

Health and functional ability

There are few epidemiological studies of the health status of the elderly in representative population samples, and interpretation of the data is rendered difficult by inconsistency in diagnostic methods and reporting and difficulty in distinguishing between the manifestations of normal aging and pathological conditions.

Two major approaches are used in the estimation of health needs. The medical approach is based primarily on the International Classification of Diseases, and diagnostic procedures are selected and developed for that purpose. This approach is often criticized for overspecialization and insensitivity to the psychosocial dimensions of health and disease. Another approach is based on the assessment of functional abilities in order to discover what limits a person's capacity to cope with the activities and stresses of everyday life (13,14). Subjective assessment of functional ability is regarded as a valuable indicator both of health and of the need for services, and this can be complemented by objective measurement of functional ability. The diagnostic procedures for the medical approach are rich and well advanced, whereas fewer tools are available for the assessment of functional abilities.

Nearly 10 diseases per person were found in a population averaging the age of 75 in the Federal Republic of Germany (32). Among young people 10–15% already have some pathological condition, but among people aged 70–80 only 2% were found to be healthy. Multiple morbidity is characteristic of the elderly: three or more chronic diseases are found in more than 50% of people aged 60 years and over, even among those regularly seen by their physician (33). In most studies the general level of health of women appears to be worse than that of men (4) but data to the contrary have also been reported; in a Gothenburg study women at the age of 70 had better health and needed less medical support than men (34), but the author assumed that sex differences in health status disappear after the age of 80. On the other hand, in surveys of subjective evaluations of health approximately one third of people aged 65 and over reported feeling themselves to be quite healthy (10,35). Old people may change their standards in relation to health and accept some symptoms as belonging to normal aging; moreover, symptoms in the elderly are often not as clear as among younger people, and manifestations of aging may also be interpreted by physicians as signs of disease if they do not use strict criteria. In a large epidemiological study in Gothenburg it was observed among persons aged 70 years that less than 50% of those

treated with digitalis showed evidence of a cardiac disease that could be assumed to benefit from such a treatment (36). Hypertension and diabetes are other well known diseases for which clear diagnostic criteria do not yet exist for every age bracket; large variations in their prevalence are observed between different studies.

Interview studies give information about people's awareness of their diseases and their health status. For some diseases the prevalence rate as observed in interview studies is higher and for others lower than that observed by careful clinical examination (37,38). People's knowledge about their health status is influenced by several factors, but usually only those diseases which physicians have told the elderly about are mentioned.

The ability to cope with daily living is determined not only by the presence and severity of disease but also by the biological, psychological, and social correlates of aging and by characteristics of the environment, including the services available. The biological processes of aging start to become manifest in several organs roughly at the age of 75, and beyond that age there seems to be a rapid decline in a number of functions, particularly among women (4). The mental condition and social status of old people greatly influence their capacity to live an independent life when somatic aging processes produce increasing handicap. Sufficient data on physical handicap in the various age groups of the elderly are not available. In Gothenburg about 3% of those aged 70 years needed institutional care (34). Impairment of mobility increases rapidly after the age of 75, and only 30% of persons over the age of 70 were found to be free of such impairment (17).

Functional ability is often measured by various indices pertaining to the activities of daily life (10,15,39). Most of the activities measured have been simple tasks connected with mobility, working, dressing, etc. In an international comparative study carried out in Denmark, Israel, Poland, the United Kingdom, and the United States (40), 61-71% of persons aged 65 and 69 years and 27-45% of persons aged 80 and over could perform all the tasks assessed. There have been a few attempts to enlarge the tests to include activities outside the basic daily tasks (16), but no larger studies using this approach have so far been published.

It may be assumed that each country has its own individual pattern of disease, the distribution of which between the sexes and the people living in urban and rural areas depends on its economic development, cultural patterns, mode of life, and climatic and geographical situation. In developed countries the disease picture is different from that of developing countries (41).

The aim of the present survey was to describe developmental trends in health and functional ability from the youngest group of the elderly (60-64 years) to the oldest (85-89 years). Differences between the sexes were also analysed. The data were analysed on the basis of four main aspects of health and functional ability:

(a) present health status and past injuries, accidents and chronic diseases affecting the activities of daily living;

(b) prevalence of various signs and symptoms during the preceding two weeks;

(c) prevalence of physical impairments;

(d) capacity for self-care and functional status.

The results are given on non-institutionalized persons only.

Present Health Status and Past Injuries, Accidents and Chronic Diseases Affecting the Activities of Daily Living

The overall rates for those interviewed who did not feel themselves to be healthy were higher for females than for males, but no major differences between the age groups were noticed (Table 18). The interregional variation on the other hand was quite large; the percentages ranged from 17% (Upper Normandy, men) to 86% (Bucharest, women) in the youngest age group and from 14% (Upper Normandy, men) to 94% (Kiev, women) in the oldest age group.

The subjects were also asked to evaluate their present health status in one of five levels ranging from very good to bad. The percentages of those evaluating their health as bad or fairly bad increases from the youngest to the oldest age group (Table 19). Both sexes evaluated their present health almost equally as average. The percentages of those who evaluated their health as very good were on average about 15% among men and about 10% among women, the percentages being slightly lower in the older age groups (Fig. 1).

When the subjects were asked to compare their health with that of other persons they knew of their own age, women more often than men felt their health to be worse than that of the other persons (Table 20). Among those who evaluated their health as about the same as the health of others, however, no sex difference was noticed.

On average about 60% of persons aged 60–64 years and about 70% of those aged 85–89 years reported having had previous accidents, injuries, or chronic diseases that affected their daily activities (Table 21). The figures for Kuwait were distinctly lower than for other study areas. In general, men reported less frequently than women health conditions affecting their daily living. An interesting point is that the percentages of reports of conditions affecting daily life were much higher than the percentages of persons who evaluated their health as bad or fairly bad.

The leading diseases will be described in detail in specific reports about health status at a later stage of the study. The range of diseases affecting daily living showed a large variation between the study areas, and rather different trends with age were observed. The prevalence of hypertension reported, for example, ranged from about 5% (Leuven, Kuwait) to about 30% (Belgrade, Bialystok) in the youngest age group and from about 1–3% (Berlin (West), Zagreb) to about 50–60% (rural Greece, Bucharest) in the oldest age group (Fig. 2). Similar large differences appeared also in the

prevalence of ischaemic heart disease, in which the variation ranged from about 2–5% (Kuwait, Leuven, rural Greece) to 40–60% (Bucharest, Brussels). In some study areas the prevalence decreased with age, in others increasing trends were recorded.

Prevalence of Various Signs and Symptoms During the Preceding Two Weeks

Multiple morbidity among the elderly is associated with a high prevalence of various signs and symptoms, of which a considerable part are diffuse in nature and cannot be connected clearly with any disease old persons are known to have. Altogether, 24 signs and symptoms were asked about. Table 22 shows the prevalence of the signs and symptoms during the preceding 2 weeks: about 50–90% of the persons interviewed in all the study areas had some of them often or nearly continuously. In general, somewhat higher rates for females than males were reported, and there was a slight increase in the prevalence of symptoms as between the youngest and the oldest age group.

When 17 of the symptoms were grouped together as an indication of psychosomatic complaints the same observation was made; women, particularly in the youngest age group, had more symptoms than men and the rates were high with the exception of the Kuwait area, in which the reported prevalences were 44% or less in all age groups (Table 23).

The prevalence of physical complaints (e.g. constipation or problems in passing urine) was in general lower than that of symptoms in which a psychological factor might play a decisive role (Table 24). Again the prevalence was higher among women than among men and in the older age groups. Interestingly large variations were recorded between the study populations in the responses, which can be assumed to reflect either biological aging processes and somatic diseases or differences in reporting.

The leading symptoms were aching or pain in the joints, back trouble, tiredness, feeling of faintness, and nervous tension or nervousness. The percentages of persons who complained of aching or pain in the joints or back trouble ranged from about 10% to over 70%. The rates were again higher for women, but no marked increase occurred in the prevalence of the signs and symptoms in the older age groups (Table 25).

Women more often than men also reported tiredness or a feeling of faintness (Table 26), and a clear increase in the prevalence of this symptom was observed in the older age groups. Exceptionally low rates were reported from the Kuwaiti population. The prevalence of nervous tension and nervousness varied between 5% and 40% (except in Kuwait in which the percentages were below 5%), women reporting higher rates than men. The prevalence was lower among the older age groups in most study populations. Headache was also a relatively common symptom, the prevalence ranging from 4% (Kuwait, men) to 57% (Low Ombrone, women). No marked differences were noticed between the age groups in the occurrence of headache. Symptoms that showed increasing trends from the youngest to the oldest age groups were impaired memory, lack of appetite, difficulty in

Table 18. Percentages of people not feeling healthy^a

	Age group (years)											
	Men					Women						
	60-64	65-69	70-74	75-79	80-84	85-89	60-64	65-69	70-74	75-79	80-84	85-89
Brussels	55	41	33	65	63	20	59	54	48	55	60	45
Leuven	21	19	22	23	19	16	26	19	35	21	17	17
Berlin (West)	47	44	46	55	56	57	48	50	64	66	67	66
Tampere	70	79	68	59	70	65	66	76	65	71	77	61
Midi-Pyrénées	31	27	29	33	27	29	30	36	36	39	41	37
Upper Normandy	17	33	25	29	43	14	29	40	41	44	41	57
Rural Greece	42	46	56	64	69	83	55	68	81	73	76	81
Florence	13	24	31	18	17	20	37	38	32	34	39	36
Low Ombrone	41	29	33	41	33	47	56	49	54	51	59	51
West Amiata	28	33	24	33	34	31	39	28	44	47	32	28
Kuwait	24	29	24	38	45	65	37	46	53	44	52	43
Bialystok	55	72	77	77	86	—	69	73	78	81	89	—
Bucharest	67	65	74	90	81	89	86	86	91	88	89	90
Kiev	72	75	82	81	79	88	83	84	90	89	91	94
Belgrade	35	42	42	52	45	52	45	50	57	57	62	59
Zagreb	65	55	74	69	76	67	66	73	72	76	85	78

^a Codebook item 74.2.

Table 19. Percentages of people who considered their health to be bad or fairly bad^a

	Age group (years)													
	Men							Women						
	60-64	65-69	70-74	75-79	80-84	85-89	60-64	65-69	70-74	75-79	80-84	85-89		
Brussels	30	13	17	19	29	4	34	0	28	31	12	15		
Leuven	14	6	7	15	7	6	21	17	21	6	0	4		
Berlin (West)	17	12	12	26	18	24	14	16	16	25	26	26		
Tampere	26	28	26	32	23	27	19	30	23	29	29	25		
Midi-Pyrénées	16	18	20	20	16	20	17	24	23	24	21	19		
Upper Normandy	9	17	13	13	23	0	14	14	27	21	25	43		
Rural Greece	15	17	16	25	44	48	18	32	35	40	43	55		
Florence	6	13	17	10	8	12	16	14	15	18	21	18		
Low Ombrone	22	15	17	27	15	25	27	20	27	29	30	32		
West Amiata	14	12	9	20	16	15	15	15	18	25	17	22		
Kuwait	4	8	9	8	16	26	13	10	23	20	24	22		
Bialystok	26	34	33	43	50	—	25	37	48	48	60	—		
Bucharest	6	13	20	26	17	11	19	21	29	25	29	26		
Kiev	18	26	35	35	37	33	33	38	44	41	55	48		
Belgrade	18	23	25	32	31	34	29	34	35	37	44	40		
Zagreb	17	20	29	35	40	30	29	36	38	38	39	32		

^a Codebook items 75.4 and 75.5.

Table 20. Percentages of people who considered their health to be worse than that of other people of their own age^a

	Age group (years)											
	Men						Women					
	60-64	65-69	70-74	75-79	80-84	85-89	60-64	65-69	70-74	75-79	80-84	85-89
Brussels	30	13	8	15	8	4	14	4	20	17	12	4
Leuven	17	9	10	10	5	6	21	14	17	6	6	4
Berlin (West)	17	14	12	19	11	11	20	16	12	18	20	16
Tampere	23	24	14	12	8	4	22	13	13	15	10	8
Midi-Pyrénées	18	13	15	14	3	11	23	22	15	7	13	8
Upper Normandy	13	22	13	6	10	0	16	17	16	12	10	0
Rural Greece	16	25	24	30	46	42	25	35	37	39	41	45
Florence	6	13	18	7	7	7	24	21	12	16	16	17
Low Ombrone	23	17	13	19	15	15	29	19	22	20	21	14
West Amiata	22	16	15	14	16	15	20	15	27	23	14	10
Kuwait	10	13	11	14	17	26	16	19	26	26	30	0
Bialystok	31	30	26	25	30	—	26	26	34	31	42	—
Bucharest	16	15	24	28	15	20	27	25	30	22	29	31
Kiev	18	20	22	18	31	21	25	30	33	24	35	28
Belgrade	13	22	20	26	15	20	19	27	22	25	31	19
Zagreb	15	14	17	20	22	22	16	25	21	30	30	14

^a Codebook item 76.3.

Table 21. Percentages of people reporting that they had had some accident, injury, or chronic disease affecting their daily living, including work^a

	Age group (years)											
	Men						Women					
	60-64	65-69	70-74	75-79	80-84	85-89	60-64	65-69	70-74	75-79	80-84	85-89
Brussels	54	52	32	37	46	52	59	37	52	41	41	63
Leuven	65	67	77	66	73	77	82	80	83	68	69	90
Berlin (West)	58	60	53	59	63	67	65	62	62	64	73	65
Tampere	71	70	66	67	81	80	62	64	68	79	77	80
Midi-Pyrénées	60	63	61	70	77	75	56	62	57	71	71	70
Upper Normandy	67	74	64	67	67	53	70	72	74	71	84	63
Rural Greece	63	70	77	83	85	92	71	83	90	90	86	89
Florence	45	35	49	55	53	58	54	52	58	63	58	75
Low Ombrone	70	63	65	75	70	75	73	70	73	71	77	78
West Amiata	53	65	57	66	71	73	56	63	68	72	74	68
Kuwait	33	41	32	36	57	54	40	46	53	53	45	64
Bialystok	51	63	48	45	51	—	41	41	43	42	49	—
Bucharest	62	53	67	79	73	90	63	77	80	80	75	82
Kiev	52	68	67	66	42	47	60	62	77	56	64	59
Belgrade	52	52	61	59	57	50	59	62	61	65	61	58
Zagreb	53	56	59	55	58	59	59	68	73	71	66	69

^a Codebook item 77.1.

Table 22. Percentages of people who, in the preceding 2 weeks, had had often or nearly continuously any of 24 signs or symptoms^a

	Age group (years)											
	Men						Women					
	60-64	65-69	70-74	75-79	80-84	85-89	60-64	65-69	70-74	75-79	80-84	85-89
Brussels	79	82	72	85	83	91	86	86	80	82	84	80
Leuven	55	58	74	74	65	68	85	69	76	78	77	78
Berlin (West)	64	63	58	64	75	72	75	78	78	80	82	81
Tampere	73	73	69	81	79	84	79	69	75	76	87	86
Midi-Pyrénées	66	62	56	64	71	72	74	73	67	77	70	78
Upper Normandy	62	69	68	75	80	71	74	79	75	84	86	71
Rural Greece	53	65	74	79	86	96	66	84	87	91	78	84
Florence	55	69	70	65	73	76	87	88	90	85	84	87
Low Ombrone	81	88	76	88	85	88	97	92	92	95	92	89
West Amiata	81	78	78	80	84	82	88	88	94	91	92	94
Kuwait	26	30	29	34	53	68	49	55	53	67	56	61
Bialystok	88	75	82	88	89	—	84	84	82	86	87	—
Bucharest	65	66	83	88	71	74	82	80	93	83	88	90
Kiev	67	60	71	69	61	75	79	86	90	84	91	92
Belgrade	52	66	63	68	69	79	70	78	70	79	84	78
Zagreb	52	51	66	61	68	78	66	71	74	73	73	84

^a Derived variable 72. 1.

Table 23. Percentages of people who, in the preceding 2 weeks, had had often or nearly continuously any of 17 psychosomatic signs or symptoms^a

	Age group (years)											
	Men					Women						
	60-64	65-69	70-74	75-79	80-84	85-89	60-64	65-69	70-74	75-79	80-84	85-89
Brussels	67	79	72	77	67	75	76	86	76	76	72	75
Leuven	48	52	64	64	50	52	76	65	76	67	69	70
Berlin (West)	52	49	47	56	63	62	69	71	66	73	70	77
Tampere	62	67	60	64	71	71	62	60	66	69	79	83
Midi-Pyrénées	44	46	46	46	66	59	57	64	56	64	64	65
Upper Normandy	49	57	53	62	71	57	63	71	69	80	76	71
Rural Greece	46	55	67	70	76	92	54	72	73	77	65	84
Florence	46	54	56	43	58	62	81	71	77	73	74	79
Low Ombrone	74	74	60	74	74	74	92	84	84	84	86	84
West Amiata	73	71	62	71	76	74	79	76	86	86	83	89
Kuwait	12	14	15	18	30	40	28	32	44	41	36	39
Bialystok	59	67	69	69	75	—	65	75	73	77	84	—
Bucharest	39	40	55	60	54	63	59	65	78	68	73	66
Kiev	55	55	61	64	52	67	72	81	83	79	85	87
Belgrade	45	54	54	54	57	60	61	67	59	68	74	68
Zagreb	45	47	59	58	50	70	59	66	72	71	64	81

^a Derived variable 74, 1.

Table 24. Percentages of people who, in the preceding 2 weeks, had had often or nearly continuously any of 7 physical signs or symptoms^a

	Age group (years)													
	Men							Women						
	60-64	65-69	70-74	75-79	80-84	85-89	60-64	65-69	70-74	75-79	80-84	85-89		
Brussels	44	25	32	36	67	52	62	58	44	64	72	50		
Leuven	38	28	39	44	35	43	68	36	56	54	51	43		
Berlin (West)	38	41	42	45	50	51	59	56	51	55	64	56		
Tampere	52	46	39	46	51	69	55	51	49	51	58	58		
Midi-Pyrénées	48	40	36	54	47	52	55	60	44	61	56	61		
Upper Normandy	38	41	46	45	60	43	49	53	50	64	65	71		
Rural Greece	39	42	57	53	66	67	45	63	65	69	71	67		
Florence	42	44	48	49	55	53	67	74	68	71	69	70		
Low Ombrone	64	62	60	71	69	76	89	82	83	80	84	75		
West Amiata	54	47	60	60	67	61	73	68	77	71	74	66		
Kuwait	19	19	21	26	41	53	32	36	44	42	42	52		
Bialystok	82	61	60	82	76	—	78	65	65	67	64	—		
Bucharest	52	43	69	70	66	60	74	64	79	70	77	77		
Kiev	41	31	48	38	43	58	53	61	66	64	68	73		
Belgrade	29	42	41	52	48	63	49	58	56	64	66	63		
Zagreb	31	30	40	39	50	48	40	37	43	45	46	57		

^a Derived variable 76, 1.

Table 25. Percentages of people who, in the preceding 2 weeks, had suffered often or nearly continuously from aching or pain in the joints or back trouble^a

	Age group (years)											
	Men						Women					
	60-64	65-69	70-74	75-79	80-84	85-89	60-64	65-69	70-74	75-79	80-84	85-89
Brussels	41	10	15	23	38	25	55	41	24	48	56	35
Leuven	31	22	29	26	24	26	53	33	41	31	34	30
Berlin (West)	25	32	32	28	28	31	49	48	43	43	42	39
Tampere	41	39	26	32	29	47	43	43	43	40	40	39
Midi-Pyrénées	39	32	28	40	37	32	44	52	35	51	47	57
Upper Normandy	28	32	33	34	29	43	42	46	43	55	55	29
Rural Greece	30	32	45	44	50	38	39	52	56	61	65	60
Florence	25	29	30	36	35	27	57	60	60	56	52	46
Low Ombrone	53	50	45	52	45	51	77	70	75	63	64	56
West Amiata	42	34	36	47	47	36	58	51	62	54	55	48
Kuwait	16	15	15	17	32	48	26	29	31	33	34	43
Bialystok	9	26	24	11	29	—	10	30	51	35	55	—
Bucharest	45	36	57	60	55	51	64	57	73	60	71	72
Kiev	31	28	38	31	33	52	45	51	60	52	55	63
Belgrade	22	26	28	29	27	42	41	43	38	51	54	44
Zagreb	20	28	22	26	36	41	29	30	38	37	39	49

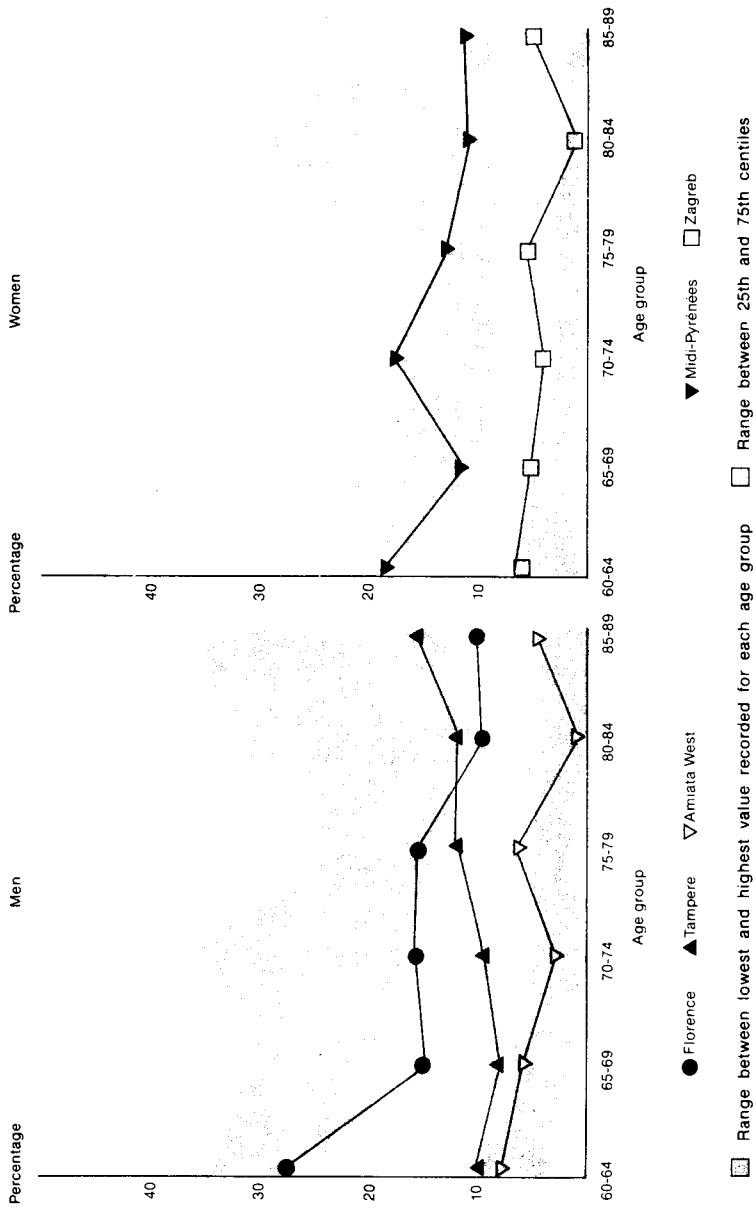
^a Codebook items 136.3 and 136.4.

Table 26. Percentages of people who, in the preceding 2 weeks, had suffered often or nearly continuously from tiredness or a feeling of faintness^a

	Age group (years)											
	Men					Women						
	60-64	65-69	70-74	75-79	80-84	85-89	60-64	65-69	70-74	75-79	80-84	85-89
Brussels	7	13	7	8	4	13	7	18	12	7	8	20
Leuven	7	3	7	15	2	20	15	17	15	11	14	9
Berlin (West)	20	10	16	22	16	23	22	16	19	25	30	34
Tampere	17	17	25	25	23	39	21	22	20	23	34	36
Midi-Pyrénées	13	16	16	14	24	23	21	27	25	26	31	31
Upper Normandy	8	15	10	17	24	21	30	25	33	41	35	14
Rural Greece	9	12	16	18	28	13	12	16	18	16	16	22
Florence	10	12	13	14	15	22	24	18	30	30	30	20
Low Ombrone	37	27	25	36	35	40	37	36	42	42	47	58
West Amiata	19	23	17	23	22	28	22	24	29	36	31	25
Kuwait	1	0	1	0	1	1	0	1	0	2	0	4
Bialystok	20	27	19	25	34	—	36	32	39	37	43	—
Bucharest	1	4	4	3	2	6	16	13	18	16	11	9
Kiev	15	19	24	28	25	31	27	39	39	50	53	48
Belgrade	10	17	19	19	22	29	22	25	21	29	37	39
Zagreb	10	12	15	20	24	37	16	26	27	33	24	38

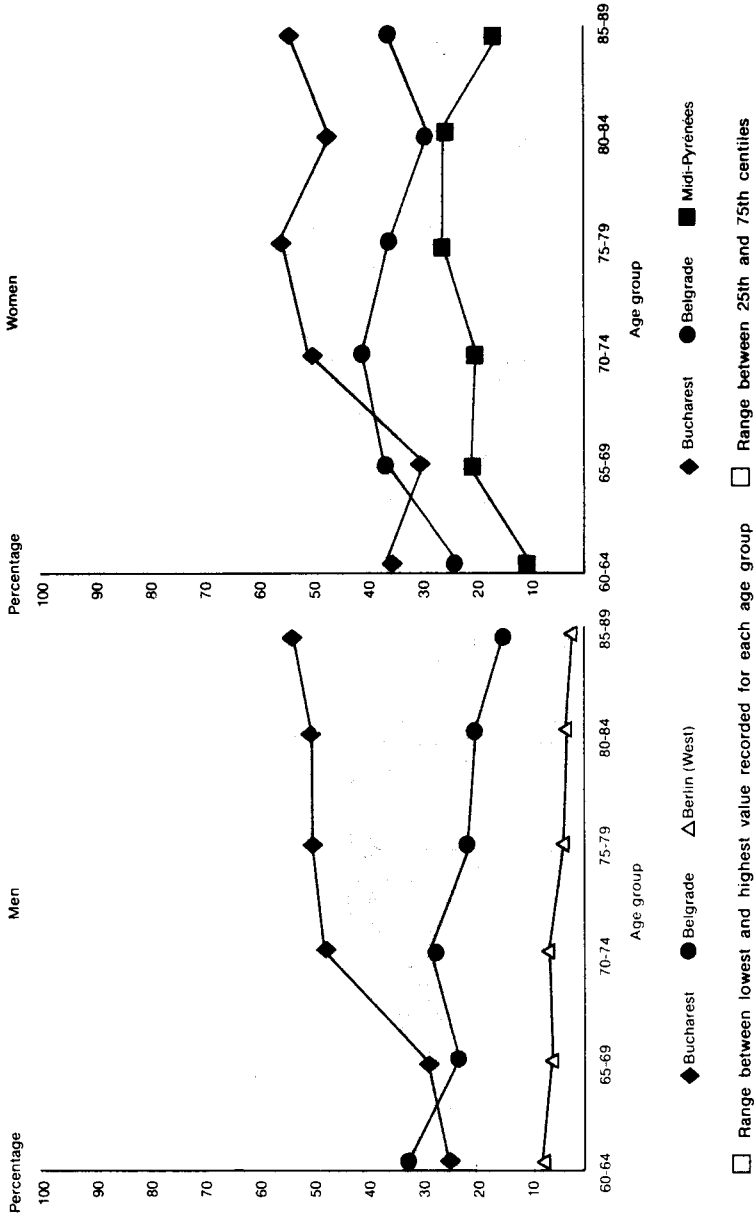
^a Codebook items 130.3 and 130.4

Fig. 1. Percentages of people who evaluated their health as very good^a



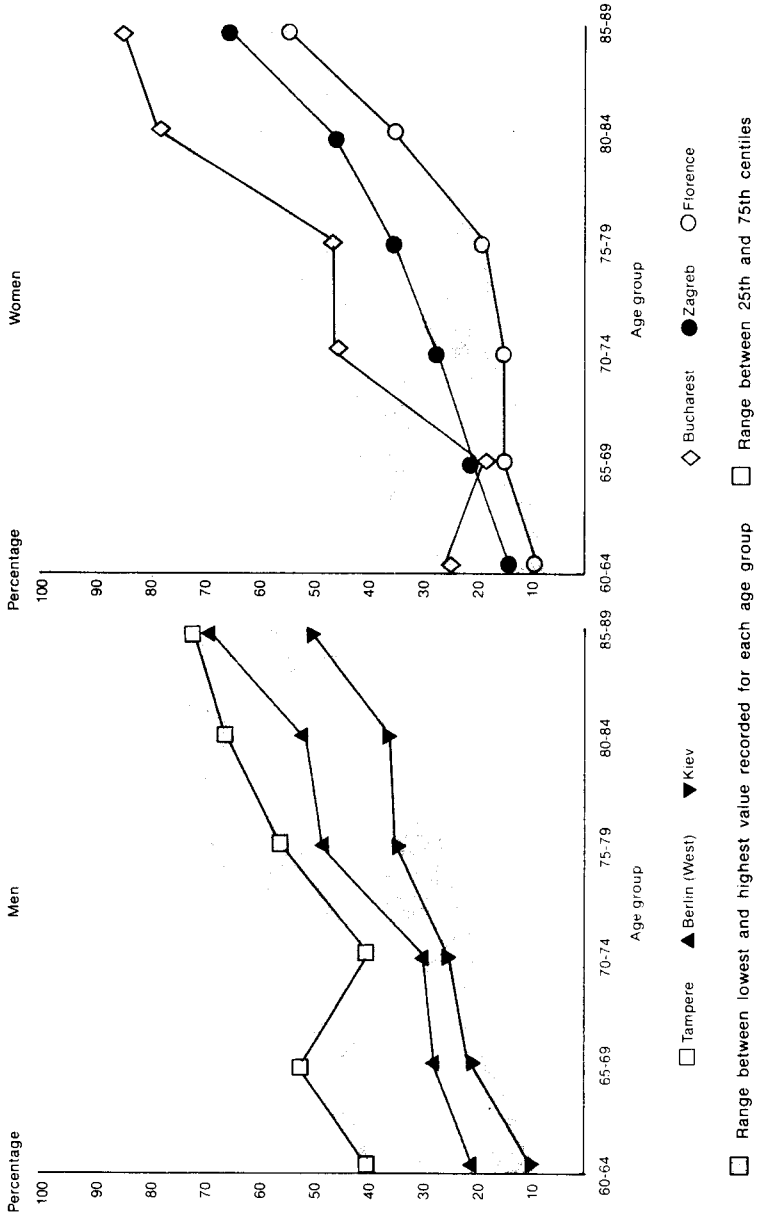
^a Codebook item 75.1.

Fig. 2. Percentages of people who reported hypertension^a



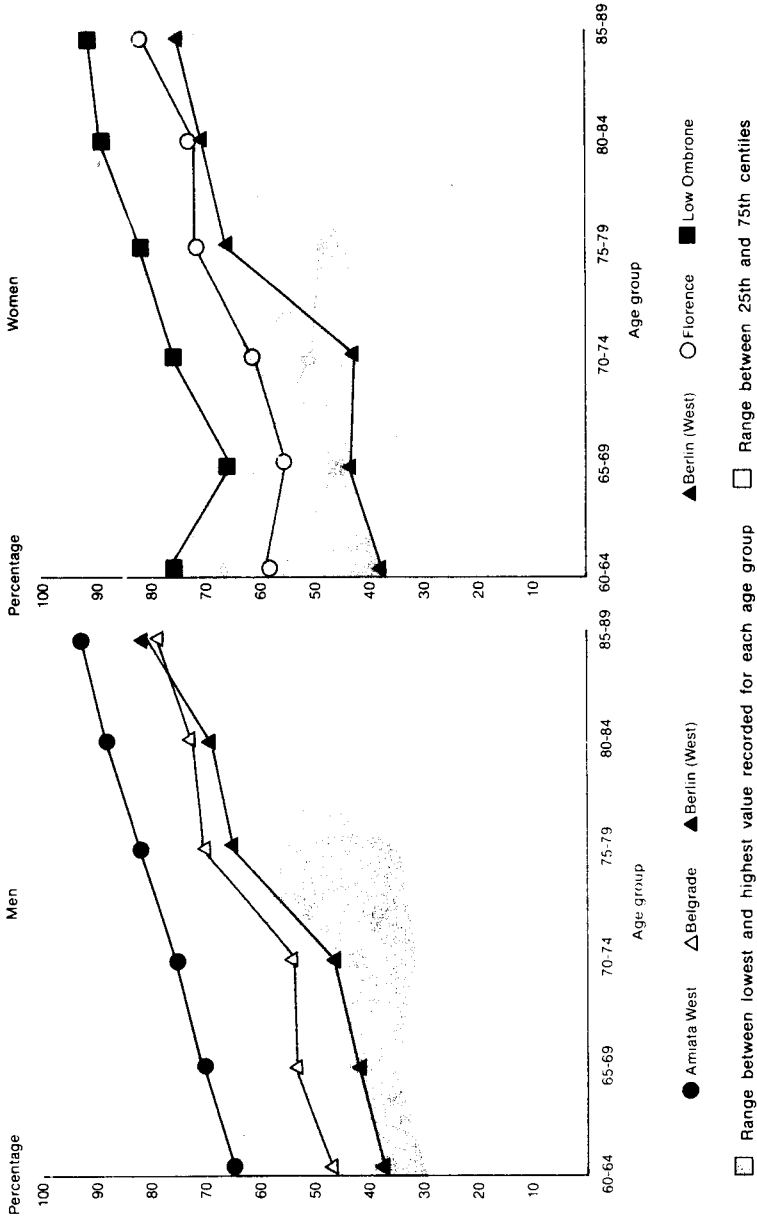
^a Derived variable 34, 1.

Fig. 3. Percentages of people who reported hearing problems^a



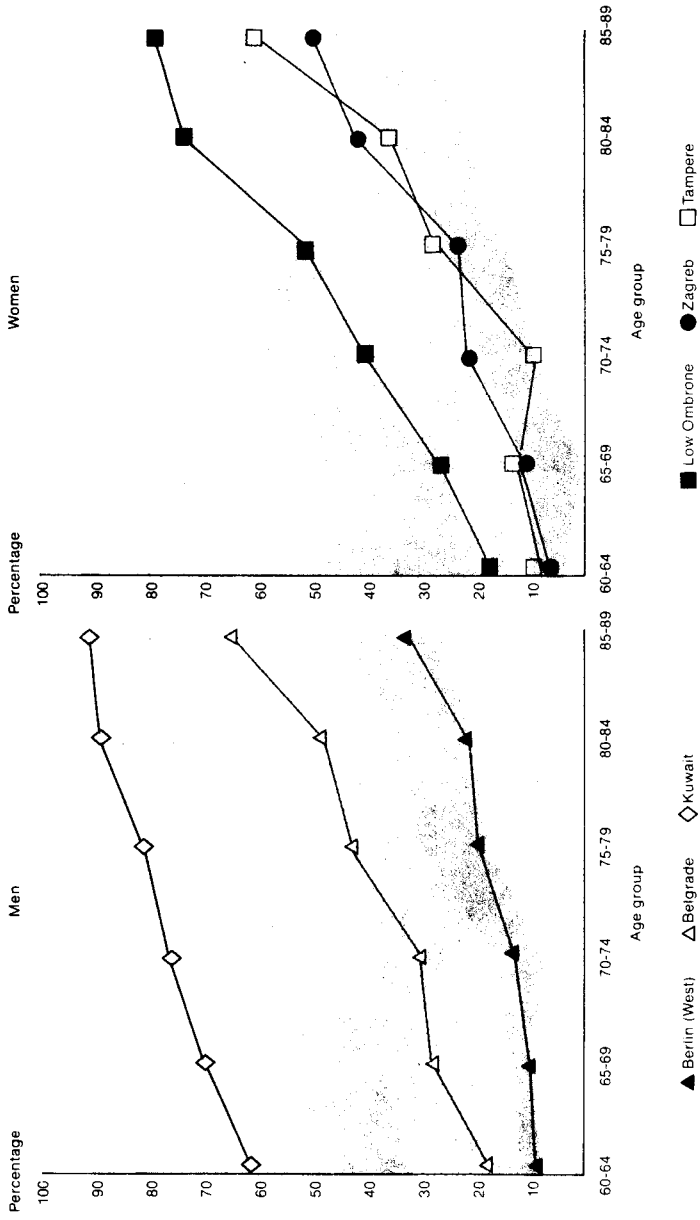
^a Derived variable 79, 1.

Fig. 4. Percentages of people who had problems with daily living^a



^a Derived variable 80.1.

Fig. 5. Percentages of people who had problems even with light housework^a



Range between lowest and highest value recorded for each age group^a
 Range between 25th and 75th centiles

^a Derived variable 167. 2.

falling asleep, giddiness, tremor of the hands, shortness of breath, lack of energy, depression, problems in passing urine, and constipation. Decreasing trends were observed in the prevalence of heartburn, stomach pains, excessive sweating without physical effort, and irritability or outbursts of anger. In all the symptoms mentioned, except problems in passing urine and irritability or outbursts of anger, the prevalence was higher among women than among men.

Prevalence of Physical Impairments

The existence of various types of physical impairment and incapacity for personal care has great importance for the planning of the care of the elderly. In this study information was collected on problems in relation to hearing and sight, dental prostheses and mastication, and personal care.

The percentage of persons reporting problems in hearing what others say increases rapidly from the youngest to the oldest age group (Fig. 3). On the average 60–70% in the age group 85–89 years had problems in hearing, in the age group 60–64 years about 20%. Slightly higher prevalences were reported by men as compared with women. Between 2% and 10% of the persons interviewed used a hearing aid, men more frequently than women. As could be expected, hearing problems were usual against a background of people talking and about half of the oldest subjects had hearing problems in such a situation.

Approximately 8% of women and 6% of men could not read newspapers or books and about 20% had some difficulty in reading. Women were more often affected than men and the condition was more frequent in the oldest age group.

The use of dental prostheses was high in the youngest age group, 60–64, the range of prevalence being 45–87% for women and 32–87% for men. Difficulties in chewing food increased from about 10% in the youngest age group to about 60% in the oldest. The rates were higher for women in all the study populations.

Between 9% and 27% of subjects had difficulty in getting to the lavatory in time. The rate increased for both sexes in all study populations from the youngest to the oldest age group.

Problems with feet and veins were relatively common; 30–60% of all age groups reported them, women and older age groups more often than men and younger age groups. These conditions often restricted daily activities; 40–77% of those who reported foot problems had restricted movement because of them.

Capacity for Self-care and Functional Status

Elderly people often have difficulty in coping with the activities of daily life and maintaining social contact with the outside world. Ability to cope with daily activities was assessed by 14 questions that ranged from such primary

functions as eating, dressing, and washing to those requiring more performance capacity such as carrying heavy weights and doing heavy domestic work.

Fig. 4 shows that on the average 80–90% of subjects in the oldest age group reported problems in some of the activities, while in the youngest age group the corresponding figures were 50–60%. The rates were higher for women than for men, chiefly in the age groups 60–64 and 65–69 years. The percentage of persons who needed help in coping with the simpler tasks was generally below 10%, such tasks including going outdoors, walking between rooms, using stairs, using the lavatory, cooking, feeding oneself, and ability to walk more than 400 metres. More difficult tasks, especially for women, were cutting toenails, working, bathing, and carrying a weight of 5 kg for 100 metres; 1–21% of women, depending on the age group, needed help in coping with those tasks.

Coping with domestic work is a problem for a large proportion of the elderly. Even light domestic work was found difficult to cope with by about 60% of the oldest age group (Fig. 5). The variation between the study populations was large, and in some areas sex differences also were marked. Help was often needed in doing heavy domestic work; 7–28% of women and 4–17% of men reported being able to cope with heavy domestic work only with help.

Women more often than men reported inability to walk or go by public transport to the nearest medical institution; 11–63% of women could not cope with this task without the help of another person. The rates for women were almost twice as high as those for men.

Conclusions

Interpretation of the results of a questionnaire on the health and functional ability of the elderly raises some methodological questions since the results reflect the subjective feelings about health of the aged populations interviewed. The level and use of health and social services, awareness of and knowledge about health problems, attitudes towards disease and the symptoms of disease, and the actual prevalence of clinically diagnosed diseases are among the factors that cause variation in the results between the populations and age groups studied. In addition, the proportion of persons in different age groups in institutions is not the same in each study area, therefore the number of interviews conducted at home represents the original sample in different proportions.

A large variation in the percentage of those who did not feel themselves healthy is, however, an interesting finding, one that requires deeper cross-cultural analysis and initial clinical examination of health status. It would be important to ascertain, for example, whether those who perceive their health as poor really are in poor health. If the correlation is not high, it would mean that, in developing services, more emphasis should be paid to the psychological and social aspects of health among the elderly.

The majority of the elderly suffer from chronic conditions that affect the activities of daily living. The variation between the study populations here

too was large, but the differences between the age groups are not so striking as might have been assumed. Functional ability, on the other hand, declines rapidly from the younger to the older age groups. This can be explained on the basis of aging processes leading to deterioration in performance without manifesting themselves as clinically defined disease. Impairment of the senses is also common in the oldest age groups, a finding supporting the hypothesis that significant impairments start at the age of 75–80 years.

The majority of the elderly suffer from various signs and symptoms whose prevalence is already high in the youngest age group. Symptoms that cannot be connected clearly with specific diseases are common and often lead to the use of drugs.

In nearly all aspects of health and capacity for self-care, and in almost all the study populations, women appeared to be not as healthy as men and less fit than them. Whether this result merely reflects a greater readiness among women to report their problems remains to be investigated.

For medical practice it is important to know to what extent deterioration in capacity for self-care can be prevented by rehabilitative and recreational measures aimed at promoting the capacity for self-care. Multiple morbidity and the frequent presence of vague symptoms call for more knowledge about the normal and pathological processes of aging. It is likely that, in medical practice, some signs and symptoms are left unnoticed because standardized approaches to assessment of the medical history of the elderly have not been adopted; other signs and symptoms may be wrongly interpreted as pathological until clear definitions between normality and abnormality have been developed.

Since complex medical records are available or can be made available for many areas of the study, it will be possible to ascertain the health status of the persons interviewed from other sources. In some areas clinical examinations are also being carried out either cross-sectionally or prospectively; they will offer opportunities for further interpretation of the interview data. In general, this report is not concerned with disease entities.

In the continuation of this study it will be possible to go beyond the general trends and differences presented here, focus attention on the interactions between various variables, and carry out deeper analyses in selected age groups and study populations. From the health point of view, the elderly are far from being a homogeneous group, even though at first glance it may seem that health deteriorates inexorably and uniformly with age. In fact many signs and symptoms either remain at the same level in different age groups or their prevalence is lower among the older groups; a significant proportion of old people even in very old age feel their health to be good. These findings suggest that there may be among the elderly a more unrealized potentiality for various activities than is generally assumed.

