

TCAM AND HEALTHCARE DISPARITIES

MT_YC Y DISPARIDADES EN EL CUIDADO DE LA SALUD

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UTS:ARCCIM

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INTEGRATIVE MEDICINE

GLOBAL HEALTH CHANGES CREATE OPPORTUNITIES FOR TCAM

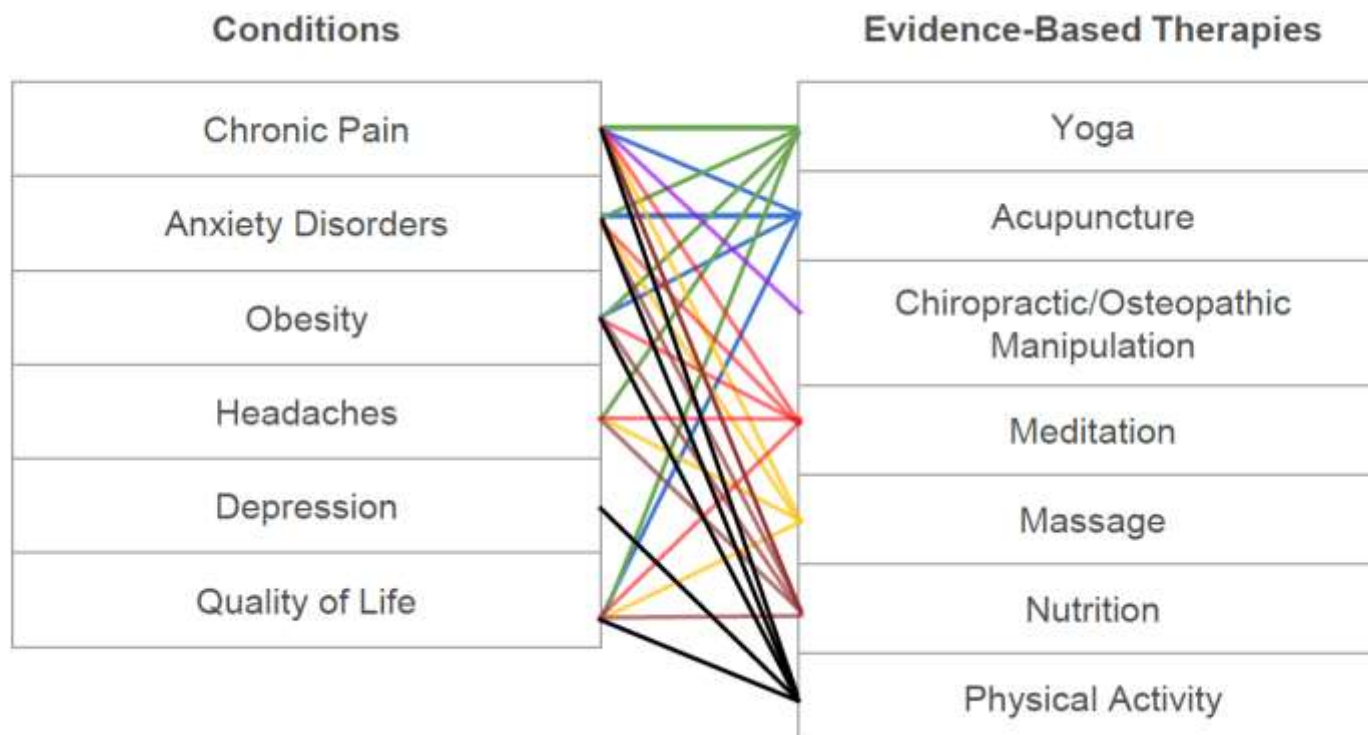
- *Is TCAM addressing current global health priorities? **Probably not***
- *Can TCAM help with global Health priorities? **Definitely!***

CAMBIOS DE LA SALUD GLOBAL CREAN OPORTUNIDADES PARA MTyC

- *Es la MTyC dirige realmente las prioridades mundiales de salud pública? **Probablemente no***
- *Podría la MTyC abordar las prioridades globales de salud pública? **Definitivamente!***

2004 Disease or injury	As % of total DALYs	Rank		Rank	As % of total DALYs	2030 Disease or injury
Lower respiratory infections	6.2	1		1	6.2	Unipolar depressive disorders
Diarrhoeal diseases	4.8	2		2	5.5	Ischaemic heart disease
Unipolar depressive disorders	4.3	3		3	4.9	Road traffic accidents
Ischaemic heart disease	4.1	4		4	4.3	Cerebrovascular disease
HIV/AIDS	3.8	5		5	3.8	COPD
Cerebrovascular disease	3.1	6		6	3.2	Lower respiratory infections
Prematurity and low birth weight	2.9	7		7	2.9	Hearing loss, adult onset
Birth asphyxia and birth trauma	2.7	8		8	2.7	Refractive errors
Road traffic accidents	2.7	9		9	2.5	HIV/AIDS
Neonatal infections and other ^a	2.7	10		10	2.3	Diabetes mellitus
COPD	2.0	13		11	1.9	Neonatal infections and other ^a
Refractive errors	1.8	14		12	1.9	Prematurity and low birth weight
Hearing loss, adult onset	1.8	15		15	1.9	Birth asphyxia and birth trauma
Diabetes mellitus	1.3	19		18	1.6	Diarrhoeal diseases

EVIDENCE / EVIDENCIA





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Editorial

Complementary and integrative medicine: The black market of health care?



Complementary and integrative medicine (CIM) is an increasingly important – yet often underestimated – part of healthcare systems globally. It is present in every country and its use is growing internationally. In some countries, CIM forms the mainstay of healthcare delivery, particularly where conventional health services may not be well-established and where that CIM is ‘traditional’ in nature – stemming from the indigenous healing traditions of that country (Chinese medicine in China and the AYUSH systems of medicine in India are prominent examples).

traced back to CIM’s role as the “black market” of healthcare [7]. If such issues can be adequately addressed, integration of CIM may have a positive role on public health outcomes [8].

However, to fulfil this potential CIM needs to be brought in from the cold. As it stands the largely (or at least comparatively) unregulated nature of CIM – like any unregulated black market – often attracts those practitioners or marketers primarily concerned with avoiding oversight or accountability of their practice, resulting in dangerous fringe and unorthodox practices being

The “Black Market” of Health Care

El “mercado negro” de la atención de la salud

WHAT DOES THIS MEAN

- Informal, undocumented, unregulated
- Assumptions abound
- Everyone is doing, no-one is talking about it
 - TCAM is unique, in that it is the only purely *patient-driven* form of health care

QUÉ SIGNIFICA ESTO

- Informal, indocumentado, no regulado
- Abundan las asunciones
- Todo el mundo está haciendo, nadie está hablandolo
 - La MTyC es única, ya que es la única forma de atención de la salud puramente *paciente-conducida*

ASSUMPTION: TCAM IS “MIDDLE CLASS MEDICINE”

- Patients are: whiter, wealthier, better educated
- But this is little different from other healthcare utilisation
- When viewed objectively, this is about **Access & Equity**, not “choice” or “preference”

LAS ASUNCIONES: LA MTyC ES “MEDICINA DE CLASE MEDIA”

- Los pacientes son: más blancos, más ricos, mejor educados
- Pero esto es poco diferente de la utilización de otros servicios de salud
- Cuando se ve objetivamente, se trata **de Acceso y Equidad**, no "elección" o "preferencia"

The Lancet · Saturday 27 February 1971

THE INVERSE CARE LAW

JULIAN TUDOR HART

Glyncorrwg Health Centre, Port Talbot, Glamorgan, Wales

Summary The availability of good medical care tends to vary inversely with the need for it in the population served. This inverse care law operates more completely where medical care is most exposed to market forces, and less so where such exposure is reduced. The market distribution of medical care is a primitive and historically outdated social form, and any return to it would further exag-

interpreted either as evidence of high morbidity among high users, or of disproportionate benefit drawn by them from the National Health Service. By piling up the valid evidence that poor people in Britain have higher consultation and referral rates at all levels of the N.H.S., and by denying that these reflect actual differences in morbidity, Rein ^{3,4} has tried to show that Titmuss's opinion is incorrect, and that there are no significant gradients in the quality or accessibility of medical care in the N.H.S. between social classes.

Class gradients in mortality are an obvious obstacle to this view. Of these Rein says:

"One conclusion reached... is that since the lower

INVERSE CARE LAW

The availability of good medical or social care tends to vary inversely with the need of the population served

LEY DE ATENCIÓN INVERSO

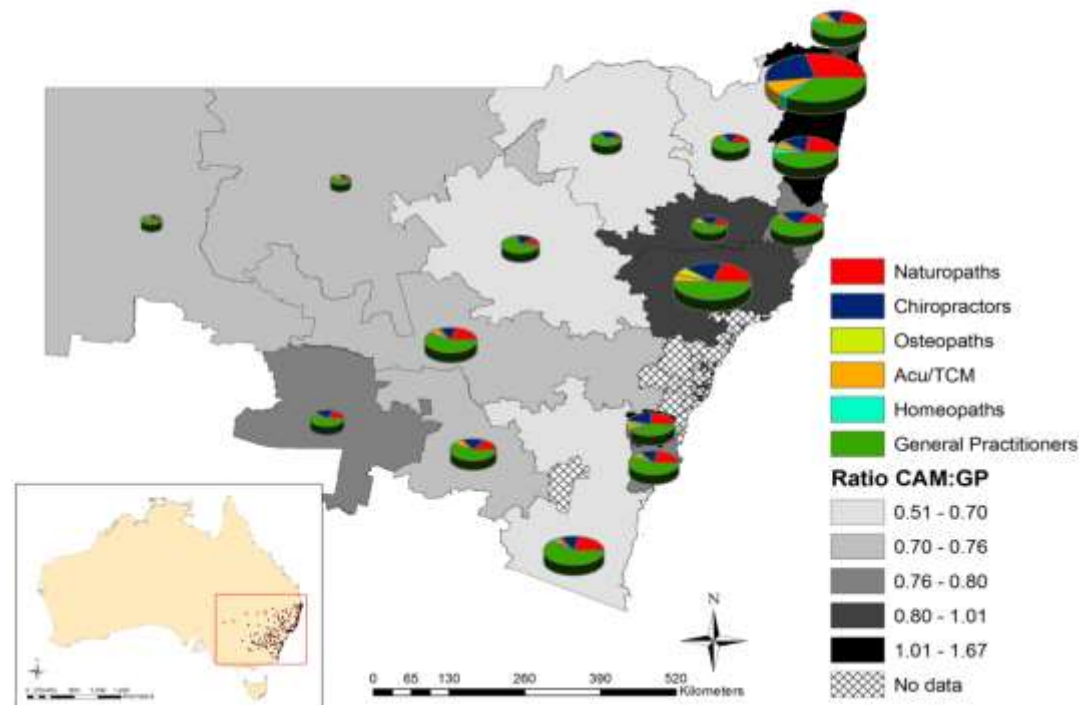
La disponibilidad de una buena atención médica o salud o social tiende a variar inversamente con la necesidad de la población atendida

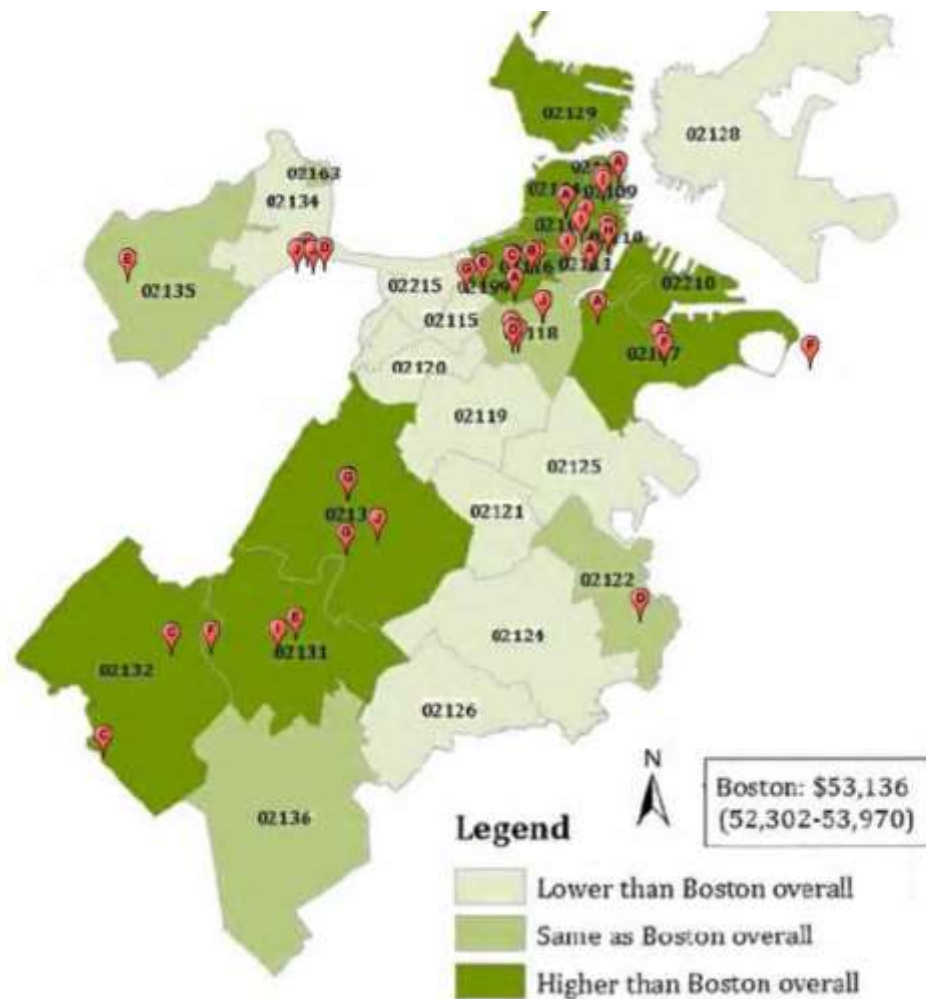
DISTRIBUTION AND ACCESS

- Biggest predictor of TCAM practitioner distribution is presence of *other* health services, not need

DISTRIBUCIÓN Y ACCESO

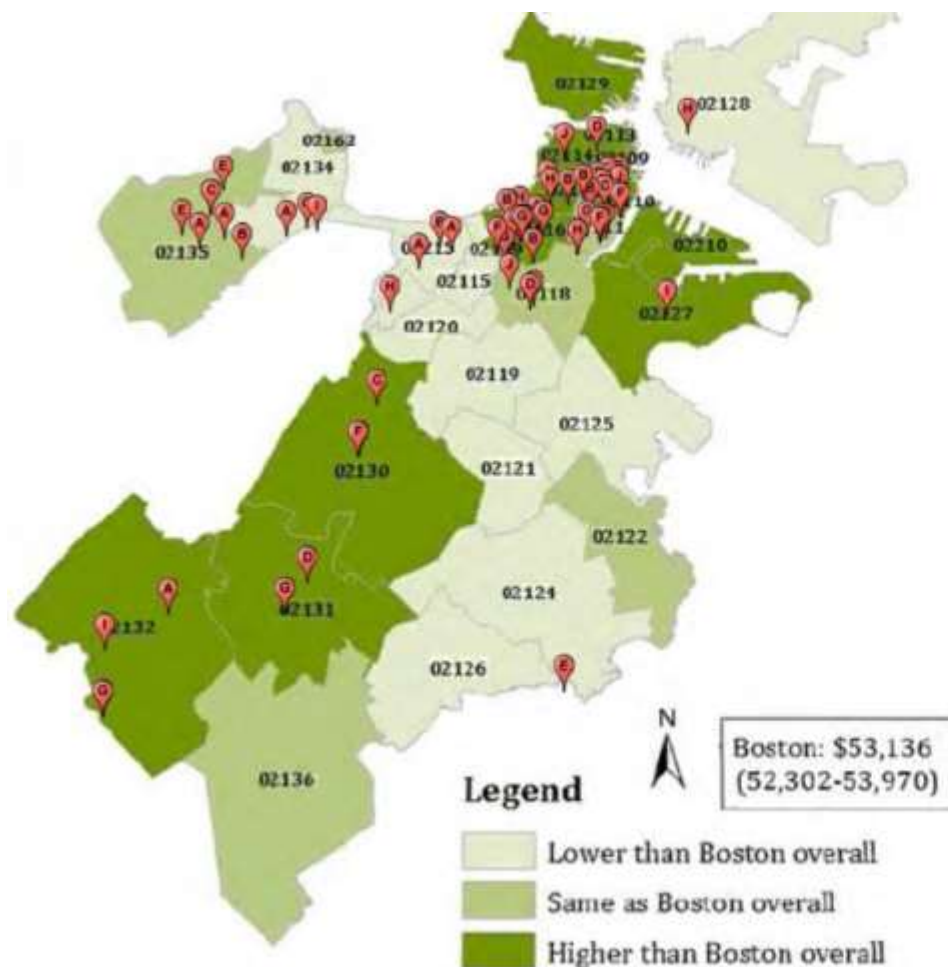
- El mayor predictor de la distribución del profesional MTyC no es necesario, pero la existencia de otros servicios de atención de la salud





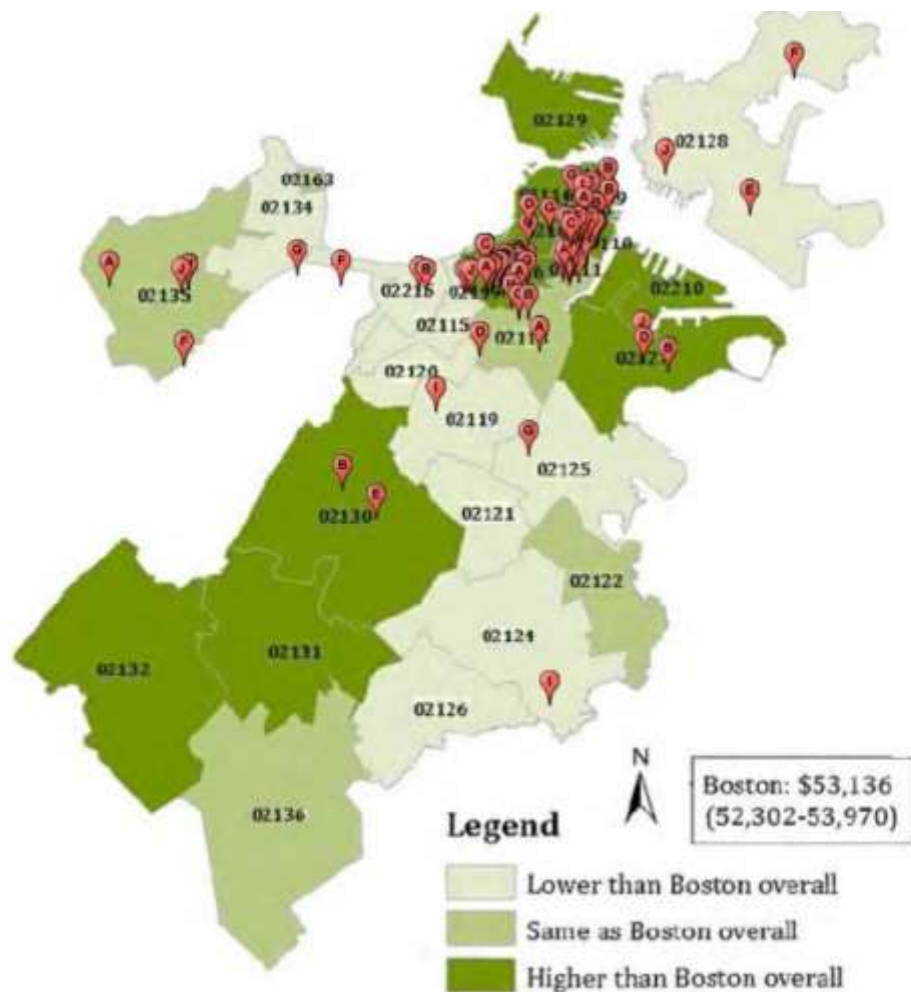
Availability: Yoga in Boston

Income by Neighborhood and Yoga Studios,
2009-2013



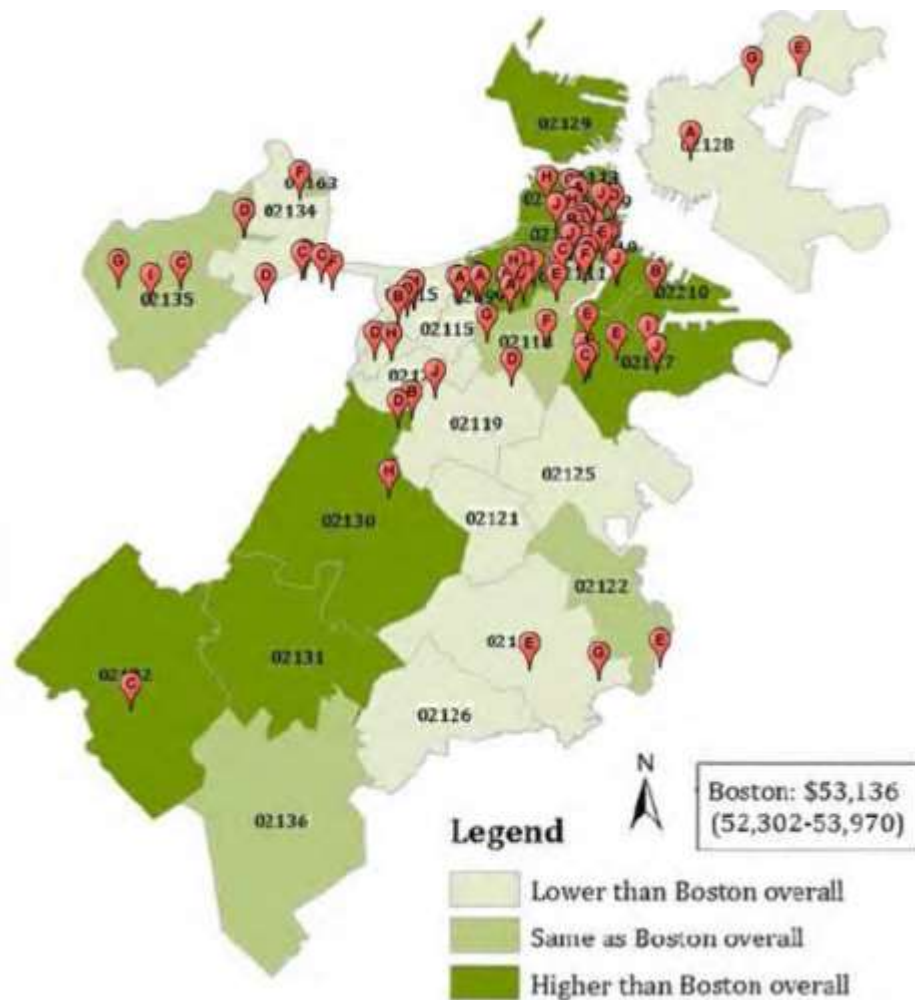
Availability: Acupuncture in Boston

Income by Neighborhood and Acupuncture
Clinics, 2009-2013



Availability: Massage in Boston

Income by Neighborhood and Massage
Clinics, 2009-2013



Availability: Fitness Centers in Boston

Income by Neighborhood and Fitness/Health
Centers, 2009-2013

AFRICAN HEALTH PRACTITIONER TCAM USE

- Medical Practitioner: *Nigeria 28%; Ghana 57%; Sierra Leone 59%*
- Paramedics: *Nigeria 55%*
- Nurses: *Sierra Leone 56%*
- Pharmacists: *Sierra Leone 56%*

USUARIO MTyC DE LA PRÁCTICA SALUD AFRICANA

- Médico: *Nigeria 28%; Ghana 57%; Sierra Leona 59%*
- Paramédicos: *Nigeria 55%*
- Enfermeras: *Sierra Leona 56%*
- Farmacéuticos: *Sierra Leona 56%*

ACCESSIBILITY

- Cultural, not just \$
 - *CALD, global movement of populations, centralisation of care*
- Health literacy
- Economic, not just financial
 - *Unemployment, low employment, autonomy, transport*

ACCESIBILIDAD

- Cultural, no sólo dinero \$
 - *Cultural y lingüísticamente diversas comunidades, el movimiento global de las poblaciones, la centralización de la atención*
- Alfabetización en salud, conciencia
- Económico, no sólo financiero
 - *Desempleo, empleo bajo, autonomía, transporte*

ORIGINAL ARTICLE

**Complementary and Alternative Medicine in Rural Communities:
Current Research and Future Directions**

Jon Wardle, MPH;^{1,2} Chi-Wai Lui, PhD;^{1,2} & Jon Adams, PhD^{1,2}

¹ School of Population Health, University of Queensland, Brisbane, Queensland, Australia

² Network of Researchers in the Public Health of Complementary and Alternative Medicine (NORPHCAM), <http://www.norphcam.org/>

CULTURAL ACCESSIBILITY

- TCAM use higher in rural areas
- Initially assumed to be access, but social and cultural drivers underlie use
- Not just about ethnicity → about being patient-centred, community-centred

ACCESSIBILIDAD CULTURAL

- MTyC uso más alto en las zonas rurales
- Inicialmente se supone que es acceso, pero los conductores sociales y culturales subyacen en el uso
- No sólo acerca de la etnia → centrado en el paciente, centrado en la comunidad

TOP 5 REASONS FOR NON-USE OF TCAM

5 PRINCIPALES RAZONES PARA EL NO USO DE MTyC

	Acupuncture <i>Acupuntura</i>	Chiropractic <i>Quiropráctica</i>	Natural Products <i>Productos naturales</i>	Yoga
No reason <i>Sin razón</i>	31.9%	31.2%	37.7%	38.3%
Do not need it <i>No lo necesito</i>	24.3%	31.3%	24.3%	18.0%
Never thought about it <i>Nunca pensé en eso</i>	22.4%	17.7%	21.2%	24.2%
Never heard of it <i>Nunca se enteró</i>	15.4%	13.5%	10.9%	12.3%
Do not believe it <i>Nunca se enteró</i>	4.8%	4.7%	5.1%	3.1%

ASSUMPTIONS / ASUNCIONES

PATERNALISM

- “African-Americans don’t like yoga”
- “Poor people won’t use a smartphone app”
- “Mindfulness won’t work in a second language”

PATERNALISMO

- "A los Afro-Americanos no les gusta el yoga"
- "La gente pobre no usará una aplicación de smartphone"
- "Atención plena no funcionará en un segundo idioma"

... → COLONIALISM / COLONIALISMO



INDIA: HOME HERBAL GARDENS

- Health 3rd largest expense in India (after food, shelter)
- Program covering 6,000 rural villages (~ 150,000 gardens) with 20 medicinal plants cultivated and sold to rural women's households self-help groups.
- Trained in cultivation, distribution, etc.

INDIA: JARDINES HERBARIOS DE CASA

- La salud es el tercer gasto más alto para los pobres en la India (después de la comida, refugio)
- En el programa que cubre 6.000 pueblos rurales (~ 150.000 jardines) grupo de 20 plantas medicinales que son útiles para las dolencias comunes fueron cultivados y vendidos a los hogares rurales de la Mujer grupos de autoayuda.
- Entrenado en cultivo, distribución, etc.



RESULTS

- Health expenditure ↓ in households with gardens and 20% of that of other households (Rs. 92 for 3 months v. Rs. 478).
- Links in with Indian goals of reducing pharmaceutical spending

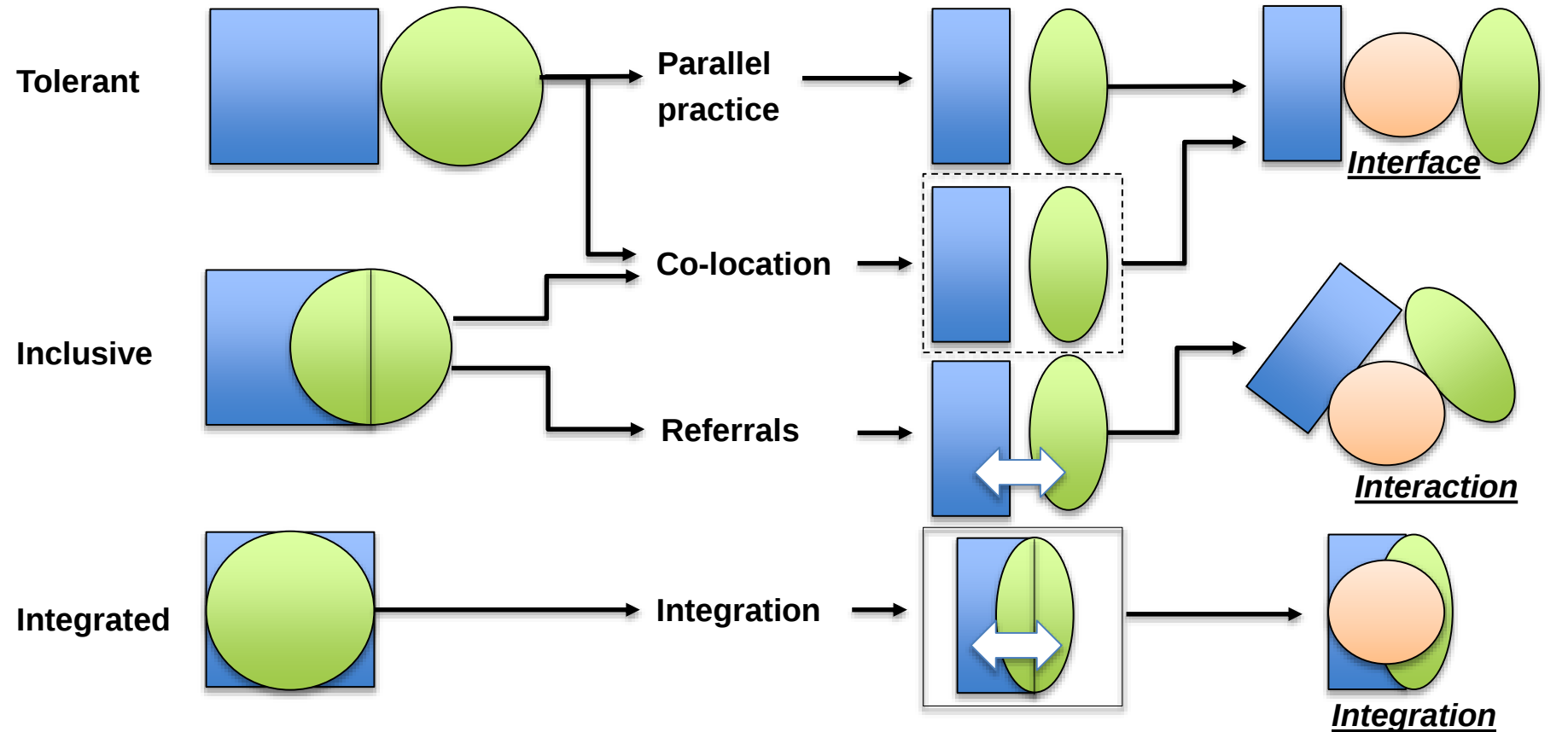
RESULTADOS

- El gasto en salud ↓, en hogares con jardines 20% de otros hogares (Rs. 92 para 3 meses v. Rs. 478).
- En la planificación de la India para la reducción del gasto nacional en productos farmacéuticos - especialmente de los pobres

POLITICAL SYSTEM

SERVICE SYSTEMS

PATIENT VIEW



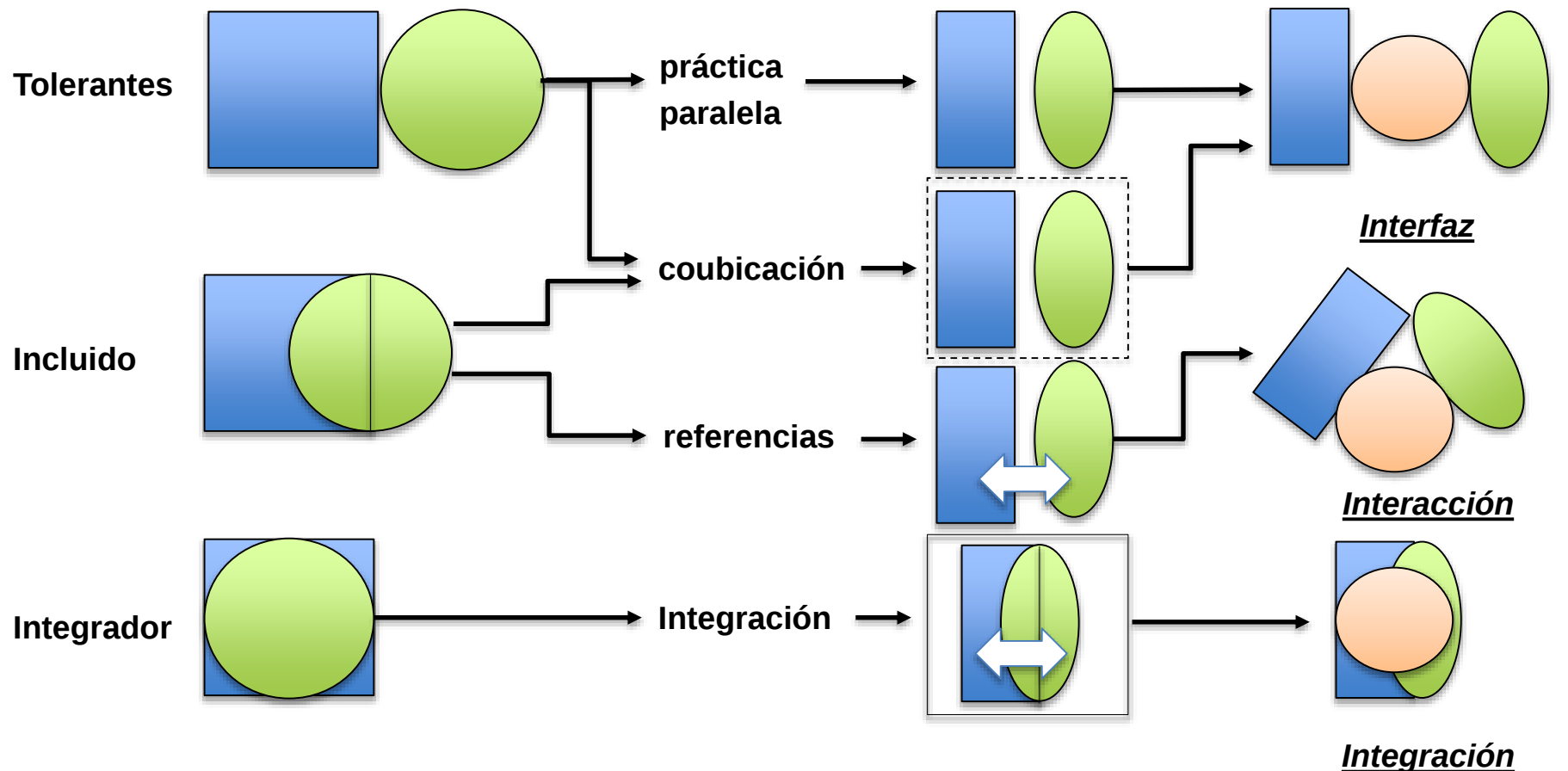
Símbolos:



Sistema de políticas

Sistema de entrega

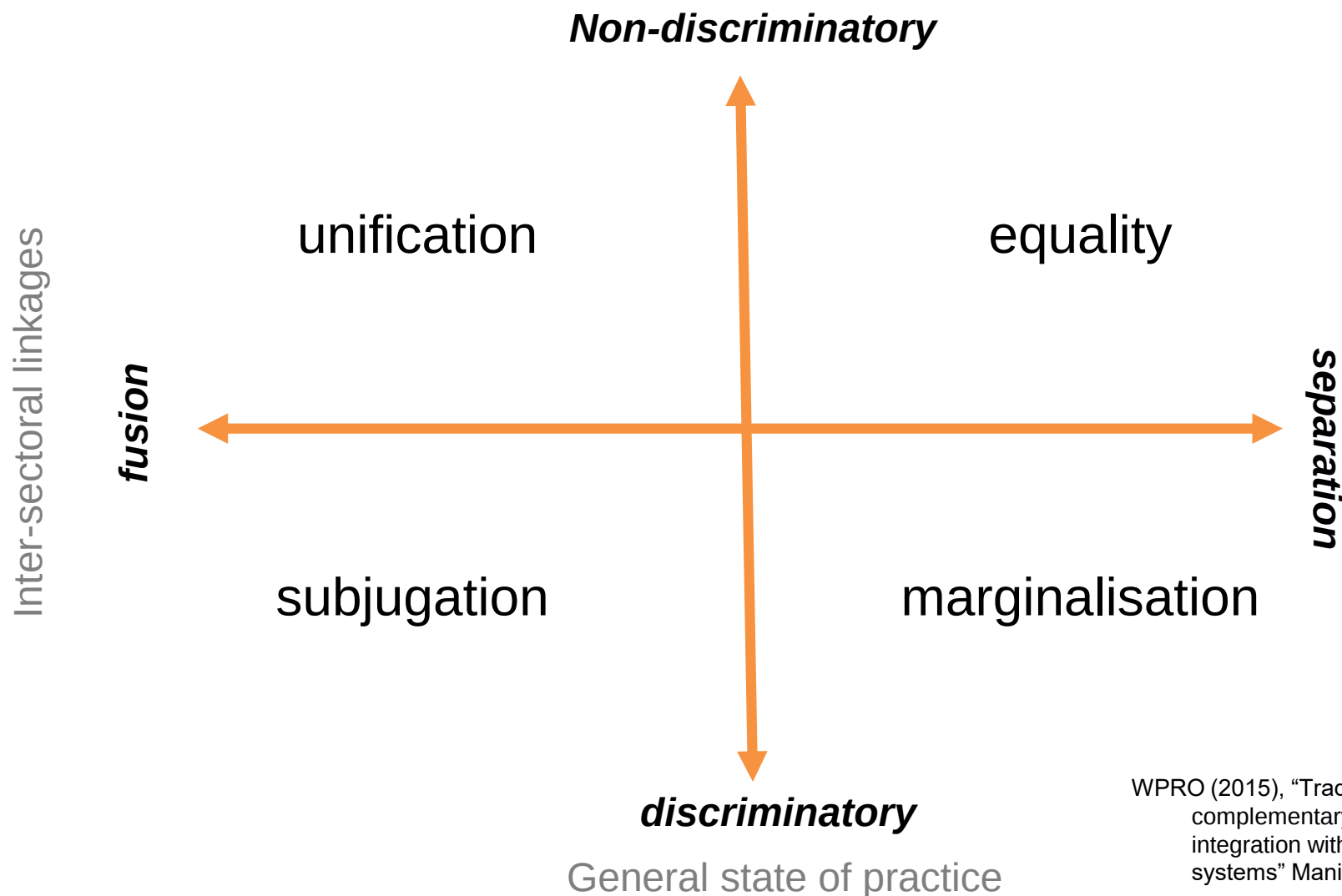
Vista del consumo



La clave

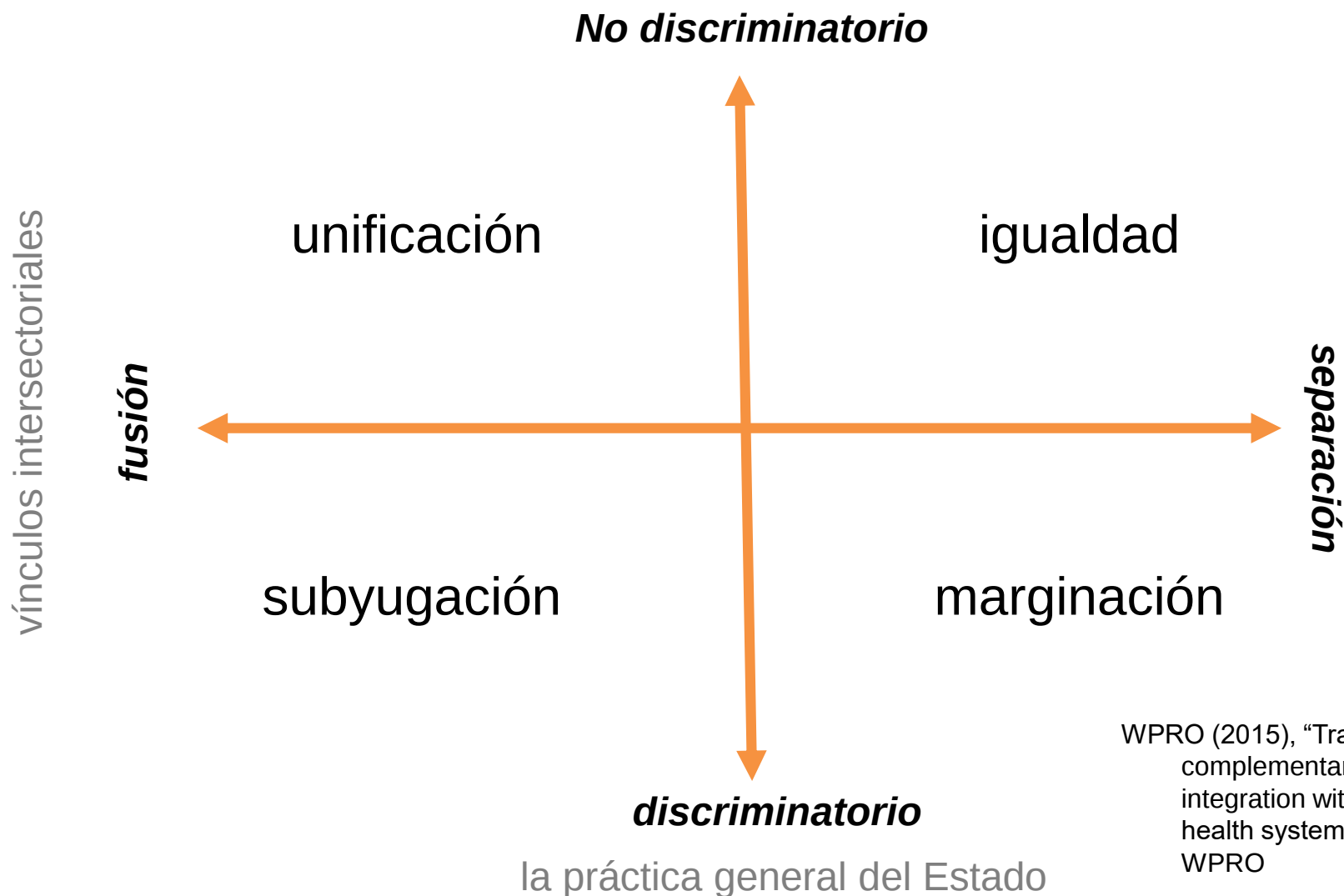


OPTIONS FOR MIXED HEALTH SYSTEMS



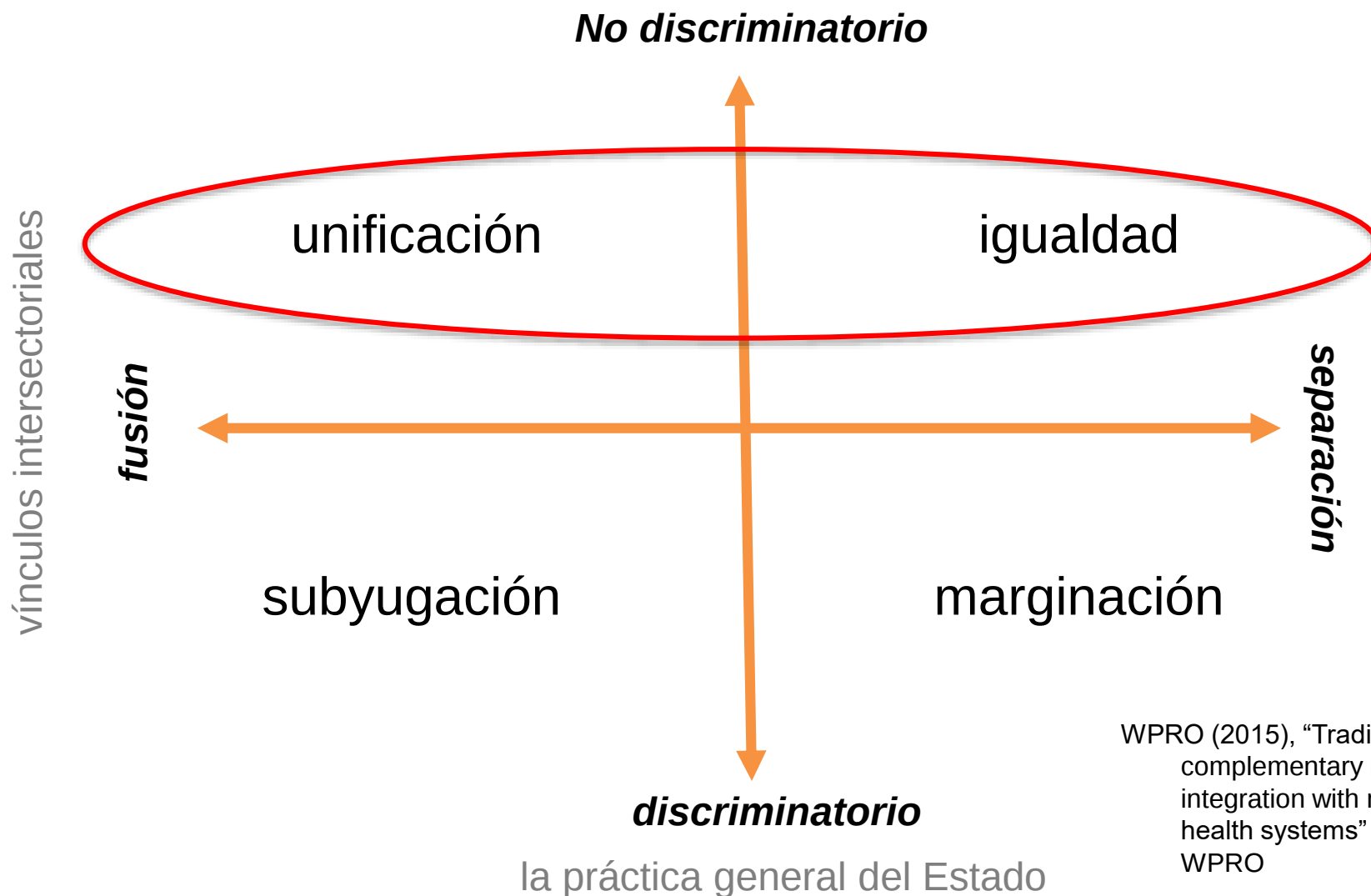
WPRO (2015), "Traditional and complementary medicine integration with national health systems" Manila, WPRO

OPCIONES PARA LOS SISTEMAS DE SALUD MIXTA



WPRO (2015), "Traditional and complementary medicine integration with national health systems" Manila, WPRO

OPCIONES PARA LOS SISTEMAS DE SALUD MIXTA



WPRO (2015), "Traditional and complementary medicine integration with national health systems" Manila, WPRO

ZAMBIA

- Traditional healers training in basic medical skills and public health, complementing their healing traditions.
- Workshops to build research capacity (and drive agenda)
- Healers already connected with the Ministry ... not always positively.
- It allows access to health services in areas where there is nothing else.

ZAMBIA

- Entrenamiento de curanderos tradicionales en habilidades médicas básicas y salud pública, complementando sus tradiciones curativas.
- Talleres para construir la capacidad de investigación entre la MTyC
- Los curanderos ya conectados con el Ministerio ... no siempre positivamente.
- Posibilita acceso a servicios de salud en áreas donde no existe nada más.



Acupuncture

Putrajaya Hospital

Sultan Ismail Hospital

Kepala Batas Hospital

Sultanah Nur Zahirah
Hospital

Duchess of Kent Hospital

Sarawak Public Hospital

Port Dickson Hospital

Sultanah Bahiyah Hospital

Sultanah Hajah Kalsom
Hospital

Malay Massage

Putrajaya Hospital

Sultan Ismail Hospital

Kepala Batas Hospital

Sultanah Nur Zahirah
Hospital

Duchess of Kent Hospital

Sarawak Public Hospital

Port Dickson Hospital

Sultanah Bahiyah Hospital

Sultanah Hajah Kalsom
Hospital

Herbal Therapy as an Adjunct Treatment for Cancer Patients

Putrajaya Hospital

Sultan Ismail Hospital

Kepala Batas Hospital

Malay Postnatal Treatment

Putrajaya Hospital

Sultan Ismail Hospital

MALAYSIA

- Government initiatives aimed at incorporating all types of TCAM into hospitals ... but focused on allopathic doctors - integration or co-option? If patients are not taken into account, will they continue to attend other practices?

MALASIA

- Las iniciativas del Gobierno dirigidas a incorporar todo tipo de la MTyC en los hospitales ... pero se centraron en los médicos alopáticos - integración o cooptación? Si no se tienen en cuenta a los pacientes, seguirán asistiendo a otras prácticas?

PROTECTING TRADITIONAL KNOWLEDGE

LA PROTECCIÓN DE LA SABIDURÍA TRADICIONAL



Complementary Therapies in Medicine (2009) 17, 121–122



available at www.sciencedirect.com

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EDITORIAL

Time for a reassessment of the use of Kava in anxiety?

Seven years after the ongoing ban of *Piper methysticum* (Kava) by the EU, UK and Canada: Where are we at? In December 2008, articles by the *Fiji Times* reported that the Kava ban was over-turned. This statement was subsequently revealed to be erroneous and is indicative of the controversy and confusion sometimes surrounding regulatory, safety and efficacy issues associated with Kava.

Cases of hepatotoxicity purportedly caused by European Kava products may have been due to a commercial cost-motivated preference for injudicious Kava cultivars or plant parts, and the use of non-traditional solvents (ethanol and acetone).¹ Conversely, traditional use of Kava (<100 g per week) is associated with remarkably few adverse effects in Pacific Island communities,² and public health concerns instead centre on issues of abuse by heavy users.^{2–5}

A puzzling and often overlooked motivation for the initial Kava withdrawal by BfArM (German drug regulatory body)

tem (whereby products are strictly classified and titled based upon place of cultivation) may not only promote a confidence in efficacy and safety, but may also provide sufficient protection of intellectual property for those traditional communities involved.^{7,8} Most of the health concerns associated with Kava have occurred from non-traditional formulations, and as such it seems unreasonable and unjust that developing Pacific economies are currently penalised in terms of not having sufficient protection of their traditional commodity and the right to export it globally. For this to be a viable commercial reality, protection of the formulation of any newly developed Kava products may be required. One possible means of achieving this may be by standardising via specific chemotypes using the Lebot system, which involves the six major kavalactones (numbers 1–6).⁸

The restriction of Kava's importation has not only

KAVA

- Kava has better safety and efficacy profile than many conventional medicines
- Used in the Pacific safely for thousands of years – but in an aqueous extract
- German Company developed solvent extraction, which had hepatotoxic compounds
- This led to worldwide bans, which still exist in many countries (e.g. EU)
- Loss of effective treatment, decimation of economies, cultural identity loss among Pacific diaspora

KAVA

- Kava uno de los fármacos ansiolíticos más seguros y más eficaces
- Kava utiliza tradicionalmente en las islas del Pacífico sin descendencia durante miles de años - extracto acuoso
- Empresa alemana comenzó a fabricar - extracto de disolvente
- Solvente extrae compuestos hepatotóxicos, resultando en muchos países (incluyendo la UE) que prohíbe el uso de kava completo
- No sólo retenido un tratamiento eficaz del mundo, los resultados de la cooptación y la adulteración devastaron las comunidades propietarias de los medicamentos (económicamente y culturalmente)

ADDRESSING HEALTH CARE DISPARITIES

- Equity as well as access
- Respecting diversity
- Equity and access at a global, as well as individual level

TRATANDO LAS DISPARIDADES DE LOS CUIDADOS DE SALUD

- Equidad y acceso
- Respetar la diversidad
- La equidad y el acceso a nivel global, así como individual

¡MUCHAS GRACIAS!

Jon Wardle.

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OFICINA REGIONAL PARA LAS **Américas**