THE FALL OF THE BAMBOO CURTAIN: A REVIEW OF COMPLEMENTARY MEDICINE IN SOUTH AFRICA

By KS Caldis, HD McLeod and PR Smith

ABSTRACT
This paper considers the increased interest in and usage of complementary medicine. The movement is being led worldwide, not by healthcare professionals or the funders of healthcare, but by consumers. In South Africa, a pilot study was undertaken in 1999 to identify existing sources of data and collate information as an initial baseline of the practice of and interest in complementary medicine. The paper summarises the findings of that study. The legal framework for the practice of complementary medicine in South Africa is described, the range of therapies is given and the number of practitioners is estimated. First indications of the use by consumers and the coverage by medical schemes are reported. An introduction to the status of African traditional medicine is given. Resources for the actuary wishing to gain more understanding of this consumer-driven movement are suggested.

KEYWORDS
Healthcare; complementary medicine; alternative medicine; traditional medicine; medical schemes.

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1. INTRODUCTION

1.1 The first definitive study of the use of complementary medicine in the USA (Eisenberg et al, 1993) estimated that more than one-third of Americans used alternative therapies. Three-quarters of the amount spent was not reimbursed by insurers or medical systems.

1.2 The Eisenberg study prompted a fundamental reassessment by healthcare funders of the direction in which consumers were leading them. A further study (Eisenberg et al, 1998) showed that alternative medicine visits exceeded visits to primary care physicians.

1.3 17 December 1997 has been heralded as “The Fall of the Bamboo Curtain”. It marks the date on which the Journal of the American Medical Association committed itself to publishing papers on complementary therapies as a result of pressure from its readers.
1.4 This paper outlines the movement that is being led worldwide, not by healthcare professionals or the funders of healthcare, but by consumers. Section 2 clarifies terminology and Section 3 highlights trends in the USA and other countries.

1.5 In South Africa, a pilot study was undertaken in 1999 to identify existing sources of data and collate information as an initial baseline of the practice of and interest in complementary medicine. This paper summarises the findings of that study. The impetus for the study is described in Section 4.

1.6 The legal framework for the practice of complementary medicine in South Africa is described in Section 5 and industry associations in Section 6. The number of practitioners and the range of therapies are described in Sections 7 to 9. Indications of use by consumers and the coverage by medical schemes are reported in Sections 10 and 11. Section 12 touches on the status of African traditional medicine. This is of necessity a short introduction to a topic that deserves a full paper in its own right. Conclusions and recommendations for further research are made in Section 13.

1.7 Appendix A gives a description of each of the registered therapies in order to give the actuarial reader a brief introduction to each modality. In Appendix B the authors suggest further resources for the reader wishing to gain more understanding of complementary medicine. The recommendations have been drawn from a list, developed by the Complementary Medicine Trust, of books that are being donated to medical school libraries in South Africa.

2. A NOTE ON TERMINOLOGY

2.1 DEFINITIONS IN COMMON USAGE

2.1.1 “Allopathic medicine” is commonly used to describe the health model that dominates the Western world. Neither “conventional medicine”, “Western medicine” nor “scientific medicine” are accurate and Leslie (1976) suggests that “cosmopolitan medicine” best describes that model when practised throughout the world. A term that is increasingly used for this model is “bio-medicine”.

2.1.2 The World Health Organisation (WHO) uses the term “traditional medicine” to refer to ways of protecting and restoring health that existed before the arrival of modern medicine. These approaches to health belong to the traditions of each country and have been handed down from generation to generation.

2.1.3 “CAM” is often used in the USA as an abbreviation for complementary and alternative medicine. The use of the word “alternative” is controversial as these modalities are not usually seen as a replacement for allopathic medicine. “Naturopathic medicine” has become widely used as an umbrella term to cover a range of therapies. The term “integrative medicine” is emerging in the USA to describe an attempt at fusion between the various schools.

2.1.4 Practitioners in South Africa prefer to use the term “complementary
medicine”. The term “complementary” is used to indicate that the therapies are complementary to the body’s own healing systems.

2.2 FORMAL DEFINITIONS OF COMPLEMENTARY MEDICINE IN SOUTH AFRICA

2.2.1 The legislation that established the legal framework for complementary medicine in South Africa does not specifically define the term. It does, however, classify professions that fall under the Allied Health Professions Council (Section 5.2) as those which have as their objective “the promotion of health, or the treatment, prevention or relief of physical or mental defects, illnesses or deficiencies in humans.”

2.2.2 A comprehensive definition of the medicinal substances used in complementary medicine is given for the first time in the SAMMDRA Act (Section 5.3):

“Complementary Medicine means any substance or mixture of substances, originating from a plant, mineral or animal, which may be, but is not limited to being classified as herbal, homeopathic, ayurvedic or nutritional, used or intended to be used for or manufactured or sold for use in complementing the healing power of a human body or animal body or for which there is a claim regarding its effect in complementing the healing power of an animal or human body in the treatment, modification, alleviation or prevention of disease, abnormal physical or mental state, or the symptoms thereof in a human being, and may encompass substances or mixtures of substances used in the disciplines generally referred to as Western Herbal medicine, African Traditional medicine, traditional Chinese medicine, traditional Dutch medicine, Homeopathy, Ayurveda, Aromatherapy and food supplementation.”

3. AN INTERNATIONAL PERSPECTIVE

3.1 THE USA STUDIES OF CONSUMER DEMAND

3.1.1 The first definitive study in the use of complementary medicine in the USA was published by David Eisenberg in 1993 in the New England Journal of Medicine. He found that more than one-third of Americans used alternative therapies. The study estimated that some $13.7 billion was spent in 1990 on alternative healthcare, including services from providers, materials, herbs and supplements. An estimated three-quarters of this amount was not reimbursed by insurers or medical systems.

3.1.2 A follow-up study (Eisenberg et al, 1998), showed the use of alternative medicine had increased by almost 50% between 1990 and 1997. By 1997, alternative medicine visits exceeded visits to primary care physicians. The authors report that 58% of users chose alternative therapies to “prevent future illness from occurring or to maintain health and vitality”, with 42% using therapies to combat existing chronic conditions.

3.1.3 Landmark Healthcare, which develops networks of CAM providers, updated the Eisenberg study in 1998 but only interviewed individuals who were covered by health insurance. 42% of individuals reported having used CAM in the previous year, with 74% of usage occurring along with conventional care. 45% of consumers would pay more for their health plan in order to have access to CAM and 67% said the availability of CAM benefits was a factor in choosing a health plan.


3.1.4 Other estimates of CAM expenditure (Stoneham, 1998) suggest a higher usage than shown by the consumer surveys. The estimate from the USA National Institute of Health (NIH) Office of Alternative Medicine is $25 billion, based on surveys of usage amongst cancer patients. An estimate by a Columbia HCA (health plan provider) work group on alternative medicine, estimated spending in the range $22 billion to $50 billion.

3.1.5 Dr Wayne Jonas of the Office of Alternative Medicine at the NIH suggests the increasing popularity of complementary and alternative medicine reflects changing needs and values in modern society in general. Those changes include an increasing societal scepticism toward (conventional) medicine, widening public access to health information, and a general rise in interest in spiritual matters.

3.2 THE REACTION OF PHYSICIANS IN THE USA

3.2.1 The editorial in the Journal of the American Medical Association (JAMA) of 17 December 1997 is regarded as being as paradigm-breaking as the first Eisenberg study. The date marks the publication by JAMA of internal surveys showing rapidly growing interest among US physicians, with the ranking of CAM moving from 68 to “the top three” in the space of one year. As a result of the surveys, the American Medical Association editors called for papers on CAM, announced a special issue of JAMA each year on CAM and committed all publications in the group to carrying more reports on CAM topics. JAMA’s editor said “The bamboo curtain (between CAM and conventional medicine) is beginning to splinter”. This announcement was hailed by commentators as “a Copernican revolution” in healthcare (Complementary Medicine Trust, 1999). The publication by JAMA of material on CAM is expected to further stimulate interest amongst physicians and consumers.

3.2.2 John Weeks, editor of the newsletter *Alternative Medicine Integration and Coverage*, explained the metaphor of the bamboo curtain as “being, appropriately, from the era of the Cold War. The freeze in communication between the medicines, behind which lies were told (on both sides), is officially melting” (Weeks, 1997).

3.2.3 Growth of interest by medical schools has been substantial, with more than 60 of the medical schools in the USA (slightly less than one half) offering some CAM instruction by 1998. Physician-education organisations have also been increasing efforts to develop standards and curricula for CAM education (Complementary Medicine Trust, 1999).

3.3 THE REACTION OF ACTUARIES IN THE USA

The Society of Actuaries has developed a special interest section on the topic, the Committee on Alternative Care.

3.4 THE REQUIREMENT FOR EVIDENCE-BASED HEALTHCARE

3.4.1 The resistance of health plans to coverage of CAM in the past has pointed to the supposed lack of controlled scientific studies. Two developments have impacted on the perceptions of the authority of “scientific medicine” (Complementary Medicine Trust, 1999).
3.4.2 The firm of Milliman & Robertson clarified the process of development by clinicians and actuaries of their widely used healthcare guidelines. These are based on best observed practices and published research, but it is noted that estimates put the proportion of current (allopathic) practices supported by controlled scientific studies at only 15%.

3.4.3 Readers may be familiar with the so-called “gold standard” of randomised double-blind controlled trials for determining the efficacy of new medications. The Federal Drug Administration in the USA, in the FDA Modernisation Act, has altered the definition of what constitutes acceptable healthcare economic information, changing the standard from randomised controlled trials to “competent and reliable scientific evidence”.

3.4.4 There is increased visibility for the literature and clinical studies of complementary medicine. By way of illustration, Murray & Pizzorno’s two volume *Textbook of Natural Medicine*, in its second edition in 1999, cited more than 10 000 peer-reviewed articles.

3.5 THE REACTION OF HEALTH PLANS IN THE USA

3.5.1 The Connecticut-based Oxford Health Plan began to experiment with CAM coverage in the early 1990s, first offering a product internally to employees. On 1 January 1997 CAM coverage was extended to its clients. At the launch, the founder and chairman, Stephen Wiggins, said, “You ignore the consumer at your own peril”.

3.5.2 Landmark Healthcare conducted a study of 80 national health maintenance organisations in 1996. The survey found that 58% intended to offer alternative-care therapies to members within two years (Landmark, 1998).

3.5.3 An Oregon insurer and HMO (Health Maintenance Organisation) added core benefits for treatment by chiropractors, acupuncturists, naturopathic physicians and massage therapists at no additional cost to its members as they renewed their policies in 2000.

3.5.4 In Washington State, health plans are mandated to provide CAM coverage alongside allopathic benefits.

3.5.5 Interested readers are referred to two publications that regularly report on the incorporation of complementary medicine by health plans, namely *Alternative Medicine Integration and Coverage* and *The Townsend Letter for Doctors and Patients*.

3.6 THE REACTION OF EMPLOYERS IN THE USA

3.6.1 World-at-Work (previously the American Compensation Association) released results of a study of compensation arrangements in April 2000. 46% of respondents reported that their employer offered some form of CAM benefits. This increased to 50% for companies with over 5000 employees

3.6.2 Of the employers who offered CAM benefits, 45% reported doing so for consumer-driven reasons. The other 55% reported a variety of cost and quality reasons as shown in Table 1.
TABLE 1. USA employers’ reasons for offering CAM benefits to employees

<table>
<thead>
<tr>
<th>% of Employers</th>
<th>Consumer-Driven</th>
<th>Cost/Quality Driven</th>
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<tbody>
<tr>
<td>45%</td>
<td></td>
<td>55%</td>
</tr>
<tr>
<td>Employee requests 27%</td>
<td>Potential for more effective and less invasive medical care 14%</td>
<td></td>
</tr>
<tr>
<td>State mandates 9%</td>
<td>Potential for long-term group health plan savings 11%</td>
<td></td>
</tr>
<tr>
<td>Employee attraction and retention 9%</td>
<td>Potential to address rising costs of health and disability benefits 14%</td>
<td></td>
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3.7 A WORLD-WIDE PHENOMENON

3.7.1 There has been substantial growth in the use of medicinal plant preparations in the developed world (WHO, 1996). In Japan, the use of mainstream pharmaceuticals doubled between 1974 and 1989, whereas the use of herbal medicines increased to fifteen times its previous level. A survey in the European Economic Community in 1991 identified 1400 herbal medicines in regular use. In Germany, the herb St John’s wort is the most frequently prescribed medicine for depression.

3.7.2 The WHO’s Traditional Medicine Programme reports that there has been a growing interest in complementary medicine in many developed countries over the last decade. Sixty per cent of the public in the Netherlands and Belgium, and 74% in the United Kingdom, are in favour of complementary medicine being available in their respective national health services.

3.7.3 A study of the prevalence of alternative medicine in Australia (MacLennan, Wilson & Taylor, 1996) indicates usage in line with the findings of the Eisenberg study in the USA. Expenditure on alternative medicines for 1993 was estimated at $AU621m compared to $AU360m for all classes of pharmaceutical drugs purchased in Australia in 1992–93.

3.7.4 In a WHO Health Bulletin, Ernst (2000) reports that more than 100 surveys have been published on the use of complementary medicine in various countries. Despite people generally having to pay from their own pockets, the popularity of complementary medicine is increasing in developed countries. A substantial proportion do not inform their doctors of the use of complementary medicine. It is generally acknowledged that this change in usage is being led by consumers, rather than medical professionals or the public sector.
4. THE SOUTH AFRICAN PILOT STUDY

4.1 The National Health Accounts Project of the South African Department of Health was due for completion in late 2000. The first objective was to collate data on total healthcare expenditure in the public and private sectors for the financial years 1997 to 1999. The longer-term objective is to create a set of information to be used to monitor the implementation of health policies and assess the efficiency of the allocation of resources.

4.2 Dr Judith Cornell, an editor of the Project, planned to include a section on the development of complementary medicine. To the knowledge of the authors, no comprehensive studies on complementary medicine usage had been undertaken in South Africa. The Complementary Medicine Trust thus commissioned and funded a pilot study to identify existing sources of data and collate information as an initial baseline of the practice and interest in complementary medicine. The study was undertaken by a research team from the University of Cape Town, led by Katy Caldis and supervised by Heather McLeod.

4.3 The researchers contacted the professional bodies representing practitioners and extended their search for source material using contacts in the complementary medicine professions. The people and organisations who assisted in this study are acknowledged at the end of the paper. The report was completed in May 2000.

5. THE LEGISLATIVE FRAMEWORK

5.1 REGULATION OF HEALTHCARE PRACTITIONERS

5.1.1 All healthcare practitioners must be registered in order to practise in South Africa. To qualify for registration, the practitioner must have achieved a minimum standard of training at an institution accredited by the relevant Council set up by the Department of Health. The Councils are responsible for the registration of practitioners, the setting of educational requirements for registration and the general regulation of the healthcare professions.

5.1.2 Legislation formalising the Health Professions Council (previously the South African Medical and Dental Council), the Dental Technicians Council, the Nursing Council and the Pharmacy Council has been enacted. The regulation structure is shown in Figure 1.

5.1.3 Legislation formalising the Allied Health Professions Council was signed on 29 November 2000. The Allied Health Professions have been governed by an “Interim Council” since February 1996. (See Section 5.2).

5.1.4 The proposed Traditional Healers Council of South Africa is still at the stage of an “Interim Committee”. (See Section 12). Neither the Health Professions Act nor the Allied Health Professions Act are to be construed as derogating from the right that herbalists have to practise their profession in terms of the Code of Zulu Law.
5.2 REGULATION OF COMPLEMENTARY MEDICINE PRACTITIONERS

5.2.1 The formal recognition of complementary medicine practitioners in South Africa has taken many years. Chiropractors, herbalists, homeopaths, naturopaths and osteopaths were able to register during a six-month period in 1974, following which the registers were closed. The Associated Health Service Professions Act, Act No. 63 of 1982, provided for the establishment of the South African Associated Health Service Professions Board. The registers for chiropractic and homeopathy were reopened in 1985. In the early 1990s, the Confederation of Complementary Health Associations of South Africa (COCHASA) lobbied for the recognition of complementary practitioners. However, apart from a window period to allow for the registration of aggrieved practitioners in 1996, the registers for phytotherapy, naturopathy and osteopathy remained closed.

5.2.2 Act No. 63 of 1982, which remains the “principal Act”, has subsequently been amended by Act No. 108 of 1985, Act No. 10 of 1990, Act No. 63 of 1993 and Act No. 40 of 1995. Since 1995, the title of the principal Act has been the Chiropractors, Homeopaths and Allied Health Service Professions Act, 1982.

5.2.3 The 1995 amendments established the Chiropractors, Homeopaths and Allied Health Service Professions Interim Council (the “Interim Council”). One of the objects of this body was to make recommendations to the Minister of Health on the constitution of a council that included other treatment modalities. The term of the Interim Council was extended twice.

5.2.4 29 November 2000 could be regarded as the fall of the South African bamboo curtain. On that date, President Mbeki signed the Chiropractors, Homeopaths and Allied Health Service Professions Second Amendment Act (Act No. 50, 2000). This
amends the principal Act of 1982, renaming it the Allied Health Professions Act, 1982, and providing for the establishment of the Allied Health Professions Council.

5.2.5 The Allied Health Professions Act allows for ten treatment modalities to be registered initially. Provision is made in the Act to accommodate other modalities that seek registration at a later date. During the term of the Interim Council, each of the ten modalities was represented by a Professional Liaison Committee. These are to remain in place and be controlled by four Professional Boards, as shown in Figure 2.

5.2.6 The Professional Boards may recommend Council to approve training schools; conduct examinations and grant certificates; recommend Council to register students, interns and practitioners; and investigate the professional conduct of registered practitioners.

5.2.7 All healthcare practitioners will be required to register separately under each treatment modality that they practise. This means, for example, that a medical doctor practising acupuncture will require dual registration, firstly under the Health Professions Council as a medical doctor and secondly under the Allied Health Professions Council as an acupuncturist.

5.3 REGULATION OF MEDICINAL SUBSTANCES

5.3.1 The South African Medicines and Medical Devices Regulatory Authority (SAMMDRA) is to replace the Medicines Control Council (MCC). The legislation was initially passed in April 1999, but was subsequently withdrawn for revision. The SAMMDRA Act provides for the regulation of medical technology and all medicinal substances.
5.3.2 It is envisaged that SAMMDRA will have four autonomous technical committees, one of which is specifically for complementary medicine (Figure 3). This is important as it means that in the future, complementary medicines will be regulated by appropriately trained and qualified specialists in the field.

5.3.3 In recent years there has been an influx of a large number of herbal and other health products to the South African market. Without an appropriate registration system, many of these are sold without control, and a grey market in these medicines has evolved.

5.3.4 Therapies like ayurveda have been unable to register substances, despite the fact that these substances have proven efficacy and safety records in other parts of the world where they form the basis of established healthcare systems.

5.3.5 The existing requirement for double-blind testing of all substances is not appropriate, considering that unlike new pharmaceuticals, many complementary medicines have been safely used around the world for many centuries.

5.3.6 A Complementary Medicines Committee has been formed, which has the goal of creating a registration process that is:
– appropriate to the disciplines falling under this group of medicines;
– responsible (i.e. not compromising the three criteria of safety, quality and efficacy); and
– quick and largely self-regulating.

5.3.7 The proposed method of control of complementary medicines is the “Accelerated Registration Programme”. A listing of products has been compiled by technical specialists representing each of the complementary medicine modalities. Substances that have been rigorously tested for safety and efficacy in other parts of the world will not have to be retested in South Africa. As long as a product contains only substances from accepted pharmacopoeia, at safe dosages, the product will then only need
testing to ascertain that it is produced under good manufacturing procedures and to verify the contents.

5.3.8 The listing of the known pharmacopoeia includes herbal medicines from France, Germany, Switzerland, China, India and the USA; anthroposophical, ayurvedic and homeopathic medicines; energy medicines (such as flower essences) and nutritional supplements.

5.3.9 It seems unlikely that the system of control described for complementary medicines could be implemented until the SAMMDRA Act is passed. Several therapies can thus not legally obtain the substances they require and this encourages a disregard for the law.

6. INDUSTRY ASSOCIATIONS AND OTHER SOURCES OF DATA

6.1 SACMA

6.1.1 The South African Complementary Medicine Association (SACMA) was established in 1991 to support and promote complementary medicine in South Africa, as practised by medical practitioners. It is a special interest group of the South African Medical Association and is responsible for setting standards for practice, training and peer review for those doctors practising complementary medicine.

6.1.2 There are five interest groups under SACMA representing different therapies. Acupuncture is the largest interest group, followed by homeopathy.

6.1.3 In early 2000 there were 400 registered members of SACMA. Associate membership is offered to students, registered paramedical practitioners, nurses, veterinarians and pharmacists. The Complementary Medicine Journal is produced and distributed quarterly.

6.2 COCHASA

6.2.1 The Confederation of Complementary Health Associations of South Africa (COCHASA) was established in November 1992, by a group of twelve associations, to represent the interests of all complementary health associations. COCHASA has assisted associations to set their scope of practice, code of ethics and standards of training. COCHASA has played an important role in the lobbying process to establish the Allied Health Professions Council.

6.2.2 COCHASA will continue to assist groups to apply for registration and to represent small groups who are unlikely to achieve registration in the near future, for example, polarity therapy. In 2000, COCHASA extended its membership to include individual practitioners.

6.3 THE NATURAL HEALTH DIRECTORY

6.3.1 The Natural Health Directory is an annual publication which includes descriptions of complementary and alternative health therapies available in South Africa. The directory includes lists of practitioners and their contact details.

6.3.2 The practitioner lists are sponsored for the major therapies; the lists therefore
include entries for all members of the professional associations. For other therapies, practitioners cover the cost of entries themselves and the numbers are under-reported.

7. PRACTITIONERS OF COMPLEMENTARY MEDICINE

7.1 NUMBERS AND REGIONAL DISTRIBUTION OF PRACTITIONERS

7.1.1 There has been a rapid growth in the number of registered practitioners since the census in 1994, as shown in Table 2. The growth is accounted for exclusively by the growth in the number of chiropractors and homeopaths, as these are the only two professions in the census for which new registration was possible during the period in question.

<table>
<thead>
<tr>
<th>Year</th>
<th>Number of Practitioners</th>
<th>Source of Data</th>
</tr>
</thead>
<tbody>
<tr>
<td>1987</td>
<td>368</td>
<td>Government census of practitioners</td>
</tr>
<tr>
<td>1994</td>
<td>424</td>
<td>Government census of practitioners</td>
</tr>
<tr>
<td>1999</td>
<td>874</td>
<td>Interim Council and Natural Health Directory</td>
</tr>
</tbody>
</table>

7.1.2 The authors estimate there may be 2,665 potential complementary medicine practitioners across all modalities. The estimate is based on data from SACMA (covering medical doctors practising complementary medicine), registered practitioners for therapies where a register is open, professional association mailing lists and where no other data is available, the numbers of practitioners advertising in the Natural Health Directory.

7.1.3 The use of data from the professional associations may result in undercounting as membership of these associations is voluntary. For the two professions where registers are already available, namely chiropractic and homeopathy, it is possible to evaluate the extent of under-counting. For chiropractic, the estimate using the professional association data and the Natural Health Directory would be 150 chiropractic practitioners, whereas the official register has 258 practitioners. For homeopathy, the estimate would be 273 practitioners whereas the official register has approximately 500 members. For these two professions the figures from the registers have been used.

7.1.4 It is possible that in the professions with no official register, the role of the professional association may be more important and thus the count of practitioners may be more accurate. Accurate numbers will only be available once the Allied Health Professions Council is fully functional.

7.1.5 Initial estimates from the Council in April 2001 are that at least 2500 registrations are expected. A breakdown by modality is not yet available. The estimate of 2665 practitioners made by the authors nearly a year earlier thus seems to be reasonable.

7.1.6 The SACMA mailing lists include doctors who practise complementary medicine as well as those who have merely expressed an interest in complementary
medicine. The authors estimate that, at most, 15% of the expected number of complimentary practitioners will have trained as medical practitioners. The provincial estimates of medically and non-medically trained practitioners are shown in Figure 4.

7.1.7 Almost all practitioners are found in urban areas. As expected, Gauteng and the Western Cape dominate in the geographical distribution of practitioners in Figure 5.

FIGURE 4. Expected numbers of complementary medicine practitioners by modality

![Expected numbers of complementary medicine practitioners by modality](image)

Source: Natural Health Directory 2000 and professional association membership lists

FIGURE 5. The expected regional distribution of complementary medicine practitioners

![Expected regional distribution of complementary medicine practitioners](image)

Source: Natural Health Directory 2000 and SACMA Mailing List
8. REGISTERED MODALITIES

8.1 CHIROPRACTIC

8.1.1 The statutory register for chiropractors has been open since 1985 and there are some 258 registered chiropractors in South Africa.

8.1.2 Courses are offered by the Natal Technikon and Technikon Witwatersrand. A Masters Degree in Chiropractic consists of five years of formal training with a practical sixth year. Approximately 30 people a year complete the training at each of these institutions.

8.1.3 The Chiropractic Association of South Africa (CASA) publishes a detailed guide to fees for its members each year. The Board of Healthcare Funders (BHF) tariff codes have been created for treatments and consultations.

8.1.4 Chiropractic is the modality most commonly covered by medical schemes. Most schemes cover the BHF tariff for chiropractic, which covers approximately two-thirds of the cost of treatment in practice, according to the Chiropractic Association of South Africa.

8.2 NATUROPATHY, OSTEOPATHY AND PHYTOTHERAPY

8.2.1 Registration for naturopaths, osteopaths and herbalists was only possible for a six month period in 1974, before the register was closed, and then again for a window period at the initiation of the Interim Council in 1996 for aggrieved practitioners only. There are consequently very few registered practitioners under these modalities. Training was not readily available and the lack of statutory registration has been a major stumbling block for these therapies in South Africa.

8.2.2 The previously-used name of “herbalism” has been replaced by “phytotherapy” in order to avoid confusion with herbalists practising African Traditional Medicine.

8.2.3 There is currently some private tuition available and naturopaths aim to establish training in tertiary institutions.

8.2.4 None of these therapies has yet developed a formal tariff structure. The typical fee for an initial consultation for naturopathy or phytotherapy is R150, with R100 for follow-up consultations, excluding medication. An initial consultation takes at least one hour and consultations thereafter take approximately 45 minutes.

8.3 HOMEOPATHY

8.3.1 There are approximately 500 homeopaths registered with the Interim Council. Approximately 40 homeopaths have dual registration as medical doctors. Not all doctors who practise homeopathy have yet registered with the Allied Health Professions Council. Amongst medical doctors there is a great variation in the extent of homeopathy practised, some doctors practising almost exclusively as homeopaths and others including as little as 10% in their practice.

8.3.2 For school-leavers, the Natal Technikon and the Witwatersrand Technikon each provide a six-year Masters programme in homeopathy. Qualified medical doctors
can complete a three-and-a-half-year part-time programme with the South African Faculty of Homeopathy in association with the British Faculty of Homeopathy.

8.3.3 There are three separate bodies representing homeopaths in South Africa and a large variation in fees charged. There is no agreed schedule for recommended fees as yet and fees for an initial consultation by a homeopath can vary from R100 to R360 or more.

8.3.4 Medical doctors who practise homeopathy are able to charge the medical scheme for the visit as a normal consultation by a general practitioner. Doctors have difficulty in claiming for the initial longer consultation time (45 minutes to one hour) required by the practice of homeopathy. (The standard allopathic consultation is 12 minutes).

8.3.5 Homeopathy by other practitioners is not covered by many schemes. Medical schemes may be prepared to cover consultations, but are hesitant to cover the medicines or remedies. Administrators have difficulty verifying whether remedies with proprietary names or general descriptions of purpose are appropriate treatment. Lack of understanding of homeopathy by administrators has led to mis-communication in this respect.

8.3.6 There is a great variation in prices of homeopathic remedies ranging from R20 to R100 for the same remedy. Some practitioners charge more for the consultation and very little for remedies, while others achieve a desired total fee by charging more for remedies. A single charge for all remedies, rather than an itemised bill, frustrates administrators of schemes.

8.3.7 A study of the prescription behaviour of general practitioners (Abratt & Lanteigne, 2000) found that 21% had prescribed homeopathic medicines. 47% expressed positive statements about homeopathic medicines and 33% expressed a negative opinion. The major reason for not prescribing was given as a lack of knowledge (56% of those who had never prescribed).

8.4 THERAPEUTIC AROMATHERAPY, THERAPEUTIC MASSAGE THERAPY, THERAPEUTIC REFLEXOLOGY

8.4.1 These three therapies have joined forces as the Integrated Health Professions Liaison Committee instead of being represented by three separate committees. It has not been possible for therapists in these modalities to obtain statutory registration in the past.

8.4.2 Many people practising aromatherapy, massage and reflexology as part of a beautician practice will not be eligible for registration. The distinction “therapeutic” is important, as eligible practitioners will have undergone more intensive training, including the study of anatomy, physiology and either applied pathology or pathophysiology.

8.4.3 The Liaison Committee estimates that a high proportion of therapists (perhaps up to 50%) will have trained in more than one modality. In addition a substantial number of therapists are trained allopathically in professions such as nursing, radiography and pharmacy.
8.4.4 Training has taken place in private institutions, and within Technikons where the therapeutic delivery of the modalities is covered by somatology training. It is estimated that between 1000 and 1200 students are trained each year.

8.4.5 The costs of therapeutic treatments depend on the type of treatment given and the time spent on treatment. An average cost for treatment in any of the modalities is about R110 for 45 minutes.

8.4.6 Very few medical aid schemes are paying for these therapeutic modalities, as few therapists have been issued practice numbers by the Board of Healthcare Funders. The Professional Liaison Committee estimates that about 90% of treatments are paid out-of-pocket by consumers.

8.5 AYURVEDA

8.5.1 The register for ayurveda is open, although practice numbers have not yet been issued to registered practitioners.

8.5.2 The categories of practitioner are:
- primary healthcare adviser;
- remedial yoga therapy teacher;
- panchakarma technician or assistant (panchakarma is a process of purification and detoxification); and
- ayurvedic doctor. (There is currently no training available in South Africa and all legally registered ayurvedic doctors have completed the 5½-year Bachelor of Ayurvedic Medicine and Surgery (BAMS) degree in India. A South African degree is being considered at the University of Natal, Durban.)

8.5.3 The Liaison Committee is considering an additional category of ayurvedic pharmacist, as ayurvedic medicine makes extensive use of a wide range of herbal preparations.

8.5.4 A standardised charging structure has been drawn up, but due to the reluctance of the Board of Healthcare Funders to supply ayurvedic practitioners with practice numbers, coverage by medical schemes is rare.

8.6 CHINESE MEDICINE AND ACUPUNCTURE

8.6.1 Traditional Chinese Medicine is a complete philosophy of healthcare, covering a wide range of interventions from primary care to tertiary care.

8.6.2 In South Africa many doctors practise only one element of Chinese medicine, namely acupuncture. Acupuncture has the largest following amongst the medical practitioners who are members of SACMA.

8.6.3 A new register will be opened for Chinese medicine and acupuncture once the Council is established. Some private training is available and the South African Medical Acupuncture Society provides training for medical doctors in acupuncture.

8.6.4 There is no standardised charging structure for Chinese medicine. BHF tariff codes exist for acupuncture using needles and laser. The average cost for these treatments is approximately R110 per session.
9 NON-REGISTERED MODALITIES

9.1 There are a great many therapies, techniques or practices that are described as “complementary”, “alternative”, “natural” and “holistic”. Table 3 covers those that might conceivably seek registration as therapeutic modalities in future. Data sources such as the Natural Health Directory cover many more modalities and services than listed here.

<table>
<thead>
<tr>
<th>Table 3. Non-registered therapeutic modalities</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alexander technique</td>
</tr>
<tr>
<td>Anthroposophical medicine</td>
</tr>
<tr>
<td>Body alignment technique</td>
</tr>
<tr>
<td>Body stress release</td>
</tr>
<tr>
<td>Bowen technique</td>
</tr>
<tr>
<td>Colon therapy</td>
</tr>
<tr>
<td>Cranio-sacral therapy</td>
</tr>
<tr>
<td>Feldenkrais</td>
</tr>
<tr>
<td>Flower essences</td>
</tr>
<tr>
<td>Iridology</td>
</tr>
<tr>
<td>Kinesiology</td>
</tr>
<tr>
<td>Macrobiotics</td>
</tr>
<tr>
<td>Polarity therapy</td>
</tr>
<tr>
<td>Unani tibb</td>
</tr>
<tr>
<td>Radionics</td>
</tr>
<tr>
<td>Reiki</td>
</tr>
<tr>
<td>Rolfing</td>
</tr>
<tr>
<td>Shiatsu</td>
</tr>
<tr>
<td>Tui-na</td>
</tr>
</tbody>
</table>

9.2 Unani tibb and the health and skincare therapists applied to the Interim Council for registration and their applications are being examined.

10 COVERAGE BY MEDICAL SCHEMES

10.1 CODING OF PRACTITIONERS, SERVICES AND MEDICINES

10.1.1 There is no standardised coding for complementary medicine in South Africa and as a result many medical schemes do not code completely or accurately for complementary medicine services.

10.1.2 The BHF tariff codes simplify the capturing and processing of claims. BHF tariff codes have been created for chiropractic and homeopathic consultations as well as acupuncture treatments. It is hoped that in the future these will cover all complementary therapies.

10.1.3 In terms of the Medical Schemes Act, schemes are legally obliged only to reimburse providers who are registered, although this may be in terms of any law.

10.1.4 Once healthcare professionals have registered with the relevant Council, they should be issued provider practice numbers by the BHF. Currently the only complementary medicine practitioners who have systematically been issued practice numbers are homeopaths and chiropractors.

10.1.5 The BHF is an industry lobby body representing medical schemes and administrators. It has no statutory powers.

10.1.6 Providers argue that the BHF had refused practice numbers to some practitioners on the grounds that there were no further numbers available. It is difficult, if not impossible, to obtain reimbursement from schemes without a practice number. Once
formal registration with the Allied Health Council is complete, the practitioners will have more leverage with the BHF.

10.1.7 The National Pharmaceutical Product Index (NAPPI) is a coding system for medicines, operated in South Africa by MediKredit. These codes enable medical schemes to analyse and assess medicine claims. The few complementary medicines that have NAPPI codes are generally products stocked by commercial pharmacies.

10.2 BENEFITS COVERED

10.2.1 The first medical scheme marketed specifically as a product for people interested in complementary medicine was launched in 1999. In general, however, very limited benefits are available through medical schemes and most expenditure is paid directly by consumers.

10.2.2 Chiropractic is the most widely covered modality, followed by homeopathy. This is almost certainly because these are the only two modalities for which practice numbers have been issued. Further information on coverage for each of the registered modalities can be found in Section 8.

10.2.3 Medical schemes cover complementary medicine inadvertently to the extent that medical doctors practise complementary medicine, for example, where a doctor practises homeopathy as described in paragraphs 8.3.4 and 8.3.7.

10.2.4 Schemes and administrators argue that it is logistically difficult to reimburse service providers who do not have a tariff schedule. However, the Medical Schemes Act allows for benefits to be paid according to a scale, tariff or recommended guide or as directed in terms of the rules. Practitioners will find greater acceptance from administrators if they develop formal tariff schedules.

10.2.5 Further reasons cited for the lack of funding of complementary medicine by medical schemes are:
– the lack of understanding of modalities, procedures performed and medicines;
– the large variation in cost;
– the lack of a definition of “good practice”; and
– the wide range of modalities.

10.3 DIFFICULTY DETERMINING SCHEME EXPENDITURE

10.3.1 The authors were unable to obtain data on expenditure by medical schemes on complementary medicine.

10.3.2 Where traditional medical schemes cover complementary medicine at all, visits to practitioners fall under the category “auxiliary services” and any products dispensed fall under the “acute medication benefit” or else under the “over-the-counter medicines benefit”. The financial limits under these categories are often so low that the data in existence is of little practical use.

10.3.3 So-called “new generation” medical schemes typically cover complementary medicine through members’ savings accounts. Data collection on expenditure from individual savings accounts varies widely amongst schemes. Data will be collected when the product design includes a threshold over which benefits are paid.
from a collective pool. The usefulness of this data is compromised as:
- there is no standardised coding practice for complementary medicine; and
- schemes focus data collection and analysis on major cost drivers (e.g. chronic
  medication and hospitalisation), rather than on day-to-day expenses.

10.3.4 The annual reports of the Registrar of Medical Schemes give expenditure
on major categories of benefits, but the delay in the production of these reports means that
the latest available data at the time of the study was from 1996. The existing
categorisation of benefit payments would not allow complementary medicine
expenditure to be fully isolated.

10.3.5 Some work has been done to establish the most effective way to extract data
on complementary medicine expenditure from medical schemes. A method using
practitioner numbers to extract information would seem to be the most useful. However,
this can only be done once provider practice numbers have been allocated to all
complementary practitioners.

11. USAGE BY CONSUMERS

11.1 CENSUS DATA

11.1.1 A comparison of the census of medical doctors and that of registered com-
plementary medicine practitioners shows that, by 1994, the fee income of complementary
medicine practitioners had increased to six times its level in 1987, compared with 3.7
times for doctors.

11.1.2 Total fee income to registered complementary medicine practitioners in
1993–94 was R99.1m, of which R52.5m was recorded in Gauteng and R13.4m in the
Western Cape. More recent data is not available.

11.2 HEALTH PRODUCT TURNOVER

11.2.1 The Health Products Association (HPA) is an association of approximately
75 manufacturers, importers and distributors of complementary medicines and health
products. The HPA is a member of the European Federation of Associations of Health
Products. Their objective is to organise industry in order to liaise with government.

11.2.2 The HPA undertook a survey of the turnover of their members in 1996 and
established that their combined turnover was some R900 million. It estimates that
turnover for 1999 was R1.29 billion, as shown in Table 4.

11.2.3 The HPA estimates that 50% of turnover in complementary medicines
occurs in pharmacies and 20% in health-food stores. The number of health-food stores is
approximately 250, and 2500 pharmacies stock complementary medicines. The balance
of the market is made up of some 600 supermarkets, chain stores and toiletry discount
outlets.

11.2.4 Despite the lack of comparative data, it would seem that the amount spent
on medicines is considerably higher than the total amount spent on practitioners. This
would be in line with worldwide trends towards self-medication using complementary
medicine.
TABLE 4. Health product turnover in South Africa

<table>
<thead>
<tr>
<th>Product</th>
<th>1996 (Rm)</th>
<th>1999 (Rm)</th>
<th>Growth</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nutritional supplements</td>
<td>840</td>
<td>1200</td>
<td>43%</td>
</tr>
<tr>
<td>Homeopathy and tissue salts</td>
<td>11</td>
<td>30</td>
<td>168%</td>
</tr>
<tr>
<td>Aromatherapy</td>
<td>6</td>
<td>10</td>
<td>79%</td>
</tr>
<tr>
<td>Energy substances</td>
<td>1</td>
<td>3</td>
<td>114%</td>
</tr>
<tr>
<td>Herbal medicine</td>
<td>18</td>
<td>40</td>
<td>120%</td>
</tr>
<tr>
<td>Anthroposophical medicine</td>
<td>4</td>
<td>7</td>
<td>67%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>881</strong></td>
<td><strong>1290</strong></td>
<td><strong>46%</strong></td>
</tr>
</tbody>
</table>

11.3 OTHER EVIDENCE

11.3.1 An increasing number of publications cover complementary medicine and their circulation is growing. In addition, established mainstream publications are finding that readers demand a higher content of articles covering complementary medicine.

11.3.2 Publications focusing on complementary modalities are *Odyssey* (bi-monthly, 9000 copies), *Link-up* (a free bi-monthly regional service listing practitioners) and *Namaste* (bi-monthly, 10 000 copies). The *Natural Health Directory* sells 12 000 copies annually.

11.3.3 *Longevity* is a mainstream publication (32 000 copies) which is including more complementary medicine topics. The editor estimates that 45% of the magazine is dedicated to complementary medicine. Readers are mostly urban and educated with a high disposable income. Other magazines in this niche are *Quality Life* and *Health Essentials*.

11.3.4 Radio is another medium that has seen an increased demand for complementary medicine topics, stations like SAFM and P4 regularly covering the topic.

12. TRADITIONAL AFRICAN MEDICINE

12.1 There are an estimated 150 000 to 200 000 traditional healers in South Africa, licensed by some 100 separate organisations (Pretorius, 2000). An Interim Co-ordinating Committee was formed in order to establish a statutory council for traditional healers and it is envisaged that the process will be completed within the next three years. See Section 5.1 for the legislative framework governing all healthcare practitioners.

12.2 Traditional African medicine practitioners are likely to be classified as:
- diviners (sangomas);
- herbalists (inyangas);
- prophets and faith healers;
– traditional surgeons; and
– traditional birth attendants.

12.3 The Traditional Medicines Programme (TRAMED) is a collaboration of the Medical Research Council, the Department of Pharmacology at the University of Cape Town, the School of Pharmacy at the University of the Western Cape and several traditional healers. TRAMED gathers medical and botanical information on plants with healing properties, with a view to setting safety standards. It has developed a comprehensive manual on primary healthcare using traditional medicines.

12.4 It is widely believed that some 60% to 80% of the South African population use the traditional medicine sector as their first contact for advice or treatment (Pretorius, 2000). Several medical schemes have offered limited benefits for services provided by traditional healers.

13. CONCLUSIONS AND RECOMMENDATIONS FOR FUTURE STUDIES

13.1 FUTURE STUDIES

13.1.1 Surveys of complementary medicine usage in other countries have generally used telephonic interviews of small samples of the population, extrapolating the results to ascertain trends for the whole population. The cost of a survey of this nature was too high to be undertaken at this time. Telephonic surveys are biased by the need to possess a telephone and are often hindered by inadequate response rates of the public.

13.1.2 A postal census of all registered practitioners would be useful once all practitioners have been registered. Statistics South Africa has conducted two previous studies using postal questionnaires with telephonic interviews to confirm missing data. The results are reported in Section 11.1.

13.1.3 A method that could be used to track complementary medicine expenditure by medical schemes is to aggregate payments according to the practice number of the provider.

13.1.4 Repeating this study in two years’ time should yield considerably more information. Once the Allied Health Professions Council is established and all ten modalities have achieved registration, it will be a simple matter to obtain information on numbers of practitioners and their geographical spread. In addition there may be considerable progress towards establishing standardised charging for the various modalities.

13.1.5 The Health Products Association is planning to repeat the survey of health product providers in 2001 and this should yield more accurate data on the amount spent on medicines.

13.2 CONCLUDING REMARKS

13.2.1 In this paper the authors have documented the fundamental changes that are occurring within the South African healthcare system. These changes reflect the deep-
seated needs that patients are expressing, needs that include access to a much broader range of healthcare interventions. The authors have concentrated on the regulatory developments in South Africa and the ten modalities that will be registered under the Allied Health Professions Council. The initial data gathered on the extent of usage of complementary medicine in this country have been presented.

13.2.2 The formal establishment of the Allied Health Professions Council is South Africa’s “fall of the bamboo curtain”. With statutory recognition will come the issuing of provider practice numbers to practitioners, the formalisation of tariff structures and increased visibility for complementary medicine. The authors believe that consumers will increasingly question health plans that continue to exclude some or all of the recognised modalities.

13.2.3 The authors have deliberately steered away from pronouncing on clinical efficacy in this paper, but would gladly provide guidance to those who want access to relevant journals and scientific studies. Those who practise complementary medicine know the therapeutic benefits of the treatments. The consumers who use complementary medicine are voting with their healthcare dollars, pounds, yen and rands.

13.2.4 Richard Grossinger in his seminal work, Planet Medicine (1995), says: “The present crisis (in the world) marks the decline of materialism and the first faint emergence of a radical new order of things … The new order must slice through the hard heart of greed and mechanism and touch the point where the universes of mind and matter meet and are interchangeable … Paradigm shifts are elusive, multidimensional phenomena. In their midst no one can guess how far they will go and what they will eclipse. I have posed [in Planet Medicine] the medical aspects of a present paradigm shift … “Holistic health is finally a refraction of environmental awakening, political activism, and a synthesis of Eastern and Western epistemologies and ethics. It is not first and foremost a medical program. The new paradigm represents a medical archetype for a larger shift of reality … “Alternative medicine has originated simultaneously everywhere and nowhere … What passes now as ‘holistic health’ or ‘alternative medicine’ is merely the faintest glimmering of a new world. A new world will come anyway, as new worlds always have.”
ACKNOWLEDGEMENTS
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REFERENCES


The Natural Health Directory 1999.


APPENDIX A
DESCRIPTIONS OF THE REGISTERED COMPLEMENTARY THERAPIES

A.1 INTRODUCTION
A.1.1 The aim of this appendix is to give the actuarial reader a brief introduction to each of the registered complementary therapies. The authors are grateful to the professional associations and the publishers of the Natural Health Directory for material presented here. Use has also been made of the excellent reference works of Murray & Pizzorno. Appendix B contains further recommended resources on certain therapies.

A.2 CHIROPRACTIC
A.2.1 Daniel Palmer (1845–1913) and his son, BJ Palmer, developed the technique in the USA. The name originates from the Greek words kheir meaning hand, and praktikos meaning action.
A.2.2 The practice of chiropractic focuses on the relationship between structure (primarily the spine) and function (as co-ordinated by the nervous system) and how that relationship affects the preservation and restoration of health.
A.2.3 Due to poor posture, poor nutrition and stress, joints of the spine may become restricted in their motion, affecting the spinal nerves that communicate with the muscles, tissues and organs of the body. When joints are restricted, muscles strain and pain is caused. Spinal problems may precipitate asthma, constipation, migraines and period problems. Chiropractic care may alleviate problems associated with muscle spasm, joint inflammation and injury to the spinal column and joints of the body.
A.2.4 Chiropractors are neuro-musculoskeletal specialists. A practitioner will perform spinal adjustment, muscle and tendon manipulation. Advice is given on posture and nutrition. Best results are achieved through a series of treatments.

A.3 OSTEOPATHY
A.3.1 Osteopathy was developed by an American medical practitioner, Dr Andrew Taylor Still (1828–1917). He reasoned that if the structure of the musculoskeletal system was regulated and corrected then the body would naturally restore and repair itself.
A.3.2 Osteopathy is the study of the relationship between the structure of the body’s framework and its function. The basic principle is that “structure governs function”.
A.3.3 A set of movement exercises is used to determine where the problem lies. This is typically followed by soft-tissue work such as topical massage or advice on stretching movement, before the osteopath structurally adjusts the body. Best results are achieved through a series of treatments.
A.4 PHYTOTHERAPY

A.4.1 Phytotherapy is the most ancient form of healthcare and the current revival of interest in herbalism is a worldwide phenomenon. The World Health Organisation estimates that herbalism is three to four times as widely practised as conventional medicine.

A.4.2 Herbs act in a wide variety of ways, such as cleansing, eliminating and detoxification. Some are used to stimulate the body’s self-healing capabilities to counteract physical symptoms, while others assist the body’s immunity and resistance to disease.

A.4.3 The human body may assimilate nutrients, vitamins and minerals, as well as antibiotic and hormonal substances from plants whilst obtaining both food and medicine. Phytotherapy facilitates healing of chronic problems with less danger of the side effects inherent in drug-based medicine.

A.4.4 Herbal medicines are prescribed for each client’s specific needs. Remedies can be taken in a variety of ways such as tinctures (alcohol-based extracts), capsules, pills or infusions (teas), depending on which herbs are being used and which condition is being treated.

A.5 HOMEOPATHY

A.5.1 Homeopathy is a highly systematised method of clinical evaluation and medical therapeutics. The word is derived from the Greek homoios, meaning similar, and pathos meaning suffering. The principle that “like cures like” was recognised by Hippocrates, who noticed that herbs given in low doses tended to cure the same symptoms they produced when given in toxic doses.

A.5.2 The homeopathic school of medicine was founded by a German doctor, Samuel Hahnemann, in the late 1700s. It forms part of the National Health System in Britain and is widely practised in Europe, India, Argentina and Mexico. It initially flourished in the USA where, despite a decline in the early 20th century, it is now experiencing a renaissance.

A.5.3 Homeopathy is based on the principle simila similibus curantur, meaning that like will be cured by like (the Law of Similars). Remedies are based on substances that would promote symptoms in a healthy person that closely resemble the symptoms of the person who is unwell. Remedies are derived from a variety of plant, animal, mineral and chemical substances.

A.5.4 Homeopathic remedies are made by a process of sequential dilution and shaking (known as “succussion”). Whilst the amount of actual substance decreases with each dilution, to the point where the substance can no longer be chemically detected, the curative power of the remedy increases. The substance, whist no longer present in a molecular state, appears to imprint its energy pattern on the carrier fluid of the remedy. It is on this point that Western bio-medicine struggles to comprehend homeopathy.

A.5.5 The patient’s symptoms are the expressions of the body’s attempts to heal itself. The palliation or suppression of symptoms at the cost of overall vitality and function is considered negligent by homeopaths. The contemporary homeopath,
Vithoulkas defines health on three levels: mental, emotional and physical. Healing is not purely at the physical level, but can enable the person to integrate into daily life and address personal needs for fulfilment.

A.5.6 The homeopathic clinical process consists of case-taking, evaluation and prescribing. A homeopath will schedule an initial consultation of approximately one hour in order to develop an understanding of both the patient’s biological individuality as well as the nature of their illness. A remedy or remedies will be prescribed and the healing reaction will be monitored at shorter follow-up visits.

A.6 NATUROPATHY
A.6.1 The philosophical roots of this system date back many thousands of years, drawing on the healing knowledge of many cultures including Indian, Arabic, Greek, Chinese and Native American. The term “naturopathy” was coined at the turn of the 19th century.
A.6.2 Naturopathy is based on the following principles:
– *Vis medicatrix naturae* or “the healing power of nature”: the body’s innate capacity to heal itself is acknowledged.
– Treat the cause rather than the effect: symptoms are viewed as expressions of the body’s natural attempts to heal itself, hence the practitioner seeks to address the underlying causes.
– First, do no harm: only safe and effective natural therapies should be used.
– Treat the whole person: the individual is seen as a multi-dimensional being, encompassing body, mind and spirit.
– The physician as teacher: practitioners are teachers who educate, empower and motivate patients to assume personal responsibility for their health.
– Prevention is the best cure: prevention of disease is accomplished through education and a lifestyle that supports health.
A.6.3 A variety of techniques and modalities may be used by the naturopath, including various forms of bodywork (such as massage), hydrotherapy, sauna, fasting and diets, nutritional advice and lifestyle counselling.
A.6.4 The initial consultation will include a thorough assessment of the person’s medical history and lifestyle. Once a good understanding of the health and disease status is established, the practitioner and the client work together to establish a treatment and health-promoting programme.

A.7 THERAPEUTIC AROMATHERAPY
A.7.1 Aromatherapy utilises the healing properties found in the essential oils of plants and flowers. The Egyptians pioneered the various forms of the extraction of essential oils from plants, shrubs and trees and the early Greek alchemists discovered how to distil oils by boiling and steaming.
A.7.2 The chemical makeup of essential oils give them pharmacological properties ranging from antibacterial, antiviral and antispasmodic, to uses such as diuretics, vasodilators and vasoconstrictors. Essential oils can energise or pacify,
detoxify and facilitate the digestive process. They are also effective for treating infection, interacting with the various branches of the nervous system, modifying immune response and harmonising moods and emotions.

A.7.3 Aromatherapy oils are administered through massage, compresses, inhalation, in burners or in the bath. The oils often have a small molecular size that facilitates penetration into the body tissues. Aromatherapy is the fastest growing complementary therapy in the world.

A.7.4 An aromatherapy treatment generally consists of a full body massage using a specific blend of essential oils mixed into a carrier oil. The type of oil used is chosen by the practitioner to address the patient’s specific issues and conditions.

A.8 THERAPEUTIC MASSAGE THERAPY

A.8.1 Massage is a systematic form of touch, which has been found to give comfort or promote good health. Throughout history people have used their hands to impart comfort and healing to one another and it is perhaps the oldest and simplest of all healing treatments.

A.8.2 There are many different forms of therapeutic massage, including relaxational, remedial, Swedish, sports, Hawaiian, Thai, seated, Tui-Na, traditional Chinese and Indian Head massage, amongst others.

A.8.3 The sense of touch is registered by the skin, the largest and most sensitive organ of the body. Although massage is applied to the soft tissues of the body, the muscles and the ligaments, this has a resulting beneficial effect on the nervous and circulatory systems. Physiologically, massage helps the flow of blood and lymph in the body, thus increasing energy, decreasing blood pressure and heart rate, decreasing tension and producing a state of well-being. Massage can be an effective treatment for stress-related headaches, asthma and back pain.

A.8.4 Generally a massage practitioner will use oil to make the movement of the hands over the body smooth and gentle.

A.9 THERAPEUTIC REFLEXOLOGY

A.9.1 Reflexology is known to have been practised in ancient Egypt, India and China. In 1917, Dr. Fitzgerald developed zone therapy, which divided the body into ten zones, or channels through which energy flowed. In the 1930s his work was followed up by the therapist Eunice Ingham, who treated the body by working only on the feet.

A.9.2 By massaging reflex areas in the feet, reflexologists treat diseases in parts of the body that are related to those areas. Reflexologists regard the feet as mirrors of the body – the left foot representing the left side, and the right foot representing the right side of the body. Different parts of the sole are related to organs such as the bladder, kidneys and lungs. The massage of the feet promotes and supports the body’s healing of itself – no drugs or instruments are used.

A.9.3 The reflexologist takes a comprehensive case history at the first treatment to form the basis of treatment assessment. Each treatment lasts 30 to 45 minutes and best results are achieved through a series of treatments at weekly intervals.
A.10 AYURVEDA

A.10.1 The origins of ayurveda have been placed in India about 6000 BC. The name is taken from two Sanskrit words: ayur meaning life, and veda meaning knowledge.

A.10.2 According to ayurvedic teaching, the universe is constructed from the five basic elements of ether (space), air, fire, water and earth. The five elements manifest in the body as the tridosha, or three humours, known in Sanskrit as vata, pitta and kapha. Vata is associated with the wind, is constantly on the move, and controls the nervous system. Pitta is associated with the sun, the source of energy, and controls the digestive system and all biochemical processes. Kapha governs the balance of tissue fluid, controlling the cell growth and the firmness of the body.

A.10.3 Vata, pitta and kapha control all human biological, psychological and physiopathological functions. Good health results from the three doshas being in harmony. Health is defined in ayurveda as soundness of body, mind and soul. The practitioner’s task is to discover the patient’s innate disposition and alleviate any imbalances that are causing distress.

A.10.4 A variety of remedies and techniques are used, from conventional surgery to massage, plant-based drugs and mineral supplements, dietary changes, counselling, exercise, yoga, meditation, massage, herbal tonics, herbal sweat baths, medicated enemas, fragrant oils and the therapeutic use of sound.

A.10.5 The practitioner will take a detailed case history, documenting the individual’s personal and professional life, medical history and lifestyle habits. The practitioner will take various pulses that give detailed information about the physical and mental condition. A specific treatment plan is designed to guide the individual back into harmony with their environment. The treatment plan is highly individualised, the choice of therapy and dose of medicine being influenced not only by the disease, but the individual’s constitution and the environmental conditions likely to affect that individual.

A.11 CHINESE MEDICINE AND ACUPUNCTURE

A.11.1 Traditional Chinese Medicine is a complete system of medicine, which evolved in ancient China. It includes acupuncture, herbalism, massage, diet therapy and exercise. Acupuncture was first described in detail in the Nei Jing (Inner Classic of Medicine), published in approximately 200 BC.

A11.2 The underlying philosophy of Chinese medicine is that good health revolves around the correct flow of chi, the subtle energy of the body. Chi flows around the body in channels or meridians, and along the meridians lie points that regulate the organs and functions of the body. The world is divided into two forces yin (considered to be dark, cold, negative, passive and feminine) and yang (light, active, warm, positive and male). Yin and yang have to be in balance for good health, as do the five elements of fire, earth, air, water and wood.
The recommendations for further resources have been drawn from a list developed by the Complementary Medicine Trust. The list details a minimum set of books on complementary medicine that are being donated to medical school libraries in South Africa.

RECOMMENDED GENERAL READING

PHYTOTHERAPY

HOMEOPATHY

NATUROPATHY
AYURVEDA

CHINESE MEDICINE AND ACUPUNCTURE

TRADITIONAL AFRICAN MEDICINE