Health Needs and Opinions of Older Adults

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TO LEARN something about how older people perceive their health needs and how they meet them, an interview survey was conducted among 95 elderly persons living in a low socioeconomic district of Boston, Mass. Although the findings may be characteristic to some extent of the socioeconomic level of the group, they are undoubtedly related in part to the respondents' age. In any event, the group is a sample of potential consumers of public health services. Their behavior, attitudes, and opinions should be of value to public health personnel planning or administering services for such a population.

The study, carried out in 1955, was designed specifically to investigate the following factors and their interrelations: state of health and health care, satisfaction with health, respondents' appraisal of health needs and care, and use of mass media for health information. With a few changes, a number of the questions in the interview schedule were taken from the much more extensive schedule used in the survey in the Kips Bay-Yorkville Health District of New York City (*1*). Most of the interviewing was done by an interviewer with considerable training and experience on research projects of the Harvard University department of social relations. The remainder was done by DiCicco.

Miss DiCicco, health educator, and Dr. Apple, sociologist, were members of the staff of the gerontology and chronic disease unit of the Harvard School of Public Health when the survey reported here was undertaken. Miss DiCicco is presently on the staff of the health division of United Community Services of Metropolitan Boston. Dr. Apple is with the Boston University School of Nursing.

Characteristics of the Sample

A random sample of 158 persons 65 years of age and over was drawn from a single census tract within the Whittier Street (Roxbury) District of the Boston Health Department. According to the 1950 census, the total population of those ages in the census tract is 377. Median rental in the residential area is $24 per month; about 35 percent of the housing is dilapidated or has no running water; less than 15 percent of the employed have "white collar" jobs or better; and more than half the population is nonwhite.

The sample yielded 95 interviews. Of the 63 nonrespondents, 26 were men and 37 women; 39 persons (16 men and 23 women) had moved, were deceased, or could not be found; 14 (9 men and 5 women) had working hours that prevented their being interviewed; and 1 man and 9 women refused to be or were incapable of being interviewed because of illness or a language handicap. The interviews averaged an hour in length. Only seven of the respondents showed any negative feelings about being interviewed.

Of the 95 respondents, 25 were between 65 and 69 years of age; 55 were in their seventies; and 15 were 80 or over. Twenty were white men, and 15 were Negro men; 40 were white women, and 20 were Negro women. Forty-four were born in the United States; of the foreign

born, 18 were born in Canada, 11 in Ireland, 7 in the British West Indies, and the remaining 15 in 13 other countries. The mean length of residence in this area of Boston was 40 years.

Twenty-nine of the respondents were married; 58 were widowed, divorced, or separated; and 8 were single. Besides the 29 married respondents, who were living with their spouses, 30 persons were living alone, 25 were living with relatives, and 11 were living with nonrelatives. Twenty-one reported owning their own homes, and 74 were tenants or lodgers. Fourteen persons had finished high school; 28 had attended high school; and 53 had not completed grammar school. Forty-six were Protestant; 40 were Roman Catholic; and 3 were members of other faiths; the others did not designate a religious affiliation. Eighteen had never worked; 14 were currently employed; and 63 had previously worked.

In summary, the sample included substantial numbers of whites and nonwhites, Roman Catholics and Protestants, native born and foreign born. The preponderance of women, the low educational level, the few still employed, and the small number living with spouses are characteristic of older persons. Their poverty and substandard housing are characteristic of the area in which they live.

The race and sex distributions of the sample were representative of the distributions of all persons aged 65 years and over in the census tract. The sample, however, tended to be older than the census tract population. Half of the 377 persons 65 years old and over in the census tract were in the 65-69 group, but only one-fourth of the sample were in this age category. The difference is probably due to the number of persons in the lower age group who were not interviewed because of their working hours.

State of Health and Health Care

The state of health of the respondent was determined through questions about the number of days spent in bed during the previous year, ailments or symptoms present at the time of the interview, and whether he was under treatment by a physician. Conditions were considered to be under treatment if medication prescribed by a physician was being taken or if the patient had been seen by a physician within the previous 6 months.

Only two-fifths of the sample reported having been in bed because of illness during the previous year. Thirty-three persons said they had been ill once, and 4 had had 2 illnesses each. These 37 persons reported a total of 696 days in bed.

Forty persons said they had an illness under treatment at the time of the interview; 28 reported an illness not under treatment; and 27 reported no illness.

As shown in table 1, of the 208 ailments reported by 68 individuals, heart and circulatory diseases, diseases of bones and joints, and hearing disorders are the three leading categories. These are chronic diseases for which medical science has little to offer in the way of cure. Practice and opinion of the group surveyed, as brought out in the data that follow, reflect a conviction that aches and pains and physical limitations are a part of old age and a general skepticism that anything can be done about them.

Index of Health

From several questions we constructed a single index of health that would distinguish the more healthy from the less healthy persons. With such an index, we could test whether the more healthy differed from the less healthy with regard to other data that we gathered from our sample.

The index we constructed is known as a Gutt-

Table 1. Ailments and symptoms reported by 68 individuals

Ailment or symptom	Number	Percent
Total	208	100.0
Heart and circulatory diseases	48	23.1
Diseases of bones and joints	34	16.3
Hearing disorders	26	12.5
Foot conditions	18	8.7
Gastrointestinal disorders	18	8.7
Nervous disorders	18	8.7
Kidney disorders	16	7.7
Vision disorders (including some in persons wearing glasses)	15	7.2
Diabetes	3	1.4
Respiratory diseases	3	1.4
Other	9	4.3

Study Advisers

Assistance in planning the study was provided by a Harvard School of Public Health Advisory Committee composed of Dr. Robert B. Reed, Dr. Beryl Roberts, Dr. Claire Ryder, and Dr. Leonid Snegireff, and Mrs. Marie F. Gately of the Boston Health Department. Dr. Reed, associate professor of biostatistics at the Harvard School of Public Health, helped in selecting the sample and setting up tables as well as with general advice.

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man scale. This method of combining replies to several questions into a single score for each person was developed during World War II by social scientists employed by the Army to study experiences and opinions of soldiers (*2*, *3*). It has been used extensively in sociologic research and has a number of advantages over other methods of combining several items of information into a single score. (Every Guttman scale reported in this paper has a coefficient of reproducibility of more than 0.90.)

For example, suppose we have information about the presence or absence of three traits, A, B, and C, in a sample of people. Suppose that these three traits are all indicators of a single underlying characteristic, such as healthiness, and that trait A occurs most frequently, trait B the next most frequently, and trait C the least frequently. If we find that persons who possess only one of the traits possess A, while those who possess two of them possess A and B, then the items form a Guttman scale. We have in our sample only four types of persons: those who have none of the traits, those who have A only, those who have A and B, and those who have all three. This stairstep arrangement means that we can conclude that each type possesses a greater degree of the single characteristic underlying the traits than does the type preceding.

Item A in our index of health was based on replies to the question about number of days in bed. Item B was based on an index of satisfaction with health constructed from replies to five questions: How would you say your health is now? Do you think your health is better or worse than that of other people your age? Is your health better or worse or about the same as it was 10 years ago? Does it keep you from doing things? Does it keep you from seeing people? Item C was based on responses to the question of whether the person was having any present trouble with his health.

Using this scale, we were able to distinguish four types of persons ranging from the most healthy to the least healthy.

As a test of validity, our state of health scale was cross-tabulated with the interviewer's rating of respondents on Zeman's rating scale of activity (*4*). Zeman's ratings are: (*a*) capable of unlimited and unsupervised activity; (*b*) capable of moderate activity in the neighborhood but perhaps requiring assistance for extended or tiring trips; (*c*) activities limited, needs supervision and assistance a good part of the time, is practically housebound, needs transportation for trips to doctor or clinic; (*d*) confined to bed or immediate vicinity; (*e*) totally blind or so self-limited that self-care is not possible. The correlation was 0.59, which is adequate evidence of the validity of our scale. (This and all other correlations were calculated by the formula for the phi coefficient, with both variables dichotomized as close to the median as possible. For this sample, a phi coefficient of correlation greater than 0.21 is large enough to be statistically significant at the .05 level.)

Health Care

We were interested in finding out whether persons who rated low on the state of health scale reported receiving more or less health care than those who rated high. To answer this question we constructed a Guttman scale of health care received. Item A was based on the question of whether the person has a physician or hospital to which he usually goes. Item B was based on replies to this question: Some people think it's a good idea to see a doctor for a regular checkup ever so often even when they aren't sick, while other people think there's no use seeing a doctor unless you have something wrong; what do you think? Item C was based on whether the person said he had

seen a physician for any purpose in the previous year.

We computed a phi coefficient of correlation between health status and health care using types as defined in the state of health scale and in the health care received scale. The two had a correlation of −0.24, which means that there is a moderate but significant tendency for people who are healthy to stay away from health care (according to their report of their activities) and for the less healthy to receive more health care.

Characteristics of the Two Groups

We were also interested in what differences there were within the "healthy" and the "unhealthy" groups between those who received much health care and those who received little. By thus holding constant the effect of health, we hoped to find indications of the reasons that some persons received more health care than others.

Within each of the two groups, we investigated the relationship between health care and age, sex, race, marital status, native or foreign birth, education, economic level, and whether the person lived alone or not. Within the healthy group, a clear difference emerged in regard to place of birth, marital status, and economic level. (Our criteria for higher, versus lower, economic level were: respondent owns his own home or he is working or chief wage earner of the household is working.) All persons who were native born, married, and economically better off than their neighbors reported a low level of health care. As we proceed to those possessing any two of these characteristics, to those possessing any one of them, and finally to those who are foreign born, nonmarried, and of a low economic status, the proportion with a high level of health care steadily increases. The difference is great enough for the chi-square test to reject the null hypothesis at the .01 level.

The same relationship between health care and place of birth, marital status, and economic level tended to appear among the less healthy, though the relationship in this group is not great enough to permit rejection of the null hypothesis.

These data indicate that it is likely that hospitals and physicians do not see a representative cross section of the population of older persons whom we studied. Therefore, health services for older people planned on the basis of knowledge of the needs, wishes, and life circumstances of patients may not be acceptable to those who are not seeking health care.

The apparent relation between the amount of health care and the three characteristics might be interpreted this way: All three characteristics have to do with social affiliation. The foreign born have disrupted their early ties by emigrating. Married people have a social tie which the widowed, divorced, and single do not have. Our measure of economic level is home ownership or employment, both of which are social ties. Since receiving health care provides an opportunity for association with other people, it may be that a desire for contact with other persons and a felt lack of social ties lead the foreign born, the nonmarried, and those with a lower economic status to obtain health care. Further research would be needed to test this interpretation. If it were found to be correct, then this motivation for seeking health care might provide a means to increase the utilization of health services by at least a part of the population of older people.

Satisfaction With Health

We hypothesized that a major variable in our sample's evaluation of their health was the degree of activity which a respondent felt he could sustain. Evidence to confirm this hypothesis was found in three ways.

First, interviewer ratings on Zeman's scale of activity had a correlation of 0.54 with our five-item index of satisfaction with health, previously described. This is a highly significant degree of correlation.

Second, the index of satisfaction with health had a correlation of 0.44 with a Guttman scale of respondent's reported activity. The activity scale was constructed from answers to four questions. These concerned (*a*) visits (sometimes or often) with relatives or friends, either in the respondent's home or elsewhere; (*b*) walks or rides (sometimes or often); (*c*) a trip "to town" in the past 6 months, and (*d*) church attendance (at least once a week).

Finally, a content analysis of statements made by respondents when they were asked how their health compared with that of others their age disclosed that one theme appeared much more frequently than any other. This was the theme of ability to get around, to get out, to do what one has to do. As one lady put it (age forgotten): "He gives me health and strength to get my work done. My 'tired' makes me fall down at night, but then I'm all right for the morning." And one 74-year-old man: "My health is better than some who are 25 or 30. I carry a big buffing machine up and down stairs all by myself."

On the basis of this evidence, we accept the hypothesis that, for a majority of these people, to be active is to be healthy. We may speculate that being active allows older persons to satisfy their need for independence and thus to live up to society's requirements. In this group, health seems to be important only as it affects an individual's capacity to carry on activities important to him.

These findings raise serious questions about the kind of health education that would be meaningful in getting this group under medical care, let alone preventive care. They often consider themselves well despite ailments so long as they can meet the requirements of everyday living.

Respondents' Appraisal

A person's ideas on what constitutes good health and good medical care are important in how well he maintains his health. A number of questions in the interview supply information on how these older people view their health needs and the care they receive.

Periodic Medical Examinations

Respondents were asked when they had last had a "regular, thorough checkup." Fifty-six reported having undergone such an examination within the previous 2 years, but further questioning revealed that only 19 persons, or one-third, had visited a doctor specifically for a checkup. The remaining 37, or two-thirds, explained that the "checkup" was given them when they went for treatment of a disorder.

Thirty-three persons, more than half of the 56, reported that their physical examination had been performed by a private physician.

As a rough measure of the scope of the examination given, information was sought as to how many of the examinations included a chest X-ray, a blood test of some sort, and a urine test. Only 20 persons had had all three and 10 had had none, as shown in the tabulation below. These findings indicate that the examination given most of these people was not a "thorough checkup," although they do not show anything about the adequacy of the examination with regard to the particular disorder under treatment.

Number of tests	*Number tested*	*Percent tested*
3	20	35.7
2	12	21.4
1	14	25.0
0	10	17.9
Total	56	100.0

All 56 respondents who said they had undergone a physical examination expressed satisfaction with the adequacy of the examination.

These facts point to a general misconception in this group as to what constitutes a "regular, thorough checkup," as this would be defined professionally. By the respondents' standards, any contact with a physician, regardless of how the physician might define the purpose of the visit, was apparently a "thorough checkup." It would be valuable to know whether this group is typical of the general population in its apparent lack of knowledge of diagnostic tools.

To obtain further data on attitudes about the value of preventive health services the sample were asked to agree or disagree with two statements: "I think it is a good idea to have a checkup ever so often even though I'm not sick." "Doctors are good people to keep away from when you're feeling well."

About half of the sample agreed with the first statement, but only one-third of the sample disagreed with the second.

In judging the responses to these questions, the consistency in the respondents' answers is important. About 78 percent of the group originally rejecting the idea of preventive care repeated their views when asked the second question. Of the 50 persons who, in answering the first question, professed belief in the idea of

a checkup even though not sick, only 50 percent were consistent in their answers to the second question. Even more significant is the small number of persons, only 19, who acted on their belief that a preventive physical examination is a good thing.

Some of the negative comments on the subject of preventive care include: "Why go to a doctor when you can always tell when you're getting sick." "Some older people are always running to doctors because they have nothing better to do, and are making themselves sick." "I don't want to worry till I have to." "If you go, he's got to find something wrong with you; it's his business."

The idea that you know when you are sick made some sense 50 years ago when a large proportion of the prevalent illnesses were infectious and were accompanied by symptoms that the layman could recognize as signs of illness. The idea seems particularly inappropriate, however, for an age group prone to chronic diseases, the onset of which may be slow and inconspicuous. It would be interesting to see to what extent these ideas are shared by younger adults who have grown familiar with the preventive aspects of pediatric care, for instance.

As long as people go on measuring health in terms of their ability to eat and sleep or keep going, they will reject the idea that a physical examination is necessary to determine health status.

Preventive Clinic Facilities

In contrast to a majority of the group's negative feelings about the value of a physical examination, about two-thirds stated that they thought older persons would use a special neighborhood clinic where they could get advice and a checkup free of charge. An opinion on this subject was sought in an effort to gain some inkling as to whether this group would use such a service if one should ever be made available.

This generally favorable reaction deserves close scrutiny. It is easy and costs nothing to say yes to an abstract question like this one concerning use of a nonexistent facility for which there will be no direct consumer cost. Also, this same group held few opinions on medical facilities with which they had not had direct experience. Since the only clinic in the Boston area like the one described was not known to any of the respondents, it is difficult to regard these assents as anything but superficial. Expressed beliefs and practices of this group as revealed elsewhere in the study do not reflect a "felt need" for preventive medical services, however much we would like to think so.

Physicians

Fifty-three respondents said they had a private physician who usually took care of them. How had they selected him? Thirty-eight of them, about three-fourths, said he had been recommended by relatives or friends. Four had heard of him through a social worker, and 11 by various other means.

Respondents' standards for evaluating a physician were elicited by asking how a person can tell whether he can trust a doctor. As this question was added to the interview schedule after some interviews had been completed, we have replies from only 79 persons. One theme in the replies had to do with the doctor's technical competence: "You can tell by his background," or "His treatment works." Another theme had to do with appreciation of the doctor's personal qualities: "I like the kind of person he is," or "I like the way he does things." Table 2 summarizes the data.

Men and women differed significantly in their responses to this question (chi-square=8.3; $P < .02$). Men emphasized the more practical-sounding "satisfaction with treatment"; with women, the doctor's personality seemed to count most. Also, of 15 persons who said they trusted a physican because he was recommended by others (included in the category labeled "other"), 13 were women.

Only two persons named valid criteria for trusting a physician: one, the doctor's background; the other, his staff position in a hospital. The apparent lack of knowledge in this area is not surprising; knowing how to judge a physician presupposes a sophistication about medical matters not usually acquired except through special education or sustained contact with the medical world.

For the same reason, the patient's ability to evaluate his physician's treatment is to be ques-

Table 2. Reasons given by 79 respondents for satisfaction with specific physician

Reason	Male		Female		Total	
	Number	Percent	Number	Percent	Number	Percent
Technical competence	12	52. 2	11	19. 6	23	29. 1
Personal qualities	6	26. 1	25	44. 6	31	39. 2
Other	5	21. 7	20	35. 7	25	31. 6
Total	23	100. 0	56	99. 9	79	99. 9

tioned. As one person put it in stating his disadvantageous position: "If you're a patient, you *have* to trust a doctor."

The patient's need to personalize this dependent relationship with his doctor is captured in one woman's statement: "I *must* like him because the doctor will help me if I have confidence in him and if I trust his judgment."

This need to like the doctor as a person is difficult to fulfill within the framework of an overcrowded clinic where many older persons receive care and where treatment is not necessarily always by the same physician. If rewards in the way of treatment are scanty for this age group, how much more is there need for allowing this doctor-patient relationship to develop within the clinic setting!

In general, attitudes toward doctors were strongly positive. Eighty percent disagreed with the negative stereotype, "Doctors aren't really interested in what happens to you," and 73.6 percent denied that "doctors tend to treat younger people better than older people." Also, there were defending statements such as these: "If some old people don't get good service, it's their own fault because they're so cranky and critical." "They're so overcrowded, they do the best they can with what they have."

Medical Facilities

Respondents were asked to name medical facilities they had actually used among the six major hospitals in the Boston area, the city health department, the visiting nurse association, and nursing homes.

Fifteen persons stated that they had never used a hospital service, but the remaining 80 had had 144 hospital admissions. Opinions about 112, or four-fifths of the 144 admissions, were frankly favorable. Ten persons had had experience with the visiting nurse association and three with the health department, each of whom expressed a favorable opinion of the facility. Respondents were also asked to give opinions on hospitals whose services they had never used, but most of them hesitated to comment without direct experience.

Knowledge and discrimination about medical care and public health facilities are not widespread. This is not surprising since most people are not interested in services until they need them. When they do, there is no readily accessible body of knowledge which could help them in making a wise choice of facilities; and even if there were, according to the data given here and elsewhere, their choice would probably still be based on recommendations of family and friends.

Perhaps the question of sponsorship of a special preventive clinic might be raised here. The desirability of a health department's undertaking this service should be explored carefully, with at least this observation in mind: Most of the group of older people in this study had never used any of the health department services, according to their statements on the subject. Moreover, the disadvantages of separating preventive and curative aspects of child care, for example, are becoming increasingly apparent. Planning of services for older people might well be done with an eye toward integration with facilities and services already known and used by this age group. Integration of a preventive service with other services is particularly important when the need for such a service is commonly unrecognized. Consideration should be given to any practice, no matter how administratively unorthodox, that would en-

hance the possibility of the services being understood and used.

Mass Media for Education

Since so much effort has been directed toward acquainting the public, chiefly through mass media, with some of the basic facts about tuberculosis, cancer, and diabetes, we asked our sample some questions to test their information about these diseases. More than two-thirds of the sample answered questions on tuberculosis and cancer correctly (table 3). Agreement with the statement that cancer can be cured was often qualified by a doubting tone or with an additional "so they say" or "they *say* it can." Perhaps information campaigns are allowing the public to make the correct responses while still clinging to old beliefs.

Only about half of the persons interviewed agreed that people with diabetes can lead a useful life, with 33 unable to give an answer. Although the prevalence of diabetes makes it seem likely that everyone is acquainted with the disease, the sizable number of "I don't know's" might reflect the feeling that one can't really judge what it's like for someone else to have the disease.

Questions were asked as to whether the respondent read articles about health in the newspaper or magazines or listened to health programs on the radio or television. There was no significant difference in information about diseases between those who use such media for health information and those who do not.

Of the 86 persons who can read newspapers, 52, or almost two-thirds, said that they read articles on health. However, very few could name columns that they read regularly. Of the 88 persons who have a radio or television set, only 34, or approximately two-fifths, said that they listen to programs on health. Common replies were: "I don't know why I don't," and "I'm just not interested."

Sex, race, or satisfaction with health status produced no significant differences in responses to these questions.

The picture is quite clear here that, although many people might feel that the aged ought to be interested in knowing more about health and illness, the people themselves probably wish just the opposite, that is, to escape the infirmities coupled with the aging process.

Summary and Conclusions

An interview survey of 95 persons aged 65 years and over who reside in a low socioeconomic district in Boston, Mass., has produced some observations that may be of value to public health personnel in planning and administering services for a similar population.

The most common perception of health among this 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 opinions and practices discovered in this survey, it makes even more difficult attempts to make preventive services meaningful.

Among the study group, there seemed to be

Table 3. Public information about tuberculosis, cancer, and diabetes

Statement	Agreed		Disagreed		No answer		Total	
	Number	Percent	Number	Percent	Number	Percent	Number	Percent
People can have tuberculosis and not know it	71	74. 7	11	11. 6	13	13. 7	95	100. 0
Cancer, if it is found early, can be cured	68	71. 6	12	12. 6	15	15. 8	95	100. 0
People with diabetes can lead a useful life	55	57. 9	8	8. 4	32	33. 7	95	100. 0

little appreciation of the newer diagnostic and therapeutic tools, and objective criteria for selecting and judging the quality of medical care received were almost completely lacking. Selection and evaluation of physicians and facilities were made almost completely on the basis of personal experience and opinion of family and friends.

There was little expressed need for preventive services, and for the most part these people had already-established patterns for using medical facilities, based chiefly on personal contacts.

These 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. The services might be paid for by health departments but administered within hospital outpatient departments or departments of welfare.

The frequently mentioned "look at the whole man" is especially important when that man is part of our aging population. The things that give life meaning for him greatly influence the narrow sphere of activities which can be described as health behavior. Sound public health planning cannot be accomplished in a vacuum.

In some communities, public health responsibility might mean taking the initiative to get community concentration on the problem. In those where the framework for action already exists, responsibility might consist of taking an objective look at all medical and public health services as they affect the elderly, putting new emphasis on already existing programs, and creating new services within whatever agency seems to offer the best chance of being used by the consumer in question.

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DOCUMENTATION NOTE

Tables presenting the data for the scales, correlations, and statistical tests described in this report have been deposited as document No. 5596 with the American Documentation Institute Auxiliary Publications Project, Photoduplication Service, Library of Congress, Washington 25, D. C. Photoprints may be obtained by remitting $1.25; a 35-mm. microfilm copy by remitting $1.25. Advance payment is required. Cite document number. Make check or money orders payable to Chief, Photoduplicating Service, Library of Congress.

Migratory Labor Notes Resumed

On April 1, 1958, the Department of Labor resumed publication of Migratory Labor Notes, a bulletin describing public and private activities affecting migrant agricultural workers and their families. Issued by the President's Committee on Migratory Labor, the organ first appeared May 11, 1955, and then, reflecting the small number of State migratory labor committees at that time, appeared only intermittently thereafter, once in November 1955 and again in May 1956. Publication on a more frequent basis was stimulated by the growing number of State migratory labor committees, which now total 17, and by the requests of many State and community organizations.