Findings from a 1995 survey of a random sample of GP practices in England indicated that 6% of practices had a complementary health care practitioner working on the premises, while 21% of practices reported having a member of the primary health care team who provided a complementary therapy to the practice patients, and 25% of practices reported making NHS referrals for complementary therapies. The study described in this executive summary was designed to increase our understanding of how these schemes operate in practice (e.g. how do the services work and what needs are they expected to meet). The study is not an evaluation of the individual services involved. The aim of the study was to inform policy making in a context of rapid change.

### Study Objectives

- To give a full descriptive analysis of a sample of ten schemes covering the range of complementary therapy provision currently provided, including the rationale for service development.
- To assess perceptions of the impact of the schemes on the organisation of each practice, on patient satisfaction, and on practice costs.
- To identify potential problems and perceived benefits as they apply in general to the provision of complementary therapies in primary care, and as they are specific to particular models of organising such a service.

### Methods

The study was conducted in 10 purposively selected sites across England. The sample was designed to include the range of complementary therapy services currently available. The study generated in-depth case studies by employing multiple research methods, including observational site visits and interviews with GPs, practitioners and patients.

### Results

The full report provides detailed descriptions of each of the 10 case study sites in relation to the following: practice/centre characteristics, the history of the complementary therapy service provided, the structure of the present service, funding sources, the meaning of integration, key features of the model of care provided, and future directions for the service. This summary focuses on the findings from the cross-case analysis which took as its material the issues for each service as they were understood and reported by the orthodox and complementary practitioners involved.

### Rationales for provision

All the study sites appeared to be striving for a more ‘holistic’, integrated service but what was envisaged by this differed. There seemed to be two principle rationales underlying reported beliefs about the benefits of what integrated care could mean in practice:

- the desire to offer a broader and more responsive range of provision, a ‘better’ primary care service in which complementary therapies address the gaps in conventional care. This can be described as the ‘additive’ model.
- the desire to develop a different ethos in primary health care, in which conventional and ‘complementary’ therapies learn from and questioning each other perspectives and practice. This can be described as the ‘transformative’ model.
These emerging typologies are not clear-cut, and often existed within the same service. Notably therefore the key service initiator may hold differing views from others in the practice. Most examples of provision could be described as conflicted models, with a lack of clear consensus amongst key participants about the vision, rationale, and potential of the service development.

**A ‘supermarket’ or a ‘deli’ service?**

The non-statutory nature of these services, and the consequent funding patterns, have led to an idiosyncratic pattern of provision around the country, and an absence of any overarching vision of the role of such therapies in a primary-care led NHS. The guiding rationale was also related to the overall vision of the style of primary care offered by the practice. Shopping metaphors may help to illustrate this point. Within existing services there are both ‘supermarket’ and ‘deli’-style approaches to the provision of complementary health care:

- In a ‘supermarket’ the principle is to maximise choice with minimal control on consumer decisions about which product (therapy) to choose.
- In contrast in a ‘deli’ the aim is to provide a narrower range of specialised products, pre-selected, and tailored to meet anticipated customer requirements (health needs).

**Perceptions of the benefits and constraints of integration**

A range of issues emerged from this study that transcended any particular model of provision. While the relative importance and weight attached to perceived benefits or constraints varied between practitioners, the principle perceived **benefits** were:

- improved patient care, particularly in the management of patients with chronic illness
- helping to fulfill the ‘promise of primary care’, by offering therapeutic relationships and a client-centred approach sometimes lost in the pressures of general practice
- benefits to the working life of the professionals involved, including relieving GP workload

And the key perceived **constraints** on integration were:

- a need to control patient demand for complementary therapy services
- ‘cultural divides’ between conventional and complementary medicine hampering effective communication
- complementary practitioners’ anxieties about losing their autonomy of practice within the NHS
- difficulties of teamworking, in particular because of time constraints, differing levels of GP involvement, and a lack of certainty about how complementary practitioners ‘fit into’ the structure of primary care.

**In-house or off-site?**

Provision was either delivered from within the practice (by complementary practitioners and/or by GPs) or by referral to an off-site clinic. Both in-house and off-site provision had perceived advantages and disadvantages. The advantages were often regarded as **potential** rather than guaranteed:

- For GPs and complementary practitioners alike, an **on-site** service offers an opportunity for the structural integration of complementary therapies into the routine work of the primary care team. It also offers ease of access to facilities and greater opportunities for communication and education.
- From the GP perspective, the **on-site** model also allows a considerable degree of control over the shape and scope of the service.
- Services located **off-site**, in a referral centre, create conditions for greater complementary practitioner control over the ethos and running of the service. Inevitably, this means that GPs have less scope for shaping the service to suit their perception of particular patients needs.
• Problems relating to communication with primary care teams and ease of access to the services are more pronounced with off-site services.

• Off-site referral centres can offer services to many general practices within an area which may enhance equity of provision within a locality. However, in practice this capacity is mediated by the willingness and financial ability of local primary care teams to make such referrals.

**Factors affecting the sustainability of complementary therapy services**

Two key issues were found to underpin perceptions of the sustainability of such service provision. These factors also influence perceptions of the form that any future service development should take:

• There was a perceived need to establish and enhance the credibility of complementary therapy provision through demonstrating savings and through developing an evidence base for the therapies.

• A second issue perceived to be essential to sustainability was funding. The current picture is one of ad hoc innovation and seizing opportunities as they emerge. There was considerable anxiety expressed in many sites about funding, particularly within health authority-funded models. There were also concerns about how best to achieve funding arrangements that are both stable and equitable in the context of NHS primary care.

**Patient perspectives**

High levels of satisfaction with complementary therapies and therapists were found amongst patients. These findings did not vary significantly between different models of delivery or the type of therapy received. Complementary therapies are experienced as efficacious in ameliorating and curing conditions, including chronic problems. Patients also welcome the way in which this effect is produced. In particular, they perceive complementary practitioners as caring, and value the development of a strong therapeutic relationship. Positive experiences of complementary therapy were often contrasted with either a failure of orthodox medicine to meet their needs, or a dislike of the orthodox approaches available to them.

**Costs to the practice of offering complementary therapies**

Collecting this type of data retrospectively at practice level proved difficult in most cases, and the feasibility of this type of study is discussed within the report. The findings from a pilot audit of costs per patient using a small consecutive sample within individual practices suggest that the average cost per patient receiving a complementary therapy in a 12 month period is £95.00 (SD £58.1), ranging from £59.00 for osteopathy (SD £34.1) to £134.00 for acupuncture (SD £72.7). These estimates exclude costs absorbed by the practice (e.g. accommodation and reception costs), any consequences for the use of conventional primary or secondary health services, and the range of schemes employed to defray the costs to the practice of providing complementary therapies to patients.

**Funding and equity**

The funding of complementary therapies in primary care is perhaps the central issue which cuts across all the lessons that can be drawn from existing models. Whether and how to fund such provision, and which therapies should be routinely funded within NHS primary care, are policy questions now facing the newly formed Primary Care Groups.

• To date, fundholding savings have provided the most accessible source of NHS finance for complementary therapy services in primary care. Other NHS funding arrangements for direct costs include Health Authority development monies, and ancilliary staff budgets. Non-NHS funding is raised through patient out-of-pocket expenditure, donations and dedicated charitable trusts. Indirect costs tend to be absorbed by the practice.

• The current pattern of provision is unevenly distributed and the frequent use of non-NHS funding sources tends to favour relatively affluent sections of the patient population; many GPs and practitioners alike expressed a high degree of frustration about a potential widening of the health care divide.
The evidence base for complementary therapies in primary care is limited and, not surprisingly perhaps, plays a relatively small part in the way that services have been set up and operate. However, there is a clearly expressed need for more research into the role of complementary therapies in primary care.

- The types of research advocated by service providers cover clinical effectiveness, patient satisfaction, service evaluation and cost-effectiveness.
- The perceived need for further research stems in part from the recognition that evidence is required to support the process of obtaining and securing reliable funding.
- With some notable exceptions, practices/centres in our sample lacked the resources to undertake extensive research, although a number of sites were undertaking some form of internal monitoring of the service which they offered.

The future of complementary therapies in a primary health care led NHS

With the publication of the NHS white paper, The New NHS (1998), existing complementary therapy services will have to survive a period of change and uncertainty affecting all aspects of primary care. For example, in-house services financed by fundholding savings perceive themselves to be at risk with the end of fund-holding. These practice-based services will survive in their present form only if a margin of flexibility and innovation is retained at individual practice level under Primary Care Groups.

Each of the complementary health care services described in this study could lend itself to changes required by locality commissioning if the provision of these therapies was perceived to be of sufficient importance by a Primary Care Group. However, a service developed for a particular practice population will not necessarily appeal to all neighbouring practices. In principle, there is no barrier to having more than one complementary service available within a given locality. In practice, however, a single centre for referral seems a more likely scenario. Off-site and ‘semi-detached’ services (where the service is associated with a GP practice, but offers care to a range of other NHS practices as well as privately) may be particularly well-suited to expand their services within a locality. However, for on-site and off-site models alike, the ‘success’ and momentum of services is mediated by the level of GP involvement and commitment, and the vision of integrated care held by key stakeholders, as well as the availability of funding.

A key policy question to be addressed will be whether the way forward lies in the present ad hoc, personality-led development of services, or whether what is required is a more standardised approach, which would offer guidelines relating to the scope, scale and practice of these services.