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COMPLEMENTARY AND ALTERNATIVE MEDICINE:

Expanding the boundaries of healthcare

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COMPLEMENTARY AND ALTERNATIVE MEDICINE:

Expanding the boundaries of healthcare

A qualitative multi-level analysis on the current position of complementary and alternative medicine (CAM) in Dutch healthcare.

A thesis submitted to the Graduate School of Social Sciences, University of Amsterdam, as a fulfilment of the requirements of the degree of Master of Sciences in Medical anthropology and Sociology.

Abstract

The purpose of this study is to explore the current position of Complementary and Alternative Medicine (CAM) in Dutch healthcare. It is of importance because there is not yet an overview study that is mapping the field in the way this study has done it. Furthermore, this study is relevant because the field of CAM and its corresponding rules and conditions are constantly changing due to internal and external pressure. This study consists of a multi-level analysis on the position of CAM, in which several relevant levels are studied and interviewed. Levels that are included are CAM associations and umbrella organizations, insurance companies, medical students and the Dutch government. The interviews are supplemented with document analysis and a literature research.

The level that contributes most to the position of CAM in Dutch healthcare is the level of the insurance companies. They control the field of, and access to, CAM by imposing rules and condition on CAM associations and practitioners. Medical students, who call for more CAM in their medical curriculum, are another level that influence, though modestly, the position of CAM in Dutch heathcare. Furthermore, CAM associations and umbrella organizations are trying to improve their level of professionalization and transparency by means of organizational changes, partly imposed by established medical institutions. Finally, consumer demands for CAM play a big role in positioning CAM. These levels together determine the position of CAM in the Netherlands and it can be concluded that CAM is in a secondary position when compared to regular biomedicine. However, due to external institutional pressure the field of CAM is rapidly changing. The fact that CAM is in a subordinate position when compared to regular medicine gives insurance companies the ability to impose their rules and conditions on CAM. This is not rejected by CAM associations as they have the internal knowledge that change is needed in order to further professionalize. Additionally, insurance companies can impose their own rules on CAM associations because the Dutch government is not interfering with CAM. The fact that the position of CAM is changing and improving in the USA and other European countries, combined with the increased number of scientific studies on the efficacy and safety of CAM is beneficial for CAM in the Netherlands and provides a future perspective.

Preface

You are looking at my final thesis; the result of six years of studying at the University of Amsterdam and the end product of the master medical anthropology and sociology. This thesis has been written in the period between May – July 2013 and is the result of a period of intense studying on the position of CAM in the Dutch healthcare system.

This research could not have existed without the help of my supervisor Dr. Maarten Bode. I am very grateful for his help and the pleasant meetings we have had during the past year. I have always enjoyed our fruitful conversations and I am very grateful for the useful and stimulating feedback that I received on my work.

Furthermore, I would like to thank my parents, who continued to support me during my six years of university studies, despite my doubts and delays and the switch to a whole new study.

And of course, this study could not have been done without all the enthusiastic participants. So I would like to thank all participants of the CAM associations and insurance companies that made time available for me to interview them, I have really enjoyed their participation and excitement about CAM. The involvement and openness during the interviews is highly appreciated. Furthermore, thanks to the people that I met at the conference day and who were enthusiastic about this research.

Tobias Nederkoorn

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List of acronyms

BIG	Professions in individual healthcare (Beroepen in de Individuele Gezondheidszorg)
CAM	Complementary and Alternative Medicine
CIM	Complementary and Integrative Medicine
CvZ	College voor Zorgverzekeringen
D.O.	Doctor of Osteopathic medicine
EBM	Evidence Based Medicine
EU	European Union
GP	General Practitioner
IHC	Integrative Healthcare
IN	Integraal Natuurlijk
M.D.	Medical Doctor
MoH	Minister of Health
NCCAM	National Center for Complementary and Alternative Medicine
NIH	National Institute of Health
NVAO	Dutch/Belgium accreditation institute (Nederlands- Vlaamse Accreditatieorganisatie)
RCTs	Randomized Controlled Trials
VtdK	Association against quackery (Vereniging tegen de Kwakzalverij)
WHO	World Health Organization

1. Introduction

Medical pluralism – the coexistence of multiple different medical systems in one society – has recently struck my attention. The joining or opposing forces that are active in a medical pluralistic society are described by Baer *et al*. (2004:109) as "the medical system of a society consists of the totality of medical subsystems that coexist in a cooperative or competitive relationship with each other." These forces between regular biomedicine and Complementary and Alternative Medicine (CAM) operating in Dutch healthcare, together with the increased use of CAM, turned out to be the perfect research subject for my thesis for the master Medical Anthropology and Sociology. But what started this interest? What did I find so interesting about medical pluralism that I wanted to research it for a couple of months and write my final thesis about it? What directed my quest for a research topic towards medical pluralism in Dutch healthcare? Perhaps it was a personal confrontation (and first encounter) of myself as a biomedical scientist clashing with the paradigm of alternative and complementary medicine.

Let me start at the beginning of my career as a social scientist, when the following issue occurred to me; I realized that regular trained doctors are strongly opposed to CAM. But what is it in their regular medical paradigm that turns them so vigorously against CAM? Allow me to analyse this question and to try to answer it, according to my own personal experiences gained during my biomedical sciences education. The use of CAM worldwide has increased significantly (Figure 1) (e.g. Eisenberg *et al*., 1998; Mansky and Wallerstedt, 2006; Molassiotis *et al*., 2005; Tindle *et al*., 2005) and Nissen *et al*. (2012) state that 70% of all citizens have used some form of CAM. Use in the Netherlands (Figure 2) has also increased, as well as the attention of regular doctors, medical institutions and educational institutions and the Dutch government. However, acceptance by regular medicine and integration into Dutch healthcare is far from complete.

During my bachelors program of Biomedical Sciences at the University of Amsterdam, I was trained to 'live' for evidence based medicine (EBM) and therefore I was very sceptical about the use, safety and efficacy of CAM. But somehow, I was intrigued by the world of CAM and by user experiences of CAM. This was enhanced by a new sociological point of view that I obtained during the masters program, in which I realized some things need to be studied in a qualitative way. This personal confrontation between the two paradigms made me decide to study the medical pluralism in the Netherlands. I wanted to study how CAM positions itself, and is positioned by others, next to the regular dominant medicine in Dutch healthcare.

Before continuing this introduction and the rest of this thesis, I need to make clear what CAM exactly consists of. In the rest of this thesis, I will be writing about CAM - Complementary and Alternative Medicine - even though the term alternative may not be very favourable anymore. I will not go into much more detail now about the definition, but more on the several definitions and which one is appropriate can be found in chapter 4. However, the dilemma in choosing a suitable term is that any term is a normative description and does never fully cover the whole field of complementary, alternative and integrative medicine at that specific moment of time. The same can be said about regular medicine. Several terms have been used to describe biomedicine, such as Western, regular, conventional or allopathic medicine. These terms refer to the situation in European countries and the USA,

where regular medicine is the dominant system. In this system, diseases are treated with substances that fight the symptoms. In this thesis I will be using the term regular medicine since that is the most appropriate term for describing the biomedical system in the Netherlands.

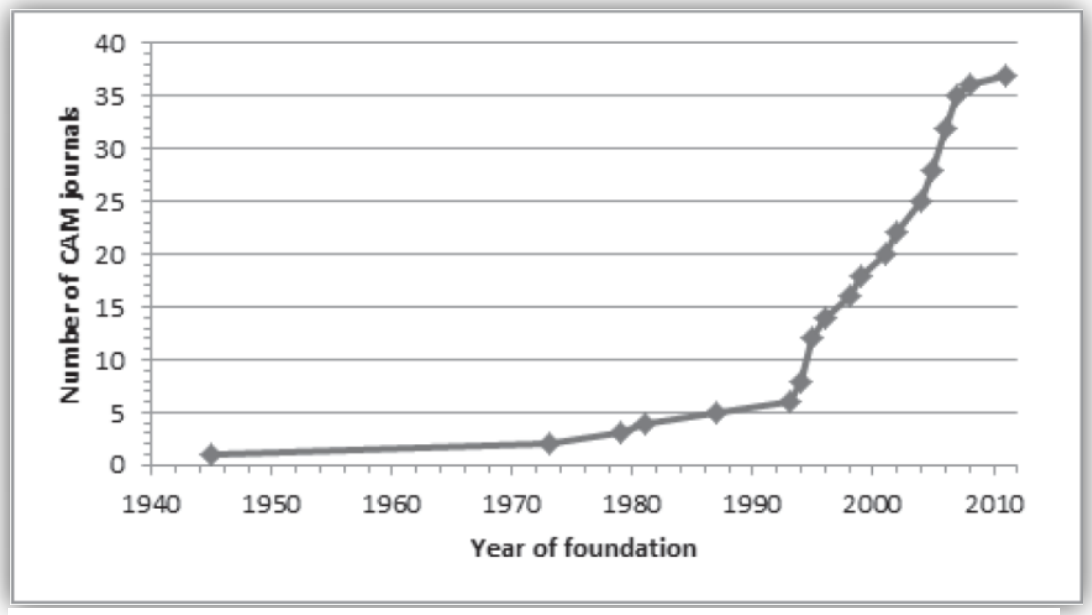

Figure 1. Development of the number of international journals on CAM since 1940 (from Reiter *et al.*, 2012)

Research objective

The objective of this research is to determine the position of CAM in Dutch healthcare. This research is an exploratory study in which multiple relevant levels are studied in order to get an objective view on the position of CAM. It is not meant to choose sides or find solutions to any problem, but it is meant to give an overview of the position, discussing the diversity of problems and/or future benefits and trends of CAM. This overview might help CAM associations and insurance companies to get a better understanding of the other parties involved.

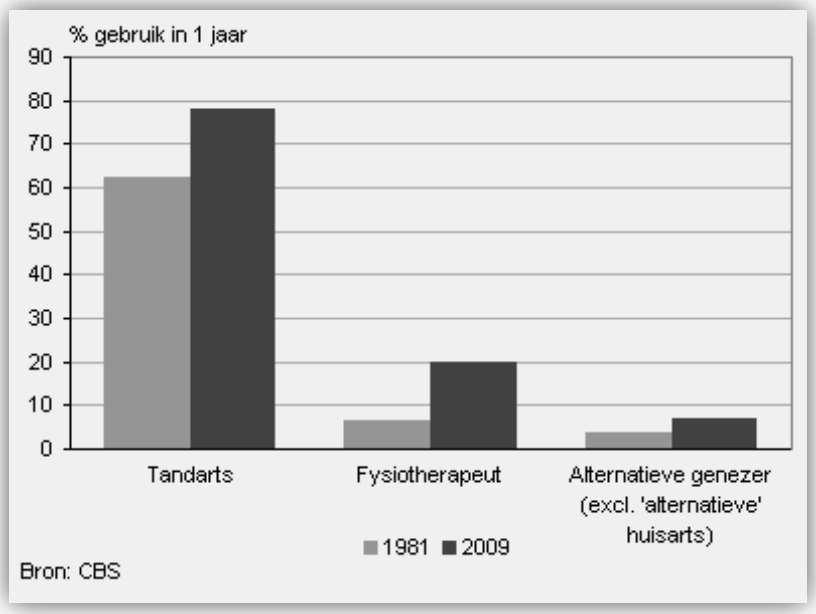

Figure 2. Use of dental care, physiotherapy and alternative care (excluding alternative GPs) in % in 1 year, comparison between 1981 and 2009 (source www.cbs.nl).

This study should help to determine the position of CAM in Dutch healthcare. To determine the position, focus should be on levels of integration and acceptation of established medical institutions like health insurance companies and academic hospitals. Furthermore, the position is determined by rules and condition of CAM associations', umbrella organizations' and insurance companies' condition for reimbursement. Finally, scientific research helps to enhance the position of CAM and it provides a network of scientific background knowledge on the efficacy and safety.

Relevance of research

The practical relevance of this thesis and research is first and foremost for the CAM field in the Netherlands; this thesis provides a broad overview of several CAM associations' and insurance companies' conditions, thereby describing the several steps that are already taken and steps that will be taken in the future, to improve professionalization and transparency. Furthermore, this research is relevant to the CAM associations, who benefit from a scientific research paper on their practices and associations.

What this research can contribute to the scientific world is less straightforward. While conducting my literature research, I came across several reports and articles about the position of CAM in Europe (ECH, ECPM, ICMART and IVAA, 2008), several articles about the US situation (including Pelletier *et al*., 2002) and articles about the Dutch situation (Verest, 2008; Kolkman *et al*., 2011). The position paper by Verest about the Dutch situation was written by six associations of CAM doctors and therefore biased as these associations are associations of professional medical doctors that are additionally trained in some form of CAM, being homeopathy, biological and natural medicine, acupuncture, neural therapy, anthroposophy and orthomanual therapy.

So the current research can contribute to the scientific literature in a way that it is the first paper that describes CAM from a multi-level perspective. It is written from the insurance companies' and CAM associations' perspective, taking into account the attitude of medical students and physicians and the perspective of the current and the former Minister of Health (MoH) (respectively Mrs E. Schippers and Mr A. Klink). Since none other position paper described the field of CAM in the Dutch healthcare system in this way, it is a unique contribution to scientific literature. Both CAM associations and insurance companies can benefit from this research, as this research is mapping the existing field and it is describing the current and future changes that are about to happen.

The social relevance is similar to the practical relevance, in the sense that it provides a unique overview of the current field of CAM, and the upcoming rules and regulations in order to professionalize the CAM associations and CAM practitioners and to better integrate CAM in Dutch healthcare. Furthermore, since the CAM user numbers are higher than ever, a large majority of Dutch citizens need information about CAM. Therefore, an overview of the field of CAM in the Netherlands can provide them with additional information.

Research question

The goal of this study is to understand what influences the position of CAM in the Netherlands. Therefore, the central research question is:

What is the current position of complementary and alternative medicine in the Dutch healthcare system?

To answer this question, CAM will be studied using a multi-level analysis. As the attitude of medical students and regular doctors is already extensively studied by Kolkman *et al*. (2011), the emphasis will be on insurance companies and CAM associations. The main question can be divided into several, participant dependent, sub-questions:

- *How do insurance companies decide about their policies and what is the influence of the medical professionals?*
- *How are the conditions for reimbursement defined?*
- *Where is the border between wellness and healthcare in CAM?*
- *What implications do reimbursement conditions have on CAM practitioners?*
- *Why is CAM reimbursed in the additional insurance packages and what is the influence of consumers demands?*
- *What is the role of scientific evidence and research in CAM reimbursement policies?*

These sorts of questions will be used to study the insurance companies and their motives for reimbursement of some CAM therapies. Questions for CAM associations are:

- *How are the membership conditions defined?*
- *What are the implications of the reimbursement and insurance company conditions?*
- *What is the importance of scientific research and evidence?*
- *How is the future of CAM going to be influenced by current trends and changes?*

These questions will help to determine the position of CAM in Dutch healthcare.

Structure of the thesis

This thesis is written as a problem analysis from the CAM associations' perspective. The questions used in this study resulted in the observation that CAM is in a subordinate state in Dutch healthcare, when compared to regular medicine. But how to solve this problem and improve the position? Therefore, this problem analysis and the data chapters are structured around the main problem. Chapters four, five and six focus on possible solutions for the obstacles that still need to be removed. These obstacles are:

- The definition and the borders of CAM, what is part of CAM and what not? This will be discussed in Chapter four.
- The need for professionalization and transparency. What actors and actions need to contribute to improve this: associations, umbrella organizations and insurance companies, but also government and medical students. This will be handled in Chapter five.
- The lack of integration in regular medicine. Several solutions for this problem will be discussed in Chapter six.

Chapter 7 is about changes and trends in foreign countries like Germany, Swiss and the US in which CAM is more accepted and integrated. But first, the theoretical framework and methods of this study will be discussed in the next two chapters.

2. Theories

During the process of researching and writing, the underlying theoretical framework is constantly in the back of your head, trying to relate the data to the theories and thinking about how to interpret the data. The theoretical framework determines the way the data is represented and therefore it is important to be clear about the theoretical framework used in this thesis. I have chosen to commit this chapter to the theoretical background and the justification of my choices.

Theoretical framework

The theoretical framework that I use in this study is a combination of two theories. Firstly, institutional theories are used to study the responses of medical institutions towards pressure from social movements. Secondly, social movement theories will be applied to study CAM practitioners, clients and CAM associations collectively as a social movement that is applying pressure to established institutions in order to reach their shared goal. These theoretical frameworks are relevant in this study because the established medical institutions in the Netherlands are possibly pressurized by the field of CAM and the public demand for CAM. CAM is an acronym of medicine and therapies and not an acronym of organizations or practitioners. CAM activists are not CAM but they use or practice CAM, but for the sake of clarity, I will continue to describe CAM practitioners and user as a social movement. Furthermore, not all CAM practitioners and activists might share the same ideology; therefore focus will be on different CAM activists and their attitude towards the biomedical system. These are the two theoretical frameworks that are used in this thesis. In the following paragraphs these two theories will be discussed more elaborately.

Institutional theories

A perspective that can be applied to the multi-level analysis of the position of CAM is the institutional theories perspective. Institutional theories focus on the way changes are made in institutions in response to pressure. Pressure can be applied either from an external source, or from within the institution. In an article about the dynamic interplay between Western medicine and the CAM movement by Goldner (2004), the focus is on the response of US hospitals and physicians towards the CAM movement. Goldner describes CAM as a social movement for reasons that will be discussed later on in this paper. In response to the high consumer demands and use of CAM, the federal government started to fund research on CAM, doctors started to refer patients to CAM practitioners, integration of CAM occurred in hospitals and reimbursement from insurance companies got more common. In Goldner's article the different responses by institutions are monitored and the focus is only on doctors and hospitals, because that "is where change is now occurring." (Goldner, 2004:711). Goldner's incentive for using institutional theories is the social movement that is pressurizing the institutions to adopt more CAM and Goldner wants to explore how institutions respond to the pressure.

In Dutch healthcare, similar changes are happening, or are starting to happen, to the dominant regular medicine and the way of thinking about health and disease. This is also referred to as hegemony of biomedicine in the Western world. Regular medicine dominates the medical system which is shown in the mindset of institutions like the government, insurance companies, universities and pharmaceutical companies. Due to the rise of the dominant hegemony of regular medicine, CAM has shifted towards a subordinate position. However, increased use and consumer demands for CAM and the fact that regular medicine

is sometimes inadequate in treating chronic diseases, CAM practitioners and users have created a niche for themselves. Since then CAM is applying pressure on the existing hegemony. Hegemony is never static but always subject to change and never complete (Natrajan, 2003). Hegemony is even created by the position of complementary and alternative medicine itself, being subordinate to regular medicine and being less evidence-based.

Institutional theories can be used to study the responses of established institutions to external pressure trying to achieve change in certain structures of institutions. Hospitals and healthcare clinics are the location for CAM movements since physicians are the main actors and they decide what response is appropriate from the hospital (Goldner, 2004:711). Besides hospitals, insurance companies are targeted by CAM movements, as they control the financial aspect for most CAM clients. Therefore, these institutions control the CAM movement; it acts as a gatekeeper for CAM and it is therefore important for CAM activists to observe every response from the institutions. Early institutional theories stated that institutions adapt to pressure from the outside and absorb new elements in order to win consent (Goldner, 2004:712). New institutional theories, or neo-institutionalism, study the way organizations interact and the way they affect society. In Goldner's article the focus is on Oliver's (1991) work which was used as general input to define the different responses from institutions. Goldner argues that social institutions, such as medicine, can avoid, join, integrate, co-opt (manipulate) or counter the demands of the CAM movement (Goldner, 2004:712-13). Most institutions share the same goal, which is to survive and be able to continue to exist. In order to survive, institutions need to adapt to pressure to increase their probability of survival (Zucker, 1987). Institutions need to do more than being economically successful: institutions need to be trusted by society and need to have gained legitimacy (Zucker, 1987).

Institutional theories can be a useful theoretical perspective for the research on the position of CAM in the Dutch healthcare system, as it focuses on the response of institutions to external pressure. This theoretical approach is suitable for studying CAM in The Netherlands from a multi-level perspective, especially since the focus of the research is going to be on insurance companies and their responses to pressure from an external source. Since this thesis is an exploratory study aimed at researching the position of CAM next to regular medicine, the five responses described above seem to resonate with the outcomes of the fieldwork. Furthermore, the two approaches of institutional response described by Zucker (1987:444) can be applied in future research. These approaches describe the process of decision making in institutions in response to external pressure, and can be divided in the adoptive approach and the individual approach. These approaches are part of institutional theories, and can be used to determine whether institutions copy from each other, or base their choice on individual normative decision making.

Institutional theories also have their limitations, since they are purely focused on institutions and their response to external pressure. To understand the position of CAM from a multi-level perspective, institutional theories are simply not enough. Institutional theories are not appropriate for the analysis of CAM movements and motives for applying pressure on healthcare institutions. Thus, to focus on CAM as a movement, to describe why CAM can be seen as a social movement and to study how social movements request change from

established institutions, social movement theories appear to be an appropriate theoretical perspective. This theoretical framework will be discussed in the next paragraph.

CAM users as a social movement

The broad overarching term complementary and alternative medicine consists of a whole range of medicines and treatments that are used by a whole range of people for lots of different purposes. CAM is mainly used as a complementary treatment next to regular medicine. To consider CAM as a social movement, focus needs to be on the CAM practitioners and patients. It should be stated that CAM itself is not a social movement, but CAM consists of practitioners, users, patients, associations and umbrella organizations that are all interfering with CAM. They are connected through some sort of cohesion; this could either be through ideologies, CAM use and practices or organizational structure of CAM associations. Not one single form of cohesion is typical for CAM movements. Because the number of people involved is so large, CAM could be conceptualised as a social movement.

To consider what a social movement is, I use Della Porta and Diani's (1999:16) definition of social movements as used in Brown *et al.* (2011): *"*informal networks based on shared beliefs and solidarity which mobilize around conflictual issues and deploy frequent and varying forms of protest." In Goldner's (2004) article, CAM practitioners and patients considered themselves as activists and their participation as activism. The collective impact they were trying to achieve, convinced Goldner to perceive CAM patients and practitioners as social movements (Goldner, 2004:711). Although the activism consists of individual acts and patients are not collaborating in their activism, the same goals are shared and this creates a collective aim. Activists identify with social movements and by collaborating they pressurize the established medical institutions to change their policies on CAM use or accept more CAM use into everyday medical practice. Although social movements refer to people as activists and the unification of beliefs as the force of pressure, CAM does not refer to people but to therapeutic itineraries that people choose. However, I want to argue that CAM can be seen as a social movement, because "of the number of people identifying as activists and the collective impact they are achieving." (Goldner, 2004:711). Although Goldner described the Canadian situation, her perspective could also be applied to the Dutch situation.

In every social movement, there are more active participants who actively spread the message and actively challenge the medical institutions and there are less active participants, who support the message but are not actively and openly challenging the institutions. This is also the case with the CAM movement; there are bigger and more active participants that have a larger number of followers to rely on for support. Although there is not one organization that identifies for all activists, there are several organizations consisting of patients or practitioners. The fact that patients and practitioners are united through ideology created united activism, which is much stronger than individual pressure and activism.

Unification of CAM users in one all-embracing social movement, thereby combining people's activism based on shared ideologies, seems a perfect way to achieve better and more thorough integration of CAM into the Dutch healthcare system. By combining associations and practitioners, CAM stands stronger against the institutions. However, not all CAM practitioners and activists agree, or are comfortable, with the integration and acceptance of CAM in the biomedical environment (Perryman, 2005:3) and "some activists

welcome integration, others prefer separation" (Goldner, 2004:712) from the biomedical health institutions. Different levels of CAM integration are desirable, including ignoring, complete integration, separation, cooperation and/or co-optation. Additionally, the terms that are used to describe CAM differ and range from integrative medicine, complementary or alternative medicine. This reflects the different goals for CAM practitioners and patients (Goldner 2004:722). "Some find co-optation to be the desired end-result, while others feel that in doing so core values will be compromised. For that reason, while integration of CAM is recognized as a symbol of its acceptance by Western medicine, it also may signal change in the methods and standards of practice." (Perryman, 2005:4). On the other hand, it can be a welcome addition for insurance companies to integrate CAM in their reimbursement policies. It will retain consumers that are interested in CAM practices and it can achieve real savings "due to the lower cost of alternative practices that do not require the intensive technology." (Perryman, 2005:3).

So it can be argued that social movement theory is a useful perspective in understanding and analysing the pressure from the CAM movement towards established health institutions. The pressure of several CAM groups in Ontario, Canada has proven to be effective as several CAM practices are now available in Canada's state sanctioned medicine (Kelner *et al.,* 2004). The only limitations are the different intentions of the different CAM practitioners, which may disrupt the unification based on similar ideologies.

Conclusion on theoretical framework

The institutional theories and social movement theories being used together in a kind of similar study (Goldner, 2004), convinced me to use these two theories in the current study. The two theoretical frameworks provide me with a lens for analysing my data. The combination of the two theories enables me to study the interaction between CAM movements and institutions. This combination is necessary because social movement theories have rarely been used in the study of social institutions and social movements which demand change from institutions have hardly been studied with the help of institutional theories (Goldner, 2004). Combining the two theories allows me to explain more thoroughly how biomedical institutions respond to CAM movements and how CAM activists conceive these responses.

3. Research methods

This chapter describes the methods used in this research; I explain why I have chosen this type of research and what the benefits and disadvantages of qualitative research are. Secondly, I define my research population and the methods of sampling and data analysis, and the efforts made to keep this research as reliable and objective as possible. In the end, nine interviews have been conducted with five CAM associations, one umbrella organization and three insurance companies. This has been combined with notes from a conference day, several government article and documents, and scientific literature. Altogether, this has created a pile of data which seems more than enough to answer the research question. Before continuing with the analysis of the data, ethical considerations will be discussed together with the reliability and validity of this research.

Research type and justification

The incentive for doing research on a certain problem or question can be many different reasons. As I have already elaborated on the relevance of this research in the introduction, I will not go into much further detail in this section. However, considering the scientific and social relevance of this research topic, qualitative research seemed the most suitable kind of research. Qualitative research comprises several data collection methods, of which interviews seemed to fit best for this thesis, supplemented with document analysis. As argued by Adler (1999:219) in Perryman (2005:5), qualitative research is very suitable for researching CAM because it accentuates “emic perspectives and a holistic style of inquiry.” Qualitative methods are much better in reflecting “diverse and complex perceptions, beliefs and practices than quantitative methodologies […] empowering interviewees as experts, rather than reductively analysed subjects.” (Perryman 2005:5). Furthermore, I want to study the position of CAM from a broad perspective, so I reckoned the multi-level analysis would fit best. The advantage of a multi-level study is that several relevant levels of society are studied and all interests and conflicting standpoints are mapped out (Van der Geest *et al.*, 1990). In this study I have focussed on CAM associations, insurance companies, the Dutch government and students and physicians. These levels will be used in the analysis where relevant. However, due to time limitations, not all relevant levels have been studied. Other interesting levels would have been the CAM users/patients, CAM researchers and CAM producers and distributors. Data are collected through interviews and document and literature analysis.

Study location and participants

In early 2013, I started to send emails to CAM associations and insurance companies (See appendix 1 and 2). I decided to focus on the larger CAM associations, because I expected them to have a better overview of the CAM situation and a more professional management, hoping they would have the time to speak with me. Not all associations responded, but the associations that replied were willing to speak with me for several reasons, one being that this research was another step towards scientific approval. I had also send a request to the two biggest umbrella organizations (RBNG and SRBAG), of which one forwarded my question to several other associations (the so called snowball sampling) and the other one was willing to speak with me.

In the end, I had made appointments with five CAM associations (VBAG/IN, IBMT, NVT, NVKH, NVPIT), one umbrella organization (SRBAG) and I registered as a participant

for the Day of Complementary Care, organised by the other umbrella organization RBNG on April 19, 2013. There were several guest speakers; one of them was Mrs. G. Verbeet, the former chair of Dutch parliament. She now is the chair of the Federation of Patients and Consumer Organizations (NPCF) in the Netherlands, and spoke about her view on patients and the complementary healthcare, and whether CAM should and could be in the basic health insurance. She also described the point of view of the current political agenda on CAM. This will be discussed in the following chapters. All interviewees hold the chair of their association. The quotations of these interviews are numbered 1 till 6.

The Dutch health insurance system is based on a basic health insurance and additional insurances, offered by several insurance companies. The role of the Dutch government is to decide what should be in the basic health insurance; this is done through the College voor Zorgverzekeringen (CvZ). Insurance companies decide for themselves which, if any, CAM is reimbursed in the additional insurance. This selection is done according to rules and regulations created by them. The situation with the CAM associations and umbrella organization is not regulated by the government and practitioners are free to set up, or join existing, associations. However, if an association wants to be part of an insurance company's reimbursement program, the associations need to conform to several conditions.

The current situation with insurance companies is that there are nine insurance companies (appendix 3), who offer one or more different types of insurance policies. I wrote to all nine companies, without selecting for additional insurance policies on CAM. Not all of them replied, but three were willing to speak with me (Achmea, ONVZ and CZ), two said that they had no time (VGZ and Menzis) but they sent me some additional information. One (ENO) said that they lacked a CAM specialist and others did not respond at all or negatively to my request. The people that I interviewed are a medical advisor, a brand manager and a policy employee. The quotations of these interviews are numbered 9 till 11 in the thesis. See appendix 4 for a detailed list of informants.

The research done by Kolkman *et al.* (2011) - on attitudes towards and knowledge of CAM among Dutch medical students - seemed appropriate to use as one level of the multi-level analysis. As another level, I wanted to involve the Dutch government and I tried to get in contact with someone from the Ministry of Health. However, this did not work. Several requests were send but it was impossible to get to speak to someone of the ministry. So the position of the Dutch government is completely build up from literature and scientific articles about the Dutch government in relation to healthcare, and on documents from the website www.rijksoverheid.nl, where answers from the current minister of health Mrs E.I. Schippers and the previous minister Mr A. Klink can be found.

Needless to say, this research does not cover the complete field of CAM associations and insurance companies in Dutch healthcare. Estimations on the number of associations vary between 250-500 different associations. In this research I often speak about the field of CAM, or the CAM movement, because several active players in the field are trying to collaborate more intensely to combine forces and really make a statement as one CAM movement towards the established medical institutions, but more on this in the next chapters.

The interviews

The interviews lasted between 45 minutes and 1,5 hour. All interviews were done in Dutch, which means that I have translated all the quotes used in this thesis. All interviews took place at a time and location that was convenient to the interviewee, which meant I travelled throughout the country to visit them in their offices. Besides holding the chair of the associations, all of the interviewees were also active practitioners and some had their practice/office at home. Some interviews were done with two people of the same association or company. Before the start of the interview, verbal consent was asked for recording and for the use of quotes in the thesis. All participants gave their informed consent and agreed on the fact that their quotes could be used in this thesis, most of them preferred to be quoted anonymously and wished for the thesis to be seen and read prior to publication. The fact that the quotes are all translated into English by the author increases the anonymity. Before the start of the interview, I introduced myself and told about my background and about the research project and mentioned the themes that I wanted to discuss.

The interviews were very flexible and I did not try to interfere too much as long as all themes were discussed. The interviews were semi-structured; I had a list of themes that I wanted to discuss (appendix 5 and 6) but the order of questions and themes depended on the structure of the interview. I mainly used open questions to give the respondents the opportunity to state their opinion, but sometimes I used probing questions or closed question to get a clear statement. The fact that I used a flexible approach in interviewing created openness for the interviewees to come up with new themes. This helped me to really understand their point of view. Furthermore, by keeping the interviews very open and flexible, I tried to keep it informal. All interviews were recorded and later transcribed using transcription software. The interview transcripts were then reviewed individually and analysed and coded using the coding software Atlas Ti v7.0. Codes were later on grouped into several overarching themes: professionalization, research, integration, CAM definition and global tendencies. These themes made it possible to group and sort data based on codes. This was convenient to compare and analyse the data. Furthermore, these themes and codes have been very helpful in writing the thesis, as can been seen in this thesis layout.

Additionally to the interview data, a wide reading of relevant literature on CAM integration, European and global developments, insurance reimbursement policies, governmental policies and literature on the definition of CAM is also included.

Reliability

This thesis is based on qualitative research. This is less standardized than quantitative research and this makes it more difficult to judge the material and methods of analysis. Qualitative research is more susceptible to subjectivity of the writer. However, the intention of this research is not to judge on any side, or to choose any position concerning CAM in Dutch healthcare. This research is purely meant as an exploratory research to study the position from as many relevant perspectives as possible. So in writing this research, I have made an effort to stay as objective as possible about the data and to write from all relevant perspectives.

To guarantee the reliability of this research, I have used the same set of themes for guiding the interviews, all interviews had an exploratory character, lasted on average one hour and were recorded. The fact that in every interview the same set of questions and

themes were used has greatly improved the reliability of this research. At the start of the interview I asked all participants to introduce themselves and to tell about their job or profession. Furthermore I asked about the therapies offered by the practitioners of that associations, this was done to create an open and informal situation in which both parties felt comfortable to talk.

Validity

A researcher analysing qualitative data and doing face-to-face interviews should always try to remain as objective as possible. However, that is very difficult as the personal background and education of the interviewer may come to the fore. In addition, the data is analysed by the same person as the one doing the interview, so what you are reading here in this thesis, is my interpretation of the data collected. It is the story of my informants, but written down and interpreted by the author, so therefore it is partly my story. However, conducting interviews as a data-collection method was the only way to collect the data needed for this research. Besides that, interviews are a useful technique to gather in-depth information from an individual, but they have limitations as well. It is very time consuming and the collected data are harder to generalize due to the smaller sample size. Subjectivity of the interviewer may jeopardize the validity of the answers given and the interpretation of the interviewer may alter the meaning of the answers given by the interviewee.

Another point that I need to be aware of is my background as a biomedical sciences student. This may have created my interest in medical pluralism, it has contributed to this research and has made me think about the whole debate on quantitative vs. qualitative research. Biomedical sciences have taught me to only accept evidence from scientifically solid and sound research methods: the randomised controlled trials (RCTs). However, this thesis, and the literature read prior to the research, has opened my mind for qualitative data, which is not so easily generalizable, but is a very effective method to go in depth in a situation. The fact that qualitative research is not easily generalizable does not make it less reliable and valid, besides, the purpose of this kind of research is not to be able to generalize the outcomes to a wider population. The purpose of this study is to explore the field of CAM.

Ethics

The subject of this research is not very delicate, but I have chosen to keep the identities of the informants anonymous. I have chosen for this because I reckon it is not of importance for the reader to know exactly what any individual said, but I have made a clear distinction in quotations between CAM associations and insurance companies (1-6 and 9-11). Furthermore, I have chosen to keep the individuals anonymous as their personal experiences with CAM might contradict their professional identity. Furthermore, I have not been studying a vulnerable population so I did not expect a lot of ethical dilemmas. But, before starting each interview, I have explained the participant the goal of my research and asked for their informed consent to record the conversation.

A consideration that I need to be aware of is, as already mentioned, my own position on CAM and my background in biomedical sciences. I was trained to ‘live’ for evidence-based medicine and need to be aware of that and try to stay as neutral and open as possible during interviews. My personal identity and attitudes towards CAM should not affect the anthropological perspective necessary in this research. On the other hand, I think that my

biomedical background might have been beneficial in order to gain trust and access to medical advisors.

4. Defining CAM

Before starting the chapters on data and the data analysis, I want to make clear what complementary and alternative medicine actually comprises and what different categories can be found in the field of CAM. Gaboury *et al.* (2012) conducted a study on the term CAM and IHC (Integrative Healthcare) and whether those overarching terms were appropriate to use. Gaboury *et al.* concluded that those terms were, for the time being, useful because it appeared difficult to reach a general consensus on the definition of CAM due to "the topic being politically charged, but also because depending on the healthcare system context (national and international)."(Gaboury *et al.,* 2012:1). The difficulty is to determine a general, worldwide, consensus on the definition of CAM that is accepted in every single country and context. But is a general and universal definition of CAM necessary? And is it possible to define the very broad field of CAM in one term? Because a certain method or therapy could be considered part of CAM in one country, while in another country this therapy might be related to normal lifestyle or regular medicine.

According to the National Center for Complementary and Alternative Medicine (NCCAM)[1], the definition of CAM is "a group of diverse medical and healthcare systems, practices, and products that are not presently considered to be part of conventional medicine" (NCCAM, 2013). But it is also noted that defining CAM is difficult due to the very broad nature of the field and the constant changes. Conventional medicine is defined "as medicine practiced by holders of the degree M.D. (Medical Doctor) or D.O. (Doctor of Osteopathic medicine) and by their allied health professionals such as physical therapists, psychologists, and registered nurses" (NCCAM, 2013). In this definition there are no clear boundaries between CAM and regular medicine and this definition is only applicable to Western countries, since these countries have a dominant Western medicine system. Additionally, the NCCAM definition does not describe what CAM is, but describes what CAM is not.

Due to changes in levels of integration of CAM in mostly the USA, the term CAM is replaced by CIM (Complementary and Integrative Medicine) and CIM is seen as an evolution of CAM. This was also stated in several interviews:

> *"I rather not talk about alternative medicine, I just don't like that word, it should be complementary and integrative medicine, I consider that this term makes perfect sense of what it's about!" (5)*

So although personal favour of the CAM associations tends to integrative medicine, several institutions have also been working on the definition of CAM, and they still favour the term complementary and alternative medicine. The definitions of two other key medical institutions dealing with CAM in the world, the World Health Organization (WHO) and the European CAMbrella will be discussed below. The WHO defines it as:

> *"Traditional medicine is the sum total of the knowledge, skills, and practices based on the theories, beliefs, and experiences indigenous to different cultures, whether explicable or not, used in the maintenance of health as well as in the prevention, diagnosis, improvement or treatment of physical and mental illness." (WHO, n.d.)*

[1] NCCAM is part of the United States' National Institute of Health (NIH) and is funded by the US government through the NIH.

Added to this was:

> *"[...] the terms 'complementary medicine' or 'alternative medicine' are used inter-changeably with traditional medicine in some countries. They refer to a broad set of healthcare practices that are not part of that country's own tradition and are not integrated into the dominant healthcare system" (WHO, n.d.).*

The great variety of terms used to describe CAM, its practices and products, has also struck the attention of one of the workgroups of the European CAMbrella project. The intention of the workgroup was to explore the existing definitions of CAM and to develop a pragmatic definition of CAM that is accepted Europe-wide. The proposed definition of CAM by the CAMbrella workgroup is:

> *"Complementary and alternative medicine (CAM) utilised by European citizens represents a variety of different medical systems and therapies based on the knowledge, skills and practices derived from theories, philosophies and experiences used to maintain and improve health, as well as to prevent, diagnose, relieve or treat physical and mental illnesses. CAM has been mainly used outside conventional healthcare, but in some countries certain treatments are being adopted or adapted by conventional healthcare"* (Falkenberg *et al.,* 2012).

In this definition of CAMbrella, parts of the WHO and the NCCAM definition can be found. It is considered a great improvement and should definitely be workable in Europe; it takes into account the different statuses of CAM in different European countries. Countries such as Switzerland, Germany and the UK are ahead when compared to other EU countries concerning CAM integration, see chapter 7.

The proposed definition by CAMbrella is still a big overarching definition and does not discriminate between the many different forms of CAM. CAM is a very broad field of practices and products and therefore it is hardly possible to include it all in one big overarching term. It could be asked whether it is necessary to create one definition of CAM, but Falkenberg *et al.* (2012) demonstrated the need for it. In their article, which is also part of the CAMbrella project, it is stated that "a lack of consensus about the definition can have negative implication for future research and clinical practice. It might prevent effective inter-professional collaboration between conventional and CAM practitioners." (Falkenberg *et al.,* 2012:6)

As a final remark on this definition of complementary and alternative medicine, perhaps the word Alternative should be replaced with Integrative, turning CAM into CIM. This was also mentioned in the interviews with CAM associations. The term for the use of CAM tends towards complementary medicine, being used next to conventional medicine and no longer as alternative to regular medicine. According to Barrett *et al.* (2003) integrative medicine refers to the integration of concepts, values and practices from alternative, complementary and conventional medicine. Despite recent movements towards integration, CAM is not yet fully integrated in the healthcare system, due to gaps in the economic, organizational and scientific setup of CAM and regular medicine. These gaps still need to be bridged in order for CAM to be fully replaced by CIM. Furthermore, the widespread lack of

understanding CAM, due to the lack of proper research and efficacy studies, continues to jeopardize the attempts at integration. Due to the fact that CAM is not fully integrated and insurance companies still talk about alternative medicine in their reimbursement conditions, I have decided to use the term CAM in the rest of this thesis, to avoid any further complications.

CAM ambiguity

The problem of defining CAM has created a certain chaotic structure in CAM and insurance companies and consumers lack the knowledge on CAM to determine what is seen as CAM treatment, product or supplement. Therefore, a possible solution might be to divide the field of CAM into several subcategories, to draw the line between healthcare, wellness, psychological, spiritual and physical therapies. Previously, consumers would get reimbursement for all CAM healthcare and wellness, because CAM itself did not make a clear distinction. This is seen in the Cochrane Collaboration[2] definition of CAM; it states that all practices and ideas outside conventional medicine are included in the definition of CAM. The practices are "defined by users as preventing/treating illness, or promoting health and well-being" (Manheimer and Berman, 2008 in Kooreman and Baars, 2011).

However, the need to create a border between healthcare and wellness is also noticed by the insurance companies as they call for a clear distinction between CAM healthcare and CAM wellness. This is also visible from the conditions, which explicitly state that reimbursement is only given for individual sessions, and not for (group) coaching and/or relaxation sessions, like yoga.

> *"Within our association we have made this pretty clear: individual therapy sessions are liable for reimbursement, [...] but group therapy activities, or a workshop about personal development, are not accountable for reimbursement." (3)*

> *"No we don't reimburse wellness or relaxation sessions, no we don't reimburse that, that's not part of alternative medicine. It should be aimed at finding a cure." (10)*

Another insurance company has recently changed their reimbursement conditions for CAM, to ensure that yoga was no longer reimbursed, because it is not considered healthcare but wellness. But Balasubramaniam *et al.* (2012) researched the effect of yoga on neuropsychiatric disorders and although more research is needed, there is emerging evidence from RCTs to support the positive effects of yoga on neuropsychiatric disorders. The reason for insurance companies to create a certain division in the field of CAM has probably to do with the financial consequences of the reimbursement. But the divisions might be subjected to change in the future, as more research will be done on benefits of CAM. Besides the insurance companies' incentive for a clear division of CAM, it is also important for the client to be able to draw the line between what CAM is and what not, to ensure the quality of care.

[2] The Cochrane Collaboration is an independent international network of people working together to help healthcare practitioners, policy-makers, patients and their advocates make the best informed decision about health care. Their work is internationally recognised as the benchmark for high quality information. http://www.cochrane.org/about-us

> *"It's for the importance of the consumer that this is really well set up, so that you can close off what you call: the grey circuit." (2)*

Insurance companies are constantly changing their conditions for reimbursement and are trying to draw the line between healthcare and wellness. But this is very difficult, as one example - given during an interview about people with problems at work, who might have difficult contact with colleagues - illustrates. These people are not mentally or physically ill, but they might benefit from certain CAM treatments, but this is not reimbursed by the insurance company.

> *"Yes at a certain point in time it becomes very difficult to make the distinction: is this still healthcare or a personal growth project? [...] This makes it very difficult for insurance companies, because they don't want to, and I completely understand, they don't want to pay things that are not part of healthcare." (3)*

What is needed for the insurance companies, it that CAM practitioners clearly state on their invoice what kind of therapy or session it is for. This way, insurance companies know whether to reimburse it or not. Additionally, it stimulates further professionalization and transparency, but more on this in the next chapter.

5. Professionalization and Transparency

The ultimate goal for CAM professional associations is to increase professionalization and transparency, and to gain acceptation by established institutions, such as insurance companies, education accreditation institutes, medical professionals and the Dutch government. But how to achieve professionalization and increased transparency? The answer to that question is found in this chapter. It is going to be build up from CAM associations' and insurance companies' demands and reimbursement conditions, to government conditions for practitioners. The final goal is professionalization of the field and this is achieved by several steps currently being taken, and in the near future.

To increase professionalization and to achieve the final goal of CAM practitioners and associations; to become an integrated part of Dutch healthcare, several steps need to be taken. These steps include independent accreditation of CAM training and education, professionalization of CAM associations' and umbrella organizations' management structure and increasing transparency of organizational structure, influencing the Dutch government with valid research results and efficacy research.

Accreditation of education programs

The first step towards professionalization and integration of CAM into Dutch healthcare is education and training. Currently in the Netherlands, the BIG law[3] is active which protects certain professions and thus the "control of entrance" to the regular medical practice (Cant and Calnan 1991:49). The BIG register is a closed register and people can only be taken up in this register when having successfully completed NVAO[4] accredited education and training programs. This is not the case for CAM training and education, however, CAM associations wish the government would interfere with it and provide CAM professions with a register like BIG. This would dramatically increase the credibility and professionalization of CAM practitioners.

> *"Yes something that we have already been pledging for for several years is that the government would interfere with the education and training. The government should accredit the education programs according to the NVAO system, because that would be best, that these alternative professions are regulated in some sort of BIG law." (2)*

Many CAM associations have specific training and education institutes that are accredited by themselves according to their own standards for education. However, these educational institutes are not accredited by an independent accreditation institute, like NVAO, and therefore any CAM association can claim that they offer HBO-bachelor level[5] CAM education. The self-accreditation of education programs may lead to biased accreditation results. To achieve complete transparency, an independent accreditation institute should

[3] The BIG law was implemented in 1997 and was created to protect certain acts of medical care (injecting, removing of tissue by cutting or endoscopies) to be solely done by professionals (doctors, dentists and midwives) due to the health dangers involved. Practitioners not registered in the BIG law may diagnose and treat patients by other ways, not mentioned in the BIG law. Furthermore, the BIG law was implemented to protect the title ´doctor´, the title ´healer´ and ´therapist´ is not a protected title. Additionally, the BIG law provides a certain financial benefit in the form of a tax remittance for persons registered (Klink, 2010).

[4] NVAO is the Dutch/Belgium independent accreditation institute for higher education institutions. It was established to ensure the quality of higher education in the Netherlands and Flanders. (NVAO, n.d.)

[5] HBO-level education: HBO is the equivalent of the University of Applied sciences

accredit the education and training programs in an open and transparent way, in order to be able to compare different programs. This need was noticed by some of the chairs of several CAM associations:

> *"When I became chair of this association, one of the first things I did was to stop with the self-accreditation of our education programs [...]. I feel that this should be done by independent professional accreditation institutes, whose regular daily job it is to accredit education program." (*5)

Due to the lack of government interference and the lack of an independent accreditation institute of CAM education and training programs, any education institute can name their program a HBO-level education, and any CAM association can offer HBO-level education programs. But what is HBO level education? What knowledge and training should be included in this? This ambiguity was noticed by insurance company VGZ for the first time and they decided to implement some rules and regulation for CAM. VGZ demanded from the CAM practitioners to have basic medical and basic psychosocial knowledge on HBO-bachelor level; this could either be obtained through CAM education or through earlier studies or training. But to determine what basic medical and psychosocial knowledge is, the five umbrella organizations [6] started to discuss which courses and how many hours/European Credits (ECTS) should be in this program. The umbrella organizations could not agree on this and the five biggest insurance companies (VGZ, Achmea, CZ, Univé and ONVZ) started to collaborate on this issue and took over from the umbrella organizations. By doing so, the insurance companies united to impose their rules and demands on the CAM associations, which is a form of manipulation of the umbrella organizations: the umbrella organizations could not compromise on the conditions themselves, due to disagreements and organizational structure, and insurance companies took over.

> *"But yes, those umbrella organizations could not agree on it [the contents of basic medical and psychosocial knowledge - TN] […] So at a certain point in time we, as collaborating insurance companies, said: 'we will do it. Because nothing is going to happen if we let you do it'. But on the other hand, it's quite odd for insurance companies to collaborate on something that is part of additional insurance packages, because it's in fact competitive. But we agreed on it, because what is at stake for all insurers is the same. […] we all benefit from this in terms of safety and quality of healthcare for our consumers. So we decided to join forces and when other insurance companies want to join later, then that's fine." (11)*

The insurance companies asked PLATO, which is affiliated with the University of Leiden, the Netherlands, to determine the conditions for basic medical and basic psychosocial knowledge on HBO-bachelor level education. CAM associations have been waiting eagerly for the PLATO conditions and it has recently been finalized[7] and released as

[6] RBNG, SRBAG, KAB and NVAZ and NAP.

[7] The conditions for basic medical and basic psychosocial knowledge have been released in June 2013 by the insurance companies, so the responses from CAM associations were not recorded and taken up in this thesis.

confidential. Now it is up to CPION[8] to start accrediting the CAM education programs according to the PLATO norms and conditions.

> *"We really encourage that, and these conditions will be finished real soon, and then we have an accreditation institute that works according to the NVAO standards and then we are finally where we want to be!" (2)*

CAM associations and practitioners have been waiting for quite a while for these conditions, and most of them really want to start implementing these conditions into their own educational programs to enhance professionalization. Although the insurance companies imposed their conditions for basic medical and basic psychosocial knowledge on the CAM associations, the associations accepted them because they know things need to change.

In all of the interviews with CAM associations, and in most of the interviews with insurance companies, the notions of transparency and professionalization came up. Insurance companies had several difficulties with CAM associations. The most frequently mentioned one being the vagueness within associations about what they are doing, what their level of education is, how many practitioners are active and what therapies they offer. Besides that, problems with the professional management of the associations and the collaboration between associations and umbrella organizations.

> *"And it hasn't been very professional in the past […], there are a lot, and you still see them, vague kind of therapies, or training programs of a year and when finished people call themselves practitioner. You see, anybody can put a sign on their front door saying they're a therapist." (3)*

These kinds of frustrations were also noticed by CAM associations and in order to make the field more structured, one association, as an example, reduced the number of therapies offered from 250 to the bare minimum of 20.

Another step towards transparency and professionalization is the rise of umbrella organizations. The establishment of umbrella organizations was seen as another step forward in the professionalization process; it would create a better overview for insurance companies and consumers and allow for efficient communication between them. Rules were set up for complaints registration and disciplinary law standards. But again, too many umbrella organizations were set up, due to disagreements within the organization and this did not contribute to a professional and transparent field of CAM organizations. This was noticed by the insurance companies, as mentioned earlier, and the five biggest insurance companies decided to combine their forces and impose their conditions on the practitioners.

However, the notion to professionalize did not only come from the insurance companies. All CAM associations had the internal knowledge that it was needed to professionalize in order enhance integration and gain acceptance in Dutch healthcare. Already in 2000, the consumer association in the Netherlands[9] did research on the quality of CAM associations and that stimulated associations to start working on the professionalization of the management of the association. Associations implemented rules for complaints and

[8] CPION is the starting point for education programs that want their postgraduate courses registered and accredited.
[9] De Consumentenbond

disciplinary law procedures, rules and conditions for training and retraining programs, and associations also started to check that.

> *"Yes complaints regulation and disciplinary law regulation is really important, for several reasons. It's all about the professionalism that you want to show." (3)*

The main reasons for associations to start working on their professional appearance towards the rest of the world, is to show their unique qualities. They want to certify to consumers that the practitioners of that specific association are regularly checked for training and retraining, and that they have a certain level of education and know how to run a practitioners practice. Secondly, an incentive for professionalization is to show the consumer what is available in CAM care:

> *"To make sure the patient knows what is out there. This way, you will get a bottom-up stream of consumers, that they start interfering with government and insurance companies and say: 'hey!, don't forget about us, it's about us and about what we want.'" (5)*

What the above quote is referring to, is that by professionalizing the CAM practice, consumers will start to talk about it more and will start to act as a collaborative movement towards government, insurance companies and policy makers to try to persuade them to integrate more CAM in the healthcare. The consumer collaborative can be seen as a loosely structured social movement of CAM consumers. The need for professionalization comes from both within the associations, in order to become more visible as part of healthcare, and from external pressure from the insurance companies, started by VGZ:

> *"I think that the movement of professionalization of the CAM associations has to do partly with VGZ, who started it, but other insurance companies also say: we no longer want this chaos of associations being reimbursed for their therapies. [...] So we also feel the need and responsibility to become more active in this field, in order to ensure the quality of care." (9)*

So even though CAM therapies are part of additional insurance packages, and it is in fact a competitive issue between insurance companies, the companies decided to work together to ensure the quality of healthcare for the consumers.

Reimbursement conditions

Besides the demand from insurance companies for HBO-bachelor basic medical and psychosocial knowledge, in order for practitioners to get reimbursement for their therapies, insurance companies have several other conditions. The most important is that every practitioner needs to be a member of a CAM association and this association needs to be accepted by the insurance company in order for the clients of the practitioner to get the therapy reimbursed. Insurance companies base their choices for CAM associations on their own criteria, by means of checklists send to associations. When returned, the insurer decides whether or not the association is accepted and is liable for reimbursement. The same can be said about CAM associations, every association has its own conditions and criteria. In the next part I will discuss some common criteria implemented both by CAM

associations and insurance companies.

> *"So yes, there are absolutely a couple of demands you need to comply with if you want to be called a complementary practitioner. You will need at least a certain level of basic medical knowledge. You will also need a decent level of pre-education, favourably externally accredited. You will also need* [...] *complaints regulation and disciplinary law regulation. It's also favourable if you know First Aid." (5)*

Furthermore, for most insurance companies, the associations needs to be nationwide and have at least 25 practitioners, have its own website containing precise descriptions of therapies and treatment possibilities, privacy statement should be available and practitioners should take certain training and retraining each year. The check for retraining and training is not done by insurance companies, but this is a task for the associations or umbrella organization. They are trusted by the insurance companies to properly check this and insurance companies do not have the time or money for this.

A final remark and trend of the past couple of years, is that insurance companies stopped reimbursing therapies for relaxation such as yoga. Insurance companies want to reimburse solely individual therapies aimed at finding a cure, and not group therapies aimed at the general wellbeing or coaching sessions and workshops on personal development. More on this is already discussed in chapter 4, but the general reason is that only cure is reimbursed, and not prevention:

> *"Yes but we actually do not reimburse therapies aimed at prevention in the alternative care. We only reimburse the curative care. " (11)*

The conditions implemented by the associations and the insurance companies serve a general purpose, namely to further professionalize the field and to create a division in the current field, all in favour of professionalization and further integration of CAM in Dutch healthcare.

> "*So I think there is going to be a division in the field and that's exactly what we want. To separate the wheat from the chaff! And that's what we want. But we feel that these demands are so minimal, that we hope that a lot of people still meet them." (9)*

Feasibility

Even though several conditions are imposed from above by insurance companies and several conditions overlap between insurance companies and associations, I asked the associations' informants about the feasibility of the reimbursement conditions, especially about the condition for HBO level education. All of the CAM spokespersons consider it as really normal to have some rules and regulations, because it favours professionalization and transparency:

> *"But the demands that are imposed on natural therapists get stricter and firmer and I think that's a good development." (6)*

> *"Why do we make such a fuss about these demands? The demands have always been very high for complementary care? Perhaps you'll need to change your education program because of these demands, but what is the problem? Actually, there isn't any!" (1)*

So even if some changes are needed due to the new demands starting from January 1st 2017, the associations do not seem to have any problem with that and they all favour it because it enhances professionalization. Some associations already comply with the 2017 demands, so it depends on the CAM associations.

Incentives for reimbursement

Now that I have written about the conditions for reimbursement, let me focus on reasons for insurance companies to take up CAM in their additional insurance packages. Almost all of the insurance companies in the Netherlands offer some kind of reimbursement for CAM in their additional packages. The most frequently heard motive, was consumer demands. This was suggested by CAM associations:

> *"Yes and look, an insurance company is paying more attention to what the consumer wants; they want to sell their additional packages." (2)*

Even though VGZ started to question their own policies concerning the reimbursement of CAM by the end of 2011 they continued to reimburse it due to their consumers' demands. This motive was confirmed during all interviews with insurance companies.

> *"Yes well look [pause], alternative care, we also reimburse it because our consumers like that!" (11)*

Furthermore, the coverage of CAM in the additional package is not a real competitive issue for the insurance companies, but every insurance company tries to reimburse almost the same as the others.

> *"If you want to offer very widespread alternative care, you must be able to explain it really well to your consumers that don't use is, and that proper explanation is currently not available. And you don't want to give them too much, because if you do, you attract all the alternative clients. So everybody is hiding in the grey area at the moment." (9)*

> *"It's taken up in our additional insurance, like in any other insurance company. And personally, it's not a big issue for me to spend a lot of time on." (10)*

As the above mentioned quotes clearly show, the CAM coverage by insurance companies is not a major item for them and the biggest incentive for coverage is because others have it. So thereby it turns out to be a competitive issue, but not a key issue because companies do not want to offer too much CAM out of fear to attract too many clients with their CAM

coverage.

Questions about whether the coverage of CAM was influenced by scientific research will be discussed later in the next chapter, but one of the CAM associations had something interesting to say. A non-scientific study was done on behalf of insurance company Menzis and the outcome was that a certain kind of CAM proved to be very effective. Menzis decided to keep this in their additional coverage of CAM due to this study; the results were more important than the rigidity of that study.

> *"So insurance companies also notice that complementary medicine can achieve things that cannot always be explained in a scientific way, but they see that these things can have a positive effect on the client." (5)*

So even though not all studies are completely scientifically solid, insurance companies do draw their own conclusion based on efficacy studies. However, not enough of these kinds of studies are conducted and insurance companies and CAM associations are asking for more. This will be discussed in the next chapters.

Role of Dutch government

The Dutch government has had a long history with alternative and complementary medicine. According to Renckens' dissertation (2004) the debate about suitable research methods for CAM already started in 1969, when a commission was set up to investigate CAM. In 1980, the Muntendam commission was set up to study the research methods for CAM.[10] The incentive for the government to start this commission was the increased use and popularity of CAM in the Netherlands as well as abroad (Renckens, 2004:116-171). Furthermore, CAM practitioners and users wanted suitable methods to study the safety and efficacy of CAM as regular methods were not considered appropriate (Ning, 2013).

The Muntendam commission recommended to increase and stimulate CAM research, and therefore the government started an advisory commission in 1983 to find suitable research methods. This report was released 10 years later and much of the contents was already outdated at the time of release. The government had already started working on the BIG law and the CAM field started to register practitioners and their education. Additionally, the suggestion to implement a certain basic medical knowledge was rejected by the Minister of Health (MoH), because this would suggest that CAM practitioners were qualified therapists. The different perception of CAM nowadays is clearly visible. Today, it is argued that CAM should not have different methods of research for studying the safety and efficacy, to enhance scientific credibility. Furthermore, the insurance companies are implementing a demand for a certain level of basic medical and basic psychosocial knowledge. This demand comes from the insurance companies and is supported by the CAM associations, but the attitude of the government on this is unknown.

Dutch government does not interfere with CAM education and insurance companies' reimbursement policies. The government only interferes with the basic health insurance, through the College voor Zorgverzekering (CvZ) and it is therefore up to the insurance

[10] I keep using the term CAM, to enhance the uniformity of this thesis – in the 80's the most frequently used term was alternative medicine.

companies to decide what CAM they want to reimburse. However, the government considers the safety of the patient as most important and referrals to alternative practitioners should be done with the utmost care. Citizens have their own responsibility in healthcare seeking behaviour. Although regular medicine is registered in the BIG law, there is not (yet) such a register for CAM practitioners. In addition to that, the minister called for some sort of blacklist for CAM practitioners (Klink, 2010), this was also mentioned during one of the interviews:

> *"We are currently working on some sort of blacklist together with Zorgverzekeraars Nederland (ZN). When a specific offense is reported; this should be communicated to the whole field. […] Yes that's very important!" (5)*

In an article about the Dutch MoH, published in a web editorial of the Vereniging tegen de Kwakzalverij (VtdK)[11], the minister was quoted saying it bothers her that there are almost none additional insurance packages without reimbursement options for CAM; this limits the consumers freedom of choice. The minister appeared as a strong promoter of regular, evidence-based medicine, because it is important for her to only reimburse scientifically proven care. And it is up to all of use to put the alternative medicine in the right perspective with the power of reason, according to the VtdK (2010). Concluding on the position of the government about CAM, the MoH does not interfere too much with the rules and conditions of insurance companies, but the minister is a firm advocate of evidence-based medicine and consumers' freedom of choice.

Even though the government does not interfere with CAM, the Dutch medical curriculum framework states that "doctors need to provide quality care, ensure continuity and an adequate cooperation with other disciplines, including complementary therapists."(van Herwaarden *et al.,* 2009 in Kolkman *et al.,* 2011). And this is also rooted in the Dutch legislative framework on medical education. Herein, the criteria for medical study are described, of which one is the verification of alternative therapies.

> **"**[...] *and the government takes its hands off it, because they cannot, and they don't want to, judge about CAM and this makes it difficult for insurance companies. Besides that, the numbers of consumers is quite big, so I feel that the government has some sort of social responsibility, to do something about it." (9)*

This quote from one of the insurance companies shows the difficulties they face when deciding about CAM in the additional insurance packages. Due to the large numbers of consumers, they feel that the government should interfere with it, as the government has some sort of social responsibility. Contradictory, the government says it is not part of the basic health insurance, so they do not interfere with it. Perhaps it is even a positive point that the Dutch government does not interfere with the world of CAM, as Mrs Verbeet mentioned on the Day of the Complementary Care; if the government decides to interfere with it, all sort of rules, regulations and conditions are imposed on CAM.

[11] The association against quackery, www.vtdk.nl

Consequences of reimbursement

To understand completely what would happen with CAM practitioners and therapies when the government decides to interfere with it, questions were asked on the consequences for CAM practitioners since their therapies are part of the additional insurance. Every insurance company has several conditions for reimbursement; first and foremost, consumers need an additional insurance. Besides that, insurers have rules set for the maximum numbers of visits, maximum price of the sessions and certain conditions for the practitioners. These conditions might have an effect on the number of clients and on the client's therapy compliance. However, most of the respondents did not notice any effects:

> *"No no, I have never had a client, not one in all these years, that wasn't able to continue the treatment due to these conditions. Because, you know, people decide on a consult and they really want to be treated. So when there is a financial consequence attached, they accept that." (1)*

> *"And I noticed, people realize that not everything is reimbursed by the insurer, so people have some money to spend on this." (3)*

This was confirmed by most of the CAM associations, but some practitioners did notice some consequences. Clients telling them they want to stop the therapy because they reached the limit of the reimbursement of their insurance. But in general, CAM clients realize they will have to spend some of their own money on the treatment and this is, usually, not a problem. Furthermore, the additional insurance packages are not just for CAM therapies, clients get a lot more for just a small price. So insurance companies state that if a client wants more CAM, he/she will need to take a more expensive package:

> "Y*es we cannot provide very extensive reimbursement in the cheapest additional packages. If a client wants very extensive reimbursement, he will need to take a bigger additional package, and this is more expensive. " (11)*

In general, CAM practitioners are content that they are taken up in the additional insurance packages; it gives them more clients and it enhances professionalization. But on the other hand, the conditions set by insurance companies sometimes create an unbridgeable gap. This is the case with the maximum number of visits, maximum amount that is reimbursed and the fact that only individual session are liable for reimbursement. This creates conflicts among the CAM practitioners, because a practitioner might realize that a group session might be really beneficial, but the client does not have the money for it. So although it is still all about the financial picture for insurance companies, practitioners are still glad to be taken up in the additional insurance.

> *"And then I think, here again it's just about money and managing expenses. But what do you want as an insurance company? Do you want to offer a quality package, or is it just about reducing costs?" (5)*

Conclusion

The words 'professionalization', 'acceptation' and 'transparency' have been intertwined in the text. All kinds of institutions are working, together or individually, to achieve more optimal integration of CAM in Dutch healthcare. This is obviously the wish of CAM associations, to

achieve integration but only when their conditions for integration are met. CAM associations and practitioners do not want to end up like physiotherapists, who are not very content about their integration in the basic health insurance, due to the limitations in time and money (interview 2). But one thing that the insurance companies and CAM associations agree upon, is that professionalization of CAM - both associations and practitioners - is essential. This is to be achieved by collaborating in a new overarching umbrella organization. But more about this and the future trends in the next chapters, in which the trends and changes concerning CAM are discussed.

6. Researching CAM

The current status of CAM is still subordinate compared to regular medicine. This is partly due to poor integration in regular healthcare and lack of scientific evidence and research. Improvements for the expansion of the current integration of CAM into, and combination with, regular medicine are developed and calls are made to increase the number of research initiatives on the safety and efficacy of CAM. Further professionalization of organizational structure of the associations and umbrella organizations is another future aspect of professionalization. The current status of CAM integration and future movements will be discussed in this chapter.

No one knows exactly what the position of CAM is going to be in the future, but many thoughts and initiatives are developed to brighten the future. CAM associations are constantly thinking ahead and developing new ways to integrate their therapies into healthcare. In this chapter I discuss the future of CAM and the aspects that influence the prospects of CAM. These aspects are the current and future integration of CAM in regular medicine and the benefits of integration, existing research on CAM and research methodology, changes in the organizational structure of umbrella organizations and new trends visible in the CAM world.

During every interview the future of CAM and the current status of integration of certain complementary therapies was discussed. Often this discussion evolved around European or American developments. These examples will be discussed in chapter 7 in a global comparison. But this chapter is about Dutch examples of integration of CAM in the regular healthcare and about combination therapies of complementary AND regular medicine. Although the number of cases of integration between regular and complementary medicine is small in the Netherlands, the trend is moving towards more integration.

This move is supported by the wish of Dutch medical students to gain more knowledge about the variety of possibilities of CAM (Kolkman *et al.,* 2011). Kolkman *et al.* did a survey in 2008 among medical students in eight Dutch universities. Several of the key findings are that 83% agreed on the fact that doctors should be able to give objective information about CAM and almost 82% stated that doctors should respect their patients' choices for the use of CAM. On questions about the medical curriculum of their study, 40% of the respondents would like to be educated on CAM and 62% thought that more attention should be paid to CAM in the curriculum. 72.3% of students mentioned that their university does not offer any form of CAM education, but seven medical schools do offer some CAM education, albeit as an elective course. So apparently, universities do not advertise their elective courses very well or these electives are poorly presented in course overviews.

The integration of CAM into the medical curriculum may be beneficial for regular medical students; it can help to develop their critical way of thinking and to give them an open mind about other non-regular medicine, which might also be beneficial for patients. Other rationales for integrating CAM in the regular medical curriculum in the US are the prevalence and growth of CAM, the need for improved communication between regular doctors and CAM patients and the need to enhance safety of CAM use (Gaylord & Mann, 2007). By giving regular medical professionals and students the opportunity to educate in CAM, it becomes easier for CAM users to disclose their use to their general practitioner (GP).

Jong *et al.* (2012) conducted a study in the Netherlands on the integration of CAM in primary care. Besides showing the benefits of CAM integration and suggesting an integrative primary care model, with full integration of CAM, Jong *et al.* studied the reasons for not disclosing CAM use to the GP. Patients still consider it not of importance to disclose it, still think of CAM and regular medicine as two separate paradigms and expect the GP not to approve CAM use. Furthermore, 92% of patients would like to have been informed about CAM by their GP. This study confirms the rationales for CAM education in regular medical schools, suggested by Gaylord and Mann (2007). Furthermore, the importance of disclosure of CAM to the GP was discussed in several of the interviews, as possible interference between regular and complementary medicine might occur:

> "*If a client decides to start a session with one of our practitioners, we strongly advise them to inform their GP before they start, after 5 therapy sessions and at the end of the therapy." (1)*

Another incentive for enhancement of CAM integration is patient satisfaction in regular medicine. Patients do not always have the feeling that they are taken serious in regular medicine, especially with chronic diseases that are difficult to treat and doctors tend to prescribe medicines too soon. This is noted by the CAM practitioners and this stimulates them to be more open towards regular medicine and to show their capabilities to GPs, with the hope that GPs will refer to a CAM practitioner the next time.

> *"And a practitioner needs to be able to give feedback to the GP in a decent manner, because the GP is often the first point of referral for a client." (5)*

Dutch medical students were asked which form of CAM could be integrated in Dutch healthcare, and 58% and 52% of the respondents held the opinion that respectively acupuncture and homeopathy should be integrated (Kolkman *et al.,* 2011:18). Furthermore, 81.4% of students "are aware of the possible safety issues, side effects and interactions with regular drugs. Additionally, 74.2% of the students indicate that their knowledge about CAM is limited" (Kolkman *et al.,* 2011:21). To gain more knowledge, 70% answered that more scientific research should be done on the efficacy and safety of CAM. This high percentage can be explained by the fact that more than 50% of medical students use scientific literature when seeking information about CAM. This opinion was confirmed by regular doctors in a questionnaire of the KNMG [12] (Medisch Contact, 2007)

Although it may look like that no CAM is yet integrated in regular medicine, examples of integration and combinations of CAM and regular medicine came up during some interviews. Several GPs have taken some sort of CAM education and are using CAM in their practice. One GP in the north of the Netherlands is using homeopathy in his daily practice but only if requested by the patient. Research has been done on this GP and one of the results is that he saves the insurance company about €700,000 per year by prescribing homeopathic medicine instead of regular medicine (interview 2). Similar research was done by Kooreman and Baars (2011); they studied all insurees of one insurance company in the period of 2006-2009 and compared the data of 1913 conventional GPs with 79 GPs with additional CAM training on costs and mortality rates. The results were impressive, as patients whose GP had additional CAM training - in either acupuncture, homeopathy or

[12] Koninklijke Nederlandsche Maatschappij tot bevordering der Geneeskunst (Royal Dutch Medical Association)

anthroposofic medicine - lead to a maximum decrease of 30% in healthcare costs and mortality rates.

Complete integration of CAM into daily practice of GPs is difficult because of the guidelines for the duration and costs of a regular consultation. However, CAM starts to make its way to hospitals, but very slowly due to resistance from medical institutions:

> *"[...] well in the Netherlands it [CAM – TN] starts to appear in hospitals. But when medical experts start using it, they are often reprimanded by their superiors or they get kicked out, or they experience so much resistance that they decide to leave." (5)*

Scepticism and resistance of medical institutions and the lack of scientific research on CAM are two reasons for the minimal integration of CAM into Dutch healthcare. A third rationale is the fact that integration is partly controlled by insurance companies and by reimbursement policies. These policies influence patients' healthcare seeking behaviour. But it seems that not all CAM associations are currently too eager to be taken up in the basic health insurance. This is due to restrictions and rules in the basic health insurance:

> *"If we would be taken up in the basic health insurance, this would have many negative effects, because [pause] for example, the insurance companies, or government, can then decide the duration of a consult and what the price should be [...] but we cannot do a consult in 10 minutes for €27, that's just impossible!" (2)*

As the above quote clearly shows, things need to change before CAM is taken up in the basic health insurance, certain rules and limitations need to be set aside and general rules that are applied to regular medicine cannot simply be copied to complementary medicine. The same can be said about GPs combining CAM and regular medicine. Consulting a GP may only last 10 minutes, but consulting a CAM practitioner for 10 minutes is impossible. That might be the explanation for the fact that there are few GPs combining CAM and regular medicine. Physical therapists are part of the basic health insurance and they have agreed with the limitations, as the next quote illustrates:

> *"Yes the physical therapists really have been limited, and they are not happy about it. They are now in the basic health insurance, but very limited in what they can do and treat. So personally, I don't want to be part of basic health insurance." (2)*

The main reasons, according to one of the informants, for the slow integration of CAM into Dutch healthcare, are fear and conservatism of Dutch politics and the medical system. Figure 3 shows the lack of integration of CAM in Dutch healthcare, compared with other countries. The interviewees were also asked why integration is slow in the Netherlands:

> *"Conservatism, and [pause] the association against quackery[13], and fear mostly. The regular medical world is afraid, because complementary healthcare is often hard to grasp." (5)*

[13] The Association against Quackery (Vereniging tegen de Kwakzalverij)

Several steps will be taken to partly remove this fear of the regular medical world. These steps will be discussed in the last paragraph of this chapter about trends in CAM associations and umbrella organizations and future trends. But first I want to discuss CAM research methods and the notion of evidence based medicine (EBM).

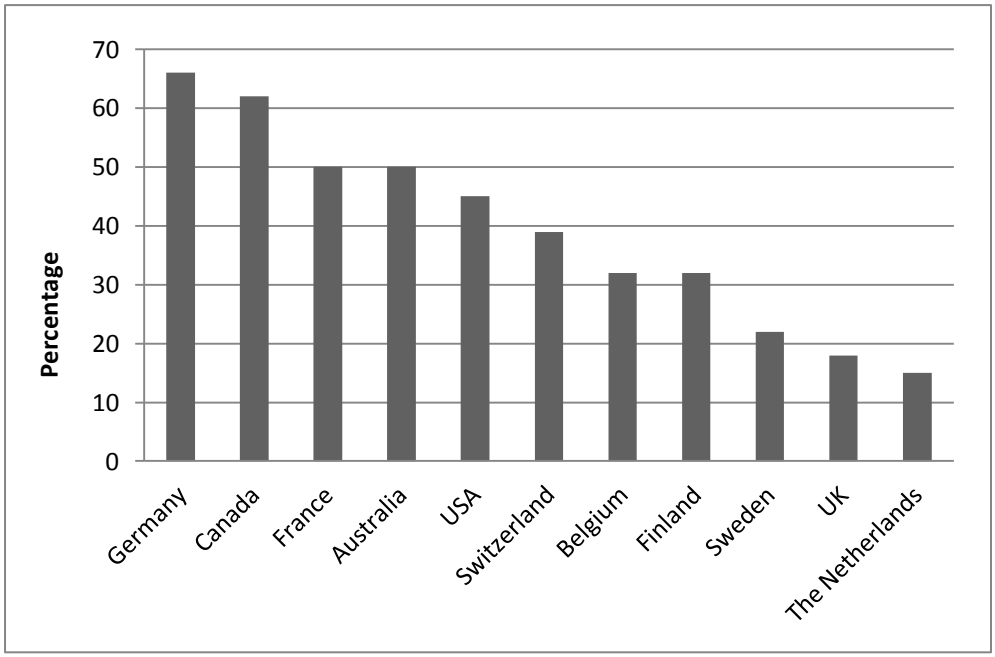

Figure 3. Percentage of people using CAM at least once a year, based on representative samples. (source: van Dijk, 2005-2006)

CAM Research methods

As the lack of scientific evidence was named one of the main reasons for the minimal integration of CAM into regular medicine, questions popped up during the interviews on ways to do research and how to convince the sceptical regular medicine of the benefits of CAM. But what are the incentives for researchers to investigate the efficacy of CAM? Is the current status of CAM not satisfactory enough? Probably not, and if CAM practitioners want to professionalize and integrate more into regular medicine, they will need to present clear scientific evidence that shows the benefits of CAM, in terms of efficacy but also financial benefits for insurance companies. The example of Kooreman and Baars (2011) is already mentioned above, but an informant said:

> "*So the chances of some complementary care to be taken up [in basic health insurance – TN] is [pause] it should really result in costs reduction, otherwise I don't expect this to happen." (9)*

This quote is from the discussion on the future of CAM and whether it will ever be part of the basic health insurance. The only reason why it might become part of it is if CAM leads to significant costs reduction, because the basic health insurance is already being cut back to the bare minimum. However, insurance companies are not the institutions that should be asking for CAM research, the associations and practitioners should be initiating research programs as part of transparency achievements. Associations want to further integrate in healthcare, but some associations are afraid of showing themselves to the outside world.

> "L*ots of people in the complementary care, and lots of associations too, have always been afraid of providing an open view to strangers and researchers. We have been afraid of losing our individuality."(1)*

> *"[...] and we also notice that practitioners in the alternative field are not very eager about research. So in a sense, they are really at the start of professionalization." (10)*

Although the incentives for research are sometimes missing in particular CAM associations, others encourage scientific research. But how to study CAM in a scientific solid way? Already in the 1980's, the discussion started on appropriate research methods for alternative medicine (Renckens, 2004). Even though standard biomedical methods are not always appropriate for CAM research (Tonelli and Callahan, 2011) and randomization of patients is not the ideal situation since it takes away "the most therapeutic of all elements; the free decision of the patient" (Walach, 2009:1141), several ideas were proposed, both by CAM associations and insurance companies to study CAM. Several scientific articles have been written about research methods for CAM (Verhoef *et al.*, 2005; Koithan *et al.*, 2012*)*. Someone called for the same methods of research currently being used in regular medicine, because not all practices in regular medicine are researched in a pure randomised, double-blind, controlled trial. But this research is still considered scientific, so why should that not be suited for CAM research?

> *"Yes and you know, it doesn't have to be pure scientific evidence, but it needs to show whether it has some effect." (9)*

This was mentioned by one of the insurance companies, who were also aware of the limitations of scientific research on CAM. It was proposed by insurance companies and all CAM associations to start with large consumer satisfaction surveys. A large qualitative research on consumer satisfaction would help to proof the efficacy of CAM.

> "*What is really needed at the moment in the Netherlands is a big patient study, in which the patients can really say for themselves what it [CAM – TN] has done for them." (6)*

Consumer satisfaction surveys seem to be a good start, but it also has several limitations. One problem is the generalizability of the data and the placebo effect, as the quote below describes:

> *"We can do a ROM[14], […] but in our profession you still don't know anything. Because the contact alone between client and practitioner accounts for 80% of the efficacy of a certain therapy, 10% accounts for the trust of the client and just 10% of the efficacy of the therapy is the methods used. So what is then effective? That is very hard to see and measure. And in regular care they have similar problems." (3)*
>
> CAM associations realise they need to start working on the evidence of their

[14] ROM measurement is a Routine Outcome Measurement in which the efficacy and progress of a certain method is measured through a survey before the start of the therapy, during, and at the end of it. ROM is mainly used in mental regular care. http://www.platformggz.nl/lpggz/newsitems/ni001086

therapies and practices and the only solution so far is to start working on large consumer satisfaction surveys. Perhaps this should be implemented in the associations' and/or umbrella organizations' conditions. Another insurance company mentioned the fact that the problem is not doing research, but funding research (interview 9). CAM associations do not have funding available for large research initiatives and thus are dependent on universities or private research initiatives.

EBM bubble - the bone of contention

As a final statement on CAM research, the notion of EBM in regular medicine, as well as evidence for complementary medicine, will be discussed. Several examples exist of scientific literature on the effects of CAM combined with regular medicine to treat symptoms or diseases. One example was brought up during an interview:

> *"For example, on IBS [Irritable Bowel Syndrome – TN] a lot of scientific research has been done on this and it showed that hypnotherapy might really do something." (4)*

The research mentioned above by Whorwell *et al.* (1984) is an example of a scientific article on the uses of CAM. It is exactly these kinds of articles that are needed for several reasons. Firstly, they are initiated by researchers who objectively want to study the effect of CAM. Secondly, these research initiatives are not funded by CAM associations. And thirdly, this kind of research helps the specific CAM associations to further integrate and gain acceptance through evidence based practice. Another example can be found in Balasubramaniam *et al.* (2013) in which the effect of yoga on neuropsychiatric disorders are discussed.

But what is the importance of EBM nowadays? Most health professionals stick to the principal that medicine needs to be proven in a scientific way. Not much CAM has been proven so far, but do the doctors and insurance companies not stick too much to this perception? The buzzword in medicine and health policies is 'evidence-based'. But why does complementary medicine need to be proven in the scientifically accepted way? And what does evidence mean? The notion that CAM is not evidence-based has been used intensively in the last decade in the campaign against CAM (Walach, 2009). The conditions for scientific clinical research were set up to ensure the safety and quality of care, and doctors and academic hospitals have said to only prescribe EBM. But do they do that? Do they not act in a bubble of fake appearance of EBM? According to Walach (2009) evidence is a social construct that is dependent on the local context. To really gain evidence, several study methods should be combined, including qualitative studies. One of my informants from a CAM association did a research for her master degree on perceptions of CAM by Dutch GPs and their ideas on integration:

> *"And the funny thing was, I asked all those GPs whether they always work according to scientific evidence, and how important that is for them. And everyone, except two, said: you know what, regular medicine is not always scientifically proven. Because studies are commissioned by pharmaceutical companies, so there is a certain bias already. […] another study states that more than 80% of the GPs do not prescribe scientifically proven medicine." (6)*

Many different articles and studies have been conducted on this issue (e.g. Tonelli 2001; Garrow 2007; Ernst 2003) and what is needed for CAM to get accepted by the regular medicine, is a change in research definitions.

> *"I think that the research conditions need to be redefined so that they will be accepted by regular and complementary medicine. If you do consumer satisfaction surveys by conducting interviews; the problem is that qualitative research is not regarded as real research by regular medicine." (6)*

A change in research definitions is necessary in regular medicine to achieve that qualitative research is regarded complementary to quantitative regular research. Qualitative research can help to interpret quantitative data and it can be used as pre-research to quantitative research. Qualitative research can be useful for mapping the field prior to quantitative research. But to achieve change in research definitions, a paradigm change is needed in many people, including doctors, GPs and other regular health professionals.

> *"What is needed first, is a paradigm change, because you cannot ask people who are used to working with a narrow vision of health and medicine [regular medicine – TN] to start working from a holistic point of view. That doesn't work and therefore a paradigm change is necessary." (6)*

This view is not only supported by CAM associations, but insurance companies also agree:

> *"Yes a lot of people have to change their mind but this is not yet happening." (10)*

This change of mind, or paradigm change, will be supported by changes that are going to be made soon by the CAM associations and umbrella organizations. This will be discussed next in this chapter. But to conclude this part about CAM research and EBM, it is difficult to find the best solution, because lack of evidence of efficacy is not the same as proof for its ineffectiveness (Kooreman and Baars, 2012) as illustrated in the next quote by one of the insurance companies:

> "*The whole problem with CAM is that they [CAM associations – TN] cannot prove it's effective, but we [insurance companies -TN] cannot prove it's not, because there are satisfied consumers. And that's what makes it so difficult." (9)*

Umbrella organizational changes

CAM associations and umbrella organizations are subjected to change due to both internal and external pressure. Regular medical institutions, mainly insurance companies, are imposing new sets of rules and demands on CAM practitioners and associations. Pressure is also applied from the CAM field itself, as associations and umbrella organization have the knowledge that change is needed in order to enhance acceptance and professionalization. Collectively, the SRBAG and several CAM associations have established a sector organization (Integraal Natuurlijk, IN), which was set up to create more transparency in the field of CAM. The final goal is to integrate all CAM associations and umbrella organizations. This organization has several wishes and actions planned for the future; one of them is to create a complementary BIG register, to ensure quality and professionalization. This will enhance and stimulate the desired paradigm change.

> *"What I really want and what would be beneficial, if CAM would be more visible, to recognize the quality of CAM and to increase and facilitate easier referrals from regular medicine." (3)*

But before IN is completely up and running, there are several obstacles to remove. The intention of IN is to take over CAM associations and become one big organization that represents all CAM practitioners in the Netherlands. Integraal Natuurlijk will have their own conditions for membership and education levels. This may cause dissatisfaction in several CAM associations, who themselves have very high standards and conditions for their practitioners; this was mentioned during one of the interview as a reason not to join IN:

> *"No we are not part of that [IN – TN], this has to do with their conditions. Because IN really has marginal conditions and demands for the practitioners, much lower than our conditions." (6)*

Some CAM associations have set very high standards for their own practitioners, in order to ensure quality and safety. If the conditions of IN will be more lenient than those of the specific associations, these associations might not join IN for this reason. But IN will only work, and be able to apply pressure as a representative of the whole field of CAM, if all associations are part of it and if they have the power of the masses. This is a problem they yet have to overcome, but it will contribute to the professionalization steps needed for CAM.

GP CAM training

The lack of integration of CAM into regular medicine, is partly caused by the fact that GPs are not aware of the many CAM possibilities. The GP is for most patients the first point of information and access. What needs to be done by CAM practitioners is to gain access to the GPs and to provide them with reliable information and evidence about their practices. The majority of the future generation of doctors (83%) thinks that doctors should be able to give objective information about CAM and 62% stressed the importance of CAM education in the medical curriculum (Kolkman *et al.*, 2011).

> ***"****The main disadvantage is that patients need to find out for themselves who to visit, they cannot go to their GP […] and I think the patient should be able to discuss the choice [between regular medicine or CAM – TN] with the GP. […] So if the GP would just have a little basic knowledge, it doesn't even have to be specific knowledge, this way, the GP takes the role of an advisor." (6)*

If GPs are trained in the basic principles of CAM, the GP will become an advisor and a point of referral for the patients. One CAM association (6) is currently working on training in CAM for GPs and other regularly trained health professionals. They want to offer a very broad training in all sorts of CAM to make sure the GP knows what is out there in the field of CAM.

Conclusion

Changes are expected in the world of CAM. More scientifically solid research might stimulate the future integration of CAM into Dutch healthcare. Furthermore, a paradigm change is needed to gain the acceptance of biomedical physicians and other medical personnel, this can be achieved by further professionalization of associations and umbrella organizations and by creating a sector organization for all CAM practitioners. Additionally, a broad CAM training offered to GPs will allow further integration of CAM into the practice of GPs, who are

the first point of contact for most patients. How Dutch CAM will be affected by this can be estimated when looking at countries where CAM is more accepted and integrated in healthcare. This will be discussed in depth in the next chapter.

7. CAM worldwide

To show the potential effects of future changes in the organizational structure of Dutch CAM associations and umbrella organizations, I discuss the position of CAM in a few other countries. Nations like Switzerland, Germany, the UK, Australia and the USA are known for their tolerance of CAM in the healthcare. In this chapter the reasons behind the enhanced integration of several CAM therapies in these countries will be discussed, starting with the European situation. During the interviews, many examples of European and/or American CAM situations came up; these will be used alongside several documents from the CAMbrella project and additional literature.

European tendencies

The European Union does not have a coherent set of rules regarding CAM legislation and therefore each EU member state can decide for itself how to organize their healthcare system and what rules to impose on CAM practitioners (Kooreman and Baars, 2012). Figure 4, found in Wiesener *et al.* (2012), shows the differences in CAM legislation across European countries. 17 countries have a general law on CAM and 11 of these 17 have specific laws on CAM; the Netherlands does not have any CAM law.

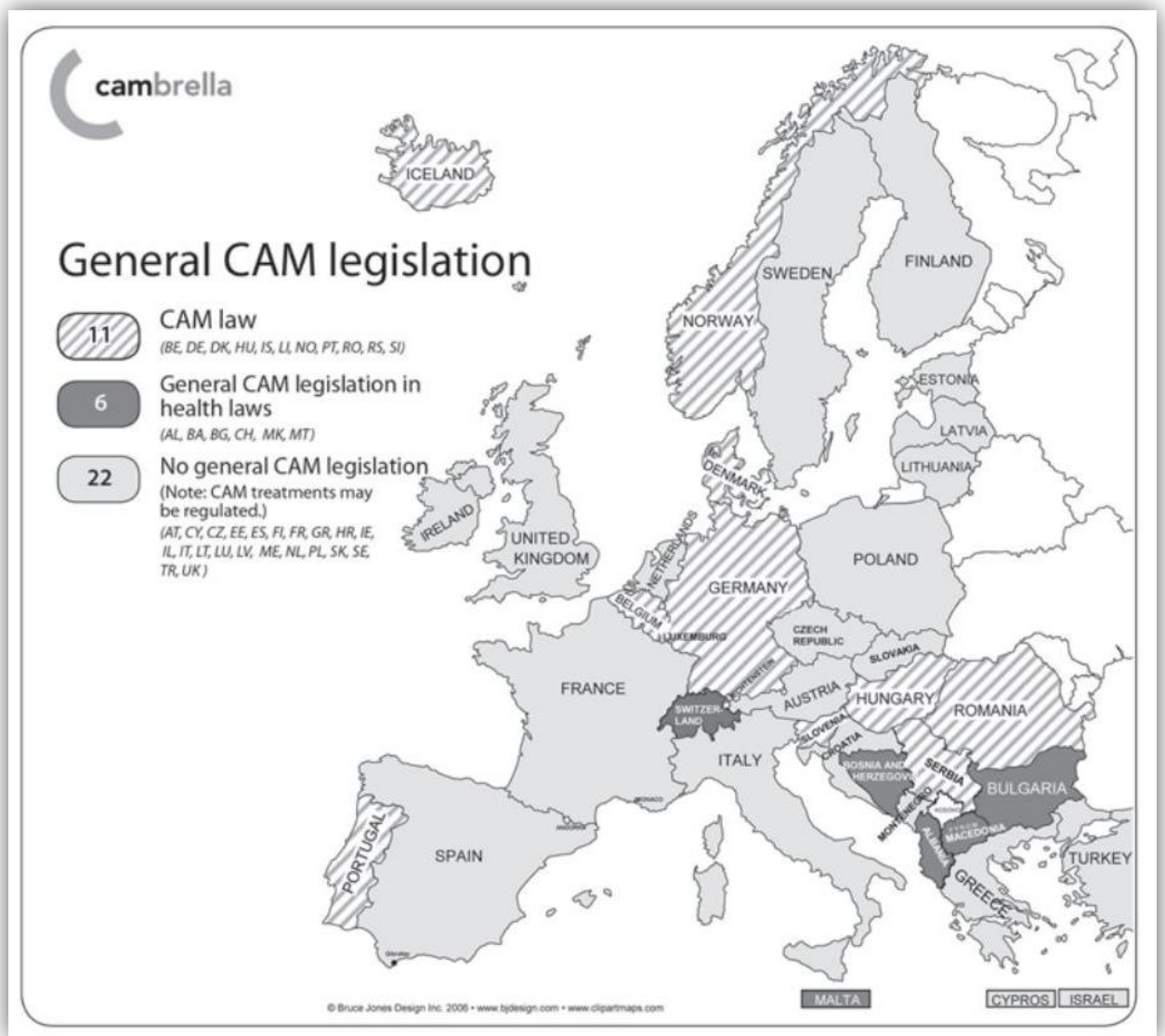

Figure 4. The status of CAM general legislation in 39 European countries (source Wiesener *et al.,* 2012)

Due to the many differences in legislation in European countries regarding CAM, one of the workgroups of the CAMbrella project was appointed to review the prevalence of CAM use. Although estimations on CAM use and prevalence vary greatly, due to poor research methods and heterogeneous studies, Eardley *et al.* (2012) conducted a systematic literature review of CAM prevalence in Europe in 2012 and found CAM prevalence among EU citizens between 0.3% and 86%. The vast range between CAM prevalence numbers in Europe varies so greatly due to legal and institutional differences among EU member countries.

Von Ammon *et al.* (2012), also part of CAMbrella, reviewed the CAM provision in the EU and found a total of 305,000 CAM providers in the EU, of which 160,000 are non-medical providers, with a huge variety in regulatory management and educational management. To show the differences in management and educational legislation for CAM practitioners, I will discuss several examples from Germany, Swiss and the UK.

CAM integration in Germany is higher due to the fact that CAM education is better represented in the curriculum of medical schools (Kolkman *et al.,* 2011) and therefore CAM prevalence is much higher (65% of people use CAM medicines, Van Dijk, 2005-2006). Furthermore, Germany has some legislation on CAM, which might have helped to further increase the levels of acceptance and integration of CAM in Germany. Another explanation that came up during an interview was the fact that Germany has professions called 'Heilpraktiker':

> *"And in Germany, Heilpraktikers can do, and request, the same kind of medical tests as a Dutch GP can do here, so it's much better integrated over there." (2)*

Heilpraktikers in Germany are regularly trained doctors specialized in any form of CAM. These professions are part of CAM healthcare.

Another example of an EU country which is ahead of other countries is Switzerland. The Swiss have held a referendum in 2009 about coverage of CAM in the public health insurance. The outcome showed that two-thirds of Swiss citizens wanted CAM to be covered by public health insurance. This resulted in the integration of five CAM streams - anthroposophical medicine, homeopathy, neural therapy, phytotherapy and Traditional Chinese Medicine - in public health insurance for 6 years, starting from 2012 (Kooreman and Baars, 2012; Walach, 2009). Additionally, the government demanded further research on the safety and efficacy of CAM. The current situation in the Swiss healthcare is that the patient is centralised and can consult his/her GP for the best possible treatment, whether this is CAM or regular medicine.

> *"And the Swiss said [in the referendum – TN]: we don't care about evidence or not, we want to be able to use it. So the government agreed on this and decided to regulate this by law […] and in the meantime additional research had to be done on CAM. Research which would satisfy both sides, and that has already happened for homeopathy."(6)*

The report on the efficacy of homeopathy (Bornhöft and Matthiessen, 2011) was received with great enthusiasm and was considered the ultimate proof of the efficacy of homeopathy. But very soon after its release, questions were asked about the objectivity of the evidence. Several critiques were aimed at this report stating that it was biased towards a

positive outcome because it was written by a group of homeopaths, edited by a German university specialised in educating doctors in alternative medicine (Rudloff and Zeno, 2012; Ernst, 2012). Thus, more work needs to be done regarding efficacy research and complete integration of CAM.

Hypnotherapy is a form of CAM integrated in the UK health system. This is mentioned as a possible treatment for IBS[15] on the website of the National Health Service[16]. Additionally, CAM education is more common in the British medical curriculum (Kolkman *et al.,* 2011) and nursing staff is known for their use of massage and relaxation therapies in cancer and palliative care (Nissen and Manderson, 2012). This reflects the institutional acceptance of some forms of CAM next to regular medicine.

Differences among European countries regarding CAM are so large and obstacles for further integration are created by the EU itself. The treaty of Lisbon (2007) states that individual EU member states have their own responsibility for the organization of their health policy and organization of health services. Thus, this keeps the diversity in CAM regulations present among nations in Europe and will not enhance further Europe-wide integration of CAM. This not only has an effect on consumers of CAM, but also on researchers, as CAM practices, research methods and results are not comparable among European countries due to the diverse statuses of CAM. Research results will therefore only be representative within the country it is studied in (Wiesener *et al.,* 2012).

Developments in the USA

Although much is going on in Europe regarding integration of CAM, it is generally agreed on that CAM is better integrated in the USA.

> *"But in general we see that the developments in the US regarding CAM become commonplace in Europe 5 years later, so now we see it finally coming to Europe." (5)*

CAM education is part of the medical curriculum at medical schools and in several academic hospitals in the USA; CAM is fully integrated into the treatment policies (Kolkman *et al.,* 2011).

> *"In the US, they have been working for 30/40 years on integrative medicine. In 35 of the largest academic hospitals, integrative medicine is used. It's completely integrated." (2)*

Reasons for the more thorough integration could be due to the fact that 85% of medical students reckon that knowledge about CAM is necessary as a future doctor and 75% feel that CAM should be part of the medical curriculum in a level that is sufficient to advise patients about the possibilities and uses of CAM (Chaterji *et al.,* 2007). CAM use and number of visits to CAM providers are large compared to European numbers: each year 38 million adults visit some sort of CAM practitioner (Consumer Reports, 2001), and these numbers have increased over the past years (see Eisenberg *et al.*, 1993; Eisenberg *et al.*, 1998; Pelletier and Astin, 2002). The NCCAM has an annual budget of 150 million US dollar

[15] Irritable Bowel Syndrome
[16] http://www.nhs.uk/Conditions/Irritable-bowel-syndrome/Pages/Treatment.aspx

(Walach, 2012) and the integration of CAM in the health insurance is supported by the new Obamacare legislation (ECCH & ICH, 2013).

The large US investments and numbers are in sharp contrast with European numbers which is disadvantageous for the European situation. Hök *et al.* (2012) proposed to establish a centralised EU CAM research center to bridge the gap between the European and the US situation concerning CAM. The goal of this center would be to achieve equality in regulation in European countries and the USA and to maximise consumers' freedom of choice.

Concluding on the foreign tendencies on the integration and acceptance of CAM, the role of CAM within regular medicine is still not clear and differs a lot among countries. However, considering the fact that statutory changes in several countries has helped CAM to integrate more in healthcare, the future for the Dutch field of CAM is looking bright. Another interesting aspects for the discussion on the need for integration of CAM in Dutch healthcare, is the understanding of health as a human right. Especially relevant is the Second Programme of Community action in the field of health (EU, 2007) which states that:

> *"The Programme should recognise the importance of a holistic approach to public health and take into account, where appropriate and where there is scientific or clinical evidence about its efficacy, complementary and alternative medicine in its actions."* (European Union, 2007)

Considering this statement of the EU, it is interesting to reflect on the status of CAM in Europe and how relevant the notion of health as a human right is in regard to the UN declaration of human rights:

> *"The right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services" (UN, 1948)*

Considering these statements, there should be no doubt about integrating CAM into regular health care.

8. Conclusion and discussion

The main focus of this research has been on the current position of complementary and alternative medicine in Dutch healthcare. The position is defined by several aspects, these include:

- levels of acceptation of established medical institutions,
- education and training conditions,
- reimbursement conditions of insurance companies,
- attitudes of medical professionals and students,
- current, and future, trends in integration and combination therapies between CAM and regular.

The goal of this research was to explore the field of CAM. This was to be achieved by conducting interviews with relevant parties contributing to the position. The multi-level analysis was used to study the position of CAM. Included levels in this study are Dutch insurance companies, CAM associations, umbrella organizations, the Dutch government and Dutch medical students. Interviews have been done with relevant parties and document analysis was conducted to create a wide overview of the position of CAM.

In the first data analysis chapter, chapter 4, the search for an appropriate CAM definition was described. Several CAM definitions exist in several countries and this does not enhance international collaboration on CAM. Furthermore, insurance companies in the Netherlands are struggling with the definition of CAM. In CAM, the border between health, wellness and beauty is sometimes hard to distinguish and insurance companies do not reimburse therapies aimed at wellness. Therefore, rules and conditions were created which caused dissatisfaction within the CAM associations.

In chapter 5, professionalization was discussed. During all interviews the need to professionalize the CAM field was mentioned, as well as the need to increase transparency towards the general public, consumers and institutions. To increase professionalization, several steps are taken: accreditation of education programs, reimbursement conditions and associations' membership conditions, and professionalization of the management of associations. These steps enhance professionalization of CAM associations and CAM practitioners and will improve the position of CAM.

Scientific research and the expansion of integration levels of CAM in regular medicine are other major steps towards an improved position of CAM. To increase integration levels and combine practices of CAM and regular medicine, several steps need to be taken by the CAM associations. One of these steps is a large consumer satisfaction survey. This is an important step for integration and one way to convince insurance companies of the benefits of CAM. Insurance companies are not only looking for evidence based practices, but also listen to their clients, what they ask for and what their experiences with CAM are. Therefore, consumer satisfaction surveys would be a welcome contribution to the efficacy research on CAM. Another step is the establishment of a sector-wide organization that represents all CAM practitioners and their interests and a broad basic training in CAM for GPs. Similar actions have taken place in other countries and the results of this have been discussed in chapter 7.

To determine the position of CAM, attention has been paid to levels of integration, the importance of efficacy research and evidence, the organizational structure of associations and umbrella organizations and the steps taken to improve the position. The gatekeepers for CAM in the Netherlands are the insurance companies. They provide access to healthcare for a large consumer cohort and they can impose their own conditions and rules on CAM practitioners and associations. But for CAM to gain access, insurance companies are imposing several rules and conditions to the practitioners and associations that they need to satisfy before reimbursement is given for their therapies. So to answer the main question on the position of CAM, it can be said that CAM is still in a subordinate position when compared to regular medicine. Regular medicine has the notion and appearance of evidence-based medicine which gives it a major advantage when compared to CAM. Not much parts of CAM are (yet) proven to be effective which creates scepticism in regular medicine. However, the position of CAM is improving, due to the fact that more conditions are imposed on CAM. These conditions are similar to regular medicine.

Although more research on the efficacy and safety is being done, CAM is still much behind regular medicine in this respect. However, CAM has several advantages that might increase integration. The main advantage for CAM is the consumer demands and the increased use of CAM. With the support of the large group of consumers, CAM can integrate more rapidly in healthcare if consumers unite and apply pressure and demand change. Although CAM associations and umbrella organizations claim to have the support of a large group of consumers, the attitude of patient organizations on CAM is unknown. The numbers on use and prevalence of CAM in the Netherlands show an increase, as described in previous chapters, but the perspective of patient federations towards CAM is not included in this thesis due to time limitations. This should be included in future research.

Additionally, dissatisfaction with regular medicine will grow, considering several factors, including the rising costs of regular medicine. Combined with future research and the lower healthcare costs of CAM patients, CAM use and acceptance will increase. However, when considering the future of CAM and the levels of integration into regular healthcare, focus should be paid to CAM associations and practitioners and their demands for integration. Because what amount of integration is ideal? Should CAM be fully integrated or completely separated, or somewhere in between? Different levels of integration can be desired by CAM associations, including ignoring, complete integration, separation, cooperation and/or co-optation. What level is achieved is very much dependent on legal rules and regulations, and the government's reimbursement and consultation conditions. Furthermore, it is dependent on the pace of new developments and this will be partly influenced by CAM education in the medical curriculum.

The goal of this research was to conduct an exploratory study in the field of CAM and to determine its position next to regular medicine. The study has been successful in a way that it has been an exploratory study in which multiple levels have been studied to determine the current position of CAM in Dutch healthcare. This research can be used for further professionalization of the CAM associations and practitioners.

Theoretical framework

Concluding on the theoretical aspects of this thesis, both theoretical frameworks have been applied and were a useful means for structuring the research data. Aspects of institutional theories can be found in the notion that insurance companies are regulating the

field of CAM. Regulation is accomplished through the conditions and rules that are imposed on CAM practitioners and associations. This is an example of co-optation, in which the insurance companies do not ignore CAM movements, but try to bend associations and practitioners to their rules and therefore create possibilities for integration of CAM. The imposed rules and regulations by insurance companies should not be seen as a form of simply allowing CAM to join Dutch healthcare, but CAM associations and practitioners are subjected to the rules and conditions of insurance companies.

Furthermore, the dissatisfaction of insurance companies with the chaotic structure of the field contributed to the incentive for insurance companies to start organizing the field. This should have come from the CAM associations and umbrella organizations themselves. Although these incentives were present, no compromises could be found. That is why VGZ started to impose several conditions for the CAM practitioners, which was beneficial for both the insurance companies and the CAM associations and practitioners.

During some of the interviews, the unification process of associations was discussed. This process is started to be able to pressurize medical institutions. Without asking for it during the interviews, several CAM associations talked about collaborating with other associations to be able to apply more pressure. This would stimulate the preservation of their interest in policymaking. One of the next steps is the joining of all associations in a sector-wide organization and to make consumers more aware of the possibilities, in order to give consumers a stronger voice:

> *"If consumers know what's out there, this will result in a bottom-up stream; the consumer will start to interfere with government and insurance companies." (5)*

So by uniting in an overarching organization, practitioners wish that consumers start interfering with politics and insurance policies and therefore, the power of the public sphere might be used to demand change. The insurance companies are pressurized by the rise in CAM use and by consumer demands for CAM integration. Although not all CAM associations could be pooled together as one social movement, several associations discussed the power of combining forces in order to gain easier acceptance, thereby applying more pressure to established institutions. The wish for consumers to partly become the force behind CAM was also stated in the closing speech of the leader of CAMbrella, Dr Weidenhammer, during the final conference of the CAMbrella project in November 2012. The title of his speech was "Citizens are the driver for the use of CAM" (ECCH & ICH 2013).

The institutional theories and social movement theories have been complementary to each other in this thesis research. Institutions have been able to impose their demands and conditions on CAM associations and practitioners. The conditions are not opposed by the field of CAM due to the loosely organizational structure of CAM associations. Due to this, insurance companies take over from CAM associations and they can bend the field of CAM according to their own rules and conditions.

There are also some remarks that need to be made about this thesis. As already mentioned in the introduction and method section, this study is far from complete. Due to time limitations I have only been able to speak to a limited number of associations and insurance companies. In the end I have been looking for more associations to interview, but

this did not work, possibly because these associations were more conservative and did not want to be part of this study. Therefore, this study does not represent the whole field of CAM and the conclusion on the position should not be generalized to other associations. Additionally, the CAM associations that I have interviewed were the least conservative and/or biggest players in the field of CAM. They were all in favour of more regulation and none of them spoke negatively about the imposed insurance conditions. But this does not mean that all associations and practitioners agree with the new conditions for education and management structure. During interviews, several comments were made about smaller and more conservative associations that had no interest in being part of a research and that are afraid of intruders in their daily practice. Furthermore, this multi-level analysis is not complete, because I was not able to include all relevant levels due to time limitations. Even though the most important levels are included, CAM users and patients, CAM researchers and producers and distributors of CAM products would have been relevant to include.

One difficulty that I took home after an interview was my own prejudice about CAM. My biomedical background was always present in the back of my head and this caused me to think analytically and scientifically about some of the issues raised during interviews. Furthermore, in the beginning of every interview I introduced myself as a former biomedical sciences bachelor student and I explained the reasons that made me switch to medical anthropology and sociology. I explained how I sometimes felt that biomedical sciences was a little blunt about alternative and complementary medicine and non-evidence based medicine. This may have biased the interview outcomes and perhaps I mentioned too much about my background, thereby guiding the interview towards a certain direction. On the other hand, during the research process I have tried to switch from a biased perspective towards a neutral and open position to give the interviewees the opportunity to speak for themselves. Additionally, I consider my interviewees of enough personal strength and motivation to tell their own story and not be influenced by my personal motivation. I reckon this has not influenced the outcomes and I think that my biomedical background gave me a certain advantage and legitimacy in gaining trust during the interviews.

This thesis is written for an English master program and that is why this thesis is written in English. All interviews were done in Dutch so information might have been lost in translation. However, while translating the quotes into English, I tried to keep the authenticity of the answers in the quotes.

The data used in this thesis comprises interviews, literature and documents. The main source of data has been the nine interviews, these are supplemented with several documents of insurance companies and several scientific articles, mainly Kolkman *et al.* (2011). This collection of data has been used to build up the data chapters. Additional literature has been used as additional and background information, to put the data in the right perspective and to interpret the data.

A suggestion for further research would be to expand the current research and to include all CAM associations, insurance companies and other relevant parties. This would greatly increase the credibility and usability of this research. More attention should then be paid to the wish of CAM associations concerning their view on optimal integration and their view on a suitable CAM definition. Furthermore, the effects of the professionalization development and the effects of the basic medical and psychosocial knowledge standards on CAM associations and practitioners could be studied. As a final suggestion for research, and

probably the most obvious and most frequently heard one, the suggestion that would be most beneficial for CAM, is to increase scientific research on the safety and efficacy of CAM, and to conduct a large consumer satisfaction survey. All these changes and developments, combined with a full multi-level analysis, determine the position of CAM in Dutch healthcare.

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Appendices

1. Email to insurance companies
2. Email to CAM associations
3. Overview of Dutch insurance companies
4. Detailed list of informants
5. Topic list of interview with insurance companies
6. Topic list of interview with CAM associations

Appendix 1. Request to CAM associations

Geachte heer/mevrouw,

Naar aanleiding van de afronding van mijn Master Medical Anthropology and Sociology aan de Universiteit van Amsterdam mail ik u met de volgende vraag. Ik wil namelijk mijn afstudeeronderzoek gaan doen over het medische pluralisme in Nederland. De laatste jaren is het aanbod en gebruik van complementaire en alternatieve geneeswijzen en medicijnen (Complementary and Alternative Medicine, CAM) toegenomen. Ik wil daarom graag onderzoek gaan doen naar de houding van verschillende instanties in Nederland tegenover de integratie en het grotere aanbod van CAM in de gezondheidszorg. Ik ga me richten op de mening van medische studenten en artsen, op beroepsverenigingen van alternatieve genezers, het advies van de Nederlandse overheid/College voor Zorgverzekeringen (CVZ) en op de houding van zorgverzekeraars. Ik zou graag van de beroepsverenigingen willen weten wat jullie mening is over de vergoeding door verzekeraars en wat jullie mening is over integratie van CAM in de Nederlandse gezondheidszorg. Wordt de vergoeding door verzekeraars door u gesteund en stellen jullie daardoor meer eisen aan jullie leden, zodat ze door verzekeraars erkend worden en hun behandelingen vergoed? Of staan jullie sceptisch tegenover vergoedingen door verzekeraars omdat CAM daardoor wellicht te ‘mainstream’ wordt/kan worden?

Dus daarom mail ik u om te vragen of er iemand binnen uw organisatie bereid is om een aantal vragen van mij te beantwoorden. Kunt u mij daarom in contact brengen met iemand binnen uw organisatie of deze mail doorsturen naar de betreffende persoon?

Alvast bedankt voor de medewerking en ik hoop graag iets van u te horen.

Met vriendelijke groet,

TobiasNederkoorn
tobiasnk@gmail.com
0640489770

Appendix 2. Request to insurance companies

Geachte heer/mevrouw,

Naar aanleiding van de afronding van mijn Master Medical Anthropology and Sociology aan de Universiteit van Amsterdam mail ik u met de volgende vraag. Ik wil namelijk mijn afstudeeronderzoek gaan doen over het medische pluralisme in Nederland. De laatste jaren is het aanbod van, en de vergoeding van verzekeraars, complementaire en alternatieve geneeswijzen en medicijnen (Complementary and Alternative Medicine, CAM) toegenomen. Ik wil daarom graag onderzoek gaan doen naar de houding van verschillende instanties in Nederland tegenover de integratie en het grotere aanbod van CAM in de gezondheidszorg. Ik ga me richten op de mening van medische studenten en artsen, op beroepsverenigingen van alternatieve genezers, het advies van de Nederlandse overheid/College van Zorgverzekeringen (CVZ) en op de houding van zorgverzekeraars. Ik zou graag willen weten van zorgverzekeraars waarom er bepaalde therapieën wel worden vergoed en waarom sommige niet, en waar die keuze op gebaseerd is en wat de invloed van beroepsverenigingen van alternatieve genezers is.

Dus daarom mail ik u om te vragen of er iemand binnen uw organisatie, een medische adviseur die advies geeft of een medewerker/manager die uiteindelijk beslist over de vergoedingen, bereid is om een aantal vragen van mij te beantwoorden. Kunt u mij daarom in contact brengen met iemand binnen uw organisatie of deze mail doorsturen naar de betreffende persoon?

Alvast bedankt voor de medewerking en ik hoop graag iets van u te horen.

Met vriendelijke groet,

Tobias Nederkoorn
tobiasnk@gmail.com
0640489770

Appendix 3. Overview of Dutch insurances

Marktstructuur

Zorgverzekeraars

Op de zorgverzekeringsmarkt zijn in 2012 26 zorgverzekeraars actief. Deze zijn verdeeld over negen concerns.

Tabel 2.1. Aanbod concerns en zorgverzekeraars 2012

Concern	Zorgverzekeraar
Achmea	AGIS ZORGVERZEKERINGEN N.V.
	AVERO ACHMEA ZORGVERZEKERINGEN NV
	DE FRIESLAND ZORGVERZEKERINGEN N.V.
	FBTO ZORGVERZEKERINGEN N.V.
	INTERPOLIS ZORGVERZEKERINGEN NV
	OZF ACHMEA ZORGVERZEKERINGEN N.V.
	ZILVEREN KRUIS ACHMEA ZORGVERZEKERINGEN NV
Achmea	**7**
ASR	ASR BASIS ZIEKTEKOSTENVERZEKERINGEN N.V.
ASR	**1**
CZ	DELTA LLOYD ZORGVERZEKERING N.V.
	OHRA ZIEKTEKOSTENVERZEKERINGEN NV
	OHRA ZORGVERZEKERINGEN N.V.
	OWM CZ GROEP ZORGVERZEKERAAR UA
CZ	**4**
DSW-SH	OWM DSW ZORGVERZEKERAAR U.A.
	OWM STAD HOLLAND ZORGVERZEKERAAR U.A.
DSW-SH	**2**
Eno	ENO ZORGVERZEKERAAR N.V.
Eno	**1**
Menzis	ANDERZORG N.V.
	AZIVO ZORGVERZEKERAAR N.V.
	MENZIS ZORGVERZEKERAAR N.V.
Menzis	**3**
ONVZ	ONVZ ZIEKTEKOSTENVERZEKERAAR N.V.
ONVZ	**1**
VGZ	IZA ZORGVERZEKERAAR NV
	IZZ ZORGVERZEKERAAR N.V.
	N.V. UNIVÉ ZORG
	NV ZORGVERZEKERAAR UMC
	VGZ ZORGVERZEKERAAR N.V.
	ZORGVERZEKERAAR CARES GOUDA N.V.
VGZ	**6**
Zorg&Zekerheid	OWM ZORGVERZEKERAAR ZORG EN ZEKERHEID UA
Zorg&Zekerheid	**1**
Totaal 9	**Totaal 26**

Bron: Nederlandse Zorgautoriteit (Modelovereenkomsten)

Tabel 2.2. Ontwikkeling aantal zorgverzekeraars 2006 – 2012

	2006	2007	2008	2009	2010	2011	2012
Concerns	16	15	12	12	11	10	9
Zorgverzekeraars	33	32	32	30	28	27	26

Bron: Nederlandse Zorgautoriteit (Modelovereenkomsten)

Source: Nederlandse Zorgauthoriteit. (2012). Nederlandse Zorgauthoriteit. In Monitors en marktscans 2012. Retrieved January 2013, from http://www.nza.nl/104107/105773/475605/Marktscan_Zorgverzekeringsmarkt.pdf.

Appendix 4. Detailed list of informants

List of informants

1. Interview with two people of a CAM association. Two women, one being chair of the association, age 60+ and other one being a practitioner, age between 35-45.
2. Interview with chair of a CAM association, female, age between 55-60.
3. Interview with chair of a CAM association, male, aged 62.
4. Interview with two people of an umbrella organization. Man and women, both aged between 60-65.
5. Interview with the chair of a CAM association, male, age between 40-50 years
6. Interview with the chair of a CAM associations, female, age between 40-50 years

9. Interview with two people of an insurance company. Male, productmanager, age between 40-50 and a female, management advisor, age around 30.
10. Interview with a medical advisor of an insurance company, female, age between 40-50
11. Interview with a policy employee of an insurance company, female, age between 30-40

Appendix 5. Topiclist of interview insurance company

Onderzoek naar de positie van de alternatieve en complementaire geneeswijzen (CAM) in de Nederlandse gezondheidszorg. Vragen interview zorgverzekeraars

- Geschiedenis van de vergoeding van alternatieve zorg
    - Sinds wanneer wordt CAM vergoedt vanuit het aanvullende pakket?
    - Worden er meer/minder therapieën opgenomen in de voorwaarden de laatste jaren?
    - Hoe komt een beroepsvereniging/therapeut in aanmerking voor vergoeding?
- Vergoedingen/voorwaarden
    - Waarom is er voor gekozen om CAM te vergoeden vanuit het aanvullende pakket?
    - Waar moet een alternatief behandelaar/beroepsvereniging aan voldoen om opgenomen te worden in het verzekeringspakket?
    - Wordt gecontroleerd of een therapeut voldoet aan de eisen, of is dit de taak van de beroepsvereniging?
    - Maximum bedrag van vergoeding/maximaal aantal bezoeken, wat is het effect daarvan op de patiënt?
    - Het gevolg van de nieuwe strengere eisen omtrent vergoeding vanaf 2017 (minimaal opleiding op bachelor niveau)
- Hoe oefenen de volgende partijen druk uit op het vergoedingsbeleid?
    - Reguliere artsen/professionals
    - Vraag vanuit de gebruikers
    - Overheid beleid omtrent de gezondheidszorg, CvZ, IGZ
    - Wetenschappelijke literatuur over CAM
    - CAM beroepsverenigingen
    - Vereniging tegen de Kwakzalverij
- Wat is het belang van wetenschappelijk onderzoek naar de veiligheid en effectiviteit van CAM?
    - Moet er op dezelfde manier onderzoek gedaan worden naar CAM als er onderzoek wordt gedaan naar reguliere geneeswijzen (Randomized controlled trials, RCTs)?
    - Wat is de invloed van organisaties als NCCAM en CAMbrella?
    - Wat is het toekomstperspectief van CAM? Zal er ooit plaats zijn voor CAM in het basispakket?
    - Wat is het grootste obstakel voor totale integratie van CAM in de gezondheidzorg?
- CAM veld is zeer divers
    - Wat verstaat u onder CAM, en wie zijn de CAM gebruikers/therapeuten? Zijn het patiënten die het gebruiken vanwege een medische noodzaak of om hun algemene gezondheid te verbeteren/stabiel te houden? Of allebei?
    - Vervaagt de grens tussen gezondheid/wellness en geneeskunde door CAM gebruik? CAM als social movement die druk uitoefent op organisaties? Of een bepaalde stroming patiënten binnen de gezondheidszorg?

Appendix 6. Topiclist of interview with CAM associations

Onderzoek naar de positie van de alternatieve en complementaire geneeswijzen (CAM) in de Nederlandse gezondheidszorg. Vragen interview CAM beroepsverenigingen

- Wat is t doel van een beroepsvereniging?
    - Sinds wanneer zit de vereniging in het aanvullende pakket van verzekeraars?
    - Actief op zoek naar nieuwe verzekeraars en vergoedingen? Waarom wordt het door sommige verzekeringen wel/niet vergoedt?
    - Wat zijn de gevolgen van de vergoeding?
    - Zijn er ook therapeuten lid waarvan de therapie niet vergoed wordt door verzekeraars? Waarom niet en wat doen de therapeuten eraan?
    - Nieuwe aanwas van leden?
- Regulering door overheid/verzekeraar. Professionalisatie en het effect op CAM behandelaars
    - Gevolg van strengere regulering door verzekeraars? HBO basis kennis ook van belang?
    - Speelt de overheid/CvZ een rol in de regulering van CAM?
    - Populariteit? Willen ze dat de behandeling mainstream wordt of identificeren ze zichzelf als alternatief?
- Doel van de klachtcommissie en gebruik ervan, randvoorwaarden van lidmaatschap
    - Waardoor zijn de strengere eisen/selectiecriteria ingevoerd?
    - Wat is het effect van de nieuwe eis dat elke behandelaar minimaal bachelorniveau behaald moet hebben?
    - Limitaties van vergoeding, wat betreft het maximum aantal sessies of maximum bedrag. Therapietrouw bij bereiken vergoedings maximum?
- Wat gebeurt er met verwijzingen tussen alternatief en conventionele arts. Verwijst een alternatieve arts ook naar een conventionele arts? Samenwerking biomedische arts en alternatieve arts?
- Belang van wetenschappelijk onderzoek, hun positie tov meer onderzoek naar effectiviteit en veiligheid.
    - Nodig om meer onderzoek te doen?
    - Hoe moet er onderzoek gedaan worden naar CAM?
- CAM veld is zeer divers
    - Wat verstaat u onder CAM, en wie zijn de CAM gebruikers?
    - Vervaagt de grens tussen gezondheid/wellness en geneeskunde door CAM gebruik?
- Toekomstperspectief van CAM.
    - Waar staat CAM over 10/20 jaar? Zal het vergoed worden in de basisverzekering?
    - Is er een goede plaats/plek voor CAM in de Nederlandse gezondheidszorg?
- Hoe is de relatie/het contact met zorgverzekeraars?
- Persoonlijke ervaring met CAM? Carrière verloop van de geïnterviewde, hoe komt hij/zij op huidige positie terecht?