Developing and promoting public health methods for integrative medicine: examples from the field in Australia

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Abstract: Integrative medicine (IM) research in China has largely focused on clinical and experimental research, which is critical to determining the efficacy of treatments and enhancing the standing of IM. Nevertheless, there is also a need to extend research activities to include methods and research perspectives from public health, which will provide a greater understanding of clinical practice and assist government and professional organizations to shape policies and directives in IM. In this article we outline the public health research methods we have used in relation to our program of research on complementary and alternative medicine use and area of residence/geography, to highlight the usefulness of these methods in IM.

Keywords: integrative therapies; public health; methodologies; medical research; Australia

Integrative or integrated medicine (IM) is defined as a model of health care that combines Western medicine and complementary and alternative medicine (CAM) and/or traditional medicine methods of diagnosis, treatment and prevention[1]. IM has been in operation in China for over 50 years[2]. During this time most IM research has focused on clinical and experimental research[3], which is understandable given that such work is critical to determining the efficacy of treatments and thereby enhancing the standing of IM. Nevertheless, there is also a need to extend research activities beyond assessment of efficacy to include methods and research perspectives from public health, providing a greater understanding of clinical practice and assisting government and professional organizations to shape policies and directives in IM[4].

To date, there has been little public health research on IM in China. A good example of public health research was that conducted by Chen et al.[5] whose cross-sectional survey revealed that the majority of medical practitioners and their patients were in favour of IM as representing the best diagnostic and therapeutic method of care.

The aim of this article is to outline public health research methods and to highlight the usefulness of these methods for IM through...
examples from the field.

1 Public health research

Public health research examines the health of populations rather than individuals. It is concerned not only with the people who use health or community services, but also with health promotion and health prevention activities. Further, Gadomski[5] states that public health research seeks new knowledge about the factors and mechanisms that shape population health. Public health research uses a variety of multi-disciplinary approaches to explore populations with a focus on the social, economic and environmental aspects of health and health care employing a wide range of study designs including cross-sectional, case-control, cohort studies and randomized clinical trials (RCTs), through to questionnaires and qualitative research methods.

2 Demonstrating the use of public health research for IM: examples from the field

To demonstrate the types of data that can be gained from public health research a number of past and current research activities in relation to CAM use and area of residence/geography from ongoing research programme are presented here. Early research was conducted on the Australian Longitudinal Study on Women’s Health (ALSWH). The ALSWH is a nationally representative cohort of 40,000 women randomly selected from the National Medicare Database (www.alswh.org.au). Through cross-sectional analyses of the ALSWH data we discovered that for women of all ages, those who resided in non-urban areas were more likely to consult a CAM practitioner than those who resided in urban areas of Australia[6]. This finding was further supported by two separate longitudinal analyses of women from the ALSWH. It was found that older women from non-urban areas were more likely to consult a CAM practitioner compared to women from urban areas, although this difference in CAM use was diminished over time[7], and women who continually lived in non-urban areas were more likely to commence consultations with CAM practitioners than women who continually lived in urban areas[8]. Other research that drew upon the ALSWH, examining middle-aged women’s consultations with particular CAM practitioners, raised additional research questions. Women from non-urban areas were more likely to consult a chiropractor or osteopath compared with women from urban areas[9], but there were no urban/non-urban differences in consultations with either naturopaths/herbalists[10] or acupuncturists[11].

At the time of publication, it was discussed that findings of higher CAM use and uptake may be due to a number of reasons. Firstly, that the imbalance in the supply and distribution of general practitioner (GP) services in Australia, where women from regional and remote areas have less availability and access to GP services compared with women from urban areas, may result in greater reliance on self-treatment or care that includes the use of CAM. Secondly, perhaps there are closer working ties between non-urban GPs and CAM practitioners. Regional GPs tend to have an extended clinical role incorporating a range of services and involvement not necessarily undertaken by urban GPs, thus placing a greater reliance on the GP as a healthcare gatekeeper. It may be that this heightened central role for GPs means that they are more closely connected and open to their patients’ CAM use. Thirdly, there may be greater dissatisfaction with GPs and other conventional health care services in non-urban areas thus leading to non-urban patients seeking alternatives. Finally, there may be stronger informal community networks in non-urban areas. Word of mouth is an important information source for CAM use and personal recommendation is often a major source of patients for CAM practitioners[12]. Such informal communications and community networks may be particularly strong in non-urban communities and this may help explain higher CAM use in regional settings. Note that many of these postulations could also be applied to IM use in China, if differences exist between rural/urban areas in the proportion of people who are treated under an IM model.

In an attempt to determine the validity of these possible reasons for greater CAM use in non-urban areas, we applied for and received significant funding from the National Health and Medical Research Council (NHMRC) to conduct a sub-study of urban and non-urban use of CAM. This new sub-study employs a specifically designed questionnaire, semi-structured qualitative interviews and diary methods. This project is still ongoing but to date there have been a number of important discoveries. The first major finding is that CAM users tended to be more dissatisfied with conventional care than CAM non-users, but this is consistent across the urban, rural and remote areas of residence. This suggests that the lack of access to conventional health practitioners and patient dissatisfaction with conventional health practitioners may not play a central role in explaining higher use of CAM by women in rural and remote areas when compared with women in urban areas. In addition, although we have identified female CAM users as having a higher percentage of health symptoms and diagnoses of chronic illnesses when compared to non-CAM users, such differences are largely consistent across urban and rural/remote areas. This suggests health status may not be an important contributing factor to differences in CAM practitioner use across the urban/non-urban divide[13]. The qualitative components of this sub-study are to be conducted later and will attempt to further explore the role, if any, that
informal community networks and GPs play in the higher CAM use by women who live in non-urban areas.

In a separate study examining the distribution of GPs and CAM providers in rural New South Wales (NSW), Australia, it was found that CAM providers form a significant part of the healthcare system in rural and regional NSW with substantial representation across all geographies and in both under-serviced and well-serviced areas (in terms of conventional healthcare). CAM practitioners outnumbered GPs in 4 of the 17 NSW Divisions of General Practice and in no Division did they number less than half of the total GP numbers identified[11]. One interpretation of these findings is that many patients may actively seek CAM services rather than passively defer to them for lack of conventional care options. If this is the reason why there are significant differences in the use of CAM by women in urban and non-urban areas, then a significant research question is: why do patients actively seek CAM services? It has been suggested that one of the reasons may be because patients perceive that CAM provides them with a more suitable model of medical care. CAM consumers desire meaning and context for their illness, and consultation with CAM practitioners and self-prescribing CAM may be one avenue for empowering them in terms of management of their illnesses[15]. If this is the case, then knowledge of the reasons for CAM use are as important as issues of efficacy and safety, and the best way to obtain such knowledge is via a public health research approach.

3 Network of Research in the Public Health of Complementary and Alternative Medicine

The dominant focus of CAM and IM research internationally has been addressing issues of clinical efficacy, often at the detriment of encouraging or promoting a wider research scope including public health and health services research priorities[16]. In direct response to these circumstances, a group of leading public health and health service researchers has established Network of Research in the Public Health of Complementary and Alternative Medicine (NORPHCAM, http://www.norphcam.org), which is the first international collaborative network dedicated to promoting and advancing the public health and health services research of traditional, complementary and alternative medicine and integrative health care. The NORPHCAM brings together investigators from around the world with strengths in a wide range of disciplines and methodologies (e.g. health economics, qualitative methods, mixed-methods design, biostatistics, survey design and more) necessary to ensure multidisciplinary, multi-method public health and health services research that is of significance and benefit to CAM practitioners and researchers. It is important to note that NORPHCAM’s program is of major significance to clinical research and researchers helping to strengthen and complement their efforts through guiding the effective and safe translation of clinical evidence into health practice and policy.

4 Conclusion

The examples from the field, highlighted in this article, demonstrate the evolution of knowledge gained regarding differences in the use of CAM between urban and non-urban residence. Furthermore, the public health research techniques employed in these examples can be readily applied to current topics of interest in IM use in China. There is considerable scope for research to explore such questions as: what motivates people to use IM; how do they use it; which CAM modalities are incorporated within the IM framework; and what are the trends in IM use over time. To conduct public health research of IM, researchers require particular skills and experience in these methods; organizations such as NORPHCAM can be utilised to assist in such research activities through collaboration and/or educational exercises.

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发展和促进结合医学研究中的公共卫生学方法：来自澳大利亚的范例

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摘要：目前中国的结合医学研究很大程度上关注于临床和实验研究，对于确定结合医学治疗手段的疗效和提高结合医学的地位有重要意义。然而，扩展结合医学的研究范围，将公共卫生学领域研究方法和观点引入结合医学，对于更好地认识临床实践的意义及协助政府和专业机构制定结合医学领域的方针政策会起到重要作用。本文介绍了作者前期研究中将公共卫生学的研究方法应用于补充替代医学的使用与澳大利亚不同地域不同人群的关系的研究当中，以研究范例的形式强调了这些研究方法在结合医学领域研究中的应用价值。

关键词：补充疗法；公共卫生；方法学；医学研究；澳大利亚