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A study of the opinions of fifty elderly persons regarding their health needs

A STUDY OF THE OPINIONS OF FIFTY ELDERLY PERSONS REGARDING THEIR HEALTH NEEDS

BY

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TABLE OF CONTENTS

TABLES

CHAPTER I

INTRODUCTION

In recent years public attention has been focused on the tremendous increase in the aged population of the United States. This longevity trend presents a challenge in meeting the needs of the aged. The challenge was plainly visible as year by year, in the past score of years, the total population of those over sixty-five rapidly accelerated until today, there are some sixteen million elderly persons in the United States, with a prospect of more than twenty million by 1970.[1] Since 1850, the average life expectancy at birth has increased from forty years to seventy years of age.[2] This is partly due to improved standards of living, a decrease in the death rates among younger age groups, and advances in medical science.

However, the health problems of older people may be aggravated by longer life expectancy. With prolongation of life it becomes increasingly difficult for the aged to

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[1]Washington, D.C., Committee on Publications and Studies of the National Advisory Committee, Aging in the States: A Report of Progress, Concerns and Goals, White House Conference on Aging (Washington: U.S. Government Printing Office, 1961), p. 1.

[2]U.S. Department of Health, Education, and Welfare, Special Staff on Aging, Enriching the Added Years (Washington: U.S. Government Printing Office, 1959), p. 3.

maintain optimum health. This is partly due to degenerative changes, susceptibility to chronic disease, and the necessity for caring for their health needs. Shanas,[3] writes that:

> Within the next two decades the average age of all persons aged 75 years old or more will become a higher proportion of the older population than they are now. The total number of the very sick in the older population who need and want medical care will therefore increase in two ways: through the numerical increase in persons yearly, and through the higher rate of increase of persons aged 75 and over, the oldest and 'sickest' segments of the older population. This 'aging' of the older population alone may be expected to increase the proportion of the very sick among the elderly to more than the present estimated 14 per cent.

This concept of the expected increase of persons aged sixty-five and over and the increase in the proportions of the very sick among the aging population can be applied to public health nursing agencies in planning their programs to meet the health needs of the aging population. Shanas,[4] is of the opinion that:

> Medical examinations would undoubtedly find pathology of some kind in almost all of the fifteen million people in the United States aged 65 years of age and older. Whether the older person thinks of himself as 'sick' or 'well' however, is often unrelated to the presence or absence of such pathology. In general, despite the extensive self-reports of specific diseases and physical complaints, most older people believe their health is 'good,' most older people use medical care and medical services only when they experience an acute illness. After all if one is 'healthy,' one does not need a doctor.

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[3]Ethel Shanas, Medical Care Among Those Aged 65 and Over, reported illness and utilization of health services by the "sick" and "well," Health Information Foundation, Research Series No. 16 (University of Chicago, 1960), p. 30.

[4]Ibid., p. 28.

Thus, the attitudes of older people themselves toward their state of health are underlying factors in understanding their health needs. This has public health nursing implications particularly in the public health nurse's approach to the prevention of illness through regular health examinations of older people. Bearing in mind that some older people believing their health is "good" are less inclined to seek medical care unless acutely ill, provides the nurse with insight into some of the reasons why older people are reluctant to seek medical care.

Statement of the Problem

What are the opinions of aged persons living alone regarding their health and social adjustments?

Justification of the Problem

Consideration of the health needs of persons over sixty-five years of age in relation to public health nursing provides thought for the following question: Does the public health nurse see the needs of older people as the older people see them? In response to this question it would be interesting for the public health nurse to know the older persons' own perception of his health and how he feels his needs are being met, thus aiding not only the individual public health nurse, but also those responsible for planning and implementing public health nursing programs.

Scope and Limitations

This study is based on data obtained from fifty persons sixty-five years of age and older, living alone in one housing project in Washington, D.C. The findings apply to the elderly persons sixty-five years of age and older who live alone in one housing project and no other generalizations would be justified.

Preview of Methodology

Fifty persons sixty-five years of age and older who live alone were selected by random sampling from the case-load of a public health nurse who served only elderly people in the project.

An interview schedule was used to collect data from the respondants in their own homes.[5] Each interview lasted approximately sixty-four minutes.

Sequence of Presentation

Chapter II presents the theoretical framework of the study. Chapter III contains a description of the methodology employed. Chapter IV covers the presentation and discussion of the data. Chapter V contains the summary and recommendations.

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[5]See Appendix.

CHAPTER II

THEORETICAL FRAMEWORK

Review of Literature

Because of the vast amount of literature on the health needs of the aged, this chapter will not attempt to present a comprehensive review of the available literature, but will review some of the more pertinent studies relating to the health needs of the aged.

One of the most informative studies of the older population was sponsored in 1957 by the National Opinion Research Center of the University of Chicago under the direction of Ethel Shanas.[1]

In May and June of 1957, 1,734 people sixty-five years of age and older selected by a nationwide sampling, were interviewed about their health, their family relationships, finances, and their living arrangements. All of the respondants lived outside of institutions. In a separate survey, further interviews were conducted in which a cross section of 2,500 adults were interviewed to ascertain their

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[1]Ethel Shanas, Medical Care Among Those Aged 65 and Over, reported illness and utilization of health services by the "sick" and "well," Health Information Foundation, Research Series No. 16, (University of Chicago: 1960).

views of the health needs of older people and the role of relatives in assuming financial and other responsibilities for older members of the family.

An index of illness was developed from the interviews to test the number of "sick" in the non-institutionalized older population. Findings from the sample were generalized to the older population living outside of institutions in the United States.

Shanas, in writing of the very sick aged population' pointed out that:

> Using self-reports of illness as a basis for classification, this group of the very sick living outside of institutions is estimated to be about 14 per cent of all persons 65 years of age and older. The very sick comprise 11 per cent of all persons 65 to 74 years of age, and 20 per cent of all persons 75 years of age and over. One in every ten persons between 65 and 74 years of age, and one in every five persons 75 years or more is very sick.
>
> Only about 10 per cent of the interview sample were classified as very sick. The characteristics of these persons may be used to describe the total group of very sick persons in the older population. The average very sick person is likely to be a woman in her mid-seventies and widowed. The chances are about one in three that the very sick older person, whether man or woman, is dependent on public assistance for financial support. Although only about 10 per cent of all older persons interviewed were classified as very sick, this group used from 17 to 31 per cent of the various medical and related services.[2]

Shanas concludes that:

> While the numbers and proportions of the very sick in the older population may be expected to increase, there is no clear-cut indication that the economic status of the very old, particularly of the very old

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[2] Ibid., p. 28.

> woman, may be expected to improve substantially in the next ten years. If there is no marked economic improvement for this segment of the aged, many among the very sick will continue to be dependent on others, their families, public assistance or private philanthropy, to meet the costs of medical care. As people live longer, they are more likely to be sick.[3]

In comparison an interesting discussion related to the wellness of the aged in the future appears in Aging in the States which concludes that:

> One of the assurances readily derived from the reports of the States is that the later years will be not only longer but more healthy and vigorous too. Older people who have grown up in the 20th century, with longer exposure to the concepts of positive health, will have developed better habits of nutrition, exercise, and activity and more compelling awareness of the need for periodic checkups to discover latent, insidious conditions.[4]

Golde and Kogan[5] assessed the attitudes of young people toward older people. The participants included 100 students between seventeen and twenty-three years of age in which they were requested to complete twenty-five sentence stems in which the term "most old people" appeared. A control factor "most people" was substituted for "most old people." Each form was completed by fifty of the participants.

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[3] Ibid., p. 30.

[4] Washington, D.C., Committee on Publications and Studies of the National Advisory Committee, Aging in the States: A Report of Progress, Concerns and Goals, White House Conference on Aging (Washington: U.S. Government Printing Office, 1961), p. 162.

[5] Peggy Golde and Nathan Kogan, Ambivalence of Views in Attitude Assessment of Young Toward Older People, Research Highlights in Aging, Public Health Service Publication No. 779 (Washington: U.S. Government Printing Office, 1959), p. 1.

The findings revealed that the participants had divided prespectives of old age in which sympathy and aversion seemed to relate to the fear of dependency.

Golde and Kogan suggest that:

> This fear was perhaps the major criterion of the young for the stigma of old age. By the same token, the prospect of activity in advanced age seemed to offer the best hope of antidote to this stigma. Although there were positive expressions regarding capacities for pleasant serenity and deep companionship in old age, the attitude was expressed that the old regard the young as wild and foolish, and the young were less inclined to picture themselves as initiating inter-personal relationships with old people than persons their own age, with whom greater spontaneity would be possible.[6]

An integrated approach to the problems of health in geriatric patients was supported by the National Institutes of Mental Health.[7] One group of patients was followed in a geriatric clinic receiving "total" care, another group received routine medical clinic care. Differences in levels of health attainment between the two groups will be evaluated.

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[6] Ibid., p. 1.

[7] Samuel Gertman, "An Integrated Approach to the Problems of Health in Geriatric Patients," Aging, A Review of Research and Training Grants Supported by the National Institutes of Health, U.S. Department of Health, Education, and Welfare, Public Health Service (Washington: U.S. Government Printing Office, 1958), p. 36.

Busse[8] evaluated the psychologic and physiologic changes that appear in old age. Extensive psychologic, social, physical, medical, and clinical evaluations were obtained on more than three hundred persons over sixty years of age. According to Busse:

> Adequacy of adjustment in later years is determined by the strengths and weaknesses found in early years. Firm evidence is brought forth in support of the concept that preparation for old age should begin in youth.[9]

An interview survey of ninety-five elderly persons living in a low socio-economic district in Boston, Massachusetts was conducted by DiCicco and Apple,[10] to learn the older person's perception of his health needs and how these needs are met. The respondents ages ranged from sixty-five years to eighty-years of age and over. The majority were women. Twenty-nine were married and lived with their spouses, thirty lived alone, twenty-five lived with relatives and eleven lived with persons other than relatives. Forty-four were born in the United States. The Guttman scaling technique

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[8]Ewald Busse, "Psychologic and Physiologic Changes which Appear in Old Age," Aging, A Review of Research and Training Grants Supported by the National Institutes of Health, U.S. Department of Health, Education, and Welfare, Public Health Service (Washington: U.S. Government Printing Office, 1958), p. 33.

[9]Ibid., p. 34.

[10]Lena DiCicco and Dorrian Apple, "Health Needs and Opinions of Older Adults," Public Health Reports (June, 1958), 73, 479-487.

was used to construct an index of health to distinguish the more healthy from the less healthy. DiCicco and Apple discussed the following conclusion:

> The most common perception of health among the group was in terms of activity. Health was important only as it became poor health and interfered with daily activity and maintenance of independence.
>
> Since perception of health is an important determinant of one's beliefs and practices in the areas of medical and preventive care, the implications of this perception are significant. It makes for difficulty in motivating such people to seek medical care for the many ailments that are not severely handicapping. And, as borne out by the opinions and practices discovered in the survey, it makes even more difficult attempts to make preventive services meaningful. Their findings suggest that preventive services for older people probably should be approached from the point of view of integration with services that they consider well established.[11]

In 1957, personal interviews with 500 persons sixty years of age and over in the Kips-Bay Yorkville area of New York City was undertaken by Kutner and others.[12] The study was done to assess health and patterns of adjustment in old age. Programs and trends in services for the aged in New York City were also examined. Kutner and others reported the effects of poor health upon individual adjustments. There was a great need among people of low status to dispel their beliefs that it was necessary to visit a physician only when ill. This view is similar to Shanas' view in that older

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[11] Ibid., pp. 479-487.

[12] B. Kutner, et al., Five Hundred Over Sixty: A Community Survey on Aging (New York: Russell Sage Foundation, 1956), pp. 244-263.

people are prone to use medical facilities only when acutely ill. Kutner and others suggest various programs to meet the needs of the aged:

> No one type of medical facility will be adequate to serve the needs of all older people requiring care. Some feel a specialized or geriatric service is more likely to take greater pains with them because of their age. Others feel a geriatric service classifies them and stigmatizes them as a group with which they do not closely identify.

The authors point out that:

> From an examination of the types of adjustment problems faced by older people there is great need for consultation or guidance centers. Hence, some means must be found to help the individual face frankly the realities of aging and to choose an intelligent course of conduct to follow. Professional counseling for the aged should involve a multiplicity of interlocking services, medical, social work, psychological, public health, and psychiatric to provide a broad base for making decisions concerning individual cases.[13]

A background paper prepared by the Planning Committee on Health and Medical Care for the White House Conference on Aging,[14] in 1960 reviewed some of the services, facilities and programs instituted at community and State levels. In relation to the health status of the aged, the Committee pointed out the following observations:

> It is evident that the health needs of the aging are complex. They involve many factors and services

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[13] Ibid., pp. 479-487.

[14] Washington, D.C. Planning Committee Health and Medical Care, Background Paper on Health and Medical Care, White House Conference on Aging (Washington: U.S. Government Printing Office, 1960), p. 9.

> other than medical care. As a group, however, older people require more medical care, from certain standpoints, than do people below 65 years of age. They can be more susceptible to fatal accidents, although their incidence of non-fatal accidents is less than that for younger people. They have a greater incidents of impairments and are more inclined to chronic illness. Most of their medical problems are cared for on an ambulatory basis or in their own homes. Aged people use long-term care facilities much more than younger people, but a sizable proportion of these stays are not medical dictated.[15]

In the District of Columbia's Report on Recommendations to the White House Conference on Aging, data obtained from the survey revealed the following observations:

> The health of the majority of individuals over 60 is compatible with living independently in a community; and that there appears to be a lack of awareness of the importance of periodic health appraisals for maintenance of physical, mental and social well being. These observations emphasise the high priority need for publicizing in an imaginative, effective, non-threatening manner the importance of regular periodic health appraisals for early detection and successful control of disease and prevention of the incapacity that inevitably follows.[16]

In February, 1959, the first Congressional Subcommittee on the Problems of the Aged and Aging[17] was established to study the needs of 16 million Americans 65 years of age and older as well as the millions of younger aging men and women.

Initial hearings were held in Washington, D.C. in which the range of problems were explored and guides for

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[15] Ibid., pp. 9-10.

[16] District of Columbia's Report on Recommendations to the White House Conference on Aging, Prepared by the District of Columbia Council of Aging (Washington, 1960), p. 21.

[17] U.S. Congress, Senate, Subcommittee of the Committee on Labor and Public Welfare, Aging Americans - Their Views and Living Conditions, 86th Cong., 2d Sess., 1960.

further investigation were discussed. The subcommittee heard the views of many experts and representatives of public and private agencies and national organizations. Some of the subjects explored included retirement incomes, employment, housing, health and medical care, nursing home standards and recreational activities. Through town hall sessions, interviews, and through visits to aged people themselves, the subcommittee obtained first hand information on the aged population's views and living conditions. The majority of the aged who spoke expressed their need for continued contribution to the nation through independent social and economic means.

Some of the findings and recommendations of the subcommittee[18] are as follows:

> Health: Most older people can't afford adequate medical care. Consequently, they are recommending that legislation be enacted in 1960 to expand the social security program to provide health service benefits for all persons eligible for such insurance.
>
> Employment: They discovered there is a tragic dilemma facing vast numbers of folks 45 and 64 who are too old to find suitable jobs because of taboos against applicants past 40, but are too young to retire. Thus the senators recommended that States enact laws prohibiting discrimination in employment because of age.
>
> Income: Substantial increases in social security insurance benefits was recommended after finding that 60 per cent of all older people have incomes of less than $1,000 per year.
>
> Housing: The subcommittee found that housing needs are particularly acute among those with lower incomes and recommended legislation to provide an additional 10,000 low cost housing units annually for the elderly, and increased loans to nonprofit groups wishing to provide senior housing.

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[18] Ibid., p. 51.

The review of literature has revealed widespread interest in the needs of the aging and aged which covered a complexity of problems. Ways and means of meeting the health problems of the aged were explored. A number of the studies referred to the importance of knowing what the aged themselves thought of the health and social needs and it was to this subject that this study was directed.

CHAPTER III

METHODOLOGY

Selection and Description of Sample

The participants in the study were fifty persons sixty-five years of age and older living alone. Only elderly persons living alone were selected for the study because of the author's view that these older persons may make poorer adjustments because of their isolation.

The participants were housed in four separate properties provided by the National Capitol Housing Authority under the direction of one housing project manager. The respondents resided in the Southeast area of Washington, D.C. The four properties in which they lived had been built as recently as one year ago to as long as twenty-five years ago. The more recently erected properties provided elevator service, basement laundries, non-slip floors, bathtub grab bars, no threshholds, windows designed to open and close easily and solariums. The respondants generally were not isolated from other age groups in housing placements. However, in one property there appeared to be a greater concentration of elderly persons in a particular housing section.

A nursing office of the Bureau of Public Health Nursing of the District of Columbia Department of Health was

located in one of the properties being accessible to the respondents. One public health staff nurse in the nursing office was assigned to serve only elderly persons. Her case load consisted of single elderly persons living alone, as well as married elderly persons living with their spouse or with their relatives. The remainder of the public health staff nurses in this nursing office served all age groups.

All elderly tenants were referred to the public health nursing office by the housing manager. The public health nurse then made home visits to each of the tenants to appraise their health needs. A report of this initial evaluation was sent to the manager's office. The public health nurse continued to visit the elderly tenants for health supervision and other nursing services as necessary. The elderly patients were encouraged by their public health nurse to call or visit the nursing office when they were in need of nursing service. The assignment of one public health nurse to supervise the health needs of only elderly persons was initiated as a demonstration project.

The respondents for this study were selected from the total number of elderly persons living alone who were sixty-five years of age and older and who were in the general case load of the public health staff nurse working exclusively with the aged. Initially a total of eighty-six respondents were selected. Respondents that were hospitalized were omitted in the selection. The eighty-six names and addresses

of the respondents were each written on a separate piece of paper and placed in an uncovered box, fifty of the names were withdrawn and these comprised the sample for the study. Five extra names were withdrawn in the event that some of the respondents were not located or refused to be interviewed. One respondent refused the interview and her name was replaced with a spare name. One respondent thought the interviewer was visiting to refer her again to the clinic for follow-up care. When it was explained this was not the purpose of the visit the participant was more responsive. A total of fifty respondents were interviewed. It was necessary for the interviewer to make some return visits when respondents were not at home for the initial interview. Thirty-two of the respondents were between the ages of sixty-five and seventy-four; ten were between seventy-five and eighty-four; and eight were between eighty-five and ninety-four.

Tools Used to Collect Data

An interview schedule was used to collect the data for this study because it permitted the participants freedom in responses and also allowed the writer the opportunity to clarify questions which might have been misunderstood by the participants.

An interview schedule of sixty-two questions was developed. The areas covered background information, health,

nutrition, recreation and social aspects. Some questions were taken from the schedule used by Kutner.[1] Other questions included in the interview schedule arose from the writer's experience with elderly people while engaged in public health nursing. The schedule was pretested by interviewing one aged person after which changes were made to clarify the schedule.

Procurement of Data

The investigator corresponded with the Deputy Chief Nurse of the Public Health Nursing Bureau of the District of Columbia Health Department to request permission to conduct the study. A conference was held with the Deputy Chief Nurse to discuss the study and the plans to be followed. The Deputy Chief Nurse suggested that the investigator wear the public health nursing uniform during the interviews. This was suggested because it was thought that the participants would converse more readily because of their association of the public health nurse in uniform.

The investigator was hindered somewhat during some of the interviews because of the previous association of some of the respondents with the investigator as their public health nurse. The respondents were inclined to overlook the primary purpose of the visit and seek advice or give a resumé of what had occurred since they had been seen by the investigator.

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[1] B. Kutner and Others, Five Hundred Over Sixty (New York; Russel Sage Foundation, 1956).

The Deputy Chief Nurse also suggested that the investigator obtain written permission from the respondents for the protection of the agency, the respondents and the investigator. The suggestions of the Deputy Chief were followed.

Arrangements were made by the personnel director with the public health staff nurse assigned to elderly persons for the investigator to do the study. The investigator then discussed the study and selection of the respondents with the public health nurse responsible for serving the elderly patients.

At the completion of the interviews another meeting took place between the investigator and the Deputy Chief nurse of the agency to discuss the progress of the study.

Each interview lasted approximately sixty-four minutes. The interviews were conducted in the respondents' own homes.

CHAPTER IV

FINDINGS

Presentation and Discussion of Data

The data presented in this chapter were obtained from personal interviews of 50 persons sixty-five years of age and older. The data will be discussed according to background information, health, nutrition, social, and recreational needs of the respondents.

Background Information

The respondents were of low socio-economic status and resided in three census tracts in the southeast section of Washington, D.C. The respondents lived in new and old housing projects provided by the National Capitol Housing Authority.

Seven of the respondents were men and 43 were women. Thirty-two were between 65 and 74 years of age; 10 were between 75 and 84 years of age; and eight were between 85 and 94 years of age. Two were white males, five were non-white males, 10 were white females and 33 were non-white females. The above ratio of men to women is typical of the aged population in the District of Columbia. Sixty-seven thousand residents of the District of Columbia are 65 years of age or older. This is nine per cent of the total population and women predominate,

by almost two to one in the senior group.[1] The age-sex ratio in the study is comparable to the nation as a whole. Forty-five respondents were widowed, three were single and two were separated.

Thirty-one of the respondents had not completed grammar school; 12 had completed eighth grade; four had attended high school; two had completed more than twelve grades, and one did not know the number of grades completed in school.

Twenty respondents had lived in Washington, D.C., for 41 years or more; 12 for 31 to 40 years; eight were born in Washington; five had lived there 21 to 30 years; four had lived there 11 to 20 years; and one had lived there less than 10 years. Twenty-seven had resided in their present living quarters for less than five years, 15 for over five years; five for six months to one year; and three for less than six months.

The monthly rent of 22 of the respondents ranged from $26 to $35; 21 ranged from $46 to $55; five ranged from $36 to $45; one ranged from $56 to $65 and one paid less than $26 per month.

The living quarters of 26 of the respondents consisted of a living room-bedrom, kitchen and bath; 24 had one bedroom, a living room, a kitchen and bath. Thirty-seven replied that they liked their living quarters very much; ten liked fairly

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[1]Board of Commissioners of the District of Columbia White House Conference on Aging 1961 (Washington, 1961), p. 3.

much; two liked not so much, and one did not like it at all. Where dissatisfaction was mentioned it usually centered around the noise of children or the lack of space to sit out of doors.

Twenty-two of the respondents had monthly incomes ranging from $80 to $89; 10 had $90 or more; seven had from $70 to $79; six had from $60 to $69; four less than $60 and one respondent's income consisted of savings. The low incomes of the respondents is typical of the economic status of the aged.

> Almost 60 per cent of Americans over 65 have yearly incomes of less than $1,000 or no money income at all.[2]
>
> In the District of Columbia one-third of the 'seniors' have income of less than $1,000 per year while only one-fourth receive more than $3,000. Only one-fourth list employment as their main income source, one-half rely on social security.[3]

Nineteen respondents derived their source of income from old age assistance; 16 from a combination of social security and/or retirement, old age assistance pension, or part-time work; six from other sources, five from retirement, two from relatives, one from savings and one from pension.

Prior to retirement 19 respondents were doing domestic work, 11 other types of work; four were housewives; three

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[2]Committee on Publications and Studies of the National Advisory Committee, White House Conference on Aging. Aging in the States: A Report of Progress, Concerns and Goals (Washington: U.S. Government Printing Office, January 1, 1961), p. 86.

[3]Board of Commissioners of the District of Columbia, White House Conference on Aging 1961 (Washington, 1961), p. 3.

child care; three clerical; two labor; two self-employed, two custodial; two rooming house managers; one professional and one never worked.

In summary, the majority of the respondents were between 65 and 74 years of age, were non-white widowed females with less than sixth grade education, and were long term residents of the District of Columbia.

Health

Despite their complaints none of the respondents were bedridden or required total physical dependence on others. This seemed to be in keeping with the usual health status of elderly persons in the District of Columbia. "Nine of ten persons living outside institutions are self-sufficient. They are able to live independently and to take care of all of their personal needs."[4] With increasing age it is expected that there will be an increase in complaints due to steadily progressive impairments of the physical and mental abilities of the aged. This trend is evident in Table 1 which gives the number of complaints by age.

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[4] Ibid., p. 3.

TABLE 1

NUMBER OF COMPLAINTS ACCORDING TO AGE

	Number of Complaints						
Age	0	1	2	3	4	5	Total
65-74	2	8	12	3	0	3	32
75-84	0	1	3	3	2	1	10
85-94	0	4	2	1	0	1	8
Total	2	13	21	7	2	5	50

Table 2 shows health status as judged by the respondents in relation to age. Both Tables 1 and 2 show a slight tendency toward better health status among younger respondents, as would be expected.

TABLE 2

SELF-EVALUATED HEALTH STATUS ACCORDING TO AGE

	Health Status				
Age	Excellent	Good	Fair	Poor	Total
65-74	11	5	14	2	32
75-84	1	2	7	0	10
85-94	2	3	3	0	8
Total	14	10	24	2	50

Although, none of the respondents were bedridden, twenty-one said they used a cane, one used crutches or a cane, one a cane and special shoes, one used crutches and twenty-six used no aids.

The primary complaints of the respondents were heart disease, arthritis, hypertension and diabetes. These complaints are chronic conditions which are prevalent in the later years.

Twenty-five respondents reported no change in their health over the last year, 15 said their health had changed for the better and 10 reported their health had become worse.

It seemed that the majority of the respondents thought they were in favorable health. Most of them had one or more complaints. Table 3 shows the distribution of complaints according to health status.

TABLE 3

NUMBER OF COMPLAINTS ACCORDING TO HEALTH STATUS

	Number of Complaints						
Health Status	0	1	2	3	4	5	Total
Excellent	1	9	3	1	0	0	14
Good	0	1	5	2	1	1	10
Fair	1	3	13	3	1	3	24
Poor	0	0	0	1	0	1	2
Total	2	13	21	7	2	5	50

Although the thirty-two respondents in the 65-74 year age group thought of themselves as healthy, 21 between 65 and 74 had seen a doctor in the last six months and 10 had seen a doctor a year or more ago, and one did not answer. A report published by the Board of Commissioners of the District of Columbia for the White House Conference on Aging in 1961

states that, "Of the 67,000 senior citizens living in the district only one-half indicate they have annual physical examinations."[5] Although 48 of the respondents had complaints only 24 stated that they had regular health check-ups, which may indicate that they did not seek medical care as long as they were able to care for their daily needs and were not incapacitated.

Of the 13 respondents having one complaint, four had regular health check-ups; of the 21 having two complaints, 11 had regular health check-ups; of the seven having three complaints, four had regular health check-ups; of the two having four complaints, one had a health check-up; and of the five having five complaints three had regular health check-ups.

The 24 respondents stating that they had regular health check-ups gave as reasons: to note their progress and for follow-up of complaints; 26 who did not have regular health check-ups, gave the following reasons: "Did not have check-ups unless ill"; "Never feel bad"; "Physical examination too embarrassing"; "Prefer to rely on self-treatment"; "Check-ups not necessary for advanced age"; "My mother never had a check-up and she lived to 96." One woman eighty-six years of age stated she had "never had a

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[5] Ibid., p. 3.

thorough check-up in my life. At my age, don't think its necessary. When its time to go, you have to go. A check-up won't hold you here." Another woman ninety-two years of age stated, "I don't think about things too much, you make yourself sick."

A male respondent stated he knew what his sickness was, and he bought medicine advertised over television for various pains. Self-treatment may be common among elderly people if they still rely on home remedies for illness. Perhaps, the question of the harmful effects of advertising may be raised here if there is a marked tendency for elderly people to rely on advertised products to treat illness rather than on professional help.

Thirty-five of the respondents stated they would attend a neighborhood medical center if one were available especially for older people; seven would not; six said maybe; two were undecided and one did not know. Of the 35 respondents in favor of a neighborhood medical center, 22 stated that they would because it would be closer to their homes. The respondents resided in an area which required considerable traveling to reach various clinics which involved the use of public transportation, taxi, or the use of private cars. Accessibility of medical facilities may have bearing on whether the aged seek medical care. It would seem that more of the respondents might seek medical

care more frequently if the facilities were located nearer their homes.

Of the seven respondents replying that they would not attend a neighborhood medical center if available especially for older people, five stated they preferred to go to their present clinics or to private physicians; one thought a neighborhood medical center would be too time consuming; and one thought it would be unnecessary since her health was good.

Thirty-two of the respondents had attended a clinic or seen a physician within the last six months; 15 had medical supervision within the last twelve months; one within nine to twelve months; one did not go to doctors; and one gave no answer. The majority of the respondents had had some type of medical supervision within the last year; although, when asked previously about regular check-ups only 24 were in favor of them. The respondents were asked if a chest x-ray, blood test for diabetes, urine test, electrocardiogram and glaucoma test were done during their check-up. None of the respondents answered "yes" to all of these tests, even though twenty-four respondents had previously stated that they had regular check-ups. Apparently, their conception of a regular health check-up did not include these diagnostic tests.

Thirty of the respondents had trouble with their vision. Nineteen of these had had optical care, wore glasses or had optical examinations; 14 had trouble with their teeth and five of these had had dental care; 14 had hearing difficulties and eight of these had been examined by a physician for hearing defects.

In Facts on Blindness in the United States, it is stated that

> more new cases of blindness occur among persons 65 years of age and over than in any other group. Cataracts, glaucoma, and diabetes are three conditions responsible for more blindness than any of the other leading causes reported in the United States, and account for 40 per cent of all blindness.[6]

These causes of blindness have implications for the public health nurse as she can emphasize periodic optical examinations to aid in preventing blindness.

Thirty of the respondents said that in cases of sudden illness they would contact their relatives for assistance and 12 their neighbors. This may indicate that they preferred to manage health emergencies themselves before requesting professional assistance. Only eight respondents said they would contact the public health nurse in the event of sudden illness. This response seemed

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[6] Facts on Blindness in the United States, Public Health Service Publication No. 706, Superintendent of Documents (U.S. Government Printing Office, Washington, D.C.), p. 3.

unusual because the public health nursing office is located near the homes of the respondents. In case of sudden illness 12 said they would contact their neighbors. Table 4 shows who the respondents would contact in cases of sudden illness.

TABLE 4

SOURCES OF HELP IN CASES OF SUDDEN ILLNESS

Sources	Number of Times Mentioned
Relative	30
Neighbor	12
Clinic or Hospital	10
Public Health Nurse	8
Doctor	7
Minister	2
Social Worker	1
Druggist	0
Project Manager	0
Police	0
Other	7
Total	77

The respondents were questioned about the frequency of home visits made to them by the public health nurse. Thirty-five thought the nurse made irregular visits; 12 said the nurse made regular visits, and three said the public health nurse made occasional visits. No attempt was

made to define what was meant by regular or irregular visits.

The respondents were asked if they would like the public health nurse to visit more often. Thirty-six said it was not necessary, and 14 wanted the public health nurse to visit more often. Although 48 of the respondents had one or more complaints, 36 did not feel the necessity for frequent visits by the public health nurse. This may be accounted for by the fact that as long as the respondents were not confined to the home they did not feel the need for frequent nursing visits.

Table 5 shows a comparison of the number of complaints of the respondents and requests for more or fewer home visits by the public health nurse. There is a trend toward those with more complaints wanting more public health nursing visits and those respondents with fewer complaints wanting fewer visits by the public health nurse.

TABLE 5

NUMBER OF COMPLAINTS IN RELATION TO DESIRED FREQUENCY OF NURSING VISITS

Number of Complaints	More Visits	Fewer Visits
0	0	2
1	2	11
2	7	14
3	1	6
4	1	1
5	3	2
Total	14	36

Some of the reasons given by the respondents for more nursing visits were to: check blood pressure, check their general condition, give pedicure, and vist when ill. No particular reason was given by one respondent, and one said she just enjoyed having the nurse visit. This may indicate that the respondents thought of the public health nurse more in relation to physical complaints than for guidance or health teaching.

When the nurse did something for or to the respondents this perhaps made more of an impression. (This suggests that the respondents think the nurse's role is limited mostly to physical contact; whereas, public health nurses usually have a broader concept of their roles which includes direct and indirect services. This may be related to why fewer of the respondents did not request more home visits by the public health nurse). The respondents associated the nurse with bedside nursing, and as the majority of the respondents did not need bedside care, frequent nursing visits were unnecessary for them.

Table 6 shows what the public health nurse did during home visits according to the respondents' perception of the nurse's duties.

TABLE 6

NURSING ACTIVITIES AS PERCEIVED BY THE RESPONDENTS

Nursing Activities	Number of Times Mentioned
Nursing Procedure	41
Health Supervision	13
Agency Referral	12
Health Teaching	5
Bedside Nursing	1
Hospitalization Arranged . . .	1
Total	73

The majority of the respondents said that the public health nurse checked their blood pressure. Seemingly, the less tangible aspects of the nurse's visit such as health teaching or demonstration were of lesser importance to the respondents.

Forty-one respondents had no requests when asked what other things they would like for the nurse to do during home visits. One would like the public health nurse to prepare a light meal if the homemaker was not available; one wanted the nurse to visit more often, but gave no particular reason; one wanted the nurse to massage her legs; two wanted the nurse to prepare food if they were unable to cook; one suggested the nurse assist her with tub baths and shampoo; one wanted assistance with tub bath only, and one wanted foot care.

In summary, it appeared that when the respondents were asked what other things they would like the public health nurse to do during home visits, the majority of the respondents had no suggestions. This may be related to the previous question regarding the activities performed by the public health nurse as the respondents perceived the duties of the nurse. The eight respondents requesting other things the nurse could do mentioned activities being done for or to the respondents; no requests were made in which health teaching, demonstration, planning or guidance were involved.

A question was asked to determine how the respondents would contact the public health nurse when needed. Thirty-five replied they would contact her by telephone; three would contact her through the social worker; three said they did not know; two by sending a message; two would visit the public health nursing office; two did not know the nursing office address; two would contact the public health nurse through the nurses at the well-baby clinic and the maternity clinic in the area; and one did not know the nursing office telephone number. Forty-four of the respondents had knowledge of how to contact the public health nurse; whereas, six were unaware of how to contact the public health nurse. This may indicate that dissemination of information regarding the nursing office and its location had been effective as the respondents were aware that such an agency was available when needed.

Twenty-six of the respondents were satisfied with the services received at the various out-patient clinics; 17 did not attend the clinic; two thought the clinic services were unsatisfactory; and one was satisfied but preferred a private physician. The remainder were satisfied with the clinic services, but they stated the doctors did not explain enough, they became tired of waiting, or they did not have time to ask questions. Due to the large clinic census it is believed that these may be common

complaints of patients attending out-patient clinics.

Forty-five respondents did not have any type of health insurance. This may be due to the limited income of the majority of the respondents and the provisions made by the public assistance division for medical and dental care expenses. Five of the respondents had some type of health insurance. The percentage of respondents covered by health insurance may be compared with elderly persons covered by health insurance in the District of Columbia.

> Health insurance coverage is largely related to income. Sixty per cent of those with at least $100 per month are covered to some extent and eighty per cent of those with less income have no such insurance.[7]

> Nationally, the picture is similar as it has been estimated that 49 per cent of older Americans now carry some form of health insurance, this leaves 51 per cent who do not, or who cannot afford health insurance.[8]

Thirty-seven of the respondents replied that their health was taken care of properly; 12 said that their health was not taken care of properly; and one was undecided. When the respondents were asked why they thought their health was or was not taken care of properly, thirty said they were

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[7]Board of Commissioners of the District of Columbia, White House Conference on Aging 1961 (Washington, 1961), p. 2.

[8]Committee on Publications and Studies of the National Advisory Committee, White House Conference on Aging. Aging in the States: A Report of Progress, Concerns and Goals (Washington: U.S. Government Printing Office, January, 1961), p. 89.

doing well; 12 gave various physical complaints; five said the doctors were doing their best; two gave no answer; and one was undecided.

Forty-one of the respondents took medications regularly for various complaints, three only took medications occasionally, and six did not take medications. The medicines mentioned most often that were prescribed by physicians were digitalis, diurectics and hypertensive medications. Medications most often prescribed by the respondents themselves were pills for the relief of headache and pain, and laxatives.

Nutrition

The following describes the existing nutritional problems derived from information supplied by the respondents. Thirty-three of the respondents replied that their appetite was good, 15 fair and two poor.

In order to evaluate the respondents' eating habits they were asked to name what they had for breakfast, lunch and dinner for the last two days. The respondents' diet was evaluated according to the lack of the basic foods such as milk and cheese, meat, fish, poultry and eggs, vegetables and fruits, and breads and cereals. The respondents' diets were also evaluated according to the number of meals omitted. Generally, the respondents remembered well what they had for their meals.

Forty-nine of the respondents lacked one or more basic foods in their diet, one person had a well balanced diet even though lunch had been omitted; 35 had omitted one or more meals. Poor eating habits are fairly common among elderly persons. This may be due to physical or emotional causes such as chronic disease, lack of teeth or loneliness. The respondents' diets showed obvious deficiencies due to poor selection of foods and frequent omission of meals.

Table 7 shows the number of basic foods lacking in the respondents' diets and the number of meals omitted.

TABLE 7

OMISSION OF BASIC FOODS AND MEALS

Basic Foods Omitted	Number of Replies	Meals Omitted	Number of Replies
One	8	One meal omitted	11
Two	7	Two meals omitted	19
Three	7	Three or more meals omitted	5
Four or more	27	No meals omitted	15
Balanced diet	1		
Total	50		50

Twenty-one respondents said they had adjusted to eating alone; 18 stated that they liked eating alone; eight disliked eating alone; six would rather share their meals; and three said it did not matter. The majority of the respondents had good appetites, did their grocery shopping at super markets, and did not have credit for food at grocery stores; 27 received surplus food, and only one needed help in preparing meals with the surplus foods. Thirty-six were not in favor of "meals on wheels" because they preferred to prepare their own food. Thirteen thought it would be a good change. Other reasons were that foods would not be served that were liked and only when there was illness would there be interest in "meals on wheels."

Twenty of the respondents thought they would eat in a cafeteria if one were available in the building. They seemed to react more favorably to a cafeteria than to "meals on wheels." Perhaps, there was some unknown feelings about having their meals brought to them, as it may signify inactivity; whereas, to go to a cafeteria would imply activity.

There appeared to be need for guidance in nutrition because of an obvious lack of balanced meals. Some of this may be attributed to poor eating habits over the years, inability to plan menus and meal preparation, poor buying habits and limited incomes.

Recreation

Most of the respondents' leisure time was spent reading, listening to the radio, viewing television, visiting friends and taking walks. Only nine attended club meetings, seven engaged in hobbies, and six belonged to a golden age club, even though 42 knew of available recreation centers in the area. Nine of the respondents attended the project recreation center regularly, and three attended occasionally.

Most of the reasons given by the respondents for non-participation in the golden age clubs were that they had never bothered with recreation clubs over the years or they were not physically able to attend. The same type of responses were given when the respondents were asked if they attended the recreational center within the project, or the several neighborhood centers in the area.

Social

Thirty-eight of the respondents had relatives living in the city, 12 did not. Twenty-eight had immediate relatives living in the city and 10 had distant relatives. The majority of the contacts with relatives was by telephone, or by fairly regular home visits.

The majority of the respondents preferred living alone, but those who did not expressed feelings of loneliness, or concern about becoming ill while living alone.

Most of the respondents seemed to be optimistic toward life when asked if they felt any differently about life as they became older. Some of the comments were: "Feel just as young as I use to"; "I don't think about dying, even though I am old and have to die some day"; "Feel no difference, just keep busy"; "Try to grow old gracefully, to share and help"; "I am proud of my old age, nice to live to get old. I have experienced many things in my age--not disgusted at all"; "Get as much out of life now as when younger, according to my health, enjoy what I do, realize I can't always be young"; "Read the Bible more"; Think more seriously as you get older."

In comparison to the respondents' optimistic comments about life, there were comments of lack of interest in life and feelings of hopelessness such as: "It's not much fun when you get older. If I died tomorrow I wouldn't mind"; "you change as years go by, don't get the same enjoyment out of life, but I trust in God when feeling left out and lonesome"; "Just existing."

Some of these negative attitudes toward aging may be attributed to our culture in which generally the aged person has been more or less made to feel useless and dependent. Fortunately, these concepts are being replaced with preparation for retirement in which these years will be more meaningful.

Thirty-four of the respondents were satisfied with their present friends and did not desire more contact with others; 16 desired more contact for reasons of companionship.

Thirty-five believed it would be better to provide housing projects for the elderly only, because there would be less noise from children, and the aged would have more in common. The 15 respondents that did not prefer separate housing for the elderly gave as some of their reasons: "Like to be around the young"; "Could have the help of the young"; "Too boring with just older people." Frequent reasons for preferring separate housing for the aged were: "Less noise"; Easier to visit other elderly people"; and "Older people have more in common."

The majority of the respondents thought that money was the greatest need of the elderly.

CHAPTER V

SUMMARY AND RECOMMENDATIONS

Summary

Fifty persons aged sixty-five years of age and over were interviewed in their own homes in the southeast area of Washington, D.C. The respondents lived alone in public housing facilities provided by the National Capitol Housing Authority. The respondents were selected by random sampling from the caseload of a public health nurse who served only the elderly.

In summarizing the health adjustments of the respondents the following observation and trends were noted: They were relatively healthy and active. Despite their complaints none were bed ridden or totally physically dependant on others. Only five had spent time in bed during the last two months prior to the interview. All with the exception of two, had one or more complaints. There was a slight trend in which with increasing age complaints also increased and a tendency for the younger respondents to possess better health. Twenty-four of the respondents used aids such as crutches, special shoes or cane.

The primary complaints were: heart disease, arthritis, hypertension and diabetes, which are chronic conditions

prevalent in the later years. The majority of the respondents had one or more complaints but only twenty-four had regular health check-ups. This may be due to a belief that if they could perform their daily routines they were well enough. The majority had had some type of medical supervision during the last twelve months prior to the interview. Their concept of regular health check-ups did not include various diagnostic tests. The respondents placed more emphasis on physical nursing activities of the public health nurse rather than other aspects such as health supervision and health teaching.

In carrying out their daily routines, shopping for groceries seemed to cause the greatest physical exertion.

The basic diets of the respondents showed marked deficiencies and numerous omissions of meals.

Improvement in nutrition and better food habits might aid in delaying the progression of senility.

There was lack of participation in creative activities. The leisure time activities of the respondents consisted of reading, watching television programs, visiting friends, taking walks, and listening to the radio. Six belonged to a "golden age club," and nine regularly attended the housing project recreation center.

The following facts about social adjustments were noted: the respondents had fairly regular contact with their relatives by telephone or by home visits. Most preferred living alone, and the majority seemed optimistic toward life.

Thirty-five preferred housing facilities only for elderly tenants which would eliminate noise from children.

The majority though money was their greatest need.

Recommendations

According to the findings of the study, the following recommendations are suggested:

1. That a nutritional program be planned in which the public health nurse would aid in communicating nutrition information to the elderly.
2. That attention be given to the attitudes and concepts of the elderly toward regular health check-ups.
3. That volunteers from various organizations visit elderly people who might be reluctant to pursue creative activities and hobbies, but who once introduced might find various recreational activities rewarding.
4. That a replication of the study be made.

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APPENDIX

INTERVIEW SCHEDULE

Background Information:

1. Sex Male _____ Female _____

2. Race White _____ Non-White _____

3. Age
   a. 65-74 years _____
   b. 75-84 years _____
   c. 85-94 years _____
   d. 94 years and over _____

4. Marital Status
   Widowed _____
   Divorced _____
   Separated _____
   Single _____

5. Highest Grade completed in school:
   a. 0 to 6 Grade _____
   b. 7 to 8 Grade _____
   c. 9 to 12 Grade _____
   d. More than 12 Grades _____

6. Number of years lived in Washington, D.C.:
   a. Birth place _____
   b. 0 to 10 years _____
   c. 11 to 20 years _____
   d. 21 to 30 years _____
   e. 31 to 40 years _____
   f. 41 years and over _____

7. Last occupation prior to retirement _____

8. Length of time lived in present quarters:

   a. Less than six months _____

   b. Six months to one year _____

   c. One year to five years _____

   d. Over five years _____

9. Previous housing before moving to present address:

   a. Owner _____

   b. Renter _____

   c. Other (Specify) _____

10. Which of these comes closest to your opinion about your present living quarters:

   a. Like very much _____

   b. Like fairly much _____

   c. Like not so much _____

   d. Like not at all _____

11. Present monthly rent:

   a. $26 to $35 _____

   b. $36 to $45 _____

   c. $46 to $55 _____

   d. $56 to $65 _____

   e. $66 to $75 _____

   f. Over $75 _____

12. Number of rooms presently occupied:

   a. One bedroom, living room, kitchenette and bath _____

b. Combination living room and kitchenette, bedroom, bath _____

13. Monthly income:

a. Under $60 _____

b. $60 to $69 _____

c. $70 to $79 _____

d. $80 to $89 _____

e. $90 and over _____

14. Source of Income:

a. Retirement _____

b. Savings _____

c. Pension _____

d. Old age assistance _____

e. Assistance from relatives _____

f. Other _____

Health

1. Would you say your health at the present time is:
   a. Excellent _____
   b. Good _____
   c. Fair _____
   d. Poor _____
   e. Very poor _____
2. Do you think your health changed over the last year for the better or worse?:
   a. Better _____
   b. Worse _____
   c. No change _____
3. Do you have any ailments or trouble with your health? (If so, what?)

4. Has your health kept you from doing the following things:
   a. Household activities Yes _____ No _____
   b. Visiting friends Yes _____ No _____
   c. Shopping Yes _____ No _____
   d. Going to church Yes _____ No _____
5. Have you spent any time in bed during the last two months due to your health?
   a. Yes _____

b. No _____

c. If yes, how many days? _____

6. Do your teeth bother you in any way?

a. Yes _____

b. No _____

c. Sometimes _____

7. If your teeth bother you, what have you done about it?

8. Do you have any difficulty with seeing?

a. Yes _____

b. No _____

c. Sometimes _____

9. If you have any difficulty seeing, what have you done about it?

10. Do you have any difficulty with your hearing?

a. Yes ___

b. No _____

c. Sometimes _____

11. If you have difficulty with your hearing what have you done about it?

12. Do you use any of the following aids?

    a. Crutches _____

    b. Wheel chair _____

    c. Cane _____

    d. Walker _____

    e. Braces _____

    f. Special shoes _____

    g. Other _____

    h. None _____

13. Is there anything about your health that you worry about?

14. If you were to become ill suddenly where would you turn for help?

    (Use the following as guide)

    a. Private doctor _____

    b. Clinic or hospital _____

    c. Public Health nurse _____

    d. Druggist _____

    e. Relative _____

    f. Neighbor _____

    g. Police _____

    h. Minister _____

    i. Project manager

j. Social worker _____

k. Other _____

15. How often does the public health nurse visit you?

16. Would you like for the public nurse to visit you more often?_____ Why? _____

17. What does the nurse do when she visits?

18. What other things would you like for the nurse to do?

19. How would you contact the public health nurse if needed?

20. Do you have regular health check-ups?

a. Yes _____

b. No _____

Why?

21. If the answer was yes to the last question were the following things included in the check-up?

    a. Chest X-Ray Yes _____ No _____

    b. Blood test for diabetes Yes _____ No _____

    c. Urine test Yes _____ No _____

    d. Electrocardiagram Yes _____ No _____

    e. Glaucoma Yes _____ No _____

22. What do you think about the services received at the clinic?

23. What medicines do you take?

Name of Medicine	How Often

24. If this neighborhood had a medical center especially for older people would you go there for medical care? Why?

25. Is there anything about your health that you think is not taken care of properly?

    Why?

26. Do you have any kind of health insurance like Blue Cross-Blue Shield?

a. Yes _____

b. No _____

Why?

27. When did you attend clinic last? _____

Why?

Nutrition

1. How do you feel about eating alone?

2. What did you eat for breakfast, lunch, and dinner yesterday and the day before?

Yesterday

Breakfast Lunch Dinner

Day Before

Breakfast Lunch Dinner

3. Where do you do most of your grocery shopping?
   a. Neighborhood stores _____
   b. Super markets _____
4. Is it necessary for you to have credit at the neighborhood store?
   a. Yes _____
   b. No _____

c. Sometimes _____

Why?

5. Do you receive any surplus foods?

a. Yes _____

b. No _____

6. Do you need any help in learning to use the surplus foods?

a. Yes _____

b. No _____

7. Do you think it would be a good idea to have "meals on wheels" in this neighborhood? (explain)

a. Yes _____

b. No _____

Why?

8. Would you use the services if offered?

a. Yes _____

b. No _____

Why?

9. If a cafeteria were available in this building would you eat your meals there?

   a. Yes _____

   b. No _____

   Why?

10. How is your appetite most of the time?

   a. Good _____

   b. Fair _____

   c. Poor _____

Social

1. Do you have any close relatives living in this city?

   a. Yes _____

   b. No _____

   Who?

2. If yes, how often do you have contact with them by phone or by home visiting?

   a. Once a week _____

   b. More than once a week _____

   c. Every two weeks _____

   d. Seldom _____

   e. Occasionally _____

   f. Never _____

3. How do you feel about living alone?

4. Some people as they get older feel differently about life than when they were younger. How do you feel about this?

5. Would you like to have more contact with other people?

   a. Yes _____

   b. No _____

   Why?

6. Do you think housing projects should be built which would house elderly people only?

   a. Yes _____

   b. No _____

   Why?

7. What do you think the elderly person needs help with most? (Use as a guide the following):

   a. Health _____

   b. Money _____

   c. Education _____

   d. Housing _____

   e. Other _____

8. When was the last time that you saw a doctor? _____

   Why?

Recreation

1. How do you spend your leisure time?
    a. Reading _____
    b. Listening to the radio _____
    c. Engage in hobbies _____
    d. Club meetings _____
    e. Visiting friends _____
    f. Taking walks _____
    g. Other _____
2. Do you belong to a "golden age" club now?
    a. Yes _____
    b. No _____
3. Do you know of any recreation centers in this area?
    a. Yes _____
    b. No _____
4. Do you attend any of the recreational centers in this area?
    a. Yes _____
    b. No _____

    Why?
5. Are you able to keep up with your usual church attendance?
    a. Yes _____
    b. No _____

    Why?

6. Do you participate in any of your church clubs?

a. Yes _____

b. No _____

Why?

<u>To be filled in by interviewer</u>

General appearance of home:

Neat	Clean
very _____	very _____
fairly _____	fairly _____
not _____	not _____

Respondent's personal appearance:

Clean	Well-groomed
very _____	very _____
fairly _____	fairly _____
not _____	not _____

Type of housing structure:

a. New Dwellings _____

b. Old Dwellings _____

Time interview began _____

Time interview ended _____

Total time of interview _____