UNIVERSITY 1 OF Nebraska Omaha

University of Nebraska at Omaha
DigitalCommons@UNO

Publications Archives, 1963-2000

Center for Public Affairs Research

10-1994

Social Conditions of Nebraska's Elderly

F. C. Powell
University of Nebraska at Omaha

James A. Thorsen
University of Nebraska at Omaha

Follow this and additional works at: https://digitalcommons.unomaha.edu/cparpubarchives

Part of the Demography, Population, and Ecology Commons, and the Public Affairs Commons

Dr. C.C. and Mabel L. CRISS LIBRARY

SOCIAL CONDITIONS OF NEBRASKA'S ELDERLY, 1994

A research report sponsored by the Eastern Nebraska Office on Aging and the Center for Public Affairs Research, University of Nebraska at Omaha

F. C. Powell, Ph.D.

Associate Professor

and

James A. Thorson, Ed.D.

Isaacson Professor & Chairman

Department of Gerontology

University of Nebraska at Omaha

Table of Contents

**University of
Nebraska at
Omaha**

October 17, 1994

This is the first in a series of reports that will be developed from a
large data base gathered from older Nebraskans. The reader should be advised
that this is preliminary, descriptive information and that errors of omission
are more likely than those of commission at this point. Much further analysis
of this data remains to be done: this study is based on 700 older peoples'
responses to 217 questions. Several additional reports and articles will be
developed from this data. The authors take responsibility for the presentation
of these findings; interpretation and opinions are theirs.

We would like to acknowledge the 700 older Nebraskans, drawn randomly from
across the State, for giving so freely of their time in participating in this
study. Their willingness to provide information in what often were lengthy
interviews will hopefully provide policy makers with insights into the hopes
and feelings of the State's older population.

We also wish to express our appreciation to Dr. Russell L. Smith, Director
of the University of Nebraska at Omaha's Center for Public Affairs Research,
for support of this study. And, we wish to similarly acknowledge the support
of Ms. Beverly Griffith, Director of the Eastern Nebraska Office on Aging, for
her support. Further, we wish to thank Dr. David W. Hinton, Dean of the
College of Public Affairs and Community Service, and Mr. Tim Himberger of the
UNO Center for Public Affairs Research, for their assistance and encouragement.

F. C. Powell, Ph.D.
Associate Professor

James A. Thorson, Ed.D.
Isaacson Professor & Chairman

Background

In 1991, the authors conducted a study of 500 older Nebraskans, comparing 300 people in Omaha and its surrounding counties with a sample of 200 who lived in the very rural Sandhills counties. The purpose of that study was to compare health and health care experience and satisfaction between urban and rural-dwelling elders. Random samples of older people were identified and interviewed by trained telephone operators; each interview took about a half hour. People were asked about their experiences with health and illness, the distance to their primary source of medical care and the distance to the hospital they use, their levels of satisfaction with that health care provider and hospital, their experience with dental care and satisfaction with it, and a number of questions dealing with their health beliefs. Levels of functioning and disability were also assessed through activities of daily living scales.

There was a small, but significant, difference among the samples by age: the 196 respondents from Douglas County had a mean age of 73.8 years, the 104 participants who lived in the surrounding counties served by the Eastern Nebraska Office on Aging (Cass, Dodge, Washington, and Sarpy) averaged 72.4 years. The average age of the 200 residents of the eleven Sandhills counties was 76.6 years. About 72% of all respondents were women; all but 14 of the 500 subjects were white. Those living in the rural areas were somewhat more likely to be widowed or living alone.

The self-assessed health of the Sandhills residents and those who

lived in Douglas County was almost identical, as was their number of months since their last visit to a doctor (9.6 and 10.6, respectively) and number of months since last physical examination (28.1 months and 28.3 months). Their hospitalization rate was the same, as was their overall satisfaction with health care. Their health beliefs were so similar that the data were pooled for reporting purposes. There were obvious distance differences between samples in terms of access to health care; these distances, however, seemed to account for little in terms of overall health, health satisfaction, or levels of disability. There was some evidence, however, for urban-rural differences in health beliefs.

A forced-entry multiple regression procedure suggested that the primary predictors of disability (defined as the inability to perform activities of daily living) were: 1) age (disability increases with chronological age), 2) self-reported health status, and 3) being a member of a minority group. Living alone and being male also contributed slightly to the variance. About 8.7% of the urban sample and 6.5% of the rural sample felt that they needed help with performing one or more of the activities of daily living. But, only nine of the respondents in Douglas County and ten in the Sandhills felt that they needed help but had no available assistance. Overall, few barriers to needed health care were identified among these samples of older Nebraskans, and few urban-rural differences were found in terms of service needs. One unexpected finding was the incidence of a "drive by" phenomenon among the Sandhills residents, many of whom would decline to patronize nearby family

physicians in order to consult urban specialists; this may have some important public policy implications in the planning of health care delivery in rural areas.

That study in some ways raised more questions than it answered. Its results have been reported (Powell & Thorson, 1991; Thorson & Powell, 1992a and 1992b; Thorson & Powell, 1993). Secondary analysis of that data by Esther Hellman of the College of Nursing, University of Nebraska Medical Center, revealed an inverse correlation between social network and physician utilization (Hellman, Thorson, & Powell, 1992). The incidence of "drive by" phenomenon that was identified led to a much more extensive study of urban and rural health care recipients by Steven S. Martin of Nebraska Blue Cross/Blue Shield; that study essentially confirmed the original finding (Martin, 1992). In terms of service needs, however, it was difficult to demonstrate many urban vs. rural differences on the basis of the data gathered, and in some ways the methodology of the study presented limitations, as only the very rural and the very urban were compared. It was clear that additional data would be needed in order to make an assessment of the older population generally in the State of Nebraska.

The Present Study

The present study was conducted in the summer of 1994. It had a somewhat different thrust than the 1991 study; it was felt that health

satisfaction, access, and belief had already been adequately assessed. Of greater importance was gathering a sample that covered the entire state and that questions in the study focus on additional variables that would give more information on the health and social status of older people in Nebraska. The 1994 study included some items on self-rated health and experience with visits to doctors and hospitals, but it also included a number of questions designed to measure:

1. Self-perceptions of social stress;

2. Self-reports of smoking and alcohol consumption;

3. Experience with dental care;

4. Number and cost of prescription medications;

5. Physical disability as assessed by the activities of daily living of the primary respondent to the survey, plus that individual's report of the activities of daily living of any other person aged 60+ in the household;

6. An assessment as to whether personal care of another individual in the household was seen as being a burden;

7. A self-assessment of satisfaction with health care received;

8. An index of social support;

9. Self-assessed fear of crime;

10. Questions dealing with actual risk of being a victim of crime;

11. Self-rated depression as assessed by the Center on Epidemiological Studies Depression scale;

12. Questions dealing with social relationships and interpersonal dynamics;

13. Participation in voluntary organizations and social activities with interpersonal contact; and,

14. Demographic items including household income.

A number of items were also included on issues of the day ("What are people talking about in your neighborhood?") as well as satisfaction with living in one's own neighborhood and in the State of Nebraska. A copy of the complete questionnaire is appended to this report.

Methodology

There were 227 variables included in the questionnaire constructed for the present study, dealing with the concepts and issues listed above. The respondents were drawn from a random list of residential telephone numbers in the State of Nebraska purchased from a national survey firm. The list permitted every person in the state an equal opportunity to participate. Six hundred of the responses were stratified by the three congressional districts in the state. Trained operators with a telemarketing research organization called from the list of random telephone numbers and asked if there was a person aged 60 or older in the household; if there was more than one present, an interview was requested with the oldest available. Calls were made during the daytime, and about one in ten of the calls

resulted in an interview; the turn-down and termination prior to completion rate was about four percent. Each interview took about half an hour to complete (with a range of from 17 to 61 minutes). In order to have a more adequate basis for racial comparisons a similar procedure was used in a geographic district in North Omaha from a separate random list of telephone numbers; calls were made until there were 100 completions.

The interview schedule was pre-tested on a random sample of 30 respondents and several minor syntax problems were corrected prior to a second field test. The overall study received approval from the Institutional Review Board for the Protection of Human Subjects of the University of Nebraska (IRB #294-94). Confidentiality was assured to research subjects.

The resultant data comes from a total of 6865 calls resulting in 700 completed interviews of people aged 60 and older in the state: 201 from the First Congressional District, 198 from the Second, and 201 from the Third Congressional District, plus a separate sample of 100 from an African-American neighborhood in the city of Omaha. Seventy re-interviews were made for the purposes of validation.

Description of Respondents

Of the 700 individuals interviewed, 421 were women and 279 were men. They ranged in age from 60 to 98 years, with a mean age of 71.9 years (standard deviation = 7.27); the modal age was 75.0 years. The age

distribution of the respondents compared to the age distribution of the general population of people in the respective age groups in the State of Nebraksa (1990 Census of Population) is found below in Table 1:

Table 1. Nebraska Elderly Population Correlated with Sample*

Age Cohorts	General Population	Sample
60 - 64 years	23.2% (67,375)	16.9% (118)
65 - 74 years	40.7% (118,220)	47.9% (335)
75 years and older	36.1% (104,846)	35.3% (247)
Total	100% (290,441)	100% (700)

*r = .9876, p < .01

Thus the sample was slightly larger among the young old, those under age 75, in comparison with the population of Nebraska, and almost exactly representative (within one percentage point) among those age 75 and above.

Among these 700 respondents, 386 (55.1%) were married, living with spouse, and 253 (36.1%) were widowed. There were 29 (4.1%) who were single and 30 (4.3%) who were divorced. A total of 590 (84.0%) listed their race as white, 107 (15.3%) African-American, one Latino, and two who were listed as "other." Table 2 contains additional demographic items:

Table 2. Demographic Descriptors of Sample

Educational Level, Nebraska Sample   National*

    133 (19.0%) less than four years of high school   28.5%

    287 (41.0%) completed four years of high school   50.0

    171 (24.4%) one to three years of college   10.9

    109 (15.6%) four years of college or more   11.6

Type of Residence

On a farm or ranch	25
In a rural area	31
In a town < 2,500	80
In a town 2,500 - 10,000	70
In a city 10,000 - 100,000	103
In a city 100,000 - 300,000	129
In a city 300,000+	<u>262</u>
	700

Home Ownership

84 (12.0%) rent	25%
615 (87.9%) own	75

Table 2, continued

Type of Dwelling

    606 single family dwelling

    16 town house or condo

    18 duplex or fourplex apartment

    47 apartment complex

    13 mobile home

Income Category

    67 less than $613 per month

    67 between $614 and $820 per month

    83 between $821 and $1,025 per month

    123 between $1,026 and $1,640 per month

    99 between $1,641 and $2,450 per month

    72 between $2,451 and $4,000 per month

    27 between $4,001 and $8,000 per month

    4 over $8,001 per month

    30 don't know

    133 refused

---

*Sources for national comparison data: U.S. Bureau of the Census Current Population Reports, Series p-20, Nos. 207, 390 and 462; Profile of Older Americans, American Association of Retired Persons, 1991.

The people in this sample were better-educated than those in the 65+ age category generally in the United States; this is consistent with the pattern of educational achievement of citizens of Nebraska in all age groups (U.S. Bureau of the Census, 1993). Higher percentages within this sample had completed some college or four years or more of college in comparison to national data for all older Americans.

Similarly, higher proportions among this sample own their own home compared to older people nationally. This is also consistent with the pattern in Nebraska compared to the nation as a whole at all ages.

According to the definition used by the 1990 U.S. Census of Population, "urban" means persons living in places with 2500 or more inhabitants; by this definition, Nebraska was 66.1% urban in 1990 (U.S. Bureau of the Census, 1993). The sample for the present study thus is slightly skewed toward an urban population; excluding the over-sampling of 100 in North Omaha, the respondents in this study were 22.67% rural and 77.33% urban.

Two ways were used to determine average income. First, respondents were asked, "Give a dollar estimate of your monthly household income." Of the 700 participants in the survey, 105 indicated "don't know" to this question and 157 refused to answer it. Of those who did answer, the range of monthly income was from $100 to $10,400 with a mean of $1,747 (standard deviation = 1,346), a median of $1,500 and a mode of $2,000.

The second question asked people to respond to a dollar figure as a series of figures were read off by the interviewer. These data are

reported in Table 2; as can be seen the refusal and "don't know" rates are lower in this instance.

DESCRIPTIVE STATISTICS

Health Status

Respondents were asked a variety of questions about their health status, the source of their primary care and distance from primary care giver, the frequency of visits to their primary health care provider, medical conditions, hospitalization, use of emergency rooms, and length of time since last physical examination. Based on a number of large-scale epidemiological studies of the elderly, Idler and her colleagues (1990) determined both that self-rating of health was at least as accurate as a clinical assessment of individuals in large populations and that self-rating has been shown to be closely related to survivorship in longitudinal studies. In the Yale Health and Aging Project, following a group aged 65+ since 1982, 11.7% reported excellent health and 8.4% reported poor or bad health; those with an "excellent" self-rating were about five times as likely to survive (Idler, 1993).

In the present study 60 of the 700 Nebraska respondents reported either poor (54) or very poor (6) health, a combined percentage of 8.5%. A total of 157 (22.4%) reported their health as being fair, 359 (51.3%) as good, and 124 (17.7%) as excellent. Most (83.9%) receive their health care from a private physician; only three individuals reported that they

rely on hospital emergency rooms for their primary source of health care. However, fully 16.4% (115 respondents) reported using an emergency room at least once during the previous twelve months; of these, 13 had two ER visits and five individuals reported three or more.

The mean number of miles traveled from home to the location of their primary health care provider was 7.66 miles; about 85% were within ten miles or less, and only 13 respondents (1.9%) lived 50 miles or more from their primary source of health care. About 84% were within 20 minutes travel time of their health care provider and 95% were within 30 minutes. Ninety percent reported being able to see a physician within a half-hour's time once they arrived.

The mean number of physician visits within the previous 12 months was 4.5, although this average was skewed by a number of frequent visitors. According to the 1992 National Ambulatory Medical Care Survey (Schappert, 1994) the average for persons 65-74 is 4.9 visits and the mean number of visits to the doctor's office of those aged 75+ is 6.3. The modal number of physician visits in the Nebraska sample was two; three-quarters of these people saw a doctor five or fewer times (a quarter reported none or only one visit within the previous year). But, 9.4% of the sample reported 10 or more physician visits. Similarly, only a small group reported the practice of receiving medical advice by telephone with any frequency: seven people reported ten or more calls and 25 people reported five or more; fully 513 of the respondents had made no physician telephone calls. The average length of time since last physical examination was

13.3 months; about 70% had made one during the previous 12 months and 86% within the previous 24 months. This average was also somewhat skewed by extremes; 84 of these respondents hadn't had a physical examination within the past five years, and 52 of them within the previous eight years.

Only 19% of these respondents had been hospitalized during the previous year, which compares very favorably with the national annual hospitalization rate of older persons (336.5/1000) during the most recent year statistics are available (National Center for Health Statistics, 1994). Of the 133 who had been hospitalized, 94 were in the hospital once, 30 twice, six individuals three times, and three people had been in the hospital four or more times. The mean length of stay of those who had been hospitalized was 6.9 days; this compares to the national mean length of stay for those 65+ of 8.2 days. Within the Nebraska sample, the median length of stay was four days; 24 people (18.0% of those who had been hospitalized at least once during the previous twelve months) had been hospitalized for ten days or longer.

Asked how many times illness or injury had kept them in bed for more than half a day, 509 respondents (72.7%) said "none," and 88 (12.6%) said one day. Only 42 of the entire sample had been in bed for two days or more because of injury or illness; however, eleven of these subjects had been bedfast for more than 25 days during the previous year.

Illness and conditions reported ranged the gamut of chronic health care problems of the elderly in general; the most frequent conditions named included hypertension, diabetes, heart trouble, and arthritis.

To summarize these health care data, then, a pattern emerges of about eight or nine percent of the elderly in the Nebraska sample reporting poor or very poor health and a little over nine percent who have seen their physician ten or more times during the past year. About five and a half percent of the total sample had been hospitalized twice or more in a year. Fully 93% of these respondents had seen a physician at least once during the previous year, although there were 48 individuals who'd not seen a doctor within two years; 18 of these had not seen a doctor in the previous eight years. Slightly over 16% of the respondents had utilized a hospital emergency room during the previous year and 19% had been hospital patients at least once during the year.

In addition to these data on personal health status, survey participants were asked a series of questions on other health matters, dental care, prescription drug use, and health habits.

Perceptions of stress were probed, and 67 people (9.6%) felt that their everyday life was very stressful; by contrast, 306 (43.7%) felt that their lives were "not very stressful." Most (75.0%) felt that stress in their lives has remained about the same over the course of the past year, while 117 (16.7%) thought it had increased and 58 (8.3%) thought it had decreased.

A total of 104 out of the 700 (14.9%) were smokers, the average consumption being 16 cigarettes a day. Only 143 (20.4%) reported that they consume alcoholic beverages at all, and only 23 of these people said yes to the question, "During the past year, were there any five days when

you consumed five or more alcoholic beverages?"

About 69% had seen a dentist within the past year and 82% within the previous two years. There were 132 (18.9%) respondents, however, who had not been to a dentist in the previous eight years. These data are consistent with our previous study (Thorson & Powell, 1991). About two-thirds still had their natural teeth.

Their average number of prescription medications was 2.3, with a range of from zero (166 respondents) to 15; the median was two. There were only 26 individuals out of the 700 in the sample who were taking eight or more prescription medications. The average monthly cost of drugs was less than $100 for 74% of these people, although 15.1% were spending $200 or more per month for prescription medications. The number of prescriptions taken has increased for 131 of these individuals during the previous year.

Functional Ability

In the field of gerontology it is common to assess health by looking at functional ability, as many older people will say that they feel all right as long as they can do things for themselves. Functional ability implies being able to accomplish activities of daily living (ADLs). These ADLs generally break down into basic, advanced, and household dimensions (and are sometimes categorized as ADLs and IADLs -- instrumental activities of daily living); it has been demonstrated that there is a relationship between cognitive impairment and inability to perform activities of daily living (Fitzgerald, Smith, Martin, Freedman &

Wolinsky, 1993). Inability to perform three of five common ADLs is often used as a criterion for denial of nursing home insurance. ADLs include bathing, dressing, eating, getting in or out of beds and chairs, mobility, using the toilet, and continence. IADLs include preparing meals, shopping, managing money, using the telephone, doing light housework, and getting outside. As a general rule, inability to accomplish or difficulty accomplishing activities of daily living goes up with age; it is also inversely related to income. About 22% of this sample (153 respondents) indicated that they had some limitation in at least one of these activities, which is comparable to rates of ADL and IADL limitations nationally for older adults (Taeuber, 1992).

Participants were also asked if there is another person aged 60 or over who resides in their household; half (350) said yes. Almost all were spouses, either wives (172) or husbands (167), with a small smattering of others (two daughters, two not specified, two other kin, five non-related). The average age of this other person aged 60 or older was 70.7 years (SD = 6.7), with a range of from 54 to 91 years of age. Respondents were asked to rate this other individual's health; for 29 of them (8.3% of the 350) it was rated as poor or very poor. Seventy-one were rated as fair, 190 good, and 60 as excellent.

They were also asked if that individual's activities are limited for any reason, and in 77 cases (22.0%) the answer was in the affirmative. The interviewees were then asked to go through the list of ADLs and IADLs and indicate if this other person in their household had any functional

disabilities. Table 3 describes responses from the Nebraska sample to ADL and IADL items in terms of percentages for the 700 individuals who were interviewed ("self") and the 350 other individuals residing in their households ("dependent").

Table 3. Functional Ability, (percentages)

Item	Need some assistance		Can't do at all	
	Self	Dependent	Self	Dependent
Can you take a bath or shower?	2.1%	0.8%	0.7%	0.0%
Can you dress and undress yourself?	0.7	1.1	0.4	0.3
Can you eat?	0.1	0.1	0.0	0.0
Can you get in and out of bed?	0.4	0.6	0.1	0.0
Can you walk?	6.4	2.0	0.9	0.3

Table 3, continued	Need some assistance		Can't do at all	
Item	Self	Dependent	Self	Dependent
Do you ever have trouble getting to the bathroom?	3.4	1.4	0.1	0.0
Can you prepare your own meals?	2.1	1.7	0.7	2.6
Can you go shopping?	6.4	4.3	2.1	2.6
Can you handle your own money?	0.5	2.0	0.3	0.6
Can you use the phone?	0.1	0.0	0.0	0.0
Can you do your own housework?	8.7	4.3	2.4	2.6
Can you get to places out of walking distance of your home?	8.4	6.3	1.7	2.0
Can you take your own medications?	0.0	1.4	0.1	0.9

It is clear, then, that item analysis is necessary to determine degree and type of disability; that is, simply reporting a percentage of people "limited in activities of daily living" does not give enough information. It should be noted that this is an independent, noninstitutionalized sample, and these data in effect report information on 700 randomly selected respondents and, through them, an additional 350 older Nebraskans. (The methodology of the survey also must be taken into account: obviously, a telephone survey questions only those able to use the phone.) That notwithstanding, these respondents and their dependents actually are remarkably disability-free and are able to maintain their independence with just a little help. Out of the total 1,050 individuals (700 respondents plus 350 dependents), only four cannot handle their own money and four can't do it at all. Four in total can't manage their own medications, and five others need some help. Only three individuals need help eating. Areas where help is needed most are doing housework and getting places out of walking distance from home, such as shopping. It might be concluded that planning for services, then, should (and does) focus on these most frequently needed areas. It is evident that most of these individuals need no services whatsoever, but that those that do can continue to get along at home with comparatively minor levels of assistance.

Another perspective on these data on functional ability, however, might take the point of view that there are certain key ADLs that predict institutionalization. That is, because hardly anyone in the sample or their dependents is not able to eat, perhaps the inability to feed oneself is

a sign that independent living is no longer tenable. Getting in or out of bed, or being able to get to the bathroom, might be similar. That is, these may be particular abilities without which independent living might not be possible. The argument would be that, since these are people who are not institutionalized in later life, and since almost all of these individuals can accomplish these few activities of daily living, perhaps the ones who can't do them have had to go into long-term care facilities. The people surveyed can do these things; the ones who cannot are already in nursing homes.

In actuality two of the people who cannot eat by themselves are being fed by their wives and the remaining one by a daughter. A daughter, wife, or husband is listed as the individual providing help in the other areas specified when it is needed. The cutting point comes when a spouse or adult child is not available to provide this needed help. Most services are provided by family members, and most people without family are especially vulnerable, ultimately, to institutionalization (Brody, Litvin, Albert, & Hoffman, 1994).

Caregiver burden is an issue that has been discussed in the gerontological literature for some years (Zarit, Reever, & Bach-Peterson, 1980). Respondents who indicated that another person was present in the household were asked to, "classify the care this person receives as a heavy burden, a burden, or not a burden to you personally?" Only three indicated "a heavy burden," and nine "a burden."

Although only a few individuals indicated that care of another was

burdensome, there were some important differences for these people on other measures. Understandably, they scored much higher on the assessment of dependents' activities of daily living, with an impairment score of 5.40 versus a score of only 0.39 among those who felt no burden; this was highly significant statistically (t = 8.79, p < .0001). They were much lower on a scale of social support that is described in greater detail below (82.17 vs. 92.79; the mean for the entire group was 87.41, $\underline{SD}$ = 15.92); this again was statistically significant (t = 3.45, p < .001). And, those who reported that care was a burden also scored significantly higher on a measure of depression (8.08 vs. 4.67; t = 2.47, p = .014). This is consistent with other research on depression among caregivers of impaired elderly people (Tennstedt, Carrerata, & Sullivan, 1992). These are people caring for someone else highly impaired in functional ability, they have little help from within a social network, and they are more likely to be depressed.

The data on burden overall can be interpreted in two ways. Either the respondents are, for the most part, able and willing to do their duty without complaint and help where help is needed (and the socially-desirable response would be to say that relative care is not really a burden, that it's something that is done gladly). Or, the point where care for another becomes a real burden might also be seen as the point where caretakers turn to institutional care for help. The accepted argument in the literature is that families typically go to the ends of their ability and beyond to help their older members -- and that service agencies should make assisting such families their service priority (Brody, 1985). One must, however, wonder

what happens to individuals who are without family helpers. Again, perhaps the reason that they are not in this sample is that they are already institutionalized. What can be concluded from these data at this point is that about eight percent or fewer of the respondents or their dependents are genuinely vulnerable, though 22% are listed as having some impairment in accomplishing activities of daily living. About 3% are in real trouble: they're caring for a highly dependent older person and they need help.

Health Care Satisfaction

The questions in the interviews at this point turned to how satisfied people were with the health care they received, and, like those in our 1991 study, respondents were overwhelmingly positive in this regard. Asked, "Are you satisfied with health care in your area?" 44.1% said they were satisfied and 50.0% said they were very satisfied. Even higher percentages were satisfied or very satisfied with their dentist, physician, and with hospital services in their area, including emergency room services. They were then asked if they had any health care needs in the previous year that had gone unmet; six (0.9%) said yes. These conditions were specified as: arthritis (2) and "early release," "overweight," "flu," and "teeth," (one each). The reasons given for lack of care in these instances included cost (5), transportation (1), and a personal disagreement (1). Asked if any member of their family needed health care and were unable to obtain it, 14 individuals were identified. Most of these were comparatively minor problems, although one who had apparently died of a heart attack in an emergency room was listed

among those needing health care and not receiving it. The most frequent reason (7) was cost.

Social Support

We have reviewed the voluminous literature on social support of the elderly elsewhere (Thorson, 1995). Briefly, a series of classic studies in the epidemiological literature indicate that social ties are significant predictors of lower mortality risk (viz. Berkman & Syme, 1979; Seeman, Kaplan, Knudsen, Cohen & Guralnik, 1987; Hanson, Isacsson, Janzon, & Lindell, 1989; Colantonio, Kasl, Ostfeld, & Berkman, 1993). In particular, those who have at least one confidant seem to be much better off in later life, especially in terms of morale and mental health. Having someone in whom to confide seemingly acts as a buffer against the forces of isolation (Lowenthal & Haven, 1968). We sought to assess these respondents' level of social support, including the presence of a confidant.

Participants were asked to respond to the Medical Outcomes Study (Sherbourne & Stewart, 1991), a 20-item inventory of social support, indicating: 1) none of the time, 2) a little of the time, 3) some of the time, 4) most of the time, or 5) all of the time, to the question, "How often is each of the following kinds of support available to you if you need it?" Responses to the respective items, expressed in percentages, are found on Table 4.

Table 4. Items on Social Support (percentage responses)

	None	Little	Some	Most	All
Someone to help you if you were confined to bed...	6.9	5.1	17.9	23.1	47.0
Someone you can count on to listen to you when you need to talk...	2.3	2.0	8.1	25.6	62.0
Someone to give you good advice about a crisis...	3.3	3.6	10.7	26.0	56.4
Someone to take you to the doctor if you need it...	1.7	0.6	5.3	17.1	75.3
Someone who shows you love and affection	1.9	2.4	3.4	17.4	74.7
Someone to have a good time with...	4.1	2.9	5.6	21.0	66.4
Someone to give you information to help you understand a situation...	2.7	2.3	8.6	24.3	62.1
Someone to confide in or talk to about yourself or your problems...	3.1	2.4	7.7	21.3	65.4
Someone who hugs you...	4.1	4.3	7.1	18.4	66.0
Someone to get together with for relaxation...	3.4	2.4	9.6	22.3	62.3
Someone to prepare your meals if your were unable to do it yourself...	6.3	4.0	8.7	20.3	60.7
Someone whose advice you really want...	4.4	3.4	11.0	22.4	58.7
Someone to do things with to help you get your mind off things...	5.0	3.3	8.6	23.4	59.7

Table 4, continued

	None	Little	Some	Most	All
Someone to help with daily chores if you were sick...	5.7	3.1	10.4	19.0	61.7
Someone to share your most private worries and fears with...	5.0	3.6	9.1	20.7	61.6
Someone to turn to for suggestions about how to deal with a personal problem...	3.9	3.4	9.4	21.7	61.6
Someone to do something enjoyable with...	3.9	2.7	6.6	22.3	64.6
Someone who understands your problems...	3.3	2.4	8.6	22.1	63.6
Someone to love and make you feel wanted...	3.1	2.4	6.1	18.4	69.9
Someone who encourages you to take care of yourself...	7.0	2.1	4.4	18.0	68.4

Thus, there were five points possible on each item (all of the time), with a possible minimum response of 20 (none of the time on each of the twenty statements) and a possible maximum of 100. The actual range of responses from this sample was from 20 to 100 with a curve skewed far to the right: over half of the respondents had a score on the scale of social support of 94.0 or higher; 201 individuals (out of 700) had a score of 100. The mean was 87.4 (SD = 15.92), a statistic that was influenced by the extreme: about 4% of this sample scored below 50; however, the mode was 100. (The mean score in Sherbourne and Stewart's 1991 study of 2987 patients was 70.1). It is evident from these data that most older Nebraskans sampled enjoy high levels of social support, but that about 8% to 10% have very little.

The lack of physical intimacy was a particularly revealing factor. In response to the item "Someone who hugs you..." there were 29 respondents who indicated "none of the time" and 30 who said "a little of the time." Taking these 59 individuals and comparing them to the remaining 641, it was found that they had significantly poorer self-rated health, rated their lives as very stressful, had lower levels of health care satisfaction, much higher depression, lower scores on a measure of interpersonal interaction, and lower scores on a measure of social activity. Similarly, the lack of emotional intimacy is a critical factor; 16 of these individuals responded "none of the time" to the item, "Someone you can count on to listen to you when you need to talk," and 14 responded, "a little of the time." Thus, about four and a half percent of the respondents from this sample lacked a confidant. Similar percentages selected "none" or "a little" to the item: "someone who shows you love and affection."

Fear of Crime and Risk of Crime

Participants were asked to respond to two scales that dealt with an important social issue that is much in the headlines: their fear of crime and their perceived risk of being a crime victim. First was a scale of ten items on fear of crime; interviewees were read the following statement: "At one time or another, most of us have experienced fear about becoming a victim of crime. Some crime probably frightens you more than others. We are interested in how afraid people are in everyday life of being a victim of different kinds of crime. I am going to read you a set of items -- please tell me if you are not

fearful, have no feeling, are somewhat fearful, very fearful, or extremely

fearful of this criminal act."

Table 5. Fear of Crime (percentages)

Act	No Fear	No Feeling	Some Fear	Very Fearful	Extreme Fear
Being approached on the street by a beggar or panhandler.	58.7	5.7	31.1	3.1	1.3
Fear of being cheated, conned, or swindled out of money.	65.0	7.1	21.9	5.4	0.6
Having someone break into your home while you are away.	41.6	5.1	41.3	10.1	1.9
Having someone break into your home while you are there.	55.3	6.0	27.3	9.0	2.4
Being raped or sexually assaulted.	72.3	5.4	14.7	5.3	2.3
Being murdered.	71.6	7.3	14.6	3.9	2.7
Being attacked by someone with a weapon.	58.3	7.1	24.6	7.4	2.6
Having your car stolen. (3.6% had no car)	51.6	6.6	27.6	8.9	1.9
Being robbed or mugged on the street.	57.7	7.3	25.1	8.4	1.4
Having your property damaged by vandals.	47.7	6.0	34.7	8.7	2.4

Next, respondents were asked these and three additional questions in a
different context, seeking to see if their fear of crime and their actual
perceived risk of crime were different. "Let's shift directions slightly and
talk about risk of crime. I will read you a list of statements; please tell me
if this event is very unlikely, it's unlikely, neutral, it's likely, or it's
very likely to happen."

Table 6. Perceived Risk of Crime (percentages)

Event	Very Unlikely	It's Unlikely	Neutral	It's Likely	Very Likely
Being approached on the street by a beggar or panhandler.	38.9	35.3	3.9	19.7	2.3
Being cheated, conned, or swindled out of money.	38.0	41.0	3.1	15.9	2.0
Having someone attempt to break into you home while you are away.	22.1	29.4	6.3	37.0	5.1
Having someone break into your home while you are there.	29.3	40.6	5.0	23.3	1.9
Being raped or sexually assaulted.	43.0	37.4	4.6	13.1	1.9
Being murdered.	43.1	37.6	5.0	13.0	1.3
Being attacked by someone with a weapon.	36.0	36.6	5.0	20.7	1.7
Having your car stolen.	26.9	28.0	5.3	30.6	5.7

(Table 6, continued)

	Very Unlikely	It's Unlikely	Neutral	It's Likely	Very Likely
Being robbed or mugged on the street.	32.1	36.3	4.6	25.0	2.0
Having your property damaged by vandals.	21.7	30.9	4.3	37.3	5.9

	Very Safe	Somewhat Safe		Somewhat Unsafe	Very Unsafe
How safe do you feel when you are out alone in your neighborhood during the day?	80.6	15.3		2.1	1.3
How safe do you feel out alone in your neighborhood at night?	35.0	29.0		22.3	12.9

	Yes	No
Is there any area within a mile of your home where you would be afraid to walk alone at night?	54.4	44.9

About a quarter to a half of the sample, then, has some fear of crime, depending on the category: being cheated or conned out of money held the lowest level of fear, while home burglary while away from the home held the highest. When asked to change perspectives and assess actual risk of these things happening, property damage by vandals and home burglary were the two most frequent categories selected, with a little over 42% saying that this was either likely or very likely to happen.

According to the U.S. Department of Justice's National Crime Victimization Survey (1994), older individuals are by far the least likely people to be crime victims in American society. For example, the victimization rate for those aged 65+ for violent crimes is 4.0 per 1,000; this can be compared to a rate of 64.6 per thousand for those aged 12 to 24. Similarly, their rate of victimization for the category "personal theft" is 19.5 per thousand, compared to a rate almost six times higher (112.7) for those in the youngest adult age category. For household crime, the rate per thousand for those 65+ is 78.5; by comparison it is 309.3 for those aged 12 to 24. Crime victimization goes down with age in a linear fashion in all crime categories. Among the elderly, those most likely to be victims of crime are males, the "young" old (those 65 to 74), African Americans, persons with lower family income, those who are divorced, and those who live in urban areas.

A theme in the literature is that while old people are the least likely to be crime victims, the high levels of fear of crime held by the aged is in itself a type of victimization (Webb & Marshall, 1989). And, it has been found that those among the elderly who are most likely to be actual victims of crime fear it most (Janson & Ryder, 1983).

We divided the sample into two groups: those who scored in the top 20% on the Fear of Crime items (those items included in Table 5) and everyone else. Similarly, we took the 20% highest in Risk of Crime (the items in Table 6) and compared them to everyone else. Those who had the highest fear of crime were: more likely to live in an urban area (t = 3.97, p < .001), more likely to be African American (t = 3.69, p < .001), more likely to be widowed or divorced

($\underline{t}$ = 2.47, p < .02), were likely to be somewhat younger (70.4 yrs. vs. 72.2 yrs.; $\underline{t}$ = 2.25, p < .03), were much more likely to be female ($\underline{t}$ = 6.33, p < .0001), scored lower on the measure of social support and thus were more likely to be socially isolated ($\underline{t}$ = 2.31, p < .02), and scored much higher on the scale that measures levels of depression (7.49 vs. 5.12; $\underline{t}$ = 4.97, p < .0001). The highest-scoring 20% in Fear of Crime were not statistically different from others in the sample on health self-rating, number of people residing in the household, monthly family income, activities of daily living, or level of social activity.

The individuals who made up the top 20% in Risk of Crime had: a lower self-rating of health ($\underline{t}$ = 3.08, p < .002), fewer people residing in their house-hold ($\underline{t}$ = 3.22, p < .001), were much more likely to live in an urban area ($\underline{t}$ = 7.32, p < .00001), were much more likely to be black ($\underline{t}$ = 7.43, p .00001), were more likely to be widowed or divorced ($\underline{t}$ = 2.65, p < .001), had a significantly lower monthly income ($1,462 vs. $1,840; $\underline{t}$ = 2.55, p < .01), were more likely to be female ($\underline{t}$ = 3.23, p < .0001), were more likely to have a functional disability ($\underline{t}$ = 2.33, p = .02), be lower in social support ($\underline{t}$ = 2.70, p < .007), and were higher in depression (7.75 vs. 5.07, $\underline{t}$ = 5.58, p < .0001). So, those highest in risk (those living in urban areas, those living alone, the subjects who were African American, and those with a lower income) were for the most part also those whose fears of crime were more realistic. Other variables associated with fear or risk included younger age, lower social support, higher levels of functional disability, and higher depression.

One must comment at this point, though, about the highly disproportionate

levels of fear and perceived risk in comparison to the actual likelihood of older subjects' victimization. Sixteen percent of these respondents said that it was likely or very likely that they would be murdered (it's very unlikely that any of them will in fact be murdered). Fifteen percent thought it was likely or very likely that they would be raped or sexual assaulted; 22% thought it was likely or very likely that they would be attacked by someone with a weapon. The actual odds of these things happening are in fact much lower. This would tend to confirm the concept that many older people live in fear of crime that is unlikely to happen. On the other hand, over 95% said they feel safe being out in their neighborhood during the day. Careful analysis of the data in Tables 5 and 6 gives an assessment of just which crimes older people fear most.

Depression

Depression is a common condition in later life, one that might be expected to go hand-in-hand with isolation or other social problems as well as with disability and physical illness. In order to screen for depression in the present sample participants were asked to respond to items from the Center for Epidemiological Studies Depression scale (CES-D), a 20-item inventory that has been used frequently in studies of community populations (Radloff & Teri, 1986). It has been shown to be appropriate for studies among older samples (Davidson, Feldman, & Crawford, 1994; Williamson & Schulz, 1992a and 1992b), and be at least as sensitive and reliable as the Beck Depression Inventory

(Zich, Attkisson, & Greenfield, 1990). It measures several concepts related to depression: depressed affect, somatic disturbance, interpersonal problems, positive affect, and self worth (Thorson & Powell, 1993). The CES-D is scored with 0 = none or a little of the time up to 3 = most or all of the time; thus the possible score on the 20-items is from zero (not at all depressed) up to 60 (severely depressed).

The actual range of CES-D scores for this sample was from zero (90 out of the 700 subjects) up to 30, with a mean score of 5.64 and a standard deviation of 5.30. This compares to a mean of about 8 or 9 in most of the samples reported by Radloff and Teri (1986). Radloff suggests a cutoff of a score of 16 or above as indicating "depressed." By this criterion the Nebraska sample had 39 individuals (5.6%) who could be considered to be depressed. In 1993, Thorson and Powell reported CES-D data on a random sample of 400 adults in Omaha (201 women and 199 men), ranging in age from 18 to 86 years of age. Their CES-D scores were from zero to 45, with a mean of 6.78 ($\underline{SD}$ = 7.68). Using a $\underline{t}$ test to assess the significance of the difference between means, the current sample of older people scored slightly, but significantly, lower in depression in comparison to the 1993 Omaha sample ($\underline{t}$ = 2.89, p < .01). (Both samples were significantly lower than a comparison population of 2,440 younger adults (CES-D mean = 8.97, $\underline{SD}$ = 8.50) reported by Radloff in 1991.) The difference between the 1993 Omaha sample of 400 and the 1994 Nebraska sample of 700 in the present study might have been influenced by a methodological factor: the 400 people aged 18 to 86 did the CES-D as a paper-and-pencil test; the 700 older people in the present study completed it by telephone interview. There

may have been a tendency to give more socially-desirable responses in a verbal interview.

This, however, does not entirely explain the remarkable lack of depression found in the present sample. For the most part, these individuals scored exceptionally low (not depressed) on the CES-D: 52.7% achieved a score of 4.0 or lower, and 90.4% scored 12 or lower.

There were some slight differences within groups. Comparing the 136 rural subjects (those who live on a farm or ranch or in a community that is smaller than 2500) to the 564 "urban" (those who live in a town or city of 2500 or larger), there was no significant difference in CES-D mean (5.24 vs. 5.73, respectively) by t test. Only a very slight, significant, correlation was achieved between CES-D score and size of community: r = .10, p < .01, indicating somewhat higher depression in urban areas. This, however, may have been compounded by the factor of race, which is probably the more important variable. Virtually all of the African Americans in the present sample are urban dwellers. The 110 individuals of a minority race had a CES-D mean of 7.37 (SD = 5.99), which was significantly higher than the mean of 5.31 (SD = 5.10) achieved by the 590 whites in the sample (t = 3.78, p < .0001).

Those who live alone (N = 280) also had higher depression scores than did the 373 persons who indicated that they live in a two-person household. The CES-D mean for those who live alone was 6.55 (SD = 5.63), compared to the others' 5.01 (SD = 4.82). This was significant at the .0001 level (t = 3.77).

An analysis of variance indicated that CES-D score increased by age (F = 9.64, p < .0001); this was also confirmed by other statistical tests. The correlation between CES-D score and age was .16 (p < .01). And, the oldest

people in the sample, the 112 individuals aged 80 to 98, had a mean score of 7.04 ($\underline{SD}$ = 5.86), compared to the youngest cohort, those 148 individuals aged 60 to 65, whose CES-D mean was 4.65 ($\underline{SD}$ = 4.98).

In addition to race, age, and living alone, other correlates of higher depression were: education ($\underline{r}$ = -.11, p < .01), depression goes down as years of education go up; marital status -- widowed and divorced people were higher in depression ($\underline{r}$ = .14, p < .01); gender -- women were higher in depression ($\underline{r}$ = -.13, p < .01); and, especially, income ($\underline{r}$ = .26, p < .001), depression goes down as income goes up (and vice versa).

Overall, then, we could say that based on this measurement there are five or six percent of the people in this study who meet at least one criterion for depression. They are more likely to be black urban dwellers, older, living alone, of lower educational level, widowed or divorced, women, and of lower income.

Interpersonal Dynamics

Respondents were asked to agree or disagree with eight statements that had to do with interpersonal relationships:

1. There are people who depend on me for help.
2. Other people do not view me as competent.
3. I feel personally responsible for the well-being of another person.
4. I do not think other people respect my skills and abilities.
5. I have relationships where my competence and skills are recognized.

6. There is no one who really relies on me for their well-being.

7. There are people who admire my talents and abilities.

8. No one needs me to care for them.

These items make up a scale designed to assess whether or not the individual feels needed as well as the concept of self-esteem. Items were scored on a four-point system going from 0 = strongly disagree to 3 = strongly agree, with the negatively-phrased items reversed in scoring. Thus it was possible to score within a range of zero to 24. The actual range of scores in the present sample was from 5 to 24, with a mean of 15.81 and a standard deviation of 2.99; the median and mode were both 16.0. Higher scores indicate that the individual has a greater sense of personal competence, being needed, sense of being responsible for the well-being of others, and self-respect. Feeling needed and respected are vital components of morale and self-esteem. Scores on this scale of interpersonal dynamics related significantly with a number of other variables, as can be seen on Table 7, which is found on the following page.

Taking the variables in the order listed, it can be seen that those higher in this measure of interpersonal dynamics tended to have more years of education, more people residing in the household, did not differ by rural vs. urban location of dwelling, tended to be white (blacks scored lower on this measure: a mean of 14.95 for blacks compared to 15.96 for whites [t = 3.24], a difference that was significant at the .001 level); were more likely to be married (widowed and divorced people scored lower on this measure);

Table 7. Correlations of variables with a measure of Interpersonal Dynamics

<u>Variable</u>	<u>r</u>	<u>p</u>
Education	.19	.001
Number in household	.31	.001
Rural/urban	.02	N.S.
Race	-.11	.01
Marital status	-.27	.001
Age	-.25	.001
Income (first query)	.16	.01
Income (second query)	.24	.001
Gender	.13	.01
ADL	-.16	.001
Health satisfaction	.11	.01
Social support	.33	.001
Fear of crime	.05	N.S.
Risk of crime	.09	.05
Depression	-.22	.001
Activity	.01	N.S.

were younger (interpersonal dynamics scores went down as age of respondent went up); had a higher income on both questions dealing with family income; were more likely to be male (females scored lower); and were less likely to have an ADL functional impairment. Those higher in interpersonal dynamics were also slightly, but significantly, higher in health satisfaction, were much higher in the measure of social support, did not differ on fear of crime, but reported a slightly higher estimate of their risk of crime. They were less likely to be depressed, and did not differ on the measure of activities that will be discussed in the next section of this report. In terms of item analysis, about a third of the respondents said that "no one needs me to care for them," or "there is no one who really relies on me for their well-being," or disagreed with the item, "I feel personally responsible for the well-being of another person." Only about three or four percent indicated that, "Other people do not view me as competent," or disagreed with the statement, "There are people who admire my talents and abilities."

Individual Activity

The final battery of items dealt with types of activities and interpersonal contacts characteristic of the respondents. These items did not make up a scale per se and results will not be reported as a scale; rather, the individual items were of some interest. Each item is reported below, along with percentage responses in several cases and a brief interpretation of the results:

1. "How many organizations and clubs are you a member of, including church
organizations?"

Responses to this item ranged from zero (16.6% of subjects) to 13, with a
mean of 2.5 (SD = 2.1). Over 83% belong to one or more clubs or organizations;
about 8% belong to five or more.

2. "Of that total, how many are church organizations?"

These responses ranged from zero (28.7% of respondents) to five, with a
mean of slightly less than 1. A little over 70% of them belong to one or more
church organizations.

3. "During a normal week, how many club, organizational or other meetings do
you attend?"

The range was from zero (49.6%) up to 20, with a mean of .89 (SD = 1.43).
About half of these individuals attend at least one meeting a week.

4. "How many church meetings or services will you attend?"

This ranged from none (28.3%) up to 21, with a mean of 1.1 and a standard
deviation of 1.7. About 72% reported one or more meetings per week.

5. "During a normal week, how many times do you telephone friends?"

This ranged from zero (10.7%) all the way up to a reported 95 weekly calls
to friends; the mean number was 5.0 (SD = 6.8) and the median was 3.0.

6. "How about friends who telephone you?"

This ranged from none for 7.4% of the respondents up to 95, with a mean of
5.2 and a standard deviation of 6.1; the median number of calls from friends
was 4.0 per week.

7. "Number of times you telephoned family members?"

The range of responses to this question were from zero (9.9% so indicating) up to 40 per week; the mean was 4.0 ($\underline{SD}$ = 4.2) and the median 3.0.

8. "Number of times family members telephoned you?"

This ranged from none for 7.1% of these subjects up to an estimated 84 calls per week on the part of one individual. The mean was 4.6 with a standard deviation of 6.2; the median number of calls per week from a family member was 3.0.

9. "Number of times friends visit you?"

The range was from none for 34.0% percent of the people up to an estimated 30 per week; the mean was 1.7 ($\underline{SD}$ = 2.5) and the median was 1.0.

10. "Number of times you visit friends?"

This ranged from zero for 39.3% of the individuals up to 40 for one person; the mean was 1.6 with a standard deviation of 2.7; the median was 1.0.

11. "Number of times family members visit you?"

The weekly number of visits from one or more family members ranged from none at all for 28.6% of these people up to an estimated 97 for one busy person. The mean was 2.3 ($\underline{SD}$ = 2.8) with a median of 1.0. Basically, we could say that over 70% of respondents were visited by a family member in the previous week.

12. "Number of times you visit family members?"

This was somewhat lower than visits from family: the range was from no visits per week to family members for 40.4% of the subjects up to 20, with a mean of 1.6 and a standard deviation for this item of 2.1; the median number of visits was 1.0.

13. "Number of times you go shopping?"

This ranged from zero for 13.7% of the sample up to 22 times for one person the mean was 1.9 shopping trips per week (SD = 1.9) and the median 1.0.

14. "Number of times you participate in a recreation activity, such as playing

cards, going to movies, and those kind of activities?"

The range for this item was from none for over half of the sample (51.4%) up to 14 times per week for one individual. The mean was 1.1 (SD = 1.8); both the median and mode were zero.

15. "Number of times you go out to eat in a normal week?"

The range here was from none for 30.3% of the individuals up to a total of 14 in one case; the mean and standard deviation were 1.5 and 1.6, respectively, and the median was 1.0.

16. "Went walking?"

Weekly events of walking ranged from none for 42.1% of the sample up to a high of 21; the mean was 2.6 (SD = 3.0) and the median 1.0.

17. "Number of hours you watch television during the week?"

The weekly hours of television viewing ranged from none at all for just eight people (1.1% of the sample) on up to a whopping 97 hours per week for one respondent. The mean for this question was 22.5 hours (SD = 14.9) and the median and mode were both 21.0.

18. "During a normal week how many hours do you spend reading?"

Reading ranged from no hours per week for 153 out of this sample of 700 (21.9%) to 97 hours per week for one person. The mean number of hours per week spent reading was 12.7 with a standard deviation of 10.4 hours; the median

was 10.0 hours.

19. "How many hours do you spend listening to the radio?"

This ranged from none at all for 153 of the people (21.9%) on up to a total of 96 for one person; the mean was 11.7 hours with a standard deviation of 15.6; the median number of hours was 7.0.

To summarize this section, then, there were items that included contacts with family and friends as well as organizational and church memberships and recreational activities. It is evident that over four out of five people surveyed belong to at least one organization; over half attend at least one meeting per week. Slightly over 70% belong to a church organization and attend church or a church organization meeting each week.

Over ten percent do not call a friend during an average week and about seven percent do not receive a call from a friend. Similarly, about ten percent do not call a family member and slightly over seven percent don't receive a phone call from a family member on a weekly basis.

About a third do not receive a visit from friends and about 40% do not visit friends during an average week. Four of ten do not visit a family member and 28% do not receive a visit from a family member on a weekly basis.

One in seven does not go shopping (compare this to the ADL item indicating that 60 of these people cannot go shopping without help). About half do not participate in recreational activities such as playing cards or going to movies. Three of ten do not go out to eat, and four out of ten do not go out for a walk at least once a week.

Table 8. Intercorrelations of Variables*

Variable	ADL	SAT	Support	FCrime	RCrime	CES-D	Intp.
Age	.13	.03	-.12	-.12	.04	.16	-.25
Race	.06	-.14	-.16	.17	.28	.12	-.11
Gender	-.04	.03	.13	-.23	-.11	-.13	.13
Income	-.13	.20	.23	-.04	.08	-.25	.24
Education	-.08	.07	.06	.00	-.06	-.11	.19
#Household	.00	.06	.25	-.03	-.09	-.12	.31
Marital Status	.07	-.03	-.21	.06	.09	.14	-.27
Rural/Urban	-.08	-.05	.09	.00	-.01	-.08	.02
ADL		-.06	-.12	.00	.02	.25	-.16
SAT			.26	-.14	-.16	-.23	.11
Support				-.10	-.10	-.33	.33
Fear of Crime					.60	.20	.05
Risk of Crime						.18	-.09
CES-Depression							-.22

*Correlations of .08 and .09 are significant at the .05 level

Correlations of .10 or greater are significant at the .01 level

depression. And, "Intp." stands for the Interpersonal Dynamics items discussed above and in part replicates data shown in Table 7.

The demographic items were scored this way: age in number of years, race coded as white = 0, African American = 1, Hispanic/Latino = 2, and other = 3 (recall that there were 590 whites in this sample, 107 blacks, and only 3 of other races; essentially what we have here is a black/white comparison); so, higher scores on this variable indicate greater likelihood of being African-American. Gender was coded as 0 = female and 1 = male, so as the score on this variable goes up so does the likelihood of being male. Income used the second query on monthly family income, where a greater response rate was achieved by reading dollar categories and letting the respondent pick the appropriate one. Education was expressed in a linear fashion: 0 = less than 4 years of high school, 1 = completed 4 years of high school, 2 = 1 to 3 years of college, and 4 = four or more years of college.

#Household simply represented the number of people living in the respondent's household. Marital status was coded as 0 = single, 1 = married living with spouse, 2 = widow/widower, and 3 = divorced. There were only 29 single individuals (4.1% of the sample) and 30 divorced ones (4.3%). So, the principal comparison here is between the 386 married persons and the 253 widowed ones; as score went up, so did the likelihood of being widowed or divorced.

Urban/rural differentiates those living on a farm or ranch or in a community of less than 2500 (the Bureau of the Census definition of "rural") from those living in towns or cities of greater than 2500.

It should be noted when reading Table 8 that any coefficient of .08 or greater is statistically significant with a sample this of this size. Coefficients of .08 or .09 are significant at the .05 level (they might have been found by chance 5 out of 100 times), and those of .10 or greater are significant at the .01 level; they might be found by chance only one time out of a hundred.

Keeping that in mind, taking the first row of numbers across the top of Table 8: age correlates positively and significantly with ADL -- that is, as age goes up, score on the ADL measure also goes up (higher ADL score means greater functional disability). There was no difference by age in health satisfaction. Social support had a negative correlation that was significant: as age of the respondent went up, the score on the support scale went down. As we have already stated in the Fear of Crime section above, fear of crime goes down with increasing age; there was no significance difference by age in perceived risk of crime. Depression was significantly higher the older the respondent was, and the interpersonal dynamics score was significantly lower as age increased.

Race and ADL did not correlate at a significant level. African Americans were lower in health satisfaction and social support, and they were higher in fear of crime and much higher in perceived risk of crime. They were also higher in depression as measured by the CES-D, but they were lower on the interpersonal dynamics scale.

Males and females did not differ in ADL or health satisfaction scores. Males were higher in social support. This is an interesting finding, as the literature generally says that women maintain a more intact social network.

However, these items had to do with the availability of helpers and confidants (viz., "Someone who hugs you," or "Someone to give you advice"). It is evident that males are less likely to have experienced the death of a spouse, and they are thus more likely to have the supports indicated in this particular scale. Men were lower than women in fear of crime and risk of crime; they were also lower in depression, a finding that is consistent with other studies using the CES-D. Women were higher than men in interpersonal dynamics (viz., "There are other people that depend on me for help").

People with more years of education were slightly less likely to have a functional disability as measured by the ADL items. There was no difference by education in health satisfaction, social support, fear of crime, or risk of crime. Those with more education were less likely to be depressed, and they were higher in the measure of interpersonal dynamics.

The number of people in one's household accounted for no difference in ADLs or health satisfaction, but there was an expected difference in social support. They were no different in fear of crime but slightly less likely to score high on risk of crime. They were less depressed, and they were much higher in interpersonal dynamics.

Marital status accounted for differences in only a few of the variables: widowed and divorced respondents were obviously lower in social support, a little higher in risk of crime, higher in depression, and much lower in interpersonal dynamics.

People living in urban areas were slightly, but significantly, more likely to have an ADL impairment; they also were a little higher in social support.

Interestingly, there were no urban/rural differences in fear of crime and perceived risk of crime. This requires further analysis, as the urban-dwelling blacks in this sample were much higher in both fear and risk of crime. Perhaps this seeming paradox in the data is a function of the Census definition of "urban:" residing in a community of 2,500 or greater. This sample had 136 rural people, 173 people living in a town of 2,500 to 100,000 in population, and 391 people who lived in a city of 100,000+. It's apparent that the mainly-white city and small-town dwellers have lower fear of crime than do the city-dwelling blacks (probably for good reason: the African-Americans are much more likely to be victimized, and they know it). It may be that their (the whites') numbers are such that they effectively cancel out the higher scores on fear of crime on the part of the African Americans when the responses are combined into one "urban" category. On the other hand, it's possible that the lack of overall urban/ rural differences can be explained by unrealistic fear of victimization on the part of the rural-dwelling respondents that inflates their overall score. These particular relationships will be analyzed further in a forthcoming article. The final urban/rural comparisons shown on Table 8 indicate slightly lower depression on the part of the urban dwellers and no difference in interpersonal dynamics score.

Those with greater ADL impairments were lower in social support and interpersonal dynamics, and they were significantly higher in depression. Those higher in health care satisfaction are much higher in social support; they're also lower in fear of crime, risk of crime, and depression. They tend to score slightly higher on interpersonal dynamics.

Individuals with greater fear of crime obviously also score much higher on their perceived risk of crime. And, those higher in fear of crime and risk of crime are more likely to be depressed. Finally, those higher in depression are lower in interpersonal dynamics.

Multiple Regression

It would seem that race is one of the very interesting variables in this data set. A multiple regression procedure was done holding race as the dependent variable and entering a number of the other variables into the equation. As can be seen in Table 9 on the next page, these predictor variables are listed in terms of their beta weight. An analysis of variance of this multiple regression procedure produced an F of 5.339 ($p < .0001$), indicating multicollinearity. For practical purposes, it might be said that the variables listed in Table 9 can be predicted by race, and that the strength of that prediction runs from greater to lesser in order on the list. Thus, the strongest relationships with race are higher perceived risk of crime, lower level of education, marital status (a greater likelihood of being widowed or divorced), lower income, higher fear of crime, gender (blacks in this sample were more likely to be female), lower self-rated health, age (blacks were older), higher satisfaction with health care in one's area, and lower score on the scale of interpersonal dynamics. About 21% of the variance in the items listed in Table 9 could be predicted by race.

Table 9. Multiple Regression with Race as the Dependent Variable

beta weight	Predictor variable
.2147	Risk of crime
-.1722	Education
.1699	Marital status
-.1004	Income
.0781	Fear of Crime
.0702	Gender
.0621	Self-rated health
.0534	Age
.0534	Are you satisfied with health care in your area?
-.0482	Interpersonal Dynamics
-.0258	Are you satisfied with your physician?
-.0256	ADL
-.0231	Are you satisfied with dental services in your area?
-.0179	Social Support
-.0178	Are you satisfied with hospital services?
.0091	Are you satisfied with emergency room services?
-.0057	Depression

ENOA Subsample

An additional analysis was done of respondents who resided in the five counties making up the Eastern Nebraska Office on Aging service district. There were 191 Caucasians and 107 African Americans within this geographic area who completed interviews. Comparisons were done on the basis of race.

There were no significant differences between blacks and whites in distance from health care provider (although the black respondents estimated higher travel time to their health care provider: 18.1 minutes vs. 13.9 minutes for the white subjects). Neither were there differences by race in number of physician visits, times hospitalized, use of emergency rooms, length of time since last physical examination, self-rated stress, or number of prescriptions. African Americans, however, gave a significantly higher estimate of the monthly cost of prescription medications: $360 vs. $148 for whites. There were no differences between white and black participants in the number of people residing in the household, the percentage of home ownership, impairments in activities of daily living, score on the social support scale, or in their level of social activity.

The reported difference in fear of crime (10.71 for whites and 12.51 for blacks) achieved a level of probability of .087, which is less than the common standard for statistical significance; that is, the mean fear of crime score for blacks was higher than it was for whites, but the difference could have been found by chance about nine in a hundred times. The expressed risk of crime was much higher (19.5 for blacks vs. 14.5 for whites), a difference that

was significant (t = 4.60, p < .001). And, the mean score on the Center for Epidemiological Studies Depression scale for the African American respondents (7.53, $\underline{SD}$ = 5.99) was higher than the 6.13 ($\underline{SD}$ = 5.34) achieved by white subjects (t = 2.08, p < .05). This may, however, have been a function of age, the blacks in the ENOA subsample being older than the whites (74.4 years vs. 71.9), a difference that was significant. Analysis of variance within this group confirmed a finding that was true in the larger sample: depression increased by age ($\underline{F}$ = 9.64, p < .00001). And, interpersonal dynamics went down with increasing age ($\underline{F}$ = 18.78, p < .00001).

Whites within the ENOA geographic district were higher in comparison to blacks in:

-- self-rated health (t = 2.78, p < .006);

-- consumption of alcoholic beverages (t = 5.02, p < .0001);

-- frequency of dental care (13.8 months since last dental visit, vs. 19.0 months for African American respondents);

-- years of education (t = 5.75, p < .0001);

-- married spouse in home rather than widowed or divorced (t = 3.84, p < .01);

-- income ($1842/mo vs. $928/mo) ($t$ = 4.28, p < .001); and,

-- health care satisfaction (t = 4.30, p < .0001).

Conclusion

A statewide random sample of 600 Nebraskans aged 60 and above, and an over-sampling of 100 people aged 60 and above from Omaha's North side, completed telephone interviews on social and health indicators. There were 421 women and 279 men in the total group; their ages ranged from 60 to 98 with a mean of 71.9 years. Slightly over 55% were married, living with a spouse; 4% were single; 4% were divorced; and 36% were widows or widowers. Their median monthly income was $1,500. Eighty-six percent live in a single family dwelling; 88% own their own home. Among the entire 700 people interviewed there were 590 whites and 107 blacks; three were of another racial or ethnic group. A little over 19% of these 700 individuals live in a rural area (on a farm or ranch or in a community of less than 2,500 people).

There were only a few, small differences between urban and rural respondents. Rural people tended to be slightly lower in functional ability and social support and slightly higher in depression.

As in other studies, increasing age was associated with lower levels of social support and interpersonal dynamics, and with higher levels of depression and ADL impairment. Interestingly, age was not associated with risk of crime, but it was with perceived risk of crime: the older the subject the lower the perceived risk of crime. Item analysis revealed a number of entirely unrealistic expectations associated with high fear and high perceived risk of crime. However, those with the greatest likelihood of crime victimization, the African Americans in this sample, also had the highest fear of crime as well as the highest perception of risk of crime.

More people in the present study reported excellent self-assessed health (17.7%) than was the case in at least one national study (11.7%). These people had a much lower annual rate of hospitalization (19%) than those aged 65+ nationally (33.6%), and they had shorter average hospital stays when they were hospitalized (6.9 days vs. 8.2 days) compared to national hospital discharge data. Only 42 of these 700 individuals had been bedfast for two or more days during the previous year. About 9% report that they are in poor or very poor health. Functional impairment rates were comparable to other epidemiological studies; about 8% of these people are physically vulnerable. However, stress was not seen as a major problem by most of these people.

Dental care, as was found in the 1991 study of 500 Nebraskans, was lacking in a meaningful number of older subjects; 19% of the current sample had not seen a dentist during the previous eight years.

About 3% of those who live with someone else find that providing care for that individual is a heavy burden; these are the individuals who need help and cannot always obtain it.

However, fully 94% of the people interviewed indicate that they are satisfied or very satisfied with the health care they receive, their access to hospital services, dental services, and emergency room services. Only six out of 700 reported having an unmet health care need.

These people scored exceptionally high on a measure of social support; about eight to ten per cent had little social support, and less than five per cent lacked a confidant. Most participate in and enjoy social and church activities. About 70% saw a family member the previous week and over 90% spoke

to one on the telephone. About seven to ten per cent had little family contact. By far the favorite activity of most of these people was watching television; the average was 22.5 hours of TV viewing per week.

These respondents were quite low on a measure of depression; only 5.6% met the criterion for being depressed. Those who were depressed were most likely to be low income, black, and older. These subjects had what might be interpreted to be highly unrealistic fears of crime.

Finally, race was a much more important predictor of disability, lack of social support, and vulnerability than was urban/rural status. In fact, the most consistent finding in this study was the lack of differences between people dwelling in rural and urban areas.

Those in the greatest need of services are the seven to ten percent who had the most functional disabilities, fewest contacts with family and friends, higher levels of depression, and, especially, lowest income.

References

Berkman, L.R., & Syme, S.L. (1979). Social networks, host resistance, and mortality: A nine-year follow-up of Alameda County residents. American Journal of Epidemiology, 109, 186-204.

Brody, E.M. (1985). Parent care as a normative family stress. The Gerontologist, 25, 19-29.

Brody, E.M., Litvin, S.J., Albert, S.M., & Hoffman, C.J. (1994). Marital status of daughters and patterns of parent care. Journal of Gerontology: Social Sciences, 49, S95-103.

Bureau of Justice Statistics. (1994, March). Elderly crime victims - National crime victimization survey. Washington, D.C.: U.S. Department of Justice (NCJ-147186).

Colantonio, A., Kasl, S.V., Ostfeld, A.M., & Berkman, L.F. (1993). Psychosocial predictors of stroke outcomes in an elderly population. Journal of Gerontology: Social Sciences, 48, S261-268.

Davidson, H., Feldman, P.H., & Crawford, S. (1994). Measuring depressive symptoms in the frail elderly. Journal of Gerontology: Psychological Sciences, 49, P159-164.

Fitzgerald, J.F., Smith, D.M., Martin, D.K., Freedman, J.A., & Wolinsky, F.D. (1993). Replication of the multidimensionality of activities of daily living. Journal of Gerontology: Social Sciences, 48, S28-31.

Graves, E.J. (1994, April 8). 1992 Summary: National Hospital Discharge Survey. Advance data from vital and health statistics; no. 249. Hyattsville, Maryland: National Center for Health Statistics.

Hanson, B.S., Isacsson, S-O., Janzon, L., & Lindell, S-E. (1989). Social network and social support influence mortality in elderly men. American Journal of Epidemiology, 130, 100-111.

Hellman, E.A., Thorson, J.A., & Powell, F.C. (1992, Nov. 20). Social network participation and health care utilization among rural and urban older adults. A paper presented at the 45th Annual Scientific Meeting of the Gerontological Society of America, Washington, D.C.

Idler, E.L. (1993). Age differences in self-assessments of health: Age changes, cohort differences, or survivorship. Journal of Gerontology: Social Sciences, 48, S289-300.

Idler, E.L., Kasl, S.V., & Lemke, J.H. (1990). Self-evaluated health and mortality among the elderly in New Haven, Connecticut, and Iowa and Washington Counties, Iowa, 1982-1986. American Journal of Epidemiology, 131, 91-103.

Janson, P., & Ryder, L.K. (1983). Crime and the elderly: The relationship between risk and fear. The Gerontologist, 23, 207-212.

Lowenthal, M.F., & Haven, C. (1968). Interaction and adaptation: Intimacy as a critical variable. American Sociological Review, 33(1), 94-110.

Martin, S.S. (1992). The incidence of "drive-by" phenomenon among rural Nebraskans seeking primary health care treatment. Unpublished master's thesis, University of Nebraska at Omaha.

Powell, F.C., & Thorson, J.A. (1991, July 1). Incidence of functionally impaired elderly: Comparing ENOA samples with a rural sample - A research report prepared for the Eastern Nebraska Office on Aging (ENOA). Omaha: Department of Gerontology, University of Nebraska at Omaha.

Radloff, L.S., & Teri, L. (1986). Use of the Center for Epidemiological Studies-Depression Scale with older adults. In T.L. Brink (Ed.), Clinical gerontology: A guide to assessment and intervention. New York: Haworth Press, 119-136.

Schappert, S.M. (1994, August 18). National Ambulatory Medical Care Survey: 1992 Summary. Advance data from vital and health statistics; no. 253. Hyattsville, Maryland: National Center for Health Statistics.

Seeman, T.E., Kaplan, G.A., Knudsen, L.; Cohen, R., & Guralnik, J. (1987). Social network ties and mortality among the elderly in the Alameda County study. American Journal of Epidemiology, 126, 714-723.

Sherbourne, C.D., & Stewart, A. C. (1991). The MOS social support measure. Social Science and Medicine, 32, 705-714.

Taeuber, C.M. (1992). Sixty-five plus in America. U.S. Bureau of the Census, Current Population Reports, Special Studies, P23-178. Washington, D.C.: U.S. Government Printing Office.

Tennstedt, S., Cafferata, G.L., & Sullivan, L. (1992). Depression among caregivers of impaired elders. Journal of Aging and Health, 4, 58-76.

Thorson, J.A., & Powell, F.C. (1992, April). Health care perceptions of Nebraska's urban & rural aged. Occasional paper No. 92-1. Omaha: University of Nebraska at Omaha Center for Public Affairs Research.

Thorson, J.A., & Powell, F.C. (1992). Rural and urban elderly construe health differently. The Journal of Psychology, 126, 251-260.

Thorson, J.A., & Powell, F.C. (1993). The CES-D: Four or five factors? Bulletin of the Psychonomic Society, 31, 577-578.

Thorson, J.A., & Powell, F.C. (1993). The rural aged, social value, and health care. In C.N. Bull (Ed.), Aging in rural America. Beverly Hills, CA: Sage, 134-145.

Webb, V.J., & Marshall, I.H. (1989). Response to criminal victimization by older Americans. Criminal Justice and Behavior, 16, 239-258.

Williamson, G.M., & Schulz, R. (1992a). Pain, activity restriction, and symptoms of depression among community-residing elderly adults. Journal of Gerontology: Psychological Sciences, 47, S367-372.

Williamson, G.M., & Schulz, R. (1992b). Physical illness and symptoms of depression among elderly outpatients. Psychology and Aging, 7, 343-351.

Zarit, S.H., Reever, K.E., & Bach-Peterson, J. (1980). Relatives of the impaired elderly: Correlates of feelings of burden. The Gerontologist, 20, 649-655.

Zich, J.M., Attkisson, C.C., & Greenfield, T.K. (1990). Screening for depression in primary care clinics: The CES-D and the BDI. International Journal of Psychiatry in Medicine, 20, 259-277.

NEBRASKA CONDITIONS SURVEY, 1994

COLLEGE OF PUBLIC AFFAIRS AND COMMUNITY SERVICE

SURVEY QUESTIONNAIRE

Case Number (Assigned by Editor): _____

Name: _____

Address: _____

City/Town: _____

Zip Code: _____

Telephone Number Used: (___) _____

Interview Date: _____

Operator Code: _____

Interview Commenced (Time): _____

Interview Completed (Time): _____

Elapsed Time (In Minutes): _____

Telemarketing Supervisor Initial: _____

CPACS Editor: _____

Ready for Data Entry (Circle One):   Yes____   No____

Data Entered (Date, Initial): _____

File Name: POW94D.QE4

CASE NUMBER: _____

CONGRESSIONAL DISTRICT: _____

INTRODUCTION

Hello, my name is _____ with the _____ (telemarketing name). We are collecting family attitudes and opinions from people here in Nebraska. For example, Nebraska as a place to live, the health of each family member in your residence, activities, and related information. We would like to include your answers in the results and let me assure you that your anonymity is guaranteed. First, I would like to ask your opinion on Nebraska as a place to live.

1. Would you say Nebraska is a very poor, poor, fair, good, or excellent place to live?
    (OPERATOR: READ CHOICES)

    ___(0) very poor ___(1) poor ___(2) fair ___(3) good ___(4) excellent

2. How about your own neighborhood, what rating would you give your neighborhood?
    (OPERATOR: READ CHOICES)

    ___(0) very poor ___(1) poor ___(2) fair ___(3) good ___(4) excellent

3. How would you classify job opportunities in Nebraska?
    (OPERATOR: READ CHOICES)

    ___(0) very poor ___(1) poor ___(2) fair ___(3) good ___(4) excellent

4. How would you classify your local schools, the schools that provide education from kindergarten to 12th grade in your community? **(OPERATOR: READ CHOICES)**

    ___(0) very poor ___(1) poor ___(2) fair ___(3) good ___(4) excellent

5. Let me ask you this -- in your own words, what are people talking about in your neighborhood -- what's on peoples minds the most? **(OPERATOR: RECORD)**

    _____

    _____

    _____

    _____

HEALTH STATUS AND UTILIZATION: PRIMARY RESPONDENT

6. Let's talk about health for a moment, how would you rate your health?
   (OPERATOR: READ)

   ___(0) very poor   ___(1) poor   ___(2) fair   ___(3) good   ___(4) excellent

7. Tell me -- do you get your primary health care from: (OPERATOR: READ)

   ___(0) a family physician
   ___(1) a clinic
   ___(2) an emergency room
   ___(3) some other health care facility

8. How far is it -- in miles -- from your home to the physician's office, clinic, or health care outlet?

   _____ miles

9. How long does it take to get from your residence to your health care provider in minutes?

   _____ minutes

10. When you arrive at your physician's office or clinic, how long do you wait -- how many minutes -- to be seen by a health professional?

    _____ minutes

11. During the past year - since May 1, 1993 - how many times have you seen your physician or visited a clinic?

    _____ # of times

12. When was the last time you visited a physician or clinic?

    _____ date   (EDITOR: CONVERT TO MONTHS) _____

13. Could you tell me what medical condition prompted the visit?

    _____

    _____

14. How many times have you received medical advice from a physician or clinic over the telephone during the past year?

    _____ # of times

15. During the past year -- since May 1, 1993 -- how many times has illness or injury kept you in bed for more than half a day?

    _____ # of times

16. How many times have you been hospitalized during the past year?

    _____ # of times (OPERATOR: IF NONE GO TO #19) (IF 1 OR MORE GO TO #17)

17. What was the length of your longest hospital stay?

    _____ # of days

18. Could you please describe the medical problem that required hospitalization?

    _____

19. Have you received health care in an emergency room during the past year?

    ___(0) No (GO TO #22)   ___(1) Yes (GO TO #20)

20. How many times have you used an emergency room for treatment of a medical problem during the past year?

    _____ # of times

21. Could you please describe the medical problem that required the emergency room visit?

    _____

22. Let's make a slight change in direction. Please give me the date of your last complete health exam -- sometimes we call this an annual physical exam.

    _____ date   (EDITOR: CONVERT TO MONTHS) _____

(COMPUTER MESSAGE: RECORD #2 COMMENCES HERE)

STRESS AND ANTI-PREVENTIVE BEHAVIOR

23. Let's talk about stress for a moment. How would you classify your everyday life? (OPERATOR: READ CATEGORIES)

    ___(0) not very stressful
    ___(1) normal stress
    ___(2) very stressful

24. During the past year, would you say the stress has: (OPERATOR: READ CATEGORIES)

    ___(0) increased
    ___(1) decreased
    ___(2) stayed about the same

25. Do you smoke?

    ___(0) No (GO TO #27)
    ___(1) Yes (GO TO #26)

26. In an average day, how many cigarettes do you smoke?

    _____

27. Do you consume alcoholic beverages?

    ___(0) No (GO TO #31)
    ___(1) Yes (GO TO #28)

28. Is your beverage of preference

    ___(0) beer
    ___(1) wine
    ___(2) other beverages such as whiskey, vodka, rum

29. On an average day, how many beverages of your preference do you consume?

    # _____

30. During the past year, were there any five days when you consumed five or more alcoholic beverages of your choice?

____(0) No
____(1) Yes

DENTAL AND PRESCRIPTIONS

31. When was your last visit to your dentist?

Date: _____   (EDITOR: CONVERT TO MONTHS) _____

32. Do you still have all of your natural teeth?

____(0) No (GO TO #33)
____(1) Yes (GO TO #34)

33. Do you have a:

____(0) partial, or
____(1) full dentures
____(2) neither

34. Let's change direction for a moment, how many prescriptions are you taking today?

_____ # of prescriptions   (OPERATOR: IF NONE GO TO #36)

35. Please give me an estimate of your monthly prescription drug bill?

$_____

36. During the past year, has the number of prescriptions you take:

____(0) decreased
____(1) remained the same
____(2) increased

ADL SCALE AND FACTORS LIMITING MOBILITY

37. Let's change direction slightly. Are your daily activities limited for any reason?

___(0) No **(GO TO #39)**
___(1) Yes **(GO TO #38)**

38. Could you tell me what limits your activities?

_____

Now I'd like to ask you about some of the activities of daily living -- things we all need to do as a part of our daily lives. I would like to know if you can do these activities without any help at all, if you need some help in these activities, or if you can't do the activity at all. First activity, **(OPERATOR: READ RESPONSES)**

39. Can you use the phone?

___(0) without any help **(GO TO #41)**
___(1) need some help **(GO TO #40)**
___(2) can't do it at all **(GO TO #40)**

40. Who provides that help? _____

41. Can you get to places out of walking distance of your home?

___(0) without any help **(GO TO #43)**
___(1) need some help **(GO TO #42)**
___(2) can't do it at all **(GO TO #42)**

42. Who provides that help? _____

43. Can you go shopping for groceries or clothes?

___(0) without any help **(GO TO #45)**
___(1) need some help **(GO TO #44)**
___(2) can't do it at all **(GO TO #44)**

44. Who provides that help? _____

45. Can you prepare your own meals?

    ___(0) without any help **(GO TO #47)**
    ___(1) need some help **(GO TO #46)**
    ___(2) can't do it at all **(GO TO #46)**

46. Who provides that help? _____

47. Can you do your own housework?

    ___(0) without any help **(GO TO #49)**
    ___(1) need some help **(GO TO #48)**
    ___(2) can't do it at all **(GO TO #48)**

48. Who provides that help? _____

49. Can you take your own medications?

    ___(0) without any help **(GO TO #51)**
    ___(1) need some help **(GO TO #50)**
    ___(2) can't do it at all **(GO TO #50)**

50. Who provides that help? _____

51. Can you handle your own money?

    ___(0) without any help **(GO TO #53)**
    ___(1) need some help **(GO TO #52)**
    ___(2) can't do it at all **(GO TO #52)**

52. Who provides that help? _____

53. Can you eat?

    ___(0) without any help **(GO TO #55)**
    ___(1) need some help **(GO TO #54)**
    ___(2) can't do it at all **(GO TO #54)**

54. Who provides that help? _____

55. Can you dress and undress yourself?

    ___ (0) without any help (GO TO #57)
    ___ (1) need some help (GO TO #56)
    ___ (2) can't do it at all (GO TO #56)

    56. Who provides that help? _____

57. Can you walk?

    ___ (0) without any help (GO TO #59)
    ___ (1) need some assistance (GO TO #58)
    ___ (2) can't do it at all (GO TO #58)

    58. Who provides that help? _____

59. Can you get in and out of bed?

    ___ (0) without any help (GO TO #61)
    ___ (1) need some assistance (GO TO #60)
    ___ (2) can't do it at all (GO TO #60)

    60. Who provides that help? _____

61. Can you take a bath or shower?

    ___ (0) without any help (GO TO #63)
    ___ (1) need some assistance (GO TO #62)
    ___ (2) can't do it at all (GO TO #62)

    62. Who provides help? _____

63. Do you ever have trouble getting to the bathroom on time?

    ___ (0) No (GO TO #65)
    ___ (1) Yes (GO TO #64)
    ___ (2) have a catheter or a colostomy (GO TO #64)

    64. Who provides help? _____

65. Let's shift the questions slightly. Is there another person who resides in the household and is over the age of 60 years?

___(0) No **(GO TO #99)**
___(1) Yes **(GO TO #66)**

66. We would like to ask you some questions about that person's health. First, what is the family relationship between you and the other person? (OPERATOR: GIVE THE PERSON A CLUE, I.E., IS THE PERSON YOUR WIFE, HUSBAND, ETC.)

___(0) your wife
___(1) your husband
___(2) your mother
___(3) your father
___(4) your daughter
___(5) your son
___(6)
___(7) other kin
___(8) non-related
___(9) NOT APPLICABLE

67. How would you describe this person's health? (OPERATOR: READ)

___(0) very poor
___(1) poor
___(2) fair
___(3) good
___(4) excellent

(COMPUTER MESSAGE: RECORD #3 COMMENCES HERE)

68. Would you say the person's activities are limited for any reason?

___(0) No **(GO TO #70)**
___(1) Yes **(GO TO #69)**

69. Could you please tell me what limits this person's activities?

_____

Now I would like to read you some activities of daily living. Please tell me if the person we are talking about can do these activities without any help -- if they need some help in performing these activities -- or if they can't do the activity at all, first: **(OPERATOR: READ RESPONSES)**

70. Can the person use the phone?

    ___(0) without any help **(GO TO #72)**
    ___(1) need some help **(GO TO #71)**
    ___(2) can't do it at all **(GO TO #71)**

    71. Who provides this help? _____

72. Can they get to places out of walking distance of your home?

    ___(0) without any help **GO TO #74)**
    ___(1) need some help **(GO TO #73)**
    ___(2) can't do it at all **(GO TO #73)**

    73. Who provides this help? _____

74. Can they go shopping for groceries or clothes?

    ___(0) without any help **(GO TO #76)**
    ___(1) need some help **(GO TO #75)**
    ___(2) can't do it at all **(GO TO #75)**

    75. Who provides this help? _____

76. Can they prepare their own meals?

    ___(0) without any help **(GO TO #78)**
    ___(1) need some help **(GO TO #77)**
    ___(2) can't do it at all **GO TO #77)**

    77. Who provides this help? _____

78. Can they do their own housework?

    ___(0) without any help **(GO TO #80)**
    ___(1) need some help **(GO TO #79)**
    ___(2) can't do it at all **(GO TO #79)**

    79. Who provides this help? _____

80. Can they take their own medications?

    ___(0) without any help (GO TO #82)
    ___(1) need some help (GO TO #81)
    ___(2) can't do it at all (GO TO #81)

    81. Who provides this help? _____

82. Can they handle their own money?

    ___(0) without any help (GO TO #84)
    ___(1) need some help (GO TO #83)
    ___(2) can't do it at all (GO TO #83)

    83. Who provides this help? _____

84. Can they eat?

    ___(0) without any help (GO TO #86)
    ___(1) need some help (GO TO #85)
    ___(2) can't do it at all (GO TO #85)

    85. Who provides this help? _____

86. Can they dress and undress them self?

    ___(0) without any help (GO TO #88)
    ___(1) need some help (GO TO #87)
    ___(2) can't do it at all (GO TO #87)

    87. Who provides this help? _____

88. Can they walk?

    ___(0) without any help (GO TO #90)
    ___(1) need some assistance (GO TO #89)
    ___(2) can't do it at all (GO TO #89)

    89. Who provides this help? _____

90. Can they get in and out of bed?

   ___(0) without any help (GO TO #92)
   ___(1) need some assistance (GO TO #91)
   ___(2) can't do it at all (GO TO #91)

  91. Who provides this help? _____

92. Can they take a bath or shower?

   ___(0) without any help (GO TO #94)
   ___(1) need some assistance (GO TO #93)
   ___(2) can't do it at all (GO TO #93)

  93. Who provides this help? _____

94. Do they ever have trouble getting to the bathroom on time?

   ___(0) No (GO TO #96)
   ___(1) Yes (GO TO #95)
   ___(2) has a catheter or colostomy (GO TO #95)

  95. Who provides this help? _____

96. Could you please give me the age of this person?

   ___ years

97. Is this person a: (OPERATOR: READ RESPONSE AS PART OF QUESTION)

   ___(0) female, or
   ___(1) male

98. Now I want **your** opinion on something. Would you classify the care this person receives as a heavy burden, a burden, or not a burden to **you personally?**

   ___(0) a heavy burden
   ___(1) a burden
   ___(2) not a burden

HEALTH CARE SATISFACTION AND UNMET NEEDS

99. Now I would like to ask you several questions regarding satisfaction with health care provided in your area. Let's start with overall health care satisfaction. Would you say you are very dissatisfied, dissatisfied, satisfied, or very satisfied with overall health care provided in your area? (OPERATOR: READ RESPONSES)

___(0) very dissatisfied
___(1) dissatisfied
___(2) satisfied
___(3) very satisfied

100. How about satisfaction with your physician/primary provider, are you

___(0) very dissatisfied
___(1) dissatisfied
___(2) satisfied
___(3) very satisfied

101. How about satisfaction with hospital services in your area, are you

___(0) very dissatisfied
___(1) dissatisfied
___(2) satisfied
___(3) very satisfied

102. How about emergency room services in your area, are you

___(0) very dissatisfied
___(1) dissatisfied
___(2) satisfied
___(3) very satisfied

103. How about dental services in your area, would you say you are

___(0) very dissatisfied
___(1) dissatisfied
___(2) satisfied
___(3) very satisfied

104. Now please think back to May 1, 1993. <u>Since</u> May 1, 1993, have you needed health care and were unable to obtain the needed care?

___(0) No (GO TO #107)
___(1) Yes (GO TO #105)

105. Could you describe the health problem that needed attention?

_____

106. In your own words, why were you unable to obtain health care on this date?

_____

107. Now please think back to May 1, 1993. Since May 1, 1993, has any member of your family needed health care and were unable to obtain the needed care?

___(0) No (GO TO #112)
___(1) Yes (GO TO #108)

108. Could you describe the health problem that needed attention?

_____

109. Could you give me the age of the individual?

_____ years

110. Was this a male or female?

___(0) female
___(1) male

(COMPUTER MESSAGE: RECORD #4 COMMENCES HERE)

111. In your opinion, why did this person fail to receive health care?

_____

SOCIAL SUPPORT BATTERY

Let's change direction for a moment and talk about support that is available to you from family and friends.

How many close friends and relatives do you have -- you know, people you feel at ease with and can talk to about what is on your mind.

112. How many family members fit this category? _____

113. How many friends fit this category? _____

People sometimes look to others for companionship, assistance, or other types of support. How often is each of the following kinds of support available to you if you need it?

(OPERATOR: READ THE FOLLOWING RESPONSES)

	None of the Time	A Little of the Time	Some of the Time	Most of the Time	All of the Time
114. Someone to help you if you were confined to bed . . .	1	2	3	4	5
115. Someone you can count on to listen to you when you need to talk . . .	1	2	3	4	5
116. Someone to give you good advice about a crisis . . .	1	2	3	4	5
117. Someone to take you to the doctor if you need it . . .	1	2	3	4	5
118. Someone who shows you love and affection . . .	1	2	3	4	5
119. Someone to have a good time with . . .	1	2	3	4	5
120. Someone to give you information to help you understand a situation . . .	1	2	3	4	5

		None of the Time	A Little of the Time	Some of the Time	Most of the Time	All of the Time
121.	Someone to confide in or talk to about yourself or your problem . . .	1	2	3	4	5
122.	Someone who hugs you . . .	1	2	3	4	5
123.	Someone to get together with for relaxation . . .	1	2	3	4	5
124.	Someone to prepare your meals if you were unable to do it yourself . . .	1	2	3	4	5
125.	Someone whose advice you really want . . .	1	2	3	4	5
126.	Someone to do things with to help you get your mind off things . . .	1	2	3	4	5
127.	Someone to help with daily chores if you were sick . . .	1	2	3	4	5
128.	Someone to share your most private worries and fears with . . .	1	2	3	4	5
129.	Someone to turn to for suggestions about how to deal with a personal problem . . .	1	2	3	4	5
130.	Someone to do something enjoyable with . . .	1	2	3	4	5
131.	Someone who understands your problems . . .	1	2	3	4	5
132.	Someone to love and make you feel wanted . . .	1	2	3	4	5

	None of the Time	A Little of the Time	Some of the Time	Most of the Time	All of the Time
133. Someone who encourages you to take better care of yourself, that is go to the dentist, get an annual physical, exercise, wear a seat belt, etc . . .	1	2	3	4	5

MEASURES: FEAR OF CRIME

Let's change and talk about crime for a moment. At one time or another, most of us have experienced fear about becoming a victim of crime. Some crime probably frightens you more than others. We are interested in how afraid people are in everyday life of being a victim of different kinds of crime. I am going to read you a set of items -- please tell me if you are not fearful, have no feeling, are somewhat fearful, very fearful, or extremely fearful of this criminal act. (OPERATOR: PLEASE READ POSSIBLE RESPONSES UNTIL SUBJECT IS COMFORTABLE.)

(COMPUTER MESSAGE: RECORD #5 COMMENCES HERE)

ACT	No Fear	No Feeling	Somewhat Fearful	Very Fearful	Extremely Fearful
134. Being approached on the street by a beggar or panhandler.	0	1	2	3	4
135. Please rate your fear of being cheated, conned, or swindled out of your money.	0	1	2	3	4
136. Having someone break into your home while you are away.	0	1	2	3	4
137. Having someone break into your home while you are there.	0	1	2	3	4
138. Being raped or sexually assaulted.	0	1	2	3	4
139. Being murdered.	0	1	2	3	4
140. Being attacked by someone with a weapon.	0	1	2	3	4

ACT	No Fear	No Feeling	Somewhat Fearful	Very Fearful	Extremely Fearful
141. Having your car stolen.	0	1	2	3	4
142. Being robbed or mugged on the street.	0	1	2	3	4
143. Having your property damaged by vandals.	0	1	2	3	4

MEASURES OF RISK OF CRIME

Let's shift directions slightly and talk about the risk of crime. I will read you a list of statements and please tell me if this event is (0) very unlikely, (1) it's unlikely, (2) neutral, (3) it's likely, or (4) it's very likely to happen.

EVENT	It's Very Unlikely	It's Unlikely	Neutral	It's Likely	It's Very Likely
144. Being approached on the street by a beggar or panhandler?	0	1	2	3	4
145. Being cheated, conned, or swindled out of money?	0	1	2	3	4
146. Having someone attempt to break into your home while you are away?	0	1	2	3	4
147. Having someone break into your home while you are there?	0	1	2	3	4
148. Being raped or sexually assaulted?	0	1	2	3	4
149. Being murdered?	0	1	2	3	4
150. Being attacked by someone with a weapon?	0	1	2	3	4
151. Having your car stolen?	0	1	2	3	4
152. Being robbed or mugged on the street?	0	1	2	3	4
153. Have your property damaged by vandals?	0	1	2	3	4

154. Let's change direction, how safe do you feel when you are out alone in your neighborhood during the day. Do you feel? (OPERATOR: PLEASE READ)

    ___(0) very unsafe
    ___(1) somewhat unsafe
    ___(2) somewhat safe
    ___(3) very safe

155. A slight change in direction. How safe do you feel out alone in your neighborhood during the night? Do you feel: (OPERATOR: PLEASE READ)

    ___(0) very unsafe
    ___(1) somewhat unsafe
    ___(2) somewhat safe
    ___(3) very safe

156. Is there any area within a mile of your home where you would be afraid to walk alone at night?

    ___(0) No
    ___(1) Yes

SELF-RATING DEPRESSION SCALE (CES-D)

Let's change direction for a moment and talk about how you have been feeling lately. I will read you a statement about your feelings during the past week. Then you tell me if you felt this way: 1. None or a little of the time, 2. some of the time, 3. a good part of the time, or 4. most or all of the time. First statement: (OPERATOR: HELP THE RESPONDENT THROUGH SEVERAL STATEMENT/RESPONSE SETS IN ORDER THAT THEY GET THE DRIFT.)

(COMPUTER MESSAGE: RECORD #6 COMMENCES HERE)

STATEMENT	None or a Little of the Time	Some of the Time	Good Part of the Time	Most or All of the Time
157. I was bothered by things that usually don't bother me.	0	1	2	3
158. I did not feel like eating; my appetite was poor.	0	1	2	3
159. I felt that I could not shake off the blues with help from family or friends.	0	1	2	3

	None or a Little of the Time	Some of the Time	Good Part of the Time	Most or All of the Time
160. I felt that I was just as good as other people.	0	1	2	3
161. I had trouble keeping my mind on what I was doing.	0	1	2	3
162. I felt depressed.	0	1	2	3
163. I felt that everything I did was an effort.	0	1	2	3
164. I felt hopeful about the future.	0	1	2	3
165. I thought my life had been a failure.	0	1	2	3
166. I felt fearful.	0	1	2	3
167. My sleep was restless.	0	1	2	3
168. I was happy.	0	1	2	3
169. I talked less than usual.	0	1	2	3
170. I felt lonely.	0	1	2	3
171. People were unfriendly.	0	1	2	3
172. I enjoyed life.	0	1	2	3
173. I had crying spells.	0	1	2	3
174. I felt sad.	0	1	2	3
175. I felt that people disliked me.	0	1	2	3
176. I could not get "going."	0	1	2	3

CURRENT INTERPERSONAL SCALE

Now I want you to think about your <u>current</u> relationships with friends, family members, co-workers, community members, and others. Please indicate the degree to which the following statements describe your current relationships with others by responding with a (0) strongly disagree, (1) disagree, (2) agree, or (3) strongly agree.

		Strongly Disagree	Disagree	Agree	Strongly Agree
177.	There are people who depend on me for help.	0	1	2	3
178.	Other people do not view me as competent.	0	1	2	3
179.	I feel personally responsible for the well-being of another person.	0	1	2	3
180.	I do not think other people respect my skills and abilities.	0	1	2	3
181.	I have relationships where my competence and skills are recognized.	0	1	2	3
182.	There is no one who really relies on me for their well-being.	0	1	2	3
183.	There are people who admire my talents and abilities.	0	1	2	3
184.	No one needs me to care for them.	0	1	2	3

(COMPUTER MESSAGE: RECORD #7 COMMENCES HERE)

INDIVIDUAL ACTIVITY THEORY

185. Let's change direction for a moment -- we all belong to clubs and organizations. How many organizations and clubs are you a member of -- including church organizations?

_____ #

186. Of that total, how many are church organizations?

_____ #

187. Now lets talk about your activities during a normal week. During a normal week how many club, organizational or other meetings do you attend?

_____ #

188. How many church meetings or services will you attend?

_____ #

189. During a normal week, how many times do you telephone friends?

_____ #

190. How about friends who telephone you?

_____ #

191. Number of times you telephone family members?

_____ #

192. Number of times family members telephoned you?

_____ #

193. Number of times friends visit you?

_____ #

194. Number of times you visit friends?

_____ #

195. Number of times family members visit you?

_____ #

196. Number of times you visit family members?

_____ #

197. Number of times you go shopping?

_____ #

198. Number of times you participate in a recreation activity, such as playing cards, going to movies, and those kind of activities?

_____ #

199. Number of times you go out to eat in a normal week?

_____ #

200. Went walking?

_____ #

201. Number of hours you watch television during the week?

_____ #

202. During a normal week how many hours do you spend reading?

_____ #

203. How many hours do you spend listening to the radio?

_____ #

(COMPUTER MESSAGE: RECORD #8 COMMENCES HERE)

DEMOGRAPHICS

204. Let's change direction for a moment, are you a military veteran -- in other words -- have served in the United States Armed forces for at least 90 days?

___(0) No (Go to #205)
___(1) Yes (Go to #206)

205. Has any member of your household served in the United States Armed Forces for at least 90 days?

___(0) No
___(1) Yes

206. Which of the following best represents your educational level?

___(0) less than 4 years of high school
___(1) completed 4 years of high school
___(2) 1 to 3 years of college
___(3) 4 or more years of college

207. How many individuals reside in your household?

_____ #

208. Which of the following best describes the location of your dwelling? (OPERATOR: READ ALL CATEGORIES)

___(0) on a farm or ranch
___(1) in a rural area
___(2) in a town of less than 2,500 people
___(3) in a town that has between 2,500 and 10,000 people
___(4) in a city that has between 10,000 and 100,000 people
___(5) in a city that has between 100,000 and 300,000
___(6) in an urban area with a population over 300,000

209. Do you own or rent your home?

___(0) rent
___(1) own

210. Which of the following best describes your dwelling?

___(0) single family house
___(1) town home or condominium
___(2) duplex or fourplex apartment
___(3) apartment complex
___(4) mobile home

211. How about race, do you consider yourself as: (OPERATOR: READ RESPONSE SET)

___(0) White
___(1) Afro-American
___(2) Hispanic/Latino
___(3) or, another race

212. How would you classify your marital status?
(OPERATOR: READ ALL CATEGORIES AS PART OF THE QUESTION)

___(0) single
___(1) married living with spouse
___(2) widow/widower
___(3) divorced

213. May I please have your age?

_____ years

214. Let's change direction slightly, give me a dollar estimate of your monthly household income.

$_____
(OPERATOR: IF YOU OBTAIN AN ANSWER GO TO #216)
(IF YOU FAIL TO OBTAIN AN ANSWER TO GO #215)

215. Fine, let me read you some dollar figures. These dollar figures could represent your monthly family income. When we come to a figure that represents your family income please stop me. Here we go: (OPERATOR: MAKE SURE THE RESPONDENT UNDERSTANDS THE EXERCISE.)

___(0) less than $613.00 a month
___(1) between $614.00 & $820.00 per month
___(2) between $821.00 & 1,025.00 per month
___(3) between $1,026.00 & $1,640 per month
___(4) between $1,641.00 & $2,450.00 per month
___(5) between $2,451 & $4,000 per month
___(6) between $4,001.00 & $8,000.00 per month
___(7) over $8,001.00 per month
___(8) don't know
___(9) refused

216. (OPERATOR: MARK SEX OF THE INDIVIDUAL NOW)

___(0) female
___(1) male

217. One last question, we hope to repeat this study of the health of Nebraska residents next year. May we please call you back next year?

___ (0) No
___ (1) Yes

Thank You!
We certainly appreciate your assistance so much and have a nice day (evening)!