# Abstracts

## Health Policy — John Bond

Sue E. Levkoff, Paul D. Cleary and Terrie Wetle, 'Differences in the appraisal of health between aged and middle-aged adults'. *Journal of Gerontology*, **42** (1986), 114–120.

In the development of health policy there has been a welcome increase in the use of data collected from representative samples of 'normal' people rather than a reliance on data collected about a biased population: the users of health services. Equally welcome has been the development of methods for identifying health status which are not based on the need for a clinical diagnosis. Thus community-based morbidity surveys have been undertaken which rely on the self-perception of health status. Studies comparing physician-rated with self-rated health status show relatively good agreement between the two methods.[1] A number of studies have reported elderly people's self-perception of health but few have compared individuals' self-perception at different stages of the life cycle. The aims of the study described in this article are to evaluate whether elderly people perceive their health more positively or negatively than do middle-aged people, and to examine whether there are differences across age groups in the kinds of factors associated with these perceptions.

The data reported in this article are based on interviews, questionnaire responses and medical records from a representative sample of people aged 18 or over living in a sampling area of 50,000 people.[2] In this article data on 460 respondents who were aged 45 or over are reported. Several well tested indicators of health status were used in the study and their reliability is reported.

The major focus of the reported analyses was to determine whether and in which circumstances elderly individuals are more optimistic or more pessimistic in their self-rating than middle-aged individuals. The comparisons are based on two groups: people aged 45 to 64 years (middle age) and people aged 65 or over (old age). The analyses focuses on three related questions:

(1) Are specific diagnoses responsible for relatively optimistic or pessimistic assessments of health among elderly people?

(2) Do middle-aged and elderly people adjust their self-perceptions in comparison to their age peers?

(3) Are there differences in self-assessment of health status across subgroups of elderly people?

The old-aged group evaluated their health status as worse than the middle-aged group, after controlling for a number of different measures of ill health. This finding is consistent with the only other study which compares middle-aged and older individuals.[3] If older people do report more health optimism, it must be only when asked to compare themselves with their age peers. In this study the 'old-old' reported worse health than the 'young-old'; a finding contrary to other studies which have suggested that very old people are more optimistic about their health than the 'young' old.[4]

The study also examined the relationship between psychological distress and self-rated health. When controlling for psychological distress in a multivariate analysis the elderly group evaluated their health worse than did the middle-aged group at every level of distress. This finding, which is consistent with previous studies,[5] suggests the following hypothesis for testing: 'The increased monitoring of normal sensations, more frequent experience of physical illness, and normative expectations may all combine to increase the elderly person's tendency to perceive and label dysphoric experiences as somatic' (p. 119).

COMMENT

This article describes a useful piece of analysis which highlights the caution required in the planning and development of health policy when using estimates of morbidity based on individuals' self perception. Our perceptions of health change are probably not simply related to chronological age but to our experiences throughout the life course. Further studies which describe and explain the complex relationships between self-perception of health status and objective physical and psychological health at different ages and stages in the life course will be of continuing value. Without this knowledge, our estimates of need will continue to be based on rather crude and often unverified assumptions.

Burton P. Halpert and Mary K. Zimmerman, 'The health status of the "old-old": a reconsideration'. *Social Science and Medicine*, **22** (1986), 893–899.

This article reports findings from a data set based on 148 people aged sixty or over living in a small town and its surrounding rural area. The

respondents were selected by a combination of snowball and quota sampling. For the purposes of analysis the sample was divided into the 'young-old' (60–74 years) and the 'old-old' (75+). The statistical analyses undertaken are more appropriate to surveys using random samples than snowball techniques so that no extrapolation to the general population is possible.

Of the people studied, those aged 75 or more years are comparable to those aged 60–74; for example, about half of each age group felt that their health was good to excellent. There was however a higher prevalence among the older group of physical conditions normally associated with old age. The relative wellbeing of the older group was found by a more favourable mental attitude about themselves and their life in general; they reported less depression, anxiety and nervousness. These findings are not necessarily inconsistent with the data reported by Levkoff *et al.*

How should one interpret these data? Given the limitations of the size and method of sampling I would suggest only heuristically. However, Halpert and Zimmerman suggest that these data point to a survivorship phenomenon in which the over-75s are the biological elite of their cohort. For them, chronic morbidity is compressed into the last few years of their lives.[6] There is little substantial evidence that Fries's[7] hypothesis stands up to empirical observation for a population,[8] although for certain groups the model of the rectangular curve deserves careful consideration. A recent study of the effects of physical activity on morbidity and mortality supports the view that a population of physically active, non-smoking, middle-aged men might provide an empirical example of the rectangular curve caused by the compression of morbidity into the later stages of the life cycle.[9] These do not however refute or support the model.

## COMMENT

The importance of this article is its emphasis upon the dangers of making assumptions about the needs of elderly people based only upon chronological age. This is particularly the case when focusing on specific localities and populations. National estimates based on chronological age may be of value to planners of services for elderly people but they also encourage what Brody has called 'the gloomy perspective'.[10] Rather than reproducing gloomy estimates, useful future research should concentrate on the changing pattern of survival among older people and on the interventions which will best extend good health into old age.

NOTES

1 LaRue, A., Bank, L., Jarvik, L. and Hetland, M., Health in old age: how do physicians' ratings and self-ratings compare?, *Journal of Gerontology*, **34** (1984), 119–135; Maddox, G. L. and Douglass, E. B., Self-assessment of health: a longitudinal study of elderly subjects, *Journal of Health and Social Behaviour*, **14** (1973), 87–93.
2 Mechanic, D., Cleary, P. and Greenley, J., Distress syndromes, illness behaviour, access to care and medical utilization, *Medical Care*, **20** (1982), 361–372.
3 Palmore, E. and Luikart, C., Health and social factors related to life satisfaction, *Journal of Health and Social Behavior*, **13**, (1972), 68–80.
4 Maddox, G. L., Self-assessment of health status: a longitudinal study of selected elderly subjects, *Journal of Chronic Diseases*, **17**, (1964), 449–460.
5 Blazer, D. and Houpt, J., Perceptions of poor health in the healthy older adult, *Journal of the American Geriatrics Society*, **27** (1979), 330–334.
6 Fries, J. F., Aging, natural health, and the compression of morbidity, *New England Journal of Medicine*, **303**, (1980), 130–135.
7 *Ibid.*
8 See the discussion of Fries, J. F. and Crapo, L. M., *Vitality and Aging: Implications of the Rectangular Curve*, W. H. Freeman & Co., San Francisco, 1981, by Bromley, D. B., Isaacs, B. and Bytheway, B., Ageing and the rectangular curve, *Ageing and Society*, **2** (1982), 383–92; and of Manton, K. G., Changing concepts of morbidity and mortality in the elderly population, *Milbank Memorial Fund Quarterly/Health and Society*, **60** (1982), 183–224 by Bond, J., Abstracts on epidemiology and community medicine, *Ageing and Society*, **3** (1983), 109–114.
9 Pekkanen, J., Marti, B., Nissinen, A., Tuomilehto, J., Punsar, S. and Karvonen, M. J., Reduction of premature mortality by high physical activity: a 20-year follow-up of middle-aged Finnish men, *The Lancet*, **i** (1987), 1473–1477.
10 Brody, J. A., Facts, projections, and gaps concerning data in aging, *Public Health Reports*, **99** (1984), 468–475.