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Original article

A national cross-sectional survey of back pain care amongst Australian women aged 60–65☆

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Abstract

Aim of the study: To analyse the use of complementary and alternative medicine (CAM), allied health and biomedicine for back pain amongst Australian women aged 60–65.
Methodology: Self-completion postal survey in 2011/2012 of 1310 women who reported seeking help for back pain from the mid-age cohort of the Australian Longitudinal Study on Women's Health (ALSWH). Questions asked about their use of, and attitudes towards, CAM, allied health and biomedicine for the treatment of back pain.
Results: Intensity of back pain was greater for those who consulted biomedical and allied health practitioners. Women reported seeking help from biomedical and allied health practitioners more quickly after onset of pain than CAM practitioners but the longer their pain persisted the more likely they were to consult CAM practitioners. Use of CAM reflected less perceived benefit of biomedicine and allied health. The perceived differences in approach of CAM practitioners (e.g. more time in consultation, more equal relationship, more holistic approach) may be influential in their use and perceived benefit. Ease of access/availability may also influence use of CAM in particular. Some communication limitations were reported regarding discussing the use of other practitioner groups with biomedical and CAM practitioners.
Conclusions: Help for back pain occurs within highly differentiated contexts of care with patients juggling multiple and often ideologically distinct provider groups in order to improve their health and well-being. Further detailed research is required to examine patient motivations and pathways across biomedical, allied health and CAM providers in order to facilitate continuity of clinical care.

Keywords: Complementary medicine; Back pain; Cross-sectional survey; Australia

Introduction

In Australia, back pain is a widespread public health issue [1], with existing studies estimating a prevalence of between 60% and 80% over the life course [2,3]. Care for back pain comes at a cost of more than AU$8 billion per year [4–6] with expenditure split between public (around 70%) and private (around 30%) providers [7]. Back pain care may involve general practitioners (GPs), allied health providers (e.g. physiotherapists) and CAM practitioners (e.g. chiropractors, osteopaths, acupuncturists and massage therapists). The three categorisations adopted in this study/analysis are defined as follows. Biomedicine refers to practices, technologies and practitioner groups who are traditionally associated with the medical profession and medical curriculum. Allied health refers to those practices, technologies and practitioner groups who are traditionally aligned with biomedicine/biomedical practitioners and who traditionally have partnered with them to provide multi-professional patient care. CAM refers to those practices, technologies and practitioner groups who are not traditionally included or associated with the medical profession or medical curriculum. Evidence internationally shows that back pain patients may explore treatment options from a range of practitioner groups and modalities [8–10]. Whilst the majority of biomedical care, some allied health care, and limited CAM therapy for back pain, is at least partially subsidised by Medicare (the national system of public funding of healthcare in Australia), most CAM therapies for back pain are largely funded by private

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health insurance funds, providing a significant split between the options available to those with insurance and those without [11]. Given the differentiated landscape of musculoskeletal care we know little about what people are using and the profile of particular groups including those who are high users of CAM, allied health or biomedicine (or indeed all three).

Economic, social and community costs of back pain

Despite being given less priority than more acute problems, back pain incurs significant direct and indirect costs in Australia, including those associated with the decreased ability or capacity to participate in work and family or community life. We know for example that sufferers are likely to live with significantly reduced mobility and experience considerable psychological distress [12]. The problems faced by people with back pain are compounded by poor success rates of biomedical treatment, with an estimated 40% of cases of acute low back pain progressing to chronic low back pain, despite being treated by 'best practice' care [13]. For some back pain sufferers, the therapeutic benefits of biomedical and allied health practices are limited [3,10], often resulting in the use or integration of CAM [14,15]. Moreover, there is some research that has illustrated a lack of satisfaction or confidence in available treatments for back pain [16,17]. This lack of confidence may be compounded by existing confusion amongst some GPs regarding the appropriateness and potential benefits/risks of the many treatment options available to treat back complaints [18]. This is a significant issue, given that GP attitudes and knowledge, as the key referrers to care, have the potential to directly impact on what people utilise across the many provider care groups for back pain [19].

Integrating or interchanging between provider groups

There has been limited research into the significance of combining biomedical, allied health and CAM treatments/practitioners within back pain care [20]. Yet, we know little about patients' perceptions of integration or diversification, nor about how patients experience combinations of (or the process of swapping between) treatments and practitioners. The utilisation and/or integration of multiple providers for back pain care present a range of important issues worthy of consideration. Whilst patients may use a range of providers for their back pain care, there is some evidence that communication and disclosure of such practices is limited [21]. That is, patients may be reluctant to talk to their practitioners about the other treatments they have used or are currently using for their back pain. Existing research has shown a lack of doctor–patient communication about CAM use [21–23], and studies have revealed that scepticism amongst some biomedical and allied health practitioners around the risk and efficacy of CAM practices may result in the aversion of patients to disclose their use of CAM therapies to their doctors [21,23,24]. For patients, consultation with practitioners from a range of professional modalities can entail experiences of contradictory or inconsistent claims to authority and legitimacy. Thus, for back pain sufferers, decision-making around who to consult and why, and who to believe regarding efficacy, can be highly problematic [25]. The integration of multiple forms of treatment by patients is not well understood, and poses key questions about the ways that patients negotiate varying or even incompatible models of care for back pain [3].

The importance of mapping usage across provider groups

We know little about the extent to which CAM therapies are experienced and/or utilised in integration with biomedical and/or allied health treatments/therapies. Just taking the mere costs associated with CAM use in Australia, it is clear that CAM therapies play a significant role in the treatment of back pain [26,27]. Yet our understanding of the ways in which CAM is used concurrently or in complement to biomedical and allied health treatments is in its infancy. Cultural, economic and political shifts are also feeding into more pluralistic approaches to back pain care. State and private subsidising of particular modalities has resulted in a wider range of treatment options being available for certain groups. Back pain represents a predominant reason for accessing certain CAM therapies (for example chiropractic, massage therapy, osteopathy, acupuncture) [15,26], yet to date there has been only very limited evidence of the utilisation of providers by mid age women [9]. In this study we provide a snapshot of the practices and practitioners utilised by mid age Australian women with back pain.

Methods

Sample

This research was conducted as part of the Australian Longitudinal Survey on Women's Health (ALSWH), designed to examine multiple factors affecting the health and well-being of Australian women over a 20-year period. Women in three age groups ('young' 18–23, 'mid age' 45–50 and 'older' 70–75 years) were randomly selected from the national Medicare database [28]. The baseline survey cohort ($n = 14{,}099$) was recruited in 1996 and the respondents have been shown to be broadly representative of the national population of women in the target age group [29]. The focus of the current sub-study is on those women in the mid age cohort. Specifically, 'mid age' women who indicated that they had sought help from a healthcare practitioner for their back pain ($n = 1620$). These participants were mailed a questionnaire, and 1310 (80.9%) returned completed questionnaires. The questionnaire consisted of a total of 50 questions, including sections focused on experiences of back pain, consultation practices and health service utilisation, attitudes towards treatment options and health status more broadly.

Demographics

The postcode of residence at the time of the baseline survey (2010) was used to classify area of residence as urban or non-urban. The participants were also asked about their current marital status and the highest educational qualification they had completed.