Queen Mary
University of London

The paradox of non-evidence based, publicly funded complementary alternative medicine in the English National Health Service: An explanation.

Sheppard, MK

doi:10.1016/j.healthpol.2015.03.007

For additional information about this publication click this link.
http://qmro.qmul.ac.uk/xmlui/handle/123456789/11492

Information about this research object was correct at the time of download; we occasionally make corrections to records, please therefore check the published record when citing. For more information contact scholarlycommunications@qmul.ac.uk

The paradox of non-evidence based, publicly funded complementary alternative medicine in the English National Health Service: an explanation

Abstract

Despite the unproven effectiveness of many practices that are under the umbrella term 'complementary alternative medicine' (CAM), there is provision of CAM within the English National Health Service (NHS). Moreover, although the National Institute for Health and Care Excellence was established to promote scientifically validated medicine in the NHS, the paradox of publicly funded, non-evidence based CAM can be explained as linked with government policy of patient choice and specifically patient treatment choice. Patient choice is useful in the political and policy discourse as it is open to different interpretations and can be justified by policy-makers who rely on the traditional NHS values of equity and universality. Treatment choice finds expression in the policy of personalised healthcare linked with patient responsibilisation which finds resonance in the emphasis CAM places on self-care and self-management. More importantly, however, policy-makers also use patient choice and treatment choice as a policy initiative with the objective of encouraging destabilisation of the entrenched healthcare institutions and practices considered resistant to change. This political strategy of system reform has the unintended, paradoxical consequence of allowing for the emergence of non-evidence based, publicly funded CAM in the NHS. The political and policy discourse of patient choice thus trumps evidence based medicine, with patients that demand access to CAM becoming the unwitting beneficiaries.

Keywords

- English National Health Service (NHS);
- Patient choice;
- Patient treatment choice;
- Non-evidence based complementary alternative medicine (CAM);
- Choice policy;
- Destabilisation

Introduction

Using the National Health Service (NHS) in England and Wales as the example this paper suggests that the provision of non-evidence based complementary alternative medicine (CAM) in a public healthcare system appears to be a paradox. In a healthcare system funded by general taxation the general public ought to be able to expect that their money is used to promote scientifically validated medicine rather than treatments of little clinically proven benefit. In the United Kingdom, the National Institute for Health and Care Excellence or

NICE [1], an independent organisation, was set up by the Government in 1999 to achieve this objective, namely to promote scientifically validated medicine and to decide which drugs and treatments are to be available in the NHS in England and Wales. Despite this emphasis on evidence-based medicine a space for CAM in the NHS has been constructed. The paper argues that it is the emphasis of governmental policy discourse on patient choice and patient treatment choice which has lead to non-evidence based CAM being made available in a public healthcare system.

Complementary alternative medicine (CAM) is a term that describes a vast number of treatment modalities. In 2000, the House of Lords Committee on Science and Technology defined CAM as a 'diverse group of health-related therapies and disciplines which are not considered to be a part of mainstream medical care'. [2] While this definition immediately differentiates CAM from orthodox medicine, it does not exclude the practice of CAM by the medical profession in the UK and nor does it exclude the referral of patients by orthodox medical practitioners to CAM practitioners. The principal CAM disciplines include those which claim to have an individual diagnostic approach, namely osteopathy and chiropractic, acupuncture, herbal medicine and homeopathy. These treatments are the ones used most widely by the public [3], and are also the most likely to have been made available by the NHS. [4]

As the Committee report suggests, similar to CAM modalities generally, these five treatments have very different theories for their modes of action [5], and none of these theories are congruent with current scientific knowledge. They have scientifically established efficacy only in a limited number of ailments [2; 5] but have the greatest claim to professional organisation by their practitioners. [6] In the UK, practitioners of osteopathy and chiropractic are regulated in their professional activities and education by Acts of Parliament. [7; 8] There are also professional organisations for medical practitioners who practise osteopathy, acupuncture or homeopathy. [9]

Only a few of the CAM modalities have been evaluated by NICE when it has developed clinical guidance. [10] Most CAM therapies have not been subjected to randomised controlled trials (RCTs), the gold standard in the hierarchy of experimental scientific evidence. For many of them, there is not even research evidence which is lower in the

hierarchy of evidence than RCTs, such as non-randomised studies or descriptive studies. [5] Nevertheless, despite the unproven effectiveness of many CAM practices, there is demand by patients for and provision of non-evidence-based, publicly funded CAM. [3] This demand may be due, amongst other things, to the dissatisfaction with biomedicine because of the side-effects of drugs and their lack of effectiveness in many chronic conditions; the belief that CAM is less invasive and more natural; the greater involvement by the patient in the treatment; and the different relationship between CAM practitioner and client. [11]

Although the figures are not up-to-date, it has been estimated that about 10% of the overall contacts with CAM practitioners in England are publicly funded as part of the NHS. [12] Access to CAM in the NHS can be through the referrals of General Practitioners (GPs) and, in NHS hospitals, by NHS-employed healthcare professionals as part of an integrated approach to cancer care and as part of end of life care. [6] Publicly funded homeopathy is still being made available in the three homeopathic hospitals in England, including the Royal London Hospital for Integrated Medicine. [13] To set the scene, the paper sketches a brief historical overview of the role of CAM in the NHS before discussing the implications of the recent health policies focused on patient choice.

A historical overview of CAM in the NHS

The National Health Service Act 1946 did not prohibit the provision of CAM under the NHS. Some groups of CAM practitioners had argued for inclusion in the NHS but entry was made subject to the reorganisation of CAM practitioners with recognised training schemes and also CAM practitioners working as medical auxiliaries under the direction of the medical profession. This proposal was rejected. [14] CAM could, however, still be provided by qualified medical practitioners as part of the NHS. Although the Medical Registration Bill 1858 had been intended to prevent the practice of non-orthodox medicine by medical practitioners, an amendment to the Bill instigated by Dr Quin, an influential doctor and homeopath, enabled the Privy Council to withdraw the right to award degrees from any university trying to dictate the type of medicine practised by its medical graduates. [15] Thus, under the Medical Act 1858, conventionally trained doctors can legally practise other types of medicine. [13] However, with the exception of homeopathy provided by medical practitioners, NHS cover of CAM treatment was rare [16; 9; 15] because the medical

establishment, through its trade union body the British Medical Association (BMA), and its medical licensing body the General Medical Council (GMC), kept control over any deviation from the biomedical model by orthodox practitioners, thus restricting the adoption of CAM treatments. [11; 14]

Interest in CAM experienced a considerable increase in the mid-1960s, possibly as part of an emerging medical counter-culture driven by the public interest in alternative lifestyles. This was associated with a rejection of scientific progress and professional experts within orthodox medicine. [17; 18] Growing demand for CAM by patients may also have been linked to the desire to try out alternative therapies, not only because of the perceived lack of efficacy and safety issues of orthodox treatments but as a challenge to professional experts. [18; 11] However, at that time, provision of CAM within the NHS was still largely restricted to the homeopathic hospitals because of the general opposition of the medical profession and the BMA to alternative medicine. [19; 18] The GMC was also opposed to the practice of unorthodox therapies. However, it relaxed its stance after 1983. [20; 16; 11]

The development of patient choice and treatment choice in the NHS

The Conservative government's 1989 White Paper, *Working for Patients*, set in motion the market reforms in the NHS. It linked these reforms with the objective of increasing choice for the patient, specifically greater choice of services. [21] Although the choice originally given to patients was very limited, namely to have a choice between GPs [22], choice has become an instrumental aim of policy makers. When New Labour first came to power in 1997, the emphasis was on the value of equity rather than featuring choice at first [23; 24]. New Labour won three consecutive elections by moving away from the socialist principles of Old Labour with the aim of providing a synthesis between capitalism and socialism and emphasising the use of free markets to deliver economic efficiency and social justice. With the introduction of the NHS Plan in 2000, patient choice was acknowledged as an important theme for New Labour. [25; 22] In 2010, choice was again confirmed as a principle in *Equity and Excellence: Liberating the NHS*, the White Paper published by the new coalition government formed by the Conservatives and Liberal Democrats. [26] Under the coalition government, patients were to have the choice of any qualified provider and choice of GP practice, choice in care for long-term conditions and now also choice of treatment. Patient

choice is enshrined in the new edition of the NHS Constitution for England [27] and the Health and Social Care Act 2012 referring to the patient having a right to make choices and being involved in discussions about these healthcare choices. There is of course a difference between a policy of patient choice of GP or of the hospital and time of appointment and a patient choice of treatment, even more so patient choice of publicly funded CAM treatment. When healthcare is funded by the public a choice of treatments for which there is no evidence of effectiveness such as much of CAM seems a paradox. While NICE was set up by government to ensure that medicines and treatments are clinically proven, the government's policy of treatment choice appears to suggest the public support through its taxes clinically unproven treatments.

Treatment choice of CAM within the NHS

With the introduction of the internal market and the emphasis on choice, CAM started to become more widely available via the NHS. [9] Increasing consumer demand in the private sector had exerted an impact on orthodox medical practitioners, in particular GPs, with a greater number of GPs practising one or more alternative therapies themselves. [16; 17; 18] The introduction of the new contracts enabled GPs that employed complementary therapists to be reimbursed by health authorities. [9] At the same time, GPs with fundholding practices could use their funds to purchase complementary therapies, for example, from CAM practitioners working outside the practice. [13] GPs could also refer patients for CAM to osteopaths and chiropractors as these practitioners had become state-regulated. [7; 8]

With New Labour, the growth of CAM within the NHS became subjected to a more systematic and collective decision-making process. [28] The choice policy was now focusing on equity and reductions in health variation rather than the market with its competition. For this purpose, New Labour established NICE to encourage uniform standards of treatment and promote evidence-based medicine across the NHS. [1] Thus, CAM therapies which were to be available on the NHS had to be scientifically validated. [29; 30] Although overall more CAM services were being accessed through the NHS, these were mostly paid for by patients directly. [4] A survey carried out in 2001 established that 50% of GP practices offered their patients some access to CAM treatments with the percentage of patients financially

supporting these services themselves having doubled. [4] It is not surprising, therefore, that in its response to the Report by the House of Lords Science and Technology Committee on CAM [2], the New Labour government emphasised that it supported the evaluation of CAM therapies by NICE but that only once a therapy had gained a critical mass of evidence supporting its efficacy should the NHS and the medical profession ensure that the public had access to it. [29]

The current coalition government has taken a different approach. It supports patient choice of CAM as a policy goal rather than depending on the principles of evidence-based medicine. [31] Funding decisions on CAM are to be left to local decision-makers, the Clinical Commissioning Groups (CCGs), and the role of NICE has been reduced. It is therefore expected that, with the demand for CAM by patients at present not being satisfied by public funding, NHS expenditure on CAM will increase. Although the current NHS website, *NHS Choices,* states that there is no evidence of the effectiveness of, for example, homeopathy, it also provides information as to where patients can receive publicly funded homeopathy. [32] In addition, personal health budgets, which were introduced in November 2012, provide patients affected by chronic conditions with greater choice of treatment. [33; 34] These enable them to purchase publicly funded health-related services either directly or through a third party. [34; 35] Patients have used the mechanism of these personal budgets to fund non-evidence based CAM treatments such as aromatherapy. [33; 34]

The usefulness of choice in political and policy discourse

Current political and policy discourse demonstrates enthusiasm for patient choice and treatment choice in the NHS. This is despite the fact that choice has been attacked for what it represents. Choice is regarded by some as a 'proxy for competition, marketisation and privatisation policies', and is challenged because it is seen to be in conflict with the traditional values of the NHS, particularly the value of equity or fairness and social justice. [36; 37] Thus, as has been claimed: 'The NHS is being dismantled and privatised … The disaster that is unfolding is overwhelming in its complexity and magnitude … [The NHS] has been made into a laboratory for market-based policy prescriptions.' [38] Whether choice in the NHS is inextricably linked with market economies is, however, questionable. Taking patient choice of primary care providers as an example, there can only be meaningful choice

if there is competition amongst providers for patients. Patients who are dissatisfied with the service of their GP would need to have the opportunity to switch practices. THE NHS healthcare market has of course never been a real but rather a quasi-market, and in many areas the choice of GPs is limited, with practices refusing patients if there are no spaces for new patients or the patients are from outside their catchment area. [39] Evidence also suggests that although choice of GP has been a policy objective since the healthcare reforms in 1990 it was rarely enacted by patients switching practices as patients' main concern is generally being treated close to home. [22]

Patient choice or individualist demand is also attacked as being in tension with healthcare which aims to be egalitarian. [40] In this light choice is criticised as the emphasis ought to be on the fair treatment of every patient, subject to the available resources, and in a healthcare system with limited resources, the range of options available has to be curtailed in order to achieve equality of provision of the core services. [41; 42] However, the conceptual foundations on which the English NHS is based conceal a number of tensions. The ambiguity of the original settlement values of comprehensiveness, universality, equity and 'free at the point of delivery' not only allows a large degree of policy divergence but has also enabled policy-makers of different political persuasions to use them to explain and justify their policies. [43; 40] The definition of equity or social justice can, for example, be stretched to encompass geographical equity of access, equity of access according to need and equity in terms of patients' unequal capabilities and health literacy. Because of this inherent vagueness the policy of patient choice is able to co-exist with equity. [44; 45]

Equity of access according to need is, for example, open to different interpretations and depends on whether need is defined according to a person's negative health status or in terms of a person's capacity to benefit. [44; 40] In a resource constrained system greater choice will be at the expense of some users judged less needy, whether they are considered to be less in need of acute assistance or less likely to benefit from treatment. But needs-assessment is controversial and may not be a purely medical assessment but also include social and moral judgments. [44; 46] A lack of consensus regarding the interpretation of need makes it difficult to realise a fair healthcare system while at the same time unwittingly assisting the proponents of choice.

Similarly, inequitable access to NHS healthcare may also refer to patients having unequal capabilities and differential knowledge with which to make choices. [45] Patients in higher socio-economic groups have, for example, been shown to be more able to act upon information often presented in an unfamiliar language by healthcare professionals. They have greater self-confidence in the consultation room and are more aware of their entitlements, and where and when to access services. [45] This inequity has, for example, been countered by New Labour by extending patient choice to the less well-off, providing them with information about choices and helping them to communicate with healthcare professionals. [41; 45]

Policy-makers of different political persuasion have thus been able to rely on the ambiguities of the definition of equity of access to help justify their policies. The need for policy-makers to do so is no doubt due to the importance placed by the public on the founding principles of the NHS, so that any explicit movement away could cause significant political damage. [43] In a similar vein, policy-makers have used and defended their patient choice policies as adhering to the settlement values of the NHS. Patient choice is a useful tool as it enables policy-makers to give the impression to the electorate that they are responsive and pay attention to satisfying patient needs and patient demands. In recent years, governments have associated patient choice with the notion of personalised healthcare [47] and with the concept of personal health budgets [48] with their greater openness to CAM. At the same time, they have defended the individualist approach of personalised healthcare by linking these themes with the idea of making patients responsible for their own health and lifestyle choices, the notion of 'patient responsibilisation'. [47; 48]

CAM and the policy of personalised healthcare

The concept of personalised healthcare introduced under New Labour is healthcare which is more tailored to the patient. Rather than people being given services when they needed them, it suggests that services can be influenced and shaped. [47] Personalised healthcare is a concept also promoted by the current coalition government, and this is seen as recognising that there are other issues in addition to medical needs that can impact on a person's total health and wellbeing. [49]

The attempt to offer greater responsiveness in healthcare and greater choice and personalised healthcare to patients has found its expression in the emerging mechanism of the personal health budgets. Experience with direct payments and personal budgets had already been gained in the social care sector. [34] The principle underlying the personal health budgets is that patients are to be allocated a budget, instead of directly provided services, with which they can purchase their own care and services. [48] The package of services so bought by the patient would be in addition to the comprehensive primary medical services provided by GPs. [48] These budgets were intended for patients with fairly stable and predictable conditions, such as patients with long-term chronic conditions. After a three year pilot programme started under New Labour, the scheme is now operational for people receiving NHS continuing care and plays a part in patient choice and personalised care planning, giving people more control over the money that is spent on their care. [50; 51] In the social care sector, it was found that people receiving direct payments also used them to buy healthcare services which included CAM. [34] People with long term conditions claiming personal budgets for NHS healthcare and wishing to buy these treatment modalities will then be able to do so [34] because non-evidence based CAM treatments are not off-limit or discouraged.

CAM and patient responsibility

Personalised healthcare has been justified by both the New Labour and the coalition government in terms of the original NHS settlement. In this regard, New Labour expressly underlined the need to uphold the key principles of the NHS, specifically 'equality and tackling inequalities'. [48] While the coalition government would not separate choice and personalisation of healthcare from the issue of cost management in the NHS, it also linked them with the value of equity [49; 50], thus making their fiscal policies more acceptable to the electorate. [52] Because the issue of cost management in the NHS is at the forefront of the political debate, policy-makers connected choice and personalised healthcare with the idea of patient 'responsibilisation'. [52; 53] Individuals are expected to become more involved with their healthcare by taking more control of their lifestyle choices in relation to health. The emphasis on the individual to assume responsibility for the management of her own health and healthcare and making responsible choices is also encapsulated in the NHS Constitution. [27] The theme of 'responsibilisation' is continued with the personal health

budgets. Thus, policy-makers of all political persuasions have related personal health budgets to people having independence and choice but also responsibility. [48; 52] Making patients take responsibility for their health and so reducing the acute episodes and hospital admissions of patients with long-term chronic conditions, rather than being resource intensive might lead to resource savings. Affording the patients choice and simultaneously making them responsible for their healthcare, it has been argued, will deepen their commitment to the value of solidarity [52] and lessen dependence on the NHS with the potential benefit of reducing the costs of publicly funded healthcare. [50; 52; 53]

'Responsibilisation' by making patients take more control over their health is a concept that also underlies the healthcare model of CAM. [16; 54] Unlike the biomedical model, the adoption of CAM with its emphasis on self-management and self-care will support a government strategy of 'responsibilisation', particularly of patients with chronic illnesses where CAM treatments have their place. Viewed in this light, personal health budgets affording patients this choice would achieve their intended purpose: patients' reliance on CAM might lead to growing self-reliance in health matters and even help curtail the rising costs of healthcare in the field of chronic care. According to the report on the early experiences of personal health budget holders, patients planned on using their budgets on chiropractic, osteopathy, Reiki, massage, reflexology, aromatherapy and hydrotherapy amongst other things. [55]

For policy-makers, the ability to defend their patient treatment choice policies as being consistent with the original settlement values helps to deflect the criticisms of the opponents of choice who view these policies as a strategy of marketisation. [52] However, choice does not only play this role. The use of patient choice by policy-makers as a device has additional functions that conceal different political intentions. [52; 36; 56]

Choice as a mechanism of destabilisation

The choice policy may be seen as a response to broader social change but it can also be interpreted as a tool to encourage change, as a policy intended to disrupt or destabilise the entrenched institutional architecture of the NHS and encourage reform. [36; 52; 57] Policy documents depict this dichotomy pointing to personalisation and choice as a result of cultural change, as user-driven. [48; 51; 52] At the same time they suggest that patient

choice will bring about a cultural shift, is disruptive and encourages further destabilisation. [48; 52]

Thus, in the context of the NHS, the motivation for the patient choice policy is complex, is not simply user-led and not limited to its function of increasing consumer satisfaction for electoral reasons. [57] Rather, apparent from policy documents, the policy of patient choice is a deliberate mechanism of destabilisation in order to achieve quality improvement, greater efficiency and responsiveness, administrative modernisation and cost containment in the NHS. [57] In this light, policy makers of different political parties refer to choice and personalisation as 'proxies for instability' [36] to achieve system reform, and 'as a radical agenda which will shake up the health service'. [526]

To take personal health budgets as an example, they can be seen as having a disruptive effect because of the way in which they are expected to cause change in NHS funding. [52; 48] As cash payments to the patient, they constitute a radical move from the tradition of risk-pooling in the NHS, difficult to square with the principles of the NHS where services are meant to be free at the point of delivery [52; 48] They can be regarded as a as a major system-level reform as they are likely to affect the use of a wide range of services and support in the NHS. [57; 48] As such they are likely to encourage the search for alternatives to traditional NHS provision, supporting innovative services outside the scope of traditional NHS purchasing and creating a dynamic provider market allowing popular services such as CAM to grow and adapt. [48]

In addition, the Health and Social Care Act 2012 has led to extensive restructuring of the English NHS, particularly in the primary care sector. It has extended primary care provision to include 'any qualified provider'. [59] The intention is to encourage 'fair and effective competition … [as] a means to give greater choice and control to patients to access high quality care'. [60] The commissioning of services which were outside the scope of NHS provision has brought about a reorganisation of the primary care sector and has changed practices within the NHS. At the same time the policy of patient choice may be a useful tool to encourage wider-ranging institutional change in the NHS. Patients demanding increased access to non-evidence based CAM in the NHS have become the unwitting beneficiaries of

this strategy of destabilisation as the volatility in the primary care sector has opened up a greater space for CAM within the NHS. [58]

Conclusion

Although the availability of non-evidence based, publicly funded CAM in the NHS is a paradox, it can be explained by the policy of patient treatment choice advocated by policy-makers of different political persuasions. This policy is not simply driven by the hope for electoral gains from promising citizens and patients that their demands and choices as users of public services will be satisfied. It is also not simply a theme in developing a market model of the NHS because policy-makers also wish to make their patient choice policy palatable to the public by relying on the traditional values of the NHS. The narrative of personalised healthcare and personal health budgets linked with the notion of 'responsibilisation' is clearly evidence of this need for justification. These objectives of policy-makers are evidently significant but the choice policy has a greater role. It is used to bring about change within the NHS and as a mechanism to destabilise the institutional structure of the NHS in order to encourage change and reform. Personalised healthcare and personal health budgets can thus be regarded as 'proxies for instability as a dynamic of system reform'. [36]

CAM fits into this overall picture and the lack of evidence for much of CAM is of little relevance. The policy of the current coalition government of extending primary care provision to include 'any qualified provider' includes CAM providers. Commissioning services within the NHS such as CAM which are currently outside the scope of NHS provision and commissioning services from providers not previously employed by the NHS is leading to volatility and destabilisation in the primary care sector. The provision of such services is clearly driven by consumer demand but at the same time the policy of patient choice is useful as a strategy to encourage wider-ranging institutional re-organisation in the NHS. CAM with its emphasis on self-management and self-care certainly fits neatly into the idea of making patients take responsibility for their health and lifestyle choices. Because of the potentially lower cost of CAM and the possibly reduced need for medical personnel [11] dependency of patients on the NHS might be lessened. Public funding of CAM could

therefore even be seen as supporting the founding values of equity and solidarity and aiding the drive for fiscal austerity.

In the political and policy discourse, despite the existence of NICE policy-makers' patient choice appears to trump evidence based healthcare and encourages the availability of CAM in the NHS despite the unproven effectiveness and potential lack of safety of most CAM treatment modalities. In this context, homeopathy is a particularly relevant example. In 2009, the House of Commons Science and Technology Committee had as its task to determine whether scientific evidence supports government policies that allow the funding and provision of homeopathy through the NHS. The Committee concluded that there was no evidence that homeopathy is anything more than a placebo. It recommended that the government should stop allowing the funding of homeopathy on the NHS. The funding of homeopathic hospitals—hospitals that specialise in the administration of placebos—should not continue, NHS doctors should not refer patients to homeopaths and homeopathy should be withdrawn from the NHS. [30] Even the government's own Chief Scientific Adviser suggested that the government stop endorsing homeopathy on the NHS. However, the response by the current coalition government to the Committee was that decisions on the appropriateness and availability of homeopathy were to be made by doctors, local healthcare commissioning groups and patients. As the government stressed: 'Efficacy cannot be the most important factor when selecting treatment; the overriding reason for the NHS provision of homeopathy was that homeopathy provides patient choice.' [31] Ministerial support for homeopathy is apparent to this day. [61]

Whatever the benefits to policy-makers of patient treatment choice as an electoral ploy or a mechanism to bring about change in the NHS, the question remains whether the NHS, while upholding the principles of evidence based medicine, should provide non-evidence based CAM. If NICE was set up as an institution to advise on cost-effective and clinically proven treatments then these criteria should also apply to publicly funded CAM. Otherwise one might well conclude that government policy of treatment choice results in the public funding placebos.

References

[1] National Institute for Clinical Excellence (Establishment and Constitution) Order (SI 1999/220).

[2] House of Lords Select Committee on Science and Technology. *Complementary and Alternative Medicine*. Report; Session 1999–2000: HL Paper 123. London: The Stationery Office; 2000.
[3] Thomas KJ and Coleman P. Use of Complementary or Alternative Medicine in a General Population in Great Britain. Results from the National Omnibus. J Public Health (2004) 26(2):152-7.
[4] Thomas KJ, Coleman P, Nicholl JP. Trends in Access to Complementary or Alternative Medicines via Primary Care in England: 1995–2001 Results from a Follow-up National Survey. Family Practice. 2003; 20(5):575-577.
[5] Ernst E, Pittler MH, Wider B, editors. The Desktop Guide to Complementary and Alternative Medicine: An Evidence-Based Approach. 2nd ed. Oxford: Mosby Elsevier; 2006.
[6] Boyle S. United Kingdom (England): Health system review. Health Systems in Transition. 2011; 13(1):1–486.
[7] Osteopaths Act 1993.
[8] Chiropractors Act 1994.
[9] British Medical Association. *Complementary Medicine: New Approaches to Good Practice*. Oxford: Open University Press; 1993.
[10] Ernst E. Assessment of Complementary and Alternative Medicine: the Clinical Guidelines from NICE. J Clin Pract. 2010; 1350–56.
[11] Cant S, Sharma U. A New Medical Pluralism? Alternative Medicine, Doctors, Patients and the State. London: UCL Press; 1999.
[12] Thomas KJ, Coleman P, Nicholl JP. Use and Expenditure on Complementary Medicine in England: A Population Based Survey. Complement Ther Med. 2001; 9(1):2-11.
[13] Zollman C and Vickers A. ABC of Complementary Medicine: Complementary Medicine in Conventional Practice. BMJ 1999;319:901.
[14] Inglis B. *Natural Medicine*. London: Collins; 1979.
[15] Inglis B. *Fringe Medicine*. London: Faber and Faber; 1965.
[16] Stone J, Matthews J. *Complementary Medicine and the Law.* Oxford: Oxford University Press; 1996.
[17] Fulder S*. The Handbook of Alternative and Complementary Medicine*. Oxford: Oxford University Press; 1996.
[18] Saks M. Political and Historical Perspectives. In Lee-Trewick G, Heller T, Spurr S, MacQueen H, Katz J, editors. *Perspectives on Complementary and Alternative Medicine*. London: Routledge; 2005.
[19] British Medical Association. *Alternative Medicine: Report of the Board of Science and Education*. London: Chameleon Press; 1986.
[20] General Medical Council. *The Blue Book*. London: GMC; 1963.
[21] Secretaries of State for Health, Wales, Northern Ireland and Scotland. Working for Patients. Cm 555; 1989.
[22] Greener I. Towards a History of Choice in UK Health Policy. Sociology of Health & Illness. 2009; 31(3): 309–324. doi: 10.1111/j.1467-9566.2008.01135.x
[23] Department of Health. *The New NHS: Modern-Dependable*. London: HMSO; 1997.
[24] Klein R. *The New Politics of the NHS: From Creation to Reinvention*. 6th ed. London: Radcliffe Publishing; 2010.
[25] Department of Health. *NHS Plan: A Plan for Investment, A Plan for Reform*. London: HMSO; 2000.
[26] Department of Health. *Equity and Excellence: Liberating the NHS*. London: HMSO; 2010.
[27] Department of Health. *NHS Constitution for England*. London: HMSO; 2012.
[28] Halpern S. Points of Engagement: The Integration of Complementary and Alternative Medicine into NHS Primary Care. In Pinder M, editor. *The Foundation of Integrated Medicine*. London: Arch Press; 2001.
[29] Department of Health. *Government Response to the House of Lords Select Committee on Science and Technology's Report on Complementary Medicine*. London: HMSO; 2001.

[30] House of Commons. Report of the Science and Technology Committee, *Evidence Check 2: Homeopathy*. London: HMSO; 2010.
[31] Department of Health. Government Response to the Science and Technology Committee Report, *Evidence Check 2: Homeopathy*. London: HMSO; 2010.
[32] NHS Choices. Homeopathy. Available at http://www.nhs.uk/conditions/homeopathy/Pages/Introduction.aspx [accessed on 24.11.14].
[33] White C. Do Personal Health Budgets Lead To Better Care Choices? BMJ 2011;343:d6532. doi: 10.1136/bmj.d6532.
[34] Rogers J. Personal health budgets: A new way of accessing complementary therapies? Complementary Therapies in Clinical Practice 2101; 17(2): 76-80, doi.101016/j.ctcp.2010.12.002.
[35] Department of Health. Personal Health Budgets update; 2012. Available at <https://www.wp.dh.gov.uk/publications/files/2013/01/PBUnewsletterDec2012.pdf> [accessed 6.01.13].
[36] Clarke J, Newman J, Westmarland L. The Antagonisms of Choice: New Labour and the Reform of Public Services. Social Policy and Society. 2008; 7(2): 245-253. doi.org/10.1017/S1474746407004198.
[37] Klein R. Values Talk in the (English) NHS. In Greer SL and Rowland D, editors. *Devolving Policy, Diverging Values: The Values of the United Kingdom's National Health Services*. London: Nuffield Trust; 2007.
[38] Pollock A. *NHS plc: The Privatisation of Our Healthcare*. London: Verso; 2005.
[39] Coulter A. Do Patients Want a Choice and Does It Work? BMJ (2010);341:c4989. doi: 10.1136/bmj.c4989.
[40] New B. *A Good Enough Service – Values Trade-offs and the NHS*. London: Institute for Public Policy Research; 1999.
[41] Fotaki M. Patient Choice and Equity in the British National Health Service: Towards Developing an Alternative Framework. Sociol Health Illn. 2010;32(6):898-913. doi.10.1111/j.1467-9566.2010.01254.
[42] Oliver A and Evans J. The Paradox of Promoting Choice in a Collectivist System. J Med Ethics 2005;31:187 doi.10.1136/jme.2005.011809.
[43] Oliver A. The English National Health Service: 1979–2005. Health Econ. 2005;14(Suppl 1):S75-99.
[44] Seedhouse D. *Fortress NHS: A philosophical Review of the Health Service*. London: John Wiley & Sons; 1995.
[45] Dixon A and Le Grand J. Is Greater Patient Choice Consistent with Equity? The Case of the English NHS. J Health Serv Res Policy. 2006;11(3):162-6.
[46] Ovretveit J. Values in European Health Care Markets. European Journal of Public Health. 1994; 4:294. doi.org/10.1093/eurpub/4.4.294.
[47] Department of Health. *High Quality Care for All: NHS Next Stage Review*: Final Report. London: HMSO; 2008.
[48] Department of Health. *Personal Health Budgets: First Steps*. London: HMSO; 2009.
[49] Department of Health. *Liberating the NHS: Greater Choice and Control, a Consultation on Proposals*. London: HMSO; 2010.
[50] Department of Health. *Equity and Excellence: Liberating the NHS*. London: HMSO; 2010.
[51] NHS choices. Personal health budgets. Available at http://www.nhs.uk/choiceintheNHS/Yourchoices/personal-health-budgets/Pages/about-personal-health-budgets.aspx ; 2014 [accessed 2.12.14].
[52] Needham C. Interpreting Personalization in England's National Health Service: A Textual Analysis. Critical Policy Studies. 2009; 3(2): 204-220. doi:10.1080/19460170903385676.
[53] Veitch K. The Government of Health Care and the Politics of Patient Empowerment: New Labour and the NHS Reform Agenda in England. Law and Policy 2010; 32(3): 313-331. doi: 10.1111/j.1467-9930.2010.00321.x
[54] Cohen MH. *Complementary and Alternative Medicine: Legal Boundaries and Regulatory Perspectives*. Baltimore: The John Hopkins University Press; 1998.

[55] Department of Health. *Personal Health Budgets: Early Experiences of Budget Holders*. 4th Interim Report. London: HMSO; 2011.
[56] Sheppard M. Fallacy or functionality: Law and policy of patient treatment choice in the NHS' Healthcare Analysis. Healthcare Analysis; 2014. doi.10.1007/s10728-014-0275-6.
[57] Schelkle W, Costa-i-Font J, van Wijnbergen C. Consumer choice, welfare reform and participation in Europe. A framework for analysis. European Research Papers Archive; 2010. Available at http://www.temoa.info/node/489760 [accessed 1.12.14].
[58] Forder J, Jones K, Glendinning C, Caiels J, Welch E, Baxter K, et al. *Evaluation of the Personal Health Budget Pilot Programme.* Discussion Paper, 2840_2, PSSRU, University of Kent, Canterbury; 2012. Available at <http://php.york.ac.uk/inst/spru/pubs/2331/ [accessed 6.12.12]
[59] Department of Health. *Operational Guidance to the NHS: Extending Patient Choice of Provider*. 2011. Available at http://www.dh.gov.uk/publications [accessed 1.12.12].
[60] Department of Health. *Health and Social Care Act Explained: Provider Regulation to Support Innovative and Efficient Services*. Available at http://healthandcare.dh.gov.uk/act-factsheets/ [accessed 6.12.12].
[62] New Scientist. Hail Jeremy Hunt, the new minister for magic; 05.09.12. Available at http://www.newscientist.com/article/dn22241-hail-jeremy-hunt-the-new-minister-for-magic.html#.VIyDmWcqWcw [accessed 03.12.14].