Two-Thirds of Survey Respondents in Southern Sweden Used Complementary or Alternative Medicine in 2015

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Summary

Background: Research has long suggested that a large and possibly growing number of people use complementary or alternative medicine (CAM). However, in many countries, such as Sweden, national and regional research on CAM use is still very limited. Existing prevalence studies are few and characterized by low comparability. This study aims to contribute towards addressing this knowledge gap. **Methods:** A web-based survey measured the use of and attitude towards CAM and conventional medicine in the southernmost Swedish province of Scania, while taking part in the development of a measurement tool for the standardized study of CAM use within the European Union (EU; I-CAM-Q). **Results:** 71% of the respondents (n = 1,534) reported having used some form of CAM in the past year. CAM consumption here includes visits to CAM providers, use of natural remedies, and use of self-help methods. Reported use was more common among women, younger age groups, and people with tertiary education. 69% of the respondents stated that collaboration between conventional medicine and complementary medicine should increase. The survey's response rate was 31%. **Conclusions:** The study confirms that CAM forms a considerable part of the health care offered to and used by the population. In the face of the existing lack of national and regional data on CAM usage, it affirms the importance of furthered investigation of CAM consumption, policy, practice, regulation, and education.

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Schlüsselwörter

Komplementär- und Alternativmedizin · CAM ·
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Zusammenfassung

Hintergrund: In der wissenschaftlichen Forschung gibt es schon länger Hinweise darauf, dass eine große und wahrscheinlich wachsende Anzahl von Leuten die Angebote der Komplementär- oder Alternativmedizin (CAM) in Anspruch nimmt. In vielen Ländern, wie z.B. Schweden, ist die nationale und regionale Forschungslage zur CAM-Nutzung jedoch immer noch sehr begrenzt. Existierende Studien zur Prävalenz sind rar und zeichnen sich durch eine geringe Vergleichbarkeit aus. Diese Studie soll dazu beitragen, diese Wissenslücke zu schließen. **Methoden:** Eine Internet-basierte Umfrage ermittelte die Nutzung von und die Einstellung zu CAM sowie konventioneller Medizin in Skåne, der südlichsten Provinz Schwedens. Sie trug gleichzeitig dazu bei, ein Messwerkzeug (I-CAM-Q) zur standardisierten Untersuchung der CAM-Nutzung innerhalb der Europäischen Union (EU) zu entwickeln. **Ergebnisse:** 71% der Antwortenden (n = 1534) berichteten, dass sie innerhalb des vergangenen Jahres CAM in irgendeiner Form genutzt hätten. CAM-Nutzung umfasst hier Besuche bei CAM-Anbietern, die Anwendung von Naturheilmitteln und den Gebrauch von Selbsthilfemethoden. Berichte von CAM-Nutzung waren üblicher bei Frauen, Gruppen jüngerer Alters oder Menschen mit Universitätsausbildung. 69% der Teilnehmer sagten aus, dass die Zusammenarbeit zwischen der konventionellen und der Komplementärmedizin verstärkt werden sollte. Die Rücklaufquote der Umfrage betrug 31%. **Schlussfolgerungen:** Die Studie bestätigt, dass die CAM einen beträchtlichen Anteil an der angebotenen und von der Bevölkerung genutzten Gesundheitsversorgung ausmacht. Angesichts des bestehenden Mangels an nationalen und regionalen Daten zur CAM-Nutzung bestätigt sie außerdem die Wichtigkeit der weitergehenden Erforschung der CAM-Inanspruchnahme, -Grundsätze, -Praktiken, -Vorschriften und -Ausbildung.

Introduction

Many research results suggest that a large and possibly growing number of people today use complementary or alternative medicine (CAM). However, in many countries, such as Sweden, national and regional research on CAM use is still very limited. Existing prevalence studies are few, far between, and characterized by low comparability. This study aims to contribute towards addressing this knowledge gap, by measuring the use of and attitude towards CAM in the Swedish province of Scania, while taking part in the development of a survey tool for standardized measurement of CAM use within the European Union (EU; International CAM Questionnaire (I-CAM-Q)) [1].

According to the US National Institutes of Health (NIH), CAM is 'a group of diverse medical and health care systems, practices, and products that are not presently considered to be part of conventional medicine' [2]. Complementary medicine refers to therapy used in combination with conventional medicine, while alternative medicine is a term for medicine used instead of it. The NIH divide CAM into 5 groups [2]: alternative medical systems (e.g., homeopathy, Chinese medicine, and Ayurvedic medicine), mind-body interventions (e.g., meditation, mental training, and art therapy), biologically based therapies (e.g., herbs and nutritional supplements), manipulation therapies (e.g., chiropractic and massage), and energy therapies (e.g., healing).

Previous CAM prevalence research [3–5], e.g., from the USA [6], Great Britain [7], Canada [8] and Australia [9], suggests that a large part of the studied populations make use of CAM, which has been said to be subject to 'exponential growth' around the world [10]. A range of studies has found high rates of CAM use in various population groups [11–13], and among people with diverse diseases such as cancer [14, 15], cardiovascular disease [16], asthma [17], and others [18–20]. Studies have also looked at reasons for, or factors associated with, the use of CAM [21–24]. Scandinavian research [25, 26] includes a study estimating, in 2005, that 45% of the Danish population and 34% of the Norwegian population had used CAM [27].

In Sweden, analogous studies are few. An investigation made in the 1980s [28] found that 22% of the population had used CAM, while 40% were open to trying CAM in the future. Scania (previously Malmöhus), the southernmost region of the country, was the area where CAM usage was at its lowest (14%). According to a 2001 study measuring CAM use among inhabitants of Stockholm [29], 49% of the population had used CAM in the previous year. Alongside these more overarching prevalence studies, research has looked at the use of nutritional supplements, herbal medicine, and/or natural remedies [30–32], patient groups with certain diseases [33–35], and CAM use in a small municipality [36]. In all, despite research made, up-to-date and adequate knowledge of CAM use in Sweden, as in other countries, is lacking. This is due not only to a paucity of large studies but also to high levels of incertitude and low comparability of the existing studies [5, 37]. Studies differ, e.g., regarding the definitions of CAM and the included study populations and time frames [38, 39]. Questions of how prevalent CAM consumption is and of how it is distributed between population groups are thereby largely left unanswered [40].

Material and Methods

The present survey study was conducted in collaboration with the market research company TNS Sifo (www.tns-sifo.se), between January 22 and February 4, 2016. The questionnaire was completed by 1,534 adults (18–79 years) living in the region of Scania, the inhabitants of which (1.25 million) make up 13% of Sweden's total population.

Respondents were randomly selected from TNS Sifo's web panel, which consists of around 120,000 people recruited through previous survey studies. The web panel is representative, with regard to categories of age and gender, of the part of the Swedish population that has regular access to the Internet. Population groups with lower income and shorter education are somewhat under-represented. For the present study, the sample was non-proportional in order to cover the population according to age and gender, and to compensate for lower response rates among younger respondents, and it was shown to be sufficiently representative of the population regarding those categories of gender and age. Each person could only respond once, and only surveys fully completed were included in the data.

The overall response rate was 31%. Web panel surveys run by TNS Sifo have an average response rate of around 40%, and the lower rate in this case is likely due to the relatively large number of questions included in the survey. The response rate was higher in the older age groups than in the younger ones (48% for age 65–79 years, 35% for age 30–49 years, 20% for age 18–29 years, and 19% for age 18–29 years). This uneven distribution was, as mentioned, compensated for by allocation of a larger number of surveys to respondents of younger age.

The questionnaire was based on the model I-CAM-Q [1], which has been developed by an international expert group, on the initiative of the National Research Center in Complementary and Alternative Medicine (NAFKAM) in Norway, with the aim of functioning as a standardized measurement instrument for the study of CAM prevalence in the EU. The questionnaire includes questions about visits to CAM providers, reception of complementary treatment in or through conventional health care, use of natural remedies like nutritional supplements and herbal medicine, and use of self-help practices such as yoga or relaxation exercises, in the last 12 months. This survey model has been adapted, validated and used in a selection of European countries [38, 39, 41].

The I-CAM-Q was adapted to Swedish conditions, e.g., through adjustment of the complementary treatments available within conventional health care or through referral. It was also modified according to experiences and critiques of previous users [38, 39], through simplification of the survey layout, reduction of some questions (primarily regarding the regularity of CAM use), and the addition of questions on the use of conventional medicine. The latter was done to increase the face validity among non-CAM users and to enable comparison between types of health care consumption. In addition, background questions regarding demographic variables and health condition and questions regarding the attitude towards CAM and conventional medicine were added. Most of these questions had been validated and used in the Public Health Survey of the Region Skåne [42] or in a previous study of CAM use in Stockholm [29].

The parts of the questionnaire adapted from the I-CAM-Q format were translated into Swedish by a professional translator, and the developed version was assessed by 4 experts in the field. An initial pilot study, including open questions about the types of CAM used and queries on the clarity of the questionnaire, was sent via e-mail to 100 randomly selected students at Lund University. The validation process was based on the description of appropriate measures in translation, adaptation, and validation of surveys on health by Sousa and Rojjanasirrat [43].

The respondents received e-mails including a brief introductory text about the survey and a reference to more information on a website belonging to the Unit of Social Epidemiology, Lund University, together with a personal link to the survey. Respondents then completed the survey via computer or mobile phone. In questions about the types of health care use, the order of response options was randomized to avoid any skewing of the results due to the sequence of alternatives.

After completion, TNS Sifo delivered the anonymized raw data to the research group. We performed the statistical analyses using SPSS Version 22.0

Table 1. Types of CAM use

	Total (n = 1,534)	Women (n = 767)	Men (n = 765)
Total CAM	71.0% (1,089)	78.1% (599)	63.9% (489)
Visits to CAM providers	32.9% (505)	36.9% (283)	28.9% (221)
Use of natural remedies	53.0% (813)	58.9% (452)	47.1% (360)
Use of self-help methods	31.7% (486)	42.8% (328)	20.5% (157)
Total CAM excluding nutritional supplements	60.6% (930)	69.5% (533)	51.8% (396)

Table 2. Types of CAM use: subcategories

CAM providers	Total (n = 505) ^a	Women (n = 283)	Men (n = 221)
Massage	52.5% (265)	52.7% (149)	52.0% (115)
Chiropractic	17.0% (86)	14.5% (41)	20.4% (45)
Naprapathy	11.3% (57)	11.0% (31)	11.8% (26)
Osteopathy	1.8% (9)	1.4% (4)	2.3% (5)
Acupuncture	5.5% (28)	6.0% (17)	5.0% (11)
Homeopathy	1.2% (6)	0.7% (2)	1.8% (4)
Reflexology	1.6% (8)	1.4% (4)	1.8% (4)
Healing	2.6% (13)	3.9% (11)	0.9% (2)
Other	6.5% (33)	8.5% (24)	4.1% (9)
Natural remedies	Total (n = 813) ^b	Women (n = 452)	Men (n = 360)
Nutritional supplements	68.5% (557)	67.5% (305)	69.7% (251)
Herbal medicine	25.3% (206)	26.1% (118)	24.4% (88)
Other remedies	6.2% (50)	6.4% (29)	5.8% (21)
Self-help practices	Total (n = 485) ^c	Women (n = 328)	Men (n = 157)
Meditation	3.9% (19)	1.8% (6)	8.3% (13)
Yoga	20.2% (98)	23.2% (76)	13.4% (21)
QiGong/TaiQi	1.6% (8)	2.4% (8)	0% (0)
Relaxation	16.5% (80)	14.3% (47)	21.0% (33)
Breathing	26.3% (128)	29.0% (95)	21.0% (33)
Visualization	7.8% (38)	6.7% (22)	10.2% (16)
Prayer	7.6% (37)	6.7% (22)	9.6% (15)
Other	16.0% (78)	15.9% (52)	16.6% (26)

^aRespondents who report visits to CAM providers, i.e., 33% of the study population.
^bRespondents who report use of natural remedies, i.e., 53% of the study population.
^cRespondents who report use of self-help practice, i.e., 32% of the study population.

(SPSS Inc., Chicago, IL, USA). We performed simple descriptive statistics, as well as multiple logistic regressions modeling the use of CAM versus conventional medicine as a function of several predictors to estimate the odds ratios (ORs) and 95% confidence intervals (95% CIs). The results were not weighted.

The study has been approved by the Regional Board of Ethics (Dnr 2015/289). It is to be regarded as a pilot study, aimed towards possible future Regional Council (Region Skåne) surveys.

Results

Use of CAM

In total, 71% of the respondents (78% of the women, 64% of the men) reported having used some form of CAM in the last year. Total CAM use here includes visits to CAM providers, use of natural remedies such as nutritional supplements or herbal medicine, and use of self-help methods like yoga and breathing exercises (table 1). This category of total CAM use does not include comple-

mentary forms of treatment given within conventional health care or through referral.

The most common types of CAM, reportedly used in the last year by 53% of the population sample, were natural remedies including herbal medicines and nutritional supplements. When nutritional supplements (like vitamins, minerals, and oils) were excluded from the total CAM use, the user percentage decreased from 71% to 61% (70% among the women, 52% among the men).

CAM providers had been consulted by 33% of the respondents (37% of the women, 29% of the men) (table 2). The large majority (53% of the mentioned 33%) of treatments consisted of massage, followed by chiropractic (17%), naprapathy (11%), acupuncture (6%), healing (3%), osteopathy (2%), reflexology (2%), homeopathy (1%), and other (7%). Massage was used frequently by both men (52%) and women (53%). More men visited chiropractors, while a larger share of women turned to healing and methods categorized as 'other'.

Table 3. Description of CAM and conventional health care users: gender, age, education, social status, and civil status

	CAM total ^a	MED total ^b	CAM only ^c	MED only ^d	CAM + MED ^e	No usage ^f
Total (n = 1,534)	71.0% (1,089)	97.5% (1,495)	1.4% (21)	27.8% (427)	69.6% (1,068)	1.2% (18)
Women	55.0% (599)	50.3% (751)	42.9% (9)	37.8% (161)	55.3% (590)	38.9% (7)
Men	44.9% (489)	49.7% (742)	57.1% (12)	62.2% (265)	44.7% (477)	61.1% (11)
Age 18–39 years	33.3% (363)	30.0% (448)	38.1% (8)	21.8% (93)	33.2% (355)	33.3% (6)
Age 40–64 years	51.3% (559)	51.0% (763)	52.4% (11)	50.4% (215)	51.3% (548)	53.0% (9)
Age 65–79 years	15.3% (167)	19.0% (284)	9.5% (2)	27.9% (119)	15.4% (165)	16.7% (3)
Basic education	5.5% (60)	6.5% (97)	9.5% (2)	9.1% (39)	5.4% (58)	25.0% (4)
Secondary education	33.3% (363)	34.4% (515)	42.9% (9)	37.7% (161)	33.1% (354)	43.8% (7)
Tertiary education	61.2% (666)	59.1% (883)	47.6% (10)	33.1% (354)	61.4% (656)	31.3% (5)
Low social status	35.3% (384)	8.5% (127)	14.3% (3)	9.8% (42)	8.0% (85)	0% (0)
Medium social status	48.3% (526)	75.0% (1,121)	72.2% (16)	73.8% (315)	75.5% (806)	66.7% (12)
High social status	15.5% (169)	15.4% (230)	9.5% (2)	14.8% (63)	15.6% (167)	33.3% (5)
Cohabiting	67.7% (737)	70.1% (1,030)	52.4% (11)	71.6% (303)	69.4% (727)	66.7% (10)
Living alone	30.4% (331)	29.9% (440)	47.6% (10)	28.4% (120)	30.6% (320)	33.3% (5)

^aRespondents reporting visits to CAM providers, use of natural remedies, and/or use of self-help methods.

^bRespondents reporting visits to conventional health care providers and/or use of pharmaceutical drugs.

^cRespondents reporting use of CAM (visits to CAM providers, use of natural remedies, and/or use of self-help methods) and no use of conventional medicine.

^dRespondents reporting use of conventional health care (visits to conventional health care providers and/or use of pharmaceutical drugs) and no use of CAM.

^eRespondents reporting use of CAM and conventional medicine.

^fRespondents reporting no use of CAM or conventional medicine.

Natural remedies, herbal medicines, or nutritional supplements were, as mentioned, used by 53% of the respondents (59% of the women, 47% of the men) (table 2). 69% of this consumption referred to nutritional supplements, while herbal medicine accounted for 25%, and other natural remedies for 6%.

Self-help methods were used by 32% of the respondents (43% of the women, 21% of the men) (table 2). Breathing exercises (26%), yoga (20%), and relaxation exercises (17%) were most common. More men used meditation, while yoga was more frequently practiced among women.

A majority of the survey respondents (70%) reported the use of both CAM and conventional medicine. Only 1.4% of the population sample reported the sole use of CAM.

Use of Conventional Medicine

Conventional medicine, reportedly used by 98% of the respondents (98% of the women, 97% of the men), here includes visits to conventional health care providers and the use of pharmaceutical drugs.

Of the respondents, 88% (90% of the women, 86% of the men) had seen a conventional health care provider in the last year. These include medical doctors, nurses, physiotherapists, psychologists, psychoanalysts, and dentists. Dentists were the most commonly visited type of providers. If this often routinely consulted provider is excluded, the level of use decreased to 31% (32% among the women, 29% among the men).

Pharmaceutical drugs were used by 91% of the population (94% of the women, 89% of the men) in the last year.

While 70% of the respondents, as mentioned in 'Use of CAM', reported the use of conventional medicine and CAM, 28% said they had used only conventional medicine.

Complementary Treatment Received within or via Conventional Health Care

A share of 8% of the respondents (10% of the women, 6% of the men) reported having received some form of complementary treatment within a conventional health care setting or through referral. Types of treatment included acupuncture (22%), massage (21%), mindfulness (15%), chiropractic (5%), naprapathy (4%), natural remedies (2%), and others (32%). More women than men received acupuncture, while more men had treatment categorized as 'other'.

The relatively large share of reported treatments defined as 'other' suggests that the questionnaire, despite the validation process, did not cover the full range of complementary treatments available within conventional health care or through referral.

Gender, Age, Education, Income, and Social Status

The survey posed questions about the level of education, the self-rated social status [44], and the civil status of the respondents (table 3). Information on age and gender was gathered from the respondents' background data. The level of education was categorized as basic, secondary, or tertiary, while in the analysis it was dichotomized as tertiary or not. The civil status was, in the analysis, dichotomized as cohabiting or living alone. The social status was self-rated along a range from 1 to 10, which in the analysis was divided into 3 levels: low (1–3), medium (4–7), and high (8–10).

Table 4. Associations between CAM and conventional health care use and gender, age, education, social status, and civil status, expressed in odds ratios (ORs) and 95% confidence intervals (CIs)

	CAM (total) ^a		MED (total) ^b	
	OR	95% CI	OR	95% CI
Women ^c	1.87	(1.48–2.37)	1.49	(0.74–3.00)
Medium age ^d	2.33	(1.66–3.26)	0.52	(0.16–1.66)
Young age ^e	1.68	(1.26–2.25)	0.54	(0.18–1.62)
Tertiary education	1.29	(1.01–1.65)	2.00	(0.98–4.10)
High social status	1.03	(0.96–1.11)	0.94	(0.76–1.17)
Living alone	0.95	(0.73–1.24)	1.95	(0.96–3.93)

^aRespondents reporting visits to CAM providers, use of natural remedies and/or use of self-help methods.
^bRespondents reporting visits to conventional health care providers and/or use of pharmaceutical drugs.
^cCategories statistically associated with health care use are presented in italics.
^dAge 40–64 years, compared to 65–79 years.
^eAge 18–39 years, compared to 65–79 years.

Table 5. Associations between CAM and conventional health care use and health condition, expressed in odds ratios (ORs) and 95% confidence intervals (CIs)

	CAM (total) ^a		MED (total) ^b	
	OR	95% CI	OR	95% CI
Bad self-rated health	1.10	(0.86–1.41)	0.90	(0.39–2.08)
Long-term health problem ^c	1.35	(1.05–1.73)	7.26	(2.12–24.86)
High level of stress	1.64	(1.16–2.32)	1.87	(0.56–6.27)
Regular exercise	1.61	(1.28–2.02)	1.03	(0.52–2.04)
Following a diet	1.67	(1.18–2.34)	0.56	(0.25–1.26)

^aRespondents reporting visits to CAM providers, use of natural remedies, and/or use of self-help methods.
^bRespondents reporting visits to conventional health care providers and/or use of pharmaceutical drugs.
^cCategories statistically associated with health care use are presented in italics.

Logistic regression showed a higher prevalence of CAM use among women (OR = 1.87, 95% CI 1.48–2.37), younger age groups (18–39 years and 40–64 years) (OR = 2.33, 95% CI 1.66–3.26 and OR = 1.68, 95% CI 1.26–2.25), and people with tertiary education (OR = 1.29, 95% CI 1.01–1.65). No statistically significant association was found between CAM use and categories of social or civil status. The references used in the regressions were males, belonging to the oldest age group (65–75 years), living alone, with less than tertiary education, and low social status, respectively (table 4).

The corresponding analysis of conventional medicine use showed no clear association with any of the mentioned factors (table 4).

This analysis does not include users of complementary medicine in conventional health care settings or through referral.

Health Status

Respondents were asked about their self-rated health, any long-term health problems or injuries, experiences of everyday stress, exercise habits, and their following of any particular diet. The questions on long-term health problems and diet were of yes/no character. The others were multiple choice questions, responses to which were later dichotomized into yes/no or good/bad.

CAM consumption was associated with high levels of experienced stress (OR = 1.64, 95% CI 1.16–2.32) and long-term health problems (OR = 1.35, 95% CI 1.05–1.73), but not with bad self-rated health. Associations were also found with good exercise habits (OR = 1.61, 95% CI 1.28–2.02) and the following of particular

diets (OR = 1.67, 95% CI 1.18–2.34). The references used in the regressions were persons with good self-rated health and no long-term health problems who experienced lower levels of stress, exercised less and did not follow a particular diet, respectively. The association between CAM use and exercise and adherence to particular diets may suggest that CAM consumption correlates with an interest in lifestyle issues or health-promoting behavior.

Conventional medicine usage was strongly associated with long-term health problems (OR = 7.26, 95% CI 2.12–24.86), but not with any of the other factors (table 5). This analysis does not include use of complementary medicine in conventional health care settings or through referral.

Purpose of Health Care Use

In relation to each reported type of health care used, except for natural remedies and pharmaceutical drugs, the respondents were asked whether the purpose was treatment, disease prevention, diagnosis, well-being, or other (table 6). CAM providers were most commonly consulted for well-being (49%), treatment (35%), and prevention (22%). Visits to conventional caregivers, in turn, had the main purposes of diagnosis (68%), treatment (51%), and prevention (23%). When the category of dentists is excluded, the visits to conventional care for purposes of prevention dropped to 0%. Complementary care sought in or via a conventional medical setting had the purposes of treatment (57%), prevention (16%), and well-being (15%). Self-help methods, finally, were used for the purposes of well-being (75%), prevention (17%), and treatment (14%).

Table 6. Self-described purpose of CAM and conventional health care use

	Treatment	Prevention	Diagnosis	Well-being	Other
Visits to CAM providers	35.2% (178)	21.8% (110)	3.4% (17)	49.1% (248)	2.6% (13)
Visits to MED providers	50.7% (685)	23.1% (312)	68.1% (920)	9.9% (134)	9.1% (123)
Visits to MED excl. dentists	56.6% (267)	0% (0)	46.8% (221)	7.8% (37)	11.9% (56)
CAM in/via MED	56.1% (69)	16.3% (20)	6.5% (8)	14.6% (18)	7.3% (9)
Self-help methods	14.2% (69)	16.5% (80)	0.2% (1)	75.1% (365)	5.8% (28)

CAM = Complementary and alternative medicine; MED = conventional medicine; excl. = excluding.

Table 7. Perceived degree of helpfulness of CAM and conventional health care use

	Very helpful	Helpful	A little helpful	Possibly helpful	Not helpful
Visits to CAM providers	69.9% (353)	27.7% (140)	5.1% (26)	1.6% (8)	1.0% (5)
Visits to MED providers	60.7% (819)	42.4% (572)	7.6% (103)	3.4% (46)	1.6% (22)
Visits to MED excl. dentists	48.7% (230)	31.8% (150)	8.3% (39)	4.2% (20)	1.5% (7)
CAM in/via MED	50.4% (62)	30.9% (38)	14.6% (18)	4.9% (6)	3.3% (4)
Self-help methods	29.0% (141)	48.6% (236)	26.3% (128)	14.6% (71)	3.7% (18)

CAM = Complementary and alternative medicine; MED = conventional medicine; excl. = excluding.

In summary, then, reported visits to CAM providers largely aimed at prevention and well-being, but also at disease treatment. Conventional medicine was mainly consulted for diagnosis and treatment. The larger emphasis on prevention found in reported CAM use supports the question of which role CAM plays, or might play, in actual disease prevention.

Perceived Degree of Helpfulness

The respondents were further asked about the perceived degree of helpfulness of each type of health care used, except for natural remedies and pharmaceutical drugs (table 7). The types of health care most commonly rated as very helpful were visits to CAM providers (70%), followed by visits to conventional caregivers (61%), complementary care in or via a conventional setting (50%), conventional care excluding dentistry (49%), and self-help methods (29%).

Matters of Opinion

Asked about the levels of trust, 59% of the respondents expressed confidence in CAM while 90% reported confidence in conventional medicine. While both genders expressed trust in conventional medicine, the level of trust in CAM was higher among the women (68%) than among the men (50%).

Regarding cooperation between conventional health care and CAM, a majority of the respondents (69%, 76% of the women and 63% of the men) expressed the opinion that it should increase. 6% of the women and 15% of the men stated that collaboration should remain the same or decrease.

Finally, the survey posed questions about opinions on background factors for disease and about attentiveness to studies and/or media reports on health risks. The data offers a very limited basis for comparison between types of health care users, due to the size of the population sample and the large and overlapping groups of health care users (CAM 71%, conventional medicine 98%, CAM and conventional medicine 70%). A minor tendency towards

higher evaluation of the influence of an individual's own actions and lifestyle as well as of economic, social, and political societal conditions on health can be seen among CAM users, as compared to users of conventional medicine. A small tendency towards higher evaluation of one's own attentiveness towards studies and media reports on health risks, and of attempts towards changing one's own lifestyle accordingly, also appears among CAM users.

Conclusions and Discussion

Of the survey respondents, 71% reported having used some form of CAM in the past year. CAM use was more common among women, in younger age groups, and among people with tertiary education. It was associated with high levels of experienced stress and long-term health problems and injuries, as well as with good exercise habits and the adherence to any particular diets. The stated purposes of CAM use were well-being and prevention and treatment of disease, and users reported having experienced a high level of helpfulness. The respondents expressed a lower level of trust in CAM than in conventional medicine. Still, the majority stated that cooperation between CAM and conventional medicine should increase.

A main limitation of the present study is the survey's low response rate (31%). The result may overestimate CAM use, as people with a favorable attitude towards or interest in CAM might have been more likely to complete the survey than others without such an interest or attitude. It is also noteworthy that people with tertiary education, who according to the present analysis are more likely to use CAM, are slightly overrepresented in the TNS Sifo web panel. On the other hand, such an overestimation may be counteracted by the lower response rates in younger age groups, among which CAM use appears to be more common. In any case, a survey completed by 1,534 individuals, with a response frequency of 31%, provides a limited base for drawing conclusions. Critique aimed

towards much CAM prevalence research regarding low levels of certitude [5, 37, 38] thus pertains to this study as well. However, while corroborating research from Sweden and other countries, this study confirms that a large number of people in Scania do indeed use various forms of CAM.

While some have questioned the relevance of CAM prevalence research [45], others have emphasized its importance both in terms of revealing the necessity of further investigation of CAM use and users, and of forming an essential part of wider projects of CAM research and development [10]. Knowledge about CAM prevalence is important for answering questions such as which population or patient groups turn to different types of CAM, and why. How can or does CAM consumption affect the population health, in positive [46] or negative [47] directions? What economic consequences does CAM use have? What needs for education, pertaining to conventional [48, 49] as well as CAM caregivers, can be identified? Do patients disclose their CAM use in clinical encounters with conventional health care [50, 51], and if not, why? Is the field suffi-

ciently regulated and researched [40]? Proper handling of such issues, on regional and national levels, requires current data on CAM usage.

In the face of the existing lack of knowledge about CAM use, nationally and regionally, and the still often marginal position of CAM in medical research and discussion, the study points to the necessity of further investigation of CAM consumption. It motivates the posing of questions about the reasons and effects of CAM use, while affirming the importance of further investigation and discussion of CAM consumption, policy, practice, and education.

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