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Final Year Dissertation

Acupuncture Bsc Hons

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‘What is Low-Cost, Multi-Bed Acupuncture?’

Abstract

The use of low-cost, multi-bed acupuncture has become increasingly prevalent in recent years, both in the United Kingdom (UK) and the United States of America (USA). Currently, there is little information available on the methods and practices undertaken in these multi-bed settings, whose rise in popularity may be due in part to the growing recognition that acupuncture treatments are financially unfeasible for many people. The purpose of this paper is to answer the question, 'What is Low-Cost, Multi-Bed Acupuncture?' Through use of a questionnaire, this paper will aim to provide a definition of low-cost, multi-bed acupuncture, describe the methods and practices used in both the UK and the USA, and compare and contrast the findings between these two countries.

The questionnaire 'What is Low-Cost, Multi-Bed Acupuncture?' was distributed via the websites for the 'Community Acupuncture Network' (USA) and 'Affordable Acupuncture UK' using the on-line survey software 'Survey Monkey'.

The findings of this survey indicate that low-cost acupuncture is practised in differing forms in the two countries. In the USA, an acupuncture treatment was more commonly offered using recliner seats and point prescriptions involving 'distal' acupuncture points. Charges were also often made on a sliding scale basis, averaging $15-35 per individual treatment.

In the UK a more traditional approach was taken to providing low-cost, multi-bed treatments, where full-body acupuncture is more commonly used but on multiple beds. Reduced rates are offered by treating more than one person at a time, but usually on a fixed rate averaging £15.

It is suggested that the differences in treatment methods, practices employed, and pricing schemes used by these countries are dependent on the style of acupuncture used, although the rationale for using different treatment styles or pricing schemes is unclear. Recommendations for future research include studies to understand treatment methods in more detail and to learn about the patients' experience of multi-bed clinics.

Introduction

1.1 Background

'Low-cost, multi-bed acupuncture' is a growing trend in both the UK and USA. Acupuncture is usually practiced in the West by one practitioner treating one patient at a time, the 'one-on-one' model. This situation arose as many practitioners came from an osteopath, homeopath or naturopath therapy background where one-on-one treatment is the norm. (Acupuncture, 2008)The cost of a traditional 'one-on-one' acupuncture treatment in the UK today generally ranges from £40 to £80 per treatment (Cancerhelp, 2008). The average annual salary is £19,856 per person (Office for National statistics 2007)with only the top 20% of people earning over £33,374 (see appendix II). With the national minimum wage currently £5.52 per hour (Hmrc, 2008) and the national average hourly wage equating to approximately £9.50 (Office for National Statistics, 2007), a single acupuncture treatment can represent more than a days pay for many people. These figures suggest that acupuncture is likely to be inaccessible to large sections of the population, at the rates charged in the UK today.

1.2 Aims and Objectives

This paper seeks to investigate alternatives to the 'one-on-one' model of acupuncture by posing the research question, 'What is low-cost, multi-bed acupuncture?' The main objectives of the paper are as follows:

- To define low-cost, multi-bed acupuncture
- To establish baseline data on treatment methods and practices
- To compare and contrast the practice of low-cost, multi-bed acupuncture in the UK and USA.

The historical context and theoretical framework for the development of low-cost acupuncture will be examined in the literature review. The questionnaire findings will be described, and differences between clinics and countries examined. Finally, the implications for further research into low-cost, multi-bed acupuncture will be discussed.

1.3 Scope and Methodology

The questionnaire was limited to practitioners of low-cost, multi-bed acupuncture in the UK and USA, as this form of treatment appeared to be more obviously prevalent in these countries by internet search. The necessity to communicate in the English language also helped define the scope of the study. An on-line questionnaire was chosen to obtain baseline, quantitative data and for its ease in administration and interpretation. Closed-end questions were developed through use of "Questionnaire design, interviewing and attitude measurement" (Oppenheim, 2000) and following discussion with the research supervisor. The questions were designed to establish baseline information about clinic practices, as it was beyond the scope of this paper to collect extensive qualitative data or detailed information on point prescriptions and specific ailments treated. The questionnaire was designed using the survey software 'Survey Monkey' and a link to the survey posted on www.communityacupuncturenetwork.com and e mailed to practitioners on www.affordableacupunctureuk.org. Results were calculated using Survey Monkey and the corresponding graphs produced using Microsoft Excel.

1.4 Rationale

Given that there is little extant literature on low-cost, multi-bed acupuncture, this is one of the first projects of its kind. It therefore does not seek to answer in-depth questions regarding micro-economics and how low-cost, multi-bed acupuncture works within established acupuncture theory. Instead, the intention is to establish some baseline data on how this form of acupuncture treatment is being delivered, by asking acupuncturists already in current practice basic questions about their practice, such as: how many beds are in your multi bed clinic? How many people are you treating? How much are you charging? Etc.

1.5 Personal Motives

It is the author's belief that social-economic justice is an intrinsic part of acupuncture, as Buddha taught 'right livelihood' is one of the foundations of the noble eight fold path. (Trungpa,1999). If acupuncture ever becomes part of

mainstream health provision then patients may receive it free at the point of access, but in the meantime alternative modes of delivery should be investigated to offer a more affordable treatment to patients.

2.0 Literature review

2.1 Chinese Medicine in Modern China

The practice of acupuncture and Chinese medicine has evolved over many centuries with the earliest written records dating back to ‘ The Yellow Emperor’s Inner Classic of Medicine’ dated 104-32 BC (Xinghua, 2008). The development of Chinese medicine and specifically acupuncture is one of diversity and complex interactions of many ‘currents’, with no one family, dynasty, text or government in control of the many disparate and conflicting ideas and theories (Schied, 2007). However since the communist revolution, and under the direction of Chairman Mao, acupuncture has been taken under the control of the government and integrated into the state health care system (Scheid, 2007). Since 1951 and the establishment of the first “Chinese medicine improvement schools” (Scheid ,2007 p 299) has led to the development of what we call, in the west, Traditional Chinese Medicine (TCM), and the one-on-one treatment practiced by most acupuncturists. However when considering the way acupuncture is practiced in the west, it is necessary to bear in mind that acupuncture is an ancient body of knowledge with many ’currents’ of thought and practice, so as not to discount any development that does not adhere to the ‘one on one’ TCM model.

2.2 The Practice and Delivery of Acupuncture in Modern China

The practice and delivery of acupuncture in modern China is outlined in ‘Acupuncture Case Histories from China ‘ (Jirui, 1988). Acupuncture is commonly delivered in hospital wards in a multi bed setting as this “allows patients to undergo treatment inexpensively and on a frequent basis” (Jirui, 1988, p.3). Acupuncture may be administered once daily for many acute conditions and twice a week for chronic complaints. Needles are usually retained for between 20 to 30 minutes, with shorter treatments for patients who are deficient or elderly (Jirui, 1988). This shows that multi bed settings are commonly used in China to deliver acupuncture to the general population.

2.2 History of the NADA Protocol

Multi-bed clinics are a popular way of delivering acupuncture treatment for the rehabilitation of drug and alcohol users, known as 'Acudetox'. The treatment of drug and alcohol addicts with acupuncture was pioneered at the Lincoln Memorial Hospital, New York, in 1974 (Nadauk, 2008)). Based on the auricular (ear) system, whereby the ear is a micro-system, 'based on the idea that the ear reflects the shape of the fetus in the womb and thus can be used to treat the whole body' (Kivity, 2006, p.23). A protocol using the same 5 auricular acupuncture points for every patient – sympathetic, shen men, kidney, liver and lung, was developed (Pinnington, 2001).

By the mid 1980's the success of this acupuncture protocol was so evident that it had spread across the USA, and led to the formation of the National Acupuncture Detoxification Association (NADA). By the early 1990's the NADA protocol had arrived in the UK ,and today around 850 acudetox practitioners work in various settings across the UK. The Acudetox treatment is given in a group setting for duration of approximately 45 minutes, and is often integrated with conventional psycho-social rehabilitation such as counseling, 12 step self help groups and often herbs are given to aid sleep. (Pinnington, 2001). The practitioners are not fully qualified acupuncturists, and are given training in the protocol only.

The success of the protocol has been reported in the 'Archives of Internal Medicine' in August 2000. The US government funded report was 'strongly supportive of the use of acupuncture in the treatment of cocaine dependency' (Pinnington, 2001) finding that those who received NADA style Acudetox treatments where much more likely to be cocaine free at any point in the study than those in the two control groups. (Pinnington,2001)
The NADA protocol has then been successfully used around the world to deliver acupuncture treatments (Pinington,2001). The Treatments are usually performed in a multi-bed setting, often for free, with patients receiving the same 'protocol' treatment, not individualized body points.

2.3 The Gateway Clinic – A Prototype for Low-Cost, Multi-Bed Clinics?

The only NHS clinic of its kind in the UK, the Gateway Clinic has been operating in Lambeth, South London ,since 1988. The clinic offers acupuncture, Chinese herbs and Qi Gong to the local community, free of charge, as part of the local NHS Primary Care Trust (PCT). The clinic was set up to treat patients drug addiction and/or HIV and AIDS, but has expanded to treat mental health, pain and other general health problems, and now treats approximately 350 people per week (Joire, 2001) The building consists of two rooms, the first contains 30 chairs, and in the second 10 treatment couches. There are no separate facilities for men or women, although screens can be drawn for those who need to undress. This lack of privacy is however perceived as a 'community setting, and although there is not much privacy , there are great benefits to be gained from this kind of situation'(Tindal, 1994).

Patients are treated in this group setting in one of three ways. Level 1 uses the NADA protocol to treat patients sitting for' relaxation and outreach work', Level 2 with the patient still sitting, uses the NADA protocol, other ear points, plus some distal points such as Ht 7 for 'general balancing' and Level 3 is full body ,individualized acupuncture to TCM principles for 'acute episodes' (Tindall,1994). This mixed model of delivery allows the clinic to treat large number of patients, in a cost effective manner, whilst still delivering a quality service. The Gateway clinic service audit was conducted in 2000-2001 to asses the quality of the service from the patient's perspective.

100 questioners where completed by patients who had completed the full course of 12 treatments at level 3, answering questionnaires based upon SF36 questions.

100 % of respondents reported being helped by the clinic, energy levels where 90 % better, mood 86 % better, 87 % of patients with chronic pain reported an improvement, 84 % of those with digestive problems reported an improvement.

Overall satisfaction was 98 % , and no matter what the presenting condition 87 % of patients reported an improvement in their general wellbeing after the course of treatments.(Joire,2001).

The Gateway Clinic shows that multi-bed acupuncture, using a mixed model of NADA protocol, 'distal points' and more traditional full body TCM ,can be successfully used to treat a large number of patients.

2.4 Use of Complementary or Alternative Medicine(CAM) in the General Population in Great Britain

The national Omnibus survey for the national office of statistics was carried out on 1794 people in 2001. It found that an estimated 10 % of the UK population had received a CAM therapy from a practitioner in the last year, with acupuncture being one of the most popular therapies. (Thomas, 2004). The survey found that there are "strong correlations between the use of CAM and gross socio-economic indicators" (Thomas, 2004, p.153). The survey investigated the link between the use of CAM and income, level of education and social class. Results indicated that "receipt of CAM from a practitioner is positively associated with higher gross income levels, on manual social class and full time education after the age of 18. However, adults from all income and social class groups reported some use of complementary therapies" (Thomas, 2004, p.154). This suggests that there is a socioeconomic barrier to accessing CAM therapies as people from all social class do use CAM but those from higher income brackets are over represented. In this case then the development of low-cost, multi-bed clinics will help a section of the community that at present find it difficult to access acupuncture treatments.

2.5 Working Class Acupuncture

In her book, 'The Remedy : Integrating Acupuncture Into American Health Care' Lisa Rohleder outlines how she came to set up her low cost multi bed acupuncture clinic ' Working Class Acupuncture' in Portland, USA. She discusses how she worked in a government funded NADA Acudetox clinic, and came to the realisation that the model could in some way be applied to her own private practice. This led to the creation of what she calls' community

acupuncture', where streamlined treatments consist of, "a brief verbal interaction conducted in a whisper, taking the patients pulse, looking at the tongue, setting the needles, walking away" (Rohleder, 2006, p.71) treatments are given to people all in one large room, recliners are used instead of beds, and a sliding scale of fee's is used to facilitate the largest possible range of accessible pricing. Patients are encouraged to come often , up to 3 times a week for acute conditions, and the needles are retained for as long the patient wants, usually around an hour. At the time of writing in 2006 Rohleder says she treats 65 patients a week charging a sliding scale of $15-35 per treatment (Rohleder, 2006, p.82).

Conclusion

The literature review has established that acupuncture has already been successfully delivered to patients in multi bed settings in China. The history of the NADA protocol shows that acupuncture delivered in group settings has also been successful in treating patients throughout the West. This has then led to the creation of the 'Gateway' and 'Working Class Acupuncture' clinics that have in turn influenced others to set up multi-bed, low-cost clinics, because of the socio-economic factors outlined.

3.0 Methodology

A questionnaire was developed using closed-end questions to address three main areas of enquiry:

- Practitioner and Clinic Information - which country the clinic was based in, the number of people working at the clinic, the length of time spent practicing multi-bed, low-cost acupuncture and the total number of beds.
- Treatment Information – the style of acupuncture used, the use of any additional techniques, and the length of time spent with patients and the number of patients treated.
- Patient Fees – the fees charged per session and use of a sliding scale system or fixed fee.

A letter of introduction described the purpose of the survey, along with a link to the Survey Monkey website (see appendix V), were posted on the 'Community Acupuncture Network' (CAN) website or emailed directly to members listed on the 'Affordable Acupuncture UK' website. These were the only associations of acupuncturists offering low-cost, multi-bed acupuncture locatable via the internet.

3.1 Participants

The questionnaire was designed to elicit a response from as wide a population of acupuncturists as possible who are currently practicing in low-cost, multi-bed settings. The 'Community Acupuncture Network', a website which lists over 50 clinics in the USA, and the 'Affordable Acupuncture UK ' website listing 12 clinics in the UK, were used to recruit participants for the survey.

3.2 Participant Inclusion

To participate in the survey, the acupuncturists must have been:

- Currently working in a low-cost, multi-bed clinic
- A user of either the 'Community Acupuncture Network' (CAN) or 'Affordable Acupuncture UK' websites.

The British Acupuncture Council (BAcC) does not allow undergraduate researchers to contact its members directly or have an on-line forum, and was therefore not an option.

3.3 Participant Exclusion

There are potential participants who may have been excluded from the survey. The CAN defines itself as:

> "…a nonprofit organization of practitioners, patients, and supporters whose goal is to make acupuncture more affordable and accessible by promoting the practice of offering acupuncture in community settings for a sliding scale ranging within $15-40 ".

This then excludes those who may consider themselves to be practicing a form of low-cost acupuncture, but not within the definition provided by CAN or as a member of CAN. The site also forbids the sending of unsolicited (spam) e-mails to members who list their clinics on the site, therefore only members who are active on the forums and saw the letter requesting participation were able to complete the survey. The Affordable Acupuncture UK website describes it philosophy thus:

> "By reducing the cost of treatments, patients are able to have acupuncture frequently enough and for long enough to properly get better and stay better. If acupuncture in the UK is only provided in private, high cost clinics in a one-to-one format, it will only ever be available to a limited, affluent section of our community; someone less well off will have to make real sacrifices to get the treatment they need. It's time to make acupuncture more accessible for people who need it."

This group is more inclusive than CAN as it does not have rules of membership but simply states its philosophy for providing low-cost, multi-bed acupuncture, so does not exclude potential respondents to the questionnaire.

Also excluded are acupuncturists practicing low-cost, multi-bed acupuncture who are not members of either organisation. This is an inherent flaw in the survey which, due to limitations of time and resources, could not be addressed.

3.4 Data Collection

The questionnaire consisted of 17 questions(see appendix IV). All were closed-ended questions requiring multiple choice, numerical value or yes/no answers. Data were collected using the web-based software 'Survey Monkey'. This package enables the user to design an on-line survey that is tailor-made for the specifics of their research project. The result is a professional-looking, easy-to-use questionnaire, accessible to a worldwide population via the internet. Its ease in delivery and user-friendliness was reflected by the high response rate of 30 participants, over a period of one month (March 2008 inclusive).

3.5 Pilot Run

A pilot run was conducted by sending the questionnaire to a colleague before putting it live on 'Survey Monkey'. It was suggested that more explanation was required regarding anonymity and confidentiality. As the survey asks for detailed information on patient numbers and monies charged, it was foreseen by my colleague that there was a disclosure issue many people might feel uncomfortable with. I amended the questionnaire accordingly and added an introductory note to the beginning of the questionnaire, re-stating that the survey was completely anonymous and totally confidential, in addition to the information already outlined in the letter of introduction.

3.6 Data Analysis

There were 30 respondents to the survey.(see Appendix III) Of these, 21 (70%) completed the survey in full. The data were collected using multiple-choice, numerical values, and yes/no questions and the content analysed using basic statistical analyses. The results were presented in bar graph format. 30% of respondents did not complete all of the questions for unknown reasons. The highest non-response rate was on the questions regarding monies charged and it can be presumed that this was deemed financially-sensitive information.

3.7 Rationale

An on-line questionnaire was chosen to gather baseline information on what practices and methods currently comprise low-cost, multi-bed acupuncture. The length was kept to 17 questions, as shorter surveys may enhance response rates. Questionnaires requiring a greater amount of time to complete and asking numerous varied and detailed open-ended questions can reduce response rates (Oppenheim, 2000). Finally, the information obtained can be used as the starting point for further enquiry, and needs to be established to help frame areas requiring future research.

3.8 Strengths and Weaknesses

The quantative data obtained by using this method can be easily analysed and reported in table and/or graph format. Using closed-ended questions helps elicit concise responses helpful in the gathering of baseline information, and also ensures that the required information is obtained (Kumar, 1999).

However there are several limitations to using a closed-ended questionnaire. The information gathered may lack depth and variety, in that it can not explore issues surrounding a question. In addition, it does not allow further information to be gathered from respondents or the ability to correct misinterpreted questions (Oppenheim 1992, p.102). There may also be an element of researcher bias in the selection of questions, and its ease of use may also mean that respondents do not think through questions before answering (Kumar, 1999).

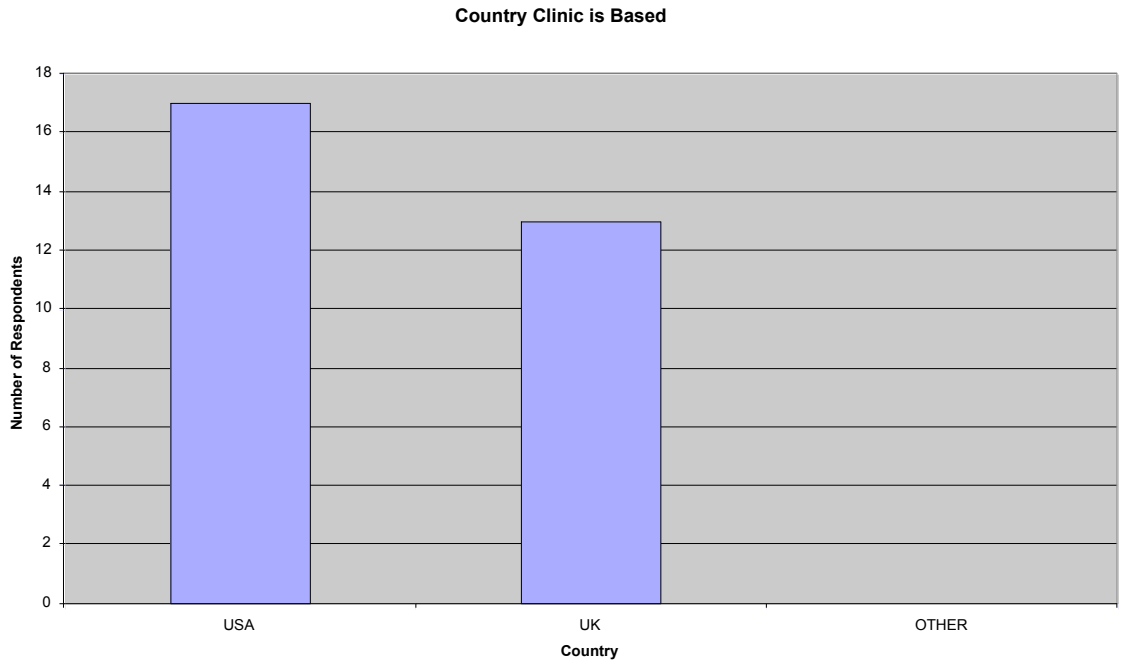
4.0 Results

The results are based on 30 respondents except where indicated (Appendix III)

4.1 Country Clinic is Based

To help contextualize the results, the first page of the questionnaire sought information regarding the participant's location and length of time practicing as an acupuncturist.

Fig.1



USA: 17 (56.7%)

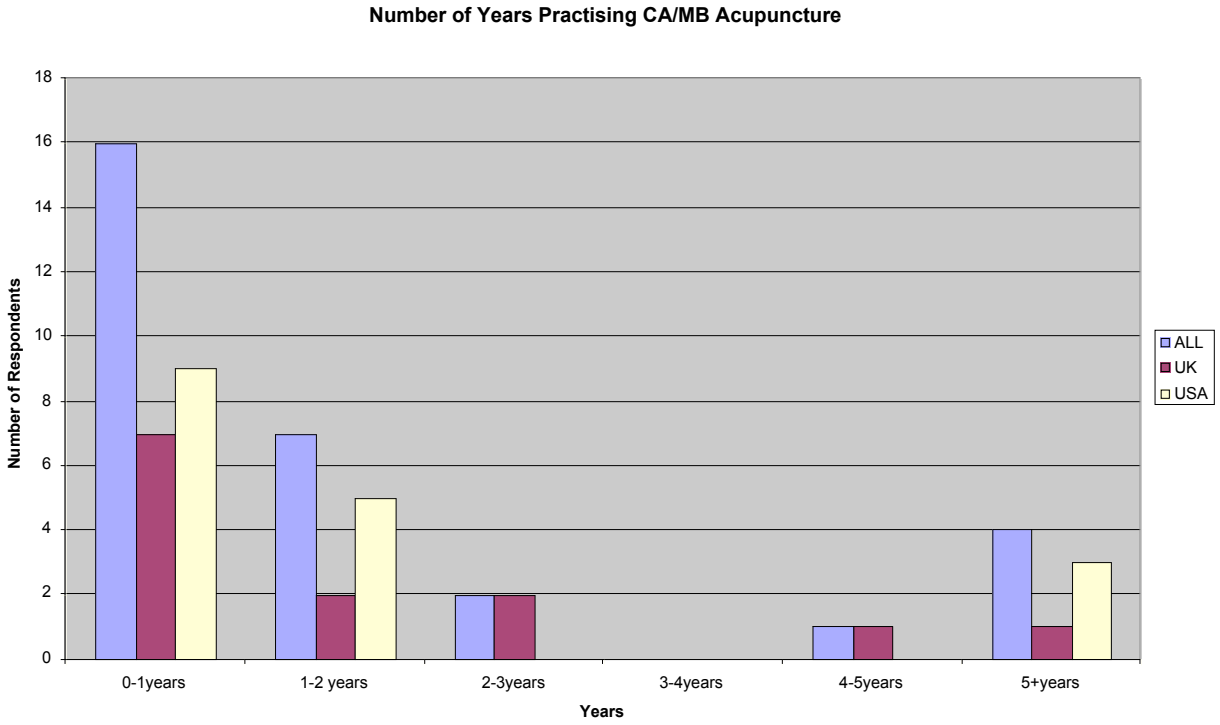
UK: 13 (43.3%)

Other: 0 (0%)

The findings are that 17(56.7%) respondents practice in the USA while 13 (43.3%) practice in the UK. It is possible that multi-bed, low-cost acupuncture exists in other locations around the world, but from this survey it is evident that it does exist in the UK and USA.

4.2 Number of Years Practicing CA/MB Acupuncture

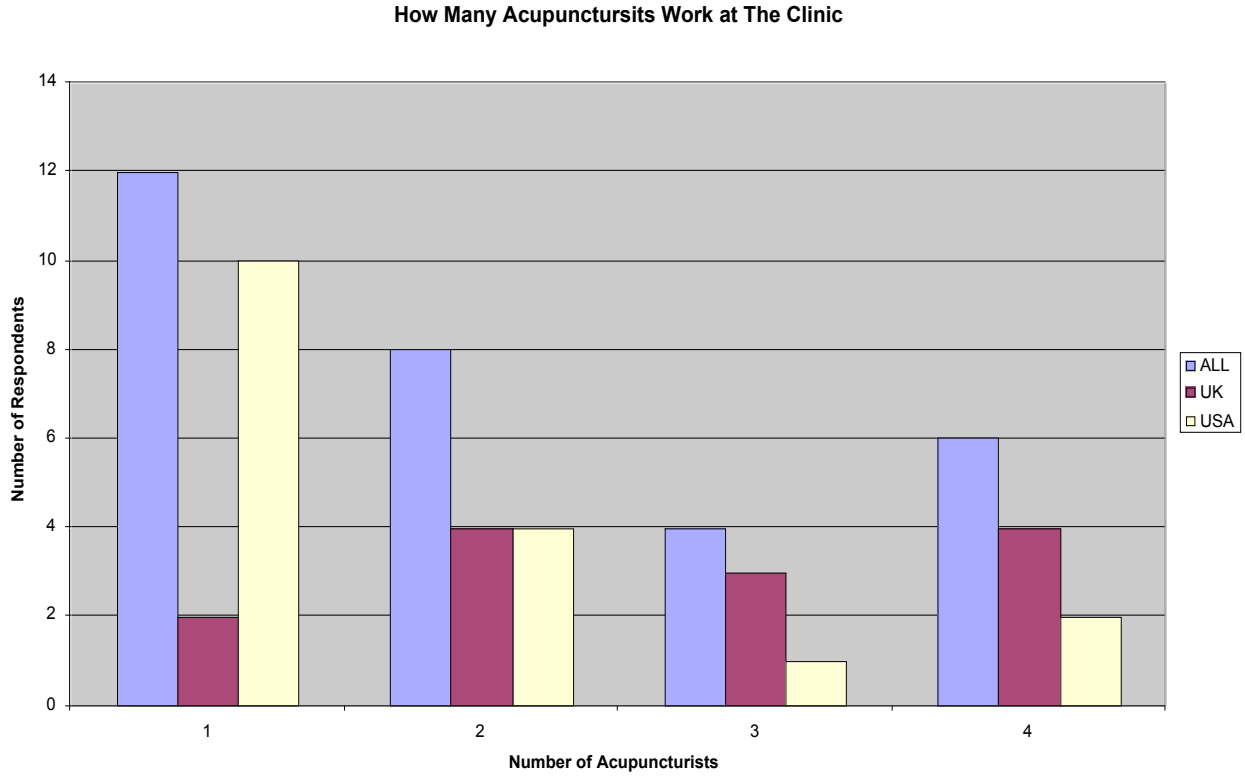
Fig 2



The majority of respondents (23; 76.6%), have under two years experience as a low-cost, multi-bed acupuncturist. This demonstrates that this is a new form of acupuncture to most practitioners. However a sizeable minority (5; 16.6%), have over four years experience, so this form of treatment has possibly been practiced by a small number of people for several years.

4.3 Number of Acupuncturists Working at Clinic

Fig 3



12 respondents (40%) are the sole practitioners in their multi-bed clinic, with the rest having no more than four acupuncturists working in a clinic. In the USA, 10 (58.8%), respondents practice alone, with only two (11.8%) clinics having four acupuncturists. In the UK, the situation is reversed with only two (15.4%) sole practitioners and most (84.7%) clinics having two or more people.

4.4 Number of Beds and/or Recliners

Fig 4

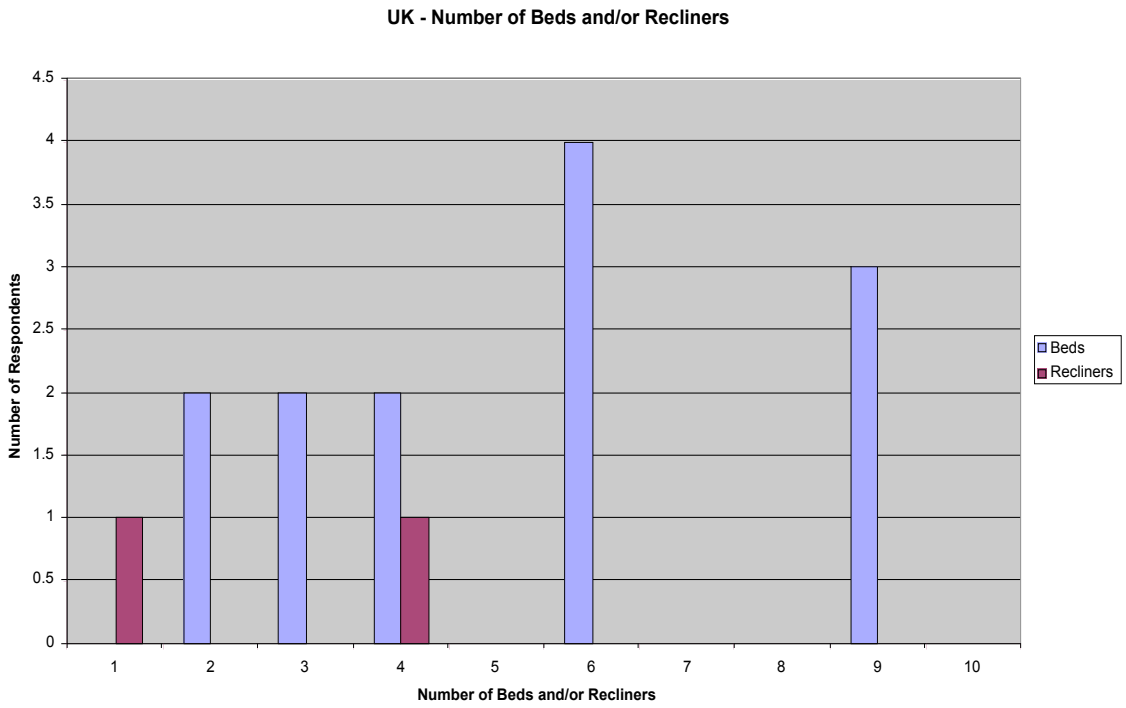
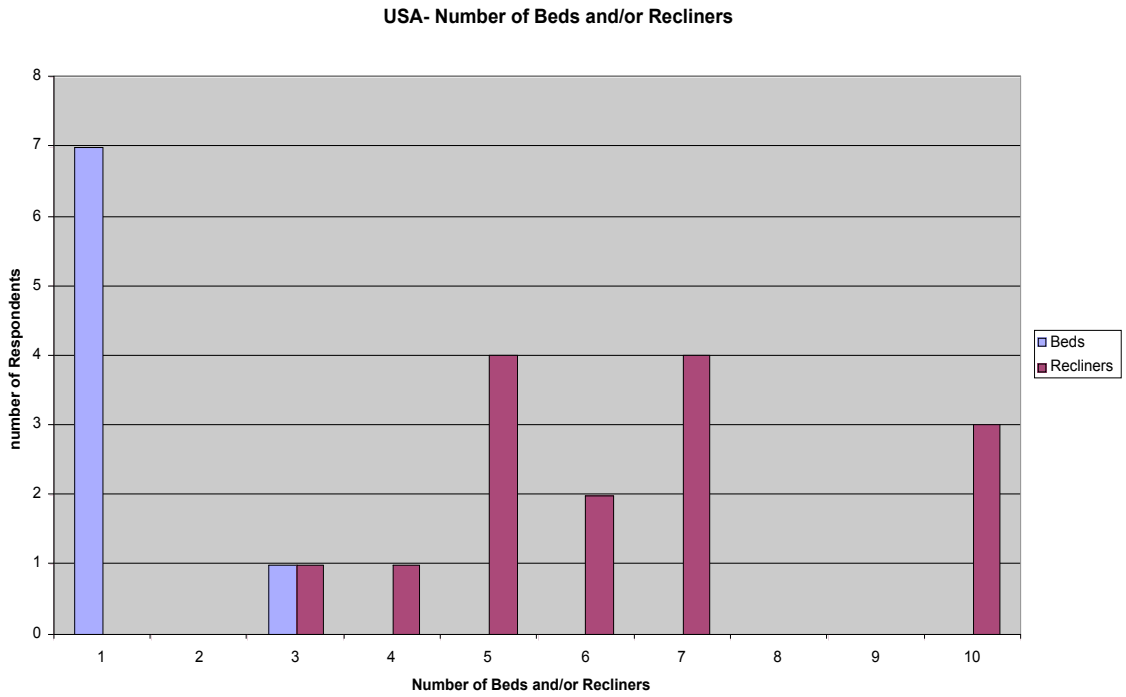


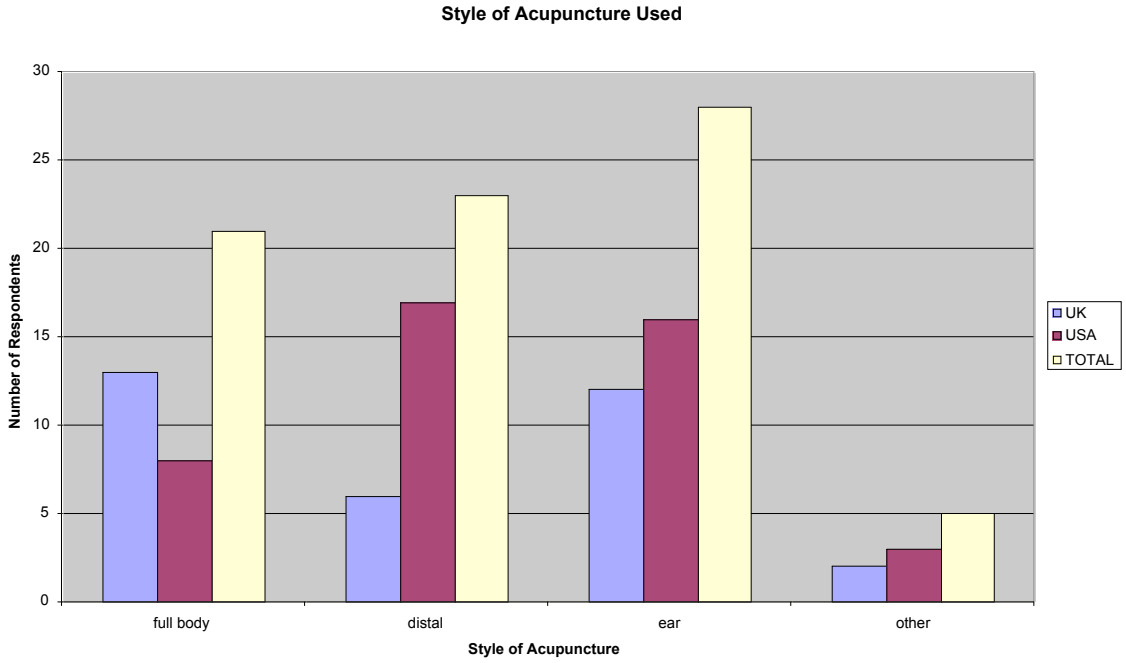
Fig 5



There is a variety of practice in and the use of multiple beds/recliners. In the UK, (fig4) the majority (11; 85.7%) use beds only, and only two (14.3%) acupuncturists use a combination of beds and recliners (based on 13 UK responses). In the USA (fig 5) the situation is very different, with most practitioners (14; 93.3%) using 3 or more recliners and 1 bed, with only one (6.7%) practitioner using 3 beds (based on 15 USA responses).

4.5 Style of Acupuncture Used

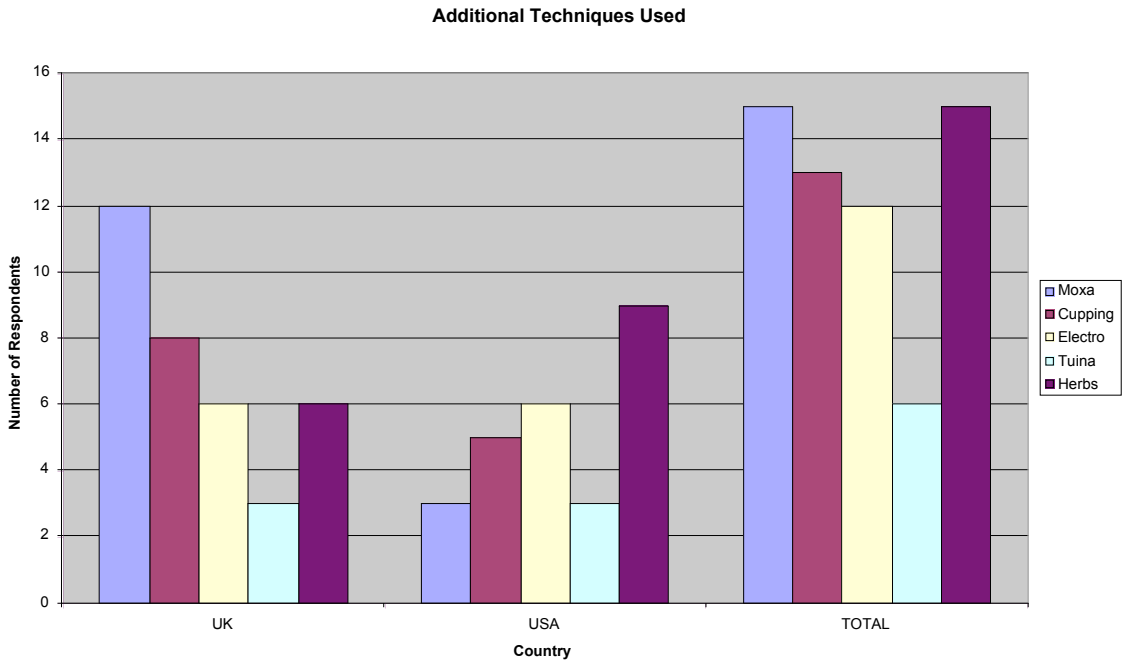
Fig 6



The style of acupuncture used differs from the UK and USA. In the UK, all of the respondents report using full body acupuncture plus some other form of acupuncture. In the USA only eight respondents (47.5%) used full body with other techniques whilst the majority (9; 52.5%) do not use full body acupuncture at all, but distal, ear or other techniques.

4.6 Additional Techniques Used

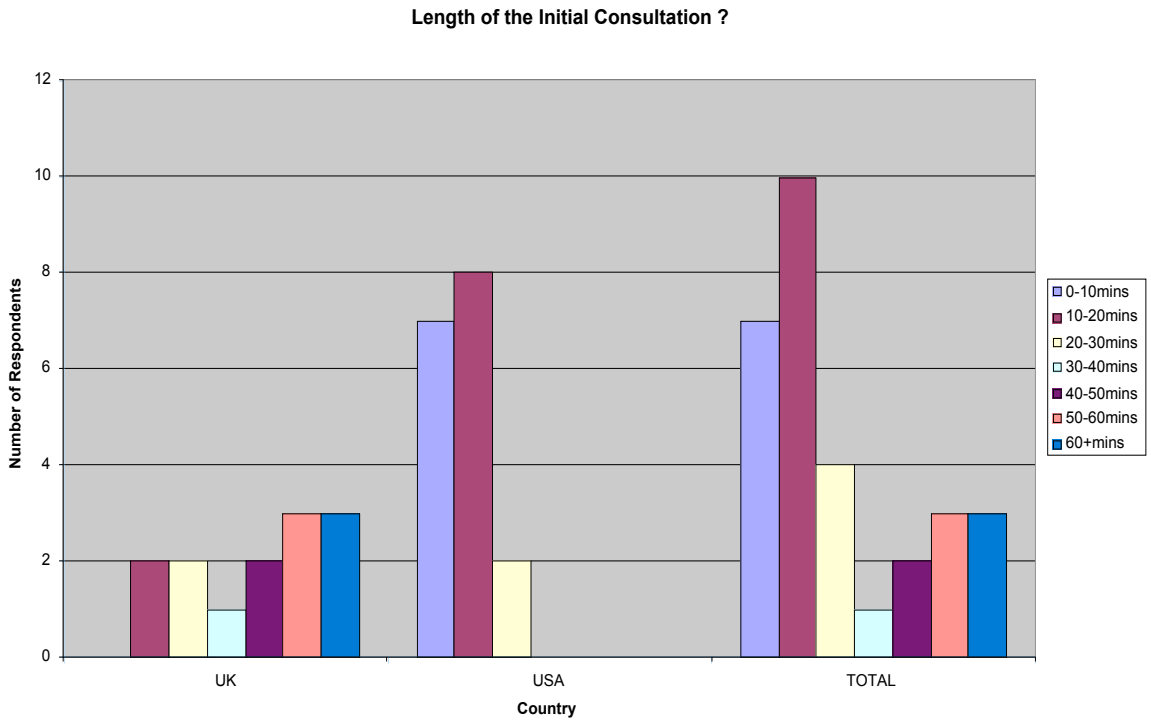
Fig 7



All of the respondents used other techniques in addition to acupuncture. However, in the UK, where full body acupuncture is more common, Moxabustion is more common with 12 (92.3%) respondents also using it. In the USA, three (25%) out of 12 respondents report using Moxabustion. In the USA, nine (75%) respondents use herbs making this the most frequently used additional technique, followed by electro acupuncture used by six (50%) respondents.

4.7 Length of Initial Consultation

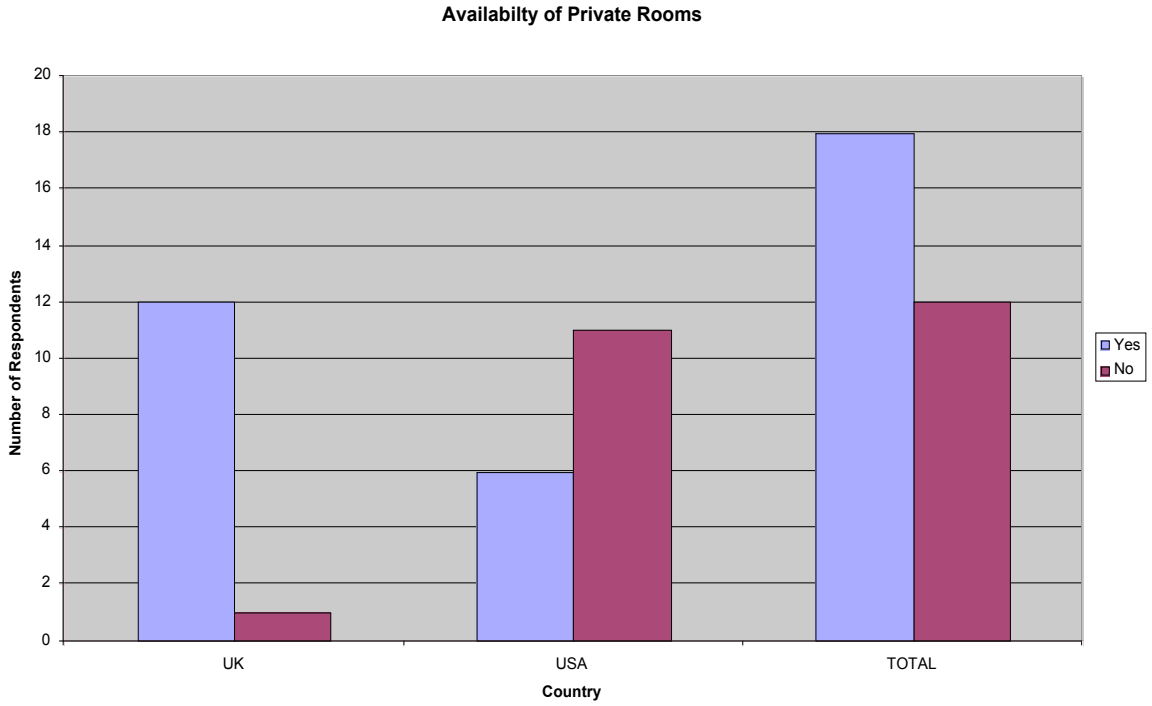
Fig 8



The initial consultation is less than 30 mins in 21 (71.9%) cases. However in the UK, nine (69%) respondents out of 13 take over 30 minutes. In the USA, 15 (88.2%) out of 17 take 20 minutes or less. This shows a large difference between the UK and USA in time taken for the initial consultation.

4.8 Availability of Private Rooms

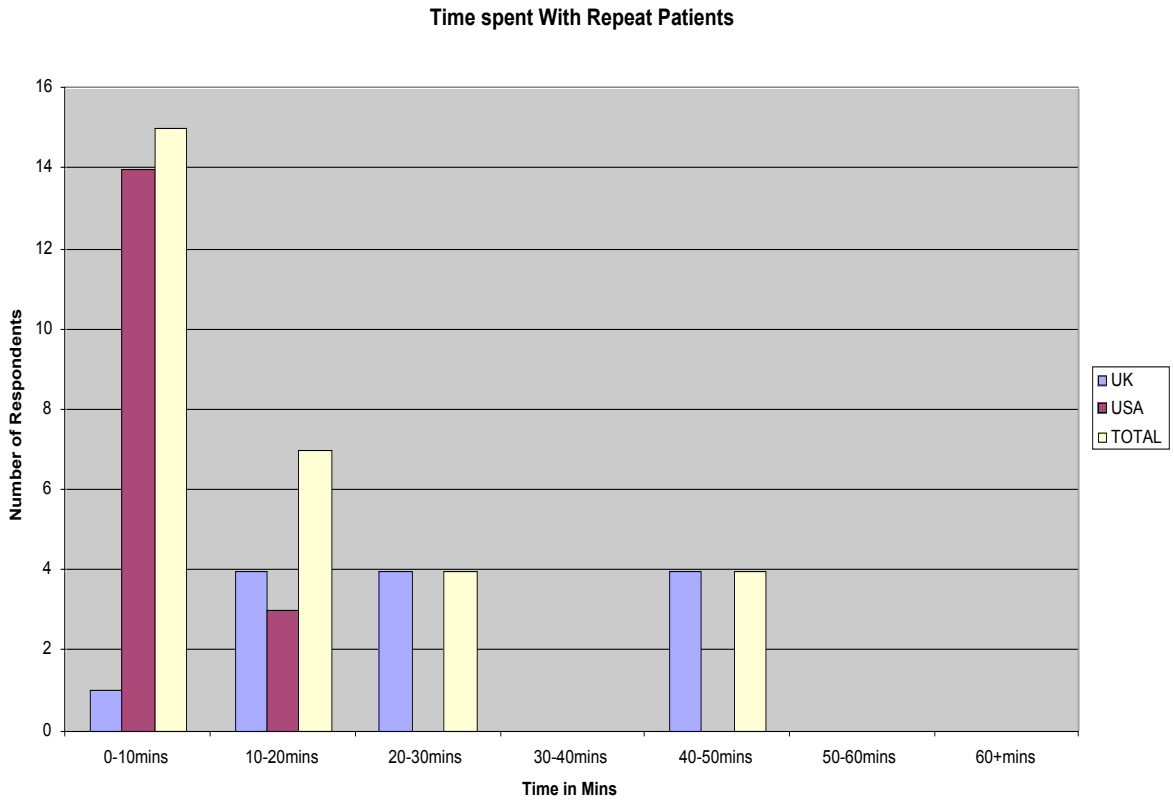
Fig 9



The multi-bed setting is often a large room with several other people, although discussion of private information in a separate room is sometimes offered. In the UK, this was the case for 12 (92.3%) respondents, but in the USA only six (35.3%) offer a private room.

4.9 Time Spent With Repeat Patients

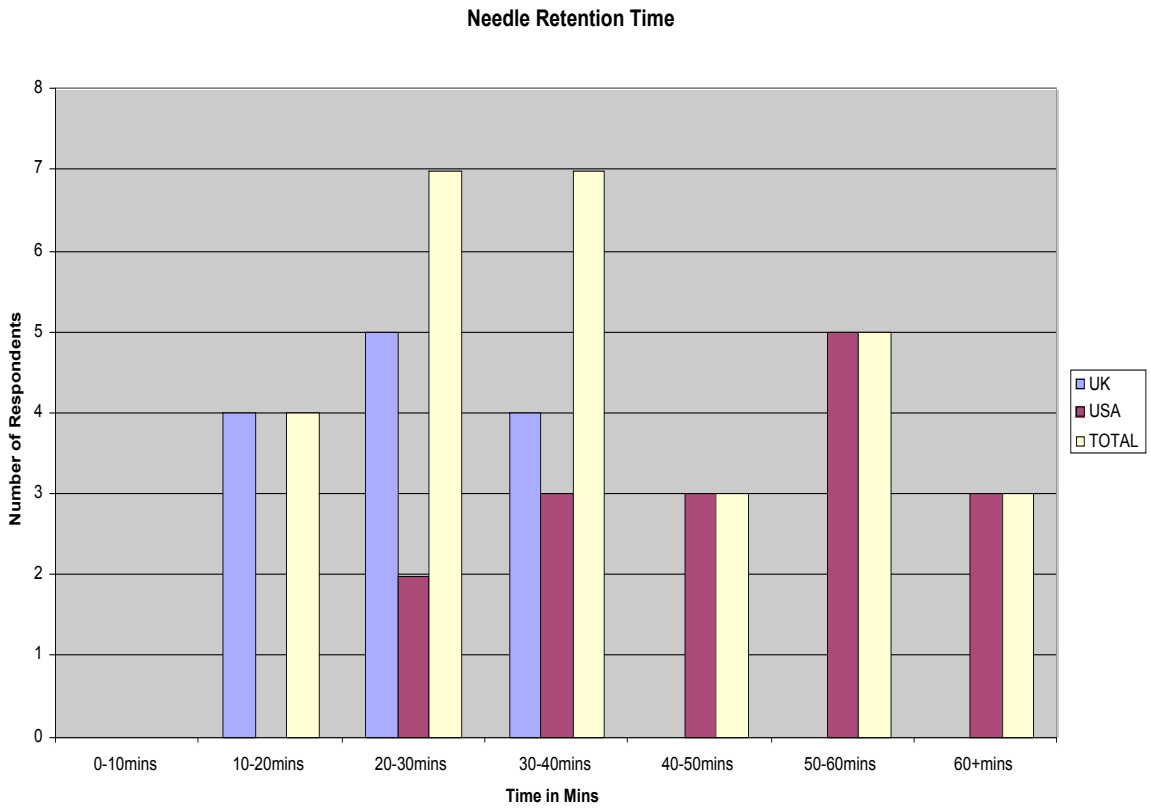
Fig 10



22 (73.3 %) of all respondents spent 20 minutes or less with repeat patients. In the UK, only four (13.3%) respondents spent 40-50 minutes with repeat patients. 14 (82.4%) of respondents from the USA saw repeat patients in 10 minutes or less, with none taking more than 20 minutes.

4.10 Needle Retention Time

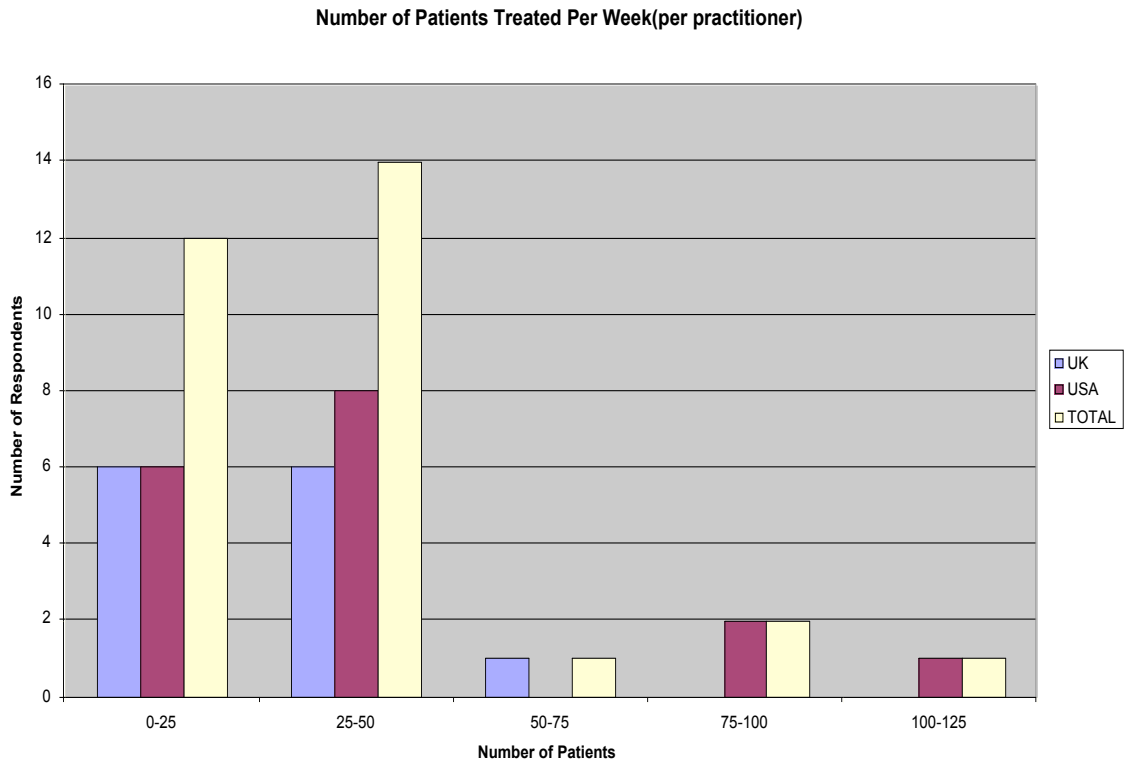
Fig 11



18 (62%) of 29 respondents leave the needles in the patients for between 20 – 40 minutes, with all leaving them in for at least 10-20 minutes. In the USA needle retention time is often longer with 13 (68.75%) respondents out of 16 retaining the needles for over 40 minutes.

4.11 Number of Patients Treated Per Week (per practitioner)

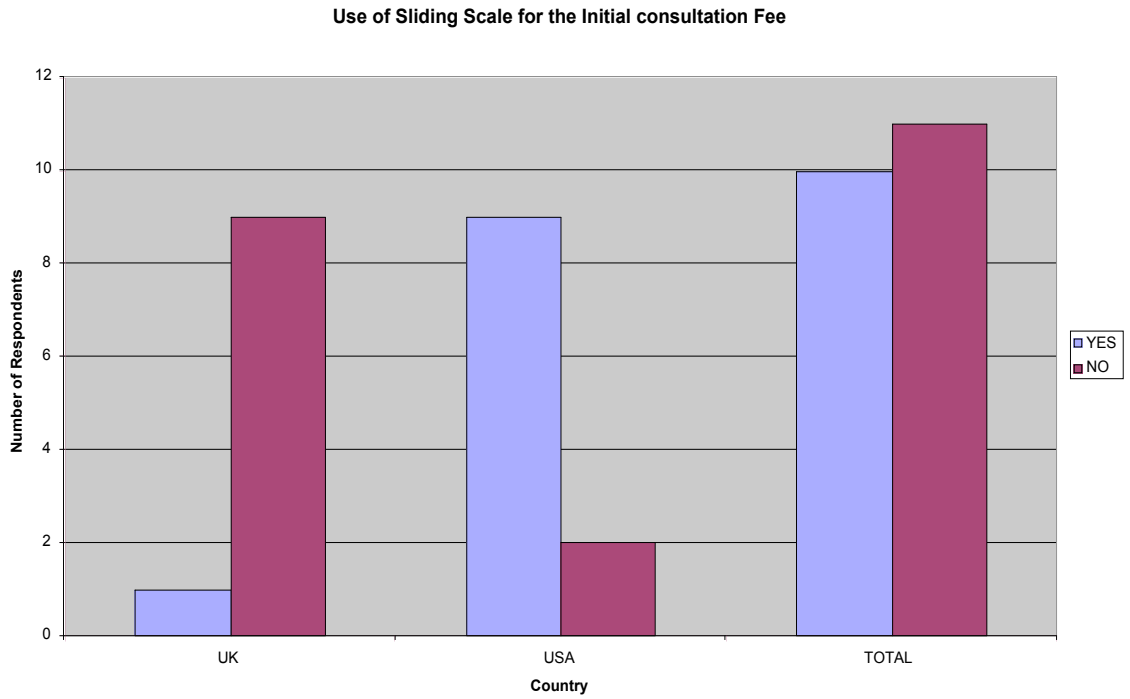
Fig 12



Almost half (14; 46.7%) of all respondents saw 25-50 patients per week. 12 (40%) practitioners saw 0-25 patients per week while 1 (3.3%) respondent treated 100-125 patients per week.

4.12 Use of Sliding Scale for Initial Consultation

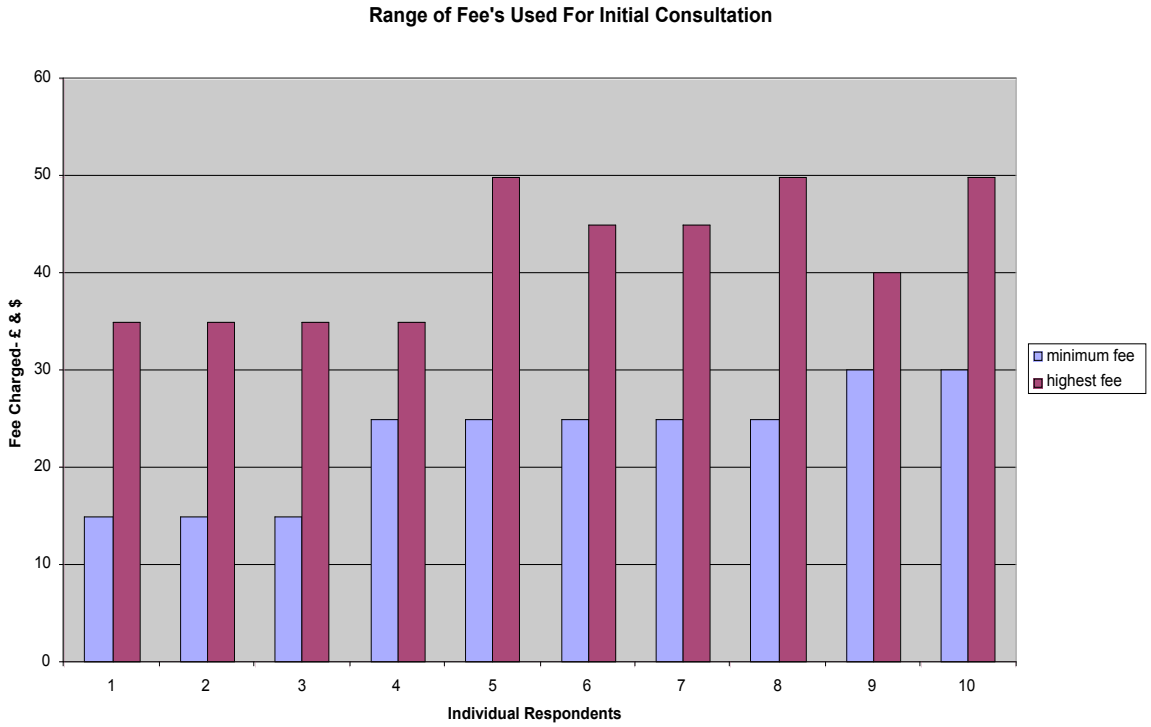
Fig 13



In the UK, only one (10%) practitioner out of 10 described using a sliding scale system for the initial consultation fee, while nine (90%) respondents use a fixed price. In the USA, nine practitioners (81.8%) use a sliding scale system, and two (18.2%) a fixed price for the initial consultation (based on 21 total responses).

4.13 Range of Fees Used for Sliding Scale

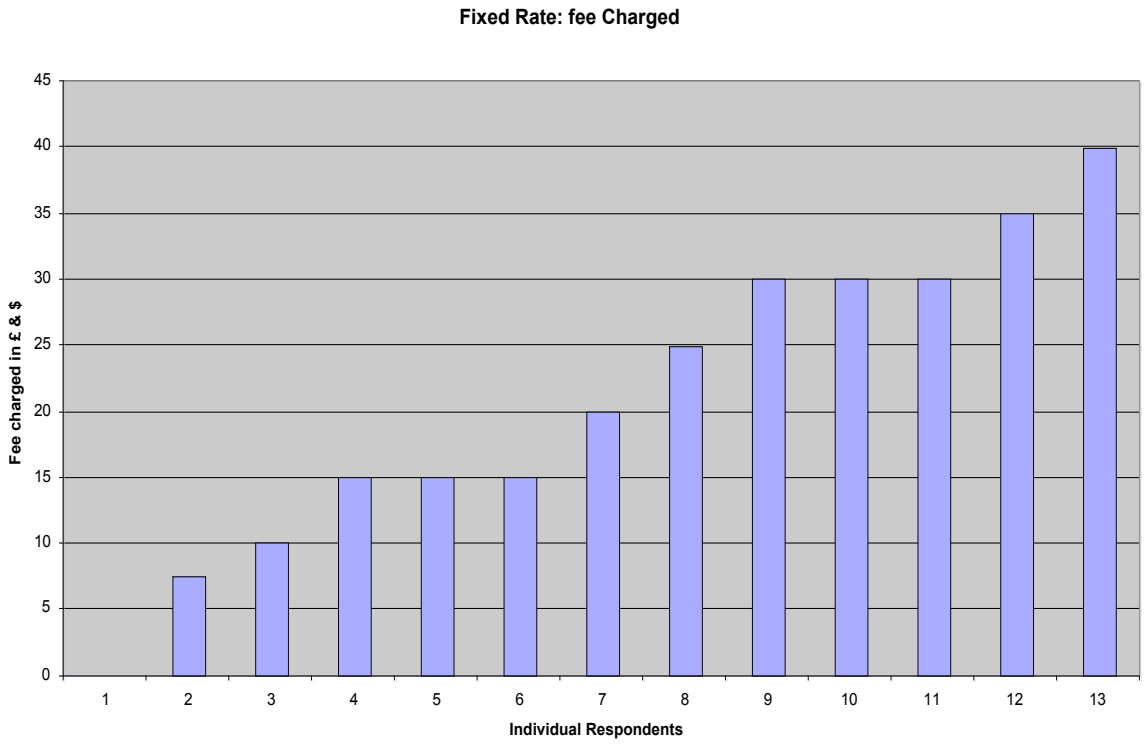
Fig14



This shows that the sliding scale is used for the initial consolation by 10 (47.6%) out of the 21 total respondents to this question. In the USA the range of fees can be as low $15 and as high as $30 per session, and as low as $35 for the maximum fee and as high as $50. Of the 10 'yes' responses to this question, 9 (90%), where from the USA. In the UK the sole respondent used £25-£40.

4.14 Fixed Rate Charges for Initial Consultation

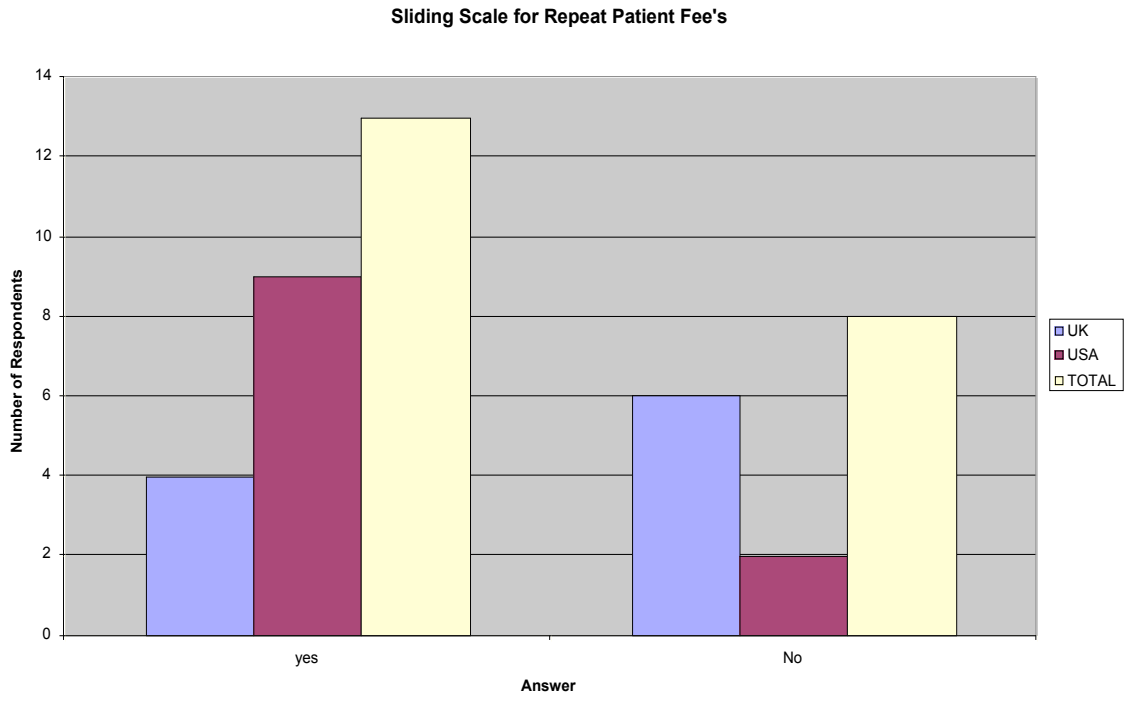
Fig 15



Of those that charged a fixed rate for the initial consultation, 13 answered the question, with 9(69.2%) in the UK and 4(30.8%) in the USA. The mean average is $16.25 in the USA and £23.05 in the UK.

4.15 Sliding Scale for Repeat Patients

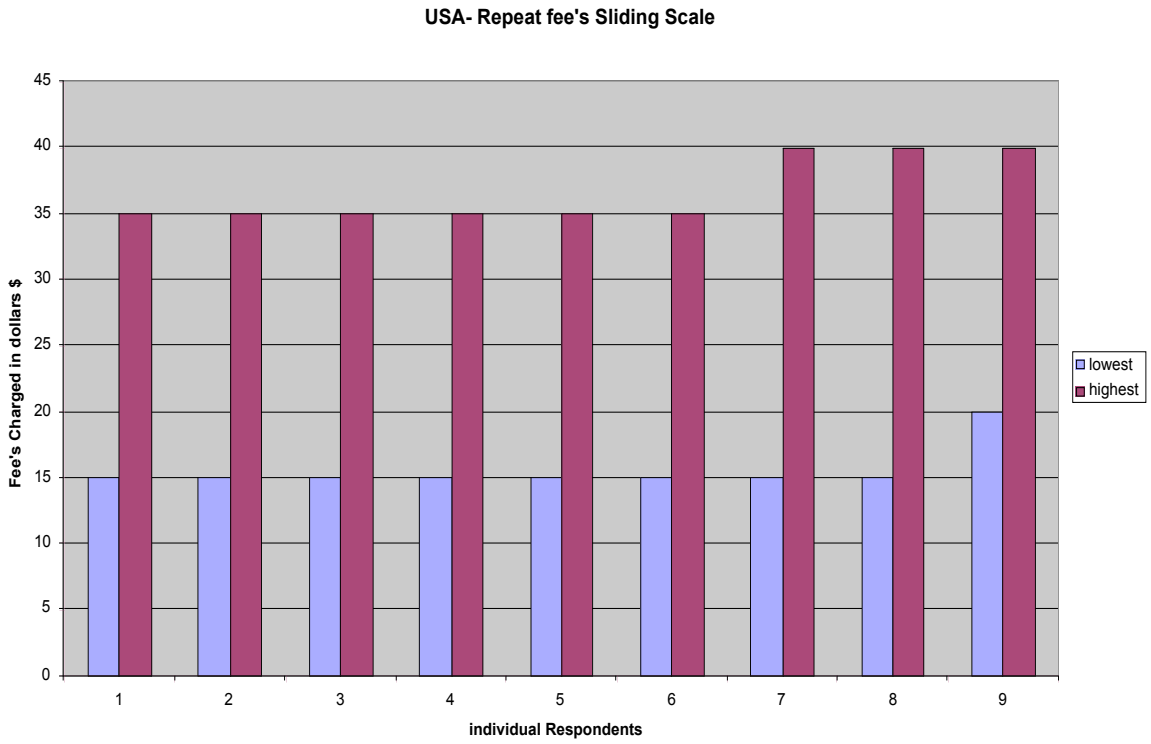
Fig 16



Of the 21 responses, 13 (61.9%) use a sliding scale for repeat patients and eight (38.1%) do not. This shows a slightly higher use of the sliding scale for treatment of repeat patients than the initial consultation. Of those that use a sliding scale, nine (69.2%) were based in the USA and four (30.8%) in the UK.

4.16 Range of Sliding Scale Fees for Repeat Patients

Fig 17



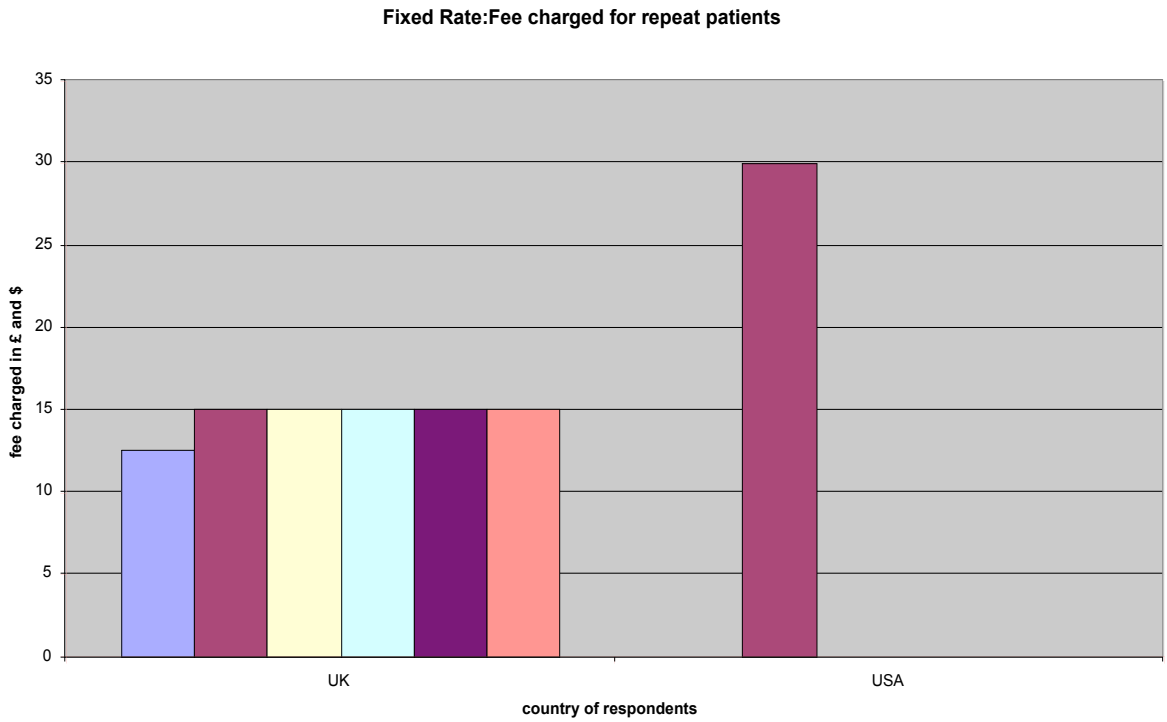
In the USA, (fig 17) the average minimum charge is $15.56 and the average maximum charge is$36.67, with a total average charge of $26.11

Fig18

In the UK, (fig 18) the average minimum charge is £14.25 and maximum charge is £20.25 average making a mean average fee of £17.25. This is from a total response of 13 to the question , 9 in the USA and 4 in the UK.

4.17 Fixed-Rate Fees for Repeat Patients

Fig 19



When no sliding scale is charged a fixed rate is applied to each patient. In the UK this ranges from £12.50 to £15 from the six respondents who answered this question, making a mean average £14.58 in the UK and a mode average of £15. In the USA only 1 respondent answered the question with $30 as the fixed rate fee.

5.0 Discussion

The results indicate that some form of low-cost, multi-bed acupuncture is currently practiced in both the UK and USA. What exactly constitutes low-cost, multi-bed acupuncture, however, is harder to define. The findings reveal that there is great variation between individual clinics, with particular differences between the UK and USA.

5.1 An Emerging Practice

The results of the questionnaire indicate that 53.8% of respondents have been practicing low-cost, multi-bed acupuncture for one year or less, with only 13.3% of respondents practicing for five or more years. The majority of clinics have been established in the last 3 years (84.6%). Overall, the practice of low-cost, multi-bed acupuncture is a relatively recent phenomenon, with only a very small number of clinics in existence for around 5 years or more. Reasons for the emergence of this treatment modality may include the development and continued success of the NADA protocol, the establishment of prototype clinics (e.g. The Gateway Clinic), and perhaps a growing collective recognition of the effectiveness of acupuncture and the inability of large sections of the population to access it for financial reasons. As individual acupuncturists experience firsthand the possible benefits and opportunities afforded by providing low-cost, multi-bed acupuncture, the movement has flourished and may to continue to grow.

5.2 A Tale of Two Countries

USA

'Community Acupuncture' is the term most often used to describe the practice of acupuncture in low-cost, multi-bed settings in the USA. Treatment was more likely to be offered in a large room with no private consulting room (74.7%), was more likely to be administered on a reclining chair (93.3 %) to facilitate quick access for treatment, as auricular and/or distal points are more commonly used

(52.5 %), and require no undressing for the patient. The majority (88.2%) of initial consultations were done in 20 minutes or under, and repeat prescriptions administered in under 10 minutes (82.4 %). The needles are retained for longer, however, for over 20 minutes in all cases and often for over 40 minutes (68.9%). Additional techniques, such as Moxabustion and cupping, are labour-intensive and are not employed as frequently in the USA (25 %), while herb prescriptions where often used (75%). 64.7% of American practitioners treat 25 or more patients per week.

UK

In the UK, low-cost, multi-bed clinics are, for the most part, run along much more traditional lines. Treatment was more likely to be offered in a large room with the option of using a private consulting room (92.3%). The treatments were more likely to be administered on a bed (84.7%) to facilitate the use of full body acupuncture, which can require the patient to undress. The majority (84.6 %) of initial consultations were done in over 20 minutes, and repeat prescriptions were also administered in 20 minutes or more (61.6%). The needles where not retained for as long, however, with needle retention time ranging from 20-40 minutes in all cases. Additional techniques, such as Moxabustion, were used more frequently than in the USA (92.3%). UK practitioners were more likely to treat fewer patients per week than their American counterparts, with the majority treating fewer than 50 patients per week(92.3 %) and many (46.2%) treating 0-25 patients per week. Many of these practices reflect the ‘one-on-one’ model, with the main difference being that numerous patients are treated in one room at the same time.

Why do such differences exist between the countries? Many of the differences seem to depend on the style of acupuncture employed. Full body acupuncture was used by all of the 13 respondents in the UK, while in the USA, distal points where used by 17 respondents, 16(94%) used auricular treatments and full body was used by only 8(47%). Accordingly, more practitioners in the USA use

recliners rather than beds to accommodate auricular and/or distal points. Shorter initial and repeat consultation times, an increased volume of patients, and less frequent use of adjunctive therapies were also reported by American practitioners. All of these differences may be attributable to the style of acupuncture used. The prevalence of NADA protocol acupuncture in each country is not known, although if used more commonly in the USA, it could explain why full body acupuncture is less commonly employed. Interestingly, needle retention time was longer in the USA with most retaining over 30 minutes(USA 87.5% vs. UK 30.8%), and herbs also used more frequently. Possible reasons for these differences are not clear.

5.3 The Bottom Line

In addition to the differences in treatment outlined above, another major difference in practices between the UK and USA relates to the fees charged. In the UK a fixed price scheme is more popular (90%), while in the USA a sliding scale is more often used (81.8%). The fixed price mode average in the UK for repeat treatments is £15 per treatment, whilst in the USA the mode average charge is the $15-35 range. The highest amount charged at the top of a sliding scale is $50 and £30 (USA and UK respectively), whilst the lowest prices charged are $15 in the USA and £12.50 in the UK. Therefore, it appears that 'low-cost acupuncture' treatments in the UK are indeed cheaper than the average cost of a 'one-on-one' treatment. Excluded from these average figures is the respondent who asks for no fee, or donations, as this might not be interpreted as 'low cost' but rather a form of 'pro bono' work or charity and would have skewed the true average figures.

Explanations for the popularity of a sliding scale fee system in the USA are not obvious from the findings. It is possible, however, that a precedent was set by the founders of the 'Community Acupuncture Network', who may have pioneered not only the use of low-cost, multi-bed acupuncture treatments but also advocated the use of a sliding scale fee system. The rationale for the prevalence of fixed rate charges in the UK is also not known, but perhaps the historical

provision of a ‘concessionary’ rate to low-income earners may help to explain this difference.

6.0 Conclusion

6.1 Strengths and Weaknesses

The research method employed was strength of this project, which elicited clear, quantitative data that could be subjected to statistical analysis and interpretation. The questionnaire used was also easy to administer and the user-friendliness of Survey Monkey ensured a good sample size. Using the World Wide Web as a delivery platform was inexpensive, allowed for quick and easy distribution, and resulted in immediate results once the questionnaire has been completed.

Using this method also had its limitations. The responses for some questions could have been more accurate if the questions had been left blank for practitioners to complete, rather than offering a range in the answer. The use of open-ended questions might have also allowed greater insight into this new treatment modality, such as the rationale for employing particular methods and the reasons for using certain pricing schemes. Other potential limitations are inherent to the particular data collection method used, as described in section 3.4.

As the survey was completed anonymously, multiple responses may have been received from different practitioners in the same clinic, thereby skewing the results.

Response rates concerning financial matters were also lower than anticipated, with only 21 respondents completing the survey in full. It can only be assumed that respondents considered this sensitive information and did not want to divulge details about their personal incomes.

Finally, the results were limited to practitioners who were listed on or frequented the above-mentioned websites from the UK and the USA. The respondents were also self-selected, which reduces the generalisability of the findings to low-cost, multi-bed practitioners around the world.

6.2 Conclusions

This paper sought to answer the question, 'What is low-cost, multi-bed acupuncture?' The objectives were to seek a definition of low-cost, multi-bed acupuncture, describe the methods and practices currently used in low-cost, multi-bed settings, and to compare and contrast the treatment modalities used in the UK and USA. A review of relevant literature provided the background to and theoretical basis for the enquiry, while a closed-ended questionnaire was administered via the internet to obtain quantitative data to answer the research aims.

Several conclusions can be drawn from the questionnaire findings. It is evident that 'low-cost, multi-bed acupuncture' is indeed a reality in the UK and USA. The definition of this treatment, however, is not clear-cut; the type of treatment a patient can expect upon entering a 'low-cost, multi-bed clinic' differs widely. Variables such as the style of acupuncture used, consultation and needle retention times, and the pricing schemes employed by practitioners vary greatly between clinics and between countries. Apart from providing the service at a relatively lower cost to the patient and in a setting where potentially more than one patient can be treated at any given time, it is perhaps impossible to define low-cost, multi-bed acupuncture in any concise and meaningful way at present. Nevertheless, significant differences in practice are evident between the UK and USA.

In the UK, the treatment is often as what could be expected in a traditional 'one-on-one' clinic, except for some loss of privacy. Full body acupuncture is most common, and consultation sessions are longer than those in the USA. Treatments are charged at below-average rates and a fixed price payment scheme is more typically used.

Treatments in the USA are less traditional and are less likely to involve full body acupuncture. American practitioners tend to use auricular and/or distal points on recliners rather than beds. Private consultation rooms are not as readily available. Consultation times are reduced, however needle retention time is

often longer than in the UK. It is clear then that definite differences exist between the two countries, although the reasons why are not always evident.
Several strengths and weaknesses were apparent in the research method used and in the findings, but baseline information has been established and proposals for future research and recommendations can thus be made.

6.3 Recommendations for Future Research

The following are recommendations for future research on the use of low-cost, multi-bed acupuncture:

- To utilise a variety of research methods for the collection of future data on the subject. For example, respondents could explain in detail which points are used, the diagnostic methods employed, and how they approach point prescription with regard to individual prescriptions and the use of protocols. The rationale for pricing schemes could perhaps also be better explained.
- The administration of randomised, controlled clinical trials to evaluate the efficacy of needle retention times, frequency of treatment, and needle prescription protocols used in a variety of multi-bed settings.
- Further information is needed to understand which pricing schemes are most beneficial to both patients and practitioners to ensure an affordable and sustainable business development model.
- A qualitative study of patients to better understand the experience of receiving acupuncture in a multi-bed setting, and the perceived satisfaction, advantages and disadvantages to this form of treatment.