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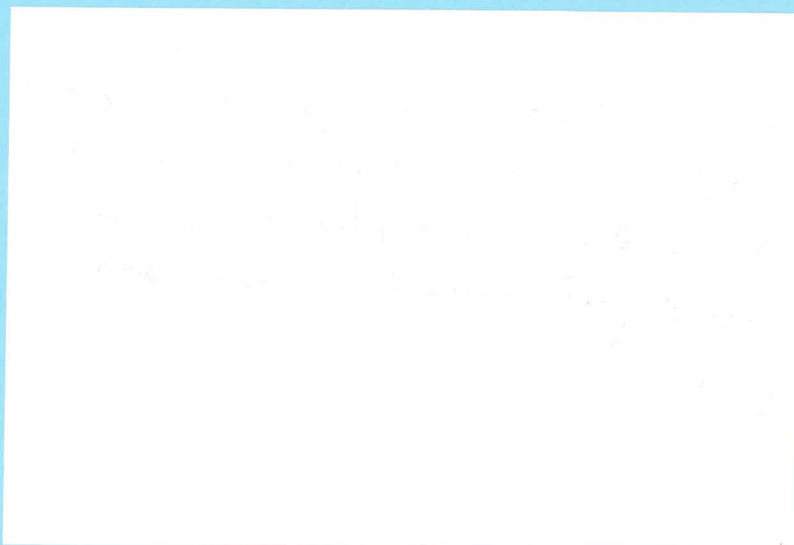

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Alternative Health Care in Belgium: an explanation of various social aspects

Background paper for Belgium

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1. Legal Measures regarding Alternative Health Care in Belgium

The practise of medicine in Belgium must be considered within the framework of an absolute monopoly for doctors. This situation is the result of history, and is to a large extent based on a law dating from before the foundation of Belgium, that of 12 March 1818, "regarding the regulation of the exercise of the various tasks of the healing arts" and the Statutory Instrument of 31 May 1818, "concerning a regulation regarding medical research and care" (1).

The intention was to bring about standardisation within the maze of different job areas and persons practising medicine. The "representatives of the Provincial Medical Commissions", who themselves were "practitioners in one of the medical fields" were entrusted by art. 4c of the law of 1818 with the responsibility of "supervision of the good and proper performance of the practise of medical science and of all having to do with the health of the population in general" (2).

By setting up the regulatory commissions an attempt was made to assess, certificates diplomas and degrees awarded to those practising medicine. To treat the sick without having followed an approved course and obtained the necessary certificates and degrees would then no longer be possible without running the risk of punishment. Although it was by control of training that the later doctor's monopoly was turned into reality, such a monopoly was certainly not then in existance. On the contrary, various tasks within the medical field were carried out by various different groups:

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(1) First report of the central section of the House of Representatives. in: Pasinomie - "Monarchie Constitutionelle" - 12 March 1818, pp 343 - 346.

(2) Huyghe, B., Over de Kwaliteitskontrole en de registratie van geneesmiddelen in België. Paper presented to the seminar "Therapievrijheid '84". Rijksuniversitair Centrum Antwerp 13-14 January 1984.

physicians, surgeons, gynaecologists, town and country barber-surgeons, obstetricians and midwives, druggists and pharmacists, are all mentioned in the law (3). The differences between these groups regarding division of labour, working environment, training, social class and other factors meant that there was no hope of uniformity within the existing medical professions.

The Law of 27 March 1833 referred to Article 18 of the Law of 12 March 1818 regarding the meaning of the term "illegally practising medicine" as follows: "illegal practise of medicine occurs when, by way of trade, an unqualified person shall give or prescribe any substance in a diagnostic or consultative manner to cure any disease or which may point to a method of curing, whether for profit or for charity and whether or not he shall give himself the title of doctor"(4) The term "unqualified person" in this sense refers to not being in possession of the required certificate, which is itself a result of not having (successfully) completed the relevant recognised course of training.

Medical schools were given the power to grant degrees as doctors in medicine, surgery and obstetrics (MB, BCh)from 1876 onwards (5). The second level schools were abolished and the secondary grades - surgeon, officer of health - were seldom awarded by the provincial medical commissions. The Law on Higher Education of 15 July 1849 recognised the degree of "doctor of medicine, surgery and obstetrics" as the sole legal degree qualification. Those qualifications recognised by previous legislation, but now no longer valid were protected by transitional provisions. It was not until the beginning of the 20th century that all doctors held the same sole valid degree of "doctor of medicine, surgery and obstetrics" and these were then drawn together in one professional body.

The Belgian GMC was set up under the Law of 25 July 1938 (6) Because of the war this body could not begin to function

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(3) Schepers, A., De medische professie. in: Nuyens, I.,Sociologie en gezondheidszorg. 1. Van Loghum Slaterus. Antwerpen - Deventer. 1982. p. 133.

(4) Sauveur, J., Histoire de la législation médicale Belge. Bruxelles. 1862. p. 215.

(5) Sondervorst, F.-A., Geschiedenis van de geneeskunde in België. Elsevier. 1981. pp. 161-162.

(6) Law of 25 July 1938 tot oprichting van een Orde der Geneesheren. Belgisch Staatsblad. 13 August 1938.

until 1947 (7). Membership of the Belgian GMC is compulsory in order to be able to practise medicine. Membership is restricted to persons in possession of a degree as "doctor of medicine, surgery and obstetrics". Statutory Instrument No. 79 of 10 November 1967 reconstituted the Belgian GMC and redefined its authority. S.I. No. 78 of 10 November 1968 (8) reiterated that the practise of medicine is the exclusive competence of specially trained doctors: "No person may practise medicine except those in possession of the legally recognised degree of "doctor of medicine, surgery and obstetrics", which has been awarded in accordance with the law on the award of academic qualifications and the schedule of university exams, or who is legally exempt from this and who moreover falls outside the categories detailed in article 7 par. 1 and 2 (which refer to advance authentification of the degree by the medical commission). Illegal practise of medicine is defined as practise by a person not fulfilling all these conditions, of any treatment on any person having as its object or calculated to have as its object the investigation of the state of health, or the identification of any disease or deficiency or the making of any diagnosis, the establishment or performance of any treatment of any mental, physical or imagined pathological condition or any inoculation . ... Illegal practise of medicine is also defined as performance by a person not fulfilling all the conditions of any treatment which results in or is calculated in resulting in the supervision of any pregnancy, birth or afterbirth as well as any action connected therewith". In addition, S.I. No.78 defines precisely the illegal practise of dentistry and pharmaceutics and details the conditions under which certain persons may carry out certain treatments prior to diagnosis or are relevant to the treatment or are part of measures involved in preventive medicine.

From the measures discussed above it can be seen that in Belgium there is legally speaking no room for free practise of medicine - whatever definition is given of this practise - by persons who are not enrolled with the Belgian GMC as doctors. This also means that the practise of any form of alternative health care by persons who are not doctors, or by doctor who do not fully fulfill the conditions laid down in SI No.78 of 1967, by reason of the law on practising, would be seen as illegal. Persons practising alternative medical or even allopatic medicine under such conditions commit a criminal offence.

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(7) Foets, M., Nuyens, I., Focus op de Belgische Gezondheidszorg Sociologisch Onderzoeksinstituut. Katholieke Universiteit Leuven. 1980. p. 29-34.

(8) Koninklijk Besluit Nr. 78 van 10 November 1967, betreffende de uitoefening van de geneeskunst, de paramedische beroepen en de geneeskundige commissies. Belgisch Staatsblad van 14/11/67.

On the other hand, it is the case that doctors of "medicine, surgery and obstetrics" enjoy clinical and diagnostic freedom. They can thus use any methods or techniques which can justifiably contribute to making a diagnosis or carrying out a treatment. So called alternative treatments fall within the bounds of this clinical and diagnostic freedom and may be used perfectly legally. However, the "Code of Medical Ethics" notes, while recognising this clinical and diagnostic freedom, clearly the limited nature of this freedom (9). Thus it is assumed that when a doctor agrees to treat a patient, he must do so taking all reasonable care given the current state of scientific knowledge. Complementary medicine is not taught in Belgian medical schools at least not as part of the official syllabus for a "doctor of medicine, surgery and obstetrics". The reason for this is that they are seen by the Belgian Royal College of Physicians as being scientifically insufficiently proven or unproveable. Although this occurs less and less frequently, it is possible that a fully qualified doctor could be called before the Belgian GMC for practising the techniques of alternative therapy. What happens more frequently is that the Belgian GMC will prosecute non-doctors for practising alternative therapies. The reason for the prosecution is thus not "using alternative medicine" but "illegal practise of medicine".

Parliamentary discussion of alternative therapies are mostly concerned with the recognition of specific methods of alternative health care and/or their practitioners and with refunds of fees by the Social Insurance System. Until now all answers have followed the same line: either reference is made to the qualifications required to practise medicine or - usually on the advice of the Belgian Royal College of Physicians - reference is made to the unscientific nature of the disciplines (10).

To sum up, it can be stated that alternative health care and allopathic medicine may not legally be practised in Belgium by persons who are not doctors. Alternative health care methods within allopathic medicine are seen as unscientific. No complementary therapies form part of legally recognised training programmes taught at schools of medicine. Existing courses are entirely the result of individual initiatives and do not enjoy any official recognition. The fact that some courses may be taught within the university does not diminish this. This being so, alternative health care may best be defined in the context of Belgium today as all diagnostic and treatment methods which are not specifically taught as

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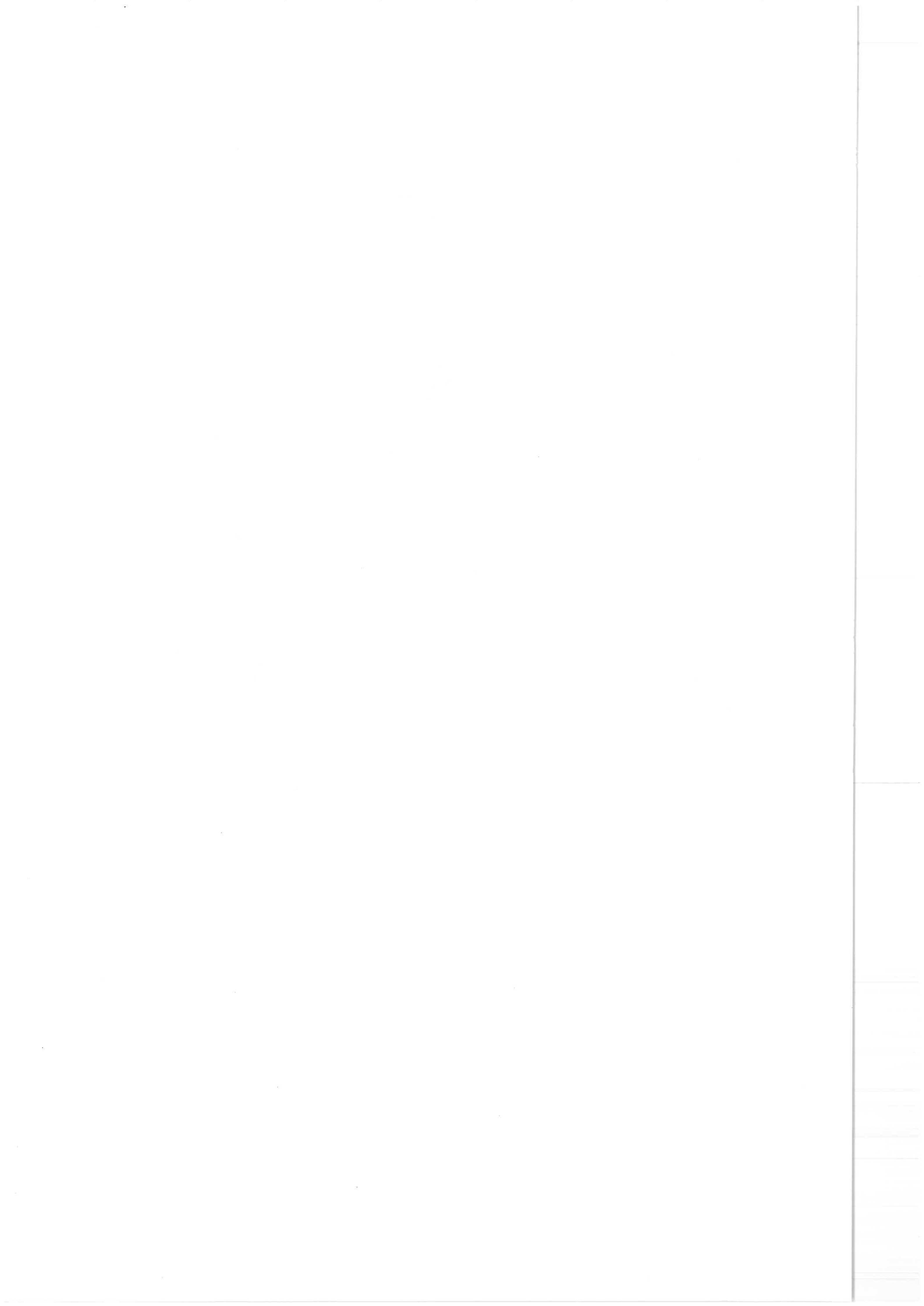
(9) Code van Geneeskundige Plichtenleer. Opgesteld door de Nationale Raad van de Orde van de Geneesheren. Brussel. 1975. Art. 34.

(10) For example: Bulletin van vragen en antwoorden van 13 november 1973, 11 juni 1974, 24 februari 1976, 7 december 1976, 24 januari 1978, 13 juni 1978.



part of the official training programme for "doctors of medicine, surgery and obstetrics". In this respect, the expression "non university" medicine is probably preferable to the terms "unofficial" or "non mainstream" medicine.

2. The Extent of Alternative Health Care in Belgium

There is only a relatively small number of studies into the range of the subject of alternative health care and, in addition, the attention of researchers has only turned to this area fairly recently. Until 1983 there were in fact no numerical research studies available to give any systematic quantitative data regarding alternative health care. A number of local and/or very specific analyses were available, which however could not be extrapolated to a regional or national level. As a result of the continued involvement in research of the Belgian Consumers' Association (11), this area of research has now become more open and the first concrete, if modest, signs of official interest have been aroused. This official interest has grown in a short period of time and thus it is possible to start a wide-ranging sociological study into the social significance of alternative health care on a national basis (12).

2.1 Demand

The first significant attempt to gain an insight into the number of persons making use of Alternative Health Care (AHC) was a study carried out in 1975 by a group of final year students at the Antwerp University (13). The study was limited to a representative sample of the adult population (18 years of age and above) in the borough of Wilrijk (a suburb of Antwerp with a population of +/- 43,000). The best known types of AHC were chiropractic, acupuncture, healing, homeopathy and phytotherapy (14). It should be pointed out

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(11) This refers to empirical and methodological research carried out by the Belgian Consumers' Association, and participation of this organisation in research projects with the European Commission and the World Health Organisation.

(12) see discussion at point 4.

(13) Van Hove, E., Deckx, N., De Keuster, G., Schurmans, M., Soetens, A., Van Gorp, M., Van Kerckhoven, G., Naar de dokter in België. Een replica onderzoek door de studenten - cohorte 1974-1976 - van het departement Politieke en Sociale Wetenschappen. Unpublished series of dissertations. Universitaire Instellingen Antwerpen. 1975-1976.

(14) Deckx, H., Het fenomeen der onbevoegde genezers. Unpublished dissertation. Departement Politieke en Sociale Wetenschappen. Universitaire Instellingen Antwerpen. 1975-1976. pp. 24-37.

that this study was hampered by a number of methodological limitations, one of which was the problem of definition of the term "alternative healers". As a result, the percentages of awareness and usage must be seen as minimum values. As regards usage, the only reliable conclusion that can be drawn is that at least 3.3% of the adult population of Wilrijk had by then made use of alternative health care carried out by a practitioner at some time. Following on from a number of hypotheses it would probably be realistic to regard the minimum percentage as approximately 10% at that time.

Following the study referred to above in 1975, it was necessary to wait another 10 years before usage of AHC was again the subject of a systematic empirical study. In the meantime several quantitative estimates and indications can be found in the literature.

The first series of estimates was based on extrapolations from various partial or specific research observations which give national percentage figures based on frequently incompletely thought out hypotheses. In 1981 J. Van Hecke estimated that 10 - 12% of the population of Belgian population made use of AHC for the purpose of attempting to solve various health problems (15). In 1982 he repeats these figures (16). In 1984 G. Sermeus suggested a significantly higher usage figure of between 18 and 28% (17). This refers to persons of 18 years of age and older who have ever made use of any form of AHC carried out by a practitioner. This author added that the greater part of this usage of alternative medicine within this period probably occured within a limited period of time, specifically during the last 2-3 years. In a publication dating from 1986, which was chiefly concerned with paranormal healing, L. Jochens suggested that the extent of use of these methods can be compared with that in the Netherlands (18). To illustrate this the author shows

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(15) Van Hecke, J., Aard en omvang van niet-officiele geneeskunde in België. in: Kultuurleven, nr. 1, 1981, p. 42.

(16) Van Hecke, J., De alternatieve genezer. in: Nuyens, I., Sociologie en gezondheidszorg. 1. Van Loghum Slaterus. Antwerpen-Deventer. 1982. p. 159.

(17) Sermeus, G., Alternatieve geneeswijzen: een dubbele dimensie. Paper prepared for the seminar "Therapievrijheid '84" Rijksuniversitair Centrum Antwerpen. 13-14 January 1984.

(18) Jochens, L., Geneeskunde op de zwarte markt. Weerstand tegen pendelaars, magnetiseurs en paragnosten. De Nederlandsche Boekhandel. Uitgeverij Pelckmans. Kapellen. 1986. p. 54.

how simple it is to search out a relatively large number of paranormal healers from a limited number of contacts. On the other hand, he adds that consumption in Belgium is probably lower, given the frequent prosecution of such practitioners which limits the range of supply.

Other research carried out in the period 1975-1984 give an impression of the relative quantitive importance of the various forms of AHC or of the share held by alternative therapies within various classes of symptoms or diseases.

A study which dates from 1978 and which was carried out on a group of hospital patients all of whom were suffering from rheumatoid arthritis showed that 75% of those questioned had made use of AHC in addition to allopathic treatment (19). Among the main remedies used were: own remedies (44.2% of patients), paranormal treatment (38.5%), pilgrimages (34%), acupuncture (20%), and homeopathy (10%). A study carried out between 1979 and 1981 on 100 people suffering from warts and 100 people suffering from rheumatism all of whom were residents within the parish boundary of Kiewit (a parish in the Hasselt area) indicated that 59% of the wart sufferers had tried AHC (20). The number of rheumatism patients who had made use of AHC was 43% A similar study was repeated one year later among 80 sufferers from warts and 80 rheumatism patients, all of whom were resident in the Limburg village of Hechtel-Eksel (a local authority area near to Maaseik with a population of approx. 9,000) (21). The combined results of the two studies were published in 1986. 25% of all those suffering from warts used AHC exclusively (22). Between 21.5% and 40% of the rheumatics patients had tried one

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(19) Heye, A., e.a., Een onderzoek naar het gebruik van alternatieve geneeswijzen bij patienten met reumatoide artritis. in: Tijdschrift voor Geneeskunde, Jaargang 36, 1980. p. 917-920.

(20) Boesmans, A., Volksgeneeskundig onderzoek te Kiewit-Hasselt anno 1979-1980. Wratten en Reuma. Unpublished dissertation. Fakulteit van Letteren en Wijsbegeerte. Katholieke Universiteit Leuven. 1980. p. 7-82.

(21) Geys, A., Volksgeneeskundig onderzoek te Hechtel-Eksel anno 1980-1981. Wratten en Reuma. Unpublished dissertation. Fakulteit van Letteren en Wijsbegeerte. Katholieke Universiteit Leuven. 1986. p. 15-16.

(22) Boesmans, A., Wratten en hun bestrijding. Resultaten van recente empirische onderzoekingen in Limburg. in: Top, S., Ethnologia Flandrica. Jaarboek van de Leuvense Vereniging voor Volkskunde. Leuven. 1986. p. 40.

or more forms of AHC (23). The major alternative treatments were paranormal therapies, acupuncture, chiropractic and homeopathy.

A poll carried out in 1983 under the auspices of the Belgian Consumers' Association enabled the relative quantitative importance of various forms of AHC to be determined (24). In this, homeopathy takes the first place (used by 80% of all of those who have ever tried AHC), followed by acupuncture (41%), manipulative treatments (19%), phytotherapy (17%), paranormal treatments (17%) and natural remedies (11%). All remaining types included made up a maximum of 5% of the total use within the group of AHC consumers. It should be noted that this study was not based on a representative sample and that it was not the intention to measure the spread of use of AHC methods. The intention was to measure the subjective feelings of satisfaction of patients who used various methods of treatment.

In 1984, at the initiative of the Ministry for the Flemish Community, Department of Health Administration, a representative study was carried out with the intention of quantifying the extent of use of AHC (25). The survey was carried out by the I.I.V.O. which planned the subject of study in cooperation with the Belgian Consumers' Association. The data only applied to the Flemish region of the country. Flemish families were used as the base of measurement. 39.1% of all families had used one or more methods of AHC. This would make up a total of approx. 607,420 families. Further analysis of this basic data gives a picture of the individual frequency on an annual basis (26). Thus, homeopathy would be

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(23) Geys, A., Reuma en Volksgeneeskunde. Resultaten van recente empirische onderzoekingen in Limburg. in: Top, S., Ethnologia Flandrica. Jaarboek van de Leuvense Vereniging voor Volkskunde. Leuven. 1986. p. 40.

(24) Sermeus, G., Rapport Alternatieve Geneeswijzen. Eerste onderzoeksgedeelte. Unpublished internal document. Belgische Verbruiksunie (Test Aankoop). Brussel. 1983. p. 55.

(25) Het verbruik van niet-officiele geneeskunde. I.I.V.O. Brussel. November, 1984. p. 7-9.

(26) Sermeus, G., further analisis on the basic data of the I.I.V.O. -study. Unpublished internal document. Belgische Verbruikersunie. Brussel. 1985.

used by 8.2% of the adult Flemish population. Acupuncture comes in the second place (4.3%), followed by manipulative treatments (3.6%), natural remedies (2.8%) and paranormal therapies (2.6%). All other methods scored less than 1% on an annual basis. The data available did not permit patients using more than one form of alternative treatment to be split up. Given a number of hypotheses it is possible to conclude, albeit hesitantly, that the individual extent of consumption of AHC in Flanders would probably lie between 15 and 20% In 1986, the extent of use of AHC was measured for the first time at a national level and by means of a representative poll (27). This consisted of an investiga- tion carried out by the Belgian Consumers' Association. The study showed that 31% of the Belgian population aged 15 or older used one or more AHC treatments annually. Homeopathy was used by 17.5% of the population (11.2% through a prac- titioner, 6.3% by self-medication). Natural remedies took the second place with 6.8% (2.4% through a practitioner, 4.4% by self-medication) followed by manipulative treat- ments with 6.1%, acupuncture with 5.8%, chiropractic with 3.4%, osteopathy with 2.7% and phytotherapy with 2.7% All other forms took up approx. 1% or less.

Regarding the characteristics of the patients, these have almost all to be found in the previously quoted research.

The Antwerp University survey of 1975-1976 could not show any significant variation with regard to sex (28). The age group 30-65 was relatively over-represented. In addition there was a light over-representation of patients who were more highly educated and white collar workers and the self- employed. A study carried out among one hundred patients of 4 alternative practitioners in the Ghent area - distributed equally between an acupuncturist, a chiropractor, a homeo- path and a paranormal healer - showed a higher number of female patients than males (29). The figures were 58% to 42% Most of the patients were middle-aged. On average those questioned had only a low level of education. This was es- pecially the case for the patients of the paranormal healer.

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(27) Sermeus, G., Bekendheid en gebruik van alternatieve genees- wijzen in België anno 1986. Representatieve bevraging onder de Belgische bevolking. Unpublished internal document. Bel- gisch Verbruikersunie (Test Aankoop). Brussel. 1986.

(28) Deckx, H., (1975-1976), op. cit. p. 28-30.

(29) Van Hecke, J., De niet officiele geneeskunde in België. So- ciologische probleemstelling. Unpublished dissertation. De- partement Sociologie. Katholieke Universiteit Leuven. 1978. p. 34-35.

The patients of the homeopath were more highly educated. The investigation carried out by the Belgian Consumers' Association in 1983 found a higher proportion of female patients in homeopathy, acupuncture, manipulative treatments and paranormal therapies (30). Homeopathy, chiropractic and osteopathy were most used by persons in the age-group 40-59 years. Acupuncture was relatively less used by patients in the age group 18-29 years. When viewed by education the survey seemed to show that paranormal therapies are more often used by patients with a low standard of education. The I.I.V.O. -survey from 1984 pointed in the same direction: more female than male patients, relative over-representation of the 45-54 age group and of higher income families (31). Finally, it is possible to look at the results of the 1986 Belgian Consumers' Association survey (32). Once again there was an over-representation of female patients, especially in homeopathy, chiropractic and manipulative treatments. AHC was used more by patients in the middle age group. Thus the age categories below 18 years and above 60 years were very under-represented. In overall terms consumers of AHC belonged to the higher socio-economic groups. This was also mainly the result of a significant over-representation of patients making use of homeopathy. A contrary tendency was noted in the field of paranormal healing.

With regard to the main areas of symptoms, J. Van Hecke noted that many patients made use of alternative treatments for problems with the limbs, muscles and joints (33). This is especially so in the case of patients of chiropractors. Problems with the stomach, abdomen and digestive system predominated within paranormal therapies. The author points out the marked absence of acute symptoms, infectious diseases, malignant tumours and confinements among the patients of alternative therapists. Approximately 72% of the patients had been suffering for more than one year from their complaints before consulting an alternative practitioner. 85% of those polled had first consulted a general practitioner (where they received treatment by allopathic methods), 56% had first consulted a specialist doctor. According to the patients own subjective experiences the general practitioners had the lowest success rate. Specialist doctors scored slightly higher and the alternative therapies came out on top. According to the author most patients visited an alternative practitioner on the advice of friends and acquaintances (lay-referral system) and can be divided into two main

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(30) Sermeus, G., (1983), op. cit. p. 80-87.

(31) I.I.V.O., (1984), op. cit. p. 15-18.

(32) Sermeus, G., (1986), op. cit.

(33) Van Hecke, J., (1978), op. cit. p. 38-61.

categories as follows: the pragmatic who opt for AHC as a last resort and the idealists who reject allopathic medicine as an "incorrect doctrine".

The survey by the Belgian Consumers' Association showed that patients of alternative practitioners have more complaints on average than patients of specialist doctors (34)(35). At the same time patients of AHC have a more negative image of their own state of general health at the moment of starting their treatment. 44% of the patients of specialist doctors (allopathic) have been suffering from their symptoms for over one year. In patient groups of AHC this figure rises to 68% Patients of alternative medicine have a longer history of treatment than patients of specialist doctors. They have generally more often been treated by other practitioners before. Regarding subjective satisfaction, general practitioners (allopathic) score highest on the extreme positive scores for complaints which can be treated in a single consultation. For symptoms requiring more than one session of treatment specialists score the highest. In both cases it is the case that treatment by alternative therapists is seen to be the best if at the same time less extreme positive judgements are included. Dissatisfaction with the results of treatment within allopathic medicine was the crucial factor which drove patients to try AHC (36). This factor is seen in conjunction with a certain unease with regard to an over narrow treatment of complaints (an over symptomatic approach). Another factor involved is connected with the fact that people are confronted both conciously and unconciously with the existance of AHC in the world around them. Once the patient has crossed the threshold of AHC, he is more and more attracted and convinced by the absence of iatrogenic effects. In addition the patient is drawn very strongly by the open and comforting relationship with the practitioner and by the fact that the practitioner takes the time to tell the patient about his condition and the proposed treatment.

2.2 The Availability

Specific research regarding practitioners of AHC in Belgium

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(34) Sermeus, G., Rapport Alternatieve Geneeswijzen. Tweede onderzoeksgedeelte. Unpublished internal document. Belgische Verbruikersunie (Test Aankoop). Brussel. September, 1983. p. 11-20.

(35) Klassieke geneeskunde en alternatieve geneeswijzen: de ervaring van de patienten. in: Test Aankoop, nr 245, December 1983. p. 4-14.

(36) Sermeus, G., Some quantative considerations on alternative health care in five European countries. An interim report prepared for the World Health Organisation - Regional Office for Europe. Belgian Consumers' Association. 1985. p. 36-39.

has been very scarce up to now. This does not mean that there are no facts at all on the availability, even though the data is mainly limited to lists regarding the mainstream educational level of the practitioners.

The survey carried out in 1983 by the Belgian Consumers' Association showed that in the fields of homeopathy and acupuncture, the major share of treatment - 84% and 74% - is carried out by doctors (37). For homeopathy, 72% of all treatments are carried out by general practitioners and 12% by specialist doctors. Within acupuncture the figures are 51% by general practitioners and 23% by specialist doctors. In the area of manipulative therapies these figures fall to 20% approximately equally divided between general practitioners and specialist doctors. What is remarkable is that about 12% of patients claim that they have been treated with paranormal therapies by a doctor. Physiotherapists are most strongly represented in the supply of manipulative treatments (33% of all treatments). As regards acupuncture they are responsible for 8% of all treatments and 3% of all homeopathic treatments. Non-medically or paramedically qualified personnel who use the authority of a specific non-regular course of training to treat patients are mostly found within paranormal (35% of all treatments) and manipulative disciplines (34% of all treatments). Non-medically or para- medically qualified personnel who in addition do not rely on any specific training account for about 52% within the sector of paranormal therapies. The I.I.V.O. study from 1984 mainly confirmed the findings of the Consumers' Association study (38). Homeopathic treatment was carried out by general practitioners in 61% of all cases, in 8% by specialist doctors and in 3.5% by physiotherapists. The figures for acupuncture are as follows: general practitioners (52%), speialist doctors (23%) and physiotherapists (3.2%). 15% of chiropractic and osteopathic treatments were performed by general practitioners, 12% by specialist doctors, 12% by physiotherapists and 59% by practitioners with specific training. According to the I.I.V.O. survey, in paranormal therapies 23% of all treatments were performed by doctors, all of them general practitioners. A third survey confirms the trend regarding training qualifications for alterna-

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(37) Klassieke geneeskunde en alternatieve geneeswijzen: de ervaring van de patiënten, (1983), op. cit., p. 8-9.

(38) I.I.V.O., (1984), op. cit. p. 27.

native practitioners (39). This is the result of an attempt undertaken in the end of 1983 and the beginning of 1984 to make up an inventare by using as data input enquiries made among organisations involved with alternative medicine. According to 22 different organisations, 85% of all homeopathic treatment available is in the hands of general practitioners and 11% in the hands of specialist doctors. Physiotherapists made up less than 0.5% or virtually none. Regarding acupuncture general practitioners make up 63%, specialists 17%, physiotherapists 11% and practitioners without mainstream training but with special training 9% . 93% of all osteopathy is in the hands of physiotherapists. Chiropractic is almost exclusively practised by persons with a special training, whereas in the field of paranormal therapies only 1% of all treatments were carried out by doctors.

The aforementioned survey was intended to throw more light on the total availability of organised alternative practitioners in Belgium. This appeared to be impossible for many reasons: methodological problems as well as problems with the reliability of the data input. Until now there is no survey which shows reliably how many practitioners of AHC, whether or not they are members of any organisational group, are at present practising in Belgium.

An attempt towards this was made by a study group within the Council of Europe (40). This put the number of practitioners of acupuncture at 1,000. About 10% of these will have a main-stream medical degree. The study group also stated that approximately 100 doctors practised manipulative treatments and 700- 800 homeopathy. The weak point of this survey is that only a limited number of alternative therapies were involved and that the educational qualifications were not all analysed in the same way. In addition some results give worries which here also raise problems with the reliability of the data input.

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(39) Sermeus, G., Beknopt kommentaar bij de organisatielijsten betreffende alternatieve geneeswijzen. Unpublished internal report. Belgische Verbruiksunie (Test Aankoop). Brussel. Maart, 1984. p. 7.

(40) Council of Europe. Legislation and administrative regulations on the use by licensed Health Service Personnel of non-conventional methods of diagnosis and treatment of illness. Strasbourg. 1984. p. 40-71.

14% of all doctors in Flanders use one or more AHC techniques (41). The major alternative techniques used are homeopathy (used by 5.8% of doctors in Flanders), acupuncture (5.4% of doctors) and manipulative treatments (4.5% of doctors). It is a fact that doctors who make use of AHC techniques only do so for a minority of their patients. 75% of such doctors treat a maximum of 26% of their patients with AHC methods. However some 2.5% of all Flemish doctors treat more than 50% of their patients with alternative methods. 61% of the doctors using AHC have a general practise degree and 68% are aged under 40. Less than half of the doctors using AHC methods (48%) are holders of a supplementary certificate or degree in the AHC method being used. It is interesting to note that a majority of doctors (56%) have referred on patients with a view to their receiving alternative treatment methods. 75% of these referrals went for manipulative treatments, 69% for acupuncture and 50% for homeopathy. Most referrals are to practitioners who hold a doctor's degree (63%). If referral is to an alternative practitioner not in possession of a doctor's degree then this is usually to practitioners with a background in physiotherapy (57%).

3. The financial position of alternative medicine in Belgium

AHC is not reimbursed by the Social Security System, whether carried out by a doctor or by a non medically qualified person. The summary of medical treatments provided does not contain any codes which refer to general or specific technical medical treatments within the area of AHC. Practically speaking, it is possible for doctors practising AHC techniques to guarantee to their patients that part of their professional fees will be reimbursed via the existing RIZIV codes. The portion that is reimbursed is thus dependant on the grade of specialisation of the doctor and the general and specialist care to which he refers.

The survey by the Belgian Consumers' Association from 1983 noted the average professional fees which must be paid by the patient (42). These have since been changed. The average

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(41) Ministerie van de Vlaamse Gemeenschap. Administratie Gezondheidszorg. Ongepubliceerde bevraging bij een representatieve steekproef van 300 geneesheren in Vlaanderen. Brussel. 1986.

(42) Sermeus, G., (September, 1983), op. cit. p. 1-3.

professional fee of a specialist doctor (allopathic) was about 70 BF higher than the average fee taken from five groups of alternative practitioners (732 BF as opposed to 663 BF per consultation). Within the various types of AHC the range was 163 BF. Homeopathic treatment were the most expensive (average fee was 715 BF) while chiropractors charged the lowest fee (average 552 BF). The study showed that 63% of all AHC consultations were reimbursed in whole or in part. In 40% of the cases at least half of the amount paid by the patient was repaid. 3% of all alternative medicine treatments were repaid in full. According to patients 96% of all reimbursements occured within the Social Security framework, and the additional 4% was reimbursed by (supplementary) private insurance policies.

There is a dearth of recent studies into fees charged for AHC treatments in addition to studies into the current methods of repayment. As there has been a great deal of development since the inventory of 1983, especially as regards supplementary insurances, the sums and percentages quoted above have long been superseded. Generally it would seem that there has been no serious research interest in the continued evolution in the financial and economic implications connected with the use of AHC. The only time that financial measures surrounding AHC were discussed in an official report was in connection with the activities of the Royal Commission set up by Statutory Instrument in 1975 with a brief "to propose the most effective methods to reorganise health insurance within the framework of health service management as a whole and to improve its working with reference to cost saving" (43). The final report of the Petit Royal Commission mentioned AHC in two short remarks. The first time it concerned a statement on the reimbursement of the cost of homeopathic medicinal specialities (44). It was stated that such remedies could be reimbursed up until 1950 but that after receiving advice from the Belgian Royal Colleges of Medicine they have not been eligible for reimbursement since 1 July 1950. The Petit Commission reported that at the beginning of 1975 both Belgian Royal Colleges of Medicine maintained their viewpoint of 28 February 1950. The second remark concerned a more precise evaluation of what the Commission referred to as "new methods of medicine" (45). This

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(43) K.B. van 10 maart 1975. Belgisch Staatsblad van 13 maart 1975. Art. 2.

(44) Petit, J., Verslag over de ziekteverzekering. Kamer van volksvertegenwoordigers. 892. 26 mei, 1976. p. 293.

(45) Petit, J., (1976), op. cit. p. 406.

expression was used by the author to refer to homeopathy anthroposophy, macrobiotics and acupuncture. According to the Petit Commission there was no evidence to suggest that these forms of treatment would be cheaper in price. The opposite is true, Petit avers, these forms are more expensive when a series of treatments is required.

Based on empirical surveys conducted with patients - both consumers and non-consumers of AHC - and with practitioners - users and non-users of AHC - it would seem that on the contrary there is an enormous gulf between the express wish of society for reimbursement of AHC charges and the relevant authorities, whose attitude is summarised in the Petit Report. The survey carried out in 1983 by the Belgian Consumers' Association shows that only a minority of those questioned think that AHC provided by non-doctors should not be reimbursed (46). This minority was 13% in patients who have already received AHC treatment, and 21.4% among patients who have never been treated by AHC. To put it another way not only 87% of all patients receiving AHC but also 79% of patients not receiving AHC would like to see reimbursement for this treatment when it is carried out by (competent/certified) persons. As in such cases we are talking about reimbursement of treatment carried out by non-doctors, it may be assumed that these percentages would be at least as high for AHC treatment carried out by doctors. In addition it is remarkable to note that 59% of users and 36% of non-users expressed themselves willing to pay higher premiums to cover such reimbursements. Similar results were found in the I.I.V.O. survey of 1984 (47). Only 11% of those questioned thought that AHC should not be reimbursed. 28% thought that treatment should be reimbursed on condition that the treatment was carried out by a doctor. 24% thought that paramedical care using AHC should also be included, whereas 21% laid down as the sole condition for reimbursement that AHC should be reimbursed if carried out by personnel of guaranteed training and experience who are subject to the control of a professional body. 15% of respondents listed no conditions at all. These figures mean that 89% of the population of Flanders is in favour of AHC being included within the Social Fund System. Indeed 61% want AHC carried out by non-doctors to be reimbursed. The I.I.V.O. survey also found that 39% of those in favour of reimbursement were prepared to pay higher contributions for this. A remarkable finding is the fact that three out of four doctors want reimbursement of AHC treatment (48). 44% of doctors can only

(46) Sermeus, G., (1983), op. cit. p. 112-114.

(47) I.I.V.O., (1984), op. cit. p. 34-35.

(48) Ministerie van de Vlaamse Gemeenschap, (1986), op. cit.

justify such reimbursement if the treatment is carried out by a qualified "doctor of medicine, surgery and obstetrics". On the other hand 30% would also approve such reimbursements with reference to non-doctors. This last point would only apply to practitioners with a qualification as dentist, pharmacist or paramedic and/or practitioners with guarantees as to their training, experience and membership of a professional body.

4. Current Research on Alternative Medicine in Belgium

The preceding evidence shows that with a little detective work it is possible to produce a reasonably accurate picture of the social significance of AHC in Belgium. However this picture is in no way complete. It lacks a solid scientific base in many areas. Thus there are more complex and detailed explanations which often have to be based on incomplete or unrepresentative surveys or which must be concluded from approximations based on research which was not carried out with the intention of permitting specific measurement and analysis based on such measurement. On the other hand there are a number of representative surveys which are, however, too limited in their intentions and thus provide insufficient opportunities for analysis and interpretation. Also the representative nature is frequently limited to small non-national areas which does not permit any national conclusions to be drawn. With the exception of these technical and methodological limitations, it is a fact that there is hardly any data regarding practitioners of AHC and their organisations.

These elements, together with the fact that the extent of use of AHC in Belgium must be seen as the highest in Europe (49), are a probable explanation of why the national authorities are showing an interest in setting up a new research project - perhaps also because they are under some social pressure to do so. This will be an extensive research project which will be both a challenge and a promise as they will link together in a systematic way with all the weak or non-existant links which have hampered all previous research regarding AHC in Belgium. The research was set up at the end of 1987 under the sponsorship of the Secretary of State for Public Health and the Disabled. The then Secretary of State, Mrs. Wivina Demeester- De Meyer requested that a project be

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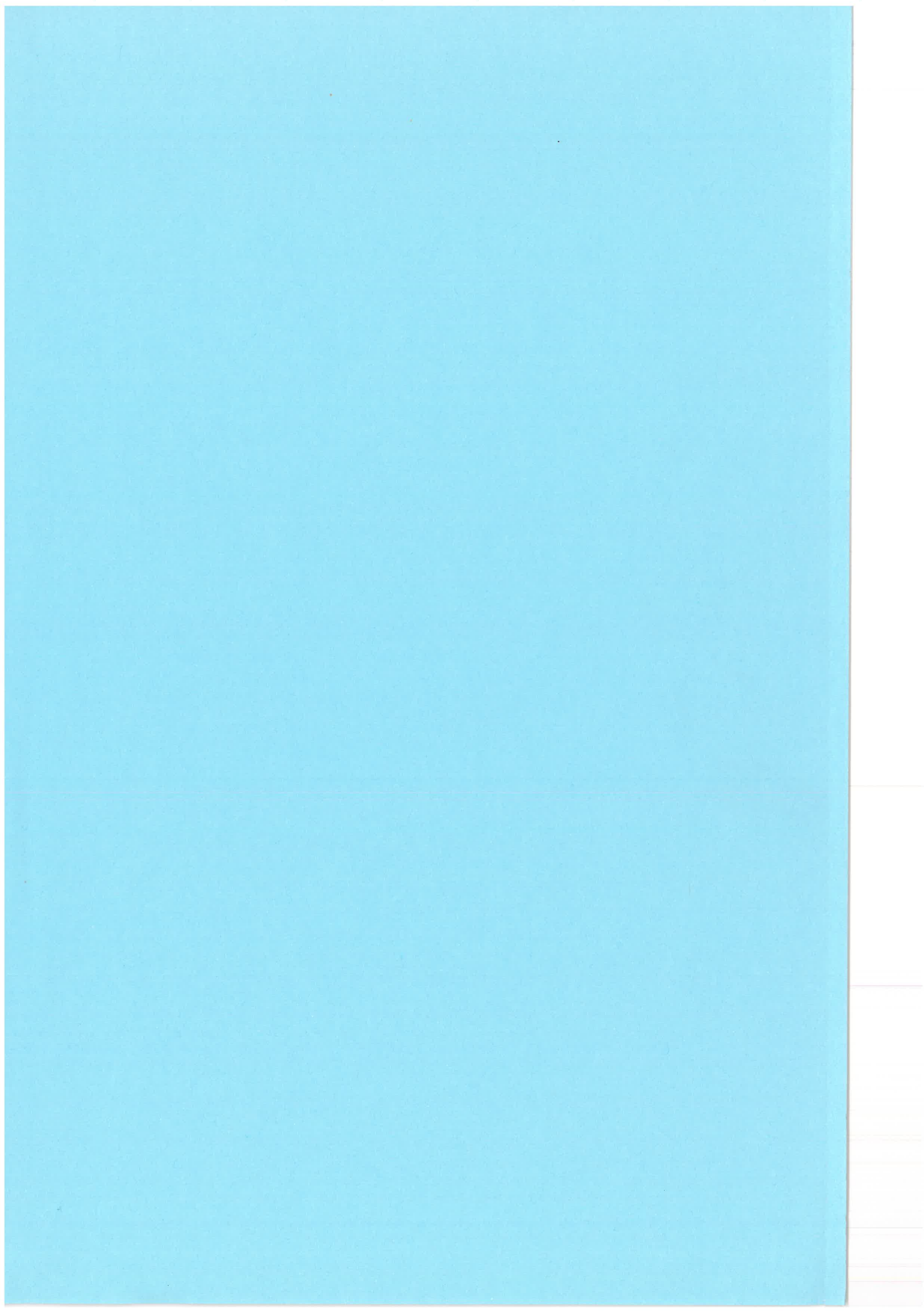
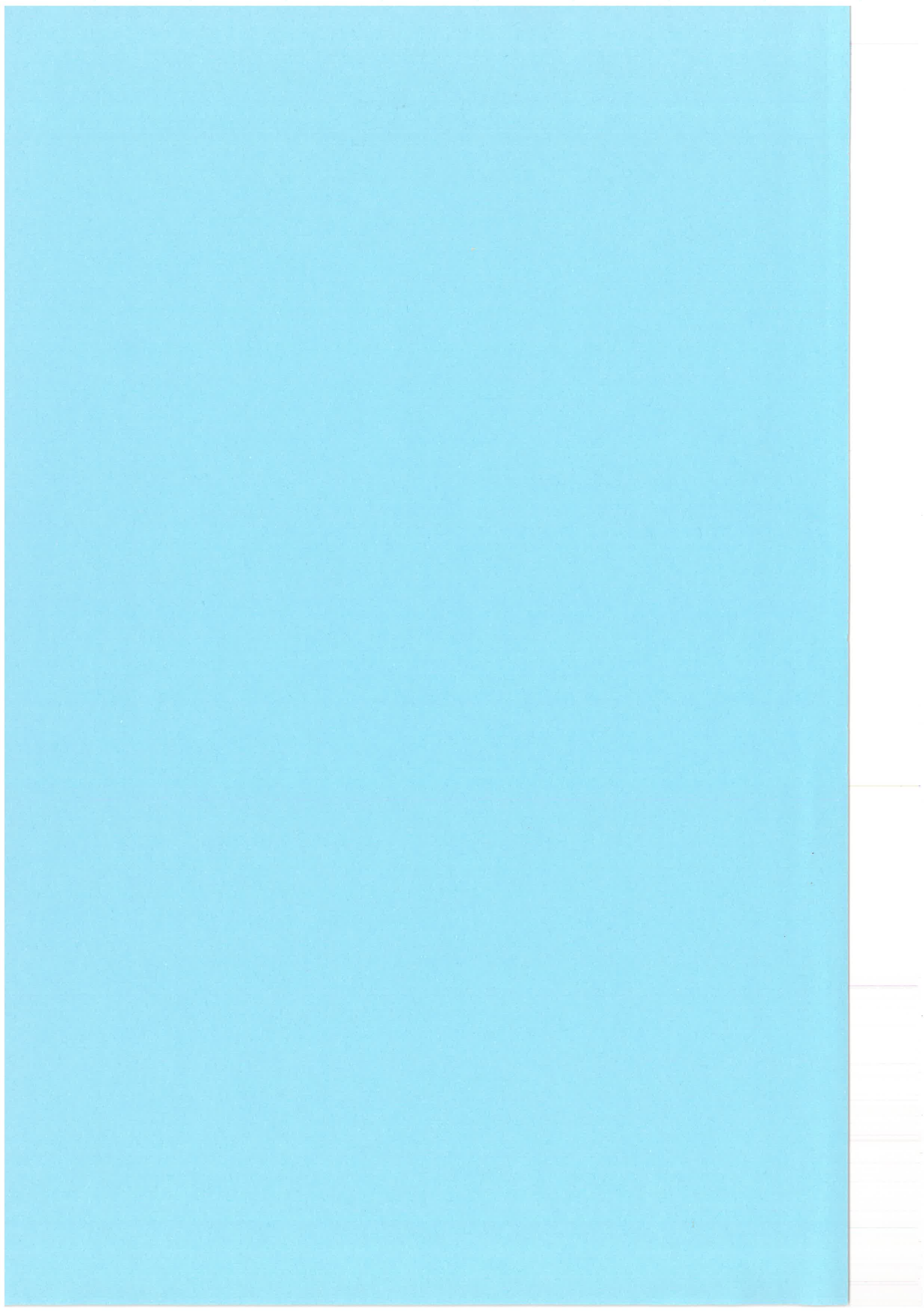
(49) Sermeus, G., Alternative medicine in Europe. A quantitative comparison of the use and knowledge of alternative medicine and patient profiles in nine European countries. Report prepared for the European Commission. Belgian Consumers' Association. Brussels. November, 1987. p. 52-58.

set up to clarify the various social aspects of AHC, taking into account the state of relevant scientific investigation and the research information specific to Belgium. This research project has been awarded to the faculty of medicine of the University of Antwerp and will be carried out under the direction of Professor A. Herman. This research project will comprise three main areas. The first will consist of a compendium of existing organisations and associations concerned with AHC in Belgium. Emphasis will be laid on their objectives and procedures in addition to the typology of such organisations as well as to the number of members and the wider social role with reference to AHC as far as can be ascertained from such bodies. At the same time the organisation will be used to create an input base to quantify the availability of organised alternative practitioners and to show their geographical distribution. A second area is concerned with the alternative practitioners themselves with the intention of further exploring the characteristics of their personalities and methods of practise and also their treatment and practical matters which are relevant to their particular profession based on a large number of factors. In the third part the patient takes centre stage. In addition to compiling a detailed quantitative profile based on consumption of type and scope of AHC, an in depth analysis is envisaged of the motivation and decision-making process which leads to conversion to AHC. A certain amount of time will be devoted to the range of symptoms which lead a patient to request alternative medicine, to his own subjective view of the treatment process in the broadest sense of the term, to the patient-practitioner relationship and to the personal characteristics of typical users and non-users of AHC. This whole research project intends at last to offer practical relevant findings concerning the parties involved, that is the patients, the alternative practitioners and the policy making area. The report should be completed by Autumn 1990.





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May 11th 1989

Use of Alternative Health Care in the Danish Adult Population

Niels Kr. Rasmussen

aper presented to workshop on Alternative Medicin
une 5-7th 1989

A recent national interview survey has studied health and morbidity in the adult danish population. Aspects of use of the health care system and of alternative health care was also studied.

This paper presents results from this survey concerning use of alternative health care and selected results from other recent studies.

Our study applies the term "alternative treatment". A variety of other terms are being used among professionals and among lay people. It reflects the different attitudes to the phenomenon: "unauthorized treatment", "nonmedical treatment", "folkmedicine", "untraditional treatment", "complementary treatment" etc.

None of the terms cover adequately the many different kinds of treatment, as common characteristics are difficult to find among them.

In lack of a commonly accepted definition our study used the criterion whether the interviewees had payd themselves for the treatment in case of doubt on what was ment by alternative treatment.

What kinds of alternative treatment are being used by the population?

Table 1 presents the various kinds of alternative treatment methods, that were most frequently used. No one of the single treatments had been used by more than 10% of the population. But 10% had during the last year used one or more of the different kinds of treatment, and almost one quarter had ever used one or more alternative treatment methods.

Who use alternative health care?

Figure 1 displays that it is more common among women than men to use alternative treatment methods. It is most frequent in the age groups 24-44 and 45-66. The figures indicate that the use of alternative treatment have increased as it is more common among the younger generations. No major social differences were found between users and non users. The main difference was found between occupationally active and occupationally non-active indicating that it is costly to use alternative health care compared to the public health services.

Illness behaviour

More than 2/3 of the population have during a two-week period been bothered by symptoms from one or more organsystems. 1/3 were heavily bothered. Most do not respond to the symptoms (40%)(figure 2). 15% consulted a physician and a fairly large group used medicines previously prescribed by a physician or used some kind of treatment previously recommended by a physician. Only 2% consulted a provider of alternative care.

In general long-term illness has a significant influence on frequency of physician-contact and use of medicines, whereas it has only a minor although significant influence on the extent to which alternative treatment was used. (Figure 3). Only 13% of those with long-term illness had used alternative treatments during the last year compared to 9% of those without long-term illness.

Table 2 presents the proportion among persons with different specific diseases having used alternative care during the last year compared to the proportion among those without specific diseases. Those having diabetes have used alternative treatment with the same frequency as the population in general, whereas for other diseases the frequency is higher among the diseased than in the general population. This is the case for men and women having migraine and for men and women with back disorders.

Use of medicines

Figure 4 presents the proportion of men and women with medicine use during the last 14 days. Large groups have used analgesics, most frequent among the women. It is only 3% who have used herbal-medicine during the last 14 days.

How alternative is the use of alternative treatment?

Table 3 presents the frequency of use of alternative health care among men and women not having been in contact with a physician during the last year compared to those having had contact with a physician. Furthermore the figures have been compared with the figures for those being dissatisfied with their physician. The table displays a very clear tendency. Persons with physician contact had a significantly higher proportion of users of alternative treatment. Especially women

that were dissatisfied with their physician contact used alternative treatment more frequently than others.

Alternative treatment is not chosen instead of traditional medical treatment. It rather serves as a supplement.

Reasons for choosing alternative treatment

Other studies in Denmark have shown that dissatisfaction with medical treatment, treatment without result, curiosity etc. had a decisive role in the choice of alternative treatment. In our study the respondents were asked about the reasons for choosing alternative treatment.

Contrary to other studies our survey found that most frequently the users of alternative treatment gave as a reason a specific illness. Is was clearly more seldom mentioned that alternative treatment was chosen because of some kind of dissatisfaction with or criticism towards traditional medical treatment (Tables 4-5).

It is suggested that the different results concerning reasons for choosing alternative treatment might be explained by the difference in research setting the very studies have been performed in. It is hypothesized that interviews in a setting in which the respondent is a patient might activate defencemechanisms. When a representative of the traditional medical system interviews, the questioning might imply criticism of the choice of alternative treatment. A natural way to defend oneself against this implied criticism might be to criticize back the establised system.

Supply and economic implications

A national voluntary organisation in support of alternative treatment methods have initiated a registration of therapists: Until now 2500 have registered. In 1978 a local community study found the ratio of alternative therapists to family physician to be 1 : 1.6. For the whole nation this equals 2000 alternative therapists.

The amount of money spent on alternative health care varies according to age, sex and socioeconomic status, being highest among the older, women and lower-income groups. In average 1300 DKr. were spent a year by users of alternative therapists. 320 DKr. were spent by users of herbal medicins.

In the general population the average yearly expenditure for authorized medicines were 200-300 DKr.

For comparison: the average hourly wage for male workers in the Copenhagen area were 120 DKr. before tax.

Conclusion

From the abowe mentioned results from our study it might be concluded that alternative health care is perceived by the general population as natural and legitimate treatment methods. It is mainly the various established professional group, primarily the physicians, that perceive alternative health care as a real alternative that they have to compete.

It is assumed that any health care system that develops and institutionalizes - including those treatment methods that are presently perceived as alternative or not - by itself as established and closed systems will force alternatives or innovations to develop outside the system.

e 1. Use of various alternative treatment methods by the Danish adult population 1987.

	During the last year	Ever
	%	
terapy	4.2	9.1
ral medicine (e.g. homeopathy)	3.6	6.4
age/manipulation	2.3	5.2
xation	1.9	3.4
uncture	1.5	2.8
ructions (on diet, exercise etc.)	1.1	1.8
of apparatus (incl. magnetic passes radioni etc.)	0.6	1.2
r	1.9	5.0
ent with one or more of the above	10.0	23.2
respondents	4753	4753

ble 2. Use of alternative treatment among persons with or without
selected specific disease.

	Proportion with alternative treatment during the last year.		
	Male	Female	
	%		
mong all	7	13	
mong those without specific disease	5	9	7
mong those with diabetes	8	11	9½
mong those with nervous conditions	7	20	13½
Among those with migraine	17	25	21%
Among those with bach disorder	12	24	19½

ble 3. Psysician contact, satisfaction with physician contact and use of alternative treatment.

	Proportion with alternative treatment during the last year.	
	Male	Female
	%	
mong those without physician ontact, during the last year	3	7
mong those with physician ontact, during the last year	8	14
mong those dissatisfied with hysician contact	12	29
mong those satisfied with hysician contact	8	12

Table 4. Disease related reasons for seeking alternative treatment. Percentage.

	Male					Female					Total
	16-24	25-44	45-66	67+	all	16-24	25-44	45-66	67+	all	22,8
with alternative treatment	14	18	20	19	18	19	31	32	21	27	22,8
N	571	1268	964	465	3268	59	1313	978	548	3429	6697
with disease/ illness related reason, hereof diseases of	76	81	84	89	83	78	76	77	83	78	
- muscular-skeletal system	39	48	51	54	49	32	30	42	47	36	41
- skin	6	6	5	7	6	5	8	4	2	5	5
- nervous system	5	4	4	6	4	7	9	12	5	9	7
- digestive system	1	3	6	6	4	4	4	3	5	4	4
- respiratory system	3	3	3	3	3	7	5	2	4	4	4
- injuries	8	5	4	1	5	2	2	-	3	1	2
- nervous conditions (mental problem)	5	6	4	2	4	3	4	2	2	3	3
N	80	230	192	87	589	110	400	310	116	936	1525

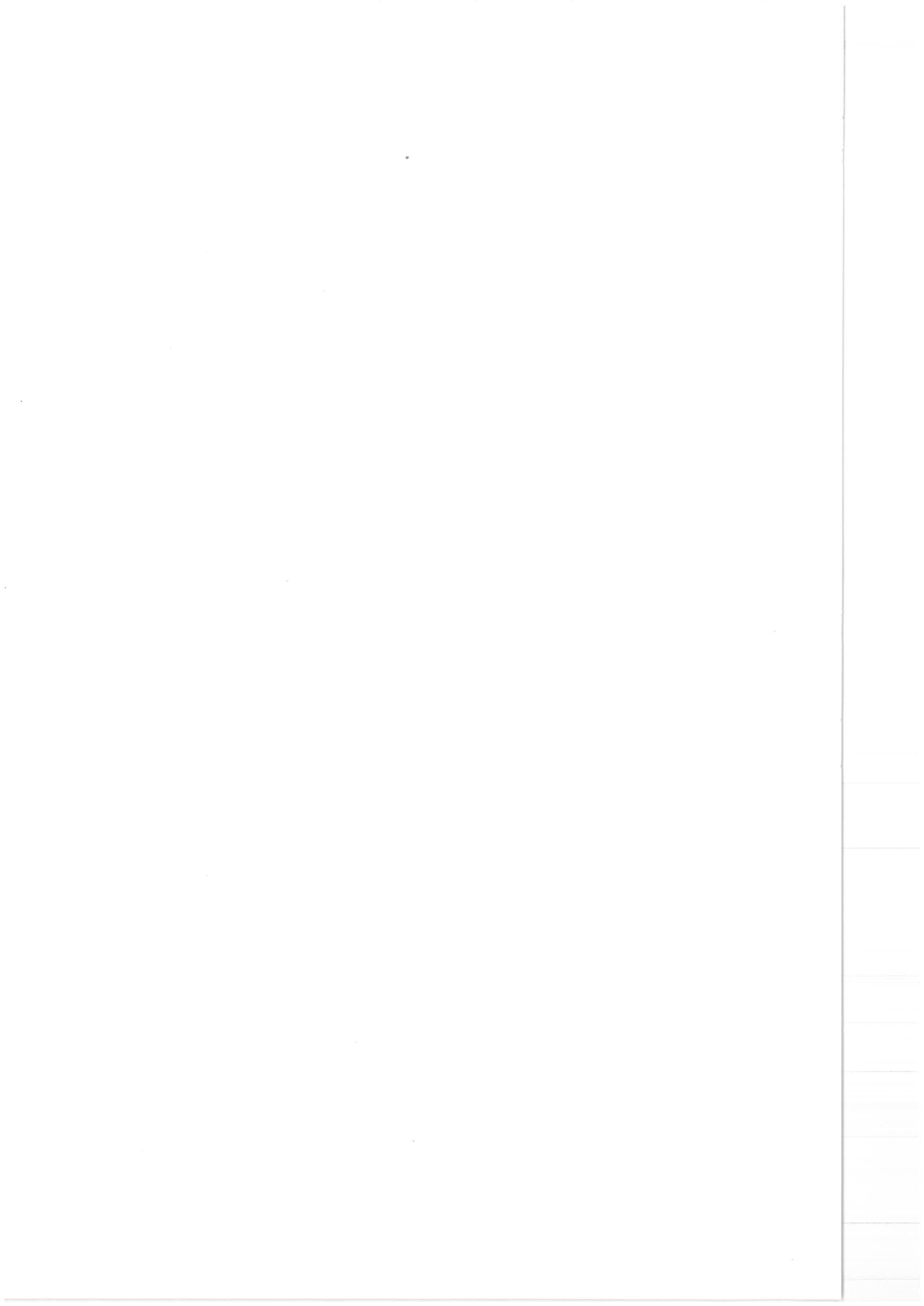


Table 5. Not-disease-related reasons for seeking alternative treatment. Percentage

	Male					Female					Total
	16-24	25-44	45-66	67+	all	16-24	25-44	45-66	67+	all	
with alternative treament	14	18	20	19	18	19	31	32	21	27	22,8
N	571	1268	964	465	3268	59	1313	978	548	3429	6697
with not-disease related reason	31	30	27	25	29	29	35	35	27	33	31,3
- dissatisfaction, neg. experiences (traditional treatment)	5	10	11	13	10	5	11	9	6	9	9,4
- curiosity	8	6	4	3	5	5	7	6	7	7	6,0
- wellbeing, health-promotion	13	10	7	5	9	7	10	11	7	10	9,3
- recommended	4	4	5	5	7	9	5	7	7	6	5,6
N	80	230	192	87	589	10	400	310	116	936	1525

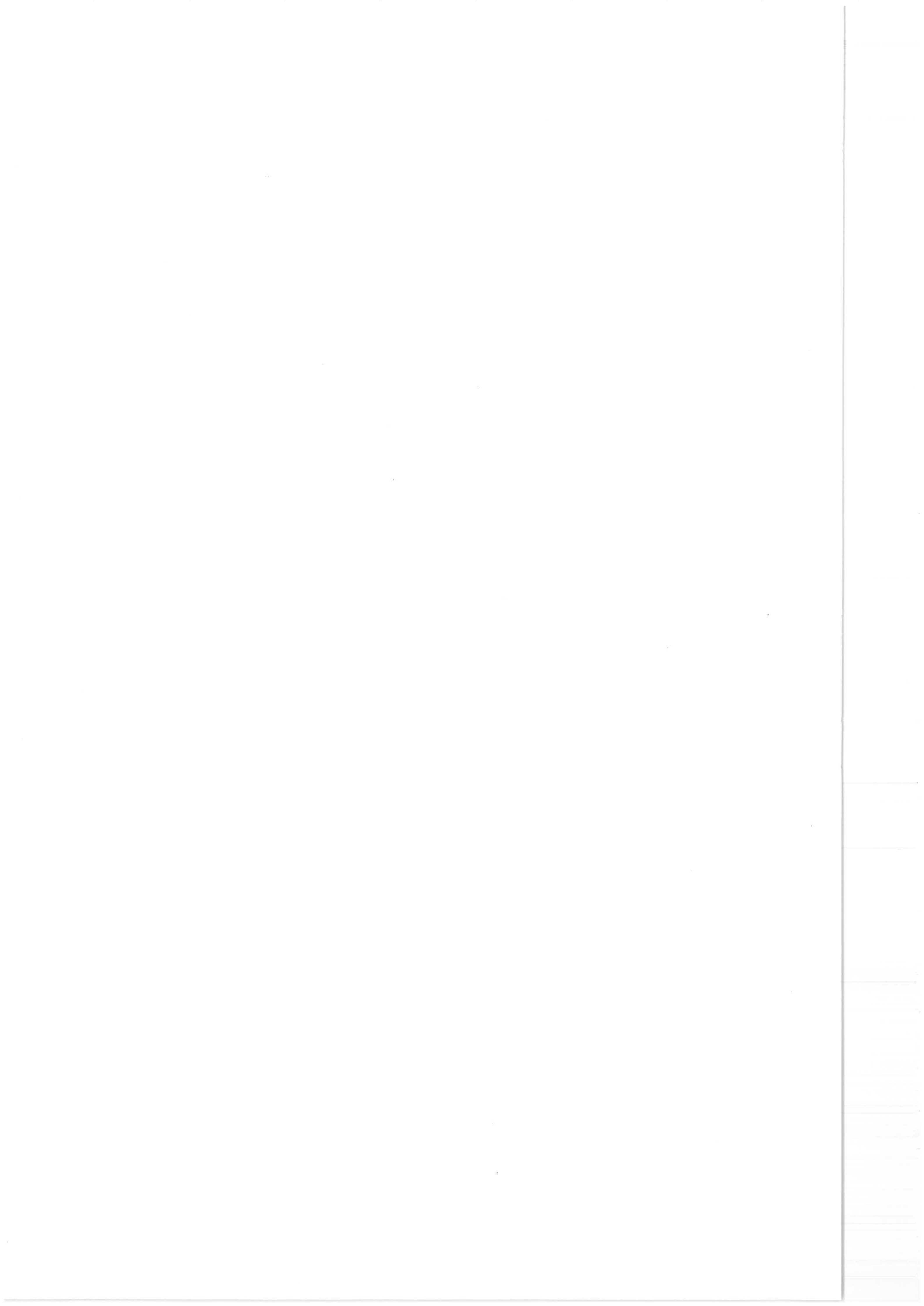
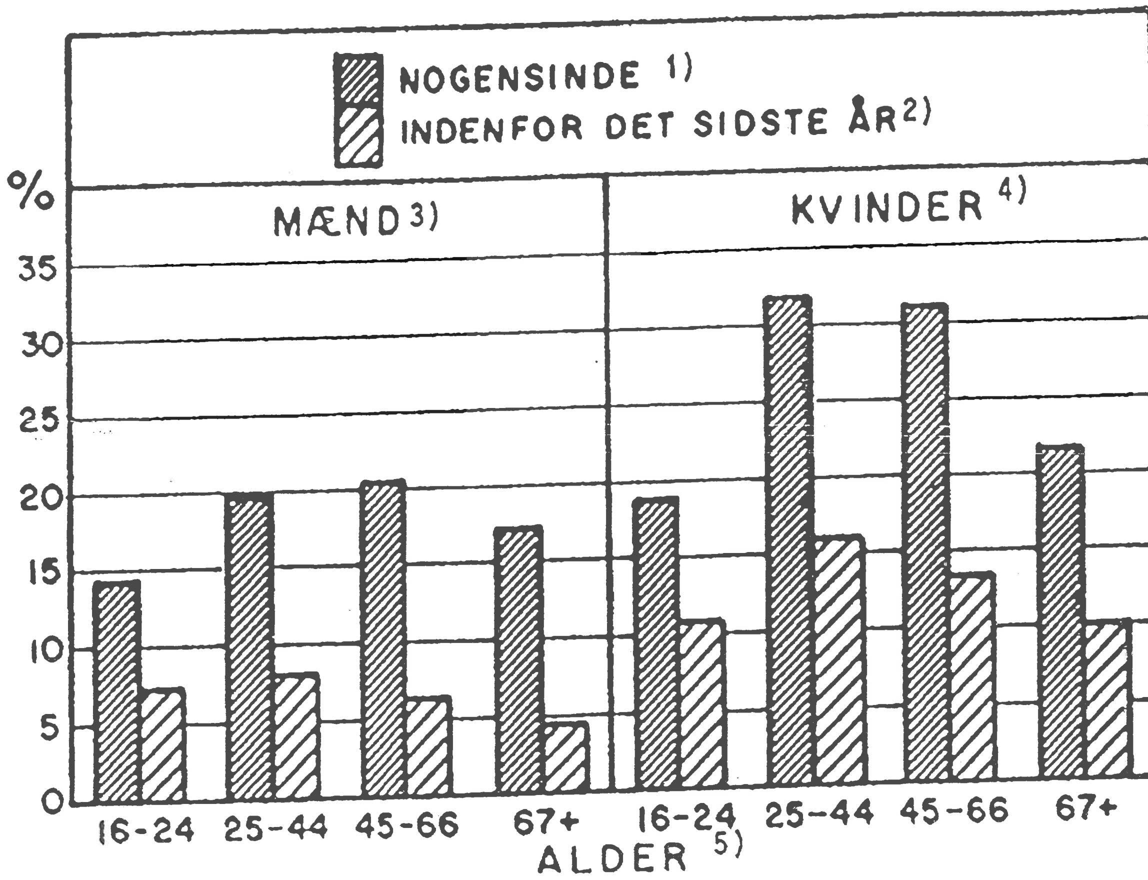


FIGURE 1. Use of alternative treatment among men and women of differents agecategories 1987.



1) Ever

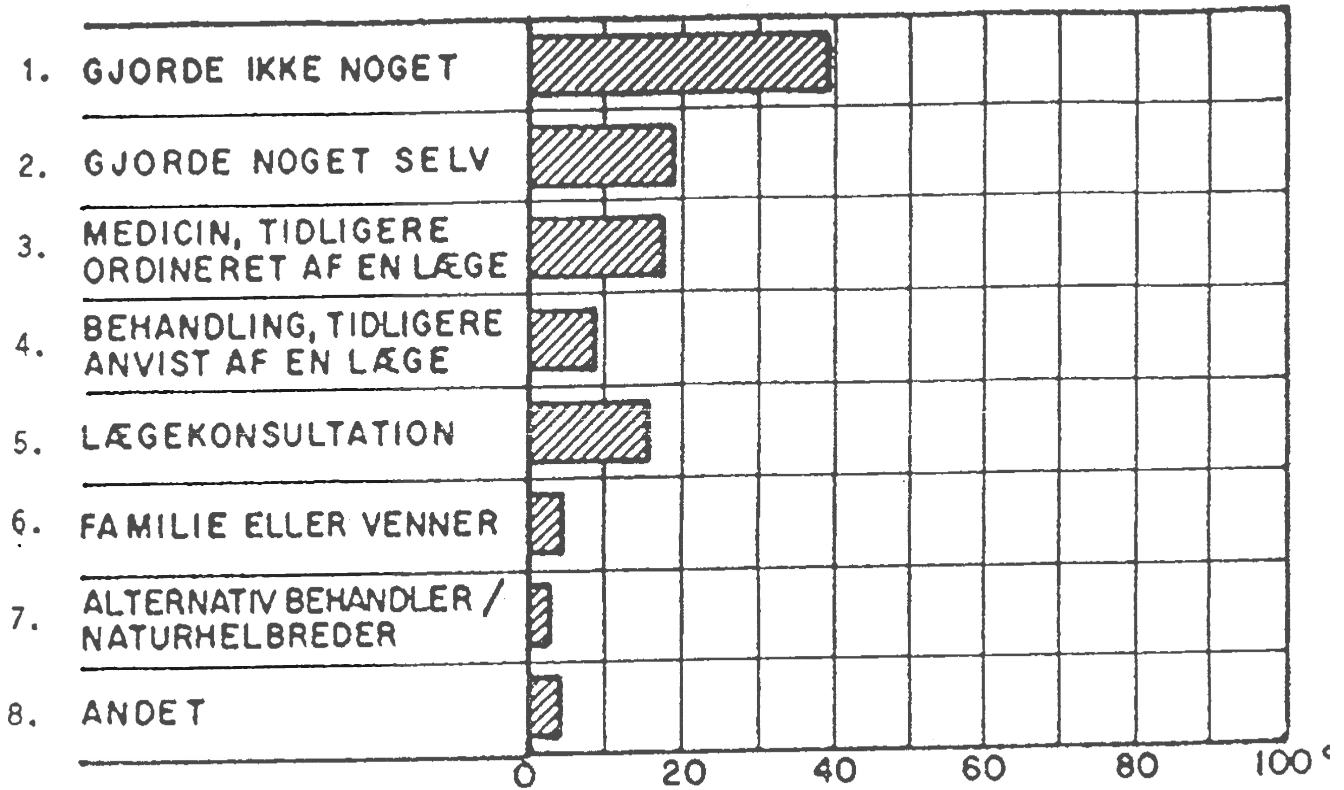
2) During the last year

3) Males

4! Females

5) Agegroups

FIGURE 2. Reactions towards symptoms in a 2 week period 1987.



1) Didn't do anything
2) Did something myself
3) Took previously prescribed medicine
4) Followed previous by recommended treatment
5) Conculted a doctor
6) Talked with family/friends
7) Talked with an alternative therapist
8) Other

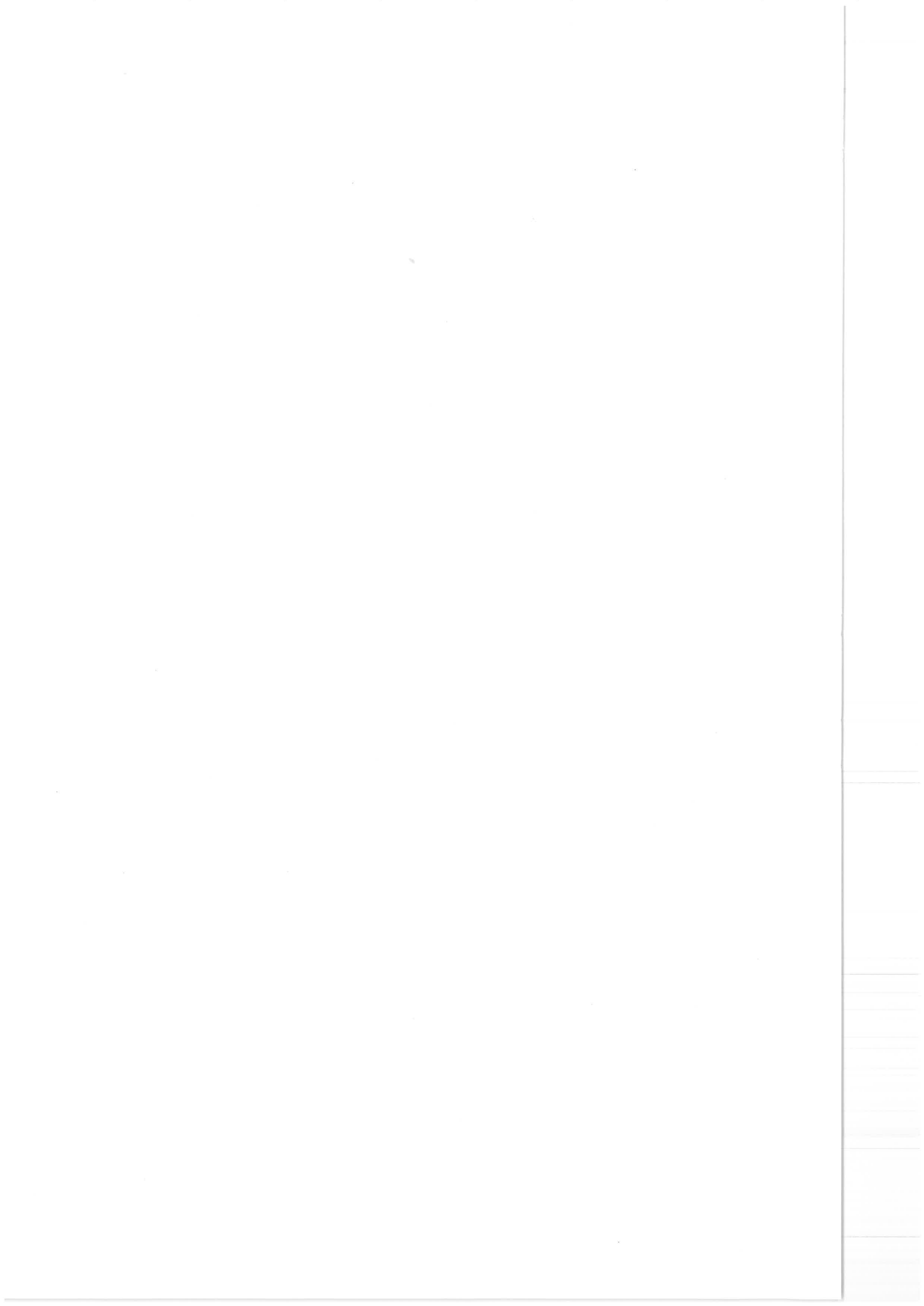
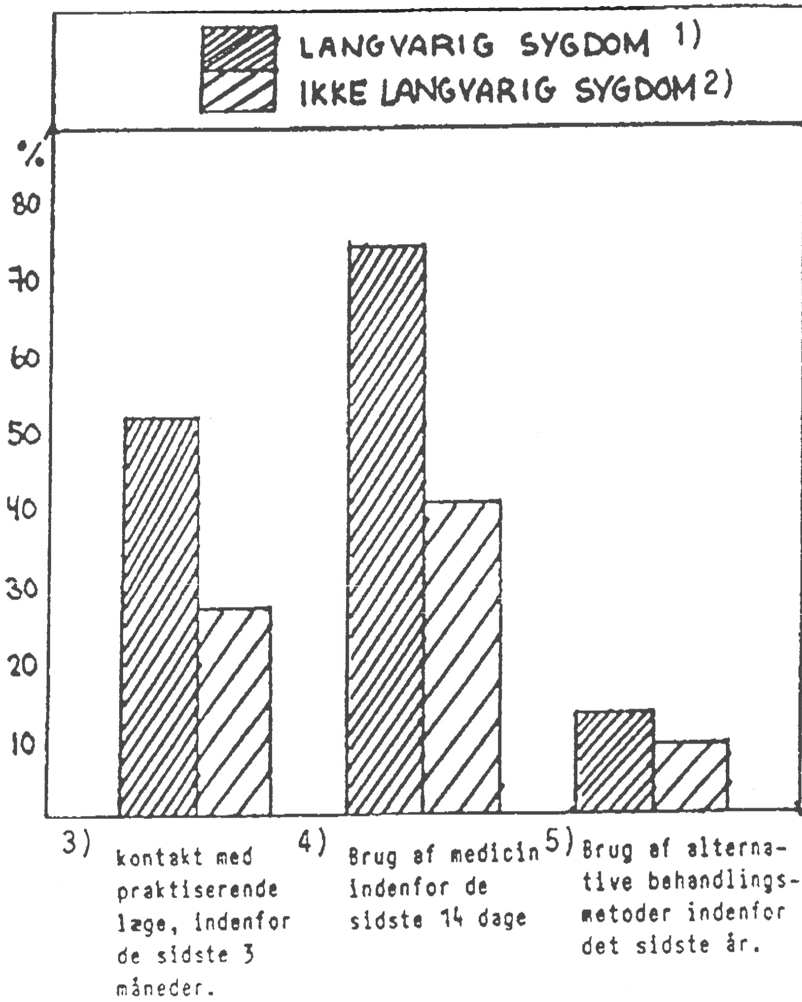


FIGURE 3. Use of family physician, use of medicine and use of alternative treatment in groups with or without long term illness.



1) with long term illness
2) without long term illness
3) contact with family physician (during last 3 months)
4) use of medicine (during last 2 weeks)
5) use of alternative treatment (during last year)

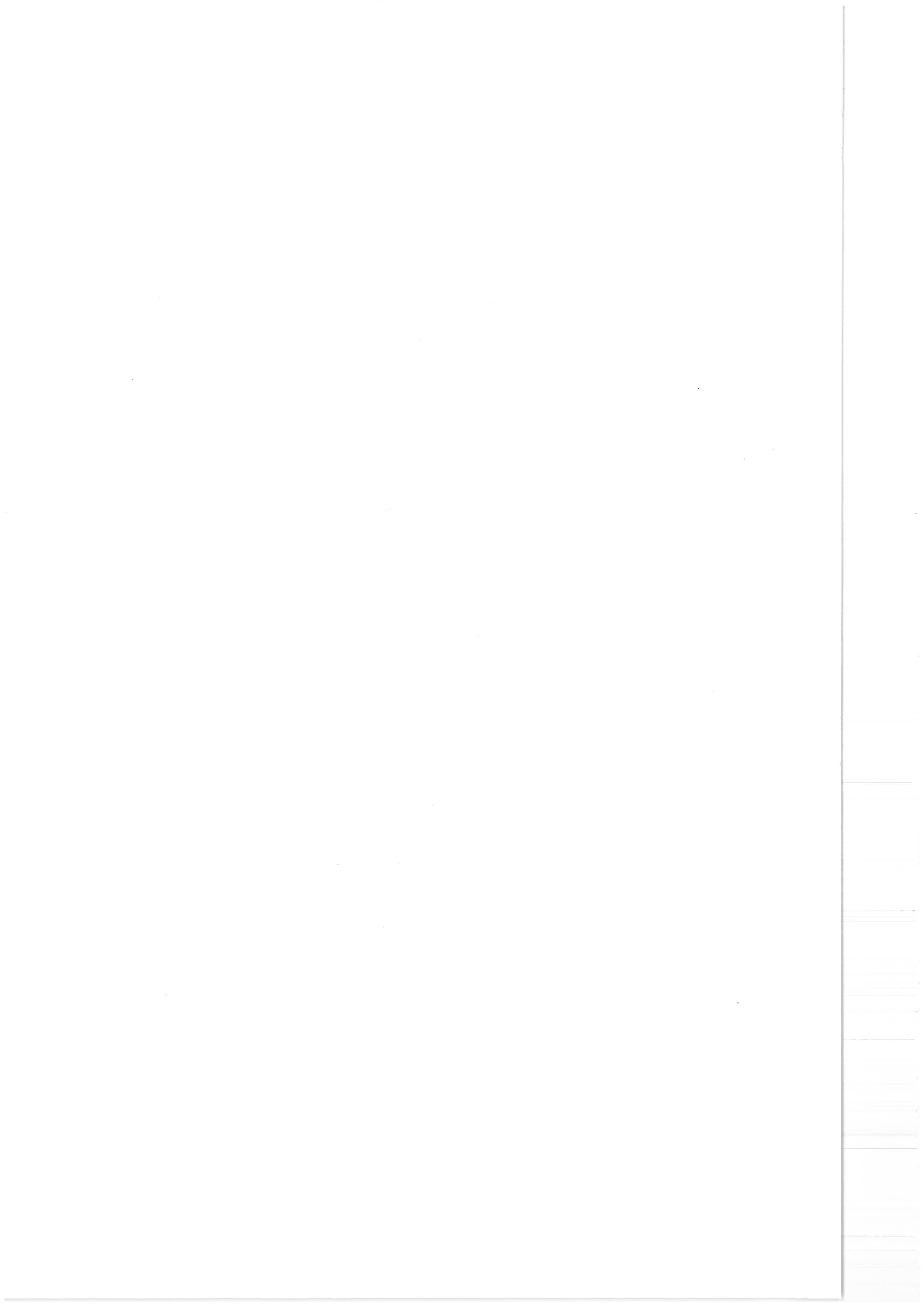
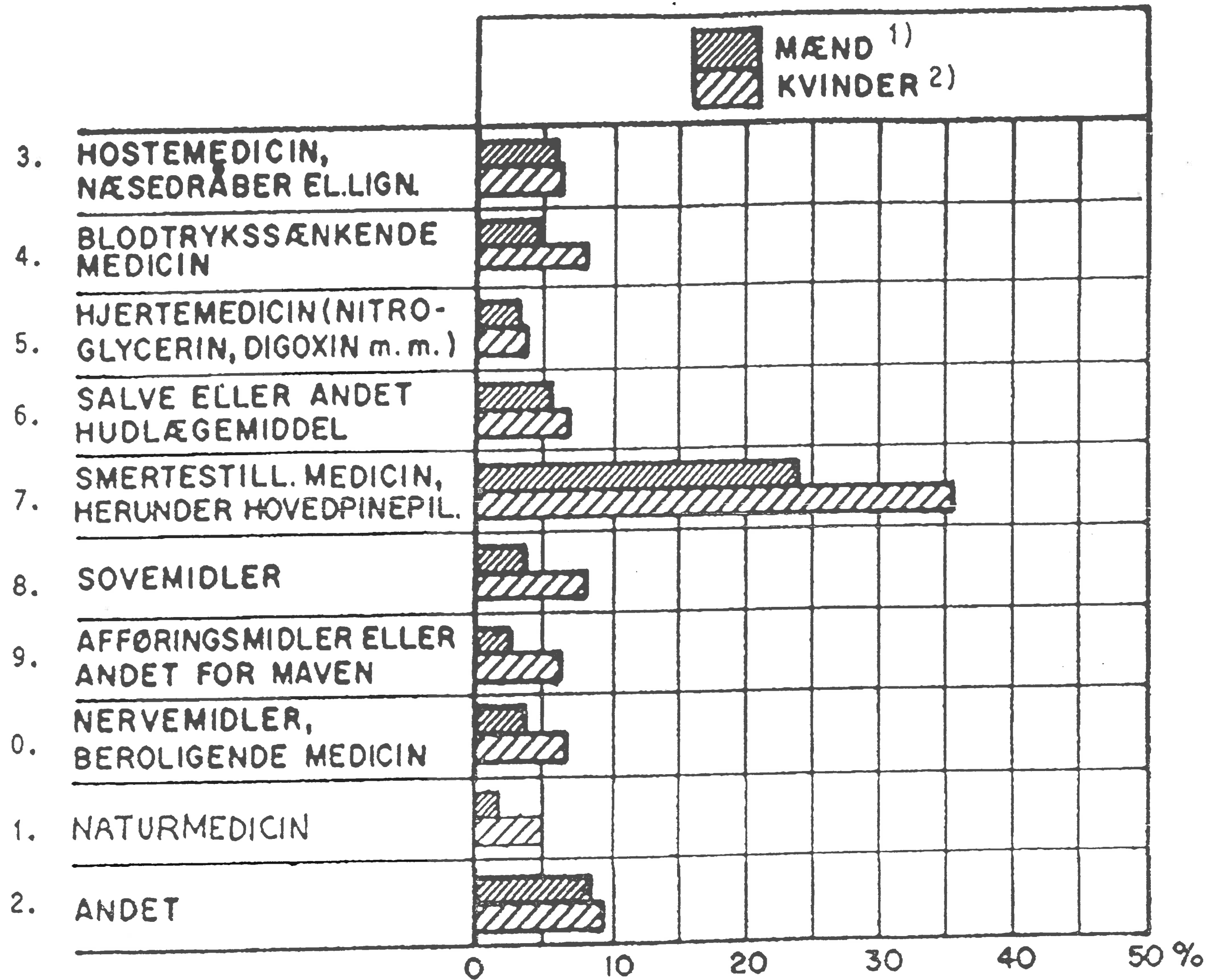
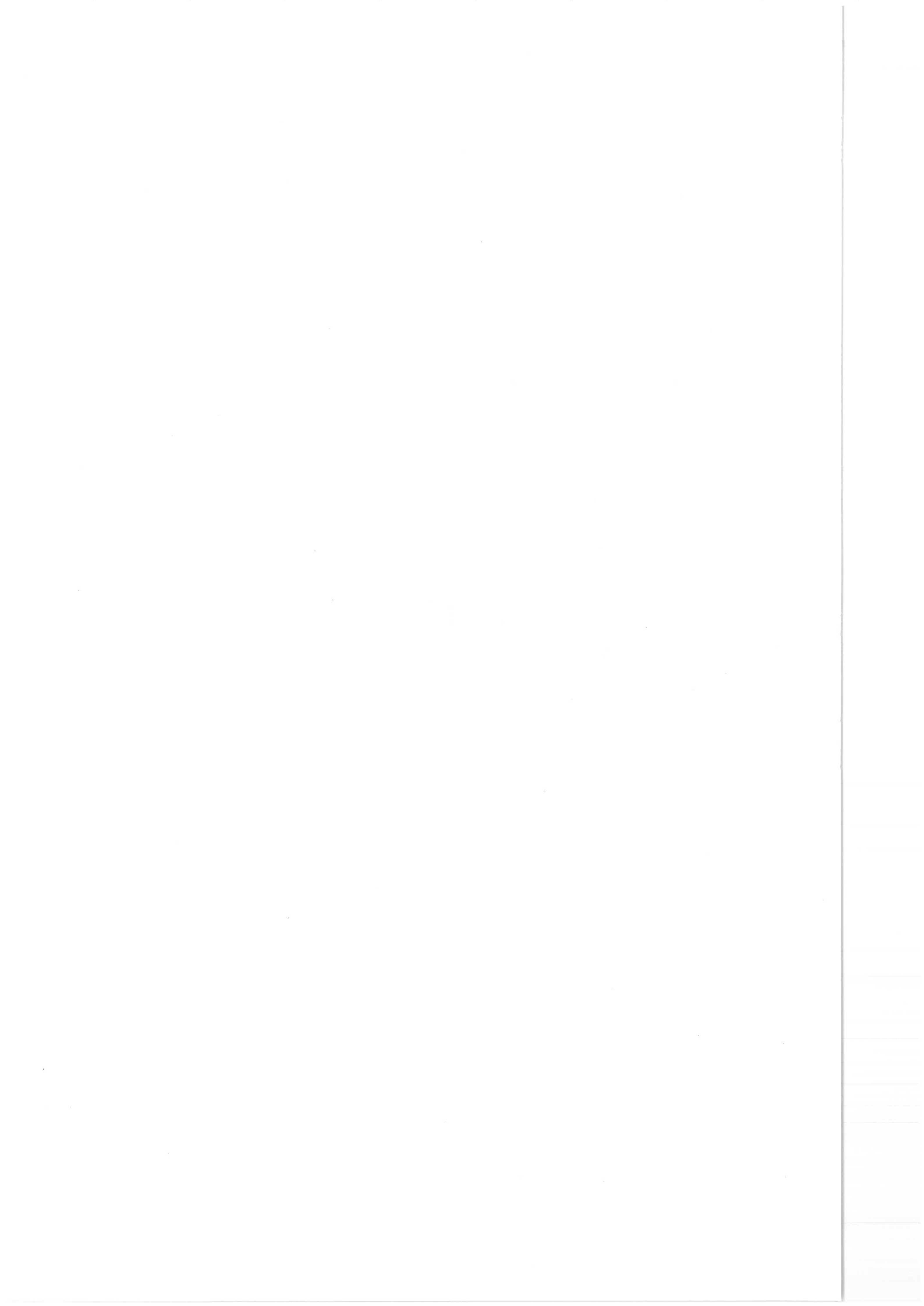
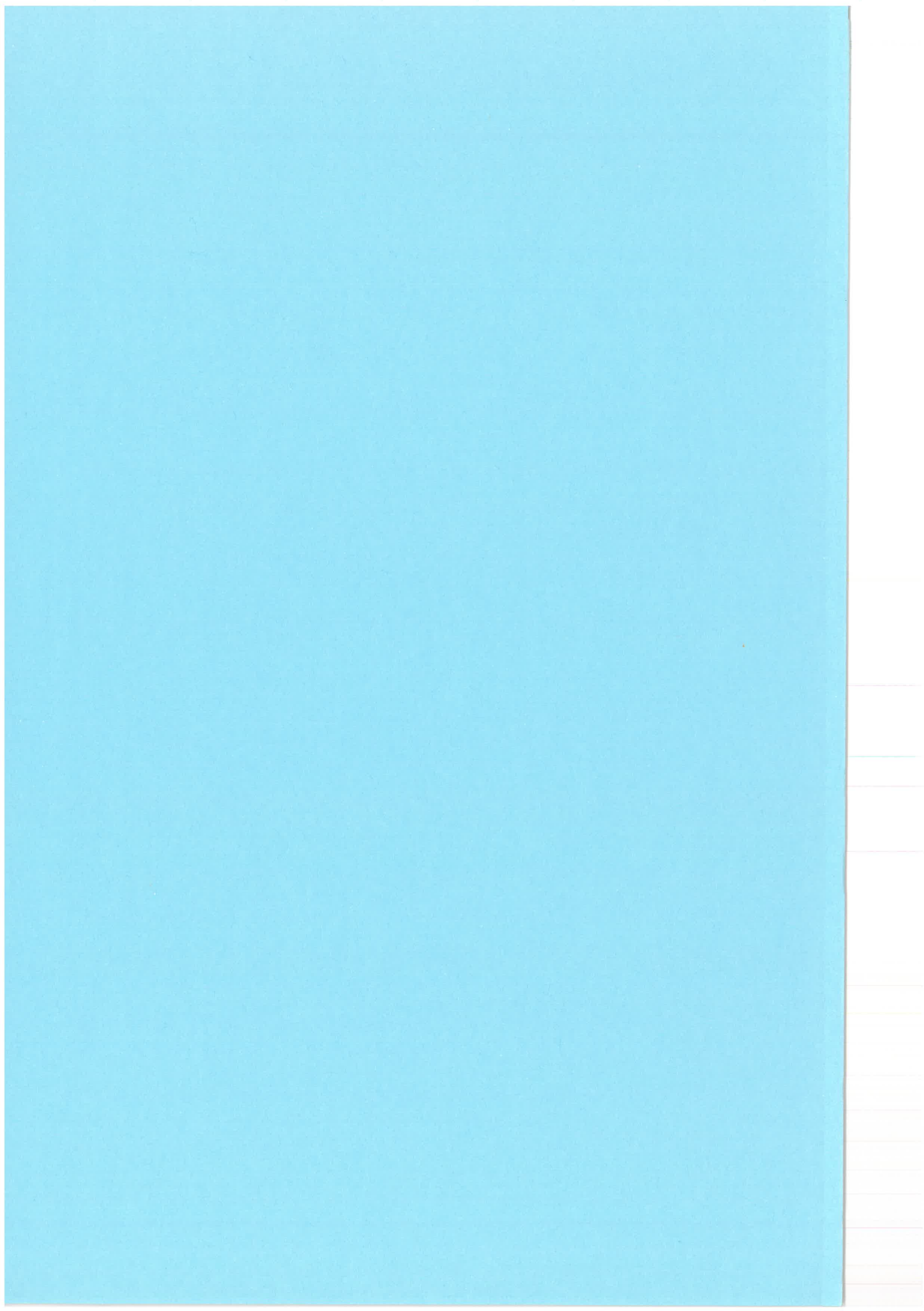


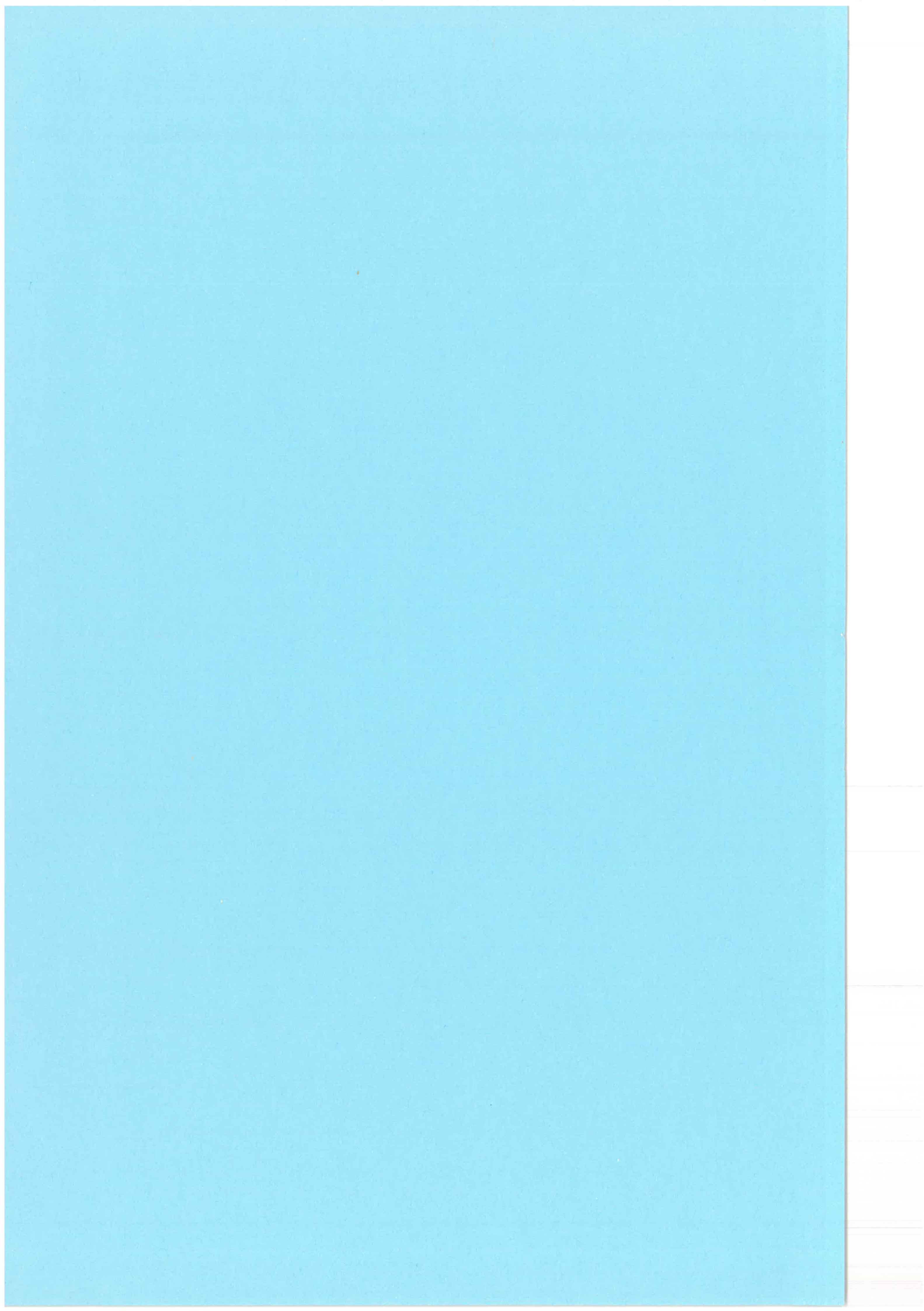
Figure 4. Use of various medicines during last 2 weeks 1987.



1) Males
2) Females
3) Cough medicine, nose drops
4) Anti-hypertensives
5) Medicine for heart trouble (Nitroglycerin, digoxin etc.)
6) Ointments or other skin remedies
7) Analgesics, incl. aspirins
8) Sleeping pills
9) Laxatives
10) Sedatives
11) Herbal medicine
12) Other







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Symposia onderwerp

The Delivery of Health Care Alternatives.

Keywords: traditional medicine, complementary medicine, health promotion, primary health care, Kur.

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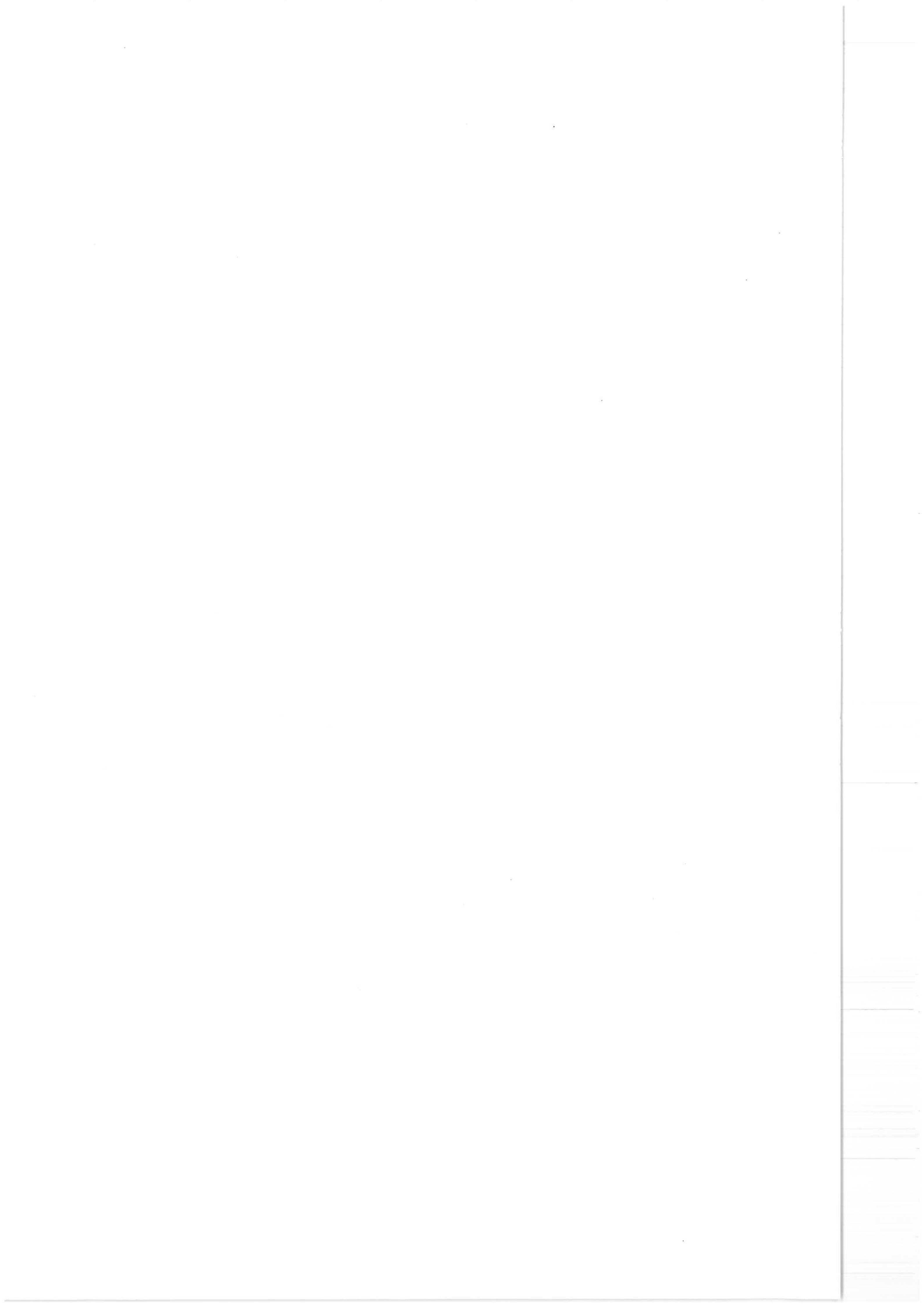
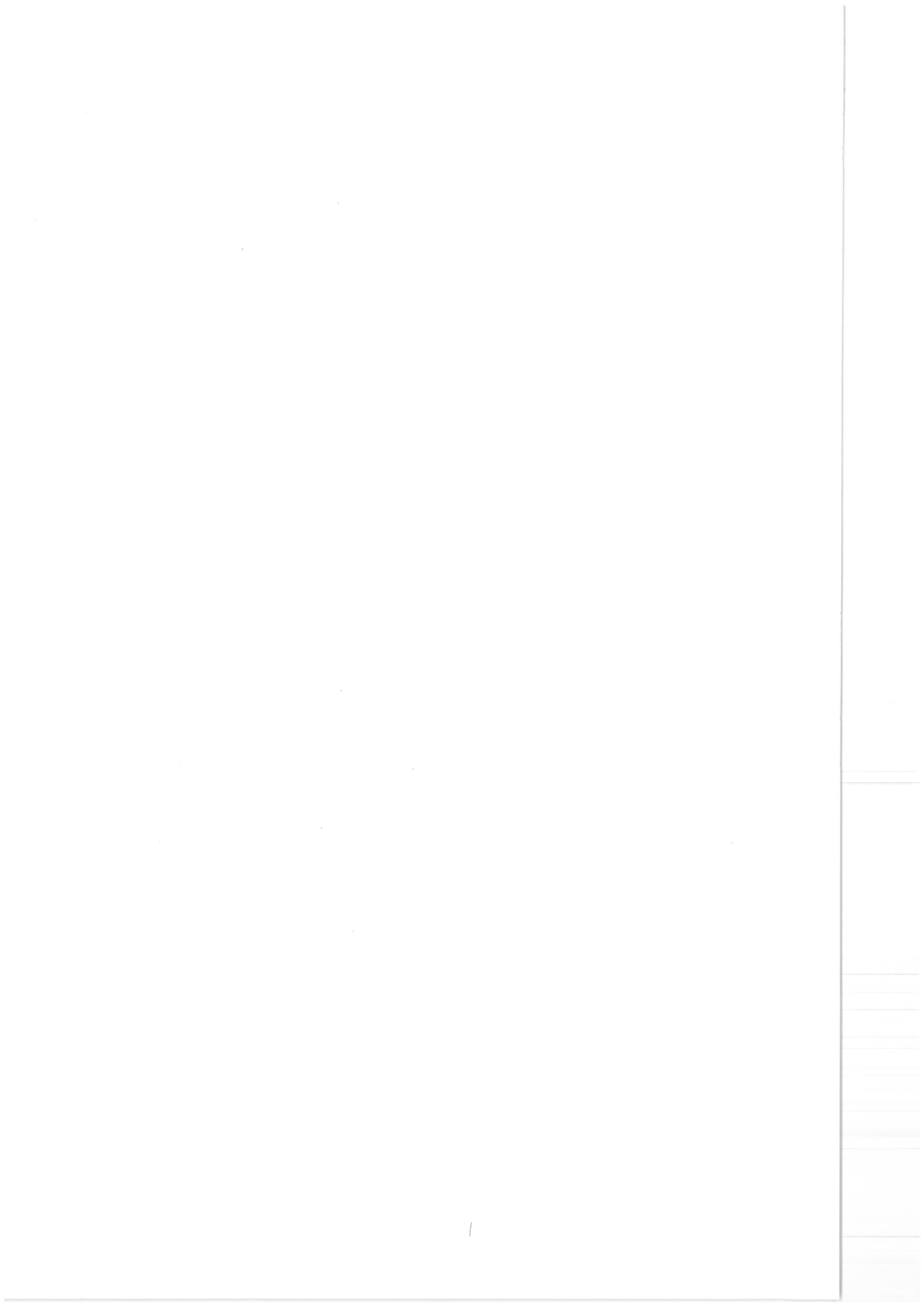


Introduction

A recent Government white paper in England (Working for Patients, January 1989) suggested a radical restructuring of health care with emphasis on a consumer-based service. This reflects a growing movement throughout Europe whereby health care initiatives are responding to consumer demand. Some of these initiatives may be based on what is currently regarded as 'complementary' medicine.

Despite the apparent growing popularity of complementary medicine, there are few population based data [1]. In a study of complementary medicine in nine European countries Sermeus [2] found that between 6% and 24% of the national populations had consulted a practitioner of alternative medicine, whether a qualified medical practitioner or not, during the previous twelve months. The most common form of complementary medicine was homeopathy, followed by acupuncture and then the manipulative therapies. Hill [3] reports that 9% of consultations in the United Kingdom, excluding those made in hospitals,, are with practitioners of complementary medicine. Yung [1] found that 2.6% of his random sample of patients in Cardiff, Wales reported some form of complementary medical treatment NOT on the National Health Service in the previous year, and suggested that demand may be suppressed by an inability to pay.

This emphasis on consumer choice and demand reflects what happens anyway. People choose how they wish to maintain and promote their own health. A possible reason for the popularity of complementary medicine is that the involvement of the patient in his or her own health care is recognised by the



practitioner. Other reasons given for choosing complementary therapies are; that they may include a psycho-social approach [4] to problems, that the patient's search for health is understood in terms of reasons and intentions [5], and that there is an acknowledgement of the intent of both parties to co-operate in health care. There is less a turning away from orthodox medical care because of dissatisfaction, more a demand for mixed pluralistic health care.

In the patient's search for treatment formal health care delivery often comes late in the chain of decision making. It is only we health professionals who emphasise the formal health care network, i.e. a 'top down' approach. Health care requirements in a consumer based approach are determined from the needs of the users, i.e. a 'bottom up' approach [6,7].

It may also be prudent for health care decision makers to consider how health care can be delivered in a pluralist European health care culture, i.e. one which acknowledges modern scientific, traditional and complementary medicine. There are lessons to be learned from our neighbours across the channel. Other European countries have attempted to integrate alternative medical approaches [2] and we can learn from each other what are the optimal conditions for a mixed health care system.

If we are to implement a consumer based health plan which emphasises choice, and which includes 'complementary ' medicine, then it will be necessary to promote an atmosphere of permissive legislation for the control and licensing of a broad spectrum of practitioners, and develop economic financing and

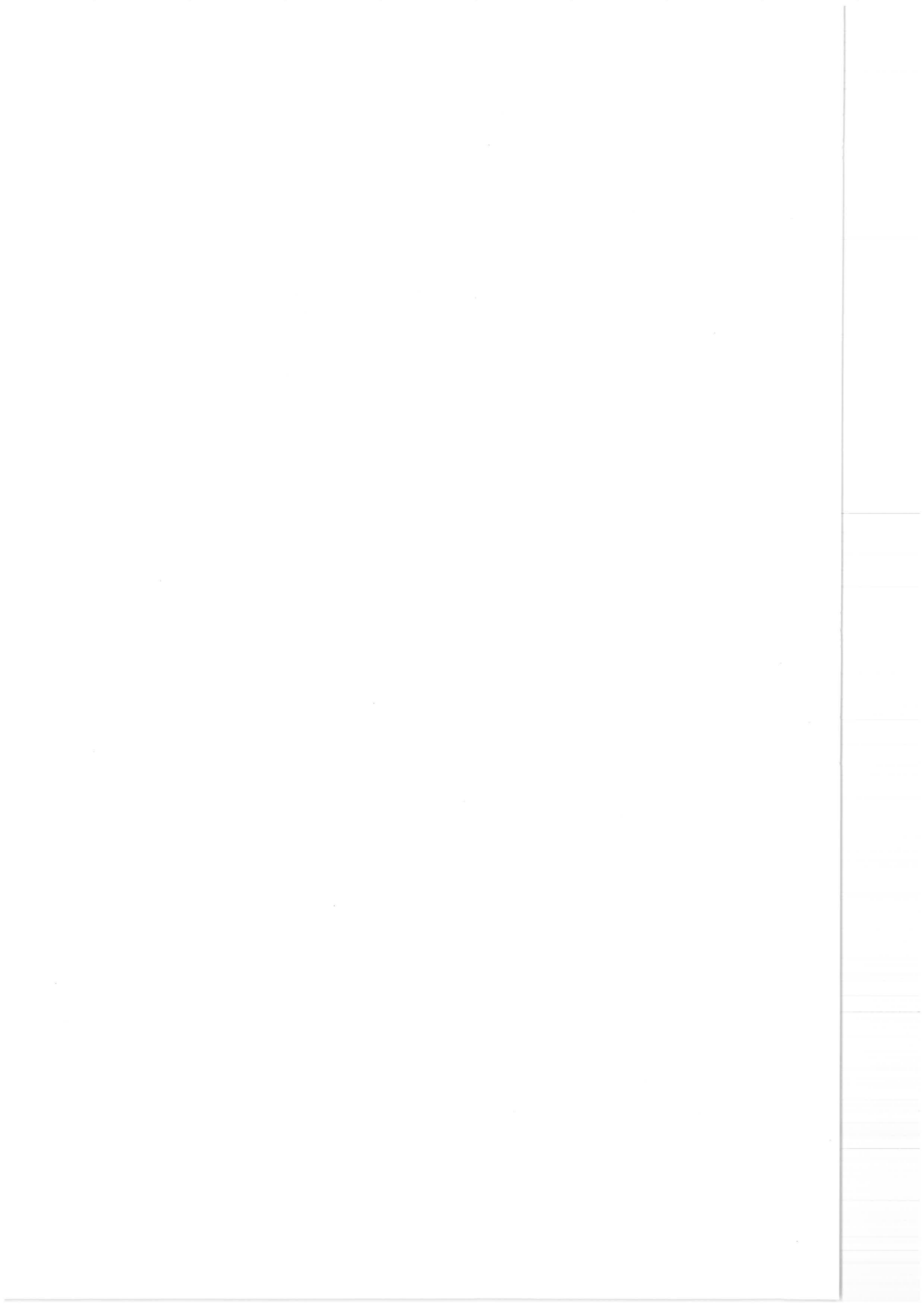
delivery arrangements [7, 8, 9]. The structure of such arrangements will depend upon knowledge of the process of health care delivery and organization [10].

Information about competing treatments may also bring about an improvement in health care and reduce the escalation of health costs [8].

Health care information

Before we can develop new ways of delivering health care we will need to rectify the serious lack of information concerning the costs, benefits and output of health care initiatives. While the British Government is attempting to introduce information technology into the National Health Service, there is no attempt to ascertain the costs of such organisational change. The implementation of procedures based on political ideology, before rigorously assessing the impact of those procedures, perpetuates the perennial problem of ad hoc health planning without understanding the need for the resources of time and trained personnel.

To attempt to implement information technology without a knowledge of the health care system is to implement non-information technology. Furthermore, to implement any information strategy without careful consideration of users' needs is folly. Such technology is not used. Strategies for the collection and dissemination of information have to be developed collaboratively with users, with commonly defined objectives and commonly understood criteria as to what counts as information. Not only do patients want to know more about their illnesses, they want to know more about the various treatments which are available.



The delivery of health care alternatives.......

If an aim of the new health care initiatives is to improve service then we can learn from industry [11]. Quality is improved by attending to the process of delivery where suppliers are in a close dialogue with consumers. This also reduces costs. Any new attempts to collect information must begin at this primary care interface between the medical practitioner and the patient, and the medical practitioner and his or her sources for referral. This would mean an emphasis on local networks according to local need.

However, we must first understand the complex process of health production before we can try to improve it, particularly in the field of chronic illness as it presents itself in primary health care. An understanding of health production must also be supplemented with measurement tools which represent the values of the producers at the workface (practitioners), and the consumers with whom they meet (patients). Epidemiological methods must be developed to establish base lines from which the success of health care initiatives can be measured and outcomes can be monitored [12]. It is imperative then that a common language for health outcomes is developed. This must be understood by the consumers (patients), deliverers (practitioners) and providers (those who pay).

When we speak of health care we are not only concerned with economic aspects of health, but the very nature of that health. It is this qualitative demand which has articulated the health care debate and stimulated the inclusion of 'complementary' medicine.

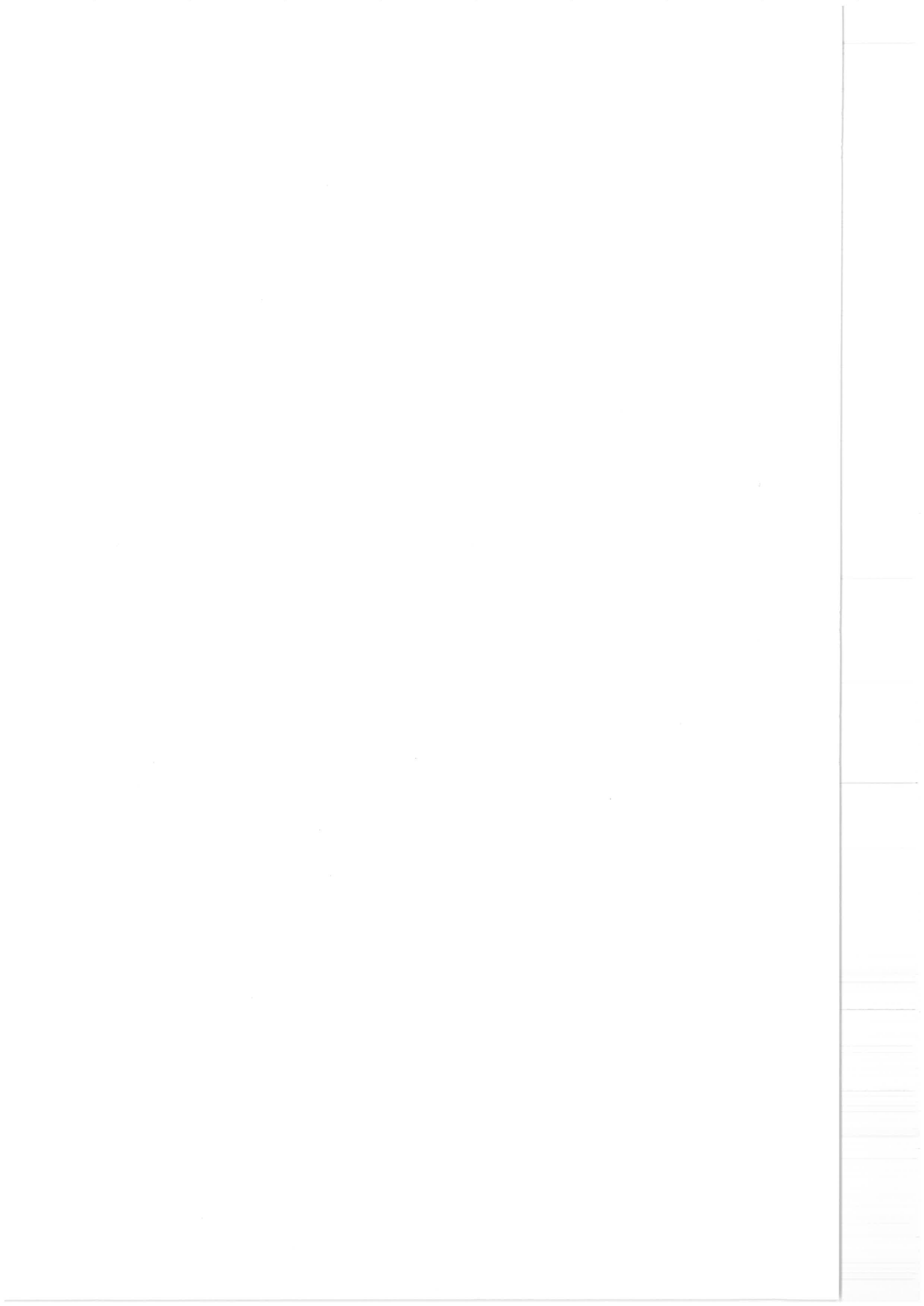
Health care and political will

Meeting health care needs is a matter of social strategy and political will. Health is not an homogenous concept, it is differentially understood. Medicine too is not an isolated discipline but an agglomeration of concepts taken from a variety of fields, only some of which belong to the natural sciences.

The social understandings of health and how to practice medicine are not fixed. Patients and primary health care professionals negotiate solutions to health care needs from an extensive cultural repertoire of possibilities. This repertoire is composed of understandings predominantly from Western medicine, but also from folk or traditional medicine and modern understandings of 'complementary' medicine.

However, there are factors common to a variety of health understandings. These include health promotion and prevention, health maintenance and treatment. Such factors are influenced by economic strategies, and cannot be divorced from considerations of community welfare. Poor housing and poverty mock any talk of initiatives based on consumer demand. There has to be a minimum level of income whereby people are fed and housed before the luxury of health choice can be exercised.

Economic factors exert a powerful influence on health care thinking by emphasising a short term political solution of expediency before the long term outlook of necessity. Governments come and go. Chronic illness has its own insidious course.

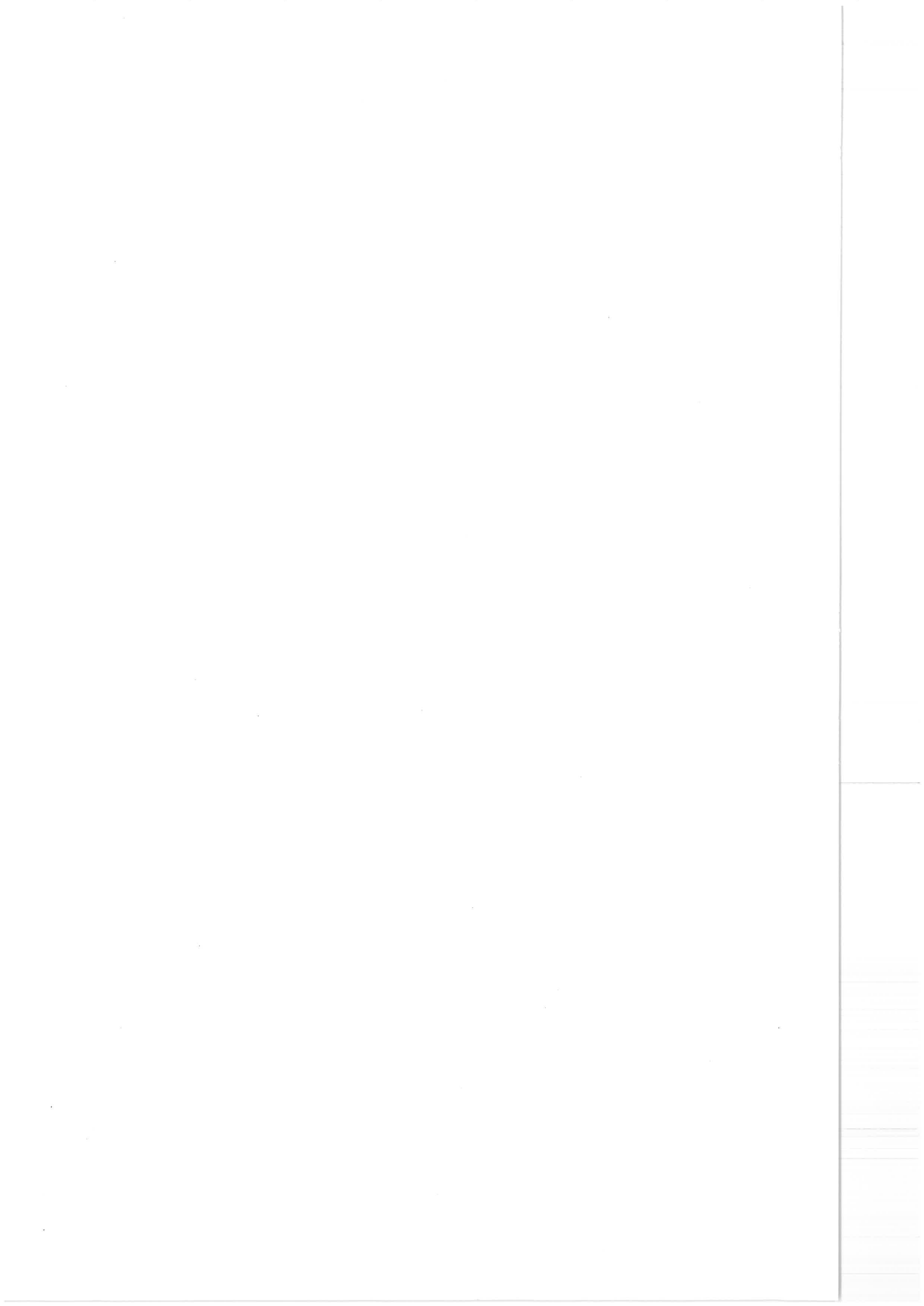


Furthermore, it is relatively easy to assess and define the cost of speciality tests and surgical procedures. Such an emphasis can inflate the demand for such tests whereby 'best' is seen as most expensive. This is not so easy with the 'softer' procedures of complementary medicine. For example, psychotherapy is permitted under insurance plans in the United States for the treatment of significant psychiatric disease, but not for marital stress, lifestyle counselling and situational depression [13].

In Great Britain no one is barred from professional medical care by cost (although supply is limited by rationing), yet the health of the lower social classes has not significantly improved since 1947. In contrast the higher social classes utilize the National Health Service more frequently. They also turn to complementary medical practice more frequently [1]. Any attempts to introduce complementary health practices will have to consider how such health care is to be reimbursed if it is to be delivered to those with low incomes. Budgetary constraint in primary care may well facilitate complementary practice while retaining universal access.

It may be that some complementary medical practices, which include an emphasis on lifestyle, health promotion and health education coupled with 'low' technology, can offer low cost alternative health care [14]. This is not to suggest a two tier system of low cheap complementary medicine and high expensive scientific medicine, rather that a plurality of approaches will meet a wide spectrum of need.

In the light of inappropriate medical procedures in some Western countries, and marked differentials in prescribing patterns throughout Europe [8],



'complementary' medical initiatives not only have an important role to play in cost reduction, but also have a place as appropriate treatment regimes. For stress related disorders complementary practices like relaxation, massage, biofeedback and psychotherapy are often not recognized as reimbursable. Yet, it is estimated in the United States that stress disorders cost the budget $150 billion a year and result in 55 million working days being lost [15].

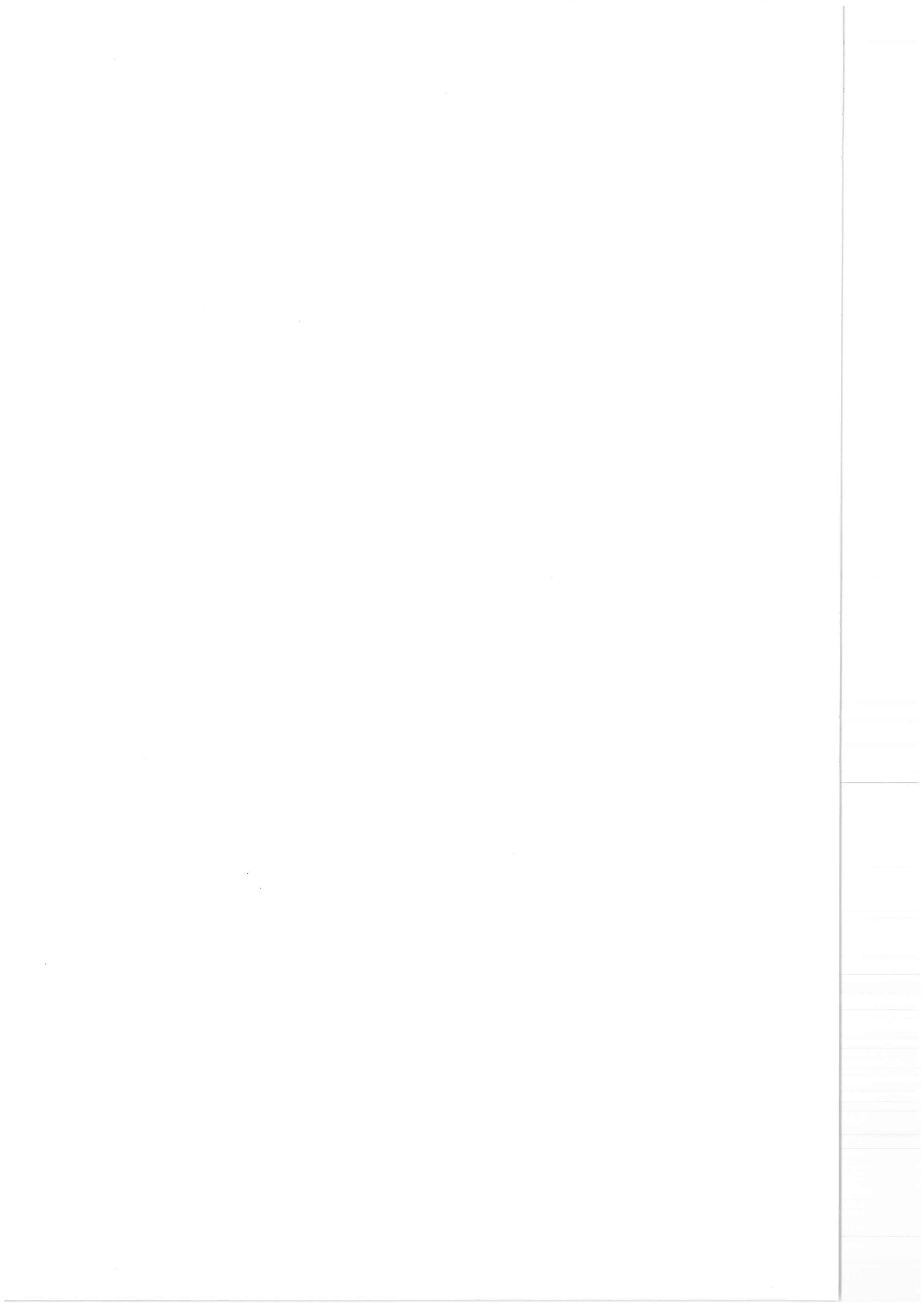
Such mixed primary health care delivery will need to be co-ordinated. There is evidence throughout the world that such an integration of differing medical initiatives can be made successfully.

Integration

Recent discussions about complementary medical practice would suggest that it is incompatible with modern scientific medicine, although some practitioners of family medicine are incorporating alternative medical practices [16, 17]. The pragmatics of health care seem to suggest a working compatability for the delivery of a mixed health care which is missed by theorists.

Throughout the world there are examples of mixed health care initiatives where the predominant traditional medicine is delivered with Western medical care.

In China, parts of Asia and India traditional medical practices are incorporated with modern Western medicine. In Africa traditional methods are also compatible with modern Western medicine [18, 19]. The introduction of modern medicine does not mean that traditional methods die out. Where plurality of service exists, there is a plurality of use. This may be because



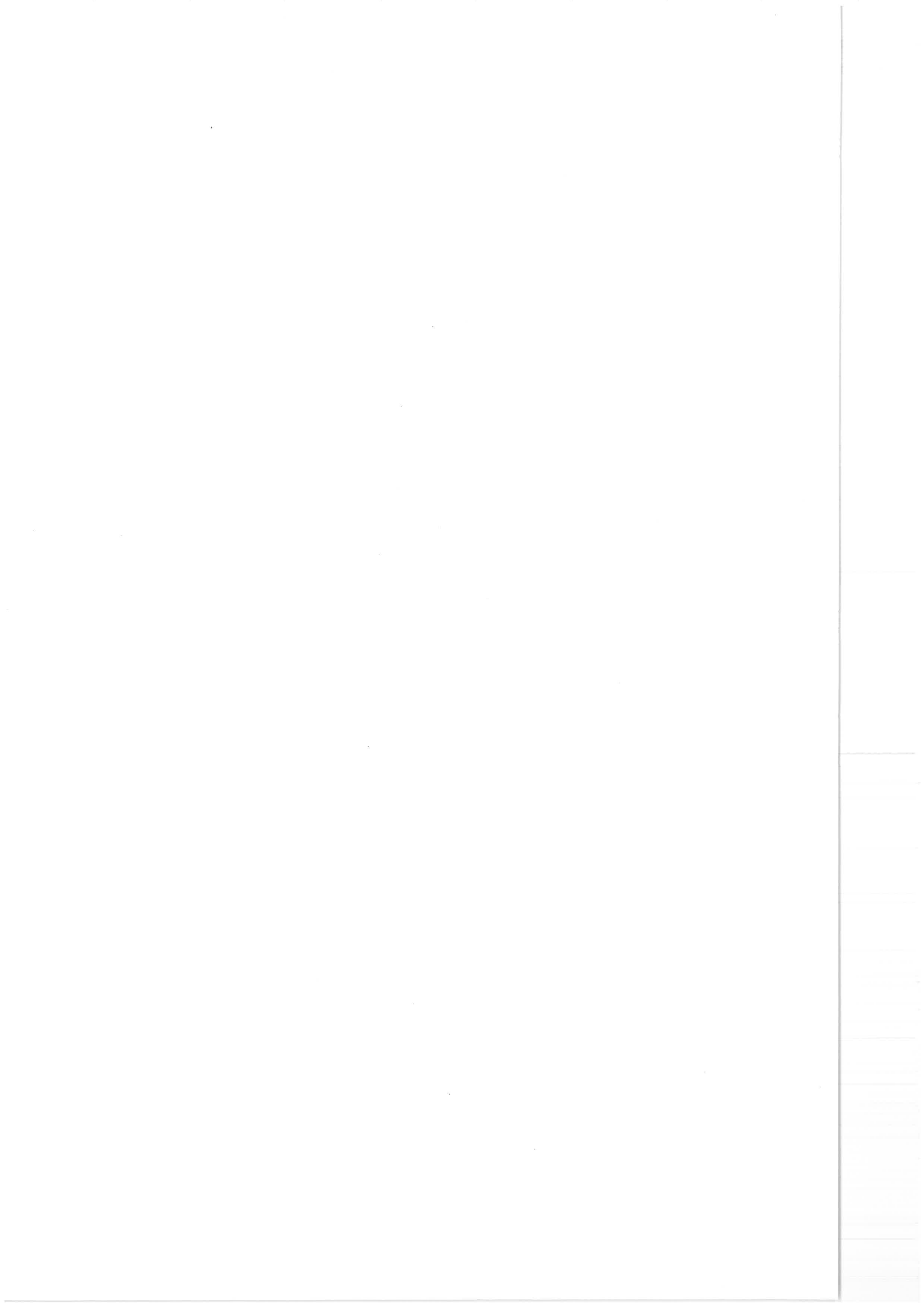
traditional medicine meets the broader health care beliefs of the patient, and partly because traditional medicine is the only financially available medicine for the Third World poor.

In the Phillipines traditional birth attendants were integrated into the medically oriented health care system by training and refresher courses [19]. This integration meant that traditional healers who were likely to be listened to by their patients, could encourage a wide variety of community health care initiatives. These initiatives included family planning advice and assisting in immunization. A similar situation has occurred in Amerindian populations.

Throughout Europe there have been varying national initiatives whereby the traditional medicine has remained active; albeit informally, and in some cases illegally. Complementary medicine in Europe has grown from the bases of naturopathy, homeopathy and manipulative techniques. There are also national cultural differences which favour differing approaches. For example; in Finland massage is the most commonly used form of complementary practice and harks back to its roots in traditional medicine [20].

For complementary medicine to flourish there has to be a climate of tolerance and active collaboration rather than restrictive licensing practices. This permissive climate leads to enhanced health care delivery. Such tolerance has been a feature of health care delivery in West Germany [21].

The *Kur*



The *Kur* in West Germany exemplifies characteristics of both orthodox and non-orthodox medicine *(unconventionelle Medizin)*. Such health care practice is not solely explained by bio-medical criteria and is best understood as a social, historical and cultural phenomenon [22, 23].

The *Kur* is an institutionalized bathing activity which is also used for health promotion. Naturopathic treatments are used alongside modern bio-medical technology. *Kur* clinics are supervised by qualified orthodox medical practitioners, but also use licensed naturopathic healers (Heilpraktiker). The medical directors of such clinics often include some aspect of their own philosophy for therapy. Treatments may include bathing, massage, exercise and dietary considerations.

This mixed approach does not seem too far a cry from what some family practitioners in England have been advocating as avant garde practice in 'holistic' medicine.

The legislative framework for practising medical alternatives in West Germany is permissive. Patients can choose whom to consult; orthodox practitioners , complementary practitioners or naturopathic healers. This situation has developed, not without controversy and vigorous debate, in a philosophical tradition which has tried to understand the basic human condition in health and illness [24]. German Romantic philosophy in the nineteenth century attempted to criticise a natural science which was seen as fracturing nature. The maintenance of health was seen as springing from a unity of mind and body, the harmony of the individual with other human beings and a concern for the natural environment.

Again, this does not seem a far cry from our current concerns with environmental pollution, the ravages of modern living and the debate about holistic medicine.

Naturopathic medicine developed into a system of ideas which attempted to reform the dehumanization and excessive curative interventions of some medical practices. To implement these reforming ideas it was necessary to develop economic strategies for public health finance and insurance schemes. These were developed in parallel with a legislative framework which supervised the practice of naturopathic healing, inspected the premises of such healers and licensed practitioners.

It is also important to emphasise that the Kur tradition is a part of the tourist industry. Some of these *Kur* activities are reimbursable, either fully or in part, by the insurance companies. In West Germany free time bathing, not necessarily swimming as a sporting activity, and sauna are leisure activities. Health care activity in this system not only belongs to the medical domain, but also belongs to a whole series of diverse activities including diet and leisure. This answers Zola's [25] concern about the medicalization of health care activities. In a way he falls into his own trap by assuming that medicine can take over health care understandings. Health care in practice is not seen as a separate activity from leisure and living. Given the opportunity of choice in the suitable cultural context which includes health education then health activity is inseparable from daily living.

Patients who attend a *Kur* clinic have often been treated in a hospital first. These patients fall into four main groups: patients who need rehabilitation

after an accident, patients with a chronic or a serious disease condition, older patients who want to maintain their health and continue working, and those who need a rest cure after retirement. Health care in this approach is not only about promoting well-being in younger patients, which might be considered a luxury, but also keeping older patients fit enough to stay in the employment market.

West German medical care incorporates both modern scientific medicine, and the traditional nature oriented medicine. The curative role of herbal medicines, mineral waters and natural food diets, and the health promotional activities of fresh air and exercise, have remained part of recognised health care activities within the wider culture of German humanism. Complementary medicine, which includes the 'newer' therapies of yoga and acupuncture, then is part of a continuing tradition of medical pluralism, not a return to traditional methods.

If the current situations of East and West Germany are considered it is possible to see how economic and socio-political realities effect health care delivery. Both countries have the same historical heritage of 'Therapiefreiheit'; "the freedom of a practitioner or patient on the basis of his world view-which always entails a perspective as to the meaning and causation of illness-to select for preventive or curative purposes a mode of therapy which is in conformity with this world view" (p16) [21]. Modern legislation in East Germany to prevent the training of Heilpraktiker, an emphasis on bio-medical proof of efficacy for treatments, a centrally planned economy and limited pharmaceutical industry has meant a restriction in health care alternatives. In West Germany a liberal market economy and an acceptance that there is more than one truth in a person's perception of his or her own

health has led to a pluralist health service which can accommodate developing alternatives.

Conclusion

A consumer based health service may well be pluralistic; i.e. it will offer modern scientific medicine and complementary medicine. The nature of such a complementary health care provision will vary according to local needs. Local health care initiatives in Europe depend upon three factors of availability:

economic; according to third party methods of reimbursement (government or private health insurance),

cultural; according to the historical and philosophical traditions, and

social; according to community needs.

This provision is located within a political context which sponsors initiatives by allocating the appropriate resources. Consumer based health care is best delivered in a climate of tolerance and active collaboration between practitioners, legislators and administrators. Such a climate fosters quality of health care.

Local initiatives throughout Europe have promoted complementary practice in primary health care. The treatment of terminal illness and chronic conditions demand an understanding of the quality of the patient's life and appear to be a logical starting place. By the year 2030 the populations of Europe will have large numbers of people aged over 65 years (Britain 19%, Italy 22%,West Germany 26%, Sweden 22%, Switzerland 29%) [26]. The potential health care costs for these polulations are massive. Active campaigns of health promotion, collaborative health care initiatives and low cost treatment approaches must be planned now while those populations are still young.

The delivery of health care alternatives.......

Health care, like the natural world, has an ecology. Short term changes may bring immediate political benefits but without a concern for long term changes and an overview of the whole system, then continuing damage to communities may occur.

If health care is delivered as a commodity then we fall prey to perceiving health only as a materialistic representation and only offer short term solutions. If we consider health as a process which can be actively promoted within the span of a person's life by the allocation of appropriate resources, and that health can also be maintained by an appropriate life-style, then the expensive, but not inevitable, end process of treatment may in some cases be avoided. This entails a long term strategy for health care. To plan a long term co-ordinated strategy takes political will and can only be accomplished by active collaboration of those in health care delivery and consumption. Where treatment does occur, then consumers can be offered alternatives which fit the ecology of their own lives. Modern scientific medicine as it is delivered in primary health care will inevitably be at the core of such a pluralistic provision.

The future delivery of health care will depend upon accurate information about the management of resources. To assess health care we will need accurate and appropriate tools of assessment. In this way quality can be raised and rising costs reduced. However, quality of care is an elusive quality dependent upon the assessor. Costs, while being easier to identify may reveal not an inefficient system but one which is financially under-resourced by a political ideology which is humanly bankrupt.

Research initiatives: The impact of non-orthodox medicine on health care expenditure in Europe

A co-ordinated research plan for Europe is necessary to meet the health needs of the population. It is essential that we take time to develop an appropriate research strategy, and the methodologies to support that strategy. A large scale survey may not be the appropriate initiative without a thorough understanding of the complex issues involved in assessing health care expenditure, the demand for non-orthodox medicine and how to finance the delivery of such medicine.

What we do need is time to formulate a strategy for understanding the impact of non-orthodox medicine which can be implemented by the resources we already possess. This strategy will mean that some research centres can investigate particular aspects of non-orthodox health care which is appropriate to their expertise, while others may investigate a different area; e.g. one country may look at legislation issues relating to non-orthodox practice, another group may investigate sources of reimbursement, another look at centres where differing health care practices are integrated, another group may consider suitable health care cost indicators.

In this way previous research need not be duplicated, but can be replicated in another country e.g. research previously carried out in Belgium may well be replicated in Germany, and the results compared.

Variables

The advantage of a European initiative is that different nations, and regions, can be used as comparative groups. For example, the use of a particular alternative medicine in one country or region may be based upon the culture of that region, historical precedents, economic factors, local legislation, or the age of the population.

It will be essential to identify appropriate variables which will be central to the research strategy.

Age, Sex and Educational Status: We may wish to concentrate on the delivery of primary care to particular groups. Given that the elderly will consume a large proportion of the health resources of Europe then such research will be timely. Similarly, we will need to look to the health care needs of differing socio-economic groups.

Health problem: If chronic diseases are the most intractable to modern orthodox medicine then we may wish to concentrate on particular health problems; chronic heart disease, musculo-skeletal disorders, chronic mood disorders.

Treatment modality: Rather than consider a whole range of differing alternative practices it may be necessary to consider those practices which will be amenable to integration with orthodox medical practice, e.g. homeopathy, acupuncture, manipulative therapies.

The delivery of health care alternatives.....

Practitioner status: An immediate need in the light of current legislation may be study the impact of non-orthodox medicine only as it is delivered by qualified orthodox medical practitioners or licensed practitioners.

Health activity: Most of research into medical practice is concerned with treatment. We may be able to propose a research strategy which assesses the impact of health prevention and health promotion using non-orthodox medicine on health care expenditure. This will entail sophisticated statistical procedures of forecasting.

Region: The integration of non-orthodox practice with orthodox medicine will vary from region to region. It should be possible to compare differing regions according to socio-economic, cultural, legislative, historical and educational factors. Furthermore, we may wish to compare regions outside the E.E.C.; e.g. East Germany as mentioned earlier has a similar historical heritage to West Germany, but particular events have led to a differing health delivery arrangement.

Baseline data and health cost indicators

Any research will rely upon valid indicators of health care impact. It could be that this will take a significant part of the intended two year programme to formulate a suitable instrument for researching the impact on health care expenditure. Not only will we need to set up an appropriate instrument, but also the means of analysing our collective results. This must be supplemented by the appropriate baseline data about health care expenditure relating to the problems which we wish to investigate. As yet we have no adequate minimum

data set which is agreed throughout the E.E.C., or recognised research procedure.

A further area of interest will be to ascertain how individuals from particular groups, given that they have a minimum level of disposable income, choose to spend that income on health care activities. What are the conditions under which people, as health care consumers, utilise a plurality of health care? This will be an intensive approach which extrapolates from small groups of terget patients.

Possible initiatives

1. To develop a research methodology suitable for determining the impact of non-orthodox medicine on health care expenditure.

This will include the development of health indicators.

2. A comparative study of the integration of named non-orthodox medicines with orthodox medicine.

This will assess the costs, and reimbursement, of such health care delivery.

3. A comparative study of finance arrangements for non-orthodox medical practice.

This will include forecasting health care expenditure requirements for alternative medicine until the year 2030.

4. A comparative study of health care expenditure for particular chronic health care problems.

This study will assess current health care expenditure for particular problems and forecast health care needs for particular chronic problems. It could be possible to include some considerations of health prevention and health promotion in such a study.

5. Factors of supply and demand in health care expenditure.

This will cover the reasons and intentions people have in their choice of health care. It will combine economic factors with social factors. For example, we could see how target groups utilise differing health care delivery services and assess the factors limiting their use of alternatives (availability).

All of these above strategies will depend upon a reliable indicator by which we can recognise a cost benefit. It is vital that we identify the minimum data

set necessary for any future research. This will not limit us to all carrying out the same research initiatives, but will allow us to have a common comparative data set within the overall umbrella of a co-ordinated strategy. In addition we will need to develop some means of forecasting from our statistics. This research will be important for health care planners and providers, particularly the third party supplies of health care reimbursement who will be made aware of the consumer needs.

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