



# HEALTH ASSESSMENT OF THE AGED

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## 28.1 SURVEYS AND INDIVIDUAL ASSESSMENT

The studies of food-health relationships reported in the present book are intended to provide reference information for communities, as baseline, for comparative purposes or for the development of insights into the nutritional contribution to or consequences of health states. Therefore, patterns of health or community-wide indices of health are required and/ or sufficient detail about individuals is required to allow their data to be used in overall correlation analysis. In this case, the individual data have not been collected for clinical purposes, to diagnose disease or plan individual management.

## 28.2 THE HEALTH ASSESSOR

The health assessor may be either the subject or a health care professional. In the case of the IUNS study, the emphasis has been on self-assessment or statement of health. This has intrinsic value because it provides information about what subjects know they have, as far as health problems are concerned. But it suffers from potential under-reporting where the health state is not personally known, or through being erroneously reported if the person has been mis-informed or information has been mis-interpreted or poorly recalled. The principal problems for full medical assessment are ones of cost, time, and of availability of health personnel. In the IUNS study it was generally possible to achieve detailed targeted nutritional assessments, but not full medical assessments.

## 28.3 LEVEL OF ASSESSMENT

The level of health assessment may range from that of wellness, to function of various kinds, risk factors for diseases as with screening, identification of diseases (morbidity profiles) or mortality and cause of death. All but mortality were available in some measure to IUNS investigators, and are reflected in the questionnaire or survey instruments.

As far as possible, integrated indices or scores at each of these level have been produced as follows:

**1) Wellness**

Self reported status of well-being included questions WB11-19 and SAR101-102 in the questionnaire. Questions WB11, WB12, WB13, WB14, WB15, WB16, WB17a e.g. feelings of worry, depression, tiredness, loss of interest, sleeplessness and contentedness with life were modified from the WHO Western Pacific Study (Andrews et al. 1986) and a score was created ranging from 0-7. Questions WB17, WB18, WB19 and SAR101-102 were created for the study; these questions described, tendency to laugh, enjoyment of music, feeling lonely, and feelings of acknowledgement and respect by friends and relatives [1].

**2) Function**

- ADL (activities of daily living)
- Mini-mental state for cognitive function

**3) Risk factors**

- Diabetes
- Coronary heart disease

**4) Disease**

- Presence or absence
- Severity

The multi-level assessment instrument (MAI), developed in Philadelphia, was adopted and embraced several levels of health assessment (see Appendix) [2].

## **28.4 SPECIAL CONSIDERATIONS IN THE AGED**

Health problems in the aged may be:

- (1) those that could occur at any age although the pattern or frequency may be age-dependent (e.g. injury, respiratory infection).
- (2) related to the ageing process, which is poorly understood, but generally regarded as inexorable and, in some way, dependent on a biological clock with cell life or the number of cell generations being limited. It may not affect all systems equally and, therefore, may be represented by systems or organs progressively failing. For example, ovarian failure, and the onset of menopause in women may represent ageing. Nevertheless, this kind of process may be amenable to "slowing down" even by nutritional means and is, therefore, worthy of identification in health studies of the aged.

- (3) age-related and not inevitable with advancing years, some populations perhaps being totally spared the problems in later life. Examples would be atherosclerotic vascular disease (thromboembolic stroke, ischaemic heart disease, peripheral vascular disease); diabetes; certain cancers like colo-rectal cancer, prostatic cancer in men, skin cancers; dementia of either the Alzheimer's or multi-infarct kind.

Clinical experience provides direction as to what might be the most commonly encountered disabling health problems in the aged:

- a) falls, osteoporosis and related fractures
- b) dementia
- c) incontinence of urine and or faeces
- d) diabetes (non-insulin dependent)
- e) cardiovascular disease, especially ischaemic heart and cerebrovascular and peripheral vascular disease
- f) degenerative joint disease - osteoarthritis

It is a moot point as to what extent each of "any age", "ageing" or "age-related" factors account for these health problems of clinical concern. An enquiry about food-health relationships will include them all. Studying the health problems of the aged is to study the problems of survivors, in the IUNS study either the over 70 year old or the upper centiles (quintile/ decile) of the population. Such people are a selection of their birth cohort and, therefore, no extrapolation can be made from them to those who died before them. Again, they may have brought with them health problems from earlier life which may have been part of the selection process, or may simply compound the emergence of additional problems in later life; either way, the survivors are entitled to have these problems analysed for their better health - with an effort to understand at what point in their lives they emerged.

## 28.5 SUMMARY

Health assessment in the aged should take account of:

- (1) How community-wide or individual the information needs to be
- (2) The health assessor - self or medical
- (3) Level of assessment-wellness, function, risk factors for diseases, disease/ morbidity, mortality (where available)
- (4) Special considerations in the aged
  - i) age-relationship
  - ii) clinical experience
  - iii) nature of survivorship

## 28.6 REFERENCES

1. Andrews GR, Esterman AJ, Braunack-Mayer AJ, Rungie CM (eds). Ageing in the Western Pacific-A four country study. World Health Organization. Western Pacific Reports and Studies no. 1 Manila; 1986.
2. Lawton MO, Moss M, Fulcomer M, Kleban MH. A research and service oriented multilevel assessment instrument. *J Gerontol* 1982; 37: 91-99.

## **CHAPTER 28**

### **HEALTH ASSESSMENT OF THE AGED**

#### **28.1 SURVEYS AND INDIVIDUAL ASSESSMENT**

#### **28.2 THE HEALTH ASSESSOR**

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