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Changes in the use of complementary and alternative medicine in Taiwan: A comparison study of 2007 and 2011

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KEYWORDS
Complementary and alternative medicine (CAM) use;
National survey;
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Medical pluralism

Summary
Objective: In this study, we explored the differences in the use of complementary and alternative medicine (CAM) based on data from 2007 and 2011 national surveys in Taiwan.
Research design: Two cross-sectional, community-based epidemiological surveys were conducted in Taiwan. Participants 18 years and older were interviewed regarding their CAM use in the previous 12 months. Nationally representative random-household telephone surveys using a sampling method with a probability proportional to size were conducted in 2007 and 2011. The data were analysed to compare the results between surveys.
Results: We obtained a total of 1260 and 2266 valid responses in 2007 and 2011, respectively. The use of at least one or more CAM therapies during the previous year decreased from 48.9% in 2007 to 37.8% in 2011 ($p < .001$). In both surveys, the most common CAM therapies used were Chinese medicinal herbs followed by health supplement products and tuina. We observed the greatest relative increase in CAM use between 2007 and 2011 in health supplement products (12.8% vs. 16.0%) and massage (1.3% vs. 2.9%), whereas the largest relative decrease occurred for tuina (24.4—13.4%) and Chinese medicinal herbs (31.6—25.4%).
Conclusion: Widespread CAM use reflects a more personal orientation towards maintaining health and selecting health care support services. Thus, a set of standards should be established for the safety and effectiveness of therapies, and consensus building is required to overcome the differences among practitioners from various backgrounds and traditions.
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Introduction

The use of complementary and alternative medicine (CAM) has been increasing rapidly worldwide.[1] Frass et al. (2012) reported that the prevalence rates of CAM in each of the studies included in their review fell between 5% and 74.8%. This wide range of CAM use in the population may result from a lack of consensus in defining CAM.[2] The National Centre for Complementary and Alternative Medicine (NCCAM) has defined CAM as a group of diverse medical and health care systems, practices, and products that are not presently considered to belong to conventional medicine.[3]

Taiwanese culture is a blend of aboriginal cultures, folk culture, Chinese classical culture, and Western-influenced modern culture, with people being exposed to CAM from both Eastern and Western cultures.[4] Traditional Chinese Medicine (TCM), a set of medical theories and practices that originated and evolved in China, is a crucial aspect of Taiwanese culture and society.[5] TCM provides a wide variety of traditional medicine treatment modalities, such as acupuncture, Chinese medicinal herbs, tuina, cupping, guasha, and traumatology manipulative therapy.[6] Because Chinese culture has strongly influenced aspects of the Taiwanese lifestyle, including health behaviours and medical decisions,[5] Western medicine and TCM are covered under the National Health Insurance Program (NHIP) in Taiwan.

Folk therapy, an integral part of TCM, plays a crucial role in the health care system in Taiwan. Folk therapy clinics often offer a wide range of services, such as massage, cupping, reflexology, and guasha. These folk practitioners are not regulated by the Taiwan Department of Health, and no statutory registration system is in place for these providers. Although the Department of Health has announced that the practice of folk medicine is not covered by government regulations, most Taiwanese people are willing to pay out-of-pocket fees for such services.[7]

Another crucial aspect of the Chinese lifestyle is the ''homology of medicine and food.'' The concept of Chinese medicines and foods having the same origin has long been a part of sociocultural thinking. Because all foods and medicines come from the natural world, they are frequently used in tandem with diet, which leads to the expectation that foods and medicinal herbs can be used for both eating and curing disease.[8]

In Taiwan, two population-representative surveys have reported that the prevalence of CAM use in the previous year was as high as 75.5% and 85.63% in 2002 and 2007, respectively.[9,10] Because the age of the target population and classification of the CAM types and therapies in these two surveys differed, determining the growth change in the CAM types and therapies used by the Taiwanese population during this period was difficult. Understanding the correlation between gender, age, education, and the CAM types and therapies was impossible.

The World Health Organization (WHO) has estimated that 80% of the population worldwide relies on ''indigenous therapies.'' The WHO Traditional Medicine Strategy 2002–2005 reported that the percentage of the population that has used CAM is 31% in Belgium, 42% in the United States, 46% in Australia, 49% in France, and 70% in Canada.[11] According to the National Health Interview Survey (NHIS), a comparison of the data from the 2002 and 2007 surveys suggests that the overall use of CAM among adults has remained relatively steady at 36% in 2002 and 38% in 2007.[12] However, the reports on the prevalence of CAM use vary greatly worldwide.[13]

Studies have indicated that younger adults, women, people with higher levels of education and higher incomes, and people who belong to higher social classes are associated with more frequent CAM use.[12,13] A systematic literature search of computerised databases[14] indicated that middle-aged women with higher levels of education tend to use CAM. However, some studies have indicated that age, gender, marital status, religion, education level, and income do not influence CAM use.[15–17] Regarding the relationship between age and CAM use, consensus amongst studies is limited beyond the observation that CAM users tend to be young or middle-aged, and are unlikely to be older adults (Bishop and Lewith, 2010).[14] The wide range of ages and various age categories examined in these studies have caused interpreting these findings to be extremely difficult.

In addition, the prevalence rates for CAM use may vary because of the differences in how CAM is defined, the study population selected, the methodology used,[18] and the sociodemographic characteristics, cultural differences, and access to conventional health care.[14] People's beliefs and the characteristics of the illness influence the types of CAM used. Consequently, assessing and comparing CAM prevalence and usage across all studies is difficult.[18]

Another consideration is that the characteristics of CAM use in Eastern countries may differ from those in Western countries because of demographic, cultural, and historical differences.[19] Little is known about recent trends in CAM use in Taiwan; therefore, further investigation is required, particularly because additional responsibility has been placed on health care professionals to offer clients comprehensive information on their health care and to ensure their safety. The purpose of our study was to explore the sociodemographic factors of CAM use, the prevalence and patterns of CAM use, and the health conditions and reasons for CAM use in Taiwan. We also assessed trends in the CAM use of Taiwanese people by comparing data from 2007 and 2011.

Methods

Study population

Two independent nationwide surveys were conducted in 2007 and 2011. Probability proportional to size sampling was applied in multistage cluster sampling, and computer-assisted telephone interviews were subsequently conducted to collect data. Data from both surveys were separately weighted according to the 2006 and 2010 census data issued by the Directorate-General of Budget, Accounting, and Statistics, Executive Yuan, Republic of China. To obtain accurate findings, we conducted 1260 interviews in 2007 to allow for a sampling error of 2.8%, and 2266 interviews in 2011 to allow for a sampling error of 2.1%. In summery, we confirmed that in 1260 people were surveyed in 2007 and 2266 people were surveyed in 2011. We are confident that using this approach enabled the findings to apply to the demographic profile of Taiwan.

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