Access to complementary medicine via general practice

Kate J Thomas, J P Nicholl and Margaret Fall

SUMMARY

Background: *The popularity of complementary medicine continues to be asserted by the professional associations and umbrella organisations of these therapies. Within conventional medicine there are also signs that attitudes towards some of the complementary therapies are changing.*

Aim: *To describe the scale and scope of access to complementary therapies (acupuncture, chiropractic, homoeopathy, hypnotherapy, medical herbalism, and osteopathy) via general practice in England.*

Design of study: *A postal questionnaire sent to 1226 individual general practitioners (GPs) in a random cluster sample of GP partnerships in England. GPs received up to three reminders.*

Setting: *One in eight (1226) GP partnerships in England in 1995.*

Method: *Postal questionnaire to assess estimates of the number of practices offering 'in-house' access to a range of complementary therapies or making National Health Service (NHS) referrals outside the practice; sources of funding for provision and variations by practice characteristics.*

Results: *A total of 964 GPs replied (78.6%). Of these, 760 provided detailed information. An estimated 39.5% (95% CI = 35%–43%) of GP partnerships in England provided access to some form of complementary therapy for their NHS patients. If all non-responding partnerships are assumed to be non-providers, the lowest possible estimate is 30.3%. An estimated 21.4% (95% CI = 19%–24%) were offering access via the provision of treatment by a member of the primary health care team, 6.1% (95% CI = 2%–10%) employed an 'independent' complementary therapist, and an estimated 24.6% of partnerships (95% CI = 21%–28%) had made NHS referrals for complementary therapies. The reported volume of provision within any individual service tended to be low. Acupuncture and homoeopathy were the most commonly available therapies. Patients made some payment for 25% of practice-based provision. Former fundholding practices were significantly more likely to offer complementary therapies than non-fundholding practices, (45% versus 36%,* P = *0.02). Fundholding did not affect the range of therapies offered, and patients from former fundholding practices were no more likely to pay for treatment.*

Conclusion: *Access to complementary health care for NHS patients was widespread in English general practices in 1995. This data suggests that a limited range of complementary therapies were acceptable to a large proportion of GPs. Fundholding clearly provided a mechanism for the provision of complementary therapies in primary care. Patterns of provision are likely to alter with the demise of fundholding and existing provision may significantly reduce unless the Primary Care Groups or Primary Care Trusts are prepared to support the 'levelling up' of some services.*

Keywords: *complementary medicine; patient access; fundholding.*

K J Thomas, MA, deputy director; M Fall, BSc, research associate; J P Nicholl, BA, MSc, CStat, Hon MFPHM, director, Medical Care Research Unit, University of Sheffield.

Submitted: 9 March 2000; Editor's response: 22 May 2000; final acceptance: 27 September 2000.

Address for correspondence

Ms Kate J Thomas, Medical Care Research Unit, University of Sheffield, Regent Court, 30 Regent Street, Sheffield S1 4DA.

Introduction

THE popularity of complementary medicine continues to be asserted by the professional associations and umbrella organisations of these therapies.[1] Within conventional medicine there are also signs that attitudes towards some of the complementary therapies are changing. The 1993 BMA report on complementary therapies was much more positive about the possible integration of some of these therapies than its very critical predecessor, published just seven years earlier.[2,3] Work undertaken by the National Association of Health Authorities and Trusts (NAHAT) in 1992 on the views of NHS purchasers towards complementary therapies, revealed largely positive attitudes towards its provision within the NHS, despite some concerns regarding the evidence base for the efficacy of particular therapies.[4]

Within primary care, the potential to provide complementary therapies was facilitated by changes in the GP Contract (in 1990) and by the subsequent introduction of GP fundholding. Non-fundholding GPs were able to use the ancillary staff budget to employ complementary therapists, while fundholding GPs were able to use the staff element of their budgets and 'practice savings' for this purpose.[5] In addition, all GPs may make private referrals or provide a complementary therapy themselves.

However, little is known about the scale or scope of the provision of complementary therapies in general practice. The only national survey, undertaken in 1992, achieved a low response rate of 43% and did not obtain information on activity within non-fundholding practices.[4]

A survey of a representative national sample of GP practices was undertaken in 1995 to ascertain the extent to which access to complementary health care (acupuncture, chiropractic, homoeopathy, medical herbalism and osteopathy) was gained through general practice; to describe the patterns of access to complementary medicine (mode of delivery, type of practitioner); to estimate the proportion of practices offering such services, and to describe the relationship between fundholding status and provision.[5] It seems particularly important to consider the role and legacy of fundholding, as Primary Care Groups begin to formulate policies that will shape the range of services accessible to patients in the future.

Methods

Study design and subjects

Multi-stage random sampling was used to select practices from all fundholding and non-fundholding practices in England. As activity with respect to complementary therapies may be related to local Family Health Service Authority (FHSA) policy, a large sample of FHSAs (one in four) were sampled first: three chosen at random from each of the eight

Health Regions, giving a total sample of 24 FHSAs. One in two practices were then randomly sampled from each of these 24 FHSAs. In this way, a sample of 1226 practices was identified (approximately one in eight practices in England).

One GP in each sampled partnership received a letter requesting their participation in the study. Within each practice, the GP was chosen randomly from the list provided by the FHSA to achieve a distribution of senior partners and other partners across the sample.

Data collection

The sampled GP from each of the 1226 partnerships received the questionnaire with a covering letter. Non-responders received up to two reminders. Reply-paid envelopes were provided for the return of completed questionnaires. A follow-up of all those GPs in the sample who did not respond to any of these contacts was conducted nine weeks after the initial mailing. This entailed a brief letter and a request to answer three key questions taken from the questionnaire relating to practice provision or referrals for any of the named complementary therapies.

Analysis

The principal estimates calculated in this report relating to access to complementary therapies via GP practices have been calculated by assuming that responders to the fourth mailing are representative of all 'non-responders' to the mailings of the full questionnaire. An alternative, more conservative, estimate is offered for some key results in which all practices not replying to any mailing are assumed to be non-active. However, there is no *a priori* reason to believe that none of the non-responders made any provision at all, and these estimates should therefore be understood as the lowest likely estimates or 'bottom line'. Confidence intervals have been calculated assuming a fixed response size and taking into account the weightings for the main survey and fourth mailing of the 'key questions' where appropriate.

No weighting was undertaken on the descriptive data describing 526 instances of provision, relating to 280 partnerships in the achieved sample. These are treated as representative of all partnerships offering complementary medicine in England in 1995.

Results

Response rate

After three mailings 760 completed forms were returned, giving a response rate of 62%. Of those who did not return forms, 33 wrote declining to participate (2.7%) and nine questionnaires were returned with an indication that the GP had retired, was on long-term sick leave or had left the practice.

The fourth mailing was sent to the 423 non-responding GPs. Of these, 204 (48.2%) replied, answering the three questions as requested. Including these responses, basic information on the provision of complementary therapies was obtained for 964 partnerships: 78.6% of the original sample of 1226 partnerships.

Representativeness of the sample

The achieved sample was assessed by comparing it with all practices and GPs in England with respect to known characteristics of practice size, fundholding status, age, and sex of GPs. Good overall representativeness was achieved. However, there was a large variation in the response rate between the 24 FHSAs sampled, with a range from 47% to 81%, around a mean of 62%. Many of the response rates (16 out of 24 FHSAs) fell outside the range expected owing to random variation (95% CI = 59%–65%), indicating a clustering of response. No significant systematic relationship was found between any relevant measurable characteristic and FHSA response rates (proportion of single-handed practices, proportion of GPs in the FHSAs known to have been born outside the UK, Jarman Deprivation Scores for each FHSA, proportion of GP responders in each FHSA responding positively to questions about complementary therapy provision). The FHSA response rate was not therefore taken into account in subsequent analyses.

The availability of complementary therapies via general practice

In 1995, almost 40% of GP partnerships in England provided access to complementary therapies for their NHS patients. An estimated 21.4% of practices were offering access to one of these therapies through the provision of treatment by a member of the primary health care team. One in four practices made NHS-funded referrals for complementary therapies. The presence of an 'independent' complementary therapist within the practice was less common, occurring in an estimated one in 16 practices (Table 1).

If all non-responders are assumed to be non-providers, the following 'lowest likely' estimates can be made: provision of complementary therapies by a member of the primary health care team 17.5%; NHS referrals by practice 18.1%; provision via an 'independent' complementary therapist 4.9%; provision by any of these avenues 30.3%.

Which complementary therapies?

Descriptive data was available for 526 instances of provision reported by responders to the full questionnaire (n = 760); this included type of therapy, source of funding, payment by patients, and referral destination. Access to the different types of complementary health care was not uniform. Acupuncture and homoeopathy were the most commonly provided forms of complementary therapy, offered by one in five and one in six practices respectively. Other therapies, especially the manipulative therapies (osteopathy and chiropractic), reflexology, and therapeutic massage were more likely to be provided by an independent therapist working within the practices, but not as part of the core primary health care team (Table 2).

'In-house' therapy provision of complementary therapies

The delivery of 'in-house' provision (by the primary health care team or an independent therapist) was equally divided between normal surgery arrangements and regular dedicated clinics or special appointments. This reflects the fact that in the majority of cases, the care was provided by a GP partner within the practice (64% of all instances of provision).

Table 1. Proportion of general practitioners in England in 1995 providing access to complementary therapies via treatment within the practice or NHS referrals. (Weighted estimates of provision and 95% confidence intervals.)

Mode of provision of complementary health care	Full questionnaire survey responders only		All survey responders (full survey responders plus weighted response to fourth mailing of 'key' provision questions	
	n = 760	%	Estimated % practices in England	95% CI for sampling error
Provision by a member of the primary health care team	178	23.4	21.4	19-24
Provision by an independent complementary therapist working in practice	48	6.3	6.1	2-10
Current NHS referrals for treatment	160	21.1	24.6	21-28
Any of these	283	37.2	39.5	35-43

Table 2. Proportion (%) of practices in England offering access to different therapies. (Type of provision.)

	Practices offering therapy via any type of provision		'In-house' provision				External NHS referrals	
			By member of primary health care team		By independent therapist			
Type of therapy *n* = 760 (100%)	*n*[a]	%	*n*	%	*n*	%	*n*	%
Acupuncture	161	21.2	95	12.5	14	1.8	68	9.0
Homeopathy	128	16.8	51	6.7	7	<1	94	12.4
Osteopathy/chiropractic	54	7.1	15	2.0	26	3.4	40	5.3
Hypnotherapy	63	8.3	42	5.5	8	1.1	15	2.0
Medical herbalism	11	1.5	4	<1	3	<1	4	<1'
'Other' therapy[b]	39	5.1	14	1.8	21	2.8	5	<1

[a]Some practices provided therapies in more than one way, e.g. inhouse referalls. [b]Other therapies mentioned more than once included aromatherapy (12 instances), reflexology (8 instances), massage (4 instances), Alexander technique (3 instances) and 'manipulation' (2 instances).

Data on the volume of patients treated was available for 198/300 instances of 'in house' provision. These services reported treating an average of six practice patients per week (range = 0–50 per week).

Most of the 'in-house' services were provided free to NHS patients. However, a quarter was paid for entirely or in part by the patients. Full or part payment by patients was most common for the manipulative therapies (38%), or 'other' therapies (49%). Of the 52 instances where the patient paid in full, 42 (81%) related to provision by 'independent' therapists employed by the practice.

NHS referrals for complementary therapies

One hundred and sixty practices (24.6%) made any referral to NHS-funded provision for treatment with a complementary therapy. A total of 227 instances of such activity were described. The scale of this provision, in terms of the number of patients affected, was not easy to ascertain from the questionnaire, but GPs from practices that made any referrals for complementary therapies reported that they personally made between one and five such referrals per month; one referral per month was the most commonly cited frequency for GPs in both fundholding and non-fundholding practices.

Overall, the largest proportion of referrals was for homoeopathy, with an estimated 12.4% of all practices making homoeopathy referrals. A total of 9% of practices referred to homoeopathic hospitals, 11.6% to other NHS hospitals (e.g. for acupuncture received in a pain clinic). A total of 5% of practices referred to locations in the private sector (Table 3).

Types of condition

GP responders were asked to indicate if the therapy provided was directed to a particular condition or group of patients. The majority of GPs answered this negatively, indicating that the therapies were provided for a range of conditions. Figure 1 lists the conditions mentioned.

The impact of fundholding

Estimates for any type of provision suggest that it was more common in fundholding practices (45.5% compared with 36.6%, $P<0.01$). Estimates for the proportion of partnerships making NHS referrals did not vary substantially with fundholding status or number of partners. Provision by a member of the primary health care team was significantly more likely in fundholding practices. As might be expected, single-handed GPs were significantly less likely to offer such provision compared with larger practices (Table 4). The total number of practices reporting an 'independent' complementary medicine therapist working from the practice was small and none of the differences observed reach statistical significance. There was a marked difference in the pattern of funding reported for these referrals. Fundholding practices funded 85% (51/60) of their referral options to complementary therapies from practice budgets and fundholding savings. In contrast, 90% (132/146) of the referral options in

Table 3. Proportion (%) of practices offering NHS referrals for complementary therapies, therapy, destination, and funding by fundholding status.

	Fundholding $n = 61$		Non-fundholding $n = 599$		All practices $n = 760$	
	n	%	*n*	%	*n*	%
Therapy						
Acupuncture	17	10.6	51	8.5	68	9.0
Homeopathy	22	13.7	72	12.0	94	12.4
Chiropractic/osteopathy	12	7.5	28	4.7	40	5.3
Other therapies[a]	9	5.6	15	2.5	24	3.2
Destination						
Homeopathic hospital	13	8.1	55	9.2	68	9.0
Other NHS Hospital	26	16.2	62	10.4	88	11.6
Private sector clinic, etc	8	5.0	32	5.3	40	5.3
GP in other practice	5	3.1	4	<1	9	1.2
Funding source						
FHSA/DHA	6	3.7	132	22.0	138	18.2
Fundholding savings	23	14.3	0	0	23	3.0
Practice budget	28	17.4	9	1.5	36	4.7
Other[b]	3	1.9	5	<1	8	1.1
All instances of referral	60		166		226[c]	
Referring practices	36		124		160	

[a]Medical herbalism, hypnotherapy, reflexology. aromatherapy. [b]Charity, patients' association, patient contribution. [c]Some practices offered more than one therapy and cited multiple destinations and funding sources. Average number of instances of provision per practice offering access = 1.4.

Table 4. Characteristics of practices offering access to complementary therapies via primary health care team, independent therapits or NHS referral.

Practice charcateristic	Any provision		PHCT		Independent therapist		NHS referral		No. of practices
	n	%	*n*	%	*n*	%	*n*	%	$n = 964$[a]
Fundholding									
Yes	94	(45.00)[b]	57	(27.3)[c]	14	(6.7)	53	(25.4)	209
No	273	(36.2)	158	(20.9)	46	(6.1)	169	(22.4)	755
Partnership size									
Single-handed GP	86	(34.8)	35	(14.2)[d]	20	(8.1)	61	(24.7)	247
2–3 GPs	134	(41.9)	81	(24.8)	19	(5.8)	80	(24.5)	327
4+ GPs	147	(37.9)	99	25.4	21	(5.4)	81	(20.8)	390
All (weighted estimate)		39.5		21.4		6.1		24.6	

[a]Includes 204 reponders to fourth mailing. Practices can offer more than one type of provision. Chi-square for difference in provision according to practice characteristic. [b] $P = 0.05$, [c] $P = 0.02$, [d] $P<0.01$.

Figure 1. Groups of patients or conditions mentioned by GPs as suitable for treatment by complementary therapies within the practice.

Acupuncture	Smokers Back Pain Joint pain Other pain Acute stress Migraine
Homeopathy	Depression Migraine Diabetes Pain Warts
Hypnotherapy	Smokers Over 75s Anxiety Psychological problems Acute stress Dental extraction Obesity
Osteopathy/chiropractic	Back pain Joint pain
Medical herbalism	Not given

non-fundholding practices were funded by the Department of Health Authority or FHSA (Table 3). Overall, patients of fundholding practices were less likely to be asked to contribute in part or in full for their complementary therapy treatment (17.8% compared to 27.6%).

Discussion

In 1992, a national survey of GP attitudes conducted on behalf of the General Medical Services Committee suggested that, assuming adequate resources, between 18% and 29% of GPs favoured the expansion of GP services to cover such treatments as homoeopathy, chiropractic, hypnotherapy, osteopathy, and acupuncture respectively.[7] However, even given increased resources, the provision of such services would clearly have to compete with the expansion of GP services in more established areas, such as physiotherapy and chiropody, which may have higher priority for the majority of GPs.

Some information about the availability of complementary therapies in general practice is available from a number of case studies of experiments in the provision of such treat-

ments[8-10] or local surveys,[11] but little is known about the scale and scope of provision nationally. This study was designed to measure access to complementary therapies at the practice or partnership level. The unit of analysis was therefore the partnership and not the GPs or their patients. The good response rate achieved allowed us to generate robust national estimates of the proportion of partnerships offering access, the range and type of services on offer, and the impact of certain practice characteristics, such as fundholding status. The study was not designed to provide estimates of the volume of activity or non-structural explanations for the variability of access observed, such as attitudes of GPs to complementary therapies.

These data from 760 representative practices show that the provision of complementary therapies was widespread but offered on a relatively small scale in terms of the patient numbers involved. The most frequently cited type of provision was NHS referral, reported by one in four practices, mostly for homoeopathy or acupuncture at NHS hospitals. However, this type of provision may influence the management of patients less than the availability of treatment within the practice, which has the potential to affect a larger number of individual patients. Provision within the practice by a member of the primary health care team was almost entirely offered by GPs and was found to be relatively common, occurring in an estimated one in five practices. GPs have a long tradition of offering homoeopathy as part of primary care and this is reflected in the distribution of therapies provided 'in house' by the primary health care team. More surprising perhaps is the relative popularity of acupuncture among GPs and other members of the team. The lower level of 'in house' provision relating to the manipulative therapies (chiropractic and osteopathy) may be due to the training and equipment requirements of these therapies, rather than a reflection of their relative popularity. This is supported by the finding that osteopathy was the most commonly provided therapy where an 'independent' therapist worked within the practice.

The study sample structure makes it hard to analyse these data by geographical area. However, the national results are similar to those reported in recent local surveys in south west Thames and Birmingham.[12,13] More local area studies are needed to establish any regional variations in the pattern of provision. However, our data suggest that patients were paying for a significant proportion of the complementary therapy treatments provided within practices. 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.

Our study findings do not support the findings of the national NAHAT survey that 14% of former GP fundholding practices employed an independent practitioner.[4] The level of such provision in this study was much lower and similar for fundholders and non-fundholders (6.7% versus 6.1% respectively). The NAHAT survey result is likely to be inflated by bias resulting from a low response rate and the non-random selection of practices. We were able to compare provision between fundholding and non-fundholding practices. Fundholding status was associated with a significantly higher level of provision from the primary health care team (27% versus 21%) and a higher overall level of access.

Funding for complementary therapies within general practice is limited and has been identified as the main barrier to provision in primary care.[13] Where the NHS is funding provision, the majority of provision within practices is accomplished by absorbing costs into the practice. Additional funding for a non-statutory service has been shown to depend on *ad hoc* service development money or the imaginative use of particular funding opportunities.[14] Provision tends to expand when policy changes favour innovative service developments. In the past, the introduction of payment for broadly defined health promotion clinics provided such an avenue;[15] GP fundholding appears to have offered a similar opportunity for expansion.

Locality purchasing by Primary Care Groups or, in the near-future by Primary Care Trusts, will have the potential to provide a new mechanism for delivering complementary health care services to NHS primary care patients. Whether the established services survive, or indeed expand, will depend on the success of one of two strategies; primary care providers who wish to see such services as part of the purchasing strategy for the locality must either convince the wider group of GPs and nurses in their PCG of their benefits and cost-effectiveness or identify a new source of practice-specific funds to ensure provision to their own patients. Many uncertainties surround the practical implications of the implementation of the New NHS policies in England.[16,17] The price of greater control for primary care through increased purchasing power may produce a significant reduction in autonomy and innovation at the individual practice level and the provision of complementary or alternative health care may be one of the casualties.

References

1. Smelskyj A. The qualifications and geographical distribution of practising osteopaths in England, Scotland and Wales. *Complementary Medical Research*, 1992; **6:** 1-8.
2. BMA. *Alternative Therapies*. London: BMA, 1986.
3. BMA. *Complementary Medicine.* London: BMA, 1993.
4. Cameron-Blackie G. *Complementary Therapies in the NHS*. Birmingham: National Association of Health Authorities and Trusts, 1993.
5. Thomas KJ, Fall M, Parry G, Nicholl JP. *National Survey of access to complementary health care via general practice. Final report to Department of Health.* London: HMSO, 1995.
6. Department of Health. [Press Release H91/600.] *Stephen Dorrell clarifies the position on alternative and complementary therapies.* London: DOH, December 1991.
7. Electoral Reform Ballot Services. *Your Choices for the Future; a Survey of GP Opinion. UK Report for the General Medical Services Committee of the British Medical Association*. London: BMA, 1992.
8. Budd C, Fisher B, Parrinder, D, Price, L. A model of co-operation between complementary and allopathic medicine in a primary care setting. *Br J Gen Pract* 1990; **40:** 376-378.
9. Logan J. The Blackthorn Trust: expanding a national health practice. *Complementary Therapies in Medicine* 1994; **2(3):** 154-158.
10. Burns K, Lyttleton LK. Osteopathy on the NHS; one practice's experience. *Complementary Therapies in Medicine* 1994; **2: 4;** 200-204.
11. White AR, Resch KL, Ernst E. Complementary medicine: use and attitudes among GPs. *Fam Pract* 1997: **14(4):** 302-306.
12. Perkin MR, Pearcy RM, Fraser JS. A comparison of the attitudes shown by general practitioners, hospital doctors and medical students towards alternative medicine. *J R Soc Med* 1994; **87:** 523-525.
13. Wearn AM, Greenfield SM. Access to complementary medicine in general practice: survey in one UK health authority. *J R Soc Med* 1998; **91:** 465-470.

14. Luff D, Thomas KJ. *Models of providing comp therapies in primary care. Final report to Department of Health*. London: HMSO, March 1999.
15. Thomas KJ, Coleman P, Williams BT. *Monitoring the provision and staffing of designated health promotion clinics in general practice. Final report to Department of Health.* London: HMSO, April 1993.
16. Secretary of State for England. *The new NHS*. London: HMSO, 1997.
17. Dixon J, Mays N. New Labour, new NHS? The White paper spells evolution not revolution. *BMJ* 1997; **315:** 1639-1640.

Acknowledgements

The authors wish to thank the FHSAs for their help and co-operation and to express their gratitude to all the GPs who somehow found the time to complete our questionnaire and return it to us. The study was funded by the Department of Health. The opinions expressed are, however, those of the authors alone.

HOW THIS FITS IN

What do we know?

Reports suggest a growing interest in complementary therapies by many GPs, and local case studies of examples of provision in primary care have been reported. GP fundholding offered a new mechanism for supporting access to complementary therapies in primary care. Nationally, the scale and scope of provision was not known.

What does this paper add?

This paper provides evidence from a national representative survey of general practices of widespread access (40% of practices) to a limited range of complementary therapies in England in 1995. Access was most frequently provided for acupuncture and homeopathy, and was more common among fundholding practices.