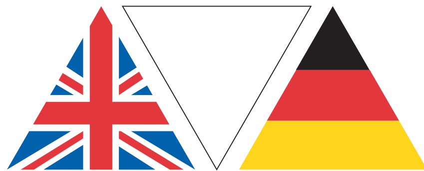

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Complementary and Alternative Medicine in the UK and Germany – Research and Evidence on Supply and Demand

Anna Dixon, Annette Riesberg, Susanne Weinbrenner, Omer Saka, Julian Le Grand, Reinhard Busse

2003

Complementary and Alternative Medicine in the UK and Germany

Research and Evidence on Supply and Demand

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Contents

List of figures iv

List of tables iv

Acknowledgements vii

Executive summary viii

PART I
Complementary and alternative medicine in the UK and Germany 1

I.1 Introduction 3

I.1.1 Rationale 3

I.1.2 Aims 4

I.1.3 Research methods 5

I.2 Definitions and classifications 6

I.2.1 Defining complementary and alternative medicine and conventional medicine 6

I.2.2 Classifications and concepts within complementary and alternative medicine 8

I.2.3 Who are considered to be CAM providers? 9

I.2.4 What are considered to be CAM therapies? 11

I.2.5 Dictionary of CAM therapies 12

I.2.6 Summary 13

I.3 Supply and demand in the United Kingdom and Germany: comparison and trends 14

I.3.1 Summary: country report United Kingdom 14

I.3.2 Summary: country report Germany 15

I.3.3 Discussion 16

I.4 Methodological challenges 20

I.4.1 Scope of CAM 20

I.4.2 Time period specification 20

I.4.3 Training and registration 21

I.4.4 Expenditure and income data 21

I.5 Relevance for policy and future research 22

I.5.1 Policy issues 22

I.5.2 Scope for future research 23

I.6 Conclusions 26

References and bibliography 27

PART II
Supply of and demand for complementary and alternative medicine in the United Kingdom: Country report 31

II.1 Methodology 33

II.1.1 Demand for CAM 33

II.1.2 Supply of CAM 37

II.2 Demand for and utilisation of CAM 44

II.2.1 Surveys on utilisation of CAM therapies/services 44

II.2.2 Surveys of CAM products 44

II.2.3 Demographics 45

II.2.4 Presenting problem/diagnosis 45

II.2.5 Reason for use 46

II.2.6 Reported out-of-pocket expenditure 46

II.2.7 Providers 47

II.3 CAM providers 48

II.3.1 Physicians 48

II.3.2 Other health care professionals 48

II.3.3 Registered CAM practitioners 49

II.3.4 Non-registered CAM providers (private market) 49

II.3.5 Employment and working conditions 50

II.4 CAM services 51

II.4.1. Health authorities 51

II.4.2 General practice fundholding 52

II.4.3 Primary care groups/primary care trusts 53

II.4.4 Inpatient services 53

II.5 CAM products 54

II.5.1 Over-the-counter medication 54

II.5.2 CAM products paid for by the NHS 54

II.5.3 Retailers 56

II.6 Service-provider-finance matrix 57

References 58

PART III
Supply of and demand for complementary and alternative medicine in Germany: a country report 63

III.1 Methodology 65

III.2 Demand for and utilisation of CAM 67

III.2.1 Utilisation of CAM providers and services 67

III.2.2 Utilisation of CAM products 70

III.2.3 Reasons for use 72

III.2.4 Reported out-of-pocket expenditure 72

III.3 CAM providers 73

III.3.1 Physicians 73

III.3.2 Other health care professionals 79

III.3.3 State-registered CAM practitioners – *Heilpraktiker* 80

III.3.4 Non-registered CAM providers 81

III.4 CAM services 83

III.4.1 Ambulatory statutory health insurance benefits 83

III.4.2 Ambulatory services financed by statutory health insurance under certain conditions 85

III.4.3 Services financed by private health insurance or out of pocket 90

III.4.4 Inpatient services 92

III.5 CAM products 95

III.5.1 CAM medicines funded by statutory health insurance 96

III.5.2 Over-the-counter medication 97

III.5.3 Retailers 98

III.6 Service-provider-finance matrix 99

References and bibliography 101

APPENDICES

Appendix 1: Authors 107

Appendix 2: Commonly used alternative terms for conventional medicine and CAM in English and German 108

Appendix 3: English–German/German–English dictionary of CAM therapies 109

3.1 English–German 109

3.2 German–English 111

List of figures

Figure III.2.1 One-year prevalence (%) of utilisation of CAM specialists and physicians (x) in correlation to satisfaction with providers (y) 67

Figure III.2.2 Lifetime prevalence for selected therapies in Germany, 2000 69

Figure III.2.3 Influence of socio-demographic factors on lifetime prevalence of reported usage of natural remedies, 1970–2002 71

List of tables

Table I.2.1 Classification of CAM providers in the UK and Germany 10

Table II.1.1 Utilisation studies of the general population: key methodological aspects 34

Table II.1.2 Utilisation studies of subpopulations in the UK: key methodological aspects 35

Table II.1.2	**Utilisation studies of subpopulations in the UK: key methodological aspects (continued)**	**36**
Table II.1.3	**Utilisation studies of the general population in the UK: key findings**	**38**
Table II.1.4	**Utilisation studies of subpopulations in the UK: key findings**	**41**
Table II.2.1	**Treatment costs of therapies in the UK (£), 2000**	**47**
Table II.5.1	**UK CAM market 1996–2000 value (£ million) and percentage change**	**55**
Table II.6.1	**Combination of funding source and provider of CAM therapy in the UK**	**57**
Table III.2.1	**Lifetime prevalence of utilisation of CAM or CAM practitioners**	**68**
Table III.2.2	**Trends in prevalence of 'natural remedies' use in West Germany, 1970–2002**	**70**
Table III.2.3	**Prevalence of 'natural remedies' use in East and West Germany**	**70**
Table III.3.1	**Qualifications in CAM and physical medicine among active physicians, 2001**	**74**
Table III.3.2	**Trends in CAM and physical medicine qualifications among active physicians, 1993–2001**	**74**
Table III.3.3	**Gender distribution of active physicians qualified in CAM or physical medicine, 2001**	**75**
Table III.3.4	**CAM users with reimbursable CAM prescriptions by provider, 2002**	**76**
Table III.3.5	**Qualifications in CAM and physical medicine among physicians working in different settings, 1995 and 2001**	**78**
Table III.3.6	**Other health professions likely to provide complementary and/or physical therapies, 2000**	**79**
Table III.3.7	**Trends in the number of *Heilpraktiker*, 1993–2000**	**80**
Table III.4.1	**Surveys of reimbursement for unconventional methods and projected one-year case prevalence, 1999–2002**	**87**
Table III.4.2	**Reimbursement and extrapolated expenditure for unconventional methods, 1999–2000**	**87**
Table III.5.1	**Trends in prescriptions of herbal medicines for selected indications funded by statutory health insurance, 1992–2000**	**96**
Table III.5.2	**Over-the-counter sales of herbal medicines and total drugs by indication, 1997–2000**	**97**
Table III.5.3	**Number of retailers of pharmaceuticals, 2000**	**98**

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Executive summary

Background

This report defines complementary and alternative medicine (CAM) broadly as a domain of healing that encompasses not only health systems, modalities and practices but also the accompanying theories and beliefs, which differ from the current dominant theories and beliefs in a given society or culture at a certain historical period (Kelner *et al.*, 2000).

CAM is of increasing interest to health care researchers because of the substantial public interest it attracts and the perceived growth in the market. It is a central but highly controversial subject in current public and political debates. Nevertheless there is very little empirical data.

Comparative analysis of the UK and Germany is of particular interest because although their health care systems differ substantially, both countries tolerate various CAM providers, services and products. However, the extent to which practitioners and products are regulated is quite different.

Objectives

This report aims to provide basic data on the demand for and supply of CAM providers, services and products in the UK and Germany. It is hoped that the report will contribute to a growing evidence base to enhance future research and policy decisions about CAM and provide some insights of broader relevance to the health care system.

Methods

A systematic review of secondary literature was conducted by searching the international database of the National Library of Medicine. This was supplemented by searches of country-specific public databases, official statistics and statistics of non-governmental bodies such as associations of health care professionals, statutory insurance companies, hospitals and the pharmaceutical industry.

Results

Germany is often regarded as having the highest utilisation of CAM in Europe. Data show that this is not correct for the total CAM market but only with respect to the reported use of natural remedies. Indeed, the prevalence of utilisation of CAM practitioners reported in the UK is, depending on the source, equal to or even higher than in Germany. Total utilisation of CAM increased in both countries in recent years, as did the number of CAM providers.

The type of CAM practitioners, the services they provide, and their training and regulation differ substantially between the UK and Germany. In both countries physicians practising CAM therapies are concentrated in the ambulatory sector/general practice. Very few doctors practise CAM in UK hospitals, while in Germany more than 10 per cent of qualifications for naturopathy, homeopathy and chiropractic are documented in the inpatient sector. The numbers of registered CAM practitioners have also risen in both countries, but there is very little information on private practice by non-registered practitioners in either country.

The main therapies in the UK are homeopathy, osteopathy, chiropractic, acupuncture and aromatherapy. In Germany naturopathy, herbalism, homeopathy, acupuncture, autogenic training and chiropractic are the most commonly reported in population surveys. While common in the UK, osteopathy, reflexology and aromatherapy were rarely delivered and reimbursed in Germany. By contrast, art therapy, anthroposophic therapies, neural therapies, hydrotherapy or auto-hematotherapy, which are commonly delivered in Germany, were hardly found in the UK.

In the UK health professionals who practice CAM do not legally require formal CAM qualifications. There is, however, growing regulation of CAM practitioners. The direction is towards specialisation, with individuals having to demonstrate their ability, skill and knowledge in a single therapeutic area, through registration with a professional body. Chiropractics and osteopaths are already statutorily regulated, and proposals for regulation have been put forward for acupuncture and herbal medicine.

In Germany physicians may qualify or specialise in CAM and are then subject to regulations depending on the qualification or specialisation they take. In addition, there are GPs and other specialists such as gynaecologists or paediatricians who practise CAM without formal qualifications. Other health care professionals such as nurses and midwives are also reported to practise CAM frequently, but there are no data and no formal regulation. In Germany CAM practitioners, who bear the title of *Heilpraktiker,* must pass an examination set by the local authority but do not require any special training. They are not allowed to provide acute care and some other services such as vaccination and treatment of sexually transmissible diseases.

An important but under-researched area is the extent to which CAM services and products are covered by public reimbursement. Reports suggest that in the UK the availability of CAM on the NHS is highly variable geographically and has also fluctuated with changes in purchaser organisations since the early 1990s. German data suggest that reimbursement has declined, with a number of products being removed from the list of reimbursable items by the statutory health insurance funds.

In Germany the over-the-counter (OTC) market in CAM pharmaceuticals has been almost constant since 1997 (by volume), while the total volume of phytopharmaceuticals has only slightly increased. In the UK the sales volume of OTC has steadily increased since 1996; for example, aromatherapy products saw an increase of up to 75 per cent.

Discussion

Some of the reported findings challenge the common perception of the CAM market in the UK or Germany as described in the international literature. Although both are ‘tolerant’ of CAM practice, the types of practitioners and the way they are regulated differ considerably. The evidence shows convergent as well as divergent trends in the market. These developments must be interpreted cautiously and understood in the national context, and in the wider European and international context.

Conclusion

This report provides a basis for future research in this area. The key policy issues in health care – such as quality, consumer protection and cost containment, professional regulation, equity of access, reimbursement and contracting arrangements – are also important in the CAM market. Given the lack of systematic, reliable and comparable data identified by this report, these topics merit further in-depth research.

PART I

Complementary and alternative medicine in the UK and Germany

Anna Dixon, Annette Riesberg, Susanne Weinbrenner, Omer Saka, Julian Le Grand, Reinhard Busse

I.1 Introduction

This report deals with the current definitions, demand for and supply structures of complementary and alternative medicine (CAM) in the United Kingdom and Germany. It is hoped that this analysis of the status quo in the field of CAM use and CAM provision will provide the empirical knowledge base necessary for future research into regulation and policy-making for CAM in both countries.

The term 'complementary and alternative medicine' is used in this report since it seeks to embrace a broad spectrum of methods and concepts that are utilised in conjunction with orthodox medicine (complementary) and those that are taken as substitutes for orthodox medicine (alternative) (Ernst, 1995). A further elaboration of the terminology employed to describe this range of therapies and medicines can be found in Chapter I.2.

In recent years the market for complementary and alternative medicine has apparently seen tremendous growth in most countries of the European Union. Results of the literature review of demand for and utilisation of CAM in both the UK and Germany are presented and discussed in the individual country reports (Chapter I.3 and Parts II and III) and a comparative analysis is presented in Section I.3.3.

There have been changes in the supply of services, including the numbers of practitioners active in the provision of CAM services. The chapter on CAM providers in each country report considers four different categories of providers: physicians practising CAM, other health care professionals practising CAM, registered CAM practitioners and non-registered practitioners (private market). For each of these groups of providers the report aims to identify information relating to the number in each category, working practices (e.g. whether full-time or part-time) and the location and size of practice.

The majority of CAM products and services continue to be paid out of pocket, but a substantial share is funded by public sources in Germany and the UK. The extent to which CAM services and products are covered is discussed under the chapters on CAM services and CAM products in each country report.

In addition, the chapters on CAM products consider the supply of CAM products (including market analysis of the main retailers of CAM products) in each country.

The report concludes by identifying the potential for future research building on the findings presented here.

I.1.1 Rationale

Complementary and alternative medical practice is a particularly promising area of research for a number of reasons:

- It attracts substantial public interest and is perceived as a growing market
- It is a central and controversial subject in international debates (World Health Organization (WHO), 2002)
- There are little empirical data and little transparency in this heterogeneous field of health care
- Issues that feature highly in the public and political debates around CAM are also key priority areas in broader health care policy in the UK and Germany, as identified for example by a basic comparative survey of the British and German health care systems (Busse, 2002)
- It may clarify and enrich understanding of more general issues of health care policy and regulation.

A comparative analysis of the UK and Germany is particularly interesting due to a variety of factors:

- The comparison of the UK and the German health care systems has a long tradition (Schuster, 1911; Giaimo and Manow, 1999; Moran, 1999; Busse, 2002)
- The professional and lay culture in practising CAM differs substantially between Germany and the UK (Payer, 1996)
- Both countries have tolerated CAM provision in some form, but regulatory approaches and reimbursement by public sources continue to differ substantially, despite some signs of convergence (Monckton, 1998; Guillod, 1999).

However, empirical data on the number, types and financing of CAM providers, services and products are scarce. In particular, the comparability of existing data has not been analysed. Lack of this fundamental information is a barrier to more thorough research and policy recommendations in the field of CAM in the future. This project has therefore focused research energies on describing existing structures of CAM supply and demand, facilitating a more detailed analysis of data on CAM practice, and on identifying key areas for future research relevant to policy-making in the future.

I.1.2 Aims

This study aims to provide a solid empirical basis for future comparative research of direct policy relevance in the area of CAM regulation and provision. It seeks to enhance transparency in the field of CAM, facilitate communication among researchers, policy-makers and professionals, and promote the exchange of good practice. In particular the research project has the following aims:

- To clarify what is meant by CAM and different CAM-related terms used in one and/or the other country by different actors and to establish a joint bilingual set of consistent definitions for the field of CAM[1]
- To provide an overview on who uses what type of CAM for what purpose

[1] Translations for terms are given in Appendix 2 and 3; definitions can be found elsewhere.

- To summarise evidence about who is doing what and in what quantity in the field of CAM in both countries
- To discuss major characteristics of CAM provision and demand in both countries from a comparative perspective.[2]

I.1.3 Research methods

This project relies primarily on an analysis of secondary literature sources:

1. Systematic literature searches were undertaken to identify relevant academic publications through databases and academic libraries in both countries
2. Further hand and electronic searches identified relevant reports published by government authorities, professional organisations, international organisations, patient organisations and private and commercial industry.

The research methods employed are further detailed in each country report.

[2] For example, issues such as human resources in health care, the patient's perspective/role including access to care and cost-sharing regulations, decision-making on reimbursement, and contracting arrangements in the ambulatory sector.

I.2 Definitions and classifications

A fundamental problem with undertaking comparative research into CAM is that there is little agreement on definitions and classifications. This chapter sets out some of the broader definitions of CAM utilised in the literature and by regulatory bodies and attempts to identify equivalent terminology in English and German.

Publications usually adopt a particular definition but do not determine its position in the spectrum of available definitions. Scientific literature sometimes neglects terms used by regulatory bodies and legal texts, e.g. 'traditional medicinal product' at EU level or '*besondere Therapierichtungen*' in Germany.

This chapter gives an overview of terminologies, classifications and definitions commonly used in the literature and in the regulatory context of both countries. It is supplemented by a dictionary of commonly used terms for both conventional medicine and CAM in English and German (Appendix 2). In addition, a dictionary details the names of CAM therapies in German and English (see Section I.2.5, Appendix 3). Although not exhaustive, the chapter and the related appendices will enhance transparency, communication and comparability in the complex field of complementary and alternative medicine in the two countries.

I.2.1 Defining complementary and alternative medicine and conventional medicine

The term 'complementary and alternative medicine' (CAM) has become widely accepted, particularly since it was adopted by the US National Institutes of Health for the creation in 1998 of the National Center for Complementary and Alternative Medicine (NCCAM)[3]. This represented a shift away from the traditional dichotomy between alternative and conventional medicine. CAM was conceived as 'an approach to health care that[,] while different from conventional medicine, is sometimes complementary to it and at other times is distinctly alternative' (Kelner *et al.*, 2000). The term CAM has quickly become widely used in scientific and policy-related discourse in Anglo-Saxon countries. A direct translation into German, *komplementäre und alternative Medizin*, is increasingly used in the German academic debate (Ostermann *et al.*, 1999). It is abbreviated 'CAM', reflecting the convergence to American and British language usage. The term 'complementary and alternative medicine' (and its abbreviation 'CAM') is a fairly neutral description for the purposes of comparative health system research and is therefore used as an umbrella term in this report. It covers a broad variety of approaches, ranging from methods within conventional care to seemingly speculative practices, and from professional care to the use of home remedies.

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[3] Formerly the Office of Alternative Medicine, established in 1991 by the US Congress.

There have been many attempts to define and classify CAM or equivalent terms. The report of the UK House of Lords' Science and Technology Committee on complementary and alternative medicine defined CAM as 'a diverse group of health related therapies and disciplines which are not considered to be part of mainstream medical care' (House of Lords Select Committee on Science and Technology, 2000: 11).

Another way of defining CAM practices is based on who delivers them; these definitions tend to employ a negative rather than positive definition. For example, a report by the British Medical Association (BMA) defines CAM as 'those forms of treatment which are not widely used by conventional healthcare professions' (BMA, 1993). This definition is problematic, as increasing numbers of conventional professionals do utilise these therapies (Hall *et al.*, 2000; Oldendick *et al.*, 2000; Perry and Dowrick, 2000). This definition may also not be appropriate for cross-country research due to differences in the regulation of scope of practice, qualifications and reimbursement by the public health systems.

The content of conventional medical training is also used as a means of defining what constitutes CAM: i.e. CAM is defined as those practices that are outside the scope of standard medical curricula. The BMA definition cited above goes on to state that the skills required to practise these therapies 'are not taught as part of the undergraduate curriculum of conventional medical and paramedical health care courses' (BMA, 1993). However, increasing numbers of conventional medical courses do now include teaching on aspects of CAM therapies (Berman, 2001; Rees and Weil, 2001). Yet a similar definition is posted on the BMA website: 'The practice of CAM involves any medical system based on a theory of disease or method of treatment other than the orthodox science of medicine as taught in medical schools' (BMA, 2003).

The German notion of 'school medicine' (*Schulmedizin)* also addresses the role of curricula at medical schools. It may be translated as 'academic medicine' but can also extend to professional requirements for specialisation in medicine or relate to curricula for non-physician health care professions.

In the US primary research on CAM utilisation has defined unconventional therapies similarly as 'medical interventions not taught widely at US medical schools or generally available at US hospitals' (Eisenberg *et al.*, 1993; 1998).

Appendix 2 provides a more extensive list of terms commonly used synonymously for 'conventional medicine'. The list also includes a broad range of terms often used in English and/or German to describe complementary and alternative therapies, each with slightly different connotations. Direct translation of all terms is not always possible. In English the antithesis of these therapies is referred to as 'allopathic medicine', 'western medicine' or 'scientific medicine'. In German direct translations of these terms are also commonly used.

A number of historical accounts describe the development of current scientific medicine (Porter, 1989; Jütte, 1996; Lindemann, 1999). They analyse the extent of competition, co-existence, co-operation, integration and modification of innovative or alternative concepts, practices and organisations within and between the different professions and other social groups. In addition, they analyse the extent to which scientific medicine has become legitimated as a major reference point within public health care institutions and has come to dominate other concepts, practitioners and institutions.

The definition of particular therapies as alternative or complementary to medicine assumes that there is an accepted definition of 'medicine'. As such it accepts the boundaries of 'conventional medicine' as defined in a particular society at a particularly point in history. This then raises an epistemological question about the origins of the meaning of 'mainstream medical care'. However, what is classified as medicine changes over time. Definitions that are sensitive to the cultural and historical specificity of what is mainstream medicine do exist. For example, the Office of Alternative Medicine at the US National Institutes for Health held a methodology symposium in Bethesda in 1995, which came up with the following definition of CAM:

> 'A broad domain of healing resources that encompass all health systems, modalities and practices, and their accompanying theories and beliefs, other than those intrinsic to the politically dominant health system of a particular society or culture in a given historical period. It includes all such products and ideas self defined by their users as preventing or treating illness or promoting health and well-being. Boundaries within complementary and alternative medicine and between complementary and alternative medicine and the domain of the dominant system are not always sharp or fixed.' (Kelner *et al.*, 2000)

This definition (the first part of which has also been adopted by the Cochrane Collaboration) suggests that CAM is classified relative to mainstream medicine and emphasises that it is both country- and time-specific. The definition encompasses the possibility of alternative theories and beliefs about health, the body and disease. It also gives consideration to the importance of the political, regulatory and economic context of CAM definitions and CAM practice, as elaborated further below.

This relative definition is therefore particularly appropriate and interesting for projects which, like this report, assess the CAM landscape in different countries. However, comparisons should as far as possible be based on common terminology and methodology as well as specific definitions and research subjects.

I.2.2 Classifications and concepts within complementary and alternative medicine

The term 'complementary medicine' emphasises the use of treatments as adjunct or supplementary to conventional medicine. 'Alternative' use would substitute and exclude utilisation of conventional medicine. These terms may be viewed from the perspective of use as well as supply. The term 'alternative medicine' often implies that its provision may lead to potentially harmful underuse of accepted medical standards (often in a sense of competition, hostility or secrecy).

A number of other ways of classifying therapies within the umbrella notion of CAM are presented briefly by Kelner *et al.* (2000) from a number of perspectives:

1. Based on the context in which they are delivered: clinical forms, psychological/ behavioural forms or social/community forms
2. The extent of legitimacy or public acceptance
3. The extent of scientific evidence to support the efficacy of the therapy
4. The extent of physical contact involved in delivering the therapy.

Fulder (1996) distinguishes five categories of therapies: ethnic medical systems, manual therapies, therapies for mind-body, nature-cure therapies and non-allopathic medicinal systems.

Some definitions, e.g. holistic medicine, highlight the distinct concepts and belief system of CAM therapies regarding the nature of health, illness and the body. Vaskilampi's analysis of CAM in Finland used a matrix along two dimensions (Lewith *et al.*, 1991): one ranging from folk medicine to learned medicine, and the other from empirical, experimental knowledge (natural) to esoteric, belief-based knowledge (supernatural).

Another useful classification, particularly for researchers, is based on the extent of integration with conventional medicine. It identifies frontier therapies (those that challenge conceptual and paradigmatic assumptions about biological and scientific reality), emerging therapies (those that involve common areas of interest for CAM and conventional medicine) and integrating therapies (those that may be considered conventional but overlap with CAM practices) (Jonas, 2002)

Concepts of health and health care present ideals, many of which may be subsumed under two classical competing practical and theoretical approaches to health care: Hygeia symbolised health through discovering and following the laws of nature, while Aesculapius represented health through the triumph of human intervention over illness. Concepts of CAM usually present the approach of Hygeia and tend to criticise modern scientific medicine for neglecting Hygeia and favouring Aesculapius.

I.2.3 Who are considered to be CAM providers?

Depending on the type of provider, Kleinman in (Furnham and Smith, 1988) distinguishes three overlapping sectors of health care: popular, folk and professional. The organised, legally sanctioned health professions are the professional sector. The folk sector may be either sacred or secular and encompasses a range of therapies including alternative therapies. The popular sector includes lay non-professionals who give advice about health.

The terminology used to describe professionals administering CAM differs between the UK and Germany. In English each individual therapy has its related title, for example 'acupuncturist', 'homeopath' etc. The terms 'healer', 'therapist' or 'professional' may be used in conjunction with the descriptors given above – for example, 'complementary practitioner' or 'alternative medical practitioner' – but there is no one single generic term that is commonly used in everyday or scientific language.

In the UK until recently therapeutic professions with statutory recognition other than for human, veterinary or dental medicine or nursing were regulated by the Council for Professions Supplementary to Medicine. Professions governed by this council included art, music and drama therapy, chiropody/podiatry, dietetics, medical laboratory scientific officers, occupational therapy, orthoptics, orthotics and prosthetics, physiotherapy, radiography, speech and language therapy, paramedics and clinical scientists. These were distinct from professions, and accordingly from therapies, with no statutory recognition that would have been considered complementary or alternative medicine.

The NHS Reform and Health Care Professions Act 2002 defines the term 'health profession' as 'a profession (whether or not regulated by or by virtue of any enactment) which is concerned (wholly or partly) with the physical or mental health of individuals' (HMSO, 2002). This broader definition and the provisions made in the Act mean that professions practising certain therapies that currently do not have statutory recognition will, in theory, be able to apply for inclusion under the Health Professions Council (which replaced the Council for Professions Supplementary to Medicine), though none have applied under this provision todate.

In addition, osteopaths and chiropractors (considered CAM therapists) have been governed by statutory regulation in in the UK since 1993, giving protection of title. This means that non-registered persons may not call themselves osteopaths but may still practise osteopathic techniques.

In contrast to the UK approach to registering single disciplines, e.g. acupuncturists or herbalists, Germany has traditionally relied on a unitary model of registration for non-physicians practising CAM: the German term *'Heilpraktiker'* has been variously translated as 'healer', 'non-physician practitioner', 'non-medical practitioner' and 'health practitioner'. This report favours the translation '(state-)registered CAM practitioner' as part of a broader systematic classification of providers (see Table I.2.1).

Regulation to access and practice as *Heilpraktiker* is negative in the sense that laws detail what *Heilpraktiker* are not allowed to do. The regulatory aim is merely to avoid harm to the health of persons and/or the public by underprovision of necessary conventional care, e.g. obstetrics and dentistry, vaccination, treatment of notifiable and sexually transmitted diseases. Other regulation is concerned with preventing fraud, misleading promises and undue competition to conventional health care professionals. The German model of unitary registration implies that *Heilpraktiker* is a professional title granted to those who pass a test at the local public health office. The test does not require any mandatory training in CAM, nor in general medical or legal issues. Candidates are tested on basic clinical knowledge and skills, biomedical understanding of the body and legal regulation pertaining to their profession. They are not tested on CAM methods or concepts.

Table I.2.1
Classification of CAM providers in the UK and Germany

English	German
Service providers	Leistungsanbieter
Physicians practising CAM	CAM-praktizierende Ärzte
Other health care professionals practising CAM	CAM praktizierende nicht-ärztliche Gesundheitsberufe
Registered CAM practitioners	Heilpraktiker mit staatlicher Tätigkeitserlaubnis, *or:* in Berufsverbänden registrierte Dienstleister im Komplementärbereich
Non-registered CAM practitioners	Nicht in Berufsverbänden registrierte Dienstleister im Komplementärbereich
Licensed retailers	Für den Vertrieb von Arzneimitteln oder Medizinprodukten zugelassene Berufsgruppen
Self-care	Selbsthilfe, Laienheilkunde

Source: Compiled by authors

I.2.4 What are considered to be CAM therapies?

The range of services considered as CAM may differ substantially between countries. This is perhaps best illustrated by contrasting the therapies utilised in population surveys in the US and UK. The following 16 principal therapies were included in Eisenberg *et al.*'s telephone survey among the US population in 1990 and repeated in 1997: relaxation techniques, herbal medicine, massage, chiropractic, spiritual healing by others, megavitamins, self-help group, imagery, commercial diet, folk remedies, lifestyle diet, energy healing, homeopathy, hypnosis, biofeedback and acupuncture (Eisenberg *et al.*, 1998).

As many as 28 different therapies were spontaneously mentioned in response to a BBC-sponsored survey of 1,204 British adults about complementary medicine in 1999: herbal medicine, aromatherapy, homeopathy, acupuncture, acupressure, massage, reflexology, osteopathy, chiropractic, flower remedies, Chinese medicine, yoga, healing, reiki, crystal therapy, Alexander technique, hypnotherapy, shiatsu, magnetic therapy, auricular therapy, tai chi, kinesiology, flotation, dance, meditation, music/art therapy, qi gong and colonic irrigation (Ernst and White, 2000).

Official reports have also included different therapies. For example, the UK House of Lords Select Committee report included 29 therapies, and yet it claimed that 'the list is not intended to be all inclusive' (House of Lords Select Committee Report on Science and Technology, 2000: 17). It considered acupuncture, chiropractic, herbal medicine, homeopathy and osteopathy as the 'Big 5' therapies in the UK. Alexander technique, aromatherapy, Bach flower remedies, body work therapies (e.g. massage), counselling stress therapy, hypnotherapy, meditation, reflexology, shiatsu, spiritual healing, Maharishi Ayurvedic medicine, nutritional medicine and yoga fell into a second category of complementary therapies. Finally included as alternative disciplines were anthroposophical medicine, Ayurvedic medicine, Chinese herbal medicine, eastern medicine (Tibb), naturopathy, and Chinese traditional medicine, crystal therapy, dowsing, iridology, kinesiology and radionics.

A review of the state of research for the German Federal Ministry for Research and Technology focused on five major therapies in Germany: phytotherapy, homeopathy, anthroposophical medicine, acupuncture and parts of physical medicine overlapping with naturopathy (especially hydrotherapy, thermic therapies, inhalation therapies and balneology) (Matthiesen *et al.*, 1992). The report identified most research potential and capacity in these areas. Other therapies listed included chiropractic, dietary systems, neural therapy, oxygen and ozone therapies, electroacupuncture according to Voll, bioresonance therapy and MORA-Concept, thermoregulation diagnosis, microbiological remedies and organic remedies (i.e. produced from animal or human organs).

The terms 'naturopathy' or 'natural therapies' ('*Naturheilkunde*', '*Naturheilverfahren*') are sometimes used as umbrella terms by the German media and population (see Appendix 2). Professional representatives in academia and practice have defined a core of 'natural therapies', called 'classical natural therapies' because they have been used since the Greek classical period and are relatively well established in professional and academic curricula and practice (see Section I.3.2). Classical natural therapies embrace the 'five pillars' first systematised by the pastor Sebastian Kneipp at the end of the 19th century:

movement therapy, nutrition therapy, phytotherapy, regulation therapy and hydrotherapy. In addition, there is substantial overlap with other physical therapies (e.g. cryotherapy, ultra-violet (UV) irradiation) and spa medicine (e.g. climatotherapy, thalassotherapy and balneology) (Bühring *et al.*, 2003; Melchart *et al.*, 2002).

Three types of CAM therapies receive special consideration or protection within the German regulatory framework: herbal medicines and homeopathic and anthroposophic remedies are defined as pharmaceuticals with the status of 'special therapeutic approaches' (*besondere Therapierichtungen*). They have to undergo licensing procedures before market entry, while in other European countries they fall under the same category as food additives. If licensing for specific indications is sought, the general rules for pharmaceutical licensing apply; however, if licensing for unspecified purposes is intended, less strict licensing requirements apply. The term 'special therapeutic approaches' is also used in Social Code Book V (SGB V), the regulatory framework for German statutory health insurance, which explicitly states that these therapies are not excluded (§ 2 SGB V) and shall be considered when setting up a positive list of reimbursable products (§ 34a SGB V).

Pharmaceutical licensing at European Union level will also provide simplified rules for so-called 'traditional medicines' (Keller, 2001), but the detailed regulations are still under debate.

I.2.5 Dictionary of CAM therapies

It is difficult to compile a comprehensive list of therapies due to the large numbers of therapies and also due to the continual development of new therapies and subspecialties within existing therapy groups. In order to establish a common understanding of CAM therapies as the basis for future collaboration between Germany and the UK, Appendix 3 contains a dictionary of CAM therapies, which illustrates the breadth of therapies that might be considered in this category.

The National Library of Medicine keywords listed under 'complementary therapies' were used as the basis for the list of CAM therapies included in Appendix 3. German translations for each therapy were then sought and therapies that are common in Germany but not represented in the National Library of Medicine list were added from German sources:

1. The 'Securvita' list (www.securvita.de) was selected in order to reflect a broad range of methods currently reimbursed by statutory sickness funds. This is a company-based sickness fund best known for reimbursing the broadest range of CAM-related therapies. It was also quoted by a recent federal health report on CAM utilisation (Marstedt and Möbius, 2002).
2. In addition, the spectrum of 'unconventional medical diagnostic and therapeutic methods' considered in the report on research needs and capacities prepared for the Federal Ministry of Research and Technology (Matthiesen *et al.*, 1992) were included. These range from therapies which are well established within the scope of conventional medicine to contentious procedures which have recently been taken

off the statutory health insurance benefit catalogue for ambulatory services due to lack of evidence on effectiveness (e.g. autohaematotherapy and ozone therapies).

3. The dictionary is complemented with terms of a glossary provided by the Complementary Healthcare Information Service – UK. The resource centre on alternative medicine, complementary therapy and natural/holistic health, an online resource which is commonly used in the UK.

Other available sources, such as the reference catalogue of appropriate services for *Heilpraktiker* and private health insurance lists of reimbursable *Heilpraktiker* services were not used due to their length. The dictionary focuses on therapies and does not single out specific CAM products or therapeutic devices used as part of these methods.

I.2.6 Summary

This initial review highlights some of the methodological difficulties in researching CAM:

1. The lack of an accepted definition
2. The cultural and historical specificity of what therapies might be considered CAM
3. The diversity and number of therapies currently available.

In terms of researching these therapies in Germany and the UK, we find a number of further challenges:

1. The terminology utilised does not always have a direct equivalent and care will have to be taken in ensuring standardisation of definitions of therapies across countries
2. Specification of a group of therapies might facilitate research, but the basis of selection is not readily apparent
3. Prevalence of therapies varies and those considered dominant differ between the two countries.

I.3 Supply and demand in the United Kingdom and Germany: comparison and trends

Country reports detailing the current state of knowledge of CAM supply and demand in the UK and Germany are presented in Parts II and III. In this chapter we summarise the main findings of these reports and highlight the main similarities and differences between the UK and Germany.

I.3.1 Summary: country report United Kingdom

The report reviews previously published evidence on population prevalence of CAM use. Despite the relatively large number of studies identified, the results of the general population studies and the subpopulation studies vary widely. This is in part due to the specification (or often lack of) of the time period over which utilisation is measured. These methodological issues are discussed in Section I.3.3. Also, despite widespread perception and rhetoric that utilisation of CAM is growing in the UK, no study has confirmed this result by repeating a survey using the same sampling and survey instrument. The most accurate population-based study identified distinguishes between use of practitioners and use of over-the-counter (OTC) remedies. This study, conducted in 1998, estimated lifetime prevalence levels of 32.1 per cent for visits at CAM practitioners, rising to 46.6 per cent when use of over-the-counter remedies was included. For one year the prevalence of visits at practitioners was 13.6 per cent, rising to 28.3 per cent when use of OTC remedies was included (Thomas *et al.*, 2001).

Most studies found prevalence levels higher among women than men, and higher among middle-aged people than either older people or children. However, few studies standardised these rates to the utilisation of other health services or tested whether there is a statistically significant difference between rates of CAM use and other health service use.

On the supply side, research has shown that a significant number of general practitioners are directly involved in the provision of CAM. There are less data on the inpatient provision of CAM services and the role of other health care professionals in the provision of CAM. The majority of CAM treatments are in the private sector, yet this segment of the market is least researched. There are no data on the number or activities of non-registered CAM practitioners or on the private practice of doctors or other health care professionals.

Referral patterns from within general practice suggest that the most ‘trusted’ CAM services are chiropractic, acupuncture and osteopathy. Interestingly chiropractic and osteopathy are also statutorily regulated, thus indicating there may be a higher willingness on the part of doctors to refer to professions that are better regulated. Some

referrals may be funded from the National Health Service (NHS), but many will be paid by the patient. Surveys of purchasing/commissioning by health authorities, GP fundholders and primary care groups (PCGs) give an impression that purchasing policies are varied throughout the UK, though there is some activity in most areas of the country. This variation is likely to increase with devolution of purchasing to primary care trusts (PCTs).

Whether more or fewer services will be available on the NHS in future may depend on a number of factors:

- Availability of CAM skills in the primary care team
- Willingness and attitude of referring GPs
- Purchasing priorities of PCTs
- Availability of information on safety, effectiveness and cost-effectiveness.

Market reports of the CAM product market suggest there has been sustained growth in the UK and that this is set to continue. Growth in OTC sales of homeopathic remedies, herbal medicines and aromatherapy oils has been strong. This growth is predicted to continue if the regulatory environment does not adversely change.

I.3.2 Summary: country report Germany

The report reviews published evidence on current status and trends in professional CAM care in Germany. According to a survey by the Institut für Demoskopie Allensbach (2002), use of natural remedies has been increasing during the last three decades: reported one-year prevalence increased gradually from 30 per cent in 1970 to 56 per cent in 2002 in West Germany. Lifetime prevalence and one-year prevalence increased between 1997 and 2002 in East Germany and in West Germany, rising from 64 per cent to 71 per cent and from 51 per cent to 56 per cent respectively (Institut für Demoskopie Allensbach, 2002). This trend was recognisable in all social groups, while inter-group differences have been decreasing.

Population surveys on the use of CAM practitioners do not allow trends to be summarised. In Germany naturopathy, phytotherapy, homeopathy, acupuncture, autogenic training and chiropractic are the most commonly used therapies reported in population surveys. About 5 per cent of German men and 9 per cent of German women reported a visit to a CAM specialist (physicians specialised in *Naturheilverfahren*, physicians specialised in homeopathy or *Heilpraktiker*), compared with approx. 70 per cent usage of general practitioners. The satisfaction with any of these providers specialised in CAM was quite high but, in contrast to common assumptions, lower than the satisfaction reported with physicians of many other specialities, especially with frequently visited specialities (less than 87.5 per cent, compared with, for example, more than 90 per cent for general practitioners).

In 2001 Germany had 15.2 active physicians per 100,000 inhabitants with additional qualifications in chiropractic, 5.2 per 100,000 with additional qualifications in homeopathy and 12.6 per 100,000 with additional qualifications in naturopathy. Based on data about the number of qualifications, this report estimates that the number of

physicians practising any of these additional qualifications doubled between 1993 and 2001. This tendency was observable in ambulatory as well as in inpatient care. In 2001, 71 per cent of chiropractic qualifications were documented in the ambulatory sector, 23 per cent in the inpatient sector and 6 per cent in other working areas. The shares for naturopathy were 78 per cent, 14 per cent and 8 per cent in the three sectors respectively, and for homeopathy 85 per cent, 9 per cent and 6 per cent. The total number of active physicians increased by only 15 per cent over the same period. In addition, many other specialities practise some form of CAM, partly within the public reimbursement schemes of ambulatory and inpatient care, partly within the framework of pilot projects and partly paid out of pocket.

The substantial increase in the number of CAM-qualified physicians and *Heilpraktiker* suggests an increase in the amount of services delivered. However, this trend cannot be confirmed through available data from population surveys on the use of services, nor through data from physicians' claims or pre-authorisation reviews from sickness funds.

With respect to products, OTC sales of herbal medicines have remained constant since 1996 in nominal terms and have probably decreased in real terms. Since 1992 there has, in fact, been a decrease in the area of publicly reimbursed herbal medicines. Evidence on current sales of medicines thus indicates a different trend compared with results of population surveys and particularly compared with perceived demand in public debate.

I.3.3 Discussion

A number of articles on the international comparison of CAM were identified (Ernst, 2000a; 2000b; Fisher and Ward, 1994; Lewith and Aldridge, 1991; Monckton, 1998; WHO Programme on Traditional Medicine, 1998; Zollman and Vickers, 1999). However, these are based on a small selection of the different surveys available for each country, which highlights the need for more comprehensive reviews of the existing literature and for truly comparable multi-centre empirical research, which as yet does not exist. The literature in both countries and international comparisons also reflect the possible fallacies of generalising from reported demand for CAM to trends in actual supply.

This report shows that readily available sources are more contradictory than commonly assumed. Some of the conventional perceptions of inter-country differences may no longer be completely accurate. Results hint at convergence tendencies around utilisation, but within these general trends of convergence between the UK and Germany the countries seem to take quite different approaches, particularly with respect to the regulation of providers and reimbursement of CAM.

While media coverage and provider-based surveys suggest a continuously increasing demand, a more differentiated analysis of trends may give a more realistic picture of the status quo. Indicators of trends and national differences need to be considered (cautiously) in the broader context of national health care and international markets and regulation. The UK data cannot confirm increases in the use of CAM practitioners; however, direct demand for CAM remedies as measured by market size and value has increased.

Data for Germany are ambiguous. The number of providers has increased as well, but sales of herbal medicines have remained stable, while publicly reimbursed herbal medicines have actually declined during the 1990s. There are no data on long-term trends of services in either country and no longitudinal comparison of product use in the UK.

A direct comparison of the most recent and reliable population surveys for Germany and UK (Thomas *et al.,* 2001; Bergmann and Kamtsiuris, 1999; Institut für Demoskopie Allensbach, 2002) yields a number of interesting points on reported use of CAM practitioners or remedies:

- One-year prevalence of visits to CAM practitioners in 1998 was 14 per cent in the UK and about 9 per cent in Germany.
- One-year prevalence of use of CAM remedies was 28 per cent in the UK in 1998 and between 52 per cent (1997) and 56 per cent (2002) in Germany.[4]
- Lifetime prevalence of CAM remedy use was 46 per cent in the UK and between 65 per cent (1997) and 73 per cent (2002) in Germany.

It seems therefore that more people in the UK consult CAM practitioners than in Germany. There are no data about how often CAM users visited one or more CAM practitioners. At the same time a larger share of Germans uses natural remedies compared with people in the UK, although commercial sales have remained constant and publicly reimbursed consumption has declined.

Differences do appear in the types of therapies used. This is partly due to differences in the therapies that are considered alternative and therefore included in the scope of the questionnaires. The therapies most commonly reported by users in the UK are homeopathy, osteopathy, chiropractic, acupuncture and aromatherapy. In Germany naturopathy, herbalism, homeopathy, acupuncture, autogenic training and chiropractic are the most commonly reported in population surveys. Osteopathy, reflexology and aromatherapy are commonly used in the UK but rarely delivered and reimbursed in Germany. By contrast, art therapy, anthroposophic therapies, neural therapies, hydrotherapy or auto-hematotherapy, commonly delivered in Germany, were hardly found in the UK. In Germany naturopathy, herbalism (phytotherapy), homeopathy, acupuncture, herbalism and autogenic training are most commonly reported in population surveys.

Like phytotherapy and homeopathy, anthroposophical medicine receives special protection and is more established in Germany than in the UK. While chiropractic may be reimbursed by German statutory health insurance if practised by doctors or physiotherapists, osteopathy is not as yet recognised by statutory insurance funds. In the UK both chiropractic and osteopathy have been legally recognised through an Act of Parliament. Reflexology is frequently practised by other health care professionals in Germany but is not publicly funded. While Reiki is widespread in the alternative market (and beginning to be studied academically), other forms of therapeutic touch seem to receive less attention in Germany. The same may be true for aromatherapy oils and Bach flower remedies, which are said to be of the highest quality if directly imported from the UK.

In future a greater convergence might be seen in the types of therapies commonly utilised as there is a decline in more traditional naturopathy and spa treatments in Germany (due

[4] In the UK,data only referred to use of over the counter homeopathic and herbal remedies.

in part to their exclusion from public reimbursement, see below) and a growth in the 'imported' therapies such as Chinese herbal medicine, acupuncture etc. These 'imported' therapies are already well established in the UK, where more traditional therapies such as hydrotherapies all but died out in the 20th century (although they have seen a revival of interest in recent years).

The degree to which information about CAM is available both to providers and to users has certainly increased. Although available (and practised) before, CAM services have become subject to public debate over funding, evidence and provision. Increased media attention is reflected in the number of UK CAM users who cited this as a source of information about CAM therapies, although personal recommendation remains a dominant factor in this area, reflecting the folk aspect of many of these treatments.

Compared with the UK and (all) other European countries, Germany has conventionally been described in international articles, official reports, narratives and in the media as a country with a high level of CAM use and supply. This has been linked to a high level of integration into conventional medical e, inclusion into third-party payer schemes and willingness to pay for CAM.

Among the countries classified worldwide as 'CAM-tolerant' Germany has been considered to have a high level of (special) regulation and legal-political protection of CAM compared with other European countries (Guillod, 1999). In relation to CAM regulation the UK was classified along with Germany as a 'tolerant' system, where the practitioners of various forms of complementary medicines are tolerated, at least to some extent, by law. Both Germany and the UK do contrast with countries such as France, Spain and Belgium, where the medical profession has maintained its monopoly over medical practice and where the activities of non-medically qualified CAM practitioners are illegal. However, there are significant differences between Germany and the UK in the level of regulation and tolerance and the approach to therapeutic practice.

In the UK there is a move towards specialisation, with individuals having to demonstrate their ability, skill and knowledge in a single therapeutic area, through registration with a professional body. In Germany the generic qualification of *Heilpraktiker* lends itself more to multi-therapeutic practice within a unitary approach to regulation. Besides the more somatic and generalist *Heilpraktiker*, the examination has also been made a prerequisite for psychotherapists who want to practise but are not qualified in a method that is included in the statutory health insurance benefit catalogue.

Integrated use of CAM therapies alongside conventional medicine occurs in the UK, but this is not formally part of medical training. Although an increasing number of medical schools include a familiarisation course with CAM therapies, the statutory regulatory bodies (such as the General Medical Council) express caution on the part of doctors and professionals to ensure that what they practise is within their competence and they have the appropriate training.

In Germany CAM has been part of medical training and examination since 1993. There are recognised specialist qualifications in CAM specialties, e.g. homeopathy and chiropractic, but there is also a generalist additional qualification in naturopathy (*Naturheilverfahren*). Apart from physiotherapists, doctors too can acquire specialisations or additional qualifications in physical therapies. Furthermore, evidence of knowledge and skills in physical therapies is a prerequisite for many specialisations. The additional qualification

in balneology and medical climatotherapy may reflect the relatively strong role and specific treatment approach of rehabilitation and more preventive 'spa therapies' that developed in rural spa resorts.

Finally, contrasting approaches regarding public reimbursement reflect the broader approach to benefit-setting in the two health care systems. In Germany the vast majority of CAM therapies and herbal medicines are explicitly either included or excluded from the statutory package of benefits. The trend has been towards reducing public reimbursement for these therapies in the ambulatory sector. However, utilisation may have been partly sustained through substitution with private purchases. In the inpatient sector CAM services have either explicitly been subject to contracting between individual hospitals and funds or have been delivered implicitly as part of *per diem* charges. Reimbursement of CAM services is expected to become more difficult following the introduction of a national uniform diagnostic-related group (DRG) system in the acute hospital sector since CAM services have traditionally not been prominently reflected in the national fee scheme.

In theory the NHS in the UK is comprehensive and does not have any explicit definition of benefits. Homeopathy has traditionally been available since the establishment of the NHS while other therapies are provided with a large amount of discretion for local providers and purchasers.

In line with rising demand the supply of practitioners is growing in both countries. Data on the number of people qualifying in Germany show significant increases, though it is not clear how many are additional qualifications for practitioners who are already practising and how many are new practitioners. In the UK the late 1990s saw dramatic increases in the numbers of practitioners registered with professional associations (although dual membership of associations means that numbers are not completely accurate).

Physicians practising CAM therapies are concentrated in the ambulatory sector/ general practice in both countries. Very few doctors practise CAM in UK hospitals, while in Germany more than 10 per cent of qualifications for naturopathy, homeopathy and chiropractic are documented in the inpatient sector. The numbers of registered CAM practitioners have also risen in both countries, but there was very little information on private practice by non-registered practitioners in either country.

Existing EU regulations concerning homeopathic and herbal medicines mean that product approval will increasingly be convergent between the two countries. In Germany the retail of CAM products, similar to that for other pharmaceutical products, is heavily regulated and limited to pharmacists. In the UK, where OTC medicines are available from a wider range of outlets, there is almost no regulation about the point of sale of CAM products.

Some homeopathic remedies are eligible for NHS prescription in the UK. However, as many of these items are cheaper than the prescription co-payment, this is not widely used. The published literature yielded no data on total numbers of homeopathic prescriptions, although a small-scale study estimated the number to be 750,000 per year (Swayne, 1989). Discussion about the effectiveness and cost-effectiveness of CAM services and products is increasingly prominent in both countries due to issues of cost containment (especially in Germany) and purchasing decisions (by sickness funds and primary care trusts).

I.4 Methodological challenges

From the literature reviewed a number of methodological issues were identified which may be important for future research work on CAM.

I.4.1 Scope of CAM

Survey instruments were not consistent in terms of which therapies were included as CAM. Indeed, some surveys used open-ended questions pertaining to use of CAM without specifying what this meant. Respondents could thus interpret the definition of complementary and alternative therapies differently. In some surveys a closed list of therapies was given, while others used a suggested list of therapies. Consistency is particularly important for making cross-country comparisons, where the interpretation by the public of what is CAM will differ (as it does within a country).

Another distinction that is not always made explicit in survey instruments, but which may account for the large differences in estimates, is whether medicines and self-care are included as well as therapies received from a practitioner. Some studies explicitly excluded self-care and only asked about care received from practitioners; other surveys did not differentiate.

Finally the inclusion of vitamins and dietary supplements in estimates of demand for and supply of OTC CAM remedies makes a significant difference to the results. Lack of clarity over definitions of CAM in survey instruments and among sample populations results in data that are not directly comparable.

I.4.2 Time period specification

Some surveys failed to make explicit the time period to which the questions applied. Some surveys specified the past 12 months as the period of interest, or they distinguished between this period and lifetime use. Some surveys also asked about current usage only. In the survey of patient groups respondents were often asked about use of CAM in relation to the disease in question. However, as some therapies are used to complement orthodox treatment, and to improve general health and well-being, this may distort the results. Accurate measures of prevalence require accurate specification of the time period to which the data refer. This would also allow a more accurate analysis of time trends. No survey was identified in the UK similar to Eisenberg *et al.*'s 1998 study in the US, which repeated questioning using the same sampling technique and questions to give time series data. Time series data for Germany were limited to the use of natural remedies.

I.4.3 Training and registration

The fact that most studies of practitioners rely on professional registers for their samples means that there is little information about the training or practice of non-registered therapists. This is likely to bias the results. Even where registers of CAM practitioners do exist, these do not necessarily record whether the person is already registered as a doctor or other health professional. In the UK the statutory professional bodies do not register CAM qualifications, so data on professional training and practice depend on survey data. In Germany qualifications are registered but without identifying whether individual physicians are trained in and practising multiple therapies.

I.4.4 Expenditure and income data

As much activity in the CAM market is in the private sector, there is poor information about expenditure on CAM by patients/population and about the income of suppliers and producers. Available data tend to come from commercial market reports; there is little independent research on the supply chain or market structure. Reliable and independent sources of expenditure and income data need to be identified to facilitate more in-depth economic assessments of the CAM market in either country. On the whole data on out-of-pocket spending are scant in both countries.

I.5 Relevance for policy and future research

Much of the current research funding and effort is concentrated on the clinical effectiveness of CAM interventions (Cooke and Ernst, 2000; Huntley and Ernst, 2000; Ernst and Pitler, 2001). Some CAM practices – such as osteopathy, chiropractic and homeopathy – have received significant attention (Vickers and Zollman, 1999a; 1999b; Vickers, 2000; Faculty of Homeopathy, 2001; NHS Centre for Reviews and Dissemination, 2002). Other therapies remain relatively undocumented.

This project has focused on quantitative aspects of the market for CAM, summarising what is known about the demand for and supply of CAM services and products as well as the CAM providers in Germany and the UK. It has compiled a dictionary with English–German and German–English translations of CAM therapies to enhance transparency and communication in the complex field of the practice of complementary and alternative medicine in the two countries.

Furthermore it has delivered the following results, which it is hoped will inform future research and policy-making in the field of CAM:

- A country report for the UK summarising available data on the demand for and supply of CAM
- A country report for Germany summarising available data on the demand for and supply of CAM
- Service-provider-finance matrices for both countries, which summarise the classifications used and the results found in this project and are intended to help systematise and compare understanding of CAM provision in each country
- Comparative analysis of the key similarities and differences between CAM demand and supply in Germany and the UK.

By discussing available data and establishing consistent definitions, this project contributes to improving the comparability of research on CAM providers, services and products in future. It lays a solid empirical base for future research in the two countries and highlights a number of areas relevant to health care policy decision-making.

I.5.1 Policy issues

The project highlights a number of topics on CAM that may be of particular importance to policy-makers in both countries and require further research (see below). The following controversial issues feature prominently in the public and political debates around CAM in the UK and Germany:

- Where are the unmet needs for consumer protection in the CAM arena? Are current consumer initiatives by governmental and non-governmental institutions sufficient to improve quality and protect consumer health effectively? How can and should consumers be protected from harmful practice, adverse events, omission of necessary care and economic exploitation?
- Should licensing of CAM products be subject to rigorous evaluation of the scientific evidence base on safety and efficacy? Should they receive special regulation?
- Should CAM practitioners be subject to statutory regulation? Which type of practitioner, practice setting, service and/or product use should be regulated? What training, accreditation and licensing procedures should be in place for CAM practitioners? Should different CAM providers be integrated into the public health care system and subject to the same regulations as other health professionals? Should regulation be generic (allowing multidisciplinary practice) or monotherapeutic?
- How will current and future EU regulations concerning the free movement of goods, professionals and patients affect the national CAM markets?
- How can the objectives of access to fair, affordable and effective care be balanced at a micro-, meso- and macro-level with targets of cost containment, health market access for producers and professionals and freedoms of professional practice and trading?
- Which, if any, CAM services and products should be financed from public funds, i.e. through statutory health insurance or by the National Health Service? On what basis should these decisions be taken? How should the decision-making process be legitimated? Which contractual relationships with public insurers and/or public health care providers have proved or are considered appropriate?

The available research tends to be highly descriptive and not oriented to these important policy questions. Understanding the nature and size of the market is an important first step before considering how it can be regulated or what policy interventions are needed. However, researchers must begin to address these questions in the context of wider health policy discussions so that health service provision responds to patient needs and consumer demands while at the same time meeting policy objectives of equity, safety, quality and allocative efficiency.

I.5.2 Scope for future research

Analysis of the available information and research on the demand and supply of CAM therapies and products highlights a number of gaps in the research base.

Despite the trends of increasing utilisation and supply of CAM, CAM practitioners, products and services have been subjected to relatively little (specific) regulation and enforcement in the UK and many countries of the European Union (Mills, 2001). In Germany *Heilpraktiker* and CAM medicines are subject to special regulations but exempt from the stricter regulations and enforcement of the public health care sector (Ernst, 1996; Keller, 2001). In the UK growing awareness of the benefits and dangers of CAM products and practices has moved questions of whether and how to change the existing state of regulation up the political agenda in recent years (House of Lords Select

Committee, 2000). Yet information on regulation is mainly available from the grey literature. The few published resources often focus on a few selected topics in CAM (Budd and Mills, 2000; Mills, 2001) or in health care generally (Saltman *et al.*, 2002; Walshe, 2003).

Demand side research has largely been restricted to individual users, while organised representation of consumer interests has been neglected. Safety information has been collected by regulatory bodies but has seldom been published. Available information tends to be useful for and accessible to regulatory institutions and pharmaceutical/ medical device companies but is often not appropriate and accessible for use by providers and consumers. Only recently has scientific literature shown increased interest in studying the safety of CAM products and services (Ernst *et al.*, 2001). Because most complementary products are traditional remedies based on 'natural' products, their safety has not been thoroughly tested, partly relying on the test of time as the main factor in determining their efficacy.

A number of factors have been identified which might render this experiential validation of the safety of complementary products invalid:

- The method of preparation may have changed
- The concentration of active ingredient in the raw material may have changed
- The route of administration may deliver more concentrated doses
- Products are used more regularly (preventively) rather than occasionally to treat a specific problem
- There may be interactions with modern pharmaceutical products previously unavailable.

(Ernst *et al.*, 1998)

These considerations, together with pressure from consumer groups and the medical profession, have meant that further regulation of products, especially herbal medicines, is being introduced by the European Union. The impact of the implementation of EU directives in this field and its effects on national CAM markets should be monitored.

Data on CAM use do not provide sufficient detail to establish whether access is equitable. Future research on utilisation should focus on whether there are population groups who would benefit from access to CAM but are unable to access services due to availability or affordability. There are only patchy data on costs, derived from self-reported questionnaires and surveys. More systematic analysis of pricing on the supply side, together with data on the range of frequency of visits, would provide a more accurate picture of the likely costs faced by a patient seeking treatment from a CAM therapist. Data suggest that the majority of consultations are paid out of pocket, with provision of services in the UK under the NHS highly variable between PCTs and practices. In Germany, where some therapies are covered through statutory health insurance, it is not clear whether these are consistently available to patients. Research could add to our understanding of who is benefiting from access to CAM through publicly funded care.

In particular, this project has identified the following areas as having potential for future research with relevance for policy-making:

- Consumer protection and quality assurance in CAM provision

- Assessment of product safety and efficacy
- Professional regulation and standards
- Equitable access to effective and affordable CAM care
- Pricing and availability of CAM products
- Decision-making criteria and processes for determining the public availability of CAM services and products
- Appropriate and efficient purchasing of CAM services and contracting with CAM providers.

I.6 Conclusions

By collating a range of published literature this project has established a firm basis for future comparative analysis in the field of CAM. It has set out what is already known in Germany and in the UK about the demand for and supply of CAM services and products and has identified trends in providers and services. Comparison of the CAM field in Germany and the UK has highlighted a number of important similarities and differences. Before final conclusions can be drawn the following hypotheses require further in-depth analysis with an orientation towards policy-relevant questions:

- Demand for CAM services and products is increasing but is shifting to other population groups which have not been traditional users of CAM.
- Traditional differences in the types of CAM services available are decreasing.
- There is divergence of CAM providers, with specialisation of monotherapeutic practitioners in the UK compared with the continuation of generalist *Heilpraktiker* in Germany.
- In both countries CAM teaching and research is established/institutionalised (or being piloted), including integration with established medical curricula.
- There is a trend towards increased professionalisation of CAM providers, including specialisation and more formal education of single CAM providers.
- Public reimbursement of CAM products and services is decreasing in Germany but increasing in the UK.
- There is a concentration of CAM services in primary/ambulatory care, with little activity in inpatient settings.
- CAM products are mainly available over the counter, but there are differences in retail venues in the two countries.

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PART II

Supply of and demand for complementary and alternative medicine in the United Kingdom: Country report

Anna Dixon and Omer Saka

II.1 Methodology

A number of different search strategies were adopted to identify published materials relating to the demand for and supply of complementary and alternative medicine (CAM) in the UK.

II.1.1 Demand for CAM

A systematic literature search was conducted to identify articles on the utilisation of CAM therapies. Studies were identified through a search of PUBMED, covering a period from the earliest available year (1950) until the end of 2002 and using the MESH terms ‘complementary therapies’ and ‘Great Britain’ and any field containing ‘utili*’.

A total of 67 studies were identified. Using the abstracts as a guide, 18 studies were selected for further analysis and inclusion in the review of utilisation. Several of the studies concerned the availability of services or involved surveys of practitioners and are included in the analysis of CAM providers and services (see sections below). Additional relevant studies were identified from the bibliographies of the original set of studies and the authors’ own files.

Ernst’s systematic review of studies of the prevalence of CAM use (2000) identified studies up to and including 1997. Criteria for inclusion were that the samples were random and representative (all studies of subpopulations were excluded). A total of 12 surveys were included in the review; of these only Vickers (1994) was based on a UK sample and Emslie *et al.* (1996) on a sample taken in the Grampian region of Scotland.

Harris and Rees’ systematic review of CAM prevalence among the general population (2000) also identified 12 studies for inclusion. The authors’ criteria for inclusion were that the studies used survey methods (either structured interview or self-completion questionnaire), applied to the general population, and that the prevalence estimate was expressed as a percentage of the population or sufficient information was provided for this to be obtained. Of the studies included by Harris and Rees only Yung *et al.* (1988) and Thomas *et al.* (1993) were based on the UK population.

This review is non-systematic and therefore encompasses a larger set of studies than either of the above studies. The survey methods of the studies included in this review are presented in Table II.1.1 and Table II.1.2. Only five studies focused on the general population, while 13 studies were of subpopulations. The subpopulations for which published studies were identified include specific disease groups, children and ethnic groups.

One systematic review of the prevalence of use by children was identified (Ernst, 1999). This included one study from the United Kingdom (Simpson *et al.*, 1998), the results of which were published in another article identified in our search (Simpson and Roman, 2001).

Table II.1.1
Utilisation studies of the general population: key methodological aspects

	Date	Sample (response rate)	Scope of questions
Emslie, M., Campbell, M. *et al.* (1996) 'Complementary therapies in a local health care setting. Part 1: Is there real public demand?' *Complementary Therapeutic Medicine* 4: 39–42.	1 April 1993–14 May 1993	Random sample of 500 adults (≥18 years old) in Grampian Region of Scotland from Community Health Index	Awareness Reasons Satisfaction Utilisation of CAM Location
Ernst, E. and White, A. (2000) 'The BBC survey of complementary medicine use in the UK.' *Complementary Therapies in Medicine* 8(1): 32–6.	Summer 1999	Representative random telephone survey of 1,204 adults (≥18 years old) using random digit dialling	Demographic Utilisation of CAM Reasons Expenditure
Swayne, J.M. (1989) 'Survey of the use of homeopathic medicine in the UK health system'. *Journal of the Royal College of General Practitioners* 39(329): 503–6.	February 1987	All consecutive consultations during one week by 73 doctors who used homeopathic medicine (7,218 consultations)	Demographic Location Utilisation Diagnosis
Thomas, K.J., Carr, J. *et al.* (1991) 'Use of non-orthodox and conventional health care in Great Britain'. *BMJ* 302(6770): 207–10.	August 1987–July 1988	Postal survey of 2,152 qualified non-medical practitioners of non-orthodox health care working in Great Britain identified from national professional association registers (73%); 3,082 patients attending one of the sampled 101 practitioners (80%)	Utilisation Demographic Expenditure Diagnosis
Thomas, K.J., Nicholl, J.P. *et al.* (2001a) 'Use and expenditure on complementary medicine in England: A population-based survey'. *Complementary Therapies in Medicine* 9(1): 2–11.	1998	Previously piloted postal questionnaire was sent to a geographically stratified, random sample of 5,010 adults in England (60%)	Demographic Health status Use of conventional medicine Utilisation of CAM Attitudes Expenditure Location

Table II.1.2
Utilisation studies of subpopulations in the UK: key methodological aspects

	Date	Sample (response rate) and survey technique	
Brown, R. (1998) 'The role of complementary therapy in Parkinson's disease'. *GM* May: 64–6.	Not specified	Members of the Parkinson's Disease Society (2,000 responses)	Utilisation Severity Reason
Cappuccio, F.P., Duneclift, S.M. *et al.* (2001) 'Use of alternative medicines in a multi-ethnic population'. *Ethnicity and Disease* 11(1): 11–18.	1994–1996	Stratified random sample of 1,577 men and women aged 40–59 from GP lists in Wandsworth, South London (64%); interview	Use of alternative medi-cines (those not prescribed by a doctor, e.g. cod liver oil, primrose oil, garlic, ginseng and vitamin supplements) Demographic
Chandola, A., Young, Y. *et al.* (1999) 'Use of complementary therapies by patients attending musculoskeletal clinics'. *Journal of the Royal Society of Medicine* 92(1): 13–16.	Not specified	All patients attending general rheumatology and orthopaedic (no fracture) clinic in the course of one week (99%); interview using structured questionnaire	Demographic Satisfaction Diagnosis Utilisation CAM Reasons
Greenfield, S.M., Innes, M.A. *et al.* (2002) 'First year medical students' perceptions and use of complementary and alternative medicine' *Complementary Therapies in Medicine* 10(1): 27–32.	December 1999	Year 1 students at Birmingham Medical School (150 of 211 questionnaires returned – 71%)	Utilisation Benefit Location
Ernst, E. (1998) 'Complementary therapies for asthma: What patients use'. *Journal of Asthma* 35(8): 667–71.	January 1997	Members of the UK National Asthma Campaign (17,000) (4,741 or 28%); postal questionnaire	Utilisation of CAM Expenditure Attitudes
Leese, G., Gill, G. *et al.* (1997) 'Prevalence of complementary medicine usage within a diabetes clinic'. *Practical Diabetes International* 14: 207–8.	Not specified	All patients attending diabetes clinic (of 328 patients 246 agreed to be interviewed – 75%); interview using questionnaire	Utilisation of CAM Expenditure Attitudes
Moore, A.D., Petri, M.A. *et al.* (2000) 'The use of alternative medical therapies in patients with systemic lupus erythematosus. Trination Study Group'. *Arthritis and Rheumatism* 43(6): 1410–18.	July 1995 –July 1997	Consecutive patients presenting at tertiary hospitals with systemic lupus erythematosus (SLE) in Canada, US, and UK (of 752 patients invited to participate 708 agreed – 94%; 211 were in the UK)	Demographic Health status Utilisation of CAM Attitudes

(continued)

Table II.1.2
Utilisation studies of subpopulations in the UK: key methodological aspects (continued)

	Date	Sample (response rate) and survey technique	
Pal, B. (1998) 'Use of alternative medicine by Sjogren's syndrome patients'. *Clinical and Experimental Rheumatology* 16(6): 763.	Not specified	All members of the Greater Manchester branch of the British Sjogren's Syndrome Association (of 130 questionnaires 114 completed – 87.6%)	Demographic Benefit Reasons Expenditure
Rees, R.W., Feigel, I. *et al.* (2000) 'Prevalence of complementary therapy use by women with breast cancer: A population-based survey'. *European Journal of Cancer* 36(11): 1359–64.	July 1997	1,023 women from the Thames Cancer Registry who had been diagnosed with breast cancer in the previous seven years; questionnaire	Demographic Utilisation of CAM Expenditure
Resch, K.L., Hill, S. *et al.* (1997) 'Use of complementary therapies by individuals with "arthritis"'. *Clinical Rheumatology* 16(4): 391–5.	Not specified	Self-selected sample of arthritis sufferers (30.1%); postal questionnaire	Utilisation Demographic Health status Benefit GP referral Expenditure Safety
Simpson, N. and Roman, K. (2001) 'Complementary medicine use in children: Extent and reasons. A population-based study'. *British Journal of General Practitioners* 51(472): 914–16.	August 1998	Random sample of 1,230 children under 16 years old from child health database (eligible sample 1,134 – 79.7%); postal questionnaire	Utilisation of CAM by children Utilisation of CAM by parents Reasons Location Benefit Expenditure
Skinner, C.M. and Rangasami, J. (2002) 'Preoperative use of herbal medicines: A patient survey'. *British Journal of Anaesthesia* 89(5): 792–5.	Not specified	All patients administered anaesthesia in operating department of Wexham Park Hospital over three- month period (of 3,349 patients forms were received for 2,723 – 81.3%)	Utilisation of herbal medicines
Vashisht, A., Domoney, C.L. *et al.* (2001) 'Prevalence of and satisfaction with complementary therapies and hormone replacement therapy in a specialist menopause clinic'. *Climactericum* 4(3): 250–6.	September–December 1999	200 consecutive patients at a specialist menopause service for peri- and post-menopausal women at Chelsea and Westminster Hospital; Anonymous structured questionnaire	Utilisation Satisfaction Information source

A systematic review of usage of complementary therapies in rheumatology (Ernst, 1998a) identified four studies in the UK.

A number of areas of interest were identified on which data in the studies were sought. These included:

- Estimate of prevalence for the general population
- Estimate of the prevalence for specified subpopulation
- Demographic profile of users versus non-users
- Presenting problem or diagnosis of users
- Motivation for seeking CAM care
- Cost of seeking CAM care
- Location of CAM care (including self-care, NHS provider or private provider).

The results of the review are presented in Table II.1.3 and Table II.1.4 and are discussed below.

II.1.2 Supply of CAM

The search for data on the supply of CAM utilised a broader set of keywords for searching in PUBMED than did the search on the demand for CAM. The keywords included were 'medicine, herbal', 'oils', 'formularies, homeopathic', 'plants, medicinal', 'phytotherapy' and 'United Kingdom'. In addition, the catalogues of the British Library and the files of the authors were searched for relevant material, and the bibliographies of other project reports were consulted, such as those for the Department of Health on professional organisations.

Table II.1.3
Utilisation studies of the general population in the UK: key findings

Study	Prevalence	Demographic	Diagnosis	Reason	Expenditure	Location
Emslie *et al.* (1996)	• 29% (no period specified in results) • Osteopathy (35%) • Aromatherapy (22%) • Homeopathy (24%) • Acupuncture (23%) • Chiropractic (16%) • Herbalism (15%) • Hypnotherapy (13%) • Reflexology (10%)	N/A	N/A	• 58% recommended by friend or colleague • 28% referred by doctor or health professional • 23% read about it • 20% practitioners known personally	• 21% had received treatment free • 65% thought reasonably priced or good value for money • 29% thought it expensive • 1% thought it had been a waste of money	• 62% received from complementary therapist • 20% by other health professional • 18% other forms of therapy including self-care
Ernst and White (2000)	• 20% (last year at least once) • Herbal medicine (34%) • Aromatherapy (21%) • Homeopathy (17%) • Acupuncture (14%) • Massage (14%) • Reflexology (14%) • Osteopathy (9%) • Chiropractic (6%)	• 59% of users were women • Highest use among 35–64 age group and social classes ABC1 • 63% of users were working • Regional variation showed lowest prevalence in West Midlands (16%) and North England (11%)	N/A	• Helps or relieves injury/condition (25%) • Just like it (21%) • Relaxing (19%) • Good health (14%) • Preventative (12%) • Do not believe conventional medicine works (11%) • Doctor's recommendation (11%) • New things (11%) • Way of life (8%) • No conventional medicine (7%)	• Average user spends £13.62 ± 1.61 per month • 37% spend less than £5.00 per month	N/A

(continued)

Table II.1.3
Utilisation studies of the general population in the UK: key findings (continued)

Study	Prevalence	Demographic	Diagnosis	Reason	Expenditure	Location
Swayne (1989)	• 35% of all consultations resulted in a homeopathic prescription; 25% in general practice • Estimate 0.75 million consultations a year by doctors in the UK yielding homeopathic prescriptions	• Proportion of older women treated with homeopathy greater than the proportion consulting routine general practice	• Respiratory disorder highly represented • Outpatient clinic saw higher proportion of arthritic, skin, neurological and cardiovascular conditions • Psychological illness accounted for highest proportion of private practice	N/A	N/A	• 27% of doctors practised homeopathy in more than one setting • 67% in general practice (majority exclusive), 47% in private practice and 21% in outpatient clinics • Very few doctors reported inpatient consultations • The proportion of consultations yielding a homeopathic prescription taking place in general practice (54.4%), hospital outpatients (12.3%), inpatients (1.3%) and private practice (32%) reflects the number of doctors in each setting
Thomas *et al.* (1991)	• 70,600 patient consultations on average each week with group of practitioners (95% confidence interval (CI) 67,800–73,400)	• 63% of consultations with women (little difference with consultations with NHS GPs 62%) • 15% with over-65s • Majority of consultations with 35–64 age group: 64%	• Musculoskeletal problems (78%) • Grouped according to patient-defined problem groups; neck, back and low back were most commonly cited problems	N/A	N/A	• All with therapists due to nature of sampling

(continued)

Table II.1.3
Utilisation studies of the general population in the UK: key findings (continued)

Study	Prevalence	Demographic	Diagnosis	Reason	Expenditure	Location
Thomas *et al.* (2001a)	• 10.6% (95% CI 9.6–11.6) visited one of six named therapist in last 12 months • 13.6% (95% CI 12.4–14.9) one of eight (including reflexology and aromatherapy) in last 12 months • 8.6% (95% CI 7.6–9.8) purchased homeopathic remedy OTC; 19.8% (95%CI 18.3–21.3) purchased OTC herbal remedy • 12-month use at least one of eight therapies or purchased OTC remedy 28.3% (95% CI 26.6–30.0) • Lifetime use rises to 28.3% for one of six, 32.1% for one of eight and 46.6% for one of eight or OTC remedy	• Women's use significantly higher than men's (12.5% compared with 8.8%) • Highest amongst 18–44 year-olds and 45–64 year-olds (11% and 12.9% respectively)	• 71% for musculoskeletal problems, 24% for other coded health problems; 5% for general health maintenance	• Aromatherapy and reflexology use different from other therapies, with 39% for stress and/or relaxation and 13% for non-health reasons	• Mean annual expenditure £108 per paying user • Total out of pocket expenditure estimated at £450 million (six therapies) or £580 million (eight therapies)	• NHS provided 10% of contacts • Highest NHS visits for acupuncture (1.02 million), osteopathy (0.45 million) and chiropractic (0.36 million) • 79% paid directly by the patient

Table II.1.4
Utilisation studies of subpopulations in the UK: key findings

Study	Prevalence	Demographic	Other
Brown (1998)	• 35% had used one or more therapy for a problem relating to Parkinson's disease	• Type of therapy used related to severity • Those with no disability utilised yoga and relaxation • Those with severe disability utilised aromatherapy and healing more	• Respondents were asked about benefits of therapy • Most experienced slight or considerable overall benefit, with yoga scoring highest overall • 67% reported extreme or considerable benefit
Cappuccio *et al.* (2001)	• 10.4% of total sample were regular users of alternative medicine • 7.4% were non-prescribed vitamins • Cod liver oil (43%), garlic and or primrose oil (~1%) • Significant difference between ethnic groups in use of alternative medicine, due to difference in use of cod liver oil, garlic and or primrose oil: African origin 8.2% compared with whites 4.8%; Africans three times as likely to use than South Asians	• Women more likely to use than men (13.4% versus 6.6%)	
Chandola *et al.* (1999)	• 28% had used CAM; 38% had considered the use of CAM • Acupuncture, homeopathy, osteopathy and herbal therapy were most popular		• Reasons given were hope for a cure (44%), personal advice (40%), side effects of conventional therapies (30%) and dissatisfaction (27%)
Ernst (1998b)	• 41% had never used CAM for asthma • Most popular therapies were breathing techniques (30%), homeopathy (12%) and herbalism (11%) • Those who rated their asthma as very severe made more use of CAM than those suffering less severely	• No regional variation found and use largely independent of age • Women used CAM more frequently than men • Most obtained information from friends and relatives (27%), media (16%), GP (13%) and National Asthma Campaign (8%), nurses (7%), adverts (5%), hospital (2%) pharmacists (2%) and personal inquiries (2%)	• 32% received treatment from private practitioner • 25% self-care and 14% through NHS • 51% had spent less than £50 on CAM in the preceding year, 9% £51–100 and 8% £101–500 • 31% stated none of the above • Most money spent on acupuncture and osteopathy

(continued)

Table II.1.4
Utilisation studies of subpopulations in the UK: key findings (continued)

Study	Prevalence	Demographic	Other
Greenfield *et al.* (2002)	• 39.3% of respondents said a member of their family used CAM • 37.3% reported use of CAM themselves • The most commonly used of 12 mentioned were aromatherapy (50.7%) and homeopathy (30.3%)	• No significant difference was found between male and female students for all therapies, though women were significantly more likely to use aromatherapy or reflexology	• 41.5% of students reporting CAM use had used self-treatment, 39.6% had consulted a therapist and 18.8% had used both
Leese *et al.* (1997)	• 17% of diabetic patients had used CAM, 4% currently using CAM • Acupuncture, homeopathy and herbal therapy most commonly used		• Cost of up to £459 per annum; mean costs £69 ± 21
Moore *et al.* (2000)	• 48.3% of UK systemic lupus erythematosus patients had used at least one alternative therapy in the past six months (specified list of 16 therapies) • Most commonly used were relaxation techniques (21.3%), massage (19%), herbal medicine (15.2%) and lifestyle diets (12.8%)	• Users were younger, better educated and had a shorter disease duration than non-users	• Cost data were not disaggregated by country
Pal (1998)	• Current prevalence of utilisation was 17.5%, rising to 41.2% for lifetime prevalence • Most commonly utilised homeopathy (14%), herbal medicine (12.3%) and osteopathy (12.3%) • Purchase of OTC remedies was 86% • Cod liver oil (63.3%), evening primrose oil (55.1%) and garlic pearls (11.2%)	• Reason for purchase of OTC remedies was primarily to alleviate complaints connected with rheumatism or sicca symptoms; general health and lethargy also frequently mentioned	• Less than 3% of patients had been referred for CAM • Median expenditure on CAM therapies in the past was £124.50 • Current usage £11.50 per month • For OTC remedies past usage £6.38 per month
Rees *et al.* (2000)	• 22.4% of women diagnosed with breast cancer consulted a practitioner in past 12 months • 31.5% had consulted a practitioner since diagnosis • 15.1% reported use prior to diagnosis • 33.2% had used OTC products (14.7% who had used OTC since diagnosis had not received treatment from practitioner) • Most commonly received therapies were massage/aromatherapy, chiropractic/osteopathy, relaxation/yoga/meditation and spiritual or faith healing		• Mean costs of consultation varied from £3.27 for yoga/meditation (often donations) to £43.50 for nutrition; mean average CAM consultation cost £10.66 • About 9% of consultations were on the NHS; 75% were private or out-of-pocket consultations; only 14 treatments were covered by health insurance

(continued)

Table II.1.4
Utilisation studies of subpopulations in the UK: key findings (continued)

Study	Prevalence	Demographic	Other
Resch *et al.* (1997)	• 32.6% recalled having received treatment from CAM practitioners • 53% listed a non-drug therapy, 15% aromatherapy or herbal drugs, 12% homeopathic and 4% named diets		• 70.9% had paid privately for CAM therapy • For 6.6% the NHS had covered costs in full and for 2.7% in part
Simpson and Roman (2001)	• For 46.5% one or both parents had used CAM • 17.9% (95%, CI 15.7–20.1) had used CAM for child at least once; 8.6% had used CAM for child more than once • Most commonly used were homeopathy, aromatherapy and herbal medicines	• 35.5% of users had visited CAM practitioner • Of the remaining users 50% obtained the CAM from shops, 21% from chemists, 5% from GPs and 24% from other sources (mainly family and friends) • Number of visits varied: 28% one visit, 44% between two and five visits and 26% five or more visits • Reasons given were personal recommendation (59.7%), dissatisfaction with conventional medicine (37.0%), fear of side effects of conventional medicine (31.8%), more personalised attention (13.2%) and child with chronic condition (8.4%)	• The majority of consultations cost less than £20 per visit; only three consultations cost more than £30 per visit • The majority of children treated with CAM had acute conditions • The majority had ENT or dermatology conditions; musculoskeletal, infant, respiratory and emotional/behavioural conditions were also commonly treated with CAM
Skinner and Rangasami (2002)	• 4.8% reported use of herbal medications • Garlic (22.9%), ginseng (18.1%) gingko (16%), St John's wort (14.4%) and echinacea (10.1%) were the most frequently used	• Female patients used herbal medicines more frequently than males	
Vashisht *et al.* (2001)	• 68.5% had used an alternative treatment for relief of menopausal symptoms; 66% of these women were regular users • Mean number of treatments per woman 3.01 ± 2.2 • The most commonly used were vitamins, followed by St John's wort, homeopathy, acupuncture and gingko, spiritual healing and Chinese herbs	• Women younger than the median age were more likely to have used complementary therapies than older women	• For the majority of women the primary source of information about complementary medicines was the media, friends and relatives, with the internet and doctors playing only a minor role • 62% of women who had tried at least one form of CAM were satisfied with the effect it had on their menopausal symptoms

II.2 Demand for and utilisation of CAM

II.2.1 Surveys on utilisation of CAM therapies/services

Estimates of the prevalence of CAM utilisation amongst the general population in the UK range from 10.6 per cent (for use of a limited list of CAM therapies in the past year) to 46.6 per cent (for use of therapy or over-the-counter (OTC) remedy during lifetime) (Thomas *et al.*, 2001a).

The most commonly used therapies and products identified in most of the surveys of both the general population and subpopulations were acupuncture, aromatherapy, chiropractic, herbalism, homeopathy and osteopathy. This is consistent with other research reported by the Research Council for Complementary Medicine, which identified that three quarters of treatments in the UK are accounted for by acupuncture, chiropractic, osteopathy, homeopathy, herbal medicine and hypnotherapy (Goldbeck-Wood, 1996).

There are no surveys in the UK that give a trend over time using a consistent survey instrument. However, the public perception of the trend in CAM use is that it is increasing: 78 per cent of respondents in a BBC poll (Ernst and White, 2000).

II.2.2 Surveys of CAM products

Surveys covering both self-care and care provided by a practitioner found lifetime prevalence rates to be much higher than practitioner-only utilisation: 40–50 per cent compared with 10–30 per cent. The majority of self-care consists of the purchase of herbal remedies, aromatherapy oils or homeopathic medicine over the counter. Thomas *et al.* (2001a) found usage of OTC-purchased homeopathic remedies over the past year to be 8.6 per cent, and OTC-purchased herbal remedies 19.8 per cent.

Surveys that include vitamins and other dietary products are likely to overestimate prevalence rates and not be comparable with other studies of CAM utilisation. The herbal products most commonly utilised are garlic, ginseng, gingko, St John's wort and echinacea (Skinner and Rangasami, 2002; Vashisht *et al.*, 2001).

In addition, estimates suggest that 750,000 consultations a year by doctors in the UK yield a homeopathic prescription (Swayne, 1989). This does not account for the large direct purchase of homeopathic remedies.

II.2.3 Demographics

The majority of the studies showed a higher prevalence of CAM utilisation among women than men and in higher rather than lower socio-economic groups (Ernst and White, 2000; Thomas *et al.*, 1991; Thomas *et al.*, 2001a; Ernst, 1998b; Cappuccio *et al.*, 2001). However, some of this difference is accounted for in the difference in utilisation of health services, particularly general practice, by women.

The age-specific prevalence varied depending on the age categories used in the studies, but overall the picture suggests that usage is currently highest among adults below 65 (Ernst and White, 2000; Thomas *et al.*, 1991; Thomas *et al.*, 2001a). Where more specific data were available, highest utilisation levels were in the 35–44 age group (Thomas *et al.*, 1991). If this is due to a different attitude to complementary therapies among a specific cohort, it could be expected that future prevalence levels will rise in the over-65s.

The specific study of utilisation among children estimated prevalence to be around 17.9 per cent (Simpson and Roman, 2001). A study of prevalence among different ethnic groups found that use of cod liver oil, garlic or primrose oil was 8.2 per cent among people of African origin compared with 4.8 per cent among whites (Cappuccio *et al.*, 2001).

II.2.4 Presenting problem/diagnosis

Thomas *et al.* (1991) found that the majority of people seeking CAM treatment did so to treat musculoskeletal disorders (78 per cent). Thomas *et al.* (2001a) observed similar results, with 71 per cent of respondents with musculoskeletal problems. Using patient-defined disease groups, the most frequently cited problems were neck, back and low back problems (Thomas *et al.*, 1991).

Studies of prevalence amongst specific disease groups showed the following:

- 32.6 per cent of patients with arthritis recalled having been treated by a CAM practitioner (Resch *et al.*, 1997).
- 28 per cent of patients attending a musculoskeletal clinic had used CAM, the most popular treatments being acupuncture, homeopathy, osteopathy and herbal medicine (Chandola *et al.*, 1999).
- 59 per cent of asthma patients recorded some use of CAM (Ernst, 1998b), with those having more severe asthma reporting higher use than those suffering less severely.
- 17 per cent of diabetic patients reported the use of CAM (Leese *et al.*, 1997).
- 22.4 per cent of women diagnosed with breast cancer had consulted a CAM practitioner in the past 12 months, while 33.2 per cent reported using an OTC remedy (Rees *et al.*, 2000).

Overall prevalence levels recorded in a systematic review of CAM use among rheumatology patients (Ernst, 1998a) were high: 60 per cent in Pullar (1982), 68 per cent

in Struthers (1983) and 71 per cent in Dimmock *et al.* (1996). However, these rates may be overestimates, as the figures include utilisation of supplements, including vitamins and diets. The utilisation of CAM practitioners was not identified.

These surveys of particular patient populations do not give an indication of general population prevalence levels. However, they do indicate that the use of CAM therapies by patients in receipt of conventional medicine is significant and should not be ignored by providers of conventional health care.

II.2.5 Reason for use

Most of the surveys showed that personal recommendation remains an important reason for obtaining CAM therapy: this reason was given by 58 per cent of respondents in Emslie *et al.* (1996), 27 per cent of asthma users in Ernst (1998b) and 59.7 per cent among parents surveyed by Simpson and Roman (2001). Referral by a doctor or health professional was the reason given by 28 per cent of respondents in Emslie *et al.* (1996), 11 per cent in Ernst and White (2000) and 24 per cent of asthma patients in Ernst (1998b). Other reasons cited in surveys were that the practitioner was known personally or the user had read about the therapy.

Previous studies have investigated the beliefs and attitudes of CAM users. This was not the focus of this review. However, a number of the reasons for CAM use given in surveys of utilisation do reveal users' beliefs and attitudes. For example, 11 per cent of respondents in Ernst and White (2000) used CAM because they do not believe conventional medicine works. Chandola *et al.* (1999) found that 30 per cent of people using CAM in musculoskeletal clinics said they did so because of the side effects of conventional therapies.

II.2.6 Reported out-of-pocket expenditure

According to the survey by Emslie *et al.* (1996), 21 per cent of respondents had received treatment free of charge. The majority of respondents who had paid for care thought it reasonably priced or good value for money (65 per cent). Ernst and White (2000) found that the average CAM user spends £13.62 per month on treatment. However, 37 per cent spend less than £5 per month. For the six established therapies included in Thomas *et al.'s* (2001a) study (acupuncture, chiropractic, homeopathy, hypnotherapy, herbalism and osteopathy) the total estimated out-of-pocket expenditure was £450 million in England in 1998.

In Ernst's (1998b) study of CAM use by asthma patients 51 per cent had spent less than £50 on CAM in the preceding year, 9 per cent had spent £51–100 and 8 per cent over £100. Rees *et al.*'s (2000) study of CAM use by women diagnosed with breast cancer found the mean average CAM consultation cost £10.66. One survey in the systematic review of rheumatology (Ernst, 1998a) recorded expenditure data: average expenditure on CAM

Table II.2.1
Treatment costs of therapies in the UK (£), 2000

Therapy	Treatment cost, first	Subsequent
Aromatherapy	21–50	21–40
Reflexology	11–30	11–30
Bowen technique	21–30	21–30
Massage	11–50	11–50
Chiropractic	31–50	21–50
Yoga	5–40	5–20
Hypnotherapy	31–50	31–50
Reiki	11–50	11–40
Magnetic therapy	<10–40	<10–40
Bach flower	<10–20	<10–20
Nutrition	21–>60	11–40
Homeopathy	31–>60	10–50

Source: Long *et al.* (2001)

was £1,240 per year (Pullar, 1982). Simpson and Roman (2001) found that the majority of consultations for children were less than £20 per visit.

A survey of CAM organisations (Long *et al.*, 2001) also elicited information about the cost of therapy. This distinguished between the cost of the first consultation, usually longer due to the need to establish case history and diagnostics, and any subsequent consultation. The results are presented in Table II.2.1.

II.2.7 Providers

Surveys of the general population indicate that the majority of CAM treatments are provided by complementary therapists (62 per cent according to Emslie *et al.*, 1996). Other health professionals provided only 20 per cent of treatments, and 18 per cent of treatments were other forms of therapy including self-care. In a survey of asthma patients 14 per cent had received therapy through the NHS and 25 per cent were self-care (Ernst, 1998b).

The majority of referrals for CAM services outside the primary care setting was to anther NHS hospital (40.1 per cent) or to a NHS homeopathic hospital (30.4 per cent). Only 17.6 per cent were to private clinics (Thomas *et al.*, 1995).

II.3 CAM providers

A number of surveys have attempted to estimate the number of providers of CAM services in the UK. These broadly distinguish between non-medical and medical practitioners of CAM therapies. Non-medical practitioners may be other health care professionals such as physiotherapists or nurses providing CAM, or they may be registered CAM practitioners.

II.3.1 Physicians

Most studies of CAM provision by medical practitioners have been of general practitioners (GPs). Approximately 40 per cent of UK GPs are now involved in the provision of CAM in the context of their own general practices (Thomas *et al.*, 2001b). In a comparative study of German and UK GPs (Schmidt *et al.*, 2002) 30 per cent of UK GPs reported self-practice of CAM therapies, the most common being chiropractic (12 per cent), acupuncture (8 per cent) and homeopathy (8 per cent). High levels of referrals were also indicated, with the most common referral to chiropractic (79 per cent), acupuncture (67 per cent) and osteopathy (66 per cent).

Lewith *et al.* (2001) conducted a survey of hospital physicians in the UK. 41 per cent of respondents referred patients to CAM. The majority of referring physicians (57 per cent) referred 0–1 patients per month, while 21 per cent referred 1–3 patients per month. Acupuncture was most commonly provided within the NHS (6 per cent referring within their own team and 11 per cent within a local health care organisation). Referral to external providers was most common for osteopathy, chiropractic and acupuncture. The actual provision of CAM therapy directly by hospital physicians was relatively small, with 4.3 per cent practising acupuncture, 2.9 per cent osteopathy and 2.1 per cent hypnotherapy.

Lewith *et al.* (2001) also include a review of nine studies of CAM provision by doctors in the UK. The studies found that 13–38 per cent of GPs were using CAM on their own patients. In one study (Perkin *et al.*, 1994) as many as 93 per cent of GPs were referring patients for CAM, though the majority of studies found that 70–80 per cent of GPs were making referrals to CAM therapy. These studies only identified direct use of CAM among 5–12 per cent of hospital consultants.

II.3.2 Other health care professionals

Among other health care professionals recorded as practising CAM activity levels are high among nurses, midwives and physiotherapists. An in-depth study by the NHS Confederation into CAM provision in one health authority in 1996 (Trevelyan, 1998) found that 34 per cent of midwives and 18 per cent of nurses were involved in providing

CAM services. The most extensively used therapies were aromatherapy and acupuncture, practised by midwives and physiotherapists respectively.

According to Mills and Budd (2000) the Royal College of Nursing Complementary Therapy Forum had 10,000 members in 2000. This gives an indication of the level of active interest in CAM among nurses in the UK. Including doctors and other statutorily registered health professionals (e.g. nurses, midwives, physiotherapists) it is estimated that 20,000 practise some form of complementary medicine (Mills and Budd, 2000).

II.3.3 Registered CAM practitioners

Davies (1984) carried out a major study of non-medical practitioners. Although somewhat dated, this information provides an interesting baseline for viewing more recent developments in the number of CAM providers. The study identified therapists from ten registers covering six therapies (acupuncture, chiropractic, homeopathy, medical herbalism, naturopathy and osteopathy) and approached 1,080 practitioners, with a response rate of 40 per cent.

The majority of providers were in the home counties and the Midlands, with Northern Ireland, Wales, Scotland and East Anglia having the fewest. However, these crude numbers are not related to population density, so it is not possible to compare the population ratio of CAM practitioners. Indeed the figures appear to reflect population concentrations.

In a more recent survey of professional organisations Mills and Budd (2000) acknowledge that estimates of the number of practitioners are problematic as membership of more than one association is not uncommon and several associations have more formal overlap of membership. However, with adjustments to take account of this, they estimate that 49,000 individuals mainly practised CAM in the UK in 1999. This followed a smaller-scale survey in 1997, which estimated that there were 40,000 practitioners (Mills and Peacock, 1997). Growth rates were calculated for individual therapies where data were available for both years. This reveals the highest increases in the less well-established therapies such as Ayurveda (+100 per cent) and crystal healing (+109 per cent), while other therapies such as aromatherapy experienced less rapid growth (+6 per cent). However, acupuncture (+36 per cent), chiropractic (+36 per cent), homeopathy (+38 per cent) and osteopathy (+37 per cent) saw steady growth over the period.

II.3.4 Non-registered CAM providers (private market)

There are almost no data on the use of non-registered CAM practitioners in the UK. These are practitioners who are working either on a paid or voluntary basis with or without training but are not registered with either a statutory or voluntary professional body. By their nature these providers are hard to identify in surveys of practitioners. Some of the utilisation studies asked from whom respondents had received care and thus act as a

proxy for the number of practitioners delivering CAM therapies in total. However, they do not distinguish between whether practitioners are registered or not.

II.3.5 Employment and working conditions

Davies (1984), discussed above, also included data on the number of specialties practised. Of the 411 practitioners practising a main therapy, 212 also practised a second therapy and 104 a third. Half the respondents in the 1983 survey of registered practitioners were working with two or more fellow practitioners in either the same field or in different fields. In Davies' sample 9 per cent worked with a medical doctor; 73 per cent worked full-time and 27 per cent part-time. The highest levels of full-time practice were among chiropractors and osteopaths: 88 per cent and 86 per cent respectively. The lowest levels of full-time working were among acupuncturists and homeopaths. No data on the income of CAM therapists were identified in the literature search.

II.4 CAM services

There is no list of CAM services that are covered by the NHS in the UK. In this sense CAM services are not explicitly excluded, but neither is there a requirement to fund them. In fact, the majority of consultations are in the private sector, with NHS-funded consultations accounting for less than 10 per cent of all CAM consultations (Thomas *et al.*, 2001a).

The purchasers of health care have some discretion over what services to buy and from whom, but their confidence for funding CAM is highly dependent on the availability of information. In a survey of health care purchasers (van Haselen and Fisher, 1999) evidence about effectiveness from clinical trials was rated to be most important, followed by safety data and economic evaluations.

During the 1990s and early 2000s the UK has seen significant health care reform, with the purchaser role first split between GP fundholders and health authorities then shifted to newly created primary care groups/primary care trusts (PCGs/PCTs). Thus there is a lot of variation over time and between areas, both in the models of provision and the sources of funding.

In their qualitative research of ten case studies of primary care provision of CAM therapies Luff and Thomas (1999, 2000) identified a number of models of CAM provision, including:

- Sessional complementary therapies in-house
- Provision by GPs
- Referrals to a local independent complementary therapy clinic (funded)
- Referrals to a local independent complementary therapy clinic (non-funded)
- Complementary therapists in an adjacent complementary health centre.

The sources of funding for these services also varied and included:

- Fundholding budgets
- Registered charity
- Charitable trust
- Fee for service (out of pocket)
- Health authority.

II.4.1. Health authorities

In 1993 the National Association of Health Authorities (NAHAT), now the NHS Confederation, conducted a national survey of district health authorities, family health service authorities and GP fundholders to find out their approach to purchasing CAM therapies. This estimated that approximately £1 million per year was being spent by

health authorities (Trevelyan and Booth, 1994). Compared with the figures calculated by Thomas *et al.* (2001a) for out-of-pocket expenditure (£45 million in England), this appears to be a gross underestimate if one accepts data that about 10 per cent of CAM consultations take place within the NHS. Following this report the NHS Confederation commissioned a more in-depth study of Leicestershire health authority. This found that activity was taking place in a range of NHS settings, including primary care, hospitals, hospices and community settings (including domiciliary care).

In 1994 Adams carried out a survey of 171 health authority public health directors (response rate 57 per cent) to establish whether the health authority had a formal policy on complementary therapies and purchasing trends. The study (Adams, 1995) found 67 per cent to be purchasing one or more CAM treatments, the most common being homeopathy and acupuncture followed by osteopathy, aromatherapy and chiropractic. Only ten health authorities had an established policy on complementary therapies, with a further ten in the process of developing a policy. Of those with no policy three had agreed to purchase only therapies considered well established and three had decided not to purchase services at all. Nearly 40 per cent reported that the health authority had developed closer links with CAM therapies over the previous two years (Adams, 1995).

II.4.2 General practice fundholding

Thomas *et al.* (1995) estimate that 39.5 per cent of GP partnerships in England provide access to complementary therapies for NHS patients. 21.4 per cent of practices do so by providing CAM services through a member of the primary care team, while 24.6 per cent of practices make NHS-funded referrals. The presence of an independent therapist in the practice is relatively rare (only 6.1 per cent).

Fundholding practices were significantly more likely to offer CAM services than non-fundholding practices, and single-handed practices were significantly less likely to offer CAM services than larger practices.

Acupuncture (33.6 per cent) and homeopathy (28.8 per cent) were the most commonly provided CAM services. Osteopathy was the most commonly provided treatment by an independent practitioner (27.3 per cent), whereas acupuncture and homeopathy were more commonly provided either by a member of the primary care team or through NHS referral. Most of the treatments provided by a member of the primary care team were provided by the GP (64 per cent).

Fundholders were able to use the staff element of their budgets and ‘practice savings’ for employing complementary therapies. Non-fundholders could use ancillary staff budgets for the same purpose. This rendered it difficult to quantify the amount actually spent on CAM therapies in the primary care sector in the UK.

II.4.3 Primary care groups/primary care trusts

Bonnet (2000) carried out a survey of PCGs in 2000 (60 per cent response rate) and found that in 58 per cent of PCGs CAM was provided via primary care. The most commonly provided therapies were acupuncture (73 per cent), osteopathy (43 per cent), homeopathy (38 per cent), chiropractic (23 per cent) and aromatherapy (18 per cent). In a survey of primary care organisations in the London region 66 per cent reported that CAM services were being accessed via primary care (Wilkinson *et al.*, 2002). This gives a fairly consistent picture of the level of provision of services in UK via primary care organisations.

II.4.4 Inpatient services

The majority of CAM services are provided/funded by the NHS through primary care or independent clinics in the community. In addition, CAM services are used in secondary and tertiary care. Lewith (2000) identified two types of inpatient CAM services: monotherapeutic services such as the Royal London Homeopathic Hospital and integrated hospital-based care such as in palliative care.

Homeopathic hospitals were incorporated into the NHS at its establishment. Currently the UK has five homeopathic hospitals providing homeopathic treatment within the NHS. In addition, complementary therapies such as aromatherapy and massage are provided to some inpatients within other NHS hospitals. Some private hospitals may offer complementary therapies as an additional incentive to attract patients.

II.5 CAM products

II.5.1 Over-the-counter medication

The main categories of CAM products sold in the UK are:

- Homeopathic remedies
- Herbal medicines
- Aromatherapy oils.

Due to their health-enhancing effects vitamin and dietary supplements are also sometimes considered part of the CAM market, but they are not included in this study.

Market reports in the UK show that herbal products dominate the CAM product market: in 2000 they accounted for 49 per cent of the market compared with aromatherapy products (42 per cent) and homeopathic products (only 9 per cent) – see Table II.5.1). However, between 1996 and 2000 aromatherapy products saw the highest growth (+75 per cent). Homeopathic product markets have grown steadily at around 10 per cent each year.

CAM products are estimated to account for approx. 22–23 per cent of the total CAM market (Market Assessment International, 1999; Key Note Market Assessment, 2001). However, twice as many people use products (68 per cent of users) than services (32 per cent of users).

Compared with Germany (36 per cent), France (33 per cent), the Netherlands (8 per cent) and Belgium (6 per cent), the UK market in homeopathic products is the smallest, representing only 2 per cent of the European total in 1995. But it has seen the strongest growth in the homeopathic market within Europe (with annual growth of between 7 and 23 per cent from 1990 to 1995 compared with growth rates of less than 10 per cent elsewhere in Europe). The main UK companies are Weleda (UK) Limited, A. Nelson & Co. Limited and Boots the Chemist.

II.5.2 CAM products paid for by the NHS

Homeopathic products are available on FP10 prescriptions and will be funded by the NHS. However, they are also available over the counter. The majority of CAM products are not available under the NHS.

Table II.5.1
UK CAM market 1996–2000 value (£ million) and percentage change

	1996 £	1997 £	1996–97 % change	1998 £	1997–98 % change	1999 £	1998–99 % change	2000 £	2000 % total CAM market	1999–2000 % change	1996–2000 % change
Herbal products	43.4	49.1	13.1	56.0	14.0	63.8	13.9	72.7	11	15.9	67.5
Homeopathic remedies/products	8.1	8.9	9.9	9.8	10.1	11.0	12.2	12.4	2	12.7	53.1
Aromatherapy products	36.0	41.5	15.3	47.7	15.0	54.8	14.9	63.0	10	15.0	75.0
Total retail	**87.5**	**99.5**	**13.1**	**113.5**	**14.1**	**129.6**	**14.2**	**148.1**	**23**	**14.3**	**69.3**
Herbalist services	10.8	13.5	25.0	17.4	29.0	22.8	31.0	29.6	5	29.8	174
Homeopath services	6.9	7.9	14.5	8.8	11.4	9.8	11.4	10.9	2	11.2	58.0
Osteopath services	99.4	108.0	8.7	117.7	9.0	128.3	9.0	141.1	22	10.0	42.0
Acupuncture services	43.1	46.2	7.2	49.9	8.0	54.9	10.0	60.4	9	10.0	40.1
Chiropractic services	32.7	36.1	10.4	39.7	10.0	43.7	10.0	48.1	8	10.0	47.1
Reflexology	47.2	50.8	7.6	55.6	9.4	61.7	11.0	68.5	11	11.0	45.1
Alexander technique services	2.6	2.8	7.7	3.1	10.7	3.4	9.7	3.4	1	8.8	30.8
Other services	19.2	22.2	15.6	25.5	14.9	29.3	14.9	33.7	5	15.0	75.5
Total services	**321.1**	**353.9**	**10.2**	**392.7**	**11.0**	**438.6**	**11.7**	**491.7**	**77**	**12.1**	**53.1**
Total CAM	**408.6**	**453.4**	**11.0**	**506.2**	**+11.6**	**568.2**	**12.2**	**639.8**	**100**	**+12.6**	**56.6**

Source: Market Assessment International (2000)

II.5.3 Retailers

In the UK the main retail outlets for CAM therapeutic products are chemists and health food shops. The major retailers are:

- Boots the Chemist – 1,167 stores nationwide
- Holland & Barrett – 331 shops nationwide (owned by Lloyds Chemists plc, the second largest pharmaceutical and healthcare retailer in the UK).

CAM products are increasingly sold in community pharmacies and supermarkets.

There is also a growing mail order market, but this remains smaller than retail and usually operates on a global basis. The European Scientific Co-operative on Phytotherapy is concerned that many unlicensed herbal medicines are becoming increasingly available in the UK through mail order and the internet (Key Note Market Assessment, 2001).

II.6 Service-provider-finance matrix

Table II.6.1
Combination of funding source and provider of CAM therapy in the UK

	Medically qualified	Other health care professional	Registered CAM	Non-registered CAM
NHS	• GPs providing CAM therapy (widespread) • Hospital consultant providing CAM therapy (rare except homeopathic hospitals)	• Nurses, midwives and physiotherapists providing CAM therapies	• Funded referral from GP/hospital doctor	• Rarely available due to lack of assurance for referring doctor
Private out of pocket	• Private practice	• Private practice	• Direct access • Unfunded referral from GP/ hospital doctor	• Direct access
Private health insurance	• Private practice (reimbursed) • Private inpatient hospital setting	• Private practice (reimbursed)	• Private practice (reimbursed)	• Rarely available due to reluctance of private health insurance to reimburse non-registered providers
Charitable/ voluntary	• Hospice services • Charitable funds for direct GP provision of CAM	• Hospice services • Charitable funds for direct primary care provision of CAM	• Charitable funds to pay for sessional services	• Personal contact/ amateur

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PART III

Supply of and demand for complementary and alternative medicine in Germany: a country report

Susanne Weinbrenner, Annette Riesberg and Reinhard Busse

III.1 Methodology

For the German country report the online database of the US National Library of Medicine, Pubmed, was searched using the same strategy as for the UK report. No limits were set with respect to time period or language. The search for [complementary therapies] AND utili* AND German* resulted in 17 hits. The Pubmed search was also extended to cover other search terms on an exploratory basis (hits in brackets), e.g.:

- CAM practitioner (17)
- [complementary therapies] AND provider* AND German* (10)
- [complementary therapies] AND product* AND German* (66)
- [complementary therapies] AND service* AND German* (33)
- [complementary therapies] AND reimbursement* AND German* (13).

Using the abstracts as a guide, publications to be used for this report were chosen according to the following criteria:

- Empirical study on the provision of CAM, utilisation of CAM providers, CAM products or CAM services
- International comparison that includes empirical information on Germany
- Studies carried out on a representative or random sample of the German population.

With respect to the common search strategy, all but one article identified for Germany were concerned either with studies on rather small subgroups of patients or they dealt with clinical, regulatory or conceptual matters. The article reporting on a representative sample dealt with a survey of qualifications, knowledge and provision of CAM services by all active physicians in a West German federal state (Haltenhof *et al.*, 1995). Results of empirical studies on subpopulations are not presented in this country report. Readers are referred to the UK report for a summary of the findings on utilisation.

The German report therefore focuses mostly on publications of public institutions, public statistics as well as relevant monographs, including:

- A review of CAM utilisation and demand in Germany, commissioned by the federal Robert Koch Institute and published in September 2002 (Marstedt and Möbius, 2002), which summarises important publications and grey sources
- The first review of CAM in Germany undertaken by Matthiesen *et al.* (1992) at the start of a major research funding project, commissioned by the federal Ministry of Research and Education and focusing mainly on systematic, clinical and research capacity aspects
- The new federal health personnel account (Statistisches Bundesamt, 2002) and the online system of the federal health report, which contains a broad variety of public statistics including sickness funds (e.g. Wissenschaftliches Institut der Ortskrankenkassen (WidO), 2002)

- Surveys and statistics from sickness funds and associations representing the pharmaceutical industry (e.g. Bundesverband der Arzneimittelhersteller, Bundesverband der pharmazeutischen Industrie)
- Websites of offices, research institutions and project organisations relevant for the research and a database on current research projects (Deutsches Institut für Medizinische Dokumentation und Information (DIMDI), Projektdatenbank), which were searched for current projects or recently published information.

Further studies and publications were also identified from the bibliography of books, articles or from authors' files. In addition, professional bodies of health care professions likely to practise CAM were approached via e-mail to provide further information on CAM provision by their members, e.g. professional bodies of medical doctors, midwives, physiotherapists, *Heilpraktiker*, dieticians and pharmacists.

III.2 Demand for and utilisation of CAM

This chapter provides information on the utilisation of and demand for CAM as reported by the general population in Germany. Representative data on the utilisation of CAM are scarce. Utilisation information is even difficult to obtain for the German health care system generally: for example, there is no standardised procedure to count the contacts between physicians and patients in the ambulatory sector.

III.2.1 Utilisation of CAM providers and services

From October 1997 to April 1999 the federal Robert Koch Institute assessed utilisation of and satisfaction with medical services during the preceding 12 months as part of the federal health survey (Bergmann and Kamtsiuris, 1999) – see Figure III.2.1. The representative survey of persons aged 18 to 80 years allows a comparison to be made between the utilisation of CAM specialists and medical doctors of other specialities (shown on the x-axis). About 7 per cent of the representative population sample had visited at least one of the three CAM specialists during the previous year. 2.8 per cent of all respondents reported that they had visited a physician with an additional qualification in naturopathy at least once during the preceding 12 months (one-year prevalence). Another 2.8 per cent had seen a physician with an additional qualification in homeopathy. In addition, 3.6 per cent of respondents had seen a *Heilpraktiker* (state-registered

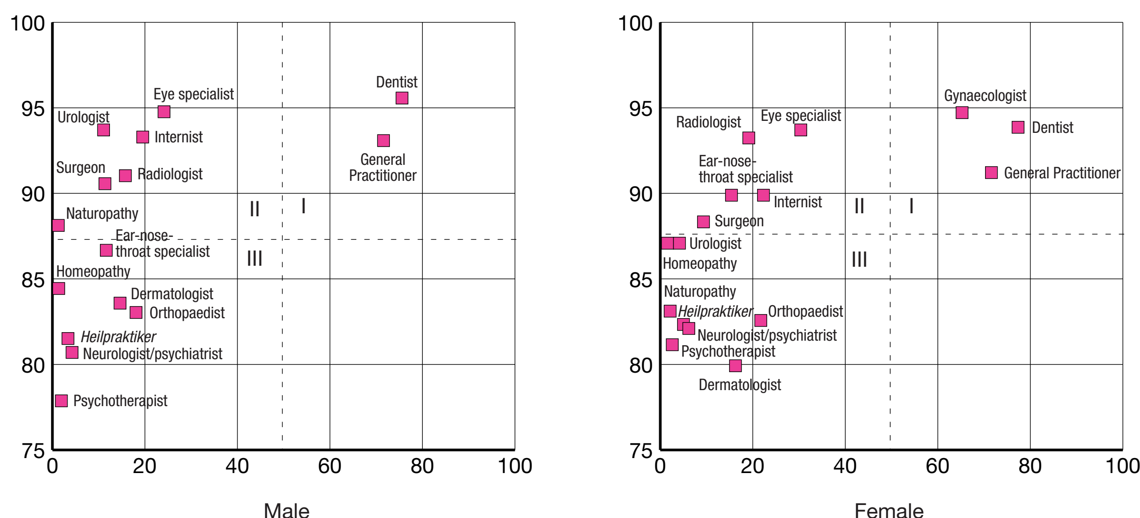

Figure III.2.1
One-year prevalence* (%) of utilisation of CAM specialists and physicians (x) in correlation to satisfaction with providers (y)

Note: * Based on the representative population sample (n = 7,124) for the federal health survey during the period October 1997 to April 1998.
Source: Bergmann and Kamtsiuris (1999)

Table III.2.1
Lifetime prevalence of utilisation of CAM or CAM practitioners*

Type of CAM	Lifetime prevalence (%)	Surveys
CAM practitioners	34	Marstedt *et al.* (1993)*
(physicians, *Heilpraktiker*, homeopaths)	10	IKK (1994)**
Alternative medicine/alternative procedures	41	Marstedt *et al.* (1993)*
	26	GfK (2001)***
	36	TKK (2001)**
'Naturopathy' generally	50	Berliner Morgenpost (2001)*
Acupuncture	15	GfK (2001)***
	12	TKK (2001)**
	29	Berliner Morgenpost (2001)*

* Surveys representative to the German population >16 years, as quoted by Marstedt and Möbius (2002)
** Surveys are representative for members (>18 years) of the respective statutory sickness funds at federal level (IKK: guild sickness funds, TKK: technicians sickness funds)
*** The survey is representative for the German population >14 years

Source: Marstedt and Möbius (2002); IKK (1994); GfK (2001); TKK (2001)

non-physician CAM practitioner, see Section III.3.3). Thus a total of 9.2 per cent of respondents had seen one of these three CAM providers. Figure III.2.1 shows that men visited CAM specialists less often than women. By contrast, 72 per cent of women and 71 per cent of men had seen a general practitioner. Altogether 78 per cent of Germans had seen a dentist and 90 per cent of Germans had seen any physician in the preceding year.

The data of this survey may overestimate the actual one-year prevalence of visits at these CAM providers since some of the respondents visiting CAM practitioners may have visited more than one type of CAM provider. On the other hand this survey may underestimate the number of visits since respondents were asked about three types of CAM providers only (see Section III.3). The frequency of visits among CAM provider users is not indicated in this retrospective survey.

Patient satisfaction (plotted on the y-axis) with CAM specialists was high but clearly lower than satisfaction with physicians of many other specialities, mainly those that were consulted more frequently, e.g. dentists and general practitioners.[5]

Marstedt and Möbius (2002) summarised the results of a number of surveys of CAM utilisation (Table III.2.1). The results of the various surveys differ substantially: for example, the lifetime prevalence of utilisation of acupuncture ranged between 12 per cent and 29 per cent. The share of the population that had ever visited CAM practitioners also ranged from 10 per cent to 34 per cent in the early 1990s (Marstedt *et al.,* 1993;

[5] The figures can only be estimated. Three fields were identified: I – high utilisation (>50 per cent) and high satisfaction (>87.5per cent), II – low utilisation (<50 per cent) and high satisfaction (>87.5 per cent), III – low utilisation (50 per cent) and relatively low satisfaction (<87.5 per cent). For women orthopaedic specialists, physicians specialised in homeopathy or naturopathy as well as *Heilpraktiker* are positioned in field III, which means that women use these consultants infrequently (<50 per cent) but are also less satisfied (<87.5 per cent). There is higher satisfaction among men with physicians specialised in naturopathy (field II).

Bundesverband der Innungskrankenkassen (IKK), 1994). In addition, the IKK survey reported that 4 per cent of the population had visited a CAM practitioner during the previous year (IKK, 1994). Such substantial differences may be due to differences in the samples, methods and definitions used, e.g. a clear formulation of the time frame in question or the understanding of the terms ‘alternative’ or ‘complementary medicine’.

In a recent representative survey of general attitudes towards health and health care (Marstedt, 2002) about one third of respondents had never been exposed to CAM while two thirds reported having experienced CAM at some time in their life (Marstedt, 2002). Twenty-four per cent of the sample interviewed had only experienced natural remedies or classical naturopathic methods such as Kneipp therapies or saline inhalation in their lifetime, while 45 per cent had also been in contact with other CAM methods, including homeopathy, relaxation techniques, Chinese medicine, reflexology, chiropractic, Bach flower or aromatherapy, anthroposophic medicine and other therapies. During the preceding 12 months half of the population had not been in contact with CAM, a quarter had experienced natural remedies or classical naturopathy and another quarter had been exposed to other forms of therapies.

Another opinion poll, performed by the Institut für Demoskopie Allensbach (2001) and commissioned by the non-profit Identity Foundation, assessed health-related behaviour and attitudes in the German population. One question to a representative sample of over-16s concerned the lifetime prevalence of utilisation of CAM therapies. Up to 50 per cent of the population had used CAM therapies, e.g. naturopathy (48 per cent), physiotherapy (including movement therapy and physical therapies) (38 per cent), acupuncture (25 per cent) and holistic medicine (23 per cent) – see Figure III.2.2. Respondents were also using procedures or therapies from the CAM sector to improve their well-being, e.g. massage (9 per cent), so called body–mind techniques for relaxing (7 per cent), autogenic training (25 per cent) and food supplements such as minerals and vitamins (20 per cent).

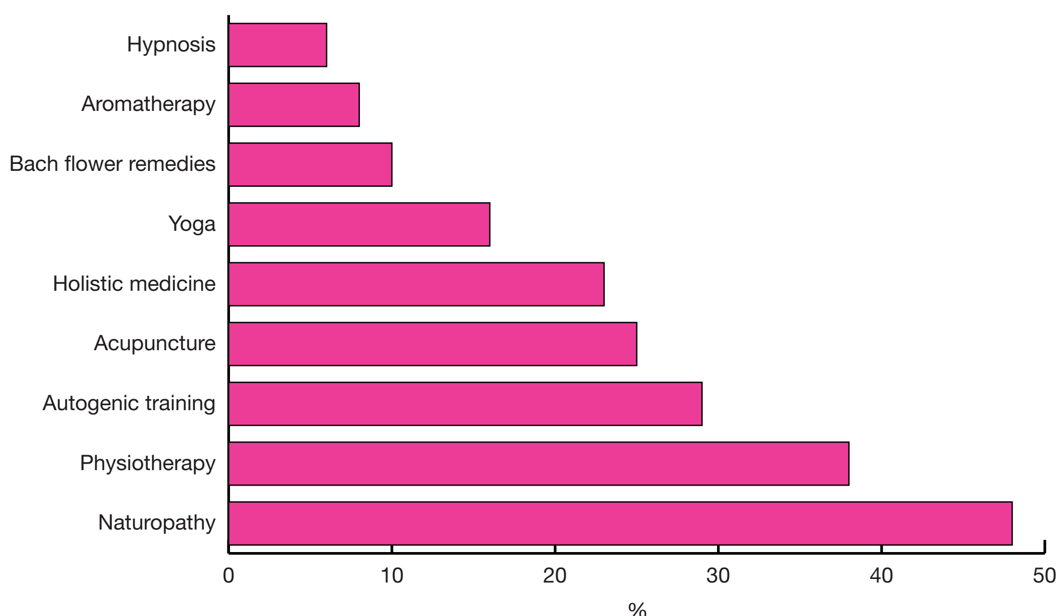

Figure III.2.2
Lifetime prevalence for selected therapies in Germany, 2000

Source: Institut für Demoskopie Allensbach (2001)

III.2.2 Utilisation of CAM products

According to a survey undertaken by the Institut für Demoskopie Allensbach (2002), the utilisation of 'natural remedies' increased in West Germany over the past three decades (Table III.2.2): one-year prevalence increased from 30 per cent to 56 per cent and lifetime prevalence from 52 per cent to 73 per cent.

Lifetime prevalence in East Germany rose from 61 per cent to 64 per cent, whereas in West Germany it rose from a higher level of 65 per cent to 73 per cent.

In Germany overall lifetime prevalence rose from 64 per cent in 1997 to 71 per cent in 2002 (see Table III.2.3).

As shown in Figure III.2.3, the numbers of CAM users in Germany have been increasing over time, especially younger users (up to 44 years), females and employees. The influence of gender on the use of CAM therapies as identified by the international literature is also evident in Germany. The difference between female and male users increased between 1970 (55 per cent vs. 49 per cent) and 1997 (74 per cent vs. 55 per cent) but slightly decreased between 1997 and 2002 (79 per cent vs. 66 per cent). In 1997 there were nearly

Table III.2.2
Trends in prevalence of 'natural remedies' use in West Germany, 1970–2002

% of population reporting use of natural remedies	1970	1980	1989	1997	2002
In the past 3 months	14	20	25	28	35
In the past 6 months	22	27	35	41	46
In the past 12 months (one-year prevalence)	30	33	44	52	56
Ever in their life (lifetime prevalence)	52	51	58	65	73

Notes:
The term 'natural remedies' relates to synthetic as well as natural medicinal products but may also include medical aids. Since 1989 the studies have been commissioned jointly by the German Society of Phytotherapy and the Federal Association of Pharmaceutical Manufacturers (Bundesverband der Arzneimittelhersteller, BAH).

Source: Institut für Demoskopie Allensbach (2002)

Table III.2.3
Prevalence of 'natural remedies' use in East and West Germany

% of population reporting use of natural remedies	East		West		Germany	
	1997	2002	1997	2002	1997	2002
In the past 3 months	29	29	28	34	28	35
In the past 6 months	40	41	40	45	41	46
In the past 12 months (one-year prevalence)	50	54	51	56	52	56
Ever in their life (lifetime prevalence)	61	64	65	73	64	71

Source: Institut für Demoskopie Allensbach (2002)

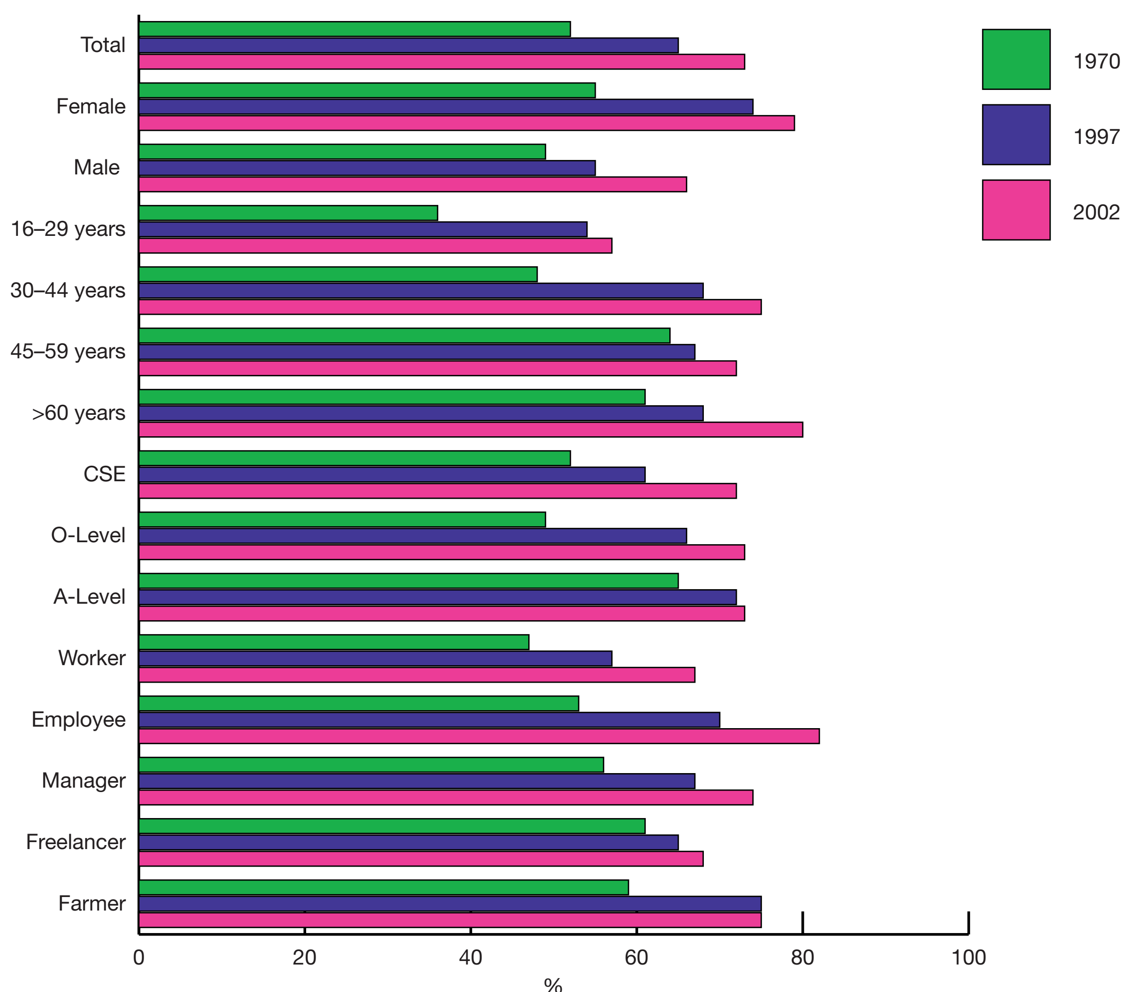

Figure III.2.3
Influence of socio-demographic factors on lifetime prevalence of reported usage of natural remedies, 1970–2002

Note: CSE = Hauptschulabschluss, O-Level = Mittlere Reife, A-Level = Abitur
Source: Institut für Demoskopie Allensbach (2002)

no differences between age groups (67–68 per cent), but in 2002 usage was highest among over-60s. The most remarkable increase was in the 16–29 and 30–44 age groups (58 per cent and 56 per cent respectively).

In the 1970s there was a remarkable difference in utilisation rates between the different educational levels (52 per cent among those with lowest qualifications, 49 per cent among those with average qualifications and 65 per cent among those with post-16 qualifications). This difference is now quite small (72 per cent, 73 per cent and 73 per cent respectively). Nevertheless there is still a difference between the professions: workers: 67 per cent, employees: 82 per cent, managers: 74 per cent, freelancers: 68 per cent and farmers: 75 per cent. Employees use natural remedies more often than the other professions and saw the highest increase between 1970 and 2002.

This data suggest a trend towards use of natural remedies in a broader population, as well as convergence in utilisation rates between age, gender and social groups.

III.2.3 Reasons for use

A number of studies have investigated the reasons why people use CAM. Studies on attitudes towards CAM and reasons for use conducted in the 1980s and 1990s (Andritzky, 1997) showed that CAM is mainly used as a complement to conventional medicine. The number of people taking natural remedies to prevent illnesses (from all users of preventive medications) hardly changed between 1989 (38 per cent) and 2002 (41 per cent) (Institut für Demoskopie Allensbach, 2002). Natural remedies are mostly used for minor ailments such as colds, headaches, sleeplessness, nervousness, fatigue, circulatory disturbance etc. They are mainly taken in combination with other drugs, e.g. in case of moderate illness. 62 per cent of respondents would take natural remedies in addition to conventional drugs, but only 4 per cent would rely exclusively on natural remedies (Institut für Demoskopie Allensbach, 2002). One potential reason for the use of natural remedies may be that the population is afraid of the adverse side effects of conventional drugs. According to the Allensbach surveys these effects are considered to be in the range of 6.7 on a scale from 0 to 10 for conventional drugs compared with 2.3 for natural remedies.

III.2.4 Reported out-of-pocket expenditure

According to the Allensbach survey (2002) the number of respondents who paid out of pocket for natural remedies rose from 56 per cent to 60 per cent between 1997 and 2002, but the period in which the drugs are bought is not clearly specified.

The Gesundheitsmonitor 2002 (Marstedt, 2002) showed that 43 per cent of CAM users had received a prescription for a CAM therapy which was reimbursable by health insurance funds, while 57 per cent of users had only paid out of pocket.

Another survey shows that therapies such as homeopathy, acupuncture, Kneipp therapy, reflexology and Bach flower remedies (most frequently cited) were paid out of pocket in 54 per cent of cases, partly paid by the insurance company in 23 per cent of cases and fully reimbursed in 21 per cent of cases. Bach flower remedies and homeopathy were paid out of pocket more often than average. By contrast, acupuncture, lymph drainage and cleansing therapies were more frequently funded or co-financed (anonymous, 2002).

III.3 CAM providers

For the purposes of this project CAM providers have been divided into physicians, other health care professionals, registered CAM practitioners and non-registered CAM providers. All may practise CAM with or without a formal qualification in CAM. The additional role of qualifications in physical medicine that may overlap with some CAM qualifications is highlighted for physicians and may also be applicable to other health care professions.

III.3.1 Physicians

III.3.1.1 CAM qualifications among physicians

Once they are specialised, medical doctors in Germany can obtain a variety of additional qualifications (*Zusatzbezeichnungen*) relating to specific CAM methods (e.g. homeopathy or chiropractic) or to a broader field of naturopathy. In this country report these three extra qualifications are classified as specific CAM qualifications for physicians, as distinct from a group of three qualifications in physical medicine: 'physical therapy' and 'balneology and medical climatotherapy' (considered additional CAM qualifications by Matthiesen *et al.* (1992) and Marstedt and Möbius (2002)) and 'physical and rehabilitation medicine', which since 1993 has replaced the specialisation of 'physiotherapy' which medical doctors could obtain in the former German Democratic Republic. In order to pass the specialist examination for physical and rehabilitative medicine, physicians have to prove knowledge and skills in manipulative therapy and the broader field of classical naturopathy (nutrition, phytotherapy and regulation therapy).

The three qualifications in physical medicine are included below to reflect the importance given to naturopathy in physical therapy in Germany. The separate presentation of qualifications in CAM and physical medicine is intended to facilitate comparison with CAM qualifications in the UK.

Table III.3.1 shows that in 2001 the German federal medical chamber documented 27,171 specific CAM qualifications among active physicians. This could mean that up to 9.1 per cent of all working physicians hold an extra qualification in CAM. In addition, 8,144 qualifications in the field of physical medicine were recorded, accounting for a maximum of 2.7 per cent of all working physicians. However, the number of physicians actually active in CAM is not necessarily the same as the number of CAM qualifications, as it is possible to hold more than one of these qualifications.

Table III.3.2 shows trends in different qualifications for CAM and physical medicine during the past decade. While the total number of physicians has increased by only 15 per cent since 1993, the number of CAM qualifications increased by about 125 per cent and the number of qualifications in physical medicine by about 110 per cent.

Table III.3.1
Qualifications in CAM and physical medicine among active physicians, 2001

Type of qualification	Qualifications		
	Total number	**As percentage of active physicians**	**Per 100,000 population**
Chiropractic*	12,519	4.2	15.2
Homeopathy*	4,285	1.4	5.2
Naturopathy*	10,367	3.5	12.6
Total CAM qualifications	**27,171**	**9.1**	**33.0**
Physical and rehabilitation medicine**	1,609	0.5	1.8
Physical therapy	4,464	1.5	5.4
Balneology and medical climatotherapy	2,203	0.7	2.7
Total qualifications in physical medicine	**8,144**	**2.7**	**9.9**
Total number of active physicians	**297,893**	**100**	**361.3**

Notes:
* Additional CAM qualifications
** Medical speciality, includes remaining holders of the former specialisation 'physiotherapy'

Source: Kassenärztliche Bundesvereinigung (2001)

Table III.3.2
Trends in CAM and physical medicine qualifications among active physicians, 1993–2001

Type of qualification	1993	1994	1995	1996	1997	1998	1999	2000	2001
Chiropractic*	5,355	5,961	6,911	7,738	9,022	10,234	11,049	11,785	12,519
Homeopathy*	1,905	2,097	2,517	2,818	3,259	3,604	3,796	4,002	4,285
Naturopathy*	4,573	4,948	5,680	6,325	7,229	8,190	8,949	9,654	10,367
Total CAM qualifications	**11,833**	**13,006**	**15,108**	**16,881**	**19,510**	**22,028**	**23,794**	**25,441**	**27,171**
As percentage of total active physicians	**4.6**	**4.9**	**5.5**	**6.0**	**6.9**	**7.7**	**8.2**	**8.6**	**9.1**
Physical and rehabilitation medicine**	–	–	266	174	1,141	1,303	1,405	1,612	1,609
Physical therapy	1,991	2,046	2,362	2,755	3,371	3,931	4,134	4,319	4,464
Balneology und medical climatotherapy	1,560	1,367	1,747	1,627	2,009	1,697	1,677	1,924	2,203
Total qualifications in physical medicine	**3,551**	**3,413**	**4,375**	**4,556**	**6,521**	**6,931**	**7,216**	**7,855**	**8,276**
As percentage of total active physicians	**1.4**	**1.3**	**1.6**	**1.6**	**2.3**	**2.4**	**2.5**	**2.7**	**2.8**

Notes:
* Specific CAM qualifications
** Medical speciality, includes remaining holders of the former specialisation 'physiotherapy'

Source: Kassenärztliche Bundesvereinigung (1997–2002), Statistisches Bundesamt (2002)

Table III.3.3
Gender distribution of active physicians qualified in CAM or physical medicine, 2001

	Total number	Male	Female	Female (%)
Chiropractic*	12,519	10,534	1,985	15.8
Homeopathy*	4,285	1,997	2,308	52.8
Naturopathy*	10,367	5,857	4,510	43.0
Physical and rehabilitation medicine**	1,834	1,145	689	37.6
Physical therapy	4,464	3,793	671	14.8
Balneology and medical climatotherapy	2,203	1,617	586	28.0
Number of all active physicians	**294,676**	**185,360**	**109,316**	**37.1**

Notes:
* Specific CAM qualifications
** Medical speciality, includes remaining holders of the former specialisation 'physiotherapy'

Source: Kassenärztliche Bundesvereinigung (1997–2002)

The proportion of female doctors specialised in CAM or physical medicine is lower than the proportion of female doctors in general (see Table III.3.3). This difference mainly stems from the overrepresentation of male practitioners in chiropractic, physical therapy and balneology und medical climatotherapy. In homeopathy and naturopathy women, on the other hand, women are overrepresented.

Since the beginning of the 1990s a further diversification of specialisations and additional qualifications has taken place. Apart from the specialisations and additional qualifications mentioned above, there are other qualifications which include CAM therapies. For example, to meet the requirements for the additional qualification in specialised pain treatment (*spezielle Schmerztherapie*) physicians have to learn CAM therapies such as acupuncture, manual therapy and 'physiotherapy' (Ärztekammer Berlin, 2000). Approximately 77 per cent of pain clinics in Germany offer acupuncture (Maddalena, 1999; Matthiesen *et al.*, 1992).

Other specialisations such as psychotherapeutic medicine or additional qualifications such as environmental medicine, rehabilitation and psychotherapy are also highly likely to offer supplementary CAM therapies. In 2001 psychotherapy and psychotherapeutic medicine alone accounted for 3,541 qualifications, with the others accounting for a further 17,400 qualifications likely to provide CAM services. Most of these formal qualifications did not exist when Matthiesen *et al.* carried out the first survey of CAM in Germany (1992).

Other medical specialists such as general practitioners (GPs), internists, gynaecologists and paediatricians use CAM without an additional CAM qualification. Some of them have to prove knowledge of physical therapy (e.g. internists and GPs). Internists have to prove knowledge of balneology, while orthopaedists have to be educated in physical therapy and chiropractic. In many cases knowledge of CAM therapies is a precondition for passing the examination for becoming a consultant.

Data differentiating between physicians holding one or more qualifications on an aggregated level are not yet available.

In 1994 a representative survey among all active physicians in the West German municipality and county of Kassel (n = 1,275, response rate 63 per cent) showed that 51 (6.5 per cent) of the respondents held at least one additional qualification for the type of CAM they practised (Haltenhof *et al.*, 1995). The type of qualifications considered was not explicitly stated but probably related to additional qualifications for homeopathy, chiropractic and naturopathy and to certificates for acupuncture. The local rate of 6.5 per cent is similar to the rate of additional qualifications among active physicians at the national level in the same year (6.2 per cent – see Table III.3.2). This indicates that relatively few doctors had obtained two additional qualifications in the mid-1990s and suggests that the number of qualifications gives quite a good picture of the number of physicians specialised in CAM. However, there may be more physicians with more than one qualification. In some medical chambers – for example in Berlin (Ärztekammer Berlin, 2001) – the number of additional qualifications is restricted to a maximum of two.

In the 1994 survey (Haltenhof *et al.,* 1995) actual provision of at least one of the CAM methods varied substantially, with orthopaedists ranking first ahead of dermatologists, gynaecologists, ear-nose-and-throat specialists, internists, neurologist-psychiatrists, anaesthetists and paediatricians. Radiologists had the least experience (4 per cent), followed by urologists, general surgeons and ophthalmologists. Around two thirds of physicians providing primary care services supported CAM: 71 per cent of general practitioners, 65 per cent of gynaecologists, 62 per cent of internal specialists and 55 per cent of paediatricians. Acceptance was higher than actual experience. The highest acceptance of CAM was indicated by specialists in orthopaedics (82 per cent), occupational medicine, neurology-psychiatry and dermatology. Lowest acceptance of CAM was expressed by urologists and surgeons (27 per cent). Current data on the reported use of CAM and related attitudes of physicians are not available.

Table III.3.4 shows the results of a representative population survey in 2002 (Marstedt, 2002). Most persons who had been partly or fully reimbursed for CAM by their sickness fund or private health insurance during the preceing 12 months (43 per cent of CAM users

Table III.3.4
CAM users with reimbursable CAM prescriptions by provider, 2002

Prescribing provider	% of CAM users with reimbursable prescription during the preceding 12 months	% of CAM users with reimbursable prescription in lifetime
'Normal' ambulatory physician	69	64
'Normal' physician in acute or rehabilitation hospital	13	12
Physician with additional qualification naturopathy	9	11
Psychotherapist, psychologist	8	11
Heilpraktiker	7	8
Homeopath	6	7

Note: 43% of all CAM users among the total representative sample (n =1,514) for the Gesundheitsmonitor 2002.

Source: Marstedt (2002)

in the Gesundheitsmonitor 2002 sample) reported that they had got their prescription from a physician without specific CAM qualification. CAM care by physicians with additional qualifications in naturopathy or homeopathy or psychotherapy was of less importance in this sample. The part of the population receiving a reimbursable CAM prescription from a *Heilpraktiker* (registered non-physician CAM practitioners) seems low as well, but relatively high when considering that only privately insured persons (9 per cent of the German population have comprehensive, 9 per cent complementary health insurance) can be reimbursed for CAM prescriptions from *Heilpraktiker* (see Section III.3.3).

In a recent study comparing general practitioners from selected UK and German regions, a significantly higher number of German GPs reported having practised CAM before and having personally used CAM themselves. 76 per cent of German GPs (compared with 70 per cent of British GPs) considered it safe to prescribe complementary medicine and therapies to patients. German GPs referred their patients mainly to acupuncture treatment, chiropractic treatment and herbal medicine to be performed by other physicians (Schmidt *et al.*, 2002).

In summary, a relatively large number of physicians hold CAM qualifications and there is widespread use of and reimbursement in both ambulatory and hospital sectors. This may be due to the fact that therapies that are considered 'unconventional' in this report (e.g. hydrotherapies, nutritional therapies and manual therapies) have in the past been integrated into conventional allopathic medicine (Bühring *et al.*, 2003).

III.3.1.2 Single or multiple therapy

In Germany some medical practices specialise in CAM, and most doctors working in this context offer different types of CAM therapies. Only a few practices are specialised in only one therapy, e.g. acupuncture or traditional Chinese medicine. These practices often serve as training units.

Nearly all of the physicians offering CAM therapies do so as a complement to conventional medicine (Matthiesen *et al.*, 1992). Many medical doctors use CAM therapies in addition to conventional medicine, and the main practice income is from conventional therapies – although some CAM services can be reimbursed additionally, e.g. chiropractic.

III.3.1.3 Practice setting

Only about 12 per cent of doctors working in hospitals have CAM qualifications, whereas in the ambulatory sector there are nearly four times as many CAM qualifications (see Table III.3.5).

Based on this data the number of physicians practising any of the additional qualifications has doubled between 1993 and 2001. This tendency is observable in the ambulatory sector as well as in inpatient care. In 2001 71 per cent of chiropractic qualifications were documented in the ambulatory sector, 23 per cent in the inpatient sector and 6 per cent in other working areas. The respective shares for naturopathy were 78 per cent, 14 per cent and 8 per cent respectively and for homeopathy 85 per cent, 9 per cent and 6 per cent respectively. The total number of active physicians increased by only 15 per cent over the same period. In addition, many other specialities practise some form of CAM, partly within the public reimbursement schemes of ambulatory and inpatient care, partly within the framework of pilot projects or paid out of pocket.

Table III.3.5
Qualifications in CAM and physical medicine among physicians working in different settings, 1995 and 2001

	Ambulatory surgeries		Inpatient sector		Governmental institutions***		Other fields		Total	
	1995	**2001**	**1995**	**2001**	**1995**	**2001**	**1995**	**2001**	**1995**	**2001**
Chiropractic*	4,897	8,915	1,661	2,930	163	282	190	392	6,911	12,519
Homeopathy*	2,099	3,655	260	369	40	67	118	194	2,517	4,285
Naturopathy*	4,394	8,112	835	1,406	126	221	325	628	5,680	10,367
Total CAM qualifications	**11,390**	**20,682**	**2,756**	**4,705**	**329**	**570**	**633**	**1,214**	**15,108**	**27,171**
Physical and rehabilitation medicine**	60	391	177	1,111	21	53	1	9	266	1,477
Physical therapy	1,245	2,146	1,013	2,111	38	75	66	132	2,362	4,464
Balneology and medical climatotherapy	1,319	1,685	334	383	31	44	63	91	1,747	2,203
Total qualifications in physical medicine	**2,624**	**4,222**	**1,524**	**3,605**	**90**	**172**	**130**	**232**	**4,375**	**8,144**

Notes:
* Specific CAM qualifications
** Medical speciality, includes remaining holders of the former specialisation 'physiotherapy'
*** Includes medical officers at public health offices and physicians employed by ministries or state agencies at *Länder* or federal level.

Source: Kassenärztliche Bundesvereinigung (1997–2002)

Overall there has been a decrease in the number of group practices (two or more medical doctors mostly of the same specialisation working together) from 30 per cent to 27 per cent between 1993 and 2000 (Kassenärztliche Bundesvereinigung, 2001). Official sources of practice data do not distinguish physicians with CAM qualifications as a separate group, but a survey of West German doctors attending a training congress for CAM therapies in the late 1980s found that 62.8 per cent were working in a single practice and 37 per cent were sharing a surgery with one or more other doctors (Wiesenauer, 1989).

III.3.1.4 Training

In order to obtain a licence to practice in Germany, a physician must have an academic degree in medicine, practical experience in this field, a license from public authorities and a medical certificate confirming that there are no physical or mental illnesses including drug abuse. CAM is part of the standard curriculum of German medical schools, and students are tested on their knowledge.

After graduating, physicians can choose several specialisations or additional qualifications in the area of CAM, e.g. homeopathy, chiropractic etc. The requirements for these qualifications vary. However, there is always a mandatory period of practice in this area and an official catalogue of procedures and skills that have to be learnt during that time (e.g. Ärztekammer Berlin, 2001).

III.3.2 Other health care professionals

Apart from physicians, a broad variety of health care professions practise some form of CAM, either as part of their daily work or out of hours in private delivery settings. However, official data on CAM qualifications are not available for these professions. Professions likely to practise CAM include pharmacists (see the section on CAM products), dentists, psychologists and particularly paramedical professions.

Table III.3.6 shows the total number of personnel working in paramedical professions most likely to practise CAM methods and/or physical therapy, e.g. nurses or midwives, dieticians and physiotherapists, masseurs or medical bath attendants (Statistisches Bundesamt, 2002). Since the share of part-time work is particularly high in these professions, data are presented in full-time equivalents rather than per-capita counts in order to better reflect the care actually delivered and to make data comparable. Data represent estimates of the Federal Statistical Office based on member counts of professional bodies.

The authors contacted the major professional bodies of the paramedical professions shown in Table III.3.6 by mail and requested additional information on the number and type of CAM qualifications and CAM services delivered by their members. Most professional bodies indicated great interest in the issue but indicated that they had no readily available information on their members' activities. The following more detailed, qualitative information could be obtained:

- According to the main professional body of midwives (Bund deutscher Hebammen – BDH), many members offer acupuncture, homeopathy and Bach flower therapy as part of their daily work. However, exact data on the mode of delivery and reimbursement are not available.
- The main professional body of physiotherapists (Deutscher Verband für Physiotherapie – Zentralverband der Physiotherapeuten/Krankengymnasten (ZVK)) indicated that its members commonly provide chiropractic and osteopathy, and that some also offer yoga, tai chi and qi gong.

Table III.3.6
Other health professions likely to provide complementary and/or physical therapies, 2000

Number of professionals*	Total	Female	Male
Dieticians	9,000	8,000	1,000
Nurses/midwives	523,000	435,000	89,000
Physiotherapists, masseurs, medical bath attendants*	96,000	66,000	31,000

Note: *Full-time equivalents

Source: Statistisches Bundesamt (2002)

III.3.3 State-registered CAM practitioners – *Heilpraktiker*

Apart from the regular health care professionals whose services are paid by public funds, Germany has one state-regulated profession – the *Heilpraktiker*. From an international perspective this profession has quite a unique position: rather than registering providers with accredited professional bodies for single CAM therapies, as in the UK, anyone wanting to practise the 'healing art' in Germany outside the publicly funded health care sector has to obtain the same state license for *Heilpraktiker* as outlined by federal law (unitary regulation). The state licence is granted on the basis of successful examinations at public health offices and submission of a health certificate (see Section III.3.3.4). Beyond the legal requirements, the content and rigour of examinations may vary from public health office to public health office.

Regulation of professional access and practice is negative in the sense that laws detail what *Heilpraktiker* are not allowed to do. The regulatory aim is merely to avoid harm to people's health (by prohibiting the provision of necessary conventional care, e.g. obstetrics) or to the public health (by prohibiting the provision of vaccination and treatment of notifiable and sexually transmissible diseases), and also to prevent fraud and misleading promises. A *Heilpraktiker* can provide a basic medical service, e.g. home visits, electrocardiogram or blood sugar tests, but cannot carry out other services, for example prescribe prescription-only drugs. However, the main focus of the *Heilpraktiker's* activities is to practise CAM methods and physical therapies (usually a variety of different therapies). They can specialise in and practise any CAM method as long as it is consistent with the general standards of good professional practice in health care as supervised by the local public health office. However, there is no positive official regulation detailing training requirements or professional registration for certain CAM methods or therapeutic systems.

III.3.3.1 Number of *Heilpraktiker*

The number of *Heilpraktiker* in Germany increased during the last decade (see Table III.3.7), but not as much as the number of CAM qualifications among physicians. In 2000 the number of *Heilpraktiker* providing CAM was about half the number of physicians offering CAM services (although the latter figure may not be accurate due to the fact that physicians may hold more than one CAM qualification as discussed in Section III.3.1). Out of 17,000 *Heilpraktiker* (13,000 full-time equivalents) registered in 2000, 40 per cent worked part-time. Part-time work was more common among women (47 per cent) than among men (28 per cent).

Table III.3.7
Trends in the number of *Heilpraktiker*, 1993–2000

	1993	1994	1995	1996	1997	1998	1999	2000
Heilpraktiker	9,000	8,000	12,000	14,000	15,000	14,000	16,000	17,000
Per 100,000 population	11	10	15	17	18	17	19	21

Source: Kassenärztliche Bundesvereinigung 1997–2001

III.3.3.2 Single or multiple therapy practice

The list of services and prices published by professional bodies of *Heilpraktiker* on a regular basis gives an overview of the CAM therapies and basic medical services commonly delivered (Hufeland-Gesellschaft, 2002). These range from basic diagnostic and psycho-social services to physical therapies, naturopathic treatments, bioenergetics, food supplements, mind-body therapies as well as homeopathy and acupuncture. The list acts as guidance for patients and professional members. Adherence to the list of services and prices is voluntary. There are no data on the actual provision of single CAM therapies, but it can be supposed that most of these practitioners offer several of the therapies mentioned.

III.3.3.3 Practice setting

Heilpraktiker only practice in the ambulatory sector but not in the same surgery as a physician. Most are self-employed and work in single-handed practices, but there are no exact data on practice setting and employment status.

Heilpraktiker services may not be covered by statutory sickness funds. However, most but not all private health insurance companies do reimburse *Heilpraktiker* services up to a certain limit (e.g. € 1,500 per year) if this is included in the insurance contract with the insured person.

III.3.3.4 Training

To be allowed to practise, a *Heilpraktiker* has to pass an examination usually at a local public health office, which is under the supervision of the states (*Länder*). The examination usually has a written and an oral part, and candidates are tested on basic clinical knowledge and skills, biomedical understanding of the body and on legal regulation of their profession. They are not tested on CAM methods or concepts. To gain accreditation to practise they also need a medical certificate showing that they have no physical or mental illnesses and no substance misuse problems.

Beyond these licensing procedures there are regulations regarding positive requirements for practising specific CAM methods. Candidates can pass the examination without having attended a course, although this is unusual. There are schools for primary and continuous professional education, but *Heilpraktiker* education is not standardised. A recent survey reported that 88 per cent of German *Heilpraktiker* had at least one type of qualification requiring training of between one and three years. However, 10 per cent of *Heilpraktiker* do not have any form of CAM-specific formal training (WHO, 2001).

III.3.4 Non-registered CAM providers

There is no reliable information on the number and qualification of providers who offer CAM but do not hold a state licence for a health care profession or as *Heilpraktiker*. As the list below shows, a wide range of therapies is offered without regulation. Some CAM providers are working in the beauty and fitness sector, others in social care or education; some do not have any education in terms of knowledge about the human body or health

and illnesses. The qualifications vary in intensity, and a variety of services and products are offered:

- Body therapies
- Body-mind therapies
- Life coaching/counselling
- Spiritual therapies
- Counselling for special therapies like aura soma
- Technical supplies (e.g. devices for orgontherapy)
- Food additives
- Spiritual advice.

There have been several initiatives in recent years to enhance consumer protection in the 'psycho-market'. However, draft legislation on 'commercial counselling for coping with life' – targeting particular fraudulent practices and interference with personal rights by religious sects – has not yet been progressed further in the Federal Assembly due to difficulties of agreeing on adequate definitions, but also on the need to apply new and specific versus existing and general legislation to this field.

III.4 CAM services

The substantial increase in the number of *Heilpraktiker* and CAM qualifications observed among physicians and other health personnel could suggest that the level of CAM services delivered and publicly reimbursed has increased. However, as has been seen in Section III.2.1, the figures reported by the population about use of CAM services vary widely and are difficult to compare. The results of different utilisation surveys and possibly private insurers (see Section III.4.3) may be taken as a sound indication of real increase only in the use or supply of the quite clear-cut treatment form of acupuncture. As the following section shows, available data from sickness funds or providers relate mainly to the years 1999 and 2000 and thus cannot indicate trends. However, it does give an idea of the magnitude of utilisation and reimbursement of CAM. The range of CAM services available and the rules for reimbursement differ between ambulatory and inpatient care, and between publicly funded and privately funded care.

III.4.1 Ambulatory statutory health insurance benefits

The German Social Code Book V defines the types of services to which everyone insured under the German health insurance system is legally entitled. There is a legal benefit catalogue for services covered by statutory health insurance in the ambulatory sector, but not in the inpatient sector. It is explicitly stated (§2 SGB V) that services, medicines and medical aids of 'specific therapeutic approaches' (*besondere Therapierichtungen*) are not excluded from reimbursable health care. Social Code book V includes conflicting legal phrases and interpretations as to whether the term 'specific therapeutic approaches' is restricted to phytotherapy, homeopathy and anthroposophy, or applies to other CAM therapies as well (Jung, 1997; Maddalena, 1999).

On the basis of these wider legal regulations the Federal Committee of Physicians and Sickness Funds, a joint committee of the Federal Physicians' Association and the Federal Associations of Sickness Funds, defines criteria that apply to the provision of services and products in the ambulatory sector. All these regulations have been substantially revised in recent years. There are stricter criteria for proving the effectiveness of treatments, conditions for provision and requirements for qualification and documentation. The revised catalogue for non-physician treatments (*Heilmittelkatalog*) includes, for example, chiropractic if delivered by specially qualified physiotherapists. Osteopathy and reflexology are not included.

Until 1997 the Federal Committee of Physicians and Sickness Funds could add services to the benefit catalogue, but it was not allowed to explicitly exclude services. This left some reimbursement decisions at the discretion of the medical service of sickness funds or fund administrators on a case-by-case basis. Since 1997 the Federal Committee of Physicians and Sickness Funds can explicitly exclude physician services and has thereby also restricted individual funds' discretion over exceptional reimbursement decisions. In addition, stricter criteria for inclusion into the benefit catalogue have been introduced, derived from

evidence-based medicine. These criteria were applied to conventional as well as to so-called unconventional methods (Busse and Riesberg, 2003).

The following 'unconventional' services had not been acknowledged before 1997 but were explicitly excluded from the ambulatory physicians benefit catalogue thereafter:

- Electro-acupuncture according to Voll
- Oxygen therapy according to Ardenne
- Immuno-augmentative therapy
- Autologous cytokine therapies
- Colon-hydrotherapy
- Bioresonance therapy and magnetic field therapy.

The following 'unconventional' services have been explicitly excluded since 1997:

- UVB radiation of blood
- Hematogenic oxidation therapy
- Diverse oxygen therapies
- Ozone therapies
- Types of normal saline injections or balneo-phototherapy (a combination of salt bath and UV irradiation which was mainly established in conventional dermatological practice).

All medical procedures in the benefit catalogue of ambulatory physician services are included in a uniform scheme of relative points per procedure at federal level, the so-called Uniform Value Scale (*einheitlicher Bewertungsmaßstab*), which has to be agreed upon by a joint committee of Federal Associations of Sickness Funds and the Federal Association of Statutory Health Insurance Physicians. At regional level joint committees negotiate which value to attach to these relative points. Thus, within a certain framework, the payment per service may differ from region to region. This depends also on the negotiated amount available per insured person in the region and to the expected volume of services (Busse and Riesberg 2003).

The Uniform Value Scale is the backbone of the fee-for-service system for ambulatory physician services (Kassenärztliche Bundesvereinigung, 2003). Some medical interventions are given a specific number in this tariff list, e.g. chiropractic procedures. Many other interventions, however, may be delivered and then charged under a broader category of this payment scheme, e.g. counselling on healthy lifestyle.

Not every physician may claim reimbursement for all types of procedures listed in the Uniform Value Scale. There are specific requirements for many procedures in order to get reimbursed, e.g. only physicians holding the additional qualification 'chiropractic' will be reimbursed for chiropractic interventions and can then claim, for example:

- For chiropractic of the spinal column (No. 3210): 200 points per session (including the documentation of a functional assessment)
- For chiropractic involving extremities (No. 3211): 180 points per session (including the documentation of a functional assessment).

The amount of CAM services actually delivered by ambulatory physicians cannot be determined. Reasons for this include the fact that tariff numbers for specific CAM services do not rank among the 20 most frequently reimbursed produres and that most CAM services are delivered as part of a broader service category and tariff number in the Uniform Value Scale (Kassenärztliche Bundesvereinigung, 2003).

However, the national health report on the utilisation of CAM (Marstedt and Möbius, 2002) has estimated that sickness funds spent DM 4000 (€ 2.1 billion) in 2000 for all diagnostic and therapeutic CAM services in ambulatory care. If this estimate was true, sickness funds would have spent a mean of approximately € 30 per insured person; this represents approximately one tenth of all statutory health insurance expenditure for ambulatory care, 1.5 per cent of all statutory health insurance expenditure and 0.2 per cent of the contribution (the average contribution rate in 2000 was 13.57 per cent). According to this report expenditure for ambulatory CAM care was even higher when taking into account private out-of-pocket payments to physicians or *Heilpraktiker* (Marstedt and Möbius, 2002, see Section III.4.3).

III.4.2 Ambulatory services financed by statutory health insurance under certain conditions

Although the sickness funds' capacity for reimbursing services following single-case review has been restricted substantially in recent years, reimbursement practices for CAM services still vary widely, even among general regional sickness funds in different regions. A popular CAM magazine surveyed 15 major statutory sickness funds in 2002 about their policies on reimbursement of CAM and found that reimbursement was often linked to certain conditions (anonymous, 2002). All funds indicated willingness to reimburse naturopathic treatments according to Kneipp (hydrotherapy, physical therapy and nutritional therapies, phytotherapy and regulation therapy), but some therapies only as part of rehabilitation. They also indicated reimbursement of homeopathy if delivered by a qualified practitioner and phytotherapy (if prescribed and not listed on the negative list or unlicensed). Some therapies were reimbursed by most of the funds, but under certain conditions only, e.g. neural therapy and magnetic field therapy. Reimbursement for therapies that have recently been excluded from the ambulatory benefit catalogue was reported by few funds. None of the funds indicated willingness to pay for aromatherapy, Bach flower therapy, colour therapy, reiki or even reflexology. A comprehensive comparison of services covered by single sickness funds which also includes information on CAM, has been published recently by the neutral foundation of consumer goods assessment (Stiftung Warentest, 2003).

The reimbursement practices of sickness funds and private insurers for CAM have been subject to several retrospective administrative reviews. The surveys available have been summarised by the federal health report on the utilisation of alternative therapies in Germany (Marstedt and Möbius, 2002). For the largest survey from the Federal Insurance Office (Bundesversicherungsamt, 2001) additional information is used in the following text.

The reviews of sickness funds all relate to 'unconventional diagnostic and treatment methods' that present a special category of ambulatory benefits within statutory health

insurance regulations. They are defined as interventions that are not (yet) explicitly included nor excluded from the ambulatory benefit catalogue. Three groups of interventions have been subsumed under the heading of 'unconventional methods':

- New methods not yet evaluated for inclusion in the benefit catalogue
- Conventional methods applied for unconventional indications
- 'Unconventional methods' – CAM therapies that are not part of the ambulatory benefit catalogue.

(Kreck, 2000; Jung, 1997).

Access to these services, including 'unconventional CAM methods', in ambulatory care is available only upon pre-authorisation by sickness funds usually following a case review of the regional medical service of all sickness funds operating in this region. However, the latitude of medical services has been narrowed recently (Kreck, 2001).

The Federal Association of Sickness Funds for Employees and Substitute Funds (VdAK/AEK) reviewed patient applications for reimbursement of ambulatory physician services to its members' funds over a period of six months from August 1994 to January 1995. Of 14,385 applications reviewed for reimbursement of unconventional CAM, one third concerned acupuncture, 13 per cent CAM products and 8 per cent oxygen therapies. Other treatments such as bioresonance therapy, ozone therapies and electro-acupuncture accounted for 1 to 5 per cent of applications. A total of DM 120 million was spent on these therapies (Marstedt and Möbius, 2002). When extrapolated to total statutory health insurance expenditure, this accounted for DM 400 million (€ 205 million), € 3 per insured person or 0.16 per cent of total expenditure. This equalled a contribution of 0.02 per cent of average gross salaries. Results are similar to the survey of the Bundesversicherungsamt (2001) in 1999, although this relates to patient demand and cumulative expenditure and does not offer sufficient information about the magnitude of CAM services actually reimbursed.

The results of the various surveys carried out by sickness funds and private insurers between 1999 and 2001 are presented in Table III.4.1 and Table III.4.2. In addition, Table III.4.1 shows the one-year prevalence of demand for ambulatory unconventional CAM (VdAK survey, 1995) and actual treatment cases (all other studies) if the survey is extrapolated to the whole statutory health insurance population (and the whole year). Table III.4.2 presents extrapolations for expenditure of statutory health insurance based on the reimbursement data of the different surveys.

The Federal Insurance Office (Bundesversicherungsamt, 2001) reviewed claims for 'new and unconventional methods' that sickness funds had reimbursed in 1999. A total of nearly 80,000 claims from a carefully selected sample of 8 per cent of the insured persons from 107 sickness funds were assessed. The majority of claims (65 per cent) concerned acupuncture (52,140 cases). Claims for autohematotherapy were paid in 143 cases (0.2 per cent). Other interventions that might be subsumed under CAM among the unconventional methods accounted for relatively few cases: balneo-phototherapy was reimbursed in 598 cases (1 per cent), hyperbaric oxygen therapy in 598 cases (1 per cent), ultraviolet cold light therapy in 116 cases (0.2 per cent) and thermotherapy in 106 cases (0.2 per cent). Altogether these therapies accounted for 70 per cent of all claims checked.

Expenditure on acupuncture was DM 21.7million (€ 11.1 million) in 1999 and accounted for 45 per cent of all claims checked (Table III.4.2). The 107 sickness funds reviewed paid

Table III.4.1
Surveys of reimbursement for unconventional methods and projected one-year case prevalence, 1999–2002

Survey				Extrapolation
Year	Denominator and surveyor	Survey sample	Cases	One-year case prevalence (%) in the total SHI population
1999	Federal Insurance Office 107 SHI funds with ca. 29m members of ca. 36m total fund members	80,000 reimbursed claims (8% sample of all reimbursed claims of 107 SHI funds); 55,678 for unconventional CAM methods	55,678	1.9
2000	All insured (n = 92,000) of the Securvita company fund	20,928 reimbursed claims	20,928	22.8
2000	Estimate based on the insured of Securvita fund	One third (estimate*)	One third (estimate)*	7.6
1999	Federal Insurance Office 107 SHI funds with ca. 29m members of ca. 36m total fund members	52,140 reimbursed claims	52,140	1.8
2000	Securvita (see above)	5,315 reimbursed claims	5,315	3.8
1999	51 private health insurance companies (PKV) with 7.5m insured	–	–	–

Note:
SHI: statutory health insurance
* Projection accounting for the higher use among Securvita members than other sickness funds, estimated at 3:1 for unconventional methods (and 1:1 for acupuncture)

Source: Marstedt and Möbius (2002); Bundesversicherungsamt (2001)

Table III.4.2
Reimbursement and extrapolated expenditure for unconventional methods, 1999–2000

Survey		Extrapolation			
	Sample	Annual expenditures of the SHI (or PKV) in the respective year			
Year of survey	Expenditures (million DM)	Million €	% of all SHI expenditures	Per capita (€)	Contribution rate points
Unconventional methods					
BVA 1999	25	222	0.17	3	0.02
Securvita 2000	6.0	2,373	1.8	33	0.22
Securvita 2000*	(estimate for SHI*)	791	0.6	11	0.07
Acupuncture					
BVA 1999	22	195	0.15	3	0.02
Securvita 2000	2.4	680	0.52	10	0.07
PKV 2000	184	95	–	6–12	–

Note:
SHI: statutory health insurance
* Projection accounting for the higher use among Securvita members than other sickness funds, estimated at 3:1 for unconventional methods (and 1:1 for acupuncture).

Source: Marstedt and Möbius (2002); Bundesversicherungsamt (BVA) (2001)

an average of DM 415 (€ 212) per case for acupuncture and DM 461 (€ 236) for autohaematotherapy. Similiarly, the sickness fund Securvita paid 452 DM (€ 231) for each acupuncture case in 2000. It has to be noted, however, that one 'case' probably consisted of a series of (about six) treatments and that individuals may have been included as a 'case' several times in 1999.

The Bundesversicherungsamt (2001) considered 69,115 of the 80,000 claims surveyed (86 per cent) to have been reimbursed on inadmissible grounds, including all cases of acupuncture. Acupuncture accounted for the majority of 'unduly reimbursed' cases (88 per cent), autohematotherapy for 0.2 per cent. Consequently, of the DM 47.9 million spent on the 80,000 claims reviewed, DM 30.5 million were seen as inadmissible expenditure, accounting for 64 per cent of all expenditure on 'new and unconventional methods' in ambulatory care.[6]

The federal health report (Marstedt and Möbius, 2002) evaluated reimbursement decisions by the Securvita company fund, a sickness fund which is known to offer a particularly broad range of CAM services. In 2000 about 10 per cent of the fund's expenditure on ambulatory physicians was spent on CAM services, equivalent to € 2.2 billion expenditure for the total statutory health insurance population. For this projection utilisation of acupuncture would be equivalent between the Securvita and the average statutory health insurance population, and the average statutory health insurance population would utilise one third of CAM services that had been used by persons insured with Securvita. However, these projections – based on estimates of the fund's board members – probably overestimate the demand and utilisation of CAM in the general statutory health insurance population.

When comparing the data of the different surveys, the utilisation of unconventional CAM services varied substantially: between 0.01 and 22.7 cases per 100 insured persons in the respective years (Table III.4.1). Acupuncture was the most commonly documented unconventional CAM service in these surveys: the data can be extrapolated to a one-year prevalence for acupuncture of 1.8 per cent in 1999 and 3.8 per cent in 2000.

According to the different surveys presented in Table III.4.2, average expenditure for unconventional services ranged between € 3 and € 33 per capita per year. The Securvita company fund (€ 33 per capita per annum) estimated that the general population covered by statutory health insurance would use about the same amount of acupuncture as people insured with Securvita, but only one third of ambulatory CAM services and about the same amount of acupuncture services as people insured with Securvita (Marstedt and Möbius, 2002) – that is € 11 per capita per annum.

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[6] It has to be noted that at the time of the survey in 1999 acupuncture had not yet been explicitly excluded from the benefit catalogue. Single-case reviews of the medical service of sickness funds were common although performed on a controversial basis since the Federal Social Court had stated on 16 September 1997 (§ 135 para. 1) and 28 March 2000 that services are excluded from reimbursement as long as they are not acknowledged as useful by the Federal Committee. In the 2000 verdict the court also stated that funds or medical services may not close 'system deficits' with their own assessment guidelines. (Bundesversicherungsamt, 2001; Kreck, 2001). On 16 October 2000 the Federal Committee agreed to admit acupuncture only for three pain indications and only within the framework of pilot projects which came into effect in 2001 (see below).

Sickness fund members paid 0.02–0.22 per cent of their total contribution rate for statutory health insurance (an average 13.57 per cent of gross salaries in 2000) on CAM treatments. The 0.02–0.22 per cent share would be equal to a monthly contribution of € 0.10 to € 1 for per month depending on salary.

When comparing the different surveys concerning acupuncture, expenditure accounted for 0.05 to 0.5 per cent of statutory health insurance expenditure (€ 1 to € 10 per insured person per year). Per-capita expenditure in 1999 was assessed at approximately € 2; it was substantially higher in private health insurance at € 6 (related to all privately insured) or € 12 (related to persons with comprehensive private insurance only) (Table III.4.2). Extrapolated further, sickness fund member spent approximately 0.01–0.07 per cent of their total contribution rate on acupuncture, i.e. approximately. € 0.10 to € 0.30 depending on gross salary.

These extrapolations give a picture of the magnitude of the utilisation and expenditure for pre-authorised unconventional CAM services delivered in ambulatory care. However, the surveys and even more so the extrapolations presented here need to be interpreted with extreme caution since the samples, the definition and selection of CAM reviewed, and the survey methods used are difficult to compare.

During the 1990s many sickness funds started pilot projects under paragraphs 63 and 64 of Social Code Book V for specific interventions, particularly CAM therapies. According to § 63 para. 1, pilot projects may only include services that have been neither explicitly excluded nor explicitly included in the ambulatory benefit catalogue of statutory health insurance. Elected fund representatives of employees and employers have to agree to include the pilot projects into the articles/ordinance of their sickness fund. Pilot projects have to be scientifically evaluated and are limited to a maximum duration of eight years.

Activities of sickness funds and private health insurance companies concerning CAM services in the 1990s reflect heightened public interest in CAM and also increased competition among insurers following the introduction of free choice of funds in 1996. By extending the range of CAM benefits, funds sought to satisfy existing members and to increase their competitiveness by attracting new members, particularly among the young, healthy and high-earning or the health-conscious older population (Busse and Riesberg, 2003)

Most of the projects during the early and mid-1990s dealt with the provision of naturopathic, anthroposophic and homeopathic methods in ambulatory practice settings; some also included acupuncture. Marstedt and Möbius (2002) report on the design and results of these pilot projects which reached about 7,500 patients. Since 2001 reimbursement for acupuncture is restricted to three pain indications and to delivery by accredited doctors within a pilot project model, and new pilot projects have been started. With an intended total of 350,000 patients involved altogether, these will be the largest studies on the effectiveness of acupuncture ever performed. The concept also includes a randomised, controlled trial with a subset of several thousand patients. These projects are expected to offer a plethora of information not only on clinical but also on health care system aspects.

III.4.3 Services financed by private health insurance or out of pocket

Data compiled by the Association of Health Insurances suggest that 51 private health insurance companies spent together € 95 million on acupuncture in 2000 (Marstedt and Möbius, 2002). This corresponds to € 6 up to € 12 expenditures on CAM for each privately insured person, depending whether expenditures are regarded in relation to all insured or only to fully insured persons – see Table III.4.2. The higher per-capita expenditure of private health insurance versus social health insurance is at first hand due to higher prices charged in private settings (see below), while the role of higher service volumes is not known. Compared to 1998, the expenditure of private health insurance companies on acupuncture has increased by 25 per cent (Marstedt and Möbius, 2002).

Reimbursement practices vary greatly between private health insurance companies. Some include CAM therapies in their core contracts, others offer supplementary insurance contracts for CAM. In contrast to statutory health insurance, private health insurance companies may finance *Heilpraktiker* services, often up to an expenditure limit of € 1500 per annum. Most have predefined criteria for reimbursement; these are often but not always broader than in statutory health insurance.

Many private insurers finance specific CAM procedures only in the following situations:

- If they are listed in one of the official catalogues of private tariffs for physicians, dentists or midwives
- If they are listed in the non-mandatory *Heilpraktiker* tariff list
- If they are listed in a broader CAM-specific list called the Hufelandverzeichnis
- On a case-by-case basis.

In Germany tariffs for services provided by physicians, dentists and midwives are generally predetermined and fixed, not only for care paid by statutory health insurance or other public social security systems but also in private delivery settings. The catalogues for private tariffs are valid in ambulatory as well as inpatient care, and for patients paying out of pocket as well as private health insurers. They are calculated on a fee-for-service basis and are determined by the Federal Ministry of Health and Social Security, which is advised by the professional bodies concerned (Bundesministerium für Gesundheit und Soziale Sicherheit, 2003). Prices are updated regularly.

In the 'catalogue of tariffs for physicians' (*Gebührenordnung für Ärzte*, GOÄ) for example, each procedure is given a tariff number and a certain amount of points. In addition, the single charge rate and the maximum charge rate are indicated. The latter is usually 2.3 times higher than the single rate, but for certain services physicians may charge only 1.8 times the rate, for other services a maximum of five times the rate. In addition, the catalogue includes information about the requirements for reimbursement, e.g. the duration, performance, documentation or limits concerning the combination of several tariff numbers. The 'catalogue of tariffs for physicians' lists the following CAM services, conditions and prices:

- Hypnosis for a single person (No. 845): € 8.74 to € 20.10

- Taking a basic homeopathic history (No. 30): € 52.46 to € 120.66 (duration: at least one hour; including documentation in standardised questionnaires; reimbursable once per year at most)
- Taking a homeopathic history for follow-up (No. 31): € 26.23 to € 60.33 (duration: at least 30 minutes; reimbursable three times in six months at most)
- Acupuncture against pain (No. 269): € 11.66 to € 26.82 (per session)
- Acupuncture against pain (No. 269a): € 20.40 to € 46.92 (per session; duration: at least 20 minutes).

However, this catalogue does not reflect daily practice very well. For reimbursement purposes many services, including CAM, are subsumed under more general items, e.g. counselling on self-medication for prevention and lifestyle purposes (No. 34; single charge rate: € 17.39 and 2.3-fold rate: € 40.23).

The tariff list of 'individual health services' (*individuelle Gesundheitsleistungen*, IGEL) presents a selection of 'services deliverable on patient demand' from the GOÄ. Services presented there may be offered to patients paying out of pocket in addition to the comprehensive range of benefits covered by statutory health insurance. Compiled by the Federal Association of Statutory Health Insurance Physicians (Kassenärztliche Bundesvereinigung, 2003), the procedures listed have neither (yet) been explicitly included nor excluded from the ambulatory benefit catalogue of statutory health insurance. The IGEL list shows under which broader tariff number frequently demanded (and proactively marketed by physicians) services for well-being and leisure purposes may be subsumed.

Biofeedback, non-conventional relaxtion techniques, art therapies, dance therapy and anthroposophic speech or dance therapy may, for example, be charged under 'training/practising interventions' (*übende Verfahren*) (No. 846, duration: at least 20 minutes, single rate: € 8.74 and 2.3-fold rate: € 20.10).

Registered health care personnel or *Heilpraktiker* may also deliver services outside statutory health insurance, as long as they comply with general quality standards and legal regulations. *Heilpraktiker* and registered non-physician health care professionals may negotiate prices with the patient directly and, in principle, without predetermined minimum or maximum limits. However, if no price is negotiated before the treatment is started, the recommended price of the list of recommended tariffs for *Heilpraktiker* applies. This list, the *Gebührenverzeichnis für Heilpraktiker,* is issued and updated regularly by professional bodies of *Heilpraktiker* and is distributed e.g. by consumer agencies.

A CAM-specific publication, the Hufelandverzeichnis, compiles a wider range of recommendable CAM services. It is edited by the Hufelandgesellschaft für Gesamtmedizin e.V. (2003), an umbrella organisation of German CAM physician organisations. It is used by a broad variety of professional bodies practising CAM to inform their members and their patients about recommendable CAM services or products. In adition, the list is used by patient information initiatives like Datadiwan (2003), training institutions of *Heilpraktiker* (Deutsche Paracelsus Schulen, 2003) and by private insurances for reimbursement decisions. The formal requirements for CAM methods to be included into the Hufelandverzeichnis focus on favourable practical experience and established use:

1. They must be based on a plausible theoretical model
2. Practice and the theoretical model have to form a plausible concept
3. The method must be teachable and learnable (vs. personal inspiration)
4. The method must have been practised successfully for a certain period of time, but it does not have to comply with the strict clinical outcome measure of decision-making in statutory health insurance.

The Hufelandverzeichnis includes CAM therapies that may be covered by statutory health insurance (e.g. physical medicine, naturopathic methods, phytotherapy, homeopathy, anthroposophic medicine, TCM including acupuncture and some forms of neural therapies) and services that have been explicitly excluded from the statutory benefit catalogue (e.g. bioresonance therapy, magnetic field therapy, orgontherapy, oxygen therapies, electro-acupuncture). In addition, therapies that have not been considered for public reimbursement are listed as well, e.g. Ayurveda medicine, micro-element therapy, osteopathy and reflexology. The catalogue of medicinal products is also broader than in statutory health insurance, e.g. with respect to 'established' CAM therapies (see above) or with more alternative forms, e.g. micro-ecological, orthomolecular and antihomotoxic or enzyme treatments, thymus preparations or regeneration cell therapies, isopathic or nosodes (Deutsche Paracelsus Schulen, 2003).

III.4.4 Inpatient services

CAM services are also provided in the inpatient sector. While most physicians with CAM qualifications are concentrated in primary and secondary ambulatory care, more than 10 per cent of medical qualifications for naturopathy, homeopathy and chiropractic are documented in the German inpatient sector. The existence and higher share of extra qualifications in balneology and medical climatotherapy may reflect the relatively strong role and specific approach to medical rehabilitation in inpatient settings and more preventive 'spa therapies' that developed in rural spa resorts.

In the inpatient sector delivery of CAM services is always integrated with conventional care and is usually delivered in a comprehensive set of CAM therapies as well. However, the setting of delivery and reimbursement arrangements may vary.

Since naturopathy was included in the curricula and examinations at medical schools at federal level, several but not all university hospitals offer naturopathy (including nutrition, thermo- and hydrotherapy, physical activity, phytotherapy and regulation therapy such as relaxation therapies) and selected complementary therapies (e.g. acupuncture, homeopathy). The delivery settings are either specialised outpatient departments on medical school premises or CAM integrated with secondary inpatient care at teaching hospitals (Charité Universitätsmedizin Berlin, Ludwig-Maximilians-Universität).

Hospitals delivering CAM services differ in the degree to which CAM is integrated with acute care services. One hospital (Gemeinschaftskrankenhaus Herdecke) integrates anthroposophic care into its regular acute secondary inpatient care. It has also been the main teaching hospital of a private medical school since 1981 (Ostermann *et al.,* 1999).

Another anthroposophic ward is integrated as a department of a general acute hospital. Most hospitals with anthroposophic (four) or traditional Chinese medicine (two) concepts belong to the group of so-called *Fachkliniken* that deliver a type of inpatient care that ranges between acute and rehabilitative care. Target groups are particularly cancer patients or patients with chronic psychosomatic, neurological and psychiatric illnesses. Most of these oligo-speciality hospitals offer several forms of unconventional somatic or psychotherapeutic services (see examples below). Apart from these more comprehensive offers of CAM services, selected CAM services may be provided in regular acute inpatient care settings (see example below).

The spectrum of services and the rules for reimbursement differ substantially between the inpatient and the ambulatory sector. In acute and rehabilitative hospital care CAM services are subject to contracting for hospital budgets and per diem charges between individual hospitals and funds, either explicitly or implicitly. Contracts for and delivery of CAM services therefore differ from hospital to hospital and possibly from year to year. With the introduction of a national uniform DRG system the situation in acute hospital care will change. CAM services at CAM-specialised hospitals are mainly funded by statutory health insurance but are often supplemented by non-profit organisations and patient co-payments. In addition, CAM services (e.g. hippotherapy (therapeutic horse riding) or art therapies) may also be cross-financed by incomes which hospitals and physicians obtain from private health insurance.

There are no publications which are specifically concerned with the range, volume or funding of CAM services in the different inpatient care settings in Germany. Public hospital plans set by the health care administration of the federal states (*Länder)* do not provide accurate information since services for physical therapy, balneology and naturopathy are often subsumed under the listed independent departments for internal medicine or other major specialities. The German Hospital Association has built up a databank of hospitals in cooperation with the 16 state hospital associations.

Most of the state hospital associations provide a list of hospitals and links to the homepages of individual hospitals. The provincial hospital association of Baden-Württemberg in the south-west of Germany has set up a more comprehensive internet database which provides a search function by type of departments and services, including CAM services, across hospitals (Baden-Württembergische Landeskrankenhausgesellschaft, 2003).

300 of the 317 acute and specialised hospitals (*Fachkliniken*) in Baden-Württemberg are documented in this database. Of these, 230 offer physical therapy, 16 naturopathy, 60 acupuncture, 2 traditional Chinese medicine, 18 chiropractic, 14 homeopathy and 55 relaxation therapies. Many of these hospitals also offer rehabilitative services. The number of institutions for rehabilitation and preventive care increased in Baden-Württemberg until 1996 and then decreased to 243. The numbers of beds and cases have increased, but the duration of stay and overall inpatient care days have decreased since 1993.

115 of the 243 institutions for rehabilitation and prevention are documented in the database. Of these, about 100 offer physical therapy, 22 naturopathy, 31 acupuncture, 1 traditional Chinese medicine, 22 chiropractic, 5 homeopathy and 65 relaxation therapies.

In addition, hospitals also offer therapies that are not usually financed by statutory health insurance if delivered in ambulatory care: 5 hospitals in the database offer balneo-phototherapy, 5 aromatherapy, 18 dance therapy, 44 art therapy and 10 hospitals with neurological and psychiatric specialisation offer hippotherapy. Four specialised hospitals offer eurhythmy as part of a more comprehensive anthroposophic care concept. Among rehabilitative institutions, one is documented to offer balneo-phototherapy, 17 aromatherapy; 16 offer dance therapy, 38 art therapy and 4 hippotherapy.

Information given in the database is based on self-reports and may not be representative, since not all hospitals in Baden-Württemberg are included in the database and since this state has a particularly strong tradition of rural spa therapy and promoting homeopathy or anthroposophy. The database does not provide information on the volume of CAM services actually delivered by the reporting institution in the past. Homepages of selected hospitals and – to a lesser extent – rehabilitative institutions do not necessarily reflect the service reported in this database. The database does not provide information on funding sources, e.g. statutory health insurance, pension insurance for medical rehabilitation, private health insurance or out of pocket. Hospitals in most other states of Germany probably offer CAM services less often than in Baden-Württemberg, where different forms of CAM traditionally find strong popular and official support.

It is expected that the introduction of a uniform DRG system will pose substantial challenges to CAM services being delivered within the framework of acute hospital care in the future. Many other hypotheses and speculations about the future of CAM in the inpatient sector deserve further analysis. This report indicates that evidence on current provision of CAM services in the inpatient sector is not easily accessible and that a reliable status-quo analysis would require more extensive primary research.

III.5 CAM products

A variety of products are used in the practice of CAM. CAM products can be divided into medicinal substances and medical devices, and the latter can be further subdivided into therapeutic and diagnostic technologies for the provider and into medical aids and prostheses for use near/by the patient. For example, several CAM therapies, such as Kirlian photography, orgontherapy, MORA therapy or anthroposcopy, need technical support. Data on the market for medical devices have not been analysed in this report.

CAM medicinal substances may be divided into five groups:

1. Non-commercial herbal, mineral or animal substances collected, conserved and prepared in the informal sector
2. Preparations which have to be prescribed by a medical doctor and consequently bought in a pharmacy
3. Preparations which are only allowed to be sold in pharmacies but do not necessarily require prescriptions
4. Preparations which are sold in drugstores only
5. Preparations which can be sold without restrictions.

This chapter focuses on CAM pharmaceuticals sold in the formal sector.

In the past decade substantial changes in the pharmaceutical market have affected CAM medicines. The range of medicinal products on the German pharmaceutical market has traditionally been very broad. In 1988, for example, 126,000 medicinal drugs were available in Germany. Special therapeutic approaches accounted for a major share of this market, with 70,000 phytopharmaceuticals, 24,000 homeopathic drugs and 3,000 anthroposophic drugs (Matthiesen *et al.*, 1992). A substantial number of these CAM medicines were removed from the market by 1993 as part of the 70,000 drugs that did not fulfil the licensing requirements enacted in 1978 (Busse and Riesberg, 2003).

The range of pharmaceuticals, including CAM medicines, available on the German market is expected to decrease further by the end of 2004, when all drugs must have been relicensed or will be removed from the German market. The extent to which European regulations will impact on the national CAM market will depend on a series of factors that deserve further scientific research.

The introduction of cost containment measures was another important factor that impacted primarily on the market share of CAM medicines reimbursed by statutory health insurance, but also on the over-the-counter (OTC) market. Cost containment measures included spending caps in the ambulatory pharmaceutical sector (1993 until 2001), a negative list and a positive list enacted in 2000 but not yet implemented (Busse and Riesberg, 2000).

III.5.1 CAM medicines funded by statutory health insurance

Between 1996 and 2000 sales of anthroposophic and homeopathic remedies reimbursed by statutory health insurance decreased from € 66.5m to € 49.9m (Wissenschaftliches Institut der Ortskrankenkassen (WIdO), 2002).

Table III.5.1 shows that there has been a decline in the number of phytopharmaceuticals reimbursable by statutory sickness funds since at least 1998. In herbal cardiac drugs (e.g. crataegus) and prostate drugs (e.g. pumpkin seeds) the decline started earlier, while reimbursement for herbal psychotropic drugs (mainly St. John's wort and kava-kava) had previously increased.

In 2002 three natural remedies were among the 100 most commonly prescribed pharmaceuticals, compared with eight in 1989 (Schwabe and Paffrath, 1989; 2003). There was a decrease in prescriptions of phytopharmaceuticals by 12 per cent from 1999 to 2000 and by 11 per cent from 2000 to 2001. This decrease was mainly compensated by an increase in out-of-pocket payments for OTC phytopharmaceuticals in this two-year-period (Bundesverband der Arzneimittelhersteller, BAH, 2002). However, since prices are higher in the OTC market than in the statutory health insurance market, demand has probably declined during this year (Flintrop, 2002).

An opinion poll in 1986 reported that 34 per cent of general practitioners and internists (n = 261) were prescribing 'natural remedies' frequently, 48 per cent reported rarely prescribing them, 10 per cent only at patients' request and 8 per cent had never prescribed natural remedies (Infratest, 1986). 72 per cent of respondents had noticed that they were asked more frequently to prescribe natural remedies than in previous years (Matthiesen *et al.*, 1992).

Table III.5.1
Trends in prescriptions of herbal medicines for selected indications funded by statutory health insurance, 1992–2000

Type of herbal medicines*	1992	1993	1994	1995	1997	1998	1999	2000
Immunological drugs	6,682	–	–	–	–	–	–	–
Cardiac drugs	5,323	4,512	5,101	5,129	3,629	3,147	2,768	2,228
Prostate drugs	–	–	–	–	3,085	2,742	2,531	2,335
Urological drugs	–	–	–	–	–	–	–	1,405
Psychotropic drugs	2,802	3,071	4,010	5,315	4,716	5,079	4,452	3,544
Total number of packages	14,807	7,583	9,111	10,444	11,430	10,968	9,751	9,512

Note: *Number of prescribed herbal medicine packages (in thousands) funded by statutory health insurance

Source: Wissenschaftliches Institut der Ortskrankenkassen (WidO, 2002)

III.5.2 Over-the-counter medication

In 2000 sales of herbal remedies accounted for nearly € 1.2 billion (see Table III.5.2). This corresponded to 25 per cent of the total market for OTC medications in Germany (BAH, 2002). Thus each German spent an average € 14 on phytopharmaceuticals in 2000. In 1988 the Federal Association of the Pharmaceutical Industry calculated a nominal sales volume of € 1 billion for phytopharmaceuticals, accounting for 11 per cent of the total gross pharmaceutical sales volume at that time (Matthiesen *et al.*, 1992).

Between 1996 and 2000 sales of phytopharmaceuticals remained constant in nominal terms but decreased in real terms. It has to be noted that data from 1999 are not directly comparable with previous data since the calculation basis has been changed.

Between 2000 and 2001 the sales volume of the three main groups of CAM medicines increased in nominal terms according to the Federal Association of the Pharmaceutical

Table III.5.2
Over-the-counter sales of herbal medicines and total drugs by indication, 1997–2000

Sales of OTC by indication	1996	1997	1998	1999*	2000*
Herbal medicines (million €)	**1,111**	**1,128**	**1,117**	**1,090**	**1,149**
Cough/cold	183	260	253	283	283
Digestive system	145	151	150	154	171
Pains	*75*	*82*	*83*	*76*	*88*
Tonics	*224*	*139*	*117*	*15*	*14*
Urogenital system	*11*	*14*	*13*	*89*	*87*
Cardiovascular system	142	138	140	144	169
Sedation/sleep	105	116	134	128	135
Others	226	227	228	201	202
Total OTC (million €)	**4,416**	**4,561**	**4,549**	**4,204**	**4,184**
Cough/cold	732	804	789	816	853
Digestive system	493	511	529	512	550
Pains	458	478	465	481	474
Skin/wounds	426	428	316	300	316
Vitamins/minerals	419	438	428	388	394
Tonics	330	331	299	282	277
Rheumatism	262	273	282	261	305
Cardiovascular system	246	276	280	279	316
Sedation/sleep	199	225	254	229	239
Others	849	799	908	656	460

Notes:
* Data not directly comparable to previous years since basis of calculation changed
OTC = over-the-counter medication (self-medication or prescribed, but paid entirely out-of-pocket)

Source: BAH (2002)

Industry (Bundesverband der pharmazeutischen Industrie, 2003):

- Phytopharmaceuticals increased by 1.4 per cent, from € 968.6 million to € 982.2 million.
- Homeopathic drugs increased by 6.6 per cent, from € 225.6 million to € 240.4 million.
- Anthroposophic drugs increased by 6.1 per cent, from € 30.8 to € 32.7 million.

III.5.3 Retailers

Table III.5.3 gives an overview of the type and number of retailers that may sell pharmaceuticals, including natural remedies or food additives. In 2001, 84 per cent of OTC medication packages were sold in pharmacies, which earned 90 per cent of total revenues from self-medication. Chemists and supermarkets together sold the remaining 16 per cent of OTC packages and obtained 10 per cent of OTC sales (BAH, 2002). Except for products that can only be obtained on prescription or sold in pharmacies, marketed via mail and internet, some medicinal CAM products (e.g. aromatherapy, food supplements) are more often sold in drugstores or specialised retail shops like whole food stores (*Naturkostläden*), health food stores (*Reformhäuser*), esoteric shops etc.

In Germany a bottle of Bach flower remedies costs about € 4, and a 5ml bottle of oil for aromatherapy costs € 4 or more. The bottle price for aura soma therapy ranks at about € 20. A consultation about the appropriate use of the appropriate preparation(s) of Bach flower remedies or aromatherapy will be charged at € 30 to € 40.

Data on this part of the German CAM market may be available from single producers or retailers but is not available on an aggregate level.

Table III.5.3
Number of retailers of pharmaceuticals, 2000

Type of retailer	Number
Pharmacies*	21,659
Chemist	6,300
Chemist chain**	11,640
Supermarket	7,505
Health food store	2,360
Total	49,464

Notes:
* Monopoly for prescription-only and pharmacy-only medications
** Larger retailers of OTC and other health and beauty products

Source: BAH (2001)

III.6 Service-provider-finance matrix

The matrix on the following page summarises the previous chapters. It shows the wide range of providers delivering CAM services (horizontal axis) integrated with the different funding options (vertical axis). The different reimbursement regulations are shown to depend on the source of finance, the type of provider offering a certain CAM service and the setting of care. Although CAM is offered less frequently in inpatient care than in outpatient care, the range of services reimbursed by statutory health insurance is broader in inpatient care due to the option of specific contracts and the lack of a uniform and positively defined benefit catalogue for hospital care in the German health care system.

<table>
<tr><th></th><th colspan="7">Physicians</th><th colspan="7">Other health care professions</th><th></th><th></th></tr>
<tr><th></th><th colspan="3">Additional qualification in CAM</th><th colspan="3">Additional qualification or specialisation in physical medicine</th><th>No formal qualifica-tion</th><th colspan="7">With or without formal CAM qualification</th><th>Registered CAM practitioners</th><th>Non-registered providers</th></tr>
<tr><th></th><th>Naturopathy</th><th>Chiropractic</th><th>Homeopathy</th><th>Physical therapy</th><th>Balneotherapy</th><th>Physical/ rehabilitation medicine</th><th>Other medical specialists</th><th>Psychologist</th><th>Pharmacist</th><th>Nurse/midwife</th><th>Physiotherapist</th><th>Occupational therapist</th><th>Speech therapist</th><th>Others</th><th>Heilpraktiker</th><th>Various professions</th></tr>
<tr><td>SHI*</td><td colspan="7">Some CAM therapies widespread in many medical disciplines
Ambulatory sector: reimbursement of services included in benefit catalogue, within pilot projects or on case-by-case review by the medical service of sickness funds
Inpatient sector: in special settings (e.g. rehabilitation) widespread and reimbursed; in acute care not that widespread but also funded publicly as part of the regular benefit catalogue</td><td colspan="7">Psychologist: CAM therapies not reimbursed in ambulatory care but possibly in inpatient care (e.g. Gestalt therapy, systemic family therapy)
Pharmacist: products reimbursed, regulated by negative list in ambulatory care
Nurse/midwife: CAM services partly reimbursed; as part of inpatient service
Occupational therapist/speech therapist mainly working in inpatient setting: funded hospital payment
Physiotherapist: physical therapies overlapping with classical naturopathic treatments and chirotherapy reimbursed in ambulatory care
Other professions: dance therapy, art therapy, hippotherapy reimbursed in inpatient care</td><td>Not reimbursed; only exception: if physician not available</td><td>–</td></tr>
<tr><td>PHI*</td><td colspan="7">Reimbursement of services in ambulatory and outpatient setting depends on contractual arrangements between the insurance company and the insured person</td><td colspan="7">Reimbursement depends on contractual arrangements between the insurance company and the insured person</td><td>Depends on contractual arrangements</td><td>Not reimbursed</td></tr>
<tr><td>Out of pocket</td><td colspan="7">Private practice</td><td colspan="7">Private practice</td><td>Direct access</td><td>Direct access</td></tr>
<tr><td>Others</td><td colspan="7">Foundations/charities support information services and information on specific CAM methods
Not-for-profit organisations offer information or service provision, e.g. hospice services that integrate CAM</td><td colspan="7">Foundations/charities support information services and research on specific CAM methods
Not-for-profit organisations offer information or service provision, e.g. hospice services that integrate CAM</td><td></td><td>Personal contact</td></tr>
</table>

Note: SHI = statutory health insurance; PHI = private health insurance
Source: Compiled by authors

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APPENDICES

Appendix 1: Authors

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Appendix 2: Commonly used alternative terms for conventional medicine and CAM in English and German

English	German
Academic medicine	Schulmedizin
Alternative medicine	Alternative Medizin
Biological medicine	Biologische Medizin
Biomedicine	Biomedizin
Classical naturopathic treatments	Klassische Naturheilverfahren, naturgemäße Heilweisen
Complementary and alternative medicine	Komplementäre und alternative Medizin
Complementary medicine	Komplementärmedizin
Conventional medicine	Konventionelle Medizin
Ethnomedicine	Ethnomedizin
Experience-based medicine	Erfahrungsheilkunde, Erfahrungsmedizin
Folk medicine, fringe medicine	Volksmedizin, Ethnomedizin
Gentle medicine	Sanfte Medizin
Ecomedicine	Grüne Medizin
Holistic medicine	Ganzheitsmedizin, ganzheitliche Heilmethoden
Integrated medicine, integrative medicine	Integrierte Medizin
Lay practices, lay medicine, lay health care	Laienheilkunde
Marginal medical practices, outsider medical practices	Außenseitermethoden
Medicine	Medizin
Natural medicine	Natürliche Medizin
Natural remedies	Naturheilmittel
Naturopathy	Naturheilkunde, klassische Naturheilverfahren
Non-orthodox medicine, unorthodox medicine	Unorthodoxe Medizin, heterodoxe Medizin
Non-established medicine	Nicht-etablierte Medizin
Non-recognised treatment methods	Nicht anerkannte Behandlungsmethoden
Non-scientific medicine	Nicht wissenschaftliche Medizin
Orthodox medicine	Orthodoxe Medizin
Paramedicine	Paramedizin
Charlatanism	Scharlatanerie
Quackery	Quacksalberei, Kurpfuscherei
Regular medicine	Etablierte Medizin
Scientific medicine	Wissenschaftliche Medizin
Special therapeutic approaches	Besondere Therapierichtungen
Traditional medicine	Traditionelle Medizin
Unconventional medicine	Unkonventionelle medizinische Richtungen, unkonventionelle medizinische Untersuchungs- und Behandungsmethoden
Western medicine	Westliche Medizin

Appendix 3: English–German/German–English dictionary of CAM therapies

3.1 English–German

English	German
Acupressure	Akupressur
Acupuncture	Akupunktur
African traditional medicine	Traditionelle afrikanische Medizin
Alexander Technique	Alexander-Technik
Anthroposophy, anthroposophical medicine	Anthroposophie
Aromatherapy	Aromatherapie, Dufttherapie
Art therapy	Kunsttherapie
Astromedicine	Astromedizin
Aura Soma	Aura Soma
Auricular therapy	Aurikulotherapie
Autogenic training	Autogenes Training
Autohaematotherapy	Eigenbluttherapie
Autosuggestion	Autosuggestion
Ayurvedic medicine	Ayurvedische Medizin
Bach flower remedies	Bach Blütentherapie
Balneotherapy	Balneotherapie
Balneology	Balneologie
Bates method	Methode nach Bates (Augenmuskeltraining)
Biochemic tissue salts	Schüssler-Salze
Biofeedback (Psychology)	Biofeedback (Psychologie)
Biorhythms	Biorhythmus
Bodywork therapies	Körpertherapien
Breathing exercises	Atemtherapie
Chinese herbal medicine	Chinesische Kräutermedizin
Chinese traditional medicine	Traditionelle chinesische Medizin
Chiropractic	Chiropraktik
Classical naturopathy	Klassische Naturheilkunde
Climatotherapy	Klimatherapie
Cognitive and behaviour therapies	Kognitive und Verhaltenstherapie
Color therapy	Farbtherapie
Complementary therapies	Komplementäre Therapien
Counselling stress therapy	Beratende Stresstherapie
Cranial osteopathy	Craniosakrale Osteopathie

(continued)

English	German
Craniosacral therapy	Craniosakral Therapie
Cryotherapy, cold therapy	Kryotherapie, Therapie mit Kälte
Crystal therapy	Kristalltherapie
Dance therapy	Tanztherapie
Dietetics	Diätetik
Ear acupuncture	Ohrakupunktur
Eastern medicine (Tibb)	Östliche Medizin (Tibb)
Electroacupuncture	Elektroakupunktur
Eurhythmy	Eurhythmie
Faith Healing, mental healing, spiritual healing	Geistheilung
Feldenkrais method	Feldenkrais-Methode
Flower remedies	Blütentherapie
Herbal medicine	Pflanzenheilkunde, Kräutertherapie
Holistic health	Ganzheitliches Gesundheitsverständnis, ganzheitliche Medizin
Homeopathy	Homöopathie
Hydrotherapy	Hydrotherapie
Hypnosis	Hypnose
Hypnotherapy	Hypnotherapie
Imagery (psychotherapy)	Imaginationstherapien
Kinesiology	Kinesiologie
Kneipp therapy	Kneipp-Therapie
Life-coaching	Lebensberatung
Macrobiotics	Makrobiotik
Maharishi Ayurvedic Medicine	Maharishi ayurvedische Medizin
Manipulative therapy	Manualtherapie
Manual lymph drainage	Lymphdrainage
Massage	Massage
Mayr regimen (fasting therapy)	Mayr-Kur (Fastenkur)
McTimoney chiropractic	Chiropraktik nach McTimoney
Medical climatology	Medizinische Klimatologie
Meditation	Meditation
Megavitamin therapy	Hochdosis-Vitamintherapie
Microbiological remedies	Mikrobiologische Therapie
Mind-body and relaxation techniques	Körper-Geist- und Entspannungstechniken
Movement therapy	Bewegungstherapie
Music therapy	Musiktherapie
Natural childbirth	Natürliche Geburt
Naturopathy	Naturheilverfahren
Neural therapy	Neuraltherapie
NLP	Neurolinguistisches Programmieren
Norris technique	Technik nach Norris
Nutrition therapy	Ernährungstherapie
Nutritional medicine	Ernährungsmedizin
Order therapy	Ordnungstherapie (Kneipp)

(continued)

English	German
Orgontherapy	Orgontherapie nach W. Reich
Oriental traditional medicine	Traditionelle orientalische Medizin
Osteopathy	Osteopathie
Oxygen therapy, oxygen therapy according to Ardenne	Sauerstofftherapie, Sauerstoff-Mehrschritt-Therapie nach v. Ardenne
Ozone therapy	Ozontherapie
Physical medicine	Physikalische Medizin
Physical therapy	Physikalische Therapie, Physiotherapie
Phytotherapy	Phytotherapie
Pilates	Pilates
Qi Gong	Qi Gong
Reflexology	Reflexzonentherapie
Regulation therapy	Regulationsverfahren
Reiki	Reiki
Relaxation technique	Entspannungsverfahren
Rolfing	Rolfing
Self-help groups	Selbsthilfegruppen
Shiatsu	Shiatsu
Spa medicine	Kurmedizin
Thalassotherapy	Thalassotherapie
Therapeutic touch	Handauflegen, therapeutische Berührung
Thermotherapy	Thermotherapie
Traditional medicine	Traditionelle Medizin
Unani medicine	Unani-Medizin
Yoga	Yoga

3.2 German–English

German	English
Akupressur	Acupressure
Akupunktur	Acupuncture
Akupunktur Analgesie	Acupuncture analgesia
Akustische Stimulation	Acoustic stimulation
Alexander-Technik	Alexander technique
Anthroposophie	Anthroposophy, anthroposophical medicine
Aromatherapie	Aromatherapy
Astromedizin	Astromedicine
Atemtherapie	Breathing exercises
Aura Soma	Aura Soma
Aurikulotherapie	Auricular therapy
Autogenes Training	Autogenic training

(continued)

German	**English**
Autosuggestion	Autosuggestion
Ayurvedische Medizin	Ayurvedic medicine
Bach Blütentherapie	Bach flower remedies
Balneotherapie	Balneo therapy
Balneo-Fototherapie	Balneo-phototherapy
Balneologie	Balneology
Beratende Stresstherapie	Counselling stress therapy
Bewegungstherapie	Kinesiatrics
Bewegungstherapie	Movement therapy
Bewegungstherapie nach Trager	Trager work
Bioelektronik nach Vincent	Bioelectronic functional diagnostic
Biofeedback (Psychologie)	Biofeedback (psychology)
Bioresonanztherapie	Bioresonance therapy
Biorhythmus	Biorhythms
Blütentherapie	Flower remedies
Buteyko	Buteyko
Chelat-Therapie	Chelation therapy
Chinesische Kräutermedizin	Chinese herbal medicine
Chiropraktik	Chiropractic
Chiropraktik nach McTimoney	McTimoney chiropractic
Craniosakral-Therapie	Craniosacral therapy
Craniosakrale Osteopathie	Cranial osteopathy
Darmhydrotherapie, Darmspülung	Colonic Irrigation, colon-hydrotherapy
Diätetik	Dietetics
Dufttherapie	Aromatherapy
Eigenbluttherapie	Autohaematotherapy
Eigenurintherapie	Autourinetherapy
Elektroakupunktur	Electroacupuncture
Entspannungsverfahren	Relaxation techniques
Ernährungsmedizin	Nutritional medicine
Ernährungstherapie	Nutrition therapy
Eurhythmie	Eurhythmy
Farbtherapie	Color therapy
Feldenkrais-Methode	Feldenkrais method
Geistheilung	Faith healing, mental, healing, spiritual healing
Handauflegen, therapeutische Berührung	Therapeutic touch
Heilmedizin	Healing
Hochdosis-Vitamintherapie	Megavitamin therapy
Homöopathie	Homeopathy
Hydrotherapie	Hydrotherapy
Hypnose	Hypnosis
Hypno-Therapie	Hypnotherapy
Imaginationstherapien	Imagery (psychotherapy)
Kinesiologie	Kinesiology

(continued)

German	English
Klassische Naturheilkunde	Classical naturopathy
Klimatherapie	Climatotherapy
Kneipp-Therapie	Kneipp therapy
Kognitive und Verhaltenstherapie	Cognitive and behaviour therapies
Komplementäre Therapien	Complementary therapies
Körper-Geist- und Entspannungstechniken	Mind-body and relaxation techniques
Körper-Geist-Beziehungen (Metaphysik)	Mind-body relations (metaphysics)
Körpertherapie nach Heller	Hellerwork
Körpertherapien	Bodywork therapies
Kräutertherapie	Herbal medicine
Kristalltherapie	Crystal therapy
Kryotherapie, Kältetherapie	Cryotherapy, cold therapy
Kunsttherapie	Art therapy
Kurmedizin	Spa medicine
Lebensberatung	Life-coaching
Lymphdrainage	Manual lymph drainage
Magnetfeldtherapie	Magnetic field therapy
Maharishi ayurvedische Medizin	Maharishi Ayurvedic medicine
Makrobiotik	Macrobiotics
Manualtherapie	Manipulative therapy
Massage	Massage
Mayr-Kur (Fastenkur)	Mayr regimen (fasting therapy)
Meditation	Meditation
Medizinische Klimatologie	Medical climatology
Meridiane	Meridians
Methode nach Bates (Augenmuskeltraining)	Bates method
Mikrobiologische Therapie	Microbiological remedies
Musiktherapie	Music therapy
Naturheilverfahren	Naturopathy
Natürliche Geburt	Natural childbirth
Neuraltherapie	Neural therapy
Neurolinguistisches Progammieren	NLP
Ohrakupunktur	Ear acupuncture
Ordnungstherapie (Kneipp)	Order therapy
Orgontherapie nach W. Reich	Orgontherapy
Osteopathie	Osteopathy
Östliche Medizin (Tibb)	Eastern medicine (Tibb)
Ozontherapie	Ozone therapy
Pflanzenheilkunde/Kräutertherapie	Herbal medicine
Physikalische Medizin	Physical medicine
Physikalische Therapie, Physiotherapie	Physical therapy
Phytotherapie	Phytotherapy
Pilates	Pilates
Qi Gong	Qi Gong

(continued)

German	English
Reflexzonentherapie	Reflexology
Regulationsverfahren	Regulation therapy
Reiki	Reiki
Rolfing	Rolfing
Sauerstofftherapie, Sauerstoff-Mehrschritt-Therapie nach v. Ardenne	Oxygen therapy, oxygen therapy according to Ardenne
Schüssler-Salze	Biochemic tissue salts
Selbsthilfegruppen	Self-help groups
Shiatsu	Shiatsu
Spieltherapie	Play therapy
Spirituelle Therapien	Spiritual therapies
Stress Management	Stress management
Tai Qi	Tai Chi
Tanztherapie	Dance therapy
Thalassotherapie	Thalassotherapy
Thermographie	Thermography
Thermotherapie	Thermotherapy
Traditionelle afrikanische Medizin	African traditional medicine
Traditionelle chinesische Medizin	Chinese traditional medicine
Traditionelle Medizin	Traditional medicine
Traditionelle orientalische Medizin	Oriental traditional medicine
Unani-Medizin	Unani medicine
Yoga	Yoga