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PUBLIC HEALTH, PRIVATE WEALTH

Complementary healthcare and the NHS

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Preface

This report was prepared by Dr Katharine Sutton and Naomi Stevenson of Fellows' Associates. Additional research was undertaken by Chris Mullan and Sarah Hancock.

The report outlines the role of complementary healthcare in delivering the government's public health policy. Through a combined analysis of published materials on healthcare and health policy, it makes recommendations for the more effective use of complementary healthcare within the National Health Service (NHS).

We are very grateful to Get Well UK for supporting this work. The views expressed in this report are those of Fellows' Associates alone.

Summary

Objectives of report
This report analyses government policy on complementary healthcare in primary care in the context of public health policy. It examines the growing use of complementary healthcare in the UK and within the NHS. It shows that whatever the debates about the efficacy or cost-effectiveness of complementary healthcare, its use is growing both outside of and within the NHS and this has ramifications for public health policy.

The report also examines complementary healthcare within the context of a growing emphasis on fully engaging individuals in the delivery of their own healthcare, and in shifting the health service from one which deals with acute problems, through more effective control of chronic conditions, to one which promotes the maintenance of good health.

The report assesses whether there is a public value case for making certain forms of complementary healthcare available on the NHS. It makes a series of recommendations for tackling current health inequalities; for obtaining greater public value from the more effective use of complementary healthcare within the NHS; and for raising the standards of care within the health service.

Complementary healthcare and public health
Throughout the western world, complementary healthcare is increasingly being used alongside conventional medicine. It is nearly five years ago since the House of Lords Select Committee on Science and Technology presented its report on complementary healthcare in which it stated that the use of complementary healthcare raises “significant issues of public health policy.” Since then the government has placed increasing stress on public health policy as a lever to improve health and well-being in the UK.

Public health focuses on improving the health of the population as a whole, rather than treating the illnesses of individual patients. The government’s public health policy is concerned with health promotion, disease prevention, the reduction of health inequalities, and ensuring the effective performance of all NHS services in meeting these goals.

Tackling health inequalities and promoting well-being

Tackling inequality is a central part of government health policy. Placing the citizen at the centre of the health service is the ambition. Choice and personalised care for everyone are the stepping stones towards a fully-engaged scenario which will provide the most cost-effective solution for the health service in the long run. Promoting well-being and preventing ill health are also central. These are ambitious goals, set against a backdrop of increasing public distrust and continuous reorganisation of the health service with the aim of promoting effective delivery.

Although health has improved dramatically over the last century, health inequalities have persisted and, according to the government's white paper on public health "remain a considerable challenge." Recent figures suggest that health inequalities have actually widened under the present government.

The Wanless review

The review led by Derek Wanless represented the first attempt to take a comprehensive view of the long-term healthcare needs in the UK. It examined the benefits of a "fully-engaged" public to healthcare. This fully-engaged scenario envisaged high levels of public involvement and engagement in their health, leading to increased life expectancy, public confidence and high quality care. This scenario, compared to those of "slow uptake" and "solid progress", provided the best health outcomes and was the least expensive scenario modelled. In absolute expenditure terms the gap between the fully-engaged and slow uptake scenarios was substantial, around £30 million by 2022/23, or half of NHS expenditure at the time the report was written.

The second Wanless review made recommendations on implementing cost-effective approaches to improving public health consistent with the fully-engaged scenario. He defines public health as the "science and art of preventing disease, prolonging life and promoting health through the organised efforts and informed choices of society, organisations, public and private, communities and individuals." He argues that: "after many years of reviews and government policy documents, with little change on the ground, the key challenge now is delivery and implementation, not further discussion . . . where the evidence exists on how to do this cost-effectively, it should be used; where it does not, promising ideas should be piloted, evaluated and stopped if the evidence shows that to be appropriate."

Complementary healthcare and public health policy

How does complementary healthcare fit into the government's public health policy? The answer is quite simply that it does not. Complementary healthcare tends to be viewed by government from a narrow health perspective, rather than a broader public health perspective. By failing to consider complementary healthcare within the context of its own public health approach, the government may be perpetuating the health inequalities it is trying to reduce, whilst hindering its realisation of the fully-engaged scenario.

Assessing the public value of complementary healthcare

In analysing complementary healthcare provision there are strong arguments for considering it within the context of public value or the social return on investment through improvements in public health, the economy and individuals' quality of life.

Because complementary healthcare has largely been seen through a narrow prism of health policy, the test for comprehensive public provision has largely been based on clinical tests of efficacy as measured by randomised controlled trials.

Yet complementary healthcare appears to consist of two key elements – clinical and social care – concerned with both the alleviation of medical conditions, often in conjunction with conventional medicine, and the promotion of good health and healthy lifestyles, consistent with the fully-engaged scenario. A fuller evaluation of complementary healthcare should take into consideration both aspects of care as well as public health considerations.

On the one hand, complementary healthcare can cause direct harm to the patient or indirect harm if they delay appropriate conventional treatment. Economic harm to the individual may occur as a result of expenditure on inefficacious treatments. Nor is there overwhelming evidence that complementary healthcare, as a whole, is either clinically effective or cost-effective.

On the other hand, there is a growing market for complementary healthcare with sustained levels of public demand driven by satisfied customers. In that sense it is effective for people. With complementary healthcare emphasis is placed both on the amelioration of the condition and also health and lifestyle issues, in line with the government's commitment to self care and patient control. The increasing use of complementary healthcare could help

to reduce demand on NHS services such as GP time or referrals to secondary care, and it may reduce dependence on medication. Wider provision of complementary healthcare on the NHS might reduce days absent from work through illness and reduce dependency on incapacity benefit. Its use in palliative care demonstrates the benefits of how it can be combined with conventional medicine in a field where the objective is to maximise patient comfort and well-being rather than finding a cure. There is a growing body of evidence to suggest certain forms of complementary healthcare such as acupuncture and osteopathy and chiropractic may provide cost-effective services for chronic conditions such as musculoskeletal problems.

Delivering and implementing effective healthcare

Realising the dream of 'fully-engaged' and harnessing citizens' involvement in their healthcare requires active individuals and effective government delivery. Citizens must experience tangible benefits as a result of their engagement. This is the context in which government policy operates and presents one of its biggest healthcare challenges.

Citizens increasingly demand public services to be tailored to their needs – and for a range of services to work together to meet those needs holistically and seamlessly. Their approach to their own experience of public services is now increasingly referential, not deferential.

Trust in the ability of government to deliver its promises and public engagement in politics are declining at a time when personal buy-in for government measures to improve public health and public services is critical. This is reflected in the latest MORI research which shows that public trust in health service policy is falling, although trust in local delivery of services is increasing.

A step change in delivery requires a sea change in government attitudes towards public health and citizens' needs. Whilst there is a need for greater devolution and less central control and micro-management, there must be central direction to eradicate disadvantage at a national level and tackle the postcode lotteries which consistently add to the health gap.

Irrespective of the fact that clinical effectiveness, as a whole, may not have been satisfactorily proven, complementary healthcare is being increasingly used within the NHS by GPs and generates high levels of public satisfaction. Seventy-five percent of patients think that complementary healthcare should be available on the NHS. Public opinion polls and consumer surveys and the

evidence of the growing market for complementary healthcare demonstrate that the public supports the growing use of complementary healthcare. However, research has found that in the Western developed countries the use of complementary healthcare is associated with higher income levels, non-manual social class and full-time education after 18.

Public health, private wealth

Patient choice in complementary healthcare is dependent on being able to afford it. Complementary healthcare remains to a large extent the reserve of those with wealth who may access it through the NHS or buy it privately. Is it in the interests of public health that private wealth should be the main form of access to complementary healthcare? If government aims to reduce inequalities, the answer must surely be no.

The decision to fund complementary healthcare on the NHS is a local one. Primary Care Trusts (PCTs) may fund complementary healthcare but they are under no duty to do so. There is no requirement on PCTs to provide access, nor an agreed list of therapies that can be provided by the NHS. The availability of these therapies is therefore dependent on a postcode lottery. 43% of PCTs provide some element of complementary healthcare, and one in two GP practices now offer their patients access to it. The percentage of services supported by full or partial patient payments rose from 26% in 1995 to 42% in 2001.

Although the government promised to introduce a national framework for access to complementary healthcare throughout the NHS, no mention of it was made in its public health white paper and no action has been taken to ensure universal access on the NHS.

The current mixture of predominantly private provision with limited NHS provision creates a two-tier health market in which choice is limited to those who can pay. This creates inequity between socially disadvantaged groups and higher income groups, at odds with the government’s commitment to combat health inequalities. The government has pledged to attack this kind of two-tier healthcare in the country by providing access and choice for everyone.

Public value and universal provision

Chronic conditions such as musculoskeletal problems produce substantial costs to both individuals and society as a whole. Research indicates that these conditions are associated with low social status, manual labour and physical and psychological stress at the workplace.

There is a public value case for making acupuncture, osteopathy and chiropractic – those therapies which are already used extensively and effectively by the NHS in primary care – universally available, whilst retaining the existing status of other complementary therapies where provision is dependent upon local discretion.

Recommendations to government

Availability on the NHS

1. Acupuncture, osteopathy and chiropractic should be made universally available on the NHS in primary care. These services should only be available through referral from a GP exercising their individual judgement on clinical need.

2. Additional therapies other than acupuncture, osteopathy and chiropractic should remain available on the NHS at the discretion of the commissioner of services. Such services should only be available on referral from a GP exercising their judgement about clinical need.

3. Those complementary therapies made universally available or where there is local discretion to provide on the NHS should be kept under review. As with conventional medicines, the list should be amended over time if alternatives were found to be more effective or if the treatments were found to have no more than a placebo effect.

4. That the discretion outlined above should be exercised following consideration of the impact on health inequalities, and that government directives and guidance should seek to ensure that local arrangements for the delivery of such services act wherever possible to reduce such inequalities.

5. Government should urgently consider the public policy case for making complementary healthcare universally available for palliative care and to tackle mental health problems. In considering the public policy case, the public value should be assessed.

6. Government should urgently consider the public value of current provision of homeopathy on the NHS to assess its clinical effectiveness and cost-effectiveness and whether patterns of use are tackling current health inequalities.

7. Government should consider the public value of other remaining forms of complementary healthcare available on the NHS to assess their clinical effectiveness and cost-effectiveness and whether patterns of use are tackling current health inequalities.

Regulation

8. The goal should be that no unregulated practitioners practise within the NHS.

9. The government should bring forward light touch regulation for all those individuals involved in disciplines where there is no statutory regulation. This could take the form of self-regulation, similar to the model currently used for fitness professionals.

10. Government should conduct a review of the current regulatory structures with a view to creating a single body for health professionals operating mainly within the NHS.

Research

11. Government needs to develop a comprehensive and co-ordinated approach to public health research and consider aspects of complementary healthcare within this context.

12. Consistent with the approach laid down by Wanless, complementary healthcare initiatives which focus on the needs of the most disadvantaged within our communities should be evaluated as a series of natural experiments. Resources should be made available to ensure that successful initiatives are rapidly rolled out in other areas, whilst those that prove unsuccessful are discontinued.

Governance

13. Government should also consider whether the current location of public health within the Department of Health can effectively prioritise the issue in the public policy arena. Given

its cross-cutting nature, there are strong arguments to support a new Ministerial post within the Cabinet Office, and/or to raise its profile by including the minister for public health within the Cabinet.

14. The new Director for Occupational Health should consider a strategy for incorporating complementary healthcare as part of a programme to tackle chronic conditions for people at work, as well as proposals on how such a strategy could be funded.

Recommendations to local healthcare services

15. Public health officers within each PCT should examine to what extent complementary healthcare is currently on offer and examine its role in reducing the health gap.

16. Local authorities should consider innovative ways of using the power of well-being to work with PCTs and GP practices to develop innovative health projects incorporating complementary healthcare as part of their community strategy. These should be aimed at eradicating the health gap and promoting healthy lifestyle and the quality of life.

17. Commissioners of complementary healthcare services should be subject to a duty to develop policies governing its use and the conduct of practitioners as outlined in Chapter 6.

Recommendations to complementary healthcare practitioners working in the NHS

18. Practitioners could consider developing practice-based research networks where practices devoted principally to the primary care of patients affiliate with each other, and often with an academic or professional organisation, in order to investigate issued in relation to community-based health practice.

19. Practitioners should consider their services within the context of public health and consider what strategies could be employed to ensure that underserved groups within local

communities are provided with effective complementary healthcare services.

20. Relevant professional bodies should consider developing effective information technology solutions which are capable of integrating with other parts of the healthcare system and developing efficient services.

21. Practitioners need to ensure that the patient is placed at the centre of the service and involved in future design. Feedback should not only be collected on how clinical need was met but also on how the service could be improved or designed to become more accessible and address health gaps.

1 Introduction

Objectives of report

1.1 This report analyses government policy on complementary healthcare in the context of public health policy.[1] It examines the growing use of complementary healthcare in the UK and within the NHS. It shows that whatever the debates about the efficacy or cost-effectiveness of complementary healthcare, its use is growing both outside of and within the NHS and this has ramifications for public health policy.

1.2 The report also examines complementary healthcare within the context of a growing emphasis on fully engaging individuals in the delivery of their own healthcare and in shifting the health service from one which deals with acute problems, through more effective control of chronic conditions, to one which promotes the maintenance of good health.

1.3 The report assesses whether there is a public value case for making certain forms of complementary healthcare available on the NHS. It also makes a series of recommendations for tackling current health inequalities; for obtaining greater public value from the more effective use of complementary healthcare within the NHS; and for raising the standards of care within the health service.

Public health and complementary healthcare

1.4 Throughout the western world, complementary healthcare is increasingly being used alongside conventional medicine.[2] Complementary healthcare consists of a group of diverse medical and healthcare systems, practices and products not presently considered to be part of conventional medicine. Its efficacy relative

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[1] The report focuses on policy made at Westminster as opposed to the devolved administrations.

[2] Throughout this report we use the term complementary healthcare to denote that not normally included in mainstream healthcare in the UK. As both the House of Lords report and the White House Commission on Complementary and Alternative Medicine Policy recognised, complementary healthcare is a heterogeneous group of therapies, and the boundaries between complementary healthcare and conventional medicine are constantly shifting. The definitions vary, and distinctions are fluid. See *Sixth report: Complementary and Alternative Medicine,* House of Lords Select Committee on Science and Technology, 2000, and *Final report*, *White House Commission on complementary and alternative medicine,* March 2002. Our report focuses primarily on the complementary therapies which are already used by the NHS in primary care. It does not explore the issue of herbal medicine to any great extent as this is a considerable topic on its own.

to conventional medicine is the subject of heated dispute. Yet it is undoubtedly popular with the public and its use is growing.

1.5 The global market for complementary healthcare is worth billions, and research has predicted a sharp increase in the value of the UK market in the next few years.[3] It is not just individuals that are turning to this form of healthcare. As discussed in more detail in Chapter 3, there is growing acceptance of its efficacy amongst practitioners of conventional medicine, many of whom either refer their patients to complementary therapists or provide certain therapies themselves.

1.6 Although in some cases there has been a tendency to polarise the debate between advocates of complementary healthcare on the one hand and supporters of conventional medicine on the other, the differences between conventional medicine and complementary healthcare are not so great.

1.7 As the Royal Society of Edinburgh, in its response to the House of Lords Select Committee, pointed out, the differences have often been overemphasised. While many of the therapies listed under the Committee's definition of complementary and alternative medicine are based on superstition it should be recognised that, prior to the early nineteenth century, the drug arm of conventional medicine was entirely herbal. Thus the Royal Botanic Garden in Edinburgh was founded as the source of herbals for the Royal Infirmary. The distinction, therefore, between conventional and alternative medicine is often overemphasised and, in some cases, the former largely represents a developmental progression of the latter.

1.8 As the Royal Australian College of General Practitioners' Australasian Integrative Medicine Association points out, people who use complementary healthcare are generally not rejecting conventional medicine but are seeking effective care for their health needs.[4]

1.9 It is nearly five years ago that the House of Lords Select Committee on Science and Technology presented its report on complementary healthcare in which it stated that its use raises

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[3] BBC News, 17 April 2003, Mintel research, 2003
[4] *Joint Position Statement*, RACGP/AIMA, 2004

"significant issues of public health policy."[5] Since then the government has placed increasing stress on public health policy as a lever to improve health and well-being in the UK and tackle health inequalities.

Tackling health inequalities

*"It is a fact of life that it is easier for some people to make healthy choices than others. Existing health inequalities show that opting for a healthy lifestyle is easier for some people than others. Our aim must be for **everyone** to achieve greater health and mental well-being by making healthier choices. That means ensuring that those people in disadvantaged areas and groups have the opportunity to live healthier lives."*

John Reid, Health Secretary, 2004

1.10 Tackling health inequalities was a central part of the Wanless reports and of the government's subsequent public health white paper, published in November 2004.[6]

1.11 Wanless defined public health policy as the "science and art of preventing disease, prolonging life and promoting health through the organised efforts and informed choices of society, organisations, public and private, communities and individuals." He argues that: "after many years of reviews and government policy documents, with little change on the ground, the key challenge now is delivery and implementation, not further discussion . . . where the evidence exists on how to do this cost-effectively, it should be used; where it does not, promising ideas should be piloted, evaluated and stopped if the evidence shows that to be appropriate."[7]

"Our health services must evolve from dealing with acute problems through more effective control of chronic conditions to promoting the maintenance of good health."

Securing good health for the population, final report, Derek Wanless, 2004

1.12 Although health has improved dramatically over the last century, health inequalities have persisted and, according to the public health white paper "remain a considerable challenge." Recent figures suggest that inequalities are actually widening. Rafts of public authorities and individuals have been tasked with taking action to reduce this gap.

1.13 The report assesses the public value case for making some forms of complementary healthcare available on the NHS. It poses four key questions:

- can complementary healthcare reduce ill health and promote well-being?

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[5] *House of Lords Science and Technology Committee*, op.cit.
[6] *Choosing Health, making healthier choices easier,* DH, 2004; *Securing our future health: taking a long-term view,* DH, 2002; *Securing good health for the whole population, final report,* Derek Wanless, 2004
[7] *Securing good health for the whole population*, op.cit.

- can complementary healthcare play a role in the public health agenda?

- can the use of complementary healthcare help to tackle health inequalities?

- are there measures that government could take in relation to complementary healthcare which would help to reduce health inequalities and promote public health?

2 UK health policy and practice

The government promise

2.1 The current government is committed to a successful economy and social justice. It has consistently promised to deliver a reduction in the health equality gap through a series of measures designed to place a new philosophy and practice of public health at the fore.

2.2 Social deprivation is a major determinant of poor health.[8] Social class whether measured by education, income or occupation is a robust predictor of health outcomes.[9]

2.3 In the last three elections it has fought and won, the government was elected on pledges to improve public services in general and health in particular.

2.4 In 1997, government promised to restore the NHS as a public service; recognise the lead role of primary care; introduce a "new public health drive", including the appointment of a minister for public health; and eradicate the postcode lottery.

2.5 In 2001, government promised to decentralise power; cut waiting times; and work with the private sector to meet demand. It reiterated its concerns about the health gap between rich and poor and stated that it saw its job as improving both the nation's health and its health service.

2.6 In 2005, government promised to put patient care centre-stage; to deliver personalised care; enable greater patient control; and support GPs in delivering more advanced and extended services locally.

2.7 Government promises have done little to build public trust. According to MORI, the percentage of people who believe that the

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[8] *Inequalities in health, report of a research group*, (Black report), DHSS, 1980
[9] *Socioeconomic determinants of Chronic Heart Disease (CHD)*, M Marmot, 1989

NHS will get better has decreased by 10% in the three months from May 2005 (33%) to September 2005 (23%), and the percentage of people believing it will get worse has increased by 9% over the same period.[10]

Tackling the health gap

2.8 In 1997 the new minister for public health commissioned former Chief Medical Officer, Sir Donald Acheson, to carry out an independent inquiry into inequalities in health.[11] His report found clear evidence of health inequalities. It made thirty nine recommendations for future policy development covering areas such as: the NHS, poverty, housing, transport, education and employment. It recommended that all policies likely to have an impact on health should be evaluated in terms of their impact on health inequalities.

"The fully-engaged scenario envisages that health services are not just a 'sickness service'."

Derek Wanless

2.9 In 1999, the government published its white paper, S*aving Lives: Our Healthier Nation*. This highlighted the importance of inequalities in health and gave full recognition to the fact that health depends on social and economic conditions. Its aim was to improve the health of the worst off in society and to narrow the health gap. [12]

2.10 Following the publication of this white paper, the government established national targets to combat particular diseases; promised to reduce the death rates from accidents and suicide; gave local health authorities the job of developing local health improvement plans; and established the Health Development Agency (HDA), which later joined with the National Institute of Clinical Excellence (NICE) in April 2005 to become the National Institute of Health and Clinical Excellence (also to be known as NICE). A key role for NICE was to build the evidence base in public health, with a special emphasis on reducing inequalities.

2.11 In 2001, the government set national targets to reduce health inequalities. These were followed by a two-year cross-cutting review. The government's 2003 report, *Tackling Health Inequalities:*

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[10] *Deloitte/MORI Delivery Index*, MORI, May and September 2005
[11] *Independent inquiry into inequalities in health report*, D. Acheson, DH,1998
[12] *Saving Lives: Our Healthier Nation,* DH,1999

a programme of action, reiterated existing initiatives designed to improve health and reduce the health gap.[13]

2.12 The Department of Health's Public Service Agreement target is to reduce inequalities in health outcomes by at least 10% by 2010. This is measured by a reduction in infant mortality and life expectancy at birth.

A fully engaged public – the Wanless Review

2.13 In 2001 the government announced an independent review of the UK's long-term healthcare needs. Led by Derek Wanless, the first report, published in 2002, looked at the resources required to deliver high-quality health services. Using scenario planning, it examined the benefits of a "fully-engaged" public to healthcare.[14]

2.14 The fully-engaged scenario envisaged high levels of public involvement and engagement in their health, leading to increased life expectancy, public confidence and high quality care. Under this scenario levels of public engagement in relation to their health are high: life expectancy increases go beyond current forecasts, health status improves dramatically and people are confident in the health system, and demand high quality care. The health service is responsive with high rates of technology uptake, particularly in relation to disease prevention, and use of resources is more efficient.

2.15 Wanless argued that this scenario, compared to those of "slow uptake" and "solid progress", provided the best health outcomes and was the least expensive scenario modelled. In absolute expenditure terms the gap between the best and worst scenarios was large: around £30 billion by 2022/23.

2.16 The fully-engaged scenario envisages that health services are not just a "sickness service". The health services would also aim to keep healthy people fit, and people with chronic conditions as active as possible.

2.17 The second report of the Wanless review, S*ecuring Good Health for the Whole Population*, focused on prevention and the "wider determinants of health" such as socio-economic and environmental

[13] *Tackling health inequalities: a programme for action,* DH, 2003
[14] *Securing our future health* op.cit.

factors. It found that "social deprivation is a major determinant of poor health status." It made recommendations on improving prevention, public health, and reducing health inequalities." It concluded that "a step change will be required to move us on to a fully-engaged path". [15]

2.18 Wanless considered that growing public concern about issues such as obesity, children's diet and smoking seemed to signal a change in the current climate for public health and believed that this concern indicated a first step towards his vision of public engagement.

2.19 Although Wanless states that individuals are ultimately responsible for their own and their children's health, he argues that people need to be supported more actively to make better decisions about their own health and welfare because there are widespread, systemic failures that influence the decisions individuals currently make. These failures include a lack of information and significant inequalities related to socio-economic and sometimes ethnic differences. Such failures should be tackled by collective action involving a wide range of social players including government, business and media. Wanless indicated that information is necessary to secure public engagement.

2.20 Wanless also examined the poor evidence base for public health expenditure decisions. He considered that there is generally little evidence about the cost-effectiveness of public health and preventative policies or their practical implementation. He argued that there is a need for significant and continuous improvement if evidence is going to be used to drive decisions. However, he argued that "the lack of conclusive evidence for action should not, where there is serious risk to the nation's health, block action proportionate to that risk." Nor did he want lack of evidence to prevent action: "the pursuit of the ideal should no longer be allowed to be used as an excuse for inaction, rather promising approaches should be piloted with evaluation a condition for funding." [16]

2.21 Wanless also considered local delivery and its implementation. He points to the importance of PCTs in achieving local objectives. He

[15] *Securing good health for the whole population,* op.cit.
[16] Ibid.

indicated that constant restructuring had tended to weaken the NHS and recommended that where it appeared locally, the best course of action would be for PCTs to join forces to tackle public health.

"Health improvement depends upon people's motivation and their willingness to act on it. The government will provide information and practical support to get people motivated and improve emotional well being and access to services so that healthy choices are easier to make."

White paper: Choosing Health

2.22 Whilst evidence was lacking, he suggested that where PCT and local authority boundaries were coterminous, the prospects for mobilising resources more forcibly seemed better.

Putting people at the heart of healthcare

The NHS Improvement Plan

2.23 The NHS Improvement Plan, published in June 2004, sets out the priorities for the NHS up to 2008.[17] It aims to "put people at the heart of public services" and seeks to move the NHS from being a service based on acute response to one which predicts and manages chronic disease and provides access to services in a seamless fashion. The government indicated that it was committed to giving local communities greater influence and say over how local services are run. It also stated that PCTs would be responsible for 80% of the NHS budget.

"The self–management movement reflects a number of converging and complementary trends in health care including the increasing prominence of chronic illness, the importance of primary care, and the need to ensure that patients and the public are given as much choice and control as possible over decisions affecting their health and their lives."

Melanie Johnson, 2004

2.24 Self care is one of the key pillars of the plan's vision and is an important strand to the government's overall strategy for health. The government has introduced the Expert Patient Programme (EPP), the objective of which is to spread good self care and self management skills to a wider range of people with long term conditions. It is intended that the EPP will be made available through all PCTs by 2008.

White paper on public health

2.25 The government accepted Wanless's view that a step change was required in public health policy. Its public health white paper, *Choosing Health*, took forward a number of recommendations.[18]

2.26 The white paper objectives were based on the "twin pillars of improving health and tackling inequalities." [19] It places a strong emphasis on the importance of individual responsibility and choice in healthcare. Its first principle was "informed choice". The second

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[17] *NHS improvement plan,* DH, 2004
[18] *Choosing Health,* op.cit.
[19] *Health trainers for disadvantaged areas,* DH press release, 11 August 2005

key principle is the personalisation of support to make healthy choices. This means: "building information, support and services around people's lives and ensuring that they have equal access to them."[20] The third key principle is partnership. In order to promote better working across government, government has established a cabinet sub-committee on public health. This acts to co-ordinate and monitor the implementation of the government's policies to improve public health and reduce health inequalities and report as necessary to the Ministerial Committee on Domestic Affairs.

Devolving power and spreading provision

Choice and personalised care

2.27 Choice and personalised care are central to the government's health agenda. In 2003 the Department of Health carried out a national consultation with the public on how to create more choice and personalised care within the NHS, whilst promoting equality. It found that "all of us – not just some among the affluent middle classes – want the opportunity to share in decisions about our health and healthcare . . . our health needs are personal and we would like the service to be shaped around our needs." [21]

2.28 It concluded that measures had to be taken to ensure choices and services genuinely reach everyone, including the most disadvantaged and marginalised groups, and above all that the NHS had to listen to what patients and the public are telling it and then act. This required "a culture change to make services more responsive to people's needs, to treat people as whole persons rather than a collection of symptoms; a process of decentralisation to pass power outwards and downwards to put patients in control. Only then will the NHS deliver the best possible care to everyone. Central to this is the extension of patient information, power and choice." [22]

2.29 To support this, the government announced a shift in "advice from on high to support from next door" and in August 2005 announced twelve areas as the first sites to benefit from new 'health trainers'. The new services are to be developed first in

[20] *Choosing Health* op.cit.
[21] *Choice, responsiveness and equity in the NHS: a national consultation,* DH 2003
[22] Ibid.

deprived communities and, if successful, there will be a national roll-out in 2007. Each area will receive £200,000 for personalised plans for individuals to improve their health. According to the white paper, "NHS health trainers will be the fundamental building blocks for health improvement in the NHS to provide much needed new capacity and approaches to tackling inequalities."

2.30 Engaging the public in service delivery and planning was put on a statutory footing by the introduction of Section 11 of the Health and Social Care Act 2001. This places a duty on NHS trusts, PCTs and Strategic Health Authorities to make arrangements to involve and consult patients and the public in service planning and operation, and in the development of proposals for changes.

Spreading provision

2.31 The government's NHS Improvement Plan set out plans for an increasing number of services in local and community settings through a mixture of provision including private and not-for-profit sector provision. The government believes that its big challenge is now to improve primary and community care and to manage conditions outside of hospital settings, with a growing emphasis on prevention.

2.32 New contractual arrangements are intended to give greater flexibility in providing local healthcare. PCTs are under a duty to secure the provision of primary medical services, to "the extent that they consider it necessary to meet all reasonable requirements" of their populations. New arrangements for discharging this contractual duty include arrangements such as Alternative Provider Medical Services (APMS) – provision through a private sector or not-for-profit organisation; and Personal Medical Services (PMS) where a NHS provider agrees to provide a range of primary clinical services to a defined population.

2.33 The government believes that GPs must play a more effective role in healthcare and be more accountable to their communities. A new General Medical Services (GMS) contract for GPs, implemented in 2004, establishes a new quality and outcomes framework for rewarding practices. Under the contract, all practices provide essential services but can opt out of providing additional and enhanced services. A separate stream of money is

available to commission enhanced services such as complementary healthcare.

2.34 Whilst commissioning of care will continue to be led by PCTs, GPs will be encouraged to develop practice-based commissioning, providing a wider range of services which the government envisages will become more responsive to patient needs. The government believes that PCTs should encourage practices to join together to commission as a group.[23]

2.35 In a recently published document backed up by a statement by the Secretary of State for Health in October, the government announced that its improvements in commissioning, the determination to make progress on working with local authorities on Choosing Health, and the commitment to make £250 million of savings in overhead costs, requires NHS organisations to change and develop. [24] It is consulting on streamlining Strategic Health Authorities (SHAs) and PCTs. Local SHAs must submit proposals in October 2005 for consideration. Any proposals for changes to PCT boundaries will go out for a three month statutory consultation which is likely to begin in early December 2005.

2.36 The government's general principle is for PCTs to have a clear relationship with social services boundaries.[25] This is likely to lead to a radical reduction in the number of PCTs. Changes to PCT organisation will be in place by October 2006.

2.37 PCTs currently directly provide services. In future, they will become patient-led and commissioning-led organisations, with their role in provision reduced to a minimum. PCTs will also make arrangements for universal coverage of practice-based commissioning by December 2006. Changes to PCT service provision will be complete by December 2008.

Joining up services

2.38 Partnerships are a key feature of the government's modernisation programme for public services, including the NHS and local

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[23] *Practice-based commissioning; engaging practices in commissioning,* DH 2004
[24] *Hansard,* October 18 2005
[25] *Commissioning a patient-led NHS,* DH, 28 July 2005

government. They are seen as integral to 'joining up' government and providing a holistic service built around the individual citizen.

Exclusion and social disadvantage

2.39 Tackling social exclusion and disadvantage has formed one of the main threads of government policy in recent years. The work of the Social Exclusion Unit has brought questions of access to services to the fore, with programmes of work examining the experience of disadvantaged groups in a range of areas from transport to education to the justice system. The government is committed to taking action to tackle poverty and unemployment and improve housing and education to improve the health of the nation. During 2005 the Department of Health is working across government to develop more detailed agreements on how to deliver the public health white paper.[26] In addition, all legislation will build health as a component into the regulatory impact assessment.

Local government

2.40 Until the 1974 reorganisation, local government held responsibility for public health, which was then taken over by the NHS.

2.41 Under the current government, the role of local authorities to tackle public health issues has been strengthened. The Health Act 1999 provided that NHS bodies and local authorities "shall co-operate with one another in order to secure and advance the health and welfare of the people of England and Wales." Joint working under the Health Act can take the form of pooled budgets, lead commissioning and integrated provision of services.

2.42 The Health and Social Care Act 2001 gave local authorities specific powers to scrutinise local health services and health organisations as well as a voice for the community in planning services.

2.43 The Local Government Act 2000 created a new discretionary power for local authorities in England and Wales to do anything they consider likely to promote or improve the economic, social or environmental well-being of their area. Section 2 of the Act builds upon the provision contained within the Health Act 1999. All local

[26] *Delivering Choosing Health: making healthier choices easier,* DH 2005

authorities are required to develop a community strategy to enhance the quality of life for local citizens.

Occupational health

2.44 The joining up of health services also extends to the employer. The government has recently published a new strategy aimed at improving the health and well-being of working people.[27] It places responsibility with employers, individuals, healthcare professions and other stakeholders. To assist in the process a new Director for Occupational Health will work across the Department for Work and Pensions, the Department of Health and the Health and Safety Executive to lead a national debate on occupational health and well-being, including how innovative proposals might be developed and funded.

Public health initiatives

Area based initiatives with a potential impact on health:

- Children's fund
- Connections
- Education action zones
- Employment zones
- Health action zones
- Healthy living centres (New Opportunities Fund)
- Healthy schools
- Neighbourhood renewal
- New deal for communities
- Sports action zones
- Sure start
- Sure start plus

2.45 Government policy on public health has resulted in a great deal of activity and initiatives with a wide body of organisations involved. A range of programmes have been introduced to try and improve health in disadvantaged communities through action on poverty, unemployment, regeneration, education, housing and crime.

2.46 Numerous bodies and individuals, from the Chief Medical Officer to PCTs, have a statutory duty to reduce health inequalities. Since April 2002 all PCTs have been required to appoint a Director of Public Health as a member of the PCT board. Improving (and reducing inequalities in) the health of the community is one of the main statutory functions of the PCT.

2.47 The government has: developed the neighbourhood renewal strategy; introduced Sure Start, a programme designed to improve the health of babies and young children and their families; established various zone-based initiatives such as Health Action Zones (which have now closed); launched its New Deal for Communities targeting some of the most deprived areas; introduced planning mechanisms such as health improvement programmes, community plans and regional development strategies; and set up Healthy Living Centres aimed at involving

[27] *Health, work and well-being – Caring for our future,* DH, DWP, 2005

local citizens in improving their health. Each of these has their own goals and targets and measures of success.

2.48 As both Wanless and the House of Commons Select Committee on Health pointed out in 2001, it is not at all clear how far all these initiatives have been channelled effectively.[28] Indeed, the multitude of initiatives could have lead to local fragmentation. Too little evidence is collected on their efficacy and evidence of what works is not sufficiently distilled into practice.

2.49 According to researchers, the plethora of local initiatives has led to partnership fatigue.[29] The government believes that one way of tackling this problem is for PCTs to engage with Local Strategic Partnerships (LSPs). This is seen as the way forward to delivering improved healthcare in a local setting.[30]

2.50 LSPs were first established to bring together local initiatives and create more coherence in partnership working, and most local authorities now have them. The government is now establishing Local Area Agreements in 21 areas, bringing together different funding streams and allowing local delivery of national targets to reflect local priorities.

Conclusion

2.51 Tackling health inequalities is a central part of government health policy. Promoting well-being and preventing ill health are also central planks.

2.52 Placing the citizen at the centre of the health service is the ambition. Choice and personalised care for everyone are the stepping stones towards a fully-engaged scenario which will provide the most cost-effective solution for the health service in the long run.

2.53 Over recent years, there has been a shift towards a primary care led NHS. Further reforms are ongoing, with the likely merger of PCTs, more ‘mixed’ provision and the success or otherwise of practice-based commissioning. It is intended that a new range of multi-

[28] *Public Health,* Second Report of the House of Commons Select Committee on Health, 2001
[29] *Practical partnerships for health and local authorities,* D. Plamping, P. Gordon, J.Platt, BMJ, 2000
[30] *Choosing Health* op.cit.

agency initiatives involving the private and the not-for-profit sector will help provide services which are both responsive and citizen-centred.

2.54 The government has ambitious goals, set against a backdrop of increasing public distrust in government policy, and continuous reorganisation of the health service to promote effective delivery. A sea change in cultural attitudes is required if success is to be achieved. And if government is genuinely concerned to meet citizens' demands, it must listen to their needs.

3 International trends and issues

Introduction

3.1 The use of complementary healthcare is both widespread and increasing in the highly developed countries of the world. In poor regions, complementary healthcare is much more accessible, with one third of the world's population and over half of the populations of the poorest parts of Asia and Africa without regular access to essential drugs.[31] In some poorer countries, such as Cuba, the strategic use of complementary healthcare in health policy has delivered 'first world' results.[32]

Growing international market

3.2 The international market for complementary and alternative medicine is now worth a considerable amount of money. Estimated out-of-pocket costs for complementary healthcare spending in the US exceeds $27 billion and between £500 million to £1 billion in Britain in 1996, with 90% purchased privately.[33] Researchers say British consumers now spend £130m on herbal remedies, aromatherapy oils and other alternative treatments each year. They predict that figure will rise sharply over the next few years and the market will be worth almost £200m by 2008.[34] In Australia, it is estimated that approximately 52% of the Australian population used complementary medicines in 2000, with an estimated out-of-pocket spending of $2.3 billion.[35] In Canada, studies show that as much as 70% of the population had used complementary medicine in the preceding six months.[36] The evidence suggests that the continuing demand for complementary healthcare will affect healthcare delivery for the foreseeable future.

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[31] *Legal status of traditional medicine and complementary/alternative medicine: a worldwide review,* World Health Organisation (WHO), 2001
[32] *Lessons from the margins of globalisation,* J. Spiegel and A. Yassi in Journal for Public Health, 2004. In Cuba, acupuncture has been used instead of anaesthetics and complementary healthcare has been fully integrated within its health service.
[33] See *Complementary and Alternative Medicine in the United States*, Committee on the Use of Complementary and Alternative Medicine by the American Public, 2005; *Do complementary therapists offer value for money* , A. White in *Complementary Medicine: an objective appraisal,* 1996
[34] *BBC News,* 17 April 2003, Mintel research, 2003
[35] *The escalating cost and prevalence of alternative medicine* in Prev. Med. 2000, MacLennan AH, Wilson DH, Taylor, AW
[36] *Legal status of traditional medicine,* op.cit.

3.3 According to the World Health Organisation (WHO), complementary healthcare has "demonstrated efficacy in areas such as mental health, disease prevention, treatment of non-communicable diseases, as well as for the ageing population."[37]

The growing use of complementary healthcare

Growing interest among patients

3.4 In the US, about 62% of adults used some form of complementary healthcare in 2002.[38] It was most often used for back pain or problems, head or chest colds, neck pain or problems, joint pain or stiffness, and anxiety or depression. In the US, as elsewhere, complementary healthcare use is associated with higher income groups.

3.5 However, there is evidence also that complementary healthcare use is associated with inability to pay for conventional medicine under the US healthcare schemes, similar to its use in countries other than the highly developed world. Although use appears to be highest among those with more financial resources, the data also shows that 43 percent of those in the lowest income group (those with incomes less than $20,000 per year) used complementary healthcare routinely.

3.6 The majority of complementary healthcare use in the US is not reimbursed by insurance, but evidence suggests that its use is likely to grow as insurance becomes increasingly available. In the US, high-frequency users of complementary healthcare tend to be high-frequency users of healthcare in general.

3.7 In Canada, it is estimated that around 50% of the population uses complementary healthcare and that the incidence of its use rises for chronic conditions. [39] Similar proportions exist in the UK and Australia.

Increased use amongst doctors

3.8 The international survey conducted by the WHO found a number of countries across the world that had legislation in relation to

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[37] Ibid.
[38] *Complementary and Alternative Medicine in the United States,* op.cit.
[39] *The use of complementary and alternative therapies by people with multiple sclerosis,* Stacey A Page, Marja J Verhoef, Robert A Stebbins, Luanne M Metz and J Christopher Levy , 2003

complementary healthcare, or incorporated it in their national health services, including Belgium, Hungary, the Netherlands, Canada, Russia and Germany. In the latter, three quarters of GPs practised alternative therapies themselves.[40]

3.9 The growing use of complementary healthcare is evident amongst both doctors and patients in the West. Research indicates that many doctors in Australia have accepted therapies such as acupuncture, chiropractic, hypnosis and meditation as potentially beneficial: research shows that over 80% of the GPs surveyed had referred patients for a complementary therapy at least a few times a year. Nearly 20% practised one complementary therapy.[41] Most US medical schools now offer courses in complementary healthcare. There is growing awareness and use of complementary healthcare particularly in palliative care, paediatrics, obstetrics and rheumatology.

User characteristics

3.10 Research demonstrates that complementary healthcare in the West is used to promote wellness and not just the treatment of disease. On the whole, women tend to use complementary healthcare more than men, and higher educated groups more than lower educated groups. In Canada, it was found that whereas 26% of individuals in the highest household income group had used alternative care in 2003, only 13% of those in the lowest income group had done so.[42]

3.11 In most Western countries the majority of patients who use complementary healthcare do not disclose its use to their doctors. Particularly for chronic conditions, complementary healthcare is used in combination with conventional care. Most adults who use both conventional and complementary healthcare tend to value both for different purposes. Evidence would suggest that doctors generally underestimate the extent to which their patients access complementary medicine. Most research has shown that it is only a minority who inform their general practitioner of its use.

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[40] *Legal status of traditional medicine.* op.cit.
[41] See *Joint Position Statement*, RACGP / AIMA, op.cit.
[42] *The Daily,* March 15, 2005

Palliative care

3.12 Recent research indicates that a third of cancer patients in Europe use some form of complementary healthcare.[43] It found that complementary healthcare users tended to be female, younger and more highly educated and that pancreatic, liver, bone and brain cancer patients (i.e. patients with poor prognosis) used complementary healthcare significantly more often than other patients.

Paying for complementary healthcare

Insurance

3.13 In recent years a number of health plans have begun to cover certain elements of complementary healthcare. In 2000, in the US 70% of employer-sponsored health plans indicated that chiropractic was covered.[44] From 1998 to 2000 the number of health plans that covered acupuncture increased from 12% to 17%. Large employers are more likely to offer complementary healthcare benefits than smaller employers. In the US it was found that health plans were amended following requests from employees.

State funding

3.14 In response to growing popular demand, some types of complementary healthcare are provided under state insurance schemes. The arguments for include the low cost and high levels of consumer satisfaction. The arguments against are based on the lack of evidence about cost-effectiveness (see below). For example, in Germany, where complementary healthcare is used regularly by more than half the population, many conventional practitioners provide it themselves, and some of this is reimbursable through insurance schemes. Integrated services are in place in developing countries such as China and Cuba.

3.15 In British Columbia, Canada, funding and comprehensive coverage is provided for complementary healthcare including physician-referred and walk-in appointments with massage therapists, naturopaths and physiotherapists. The province has legally recognised acupuncture as a health profession and it is

[43] *Use of complementary and alternative medicine in cancer patients: a European Survey.* Annals of Oncology. 2005
[44] *White House commission on complementary and alternative medicine policy,* 2002

likely that this will soon be covered. Chiropractic is classed as primary healthcare in Canada.

Regulation

3.16 The main purpose of regulation is citizen safety. Whether it is statutory or voluntary is of lesser importance than whether it is effective in protecting the citizen. The costs of statutory regulation tend to be higher than voluntary. Voluntary or self-regulation is more common in complementary healthcare than statutory regulation.

3.17 Statutory regulation of complementary healthcare is most often applied to more invasive and higher-risk types such as chiropractic, osteopathy, acupuncture and herbal medicine. In Australia and the US, osteopathy and chiropractic are regulated in all states.

Research and evidence

3.18 There is currently a move towards evidence-based medicine in healthcare systems worldwide, with professionals more aware than ever before of the need for critical evaluation of the effects of clinical interventions. Safety must not be compromised and public money should not be wasted on ineffective or harmful treatments. Evidence-based medicine is based on the belief that decisions on which treatment to use should be founded on sound evidence produced by well-conducted research studies. Quantitative methods such as randomised controlled trials (RCTs) and systematic reviews are regarded as the gold standard.

3.19 Recent research by Smallwood and others in the UK demonstrates the paucity of evidence about clinical effectiveness and cost-effectiveness of complementary healthcare as a whole.[45] The evidence base is generally perceived to be poor, although work undertaken by Professor Ernst at Exeter University has sought to remedy this through a more rigorous and robust approach.[46]

3.20 There have been a growing number of studies which indicate cost-effectiveness in certain areas such as acupuncture and

[45] *The Role of Complementary and Alternative Medicine in the NHS – An Investigation into the Potential Contribution of Mainstream Complementary Therapies to Healthcare in the UK*, led by Christopher Smallwood, 2005
[46] *The Desktop Guide to Complementary and Alternative Medicine, an evidence-based approach,* Edzard Ernst (ed.), 2001

manipulation therapies.[47] A recent study on acupuncture for migraine headaches showed that whereas healthcare costs increased, these were less than that of another NHS recommended medication.[48] In the Netherlands, a second randomised controlled trial paired with an economic analysis examined the treatment of neck pain with physiotherapy, manual therapy, and through general practitioner care.[49] The analysis showed that manual therapy cost less and was more effective than physiotherapy or general care.

Health promotion and the causes of growth

3.21 In recent years there has been increasing emphasis on wellness and health promotion. People with better health survive longer and postpone and shorten disability. Complementary healthcare is seen as an aid to all-round better health, with the practitioner advising on general lifestyle and promoting good health.

3.22 In the US, the White House Commission found that wellness and health promotion had for the most part been left to the initiative and discretion of the individual. It suggested that: "the concomitant interest in complementary healthcare and in wellness and prevention presents many new and exciting opportunities for the healthcare system."[50] It found that the principles that underlie complementary healthcare are consistent with the two overarching goals of the Federal Government's report on the health status of the nation *Healthy People 2010: increasing the quality and years of healthy life*; and eliminating disparities in health. The report also recommended a positive role for complementary healthcare in occupational health promotion programmes.

3.23 The growing use of complementary healthcare has also been associated with the lessening dominance of the medical profession and the growing power of the consumer movement. People are able increasingly to exercise choice and to have it met by complementary healthcare providers, with an element of funds being met by the state.

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[47] *The Role of Complementary and Alternative Medicine in the NHS,* op.cit.
[48] *Cost-effectiveness analysis of a randomised trial of acupuncture for chronic headache in primary care* David Wonderling, 5 March 2004, BMJ
[49] *Cost effectiveness of physiotherapy, manual therapy, and general practitioner care for neck pain: economic evaluation alongside a randomised controlled trial*, Korthals-de Bos et al., BMJ 2003
[50] *White House Commission,* op.cit.

3.24 There are a wide range of other reasons that could be put forward to explain its increased use, including: increased access to information and cultural exchange through the power of the internet and globalisation; a growing move to self management and control over health choices; living longer; and the growing problem of managing chronic conditions.

4 Complementary healthcare law and policy

The law

4.1 In the UK, in 1999 there were 50,000 complementary healthcare practitioners, 10,000 GPs who practise some form of complementary healthcare and up to 5 million patients who consulted a complementary healthcare practitioner.[51] In the NHS, some forms of complementary healthcare are provided by GPs, along with other healthcare professionals such as nurses, midwives and physiotherapists.

Common law

4.2 Under common law activities are tolerated unless expressly prohibited. Complementary healthcare practitioners are largely free to operate so long as they do not falsely claim to be members of a regulated profession.

4.3 When doctors propose complementary healthcare for their patients they theoretically remain liable and owe a duty of care to them. When they employ complementary therapists they must make sure that the person is suitably qualified and competent to perform the duties for which they are employed.

4.4 Under the Medical Act of 1858, conventionally trained doctors can legally administer any unconventional clinical treatments they choose. The “Bolam test” is used to determine appropriate standards of care. This means that “a doctor is not guilty of negligence if he or she has acted in accordance with a practice accepted as proper by a responsible body of medical men skilled in that particular art as long as it is subject to logical analysis.” In other words, if a doctor has undergone additional training in a complementary discipline and practises in a way that is reasonable

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[51] *House of Lords Select Committee on Science and Technology*, op.cit.

and would be considered acceptable by a number (not necessarily a majority) of other medically qualified complementary practitioners, his or her actions are defensible.

4.5 Guidance on referrals published by the General Practitioners Committee of the British Medical Association states that GPs can refer patients to other doctors or nurses who practise complementary therapies as they are accountable to their regulatory authorities. This also applies to osteopaths and chiropractors as they are also statutorily regulated. In either case the GP must be satisfied that the patient will benefit.

4.6 When referring to non-clinically qualified practitioners, doctors should ask themselves three main questions: Is my decision to delegate to this complementary healthcare appropriate? Have I taken reasonable steps to ensure that the practitioner concerned is qualified and insured? Has my clinical follow-up been adequate?

Regulation

4.7 With regards to practitioners outside of the NHS, the Osteopaths Acts in 1993 and the Chiropractor Act in 1994 gave official recognition to the above therapists and protection of their titles.

4.8 All UK chiropractors must, by law, register with the General Chiropractic Council (GCC). They must keep to the legal standards of education, conduct and practice set by the councils. It is a criminal offence for a person to describe himself or herself as a chiropractor unless GCC registered. The General Osteopathic Council (GOsC) is responsible for regulating, developing and promoting osteopathy in the UK. The statutory register came into force in May 2000. All osteopaths must register with the Council in order to call themselves osteopaths and to legally practise osteopathy in the UK.

4.9 The Health Provisions Order (2001) set up the Health Professions Council which currently regulates 13 professions: arts therapists; chiropodists; clinical scientists; dieticians; clinical laboratory technicians; occupational therapists; orthoptists; paramedics; physiotherapists; prosthetists and orthotists; radiographers; and speech and language therapists. The Council is required to set standards of education, training, conduct and performance and to put in place arrangements to ensure that they are met.

The complementary healthcare market

4.10 Principally the complementary healthcare market operates as a 'free market' in which healthcare cost is not contained and its services are treated as commodities. This is the most inequitable means of financing healthcare and one of the least efficient.

4.11 Complementary healthcare is usually used alongside conventional treatments. Research shows that the most commonly used forms are acupuncture, aromatherapy, chiropractic, herbal medicine, homeopathy and osteopathy, and that the majority of people are seeking treatment for musculoskeletal conditions. There are high satisfaction levels amongst complementary healthcare users.[52] It is often used without GP referral. The reason for its use is varied. Users gain more control and choice over their health and well-being. They may be frustrated that conventional medicine is not addressing long-standing health concerns. They like the patient-centred approach and/or the philosophy of care. They are given more time, and attention is paid to their emotional well-being. Whilst for some the use of complementary healthcare may be a political act, rejecting the bureaucracy associated with conventional medicine, for the majority it is a matter of healthcare.

4.12 Complementary healthcare remains to a large extent the reserve of those able to pay for it. Patient choice in complementary healthcare means having the necessary funds. The government has pledged to attack this kind of two-tier healthcare by providing choice for everyone.

4.13 Complementary healthcare is largely provided by the private sector through private clinics, private gyms, over the counter purchases and beauty salons. Individuals will pay for treatments themselves or some may be covered by private insurance schemes. It has been estimated that the UK has an annual expenditure of £1.6 billion on complementary healthcare.[53]

4.14 Mintel, the market research company, estimates that the market in complementary medicines has continued to expand, growing by 45% in real terms from 1999 to 2004. Most market growth has

[52] *House of Lords Select Committee on Science and Technology,* op.cit.
[53] Ibid.

come from herbal and homeopathic remedies, with essential oils not quite keeping pace. Sales of herbal medicines account for more than half of category value, having risen by 16% since 2002, while homeopathic remedies have experienced a 10% rise in value over the same period, and sales of aromatherapy essential oils have increased by 8%.[54]

Insurance

4.15 In the UK, around 11.5% of the population have supplementary private medical insurance.[55] Higher income groups are most likely to have private medical insurance. Forty percent of adults with such insurance are in the highest income decile compared to less than 5% in the lowest. Whereas 22% of the professional and managerial occupations have private medical insurance only 2% of those in semi-skilled manual and personal services do. Private medical insurance policy holders are concentrated in London and the South East of England, where around 20% of the population have private medical insurance. In Scotland and the North the figure is as low as 5% of the population.[56] Most of the largest private medical insurers such as BUPA and AXA PPP offer complementary healthcare add-ons to their core insurance.

NHS provision

4.16 The National Health Service Act 1977 places a general responsibility on the Secretary of State to provide services “to such extent as he considers necessary to meet all reasonable requirements”. NHS services are, therefore, not explicitly defined. All NHS complementary healthcare services are accessed through the GPs. In addition, inpatient complementary healthcare services are provided at homeopathic hospitals and in integrated provision such as palliative care.

Homeopathy

4.17 Homeopathy has been a part of the NHS since its inception and is available at five NHS Homoeopathic Hospitals in London, Glasgow, Liverpool, Bristol and Tunbridge Wells. Homeopathic

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[54] *Complementary medicines,* Mintel, 2005
[55] *Healthcare systems in eight countries: trends and challenges,* commissioned by the Health Trends Review, HM Treasury, prepared by the European Observatory on Healthcare Systems, 2002
[56] Ibid.

physicians are licensed to practise under the National Health Service.

Local discretion

4.18 The decision to fund complementary healthcare is a local one, and PCTs are under no duty to do so. There is no requirement on PCTs to provide access, nor an agreed list of therapies that could be provided by the NHS. The availability or otherwise of these therapies is therefore dependent on a postcode lottery.

Regional inequalities

4.19 A survey of complementary healthcare provision in England found that 43% of PCTs had complementary healthcare services in their area wholly or largely free at the point of delivery.[57] London had by far the highest proportion, with an estimated 84% of PCTs offering such services. This was followed by the South where 43% had access, by the Midlands and the Eastern region with 41% and the North region having only 33%. Acupuncture, osteopathy, homeopathy, therapeutic massage, chiropractic and nutritional therapy are the services most commonly provided by PCTs.

Paying for services on the increase

4.20 In 1995 almost 40% of GP partnerships in England provided access to complementary healthcare for their NHS patients.[58] Twenty-five percent had made NHS-funded referrals to complementary therapists, 21% provided access through a member of the primary healthcare team and 6% employed an independent complementary therapist. Sixty-four percent of in-house care was carried out by doctors. Acupuncture and homeopathy were the most commonly used practices, offered by one in five and one in six respectively. Former fund-holding practices were significantly more likely to offer complementary healthcare services than other practices – 45% versus 36%.

4.21 Twenty-six percent of practice-based provision included some element of payment. Most in-house services were provided free. 81% of those who paid in full, paid it to an independent therapist working within the practice. The research pointed out that patients

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[57] *Clinical Governance for Complementary and Alternative Medicine in Primary Care, Final Report to the Department of Health and the King's Fun,* University of Westminster, 2004

[58] *Trends in access to complementary or alternative medicines via primary care in England:1995-2001, results from a follow up national survey,* in Family Practice, 2003

were paying for a significant proportion of the complementary healthcare provided within practices. It stated that: "as a way of meeting patient demand for services, this can only flourish in relatively affluent areas and its continuation will inevitably lead to an uneven distribution of provision and access across the country and between practices."[59] It also found that provision tends to expand when policy changes favour innovative service developments.

4.22 A repeat survey, carried out in 2001, showed that one in two GP practices in England offered their patients some access to complementary healthcare. This change was due to increased in-house provision. Whereas 29% of primary care teams provided complementary healthcare, the percentage of teams using independent complementary healthcare providers doubled to 12%. The proportion of practices making NHS referrals remained unchanged. The percentage of services supported by full or partial patient payments rose from 26% to 42%. Eleven percent of practices reported using complementary healthcare to support NHS priority groups including cancer patients, elderly patients, mental health patients and for diabetes and coronary healthcare patients. The report concluded that: "assuming that these services are provided according to perceived patient need, the reported growth in patient payment for these services has clear equity implications."[60]

Local initiatives

4.23 Some areas have multidisciplinary complementary healthcare teams in the community or on hospital premises. These include Lewisham Hospital Complementary Therapy Centre and the Marylebone Centre in London. The advantages of such an approach are that there are clear referral guidelines, practice evaluation, good communication with general practitioners, and supervised and accountable complementary practitioners.

4.24 Other pilot programmes have been funded by the various streams available. Research on the New Deal indicates that one of the key benefits of the projects that it funds is that it reduces inequality in access to these forms of healthcare.[61] The Complementary Health

[59] Ibid.
[60] Ibid.
[61] *Complementary and alternative therapies in New Deal Communities, Research report 32,* Sheffield Hallam University, 2004

in Partnership Scheme (CHIPs) provides innovative complementary healthcare services in Bristol.

4.25 In Salford, a separate project aims to provide integrated services and to reduce inequalities in health by offering alternatives to existing services that may not be accessed equally by all population groups. It found that after six months, 83% of patients treated reported that they required no further treatment from their GP during treatment and for six months after. Over two thirds of GPs supported the continued provision of complementary healthcare within the PCT.

4.26 In Haringey, a pilot project with Get Well UK was set up to provide access to complementary medicine for people from disadvantaged communities with chronic conditions. A preliminary, independent analysis found: “the benefit reported by patients and observed by practitioners is more than encouraging.”[62] The group of patients had chronic and complex health problems and many were jointly using complementary and conventional healthcare and significant improvements were observed. The Smallwood enquiry found that acupuncture and osteopathy were the most commonly referred treatments by doctors, the majority of whom highlighted the holistic benefits of the treatment, noting both definite physical improvements in patients and a positive impact on the psychological health of the patient.[63] Most GPs wanted greater regulation of complementary healthcare, and one told the enquiry that the problem concerning complementary healthcare was: “a legal, official and bureaucratic one, and *not* an issue of the value to patients’ well-being or health.”

4.27 In Westminster, the PCT provides a budget for complementary healthcare which is largely spent on osteopaths and acupuncturists tackling musculoskeletal conditions. This followed a three year pilot project designed to test its effectiveness.

4.28 Other innovative projects have been established in Sheffield and Newcastle. In Newcastle, chosen therapists were located in GP surgeries with access via the patient’s GPs to treat chronic conditions. Research found that the “therapies provided are well tolerated, popular treatments, of which there is evidence of health

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[62] *Does it work? A pilot project investigating the integration of complementary medicine into primary care,* N. Robinson, 2005
[63] *The Role of Complementary and Alternative Medicine in the NHS*, op.cit.

improvement, and a cost offset for conventional care."[64] According to the project the number of GP consultations was reduced by 30% and there was a 39% reduction in the number of prescriptions taken in the six months after treatment. 69% of GPs supported continued provision in the PCT. However, there were significant differences in the support of various treatments. Whereas 60% supported acupuncture, 55% chiropractic and 46% osteopathy, only 6% supported the use of homeopathy.

4.29 Other local initiatives such as Glastonbury Health Centre which runs an integrated complementary healthcare centre established in 1993 rely, at least in part, on charitable donations. An early evaluation of its work demonstrated that of the 600 patients referred for treatment during the evaluation period, most were for chronic health problems, especially problems relating to muscles and joints. Thirty-four percent of patients were referred because their problem had failed to respond to conventional treatments. Eighty-five percent of patients reported improvement in their illness following treatment, which most ascribed to the treatment itself. A cost benefit study of a sub-sample of patients with long-term health problems demonstrated that their utilisation of health services changed after treatment. Savings made through a reduction in medical care for these patients paralleled the cost of providing the complementary medicine service.[65]

Palliative care

4.30 In the UK, palliative care has a well-established working relationship with complementary healthcare. Recent research indicates that up to 30% of cancer patients have used complementary healthcare.[66] Many hospices and oncology departments in the UK offer at least one complementary therapy to patients, with over 50% of services offering more than five therapies. Two-thirds of oncology departments claim to provide complementary healthcare.

NICE guidelines

4.31 The National Institute of Health and Clinical Excellence provides guidance on complementary healthcare. Amongst its provisions it

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[64] *Complementary and alternative therapies in New Deal Communities,* op.cit.
[65] For a copy of the report go to www.integratedhealth.org.uk
[66] *Guidance on cancer services: improving supportive and palliative are for adults with cancer,* March 2004 The Manual

states that all organisations should develop policies on qualifications, professional regulation and indemnity; that providers should ensure that individuals get access to high quality information and an experienced person to talk to regarding their care; and that practitioners, where possible, should get engaged in research and evaluation.

4.32 According to NICE, patients with cancer use complementary healthcare because they feel the remedies are non-toxic and holistic, allow them more participation in their treatment and involve supportive relationships with practitioners. They also see complementary healthcare as a means of improving their quality of life and controlling symptoms of cancer or cancer treatments. Users tend to be women, are on average younger and come from higher socio-economic backgrounds than non-users.

4.33 The NICE guidelines also pursue the issue of evidence. It points out that the evidence base for the effectiveness of complementary healthcare does not offer the same level of assurance for interventions supported by randomised controlled trials. According to NICE, although the evidence is "not as rigorous" as might be desired, "the fact that these therapies are already in wide and effective use in the NHS and voluntary sector may be taken as a significant indication of their value."[67]

Growing inequalities in provision of complementary healthcare

4.34 An exploration into the relationship between use of complementary healthcare and socio-economic indicators found that one in ten of the adult population had used complementary healthcare and that more than 60% of these had used one of the main five forms of complementary healthcare in the UK: acupuncture, homeopathy, chiropractic, osteopathy or herbal medicine. Over half had not told their doctor. It also found that use of complementary healthcare is "positively associated with

[67] *Guidance on Cancer Services, Improving Supportive and Palliative Care for Adults with Cancer, The Manual*, NICE, 2004

higher gross income levels, non-manual social class and full-time education after the age of 18." [68]

4.35 A report on complementary healthcare in New Deal communities outlines that poorer sections of the community are unlikely to access complementary healthcare services set up in private gyms or private practice.[69] The New Deal aims to tackle this inequality in access by providing affordable complementary healthcare within, or in association with, the healthcare services available to New Deal community residents.[70]

Funding

4.36 Funding for complementary healthcare within general practice is limited and has been identified as the main barrier to provision in primary care. The University of Westminster believes that practice-based commissioning is likely to represent a major opportunity for complementary healthcare, and patients and practices may choose to use budget under spends for complementary healthcare therapies.[71] At the same time there may be opportunities through independent service contracts with alternative providers of medical services (APMS). Others are less clear that the necessary incentives have been built into the system to enable greater provision.

Complementary healthcare policy

4.37 Government policy on key aspects of complementary healthcare has largely been formulated in response to the pivotal report by the House of Lords.

House of Lords Select Committee report

4.38 The House of Lords Select Committee report is recognised around the world as one of the most comprehensive studies for complementary healthcare.[72] The inquiry was launched in response to the increasing use of complementary medicine and therapies in the UK and across the world. The findings and recommendations contained in the report have been used by a number of other

"It marks the defining moment in the use of complementary healthcare in this country."

David Tredinnick MP, 24 Jan 2001

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[68] *Use of complementary or alternative medicine in a general population in Great Britain. Results from the National Omnibus survey* , K. Thomas, P.Coleman, Journal of Public Health, 2004
[69] *Complementary and alternative therapies in New Deal Communities,* op.cit.
[70] Ibid.
[71] *Clinical Governance,* op.cit.
[72] *House of Lords Science and Technology Committee,* op.cit.

countries to determine their own regulatory frameworks in this area.

4.39 The report makes key recommendations on: regulation; evidence; research; public information; training and education; and the delivery of complementary healthcare by the NHS.

4.40 The report organises complementary healthcare into three main groups: the first group includes the big five of the complementary healthcare world: osteopathy, chiropractic (both of which are regulated), acupuncture, homeopathy and herbal medicine. Each of these claims to have an individual diagnostic approach. Group 2 is composed of what the House of Lords considered to be complementary treatments that did not purport to diagnose. Group 3 consists of other disciplines which purport to offer diagnostic information as well as treatment.

4.41 By and large the government supported the Committee's call for: more quantitative information on complementary healthcare; clear guidelines by the complementary healthcare disciplines on competency and training; more collaboration on improving public information; improved standards of clinical practice, governance and continuous professional development; and enhanced research.

Statutory regulation

4.42 The Committee proposed that it was in the best interests of patients that the various forms of complementary healthcare should unite under a single voluntary body for each profession and that acupuncture and herbal medicines should have statutory regulation.

4.43 Following this recommendation, in 2002 the government established two working groups on the regulation of acupuncture and herbal medicine. Both working groups published their reports in September 2003.

4.44 The independent working group on regulation for acupuncture dismissed applying to the Health Professions Council as the route to regulation. It believed it was evident from the recently published entry criteria for the HPC that a precondition of entry for any new group was that it was to have functioned as a mature profession for

several years prior to application. Its preferred option was a separate council for acupuncture.

4.45 Following the publication of the reports, in March 2004 the government issued a consultation paper on the statutory regulation of acupuncture and herbal medicine.[73] The government recommended that a "shared CAM Council" be established to regulate both therapies which could potentially be extended to other unregulated complementary and alternative medicine professions, should statutory regulation be considered necessary in order to ensure patient and public safety. The government's report of the consultation was published in February 2005, and legislation on statutory regulation is expected to be brought forward later in 2005.

4.46 The King's Fund helped establish forums to develop structures for single, voluntary self-regulation bodies for complementary healthcare professions. The forums represent 137 separate registering associations and the Department of Health has now funded further work on voluntary self-regulation.

Evidence

4.47 The House of Lords Select Committee recommended that an evidence base should be built up using both randomised controlled trials and other research designs.[74] The government's view was that any therapy that made specific claims for being able to treat specific conditions should have evidence of being able to do this above and beyond the placebo effect. This was especially so for any of the therapies in Group 1. Therapies in Group 2 which aimed to operate as an adjunct to conventional medicine, such as aromatherapy, reflexology and hypnotherapy were, in the government's view, in lesser need of proof of treatment-specific effects.

Provision on the NHS

4.48 "We recommend that only those CAM therapies which are statutorily regulated, or have a powerful mechanism of voluntary self-regulation, should be available, by reference from doctors and

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[73] *Regulation of herbal medicine and acupuncture: Proposals for statutory regulation*, DH, 2004
[74] *House of Lords Select Committee on Science and Technology,* op.cit.

other healthcare professionals working in primary, secondary or tertiary care, on the NHS."[75]

4.49 The government's response to the report, published in March 2001, endorsed this recommendation, adding that responsibility for referral for such treatments on the NHS should always remain with the individual with lead clinical responsibility for the patient, and that the patient themselves should judge whether there would be any benefit to them. [76]

Public information

4.50 The government supported the need for greater and enhanced public information on complementary healthcare. NHS Direct now provides information to the public. It also advises people to contact their Patient Advice and Liaison Service if they are not able to access complementary healthcare in their area.

The Smallwood report

4.51 Most recently, the Smallwood report recommended that NICE should carry out a full assessment of the cost-effectiveness of key therapies which make an important contribution to the delivery of healthcare.[77] The main areas identified by the report comprised: chronic and complex conditions, anxiety, stress and depression and palliative care relating particularly to pain and nausea. Although Smallwood pointed to the fact that there appeared to be a social case for extending the use of complementary therapies because the conditions identified are particularly prevalent in poorer communities, and there is evidence to suggest substantial regional differences in its provision, the analysis did not consider in detail the public health considerations of complementary healthcare.

4.52 A recent article in the BMJ has criticised the recommendation that NICE carry out a full assessment of cost-effectiveness. The authors suggest instead that each therapy should be judged on its own merits, and recommends that NICE works with practitioners in

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[75] *House of Lords Committee on Science and Technology,* op.cit.
[76] *Government response to the House of Lords Select Committee on Science and Technology's report on complementary and alternative medicine,* DH, 2001
[77] *The Role of Complementary and Alternative Medicine in the NHS*, op.cit.

'guideline development groups' to agree the evidence based needed for each particular therapy.[78]

Public health

4.53 How does complementary healthcare fit into the government's public health policy? The answer so far is quite simply that it does not. Although the government promised to introduce a national framework for access to complementary healthcare throughout the NHS, no mention of this has been made in recent policy documents. [79]

4.54 Despite the acceptance of the benefits of certain forms of complementary healthcare, additional funding for research [80], and the use of such healthcare by GPs and PCTs across the country, the public health white paper neglected to mention the subject once. Neither did the two Wanless reports.

4.55 Complementary healthcare tends to be viewed from a narrow health perspective, rather than a broader public health perspective. By failing to consider complementary healthcare within the context of its public health approach government may, by default, be perpetuating the health inequalities it is so intent on reducing and restricting its ability to reach the fully engaged scenario outlined by Wanless.

4.56 Department of Health concerns that universal provision of some forms of complementary healthcare on the NHS will increase costs fail to take account of the wider potential for effective universal use in reducing the strain on primary care, increasing well-being, reducing social security benefits and delivering benefits to the economy through reductions in lost output.

[78] *Complementary therapies and the NHS,* T. Thompson and G. Feder, BMJ, October 2005
[79] *Building on the best, choice responsiveness and equity in the NHS.* DH, 2003
[80] *Press release,* DH, 22 Dec 2004

5 Complementary healthcare and public value

Public value

"Unfair inequalities in health have persisted and remain a key challenge."
Choosing heath

"Increasing choice and increasing equity go hand in hand. We can only improve equity by equalising as far as possible the information and the ability to exercise choice"
Building on the best

"This has been a wonderful service for our patients, especially those who would not normally think to access complementary therapy or could not afford to."
GP, Islington

"All patients have benefited and there are many more we could refer."
GP, Islington

"Having complementary medicine is better for me because I may have to rely on pain killers if I didn't have this treatment."
Patient, Islington

5.1 Public services have multiple objectives, including: delivering ethical, accountable and inclusive services; cost-effectiveness; efficient outcomes; customer satisfaction; legitimacy; and trust. In a democracy, the public defines the value of public services, and part of the legitimacy of government rests on how much it adds to the public value. Governments provide public services not only because there is market failure but also to satisfy public preference.

5.2 Because complementary healthcare has largely been seen through the narrow prism of health policy, the test for comprehensive public provision has largely been based on clinical tests of efficacy as measured by randomised controlled trials.

5.3 Yet complementary healthcare appears to consist of two key elements – clinical and social care – concerned both with the alleviation of clinical conditions, often in conjunction with conventional medicine, and with the promotion of good health and healthy lifestyles.

5.4 In analysing complementary healthcare provision there are strong arguments for considering it within the context of public value or the social return on investment through improvements in public health, the economy and the quality of life.

Disadvantages

Cause of harm

5.5 Complementary healthcare can produce direct harm, which results in adverse patient outcomes. Indirect harm to the patient may occur if they delay appropriate conventional treatment or through creating unreasonable expectations that discourage patients from

dealing effectively with their condition. Economic harm may occur as a result of expenditure on harmless and inefficacious treatment or products.

Vulnerable groups

5.6 Particular groups may be placed at risk through use of complementary healthcare. Certain herbal medicines can create problems with surgery, for example by affecting blood clotting, or altering the way anaesthetics work. Pregnant women may create unknown risks to their unborn babies by taking herbal remedies and food supplements. The elderly may become less efficient at dealing with medications including herbal remedies and supplements as they get older. Children's health may be placed at risk because they may be more vulnerable to any side-effects of treatments such as herbs or nutritional supplements. Those with cancer or other life-threatening conditions may place undue reliance on such treatments.

Clinical effectiveness

5.7 Whilst research has clearly demonstrated the efficacy of some forms of complementary healthcare for certain conditions, there is not overwhelming evidence that it is clinically effective as a whole. There is also a danger that people will miss out on a conventional clinical diagnosis because they choose only to consult a complementary practitioner. This is more likely in therapies which are labelled 'alternative'.

"It opened my eyes to new techniques of self care and ways to be more proactive in my looking after my health."
Patient

"The massage session reinforced my view that complementary medicine works so well in tandem with traditional medicine."
Patient

"It helped me to gain more strength to deal with problems in my life."
Patient

"It made a difference to my condition and not just that specific area (shoulder and neck) but improved my overall health as well."
Patient

"I gained a sense of control over my pain"
Patient

Cost-effectiveness

5.8 There is not much evidence about the cost-effectiveness of providing complementary healthcare on the NHS. There is a danger that ineffective provision would create additional demand on the NHS, both in the short and long-term, and that scarce resources could be better spent on other aspects of healthcare.

Advantages

Consumers are making the choice

5.9 What we know through the growing market for complementary healthcare is that there is public demand for it, and that this demand is driven by satisfied customers. In that sense it is effective

for people. The Patients Association has also recently called for greater access to complementary therapies on the NHS.[81]

Holistic care

5.10 High levels of patient satisfaction with complementary healthcare relate also to the nature of care that they receive from practitioners. Greater emphasis is placed both on amelioration of the condition and health and lifestyle, in line with the government's commitment to self care and patient control. It is the holistic approach which not only helps to tackle physical conditions but also promotes psychological health.

Self management

5.11 The private market for self medication will continue to grow. Limited universal provision of complementary healthcare on the NHS may help to influence greater and informed use of self care and self medication across a wider range of income groups, thus relieving pressures on the NHS. The increased use of complementary healthcare could help to reduce demand on NHS services such as GP time or referrals to secondary care.

Helping to tackle chronic conditions

5.12 Complementary healthcare may play an important role in the management of chronic conditions. People with chronic conditions are significantly more likely to see their GP (accounting for about 80% of GP consultations), to be admitted as inpatients, and to use more inpatient days than those without such conditions.

5.13 The World Health Organisation has identified that such conditions will be the leading cause of disability by 2020 and that, if not successfully managed, will become the most expensive problem for healthcare systems.

Tackling musculoskeletal conditions

5.14 Musculoskeletal conditions have a major negative impact, not only on individual well-being but on the economy as a whole. In 2003/4 there were 609,000 new cases of workplace ill health, and musculoskeletal conditions were the second largest category after stress, accounting for 33% of the cases.[82] Twenty to thirty percent of the adult population are affected by musculoskeletal pain. It is

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[81] *BBC News online,* 16th August 2005
[82] *Health, work and well-being*, op.cit.

estimated that about 40% of those attending walk-in centres and one in five of those consulting their GPs do so because of musculoskeletal complaints. These conditions are the most common reason for repeat consultations with a GP. Up to 60% of people on early retirement or long-term sick leave claim to have musculoskeletal conditions, and four out of ten are limited in their everyday activities. Those with musculoskeletal conditions are the second largest group in receipt of incapacity benefit.

5.15 The burdens and costs of musculoskeletal conditions are high. A number of European countries have performed 'cost-of-illness' studies. In the Netherlands in 1999 around 50% of all disability payments and 6% of total healthcare costs were accounted for these conditions. A Swedish study from 1994 estimated that 90% of the total socio-economic costs of these conditions were indirect (31.5% for sick leave and 59% for early retirement). Forty seven percent of the total costs were attributed to back disorders, 14% to osteoarthritis and 6% to rheumatoid arthritis.[83]

5.16 Research indicates that musculoskeletal conditions are associated with low social status, manual labour and physical and psychological stress at the workplace. The prevalence and severity of back pain, for example, are influenced by socio-economic status, psychological and occupational factors.

5.17 The evidence would suggest that acupuncture, osteopathy and chiropractic can assist patients with musculoskeletal disorders where more orthodox treatments may not. Universal provision of these forms of treatment for conditions of this nature may not only provide savings for the economy in the long run but help tackle the growing inequalities in health.

Increased economic output

5.18 Wider provision of complementary healthcare on the NHS might reduce days absent from work because of illness. In 2003/04, 29.8 million working days were lost to work-related illness. An estimated 2.2 million people in Great Britain took, on average, 22 days off during a twelve month period. Musculoskeletal disorders followed by stress, depression or anxiety were the most commonly reported type of work related illness. On average each person suffering from

[83] *Musculoskeletal Problems and Functional Limitation Indicators for Monitoring Musculoskeletal Problems and Conditions, The Great Public Health Challenge for the 21st Century,* European Commission, 2003

a condition affecting their back took an estimated 19 days off work.[84] The impact of work-related illness on the running costs of organisations and on UK productivity overall is immense. In 1998, the cost of 'informal care' and associated production losses in relation to back pain was estimated to be £10,668 million.[85]

Enhanced psychological well-being

5.19 Research by the Mental Health Foundation indicates that users of mental health services require wider access to complementary healthcare. There is some evidence to suggest that it works: acupuncture can have a positive effect for some people diagnosed with schizophrenia; homeopathy has been shown to help people with severe mental health problems to recover, if used over long periods and if used alongside conventional antipsychotic medication; herbal medicines, for example St John's Wort (hypericum), have been linked to the relief of mild to moderate depression. Massage has been shown to reduce levels of anxiety, stress and depression in some people.

Palliative care

5.20 The use of complementary healthcare in palliative care demonstrates the benefits of how this can be combined with conventional medicine in a field in which the goal is maximising patient comfort and well-being rather than finding a cure.

5.21 In a society where health, as opposed to clinical care, is the goal, complementary healthcare can assist in the transition towards the medical profession working alongside an ever-broadening number of other professions within public health, most of whom share the same social goal of support.[86]

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[84] *Self-reported work-related illness in 2003/4: Results from the Labour Force Survey*, Health and Safety Executive, 2004
[85] *The economic burden of back pain in the UK.* Maniadakis N and Gray A. Pain 84(1): 95:103. January 2000
[86] *Complementary medicine: is it more acceptable in palliative care practice?,* Allan Kellehear, MJA 2003

6 Towards the effective use of complementary healthcare in the NHS

The government challenge

Growing health inequalities

6.1 The government has so far failed in its objective to reduce inequalities in health. Inequalities persist in terms of the wider determinants of health such as employment, housing, education and transport. These inequalities in service provision are reflected in persistent health inequalities. In some communities health inequalities are actually increasing.

6.2 Recently published statistics show that although child poverty has fallen by nearly a fifth between 1998/99 and 2003/04, and the number of people living in poor housing has decreased by a third since 1996, the life expectancy in the wealthiest areas is still seven to eight years longer compared to the poorest.[87] The figures show that the gap in life expectancy between the bottom fifth and the population as a whole has widened by 2% for males and 5% for females between 1997-99 and 2001-03. The gap in the infant mortality rate between the poorest and the general population also increased to 19% in 2001-03, compared with 13% in 1997-99.[88]

6.3 According to the King's Fund, communities in greatest need are least likely to receive the health services that they require in many parts of the country.[89] They are less likely to receive operations and other services such as screening. This is not just a matter of social class or geography, but relates also to the needs of minority ethnic communities.[90] Inequalities relate to both access and use of services. And the evidence would suggest that such inequalities also relate to access and the use of complementary healthcare.

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[87] *DH press release*, 11 August 2005
[88] Ibid.
[89] *Health inequalities,* Kings Fund, 2005
[90] Ibid.

6.4 Inequalities also relate to how people feel about their health and their level of engagement in self care, so critical to the government's agenda of informed choice and personalised care. Recent research for the Department of Health, carried out by MORI, demonstrates this clearly.[91] It concludes that the elderly, socio-economically deprived and ethnic minority groups may need particular attention to undertake enhanced self care – whilst tending to be of poorer health, they are less active in self care and less confident in their knowledge and understanding of how to.[92] Responses to a recent Healthcare Commission survey also highlight that the patient experience of PCTs is more negative in deprived areas.[93] Complementary healthcare is associated with greater levels of self management and control of individual health.

Engagement and control

6.5 Engagement, control and 'personalised' services are the mechanisms through which the government hopes to realise its ambitions for public health reform. Its continued pledges to enhance public health have been accompanied by a wide range of initiatives, whose efficacy to reduce inequality has not been proven.

6.6 The immediate result of a pledge to improve public services is increased expectation, regardless of success. Citizens increasingly demand public services to be tailored to their needs – and for a range of services to work together to meet those needs holistically and seamlessly. Their approach to their own experience of public services is now increasingly referential, not deferential.

6.7 Reorganising services to focus around the citizen is no small feat. It requires the buy-in of leaders, directors, managers, employees and citizens in moving away from established ways of working and delivering.

6.8 Realising the dream of 'fully-engaged' and harnessing citizens' involvement in their healthcare requires active individuals and effective government delivery. It requires that citizens experience

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[91] MORI research carried out for the DH, contained within *Public attitudes to self care – baseline survey,* DH 2005
[92] Ibid.
[93] *Variations in the experiences of patients in England: Analysis of the Healthcare Commission's 2003/2004 national surveys of patients*, Healthcare Commission, 2005

tangible benefits as a result of their engagement. This is the context in which government policy operates and presents one of its biggest healthcare challenges.

Public distrust persists

6.9 Trust in the ability of government to deliver its promises and public engagement in politics are declining at a time when personal buy-in for government measures to improve public health and public services is critical. This is reflected in the latest MORI research which shows that public trust in government health policy is falling.[94]

6.10 While many local initiatives have been launched, lack of ownership by the public remains an issue. In 2001, the House of Commons Select Committee on Health found that: "At the moment, the impression is of grandiose schemes being foisted on to communities . . . We are not convinced that any wider sense of "ownership" has yet been established. It seems to us particularly regrettable that area-based initiatives have often failed to engage the communities they aim to serve."[95]

6.11 A step change in delivery requires a sea change in government attitudes towards public health and citizen needs. Greater devolution must involve less central control and micro-management of services but requires central direction in eradicating disadvantage at a national level and tackling postcode lotteries which consistently add to the health gap.

Building public trust and public value

6.12 The first steps in building public trust and enhancing delivery are: to build individual trust through improved service provision; to develop effective dialogue between the citizen and the service provider so that individual needs can be met by public goods; and to robustly tackle overt examples of inequality where they persist within the health service.

6.13 Irrespective of the fact that clinical effectiveness, as a whole, may not have been satisfactorily proven, complementary healthcare is

[94] *Public perceptions of the NHS,* DH 2005
[95] *Public Health, Second Report* op.cit.

being increasingly used in the NHS by GPs and generates high levels of public satisfaction.

6.14 The current mixture of predominantly private provision and limited NHS provision in complementary healthcare creates a two-tier health market in which choice is limited to those who can pay. This creates inequity between socially disadvantaged groups and higher income groups, at odds with the government's commitment to combat health inequalities, promote self management and good health.

6.15 The current provision of complementary healthcare on the NHS is subject to a postcode lottery, and patients' needs rely on provider preference.

6.16 There is a public value case for making acupuncture, osteopathy and chiropractic – those therapies which are already used extensively and effectively by the NHS in primary care – universally available, whilst retaining the existing status of other complementary therapies where provision is dependent upon local discretion.

6.17 With one in two GPs making referrals to complementary healthcare practitioners and 43% of PCTs funding some provision, it is clear that there is strong demand within the NHS for such services. It is inequitable that such services may have to be paid for.

6.18 Research by Westminster University demonstrates that those areas with the poorest health are least likely to have complementary healthcare provision through PCTs.[96] For example, whereas 84% of PCTs in the London region provided complementary healthcare services, only 33% of those in the North did so.

6.19 There is clear evidence in relation to musculoskeletal conditions, for example, that it is directly related to social class. Lower status workers, less educated people and those on lower incomes are more likely to suffer such problems than other groups.[97]

6.20 The call for more research on clinical effectiveness is perpetuating an unacceptable health gap in the NHS. As Wanless indicated,

[96] *Clinical Governance,* op.cit.
[97] *Work inequality and musculoskeletal health,* University of Surrey, 2002

"The pursuit of the ideal should no longer be allowed to be used as an excuse for inaction, rather promising approaches should be piloted with evaluation as a condition for funding."[98] Practice-based research can addresses real world issues and facilitate practice changes that are based on research results.

6.21 The NICE guidelines on palliative care indicate that a theoretical search for the holy grail of clinical effectiveness through more research should be balanced against the fact that such therapies are widely in use within the NHS. Research should continue but effective use of forms of complementary healthcare should not be solely reliant on this.

6.22 There are several reasons why GPs may be increasing their use of complementary healthcare. It may indicate changing attitudes that illness must be placed within the broader context of public health. It may simply be economic pragmatism or a response to patients' demands. The fact is that GPs are making judgements that certain services are effective for their patients and their practices.

6.23 Ending the postcode lottery for three key therapies is an essential part of unravelling those parts of the NHS which create their own inequalities and undermine the very principles of the government's public health policy.

6.24 A further priority should be to consider the public policy case for making complementary healthcare universally available for palliative care and for tackling mental health problems, as well as assessing the public value of homeopathy currently available on the NHS.

6.25 If public safety is to be enhanced there is a need to retain the current situation where GPs act as the gatekeepers for complementary healthcare on the NHS. There are also a range of other protections that need to be put in place to guarantee higher standards of care for those receiving this form of healthcare within the NHS. These are examined in the next sections.

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[98] *Securing good health for the whole population*, op.cit.

Regulation

6.26 It is quite possible that current NHS provision of complementary healthcare is being sustained by unregulated practitioners. This is neither sustainable nor desirable if the public is to be fully protected. Whilst certain professions have achieved or are moving towards statutory regulation, other service providers within the NHS will remain unregulated.

Light touch regulation

6.27 The government argued against an umbrella group for regulation in its response to the House of Lords report on the grounds that each form of complementary healthcare should form a professional regulatory body. However, there is an argument for light touch regulation to ensure that all complementary healthcare practitioners working within the NHS comply with minimum standards concerning care, clinical governance, competency and professional indemnity.

6.28 During the passage of the Care Standards Act 2000, the Opposition tabled a clause which would have enabled the then Care Standards Commission (now the Commission for Healthcare Audit and Inspection) to regulate complementary healthcare by requiring it to maintain a register of therapists. It would have given the Secretary of State powers to protect the public in respect of the description of services, claims made in respect of services, and techniques that might be employed.

6.29 There are arguments in terms of public safety for developing some light touch regulation for therapists providing services on the NHS, outside of those professions which are seeking or already have statutory regulation. This would provide protection for the public and GPs, who could only refer to those practitioners who were registered.

6.30 One valuable model to explore is of establishing a register similar to that for fitness professionals. Registration is available for all fitness professionals who are involved in gym instruction, group exercise classes, circuits, keep fit, personal training, yoga, aquafit, advanced instruction techniques, or working with special populations and exercise referral and physical activity

programmes. Its objective is to embrace all disciplines involved in physical activity programmes.

6.31 GPs can only refer patients to registered fitness professionals. Registration signifies that the exercise professional meets standards for practise, including continuing education and insurance. For fitness professionals who wish to work within the NHS, this is the incentive to join the register.

6.32 As a member of the Register of Exercise Professionals (REP), individuals are issued with a membership card and a certificate of registration which shows their level of practice and date of expiry. They also receive a copy of the Code of Ethical Practice. The Register of Exercise Professionals is owned by SkillsActive, the Sector Skills Council for active leisure and learning and is a charity.

6.33 There is a strong case for considering such a register to embrace those forms of complementary healthcare within Groups 2 and 3 of the House of Lords Report. Skills for Health has already developed some competency frameworks in the field of complementary healthcare including aromatherapy, herbal medicine, homeopathy and reflexology.

6.34 A similar model, except on a statutory basis, exists in Germany. However, this provides protection for people outside of the state sector. In Germany, rather than registering providers with accredited professional bodies for particular complementary health therapies, anyone wanting to practise 'the healing art' outside of the public sector has to obtain a state licence for Heilpraktiker from a public health office.

6.35 A Heilpraktiker can provide a basic complementary healthcare service and practise any complementary healthcare method so long as it is consistent with the general standards of good professional practice in healthcare as supervised by the local public health office.[99] There are no special training requirements in complementary healthcare but a Heilpraktiker must certificate that they have no physical or mental illness.

[99] *Complementary and alternative medicine in the UK and Germany,* Anglo-German Foundation, 2003

Clinical governance

6.36 Clinical governance requires a patient-centred approach, accountability for quality, high standards of safety and improvement in patient services and care.[100] It is essential that in commissioning services PCTs and practice-based commissioners incorporate clinical governance into complementary healthcare practice.

6.37 Research into London services demonstrated that complementary healthcare services were engaged in significant ways with clinical governance.[101] If practitioners wish to develop their services within the context of the NHS, it is critical that they develop a proactive role in developing effective clinical governance.

Healthcare policies

6.38 It is essential that in commissioning services PCTs and practice-based commissioners develop robust policies for ensuring the best quality care for their patients.

6.39 Policies should be put in place by commissioners of complementary healthcare services which should, as a minimum, cover the following:

- *Accountability:* the healthcare practitioner should be personally accountable for their practice and for delivery of high standards of care to the patient/client. In exercising this accountability each healthcare practitioner should be responsible for adhering to any existing professional guidelines.
- *Competency:* qualifications, evidence of current knowledge and continuing practice, participation in assessment of competency.
- *Informed patient consent:* practitioners should provide patients with sufficient information to allow them to make informed choices at all stages of their assessment, investigation and treatment; the risks and benefits must be explained to the patient, and they should give their written informed consent.

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[100] *Clinical Governance,* op.cit.
[101] Ibid.

- *Records*: practitioners should keep adequate records including patient information, evidence of referral, consent, details of treatments, and efficacy of the treatment.

- *Evaluation:* practitioners should be made responsible for the evaluation of their services, using appropriate audits for the specific therapy practised. Evaluation should include the number of patient referrals and patient satisfaction.

- *Competence:* measures should be put in place to ensure that practitioners' competence is regularly assessed.

- *Complaints procedures:* practitioners should put in place complaints procedures.

- *Ethical code:* practitioners must abide to a clearly laid out ethical code of practice, act honestly and only in their patient's best interests.

- *Collaboration:* practitioners should work collaboratively with other healthcare professionals in the sector.

- *Practice-based research:* whilst principally devoted to patient care, practitioners should, at the minimum, ensure that they hold sufficient data for cost benefit and cost-effectiveness analysis to be carried out.

- *Audit:* clinical audits and risk management audits should be in place.

Information

6.40 There is general acceptance that there is a greater need for evidence, research and information on complementary healthcare. This is as true of NHS practitioners and other practitioners as for patients. There is a danger that those who are most able to access information about health matters will be those with higher incomes and therefore most likely to benefit. It is essential, therefore, that information is directly targeted particularly at underserved groups.

6.41 GPs continue to generate high levels of public trust. An individual's first contact with healthcare and advice is usually through their

own GP or another member of the primary care team. GPs are seen as very influential people locally and they are the preferred source of information on NHS matters.[102] In any one year, 70% of patients consult their GP, and over seven years this rises to 97%.[103]

6.42 Patients from lower socio-economic groups suffering from chronic conditions may be underserved. As too are many women (who disproportionately suffer from musculoskeletal disorders) and certain minority ethnic groups. Conditions include chronic joint or back pain, migraine, asthma and eczema. GPs may find that a complementary healthcare approach is appropriate for patients who have chronic symptoms but few detectable signs of a specific medical condition.

6.43 At the same time, it is essential that patients are given enough information from the practitioner to enable them to make an informed choice. The Prince of Wales's Foundation for Integrated Health has published a useful guide for patients.[104]

6.44 Dr Foster recommends the following:

"We believe practitioners should routinely provide the following information to their patients:

- What other treatment is available for their condition (Acupuncture, Chiropractic, Osteopathy, Homeopathy, Herbal Medicine)
- What the treatment will involve (Acupuncture, Chiropractic, Osteopathy, Homeopathy, Herbal Medicine)
- Frequent side effects of treatment (Acupuncture, Chiropractic, Osteopathy)
- Any serious complications related to treatment (Chiropractic, Osteopathy)
- How the therapist can be contacted out of hours (Acupuncture, Chiropractic, Osteopathy, Homeopathy, Herbal Medicine)
- How long the patient should wait to test the reaction of the remedy (only Homeopathy)
- Possible antidotes to the remedy (only Homeopathy)
- Potential herb-drug reaction (only Herbal Medicine)" [105]

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[102] *Public attitudes to self care,* op.cit.
[103] *Public Health, Second Report,* House of Commons Select Committee on Health, 2001
[104] *Complementary Healthcare: a guide for patients,* Foundation for Integrated Health, 2005
[105] *Dr Foster recommended consumer standards for complementary healthcare* on www.drfoster.co.uk

Measurement, research and evidence

6.45 There is a clear need to enhance the evidence base for complementary healthcare, and the work undertaken by Professor Ernst has brought much-needed rigour and a dispassionate voice to the evidence debate.[106]

6.46 Wanless's comments in relation to public health evidence are also relevant here. He pointed out that the "dearth of evidence is not unrelated to the lack of funding of public health intervention research – with funding from research organisations and the private sector heavily directed towards clinical, pharmaceutical, biological and genetic research – and the lack of a clear and coherent set of government priorities for the public health research which does exist."[107]

6.47 Just as in public health, promising initiatives in complementary healthcare should be evaluated as a series of natural experiments, so that over time an evidence base can be built up which can deliver a step change in making cost-effective interventions. There is also a need to ensure that evidence-based research takes into account the experience of the user and the informed practitioner.

6.48 There are strong arguments for the government to consider the development of complementary healthcare research within the context of public health research as a whole.

6.49 As part of this process, practitioners could consider developing practice-based research networks where practices devoted principally to the primary care of patients affiliate with each other, and often with an academic or professional organisation, in order to investigate questions related to community-based practice.

Multi-agency working and well-being

6.50 Complementary healthcare practitioners will increasingly interface with a wider number of health providers within their communities. Some of the more innovative projects working to tackle

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[106] See *The Desktop Guide,* op.cit.
[107] *Securing good health for the whole population,* op.cit.

inequalities have combined agencies working together in their community.

6.51 Local authorities could consider how they can use the power of well-being to reduce the health gap by promoting complementary healthcare, e.g. sessions for chronic sufferers could be offered in public libraries, along with information about healthy living.[108]

6.52 Government should also consider whether the current positioning of public health within the Department of Health can effectively prioritise public health within the public policy arena. Given its cross-cutting nature, there are strong arguments to support a new Ministerial post within the Cabinet Office, and/or to raise its profile by including the minister for public health within the Cabinet.

Information technology

6.53 Information technology has a powerful role to play not only in collecting and analysing information, but also in developing collaborative services with the increasing number of agencies involved in preventing illness and promoting community well-being. Organisations may benefit from sharing back office systems and developing integrated systems for the analysis of information. These could be linked to the practice-based research networks.

Patient centred care

6.54 The patient must be placed at the centre of the service and involved in the future design of effective services. Feedback should not only be collected on how clinical need was met but also on how the service could be improved or designed to close the health gap. It is particularly important that those who are underserved within the health service are given every opportunity to take an active role in participating in the future design and development of services.

[108] The power of well-being was made available to local authorities under Part 1 of the Local Government Act 2000, enabling them to take action to promote the economic, social and environmental well-being of their local communities.

7 Conclusions and recommendations

Conclusions

"Complementary therapy is gradually becoming more widely available on the NHS. At the moment, the kind of complementary treatment you can access depends somewhat on where you live in England."
NHS-Direct

7.1 This report posed four key questions in assessing the public value of complementary healthcare on the NHS. Firstly, can complementary healthcare reduce ill health and promote well-being? The answer would appear to be no and yes! The clinical efficacy of complementary healthcare which embraces all treatments considered by the House of Lords is not proven. However, the efficacy of several treatments in tackling a wide range of chronic conditions is evidenced by their increasing use not only by the public but by GPs who provide them, most often alongside conventional treatment, to care for their patients. Does complementary healthcare promote well-being? There is little doubt that its increasing use suggests that it is seen as effective. In particular, the evidence would appear to support the effectiveness of manipulation therapies for musculoskeletal conditions.

7.2 Secondly, does complementary healthcare have a role to play in the public health agenda? The emphasis of complementary healthcare on the whole patient links in well with the government's emphasis on healthcare, patient choice and self management. Its emphasis on lifestyle strategies ties in to the need to promote good health, moving away from "a pure diagnosis and treatment mantra to one of predict and manage."[109] It is this holistic approach which is so consistent with the government's objectives of engaging individuals in their own care.

7.3 Thirdly, can the use of complementary healthcare help tackle health inequalities? Complementary healthcare is seen by doctors to be particularly useful in tackling chronic conditions, many of which are disproportionately suffered by lower socio-economic groups. Wanless's analysis concluded that higher mortality rates

[109] *Clinical Governance,* op.cit.

amongst this group were not simply a matter of lifestyle, but also due to access to or quality of healthcare. The postcode lottery of current provision exacerbates rather than ameliorates this.

"We're almost seeing a popular movement in that direction, which is kind of swelling up underneath government and underneath the conventional medical establishment and saying we shouldn't be at war here between conventional and complementary medicine, we should be working together."

"Well I'm in favour of rigorous research; of course, I'm not in favour of just introducing it willy-nilly without proper regulation. But here are proven results over many decades and I think we would be failing in our responsibilities to just simply be saying we want to keep on testing forever, when actually what I think is behind that demand lies a certain scientific prejudice against complementary medicine from the traditionalists in the conventional medical camp. And I think they should be more open-minded as frankly more and more doctors and other medical practitioners and experts are and that is why they are prescribing more complementary medicines and good luck to them."

Peter Hain, BBC Radio 4, 26 October 2004

7.4 Fourthly, are there measures that government could take in relation to complementary healthcare which would help to reduce health inequalities and promote public health policy? Wider availability on the NHS would help to ensure greater access for lower income groups which are more reliant on the NHS for their care. It would reduce the health gap that currently exists and foster the promotion of healthy lifestyle and self management consistent with the government's philosophy.

7.5 Tackling health inequalities is at the forefront of the government's agenda. Complementary healthcare is increasingly popular. The government has a choice. Placing patients at the centre of the health service requires listening to their concerns. The public wants a wider solution to their healthcare needs. Government can continue to walk away from what people want or begin working together to deliver healthcare fit for the needs of tomorrow.

Recommendations to government

Availability on the NHS

7.6 Acupuncture, osteopathy and chiropractic should be made universally available on the NHS in primary care. These services should only be available through referral from a GP exercising their individual judgement on clinical need.

7.7 Additional therapies other than acupuncture, osteopathy and chiropractic should remain available on the NHS at the discretion of the commissioner of services. Such services should only be available on referral from a GP exercising their judgement about clinical need.

7.8 Those complementary therapies made universally available or where there is local discretion to provide on the NHS should be kept under review. As with conventional medicines, the list should be amended over time if alternatives were found to be more effective or if the treatments were found to have no more than a placebo effect.

7.9 That the discretion outlined in 7.8 above should be exercised following consideration of the impact on health inequalities, and that government directives and guidance should seek to ensure that local arrangements for the delivery of such services act wherever possible to reduce such inequalities.

7.10 Government should urgently consider the public policy case for making complementary healthcare universally available for palliative care and to tackle mental health problems. In considering the public policy case, the public value should be assessed.

7.11 Government should urgently consider the public value of current provision of homeopathy on the NHS to assess its clinical effectiveness and cost-effectiveness and whether patterns of use are tackling current health inequalities.

7.12 Government should consider the public value of other remaining forms of complementary healthcare available on the NHS to assess their clinical effectiveness and cost-effectiveness and whether patterns of use are tackling current health inequalities.

Regulation

7.13 The goal should be that no unregulated practitioner should practise within the NHS.

7.14 The government should support light touch regulation for all those individuals involved in disciplines where there is no statutory regulation. This could take the form of self-regulation, similar to the model currently used for fitness professionals.

7.15 Statutory regulation is becoming complex and fragmented particularly if each individual discipline within complementary healthcare moves towards establishing statutory regulation. This is neither cost-effective nor efficient. The Health Professions Council provides a means by which health professionals could be effectively regulated, but this has been rejected as too cumbersome by acupuncturists. The current system of regulation is leading to excessive fragmentation at a time when healthcare professionals are being asked to work more effectively together. Government should conduct a review of the current regulatory structures with a view to creating a single body for health professionals operating mainly within the NHS.

Research

7.16 Government needs to develop a comprehensive and co-ordinated approach to public health research and consider aspects of complementary health research within this context.

7.17 Consistent with the approach laid down by Wanless, complementary healthcare initiatives which focus on the needs of the most disadvantaged within our communities should be evaluated as a series of natural experiments. Resources should be made available to ensure that successful initiatives are rapidly rolled out in other areas, whilst those that prove unsuccessful are discontinued.

Governance

7.18 Government should also consider whether the current location of public health within the Department of Health can effectively prioritise the issue in the public policy arena. Given its cross-cutting nature, there are strong arguments to support a new Ministerial post within the Cabinet Office, and/or to raise its profile by including the minister for public health within the Cabinet.

7.19 The new Director for Occupational Health should consider a strategy for incorporating complementary healthcare as part of a programme to tackle chronic conditions for people at work, as well as proposals on how such a strategy could be funded.

Recommendations to local healthcare services

7.20 Public health officers within the PCT should examine to what extent complementary healthcare is currently on offer and examine its role in reducing the health gap.

7.21 Local authorities should consider innovative ways of using their well-being powers to work with PCTs and practices to develop innovative health projects incorporating complementary healthcare as part of their community strategy. These should be aimed at eradicating the health gap and promoting healthy lifestyles and the quality of life.

7.22 Commissioners of complementary healthcare services should be subject to a duty to develop policies governing its use and the conduct of practitioners as outlined in Chapter 6.

Recommendations to complementary healthcare practitioners

7.23 It is critical that practitioners develop a proactive role in developing effective clinical governance through evidenced-based research. As part of this process, practitioners could consider developing practice-based research networks where practices devoted principally to the primary care of patients affiliate with each other, and often with an academic or professional organization, in order to investigate questions related to community-based practice.

7.24 Practitioners should consider their services within the context of the government's public health policy and consider what strategies are required to ensure that underserved groups within local communities are provided with effective complementary healthcare services.

7.25 Practitioners need to ensure that the patient is placed at the centre of the service and involved in future design. Feedback should not only be collected on how clinical need was met but also on how the service could be improved or designed to become more accessible and address health gaps.

7.26 Practitioners should consider developing effective information technology solutions which are capable of integrating with other parts of the healthcare system and developing efficient services.