Introduction

The growth of public interest in, and use of, traditional and complementary medicine (T&CM) and integrative medicine (IM) has been well documented. In several industrialized countries, more than half of the population regularly uses some form of T&CM: the figures for Australia and South Korea are 69% and 75%, respectively (Table 1). Considerable T&CM use also exists in many nonindustrialized ('developing') countries: 40% in China and Colombia, 71% in Chile, and up to 80% in some African countries (Kasilo et al., 2005; Abdullahi, 2011).

Here, the term ‘traditional medicine’ (TM) is used to refer exclusively to the indigenous health traditions of the world, in their original settings; while ‘complementary medicine’ (CM) is a broader term referring to health care approaches outside the biomedical mainstream. Following the World Health Organization (WHO, 2013), T&CM is used here to encompass both. The older acronyms ‘TCM’ and ‘CAM,’ referring respectively to [traditional], ‘complementary and alternative medicine,’ are still used in some contexts.

The term ‘integrative medicine’ (IM) is increasingly used to replace ‘complementary (and alternative) medicine,’ but has two contrasting interpretations:

- In some contexts, integrative medicine is understood as the incorporation of specific traditional or complementary therapies within mainstream health services, without affecting the nature or underlying assumptions of biomedical (‘Western’) treatment (e.g., Schiff et al., 2012; Cant et al., 2012). This approach may be appropriately termed ‘T&CM integration.’
- In other contexts, integrative medicine has been defined as helping individuals to attain healthy lifestyles in a holistic sense, by “address[ing] the full range of physical, emotional, mental, social, spiritual and environmental influences that affect a person’s health” (Guarneri et al., 2010: p. 1, emphasis added). This reflects a similar position outlined by the American Association of Naturopathic Physicians (2015). It is in this latter sense that we use the term ‘integrative medicine’ (IM) in this article.

Reinforcing the latter position, the Academic Consortium for Integrative Medicine and Health (a collaboration between 56 leading medical schools in North America) defines integrative medicine as a practice that “reaffirms the importance of the relationship between practitioner and patient; focuses on the whole person; is informed by evidence; and makes use of all appropriate therapeutic approaches, healthcare professionals and disciplines to achieve optimal health and healing” (Academic Consortium for Integrative Medicine and Health, 2015).

Popular use of T&CM/IM and increasing consumer demand has been accompanied by a growth in research, and an increase in evidence-based approaches, over the past decade. However, the global research agenda is struggling to keep pace with the shift from ‘alternative’ to ‘complementary’ and more recently, ‘integrative’ medicine. Clinical research has historically focused on efficacy, safety and mechanisms of specific T&CM medications, such as individual herbs - often overlooking critical issues such as the risk of interactions between therapies used simultaneously (WHO, 2013), and neglecting wider public health dimensions. However, there is a growing research interest in person-centered integrative medicine, and evidence is accruing for its efficacy and cost-effectiveness (Guarneri et al., 2010).

Interest has been building over the past two decades for a policy framework for T&CM/IM within national health-care systems, and guidelines have been developed (Bodeker, 2001; WHO, 2013). Considerable progress has been made in the development of national policies on T&CM: since the World Health Organization’s first Traditional Medicine Strategy was launched in 2002, the number of Member States with T&CM policies has increased from 22 to 69 in 2012 (Bodeker et al., 2005; WHO, 2013). The WHO’s current Traditional Medicine Strategy 2014–23, in common with earlier strategies, reiterates the need for building the knowledge base, sustaining resources and strengthening quality, safety and effectiveness; but it also identifies a new strategic objective with a specific focus on integrative medicine, namely:

Table 1 Utilization of traditional and complementary medicine (T&CM) in industrialized countries

<table>
<thead>
<tr>
<th>Country</th>
<th>Utilization (% population)</th>
<th>References</th>
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<tbody>
<tr>
<td>Australia</td>
<td>69</td>
<td>Xue et al. (2007)</td>
</tr>
<tr>
<td>Canada</td>
<td>54</td>
<td>Nadeem, The Fraser Institute (2007)</td>
</tr>
<tr>
<td>Israel</td>
<td>43</td>
<td>Ben-Arye et al. (2011)</td>
</tr>
<tr>
<td>South Korea</td>
<td>75</td>
<td>Ock et al. (2009)</td>
</tr>
<tr>
<td>Switzerland</td>
<td>23</td>
<td>Klein et al. (2012)</td>
</tr>
<tr>
<td>United Kingdom</td>
<td>52</td>
<td>Posadzki et al. (2013)</td>
</tr>
<tr>
<td>USA</td>
<td>38</td>
<td>Barnes et al. (2008)</td>
</tr>
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*These figures are quoted from primary literature and no attempt has been made to analyze or standardize the definition of T&CM, which may vary between studies.
Contexts for Integration and Evaluation: Shaping Questions and Establishing Priorities for Action

Diverse approaches to wellness can be integrated in many different ways, sometimes simultaneously, for example, by patients themselves; by individual practitioners working within the biomedical sector whose use of T&CM is tolerated, although not explicitly endorsed, by their institution (e.g., Cant et al., 2012); by IM providers, including naturopaths, working in private practice; at the institutional level (e.g., Horigan et al., 2012; Schiff et al., 2012); and at a wider policy level, as in China and India.

Many patients avoid disclosing their use of T&CM to their mainstream health care providers, because they feel that disclosure is not important, they fear a negative response or simply because the practitioners do not ask (Robinson and McGail, 2004; Medicines and Healthcare Products Regulatory Agency, 2009). As a result, they are less likely to be aware of potential problems such as herb–drug interactions, contraindications or side-effects of T&CM therapies.

In addition to patients' and even medical practitioners' general lack of information about T&CM, what is lacking is a detailed understanding of the public health dimensions of T&CM and/or IM use: for example, differing patterns of use according to disease, income, gender, age, geography, and culture. Other important research questions relate to the quality of services; the impacts of T&CM/IM on population health and on health expenditures; and how social, spiritual and ecological aspects of wellness are being addressed within ‘integrative’ practice.

Social and Cultural Dimensions

In a recent study conducted in Taiwan it has been suggested that the high use of T&CM reflects the cultural traditions and the compatibility of health beliefs in the Chinese society. Factors such as gender, educational level, monthly income, residence, perceived health status and the cost, effect and satisfaction with T&CM were the main predictors for T&CM use. Aging population, medical resource and socioeconomic status also predicted T&CM use. Most subjects in this study (n = 2130) had at least a senior high school education, earned less than $2000 monthly, had a positive perception of their health status, conveniently obtained information about T&CM and spent less than $17 monthly on T&CM (Yeh et al., 2015).

Another study explored the psychosocial factors predicting T&CM use in Queensland, Australia and found that females, more educated individuals and nonsmokers were more likely to use T&CM. Respondents who agreed the most important knowledge comes from spiritual experience, and those who agreed they are open to new experiences were also more likely to use T&CM (Thomson et al., 2014). Social network use of T&CM was identified as a predictor of T&CM use among American college students (Nowak and Dorman, 2008).

Ethnic minorities in industrialized countries often continue to use the traditional medicine from their culture alongside, or even in place of, conventional medicine (Kronenberg et al., 2006; Reiff et al., 2003; Wade et al., 2007). This can be applied even in settings where conventional health care is provided free of charge, but traditional health care services must be paid out of pocket. As in nonindustrialized countries, the affordability, availability, and cultural familiarity of traditional medicine, together with family influence, contribute to the continued use of traditional medical providers and medicines in ‘ethnic enclaves.’

Economic Factors

Out-of-pocket spending is the most important means of financing T&CM treatments worldwide, and the only available financing mechanism in most nonindustrialized countries (Burford et al., 2007). Even in industrialized countries, insurance coverage for T&CM and IM services is relatively new and incomplete, so out-of-pocket spending is considerable. In the United States, the 2007 National Health Interview Survey revealed that $33.9 billion was spent out-of-pocket on T&CM over 12 months, representing 11.2% of all out-of-pocket health expenditure for that year. This was comprised of $22 billion spent on self-care, and $11.9 billion on visits to practitioners (Barnes et al., 2008). In Australia, an estimated AU$4 billion is spent out-of-pocket on T&CM every year (Commonwealth of Australia, 2014).

Of 213 WHO Member States surveyed for the WHO Global Atlas in 2005 (Bodeker et al., 2005), only 58 (27%) were clearly identified as having any form of public financing for T&CM, whether full or partial. Reimbursement of T&CM costs by public health insurance is often restricted to specific therapies, or to certain categories of practitioners, and only in a few countries – such as China, Korea, and Viet Nam – are traditional treatments and products fully covered by public health insurance. Dedicated public-sector hospitals for T&CM (not necessarily all therapies) are found in China, Vietnam, India, Pakistan, Cuba, and the United Kingdom, although individual therapies are offered in public sector general hospitals in a number of other countries (Bodeker et al., 2005). Specific examples of public sector financing for T&CM/IM are shown in Table 2.

Questions relevant to the economics of T&CM include: Is the public getting value for its money? What are the safest and most cost-effective therapeutic protocols for managing the conditions that are the largest burden on national health budgets, and how can integrative approaches also contribute to cost savings through preventing illness? What impact does insurance coverage have on utilization? To what extent can financing mechanisms cope with the integration of traditional, complementary and biomedical approaches in seamless person-centred care? In nonindustrialized (‘developing’) countries, how might international funders evaluate and potentially include traditional wellness approaches within public health programs relating to the treatment and prevention of priority diseases?

Ecological Dimensions

The conservation and sustainable use of the natural resource for T&CM therapies, especially medicinal plants, has long been recognized as an important policy theme relating to access rights and livelihood security (Bodeker and Burford, 2006; WHO,
Table 2 Public sector financing for traditional and complementary medicine (T&CM) or integrative medicine (IM): selected examples

<table>
<thead>
<tr>
<th>Country</th>
<th>Details</th>
<th>References</th>
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<tr>
<td>Australia</td>
<td>The public health care system Medicare reimburses chiropractic and osteopathy when referred by a medical doctor. More recently, the ‘MedicarePlus’ initiative of the central government has sought to “enhance the integration of complementary medicine into Western medicine.”</td>
<td>King’s Fund (2008)</td>
</tr>
<tr>
<td>China</td>
<td>Both public and private health insurance offer full coverage of traditional therapies, including Tibetan, Mongolian, Uygur and Dai traditional medicine. 90% of general hospitals include a traditional medicine department.</td>
<td>Government of China (2011)</td>
</tr>
<tr>
<td>Switzerland</td>
<td>In 2009, following a national referendum in which more than two-thirds of the population voted in favor, Switzerland became the first country in Europe to integrate T&amp;CM formally into the public healthcare system. Reimbursement for five therapies – anthroposophic medicine, homeopathy, herbal medicine, Traditional Chinese Medicine and neural therapy – is being offered under the universal public health insurance scheme for a trial period of 5 years, from 2012 to 2017.</td>
<td>Swiss Confederation (2011)</td>
</tr>
<tr>
<td>United States</td>
<td>Insurance coverage of CAM and integrative medicine services varies from one provider to another, and in some cases both cash and public or private insurance payments are made for the same service. In 2012, around 62% of Integrative medicine consultations received at least some reimbursement through the Medicare and Medicaid public health insurance schemes, but reimbursement rates for the therapies themselves through these public schemes were typically under 10% (e.g., 7% for homeopathy and acupuncture; 3% for Reiki, massage and meditation) and there was no public reimbursement for naturopathy.</td>
<td>Horrigan et al. (2012)</td>
</tr>
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2013). In India alone, 316 medicinal plant species are in imminent danger of extinction (UNDP India, 2014). The utilization of body parts from endangered animal species, such as rhinoceros horn, in T&CM therapies – especially in China – is another issue that has generated growing concern (Still, 2003).

Another ecological issue of public health relevance is the emergence, especially in the United Kingdom and United States, of therapeutic approaches for mental health conditions that are based on (re)connection with the natural environment (e.g., Buzzell and Chalquist, 2009; Jordan, 2015). While not historically included within the domain of T&CM, these approaches are reminiscent of traditional wellness practices such as the Maasai use of sacred forests for healing rituals (cf. Burford et al., 2001), and may have important contributions to make in future integrative healthcare.

**Priority Disease Management**

T&CM/IM is being widely used by the public in the management of chronic conditions that are costly to society, including pain and arthritis, and for more life-threatening diseases such as heart disease, cancer, and HIV-related illness (Bodeker, 2001; Wootton and Sparber, 2001a,b; Lengacher et al., 2002; Saydah and Eberhardt, 2006; Molassiotis et al., 2006; Shih et al., 2009; Teng et al., 2010; Chow et al., 2010; Armstrong et al., 2011; Bhalerao et al., 2013; Lorenc and Robinson, 2013).

A number of randomized-controlled trials have demonstrated that an integrative approach (incorporating stress management through yoga and meditation, as well as a low-fat vegetarian diet, smoking cessation, moderate exercise and social support) was able to halt or even reverse severe coronary heart disease without the use of drugs or surgery (Koertge et al., 2003; Ornish et al., 1982, 1990; Pischke et al., 2008). Depression, which can worsen co-existing health conditions and is associated with higher utilization of emergency medical services, has also been shown to respond well to integrative medicine (Guarneri et al., 2010).

Prevention of disease is a cornerstone of many traditional and complementary health systems, with diet as well as traditional forms of exercise (e.g., yoga, t’ai chi) and stress reduction often being used in various combinations to promote balanced health, prevent illness and even extend life span (Rainforth et al., 2007; Ornish et al., 2008; Guarneri et al., 2010).

In lower-income countries, the search for effective and affordable treatments for such epidemics as malaria and opportunistic infections associated with AIDS has driven policy interest in alternative medicine, although herbal medicines are not always the first treatment choice (WHO, 2002).

**A Policy Framework**

**Equity**

In industrialized societies, complementary medicine use has been found to be associated with higher income and education (Schwarz et al., 2008; Fox et al., 2010; Armstrong et al., 2011; Thomson et al., 2014; Yeh et al., 2015; Naja et al., 2015). Those with lower incomes and educational levels tend not to use complementary medicine, which may be due to less disposable income and less exposure to T&CM information.

Conversely, traditional medicine use by ethnic minorities in those same societies is substantive and at times may be the first-line treatment for the poor and for those not speaking the language of the dominant society (Wade et al., 2007). Inadequate and expensive conventional medical services are factors contributing to reliance on traditional medicine. ‘Complementary’ medicine in these situations is not complementary; rather, since basic conventional medical care may not be accessible, a danger exists of facilitating a ‘separate but unequal health care system’ (White House Commission on Complementary and Alternative Medicine Policy, 2002).
Intelectual Property Rights

Exploitation of traditional medical knowledge for drug development without the consent of customary knowledge holders is forbidden under the UN Convention on Biological Diversity. Researchers evaluating traditional medicines need to recognize that under international law, the customary owner – and often the country of origin – holds rights over the knowledge being evaluated. This has implications for patenting. If a patent is sought by a nonindigenous group, prior informed consent and just benefit sharing with customary owners must be established (Posey, 2001; Nagoya Protocol, 2014; Payyappallimana et al., 2015).

Regulation

For T&CM to be incorporated into national healthcare systems, qualified practitioners must be distinguished from those without such qualifications and safer T&CM products distinguished from potentially hazardous ones (Barnes, 2007). As in the case of conventional medications, the concept of safety is a relative one. No healthcare product can ever be entirely risk-free, and there is a need to balance risks and benefits, especially in the case of conditions for which no effective conventional treatment exists.

Two alternative regulatory models exist for specific T&CM professions: statutory regulation (i.e., compulsory registration and licensing of practitioners by the state) and voluntary self-regulation through professional organizations. Voluntary self-regulation is the norm in most countries and states, with a few notable exceptions:

- Osteopathy and chiropractic are subject to statutory regulation in several industrialized countries, including the United States, United Kingdom and Australia (Bodeker et al., 2005; House of Lords Select Committee, 2000; King’s Fund, 2008).
- Acupuncture is also subject to statutory regulation in 43 US states plus the District of Columbia, with licensing examinations set by the National Certification Commission for Acupuncture and Oriental Medicine (NCCAOM, 2014), and Traditional Chinese Medicine is regulated in Australia in the state of Victoria only (King’s Fund, 2008).
- In the United Kingdom, proposals for statutory regulation of herbal medicine, acupuncture and traditional Chinese medicine were debated for 15 years and received ministerial approval in 2011, but were finally rejected by a Government working group in 2015, in favor of accreditation of voluntary registers by the Professional Standards Authority for Health and Social Care (Walker, 2015).

Asia has seen the most progress in incorporating traditional health systems into national health policy. In China, this began in 1951 with the establishment of a Traditional Chinese Medicine Division within the Ministry of Public Health, upgraded to a Department in 1954. In 1988, the State Council established the State Administration of Traditional Chinese Medicine as an independent administrative body in its own right, with eight major departments. The Government’s commitment to “develop modern medicine and Traditional Chinese Medicine” has been written into the National Constitution and the two are regarded as equally important. In 1997 China reinforced its position about traditional medicine by emphasizing the equality between policies related to traditional and allopathic medicine as one of the guiding principles in the field of health care (WHO, 2001).

In India, a specific national policy has been developed to facilitate the integration of Indian Systems of Medicine and Homeopathy (ISM&H) into national health programs. The policy emphasizes affordability, safety, efficacy, and the sustainable use of raw materials, as well as recommending the inclusion of at least one ISM&H physician in every primary health care center and the creation of specialist rural hospitals. The Department for Ayurveda, Yoga, Unani, Siddha and Homeopathy (AYUSH) was elevated in November 2014 to an independent Ministry (Ministry of AYUSH, 2014).

Financing

As discussed above, reimbursement of T&CM/IM treatment by publicly funded health insurance schemes or national health systems has not yet been fully established in the majority of countries. The provision of public sector financing for T&CM consultations and treatment is an important policy issue, especially in relation to the WHO goal of affordable, safe and effective healthcare for all.

There is a risk that improved regulation and training may have the unwanted ‘side effect’ of destroying the flexibility and community-centered focus inherent in many traditional health systems, which permits the poorest clients to pay by installments or make a gift in kind to the practitioner. Careful planning by policy makers is required to ensure that, in becoming ‘modernized’ and ‘professionalized,’ traditional health-care services do not lose the advantages that currently make them an attractive option for some billions of the world’s population (Burford et al., 2007).

Knowledge Generation

The U.S. National Center for Complementary and Alternative Medicine (NCCAM) has led a focused program of clinical and basic science research, seen internationally as a model for how to proceed in conventional scientific research in T&CM (Bodeker and Kronenberg, 2002). This has been followed by funding initiatives from national and international foundations.

It is often asserted that there is limited evidence for the effectiveness of T&CM. However, a growing body of data resources is available, providing an increasingly strong body of evidence for many T&CM modalities. The Cochrane group has had an ‘Integrative & Complementary Medicine’ field for about a decade and a half (Cochrane, 2016). The Cochrane IM field has constructed a database on randomized-controlled clinical trials and controlled clinical trials in IM. Over 6000 trials have been identified and IM Field members regularly hand search over 40 journals.

According to the Cochrane IM database, the most widely used complementary therapies, such as acupuncture, various herbal medicines, massage, osteopathy and chiropractic care, have been evaluated with the rigorous methods of randomized-controlled trials (RCTs) and have been shown to be safe and efficacious. Other aspects of the Cochrane IM field include:
Dissemination of Systematic Reviews And Other Research.

Trials Register-the IM Field maintains the register of IM trials. The entire contents of the IM Field register is submitted regularly to the US Cochrane Center for publication in the Cochrane Library’s CENTRAL Register of Controlled Trials, the most comprehensive register of trials in the world.

Methodological Research-improvements in the methodology of conducting trials and preparing systematic reviews in IM.

In terms of commercially available evidence, highly regarded online IM databases and Continuing Education courses are offered by the Natural Standard (2016) and Natural Medicines Comprehensive Database (2016), both in the US. In the UK, MedicinesComplete is produced by Pharmaceutical Press, the publishing division of the Royal Pharmaceutical Society of Britain (2016). It includes the following data resources:

1. Herbal Medicines
2. Stockley’s Herbal Medicines Interactions
3. Dietary Supplements

Medicines Complete does not, however, provide online courses in specific medical conditions or herbs/supplements, as do the above two American resources.

The most recent evolution of this field has been an expansion to include lifestyle and well-being/wellness as part of IM practice and research. A recent review on Lifestyle & Cancer, drawing on the Cochrane database, includes a large number of studies on Integrative Medicine modalities, including nutritional and dietary supplements and regimens (Thomas et al., 2016). Further evidence on wellness modalities is available from the Global Wellness Institute’s (2016) wellness evidence resource.

Based on the availability of high quality evidence in the T&CM field, over 60 leading medical schools have come together in North America with a common agenda through the Academic Consortium for Integrative Medicine and Health (2016). The Consortium’s mission is to advance the principles and practices of integrative healthcare in academic institutions. Its mission includes "disseminating information on rigorous scientific research, educational curricula in integrative health, and sustainable models of clinical care."

Yet, despite an escalation in biomedical research momentum, this wave has yet to reach public health research. Clearly, priority should be assigned to strengthening the public health research agenda if knowledge generation is to keep abreast of consumer demand for cost-effective services, and government and insurer demands for policy information.

Capacity Building

Investment in professionals could result in leaders who could contribute to implementing public health responses to the growth in integrative, complementary and traditional medicine. A notable gap is in the curricula of schools of public health, which could contribute by offering training for students and professionals in the public health dimensions of T&CM/IM, complementing the existing training courses that focus on clinical aspects of practice.

Expanded capacity would include greater understanding of the potential for benefit, risks, and the costs of these healthcare approaches. This in turn would enable an evidence-based approach to harnessing the T&CM sector’s contributions in meeting public health challenges.

Research Environment, Methods, and Ethics

While the randomized-controlled clinical trial (RCT) is considered the gold standard of biomedical evidence, RCTs have limitations that can be addressed by social science and public health research methodologies. For example, RCTs are often too small or time-limited to provide accurate information on infrequent adverse outcomes, such as rare side effects of drugs; double-blinding is often impossible for the complex, holistic and person-centered interventions that characterize integrative medicine; and there are also limitations in adequately evaluating the long-term consequences of therapy, such as toxicity from chronic, low-level exposure to medications.

It has been argued by Kienle et al. (2011) that T&CM/IM requires comprehensive research methods for studying the intact, whole and complex systems that make up real-world practice. Cohort studies, qualitative research, high-quality case reports and case series, safety analyses, economic analyses and studies of patient perspectives as well as the use of large administrative data sets can all make important contributions to this whole-system approach. Some of the subtleties of T&CM therapies might be more appropriately examined if clinical trial design included stratification according to diagnostic categories of traditional and complementary systems, such as the Ayurvedic recognition of constitutional types or prakriti which confer susceptibility to different health conditions and demand different clinical and dietary regimen (cf. Debnath et al., 2015; Patwardhan and Bodeker, 2008).

In related work, bridging the Western notion of ‘inflammation’ and the Eastern concept of ‘heat’ or ‘heatiness,’ UCLA’s Professor Ka-Kit Hui and colleagues note: “Although inflammation is the body’s natural mechanism to heal and fight against infection, an overactive immune system that results in chronic inflammation is now thought to be the underlying cause of multiple health conditions, including cancer, diabetes, heart disease, and obesity of multiple health conditions, including cancer, diabetes, heart disease, and obesity.” Inflammation, it is noted, is viewed by Eastern medical theory as “internal heat” held to result from dysregulation of the internal organs, psychological stress, and heat-producing foods. These would be seen as ‘pro-inflammatory foods’ in Western terminology (Wongvibulsin et al., 2011: p. 3).

This helpful paradigmatic bridge – linking concepts from separate traditions into a comprehensible and translational framework – highlights an antiinflammatory approach deep within Chinese medical traditions. With all that is now known about inflammation and cancer risk, this can be viewed from the perspective of modern biomedicine as having implications for cancer and cardiovascular disease prevention. Increasingly, Western educated scientists from Asia are exploring the bridging potential of the two seemingly irreconcilable paradigms of modern medicine and traditional Eastern medicine.

Unmet health needs of ethnic minorities, women, children, the poor, the elderly, and those with special medical conditions
must be considered in the establishment of a public health research framework and priorities for action. Also needing attention are diseases for which current conventional treatment regimens are unsatisfactory, such as many cancers and chronic debilitating conditions, for which the public are turning to Title CM.

Conclusion

Over half of the population of many industrialized countries is now using complementary medicine as a part of their general health care and also for wellness and preventive purposes. At the same time, traditional medicine continues to exist in the nonindustrialized world as a major source of health care for the majority of the population.

There is a growing trend toward integrative medicine, either through partnerships between biomedical and traditional/complementary health practitioners or as a holistic person-centred approach, to provide adequate health-care coverage in the face of limited resources. The public health dimensions of this trend are clear – the public are using healthcare approaches that are typically outside the purview of mainstream medicine. Why? To what benefit or detriment – medically, financially, socially? And what does this portend for health care in the future? These are all public health questions and warrant a comprehensive research and policy response from public health professionals and academics. Indeed, while overdue, this is now expected by the public and healthcare providers.

See also: Agenda Setting in Public Health Policy; Cultural Factors Influencing Therapeutic Practice; East Asia and Pacific States, Health Systems of; Health Care of Indigenous Peoples/Nations; Health Inequalities; Health Policy: Overview; Health Systems of Africa, Middle East and North Africa Region; South America, Health Systems of; Traditional Asian Medical Systems.

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