HEALTH CARE SYSTEMS FACTORS AFFECTING BREAST CANCER TREATMENT CHOICES

by

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ABSTRACT

The purpose of this research was to explore and describe health care systems factors that influence treatment decisions for women with breast cancer in the United States (U.S.) and Norway. The specific aims of the study were to: (a) explore and describe how health care systems processes create barriers and facilitators of breast cancer treatment decisions for patients diagnosed with breast cancer in the US and Norway; and (b) compare and contrast the US and Norwegian system processes to identify advantages and disadvantages of each system as they relate to breast cancer treatments. A descriptive qualitative design was used to address the research aims and questions. Data were collected from key informants from the US and Norway. Content and matrix analysis were the primary descriptive and comparative approaches used for this study. First and second order matrices were created to display and analyze data obtained from key informant interviews. Findings indicate that financing allopathic care is a significant barrier for breast cancer patients within the US and financing CAM therapies are challenging in both countries. While allopathic treatment guidelines for breast cancer care are clearly outlined in both the US and Norway, both countries currently lack CAM treatment guidelines for use in this patient population, leading to inconsistent recommendations provided for patients. There are also significant barriers that prevent patient access of CAM providers, particularly by patients in an in-patient, hospital setting. Ultimately, when evaluating care and treatment plans for women diagnosed with breast cancer, health care providers should appreciate and acknowledge the significant system factors that may act as barriers or facilitators of care.
CHAPTER 1: INTRODUCTION

Health care systems and health policies have a powerful influence on health care delivery and ultimately health outcomes of a nation. A country’s health policies that focus on financing of health care, the structure and processes required to provide care, and governance of health care institutions and health provisions all affect the health care choices people make and the care that can be accessed and delivered to its citizens (Blank & Burau, 2007). Policies decide what types of treatments will receive reimbursement by third parties (private or governmental), the licensing and credentialing requirements that must be met by health care providers, and which providers will have access to specific patient populations.

Persons with chronic illnesses are particularly affected by health care policies because of their ongoing treatment decisions (Caspi, Koithan & Criddle, 2004). These decisions may include treatment types (allopathic or complementary/alternative), provider types (medical doctors, osteopathic doctors, nurse practitioners, physician assistants, or alternative therapists), and treatment locations (agency-based or community-based) (Balneaves, Truant, Kelly, Verhoef, & Davison, 2007). Health policies affect each of these decisions and the access that people have to a variety of services (Boon, MacPherson, Fleishman, Grimsaard, Koithan, Norheim, et al, 2006).

Breast cancer is a chronic illness where patients face multiple treatment decisions. Decisions are made about treatment of the disease process as well as management of symptoms (Love & Lindsey, 2000). Following disease treatment, breast cancer survivors continue to access the health care system to prevent recurrence, decrease the effects of treatments, and to improve the quality of their life (Ganz, Desmond, Leedham, Rowland, Meyerowitz, & Belin, 2002). These survivors report using a variety of health care services although at times their treatment
decisions have been negatively affected by shifting health policies and access to care; they are unable to afford desired services or they are unable to find credible providers for the services that they have selected (Balneaves et al, 2007). Therefore, it is important to examine how current health care systems factors affect the treatment choices for persons with a history of breast cancer.

This study used a descriptive qualitative design and comparative analysis techniques to explore the influence of different health care systems and health policies on treatments available to patients with breast cancer in Norway and the United States (US). While clinicians believe that there are differences in treatment pathways or trajectories constructed by women with breast cancer, the reasons for the differences are less well known. This study explored in greater depth the health care systems differences that exist between two countries participating in the parent project, Pathways of Cancer Care, a study that is currently underway in the US, Canada, and Norway to describe treatment decisions of persons with cancer. This paper reviews existing knowledge about cancer care, types of treatments used to treat cancer, health care systems issues as they relate to patients diagnosed with breast cancer, identifying current gaps in knowledge. This paper also identifies and describes the methods that have been used in this study and presents results. Lastly, a discussion and interpretation of data results are provided.

**Purpose and Specific Aims**

The purpose of this study was to explore and describe health care systems factors that influence treatment decisions for women with breast cancer in the US and Norway. More specifically, the purpose was to: (a) explore and describe how health care systems processes create barriers and facilitators of breast cancer treatment decisions for patients diagnosed with
breast cancer in the US and Norway; and (b) compare and contrast the US and Norwegian system processes to identify advantages and disadvantages of each system as they relate to breast cancer treatments. This study was an addendum to an existent international study, the Pathways of Cancer Care, extending that study’s description of treatment decision making patterns and factors that affect these treatment decisions during the cancer experience. Two aims, each with specific research questions, were identified for this study.

**Aim 1**

To explore and describe health care systems processes that create barriers and facilitators of breast cancer treatment decisions. This is accomplished by addressing several research questions, including: (a) What are the funding sources for allopathic care in the US and Norway? (b) What are the funding sources for complementary/alternative/integrated care in the US and Norway? (c) What access to health care providers processes are in place for each country? (d) What are the credentialing and regulation requirements for different types of health care providers in each country? (e) Are treatment guidelines used in each country? and (f) What are the breast cancer treatment goals in each country?

**Aim 2**

To compare and contrast the US and Norwegian system processes to identify advantages and disadvantages of each system, with respect to breast cancer treatment. Comparisons were completed by addressing the following questions: (a) What are the similarities/differences between funding for allopathic care? (b) What are the similarities/differences between funding for complementary/alternative/integrated care? (c) What are the similarities and differences in access to care? (d) What are the similarities/differences related to credentialing of allopathic and
CAM providers? (e) What are the similarities/differences for treatment guidelines? (f) What are the similarities/differences with respect to treatment goals?
CHAPTER 2: BACKGROUND

Health care systems experts and scientists interested in health care decision making claim that health care systems structures and processes, as well as the health policies that are implemented by different countries, have a profound impact on treatment decisions patients make (Institute of Medicine, 2009). A health system is defined as an organized plan of health services by which health care is made available to the population and financed by government or private enterprise or both. A health care system includes acute, chronic, and preventive health services; products; facilities; payment sources; teaching resources; and research structures/processes for the purpose of preventing and treating disease and restoring health. (Health care, 2009). Health policy consists of the actions taken by governments with the intent of affecting the health of its population (Blank & Burau, 2007). It encompasses elements of financing, provision, and governance (Blank & Burau, 2007).

Both health care systems and policies are specific geopolitical entities. Therefore, treatment decisions are based both on the intersect between what is known about the efficacy and effectiveness of specific treatment regimens (science) and the realities associated with access to and payment for particular services (politics, policy, and geography). It may well be that patients with the very same disease (breast cancer) are offered and then decide upon very different treatment pathways based where they live. Further, the cancer journey (the process of making decisions and the bio-, psycho-, social-, spiritual- responses to the decision making process) may be very different based on the impact that the health care system and the policy of the country of residence has on the decision making process.
At this time of health care reform in the US, it is critical to determine how the health care system affects the translation of science to care. Does policy affect the ability of the patient, as well as the provider, to seek the best care for any particular disorder, and does the health care system impacts decision making by patients? The opportunity afforded by the existent Pathways of Cancer Care Project was unique; it allowed an in-depth examination of the influence that health care systems and policy factors might have on treatment choices and decision making in two of the countries already participating in the study, the US and Norway.

Norway is recognized for its exemplary health care system and for its outcomes (Vallgarda, 2008). The World Health Organization (WHO) (2000) places Norway 11th, on its 2000 ranking of health status by country. Further, Norway’s health care system is often touted as an exemplar system in the US health care reform debate. In contrast, the US outspends Norway (in 2005, the US 15.2% of its GDP was spent on health care, while in the same year in Norway, 9.1% of its GDP was spent on health care) in health care costs while placing 37th on the list for overall health status by country (World Health Organization, 2005). This study explored differences contributing to this outcome and how those systematic differences between nations change the way that one particular disease is treated.

**Cancer Incidence and Prevalence**

Breast cancer is the second most common form of cancer affecting women within the US (skin cancers are most common), and it is the second leading cause of cancer-related deaths (lung cancer is the current leading cause) (American Cancer Society, 2010). Currently, women within the US have a 12% chance of developing breast cancer throughout their lifetimes (American Cancer Society, 2010). Death rates from breast cancer have been declining since the 1990s and
this decrease is believed to be related to screening programs (mammograms), early detections, and increased education (American Cancer Society, 2010). While there are numerous studies that present research on cancer, cancer treatments, and physical/psychological effects of cancer treatment trajectories, there is currently limited research about health care systems and how they may act as barriers or facilitators to receiving care.

**Cancer Care and Treatment Choices**

Care of patients with breast cancer is primarily focused on prevention and cure of the disease using traditional allopathic treatments, including chemotherapy, radiation, and surgery (mastectomy). This is particularly true in the US; treatment recommendations by National Cancer Institute (NCI) identifies five “standard” treatments for breast cancer, including surgery, chemotherapy, radiation therapy, hormone therapy, and targeted therapy (National Cancer Institute, 2009). These recommendations come with little surprise. Reimbursement for services in the US are largely focused on overcoming illness (White House Commission on Complementary and Alternative Medicine Policy (WHCCAMP), 2002), with a secondary emphasis on quality of life, functional status, and patient comfort.

What is somewhat unique is the US focus on prevention of breast cancer. Women within certain age groups and with particular risk factors are reminded continually to schedule yearly mammograms. This prevention activity is so important in US health care that mammograms and other preventive services for breast cancer are often offered free of charge for those who are under- or uninsured. Women are also urged to maintain a BMI between 18-25; eat low fat diets that are nutrient/vegetable rich; increase exercise; limit exposure to alcohol; reduce use of exogenous hormones, including estrogen and progesterone; and reduce levels of anxiety and
stress, all known risk factors associated with increased incidence of breast cancer, particularly among women in high-risk groups. What is seldom recommended by the NCI is the primary use of complementary or alternative therapies (Appendix A identifies categories of CAM) for the prevention and treatment of breast cancer, although there is increasing acknowledgement that integrative approaches are effective in reducing side effects and symptoms resulting from surgery, chemotherapy, and radiation.

One in three Norwegians are at risk for developing some type of cancer throughout their lives and that one third of these cancers may be prevented by making simple changes, including smoking cessation, limiting alcohol consumption, maintaining a healthy body weight, and eating a nutritious diet (Norwegian Cancer Society, 2009). Cancer care in Norway heavily focuses on prevention, focusing much of their resources on assisting patients to make positive lifestyle changes associated with decreasing cancer risk (Norwegian Cancer Society, 2009). The Norwegian Cancer Society identifies three goals to achieve during 2010, including reduce the risk of cancer, increase survival rate, and ensure optimal quality of life (Nordic Cancer Union, 2009). A main component of this initiative is prevention which includes education about smoking cessation, proper nutrition, and physical health maintenance.

The Cancer Registry of Norway focuses on the importance of early detection of breast cancer. The website discusses how breast cancer will affect one out of ten Norwegian women, as the most common form of cancer among women in Norway (Cancer Registry of Norway, 2010). Their website presents that early detection of breast cancer via mammograms and regular participation in the Norwegian Breast Cancer Screening Program decreases the risk of dying from breast cancer and makes breast-conserving surgery more possible (Cancer Registry of
Norway, 2010). This program is specifically available to Norwegian women ages 50 to 69 and they will receive free mammograms during this age timeframe (Cancer Registry of Norway, 2010).

While official treatment guidelines in the US do not point to “endorsement” of complementary or integrative strategies for breast cancer, there is increased use of CAM overall in US and international populations and specifically within the population of women with breast cancer. (Nahin, 2009). The situation is similar in Norway, where guidelines for CAM use in the treatment of breast cancer currently are not available, yet there is an increasing proportion of breast cancer patients who are accessing complementary and alternative therapies.

**Complementary and Alternative Therapy Use in the US and Norway**

Awareness of CAT therapy and its use has increased noticeably over the last few decades internationally (Fonnebo, Verhoef, & Paterson, 2007). Because of this growing understanding and use of complementary therapies, it is important to assess the regulation of, payment for, and access to these therapies during cancer care. The National Center for Complementary and Alternative Medicine (NCCAM) defines complementary and alternative medicine (CAM) as “a group of diverse medical and health care systems, practices, and products that are not presently considered an integral part of conventional medicine (NCCAM, 2005). Complementary medicine is used together with conventional medicine, and alternative medicine is used in place of conventional medicine.” (NCCAM, 2005). There are currently six categories of CAM including, mind-body, biological therapies, body manipulation, dance and movement therapies, energy therapies, and whole systems of medicine/care (NCCAM, 2010). Refer to Appendix A for complete definitions and examples of CAM categories.
Complementary Therapy Use in the US

The use of CAM in the US has steadily increased between 1998 and 2010 due, in part, to the growing belief that health is not simply the absence of disease or illness, but rather a holistic sense of well being (WHCCAMP, 2002). The White House Commission on Complementary and Alternative Medicine (CAM) policy statement, developed in 2002, provides recommendations about ways to incorporate CAM into health care for all ages of Americans (WHCCAMP, 2002). According to the 2007 National Health Interview Survey (NHIS) conducted by the National Center for Complementary and Alternative Medicine (NCCAM), approximately 38% of adults and 12% of children in the US use some form of CAM (NCCAM, 2009). This same survey found that CAM use in the US is highest amongst women, specifically those with higher levels of education and income (NCCAM, 2009). In the US, American Indians use CAM therapies more than any other ethnic group, closely followed by white Americans, and Asian Americans (NCCAM, 2009). Additionally, because the US has a complex and diverse system of health care financing, insurance reimbursement for CAM therapies varies depending upon the patient’s type of insurance.

Complementary Therapy Use in Norway

Norwegians show increasing interest in combining complementary therapies with traditional allopathic therapies to achieve a form of integrative care for cancer treatment. They are focused on providing holistic, patient-centered care that is supported by and accessible within governmental health care systems as well as private pay venues (Fonnebo & Launso, 2009; Gamst, Haahr, Kristoffersen & Launso, 2006).
Recent statistics (2007) indicate that 50% of the adult Norwegian population received some form of CAM within the past year. Similar to statistics in the US, Norwegian women report increased use of complementary therapies compared to Norwegian men, and the highest proportion of female users of CAM were in the 15-24 year-old age group (Fonnebo & Launso, 2009). In Norway, complementary therapies are provided within the publically funded health care system by licensed health care providers, including such widely used therapies as massage and acupuncture (Fonnebo & Launso, 2009). These CAMs can also be provided outside of the recognized health care system by independent providers (Fonnebo & Launso, 2009). According to a recent study in 2009 in Norway, CAM use was not influenced by the type of system used to access the services (Fonnebo & Launso, 2009).

**Complementary and Alternative Therapy Use for Cancer Treatment**

Cancer patients report rates of CAT use ranging from 5% to over 90% (DiGianni, Garber & Winer, 2002; Sparber & Wootton, 2001; Verhoef, Balneaves, Boon & Vroegindewey, 2005a). This range is partly due to the wide variation in CAM definitions, scope, target population, sampling strategies and analytical methods used in the surveys. In addition, reports of use vary widely because the actual incidence and prevalence of CAM is unknown because some treatments are reported to oncologists and surgeons, others are not. The Pathways of Care Project was designed to address this gap in the literature by prospectively questioning patients about their various treatments and self-care activities following the diagnosis of cancer.

CAM use during cancer is primarily complementary (used with allopathic therapies), not an alternative to conventional treatments. Internationally, biologically-based therapies are used most often, followed by mind body interventions (Hann, Baker, Roberts, Witt, McDonald,
Livingston, et al., 2005; Helyer, Chin, Chui, Fitzgerald, Verma, Rakovitch, et al., 2006; Molassiotis, Fernadez-Ortega, Pud, Ozden, Scott, Panteli, et al., 2005; Navo, Phan, Vaughan, Palmer, Michaud, Jones, et al., 2004; Scott, Kearney, Hummerston & Molassiotis, 2005; Yap, McCready, Fyles, Manchul, Trudeau & Narod, 2004; Yates, Mustian, Morrow, Gillies, Padmanaban, Atkins, et al., 2005). Patients with cancer often create individualized, more or less integrated, treatment packages in which they combine their conventional cancer treatment with complementary treatments ranging from herbal preparations to modalities provided by (conventional and CAM) practitioners (Caspi, Koithan & Criddle, 2004; Truant & Bottorff, 1999).

Reasons cited for CAM use vary. Cancer is a traumatic disease. It has high mortality and co-morbidity rates, in addition to the presence of side effects from many of the cancer treatments patients are expected to endure. Because of this, cancer patients explore a variety of treatment options including allopathic and complementary therapies (Fonnebo, Verhoef & Paterson, 2007). In addition, patients diagnosed with cancer may turn to complementary therapies because they have been told that they may not be cured through the use of conventional therapies (Kristoffersen, Fonnebo & Norheim, 2009). In total, there is an increased self-reported CAM use among cancer patients (Cassileth, Schraub, Robinson & Vickers, 2001).

**Complementary Therapy Use During Cancer in the US**

In the United States, use of CAM during cancer has steadily been increasing over the last 10 years (Eisenberg, Davis, Ettner, et al., 1998). A large proportion of those using CAM for cancer have done so within the last 12 months (Lo, Desmond & Meleth, 2009). Since regulation and licensure of CAM providers varies from state to state (Lo, Desmond & Meleth, 2009), it is
difficult to form a national consensus on the prevalence of use and the role of complementary therapies during cancer treatment. However, some states have health objectives stating that they plan to incorporate CAM practitioners into conventional cancer treatment programs, including Arizona (Lo, Desmond & Meleth, 2009). These and other changes in health policy may change the use of CAM by patients with cancer and may alter the way that cancer is treated in the US over the coming years.

**Complementary Therapy Use During Cancer in Norway**

According to a study from 1998, 45% of patients in Norway diagnosed with cancer received some form of CAM therapy to help treat their disease (Risberg, Lund, Wist, et al., 1998). Another study found that patients diagnosed with cancer and a poor prognosis were more likely to seek out and use complementary therapies compared to patients diagnosed with cancer with better prognoses (Norwegian Cancer Society, 2009). Therefore, Norwegians with cancer can choose to create treatment packages that include both allopathic treatment and CAM. What is not known is the influence of the Norwegian health care system (finance, access to providers, attitude/beliefs about CAM and cancer care by the health care system) and health policies on these treatment decisions by patients.

**Health Care Systems and Policy Overview**

Health care systems and health policies have a powerful influence on health care delivery and ultimately health outcomes of a nation. Blank and Burau (2007) state that health policies are actions that are proposed or carried out by a government that affect the health of its population. Health policy is influenced by many factors including, economics, social welfare, employment, and housing policy (Blank & Burau, 2007). Because of this interdependence, it is argued that the
health of a population may be equally dependent on these policies as it is on health policy (Blank & Burau, 2007). Health policies focus on the financing of health care, the structure and processes required to provide care, and governance of health care institutions and health provisions (Blank & Burau, 2007).

Funding focuses on the raising financial resources for the provision of care and the allocation of those resources to appropriate health care providers. Funding can be achieved through many different means, such as taxes and social insurance contributions to private insurance premiums, and by out-of-pocket payments by patients. The type of health funding results in different levels of public control as well as access to particular types of services (Blank & Burau, 2007).

Provision of care focuses specifically on the delivery of health care services. Services can come from many different providers, including public and private, profit and non-profit, hospitals. Depending on the mix of delivery systems, health care and types of services may be more or less publically integrated (Blank & Burau, 2007).

Governance refers to the modes of organizing health systems and their members. Governance is influenced by elements from public and private sectors of society and is generally thought of as a government authority over the health care system. It includes regulation of health areas including medical practice and pharmaceuticals (Blank & Burau, 2007).

These three sectors of health policy collectively play a great role in defining health system models (Blank & Burau, 2007). In turn, how a nation defines its health care policy affects access to and use of particular health care resources. Evaluation of these systems and policies is crucial if we are to understand the full package of care (allopathic, complementary treatments
and self-care regimens) that individuals use to treat particular diseases (such as cancer, diabetes, arthritis), the influence of systems and policy on the construct of these packages by patients and providers, as well as eventual outcomes of these different complex packages of care that people ultimately use.

Health care systems and policies are often examined in a “comparative context,” where similarities and differences between countries are evaluated in an attempt to resolve questions about health problems and issues (Blank & Burau, 2007). This type of examination is important in systems and policy evolution, because it provides cross-cultural insights that result in evidence that can help structure future global changes to health care systems and policies. This comparison offers a basis of evaluation to assess the relative successes and failures of specific health policies (Blank & Burau, 2007).

**Literature and Knowledge Gaps**

Differences in cancer treatment decisions between countries exist for many reasons in spite of shared knowledge about disease progression, recurrence, and the effectiveness of many treatment regimens. Reasons for those differences are poorly understood although it is most likely a complex interplay between health beliefs held by different populations, health care priorities, fiscal resources, health care systems (i.e., access to providers, reimbursement/payment for services, accepted treatment guidelines), and health policy. In the US, access to both conventional and CAM therapies is compromised by many factors, namely insurance, lack of insurance, or limited insurance, access due to geographic location, and many other systems and policy issues (Koithan, Maizes, Cook & Konkel, in review). Therefore, the interplay between treatment decisions during cancer and health care systems need to be more closely investigated.
CHAPTER 3: METHODS

Sample

Key informants from the US and Norway comprised the sample for this study. A key informant is defined as a person with specific expertise who knows what is going on in the community. They have first-hand knowledge about the community or phenomenon of interest and can provide insight into the nature of things, problems, issues, and recommendations for solutions (Spradley, 1979). The key informants were selected, with the advice of Dr. Mary Koithan (US PI for the Pathways of Cancer Care study) and Dr. Gro Berntsen (Norwegian Project Coordinator and Co-PI for the Pathways of Cancer Care study) based on satisfying the following inclusion and exclusion criteria.

Inclusion Criteria

- English-speaking;
- knowledgeable about the range of treatments (allopathic, CAM or both as appropriate to their specialty) available for women diagnosed with breast cancer in stage I-III;
- knowledgeable about financing care, access to providers, credentialing of providers, structure of the health care system, and treatment guidelines; and
- willing to be tape recorded during the interview.

Exclusion Criteria

- unwilling to be tape recorded during the interview; and
- Non-English speaking.

Dr. Marja Verhoef, Canadian PI and International Project Director for the Pathways of Cancer Care Study also provided input and approval for these key informants. Institutional Review
Board approval was received for the primary study in 2009 and an amendment was approved for this portion of the study in the US in early 2010. The primary study was approved by the Institutional Review Board at the University of Tromsø, Norway in May 2010 and this portion was deemed exempt from IRB review (Appendix B and C).

**Data Collection**

Data were collected from key informants using 1:1 in-depth, semi-structured interviews. Interview questions were constructed to gain specific information and expert opinion about: (a) health care systems factors in the US and Norway that study participants have identified as impacting cancer care decisions, and (b) health care systems barriers and facilitators of care in their respective countries. US interviews took place between August and November 2010. Norwegian interviews took place between June and August 2010. Private appointments for 1-1.5 hours were scheduled with these key informants for the interview. For one Norwegian interview, the interviewer traveled approximately 300 miles by air from Tromsø to Oslo, Norway to secure the data.

Norwegian participants were informed about the study and provided verbal assent for the data collection process. US participants completed the informed consenting process. Interviews were then conducted and were digitally recorded. Topics/questions that were discussed during the interviews included: (a) funding for allopathic care in the US and Norway; (b) funding for complementary/alternative/integrated care in the US and Norway; (c) access to and credentialing of health care providers in each country; (d) use of treatment guidelines in each country; and (e) breast cancer treatment goals in each country. A copy of the interview guide can be found in Appendix D.
Although these interviews were semi-structured, the actual format and content was modified based on the unique directions that the respondent took. During the interview, questions that clarified, amplified, and verified information that was identified by the respondent were asked. Following completion of the interviews, transcriptions were created as MS-Word files. These files were then used for analysis of the data.

**Data Analysis**

Two qualitative data analysis strategies were used to answer the research questions and address the two study aims. Content and matrix analyses were the primary descriptive approaches used for this study (Krippendorf, 1980; Miles & Huberman, 1994). Content analysis allowed the researcher to identify concepts and categories of responses to the various questions that were similar across participant interviews (Krippendorf, 1980). Descriptive matrix analysis was then used to create individual data displays (1st order data matrices) for each health care system factor by country so that the primary factors that affect health care treatment choices could emerge. The outcome of these analytic processes addressed study aim 1.

To complete the descriptive analysis, raw data were deductively coded into categories that were derived from the research aims and questions. Recurrent themes were identified from these data and displayed by category and country in 1st order data matrices. A total of nine data tables, were created with data for each country that described: (a) general information about health care financing, (b) financing allopathic health care, (c) financing CAM care, (d) access to CAM care, (e) access to allopathic care, (f) credentialing and regulating allopathic care, (g) credentialing and regulating CAM care, (i) treatment guidelines, and (j) treatment goals.
These data were then further analyzed to identify: (a) strengths of the different health care systems; (b) weaknesses of each system; and (c) potential implications that the findings have on (i) health care delivery or practice, (ii) health care policy, professional education, and (iii) future research. These areas were added to the data tables to complete the descriptive analysis process. Table 1 provides a sample 1st order data (descriptive) matrix.

**TABLE 1: Sample First Order (Descriptive) Matrix**

<table>
<thead>
<tr>
<th>Financing General: US</th>
</tr>
</thead>
<tbody>
<tr>
<td>Data Results</td>
</tr>
<tr>
<td>Positive Aspects (Strengths)</td>
</tr>
<tr>
<td>Negative Aspects (Weaknesses)</td>
</tr>
<tr>
<td>Implications</td>
</tr>
<tr>
<td>- Practice</td>
</tr>
<tr>
<td>- Policy</td>
</tr>
<tr>
<td>- Research</td>
</tr>
<tr>
<td>- Professional Education</td>
</tr>
</tbody>
</table>

Comparative matrix analysis was then used to compare and contrast these the various health care systems factors across countries (Averill, 2002; Miles & Huberman, 1994). Second order matrices were then constructed to provide a visual, “conceptually oriented” display of specific health care systems factors that are shared and factors that are different. The outcome of this comparative analysis procedure addressed study aim 2.

To complete the comparative analysis, seven 2nd order data matrices were constructed by entering the data themes from the US and Norwegian 1st order matrices into the data display. Data across countries were then compared and contrasted to identify the similarities and differences between the US and Norwegian health care systems factors, including financing general, financing allopathic care, financing CAM care, access to care, credentialing and
regulation, treatment guidelines, and treatment goals. From these comparisons between the US and Norway, conclusions were reached and presented in the “conclusions” portion of the matrices. A sample 2nd order matrix is provided below.

**TABLE 2: Sample Second Order (Comparative) Matrix**

<table>
<thead>
<tr>
<th>Financing General</th>
</tr>
</thead>
<tbody>
<tr>
<td>U.S. Data</td>
</tr>
<tr>
<td>Norway Data</td>
</tr>
<tr>
<td>Similarities</td>
</tr>
<tr>
<td>Differences</td>
</tr>
<tr>
<td>Conclusions</td>
</tr>
</tbody>
</table>

During the coding and analysis process, Dr. Koithan served as an expert reviewer and auditor. She reviewed transcriptions and coding processes as well as descriptive and comparative matrices in order to establish trustworthiness (the qualitative equivalent of reliability and validity) of the analysis process.
CHAPTER 4: RESULTS

Digitally recorded key informant interviews were transcribed into MS-Word files. These transcriptions were then deductively coded using the Atlas.ti data management system based on categories derived from the research questions, including: financing general, financing allopathic, financing CAM, access to allopathic care, access to CAM care, credentialing and regulation of allopathic care, credentialing and regulation of CAM care, treatment guidelines, and treatment goals. These data were then reduced into recurring themes and then organized into 1st order matrices to facilitate presentation and interpretation. Second order matrices were constructed to display comparison data between content areas for the US and Norway and provide additional analysis.

Sample

Six key informants constitute the sample for this research study. Two key informants were interviewed for the US portion of this study. The first US key informant is a family practitioner who is part of the faculty at the University of Arizona, College of Medicine and is the faculty coordinator for the US Integrative Family Medicine Residency Program, a four-year residency program that is used throughout the US to train integrative family medicine physicians. She is also a University of Arizona residency family medicine attending physician, teaching within their integrative medicine residency program. She teaches residents, treats patients at the Arizona Cancer Center, and has recently developed a curriculum for teaching integrative medicine to medical students. She has been focusing on implementing integrated care within conventional care plans for patients diagnosed with cancer and is a member of the Arizona Cancer Center in Tucson, Arizona. The second US key informant is a faculty member at the
University of Arizona, College of Nursing. She is a board certified palliative care nurse practitioner as well as a clinical assistant professor at the College of Nursing, teaching in the graduate nurse practitioner program. She primarily interacts with patients during end-of-life care and treats patients diagnosed with cancer. She is knowledgeable about complementary and alternative therapies used by cancer patients during end-of-life care. Both US key informants met the inclusion criteria for the study because they were English-speaking, agreed to being recorded, and were knowledgeable about specific study topics including, breast cancer treatments (allopathic and CAM), health care financing, access to health care, and credentialing and regulation of care. A total of five additional key informants were identified for recruitment to this study but declined participation, including two integrative medicine faculty members from the University of Arizona Center for Integrative Medicine, one medical social worker from the Arizona Cancer Center, one community oncologist, one College of Medicine oncologist, and one psychiatrist working exclusively with cancer patients. A variety of reasons were provided for their refusal although most cited time restrictions.

Four key informants were interviewed for the Norwegian portion of the study. The first key informant is a general practitioner and CAM researcher in Tromsø. He is a faculty member at the College of Medicine at the University of Tromsø and is an adjunct faculty member at the University of Arizona College of Medicine and Center for Integrative Medicine. He is the director for the Norwegian National Center for Research in Complementary and Alternative Medicine (NAFKAM) and is knowledgeable about the health care system and current CAM therapies being used by patients diagnosed with cancer in Norway as well as research about the effectiveness of CAM therapies during cancer treatment. The second Norwegian key informant
is oncologist at the University of Tromsø Hospital who specializes in breast and colon cancer treatment. He is knowledgeable about CAM therapies used by breast cancer patients and how they incorporate these therapies within conventional cancer treatment plans. The third Norwegian key informant is the general director for the Norwegian Board of Health Supervision, the controlling and supervising organization for healthcare in Norway. He is involved in evaluating current health care system issues and policies that are in place. The fourth and final Norwegian key informant is a researcher working for NAFKAM who is currently conducting research about CAM and its uses for cancer patients. She is knowledgeable about the integration of and westernized medicine, specifically for use by breast cancer patients. All four of the Norwegian key informants satisfy the inclusion criteria for this study because they all spoke English, agreed to the digital recording of the interview, and were knowledgeable about study topics including, breast cancer treatments (allopathic and CAM), health care financing, access to health care, and credentialing and regulation of care.

Aim 1

The first aim of this study was to explore and describe health care systems processes that create barriers and facilitators of breast cancer treatment decisions. A total of nine matrices (Appendix E) were created with US data results. A total of nine matrices (Appendix F) were created with Norwegian data results.

Research Question 1

The first research question was: What are the funding sources for allopathic care in the US and Norway? Key informants were queried asking: How is conventional/allopathic care financed? What is the government’s role in regulating funding of health care? Can individuals
pay for different types of services if they have more money? Individual first order matrices that identify funding for allopathic care in the US and Norway are provided in Appendices E and F, respectively.

**Research Question 2**

The second research question was: What are the funding sources for complementary/alternative/integrated care in the US and Norway? Key informants were asked the following questions: How is CAM care financed? What are the major differences in terms of financing between the allopathic and alternative/complementary/integrated care? Is there reimbursement/payment for services for patients who chose to use complementary/alternative/integrated care? Individual first order matrices that identify funding for CAM in the US and Norway are provided in Appendices E and F, respectively.

**Research Question 3**

The third research question was: What access to health care providers processes are in place for each country? Interview questions for this question included: How to patients access conventional health care? How do patients go about accessing complementary/alternative/integrated (CAM) treatments/therapies? What would happen if a patient wanted to change his/her health care provider? And how would he/she go about doing this? Is there equal/unequal access to conventional care providers? Is there equal/unequal access to CAM providers? Individual first order matrices presenting access information for the US and Norway are provided in Appendices E and F, respectively.
Research Question 4

The fourth question was: What are the credentialing and regulation requirements for different types of health care providers in each country? In order to respond to this question, key informants were asked: How is allopathic care regulated? How is CAM regulated? Are different CAM providers regulated differently? Are there different credentials required by the different types of CAM providers? Are there differences between regulation and credentialing of CAM practitioners verses allopathic practitioners? Individual first order matrices were created that display information regarding credentialing and regulation of health care providers in the US and Norway in Appendices E and F, respectively.

Research Question 5

The fifth research question asked are treatment guidelines used in each country? Key informants from the US and Norway were individually queried about: Are there conventional treatment guidelines for cancer care? Are the CAM treatment guidelines for cancer care? Are there specific conventional treatment policies in terms of caring for patients diagnosed with breast cancer? Are there specific CAM treatments recommended for patients diagnosed with breast cancer? Do you believe these current conventional/allopathic treatment guidelines for cancer care are effective? Why? Do you believe these current CAM treatment guidelines for cancer care are effective? Why? Data obtained from these interviews were organized into first order matrices, representing US and Norwegian data in Appendices E and F, respectively.

Research Question 6

This question was: What are the breast cancer treatment goals in each country? Key informants in the US and Norway answered the following interview questions related to this
topic: What are the goals of treatment for women diagnosed with breast cancer? What are the conventional/allopathic interventions employed to achieve these goals? What are some CAM interventions employed to achieve these goals? Is complementary/alternative/integrated care considered to be a goal of cancer care? If a patient diagnosed with breast cancer expresses specific requests in terms of her care, are these requests often met/attempted to be met/denied? Information obtained from key informant responses were organized into first order matrices and US and Norwegian data are represented in Appendices E and F, respectively.

**Summary Aim 1**

After interviewing my Norwegian and US key informants and coding their transcripts, I created 1st order descriptive matrices to organize the data themes. From these results, I identified strengths and weaknesses within content areas for US and Norwegian health care systems and described potential implications for health care delivery and practice, future policy questions and potential needs, educational needs for providers, and additional research questions that require attention.

**Aim 2**

The second aim of this study was to compare and contrast the US and Norwegian system processes, and identify advantages and disadvantages (strengths and limitations) of each system with respect to breast cancer treatment. Second order matrices were developed to compare data from the US and Norway to address each of the sub-aims. A total of seven matrices are reported in Appendix G that address: (a) the similarities/differences between funding for allopathic care; (b) the similarities/differences between funding for complementary/alternative/integrated care; (c) the similarities and differences in access to a variety of cancer treatment options; (d) the
similarities/differences related to credentialing of allopathic and CAM providers; (e) the similarities/differences for treatment guidelines; and (f) the similarities/differences with respect to treatment goals?

**Financing: General**

The Norwegian health care system is based on a socialized model where equal care is provided to all individuals. This means that every individual receives the same type of care, regardless of their ability to pay for health services. This contrasts to the US health care system which is based on individuals’ abilities to pay for services. In order to receive care within the US, individuals must purchase private insurance, qualify for government-provided insurance, or pay for health services out of their own pockets. The general financial structure of the US health care system limits the care that breast cancer patients receive which may have drastic negative health consequences, including delay of diagnosis, delay/inaccessibility of treatment initiation/continuation, and may ultimately potentiate preventable deaths.

**Financing Allopathic Treatment**

For most Norwegians, financing is not the barrier to care as it is for breast cancer patients seeking allopathic care within the US, this is because all breast cancer patients receive standard care and treatments that are provided by the government-funded health care system. This is in contrast to the financing of allopathic care in the US, where in order for patients to receive allopathic treatments, they must have purchased private health insurance, qualify for government-provided insurance, or pay for allopathic treatment expenses with their own personal funds. In the US, accessibility of allopathic treatments is contingent on an individual’s capacity to finance services provided.
Financing Complementary and Alternative Treatment

While key informants in both Norway and the US agree that complementary services are mostly paid for out-of-pocket by patients, Norwegian key informants agree that for the majority of Norwegian patients interested in accessing complementary therapies financing does not present a significant barrier. This is because the median individual income in Norway is sufficiently great enough that individuals are not be restrained financially from accessing those CAM services that they desire. In the US, key informants felt that the lack of a payment system pose a significant financial barrier to the access of complementary therapies and impacts decisions made by patients with breast cancer. Additionally, CAM may be more openly provided to and accessible by patients in Norwegian hospitals compared to US hospitals because Norway does not have complex issues related to reimbursement and payment of CAM services as was found in the US.

Access to Care

Significant factors that were identified as impacting patients’ access to both allopathic and CAM care in Norway and the US. The first factor was physician bias and influence. Physicians were identified as being extremely influential in the decision-making process for women diagnosed with breast cancer during their allopathic treatment trajectories. Physicians in the US and Norway also impact patients’ ability to access CAM care as they may censor the information provided on this topic. Because of this lack of education and information sharing by physicians with breast cancer patients, these women must seek out information about complementary therapies independently. They seek information from friends and family, the internet, books and magazines and other sources. Further, they may not notify their physician
when using these therapies because they may believe that their physician does not approve of them. This could potentially lead to negative health outcomes relating to harmful treatment interactions. Norwegian patients interested in accessing complementary therapies may have limited access due to geographical limitations. While there are many forms of complementary therapies available to patients in the capitol, Oslo, complementary therapies are not as widely available throughout Norway, and are especially limited in regions with small populations. Accessing complementary therapies in Norway is further limited by the national law on complementary and alternative therapies that explains that CAM providers may not present therapies as treating the cancer specifically. CAM practitioners may treat patients with cancer but they are only allowed to treat the symptoms of the disease, not the actual cancerous cells

**Credentialing and Regulation**

Allopathic care providers for breast cancer patients within the US are more strictly regulated than providers in Norway. In turn, this means that US providers must also adhere to certain standards and achieve specific certifications to treat patient populations than their counterparts in Norway. Additionally, complementary therapies are not as strictly regulated as allopathic care within both the US and Norway.

**Treatment Guidelines**

Allopathic treatment guidelines for breast cancer are clearly outlined both countries and are based on current research and evaluation of available treatments. This encourages the provision of current, optimal care to breast cancer patients. Additionally, key informants from both countries agree that, while there are recognized forms of CAM that are useful in treating the symptoms of allopathic treatments used by breast cancer patients (e.g. chemotherapy), there are
currently no specific treatment guidelines for the use of CAM therapies in breast cancer. Both the US and Norway currently agree that complementary therapies may be used as complements to allopathic care; however, neither system encourages the use of alternative treatments for cancer.

**Treatment Goals**

While the integration of complementary therapies to treat breast cancer is not the goal of allopathic health care providers in both countries, it is however a priority of this patient population. Ultimately, the goals of health care providers in both countries are to cure their breast cancer patients and ensure a swift recovery. They want their patients to survive this illness at all costs, believing that although quality of life suffers in the short term, survival outweighs psychosocial needs. Yet, this runs in direct opposition to the goals of breast cancer patients who want what?

**Summary Aim 2**

US and Norwegian data results were organized into 2nd order matrices, identifying similarities and differences between the two systems. Following this analysis, I identified conclusions for each health care system factor with possible effects on the treatment choices and decision making during the breast cancer experience.
CHAPTER 5: DISCUSSION AND INTERPRETATION

Health System Factors Affecting Breast Cancer Treatment Options

Patient treatment choices and decision-making processes during their breast cancer experiences are influenced by the structure of the health care system. Financing care (both allopathic and CAM) have been identified as significant contributors to what care is ultimately decided on and provided. If patients are lucky enough to have private insurance or qualify for government insurance, then they will receive standard allopathic treatments for breast cancer. However, if they do not own insurance or do not qualify, they most likely will be unable to afford treatment, which will only allow the cancer to grow and spread. Another significant influence of the US health care system is the power of the physicians and how they are able to influence patients into “choosing” a specific cancer treatment. Patients are generally very trusting of their physicians and will do what they recommend. Physicians need to be aware of this power and how their opinions and perceptions may greatly impact their patients’ lives.

While treatment guidelines exist for allopathic care of breast cancer, there are currently no treatment guidelines that outline use of CAM in patients with breast cancer. This limits the accessibility of CAM because patients and physicians are unaware of which therapies may be used in the standard treatment of breast cancer.

The structure of the Norwegian health care system impacts the treatment choices of breast cancer patients during their cancer care plans. Because Norway has a socialized form of health care, all individuals have equal access to standard allopathic treatments. This is extremely beneficial because it allows patients to receive care regardless of their ability to pay. However, because this is a socialized system where everyone receives “equal” care, patients receive the
standard of care, but it may not be the optimum care. Additionally, patient prioritization occurs because there is only a certain amount of resources (e.g. money, medicine, time). This prioritization is based on the arbitrary assessments of patients’ physicians, which means that breast cancer patients do not have a strong voice in the care they receive. Norwegian physicians may act as barriers to patients accessing complementary therapies because they do not recommend that breast cancer patients seek out these treatments. This may be because they do not believe they are effective or that they may interact negatively with the allopathic treatments the patient is receiving. By limiting the information about CAM to breast cancer patients, these women may be less likely to seek out information about CAM independently and, if they do, they may not disclose using such therapies to their physicians. This may have negative consequences including harmful treatment interactions and negative health outcomes.

**Similarities and Differences in Health Care Systems Factors: US and Norway**

The US and Norwegian health care systems are similar in some aspects, yet different in others. It is important to appreciate how these similarities and differences impact the allopathic treatment and CAM experiences that breast cancer patients endure.

**Similarities Between the US and Norway**

Breast cancer patients in the US and Norway may purchase private insurance that allows them to have a say in who their physician is. Private insurers in the two countries may cover some specific forms of CAM. However, patients are often unaware which services are or are not covered by their insurance. This is a potential barrier to accessing CAM relating to knowledge deficit. US insurance providers and the Norwegian health care system generally do not cover
CAM. This is a limitation because patients must finance CAM out-of-pocket which may not be a feasible option based on personal incomes.

Additional barriers to accessing CAM include, physicians perceptions of CAM and the culture of medical institutions that value westernized medicine over CAM. These barriers to accessing CAM may decrease patients’ senses of well-being and quality of life throughout their breast cancer treatment trajectories. Physicians in the US and Norway do not advise breast cancer patients to seek out complementary treatments. This is potentially harmful to patients because they may look for information from unreliable sources such as the internet and seek out therapies that may be incompatible with their allopathic treatments. Because of this, physicians need to be open to CAM and educate their patients on its uses.

CAM is not as strictly regulated compared to allopathic therapies within the US and Norway. While this is beneficial for breast cancer patients because it keeps consumer expenses low and improves accessibility, there may be negative implications that include unsafe practice, inadequate outcomes monitoring, and under-reporting of negative patient outcomes. Due to this lack of regulation, providers within the US and Norway should be aware that breast cancer patients may be using CAM therapies that could be harmful to their health or interact negatively with other treatments throughout their care trajectories. Additionally, integration of complementary and allopathic therapies will satisfy the wants of physicians as well as breast cancer patients because physicians will be able to treat them with their preferred form of westernized medicine while patients are able to access CAM and feel a greater sense of well-being.
Differences Between the US and Norway

Norway provides equal health care to all individuals regardless of their ability to pay for services, while, in the US, in order for patients to receive medical care they must purchase private insurance, qualify for government-provided insurance, or pay for services out-of-pocket. The Norwegian structure facilitates breast cancer patients’ accessing allopathic treatments, while the US system is a barrier for patients to receive care because they must first meet certain qualifications. This limit to receiving care can create preventable serious complications. Because of this, the US health care system needs a reconstruction where provision of care is not contingent on one’s ability to pay.

Within the US, insurance companies ultimately decide the care that is provided or not provided to breast cancer patients based on which services they decide to cover. So, this means that consumers do not have a choice when it comes to the care they receive and that they are ultimately at the mercies of their health insurance plans. This also means that insurance companies, rather than physicians, are ultimately determining the care provided to breast cancer patients. In this situation, therapies that may benefit breast cancer patients but that are not covered by health insurance will not be provided to patients. This current system is unfair to physicians and patients and is not encouraging use of best practices or facilitating optimum patient outcomes. There are barriers to provision of CAM in the hospital setting in both the US and Norway, but for different reasons. In Norway, CAM therapies that may be delivered to breast cancer patients while they are in the hospital are decided on by the department leader. In the US, CAM provided in hospitals are limited based on the ambiguity on how it should be regulated and reimbursement for services. These issues with limiting CAM delivered to patients
in hospitals in Norway and the US should be evaluated and corrected so that patients may more easily access these services.

**Practice Implications**

The results of this study have many potential practice implications. Firstly, resources need to be made available to patient populations, specifically breast cancer patients, providing information about complementary therapies. These resources should be made easily available to patients (e.g. via a website so that a large population may access this information) and it should outline specific therapies that have been researched and shown to have positive influence on patients diagnosed with breast cancer. This need is based on the trend that women diagnosed with breast cancer are open to accessing CAM therapies and that the rates of CAM use in conjunction with allopathic therapies are increasing. An additional practice implication is that patients should receive education and educate themselves about accessing CAM therapies within the hospital. Patients may not currently be aware that they may access CAM therapies while receiving treatments in the hospital. If patients were made aware of the accessibility of CAM within hospital settings they may access it more readily. Patients also need to be aware of the lack of credentialing and regulation that is currently employed for CAM. This lack of regulation increases one’s ability to access CAM; however, patients may use potentially unsafe forms of CAM or forms that negatively interact with their allopathic treatments. This may potentiate negative health outcomes that, with education and disclosure of information to their physicians, could have been prevented.
**Policy Implications**

Various policy implications arose out of this research. Insurance companies should be presented with research data proving effectiveness of CAM therapies on health outcomes for breast cancer patients so that they may reevaluate current coverage standards to include covering some forms of CAM. For example, acupuncture has been proven effective in treating nausea and vomiting relating to chemotherapy. This therapy is useful in treating breast cancer patients and should be covered by insurance companies. Another issue that was identified within this study was the impact that the current US health care system has on individuals’ abilities to access allopathic and CAM care. US health policy should be revised to a single payer system where all individuals have equal access to medical care and treatments. Another potential policy implication relates to how CAM is currently regulated. While the limited regulations currently in place for CAM therapies keep costs low and, in turn, increase patient access to such therapies, this has potentially negative impacts including causing negative health outcomes if performed incorrectly. Ultimately, patient safety is the highest priority and regulations should reflect this. Additionally, reputable organizations such as the National Cancer Institute, the National Comprehensive Cancer Network, and the American Society of Clinical Oncology should provide recommendations for CAM use for breast cancer patients.

**Professional Education Implications**

Implications for future professional education have also been identified. One emerging trend from the interviews was that patients often use CAM without notifying their physicians because they either believe they will get into trouble with their physicians or that their physicians would refuse to treat them if they found out they were using CAM. Because of this, physicians
need to educate themselves on CAM use by patients diagnosed with breast cancer and they should be aware that patients may be using such therapies without notifying their physicians. Providers must ask their patients about using CAM therapies so they may make safe recommendations about treatments and assess if multiple therapies may be used safely concurrently. This will positively impact patient safety and well-being. Also, because CAM use has been shown to increase quality of life of breast cancer patients, oncologists should be aware of current research outlining specific CAM therapies that prove this. Oncologists should be open to these therapies and should consider referring breast cancer patients to CAM providers so that they may have increased satisfaction and quality of life throughout their cancer treatment plan.

**Research Implications**

Numerous implications for future research can be identified from the outcomes of this study. Firstly, researchers should continue to investigate CAM therapies that may benefit patients diagnosed with breast cancer. This emerging research along with existing research outlining positive impacts of CAM on breast cancer patients should be compiled into a website database that patients may easily access to determine which CAM therapies may best benefit them throughout their cancer trajectories. Additional research projects should investigate how the goals of oncologists relate to the goals of breast cancer patients. From my analysis, it appears that there may be a disconnect between what patients prioritize compared to their oncologists. It should be researched if this hypothesis is indeed true and if, and to what extent, this incongruence impacts treatment plans and health outcomes. Relating specifically to Norway and how the patient care delivered is often based on prioritization of patients based on presenting disease characteristics, researchers should evaluate how this physician-directed prioritization
impacts breast cancer patients and their health outcomes. Also, relating specifically to Norway, how do limited resources (e.g. time, money, medications) affect breast cancer patient outcomes?

**Study Limitations**

A significant limitation of this study was the sample size, with only two key informants in the US. This limitation is a result of non-responsiveness from providers within the community, hospitals, and faculty at the University of Arizona. Despite many efforts to contact potential key informants, there was an extreme lack of response that limited the total number of US key informant sample to two individuals.

An additional limitation was that only health care providers were interviewed to obtain their opinions regarding facilitators and barriers to cancer care. It would have been beneficial to interview breast cancer patients to determine facilitators and barriers to care from their points of view. Norwegian patients could not be interviewed for several reasons, including language barriers, lack of access to patients because of IRB issues, and lack of access to translation services. However, participant interviews from the US Pathways of Cancer Care study were read to determine whether the issues that were identified during analysis were similar to the ones that they reported. Information from these interviews confirmed my findings and the health care systems factors that were identified by the providers as affecting treatment choices. Yet, interviewing breast cancer patients would have been preferable because assessing patient perspectives first-hand would have increased the credibility of the reported findings.

Lastly, a limitation of this study is that health care systems, especially the US health care system, are very complex. It was a very big undertaking to attempt to understand both the
Norwegian and US health system systems completely. However, it should be appreciated that this was a preliminary study and is a resource for future related studies.

**Conclusions**

In this study, health care systems factors that influence treatment decisions for women diagnosed with breast cancer in both the US and Norway were described and compared between countries. Data from key informant interviews were analyzed to determine similarities and differences between the US and Norway and identify potential implications. Barriers to accessing CAM in the US and Norway are out-of-pocket financing of services and lack of physician-provided information about CAM use in conjunction with allopathic breast cancer treatments. While credentialing and regulation of allopathic breast cancer therapies are clearly outlined in both countries, CAM therapies are not closely monitored. This lack of regulation is beneficial to patients because it maintains low fees for services and therefore increases accessibility, but it is also potentially harmful because unsafe practices may occur and negative patient health outcomes may result. US and Norwegian physicians both consider survival to be the ultimate goal of breast cancer treatment and do not consider CAM therapies to be a goal of breast cancer treatments. These priorities may not align with the priorities of patients diagnosed with breast cancer, who may want a more holistic treatment plan where quality of life is still a priority. Education needs to be provided to or made easily accessible for both patients and physicians about CAM therapies and their beneficial uses in breast cancer care because this may increase integration of CAM therapies within allopathic treatment regimens and increase patients’ overall senses of well-being and quality of life.
APPENDIX A: NCCAM CATEGORIES
<table>
<thead>
<tr>
<th>CAM Category</th>
<th>Definition</th>
<th>Example</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mind-Body Medicine</td>
<td>The use of various techniques to increase mental and physical functioning and to prevent or treat diseases/disorders and/or their symptoms</td>
<td>Meditation, yoga</td>
</tr>
<tr>
<td>Biological Therapies</td>
<td>The use of substances found in nature to improve health and well-being</td>
<td>Herbal or botanical products, probiotics, vitamins, minerals</td>
</tr>
<tr>
<td>Body Manipulation</td>
<td>The use of manipulation of movement of body parts.</td>
<td>Massage, chiropractic manipulation, and osteopathic manipulation</td>
</tr>
<tr>
<td>Dance and Movement Therapies</td>
<td>The use of movement and dance to improve mental and physical well-being.</td>
<td>Movement improvisation, breathing techniques</td>
</tr>
<tr>
<td>Energy Therapies</td>
<td>The use of forms of energy. It is based on the belief that living things possess and emit energies and can be affected by external energies.</td>
<td>Aselectromagnetic radiation and sound</td>
</tr>
<tr>
<td>Whole Systems of Medicine/Care</td>
<td>A general term used to describe the combination of medical and health energy medicine.</td>
<td>Psychotherapy in mind-body medicine, pharmaceuticals in biologically based practices, traditional Chinese medicine, homeopathy, naturopathy</td>
</tr>
</tbody>
</table>
APPENDIX B: INSTITUTIONAL REVIEW BOARD APPROVAL (US)
May 12, 2009

Mary Kothian, PhD
Department of Nursing
PO Box 210203

RE: PROJECT NO 09-0428-02 Understanding Cancer Patients’ Pathways of Care: A Pilot Study

Dear Dr. Kothian:

We received your research proposal as cited above. The procedures to be followed in this study pose no more than minimal risk to participating subjects and have been reviewed by the Institutional Review Board (IRB) through an Expedited Review procedure as cited in the regulations issued by the U.S. Department of Health and Human Services [45 CFR Part 46.110(b)(1)] based on their inclusion under research categories 5 and 7. Please make copies of the Subject Informed Consent Forms available to your subjects.

Although full Committee review is not required, notification of the study is submitted to the Committee for their endorsement and/or comment, if any, after administrative approval is granted. This project is approved with an expiration date of May 11, 2011.

The Institutional Review Board (IRB) of the University of Arizona has a current Federalwide Assurance of compliance, FWA00004218, which is on file with the Department of Health and Human Services and covers this activity.

Approval is granted with the understanding that no further changes or additions will be made to the procedures followed without the knowledge and approval of the Human Subjects Committee (IRB) and your College or Departmental Review Committee. Any research related physical or psychological harm to any subject must also be reported to each committee.

A university policy requires that all signed subject consent forms be kept in a permanent file in an area designated for that purpose by the Department Head or comparable authority. This will assure their accessibility in the event that university officials require the information and the principal investigator is unavailable for some reason.

Sincerely yours,

[Signature]

Elaine G. Jones, PhD, RN, FNP
Chair, IRB2 Committee
UA Institutional Review Board

BGJ/maj
cc: Departmental/College Review Committee

Arizona's First University — Since 1885
**HSPP Correspondence Form**

**Date:** 04/22/10  
**Investigator:** Mary Koithan, PhD  
**Department:** Nurs  
**Project No./Title:** 09-0428-02 Understanding Cancer Patients’ Pathways of Care: A Pilot Study  
**Current Period of Approval:** 03/30/10 – 03/29/11

### IRB Committee Information

| IRB2 – IRB00001751 | Expedited Review – Amendment  
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<td>FWA Number: FWA00004218</td>
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<th>Documents Reviewed Concurrently</th>
<th>Status</th>
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<tbody>
<tr>
<td>Request for Amendment Form – PI Initiated Changes (received 04/19/10)</td>
<td>Appr</td>
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<tr>
<td>Consenting Instruments: Addendum to Informed Consent Form</td>
<td>Appr</td>
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### Description of Modifications

*Protocol change [request to continue enrollment for an additional 1-2 months, extending subject participation from 6 to 8 months due to low enrollment (Note: Subjects will continue to complete a monthly calendar and questionnaire and have a monthly interview with staff as previously approved); new Addendum Consent [as noted above].*

**IRB Comment:** Effective January 2010, the HSPP will require prior IRB approval only for the following personnel: PI, Co-PI, Student PIs, Investigators, any person consenting, and study coordinator(s)/contact person. A VOTF with ALL current study personnel must be submitted at the time of continuing review. It is expected that the PI will continue to ensure that all persons working on a research study have up-to-date human subjects training. This will be monitored through random and for-cause auditing by the HSPP office.

**Approved** as submitted effective 04/22/10

### Committee/Chair Determination

☑ Not Applicable

04/22/10

Elaine G. Jones, PhD  
Chair, IRB 2 Committee  
UA Institutional Review Board

EGJ:mm

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**Reminders:** Continuing Review materials should be submitted 30–45 days prior to the expiration date to obtain project re-approval
- Projects may be concluded or withdrawn at any time using the forms available at [http://ocrvpr.arizona.edu/irb](http://ocrvpr.arizona.edu/irb).
- No changes to a project may be made prior to IRB approval except to eliminate apparent immediate hazard to subjects.  
- Original signed consent forms must be stored in the designated departmental location determined by the Department Head.
APPENDIX C: INSTITUTIONAL REVIEW BOARD APPROVAL (NORWAY)
Koithan, Mary

From: Gro Berntsen [Gro.Berntsen@telemed.no]
Sent: Tuesday, May 11, 2010 5:03 AM
To: Koithan, Mary
Cc: Marja Verhoeof
Subject: SV: Berntsen 2009 1293 ethics commitee reply english.pdf
Attachments: Plan for Elizabeth.docx

Dear Mary,

I am so sorry to hear that you are not coming to Norway! Good luck with the grant proposal!

Marja and I had a meeting where we discussed Elizabeth's stay on the basis of her protocol. I wrote up a summary of our discussion. I was waiting for Marja to give me feedback on what I had written before sending it to you, but since she is gone most of this week, and will have to catch up - I will risk sending you my notes directly to you.

I apologize profusely for not thinking carefully about Elizabeth's project before – but here you are – our preliminary thoughts.

As Marja and I see it now – we do not think she will be involved with patients or with any new sensitive data. If you and she decide you do want to move forward with point 3 in her protocol - something we at the moment do not quite recommend – we already have ethics approval for that. I don't think we need to involve ethics committee here for Elizabeth.

Gro

Fra: Koithan, Mary [mailto:mkoithan@nursing.arizona.edu]
Sended: 10. mai 2010 17:36
Tit: Gro Berntsen
Kopi: Marja Verhoeof [mverhoeuf@uocalgary.ca]
Emne: RE: Bernts 2009 1293 ethics commitee reply english.pdf

Dear Gro --- I was planning to talk to you about Elizabeth's project when I was in Tromso starting next week. But I will be unable to attend in person due to a potential grant interview required here in Tucson on the 18th.

Therefore, I would like to know what (if any) IRB processes need to be completed for Elizabeth's study and how I can facilitate those from here.

Thanks- Mary

Mary Koithan, PhD, RN-C, CNS-BC
Associate Professor
Univ of Arizona, College of Nursing
Phone: 520-626-2036
Cell: 520-990-6701
FAX: 520-626-7891

From: Gro Berntsen [Gro.Berntsen@telemed.no]
Sent: Wednesday, April 21, 2010 10:39 AM
To: Koithan, Mary
Cc: Marja Verhoeof; Frnks2?, Vinjar Magne
Subject: Berntsen 2009 1293 ethics commitee reply english.pdf
APPENDIX D: KEY INFORMANT INTERVIEW GUIDE
Health care systems: values/priorities.
- Can you please describe the structure of the health care system?
- Who does this health care system provide for? What kinds of conditions are typically treated in this system?
- How do people access the system?
- What are the priorities of the health care system?
- How does the health care system view complementary/alternative/integrated care (attitudes/beliefs)?
- Specifically what kinds of services are used/paid for (allopathic/CAM) for women diagnosed with breast cancer?

Financing health care.
- How is healthcare financed?
  o How is conventional/allopathic care financed?
  o How is complementary/alternative/integrated care financed?
- What is the government’s role in regulating funding of health care?
- Do you believe this is an effective/efficient way of funding care?
- What would you like (if anything) to be changed about the current financing of this system?
- Can individuals pay for different types of services if they have more money?
- What are the major differences in terms of financing between the allopathic and alternative/complementary/integrated care?
- Is there reimbursement/payment for services for patients who chose to use complementary/alternative/integrated care?
- Do you believe that patients consider these funding differences when choosing to use allopathic verses complementary/alternative/integrated care?
  o If yes, how and to what extent?
- Do you believe that funding for conventional/allopathic care is equal to the funding of complementary/alternative/integrated care?
  o If not, do you think it should be equal?
- What would you like (if anything) to be changed about how funds are allocated for conventional/allopathic care?
- What would you like (if anything) to be changed about how funds are allocated for complementary/alternative/integrated care?
- How would these changes benefit patients overall?

Access to health care.
- How to patients access conventional health care?
  o How do they find out information about health care treatments (i.e. the internet-webMD, mayo clinic, or from their GP?)
- How do patients go about accessing complementary/alternative/integrated (CAM) treatments/therapies?
  o How do patients find out this information?
• How do patients use these therapies? (i.e. self-care, self-taught, provider-directed, etc.)
• What would happen if a patient wanted to change his/her health care provider? And how would he/she go about doing this?
• Is there equal/unequal access to conventional care providers?
  o If unequal, what do you believe to be the patient and provider characteristics that limit this access? Why?
• Is there equal/unequal access to CAM providers?
  o If unequal, what do you believe to be the patient and provider characteristics that limit this access? Why?

Credentialing and regulation of health care providers.
• Could you talk to me about how health care regulated in this country.
  o How is allopathic care regulated?
  o How is CAM regulated?
  o Are different CAM providers regulated differently?
  o Are there different credentials required by the different types of CAM providers?
• Are there differences between regulation and credentialing of CAM practitioners verses allopathic practitioners?
  o If yes, what are they?
• Is there a way to evaluate quality care provided to patients?
• Do you believe the current system of regulating health care is effective? Why?
• Are there quality of care issues in your country (related to allopathic care/CAM)?
• What, is anything, would you like to see change in terms of regulating conventional/allopathic practitioners?
• What, if anything, would you like to see change in terms of regulating CAM practitioners?

Treatment guidelines for cancer care.
• Are there conventional treatment guidelines for cancer care?
  o How do you stay up to date?
• Are the CAM treatment guidelines for cancer care?
• Are there specific conventional treatment policies in terms of caring for patients diagnosed with breast cancer?
• Are there specific CAM treatments recommended for patients diagnosed with breast cancer?
• Do you believe these current conventional/allopathic treatment guidelines for cancer care are effective? Why?
  o If not, how would you suggest they be revised?
• Do you believe these current CAM treatment guidelines for cancer care are effective? Why?
  o If not, how would you suggest they be revised?
Breast cancer treatment goals.
• What are the goals of treatment for women diagnosed with breast cancer?
• What are the conventional/allopathic interventions employed to achieve these goals?
• What are some CAM interventions employed to achieve these goals?
• Is complementary/alternative/integrated care considered to be a goal of cancer care?
  o If yes, how is this care used or implemented?
• If a patient diagnosed with breast cancer expresses specific requests in terms of her care, are these requests often met/attempted to be met/denied?
  o Why?
  o Do you think this is an issue in terms of care and health outcomes?
APPENDIX E: DESCRIPTIVE DATA FOR US
<table>
<thead>
<tr>
<th>Financing General: U.S.</th>
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<tbody>
<tr>
<td><strong>Data Results</strong></td>
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<tr>
<td>• It is just interesting that people will pay to get massage therapy, but they won’t want to pay to see a physician. They want the insurance to pay. <em>(USP1)</em></td>
</tr>
<tr>
<td><strong>Positive Aspects (Strengths)</strong></td>
</tr>
<tr>
<td>• Coverage is available for people who meet specific qualifications</td>
</tr>
<tr>
<td><strong>Negative Aspects (Weaknesses)</strong></td>
</tr>
<tr>
<td>• Must qualify to receive coverage</td>
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<tr>
<td>• Insurance dictates care provided. So, there is not consumer choice when it comes to health care.</td>
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<tr>
<td><strong>Implications</strong></td>
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<tr>
<td>• Practice</td>
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<tr>
<td>• Policy</td>
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<tr>
<td>• Do consumers have a choice in the care they receive? Is the care provided solely decided on by insurers?</td>
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<tr>
<td>• Research</td>
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<td>• Professional Education</td>
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<tr>
<th>Financing Allopathic Care: U.S.</th>
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<tbody>
<tr>
<td><strong>Data Results</strong></td>
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<tr>
<td>• The medical treatment is pretty extensive, but it is covered by insurance. Patients who have insurance have access to that. <em>(USP1)</em></td>
</tr>
<tr>
<td>• The medical expenses should be covered by their health insurance. <em>(USP1)</em></td>
</tr>
<tr>
<td>• If they are likely to have a primary care physician, they will start there where the primary care physician will send them to the oncologist, or surgeon, or where ever they need to go for treatment. So, or if they don’t have a primary care physician, they go to the emergency room, and they do a chest X-ray, and they find a big mass in the lungs. Also, the emergency physicians will, you know, hook them up with the healthcare system, hopefully, for them to be treated. I think that’s how people get into conventional treatment. <em>(USP1)</em></td>
</tr>
<tr>
<td>• But, that’s not an unusual story of people first having private insurance, then losing their job, then not having any insurance, losing all their savings, and then having to apply to disability or Medicaid access here to be able to have those treatments covered. So, it is very complicated. <em>(USP1)</em></td>
</tr>
<tr>
<td>• Most cancer therapies for example surgeries, chemotherapy, radiation, medications are covered well by private insurance and Medicare. There are some exceptions to that, but in general, I’ve found that’s well covered. <em>(USP2)</em></td>
</tr>
<tr>
<td>• I think, in my mind, that’s what drives how decisions are made about what is offered. If it’s not reimbursable, it’s not done, generally. Even if it would help the patient. <em>(USP2)</em></td>
</tr>
</tbody>
</table>
| Positive Aspects (Strengths) | • Patients with private insurance and Medicare have access to standard allopathic treatments for breast cancer.  
• Allopathic treatments are generally covered by patients’ health insurance. |
| Negative Aspects (Weaknesses) | • Insurance may dictate what care patients receive.  
• Decisions relating to types of care/treatments proved to patients are made by insurers, not necessarily health care providers.  
• Treatments that may benefit breast cancer patients may not be provided based on funding and likelihood of reimbursement. |
| Implications | • Practice  
• Policy  
• Research  
• Professional Education |
| • Research | • Research proving that certain CAM treatments benefit patients diagnosed with breast cancer should be presented to insurers and they should consider covering these therapies. |

**Financing CAM Care: U.S.**

| Data Results | • The CAM treatments are usually not covered by insurance, but they are less expensive on an individual basis. As a whole, I think there has been some studies in the past of how much people spend out of pocket for CAM versus the healthcare costs, and they are pretty comparable. (USP1)  
• It is accepted that people will pay out of pocket to see a CAM provider (USP1)  
• There are some things that are covered, but you know, massage, healing touch, nutrition counseling is usually covered. But some insurance companies pay membership to gyms and stuff like that but it is a minority. Supplements, for the most part, are not covered. And then, I am not even talking about the very controversial I.V. vitamins C treatments and all these other treatments. (USP1)  
• These clinics where people go and pay thousands of dollars for treatment for cancer, like vitamin C and other treatments like that. But, those are not covered by insurance. (USP1)  
• You know, people go to Mexico to these clinics to get these treatments and those are not covered too. So, for the most part, they are not covered. (USP1) |

I just see patients coming to me spending 800 dollars or thousands of dollars in CAM treatments. And then expecting everything that everything is going to be covered through their insurance for their conventional treatments. (USP1)

But then, you know, there are many patients that say “I am not interested in any CAM because I cannot afford them. I cannot afford anything that is not covered.” (USP1)

That’s why I think some of the treatments, the ones that have more evidence that they work…they should make acupuncture for side effects of chemotherapy. That’s something that’s published. It is out there. It is not very expensive. You know, people tolerate their chemo better. They have better results. Acupuncture is something that should be covered, and most insurances don’t. (USP1)

As an in-patient, it’s quite different and there’s a lot of reimbursement and billing issues. (USP2)

No, it’s not billed for. They receive it as a kind of, they do it kind of pro-bono, the practitioners. So, there’s no billing for it, um, it’s volunteer. They come as volunteers. (USP2)

The first barrier that I see is a very practical financial issue in terms of reimbursement. So, we have a lot of wonderful services, especially in Tucson, I think, but getting them into the acute care setting in a way that’s financially viable is a huge challenge. (USP2)

I personally don’t know that much about which insurances cover which complementary therapies. I think it’s, in my experience, very limited, but um, I don’t know for sure. (USP2)

I think for a lot of patients it’s a huge factor because it can be extremely expensive, I think in the hundreds of dollars to go and maybe have a consultation with a, you know naturopath or um, so I think it’s a huge factor. (USP2)

| Positive Aspects (Strengths) | CAM treatments are less expensive than allopathic treatments on an individual basis |
| Negative Aspects (Weaknesses) | Lack of funding for CAM services |
| | CAM is generally an out of pocket expense for patients |
| | Lack of patient interest in CAM because they are responsible for paying completely for CAM services |
| | Coverage/lack of coverage drives patients’ choices and interests in CAM |
| | Minimal CAM treatments available in the in-patient hospital setting relating to reimbursement issues |
| | Patients may not be aware of possible CAM treatments that are |
| Implications | covered by health insurance plan  
| | • Supplements are not covered by health insurers |
| **Practice** | • Educate patients about flexible spending accounts so they may be able to afford CAM therapies |
| **Policy** | • Insurance companies should consider providing coverage for CAM therapies like acupuncture therapy. There is research and evidence that support its use for the treatment of nausea and vomiting associated with chemotherapy. |
| **Research** | |
| **Professional Education** | |

| Access to CAM Care: U.S. | |
| **Data Results** | • In medical school most physicians get trained how to diagnose problems, how to treat problems with medications...prescription medications, how to do diagnostic procedures, or treatment procedures. But there’s not that much of a holistic emphasis in terms of how do you treat illness with nutrition, physical activity, mind/body technique, etc, which is kind of a integrated medicine approach to things where you use different kind of tools to help patients feel better or be well. (USP1)  
| | • There is not evidence-base behind it. And since it is something that they don’t learn in medical school, they tend not to value it because it is not what they learned. (USP1)  
| | • You do physical activity, and after awhile you start getting your stamina, you sleep better. But those are the combinations that not too many conventional oncologists work on. Number one, because they are very overwhelmed with the number of patients and how risky treatments are, and how much attention they have to pay to the side effects. But they are not going to recommend a certain diet. Or, they are not going to, you know, spend time talking about physical activity or depression. They might prescribe a medication for the patient. (USP1)  
| | • Also for insurance companies to cover some of them too. That would be good for people to have access to practitioners that are licensed, or techniques...again, that there is some evidence that it could be beneficial or at least that they don’t have any risks. (USP1)  
| | • You know, people go to Mexico to these clinics to get these treatments and those are not covered too. So, for the most part, they are not covered. (USP1)  
| | • They heard that, you know, they should take these supplements |
from a friend or they should take these vitamins from another (USP1)

- But then, you know, there are many patients that say “I am not interested in any CAM because I cannot afford them. I cannot afford anything that is not covered.” (USP1)
- How do patients in the U.S. usually find out about complementary and alternative therapies? P: Well I think that they start learning through the internet (USP1)
- So, they are definitely not referred by physicians, most physicians. Patients, mainly family friends, internet…some books, there are some movies out there, and just the dissatisfaction of the way they feel and wanting to feel better. Or wanting an answer for something that cannot be treated with conventional therapy, and they go outside the system to try to be cured. (USP1)
- People do, um, mind-body, you know…support groups. A lot of people go to support groups, or mind-body medicine groups. (USP1)
- I wish that it was more available. I think a lot of the patients that I see are eager to explore it and have that option. (USP2)
- At the cancer center I know they have, there are a lot of services offered there that are part of being seen at the cancer center. But, as an in-patient, it’s quite different and there’s a lot of reimbursement and billing issues. So, we don’t have people getting massage or acupuncture or a lot of other therapies that I wish we could have in the in-patient setting. The one that we do have is we do have Reiki therapy for adult cancer patients. (USP2)
- I think there are 2 big barriers. The first barrier that I see is a very practical financial issue in terms of reimbursement. So, we have a lot of wonderful services, especially in Tucson, I think, but getting them into the acute care setting in a way that’s financially viable is a huge challenge. I think the second huge challenge is that there are still some health care providers that are very resistant to fully integrating that. (USP2)
- I think the second huge challenge is that there are still some health care providers that are very resistant to fully integrating that. I: referring to traditional care providers? P: who are, who have been trained and practice in a very allopathic western-oriented medical mind-set. Which certainly has its place, definitely, um, and I think that is changing. But it’s still, I’d say a prevalent theme. So I think those, in my opinion, and again these are my opinions, those are the 2 big barriers
- Those are the 2 big barriers- financial and then a culture of the institution. (USP2)
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<thead>
<tr>
<th>Positive Aspects (Strengths)</th>
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<tr>
<td>• Breast cancer patients may access information about CAM from a variety of sources including the internet, friends, family members, members of the breast cancer community, books, and movies.</td>
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<td>• There is an increased amount of information relating to CAM therapies today than in the past.</td>
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<tr>
<th>Negative Aspects (Weaknesses)</th>
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<tr>
<td>• In general, physicians don’t recommend CAM therapies and patients follow their doctors’ advice. This creates a lack of access to CAM therapies based on knowledge deficit.</td>
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<tr>
<td>• Physicians do not recommend CAM therapies because they believe there is a lack of evidence to support such a recommendation</td>
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<tr>
<td>• Out of pocket financing of CAM is a barrier for patients to access therapies</td>
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<tr>
<td>Implications</td>
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<tr>
<td>• Practice</td>
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<td>• Professional Education</td>
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**Access to Allopathic Care: U.S.**

| Data Results | • For most people that need treatment hopefully they have health insurance so they can get that covered through the insurance, but that’s kind of standard of care. (USP1)  
• If they are likely to have a primary care physician, they will start there where the primary care physician will send them to the oncologist, or surgeon, or where ever they need to go for treatment. So, or if they don’t have a primary care physician, they go to the emergency room, and they do a chest X-ray, and they find a big mass in the lungs. Also, the emergency physicians will, you know, hook them up with the healthcare system, hopefully, for them to be treated. I think that’s how people get into conventional treatment. (USP1)  
• Once they enter any part of the healthcare system, being primary care or emergency, they will be channeled to be treated conventionally. (USP1)  
• He was diagnosed and first thing is, you know, a resistance to any kind of surgery…or you know, very resistant to treatment with conventional…number one, because of the cost, and number two, because you know, they believe in Shamans and medicine-mans. (USP1)  
• He was convinced to go to conventional. He started treatments, and then his insurance stopped paying because he reached the maximum. And then he lost his insurance because he had to stop his job. And he used all of his savings, and he had to start working because he was not feeling well. Then he was resistant to have surgery because he knew it required a colostomy, and in his belief system he couldn’t imagine having a colostomy. But, then he  |
| --- | --- |
agreed to do that, so he went to surgery. Then, he needed more chemotherapy, and then he ran out of money and they had to stop chemo for two months until he got into the Medicaid system in California, that’s where they live. But, that’s not an unusual story of people first having private insurance, then losing their job, then not having any insurance, losing all their savings, and then having to apply to disability or Medicaid access here to be able to have those treatments covered. So, it is very complicated. (USP1)

- They do trust their oncologists. They feel very comfortable with them, for the most. The ones that don’t, they probably change doctors. There are a lot of doctors out there (USP1)
- Private insurance dictates a lot of the sort of care we are able to offer somebody and the choices we make for better or for worse (USP2)
- Most cancer therapies for example surgeries, chemotherapy, radiation, medications are covered well by private insurance and medicare. There are some exceptions to that, but in general, I’ve found that’s well covered. (USP2)
- If an oncologist dismisses a therapy or is not supportive of something, the patient generally won’t do it. So I think it’s very influential. (USP2)
- It’s dictated by private insurance companies that really determine what people have covered and what they don’t. (USP2)
- I think a lot of it’s on the web now. Almost all of my patients have come in with stuff from the web. So, I think that’s a lot of it. I’m sure a lot of it’s talking to friends and family too, especially with cancer diagnosis, there’s so much information out there. Some of it’s really good some of which is not so good, um, you know books, magazine articles, but I would say largely the internet. (USP2)
- I think a lot of things, a lot of decisions that cancer patients make about what they choose to do and what they choose not to do happens in those, they get the information from other people they are going through therapy with along this kind of journey. (USP2)
- If an oncologist dismisses a therapy or is not supportive of something, the patient generally won’t do it. So I think it’s very influential. (USP2)
- Do you believe there to be equal or unequal access to conventional care providers in the US. P: I would say unequal based on a lot of financial, geographic, cultural, social issues. (USP2)
- I think a lot of decisions are made with the financial framework instead of necessarily the really what’s best for this patient framework, which I think is really unfortunately. (USP2)
I think, in my mind, that’s what drives how decisions are made about what is offered. If it’s not reimbursable, it’s not done, generally. Even if it would help the patient. (USP2)

Your questions make me realize that most allopathic practitioners are not very knowledgeable about CAM, even ones that have no issue with it. It’s not something that is emphasized in training at all. You kind of know it’s out there, but, you know, I have no training in herbal therapies. I know a little bit about massage acupressure and acupuncture, but, and Reiki, but not enough to really talk intelligently to patients about it. (USP2)

<table>
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<tr>
<th>Positive Aspects (Strengths)</th>
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<tbody>
<tr>
<td>• Allopathic services are provided to patients</td>
</tr>
<tr>
<td>• To decrease information overload, oncologists filter information provided to cancer patients that impacts access to allopathic treatment decisions</td>
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<tr>
<td>• The internet facilitates access to information on allopathic cancer treatments.</td>
</tr>
<tr>
<td>• Once patients are diagnosed with breast cancer, they will be directed through the allopathic health care system to receive standard conventional treatments.</td>
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<th>Negative Aspects (Weaknesses)</th>
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<tr>
<td>• A serious policy gap exists wherein cancer treatment may create potential problems in receiving future care. For example, patients with private insurance may lose their jobs because of factors relating to their cancer treatment, which in turn will lead to loss of personal insurance that was previously provided through their employer, which leads to patients paying out of pocket for treatment or, if they qualify, they may apply for public assistance programs (e.g. Medicare, Medicaid).</td>
</tr>
<tr>
<td>• Oncologists filter information provided to patients so patients may not be presented with all of their treatment options</td>
</tr>
<tr>
<td>• Oncologists influence the services and treatments cancer patients choose to access.</td>
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<tr>
<td>• Insurance companies act as barriers to allopathic care because they determine which treatments are covered and which treatments are not covered.</td>
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<tr>
<td>• There is unequal access to conventional care based on financial, geographic, cultural, and social issues.</td>
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<tr>
<td>• Decisions regarding patient care and treatments are greatly influenced by financial considerations, rather than what may be optimal for the individual patient.</td>
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<tr>
<td>• Health care providers are not educated during their trainings about CAM therapies and how they may be integrated within patient care frameworks</td>
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<table>
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<tr>
<th>Implications</th>
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<tr>
<td>Practice</td>
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| Research | Future research should investigate how, and to what extent, patients value the recommendations of their oncologists and if these recommendations ultimately influence the treatment route these patients “choose”.  
Future studies should explore what types of information cancer patients want to receive from their oncologists and if they prefer to be presented with all treatment options, or only the ones that their doctors recommend. |
| Professional Education | CAM therapies should be presented within training/education programs for health care professionals so that these people may be knowledgeable about available services that may help improve patient well-being and quality of life. |

### Credentialing and Regulating Allopathic Care: U.S.

**Data Results**

- In terms of physicians, physicians have to go through training, residencies. There are board certifications. There are board recertifications. You have to get your license. So, in terms of the proficient point of view, there is more overseeing of the medical professional than the CAM professionals. (USP1)
- In terms of medications, you have medications that are FDA approved, medications that are in the stages of being researched. (USP1)
- So, I think, you know, regulating healthcare system...the time that the physicians spend with the patients is reimbursed and valued, that would help a lot. I think that the business is too big to be able to be regulated. I don’t foresee that that is an option. (USP1)
- I think it’s regulated broadly by the medicare system, which a lot of insurances use as their benchmark for what they will and will not cover. (USP2)
- Beyond that would be our, you know, congress and then you have private insurers that regulate it heavily. Um, then you have the institutions themselves, hospitals, clinics, urgent care centers, that regulate what insurances they may or may not take or what kind of things they do. You have practitioners that regulate it. (USP2)
- You have FDA and other government, I forgot to say that. Other things that influence what drugs are marketed and how they’re marketed. (USP2)
- The licensing board like, in terms of practitioners like whose authorized to perform certain skills in an allopathic model is very well delineated. (USP2)
| Positive Aspects (Strengths) | • Because there are regulating authorities for allopathic care, there are standards set for quality care provided to patients.  
• Credentialing for health care providers regulates and qualifies individuals to provide certain levels of care (e.g. oncologists are certified as experts on cancer care and are most qualified to treat this specific patient population)  
• Consumers (patients) regulate health care professionals. Consumers must have confidence in their physician/oncologist to continue to receive care from him/her or to give recommendations to fellow cancer patients. |
| Negative Aspects (Weaknesses) | • Costs will increase with increased levels of regulation |
| Implications | • Practice  
• Policy  
• Research  
• Professional Education |

| Data Results | • In CAM, there is nutrition, and you have license dietitians. There is physical, you know, trainers. There are body workers, and there are some of the physicians have license. (USP1)  
• There are some that can be licensed acupuncturists. You could be a licensed naturopath. There are courses to learn healing touch from the nursing point of view. So, there are some regulations, but there are not as prevalent and straight across the board like the medical credentials. (USP1)  
• And then, you get to supplements and botanicals, there is a lot out there and there is not a lot of quality control. There is some. (USP1)  
• Who knows whether the vitamin they are buying has the content that they say they have, because there is no regulating on the prescription medication. So, and there is a lot of business of selling a combination of supplements and botanicals. Some of the CAM providers do that in their practices. They sell all the supplements and get a percentage of the supplement, of what they sell. I mean, we cannot do that in the medical profession. You cannot sell your own products in your clinic. (USP1) |
| Positive Aspects (Strengths) | You really don’t know what kind of quality control that they are making of the products. So, that’s a problem. (USP1)  
|                            | I don’t think a lot of it is regulated by the FDA. I think a lot less of it. (USP2)  
|                            | And CAM, I know there are credentials and licensing, but I don’t know if I’m as clear about the extent to how that all works. Um, so I think there are components of it that are similar, but in my mind, and maybe this is my own ignorance, I think of CAM as less regulated. (USP2) |
| Negative Aspects (Weaknesses) | Because CAM is regulated less than allopathic treatments, the costs are not as high for consumers. This, in turn, allows for easier access to treatment options.  
|                            | It is difficult to define which therapies are classified as being CAM therapies. This ambiguity creates difficulty in regulating various CAM services.  
|                            | Because CAM is not regulated as tightly as allopathic therapies, patient safety is an issue in terms of provider and product safety. (Buyer Be Ware Model).  
|                            | Because there is less regulation on CAM therapies, allopathic providers may not be aware of the CAM modalities cancer patients are using in tandem with conventional care services. This could potentially lead to negative health outcomes.  
|                            | Lack of regulation may lead to complications relating to safety and the benefits of supplements and services. |

Implications

- **Practice**
  - Education should be provided to patients using, or interested in using various CAM therapies so that they are aware of what they are receiving (e.g. teach patients about the contents of supplements and their impact on health, teach patients about potential drug/supplement interactions)

- **Policy**
  - Evaluate the current system in how CAM is regulated. Consider increasing regulation on certain services and supplements that may potentially have negative patient outcomes if performed incorrectly.

- **Research**
  - Future research should focus on current positive and negative patient experiences resulting from the way in which CAM is currently regulated.

- **Professional Education**
  - Health care providers should appreciate that many patients may be using CAM therapies without telling them. Because of this, medical professionals should ask their patients about which additional therapies they may be using outside of conventional care.  
|                            | Health care professionals should be knowledgeable or open to |
investigating various CAM therapies patients report using in addition to conventional care. This is a matter of patient safety and well-being.

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<th>Treatment Guidelines: U.S.</th>
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<tr>
<td><strong>Data Results</strong></td>
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<tr>
<td>- I think that there are a lot complementary treatments mainly to increase well being. Most patients that come complain of fatigue, insomnia, depression, inability to lose weight, body pain from their medications, or neuropathy. So, um, I don’t think that there are actually treatments that are like chemotherapy treatments or radiation that are focused and directed to kill cancer cells. (USP1)</td>
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<tr>
<td>- Acupuncture that could be used for decreasing nausea and vomiting as side effects of the chemotherapy. There are studies now with yoga that increase a sense of well being. There are mind-body techniques and groups. They support that women live longer and better. They have better survival. They have a support system, they have the resources. But there are no guidelines. (USP1)</td>
</tr>
<tr>
<td>- There are conventional guidelines, in terms of, you know, treatment and then how you follow cancer survivors in terms of how often do you do mammograms, how often do you do MRIs, how long do they have to be on hormonal therapy, etc. But, there are really no guidelines for CAM treatment. (USP1)</td>
</tr>
<tr>
<td>- There is more standard of an approach to patients with breast cancer from the conventional point of view. Both for treatment and follow-up. (USP1)</td>
</tr>
<tr>
<td>- They have very national guidelines for cancer treatment. NCCN, national comprehensive cancer network, has an extensive; I think it’s the gold standard one that’s used. You can go online. It’s like algorithms, extensive. There’s also ASCO, American Society of Clinical Oncologists has treatment guidelines. Those are the 2 big ones. (USP2)</td>
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</table>

| **Positive Aspects (Strengths)** |
| - There are organizations (e.g. NCCN, NCI, and ASCO) that outline standard breast cancer treatment guidelines based on patient criteria. This creates a standardized approach to breast cancer care. |
| - CAM therapies are used to manage symptoms of conventional treatments and to increase patient well-being and quality of life. |

| **Negative Aspects (Weaknesses)** |
| - Currently, there are no guidelines for CAM use for patients diagnosed with breast cancer. |
| - Oncologists in private practices are not reviewed/monitored for compliance with national cancer treatment guidelines. Because of this, consumers largely regulate health care providers and evaluation or disciplinary action may only be taken after serious complications or negative outcomes have occurred. |
### Implications

| • Practice                      | • Organizations such as the NCCN, NCI, or ASCO should provide recommendations for CAM use for breast cancer patients. |
| • Policy                        | • Investigate current CAM therapies applicable to patients diagnosed with breast cancer and undergoing conventional treatment. Compile database of resources and make available to general public. |
| • Research                      | • Health care providers should be aware of research proving that CAM therapies can have positive impacts on breast cancer patients undergoing conventional therapies. These CAM treatments have been proven to increase quality of life and patient satisfaction (e.g. acupuncture used to treat the nausea and vomiting side effects of chemotherapy). |
| • Professional Education        |                                                                       |

### Treatment Goals: U.S.

| Data Results | • Chemotherapy and radiation surgery kills the cancer. That’s the goal. You kill the cancer. (USP1)  
               | • Or you suppress the growth. (USP1)  
               | • Support the patient’s well-being. And for example, in breast cancer, one of the main things to decrease recurrence in cancer patients is for them to stay at a healthy weight, not to gain weight, because if they gain weight they have the fat cells that can make endogenous estrogens, which puts women more at risk for recurrences. (USP1)  
               | • I would say most patients go first line to be treated with an oncologist, a surgeon or radiation therapy. I think most patients go to the conventional treatment because they work. And they use CAM either if the cancer is advanced, or conventional physicians cannot offer them anymore treatment or hope, or if they have so many side effects, or if they want to prevent recurrence. (USP1)  
               | • We want to cure them. That’s kind of the goal. (USP1)  
               | • For the patient to be cancer free. So that’s the ultimate goal. (USP1)  
               | • I think, first, is the curative type of approach. But, then there is a palliative approach, which people think, “oh, palliative, it is withdrawal all treatments, and let you die.” But, that is not what palliative means. Palliative treatment means that you will try to maintain the quality of life as long as you live. (USP1)  
               | • Some of the oncologists, especially the academic oncologists, they are trying to prolong life, some of them. No matter what the conditions is, they want to keep people alive. So, they don’t really refer for hospice early on, and they keep treating patients until they... |
die. So, but it is a tricky thing because it is variable of how patients are in relationship to death. (USP1)

- If an oncologist dismisses a therapy or is not supportive of something, the patient generally won’t do it. So I think it’s very influential. (USP2)

- The goals for someone who’s diagnosed you know, with DCIS, or in situ very early stage cancer, um, the goal will be to cure them. To completely eradicate their chances of cancer coming back. The goals of someone who’s diagnosed with stage 4 metastatic breast cancer are different. The goal there would most likely be to extend their life in a way that’s meaningful as much as quality, but you know you’re not going to cure the underlying disease. So, I think the goals are really dependent on where they enter in terms of their staging of their disease and also in terms of what’s important to them too. (USP2)

- I think the goals of breast cancer treatment are individually driven based on the person’s own, what they want, and also, um, what’s feasible medically based on what kind of disease they present with. (USP2)

- For oncologist specifically, do you believe that CAM care is considered to be a goal within the overall cancer care plans for these patients? P: no. I: no? Is it more relying on westernized medicine? P: that is based on my experiences here at this institution. I think it’s heavily allopathic driven. (USP2)

| Positive Aspects (Strengths) | • The ultimate goals of cancer treatment are to eradicate the cancer, suppress cancer growth, and prevent recurrence.
• CAM is used as a means to suppress symptoms related to conventional cancer treatments. Incorporation of CAM therapies within allopathic treatments may increase compliance with treatment plan. |
| Negative Aspects (Weaknesses) | • In relation to conventional treatment goals and focus is placed highly on eradication of the cancer, CAM is less of a priority.
• If/when patients experience side effects of symptoms of conventional cancer treatments; they must independently seek out information relating to CAM therapies and discover a way in which to access this care.
• Oncologists have great influence of treatment goals and ultimately prioritize which goals are more important/valued than others. |

Implications

- Practice
- Policy
- Research • Future research should focus on the goals of the oncologists in relation to the goals of the patients. For example, if the goal of the
An oncologist is to cure the cancer at all costs, but the patient wants to maintain quality of life, does the physician attempt to change the priorities of the patient to meet his/her own? Is this in the best interest of the patient?

<table>
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<tr>
<th>Professional Education</th>
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<tbody>
<tr>
<td>Health care professionals should receive education on how to best integrate their own treatment goals for patients alongside the individual treatment goals of patients so as to maximize patient satisfaction and involvement with care plan.</td>
</tr>
<tr>
<td>Health care professionals should be educated on the positive impact CAM therapies may have on treating the negative symptoms associated with traditional cancer treatments. They should learn how to incorporate these therapies within the allopathic medical framework.</td>
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APPENDIX E: DESCRIPTIVE DATA FOR NORWAY
<table>
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<tr>
<th>Financing General: Norway</th>
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<tbody>
<tr>
<td><strong>Data Results</strong></td>
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<tr>
<td>• Access to health care should not be limited by financial resources of whether I can afford to get health care. And another underlying principle is that health care provision should be provided solely on the basis of your condition and your disease-your illness and should have nothing to do with either your ability to pay or where in what level of society you come from (NP1)</td>
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<td>• The primary care system is a situation where you as a patient need, are require to pay- you have a co-payment (NP1)</td>
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<tr>
<td>• Children and in certain situations that you don’t pay. But basically, everyone has to pay. But then, when you reach a total sum for the whole calendar year, that not only includes your copayment at the doctor but it includes the cost of your transporting yourself to the doctor or having other kinds of treatments that goes into that same limit so when you exceed a limit that is at the moment I think it about three to four hundred dollars for a whole year. When you exceed that, then everything is free. And you don’t pay anything. (NP1)</td>
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<td>• We do also have private specialists outside of the hospital system but they’re funded by kind of the same chuck of money that funds the hospital system (NP1)</td>
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<td>• Then the hospital system is then funded by the government, the central government but is divided into four regional health authorities...those are geographically. (NP1)</td>
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<tr>
<td>• In practice, that whole hospital system is government-funded, but, a very small private hospital system (NP1)</td>
</tr>
<tr>
<td>• But they are privately funded what, there can be areas of cardiology, ophthalmology, orthopedics, and of course plastic surgery is <em>laughs</em> a is is a big part of that (NP1)</td>
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<tr>
<td>• And the government system, the regional health authorities, if they have problems, kind of taking care of all the patients, they can buy services from this private hospital system. And they’re actually required to buy from them if people have been on a waiting list that’s you know it’s been too long, then the patient is entitled to get the treatment so they have to buy it either from the private hospital system in the country or they can buy it abroad, in other countries...as they also do (NP1)</td>
</tr>
<tr>
<td>• Now if you, as a patient, need to go to let’s say the united states cuz there’s a treatment there that you think is the perfect for you, that can be done, but it is your local regional health authority that has to approve that if they are going to pay your treatment. I mean you can go to the U.S. and get treatment any time you want if you pay yourself (NP1)</td>
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</table>
• In the primary care system, eh, the the local municipality can fund or does fund like, physical therapy, like, eh, chiropractor, but different, how much they fund because, like, physiotherapy they are organized where they have quite a large part of their funding comes from the municipality, the public, while chiropractors, only eh, kind of eh, symbolic sum is given. So they are basically running privately. (NP1)

• In practice, there’s a lot of priority going on, but it’s not conscious because that’s too difficult. So it just has to be you know, we don’t have enough money (NP1)

• In practice, of course there is a limited sum of money so it’s to up to the individual regional health authority or the individual doctor at some level to say this is what I want to do and I don’t want to do that. (NP1)

• I’ll just mention one example and that’s invitro fertilization. Where you get eh, you’re allowed three tries funded by the government, but if you want to do more than three, then you have to pay. And you have to pay all the medication yourself for that. (NP1)

• The biggest expense in our national budget is, as far as I know is, is health care and our eh retirement and all that because that’s all funded by the government.(NP1)

• The money come from taxes we all pay 7.8% eh but that’s mostly for retirement, is it? Well whatever they call it *laughing* eh, it comes from taxes. Either direct taxation eh from income tax or from all eh direct taxation I mean or from all our indirect taxes like our valued added tax which is 25% anything you buy in this country you pay 25% tax on it. Or from our cars that cost twice as much as they actually should or you know the taxation or the gas (NP1)

• The hospitals they get kind of eh eh a lump sum every year. Eh, they get a letter from the government, these regional health authorities, they say we’re now giving you this many billions of dollars to run your regional health care and in that letter they also indicate some guidance at to what they want then to do with that money (NP1)

• In the primary care system, this is funded by the local municipalities. (NP1)

• But they get their money, again from the central government because they’re not allowed to take their citizens ehhh, kind of independently. So, Tromsø cannot decide oh we want to tax people 40% tax in addition to whatever the government centrally does. Everyone pays kind of the same amount of taxes into the central government and then they allocate money back to the
municipalities that they can use. But what the local municipality can do, they can, they can levy property tax. And some do and some don’t. So they put property tax on property and that money they can use then to top up their expenses in whatever area they they want to top it up. (NP1)

- But I think it’s important to collect money from everyone and then that that applies to everyone getting the same health care. (NP1)
- You have to then privately purchase that insurance or your employer might. Cuz there’s an increasing trend now that employers buy private health insurance for their workers not because they, it’s just in addition to, because everybody’s entitled to this government run system, (NP1)
- The government does not pay for bad eye sight or dental health problems. So if you go to the dentist you have to pay everything yourself and you have to buy your glasses yourself. So, eh, there’s already principle that they don’t pay for everything (NP1)
- My principle thinking is that we should not, kind of have a system where’s it’s totally unpredictable how much money we need to spend on health problems. (NP1)
- To a very a high degree it is financed by public resources. Certainly a lot of patient co-payment but the basis financing is structures related to money coming from the government, from taxation, from public sources of income. (NP3)
- The money from the state budget comes from taxation, direct taxation, indirect taxation, income from national resources, production of oil and gas, for example. And I don’t have exact figures on different sources in my head so we have to look it up in public statistics to see that. But I think it’s correct to say that less than…..There’s also some kind of patient co-payment. Not related to in hospital treatment but to, to primary health services. But the maximum per individual to pay annual should be about 2,000 Norwegian krone…that would be about $160 U.S. dollars. (NP3)
- The health system, so free to everyone-- that’s doesn’t mean that we don’t pay for it. (Chuckles) But, everyone working will have to pay. (NP2)

| Positive Aspects (Strengths) | • Norway has a socialized health care system that allows equal access to services regardless of ability to pay.  
• Funds allocated to national health care come from direct and indirect taxes that all individuals pay and income from national resources (i.e. oil, gas). |
| Negative Aspects (Weaknesses) | • There is prioritization of patients based on various criteria (e.g. severity of illness, prognosis, etc.) because there are not enough resources to treat all patients at the same time. Because of this, |
patients are ranked and will receive care based on their condition and availability of resources.

- Because there is a limited sum of allocated funds to the national health care systems, individual regional health authorities and doctors must decide which services to provide to patients and which services to dismiss.
- Services not provided by the national health care plan include vision and dental. So, if individuals seek this care, they must pay for it out of pocket.

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<th>Implications</th>
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<td><strong>Practice</strong></td>
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<td><strong>Policy</strong></td>
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<tr>
<td>Should the current structure of health care and allocation of funds be reevaluated to provide even more equal care to all Norwegians? If the Norwegian health care system received more funds, would patients be able to access care faster? What is this potential impact on patient health outcomes?</td>
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<tr>
<td><strong>Research</strong></td>
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<tr>
<td>Further investigate if health care decisions ultimately made by physicians based on patient prognosis yield positive outcomes. Is patient prioritization effective in terms of individual care?</td>
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<tr>
<td><strong>Professional Education</strong></td>
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**Financing Allopathic Care: Norway**

<table>
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<th>Data Results</th>
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<tr>
<td>Everyone has to pay when they go to see their GP (NP1)</td>
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<tr>
<td>If you want this funded by the Norwegian government, then a regional health authority has to approve that treatment and it could be, it’s usually kind of conventional treatment that is kind of new, it’s not existing here in this country (NP1)</td>
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<tr>
<td>In allopathic services of course everything is paid for that is regarded necessary for her treatment. So, that’s just a matter of choice for the professional taking care of her (NP1)</td>
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<tr>
<td>We have an issue in Norway, again what I talked about the prioritizing, because, in practice, in cancer treatment in Norway, there’s there is a political debate right now I saw online today that the politicians in in in, eh, in the parliament had to kind of pressure the government to provide for more cancer treatment for cancer patients because you know because of money they don’t necessarily give the, what is regarded as the best medication (NP1)</td>
</tr>
<tr>
<td>The government pays even your travel to Bergen. So, and the regional health authority in this region has to pay for your treatment in Bergen even though it was your decision, not theirs. (NP1)</td>
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<tr>
<td>The incentive for the regional health authority is to make sure they</td>
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can offer you treatment that you’re happy with so you don’t choose
to go somewhere else where they have to pay for you. (NP1)
• If it was unavailable in any kind of Norwegian government-funded
institution...she would have to pay out-of-pocket, and we have
those examples where people say “oh there’s somebody in
Germany giving a treatment and it doesn’t exist anywhere in
Norway” and if she said “I want that treatment” even though it’s
within allopathic medicine and if she went to Germany and got that
treatment she would have to pay it herself... (NP1)
• If she couldn’t convince her regional health authority that they
should pay for that (NP1)
• I would add that I think maybe a lot of things in conventional
health care should not be covered as well (NP1)
• IVF invitrofertilization. That, personally I am not sure we should
fund that. I don’t think it’s a human right to to eh reproduce and
that the government should pay that (NP1)
• If that was something that they could not provide within their
budget, they would um, either say well this is not necessary for you
or they would eh try to convince her that is not what she needs at
the moment. (NP1)
• It’s of course all funded by the government, so everything is free
for the woman. (NP1)
• I think they would be very eh listening, they would listen to what
she wanted, but eh, if that was something that they could not
provide within their budget, they would um, either say well this is
not necessary for you or they would eh try to convince her that is
not what she needs at the moment. Um, because I think they’re
very reluctant to to admit that they actually do not have what she
would need. So, um, if it’s in kind of a spiritual nature, they’re
very accommodating because they just call the chaplain. So if it’s
kind of a that nature, that’s not a problem, then they just call the
chaplain and he or she takes care of that. (NP1)
• They know what they get from the public services., at least what
you get as an inpatient from public services, is totally covered by
public financial sources (NP3)
• Traditional treatment with chemotherapy and radiotherapy, you
have for free (NP2)
• The costs are very high, like in a lot of countries, and it is very
difficult to treat all the new sorts of medicines that we can see
coming up the next few years, they’re very, very costly, you know.
But in my practice, I work with cancer and Herceptin is very
expensive, it’s about 300, 000 kronars for one year of treatment,
for one patient and you see a lot of new drugs coming up. So we
have a problem with the costs as you know, we are happy that everyone gets the same sort of treatments. (NP2)

- All the treatment is free and all the CAM costs you whatever it costs you (NP4)
- So, patients diagnosed with cancer, are they able to pay for different types of services if they have more money? If you have more many can you pay for additional care? P: Not in allopathic, everything that is available is all free. (NP4)
- In allopathic medicine, we have private hospitals, and some people have insurance there, because if you have something like life threatening cancer here, you will be treated right away. But if you have non-life-threatening cancer, you may have to wait some time to have an operation, and if you are member of a private hospital, you can come right in. (NP4)

### Positive Aspects (Strengths)
- All services and treatments considered to be standards of cancer care are provided free of charge to breast cancer patients (e.g. chemotherapy, radiation, surgery).
- If patients wish, they may purchase private insurance, which would allow them to be in control of the timing of their treatments. With private insurance, they would be able to receive care faster than within the traditional system.

### Negative Aspects (Weaknesses)
- If a patient wants to receive a treatment not currently funded by the national health care system, they must apply to the regional health authority for approval
- Because there is a limit on the funding of the national health system, patients may not receive optimal care or the best medication based on availability of funds and resources.
- While patients do receive “the same” care, they may not receive it during the ideal time frame or may not have access to “the best” medications because of funding limitations.
- Within the conventional care system, if a patient has more money, she is not able to purchase additional services. She will receive the same standard of care as all other breast cancer patients.
- Patients diagnosed with non-life-threatening forms of cancer by their physicians may have to wait to receive care because delivery of care is based on prioritization, wherein patients with more severe, progressive disease processes will receive care first.
- Providers are reluctant to admit they do not have what patients need because of financial limitations. They try to convince patients they either do not need a treatment or that it is not necessary. This is not optimal health care.

### Implications
- Practice
### Policy
- Financing of the allopathic Norwegian health care system should be evaluated for optimal effectiveness and potential changes that should be made based on patient outcomes.

### Research
- How do access to medications and care provided based on time availability act as barriers to patients receiving optimal care? How does this affect health outcomes?

### Professional Education

#### Financing CAM Care: Norway

<table>
<thead>
<tr>
<th>Data Results</th>
<th>I know of actually one example of the regional health authority paid for acupuncture and alurvedic treatment in Shrilanka for a patient. (NP1)</th>
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<td></td>
<td>With regard to to CAM care, whatever a patient gets in hospital is funded by the government, so if you have an acupuncturist giving acupuncture in hospital for fatigue that is part of the hospital service and of course funded, payed for. The patient doesn’t pay for that. IF the patient seeks eh, CAM care outside the hospital, there is no... Interviewer: no funding (NP1)</td>
</tr>
<tr>
<td></td>
<td>Is that...that’s for all types of CAM therapies within Norway? Vinjar: yes (NP1)</td>
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<td></td>
<td>I have to then add that chiropractic is not regarded as CAM therapy in Norway and partly because it is partly funded by the government as I said, a small symbolic eh eh sum. So, you have to think about that. What do we define as CAM. So I think comparing to the US I think actually chiropractic is the only one (NP1)</td>
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<td>Everything else you think of as CAM totally out of pocket, everything (NP1)</td>
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<td></td>
<td>But if she chose CAM treatment, then, nobody would pay for that (NP1)</td>
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<td></td>
<td>Even for CAM there’s no reimbursement whatsoever? Vinjar: no (NP1)</td>
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<td>No...you could, well, there’s a tiny tiny catch to that because you might have a kind of a private health insurance kind of scheme that I don’t know the details about that there might be some scheme that would cover something (NP1)</td>
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<tr>
<td></td>
<td>But, in general, the income level in Norway is high enough that most patients at least that’s my experience, they they eh they do the CAM treatment if they really think that’s important for them even though they have to pay (NP1)</td>
</tr>
<tr>
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<td>Would you like to see that government funds are allocated for CAM care? Do you feel like that’s... Vinjar: no actually not...I do</td>
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not see that that would be the eh a wise decision. (NP1)

• If we said they had to pay for CAM, that would of course, either
  necessitate tax increases, because it’s not either or...all the data we
  have is that people use both systems. And so, and there’s you
  know, where should you put the limit to that? So, actually my
  personal opinion is that no, we should not necessarily go down that
  road (NP1)

• Other than that, eh, it’s basically the money issue I would say
  (NP1)

• Certainly also there’s no compensation for complementary
  treatment. So if you’d like to go into some sort of complimentary
  treatment then you have to pay for it all by yourself. (NP3)

• CAM does not really fit into our healthcare system very much,
  because of the cost. That means we have decided that people must
  use whatever they like, really. But the government will not pay for
  it. So when you talk about CAM treatment, it will be like, for
  example in the United States, you have to pay for your own
  treatment. So the big difference is that traditional treatment with
  chemotherapy and radiotherapy, you have for free; but CAM
  treatment, you will have to pay for yourself. (NP2)

• I believe that people in Norway, we are very—we are sort of rich,
  most of us have very good possibility to eat what we like, and
  drink what we like and go—so I guess that people who use a lot of
  money on cars and cinemas, they can also use them on acupuncture
  and the like. So, I guess I believe right now I find it OK. In my
  opinion, until this CAM has not proven to give us a longer life,
  maybe a better life, so you have to use your own money. (NP2)

• Because we now can buy some insurance that you can get
  traditional treatments and so I guess this is something that is a
  problem for us, yes, the backbone of the medical system that
  everyone should advocate for the same rights and the same sort of
  treatments, yes. It’s difficult to see that some people have more
  money than others can reimburse and get money from—or get the
  treatment from insurance companies. (NP2)

• They never take any money and they just work in their local
  community and everybody knows who they are, and that is one
  group of treatments that’s used a lot for cancer treatment, the
  traditional healing that’s been used in Norway. (NP4)

• All the treatment is free and all the CAM costs you whatever it
  costs you (NP4)

• In CAM medicine, it is more of a big factor, but you don’t even
  know how it works, the treatment you are offered, it’s expensive
  (NP4)
### Positive Aspects (Strengths)
- CAM care provided in hospitals is funded by the government.
- Average personal incomes in Norway are high enough that, for most patients, independently financing CAM care is not a significant barrier to receiving treatments.
- If you are able to afford and purchase private insurance, it may cover some CAM therapies.
- There are native healers that provide CAM therapies to patients for free.

### Negative Aspects (Weaknesses)
- CAM care provided outside of the hospital setting is financed by the individual- out of pocket, and there is no reimbursement.
- KIs generally believe that CAM care should not be financed by the government until it has been proven to increase length of life, not only quality of life.

### Implications
- **Practice**
  - Patients should be educated that they have access to free CAM therapies within the hospital setting if they wish to use them.
- **Policy**
- **Research**
  - Research relating to effectiveness of CAM therapies should continue to be a priority. If/when there is “sufficient” information about its effectiveness on increasing length of life (among other factors) the health care system may consider covering CAM services for society.
- **Professional Education**
  - Health care professionals should be aware that, while patients may wish to access CAM therapies, they may be unable to do so due to financial limitations. Since CAM provided in hospitals is covered under insurance, if providers are aware of the wishes of their patients in seeking CAM, they should facilitate provision of this care while patients are in the hospital.

### Access to CAM Care: Norway

**Data Results**
- What they don’t talk about is that and by what we know is that even at the hospital level there’s quite a lot of CAM being practiced in Norwegian hospitals (NP1).
- Ok and do you believe that patients consider these differences between accessing allopathic care compared to CAM care knowing that they won’t have to pay for one and knowing that they will have to pay for the other? Vinjar: if they’re aware of that? Interviewer: yeah, and if that does influence their decision. Vinjar: oh yes it does influence their decisions. (NP1)
- But of course there will be eh some situation where they say “I can’t afford this or I can’t do this” (NP1)
- In CAM they really research, they really they listen to neighbors and they get they try to collect a lot of information and then they
choose, while in in allopathic they just go with the flow. (NP1)

- I think it’s mostly practiced by practitioners and eh, dietary supplements and stuff you buy in a health food shop. This self-care, the kind of develop myself, eh, like thai-chi, yoga, meditational, that...my impression is that it is increasing, but it’s still not kind of a major part of this (NP1)
- Do you believe that there is equal or unequal access to CAM providers? Obviously an unequal thing would be the funds required to pay for such services, but are there other specific patient and even provider characteristics that would limit...Vinjar: I think that mostly geography (NP1)
- That these are concentrated much more in Oslo than in like Finnmark county. So they’re very unevenly geographically, other than that, eh, it’s basically the money issue I would say (NP1)
- If it’s regarding CAM, eh, they will not provide it, but they are required to allow her to have a CAM provider come into the hospital and actually give treatment to her when she’s in the hospital if it does not interfere with her conventional treatment. (NP1)
- And as far as we have seen related to cancer treatment, complimentary medical treatment is not to a high extent given by Norwegian hospitals or Norwegian authorized healthcare workers. But we see that quite a lot of patients they search for complimentary help outside the health service, outside the recognized health service (NP3)
- And when it comes to information about complementary care I think it is the colleagues, or the family members, friends are the main persons giving information, it is not the health personnel. (NP3)
- And so if a patient did want to go about accessing a provider of complementary and alternative therapies, how would one go about doing this? P: Look up on the Internet, look in a telephone book...because in Norwegian telephone books you will find who is practicing different types of complementary medicine. And ask people in the local community who know something about it. Perhaps also if you’ve decided to do that ask you family doctor if he knows about some kind of alternative therapies in the area. But that’s not the main source I think. I think the main source is friends, colleagues or family members. (NP3)
- We have not a very big market with completely self-taught practitioners. We have quite market with people that have attended weekend courses and one week courses, one month courses in Norway, in other parts of Europe in China. But more or
less the people that I meet when I speak to complimentary practitioners, they have some kind of a basic education in their complimentary medical tradition. If you go back to 10, 20, 30 years I think the number of self taught people basing their therapeutic practices on self made ideas even is fewer now than there used to be. (NP3)

- You will get nothing of this sort in the hospital; you have to get it outside. (NP2)
- If you want to have many sorts of CAM it will not be allowed within the department. For example, injections of so many kinds, we will not allow that. So, it’s not like you can do anything within our department- I: Within oncology, you mean? P: Yeah, it will be a huge barrier there. So, the only thing they can do is take with them some pills or whatever they use from their own purse. But normally, we don’t allow that a healer is coming in to the department without schedule. (NP2)
- We had a traditional healer that wanted to get into the hospital and she wanted to have the possibility to heal people there, and we had to tell her no; because that is not an option for our patients. I: OK, and who makes these decisions about which CAM therapies are allowed to be used in the hospital and which aren’t? P: Well, in our system, we have a leader, a consultant that is the leader of the department and he will make the medical decisions, what we can do and what we cannot do. (NP2)
- With CAM treatment, it will depend on which part of the country you live in, if there are no acupuncturists in the place where you live, you will not get it. So in Oslo, it is much easier to get all sort of CAM treatment, but not if you live in many other places in the country. (NP2)
- With CAM care, it is very often given through colleague press (30:35) and in my studies in Norway, I have found if you have eczema, or fibromyalgia, or anything that doesn’t really threaten you very much, then the advisors from the colleague press are very much used, but among cancer patients, it’s much more family, and close friends and people you believe in, that are giving the advice. So, we found that seventy percent of the CAM patients that use CAM have got the most information and advice from close family and friends. (NP2)
- Some of them are going to practice this sort of CAM and they might get good advice from them, or ignore their advice and they can go, but you also have this huge internet world giving people the freedom to believe whatever they like, and also to be fooled by everyone they like. (NP2)
But the cancer patients, they were allowed to use CAM, but practitioners were not allowed to treat them. I: OK. P: So, when they got sick and wanted someone to help them—people had knowledge to help them, but they weren’t allowed to. So, what happened were the people who were the best ones, who we had practices going and things, they didn’t take the risk you know? In helping people with cancer, because it was illegal. (NP4)

So the only people who helped those people were the ones who—I want to say they worked under cover, but they didn’t have it as as full time job, they did it a little on the side, and they didn’t have so much to risk, and that way, you know, they were not offered the best treatment (NP4)

My start into this was that my father was getting lung cancer and the hospital couldn’t offer anything, he was dying, and we found out that CAM treatment could help him, couldn’t find that they were willing to treat him, so he died (NP4)

The one thing that is used most is the reading and the traditional way of healing, which is very strong in the northern part of Norway and the western part of Norway (NP4)

If you want CAM treatment you must find a doctor yourself, you will have no references from the hospital (NP4)

How do patients go about finding this kind of information? P: That is one of the hardest parts in Norway. That is why NIFA started, because before NIFA started, you needed to know somebody who had tried something, or people went to the internet, that is also quite new. (NP4)

In Norway, people are very good with having contact with cancer to give you all kinds of information about what you should do, and that is actually a problem because they have the cancer and they have all the friends and all their family and all the relatives telling them, “Oh, she did this and oh, she did that.” Most of them really feel like this. So, the information is really kind of available, but there is now information that is just worth it for them, so that is why NIFA came, to try and produce information about CAM treatment for sicknesses and illnesses that isn’t based on just one story, but based on research and more broadly accepted theories. But there is a few pages and telephone numbers you can call for the treatments that’s from practitioners, you know, they have their own websites and their own telephone numbers that give information about all the practitioners, but that is of course only the practitioners who paid to be there, so that’s not either. So this is the hardest part for cancer patients, is where to get the information. (NP4)
| Positive Aspects (Strengths) | • It really is no official place they can go for this information, and that is the hardest part for people, because they don’t have so much time when they get sick, and they need information, and there’s no one there. (NP4)
• We have a cancer society in Norway, and they are supposed to give people information about cancer treatments and information around cancer, and they also have one part that should give information on CAM, but if you come from the CAM field, they really don’t suggest it, they all the information is put out in a way that says we really don’t know about this, so we had better not. (NP4)
• The problem is that the hospitals don’t offer CAM treatment. (NP4)
• If you wanted CAM therapies and if you had enough money, do you feel like that is a barrier in terms of accessing CAM care, is funding for it? P: Yes. (NP4)
• So, in that way, money is a factor, you know, because when you spend all your money on this, it’s really hard for Norwegian cancer patients to go the CAM path (NP4)
• This is available for people who can pay for it and the resources to find it, these people, but for other people, it doesn’t exist. (NP4)
• The access to CAM is much harder, because where should you go, if you don’t know anyone? (NP4)
• The access is there immediately, if you have the money, because then you could just make a phone call, and all the traditional healing is free, but it can get hard to get a hold of them, because all the people have heard about this book by a famous healer in Norway, about fifty thousand patients a year or something ridiculous, it’s something enormous, it’s really a huge amount. So people calling all day and night to get access to him, and of course it was very hard to get access and he didn’t take anything, so of course everyone would try it, because he was free, so everyone would try it. So people like that are hard to get access to (NP4)
• People don’t know where to start. So access is there and not there, if you know where to go, if you don’t know where to go, it’s hard because you wouldn’t have the slightest idea where to start (NP4)
• Hospitals and providers are required to allow CAM practitioners to enter the hospitals and provide care to patients at the request of the patients as long as the treatment does not interfere with the allopathic treatment
• NIFAB originated out of the need to provide information about safe and effective CAM therapies for various illnesses. Their suggestions are based on research and broadly accepted theories. |
This creates a resource for patients wanting to find out more information about CAM.

| Negative Aspects (Weaknesses) | • Aside from financing issues relating to accessing CAM, the other major issue is location of CAM providers. While there are many located in Oslo, there are limited CAM resources throughout the rest of the country. And, the type of CAM resources are often defined by region (e.g. the CAM therapies provided by the indigenous healers that live in that region)  
  
  • Patients access information about CAM from mainly friends and family. There is limited standardized information about CAM available to society.  
  
  • Allopathic practitioners will not provide patients with references to CAM practitioners. The patients must access CAM providers on their own.  
  
  • Main barriers to accessing CAM: financing, resources to find it (both information and geographically), if there is time for patients to be seen by CAM providers (more common issue with traditional healers) |

| Implications |  
| --- | --- |
| • Practice |  
| • Policy |  
| • Research | • There needs to be a standardized national resource that patients can access that provides information about CAM therapies and their use in specific illnesses. |
| • Professional Education | • Doctors need to be educated about various CAM therapies that patients commonly use based on their illnesses so they can make safe recommendations to these patients. If doctor increase their own knowledge and recognition that patients are indeed accessing CAM, they will be able to ensure safe practice. |

| Access to Allopathic Care: Norway |  
| --- | --- |
| Data Results | • Equality issue, fairness should be the same whether you are the king or you’re a bum on the street. That’s the same treatment once you get into the health care system (NP1)  
  
  • Everything you take to your primary care physician, and you know whatever and eh, I’ve been working as a primary care physician here for 25 years and there is no limit to what people come to the primary physician for (NP1)  
  
  • They cannot refuse to accept the patient coming to them, but of course in the consultation they can say “well there’s nothing I can do about this” (NP1)  
  
  • They cannot refuse anyone wanting to seek their services (NP1)  
  
  • Within conventional care and if if you’re if you’re not talking |
about the primary care level, there is if you if you if your doctor who you’re assigned to, does not want to give you or offer you the treatment the system has built in it that you’re entitled to a second opinion. (NP1)

- At the hospital level, of course at usually there’s a team of doctors so that there will be different opinions but if you know you don’t get it here you’re actually also in Norwegian system, you have eh eh you’re entitled to choose a different hospital. So if, if you’re here in Tromso and you you say “I don’t want to get treated in Tromso because they don’t offer this treatment, but they do in Bergen” then actually you can choose to be treated in Bergen instead (NP1)

- The employers sometimes buy health insurance for their workers so they can circumvent that waiting time and get treated at private hospitals either in Norway or abroad (NP1).

- My impression is that this is kind of so eh kind of default in the thinking that they only if they’re a very special condition, do they kind of seek special information, cuz they, we have my our doctor, he knows what to do with my health problems (NP1)

- My impression is in my 25 years of practicing medicine is that most of my patients, and these are not in the big cities, out in the country, they say “you know this, you decide” and so, they’re not that interested in different treatment options. (NP1)

- Whereas with um, general practitioners, they’re evenly distributed based on patient populations in the region? Vinjar: yes (NP1)

- But if it’s kind of some treatment, I think then that they’re very reluctant to, to provide that and there are many cases reported where people have complained about those issues as well. (NP1)

- Who does the system provide care for within Norway? P: All people situated in Norway. It is not so that you need to be a Norwegian citizen to have services from the Norwegian healthcare…You have to be legally based in Norway so to say, that’s the main requirement. (NP3)

- Mainly the treatment of patients with breast cancer is coordinated by the specialized health services. (NP3)

- The barriers are not in the entrance, it’s more that when you have entered the system they suffer quite a lot of experiences with delays, and delays, and delays with how to get further and through the system, especially when the initial diagnosis and urgent treatment phase is over, then there may be some kind of delays in the system. And we’ve also had single cases of delays in the diagnostic process and procedure. (NP3)

- A very small number, small private funded services in Norway. As
far as I see they are not very much occupied with extensive cancer treatment for example. If people in Norway should not be satisfied with what they get from the public health service, they tend…but it’s only a very small fraction…they tend to if they would like to use their private money for more treatment they tend to go abroad to do that. (NP3)

- The main sources for knowledge on the conventional care is through their general practitioner and through the healthcare personnel they meet through the process. And certainly there is a general coverage of knowledge through the media and that kind of thing. But when you get into a situation where you need it by yourself then the first person I think most ask about further advice is the general practitioner the family practitioner. (NP3)

- We have a very sort of socialized healthcare system, everyone in our society will have the same sort of treatment and they will get it for free. So, the school system and the health system, so free to everyone—that’s doesn’t mean that we don’t pay for it. (Chuckles) But, everyone working will have to pay. You know these things, I guess, but a part of what I earn will always go to the tax, and 9% or 10% of what we pay will go in to the healthcare system. But that means that even though you don’t earn any money, you will have the same rights. (NP2)

- We know the barriers in all kinds of system will be delay and sometimes you won’t get it when you need it or when you want it. You have to wait maybe. (NP2)

- With these individuals who do choose to purchase private insurance in addition to the government funded insurance, or just people in general who have sufficient funds, can they pay for different types of services compared to other people who are unable to do so? P: Yes, there are some private hospitals in Norway, so you might get some Herceptin, or other substance faster than you can have in the normal hospitals, you might go abroad (NP2)

- Conventional care is easy to access, but you have to follow the formal line in Norway. If you have a lot of money on your own, you can hound the professor that you heard about, and you can get an hour to see him. Normally, you have to go to your own doctor, and he will then write a letter or send you to the local hospital, and then they will send you to the special unit and then you will meet a group of doctors, you will never have the possibility to say, “I’m very important, I need to see the professor.” They will have-at the department; they will make the decisions, which physician you will see. But still, everyone will have to go this a little bit, on a way
than I would do it. That’s-so the time aspect it might be one of the weaker points in our system, but it will easily be a delay of eight weeks or something from your breast cancer to you get the treatment. (NP2)

- I believe that the conventional care information is very often given by the general practitioners and your healthcare chief. (NP2)
- Norway, the health care system is free. No one pays for anything. No matter what happens to you, you get the treatment for free and you don’t need insurance, nothing. So, no matter what treatment you will need for cancer, it will be offered directly. But that is not CAM treatment. That is only allopathic treatment, (NP4)
- We have a cancer society in Norway, and they are supposed to give people information about cancer treatments and information around cancer, and they also have one part that should give information on CAM, but if you come from the CAM field, they really don’t suggest it, they all the information is put out in a way that says we really don’t know about this, so we had better not. (NP4)
- So, patients diagnosed with cancer, are they able to pay for different types of services if they have more money? If you have more many can you pay for additional care? P: Not in allopathic, everything that is available is all free. (NP4)
- In allopathic medicine, we have private hospitals, and some people have insurance there, because if you have something like life threatening cancer here, you will be treated right away. But if you have non-life-threatening cancer, you may have to wait some time to have an operation, and if you are member of a private hospital, you can come right in. (NP4)
- So, it’s a time factor, everything is offered, proper treatment for cancer, but people who have membership in private hospitals can buy the time factor of it. (NP4)
- The access to allopathic treatment is very easy, because what you do when you don’t feel well, is that you make an appointment with a GP and he will send you forward to the hospital or a specialist. So cancer-is-your GP or specialist will diagnose the cancer if you find a lump somewhere and you go and have it scanned and the specialist tells you it’s cancer. But, by the time your cancer diagnosis is confirmed, you are already within the system. So they will immediately suggest some kind of treatment, so you don’t have to do anything to access allopathic treatment, because by the time of the cancer diagnosis, you are already within it. And they will take care of you, they will offer a treatment plan for you, they will take your diagnosis to a meeting with the other doctors and put
up a plan and represent the plan for you, so you don’t have to do anything. The only thing you need to do is make the first call to the GP, and then you are within the system. (NP4)

- Everyone has a GP. As soon as you move somewhere, you get a call saying that this will be your GP and if you want to change, you can go on the internet and change, find another one. So, everyone is given a GP ultimately (NP4)
- There are checks for cancer in Norway that healthy people, there’s quite a few actually. There’s old women in Norway who are suggested to check for cancer in their third year then the GP takes a test and old women of the age of forty and more are going for a test for mammo-cancer (sic) I think it’s in the third year that it’s offered (NP4)
- But aside from that you do need to say something to convince the doctor that you do need to be tested for cancer and of course the doctors have a lot of other people coming in every other week, you know, all sorts of things. He probably does his first few years but then the specialists tell him over time, that he’s got nothing wrong, then perhaps I will have to convince him. But normally not, the doctor is normally not going to question you (NP4)

| Positive Aspects (Strengths) | • Access to allopathic care is equal.  
|                            | • Individuals may purchase private insurance or private insurance may be provided to them by their employers to avoid waiting times.  
|                            | • Patients receive most of the information about their health, diagnosis, treatment options, etc. from their doctor. They do not seek out information from other sources.  
|                            | • There is a very strong structure in place for treating cancer patients. Patients go to their GP, who refer them to a specialist, who diagnose them, who send them to treatment.  
|                            | • There are cancer screenings done on at risk populations. |

| Negative Aspects (Weaknesses) | • While the care provided is equal from person to person, the time that patients receive care is based on physician recommendations, which are often focused on severity of illness, prognosis, etc. This particularly relates to breast cancer treatment once diagnosis and the urgent treatment phases are over. Often, delays are common. There have also been delays in the diagnosis of breast cancer. |

| Implications |  
|              | • Practice  
|              | • Policy  

- The current issues with delays should be evaluated and potential solutions to this problem should be identified because these delays may have serious implications for patients and their health statuses.
<table>
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<th>Research</th>
<th>Future research should investigate how the delays to care caused by the system structure impact patients diagnosed with breast cancer.</th>
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<td>Professional Education</td>
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**Credentialing and Regulating Allopathic Care: Norway**

**Data Results**

- That private hospital system is is really private. But they do have to ssss... apply for kind of a license...you know they have to fulfill criteria to be allowed to to have run a hospital. (NP1)
- Well it's regulated by by law indicating what kind of services should be provided to the to the eh population. So that kind of regulates hospitals and primary health care and all that. Adn then the practitioners, they’re regulated through eh eh legislation that’s called the law about healthcare personnel and so all health care practitioners that are have a licence, need a licence to practice are regulated in the same law and and um, it it does not in detail indicate what every profession is allowed to do (NP1)
- It does indicate that if you’re a health care professional, you have to practice by law requires you to practice responsibly, and that is the only kind of eh what do you say, professional requirement that the legislation says. So, when I teach, I was teaching the other day in Oslo to nurses and I said any of you could start practicing brain surgery whenever you want to, the law does not eh prohibit you to do that. The only thing you have to provide is to provide documentation that ha is something you can do responsibly. You don’t need to be an MD to do brain surgery, but in practice, I have not heard of anyone doing that. (NP1)
- You have to be an MD to write prescriptions (NP1)
- How is conventional care regulated here in Norway? P: Yes, it’s regulated through a huge set of acts and regulations. The main two service acts I mentioned is the Act on Municipal Care and the Act on Specialized Healthcare. They gave the responsibility for the municipality and government to set up primary healthcare and specialized healthcare. As a mirror so to say, as a reflection of those responsibilities, public responsibility. There is an act on patient rights telling what each patient can expect from the public health services. So it’s a mirror of the acts on the provision side. So on one side you have two acts regulating provisional health care and on the other side you have the act on patient rights describing what patients could expect from the public side. In between there is an act on health personnel saying something about requirements for practicing healthcare. For example, the requirement for
practicing according to principles for professional practice and keep confidentiality, keeping patient files and that kind of thing. That’s the act on health personnel. That’s the main regulation. In addition you have a separate act on contagious disease, on compulsory treatment of psychiatric patients and you have an act on complimentary medicine. (NP3)

- Directorate of Health is the policy and guidelines making institution and they produce guidelines. We use their guidelines when we are evaluating and controlling the health services. (NP3)
- How is the quality of care regulated within the conventional healthcare system. P: It’s regulated mainly by that individual standard saying that you have to adhere to some kind some professional standard on the basis of your education and your professional training and what should be expected for a professional person in that situation. That’s the one thing. The other thing is that every care provider has responsibility to put up some kind of quality assurance scheme- we call them internal control scheme, showing how they fulfilled their legal obligations in a certain setting. (NP3)

| Positive Aspects (Strengths) | • There are regulations in place that outline the abilities and responsibilities of health care providers (e.g. only doctors may prescribe medications) |
| Negative Aspects (Weaknesses) | • The regulations in place are not clear about what one provider may do compared to another. The regulations only outline that providers practice responsibly. (e.g. you do not need to be a surgeon to do brain surgery. Anyone can do it as long as they are responsible) |

**Implications**

- **Practice**
  - Patients should be aware that the regulations for health care providers in Norway are vague and that they should monitor the care they receive as being effective.

- **Policy**
  - There is a need for further regulation. There should be clearly identified rules stating who can provide which services because we are dealing with complex treatments that, if provided incorrectly, could have very serious, life-threatening complications for patients.

- **Research**

- **Professional Education**

**Credentialing and Regulating CAM Care: Norway**

| Data Results | • CAM care is eh, basically not regulated at all, but we have a piece of legislation around that eh that does eh give some eh some eh eh |
legislation about eh they can be prosecuted if they harm people or or or things like that and it does say they have to have confidentiality and things like that. But they’re basically regulated as are providers of services and products. (NP1)

- So that’s the way they’re seen in eh, kind of eh a judicial system. So they’re not regulated by the health authorities. (NP1)
- So CAM practitioners CAM practioner does not have to have any specific credentials or certifications or anything? Vinjar: nothing (NP1)
- You can open shop tomorrow as any kind of CAM practitioner. There is no law for stopping you. (NP1)
- Up to 7 years ago, it was illegal for anyone else than doctors to treat cancer (NP1)
- We have no obligation for supervising a complementary medical procedures when they are given by other than health personnel. (NP3)
- In addition you have a separate act on contagious disease, on compulsory treatment of psychiatric patients and you have an act on complimentary medicine. (NP3)
- How is complementary and alternative medicine regulated? P: It’s regulated through a separate act saying that everyone practicing complementary and alternative in medicine they should obey to the requirements in that act. But if you are an authorized health personnel then you are not bound on those regulations then you are bound on the requirements in the health personnel act. (NP3)
- The act on complimentary health personnel say that the associations can establish some kind of registers. For example, the acupuncturists have made a register where they can put people living up to certain standards set by the professional organizations into that register. (NP3)
- Whoever could put up a sign acupuncturist and you have no control over it. But if you have registered acupuncturist then at least you know that this person is registered by some kind of professional association that have gone into his education and said that ok, at least he or she complies with our requirements. So that’s some kind of quality insurance measure. And the difference between the act regulating complimentary practitioners compared to ordinary health personnel is not very big. The biggest difference is that there is a general requirement on practicing according to some professional standards related to ordinary health personnel. But the same requirement is not applicable to complimentary practitioners, there is not requirement to practice according to some professional standards for complimentary practitioners.
| (NP3) | • We had a traditional healer that wanted to get into the hospital and she wanted to have the possibility to heal people there, and we had to tell her no; because that is not an option for our patients. I: OK, and who makes these decisions about which CAM therapies are allowed to be used in the hospital and which aren’t? P: Well, in our system, we have a leader, a consultant that is the leader of the department and he will make the medical decisions, what we can do and what we cannot do. (NP2)  
| | • We have a new outside care medical law from 2004, have you heard about that? I: Yes I have. P: Yes, and in that law, it says as long as-if the patient has a lot of disease-metastatic disease, they can do whatever they like. That means also that the CAM practitioners might treat them. But if they are in another position that is built by curative treatment, they can be in a sort of cooperation between the CAM practitioners and the treating physician. (NP2)  
| | • How are these CAM practitioners held accountable for the services that they provide? P: I think it’s very loosely, it’s like this, if you treat-you can treat a hundred patients, it’s absolutely OK, but then if number a hundred and one dies, and if then that was the sort of patient that you should have understood, who should have had another sort of treatment, a traditional treatment, for example a cancer patient, you will be held accountable for that. So, as long as things move smoothly on, you might just treat. But if the patients die, or if you get major problems, you might get in trouble yourself. I can give you an example, after the new law, it’s practitioners that are responsible. If a CAM practitioner is calling me and saying, “I have patients with this and that, I want to treat her with herbs from Dome Hill, Mongolia, it’s very good.” I say, “OK, I don’t mind that. If you tell me the medicine is very good.” And the patient might die. And then I-it is the CAM practitioners that might go to court and not me. (NP2)  
| | • But CAM practitioners don’t necessarily need a license to practice. P: No, but if they are only believing, but not knowing what they do- (NP2)  
| | • The new regulation with CAM is that we try to make some sort of assistance where they might wish therapy, and the staff can only do what they can, they have to be part of a group, they have to have some rules for their conduct, and then they have to sign that they are legitimate, that they are on official-for instance if you are an academic, you will not be named acupuncture without-you have to have a certain number of hours and you have to have a lot of |
schooling before you can be in that group. So they try to group them, so patients know that if you go to such a practitioner’s, he’s better than if you only have a course-a short course in his treatment. (NP2)

- But the cancer patients, they were allowed to use CAM, but practitioners were not allowed to treat them. I: OK. P: So, when they got sick and wanted someone to help them—people had knowledge to help them, but they weren’t allowed to. So, what happened were the people who were the best ones, who we had practices going and things, they didn’t take the risk you know? In helping people with cancer, because it was illegal. (NP4)

- So it was replaced with a new law, saying that you can treat cancer patients, but you can’t treat the cancer. But that’s not that hard, because CAM practitioners don’t treat one illness, they treat the whole person. So, no one is really treating that cancer cell or that carcinoma, they are treating the whole person, and to be sure to not to get into any difficulties, they are making the people signing up saying that they are not receiving any treatments for the cancer but for strengthening the immune system and the whole body, and that way, a CAM practitioner can treat a cancer patient. (NP4)

- If a person says they are a conjurer or healer— I: They’re self-proclaimed. P: Yes, so what some of them do is, members of the organizations that say that members have to have a background in acupuncture can be members of this organization, and then they use that so they can say, “Yeah, I am a member of this organization.” (NP4)

- If CAM practitioners aren’t required to have any specific credentials, and they aren’t necessarily regulate by the government, who is responsible for them if something were to go wrong? P: No one. (NP4)

- They are trying to come up with registry where people can become registered; and if you are registered, you have to have an education, you have to have insurance (NP4)

- It’s not organized the way allopathic medicine is organized here, the way CAM is organized in the states, you need a specific education and specific things around it to call yourself a CAM practitioner. So this is very open here. (NP4)

- You have no proof of it working, you just have the word of the practitioner who says, “I think we can help you.” And they’re not allowed to say they can help you either, because of the marketing law in Norway, they’re not allowed to say that this can help you unless there’s enough research behind it saying that this is perfect (NP4)
| Positive Aspects (Strengths) | • Lack of regulation of CAM keeps costs of CAM low for consumers. CAM is largely consumer-regulated in Norway.  
• Within the complementary health personnel act, providers may join associations/registers. These registers outline specific standards, criteria, education and licensing that members must have. This ensures minimum standards and acts as a quality insurance measure. |
|-----------------------------|-------------------------------------------------------------------------------------------------------------|
| Negative Aspects (Weaknesses) | • Lack of regulation of CAM therapies (CAM providers do not have to have specific credentials, they may provide whatever services they wish) may lead to patient safety issues and health complications  
• In hospitals, CAM is regulated by department leaders who decide which CAM therapies may be provided to patients and which ones are not allowed to be provided. This creates a barrier to patients in the hospital accessing CAM. |
| Implications | • Practice  
• Doctors should be open and honest with patients about potential interactions between allopathic care and CAM care.  
• Patients should be educated about the lack of regulation and to investigate for themselves potential implications of CAM therapies on their health prior to using them. |
| Policy | • Should one “department leader” be able to say “yes” or “no” in terms of providing CAM therapies to patients in the hospital? What qualifies them to make this decision? Is it fair? |
| Research | • Future research should investigate how this lack of regulating CAM affects patients positively/negatively.  
• Identify potential changes to be made in terms of regulating CAM to increase positive health outcomes for patients. |
| Professional Education | • Doctors should be aware that, due to limited regulation, patients could be using CAM without their knowledge. They should be aware of potential interactions between therapies. |
| Treatment Guidelines: Norway | • Through scientific literature, through meetings in you know cancer, oncologist societies and of course they’re heavily influenced by vendors of both, eh radiation technology, the pharmaceutical industry and all that. So those are basically the ways they keep updated. Eh, once you’re an oncology, once you’re a specialist in this country, I don’t know if you have any requirement for then keeping up with your level of... (NP1)  
• So there are no uh, CAM treatment guidelines for cancer care in Norway because there are no CAM treatment guidelines? Vinjar: no (NP1) |
Are there specific CAM treatments recommended for patient diagnosed with breast cancer? Vinjar: no, I mean if you...that have been recommended by the health authorities or doctors or anything? Interviewer: ummm, hmmm. Vinjar: no (NP1)

The only one you could possibly say was acupuncture for nausea and you know in connection to chemotherapy. There are some hospitals that recommend that. (NP1)

Effective in sense that the I think cancer treatment in Norway in general if you look at survival and those endpoints are well up to standard, up to international standard. Eh, whether they’re good enough in taking care of the women with breast cancer, I’m not sure. (NP1)

Having a woman experience her disease trajectory as something that is optimal with regard to taking care of her as a person through all this and not only getting rid of her cancer (NP1)

Mammography had been introduced in Norway, so it’s offered to all women I think between 50 and 60 but it’s...50 is the age limit. And eh, it’s of course all funded by the government, so everything is free for the woman (NP1)

Are there any CAM treatment guidelines for cancer care in Norway? P: I don’t think there is….not from the public authorities there isn’t any guidelines specifying complementary and alternative medicine on cancer treatment. I’ve never heard about that and I don’t think the directorate of health have ever made it and neither has the institute of public health. No I am not aware of that. I guess I would have heard it if they had made any public guidelines on complementary and alternative medicine on cancer treatment. (NP3)

That there should be some kind collaboration between the complimentary and the conventional medical sides. But the complimentary side would not be introduced unless suggested by the patient. (NP3)

I’m in the Norwegian board for treatment of breast cancer; so we have meetings every year and we decide what sort of medication we should give to patients with different sorts of breast cancer. SO, this is so everyone will get the same sort of treatment. (NP2)

That means that for those with cancer, everyone gets the standard treatment after what sort of disease they have. Later, if they have metastatic disease, it will always be a discussion between the doctor of what sort of treatment she will have and depending on the side-effects and such. (NP2)

In Norway, if you get breast cancer, it’s very regulated, the guidelines, because we have a national group trying to find the best
treatment, so it’s quite regulated. (NP2)
- CAM treatment guidelines for Norway?
P: It’s just wrong. Very simple, you can read the law. Yeah, you just read the law and you can find the guidelines. It’s basically that you can’t treat the cancer itself, only the side conditions, and you can’t claim a certain healing of the cancer. (NP4)

| Positive Aspects (Strengths) | • Acupuncture is a recognized form of CAM used to treat the nausea associated with chemotherapy  
• There is a national Norwegian board for the treatment of breast cancer that meets annually to decide which medications and treatments should be given to women diagnosed with breast cancer based on their presenting disease characteristics. This allows for standardization of care so that all patients receive the same care.  
• Current guidelines for CAM use in cancer treatment include that the CAM treatments may not treat the cancer itself, it may treat the symptoms of cancer or cancer treatments, and CAM practitioners may not claim to be curing the cancer. |
| Negative Aspects (Weaknesses) | • Currently there are no treatment guidelines for CAM used as a means of curing patients diagnosed with breast cancer.  
• CAM is considered within the treatment plan only when the idea is introduced by the patient. |

Implications
- **Practice**
  - Patients should be educated about the positive impacts CAM therapies have been shown to have on managing symptoms of cancer treatments.
  - Patients should know that if they wish to include CAM within their plans of care, they will need to present that to their oncologist; otherwise, CAM care will not be offered.

- **Policy**

- **Research**
  - Continued research needs to focus on use of CAM therapies within cancer treatment.
  - Resources for CAM treatments should be compiled and categorized based on use with which illnesses and should be presented to patients

- **Professional Education**
  - Allopathic physicians should stay updated with current research proving effectiveness of CAM therapies and there use within breast cancer treatment.

**Data Results**
- the goals for treatment is of course dependent on what kind of stage eh she is in, but eh, it is for an oncologist or a surgeon here I think it is to have her survive her condition that is, and that’s kind of a goal you pursue beyond even reasonable situations (NP1)
I think so and I guess that’s not very specific to the Norwegian health care system, but I think that the value that eh that the surgeon or the oncologist has is that survival at all costs and if the woman doesn’t see it or feel it that way at the moment, that I think that I think that they’re thinking is that eventually, if she survives, she will look back and say “I’m glad they did it” and eh, but um, eh, in the situation right then and there, I definitely think that they are not enough aware of other eh needs that a patient will have in that kind of situation. But, um, if they have to make a strict priority they’ll say “ok, we’ll deal with the the tumor and get that done with and then other things will have to be taken care of either at a different time or a different place” (NP1)

I think it definitely is an issue with regard to how they experience the care. I, I don’t think it’s an issue with regard to outcome if we’re talking about the hard endpoints, like survival. As far as I’m know and at least, what I eh think is the status of knowledge is that there is as I usually phrase is, there is no breakthrough with regard to CAM treatment for the tumor itself. (NP1)

He’s also shown that the the possible benefits of mammography with regard to breast cancer mortality is not nearly as as eh high as has been claimed. So, it’s in some scientific circles it’s still under debate. While, in the population, it’s still seen as only blessing. (NP1)

The most important thing is to diagnose it as early as possible to see if there’s a great possibility for complete recovery. And if there is no possibility for complete recovery it is to get as good of care as possible including pain treatment if that should be necessary (NP3)

As a physician, we are very fixated on getting them free from tumors. We have much too little time to explore the rest of their life, really. We have also the sign not to be at our goal, really. We are treating the cancer and the rest of their lives, they have to get help from many sort of-so, I guess the CAM treatment would be how that would be more important for that part of their lives. (NP2)

<table>
<thead>
<tr>
<th>Positive Aspects (Strengths)</th>
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<tbody>
<tr>
<td>• Eliminate the cancer</td>
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<td>• Earliest detection of cancer as possible</td>
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<td>• Initiate treatment as soon as possible</td>
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<tr>
<th>Negative Aspects (Weaknesses)</th>
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<tr>
<td>• While the ultimate goal of oncologists is survival for their patients, this goal may be pursued in spite of the wants of the patient or the reality of the situation. Quality of life may suffer.</td>
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<tr>
<td>• “Survival at all costs” mentality outweigh the needs of the individual patient</td>
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| Implications |  • CAM is not a goal of cancer treatment for allopathic providers.  
| |  • Oncologists are there to treat the cancer, not the rest of the patient. |
| Practice |  • Patients should know that if they want to receive a certain type of care, they must present their case and advocate for themselves. |
| Policy |  • More research should be done and compiled showing evidence for the integration of CAM therapies within cancer treatment plans.  
| |  • Researchers should investigate the oncologist-patient relationship and how disease outlook and treatment prioritization impacts care and outcomes. |
| Research |  • Physicians and oncologists should be educated about the research showing how patient outcomes improve with whole-body treatments. It is not enough to cure the cancer- they must cure the person. |
APPENDIX G: US AND NORWEGIAN HEALTH CARE SYSTEMS COMPARATIVE ANALYSIS
Second order or level 2 matrix

<table>
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<tr>
<th>Financing General</th>
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| **US Data**       | • US health care is comprised of private insurance companies and government-funded insurance companies (e.g. Medicare, Medicaid, Veterans Health)  
• To possess health care insurance, it may either be personally purchased/employer provided or individuals must qualify for government insurance based on existing criteria (e.g. age-Medicare, income-Medicaid, enrolled in the armed forces-VA)  
• Insurance dictates the care provided/received (private insurance and Medicare) |
| **Norway Data**   | • Norway has a socialized health care system that is funded by taxation  
• This system allows equal access to standard health care services regardless of an individual’s ability to pay for services  
• There are limited funds allocated to fund the health care system. Because of this, patients are treated based on disease/illness factors.  
• Physicians and the regional health authorities make clinical judgments about which services to provide to patients based on allocated funds. |
| **Similarities**  | • The health care in Norway and the government-funded health programs in the U.S. both receive their funds via taxation of citizens. |
| **Differences**   | • Norway considers health care to be a societal need and provides basic health care to all while, in the U.S. health care is not considered an essential need, but rather a supplemental service that individuals may access if they have sufficient resources.  
• In the U.S. health care insurers decide which services to provide/cover, while in Norway, the physicians make these decisions based on their current funding. |
| **Conclusions**   | • The health care system in Norway is structured to provide equal care to individuals. This means that no individuals will go without receiving care simply because they are unable to pay for it- as is the current situation within the U.S. Because of this, patients in Norway receive the care they need to cure their illnesses, whereas patients in the U.S., based on insufficient financial resources, will not receive the care required to cure them, which may ultimately result in preventable deaths. |

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<th>Financing Allopathic Care</th>
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| **U.S. Data**            | • Allopathic treatments for breast cancer are typically covered by private insurers and Medicare  
• The insurance companies and Medicare decide which allopathic therapies/treatments are priorities and choose to cover them for patients  
• Services that they believe are not high enough priorities will not be covered and patients will have to finance them on their own |
| **Norway**               | • Allopathic care is provided to cancer patients free of charge and is financed by |
Data
- Taxation
  - Funds are allocated by the government to the health care system which then further portions out funds to the different health care sections.
  - Patients do not need to purchase insurance or pay out of their own pockets to access the allopathic care system; however, they may choose to purchase private insurance which would allow them to avoid potential delays within the government health care system.

Similarities
- Private insurance purchased by individuals in the U.S. and Norway are similar, in that individuals must pay for the care provided and that they have a certain degree of control over who their physician is and what treatments they receive.
- The government funded health care within the U.S. and the health care in Norway are both financed via taxation of citizens.

Differences
- Individuals in the U.S. must purchase insurance or qualify to receive government insurance to receive allopathic care, while, in Norway, all individuals have equal access to allopathic care.
- For most individuals in Norway, private insurance is an additional resource that individuals may purchase if they so desire, while, in the U.S. the majority of individuals (those who do not qualify for government-provided insurance) have two choices: purchase private health insurance or, if they are unable to afford this, live without health insurance and pay for medical expenses completely on their own.

Conclusions
- In Norway, funding of allopathic care is not as significant a barrier to accessing care as it is in the U.S. Norwegians have equal access to allopathic treatments regardless of their ability to pay for health services because the allopathic system is financed and run by the government- not by insurance companies. In the U.S., individuals must purchase their own private insurance or qualify for government-provided insurance to receive allopathic treatments. Health care in the U.S. is based on an individual’s ability to pay for services provided.

Financing CAM Care

U.S. Data
- CAM is financed by individuals out of their own pockets and it is evident that this personal financial burden often is a significant barrier for patients accessing CAM therapies.
- In relation to allopathic therapies, individual financing of CAM therapies is significantly lower, and therefore easier to access.
- CAM care is rarely provided to patients in the hospital setting because of the ambiguity relating to reimbursement for services provided.
- Some private insurers will cover some specific forms of CAM therapies; however, patients are not commonly aware of the services included.

Norway Data
- While CAM is financed by individuals out of their own pockets, the standard incomes of Norwegians are high enough so that inability to pay for CAM
services is not a significant barrier to accessing care.

- Some private insurers will cover specific CAM therapies so patients will not have to pay for these services
- Native healers do not charge for the CAM services they provide so financial barriers to accessing these therapies do not exist.
- CAM is allowed to be provided within hospitals and this care is free of charge to individuals

| Similarities | In both the U.S. and Norway, CAM is generally financed by individuals.
- Private insurers in the U.S. and Norway may cover specific types of CAM therapies for their members. |

| Differences | CAM provided in hospitals in Norway is completely free to individuals, while, in the U.S., CAM therapies are not frequently provided to patients because of the complexities surrounding payment for services provided by the practitioners.
- Personal financing of CAM therapies is a bigger barrier to accessing treatments in the U.S. than in Norway because incomes are higher in Norway and individuals have sufficient funds to pay for these services. |

| Conclusions | While CAM services in both the U.S. and Norway are largely funded by individuals, Norwegians do not consider this to be a significant barrier to care, while, in the U.S., personal financing of these therapies is considered to be a significant barrier to accessing CAM care.
- CAM may be more widely provided to patients in Norwegian hospitals compared to U.S. hospitals because they do not have complex issues relating to reimbursement and payment of services like we have in the U.S. |

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<th>Access to Care</th>
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| U.S. Data | There is an increased availability of information relating CAM currently compared to the past and many breast cancer patients seek out this information from the internet, friends, family, and other patients.
- In general, physicians value westernized medicine over CAM therapies. Because of this, they do not suggest CAM therapies to their patients. This is a knowledge barrier for patients accessing CAM.
- Physicians filter the information the present to patients. This leads patients to make decisions about their treatment that the physicians perceive as being the best option. And, once patients are diagnosed with breast cancer, they are introduced into the conventional health care system and work their way through conventional treatment plans.
- Significant barriers to accessing care include financial, geographic, cultural, and social issues.
- Allopathic physicians value westernized medicine over CAM and do not provide their patients with information about CAM therapies. |
| Norway Data | There is limited standardized information about CAM. However, the National Information Center for Complementary and Alternative Medicine, Norway |
(NIFAB) was created to provide patients with information about CAM. Patients access information about CAM from the internet and their friends and families.
- The main barriers for patients wanting to access CAM in Norway include financing, location, and time availability of providers.
- Allopathic physicians provide patients with information about their cancer and treatment plans. Patients trust their physicians and ultimately do what they recommend.
- The allopathic health care system has a strong structure that guides breast cancer patients through the different levels of care (e.g. diagnosis, treatment, recovery).

| **Similarities** | The main ways that breast cancer patients access information about CAM in the U.S. and Norway is via the internet and their friends and families. Both physicians in the U.S. and in Norway do not recommend or provide information about CAM therapies to their patients because they value westernized medicine more. Allopathic physicians in the U.S. and Norway are very powerful in that they significantly influence the treatment decisions breast cancer patients make. Once breast cancer patients enter the allopathic systems in the U.S. and Norway, they will be lead through the different system levels to receive care. |
| **Differences** | The U.S. currently does not have resources that provide standardized information about CAM therapies and their therapeutic uses. Norway has NIFAB, which provides current information about CAM treatments to patients. |
| **Conclusions** | Allopathic physicians are extremely influential in the treatment decisions that breast cancer patients ultimately make. Also, physicians do not provide information about CAM therapies to their patients. When physicians sensor information in this way, patients must seek out information about CAM therapies on their own. Additionally, because physicians do not recommend CAM use, patients may not tell their doctors they are using CAM. This could lead to potential negative health complications. |

**Credentialing and Regulation**

| **U.S. Data** | There are strict regulations for allopathic care which set standards for care provided to breast cancer patients. Health care providers and specialists are tightly regulated and must obtain specific certificates and qualifications to treat specific patient populations. CAM is not regulated as closely compared to allopathic care. This is beneficial because it maintains low costs for consumers but has potential negative effects including safety problems and negative health outcomes. The definition of CAM is ambiguous. Because of this, it is difficult to know which therapies are considered to be CAM therapies. This contributes to the difficulty in regulating CAM. |
Norway Data

- There are regulations within the allopathic system that outline specific skills that only health care providers are able to perform (e.g. prescribing medications). However, the regulations outlining what one health care provider is able to do compared to another is very ambiguous. This uncertainty could cause negative health outcomes for patients.
- There is a significant lack of regulating CAM therapies provided by CAM practitioners. On the one hand, this is beneficial to consumers because it keeps the cost of treatments low. However, potential negative effects of this limited regulation include problems relating to patient safety and negative health outcomes.
- Within the hospital setting, CAM is regulated by department leaders who ultimately decide which CAM therapies are and are not allowed to be provided to patients.

Similarities

- In the U.S. and Norway, CAM is not regulated as closely as allopathic treatments. This is beneficial because it keeps out of pocket costs low for consumers. This is potentially negative because there is a lack of patient security surveillance which could potentiate negative health outcomes.
- Because CAM is not closely regulated by the governments, CAM is largely regulated by consumers.

Differences

- Allopathic care is more tightly regulated within the U.S. compared to Norway.
- In Norway, CAM therapies in hospitals are provided based on the decisions of the department leader. In the U.S. CAM therapies are generally not provided within the hospital setting because there is not a clear way in regulating them.

Conclusions

- Allopathic care providers in the U.S. are more tightly regulated than the providers in Norway. This means that providers in the U.S. are held to standards of care more so than Norwegian providers.
- CAM is not closely regulated in the U.S. and Norway, which is positive because it keeps consumer costs low, but negative because lack of regulation may result in unsafe practice and negative patient health outcomes. Because of this, physicians should be aware that patients may be using CAM therapies that may not be beneficial or even harmful to their health during their cancer treatment process.

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<th>Treatment Guidelines</th>
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<td><strong>U.S. Data</strong></td>
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<tr>
<td>- There are standardized treatment outlines for breast cancer care based on presenting criteria. These treatment outlines are updated based on current research and are presented by national organizations including, NCCN, NCI, and ASCO.</td>
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<tr>
<td>- Oncologists in private practices are not monitored for compliance with standard breast cancer treatments. Because of this, consumers largely regulate these providers.</td>
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<tr>
<td>- Currently, there are no treatment guidelines for CAM therapies being used in treatment of breast cancer. When CAM therapies are used by patients</td>
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Diagnosed with breast cancer, they are used to treat the symptoms that result from conventional cancer treatments (e.g., acupuncture to treat the nausea and vomiting resulting from chemotherapy).

### Norway Data
- Standard breast cancer treatment guidelines are outlined annually by the national Norwegian board for the treatment of breast cancer.
- There is a law currently in place that states the CAM treatments may only be used in the treatment of cancer patients when the CAM treatments do not target the cancer. It may treat the symptoms of cancer or cancer treatments and CAM practitioners may not claim to be curing the cancer.
- Acupuncture is a therapy that is used to treat the nausea and vomiting associated with chemotherapy.

### Similarities
- Both countries have specific guidelines for allopathic treatments provided to cancer patients.
- Both countries have recognized CAM therapies that treat the side effects of traditional cancer therapies.

### Differences
- Norway has a specific law that limits the extent to which CAM may be used and presented to patients diagnosed with cancer.

### Conclusions
- Allopathic treatments are clearly outlined both in the U.S. and in Norway based on current research and evaluation of available treatments. This allows for optimal care provided to breast cancer patients.
- While there are recognized forms of CAM that are useful in treating the symptoms of traditional treatments used by breast cancer patients, there are currently no CAM therapies recognized to treat breast cancer specifically.

### Treatment Goals

#### U.S. Data
- The ultimate goals of breast cancer treatment are to eliminate the cancer, repress cancer growth, and prevent recurrence.
- CAM may be a treatment goal of patients to decrease the symptoms relating to conventional treatments. Incorporation of CAM therapies may increase patient satisfaction with treatments.
- CAM is not a priority of conventional practitioners. Because of this, patients must seek out information on their own about CAM and its uses in conjunction with breast cancer treatments.

#### Norway Data
- Priorities of treatment include early detection, eradication of the cancer, and rapid recovery.
- The goals of treatment for the oncologists often are of higher priority than the wants of the patient. This may result in a decreased quality of life as perceived by breast cancer patients.
- CAM is not included in the treatment goals outlined by allopathic care providers.

#### Similarities
- Allopathic providers in the U.S. and Norway have very similar treatment goals ultimately centered on eliminating the cancer and ensuring patient recovery.
In the U.S. and Norway the goals of the physicians to cure the cancer at all costs may not be in congruence with the priorities of the patients. This may have negative consequences including decreased quality of life of the patients and dissatisfaction in overall treatment. 
CAM is not a treatment goal of allopathic care providers in the treatment of breast cancer. Because of this, patients may access information on their own and may incorporate CAM therapies within their conventional plans of care without notifying their physicians. This could potentiate serious health complications.

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<th>Differences</th>
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<td>The treatment goals of breast cancer patients in the U.S. are processed and evaluated by allopathic physicians more so than in Norway. This may be because physicians in the U.S. are regulated more by patients compared to Norwegian physicians. Because of this, U.S. physicians must be a bit more compliant to patient desires than Norwegian physicians.</td>
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<th>Conclusions</th>
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<td>Integration of CAM therapies is not a goal of allopathic health care providers in the treatment of breast cancer; however, it is often a priority of patients throughout their treatments. There should be an integration of both conventional and CAM treatments to ensure optimal patient satisfaction and compliance with treatment regimen. Ultimately, the goals of health care providers in both countries are to cure their breast cancer patient and ensure a swift recovery. They want their patients to survive this illness even if they have to go to hell and back to do it.</td>
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REFERENCES


