

**A SURVEY OF THE HEALTH AND SOCIAL SERVICE NEEDS OF
PEOPLE AGED 65 TO 84 YEARS LIVING IN CITY AND HACKNEY**

MAIN FINDINGS

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AUTUMN 1989

We are grateful to all those who made this project possible, especially Carol Gibson who helped code the data; Andrew Dunlop who arranged for the raw data to be entered onto the computer; Peter Browne for advice on computing procedures; Mary Buck for assistance with the extraction of names and addresses and compilation of the sampling frame; to our team of interviewers (including Juliet Formby, Geraldine Barry, Ann Symons and Elizabeth White) and finally, to Jenny Stanley who typed the report. Special thanks are also needed to the 465 elderly people who agreed to be interviewed.

The study was funded by City and Hackney Health Authority.

INTRODUCTION

This study of the health and social service needs of people aged 65-84 living at home in City and Hackney was commissioned and funded by City and Hackney Health Authority.

The number and proportion of people aged 65 and over is increasing, and future projections indicate that this trend will continue into the 21st century. Although the proportion of the population aged between 65 and 75 is projected to decline slightly, the proportion of people aged 75 and over is expected to increase steadily by 28% up to 2001 (1).

These increases, together with changing philosophies of care and increasing financial constraints, have given prominence to the concept of 'community care' in the provision of health and social services. As the balance shifts towards a higher proportion of 'very elderly' people, there is likely to be a greater demand for resources to provide for their needs. Consequently health authorities have begun to develop a more comprehensive range of services to enable 'priority groups', such as the frail elderly, to live in the community. Also, because of the increase in the size of the elderly population, and the predicted rise in the future, there is emphasis on the problem of the identification of, and provision for, their health and social care needs.

A recent survey of the health and social service needs of people aged 85 and over living in City and East Hackney found higher than expected levels of informal help and support from family and friends, and lower than expected demands for community health and social services. A repeat of the survey was carried out with people aged 65-84, in order to facilitate planning for this group of people.

AIMS OF SURVEY

The aims of the study were to measure, among people aged 65-84:

1. Need for, and use of, health and social services
2. Functional disability
3. Life satisfaction
4. Psychiatric disturbance
5. Level of informal support from family and friends
6. The effects of supporting the elderly person upon their relatives 'mental and physical health' morale, social and economic circumstances. The findings relating to these will be presented in a separate report.

METHODS

The Family Practitioner Committee's records of general practitioners' patients aged 65-84, in the Autumn of 1988, were used as the sampling frame. It was known that this would be somewhat out of date but this was the best sampling frame available.

The interview schedule was based on that used in the survey of people aged 85 and over, using tested and validated measures of life satisfaction, mental state, social networks and functional disability, as well as individual pre- and open coded questions.

Ten interviewers were recruited locally and given one week's training. Most of them were unemployed graduates. Many of these left before the interviewing period was complete to take up permanent employment, and were replaced by new recruits.

SAMPLE SIZE

Population projections for 1988 from the London Research Centre were available for people aged 65-74 and 75-84. Estimates based on the last census indicated that we could expect to find 14504 people aged 65-74 and 8979 people aged 75-84 living at home in City and Hackney.

In contrast to this estimate the Family Practitioner Committee listed 17002 people aged 65-74 and 11037 people aged 75-84 living at home in City and Hackney - 4500 (16% more; or 15% for people aged 65-74 and 18% for people aged 75-84) more people than expected. The implication is that the FPC lists of people aged 65-84 are more accurate than the lists for people aged 85+ (the FPC lists recorded more than twice as many people as expected for the 85+ study).

Names and addresses were then checked on the electoral register in an attempt to eliminate people who have moved or died. Most elderly people who are eligible to vote are registered (Todd and Butcher, 1982; Cartwright and Smith, 1987). The problem is usually the reverse: people who have died or moved are still registered at their last addresses.

The electoral register did not list 43% of people aged 65-74, and 60% of people aged 75-84 who were on the original Family Practitioner Committee list.

The previous study of people aged 85+ was based on a total census, but numbers were smaller and therefore more manageable for interviewing. For the study of people aged 65-84 it was decided to aim for personal interviews with 500 people, as the total census of this age groups was considerably larger and therefore not possible for a interview survey. It was judged that 500 people would permit sufficient numbers in sub groups for separate analysis and would also permit analysis by age group (65-74 and 75-84).

It was aimed to sample elderly people proportional to their age distribution in the population. As it was expected that there would be more blanks (deaths and moves) among older people on the Family Practitioner Committee list, based on the experience of the 85+ study, the age group 75<84 was intentionally oversampled. The sampling fraction for the age group 65<74 was 1/23, which gave a sample of 753 people, and the sampling fraction for the age group 75<84 was 1/16, which gave a sample of 683 people. These names and addresses were then checked with the electoral register and 806 people remained in total. This 806 consisted of 401 people aged 65<74, and 405 people aged 75<84, 50%:50% instead of the expected 61%:39% distribution of these age groups which would have reflected the true population. As there were fewer blanks than expected among the older age group, this meant that the interviewed sample contained 45% of people aged 65<74 and 55% of people aged 75<84 instead of the expected 61%:39%. A separate report of results by age group is in production.

The addresses of people still on the register were allocated to interviewers who found the sample to be further inflated with those who had died or moved: 56 had moved and could not be traced, 9 had moved to an address outside the borough, and 9 had moved into institutions, 6 said they were aged over 84 or under 65, 29 had died and 6 addresses were old peoples homes. This left 691 people eligible for inclusion in the sample.

Of the 691 people finally eligible for inclusion in the sample, 67% were successfully interviewed, 19% refused to be interviewed (often commenting that they did not need anything), and 11% were never at home (or did not answer the door) when the interviewers called, despite four visits at different days/times. The other 3% were either too ill, frail or confused.

A list of those people who could not be traced, together with their last known address (from the FPC list), was sent to the London Electricity Board local area office who checked them against their records. They were then able to tell us whether any of these people remained as customers at the address given, or whether they had died or moved outside the borough.

STATISTICAL ANALYSIS

Most of the interviews were carried out from November to June, and all were completed by August 1989 (people who had been temporarily away were revisited during the summer).

The completed questionnaires were coded and entered onto the computer at St. Bartholomew's Hospital in September 1989. A magnetic tape of the data was obtained and the data transferred to a London University Computer Centre via St. Bartholomew's Hospital Medical College Computer Centre. Analyses were carried out using the Statistical Package for the Social Sciences (Xth version). These were completed by October 1989.

In the tables presented, the sample size will not always be the same due to non-response to, or non-applicability of, individual questions. Non-response to individual questions was, however, low.

Statistical tests of significance are not included in the tables in order to simplify the presentation. Where appropriate results have been compared with the findings of the previous study in Hackney of people aged 85+.

RESULTS

DEMOGRAPHIC DETAILS

Sixty per cent of the sample were female and 40% were male, in contrast 90% of the people aged 85+ were female and 10% were male.

Forty five per cent of the recent sample were aged between 65 and less than 75, and 55% were between 75, and less than 85.

Forty one per cent of the sample were widowed, 40% were married and 12% were single (6% were divorced or separated). Sixty two per cent of those who were widowed had been widowed for 10 years or more.

Most respondents, 91%, and most married female respondents' husbands, 95%, had left school with no educational qualifications. Just 25% of respondents, and 25% of married female respondents's husbands were in non-manual occupational groups (socio-economic groupings I-III non manual).

The majority of respondents were white Europeans (table 1)

TABLE 1: ETHNIC GROUPS OF RESPONDERS

<u>Ethnic Group</u>	<u>%</u>
White European	76
Jewish	16
Irish	3
Caribbean	2
Black British	1
Greek Cypriot	*
Asian	*
African	*
Other	2
<u>Number of respondents</u>	<u>456</u>

(* = LESS THAN 1%)

ACCOMMODATION

Over three quarters, 76% had been living in their present homes for 10 years of more (and most of these for over 20 years)

Table 2 shows that most lived in flats.

<u>TABLE 2. TYPE OF ACCOMMODATION</u>	%	*
Sheltered housing flatlet	9	
Other ground floor flat	24	
Other upper floor flat	52	
House	17	
Other (eg bedsit)	3	
<u>Number of respondents</u>	<u>456</u>	

(* Per cents do not equal 100 as respondents can be in more than one category.)

Most respondents were council tenants (65%), 12% were private tenants, 12% owned their own homes and 11% had other arrangements (eg lived with relatives). Most lived alone (Table 3):

<u>TABLE 3 HOUSEHOLD COMPOSITION</u>	%
Lives alone	47
Lives with spouse	34
Lives with other relatives	16
Lives with friends/lodger	3
<u>Number of respondents</u>	<u>458</u>

The vast majority of those living alone, 64% (168) wanted to remain living alone.

About two thirds (64%) said they liked living in the area, 24% disliked it and 12% were uncertain or had mixed feelings.

Over a third (39%) wanted to move home. Few of those wanting to move, wanted to move to a residential care or nursing home (2%), although 20% wanted to move into sheltered accommodation, and 20% wanted to live in a house; 44% wanted a flat somewhere else (eg near relatives).

Sixty five per cent said their homes were usually or always warm enough, a further 8% gave a qualified answer and added that the heating was too expensive; 2% (10) said their accommodation was too warm. A quarter said their homes were not warm enough (of these 19 people said their heating was too expensive; 54 said the heating was inadequate (eg no central heating); 6 commented on damp and draughts. Warmth was not a problem for the majority as heating and hot water were automatically supplied in their council accommodation.

Over half 59%, said they had anxieties or fears about intruders, going out or opening the door at home. Forty per cent said there were other things in their life that they thought were risky (eg falling).

Few respondents were on waiting lists for hospitals or residential care: 10%. Six people (1%) were waiting for residential care, 11 (2%) were waiting for an operation, one person was waiting for another type of acute hospital bed, 11 (2%) for sheltered housing, and 39 (8%) for other types of rehousing. No-one was waiting for a long stay geriatric bed.

FAMILY AND FRIENDSHIP NETWORKS

Research has found that dense (integrated) social networks, with strong ties, and narrow geographical spread, best meet the needs of elderly people, especially when facing life events such as bereavement (Walker et al, 1977).

Early work on the elderly in the East End of London, particularly in Bethnal Green, showed that old people's contacts with adult children were more common than stereotyped images of the isolated elderly suggested (Townsend, 1957; Marris, 1958; Young and Wilmott, 1957). Others have also shown that it is rare for the family not to care for its members who are old and ill (Isaacs, 1971; Cartwright et al, 1973; Finch and Groves, 1980; Bowling, 1984).

However, much of the work in the East End was carried out before new building developments, when people lived in houses rather than tower blocks or flats. There is little information about current family structures in this area, although common assumptions are that they have disintegrated. The existence of a close and supportive family structure has obvious implications of service provision, insofar as the bulk of caring is generally carried out by families where they exist.

A good measure of network size and type is the Social Network Scale (Hirsh, 1980; Stokes, 1985). This scale was used in the present study. This yields information on the number of people in the respondent's social network; the number of people respondents feel close to (confides in/could turn to for help in an emergency); the percentage of relatives in the network; the density of the network (relationships between network members).

Table 4 shows that all but nine respondents listed someone in the Social Network Scale as 'significant in their lives and with whom they had at least monthly contact'. The distributions were similar to those for people aged 85+.

TABLE 4 SOCIAL NETWORK SCALE: NUMBER OF SIGNIFICANT CONTACTS

	%
No one	2
One Person	7
Two people	15
Three People	19
Four People	20
Five People	14
Six People	11
Seven to Twenty People	12
<u>Number of respondents</u>	<u>465</u>

Of those with a network, 90% had network members who were relatives.

Table 5 shows the integration (density) of their networks: all but (10%) of respondents (41) said some or all of the people significant in their own lives, and with whom they were in at least monthly contact, were also significant in each others lives, and had at least monthly contact.

Table 5. Integration (density). Per cent of people significant to the elderly person and significant to other network members.

	%
100% (everyone in the network knows each other	53
50<100% (half to all the people in the network know each other	20
1<50 (1% to 50% of the people in the network know each other)	17
0 (no-one in the network knows anyone else in the network)	10
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Number of respondents	425*

(* base= those with a network of 2 or more people).

The implication is that all but nine respondents had significant people in their lives, most of these had relatives in their network and 53% had completely (100%) integrated networks (see table 5).

The Social Network Scale asked respondents to indicate people who they felt could confide in and turn to for help in an emergency (confidantes). Of those with an identified network, all but 24 people felt they could turn to at least one person: 31% identified one person; 22% two people, 18% three people, 12% four people, and 17% five or more people. These figures were almost identical to those identified in the 85+ study.

The Scale also asked which person gave them the most help and support, again 95% identified someone: 72% mentioned a relative, 18% a friend or neighbour and 10% mentioned a friend/neighbour and relative equally. This confirmed the significant role played by relatives in their lives.

Three additional questions were asked in order to more fully assess the quality of their social networks. These, and responses to them, are shown in table 6. They indicate the extremely supportive, high quality nature of social networks among these elderly people. Again these figures are almost identical to those identified in the 85+ study.

TABLE 6 MEASURES OF THE QUALITY OF SOCIAL SUPPORT

A. "IF YOU NEEDED THE HELP OF A RELATIVE OR FRIEND DO YOU KNOW THERE IS ONE WHO WOULD HELP?"

94% SAID "YES"

B. "DO YOU HAVE AT LEAST ONE FRIEND OR RELATIVE WHO UNDERSTANDS YOU?"

94% SAID "YES"

C. "DO YOU HAVE AT LEAST ONE FRIEND OR RELATIVE WHO SHOWS THEY CARE ABOUT YOU?"

97% SAID "YES".

(Number of respondents varied from 460-463)

When asked who would they call on for immediate help 25% said their son or daughter, 12% said another relative, 13% a friend, 16% a professional, and the remainder mentioned combinations of these.

In a further attempt to assess respondents' levels of satisfaction with their relationships they were asked a series of indepth probes about their level of satisfaction with the quality of their supportive relationships and the quality of their friendships. Interviewers were then asked to sum up by marking a visual analogue scale, with a range of 1-6 (very to not very satisfied) to indicate the respondents feelings.

Most respondents with relatives indicated to interviewers that they were very satisfied with the quality of their supportive relationships with relatives (64%: '1'), a further 20% were given a '2' rating, 9% were rated '3' and 7% between '4' and '6'.

Half of the respondents who had friends indicated to interviewers that they were very satisfied with the quality of their friendships (50% were rated by interviewers as '1'), a further 27% were given a '2' rating, 12% were given a '3' rating and 11% were given a rating between '4' and '6'.

Respondents were asked in depth about what happened last time they needed immediate help, 44% could not recall needing this, 32% referred to an illness, 12% to an accident or fall, 6% to a burglary, 3% to a practical domestic problem, 2% to a "mugging", and the remaining 1% to other emergencies.

The main helpers called were professionals (45%), relatives (32%), neighbours (20%), and then friends or bystanders (3%).

Twenty five per cent of respondents had no live children, 30% had one child, 23% had two, 12% had three and 10% had four or more.

About three quarters, 65% spoke (face to face) to a relative, friend or neighbour daily, 22% spoke less than daily but more than weekly, 7% spoke at least weekly and 6% spoke to someone less often. No one said they never spoke to anyone. Most, 90%, had their own telephone, and 87% spoke at least weekly to a relative, friend or neighbour on the telephone. In the 85+ study, 81% of respondents had their own telephone.

Nearly two thirds, 64%, said they 'never' or 'rarely' felt lonely 23% said they 'sometimes' felt lonely, 11% 'often' felt lonely and 2% said they were lonely 'most of the time'. In contrast in the study of people aged 85+, more respondents (23%) said they felt lonely often or most of the time. Also an earlier survey of applicants for residential care in City and Hackney (Bowling and Salvage, 1984) found that 40% said loneliness was a severe problem. This was also one of the main reasons given for the application. The implication is that the applicants for care feel more lonely.

Seventy five per cent said they saw "enough" of their children, and 25% said they saw "too little" of them. Sixty five per cent said they saw "enough" of their other relatives, 35% saw "too little" of them and 1 person said they saw "too much" of them. Eighty three per cent said they saw "enough" of their friends, and 17% said they saw too little.

A main carer (non-professional), who provided help with tasks of daily living at least weekly, was identified by 120 respondents. A further 40 respondents identified a carer who provided less frequent help.

Less than a quarter of the 120 (23%, 28 respondents) gave permission for the carers to be contacted for interview. These interviews are described in a separate report.

The level of reported informal support is comparable to that identified in the study of people aged 85+, and found by Townsend (1963) and Young and Wilmott (1957) in their studies of family networks in Bethnal Green around thirty years ago. Although kinship networks may be increasingly dispersed with population mobility and new building developments in the East End, kinship is still an important force in people's lives and overwhelmingly the main source of help and support.

Table 7 Shows their level of activity.

Table 7: Frequency of activity

	Never/ rarely	Occasionally/ sometimes	Regularly/ often
	%	%	%
Watch TV/ Listen to radio	3	9	88
Reading	21	18	61
Crafts	67	13	20
Games	75	12	13
Walking	30	21	49
Shopping	16	13	71
Visiting friends/family	30	37	33
Other (church/pubs)	55	11	34
Nothing-just sit	48	40	12
Nothing-just sleep	56	30	14

No of respondents = 455 -465

Twenty six per cent attended a club for older people, 8% attended a day centre, 5% attended a lunch club, and 61% went to other recreational clubs.

HEALTH, FUNCTIONAL ABILITY AND CONTACT WITH SERVICES

REPORTED SYMPTOMS AND HEALTH PROBLEMS

Just over a third of respondents, 37% had experienced a major illness/operation/accident or fall in the previous 12 months.

People were asked about whether they currently suffered from a number of symptoms, and whether they had reported these to their GPs.

The most common problems were aches/pains/stiffness in muscles and joints, 62% reported this; followed by trouble with feet, 38%; and sleeplessness, 34%.

About a quarter reported problems with sight (25%), nerves (26%), bronchitis (23%) and high blood pressure. Other problems included hearing (19%), incontinence (17%) and forgetfulness (15%).

CONTACT WITH GP

Where respondents stated they had a health problem, they were asked whether or not they had seen their GP for the problem; between 62 and 98% of those reporting physical health problems had consulted their GPs over them. Far fewer of those with more psychosomatic problems had consulted their GPs over these: 62% had consulted over sleeplessness; a third had consulted over nerves/stress/depression; 59% over a loss of appetite; a third over confusion and about a quarter over forgetfulness (table 8). Seventy three per cent of the sample were taking prescribed medication; the average number of the types taken was 2.32.

TABLE 8 HEALTH PROBLEMS AND CONSULTATION PATTERNS

<u>Health Problem</u>	<u>% with problem</u>	<u>(n)</u>	<u>Of those with problem, % consulting GP</u>
Poor eyesight (even with glasses on)	25	(116)	84
Poor hearing (even with aid in)	19	(89)	70
Problems with feet	38	(174)	81
Nerves/Stress/ depression	26	(121)	62
Forgetfulness	15	(68)	24
Confusion	6	(29)	33
Bronchitis	23	(106)	93
High blood pressure	26	(121)	98
Stroke	6	(29)	91
Incontinence (urine)	17	(79)	73
Constipation	11	(51)	76
Alternatively constipated/ loose	4	(19)	73
Blood/tar motions	2	(10)	62
Piles	5	(23)	69
Indigestion/heartburn	13	(61)	70
Abdominal pain/discomfort	12	(57)	87
Vomiting blood	2	(8)	64
Aches/pains/stiffness in muscles/joints	62	(289)	78
Sleeplessness	34	(159)	61
Appetite loss	12	(57)	59
Headaches	18	(82)	73
Heart trouble/chest pains	24	(109)	91
Giddyness	31	(145)	77
Diabetes	9	(41)	100

No of respondents =

460 - 465

Most respondents had seen their GPs within the last 12 months. The proportion consulting within the last month approximately reflects the figure from General Household Survey (OPCS, 1984). These figures are similar to those in the 85+ study.

Table 9. Contact with General Practitioners

LAST SAW GP:	%
WITHIN LAST 7 DAYS	12
7 DAYS < 1 MONTH	25
1 MONTH < 3 MONTHS	24
3 MONTHS +	38
<u>Number of respondents</u>	<u>435</u>

FUNCTIONAL DISABILITY

A modified activities of daily living scale was used to measure functional disability (Katz et al, 1963; Townsend, 1979; Bowling and Salvage, 1984).

This scale lists 23 tasks of daily living (domestic, personal care and mobility tasks) and asks respondents to rank themselves across a range of categories from no difficulty to cannot do at all.

Most respondents had no difficulties at all with personal care tasks (getting in/out of bed, using WC, washing themselves (including their hair), dressing, brushing/combing their hair, managing their teeth/dentures, cooking and eating/cutting up food (between 73% and 95% of respondents had no problem with these).

The tasks respondents were most likely to have some difficulty with were odd jobs (65%), climbing stairs (52%), cutting toe nails (47%), getting in/out of the bath (40%), heavy household chores such as housework (38%), laundry (35%), shopping (37%), and using public transport (35%). However, these figures reflect a wide range of severity from 'slight difficulty' to 'unable to do at all'.

TABLE 10 ABILITY TO PERFORM ACTIVITIES OF DAILY LIVING

Activity of daily living	On own without difficulty	On own with difficulty:			Only with help	Unable to do
		slight	moderate	severe		
Get in/out bed	84	8	5	3	*	*
Rise from chair/ wheelchair	77	13	7	2	*	1
Climb steps/stairs	48	15	16	8	5	8
Use toilet/commode	91	5	3	1	*	*
Wash Self	88	4	4	2	1	1
Bath self	73	5	6	4	4	8
Get in/out of bath	60	7	9	8	6	10
Dress self	87	6	3	2	1	1
Brush/comb hair	96	2	1	-	-	1
Wash hair	83	3	4	2	3	5
Cut toe nails	53	9	8	4	8	18
Manage teeth/dentures	96	2	1	*	-	1
Eat/cut up food	94	2	1	1	1	1
Housework	62	7	9	4	9	9
Laundry (sheets etc)	65	5	7	3	8	12
Shopping	63	6	5	3	9	14
Handle pension/money	78	3	4	1	4	10
Get about indoors	83	7	6	2	1	1
Get about outdoors	68	9	7	4	4	8
Use public transport	65	7	5	4	4	15
Odd jobs	45	7	8	5	12	25
Filling in forms/writing	76	9	4	3	4	4

No. of respondents = 457-464

(* = < 1%)

Table 10 shows respondents difficulty with household tasks. All but 4 people had at least some difficulty with a least one task.

At the other extreme, 60% had severe difficulties with or could not do one or more tasks. Table 11 shows the number of tasks respondents had at least severe difficulty with.

Table 11: Number of personal, domestic and mobility tasks respondents had severe difficulty with - cannot do at all.

	% of respondents
Does not have severe or more difficulty with any tasks	40
Has severe or more difficulty with:-	
1 task only	15
2-3 tasks	15
4-8 tasks	1
9-23 tasks	14
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Number of respondents	464
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As would be expected table 12 shows that the younger age groups were less likely to be unable to do tasks of daily living.

TABLE 12. EXAMPLES OF TASKS RESPONDENTS TO EACH STUDY WERE UNABLE TO DO AT ALL

	% of 65-84 sample	% of 85+ sample
Odd jobs around the home	25	61
Use of public transport	15	57
Cut toe nails	18	53
Shopping	14	53
Laundry	12	46
Get in/out of bath	11	38
Housework	9	36
Get about outdoors	9	31
Bath self	8	26
Fill in forms etc	5	26
Handle pension/money	10	26
Climb steps/stairs	8	24
Wash hair	5	23
Cooking	6	19
<u>Number of respondents</u>	<u>458-464</u>	<u>625</u>

The vast majority of people with difficulty with household tasks had help with these (between 74% and 90%). This is similar to the proportion having help in the 85+ study sample. However less than 40% of those with difficulties with personal care tasks had help, except for with washing their hair (76%), cutting their toe nails (68%), and eating/cutting up their food (57%). Less than half those with mobility problems received help: 29% of those with a difficulty had help with getting around indoors, 35% had help with using public transport, and 41% had help with getting around outdoors.

Relatives were the main helpers except with bathing and cutting toe nails and housework, where professionals provided most help (professionals provided this care in 58% to 77% of cases). The proportions were similar to the findings of the 85+ study. The most common item which people mentioned would make it easier for

them to maintain their independence at home were adaptations to their homes (34%), followed by someone to do odd jobs (12%), and home helps (5%).

SERVICE DEMANDS

Table 13 shows that the largest category of help wanted was with odd jobs. In contrast the 85+ study reported cutting toe nails as the task people were most likely to want help with.

Table 13. Most frequently listed tasks respondents wanted help/more help with.

	% with some difficulty/ cannot do	% of these who want help/ more help
Cutting toe nails	47	23
Odd jobs around the home	55	27
Bathing or getting in/out of bath	40	24
<u>Number of respondents</u>	<u>458-464</u>	<u>22-234</u>

Interviewers identified 40% respondents as in need of help, mainly with provision of an emergency alarm, an adaptation to their home, or for chiropody services.

Opticians (39%) and hospital doctors (32%) were the professionals respondents were most likely to be in contact with, however most of these contacts were less often than monthly. Chiropodists were the next group of professional respondents were most likely to be in contact with (28%), although this was a fairly infrequent service; followed by dentists (23%), although infrequently; and home helps (22%), 96% of whom visited at least weekly. In contrast the 85+ study reported that 54% of respondents had a home help.

Few received other services (eg. social worker, bathing service-other than nursing service, carer relief schemes, incontinence laundry, physiotherapy, occupational therapy, health visitor, voluntary visitor).

Table 14 compares service receipt in Hackney with the findings of an identical study in Braintree, Essex.

Table 14 RECEIPT OF PROFESSIONAL SERVICES - RESPONDENTS COMPARED TO BRAINTREE RESPONDENTS.

<u>Service</u>	<u>% of Hackney respondents in receipt of services</u>	<u>% of Braintree respondents in receipt of services</u>
Health Visitor	4	2
District Nurse	8	3
Carer Relief Scheme	1	2
Social Worker	7	3
Occupational Therapist	3	1
Physiotherapist	5	2
Optician	59	63
Dentist	22	30
Meals on Wheels	8	3
Home Help	22	30
Chiropodist	28	21
Incontinence Laundry	2	1
Hospital Doctor	32	18
Other (eg. voluntary visitor)	6	4
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No of respondents =	463 - 464	288

Ninety per cent of respondents said there were no problems with the services they received.

Few wanted the professional services asked about (with the exceptions of chiropody: 7% wanted help with this); between 1% and 5% wanted the other professional services asked about (home help, social worker, health visitor, bathing service).

This is probably explained by the high level of social and practical support they received from relatives as well as the fact that these are the younger elderly. Again, the implication

for services is that their demands, if met, are of manageable proportions. The comments from those refusing to be interviewed that they did not need any help, implies that there were similarities between responders and non-responders to the study.

When asked an open question about what improvements they would like to see to services, 8% said more funding or better staffing or greater frequency of services, 1% said different times available, 1% said better qualified staff, 87% said they could think of no improvements, while the remainder made a variety of other comments.

When asked what made it difficult to ask for help, 66% of respondents said they did not want help and, of the remaining 34%, 55% said the services were shortstaffed or inadequate, 5% were afraid of being a burden, 2% were afraid of losing their independence, and the remainder gave a variety of other replies.

INCONTINENCE OF URINE

The 79 respondents who reported problems with urinary incontinence were asked about the restrictions this imposed on their lives. Thirteen per cent (10 people) said it stopped them going out, but only 1 person said it stopped them having visitors. Nine people said they had to get up in the night because of their problem, 3 avoided long journeys, and others spoke of embarrassment, depression, problems of pad disposal and a reluctance to stay with relatives.

Of the 60 who consulted their GPs with the problem, 28% were referred to hospital, 30% received a prescription only, 10% were referred to a district nurse, 12% mentioned other actions, and 20% said their GP had taken no action.

Of the 19 who had not consulted, 7 felt their doctors could not help, five were uncertain, and two felt their doctors could help (5 people did not respond). Three people had spoken to either a relative or a friend about their problem.

PROBLEMS WITH EYESIGHT

The 116 with eyesight problems (even with glasses) were also asked about restrictions on their lives. The 97 who had consulted their GP were asked what their GP had done. Sixty one per cent were referred to hospital, and 13% to an optician, 3% were given a prescription only, 1% mentioned other actions, and 22% said no action was taken. Of the 19 who had not consulted their doctors, 5 felt their doctors could not help, 7 were uncertain, and 4 felt they could help (3 did not respond).

PROBLEMS HEARING

Of the 89 with problems hearing (even with an aid), 63 had seen their GPs about this. Of these, 30% had been referred to hospital,

16% to an audiologist, 11% were given a prescription only, 16% mentioned other actions, and 27% reported no action taken. Of the 26 who had not consulted their doctor, 35% felt their doctors could not help them, 23% were uncertain, and 8% felt they could help (9 people did not respond).

PROBLEMS WITH FEET

Of the 174 with problems with their feet, 143 had seen their GPs about this. Of these, 43% were referred to a chiropodist, 20% were referred to hospital, 8% were given a prescription only, 6% mentioned other actions, 23% reported no action taken. Of the 31 not consulting, 15 felt their doctors could not help, 4 were uncertain and 12 felt they could help.

Respondents were also asked if they would like their doctor or a nurse to give them an annual health check up. Twenty three per cent said "yes" by a GP, 2% said "yes" by a nurse, 15% said "yes" by either, 37% said "no", 17% were uncertain, and 6% said they already had a regular check up.

LIFE SATISFACTION

Life satisfaction and well-being are useful concepts in the assessment of mental health (Gurin et al, 1960; Bradburn, 1969).

There are four major scales or global items measuring these concepts, which are suitable for use with elderly people (Neugarten et al, 1961; Lawton, 1975; Bradburn and Caplovitz, 1965; Bradburn 1969; Campbell et al, 1976).

The Neugarten Life Satisfaction Scale A was used to assess life satisfaction and morale in the current study. This is a well tested scale, suitable for use with the elderly (Neugarten et al, 1961; Wood et al, 1969; Wylie, 1970; Loumann, 1977; Larson, 1978; Stull, 1985; George and Bearon, 1980).

The Scale consists of 20 items containing positive and negative statement about past and present life circumstances. The items are written on cards which the respondents have to sort into 'agree' and 'disagree' piles. Each positive view of life is scored 1, so each respondent can score between 0 and 20. The average score for a general sample of the population is 14, but some studies have reported an average of 17 (George and Bearon, 1980). The implication of the scoring method is that the higher the score, the higher the degree of life satisfaction and morale.

The average score among respondents in the current study was 12.56, compared to 13.37 for respondents to the 85+ study.

More than a third (42%) of respondents in the present study scored over this average of 13, 37% scored between 10-12, and 21% scored below this.

Analysis of individual items revealed that most people satisfied with their past lives and achievement, but half felt that the present was the 'dreariest time of their lives'.








In contrast to the 85+ study respondents, about half made plans for the future, and less than a third said their lives could be "happier". As with the 85+ study, just over half agreed that, 'As I grow older, things seem better than I thought they would be'.

The delighted-terrible faces scale was used as a more precise measure of life satisfaction of with specific aspects of daily life. This has been shown to have good reliability and validity (Andrews and Whithey, 1977).

Respondents were shown seven faces, depicting a range of happy, neutral and unhappy faces. They were asked to pick a face to represent how they felt about their: life as a whole; accommodation; activities; independence; and loneliness.

TABLE 15 DELIGHTED TERRIBLE TERRIBLE FACES LIFE SATISFACTION SCALE

Percentage of respondents selecting face to represent feelings:-

	A 	B 	C 	D 	E 	F 	G 
	%	%	%	%	%	%	%
Life as a whole	12	31	37	11	5	1	3
Accommodation	14	28	29	15	6	2	6
Activities	11	30	37	12	5	2	3
Independence	18	28	33	11	6	2	2
Loneliness	16	29	26	15	8	3	3

No of respondents 433 - 437

As table 15 shows, between 71% and 79% of respondents, at each question, chose one of the three delighted faces to represent their feelings, and between 11% and 15% chose the neutral face. The remainder, 9%-14%, chose terrible faces. This indicates that they had slightly more positive views of their lives than the 85+ sample.

GENERAL HEALTH QUESTIONNAIRE

The short version of the General Health Questionnaires (GHQ) was used to measure mental disturbance. This was designed and tested by Goldberg (1967; 1972; 1978) to detect psychiatric disorders among people in community settings (excluding dementia, subnormality and mania). It concentrates on the detection of depression and anxiety. The probability of an individual being a case occurs when the individual's score is over the threshold of 4-5. While not perfect, it correlates well with psychiatric diagnoses of disturbance, and the depression items correlate well with independent psychiatric diagnoses of depression. It is relatively short and easy to administer in comparison with other measures. The latter is inevitably a major consideration in a survey of a population of frail elderly people.

Table 16 shows that just over a quarter achieved a score over the threshold, and are probably psychiatrically disturbed.

Table 16 General Health Questionnaire Score By Age Group

Score:	65-84 Years %	85+ Years %
0-3	72	62
4-5 THRESHOLD	10	11
6-9	10	13
10-16	6	11
17-28	2	3
Number of respondents	434	587

(Mean score: 65-84 years olds 2.8; 85+ year olds 4.3).

The proportion of men and women in their sixties with scores over 12 has been found in previous research to be 9%, which is comparable to the proportion found in the current study. However previous research has also reported that these figures more than treble for those who are widowed, divorced or separated, and increase slightly for those leaving school at younger ages (see Goldberg, 1978).

The proportion of respondents aged 65-84 scoring over the threshold was 18%, in comparison, the proportion of respondents aged 85+ scoring over the threshold was 27%; also another recent survey of a sample of the total population in City and Hackney found 33% to score over the threshold (also using the short version of the GHQ) (Kathy Elliot, personal communication). A similar figure was reported from the health and lifestyle survey of over 9,000 British adults (using the short 30 item GHQ). The latter survey also found the gap between the sexes (females having higher GHQ scores than males) declined with age (Cox et al, 1987), although ages were not broken down into groups beyond 75+. This supports the earlier work cited above suggesting that scores for females decline with age.

When asked how they would ideally like to spend their time now, 44% replied "just as I am", 12% said "on holiday", "travelling", or "six months abroad", 11% said "out and about more", 6% said "in the countryside", or "by the sea", 5% said "in better health", 4% said "nearer their family" and the remainder gave a variety of other reasons.

Respondents were also asked whether they expected eventually to move into a residential or nursing home or hospital ward for older people, or whether they expected to remain at home. Eight per cent said they expected to remain at home, 12% said they were

uncertain, 3% expected to move into an institution and a further 4% said they expected to move into sheltered accomodation.

'RISK GROUPS'

Attention has been focused in much of the primary care literature on the elderly 'at risk' of neglected needs for care (Taylor and Ford, 1983; Taylor, 1986). Table 17 shows the proportion of respondents in the present sampling falling into previously identified 'risk' groups, compared with the respondents to the 85+ study.

TABLE 17. COMPARISON OF RISK GROUPS IN EACH AGE GROUP

	65-74 yrs	75-84 yrs	85+ yrs
In the past 12 months experienced:			
Major illness/accident/fall/operation	34	40	36
Death of someone close	16	20	25
Widowed	8	2	3
Moved home	1	1	2
Not seen GP	18	15	14
Difficulty seeing	16	32	52
Difficulty hearing	20	20	40
Childless	21	28	29
Currently unmarried and childless	17	22	16
Lonely often/most/all the time	11	15	23
Severe difficulty with or cannot do:			
Cook/prepare food	7	14	28
Housework	14	30	61
Get outdoors	9	21	51
Self reported nerves/stress/depression	28	24	33
GHQ score over the threshold	13	22	27
Below average life satisfaction score	56	59	67
Low life satisfaction score	27	28	32
Lives alone	36	55	61
Wants to move home	50	31	27
Has no friend/relative/neighbour to rely on for help	6	5	7

(Proportion of respondents varied from 456 to 662).

SUMMARY OF MAIN FINDINGS

The main findings of this survey were:

FUNCTIONAL ABILITY

1) The tasks of daily living respondents were most likely to be unable to do were: odd jobs around the home, cutting toe nails, use of public transport, shopping, laundry, get in/out of the bath, handle money, housework and get about out-doors. Between 9% and 25% were unable to do one of these things, in contrast with respondents to the 85+ study.

LIFE SATISFACTION AND PSYCHIATRIC DISTURBANCE

ii) Most respondents expressed satisfaction with their past lives as a whole and about half had made plans for the future, although half felt the present was 'dreary'.

iii) About a fifth (18%) had high GHQ score, indicating psychiatric disturbance (usually anxiety/depression).

DEMANDS FOR SERVICES

iv) Respondents had a high level of informal help (from relatives) and social support. They appeared anxious to retain independence from professional care givers ie only 22% had regular visits from a home help, in contrast to the 54% of people aged 85+ who had a home help.

v) The demands for services likely to be made by people aged 65-85+ in City and Hackney in the near future appeared to be of manageable proportions. However, given that their service use was much smaller than that of people aged 85+, their demand for care will increase in the long term. However the 85+ study indicated that this demand was still of manageable proportions.

vi) The greatest demand was for help with odd jobs (27%). Examples given by respondents included decorating and window cleaning.

vii) As with the study of people aged 85 and over, other services for which this study has implications are chiropody and bathing services (23% and 24%).

HOUSING

viii) Although more than a third of respondents wanted to move home, very few (2%) wanted to move into residential or hospital care (only 1% were on a waiting list for long stay care). About a quarter of those wanting to move wanted to live in sheltered housing and the remainder wanted different types of accommodation or to move nearer relatives. This is not surprising as over half said they had anxieties or fears about intruders, going out or

opening the door at home. Despite these fears, about two thirds liked living in the area. These were identical proportions as those reported for people aged 85 and over. This has policy implications in terms of creating safer environments on the large council estates in which most respondents lived.

CONCLUDING STATEMENT

People aged 65-84 are fitter than people aged 85+ and those applying for residential care places. They have a similar (high) level of social support, but were less lonely than people aged 85+. Undoubtedly they will have greater need for professional care when older, but currently they are not a group with infinite needs which are likely to be expressed as demands for care.

This report comprises only some of the main findings from the study, further analysis will be written up separately in the form of papers for publication. Anyone who would like to be included on the mailing list for copies of these should send their name and address to the authors.

Further reports will shortly be available:

- 1) "The carers of people aged 65-84 living in Hackney".
- 2) "The health and social service needs of elderly people living in Hackney analyses by age groups".

Anyone who would like a copy please send their name and address to the author.

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