The Prince of Wales's Foundation for Integrated Health

occasional paper 2

Chi-Keong Ong and Bridget Banks

Complementary and Alternative Medicine: the consumer perspective

Report of a pilot study into consumer use and preference for complementary and alternative medicine for The Prince of Wales's Foundation for Integrated Health

The Prince of Wales's Foundation for Integrated Health

occasional paper 2

Chi-Keong Ong and Bridget Banks

Complementary and Alternative Medicine: the consumer perspective

Report of a pilot study into consumer use and preference for complementary and alternative medicine for The Prince of Wales's Foundation for Integrated Health

Consultant Editor: Helen Caton

Published by

The Prince of Wales's Foundation for Integrated Health
12 Chillingworth Road
London
N7 8QJ
England

Telephone: 020 7619 6140
Email: enquiries@fimed.org
Website: www.fimed.org

First published 2003

ISBN 0 9539453 2 4

British Library Cataloguing in Publication Data
A catalogue record for this book is available from the British Library

Designed by Axiom Partners
Printed by Arch Press

Contents

List of tables

List of charts

Acknowledgements

Special thanks goes to the research advisory, focus and support group which consisted of Dr. Janet Richardson, Dr. David Peters, Dr. Peter Fisher and Dr. Kim Jobst.

A big thank you to all of our contributors. We hope that we have done your hard work justice.

Chi-Keong Ong and Bridget Banks

The Prince of Wales's Foundation for Integrated Health gratefully acknowledges funding support from the Department of Health for this project.

Note: The short form 'CAM' is used to refer to any form of complementary or alternative medicine or therapy.

Foreword

By Professor David Peters

Chair, The Prince of Wales's Foundation for Integrated Health Delivery Advisory Group

Despite the huge growth in the use of complementary medicine over the last decade, there is much we still do not know about why it has become so popular at this time. Although many theories have been put forward, the evidence to support some of them has been thin. This report, which looks at a range of published and unpublished research into why and how people are using complementary medicine, is therefore very timely and adds considerably to the existing body of knowledge.

The findings in this report are of particular interest to anyone concerned with developing integrated healthcare. Many of us believe that a person-centred, person-empowering approach to health care best facilitates healing. Such an approach has to recognise the many dimensions of health and well-being and must for that reason consider multiple disciplines and modalities.Therefore, bringing together the best of complementary and conventional approaches could take us a step nearer to more acceptable, effective and affordable healthcare.

As a doctor and a practitioner of complementary medicine I believe there is a great deal we have to learn about peoples' aspirations and expectations. Studies like these can help us understand what patients really want from a healthcare system and what they have found helps them. So I welcome the publication of this report, which I believe is very significant. A great deal of work has gone into its production and I am pleased that the information is now being made available to a wide audience. I am sure it will prove useful to healthcare practitioners of all disciplines and to those given responsibility for managing or improving our healthcare systems.

1 Introduction

The Prince of Wales's Foundation for Integrated Health developed a brief for a project, looking at consumer use and preference, which sought to find out answers to the following questions.

- **What** types of CAM are people using?
- **How many** people are currently using CAM?
- For **what conditions** do they use CAM?
- What are patients' health **outcomes** and their levels of satisfaction with CAM treatment?
- **How** do patients use CAM, for example, alongside or instead of, orthodox medicine?
- **How** do patients gain access to complementary treatment?
- **Where** do people receive treatment and from whom?
- **Why** do people choose CAM?

Methodology

This report summarises a seven month project to produce a preliminary portrait of then unpublished complementary and alternative medicine (CAM) research already conducted or currently being undertaken into the use and preference for complementary medicine by the general public. A survey of grey or unpublished material from 1988-2001 was commissioned and the research methods and findings summarised, as they related to this study.

The following methods were used to identify and contact potential contributors.

1. The Internet was used to search for contacts, organisations and education centres involved with CAM. Keywords were submitted to a number of broad based search engines; in addition, the grey literature databases SIGLE (System for Information on Grey Literature in Europe, available from SilverPlatter) and CISCOM (maintained by the Research Council for Complementary Medicine, http://www.rccm.org.uk) were searched.
2. The following were contacted by letter, telephone and email.
   - All health authorities in the UK (124)

- Universities and higher education centres that provide complementary medicine courses
- Companies: Boots Plc, Potters, Holland and Barrett, Seven Seas
- Private health companies PPP and BUPA
- Primary care organisations, private clinics, health centres, charities, individual therapists and GP clinics that had set up various elements of CAM practice
- The NHS homeopathic hospitals, pain clinics, and the Patients' Association

3. Advertisements were taken out in:
   - The British Medical Journal
   - The Nursing Times
   - The British Journal of General Practitioners
4. Other professions allied to medicine were contacted through their professional bodies. Contributors were also gained through networking at conferences, from telephone conversations and replies to letters.

Requests were made for any dissertations, theses, unpublished papers, literature, small local projects and reports that fell within the project criteria. Non-respondents were sent a follow-up letter and then telephoned. Email communication was also used. All contacts were held in a Microsoft Access database and updated regularly.

The purpose of this report

It must be stressed that it is not possible to draw definitive conclusions or generalisations from pilot projects such as this, which look at unpublished or grey literature. Small sample sizes, limited sampling opportunities and mixed and varied target populations are all problematic. Grey literature was seen as the quickest way of identifying individuals or groups who were studying various aspects of CAM. It is recommended that the findings from this study are compared with the more widely-available published research literature on CAM.

In addition, a study which is time and resource limited cannot answer larger questions, such as the current European context, or investigate questions which are not covered by existing research, such as more in-depth issues.

Nonetheless, the authors believe that a pilot study of this nature has a valid role in setting out broad issues and establishing a valuable dialogue between CAM consumers and service providers.The findings, set out in more detail below, act as useful indicators of what CAM services people use, how they are funded and, importantly, why they use CAM. The findings can also indicate priorities for future studies and primary research in the CAM field. For service providers already integrating, or planning to integrate, CAM practice into their service delivery, this report indicates ways in which outcomes might be measured and patient and carer satisfaction monitored. It also suggests areas for improvement in the delivery of both conventional and CAM healthcare practice, notably in the area of communications.

2 Summary of findings

This report presents the answers to the questions asked in the project brief, as indicated by the studies reviewed. Because of the nature of some of the primary research surveyed, these findings should be taken as an indication only of the consumers' perspective and their reasons for using CAM.

Two main surveys, Thomas et al and the BBC Radio 5 Live survey carried out by ICM Research Ltd, [1] represent the academic and market research approaches to the subject and provide useful parameters for estimates of usage. The smaller studies provide valuable insights into consumer perspectives and behaviour. By drawing a number of smaller studies together, this report provides a unique picture of the reasons why consumers are choosing CAM.

1. The types of CAM used

Eight CAM therapies were indicated in the surveys as the most commonly used, these are:

- Acupuncture
- Aromatherapy
- Chiropractic
- Homeopathy
- Hypnotherapy
- Herbal medicine
- Osteopathy
- Reflexology

The popularity of these therapies was ranked in two major studies reviewed in this report. In one (Thomas et al) two of the therapies (reflexology and aromatherapy) were added due to the high number of mentions given by respondents. In the Radio 5 Live survey, the rank order excluded chiropractic from the top seven and placed osteopathy at number seven. This difference may in part be accounted for by the mixture of significant use of over the counter remedies, notably herbal and homeopathic remedies or aromatherapy oils being included within the Radio 5 Live survey rankings, or by differences in the way questions were phrased in the studies. There is also the possibility that consumers may no longer define commonly available treatments such as osteopathy as complementary or alternative but rather as a mainstream treatment.

1 Thomas KJ et al. Use and expenditure on complementary medicine in England: a population based survey. *Complementary Therapies in Medicine* 2001 9, 2-11 and Ernst E, White, A. The BBC survey of complementary medicine use in the UK. *Complementary Therapies in Medicine* 2000, 8: 32-36.
(Data provided by ICM Research Ltd)

With the sales of over the counter remedies now so high, there is a need to distinguish between this practice and consulting a CAM practitioner, or attending a taught group for yoga or tai chi, for example. In the delivery of CAM in an integrated health context, each of these interventions has a different range of opportunities and benefits, according to the presenting condition. There is also a need to consider potential interactions between orthodox and complementary interventions, which need to be managed.

2. The presenting conditions for which CAM is used

The most significant finding from this review is that CAM is typically used for long-standing illnesses, i.e. conditions lasting more than one year. It is also regularly used for multiple reasons and multi-system conditions such as ME, particularly in conditions recognised by doctors as benefiting poorly from conventional treatments. There was a consistent finding, across studies, of use for the following specific conditions:

- Musculo-skeletal problems, back and/or neck pain
- Injuries
- Bowel problems
- Indigestion
- Stress, anxiety, depression
- Migraine
- Asthma

Maintenance of well-being was another key reason for using CAM and the pleasant nature of some of the treatments was reflected in the fact that many were given as gifts or used for relaxation.

3. Who uses CAM?

Women are greater users of CAM than men, both in terms of practitioner interventions and over the counter purchases of homeopathic and herbal remedies. This is broadly similar to female use of GP and outpatient services. Users are more likely to be in the 35-44 age band.

In terms of social class, those from groups AB (professional and white-collar workers) and C1 (clerical, junior managerial and administrative workers) are more likely to be users than

non-users, while those in groups C2 (skilled working class e.g. engineer) and DE (unskilled and manual workers) are more likely to be non-users. This applies where the majority of CAM use is in the private sector, paid for by people with sufficient disposable income. The profile of users within NHS settings may be different.

4. The number of people using CAM

Estimates are that between 6.6% and 20% of the population use CAM (using a stringent assumption that non-respondents are non-users).

The average number of visits to a practitioner ranges from 2.8 to 5.3 per year, leading to an extrapolation that around 5.3 million people over the age of 18 made 31.7 million visits to practitioners of one of eight therapies. This is considered to be a conservative estimate.

It is also estimated that usage has increased between 1993 and 1998 and the majority of the BBC Radio 5 Live survey [2] respondents reported that they were, or felt that other people were, using CAM therapies more than they were 5 years ago. Thomas et al [3] measured usage up from 8.5% of the adult population in 1993 to 10.6% by 1998.

5. Payment for CAM treatments

Seventy nine percent of CAM is paid for directly by the patient and their mean expenditure is £13.62 per month. The NHS accounts for around 10% of consultations at an estimated cost of £50-55m in 2001, with total expenditure on CAM estimated at £580m. By contrast, the BBC Radio 5 Live survey estimated a value of £1.47bn in 1999, including practitioner visits and over the counter use. At least one opinion group shows that there is a belief in the principle that the NHS should pay for CAM treatments, although dis-investment from existing services is not supported by the majority.

6. Why CAM is used

In addition to the presenting reasons outlined in section 2 above, there is an increasing notion of consumer choice and of shopping around for health care. There is also evidence of the

2 Ernst E, White A. 2000. Op cit.

3 Thomas KJ, et al. 2001. Op cit.

belief in the right to a personal approach and a positive relationship with the healthcare practitioner.

Patient expectations can be expressed as four major factors which impact on all healthcare interventions, whether orthodox or CAM.

- A comprehensive examination
- A satisfactory diagnosis
- Effective treatment interventions
- Freedom from unwanted side-effects

Across the studies, health consumers consistently report four negative and four positive reasons for using CAM.

Negative reasons for choosing CAM:

- Poor outcome from conventional treatment
- Adverse effects from pharmaceutical drugs
- Negative experience of doctor/patient relationship
- Health views not in line with conventional medical model

Positive reasons for choosing CAM:

- Good outcome from CAM treatment
- An active participant in health care
- Positive experience of CAM practitioner relationship
- Health views in line with CAM model

These studies offer healthcare providers the first comprehensive picture of patient expectations of their healthcare provision and a clear understanding of why consumers are turning to CAM.

A survey amongst the Oxfordshire Chinese population indicated that the use ofTraditional Chinese Medicine (TCM) was not related to a perception of poor health or poor physical functioning, nor did it vary according to educational status. It was shown to be linked to lower use of the GP service.

7. Expectations, health outcomes and patient satisfaction

Section 6, above, explains why people turn to CAM interventions and what their expectations are. In the reports quoted patients broadly appear to have their expectations met by CAM. Their health outcomes appear to be positive and there are also reports of economic outcomes, notably, evidence of a decrease in medication and use of GP time.

Positive health outcomes for palliative care patients have been reported, in terms of both primary and secondary symptoms; this includes cancer patients. Other benefits reported include improved coping mechanisms, greater acceptance of end stage illness and increased self esteem. Improvements have also been reported in dementia patients in a study in progress at the time of writing.

Negative outcomes were reported, notably some dissatisfaction with CAM methods and health outcomes. For example, some patients assumed that speed of recovery using CAM would be similar to that expected of conventional medicine. However, the biggest cause of dissatisfaction was that there were not enough CAM sessions, or that CAM sessions did not last long enough. These are important factors when considering integrating CAM into an NHS context, where the typical amount of contact time is reduced to a minimum.

Conclusions

There are some strong developments indicated by these studies which would merit close examination in future health and economic outcome research and patient satisfaction surveys.

As well as an explanation for the still increasing use of CAM, and the tendency for some treatments to be increasingly mainstream, the findings also point to a dissatisfaction with elements of the delivery of orthodox healthcare, notably the quality of the doctor/patient relationship and the time available for thorough examination and diagnosis.

This study highlights implications for integrating CAM practice into the NHS and acts as a warning against the reduction of two of the most valued aspects of the CAM experience: the practitioner/patient relationship and time.

In a society which increasingly values the consumer perspective and the principle of choice in healthcare, these findings provide a basis for discussion of what we mean by a diverse and integrated health service.

3 What types of CAM do people use?

Types of CAM used

Studies by Sheffield University [4] started out with a list of six therapies described as 'more established', and a further two (reflexology and aromatherapy) were added due to the high number of mentions from respondents.

Table One Therapies and their rank order (Thomas et al, 2001)

RANK ORDER	USE IN PAST 12 MONTHS THERAPY	N=2669 (WEIGHTED) N
1st	Osteopathy	116
2nd	Chiropractic	95
5th	Acupuncture	42
6th	Homeopathy	31
7th	Medical herbalism	25
8th	Hypnotherapy	18
	Visited 1 of 6	282
4th	Reflexology	63
3rd	Aromatherapy	92
	Visited 1 of 8	363
	Other	43
	OTC homeopathic remedy	230
	OTC herbal remedy	524
	Used 1 of 8 or OTC	756

OTC = over the counter

The BBC Radio 5 Live survey [5] was carried out by ICM Research Ltd in 1999. They undertook a survey of UK wide CAM use, randomly surveying 1204 people by phone. As shown in Table Two overleaf this produced a different ranking of therapies to Thomas et al. In addition, use of a further 22 different types of CAM was reported, including movement therapies (e.g. tai-chi, qi gong and yoga), art and music therapies, and over the counter purchases. It is not possible to be sure from the data whether references to herbal medicine includes or excludes a consultation with a qualified herbalist. Thomas et al records a 19.8% use of over the counter herbal remedies and 8.6% use of homeopathic remedies over the counter, and makes a distinction between those purchases and visits to practitioners.

4 Thomas KJ, et al. Use and expenditure on complementary medicine in England – a population based survey, *Complementary Therapies in Medicine* 2001: 9, 2-11.

5 Ernst E, White A. 2000. Op cit.

Table Two Popularity of therapies (Ernst & White 2000)

RANK	THERAPY	N	% OF ALL USERS OF CAM (WEIGHTED N=245)
1st	Herbal medicine	82	33.5
2nd	Aromatherapy	51	20.8
3rd	Homeopathy	42	17.1
4th	Acupuncture/acupressure	34	13.9
5th	Massage	14	5.7
6th	Reflexology	14	5.7
7th	Osteopathy	9	3.7

These studies agree about the top seven CAM therapies used by the public, apart from chiropractic. Their rank order is, however, very different. In addition,Thomas et al makes a clear distinction between practitioner encounters and purchase of over the counter remedies.

What CAM is typically used for

The studies reviewed indicate that CAM is used widely, including within an NHS context, for musculo-skeletal pain, particularly back and neck problems. In addition, many users report the presence of a long-standing illness, where problems have been experienced for more than one year. Stress, anxiety and depression are also linked with higher levels of CAM use. Some CAM users report multiple reasons, one of which is "maintenance of general wellbeing".

In 1999 a population survey of four counties, [6] reported that 60% (N=417) of respondents who indicated that they had visited a CAM practitioner also reported at least one long standing illness.This is significantly higher than the proportion of the general population reporting long standing illnesses (41.6%, N=3697) ($p<0.001$).

In Liverpool [7] a study evaluated the first year of a service offering CAM therapies on the NHS at the Liverpool Centre for Health. Most patients presenting for therapy had been experiencing their problems for over a year (72%; N=129) with 15% (N=27) having had their problems for 10 years or more.

6 Ong CK, et al. Use of complementary and alternative medical services in England: A population survey of four counties 1997. *American Journal of Public Health.* 2002, 92:1653-1656.

7 Hotchkiss K. *Liverpool Centre for Health (LCH): The first year of a service offering complementary therapies on the NHS 1995.* Observatory report series no.25: Liverpool Public Health Observatory, 1995.

Table Three Proportion of sufferers of specific long standing illnesses consulting CAM practitioners. [8] (Only diseases which predicted the use of a CAM practitioner in univariate analyses are included in this table)

LONGSTANDING ILLNESS REPORTED	PROPORTION CONSULTING CAM PRACTITIONERS % (N)	p (PEARSON'S χ^2)
Back pain	18.0 (248)	<0.0001
Bowel problems	16.1 (83)	<0.0001
Problems resulting from an injury	13.3 (57)	<0.0001
Indigestion	12.3 (48)	<0.005
Anxiety	12.3 (58)	<0.0001
Depression	12.0 (70)	<0.0001
Arthritis	11.8 (71)	<0.0001
Migraine	11.7 (72)	<0.0001
Problems with single joints	10.9 (101)	<0.0001
Asthma	10.3 (64)	<0.025
No longstanding illnesses	5.4 (278)	

In the 1998 survey by Thomas et al, for visits to any one of the six therapies described as "more established", 71% of consultations were found to be for musculo-skeletal problems, 24% for other health problems and 5% for general health maintenance. A different profile was found by Thomas et al for aromatherapy and reflexology, where only 25% of such consultations were for musculo-skeletal problems. The largest single proportion of visits were for "stress and/or relaxation", 39%, and 8% utilised aromatherapy and reflexology for general health maintenance. In addition, 13% consulted aromatherapists or reflexologists for "non health reasons", described as "birthday treat", "Christmas present", "beauty treatment" and "pleasure".

Nearly one in five respondents in the Ong et al [9] study (18%) reporting back pain had visited a CAM practitioner. The next most predictive illnesses were bowel problems and problems resulting from long term injuries. Table three lists the long standing illnesses that significantly predicted visits to any of the named categories of CAM practitioners in univariate analyses and the proportion of respondents who reported such consultations. Respondents in this study reporting heart disease, diabetes, raised blood pressure, skin problems and

8 Ong CK, et al. *Use of Complementary and Alternative Medicine (CAM) in England: Lifestyle, gender and their impact on CAM use*. Health Services Research Unit: University of Oxford 2001a.

9 Ong CK, et al. 2001a. Op cit.

epilepsy were no more likely to use CAM than the general population.

Other studies identify the use of CAM for musculo-skeletal problems. In a project which set out to establish the concurrent use of CAM and primary care services in the past month in six health centres in Grampian and Tayside, [10] 31.6% of users cited musculo-skeletal problems for CAM use (N=125), followed by 22.2% of users who said that they utilised CAM for preventive reasons, stress or relaxation. Similarly, a survey which looked at provision in southern Derbyshire, [11] either by NHS staff or referral to CAM practitioners, found that pain relief (musculo-skeletal, especially back pain) was the most common reason for providing CAM. It found that 52% of referrals to CAM therapists by GPs were for osteopathy. The most popular therapies provided were reported as acupuncture, aromatherapy and hypnotherapy.

In the Liverpool Centre for Health study, 51% (N=107) of patients were referred for CAM because of musculo-skeletal problems. Nearly half of these patients, 48.6% (N=52), reported suffering from back or neck problems. The functional ability of patients was assessed at point of entry to treatment. Fifty seven percent (N=103) of patients indicated that their medical problems hindered their ability to conduct normal activities most or all of the time. In addition, 34% (N=72) were attending CAM therapy for psychological problems and more than half of these patients (54.2%, N=39) were reported to be suffering from depression or anxiety.

Between 1994 and 1997, a GP practice in Somerset [12] set up a CAM service offering acupuncture, homeopathy, massage, herbal medicine, and osteopathy. Six hundred and sixty one referrals (17% of the total practice population) were made to the CAM therapists during this time. Musculo-skeletal (59%), psycho-social (15%) and multi-system problems e.g. Myalgic Encephalomyelitis (ME) (5.3%) were found to be the most common chronic conditions seen by the CAM therapists.

Multiple reasons for the use of CAM is demonstrated by a study from Birmingham, [13] in which "maintenance of general well-being" was the most commonly cited reason for using CAM (60%). Fifty one percent of respondents also said that they were using CAM for stress, 40% indicated CAM use for anxiety and another 42.8% said they used CAM for back pain.

10 Featherstone C, et al. *Concurrent use of CAM and primary care services in Tayside and Grampian*. Highlands and Islands Research Network: Scotland 2000.

11 Ward K. *A survey of the use of therapies in primary and secondary care settings in southern Derbyshire*. South Derbyshire Health Authority, 1996.

12 Hills D, and Welford R. *Complementary Therapy in General Practice*. Somerset Trust for Integrated Healthcare, 1998.

13 Tischler V. *Who uses CAM and why?* Study of users at Birmingham. Masters of Social Science dissertation: University of Birmingham. 1998

4 Who are CAM users?

Gender

Thomas et al [14] estimated levels of use of the six more established therapies as significantly (p=0.005) higher for women than for men (see table four). Similar patterns were observed for over the counter purchase of homeopathic and herbal remedies.

Table Four Gender usage patterns (Thomas et al)

	Male				Female				Both Sexes			
	N = total sample	N = CAM users	%	95% CI	N= total sample	N= CAM users	%	95% CI	N= total sample	N= CAM users	%	95% CI
Use of any of 6 therapies	1313	115	8.8	(7.3 – 10.3)	1319	165	12.5	(10.7 – 14.3)	2669	282	10.6	(9.4 – 11.7)
Use of OTC herbal or homeopathic remedies												
All known OTC remedy use	1301	156	12.0	(10.2– 13.8)	1306	425	32.6	(30.0 – 35.1)	2644	585	22.1	(20.5 – 23.7)
OTC use not known	12				13				25			

p<0.01 for difference in proportions between sexes for both therapies use and use of herbal or homeopathic remedies over the counter comparisons

Similarly, the BBC Radio 5 Live survey, reported by Ernst & White (2000), and Ong et al (2001) studies found higher female CAM usage. The BBC Radio 5 Live survey found that 59.6% (N=146) of users of CAM were female.This was significantly higher than the weighted gender distribution of the survey population where females constituted 614 out of 1204 (51.0%) respondents (p<0.025). In the Ong et al [15] study, women were nearly twice as likely as men to visit CAM practitioners (p<0.001).

This concurs with findings relating to the use of GP and outpatient services, where women are also likely to be higher users than men. [16]

Age

Chart One illustrates the age group distribution from the BBC Radio 5 Live survey for those who said that they had utilised CAM at least once and those who indicated non use. Sixty two point eight percent (N=154) of those who said that they had used CAM in 1999 were from the 35-64 age group versus only 44.2% (N=424) of non-users (p<0.001). This age group is rather

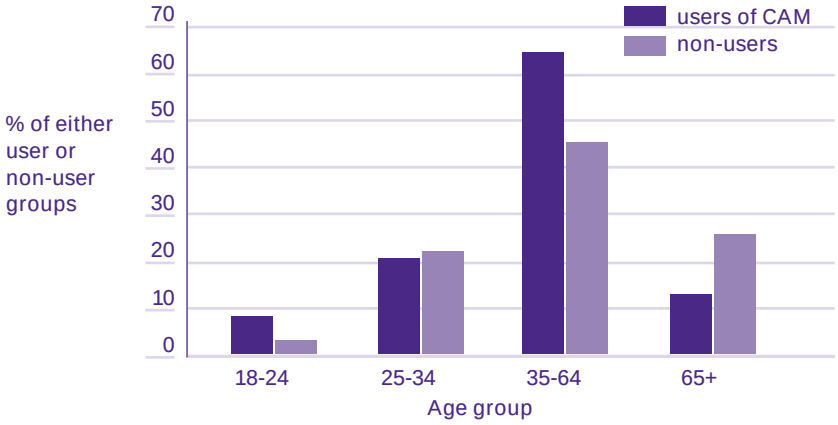
14 Thomas KJ, et al. 2001. Op cit.

15 Ong CK, et al. 2002. Op cit.

16 Petersen S, et al. *Health and lifestyles in four counties: Results from the third Oxford Healthy Lifestyle survey*. Health Services Research Unit: Oxford, 1998.

broad, however Ong et al [17] found that more people in the 35-44 age band used CAM services than in other age groups, with about one in ten respondents (9.2%, N=195) reporting a visit to a CAM practitioner. This indicates greatest usage by those aged 35-44.

Chart One Age group distribution of users versus non-users of CAM



Geographic location of users

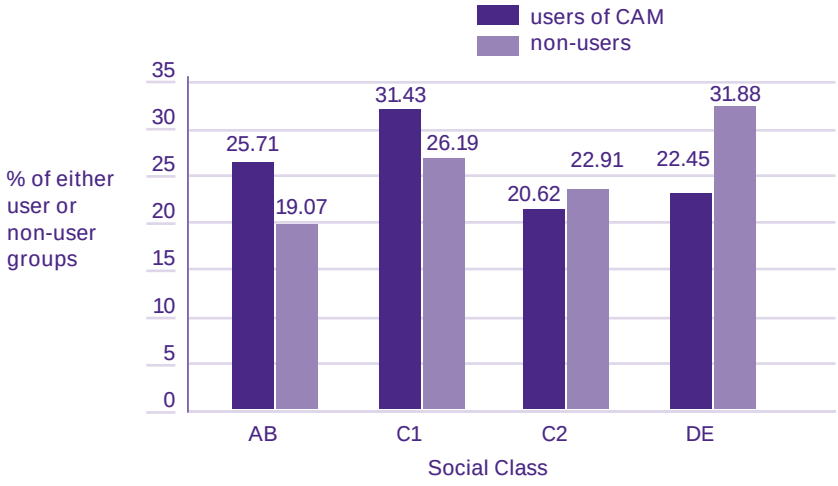
The BBC Radio 5 Live survey, reported by Ernst & White (2000), showed significant differences ($p<0.05$) in use between the geographical regions defined as "the north" (22.5%, N=95), compared with 26.2% in "the midlands" (N=79) and 29.9% (N=144) in "the south". Thirty percent (N=112) of respondents from London and the south east region said that they or some member of their household had used CAM in 1999 compared with 21.7% (N=68) of those from the north/north-west/Yorkshire. This difference in levels of use was significant ($p<0.025$).

Social Class

The BBC Radio 5 Live survey compared the social class distribution for those who utilised CAM and those who did not and found that 25.7% (N=63) of users were from class AB (professional and white-collar workers), while 31.4% were from C1 (clerical, junior managerial and administrative workers). Both these classes indicated a higher use than non-use of CAM. By contrast, non-use increases in Class C2 (semi-skilled workers) 22.9% non-users compared to 20.8% users, and DE (unskilled and manual workers), 31.8% non-users compared to 22.45% users.

17 Ong CK, et al. 2002. Op cit.

Chart Two: Social class distribution of users of CAM versus non-users [18]



The BBC Radio 5 Live survey, reported by Ernst & White (2000), made no distinction between self-funded use or purchase of CAM and NHS provision. It found that 31% (N=17) of all those in social class DE (unskilled manual labour) indicated that they spent more than £10 a month on CAM compared with 49.2% (N=31) of those from class AB (professional and white-collar workers) ($p<0.05$).

By contrast, the Liverpool Centre for Health survey [19] described an NHS-funded service. Of the patients referred in 1993, 73% lived within a catchment area in Liverpool (Everton, Vauxhall, Melrose and Breckfield) which scored high on the Jarman index of deprivation. At the time, unemployment rates were 32% as against 21% for Liverpool as a whole and the limiting long term illness rate among adults was 24% in the centre's catchment area.

Ong et al [20] found that 78.3% (N=544) of those who consulted CAM practitioners were from social classes I, II and IIIN (non-manual work classes) by the Registrar General's classification with over 45% from social class II alone.

18 Ernst E, White A. 2000. Op cit.

19 Hotchkiss J. *Liverpool Centre for Health: The first year of a service offering CAM on the NHS*. Observatory report series no.25: Liverpool Public Health Observatory 1995.

20 Ong CK, et al. 2002. Op cit.

5 How many people use CAM?

Estimates are that between 6.6% and 20% of the population use CAM (using a stringent assumption that non-respondents are non-users).

The average number of visits ranges from 2.8 to 5.3 per year, leading to an extrapolation that around 5.3 million people over the age of 18 made 31.7 million visits to practitioners of one of eight therapies. This is considered to be a conservative estimate.

It is also estimated that usage has increased between 1993 and 1998 and the majority of the BBC Radio 5 Live survey respondents reported that they were, or felt that other people were, using CAM therapies more than they were 5 years ago.

Recent use

Thomas et al [21] estimated that 10.6% (N=283, 95% CI= 9.6 – 11.6) of the adult population consulted a therapist for one of six more established therapies (acupuncture, chiropractic, homeopathy, herbal medicine, hypnotherapy and osteopathy) in the past 12 months. If reflexology and aromatherapy were included, then 13.6% (N=363, 95% CI = 12.3 to 14.9) of adults were estimated to have visited a practitioner for CAM treatment in 1998.

A lower estimate of use was also calculated, applying the stringent assumption that all non-respondents were also non-users, reducing the estimate of use in the past 12 months to 6.6%. By contrast, the BBC Radio 5 Live survey, reported by Ernst & White (2000), found that 20% (N=245) of respondents indicated that they or they and someone else in their household had utilised CAM at least once in the past year.

The average number of visits per year, reported by Thomas et al, ranged from 2.8 for users of homeopathy to 5.3 for users of chiropractic. The mean for the six more established therapies was 4.5 visits (95% CI 3.9 – 5.2). Using these figures, an estimated 5.3 million persons over the age of 18 made 31.7 million visits to one of the eight therapies, including aromatherapy and reflexology.

In Ong et al, [22] 695 people (7.8%) reported that they had consulted a CAM practitioner in a three month period in 1997. Of these, 83.7% (582/695) had consulted only one kind of practitioner in the 3 months prior to the survey.

21 Thomas KJ, et al. 2001. Op cit.

22 Ong CK, et al. 2002. Op cit.

Featherstone et al [23] found that nearly one in two respondents had utilised CAM in the past month in 2000 (48.2% from a sample size of 2184 and an adjusted response rate of 51.9%, n=1134).

Lifetime use

Thomas et al estimated that approximately 32.1% (857/2669, 95% CI= 30.3 – 33.9) of the adult population (over the age of 18) had used one of the eight therapies in their lifetime. With the exception of reflexology, the ranking of the therapies for lifetime use was the same as for use over the past 12 months (see table five).

Assuming that CAM use is taken to mean visits to practitioners of any of the eight named therapies, visits to other therapists or over the counter purchases of herbal or homeopathic remedies, then this study estimated that utilisation in 1998 by all persons over the age of 18 would be 28.3% (95% CI 26.6 to 30.0). The lifetime usage estimate was 46.6%.

Table five Therapies and their recorded usage (Thomas et al 2001)

		USE IN PAST 12 MONTHS		LIFETIME USE	
Rank order	Therapy	N=2669 (weighted)		N=2669 (weighted)	
		N	% (95% CI)	N	% (95% CI)
1st	Osteopathy	116	4.3 (3.6 – 5.1)	339	13.0 (11.7 – 14.3)
2nd	Chiropractic	95	3.6 (2.9 – 4.3)	269	10.3 (9.2 –11.5)
5th	Acupuncture	42	1.6 (1.1 – 2.1)	186	7.0 (6.1 – 8.1)
6th	Homeopathy	31	1.2 (0.8 –1.6)	151	5.7 (4.9 – 6.8)
7th	Medical herbalism	25	0.9 (0.6 – 1.3)	114	4.4 (3.6 – 5.1)
8th	Hypnotherapy	18	0.7 (0.4 – 1.0)	81	3.1 (2.5 – 3.8)
	Visited 1 of 6	282	10.6 (9.4–11.7)	742	28.3 (26.6–30.1)
4th	Reflexology	63	2.4 (1.8 – 2.9)	142	5.4 (4.5 – 6.3)
3rd	Aromatherapy	92	3.5 (2.8 –4.1)	214	8.2 (7.1 – 9.2)
	Visited 1 of 8	363	13.6 (12.3–14.9)	841	32.1 (30.3–33.9)
	Other	43	1.6 (1.1 – 2.1)	39	1.5 (1.0 –2.0)
	OTC homeopathic remedy	230	8.6 (7.6 – 9.8)	374	14.6 (13.3 – 16.0)
	OTC herbal remedy	524	19.8 (18.3 – 21.3)	805	31.4 (29.6 – 33.2)
	Used 1 of 8 or OTC	756	28.3 (26.6–30.0)	1210	46.6 (44.6–48.5)

OTC = over the counter

23 Featherstone C, et al. 2000. Op cit.

Increased CAM use

Thomas et al [24] suggested that the use of CAM in England has increased between 1993 and 1998.Their 1993 pilot had indicated that 8.5% of the adult population had seen a practitioner for one of the six more established therapies in 1993 compared to 10.6% in 1998. In 1999, the BBC Radio 5 Live survey reported that 78% of respondents said that they were, or felt that other people were, using CAM therapies more than they were 5 years ago.

24 Thomas KJ, et al. 2001. Op cit.

6 Who pays for CAM and how much do they pay?

CAM availability through the NHS

Views on the use and provision of CAM were assessed as part of a study in Birmingham. [25] High scores were found in support of provision of CAM through the NHS and primary care. High scores were also registered in favour of the NHS providing CAM free to all who want it.

The reality is that the majority of CAM treatments are paid for privately, even within well-established interventions, such as chiropractic or osteopathy. For example, it has been estimated that only 5-10% of osteopathic practice is accounted for by the NHS. [26]

TheThomas et al study estimated that 79% of consultations were paid for directly by the patient while the NHS provided an estimated 10% of consultations.The mean annual expenditure on CAM visits was estimated to be about £108 per user. Therefore, total out of pocket annual expenditure on any of the eight named therapies was estimated to be about £580 million with provision through the NHS costing around £50-£55 million.

Payments by patients

The BBC Radio 5 Live survey, reported by Ernst & White (2000), identified that 60% of CAM expenditure per month was £10 or less and that the mean expenditure for all respondents was £13.62 per month.This translates to an estimated average annual expenditure of £163.44.Table six illustrates the mean expenditure by gender, age group, social class and by region.There was little difference in the mean expenditure by gender (£13.11 for males versus £13.96 for females). Mean expenditure was

Table Six Mean expenditure [27]

	Mean expenditure per month £
ALL	13.62
Sex	
Male	13.11
Female	13.96
Age Group	
18-24	18.61
25-34	15.57
35-64	12.56
65+	13.29
Social Class	
AB	13.39
C1	16.89
C2	13.44
DE	9.10
Region	
North	12.59
Midlands	11.57
South	15.49

25 Tischler V. 1998. Op cit.

26 Wadsworth R. Commissioning complementary medicine. *Quality in complementary medicine: A meeting of the forum on quality in health care of the Royal Society of Medicine.* Royal Society of Medicine: London. 1998.

27 Ernst E, White A. 2000. Op cit.

highest amongst those in the 18-24 age group (£18.24) and in the south (£15.49) and lowest in the Midlands (£11.57).

Office of National Statistics figures showed that, in 1998, there were approximately 45 million people in the UK over 18. From this it was estimated, based on the Radio 5 Live survey, that approximately 9 million people (20% of people over 18) in the UK had used some form of CAM in 1999. This suggests that approximately £1.47 billion (£13.62 x 12 x 9,000,000) was spent on CAM in 1999. This included both practitioner visits and over the counter purchases.

Opinions about CAM payment and/or NHS availability

Public perceptions of CAM within primary care in Somerset [28] were assessed in 1999. Ten panels each comprising eight to ten members of the public, were selected as being broadly representative of the views of the Somerset people. Eighty nine panel members took part in the discussions and completed a questionnaire; 47% of panel members had used CAM themselves.

Twenty nine percent of panel members thought that all forms of CAM should be available at no charge to all patients. However, 50% felt that only therapies with a proven scientific evidence base should be made available without charge and six percent felt that CAM should only be available privately. The remaining 15% of panel members were of the opinion that CAM should be made free for certain select groups of patients only. It was generally felt that therapies should be provided free to those on benefit or low income.

A study in a Lancashire hospital [29] was undertaken to see whether there would be a market for a subsidised complementary medicine service. Members of the hospital staff were offered a variety of treatments and then asked to complete a questionnaire. The questionnaire offered a range of prices that were thought to be suitable as a subsidised fee.

Respondents were also asked about whether the cost of therapies would influence their decision to attend in the future and what they might be prepared to pay for this service. Seventy four percent (N=23) of respondents felt that cost would be an issue that affected their decision to have CAM. A breakdown of prices on offer can be seen in table seven with a majority figure of <£12.

28 Coe N and Pearson V. *Complementary therapy in primary care in Somerset: Access to services and public perceptions*. Directorate of Public Health and Strategy: Somerset Health Authority 1999.

29 Buck G and Banks B. *A study of the use of an in-house complementary medicine service by staff in a Lancashire hospital.* GB Holistic Clinic: Lancashire, 2001.

Table seven Amount respondents willing to pay for CAM treatments. (Buck & Banks 2001)

Price range	Frequency	Percentage
£5-£8	12	39
£9-£12	13	42
£13-£15	5	16
£16-£20	1	3
Over £20	0	0
Total	31	100

In a survey [30] which sought to determine whether residents of South Cheshire Health Authority wanted CAM to be locally available on the NHS, 83% of responses said it should be available. Out of all respondents, 44% (N=140) said that they had tried CAM and 97% of those who had tried CAM said that CAM should be available on the NHS. Seventy three percent (N=126) of those who had not tried CAM also felt that it should be available on the NHS. The top interventions rated by the respondents were: osteopathy, chiropractic, acupuncture, massage, herbalism, Alexander technique, reflexology, aromatherapy and homeopathy, respectively.

However, when asked whether they were in favour of taking money from existing health services in order to fund locally available CAM services, 23.4% of respondents supported dis-investment from existing NHS services while 50.3% said that they did not support such a move.

30 Meredith W. *Public Participation in Health Service Priority Setting: A study in South Cheshire*. Master of Public Health Dissertation: University of Liverpool 1995.

7 Why do people choose CAM?

The existence of a long-standing condition or musculo-skeletal injury has already been identified as a reason why people use CAM, but there are other reasons. Janet George in her masters dissertation for the University of Durham [31] asked why people use CAM and found that modern health consumers feel more in control of their own healthcare, and have higher expectations of their therapist or practitioner. They understand they have a choice of healthcare and may shop around until they feel happy with a therapy or doctor. They expect to be listened to, be given a personal approach and receive priority for their needs. Patients want to feel that they have had quality time with their practitioner, and a full and comprehensive examination resulting in a satisfactory diagnosis and effective intervention, without unwanted side effects.

The BBC Radio 5 Live survey (1999), reported by Ernst & White (2000), asked 245 CAM users what their reasons were for using CAM.

Table eight Reasons for using CAM (Ernst & White 2000)

Reasons	No.	%
1. Helps relieve injury/condition	60	24.5
2. Just like it	51	20.8
3. Find it relaxing	46	18.8
4. For good health/well being	34	13.9
5. Preventative	30	12.2
6. Don't believe in conventional medicine	27	11.0
7. Doctor's referral	27	11.0
8. Find out about other ways of life	26	10.6
9. Way of life/lifestyle	20	8.2
10. Can't get NHS treatment	17	6.9
11. Exercise	5	2.0
12. To meet other people/make friends	2	0.8
13. Other	15	6.1
14. Don't know/not sure	9	3.7

These responses are problematic in that, as noted above, this survey does not distinguish between over the counter purchases, practitioner interventions or classes, such as yoga or t'ai chi.

31 George J. *Why do people use complementary medicine? A study of users of a homeopathic clinic.* Masters in Sociology and Social Policy dissertation: University of Durham 1999.

The Somerset Health Authority survey [32] identified factors which participants thought should influence provision of CAM through the NHS.

Table nine Factors influencing the provision of CAM (Somerset Health Authority 1999)

Most Important	It improves the quality of life of the patient
	The qualifications of the therapist
	What is known about the treatment
	Whether it works
	When conventional medicine cannot help
	The seriousness of the disease or illness
	The availability of the service
	Value for money
	How easy it is to access
	How many people will benefit
	How accepted it is by health professionals
	How much it costs
	Where the service is provided
	The length of time it has been available
Least Important	How accepted it is by the public

Six further studies have identified additional reasons for CAM use:

- General practitioner (GP) treated the symptoms only and not the cause of the medical problem [33]
- There was not enough time for consultation with the GP
- Their GPs had little interest in them or appeared not to listen
- They had a poor doctor-patient relationship
- End stage to conventional medicine [34]
- No improvement or alleviation of their condition

In a study at Lewisham Hospital, [35] more than one in five respondents (20.4%, N=180) said that "Conventional treatment was not beneficial, hence their decision to try CAM."

Adverse reactions to pharmaceutical drugs may also be an issue: in a study of 541 patients from Guys and St.Thomas' Hospital, [36] 46% (N=249), of respondents were taking herbal medicines, vitamins and food supplements and 39% (N=210) indicated prior experience of adverse health effects from pharmaceutical drugs.

32 Somerset Health Authority 1999. Op cit.

33 Hogan K. *Reasons for choosing complementary medicines over orthodox medicine*. BSc dissertation in Physiotherapy: University of Southampton 1999.

34 George J. 1999. Op cit.

35 Richardson J. *Complementary therapy in the NHS: A service evaluation of the first year of an outpatient service in a local district hospital*. Health Services Research and Evaluation Unit:The Lewisham Hospital NHSTrust 1995.

36 Shaw D. *A survey of herbal and nutritional supplement use among patients at Guy's and St Thomas's Hospital*.Toxicology Unit: Guy's and St Thomas' Hospital, London 2001.

Other motivating factors have been identified in the Birmingham study [37] which included interviews with ten respondents. Two issues scored highly:

- Belief in the effectiveness of CAM
- Extra personal attention from a CAM practitioner

The spiritual and religious beliefs of women were identified as a strong influencing factor on their reasons for choosing CAM and they are more likely to believe that CAM is an alternative to conventional medicine. Male respondents expressed the view that CAM needs to develop better science-based evidence for effectiveness.

In the Somerset general practice evaluation [38] patients said that the therapists were "Competent and skilful, easy to talk to, warm and committed, able to understand their problems and explain the treatment needed in a clear manner." Seventy eight point one percent of patients felt that the therapist held "similar views on health to their own."

In total 85% of patients felt that, on completion of their treatment, there had been some or a great deal of change for the better in their condition. Almost all patients attributed this to their treatment. Generally women assessed themselves as having a greater level of change following treatment.

In a report describing the use of aromatherapy in labour, [39] the following reasons were cited for use:

- Greater awareness of pharmacology side effects and limitations
- The need to remain in control
- The client is able remain an active participant in her care

Positive and negative reasons for using CAM

The above findings may be summarised as four positive and four negative reasons for turning towards CAM.

Positive

- Health views in line with CAM model
- Positive experience of CAM practitioner relationship
- Good outcome from CAM treatment
- An active participant in health care

Negative

- Health views not in line with conventional medical model
- Negative experience of GP relationship
- Poor outcome from conventional treatment
- Adverse effects from pharmaceutical drugs

37 Tischler V. 1998. Op cit.

38 Hills D, & Welford R. 1998. Op cit.

39 Burns E, et al. *The use of aromatherapy in intrapartum midwifery practice: An evaluative study*. Oxford Centre for Health Care Research and Development: Oxford Brookes University 2000.

Ethnic minority use

One survey available to the researchers looked at the Chinese population within the UK, [40] to assess their health needs, healthcare access and general health status. An adjusted response rate of 59.2% (N=1515) was achieved. The data was analysed to determine if self perception of poor health was associated with preference for Traditional Chinese Medicine. It was found that 78% (N=373) of respondents whose personal health perception SF-36 dimension score matched or exceeded the Oxfordshire population norm [41] (>=72.3) indicated that they preferred Traditional Chinese Medicine for some, most or all medical conditions. Amongst those with poor perceptions of their own health (personal health perception dimension score <=60), 82.5% (N=476) expressed a similar preference.

The data was also analysed to ascertain whether poor health as defined by poor physical functioning scores was associated with preference for Traditional Chinese Medicine. It was found that 78.2% (N=811) of respondents whose physical functioning SF-36 score matched or exceeded the Oxfordshire population norm (>=89.7) indicated that they preferred Traditional Chinese Medicine for some, most or all medical conditions. Amongst those with poor physical functioning scores (<=70), 83.7% (N=185) expressed a similar preference.

There was no significant difference in preference according to educational status. About three quarters (76.3%, N=429) of university graduates and post-graduate degree holders preferred Traditional Chinese Medicine for some, most or all of their medical conditions. Eight out of ten (81.9%, N=751) Chinese who were illiterate or had post-secondary, secondary or primary education expressed partial or total preference for Traditional Chinese Medicine. Seventy four point eight percent (N=327) of Chinese aged 35-64 who were registered with a GP [42] had visited their GP at least once in the previous year compared with 86.3% (N=1151) of the general Oxfordshire population aged 35-64.

40 Ong CK, et al. *Do factors which influence preference for Traditional Chinese Medicine (TCM) in the Oxfordshire Chinese community affect access to GP care?* Health Services Research Unit: University of Oxford, 2001b.

41 Petersen S, et al. 1998 Op cit.

42 Petersen S. et al. 1998 Op cit.

8 Expectation of CAM, outcomes and patient satisfaction

Overall patient satisfaction can be separated into patients' (or carers') hopes or expectations of a treatment, and the health outcomes (typically measured by the SF36 tool, SF12, or MYMOP). There are also observable and measurable economic outcomes. Decrease in the use of conventional medication is sometimes used as an outcome measure, as is the subsequent number of post CAM treatment visits to the GP.

Expectations

Expectations have a direct bearing on the nature and quality of the therapeutic relationship between therapist and patient. Much depends on whether the patients see themselves as being a part of the healing experience or whether they see themselves merely as consumers of healthcare expecting a cure. Richardson [43] reported that 60% (N=122) expected to have their symptoms controlled, while 26.4% (N=53) of respondents expected to be cured.

Patients in a number of studies had been to their GP before coming to the CAM practitioner. [44] The majority of patients appeared to expect a high level of improvement with CAM, but also accepted that their condition might need ongoing treatment in the future. Patients primarily wanted to prevent their condition from deteriorating further.They also wanted to arrive at a better understanding of their condition and the trigger factors that could have made them unwell. [45]

Expectations of the GP appear to be linked to future use of CAM. Hogan [46] used the Likeart scale to measure responses in her semi-qualitative study. High mean scores of 4.71 and 4.65 (out of 5) were registered for two statements respectively:

- The doctor will spend time listening to my concerns
- I expect the doctor to take a detailed history

Over two thirds of respondents felt that just a single visit to the doctor would suffice to help them overcome their medical conditions.Those who thought that their conditions would be helped with just a single visit said that they would consider CAM in the future. Respondents who anticipated more appointments over a longer period of time were unsure whether they would see a CAM practitioner in the future.

43 Richardson J. 1995. Op cit.

44 George, 1999; Bendle et al 2000 and Hogan 1999.

45 Hills D & Welford R. 1998. Op cit.

46 Hogan K. 1999. Op cit.

An evaluation of the Bristol Cancer Help Centre's support programme [47] used the Likeart scale to assess whether patients felt that their hopes were realised three weeks after their initial assessment stay.The majority of respondents felt that their hopes were realised by their stay at the centre and the treatment they had received. In the Glastonbury evaluation [48] over 85% of the patients treated were satisfied with their treatment and felt that their expectations were met.

Health outcomes: alleviation of primary and secondary symptoms

Where cancer and palliative care are concerned, expectations and satisfaction are not always linked to health outcomes; however, patients do report improvements with primary and secondary symptoms following use of CAM.

For example, in three hospice units in East Lancashire, palliative care patients were asked to complete a questionnaire following CAM treatments. [49] The majority of patients who received treatment with aromatherapy, reiki, reflexology, hypnotherapy, psychotherapy or neuro-linguistic programming reported some relief from their primary symptoms. In addition, there was relief from secondary symptoms such as insomnia, exhaustion and stress producing a feeling of enhanced well being. Other benefits included improvement of coping mechanisms, greater acceptance of end stage illness and increased self-esteem, important issues in palliative care. Overall, only a small number of patients felt that they had no symptom relief.

There is work in progress on a review of the use of CAM by people with dementia. Commissioned by the Mental Health Foundation, [50] it invited participation by carers, therapists and healthcare professionals. Qualitative data provided by the respondents suggest that complementary therapies may be effective in positively affecting the mood or behaviour of a person with dementia. It is reported that the patients frequently experienced enjoyment. It is uncertain, however, whether the benefits are derived from the therapy, the sustained communication or physical contact, or the relationship with the therapist.

Health outcomes and patient satisfaction were evaluated in a CAM outpatient service, [51] which reported the results pre and

47 Cooke H (2000). *Is the adapted Measure yourself medical outcome profile (MYMOP) questionnaire an appropriate tool to evaluate the Bristol Cancer Help Centre's supportive programme?.* MA dissertation in Complementary Health Studies: University of Exeter.

48 Hills D & Welford, R. 1998. Op cit.

49 Taylor EE and Hills HM. *Complementary therapies in palliative care.* East Lancashire Integrated Health Care Department: Rossendale, Lancashire 2000.

50 Wiles *A. Survey on complementary medicine use for treatment of dementia*. School of Healthcare: Oxford Brookes University 2001.

51 Richardson J. 1995. Op cit.

post treatment, using the SF-36, of a waiting list control group compared to a treatment group receiving CAM. At initial assessment, the two groups did not differ significantly in any of the SF-36 dimensions. After three months, the treatment group reported significantly higher scores in seven out of eight SF-36 dimensions compared with the control group. These improvements encompassed all areas of health including physical, mental health and social functioning. The control group displayed no improvement at initial assessment or during the three month follow-up. Ninety seven percent (N=73) of patients receiving treatment pronounced themselves satisfied or very satisfied with the CAM care that they had received.

Table ten SF-36 dimension scores. Improvements made by patients using CAM who had their medical condition for more than a year compared with patients who had their condition for less than a year. [52]

Dimensions on SF36 scale	Mean change for patients with a problem for a year or more	Mean change for patients with a problem for less than a year
Physical functioning	2.1	12.2***
Physical role performance	9.1	31.2**
Body pain	8.5	18.2**
General health	0.4	2.2
General vitality	1.6	8.2**
Social functioning	5.2	12.7*
Emotional role performance	7.7	3.3
Mental health	2.7	6.2*
Total questionnaires	88	63.0

*The difference between the two groups was significant at only .1
**The difference between the two groups was significant at .05
***The difference between the two groups was significant at .001

In the Glastonbury CAM service, patients who had experienced their condition for less than a year at the point of referral reported the highest levels of improvement compared with patients who had had their conditions for more than a year (Table ten).

Decrease in conventional medication

In the Somerset Health Authority [53] study, panel members felt that CAM provision might save money through potential

52 Hills D & Welford R. 1998 Op cit.

53 Somerset Health Authority 1999. Op. Cit.

reductions in pharmaceutical drug prescription and that appropriate referral to CAM practitioners could potentially reduce inefficient use of GP time, by using CAM to treat conditions that benefit poorly from conventional medicine.

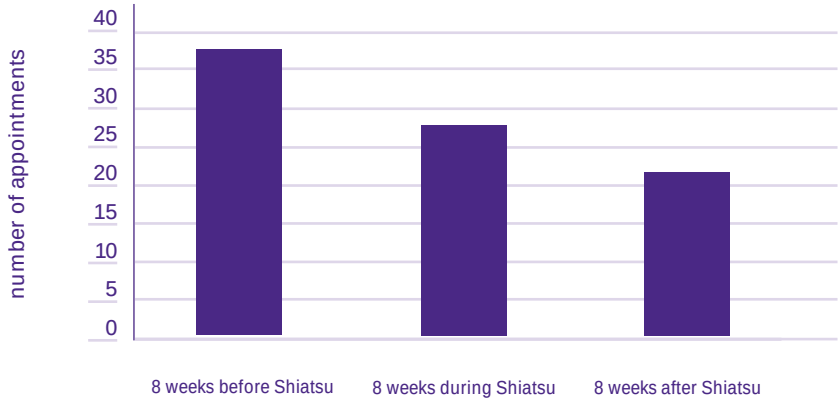
In a study on medical herbalism [54] relief from symptoms was monitored over 4 consecutive appointments and 10% (N=6) of patients reported a decreased intake of conventional medication. By comparison, in another study, [55] it was reported that during the course of treatment, 41% (N=12) indicated that they had reduced their dosage of conventional medication.

In a study of treatments provided at the Royal London Homoeopathic Hospital, [56] a decrease in medication level was also indicated. Of the 262 patients who said that they had been using conventional medication at the start of the survey, 29% (N=76) stopped all conventional medication after receiving treatment at the hospital and 32% (N=84) decreased their medication.

In the study by the Glasgow Homoeopathic Hospital, [57] 46% (N=35) of patients reported a decrease in their use of conventional medication and 72% (N=55) reported significant improvement to their state of overall well-being three months after discharge.

In interviews with ten female shiatsu patients, the numbers of consultations with their GPs fell post treatment [58] (Chart three).

Chart three Total number of GP consultations for ten patients at 8 weeks before, during and after shiatsu treatment (Pirie 2001)



54 Bendle C, et al. Foxhill Medical Herbalist Report. Foxhill Medical Centre: Sheffield 2000.

55 Stedman C. *Assessing herbal treatment within a primary care setting by means of a patient satisfaction survey.* Edmonton NHS Health Centre: London 1999.

56 Sharples F and Van Haselen R. *Patients' perspective on using a complementary medicine approach to their health: A survey at The Royal London Homoeopathic Hospital NHS Trust*. The Royal London Homoeopathic Hospital NHS Trust: London 1997.

57 International Data Collection Centres for Integrative Medicine. *A review of inpatient care integrating complementary and orthodox medicine at Glasgow Homoeopathic Hospital*. The Academic Departments: Glasgow Homoeopathic Hospital 1998.

58 Pirie Z. *Magic or medicine? Delivering shiatsu in general practice*. PhD thesis: Institute of General Practice and Primary Care, University of Sheffield 2001.

Outcomes and satisfaction with specific CAM interventions;

Herbal medicine

The results from Bendle et al, [59] showed that there was a reduction in primary symptoms between each subsequent appointment compared with the initial assessment visit ($p<0.02$). Well-being analyses also revealed significant improvements between the first appointment and all subsequent appointments ($p<0.001$). Stedman [60] found that 84% (N=36) of patients said that the symptoms related to their main health problem had improved following treatment. Seventy two percent (N=31) also felt that they had noticed improvements in their general health.

Osteopathy

Two hundred patients who had been seen at the British School of Osteopathy [61] were studied. One hundred of these had returned for subsequent treatment after an initial visit (Group 1) and 100 did not (Group 2). Ninety eight percent (N=98) of those who returned for further treatment indicated that they had enjoyed their experience at the school. Only 80% (N=80) of those patients who did not return for follow up treatment indicated satisfaction. The primary reason cited for satisfaction in Group 1 was relief of symptoms.

An audit of patient satisfaction with osteopathy in 1999 [62] found that 58% (N=607) of patients felt that their treatment had helped quite a lot, and 24% (N=251) felt that their osteopathy treatment had helped their condition completely.

MacTimoney Chiropractic

A 1997 survey of MacTimoney chiropractic [63] found that 85% (N=529) of patients felt that their treatment was "very beneficial", with 93% (N=605) saying they had recommended the therapy to family and friends post treatment.

Acupuncture

In a Dunfermline study of acupuncture provided within a GP setting, [64] 62% (N=38) of patients assessed their treatment as extremely helpful. Forty four percent (N=27) of patients reported that through acupuncture they had managed to stop conventional medication totally with an additional 16% (N=10) reporting that they had lowered their levels of medication.

59 Bendle C, et al. 2000. Op cit.

60 Stedman C. 1999. Op cit.

61 Alexander L. *Why patients don't come back*. BSc dissertation in Osteopathy: The British School of Osteopathy 2000.

62 Gilmour Piper and Associates. *Audit of patient satisfaction* (Osteopathy). Gilmour Piper and Associates: Ipswich 1999.

63 MacTimoney Chiropractic Association. *1997 client survey results*. MacTimoney Chiropractic Association: Oxford 1997.

64 Masson A. *New Park Medical Practice – Audit of acupuncture service*. New Park Medical Practice: Dunfermline 1999.

One hundred percent of the respondents indicated that they were satisfied with the service that was provided.

Shiatsu

In interviews with 10 post treatment patients, [65] respondents reported that shiatsu improved their health in a number of ways, physically and mentally. Physical changes included improved pain relief, better digestion, stronger immune system, and increased energy. Patients reported reduced stress, depression and anger; a greater sense of patient empowerment and new perceptions of health. These qualitative perceptions were borne out by analyses of the SF-12 physical and mental health scores which showed significant improvements post treatment and during follow up.

Aromatherapy

The aromatherapy in labour study [66] was set in the delivery suite of a women's centre. Satisfactory relief from symptoms of labour was very high. Effectiveness ratings showed that aromatherapy was most helpful in the transitional stage for most clients (88%, N=7040). In the group of women who used an aromatherapy oil for anxiety or fear, 50% (N=4000) (mean of primigravidas and multiparous statistics) found it helpful regardless of their method of labour onset. In the group of women who used the oil for pain, 59% (N=4720) found it helpful.

Negative outcomes and patient dissatisfaction

Patient expectations cannot always be met. Both Bendle et al [67] and George [68] revealed that some patients expected that the speed of recovery using CAM would be similar to that expected of conventional medicine. It is not always appropriate to expect CAM to work as quickly as conventional medicine.

In the British School of Osteopathy study, patients who did not enjoy their experience cited poor communication as a reason. Through qualitative interviews, group 2 (those who did not return after initial visit) expressed their unhappiness about undressing in front of strangers and discomfort with the length of time the physical examination took. In the 1999 osteopathy patient satisfaction survey, 1% (N=10) felt that the treatment had made their condition worse.

65 Pirie Z. 2001. Op cit.

66 Burns E, et al. 2000. Op cit.

67 Bendle et al. 2000. Op cit.

68 George J. 1999. Op cit.

In the Royal London Homoeopathic Hospital study, 4% (N=15) of respondents had to increase their medication.

Seven point six percent (N=45) of patients in the Glastonbury evaluation ceased treatment before the end of the course. This was due to:

- dislike of treatments
- they no longer needed treatment
- condition thought to have been exacerbated by treatment
- poor information given
- sessions were too rushed

In a survey of 541 patients at Guy's and St. Thomas' Hospital, Shaw (2001) found that 19% (N=102) of patients thought that even normal doses of herbal medicines and supplements might have harmful effects. Four percent (N=22) reported that they had direct experience of adverse side effects with CAM.

The Glastonbury evaluation found that it was the number and length of sessions that caused the most dissatisfaction. Sixty five percent (N=390) of patients felt that there were not enough sessions. Thirty three percent (N=198) felt that the sessions were not long enough and that they were just beginning to benefit when the sessions came to an end. They could have further sessions but that would mean going through the referral process again and they would be moved to the end of the waiting list. This often meant that there were months between each course of treatment.

George [69] mentioned that CAM therapists were concerned about integration into primary care services because this could subject them to the time constraints experienced by GPs.

69 George, J. 1999. Op cit.

9 Who influences the choice of CAM or recommends its use?

Who recommends/refers patients to CAM?

The majority of CAM referrals are patient initiated, with most studies indicating that GP initiation is less common. Positive experience of CAM therapies by family or close friends appears to be an important influence on the development of an individual's preference for CAM.

Patient initiated

The Glastonbury evaluation [70] found that the majority of referrals were made by patients asking for CAM treatment through their GP and Richardson [71] reported that 52% (N=105) of patients said that they themselves had suggested CAM to the GP. Seventy nine percent (N=385) of the Royal London Homoeopathic Hospital referrals were patient initiated with 6% coming from inter-hospital referrals

GP initiated

The Glastonbury evaluation found that 26% of patients were referred by their GP at the GP's own initiative. Sixty four percent (N=49) of the referrals to the Glasgow Homoeopathic Hospital [72] were also made by GPs. By contrast, the BBC Radio 5 Live study reported that 11% (27/245) of respondents said that they had been recommended or referred to CAM by their doctors while the Royal London Homoeopathic Hospital [73] survey found that 15% (N=73) of referrals were at the GP's suggestion. Richardson's study found that 25.4% (N=51) of patients said that the instigation had come from their GPs.

Influence of friends and family

Stedman's [74] study on medical herbalism found that the majority of patients (72%, N=31) would use or recommend CAM to friends and family. This was also found in the British Reflexology Association [75] audit, in which 54% (N=103) of the reflexology practitioners reported that clients came for treatment because of personal recommendations. Richardson also reported that family and friends were seen to have influenced 11.5% (N=23) of patients who utilised a Lewisham District General hospital CAM out-patient service.

70 Hills D & Welford R. 1998. Op cit.

71 Richardson J. 1995. Op cit.

72 International Data Centres for Integrative Medicine. 1998.

73 Sharples F and Van Haselen R. 1997. Op cit.

74 Stedman C. 1999. Op cit.

75 British Reflexology Association. *B.R.A. Structure and symptom Audit*. The British Reflexology Association: Worcester 1998.

Sutcliffe's [76] study found that 58% (N=36) of respondents had obtained information about osteopathy from friends or relatives who had experience of the therapy. Similarly a majority of patients in Grau's study, [77] (54.6% N=53) tried homeopathy after observing friends or family having successful homeopathic treatment.

Self-referral and the influence of advertising

Where patients may find information (other than from friends and family) that could lead to CAM use is an area which is little explored. Lane's study, [78] within the context of hypnotherapy, found that 45% of her referrals had self-referred after having followed up an advertisement in the newspaper (N=28) and an additional 16% (N=10) reported using the Yellow Pages.

Telling the GP about CAM use

Hogan [79] found that two thirds of her respondents (67%, N=11) stated that they did not discuss attendance at a complementary health centre with their GPs. George [80] also suggested that patients who use CAM may not inform their GP that they are doing so. None of her ten interviewees made any comments about discussing CAM use with their GPs. The public was also found to utilise over the counter medicines, presumably in combination with conventional treatments.

Over the counter: CAM and conventional medicine

Grau [81] found that as many as 59% (N=59) of patients had bought over the counter homeopathic products and Thomas et al [82] estimated that in 1998 in England, over the counter homeopathic and herbal remedies were purchased by 22.1% of the English public. Therefore, CAM users could be supplementing their conventional treatment with over the counter products.

The Scottish study by Featherstone et al [83] found that nearly one in two respondents (48.2%) using primary care services within the Grampian and Tayside region, had concurrently utilised CAM in the past month.

George [84] indicated that patients were pluralistic in their choice of healthcare, seeing the GP for acute conditions and CAM therapists for chronic ailments.

76 Sutcliffe M. *The lay person's concept of osteopathy*. Dissertation: The British School of Osteopathy, London 1991.

77 Grau M. *Satisfaction, perceived efficacy, emotional expressivity and emotion control of homeopathic patients*. MSc Psychology and Health dissertation: University of Stirling 1998.

78 Lane A. *A post consultation consumer satisfaction survey of a private hypnotherapy practice over a 12 month period*. Anna Lane Clinic: Stourbridge 2001.

79 Hogan K. 1999. Op cit.

80 George, J. 1999. Op cit.

81 Grau M. 1998. Op cit.

82 Thomas KJ, et al. 1999. Op cit.

83 Featherstone C, et al. 2000. Op cit.

84 George J 1999. Op cit.

The fact that CAM users are concurrently using over the counter CAM products with conventional medication is a cause for some concern. Adverse reactions due to the combination of over the counter CAM products and pharmaceutical products is an under researched area which, from a safety and efficacy viewpoint, should be given greater prominence.

Concurrent GP consultation/CAM use

The highest ratio found by this study was in a report from Scotland [85] where nearly one in two respondents had utilised CAM in the past month in 2000 (48.2%), and nearly one in two respondents had used conventional primary care services and CAM at the same time.

85 Featherstone C, et al. 2000. Op cit.

10 Discussion & conclusions

By asking seemingly simple questions about who uses CAM and why, The Prince of Wales's Foundation for Integrated Health has uncovered some essential issues about the nature of healthcare in the UK. The answers offer solutions to current healthcare delivery issues and suggest the direction for a new health service in the 21st century, focused on the needs of those consumers using a new model of integrated healthcare.

This study has confirmed a list of therapies commonly used in the UK. This list is only part of the picture, as many of these individually identified interventions are often parts of a greater whole, where the consumer combines nutritional approaches, homeopathic or herbal treatments, exercise and relaxation techniques in a holistic mix based on a mind, body, spirit model of health.

The studies reviewed in this report make some distinction between the use of CAM practitioners and over the counter sales of herbal and homeopathic remedies but studies have not yet included further distinctions between, for example, exercise or relaxation elements of interventions such as yoga, or tai-chi, which may be taught in groups, or practised at home, as part of an integrated therapeutic approach. To date there is no holistic measurement of how consumers integrate their health maintenance and care, although measures do exist for holistic practice. [86.] These holistic approaches are gradually being rediscovered in the UK, thanks in part to our cultural diversity and the greater popularity of holistic approaches such as traditional Chinese or Ayurvedic medicine.

As identified in this report, CAM is typically used for treating conditions lasting more than a year, which are poorly treated by conventional medicine. There are some indications that potentially chronic conditions could benefit from earlier CAM intervention, which has implications for earlier referral to these treatments. The list of conditions includes musculo-skeletal problems, back and neck pain, injuries, bowel problems, indigestion, stress, anxiety and depression, migraine and asthma. The increasing number of CAM users for chronic or multi-system conditions indicates that those most in need of health care are currently let down by the existing healthcare system when they need it most. These conditions are now readily identifiable; they drain the orthodox practitioner and may contribute to a breakdown in doctor patient relations unless steps are taken to work in a more integrated fashion.

86 Long AF, et al. Developing a tool to measure holistic practice: a missing dimension in outcomes measurement within complementary therapy. *Complementary Therapies in Medicine* 2000, 8 (1): 26-31.

These findings provide a useful focus for healthcare planning and provision. They help to prioritise CAM research in the short to medium-term into considerations of efficacy, health outcomes and economic implications. They focus on the impact on people affected by conditions, which if left to orthodox care only, might become debilitating and chronic. They have also been useful in identifying some of the negative issues experienced by a small minority of consumers. Failure to meet consumers' expectations of time spent with the CAM therapist, or rationing access to CAM have caused the greatest negative response.

The fact that wellbeing maintenance and relaxation figure prominently in the findings indicates that consumers are taking increased responsibility for their own health. This partnership approach could reduce the strain on hard-pressed GPs or hospital services. This model of health maintenance is also broadly consistent with that proposed in healthy living centres and it is notable that successful funding applications have included CAM sessions in their business plans. An evaluative study of the health and other outcomes from healthy living centres using CAM may provide one basis for future integration of CAM within the NHS.

For patients, all health improvements are to be welcomed: whether it is the CAM intervention, the therapeutic relationship, or the patient's own determination which delivers the health benefits. For a publicly-funded health service, however, the considerations are different. Those CAM interventions which demonstrate lasting health benefits for chronic conditions, offer improved choices in palliative care, or address the pressures on the existing public healthcare system should be prioritised.

This study highlights the fact that current CAM provision is predominantly within the private sector and, as such, currently benefits the more affluent sectors of society. This underlines the increasing gap in inequalities between those who can afford to pay for treatments or remedies and those who cannot. NHS funded services, such as the homeopathic hospitals or semi-autonomous services such as healthy living centres, offer a more equitable delivery model. Indications as to who uses CAM should also be tracked over time, both within healthy living centres and the wider NHS. As well as tracking outcomes for people affected by chronic conditions,

studies which identify whether the traditionally hard to reach groups are accessing CAM (men, the elderly and minority ethnic communities, for example) could be helpful. In addition, closer attention should be paid to extending consumer choice for the country's diverse ethnic minority communities for whom western medicine may not be the preferred first choice.

This report indicates that public opinion is behind the principle of delivering CAM services within the NHS framework, without dis-investment from current services. A different debate, for which this report shows further evidence, is in the area of diverting saved funds from one budget to another (virement), through savings gained, for example, in reduced use of drugs. This confirms the work of earlier studies into CAM use within the NHS. [87] In addition, there are wider economic outcomes and potential benefits to health service delivery through patients' freedom from unwanted side effects and reduced medication use. As well as creating a wider choice by using or referring to CAM services, the NHS has the potential to benefit from reduced repeat visits to GPs or fewer referrals for complex diagnostic tests or consultant appointments.

This study has been particularly useful in articulating the reasons why health consumers choose CAM. By beginning to appreciate these factors, consideration can be given to improvements in the way services are delivered, particularly in terms of the therapeutic relationship. In addition, there are positive benefits both to patients and to healthcare services in accepting that there is not a pill for every ill and that other options are available. The issue of unwanted side effects, which is not often debated publicly, is significant. This report highlights the link between side effects of treatment and patients turning towards CAM treatments. An important area of clinical research will be into understanding the typical interactions between, for example, prescription medicines and herbal or other remedies. This also impacts on the continuing professional development of doctors and pharmacists who need to be aware of the prescribing and safety implications.

This report indicates that being an active participant in their health care is also important to consumers. It is easy to understand why this may be, particularly for those affected by chronic conditions, where the need to regain some sense of

87 THe NHS Confederation. *Complementary medicine in the NHS: managing the issues*. Research paper no. 4, 1997.

control may be a priority and where the quality of care may be more important than the notion of cure. The understanding of patients' expectations by those involved in their care could enhance the quality of their experience and may help modify patient demands on the healthcare service. New research in this area includes an example of looking at both clients' and practitioners' perspectives of treatment experience and effect, with implications for practitioner education [88] and service delivery.

It is not only those with chronic conditions who are reporting benefits from CAM. [89] Studies indicate that people affected by life threatening illnesses are benefiting, both in their primary and secondary symptoms. Both of these client groups are particularly vulnerable to abuse from unethical sales techniques and products. This is an area where careful research, building on the existing evidence base, may validate reliable CAM approaches and promote access by patients and carers to credible information.

The use of the internet by healthcare consumers has now reached record levels. Many people with long term conditions are older people, who are making increasing use of the Internet. [90] For example, in October 2001 37% of people aged 55-64 and 11% of people aged 65 and over, had used the Internet. Ways should be found to direct consumers towards CAM information of high quality and validity, for example through a health portal on the net. Paternalistic approaches to healthcare, which do not give the patient or carer due respect for their intelligence or diligence in researching appropriate alternatives, should be a thing of the past.

Conclusions

The information gleaned from this study highlights the need for more research into working models of CAM delivery. The research undertaken should take account of the needs of the health service, and look at both health and economic outcomes, which in turn should help to develop CAM models that deliver timely, appropriate, services to patients. [91]

This report suggests a model for integrated healthcare which:

- Accepts responsibility on the part of the consumer for maintaining wellbeing and appropriate self-help, re-defining

88 Mackay H and Long AF. *The Experience and Effects of Shiatsu: Findings from a Two Country Exploratory Study*, Salford: University of Salford, Health Care Practice R&D Unit. (In press)

89 Taylor EE and Hills HM. *Complementary therapies in palliative care.* East Lancashire Integrated Health Care Department: Rossendale, Lancashire 2000.

90 *Use of the Internet by age and gender*, July 2001; www.statistics.gov.uk.

91 Long AF and Mercer G. *Reviewing the State of the Evidence on Efficacy and Effectiveness of Complementary Therapies*, Leeds, University of Leeds, Nuffield Institute for Health, Yorkshire Collaborating Centre for Health Services Research 1995.

the public health service purpose to include an informing and enabling role

- Places a high value on the role of the healthcare practitioner, as a diagnostician, advisor and referrer to appropriate therapeutic techniques whether orthodox or CAM
- Recognises the consumer as a valued partner in the therapeutic relationship and as someone with informed choice and control over their treatment options

The relationship between the GP and patient is highlighted by this study and the opportunity exists both to free up GP time and to improve doctor patient relationships through the use of appropriate CAM treatments.There appears to be a potential for economic benefits in using CAM but rather than suggest that the economic savings identified should be used to improve GP efficiency for example, it may be that appointment time saved could be spent with other patients, thereby improving the overall quality of the therapeutic relationships.

For this to be achieved, there needs to be greater respect for and confidence in integrated healthcare:

- For the evidence being presented for different models of integrated healthcare
- For the specific benefits of CAM approaches to potentially chronic conditions
- For the responsible consumer working with their GP to appraise alternatives

Continued and improved research evidence on CAM will go some way to eliciting this respect from clinicians. The indications that consumers are willing to take greater responsibility for their health and that they do appreciate the cost/benefit arguments should inspire healthcare managers with confidence. When this happens, we can be sure (to paraphrase Rees and Weil [92]) that "The integrated medicine of today will be the medicine of the new millennium."

92 Rees L, and Weil A. *Integrated Medicine*, BMJ 2001, 322 (7279): 119-120.

11 References

Alexander L. *Why patients don't come back*. BSc dissertation in Osteopathy: The British School of Osteopathy 2000.

Bendle C, Fitter M, Nohr K. *Foxhill Medical Herbalist Report*. Foxhill Medical Centre: Sheffield 2000.

British Reflexology Association. *B.R.A. Structure and symptom audit*. The British Reflexology Association: Worcester 1998.

Buck G and Banks B. *A study of the use of an in-house complementary medicine service by staff in a Lancashire hospital*. GB Holistic Clinic: Lancashire 2001.

Burns E, Blamey C, Ersser SJ, Lloyd AJ, Barnetson L. *The use of aromatherapy in intrapartum midwifery practice: An evaluative study*. Oxford Centre for Health Care Research and Development: Oxford Brookes University 2000.

Coe N and Pearson V. *Complementary therapy in primary care in Somerset: Access to services and public perceptions*. Directorate of Public Health and Strategy: Somerset Health Authority 1999.

Cooke H. *Is the adapted "Measure yourself medical outcome profile" (MYMOP) questionnaire an appropriate tool to evaluate the Bristol Cancer Help Centre's supportive programme?* MA dissertation in Complementary Health Studies: University of Exeter 2000.

Ernst E, White, A. The BBC survey of complementary medicine use in the UK. *Complementary Therapies in Medicine* 2000, 8: 32-36. (Data provided by ICM Research Ltd)

Featherstone C, Godden D, Gault C, Emslie M, Took-Zozaya M. *Concurrent use of CAM and primary care services in Tayside and Grampian*. Highlands and Islands Research Network: Scotland 2000.

Fulder S and Monro R. *The status of complementary medicine in the United Kingdom*. Threshold Foundation: London 1981.

George J. *Why do people use complementary medicine? A study of users of a homeopathic clinic*. Masters in Sociology and Social Policy dissertation: University of Durham 1999.

Gilmour Piper and Associates. *Audit of patient satisfaction (osteopathy)*. Gilmour Piper and Associates: Ipswich 1999.

Grau M. *Satisfaction, perceived efficacy, emotional expressivity and emotion control of homeopathic patients*. MSc Psychology and Health dissertation: University of Stirling 1998.

Hills D, and Welford R. *Complementary Therapy in General Practice*. Somerset Trust for Integrated Healthcare 1998. Website: http://www.integratedhealth.org.uk/home.html.

Hogan K. *Reasons for choosing complementary medicines over orthodox medicine*. BSc dissertation in Physiotherapy: University of Southampton 1999.

Hotchkiss J. *Liverpool Centre for Health: The first year of a service offering CAM on the NHS*. Observatory report series no.25: Liverpool Public Health Observatory 1995.

International Data Collection Centres for Integrative Medicine. *A review of inpatient care integrating complementary and orthodox medicine at Glasgow Homoeopathic Hospital*. The Academic Departments: Glasgow Homoeopathic Hospital 1998.

Lane A. *A post consultation consumer satisfaction survey of a private hypnotherapy practice over a 12 month period*. Anna Lane Clinic: Stourbridge 2001.

Lazarou J, Pomeranz BH, Corey PN. Incidence of adverse drug reactions in hospitalised patients: a meta-analysis of prospective studies. *JAMA* 1998, 279:1200-5.

Long AF, Mercer G and Hughes K. Developing a tool to measure holistic practice: a missing dimension in outcomes measurement within complementary therapy. *Complementary Therapies in Medicine* 2000, 8 (1): 26-31.

Long AF and Mercer G. *Reviewing the State of the Evidence on Efficacy and Effectiveness of Complementary Therapies*, Leeds, University of Leeds, Nuffield Institute for Health, Yorkshire Collaborating Centre for Health Services Research 1995.

Mackay H and Long AF. *The Experience and Effects of Shiatsu: Findings from a Two Country Exploratory Study*, *Salford*: University of Salford, Health Care Practice R&D Unit (in press).

MacTimoney Chiropractic Association. *1997 client survey results*. MacTimoney Chiropractic Association: Oxford 1997.

Masson A. *New Park Medical Practice – Audit of acupuncture service*. New Park Medical Practice: Dunfermline 1999.

Meredith W. *Public Participation in Health Service Priority Setting: A study in South Cheshire*. Master of Public Health Dissertation: University of Liverpool 1995.

NHS Confederation (The). *Complementary medicine in the NHS: managing the issues.* Research paper no.4, 1997.

Ong CK, Petersen S, Stewart-Brown S, Doll H, Bodeker GC. Use of Complementary and Alternative Medical Services in England: A Population Survey of Four Counties. *American Journal of Public Health*. 2002, 92:1653-1656.

Ong CK, Petersen S, Stewart-Brown S, Doll H, Barlow J, Bodeker GC. *Using of Complementary and Alternative Medicine (CAM) in England: Lifestyle, gender and their impact on CAM use*. Health Services Research Unit: University of Oxford 2001a.

Ong CK, Patterson J, Doll H, Stewart-Brown S, Bodeker GC, Griffiths S. *Do factors which influence preference for Traditional Chinese Medicine (TCM) in the Oxfordshire Chinese community affect access to GP care?* Health Services Research Unit: University of Oxford 2001b.

Office of National Statistics. *Population Trends (98), Report: Mid-1998 Population estimates*. http://www.statistics.gov.uk. Office of National Statistics: London 1998.

Office of National Statistics. *Use of the Internet by age and gender*, www.statistics.gov.uk Office of National Statistics:London July 2001.

Petersen S, Stewart-Brown S and Peto V. *Health and lifestyles in four counties: Results from the third Oxford Healthy Lifestyle survey*. Health Services Research Unit: Oxford 1998

Pirie Z. *Magic or medicine? Delivering shiatsu in general practice*. PhD thesis: Institute of General Practice and Primary Care, University of Sheffield 2001.

Rees L and Weil A. Integrated Medicine. *BMJ* 2001, 322 (7279): 119-120

Richardson J. *Complementary therapy in the NHS: A service evaluation of the first year of an outpatient service in a local district hospital*. Health Services Research and Evaluation Unit:The Lewisham Hospital NHSTrust 1995.

Sharples F and Van Haselen R. *Patients' perspective on using a complementary medicine approach to their health: A survey at The Royal London Homoeopathic Hospital NHS Trust*.The Royal London Homoeopathic Hospital NHSTrust: London 1997.

Shaw D. *A survey of herbal and nutritional supplement use among patients at Guy's and St Thomas's Hospital*. Toxicology Unit: Guy's and StThomas' Hospital, London 2001.

Stedman C. *Assessing herbal treatment within a primary care setting by means of a patient satisfaction survey*. Edmonton NHS Health Centre: London 1999.

Sutcliffe M. *The lay person's concept of osteopathy*. Dissertation:The British School of Osteopathy, London 1991.

Taylor EE and Hills HM. *Complementary therapies in palliative care*. East Lancashire Integrated Health Care Department: Rossendale, Lancashire 2000.

Thomas KJ, Nicholl JP, Coleman P. Use and expenditure on complementary medicine in England: a population based survey. *Complementary Therapies in Medicine* 2001 9, 2-11.

Tischler V. *Who uses CAM and why? Study of users at Birmingham*. Masters of Social Science dissertation: University of Birmingham 1998.

Wadsworth R. *Commissioning complementary medicine. Quality in complementary medicine: A meeting of the forum on quality in health care of the Royal Society of Medicine*. Royal Society of Medicine: London 1998.

Ward K. *A survey of the use of therapies in primary and secondary care settings in Southern Derbyshire*. South Derbyshire Health Authority 1996.

Wiles A. *Survey on complementary medicine use for treatment of dementia.* School of Healthcare: Oxford Brookes University 2001.

Index

Key to abbreviations

CAM = complementary and alternative medicine
ME = Myalgic Encephalomyelitis
TCM = traditional Chinese medicine

Numbers in bold indicate tables or charts

The Prince of Wales's Foundation for Integrated Health
Occasional Papers No. 2

Complementary and Alternative Medicine: the consumer perspective

Report of a pilot study into consumer use and preference for complementary and alternative medicine for The Prince of Wales's Foundation for Integrated Health

This report looks at a range of published and unpublished research into why and how people are using complementary medicine, throwing light on what patients want from a healthcare system. For service providers already integrating, or planning to integrate, complementary medicine practice into their services this report indicates ways in which outcomes might be measured and patient satisfaction monitored. It also suggests areas for improvement in the delivery of both conventional and complementary healthcare practice.

This publication will be of particular interest to healthcare professionals, students, researchers and academics interested in complementary and alternative medicine.

"I welcome the publication of this report, which I believe is very significant…. I am sure it will prove useful to healthcare practitioners of all disciplines and to those given responsibility for managing or improving our healthcare systems."

Professor David Peters, School of Integrated Health, University of Westminster.

The Prince of Wales's Foundation for Integrated Health aims to promote the development and integrated delivery of safe, effective and efficient forms of healthcare, including orthodox and complementary medicine, to patients and their families through encouraging greater collaboration between all healthcare practitioners.

The Prince of Wales's Foundation
for Integrated Health

ISBN 0 9539453 2 4

£3.99