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Traditional and Complementary Medicine

Abstract

South Africa is one of the few nations that have made significant progress to integrate traditional and complementary medicine into the legislative framework for health practitioners. Traditional medicine, represented by approximately 190 000 traditional health practitioners, has sustained the health of millions of South Africans over centuries. There are currently about 3 600 registered Allied Health Care Professionals in South Africa.

In recent years there has been an influx of a number of herbal and other health products onto the South African market. Without an appropriate registration system many of these products are currently sold without control. It is estimated that there are approximately 25 000 complementary medicines, including traditional medicines, that have been submitted to the Medicines Control Council to facilitate the implementation of the Accelerated Registration Programme. There is evidence of cooperation between traditional healers and practitioners of allopathic medicine and this trend is expected to grow.

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Traditional medicine

The World Health Organization (WHO) defines traditional medicine (TM) as *"health practices, approaches, knowledge, and beliefs incorporating plant, animal and mineral based medicines, spiritual therapies, manual techniques and exercises, applied singular or in combination, to treat, diagnose and prevent illnesses or maintain well-being"*.[1] Traditional medicine in South Africa is not to be confused with complementary and alternative medicine (CAM).[a]

According to the WHO approximately 80% of the population of African Member States use TM to meet their health care needs.[2] TM has sustained the health of millions of Africans over hundreds of years. In 1999, Pretorius noted, *"In a sense much more has transpired in the traditional medical sector in the past five years [since 1994] than in the rest of this century. The government has made good on its promise to incorporate this sector into the national health system and they have set the necessary procedures in motion. Despite this major breakthrough, very little has changed on the ground."*[3] In the period following the review by Pretorius there have been substantial international and regional developments in recognising and facilitating the role and forms of healing other than the dominant allopathic model.

International policy and regional commitments

The WHO Traditional Medicines Strategy 2002-2005 provides a framework for action to promote the use of TM/CAM in reducing mortality and morbidity, especially among impoverished nations. The strategy outlines four objectives.[4]

1. **Policy:** To integrate TM/CAM into national health care systems, where appropriate, by developing and implementing national TM/CAM policies and programmes.
2. **Safety, efficacy and quality:** To promote the safety, efficacy and quality of TM/CAM by expanding the knowledge base of these remedies and by providing guidance on regulatory and quality assurance standards.
3. **Access:** To increase the availability and affordability of TM/CAM where appropriate, focusing on poorer populations.
4. **Rational use:** To promote therapeutically sound use of appropriate TM/CAM by providers and consumers.

The strategy aims to assist countries to:

- develop national policies on the evaluation and regulation of TM/CAM practices. To this end several useful documents on the legal status of TM/CAM around the world have been published;[5,6]
- create a strong evidence base on the safety, efficacy and quality of TM/CAM products and practices;
- ensure availability and affordability of TM/CAM including essential herbal medicines;
- promote therapeutically sound use of TM/CAM by providers and consumers; and
- document traditional medicines and remedies.

The international People's Charter for Health is a statement of shared vision, goals, principles and action and is the most widely endorsed consensus document on health since the Alma Ata Declaration. The People's Charter calls for the provision of universal and comprehensive primary health care, irrespective of people's ability to pay. It *"calls on people of the world to support, recognise and promote traditional and holistic healing systems and practitioners and their integration into Primary Health Care"*.[7]

The WHO African Regional Strategy on TM was adopted in 2000.[2] In 2001, the strategy was endorsed by the Assembly of Heads of State and Government of the Organization of African Unity (OAU) and the period 2001-2010 was declared as the Decade for African Traditional Medicine.[8] An annual African Traditional Medicine Day was also declared. As a consequence of the OAU resolutions, the WHO Regional Office for Africa established a 12-member WHO Regional Expert Committee on TM to assist countries to accelerate the implementation of policy decisions.[9]

A review of the progress on the Decade for African Traditional Medicine was placed on the agenda of the Third Session of the African Union Conference of Ministers of Health, which was held in Johannesburg in April 2007. The report tabled at the meeting argued for urgent strategies to accelerate the implementation of the plan and for significant advocacy for TM.[10] Action has been lacking and a resolution

a Using the WHO terminology, in countries where the dominant health care system is based on allopathic medicine or where TM has not been incorporated into the national health care system, TM is often termed 'complementary', 'alternative' or 'non-conventional' medicine. For example, Traditional Chinese Medicine and acupuncture would be termed 'Traditional Medicine" when used in China, but 'Complementary and Alternative Medicine' when used in Europe, North America or South Africa.

was taken to gather data on the state of implementation of TM for a 'mid-term' review to be held in 2008. The commitments made by South Africa to TM in this forum have not penetrated the health sector and are virtually unknown in the private sector.

It was recommended that the African Union Ministers of Health adopt the OAU Pharmacopoeia on Medicinal Plants, which could serve as a basis for each Member State to develop their own first volumes of pharmacopoeia on TM. The adoption of the OAU would facilitate and allow tangible cultivation, production and registration of medicinal plants that are in the pharmacopoeia.

Policy and legislative framework

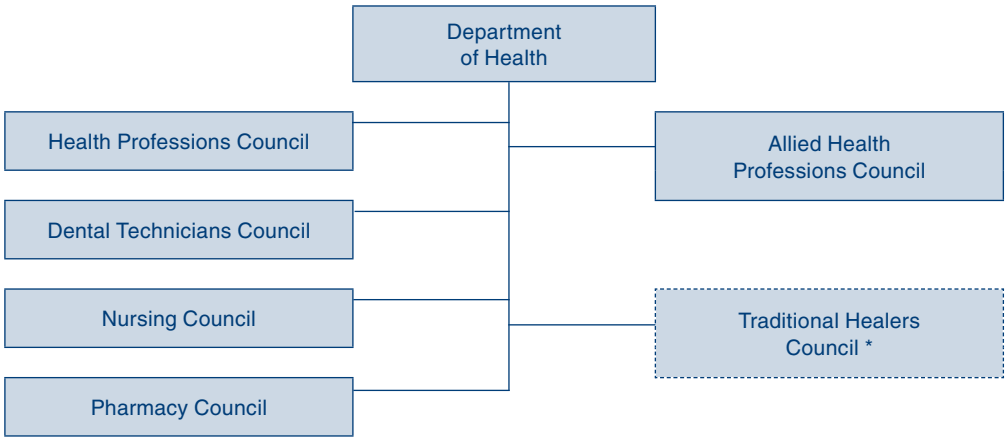
The topic of TM was escalated to the national health agenda by the African National Congress Health Plan of 1994 where it was stated that *"traditional healing will become an integral and recognised part of health care in South Africa. Consumers will be allowed to choose whom to consult for their health care, and legislation will be changed to facilitate controlled use of traditional practitioners"*.[11] The plan contained a powerful statement as the basis for policy which noted, "*people have the right of access to traditional practitioners as part of their cultural heritage and belief system*".[11]

The long awaited Traditional Health Bill was gazetted as a draft Bill in 2003 and passed as the Traditional Health Practitioners Act (Act 35 of 2004).[12,13,14] This Act provided a regulatory framework to ensure the efficiency, safety and quality of traditional health care services and the establishment of the Interim Traditional Health Practitioners Council of South Africa. The Constitutional Court however ruled that this Act return to Parliament as it was improperly processed by the National Council of Provinces (NCOP). Following public meetings in all provinces during August and September 2007, the Traditional Health Practitioners Bill (Bill 20 of 2007) was approved in October 2007. The Bill now awaits the signature of the President. Once the Act is passed, it will allow for the establishment of the Interim Traditional Health Practitioners Council which, in terms of the Act, will be appointed to assist with the development of Regulations. The registration, training and conduct of practitioners will in time also be regulated by this Act, in line with similar protocols followed by other health professions.

The implementation of the Traditional Health Practitioners Act will ensure that traditional healers are placed on an equal footing with other types of health care practitioners in South Africa. All health care practitioners must be registered in order to practice and to qualify for registration, a practitioner must have achieved a minimum standard of training at an institution accredited by the relevant council set up by the Department of Health (DoH). Councils are responsible for the registration of practitioners, the establishment of educational standards for registration and the general regulation of the health care professions. The regulation structure for health care practitioners is shown in Figure 1.

The DoH issued the Patients Charter in 2002, emphasising the right of patients to choose a particular health care provider for services.[16]

Figure 1: The regulation of health care practitioners in South Africa



* Interim Committee

Source: Caldis et al, 2001.[15]

The speech by the Minister of Health at the African Traditional Medicine Day in September 2007 highlighted the importance of the holistic inclusion of African Traditional Medicine in the national health system.[17] Initiatives that have been completed or are underway include:

- work on the policy framework on African Traditional Medicine by the Presidential Task Team;
- the prioritisation of registration and the regulatory framework for practitioners;
- work undertaken with the Medicine Regulatory Authority by the Ministerial Task Team to facilitate the registration and regulation of African Traditional Medicines;
- making funds available for research and development of medicines; and
- the establishment of a unit for TM within the DoH.

The Minister further announced that consideration is being given to the establishment of an Institute for African Traditional Medicine for research and training.

Traditional medicine practitioners in South Africa

In 1999, Pretorius estimated that there were between 150 000 to 200 000 traditional healers in South Africa, belonging to some 100 separate organisations.[3] This estimate was confirmed in 2007 by investigations conducted by the authors as indicated in Table 1.

Table 1: Number of traditional healers in South Africa, 2007

Province	Number of practitioners
EC	10 780
FS	22 645
GP	61 465
KZN	14 941
LP	7 366
MP	57 524
NC	2 221
NW	5 935
WC	2 600
Total	185 477

Source: Compiled based on research by authors.

The KwaZulu-Natal DoH have developed a system to enumerate traditional healers in the province. Results indicate that there are approximately 25 000 traditional healers in KwaZulu-Natal (KZN).[b] More than half of these are actually practising (14 941, see Table 1) and a further half (about 7 000) is estimated to be registered with their interim professional body. This reveals that there is a possible under estimate of the actual numbers of traditional healers in South Africa.

The Traditional Health Practitioners Act classifies traditional healers as:

- Diviners (Izangoma / Amagqirha)
- Herbalists (Izinyanga / Amaxhwele)
- Prophets / faith healers (Abaprofeti / Abathandazeli)
- Traditional surgeons (Iingcibi)
- Traditional birth attendants[c] (Ababelethisi / Abazalisi)

At this stage it is not possible to determine the number of healers in each category and an assessment will only be available once the Act has been implemented and formal registration of practitioners has occurred.

Complementary and alternative medicine

Policy and legislative framework

The formal recognition of complementary and alternative medicine practitioners in South Africa has taken many years.[15] Chiropractors, herbalists, homeopaths, naturopaths and osteopaths were able to register during a six month period in 1974, following which the registers were closed. The Chiropractors, Homeopaths and Allied Health Service Professions Act (Act 63 of 1982) provided for the establishment of the South African Associated Health Service Professions Board. The registers for chiropractic and homeopathy were reopened in 1985. In the early 1990s, the Confederation of Complementary Health Associations of South Africa (COCHASA) lobbied for the recognition of complementary practitioners. However, apart from a window period to allow for the registration of aggrieved practitioners in 1996, the registers for phytotherapy, naturopathy and osteopathy remained closed.

b Personal communication, N Mtshali, KwaZulu-Natal Department of Health, May 2007.

c The latter term does not reflect the scope of practice of traditional birth attendants. A more appropriate term might be traditional reproductive health attendants.

Table 2: Number of registered Allied Health professionals, interns and students, 2007

Professional Boards	Allied Health Profession	Number of practitioners	Total by Board
Professional Board for Ayurveda, Chinese Medicine and Unani-Tibb (PBACMU)	Ayurveda Doctor	10	399
	Ayurveda Primary Health Care Advisor	41	
	Ayurveda Therapist	15	
	Panchakarma Technician	4	
	Maharishi Practitioner	3	
	Chinese Medicine	152	
	Acupuncture	174	
Professional Board for Chiropractic and Osteopathy (PBCO)	Osteopathy	50	541
	Chiropractic	491	
Professional Board for Homoeopathy, Naturopathy and Phytotherapy (PBHNP)	Homeopathy	552	669
	Naturopathy	94	
	Phytotheraphy	23	
Professional Board for Therapeutic Aromatherapy, Therapeutic Massage Therapy and Therapeutic Reflexology (PBARM)	Therapeutic Aromatherapy	630	2 013
	Therapeutic Massage Therapy	240	
	Therapeutic Reflexology	1 143	
Total		3 622	3 622

Source: Allied Health Professions Council.[d]

The Chiropractors, Homeopaths and Allied Health Service Professions Act of 1982 remains the 'principal Act', which has subsequently been amended by Act 108 of 1985, Act 10 of 1990, Act 63 of 1993 and Act 40 of 1995. The 1995 amendments to the Act established the Chiropractors, Homeopaths and Allied Health Service Professions Interim Council. One of the objectives of this body was to make recommendations to the Minister of Health on the constitution of a Council that included other treatment modalities.

Caldis et al. argue that 29 November 2000 should be regarded as the fall of the South African 'bamboo curtain'.[e,15] On this date, the President signed the renamed Allied Health Professions Act of 1982[f] providing for the establishment of the Allied Health Professions Council. This brought CAM onto an equal legislative footing with other healing modalities, as shown in Figure 1.

Complementary and alternative medicine practitioners in South Africa

The Allied Health Professions Act allowed for ten treatment modalities to be initially registered. These included, Ayurveda,[g] Traditional Chinese Medicine,[h] Osteopathy, Chiropractic, Homeopathy, Naturopathy, Phytotherapy[i] and the three therapeutic professions[j] of Aromatherapy, Massage Therapy and Reflexology. The Act makes provision to accommodate other modalities that may require registration at a later date. An eleventh modality, Unani-Tibb,[k] has been recommended for inclusion and the relevant legal notices are in the process of being prepared.

These modalities are controlled by Professional Boards of the Allied Health Professions Council of South Africa (AHPCSA). The Boards may recommend Council to approve training schools; conduct examinations and grant certificates, recommend Council to register students, interns and practitioners and investigate the professional conduct of registered practitioners. The AHPCSA had 3 622 registered

d Available at: http://www.ahpcsa.co.za

e The fall of the "bamboo curtain" has been used elsewhere in the world to describe the integration between West and East in terms of healing modalities, or in other words the integration of complementary health practices with Western allopathic medicine.

f The Act was renamed the Chiropractors, Homeopaths and Allied Health Service Professions Second Amendment Act (Act 50 of 2000). Available at: http://www.info.gov.za/gazette/acts/2000/a50-00.pdf

g Indian / Asian traditional system of medicine.

h Incorporating Acupuncture.

i Previously know as herbal medicine.

j Therapeutic professions are not permitted to diagnose.

k Islamic traditional system of medicine.

complementary medicine practitioners, interns and students across all modalities in 2007. These practitioners are regulated by four Professional Boards as shown in Table 2.

The number of practitioners by province is not available from the AHPCSA. Prior to the establishment of the AHPCSA, the Health Product Association (HPA) mailing lists and the Natural Health Directory were used to determine the regional breakdown of interest in CAM. Almost all practitioners are located in urban areas and thus Gauteng and the Western Cape dominated in the geographical distribution of practitioners.

The lists included medical doctors who practiced complementary medicine as well as those who had merely expressed an interest in complementary medicine. The HPA estimated that, at most, 15% of the expected number of complementary medicine practitioners would have trained as medical practitioners. All health care practitioners are required to register separately under each treatment modality that they practice. For example, a medical practitioner practising acupuncture requires dual registration, firstly under the Health Professions Council of South Africa (HPCSA) as a medical doctor and secondly, under the AHPCSA as an acupuncturist.

The Board of Healthcare Funders (BHF) is accredited by the Council for Medical Schemes (CMS) to issue practice code numbers to all health care practitioners who seek reimbursement from medical schemes. Practitioners are required to have two numbers if the disciplines belong to separate statutory councils. In 2006, the difficulties with obtaining practice code numbers for Ayurveda Primary Health Care Advisors and Yoga Therapists were resolved however, Chinese Medicine practitioners and Ayurveda Panchakarma Technicians[l] are not yet eligible for practice numbers.[18] Information issued on practice code number registrations by the BHF include:

- 1 583 practitioners registered with the AHPCSA;
- 122 practitioners have more than one AHPCSA registration (i.e. are practicing more than one CAM healing modality);
- 34 practitioners have both AHPCSA and HPCSA registrations (i.e. are medical doctors also registered for CAM); and
- 1 practitioner has more than one AHPCSA and HPCSA registration.

According to these figures, only 35 medical practitioners practice CAM therapies.

The South African Society of Integrative Medicine (SASIM) was formed in 2001 as an association of registered health practitioners, who practice, or have an interest in the emerging field of Integrative Medicine.[19] This movement is more than the integration of CAM and conventional practice as it envisages a paradigm shift in medicine, moving away from the specialisation in biochemistry and drugs, towards a more holistic and energetic understanding of the person and healing system. SASIM currently has some 50 members which is higher than the number of practitioners with dual practice code numbers.[m] This is also not a fair reflection of interest in CAM as SASIM members were required to register with the South African Medical Association (SAMA).

Based on personal knowledge of the authors, several doctors who are interested in CAM do not seek formal registration, but increasingly make use of the remedies and philosophical approach. Even those with formal registration may not seek a separate practice code number. To avoid difficulties with medical schemes that may not have incorporated CAM benefits, doctors find it convenient to bill for a normal general practitioner (GP) visit rather than a CAM visit. Thus, much CAM practice and expenditure is probably occurring under the radar screen of official figures.

Medicines used in traditional and complementary practice

Policy and legislative framework

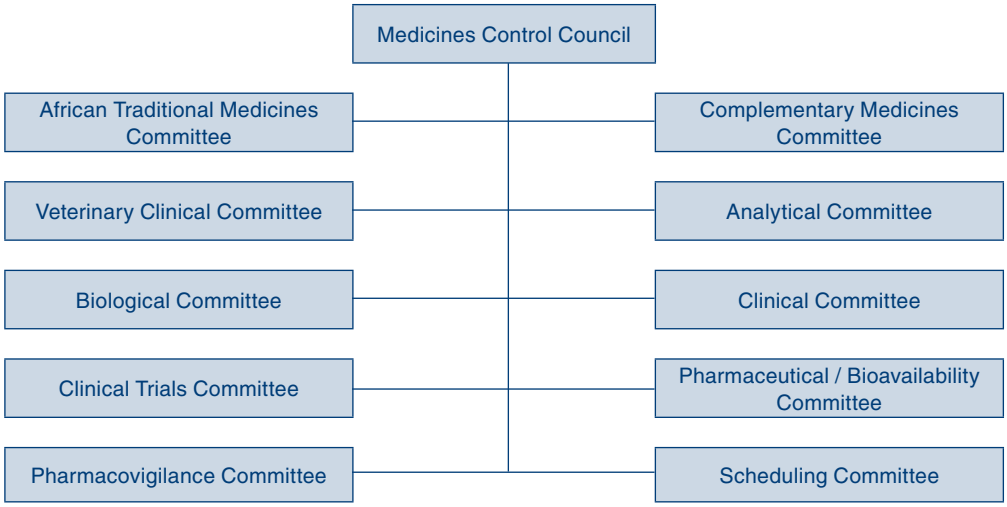
The Medicines Control Council (MCC) was established by the Medicines and Related Substances Act (Act 101 of 1965).[20] The MCC has eleven technical expert committees, two of which are specifically concerned with complementary and African traditional medicine as shown in Figure 2. This is important as it means that in the future, complementary and traditional medicines will be regulated by appropriately trained and qualified specialists in the field.

A comprehensive definition of the medicinal substances used in complementary medicine is given for the first time in section 5.3 of the South African Medicines and Medical Devices Regulatory Authority (SAMMDRA) Act (Act 132 of 1998). The SAMMDRA was to replace the MCC. The legislation was initially passed in April 1999, but was subsequently repealed in 2002. The SAMMDRA Act provided for the regulation of medical technology and all medicinal substances. Currently,

l Personal communication, H Kruger, Board of Healthcare Funders, May 2007.

m Personal communication, D Nye, Co-Chair of South African Society of Integrative Medicine, September 2007.

Figure 2: Expert Committees of the Medicines Control Council of South Africa



Source: Medicines Control Council.[n]

the National Health Act (Act no. 61 of 2003) enables the Minister of Health to make regulations pertaining to, amongst other things, medical technology.[21] The Medicines and Related Substances Act, (Act 101 of 1965) governs all medicinal substances, and makes no distinction between orthodox and complementary medicines.

One of the proposed methods of control of complementary medicines is the Accelerated Registration (AR) Programme. A listing of products has been compiled by technical specialists representing each of the complementary medicine modalities. Substances which have been rigorously tested for safety and efficacy in other parts of the world will not have to be re-tested in South Africa. As long as a product contains substances from accepted pharmacopoeia, at safe dosages, the product will undergo testing to ascertain that it is produced under good manufacturing procedures and to verify the contents. So far, it is estimated that there are about 25 000 complementary medicines, including traditional medicines, that have been submitted to the MCC to facilitate the implementation of the AR Programme.[o]

Research into African traditional medicine

The Medical Research Council Traditional Medicines Research Unit was founded in 1997 as a collaboration between the Department of Pharmacology at the University of Cape Town, the School of Pharmacy at the University of the Western Cape and traditional healers. The initial objectives have been to establish a research culture and to highlight modern research methods around the use and understanding of traditional medicines with the aim of attracting young scientists to this area of work. The longer term research goals include a series of patents for promising new entities derived from medicinal plants by developing potential new drugs to the point of proof of concept.

The Medical Research Council (MRC) Research Unit has established a computer knowledge network system addressing indigenous health knowledge. TRAMEDIII, a data base of South African Traditional Medicines, is maintained by the Unit.[p] Collaboration with traditional healers throughout South Africa has been encouraged through this network and a publication entitled 'The South African Primary Health Care Handbook Combining Western and Traditional Practices', has been the outcome of these collaborative efforts.[22]

The Department of Arts, Culture, Science and Technology (DACST) Innovation Award has been made to a consortium comprising the Council for Scientific and Industrial Research (CSIR), National Botanical Institutes (NBI), Medical Research Council Malaria programme, and the Universities of Pretoria and Cape Town. The MRC Research Unit is currently exploring collaborative links with universities in Botswana, Kenya, Zimbabwe, Uganda, Nigeria and Brazil to develop joint research on anti-malarial drug therapy, mechanisms of drug resistance and discovery of drug resistance reversing agents from herbal medicines. The WHO Research and Training in Tropical Diseases programme will collaborate with the MRC Research Unit and the DACST consortium towards further

n Available at: http://www.mccza.com

o Personal communication, D Nchele Letsoane, Department of Health, 9 July 2007.

p Available at: http://www.mrc.ac.za/Tramed3/

development of novel agents once proof of concept has been established.

The Innovation Fund has supported the development of a technology platform to develop new medicines, based on indigenous plants and local knowledge for the treatment of immune modulation and a number of diseases including malaria, tuberculosis and diabetes mellitus. The MRC Research Unit is one of the partners in this initiative.

The South African Research Chairs Initiative of the Department of Science and Technology and the National Research Foundation have appointed a new Chair in Indigenous Health Care Systems Research, based the University of KwaZulu-Natal (UKZN).[q] This is a strategic initiative, which aims to stimulate strategic research across the knowledge spectrum, thereby increasing the level of excellence in research areas of national and international importance.

Consumer use of complementary medicines and health products

Complementary medicines are currently widely available in pharmacies and health shops than in 1994 when products were typically only available in specialised shops.

The HPA was formed in 1978 as an association of manufacturers, importers and distributors of complementary medicines and health products. The HPA Self-Monitoring Technical Committee assists in maintaining ethical standards of production, quality control, marketing and advertising within the industry and in the market place and ensures that good manufacturing procedures are implemented by manufacturing concerns subject to the legislative controls of the DoH.

The HPA has undertaken several surveys of the turnover of their members. A 1996 survey established that the combined turnover of members was R0.881 billion while a 2003 survey showed a 53% increase to sales revenue of R1.348 billion. In 2003, the market for complementary medicines and health products at consumer level was approximately R1.9 billion compared to the total medicine expenditure by medical schemes which was R8.6 billion.[r] The survey results are summarised in Table 3.

In 2000, the HPA estimated that 50% of turnover in complementary medicines occurred in pharmacies and 20% in health food stores. At the time there were 250 health food stores and 2 500 pharmacies stocking complementary medicines.[15] The balance of the market was made up of some 600 supermarkets, chain stores and toiletry discount outlets. Despite the lack of comparative data, it would seem that the amount spent on medicines is considerably higher than the total amount spent on practitioners. This would be in line with worldwide trends towards self-medication using complementary medicine.

An expanded MediCAMS Index was published in 2003 as a reference book for pharmacists, doctors, CAMs practitioners and health care funders.[23] The Index outlines the dosage and side-effects of all herbal remedies, homeopathics, natural medicines and dietary supplements available in South Africa.

Integration of traditional and complementary medicine with public health

The development and empowerment of traditional healers to play a meaningful and significant role in health care service delivery in South Africa forms one of the strategic objectives of a number of institutions in South Africa, including but not limited to the Nelson R Mandela School of Medicine at the UKZN, the MRC Municipalities, provincial DoHs and a number of non-governmental organisations.

The Nelson R Mandela School of Medicine has established strong relationships with traditional healers leading to the signing of a memorandum of understanding with traditional healers in KZN. The relationships are based on sound philosophical principles and have become a model for partnerships in this country and the continent. Following the signing of this agreement a collaborative project was initiated with the eThekwini Municipality and eThekwini health district, which focused on developing and strengthening relationships between traditional healers and public health facilities at district and local level.

q N Gqaleni was appointed as the 2007 Research Chair in Indigenous Health Care Systems Research, UKZN.

r 2003 medicine expenditure was originally stated as R7.0 billion in the CMS Annual Report 2003 but restated as R8.6 billion in the CMS Annual Report 2004.

Table 3: Turnover on complementary medicines and health products (Rand thousands)

Product category	1996 estimate	1998	1999	2000	2001	2002	2003	Growth 1998 to 2003 (%)	Growth 2001 to 2003 (%)	Proportion of Total in 2003 (%)
Homeopathy	**16 000**	**41 172**	**47 693**	**52 509**	**52 678**	**57 766**	**68 102**	**65.4**	**29.3**	**5.1**
Homeopathic remedies	11 000	24 917	29 429	32 445	30 502	33 270	41 236	65.5	35.2	3.1
Tissue salts		2 216	2 706	2 631	3 629	3 742	4 107	85.3	13.2	0.3
Homeopathic creams		4 648	5 397	6 642	5 755	6 209	6 487	39.5	12.7	0.5
Anthroposophical	4 000	7 100	7 600	7 910	9 697	9 327	9 327	31.4	-3.8	0.7
Energy substances	1 000	2 291	2 561	2 881	3 094	5 219	6 946	203.3	124.5	0.5
Herbals	**18 000**	**45 862**	**65 705**	**86 733**	**111 034**	**145 252**	**141 673**	**208.9**	**27.6**	**10.5**
Western herbal		45 593	65 018	84 967	107 171	133 609	129 717	184.5	21.0	9.6
Chinese herbal		-	-	-	3 093	8 592	7 273		135.2	0.5
Ayurveda & Unani Tibb		0 269	0 326	0 326	0 220	1 051	2 684	896.7	1 119.0	0.2
African herbal		-	0 360	1 440	0 550	2 000	2 000		263.6	0.1
Aromatherapy	**6 000**	**3 475**	**4 711**	**6 083**	**9 928**	**11 392**	**11 075**	**218.7**	**11.6**	**0.8**
Nutritional supplements	**840 000**	**254 419**	**297 192**	**326 070**	**587 520**	**714 573**	**889 066**	**249.4**	**51.3**	**65.9**
Vitamins	(Including foods)	60 501	70 553	88 812	53 640	69 329	72 419	19.7	35.0	5.4
Minerals		46 506	47 402	54 080	45 233	48 543	62 768	35.0	38.8	4.7
Amino acids		4 915	5 835	6 455	4 707	4 410	12 437	153.0	164.3	0.9
Multivitamins		55 274	67 343	70 314	95 069	104 202	113 224	104.8	19.1	8.4
Vitamin / mineral		42 512	53 083	52 273	200 297	216 152	256 703	503.8	28.2	19.0
Vitamin combinations		44 712	52 977	54 137	180 168	257 919	338 307	656.6	87.8	25.1
Other combinations		n/a	n/a	n/a	8 405	14 018	33 206		295.1	2.5
Foods	**Not available**	**174 212**	**240 334**	**319 179**	**208 688**	**230 042**	**238 550**	**36.9**	**14.3**	**17.7**
Food supplements		58 753	90 461	126 074	48 914	59 634	65 259	11.1	33.4	4.8
Sports nutrition		21 934	27 272	32 924	12 109	17 307	29 846	36.1	146.5	2.2
Slimming products		46 269	58 226	56 863	49 536	59 798	47 598	2.9	-3.9	3.5
Health drinks		24 257	31 216	64 574	60 507	43 934	48 670	100.6	-19.6	3.6
Herbal teas		13 088	20 715	23 963	28 872	38 322	36 400	178.1	26.1	2.7
Whole foods		9 911	12 443	14 780	8 750	11 048	10 775	8.7	23.1	0.8
Total invoiced sales revenue (excluding VAT)	**881 000**	**519 141**	**655 636**	**790 573**	**969 848**	**1 159 027**	**1 348 466**	**159.7**	**39.0**	**100.0**
Estimate consumer retail turnover (excluding VAT)		**Not available**			**1 377 308**	**1 636 335**	**1 928 661**		**40.0**	

Source: Health Products Association.[s]

The AIDS Law Project (ALP) has argued that traditional healers have a crucial role to play in building the health system in South Africa and strengthening and supporting the national response to HIV and AIDS. A paper by the ALP provides a background to traditional healing in South Africa and discusses international policies, guidelines and the South African legal framework on traditional health practitioners. It argues for the regulation of traditional healers and traditional medicine, as well as for the application of human rights principles within the traditional healing profession. The paper concludes with advocacy strategies and ways of aligning traditional healing with a human rights framework.[24]

In 1980, a number of traditional healers volunteered to be part of a new Community Health Worker programme in KZN.[25] Apart from their involvement in the training programme, meetings were held with traditional healers to exchange views and to share knowledge and experiences. Traditional

s While HPA is an industry body the survey only covers HPA members and is thus not complete industry coverage. No adjustments or allowances have been made for non-HPA members.

healers were encouraged to bring their patients to the clinic when biomedical treatment was needed. Through constructive engagement, a good relationship between the two systems of practice was fostered, which assisted in improving access to health care.

The difficulty in obtaining other relevant examples of TM integration points to a lack of research in the area including a central source where information can be gathered, shared and distributed.

Traditional and complementary medicine and medical schemes

Pretorius noted that since 1994 some medical schemes like Eskom had allowed employees to claim a limited number of visits to traditional healers on the company's medical plan.[3] The Medical and Burial Savings Scheme and other schemes administered by Medscheme were found to have included limited TM benefits. Several Old Mutual administered medical schemes also developed benefits for TM in the 1990s.

However, when the Medical Schemes Act (Act 131 of 1998) was published, schemes withdrew, citing that they were legally obliged only to reimburse registered providers.[26] The implementation of the delayed Traditional Health Practitioners Act will remove any legal obstacles to providing TM benefits in medical schemes and will place the issue firmly on the agenda for medical scheme trustees.

The first medical scheme marketed specifically as a product for people interested in complementary medicine was launched in 1999, but closed several years later with the implosion of Fedsure Health. However, very limited benefits are available through medical schemes and most expenditure is paid directly by consumers from their medical savings accounts or directly out-of-pocket. Table 4 compares the extent to which various primary care benefits are paid from savings accounts. CAM therapies appear to be at slightly lower levels of expenditure from savings accounts, but this is not a complete reflection of all payments. It is likely that members of medical schemes have elected to pay CAM benefits directly out-of-pocket in many cases, rather than to submit bills to their medical scheme.

Table 4: Medical scheme expenditure on CAM, 2005 (Rands)

All registered schemes in 2005	Benefits paid from			
	Total benefits	Risk pool benefits	Personal savings accounts	Savings account as % total
General practitioners	**3 633 078 604**	**2 737 444 774**	**895 633 829**	**24.7**
Complementary practitioners	**62 073 868**	**34 067 151**	**28 006 717**	**19.8**
Chiropractors & Osteopaths	40 962 086	22 959 860	18 002 226	43.9
Homeopaths	20 617 553	10 642 408	9 975 145	48.4
Naturopaths & Phytotherapists	28 260	13 692	14 568	51.5
Therapeutic Massage Aromatherapy & Reflexology	319 299	312 582	6 717	2.1
Ayurvedic Practitioners	144 662	137 661	7 001	4.8
Acupuncture & Chinese medicine	2 008	948	1 060	52.8
Medicines	**7 185 152 825**	**5 607 278 886**	**1 577 873 939**	**22.0**
Dispensed by pharmacists	6 381 064 777	4 952 878 720	1 428 186 057	22.4
Dispensed by practitioners	769 128 256	623 876 900	145 251 356	18.9
Dispensed by Allied and Support Professionals	34 959 793	30 523 266	4 436 526	12.7
Total benefits	**45 620 539 398**	**40 276 211 753**	**5 344 327 645**	**11.7**

Source: CMS, 2005.[27]

Chiropractic is the most widely covered CAM modality, followed by homeopathy. This is a reflection of the early registration of these modalities and the extent to which practitioners have worked with the medical schemes industry to recognise and fund treatment. Total expenditure by medical schemes on Chiropractors and Osteopaths has increased from R7.7 million in 1994 to R44.6 million in 2006.[28] Expenditure on Homeopaths has grown at about half that pace from R7.2 million in 1994 to R20.5 million in 2006. While data on expenditure on other licensed CAM modalities has been collected since 2000, the total amount spent in 2006 was only R213 000. Chiropractic and homeopathy together accounted for 99.7% of CAM practitioner expenditure in 2006. Expenditure on TM practitioners is not gathered by the CMS.

Schemes and administrators argue that it is logistically difficult to reimburse service providers who do not have a tariff schedule. However, the Medical Schemes Act allows for benefits to be paid according to a scale tariff recommended guide or as directed in terms of the rules. Practitioners would find greater acceptance from administrators if they develop formal tariff schedules. Further reasons cited for the lack of funding of complementary medicine by medical schemes include:

- the lack of understanding of modalities, procedures performed and medicines;
- the large variation in cost;
- the lack of a definition of 'good practice'; and
- the wide range of modalities.

CAM practitioners governed by the AHPCSA have made considerable efforts to become compliant with the requirement by medical schemes that ICD-10 diagnosis codes be provided for every patient visited. Traditional healers are likely to find themselves excluded from submitting bills to medical schemes unless they can obtain practice code numbers from the BHF and find some means to supply acceptable ICD10-codes. Considerable interaction between the BHF, the CMS, the DoH and organised associations of traditional healers will be needed.

The National Pharmaceutical Product Index (NAPPI) is a coding system for medicines, operated in South Africa by Medikredit. These codes enable medical schemes to analyse and assess medicine claims. Progress has been made on NAPPI codes for complementary medicines. These medicines generally include products stocked by commercial pharmacies. Many CAM practitioners also dispense their own medicines and professions such as homeopathy have ensured that their members comply with regulations for the dispensing of medicines by practitioners. There is no evidence of any progress towards developing NAPPI codes and dispensing courses for African traditional medicines.

Legislation requires that the set of Prescribed Minimum Benefits (PMBs)[t] be revised every two years. These reviews should provide recommendations for the revision on the basis of:

- inconsistencies or flaws in the current regulation;
- the cost effectiveness of health technologies and interventions;
- consistency with developments in health policy; and
- the impact on medical scheme viability and its affordability.

A review is four years overdue since Regulations were published in January 2000.

The proposal by the BHF around the revision of the current PMBs has been submitted to the national DoH and the CMS. The proposal recommends a shift away from the emphasis on hospital and referred based conditions as in the current PMB package, to an essential health care package, which centres around primary health care based on the burden of disease of the country. The BHF proposes an essential health care package, which includes a primary care component (focusing on preventative programmes) and a hospital component differentiated by hospital level (secondary, tertiary and quaternary).

Another tenet of the BHF proposal in the revision of the essential health care package is a shift away from the current disease-based benefit to a package which specifies services. This involves defining categories of services, for instance, consultation, medicine and pathology that should be provided without listing all the specific conditions and diseases. The merit of this is that the proposed benefit package will meet the essential elements of primary care and therefore would reduce inequity at the point of first contact. This would reduce the administrative burden associated with disagreements over case definitions. This shift could pave the way for TM/CAM to play a larger role in the screening and

t The minimum package that must be offered by all medical schemes. Beneficiaries must be covered in full with no limits or co-payments but schemes may insist on the use of a contacted network of providers and formularies of drugs to manage care. The PMBs consist of a list of some 270 diagnosis and treatment pairs (PMB-DTP) primarily offered in hospital (introduced 1 January 2000); all emergency medical conditions (clarified from 1 January 2003); diagnosis, treatment and medicine according to therapeutic algorithms for 25 defined chronic conditions on the Chronic Disease List (PMB-CDL) (introduced 1 January 2004).

detection of diseases thereby positively influencing health outcomes.

The Risk Equalisation Fund (REF), which is discussed in the Medical Schemes Chapter, uses the concept of a 'treated patient' to determine who will receive risk-adjusted subsidies from medical schemes. While the REF is still in 'shadow mode' where no funds are exchanged, the lead times for all schemes to include data on TM/CAM treatments are lengthy. At present, the concept of treatment envisages the patient being identified by an ICD-10 code and receiving allopathic drugs identified by the Anatomical Therapeutical Chemical (ATC)[u] classes for approximately two out of every three months. Treatment of the REF chronic diseases by any of the CAM modalities would not count and thus it is suggested that CAM practitioners are being discriminated against by the current definitions. Traditional medicine practitioners have not been considered at all in the current PMBs and REF definitions.

Priorities for integration of traditional and complementary medicine

The WHO has defined three types of health systems to classify the extent to which TM/CAM is an officially recognised component of health care.[4]

In an **integrative system**, TM/CAM is officially recognised and incorporated into all areas of health care provision. In this system:

- TM/CAM is included in the relevant country's national drug policy;
- providers and products are registered and regulated;
- TM/CAM therapies are available at hospitals and clinics (both public and private);
- treatment with TM/CAM is reimbursed under health insurance;
- relevant research is undertaken; and
- education in TM/CAM is available.

The WHO considers only China, the Democratic People's Republic of Korea, the Republic of Korea and Vietnam as countries that have attained an integrative system.

An **inclusive system** recognises TM/CAM, but has not yet fully integrated it into all aspects of health care provision. In this system:

- TM/CAM might not be available at all health care levels;
- health insurance might not cover treatment with TM/CAM;
- official education in TM/CAM might not be available at university level; and
- regulation of TM/CAM providers and products might be lacking or only partial.

Ultimately, countries operating on an inclusive system can be expected to attain an integrative system.

In countries with a **tolerant system**, the national health care system is based entirely on allopathic medicine, but some TM/CAM practices are tolerated by law.

According to the WHO classification, South Africa can be categorised as moving towards an inclusive system. Since 1994, South Africa has made great strides in including TM/CAM practitioners and medicines into the legal framework for health care. Education and training of CAM practitioners has progressed making training equivalent to university standards. While substantial progress has been made on TM research, the formal training of TM practitioners will need integration with universities.

Two critical areas of consideration for the legislative programme are identified.

1. Legislation pertaining to traditional healers should make allowances for and take into consideration the fact that the various categories of traditional healers could differ from region to region. Thus, consideration should also be given to the fact that there is often inter-regional (either within Southern Africa or within Africa) collaboration which manifests itself through continental traditional healers organisations with branches in South Africa. Examples of such organisations include, the Association for the Promotion of Traditional Medicines (PROMETRA) and the Traditional Healers Organisation (THO).[v]
2. The patenting of plants or compounds containing plants could have serious intellectual property implications and this should be taken into account when legislation is formulated. Intellectual property rights should

u The ATC classification system is an international classification system for drugs, adopted by the WHO.

v The THO, established in 1970, is the largest umbrella organisation of traditional healers in South Africa.

not result in the disadvantaging of the community. Consideration should be given to the rights of those who hold the knowledge and those who make use of the knowledge.

Conclusion and Recommendations

The integration of TM/CAM into public and private facilities and the reimbursement by medical schemes is far behind with respect to legislative developments. Attention is urgently needed to ensure that barriers to inclusion of TM/CAM are removed and thus the excuses offered by trustees of medical schemes are invalidated. With particular respect to medical schemes, the following requires prioritisation by government in its role as steward of the health system.

- Practice code numbers to be made available for all TM practitioners and the remaining CAM practitioners who are not yet assigned numbers (responsibility of the BHF under mandate from the CMS).
- Inclusion of all TM/CAM therapies in the determination of the annual National Health Reference Price List (national DoH).
- NAPPI coding of all substances used by TM/CAM practitioners (industry bodies).
- Discussions about the usage of ICD-10 coding by TM practitioners (CMS and ICD-10 Task Team).
- The definition of the PMBs package to ensure that TM/CAM is not excluded by the definitions (national DoH on the advice of the CMS).
- The revision of the REF 'treated patient' criteria to ensure that all TM/CAM therapies are included in the definition of treatment for chronic diseases (CMS).

Once obstacles to the inclusion of TM/CAM have been removed, extensive advocacy amongst medical scheme trustees will be needed. TM/CAM is a consumer-led movement and members will need to exert pressure on their medical scheme trustees to begin to include reimbursement of TM/CAM practitioners and medicines.

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