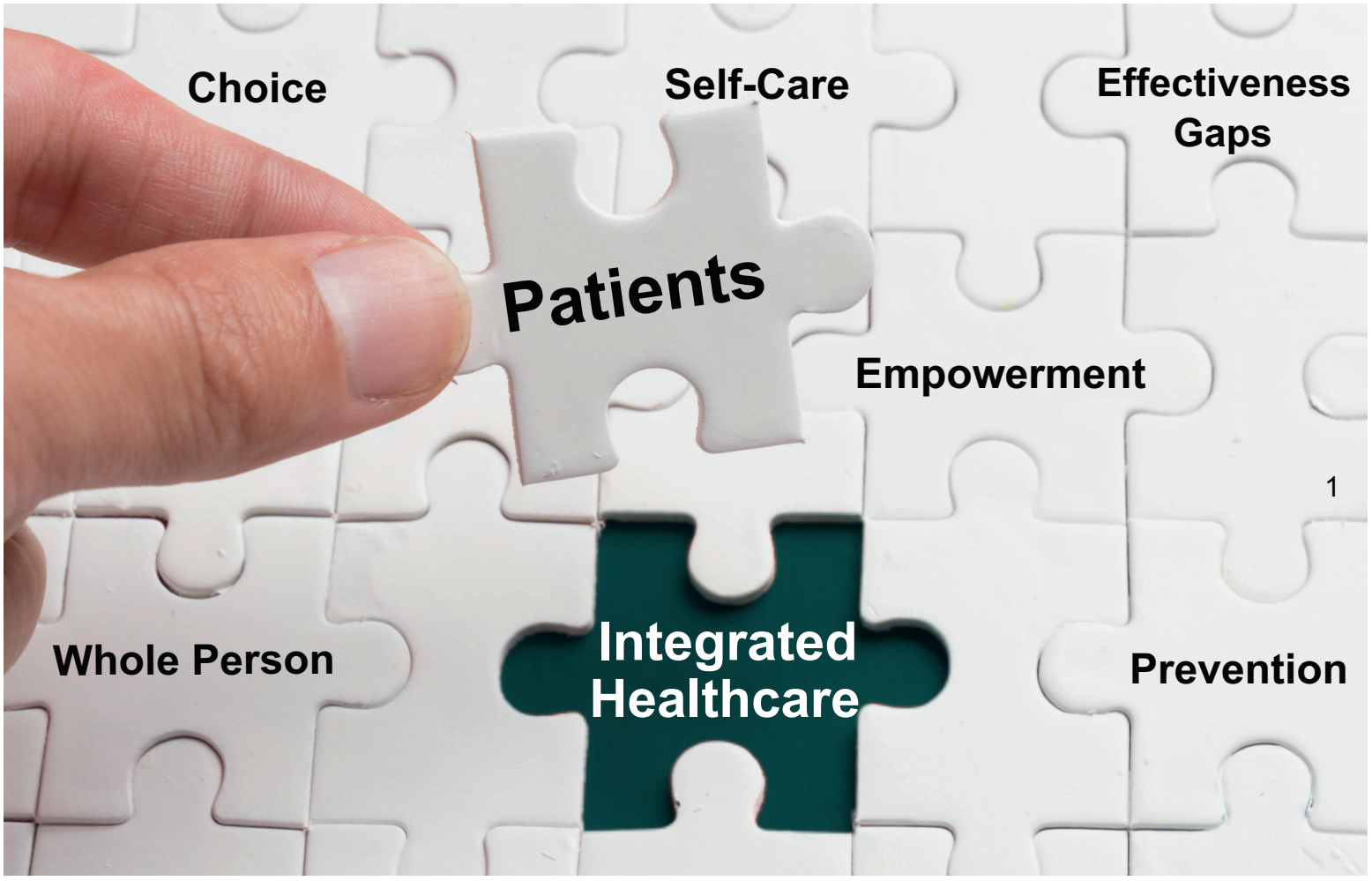
All-Party Parliamentary Group for Integrated Healthcare

December 2018

Integrated Healthcare:
Putting the Pieces Together



"The future of healthcare lies in our health system recognising that physical, emotional and mental health are intrinsically linked, and that only by treating a patient as a whole person can we tackle the root cause of illness and deal with the problem of patients presenting with multiple and complex conditions."

This report was written by Matthew Williams on behalf of the All-Party Parliamentary Group for Integrated Healthcare

Contents

Foreword

The All-Party Parliamentary Group for Integrated Healthcare (PGIH) has been in existence for over 30 years, starting life as the Parliamentary Group for Alternative and Complementary Medicine.

It was formed because there was little to zero awareness in Parliament about issues surrounding complementary, traditional and natural healthcare, and how these therapies could be integrated with mainstream medicine.

Today, it is one of the longest standing, diverse, and well-supported All-Party Groups at Westminster, bringing together the major organisations within the field, MPs and Peers, and other stakeholders.

It has held well over 130 meetings and events since 1992 on topics ranging from Personal Health Budgets and Antimicrobial Resistance, to Cancer Care and Brexit.

High profile speakers such as Professor Dame Sally Davies, the government's Chief Medical Officer, and Duncan Selbie, Chief Executive of Public Health England, have addressed the PGIH.

The PGIH's overriding aim is to bring about improvements in patient care, and believes that by providing healthcare in an integrated and whole person way, with complementary, traditional and natural medicines working in collaboration with conventional medicine, that patient outcomes could be improved and cost savings achieved.

Between 6th February and 31st March 2017 the PGIH launched an extensive consultation on all aspects of complementary, traditional and natural healthcare.

One hundred and thirteen organisations and other stakeholders responded to the consultation and made submissions. It was the first time in the PGIH's history that such an exercise had been undertaken.

'*Integrated Healthcare: Putting the Pieces Together'* looks at the key health issues affecting the country, discusses how these should be addressed, and proposes solutions which would help to improve patient care and bring more equitable access to complementary, traditional and natural therapies for the general public where appropriate, both within the National Health Service (NHS) and outside.

The following report is based on the submissions received.

Recommendations

Changing Health Needs
The increasing prevalence of polypharmacy and multimorbidity is a significant threat to the future economic viability of the NHS, and government needs to take steps to fully assess the degree of drugs interactions, determine the long-term health effects on patients, and arrest the trend of over medicating the population.
The government needs to ensure that every patient is treated as an individual whole person, and provide co-ordinated, joined-up care so that people are not treated as patients with a variety of illnesses which are managed separately.

Choice and Patient Centred Care
The government should assess the success of NHS reforms in delivering patient choice and patient-centred care to ensure that patients are not marginalised from the delivery of their care in the NHS.
The government should ensure that patients' cultural and philosophical beliefs are respected and considered when making decisions on the provision of traditional medicines in the NHS.
Personal Health Budgets should be extended to include more patients suffering from long-term, chronic and Effectiveness Gaps conditions to form part of a wider empowering patients strategy by providing more scope and flexibility in what services patients can access, and allow the design of innovative care plans.

Commissioning and Access
CCGs should be encouraged to support the development of innovative and entrepreneurial practices which redesign clinical pathways and deliver services that are needed locally, to include exploring opportunities to develop the use of complementary, traditional and natural health services to address the needs of patients with conditions for which there are Effectiveness Gaps.
NHS commissioners and CCGs should give greater weight to patient outcomes and experiences, and qualitative research, alongside RCT evidence if they want to encourage the use of individualised patient-centred care in a real practice environment.

Taking Pressure off the NHS
The role of Physician's Associates offers the opportunity for patients to be signposted to other treatment options and take the pressure off GPs, but training should incorporate a broader course content.
Our health system needs to make greater use of pharmacists, as is the case in other European countries such as France, instead of patients opting to go to their GP or A&E as a first port of call.
The Government should take on board and act on the recommendations in the 2017 Joint PSA/RSPH Report '*Untapped Resources: Accredited Registers in the Wider Workforce'* , which looked at the potential ways that practitioners on Accredited Registers (ARs) could contribute to addressing the growing public health crises in the UK.

Effectiveness Gaps
The government should undertake a full audit to discover where effectiveness gaps exist in our healthcare system, investigate how these conditions could be treated differently, and carry out research to determine whether patient outcomes could be improved and cost savings made.

Working Together
Professional associations representing complementary, traditional and natural healthcare should work more closely together on common issues, to share knowledge and experience. A formal collaborative should be established which brings together major associations to take the field forward collectively.

Raising Standards
The PSA and government should engage more fully to engender active political support for the Accredited Registers scheme, and PSA should continue to explore ways of publicising the registers more widely to make maximum use of the opportunities this scheme brings.
The PSA should ensure that smaller organisations that wish to join the Accredited Registers scheme are advised on, and supported in potential clustering, and not excluded on cost grounds.

Recommendations

Evidence Base and Research
NICE guidelines are too narrow and do not fit well with models of care such as complementary, traditional and natural therapies, and should incorporate qualitative evidence and patient outcomes measures as well as RCT evidence.
Complementary, traditional and natural healthcare associations should take steps to educate and advise their members on the use of Measure Yourself Medical Outcome Profiles (MYMOP), and patient outcome measures should be collated by an independent central resource to identify for what conditions patients are seeking treatment, and with what outcomes.

Information
The ASA should ensure it is fully transparent in decision-making regarding complementary, traditional and natural healthcare therapies, taking advice from independent experts in the field, whilst allowing reasonable claims to be made based on qualitative research, documented case studies and patient testimonies.
The government should ensure that information produced on this sector is balanced and objective, and based on a broader view of evidence, to help patients obtain accurate information through official sources instead of those of unknown validity and quality.

Cancer Care
Every cancer patient and their families should be offered complementary therapies as part of their treatment package to support them in their cancer journey.
Cancer centres and hospices providing access to complementary therapies should be encouraged to make wider use of Measure Yourself Concerns and Wellbeing (MYCaW) to evaluate the benefits gained by patients using complementary therapies in cancer support care.
Co-ordinated research needs to be carried out, both clinical trials and qualitative studies, on a range of complementary, traditional and natural therapies used in cancer care support.

Antibiotic Resistance
The government should commission a study to consider why GP surgeries with doctors who have training in complementary medicines appear less likely to prescribe antibiotics to patients, and whether lessons could be learned.
The government's antimicrobial strategy should be widened to include exploration of, and research into, the role that less orthodox approaches could make in reducing antibiotic usage.

Cost Savings
The government should run NHS pilot projects which look at non-conventional ways of treating patients with long-term and chronic conditions affected by Effectiveness Gaps, such as stress, arthritis, asthma and musculoskeletal problems, and audit these results against conventional treatment options for these conditions to determine whether cost savings and better patient outcomes could be achieved.

Around the World
The government should take note of the WHO's Traditional Medicine Strategy 2014-2023, and develop solutions which harness the potential contribution of traditional medicine to health and which contribute to a broader vision of improved health focused on patient autonomy, wellness and person-centred health care.
The government should engage with governments of countries in which complementary, traditional and natural medicines are integrated with conventional Western medicine to share knowledge and discover what benefits similar integration could bring to the NHS.

Sustainable Healthcare
The government must recognise that physical, emotional and mental health are intrinsically linked, and that only by treating a patient as a whole person can we tackle the root cause of illness and deal with the problem of patients presenting with multiple and complex conditions.

Changing Health Needs

The NHS was founded in 1948 in the belief that good healthcare should be available to everyone, regardless of their ability to pay. It aimed to alleviate the burden of ill health that had plagued previous generations.

Seventy years later, it continues to provide care free at the point of access. However, the country faces different health challenges than back then.

Society has changed, patient demands have changed, and the nature of illness has changed, and the NHS struggles financially, philosophically and structurally to keep up.

Spending

When the NHS was launched in 1948, it had a budget of £437 million.[1]

That is roughly £15 billion at today's value. Spending for the Department of Health and Social Care in England is approximately £124.7 billion in 2017/18, with planned spending rising to £128.3 billion and £130.9 billion in 2018/19 and 2019/20 respectively.[2]

Despite this long-term trend in increased funding by governments of all political persuasions, and the welcome announcement of an extra £20.5 billion by 2023[3], the NHS has to deal with significant challenges. Doctors, nurses and other NHS staff face considerable pressures to meet increased demands.

Successes and Challenges

Modern medicine has been successful in fighting infectious and acute disease, but has been less successful in dealing with the emergence of chronic, long-term and lifestyle related diseases which are growing in society today.

In 2014, the House of Commons Health Committee released a report titled *'Managing the care of people with long-term conditions',* which said that *"Effective management of long-term conditions is widely recognised to be one of the greatest challenges facing the 21st century National Health Service in England".*[4]

Through changes in demographics, longer life expectancy, and this increase in chronic and long-term conditions and lifestyle illnesses, the health burden of the nation is increasing. Simply pouring more money into the NHS will not solve the health problems we face.

DHSC TOTAL DEPARTMENTAL EXPENDITURE LIMIT (TDEL)
£ billions

	Cash	Real terms 2018/19 prices
2002/03	57.0	78.3
2003/04	64.2	86.3
2004/05	69.1	90.4
2005/06	74.4	94.9
2006/07	78.9	97.8
2007/08	85.8	103.7
2008/09	91.0	107.2
2009/10	98.4	114.2
2010/11	100.4	114.4
2011/12	102.8	115.7
2012/13	105.2	116.0
2013/14	109.8	118.9
2014/15	113.3	121.2
2015/16	117.2	124.3
2016/17	120.5	125.0
2017/18	124.7	127.0
2018/19 planned	128.3	128.3
2019/20 planned	130.9	128.6

Growing Health Burden

It is estimated that the NHS spent £6.1 billion on overweight and obesity-related ill-health in 2014 to 2015, with the overall cost of obesity to wider society estimated at £27 billion.[5] The UK-wide NHS costs attributable to obesity and being overweight are

Changing Health Needs

projected to reach £9.7 billion by 2050, with wider costs to society estimated to reach £49.9 billion per year[5]. Almost 3.7 million people have been diagnosed with diabetes in the UK.[6]

The incidence of lower back pain is increasing, with disability due to back pain rising by more than 50% since 1990. It affects around one-third of the UK adult population each year. Around 20% of patients will consult their GP about back pain each year.[7] 43% of people in the UK experience chronic pain.[8]

There are also around 7 million people living with heart and circulatory disease in the UK.[9]

Multimorbidity

These alarming figures hide an even greater problem. There are more patients suffering from multimorbidity (suffering from 2 or more long-term health conditions) than ever before, with the number of people in England with one or more long-term condition projected to increase to around 18 million by 2025. 70% of total health expenditure on health and care in England is associated with treating the 30% of the population with one long-term condition or more.[4]

Polypharmacy

The result of these complex health conditions is the growing problem of polypharmacy (the use of several drugs at the same time). This is perhaps the biggest threat to the future economic viability of the NHS, with increasing costs of pharmaceutical drugs needed to treat patients with multiple illnesses, coupled with largely unknown effects of the long-term use of these drugs in combination.

Polypharmacy works only to increase drugs dependency and cost to the taxpayer rather than tackling the underlying root causes of illness. The result is that increasing numbers of patients remain well enough to function, but without ever being well.

Expensive Condition Management

These patients cost the NHS billions each year in managing their conditions, and the inability to effectively treat them risks the very future of the NHS. There is simply not enough money to fund this type of service in the long-term.

Individualised Care

Health provision needs a greater focus on empowering patients and treating them as a whole person, not patients with a variety of illnesses that are treated separately which can happen because of the specialist nature of medicine.

Recommendations

The increasing prevalence of polypharmacy and multimorbidity is a significant threat to the future economic viability of the NHS, and government needs to take steps to fully assess the degree of drugs interactions, determine the long-term health effects on patients, and arrest the trend of over medicating the population.

The government needs to ensure that every patient is treated as an individual whole person, and provide co-ordinated, joined-up care so that people are not treated as patients with a variety of illnesses which are managed separately.

Choice and Patient Centred Care

The NHS Constitution has seven key principles which guides the NHS in all it does. The fourth states: *"The patient will be at the heart of everything the NHS does".*

It goes on to say: *"It should support individuals to promote and manage their own health. NHS services must reflect, and should be co-ordinated around and tailored to, the needs and preferences of patients, their families and their carers."*[10]

Doctor-Patient Relationship

The relationship between doctor and patient forms an essential part of the success of any treatment given, and it is important that patients continue to have access to a named GP to provide continuity of care.

Time

Giving time to the patient is also important, especially with respect to emotional, psychological and mental health problems. Acting swiftly could prevent more serious and ongoing problems in future.
Patients often wait too long for treatment, which costs more because the condition is worse by the time it is treated.
It is well-documented of the challenges faced by GPs under a time limited appointment system. Indeed, one of the benefits gained when patients consult complementary, traditional and natural practitioners is that they are given time during the consultation and feel listened to, which is in itself important to the healing process.

Whole Person Care

The central philosophy of complementary, traditional and natural healthcare is looking at the patient as a

whole person.
Patients often choose complementary, traditional and natural therapies because they have not had success with conventional medicine, or because they are worried about side-effects or have contraindications to conventional drugs, usually paying out of their own pocket. Even in these times of austerity patients continue to seek help from complementary, traditional and natural practitioners privately, which shows that these therapies provide something which they cannot get for free through the NHS.

Engaging Patients

The degree to which patient choice is present in the provision of services in the NHS is still not clear. The NHS cannot blindly follow conventional routes of treatment when patients would prefer something else, and empowering patients first requires listening to patients.

Empowering Patients

Secretary of State for Health and Social Care Matt Hancock said: *"Individuals have responsibilities, and we*

Choice and Patient Centred Care

want to empower people to make the right choices".[11]

If, in a country with great diversity like the UK, the government wants to empower all sections of the community to buy into its vision of health, and involve patients in taking responsibility for their own health, then it is important to recognise peoples' cultural and philosophical health beliefs, which often include use of traditional medicines. Dismissing such traditional approaches risks marginalising large sections of the UK population from health provision.

Personal Health Budgets

Personal Health Budgets are a different way of spending health funding to support the identified healthcare and wellbeing needs of an individual, which is planned and agreed between the individual and the local Clinical Commissioning Group (CCG).

They are designed to give people with long-term health conditions and disabilities more choice and control over the money spent on meeting their health and wellbeing needs.

Since October 2014 adults eligible for NHS Continuing Healthcare and children in receipt of continuing care have had a right to have a Personal Health Budget. NHS England and the Department of Health and Social Care have just run a public consultation (April-June 2018) on extending the legal rights to have a Personal Health Budget or integrated personal budget.

Personal Health Budgets offer a good opportunity to allow patients to become more involved in their own healthcare and manage their own health budgets. The underlying principle is welcome. However, there are concerns they don't provide patients with any additional flexibility and scope than is already permitted by CCGs.

An extension of this scheme to include more patients suffering from long-term, chronic and Effectiveness Gaps conditions could form part of a wider empowering patients strategy and help to arrest the growing prevalence of these conditions by allowing patients to develop innovative care plans.

Recommendations

The government should assess the success of NHS reforms in delivering patient choice and patient-centred care to ensure that patients are not marginalised from the delivery of their care in the NHS.

The government should ensure that patients' cultural and philosophical beliefs are respected and considered when making decisions on the provision of traditional medicines in the NHS.

Personal Health Budgets should be extended to include more patients suffering from long-term, chronic and Effectiveness Gaps conditions to form part of a wider empowering patients strategy by providing more scope and flexibility in what services patients can access, and allow the design of innovative care plans.

Commissioning & Access

The government's current policy is that decision-making on individual clinical interventions, whether conventional, or complementary, traditional and natural, is a matter for local NHS service providers, GPs and practitioners, as they are best placed to know their community's needs.

It is vital that GPs are able to treat their patients in the most appropriate way based on their clinical judgement, and not be curtailed by restrictive commissioning policies. At present, GPs' professional judgment can be overridden by Clinical Commissioning Groups' (CCGs) commissioning policies, which disempowers doctors and isolates patients from the process.

The government needs to ensure that patients' preferences and patients' experiences translate through to the commissioning of services by the CCGs, as at present, there are reports of problems in this area.

More power must be put in the hands of front-line staff and organisations in order to make the service even more patient-centred.

Access to Services

Complementary, traditional and natural healthcare is an example of how the NHS is failing to meet the aspirations of significant numbers of patients in terms of equitable access to services. Provision is patchy at best. Studies have shown that 75% of patients support access to complementary, traditional and natural therapies through the NHS.[12]

In an NHS that puts the patient at its heart, and which reflects patients' aspirations, needs and choices, this type of healthcare should be more widely available.

Innovation

CCGs should be encouraged to support the development of innovative and entrepreneurial practices which redesign clinical pathways and deliver services that are needed locally. This should include exploring opportunities to develop complementary, traditional and natural health services. This does not appear to be happening on the ground to the degree it should. More research needs to be done to find out what works, and for what conditions, and then allow innovative service providers to run pilot schemes.

NHS commissioners and CCGs should give greater weight to patient outcomes and experiences, and qualitative research, alongside RCT evidence if they want to encourage the use of individualised patient-centred care in a real practice environment.

Recommendations

CCGs should be encouraged to support the development of innovative and entrepreneurial practices which redesign clinical pathways and deliver services that are needed locally, to include exploring opportunities to develop the use of complementary, traditional and natural health services to address the needs of patients with conditions for which there are Effectiveness Gaps.

NHS commissioners and CCGs should give greater weight to patient outcomes and experiences, and qualitative research, alongside RCT evidence if they want to encourage the use of individualised patient-centred care in a real practice environment.

Taking Pressure off the NHS

Easing the burden on the NHS involves three key elements – adequate funding, increasing supply by making full use of existing resources, and reducing demand.

Complementary, traditional and natural healthcare has a part to play in two of these areas.

Prevention and Self-Care

Secretary of State for Health and Social Care Matt Hancock MP said, *"Prevention is better than cure."*[11]

Reducing demand for services is key to taking the pressure off the NHS. Prevention and appropriate self-care is part of this, and the PGIH welcomes the government's initiatives in this area.

Patients seeking treatment from, and practitioners providing treatments in complementary, traditional and natural healthcare have prevention, patient empowerment and facilitating the body to heal itself as their central philosophy.

Patients who use these approaches often take a greater interest in maintaining their own health, and this is important if the government wants people to buy into the idea of personal responsibility when it comes to health.

Once patients have consulted complementary, traditional and natural practitioners they can often manage their own health more effectively, and avoid the need to access NHS services for common, self-limiting conditions for which patients often visit their GP.

Under-utilised Resources

Increasing workforce supply is the second important element. There are thousands of practitioners working in every corner of the country, mainly in the private sector, who could be used more widely to treat patients for conditions which the NHS finds hard to treat, and to improve general health and wellbeing. There is an enormous potential for this under-utilised resource of properly regulated practitioners.

Accredited Registers

In November 2017, the joint report '*Untapped Resources: Accredited Registers in the Wider Workforce*'[13] was released by the Professional Standards Authority for Health and Social Care (PSA) and the Royal Society for Public Health (RSPH). It looked at the potential ways that practitioners on Accredited Registers (ARs) could contribute to addressing the growing public health crises in the UK.

RSPH Chief Executive Shirley Cramer said *"The AR workforce accounts for thousands of interactions with members of the public every day: we are calling for these practitioners to be given the right support, so that we can unleash their full potential to improve the public's health."*[13]

A key recommendation is for AR practitioners to have the authority to make direct NHS referrals, in appropriate cases, thereby reducing the administrative burden on GP surgeries.

However, in response to a Written Parliamentary Answer on 27th February 2018, the Parliamentary Under-Secretary for Health and Social Care, Steve Brine MP, said *"There is no plan to make an assessment of the merits of the recommendations in the report 'Untapped Resources: Accredited Registers in the Wider Workforce'."*[14]

Taking Pressure off the NHS

There are concerns that the government seems uninterested or unwilling to even consider the recommendations within this report, as properly regulated complementary, traditional and natural healthcare practitioners have the potential to ease the burden on doctors and the health service. The government set up the Accredited Registers programme, so it would seem prudent to consider the benefits on wider healthcare provision that this scheme could bring. The PGIH urges the government to take on board and act on its recommendations.

Pharmacists

Many patients bypass their pharmacist and go straight to their GP, or worse still, A&E, often for self-limiting conditions which a pharmacist would be as well placed to advise. We need to make greater use of pharmacists.

Secretary of State for Health and Social Care Matt Hancock MP said, *"Community pharmacies have a hugely important role to play in keeping people out of hospital and in supporting GP surgeries by doing more. Here, it is the French model that I look to for inspiration."*[11]

The Group welcomes the Minister's desire to learn from the experiences of other countries, and notes that almost all French pharmacies dispense homeopathic remedies and its use is covered by state social security. We urge him to keep an open mind in these matters.

Physician's Associates

Many people have not heard about Physician's Associates, yet there are approximately 350 practising in both primary and secondary care in England, around 20% in primary care, and another 550 in training.[15] By 2020, the Department of Health and Health Education England (HEE) want to see a total of 1,000 Physician Associates recruited to primary care roles to address GP shortages and help deliver the five-year plan for primary care. Physician Associates can provide continuity of care for patients with long-term conditions.

Physician's Associates offer the opportunity for patients to be signposted to other treatment options as appropriate, and take the pressure off GPs.

However, the training of Physician Associates should incorporate a much broader course content than an orthodox medical model if they are to truly provide patient-centred, join-up care.

Recommendations

The role of Physician's Associates offers the opportunity for patients to be signposted to other treatment options and take the pressure off GPs, but training should incorporate a much broader course content.

Our health system needs to make greater use of pharmacists, as is the case in other European countries such as France, instead of patients opting to go to their GP or A&E as a first port of call.

The government should take on board and act on the recommendations in the 2017 Joint PSA/RSPH Report '*Untapped Resources: Accredited Registers in the Wider Workforce'* , which looked at the potential ways that practitioners on Accredited Registers (ARs) could contribute to addressing the growing public health crises in the UK.

Effectiveness Gaps

Modern medicine has been very effective in tackling many of the health conditions we face today. However, there are areas, often called Effectiveness Gaps (EGs), where available treatments in modern clinical practice are not fully effective.

Musculoskeletal problems are commonly regarded as being affected by EGs. Depression, eczema, allergies, chronic pain, and irritable bowel syndrome are also frequently mentioned.

Whilst estimates suggest that the average one-year prevalence of use of complementary, traditional and natural therapies in the UK population is 41.1%, with an average lifetime prevalence of 51.8%[16], usage levels rise, sometimes as high as 90%, when looking at sufferers of long-term conditions who have had little success with mainstream medicine.

For these types of conditions a different approach is needed, one which does not involve giving more and more costly but ineffective drugs.

Back Pain

Back pain is routinely poorly treated, with many patients administered painkillers that do little or no good. It is Britain's leading cause of disability, but needless treatments waste up to £180 million a year, and costs the UK economy 31 million sick days annually.[17] The total cost of back treatments to the NHS is estimated at £12 billion a year.[18]

Manual medicine, such as osteopathy and chiropractic, as well as acupuncture, have significant potential in the management of both musculoskeletal problems and a variety of chronic long-term conditions.

Harnessing the Potential

There is promising work in the field of acupuncture and mind body therapies (particularly mindfulness-based techniques) showing them to be effective and safe in the management of chronic, long-term conditions (pain, anxiety and depression). They contribute greatly to the wellbeing of patients.

Patients turn to a range of complementary, traditional and natural therapies for a wide variety of conditions affected by EGs. This includes emotional, psychological and mental health problems, as patients are often concerned about the effectiveness and side-effects of pharmaceutical drugs such as Selective Serotonin Reuptake Inhibitors (SSRIs) for these conditions.

Complementary, traditional and natural treatments are often cheaper to provide, and can produce improved patient outcomes in this area, which could provide cost savings to the NHS and free up resources for use elsewhere. Patient satisfaction is high in those who use these therapies.

Integrated healthcare should be seen as a mechanism for facilitating patient buy-in to create lifestyle change. The individualised approaches within integrated healthcare have much to offer in this area.

Recommendation

The government should undertake a full audit to discover where Effectiveness Gaps exist in our healthcare system, investigate how these conditions could be treated differently, and carry out research to determine whether patient outcomes could be improved and cost savings made.

Working Together

A common theme that emerged from patients and stakeholders during the consultation was that the field of complementary, traditional and natural healthcare is too fragmented and potentially confusing. The consensus was that the field needs to work more collectively together to develop and collaborate on common issues, and that it would be strengthened, and better engagement with government bodies and other organisations facilitated, from such a joined-up approach.

Driving Up Use

In a recent debate in the House of Commons Secretary of State for Health and Social Care Matt Hancock MP said *"I am a huge fan of social prescribing. I essentially think that because drugs companies have a big budget to try to market their drugs—and of course many drugs do wonders—there is not the equivalent level of organisation to drive up the use of social prescribing."* [11]The same applies to complementary, traditional and natural healthcare. Unless there is some form of organisation to drive up use and availability then it will continue to be side-lined in the health debate.

A Strong Collaborative

The PGIH notes that some groups within certain therapies are already collaborating, with some collaboration between associations of different disciplines too. It feels that a collaborative of this nature, which encapsulates the whole field, would provide a foundation to collectively take forward other initiatives in this report.

The PGIH recognises that the complementary, traditional and natural healthcare field is made up of a wide range of professional associations, each at potentially different stages of development. It does not believe that this should act as a barrier to closer collaboration. Some have expressed concern that greater collaboration might lead to a greater target for negative actions against the field. However, the PGIH believes that the potential of a formal collaborative outweighs this, and that it would strengthen the field.
Such a body would work to bring professional associations together to provide a focal point for collective action, promotion, and external engagement as required. It would, nor should not seek in any way to regulate therapists, replicate the work of professional associations, or take away their autonomy. In working together on these common themes the PGIH believes that positive advancement of the field could be achieved for the benefit of practitioners and patients, and for the wider health of the nation.

Cost and Structure

The collaborative could be set up and run at a small cost, and would be an independent, self-funding organisation, with a federal structure in which every professional association that met pre-determined criteria would be eligible to join and would have an equal voice.

Recommendation

Professional associations representing complementary, traditional and natural healthcare should work more closely together on common issues, to share knowledge and experience. A formal collaborative should be established which brings together major associations to take the field forward collectively.

Raising Standards

The field of complementary, traditional and natural healthcare is diverse, but has made significant efforts in the last 30 years to improve regulation and standards. Osteopathy and Chiropractic have been statutory regulated since the 1990s. Some areas are, however, still considered confusing for therapists and the public alike.

Regulation

Most professions have robust systems of voluntary self-regulation in place, or are in the process of developing them. The safety record of properly regulated complementary, traditional and natural practitioners is high, and complaints and issues of public safety mainly involve those of conduct such as violation of professional and sexual boundaries, financial exploitation and other ethical considerations, not the therapies themselves.

The broad consensus is that the system of voluntary self-regulation in the UK is sufficient for public protection purposes. There are some professions who still aspire to the goal of statutory regulation, and the PGIH encourages all professions within the field to strive towards the highest standards of regulation. However, whilst the Labour government of the late 1990s wanted to facilitate statutory regulation for those professions who wished to do so through the 1999 Health Act, the present government has expressed a policy of light touch regulation based on identifiable risk, the result of which is that it is unlikely that other complementary, traditional and natural healthcare professions will be statutorily regulated in the near future unless significant risks to public safety are identified.

Acupuncture

With regards to the regulation of acupuncture, in a House or Commons Statement on 16 February 2011, the then Secretary of State for Health Andrew Lansley MP said, *"I am confident that acupuncturists have their own voluntary regulatory measures in place, which are sufficiently robust."*[19]

Herbal Medicines

Nicola Blackwood MP, the then Parliamentary Under-Secretary of State for Health, said the following in the government's response to Professor Walker's advice on Regulation of Herbal Medicines and Practitioners, *"The government is open to further consideration of the case for statutory regulation once there is further evidence to understand the risk and confirm what level of assurance is appropriate and proportionate. This evidence would be obtained from experience of voluntary registration accredited by the Profession Standards Authority and further research undertaken by the sector."* [20]

Future Development

Those professions with aspirations of statutory regulation should continue to develop their professions as advised by the government with respect to herbal medicine.

In the meantime, the commitment amongst complementary, traditional and natural healthcare professions should be to ensure that the public can access clear information on training, qualifications, and complaints procedures, so that patients can make informed choices when searching for a suitably qualified practitioner.

Raising Standards

Professional Standards Authority Accredited Registers Scheme

In February 2013 the Professional Standards Authority (PSA) launched its Accredited Registers (AR) scheme. Five years later, 26 registers have been accredited, registering around 80,000 practitioners, some of which fall within the complementary, traditional and natural medicine field.

These organisations have gone through a rigorous process from the PSA, which indicates that organisations within the field are willing to be scrutinised, and are able to meet high standards. This should be encouraged, and the PGIH welcomes the drive towards higher standards. It offers opportunities for greater assurance for the general public when seeking a complementary, traditional and natural healthcare practitioner.

However, there are concerns that the scheme does not have adequate political support, and that public awareness is low, creating concerns amongst registrant organisations as to the material benefits achieved by accreditation. If the scheme is to succeed in the long-term it requires more work by the PSA to deliver material benefits. What those benefits should be needs further discussion - perhaps the ability to make direct referrals as per the PSA/RSPH Report *'Untapped Resources: Accredited Registers in the Wider Workforce'.*

Some organisations have also expressed concern that should they work to develop their organisation and increase membership numbers, then they are charged more, and feel penalised. In addition, whilst the PGIH recognises that the scheme has to be funded, it risks stopping some well-run organisations from being accredited on cost grounds.

Registrant organisations within complementary, traditional and natural healthcare should continue to work in collaboration to help guide the PSA on their expectations for the future in delivering value for money and material benefits.

Government Support

The perceived lack of government engagement in, and support for this scheme beyond an annual payment is a concern. This is a waste of a potential resource, and the government's passive stance is hindering its development. Prospective registrant organisations are neither sure of its future viability, relevance or financial sustainability, and are often reluctant to commit time and resources to joining it.

Whilst additional government financial support would be welcome, the PGIH recognises that this scheme must be self-funding in the long term.

Recommendations

The PSA and government should engage more fully to engender active political support for the Accredited Registers scheme, and PSA should continue to explore ways of publicising the registers more widely to make maximum use of the opportunities this scheme brings.

The PSA should ensure that smaller organisations that wish to join the Accredited Registers scheme are advised on, and supported in potential clustering, and not excluded on cost grounds.

Evidence Base and Research

The evidence base for complementary, traditional and natural therapies remains one of the most contentious issues, and one which is commonly used to argue for its exclusion from healthcare provision and not to commission services.

Whilst the PGIH recognises that there is a hierarchy of evidence, what constitutes good evidence is more complex and multi-faceted than the one-dimensional approach often applied to complementary, traditional and natural therapies.

Disputed Evidence

The evidence base for these therapies is highly disputed and mostly disregarded as being weak. It is important to say that there is a difference between evidence that something doesn't work, and not enough good quality evidence. In addition, knowing how a medicine works has never been a pre-requisite for its use.

There is evidence both in the UK and abroad for a range of complementary, traditional and natural therapies for a range of conditions. However, these are often regarded as poor quality, the sample sizes are small, or they have not been replicated, and are, as such, dismissed out of hand by conventional medicine.

Indeed, even experts disagree on the same piece of evidence. For instance, during the oral evidence sessions for the House of Commons Science and Technology Evidence Check 2: Homeopathy 2009-10 Professor David Harper CBE, Chief Scientist, Department of Health, said, *"One of the real difficulties that we face is that it is not so much a lack of research or a lack of randomised controlled trials: it is a lack of agreement between experts working in this field."* [21]

This very much sums up the problems with RCT evidence for complementary, traditional and natural healthcare.

More Evidence Needed

At the same time, complementary, traditional and natural medicine needs to be honest about the evidence it doesn't have, and not claim cures for everything, and should focus initially on improving information gathering and record keeping.

More Research Needed

There is certainly a need for more robust research into complementary, traditional and natural therapies, as modern healthcare requires that publicly funded treatments have an evidence base to support their provision.

The research agenda should begin by focusing on areas affected by EGs.

In addition to better collation of existing research, and the carrying out of new trials, possibly funded through the National Institute for Health Research, there needs to be a more wide-ranging consideration of real practice evidence.

Individualised treatments are not suitable for RCTs, and research cannot seek to try and isolate one particular component of a treatment.

Evidence Base and Research

Evidence Based Medicine

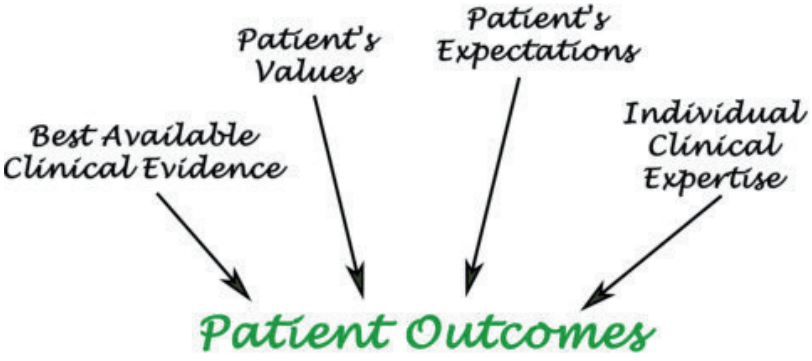
One of the most commonly cited definitions of Evidence Based Medicine (EBM) is found in a 1996 British Medical Journal editorial by Professor David Sackett, *Evidence Based Medicine: what it is and what it isn't*. It states:

"The practice of evidence based medicine means integrating individual clinical expertise with the best available external clinical evidence from systematic research. By individual clinical expertise we mean the proficiency and judgment that individual clinicians acquire through clinical experience and clinical practice…By best available external clinical evidence we mean clinically relevant research...Good doctors use both individual clinical expertise and the best available external evidence, and neither alone is enough."[22]

This definition should form the basis of what constitutes Evidence Based Medicine in NHS provision of services.

The current system risks marginalising the doctor's clinical expertise, the doctor-patient relationship, and the patient's own preferences by following a narrow prescriptive and RCT focused model of practice.

Doctors must not lose their ability to use their best clinical judgement to treat their patients, and patients must not feel marginalised by a system which ignores their individuality.



National Institute for Health and Care Excellence (NICE)

NICE says its guidelines are based on *"the best available evidence of what works and what it costs".* NICE guidelines are positive towards good practice and helping make treatments consistent, but are too narrow and do not capture the complexities associated with multimorbidity and polypharmacy.

NICE also states on its website that *"NICE is committed to involving patients, carers and the public in the development of its guidance and other products. By involving the very people for whom the guidance will be relevant, we put the needs and preferences of patients and the public at the heart of our work.*[23] The PGIH agrees with this position, but feels that NICE recommendations do not go far enough.

Evidence Base and Research

NICE provides guidance on a range of conditions for which patients currently use complementary, traditional and natural therapies.

If these therapies are to be provided through the NHS then NICE must take the lead in assessing their efficacy, particularly where patients are already widely using these interventions in the private sector, or where they might choose to use them should patient choice play a greater part in the commissioning process.

There is evidence available for a range of conditions including allergies and eczema, insomnia, back pain, fibromyalgia, and pain relief.

NICE guidelines in such areas would help to ensure that the taxpayer is getting value for money, and that the patient is not getting a suboptimal solution from a clinical point of view.

A Wider View of Evidence

The complementary, traditional and natural healthcare community rightly believes that taking a narrow RCT view of evidence ignores qualitative research, documented case studies, and patient outcomes and experiences.

However, if it wants additional weight to be given to these types of evidence then it needs to be more efficient in monitoring cases, record keeping, and collecting and analysing this evidence.

It is not sufficient to employ a sporadic, sometimes apathetic approach to being professional in this area.

Measuring Patient Outcomes

Complementary, traditional and natural healthcare associations need to be more proactive in educating, training, and supporting their members in collecting qualitative patient outcome measures by wider and more effective use of Measure Yourself Medical Outcome Profiles (MYMOP).

This data should then be collated and analysed by an independent central resource to build the evidence base within the field, and provide documented information on what conditions patients are seeking advice on, and with what outcomes.

Recommendations

NICE guidelines are too narrow and do not fit well with models of care such as complementary, traditional and natural therapies, and should incorporate qualitative evidence and patient outcomes measures as well as RCT evidence.

Complementary, traditional and natural healthcare associations should take steps to educate and advise their members on the use of Measure Yourself Medical Outcome Profiles (MYMOP), and patient outcome measures should be collated by an independent central resource to identify for what conditions patients are seeking treatment, and with what outcomes.

Information

Patients seek information on complementary, traditional and natural therapies from a range of sources. They include word of mouth, advertising, online and media, and official sources such as NHS Choices.

Word of Mouth

Word of mouth is highly prevalent in the field, because well-regarded therapists are readily recommended by patients to friends, family and colleagues. This first-hand experience of treatment is useful, but limited in that patients without people to ask cannot obtain suitable information.

If there were an independent online resource which could capture the essence of word of mouth recommendations, but available to all, it could be a useful addition to providing information for patients.

Advertising

Advertising is a common way for patients to seek services. Advertising controls are necessary, and it is fair to insist that therapists do not make unrealistic claims and are accurate about qualifications. However, there are concerns that advertising regulations are too restrictive and are limiting how complementary, traditional and natural healthcare practitioners can describe their treatment, how they can display client personal outcomes from treatment, and whether it has traditional usage.

Whilst it is not appropriate for the PGIH to determine specific cases of advertising, there is a risk of patients going to the internet instead where information is less scrutinised.

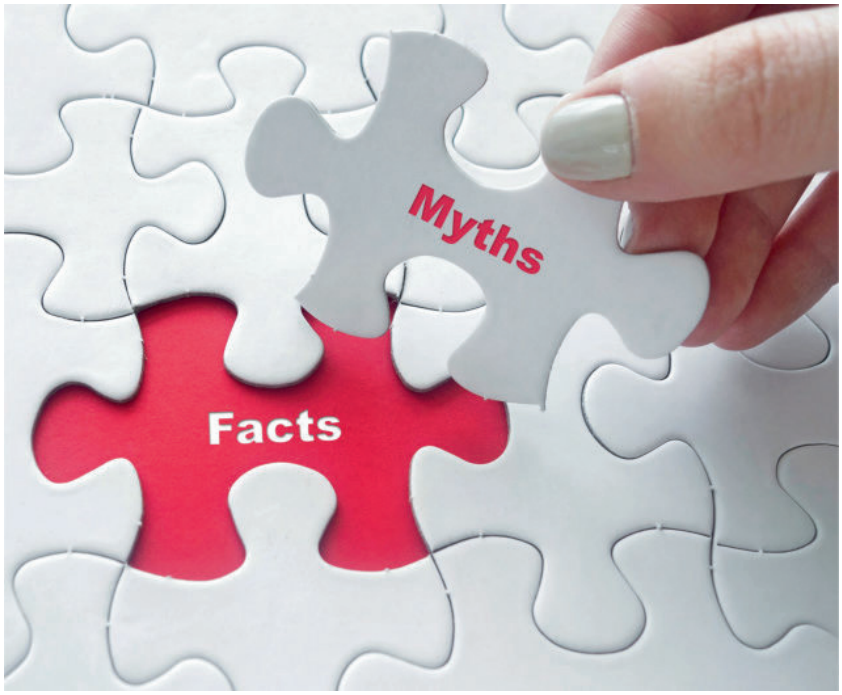
As such, the Committees on Advertising Practice (CAP) and the Advertising Standards Authority (ASA) should adopt a pragmatic approach that accepts other forms of evidence other than double-blind RCTs. It should allow reasonable claims to be made based on qualitative research, documented case studies and patient testamonies where no incentive has been given and it represents a true account of the patient's own experience.

In addition, it would be advisable, as the ASA has no specific expertise in complementary, traditional and natural therapies, to ensure that it is fully transparent in decision-making and takes advice from unbiased and independent experts in the field when setting guidance in this area.

Information

Online and Media

Newspaper, magazine and online articles, together with social media and blogs, are a very common way for patients to seek information on complementary, traditional and natural healthcare.



These unedited and unregulated forms of information are valuable to those patients who will take time to thoroughly research online to obtain a balanced view.

However, the danger of this method is that there are no guarantees or safeguards that the information obtained is accurate, safe and unbiased.

Whilst the PGIH would not seek to restrict a patient's ability to access such information it would always recommend that numerous sources are consulted to gain more accurate and balanced information.

Official Information

There are government and other official sources of information on complementary, traditional and natural healthcare, such as NHS Choices.

However, there are concerns that these sources of information only give limited, narrow and mainstream biased information. As such, they are often not consulted by the public.

The government should ensure that information produced on this sector is balanced, accessible and objective, and based on a broader view of evidence, to help patients obtain accurate information through official sources online and via apps instead of those of unknown validity and quality.

Recommendations

The ASA should ensure it is fully transparent in decision-making regarding complementary, traditional and natural healthcare therapies, taking advice from independent experts in the field, whilst allowing reasonable claims to be made based on qualitative research, documented case studies and patient testimonies.

The government should ensure that information produced on this sector is balanced and objective, and based on a broader view of evidence, to help patients obtain accurate information through official sources instead of those of unknown validity and quality.

Cancer Care

One in two people will develop cancer at some point in their lives.[24] Along with chronic and long-term conditions it is one of the main conditions for which patients often look to complementary, traditional and natural therapies, whether that is as a support alongside their orthodox treatment, or to improve their quality of life when orthodox treatments have been deemed no longer beneficial.

Usage

Indeed, in the UK, more than 1 in 3 people with cancer use some sort of complementary, traditional and natural therapy at some time during their illness[25]. Studies suggest that for some types of cancer, such as breast cancer, this number is even higher. These therapies are an important part the treatment journey for a great many cancer patients.

MacMillan Cancer Support says, *"Complementary therapy covers a wide range of practices used alongside conventional treatments for illnesses including cancer. They can help some people cope with the symptoms of disease and its treatment, aid relaxation, and reduce tension and anxiety. We know that they are used by more than one in three of cancer patients and many report finding them helpful."*[26]

Why are they Used?

Many complementary, traditional and natural therapies are used alongside conventional cancer treatments, such as radiotherapy or chemotherapy.

People use them to help themselves feel better and cope with having cancer and treatment, often reducing symptoms or side-effects. How a patient feels plays an important part in how they cope.

Many therapies concentrate on relaxation and reducing stress. They might help to calm a patient's emotions, relieve anxiety, and increase the general sense of health and well-being.

In addition, they allow the patient to take a more active role in their treatment and recovery, in partnership with their therapist, and help people to feel more in control of their feelings and emotions. Positive emotions can improve health.

Availability

Complementary, traditional and natural therapies are provided to support patients in some of the most well-known and respected hospitals and cancer centres around the country. Some examples that have been highlighted to the PGIH are:

- Sir Robert Ogden Macmillan Centre, Harrogate and District NHS Foundation Trust
- Dimbleby Cancer Care, Guys and St Thomas' NHS Foundation Trust
- Barts Health NHS Trust
- Chelsea and Westminster Hospital NHS Trust
- Full Circle Fund, St George's University Hospitals NHS Foundation Trust
- Christie NHS Foundation Trust
- Velindre Cancer Centre
- Royal London Hospital for Integrated Medicine

They provide a range of therapies from Aromatherapy and Massage, to Reflexology, Reiki, Acupuncture and Hypnotherapy.

Research and Evidence

There is growing evidence that complementary therapies can help to control some symptoms of cancer and treatment side-effects, and with a greater focus on individualised care packages, the

Cancer Care

demand for such services will no doubt grow.

Healing is a common complementary therapy that people with cancer use. There is some evidence to suggest that seeing a healer can help people with cancer feel better. There have been no large scale clinical trials to find out whether or not healing works when used alongside conventional cancer treatments, such as chemotherapy or radiotherapy.

Acupuncture can help to relieve sickness caused by some chemotherapy drugs or relieve a sore mouth after having treatment for head and neck cancer. Acupuncture can also help to relieve pain after surgery to remove lymph nodes in the neck; reflexology for arm swelling after breast cancer; mindfulness based stress reduction for advanced breast cancer and osteopathy treatment for pain after breast cancer surgery are also examples of potential usage.

There are many other studies going on in universities, cancer centres and units around the UK. Many studies may be quite small, but bringing all their results together will help define the role of complementary therapies in cancer care. Larger studies are now needed in most of these areas.

MacMillan Cancer Support Says, *"We know that the scientific evidence base is growing for the use of some therapies in cancer care. However, we would like to see more high-quality research into complementary therapies in order to support patients, health professionals and commissioners to make informed decisions on the application of these therapies."*[26]

With such widespread use of complementary therapies by patients as part of their cancer journey the PGIH believes that greater research needs to be carried out, by way of clinical trials, qualitative studies and patient outcome measures.

Evaluating Therapies

There is perhaps not enough attention paid to observational studies, patient experiences and quality of life studies. Measure Yourself Concerns and Wellbeing (MYCaW), is an individualised questionnaire designed for evaluating complementary therapies in cancer support care. MYCaW is now being used routinely in several cancer support centres. Cancer centres and hospices providing access to complementary therapies should be encouraged to make wider use of MYCaW to evaluate the benefits gained by patients using complementary therapies in cancer support care.

Recommendations

Every cancer patient and their families should be offered complementary therapies as part of their treatment package to support them in their cancer journey.

Cancer centres and hospices providing access to complementary therapies should be encouraged to make wider use of Measure Yourself Concerns and Wellbeing (MYCaW) to evaluate the benefits gained by patients using complementary therapies in cancer support care.

Co-ordinated research needs to be carried out, both clinical trials and qualitative studies, on a range of complementary, traditional and natural therapies used in cancer care support.

Antibiotic Resistance

The key features of the government's Five Year Antimicrobial Resistance (AMR) Strategy 2013 to 2018 are better stewardship of antibiotics, improved diagnostic methods, and the development of new antibiotics. However, unless there is a turnaround in the decline in antibiotic discovery, such a strategy will slow the spread of AMR, but not reverse it in the long-term.

Rising Incidence

Indeed, Public Health England's (PHE) English Surveillance Programme for Antimicrobial Utilisation and Resistance (ESPAUR) report, published on 23rd October 2018, shows that antibiotic-resistant bloodstream infections rose by an estimated 35% between 2013 and 2017.[27]

Chief Medical Officer

Professor Dame Sally Davies, Chief Medical Officer for England has said *"The evidence is clear that without swift action to reduce infections, we are at risk of putting medicine back in the dark ages – to an age where common procedures we take for granted could become too dangerous to perform, and treatable conditions become life-threatening."*[28]

Primary Care

The most common reason for antibiotic prescriptions in primary care are acute infections (respiratory and urinary). However, in most instances, these infections get better without the use of antibiotics and a number of powerful educational strategies are needed.

Alternative, safe and effective strategies must be developed to reduce the demand placed on GPs by people with acute infections, and help them develop responses to these requests without creating further antimicrobial resistance. Current public awareness raising campaigns by PHE are welcome.

Self-Care

Complementary, traditional and natural medicines including herbal medicine and homeopathy are strongly associated with self-care. Appropriate self-care is an important strategy to reduce patient requests for antibiotics. With appropriate promotion of their safe use, and information and training for health care professionals, such approaches could contribute to reducing inappropriate use of antimicrobial agents and allow patients who prefer such interventions a wider range of treatment options.

Antibiotic Prescribing in Integrated Practices

A recent study published in the BMJ Open journal *'Do NHS GP surgeries employing GPs additionally trained in integrative or complementary medicine have lower antibiotic prescribing rates? Retrospective cross-sectional analysis of national primary care prescribing data in England in 2016'*[29] found that GP surgeries with doctors who have training in complementary medicines appear less likely to prescribe antibiotics to patients.

The authors acknowledged that this difference could be explained by patients seen by GPs trained in integrated medicine being less keen on receiving antibiotics, or the practices having other avenues to offer patients, and that the study was limited by the small sample size of integrated practices. However, the difference seen in antibiotic prescribing rates seen at

Antibiotic Resistance

practices with GPs trained in integrative medicine warrants further study.

The government should investigate why these GP practices prescribed less antibiotics, because a similar 25% national reduction in antibiotic prescribing would have an important impact on tackling antimicrobial resistance.

Parliamentary Inquiry

In her oral evidence to the 2014 House of Commons Science and Technology Inquiry First Report: Ensuring access to working antimicrobials, Dame Sally Davies said *"the Chinese are putting a lot of effort into herbal medicines…looking for the active products and isolating them using HPLC and modern science. They were aware of Artemisinin before the Wellcome Trust picked it up and developed it for malaria".*[30]

Chinese Medicine Studies

Chinese Herbal Medicine (CHM) has a recorded history of treating symptoms of Urinary Tract Infections (UTIs) for over 2000 years. In China, treatment of endometriosis using CHM is routine and considerable research has provided preliminary evidence. However, more rigorous trials are needed.

Southampton University

A Southampton University study on the use of Chinese Herbal Medicines in treating recurrent urinary tract infections (RUTIs) was the first clinical trial of its kind in the UK. The double blind, randomised, placebo controlled feasibility RUTI trial, funded by the National Institute for Health Research (NIHR), showed promising conclusions.[31] However, further research is required to accurately assess the potential role of CHM in treating endometriosis.

Other studies exist, sometimes with small sample sizes or not replicated, but facilitating research requires specialist skills, and a clear policy from the NIHR is needed as many of these products are not patentable.

Exploring Alternatives

The Five Year AMR Strategy also says that development of novel therapies is an important element of the multi-faceted approach to tackling AMR.

Complementary, traditional and natural medicines offer a novel approach to the treatment of infection and could therefore play an important role in averting antibiotic prescriptions for upper respiratory tract infections in primary care.

A wider strategy by the government which incorporates complementary, traditional and natural therapies could contribute towards the fight against antimicrobial resistance.

Recommendations

The government should commission a study to consider why GP surgeries with doctors who have training in complementary medicines appear less likely to prescribe antibiotics to patients, and whether lessons could be learned.

The government's antimicrobial strategy should be widened to include exploration of, and research into, the role that less orthodox approaches could make in reducing antibiotic usage.

Cost Savings

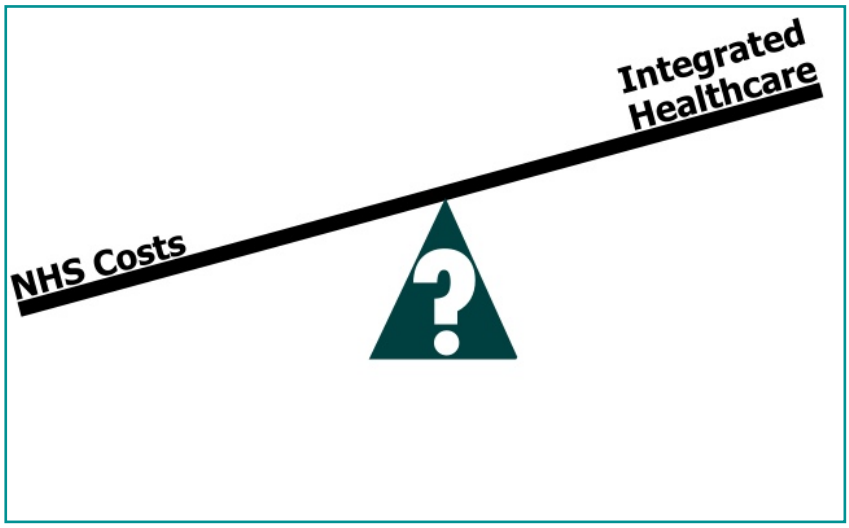
Could cost savings be made, and patient outcomes improved, with greater integration of complementary, traditional and natural therapies within our health services? That is a question often asked. Proponents of these therapies certainly believe so.

The PGIH has considered this matter, and there is a great deal of anecdotal and other evidence that patients who use complementary, traditional and natural therapies gain improvements to their health, and that they are often cheaper to provide than their equivalent conventional interventions.

As such, there is a reasonable argument that cost savings could potentially be made. However, anecdotal evidence alone is not enough to recommend widespread provision within any publicly funded service.

More UK Studies Needed

There are papers which have looked into the potential cost-effectiveness of complementary, traditional and natural therapies, although much of this work has been carried out abroad, and despite the widespread usage globally, not enough studies have been carried out.



In order to determine the potential costs savings of complementary, traditional and natural therapies, in the absence of overwhelming RCT evidence and emerging qualitative research, the PGIH believes that greater use of comparative research could be a useful way of determining value to the public purse.

CCGs should carry out comparative trials in known areas where clinical Effectiveness Gaps in conventional treatments exist, such as back pain, stress and arthritis, and compare outcomes to determine whether improved patient outcomes and cost savings could be achieved.

It would be in the interests of patients, and those who commission services, to investigate whether there is potential here to get better value for money in government health expenditure.

Recommendation

The government should run NHS pilot projects which look at non-conventional ways of treating patients with long-term and chronic conditions affected by Effectiveness Gaps, such as stress, arthritis, asthma and musculoskeletal problems, and audit these results against conventional treatment options for these conditions to determine whether cost savings and better patient outcomes could be achieved.

Around the World

Provision and availability of complementary, traditional and natural therapies varies greatly around the world.

In some countries, such as India and China, traditional medicines are integrated in their respective systems of health through the Indian Ministry of Ayurveda, Yoga and Naturopathy, Unani, Siddha and Homoeopathy (AYUSH), and Chinese Government, and work alongside conventional Western medicine. In others, like France, Germany and Switzerland, there is promising integration. However, there appears to have been little engagement between the British Government and other governments on health related matters.

World Health Organisation (WHO) Traditional Medicine Strategy

The WHO Traditional Medicine Strategy 2014–2023[32] builds on previous work, and devotes more attention to prioritising health services and systems, including traditional and complementary medicine.

Dr Margaret Chan, Director-General of WHO said *"Traditional and Complementary Medicine (T&CM) is an important and often underestimated part of health care. T&CM is found in almost every country in the world and the demand for its services is increasing. Traditional Medicine, of proven quality, safety, and efficacy, contributes to the goal of ensuring that all people have access to care. Many countries now recognise the need to develop a cohesive and integrative approach to health care that allows governments, health care practitioners and, most importantly, those who use health care services, to access T&CM in a safe, respectful, cost-efficient and effective manner. A global strategy to foster its appropriate integration, regulation and supervision will be useful to countries wishing to develop a proactive policy towards this important - and often vibrant and expanding - part of health care. More countries have gradually come to accept the contribution that T&CM can make to the health and well-being of individuals and to the comprehensiveness of their health-care systems."*

A Global View of Health

Secretary of State for Health and Social Care Matt Hancock MP said, *"We should look all across the world to improve our health service."*[12]
With the huge diversity of healthcare delivery globally, the PGIH believes lessons could be learnt, knowledge gained, and health improved in the UK from greater assessment of integrated healthcare provision around the world, and urges the Minister to take a global view on health.

Recommendations

The government should take note of the WHO's Traditional Medicine Strategy 2014-2023, and develop solutions which harness the potential contribution of traditional medicine to health and which contribute to a broader vision of improved health focused on patient autonomy, wellness and person-centred health care.

The government should engage with governments of countries in which complementary, traditional and natural medicines are integrated with conventional Western medicine to share knowledge and discover what benefits similar integration could bring to the NHS.

Sustainable Healthcare

The key challenge in the future provision of healthcare is how our strategies on health, care and wellbeing can be financially sustainable and tackle the changing trends in illness and disease faced by society today. Innovation is an important part of long-term sustainability, because it allows providers to find new solutions to health problems we face.

Prevention

The strategy needs to begin with prevention – what we eat, how we exercise, the social and environmental factors that underpin health, and how we protect and improve our health.

Good health is about more than the absence of illness, and health education needs to happen long before we become unwell, when we are children as part of our education, as is becoming more and more commonplace.

Self-Care and Responsibility

This is followed by appropriate self-care. Educating people when they can treat themselves, and when they need to access medical services can empower patients. Giving patients control and responsibility for their own health is important.

Many patients use complementary, traditional and natural therapies to maintain good health and to treat themselves for self-limiting conditions which do not require NHS resources.

We need to prevent illness where possible, and then effectively manage or treat illness when people become ill. Feeling in control of your health is an important part of the healing process. Complementary, traditional and natural therapies empower the patient to take control of their health.

In future, many patients will live with multiple conditions that will be largely managed themselves with the support and guidance of the health and care system.

Physical, emotional and mental health are intrinsically linked, and that only by treating a patient as a whole person can we tackle the root cause of illness and deal with the problem of patients presenting with multiple and complex conditions.

However, the government alone cannot take responsibility for its citizens' health. Personal responsibility is integral to future viability.

A Bold Vision

The government should take a bold vision of health based on individualised patient-centred care and empowering patients, which brings together the best of conventional medicine with complementary, traditional and natural healthcare.

Together we can create a truly integrated healthcare system and improve the health of the nation.

Recommendation

The government must recognise that physical, emotional and mental health are intrinsically linked, and that only by treating a patient as a whole person can we tackle the root cause of illness and deal with the problem of patients presenting with multiple and complex conditions.

References

1. NHS Official Figures - https://www.nhs.uk/using-the-nhs/about-the-nhs/the-nhs/
2. HM Treasury Public Expenditure Statistical Analyses 2018 Budget 2018, Tables 1.5 and 1.6 - https://www.gov.uk/government/collections/public-expenditure-statistical-analyses-pesa
3. NHS Funding Settlement 18 June 2018 - https://www.gov.uk/government/news/prime-minister-sets-out-5-year-nhs-funding-plan
4. 'Managing the care of people with long–term conditions', House of Commons Health Committee Report of Session 2014–15 HC 401, July 2014
5. Public Health England 'Health matters: obesity and the food environment' - https://www.gov.uk/government/publications/health-matters-obesity-and-the-food-environment/health-matters-obesity-and-the-food-environment, March 2017
6. Diabetes UK Facts and Figures Diabetes Prevalence - https://www.diabetes.org.uk/professionals/position-statements-reports/statistics/diabetes-prevalence, November 2017
7. NICE Clinical Guidelines, No. 88, 'Low Back Pain: Early Management of Persistent Non-specific Low Back Pain', May 2009
8. 'Prevalence of chronic pain in the UK: a systematic review and meta-analysis of population studies', BMJ Open Journal - https://bmjopen.bmj.com/content/6/6/e010364
9. British Heart Foundation UK Factsheet, November 2018 - https://www.bhf.org.uk/what-we-do/our-research/heart-statistics
10. NHS Constitution for England, Department of Health and Social Care, updated October 2015
11. House of Commons Hansard 'Prevention of Ill Health: Government Vision' Volume 648, Column 1263, 5 November 2018
12. 'Integrating complementary medicine?' J R Soc Health 1997, *117(5):* 285—286.
13. 'Untapped Resources: Accredited Registers in the Wider Workforce', Royal Society for Public Health and Professional Standards Authority, November 2017
14. House of Commons Hansard, Written question - 127979, 27 February 2018
15. NHS England website
16. 'Prevalence of use of complementary and alternative medicine (CAM) by patients/consumers in the UK: systematic review of surveys', Clin Med April 1, 2013 vol. 13 no. 2 126-131
17. Sickness absence in the UK labour market 2016, Office for National Statistics
18. 'Low back pain and sciatica in over 16s: assessment and management', NICE guideline [NG59], November 2016
19. 'Acupuncture, Herbal Medicine and Traditional Chinese Medicine', Health written statement, 16 February 2011
20. 'Government Response to Professor Walker's advice on Regulation of Herbal Medicines and Practitioners', written statement HCWS505, 28 February 2017
21. 'Evidence Check 2: Homeopathy', House of Commons Science and Technology Committee - Fourth Report, February 2010
22. 'Evidence based medicine: what it is and what it isn't', BMJ January 1996
23. National Institute for Health and Care Excellence website
24. 'Trends in the lifetime risk of developing cancer in Great Britain: comparison of risk for those born from 1930 to 1960', British Journal of Cancer volume 112, pages 943–947, March 2015
25. 'Use of complementary and alternative medicine in cancer patients: a European survey'. Annals of Oncology 2005: 16(5) p655-663
26. MacMillan Cancer Support website
27. 'English surveillance programme for antimicrobial utilisation and resistance' (ESPAUR) report, October 2014
28. Public Health England website 'Keep antibiotics working campaign returns'
29. 'Do NHS GP surgeries employing GPs additionally trained in integrative or complementary medicine have lower antibiotic prescribing rates? Retrospective cross-sectional analysis of national primary care prescribing data in England 2016', BMJ Open Journal
30. 'Ensuring access to working antimicrobials', House of Commons Science and Technology Committee, First Report, July 2014
31. 'Standardised Chinese herbal treatment delivered by GPs compared with individualised treatment administered by practitioners of Chinese herbal medicine for women with recurrent urinary tract infections (RUTI)', Southampton University
32. WHO Traditional Medicine Strategy: 2014-2023

All-Party Parliamentary Group for Integrated Healthcare

Purpose:

To provide a forum for discussion on issues related to integrated healthcare; to stimulate well-informed debate among politicians and stakeholders; and to contribute towards the development of knowledge and policies on the subject.

Chair and Registered Contact:
David Tredinnick MP
All-Party Parliamentary Group
for Integrated Healthcare
House of Commons
London
SW1A 0AA.
Tel: 020 7219 4514
Email: tredinnickd@parliament.uk

Public Enquiry Point:
Matthew Williams
c/o David Tredinnick MP
House of Commons
519 Norman Shaw North
Victoria Embankment
London SW1A 2HZ
Tel: 020 7219 4474
Email: williamsmr@parliament.uk