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Private complementary medicine and older people: service use and user empowerment

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ABSTRACT
Increasing numbers of people are using complementary therapies, and many are in older age groups. Although recent empirical research has considered the demands for complementary medicine, and in particular its recent consumer boom, little acknowledgement is given in research to the different social categories of users, and to the intricacies of their different motivations and consumer behaviours. In the context of a relative paucity of dedicated research investigations, the paper highlights the relevance of social gerontological perspectives. Based on a questionnaire survey of 144 older users, and in-depth interviews with 20 older users in southern England, it considers trends in local use and user actions, attitudes and opinions. From a disciplinary perspective, the paper also contributes to a growing body of research which focuses on older peoples' self-implemented health and health care strategies. There is a substantial degree of user satisfaction with the therapies used, and many respondents claimed to have benefited in terms of their physical and mental health. Older users are also empowered by their treatment decisions and negotiations, many of which are made either independently, or jointly between themselves and their therapists. Treatment solutions are typically constructed with combinations of complementary therapies, or combinations of complementary therapies and orthodox health services.

KEY WORDS – complementary medicine, alternative medicine, private health care, attitudes, empowerment, older users, lay beliefs.

Introduction

The term 'complementary medicine' (CM) is widely used to describe a diverse range of therapeutic and diagnostic therapies which have developed largely independently from orthodox/mainstream medicine

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(OM). As a guide, most commentators agree that approximately 12 core CM disciplines exist, these being acupuncture, chiropractic, creative and sensory therapies, healing, herbalism, homeopathy, hypnotherapy, manual therapies, reflexology, naturopathy and osteopathy (Ernst 1996; Zollman and Vickers 1999*a*). Over the past 20 years CM has undoubtedly grown as a significant provider of health care in the United Kingdom. Vickers (1994) suggests that between seven per cent and 11 per cent of people visit complementary practitioners every year, and Thomas *et al.* (1995) estimate that 33 per cent of the population have used some form of CM at least once in their lives. Meanwhile, the House of Lords Select Committee on Science and Technology (2000) estimates there to be 15 million users of CM nationwide.

A small, but increasing, number of therapists are paid directly by public finance, and work for the National Health Service (NHS) in the hospital sector. However, the overwhelming majority of therapists make a living from direct out-of-pocket payments made by privately-paying clients (Sharma 1995; Zollman and Vickers 1999*b*; Andrews 2002*a*; 2002*b*). Most private practitioners operate independently, either practising alone or in shared facilities, whilst a small number are based in GP surgeries and in health centres. Indeed, nationally, the sector may enjoy a considerable financial turnover, but the organisational nature of the sector remains one of small private business, essentially a cottage industry (Sharma 1995; Fulder 1996). The exact number of complementary practitioners in the UK remains disputed because not all CM disciplines are regulated and practitioners registered. Nevertheless, Zollman and Vickers (1999*b*) estimate the numbers of therapists to have more than trebled from 13500 in 1981 to 40000 in 1997, whilst both Fulder (1996) and The House of Lords Select Committee on Science and Technology (2000), estimate there to be approximately 50000 therapists in the UK.

Albeit with the exception of a very small number of isolated studies, the two research traditions in CM and health and health care for older people are largely independent, and few empirical or theoretical connections have been made (Kelner and Wellman 2001; Wellman *et al.* 2001; Andrews 2002*b*). The reasons for this are not certain, although they may match the conventional wisdom, and some limited and dated research evidence, which suggests that older people are not significant users of either private health care or CM (Ooijendijk *et al.* 1981; Fulder and Munro 1985). The standard explanation given for this pattern is that older people have insufficient financial resources to pay privately (Fulder and Munro 1985). Arguably however, given

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more recent research evidence, this assumption may be incorrect, or at least simplistic. For example, a recent and comprehensive British study found that the use of CM in the over 65 age group is only slightly lower than the average for all age groups (Ernst and White 2000). Another study by Wellman *et al.* (2001) found almost one-in-five CM users to be aged over 55 years and, moreover, that a high proportion are in the 'baby boom' generation (now aged 50–60) and may in the next decade demonstrate similar health care needs and patterns of consumption.

In focusing on CM use, the research also connects to wider debates on lay health knowledge. In particular, Conway and Hockey (1998) suggest that much of the relevant research which focuses on older people uses a rather narrow conception of health. This is despite the fact that older people are a group for which bodily change and illness represent a focus of individual and institutional attention. Indeed, later life and health care are often combined in much gerontological literature which focuses, rather paternally, on either the plight of 'sick and needy' older people, or from a policy perspective, on the challenges of meeting 'the burden of older people' to the state, health and social care services (Sidell 1995; Conway and Hockey 1998). The dominance of such foci, Conway and Hockey argue, may support the assumption that health and social care for older people are universally provided, and that broad solutions to provision dilemmas can be found. They may also support the belief that older people themselves play a rather passive role in meeting their own health care needs. In response to and in support of these criticisms, the study adds to a small but growing number of studies which are concerned with older peoples' own personal health and health care strategies (Cornwell 1984; Kaufman 1986; Bury and Holme 1991; Conway and Hockey 1998; Andrews 2002*b*). Indeed, it is argued that CM use is one way that these strategies are exercised.

The use of complementary medicine: a review of the literature

Many studies have investigated the reasons why people use CM. Commentators have suggested that the recent consumer trend of increasing CM use represents a 'flight from science' by the general public (Smith 1983), and that users are effectively 'pushed' towards CM because they have become dissatisfied with OM, or lack confidence in its ability effectively to treat a range of prevalent chronic conditions

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(Furnham and Forey 1994; Furnham *et al.* 1995; Furnham and Kirkcaldy 1996; McGregor and Peay 1996). Other studies cite the perceived negative side-effects of drugs (Verthoef *et al.* 1998; Wysong 1998), or argue that, although scientific advancement has enabled OM to treat a greater number of people and conditions, a disparity is evident between these rapid technical advancements, and slower developments in meeting the emotional needs of patients through comfort and support (Peters 1997). Of the specific social gerontological research which considers the 'push factors' of dissatisfaction with OM, Conway and Hockey (1998) consider older users of homeopathy as part of a much broader qualitative study of lay health beliefs in later life. They find evidence of continuity with other age groups of CM users. The older users interviewed expressed an incredulity, and a disdain, towards the meta-narrative of OM, a dislike for the production-like nature of OM health care delivery, and the disempowering experience of being an older NHS patient. Similarly, two quantitative Canadian-based studies (Kelner and Wellman 2001; Welman *et al.* 2001), found that many older users sought CM after experiencing failures with OM in treating long-term chronic conditions. Other users were dissatisfied with the standardisation of the OM care they received. Many acknowledged, however, that over one half of older users were referred to CM by their family physician.

Other research emphasises the positive and attractive 'pull factors' of CM, such as the holistic and personalised nature of many treatments, the greater time spent in consultations, and the spiritual dimension to CM care (Vincent and Furnham 1996). Related research extends these arguments, and suggests that many people use CM because it is more consistent with their own personal values and philosophical orientations towards health (Astin 1998; Siahpush 1999*a*, 1999*b*), or because it forms part of a wider identification with an alternative ideology or subculture (Pawluch *et al.* 1994; Fulder 1996; Kelner and Wellman 1997*a*). Again, Conway and Hockey (1998) report that they found CM to offer empowerment, and even a form of resistance against often paternalistic and patronising experiences of OM geriatric medicine. Meanwhile, Kelner and Wellman (2001) and Wellman *et al.* (2001), found older users to be attracted by the greater attention and time that CM offered them over OM.

An added influence on, or pathway to CM use may also come from wider societal changes. In this respect, Kelner and Wellman (1997*b*) argue that the increasing use of CM reflects a greater number of 'smart consumers' in society: people who are well informed about health related issues, and who prefer to use their own informed judgements

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regarding their health and health care. This, the authors state, reflects a wider consumer interest in health and body matters in western society. It is also argued that the media have a part to play in promoting this consumerist health culture. Indeed, both Sharma (1995) and Doel and Segrott (2002) discuss how the media create and sustain the demand for CM, by providing a wealth of information published in popular magazines and newspapers on diseases and available treatments. Nevertheless, the most common reported source of information, and introduction to CM, is 'word-of-mouth' and information provided by relatives, friends, acquaintances and colleagues, both for younger (Sharma 1995) and older users (Kelner and Wellman 2001).

Research has established the general patterns of CM use. Sharma (1995), for example, caricatures four categories of CM users: 'one-off users' who discontinue treatment after a limited experimentation; 'earnest seekers' who are desperately seeking a successful remedy to an intractable health problem; 'stable users', the most common type, who have experienced initial successes and have developed a fairly regular relationship with a particular practitioner or type of treatment; and 'eclectic users' who tend to shop around with a consumerist attitude to their health care, selecting different therapies depending on their specific health problem and preferences. Little research has specifically considered the frequency of CM use. Kelner and Wellman (1997*b*), however, in a comparative study of the Canadian users of family physicians and of CM, claim that users of CM saw their therapists almost twice as frequently, 55 per cent visiting their therapist more than once a month. Wellman *et al.* (2001), meanwhile, find the same to be the case for their sample of older users.

Complementing the literature on the extent of CM use by older people (discussed above), other research focuses on the social characteristics of CM users. A range of studies has contrasted the users of OM and CM, and a divergence of opinion has emerged. Some authors argue that users of CM and OM do not differ significantly in terms of their sex, education, marital status, religion and income levels (Furnham and Smith 1988; McGregor and Peay 1996), or political views and ethnic grouping (Furnham and Forey 1994). Other research however finds that CM patients have more education and higher incomes (Fulder and Munro 1985; Sharma 1991, 1995; Fulder 1996; Kelner and Wellman 1997*a*, 1997*b*; Astin 1998; Ernst and White 2000). Wellman *et al.* (2001) found Canadian older users to be better educated and more affluent in a national comparison. Little research evidence is available on the affluence of older users

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in the UK except from the Conway and Hockey (1998) in-depth study of four older users, all of whom were from higher income groups.

The types of conditions that consumers present have been considered by the dedicated CM literature. There is a general consensus that CM is most frequently used to treat chronic and non-life threatening conditions that are not easily cured by OM. In contrast, complementary therapies are reported to be used less frequently for acute traumatic infectious and genetic conditions which are more effectively treated by OM (Thomas *et al.* 1991; Sharma 1995; Furnham 1996; Fulder 1996). Of all conditions, musculo-skeletal, aches and strains are by far the most common types reported by users, representing 42 per cent and 78.2 per cent of all health problems presented in two large surveys (Boven *et al.* 1977; Thomas *et al.* 1991). Infections, allergies and cardiovascular problems are also reported to be common (Fulder 1996). There is a growing number of users of CM with difficult-to-manage diseases such as cancers and HIV infection, who use therapies to relieve their symptoms and pain. In addition to those who present specific health problems, there are also those who are essentially healthy, but who use CM for preventative reasons or for the maintenance of their general wellbeing.

Research has considered consumers' treatment profiles, and despite acknowledging that the growth in CM is partly due to disillusionment with OM, most research also argues that CM is generally used alongside OM, rather than as a complete replacement to it, both in younger (Thomas *et al.* 1991; Fulder 1996; Furnham 1996), and in older age groups (Kelner and Wellman 2001). Indeed, Eisenberg *et al.* (1993) suggest that most users consider a range of OM and CM options, make use of the different types of health care on different occasions, and implement their own planned mixing, rather than an either/or approach to their care. Users therefore obtain the most out of both CM and OM systems concurrently (Eisenberg *et al.* 1993; Fulder 1996; Furnham 1996). There is a small literature which considers the popularity of particular therapies nationally. Ernst and White (2000), for example, found herbal medicine to be the most common form of CM in the UK, followed by aromatherapy, homeopathy, acupuncture, reflexology, massage, osteopathy and chiropractic. Zollman and Vickers (1999*b*), however, report that three comprehensive independent UK surveys all list acupuncture as the most common CM modality followed by chiropractic, herbal medicine, homeopathy and osteopathy (*Which* 1986; Market and Opinion Research International 1989; Thomas *et al.* 1993).

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A general observation of the literature is that most studies use purely quantitative methods to identify the broad trends of CM use. Although there is evidently a value in this research, these studies often tell us very little about how and why people use CM, and even less about the meaning of CM to individuals. Furthermore, little research considers individual sub-groups of users and the intricacies of their particular actions, attitudes and experiences. Indeed, in much research, users are wrongly assumed to be a homogeneous group. Consequently, there is both a need for more qualitative studies on CM use and for dedicated research foci on different types of users. By using a mixed methodology, and by focusing on older users, the current study addresses these two gaps in the literature. At the same time, it is part of a research tradition within social gerontology which challenges passitivity and investigates older peoples' own self-implemented health and health care strategies. In particular, it aims to provide some impressionistic evidence on localised trends in older peoples' use; the demographic background of older users, the conditions which they present, the types of therapies they use and the frequency of their use. This provides contextual information for the more in-depth investigation of their motivations, experiences and satisfaction. In particular, the study investigates why older people are attracted to CM, the access routes that lead to use, their direct experiences of care, their health gains, the way CM is combined with OM, and potential user empowerment. Where possible, the findings are compared and contrasted with the existing CM literature.

Research methods

Two English counties, Devonshire and Buckinghamshire, were selected as study sites because they both have diverse urban and rural areas, and intra-county contrasts in the demography of their resident populations. Their populations are also relatively old in national comparison, due both to population ageing *in situ*, and the net in-migration of older people (Phillips and Vincent 1986; Warnes and Ford 1992; Andrews and Kendall 2000; Andrews and Phillips 2000, 2002). An additional reason for their selection was the very high number of practitioners observed in the two counties who advertise in telephone directories and that are listed by CM representative bodies. It was assumed that correspondingly high numbers of CM users might also be found in these areas. On another note, initial analysis from a related survey of CM

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practitioners currently being undertaken by the author, found almost one-quarter (22 per cent) of practitioners' clients in these two study areas to be older people. Whether or not this proportion is related to the high proportions of older people resident in these areas, is yet to be examined. Although I selected no study area in northern England, where the use of CM is reported to be much lower (Fulder 1996, Zollman and Vickers 1999*b*), I considered this to be acceptable. This is because recent research evidence suggests that the distribution of CM practitioners in the UK reflects access to, and the availability of complementary practitioners, rather than regional differences in public attitudes or interest (Fulder 1996; Zollman and Vickers 1999*b*).

Because little previous research had specifically considered older people and CM, the current study would generate baseline data. It was therefore considered appropriate, and preferable, for the data to have some degree of localised generalisability. However, in order to investigate the intricacies of consumer opinion in detail, and address the disciplinary concerns outlined above (see Conway and Hockey 1998), it was also necessary to obtain an in-depth focus, and collect detailed attitudinal data from individual users. Consequently, a flexible design was required, and a dual approach was selected for data collection. An initial questionnaire survey was used to elicit quantitative data, and a subsequent in-depth interview survey to elicit complimentary qualitative data. Five pilot interviews, and five pilot questionnaires, were first completed to highlight key themes and to develop a definitive questionnaire design. This was then administered, and the preliminary analysis of the data then partly informed the design of the interview survey by highlighting key issues to be investigated in greater depth. The dual approach was not conducted for purposes of methodological triangulation; rather a two-stage approach provided different, and complementary, levels of focus on broadly the same range of issues.

Stage one – the questionnaire survey

At the same time as working on the current study, I was also undertaking a national questionnaire and interview survey of complementary practitioners funded by the Nuffield Foundation. This associated research provided contact with many practitioners and, given their willingness to assist, potentially provided access to their clients. Practitioners were initially asked if they would like to take part in the study, and the general response was very positive. I took care to ensure that the range of different therapies that participating therapists

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offered generally mirrored the national range of private CM provision. In addition, the agreement of four group practices, each with over seven practitioners, assisted in obtaining a good overall spread of CM modalities. Participating practitioners agreed to given their older customers (aged 60 and over) a questionnaire following their treatment, but not to influence their responses in any way. A total of 400 questionnaires were distributed to approximately 20 practitioners (200 in each study area); 144 were successfully completed and returned, 93 from Devon (64.5 per cent of the total response) and 51 from Buckinghamshire (35.5 per cent). The local response rates (46.5 per cent in Devon, 25.5 per cent in Buckinghamshire, 36 per cent in total) were undoubtedly improved by the practitioners' encouragement. The reasons for differences in the response rates between the counties are not clear, but I knew a greater number of Devon practitioners, and they probably put a greater effort into distributing questionnaires. Nevertheless, the differences in response rates are not necessarily problematic. Moreover, it is the combined response rate that is most important, as I had no intention to analyse county-specific trends. The total response ($n = 144$), may not be large enough confidently to project findings to a national level, although it is thought to be large enough to give a strong indication of local trends in older peoples' use of CM. The questionnaire design was loosely structured, allowing respondents to write detailed answers to 26 open questions. Formal measurement scales were not used in the questionnaire design because data were required that would compliment the rich descriptive data to be collected in the subsequent interview survey.

Stage two – interviews

A semi-structured interview survey added to the questionnaire survey by investigating key issues in greater depth, and collecting focused qualitative attitudinal data. Twenty semi-structured interviews (10 in each of the two study sites) were completed with older people who had participated in the questionnaire survey, and who had agreed to be interviewed in person. The sample was stratified so that the demographic profile of interviewees, and the frequency of use of the therapies, generally mirrored those of the respondents of the questionnaire survey. Some interviews were conducted in respondents' own homes, but most at the person's CM practice. The majority of interviews took between half and three quarters of an hour to complete. Audiotapes were used to record all conversations, and detailed record

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sheets were completed following each interview to note environmental, contextual, and general observations.

Analytical approach

The analytical approach utilised techniques derived from the principles of grounded theory. The original Glaser and Strauss (1967) theory has been refined over time and diverse techniques developed. It is these derived techniques that are used in the current study, rather than the exact and original documented approach. When using grounded theory and associated techniques, theory evolves during the actual research, and does so through the continuous interplay between analysis and data collection (Strauss and Corbin 1998). A central feature of this analytical approach is therefore constant comparative analysis (Glaser and Strauss 1967), and the circular movement between data collection and interpretation, theory development, and back to research. Indeed, incoming data are used to formulate theory, or are meticulously played against existing theory and used to replace, extend, or modify it. This is what Vaughan (1992) terms 'theoretical elaboration' (Strauss and Corbin 1998). So, in grounded theory, generating theory and doing research are essentially two parts of the same process (Glaser 1978). In the current study, the analysis initially prioritised and focused on codes and key areas of interest suggested by the initial research questions, and was subsequently directed by the iterative theory development process. In particular, preliminary analysis of the questionnaire survey influenced the design and content of the interviews, and they in turn were further developed and refined as they progressed.

Findings

The demographic profile of older users

Of the 144 respondents, 34 were male (23.6 per cent) and 110 were female (76.3 per cent). In comparison, a high proportion of female users have also been identified in other user studies. For example, Ernst and White (2000), in a study of all ages of CM users, found 40.6 per cent to be male and 59.4 per cent to be female (n = 246), whilst Kelner and Wellman (1997*a*) found 25.5 per cent to be male and 74.5 percent to be female (n = 240). In the current study, however, the gender distribution of the *older age groups* is biased towards women (Phillips

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TABLE 1. *The age of older users of complementary medicine*

Ages (years)	Frequency	Percentage
60–69	46	32.0
70–79	61	42.4
80–89	35	24.3
90+	2	1.4
Total	144	100.0

and Bartlett 1995). Consequently, given that older women generally outnumber older men, although the findings support the argument that most users of CM are female, and that most older users of CM are also female, in the current study the evidence may actually support the argument that in the older age groups, men have a higher propensity to use CM than women.

The mean age of older users was just over 73 years, and as Table 1 indicates, there were only two respondents out of 144 who were aged over 90 years, and the average age of users is relatively young. This finding may reflect the inability or unwillingness of this oldest age group to complete questionnaires. It may, however, equally reflect a low level of demand for CM, influenced by low levels of mobility and affluence, or more simply, by a general reluctance of older age groups to use CM.

Most of the respondents were previously employed in the professions and white collar occupations. Indeed, over one-third had previously worked as either office workers, teachers or secretaries (Table 2). Given that the respondents were mostly retired, and that therefore these statistics relate to times characterised by different social and employment trends, the argument for a middle class dominated local user profile is compelling. Furthermore, relatively few users (10.7 per cent) described themselves as housewives, and 89.3 per cent reported that they had a former career. A much lower percentage of professional women may have been expected for this particular age group. Although the local populations of Devonshire and Buckinghamshire are relatively affluent, as suggested earlier, these counties do contain a broad mix of social classes, especially in their larger towns and cities. Indeed, in may cases, working class populations are located in close proximity to the practices used by respondents.

It follows that these findings do, to an extent, support previous research which has found CM users to be of higher income groups and

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TABLE 2. *The previous occupations of older users of complementary medicine*

Previous occupation	Frequency	Percentage
Office worker/clerk	25	15.7
Teacher	20	12.6
Secretary	18	11.3
Housewife	17	10.7
Cook	9	5.7
Manufacturing industry	9	5.7
Complementary therapist	5	3.1
Care assistant	6	3.8
Other	3	1.9
Total	112	100

Note: There were 32 non-respondents.

classes (Fulder and Munro 1985; Sharma 1991, 1995; Fulder 1996; Furnham 1996; Kelner and Welman 1997*a*, 1997*b*; Astin 1998; Ernst and White 2000), and the consistent yet limited evidence on the older users (Conway and Hockey 1998; Wellman *et al*. 2001). The findings equally oppose those studies which found CM users not to differ from the general population in terms of income and class (Furnham and Smith 1988; McGregor and Peay 1996). Nevertheless, an issue that potentially confuses these classifications, is that class, former employment type, and current income levels, may not necessarily be as interrelated in older age groups as among younger people, primarily because most older people are no longer employed. Indeed, while a definition of the class of older people based purely on former employment may give some indication of their social attitudes, it may not accurately indicate their current levels of income or financial wellbeing. On a related note, over one-quarter (27 per cent) of all respondents commented that their previous occupation had contributed toward their ill health, and consequently their need to use CM. Indeed, of those, 38 per cent suggested that their previous occupation had caused stress-related conditions, whilst 31 per cent cited back injuries associated with either repetitive office tasks or heavy manual labour.

Consumer behaviour

A broad range of therapies were accessed by older users, including most of the core CM modalities and the more obscure variants (Table 3). Most respondents reported that they used more than one type of

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therapy. Indeed, the 144 respondents reported a total of 376 treatment experiences for the period between April 2000 and April 2001, the mean number of therapies used being 2.6.

The types of therapies used most frequently by older people differed from those used most frequently by the general population, as reported in the dedicated CM literature (Eistenberg *et al.* 1998; Zollman and Vickers 1999*b*; Ernst and White 2000). In particular, gentle manual therapies such as massage and reflexology were reportedly used much more frequently by the respondents of the current study, together representing almost one-third (30.3 per cent) of all treatment experiences. In contrast, use of other core modalities including homeopathy and herbalism were reportedly used less frequently. In some respects, these patterns of usage are influenced by the specific types of conditions that older users presented. In the older users, by far the most frequent conditions presented were musculoskeletal, which together accounted for 59 per cent of all conditions. Indeed, chronic back pain alone accounted for 20 per cent of all conditions reported. This finding is consistent with studies of the general population of CM users, which find musculoskeletal conditions to account for more than one-half of all conditions presented to practitioners (Kelner and Wellman 1997*b*). Much more prevalent in older age groups however are arthritis and mental health related conditions, which accounted for 11.3 per cent and 16 per cent of conditions respectively. It is also notable that 144 respondents reported 212 conditions in total. Many of them were therefore using CM to treat multiple health problems.

Respondents frequently reported that they had initially adopted CM due to perceived inadequacies of OM, such as rushed appointments, long waiting lists, a lack of care and attention by clinicians, and lack of success in solving their particular health problems. As with previous qualitative research on older users, many had a personal story to tell (Conway and Hockey 1998; Kelner and Wellman 2001). Equally however, respondents cited the attractions of CM, such as individualistic treatments, and the holistic approach as pull factors in their initial consumer decisions. Older users' original motivations are arguably therefore not very different from those reported for younger users, in traditional push and pull factor explanations (Furnham and Forey 1994; Sharma 1995; Furnham *et al.* 1995; Furnham and Kirkcaldy 1996; McGregor and Peay 1996). Respondents reported a variety of ways in which they had first been introduced to CM, and which had encouraged them first to use a therapy. Consistent with Wellman *et al.* (2001), the most common point of introduction, or gateway, to CM use was found to be a suggestion by a friend (35.7 per cent). This was

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TABLE 3. *Types of therapies used in the past 12 months*

Type of therapy	Frequency	Percentage
Reflexology	63	16.7
Massage	51	13.6
Acupuncture	50	13.3
Chiropractic	31	8.2
Aromatherapy	30	8.0
Osteopathy	29	7.7
Homeopathy	22	5.9
Herbalism	17	4.5
Reiki	13	3.5
Alexander technique	12	3.2
Spiritual healing	12	3.2
Cranial-sacral	9	2.4
Bowen technique	2	6.0
Cranial massage	4	1.0
Polarity	3	0.8
Bach remedies	3	0.8
Naturopathy	3	0.8
Meditation	2	0.5
Astrology	2	0.5
Total	376	100

followed by advice from a GP (17 per cent), and information in magazines (11.1 per cent). Some users, (8.0 per cent) used CM after witnessing a demonstration in sheltered or residential accommodation, or after being given advice in a day care centre (4 per cent). The regularity of use varied according to the types of therapies and what conditions they were being used to treat. Nevertheless, most respondents claimed to use treatments regularly. As indicated on Table 4: 3.2 per cent daily; 23.1 per cent weekly; and 22.5 per cent fortnightly. Although it is difficult to generalise about usage, the research does support Kelner and Wellman (1997*b*) and Wellman *et al.* (2001), who found that over one-half of CM users visited their therapist more than once a month, and Andrews (2002*b*), who argued that CM is an everyday and common experience for older users.

Another interesting consumer trend is the length of time that older users had been using CM. Consistent with the consensus of opinion on CM use, most respondents claimed to have adopted therapies relatively recently. Indeed, Wellman *et al.* (2001) found the mean number of years of usage for older people to be three, whilst in the current study, almost two-thirds (61.2 per cent) claimed to have been using CM for less than two years (Table 5). However, the current study differs in that many respondents had been using CM for considerably longer. Almost

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TABLE 4. *Frequency of use of complementary medicine*

Frequency	Number of cases	Percentage
Daily	6	3.2
Weekly	43	23.1
Every 2 weeks	42	22.5
Every 4 weeks	23	12.4
Every 6 weeks	7	3.8
Every 2 months	6	3.2
Every 3 months	5	2.7
Every 4 months	6	3.2
Every 6 months	3	1.6
Every 12 months	3	1.6
Once only or few occasions	12	6.4
Highly variable	30	16.1
Total treatments cited	186	100.0

TABLE 5. *Duration of use of complementary medicine*

Duration	Cases	Percentage
Less than 6 months	20	18.0
6 months–1 year	26	23.4
1–2 years	22	19.8
2–3 years	5	4.5
3–4 years	3	2.7
4–5 years	3	2.7
5–10 years	6	5.4
10–20 years	14	12.6
Over 20 years	12	10.8
Total	111	100

Notes: There were 33 non-respondents.

one-quarter (23.4 per cent) claimed to have been using CM for over 10 years, and 10 per cent for over 20 years.

Evidence from the survey therefore suggests that a significant proportion of these older users have been using CM throughout their lifespan, to treat different conditions experienced at different times in their lives. It follows that many of these older users would appropriately be considered as 'long-term users' rather than 'older users', because their prolonged usage may reflect a range of use factors that are not necessarily age-related. For these users, CM has long played a part in their lives. Comments from two interviewees support this:

I may use the therapies for different things now I'm older, but I've always believed in them.

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Natural healing methods have been around for ages. There is a re-emergence, yes, but at the grass-roots there has always been a recognition that we can benefit without the toxic effects of allopathic medicines.

These findings should be considered in the light of those of Wellman *et al.* (2001) which, as suggested, found high proportions of CM users in the 'baby boom' generation. In particular, the findings support their view that middle-aged users may in the next decade become older users with associated health care needs and patterns of consumption. Also highlighted was the fact that some older peoples' use of CM pre-dated the creation of the NHS in 1947. Indeed, in this context, the use of CM may be viewed in terms of a more general tradition of people seeking their own solutions to their health problems. Two interviewees commented:

I think that you'll find that a lot of elderly people like me have used these types of therapies. We used them before the NHS was around.

The NHS has not always been here! You used to have to listen to your family and friends, and learn ways on what to do when you are poorly.

Consistent with Kelner and Wellman (2001), there is a high level of reported user satisfaction amongst older users with the treatments received. To some extent this was expected, given that respondents are current purchasers of therapies. However, the overall degree of satisfaction is substantial, given that 376 treatments were experienced by 144 respondents in 12 months, and that all claimed that they made them feel better in some way. Indeed, only nine responses were qualified with the comment 'over time', and a further 10 with either 'possibly' or 'sometimes'. The ways in which treatments made people feel better very much depended on the type of treatment received and the condition that the older person presented with. Most often, however, therapies were reported to relieve pain and to improve feelings of mental wellbeing. Particularly relevant is how physical and mental wellbeing are not only interrelated but also difficult to separate. Two interviewees commented:

They alleviated my back pain miraculously and cured my attitude to stress so that I could cope much better. They have changed my life and given me a tremendous feeling of wellbeing, happiness, and improved my relationships.

I no longer experience depression and feel much lighter altogether. The greatest benefit of complementary therapies are in mental, emotional and spiritual health.

The counselling service provided by many therapists, and the opportunity to talk to someone, were important to many users,

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especially in times of trauma and change. This was often experienced after the death of a spouse. Two interviewees commented:

> It's relaxing and they are nice to talk to. I am not upset and irritable any more. I laugh more and get my troubles into perspective.

> After my husband died, it was nice to have someone else to talk to. My therapist is very good at listening and giving advice, she helped me get myself together.

Although respondents were arguably from relatively high social classes, and (perhaps) income groups, one restricting factor of their use of CM was nevertheless reported to be the cost of private treatment which varied from an average of £27.10 for osteopathy and £25.80 for chiropractic, to £14.50 for reflexology and £16.20 for massage (Andrews 2002*b*). Indeed, given that reflexology and massage are the most frequently used therapies, there appears to be a weak inverse relationship between the price of different treatments and the frequency of their use by older people. When viewed in terms of the accumulative costs of treatment, the majority of therapies which were used in the long term for long-term conditions could cost the user between £750 and £1,250 per year. Exactly one-third of all respondents stated that their treatment was affordable, while 31 per cent qualified their comment with 'only just'. Others reported that it was not affordable (12 per cent), that their relatives had to pay for them (4.8 per cent), that they could benefit from more treatment but could not afford it (4.8 per cent), or that they went without other things so they could afford treatment (six per cent). Respondents reported that formal concessions were not generally available for older people. Over one-quarter (26.8 per cent), however, stated that their therapist would negotiate an affordable price on a case-by-case basis, were they unable to continue treatment because of their financial circumstances. Many interviewees commented that the cost of treatment restricted their usage of CM, as in the following:

> Reflexology has helped me manage with less medication and sometimes has stopped me taking pills altogether. Depression comes and goes: when I am down I need my reflexology more often but I cannot afford to go more than once a month now.

> I once tried acupuncture early last year on the onset of my depression and pain, but I found that I required more treatments than I could afford. I would try any therapies that are suitable but I cannot afford to do this. Some are very expensive and would have to be stopped even if they were helping me get well.

These comments do raise speculative, yet important, questions about the potential benefits of CM for many older people who do not

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currently use it, but who might do so were private provision more affordable or subsidised, or public sector provision more extensive. Indeed, for most older users, the relatively high cost of treatment is at least a concern.

Treatment profiles

It is possible to classify each of the 144 respondents' current treatment profiles into one of four loosely constructed categories. However, it is acknowledged that individuals may themselves not categorise or articulate their treatment decisions in the same way. First, there were 42 users (29.2 per cent) who claimed to be using CM exclusively, but who were very definite about using separate CM therapies to treat separate conditions. Two interviewees commented:

I use reflexology for foot and ankle problems, and chiropractic for trapped nerves.

I use chiropractic and massage for my back pain and acupuncture for my hand tremor.

Second, there were 40 users (27%) who also claimed to be using CM exclusively, but who displayed a more flexible approach and mixed different CM therapies to treat individual or multiple conditions. Two interviewees commented:

I don't visit a doctor at the moment. I use osteopathy, acupuncture and massage for my back problems, and homeopathy and acupuncture for my pneumonia.

I have acupuncture, reflexology and massage for sciatica and homeopathy for digestive trouble.

Although a majority (57%) reported to be using CM exclusively, this may well have been due to the current health problems they had, and may not necessarily exclude them from future use of OM. An interviewee commented:

Of course I use the NHS, but not at the moment and only when I have to.

Third, there were 14 users (9.7 per cent) who reported currently using combinations of OM and CM, but using them independently to treat separate conditions. Two interviewees commented:

I have skin checks on the NHS and go to the eye hospital, but I have acupuncture and natural healing for my irritable bowl syndrome.

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I go to the eye clinic so that's NHS, but I have homeopathy, reflexology and acupuncture for ME and bronchitis.

Fourth, there were those who claimed to be using both OM and CM, and to integrate them to treat the same conditions. These users (48) accounted for one-third of the respondents. Three interviewees commented:

I recently completed some drugs and a course at a self-help group for sufferers of irritable bowl syndrome. This, together with the reflexology, stopped my terrible stomach rumblings. I hope that the reflexology will keep up its good work.

I've had a hip-replacement and then acupuncture, osteopathy and aromatherapy for my back and hip problems.

I go to the surgery for drugs and X-rays when absolutely necessary (for arthritis). However, I have shiatsu, homeopathy and chiropractic as well.

It is notable that many older users tailored their own treatment profiles, either independently or with advice from their therapists. Although a general observation, it did not appear that older users' multi-use of CM, and the tailoring of treatments, were a function of excessive influence by private practitioners. In contrast, older users seemed to have a great deal of market knowledge about the treatments that they were purchasing, and the treatment options open to them. This finding somewhat opposes the argument that consumers are being duped or, in economic terms being made victims of 'supplier induced demand'. Conversely, these findings support the theory that older users, like younger ones, are to an extent 'smart consumers', with a high degree of knowledge about the health and the healthcare options available to them (Kelner and Wellman, 1997*a*). Indeed, this evidence potentially supports advocates of market solutions to health provision in the UK, who typically cite the associated benefits to patients of consumer sovereignty and market power. An alternative explanation for the use of a range of therapies by older users is that they were searching desperately for a solution to their unsolved health problems – the 'earnest seekers' highlighted by Sharma (1995). During interviews, however, no respondent either reported, or exhibited, this type of behaviour, at least not to the point of desperation. Although the study is unable to capture what Sharma (1995) refers to as 'one-off users' who discontinued their treatment after a limited experimentation or failure, most users in the current study were either 'stable users' who had cemented a fairly personal relationship with a therapist or therapists, or were 'eclectic users' who shopped effectively for their care.

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Respondents would often tell a CM therapist if they were also receiving another type of complementary therapy, either for the same or a different condition. Some people were actively encouraged to use CM by their GP, and for these users OM and CM were openly integrated. An interviewee commented:

> I tell him (her GP) about the reflexology. In fact, it was him that suggested that I try it.

Equally likely, however, was that respondents would not tell their GP of the CM that they were receiving, and thus in these cases CM and OM were not as openly integrated. Two interviewees commented:

> It's very difficult for me to mix NHS and complementary. My doctor is very cynical and so I don't discuss treatments with him. However, I do emphasise how wonderful the other practice is in general.

> No, I don't bother to tell him. I think that he wouldn't agree with my therapies. He's quite stuck in his ways.

It is possible that these statements reflect the mixed attitudes of local GPs towards CM; alternatively, they may also reflect inaccurate perceptions on the part of respondents. Given either scenario, however, the implication is that the complementary position of many treatments is in some cases actively supported by OM, in others it is unrecognised by OM, or may even be covert and possibly, as Conway and Hockey (1998) suggest, used by consumers as a form of resistance to OM. Other studies also highlight both conflict and synergy between older people's lay and institutional-related health behaviours (Helman 1986, 1990; Conway and Hockey 1998). These findings also support the argument that despite the growth in CM being partly an expression of disillusionment with OM, CM is generally used alongside rather than as a complete replacement to OM, and that most patients manage the combination (Thomas *et al.* 1991; Eisenberg *et al.* 1993; Fulder 1996; Furnham 1996). Furthermore, in many respects, the older users' health beliefs and own health care solutions are opposed to the traditional stereotype of passive older patients. Indeed, older users were often, in an explicit and conscious sense, implementing their own strategies and potentially manipulating the dominant meta-narrative of OM (Conway and Hockey 1998).

Feelings of control and user empowerment were also highlighted, often because respondents had taken a positive, and often self-motivated, action in taking the decision to use CM. Many reported a feeling of greater control over their health problems. Two interviewees commented:

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I have taken a positive choice of how to remain as well as possible, which is as good a way to wellness as any.

In a way, they make me feel better because I am doing something positive about my health.

As Conway and Hockey (1998) suggest, empowerment for older people is also experienced through the exercise of choice, and through influencing their treatments. Two interviewees commented:

My therapist talks to me one-to-one, and doesn't tell me what I should do.

I can decide what I want to do about my health, and the therapists are there to advise me. We will sit down and talk about all the options open to me, and move on from there. It's better than taking orders from someone.

Older people are evidently using this form of private health care effectively for their own ends. Much CM remains unregulated in the UK, and the government supports greater regulation to protect consumers (Department of Health, 2001). Whilst acknowledging a need for protection, the current study demonstrates a great degree of market knowledge amongst a social group that is sometimes assumed to lack these insights.

Conclusion

Diverse demographic and attitudinal data have provided insights into some important aspects of older peoples' use of CM. Although the study sample of older users was restricted to two geographical areas of the country, and the overall number of responses (n = 144) was perhaps insufficient to predict trends in CM use at a national level, nevertheless, when considered in combination with the qualitative data elicited from the interview survey (n = 20), some indicators of trends are combined with rich descriptive attitudinal data.

The demographic profile of older users suggests that it is younger retired, and perhaps more affluent, older people who use CM. These findings are consistent with previous studies of CM use. The types of therapies used by older people do generally mirror other users of CM, the research has identified manual therapies, such as massage and reflexology, as being the most popular. Indeed, this may reflect the types of conditions that older people present, and also the cost of these particular therapies which were considerably lower than others. As with research on the general population, musculo-skeletal problems are

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common with the older CM users who use therapies primarily for pain relief. Older users, however, reported additional age-related conditions such as arthritis.

Older users were introduced to CM in a variety of ways, the most common being through advice from their friends and relatives who were current users of CM themselves. GPs' recommendations were also a common source of introduction, and, specific to older people, advice and demonstrations in day care centres and in residential and sheltered accommodation were frequently mentioned as introductory gateways. In contrast, the role of the media in providing information and actively promoting CM was not reported as widely as for other ages of users (Sharma 1995). Nevertheless, the influence of the media may be more subtle and underlying. Even though older users seemed to be relatively affluent, the cost of treatment was still a potential factor restricting CM use. Many users claimed that they would benefit from more frequent treatment but could not afford it. Indeed, questions are also raised regarding the potential benefits of CM to current non-users of CM, who would use privately provided therapies if they were more affordable.

Mirroring the recent growth in private CM provision, many older users had adopted CM relatively recently. However, a significant proportion also claimed to be long-term users, some for over 15 years. Many older users displayed a considerable market knowledge of CM. More generally, older users fitted a description of being 'eclectic users', effectively shopping for their healthcare, or of being 'stable users', rather than the more desperate 'earnest seekers' or 'one-off users' identified by Sharma (1995). Indeed, a consideration of older users' treatment profiles suggests that many of them use combinations of CM and OM to suit their individual circumstances, and tailor their treatments on their own or with advice from their therapists. In this way, CM may be openly integrated with OM, or more covertly used. In either case, older users seemed to hold a considerable amount of consumer power and, contrary to stylised models of market failure, did not appear to be influenced unduly by private providers and an asymmetry of information. In many ways, they therefore actively challenged the dominance of the meta-narrative of OM, and the stereotype of older peoples' passivity in the consumption of health care. There is evidently a need for further qualitative and quantitative research into the consumption of CM. From a disciplinary perspective, given the many different types of users and reasons for their use of CM, further contributions would be welcomed on the subject, including closer consideration from social gerontologists. More generally, both

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research on CM and in social gerontology can benefit from investigating older peoples' activities in emerging health markets.

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