Complementary and Alternative Medicine

Current Policies and Policy Issues in New Zealand and Selected Countries

A Discussion Document

2003

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MINISTRY OF HEALTH
MANATŪ HAUORA

Ministerial Advisory Committee on Complementary and Alternative Health
Te Kōmiti Tohutohu Minita mō te Hauora Whakahāngai

Foreword

The Ministerial Advisory Committee on Complementary and Alternative Health (MACCAH) was established in June 2001 to advise the Minister of Health on matters related to complementary and alternative medicine. MACCAH's terms of reference require it to provide advice on the following key areas: regulation, consumer information needs, research and efficacy, integration, and the contribution that complementary medicine might make towards achieving the goals of the New Zealand Health Strategy.

This discussion document aims to identify the main policy issues surrounding complementary and alternative medicine in New Zealand, as they relate to MACCAH's terms of reference. The document is in two parts. The first part examines the status of complementary and alternative medicine in New Zealand and six overseas countries. The second focuses on some of the key questions facing policy makers in New Zealand. Identifying the policy issues most relevant to the New Zealand situation will enable MACCAH to formulate its advice in this area more effectively.

In addition, the discussion document offers you an opportunity to have your say on the role of complementary and alternative medicine in New Zealand, and I invite you to make a submission.

Prof Peggy Koopman-Boyden
Chair,
Ministerial Advisory Committee on Complementary and Alternative Health

How to Have Your Say

We are asking the public for their comments on this document in order to help us advise the Minister of Health on developing policy on complementary and alternative medicine. You might like to use the questions in the accompanying submission booklet as a way of organising and presenting your feedback. Please feel free to make additional comments if you wish. Your assistance is much appreciated.

There are four ways in which you can make a submission:

1. Write your comments in the accompanying submission booklet and send them back to the Ministry of Health by post.
2. Complete the submission booklet as a Word document and either email it to the Ministry or send it by post. The Word document is on the Ministry of Health website at http://www.newhealth.govt.nz/maccah.htm.
3. Write your comments as a letter or as an email and send it to the Ministry of Health.
4. Attend a consultation meeting and present your submission in person.

Send submissions to:

Ministerial Advisory Committee on Complementary and Alternative Health (MACCAH)
Submissions
Ministry of Health
133 Molesworth Street
PO Box 5013
Wellington
Fax: (04) 496 2340
Email: maccahdoc@moh.govt.nz

The closing date for submissions is 5 pm on Monday 30 June 2003.

All submissions will be acknowledged by the Committee and a summary of submissions will be sent to all those who request a copy. Unless you state otherwise, the summary will include the names of those who made a submission. Any request for confidentiality will be subject to the Official Information Act 1982.

If you require additional copies of this document, please contact:

Wickliffe Press
PO Box 932
Dunedin
Phone: (04) 496 2277
Email: moh@wickliffe.co.nz

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Introduction

Aim and scope

The Ministerial Advisory Committee on Complementary and Alternative Health (MACCAH) was set up in June 2001 and is funded to run until 2004. MACCAH is responsible for providing the Minister of Health with information and advice on complementary and alternative health care in New Zealand. MACCAH's terms of reference are outlined in Appendix 1. A list of MACCAH's members is given in Appendix 2.

This discussion document aims to provide background and comparative information on complementary and alternative medicine (CAM) in New Zealand and overseas, and to identify policy issues of particular concern here in New Zealand.

The first part of the document, the 'Review of Complementary and Alternative Medicine in New Zealand and Abroad', gives an overview of current policies on CAM in the following countries:

- New Zealand
- the United Kingdom
- the United States of America
- Canada
- Australia
- Singapore
- China.

These countries were selected to give a balance between Western and Eastern perspectives. The English-speaking countries were chosen because they have similar judicial and governmental systems. China is included because biomedicine and CAM, in the form of traditional Chinese medicine, are integrated within the Chinese health system.

Within each country the relevant policies are discussed under four headings:

- regulation
- consumer information needs
- research, evidence and efficacy
- integration.

These four policy areas are in line with MACCAH's terms of reference (see Appendix 1).

The second part of the document, 'Policy Issues Surrounding CAM', identifies and examines some of the questions and areas of uncertainty that arise from the survey of CAM in New Zealand and overseas. These are some of the issues that MACCAH believes policy-makers, practitioners and consumers here in New Zealand need to consider.

What is CAM?

The definition of CAM used in this document is as follows:

> *Complementary and alternative medicine (CAM) is a broad domain of healing resources that encompasses all health systems, modalities, and practices and their accompanying theories and beliefs, other than those intrinsic to the politically dominant health system of a particular society or culture in a given historical period. CAM includes all such practices and ideas self-defined by their users as preventing or treating illness or promoting health and well-being* (O'Connor et al 1997).

The term is also understood to include those modalities that are perceived as forming part of the CAM spectrum in the countries under discussion. A fuller explanation of the terminology used by MACCAH is given in our terminology paper (MACCAH 2002).

The CAM modalities most commonly available in New Zealand are listed in Appendix 3.

Traditional Māori healing

Under the Treaty of Waitangi, the Government has an obligation to protect and support Māori systems of knowledge. Development of policy advice with respect to traditional Māori healing should be led by Māori to be consistent with the principle of rangatiratanga, or self-determination. In light of this, MACCAH will not be considering traditional Māori healing within the scope of its policy advice to the Minister of Health.

Advice in this area will instead be led by the Ministry of Health's Māori Health Directorate in the context of implementing He Korowai Oranga, the Māori Health Strategy.

Section 1: Review of Complementary and Alternative Medicine (CAM) in New Zealand and Abroad

1.1 Regulation of CAM

Effective regulation of the complementary and alternative health sector serves the public interest by protecting consumers from unsafe or inadequately trained practitioners, and from products that are unsafe or make misleading claims. All the countries surveyed in the first part of the discussion document regulate CAM products and practitioners separately. Some (eg, Australia) have or are developing a national system for regulating products, but regulate practitioners on a regional basis.

Regulation of practitioners can be statutory or voluntary. Both forms have similar functions, but only statutory regulation is upheld in law. Statutory regulation usually requires practitioners to register with a single national or state council or licensing board. It may also confer protection of title, allowing only registered practitioners to use a particular professional title.

Statutory regulation is most often applied to higher-risk CAM modalities. These include modalities that use interventions such as spinal manipulation (eg, chiropractic, osteopathy), invasive techniques (eg, acupuncture) or ingested substances (eg, herbal medicine). Products such as dietary supplements and herbal remedies may also be regulated by statute.

Voluntary or self-regulation of practitioners is more common in CAM than statutory regulation. Professional bodies representing CAM practitioners who are not regulated by statute often establish protocols for self-regulation. The House of Lords Select Committee on Science and Technology has identified several key features of an effective self-regulating professional body. For example, such a body should enforce ethical and conduct codes, disciplinary and complaints procedures, and educational standards (House of Lords Select Committee 2000).

NEW ZEALAND

Currently the only legislation that specifically regulates complementary and alternative health practitioners in New Zealand is the Chiropractors Act 1982. The Medicines Act 1981 and the Medicines Regulations 1984 impose some regulatory controls on CAM products. However, there are several legislative provisions and policies that have an impact on CAM practice and products.

Legislation and policies relating to the regulation of health practitioners and therapeutic products are currently in development. These are highly relevant to CAM. The Health Practitioners Competence Assurance Bill and the proposed joint Trans-Tasman agency for the regulation of therapeutic products are discussed below.

Regulation of practice

The following legislation and policies currently regulate individuals who practise complementary and alternative medicine: the Physiotherapy Act 1949, the Massage Parlours Act 1978, the Medicines Act 1981, the Chiropractors Act 1982, the Health and Disability Commissioner Act 1994, the Medical Practitioners Act 1995, the Fair Trading Act 1996, and the Code of Health and Disability Services Consumers' Rights 1996 (pursuant to the Health and Disability Commissioner Act 1994).

Health professionals who are regulated by statute (for instance, doctors, nurses and dentists) and who also practice CAM are subject to the above provisions as well as to their own professional statutes.

In some areas (eg, Auckland) the premises and equipment used by CAM practitioners also have to comply with local bylaws.

Chiropractors are currently the only statutorily regulated CAM profession in New Zealand. They must complete a recognised training course and register with the New Zealand Chiropractic Board.[1] Membership of the main professional body, the New Zealand Chiropractors' Association, is voluntary. Members are required to participate in continuing professional development.

Practitioners of other CAMs may, if they wish, register with a voluntary, self-regulating professional body. These include umbrella organisations that represent many different CAM modalities, such as the New Zealand Charter of Health Practitioners (the Charter), or modality-specific professional groups, such as the New Zealand Register of Acupuncturists. Many of the latter organisations are affiliated with the Charter.

Many of the individuals currently practising CAM have received formal training from private training establishments registered with the New Zealand Qualifications Authority (NZQA). These offer a range of NZQA-approved courses on CAM.[2] The various voluntary, self-regulating professional bodies usually require their members to hold specified qualifications. However, as membership of such bodies is voluntary, standards of training may vary between, and even within, the various CAM modalities.

Voluntary registration bodies may also require their members to undertake post-qualification training and development. It has been suggested that continuing professional development is not common in CAM (House of Lords Select Committee 2000); however, the New Zealand Charter of Health Practitioners does require its members to undergo continuing professional development.

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1 See http://www.regboards.co.nz/chiropractic/

2 See http://www.nzqa.govt.nz/site/framework/browse/browse.html

Regulation of products

Complementary and alternative health products can be categorised as medicines, dietary supplements or foods, and are regulated accordingly. The categorisation depends on the nature of the product itself and on the wishes of the manufacturer.

Complementary and alternative health products are currently regulated by the following legislation and policies: the Medicines Act 1981, the Food Act 1981, the Medicines Regulations 1984, the Food Regulations 1984, the Dietary Supplements Regulations 1985, the Fair Trading Act 1986, the Consumer Guarantees Act 1993, the New Zealand Code of Good Manufacturing Practice for Manufacture and Distribution of Therapeutic Goods 1993: Part 1: Manufacture of Pharmaceutical Products, and the Australia New Zealand Food Standards Treaty 1995.

Most CAM products are marketed as dietary supplements, which require no pre-market approval. Controls on safety and quality are minimal, and problems may only be detected if adverse reactions occur. There is currently no specific reporting system for monitoring adverse events related to CAM products. However, the Centre for Adverse Reaction Monitoring[3] based at the University of Otago encourages the reporting of such events. It is currently illegal to make specific therapeutic claims for products such as dietary supplements and herbal and homoeopathic remedies. However, this situation may change under the proposed joint agency for the regulation of therapeutic products (see below).

Legislation and policy in development in New Zealand

Health Practitioners Competence Assurance (HPCA) Bill[4]

The Bill is intended to protect the health and safety of the public by establishing processes to ensure that regulated health practitioners are competent to practise. It will replace the 11 existing health occupational regulatory statutes.

The HPCA Bill proposes a single overarching Act containing a framework for the governance and functions of registering authorities. It is intended to ensure consistency between the professions.

The proposed Bill will enable one currently unregulated profession, osteopathy, to become regulated by statute. It also provides a mechanism for other CAM professions to be added to the regulatory regime without the need for separate Acts of Parliament. In the future, new professions that meet the criteria for statutory regulation may be added by Order in Council.

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[3] http://telperion.otago.ac.nz/carm/

[4] See http://www.moh.govt.nz/moh.nsf/7004be0c19a98f8a4c25692e007bf833/a68075776584ee94cc256bdb007effce?OpenDocument

The HPCA Bill provides for the statutory regulation of professions that meet one or both of the following criteria:

- practice of the profession poses a 'risk of harm to the public'
- it is 'otherwise in the public interest' that the profession be regulated.[5]

Proposed trans-Tasman agency for the regulation of therapeutic products

It has been proposed that a joint trans-Tasman agency be established to regulate therapeutic products.[6] The proposal is outlined in a discussion paper (Medsafe 2002). The proposed agency would regulate all medicines, medical devices, dietary supplements and complementary and alternative health care products in Australia and New Zealand. It would replace Medsafe in New Zealand and the Therapeutic Goods Administration (TGA) in Australia.

Under the proposed agency, new legislation would be drawn up to specify the controls applying to therapeutic products in both countries. Items with a higher risk profile, such as prescription medicines, would be more strictly controlled than those with a low risk profile, such as dietary supplements.

The New Zealand and Australian governments have agreed in principle to establish such a joint agency, subject to satisfactory negotiation of governance and operational arrangements. If the proposals are approved, the new joint agency will be established in 2004.

UNITED KINGDOM

Complementary and alternative practitioners and products in the UK are subject to a range of general statutory controls, including the Health and Safety at Work Act 1974, the Consumer Protection Act 1987 and the Food Safety Act 1990. Common law also impacts on the practice of CAM as it contains a right to practise medicine (House of Lords Select Committee 2000). Under common law, activities tend to be tolerated unless expressly prohibited. CAM practitioners in the UK are therefore largely free to operate so long as they do not falsely claim to be a member of a regulated profession (eg, a medical doctor, an osteopath), practise in protected disciplines such as dentistry or midwifery, or supply prescription-only drugs (Mills 2001a).

Regulation of practice

In the UK, osteopaths and chiropractors are currently the only CAM practitioners regulated by specific legislation: the Osteopaths Act 1993 and the Chiropractors Act 1994, respectively. Note that it is the practitioners, rather then the modalities, that are regulated. Other therapists may use osteopathic or chiropractic techniques provided they do not claim or imply that they are osteopaths or chiropractors.

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5 HPCA Bill, Clause 112.

6 http://www.jtaproject.com/

The House of Lords Select Committee on Science and Technology recommended in 2000 that acupuncture and herbal medicine should be regulated by statute. They also suggested that statutory regulation for non-medical homoeopaths might eventually be appropriate. The Select Committee recommended that the various voluntary bodies representing other CAM professions come together to form a single, voluntary, self-regulatory body for each modality. It cautioned against the establishment of multidisciplinary bodies (House of Lords Select Committee 2000).

The herbal medicine and acupuncture professions in the UK are currently preparing to apply for statutory regulation. Such regulation is also expected to encompass traditional practitioners who use acupuncture or herbalism as part of their practice (eg, practitioners of Ayurvedic and traditional Chinese medicine). In the future, CAM professions who apply for statutory regulation in the UK will be able to do so under Section 60 of the Health Act 1999, rather than through the time-consuming process of pursuing their own Act of Parliament. In this way the Health Act 1999 resembles New Zealand's Health Practitioners Competence Assurance bill.

Legislation regulating herbalists could be drawn up by the end of 2004. The UK government may link such legislation to planned changes in the Medicines Act 1968. These changes are intended to improve the safety and quality of some herbal remedies that are currently unlicensed and only available from herbalists. The intention is to link access to such remedies to a requirement for registration under the new statutory regulation scheme for herbalists.

It is doubtful that legislation regulating acupuncturists will be in place before 2005 (A. Walker, Department of Health [London], personal communication 2002).

Regulation of products

Medicines sold or supplied in the UK are regulated by the Medicines Act 1968. If defined as a medicine under the Act, CAM products require a marketing authorisation (or 'product licence') before entering the market. To be granted a licence, manufacturers must supply evidence of safety, quality and efficacy. Herbal remedies are exempt from licensing requirements if they meet the following conditions set out in Section 12 of the Act:

- they are supplied by a herbal practitioner following a personal consultation (but see the above paragraph about possible changes to the regulation of some herbal products)
- they contain only herbs that have been subjected to simple processes
- they are sold by their botanical name alone
- they are sold without any written recommendation as to their use.

Although there are several hundred licensed herbal remedies on the market in the UK, the majority are unlicensed products.

New homoeopathic remedies must be registered before entering the UK market. Specific recommendations for their use are not permitted. Remedies must satisfy quality and safety criteria. Evidence of efficacy is not required.[7]

Proposed changes to the Medicines Act 1968 might affect the regulatory status of some unlicensed CAM products that are currently only available from practitioners.

UNITED STATES

Regulation of practice

Osteopathy and chiropractic are recognised in all US states. Osteopaths are fully licensed physicians with the protected title Doctor of Osteopathy (DO). They are entitled to practise in any state and are generally regarded as part of mainstream medicine. Osteopaths have their own medical schools and are required to undergo training similar to that of biomedical doctors. Chiropractors are regulated in all states but, unlike osteopaths, are not licensed physicians and are not regarded as mainstream. Chiropractic achieved recognition despite sustained objections from the American Medical Association. The debate culminated in a Supreme Court judgement in favour of the chiropractors. US doctors are now obliged to refer to and receive referrals from chiropractors.

The situation with regard to other CAMs is complex, as each state decides its own independent policy on the regulation of practitioners within its jurisdiction. State Medical Practice Acts generally limit the practice of medicine to licensed professionals such as doctors. As state statutes tend to define 'medicine' broadly, CAM practitioners in the US can face legal risks (Cohen 2000).

Some states have developed regulatory or licensing arrangements for some CAM practitioners. For example, many regulate acupuncture and require practitioners to be trained to a specified standard. The National Certification Commission for Acupuncture and Oriental Medicine[8] plays a role in setting standards in individual states. Some states limit the practice of acupuncture to medical practitioners or to those under a medical practitioner's supervision. Naturopathic medicine is also recognised and licensed in several states.

New York State passed an Alternative Medical Practice Act in 1994. New York now recognises all CAMs and supports consumer choice in health care.

The White House Commission on Complementary and Alternative Medicine Policy (WHCCAMP) recommends that 'states should evaluate and review their regulation of CAM practitioners and ensure their accountability to the public'. It also recommends that the Federal government assist states and professional associations in improving the regulation of CAM practitioners (WHCCAMP 2002).

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7 From *Medicines Act 1968 and Complementary Medicine*, http://www.nhsatoz.org/nhsd

8 http://www.nccaom.org/

Regulation of products

CAM products that are defined as dietary supplements under the Dietary Supplement Health and Education Act 1994 are covered by a different and less rigorous set of regulations to conventional medicines.[9] Manufacturers do not require Food and Drug Administration (FDA) approval before producing or selling dietary supplements. The regulations put the onus on manufacturers to ensure that supplements are safe prior to marketing. If safety concerns arise over a particular product, the FDA must prove that the product is unsafe before it can restrict its availability or remove it from the market. Manufacturers and distributors are not required to report any adverse reactions to the FDA. However, they must ensure that information on product labels is truthful and not misleading.

After products reach the market the FDA is responsible for monitoring safety. This is done mainly through voluntary adverse event reporting. The FDA also oversees the labelling and information content of dietary supplements. The Federal Trade Commission regulates the advertising of supplements.

CANADA

Regulation of practice

In Canada each province may impose its own regulations on health professionals. There is, however, an umbrella organisation, the Federation of Medical Licensing Authorities, which has developed a set of criteria to guide provincial bodies on developing regulations for CAM practitioners. These criteria are aimed at promoting a level of consistency between provinces. They also recommend that, in all jurisdictions, practitioners be required to provide evidence on safety and efficacy. CAM practitioners are regulated by statute in the jurisdictions set out in Table 1.

Table 1: CAM practitioners and their Canadian jurisdictions

Practitioners	Jurisdictions
Acupuncturists	Alberta, British Columbia, Quebec
Chiropractors	All provinces
Massage therapists	British Columbia, Ontario
Naturopaths	British Columbia, Manitoba, Ontario, Saskatchewan[10]
Osteopaths	Alberta, British Columbia, New Brunswick, Nova Scotia, Ontario, Quebec, Saskatchewan

Source: York University Centre for Health Studies 1999

[9] http://www.cfsan.fda.gov/~dms/supplmnt.html

[10] Regulation in Alberta is currently pending.

Many CAM modalities and practitioners remain outside specific regulation. They are, however, subject to 'laws of general application' such as the Criminal Code, relevant legislation on consumer protection, and laws governing civil matters (de Bruyn 2001).

Regulation of products

In 1998 concerns over safety and quality led the House of Commons Standing Committee on Health to review the regulation of natural health products in Canada. The Committee's report, *Natural Health Products: A new vision*, recommended the establishment of a new regulatory body (Standing Committee on Health 1998). The Canadian government accepted all of the Standing Committee's recommendations on product regulation and a new Office of Natural Health Products was set up within Health Canada in 1999. That body is now known as the Natural Health Products Directorate (NHPD). The NHPD has recently published a new regulatory framework for CAM products.[11] The regulations will require manufacturers of natural health products to be licensed and to comply with minimum labelling requirements. To obtain a licence, manufacturers will have to submit detailed product information and evidence for safety and efficacy before they can market their products. Holders of natural product licences will have to monitor adverse reactions associated with their products and report any serious reactions to Health Canada. Manufacturers and distributors will also have to meet standards for good manufacturing practices.

The new regulatory framework was published at the end of December 2001. Publication was followed by a 90-day consultation period. The regulations are now being implemented and will come into full force over the next two years. In the meantime natural health products will continue to be regulated under existing legislation as either foods or drugs.

AUSTRALIA

Regulation of practice

Until the various State Medical Acts were passed, CAM practitioners throughout Australia were free to practise under a common law right similar to that of the UK (Fulder 1996). However, the regulation of CAM practitioners is now the responsibility of individual states or territories. Chiropractors and osteopaths are currently regulated in all Australian states. Medicare reimburses fees for osteopathic and chiropractic treatment. The State of Victoria has recently passed legislation to implement a regulatory system for practitioners of traditional Chinese medicine, and a Traditional Chinese Medicine Board has been set up to register practitioners. Queensland and New South Wales are expected to implement similar arrangements.

[11] See http://www.hc-sc.gc.ca/hpfb-dgsa/nhp_reg_framework_3_e.html

In April 2002 the federal government granted five CAM practitioner associations $A100,000 each to assist in the development of 'national uniform registration systems for suitably qualified practitioners in acupuncture, herbal medicine and naturopathy'.[12] This is to enable practitioners to achieve registration before the introduction of goods and services tax (GST) in June 2003. After this date only 'recognised professionals' will be able to practise these modalities without charging GST. This is a one-off initiative and is not intended to replace the regulatory functions of the states and territories.

Regulation of products

Australia has a national regulatory system administered by the Therapeutic Goods Administration (TGA) which covers all therapeutic products. The TGA includes an Office of Complementary Medicine, which deals specifically with CAM. A statutory committee, the Complementary Medicines Evaluation Committee (CMEC), has been established to provide the TGA with specialist advice on CAM products.[13] CMEC evaluates new complementary medicines and considers the evidence to support any claims or indications for their use.

To be legally sold in Australia, products defined as 'therapeutic goods' must be included on the TGA's Australian Register of Therapeutic Goods. Regulation is on the basis of risk. Low-risk products must simply be *listed* on the Register. Their ingredients are evaluated for safety and quality, and manufacturers must have evidence for any claims that are made for efficacy. High-risk products have to be *registered*. They must be evaluated by an expert committee, which also examines the evidence on efficacy. Manufacturers of therapeutic goods must also comply with the appropriate codes on good manufacturing practice.[14]

Raw herbs are outside the jurisdiction of the TGA.

SINGAPORE

Health care in Singapore is largely based on Western biomedicine. However, the Singapore health authorities recognise the importance of CAM and are taking steps to ensure it is practised safely. The Singapore Ministry of Health established a traditional medicine unit in 1995 (World Health Organization 2001).

The most popular form of CAM in Singapore is traditional Chinese medicine (TCM). Traditional Malay and Indian medicine are also available, as are 'Western' CAM modalities such as aromatherapy and chiropractic.

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[12] See http://www.health.gov.au/mediarel/yr2002/tw/tw02007.htm

[13] See Functions of the Complementary Medicines Evaluation Committee at http://www.health.gov.au/tga/docs/html/cmec/function.htm

[14] See http://www.health.gov.au/tga/docs/html/gmpcodau.htm

Regulation of practice

Regulation of TCM is currently being phased in under the TCM Practitioners Act 2000. This Act required all acupuncturists to be registered by the beginning of 2002. TCM general practitioners are to become registered in two to three years' time, and TCM herbalists will become registered some time after that. Apart from TCM there is no direct regulation of CAM practices, but some indirect regulation is provided by legislation covering biomedicine. The Singapore Ministry of Health is currently monitoring the situation (Wong Kum Leng, Singapore Ministry of Health, presentation, 2001).

Regulation of products

All traditional Chinese proprietary medicines have to be approved by the Singapore Ministry of Health prior to import or sale. There is also legislation that governs the labelling of, and information provided with, traditional Chinese medicines. There is no legislation that directly covers any other CAM products.

CHINA

Traditional Chinese medicine (TCM) is a complete diagnostic and treatment system dating back thousands of years. Its main tools are acupuncture and herbal medicines. China relied entirely on TCM until Western medicine was introduced at the end of the 17th century. By the end of the 19th century Western biomedicine had almost displaced TCM in urban areas. Although the Communist Party was originally committed to eradicating TCM, which they regarded as a legacy from imperial times, Chairman Mao felt that integration of the old and the new was the best way forward for the health of the nation. At the First National Health Conference in 1950 it was decided that TCM and Western medicine should be integrated into a universal health system (Fulder 1996). Today approximately 95 percent of general hospitals in China have traditional medicine departments (Bodecker 2001).

Regulation of practice

Practitioners are regulated by the State Administration of Traditional Chinese Medicine (SATCM). The regulations governing TCM are set out in the *Anthology of Policies* (SATCM 1997). Practitioners must have appropriate qualifications before they can offer TCM treatment. A degree is required to become a TCM physician. Holders of diploma-standard qualifications may practise TCM in a more limited fashion as a 'medical assistant'.

Regulation of products

The regulations governing TCM products are set out in the *Anthology of Policies* (SATCM 1997). Products must satisfy quality and safety standards before they can be marketed in China or exported to other countries.

1.2 Consumer information needs

Consumers need easily accessible information about CAM. This information should be reliable, objective and, where possible, based on sound evidence. High-quality consumer information about CAM is necessary to ensure public safety and to enable people to make informed choices about their health care.

If information about CAM is limited, unreliable or difficult to access, consumers may be unable to identify the therapies that are most likely to be safe, effective and appropriate to their needs.

NEW ZEALAND

No organisation currently has overall responsibility for providing consumer information about CAM. The Ministry of Health provides some information about herbal medicines via the Medsafe website.[15] Medsafe also produces guidelines for medicinal product manufacturers on the form and content of the consumer information they supply (Medsafe 2001).

The Consumers' Institute website,[16] Consumer Online, has a section on alternative health. However, access is only available to Consumer Online subscribers and coverage is currently limited to medicinal plants. The New Zealand Charter of Health Practitioners produces a directory and a website[17] that list practitioners and affiliated practitioner organisations. They also provide some basic information on consumer rights and complaints procedures. Many of the other voluntary registration and professional bodies also supply information about individual CAM modalities.

Other sources of information include:

- special interest and lobby groups (eg, Citizens for Health Choices)[18]
- government bodies (eg, the Ministry of Consumer Affairs)
- health information websites (eg, Everybody)[19]
- consumer health magazines (eg, *Healthy Options*).

It is generally agreed that consumers need better access to comprehensive, reliable and objective information about CAM. The Ministry of Health is therefore establishing a database of CAM research, which is expected to go live in the second half of 2003. The database will give New Zealand consumers a convenient and easy-to-use portal to existing worldwide research on the safety and efficacy of CAM. The database has been granted funding of $600,000 over four years.

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15 See http://www.medsafe.govt.nz/cons.htm

16 See http://www.consumer.org.nz/

17 See http://www.healthcharter.org.nz/home.html

18 See http://www.choices.org.nz/

19 See http://www.everybody.co.nz/

UNITED KINGDOM

Consumers in the UK have access to information about CAM through a variety of sources, including:

- the National Health Service (NHS)
- the UK Department of Health
- the UK Consumers' Association
- the Complementary Healthcare Information Service UK (CHIS-UK) website, funded and maintained by CAM practitioners[20]
- CAM professional associations, both statutory and voluntary
- organisations such as the Institute for Complementary Medicine,[21] the Foundation for Integrated Medicine and the Research Council for Complementary Medicine.

The House of Lords Select Committee on Science and Technology has recommended that the NHS takes responsibility for providing contact details of CAM organisations and information about NHS provision of CAM in each area. The Select Committee recommended that the NHS also offers guidance to help consumers evaluate different CAM therapies (House of Lords Select Committee 2000).

The NHS operates a Web-based health information service for consumers, NHS Direct Online. Coverage of CAM has been improved in response to the Select Committee's recommendations. Sections on CAM are now available on the NHS Direct Online website.[22]

The UK Department of Health has also commissioned a leaflet to provide consumers with information on CAM.

UNITED STATES

The National Center for Complementary and Alternative Medicine (NCCAM) provides information for consumers and practitioners of CAM via its website.[23] The information ranges from general descriptions of the modalities available in the US to summaries of research on specific treatments. As NCCAM's primary focus is research, information on CAMs that are easier to evaluate using quantitative techniques (eg, herbal remedies) tends to predominate.

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[20] See http://www.chisuk.org.uk/

[21] See http://www.icmedicine.co.uk/

[22] See http://www.nhsdirect.nhs.uk/nhsdoheso/display.asp?sTopic=Alternativemedicine and http://www.nhsdirect.nhs.uk/innerpage.asp?Area=11&Topic=20&Title=Complementary

[23] See http://nccam.nih.gov/

The US Food and Drug Administration (FDA) also provides consumer advice on dietary supplements via its website.[24] It has published a guide to help consumers make informed choices about supplements (US FDA 2002).[25]

In 2002 the White House Commission on Complementary and Alternative Medicine Policy (WHCCAMP) recommended that 'Federal government should make available accurate, useful, and easily accessible information on CAM practices and products, including information on safety and effectiveness'. The volume of CAM information provided by the US government may therefore increase in the future (WHCCAMP 2002).

Consumers in the US also have access to a wide range of information from practitioner bodies, consumer organisations and special interest groups, much of it provided via the Internet.

CANADA

Consumers in Canada currently have access to a variety of information on CAM. Until recently provision of information has been fragmented and the main sources have traditionally been CAM practitioners, practitioner and patient organisations, the media and the Internet. However, increasing demand for CAM has prompted Health Canada to provide information in a more co-ordinated and accessible manner. The Canadian Health Network, a national Internet-based health information service funded by Health Canada, now includes a section on CAM on its website.[26] This gives information on different modalities and advice on choosing a practitioner, and offers links to other CAM resources on the Internet.

Another useful Canadian resource is the Camline website, which was set up to provide health professionals and the public with evidence-based information on CAM.[27] The Camline initiative is a collaboration between various CAM and biomedical organisations.

AUSTRALIA

The Therapeutic Goods Administration provides information about CAM products on its website.[28] The Complementary Healthcare Consultative Forum, established by the Australian Federal Government, is currently examining the provision of consumer information on CAM with a view to implementing formal policies. It has particular concerns about the claims made in product advertising and the marketing of remedies and supplements via the Internet.

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[24] See http://www.cfsan.fda.gov/~dms/supplmnt.html

[25] See http://www.cfsan.fda.gov/~dms/ds-savvy.html

[26] See http://www.canadian-health-network.ca/1alternative_health.html

[27] See http://www.camline.org/index2.htm

[28] See http://www.health.gov.au/tga/cm/cm.htm

The Consumers' Health Forum of Australia has published a guide to complementary medicines (Consumers' Health Forum 1999). The Cochrane Collaboration Consumer Network, based in Australia, provides simplified summaries of Cochrane reviews via its website.[29] These are designed to help consumers make informed decisions about health care. The summaries often include information about CAM therapies. It should be noted that although based in Australia, the Consumer Network is a worldwide initiative. It is part of the international Cochrane Collaboration[30] and the information on the website is therefore international in scope.

SINGAPORE

There are laws governing the labelling of, and information provided with, Chinese proprietary medicines. The Singapore Ministry of Health must approve these products prior to import or sale. Information on other CAM therapies and products is provided by practitioners and practitioner associations.

CHINA

The advertising, labelling and information content of TCM products must comply with legislation on general drug advertising. The rules are described in the *Anthology of Policies* (SATCM 1997). The various provincial, regional and municipal health administrative departments are responsible for enforcing these laws within their jurisdictions. Generally speaking, drug advertisements are required to be truthful and accurate. Advertisements in the media must carry the warning 'Please follow your doctor's advice'.

1.3 Research, evidence and efficacy

The evidence base for complementary and alternative medicine is generally perceived to be poor. Although more than 4000 trials have been carried out (Peters and Gillam 2001), there is still a shortage of strong evidence on the safety and efficacy of many CAM treatments. The reasons for this lack of high-quality evidence include the difficulties of applying standard medical research methods to some forms of CAM, and the lack of funding available for CAM research. However, the quality and clinical relevance of CAM research is said to be improving (Vickers 2000).

There is currently a move towards evidence-based medicine in health care worldwide. Proponents of evidence-based medicine believe that decisions on which treatment to use should be based on sound evidence produced by well-conducted research studies. Quantitative methods such as randomised controlled trials (RCTs) and systematic reviews are regarded as the 'gold standard' in evidence-based medicine. The quality of evidence for particular treatments is sometimes graded according to the type of research studies from which it is derived.

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[29] See http://www.cochraneconsumer.com/welcome.asp

[30] The Cochrane Collaboration is an international network of researchers who undertake 'systematic reviews' on the effectiveness of medical treatments. A systematic review pools and interprets the results of all existing research on the effectiveness of a particular treatment.

Table 2: The hierarchy of evidence model

I.	Systematic reviews and meta-analyses
II.	Randomised controlled trials with definitive results
III.	Randomised controlled trials with non-definitive results
IV.	Cohort studies
V.	Case-control studies
VI.	Cross-sectional surveys
VII.	Case reports

Source: Clinical Evidence Online 2002

There has been considerable debate over whether methodologies such as the RCT, with its emphasis on readily quantifiable outcomes and standardised treatment for all participants, can be effectively applied to CAM. For example, critics argue that while RCTs aim to determine whether treatments have an effect over and above the 'placebo effect',[31] interaction between patient and practitioner is an essential component of many CAM modalities.

However, others have argued that it is both possible and appropriate to apply the key principles of evidence-based medicine – including the RCT methodology – to CAM (Vickers 1999).

NEW ZEALAND

Very little research has been published in New Zealand on the safety or efficacy of CAM. No quantitative research has been published in New Zealand, nor does it appear that any large-scale studies have been carried out.

There is, however, a great deal of anecdotal evidence regarding the safety and efficacy of some complementary and alternative therapies. There are also many unpublished case studies collected by complementary and alternative practitioners supporting the efficacy of various therapies.

There is currently no specific policy on CAM research. However, the Ministry of Health is establishing a database of known evidence for the safety and efficacy of CAM treatments. This will take the form of a searchable website presenting summaries of existing international CAM research and providing links to other evidence-based CAM websites. The database is expected to go live in the latter half of 2003. It has funding of $600,000 over four years.

[31] 'The healing process is traditionally in three parts: the self-healing properties of the body; the changes induced by non-specific effects of the therapist and the setting in which the therapy takes place; and specific effects of physical and pharmacological interventions' (Kleijnen et al 1994). The second part is often referred to as the *placebo effect*.

UNITED KINGDOM

In 2000 the UK House of Lords Select Committee on Science and Technology reported that very little high-quality research on CAM has been carried out. There are, however, a variety of environments within which CAM research takes place in the UK, including the following:

- The Department of Complementary Medicine at the University of Exeter is based within a school of postgraduate medicine and supports a Chair of Complementary Medicine. The Department carries out systematic reviews of research, as well as conducting its own clinical trials and surveys.[32]
- There is a Complementary Medicine Research Unit of the School of Medicine at the University of Southampton.
- The Marylebone Health Centre, a GP practice, offers CAM therapies alongside conventional care and supports practice-based research.

The House of Lords Select Committee recommended that a small number of centres of excellence be established. However, in its response the UK Department of Health stated that such a move would be premature given the limited research capacity in CAM (Department of Health [London] 2001).

A strategy to build research capacity in CAM has since been developed by the Department of Health's Research and Development Workforce Capacity Implementation Group in conjunction with the Foundation for Integrated Medicine and the Research Council for Complementary Medicine[33] (Grey and Bailey 2001). Funded research posts will be created at a small number of selected higher education institutions. It is hoped that this initiative will enable the development of several centres of excellence in CAM research in the United Kingdom (A. Walker, Department of Health [London], personal communication 2002). The United Kingdom CAM research strategy was formally launched in April 2002.

As stated in their response to the Select Committee, the Department of Health is also planning to issue a call for research proposals on the use of CAM in the care of patients with cancer (Department of Health [London] 2001).

The Medical Research Council plans to encourage collaboration among researchers in the biomedical and CAM fields. At least two groups have expressed interest in applying for Council funding to pursue CAM research. These are based at academic institutes in Southampton and Bournemouth (B. Smith, Department of Health [London], personal communication 2002).

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[32] See University of Exeter website http://www.ex.ac.uk/sshs/compmed/new_title.htm

[33] Set up in 1983 to carry out and promote rigorous research into complementary medicine. See http://www.rccm.org.uk/

UNITED STATES

In 1998 Congress established the National Center for Complementary and Alternative Medicine (NCCAM) at the National Institutes of Health (NIH). NCCAM has an annual budget of around $US 68 million to develop and promote CAM research. It conducts its own studies and also supports and funds the work of other organisations. In addition, NCCAM is involved in training CAM researchers and providing information on CAM.

NCCAM is currently focusing on:

- evaluating the safety and efficacy of widely used natural products such as herbal remedies and nutritional and food supplements (eg, mega-doses of vitamins)
- supporting pharmacological studies to determine the potential interactions of CAM products with standard treatment medications
- evaluating CAM modalities such as acupuncture and chiropractic.

NCCAM replaces a previous organisation, the Office of Alternative Medicine (OAM). Whereas OAM was primarily concerned with co-ordinating research and disseminating information, NCCAM has a much greater capacity to initiate and fund research.

There are also several CAM research centres based in academic institutions. These include the Center for Integrative Medicine[34] and the Cochrane Collaboration Complementary Medicine Field at the University of Maryland.

The White House Commission on Complementary and Alternative Medicine Policy (WHCCAMP) has made several recommendations for improving the quality and co-ordination of CAM research, including increased funding for Federal agencies that carry out research on CAM (WHCCAMP 2002).

CANADA

Apart from the evaluation of CAM products carried out by the Natural Health Products Directorate, there is as yet no national strategy on CAM research in Canada. The Natural Health Products Directorate has a comparatively small research budget of $Can 3 million over the next three years.

There are, however, many researchers working in the field in universities, and also two specialist research centres that focus specifically on CAM: the Research Centre for Alternative Medicine in Calgary, and the Tzu Chi Institute for Complementary and Alternative Medicine in Vancouver.

[34] See http://www.compmed.umm.edu

Research capacity and opportunities for collaboration in CAM research are growing. In 1999 the Integrative Medicine and Health Network was established. This group includes both CAM and non-CAM practitioners, researchers and scientists. It has proposed that a Canadian Office for Complementary and Alternative Health Care be established to guide the development of a coherent CAM research policy. The proposed Office would be part of the Canadian Institutes of Health Research, which is currently under development (de Bruyn 2001).

AUSTRALIA

Apart from the evaluation of complementary medicines and their ingredients carried out under the auspices of the Therapeutic Goods Administration, there is no national strategy on CAM research. In its 2002–03 Federal Budget Submission, the Australian Medical Association called on the federal government to provide $A 1 million to fund research on the potential benefits and adverse effects of complementary medicines and therapies (Australian Medical Association 2002), but this bid was not successful.

Current Australian research initiatives that deal with CAM include:

- the Centre for Complementary Medicine based at Monash University
- the Joanna Briggs Institute for Evidence Based Nursing and Midwifery,[35] which carries out and evaluates research on all aspects of nursing practice, including nurses' use of CAM
- the Australian Centre for Complementary Medicine Education and Research[36] (ACCMER), a new joint venture of the University of Queensland and Southern Cross University.

SINGAPORE

Traditional Chinese medicine (TCM) is covered by the Singapore government's life sciences research initiative. Some TCM research has been carried out by the National University of Singapore, the Health Sciences Authority, the National Cancer Centre and other institutions. There have been no structured studies of the improvement of outcomes by other CAM modalities.

[35] See http://www.joannabriggs.edu.au/

[36] See http://www.uq.edu.au/accmer/

CHINA

There are 72 traditional Chinese medicine (TCM) research institutes throughout China (Wong Kum Leng, Singapore Ministry of Health, Presentation 2001). TCM research is funded and co-ordinated by the State Administration of Traditional Chinese Medicine. There is a large amount of published and ongoing research on drugs and treatment techniques. Research is also under way to identify the mechanisms by which acupuncture works. Acupuncture has traditionally been explained as healing through manipulation of *chi* (vital energy), but Chinese as well as Western researchers now wish to understand it in modern scientific terms (Moyers 1993).

1.4 Integration of CAM into mainstream medicine

If some complementary and alternative treatments have the potential to relieve symptoms and improve health, consideration should be given to integrating such treatments into the publicly-funded health system. Arguments in favour of integration include the low cost and high degree of consumer satisfaction associated with some CAM treatments.

There are several issues to be considered when designing integrated health services. The House of Lords Select Committee on Science and Technology has identified a six-stage process for integrating CAM into mainstream general practice, and this process could be adapted and applied to integration in different health care settings (see Table 3).

Table 3: The six stages of integrating CAM into general practice

I.	Practice review – which needs are being poorly met?
II.	Resource assessment – is CAM relevant? What is its evidence base? Is integration feasible?
III.	Designing a service – asking how will GPs use the service? What will be its aims? How will CAM practitioners be integrated into the primary care team?
IV.	Delivering the service – developing referral procedures and working on resource monitoring.
V.	Management servicing – including quality assurance procedures and evaluating outcomes.
VI.	Modifying the service in response to experience.
Once modification has taken place the steps can start all over again, so the service is constantly self-monitoring and improving.	

Source: House of Lords Select Committee 2000: 105.

Integration of CAM and biomedicine occurs at different levels, from collaboration in the treatment of a particular patient (eg, referral from a GP) to full organisational integration (eg, the homoeopathic hospitals in the UK, see below). Integration can also take place in practitioner education, where the training courses available to CAM and biomedical practitioners might share some common elements, or at least seek to promote mutual understanding.

NEW ZEALAND

CAM is not currently formally integrated into the publicly-funded health system in New Zealand. There are, however, some CAM health services that receive public funding, including the following:

- ACC currently subsidises the cost of treatment for acupuncture, chiropractic and osteopathy services provided by specified providers.
- Work and Income New Zealand has a policy of paying a Disability Allowance for fees for alternative treatment needed by a person because of their disability. The service must, however, be provided by a registered health professional. Under some circumstances the cost of vitamins, supplements, herbal remedies and minerals can be included in the Disability Allowance.[37]

CAM services are also incorporated into some hospitals and health services, such as the following:

- The oncology ward at Wellington Hospital (Capital and Coast District Health Board) uses healing touch and aromatherapy as part of its care. No formal policy exists for their use (L. Johnson, Team Leader, Oncology Ward, personal communication, 2002). Aromatherapy is used for patients suffering from anxiety or insomnia. It is also sometimes used for nausea when conventional methods are unsuccessful. Healing touch is provided by one of the unit's nurses, who is fully trained in the modality. This is mainly used to relieve anxiety, insomnia and pain.
- The Pain Service at Burwood Hospital in Christchurch uses some CAM techniques in palliative care.
- The Health Enhancement Lifestyle Programme (HELP) has recently been launched in Rotorua. HELP is an integrated community initiative, which will advise patients on how to use CAM to improve their health.

The Medical Council of New Zealand has published guidelines for doctors who wish to incorporate elements of complementary or alternative medicine into their mainstream practice (Medical Council of New Zealand 1999). These recommend that doctors focus on treatments that have been proven to be effective, whether these treatments be biomedical or CAM-based.

An Australasian Integrative Medicine Association has been established to promote the integration of CAM into mainstream medical practice in Australia and New Zealand.[38]

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[37] See http://www.workandincome.govt.nz/manuals_and_procedures/income_support/extra_help/disability_allowance/index.htm

[38] See http://www.aima.net.au/

UNITED KINGDOM

CAM is not formally integrated into the UK health system. However, there is limited provision through the National Health Service (NHS).

Currently most NHS CAM is delivered through primary care, with some cases of CAM being delivered through secondary care. An independent study commissioned by the UK Department of Health reported that 40% of GP partnerships in England provide some level of access to CAM for NHS patients (House of Lords Select Committee 2000).

Whether primary care patients have NHS-funded access to CAM is dependent on their particular Primary Care Group (PCG) or Primary Care Trust (PCT). In June 2000 the Department of Health published a *Complementary Medicine Information Pack for Primary Care Groups*. This is intended to help PCGs and PCTs make informed decisions on the provision of CAM. It contains information on the CAM treatments most commonly encountered in primary care and offers guidance on commissioning services. A companion publication specifically for primary care clinicians has also been produced (Department of Health [London] 2000a; 2001b).

The Foundation for Integrated Medicine has identified 80 examples of successful integration within both primary and hospital services, demonstrating that provision is increasingly becoming available through the NHS. However, access to these services remains patchy (House of Lords Select Committee 2000).

The following are two examples of integration of CAM into primary care in the UK (House of Lords Select Committee 2000).

- The Marylebone Health Centre is an NHS general practice with a multidisciplinary team that includes CAM practitioners.
- The Southampton Centre for the Study of Complementary Medicine is an independent-provider organisation contracted by district health authorities to offer CAM services for specified conditions.

Areas where CAM is integrated into secondary care are as follows (House of Lords Select Committee 2000):

- Manipulative therapies such as osteopathy and chiropractic are integrated into orthopaedic care in some instances.
- Acupuncture and some ‘relaxant’ therapies have been integrated into some pain clinics.
- Acupuncture and occasionally aromatherapy have been integrated into some obstetric and cancer services, palliative care, rehabilitation and care of the elderly.
- Homoeopathy is provided within secondary care through five homoeopathic hospitals, such as the Glasgow Homoeopathic Hospital.

The Foundation for Integrated Medicine[39] has published a discussion document, *Integrated Healthcare: A way forward for the next five years?* (Foundation for Integrated Medicine 1997). It has also published a book on good practice in setting up and running integrated health services, which presents UK case studies from both primary and secondary care (Russo 2000).

UNITED STATES

Complementary medicine is not formally integrated into the US health care system. However, the concept of integrated medicine is probably more familiar to biomedical practitioners in the US, where it is known as *integrative medicine*, than it is in the UK. This is partly because many US medical schools already offer elective classes and seminars on complementary medicine (Bhattacharya 2000). Other medical courses are being restructured to increase their coverage of complementary medicine. A Consortium of Academic Health Centers for Integrative Medicine has been established to expand this process. The Consortium aims to have programmes on integrative medicine included in 20% of the 125 medical schools in the US within the next few years (Rees and Weil 2001).

A wide variety of biomedical practitioners and institutions in both the primary and secondary care sectors offer integrative medicine. One example is the Memorial Sloan-Kettering Cancer Center,[40] a private institution based in New York. The Center uses those CAM modalities that have the strongest evidence base to complement, rather than replace, mainstream treatments.

The White House Commission on Complementary and Alternative Medicine Policy (WHCCAMP) recommends that an agency be established within the Department of Health and Human Services to facilitate the integration of those CAM products and practices that have been shown to be safe and effective. It also calls for greater emphasis on the use of CAM in the management of chronic disease, and for insurers, managed care organisations and health purchasers to expand their coverage of CAM (WHCCAMP 2002).

CANADA

CAM is not formally integrated into the Canadian health care system. There are, however, some institutions that offer integrated health care. They include the following:

- The Tzu Chi Institute for Complementary and Alternative Medicine[41] in Vancouver is an independent, non-profit organisation. It offers integrated care delivered by a team that includes biomedical and naturopathic doctors, chiropractors, acupuncturists, massage therapists and registered nurses (York University Centre for Health Studies 1999).

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[39] The Foundation was set up to promote the development and integrated delivery of safe, effective and efficient forms of health care to patients and their families, through encouraging greater collaboration between all forms of health care. The Foundation undertakes work in the areas of delivery, education, information, regulation and research and development. See http://www.fimed.org

[40] See http://www.mskcc.org/mskcc/html/1979.cfm

[41] See http://www.tzu-chi.bc.ca/

- The Seven Oaks Wellness Centre in Winnipeg, which is associated with a general hospital, aims to 'provide the community with services that promote health, prevent illness and disability, and restore wellness of the body, mind and spirit' (Tataryn and Verhoef 2001).

AUSTRALIA

CAM is not formally integrated into the Australian health care system. However, many regulated biomedical practitioners offer CAM therapies alongside their mainstream practice.

Within primary care, a survey of GPs in Victoria found that over 80 percent of respondents had referred patients to CAM practitioners and 20 percent of respondents practise a complementary therapy themselves (Pirotta et al 2000). Acupuncture is the CAM most commonly adopted by GPs for inclusion within mainstream general practice (Australian Medical Association 2001). Around 15 percent of Australian GPs practise acupuncture. The Royal Australian College of General Practitioners now has special interest groups for members who practise acupuncture or nutritional medicine.

Interest in CAM has also grown within secondary care, particularly in obstetrics, gynaecology and rheumatology (Australian Medical Association 2002). Concerns have been raised about the lack of formal policies on patients who wish to continue using CAMs during their stay in hospital.

The Australian Medical Association has recently published a position statement on complementary medicine (2002). It acknowledges the growing popularity of CAM and recognises that 'evidence based aspects of complementary medicine are part of the repertoire of patient care and may have a role in mainstream medical practice'. An Australasian Integrative Medicine Association has been set up to promote the integration of CAM into mainstream medical practice in Australia and New Zealand.[42]

SINGAPORE

There are currently no plans to integrate CAM into the mainstream health care system in Singapore.

[42] See http://www.aima.net.au/

CHINA

Traditional Chinese Medicine (TCM) and biomedicine are fully integrated. The position of TCM is protected within China's constitution. The integration of TCM into the national health care system began in the late 1950s. This was overseen by health officials trained in biomedicine and the aim was to harmonise TCM with modern Western medicine. There has therefore been an emphasis on research and science-based education for TCM practitioners. It has been argued that biomedical control over the process of integration has led to important traditional aspects of TCM being lost or undervalued (Bodecker 2001), and some traditional practitioners feel that the form of TCM practised in places such as Taiwan and Hong Kong is more authentic than that found in mainland China.

The TCM sector is now managed by the State Administration of Traditional Chinese Medicine, which oversees all aspects of the TCM component of China's integrated health system. Today about 95 percent of general hospitals in China have traditional medicine departments. Each year they treat 200 million outpatients and almost three million inpatients (Bodecker 2001). Primary care is also integrated. Integration is more evident in primary and outpatient services than in inpatient care.

Section 2: Policy Issues Surrounding CAM

2.1 Regulation of CAM

Objectives of regulation

The main objective of regulation is improved consumer safety. It has been argued that effective regulation of the CAM sector is necessary to protect both consumers and the wider public interest (House of Lords Select Committee 2000). The Select Committee felt that statutory regulation is appropriate for some modalities and self-regulation for others. It recommended that statutory regulation be implemented for CAM modalities that potentially pose a significant risk to public safety (see pages 6–7). Likewise, all of the countries examined in Section 1 exercise some degree of regulatory control over CAM products as they recognise that, like conventional medicines, complementary medicines can pose risks to health.

Under the Health Practitioners Competence Assurance Bill, 'risk of harm to the public' is one of the key criteria for the statutory regulation of new professions. Currently unregulated or self-regulated CAM practitioners may therefore be eligible for statutory regulation in the future if their practice is judged to pose such a risk. The other test contained in the bill is whether it is 'otherwise in the public interest' that a profession be regulated.[43]

Statutory versus voluntary regulation

The House of Lords Select Committee remarked that whether regulation is statutory or voluntary might ultimately be of less importance than whether it is delivered effectively – by a single united body for each modality – and succeeds in protecting the public. It recommended that each self-regulated CAM modality establish a single professional body, and that these should be well promoted so that consumers are aware of them and can approach them for information.

However, some members of the Select Committee felt that encouraging formal self-regulation could endow some of the more controversial modalities with a status that was not justified by the evidence, and that this could potentially mislead consumers (Mills 2001b).

Effects of regulation on the CAM sector

For CAM practitioners, the advantages of effective regulation include enhanced professional status and the opportunity to enforce minimum standards for training and professional practice. Regulation may entitle practitioners to receive insurance-based or even mainstream health funding. Statutory regulation may also confer protection of title.

[43] HPCA Bill, clause 112.

For practitioners, the main disadvantage of regulation is the cost of becoming registered. In addition, practitioners who are unable to meet the criteria or costs of regulation might lose the right to practise. Consumer choice could therefore be restricted and costs to consumers increased. The costs of statutory regulation tend to be substantially higher than those of voluntary regulation.

Some of the countries discussed in Section 1 (eg, Canada) are currently changing the way CAM products are regulated. As with practitioners, stricter regulation of CAM products has the potential to raise compliance costs for manufacturers. If products are priced higher as a result, and some products withdrawn, consumer choice could be adversely affected.

Question

1 In your opinion, what are the main benefits and drawbacks of different types of regulation (eg, statutory, voluntary) for:
   – consumers and the wider public?
   – CAM practitioners?
   – other stakeholders?

Mainstream health professionals who also practise CAM

Regulated mainstream professionals such as doctors, nurses and dentists who also practice CAM are currently subject to the general provisions governing CAM (see pages 3–4) and to their own professional statutes.

Under the Health Practitioners Competence Assurance Bill, the registration authorities for the health professions covered by the legislation will be required to draw up scopes of practice describing the activities that practitioners are qualified to perform. Practitioners will be required to maintain lifelong competence within their scope of practice. Activities that carry significant risk will be restricted to regulated practitioners with appropriate training. This would have implications for statutorily regulated biomedical professionals who wish to practise CAM, and also for CAM practitioners who achieve statutory regulation in the future.

Voluntary CAM regulatory bodies may make specific rules for members who are also regulated health professionals. In the UK, the House of Lords Select Committee recommended that biomedical professionals who practise CAM 'should be trained to standards comparable to those set out for that particular therapy by the appropriate (single) CAM regulatory body' (House of Lords Select Committee 2000: para 5.83). The Select Committee also recommended that the biomedical regulatory bodies should develop clear guidelines for their members wishing to practise CAM. They were encouraged to communicate with the relevant CAM regulatory bodies to obtain advice on competency, best practice and appropriate training courses.

Question

2 How should mainstream health professionals (eg, doctors, nurses) who also practise CAM be regulated? For instance, should they:
   – have to obtain full registration as a CAM practitioner?
   – be required to meet minimum competence standards for CAM?
   – be exempt from additional regulation?

Multidisciplinary CAM practitioners

Some CAM disciplines encompass more than one modality. For example, practitioners of traditional Chinese medicine (TCM) often use both acupuncture and Chinese herbs. Should they be regulated separately under each modality? Or should there be a distinct regulatory category for practitioners of TCM that covers both modalities? This could be problematic if such practitioners decide to pursue statutory regulation.

Similarly, there are CAM practitioners who offer multiple, discrete therapies that are not necessarily related (eg, reflexology and homoeopathy). Should they be regulated separately under each modality? Or should there be special regulatory arrangements for multi-modality practitioners? The House of Lords Select Committee cautioned against the latter approach and expressed concerns about 'multi-therapy practitioners who want to mix a number of different therapies without being properly trained in one or more of them' (House of Lords Select Committee 2000: para 5.67). The Select Committee went further and suggested that such practitioners should have a grounding in a clinical discipline and some training in basic medical sciences.

Questions

3 Some CAM practitioners practise more than one form of CAM. In your opinion, how should such practitioners be regulated?

4 Should CAM practitioners be required to have sufficient medical science education to be able to:
   – make a safe diagnosis?
   – know when to refer patients on to mainstream health services?

Routes to statutory regulation

The Health Practitioners Competence Assurance Bill would enable CAM professions that meet the criteria (see page 26) for statutory regulation to become regulated in the future without the need for separate Acts. Such professions could simply be brought under the Act by Order in Council.[44]

[44] HPCA Bill, clause 111.

However, as well as meeting the risk and public interest criteria for statutory regulation, professions would need to work towards reaching a general agreement on qualifications, standards and competencies.[45] Because the CAM modalities vary widely in their stages of development and levels of organisation, it might be useful to develop a pathway or process to guide them to a common stage from which to apply for statutory regulation.

As statutory regulation will not be appropriate for all modalities, this pathway could include routes to alternative best practice options, such as voluntary self-regulation under a single, united professional association.

Question

5 The Health Practitioners Competence Assurance Bill may enable some CAM professions to become regulated by statute in the future. Do you agree that a clear process to achieve statutory regulation should be developed for such professions?

Can New Zealand learn from the experience of other countries?

New Zealand's approach to the statutory regulation of CAM practitioners differs from that of the other Western countries reviewed in Section 1 because it:

- regulates on a national rather than a state-by-state basis (unlike Canada, Australia and the United States)
- is proposing a single route to statutory regulation through the provisions of the Health Practitioners Competence Assurance Bill (the UK offers a similar option, through the provisions of the Health Act 1999, but the UK legislation offers practitioners two distinct routes to statutory regulation) (House of Lords Select Committee 2000: paras 5.41–5.50).

However, New Zealand may be able to learn from overseas experience in the area of voluntary or self-regulation, or in the regulation of CAM products. For example, it might be appropriate to adopt some of the House of Lords Select Committee's recommendations on the organisation of voluntary regulation within CAM, such as encouraging CAM modalities to organise themselves under effective self-regulatory protocols and strive to work together to overcome any conflicts within the profession.

[45] HPCA Bill, clause 112.

Questions

6 Should appropriate aspects of regulatory systems developed in other countries be adopted in New Zealand?

7 Which aspects would you suggest as most helpful? For instance, these might include overseas approaches to:
- statutory regulation
- voluntary regulation
- regulation of CAM practitioners
- regulation of CAM products
- other (please specify).

Is there an ongoing need for policy advice on CAM?

There is currently no ongoing capacity to provide advice on matters related to CAM at the national level. Given the growing popularity of CAM and the debate surrounding issues such as regulation, it might be appropriate for the Ministry of Health to include some capacity for an ongoing advice function in relation to CAM.

International models for such a capacity include the CAM team within the UK Department of Health. This is a small team that advises policy-makers on CAM-related matters, implements statutory regulation of CAM practitioners and promotes best practice in integration.

If the proposed trans-Tasman agency for the regulation of therapeutic products is established in 2004, some capacity for ongoing advice on CAM products would be built into the structure of the new regime. For example, the proposed joint agency would include a specialist sub-unit comprising staff with skills in CAM. It would obtain specialist technical advice from an advisory committee made up of New Zealand and Australian experts in CAM.

Questions

8 Should the Ministry of Health develop an ongoing capacity to address regulation and other policy issues connected with CAM?

9 Do you have any other comments about the regulation of CAM?

2.2 Consumer information needs

What sort of information do consumers require?

Provision of consumer information is currently fragmented. Action is required to find out what consumers need to know, and to give them better access to comprehensive, reliable and objective information about CAM. The proposed CAM database should go some way to meeting consumers' needs for information on safety and efficacy (see page 13).

Questions

10 Do you think that consumers need more, or better quality, information about CAM?

11 On what aspects of CAM do you feel consumers need more, or better quality, information? For example:
- safety
- effectiveness
- practitioners (eg, qualifications, contact details)
- regulation
- complaints procedures
- other (please specify).

Who should be responsible for informing consumers about CAM?

A variety of organisations currently provide information on different aspects of CAM. These include the Ministry of Health, consumer associations and various groups and individuals within the CAM sector (eg, practitioners, professional bodies, supplement manufacturers). However, no agency has overall responsibility for providing or co-ordinating consumer information on CAM in general, or for ensuring the quality and reliability of such information.

Through Medsafe, the Ministry of Health has taken the lead in providing safety information on herbal medicines (eg, product alerts) and has developed guidelines for manufacturers on providing consumer medicine information (CMI) (Medsafe 2001). The CMI guidelines could be adapted for use by CAM product manufacturers.

If the responsibility for informing consumers is left primarily to the CAM sector, there may be concerns about the quality and independence of the information available. Similarly, should the Ministry of Health decide to take on greater responsibility for the provision of consumer information, or adopt a co-ordinating role, the CAM sector may have concerns about objectivity, particularly regarding areas such as efficacy and risk.

It might therefore be appropriate for the Ministry to collaborate closely with CAM practitioners, practitioner associations and industry groups to agree roles in relation to information provision. It may not be desirable for all consumer information on CAM to come from one source, as consumers may want access to different viewpoints.

Questions

12 In your opinion, who should provide information on CAM? For example:
- individual CAM practitioners
- practitioner associations
- consumer groups
- the Ministry of Health
- other (please specify).

13 How do you think the information should be made available? For example, through:
- internet sites
- printed booklets or information sheets
- consultation with a health professional
- other (please specify).

14 Do you have any other comments about consumer information needs in relation to CAM?

2.3 Research, evidence and efficacy

Existing research and evidence on CAM

It is estimated that over 4000 research trials have been carried out on CAM to date (Peters and Gillam 2001). However, the quality of the research has been variable and there is a perception that the evidence base for CAM is weak (see pages 16–17). In addition, CAM research is not always easy to access and may be difficult for lay people to interpret.

It is important that consumers, practitioners and policy-makers have access to up-to-date, research-based evidence on CAM in order to make informed decisions. In particular, they need evidence on safety, efficacy and cost-effectiveness. The Ministry of Health's proposed CAM database will provide summaries of existing evidence on the safety and efficacy of CAM treatments (see page 13). It will also offer links to evidence-based CAM websites.

Evidence on the safety of CAM is particularly important. Apart from the legislation described in Section 1, there is currently no specific requirement for self-regulated CAM practitioners to provide evidence for the safety of their practice. However, if the proposals for a trans-Tasman agency to regulate therapeutic products become law, importers and manufacturers of CAM medicines will have to provide evidence for the safety of their products.

Very little research has been carried out on the cost-effectiveness of CAM, either in New Zealand or overseas (Peters and Gillam 2001).

Questions

15 Do you consider that consumers have satisfactory access to existing research on CAM?

16 What steps should be taken to improve access to existing research on CAM?

17 Do you believe that more research is required on CAM?

18 In your opinion, what aspects of CAM require further research? For example:
- safety
- efficacy
- cost-effectiveness
- other (please specify).

Appropriate research methods

There are difficulties in using 'conventional' quantitative methodologies, such as the randomised controlled trial (RCT), to evaluate some CAM modalities (Nahin and Strauss 2001). However, many argue that it is possible to apply the key principles of evidence-based medicine to CAM (Vickers 1999). For instance, RCTs can be designed to take important aspects of CAM, such as the patient–therapist interaction, into account (Vincent and Furnham 1997).

Other quantitative and qualitative methodologies may be more appropriate than RCTs, depending on the modality to be evaluated and the research question. The Foundation for Integrated Medicine has published a table suggesting appropriate research designs for investigating key CAM research questions (Foundation for Integrated Medicine 1997: section 2, p. 11).[46] The methods include case-control studies, action research and qualitative studies.

Question

19 What comments do you have, if any, on the kind of research methods that are appropriate for investigating CAM?

The concept of 'levels of evidence'

Biomedicine often uses a 'levels of evidence' model to grade evidence from treatment evaluation studies according to the research methods used (see Section 1.3, pages 16–17). Systematic reviews and RCTs are considered to offer the strongest evidence for the effectiveness of medical treatments. It might be appropriate to develop a similar model for research methods used to evaluate CAM treatments.

[46] Available at http://www.fimed.org/

Questions

20 Do you think the concept of 'levels of evidence' is useful in CAM research?

21 What 'levels of evidence' do you believe are appropriate?

CAM research in New Zealand

It may be appropriate to establish some kind of research group, or at least commission individual research projects, to evaluate CAM in the New Zealand context. There may be a role here for the Health Research Council,[47] the government-funded agency responsible for purchasing and co-ordinating health research in New Zealand.

Arguments against setting up such a group or commissioning New Zealand-based projects include the costs involved and the shortage of expertise in this field. An alternative option would be to build up links with, or commission work from, overseas research institutes with specialist CAM knowledge.

Given the limited capacity and funding available to support CAM research in New Zealand, it might be appropriate to examine areas such as consumer satisfaction here but look overseas for research on effectiveness and safety.

Questions

22 Should New Zealand be carrying out its own CAM research?

23 What areas should New Zealand CAM research focus on? For example:
- individual CAM modalities (eg, acupuncture, herbal medicine)
- particular disorders or health issues (eg, CAM for depression)
- certain population groups (eg, CAM for people with disabilities)
- other (please specify).

24 Who should carry out CAM research in New Zealand? For example:
- government agencies
- universities
- private research institutions
- CAM professional associations
- the CAM industry
- other (please specify).

[47] See http://www.hrc.govt.nz/

Evaluating existing research

If a dedicated CAM research programme is not possible given New Zealand's limited capacity, it might be appropriate to devote resources to evaluating the existing international research on CAM. An established research institute might be commissioned to carry out such an evaluation and advise on which findings to implement. The New Zealand Health Technology Assessment clearing house (NZHTA[48]) is an example of a New Zealand-based organisation that carries out this type of work. The NZHTA reviews and evaluates research on all aspects of health care, and has already carried out some work on CAM. NZHTA is based at the Christchurch School of Medicine.

Evaluated research summaries on the proposed CAM database may also eventually play a role in informing health policy in relation to CAM.

Questions

25 Who should be responsible for evaluating existing research on CAM?

26 Do you have any other comments about research, evidence and efficacy?

2.4 Integration of CAM into mainstream medicine

Integration of CAM into mainstream health services

It has been argued that complementary and alternative treatments that have the potential to relieve symptoms and improve health should be integrated into the mainstream, publicly-funded health system (see page 21).

Apart from China, none of the countries reviewed in Section 1 have formal policies on integrating CAM into the mainstream health system, and there is currently little research or guidance available on integration at the health system or organisational level.

Guidance on integration in primary care has been published in the UK (Department of Health [London] 2000a; 2000b), but there is currently no equivalent UK guidance on integration into secondary care.

The Foundation for Integrated Medicine has identified the main ways in which integrated care and publicly-funded CAM are delivered in the UK (Foundation for Integrated Medicine 1997). It found that most integrated care is provided by GPs and that, apart from specialist centres (eg, pain clinics, NHS homoeopathic hospitals), use of CAM in secondary care is 'haphazard'.

[48] See http://nzhta.chmeds.ac.nz/

Questions

27 Do you think there should be greater integration of CAM into mainstream health services?

28 In which health services would you like to see more integration of CAM? For example:
- general practice
- hospitals
- pain management clinics
- hospices
- other (please specify).

What are the criteria for greater integration of CAM?

Evidence of efficacy and safety is often regarded as a prerequisite for the integration of CAM into mainstream medicine, or for increased public funding of CAM (House of Lords Select Committee 2000; Australian Medical Association 2002). The Select Committee recommends that CAM practitioners who make specific claims about efficacy should be able to back these up with evidence 'above and beyond the placebo effect' (para 4.18), and that this is particularly important where CAM treatments are to receive public funding.

It has also been argued that integration should focus on chronic conditions and those for which biomedicine has been unable to fully meet patients' needs (Foundation for Integrated Medicine 1997).

Evidence of cost-effectiveness is also desirable, but little is currently available. However, some argue that it is occasionally appropriate to develop services in response to need and without conclusive evidence of cost-effectiveness (Peters and Gillam 2001). Examples are counselling and hospice care.

Question

29 Do you agree that:
- evidence of safety should be required before CAM is further integrated into mainstream health services?
- evidence of efficacy should be required before CAM is further integrated into mainstream services?
- integration should focus on conditions where mainstream medicine may not fully meet patients' needs (eg, pain, chronic fatigue)?

Models of successful integration

The House of Lords Select Committee suggests that there are several approaches to, and models of, successful integration, rather than a single route to be followed in all circumstances (para 9.8). It does, however, identify a basic six-stage pathway for integrating CAM into mainstream general practice, with key questions to be asked at each stage (see Section 1.4, Table 3, page 21). This could be used as a framework for integrating other types of health services.

For examples of different approaches to integration, the Foundation for Integrated Medicine has published a book on good practice in setting up and running integrated health services (Russo 2000).[49] It presents case studies from both primary and secondary care in the UK.

Question

30 There are different approaches to integrating CAM into mainstream health services. Do you think that the six-stage process outlined in Table 3 is a good model to follow?

Integration in practitioner education

It is sometimes suggested there should be common elements in the core undergraduate curriculum of all health practitioners, whether biomedical or CAM (eg, Foundation for Integrated Medicine 1997). Medical schools in New Zealand currently offer no formal study options on complementary medicine, but CAM may be covered to some extent within other modules. Most nursing courses do at least touch on CAM, and more formal education is available at some polytechnics and to nurses training for certain specialties (eg, palliative care).

Many CAM training courses include 'conventional' biomedical subjects such as anatomy and physiology. However, the depth of coverage varies between modalities and even from course to course within modalities. Chiropractic and osteopathy courses tend to have a particularly strong biomedical component. For example, the double degree in chiropractic currently based at the University of Auckland requires students to complete a bachelor's degree in physiology as part of their studies for a master's degree in chiropractic.

Question

31 Integration can also take place in practitioner education and training. In your opinion, should:

- mainstream practitioners (eg, doctors, nurses, physiotherapists) undergo some formal education about CAM?
- CAM practitioners receive some basic medical training?

[49] Details available from http://www.fimed.org/

Creating a more integrated culture

Integrated services are more likely to succeed in a culture that values both CAM and mainstream practitioners, and encourages tolerance and mutual respect. Even when services are not formally integrated, an integrated culture has several advantages. For example, it enables patients who use CAM to be open with their doctor and share important information about any CAM medicines they are taking.

The Foundation for Integrated Medicine has identified a number of factors that promote an integrated culture (Foundation for Integrated Medicine 1997). These include:

- high-quality training and research
- communication and collaboration between medical and CAM professions
- evidence-based protocols for referral and care
- early recognition of the relevance of non-conventional approaches
- enabling patients to actively participate in their own healing processes
- monitoring of both patient and practitioner satisfaction with services
- mutual recognition of the limitations of practitioners and services
- networking to disseminate good practice.

Developments overseas suggest that biomedical tolerance and acceptance of CAM is growing. For example, the Australian Medical Association's recent position statement acknowledges the growing popularity of CAM in Australia and recognises that 'evidence based aspects of complementary medicine are part of the repertoire of patient care and may have a role in mainstream medical practice' (Australian Medical Association 2002).

Question

32 Do you have any comments on how a more integrated culture that embraces both CAM and mainstream practitioners, and promotes tolerance, autonomy and professionalism, might be created?

Can CAM help achieve the goals of the New Zealand Health Strategy?

The New Zealand Health Strategy identifies 13 priority objectives for improving the health of the population (Minister of Health 2000). These are:

- reducing smoking
- improving nutrition
- reducing obesity
- increasing the level of physical activity
- reducing the rate of suicides and suicide attempts
- minimising harm caused by alcohol and illicit and other drug use to individuals and the community
- reducing the incidence and impact of cancer
- reducing the incidence and impact of cardiovascular disease

- reducing the incidence and impact of diabetes
- improving oral health
- reducing violence in interpersonal relationships, families, schools and communities
- improving the health status of people with severe mental illness
- ensuring access to appropriate child health care services including well child and family health care and immunisation.

It may be appropriate to determine whether greater integration of CAM into mainstream medicine would help to achieve these objectives, and to examine how this could be done. For example, evidence-based CAM treatments could be incorporated into the toolkits[50] developed for some of the 13 priority areas.

Questions

33 Do you think that greater integration of CAM into mainstream medicine could help achieve the objectives of the New Zealand Health Strategy?

34 How might the New Zealand Health Strategy priority areas benefit from further integration of:
- CAM practitioners?
- CAM modalities?
- CAM products?

35 Do you have any other comments about the integration of CAM into mainstream medicine?

36 Do you want to make any other comments about the issues raised in this discussion document?

[50] Toolkits have been developed for each of the 13 priority areas of the New Zealand Health Strategy. They contain resources and useful information, such as details of relevant evidence-based treatments. See http://www.newhealth.govt.nz/toolkits/toolkits.htm

Appendix 1: Terms of Reference for the Ministerial Advisory Committee on Complementary and Alternative Health (MACCAH)

The key tasks for the Committee are to:

a) provide information and advice to the Minister on complementary and alternative health care

b) provide advice on how complementary and alternative health care can improve outcomes in the priority areas signalled in the New Zealand Health Strategy

c) provide advice on the need, or otherwise, to regulate complementary and alternative health care practitioners in order to protect consumers who use complementary and alternative health care

d) provide advice on consumer information needs and, in particular, advice on the benefits, risks and costs of complementary and alternative therapies

e) review overseas evidence-based research, identify priorities for the development of New Zealand evidence-based research on the safety and efficacy of specific complementary and alternative therapies, and support the development of guidelines

f) provide advice on whether, and how, specified complementary and alternative health practitioners should be integrated into the mainstream health system.

Appendix 2: Membership of MACCAH

Prof Peggy Koopman-Boyden (Chair)
David Holden
Dr Rhys Jones
Melva Martin
James McNeill
Janine Randle
Dr Maika Veikune
Marilyn Wright
Dr Tim Ewer (Committee Advisor)

Secretariat

Amanda Bowens (Analyst)
Sheryl Hall (Executive Assistant)

Contact details

Ministerial Advisory Committee on Complementary and Alternative Health (MACCAH)
Ministry of Health
133 Molesworth Street
PO Box 5013
Wellington
Fax: (04) 496 2340
Email: maccahdoc@moh.govt.nz
Web: http://www.newhealth.govt.nz/maccah.htm

Appendix 3: CAM Modalities Currently Practised in New Zealand

CAM modalities currently practised in New Zealand[51]	
Action potential stimulation therapy	Intuitive healing
Acupuncture	Iridology
Alexander technique	Isopathy
Anthroposophical medicine	Jin Shin Jyutsu
Applied Feng Shui	Kinesiology
Applied iridology	Maharishi's Vedic approach to health (Maharishi Ayur-Veda)
Aromatherapy	Massage (therapeutic and remedial)
Aura-soma colour therapy	Medical herbalism
Ayurveda	Medium channelling/intuitive healing
Bach flower remedies	Natural healing sciences
Bio-energy therapy	Naturopathy
Biological medicine	Neurofeedback (EEG biofeedback)
Body electronics	Neuro-linguistic kinesiology
Bowen therapy	Neuro-linguistic programming (NLP)
Caeteris body/mind energy balancing	Oriental massage
Chi Kung	Ortho-bionomy
Chinese herbal medicine	Osteopathy
Chiropractic	Paramedical aesthetics and aesthetic medicine
Colon hydrotherapy	Pacific traditional healing modalities
Colour therapy	Pilates based body conditioning
Cranio-sacral therapy	Primal healing
Crystal therapy	Psychotherapy
Dynamic phytotherapy	Rebirthing
Educational kinesiology	Reflexology
Feldenkrais	Reiki
Flower essence therapy	Rife therapy
Gentle therapeutic manipulation	Rolfing (structural integration)
Hellerwork	Sclerology
Herbal medicine	Shiatsu
Holistic animal therapy	Spiritual healing
Holistic pulsing	Sports therapy
Homoeobotanical therapy	Touch for health
Homoeopathy	Traditional Chinese medicine
Human potential	Vegatest method
Hypnotherapy	
Ifas	

[51] This table lists complementary and alternative therapies currently practised in New Zealand. It provides an indication of the range and number of therapies available, but should not be regarded as a definitive list.

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