Complementary Therapies in Clinical Practice 30 (2018) 50–57

Contents lists available at ScienceDirect

Complementary Therapies in Clinical Practice

journal homepage: www.elsevier.com/locate/ctcp

Integrative health care - Toward a common understanding: A mixed method study

Matthew J. Leach [a, *], Marlene Wiese [b], Manisha Thakkar [c], Tamara Agnew [d]

[a] Department of Rural Health, University of South Australia, Adelaide, South Australia, Australia
[b] Southgate Institute for Health, Society & Equity, Flinders University of SA, Bedford Park, South Australia, Australia
[c] Department of Bioscience, Endeavour College of Natural Health, Adelaide, South Australia, Australia
[d] Health Economics & Social Policy Group, University of South Australia, Adelaide, South Australia, Australia

ARTICLE INFO

Article history:
Received 14 August 2017
Received in revised form
22 October 2017
Accepted 5 December 2017

Keywords:
Definition
Integrated health care
Integrative medicine
Integrative health care
Mixed-method

ABSTRACT

Objective: To generate a multidisciplinary stakeholder-informed definition of integrative health care (IHC).
Methods: A mixed-method study design was used, employing the use of focus groups/semi-structured interviews (phase-1) and document analysis (phases 2 and 3). Phase-1 recruited a purposive sample of Australian health consumers/health providers. Phase-2 interrogated websites of international IHC organisations for definitions of IHC. Phase-3 systematically searched bibliographic databases for articles defining IHC. Data were analysed using thematic analysis.
Results: Data were drawn from 54 health consumers/providers (phase-1), 23 IHC organisation webpages (phase-2) and 23 eligible articles (phase-3). Seven themes emerged from the data. Consensus was reached on a single, 65-word definition of IHC.
Conclusion: An unambiguous definition of IHC is critical to establishing a clearer identity for IHC, as well as providing greater clarity for consumers, health providers and policy makers. In recognising the need for a clearer description, we propose a scientifically-grounded, multi-disciplinary stakeholder-informed definition of IHC.

1. Introduction

The delivery of health care in developed countries has undergone significant transformation in recent decades [1–3]; these changes have been largely in response to an upsurge in the prevalence of chronic health conditions and an ageing population [1,4]. Advancements in medical science, health technology, and health promotion have all contributed to the prolongment of life [5]; however, the extension of life comes at a cost - adding considerable financial burden to the healthcare system [6].

Accompanying this changing landscape have been shifting views in the way health care is and should be, delivered. The health consumer today is now much more health savvy, with much higher expectations of the service they receive [1]. Improved access to health information, and greater awareness of patient rights, have also contributed to a more informed and empowered health consumer [7,8].

The dominant biomedical model has provided the framework for healthcare delivery for many decades [9]. This reductionist model of “illness” equates ill health to an underlying abnormality [9] and cure to the elimination of the abnormality [10]. However, with chronic disease, cure is often not an option, rather the emphasis is on secondary/tertiary prevention; this focus on prevention does not align well with the treatment-/cure-focussed approach of the biomedical model [11].

The biomedical model also places emphasis on the expertise of the medical professional [12], where its main strengths are observed in life-saving situations in which decisions are often made in lieu of patient consent [13]. However, this model disregards the sovereignty of the patient as there is a tendency to favour physician preference over a patient's unique needs [13]. Similarly, the biomedical model places little emphasis on the biopsychosocial nature of health [10], despite holism being an integral element of the World Health Organisation's definition of health (i.e. “a state of

* Corresponding author. Department of Rural Health, University of South Australia, Adelaide, South Australia, 5000, Australia.
E-mail addresses: matthew.leach@unisa.edu.au (M.J. Leach), marlene.wiese@flinders.edu.au (M. Wiese), manisha.thakkar@endeavour.edu.au (M. Thakkar), tamara.agnew@unisa.edu.au (T. Agnew).

https://doi.org/10.1016/j.ctcp.2017.12.007
1744-3881/

complete physical, mental, and social well-being and not merely the absence of disease or infirmity") [14]. This suggests (in the author's view) that the biomedical model of care has not kept pace with the changing landscape of healthcare (in spite of the above-mentioned consumer, social, financial and political drivers of change), and that a change in the approach to healthcare is warranted.

Integrative Heath Care (IHC) represents a model of care that has perhaps (among other possible reasons) responded to the needs of consumers (i.e. By adopting a holistic, patient-centred focus) [15], government (i.e. By reducing health service demand, and focussing on prevention) [16,17], and other health care providers (i.e. By fostering collaboration). However, what IHC actually signifies is uncertain as there is no consistent definition of integrative health care; to date, IHC has been described as a component of patient-centred care [18]; a combination of conventional medicine and complementary medicine [19]; the intermingling of two models of care in hospitals or primary care settings, and the employment of CAM providers in conventional healthcare settings [20]. Others have defined IHC as an approach that includes aspects of CAM [21]. Boon et al. [22] describe a continuum of care ranging from parallel practice to full integration; the further along the continuum the practice is placed, the more likely the client will experience diverse healthcare models, complex interventions, and encounter multiple clinicians who will address multiple aspects of the presenting condition. IHC is also used interchangeably with terms such as integrative medicine, which refers more to the individual approach of a provider than a service delivery approach [23].

Developing a clearer definition of IHC is critical to fostering a common understanding of the term, both for those within and outside the discipline. Not only may this facilitate the generation of a shared identity and a shared agenda for those in the field, but it may also help to reduce ambiguity around the term, dissolve current (potentially misinformed) assumptions about IHC, and in turn, improve communication between IHC providers and relevant stakeholders (e.g. Consumers, government, educators, other health care providers). In recognising the necessity and value in creating a common understanding of IHC, this research set out to draw meaning from various sources of evidence in order to develop a shared, stakeholder-informed definition of integrative health care.

2. Methods

2.1. Study design

The research uses a concurrent triangulation mixed-method design, employing the use of focus groups/semi-structured interviews (phase 1) and document analysis (phases 2 and 3). The study represents the first stage of The Integrative health care Model development and Evaluation (TIME) project, a seven-stage, mixed-method research program designed to develop and evaluate a stakeholder-informed integrative health care service delivery model.

2.2. Aims and objectives

The aim of the study was to explore the meaning that health consumers, health providers and key stakeholders attribute to the term integrative health care (i.e. at the health system level, and not at the individual consumer or clinician level); specifically, to identify the themes that are embedded within the term integrative health care, and to generate a scientifically-grounded, multidisciplinary stakeholder informed, international definition of integrative health care.

2.3. Sample

2.3.1. Phase 1

In order to capture a wide range of perspectives on integrative health care, a maximum variation sampling technique was used. Seventeen stakeholder/occupational groups were identified as playing an essential role in the delivery of IHC, including health consumers and those from the disciplines of acupuncture/traditional Chinese medicine, chiropractic/osteopathy, dentistry, dietetics, exercise physiology, general practice, naturopathy/western herbalism, homeopathy, massage therapy, occupational therapy, pharmacy, physiotherapy, podiatry, practice nursing, psychology, and social work. Participants from each group were informed about the study through their representative associations/organisations via newsletters, email blasts and website notices. The alumni of a large South Australian University and national college of complementary medicine (offering diverse undergraduate qualifications in nursing/allied health, and complementary medicine, respectively) were also notified of the study by email. This approach was supplemented with a snowballing sampling technique, in which participants expressing an interest in the study were invited to speak with, and distribute study information to, their professional contacts. Purposive sampling was also employed to improve participant numbers, in which persons identified as having expert knowledge in their respective area (identified via the academic directories of South Australian tertiary education providers, and online clinical expert directories) were invited by email to participate. All participants were aged over 18 years and were actively involved (either clinically, academically, or in the case of consumers, personally) in their field of expertise. To ensure adequate representation from each of the 17 stakeholder/occupational groups, the study aimed to recruit between three and six participants per group.

2.3.2. Phase 2

The Google search engine was used to search for any national or international integrative health care organisations (including professional associations and clinical centres). The search terms included: [integrated or integrative] and [medicine or nursing or health] and [society or association or organisation or college]. To contain the search, only the first 300 websites were assessed for eligibility. Whilst sites/documents had to be published in the English language by an IHC association, no limits were placed on the geographical location of the association. Sites/definitions referring to integration as a uni-disciplinary model of care were excluded. Each site was then interrogated to isolate a definition of integrative health care. Eligible source documents included association webpages, position statements and policy documents.

2.3.3. Phase 3

Definitions of IHC published in the peer-reviewed literature were identified by searching the following bibliographic databases (from their inception to May 2016): AMED, CINAHL, MEDLINE and PubMed. Search terms included: [Integrated health care OR integrative health care] AND [define or definition]. Refereed articles of any type, published in the English language, and providing an explicit definition of IHC, were eligible. Articles referring to integration as a uni-disciplinary model of care, or the merging of administrative systems, were excluded.

2.4. Measures

2.4.1. phase 1

Focus groups were conducted with the various stakeholder/occupational groups; where focus groups were not feasible (i.e. due