

A SURVEY OF A SELECT GROUP OF FIFTY
ELDERLY PERSONS REGARDING THEIR HEALTH NEEDS

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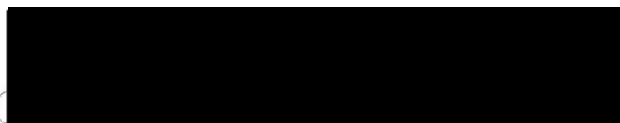
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A Thesis

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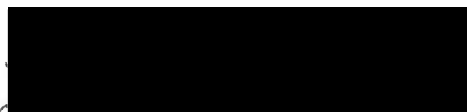
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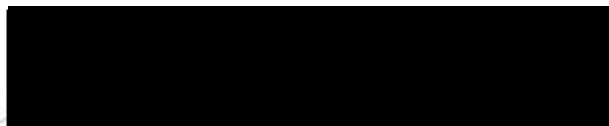
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d. e. w.

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CHAPTER I

INTRODUCTION

Introduction to the Problem

In our society today old age is commonly and popularly associated with illness. This analogy is not always true. To be old does not necessarily mean to be ill. There are many elderly people who are in good health and do not seek medical attention. However, those elderly who are sick may require a great deal of help and often present multiple problems.

The public is becoming increasingly concerned not only with the rising costs of medical care, but with the inadequacies of facilities and personnel needed for delivery of health care to the community. Paramount within this area of concern is the task of delivering health services to the poor, a large majority of whom are elderly. As people become more knowledgeable about health care and maintenance, the demands of old people and of the families of old people for services for the elderly are certain to rise. Prolongation of life is one of the effects of modern research in the chronic diseases characterizing the aging population. This adds to the magnitude of the delivery of health care not only to the elderly but to the

rest of the community as well.

Nurses as responsible members of society must be concerned and involved in the problems and needs of the expanding segment of this population.

Statement of the Problem

The Oregon State Council on Aging, in their Third Biennial Report to the Governor: 1961-1963, expressed the concern that there are "too many unmet needs". The report stated further that,

This is so, largely because there is a lack of knowledge of the specific needs, as well as the capabilities of the elderly. How to ascertain the needs of older citizens, the services and opportunities available to them, and make sure that services are made known and available to every individual who needs them, regardless of economic, social and cultural background is indeed the number one unsolved problem. (37)

Comprehensive health planning is a current concept of those concerned with providing health care for our nation's people. However, many complex problems must be solved before the ultimate aim can be achieved. Mattison suggests the planning should start with the consumer of health services who should help shape them. In reporting the guidelines and goals proposed by the American Public Health Association for organizing health practice, he lists among others: "To identify health needs and problems and help to set realistic goals there must be involvement of the receiver of the services.

He must be able to express his desires and his needs." (11)

Prerequisite to planning for meeting the health needs of the elderly must certainly come knowledge as to what their specific needs are as they perceive them. Pihlblad and McNamara point out that although there may not be a perfect correlation between perception of health and actual health, the former may be more significant than the latter in determining how the individual functions in the community and how he perceives himself in terms of contentment and adjustment. (22) Further comment regarding community participation is supplied by Salber who states, "One of the problems faced by the consumers and the providers of health services is their lack of exposure to each other, resulting in unrealistic expectations, hostility and frustration." (27)

With these aforementioned concepts in mind, the problem that is to be investigated in this study is: To identify the health needs of a select group of elderly people as they perceive them, to determine whether there are common health needs among this group and to report implications for needed health services.

Importance of the Problem

The increase in the number of older people is accelerating yearly. According to the census figures in 1960, the age group 65 years of age and older constituted 9.2 percent of the total population

in the United States. The United States Bureau of the Census also reports that in 1960 there were 17 states with more than ten percent of their population age 65 and over. Among those, Oregon ranked 13th and was the only western state in the list of seventeen. (37)

The advance report of the 1970 Census for Oregon contains information shown in Table 1.

Table 1. Number of Men and Women 60 Years of Age and Older Residing in Oregon During the Conduct of the 1970 Census

	Age	Men	Women
Oregon	60-64	45,809	48,599
	65-74	62,842	73,080
	75+	37,361	53,516
Multnomah County	60-64	12,614	14,395
	65-74	17,020	23,284
	75+	11,310	18,901
Portland	60-64	9,551	11,269
	65-74	13,250	18,929
	75+	8,940	15,563

With the increase in the number in the population of this age group and the lengthening life span, demands for health services are far exceeding their supply.

A major unit within the framework of health services is the nursing profession. Doris Schwartz points out that increasing demands have been placed on nursing personnel by elaboration of their roles in nursing homes, retirement communities, out-patient

departments and community health centers.

Professional nursing is concerned with providing care both to individuals and to populations. In any assessment of the nursing needs of the aged, all that affects the health status of the population as a whole must influence our planning, our educational curricula, and the allocation of our manpower. (28)

It is of great importance to know the types, occurrence and extent of illness among the older people. It is also important to know if medical care was sought and available. Often only the older person whose need is greatest comes to public attention. What concerns are expressed for the group who may have significant effects of chronic long term illness and are coping with these inadequacies without medical help? Susser reports that with few exceptions, health needs are greatest among those whose demands for health care are the least. In most investigations, the aged, the poor, and the least educated are found to suffer more ill health than the young, the wealthy, and the educated, and yet to make relatively less use of services. (36)

Virginia Henderson proposes the unique function of the nurse is to assist the individual, sick or well, in the performance of those activities contributing to health or it's recovery (or to peaceful death) that he would perform unaided if he had the necessary strength, will or knowledge; and to do this in such a way as to help him gain independence as rapidly as possible. (5) It is the duty of health service

providers to help the older person live his remaining years functioning at optimum physical and mental capacity. There cannot be adequate planning and ultimate provision for these health services unless the needs of the elderly are known.

Terminology

For the purposes of this study, the following terms were utilized:

Elderly, aged, old: Used interchangeably throughout the study to identify the stage of life 60 years and older. The age of 60 was arbitrarily selected as the lowest boundary for this particular study.

Health needs: Encompass the physical, psychological and social needs that are necessary for an individual to maintain a level of wellness.

Health services: Services which provide help for the maintenance of health and/or prevention of disease.

Assumptions

For the purposes of this study it is assumed that:

1. elderly persons have health problems (or problems regarding health care) that they can identify and discuss.
2. information obtained from the interviews will have merit in assessing the available services and in determining

what needs are unmet.

Limitations

This study is limited

1. to a select group of fifty elderly persons 60 years of age and older who reside in northwest Portland.
2. to data collected during July and August of 1971.
3. to data collected by means of a structured interview.
4. to expressed health needs of those interviewed.

Research Design

Sources of Data

The primary sources of data are the responses obtained from 50 elderly persons interviewed in northwest Portland. An overview of the study neighborhood is included in Chapter III.

The secondary source of data is information obtained from reviewing the literature concerning health needs of the elderly and the present trends in the delivery of health care to this age group.

Procedure

The study is defined as an exploratory study, descriptive in nature and non-experimental in design. The steps utilized in

conducting the study were as follows:

1. Unstructured interviews were arranged with people presently engaged in delivering services to the elderly. It was felt further insight into the local situation could be gained. Interviews were arranged with:
 - a. Mr. James Gates, Portland-Multnomah Council on Aging.
 - b. Miss Gertrude Deutsch PHN, Family Worker, Friendly House.
 - c. Mr. Edd Crawford, Director, Friendly House.
 - d. Father Peter Paulson, Director, Northwest Pilot Project.
2. Arrangements were made through the Northwest Pilot Project to accompany two volunteer visitors to the elderly one day per week for a period of approximately two months for preliminary investigation of the field to be studied. This contributed further to the investigator's understanding of the problems of the elderly. It also served to help develop and refine the interview tool to be used in the study.
3. Permission to interview elderly persons being visited by volunteers from the Northwest Pilot Project was given by Father Paulson.

4. A data collection tool was constructed. The device, an interview guide, is subdivided into three sections. The first section is designed to obtain basic personal data. Section two pertains to the individual's health status with specific questions relating to major health problem areas. The third section deals with knowledge, availability and use of health care facilities. The tool is a modified version of that used in the Kutner survey. (8)
5. A pilot study was conducted by interviewing five elderly persons to determine the appropriateness of the data collecting device. It was decided two questions were irrelevant for the purposes of this study and they were deleted from the interview guide. These questions were ethnic in origin; race and country born. There was a very small percent nonwhite who resided in northwest Portland during the interviewing period, therefore, it was felt the information from these two questions would produce nebulous data.
6. Interviews were conducted during a nine week period in the summer of 1971.
7. The data from the interview guides were categorized, numbers and percentages compiled, tables constructed and findings discussed.

8. The study was summarized, conclusions drawn, recommendations made for further study as reported in Chapter IV.

CHAPTER II

REVIEW OF LITERATURE

Introduction

We speak of aging and of being old as though there is no more living to be done. The last 10 to 25 percent of life is as important a part as any other part. The focus should not be on old or aging, but on living. It is fatal to say only that this is what it means for some to be old, and conclude that the best we can hope to do is to keep the bedsores from getting worse and the bones from collapsing. We must see the difference between lonely, broken old bodies and the living old. Living or not living may depend upon little things such as whether or not the older person can use the kitchen, or smoke a pipe. (38)

The preceding statement was made by Dr. Prescott W. Thompson of the Menninger Clinic in a recent keynote address to the National Council on Aging, North Central Training Institute. Berwick reiterates the cliché that virtually no one dies of old age, but the evidence suggests that more and more people are being consigned to an old age that is itself a form of death. (1) Without reasonably good health, the later years may hardly be worth living.

Warner acknowledges the concept that in the society of the United States, youth is looked upon as a positive value, whereas aging and old age tend to be regarded as something akin to tragedy. (43)

This concept is not limited to those of the younger and middle age groups. Studies imply that the aged have even more negative attitudes toward themselves than other age groups have toward them. (12, 33) Linden describes this process as "self-rejection". Since the older person himself has contributed to and participated in the social attitudes of elder exclusion, he often experiences this psychological phenomenon characteristic of aging. (10)

In addition to the apparent lack of self esteem among the elderly, other psychological manifestations may be present. These are often precipitated by physical limitations of chronic disease. In July, 1970 the Legislative Task Force of the Multnomah County Ad Hoc Committee for Geriatric Mentally Ill reported, "The real need for geriatric cases is for medical care, diet, and socialization control". (16) At a meeting of the Ad Hoc Committee on April 28, 1971, Dr. Harry Cloyd of Dammasch Hospital stated.

Often we get elderly patients who have been brought to us diagnosed as mentally ill. We treat their physical illnesses, feed them some good food, and their mental condition stabilizes.

It is a conjecture of others in the field of elderly mental health that self awareness of ill health in old people is associated with low morale and feeling old. (26)

Arnold Rose did a study regarding the mental health of normal older persons. A nonrepresentative sample of older people living in

permanent dependence among older persons may derive from the adverse effects of such social conditions as retirement, isolation or widowhood. (36)

Causal connections among important areas of need, such as health needs, are often difficult to establish and more studies are needed in these areas of concern. An example of this dilemma is described in Aging and Society:

If it were to be established that good health derives from a high standard of living, then it might be argued that income maintenance must be accorded a higher priority than the expansion of health services. If one area of need is found to result from another, then both will be served by attacking the area of primary causation. (7)

The older person has the right to establish his own priorities of need. Attention must be paid to his demands and desires based on his values.

Schwartz summarizes, "The needs of older people reflect the needs of human beings everywhere--to have someone to love, somewhere to live, something to do, and to avoid, when possible, discomfort and suffering". (28)

Related Studies

The Russell Sage Foundation provided the funds for Cornell University to conduct an interdisciplinary study to learn what are the fundamental needs of old people. The report was prepared by

Dr. Bernard Kutner (1956) as Five Hundred Over Sixty. (8) The project was initiated because of the recognition of the growth in the aged population and the necessity for locating the problems and needs of the elderly. The study was conducted in a major urban center with the purpose aimed at obtaining clues and directions specifically for planning and developing a service program for the older people. Five hundred noninstitutionalized persons over the age of 60, residing in an urban neighborhood on the East Side of Manhattan Island, were interviewed. Areas covered in the questionnaire, in addition to basic personal data, were: the individual's health status with a detailed survey of major health problem areas, their knowledge of, attitudes toward, and use of various medical and health services, social activities, extent of contact with peers and relatives, attitudes toward old age, feelings concerning their own aging, areas of satisfaction or dissatisfaction with unemployment or retirement, specific complaints and problems concerning their style of life, standard of living, housing, leisure time, community participation, and their attitudes toward the use of specialized services for the aged. The population studied ranged in age from 60 to 90 years, with the average a little under 70 years.

Concerning health status, the focus was on the extent and nature of illness in old age and functional consequences of illness. More than 43 percent stated they were free of illness; comparatively mild

consequences were reported among those with current illnesses. Further questioning focused on specific illnesses or physical disabilities, however, reduced the proportion of those initially reporting no illnesses from 43 percent to 23 percent indicating a discrepancy between reports of health problems "bothering" an individual and of actual health problems. Trela and Simmons referred also to the paradox of the elderly and their health complaints. "While many of the aged experience physical impairment, they often do not think of themselves as having a health problem and appear to accept some incapacity as 'normal' or 'just being old'". (39)

Other studies of life attitudes of older people reveal that older people define many of life's ills as inevitable. They take aches and pains for granted, put relatively little faith in medical science, and feel they understand their own health best.

This is sometimes realistic because most old people are in fact living with one or more ailments that are of long standing and not completely curable, such as defects of hearing or vision, rheumatism, heart trouble and high blood pressure. (26)

The Cornell study reported that over half admitted having some chronic ailment with one and two specific complaints for each older person. An examination of the functional consequences, however, indicated fewer than one person in ten was totally homebound by ill health or required considerable time in bed. The research team found that the older the individual, the more likely he was to be

afflicted with some illness, although often minor in character. It was concluded that although the number of complaints increased with age, the seriousness of the complaints did not increase. With any degree of illness, the proportions of men and women were equal.

An examination of the survey findings indicated that the availability of a regular physician in time of illness was unrelated to health status. If the individual was sufficiently ill, in one way or another he received some form of medical care. More than half had physicians who regularly cared for their illnesses. The main reasons offered for not having a regular doctor were lack of funds and having no need for a physician.

There is a notable association between health and status and income. Employed people have complaints less frequently than the unemployed, the retired, the housewife, and the widow. Poor people suffer more frequently from ill health than do the wealthy. There is a hint that those who possess health insurance that protects against the economic hardships of illness in old age are more willing to undertake costly medical care than those who do not own insurance. (8)

One-fifth of the respondents were considered at the bottom of the economic ladder and living in absolute poverty. The challenge for community health planners was clearly indicated. This subgroup was found to be: 1) in poor health, 2) primarily widows, 3) unemployed and receiving their income from welfare for federal benefits or from relatives and 4) over 70 years of age. Half of this group were not obtaining the extensive medical attention their condition

would seem to warrant.

Shanas has contributed extensively to the knowledge about older people. A nationwide survey (1957) was conducted focusing on the health needs of older people, as reported by persons 65 years or age and older and by those to whom older people would turn in a health crisis. (30)

In this project the health situation of older people and their use of medical facilities was investigated against the background of their living arrangements, their economic status, their family relationships and their concepts of their health status. The data were collected by means of the household interview. A random cross section of 1734 non-institutionalized persons ages 65 and over was interviewed. Among those interviewed, 43 percent rated their health as good or excellent; 14 percent reported themselves as very sick at the time they were interviewed (a proportion that was higher among women and advanced old age).

In answer to the question, "In the past four weeks, did anything like sickness, or any old injury or any health problem bother you? What was it?", half of all older people named one or more illnesses. An additional third, although they said "no" to this question, reported one or more current illnesses when read a list of specific chronic conditions and symptoms. These results appeared analagous to the findings of the Cornell study and indicated again the elderly person's

acceptance of some incapacities as 'normal'. In the Shanas survey the average number of illnesses reported was four per person whereas in the Cornell study an average of one to two was found. In response to the higher report of illness it can be noted that,

In the United States each recent household survey of illness has consistently secured higher rates for most diagnostic categories than the previous survey and significantly higher than those reported in household surveys some years ago. (30)

Twenty-four percent of the older population reported at least one impairment or disability: blindness or other visual impairment, a hearing or speech impairment, paralysis, missing fingers or toes, or other impairments of the extremities, limbs, back or trunk; two-thirds of which were of five or more years duration.

The Cornell study indicated that fewer than one person in ten was totally homebound or required considerable time in bed, but the Shanas survey was more specific in estimates of restrictions on activities: 1) one of every fourteen was unable to leave the house and 2) one in twenty spent most of his time in bed or in a wheelchair.

The findings of the Shanas survey indicated a heavy use of physician's services by the older population. Sixty-two percent had seen or consulted a doctor during the preceding year. Their visits were for treatment of specific complaints, for "check-ups" and for treatment of acute illnesses.

One person in 14 reported that he had nursing care at home

during the four weeks preceding the interview. In almost every instance a relative or friend provided such care. The use of employed nurses or of public health nurses was mentioned by only one person in 20 who had had nursing care. All respondents, whether they had reported home nursing care nor not, were asked, "Is there a Visiting Nurse Service (Public Health Nurse) available here?" Twenty-four percent said there was such a service, 45 percent said there was no such service and the remainder, 31 percent said they did not know if this service was available. A similar finding is reported from the results of a study conducted in Monroe County, New York. The conclusions from this report indicated that for every elderly person in their sample who was receiving Public Health Nurse Services at home, there were four others who were judged to need it and were not getting it.

Public Health Nursing Service is not as well known by the health professions nor by the general public as are the various forms of institutional care and it is a service that is perhaps easier to manage without than is institutional care. (13)

The Shanas survey also reported about one person in five had to make special arrangements for health care during the four weeks preceding the interview. Listed were problems concerning special diets, "shots" or injections, the need for someone to do the shopping or their housework or chores.

With the purpose of broadening the scope of knowledge

regarding the elderly, a collaborative, interdisciplinary approach was made to investigate the commonalities and differences of older people in Western Societies. Shanas headed the team of investigators from the United States joining Peter Townsend as director of the British segment and Henning Friis, director of the Denmark research. The interviewing was done during 1962 and the results were published in 1968 in Old People in Three Industrial Societies. (31) In general, the study was designed to explore various aspects of the elderly citizens, their physical capacities, their relationships with relatives and others, the roles they perform whether in employment or a home, the incomes they depend on, the services they receive, and some of the attitudes they have toward, for example, retirement or isolation.

The data was obtained by structured interviews with national samples of approximately 2,500 persons in each country, aged 65 and over, and living in private households in Denmark, Britain and the United States. Results from this study provide a number of considerations about the health of old people and implications for needed services to maintain them in their homes:

1. In all three countries a small proportion of persons over 65, five in every hundred or less, were in institutions.

The reasons for institutionalization appeared to be similar in each country: the physical and mental decrepitude of the old person, the inability or lack of family members

to cope with nursing needs and supervision, and finally, the failure of community services.

2. In each of the three countries more old people were found to be bedfast and housebound at home than were resident in institutions. In Britain, four times as many old people were bedfast and housebound as live in institutions; in the United States and Denmark, twice as many.
3. The proportions of people over 65 who were bedfast, housebound, or limited in mobility, who were living at home, were roughly 24 percent in Denmark, 21 percent in Britain, and 14 percent in the United States.
4. One-half of all noninstitutionalized old people in Denmark and Great Britain, and two-thirds of all old people in the United States, reported no functional incapacities.
5. In each of the three countries the most serious incapacitated among the aged could be categorically described as old women, either single or widowed. These women in every country were also among the poorest persons in the elderly population.
6. In all three countries the very old living at home made the greatest use of physicians. The American aged were almost as likely as the British and more likely than the Danes to have recently seen a doctor.

7. Old people in the United States were less likely than old people in either Denmark or Britain to be housebound or restricted in their mobility or to report incapacities in functioning.

Some of this difference in self-reports of incapacity between older Americans and older Danes and Britains undoubtedly results from the feeling of many older Americans that, irrespective of age and infirmity, it is necessary to be active and completely self-sufficient. Old people in the United States, more than old people in Europe, seem to feel that to admit illness or incapacity is somehow psychologically wrong. (31)

In 1966-67 additional data were collected in Poland and Israel. Shanas incorporated these results in a paper "Measuring the Home Health Needs of the Aged in Five Countries". An attempt was made to measure in several countries the need by old people for community health services.

These services are either delivered to old people at home, or alternatively, should be so organized that bedfast and housebound old persons and persons so enfeebled that they can only go outdoors with assistance can have ready access to them. (32)

It is estimated from the results of these surveys that the number of aged living at home who need a full program of health services is about one old person in twelve in the United States.

The survey also found a substantial group who can go outdoors only with difficulty. As a result, they cannot avail themselves of

health services outside of their homes unless they have some assistance in reaching such services, which in many instances is not available.

If those persons who can only go outdoors with difficulty are considered as candidates for a full spectrum of community services along with the bedfast and the housebound, the minimum estimates of persons who require community health services range from one in seven in the United States and one in four in Poland and Denmark. An estimate of this magnitude means that in the United States alone, almost three million older persons require community health services. (32)

Shanas indicated the health needs of the elderly included not only medical care, but also nursing services, health screening examinations, occupational and physical therapy, prescribed drugs, hearing aides, eyeglasses, improved nutrition and home helps.

The National Council on Aging sponsored a project FIND (friendless, isolated, needy and disabled) interviewing 50,000 persons between August 1967 and November 1968. Surveys were made in twelve locations, including large urban areas, smaller cities and rural areas. Data were collected by using an eighteen page questionnaire. The interviewing aides were elderly themselves, mostly in their sixties with a few eighty years of age and older. The data provided significant clues to the needs of the millions of the most deprived elderly in the nation. Some of the observations made by the interviewers were:

1. Of those interviewed, 18,968 were considered older

poor persons. 5,101 more had incomes slightly above the poverty line.

2. There appeared to be a relationship between age, poverty, past level of education, marital status, sex and race. The older persons living alone had lower incomes and more serious needs.
3. Elderly people need help with proper nutrition, which they do not receive from food stamp or surplus commodities programs.
4. The older poor face a crisis due to a nationwide lack of facilities and services in such areas as housing, health supportive services, and transportation.
5. Health needs ran second only to finance in the number of requests for help, "requests which are often not met because services and facilities are nonexistent or in limited supply, or inaccessible." (18)

Steinfeld supported and expanded this last observation by commenting, "The elderly, like Americans of all ages, are victimized to a certain extent by obvious shortcomings in the health care delivery system." (35) He also indicated one of the essential steps necessary in overcoming this critical problem is the construction and modernization of health facilities, especially those which provide ambulatory care. This, of course, is only one of the additional

problems in planning health facilities for the aged.

James Birren (1969) emphasized the fact that the elderly person cannot cope with professional specializations which are widely separated geographically.

The problem of transportation to a remote health facility, whether it be mental, physical or rehabilitative is a problem to overcome. Low mobility of the aged requires that services be brought close to the individual. They should live in a community in which most of the common daily needs can be met within walking distances. (2)

Dr. D. G. Nishets, a county medical officer from England, at the annual meeting of the American Public Health Association in Houston emphasized the following point:

Humanity must be the uppermost consideration and, to care for the elderly in the community, services must be provided which can be of maximum benefit in increasing the quality of their life by making medical and social services widely available. (19)

Summary of Literature

Many studies have been concerned with the health needs of older people. The focus of these studies has been the health status as perceived by the older person. Discrepancies have been found between reports of health problems and actual health problems indicating some of the elderly population may accept their incapacities as part of 'being old'. Although a large percentage of the elderly are afflicted with some chronic ailment, the functional consequences

were not found to be significantly grave. With regard to utilization of physician's services, it appeared most old people do have a regular doctor; however, the purposes for seeing him were usually for specific complaints of illness with very few indicating they have regular physical examinations.

Accessibility or availability of health services for the elderly population has been identified as a primary need by those concerned with comprehensive health planning. Lack of transportation for the elderly to remote medical facilities is designated as one of the problems to overcome. Those who are housebound or who can go out of their homes only with assistance were found to be in critical need of community services. The challenge to community health planners has been clearly indicated as a result of studies of the health needs of the elderly.

CHAPTER III

REPORT OF THE STUDY

Introduction

Purpose of the Study

This study was undertaken to identify the health needs of a select group of elderly people as they perceive them, to determine whether there are common health needs among this group and to report implications for needed health services.

A nonprobability purposive sample was used; it is basically a restricted sample of a special population. It was felt the data should be provided by those most likely to demonstrate the need for health services and who had less means to fulfill these needs. A prestudy investigation of the study neighborhood served as the basis for the selection of the study sample. A descriptive report on the neighborhood will be included later in this chapter. The importance of ascertaining the health needs of the elderly in order to provide for adequate health care delivery has been an expression of concern by many who are actively engaged in providing services to the elderly. (11, 27, 30, 37)

The Study Tool

The method selected for the study was a survey of 50 elderly persons using the personal interview technique. Related studies were reviewed and the interview guide selected for this study was adapted from the Field Survey Questionnaire used in the Kutner survey. (8) The Kutner survey considered many more variables than included in this study. Therefore, the questions extracted from the Field Survey Questionnaire were those felt to be pertinent to this report: basic personal data, individual health status with specific questions relating to major health problem areas and the use of health care facilities. The data regarding illnesses were limited to personal evaluation. The statements of illness by those interviewed were not medically verified; they consisted of information regarding health problems as the individual perceived them. See Appendix A.

The Study Neighborhood

Authorities in the field of social planning and those involved in programs in aging have suggested some practical approaches to comprehensive urban planning including a searching out of concentrations of older persons living in normal community settings, followed by an adaptation of the special services believed to be necessary in such geographical areas of the city. These large aggregates of

older persons might be viewed as "populations at risk" in planning the organization of health, protective, leisure-time and social services. Services of all kinds for the aged might be usefully centered in one or more of those concentrations. (15)

Urban neighborhoods are as unique as individuals in their interests and needs. The district of northwest Portland could be referred to as a cluster of neighborhoods, each with individual problems and needs. The Portland City Planning Commission has conducted studies of the northwest area to establish a base of information on the area from which a set of goals and objectives can be developed. (24) The latest study of this area included the following description:

The extremely large number of apartment houses provides convenient close-in living at modest rents for a large number of elderly and young, unattached persons. The highest population density in the state occurs in the northwest (part of Portland).

In their report on land use in the area, a fact pertinent to this study is

The Housing Authority of Portland is sponsoring the construction of a 101 unit apartment for single, elderly persons. This new facility is located near the present Housing Authority facility for the elderly, Northwest Towers, and in the area of the highest concentration of persons over 65 in the city.

(This building has since been completed and the apartments are currently occupied). The report stated further,

The kinds of services and conveniences this segment of the population requires are only partially being met in

the northwest and planning should include meeting the latent demand that persists for additional facilities and services. (24)

Although the Planning Commission has conducted studies focused on social, economic, physical and political aspects, none has been specifically directed toward ascertaining health needs of this segment of the population.

Friendly House sponsored an "Operation Medicare Alert" in 1966 and issued the resulting statement:

The population over age 65 has increased in northwest Portland since 1960 and many of these people are isolated, lack relatives or other significant people who are willing and able to give them needed attention, are afflicted with chronic illnesses and declining strength, and are unaware of services that are available to them. A great many older adults are being institutionalized for lack of alternatives to nursing home care, which is costly both to the individual in terms of his dignity and financial resources, and to the community in terms of the enormous amount of money now spent for institutional care. (4)

The study area is that assumed by the Portland City Planning Commission. The area is bounded on the south by N. W. Burnside Street, on the east by the Stadium Freeway, the west by N. W. Cornell Road and Westover Road, and on the north by N. W. Nicolai Street. The area pertains to census tracts 45, 47, 48, 49 and 50. A map of the area boundaries is in Appendix C.

The study area had a 1960 population of 14,833. The 1970 detailed figures are not available at this time. A majority of the population are renters; only 16.8 percent are homeowners. The

average family size for the study area is 1.8 with over 40 percent of all residents unrelated. There is also a very high percentage of unmarried individuals in certain areas. The population consists largely of older adults, in fact only 5.3 percent of the total population is under five years of age. (23) Table 2 shows a comparison of the northwest Portland population characteristics with those of the total Portland population characteristics based on the 1960 census.

Table 2. Comparison of Northwest Portland Population Characteristics to Portland Population Characteristics Based on 1960 Census Figures as Presented by Portland Planning Commission (23)

Characteristics	N. W. Area	Portland
Total population	14,833	372,676
Percent nonwhite	2.5	5.6
Average age	45.7	36.6
Average family size	1.8	2.6
Percent male	46.3	47.5
Percent under 5 years	5.3	8.7
Percent 21-64 years	48.8	53.9
Percent over 65 years	21.0	14.2
Average rent	\$62	\$71
Average family income	\$5,226	\$6,333
Percent income under \$3000	23.6	15.1

The Portland Planning Commission also listed the number of Public Health Nurse visits to the northwest area as reported by the Multnomah County Health Department. (23) This information is presented in Table 3.

Table 3. Public Health Nurse Visits July 1969 Through June 1970
by Northwest Portland Census Tracts and Multnomah
County

Tract number	45	47	48	49	50	Multnomah County
Population ^{a/}	2371	4637	3720	3734	615	555,900
People visited ^{b/} per 1000	119 50.2	89 19.2	98 26.3	113 30.3	53 68.0	13,198 23.8
Total visits ^{c/} per 1000	253 106.7	243 52.4	479 129.0	557 15.0	183 298.0	39,679 71.0

^{a/} 1970 population estimate

^{b/} People visited--new admission visits and readmission visits

^{c/} Total visits--new admission visits and readmission visits
and revisits

In 1969 a West Side Community Development Program was initiated. It was proposed at this time that an association of community centers be developed over a three year to five year period. Specialized service projects were to be included, among those the Cooperative Youth Project and the Northwest Pilot Project. The Board of Directors of Friendly House, a proven social work agency, was appointed to function as the administrative and fiscal unit.

The Northwest Pilot Project was initiated in the Pastoral Care Commission of the Greater Portland Council of Churches in 1965 when members realized that a vast number of lonely older people had needs not being met by any church or community agency in the

northwest area of Portland. The project is seeking to provide a volunteer service of supportive care to older adults within their place of residence. Volunteers go to older adults where they live in rooming houses, homes for the aged, nursing homes and apartment houses. Relationships are initiated to help the lonely older adult regain confidence and maintain dignity in an otherwise impersonal urban environment. (20) Funds are provided for the project from the federal government under the Older Americans Act; from United Good Neighbors and contributions. Currently these volunteer services are being extended to approximately 180 elderly persons.

Selection of Participants for the Study

Names and addresses of elderly people being visited by volunteers from the Northwest Pilot Project were provided by Rev. Peter Paulson, director of the project. The people were categorized according to types of residences. Those currently residing in convalescent homes, nursing homes or other institutional settings were omitted from the survey list. Those living in noninstitutional settings were grouped according to apartment buildings, hotels and individual addresses and this information was placed on index cards. Cards were selected arbitrarily at the beginning of each interview day. Forty-three persons were interviewed from the list provided by Northwest Pilot Project. The remaining seven persons consisted

of on-the-street interviews; the interviews conducted on street benches that are placed in various areas of northwest Portland by the Pilot Project for the convenience of the residents of that area. The people were selected on the basis of the following criteria:

1. The person was age 60 and over.
2. The person resided in northwest Portland.
3. The individual indicated a willingness to answer a questionnaire concerning his or her health.

The length of time originally anticipated to complete an interview was estimated to be forty-five minutes to one hour. The actual length of time needed ranged from one-half hour to as long as three hours. The great majority of the individuals were found to be lonely people and very responsive to conversation. This factor contributed to the necessary extension of time needed to complete 50 interviews from the anticipated one month to approximately nine weeks.

Plan for Analysis

The data from the interview guides were transferred to a master tabulation sheet from which figures and percentages were compiled and tables constructed. Percentages were calculated using the formula:

$$\text{Percent} = \frac{\text{category frequency}}{\text{total N}} \cdot 100$$

Report of the Study

The analysis of the data will be presented in sections in the sequence of the interview guide.

Section I

The first section was designed to obtain basic personal data.

Question 1. Sex? Of the 50 interviewed, 22 were men and 28 were women.

Question 2. Age? The ages were divided into three categories: 60 to 64 years, 65 to 74 years and 75 years and over. The median age for men was 67 years and for women, 66.7 years of age. Table 4 shows the sex and age characteristics of the study sample.

Table 4. Age and Sex Characteristics of the Study Sample

Age	Men N	Women N	Total N
60 to 64 years	8	10	18
65 to 74 years	7	10	17
75 + years	7	8	15
Total	22	28	50

Question 3. Marital status? It was found that 21 were divorced, 17 widowed, seven single, two couples married and one was

separated. Table 5 illustrates the marital status of the group studied according to sex.

Table 5. Marital Status of Study Group According to Sex

Marital Status	Men N	Women N	Total N
Divorced	11	10	21
Widowed	6	11	17
Single	2	5	7
Married	2	2	4
Separated	1	0	1
Total	22	28	50

The literature points out that although most adults are or have been married, the proportions who have been widowed (or divorced) increase by age categories beyond the middle years. (26) Breaking the sample into subgroups according to age, it can be noted that the widowed segment of the sample did increase with age, most notably in women. The divorced group, however, had the largest incidence occurring in the youngest age category. See Table 6.

Table 6. Marital Status of Participants According to Age and Sex

Marital Status and Age Group		Men N	Women N	Total N
Divorced				
Age	60-64	7	7	14
	65-74	1	0	1
	75+	3	3	6
Widowed				
Age	60-64	0	2	2
	65-74	3	4	7
	75+	3	5	8
Single				
Age	60-64	0	0	0
	64-74	1	5	6
	75+	1	0	1
Married				
Age	60-64	1	1	2
	65-74	1	1	2
	75+	0	0	0
Separated				
Age	60-64	0	0	0
	65-74	1	0	1
	75+	0	0	0
Sum Total		22	28	50

The second part of question three was included to determine how long the respondents had been widowed, divorced or separated and if married, the age of the spouse. There were only two married couples in the sample. The man and wife in couple number one were both 63 years of age and couple number two reported the wife's age as 69 years and the husband's 72 years. The group which had

previously been married but who were now either widowed, divorced or separated, were further subdivided into groups according to age as shown in Table 6. The length of time the subjects have been widowed, divorced or separated was divided into four groups: one to five years, six to fifteen years, sixteen to twenty-five years and twenty-six years or more.

Seven of the 21 in the divorced group have been divorced for more than 25 years. Almost 50 percent of those who have been widowed were 75 years or age and over; most have been without their mates from 16 to 25 years. Five have been widowed for more than 25 years and eight for less than 15 years. One person stated he had been separated "for years". See Table 7.

Table 7. Previously Married Segment of Study Sample According to Age and Length of Time Widowed, Divorced or Separated Reported by Thirty-Nine Participants

Marital Status and Age Group		Length of Time in Years				Total
		1-5	6-15	16-25	26+	
Divorced						
Age	60-64	1	7	3	3	14
	65-74	0	1	0	0	1
	75+	0	0	2	4	6
	Total	1	8	5	7	21
Widowed						
Age	60-64	0	1	0	1	2
	65-74	2	4	0	1	7
	75+	0	1	4	3	8
	Total	2	6	4	5	17
Separated						
Age	60-64	0	0	0	0	0
	65-74	0	0	0	1	1
	75+	0	0	0	0	0
	Total	0	0	0	1	1

Question 4. Type of residence? Thirty-six of the participants were living in rented apartments, ten resided in hotel rooms and three were living in boarding houses. One respondent occupied a furnished room. See Table 8.

Table 8. Types of Residence Occupied by Study Group

Residence	Number
Rented apartment	36
Hotel room	10
Boarding house	3
Furnished room	1
Total	50

Question 5. Do you live alone? Forty-six respondents were elderly persons living alone. The other four were married and living with their spouses.

The findings from questions four and five appear to be comparable to other studies. The bulk of retired persons, even though they may be living on submarginal incomes, are still capable of opting against congregate living in which rooms must be shared with strangers, and choosing instead private housing, even though it may be substandard in quality. (15)

Question 6. Approximate monthly income? Two of the twenty

men living alone preferred not to answer the question regarding income. The remaining 18 men reported incomes ranging from \$124 per month to \$189 per month with the median income \$142.50 per month or \$1,710 per year. Twenty-two women living along voluntarily reported their income status and three refused to answer. One lady gave \$64.50 as her monthly income. She admitted, however, she had a savings account she drew from monthly to supplement her Social Security, but she desired to withhold the amount. Since her total income was unknown, this information was not included in the analysis of income data, leaving a total of 22 single women who reported incomes. The range of income for women was \$99.40 to \$350 with a median of \$130.35 per month or \$1,564.20 per year. The two married couples reported their combined income as approximately \$2,458 and \$3,240 per year. Table 9 compares the median incomes of the study sample who reported their incomes with that of the United States Population age 65 and over. (40)

Table 9. Comparison of Median Incomes of Forty-Four Participants to United States Population Age 65 and Over

Area	Men Income	Women Income
Study Sample	\$1,710	\$1,564
United States	\$2,652	\$1,311

The data from the northwest Portland sample indicated the majority were living at poverty level or below. The amount needed at the poverty line (estimated by Orshansky with the Social Security Administration for 1968) is approximately \$1,717. (21) Utilizing these figures and without allowing for cost of living increase for 1971, fifteen of the women participants living alone were existing below the 1968 poverty line. An additional three were on the line and reported \$1,740 as their annual income; making a total of 18 women living alone at poverty level or below. Ten men were living at poverty level or below. Compared to Orshansky's proposed level for a family of two in 1968 at approximately \$2,221, the two married couples were above the poverty line, although one couple was only around \$12 per month above the 1968 figure. Table 10 compares the income status of the sample with estimated poverty level of 1968.

Table 10. Comparison of Income Status of Sample to Estimated United States Poverty Level, 1968

Level of Income	Single		Married	Total
	Men	Women		
	N	N	N	N
Below poverty level	9	15	0	24
Poverty level	1	3	2	6
Above poverty level	8	4	2	14
Refused answer	2	3	0	5
Disqualified	0	1	0	1
Total	20	26	4	50

The majority of those interviewed were receiving their incomes from either Social Security or Welfare payments. It is estimated that 750 out of each 1,000 elderly are Social Security beneficiaries.

Social security based in large part on life time earnings in the labor force and, like any income maintenance program based upon wage-related pensions inevitably introduces inequities. The long-term rise in cost of living which depresses the value of fixed income, suggests that a gap between benefits and requirements may persist indefinitely. (15)

The concept of wage-related incomes is demonstrated in the study sample. Two women and one man are retired with their incomes provided by pension or retirement plans from their previous occupations. The man has been retired for almost 22 years and is receiving considerably less income (\$163 per month) than the women who have retired more recently and are receiving \$300 and \$370 per month.

Briefly summarizing the data from Section I of the interview guide, certain characteristics of the sample can be noted. The sexes were represented almost equally, with a median age of approximately 67 years. The majority of the sample were either divorced or widowed with the proportion of those widowed increasing with age. Rented apartments were the usual place of residence and all but four of the sample were living alone. The majority of the study group were living at poverty level or below.

Section II

The second section of the interview guide pertained to the individual's health status with specific questions related to major health problems.

Question 1. Concerning your health now, would you say your health is excellent, good, fair, poor or very poor? The question was asked in order to reflect the person's own assessment or self evaluation of his health. Half of those interviewed indicated they regard their health as fair, while the remainder considered themselves to be in varying degrees of good or poor health.

The data indicated the women tended to assume the "middle of the road" position in evaluating her health status. Eighteen women stated they felt their health was fair while only four believed their health to be good or excellent and six claimed to be in poor health. None of the women interviewed felt her health was very poor.

Within the male sample, as many subjects said their health was good or excellent as considered it to be only fair. The men tended to regard their health as excellent or good more than the women. These findings are consistent with the findings of Shanas and others in their study of older people in three countries. It was their conclusion that whether or not an old person says his health is good or poor is related to his degree of incapacity. In each country old men reported

less incapacity than old women and they were more likely than women to say their health was good. (31) Seven of the men stated their health was excellent or good compared to only four of the women. At the lower end of the health spectrum, however, only the men admitted being in very poor health. This hints at the tendency for the men to imply greater concern about their health, or at least less apathy. This tendency was also mentioned in the report of the Kutner survey. (8) The responses of the sample according to health status and sex are shown in Table 11.

Table 11. Self-Perceived Health Status of the Sample Population According to Sex

Status	Men N	Women N	Total N
Excellent	5	2	7
Good	2	2	4
Fair	7	18	25
Poor	2	6	8
Very poor	6	0	6
Total	22	28	50

The differences among the age categories of the sample according to their perceived health were only slight. The number reporting their health as very poor gradually increased with age; however, considering the sample size, no conclusions can be drawn from the

data. The differences in age categories and health were not sufficient to account for their differences in health. Table 12 summarizes the self-perceived health status according to age.

Table 12. Self-Perceived Health Status and Age Category of Sample Population

Status	Age Category			Total
	60-64	65-74	75+	
Excellent	3	1	3	7
Good	2	2	0	4
Fair	8	11	6	25
Poor	4	1	3	8
Very poor	1	2	3	6
Total	18	17	15	50

It has been suggested that the older person living alone and vulnerable to loneliness is much more likely to develop increasing personal incapacity. (33) Older people living alone comprised 92 percent of the northwest Portland sample; therefore it is not possible to compare health among the single and married groups. Regardless of marital status, however, there was a tendency for the majority of all groups in the sample to report their health as fair. Table 13 shows health perception according to marital status.

Table 13. Health Perception of the Sample Group According to Marital Status

Health Perception	Marital Status					Total
	Single	Married	Widowed	Divorced	Sep.	
Excellent	1	1	1	4	0	7
Good	0	0	2	1	1	4
Fair	5	2	10	8	0	25
Poor	1	0	3	4	0	8
Very poor	0	1	1	4	0	6
Total	7	4	17	21	1	50

It was decided to try to determine if the length of time a person has been widowed or divorced had any bearing on how the participants perceived their health. It was postulated that those in an early adjustment period to being alone might reflect their depression by reporting poorer health. The analysis of these data does not substantiate this theory. None of those who have been separated from their mates within the past five years reported health as poor or very poor. The group who had been widowed or divorced more than fifteen years complained more of poor health than others. One explanation may be that 69 percent of those who had been widowed or divorced longer than fifteen years were in the age group 75 years and over as previously indicated in Table 7. Data presented earlier demonstrated a gradual increase of "very poor" health with age. The following

table contains data pertaining to the length of time respondents have been widowed or divorced and how they perceive their health.

Table 14. Health Perception and Length of Time Widowed or Divorced Reported by Thirty-Eight Participants

Health Perception	Time Widowed or Divorced in Years				Total N
	1-5 N	6-15 N	16-25 N	26+ N	
Excellent	1	1	1	2	5
Good	1	2	0	0	3
Fair	1	7	3	7	18
Poor	0	3	2	2	7
Very poor	0	1	3	1	5
Total	3	14	9	12	38

As noted previously, an individual's assessment of his health is based upon various factors regardless of the age of the individual. Studies of older people in the United States as well as other countries indicate some old people with major or minor impairments say they are well while others with similar complaints say they are sick. (30)

For the purpose of illustrating this phenomenon, the groups describing their health as excellent or good were compared with those who perceived their health as poor or very poor.

Examination of the responses of the study sample who perceived their health as excellent tends to substantiate the feeling that often

the aged accept incapacities as 'just being old' or that possibly they tend to turn away from their health problems by ignoring them.

Five men and two women said they were in excellent health. The women in this group did not admit to any illnesses or health problems. The men presented a contrast. One 63 year old man considered his health as excellent even though arthritis of his back limited his activity. In addition, further questioning revealed he suffered a stroke two years ago which left him partially hard of hearing. He has since had two "hemorrhages" as a "complication of Coumadin therapy". He is being treated for Tuberculosis. The man's wife had previously explained her husband is reluctant to admit he has any physical limitations. Three other men experienced problems in mobility, two due to arthritis and one from an old compound fracture of the leg that has left an unhealed, open wound. The fifth man in the group admits he drinks too much alcohol but denies any physical illnesses.

There were only four persons in the study who considered their health as "good". None of this group reported any major difficulty; however, two reported they are "bothered" with arthritis, one with high blood pressure, and one with phlebitis of the leg. The latter had undergone surgery three weeks prior to the interview for the repair of a diaphragmatic hernia but appeared to be recovering without difficulty.

In summarizing in the group who considered their health excellent or good, almost one-half were afflicted with arthritis, the majority of them claiming it incapacitated them to some degree. Two men complained of circulatory problems in the lower extremities that required frequent medical treatment. One person was infected with Tuberculosis and two persons had hearing defects.

It can be noted some of those who viewed their health as excellent or good were indeed afflicted with illness or incapacities in varying degrees. A small proportion of the sample with very similar complaints as those of the "good or excellent group" considered their health poor. The following examples from the "poor health group" demonstrates the causal relationships between depression and health perception and incapacity and health perception. A 60 year old controlled epileptic, and lacking other physical ailments, admitted her major problem was depression. Anxiety and depression are not uncommon manifestations in the epileptic individual. (3) Rose, in his study of elderly persons in Minneapolis and St. Paul, indicated that people who report themselves unhealthy were more depressed and less active than those reporting themselves as healthy. (25) A previously very active man considered his health to be poor due to pain and some incapacity associated with arthritis of the back, although he was apparently free from other illness. The remaining twelve persons who considered their health poor or very poor were

afflicted with major chronic conditions, all with more than one health problem. See Table 15.

It would appear the majority of those persons rating themselves poor or very poor assess their health realistically. It must be pointed out these are personal evaluations and reports of incidences of illness. Without medical evaluations the data cannot be regarded as conclusive in defining the person's actual status of health,

Further analysis of numbers, types and consequences of illness will be discussed later in the chapter. Some reference is made to select groups at this time only to demonstrate differences in how people perceive their health.

Question 2. Has it (health) been the same, better or worse over the past five years? Sixteen reported their health has remained the same, 32 felt their health was worse and only two perceived a better health status. The latter group were women; one with arthritis and one with "heart trouble" who felt their health was better. The women exhibited more of a tendency to report their health was worsening than the men, although the majority of both sexes shared this tendency. See Table 16.

Table 15. Summary of Incidence of Health Complaints According to Self Perceived Health Status Reported by Study Group

Health Complaint	Health Status					Total N=50
	Excel- lent N=7	Good N=4	Fair N=25	Poor N=8	Very Poor N=6	
Alcoholism	1	0	2	0	0	3
Arthritis	3	2	12	4	3	24
Asthma	0	0	0	1	1	2
Cancer	0	0	2	0	1	3
Cataracts	0	0	9	4	2	15
Circulatory problems	0	1	3	0	0	4
Diabetes	0	0	6	0	1	7
Emphysema	0	0	2	1	4	7
Epilepsy	0	0	0	1	0	1
Gastrointestinal problem	0	0	8	0	0	8
Gallbladder problems	0	0	3	0	0	3
Glaucoma	0	0	1	0	0	1
Hard of hearing	1	1	9	2	2	15
Heart disease	0	0	12	3	6	21
High blood pressure	0	1	13	0	1	15
Kidney or bladder problem	0	0	6	0	0	6
Neuritis	0	0	1	0	0	1
Pleurisy	0	0	1	0	0	1
Psoriasis	0	0	1	0	0	1
Psychiatric	0	0	0	2	0	2
Sinus problem	0	0	2	0	0	2
Skeletal immobility	0	0	7	0	0	7
Tuberculosis	1	0	4	0	0	5
Unhealed leg wounds	0	1	1	0	0	2
Vertigo	0	0	1	0	0	1
Visual disturbances	0	0	12	1	0	13
Total	6	6	118	19	21	170

Table 16. Health Status Over Past Five Years According to Sex as Reported by Study Group

Health Status	Men	Women	Total
	N	N	N
Same	9	7	16
Better	0	2	2
Worse	13	19	32
Total	22	28	50

To determine if the degree of illness increased with age, the participants were grouped according to ages. See Table 17.

Table 17. Health Status Over Past Five Years According to Age of the Study Group

Health Status	Ages in Years			Total N
	60-64	65-74	75+	
	N	N	N	
Same	4	7	5	16
Better	1	0	1	2
Worse	13	10	9	32
Total	18	17	15	50

It was anticipated that those who perceived their health as poor or very poor would also claim it had become worse over the past five years; those who felt their health was good or excellent would probably admit to it being the same over the past five years. The

data appear to substantiate this. It can be noted 32 of the participants stated their health was worse. This suggests either they had previously been in good health but were now experiencing some degree of illness or incapacity or they actually were in poorer health than they recognized. See Table 18.

Table 18. Health Groups and Status Over Past Five Years as Reported by Study Group

Health Status	Excellent N	Good N	Fair N	Poor N	Very Poor N	Total N
Same	6	2	8	0	0	16
Better	0	1	1	0	0	2
Worse	1	1	16	8	6	32
Total	7	4	25	8	6	50

Question 3. Is there any particular physical or health problem that bothers you at present? Forty-four participants responded positively to this question. Only six persons denied they had any health problems.

There appears to be relatively little difference between the men and the women in their response to the question. This is analagous to the Kutner survey where the proportions of illnesses reported were equal among the sexes. Table 19 describes the responses according to sex.

Table 19. Incidence of Current Complaints According to Sex as Reported by the Study Group

Report of Illness	Men N	Women N	Total N
Health problems	20	24	44
No health problems	2	4	6
Total	22	28	50

Question 4. A series of follow up questions were posed for those answering in the affirmative to the preceding question.

- a. What is the trouble?
- b. Is it being taken care of by a doctor?
- c. Does it keep you in the house?
- d. Does it keep you from doing things?
- e. Does it keep you from seeing people?
- f. Does it keep you from work?
- g. Has it kept you in bed during the past year? If yes, how long?

The problem to be explored in these questions is the extent and nature of specific illnesses "bothering" the participants, the incapacities suffered as a consequence of illness, and if a doctor's services were being utilized. This is the initial question of the data collecting tool regarding specific health complaints. The data compiled from the responses to this question pertain to the particular

complaints or illnesses that were bothering the participants enough that they perceived them as significant health problems.

As noted all but six participants reported they did have a physical or health problem. Twenty-three named only one illness, the remainder admitted to two or more conditions. This is consistent with the findings of other studies. (8, 22) See Table 20.

Table 20. Incidence of Reported Complaints of Study Group

Number of Complaints	Incidence of Complaints
None	6
One	23
Two	16
Three	3
Four	1
Five	1
Total	50

The types of complaints were categorized for simplification. Cardiovascular complaints were mentioned by 20 participants. The second most frequently mentioned condition was arthritis with 12 participants reporting they were 'bothered' by this ailment. Other skeletal disorders were conditions of immobility due to old hip fractures (two), lame legs due to polio (two), frozen shoulder following

injury to same (two) and one suffering limited mobility due to an old back injury.

Respiratory ailments reported by 10 participants comprised 14 percent of the complaints with emphysema as the most prevalent problem. Others mentioned were asthma and Tuberculosis. Visual disturbances were listed separately from cataract incidences for purposes of clarity. The person with a visual disturbance complained of poor eye sight but did not know the etiology of the condition. There were two incidences reported of psychiatric nature. One respondent said mental depression was her worst problem and the other complained fo being nervous all the time.

The gastrointestinal complaints reported were colitis, cirrhosis and an inguinal hernia. Both urological complaints were defined as "bladder problems". Diabetes ranked fifth in the number of complaints of illness with six people listing this as a major problem. The miscellaneous complaints included were epilepsy (one), cancer (one), vertigo (one), Psoriasis (one), sinus problems (two) and unhealed wounds of legs or feet (two).

According to the Kutner survey,

The discrepancy between reports of health problems "bothering" an individual and of actual health problems raises an interesting question concerning one's attitudes toward and feeling about one's illnesses. Reporting a health complaint to an interviewer may or may not represent the existence of an illness or disability. On the other hand, some persons having legitimate medical

complaints fail to report them. (8)

Other studies substantiate this. (36, 30, 31).

In response to the second part of the question, "Is it being taken care of by a doctor?", 75 percent of the group with initial health complaints stated they were under a doctor's care; the remainder were not being treated by a physician. The data implied that utilization of physicians' services increased with the severity of the disorder. Table 21 summarizes these data.

Table 21. Incidence of Illnesses or Complaints Reported by Study Group and Utilization of Physician for Treatment

Illness Reported	Incidence N	Treated by Doctor		Total N
		Yes	No	
Arthritis	12	6	6	12
Cardiovascular	20	20	0	20
Cataracts	2	2	0	2
Diabetes	6	6	0	6
Gastrointestinal	3	3	0	3
Psychiatric	2	2	0	2
Respiratory	10	8	2	10
Skeletal immobility	7	3	4	7
Urological	2	0	2	2
Visual disturbances	1	0	1	1
Miscellaneous	8	7	1	8
Total	73	57	16	73

The remainder of question four is concerned with defining the functional consequences of the illnesses with the purpose of indicating how basic is the problem of health. Whereas Kutner reported in the Cornell study only one person in ten was homebound by ill health and Shanas indicated one in every fourteen was unable to leave the house, the sample from northwest Portland demonstrated a much higher ratio. Twenty-two participants who reported illnesses stated they were confined to their homes because of ill health and 34 claimed they are kept from doing things. Although a majority reported their health kept them from work it must be established only eleven out of the 44 persons who reported illnesses were under age 65. Fourteen persons had been confined to bed within the year previous to the interview. The amount of time varied from one day to two months, with the majority confined two weeks or less. Table 22 presents the consequences of the illnesses reported.

Table 22. Incidence of Incapacity Due to Illness Reported by Forty-Four Participants

Incapacity Due to Illness	Yes N	No N
Kept person in the house	22	22
Kept person from doing things	34	10
Kept person from seeing people	12	32
Kept person from work	36	8
Kept person in bed past year	14	30

The major causes of activity limitation within the study group were arthritis, heart conditions and emphysema. These findings are similar to those found by others. (15, 18). See Table 23.

The remaining questions of Section II focus on specific illnesses or disabilities. The conditions reported in this part of Section II are those previously not mentioned as "bothering" the persons in the study sample. The Kutner and Shanas studies both report an increase in the incidence of health complaints when the people interviewed were read a list of chronic conditions and symptoms. (8, 30)

In analyzing the data from the northwest Portland sample, an additional 97 complaints of health or disability problems were tabulated from the responses to the questions regarding specific illnesses, bringing the total complaints from the initial 73 to 170. This information will be summarized later in this chapter and presented in Table 26.

Question 5. Do you have trouble with your teeth? Forty-one of the participants deny having dental problems, but half of the group have dentures; four stated they did not fit properly and three only had an upper or a lower plate. Those with dental problems complained of pyorrhea or lack of all or most teeth. It appears that people with poorly fitting dentures simply accept the problem and for the most part do not wear the dentures.

Question 6. Are you hard of hearing? Fifteen claim to be

Table 23. Incapacity According to Illness Reported by Forty-Four Participants

Incapacity	Arthritis *N=12		Heart Problem N=15		Emphysema N=7		Skeletal N=7		Miscel- laneous N=3		Total N=44
Kept person in the house	7	6	7	1	7	1	7	1	1	22	
Kept person from doing things	11	11	7	3	7	2	7	2	2	34	
Kept person from seeing people	2	5	5	0	5	0	5	0	0	12	
Kept person from work	11	11	7	5	7	2	7	2	2	36	
Kept person in bed past year	1	6	5	1	5	1	5	1	1	14	

* Number of cases reported

hard of hearing. Within this group there was only one person who wore a hearing aide.

Question 7. Is your eye sight bad enough to keep you from reading? Twelve persons stated their eye sight is too poor to permit them to read; one person needed glasses but was unable to afford them. Forty-seven of the participants had glasses, although many admitted they usually purchased them in a hock shop or variety store.

Question 8. Did the doctor ever tell you that you have cataracts or glaucoma? One person was afflicted with glaucoma and 13 persons said they had cataracts, most of them having bilateral involvement.

Question 9. Do you have asthma or emphysema? One complaint of asthma was added to the data. All of those with emphysema had previously reported this illness as a health problem "bothering" them.

Question 10. Do you have or have you ever had Tuberculosis? Four persons responded in the affirmative bringing the incidence to five. Of these five individuals, two were being treated and three claim they had arrested cases. The two currently receiving treatment are checked once every three months and once every six months respectively. Two of the arrested group indicated they "never" have had a checkup; one goes annually to the health clinic for this purpose.

Question 11. Do you have heart trouble? If yes, what did the doctor say was the trouble? The majority of those with heart disease

had reported it earlier, but an additional six persons were added as a result of question 11. Descriptions of the type of heart conditions were somewhat vague. The participants did not appear to know the nature of the problem but referred to it only as a "bad heart". Three specific responses were: tachycardia, heart block and angina.

Question 12. Do you have high blood pressure? Thirteen persons said they had high blood pressure.

Question 13. Do you have kidney or bladder trouble? Forty-five participants denied any problems of this nature, but five others claimed they had "bladder troubles".

Question 14. Do you have gallbladder troubles? Three individuals were currently having gallbladder problems, although several have previously had their gallbladder removed.

Question 15. Do you have a stomach ulcer? Four answered with the affirmative. Seven people complained of their stomach "burning" but said they had not sought medical advice for this problem.

Question 16. Do you have diabetes? Only one additional incidence of diabetes was noted at this time.

Question 17. Do you have arthritis? If so, where? It has been suggested in previous studies that the conditions with the most obvious symptoms, such as arthritis, are those most likely to be reported to the interviewer. (32) In analyzing the data of this study,

extremity on the affected side. The fifth person involved in an automobile accident was a passenger during the time and suffered bilateral leg fractures, one of which has failed to heal, eight years later. The groups suffering from previous falls reported the results as: two with fractured hips, four with single leg fractures, one with bilateral leg fractures, one fractured arm and one fractured shoulder. The person suffering the shoulder fracture has a "frozen shoulder" as a result of the accident. He reported the doctors were unable to repair the fracture at the time of the fall because he had a cardiac arrest on the operating table immediately prior to the planned repair.

Ten persons have had major surgery since age 50; four experienced complications post operatively such as pneumonia, intestinal obstruction, kidney infection and heart failure. Eight persons had been hospitalized with acute heart problems, most of them more than once. Respiratory problems plagued three persons, two of them have severe emphysema; all three incidences involved hospitalization for pneumonia. Other conditions severe enough to require hospitalization were ulcers, stroke, back injury, cirrhosis, phlebitis with thrombosis of the leg and "nervous breakdown". See Table 24.

Table 24. Incidences of Major Ailments Since Age 50 Requiring Hospitalization Reported by Thirty-Three Participants

Ailments Reported	Incidence N
Ailments resulting from accidents	5
Ailments resulting from falls	9
Back injury	1
Cirrhosis	1
Nervous breakdown	1
Phlebitis and thrombosis of leg	1
Respiratory problems	3
Severe heart problem	8
Stroke	1
Surgery with complications	4
Surgery without complications	6
Ulcers	1
Total	41

Question 20. Is there anything (else) you've been letting go which might better be treated by a doctor? All responded in the negative.

Question 21. Did a doctor ever say you had cancer? Two persons reported the incidence of cancer bringing the total to three participants so afflicted.

Question 22. Do you take medicines regularly? If yes, which ones? Thirty-five of the participants said they took medicines regularly. The medications most frequently mentioned were those analgesic in nature such as aspirin, anacin and tylenol; the second largest group of medications consumed regularly were the sedatives and tranquilizers; others were diuretics, cardiotonics, expectorants, vitamins and vasodilators. Table 25 shows this information. An itemized list of medications is included in Appendix B.

Table 25. Medications Consumed Regularly by Thirty-Five Participants

Drug Category	Number Using Drug
Antacid	2
Analgesic	11
Anorexic	1
Anticonvulsent	1
Antihypertensive	2
Antituberculosis	2
Bronchial dilator	2
Cardiotonic	7
Cathartic	1
Diabetic	4
Diuretic	8
Expectorant	5
Potassium replacement	3
Sedatives or tranquilizer	9
Sinus	3
Vasodilators	4
Vitamins	5

In summary: the data from Section II shows that half of the participants perceived their health only as fair; this was expressed

more often by women than men. The remainder considered themselves in varying degrees of good or poor health, with more indicating they were in poor health. Slight differences of perceived health were noted among the various age categories but not sufficient to account for the differences in health.

The majority of the interviewees said their health had deteriorated over the past five years. Forty-four persons initially reported illnesses, however further questioning regarding specific illnesses increased the proportion reporting illnesses to forty-seven participants. The majority had two or more health complaints for a final total of 170 health problems reported. Incapacity due to health problems was a common phenomenon in the group, indicating functional consequences of illness were relatively high within the sample. One-half of those reporting illness were confined to their homes due to their health problems.

Table 26 summarizes the incidence of health complaints reported in Section II.

Table 26. Summary of Incidence of Health Complaints Reported by Study Group

Health Complaint	When Reported in Interview		Total Incidence
	Initially	Later	
Alcoholism	0	3	3
Arthritis	12	12	24
Asthma	1	1	2
Cancer	1	2	3
Cataracts	2	13	15
Circulatory problem	3	1	4
Diabetes	6	1	7
Emphysema	7	0	7
Epilepsy	1	0	1
Gastrointestinal problem	3	5	8
Gallbladder problem	0	3	3
Glaucoma	0	1	1
Hard of hearing	0	15	15
Heart disease	15	6	21
High blood pressure	2	13	15
Kidney or bladder problem	2	4	6
Neuritis	0	1	1
Pleurisy	1	0	1
Psoriasis	1	0	1
Psychiatric	2	0	2
Sinus problem	2	0	2
Skeletal immobility	7	0	7
Tuberculosis	1	4	5
Unhealed leg wounds	2	0	2
Vertigo	1	0	1
Visual disturbances	1	12	13
Total	73	97	170

Section III

The final section of the interview guide attempted to determine the participants' knowledge of the health care facilities and the availability and use of health services. The Portland Planning Commission, in reporting on conditions and problems of northwest Portland, suggested services and conveniences required by the elderly in that area of the city were only partially being met. (24) In 1966 it was reported that most of the elderly in northwest Portland were unaware of services that were available to them. (4) The data reported in Section II regarding health problems of the group indicate a definite need for health services.

Question 1. If you were suddenly taken very sick, where would you turn for help? It has been noted earlier, in Section II, that thirty-three of the forty-four participants reporting illnesses stated they were receiving medical care for their health problems. In answer to the present question, sixteen persons reported they would contact a private physician and an additional thirteen would go to a clinic or hospital. Six persons would contact a friend, six a relative and one reported he would call the police. Others mentioned are: landlady (three), hotel desk clerk (three), neighbor (one) and County Physician (one). Table 27 depicts the responses to this question.

Table 27. Place or Person Fifty
Participants Would Contact
in Health Emergency

Contact	Number
Private doctor	16
Clinic or hospital	13
Other	8
Friend	6
Relative	6
Police	1
Total	50

Question 2. How often do you have a physical checkup? If seldom or never, why don't you have a physical checkup more often? Twenty-four indicated they seldom or never have a physical checkup. Nineteen claimed they have a physical checkup "often"; two go to the doctor every three to six weeks for "checks" and eight regularly see their doctor every three to six months. See Table 28.

Table 28. Frequency of Physical Examinations Among the Study Group

Frequency of Examinations	Number
Often	19
Seldom	18
Never	6
Yearly	4
Only when sick	3
Total	50

In the northwest Portland group who claim they seldom or never have a physical examination, eight feel they don't need an examination and five proclaim they distrust doctors. The statements concerning distrust of physicians are as follows: 1) "Doctors don't know anything.", 2) "I don't trust doctors"., 3) "They keep me coming back when I don't need to.", 4) "They magnify all the little things out of proportion.", and 5) "I don't like doctors". An additional four did not believe a doctor could help them. Only two persons stated their reason for not having a physical examination often was because of lack of finances. Other reasons mentioned were: "I don't need one" (three), "I'm never sick" (one), and "I don't know where to go" (one). See Table 29.

Table 29. Reasons Expressed by Twenty-Four Participants for Seldom or Never Having a Physical Examination

Reason	Number
Don't need one	8
Distrust doctors	5
Don't think a doctor can help	4
Can't be bothered	3
Can't afford to go	2
Never sick	1
Don't know where to go	1
Total	24

Question 3. Do you usually have this checkup done by a private doctor or at a clinic? Although 24 participants claimed they seldom or never had a physical examination, 40 respondents stated they do have a doctor they can go to or a clinic they can attend. See Table 30.

Table 30. Responses of Fifty Participants Regarding Utilization of Private Physician or Clinic for Physical Examinations

Utilized for Examinations	Number
Clinic	22
Private doctor	18
Doctor years ago	7
None of the above	3
Total	50

Question 4. Do you have a regular physician who usually takes care of your illness? The majority do not have a regular physician. One explanation may be due to the high use of clinic facilities. Only three persons attending clinics for their health problems see the same doctor on a regular basis. The remainder do not have any one person treating their illnesses, although all but six reported one or more health complaints. See Table 31.

Table 31. Reported Use of Regular Physician by Fifty Participants

Regular Physician	Yes N	No N	Total N
Regular doctor	18	10	28
Regular clinic doctor	3	19	22
Total	21	29	50

Question 5. If you do not have a regular physician what is the reason? The reasons given are similar to the above. As noted in Table 31, there were 29 persons who claimed they did not have a regular physician treating their illnesses. The reasons given by this group for not having a regular physician were: "Can't afford one.", "Don't need one.", "Rather go to a clinic.", and "Don't know where to go." See Table 32.

Table 32. Reasons Expressed by Twenty-Nine Participants For Not Having a Regular Physician

Reason	Number
Can't afford one	17
Don't need one	7
Rather go to a clinic	4
Don't know where to go	1
Total	29

Question 6. have you ever heard of the following health services: Visiting Nurse (or Public Health Nurse), Home Health Care and Medical Outpatient Clinics? The Visiting Nurse or Public Health Nurse was known to thirty-nine of the sample. One reason may be most of the participants reside in census tracts 48 and 49. (See Table 3 which reports a higher number of visits by the Public Health Nurse in these two census tracts than the other three in northwest Portland; Census tract 48 reports more visits per 1,000 population than the whole Multnomah County). Medical outpatient clinics were familiar to 39 participants. It was determined earlier in this section that 22 respondents were utilizing the services of an outpatient clinic. Forty-one had not heard of Home Health Care, and none have received help from this private health facility. See Table 33.

Table 33. Knowledge of Three Specific Health Services Reported by Study Group

Health Service	Yes N	No N	Total N
Visiting Nurse or Public Health Nurse	39	11	50
Medical Outpatient Clinic	39	11	50
Home Health Care	9	41	50

Question 7. Have you ever gone to a clinic for medical help? Were you satisfied or dissatisfied? If dissatisfied, why? Twenty-two stated they had attended a clinic for medical services at one time or another. All but three were satisfied with the care they received. The reasons given for dissatisfaction were:

1. "You have to wait too long, it takes all day."
2. "It's so hard to get in and you have to wait so long while you're there."
3. "Too many young punks looking at you."

Question 8. If you needed medical treatment and had your choice, would you rather go to a private doctor or to a public hospital clinic? Thirty-one participants said they would prefer to go to a private physician for treatment.

Question 9. Do you have difficulty in obtaining medical help when you need it? All but two persons stated they do not have problems getting help when it is needed. One person replied, "I haven't

tried because I haven't needed any help". Another lady complained, "It took two months to get my husband into the Veterans' Hospital, where he finally died." It would appear from these data that if the person is ill he does receive care. This is consistent with the findings of the Kutner survey.

Question 10. Do you have any kind of health insurance or belong to a medical plan? Thirty participants indicated they subscribed to a medical insurance plan, mostly Medicare. Twenty-seven of the 32 people over 65 have Medicare coverage; four subscribed to supplemental plans in addition to Medicare. Twenty persons did not have any health insurance coverage, but most are not yet 65 years of age and therefore do not qualify for Medicare benefits. Most of this group imply lack of funds prevent them from maintaining coverage. See Table 34.

Table 34. Health Insurance Coverage
Reported by Sample

Insurance	Number
Medicare	23
No medical insurance	20
Medicare plus supplement	4
Blue Cross	3
Total	50

Question 11. If this neighborhood had a medical center especially for older people, would you go there for advice on your health problems? Why? Half of the respondents stated they would use a neighborhood health center designed for older people. Eight listed convenience as the reason they would probably use the facility; others said, "We need somewhere close". Eleven stated a center especially for older people is a good idea; four felt older people have different problems than those in the younger age group and need special understanding. One response implied an attitude of resignation, "I might as well go where the older people are!"; two others stated they prefer to be with people their own age. An elderly man replied he would use a clinic "If it's as good as County Hospital"; while another said he would go to a neighborhood facility "If I trusted the people running the clinic". One individual said she would use a neighborhood clinic, but the age of those being treated wasn't an important factor.

Twenty-three would not use a medical center designed especially for older people. Over half of this group prefer to stay with their present doctor or clinic. Other reasons given were as follows:

1. "I'm not that old". (two)
2. "Doctors don't keep up as well if they only treat older people". (one)
3. "Don't need to go". (three)

4. "I won't live that long, I'm dying now". (one)

5. "No one can help me". (one)

Two persons were uncertain whether they would use such a facility. See Table 35.

Table 35. Willingness to Use Neighborhood Health Center Especially for Older People Reported by Fifty Participants

Willingness to Use Center Especially for Older People	Number
Yes	25
No	23
Uncertain	2
Total	50

Question 12. Would you rather go to a center where people of all ages were treated? Why? This question is more directly aimed at ascertaining the preference for specialized geriatric services or for age integrated services. In response, eight persons definitely preferred a clinic where people of all ages are treated, seven of them stating they would rather be around younger people. Eight would rather go to a specialized clinic with the basic context of their feeling being "older people have different problems". Thirteen said they wouldn't use a neighborhood clinic, the main reasons being they preferred to remain with their present doctor

or clinic, or that they felt they did not need medical treatment.

Twenty-one stated age did not matter, but that they would use a neighborhood facility. See Table 36.

Table 36. Preference Toward Types of Medical Centers Reported by Study Group

Preferred Center	Number
No Preference	21
Would not use neighborhood center	13
Older people only	8
All ages	8
Total	50

There is currently much controversy among the people concerned with supplying health care to the aged regarding the feasibility of providing segregated, special geriatric services. The opposition argues that the health problems of the older citizen are no different from those of the younger ages, therefore they do not need isolated attention. Others feel the elderly benefit from having centrally located services dealing with all problems of the aging person. The purpose in asking the previous two questions was to determine whether the older person would use a specialized health service center or would prefer a facility established for all age groups. These data imply over half of the group would use a neighborhood center

but that the age of those being treated would not be a significant factor.

Question 13. Where do you think would be the best location for a health center in this neighborhood? Thirty-five persons could not suggest a location for a center. This would seem understandable considering one-half of the participants are homebound and do not have a vivid geographical picture of the area. Of the remaining 15, nine indicated a definite location but eight only replied, "Around here close". A few suggestions were: 1) close to the Pilot Project, 2) around the two new low cost housing buildings, 3) William Temple House, 4) Captain Brown House, 5) the empty automobile agencies on Burnside Street and 7) Fifth and Ankeny Street with the Public Health Department.

There appears to be a growing concern for involving the consumer of health services in planning of these services. Birren feels the elderly should live in a community in which most of the common daily needs can be met within walking distances. (2) This, of course, seems impossible in an area as large as northwest Portland. A health center would not be readily accessible to many. However, some feel a center would be feasible within the nucleus of a high concentration of older people, with transportation services provided for those in the outlying area.

Question 14. Are you on a special diet? If yes, what kind?

Nineteen said they were on a special diet. See Table 37.

Table 37. Diets Utilized by Fifty Participants

Type of Diet	Number
No restrictions	31
Diabetic, restricted salt	4
Diabetic	3
Bland, low roughage	3
High protein	3
Salt free	2
Low cholesterol	1
Low fat	1
Low fat, restricted salt	1
Low salt, bland, pureed foods	1
Total	50

Question 15. Do you have difficulties trying to keep on this diet? If yes, what are they? Almost two-thirds of the people on special diets stated they had some difficulty fulfilling the diet requirements. Schwartz maintains diet management with the older people is a major area of difficulty. Reports of her study indicate that

Some persons for whom special diets had been prescribed were unaware of these restrictions, others were unable to adhere to special diets because of difficulties in shopping for and preparing prescribed foods, and still others, not restricted in their diet, had nutritionally inadequate

eating patterns for want of interest or energy to do otherwise. (28)

Following are statements made by the study group of reported difficulties in maintaining special diets:

1. "Unable to afford the foods required"; diabetic, restricted salt (one person), high protein (two persons; one with Tuberculosis), diabetic (one person).
2. "Unable to have special diets at the hotel"; salt free (one person).
3. "Get hungry for sweets"; diabetic (one person).
4. "Hard to get used to no salt"; salt free (one person).
5. "I don't try, if I eat what I want I feel better!"; low fat (one person).
6. "I like salads too well"; bland, low roughage (one person).
7. "I have so many problems and a poor appetite"; low salt, pureed bland foods (one person).
8. "It's hard to cook; only have a hot plate"; high protein (one person).

It can be noted about one-half of the group reporting dietary difficulties have problems financially, in preparing foods or acquiring foods. One person with a poor appetite not only has the problem of a tasteless diet, but is quite ill. He is almost totally incapacitated with emphysema. It is necessary for him to remain in bed most of

the time. He also has cancer of the throat and stomach lending difficulty to swallowing or digesting food. The remaining four persons appeared to lack motivation in adhering to their diets.

Question 16. Would it be helpful to you to have somewhere to go to get help in preparing foods for your special diet or to have a place in the neighborhood where you could eat that would provide you with this type of meals? Only one of the nineteen on special diets reported he would find such a service helpful. This individual previously reported difficulties in preparing his foods. He resides in a hotel with only a hot plate for cooking facilities. All the others prefer to eat their meals at home, even though the diet may be nutritionally inadequate.

Question 17. How much do you spend a week on groceries. Do you feel you have enough to eat? Where do you usually eat your meals?

The thirteen persons residing in hotel rooms or boarding houses were unable to report the amount spent on food since they pay their board and room in one sum. Ten persons buy \$28.00 worth of food stamps per month for the purchase price of \$18.00. Seven reported this is the total amount they spend on groceries per month. Three stated they supplement their food stamps with an additional \$10.00 to \$15.00 per month. Only three spend close to \$20.00 a week for groceries; nearly twice as many reported they spend less

than \$10.00 a week. Table 38 compares the amount of money spent on food among the participants. The monthly amounts are divided by four to estimate a weekly amount.

Table 38. Money Spent for Groceries Per Week as Reported by Fifty Participants

Amount	Number
Varies or don't know	21
\$10 to \$15	10
\$7 (food stamp dollars)	7
Under \$10 (no food stamps)	6
\$7 (food stamp dollars) plus \$2 to \$3	3
\$16 to \$20	3
Total	50

Most participants expressed that they have enough to eat, but some stipulated their diet intake was adequate in quantity but not necessarily quality. Three persons reported they did not have enough to eat.

All of those living in apartments cook their own meals and eat at home alone. Only two persons stated they occasionally eat with a neighbor. All but two of the hotel and boarding house residents eat in the dining rooms with the others living in the same place. Two eat in their hotel rooms, one cooked on a hot plate and one was too

ill to leave his room; his meals are brought to him.

Question 18. Do you have any special difficulty traveling? Can you: use a bus, a car, climb stairs, climb a curb? As was pointed out earlier the degree of physical mobility is closely associated with health. (22) Schwartz reported that although many elderly were labeled ambulatory, some were, in fact, not. (29) Many of those impairments afflicting the northwest Portland sample were summarized in Table 27. This question pertains to information regarding special difficulties in traveling.

Thirty participants reported some difficulty in traveling. Riding a bus and climbing stairs appeared to be the most difficult to achieve. Twenty-nine participants reported they either could not climb stairs at all or could do so only with difficulty. Almost as many of the group could not use a bus. Ten stated they could not use a bus because the steps to the buses are too high. All reported they could use a car, although a few indicated difficulty entering and leaving a vehicle or traveling to and from a car. Six persons cannot climb curbs due to skeletal mobility problems. See Table 39.

Table 39. Mode of Travel as Reported by the Study Group

Mode of Travel	Yes	No	Difficult	Total
Use a bus	26	22	2	50
Climb stairs	21	9	20	50
Climb a curb	43	6	1	50
Use a car	45	0	5	50

Question 19. Do you have problems in trying to get to places where medical help is available? If yes, what is the problem?

It has been reported that large numbers of older people with chronic afflictions are ambulatory and able to travel to doctors or clinics for medical care. (29) This appears to be the situation within the study group. Forty-five participants stated that they do not have any special problems traveling to where medical help is available, but twenty-two persons have to be taken in cars or cabs. Five persons reported specific difficulties. Three find the distance that must be traveled is difficult to manage on the bus, two cannot use the bus and must pay for cab fare which is a financial hardship.

Question 20. Are there any special services that could help you in your daily living: housekeeping service, Home Health Care, Public Health Nurse, help with shopping, other? Over half of the study group said they needed housekeeping help or assistance with their shopping. Eighteen were already receiving help with their shopping from a Northwest Pilot Project visitor. A few had neighbors who help with shopping and three have children who perform this task. Those residing in hotel rooms do not have the problem of shopping for food, but occasionally they need some personal shopping done for them. Housekeeping is provided at the hotels but at least twelve of those who reside in apartments are able to do only the barest essentials such as cooking and washing the dishes; (some

even having difficulty with these duties). None expressed the need for Home Health Care; however 41 had not previously heard of the service and perhaps had not thought about it before. Only one person is being visited regularly by a Public Health Nurse at the present time; however, five said they have benefitted by this service in the past. No additional participants indicated the need for a visit by a Public Health Nurse. See Table 40.

Table 40. Special Services Needed to Aid Daily Living

Services Needed	Number
Shopping	18
Housekeeping	12
Public Health Nurse	1
Home Health Care	0
Other	0

Question 21. Thinking about all of these problems, what do you think is the biggest problem older people experience? Loneliness and boredom headed the list, but "Not enough money" seemed to be a priority problem. Only five persons expressed no opinion. Other responses were:

1. "Everyone takes advantage of them. They are not considered a group with worth."

2. "Too many are lazy, they don't want to help themselves."
3. "The trouble with most old people, they think they're too old to have anything to do with anyone else."
4. "They need someone to shop for them, someone to look in on them to make sure they're o.k."
5. "Nothing to live for."
6. "Children forget them and nobody cares."
7. "Growing old."
8. "Losing your mate."
9. "Poor health and inability to work."
10. "Housekeeping help."

See Table 41.

Table 41. Priority Problems of Old People as Perceived by the Study Group

Problem	Number
Loneliness or boredom	21
Not enough money	14
Other	7
No opinion	5
Aides to daily living	2
Poor health	1
Total	50

Lately there seems to be an increased awareness among the older persons themselves regarding deprivations. There has been some recognition of the powerlessness of the aged and the failure to consider the aged a real group. (36) Even though they may not be a recognized group, many express compassion and understanding of their peers, the association possibly being one of major support.

In summarizing the information gathered from Section III, it appears that in the event of a health emergency, the majority of the participants would have someone to whom they could turn for help. Most reported they would call their doctor, go to a clinic or to a hospital.

The groups showed some hesitancy in having regular physical examinations, with half of them admitting they seldom or never went to a doctor for this purpose. The reason most often given for not having a regular examination was, "I don't need one", even though the majority expressed one or more complaints of chronic illness.

Most interviewees reported they did have a doctor of clinic they could contact in the event of illness; however, the majority did not have a regular doctor. One explanation could be the reported high utilization of public clinics; only three people saw the same doctor at each clinic visit.

Most would prefer to go to a private doctor for medical treatment but expressed that they could not afford one.

Public Health Nurses and Medical Outpatient Clinics were well known to the participants whereas Home Health Care was not a familiar service among the group.

Slightly more people had medical insurance coverage than did not, with 54 percent subscribing to Medicare. Almost all of those under 65, and therefore not qualified for Medicare, did not have health insurance. Lack of funds was the primary reason given for not subscribing to an insurance plan.

The majority said they would use a neighborhood health center but only 16 percent stipulated they would prefer a specialized geriatric center. Of those who were on special diets, almost two-thirds experience some difficulty fulfilling the dietary requirements, usually due to lack of funds. More than one-half of the participants spend less than ten dollars a week on groceries; the majority felt they have enough to eat.

Traveling is difficult for most of the participants but largely they could find some way of reaching medical facilities if necessary. Housekeeping services and help with shopping are areas where more help is needed in the activities of daily living. The group perceived the biggest problems of older people to be loneliness and not enough money.

CHAPTER IV

SUMMARY, CONCLUSIONS AND RECOMMENDATIONS

Summary

The increase in the number of older people in our society is accelerating yearly. Within this expanding population there are many unmet needs, among these problems relating to health. Authorities involved in programs for the aging have suggested one practical approach to planning to meet the problems of the elderly is to search out concentrations of older persons living in community settings followed by adaption of special services believed to be necessary in such geographical areas. The district of northwest Portland contains the highest concentration of persons over 65 in the city and was the area selected for this study. The purpose of the study was to identify the health needs of a select group of elderly people as they perceive them, to determine whether there are common health needs among this group and to report implications for needed health services.

The method selected for the study was a survey of statements of needs of 50 elderly persons using the personal interview technique. The study was descriptive in nature with the thought that the

response of the participants to six personal items, 22 items pertaining to health status and 21 items dealing with knowledge, availability and use of health care facilities would provide sufficient data to describe the population under study and provide a basis for reporting their health needs and needs for health services.

The study group ranged in ages from 60 years to 88 years with the median age approximately 67 years. The sexes were represented almost equally, 28 women and 22 men. The majority were either divorced or widowed with the proportion of those widowed increasing with age. Rented apartments were the usual place of residence and all but four were living alone. Most of the study group were living at poverty level or below.

Regarding perceived health status, half of the participants regarded their health as only fair. The remainder considered themselves in varying degrees of good or poor health, with more indicating they were in poor health. Slight differences of perceived health were noted among the various age categories but not sufficient to account for differences in health.

The majority of the interviewees reported their health had deteriorated over the past five years. Forty-three initially reported illnesses, however further questioning regarding specific illnesses increased the number reporting illnesses to forty-seven participants. The majority had two or more health complaints for a final total of

170 health problems reported.

Incapacity due to health problems was a common phenomenon in the group, indicating functional consequences of illness were relatively high within the sample. One-half of those reporting illnesses were confined to their homes due to health problems.

With regard to health facilities, the participants indicated that in the event of a health emergency, the majority would have someone to whom they could turn for help. Most reported they would call their doctor or go to a clinic or hospital.

The group demonstrated some hesitancy in having regular physical examinations, with half of them admitting they seldom or never went to a doctor for this purpose. Most interviewees reported they did have a doctor or clinic they could contact in the event of illness; with slightly more using clinic facilities than private physicians. The majority would prefer to go to a private doctor for medical treatment but indicated they could not afford one.

Inquiring into knowledge of specific health care facilities, the study group indicated Public Health Nurses and Medical Outpatient Clinics were well known whereas Home Health Care was not a familiar service among the group. The majority of the sample said they would use a neighborhood health center if there was one available; but only eight stipulated they would prefer a specialized geriatric center.

Of those on special diets, two-thirds experience some difficulty fulfilling the dietary requirements, usually due to lack of funds. Traveling was found to be an area of difficulty but most could find a means of reaching medical facilities if necessary.

Help with housekeeping and shopping were services over half the group felt would aid their daily living. The participants perceived the biggest problems of older people to be loneliness and not enough money. Only one respondent felt poor health was a major problem of the elderly.

Conclusions

It is concluded on the basis of this study that there are many health needs among the elderly. The reliability of the information may be questioned because it consists of subjective evaluation of health status rather than on objective information obtained through more reliable means, such as a physical examination. The literature indicates that information such as this does have some value in determining how the individual functions in the community and how he perceives himself in terms of contentment and adjustment.

The findings do raise an important question regarding the role health plays in the meaning of old age to the older people themselves. Although the participants appeared to be apathetic regarding preventive health care, and complacent or accepting regarding existing

health problems, they did identify numerous needs. Loneliness and lack of money were of greater concern than physical health. If these aggregates of older people are to be viewed as "populations at risk" in planning health care services, more investigation into the priorities of concern as perceived by the population involved would seem to have merit. Questions also arise as to the kinds of health care facilities the older person would prefer to utilize.

Recommendations for Further Study

On the basis of this study the following recommendations would appear relevant:

1. Further study should be carried out in which the participants' subjective evaluation of health status is correlated to objective medical findings.
2. Separate and extensive studies should be done on all areas of expressed health service needs in an attempt to establish perceived priorities of the elderly.
3. Explore the matter of loneliness among the aged, particularly among those who are not very mobile. Ascertain what is being done to reduce loneliness, what more can or should be done.

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APPENDICES

APPENDIX A

THE INTERVIEW GUIDE

Section I

1. Sex _____
2. Age _____
3. Marital Status:
 Single _____
 Married _____
 Widowed _____
 Divorced _____
 Separated _____
- Age of husband (wife) _____
 How long _____
 How long _____
 How long _____
4. Type of Residence:
 Rented apartment _____
 Furnished room _____
 Room in relative house _____
 Room in nonrelative house _____
- Own coop. apartment _____
 Hotel room _____
 Boarding house _____
 Own house _____
 Rented house _____
5. Do you live alone? _____ If not, who else lives here?
 ages sex relation

6. Approximate monthly income? _____

Section II

1. Concerning your health now, would you say your health is?
 excellent _____ poor _____
 good _____ very poor _____
 fair _____
2. Has it been the same over the past five years? _____
 better _____ worse _____

3. Is there any particular physical or health problem that bothers you at present? yes _____ no _____
4. If yes: a. What is the trouble? _____
 b. Is it being taken care of by a doctor? _____
 c. Does it keep you in the house? _____
 d. Does it keep you from doing things? _____
 e. Does it keep you from seeing people? _____
 f. Does it keep you from work? _____
 g. Has it kept you in bed during the past year? _____
 If yes; How long? _____
5. Do you have trouble with your teeth? yes _____ no _____
 all or most are missing _____
 false teeth _____ other _____
6. Are you hard of hearing? yes _____ no _____
 If yes; Do you wear a hearing aide? _____
7. Is your eye sight bad enough to keep you from reading? _____
 need glasses _____ have glasses _____
8. Did the doctor ever tell you you had cataracts?
 yes _____ no _____ glaucoma? yes _____ no _____
9. Do you have asthma? _____ emphysema? _____
10. Do you have or have you ever had TB? yes _____ no _____
 under Rx for _____ arrested _____
 how often checked _____
11. Do you have heart trouble? yes _____ no _____
 If yes; What did the Dr. say was the trouble? _____
12. Do you have high blood pressure? yes _____ no _____
13. Do you have kidney or bladder trouble? yes _____ no _____
14. Do you have gallbladder trouble? yes _____ no _____
15. Do you have a stomach ulcer? yes _____ no _____
16. Do you have diabetes? yes _____ no _____
17. Do you have arthritis? yes _____ no _____
 Where? _____
18. Any other trouble? _____
19. Since the time you were about 50, have you had any serious ailment (operation, accident or illness) which bothers you at all now?

20. Is there anything (else) you've been letting go which might better be treated by a doctor? yes _____ no _____
If yes; What is it? _____
21. Did a doctor ever say you had cancer? yes _____ no _____
22. Do you take medicines regularly? yes _____ no _____
If yes; Which ones? _____

Section III

1. If you were suddenly taken very sick, where would you turn for help?
private doctor _____ clergyman _____
friend _____ clinic or hospital _____
relative _____ police _____
druggist _____ other _____
2. How often do you have a physical checkup? _____
If seldom or never; Why don't you have a physical checkup more often even though you think it's a good idea? _____
3. Do you usually have this checkup done by a private doctor or at a clinic? _____
4. Do you have a regular physician who usually takes care of your illness? yes _____ no _____
5. If you do not have a regular physician, what is the reason?
6. Have you ever heard of the following health services?
Visiting Nurse (Public Health Nurse) _____
Home Health Care _____ Medical Outpatient Clinics _____
7. Have you ever gone to a clinic for medical help? yes ___ no ___
Were you satisfied or dissatisfied? _____
If dissatisfied; Why? _____
8. If you needed medical treatment and had your choice, would you rather go to a private physician or a public hospital clinic?
9. Do you have difficulty in obtaining medical help when you need it? yes _____ no _____

10. Do you have any kind of health insurance or belong to a medical plan? _____
 Medicare _____ Other _____
11. If this neighborhood had a medical center especially for older people, would you go there for advice on your health problems? yes _____ no _____
 Why? _____
12. Would you rather go to a center where they treated people of all ages? yes _____ no _____
 Why? _____
13. Where do you think would be the best location for a health center in this neighborhood? _____
14. Are you on a special diet? yes _____ no _____
 If yes; What kind? _____
15. Do you have difficulties trying to keep on this diet? _____
 If yes; What are they? _____
16. Would it be helpful to you to have somewhere to go to get help in preparing foods for your special diet or to have a place in the neighborhood where you could eat your meals that would provide you with this type of meals? yes ___ no ___
17. How much do you spend per week on groceries? _____
 Do you feel you have enough to eat? yes _____ no _____
 Where do you usually eat your meals? _____
18. Do you have any special difficulty traveling? _____
 Can you use a bus? _____ Climb stairs? _____
 Can you use a car? _____ Climb a curb? _____
19. Do you have problems in trying to get to places where medical help is available? yes _____ no _____
 If yes; What is the problem? _____
20. Are there any special services that could help you in your daily living?
 housekeeping service _____ someone to help with
 Home Health Care _____ shopping _____
 Public Health Nurse _____ other _____
21. Thinking about all of these problems, what do you think is the biggest problem older people experience? _____

APPENDIX B

SUMMARY OF DATA

Section I

1.	Sex	<u>Women 28</u>	<u>Men 22</u>	
2.	Age	<u>Range 60-88</u>		
		<u>Median age</u>	Females 66.7	
			Males 67	
		<u>Groups</u>	<u>Men</u>	<u>Women</u>
				<u>Total</u>
		60-64	8	10
		65-74	7	10
		75+	7	8
3.	Marital Status:			
	Part A:	Single	<u>7</u>	(Men 2, Women 5)
		Married	<u>4</u>	
		Widowed	<u>17</u>	(Men 6, Women 11)
		Divorced	<u>21</u>	(Men 11, Women 10)
		Separated	<u>1</u>	(Men)
	Part B:	Age of husband (wife)		
		Couple # 1: wife 63, husband 63		
		Couple # 2: wife 69, husband 72		
		How long widowed:	1 - 5 years	<u>2</u>
			6 - 15 years	<u>6</u>
			16 - 25 years	<u>4</u>
			26 + years	<u>5</u>

How long divorced: 1 - 5 years 1
 6 - 15 years 8
 16 - 25 years 5
 26 + years 7

How long separated: "for years"

4. Type of Residence:

Rented apartment <u>36</u>	Own coop. apartment <u>0</u>
Furnished room <u>1</u>	Hotel room <u>10</u>
Room in relative house <u>0</u>	Boarding house <u>3</u>
Room in nonrelative house <u>0</u>	Own house <u>0</u>
	Rented house <u>0</u>

5. Do you live alone? yes 46 no 4

If not, who else lives here?

age	sex	relation
<u>63</u>	<u>Fe</u>	<u>wife</u>
<u>63</u>	<u>M</u>	<u>husband</u>
<u>72</u>	<u>M</u>	<u>husband</u>
<u>69</u>	<u>Fe</u>	<u>wife</u>

6. Approximate monthly income? Single Men: Range \$124-\$189; Median income: \$142.50 per month; \$1,710 per year
 Single Women: Range \$99.40-\$370; Median income: \$130.35 per month; \$1,564.20 per year
 Married couple: Couple # 1 \$204.90 per month
 \$2,458.80 per year
 Couple # 2 \$270 per month
 \$3,240 per year

Section II

1. Concerning your health now, would you say your health is?
 excellent 7 fair 25
 good 4 poor 8
 very poor 6
2. Has it been the same over the past five years?
 same 16 better 2 worse 32
3. Is there any particular physical or health problem that bothers you at present? yes 44 no 6
4. If yes: a. What is the trouble?
- | | |
|------------------------------|------------------------------|
| Arthritis <u>12</u> | Kidney or bladder |
| Asthma <u>1</u> | problem <u>2</u> |
| Cancer <u>1</u> | Pleurisy <u>1</u> |
| Cataracts <u>2</u> | Psoriasis <u>1</u> |
| Circulatory problem <u>3</u> | Psychiatric <u>2</u> |
| Diabetes <u>6</u> | Sinus problem <u>2</u> |
| Emphysema <u>7</u> | Skeletal immobility <u>7</u> |
| Epilepsy <u>1</u> | Tuberculosis <u>1</u> |
| Gastrointestinal | Unhealed leg wounds <u>2</u> |
| problem <u>3</u> | Vertigo <u>1</u> |
| Heart disease <u>15</u> | Visual disturbances <u>1</u> |
| High blood pressure <u>2</u> | |
- b. Is it being taken care of by a doctor?
 yes 34 no 10
- c. Does it keep you in the house? yes 22 no 22
- d. Does it keep you from doing things?
 yes 34 no 10
- e. Does it keep you from seeing people?
 yes 12 no 32

- f. Does it keep you from work? yes 36 no 8
- g. Has it kept you in bed during the past year?
 yes 14 no 30
 If yes: How long? Less than one week 4
 one to two weeks 2
 three weeks to one month 2
 one month 1
5. Do you have trouble with your teeth? yes 9 no 41
 all or most missing 4 only upper or lower 3
 false teeth 25 other (pyorrhea) 2
 don't fit 4
6. Are you hard of hearing? yes 15 no 35
 If yes; Do you wear a hearing aide? yes 1 no 14
7. Is your eye sight bad enough to keep you from reading?
 yes 12 no 37 previously mentioned 1
 need glasses 1 have glasses 47
8. Did the doctor ever tell you you had cataracts?
 yes 13 no 35 previously mentioned 2
 Did the doctor ever tell you you had glaucoma? yes 1 no 49
9. Do you have asthma? yes 1 no 48 previously
 mentioned 1; Emphysema? yes 0 no 43
 previously mentioned 7
10. Do you have or have you ever had TB? yes 4 no 45
 previously mentioned 1 under Rx for 2
 arrested 3
 How often checked: every 6 months (1)
every 3 months (1) never (2)
yearly (1)

11. Do you have heart trouble? yes 6 no 29
 previously mentioned 15
 If yes; What did the doctor say was the trouble?
 tachycardia 1 heart block 1
 angina 2 "bad heart" 3
 don't know 14
12. Do you have high blood pressure? yes 13 no 35
 previously mentioned 2
13. Do you have kidney or bladder trouble? yes 4 no 45
 previously mentioned 1
14. Do you have gallbladder trouble? yes 3 no 47
15. Do you have a stomach ulcer? yes 4 no 46
16. Do you have diabetes? yes 1 no 42 previously
 mentioned 7
17. Do you have arthritis? yes 12 no 26
 previously mentioned 12
 Where? hands 12, knees 2, back 6, legs 9,
 hips 7, arms 2, shoulder 2,
 ankles 2, wrists 1, feet 1.
18. Any other trouble?
 constipation 1, alcoholic 3, colitis 1, neuritis 1,
 varicose veins 1.
19. Since the time you were 50, have you had any serious ailment
 (operation, accident or illness) which bothers you at all now?
 a. Accidents 5
 1) Passenger in automobile involved in accident. Frac-
 tured both legs, left wound fails to heal eight years
 later.
 2) Motorcycle accident at age 78, fractured eight ribs,
 collarbone and shoulder.
 3) Hit by car, suffered concussion (required burr holes),
 crushed left arm, vertigo and nervousness since.

- 4) Hit by car, fractured skull, fractured leg. Has chronic osteomyelitis of leg in fracture site and suffers "black out" spells since accident.
 - 5) Hit by car, fractured hip, remained in body cast six months, complains of "frozen hip".
- b. Falls 9
- 1) Severe emphysemic, "blacked out" during coughing spell, fell fracturing ankle and leg.
 - 2) Fell fracturing lame leg (due to polio). Confined to a wheelchair since, was previously able to walk.
 - 3) Bilateral leg fractures.
 - 4) Fractured hip, (2)
 - 5) Fractured shoulder socket, unable to repair, suffered cardiac arrest on operating table previous to scheduled repair.
 - 6) Fell while drunk, fractured leg and slipped disc.
 - 7) Fractured leg.
 - 8) Fractured arm.
- c. Severe heart problems 8
- 1) Heart attack four years ago, hospitalized almost yearly since for about two weeks at a time.
 - 2) Two heart attacks within past year.
 - 3) Myocardial infarct six years ago.
 - 4) Heart attack seven years ago.
 - 5) Heart attack two years ago.
 - 6) Heart attack five months ago.
 - 7) Pacemaker installed two years ago.
 - 8) Two heart attacks within last two years.
- d. Surgery without complications 6
- 1) Cervical laminectomy for calcium deposits.
 - 2) Herniorrhaphy (still persists).
 - 3) Gastric resection.
 - 4) Diaphragmatic hernia.

- 5) Radical mastectomy.
- 6) Cataract removal.
- e. Surgery with complications 4
- 1) Hemorrhoidectomy followed by pneumonia.
- 2) Cholecystectomy followed by intestinal obstruction.
- 3) Gastric resection followed by pneumonia and kidney infection.
- 4) Prostatectomy with post operative heart failure.
- f. Other medical problems 9
- 1) Stroke.
- 2) Ulcers.
- 3) Pneumonia 3.
- 4) Phlebitis and thrombosis of leg.
- 5) Old back injury.
- 6) Nervous breakdown.
- 7) Cirrhosis.
20. Is there anything (else) you've been letting go which might better be treated by a doctor? yes 0 no 50
21. Did the doctor ever say you had cancer? yes 2 no 47
previously mentioned 1
22. Do you take medicines regularly? yes 35 no 15
If yes; Which ones?
- | | |
|--|--|
| a. Antacid <u>2</u> | e. Antihypertensive <u>2</u> |
| 1) maalox <u>2</u> | 1) Reserpine <u>1</u> |
| b. Analgesic <u>11</u> | 2) "High blood pressure pill" <u>1</u> |
| 1) aspirin <u>5</u> | f. Antituberculosis <u>2</u> |
| 2) anacin <u>5</u> | 1) Isoniazid <u>2</u> |
| 3) tylenol <u>1</u> | g. Bronchial dilator <u>2</u> |
| c. Anorexic <u>1</u> | 1) Aludrin <u>1</u> |
| 1) chlorphentermine hydrochloride <u>1</u> | 2) Isuprel nebulizer <u>1</u> |
| d. Anticonvulsent <u>1</u> | |
| 1) Dilantin <u>1</u> | |

h. Cardiotonic	<u>7</u>	n. Sedatives or tranquilizers	<u>9</u>
1) Digitoxin	<u>4</u>	1) Phenobarbital	<u>4</u>
2) Digitalis	<u>3</u>	2) Librium	<u>2</u>
i. Cathartic	<u>1</u>	3) "Nerve pills"	<u>2</u>
1) Milk of magnesia	<u>1</u>	4) "Sleeping pill"	<u>1</u>
j. Diabetic	<u>4</u>	o. Sinus medication	<u>3</u>
1) Diabinese	<u>3</u>	1) Bronatine	<u>1</u>
2) Insulin	<u>1</u>	2) Asthma-nephrin nose drops	<u>2</u>
k. Diuretic	<u>8</u>	p. Vasodilators	<u>4</u>
1) Diuril	<u>1</u>	1) Peritrate	<u>1</u>
2) Lasix	<u>3</u>	2) Nitroglycerin	<u>3</u>
3) "Water pills"	<u>3</u>	q. Vitamins	<u>5</u>
4) Hydrochlorothiazide	<u>1</u>	1) Geritol	<u>1</u>
l. Expectorant	<u>5</u>	2) Vigran	<u>1</u>
1) Potassium iodide drops	<u>5</u>	3) Theragran	<u>1</u>
m. Potassium replacement	<u>3</u>	4) One a day	<u>1</u>
1) Potassium chloride	<u>3</u>	5) Pyridoxine (B6)	<u>1</u>

Section III

1. If you were suddenly taken very sick, where would you turn for help?
- | | | | |
|----------------|-----------|--------------------|-----------|
| private doctor | <u>16</u> | druggist | <u>0</u> |
| friend | <u>6</u> | clergyman | <u>0</u> |
| relative | <u>6</u> | clinic or hospital | <u>13</u> |
| police | <u>1</u> | other | <u>8</u> |
2. How often do you have a physical checkup?
- | | | | |
|--------|-----------|----------------|----------|
| never | <u>6</u> | yearly | <u>4</u> |
| seldom | <u>18</u> | only when sick | <u>3</u> |
| often | <u>19</u> | | |

10. Do you have any kind of health insurance or belong to a medical plan?

Medicare 23 Medicare plus other 4
 Blue Cross 3 none 20

11. If this neighborhood had a medical center especially for older people, would you go there for advice on your health problems?

yes 25 no 23 don't know 2

Why: Those answering yes:

Convenience 8 Good idea 7
 Older people have special problems 4
 Prefer to be with people my own age 2
 If it's as good as County hospital 1
 If I trusted the people running it 1
 Age doesn't matter 1
 Might as well go where the old people are 1

Why: Those answering no:

Rather stay with my own doctor or clinic 15
 I'm not that old 2 Don't need to go 3
 Doctors don't keep up as well if they only treat older people 1
 I won't live that long, I'm dying now 1
 No one can help me 1

12. Would you rather go to a center where they treated people of all ages?

yes 8 no 8 doesn't matter 21 wouldn't use it anyway 13

Why: Those answering yes:

Rather be around young people 7
 Doctor's don't keep up as well if they only treat older people 1

Why: Those answering no;

Older people have different problems _____ 4 _____

Rather be with people my own age _____ 3 _____

Might as well go where the older people are _____ 1 _____

13. Where do you think would be the best location for a health center in this neighborhood?

don't know _____ 35 _____ around here close _____ 8 _____

suggested locations _____ 7 _____

suggested locations

close to Pilot Project _____ 1 _____ around the two new low cost

William Temple House _____ 1 _____ housing buildings _____ 1 _____

Captain Brown House _____ 1 _____ The empty automobile agencies

on Burnside _____ 1 _____

Fifth and Ankeny with Public Health Dept. _____ 1 _____

14. Are you on a special diet? yes _____ 19 _____ no _____ 31 _____

If yes, what kind?

Diabetic _____ 3 _____ Diabetic, restricted salt _____ 4 _____

Bland, low roughage _____ 3 _____ High protein _____ 3 _____

Salt free _____ 2 _____ Low cholesterol _____ 1 _____

Low fat _____ 1 _____ Low fat, restricted salt _____ 1 _____

Low salt, bland, pureed foods _____ 1 _____

15. Do you have difficulties trying to keep on this diet?

yes _____ 11 _____ no _____ 8 _____

If yes, what are they?

Unable to afford foods required _____ 4 _____

Unable to have special diets at the hotel _____ 1 _____

Get hungry for sweets _____ 1 _____

Hard to get used to no salt _____ 1 _____

I don't try, if I eat what I want I feel better _____ 1 _____

I like salads too well _____ 1 _____

I have so many problems and a poor appetite _____ 1 _____

It's hard to cook, only have a hot plate _____ 1 _____

16. Would it be helpful to you to have somewhere to go to get help in preparing foods for your special diet or to have a place in the neighborhood where you could eat your meals that would provide you with this type of meals?
 yes 1 no 18
17. How much do you spend per week on groceries?
 \$7 (food stamp dollars) 7 \$7 (food stamp dollars) plus \$2 to \$3 3
 under \$10 6
 \$11 to \$15 10 \$16 to \$20 3
 varies or don't know 21
 Do you feel you have enough to eat? yes 47 no 3
 Where do you usually eat your meals?
 own apartment 36 hotel dining room 12
 hotel room 2
18. Do you have any special difficulty traveling? yes 30 no 20
 Can you use a bus? difficult 2 yes 26 no 22
 Can you use a car? difficult 5 yes 45 no 0
 Climb stairs? difficult 20 yes 21 no 9
 Climb a curb? difficult 1 yes 43 no 6
19. Do you have problems in trying to get to places where medical help is available? yes 5 no 45
 If yes, what is the problem?
 Distance difficult on bus 3
 Have to go in cab, (difficult financially) 2
20. Are there any special services that could help you in your daily living?
 housekeeping service; yes 12 no 38
 Home Health Care; yes 0 no 50
 Public Health Nurse; yes 1 no 49
 help with shopping; yes 18 no 32
 other; yes 0 no 50

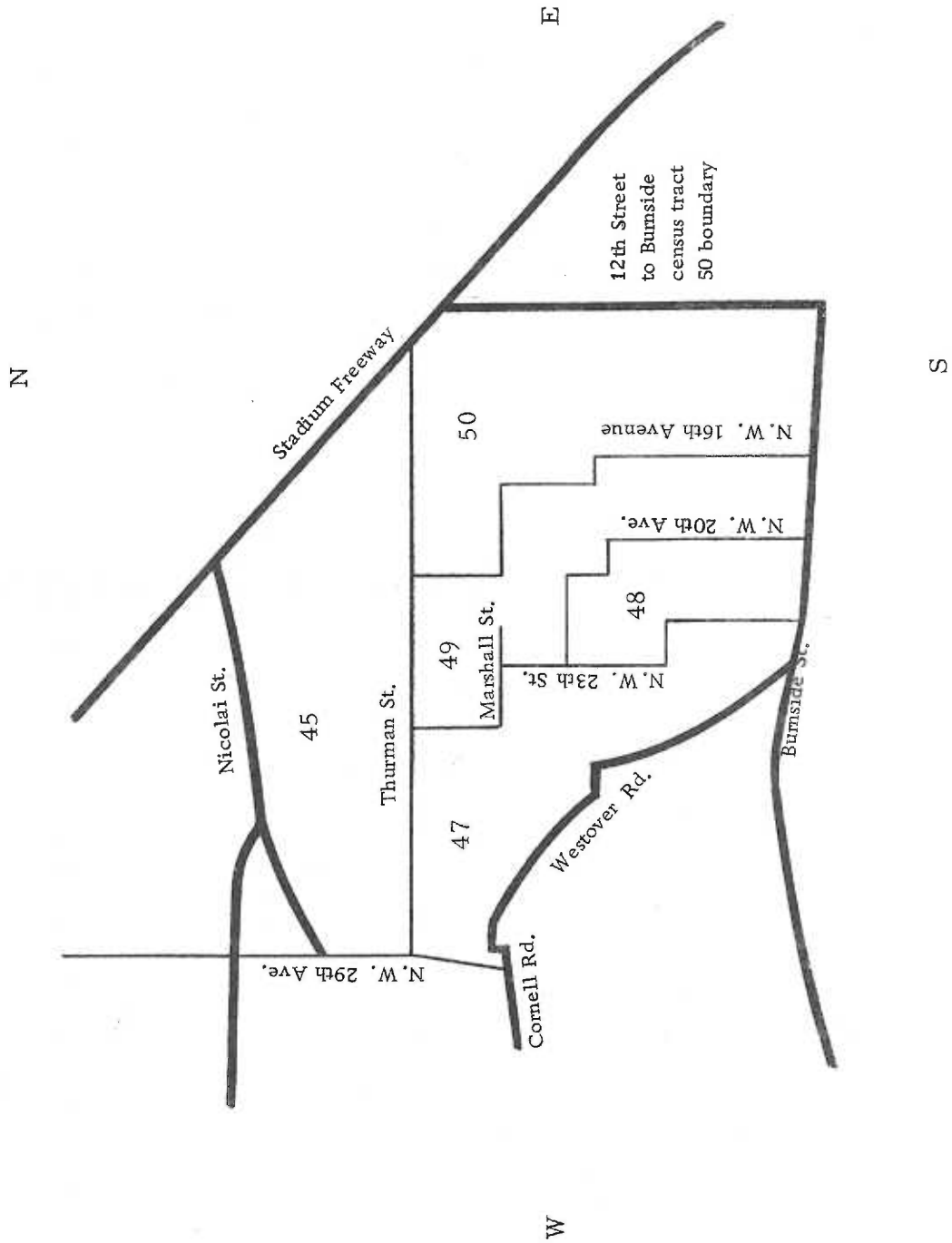
21. Thinking about all of these problems, what do you think is the biggest problem older people experience?

Loneliness or boredom	<u>21</u>
Not enough money	<u>14</u>
Help in daily living activities	<u>2</u>
Poor health	<u>1</u>
Don't know	<u>5</u>
Other	<u>7</u>

- a. Everyone takes advantage of them. They are not considered a group with worth.
- b. Too many are lazy, they don't want to help themselves.
- c. The trouble with most old people, they think they're too old to have anything to do with anyone else.
- d. Nothing to live for.
- e. Children forget them and nobody cares.
- f. Growing old.
- g. Losing your mate.

APPENDIX C

MAP OF NORTHWEST PORTLAND SHOWING
1960 CENSUS TRACT BOUNDARIES



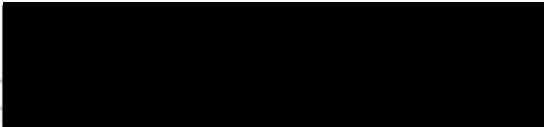
AN ABSTRACT OF THE THESIS OF

DOROTHY E. WALTIE

For the MASTER OF SCIENCE IN NURSING EDUCATION

Date of receiving this degree: June 9, 1972

Title: A SURVEY OF A SELECT GROUP OF FIFTY
ELDERLY PERSONS REGARDING THEIR HEALTH NEEDS

Approved: 

(Associate Professor in Charge of Thesis)

The purpose of this study was to identify the health needs of a select group of elderly people as they perceive them, to determine whether there were common health needs among this group and to report implications for needed health services.

The study was limited to 50 elderly persons age 60 and over who resided in northwest Portland and who indicated a willingness to participate in the study by answering questions concerning his or her health.

Information was obtained using the personal interview technique. The questionnaire was subdivided into three sections: one for basic personal data, one pertaining to the individual's health status with

specific questions relating to major health problem areas and one for knowledge, availability and use of health care facilities.

Findings

The findings are summarized as follows:

1. Half of the participants regarded their health as only fair with the remainder considering themselves to be in varying degrees of good or poor health; more indicating poor health. Most reported their health had deteriorated over the past five years.
2. A total of 170 health complaints were reported by 47 participants. Incapacity due to health problems was found to be a common phenomenon in the group with half of those reporting illnesses confined to their homes.
3. The majority of the participants reported they had a doctor or clinic they could contact in the event of illness, however, one-half reported they seldom or never have a physical examination.
4. Help with housekeeping and shopping were services over half the group felt would aid their daily living. The participants indicated loneliness and not enough money were their biggest problems.

Conclusions

The following conclusions were derived from the data collected from the study:

1. Although numerous health needs were found among the elderly, the participants appeared to be apathetic regarding preventive health care and complacent or accepting regarding existing health problems.
2. Loneliness and lack of money were of greater concern to the participants than physical health.

Recommendations for Further Study

Based on the findings of this study, the following studies are recommended:

1. Further study should be carried out in which the participants' subjective evaluation of health status is correlated to objective medical findings.
2. Separate and extensive studies should be done on all areas of expressed health service needs in an attempt to establish perceived priorities of the elderly.
3. Explore the matter of loneliness among the aged, particularly among those who are not very mobile. Ascertain what is being done to reduce loneliness, what more can or should be done.

Typed by Ilene Anderton