Complementary Therapies under Primary Care Groups

Final report to Department of Health

2003

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ACKNOWLEDGEMENTS

We would like to thank the participating GPs and PCG staff who contributed to the data for this report, and Professor David Wilkin and colleagues in Manchester for allowing us to add questions to the PCG Tracker Surveys.

This work was supported by the Department of Health. The views expressed are, however, those of the authors alone.
EXECUTIVE SUMMARY

Background

There is good evidence of substantial use by the general population of the different types of therapy contained within the umbrella term ‘Complementary and Alternative Medicines’ (CAMs). This, and a recommendation for the increased provision of CAM therapies for NHS patients from a House of Lords’ enquiry in 2001, raises important policy research questions regarding the provision and commissioning of CAM therapies within the NHS. The series of investigations incorporated within this report was undertaken as part of a wider research programme designed to address some of these questions.

Previous studies in the programme have shown that small scale CAM provision is widespread in general practice, with 40% of practices in England offering some access to CAM in 1995. NHS primary care patients receive CAM therapies via one of three routes; from an existing member of the primary health care team (usually a GP); via referral to a CAM specialist working outside the practice (e.g. at a homeopathic hospital); and via an internal “in-house” referral to a CAM specialist working within the practice. All GP practices have been able to offer CAM services via one of these three routes for a number of years. Historically, the “In-house” services have treated the highest volume of patients. Case studies conducted in 1999 showed that the more established CAM services were characterised by a high level of personal commitment by the GPs involved. Perhaps unsurprisingly, GPs who had initiated such services also expressed high levels of belief in the potential contribution of CAM therapies to health care, and reported high levels of satisfaction amongst patients using the service.

The work described in this report was undertaken at a time of major change in primary care, heralded by the 1998 Government White Paper: ‘The New NHS: Modern, Dependable’. The introduction of Primary Care Groups (PCGs) and Primary Care Trusts (PCTs), brought together groups of geographically proximate GP practices with greater commissioning powers, created a new climate for service development. In 1999, the likely direction of development for CAM services within PCGs/Ts was not clear, and the factors that would influence their future provision remained speculative. While PCGs with unified budgets would have the capacity to be more innovative commissioners than individual practices, they would also be more accountable for their decisions. Amongst other considerations, future commissioning of CAM therapies by PCGs would need to address the requirement to develop services to meet the health needs of the local population, as well as tackle the issue of adequate clinical governance.

The overall aim of the studies reported here was to understand how the reorganisation of primary care services in 1999 impacted on policy development and the provision of NHS
CAM therapy services. Each of the component studies provides a different perspective on the processes underpinning the reconfiguration of CAM services under PCGs.

As it progressed, the research also provided an insight into the way some PCGs approached the problem of unevenly distributed, practice-based, non-statutory services. The following specific questions were also addressed in the research;

a) How did the introduction of PCGs impact on the short-term survival of a sample of existing CAM services in primary care?

b) What proportion of PCGs was addressing the issue of CAM provision in the first year of their operation?

c) How did the question of CAM provision find its way onto the PCG agenda?

d) Where there any discernable changes in the proportion of PCGs addressing the issue of CAM provision in the second year of their operation?

e) How was policy development in relation to the provision/commissioning of CAM services viewed in a sample of PCGs known to be actively engaged in such a process?

**Methods**

Qualitative and quantitative data were collected between October 1999 and February 2001. These included;

1. Semi-structured interviews with providers of NHS CAM services (mostly GPs), known to us through case studies conducted in 1997/8.

2. Questions about CAM services and commissioning added to the National Tracker Survey, using structured interviews with PCG Chairpersons in a representative sample of 72 PCGs. Data were collected in 1999 and 2000. Interviewers asked specifically about acupuncture, chiropractic, homeopathy and osteopathy, and excluded counselling, psychotherapy, and physiotherapy.

3. Telephone interviews with a purposive sample of nine PCG officers with responsibilities for commissioning in PCGs, identified from the 1999 National Tracker Survey as currently developing a policy relating to CAM.

The qualitative interviews were tape-recorded, transcribed verbatim and analysed thematically according to the principles of framework analyses supported by WinMAX software. Quantitative data were coded, processed and analysed using SPSS.
Results

The service providers’ perspective

In 1999, GPs and providers of existing primary care CAM services reported that these were still available to patients. However, ex-fundholding services in particular were perceived to be undergoing a period of review and experiencing considerable uncertainty regarding the future. At this time, providers were committed to trying to maintain services in some way. Equity issues were seen as a key argument in the case for wider provision of complementary medicine under PCGs, although respondents saw complementary medicine as a low priority for their PCGs, and expressed the view that existing providers would need to work hard to keep CAM on the PCG agenda. The need for strong research evidence that supported complementary medicine provision, particularly in terms of clinical and cost-effectiveness, was seen as being more important than ever in the new PCG culture.

The message from these service providers was that most PCGs had yet to get their position on CAM clear, and this was confirmed in the PCG data. From the PCG perspective, an interim policy of ‘provide and review’ emerged as the dominant short-term strategy, particularly in relation to services located in ex-fundholding practices. From the providers’ perspective, this clearly contributed to perceptions of instability and insecurity.

PCG policy decisions

In 1999, one year after the introduction of PCGs, CAM was rated a ‘low’ or ‘very low’ priority by the majority of PCGs - none rated its priority higher than ‘medium priority’ on a five point scale. However, over half of those interviewed reported having discussed CAM at Board level, or said that they expected to do so in the next 12 months. Policy development in those PCGs that had already discussed CAM (N=33) varied. The majority of these PCGs had postponed making a decision regarding CAM by opting to continue funding in the short-term, subject to review. Fifteen PCGs claimed to have to have a ‘policy’ in place (an estimated 21% of all PCGs). These policies were divided equally between positive (to provide, increase or ‘roll out’ a CAM service) and negative (decision to cease funding a CAM service). Provider and patient pressure were identified most frequently as reasons for CAM reaching the agenda for PCGs. In PCGs where CAM had already been discussed, debate regarding the future of an existing service was clearly a strong driver for ensuring that CAM reached the agenda. Strategic planning and local consultation exercises were mentioned by 19% of all PCGs as having been the occasion for debate or discussion relating to local CAM provision.

One year later little had changed. 37% of PCGs reported having a policy relating to CAM in place. The proportion that reported having a ‘positive’ CAM policy in place increased, and so did the proportion of PCGs with a ‘negative’ policy. The balance of decisions observed between 1999 and 2000 indicated a marginal increase towards providing CAM services, but the overall priority of CAM for most PCG boards remained ‘low’ or ‘very low’. By the end of
2000, all except 11 PCGs in the sample reported that they had discussed CAM provision at some point, and 32% reported that it had reached the agenda by being raised by a member of the PCG Board, compared to 10% in 1999.

**PCG commissioning issues**

Interviews with a sample of key commissioning personnel in PCGs engaged in local CAM policy development echoed the findings from the Tracker Survey and the service provider interviews. By the end of 2000 the dominant approach was still very much one of ‘provide and review’. The most common positive policy development was the extension or ‘roll out’ of a practice-based CAM service across the PCG. This was justified in terms of providing equity of patient access to the service, (and was sometimes achieved by lowering the level of provision that had previously been available to patients at the practice). The perceived impossibility of achieving equity of access within existing resource constraints was also given as the reason for discontinuing one CAM service.

Evidence of PCG innovation was seen where a CAM service was viewed as a potential solution to problems associated with achieving NHS targets and addressing priorities. For example, one PCG was considering a CAM service as part of an initiative to reduce secondary referrals to orthopaedic waiting lists.

The absence of strong published evidence of the clinical effectiveness of CAM emerged as an important brake on policy development within the PCGs. The need to demonstrate the credibility of therapies before committing NHS resources to their provision was seen as paramount. However, when other factors were present — including some budgetary flexibility and an open-mindedness regarding the potential contribution of CAM — local evidence based on patient demand, satisfaction and service audit was more likely to be viewed as relevant.

Our data suggest that CAM provision is likely to remain on the PCG/PCT agenda, but the future pace of development of NHS CAM services will be characterised by ‘small steps’ and ‘small growth’;

“I think that it [CAM] is something that the Board has to review in the future because complementary therapies are becoming quite popular aren’t they?…And I think it is not something that’s going to go away ….. whether they [the Board] want to or not it is something that we have to look at really as an alternative way of treating people…”

“My guestimate will be that we will start using complementary therapies more, but we really don’t have … a groundswell of support within the PCG to move forward at a very rapid pace. So I think it’s more likely to be a gradual process rather than a ‘big bang’ approach where we suddenly come up with
a range of options that are available to add to the existing referral routes that GPs have…”

**Conclusions**

There is evidence of a willingness to consider CAM provision at PCG Board level. The combined results of this series of studies suggest a pattern of gradual increase in the numbers of PCGs providing limited access to CAM therapy services for NHS patients, and indicate that, under PCGs, this was most likely to be achieved by building on existing services. In this time of transition, emerging services were likely to be time-limited, and subject to review.

Locality-based, CAM services integrated with conventional health care in packages of care for NHS priority patient groups may to offer a model for the future development of CAM services in NHS primary care.
1. KEY ISSUES AFFECTING PROVISION AND POLICY 1999-2000

1.1 Background

This section includes the early results based on work undertaken between October 1999 and January 2000. The purpose was to give an early indication of the extent to which CAM services are being considered by PCGs, and of the key issues relating to their provision from both the practice and PCG perspective. A ‘scoping’ survey was also undertaken in order to yield a sufficient sample of PCGs that are currently engaged with issues relating to CAM provision to form a sample for later, in-depth work.

1.2 Methods

This study was in two parts 1.2.1 follow-up of sites from the ‘Models of Complementary Therapy Provision in Primary Care’ study and 1.2.2 survey of PCG policy formation in relation to CAM - Tracker Survey Data 1999.

1.2.1 Follow-up of sites from the Models of Complementary Therapy Provision in Primary Care study

We undertook semi-structured interviews with GPs from a sample of practices (N=10) with established services known to be offering CAM services in 1997/8. These practices represent a geographically and structurally diverse sample of services, and we have established a good working relationship with each of them through a previous study. Lead GPs or service instigators from the 10 sites who had participated in the ‘Models’ study were contacted, first by letter and then by phone. Short semi-structured telephone interviews were conducted by the researcher (DL) with nine of these key informants, while one informant was interviewed face-to-face by the researcher using the same schedule as for the telephone interviews.

The interviews explored issues that faced these practices in this transition period; specifically the +survival of the CAM service that they offer, and the expected short-and medium term impact of practice PCG membership on the service. The interview schedule is in Appendix 1. We also surveyed a representative sample of Primary Care Groups to identify plans for the reduction or extension of CAM services to the wider PCG population.

1.2.2. National Tracker Survey 1999 data

As preliminary enquiries indicated that CAM was seen as relevant to Chief Executives, we used the national representative sample of PCGs which forms ‘Longitudinal Tracker survey’ conducted by the National Primary Care Research and Development Centre (NPCRDC ) in Manchester in partnership with the King’s Fund to include specific questions relating to complementary medicine. The results have been made available to us, along with a ‘core’ data set of general characteristics and data relating to current activity in PCGs. Two Chief Executives declined to be interviewed. Thus we avoided any duplication of information
requests, and were able to time our approach appropriately to reduce the burden on PCGs. The survey questions are shown in Appendix 2. The Tracker survey included interviews with Chief Executives of a representative sample of 72/481 PCGs was carried out in Autumn 1999 by researchers at the NPCRDC. Data from these interviews relating to our

1.3 Results

1.3.1 Follow-up of sites from the 'Models of Complementary Therapy Provision in Primary Care' study

In one site, the lead GP has left the practice and was unable to provide a complete current picture of the services offered at the original study site. As a result, the information available for this site is at present less complete than for the other nine sites.

i) Update on service provision

Figure 1 below provides details of the cases studied for the 'models' report and an update on any changes to service provision that have resulted from the introduction of Primary Care Groups.

In summary, our findings show the following:

Services provided ‘on-site’ in a General Practice

Services that were previously financed by fund-holding seem to be experiencing more change than other services. Although all of these services were continued unchanged for the period 1999-00, several can be classed as being in a situation of ‘provide and review’. In the coming financial year, one service will no longer be funded in its present form, although alternatives are emerging (Case 7), one service is under severe threat (Case 3), and a further service is currently under-going active review and is making a case for its continuation (Case 5). A further ‘ex-fund-holding’ service appears to have been reduced since the introduction of PCGs but information is as yet incomplete for this service (Case 2).

One ex-fund-holding service seems less subject to change. This practice has in fact expanded its service to other practices within the PCG, and although technically subject to review, the likelihood of any change to the service is not perceived as imminent.

The one on-site service that was previously supported by the Health Authority also continues as before, and again though subject to review, any short-term change appears unlikely. Finally the two on-site services that relied on charitable or private sources of funding (Cases 1 and 8) have, perhaps unsurprisingly, continued as before.

Referral centre provision

The referral centre, which was supported by the local NHS Community Trust, continues to provide services as before (Case 9). The management of the service is under review, as are
some aspects of referral procedures, but there are no perceived threats to the survival to the 
continuity of the Centre.

The charitably-funded centre (Case 10) has experienced a loss of funded-referrals from fund-
holding GPs and these have not been replaced by PCG funded referrals. There appears to 
be little likelihood of a PCG contract in the short to medium term. However, the Centre 
continues, as before, to raise funds from other sources and to provide services regardless of 
client ability to pay.

**Figure 1** Details of services

<table>
<thead>
<tr>
<th>Case</th>
<th>Therapies offered in 1999</th>
<th>Funding Source and Provider Type</th>
<th>Update: Current Situation</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Acupuncture, Osteopathy.</td>
<td>Non-fund-holding. Service provided by sessional complementary practitioners in-house, funded via a charitable trust. (Additional private complementary suite at a branch surgery)</td>
<td>Service continues as before.</td>
</tr>
<tr>
<td></td>
<td>(Reflexology, Massage, Homeopathy, Aromatherapy)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Herbalism, Homeopathy, Chiropractic Acupuncture.</td>
<td>Ex-Fund-holding. Service provided by GPs and by sessional complementary practitioners in-house and from referrals to a local independent complementary therapy clinic, funded from fund savings.</td>
<td>Information is currently incomplete for this site. The service continues, however a key GP, who practised one of the therapies, has left and feels that the level of provision overall has declined since the end of fund-holding.</td>
</tr>
<tr>
<td>3</td>
<td>Homeopathy, Acupuncture, Osteopathy</td>
<td>Ex-Fund-holding. Service provided by sessional complementary practitioners in-house, funded from fund savings.</td>
<td>Since the end of fund-holding, the service has been continued, but the practice currently only has three months notice of continuation. This is felt to be an unworkable situation and there are serious concerns that the service will terminate within the next 12 months. To date offers by the practice to extend the service to other practices within the PCG have not been taken up.</td>
</tr>
<tr>
<td>4</td>
<td>Acupuncture, Osteopathy</td>
<td>Non-fund-holding Service provided by sessional practitioners in-house, reimbursed by the Health Authority.</td>
<td>The service continues as before.</td>
</tr>
<tr>
<td>5</td>
<td>Osteopathy, Acupuncture and Chinese herbs, Massage.</td>
<td>Ex-Fund-holding Service provided by sessional practitioners in-house, funded from GMS monies</td>
<td>The service was continued for the year. The budget for the coming year is currently under discussion within the PCG, so the shape of future</td>
</tr>
<tr>
<td>and practice budget. Further private provision from the same practitioners.</td>
<td>service is uncertain.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Details of services (con’t)</td>
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<td></td>
<td></td>
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<tr>
<td>6</td>
<td><strong>Osteopathy, Traditional and Medical Acupuncture, Reflexology. (Aromatherapy Nutritional Therapy, Reflexology)</strong> Ex-Fund-holding. Service provided by sessional practitioners in-house, funded from fund savings. (Further private provision). The service has continued for the current year, but access has been expanded to all practices within the PCG. In practice, the service is still used predominantly by the original practice population. The future remains uncertain but the service is not perceived to be under any immediate threat.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>7</td>
<td><strong>Osteopathy, Chiropractic. (Massage, Aromatherapy, Colonic Irrigation, Homeopathy, Acupuncture, Alexander Technique, Reflexology, Hypnotherapy)</strong> Ex-Fund-holding. Service provided by complementary practitioners in an adjacent complementary health centre. GP referrals for osteopathy and chiropractic, funded from fund savings (Further private provision). The funded referrals have been continued for the current year, but will then cease. The practice is involved in developing pilot care schemes within the PCG, which will mean that chiropractic will still be available, and will be extended to a wider population.</td>
<td></td>
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<tr>
<td>8</td>
<td><strong>Hypnotherapy (Acupuncture, Alexander Technique, Herbalism, Homeopathy, Osteopathy, Massage, Reflexology, Aromatherapy)</strong> Non-fund-holding. Service provided by sessional complementary practitioners in-house in a designated complementary suite. All provision is private, except limited hypnotherapy provision from one GP. The service remains unchanged.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>9</td>
<td><strong>Acupuncture Homeopathy, Osteopathy, Massage, and Hypnotherapy</strong> Independent centre funded by the local community Trust and accepting local GP referrals. Service provided by complementary practitioners on a sessional basis with a Trust contract. The service remains unchanged at present though there are current discussions about the future management of the centre. There is no perceived threat to the continuation of the service in the short term, and the PCG is seen as supportive.</td>
<td></td>
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<tr>
<td>10</td>
<td><strong>Healing, Acupuncture</strong> Centre is a registered charity. Funded referrals from local fund-holding GPs and (1995-96) from a HA scheme for non-fund-holding GPs. The policy of the Centre is to accept clients regardless of ability to pay. Funded referrals from fund-holding GPs have ceased and the PCG has decided not to fund any referrals in the short –to medium term. The centre continues to look for other funding sources outside the NHS. Given the ethos of the centre non-funded referrals from local GPs continue.</td>
<td></td>
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</tbody>
</table>
ii) Perceptions of the longer term priority accorded to CAM provision

A summary of perceptions of service providers of the priority of complementary medicine within the local PCG is given in Figure 2. Most of the service providers who rated complementary medicine as a low priority within their PCG at the moment, felt that this situation was likely to continue in the medium to long term.

‘I have been told off the record that it would be two to three years, but my personal reading of the situation is that it would be very iffy even then’

‘you know it’s working well, you leave it as it is until you get round you know to prioritising really……..that could be two or three years down the line’

Figure 2 Summary of perceptions of the priority of complementary medicine within PCG for the next 12 months

<table>
<thead>
<tr>
<th>Priority</th>
<th>Cases</th>
<th>Reasons given for priority level</th>
</tr>
</thead>
<tbody>
<tr>
<td>Low</td>
<td>1, 4, 6, 8, 9, 10</td>
<td>‘Too early’; ‘they have more pressing issues’; ‘other things to do’; ‘our PCG I would say is still in total disarray’.</td>
</tr>
<tr>
<td>‘Pretty Low’</td>
<td>7</td>
<td>They’re ‘more interested in the drug budgets’. Only on the agenda because brought it to their attention ‘if I wasn’t involved it wouldn’t be happening’.</td>
</tr>
<tr>
<td>High</td>
<td>5</td>
<td>Because interested GPs in area have made it so.</td>
</tr>
<tr>
<td>‘Too High’</td>
<td>3</td>
<td>Perceives PCG as a ‘shambles’ and that too much (negative) attention being paid to service when should be concentrating on other areas.</td>
</tr>
</tbody>
</table>

Some respondents, whose services had only been continued for 12 months in the first instance expected the service to be discussed in the shorter-term and expressed more worry about the future. However, this was tempered by perceptions of support within the PCG, including personal involvement with the PCG, and a commitment to service continuation whatever may happen:

‘You know we are worried about what will happen to it, but there is certainly no threat or change planned at all……You know the more kind of pressures there are on NHS money, then I suppose these are the kind of things that may get looked at, but there is no pressure at the moment’ (PCG board member).

‘I think we would make every effort to keep them going anyway, because we certainly see them as value for money, and I think that we as a practice would work somehow to keep the thing running anyway’ (other GP in practice on PCG board).
One GP felt that it was inevitable that in the longer-term, all PCG would have to consider complementary medicine: ‘(they will be) very much an issue for PCGs in future’.

iii) Issues for the provision of complementary medicine under Primary Care Groups

Equity

Some GPs felt that, in the interests of equity across the PCG, the service might be expanded to cover other practices. Whilst the emphasis on equity was considered important, there were concerns that in the absence of additional resources this would mean ‘the same service but thinner’. Alternatively one GP thought that there practice-based service would continue ‘only it will be somewhat reduced’ to enable primary care group services for everybody. One GP (7) was more optimistic and felt that making services more widely available might increase overall service provision in the long run, as the benefits became obvious to a wider group of GPs. The only GP whose service had currently been expanded noticed little real change and was also optimistic:

‘It is openly available to them, should they want it, and I think it is important that we say that......I am aware of a colleague of mine that I know quite well......he sometimes uses the acupuncturist, but apart from that I am not really aware of other GPs doing that. I think perhaps quite a lot of other GPs are now sort of getting into having an osteopath and an acupuncturist in their own surgery’

Continuing need for evidence

Several GPs mentioned the continuing need for more evidence, especially in the areas of cost-and clinical-effectiveness in order to support and develop service provision:

‘I think our feeling at the moment is the only way we might move forward....is by producing research which shows the cost-effectiveness or other people producing research which show cost-effectiveness’

‘It very difficult because if you’re looking at evidence-based medicine, which is what you know the sort of primary agenda (is) for primary care groups and trusts......I mean there is increasing evidence that osteopathy, for instance, is an effective treatment, so I mean there is going to be a need for primary care groups to provide access to therapies that are useful’

‘I am worried that we might lose it, I think its got to be seen to be obviously providing value for money sort of thing. And it’s got to be seen to be effective, and you know we will be arguing very strongly from our point of view.....I know that (the acupuncturist) has been doing some audit on migraine and there are, some what look like very impressive figures...and I
think that’s going to help us when we argue the case with the PCGs, that hopefully we will be allowed to keep funding for it’.

‘As always I think research into outcomes needs to be enhanced…. I think the research programme, the new technology assessment (HTA) programme... I think it would be sensible for them to look at aspects of complementary therapies and to think about funding that at a funding stream, if they’re not doing already’

Some services were actively involved in research pilot schemes and all expressed interest in and/or engagement with research and audit. As noted in the ‘models’ report however the reality of conducting research was often very difficult for services and for some on-going research had not necessarily resulted in funding (e.g. Cases 8 and 10) which was experienced as frustrating. In one case, the service had been asked to produce research evidence that the service provider felt would have required considerable input from trained researchers over a considerable period of time:

‘there is no way we can provide them with that information.......... you know, so the primary care group.. I’m not suggesting that they are wrong to ask for that, I’m just suggesting that the logistics are that you can’t do it’

iv) Other Issues

A range of other issues were raised by interviewees in relation to PCGs. Mostly these related to doubts about the possibilities or likelihood of PCG’s enabling or supporting innovation in primary care, in complementary medicine or elsewhere.

One GP was especially concerned about the ‘domination of GPs’ and their attitudes within PCGs. This GP also worried that the approach of PCGs was too ‘top down’ and fostered a ‘blame culture rather than an enabling culture’ which impacted on the potential for the development of services and the morale of GPs. Another GP felt that PCGs were highly ‘variable’ in their approach and that it wasn’t necessarily worth investing too much effort in persuading an unsympathetic PCG:

‘I think its very difficult to know how they are going to take off, when we heard five years ago that fund-holding was going to be the thing and everyone was going to become fund-holders and its going to take over and that didn’t happen... Everyone is so focused on PCGs at the moment, I am not personally convinced that they will necessarily carry on in the way that they are planned’

Another service provider felt very disillusioned about the expectations surrounding the possibilities for complementary provision under PCGs:
'we have received so much conflicting advice from within the health service, well-meaning but totally conflicting. People would say, you would be in with a good chance because it will be in the hands of the GPs, or you should go to meetings, this is going to mean many new opportunities opening up, and I am sure that many other small providers like us have put in an enormous amount of time and energy which is literally wasted and they knew it, from a long time ago'

One ex-fund-holder GP felt that PCGs would be dogged by conflicts between ex-fund-holders and ex-nonfund-holders and that in terms of complementary medicine, the prospects were bleak. For this GP, primary care group commissioning was ‘a charter for private provision’.

Overall, most providers felt that complementary therapy provision in primary care would continue to survive in some form. However, this survival, and in particular any expansion, would depend on current providers keeping it ‘high profile’. As one provider said:

‘It’s going to bob about in the background. I don’t think it is going to go away, and then one day someone might, you know, put some money into it!’

v) Discussion points

- All services have been continued in short-term, but ex-fund-holding services in particular are undergoing a period of ‘provide and review’ and experiencing some considerable instability.

- Current providers seem committed to trying to maintain services in some way. In this sense their talent for innovation and seizing opportunities as they emerge, noted in the ‘Models’ research, remains important to service survival.

- Equity issues are seen as key to the provision of complementary medicine under PCGs. As a result services which continue may need to expand the population that they serve. This raises concerns about adequate resourcing.

- Complementary medicine is generally seen to be a low priority for PCGs, in both the short and longer terms, and there is a perception that existing providers will need to keep it on the agenda.

- The need for research evidence to support complementary medicine provision, particularly in terms of cost-and clinical-effectiveness is seen as still, if not more, important in a PCG culture.

1.3.2. Tracker Survey Data 1999.

Overall, CAM was rated a ‘low’ or ‘very low’ priority by the majority of PCGS, and none rated its priority higher than medium on a five point scale. However, over half the Chief Executives interviewed reported having discussed CAM at Board level, or said that they expected to do
so in the next 12 months (Figure 3). Policy development in those PCGs which had discussed CAM (N=33) varied. Twenty Chief Executives reported that a decision had been made about CAM provision in the PCG, and 15 PCGs could be said to have a ‘policy’ in place (21% of all PCGs). These policies were divided equally between positive and negative outcomes for CAM (Figure 4).

Figure 3
Has the provision of CAM been discussed by the PCG Board?
Figure 4
State of play in PCGs regarding CAM policy formation.

<table>
<thead>
<tr>
<th>Q: “Has the provision of complementary therapies ever been discussed by the Board?”</th>
<th>N=70 (100%)</th>
<th>Any decision re service provision</th>
</tr>
</thead>
<tbody>
<tr>
<td>“Yes, already been discussed or is being discussed”</td>
<td>n=33 (47%)</td>
<td>Will not provide (6)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Stop existing provision (1)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Expand (3)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Provide – maintaining status quo (5)</td>
</tr>
<tr>
<td>Shaded cases could be said to have a ‘policy’ N=15 (21.4%)</td>
<td></td>
<td>Review / Provide and review (7)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>To discuss as part of HAZ plan (1)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Decision anticipated (2)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>No decision yet (8)</td>
</tr>
<tr>
<td>“No, but expect to discuss in next 12 months”</td>
<td>n=9 (13%)</td>
<td>No decision /‘Parked’ (9)</td>
</tr>
<tr>
<td>“No, but might have to discuss in future”</td>
<td>= 22 (31%)</td>
<td>No decision (22)</td>
</tr>
<tr>
<td>“No, don’t expect to discuss this”</td>
<td>n=16 (23%)</td>
<td>No decision (16)</td>
</tr>
</tbody>
</table>

Seven PCGs (10%) reported that the outcome of discussions was not to fund CAM within the PCG. Reasons given for this were lack of funds to enable provision across the PCG, lack of evidence of effectiveness, and lack of support from the Health Authority,

“We have not got the resources to support them, to be supported they require more evidence of benefit.”

[We have decided] “to stop it. Acupuncture was provided by some fund-holders. It was stopped because (we) couldn’t roll it out.”

A similar proportion of PCGs (10%) reported that the outcome of discussions was to undertake a review of CAM services or therapies – some were prepared to do this alongside the continuation of existing services for a specified limited period. Several PCGs remarked that CAM provision was ‘controversial’. Review seemed appropriate, particularly given the perceived lack of support from the Health Authority for the provision of therapies in the absence of good evidence of effectiveness. Three PCGs reported plans to expand CAM services by ‘rolling them out to all practices in the locality’. These policies included plans to reduce the level of services at practice level in order to make a more limited service available across the PCG,

“Fund-holders were purchasing services, such as chiropractors or acupuncture…..It has been decided that the same service must be made
available everywhere, but some practices have had to reduce the level of services available”.

The majority of PCGs had not made any decision regarding CAM. Some of these PCGs appeared to have deferred taking any decision, but expected to do so in the next 12 months, while just over half the PCGs see CAM as an issue which might arise in the more distant future, if at all.

In the wider interview, Chief Executives were asked about the future of ex-fund-holder services in general. Responses indicate that some ex-fund-holding services are indeed under review, particularly consultant outreach clinics, some “in-house”/practice-based services, and services purchased from the private sector. The majority of PCGs mentioned some services which had ceased, or were under threat of discontinuation or reduction. Practice-based counselling and physiotherapy were the most frequently mentioned services, and CAM was mentioned specifically by ten PCGs.

At this early stage, no relationship was found between CAM policy formation and known PCG characteristics such as PCG size, deprivation payments or the proportion of ex-fund-holders. Nor was there any observable relationship between these characteristics and whether a PCG perceived CAM to be an issue or not. However, as a group, the 31 PCGs that identified one or more external factors supporting CAM on the agenda (saw CAM as an issue) responded less pessimistically to a question about their perceived capacity to manage expenditure, and more optimistically to questions about the potential impact of the PCG on the health of the locality in general, and chronic illness care in particular. As the numbers are small, these differences did not reach statistical significance. Despite the fact that private CAM use and provision tends to be concentrated in the south and south west, there was no discernible pattern between the geographical location of the PCG and their policy position regarding CAM.

Given the uniformly low priority accorded to CAM, it is interesting to note that it had been discussed by over half the PCGs, and one in ten PCGs were planning to undertake a review of CAM services and/or review the literature on efficacy for particular therapies. One of the reasons for this is likely to be the degree to which CAM is being ‘put on the agenda’ by external groups or by lobbying from purchasers or providers of existing services. If one in 12 practices offered CAM to patients via an ‘in-house’ service prior to the introduction of PCGs, the chances are that a significant proportion of PCGs contain at least one practice which is actively supportive of one form of CAM or another. Chief Executives were asked if they thought CAM was an issue for the PCG, and if so, what was it that had put it on the agenda; 40% of PCGs saw CAM as an issue, and on average PCGs identified two reasons. PCGs that had already discussed CAM at Board level identified an average of four reasons, and were twice as likely to mention each of the individual reasons. The reasons identified were, however, similarly ranked in both groups (Figure 5).
Provider and patient pressure were identified most frequently as the reason for CAM reaching the agenda for PCGs. In PCGs where CAM had already been discussed, the future of an existing service was clearly a strong driver for ensuring that CAM reached the agenda. Strategic planning and local consultation were comparatively rare contexts for CAM to emerge in. However, one of these two contexts was mentioned by 13 PCGs (19% of all PCGs). A similar range of pressures was observed for those PCGs that had not yet discussed CAM but expected to do so in the future.

1.4 Discussion

The picture provided by the Tracker Survey data in 1999 supports and complements that provided by the small sample of service providers. Only two provider practices saw CAM as a higher priority for their PCG than would be expected given the views of the representative sample of PCG Chief Executives in the PCG Tracker Survey. The message from the practices is that the PCGs have yet to get their position on CAM clear, and this is mirrored in the PCG data. From the PCG perspective, an interim policy of ‘provide and review’ may seem to be a good short-term strategy, particularly in relation to services provided by ex-fund-
holding practices. From the providers’ perspective, this is clearly less acceptable, and may lead to perceptions of instability and insecurity.

It is clear that a comprehensive picture of the impact of PCGs on CAM provision in primary care will not emerge for a while. For those PCGs that intend to roll out services, the key issue is likely to be finding resources to provide a worthwhile service that can provide equity of access for the entire PCG population. Possible strategies for limiting demand may include a low key approach to advertising the fact that existing services will be opened up, the introduction of a limited number of treatment sessions per episode, and the identification of particular patient groups for referral. In the longer term, the experiences of these pioneering PCGs will be invaluable to those considering setting out down the same path.

In the medium term, those PCGs that are planning to undertake service reviews will be looking for local evidence of service effectiveness, as well as published evidence of therapeutic or cost effectiveness. A small number of experimental service evaluations have been undertaken\textsuperscript{15,16,17}, but resources are rarely made available for the type of evaluation which results in a published or publicly available report. Some mechanism for sharing information, particularly with respect to local services, would therefore seem appropriate, thus increasing the pool of evidence and reducing the resources required to replicate evidence reviews in each PCG.
2 CHANGES IN PRIORITIES AND POLICIES BETWEEN 1999-2000

2.1 Background

This section examines changes in priorities and policies relating to CAMs in Primary Care Groups.

The new data in this section were collected in 2000, and the results compare changes observed in CAM between 1999 and 2000. The survey in 1999 (Section 1.0) showed at that time the priority of CAM provision by most PCGs was low. About half of PCGs had not yet reviewed the provision of CAM and only a minority had formulated a policy. Of the PCGs who had decided on a CAM policy, around half were ‘positive’ - to continue providing existing services or to provide these across all practices within the PCG. A few PCGs had decided to roll out provision across all practices. The experiences of these PCGs in attempting to find resources to provide a worthwhile service and equity of access for the whole PCG population will be beneficial to other PCGs considering a similar provision. For most PCGs in 1999, the issue of CAM had been brought by GPs who wanted to continue existing services. It seems, then, that the future of existing services, rather than the provision of new services, was what drew CAM to the agenda of the PCG boards.

Study objectives

i) A description of the progress made in the intentions of PCG board members to discuss CAM. Changes in this intention are shown by comparing the data for 1999 and 2000 on the question of whether CAM had been, or was expected to be discussed.

ii) To compare 1999 and 2000 data on how CAM became an issue for members of the PCG board.

iii) An assessment of the impact that a year of PCG structure has had on policies about the provision of CAM services in primary care by comparing the overall policy for CAM provision that was current in 1999 with the overall policy for CAM provision in 2000.

iv) An assessment of changes in priorities about the provision of CAM after a year of PCG structure by comparing 1999 priorities and 2000 priorities for each PCG illustrate where any changes have occurred.

2.2 Methods

2.2.1 National Tracker Survey Data 2000

Telephone interviews with Chairpersons of a representative national sample of 71 PCGs in England (approximately one in seven) were carried out in Autumn/Winter 2000 by researchers at the National Centre for Primary Care Research in Manchester. These PCGs
were the same as those 72 surveyed in 1999; two PCGs had become incorporated into one. Additional questions relating to complementary medicine were added to the schedule on behalf of the MCRU and the data made available to us for analysis. The questions are in Appendix 3.

2.3 Results

2.3.1 Progress on discussions about CAM at PCG board level

In 2000, over half the Chairpersons interviewed (73%) reported having discussed CAM at Board level, or said that they expected to do so in the next 12 months.

Half (11/20) of sampled PCGs whose Chairs had stated an intention to discuss CAM in 2000 had done so, and a further 50% of PCGs who in 1999 stated an intention to discuss CAM ‘sometime in the future’ had done so by November 2000. During 2000, CAM was discussed by over half the sampled PCGs (37/71=54%) and two thirds of the PCGs sampled (45 /63%) had discussed CAM either in 1999 or during 2000 (or in both).

Of those PCGs who, in 1999, did not expect to discuss CAM, 26% had in fact done so in 2000. Only 11 sampled PCGs (15%) had never discussed CAM and still expected not to have to do so in the future. The progress of intentions to discuss CAM is shown in Figure 1.

**Figure 1 Progress of intentions to discuss CAM**

![Figure 1](image_url)
2.3.2 What has put CAM on the agenda of PCGs?

Between the years 1999 and 2000, there are differences in the way in which CAM became an issue for the PCG board. In particular, an individual member of the board was more likely to have raised CAM as an issue in 2000 (32%) than in 1999 (10%).

**Figure 2: What has put CAM on the agenda in your PCG? (for those PCGs who have discussed CAM)**

Key:

A  Raised by local general practice currently offering a service
B  Raised by individual member of the Board
C  Raised by local GP(s) on behalf of patient requesting treatment
D  Raised by local complementary therapy provider(s)
E  Other
F  Raised in context of service development plans (eg HlmP or PCIP)
G  Raised through wider priority consultation exercise (eg with public)

Figure 2 describes what put CAM on the agenda for each PCG. PCGs who had discussed CAM at board level had on average one reason each for CAM being raised for discussion.
Twelve PCGs gave up to five reasons for raising it. Board members and practices currently providing a CAM service were identified most frequently as raising CAM as an issue for the agenda of PCG Board meetings. As in the 1999 survey, the future of an existing service was the single most important driver for ensuring that CAM reached the agenda. Service development plans and local consultation were, as in 1999, comparatively rare contexts in which CAM emerged as an issue. However, 8 PCGs (11% of all PCGs surveyed) mentioned one of these two contexts.

2.3.3 New decisions regarding CAM since 1999

The majority of PCGs had not made any decision regarding CAM. Twenty five (35%) of the sampled PCGs reported having made a decision in the 2000 survey, and for 14 (20%) of these, a decision had not been reported in the previous survey. Eight PCGs (11%) reported that the outcome of discussions since 1999 was to reduce or cease existing CAM within the PCG. Reasons given for this were lack of funds to enable provision across the PCG and change of contractual arrangements within the PCG. One PCG (1%) had discussed CAM and decided not to provide it at present. Their reason was reference to a Health Authority list of therapies not accepted under the NHS.

Five PCGs (7%) reported that the outcome of discussions was to undertake or continue a review of CAM services or therapies – some were doing this alongside the continuation of existing services for a specified limited period. Four PCGs reported plans made since 1999 to expand CAM services by rolling them out to all practices in the PCG. One of these PCGs, while rolling out one CAM service (acupuncture) was stopping provision of another (homeopathy).

“Cease homeopathy. Provide GP-run acupuncture clinic in the local Community Hospital.”

“(We will) increase acupuncture services to make (them) available to all 19 practices and rollout chiropractic sessions,...” (Interestingly, a potential “shortage of providers” was anticipated by this PCG)

“Acupuncture and osteopathy to be rolled out.”

“(We will) roll out osteopathy.”

Three additional PCGs stated in 1999 that they would rollout CAM provision across the PCG. One of these reported in 2000 that they were now piloting a PCG-wide service under the Health Action Zone scheme. One had ceased the rollout of chiropractic and acupuncture, as it was not deemed possible to provide it for everyone across the PCG, but had rolled out counselling across the PCG. The third had intended in 1999 to rollout provision of homeopathy from a single GP practitioner to the whole PCG, but by 2000 had ceased the service.
2.3.4 CAM policy formation

The overall level of policies regarding CAM in the sampled PCGs was also reviewed. In 1999, the number of sampled PCGs with an identifiable CAM related policy was 15 (21%). In 2000, 26 (37%) of the sampled PCGs reported a policy about CAM provision. In 1999 nine PCGs (13%) could be considered to have a positive policy (to provide, increase provision or rollout provision over the PCG). By 2000, this number had increased to 13 (19%). However, the number of sampled PCGs with a negative policy also increased. In 1999, 6 of PCGs (8%) had a ‘negative’ CAM policy (to reduce or cease, not to provide); compared to 11 of PCGs (16%) in 2000 (See Figure 3). Two PCGs had a positive policy for one CAM therapy and negative for another.

Figure 3 Changes between 1999 – 2000 in PCG policy on the provision of CAM

At this stage, no relationship has been found between CAM policy formation and known PCG characteristics such as number of registered patients, number of principals or trust status. There was no observable relationship between these characteristics and whether a PCG perceived CAM to be an issue or not.

2.3.5 CAM priority in the PCG

For 42% of PCGs, the provision of CAM was of a higher priority in 2000 than it had been in 1999, although for most of these, the change was from ‘very low’ to ‘low’ priority. Overall, CAM was still rated a ‘low’ or ‘very low’ priority by the majority (85%) of sampled PCGS in
2000. Only one PCG (1.5%) rated its priority higher than medium on a five point scale. (Figure 4).

**Figure 4** Changes between 1999–2000 in the Priority of the provision of CAM within the PCG

![Bar chart showing changes in priority]

2.4 Discussion

The picture provided by the Tracker Survey data supports and complements the findings of a small sample of service providers reported in Section 3 of this report.

Although the overall priority of CAM for most PCGs in 2000 is still low or very low, 42% of PCGs considered the provision of CAM to be a higher priority in 2000 than it had been in 1999 and only 20% stated it had lower priority than in 1999. By 2000, most PCGs had discussed the provision in either 1999, 2000 or both. As in 1999, the most likely route for CAM to be put on the PCG board agenda in 2000 was by being raised by a practice already offering a service. The existence of a service still seems to be the main driver to discussing CAM provision.

In the Section 1.0, we speculated that for PCGs intending to roll out services, the key issue was likely to be finding resources to provide a worthwhile service that can provide equity of access for the entire PCG population. Of those three PCGs reporting a decision in 1999 to rollout service provision across the PCG, all had discussed CAM at Board level in 2000. Two PCGs were continuing to provide the service PCG-wide and another had ceased the service, as it was not possible to provide it for everyone. The PCGs continuing to rollout CAM provision reported a higher priority for CAM in 2000 than they had in 1999. It is interesting to note than concerns about provider availability are beginning to be voiced.
Overall, in 2000, the picture of policies about CAM provision and the priority that this is given by PCGs is not radically different from that seen in 1999. There is some indication that it is slowly increasing in its overall priority as an issue for PCGs to discuss.

In 1999 13% of the sampled PCGs reported a policy relating to CAM provision. These policies were slightly more likely to be positive (to provide or expand existing provision) than negative (to reduce or cease provision, or not to provide a new service under consideration). A year later more than one in three of the same sample of PCGs reported a policy relating to CAM. New decisions were evenly balanced between those with a ‘positive’ policy and those with a ‘negative’ policy, resulting in 19% of all sampled PCGs reporting a positive CAM policy in 2000. This balance between negative and positive policies probably reflects current dissatisfaction and uncertainty about the evidence base for CAM. By October 2000 6 PCGs (8%) reported a CAM service operating across the PCG. If the 71 ‘Tracker’ PCGs reflect national picture, we can expect up to 40 PCGs in England to be currently operating a PCG–wide CAM service for NHS patients.
3 KEY INFLUENCES ON POLICY DEVELOPMENT 2000-2001

3.1 Background

This Section is based on work undertaken between 2000 and 2001 and examines the influences shaping PCG policy development in relation to CAM services. Previous work had shown that services were funded through a variety of mechanisms, and lack of stable funding proved the key barrier to maintaining the services, and considerable concern was expressed for those services supported through fund-holding initiatives.

Building on previous work, we set out to provide an expanded view of the influences affecting CAM in a sample of PCGs identified via the Tracker Survey as being engaged in positive policy formation about CAM services, one year into the operation of PCGs.

3.2 Methods

Sample frame

The sample frame consisted of the 72 PCGs included in the 1999 Longitudinal Tracker Survey (NPCRDC). PCGs were classified according to their current reported policy status regarding CAM services (See Appendix 4).

Sample

A purposive sample was identified from the responses by Chief Executives of PCGs indicating active involvement in positive policy formation relating to the provision of CAM services. Ten PCGs located in seven of the eight NHS Executive health regions in England as configured pre-April 1999, met the sample criteria. The nature of the policy decisions anticipated in relation to CAM services existing at the time of the 1999 Tracker by these PCGs, were to ‘expand’ provision (n=4/9), ‘review provision’ (n=5/9) and ‘review and expand provision’ (1/9). PCGs ranged in size from 8 to 42 practices (Figure 1).
Table 1

<table>
<thead>
<tr>
<th>PCG id</th>
<th>NHS Executive Regions</th>
<th>No of practices in PCG*</th>
<th>% practices previously fund-holders*</th>
<th>Interviewee designation</th>
<th>Date of Interview</th>
<th>Interviewer</th>
</tr>
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<tbody>
<tr>
<td>1</td>
<td>South East</td>
<td>8</td>
<td>38%</td>
<td>Primary Care Development Manager</td>
<td>05/12/00</td>
<td>PC</td>
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<td>2</td>
<td>South West</td>
<td>14</td>
<td>No information</td>
<td>Assistant General Manager</td>
<td>18/09/00</td>
<td>PC</td>
</tr>
<tr>
<td>3</td>
<td>West Midlands</td>
<td>18</td>
<td>11%</td>
<td>Commissioning Manager</td>
<td>07/11/00</td>
<td>PC</td>
</tr>
<tr>
<td>4</td>
<td>North &amp; Yorks</td>
<td>16</td>
<td>0%</td>
<td>Chief Executive</td>
<td>27/09/00</td>
<td>PC</td>
</tr>
<tr>
<td>5</td>
<td>North &amp; Yorks</td>
<td>33</td>
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<td>Primary Care Development Manager</td>
<td>27/09/00</td>
<td>PC</td>
</tr>
<tr>
<td>6</td>
<td>North &amp; Yorks</td>
<td>11</td>
<td>64%</td>
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<tr>
<td>7</td>
<td>Eastern</td>
<td>19</td>
<td>42%</td>
<td>Head of Health Development</td>
<td>18/09/00</td>
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</tr>
<tr>
<td>8</td>
<td>London</td>
<td>42</td>
<td>26%</td>
<td>Consultant in Public Health Medicine</td>
<td>20/09/00</td>
<td>PC</td>
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<tr>
<td>9</td>
<td>North West</td>
<td>20</td>
<td>50%</td>
<td>Commissioning Manager</td>
<td>18/09/00</td>
<td>KJT</td>
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<tr>
<td>10</td>
<td>North &amp; Yorks</td>
<td>13</td>
<td>23%</td>
<td>Abandoned following exhaustive attempts to set up interview</td>
<td>-</td>
<td>-</td>
</tr>
</tbody>
</table>

*Source: Responses to Tracker survey (NPCRDC Manchester, 1999)

Data collection

All Chief Executives from the 10 sampled sites who had participated in the ‘Tracker Survey’ interview were contacted first by letter requesting that they agree to a telephone interview regarding CAM service provision and policy, or nominate a suitable person in the organisation. Telephone interviews were arranged with the designated person in each PCG. Decisions about CAM provision in the PCG, developed since completion of the 1999 Tracker survey were explored by the researcher using a semi-structured telephone interview schedule (Appendix 5). With permission of the interviewee, the interview was tape-recorded and transcribed.

Analysis

Each interview generated a brief descriptive case study of policy and provision, as well as further cross–case thematic analysis. Texts were coded and analysed using a ‘Framework’ approach. Analysis was supported by ‘winMAX’ qualitative analysis software. A simple thematic analysis was conducted, looking for a priori themes from the schedule and for emergent themes across and within the different sites. Initial themes included ‘models of

3.3 Results

3.3.1 Response

Nine of the ten interviews planned were achieved. One PCG failed to nominate a suitable interviewee, despite a number of contacts by phone and letter. The most frequent title of the interviewees designated by the PCG was Commissioning Manager or Primary Care Development Manager (see Figure 1).

3.3.2 A descriptive account of CAM provision in PCGs indicating a positive policy orientation in 1999.

Current provision

Of the nine PCGs for which we have data, two reported no CAM services. One, a level 2 PCG, was guided by a decision by the Health Authority not to include osteopathy (provided previously) on its list of approved services (PCG 3). Another had ceased supporting what had been a fund-holding, practice–based CAM service (PCG 7), but was in the process of evaluating all services and reported an expectation that osteopathy and acupuncture services would be reinstated. In the meantime, the acupuncture service had indicated the intention to continue with charges to patients. One PCG (6) indicated that an existing, practice–based service would continue for the immediate future. All other six PCGs reported that they had expanded CAM provision to make it accessible across the PCG, sometimes with the level of service diluted. A summary of the provision reported is given in Figure 2.

Box 1 Key characteristics of current provision

- Diversity of delivery models remains
- Limited range of CAM therapies (mostly the ‘big five’)
- GP provision predominates
- Building on existing services
- ‘Rolled–out’ services are often scaled down
- Services are time–limited and monitored
- Quality assurance mechanisms are variable
- Funding sources are critical
## Figure 2 Summary of provision of CAMs

<table>
<thead>
<tr>
<th>PCG</th>
<th>Position as at November 1999 (Tracker survey data)</th>
<th>Position as at December 2000 (Interview data)</th>
<th>Service change under PCG</th>
<th>Service scope</th>
<th>Details of service(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Service change under PCG</td>
<td>Service scope</td>
<td></td>
<td>Details of service(s)</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>The existing osteopathy provision will continue for the next 3 years. The service is available to all patients in the PCG and provided by private providers who come into several of the practices. It is funded by the GPs. Several GPs provide homeopathic and other CAM remedies as part of their services to their own patients. Several GPs are trained in acupuncture. There is a lot of expertise in CAM within the PCG but future expansion in PCG provision will depend on the drivers of the health services.</td>
<td></td>
</tr>
<tr>
<td>1.</td>
<td>Review — the question is whether or not we should continue the following services, how and in what way; osteopathy, counselling and some existing acupuncture.</td>
<td>Expanded</td>
<td>PCG-wide service  + Practice-based services maintained</td>
<td>New Dorset-wide initiative – PCG holds additional budget to provide an acupuncture service for East Dorset. Service is provided by a single practice with open referral according to protocols. The service is being audited. Two practice-based services offering acupuncture and chiropractic will continue. For the future, nothing planned; “our development money is tied up with our prescribing budget….it would largely depend on practice priorities….acupuncture provision isn’t high on our agenda”</td>
<td></td>
</tr>
<tr>
<td>2.</td>
<td>Review — Acupuncture and chiropractic in some practices. Review of complementary therapies is being undertaken. Formal proposal to the board regarding policy.</td>
<td>Expanded</td>
<td>Health Authority-wide service  + Practice-based services maintained</td>
<td>No CAM provision currently. Health Authority provides a portfolio of approved services. PCG is level 2 PCG and does not make decisions independently of the HA. There is some pressure from patients for CAM and provision may change in the future as the PCG moves towards Trust status and greater independence from the HA.</td>
<td></td>
</tr>
<tr>
<td>3.</td>
<td>Review — HA has linked all therapies not accepted under NHS (inc. osteopathy – which has been very controversial). No decisions yet by Board about what to do about this.</td>
<td>Reduced</td>
<td>No provision</td>
<td>Maintaining existing service - one homeopathy clinic provided by one GP each week open to all practices, and funded by the PCG. Board decision not to expand provision in the immediate future. The main reason for this decision, CAM not a high priority for expansion when faced with competing health priorities.</td>
<td></td>
</tr>
<tr>
<td>4.</td>
<td>Expand — Funding a GP for homeopathy with access for all PCG patients.</td>
<td>Expanded</td>
<td>PCG-wide service</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### Figure 2 Summary of provision of CAMs (Cont’d)

<table>
<thead>
<tr>
<th>PCG</th>
<th>Position as at November 1999 (Tracker survey data)</th>
<th>Position as at December 2000 (Interview data)</th>
<th>Details of service(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Service change under PCG</td>
<td>Service scope</td>
<td></td>
</tr>
<tr>
<td>5.</td>
<td>Review — To investigate further the effectiveness of complementary therapies before making decisions</td>
<td>Expand following pilot</td>
<td>PCG-wide service anticipated</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>The piloting of two CAM services: homeopathy and acupuncture approved in principle with an expected implementation date early in January 2001. Currently homeopathy and acupuncture are provided by one GP to his/her patients with private referrals from other GPs. As part of a local development scheme initiative, the pilot will make funds available to allow referrals across the PCG. The pace of change is slow but moving forward. Equity of access to services, training and qualifications of the practitioners are important issues around future provision.</td>
</tr>
<tr>
<td>6.</td>
<td>Expand — Acupuncture clinic carrying on for one year only – if it can be demonstrated to be effective, we will try to expand the service.</td>
<td>Maintained status quo</td>
<td>Practice-based service</td>
</tr>
<tr>
<td>7.</td>
<td>Expand — F/holders were purchasing chiropractic and acupuncture. Same services must be made available everywhere, but may have to reduce the level of services available.</td>
<td>Reduced</td>
<td>No NHS provision</td>
</tr>
</tbody>
</table>
### Figure 2 Summary of provision of CAMs (Cont'd)

<table>
<thead>
<tr>
<th>PCG</th>
<th>Position as at November 1999 (Tracker survey data)</th>
<th>Position as at December 2000 (Interview data)</th>
<th>Details of service(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>8.</td>
<td><strong>Expand and review</strong> — Osteopathy – have extended this as a pilot for 6 months. Will evaluate. Homeopathy is still funded via referrals to Royal Homeopathic Hospital.</td>
<td>Expanded PCG-wide service</td>
<td>Practice-based osteopathy service was extended to neighbouring practices, with referral protocols and reduced access. High levels of satisfaction with this service. Service to be rolled out to entire PCG as part of an integrated musculoskeletal service, using Health Authority growth money. Royal Homeopathic Hospital is local provider. Referrals will continue to local for packages of CAM care (e.g. eczema clinic). No future expansion of CAM anticipated but consultations ongoing towards providing an integrated service with physiotherapy.</td>
</tr>
<tr>
<td>9.</td>
<td><strong>Review</strong> — Chiropractic service funded and under review</td>
<td>Expanded PCG-wide service + Practice-based services maintained</td>
<td>Acupuncture service – former fund-holding GP providing service to own and one other practice. From October 2000 GP will do 2 evening acupuncture sessions at local hospital pain clinic, with open access to all GPs. Decision taken in context of equity of access, impact on waiting times - funded by f/holding and new development budgets. For future, the PCG will choose one of these to integrate with physiotherapy as gatekeeper or triage - as a locality service with PCG-wide access. Other provision for two practices only, one offering referrals to private clinic for chiropractic and one for osteopathy - for practice patients only. Both services are funded as waiting list initiatives through the Health Authority. Both being evaluated and will continue until March 2001. For future, the PCG will monitor this service for 18 months and assess demand and impact. Second GP interested in training.</td>
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CAM provision was equally likely to be provided from within a practice as from a central location (private surgery or NHS hospital). Four CAM therapies: osteopathy, acupuncture, chiropractic and homeopathy were available (Figure 3).

A proposal to provide hypnotherapy (PCG 6) had not been supported by the Board. The patients of one PCG might receive additional therapies through referral to the clinics of a local CAM provider unit offering a range of therapies appropriate to particular health problems (PCG 8). All the acupuncture was provided by GPs from practices in the PCGs, and most of the homeopathy was provided by practice-based GPs. In this sample, osteopathy and chiropractic were the only therapies provided exclusively by independent CAM practitioners. The majority of services were extensions or continuations of existing practice–based services. The exception was a new area-wide service where a GP was providing acupuncture pain relief service based in the local hospital (PCG 2). All services were time–limited. The longest commitment for support was for three years (PCG 1).

Figure 3 Summary of CAM provision by therapy

<table>
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<tr>
<th>PCG</th>
<th>Osteopathy</th>
<th>Homeopathy</th>
<th>Acupuncture</th>
<th>Chiropractic</th>
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<td>All</td>
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Most of the PCGs providing CAM had developed or were in the process of developing some form of audit and/or referral protocols although some of these were kept by the provider in the practice rather than at PCG level. Four PCGs in the sample (4, 5, 8 and 9) had carried out their own evaluations of the services following pilots of the CAM services they intended to provide before rolling out their particular CAM services across the PCG.

Funding sources

Within this sample, additional Health Authority funding, either currently or in the past, emerged as a significant factor in the decision to provide PCG-wide CAM services. Of the six PCGs that had extended CAM across the PCG, five referred to Health Authority development money. In PCGs 1 and 8 growth money from the Health Authority has been used by the
respective PCGs to support the expansion of the previous practice-based CAM services across the PCG,

“….it’s [CAM] funded from our own PCG – we’ve had development money but when I answered that question its part of the PCG budget – we decide how to use that money.” PCG 1

The PCG-wide osteopathy and chiropractic services of PCG 9 were funded by the Health Authority until March 2001 as part of current waiting list initiatives,

“….it [CAM] was funded as a waiting list initiative through the Health Authority, and basically, we’ve just supported that….” PCG 9

PCG 2 continued to fund CAM services for patients in two of its practices but additionally, held a separate budget from the Health Authority to provide an area-wide acupuncture service,

“….the Health Authority has basically devolved the budget for extended primary care services that are actually delivered to patients at a practice level….straight to the Primary Care Groups.” PCG 2

“….the only thing that’s happened ….is that the PCG [has] now been allocated budgets to provide [area]-wide services for complementary therapy….” PCG 2

PCG 4 had been in receipt of Health Authority development money for CAM services in the past, but this had now become part of the PCG budget,

“…. I mean originally, at some point, you know a long time in the past, somebody found some sort of development money to pilot it [CAM] and then once it worked we simply rolled the money over into our mainstream budgets.” PCG 4

Four PCGs did not refer to being in receipt of additional HA money. Of these, PCG 6 was continuing to fund NHS access to CAM in one practice only, although the patients of other practices could be referred on a private fee-paying basis. The problematic nature of this state of affairs was recognised,

“that’s an anomaly we need to sort out. It’s either a service that everybody pays for because we don’t support it or it should be a service that nobody pays for because we do support it” PCG 6

Two others (PCG 3 and PCG 7) were not funding any CAM activity at all. PCG 3 was a level 2 provider and, in relation to CAM services, was guided by the local Health Authority agenda. PCG 7 had decided not to continue to fund CAM for the time being, but the services were was still available privately to patients,
“….the decision was to cease funding from the beginning of this financial year excepting that we would meet the cost of patients who were already in the system…….[but]….the demand for that [acupuncture] has not gone down and the practice concerned is still continuing to do it, but not being given money to do it, so unfortunately it is having to charge patients, but the patients are not going away because they genuinely believe in it…..”  PCG 7

Following a pilot, PCG 5 had in principle approved some level of PCG-wide CAM activity funded from their mainstream budget to begin early in 2001, but at the time of the interview, the detail of this provision was still being developed.

Future plans for existing services

In all PCGs in this sample, the development of current CAM services is expected to be a gradual process, dependent on funding opportunities and competing national and local health priorities. CAM was seen as a low priority for PCGs when compared to other health priorities such as those in the National Service Frameworks. The pace that CAM in primary care develops will also depend on patient demand. Despite a lot of publicity, one initiative was reportedly “…very, very slow to take off” (PCG 8). In response to a direct question, one interviewee (PCG 5) said that CAM was mentioned in their Health Improvement Plan, but most either were unsure or felt the plans were not developed sufficiently at this stage. In one PCG (PCG 6) CAM may form part of a Healthier Living Bid, and is currently being discussed as a component of health promotion for reducing stress for NHS staff in the workplace. The PCG that had taken a decision to cease funding any CAM (PCG 7), was reviewing that decision in the context of a wider review of all services.

3.3.3. Influences on policy formation and development

The PCGs sampled were not selected to be representative of all PCGs, rather they represent a sub-set of PCGs which indicated in 1999 that they were developing positive policy in this area. Policy development in relation to CAM services at PCG level was examined in the light of a thematic analysis of the perceived ‘brakes’ and ‘drivers’ shaping policy formation.

‘Brakes’ on CAM policy and service development in PCGs

A number of sub-themes were identified encompassing issues acting as ‘brakes’ on CAM provision in that either they were referred to as impacting directly on the decision not to provide CAM, or as slowing the pace of development of CAM services. Those that emerged across the interviews included the following;
The most frequently mentioned obstacle to NHS provision was the perceived need to ensure equity of access to services (PCGs 3, 5, 6, 7, 8 and 9). This becomes a reason for not planning CAM services because PCG or practice-based services may result in de facto ‘post-code prescribing’, and PCG-wide services are perceived as too expensive,

“….the equity issue is a big issue…we don’t want it to become just for a number of patients, we want it to be opened up for everyone…..” PCG 5

“That’s one of the anomalies we need to sort out. It’s either a service that everybody pays for because we don’t support it or it should be a service that nobody pays for because we do support it….we haven’t actually sorted that out properly “ PCG 6

“…we’ve also looked at equity of access along the way because as they were they were very practice-based and we said if we want to continue these services we want them equal access across the whole of [the PCG]” PCG 9

“The main reason that we’re doing that is this issue around post-code prescribing........if our PCG says right Ok we’re going to start funding homeopathy or something and the PCG down the road isn’t doing that... I think it’s unfair really…it doesn’t give equity of access for patients in the area.” PCG 3

“If we were to make it available to al 19 practices we couldn’t afford to put any more money into them and equally we wouldn’t want to make the service we currently have so diluted that it would be meaningless.” PCG 7

For other PCGs, diluting the service was seen as the solution to the equity issue, even if this meant limiting the scope of the available service. In PCG 8 the overall of funding of CAM activity had been increased, but the service at individual practice level was less than had been available under fund-holding,

“….there was a level of funding going in from the fund-holding practice and what happened was that we funded a level of activity which was obviously an
increase on that, but we didn’t expect all of the practices to make use of the service as the fund-holding practices did, and in fact they had to reduce their levels of referral.” PCG 8

The second most frequently mentioned obstacle was the adequacy of the evidence base for CAM. A perception of the lack of appropriate evidence of effectiveness in relation to CAM was mentioned by the majority of interviewees (PCGs 2, 3, 4, 5, 6 and 7),

“….one of our GPs said that well we find it difficult enough to get things funded which are evidence-based quite often...you know, cancer drugs or whatever, and so how can we support something [CAM] which in theory isn’t evidence-based in the way that other research is…..that’s the dilemma really….I think if it [CAM] were more evidence based it would come higher up the agenda…it would have the same weight as other treatments” PCG 3

“The evidence base has always been the issue hasn’t it? ………there was a proposal put forward by a different GP to actually provide that service but on the evidence-base to hand at the time, we were not convinced that it was an effective provision…” PCG 6

“ what Board members are concerned about is having an evidence base for the therapy……for example - “Is acupuncture an effective [treatment ] for pain control?” PCG 2

The specific sources of funding for CAM services have been described above (1.2), and of course all decisions around which health services to provide are linked to availability of funding, and wider health agendas. However, competing priorities for funding were referred to by PCGs 2, 4, and 7, and cost pressures were raised specifically by the interviewees in PCGs 2, 3 and 7, as barriers to providing or extending CAM provision,

“….you’ve got a choice which says you’ve got X amount to invest and your priorities might be re-vascularisation, in heart disease, mental health services, diabetes…It is very difficult for alternative therapies to argue their case as a priority when you do have some very big priorities which you have to deal with.” PCG 4

“….what happened then is hit by cost pressures specifically and particularly continuing care where …we have had a number of really high cost patients coming on which were very, very expensive…” PCG 7

“financial cost pressures swayed the vote and the vote went against continuing to fund complementary medicine.........we can’t afford to do it because of the financial pressures rather than service issues” PCG 7
“Our money is tied up……our development money’s tied up with our prescribing budget as many PCGs are” PCG 2

“it’s difficult for us to support that [CAM], especially when we have limited resources for other areas or other purposes PCG 3

Four interviewees (PCG 3, 4, 6 and 7) referred specifically to prejudice against CAM and to tensions between the beliefs and attitudes of general practitioners, and the holistic ideas that underpin CAM, as contributing to an environment that is not always sympathetic to the development of CAM services,

“you can guess the normal sort of comments….well I don’t refer to it” ….“I’ve never seen an evidence base for it” PCG 4

“…And the whole philosophy really and I think for the GPs that’s quite difficult for them [GPs] to adopt a more holistic view whereas they’ve been trained in a different way….the GPs are very medically-orientated….very treatment based aren’t they, and complementary therapies are more holistic and it’s a very different model of care isn’t it?” PCG 3

“….And you know, there are some, let’s be honest you will get them, some GPs with their scientific background, saying that there is not the evidence to support complementary medicine as against the normal sort of medicine” PCG 7

Two PCGs (PCGs 5 and 6) discussed the need to ensure that the appropriate quality assurance indicators, covering both training, qualifications and competence of the practitioner, as barriers to provision,

“….there were some people [on the Board] who just wanted to made sure that the GP was actually qualified and could cope with complications and training, that the appropriate audits were in place and clinical governance standards were adhered to….“ PCG 5

“The thing from our point of view is whether there is a clear evidence base and that referring GPs can be satisfied with the competence and the effectiveness of the individual providing the service” PCG 6

Finally, the need to have clear referral protocols and audit trails in place, before carrying decisions to provide CAM forward to implementation was also mentioned as a potential obstacle to service development in CAM,

“….we’re going to have to have some reasonably strict protocols in place and he’s able to treat patients who are seen as suitable and I suppose to make sure that it [CAM service] doesn’t become a ‘dumping ground’ for GPs to pass them [patients] on…..” PCG 5
Provision ‘Drivers’

A number of issues were identified as facilitators or ‘drivers’ of CAM provision. Key issues that emerged across the interviews included the following:

<table>
<thead>
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<th>Box 3 Drivers of CAM provision by PCGs</th>
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<tbody>
<tr>
<td>• Existing provision</td>
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<tr>
<td>• GP interest and ‘champions’</td>
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<td>• Perceptions of benefit</td>
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<tr>
<td>• Evidence of patient demand and satisfaction</td>
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<td>• HA funding and growth money</td>
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Not surprisingly, new and emerging services are developing out of existing provision that pre-dated the introduction of PCGs. The existence of an ‘up and running’ practice-based service is clearly a strong driver for the development of positive policy in this area,

“[CAM] was looked at because it was already running in two practices........ It’s hard to stop it for GPs who are using the service and if you do stop it, you have to look at extra demand on other services. We like to think that our GPs have set up these services for a reason, we need to look at that...PCG 9

“……originally at some point you know a long time in the past, somebody found some sort of development money to pilot it [homeopathy] and then, once it worked, we simply rolled the money over into our mainstream budgets” PCG 4

“The initial service was obviously practice-led....basically we just supported that....while we looked at it” PCG 7

A pre-existing service also means that there is at least one GP ‘champion’ within the PCG who had an interest or expertise in some aspect of CAM. The perceived benefits of CAM for patients therefore were significant factors in the continuation or expansion of all types of CAM service, including those not provided directly by a GP,

“It's not just enthusiasm........there’s a fair degree of expertise [in CAM] and in most cases, this is incorporated into the way they deliver their medicine .... I mean we've got a number of GPs who do provide homeopathic remedies or other complementary therapies as part of their services. We've got several GPs who are trained in acupuncture or other aspects of complementary medicine.” PCG 1
“There were a number of more supportive voices, you know perhaps from the younger GPs who sort of said “I've referred a few patients in and got good results, so I could refer some more patients” PCG 4

“There were two practices that I recall that funded osteopathy, so it was a minority, but it was one practice which were particularly advocates of the service………………they were able to refer to their own very positive experiences as GPs………the real mover behind the service was not a Board member……..the thing that made it get approved was…the pitch if you like…made by the osteopath and the GP together.” PCG 8

Patient demand for CAM services was cited specifically as a significant driver of service provision, and awareness that patients were accessing services privately was also a consideration with ‘willingness to pay’ for CAM services being accepted as evidence of demand,

“…patient demand. I think it has changed over the last few years and patients are now looking at complementary medicine rather than just accepting “Oh I need to see a consultant and he'll sort it out”. A lot of it is word of mouth…..if the service has been used and the person has benefited then they will go along to the GP and ask for it.” PCG 9

“we do have some individual requests by either patients or practices…you know…for some form of complementary therapy….I'm thinking about chiropractic for example” PCG 3

“we looked at the local plan to see whether there are any gaps in services [and] there are a number of people having things like complementary therapy, aromatherapy, counselling…” PCG 2

“It's difficult to gauge whether demand expands to fill the [CAM] service available. There is always a suspicion about that, but….. we've always got plenty of referrals and a small waiting list.” PCG 4

“I think patients are the main driver as well……patients are beginning to say “look, we want to try……we want to have access to be able to try all types of medicine to see how it can help our condition”……The patient demand is still there …..with the acupuncture service that was [discontinued] the practice is having to charge patients, but the patients are not going away – because they genuinely believe in it…..We have to stop being the ones who say “this is what the patients want” – well, have we actually asked the patients?” PCG 7
“…it's a GP whose got some expertise...I think he's being doing it privately for a number of years and basically wants to make it more mainstream and to open it up to all patients not just his own patients....” PCG 5

Those who also indicated a commitment to developing new services in the future tended to adopt a more flexible and pragmatic approach to what counted as ‘evidence’. For example, looking at the results of audits and patients’ self-reported outcomes and satisfaction. Where it was available, evidence from local audits and evaluations appeared to contribute directly to positive policy decisions,

“...I think if you tried to apply the rules of evidence-based medicine that you’d apply to some other things you might have trouble with homeopathy” PCG 4

“An audit was carried out looking at...who was using the service and user satisfaction with the service....both the GPs and users were very happy ....the numbers were not huge but on self-reported outcomes, all the indications are that it went down very well indeed...It would have been very difficult with the level of satisfaction and self-reported outcomes not to continue.....it [CAM] was obviously feasible, people liked it, used it and it appeared to work well” PCG 8

Whilst local champions, patient demand and satisfaction with existing CAM services were all acknowledged to be important contributing factors however, the overwhelming perception was that policy development in this area, as in most others, was critically dependent on the availability of adequate funding. The PCG with the most ambitious CAM policy, acknowledged the vital role of growth money,

“As regards the work that the PCG has done. It’s probably worth knowing that that's in the context of us as a Health Authority funding quite a significant amount of growth so whether we would have made the same provision is weren't in receipt of substantial growth I don’t know. It’s much easier to do these things when you’ve got the money to develop these services.” PCG 8

The wider policy context

This study was conducted during the first year of PCGs. It is not possible to understand the policy development relating to CAM without setting it in the wider context of the reconfiguration of primary care delivery and commissioning and the ending of GP fund-holding. The key issues that emerged here were:
The wider policy context was paramount in determining the shape of services within the PCG. Competing NHS national and local agendas were sometimes cited as constraints on providing CAM services, but in other PCGs it emerged that CAM had developed where the benefits of doing so coincided with national NHS priorities. Within the wider health agenda therefore managing the transition from fund-holding, and opportunities where ‘services and priority’ converged came out as strong drivers of CAM policy.

With one exception (PCG 4) all the sampled PCGs contained ex-fund-holding practices. For many PCGs, managing the transition from fund-holding, was a consideration in the development of policy relating to CAM services,

“It was very much about the end of fund-holding and how that was managed, as well as being about osteopathy” PCG 8

“[We] obviously inherited services purchased under the fund-holding scheme. We had 93% of our population covered by fund-holding. When we became a PCG, we had to make the decision about what to do about those services that were practice specific and funded because of fund-holding and nothing else. What we said as a PCG [was] we would support everything for a minimum of one year, so that we didn’t disrupt services…then evaluate and decide if we could support continued funding”. PCG 7

“Everything that happened as part of fund-holding has continued…PCGs have to spend money where they can get value without disrupting services for patients initially” PCG 2

A position of ‘provide and review’ was a realistic option at this point in the transition, when some decisions were effectively put on the ‘back burner’ or ‘parked’, while the more pressing issues were addressed, but is unlikely to be tenable in the longer term. Only one PCG (PCG 7) had actually reached a decision point by late 1999. That decision was to cease funding the CAM service from the beginning of the new financial year. Interestingly, this PCG was the only one in the sample to acquire PCT status in April 2000. By September it was already beginning to reconsider the decision about CAM,

“Financial cost pressures swayed the vote and the vote went against continuing to fund complementary medicine……[but] actually we have almost done an about turn…now we are saying that actually service delivery
issues should be the driver here and not necessarily financial issues….I think there is a drive now to get it [acupuncture] reinstated PCT wide” PCG 7

Managing the transition from PCG status to PCT status will bring challenges to all PCGs. PCTs will have the capacity to be more powerful as commissioners than PCGs. Greater freedom to act and develop policy independently of the Health Authority in the future was mentioned by one PCG explicitly, who saw their current lack of autonomy as a constraint. Two distinct patterns are observable in the influence of the Health Authority in CAM policy development. ‘Direct’ influence is characterised by the Health Authority-led agenda, a ‘portfolio’ of ‘approved’ services which excludes CAM (PCG3), a waiting list initiative (PCG 9) that can include CAM, and an area-wide acupuncture service (PCG 2),

“At the moment we’re sticking to the guidelines from the Health Authority … …when we go to Primary Care Trusts, then obviously this [CAM] is something we would look at because the Trust will be able to make more independent decisions” PCG 3

“Indirect influence” was typified by development funding, with PCG autonomy in how to use the money – (PCG1, PCG8, PCG 4, PCG 9),

“We’ve had development money, …but it’s part of the PCG budget – we decided how we use that money” PCG 1

“Whether we would have made the same provision is weren’t in receipt of substantial [health Authority funded] growth I don’t know. It’s much easier to do these things when you’ve got the money to develop these services. Obviously we had to prioritise where we spent our growth money” PCG 8

A strong theme to emerge from a number of interviews was the perception that CAM services per se were neither high priority nor the real issue:

“The problem about it is that anything like that has to compete as a priority against other priorities and in all candour, it is quite hard to make a case for a big expansion in alternative medicine when it would be at the expense of an expansion in amore high profile service” PCG 4

“Starting from the point of view of complementary medicine is not where we started from…We started from considering the individual services, and musculoskeletal services was a big issue for us … osteopathy came up really as a response to the really, really major work that needed to go on in musculoskeletal services, and the transition to fund-holding, rather than being about complementary therapies”. PCG 8

An emphasis on wider NHS priorities was turned from an obstacle to a positive force for change in certain PCGs. This happened where there was a clear vision of how CAM service
development could be made to intersect with NHS priorities such that opportunities for development emerged that also addressed current, and more pressing concerns, or where CAM services seemed to offer the possibility of an innovative solution to a particular service delivery problem. Examples of this are found in the way in which CAM service development was being undertaken or considered in three PCGs as part of waiting list/ waiting times initiatives, in each case relating to orthopaedic referrals,

“Waiting lists…if it has an impact on waiting lists…..because if there wasn’t a waiting list in the area it would be very much harder to justify putting funding into it [CAM].” PCG 9

“We have a commissioning group within the PCG who are looking at several options for reducing waiting lists and waiting times, particularly in orthopaedics…..at the moment we are looking at the [chiropractic] service along with the osteopathy service to see which would be better to reduce waiting times in physio and orthopaedic services” PCG 9

“We started from kind of considering the individual services, and musculoskeletal services was a big issue for us, and osteopathy came up as a response to the really major work that needed to go on in musculoskeletal services …rather than about complementary therapies…if that makes sense” PCG 8

And for the PCT which had ceased funding CAM, the possibility of reinstating it as an intermediate stage or “stop-off station” between a GP and an acute sector referral was clearly being considered in some detail,

“And interesting now is that things have gone forward and we have looked more and more closely especially in the orthopaedic waiting lists and ………now there is talk amongst a number of the executive members that we should be looking to be innovative in the way that we deal with orthopaedic referrals…. And what some of our GPs are now arguing is that things like osteopathy and acupuncture can help in pain relief and help in the treatment of some of these cases that could prevent them from going on to the waiting lists in the first place, and therefore it’s really getting to understand fully the drivers behind some of our referrals and then saying ‘well OK then what other means of dealing with these referrals can we do within an enhanced primary and community care set up?…..and I think that the whole package of care is looking at the role that complementary medicine can play in that. So actually, we’ve almost done an about turn – we’ve said ‘no we can’t afford to do it because of the financial pressures rather than the service issues, if you get my drift … but now, because we now taken a step back and audited
some of our referrals, we’re saying that actually service delivery issues should be the driver here and not necessarily financial issues.” PCG 7

“I think there is a drive now to get [acupuncture] reinstated PCT-wide so we’ve got another stopping station on the way to the acute sector. You could put it that way, … another branch that you could try before you go onto the waiting list and add yet more on to the waiting list where it’s not in the best interests of the patient because when we’ve done an audit of our referrals …we have found that quite a number of them look, even by the referral letter, as though it could be an inappropriate referral to the acute med. sector and that could be ….because there’s not necessarily the knowledge within primary care or [because] there isn’t the stop-off stations available and the only one you’ve got is based in the acute sector” PCG 7

At the time the interviews were conducted, the two PCGs who were developing CAM services for musculoskeletal patients were taking policy one stage further, and exploring the possibility of an integrated CAM service involving osteopathy/chiropractic and physiotherapy,

“What we want to do is to look at it as a locality-based service so that any practice within the PCG will be able to refer to either the chiropractic or osteopathy ….we’ve decided we’d rather only run with one service……..and what we’re doing, we’ve had discussions with the local Community Trust who run the physio service, …..to see whether we can sort of bring this along as an alternative and perhaps use the physiotherapy service to triage or gate-keep referrals” PCG 9

“What we’re doing now is exploring… ..a proposal is going to the Board to roll out to the whole of the PCG …so it will cover the whole area but with some modifications to the model because although, as I mentioned, we tried to ensure that the physiotherapy and the osteopathy were….well at least access to them was equitable so we weren’t getting substitutions on waiting times, we’re now trying to develop a much, much, much more integrated model so rather than running sort of two parallel services, actually having a service where you can be referred in and then within the service will decide what is most appropriate for the patients.” PCG 8

Realistically this PCG (8) saw integrating the two services as a major project,

“Achieving the integrated osteopathy and physio service we think will take us the best part of a year. That will be quite a major piece of work. It’s not necessarily going to be easy to bring together the two professional groups…” PCG 8
**Future developments**

Overall the respondents in our sample of PCGs were cautious about the future prospects for CAM in primary care. The future was seen in terms of ‘small steps’ and ‘slow growth’,

“it’s a pilot and I think in principle the Board are quite keen on developing this but it depends on how it works out…the equity issue is a big condition …We want to make sure that everyone has equity “ PCG 5

“We’ve got several GPs who are trained in acupuncture or other aspects of complementary medicine so I know it will be an issue that’s raised again at some point because I think there’s a commitment for providing a service that reflects that….you know…a perceived need, but I don’t know how that will develop formally within the PCG. I don’t know it depends on the drivers of the health services. PCG 1

“I think that it [CAM] is something that the Board has to review in the future because complementary therapies are becoming quite popular aren’t they?…More than perhaps they were perhaps five or ten years ago…reflexology for example. And I think it [CAM] is not something that’s not going to go away and whether they [the Board] want to or not it is something that we have to look at really as an alternative way of treating people…” PCG 3

“my guestimate will be that we will start using complementary therapies more but we really don’t have I think a groundswell of support within the PCG to move that forward at a very rapid pace so I think it’s more likely to be a gradual process rather than a ‘big bang’ approach where we suddenly come up with a range of options that are available to add to the existing referral routes that GPs have…” PCG 5

**3.4 Discussion**

The contribution made by these interviews provides an insight into policy development one year into the operation of the PCG/Ts. At this point the majority of PCGs in the sample had maintained CAM provision and extended previously established practice-based services across the PCG. In our sample, clear differences emerge between CAM service development within practices, and service development where the intention is to create access for patients across the entire PCG. Many PCGs currently offer both types of access to CAM. Practice-based services may be seen as the relics of fund-holding, they are driven by GP ‘champions’ who are often also practitioners, or who have an interest in the benefits to patients of a particular therapy. Acupuncture and homeopathy dominate provision of this type. Some of these services have the capacity to expand but, without additional funding, they will remain practice-based and limited in their scope.
A second model of CAM service provision is indicated where there is a PCG level commitment to the development of innovative services to address national and local priorities. The necessary conditions for these developments would appear to be the existence of local CAM advocates, development money that can be deployed flexibly, and planning driven by service delivery issues.

For all policy development in this area, the lack of published evidence of clinical effectiveness of CAM emerges as important barrier, but when other factors are present, including some flexibility in the budget, and a GP who is also a CAM practitioner, or GPs with a commitment to the benefits that CAM can offer to some patients, the indications are that this barrier can be overcome. PCG-wide services involving more substantial investment clearly require higher levels of evidence, but where there is the will to introduce a service, evidence of acceptability and effectiveness derived from pilot services may be sufficient.

Crucially, the ability to provide equity of access to services depends on sources of funding. It was notable that where CAM services were available to all practices in the PCG, this had been facilitated by use of development money or additional funding for initiatives driven by the Health Authority.

It seems that the future direction of CAM provision in primary care depends on the existence of flexibility within budgets and a willingness to consider the benefits that alternative forms of treatment can bring to some patient groups. These data relate to the situation in late 2000. At that time, the process of creating PCG-wide access to CAM services that were previously practice-based was best understood in the context of managing the transition from fund-holding, against the backdrop of national directives around equitable access to services, waiting list reduction, and specific health priorities. However, there are indications that opportunities for development of CAM services are most likely to occur in those health areas where the priorities intersect. For example, as part of an initiative, to reduce secondary referrals to orthopaedic waiting lists using an integrated care package. New challenges and developments will emerge in response to the transition to PCTs in 2001.

Locality based, integrated CAM services responsive to NHS priorities, such as those being developed in two PCGs in our sample, may offer a model for future CAM services in NHS primary care.
APPENDIX 1

Telephone Interview Schedule 1999/2000
Telephone Interview Schedule 1999/2000

1. I would like to get an update on your complementary therapy provision. Has your service changed in any way since I visited in 1997/98?

2. Has the introduction of Primary Care Groups had any impact on the service you provide?

3. Have you or another GP from the practice been involved with your local Primary Care Group in any way?

4. Do you know if your Primary Care Group has discussed the provision of complementary therapies in your area?

5. Do you know if your primary care group has taken any decisions relating to complementary therapy provision?

6. Do you anticipate any decision or action relating to complementary therapies in the next 12 months?

7. Why do you think complementary therapies are/are not an issue for your PCG?

8. What priority would you say complementary therapy provision has within your PCG at the moment?

9. Do you expect your service to continue in its present form over the next 12 months?

10. In the longer term, do you currently foresee any major changes to the service you provide?

11. Do you have any other comments about the provision of complementary therapies in the Primary Care Group context?

12. Is there anything else you would like to tell me?
CAM questions in Tracker Survey 1999
I’d like to ask a few questions about the provision of complementary therapies within your PCG (such as acupuncture, chiropractic, homoeopathy, or osteopathy)?

**Note for interviewers**

If asked about any other ‘complementary therapies’

Exclude; counselling, psychotherapy and physiotherapy

Include; anything else mentioned.

If in doubt include

Make a note of what is mentioned if clarification is sought;

Q1: Has the provision of complementary therapies ever been discussed by the Board?

Tick all that apply

O Yes, has already been discussed or is currently being discussed

O Not yet, but expect this issue to be discussed in the near future

O Not yet, but expect it to be discussed within the next 12 months

O Not expected to be discussed

O Other (please note what)

If “not expected to be discussed” go to question Q5

Q2: Has the PCG actually taken any decisions relating to complementary therapies?

O Yes

O No

If YES, what was the nature of the decision?
Q3: Do you anticipate any decision or action in the next few months?

O Yes
O No

If YES, what?

Q4: Can I just clarify how complementary therapies came to be an issue for the PCG?

Tick all that apply

O Raised by individual member of the Board
O Raised by local general practice currently offering a service
O Raised by local complementary therapy provider(s)
O Raised through wider priority consultation exercise (e.g. with public?)
O Raised in context of service development plans (e.g. HImP or PCIP)
O Other (please note what)

Q5: What priority would you say the provision of complementary therapies has within your PCG at the moment?

O Very low
O Low
O Medium
O High
O Very high

End of questions
CAM questions in Tracker Survey 2000
Supplementary questions to Chief Executives on complementary therapy provision

I’d like to ask a few questions about the provision of complementary therapies within your PCG (such as acupuncture, chiropractic, homoeopathy, or osteopathy)?

**Note for interviewers**

If asked about any other ‘complementary therapies’

**Exclude;** counselling, psychotherapy and physiotherapy

**Include;** anything else mentioned.

**If in doubt include**

Please note what is mentioned if clarification is sought;

---

**Q1:** Has the provision of complementary therapies been discussed by the Board in the past 12 months?

*Tick one*

- **O** Yes, has been discussed
- **O** No, but expect it to be discussed within the next 12 months
- **O** No, and not expected to be discussed

**Q2:** Has the PCG taken any decision(s) relating to complementary therapies in the past 12 months?

*Tick one*

- **O** Yes
- **O** No
If YES, what was the nature of the decision relating to CAM?

<table>
<thead>
<tr>
<th>Tick any that apply</th>
<th>ACTION</th>
<th>THERAPY (IES) INVOLVED</th>
</tr>
</thead>
<tbody>
<tr>
<td>o To ‘rollout’ or expand existing service / provision across the PCG</td>
<td></td>
<td></td>
</tr>
<tr>
<td>o To maintain an existing service / provision</td>
<td></td>
<td></td>
</tr>
<tr>
<td>o To cease provision or terminate a service / provision</td>
<td></td>
<td></td>
</tr>
<tr>
<td>o To reduce the level of an existing service / provision</td>
<td></td>
<td></td>
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<tr>
<td>o Other</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Comments
If CAM has been discussed, or a decision has been taken, in the past 12 months:

Q 3: How did complementary therapies come to be an issue for the PCG?

Tick all that apply

O Raised by individual member of the Board
O Raised by local general practice currently offering a service
O Raised by local GP(s) on behalf of patient requesting treatment
O Raised by local complementary therapy provider(s)
O Raised through wider priority consultation exercise (eg with public?)
O Raised in context of service development plans (eg HImP or PCIP)
O Other (please note what)

For all PCGs

Q4: What priority would you say the provision of complementary therapies has within your PCG at the moment?

O Very high
O High
O Medium
O Low
O Very low

End of questions
Status of PCG CAM policy formation 1999
<table>
<thead>
<tr>
<th>Q: “Has the provision of complementary therapies ever been discussed by the Board?”</th>
<th>N=70 (100%)</th>
<th>Decision re service provision</th>
</tr>
</thead>
<tbody>
<tr>
<td>“Yes, already been discussed or is being discussed”</td>
<td>n=33 (47%)</td>
<td>Will not provide (6)</td>
</tr>
<tr>
<td>Shaded cases could be said to have a ‘policy’</td>
<td></td>
<td></td>
</tr>
<tr>
<td>N=15 (21.4%)</td>
<td>Stop existing provision (1)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Expand (3)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Provide – maintaining status quo (5)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Review / Provide and review (7)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>To discuss as part of HAZ plan (1)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Decision anticipated (2)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>No decision yet (8)</td>
<td></td>
</tr>
<tr>
<td>“No, but expect to discuss in next 12 months”</td>
<td>n=9 (13%)</td>
<td>No decision /’Parked’ (9)</td>
</tr>
<tr>
<td>“No, but might have to discuss in future”</td>
<td>n= 22 (31%)</td>
<td>No decision (22)</td>
</tr>
<tr>
<td>“No, don’t expect to discuss this”</td>
<td>n=16 (23%)</td>
<td>No decision (16)</td>
</tr>
</tbody>
</table>
Telephone Interview Schedule
and influences on CAM policy
Telephone Interview Schedule 2000/1  KJT/PC

Explain the process and obtain permission to record!

Background

• Why we are interested in CAM provision
  o MCRU has an ongoing programme of work around CAM for the Department - policy-related research
  o Element of current work is looking at the impact of PCGs (and the demise of fundholding) on the provision and commissioning of CAM
  o How we are doing this
    ▪ Tracker survey 1999 and 2000 see interim report
    ▪ Follow-up interviews like this

• Why we chose them
  o We are particular interested PCGs that have chosen to be proactive about offering CAM services – for example rolling out services that were previously practice-based to all GPs in the PCG.
  o We interested in describing examples of innovatory service development and good practice in the review of CAM provision.
  o We have minimal information from the 1999 Tracker survey, but from that your PCG looked like a PCG with an active interest in complementary medicine provision that had taken some decision about what services to provide

• What we think we know already
  o In particular in ’99 the CEO mention that you intended to ………..‘ pick up from the survey’.
  o Can you tell me a bit more about that?
    ▪ What is happening now?
      • What is offered – therapy/ies
      • By whom?
      • How does it work in practice?
      • Referral – who can refer?
        o How many GPs make use of the service?
      • Is it being monitored?
        o Quality control issues/ evaluation/ review
      • How is it funded?
Any documentation available?

- How did it come about?
  - Where did the idea/impetus come from?
  - Did it have support across the Board?
  - What was the rationale for the service?
  - Is it mentioned in the Health Improvement Plan?
  - Is it linked to a Healthy Living Centre bid?
  - Was the evidence important?
  - Was public/patient demand important?

Any other CAM services or developments in this area?

Repeat questions if YES

What about the future?

- In your opinion, where is it all going to go from here?

Clarify interviewee’s involvement with CAM in the PCG

What can we offer YOU perhaps

As I mentioned, we’ve done other work in this area - in particular,

1. Study of models of provision of CAM services in general practice
2. Evaluation of osteopathy in extended fund-holding

Have you see the 4 page executive summary of these?
No  Would you like to them?
Yes  Would you like a copy of the full report?

3. We conducted a national survey on the use (private and NHS) and expenditure on CAM;
Would you like a one-page summary of the results?

4. We also developed several evaluative tools for the extended fund-holding project on osteopathy and chiropractic – Referral form, Patient satisfaction, GP and practitioner questionnaires - they can be adapted. Also SF-36.
Would you like to see these?

✓ Recap if they have promised to send us something
✓ Can we get back to you if necessary?
✓ We will send you out a short draft report of this work
✓ Thanks very much for your valuable time!!!
REFERENCES


3. Thomas K and Luff D, The provision of complementary medicine under Primary Care Groups. 1st Interim Report to Department of Health, Medical Care Research Unit. April 2000.


5. Weatherley-Jones E and Thomas K, Changes in priorities and policies regarding the provision of complementary medicine in Primary Care Groups. 3rd Interim Report to Department of Health, Medical Care Research Unit. August 2001.


8. Luff D and Thomas K J, Models of Complementary Therapy in Primary Care, Medical Care Research Unit, Sheffield 1999.


