



## Complementary health approaches for health and wellness in midlife and older US adults



Pamela Jo Johnson<sup>a,b,\*</sup>, Judy Jou<sup>a,b</sup>, Taeho Greg Rhee<sup>a,c</sup>, Todd H. Rockwood<sup>b</sup>, Dawn M. Upchurch<sup>d</sup>

<sup>a</sup> Center for Spirituality & Healing, University of Minnesota, 420 Delaware St. SE, MMC-505, Minneapolis, MN 55455, United States

<sup>b</sup> Division of Health Policy & Management, School of Public Health, University of Minnesota, 420 Delaware St. SE, MMC-729, Minneapolis, MN 55455, United States

<sup>c</sup> Department of Pharmaceutical Care and Health Systems, College of Pharmacy, University of Minnesota, 7-168 Weaver-Densford Hall, 308 Harvard Street SE, Minneapolis, MN 55455, United States

<sup>d</sup> Department of Community Health Sciences, Fielding School of Public Health, UCLA, 650 Charles Young Drive South, Los Angeles, CA 90095, United States

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### ABSTRACT

**Objectives:** To characterize the use of complementary health approaches (CHA) and examine the perceived benefits of using CHA by reason for use among midlife and older adults.

**Study design:** Analysis of 2012 National Health Interview Survey data, a nationally representative US sample using cross-tabulations with design-based F-tests and multiple logistic regression. The analytic sample included adults aged over 50 years (N = 14,849).

**Main outcome measures:** The proposed benefits of using CHA included: (1) better control over health, (2) reduced stress/relaxation, (3) better sleep, (4) feeling better emotionally, (5) coping with health problems, (6) improved health/feeling better, and (7) improved relationships.

**Results:** Overall, 31% of this sample of midlife and older US adults had used CHA in the past year. Among users, 15% had used CHA for treatment only, 40% for wellness only, and 45% for combined wellness and treatment. Herbs (60%), chiropractic (28%), massage (22%), and yoga (19%) were the most common CHA. Wellness-only and combined users had significantly higher odds of reporting that CHA conferred benefit compared with treatment-only users.

**Conclusions:** CHA are used by nearly a third of midlife and older adults and are perceived to provide substantial benefit. Integrating CHA as part of a healthy lifestyle has the potential to contribute to healthy aging among midlife and older adults.

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### 1. Introduction

One-third of the United States (US) population is 50 years or older, and promotion of healthy aging is a public health priority. Nearly 20% of the US population is midlife (ages 50–64), a crucial stage for determining health and wellbeing after age 65. However, this group is at high risk for future disease and disability, with 70% of midlife adults having at least one chronic condition, and nearly half having two or more [1]. Chronic diseases, such as heart and pulmonary diseases, cancer, and diabetes, are leading causes of death in the US [2]. The impact of chronic conditions on health status is detrimental and decreases functioning and wellbeing [3]. Addition-

ally, more than 86% of US healthcare costs are due to treating those with chronic conditions [4]. By 2030, over 20% of the US population will be 65 or older, compared with only 10% in 1970 [5]. This demographic shift demands innovative ways to promote health, prevent disease, and cut healthcare costs for aging adults.

Americans are increasingly turning to complementary and alternative medicine (CAM) to either improve or maintain good health [6,7]. CAM has traditionally been defined as “a group of diverse medical and health care systems, practices, and products that are not generally considered part of conventional medicine [8].” More recently, the National Center on Complementary and Integrative Health (NCCIH) adopted the term “complementary health approaches” (CHA), since most people who use CAM do so in addition to conventional treatments [9]. CHA include a wide range of products, practices, and providers, most of which have a wellness component [10]. Accordingly, individuals’ motivations for use are

\* Corresponding author at: Center for Spirituality & Healing, University of Minnesota, 420 Delaware St. SE, MMC-505, Minneapolis, MN 55455, United States.  
E-mail address: [johns245@umn.edu](mailto:johns245@umn.edu) (P.J. Johnson).

varied and may include the treatment of specific conditions such as back and neck pain, relief of symptoms associated with common colds, as well as supporting general health and wellness [11–14].

This study utilizes a sociobehavioral wellness model to investigate the patterns, reasons, and perceived benefits of CHA use in midlife and older adults [15]. We focus on midlife and beyond because we are especially interested in identifying the potential contributions of CHA as part of health self-management and healthy aging. Our model is an extension of the Andersen Behavior Model of Health Care Utilization [16], which is often used to understand and characterize health services use relative to need(s) and outcomes. It has also been applied more recently to use of CHA [10,17–19]. Within this model, CHA use is hypothesized to be influenced by four domains. Predisposing factors include demographic characteristics that reflect social placement and access to resources and shape how people manage health issues. Enabling factors are resources that aid or hinder use of CHA services and include measures of income, health insurance status, and location and accessibility to services (including alternative providers). Need factors encompass both subjective and evaluated medical needs, as well as motivation for wellness and health promotion. Lastly, personal health practices reflect overall lifestyle behaviors.

The objective of this study was to examine the use of CHA for wellness compared with treatment, as well as the perceived benefits of using CHA by reason for use among midlife and older US adults. Specifically, we sought to answer the following research questions: (1) How do characteristics of midlife and older adults differ by reason for CHA use? (2) What is the rate of use and reasons (treatment and/or wellness) for use of specific types of CHA? and (3) What are the perceived benefits of using CHA among midlife and older adults who use it for wellness compared with those who use it for treatment alone?

## 2. Materials and methods

### 2.1. Data source and sample

We examined use of CHA for treatment and wellness by midlife and older adults using National Health Interview Survey (NHIS) data from 2012, which includes an alternative health supplement fielded every five years. The 2012 data are the most current nationally representative data available on complementary and alternative health practices in the US. The NHIS is an annual household survey of the health and healthcare of the US non-institutionalized, civilian population [20]. The NHIS uses a multistage probability sample design with clustering and stratification, and the sample is drawn so that data analyzed using the sampling weights are representative of the US population [21]. Our analytic sample included adults, ages 50 years and older, who completed the NHIS alternative health supplement and had complete data for all covariates ( $n = 14,489$  unweighted).

### 2.2. Measures

#### 2.2.1. Use of CHA

Use is represented by global measures of use of CHA and reasons for using CHA. Any CHA indicates past year use of any of the 36 types reported in the NHIS (see Appendix A) [6]. The NHIS also asks for the three CHA used in the past year that respondents identified as being most important to their health. Reasons for using CHA were elicited through yes/no questions for each of the top three CHA reported. Respondents were asked whether each CHA type was used: to improve energy, for general wellness, to enhance immune function, to improve athletic or sports performance, or to improve memory. We aggregated “yes” responses for any of these

five reasons to create an indicator variable representing past year use of CHA for wellness. For each of the top three CHA, respondents were also asked whether it was used to treat one or more specific health problems, symptoms, or conditions. We aggregated “yes” responses to create an indicator variable representing past year use of CHA for treatment. Using the two indicator variables, we created a categorical response to classify each respondent as having used CHA for wellness only, for treatment only, or for a combination of wellness and treatment.

#### 2.2.2. Benefits of CHA

Outcomes of interest were indicators of perceived benefit of using CHA. For each of the top three CHA used in the past year, respondents were asked whether or not each CHA used provided specific benefit. Benefits of using CHA included: (1) better sense of control over health, (2) reduced stress/relaxation, (3) better sleep, (4) feeling better emotionally, (5) made it easier to cope with health problems, (6) improved overall health/feeling better, and (7) improved relationships. An additional outcome of interest was a rating of the importance of using each of the top three CHA for maintaining health and wellbeing with response options of very, somewhat, slightly, or not at all important, which we collapsed to represent important versus not important for analysis.

#### 2.2.3. Covariates

Our variable selection was based on the sociobehavioral wellness model, which posits that a health-promoting lifestyle is a function of the predisposition to engage in healthy lifestyles, factors which enable or hinder a healthy lifestyle, a perceived need for healthy lifestyle, and personal health practices. Predisposing factors include: age, sex, race/ethnicity, marital status, and educational attainment. Enabling factors include: poverty status, health insurance coverage, and geographic region. Need factors include: self-reported health status, psychological distress measured using the K6 [22], multiple chronic conditions [23], and functional limitations. Personal health practices was operationalized as a healthy behavior index and was represented by a count of each person's number of healthy behaviors ranging from 0 to 4 (i.e., healthy weight, non-smoker, light or modest drinker, sufficient physical activity).

### 2.3. Analytic methods

First, we examined whether background characteristics differed by past year use of CHA and reason for use. Next, we estimated the prevalence of past year use of specific CHA among midlife and older adults in the US overall and by reason for use. We used cross-tabulations and design-based  $F$ -tests to test for differences by reason for using CHA. In separate multivariate logistic regression models, we estimated the odds of perceived benefits of CHA by reason for use. All models were adjusted for age, sex, race/ethnicity, marital status, educational attainment, poverty status, health insurance coverage, geographic region, self-reported health status, mental health status, multiple chronic conditions, functional limitations, and the healthy behavior index. All analyses were conducted with Stata statistical software (SE version 13.1) and used techniques to account for the complex sample design of the NHIS design [24,25].

## 3. Results

Those who used CHA in the past year were significantly different than those who did not use CHA on all background characteristics. Among those who used CHA in the past year, 85% used it for wellness only (40%) or for combined wellness and treatment (45%). CHA wellness-only users were generally younger, female, higher

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