Complementary and Alternative Medicine, CAM: The research priorities for it’s use in citizen health and healthcare systems reform.

Introduction

This submission is presented on behalf of EFCAM, a European Federation of European federations of CAM modalities and National CAM practitioners organisations.

Our focus is on citizen health and health research so this submission deals with the contribution of Complementary and Alternative Medicine, CAM, to health and healthcare systems in Europe and to the research priorities pertaining to that.

For CAM professionals there is an obvious synergy between the underlying values and the practice objectives of the various CAM modalities and the three strategic objectives of the current health strategy:

- fostering good health in an ageing Europe,
- protecting citizens from health threats
- supporting dynamic health systems and new technologies.

In our briefing document of March 18th 2009, CAM Community Policy and the Citizen, we state:

"Our healthcare system should shift its focus from a mainly treatment-oriented framework of public health to a more prevention-centred society in which healthy lifestyles are promoted and sustained."

CAM’s twin objectives of maintaining health and of treating illness in an individualised way where the focus is on salutogenesis, and sustainable and safe treatment of illness, are inherently geared to fostering good health, strengthening health for resistance to health threats and to sustainable, safer and more cost-effective health delivery systems.

CAM is used by millions of EU citizens annually. Surveys on reasons for use indicate that the major reasons are health maintenance, prevention of illness and treatment for a range of chronic illnesses. Evidence shows that treatment is safe, non-invasive and contributes greatly to health literacy and self responsibility for health.

In the order of half a million CAM professionals between doctors and non-medically trained practitioners practice a range of CAM modalities. Use is predominantly through private practise and access is rare for millions of citizens who cannot afford to pay. Surveys also show that it is in early middle age that citizens begin to use CAM when awareness about the need to stay healthy and the onset of chronic illness tend to coincide. Surveys of user satisfaction report high levels of satisfaction and a range of benefits beyond the care of specific symptoms which promote health literacy, self responsibility for health and which motivate lifestyle change. Notwithstanding this we are not aware of any partnerships in health programme projects or FP7 projects that have included CAM to any significant extent, CAMbrella notwithstanding.

To date the synergy referred to above has not lead to practical effective measures involving the use of CAM, despite the potential suggested in the Health Programme itself. A major reason for this is the lack of sufficient and appropriate research.
Benefits for the Community of Research into CAM

Currently there is no coordinated approach to research into CAM. There are insufficient studies of sufficient size and power to provide sufficient reliably generalisable results. There are serious methodological challenges that continue to inhibit the appropriate study of the complex interventions of CAM. Large scale studies of CAM’s potential to maintain health and prevent illness are lacking. Studies into cost-effectiveness and models of integration of CAM with existing healthcare provision are also lacking. Building on the existing evidence of positive effect on health promotion and contribution to the major public health priorities is lacking. Partnerships between the various CAM stakeholders, providers, users, health system managers, health and research policy makers, researchers and product producers are almost non-existent.

Individual citizen demand for CAM is growing but the evidence base for policy and service provision lags far behind. The critical area where our experience and, the admittedly limited research evidence, suggests research into CAM offers the greatest added value, is in public health via it’s inherent focus on strengthening individual health and thereby combating health threats, the promotion of health, and safer and more cost effective treatment of chronic illness. Specifically, we would like to suggest the following:

1. Partnerships and Research Methodology

In order to ensure value and subsequent practical application from research into CAM’s contribution to the Community’s health strategy initial research on how to build mutually beneficial partnerships and the development of appropriate CAM research methodology is required.

2. Health Maintenance and Prevention

Following this, research into CAM’s contribution to health maintenance, illness prevention and health literacy both on its own and integrated within existing public health systems is more assured to provide evidence for practical application.

Modern prevention within the biomedical model, as anthropologist Rabinow (1995), cited by Kalitzkus (2004)¹, points out, is especially concerned with the identification of risk factors. Risk is understood as a composite of impersonal ‘factors’ increasing the possibility of an illness. These factors are pinned down in relation to statistically derived at norms.

The holistic model of health and disease shifts a greater responsibility not only for health maintenance, but also for treatment of disease, from the provider to the patient. It gets the patient more actively involved in managing his or her health and disease. The concept of self-care requires a daily conscious focus on one’s physical, mental, and emotional state and the ability to take corrective action whenever imbalance is sensed. According to Rosenman²

(1997), it appears prudent to pay increased attention to the individual who possesses a risk factor, and not the risk factor per se.

How to inspire, motivate, empower, and facilitate patient self-care is an important issue in a health-oriented healthcare system. Self-care is a two dimensional construct that includes processes for health in self-care practice and action capabilities. The processes include life experience, learning processes, and ecological processes. Action capabilities include power and performance capabilities. The primary aim of inspiring, motivating, and empowering patients is towards a single goal—being able to bring about a positive behaviour change. Several models have been developed to address behaviour change. A common theme that emerges from a critical evaluation of all these models is that a planned intervention should ideally incorporate several essential components for successful behaviour change. The two steps in this process involve assessment and action. Components of assessment include ascertaining the need for behaviour change, resources, individual perception of need for change, and self-efficacy. Most of these models were developed to address a specific medical condition. There exists a need to test behaviour change models within the context of multiple complex health conditions that is representative of the patient population today.

Current medical research is typically interested in the way disease processes develop and focused on how to improve ways to fight disease with the aid of ever more powerful drugs. However, host factors, which are one of the three variables in the triangle of disease causation (agent, host, and environment), remain sub-optimally addressed. The concept of positive health, or salutogenesis, focuses on how and why people stay well; it highlights the inadequacy of pathogenic explanatory factors and concentrates on the adaptive coping mechanisms underscoring the movement to the healthy end of the ‘ease–dis-ease’ spectrum.

Additional research is needed to enhance understanding of resilience factors that protect an individual from developing physical and emotional illness in the face of stress, to identify optimal strategies in developing resilience within healthcare, and to identify social factors that can be modified to support resilience to promote public health. Integrated models for behavioural change need to be developed and tested to motivate patients with multiple complex health problems for a sustained change in behaviour. Research into designing and testing resilience interventions incorporating the wisdom of complementary and alternative healing systems and further understanding the neurobiology of resilience has the potential to transform patient care.

3. Chronic Disease and Health Service Delivery

A further strand of most benefit would be the contribution of CAM in the treatment of chronic illness, more cost effective treatment, the reconfiguration of health service staff training and service delivery, it’s impact on healthy ageing, and treatment of conditions highly costly in lost social and industrial productivity. Just as a single example, musculo-skeletal injuries and conditions are a primary cause of absenteeism, loss of productivity and health system costs for which there is already evidence of effective treatment by CAM modalities. We suggest that there be funding for study of the integration of CAM and conventional medical care for such conditions that includes evaluation of the impacts on personal health, productivity, cost effectiveness and the impact on healthy work-life balance.

In this regard outcomes should include not only traditional measures of morbidity, mortality, cost of care, and patient satisfaction, but also the impact of care on family cohesiveness, cultural identity, spiritual beliefs, resilience, coping, and self-efficacy.

The impact on the environment also should be considered. Additional outcome measures
may need to be developed to address the concept of health as optimal functioning rather than as the absence of disease and to address patient priorities, particularly when there are multiple co-existing priorities.

It is in this area of chronic disease care that there is perhaps the greatest potential for collaborative innovation between CAM providers, conventional health services, SMEs, and service users. Funding to establish such collaborations has the capacity to practically demonstrate the transformation of service delivery and the cost of delivery.

4. Health Inequalities

A major objective of the current health programme is to reduce health inequalities. The benefits that motivate use of CAM are currently available only to those with private means to access their own healthcare because it is extremely rare to find CAM modalities offered within State healthcare systems. We suggest that there is enormous potential to establish monitored coordinated pilot projects throughout the Community to assess the contribution of CAM to reducing health inequalities with relatively low cost projects which have a focus on health literacy, and health maintenance. The health programme as currently structured would not appear to be able to facilitate this. In an environment of economic cutbacks, severe staff strain to deliver more with less, the vision to embark on such projects is unlikely to be available or fostered locally. Community inspired and supported action is necessary.

5. Contribution of CAM Professionals

The current health programme speaks of the need to improve capacity in public health systems is. This includes “the development of public health professionals as well as the development of public health skills and knowledge of those who are not full time public health professionals….. (including other health professionals...)”.

It is acknowledged now that there is a drain and a recruitment strain on medical professionals in Europe. At the same time there is in the order of 400,000 professionals working with CAM mostly outside of official healthcare systems in private practice. Here, there is a significant untapped resource that can contribute to public health programmes on health determinants, healthy ageing and health information. They can contribute their unique knowledge and skills through integration into existing or new public health programmes, and, through contributing to the education of existing health professionals in the public health area. We suggest therefore that there be inclusion of funding to pilot and test these contributions.

Conclusions

Health maintenance and health promotion are essential to ensure the success of Europe’s 20/20 strategy. Research to help optimise public health programmes at a level that only the EU has the capacity to enable should be a cornerstone of the health strategy. The innovative contribution of complementary and alternative medicine needs to be established. A major start on this should be usefully included in FP8.

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