SELF-REPORTED HEALTH STATUS AND MEDICAL HISTORY

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7.1 SELF-RATED HEALTH

The relationship of food intake and lifestyle to health is a central theme in this study. Thus, a valid and reliable method of measuring health was required. Fillenbaum (1984) [4] reviews all available questionnaires measuring the health status of the elderly and concludes that the multi-level assessment instrument (MAI) designed by Lawton et al (1982) [9] is a valid and reliable measure to use on such populations (see Appendix A1). It is carefully constructed and has been tested for reliability and validity. It includes a physical health domain index (or total health score), composed of subindices measuring self rated health, health behaviour and health conditions. The subindices can be scored by counting or summing and can be used in isolation from each other and from the rest of the questionnaire. A higher score in all cases indicates better health. All questions and subindices are based upon subjective reports from the interviewee.

The health questions and subindices include:

1. Total Health score (33-74)

a) Self rated health subindex (score 4-13): Questions H34, H35, H36, H37 (e.g. how would you rate your overall health at present, is your health better, same or not as good as people your age).

b) Health behaviour subindex (score 3-9): Questions H38, H39, H40 (e.g. frequency of physician visits, days spent in hospital, days spent in bed because of illness).

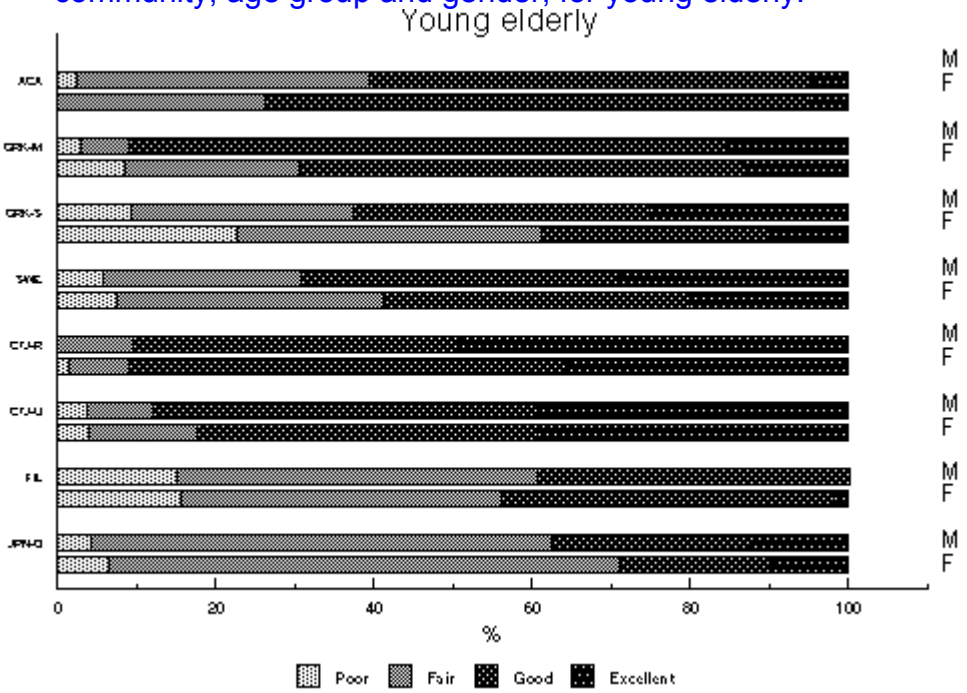
c) Self reported health conditions subindex (score 25-50): Question H43 (23 item check-list of common health conditions e.g. diabetes, high blood pressure), question H41 and H42 on eyesight and hearing and question on whether arms or legs are missing/ handicapped (H46).

d) Non index item (score 1-2): use of a wheel chair (H47c).

e) Total (General) Health Score = self rated health + health behaviour + health conditions + non index item = 33-74.

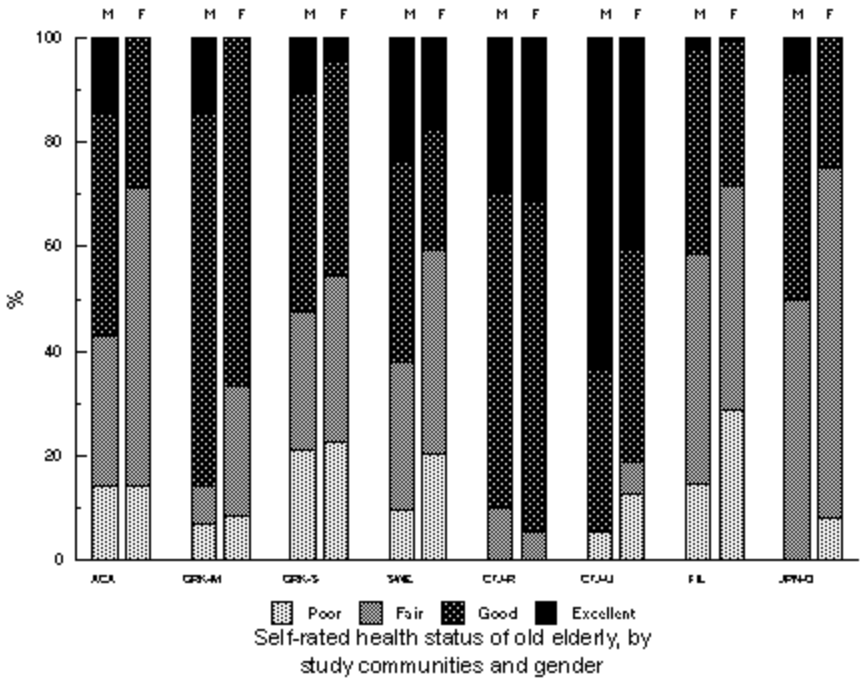
Figure 7.1 (young elderly) shows that, when health status is categorised as poor, fair, good or excellent, the combination of poor and fair did not exceed 58% for men (Filipino men), but was as high as 77% for Japanese women in Okazaki. On the other hand, this combination had a prevalence as low as 3% for Chinese men in urban Tianjin and 3% for Chinese women in rural Tianjin. Thus it is possible for Chinese elderly to rate their health well where socio-economic means and the food supply are limited, and where life expectancy at birth is relatively less good; and at the same time, for elderly Filipino men or Japanese women to note their health more often as poor or fair. In the case of the Japanese, socio-economic factors are more favourable and their life expectancy at birth is amongst the best in the world.

Figure 7.1. Prevalence of the self-reported health status, by study community, age group and gender, for young elderly.



These apparent paradoxes are worthy of further enquiry and may suggest that self-reported health is, in significant measure, attitudinal or psychological and, to a lesser extent physical. Figure 7.2 shows similar findings for the older elderly. It will also be of interest to ascertain prospectively how predictive self-rated health is of subsequent morbidity and mortality. Recent Australian work, from the Australian Institute of Health and Welfare suggests that such indices have considerable predictive power.

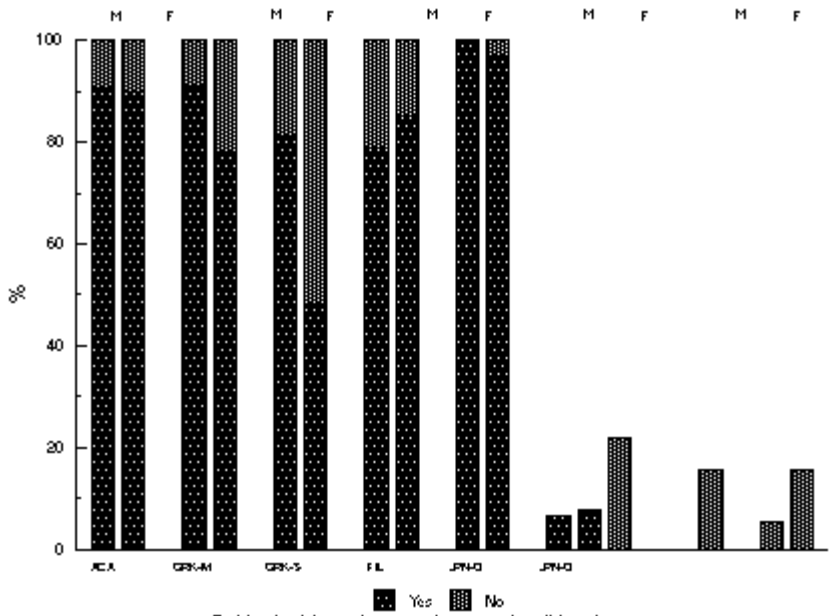
Figure 7.2. Prevalence of the self-reported health status, by study community, age group and gender, for old elderly.



Self-rated health status of old elderly, by study communities and gender

An interesting additional insight into the state of mind of elderly people is further provided by Figure 7.3 where at least 50%, and usually more than 80% of elderly people, men or women, European or Asian, feel happy on an every day basis. This clearly does not necessarily translate into feeling healthy, as indicated earlier. So that attitude may allow one to adjust to varying levels of medically-defined health, to differing extents, but, whatever is achieved in this respect, in the aged, one tends to be happy with one's lot.

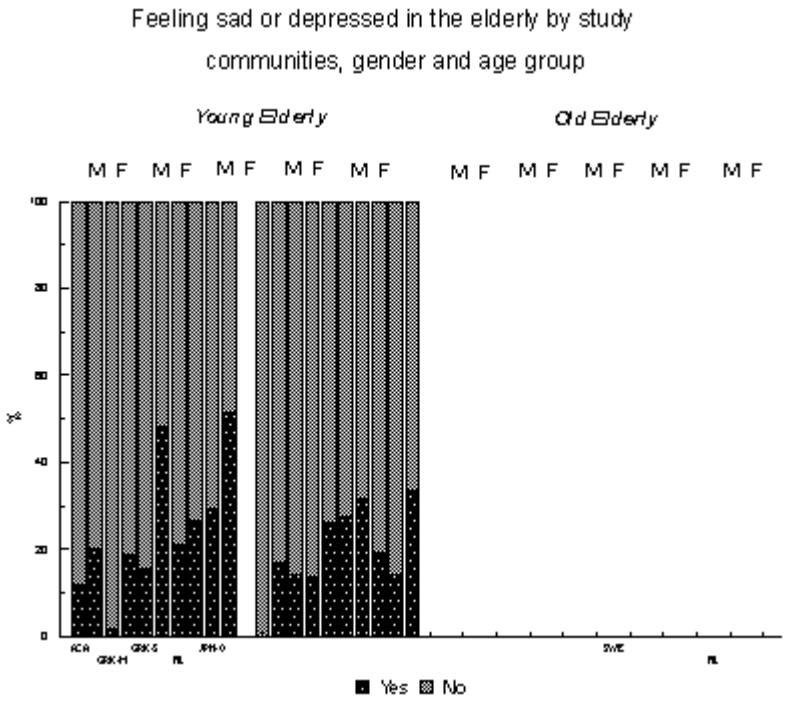
Figure 7.3. Self-rated happiness of every day life, by study community, age group and gender, for young elderly.



Self-rated happiness of every day life of young elderly, by study communities and gender

On the other hand, 20 to 30% of the elderly reported feeling sad or depressed, except Spatan and Japanese women (50%). Overall, a greater proportion of women reported feeling depressed or sad compared with the men (Figure 7.4).

Figure 7.4. Percentage feeling sad or depressed, by study community, age group and gender.



Women tend to report sleeping less well than men, and older women less well than younger women. The range of self-reported sleep disorder is wide, from 8% in older Japanese women to 43% in older Anglo-Celtic Australian women (Figure 7.5). It is interesting that Chinese men and women in Tianjin reported sleeping more than their Anglo-Celtic or Swedish counterparts (Figure 7.6).

Figure 7.5. Self reported sleeping disorders, by study community, age group and gender.

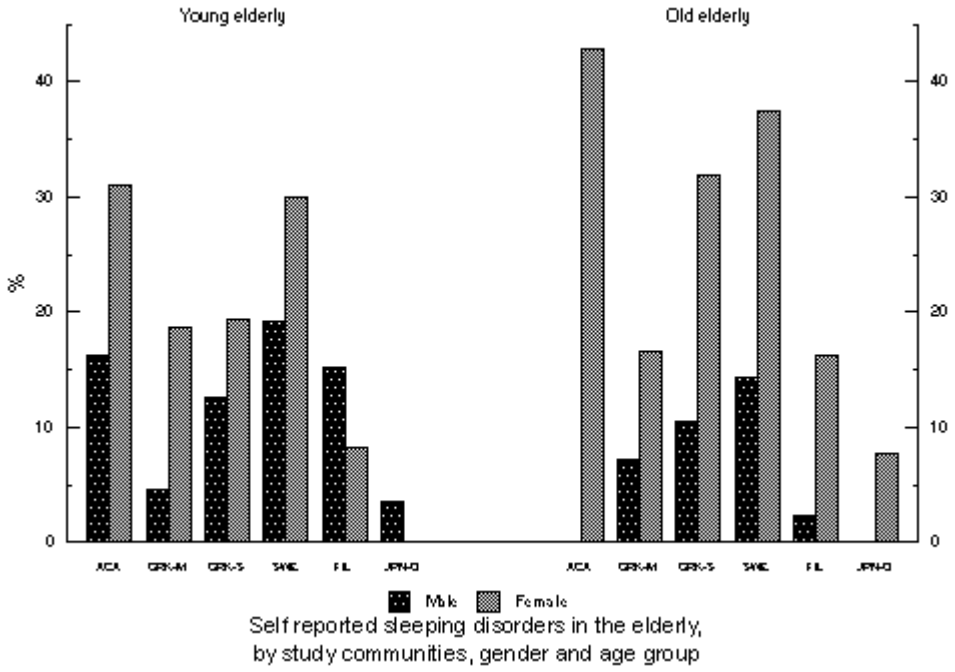
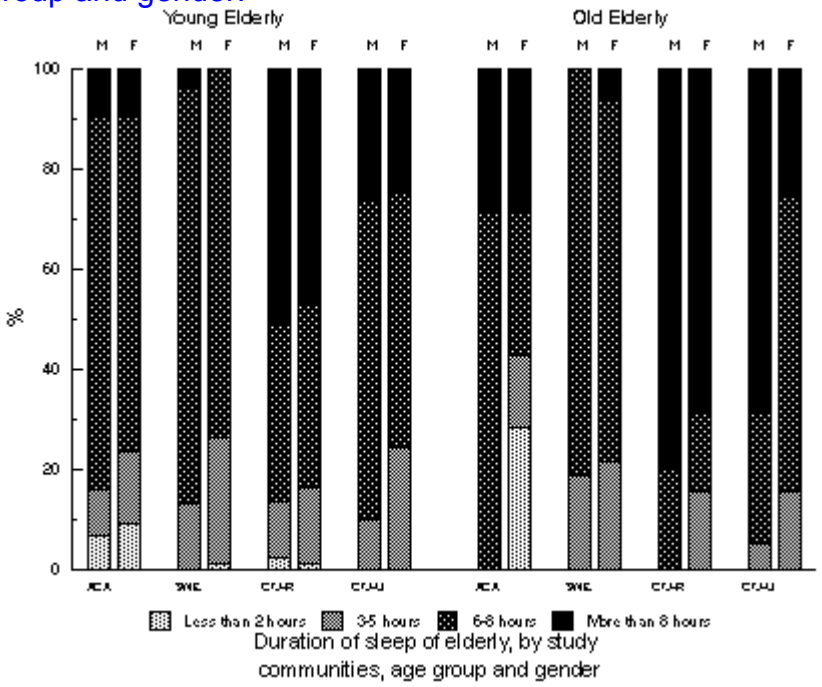


Figure 7.6. Duration of sleep at night, by study community, age group and gender.



According to Birrel, a psychologist and sleep expert at the University of New South Wales in

Sydney, Australia, historical evidence indicates that people used to sleep for longer periods than they do presently, so that repeat studies in subsequent years may reflect interesting cohort effects on the sleep patterns of the elderly.

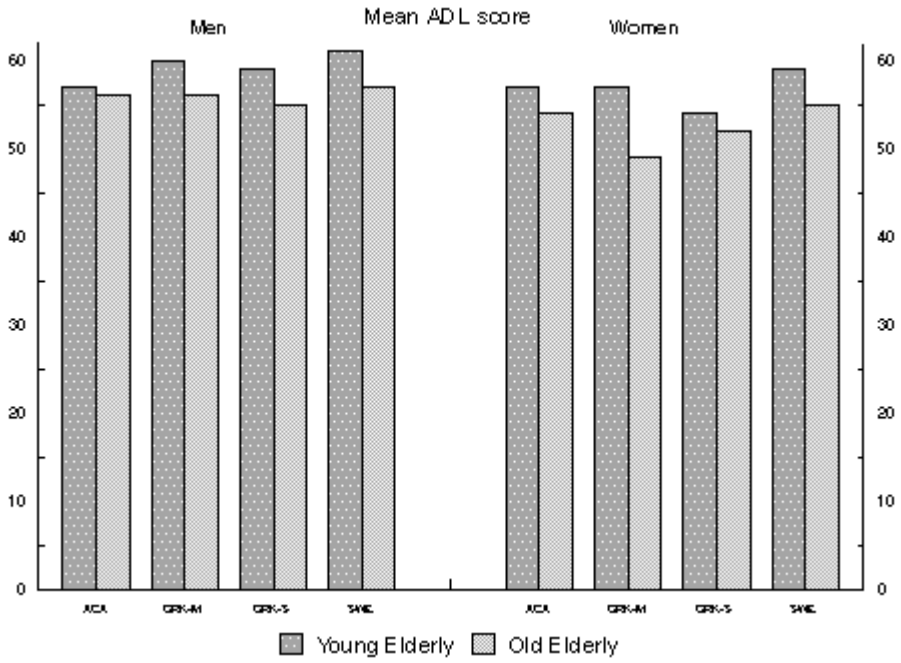
Birrel also indicates that the literature suggests that in women, at least during the child-bearing and child-rearing years, more sleep appears to be required than for men. To what extent these patterns reflect eating habits or contribute to nutritional states is worthy of further exploration.

Chapter 17, which deals with disability, discusses activities of daily living (ADL); some of the histograms are shown here for convenience (Figures 7.7-7.9). Questions regarding degree of difficulty in coping with basic bodily function (e.g. using the toilet, eating) and with performing basic tasks (e.g. cooking, housework, walking between rooms) are encompassed in questions ADL88a-n2, ADL880 and ADLP. These questions were taken from the WHO 11 country elderly study questionnaire [5] which were originally adapted from the validated instrument developed by Katz and Apkom (1976) [8].

The Euronut-Seneca study of elderly in Europe (de Groot et al; 1991) [3] have also used these questions from the WHO elderly study. For each item, the level of competence or grades of difficulty are measured on a 4-point scale (4 = without difficulty, 3 = with difficulty but without help, 2 = with help only, 1 = unable to complete).

A total ability score or ADL score was created for the study as a sumscore over all items, ranging from 15-62 (a higher score indicates better performance) (Figure 7.7) (see Appendix A1).

Figure 7.7. Mean score for activities of daily living, by study community, age group and gender.



One aspect of ADL is the ability to walk between rooms, or about the house (Figures 7.8, 7.9). Most older and younger elderly people do this without difficulty which reminds us just how independent people over 70 years old can actually be.

Figure 7.8. Percentage reporting difficulty with walking between rooms, by study community and gender, young elderly.

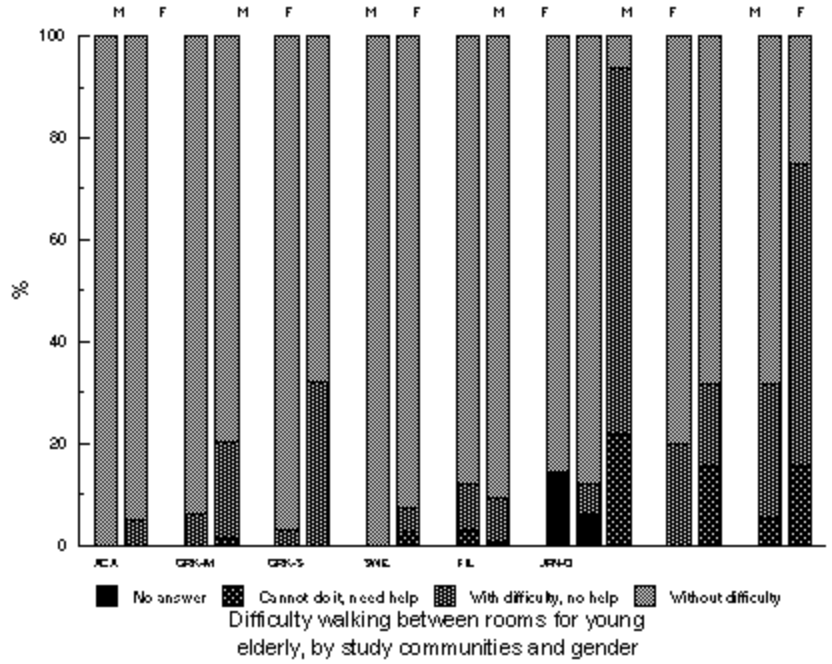
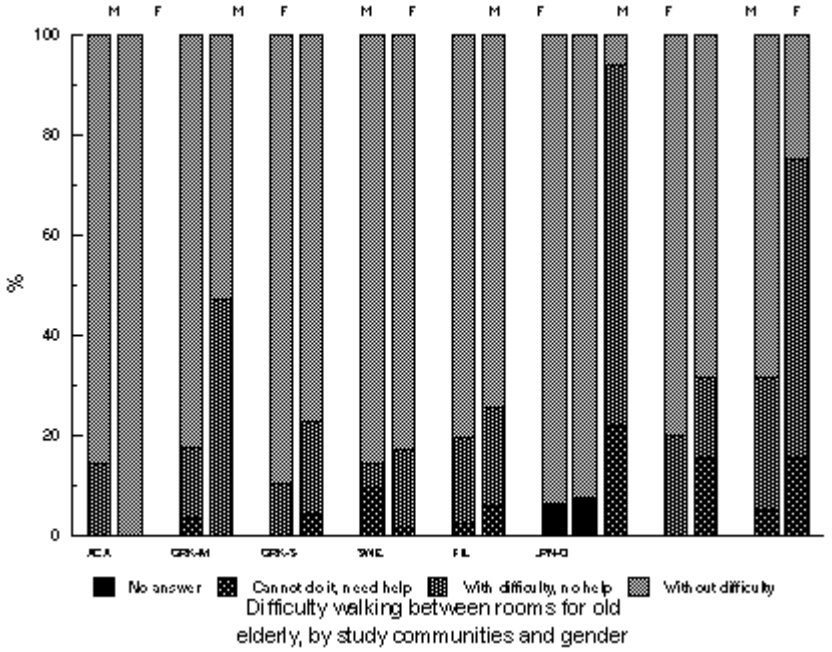


Figure 7.9. Percentage reporting difficulty with walking between rooms, by study community and gender, old elderly.



7.2 SELF-REPORTED HEALTH CONDITIONS

The health conditions reported with frequencies in excess of 5% in 2 or more communities were "heart trouble", strokes, hypertension, diabetes, cancer, rheumatism, "broken bones" and cataracts. These frequencies are depicted in the ensuing histograms (Figures 7.10-7.17). Thus cardiovascular disease (heart and cerebrovascular) is a major source of morbidity affecting both occidental and oriental elderly, up to 58% for heart disease (Anglo-Celtic Australian men) and 30% for stroke (younger elderly Chinese men in rural Tianjin) (Figures 7.10, 7.11). Some of the heart disease was valvular or cardiomyopathic of a non-ischaemic kind, but most were ischaemic heart disease.

Figure 7.10. Prevalence of self-reported heart trouble, by study community, age group and gender.

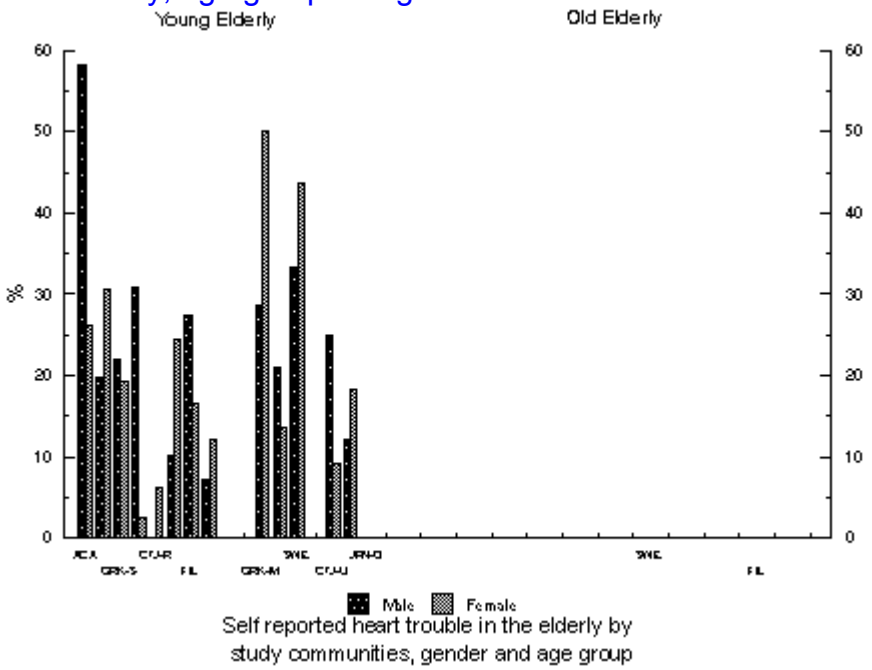
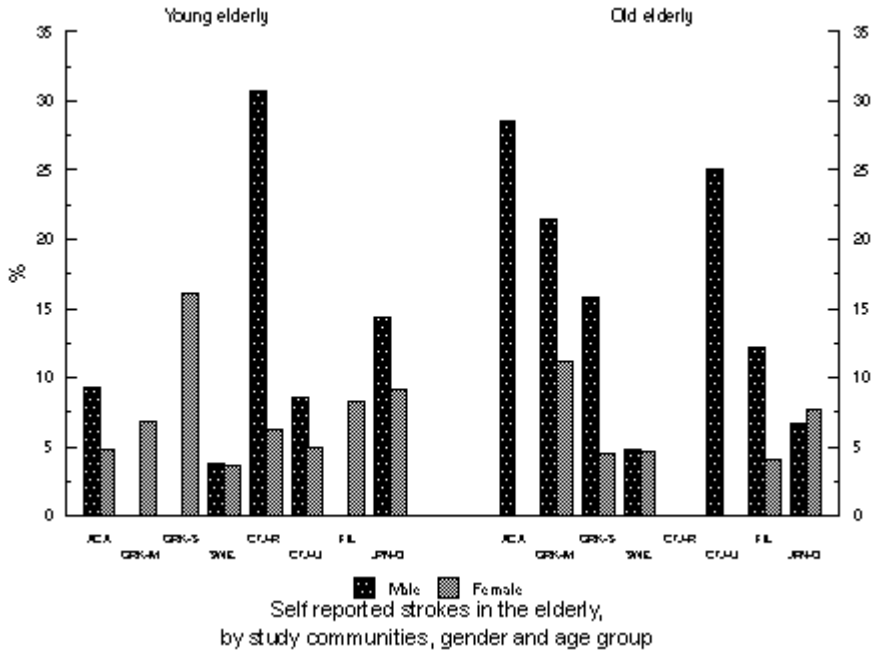
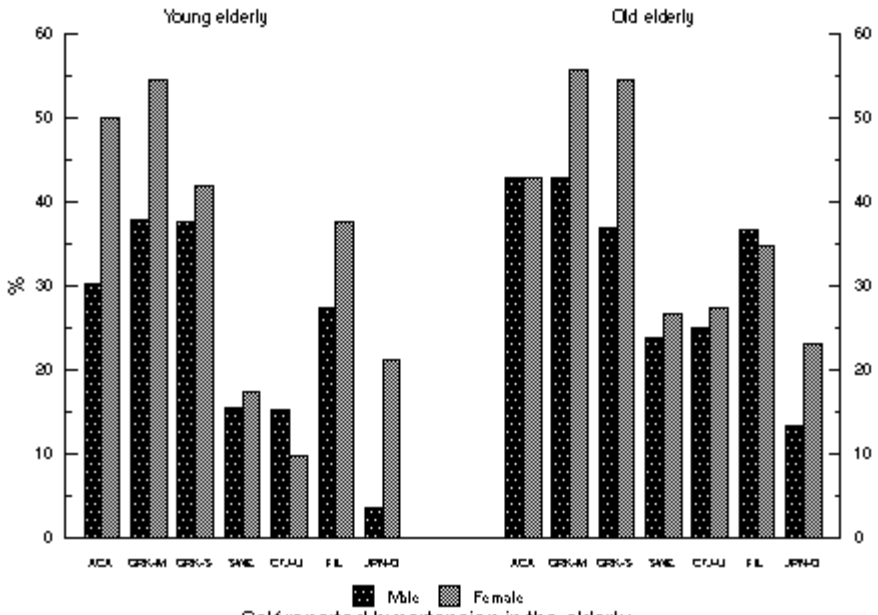


Figure 7.11. Prevalence of self-reported strokes, by study community, age group and gender.



For ischaemic heart disease and cerebrovascular disease (thrombo-embolic and haemorrhagic) hypertension is a risk factor, as shown in Figure 7.12 as self-reported rates (actual recorded blood pressures are shown in Section 14.3). Other cardiovascular risk factors of body fatness (Chapter 13) and serum lipids (Section 14.4) are to be found elsewhere in this report where they are available.

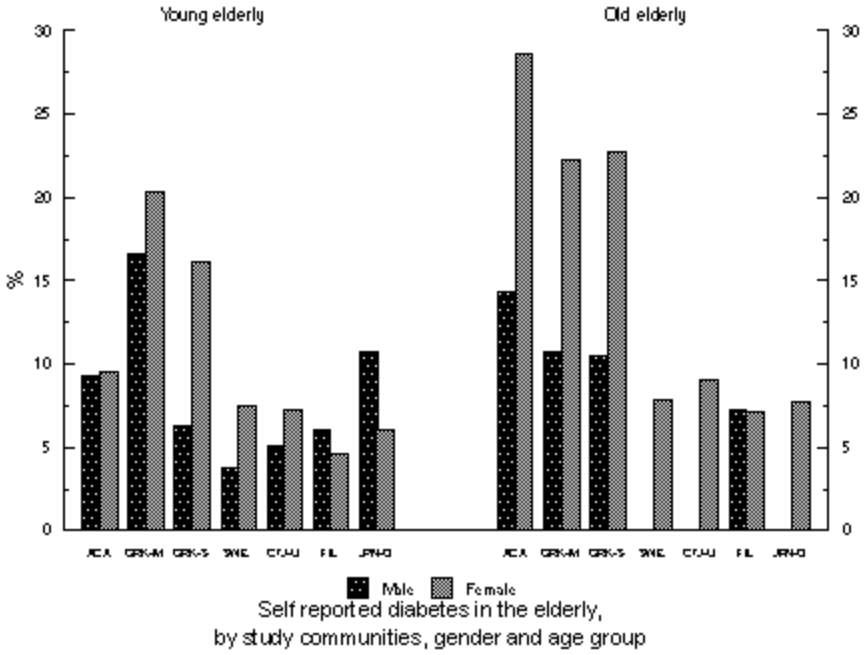
Figure 7.12. Prevalence of self-reported hypertension, by study community, age group and gender.



Self reported hypertension in the elderly,
by study communities, gender and age group

Diabetes itself is a risk factor for atherosclerotic or macrovascular disease affecting several territories. In the younger elderly, it has already reached self reported rates which exceed 10% (Greeks in Melbourne and Spata) (Figure 7.13). The fasting blood glucose concentrations, as a criterion for diabetes, are also available for some communities (Section 14.4) and prevalences of abnormal values exceed the self-reported rates for diabetes. Thus diabetes looms large as a health problem amongst the aged in quite culturally disparate communities.

Figure 7.13. Prevalence of self-reported diabetes, by study community, age group and gender.



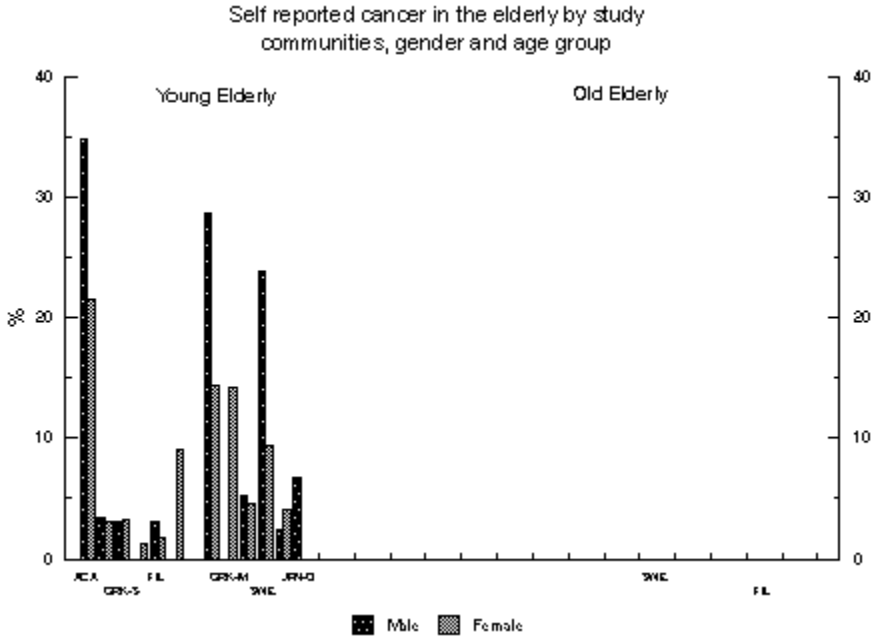
Self reported diabetes in the elderly,
by study communities, gender and age group

Photo 7.1. Melbourne, Australia (Greek) (1990-91): A woman turning eighty (with diabetes), photographed here with her two younger sisters.

In regard to cancer (Figure 7.14), the self-reported rates refer to all forms of cancer, including skin cancer. This particular cancer (of skin) undoubtedly accounts for the disproportionately high rates amongst Anglo-Celtic Australians, where the rates are appreciably higher in men (35% in younger elderly) than women (22% in younger elderly). By contrast, the cancer prevalences as reported by younger Greek Melburnian and Spatan elderly are around 6%, increasing in the older Greek elderly. It is known that the cancer incidences of Australian-born individuals and Greek born Melburnians for lung (in men) and breast (in women) are comparable and, for colo-rectal

cancer, approach those of locally born individuals after about 16 years of residence [10].

Figure 7.14. Prevalence of self-reported cancer, by study community, age group and gender.

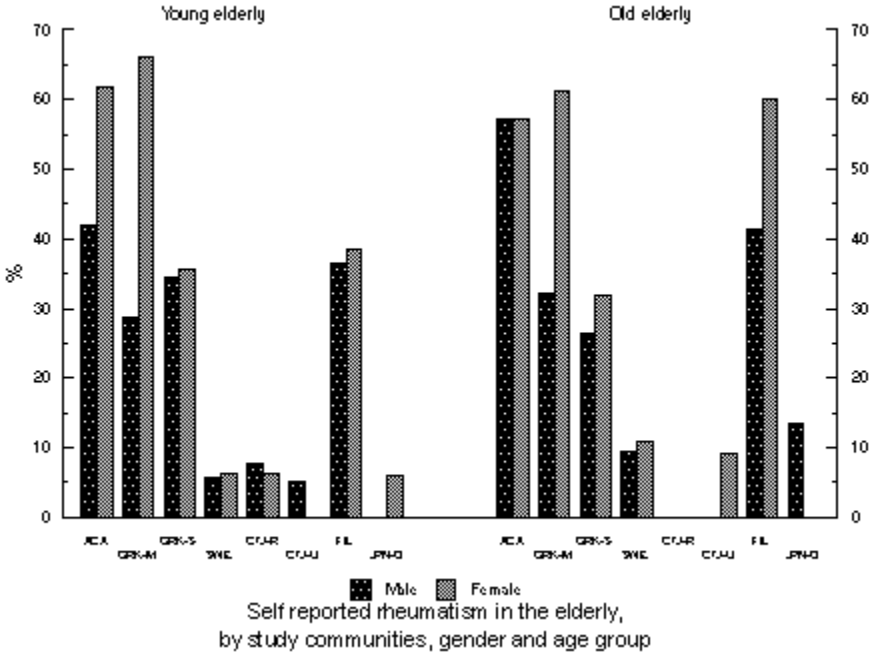


Most of the difference between Anglo-Celtic and Greek Melburnian elderly in reported cancer prevalence is likely to be attributable to skin cancer. Future enquiries about cancer must be specific about type. In the meantime, leaving aside Anglo-Celtic Australians, in European and Asian elderly, cancer prevalences in those between 70 and 80 years of age are less than 10%, increasing in the older aged. Regional differences in cancer type are likely to reflect lower incidences of large bowel prostate and breast cancers and higher incidences of gastric, primary liver cell, nasopharyngeal and oral cancers amongst Asian than European elderly.

Musculo-skeletal problems are generally regarded as contributory to a significant proportion of morbidity amongst the aged and this is borne out in the detail of the ADL (activities of daily living). However, there are high prevalences of self-reported "rheumatism", meaning pain or discomfort in muscles and/ or joints, in younger and older elderly Anglo-Celtic Melburnians (40-60%), Greeks in Melbourne and Spata (about 30-60%), and Filipinos in Manila (30-60%) (Figure 7.15). It is acknowledged that the Filipinos may be less representative of their communities than are those of Anglo-Celtic or Greek ethnicity, but the prevalences are undoubtedly indicative. Much lower prevalences of "rheumatism" were reported amongst Chinese and Japanese elderly, and this provides an interesting comparison for hypothesis generation in relation to cultural, including food cultural, determinants of rheumatism. For example, what do higher fish intakes amongst Japanese, or lower animal fat intakes, or higher

rice intakes amongst Chinese and Japanese signify for rheumatism? And why should rice eating Filipinos experience more rheumatism than rice-eating Chinese and Japanese?

Figure 7.15. Prevalence of self-reported rheumatism, by study community, age group and gender.



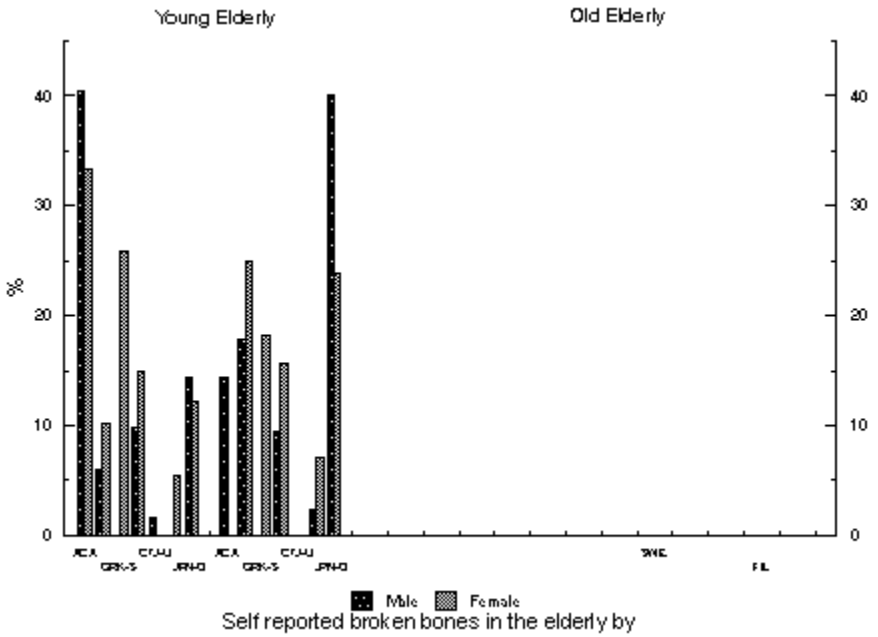
Self reported rheumatism in the elderly, by study communities, gender and age group

Photo 7.2. Spata, Greece (1988): an elderly couple in their late 70s, complaining of "arthritis".

Proneness to fracture amongst the young is seen more amongst men than women and is usually related to significant trauma, but amongst the elderly it is generally a result of the twin risk factors of falls and osteopenia (mainly osteoporosis, but sometimes osteomalacia as well [11]. In Australia, we know that life-time fracture experience for men and women involves about 40% of the population [11] and the Anglo-Celtic Melburnians would appear to fit this picture.

However, other communities of aged people seem to have a lesser experience of fracture, and usually less than 20% for Swedes, Chinese, Filipinos, Greek elderly (except younger elderly in Spata and older elderly in Melbourne-- less than 30%), and younger Japanese elderly (but not older Japanese elderly where it exceeds 20%) (Figure 7.16).

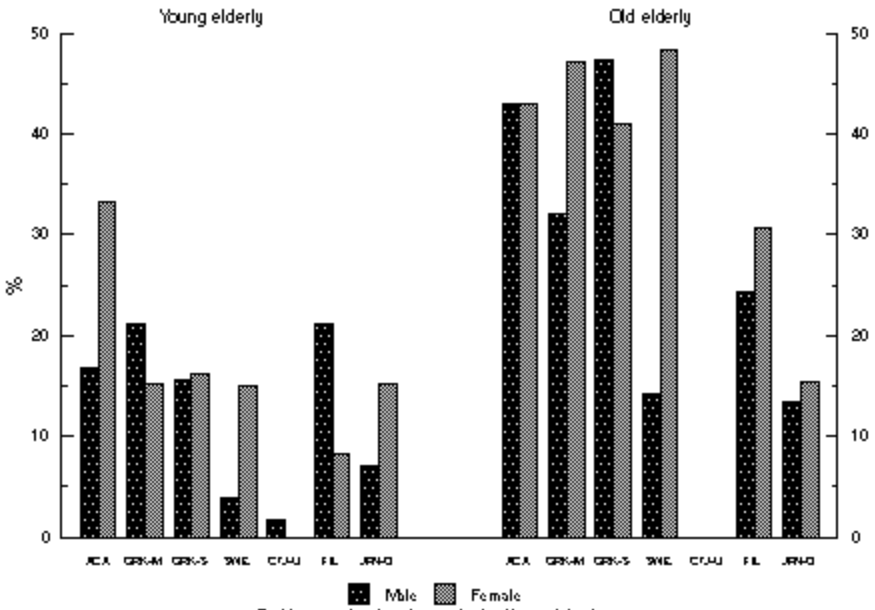
Figure 7.16. Prevalence of self-reported broken bones, by study community, age group and gender.



Self reported broken bones in the elderly by study communities, gender and age group

Impaired vision is also an important potential adverse contributor to quality of life in the elderly. Peculiar to the aged are senile cataracts, macular degeneration and glaucoma, with added risk of diabetic retinopathy and cerebrovascular disease affecting vision. There may also be a legacy of earlier life problems affecting vision like trachoma (e.g. with Aboriginal Australians) and xerophthalmia (in Asia). Presbyopia is progressive throughout life and usually becomes significant in the 5th decade of life, although correctable with spectacles. Amenable to simple inquiry is the phenomenon of cataracts about which many elderly people will have been informed by health care workers, doctors or opticians. We found in the IUNS study communities a big change in prevalence from about 10-15% overall in younger elderly to about 20-50% in older elderly (Figure 7.17). This age period may, therefore, present an opportunity for intervention and prevention. There were also cross-cultural differences in this change with late age-related increased cataract prevalence being less reported by Japanese elderly. There is a growing interest in nutritional factors, like antioxidants found in fruits and vegetables, being protective against cataract formation.

Figure 7.17. Prevalence of self-reported cataracts, by study community, age group and gender.



Self reported cataracts in the elderly,
by study communities, gender and age group

7.3 SELF-REPORTED USE OF MEDICATION

Whilst there is little doubt that life-saving and quality-of-life-improving medication has become part of the lives of elderly people, the risk-benefit ratio is often a problem. This problem arises because of errors in drug usage, decreased physiological ability to handle drugs by gut, liver or kidneys, and through the need for multiple medication because of multi-system disease [12]. Added to this may be the effects of protein energy malnutrition on drug handling, and the exacerbation of states of marginal nutrition by drugs themselves, through loss of appetite, nausea or drug-nutrient interactions.

Knowledge of medication use, whether medically prescribed or self-initiated, is therefore of considerable importance in the health assessment of the elderly. Its analysis is complex because extent of medication use may reflect:

a) severity and extent of disease
b) access to the health care system
c) personal concern about disease which may be responsive to medication
d) inappropriate use of medication

Elsewhere in this book, the interplay between medication use and health and nutritional status are explored.

7.4 SELF-REPORTED USE OF MICRO-NUTRIENT SUPPLEMENTS

A particular form of medication, whether it is medically-prescribed or self-initiated, is the use of micro-nutrients and other putatively nutritional supplements like dietary fibre, herbs and natural remedies. We specifically asked about micro-nutrient supplements in the IUNS study. Where we have the data, use is significant. For example, vitamin supplement use was about 15% amongst Greek men and 25% amongst Greek women in both Spata and Melbourne. The most common supplements used were:

- vitamin B12 injection (4%),
- potassium (4%),
- iron/ folate (4%),
- calcium (3%),
- multivitamins (2%),
- B group vitamins (2%)
- and vitamin C (1%).

In Australian [6] and North American studies (NHANES) reported elsewhere [2], the prevalence of usage of nutritional supplements exceeds 30% amongst the elderly. The most popular supplement used by elderly in Australia and America include multivitamins, vitamins B, C & E , bran and wheat germ.

7.5 ADDITIONAL INFORMATION

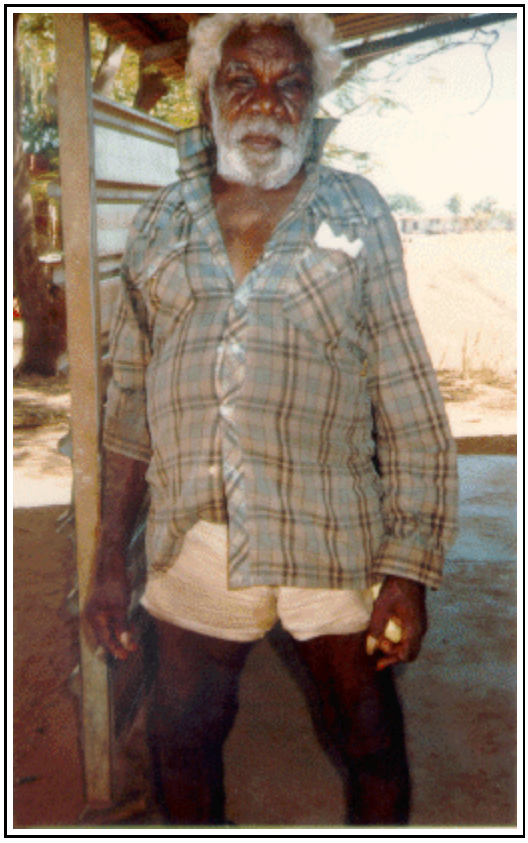
7.5.1 Aboriginal Australians (A Kouris-Blazos)

It had been our intention in the IUNS study to have a statement by people about their perceived health status. However, it was found that the Junjuwa elderly did not have a concept of health, but instead the issue appeared to be one of spiritual well-being. So for health status we were entirely dependent on medical records for 48 subjects. These provided us with the percentages of occurrences of the following, between the period 1958-1988:

- hypertension 44%,
- heart disease 21%,
- diabetes 27% (13% <5 years, 13% >5 years),
- obesity, BMI >30 14% (F 12%, M 2%, n=42),
- alcohol abuse 10%,
- cataract 33%,
- arthritis 21%,
- leprosy 10%,
- breast cancer 8%,
- trachoma 8%,
- anaemia 19%,

- bronchopneumonia 27%,
- asthma 8%,
- urinary tract infection 21%,
- kidney stones 4%,
- renal failure 4%,
- and leprosy 10%.

Photo 7.3. West Australia, Fitzroy Crossing, Junjuwa (1988): man in his 70s with rickets.



The health worker and nurse indicated that most of the elderly have had worms (tape worms, giardia, hook worm), sexually transmitted disease and boils at some stage. The anaemia is thought to be mainly caused by worms. Most of the elderly had pterygia. The elderly frequently used the medical centre at Junjuwa as well as the community health centre and hospital located at the Fitzroy Crossing townsite. Even though medications were prescribed to the elderly, to treat their diabetes or heart condition, they did not see the importance of taking the required daily dose of tablets.

7.5.2 Chinese in Beijing (Y Wang & D Roe)

The characteristics of the health status and health behaviour of the study participants presented here includes self-reported health status, self-reported current disease problems, use of medications and vitamin supplements.

Photo 7.4. Rural Tianjin, China (1989): a woman in her 80's.

7.5.2.1 Self-reported health status

The subjects evaluated their health status and reported it as being one of four levels: better than others, the same as others, worse than others, and don't know. Table 7.1 shows the numbers and percentages of self-reported health status for males, females and total subjects. Over half (53%) considered their health status was better than others; 24% reported their health status as the same as the other elders in their community; and about 10% answered as "I don't know".

As had been observed during the interview, 96% of study participants could take care of themselves. Many of them could do some types of housework, such as cooking, cleaning, washing clothes by hand, food shopping for daily meals and taking care of their grandchildren. The gender difference in self-reported health status was not statistically significant (P >0.05), although more males (60%) reported having better health status than females (50%).

Table 7.1. Self-reported health status

	Male		*Female*		*Total*	
	N	*%*	*N*	*%*	*N*	*%*
Better	74	59.7	88	48.6	162	53.1
Same	23	18.6	49	27.1	72	23.6
Worse	19	15.3	22	12.2	41	13.4

Don't Know	8	6.5	22	12.2	30	9.8	

Chi-Square = 6.942P = 0.074

7.5.2.2 Current health problems

The diseases considered as the major health problems in the study population are listed in Table 7.2. These diseases are ranked by the number of people reported as having the following: hypertension, various heart diseases, respiratory system diseases, diabetes, arthritis/ rheumatism, stroke, etc. All of the health problems were reported by participants and these had been previously diagnosed by their doctors. Hypertension has been a very common disease in the northern part of China. In this study, a high prevalence of hypertension was also observed in the study population. More than one third of study participants (36%) reported that they had been diagnosed as "having hypertension" by their doctors. Heart diseases that include coronary heart disease, rheumatic heart disease and cor pulmonale were also reported by the elderly subjects.

Respiratory diseases have long been a problem for the elderly in Northern China, although the Chinese government has run numerous programmes for prevention of respiratory system disease. Respiratory system disease was very closely related with smoking ($P<0.05$). Table 7.3 indicates that among a total of 41 people who had respiratory system diseases, 56.1% (23) of them were either regular smokers or had stopped smoking under their doctor's order. Differences in the prevalence of respiratory disease was found between the two communities ($P<0.05$). Seventeen per cent (30) of the subjects in Community 1 suffered respiratory disease, compared to only 9% in Community 2 (11).

Another common health problem listed in Table 7.2 is stomach/ intestine problems, which influenced 28% (28) of the study participants. Twenty-one of the study participants reported they had diabetes (gender differences were not found for this disease). However, 4 subjects in Community 1 did not report diabetes even though they had elevated blood glucose values. Arthritis/ joint symptoms, which were mainly reported in women, affected 9% [16] of female subjects, however, only 2.5% [3] complained of arthritis. Only one person was diagnosed as "having osteoporosis" by her doctor although 3 females subjects had a history of broken bones.

Psychiatric diseases were not reported by the study participants. Dental problems were reported by 25 people (8.2%), and their ability to eat certain foods had been affected. Differences in the incidence of dental problems were not found either between genders and communities, or among elderly in different age groups ($P<0.05$) and education levels ($P<0.05$). Blood pressure and blood glucose were also measured during the home visit. The average systolic/ diastolic blood pressure for males and females were 149/84 and 152/85 mmHg respectively. Significant differences were not found for blood pressure between genders. The average blood glucose of females (139mg/dl) was found to be significantly higher than males (119 mg/dl) ($P>0.05$).

Table 7.2. Description of health problems.

Disease	*N*	*%*
Hypertension	110	36.1
Heart Diseases	55	18.0
Respiratory Diseases	41	13.4
Stomach/Intestine Problems	28	9.2
Diabetes*	21	6.9
Arthritis/Rheumatism*	19	6.2
Stroke	11	3.6
Stomach Ulcer	11	3.6
Cataracts*	11	3.6
Tenseness	10	3.3
Gall Bladder Trouble	8	2.6

*Gender difference

Table 7.3 Smoking and respiratory diseases.

	Respiratory diseases					
Smoking	**Yes**		**No**		**Total**	
Yes	23	(18.7%)	10	(81.3%)	123	(40.5%)
No	18	(9.9%)	163	(90.1%)	181	(59.5%)
Total	41	(13.5%)	263	(86.5%)	304	(100.0%)

Chi-Square = 8.104; P = 0.017

7.5.2.3 Use of Medicine

Both western medications and traditional Chinese medicines were taken by the elderly for the various health problems found in this study. Among the total study participants, more than half (58%) reported not taking any kind of medication, which corresponds with the proportion reporting to be in good health condition (53%). Among the total 305 elderly participants, only 126 of them reported that they had taken medicines. The maximum reported number of western medicines per subject was 4. Fourteen elderly people regularly took 3 types of medication, 41 took 2 different medications and 70 reported taking 1 type of medication. The medication most frequently reported was an antihypertensive (13.8%), which was lower than the reported percentage of subjects with hypertension (36%). Other commonly used medications included anti-anginals for chest pain (11.5%), digestants (5.6%), anti-diabetes medicine (3.9%), and medications taken for problems related to the respiratory system (3.3%). Sleeping pills were taken by 2.6% of the study participants.

Table 7.4. Use of the western medications.

Medications	**N**	**%**

High Blood Pressure Medicine	42	13.8
Nitro-glycerine Tablet	35	11.5
Digestants	17	5.6
Medicines for Diabetes	12	3.9
Medicines for Respiratory Diseases	10	3.3
Sleeping Pills	8	2.6

Traditional Chinese medicine was also commonly used by the study population for various health problems, especially for some chronic diseases such as hypertension, diabetes, respiratory diseases, as well as for the flu, the common cold, and others. About 35% (n = 107) of the elderly reported taking traditional Chinese medicines. There was no significant gender difference in those taking traditional Chinese medicines. Moreover, education level and age were not significantly correlated with the usage of traditional Chinese medicine.

7.5.2.4 Use of vitamin supplements

Vitamin supplements were taken by study subjects either because they were prescribed by their doctors or they were self prescribed. About 13% (n = 41) of study participants reported taking vitamin supplements and this correlated with their education level. Table 7.5 shows that percentages taking vitamin supplements from lower to higher education level were 3.7%, 7.4%, 29.8% and 27.9%, respectively. This suggests that those elderly with higher education levels were more likely to take vitamin pills than those with lower education levels. No gender difference was found in those using vitamin supplements.

Table 7.5. Use of vitamin supplements by education levels.

Taking vitamins		Level of Education (Year) 0	1-6	7-12	>12	Total
Yes	(n)	3	9	17	12	41
	(%)	3.7	7.4	29.8	27.9	13.4
No	(n)	80	113	40	31	264
	(%)	96.4	92.6	70.2	92.1	86.6
Total	(n)	83	122	57	43	305
	(%)	27.2	40.0	18.7	14.1	100

Chi-Square = 31.6; P = 0.000

7.5.3 Filipinos in Manila (P De Guzman)

7.5.3.1 Memory, eyesight and general health of the elderly

The elderly's awareness of the current year, month, day, their address and direct questions on whether they could recall names of friends and relatives or where they last left things were used

to gauge memory. On the whole, it was most common to have memory lapses with regard to names of friends/ relatives or where things were last left. Memory lapses of such sort were more prevalent among the elderly who resided with family members, presumably because they have access to all parts of the house while their counterparts in institutions have designated rooms and limited space. For all memory questions, the proportion of correct responses was lowest among the elderly in the public institution for the aged. Perhaps the fact that the elderly in such institutions tend to be abandoned and destitute cases (many found wandering in the streets) could explain their poorer memory.

Eyesight was good or adequate for about two-thirds of the elderly residing with family members and in the private home for the aged. On the other hand, more than one-half of the elderly in the public institution had impaired vision; the government does not cover the cost of correction. Having, in a sense, found a home and friends to share life with, a smaller proportion of the institutionalised elderly believed their health was not as good as it was three years ago compared with the community based subjects. When asked to compare themselves with their contemporaries, the majority of the elderly in all community types considered their health to be better. Most experienced low incidence of hospitalisation and sickness in bed, and generally felt it unnecessary to visit the doctor.

The most common health problems that afflicted the elderly in the barangays was bladder trouble or difficulty in urination. None of the institutionalised elderly suffered the same disorder. The prevalences of high blood pressure, heart disorders, arthritis and cancer/ tumour, (commonly associated with affluence), are higher among the elderly confined in the private institution (see Table 7.6).

Table 7.6. Percentage distribution of respondents by community by health problems experienced in the past year.

	San Juan	Golden Acres	RVM	All Groups
Diabetes	6.9	5.9	15.8	7.3
High blood	36.1	25.0	57.9	34.9
Heart trouble	19.3	13.2	31.6	18.7
Circulation problem	2.0	1.5	-	1.7
Paralysed	2.5	1.5	15.8	3.1
Effects of stroke	3.0	2.9	10.5	3.5
Arthritis	45.5	47.1	63.2	47.1
Stomach ulcer	13.9	4.4	10.5	11.4
Asthma	10.0	11.8	-	10.4
Glaucoma	1.0	4.4	-	1.7
Cataracts	16.3	29.4	42.1	21.1
Cancer/ tumour	2.5	-	10.5	2.4
Liver trouble	-	-	-	-
Gall bladder	3.5	-	5.3	2.8
Kidney trouble	5.9	2.9	5.3	5.2
Bladder trouble	91.6	-	-	64.0
Broken hip	0.5	-	-	0.3
Broken bones	4.0	5.9	15.8	5.2
Anaemia	6.4	2.9	5.3	5.5
Parkinson's	0.5	-	-	0.3
Insomnia	12.9	7.4	-	10.7
Nervousness	23.3	11.8	15.8	20.1
Prostrate	2.0	-	-	1.4
Osteoporosis	-	-	-	-
UTI	3.5	1.5	5.3	3.1
Uric acid	4.0	-	5.3	3.1
Constipated	9.4	11.8	15.8	10.4
Stomach/ intestinal.	4.5	2.9	10.5	4.5
Lung trouble	11.4	7.4	10.5	10.4
Other ailments	13.9	26.5	26.3	17.6

Table 7.7. Percentage distribution of respondents by community by medications regularly taken.

	San Juan	Golden Acres	RVM	All Groups	
Arthritis	15.3	16.2	15.8	15.6	
Pain killer	5.9	4.4	5.3	5.5	
Aspirin	10.4	10.3	5.3	10.0	
High blood pressure	27.7	19.1	47.4	27.0	
To loose water/ salt	1.5	-	5.3	1.4	
Digitalis pills (heart)	10.9	14.7	5.3	11.4	
Nitroglycerine(chest pain)		1.0	2.9	5.3	1.7
Anticoagulants	-	1.5	-	0.3	
To improve circulation	2.5	-	-	1.7	
Insulin injections	-	-	-	-	
Diabetes pills	1.5	2.9	5.3	2.1	
Ulcer	4.5	-	15.8	4.2	
Seizures	-	-	-	-	
Thyroid pills/cortisone	-	-	-	-	
Antibiotics	11.4	4.4	-	9.0	
Tranquillisers	1.0	-	5.3	1.0	
Sleeping pills	0.5	-	-	0.3	
Hormones	-	-	-	-	
Anxiety/ depression	-	-	-	-	
Glaucoma	1.5	-	5.3	1.4	
Muscle relaxant	4.5	2.9	-	3.8	
Allergy	3.0	2.9	-	2.8	
Constipation	1.5	-	-	1.0	
Lung medication	4.0	7.4	5.3	4.8	
Others	8.4	20.6	15.8	11.8	

Table 7.8. Percentage distribution of respondents by community by psychological character.

	San Juan	Golden Acres	RVM	All Groups
Worry too much	59.4	38.2	21.1	51.9
Lost interest, often sad/depressed	50.0	58.8	15.8	49.8
(felt like dying)	25.7	26.5	5.3	24.6
Often tired	66.3	55.9	42.1	62.3
Not happy/contented with life	17.8	13.2	5.3	15.9

7.6 SUMMARY

Elderly people generally regard themselves as happy. Perceived health is more variable cross-culturally with a majority or a minority regarding their health in the "least good" category.

Functionally, by way of activities of daily living or, specifically, ability to independently move around their place of abode, most (more than 80%) elderly people in various cultures managed without difficulty. Furthermore, most slept at least 6 hours at night, although it was common to regard this as disordered sleep.

Self-reported health disorders were, in the main, cardiovascular, diabetes, cancer, rheumatological, visual or incontinence.

The importance, and complexity, of medication use as an index of and risk factor for health states was borne out in the IUNS studies. Elderly people were often interested in nutrient or nutritional supplementation.

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7.8 LEGEND FOR FIGURES

Figure 7.1 Prevalence of the self-reported health status, by study community, age group and gender, for young elderly.

Figure 7.2 Prevalence of the self-reported health status, by study community, age group and gender, for old elderly.

Figure 7.3 Self-rated happiness of every day life, by study community, age group and gender, for young elderly.

Figure 7.4 Percentage feeling sad or depressed, by study community, age group and gender.

Figure 7.5 Self reported sleeping disorders, by study community, age group and gender.

Figure 7.6 Duration of sleep at night, by study community, age group and gender.

Figure 7.7 Mean score for activities of daily living, by study community, age group and gender.

Figure 7.8 Percentage reporting difficulty with walking between rooms, by study community and gender, young elderly.

Figure 7.9 Percentage reporting difficulty with walking between rooms, by study community and gender, old elderly.

Figure 7.10 Prevalence of self-reported heart trouble, by study community, age group and gender.

Figure 7.11 Prevalence of self-reported strokes, by study community, age group and gender.

Figure 7.12 Prevalence of self-reported hypertension, by study community, age group and gender.

Figure 7.13 Prevalence of self-reported diabetes, by study community, age group and gender.

Figure 7.14 Prevalence of self-reported cancer, by study community, age group and gender.

Figure 7.15 Prevalence of self-reported rheumatism, by study community, age group and gender.

Figure 7.16 Prevalence of self-reported broken bones, by study community, age group and

gender.

Figure 7.17 Prevalence of self-reported cataracts, by study community, age group and gender

7.9 ILLUSTRATIONS

Photo 7.1. Melbourne, Australia (Greek) (1990-91): A woman turning eighty (with diabetes), photographed here with her two younger sisters.

Photo 7.2 Spata, Greece (1988): an elderly couple in their late 70s, complaining of "arthritis".

Photo 7.3 West Australia, Fitzroy Crossing, Junjuwa (1988): man in his 70s with rickets.

Photo 7.4. Rural Tianjin, China (1989): a woman in her 80's.

CHAPTER 7

SELF REPORTED HEALTH STATUS AND MEDICAL HISTORY