke registrations.
- Exemption, which accords special status to religious healers. Medical licensing statutes do not apply to these healers, provided they practice within the tenets of a recognized church.

State and Federal policy-makers and others with an interest in these issues should recognize three unique challenges that face regulation of CAM

practitioners. First, views vary among CAM practitioners regarding how much training should be required for licensure in any given field, the extent to which such training should be required for licensure, and whether and how such education and training can incorporate intuitive skills and individualized approaches to providing health care services. For many CAM providers, licensure presents a tension between the desire to increase standardization of CAM education, training, and practices across states and the desire to keep CAM practice flexible, non-standardized, and linked to subjective, interpersonal and intuitive aspects of care. While increased licensure of CAM may help facilitate research, ease referrals, enhance patient access, and increase consumer protection, it may decrease individualization of services, time spent per patient, and range of patient options, qualities of CAM practice valued by practitioners and patients alike.

Second, variation in what constitutes "CAM" makes any assessment of CAM as value-added services difficult. Disagreement also surrounds the nature and scope of various CAM professions. In 2001, the University of California, San Francisco Center for Health Professions published a report that addresses this issue². Questions it raised include: How does the profession describe itself in terms of the types of care it provides, and the types of care that are beyond its professional scope? Are there differences of opinion within the profession about the range of care that is appropriate for the profession to provide? What interventions and modalities does the profession use? Answers to these questions will help define the various CAM professions.

A third, related concern involves the confusion and potential legal consequences that arise from the overlap of approaches and techniques used by CAM practitioners. For example, some states include homeopathy and acupuncture within the definition of the practice scopes for naturopathy or chiropractic, whereas others do not. Practitioners from states with a broad scope of practice who move to states with a more limited one may be unsure whether they risk state censure by providing these services. Confusion and legal risk can occur within a state if the legal authority to practice is not well defined or lacks clarity as to boundaries for practice. The potential for liability creates fear and uncertainty for some CAM practitioners. All providers, CAM and conventional, can be prosecuted if they are considered to have exceeded their scope of practice.

To address some of these issues the Pew Health Professions Commission, established in 1989, conducted an in-depth study of reform in the regulation of health care practitioners. They recognized that health care workforce reform would necessitate regulatory reform and created a task force to propose new approaches that would better serve the public's interest. In 1995, they published 10 recommendations for regulatory reform and offered policy options, hoping to stimulate debate and discussion by states.³ The recommendations focus primarily on regulation of conventional health care practitioners but they are

applicable to CAM practitioners as well. Recommendations from the Pew Commission Taskforce are in Appendix B.

Recommendation 19: The Federal Government should offer assistance to states and professional organizations in 1) developing and evaluating guidelines for practitioner accountability and competence in CAM delivery, including regulation of practice, and 2) periodic review and assessment of the effects of regulations on consumer protection.

Actions

- 19.1 The Secretary of Health and Human Services should create a policy advisory committee, including CAM and conventional practitioners and representatives of the public, to address issues related to providing access to qualified CAM practitioners, provide guidance to the states concerning regulation possibilities, and provide a forum for dialogue on other issues related to maximizing access.
- 19.2 The Secretary of Health and Human Services, in collaboration with states, should assist CAM organizations that wish to develop consensus within their field of practice regarding standards of practice, including education and training. The conclusions reached by CAM professional groups concerning these matters should be considered by states and regulatory bodies in determining the appropriate status of these practitioners for such regulatory options as registration, licensure or exemption.

Recommendation 20: States should evaluate and review their regulation of CAM practitioners and ensure their accountability to the public. States should, as appropriate, implement provisions for licensure, registration, and exemption consistent with the practitioners' education, training, and scope of practice.

Actions

- 20.1 The Department of Health and Human Services' policy advisory committee, in partnership with state legislatures, regulatory boards, and CAM practitioners, should develop model guidelines or other guidance for the regulation and oversight of licensed and registered practitioners who use CAM services and products. This guidance should balance concerns regarding protection of the public from the inappropriate practice of health care, provide opportunities for appropriately trained and qualified health practitioners to offer the full range of services in which they are trained and competent, maintain competition in the provision of CAM and other health services, preserve CAM styles and traditions that have been valued by both practitioners and consumers, and determine the extent of the public's choice among health care modalities.

Hospitals, Nursing Homes, Hospice, Community Health Centers, and other Health Care Delivery Organizations

Hospitals and Other Conventional Health Care Settings

Because of the increased use of CAM, access and safety issues involving delivery of CAM in hospitals, hospices, nursing homes, community health centers, and other health delivery organizations are increasing. Patients sometimes bring CAM products and even CAM practitioners into inpatient settings. Health delivery organizations vary in their policies and procedures regarding such situations, and there is little monitoring of interactions between CAM and conventional health care in these settings.

Health care facilities credential practitioners who provide services at their facilities. The question of who may practice and under what conditions within health delivery facilities is not addressed consistently for CAM practitioners. In some facilities, CAM practitioners who are not credentialed are permitted to provide services to patients; in others, only practitioners already credentialed by the facility may provide services.

Issues of safety and quality of care also arise when conventional practitioners who are credentialed by a facility use CAM in their practice. An increasing number of physicians use CAM practices for their patients in both inpatient and outpatient settings.

One way to address the growing number of issues related to the use of CAM interventions in hospitals, nursing homes, hospices, other clinical settings, and home health care is through the initiatives and leadership of nationally recognized accrediting organizations, including those that accredit health care networks and managed care organizations. For example, the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), an independent nonprofit organization, surveys and accredits nearly 18,000 facilities, other health delivery settings, and health plans using professionally based standards to measure compliance. Other nationally recognized accrediting organizations include the National Committee for Quality Assurance and the American Accreditation HealthCare Commission. The efforts of these organizations to address CAM in all health care settings will contribute greatly to the public's safety. In addition, these efforts will assist state and Federal regulators of health delivery organizations and health plans, who often use accreditation as a proxy for government oversight.

One important initiative that national accrediting organizations may take is to review their standards, guidelines, and interpretations for areas that affect or are affected by trends in CAM. For instance, one JCAHO standard addresses "the

relationship of the hospital staff and its staff members to other health care providers, educational institutions, and payers." In this case, more specific guidance is needed as to how a facility can meet the standard when incorporating CAM interventions into hospital services, serving as a component of an integrated delivery system that includes CAM, or participating in collaborative treatment plans with CAM providers.

The work of national accrediting organizations includes not only a wide range of standards and guidance, but also measurement tools, quality and performance improvement initiatives, and surveys. The work usually is conducted by staff along with representatives of the health care industry, other industry experts, and consumers who serve on various committees and special working groups. It is important for national accrediting organizations to include CAM experts and representatives of CAM organizations on any group that addresses issues related to CAM.

Recommendation 21: Nationally recognized accrediting bodies should evaluate how health care organizations under their oversight are using CAM practices and should develop strategies for the safe and appropriate use of qualified CAM practitioners and safe and effective products in these organizations.

Actions

- 21.1 National accrediting bodies, in partnership with other public and private organizations, should evaluate present uses of CAM practitioners in health care delivery settings and develop strategies for their appropriate use in ways that will benefit the public.
- 21.2 Nationally recognized accrediting bodies of health care organizations and facilities should consider increasing on-going access to CAM expertise to ensure that processes to develop accreditation standards and interpretations reflect emerging developments in the health care field.
- 21.3 Nationally recognized accrediting bodies, using CAM experts, should review and evaluate current standards and guidelines to ensure the safe use of CAM practices and products in health care delivery organizations.

Community Health Centers, Hospices, Independent Centers and Other Programs

A growing number of Americans use community health centers and other public health programs to meet their health care needs, including help with mental health and substance abuse treatment. These centers and programs often emphasize patient-centered care. A few community health centers have begun to

use the services of CAM practitioners such as chiropractors, naturopathic physicians and acupuncturists. These centers might serve as models for the use of CAM practitioners by other community health centers and other public health service programs; however, they need to be evaluated to determine their impact on health care access and cost-benefits.

Hospice care for the terminally ill is another important model that should be evaluated further. Some hospice programs are beginning to include CAM practitioners on the treatment team. Some of the CAM practices they use are chiropractic, acupuncture, music therapy, meditation, and visualization. In some instances, these services are believed to help reduce anxiety and pain.

Some independent CAM centers, which may not have any direct hospital affiliation and may not have a physician on staff, also offer a variety of CAM services. These centers tend to be client-oriented with flexible hours and a broad spectrum of practitioners available. Many of the centers encourage patients to actively improve their health and concentrate on health maintenance rather than disease care and encourage coordination and collaboration among CAM practitioners who are seeing the same patient or client. More information is needed on who uses these centers, their impact on access and delivery, whether appropriate referral procedures are in place, and the quality of care provided. Only when more systematic data are available can the advantages and disadvantages of independent CAM centers be assessed.

Special and Vulnerable Populations

Special populations, such as racial and ethnic minorities, and vulnerable populations, such as the chronically and terminally ill, have unique challenges and needs regarding access to CAM. Efforts to address access to CAM need to be balanced with the need for access to conventional health care. Scarce resources need to be carefully allocated so that these populations are not denied opportunities available to others to access safe and effective conventional and CAM services.

Increased information on CAM use and barriers to access for these populations is needed. Although some studies have described CAM use among African Americans, Native Americans, Hispanics, and Asian Americans, reliable access and utilization data are largely lacking. In the case of Native Americans, information gathering is limited by their status as sovereign nations. Nonetheless, the Indian Health Service has a program to encourage communication with practitioners of traditional Indian medicine, which will help ensure safety when both Native American and conventional medical systems are used.

Surveys of CAM use in the general population indicate that it is being used disproportionately by highly educated, and upper-income Americans.⁴ However,

early studies used telephone interviews with English speakers, thus providing little information about CAM use among those who do not speak or have limited ability in English, who have lower income, or who lack telephones.⁵ Later studies corrected for these biases, but they did not use adequate statistical sampling to estimate the use of CAM in minority populations.^{6, 7, 8, 9, 10, 11} Other surveys have focused on low-income and ethnic groups, but these studies frequently had small, unrepresentative samples.^{12, 13, 14, 15} The National Center for Health Statistics is conducting a nationwide survey on access to and use of CAM among racial and ethnic minorities that is expected to provide statistically reliable estimates of CAM use in these groups.

In an October 2000 letter to community health centers and other public health programs, the Health Resources and Services Administration's Bureau of Primary Health Care (BPHC) endorsed the use of CAM in these centers where appropriate.¹⁶ In 2001 they began surveying the use of CAM by persons receiving health services from BPHC-funded community health centers. Information being gathered includes participants' use of six modalities (acupuncture, manual healing, botanicals and herbs, homeopathy, traditional healing, and mind-body techniques); whether the CAM service was provided onsite or by referral, either with or without payment by the community health center; and demographic data. Results should be available in 2002 and will provide a significant, statistically reliable portrait of the use of a variety of CAM services and products by community health center clients, whose come disproportionately from rural, low-income, and minority populations. It is important to continue collecting this kind of information in the future.

Discussions are currently underway between BPHC and the National Center for Complementary and Alternative Medicine to include clients of community health centers in CAM clinical trials, in order to increase the relevance of findings for application to the health needs of minority populations.

Use of CAM is especially high among populations with potentially life-threatening diseases. Surveys show that people with cancer use CAM practices and products more frequently than the population as a whole, with CAM most often being used in conjunction with conventional therapies.^{17, 18, 19} Similarly, there is high use of CAM by people who are terminally ill and their care-takers. Many people in these vulnerable populations are using CAM services regardless of whether they have insurance coverage and sometimes without the knowledge or cooperation of their conventional physician.

The chronically and terminally ill consume more health care resources than the rest of the population. Approximately 75 percent of all health care spending in the U.S. currently is for the treatment of chronic disease²⁰, and 25 percent of Medicare spending is for costs incurred during the last year of life.²¹ The great interest in CAM practices among the chronically ill, those with life-threatening conditions, and those at the end of their lives suggests that increased access to

some CAM services among these groups could have significant implications for the health care system. Health services research, demonstrations, and evaluations are needed to assess whether CAM services can improve care and quality of life for people in these groups, and possibly lessen the use of expensive technological interventions.

With the number of older Americans expected to increase dramatically over the next 20 years, alternative strategies for dealing with end-of-life processes will be increasingly important in public policy. This demographic shift should influence priorities for the kinds of research and demonstration projects that would be carried out in the near future. A more careful assessment of the potential and limitations of CAM approaches in the health care system as a whole might lead to more effective use of resources. For example, Congress could direct the Center for Medicare and Medicaid Services to develop a demonstration project to study evidence-based CAM interventions as part of comprehensive care of persons with chronic disease in both the Medicare and Medicaid programs. The demonstrations would assess health outcomes and total costs of care for beneficiaries in settings where physician leaders are committed to evidence-based medicine, high quality, client-centered care, and openness to CAM approaches. If evaluations show that some uses of CAM can lessen the need for more expensive conventional care in these populations, the economic implications for these Medicare and Medicaid could be significant.

If safe and effective CAM practices become more available to the general population, special and vulnerable populations should also have access to these services, along with conventional healthcare. CAM would not be a replacement for conventional health care, but would be part of the options available for treatment. In some cases, CAM practices may be an equal or superior option.

Evidence for assessing the potential of CAM interventions in treating vulnerable and special populations is still being gathered. While it is too early to judge the effectiveness of CAM in addressing their health care needs, CAM nonetheless offers the possibility of a new paradigm of integrated health care that could affect the affordability, accessibility, and delivery of health care services for millions of Americans.

Recommendation 22: The Federal government should facilitate and support the evaluation and implementation of safe and effective CAM practices to help meet the health care needs of special and vulnerable populations.

Actions

22.1 The Department of Health and Human Services and other Federal Departments should identify models of health care delivery that include safe and effective CAM practices, evaluate them, and then support those

- models which are successful for use with special and vulnerable populations, including the chronically and terminally ill.
- 22.2 The Department of Health and Human Services should sponsor the development and evaluation of demonstration projects that integrate the use of safe and effective CAM services as part of the health care programs in hospices and community health centers.
- 22.3 The Department of Health and Human Services should identify ways to support the practice of indigenous healing in the United States and to improve communication among indigenous healers, conventional health care professionals, and CAM practitioners.

Table 1. Provider Licensing by State and Specialty

STATE	CHIROPRACTORS	ACUPUNCTURISTS				MASSAGE THERAPISTS			NATUROPATHS	DIETITIANS		
	Licensing Laws	Licensing Laws	Access Requires MD Referral and/or Prior Diagnosis	MD Supervision Required	May dispense TCHS	MD Supervision Required	Licensing Laws Regulated	Licensing Laws Pending	Licensing Laws	Registration Laws	Licensing Laws	Certification Laws
Alabama	x											
Alaska	x	x							x	x	x	
Arizona	x	x							x	x	x	
Arkansas	x	x							x	x	x	
California	x	x								x		
Colorado	x	x								x		
Connecticut	x	x							x	x		x
Delaware	x									x		x
Florida	x	x								x	x	
Georgia	x	x								x	x	
Hawaii	x	x							x	x	x	
Idaho	x	x								x	x	
Illinois	x	x	x							x	x	
Indiana	x	x	x							x		x
Iowa	x	x								x	x	
Kansas	x									x	x	
Kentucky	x									x	x	
Louisiana	x	x		x		x				x	x	
Maine	x	x							x	x	x	
Maryland	x	x								x	x	
Massachusetts	x	x			x					x	x	
Michigan	x									x		
Minnesota	x	x			x					x	x	
Mississippi	x							x		x	x	
Missouri	x	x								x	x	
Montana	x	x							x	x	x	
Nebraska	x									x	x	
Nevada	x	x			x					x		
New Hampshire	x	x			x				x	x	x	
New Jersey	x	x	x		x					x		
New Mexico	x	x			x					x	x	
New York	x	x								x		x
North Carolina	x	x			x					x	x	
North Dakota	x									x	x	
Ohio	x	x	x	x		x				x	x	
Oklahoma	x									x	x	
Oregon	x	x			x				x	x	x	
Pennsylvania	x	x			x					x		
Rhode Island	x	x								x	x	
South Carolina	x	x	x	x		x				x		
South Dakota	x									x	x	
Tennessee	x	x								x	x	
Texas	x	x	x		x					x	x	
Utah	x	x							x	x		x
Vermont	x	x			x				x	x		x

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