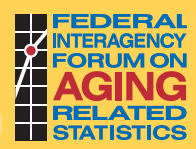
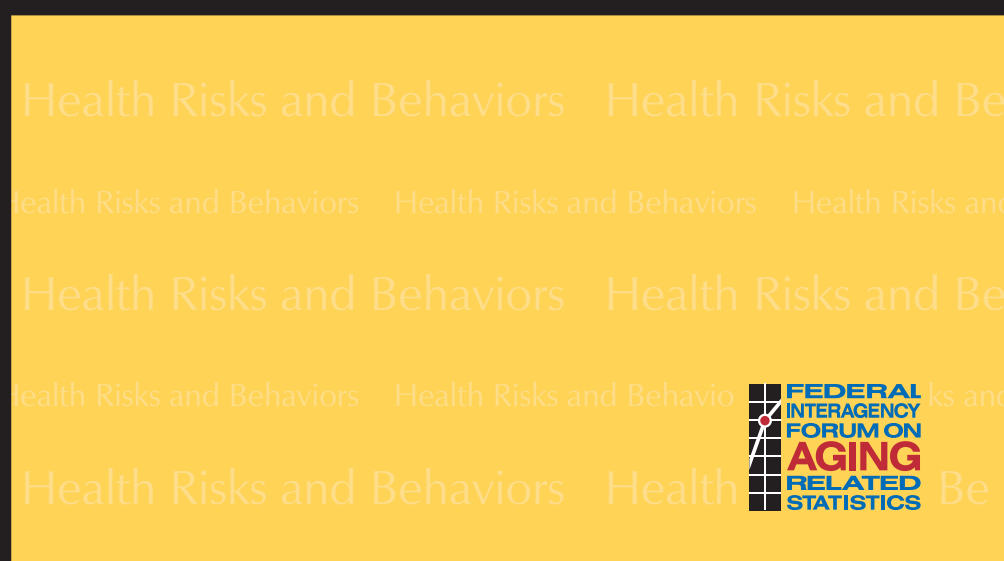


Older Americans 2004

Key Indicators of Well-Being



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Older Americans 2004

Key Indicators of Well-Being

The Federal Interagency Forum on Aging-Related Statistics (Forum) was founded in 1986 to foster collaboration among Federal agencies that produce or use statistical data on the older population. Members of the Forum as of September 2004 are listed below.

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Foreword

Americans age 65 and over are an important and growing segment of our population. Many Federal agencies provide data on various aspects of the challenges confronting older Americans. Because these data come from multiple agencies, it is sometimes difficult to understand how this group is faring overall. In light of the anticipated growth of this segment of our population, it is increasingly important for policymakers and the general public to have an accessible, easy to understand portrait that shows how older Americans are doing.

Older Americans 2004: Key Indicators of Well-Being (Older Americans) provides a unified picture of the health and well-being of our older population. This is the second chartbook prepared by the Interagency Forum on Aging-Related Statistics (Forum), which now has participants from a dozen Federal agencies. As with the previous volume issued in 2000, readers will find here an accessible compendium of indicators—drawn from the most reliable official statistics—illustrative of both the promises and the difficulties confronting older Americans.

This publication provides 37 key indicators about important aspects of older Americans' lives. The indicators in this volume are categorized into five broad groups: population, economics, health status, health risks and behaviors, and health care. This year's report includes a number of new measures, including older veterans and veterans' health care, sensory impairments, obesity, cigarette smoking, air quality, prescription drugs, health insurance, sources of payment for health care, and residential services. All of the indicators are easy to understand by broad audiences, objectively based on substantial research connecting them to reliable data on well-being, balanced so that no single area dominates the report, measured regularly so that they can be updated to show trends over time, and representative of large segments of the population rather than one particular group.

While Federal agencies currently collect and report substantial information on the population age 65 and over, there remain several important areas where there are gaps in our knowledge. In addition to the data needs listed in the previous volume, three new data needs have been added to this year's chartbook. The Forum continues to work together to find innovative ways to fill these data needs. By displaying what the government knows and what it does not know, this report challenges Federal statistical agencies to do even better.

The value of the *Older Americans* reports reflects the Forum's innovative, determined spirit to advance our understanding of where older Americans are today and what may be needed to bring them a better tomorrow. The agencies participating in the Forum should be congratulated on the effort that went into creating *Older Americans*. This volume reflects the dedication of the Forum agency staff members who conducted special analyses, evaluated strategies to make data presentations more consistent and clear, and coordinated the assessment of data needs. They joined together to give the American people a valuable tool for tracking the condition of those who are age 65 and over, and for making policy decisions that will affect them. Last, but not least, none of this work would be possible without the continued cooperation of millions of American citizens who willingly provide the data that are summarized and analyzed by staff in the Federal agencies.

The Forum anticipates publishing additional volumes of this chartbook on a periodic basis, every 3 to 5 years. We invite you to suggest ways we can enhance this portrait of our population age 65 and over. Please send comments to us at the Forum's Web site (<http://www.agingstats.gov>). I applaud the Forum's collaborative efforts in producing this report and hope that it will be a useful contribution to your work.

Katherine K. Wallman

Chief Statistician

Office of Management and Budget

Acknowledgments

Older Americans 2004: Key Indicators of Well-Being is a report of the Federal Interagency Forum on Aging-Related Statistics (Forum). This report was prepared by the Forum's planning committee and reviewed by the Forum's principal members.

The Forum's planning committee members include Saadia Greenberg, Administration on Aging; D.E.B. Potter and Jan Valluzzi, Agency for Healthcare Research and Quality; Ryan Helwig, Bureau of Labor Statistics; Karen Humes, Annetta Clark Smith, and Victoria Velkoff, U.S. Census Bureau; Gerald Riley, Centers for Medicare & Medicaid Services; Kathy Sykes, Environmental Protection Agency; Ellen Kramarow and Julie Dawson Weeks, National Center for Health Statistics; Elayne Heisler and Laura Shrestha, National Institute on Aging; Hakan Aykan and William Marton, Office of the Assistant Secretary for Planning and Evaluation, U.S. Department of Health and Human Services; Brian Harris-Kojetin, Office of Management and Budget; Howard Iams, Social Security Administration; Robert E. Klein and Donald Stockford, Department of Veterans Affairs; and the Forum's Staff Director, Kristen Robinson, National Center for Health Statistics.

The following staff members of the Forum agencies reviewed the chartbook and provided valuable guidance and assistance: Frank Burns, Administration on Aging; Jennifer Madans and James Lubitz, National Center for Health Statistics; Judy Salerno and Richard Suzman, National Institute on Aging; Ruth Katz, Office of the Assistant Secretary for Planning and Evaluation, U.S. Department of Health and Human Services; and Mary E. (Beth) Martindale, Department of Veterans Affairs.

In addition to the 12 agencies of the Forum, the Department of Agriculture (USDA) was invited to contribute to this report. The Forum greatly appreciates the efforts of WenYen Juan

and Mark Lino, Center for Nutrition Policy and Promotion, USDA, in providing valuable information from their agency.

Other staff members of Federal agencies who provided data and assistance include Liana Abrahamyan, Administration on Aging; Karen J. Migdail, Agency for Healthcare Research and Quality; Geoffrey Paulin, Bureau of Labor Statistics; Joseph Dalaker, Kimberly DeBarros, Jason Fields, Campbell Gibson, and Marjorie Hanson, U.S. Census Bureau; Nancy DeLew, Franklin Eppig, David Gibson, Jessica Herrera-Cancel, Deborah Kidd, Chris McCormick, Renee Mentnech, and John Poisal, Centers for Medicare & Medicaid Services; Margaret D. Carroll, Margaret L. Cejku, Alan Cohen, Robin A. Cohen, Virginia Freid, Margie Goulding, Adrienne Jones, Cynthia L. Ogden, Laurie Pratt, Robin E. Remsburg, Sandra S. Smith, Ronald B. Tiggler, and Henry Xia, National Center for Health Statistics; Vicky Cahan and Jeannine Mjoseph, National Institute on Aging; Ralph Eskenazi and Randall J. Remmel, Department of Veterans Affairs; and Melissa Koenig, Social Security Administration.

The Forum is also indebted to the many people outside the Federal government who contributed to this chartbook: Gwen Fisher, Elena Gouskova, Joe Lupton, Kate McGonagle, Mary Beth Ofstedal, Bob Schoeni, Frank Stafford, David Weir, and Robert J. Willis, University of Michigan; and Brenda Spillman, Urban Institute.

Member agencies of the Forum provided funds and valuable staff time to produce this report. The National Center for Health Statistics and its contractor, NOVA Research Company, facilitated the production, printing, and dissemination of this report. Linda Bean provided general production oversight. Odell D. Eldridge, NOVA, designed the layout and supervised the overall presentation of the report. Kyung Park, NOVA, designed and produced the data tables. Kathy J. Sedgwick, NOVA, provided editorial oversight and review. Patty Wilson managed the printing of the report.

About This Report

Older Americans 2004: Key Indicators of Well-Being (Older Americans 2004) is the second in a series of reports produced by the Federal Interagency Forum on Aging-Related Statistics (Forum) that describe the overall status of the U.S. population age 65 and over. This report provides Federal statistics from over a dozen national data sources to monitor several important areas in the lives of older Americans—population, economics, health status, health risks and behaviors, and health care.

The Forum has once again collaborated to update and expand the comprehensive set of indicators that first appeared in *Older Americans 2000: Key Indicators of Well-Being (Older Americans 2000)*. This series of reports provides the Nation with a broad summary of national indicators of well-being for the U.S. population age 65 and over and monitors changes in these indicators over time. By following these data trends, more accessible information will be available to target efforts that can improve the lives of older Americans.

Older Americans 2004 has added several new indicators to provide a more complete picture of the health and well-being of older Americans: sensory impairments and oral health; obesity; cigarette smoking; air quality; prescription drugs; sources of health insurance; sources of payment for health care services; and residential services. In addition to these new indicators, this report has been expanded to highlight an important and rapidly growing group of older Americans—older veterans.

The Forum hopes that this report will stimulate discussions by policymakers and the public, encourage exchanges between the data and policy communities, and foster improvements in Federal data collection on older Americans. By examining a broad range of indicators, researchers, policymakers, service providers, and the Federal Government can better understand the areas of well-being that are improving for older Americans and the areas

of well-being that require more attention and effort.

Structure of the Report

Older Americans 2004 is designed to present data in a nontechnical, user-friendly format; it complements other more technical and comprehensive reports produced by the individual Forum agencies. The report includes 37 indicators that are grouped into five sections: Population, Economics, Health Status, Health Risks and Behaviors, and Health Care. A list of the indicators included in this report is located in the Table of Contents on page IX.

Each indicator includes:

- ◆ An introductory paragraph that describes the relevance of the indicator to the well-being of the older population.
- ◆ One or more charts that graphically display analyses of the data.
- ◆ Bulleted highlights of salient findings from the data and other sources.

The data used to develop the indicators and their accompanying bullets are presented in table format in Appendix A. Data source descriptions are provided in Appendix B. A glossary is supplied in Appendix C.

Selection Criteria for Indicators

Older Americans 2004 presents 37 key indicators that measure critical aspects of older people's lives. The Forum chose these indicators because they are:

- ◆ Easy to understand by a wide range of audiences.
- ◆ Based on reliable, nationwide data (sponsored, collected, or disseminated by the Federal Government).
- ◆ Objectively based on substantial research that connects them to the well-being of older Americans.
- ◆ Balanced so that no single area dominates the report.
- ◆ Measured periodically (not necessarily annually) so that they can be updated as appropriate and show trends over time.
- ◆ Representative of large segments of the aging population, rather than one particular group.

Considerations When Examining the Indicators

Older Americans 2004 generally addresses the U.S. population age 65 and over. Mutually exclusive age groups (e.g., age 65-74, 75-84, and 85 and over) are reported whenever possible.

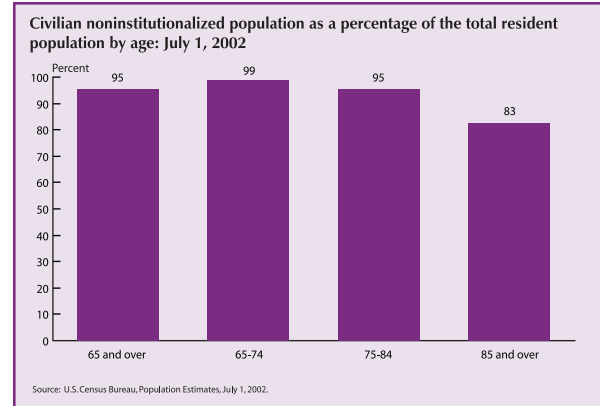
Data availability and analytical relevance may affect the specific age groups that are included for an indicator. For example, because of small sample sizes in some surveys, statistically reliable data for the population age 85 and over often are not available. Conversely, data from the population younger than age 65 sometimes are included if they are relevant to the interpretation of the indicator. For example, in “Indicator 11: Participation in the Labor Force,” a comparison with a younger population enhances the interpretation of the labor force trends among people age 65 and over.

Because the older population is becoming more diverse, analyses often are presented by sex, race and ethnic origin, income, and other characteristics.

Updated indicators in *Older Americans 2004* are not always comparable to the original indicators in *Older Americans 2000*. The replication of certain indicators with updated data is sometimes difficult because of changes in data sources, definitions, questionnaires, and/or reporting categories. A comparability table is available on the Forum’s Web site at <http://www.agingstats.gov> to help readers understand the changes that have taken place.

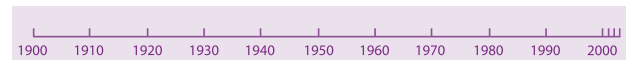
The reference population (the base population sampled at the time of data collection) for each indicator is clearly labeled under each chart and table and defined in the glossary. Whenever possible, the indicators include data on the U.S. resident population (i.e., people living in the community and people living in institutions). However, some indicators show data only for the civilian noninstitutionalized population. Because the older population residing in nursing homes (and other long-term care institutional settings) is excluded from samples based on the noninstitutionalized population, caution should be exercised when attempting to generalize the

findings from these data sources to the entire population age 65 and over. This is especially true for the older age groups. For example in 2002, only 83 percent of the population age 85 and over was included in the civilian noninstitutionalized population as defined by the U.S. Census Bureau.



Survey Years

In the charts, tick marks along the x-axis indicate years for which data are available. The range of years presented in each chart varies because data availability is not uniform across the data sources. To standardize the time frames across the indicators, a timeline has been placed at the bottom of each indicator that reports data for more than one year.



Accuracy of the Estimates

Most data in this report are based on a sample of the population and are, therefore, subject to sampling error. Standard tests of statistical significance have been used to determine whether the differences between populations exist at generally accepted levels of confidence or whether they occurred by chance. Unless otherwise noted, only statistically significant differences between estimates are discussed in the text. To indicate the reliability of the estimates, standard errors for selected estimates in the chartbook can be found on the Forum’s Web site at <http://www.agingstats.gov>.

Finally, the data in some indicators may not sum to totals because of rounding.

Sources of Data

The data used to create the charts are provided in tables in the back of the report (Appendix A). The tables also contain data that are described in the bullets below each chart. The source of the data for each indicator is noted below the chart.

Descriptions of the data sources can be found in Appendix B. Additional information about these data sources is available on the Forum's Web site at <http://www.agingstats.gov>.

Occasionally, data from another publication are included to give a more complete explanation of the indicator. The citations for these sources are included in the References section (page 62). For those who wish to access the survey data used in this chartbook, contact information is given for each of the data sources in Appendix B.

Data Needs

Because *Older Americans 2004* is a collaborative effort of many Federal agencies, a comprehensive array of data was available for inclusion in this report. However, even with all of the data available, there are still areas where scant data exist. Although the indicators that were chosen cover a broad range of components that affect well-being, there are other issues that the Forum would like to address in the future. These issues are identified in the Data Needs section (page 59). By identifying and highlighting these data needs, the Forum—as well as other policymakers, researchers, and service providers—will be better able to focus their future efforts.

Mission

The Forum's mission is to encourage cooperation and collaboration among Federal agencies to improve the quality and utility of data on the aging population. To accomplish this mission, the Forum provides agencies with a venue to discuss data issues and concerns that cut across agency boundaries, facilitates the development of new databases, improves mechanisms currently used to disseminate information on aging-related data, invites researchers to report on cutting-edge analyses of data, and encourages international collaboration.

The specific goals of the Forum are to improve both the quality and use of data on the aging population by:

- ◆ Widening access to information on the aging population through periodic publications and other means.
- ◆ Promoting communication among data producers, researchers, and public policy-makers.
- ◆ Coordinating the development and use of statistical databases among Federal agencies.
- ◆ Identifying information gaps and data inconsistencies.
- ◆ Investigating questions of data quality.
- ◆ Encouraging cross-national research and data collection on the aging population.
- ◆ Addressing concerns regarding collection, access, and dissemination of data.

Financial Support

The Forum members provide funds and valuable staff time to support the activities of the Forum.

More Information

If you would like more information about *Older Americans 2004* or other Forum activities, contact:

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Older Americans on the Internet

An expanded version of this report can be found at <http://www.agingstats.gov>. The Web site version of the report contains:

- ◆ Continuously updated data tables (as the data become available).
- ◆ PowerPoint slides of the charts.
- ◆ Excel spreadsheets of all the data tables (some with standard errors).
- ◆ A comparability table explaining the changes to the indicators that have taken place between *Older Americans 2000* and *Older Americans 2004*.

The Forum's Web site also provides:

- ◆ Ongoing Federal data resources relevant to the study of the aging.
- ◆ Past products of the Forum (including *Older Americans 2000*).
- ◆ Agency contacts.
- ◆ Subject area contact list for Federal statistics.
- ◆ Information about the Forum.

Additional Online Resources

Administration on Aging

A Profile of Older Americans

<http://www.aoa.gov/prof/Statistics/profile/profiles.asp>

Online Statistical Data on the Aging

http://www.aoa.gov/prof/Statistics/online_stat_data/online_stat_data.asp

Agency for Healthcare Research and Quality

AHRQ Data & Surveys

<http://www.ahrq.gov/data>

Bureau of Labor Statistics

Bureau of Labor Statistics Data

<http://stats.bls.gov/data>

U.S. Census Bureau

Statistical Abstract of the United States

<http://www.census.gov/statab/www/>

Age Data

<http://www.census.gov/population/www/socdemo/age.html>

Local Employment Dynamics—Aging and Pension Benefits

<http://lehd.dsd.census.gov/led/05/index.html>

Centers for Medicare & Medicaid Services Statistics and Data

<http://www.cms.hhs.gov/researchers>

Department of Veterans Affairs

Veteran Data & Information

<http://www.va.gov/vetdata>

Environmental Protection Agency

Aging Initiative

<http://www.epa.gov/aging/index.htm>

National Center for Health Statistics

Data Warehouse on Trends in Health and Aging

<http://www.cdc.gov/nchs/agingact.htm>

Longitudinal Studies of Aging

<http://www.cdc.gov/nchs/lsoa.htm>

Health, United States

<http://www.cdc.gov/nchs/hus.htm>

National Institute on Aging

NIA Centers on the Demography of Aging

<http://agingmeta.psc.isr.umich.edu>

National Archive of Computerized Data on Aging

<http://www.icpsr.umich.edu/NACDA>

Office of the Assistant Secretary for Planning and Evaluation, HHS

Office of Disability, Aging, and Long-Term Care Policy

<http://aspe.hhs.gov/daltcp/home.shtml>

Office of Management and Budget

FedStats (Gateway to Federal Statistics)

<http://www.fedstats.gov>

Social Security Administration

Social Security Administration Statistical Information

<http://www.ssa.gov/policy>

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Highlights

Today's older Americans are living longer, healthier lives and enjoying greater prosperity than any previous generation. The indicators of well-being included in this chartbook reflect this progress and, at the same time, point out the inequalities that continue to exist between the sexes, income levels, and racial and ethnic groups. As the Baby Boomers continue to age and America's older population grows larger and more diverse, community leaders, policymakers, and researchers will have an even greater need to monitor the health and economic well-being of older Americans.

Population

- ◆ In 2003, nearly 36 million people age 65 and over lived in the United States, accounting for just over 12 percent of the total population. During the 20th century, the older population grew from 3 million to 35 million and is projected to grow to almost 87 million by 2050. (See Indicator 1.)
- ◆ Women make up 58 percent of the population age 65 and over and 69 percent of the population age 85 and over. Older women are less likely than older men to be currently married and are twice as likely to live alone. (See Indicators 1, 3, and 5.)
- ◆ A majority of older men are veterans. Between 1990 and 2000, the proportion of men age 65 and over who were veterans increased from 54 percent to 65 percent. Although the number of older veterans is projected to decline slightly from 2000 to 2010, the number of veterans age 65 and over is projected to increase again after 2010 as the large Vietnam era cohort ages. (See Indicator 6.)

Economics

- ◆ The trend in median household income of the older population has been positive. Between 1974 and 2002, the median household income for people age 65 and over increased (in 2002 dollars) from \$16,882 to \$23,152. Correspondingly, fewer older people are living below the poverty threshold. The

percentage of older people living in poverty declined from 35 percent in 1959 to 10 percent in 2002. (See Indicators 7 and 8.)

- ◆ In 2002, aggregate income for the population age 65 and over came largely from four sources: Social Security (39 percent), earnings (25 percent), pensions (19 percent), and asset income (14 percent). Among older Americans in the lowest fifth of the income distribution, Social Security accounts for 83 percent of aggregate income. For those whose income is in the highest income category, Social Security accounts for approximately 20 percent of total income. (See Indicator 9.)
- ◆ Between 1984 and 2001, the median net worth of households headed by people age 65 and over increased by 82 percent (after accounting for inflation). Although the rate of growth of wealth between 1984 and 2001 has been substantial for both older black and older white households, large differences continue to exist—the median net worth of older white households (\$205,000) is five times larger than that of older black households (\$41,000). (See Indicator 10.)
- ◆ The proportion of housing costs relative to all expenditures declines as income increases. In 2002, households headed by people age 65 and over in the lowest fifth of the income distribution allocated an average of 40 percent of all expenditures to basic housing, while households in the highest income category spent an average of 28 percent. (See Indicator 12.)

Health Status

- ◆ Americans are living longer than ever before. In 1900, life expectancy at age 65 was almost 12 years, and at age 85 it was 4 years. By 2001, life expectancy at age 65 had increased to more than 19 years for women and about 16 years for men, and at age 85 it was 7 years for women and 6 years for men. Life expectancy varies by race, but the difference decreases with age. At age 65, white people can expect to live an average of nearly 2 years longer than black people, but at age 85, black people have a slightly higher life expectancy. (See Indicator 13.)

- ◆ In 2002, close to one-half of older men and nearly one-third of older women reported trouble hearing without a hearing aid. Vision trouble (even with glasses or contact lenses) affects 18 percent of the older population, 16 percent of men and 19 percent of women. In 2002, the proportion of people with moderate or severe memory impairment ranged from approximately 5 percent among people age 65-69 to 32 percent among people age 85 and over. The proportion of older people with clinically relevant depressive symptoms was 11 percent for older men and 18 percent for older women. (See Indicators 16, 17, and 18.)
- ◆ The age-adjusted proportion of older Americans with a chronic disability declined from 25 percent in 1984 to 20 percent in 1999. This proportion declined for both older men (19 percent to 15 percent) and older women (28 percent to 23 percent). Despite the decline in rates, the number of older Americans with chronic disabilities increased from about 6.2 million in 1984 to 6.8 million in 1999 as the size of the older population grew at a rapid enough pace to outweigh the decline in the disability rates. (See Indicator 19.)
- ◆ During the period 2000 to 2002, 73 percent of people age 65 and over rated their health as good or better. This pattern was true for the decade preceding 2002 as well; the majority of older people reported their health to be good to excellent. (See Indicator 20.)

Health Risks and Behaviors

- ◆ In 2001-2002, 21 percent of people age 65 and over reported engaging in regular leisure time physical activity. The percentage of older people engaging in regular physical activity was lower at older ages, ranging from 26 percent among people age 65-74 to 9 percent among people age 85 and over. (See Indicator 24.)
- ◆ The increase in the prevalence of overweight and obesity among older adults has been dramatic. In 1999-2002, 69 percent of Americans age 65 and over were overweight, and 30 percent were obese. In the last 2 decades, the increases among

those age 65-74 have been especially striking. Between 1976-1980 and 1999-2002, the percentage of people age 65-74 who were overweight rose from 57 percent to 73 percent; the percentage who were obese rose from 18 percent to 36 percent. (See Indicator 25.)

- ◆ The percentage of older men who are current cigarette smokers declined from 29 percent in 1965 to 10 percent in 2002. The corresponding percentage for women has remained relatively constant, declining slightly from 10 percent in 1965 to 9 percent in 2002. (See Indicator 26.)
- ◆ The air pollutants that have the greatest potential to affect the health of older adults are ozone and fine particulate matter (PM 2.5). In 2002, 46 percent of people age 65 and over lived in a county where ozone concentrations reached levels that were above the EPA standards compared with 26 percent in 2000. About 19 percent of people age 65 and over lived in a county where PM 2.5 concentrations reached levels that were at times above EPA standards, compared with 27 percent in 2000. (See Indicator 27.)

Health Care

- ◆ Health care costs increased significantly between 1992 and 2001 among older Americans enrolled in Medicare (after adjusting for inflation). Average costs were substantially higher for people with lower incomes, for people at older ages, and for people with multiple chronic conditions. The mix of health care services (and their associated costs) varied with age. For example, average costs for nursing home and long-term institutional services were much higher among people age 85 and over than among those age 65-74. (See Indicator 29.)
- ◆ Most older people enrolled in Medicare are generally satisfied with their health care and report few difficulties in obtaining health care services. The percentage who reported they delayed getting care because of cost declined from 10 percent in 1992 to 5 percent in 1997 and remained relatively constant thereafter. (See Indicator 29.)

- ◆ Average prescription drug costs for older Americans increased rapidly throughout the 1990s, especially after 1997. Average costs per noninstitutionalized Medicare enrollee age 65 and over were \$1,340 in 2000. The average number of filled prescriptions for this population also rose substantially over time, averaging 18 prescriptions in 1992 and 30 in 2000. (See Indicator 30.)
- ◆ Medicare pays for slightly more than one-half (54 percent) of the overall health care costs for its enrollees age 65 and over. This population pays 21 percent of their health care costs out of pocket. Medicaid covers 10 percent of their health care costs (including 46 percent of nursing home costs), and other payers (primarily private insurers) cover another 15 percent. Lower-income individuals pay a lower percentage of health care costs out of pocket but use more services than individuals with higher incomes. (See Indicator 33.) The percentage of noninstitutionalized people age 65 and over with out-of-pocket spending for health care services increased between 1977 and 2001—from 83 percent to 95 percent (See Indicator 32.)
- ◆ An increasing number of older veterans are turning to the Veterans Health Administration (VHA) for their health care needs despite their potential eligibility for other sources of health care. In 2003, approximately 2.3 million veterans age 65 and over received health care from VHA, and an additional 1 million older veterans were enrolled to receive health care from VHA but did not use its services that year. (See Indicator 34.)
- ◆ The age-adjusted rate of nursing home residence among the older population declined from 54 per 1,000 in 1985 to 43 per 1,000 in 1999. Despite this decline, the number of current nursing home residents has increased—from 1.3 million in 1985 to 1.5 million in 1999—because of the growth of the older population. (See Indicator 35.)
- ◆ In 2002, 2 percent of the Medicare population age 65 and over resided in community housing with at least one service available, such as meal preparation, housekeeping services, laundry services, and help with medications. Approximately 5 percent resided in long-term care facilities. Residents of community housing with services had more limitations in activities of daily living than those in traditional community housing but fewer than residents of long-term care facilities. (See Indicator 36.)

Population

Indicator 1: Number of Older Americans

Indicator 2: Racial and Ethnic Composition

Indicator 3: Marital Status

Indicator 4: Educational Attainment

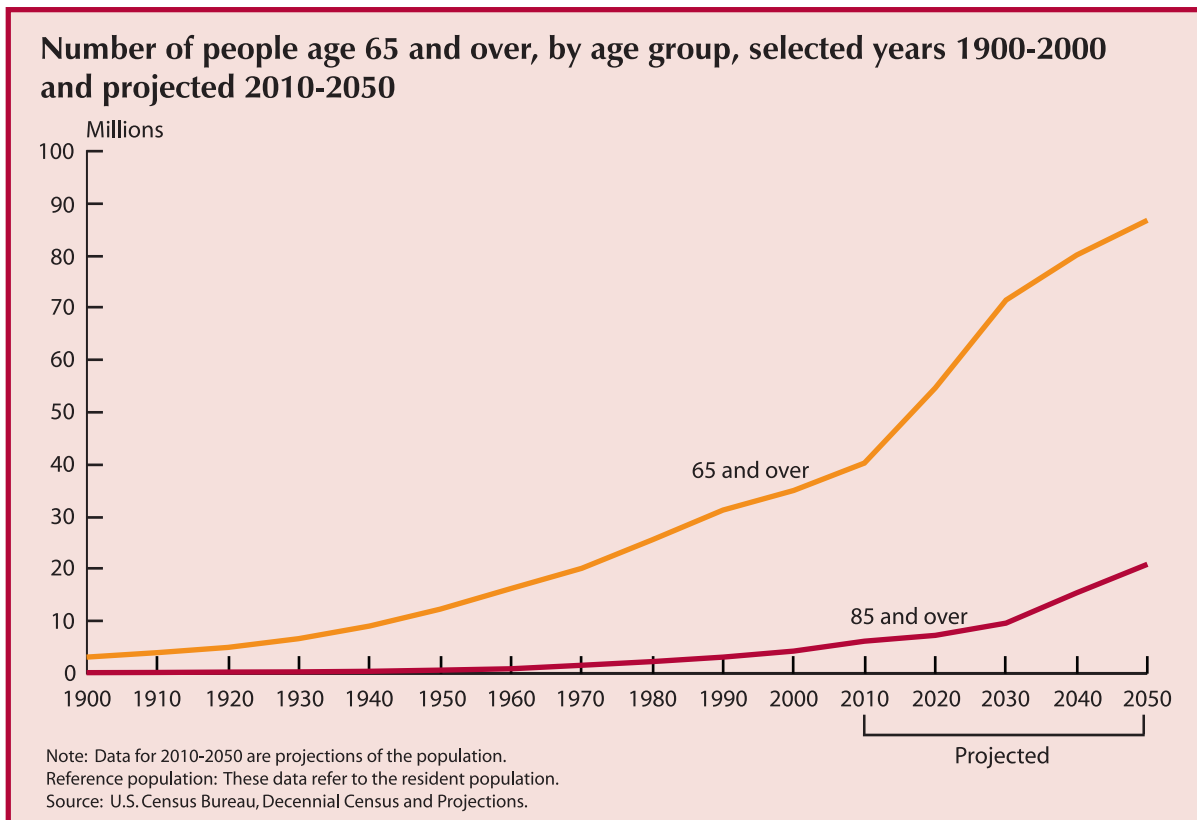
Indicator 5: Living Arrangements

Indicator 6: Older Veterans

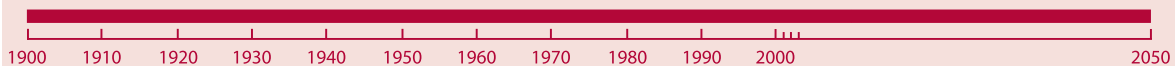
INDICATOR 1

Number of Older Americans

The growth of the population age 65 and over affects many aspects of our society, challenging policymakers, families, businesses, and health care providers, among others, to meet the needs of aging individuals.

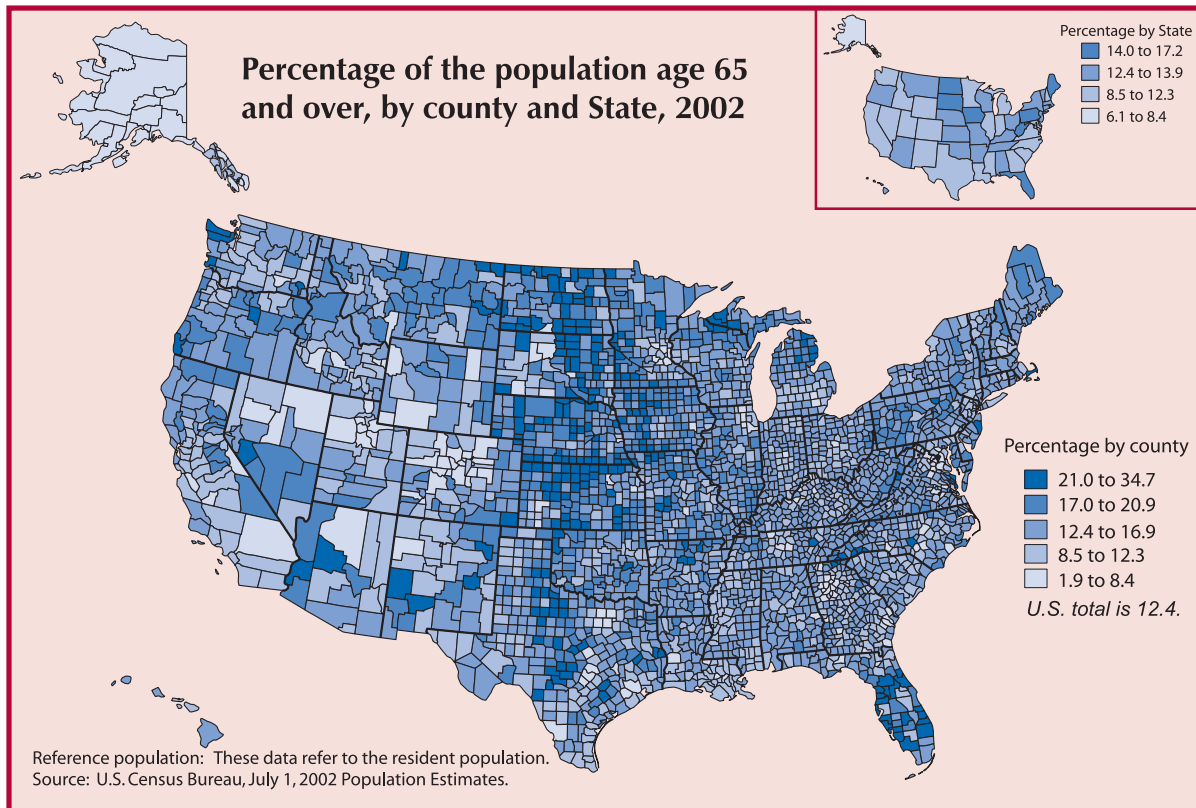


- ◆ In 2003, nearly 36 million people age 65 and over lived in the United States, accounting for just over 12 percent of the total population.¹ Over the 20th century, the older population grew from 3 million to 35 million. The oldest-old population (those age 85 and over) grew from just over 100,000 in 1900 to 4.2 million in 2000.
- ◆ The Baby Boomers (those born between 1946 and 1964) will start turning 65 in 2011, and the number of older people will increase dramatically during the 2010-2030 period. The older population in 2030 is projected to be twice as large as their counterparts in 2000, growing from 35 million to 71.5 million and representing nearly 20 percent of the total U.S. population.
- ◆ The growth rate of the older population is projected to slow after 2030, when the last Baby Boomers enter the ranks of the older population. From 2030 onward, the proportion age 65 and over will be relatively stable, at around 20 percent, even though the absolute number of people age 65 and over is projected to continue to grow. The oldest-old population is projected to grow rapidly after 2030, when the Baby Boomers move into this age group.
- ◆ The U.S. Census Bureau projects that the population age 85 and over could grow from 4.2 million in 2000 to nearly 21 million by 2050. Some researchers predict that death rates at older ages will decline more rapidly than is reflected in the U.S. Census Bureau's projections, which could lead to faster growth of this population.²⁻⁴



INDICATOR 1

Number of Older Americans continued



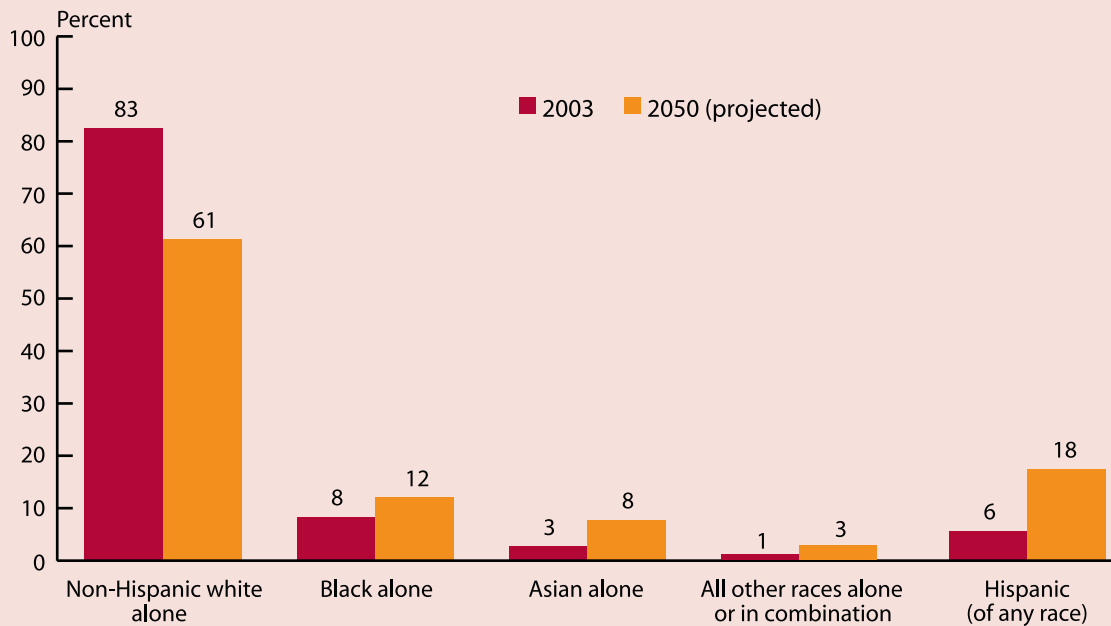
- ◆ The proportion of the population age 65 and over varies by State. This proportion is partly affected by the State fertility and mortality levels and partly by the number of older and younger people who migrate to and from the State. In 2002, Florida had the highest proportion of people age 65 and over, 17 percent. Pennsylvania and West Virginia also had high proportions, over 15 percent.
 - ◆ The proportion of the population age 65 and over varies even more by county. In 2002, 35 percent of McIntosh County, North Dakota, was age 65 and over, the highest proportion in the country. In several Florida counties, the proportion was over 30 percent. At the other end of the spectrum was Chattahoochee County, Georgia, with only 2 percent of its population age 65 and over.
 - ◆ As in most countries of the world, older women outnumber older men in the United States, and the proportion that is female increases with age. In 2003, women accounted for 58 percent of the population age 65 and over and for 69 percent of the population age 85 and over.¹
 - ◆ The United States is fairly young for a developed country, with just over 12 percent of its population age 65 and over. The older population made up more than 15 percent of the population in most European countries and nearly 19 percent in both Italy and Japan in 2003.
- Data for this indicator's charts and bullets can be found in Tables 1a, 1b, 1c, 1d, and 1e on pages 68-71.*

INDICATOR 2

Racial and Ethnic Composition

As the older population grows larger, it will also grow more diverse, reflecting the demographic changes in the U.S. population as a whole over the last several decades. By 2050, programs and services for older people will require greater flexibility to meet the needs of a more diverse population.

Population age 65 and over, by race and Hispanic origin, 2003 and projected 2050



Note: The term “non-Hispanic white alone” is used to refer to people who reported being white and no other race and who are not Hispanic. The term “black alone” is used to refer to people who reported being black or African American and no other race, and the term “Asian alone” is used to refer to people who reported only Asian as their race. The use of single-race populations in this report does not imply that this is the preferred method of presenting or analyzing data. The U.S. Census Bureau uses a variety of approaches. The race group “All other races alone or in combination” includes American Indian and Alaska Native, alone; Native Hawaiian and Other Pacific Islander, alone; and all people who reported two or more races.

Reference population: These data refer to the resident population.

Source: U.S. Census Bureau, Population Estimates and Projections, 2004.

- ◆ In 2003, non-Hispanic whites accounted for nearly 83 percent of the U.S. older population. Blacks made up just over 8 percent, Asians made up nearly 3 percent, and Hispanics (of any race) accounted for nearly 6 percent of the older population.
- ◆ Projections indicate that by 2050 the composition of the older population will be 61 percent non-Hispanic white, 18 percent Hispanic, 12 percent black, and 8 percent Asian.
- ◆ The older population among all racial and ethnic groups will grow; however, the older

Hispanic population is projected to grow the fastest, from just over 2 million in 2003 to 15 million in 2050, and to be larger than the older black population by 2028. The older Asian population is also projected to experience a large increase. In 2003, nearly 1 million older Asians lived in the United States; by 2050 this population is projected to be almost 7 million.

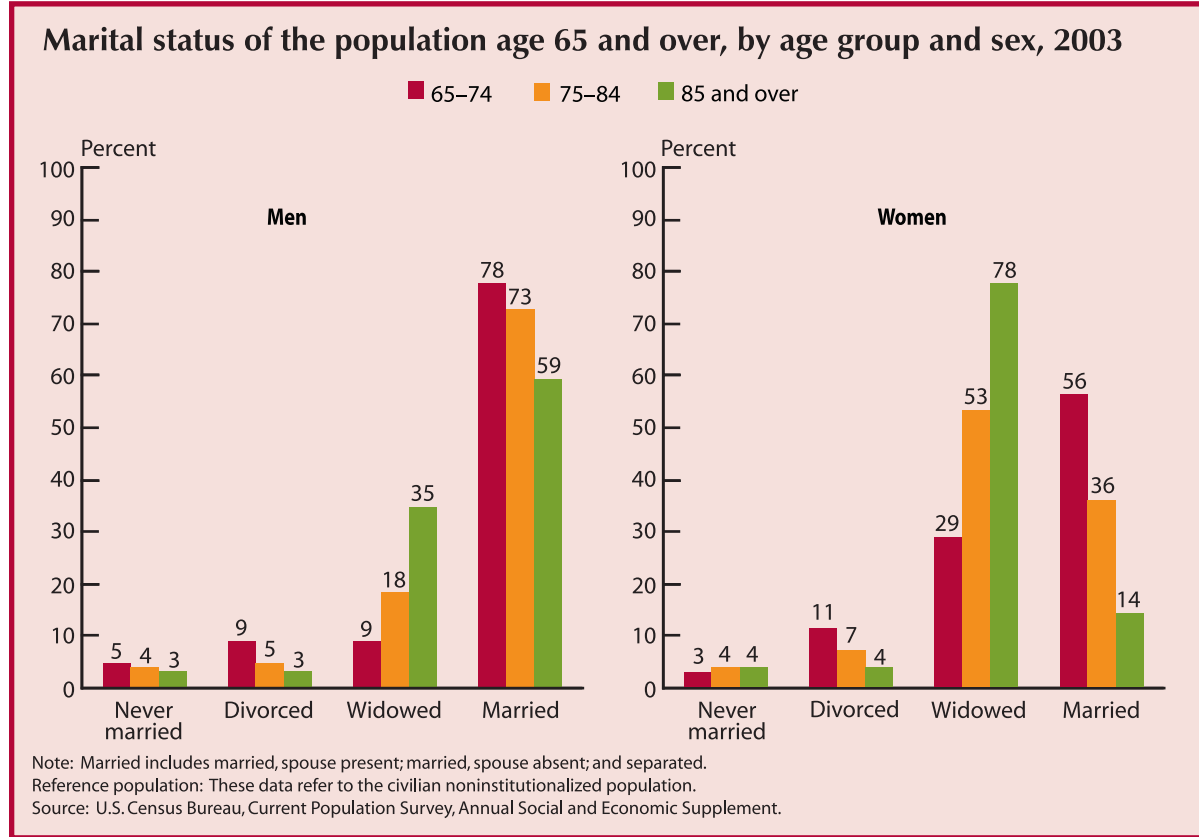
Data for this indicator’s chart and bullets can be found in Table 2 on page 71.



INDICATOR 3

Marital Status

Marital status can strongly affect one’s emotional and economic well-being. Among other factors, it influences living arrangements and the availability of caregivers for older Americans with an illness or disability.



- ◆ In 2003, older men were much more likely than older women to be married. Over three-quarters (78 percent) of men age 65-74 were married, compared with over one-half (56 percent) of women in the same age group. The proportion married is lower at older ages: 36 percent of women age 75-84 and 14 percent of women age 85 and over were married. For men, the proportion married also is lower at older ages but not as low as for older women. Even among the oldest old, the majority of men were married (59 percent).
- ◆ Widowhood is more common among older women than older men. Women age 65 and over

were three times as likely as men of the same age to be widowed, 44 percent compared with 14 percent. The proportion widowed is higher at older ages, and the proportion widowed is higher for women than men. In 2003, 78 percent of women age 85 and over were widowed, compared with 35 percent of men.

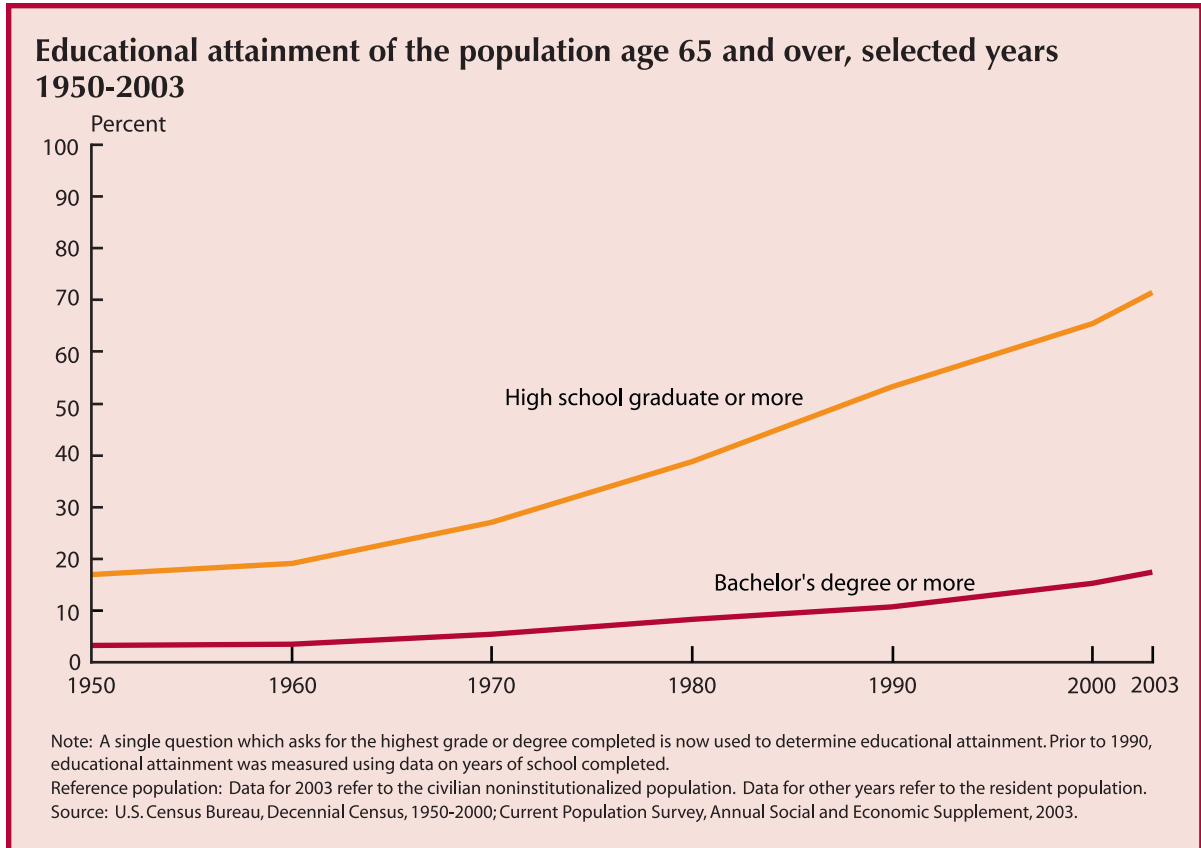
- ◆ Relatively small proportions of older men (7 percent) and women (9 percent) were divorced in 2003. A small proportion of the older population had never married.

Data for this indicator’s chart and bullets can be found in Table 3 on page 71.

INDICATOR 4

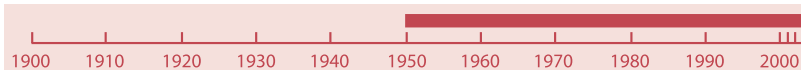
Educational Attainment

Educational attainment influences socioeconomic status, which in turn plays a role in well-being at older ages. Higher levels of education are usually associated with higher incomes, higher standards of living, and above-average health.

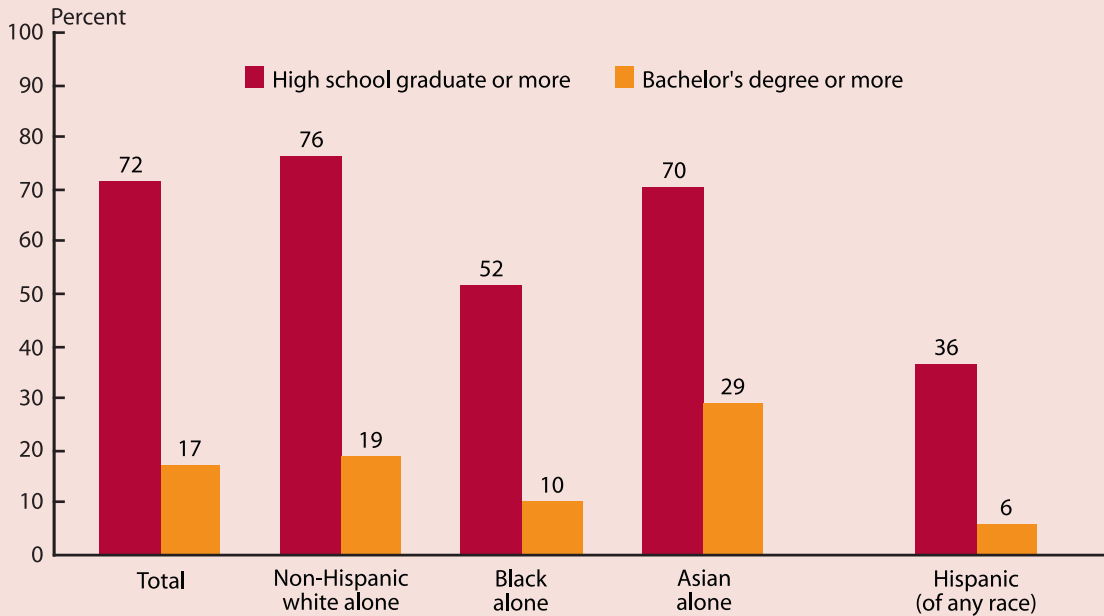


- ◆ In 1950, 17 percent of the older population had graduated from high school, and only 3 percent had at least a Bachelor's degree. By 2003, 72 percent were high school graduates, and 17 percent had at least a Bachelor's degree.
- ◆ In 2003, older men were more likely than older women to have graduated from high school, though not by very much—72 percent

compared with 71 percent. Older men also attained at least a Bachelor's degree more often than older women (23 percent compared with 13 percent).¹ The gender gap in completion of a college education will narrow in the future because men and women in younger cohorts are earning college degrees at roughly the same rate.¹



Educational attainment of the population age 65 and over, by race and Hispanic origin, 2003



Note: The term "non-Hispanic white alone" is used to refer to people who reported being white and no other race and who are not Hispanic. The term "black alone" is used to refer to people who reported being black or African American and no other race, and the term "Asian alone" is used to refer to people who reported only Asian as their race. The use of single-race populations in this report does not imply that this is the preferred method of presenting or analyzing data. The U.S. Census Bureau uses a variety of approaches.
 Reference population: These data refer to the civilian noninstitutionalized population.
 Source: U.S. Census Bureau, Current Population Survey, Annual Social and Economic Supplement.

◆ Despite the overall increase in educational attainment among older Americans, substantial educational differences exist among racial and ethnic groups. In 2003, 76 percent of non-Hispanic whites age 65 and over had completed high school. Older Asians also had a high proportion with at least a high school education (70 percent). In contrast, 52 percent of older blacks and 36 percent of older Hispanics had completed high school.

◆ In 2003, older Asians had the highest proportion with at least a Bachelor's degree (29 percent). Almost 20 percent of older non-Hispanic whites had this level of education. The proportions were 10 percent and 6 percent, respectively, for older blacks and Hispanics.

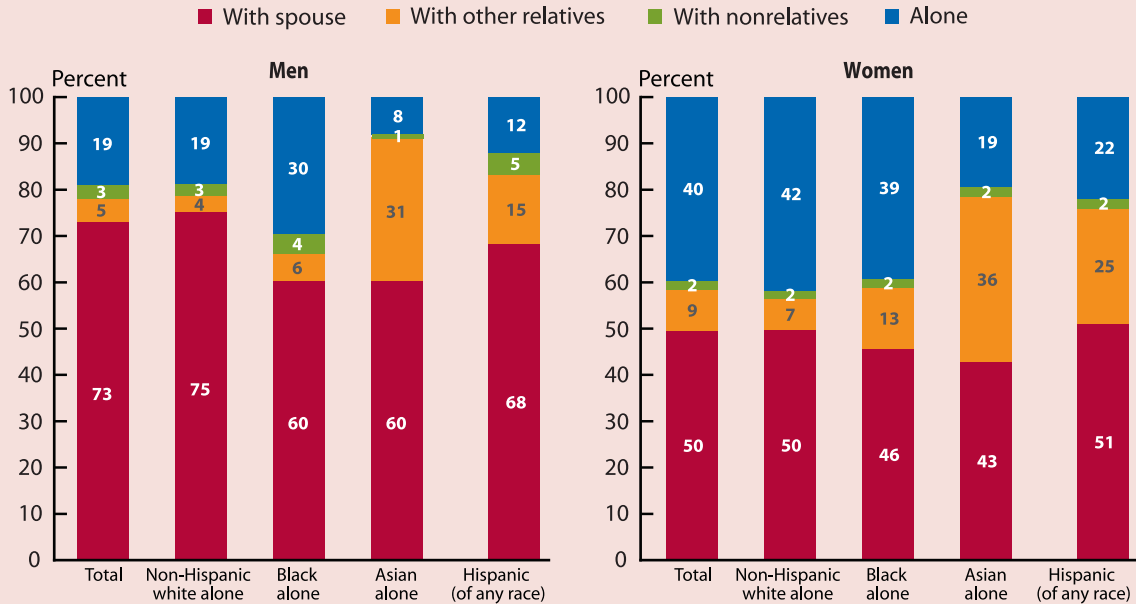
Data for this indicator's charts and bullets can be found in Tables 4a and 4b on page 72.

INDICATOR 5

Living Arrangements

The living arrangements of America's older population are important indicators because they are linked to income, health status, and the availability of caregivers. Older people who live alone are more likely than older people who live with their spouses to be in poverty.⁵

Living arrangements of the population age 65 and over, by sex and race and Hispanic origin, 2003



Note: Living with other relatives indicates no spouse present. Living with nonrelatives indicates no spouse or other relatives present. The term "non-Hispanic white alone" is used to refer to people who reported being white and no other race and who are not Hispanic. The term "black alone" is used to refer to people who reported being black or African American and no other race, and the term "Asian alone" is used to refer to people who reported only Asian as their race. The use of single-race populations in this report does not imply that this is the preferred method of presenting or analyzing data. The U.S. Census Bureau uses a variety of approaches.

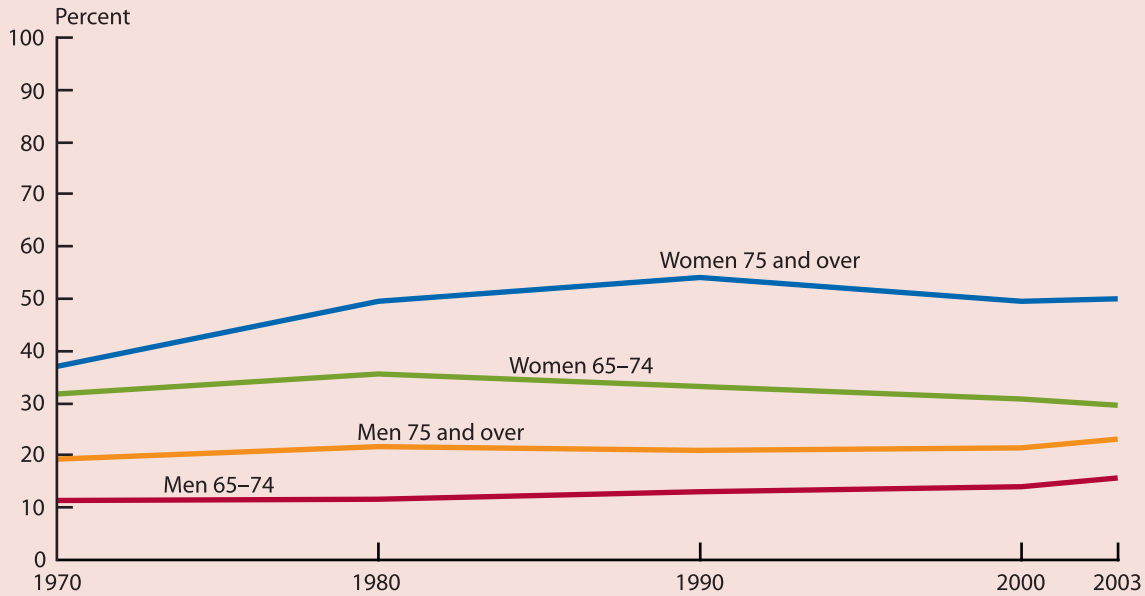
Reference population: These data refer to the civilian noninstitutionalized population.

Source: U.S. Census Bureau, Current Population Survey, Annual Social and Economic Supplement.

- ◆ Older men were more likely to live with their spouse than were older women. In 2003, 73 percent of older men lived with their spouse while only one-half (50 percent) of older women did. In contrast, older women were twice as likely as older men to live alone (40 percent and 19 percent, respectively).
- ◆ Living arrangements of older people differed by race and Hispanic origin. Older Asian women were far more likely than women of other races to live with relatives other than a spouse. For example, in 2003, 36 percent of

older Asian women compared with 25 percent of older Hispanic women lived with relatives other than a spouse. Older non-Hispanic white and black women were more likely than others to live alone (about 40 percent each compared with about 20 percent for older Asian and Hispanic women). Older black men lived alone three times as often as older Asian men (30 percent compared with 8 percent). Older Asian men were more likely (31 percent) than men of other races and ethnicities to live with relatives other than a spouse.

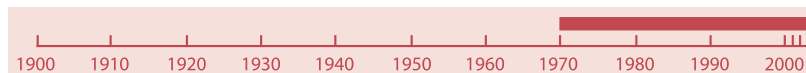
Population age 65 and over living alone, by age group and sex, selected years 1970-2003



Reference population: These data refer to the civilian noninstitutionalized population.
 Source: U.S. Census Bureau, Current Population Survey, Annual Social and Economic Supplement.

- ◆ As age increases and widowhood rates rise, the percentage of the population living alone increases accordingly. Historically, older women lived alone at much higher rates than older men, but in the last decade, the rates for women have decreased slightly while the rates for men have increased slightly.
- ◆ The percentage of women age 75 and over living alone increased from 37 percent in 1970 to 54 percent in 1990. However, the proportion had decreased slightly by 2003, when around half of women in this age group lived alone. The proportion of men age 75 and over living alone did not increase significantly from 1970 to 1990 or from 1990 to 2003; however, it increased from 19 percent in 1970 to 23 percent in 2003.
- ◆ Women age 65-74 were less likely to live alone than women age 75 and over (30 percent and 50 percent, respectively) in 2003. The same was true for men—16 percent compared with 23 percent.
- ◆ Older people who lived alone had higher poverty rates than those who lived with their spouse. In 2002, 16 percent of older men and 21 percent of older women who lived alone lived in poverty. In contrast, the poverty rate for older married men and women did not differ at only 5 percent each.

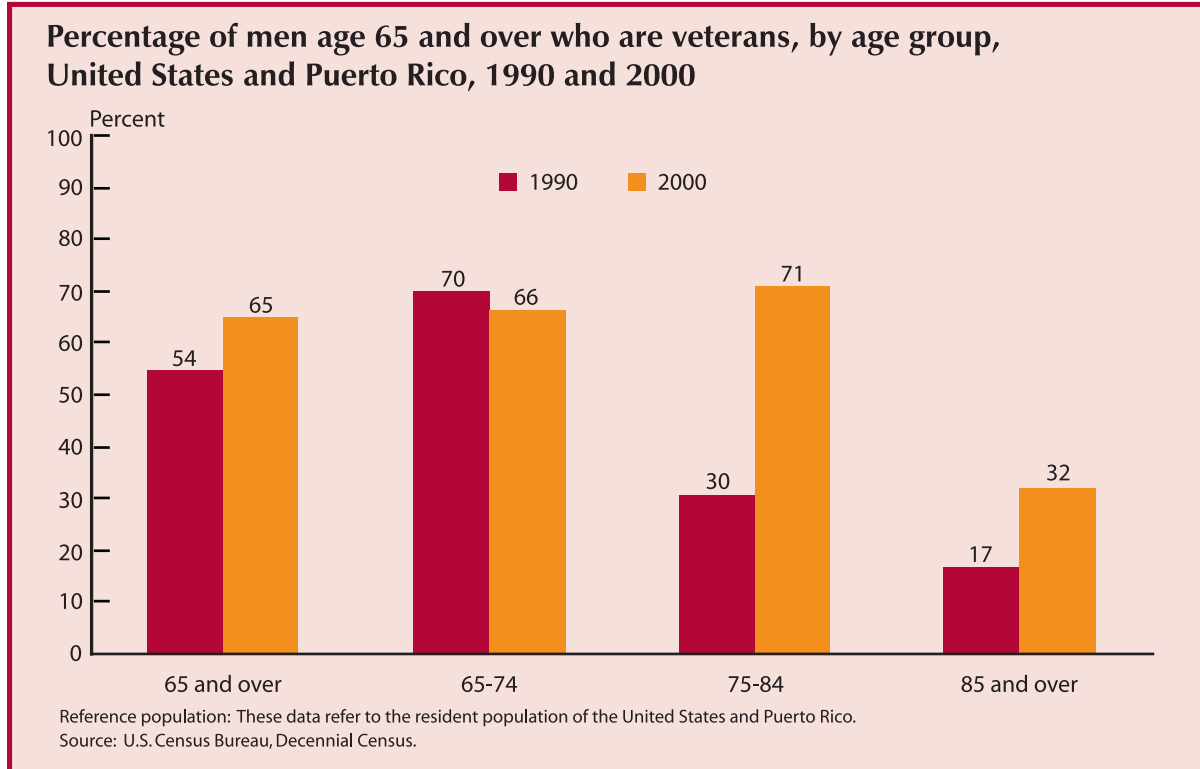
Data for this indicator's charts and bullets can be found in Tables 5a, 5b, and 7b on pages 73 and 76.



INDICATOR 6

Older Veterans

According to Census 2000, there were 9.8 million veterans age 65 and over in the United States and Puerto Rico, composed mainly of the sizeable World War II, Korean War, and, increasingly, Vietnam era cohorts; two of three men age 65 and over were veterans.

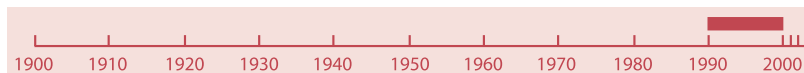


- ◆ Among veterans age 65 and over, more than 95 percent are male. Because of the large Korean War and World War II veteran cohorts, the number of male veterans age 65 and over increased between 1990 and 2000 from 6.9 million to 9.5 million.
- ◆ Older veterans make up an increasing proportion of older males. Between 1990 and 2000, the proportion of males age 65 and over who were veterans went up from 54 percent to 65 percent.
- ◆ Change in the population of male veterans age 85 and over is even more pronounced. Between 1990 and 2000, the number of male veterans age 85 and over increased from 142,000 to

400,000. The proportion of males age 85 and over who were veterans increased from 17 percent to 32 percent.

- ◆ Projections from the Department of Veterans Affairs indicate slight declines in the number of all veterans age 65 and over during the first decade of this century. However, after 2010, there is a projected increase, as the large Vietnam era cohort ages. In contrast, the number age 85 and over is expected to increase steadily and dramatically during this first decade, to a peak of nearly 1.4 million in 2012.

Data for this indicator's chart and bullets can be found in Tables 6a and 6b on page 74.



Economics

Indicator 7: Poverty

Indicator 8: Income

Indicator 9: Sources of Income

Indicator 10: Net Worth

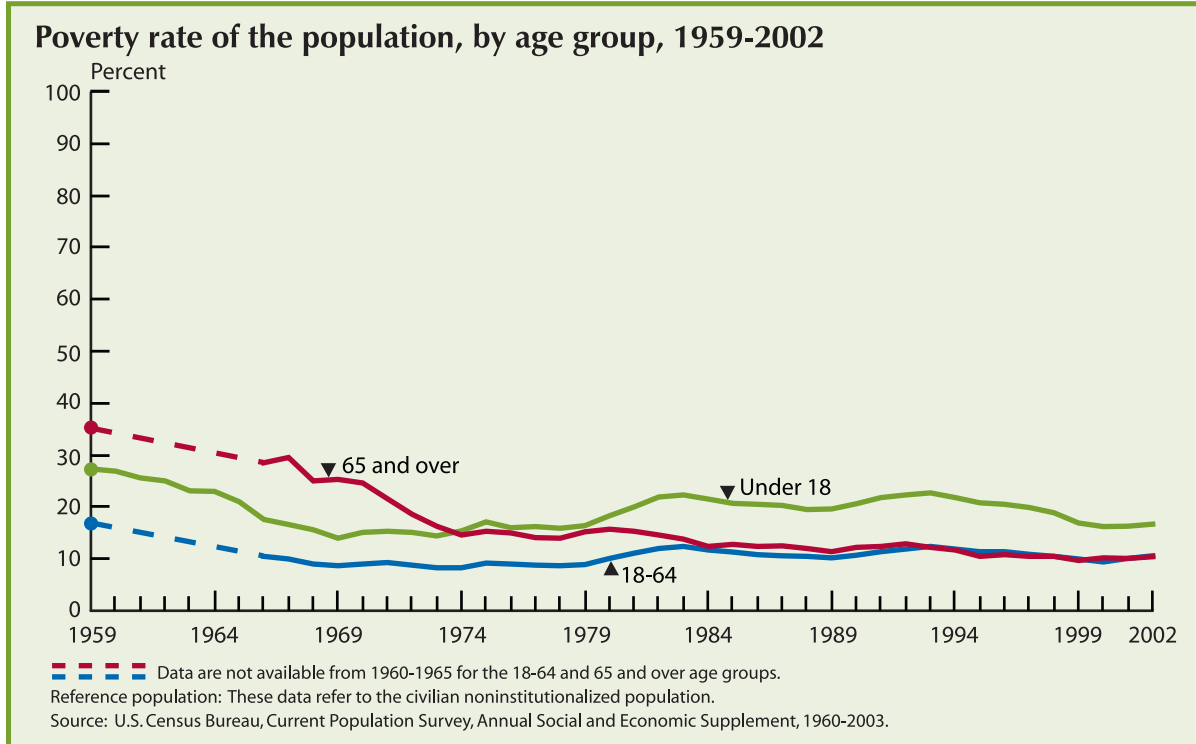
Indicator 11: Participation in the Labor Force

Indicator 12: Housing Expenditures

INDICATOR 7

Poverty

Poverty rates offer one way to evaluate economic well-being. The official poverty definition is based on annual money income before taxes and does not include capital gains and noncash benefits. To determine who is poor, the U.S. Census Bureau compares family income (or an unrelated individual's income) with a set of poverty thresholds that vary by family size and composition and are updated annually for inflation. People identified as living in poverty are at risk of having inadequate resources for food, housing, health care, and other needs.



- ◆ In 1959, 35 percent of people age 65 and over lived below the poverty threshold. By 2002, the proportion of the older population living in poverty had decreased dramatically to 10 percent.
- ◆ Relative levels of poverty among the different age groups have changed over time. In 1959, older people had the highest poverty rate (35 percent), followed by children (27 percent) and those in the working ages (17 percent). By 2002, the proportions of the older population and those of working age living in poverty did not differ (about 10 percent each), while 17 percent of children lived in poverty.
- ◆ Poverty rates differed by age and sex among the older population. Older women (12 percent) were more likely than older men (8 percent) to live in poverty in 2002. People age 65-74 had a poverty rate of 9 percent, compared with 12 percent of those age 75 and over.
- ◆ Race and ethnicity are related to poverty among the older population. In 2002, older non-Hispanic whites were far less likely than older blacks and older Hispanics to be living in poverty—about 8 percent compared with 24 percent of older blacks and 21 percent of older Hispanics (not a statistically significant difference between the latter two groups). Older non-Hispanic white and black women had higher poverty rates than their male counterparts.

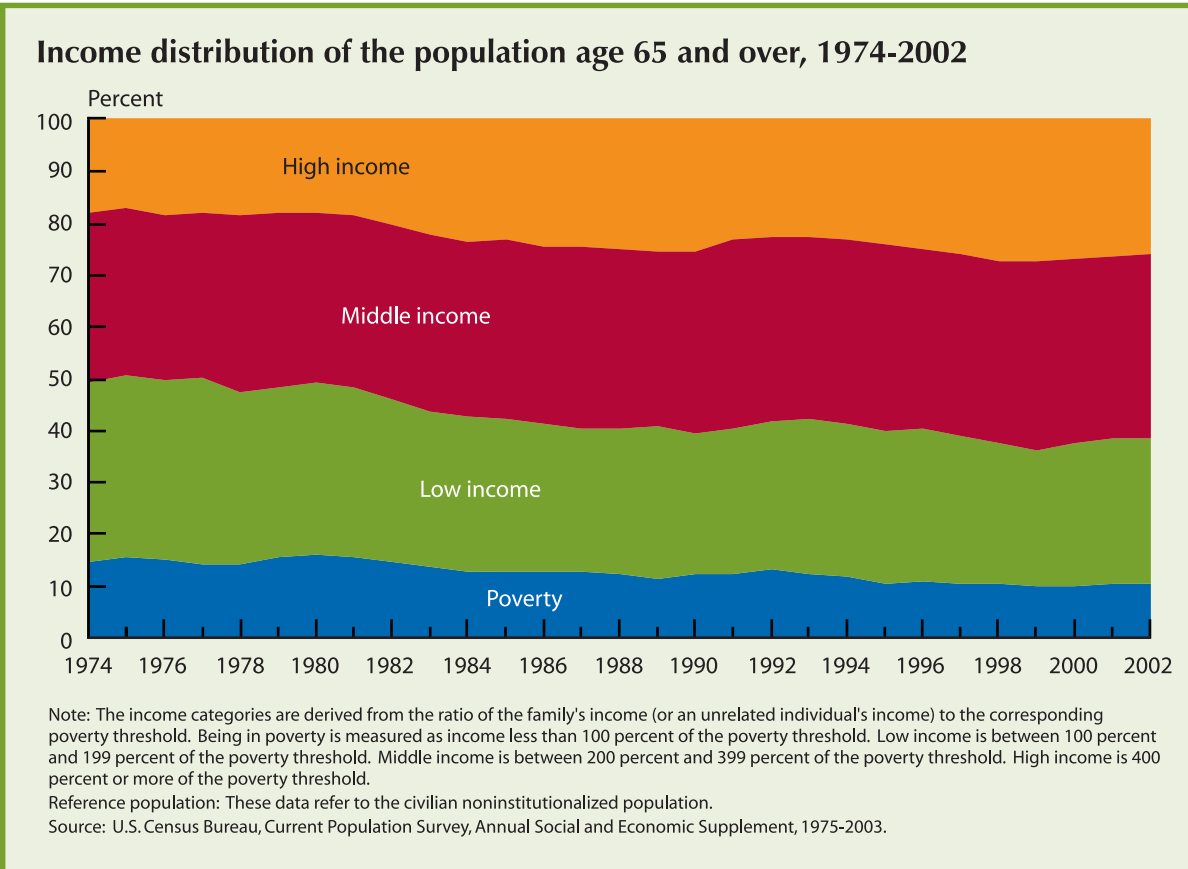
Data for this indicator's chart and bullets can be found in Tables 7a and 7b on pages 75 and 76.



INDICATOR 8

Income

The percentage of people living below the poverty line does not give a complete picture of the economic situation of older Americans. Examining the income distribution of the population age 65 and over and their median income provides additional insights into their economic well-being.



- ◆ Since 1974, the proportion of older people living in poverty and in the low-income group has generally declined so that, by 2002, 10 percent of the older population lived in poverty and 28 percent of the older population were in the low-income group.
- ◆ In 2002, people in the middle income group made up the largest share of older people by income category (35 percent). The proportion with a high income has increased over time. The proportion of the older population having a high income rose from 18 percent in 1974 to 26 percent in 2002.
- ◆ The trend in median household income of the older population has also been positive. In 1974, the median household income for older people was \$16,882 when expressed in 2002 dollars. By 2002, the median household income had increased to \$23,152.⁶

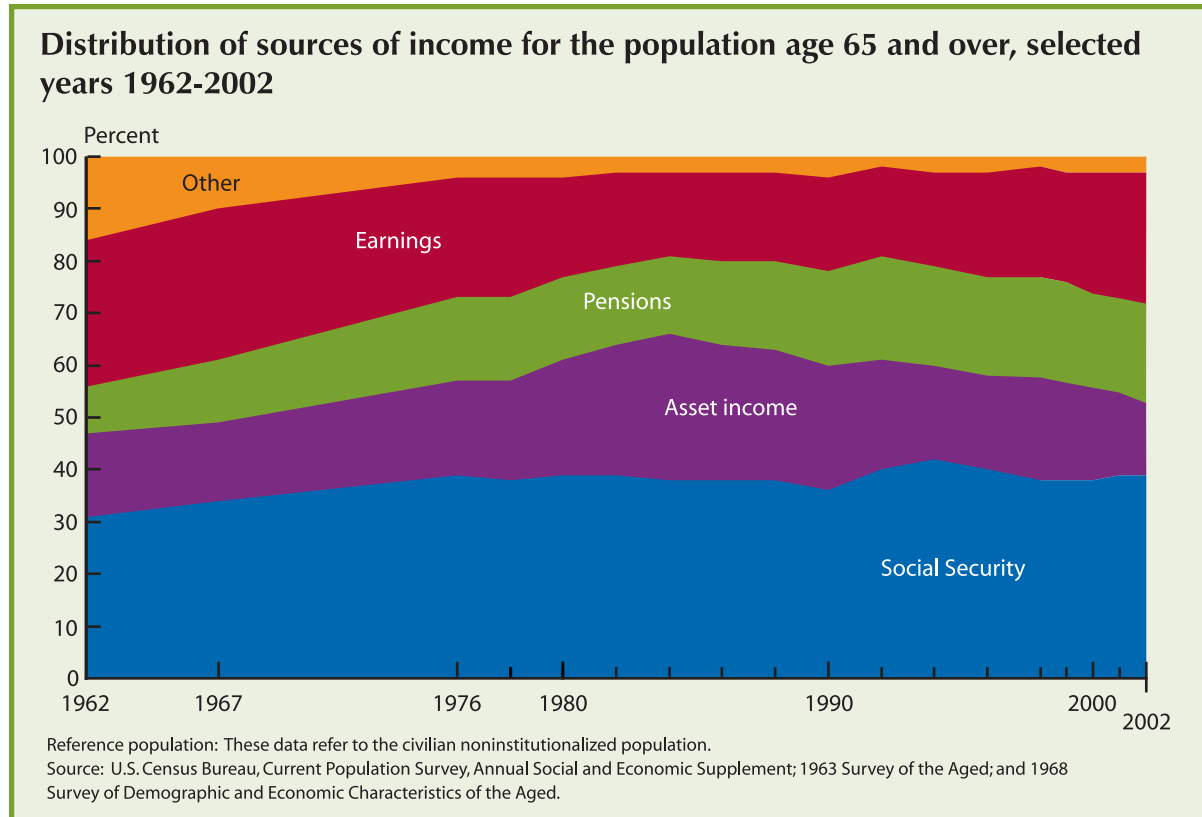
Data for this indicator's chart and bullets can be found in Table 8 on page 77.



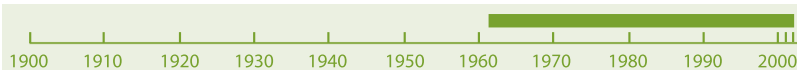
INDICATOR 9

Sources of Income

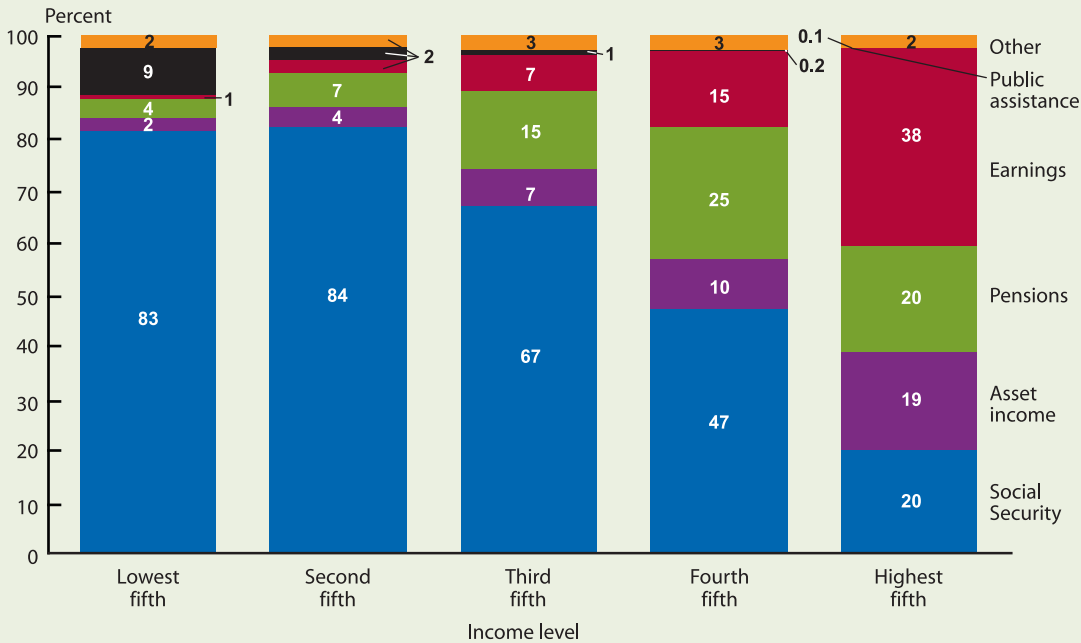
Most older Americans are retired from full-time work. Social Security was developed as a floor of protection for their incomes, to be supplemented by other pension income, income from assets, and to some extent, continued earnings. Over time, Social Security has taken on a greater importance to many older Americans.



- ◆ Since the early 1960s, Social Security has provided the largest share of aggregate income for older Americans. The share of income from pensions increased rapidly in the 1960s and 1970s and more gradually since then. The share of income from assets peaked in the mid-1980s and has generally declined since then. The share from earnings has had the opposite pattern—declining until the mid-1980s and generally increasing since then.
- ◆ In 2002, aggregate income for the population age 65 and over came largely from four sources. Social Security provided 39 percent, earnings accounted for 25 percent, pensions provided 19 percent, and asset income accounted for 14 percent.
- ◆ Pension coverage expanded dramatically in the 2 decades after World War II, and private pensions accounted for an increasing proportion of income for older people during the 1960s and early 1970s. Since then, the coverage rate has been stable at about 50 percent of all workers on their current jobs.^{7,8}
- ◆ There has been a major shift in the type of pensions provided by employers, from defined-benefit plans (in which a specified amount is typically paid as a lifetime annuity) to defined-contribution plans such as 401(k) plans (in which the amount of the future benefit varies depending on investment earnings). Employers increasingly offer defined-contribution plans to employees. The percentage of workers



Sources of income for the population age 65 and over, by income quintile, 2002



Reference population: These data refer to the civilian noninstitutionalized population.
 Source: U.S. Census Bureau, Current Population Survey, Annual Social and Economic Supplement.

with a pension plan who have defined-benefit coverage has decreased from 80 percent in 1985 to 33 percent in 2003.^{9,10} Over the same period, participation in defined-contribution plans increased from 41 percent to 51 percent. In recent years, a growing number of employers have converted their defined-benefit plans to cash balance plans. Cash balance plan participation has increased nearly fourfold between 1997 and 2000, from 6 percent to 23 percent.^{11,12}

◆ Among older Americans in the lowest fifth of the income distribution, Social Security accounts for 83 percent of aggregate income,

and public assistance accounts for another 9 percent. For those whose income is in the highest income category, Social Security, pensions, and asset income each account for about one-fifth of aggregate income, and earnings account for the remaining two-fifths.

◆ For the population age 80 and over, Social Security and asset income account for a larger proportion of aggregate income and earnings a smaller proportion, compared with the population age 65-69.¹³

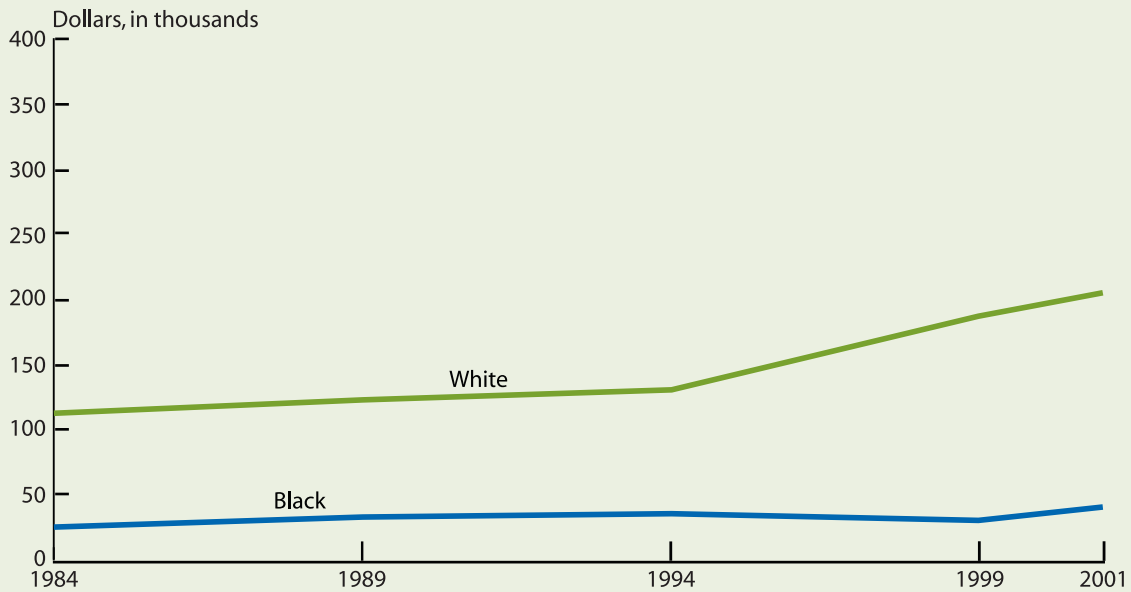
Data for this indicator's charts and bullets can be found in Tables 9a and 9b on page 78.

INDICATOR 10

Net Worth

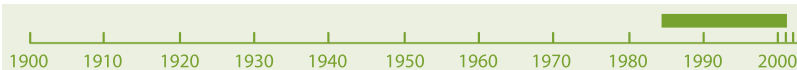
Net worth (the value of real estate, stocks, bonds, and other assets minus outstanding debts) is an important indicator of economic security and well-being. Greater net worth allows a family to maintain its standard of living when income falls because of job loss, health problems, or family changes such as divorce or widowhood.

Median household net worth, by race of head of household age 65 and over, in 2001 dollars, selected years 1984-2001

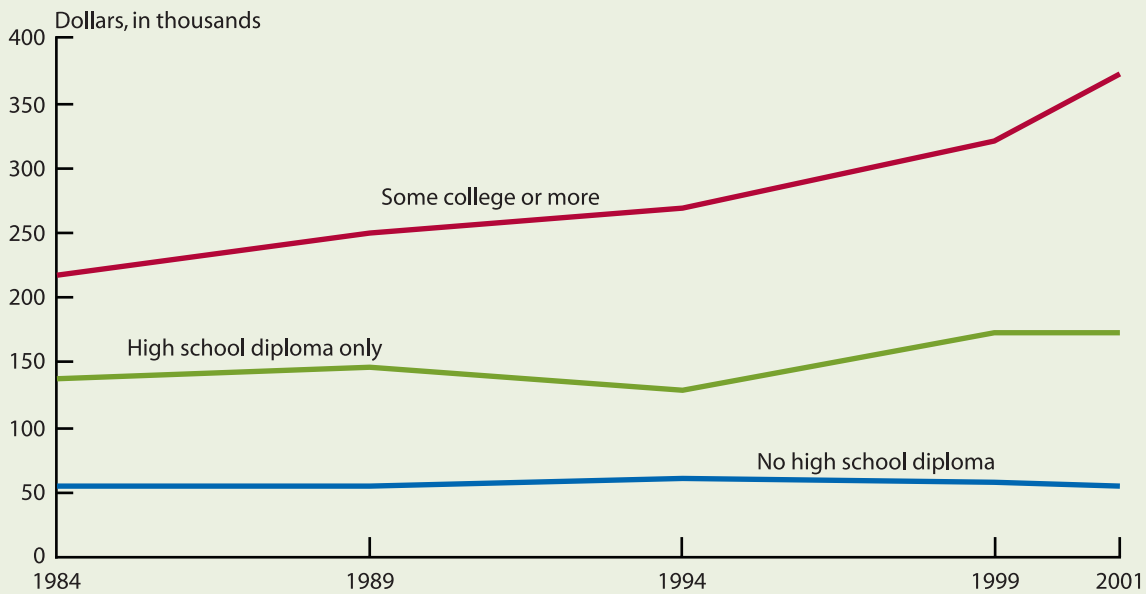


Note: Net worth data do not include pension wealth. This excludes private defined-contribution and defined-benefit plans as well as rights to Social Security wealth. Tests of statistical significance were performed on the mean household net worth.
Reference population: These data refer to the civilian noninstitutionalized population.
Source: Panel Study of Income Dynamics.

- ◆ Between 1984 and 2001 the median net worth of households headed by white people age 65 and over increased 81 percent from \$113,400 to \$205,000. The median net worth of households headed by black people age 65 and over increased 60 percent from \$25,600 to \$41,000.
- ◆ Although the rate of growth of wealth between 1984 and 2001 has been substantial for both older black households and older white households, large differences continue to exist, with the median net worth of older white households (\$205,000) five times larger than older black households (\$41,000).
- ◆ In 2001, the median net worth of households headed by married people age 65 and over (\$291,000) was more than twice that of households headed by unmarried people (\$100,800) in the same age group.
- ◆ Overall, between 1984 and 2001 the median net worth of households headed by people age 65 and over increased by 82 percent (from \$98,900 to \$179,800).



Median household net worth, by educational attainment of head of household age 65 and over, in 2001 dollars, selected years 1984-2001



Note: Net worth data do not include pension wealth. This excludes private defined-contribution and defined-benefit plans as well as rights to Social Security wealth. Tests of statistical significance were performed on the mean household net worth.
 Reference population: These data refer to the civilian noninstitutionalized population.
 Source: Panel Study of Income Dynamics.

- ◆ In 2001, households headed by people age 65 and over with some college or more reported a median household net worth (\$360,500) more than six times that of households headed by older people without a high school diploma (\$57,300).
- ◆ Between 1984 and 2001, the median net worth of households headed by people age 65 and

over without a high school diploma increased by only 4 percent while the median net worth of households headed by people with some college or more increased by 67 percent.

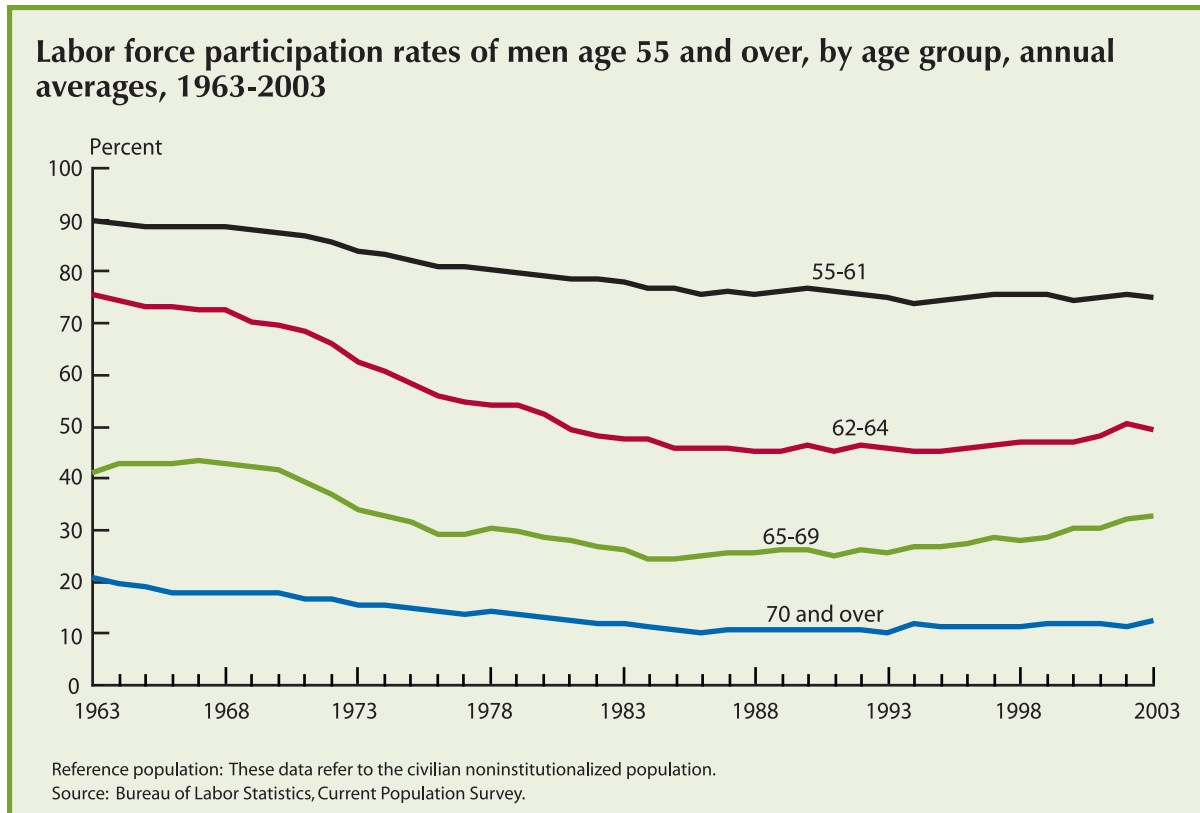
Data for this indicator's charts and bullets can be found in Table 10 on page 79.



INDICATOR 11

Participation in the Labor Force

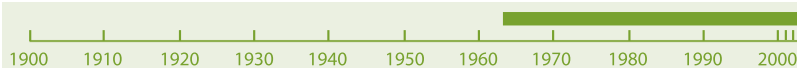
The labor force participation rate is the percentage of a group that is in the labor force—that is, either working (employed) or actively looking for work (unemployed). Some older Americans work out of economic necessity. Others may be attracted by the social contact, intellectual challenges, or sense of value that work often provides.



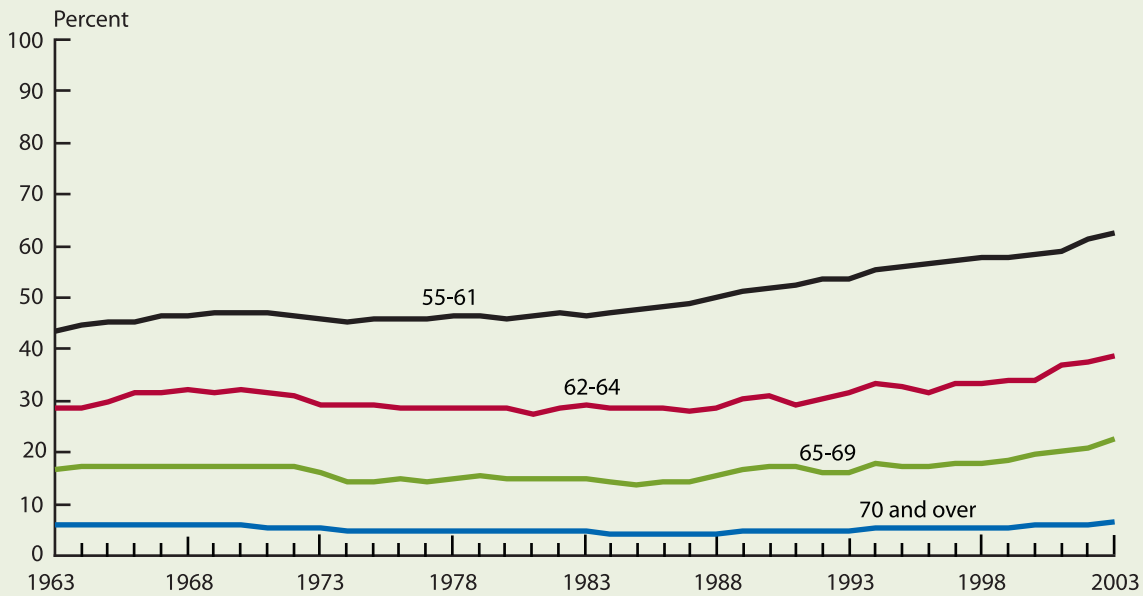
- ◆ Between 1963 and 2003, labor force participation rates declined from 90 percent to 75 percent among men age 55-61. Over this period, participation rates declined from 76 percent to 50 percent for men age 62-64 and from 21 percent to 12 percent for men age 70 and over. For all of these groups, most of these declines occurred prior to 1980.¹⁴
- ◆ The decline in labor force participation among older men before the 1980s has been attributed to several factors. The youngest age of eligibility for Social Security benefits was reduced from 65 to 62 in the early 1960s. Greater wealth also allowed older Americans to retire earlier.¹⁵ The more recent stability of participation rates has been partially explained by the elimination of mandatory retirement

laws, liberalization of the Social Security earnings test (the reduction of Social Security benefits as earnings exceed specified amounts), and gradual increases in the delayed retirement credit for Social Security beneficiaries.¹⁶

- ◆ While men age 65-69 also have experienced an overall decline in labor force participation over the past 4 decades, this group has gradually increased its participation rate in more recent years. Men age 65-69 experienced declines in labor force participation similar to the other older age groups prior to the early 1980s, then saw their participation level off between 1983 and 1993 with rates in the 24 percent to 26 percent range. Since then, their participation rate has increased to nearly 33 percent in 2003.



Labor force participation rates of women age 55 and over, by age group, annual averages, 1963-2003



Reference population: These data refer to the civilian noninstitutionalized population.
Source: Bureau of Labor Statistics, Current Population Survey.

- ◆ Labor force participation rates have risen among most women age 55 and over during the past 4 decades. The increase has been largest among women age 55-61, from 44 percent in 1963 to nearly 63 percent in 2003. In recent years, the increase in participation rates for women age 55-61, 62-64, and 65-69 has been somewhat larger.
- ◆ Labor force participation rates for older women reflect changes in the work experience of successive generations of women. Many women now in their 60s and 70s did not work outside the home when they were younger, or they moved in and out of the labor force. As new cohorts of women approach older ages, they are participating in the labor force at higher rates than previous generations. As a result, in 2003, nearly 63 percent of women age 55-61 were in the labor force, compared with 44 percent of women age 55-61 in 1963. Over the same period, the labor force participation rate increased from 29 percent to 39 percent among women age 62-64 and from 17 percent to 23 percent among women age 65-69.
- ◆ The difference between labor force participation rates for men and women has narrowed over time. Among people age 55-61, for example, the gap between men's and women's rates in 2003 was 12 percentage points, compared with 46 percentage points in 1963.

Data for this indicator's charts and bullets can be found in Table 11 on page 80.



INDICATOR 12

Housing Expenditures

Most older people live in adequate, affordable housing,¹⁷ but some older Americans are allocating a large proportion of their total expenditures to housing. When housing expenditures comprise a relatively high proportion of total expenditures, less money is available for health care, savings, and other vital goods and services.

Percentage of total annual expenditures allocated to housing costs in households headed by people age 65 and over, by income level, 1987 and 2002



Note: Housing expenditures include mortgage payments (interest, property taxes, and insurance), rent, and utilities.

Reference population: These data refer to the resident noninstitutionalized population.

Source: Bureau of Labor Statistics, Consumer Expenditure Survey.

- ◆ The burden of housing costs relative to all expenditures declines as income increases. Among households headed by people age 65 and over, those with income in the bottom fifth of the income distribution in 2002 allocated an average of 40 percent of all expenditures to basic housing. That proportion fell to about 33 percent for those in the middle income fifth and to 28 percent for those in the top fifth of the income distribution.
- ◆ In 2002, households in the lowest income group spent an average of \$5,116 on housing. This compares with an average of \$11,544 spent on housing by those in the highest income group. The 12 percentage point difference in the share spent on housing between the lowest and highest income groups is similar to that measured in 1987 (i.e., 33 percent compared with 21 percent).
- ◆ Between 1987 and 2002, the percentage of expenditures devoted to housing rose among households headed by older Americans in each of the five income groups.

Data for this indicator's chart and bullets can be found in Table 12 on page 81.



Health Status

Indicator 13: Life Expectancy

Indicator 14: Mortality

Indicator 15: Chronic Health Conditions

Indicator 16: Sensory Impairments and Oral Health

Indicator 17: Memory Impairment

Indicator 18: Depressive Symptoms

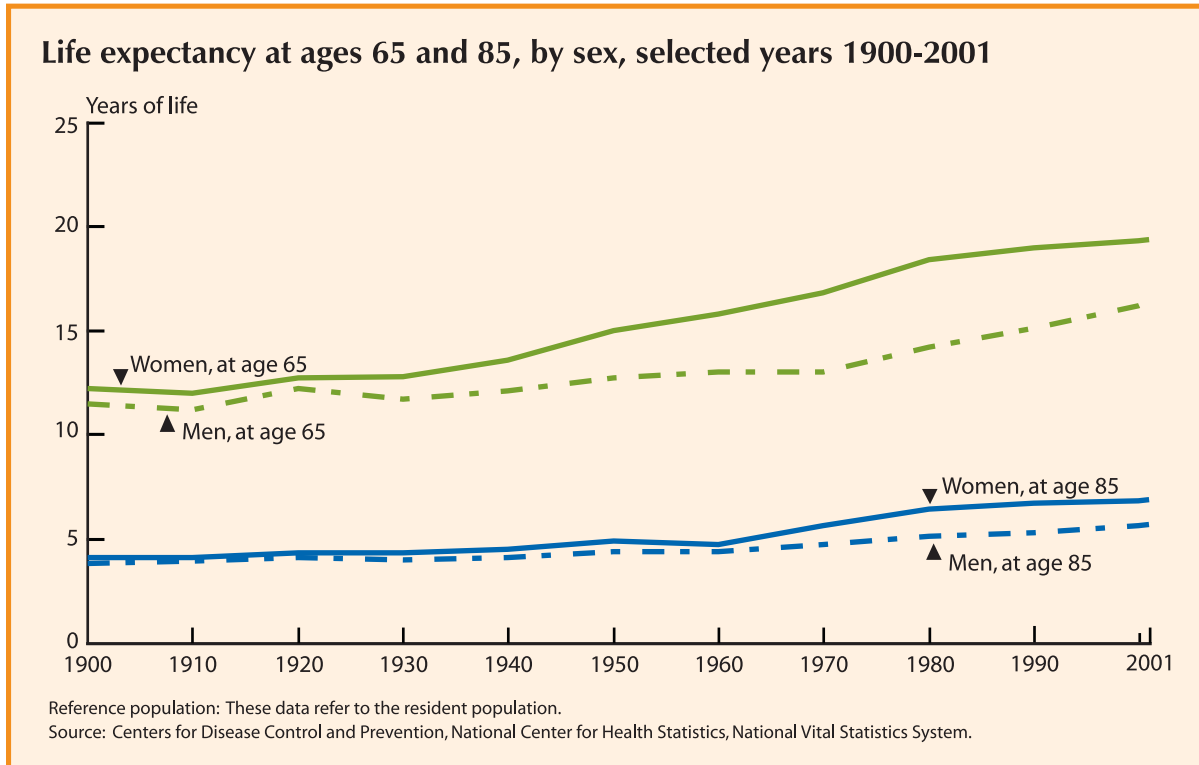
Indicator 19: Disability

Indicator 20: Respondent-Assessed Health Status

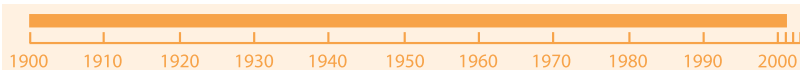
INDICATOR 13

Life Expectancy

Life expectancy is a summary measure of the overall health of a population. It represents the average number of years of life remaining to a person at a given age if death rates were to remain constant. In the United States, improvements in health have resulted in increased life expectancy and contributed to the growth of the older population over the past century.



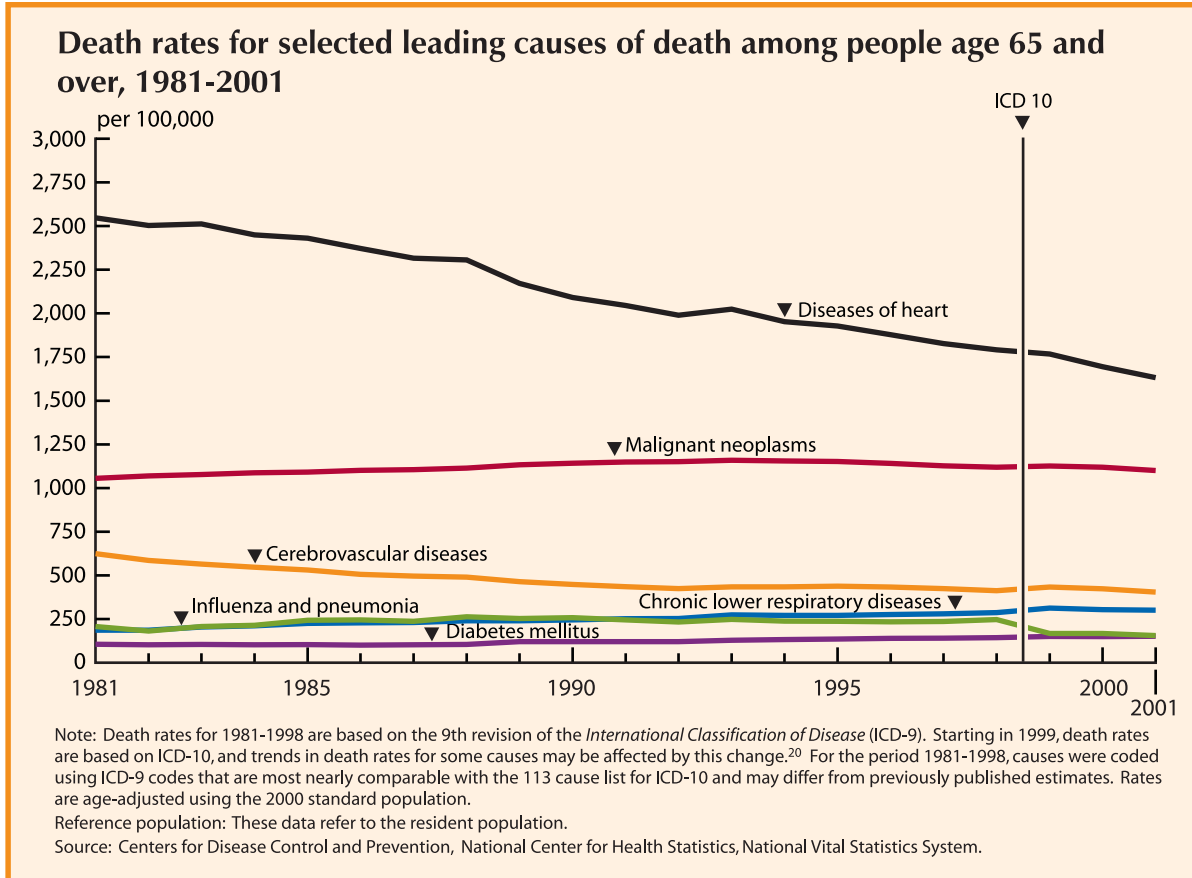
- ◆ Americans are living longer than ever before. Life expectancies at both age 65 and age 85 have increased. Under current mortality conditions, people who survive to age 65 can expect to live an average of nearly 18 more years, more than 6 years longer than people age 65 in 1900. The life expectancy of people who survive to age 85 today is about 7 years for women and 6 years for men.
 - ◆ Life expectancy at age 65 in the United States is lower than that of many other industrialized nations. In 1999 women age 65 in Japan could expect to live on average 2.8 years longer than women in the United States. Among men, the difference was 0.9 years.¹⁸
 - ◆ Life expectancy varies by race, but the difference decreases with age. In 2001, life expectancy at birth was 5.5 years higher for white people than for black people. At age 65, white people can expect to live an average of nearly 2 years longer than black people. Among those who survive to age 85, however, the life expectancy among black people is slightly higher than among white people. Differences in life expectancy at birth have been declining over time.
- Data for this indicator's chart and bullets can be found in Tables 13a and 13b on page 82.*



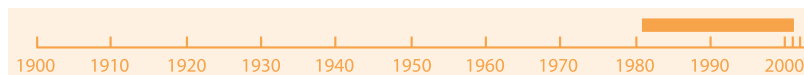
INDICATOR 14

Mortality

Overall, death rates in the U.S. population have declined during the past century. But for some diseases, death rates among older Americans have increased in recent years.



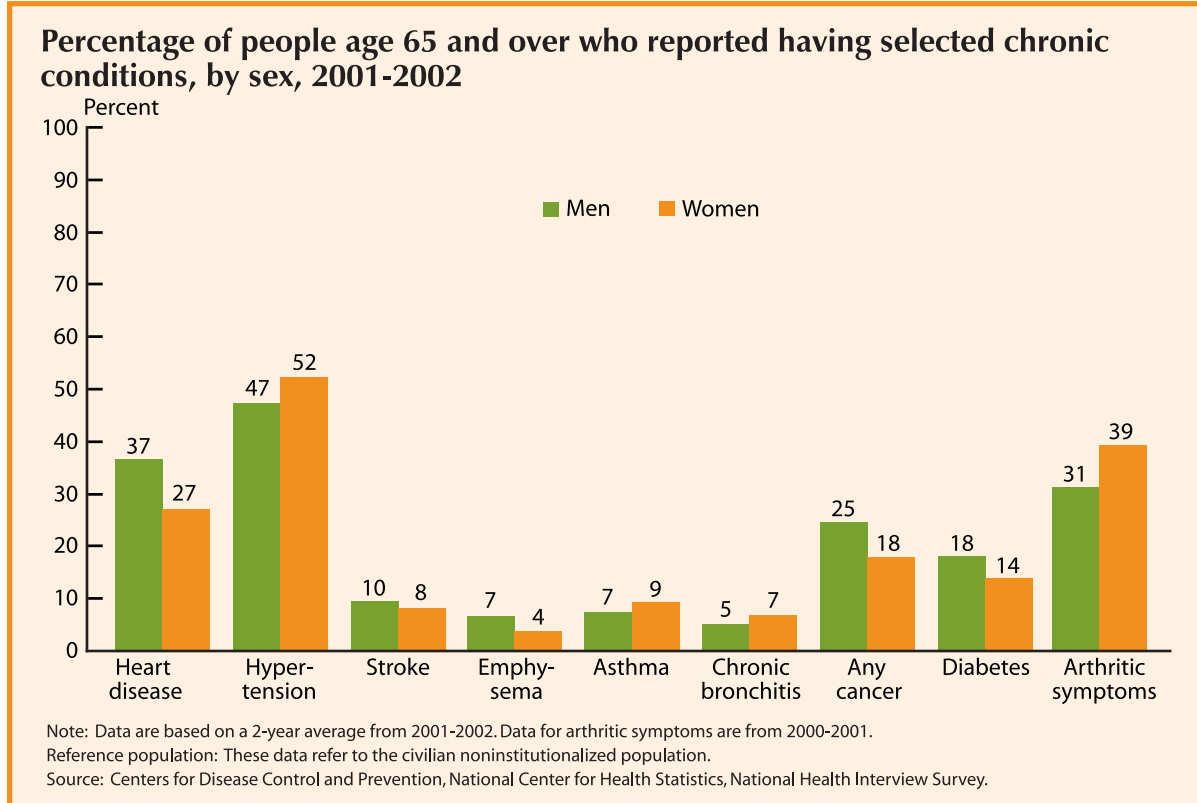
- ◆ In 2001, the leading cause of death among people age 65 and over was diseases of heart (1,632 deaths per 100,000 people), followed by malignant neoplasms (cancer) (1,100 per 100,000), cerebrovascular diseases (stroke) (404 per 100,000), chronic lower respiratory diseases (301 per 100,000), influenza and pneumonia (155 per 100,000), and diabetes mellitus (151 per 100,000).
 - ◆ Between 1981 and 2001, age-adjusted death rates for all causes of death among people age 65 and over declined by 12 percent.¹⁹ Death rates for diseases of heart and cerebrovascular diseases (stroke) declined by approximately one-third. Age-adjusted death rates for diabetes mellitus increased by 43 percent since 1981, and death rates for chronic lower respiratory diseases increased by 62 percent.
 - ◆ Diseases of heart and malignant neoplasms are the top two leading causes of death among all people age 65 and over, irrespective of sex, race, or Hispanic origin.
 - ◆ The relative importance of certain other causes of death varied among groups. For example, in 2001, diabetes mellitus was the fifth leading cause of death among black men, the fourth among Hispanic men, and the sixth among white and Asian or Pacific Islander men. Among women age 65 and over, diabetes mellitus was the fourth leading cause of death among Hispanics and blacks and the seventh leading cause among whites.
- Data for this indicator's chart and bullets can be found in Tables 14a, 14b, and 14c on pages 83-87.*



INDICATOR 15

Chronic Health Conditions

Chronic diseases are long-term illnesses that are rarely cured. Chronic diseases such as heart disease, stroke, cancer, and diabetes are among the most common and costly health conditions.²¹ Chronic health conditions negatively affect quality of life, contributing to declines in functioning and the inability to remain in the community.²² Many chronic conditions can be prevented or modified with behavioral interventions. Five of the six leading causes of death among older Americans are chronic diseases. (See “Indicator 14: Mortality.”)



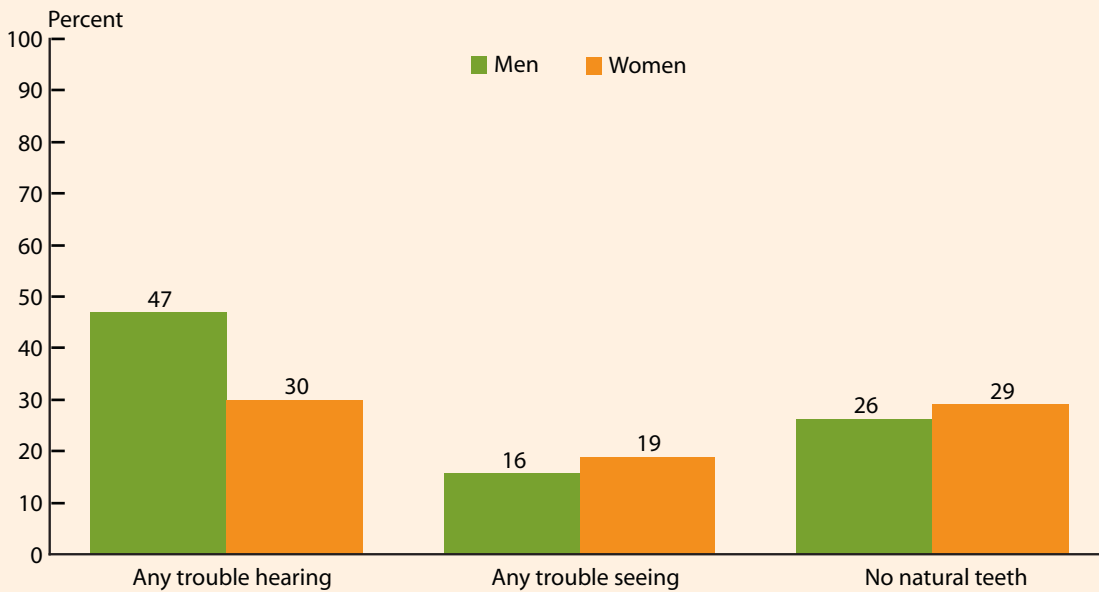
- ◆ The prevalence of chronic conditions differs by sex. Women report higher levels of hypertension, asthma, chronic bronchitis, and arthritic symptoms than men. Men report higher levels of heart disease, cancer, diabetes, and emphysema.
 - ◆ There are differences by race and ethnicity in the prevalence of certain chronic conditions. Among people age 65 and over, non-Hispanic blacks report higher levels of hypertension and diabetes than non-Hispanic whites (66 percent compared with 49 percent for hypertension and 23 percent compared with 14 percent for diabetes). Hispanics also report higher levels of diabetes than non-Hispanic whites (24 percent compared with 14 percent) but similar levels of hypertension (48 percent).
 - ◆ The prevalence of some conditions is increasing over time. In 1997-1998, 47 percent of people age 65 and over reported having hypertension compared with 50 percent in 2001-2002. Diabetes is also increasing among the older population, from 13 percent in 1997-1998 to 16 percent in 2001-2002.
- Data for this indicator’s chart and bullets can be found in Tables 15a and 15b on page 88.*

INDICATOR 16

Sensory Impairments and Oral Health

Vision and hearing impairments and oral health problems are often thought of as natural signs of aging. Often, however, early detection and treatment can prevent, or at least postpone, some of the debilitating physical, social, and emotional effects these impairments can have on the lives of older people. Glasses, hearing aids, and regular dental care are not covered services under Medicare.

Percentage of people age 65 and over who reported having any trouble hearing, any trouble seeing, or no natural teeth, by sex, 2002



Note: Respondents were asked "Which statement best describes your hearing without a hearing aid: good, a little trouble, a lot of trouble, deaf?" For the purposes of this indicator the category "Any trouble hearing" includes "a little trouble, a lot of trouble, and deaf." Regarding their vision, respondents were asked "Do you have any trouble seeing, even when wearing glasses or contact lenses?" and the category "Any trouble seeing" includes those who in a subsequent question report themselves as blind. Lastly, respondents were asked, in one question, "Have you lost all of your upper and lower natural (permanent) teeth?"
 Reference population: These data refer to the civilian noninstitutionalized population.
 Source: Centers for Disease Control and Prevention, National Center for Health Statistics, National Health Interview Survey.

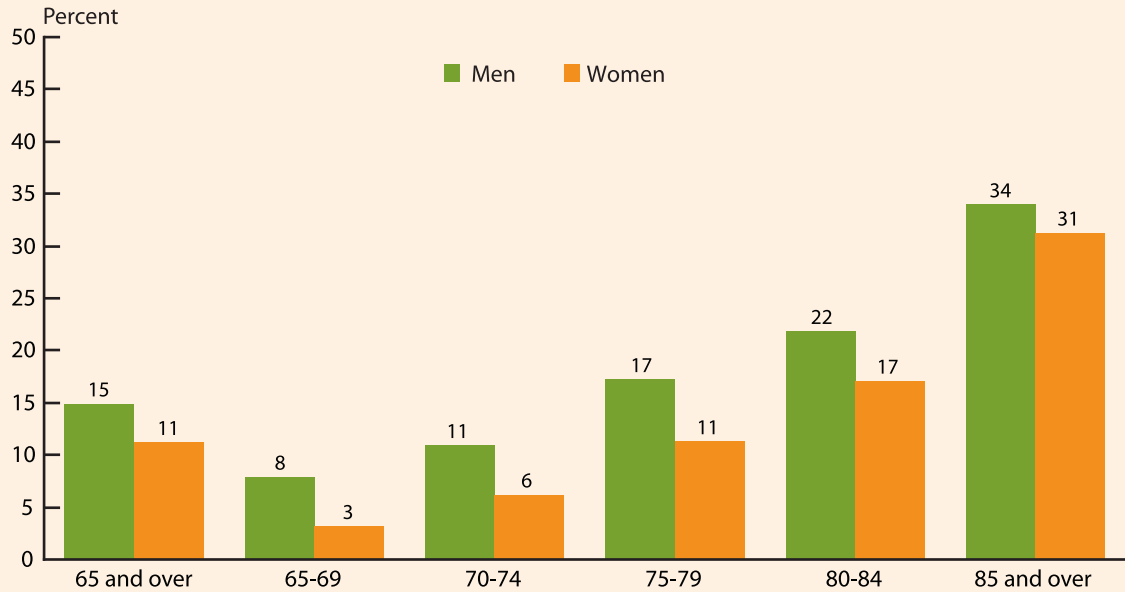
- ◆ In 2002, close to one-half of older men and nearly one-third of older women reported trouble hearing. The percentage with trouble hearing was higher for people age 85 and over (60 percent) than for people age 65-74 (30 percent). Ten percent of all older women and 19 percent of all older men reported having ever worn a hearing aid.
 - ◆ Vision trouble affects 18 percent of the older population, 16 percent of men and 19 percent of women. Among people age 85 and over, 33 percent reported trouble seeing. In 2002, among people age 65 and over who reported trouble seeing, 16 percent reported having ever had glaucoma, 16 percent reported ever having had macular degeneration, and 44 percent reported having had cataracts in the past 12 months.
 - ◆ The prevalence of edentulism, having no natural teeth, was higher for people age 85 and over (38 percent) than for people age 65-74 (24 percent). Socioeconomic differences are large. Forty-six percent of older people with family income below the poverty line reported no natural teeth compared with 27 percent of people above the poverty threshold.
- Data for this indicator's chart and bullets can be found in Tables 16a, 16b, and 16c on pages 89 and 90.*

INDICATOR 17

Memory Impairment

Memory skills are important to general cognitive functioning, and declining scores on memory tests are indicators of general cognitive loss for older adults. Low cognitive functioning (i.e., memory impairment) is a major risk factor for entering a nursing home.^{23,24}

Percentage of people age 65 and over with moderate or severe memory impairment, by age group and sex, 2002



Note: The definition of "moderate or severe memory impairment" is four or fewer words recalled (out of 20) on combined immediate and delayed recall tests among self-respondents. Self-respondents who refused either the immediate or delayed word recall test were excluded from the analysis. Proxy respondents with an overall memory rating of "poor" were included as having moderate or severe memory impairment. Because of some changes in methods from the 2000 edition of *Older Americans*, no inference should be made about longitudinal trends.

Reference population: These data refer to the civilian noninstitutionalized population.

Source: Health and Retirement Study.

- ◆ Older men are more likely to experience moderate or severe memory impairment than older women. In 2002, 15 percent of men age 65 and over experienced moderate or severe memory impairment compared with 11 percent of women. At age 85 and over, the difference narrowed, and approximately one-third of both men and women experienced moderate or severe memory impairment.
- ◆ The prevalence of moderate or severe memory impairment is six times as high for people age

85 and over as it is for people age 65-69. In 2002, the proportion of people age 85 and over with moderate or severe memory impairment was 32 percent compared with 5 percent for people age 65-69.

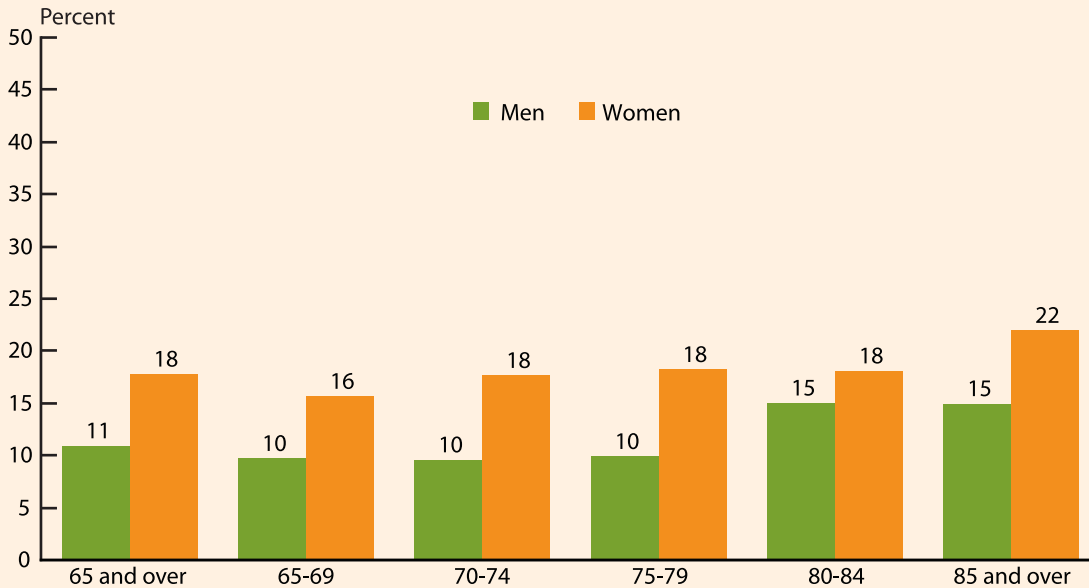
Data for this indicator's chart and bullets can be found in Table 17 on page 90.

INDICATOR 18

Depressive Symptoms

Depressive symptoms are an important indicator of general well-being and mental health among older adults. People who report many depressive symptoms often experience higher rates of physical illness, greater functional disability, and higher health care resource utilization.^{23,25}

Percentage of people age 65 and over with clinically relevant depressive symptoms, by age group and sex, 2002



Note: The definition of "clinically relevant depressive symptoms" is four or more symptoms out of a list of eight depressive symptoms from an abbreviated version of the Center for Epidemiological Studies Depression Scale (CES-D) adapted by the Health and Retirement Study. The CES-D scale is a measure of depressive symptoms and is not to be used as a diagnosis of clinical depression. A detailed explanation concerning the "4 or more symptoms" cut-off can be found in the following documentation, <http://hrsonline.isr.umich.edu/docs/userg/dr-005.pdf>.
Reference population: These data refer to the civilian noninstitutionalized population.
Source: Health and Retirement Study.

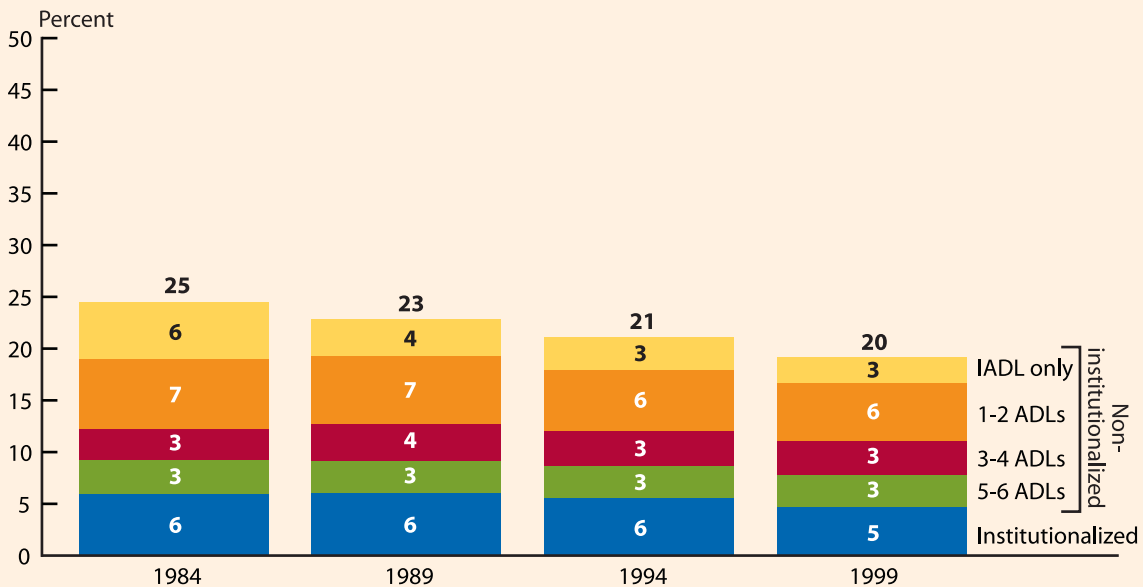
- ◆ Older women are more likely to report clinically-relevant depressive symptoms than older men. In 2002, 16 percent of women age 65-69 reported depressive symptoms compared with 10 percent of men. At age 85 and over, 22 percent of women reported depressive symptoms compared with 15 percent of men.
 - ◆ The prevalence of clinically-relevant depressive symptoms is related to age. In 2002, the proportion of people age 65 and over with clinically-relevant depressive symptoms was higher for people age 85 and over (20 percent) than for people age 65-69 (13 percent).
 - ◆ Serious mental illness is another measure of mental health. It identifies people who have a diagnosable mental disorder, such as schizophrenia, bipolar disorder, or severe forms of depression, resulting in functional impairment in major life activities.²⁶ In 2000-2001, 3 percent of women and 2 percent of men age 65 and over reported experiencing symptoms of serious mental illness.²⁷
 - ◆ Psychotropic medications are commonly prescribed by doctors to treat mental disorders in older patients. In 1996, more than 6 million noninstitutionalized people age 65 and over used psychotropic medications (e.g., antidepressants, anti-anxiety agents, and sedative/hypnotics).²⁸
- Data for this indicator's charts and bullets can be found in Table 18 on page 90.*

INDICATOR 19

Disability

Functioning in later years may be diminished if illness, chronic disease, or injury limits physical and/or mental abilities. Changes in disability rates have important implications for work and retirement policies, health and long-term care needs, and the social well-being of the older population.

Age-adjusted percentage of Medicare enrollees age 65 and over who are chronically disabled, by level and category of disability, 1984, 1989, 1994, and 1999

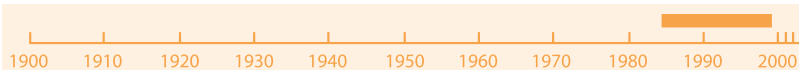


Note: Disabilities are grouped into two categories: limitations in activities of daily living (ADLs) and limitations in instrumental activities of daily living (IADLs). The six ADLs included are bathing, dressing, getting in or out of bed, getting around inside, toileting, and eating. The eight IADLs included are light housework, laundry, meal preparation, grocery shopping, getting around outside, managing money, taking medications, and telephoning. Individuals are considered to have an ADL disability if they report receiving help or supervision, or using equipment, to perform the activity, or not performing the activity at all. Individuals are considered to have an IADL disability if they report using equipment to perform the activity or not performing the activity at all because of their health or a disability. Individuals are considered to be chronically disabled if they have at least one ADL or one IADL limitation that is expected to last 90 days or longer, or they are institutionalized. Data for 1989 do not sum to the total because of rounding.

Reference population: These data refer to Medicare enrollees.

Source: National Long Term Care Survey.

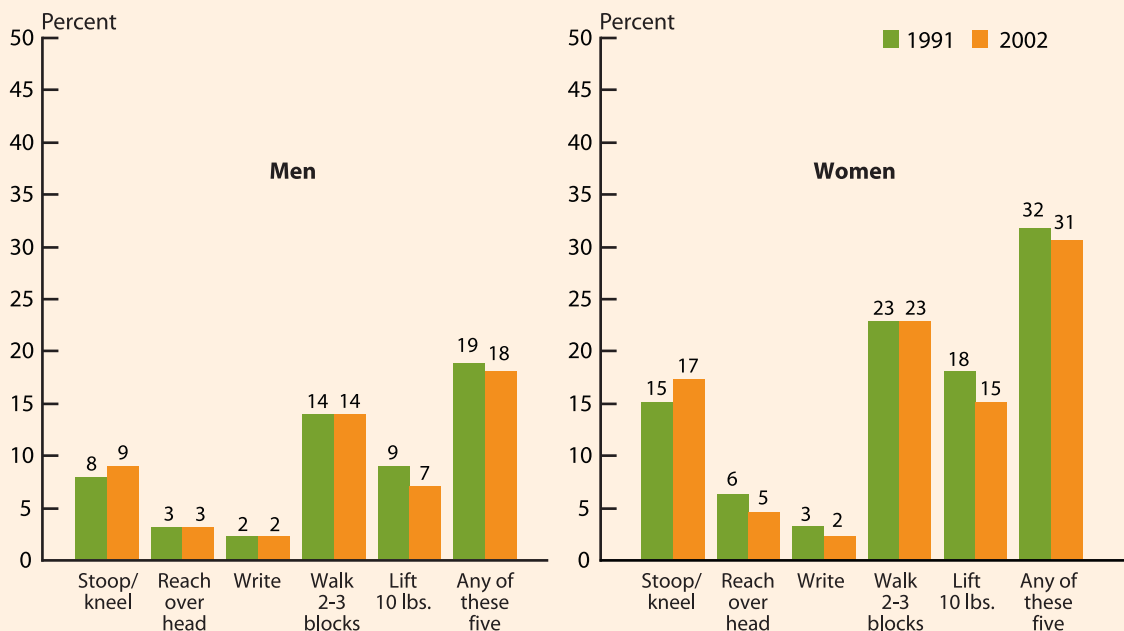
- ◆ The age-adjusted proportion of Americans age 65 and over with a chronic disability declined from 25 percent in 1984 to 20 percent in 1999. Some researchers have estimated that disability rates have declined more rapidly during this period.²⁹
- ◆ This proportion declined for both sexes—from 28 percent in 1984 to 23 percent in 1999 for older women and from 19 percent in 1984 to 15 percent in 1999 for older men.
- ◆ Despite the decline in rates, the number of older Americans with chronic disabilities increased from about 6.2 million in 1984 to 6.8 million in 1999. This is because the overall population of older people was growing fast enough to outweigh the decline in disability rates from 1984 to 1999.



INDICATOR 19 Disability continued

Different indicators can be used to monitor disability, including limitations in activities of daily living (ADLs) and instrumental activities of daily living (IADLs) and measures of physical, cognitive, and social functioning. Aspects of physical functioning such as the ability to lift heavy objects, walk 2-3 blocks, or reach up over one's head are more closely linked to physiological capabilities than are ADLs and IADLs, which may be influenced by social and cultural role expectations and by changes in technology.

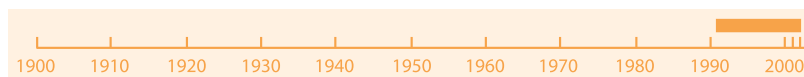
Percentage of Medicare enrollees age 65 and over who are unable to perform certain physical functions, by sex, 1991 and 2002



Note: Rates for 1991 are age-adjusted to the 2002 population.
Reference population: These data refer to Medicare enrollees.
Source: Centers for Medicare & Medicaid Services, Medicare Current Beneficiary Survey.

- ◆ Older women reported more problems with physical functioning than older men. In 2002, 31 percent of women reported they were unable to perform at least one of five activities, compared with 18 percent of men.
- ◆ Problems with physical functioning were more frequent at older ages. Thirteen percent of men age 65-74 reported they were unable to perform at least one of five activities, compared with 35 percent of men age 85 and over. Among women, 20 percent of those age 65-74 were unable to perform at least one activity, compared with 58 percent of those age 85 and over.
- ◆ Physical functioning was related to race, but not strongly. Among men, 17 percent of non-Hispanic whites were unable to perform at least one activity, compared with 26 percent of non-Hispanic blacks and 22 percent of Hispanics. Among women, 30 percent of non-Hispanic whites were unable to perform at least one activity, compared with 36 percent of non-Hispanic blacks and 29 percent of Hispanics.

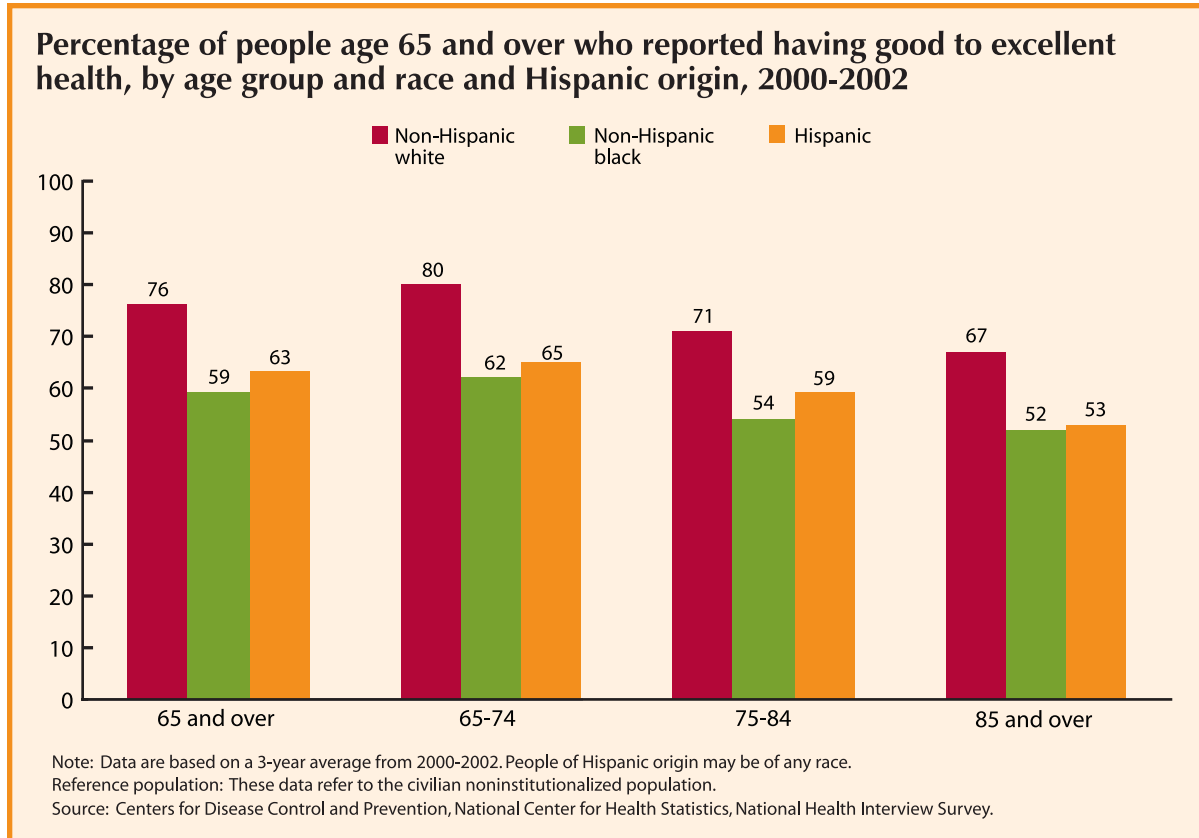
Data for this indicator's charts and bullets can be found in Tables 19a, 19b, and 19c on pages 91 and 92.



INDICATOR 20

Respondent-Assessed Health Status

Asking people to rate their health as excellent, very good, good, fair, or poor provides a common indicator of health easily measured in surveys. It represents physical, emotional, and social aspects of health and well-being. Respondent-assessed health ratings of good, very good, and excellent correlate with lower risks of mortality.³⁰



- ◆ During the period 2000-2002, 73 percent of people age 65 and over rated their health as good or better. This pattern was true for the decade preceding 2002 as well; the majority of older people reported their health to be good to excellent. In fact, the percentage of people age 65 and over reporting fair or poor health declined from 29 percent in 1991 to 27 percent in 2001.³¹
- ◆ The proportion of people reporting positive health decreases among the older age groups. Among non-Hispanic white men, 79 percent of those age 65-74 report good or better health. At age 85 and over, 65 percent of non-Hispanic white men report good or better ratings. While

the difference is greatest among white males, this pattern is evident for non-Hispanic black men, Hispanic men, and women of similar race and ethnic categories.

- ◆ Regardless of age, older non-Hispanic white men and women are more likely to report good health than their non-Hispanic black and Hispanic counterparts. The greatest differences in reporting good health occurred between non-Hispanic whites and blacks. Non-Hispanic blacks and Hispanics are similar to one another in their positive health evaluations.

Data for this indicator's chart and bullets can be found in Table 20 on page 93.

Health Risks and Behaviors

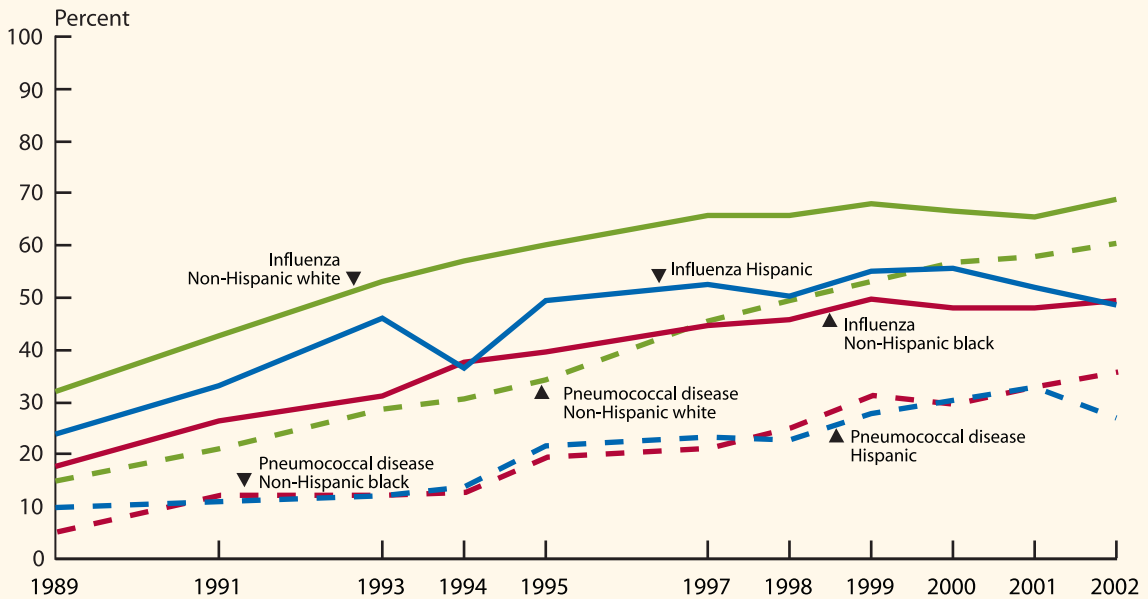
- Indicator 21: Vaccinations**
- Indicator 22: Mammography**
- Indicator 23: Dietary Quality**
- Indicator 24: Physical Activity**
- Indicator 25: Obesity**
- Indicator 26: Cigarette Smoking**
- Indicator 27: Air Quality**

INDICATOR 21

Vaccinations

Vaccinations against influenza and pneumococcal disease are recommended for older Americans, who are at increased risk for complications from these diseases compared with younger individuals.^{32,33} Influenza vaccinations are given annually, and pneumococcal vaccinations are usually given once in a lifetime. The costs associated with these vaccinations are covered under Medicare Part B.

Percentage of people age 65 and over who reported having been vaccinated against influenza and pneumococcal disease, by race and Hispanic origin, selected years 1989-2002



Note: People of Hispanic origin may be of any race. For influenza, the percentage vaccinated consists of people who reported having a flu shot during the past 12 months. For pneumococcal disease, the percentage refers to people who reported ever having a pneumonia vaccination. Reference population: These data refer to the civilian noninstitutionalized population. Source: Centers for Disease Control and Prevention, National Center for Health Statistics, National Health Interview Survey.

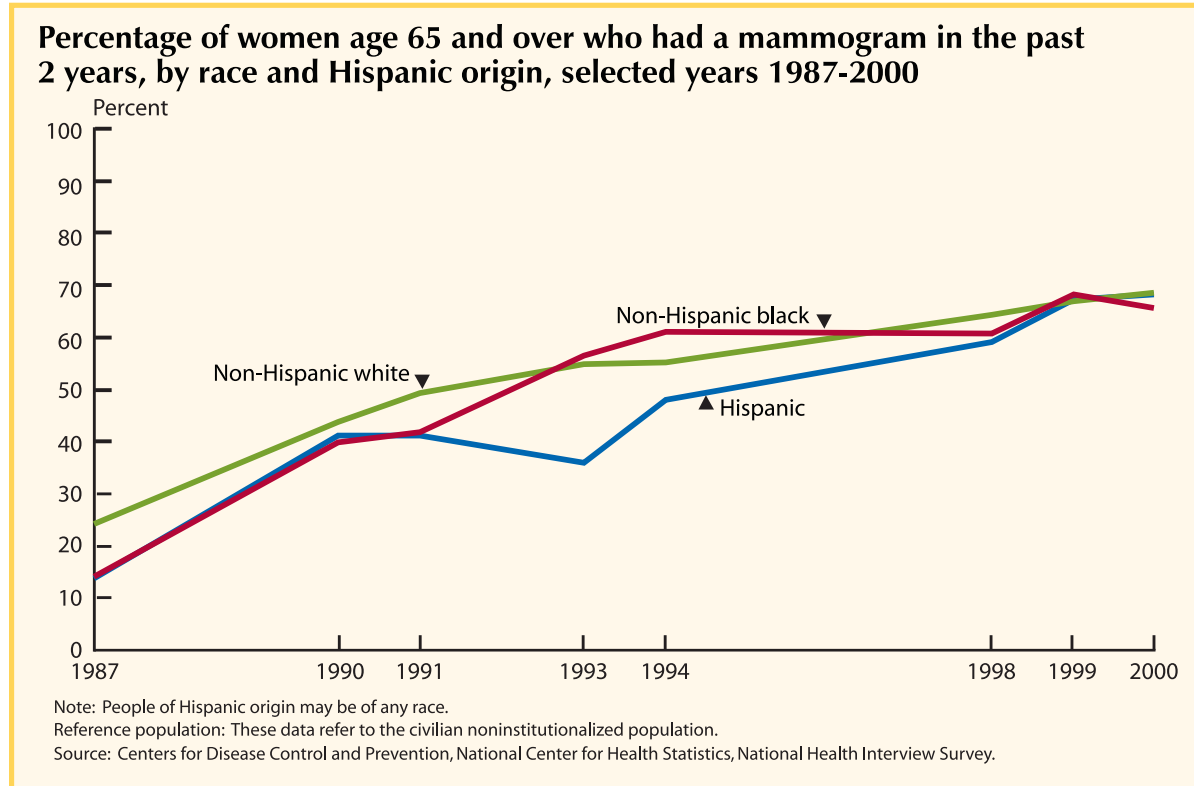
- ◆ In 2002, 66 percent of people age 65 and over reported receiving a flu shot in the past 12 months. Influenza vaccination rates have increased for all groups in the past decade, but there are still differences by race and ethnicity. Sixty-nine percent of non-Hispanic whites reported receiving a flu shot compared with 50 percent of non-Hispanic blacks and 49 percent of Hispanics.
- ◆ In 2002, 56 percent of people age 65 and over had ever received a pneumonia vaccination. Despite recent increases in the rates for all groups, non-Hispanic whites are more likely to have received a pneumonia vaccination (60 percent) compared with non-Hispanic blacks (37 percent) or Hispanics (27 percent).
- ◆ Older people are more likely to have been vaccinated than younger people. In 2002, 61 percent of people age 65-74 had received a flu shot in the preceding 12 months compared with 70 percent of people age 85 and over. Fifty percent of people age 65-74 have ever received a pneumonia vaccination compared with 63 percent of people age 85 and over.

Data for this indicator's chart and bullets can be found in Tables 21a and 21b on page 94.

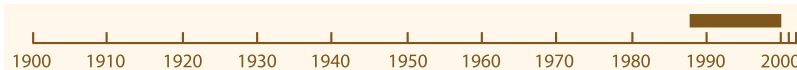
INDICATOR 22

Mammography

Health care services and screenings can help prevent disease or detect it at an early, treatable stage. Mammography has been shown to be effective in reducing breast cancer mortality among women age 40 and over, especially for the 50-69 age group.³⁴



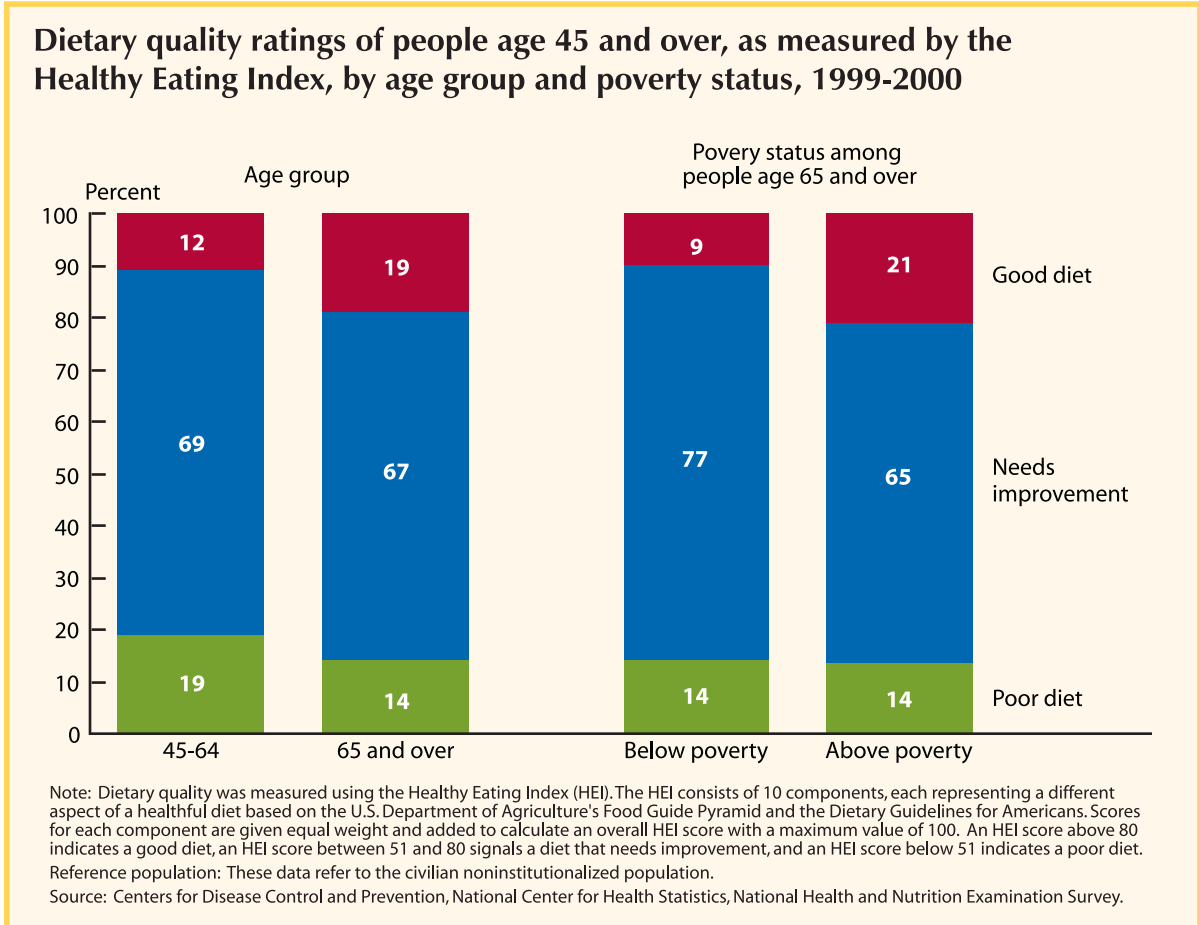
- ◆ Among women age 65 and over, the percentage who had a mammogram within the preceding 2 years almost tripled from 23 percent in 1987 to 68 percent in 2000. While there was a significant difference in 1987 between the percentage of older non-Hispanic white women (24 percent) and the percentage of older non-Hispanic black women (14 percent) who reported having had a mammogram, in recent years this difference has disappeared.
 - ◆ Older women living below the poverty level were less likely to have had a mammogram in the preceding 2 years than older women living above the poverty level. In 2000, 55 percent of women age 65 and over living below the poverty level reported having had a mammogram compared with 70 percent of older women living above the poverty level.
 - ◆ Older women without a high school diploma were less likely to have had a mammogram than older women with a high school diploma. In 2000, 58 percent of women age 65 and over without a high school diploma reported having had a mammogram in the preceding 2 years compared with 72 percent of women who had a high school diploma and 74 percent of women who had some college education.
- Data for this indicator's chart and bullets can be found in Table 22 on page 95.*



INDICATOR 23

Dietary Quality

Dietary quality plays a major role in preventing or delaying the onset of chronic diseases such as coronary heart disease, certain types of cancer, stroke, and Type 2 diabetes.³⁵ A healthy diet can reduce some major risk factors for chronic diseases, such as obesity, high blood pressure, and high blood cholesterol.³⁶



- ◆ Dietary quality was rated good for a higher percentage of the population age 65 and over (19 percent) than for people age 45-64 (12 percent). Even so, a majority of older people reported diets that needed improvement (67 percent) or were poor (14 percent).
- ◆ Older people living in poverty were less likely to report a good diet (9 percent) than older people living above the poverty level (21 percent).
- ◆ Older peoples' scores were lowest for the components of the Healthy Eating Index measuring daily servings of fruit and milk products. Older peoples' scores were highest for the components of the index measuring cholesterol intake and the variety of the diet.

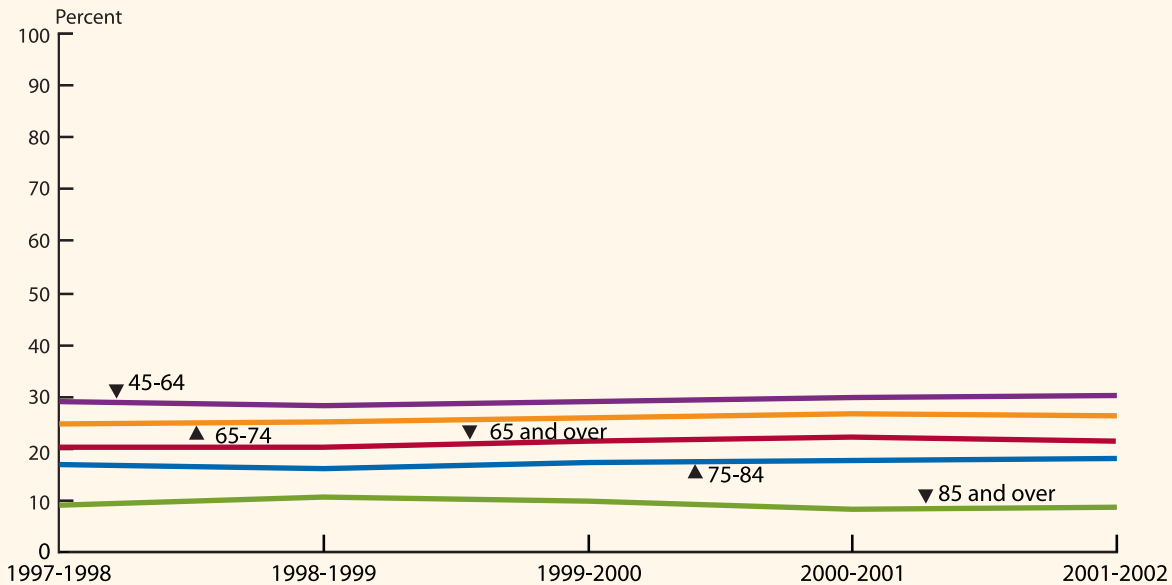
Data for this indicator's chart and bullets can be found in Tables 23a and 23b on pages 95 and 96.

INDICATOR 24

Physical Activity

Physical activity is beneficial for the health of people of all ages, including the 65 and over population. It can reduce the risk of certain chronic diseases, may relieve symptoms of depression, helps to maintain independent living, and enhances overall quality of life.^{37,38} Research has shown that even among frail and very old adults, mobility and functioning can be improved through physical activity.³⁹

Percentage of people age 45 and over who reported engaging in regular leisure time physical activity, by age group, 1997-2002



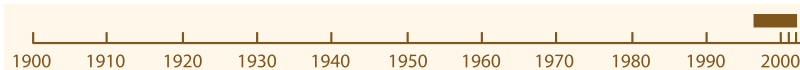
Note: Data are based on 2-year averages. "Regular leisure time physical activity" is defined as "engaging in light-moderate leisure time physical activity for greater than or equal to 30 minutes at a frequency greater than or equal to 5 times per week, or engaging in vigorous leisure time physical activity for greater than or equal to 20 minutes at a frequency greater than or equal to 3 times per week." Reference population: These data refer to the civilian noninstitutionalized population. Source: Centers for Disease Control and Prevention, National Center for Health Statistics, National Health Interview Survey.

- ◆ In 2001-2002, 21 percent of people age 65 and over reported engaging in regular leisure time physical activity. The percentage of older people engaging in regular physical activity was lower at older ages, ranging from 26 percent among people age 65-74 to 9 percent among people age 85 and over. There was no significant change in the percentage reporting physical activity between 1997 and 2002.
- ◆ Men age 65 and over are more likely than women in the same age group to report engaging in regular leisure time physical activity (26 percent and 18 percent, respectively, in 2001-2002). Older non-Hispanic white people report higher levels of physical activity than non-Hispanic

black people or Hispanics (23 percent compared with 14 percent for Hispanics and 13 percent for non-Hispanic blacks in 2001-2002).

- ◆ Other forms of physical activity also contribute to overall health and fitness. Strength training is recommended as part of a comprehensive physical activity program among older adults and may help to improve balance and decrease risk of falls.⁴⁰ Twelve percent of older people reported engaging in strengthening exercises in 2001-2002.

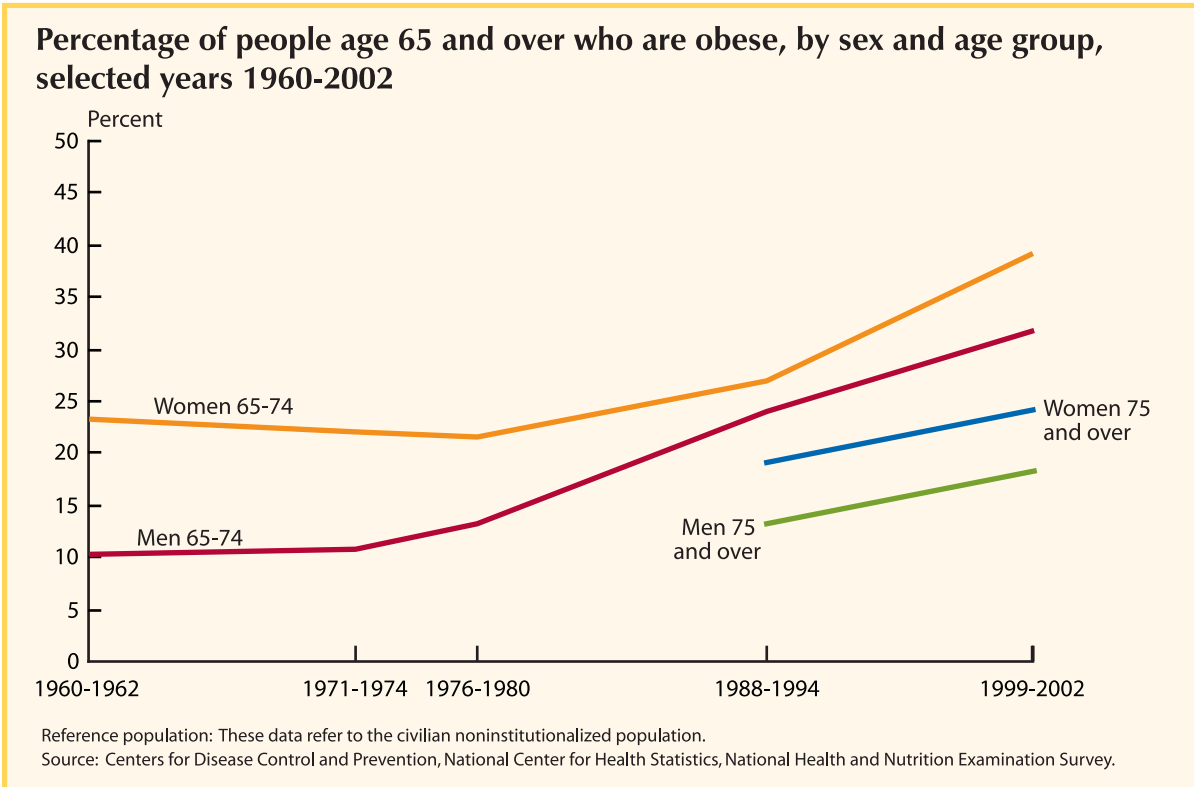
Data for this indicator's chart and bullets can be found in Tables 24a and 24b on pages 96 and 97.



INDICATOR 25

Obesity

Obesity and overweight have reached epidemic proportions in the United States and may soon rival cigarette smoking as a major cause of preventable disease and premature death.⁴¹ Both are associated with increased risk of coronary heart disease; Type 2 diabetes; endometrial, colon, postmenopausal breast, and other cancers; asthma and other respiratory problems; osteoarthritis; and disability.^{42,43} The increase in prevalence of obesity among older adults has been especially dramatic.⁴⁴



- ◆ The percentage of older Americans who were obese or overweight increased significantly in the last 4 decades. In 1960-1962, 18 percent of people age 65-74 were obese; 55 percent were overweight. By 1999-2002, more than one-third (36 percent) were obese; nearly three-quarters, or 73 percent, were overweight. Most of the increase in the prevalence of obesity and overweight has occurred since 1976-1980.
- ◆ In 1999-2002, 32 percent of older women age 65 and over were obese, compared with 27 percent of men. Conversely, older men were more likely to be overweight (73 percent of men compared with 66 percent of women.)
- ◆ The prevalence of obesity is greater among people age 65-74 than among people age 75

and over. Thirty-two percent of men age 65-74 are obese compared with 18 percent of men age 75 and over. Thirty-nine percent of women age 65-74 are obese compared with 24 percent of women age 75 and over.

- ◆ The prevalence of underweight among people age 65 and over is quite low. In 1999-2002, 2 percent of older men and women were underweight. Older women age 65 and over were three times as likely as their male counterparts to be underweight (3 percent of women versus 1 percent of men).

Data for this indicator's chart and bullets can be found in Table 25 on pages 97 and 98.

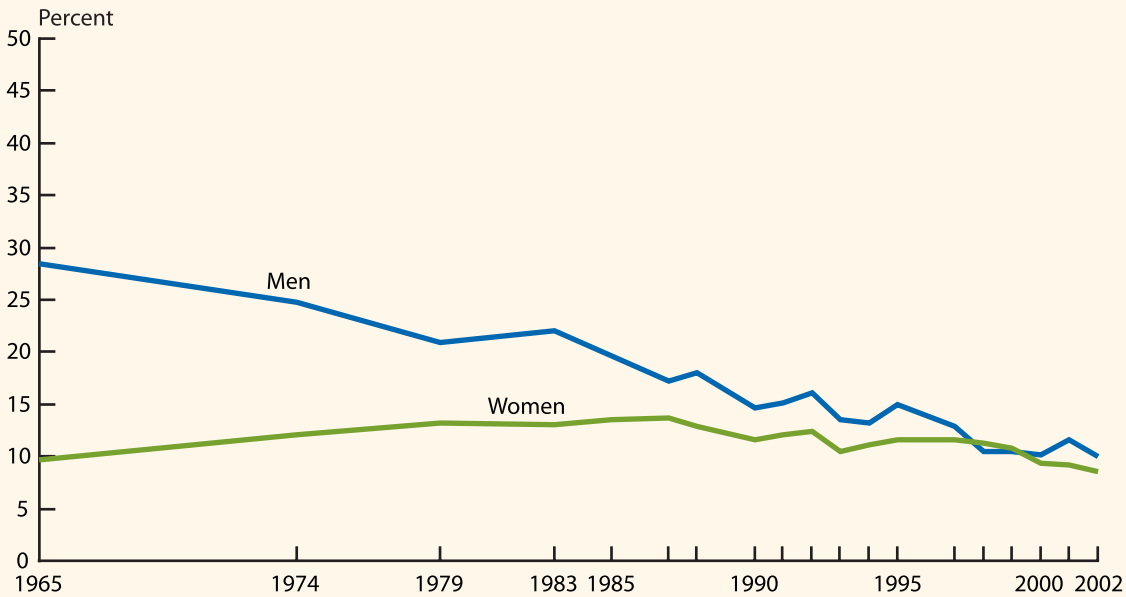


INDICATOR 26

Cigarette Smoking

Smoking has been linked to an increased likelihood of cancer, cardiovascular disease, chronic obstructive lung diseases, and other debilitating health conditions. Among older people, the death rate for chronic lower respiratory diseases (the fourth leading cause of death among people age 65 and over) has increased since 1980.⁴⁵ This increase reflects, in part, the effects of cigarette smoking.⁴⁶

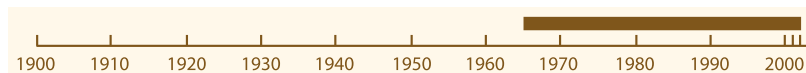
Percentage of people age 65 and over who are current cigarette smokers, by sex, selected years 1965-2002



Reference population: These data refer to the civilian noninstitutionalized population.
 Source: Centers for Disease Control and Prevention, National Center for Health Statistics, National Health Interview Survey.

- ◆ The percentage of older Americans who are current cigarette smokers has declined dramatically over the past 37 years. Most of the decrease is the result of the declining prevalence of cigarette smoking among men (from 29 percent in 1965 to 10 percent in 2002). The percentage of women who smoke cigarettes has remained relatively constant, increasing slightly from 10 percent in 1965 before declining to 9 percent in 2002.
- ◆ A similar pattern of decline is observed by race, although the prevalence of smoking remains much higher for blacks. Again, the decline is due almost exclusively to the higher percentage of cigarette smokers among older black men, which declined from 36 percent in 1965 to 19 percent in 2002.
- ◆ The long-run decline in the prevalence of cigarette smoking also occurred in younger age groups. For example, 52 percent of men age 45-64 were current cigarette smokers in 1965. By 2002 this percentage had declined by more than one-half to 25 percent. The corresponding percentages for women age 45-64 are 32 percent and 21 percent, respectively.
- ◆ A large percentage of men and women age 65 and over are former smokers. In 2002, 57 percent of older men previously smoked cigarettes, while nearly 29 percent of women age 65 and over were former smokers.

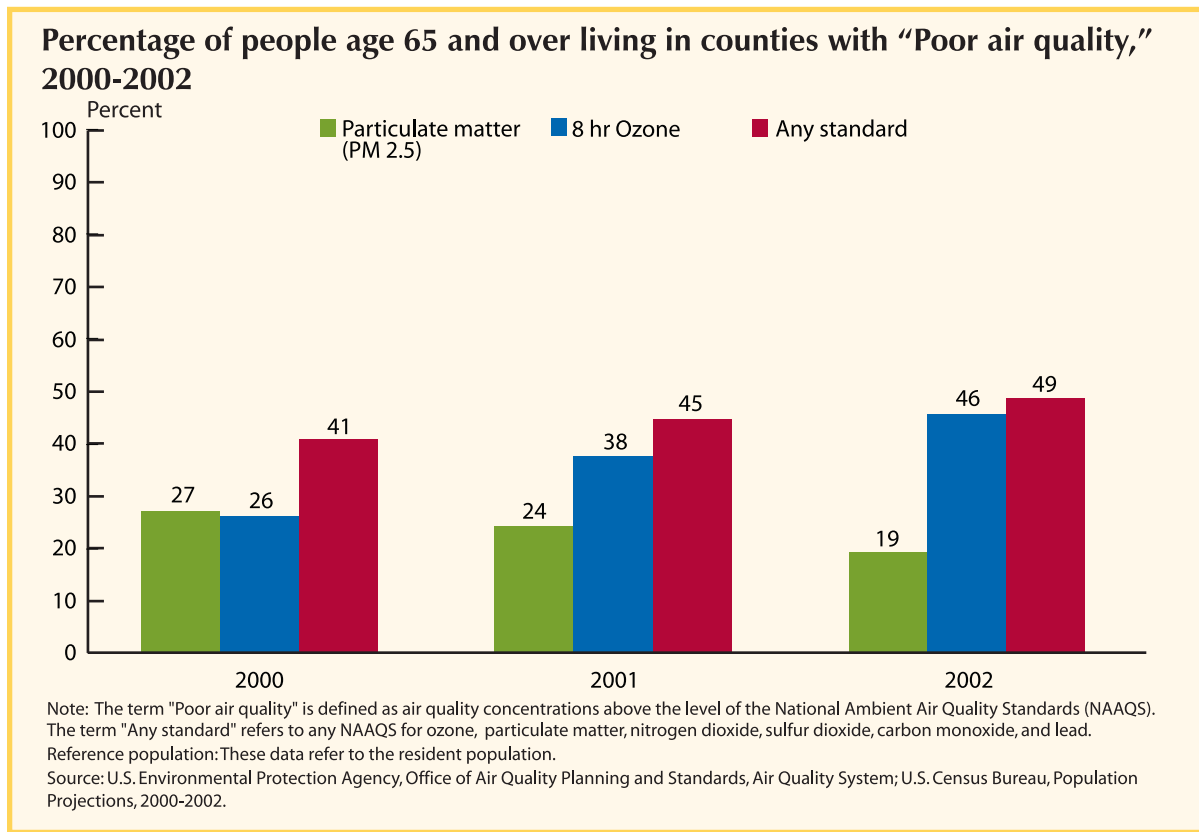
Data for this indicator's chart and bullets can be found in Tables 26a and 26b on pages 99 and 100.



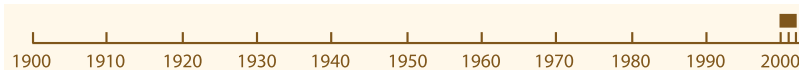
INDICATOR 27

Air Quality

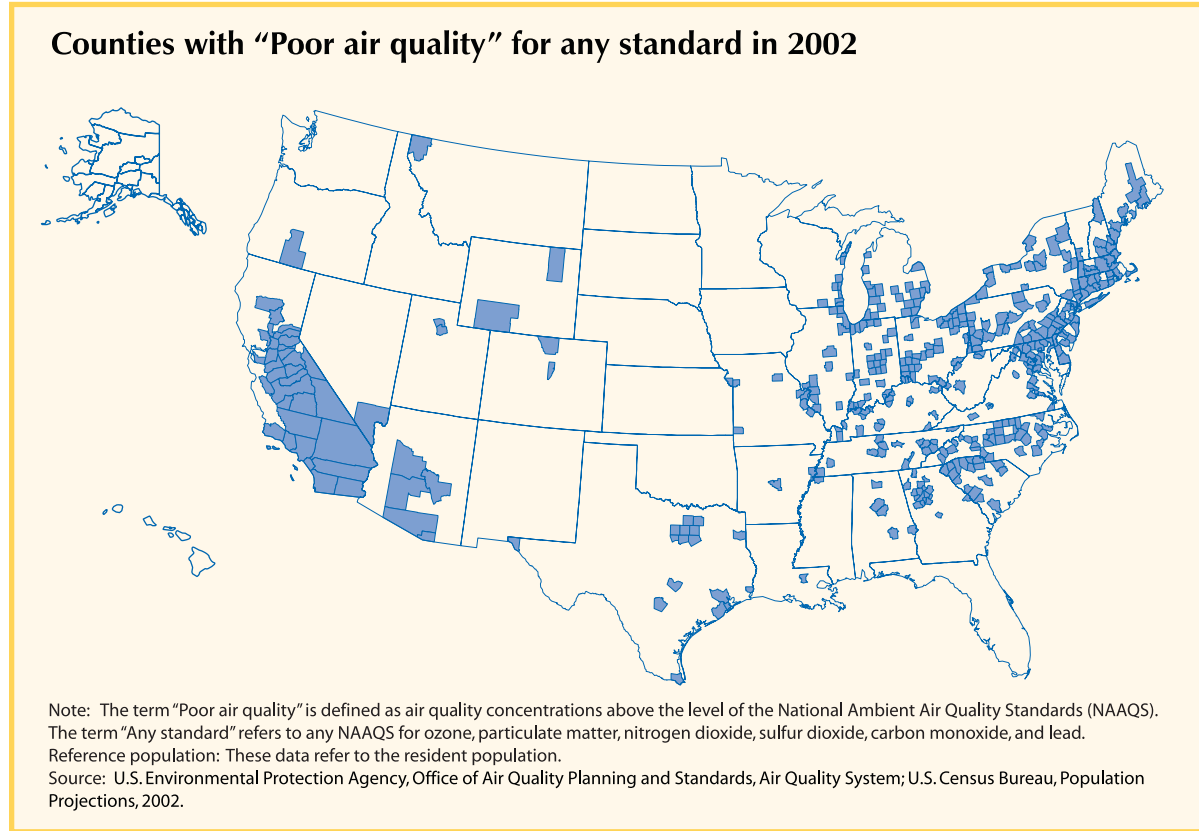
As people age, their bodies are less able to compensate for the effects of environmental hazards. Air pollution can aggravate heart and lung disease, leading to increased medication use, more visits to health care providers, admissions to emergency rooms and hospitals, and even death. An important indicator for environmental health is the percentage of older adults living in areas that have measured air pollutant concentrations above the Environmental Protection Agency’s (EPA) established standards. Ozone and particulate matter (PM) (especially smaller, fine particle pollution called PM 2.5) have the greatest potential to affect the health of older adults. Fine particle pollution has been linked to premature death, cardiac arrhythmias and heart attacks, asthma attacks, and the development of chronic bronchitis. Ozone, even at low levels, can exacerbate respiratory diseases such as chronic obstructive pulmonary disease or asthma.⁴⁷⁻⁵¹



- ◆ In 2002, 46 percent of people age 65 and over lived in counties with poor air quality for ozone compared with 26 percent in 2000. The hot, dry 2002 summer climate was particularly conducive to the formation of ground-level ozone, and this, in turn, may have contributed to the higher ozone measurements in 2002.
- ◆ A comparison of 2000 and 2002 shows a reduction in PM 2.5. In 2000, 27 percent of people age 65 and over lived in a county where PM 2.5 concentrations were at times above the EPA standards compared with 19 percent of people age 65 and over in 2002.
- ◆ The percentage of people age 65 and over living in counties that experienced poor air quality for any air pollutant increased from 41 percent in 2000 to 49 percent in 2002. This increase was largely due to the increased number of areas that experienced poor air quality for ozone in 2001 and 2002.



Air quality varies across the United States; thus, where people live can affect their health risk. Each State monitors air quality and reports findings to the EPA. In turn, the EPA determines whether pollutant measurements are above the standards that have been set to protect human health.



- ◆ In 2002, nearly 50 percent of the population lived in a county where measured air pollutants reached concentrations above EPA standards. This percentage was fairly consistent across all age groups, including people age 65 and over.
- ◆ Overall, approximately 146 million people lived in counties where monitored air in 2002 was unhealthy at times because of high levels of at least one of the six principal air pollutants:

ozone, particulate matter (PM), nitrogen dioxide, sulfur dioxide, carbon monoxide, and lead. The vast majority of areas that experienced unhealthy air did so because of one or both of two pollutants—ozone and PM.

Data for this indicator’s charts and bullets can be found in Tables 27a and 27b on page 100.

Health Care

Indicator 28: Use of Health Care Services

Indicator 29: Health Care Expenditures

Indicator 30: Prescription Drugs

Indicator 31: Sources of Health Insurance

Indicator 32: Out-of-Pocket Health Care Expenditures

Indicator 33: Sources of Payment for Health Care Services

Indicator 34: Veterans' Health Care

Indicator 35: Nursing Home Utilization

Indicator 36: Residential Services

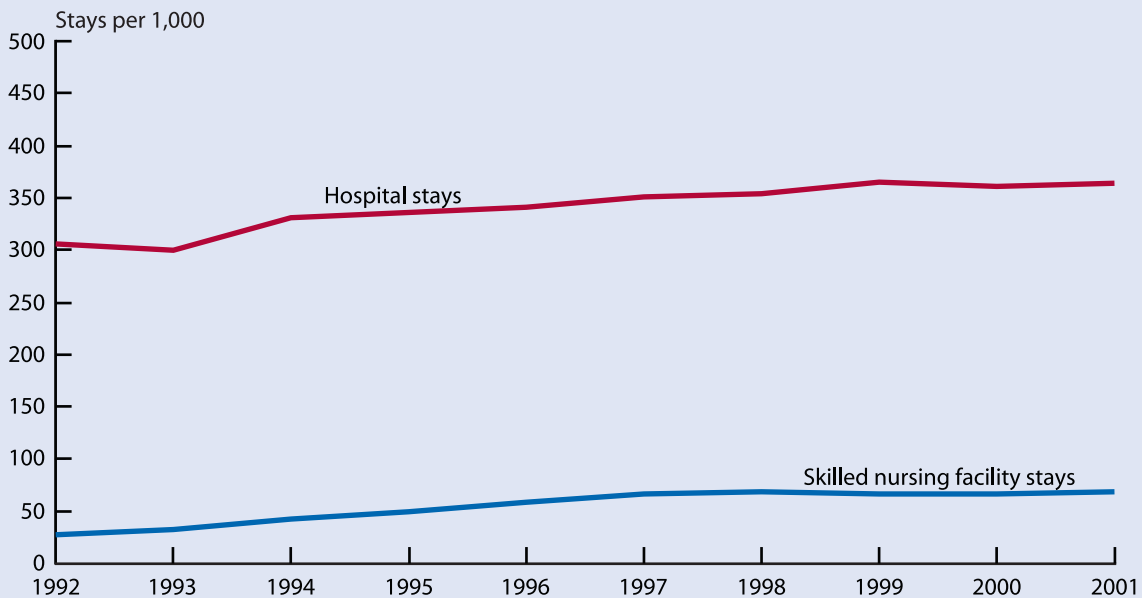
Indicator 37: Caregiving and Assistive Device Use

INDICATOR 28

Use of Health Care Services

Most older Americans have health insurance through Medicare. Medicare covers a variety of services, including inpatient hospital care, physician services, hospital outpatient care, home health care, skilled nursing facility care, and hospice services. Utilization rates for many services change over time because of changes in physician practice patterns, medical technology, Medicare payment amounts, and patient demographics.

Medicare-covered hospital and skilled nursing facility stays per 1,000 Medicare enrollees age 65 and over in fee-for-service, 1992-2001

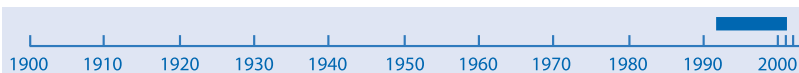


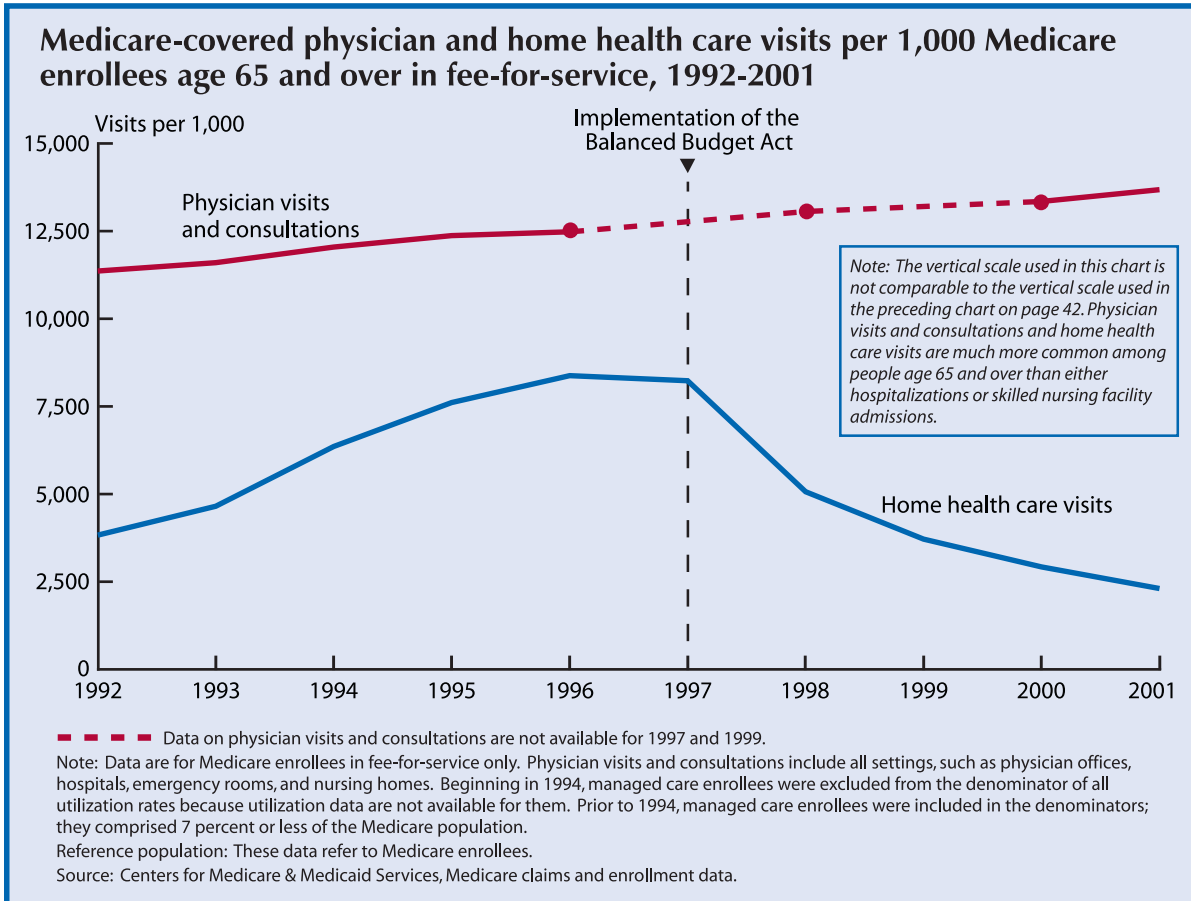
Note: Data are for Medicare enrollees in fee-for-service only. Beginning in 1994, managed care enrollees were excluded from the denominator of all utilization rates because utilization data are not available for them. Prior to 1994, managed care enrollees were included in the denominators; they comprised 7 percent or less of the Medicare population.

Reference population: These data refer to Medicare enrollees.

Source: Centers for Medicare & Medicaid Services, Medicare claims and enrollment data.

- ◆ Between 1992 and 1999 the hospitalization rate increased from 306 hospital stays per 1,000 Medicare enrollees to 365 per 1,000. The hospitalization rate remained essentially the same in 2000 and 2001. The average length of a hospital stay decreased from 8 days in 1992 to 6 days in 2001.
- ◆ Skilled nursing facility stays increased significantly from 28 per 1,000 Medicare enrollees in 1992 to 69 per 1,000 in 2001. Nearly all of the increase occurred from 1992 to 1997.





- ◆ The number of physician visits and consultations also increased. There were 11,359 visits and consultations per 1,000 Medicare enrollees in 1992, compared with 13,685 in 2001.
- ◆ The number of home health care visits per 1,000 Medicare enrollees increased rapidly from 3,822 in 1992 to 8,227 in 1997. Home health care use increased during this period in part because of an expansion in the coverage criteria for the Medicare home health care benefit.⁵² Home health care visits declined after 1997 to 2,295 in 2001. The decline coincided with changes in Medicare payment policies for home health care resulting from

implementation of the Balanced Budget Act of 1997.

- ◆ Use of skilled nursing facility and home health care increased markedly with age. In 2001, there were 26 skilled nursing facility stays per 1,000 Medicare enrollees age 65-74, compared with 203 per 1,000 enrollees age 85 and over. Home health care agencies made 1,082 visits per 1,000 enrollees age 65-74, compared with 5,475 per 1,000 for those age 85 and over.

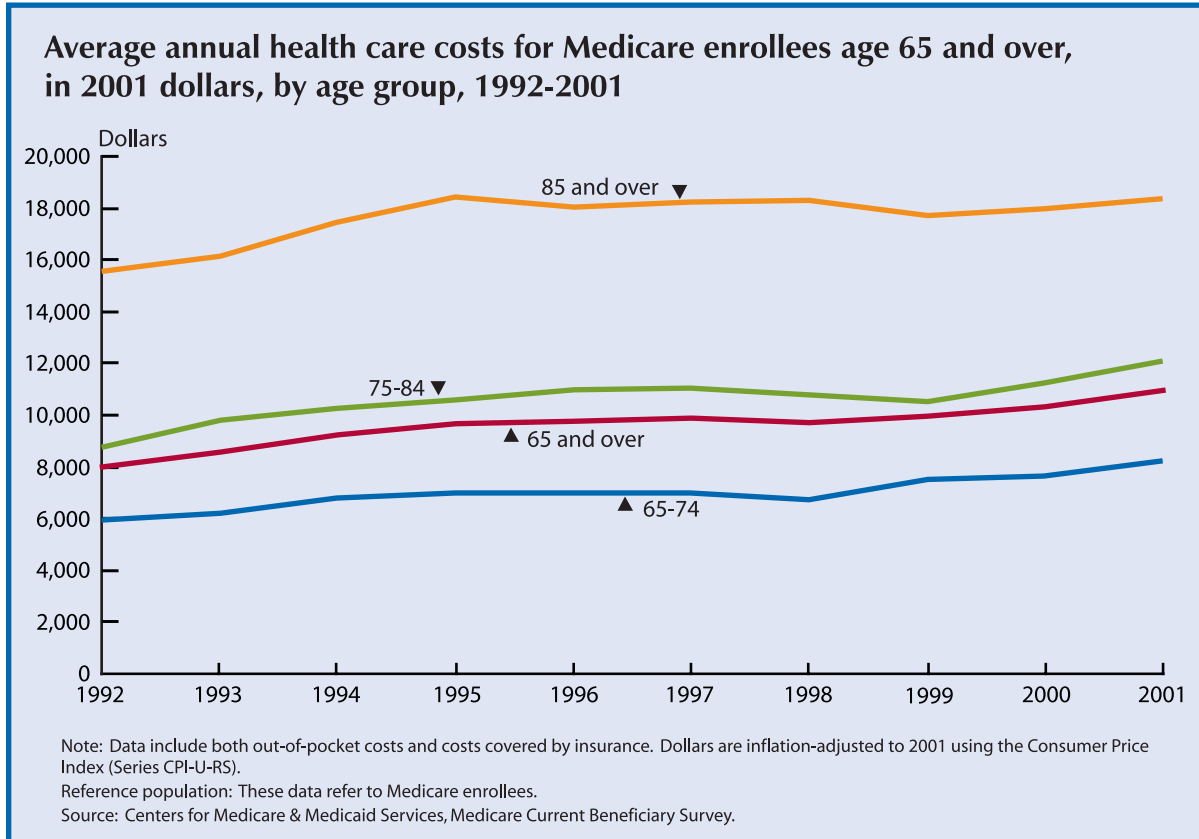
Data for this indicator's charts and bullets can be found in Tables 28a and 28b on page 101.



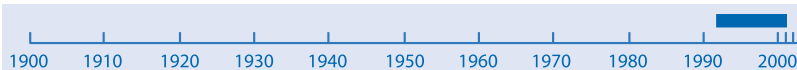
INDICATOR 29

Health Care Expenditures

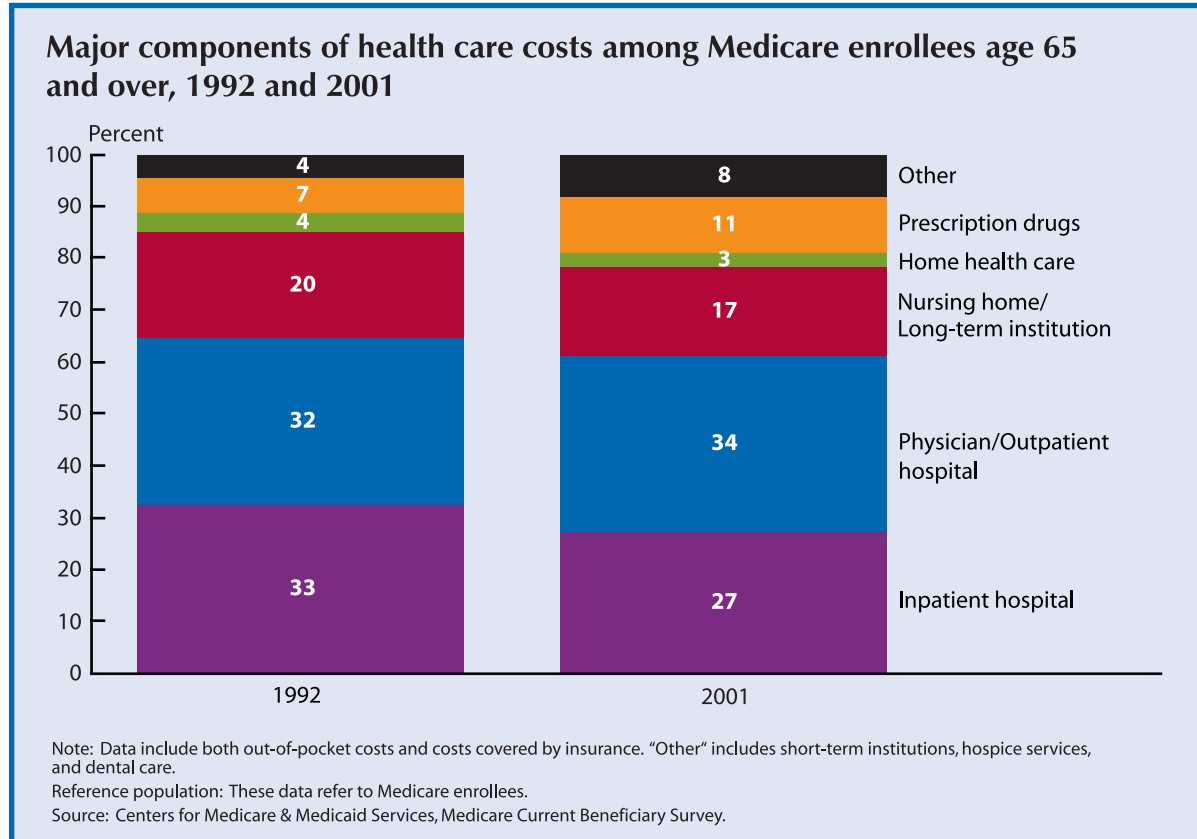
Older Americans use more health care than any other age group. Health care costs are increasing rapidly at the same time the Baby Boom generation is approaching retirement age.



- ◆ After adjusting for inflation, health care costs increased significantly among older Americans from 1992 to 2001. Average costs were substantially higher with older ages.
- ◆ Average health care costs varied by demographic characteristics. Average costs among non-Hispanic blacks were \$13,081 compared with \$11,032 among non-Hispanic whites and \$8,449 among Hispanics. Low income individuals incurred higher health care costs; those with less than \$10,000 in income averaged \$14,692 in health care costs whereas those with more than \$30,000 in income averaged only \$8,855.
- ◆ Costs also varied by health status. Individuals with no chronic conditions incurred \$3,837 in health care costs on average. Those with five or more conditions incurred \$15,784. Average costs among residents of nursing homes and other long-term care institutions were \$46,810 compared with only \$8,466 among community residents.
- ◆ Access to health care is determined by a variety of factors related to the cost, quality, and availability of health care services. The percentage of older Americans who reported they delayed getting care because of cost declined from 10 percent in 1992 to 5 percent in 1997 and remained relatively constant thereafter. The percentage who reported difficulty obtaining care varied between 2 percent and 3 percent.



Health care costs can be broken down into different types of goods and services. The amount of money older Americans spend on health care and the type of health care that they receive provide an indication of the health status and needs of older Americans in different age and income groups.



- ◆ Hospital and physician services were the largest components of health care costs. Nursing homes and other long-term care institutions accounted for 17 percent of total costs in 2001. Prescription drugs accounted for about 11 percent of health care costs.
- ◆ The mix of health care services changed between 1992 and 2001. Inpatient hospital care accounted for a lower share of costs in 2001 (27 percent compared with 33 percent in 1992). Prescription drugs increased in importance from 7 percent of costs in 1992 to 11 percent in 2001. "Other" costs (short-term institutions, hospice services, and dental care) also increased as a percentage of all costs (from 4 percent to 8 percent).
- ◆ The mix of services varied with age. The biggest difference occurred for nursing home and long-term institutional services; average costs were \$6,968 among people age 85 and over, compared with just \$516 for those age 65-74. Costs of home health care and "Other" services also were higher at older ages. Costs of physician/outpatient services and prescription drugs did not show a strong pattern by age.

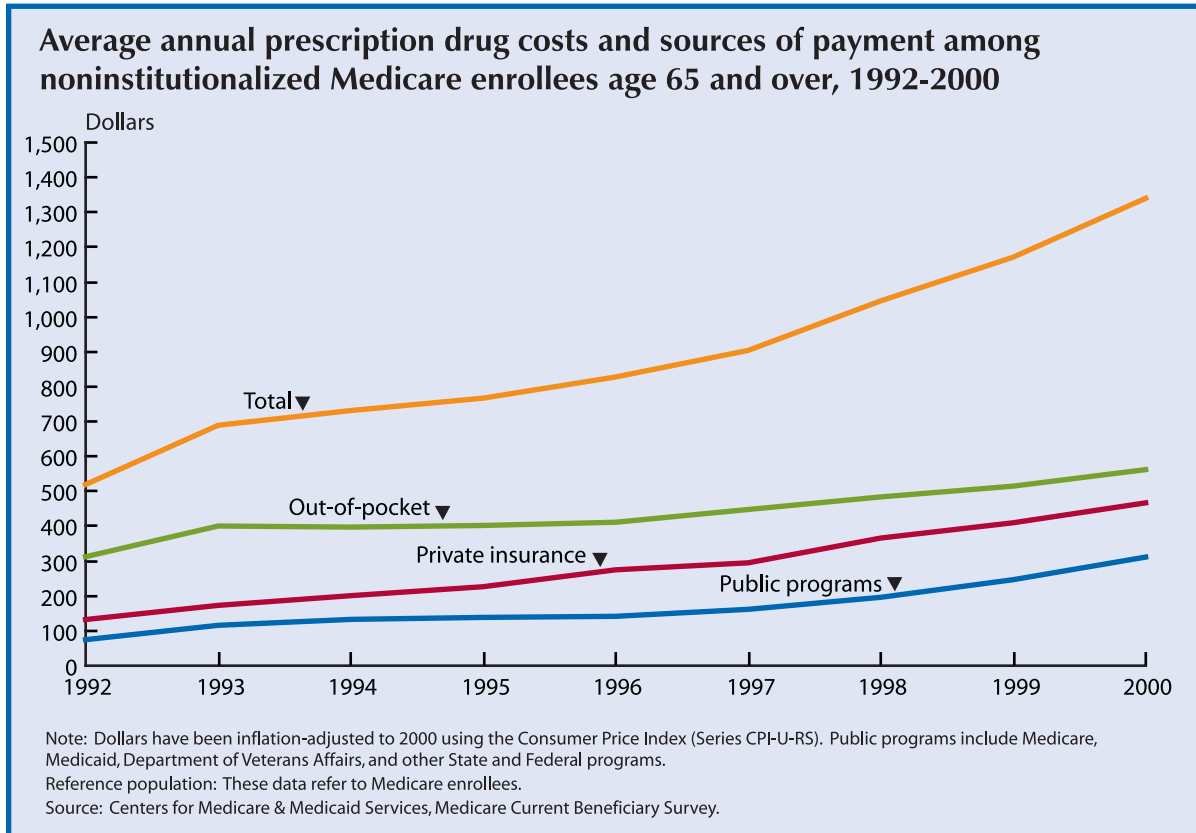
Data for this indicator's charts and bullets can be found in Tables 29a, 29b, 29c, 29d, and 29e on pages 101-103.



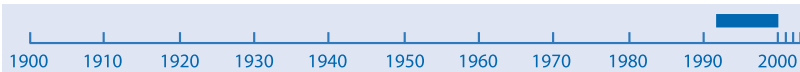
INDICATOR 30

Prescription Drugs

Prescription drug costs have increased rapidly in recent years, as more new drugs have become available. Lack of prescription drug coverage creates a financial hardship for many older Americans. Medicare currently does not cover most outpatient prescription drugs, although Medicare-approved prescription drug discount cards have recently become available. Medicare coverage of prescription drugs will begin in 2006.

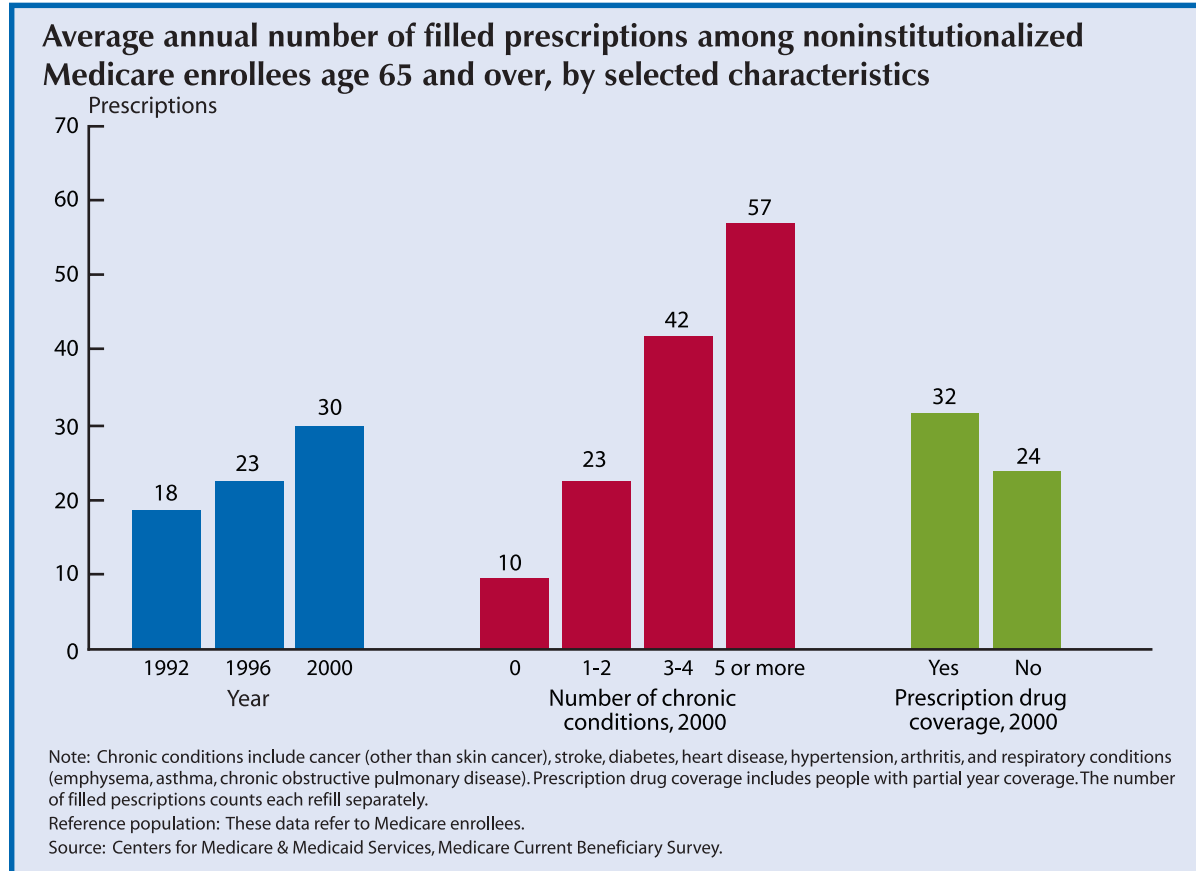


- ◆ Average prescription drug costs for older Americans increased rapidly throughout the 1990s, especially after 1997. Average costs per person were \$1,340 in 2000.
- ◆ Average out-of-pocket costs also increased, though not as rapidly as total costs because more Medicare enrollees had supplemental drug coverage. Older Americans paid 60 percent of prescription drug costs out of pocket in 1992, compared with 42 percent in 2000. Private insurance covered 35 percent of prescription drug costs in 2000; public programs covered 23 percent.
- ◆ Costs varied significantly among individuals. Approximately 9 percent of older Americans incurred no prescription drug costs in 2000. Conversely, over 17 percent incurred prescription drug costs of \$2,000 or more in that year.



INDICATOR 30 Prescription Drugs continued

Use of prescription drugs varies significantly by individual characteristics, including whether the person has prescription drug coverage. Those with multiple chronic conditions tend to be especially heavy users of prescription drugs.



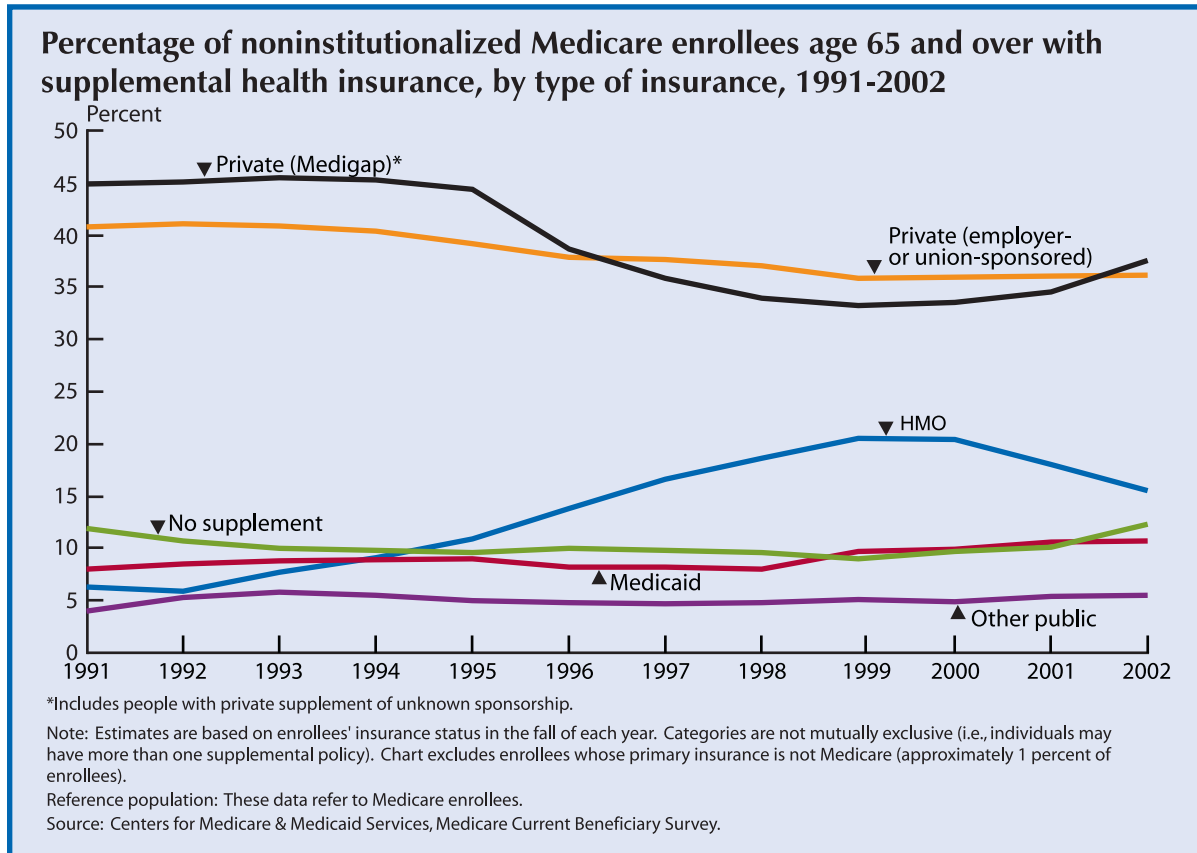
- ◆ The average number of filled prescriptions for older Americans increased from 18 prescriptions in 1992 to 30 prescriptions in 2000.
- ◆ Use of prescription drugs was much higher for individuals with multiple chronic conditions. People with no chronic conditions averaged 10 filled prescriptions in 2000; those with 5 or more conditions averaged 57 prescriptions.
- ◆ Prescription drug coverage was associated with a higher level of prescription drug use. In 2000, older Americans with prescription drug coverage averaged 32 filled prescriptions; those without drug coverage averaged 24 prescriptions.
- ◆ Lower income individuals used more prescription drugs. Those reporting an income of \$10,000 or less in 2000 averaged 33 filled prescriptions; those reporting an income of \$30,001 or more averaged 26 prescriptions.
- ◆ Prescription drug coverage was lower among older age groups, ranging from 79 percent of people age 65-74 to 72 percent of those age 85 and over. Medicare enrollees with incomes of \$10,001-\$20,000 had the lowest percentage with coverage (73 percent). The lowest income group (less than \$10,001) had a slightly higher percentage with coverage (77 percent) because of eligibility for Medicaid.

Data for this indicator's charts and bullets can be found in Tables 30a, 30b, 30c, and 30d on pages 103-105.

INDICATOR 31

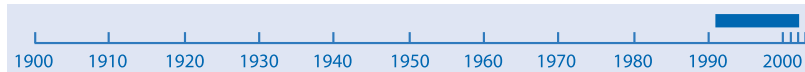
Sources of Health Insurance

Nearly all older Americans have Medicare as their primary source of health insurance coverage. Medicare covers mostly acute care services and requires beneficiaries to pay part of the cost, leaving about half of health spending to be covered by other sources. Many beneficiaries have supplemental insurance to fill these gaps and to obtain services not covered by Medicare.



- ◆ Most Medicare enrollees have a private insurance supplement, about equally split between employer-sponsored and Medigap-type policies. About 10 percent have Medicaid, and about 10 percent have no supplement. Enrollment in Medicare HMOs, which are usually equivalent to Medicare supplements because of their benefit structures, varied from 6 percent to 21 percent.
- ◆ HMO enrollment increased rapidly throughout the 1990s, then decreased beginning in 2000, as many HMOs withdrew from the Medicare program. The percentage with Medigap policies decreased in the late 1990s, then increased as enrollment in HMOs declined. The percentage of Medicare enrollees without a supplement was relatively constant but increased slightly in 2002 to 12 percent.
- ◆ While almost all older Americans have health insurance via Medicare, a significant proportion of people younger than age 65 have no health insurance. In 2002, 12 percent of people age 55-64 were uninsured. The percentage of people under age 65 not covered by health insurance varies by poverty status. In 2002, 28 percent of people age 55-64 who lived below the poverty level had no health insurance compared to 7 percent of people who had incomes greater than or equal to 200 percent of the poverty threshold.

Data for this indicator's chart and bullets can be found in Tables 31a and 31b on pages 105 and 106.

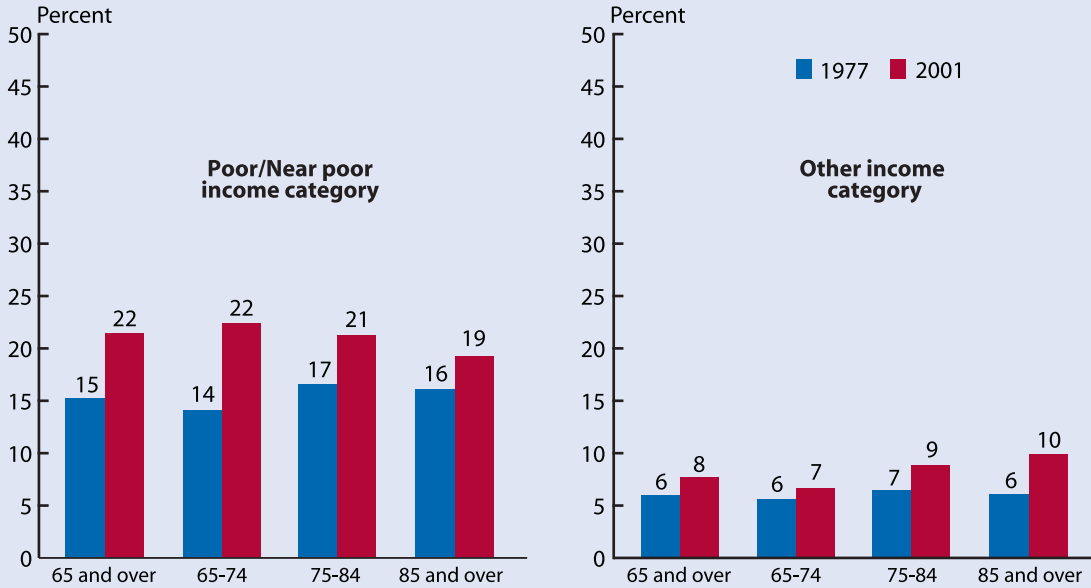


INDICATOR 32

Out-of-Pocket Health Care Expenditures

Large out-of-pocket expenditures for health care service use have been shown to encumber access to care, affect health status and quality of life, and leave insufficient resources for other necessities.^{53,54} The percentage of household income that is allocated to health care expenditures is a measure of health care expense burden placed on older people.

Out-of-pocket health care expenditures as a percentage of household income, among people age 65 and over,* by age and income category, 1977 and 2001



*Includes only people with out-of-pocket expenditures.

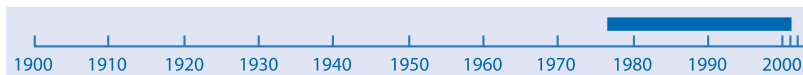
Note: Out-of-pocket health care expenditures exclude personal spending for health insurance premiums. Including expenditures for out-of-pocket premiums in the estimates of out-of-pocket spending would increase the percentage of household income spent on health care in all years. People are classified into the "poor/near poor" income category if their household income is below 125 percent of the poverty level; otherwise, people are classified into the "other" income category. The ratio of a person's out-of-pocket expenditures to their household income was calculated based on the person's per capita household income. For people whose ratio of out-of-pocket expenditures to income exceeded 100 percent, the ratio was capped at 100 percent.

Reference population: These data refer to the civilian noninstitutionalized population.

Source: Agency for Healthcare Research and Quality, Medical Expenditure Panel Survey (MEPS) and MEPS predecessor surveys.

- ◆ The percentage of people age 65 and over with out-of-pocket spending for health care services increased between 1977 and 2001 (83 percent to 95 percent, respectively).
- ◆ From 1977 to 2001, the percentage of household income that people age 65 and over with out-of-pocket spending allocated to out-of-pocket spending for health care services increased among those in the poor/near poor income category, from 15 percent to 22 percent. Out-of-pocket spending allocations also increased among people in the poor/near poor income category age 65-74 and 75-84 and among people in the other income category age 65-74, 75-84, and 85 and over. Increases were also seen for those in poor or fair health age 65-74 (from 10 percent in 1977 to 13 percent in 2001).
- ◆ In 2001, people age 85 and over were less likely than people age 65-74 to spend out-of-pocket dollars on dental services or office-based medical provider visits but more likely to spend out-of-pocket dollars on other health care (e.g., home health care and eyeglasses). Fifty-six percent of out-of-pocket health care service spending by people age 65 and over was used to purchase prescription drugs.

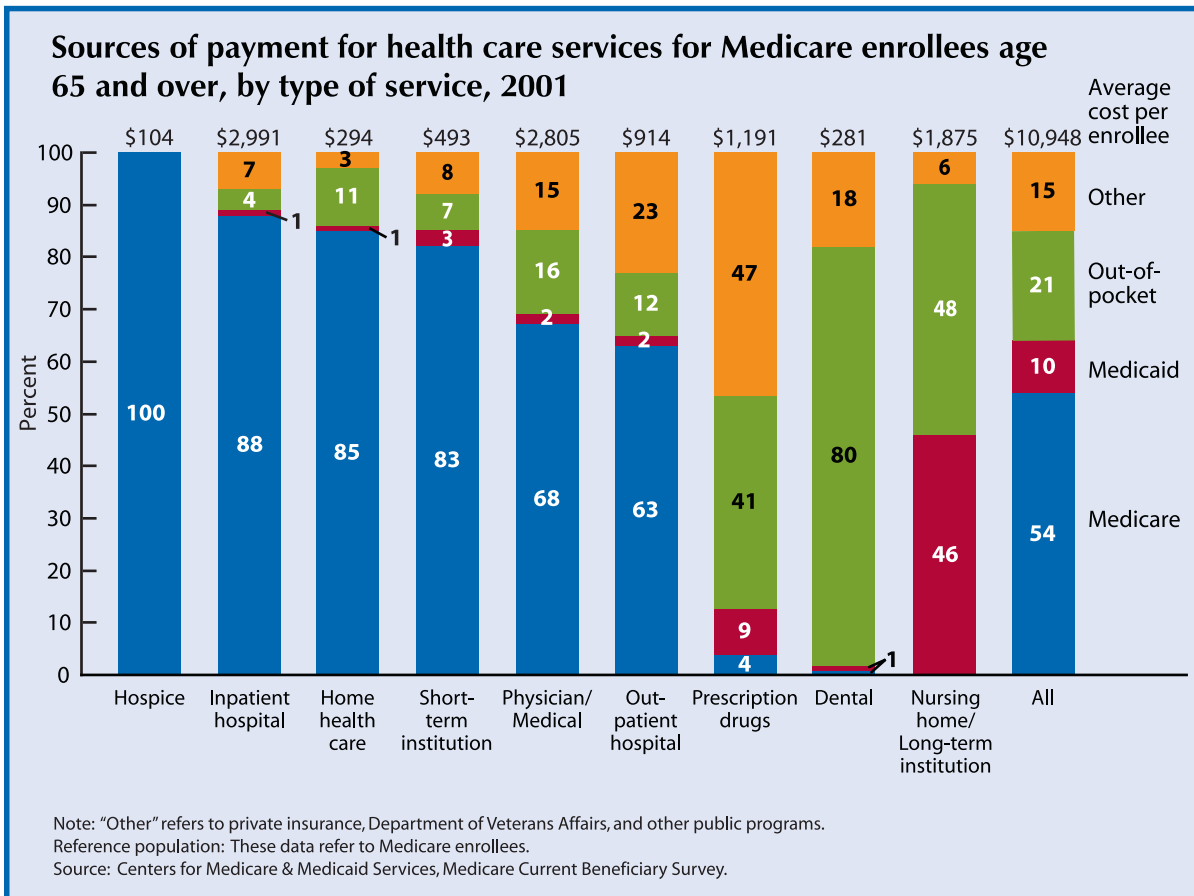
Data for this indicator's chart and bullets can be found in Tables 32a, 32b, and 32c on pages 106-108.



INDICATOR 33

Sources of Payment for Health Care Services

Medicare covers about half of the health care costs of older Americans. Medicare's payments are focused on acute care services such as hospitals and physicians. Nursing home care, prescription drugs, and dental care are primarily financed by other payers.



- ◆ Medicare pays for slightly more than one-half (54 percent) of the health care costs of older Americans. Medicare finances most of their hospital and physician costs, as well as a majority of short-term institutional, home health, and hospice costs.
- ◆ Medicaid covers 10 percent of health care costs of older Americans, and other payers (primarily private insurers) cover another 15 percent. Older Americans pay 21 percent of their health care costs out of pocket.
- ◆ Forty-six percent of nursing home costs for older Americans are covered by Medicaid; another 48 percent of these costs are paid out of pocket. Forty-seven percent of prescription drug costs are covered by third party payers

other than Medicare and Medicaid, consisting mostly of private insurers. Forty-one percent of prescription drug costs are paid out of pocket. About 80 percent of dental care received by older Americans is paid out of pocket.

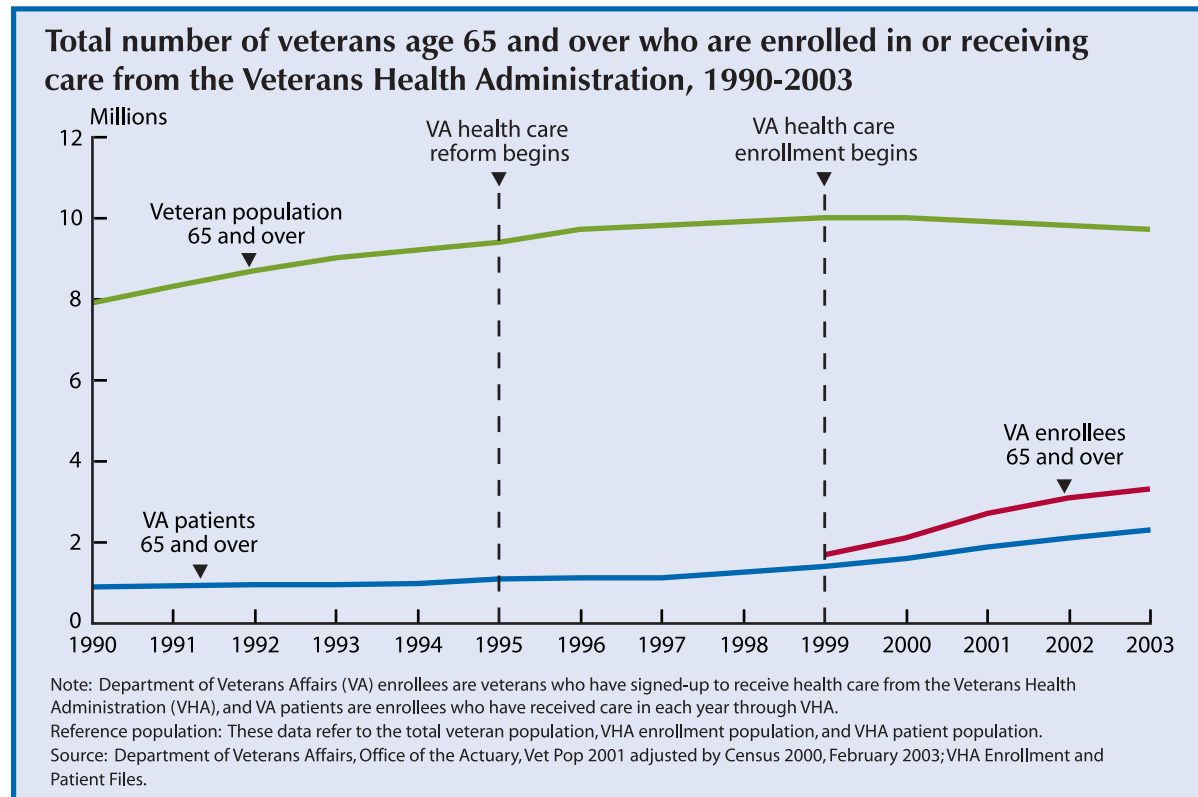
- ◆ Sources of payment for health care vary by income. Lower income individuals rely heavily on Medicaid; those with higher incomes rely more on private insurance. Lower income individuals pay a lower percentage of health care costs out of pocket but use more services than individuals with higher incomes.

Data for this indicator's chart and bullets can be found in Tables 33a and 33b on pages 108 and 109.

INDICATOR 34

Veterans' Health Care

The number of veterans age 65 and over who receive health care from the Veterans Health Administration (VHA), within the Department of Veterans Affairs (VA), has been steadily increasing. This increase may be because VHA fills important gaps in older veterans' health care needs not currently covered or fully covered by Medicare, such as prescription drug benefits, mental health services, long-term care (nursing home and community-based care), and specialized care for the disabled.



- ◆ In 2003, approximately 2.3 million veterans age 65 and over received health care from VHA. An additional 1 million older veterans were enrolled to receive health care from VHA but did not use its services that year.
- ◆ Reforms and initiatives implemented by VA since 1995 have led to an increased demand for VHA health care services despite the short-term decline in the number of older veterans (see “Indicator 6: Older Veterans”). Some of those changes include: opening the system to all veterans (1995); implementing enrollment for VHA health care (1999); and reducing inpatient care with increased access to outpatient care and other services.
- ◆ An increasing number of older veterans are turning to VHA for their health care needs despite their potential eligibility for other sources of health care. VHA estimates that 91 percent of its patients age 65 and over are covered by Medicare Part A, 83 percent by Medicare Part B, 48 percent by Medigap, 8 percent by Medicaid, 14 percent by private insurance (excluding Medigap), and 7 percent by TRICARE for Life. About 4 percent have no public or private coverage at all.⁵⁵

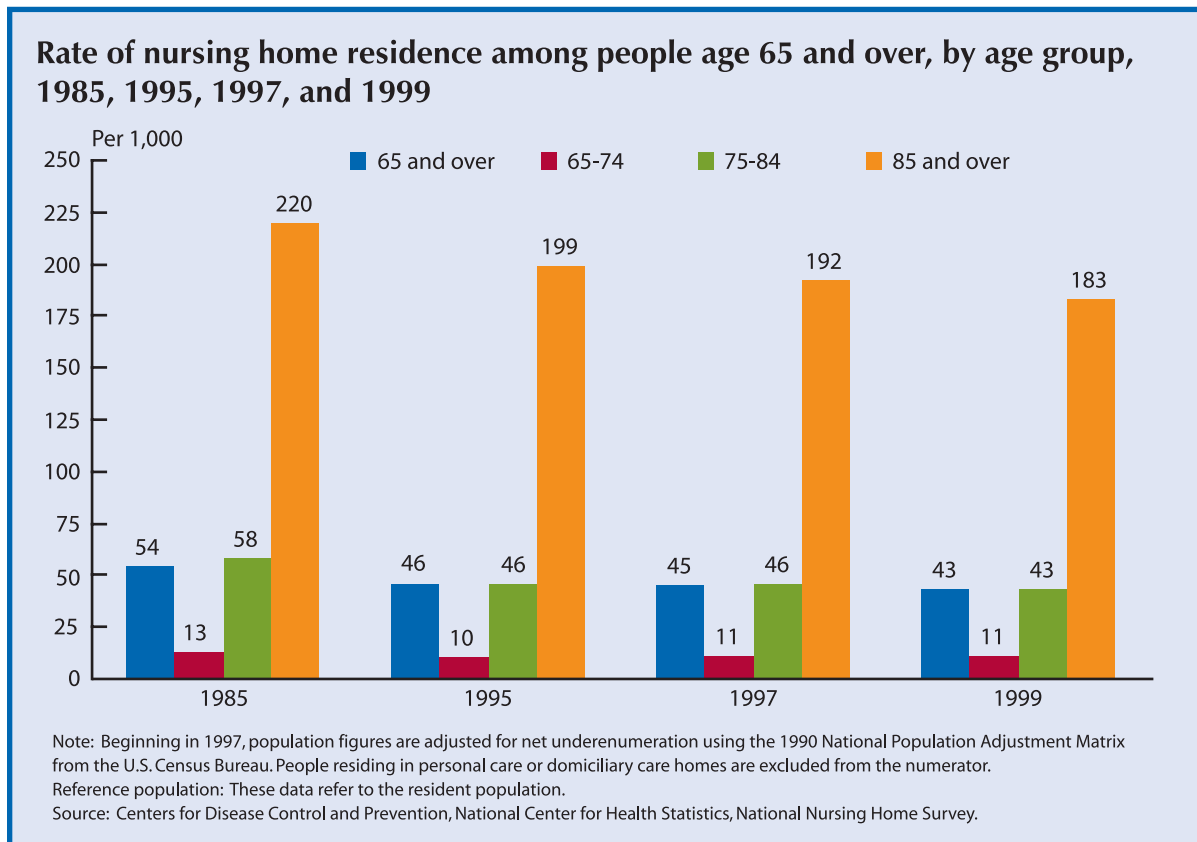
Data for this indicator's chart and bullets can be found in Table 34 on page 109.



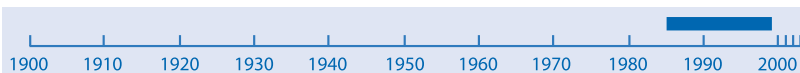
INDICATOR 35

Nursing Home Utilization

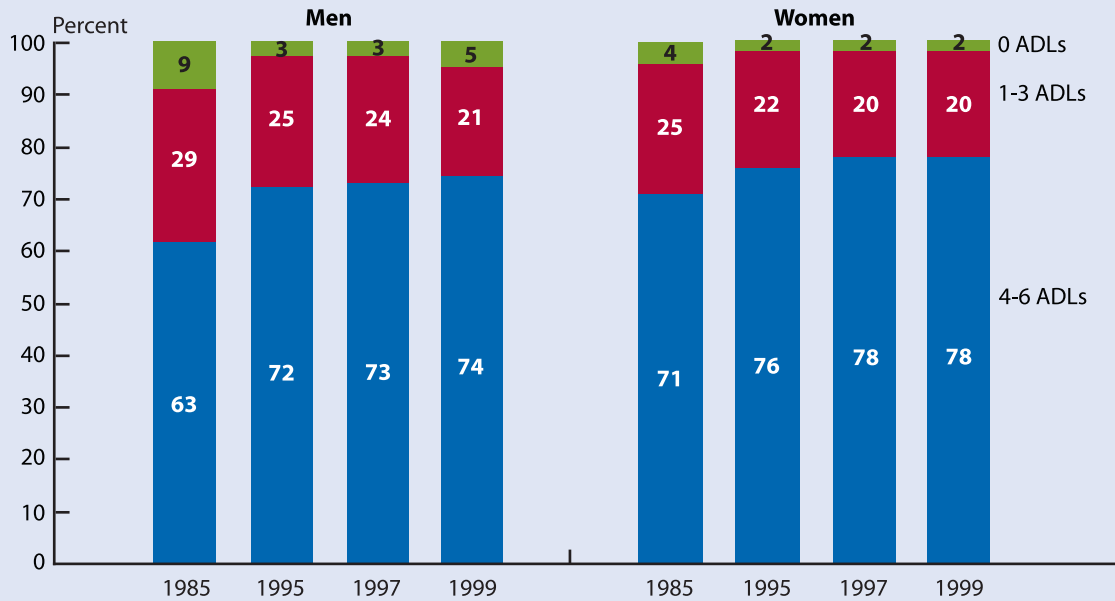
Residence in a nursing home is an alternative to long-term care provided in one's home or in other community settings. Recent declines in rates of nursing home residence may reflect broader changes in the health care system affecting older Americans. Other forms of residential care and services, such as assisted living and home health care, have become more prevalent as rates of nursing home admissions have declined.



- ◆ In 1999, 11 people per 1,000 age 65-74 resided in nursing homes, compared with 43 people per 1,000 age 75-84 and 183 people per 1,000 age 85 and over.
- ◆ The total rate of nursing home residence among the older population declined between 1985 and 1999. In 1985, the age-adjusted nursing home residence rate was 54 people per 1,000 age 65 and over. By 1999 this rate had declined to 43 people per 1,000. Among people age 65-74, rates declined by 14 percent, compared with a 25 percent decline among people age 75-84 and a 17 percent decline among the population age 85 and over.
- ◆ Despite the decline in rates of nursing home residence, the number of nursing home residents age 65 and over has been increasing because of the rapid growth of the older population. Between 1985 and 1999 the number of current nursing home residents age 65 and over increased from 1.3 million to 1.5 million. In 1999, almost three-fourths (1.1 million) of older nursing home residents were women.



Percentage of nursing home residents age 65 and over receiving assistance with activities of daily living, by sex, 1985, 1995, 1997, and 1999



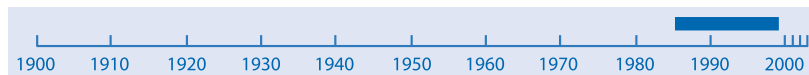
Note: The six activities of daily living (ADLs) included are bathing, dressing, eating, walking, toileting, and transferring in and out of bed or chairs. The resident's receipt of assistance with these activities refers to personal help received from facility staff at the time of the survey (for current residents) or the last time care was provided (for discharges). Help that a resident may receive from people who are not staff of the facility (e.g., family members, friends, or individuals employed directly by the patient and not by the facility) is not included.
 Reference population: These data refer to the population residing in nursing homes. People residing in personal care or domiciliary care homes are excluded.
 Source: Centers for Disease Control and Prevention, National Center for Health Statistics, National Nursing Home Survey.

- ◆ The percentage of nursing home residents receiving assistance with functional limitations increased between 1985 and 1999. In 1985, 95 percent of all residents age 65 and over received assistance with one or more activities of daily living (ADLs). In 1999, 97 percent of residents received such assistance.
- ◆ Nursing home residents are receiving greater levels of care and assistance. The majority of nursing home residents receive assistance with 4-6 ADLs (77 percent in 1999). The increase in receipt of assistance between 1985 and 1999 is greatest among residents receiving this level of assistance.
- ◆ Among the nursing home population, women are more likely than men to receive assistance with daily activities. In 1999, 5 percent of men who were nursing home residents did not receive assistance with any ADL. Less than half that many women received no such assistance (2 percent).

This gender gap has narrowed over time, however. The increase over time in receipt of assistance for 4-6 ADLs is greatest among men.

- ◆ The latest data show few differences between Hispanics and non-Hispanics in the level of care received with ADLs and small differences between whites and blacks. Between 1985 and 1999, declines in the percentage receiving care with 0 and with 1-3 ADLs occurred for both white and black residents. Increases in the receipt of assistance occurred, however, for those requiring care with 4-6 ADLs—between 1985 and 1999, an increase of 8 percentage points for whites and 5 percentage points for blacks.

Data for this indicator's charts and bullets can be found in Tables 35a, 35b, and 35c on pages 110 and 111.

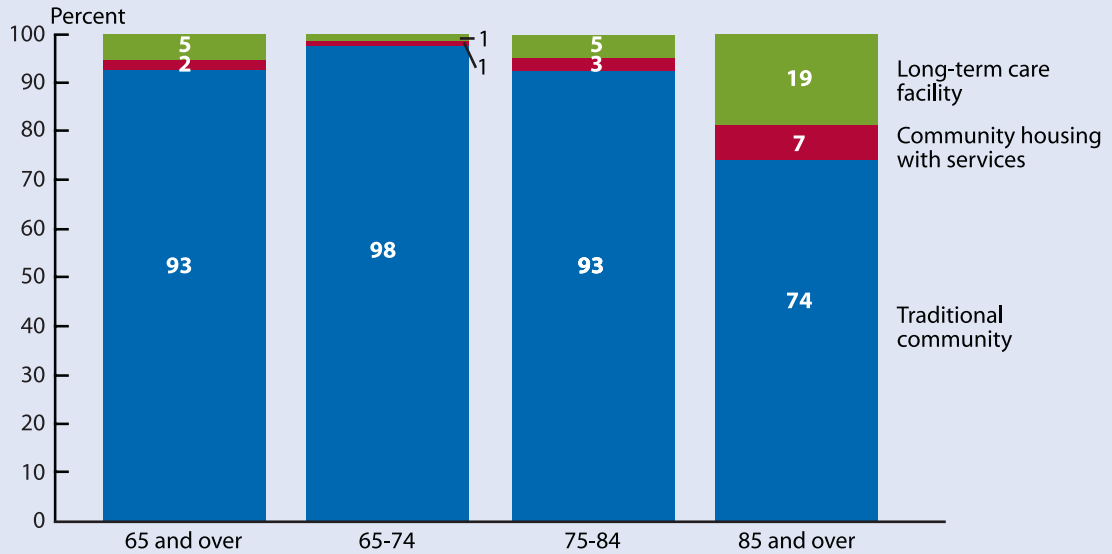


INDICATOR 36

Residential Services

Some older Americans living in the community have access to various services through their place of residence. Such services may include meal preparation, laundry and cleaning services, and help with medications. Availability of such services through the place of residence may help older Americans maintain their independence and avoid institutionalization.

Percentage of Medicare enrollees age 65 and over residing in selected residential settings, by age group, 2002



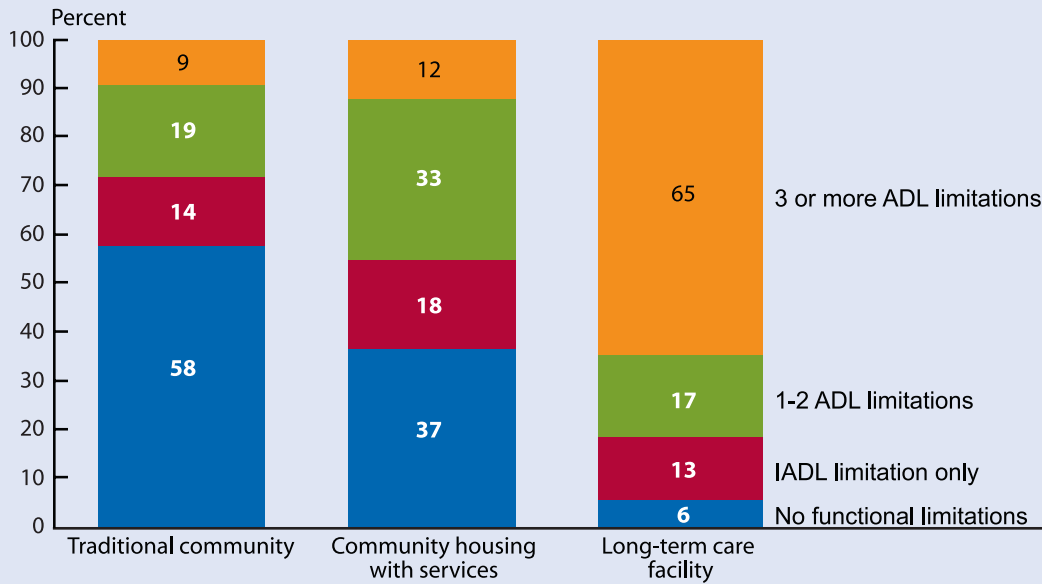
Note: Community housing with services applies to respondents who reported they lived in retirement communities or apartments, senior citizen housing, continuing care retirement facilities, assisted living facilities, staged living communities, board and care facilities/homes, and other similar situations, AND who reported they had access to one or more of the following services through their place of residence: meal preparation, cleaning or housekeeping services, laundry services, help with medications. Respondents were asked about access to these services but not whether they actually used the services. A residence is considered a long-term care facility if it is certified by Medicare or Medicaid; or has 3 or more beds and is licensed as a nursing home or other long-term care facility and provides at least one personal care service; or provides 24-hour, 7-day-a-week supervision by a caregiver.

Reference population: These data refer to Medicare enrollees.

Source: Centers for Medicare & Medicaid Services, Medicare Current Beneficiary Survey.

- ◆ In 2002, 2 percent of the Medicare population age 65 and over resided in community housing with at least one service available. Approximately 5 percent resided in long-term care facilities. The percentage of people residing in community housing with services and in long-term care facilities was higher for the older age groups; among individuals age 85 and over, 7 percent resided in community housing with services, and 19 percent resided in long-term care facilities. Among individuals age 65-74, 98 percent resided in traditional community settings.
- ◆ Among residents of community housing with services, 86 percent reported access to meal preparation services, 80 percent reported access to housekeeping/cleaning services, 68 percent reported access to laundry services, and 47 percent reported access to help with medications. These numbers reflect percentages reporting availability of specific services but not necessarily the number that actually used these services.
- ◆ More than half of residents in community housing with services (53 percent) reported that there were separate charges for at least some services.

Percentage of Medicare enrollees age 65 and over with functional limitations, by residential setting, 2002



Note: Community housing with services applies to respondents who reported they lived in retirement communities or apartments, senior citizen housing, continuing care retirement facilities, assisted living facilities, staged living communities, board and care facilities/homes, and other similar situations, AND who reported they had access to one or more of the following services through their place of residence: meal preparation, cleaning or housekeeping services, laundry services, help with medications. Respondents were asked about access to these services but not whether they actually used the services. A residence is considered a long-term care facility if it is certified by Medicare or Medicaid; or has 3 or more beds and is licensed as a nursing home or other long-term care facility and provides at least one personal care service; or provides 24-hour, 7-day-a-week supervision by a caregiver. IADL limitations refer to difficulty performing (or inability to perform, for a health reason) one or more of the following tasks: using the telephone, light housework, heavy housework, meal preparation, shopping, managing money. ADL limitations refer to difficulty performing (or inability to perform, for a health reason) the following tasks: bathing, dressing, eating, getting in/out of chairs, walking, using the toilet. Long-term care facility residents with no limitations may include individuals with limitations in certain IADLs: doing light or heavy housework or meal preparation. These questions were not asked of facility residents. Reference population: These data refer to Medicare enrollees. Source: Centers for Medicare and Medicaid Services, Medicare Current Beneficiary Survey.

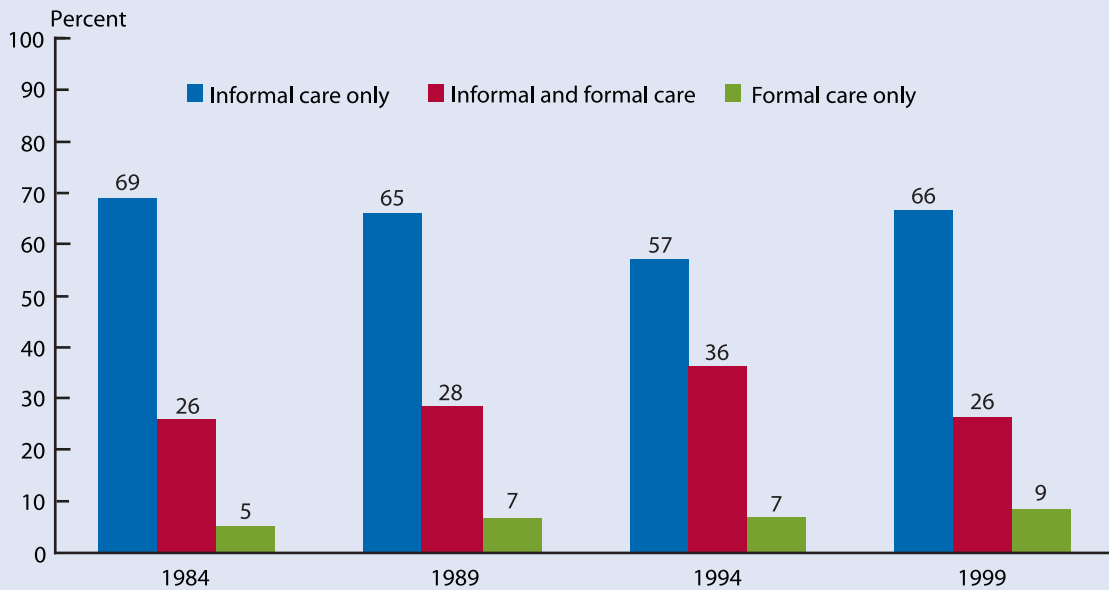
- ◆ People living in community housing with services had more functional limitations than traditional community residents but not as many as those living in long-term care facilities. Forty-five percent of individuals living in community housing with services had at least one activity of daily living (ADL) limitation compared with 28 percent of traditional community residents. Among long-term care facility residents, 81 percent had at least one ADL limitation. Thirty-seven percent of individuals living in community housing with services had no ADL or instrumental activity of daily living (IADL) limitations.
 - ◆ Residents of community housing with services tended to have slightly lower incomes than traditional community residents but higher incomes than long-term care facility residents. Almost one-quarter (24 percent) of residents of community housing with services had incomes of \$10,000 or less in 2002, compared with 17 percent of traditional community residents and 43 percent of long-term care facility residents.
 - ◆ Over one-half (53 percent) of people living in community housing with services reported they could continue living there if they needed substantial care.
 - ◆ The availability of personal services in residential settings may explain some of the observed decline in nursing home use. (See “Indicator 35: Nursing Home Utilization.”)
- Data for this indicator’s charts and bullets can be found in Tables 36a, 36b, 36c, 36d, and 36e on pages 112-114.*

INDICATOR 37

Caregiving and Assistive Device Use

Although most long-term care spending in the United States is for nursing home and other institutionalized care, the majority of older people with disabilities live in the community and receive assistance from spouses, adult children, and other family members. Most of this care is unpaid, although an increasing number of older Americans with disabilities rely on a combination of unpaid and paid long-term care.

Distribution of Medicare enrollees age 65 and over receiving personal care for a chronic disability, by type of care, 1984, 1989, 1994, and 1999

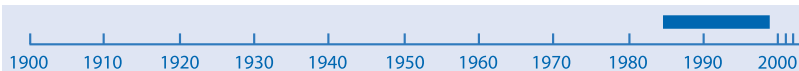


Note: Informal care refers to unpaid assistance provided to a person with a chronic disability living in the community. Formal care refers to paid assistance.

Reference population: These data refer to Medicare enrollees living in the community who report receiving personal care from a paid or unpaid helper for a chronic disability.

Source: National Long Term Care Survey.

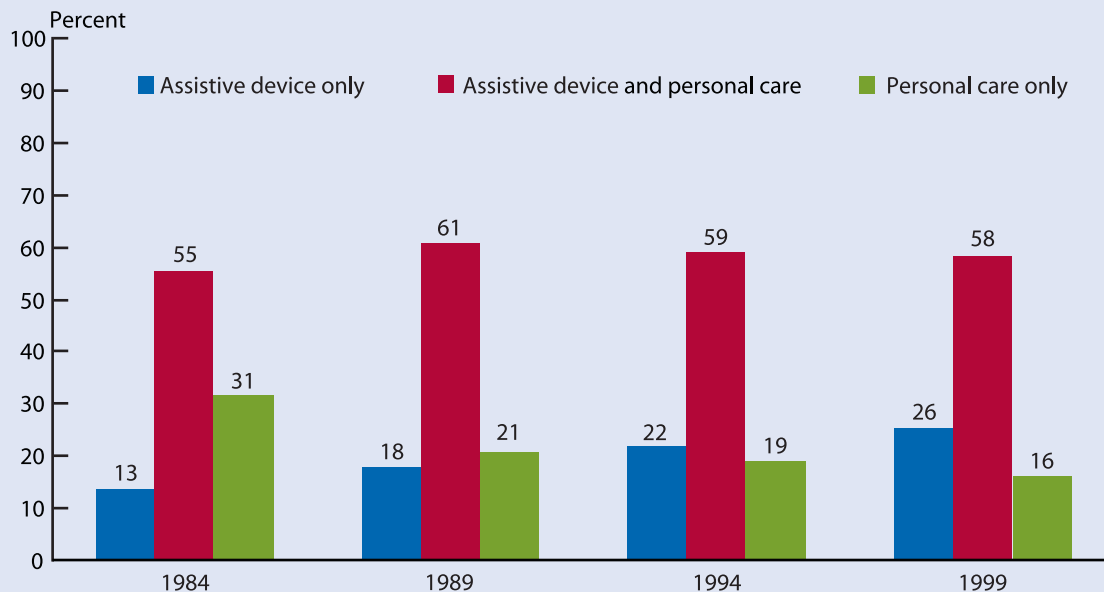
- ◆ The percentage of older Americans who received personal care from a paid or unpaid source for a disability declined from 15 percent in 1984 to 11 percent in 1999. The number of older Americans who received such care also declined from 4.1 million to 3.7 million over this period.
- ◆ The proportion of older people with disabilities who received informal care, either alone or in combination with some formal care, exceeded 90 percent in all 4 years, although this proportion declined from 95 percent in 1984 to 92 percent in 1999.
- ◆ The use of informal care as an exclusive means of assistance declined between 1984 and 1994 from 69 percent to 57 percent and increased to 66 percent in 1999. This upward shift between 1994 and 1999 in reliance upon informal care only is accompanied by a decline in the use of both informal and formal care from 36 percent in 1994 to 26 percent in 1999.
- ◆ There was an increase in the proportion of older Americans with disabilities who rely solely on formal care for their personal assistance needs, rising from 5 percent in 1984 to 9 percent in 1999.



INDICATOR 37 Caregiving and Assistance Device Use continued

Possible reasons for the decline in the use of long-term care in the community include improvements in the health and disability of the older population, changes in household living arrangements (e.g., the move toward assisted living and other residential care alternatives), and greater use of special equipment and assistive devices that help older disabled people living in the community maintain their independence.

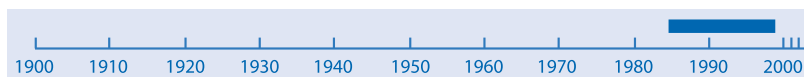
Distribution of Medicare enrollees age 65 and over using assistive devices and/or receiving personal care for a chronic disability, 1984, 1989, 1994, and 1999



Note: Personal care refers to paid or unpaid assistance provided to a person with a chronic disability living in the community.
Reference population: These data refer to Medicare enrollees living in the community who report receiving personal care from a paid or unpaid helper, or using assistive devices, or both, for a chronic disability.
Source: National Long Term Care Survey.

- ◆ The percentage of older Americans who either receive personal care or use assistive devices for a disability declined from 17 percent in 1984 to 15 percent in 1999. This occurred even though the number of these older Americans increased slightly from 4.7 million to 5 million over this period.
- ◆ Among older Americans who either receive personal care or use assistive devices for a disability, the proportion of those using an assistive device only increased from 13 percent to 26 percent while the proportion of those receiving personal care only declined from 31 percent to 16 percent between 1984 and 1999.
- ◆ Between 1984 and 1999, the proportion of people with lower levels of disability (limitations in 1-2 ADLs or in IADLs only) who were using assistive devices only increased while the proportion receiving personal care only decreased. In 1984, 14 percent of those with IADL limitations only and 22 percent of those with 1-2 ADL limitations used an assistive device only. The corresponding percentages in 1999 were 31 percent and 44 percent, respectively.

Data for this indicator's charts and bullets can be found in Tables 37a, 37b, 37c, and 37d on pages 114-116.





Data Needs

In preparing this report, the Federal Interagency Forum on Aging-Related Statistics (Forum) identified several areas where more data are needed to support research and policy efforts. The Forum's observations complement suggestions that were reported at a National Academy of Sciences' workshop on how to improve data on aging.⁵⁶

Extending the age-reporting categories

Although a respondent's age is almost always collected in single-year increments, it is often reported in categories. Typically, the standard age categories used by statisticians and researchers to describe and analyze the older population are 65-74, 75-84, and 85 and over. However, because the average age of the 85 and over group has steadily increased over the past 15 years, it is now necessary to consider replacing the 85 and over age category with two new categories: 85-94 and 95 and over. This change may require sampling strategies to ensure an adequate sample size in these older age groups.

Gathering information on older minorities

Although the number of studies that oversample older minorities has been increasing, the amount and quality of data available to researchers are still limited. There is a lack of basic data about aging minority populations, largely because of the small sample sizes of these populations and language barriers that prevent certain racial and ethnic groups from participating in surveys. The increasing number of older immigrants highlights the need to collect data on nativity and to analyze generational differences in health and well-being. Policy changes and cultural perceptions have brought increasing complexity to the definition and measurement of race and ethnicity. Currently, only the decennial census and the American Community Survey have a sufficient number of cases to make reliable estimates of the smallest racial and ethnic groups, but even these data lack critical health and disability information that is essential

to adequately study the well-being of older minorities.

Improving measures of disability

Information on trends in disability is critical for monitoring the health and well-being of the older population. However, the concept of disability encompasses many different dimensions of health and functioning and complex interactions with the environment. Furthermore, specific definitions of disability are used by some government agencies to determine eligibility for benefits. As a result, disability has been measured in different ways across surveys and censuses, and this has led to conflicting estimates of the prevalence of disability. To the extent possible, population-based surveys designed to broadly measure disability in the older population should use a common conceptual framework. At a minimum, questions designed to measure limitations in activities of daily living (ADLs), instrumental activities of daily living (IADLs), physical functioning, and other activities should use consistent wording and response categories whenever possible. Performance-based measures are another way to measure disability but often require additional survey resources. Studies using vignettes to measure disability are showing promising results.⁵⁷ Several interagency efforts currently are underway to compare disability measures across surveys and to assess the possible reasons for the different estimates. Federal agencies are working together to refine the way disability is measured for older people as well as to collect more systematic information on assistive technologies.

Including the institutionalized population in national surveys

Because of the complex methodological issues involved with collecting data from people in institutions (along with the associated high data collection costs), the institutionalized population is often excluded from large national household-based surveys. According to the U.S. Census Bureau, the institutionalized population "includes persons under formally authorized, supervised care or custody in institutions at the time of enumeration. Such persons are classified as 'patients or inmates' of an institution regardless of the availability of

nursing or medical care, the length of stay, or the number of persons in the institution.”⁵⁸ Because this definition includes people in nursing homes, psychiatric hospitals, and long-term care hospitals for the chronically ill, mentally retarded, and physically handicapped,⁵⁹ this exclusion can become a critical issue for researchers who are interested in studying the entire older population. This is especially true for the older age groups. For example, in 2002, only 83 percent of the population age 85 and over was included in the civilian noninstitutionalized population (see “About This Report,” page VI).

Distinguishing between types of long-term care facilities and the transitions that occur between them

The use of assisted-living facilities, group homes, continuing-care retirement communities, and other types of residential settings as alternatives to long-term care in a nursing home has grown over the last 15 years. For the purposes of demographic surveys, the U.S. Census Bureau typically defines people living in these settings as being part of the noninstitutionalized population.⁵⁹ Current surveys and censuses that include information on the noninstitutionalized population (as many federally-sponsored surveys do) rarely distinguish between these types of noninstitutional long-term care residences (or have sufficient sample size to do so). As a result, there is a lack of information on the characteristics of older people in different community-based residential care settings and their service use and health care needs. Perhaps more importantly, there is little information on the costs, duration, and transitions into and between different long-term care settings. This is made more difficult by the exclusion of the institutionalized population in many surveys, which precludes measuring transitions between community-based and institutional-based long-term care residential settings. Working in conjunction with several other interagency efforts, the Forum is collecting key data elements from federally-sponsored surveys to produce a compendium that provides detailed information on how the surveys include or exclude institutions from their sampling frames. Researchers and policymakers should consider developing consistent definitions of residential settings and include these data items on surveys.

Gathering national statistics on elder abuse

The Institute of Medicine reports a “paucity of research” on elder abuse and neglect, with most prior studies lacking empirical evidence.⁶⁰ In fact, there are no reliable national estimates of elder abuse, nor are the risk factors clearly understood. Most studies have been cross-sectional and have not investigated the history of abuse. The need for a national study of elder abuse and neglect is supported by the growing number of older people, increasing public awareness of the problem, new legal requirements for reporting abuse, and advances in questionnaire design. In 2003, the National Research Council published a report that highlighted the need for funding agencies to make a long-term commitment to funding elder mistreatment research.⁶¹

Gathering information to understand the reasons for improvements in life expectancy and functioning

One of the major successes of the 20th century is the increase in longevity and improved health of the older population. As life expectancy increases, the importance of effectively treating chronic diseases and reducing disability becomes ever greater. Understanding the underlying reasons for the improvements in longevity and functioning is a critical first step to further advances toward these goals. To this end, information is needed to understand the long-term improvements in the health of the older population stemming from better nutrition, increased access to medical care, improvements in the public health infrastructure, changes in lifestyles, better treatment of chronic diseases through new medical procedures and pharmaceuticals, and use of assistive devices and other technology.

Measuring Medicare enrollees’ health care use when they are in HMOs

The percentage of Medicare enrollees in Health Maintenance Organizations (HMOs) peaked at 21 percent in 1999 and then declined; however, recent increases in payments to managed care plans under the Medicare Prescription Drug

Improvement and Modernization Act are expected to increase enrollments in HMOs. To date little information has been available on the use of health care services by Medicare enrollees who are in HMOs. The lack of such information leaves a major gap in our knowledge about the older population's use of care, and the gap is likely to become more serious.

Improving the way data are collected to measure both income and wealth

Collecting data on economic well-being is often a difficult task. Many survey respondents either do not know their incomes or are unwilling to share this information with interviewers. This can result in missing data for a large proportion of respondents. A related problem with the collection of economic data is that most surveys use only income-based measures. This type of survey methodology does not capture the accumulated wealth (including the value of future pension payments) and assets on which many older people rely. New methods to gather income and wealth data are coming into use and are being refined, and their use should be encouraged in surveying older people. These methods are aimed at providing a better understanding of the total financial picture of older Americans facing retirement and those already retired, specifically at including information on individual retirement accounts and 401(k) and Keogh plans. While efforts are underway at a number of Federal agencies to change or improve the way income and wealth data are collected, it still remains a challenge to collect these data without adding to respondent burden.

Gathering information on the impact of transportation needs on the quality of life of older Americans

While much is known about the safety issues of crash involvement and fatality rates of older people, more information is needed on the effects of transportation on the quality of life. The ability to move freely from place to place, while often taken for granted, is as crucial to the well-being of older people as it is to the rest of the population. For example, access to quality health care is effectively removed if an older person cannot get from his or her home to a medical facility. Although the

Bureau of Transportation Statistics collected this type of information in the 2001 National Household Travel Survey, an ongoing data collection effort is needed to continue to monitor the number of trips older people take and the types of transportation they use. This critical information will aid policymakers in planning for the transportation needs of older Americans.

Accounting for uncertainties in population projections that assess the size of the older population

Population estimates and projections are used to assess the size of a population. Although estimates generally provide figures for the present and the past, projections estimate the size, composition, and distribution of the future population. Imbedded in population projections are assumptions about future trends in fertility, mortality, and migration. Different assumptions about these demographic processes can result in different projections of the future size of the population. Some researchers, for example, predict that death rates at older ages will decline more rapidly than the death rates assumed in the U.S. Census Bureau's current projections. This could result in the older population growing at a faster pace than is currently projected.²⁻⁴ The U.S. Census Bureau is currently working on stochastic population projections that include confidence intervals to model the uncertainty of the agency's projections. It may be useful to be aware of alternative projections of the older population when creating policies and programs.

Collecting more State and local level data

More data are needed at the State and local levels to help governments, communities, and organizations better monitor the health and economic status of their older populations. While there are a limited number of data collection efforts that yield reliable estimates at the State level (e.g., American Community Survey, Behavioral Risk Factor Surveillance System, and Local Employment Dynamics Program), more comprehensive data collection efforts are needed to accurately assess the well-being of older Americans within and between the States.

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Appendix A: Detailed Tables

INDICATOR 1 Number of Older Americans**Table 1a. Number of people age 65 and over and 85 and over, selected years 1900–2000 and projected 2010–2050**

<i>Year</i>	<i>65 and over</i>	<i>85 and over</i>
Estimates		
In millions		
1900	3.1	0.1
1910	3.9	0.2
1920	4.9	0.2
1930	6.6	0.3
1940	9.0	0.4
1950	12.3	0.6
1960	16.2	0.9
1970	20.1	1.5
1980	25.5	2.2
1990	31.2	3.1
2000	35.0	4.2
Projections		
2010	40.2	6.1
2020	54.6	7.3
2030	71.5	9.6
2040	80.0	15.4
2050	86.7	20.9

Reference population: These data refer to the resident population.

Source: U.S. Census Bureau, 1900 to 1940, 1970, and 1980, U.S. Census Bureau, 1983, Table 42; 1950, U.S. Census Bureau, 1953, Table 38; 1960, U.S. Census Bureau, 1964, Table 155; 1990, U.S. Census Bureau, 1991, 1990 Summary Table File 1; 2000, U.S. Census Bureau, 2001, Census 2000 Summary File 1; 2010 to 2050, International Programs Center, International Data Base, 2004.

Table 1b. Percentage of the population age 65 and over and 85 and over, selected years 1900–2000 and projected 2010–2050

<i>Year</i>	<i>65 and over</i>	<i>85 and over</i>
Estimates		
Percent		
1900	4.1	0.2
1910	4.3	0.2
1920	4.7	0.2
1930	5.4	0.2
1940	6.8	0.3
1950	8.1	0.4
1960	9.0	0.5
1970	9.9	0.7
1980	11.3	1.0
1990	12.6	1.2
2000	12.4	1.5
Projections		
2010	13.0	2.0
2020	16.3	2.2
2030	19.6	2.6
2040	20.4	3.9
2050	20.6	5.0

Reference population: These data refer to the resident population.

Source: U.S. Census Bureau, 1900 to 1940, 1970, and 1980, U.S. Census Bureau, 1983, Table 42; 1950, U.S. Census Bureau, 1953, Table 38; 1960, U.S. Census Bureau, 1964, Table 155; 1990, U.S. Census Bureau, 1991, 1990 Summary Table File 1; 2000, U.S. Census Bureau, 2001, Census 2000 Summary File 1; 2010 to 2050, International Programs Center, International Data Base, 2004.

INDICATOR 1

Number of Older Americans continued

Table 1c. Population of countries with at least 10 percent of their population age 65 and over, 2003

Region or country	Total	65 and over	
		Number	Percent
Italy	57,998,353	10,893,973	18.8
Japan	127,214,499	23,720,030	18.6
Greece	10,625,945	1,947,336	18.3
Germany	82,398,326	14,643,067	17.8
Spain	40,217,413	7,075,743	17.6
Sweden	8,970,306	1,545,515	17.2
Belgium	10,330,824	1,777,398	17.2
Bulgaria	7,588,399	1,293,949	17.1
Portugal	10,479,955	1,749,225	16.7
France	60,180,529	9,801,524	16.3
Croatia	4,497,779	723,788	16.1
Estonia	1,350,722	217,199	16.1
Austria	8,162,656	1,282,955	15.7
United Kingdom	60,094,648	9,429,087	15.7
Finland	5,204,405	805,215	15.5
Latvia	2,322,943	358,400	15.4
Switzerland	7,408,319	1,131,164	15.3
Ukraine	48,055,439	7,212,722	15.0
Georgia	4,710,921	706,380	15.0
Denmark	5,394,138	802,456	14.9
Norway	4,555,400	676,160	14.8
Hungary	10,057,745	1,492,216	14.8
Slovenia	2,011,604	298,344	14.8
Serbia and Montenegro	10,823,280	1,592,794	14.7
Lithuania	3,620,094	530,425	14.7
Luxembourg	456,764	65,985	14.4
Belarus	10,322,151	1,478,835	14.3
Romania	22,380,273	3,169,849	14.2
Czech Republic	10,251,087	1,432,188	14.0
Netherlands	16,223,248	2,241,317	13.8
Russia	144,457,596	19,203,848	13.3
Malta	395,178	51,969	13.2
Uruguay	3,381,606	442,733	13.1
Canada	32,207,113	4,167,291	12.9
Poland	38,622,660	4,924,081	12.7
Australia	19,731,984	2,502,665	12.7
United States	290,342,554	35,878,341	12.4
Hong Kong S.A.R.	6,809,738	836,153	12.3
Puerto Rico	3,878,679	461,501	11.9
Iceland	291,064	34,055	11.7
Slovakia	5,416,406	630,190	11.6
New Zealand	3,951,307	457,805	11.6
Ireland	3,924,023	447,070	11.4
Cyprus	771,657	85,629	11.1
Macedonia	2,063,122	217,965	10.6
Argentina	38,740,807	4,042,311	10.4
Martinique	425,966	43,818	10.3
Armenia	3,001,712	306,182	10.2
Moldova	4,439,502	452,797	10.2
Bosnia and Herzegovina	3,989,018	401,929	10.1

Source: U.S. Census Bureau, International Data Base, 2004.

INDICATOR 1 Number of Older Americans continued**Table 1d. Percentage of the population age 65 and over, by State, 2002**

<i>State (Ranked alphabetically)</i>	<i>Percent</i>	<i>State (Ranked by percentage)</i>	<i>Percent</i>
United States	12.4	United States	12.4
Alabama	13.1	Florida	17.2
Alaska	6.1	Pennsylvania	15.5
Arizona	12.9	West Virginia	15.3
Arkansas	13.9	North Dakota	14.8
California	10.6	Iowa	14.8
Colorado	9.6	Maine	14.4
Connecticut	13.6	South Dakota	14.3
Delaware	13.0	Rhode Island	14.2
District of Columbia	12.0	Arkansas	13.9
Florida	17.2	Montana	13.6
Georgia	9.5	Connecticut	13.6
Hawaii	13.4	Nebraska	13.4
Idaho	11.3	Hawaii	13.4
Illinois	12.0	Missouri	13.4
Indiana	12.3	Massachusetts	13.4
Iowa	14.8	Ohio	13.3
Kansas	13.1	Oklahoma	13.2
Kentucky	12.5	Alabama	13.1
Louisiana	11.6	Kansas	13.1
Maine	14.4	New Jersey	13.1
Maryland	11.3	Delaware	13.0
Massachusetts	13.4	Wisconsin	13.0
Michigan	12.3	New York	12.9
Minnesota	12.0	Arizona	12.9
Mississippi	12.1	Vermont	12.9
Missouri	13.4	Oregon	12.7
Montana	13.6	Kentucky	12.5
Nebraska	13.4	Tennessee	12.4
Nevada	11.1	Indiana	12.3
New Hampshire	11.9	South Carolina	12.3
New Jersey	13.1	Michigan	12.3
New Mexico	11.9	Mississippi	12.1
New York	12.9	North Carolina	12.0
North Carolina	12.0	Minnesota	12.0
North Dakota	14.8	District of Columbia	12.0
Ohio	13.3	Illinois	12.0
Oklahoma	13.2	New Hampshire	11.9
Oregon	12.7	New Mexico	11.9
Pennsylvania	15.5	Wyoming	11.9
Rhode Island	14.2	Louisiana	11.6
South Carolina	12.3	Idaho	11.3
South Dakota	14.3	Maryland	11.3
Tennessee	12.4	Virginia	11.3
Texas	9.9	Washington	11.2
Utah	8.6	Nevada	11.1
Vermont	12.9	California	10.6
Virginia	11.3	Texas	9.9
Washington	11.2	Colorado	9.6
West Virginia	15.3	Georgia	9.5
Wisconsin	13.0	Utah	8.6
Wyoming	11.9	Alaska	6.1

Reference population: These data refer to the resident population.

Source: U.S. Census Bureau, July 1, 2002 Population Estimates.

INDICATOR 1 Number of Older Americans continued

Table 1e. Percentage of the population age 65 and over, by county, 2002

Source: U.S. Census Bureau, July 1, 2002 Population Estimates.

Data for this table can be found at <http://www.agingstats.gov>.

INDICATOR 2 Racial and Ethnic Composition

Table 2. Population age 65 and over, by race and Hispanic origin, 2003 and projected 2050

Race and Hispanic origin	2003 estimates		2050 projections	
	Number	Percent	Number	Percent
Total	35,878,341	100.0	86,705,637	100.0
Non-Hispanic white alone	29,597,559	82.5	53,159,961	61.3
Black alone	3,011,410	8.4	10,401,575	12.0
Asian alone	954,967	2.7	6,776,033	7.8
All other races alone or in combination	398,551	1.1	2,328,390	2.7
Hispanic (of any race)	2,034,994	5.7	15,178,025	17.5

Note: The term "non-Hispanic white alone" is used to refer to people who reported being white and no other race and who are not Hispanic. The term "black alone" is used to refer to people who reported being black or African American and no other race, and the term "Asian alone" is used to refer to people who reported only Asian as their race. The use of single-race populations in this report does not imply that this is the preferred method of presenting or analyzing data. The U.S. Census Bureau uses a variety of approaches. The race group "All other races alone or in combination" includes American Indian and Alaska Native, alone; Native Hawaiian and Other Pacific Islander, alone; and all people who reported two or more races.

Reference population: These data refer to the resident population.

Source: U.S. Census Bureau, Population Estimates and Projections, 2004.

INDICATOR 3 Marital Status

Table 3. Marital status of the population age 65 and over, by age group and sex, 2003

Selected characteristic	65 and over	65-74	75-84	85 and over
	Percent			
Both sexes				
Married	56.6	65.9	50.7	29.4
Widowed	31.6	20.0	39.3	63.5
Divorced	8.0	10.2	6.0	3.4
Never married	3.9	4.0	3.9	3.7
Men				
Married	74.4	77.6	72.8	59.4
Widowed	14.3	8.8	18.4	34.6
Divorced	7.0	9.0	4.7	3.2
Never married	4.3	4.6	4.1	2.8
Women				
Married	43.4	56.1	36.0	13.9
Widowed	44.3	29.4	53.3	78.3
Divorced	8.6	11.2	6.9	3.5
Never married	3.7	3.4	3.8	4.2

Note: Married includes married, spouse present; married, spouse absent; and separated.

Reference population: These data refer to the civilian noninstitutionalized population.

Source: U.S. Census Bureau, Current Population Survey, Annual Social and Economic Supplement.

INDICATOR 4 Educational Attainment**Table 4a. Educational attainment of the population age 65 and over, selected years 1950–2003**

<i>Educational attainment</i>	1950	1960	1970	1980	1990	2000	2003
	Percent						
High school graduate or more	17.0	19.1	27.1	38.8	53.2	65.5	71.5
Bachelor's degree or more	3.4	3.7	5.5	8.3	10.7	15.4	17.4

Note: A single question which asks for the highest grade or degree completed is now used to determine educational attainment. Prior to 1990, educational attainment was measured using data on years of school completed.

Reference population: Data for 2003 refer to the civilian noninstitutionalized population. Data for other years refer to the resident population.

Source: U.S. Census Bureau, Decennial Census, 1950-2000; Current Population Survey, Annual Social and Economic Supplement, 2003.

Table 4b. Educational attainment of the population age 65 and over, by race and Hispanic origin, 2003

<i>Race and Hispanic origin</i>	<i>High school graduate or more</i>	<i>Bachelor's degree or more</i>
	Percent	
Total	71.5	17.4
Non-Hispanic white alone	76.1	18.6
Black alone	51.6	10.3
Asian alone	70.3	29.1
Hispanic (of any race)	36.3	6.1

Note: The term "non-Hispanic white alone" is used to refer to people who reported being white and no other race and who are not Hispanic. The term "black alone" is used to refer to people who reported being black or African American and no other race, and the term "Asian alone" is used to refer to people who reported only Asian as their race. The use of single-race populations in this report does not imply that this is the preferred method of presenting or analyzing data. The U.S. Census Bureau uses a variety of approaches.

Reference population: These data refer to the civilian noninstitutionalized population.

Source: U.S. Census Bureau, Current Population Survey, Annual Social and Economic Supplement.

INDICATOR 5 Living Arrangements

Table 5a. Living arrangements of the population age 65 and over, by sex and race and Hispanic origin, 2003

<i>Selected characteristic</i>	<i>With spouse</i>	<i>With other relatives</i>	<i>With nonrelatives</i>	<i>Alone</i>
Men	Percent			
Total	73.0	5.0	3.0	19.0
Non-Hispanic white alone	75.0	3.5	2.7	18.7
Black alone	60.3	5.7	4.4	29.5
Asian alone	59.7	30.6	0.5	8.1
Hispanic (of any race)	68.3	15.0	4.7	12.0
Women				
Total	50.0	9.0	2.0	40.0
Non-Hispanic white alone	49.6	6.8	1.7	41.8
Black alone	45.6	13.2	2.1	39.1
Asian alone	42.8	35.6	2.2	19.4
Hispanic (of any race)	50.9	24.8	2.2	21.8

Note: Living with other relatives indicates no spouse present. Living with nonrelatives indicates no spouse or other relatives present. The term "non-Hispanic white alone" is used to refer to people who reported being white and no other race and who are not Hispanic. The term "black alone" is used to refer to people who reported being black or African American and no other race, and the term "Asian alone" is used to refer to people who reported only Asian as their race. The use of single-race populations in this report does not imply that this is the preferred method of presenting or analyzing data. The U.S. Census Bureau uses a variety of approaches.

Reference population: These data refer to the civilian noninstitutionalized population.

Source: U.S. Census Bureau, Current Population Survey, Annual Social and Economic Supplement.

Table 5b. Population age 65 and over living alone, by age group and sex, selected years 1970–2003

<i>Year</i>	<i>Men</i>		<i>Women</i>	
	<i>65-74</i>	<i>75 and over</i>	<i>65-74</i>	<i>75 and over</i>
	Percent			
1970	11.3	19.1	31.7	37.0
1980	11.6	21.6	35.6	49.4
1990	13.0	20.9	33.2	54.0
2000	13.8	21.4	30.6	49.5
2003	15.6	22.9	29.6	49.8

Reference population: These data refer to the civilian noninstitutionalized population.

Source: U.S. Census Bureau, Current Population Survey, Annual Social and Economic Supplement.

INDICATOR 6 Older Veterans**Table 6a. Percentage of men age 65 and over who are veterans, by age group, United States and Puerto Rico, 1990 and 2000**

Year	65 and over	65-74	75-84	85 and over
	Percent			
1990	54.2	69.7	30.0	16.6
2000	64.9	66.3	70.7	32.3

Reference population: These data refer to the resident population of the United States and Puerto Rico.

Source: U.S. Census Bureau, Decennial Census.

Table 6b. Estimated and projected number of male veterans and total veterans age 65 and over, by age group, United States and Puerto Rico, 1990, 2000, and projected 2005–2015

Year	65 and over		65-74		75-84		85 and over	
	Male	Total	Male	Total	Male	Total	Male	Total
	Number in thousands							
Estimates								
1990	6,860	7,190	5,579	5,836	1,140	1,200	142	154
2000	9,455	9,808	5,569	5,683	3,486	3,695	400	431
Projections								
2005	8,984	9,308	4,290	4,400	3,790	3,931	904	977
2010	8,539	8,835	4,044	4,158	3,276	3,359	1,219	1,318
2011	8,711	9,006	4,342	4,463	3,120	3,203	1,249	1,340
2012	8,848	9,143	4,592	4,720	2,983	3,067	1,273	1,357
2013	8,863	9,159	4,730	4,866	2,884	2,967	1,249	1,325
2014	8,820	9,119	4,809	4,954	2,774	2,857	1,237	1,308
2015	8,666	8,971	4,782	4,939	2,655	2,737	1,229	1,295

Reference population: These data refer to the resident population of the United States and Puerto Rico.

Source: U.S. Census Bureau, Decennial Census, 1990 and 2000; Department of Veterans Affairs, Office of the Actuary, VetPop2001 adjusted by Census 2000, February 2003, projected 2005-2015.

INDICATOR 7 Poverty

Table 7a. Percentage of the population living in poverty, by age group, 1959–2002

<i>Year</i>	<i>65 and over</i>	<i>Under 18</i>	<i>18-64</i>	<i>65-74</i>	<i>75-84</i>	<i>85 and over</i>
	Percent					
1959	35.2	27.3	17.0	na	na	na
1960	na	26.9	na	na	na	na
1961	na	25.6	na	na	na	na
1962	na	25.0	na	na	na	na
1963	na	23.1	na	na	na	na
1964	na	23.0	na	na	na	na
1965	na	21.0	na	na	na	na
1966	28.5	17.6	10.5	na	na	na
1967	29.5	16.6	10.0	na	na	na
1968	25.0	15.6	9.0	na	na	na
1969	25.3	14.0	8.7	na	na	na
1970	24.6	15.1	9.0	na	na	na
1971	21.6	15.3	9.3	na	na	na
1972	18.6	15.1	8.8	na	na	na
1973	16.3	14.4	8.3	na	na	na
1974	14.6	15.4	8.3	na	na	na
1975	15.3	17.1	9.2	na	na	na
1976	15.0	16.0	9.0	na	na	na
1977	14.1	16.2	8.8	na	na	na
1978	14.0	15.9	8.7	na	na	na
1979	15.2	16.4	8.9	na	na	na
1980	15.7	18.3	10.1	na	na	na
1981	15.3	20.0	11.1	na	na	na
1982	14.6	21.9	12.0	12.4	17.4	21.2
1983	13.8	22.3	12.4	11.9	16.7	21.3
1984	12.4	21.5	11.7	10.3	15.2	18.4
1985	12.6	20.7	11.3	10.6	15.3	18.7
1986	12.4	20.5	10.8	10.3	15.3	17.6
1987	12.5	20.3	10.6	9.9	16.0	18.9
1988	12.0	19.5	10.5	10.0	14.6	17.8
1989	11.4	19.6	10.2	8.8	14.6	18.4
1990	12.2	20.6	10.7	9.7	14.9	20.2
1991	12.4	21.8	11.4	10.6	14.0	18.9
1992	12.9	22.3	11.9	10.6	15.2	19.9
1993	12.2	22.7	12.4	10.0	14.1	19.7
1994	11.7	21.8	11.9	10.1	12.8	18.0
1995	10.5	20.8	11.4	8.6	12.3	15.7
1996	10.8	20.5	11.4	8.8	12.5	16.5
1997	10.5	19.9	10.9	9.2	11.3	15.7
1998	10.5	18.9	10.5	9.1	11.6	14.2
1999	9.7	17.1	10.1	8.8	9.8	14.2
2000	9.9	16.2	9.6	8.6	10.6	14.5
2001	10.1	16.3	10.1	9.2	10.4	13.9
2002	10.4	16.7	10.6	9.4	11.1	13.6

na Data not available.

Note: The poverty level is based on money income and does not include noncash benefits such as food stamps. Poverty thresholds reflect family size and composition and are adjusted each year using the annual average Consumer Price Index. For more detail, see U.S. Census Bureau, Series P-60, No. 222.

Reference population: These data refer to the civilian noninstitutionalized population.

Source: U.S. Census Bureau, Current Population Survey, Annual Social and Economic Supplement, 1960-2003.

INDICATOR 7 Poverty continued**Table 7b. Percentage of the population age 65 and over living in poverty, by selected characteristics, 2002**

<i>Selected characteristic</i>	<i>65 and over</i>	<i>65 and over, living alone</i>	<i>65 and over, married couples</i>	<i>65-74</i>	<i>75 and over</i>
	Percent				
Both sexes					
Total	10.4	19.2	5.1	9.4	11.7
Non-Hispanic white alone	8.3	16.1	3.8	6.9	9.8
Black alone	23.8	37.2	11.8	23.3	24.4
Asian alone	8.4	23.4	6.1	6.9	10.9
Hispanic (of any race)	21.4	44.1	16.0	20.2	23.1
Men					
Total	7.7	15.6	5.3	7.7	7.8
Non-Hispanic white alone	5.8	12.1	3.8	5.6	6.0
Black alone	18.1	30.2	11.3	18.1	18.2
Asian alone	6.8	(B)	7.1	4.9	10.6
Hispanic (of any race)	19.3	37.2	17.0	19.0	19.8
Women					
Total	12.4	20.5	4.9	10.8	14.1
Non-Hispanic white alone	10.1	17.4	3.7	8.0	12.2
Black alone	27.4	40.6	12.3	27.2	27.7
Asian alone	9.6	25.3	5.2	8.7	11.1
Hispanic (of any race)	23.0	47.1	14.9	21.2	25.6

(B) Base is not large enough to produce reliable results.

Note: The poverty level is based on money income and does not include noncash benefits such as food stamps. Poverty thresholds reflect family size and composition and are adjusted each year using the annual average Consumer Price Index. For more detail, see U.S. Census Bureau, Series P-60, No. 222. The term "non-Hispanic white alone" is used to refer to people who reported being white and no other race and who are not Hispanic. The term "black alone" is used to refer to people who reported being black or African American and no other race, and the term "Asian alone" is used to refer to people who reported only Asian as their race. The use of single-race populations in this report does not imply that this is the preferred method of presenting or analyzing data. The U.S. Census Bureau uses a variety of approaches.

Reference population: These data refer to the civilian noninstitutionalized population.

Source: U.S. Census Bureau, Current Population Survey, Annual Social and Economic Supplement, 2003.

INDICATOR 8 Income

Table 8. Income distribution of the population age 65 and over, 1974–2002

<i>Year</i>	<i>Poverty</i>	<i>Low income</i>	<i>Middle income</i>	<i>High income</i>
		Percent		
1974	14.6	34.6	32.6	18.2
1975	15.3	35.0	32.3	17.4
1976	15.0	34.7	31.8	18.5
1977	14.1	35.9	31.5	18.5
1978	14.0	33.4	34.2	18.5
1979	15.2	33.0	33.6	18.2
1980	15.7	33.5	32.4	18.4
1981	15.3	32.8	33.1	18.9
1982	14.6	31.4	33.3	20.7
1983	13.8	29.7	34.1	22.4
1984	12.4	30.2	33.8	23.6
1985	12.6	29.4	34.6	23.4
1986	12.4	28.4	34.4	24.8
1987	12.5	27.8	35.1	24.7
1988	12.0	28.4	34.5	25.1
1989	11.4	29.1	33.6	25.9
1990	12.2	27.0	35.2	25.6
1991	12.4	28.0	36.3	23.3
1992	12.9	28.6	35.6	22.9
1993	12.2	29.8	35.0	23.0
1994	11.7	29.5	35.6	23.2
1995	10.5	29.1	36.1	24.3
1996	10.8	29.5	34.7	25.1
1997	10.5	28.1	35.3	26.0
1998	10.5	26.8	35.3	27.5
1999	9.7	26.2	36.4	27.7
2000	9.9	27.5	35.5	27.1
2001	10.1	28.1	35.2	26.7
2002	10.4	28.0	35.3	26.2

Note: The income categories are derived from the ratio of the family's income (or an unrelated individual's income) to the corresponding poverty threshold. Being in poverty is measured as income less than 100 percent of the poverty threshold. Low income is between 100 percent and 199 percent of the poverty threshold. Middle income is between 200 percent and 399 percent of the poverty threshold. High income is 400 percent or more of the poverty threshold.

Reference population: These data refer to the civilian noninstitutionalized population.

Source: U.S. Census Bureau, Current Population Survey, Annual Social and Economic Supplement, 1975–2003.

INDICATOR 9 Sources of Income**Table 9a. Distribution of sources of income for the population age 65 and over, selected years 1962–2002**

<i>Year</i>	<i>Total</i>	<i>Social Security</i>	<i>Asset income</i>	<i>Pensions</i>	<i>Earnings</i>	<i>Other</i>
Percent						
1962	100	31	16	9	28	16
1967	100	34	15	12	29	10
1976	100	39	18	16	23	4
1978	100	38	19	16	23	4
1980	100	39	22	16	19	4
1982	100	39	25	15	18	3
1984	100	38	28	15	16	3
1986	100	38	26	16	17	3
1988	100	38	25	17	17	3
1990	100	36	24	18	18	4
1992	100	40	21	20	17	2
1994	100	42	18	19	18	3
1996	100	40	18	19	20	3
1998	100	38	20	19	21	2
1999	100	38	19	19	21	3
2000	100	38	18	18	23	3
2001	100	39	16	18	24	3
2002	100	39	14	19	25	3

Reference population: These data refer to the civilian noninstitutionalized population.

Source: U.S. Census Bureau, Current Population Survey, Annual Social and Economic Supplement; 1963 Survey of the Aged; and 1968 Survey of Demographic and Economic Characteristics of the Aged.

Table 9b. Sources of income for the population age 65 and over, by income quintile, 2002

<i>Income source</i>	<i>Lowest fifth</i>	<i>Second fifth</i>	<i>Third fifth</i>	<i>Fourth fifth</i>	<i>Highest fifth</i>
Percent					
Total	100.0	100.0	100.0	100.0	100.0
Social Security	82.6	84.0	67.0	47.0	19.8
Asset income	2.4	3.7	7.4	9.8	18.9
Pensions	3.5	6.7	15.0	25.4	20.4
Earnings	1.1	2.3	7.0	14.7	38.4
Public assistance	8.9	1.6	1.0	0.2	0.1
Other	1.5	1.7	2.7	2.9	2.4

Reference population: These data refer to the civilian noninstitutionalized population.

Source: U.S. Census Bureau, Current Population Survey, Annual Social and Economic Supplement.

INDICATOR 10 Net Worth

Table 10. Median household net worth of head of household, by selected characteristics, in 2001 dollars, selected years 1984–2001

<i>Selected characteristic</i>	<i>1984</i>	<i>1989</i>	<i>1994</i>	<i>1999</i>	<i>2001</i>
			In dollars		
Age of family head					
65 and over	\$ 98,900	\$107,800	\$119,500	\$160,700	\$179,800
45-54	117,600	104,700	106,400	94,600	97,000
55-64	126,600	159,200	166,700	153,100	165,000
65-74	116,200	134,300	138,600	187,100	205,000
75 and over	85,200	89,300	98,800	136,100	144,000
Marital status, family head age 65 and over					
Married	155,100	196,400	219,600	250,900	291,000
Unmarried	69,900	65,700	73,900	96,300	100,800
Race, family head age 65 and over					
White	113,400	122,800	131,500	187,100	205,000
Black	25,600	33,100	37,000	29,800	41,000
Education, family head age 65 and over					
No high school diploma	55,200	54,700	59,800	58,500	57,300
High school diploma only	136,900	145,500	129,100	170,100	172,000
Some college or more	216,500	249,900	268,900	320,000	360,500

Note: Median net worth is calculated using sample weights. Tests of statistical significance were performed on the mean household net worth. From 1984 to 1994, net equity in homes and nonhousing assets was divided into six categories: other real estate and vehicles; farm or business ownership; stocks, mutual funds, investment trusts, and stocks held in IRAs; checking and savings accounts, CDs, treasury bills, savings bonds, and liquid assets in IRAs; bonds, trusts, life insurance, and other assets; and other debts. Starting in 1999, IRAs were measured as a separate category. Panel Study of Income Dynamics (PSID) net worth data do not include pension wealth. This excludes private defined-contribution and defined-benefit plans as well as rights to Social Security wealth. See Appendix B for the definition of race and ethnicity in the PSID.

Reference population: These data refer to the civilian noninstitutionalized population.

Source: Panel Study of Income Dynamics.

INDICATOR 11 Participation in the Labor Force**Table 11. Labor force participation rates of people age 55 and over, by age group and sex, annual averages, 1963–2003**

Year	Men				Women			
	55–61	62–64	65–69	70 and over	55–61	62–64	65–69	70 and over
	Percent							
1963	89.9	75.8	40.9	20.8	43.7	28.8	16.5	5.9
1964	89.5	74.6	42.6	19.5	44.5	28.5	17.5	6.2
1965	88.8	73.2	43.0	19.1	45.3	29.5	17.4	6.1
1966	88.6	73.0	42.7	17.9	45.5	31.6	17.0	5.8
1967	88.5	72.7	43.4	17.6	46.4	31.5	17.0	5.8
1968	88.4	72.6	43.1	17.9	46.2	32.1	17.0	5.8
1969	88.0	70.2	42.3	18.0	47.3	31.6	17.3	6.1
1970	87.7	69.4	41.6	17.6	47.0	32.3	17.3	5.7
1971	86.9	68.4	39.4	16.9	47.0	31.7	17.0	5.6
1972	85.6	66.3	36.8	16.6	46.4	30.9	17.0	5.4
1973	84.0	62.4	34.1	15.6	45.7	29.2	15.9	5.3
1974	83.4	60.8	32.9	15.5	45.3	28.9	14.4	4.8
1975	81.9	58.6	31.7	15.0	45.6	28.9	14.5	4.8
1976	81.1	56.1	29.3	14.2	45.9	28.3	14.9	4.6
1977	80.9	54.6	29.4	13.9	45.7	28.5	14.5	4.6
1978	80.3	54.0	30.1	14.2	46.2	28.5	14.9	4.8
1979	79.5	54.3	29.6	13.8	46.6	28.8	15.3	4.6
1980	79.1	52.6	28.5	13.1	46.1	28.5	15.1	4.5
1981	78.4	49.4	27.8	12.5	46.6	27.6	14.9	4.6
1982	78.5	48.0	26.9	12.2	46.9	28.5	14.9	4.5
1983	77.7	47.7	26.1	12.2	46.4	29.1	14.7	4.5
1984	76.9	47.5	24.6	11.4	47.1	28.8	14.2	4.4
1985	76.6	46.1	24.4	10.5	47.4	28.7	13.5	4.3
1986	75.8	45.8	25.0	10.4	48.1	28.5	14.3	4.1
1987	76.3	46.0	25.8	10.5	48.9	27.8	14.3	4.1
1988	75.8	45.4	25.8	10.9	49.9	28.5	15.4	4.4
1989	76.3	45.3	26.1	10.9	51.4	30.3	16.4	4.6
1990	76.7	46.5	26.0	10.7	51.7	30.7	17.0	4.7
1991	76.1	45.5	25.1	10.5	52.1	29.3	17.0	4.7
1992	75.7	46.2	26.0	10.7	53.6	30.5	16.2	4.8
1993	74.9	46.1	25.4	10.3	53.8	31.7	16.1	4.7
1994	73.8	45.1	26.8	11.7	55.5	33.1	17.9	5.5
1995	74.3	45.0	27.0	11.6	55.9	32.5	17.5	5.3
1996	74.8	45.7	27.5	11.5	56.4	31.8	17.2	5.2
1997	75.4	46.2	28.4	11.6	57.3	33.6	17.6	5.1
1998	75.5	47.3	28.0	11.1	57.6	33.3	17.8	5.2
1999	75.4	46.9	28.5	11.7	57.9	33.7	18.4	5.5
2000	74.3	47.0	30.3	12.0	58.3	34.1	19.5	5.8
2001	74.9	48.2	30.2	12.1	58.9	36.7	20.0	5.9
2002	75.4	50.4	32.2	11.5	61.1	37.6	20.7	6.0
2003	74.9	49.6	32.8	12.3	62.5	38.6	22.7	6.4

Reference population: These data refer to the civilian noninstitutionalized population.

Source: Bureau of Labor Statistics, Current Population Survey.

INDICATOR 12 Housing Expenditures

Table 12. Total annual expenditures allocated to housing costs in households headed by people age 65 and over, by income level, selected years 1987–2002

<i>Income level</i>	<i>1987</i>	<i>1989</i>	<i>1992</i>	<i>1994</i>	<i>1996</i>	<i>1998</i>	<i>2002</i>
Proportion of total expenditures spent on housing (percent)							
Lowest fifth	33.4	34.8	37.5	34.5	36.2	36.0	40.3
Second fifth	33.0	31.4	32.5	35.5	34.0	35.3	35.3
Third fifth	28.8	28.3	30.0	26.3	29.8	28.7	32.6
Fourth fifth	26.7	23.9	26.1	26.4	28.9	28.0	29.1
Highest fifth	20.5	21.8	23.3	23.6	24.1	25.8	28.0
Average expenditures on housing (in dollars)							
Lowest fifth	\$ 2,842	\$ 3,076	\$ 3,813	\$ 3,919	\$ 4,309	\$ 4,686	\$ 5,116
Second fifth	3,410	3,648	4,161	4,885	4,891	5,743	6,276
Third fifth	3,525	4,232	4,853	4,834	5,753	5,930	7,220
Fourth fifth	4,186	4,739	5,737	6,575	6,826	7,147	7,736
Highest fifth	5,403	7,010	7,625	8,925	9,791	10,119	11,544
Average total expenditures (in dollars)							
Lowest fifth	\$ 8,502	\$ 8,835	\$10,172	\$11,375	\$11,900	\$13,032	\$12,688
Second fifth	10,332	11,617	12,784	13,747	14,378	16,252	17,768
Third fifth	12,232	14,965	16,189	18,401	19,315	20,696	22,132
Fourth fifth	15,676	19,788	22,011	24,894	23,647	25,509	26,548
Highest fifth	26,301	32,117	32,659	37,757	40,602	39,170	41,204

Note: For the purpose of this report, housing is defined as “basic housing” (i.e., shelter and utilities). Shelter includes payments for mortgage interest and charges; property taxes; maintenance, repairs, insurance, and other expenses; rent; rent as pay (reduced or free rent for a unit as a form of pay); and maintenance, insurance, and other expenses for renters. “Basic housing” is defined to include utilities because some renters have these costs included in their rent; furthermore, they are a cost that most consumer units incur to provide a tolerable living environment, whether it be for heating and cooling, cooking, or lighting. Levels/income fifths are used to define five levels of income. In this analysis, the term “household” is used in place of the term “consumer unit.” A consumer unit is used to describe members of a household related by blood, marriage, adoption, or other legal arrangement; single people who are living alone or sharing a household with others but who are financially independent; or two or more people living together who share responsibility for at least two of three major types of expenses (food, housing, and other expenses). The income distribution was determined for the subset of all consumer units in which the reference person was age 65 or over.

Reference population: These data refer to the resident noninstitutionalized population.

Source: Bureau of Labor Statistics, Consumer Expenditure Survey.

INDICATOR 13 Life Expectancy**Table 13a. Life expectancy, by age and sex, selected years 1900–2001**

<i>Age and sex</i>	<i>1900</i>	<i>1910</i>	<i>1920</i>	<i>1930</i>	<i>1940</i>	<i>1950</i>	<i>1960</i>	<i>1970</i>	<i>1980</i>	<i>1990</i>	<i>2000</i>	<i>2001</i>
	Years											
Birth												
Both sexes	49.2	51.5	56.4	59.2	63.6	68.1	69.9	70.8	73.9	75.4	77.0	77.2
Men	47.9	49.9	55.5	57.7	61.6	65.5	66.8	67.0	70.1	71.8	74.3	74.4
Women	50.7	53.2	57.4	60.9	65.9	71.0	73.2	74.6	77.6	78.8	79.7	79.8
At age 65												
Both sexes	11.9	11.6	12.5	12.2	12.8	13.8	14.4	15.0	16.5	17.3	18.0	18.1
Men	11.5	11.2	12.2	11.7	12.1	12.7	13.0	13.0	14.2	15.1	16.2	16.4
Women	12.2	12.0	12.7	12.8	13.6	15.0	15.8	16.8	18.4	19.0	19.3	19.4
At age 85												
Both sexes	4.0	4.0	4.2	4.2	4.3	4.7	4.6	5.3	6.0	6.2	6.4	6.5
Men	3.8	3.9	4.1	4.0	4.1	4.4	4.4	4.7	5.1	5.3	5.6	5.7
Women	4.1	4.1	4.3	4.3	4.5	4.9	4.7	5.6	6.4	6.7	6.8	6.9

Note: The life expectancies (LEs) for decennial years 1910 to 1990 are based on decennial census data and deaths for a 3-year period around the census year. The LEs for decennial year 1900 are based on deaths from 1900 to 1902. LEs for years prior to 1930 are based on the death registration area only. The death registration area increased from 10 States and the District of Columbia in 1900 to the coterminous United States in 1933. LEs for 2000 were computed using population counts from Census 2000. LEs for 2001 were computed using 2000-based postcensal estimates.

Reference population: These data refer to the resident population.

Source: Centers for Disease Control and Prevention, National Center for Health Statistics, National Vital Statistics System.

Table 13b. Life expectancy, by age and race, 2001

<i>Age</i>	<i>Total</i>		<i>Men</i>		<i>Women</i>	
	<i>White</i>	<i>Black</i>	<i>White</i>	<i>Black</i>	<i>White</i>	<i>Black</i>
	Years					
Birth	77.7	72.2	75.0	68.6	80.2	75.5
At age 65	18.2	16.4	16.5	14.4	19.5	17.9
At age 85	6.4	6.7	5.6	5.7	6.7	7.0

Note: See Appendix B for the definition of race and ethnicity in the National Vital Statistics System.

Reference population: These data refer to the resident population.

Source: Centers for Disease Control and Prevention, National Center for Health Statistics, National Vital Statistics System.

INDICATOR 14 Mortality

Table 14a. Death rates for selected leading causes of death among people age 65 and over, 1981–2001

Year	Diseases of heart	Malignant neoplasm	Cerebrovascular diseases	Chronic lower respiratory diseases	Influenza and pneumonia	Diabetes mellitus
Number per 100,000 population						
1981	2,546.7	1,055.7	623.8	185.8	207.2	105.8
1982	2,503.2	1,068.9	585.2	186.1	181.2	102.3
1983	2,512.0	1,077.5	564.4	204.3	207.2	104.4
1984	2,449.5	1,087.1	546.2	210.8	214.0	102.6
1985	2,430.9	1,091.2	531.0	225.4	242.9	103.4
1986	2,371.7	1,101.2	506.3	227.7	244.7	100.8
1987	2,316.4	1,105.5	495.9	229.7	237.4	102.3
1988	2,305.7	1,114.1	489.4	240.0	263.1	104.7
1989	2,171.8	1,133.0	463.7	240.2	253.3	120.4
1990	2,091.1	1,141.8	447.9	245.0	258.2	120.4
1991	2,045.6	1,149.5	434.7	251.7	245.1	120.8
1992	1,989.5	1,150.6	424.5	252.5	232.7	120.8
1993	2,024.0	1,159.2	434.5	273.6	247.9	128.4
1994	1,952.3	1,155.3	433.7	271.3	238.1	132.6
1995	1,927.4	1,152.5	437.7	271.2	237.2	135.9
1996	1,877.6	1,140.8	433.1	275.5	233.5	139.4
1997	1,827.2	1,127.3	423.8	280.2	236.3	140.2
1998	1,791.5	1,119.2	411.9	286.8	247.4	143.4
1999	1,767.0	1,126.1	433.2	313.0	167.4	150.0
2000	1,694.9	1,119.2	422.7	303.6	167.2	149.6
2001	1,631.6	1,100.2	404.1	300.7	154.9	151.1
Percent						
Percentage change						
1981-2001	-35.9	4.2	-35.2	61.8	-25.2	42.8

Note: Death rates for 1981-98 are based on the 9th revision of the *International Classification of Disease* (ICD-9). Starting in 1999, death rates are based on ICD-10. For the period 1981-98, causes were coded using ICD-9 codes that are most nearly comparable with the 113 cause list for ICD-10 and may differ from previously published estimates. Population estimates for July 1, 2000, and July 1, 2001, are post-censal estimates and have been bridged to be consistent with the race categories used in the 1990 Decennial Census. These estimates were produced by the National Center for Health Statistics under a collaborative arrangement with the U.S. Census Bureau. Population estimates for 1990-1999 are intercensal estimates, based on the 1990 Decennial Census and bridged estimates for 2000. These estimates were produced by the Population Estimates Program of the U.S. Census Bureau with support from the National Cancer Institute (NCI). For more information on the bridged race population estimates for 1990-2001, see <http://www.cdc.gov/nchs/about/major/dvs/popbridge/popbridge.htm>. Death rates for 1990-2001 may differ from those published elsewhere because of the use of the bridged intercensal and post-censal population estimates. Rates are age-adjusted using the 2000 standard population.

Reference population: These data refer to the resident population.

Source: Centers for Disease Control and Prevention, National Center for Health Statistics, National Vital Statistics System.

INDICATOR 14 Mortality continued**Table 14b. Leading causes of death among people age 65 and over, by sex and race and Hispanic origin, 2001**

	<i>All races</i>	<i>White</i>	<i>Black</i>	<i>Asian or Pacific Islander</i>	<i>American Indian</i>	<i>Hispanic</i>
Men						
1	Diseases of heart	Diseases of heart	Diseases of heart	Diseases of heart	Diseases of heart	Diseases of heart
2	Malignant neoplasms	Malignant neoplasms	Malignant neoplasms	Malignant neoplasms	Malignant neoplasms	Malignant neoplasms
3	Cerebrovascular diseases	Chronic lower respiratory diseases	Cerebrovascular diseases	Cerebrovascular diseases	Cerebrovascular diseases	Cerebrovascular diseases
4	Chronic lower respiratory diseases	Cerebrovascular diseases	Chronic lower respiratory diseases	Chronic lower respiratory diseases	Chronic lower respiratory diseases	Diabetes mellitus
5	Influenza and pneumonia	Influenza and pneumonia	Diabetes mellitus	Influenza and pneumonia	Diabetes mellitus	Chronic lower respiratory diseases
6	Diabetes mellitus	Diabetes mellitus	Nephritis, nephrotic syndrome and nephrosis	Diabetes mellitus	Influenza and pneumonia	Influenza and pneumonia
7	Accidents (unintentional injuries)	Accidents (unintentional injuries)	Influenza and pneumonia	Accidents (unintentional injuries)	Accidents (unintentional injuries)	Nephritis, nephrotic syndrome and nephrosis
8	Alzheimer's disease	Alzheimer's disease	Septicemia	Nephritis, nephrotic syndrome and nephrosis	Nephritis, nephrotic syndrome and nephrosis	Accidents (unintentional injuries)
9	Nephritis, nephrotic syndrome and nephrosis	Nephritis, nephrotic syndrome and nephrosis	Accidents (unintentional injuries)	Septicemia	Septicemia	Chronic liver disease and cirrhosis
10	Septicemia	Septicemia	Essential (primary) hypertension and hypertensive renal disease	Aortic aneurysm and dissection	Chronic liver disease and cirrhosis	Septicemia

See footnotes at end of table.

INDICATOR 14 Mortality continued

Table 14b. Leading causes of death among people age 65 and over, by sex and race and Hispanic origin, 2001 (continued)

	<i>All races</i>	<i>White</i>	<i>Black</i>	<i>Asian or Pacific Islander</i>	<i>American Indian</i>	<i>Hispanic</i>
Women						
1	Diseases of heart	Diseases of heart	Diseases of heart	Diseases of heart	Diseases of heart	Diseases of heart
2	Malignant neoplasms	Malignant neoplasms	Malignant neoplasms	Malignant neoplasms	Malignant neoplasms	Malignant neoplasms
3	Cerebrovascular diseases	Cerebrovascular diseases	Cerebrovascular diseases	Cerebrovascular diseases	Cerebrovascular diseases	Cerebrovascular diseases
4	Chronic lower respiratory diseases	Chronic lower respiratory diseases	Diabetes mellitus	Diabetes mellitus	Diabetes mellitus	Diabetes mellitus
5	Alzheimer's disease	Alzheimer's disease	Nephritis, nephrotic syndrome and nephrosis	Influenza and pneumonia	Chronic lower respiratory diseases	Influenza and pneumonia
6	Influenza and pneumonia	Influenza and pneumonia	Chronic lower respiratory diseases	Chronic lower respiratory diseases	Influenza and pneumonia	Chronic lower respiratory diseases
7	Diabetes mellitus	Diabetes mellitus	Influenza and pneumonia	Nephritis, nephrotic syndrome and nephrosis	Accidents (unintentional injuries)	Alzheimer's disease
8	Nephritis, nephrotic syndrome and nephrosis	Accidents (unintentional injuries)	Septicemia	Accidents (unintentional injuries)	Nephritis, nephrotic syndrome and nephrosis	Nephritis, nephrotic syndrome and nephrosis
9	Accidents (unintentional injuries)	Nephritis, nephrotic syndrome and nephrosis	Alzheimer's disease	Essential (primary) hypertension and hypertensive renal disease	Alzheimer's disease	Accidents (unintentional injuries)
10	Septicemia	Septicemia	Essential (primary) hypertension and hypertensive renal disease	Alzheimer's disease	Chronic liver disease and cirrhosis	Septicemia

Note: See Appendix B for the definition of race and ethnicity in the National Vital Statistics System.

Reference population: These data refer to the resident population.

Source: Centers for Disease Control and Prevention, National Center for Health Statistics, National Vital Statistics System.

INDICATOR 14 Mortality continued**Table 14c. Leading causes of death among people age 85 and over, by sex and race and Hispanic origin, 2001**

	<i>All races</i>	<i>White</i>	<i>Black</i>	<i>Asian or Pacific Islander</i>	<i>American Indian</i>	<i>Hispanic</i>
Men						
1	Diseases of heart	Diseases of heart	Diseases of heart	Diseases of heart	Diseases of heart	Diseases of heart
2	Malignant neoplasms	Malignant neoplasms	Malignant neoplasms	Malignant neoplasms	Malignant neoplasms	Malignant neoplasms
3	Cerebrovascular diseases	Cerebrovascular diseases	Cerebrovascular diseases	Cerebrovascular diseases	Cerebrovascular diseases	Cerebrovascular diseases
4	Chronic lower respiratory diseases	Chronic lower respiratory diseases	Influenza and pneumonia	Influenza and pneumonia	Influenza and pneumonia	Influenza and pneumonia
5	Influenza and pneumonia	Influenza and pneumonia	Chronic lower respiratory diseases	Chronic lower respiratory diseases	Chronic lower respiratory diseases	Chronic lower respiratory diseases
6	Alzheimer's disease	Alzheimer's disease	Nephritis, nephrotic syndrome and nephrosis	Accidents (unintentional injuries)	Diabetes mellitus	Diabetes mellitus
7	Nephritis, nephrotic syndrome and nephrosis	Nephritis, nephrotic syndrome and nephrosis	Diabetes mellitus	Diabetes mellitus	†Nephritis, nephrotic syndrome and nephrosis †Accidents (unintentional injuries)	Alzheimer's disease
8	Accidents (unintentional injuries)	Accidents (unintentional injuries)	Septicemia	Nephritis, nephrotic syndrome and nephrosis		Nephritis, nephrotic syndrome and nephrosis
9	Diabetes mellitus	Diabetes mellitus	Alzheimer's disease	Alzheimer's disease	†Septicemia †Alzheimer's disease	Pneumonitis due to solids and liquids
10	Pneumonitis due to solids and liquids	Pneumonitis due to solids and liquids	Essential (primary) hypertension and hypertensive renal disease	Pneumonitis due to solids and liquids		Accidents (unintentional injuries)

See footnotes at end of table.

INDICATOR 14 Mortality continued

Table 14c. Leading causes of death among people age 85 and over, by sex and race and Hispanic origin, 2001 (continued)

	<i>All races</i>	<i>White</i>	<i>Black</i>	<i>Asian or Pacific Islander</i>	<i>American Indian</i>	<i>Hispanic</i>
Women						
1	Diseases of heart	Diseases of heart	Diseases of heart	Diseases of heart	Diseases of heart	Diseases of heart
2	Cerebrovascular diseases	Cerebrovascular diseases	Cerebrovascular diseases	Cerebrovascular diseases	Malignant neoplasms	Malignant neoplasms
3	Malignant neoplasms	Malignant neoplasms	Malignant neoplasms	Malignant neoplasms	Cerebrovascular diseases	Cerebrovascular diseases
4	Alzheimer's disease	Alzheimer's disease	Diabetes mellitus	Influenza and pneumonia	Influenza and pneumonia	Influenza and pneumonia
5	Influenza and pneumonia	Influenza and pneumonia	Alzheimer's disease	Chronic lower respiratory diseases	Diabetes mellitus	Diabetes mellitus
6	Chronic lower respiratory diseases	Chronic lower respiratory diseases	Influenza and pneumonia	Diabetes mellitus	Chronic lower respiratory diseases	Alzheimer's disease
7	Diabetes mellitus	Diabetes mellitus	Nephritis, nephrotic syndrome and nephrosis	Alzheimer's disease	Alzheimer's disease	Chronic lower respiratory diseases
8	Nephritis, nephrotic syndrome and nephrosis	Accidents (unintentional injuries)	Septicemia	Nephritis, nephrotic syndrome and nephrosis	Accidents (unintentional injuries)	Nephritis, nephrotic syndrome and nephrosis
9	Accidents (unintentional injuries)	Nephritis, nephrotic syndrome and nephrosis	Essential (primary) hypertension and hypertensive renal disease	Essential (primary) hypertension and hypertensive renal disease	‡Pneumonitis due to solids and liquids ‡Nephritis, nephrotic syndrome and nephrosis	Septicemia
10	Septicemia	Atherosclerosis	Chronic lower respiratory diseases	Pneumonitis due to solids and liquids		Essential (primary) hypertension and hypertensive renal disease

†For American Indian men, Nephritis, nephrotic syndrome and nephrosis was tied with Accidents (unintentional injuries) for seventh. Septicemia and Alzheimer's disease tied for ninth.

‡For American Indian women, Pneumonitis due to solids and liquids tied with Nephritis, nephrotic syndrome and nephrosis for ninth.

Note: See Appendix B for the definition of race and ethnicity in the National Vital Statistics System.

Reference population: These data refer to the resident population.

Source: Centers for Disease Control and Prevention, National Center for Health Statistics, National Vital Statistics System.

INDICATOR 15 Chronic Health Conditions**Table 15a. Percentage of people age 65 and over who reported having selected chronic conditions, by sex, 2001–2002**

Sex	Heart disease	Hypertension	Stroke	Emphysema	Asthma	Chronic bronchitis	Any cancer	Diabetes	Arthritic symptoms
	Percent								
Total	31.2	50.1	8.8	5.0	8.4	6.1	20.7	15.6	35.9
Men	36.6	47.3	9.5	6.5	7.3	5.1	24.5	18.0	31.3
Women	27.1	52.2	8.2	3.8	9.2	6.8	17.9	13.9	39.3
White, not Hispanic or Latino	32.4	48.5	8.6	5.3	8.3	6.4	23.1	14.1	36.5
Black, not Hispanic or Latino	26.2	66.3	9.3	3.9	9.1	5.3	9.4	23.4	35.0
Hispanic or Latino	22.0	47.9	8.8	2.4	8.1	4.7	9.4	23.7	31.4

Note: Data are based on a 2-year average from 2001–2002. Data for arthritic symptoms are from 2000–2001. See Appendix B for the definition of race and ethnicity in the National Health Interview Survey.

Reference population: These data refer to the civilian noninstitutionalized population.

Source: Centers for Disease Control and Prevention, National Center for Health Statistics, National Health Interview Survey.

Table 15b. Percentage of people age 65 and over who reported having selected chronic conditions, 1997–2002

Condition	1997-1998	1998-1999	1999-2000	2000-2001	2001-2002
	Percent				
Heart disease	32.3	30.8	29.8	31.1	31.4
Hypertension	46.5	46.1	47.3	49.2	50.2
Stroke	8.2	8.2	8.2	8.8	8.9
Emphysema	5.2	5.1	5.2	5.2	5.0
Asthma	7.7	7.1	7.4	8.5	8.3
Chronic bronchitis	6.4	6.1	6.2	6.6	6.1
Any cancer	18.7	18.8	19.9	20.0	20.8
Diabetes	13.0	13.0	13.7	14.8	15.5
Arthritic symptoms	37.0	35.1	35.2	36.1	na

na Comparable data for arthritic symptoms for 2001–2002 are not available.

Note: Data are based on 2-year averages.

Reference population: These data refer to the civilian noninstitutionalized population.

Source: Centers for Disease Control and Prevention, National Center for Health Statistics, National Health Interview Survey.

INDICATOR 16 Sensory Impairments and Oral Health

Table 16a. Percentage of people age 65 and over who reported having any trouble hearing, any trouble seeing, or no natural teeth, by selected characteristics, 2002

Sex	Age and poverty status	Any trouble hearing	Any trouble seeing	No natural teeth
		Percent		
Both sexes	65 and over	37.2	17.5	27.9
	65-74	29.7	14.5	24.0
	75-84	42.2	17.9	31.1
	85 and over	60.0	32.8	37.8
	Below poverty	36.6	24.9	45.9
	Above poverty	38.2	18.0	27.3
Men	65 and over	46.9	15.6	26.3
	65-74	39.9	13.3	24.1
	75-84	54.2	16.2	28.3
	85 and over	66.8	29.2	34.3
Women	65 and over	29.9	19.0	29.1
	65-74	21.1	15.5	23.9
	75-84	34.0	19.1	32.9
	85 and over	56.4	34.7	39.7

Note: Respondents were asked "Which statement best describes your hearing without a hearing aid: good, a little trouble, a lot of trouble, deaf?" For the purposes of this indicator the category "Any trouble hearing" includes "a little trouble, a lot of trouble, and deaf." Regarding their vision, respondents were asked "Do you have any trouble seeing, even when wearing glasses or contact lenses?" and the category "Any trouble seeing" includes those who in a subsequent question report themselves as blind. Lastly, respondents were asked, in one question, "Have you lost all of your upper and lower natural (permanent) teeth?"

Reference population: These data refer to the civilian noninstitutionalized population.

Source: Centers for Disease Control and Prevention, National Center for Health Statistics, National Health Interview Survey.

Table 16b. Percentage of people age 65 and over who reported ever having worn a hearing aid, 2002

Age group	Both sexes	Men	Women
Percent			
65 and over	13.6	18.8	9.8
65-74	8.4	13.2	4.3
75-84	16.8	23.4	12.3
85 and over	30.7	39.5	26.1

Reference population: These data refer to the civilian noninstitutionalized population.

Source: Centers for Disease Control and Prevention, National Center for Health Statistics, National Health Interview Survey.

INDICATOR 16 Sensory Impairments and Oral Health continued**Table 16c. Percentage of people age 65 and over who reported certain conditions among those who reported having trouble seeing, 2002**

<i>Condition</i>	<i>Percent</i>
Glaucoma	15.9
Macular degeneration	16.2
Cataracts in past 12 months	44.3

Note: Respondents were asked "Do you have any trouble seeing, even when wearing glasses or contact lenses?" and includes those who in a subsequent question report themselves as blind.

Reference population: These data refer to the civilian noninstitutionalized population.

Source: Centers for Disease Control and Prevention, National Center for Health Statistics, National Health Interview Survey.

INDICATOR 17 Memory Impairment**Table 17. Percentage of people age 65 and over with moderate or severe memory impairment, by age group and sex, 2002**

	<i>Both sexes</i>	<i>Men</i>	<i>Women</i>
65 and over	12.7	14.9	11.2
65-69	5.1	7.8	3.1
70-74	8.2	10.9	6.1
75-79	13.6	17.2	11.2
80-84	18.8	21.8	17.0
85 and over	32.1	33.9	31.2

Note: The definition of "moderate or severe memory impairment" is four or fewer words recalled (out of 20) on combined immediate and delayed recall tests among self-respondents. Self-respondents who refused either the immediate or delayed word recall test were excluded from the analysis. Proxy respondents with an overall memory rating of "poor" were included as having moderate or severe memory impairment. Because of some changes in methods from the 2000 edition of *Older Americans*, no inference should be made about longitudinal trends.

Reference population: These data refer to the civilian noninstitutionalized population.

Source: Health and Retirement Study.

INDICATOR 18 Depressive Symptoms**Table 18. Percentage of people age 65 and over with clinically relevant depressive symptoms, by age group and sex, 2002**

	<i>Both sexes</i>	<i>Men</i>	<i>Women</i>
65 and over	15.0	10.9	17.8
65-69	13.1	9.7	15.6
70-74	14.2	9.6	17.6
75-79	14.9	9.9	18.2
80-84	16.9	15.0	18.1
85 and over	19.6	14.9	21.9

Note: The definition of "clinically relevant depressive symptoms" is four or more symptoms out of a list of eight depressive symptoms from an abbreviated version of the Center for Epidemiological Studies Depression Scale (CES-D) adapted by the Health and Retirement Study (HRS). The CES-D scale is a measure of depressive symptoms and is not to be used as a diagnosis of clinical depression. A detailed explanation concerning the "4 or more symptoms" cut-off can be found in the following documentation, <http://www.hrsonline.isr.umich.edu/docs/userg/dr-005.pdf>. Proportions are based on weighted data using the preliminary respondent weight from HRS 2002.

Reference population: These data refer to the civilian noninstitutionalized population.

Source: Health and Retirement Study.

INDICATOR 19 Disability

Table 19a. Age-adjusted percentage of Medicare enrollees age 65 and over who are chronically disabled, by selected characteristics, 1984, 1989, 1994, and 1999

Selected characteristic	1984	1989	1994	1999
			Percent	
Both sexes total	24.5	23.1	21.1	19.7
Living in the community				
IADL only	5.5	3.6	3.1	2.6
1-2 ADLs	6.7	6.6	6.0	5.8
3-4 ADLs	3.0	3.5	3.3	3.4
5-6 ADLs	3.3	3.1	3.1	3.1
Living in an institution	6.0	6.2	5.6	4.8
			Number in thousands	
Total Medicare population	27,968	30,871	33,125	34,459
Total Medicare population with chronic disabilities (not age-adjusted)	6,181	6,576	6,658	6,788
			Percent	
Men total	19.4	17.4	15.5	14.5
Living in the community				
IADL only	5.0	3.3	2.9	2.5
1-2 ADLs	5.1	4.8	4.6	3.9
3-4 ADLs	2.4	2.7	2.1	2.4
5-6 ADLs	3.1	2.7	2.4	2.5
Living in an institution	3.8	3.9	3.5	3.1
			Number in thousands	
Total Medicare population (men)	11,287	12,411	13,410	14,260
Total Medicare population with chronic disabilities (men) (not age-adjusted)	1,998	2,023	1,985	2,068
			Percent	
Women total	27.9	26.8	24.8	23.4
Living in the community				
IADL only	5.8	3.8	3.3	2.7
1-2 ADLs	7.8	7.9	7.0	7.1
3-4 ADLs	3.4	4.1	4.0	4.1
5-6 ADLs	3.5	3.4	3.5	3.5
Living in an institution	7.4	7.6	7.0	6.0
			Number in thousands	
Total Medicare population (women)	16,681	18,460	19,715	20,200
Total Medicare population with chronic disabilities (women) (not age-adjusted)	4,170	4,560	4,672	4,727

Note: Disabilities are grouped into two categories: limitations in activities of daily living (ADLs) and limitations in instrumental activities of daily living (IADLs). The six ADLs included are bathing, dressing, getting in or out of bed, getting around inside, toileting, and eating. The eight IADLs included are light housework, laundry, meal preparation, grocery shopping, getting around outside, managing money, taking medications, and telephoning. Individuals are considered to have an ADL disability if they report receiving help or supervision, or using equipment, to perform the activity, or not performing the activity at all. Individuals are considered to have an IADL disability if they report using equipment to perform the activity or not performing the activity at all because of their health or a disability. Individuals are considered to be chronically disabled if they have at least one ADL or one IADL limitation that is expected to last 90 days or longer, or they are institutionalized.

Reference population: These data refer to Medicare enrollees.

Source: National Long Term Care Survey.

INDICATOR 19 Disability continued**Table 19b. Percentage of Medicare enrollees age 65 and over who are unable to perform certain physical functions, by sex, 1991 and 2002**

<i>Function</i>	<i>1991</i>	<i>2002</i>
	Percent	
Men		
Stoop/kneel	7.8	8.8
Reach over head	3.1	2.8
Write	2.2	1.6
Walk 2-3 blocks	13.9	13.7
Lift 10 lbs.	9.1	6.9
Any of these five	18.8	18.0
Women		
Stoop/kneel	15.0	17.3
Reach over head	6.2	4.5
Write	2.6	2.0
Walk 2-3 blocks	22.8	22.9
Lift 10 lbs.	18.1	14.9
Any of these five	31.8	30.6

Note: Rates for 1991 are age-adjusted to the 2002 population.

Reference population: These data refer to Medicare enrollees.

Source: Centers for Medicare & Medicaid Services, Medicare Current Beneficiary Survey.

Table 19c. Percentage of Medicare enrollees age 65 and over who are unable to perform any one of five physical functions, by selected characteristics, 2002

<i>Selected characteristic</i>	<i>Men</i>	<i>Women</i>
	Percent	
65-74	13.0	20.0
75-84	21.3	32.9
85 and over	35.1	57.5
White, not Hispanic or Latino	17.3	30.4
Black, not Hispanic or Latino	25.5	35.9
Hispanic or Latino	21.7	28.6

Note: The five physical functions include stooping/kneeling, reaching over the head, writing, walking 2-3 blocks, and lifting 10 lbs. See Appendix B for the definition of race and ethnicity in the Medicare Current Beneficiary Survey.

Reference population: These data refer to Medicare enrollees.

Source: Centers for Medicare & Medicaid Services, Medicare Current Beneficiary Survey.

INDICATOR 20 Respondent-Assessed Health Status

Table 20. Respondent-assessed health status among people age 65 and over, by selected characteristics, 2000–2002

<i>Selected characteristic</i>	<i>Total</i>	<i>Not Hispanic or Latino</i>		
		<i>White only</i>	<i>Black only</i>	<i>Hispanic or Latino</i>
Percent				
Fair or poor health				
Both sexes				
65 and over	26.7	24.4	41.1	37.5
65-74	22.6	19.8	37.6	35.0
75-84	30.6	28.6	45.7	40.7
85 and over	34.9	32.9	47.6	47.3
Men				
65 and over	26.9	25.3	38.9	35.2
65-74	23.1	21.3	34.8	31.7
75-84	31.2	29.5	45.3	41.8
85 and over	36.6	34.8	47.7	43.1
Women				
65 and over	26.5	23.8	42.5	39.2
65-74	22.2	18.6	39.6	37.6
75-84	30.1	28.0	45.9	40.0
85 and over	34.0	31.9	47.7	49.7
Good to excellent health				
Both sexes				
65 and over	73.3	75.6	58.9	62.5
65-74	77.4	80.2	62.4	65.0
75-84	69.4	71.4	54.3	59.3
85 and over	65.1	67.1	52.4	52.7
Men				
65 and over	73.1	74.7	61.1	64.8
65-74	76.9	78.7	65.2	68.3
75-84	68.8	70.5	54.7	58.2
85 and over	63.4	65.2	52.6	56.9
Women				
65 and over	73.5	76.2	57.5	60.8
65-74	77.8	81.4	60.4	62.4
75-84	69.9	72.0	54.1	60.0
85 and over	66.0	68.1	52.3	50.3

Note: Data are based on a 3-year average from 2000-2002. People of Hispanic or Latino origin may be of any race. See Appendix B for the definition of race and ethnicity in the National Health Interview Survey.

Reference population: These data refer to the civilian noninstitutionalized population.

Source: Centers for Disease Control and Prevention, National Center for Health Statistics, National Health Interview Survey.

INDICATOR 21 Vaccinations**Table 21a. Percentage of people age 65 and over who reported having been vaccinated against influenza and pneumococcal disease, by race and Hispanic origin, selected years 1989–2002**

Year	Not Hispanic or Latino		Hispanic or Latino
	White	Black	
	Percent		
Influenza			
1989	32.0	17.7	23.8
1991	42.8	26.5	33.2
1993	53.1	31.1	46.2
1994	56.9	37.7	36.6
1995	60.0	39.5	49.5
1997	65.8	44.6	52.7
1998	65.6	45.9	50.3
1999	67.9	49.7	55.1
2000	66.6	47.9	55.7
2001	65.4	47.9	51.9
2002	68.7	49.5	48.5
Pneumococcal disease			
1989	15.0	6.2	9.8
1991	21.0	13.2	11.0
1993	28.7	13.1	12.2
1994	30.5	13.9	13.7
1995	34.2	20.5	21.6
1997	45.6	22.2	23.5
1998	49.5	26.0	22.8
1999	53.1	32.3	27.9
2000	56.8	30.5	30.4
2001	57.8	33.9	32.9
2002	60.3	36.9	27.1

Note: People of Hispanic or Latino origin may be of any race. For influenza, the percentage vaccinated consists of people who reported having a flu shot during the past 12 months. For pneumococcal disease, the percentage refers to people who reported ever having a pneumonia vaccination. See Appendix B for the definition of race and ethnicity in the National Health Interview Survey.

Reference population: These data refer to the civilian noninstitutionalized population.

Source: Centers for Disease Control and Prevention, National Center for Health Statistics, National Health Interview Survey.

Table 21b. Percentage of people age 65 and over who reported having been vaccinated against influenza and pneumococcal disease, by selected characteristics, 2002

Selected characteristic	Influenza	Pneumococcal disease
	Percent	
Both sexes	65.8	56.0
Men	67.0	55.6
Women	64.5	55.8
65-74	60.8	50.0
75-84	71.5	62.5
85 and over	70.2	62.8
High school graduate or less	62.8	52.8
More than high school	70.9	61.7

Note: For influenza, the percentage vaccinated consists of people who reported having a flu shot during the past 12 months. For pneumococcal disease, the percentage refers to people who reported ever having a pneumonia vaccination.

Reference population: These data refer to the civilian noninstitutionalized population.

Source: Centers for Disease Control and Prevention, National Center for Health Statistics, National Health Interview Survey.

INDICATOR 22 Mammography

Table 22. Percentage of women age 65 and over who reported having had a mammogram within the past 2 years, by selected characteristics, selected years 1987–2000

<i>Selected characteristic</i>	1987	1990	1991	1993	1994	1998	1999	2000
	Percent							
All women 65 and over	22.8	43.4	48.1	54.2	55.0	63.8	66.8	68.0
White, not Hispanic or Latino	24.0	43.8	49.1	54.7	54.9	64.3	66.8	68.3
Black, not Hispanic or Latino	14.1	39.7	41.6	56.3	61.0	60.6	68.1	65.5
Hispanic or Latino	13.7	41.1	40.9	35.7	48.0	59.0	67.2	68.2
Below poverty	13.6	30.8	35.2	40.4	43.9	52.3	57.3	55.4
Above poverty	25.5	46.2	51.1	56.4	57.7	66.2	67.8	70.0
No high school diploma or GED	16.5	33.0	37.7	44.2	45.6	54.7	56.6	57.5
High school diploma or GED	25.9	47.5	54.0	57.4	59.1	66.8	68.4	72.0
Some college or more	32.3	56.7	57.9	64.8	64.3	71.3	77.1	74.1

Note: Questions concerning use of mammography differed slightly on the National Health Interview Survey (NHIS) across the years for which data are shown. In 1987 and 1990 women were asked to report when they had their last mammogram. In 1991 women were asked whether they had a mammogram in the past 2 years. In 1993 and 1994 women were asked whether they had a mammogram within the past year, between 1 and 2 years ago, or over 2 years ago. In 1998 women were asked whether they had a mammogram a year ago or less, more than 1 year but not more than 2 years, or more than 2 years ago. In 1999 women were asked when they had their most recent mammogram in days, weeks, months, or years. In 1999, 10 percent of women in the sample responded “2 years ago,” and in this analysis these women were coded as “within the past 2 years” although a response of “2 years ago” may include women whose last mammogram was more than 2 but less than 3 years ago. Thus estimates for 1999 are overestimated to some degree in comparison with estimates in previous years. In 2000 women were asked when they had their most recent mammogram (give month and year). Women who did not respond were given a followup question that used the 1999 wording, and women who did not answer the followup question were asked a second followup question that used the 1998 wording. In 2000, 2 percent of women in the sample answered “2 years ago” using the 1999 wording, and they were coded as “within the past 2 years.” Thus estimates for 2000 may be slightly overestimated in comparison with estimates for years prior to 1999. People of Hispanic or Latino origin may be of any race. See Appendix B for the definition of race and ethnicity in the NHIS.

Reference population: These data refer to the civilian noninstitutionalized population.

Source: Centers for Disease Control and Prevention, National Center for Health Statistics, National Health Interview Survey.

INDICATOR 23 Dietary Quality

Table 23a. Dietary quality ratings of people age 45 and over, as measured by the Healthy Eating Index, by age group and poverty status, 1999–2000

<i>Rating</i>	<i>Age group</i>		<i>Poverty status among people age 65 and over</i>	
	<i>45-64</i>	<i>65 and over</i>	<i>Below poverty</i>	<i>Above poverty</i>
	Percent			
Good	12.4	19.4	8.8	21.3
Needs improvement	69.0	66.7	77.2	64.8
Poor	18.6	13.9	14.0	13.9

Note: These data were collected between 1999 and 2000. Dietary quality was measured using the Healthy Eating Index (HEI). The HEI consists of 10 components, each representing a different aspect of a healthful diet based on the U.S. Department of Agriculture’s Food Guide Pyramid and the Dietary Guidelines for Americans. See <http://www.cnpp.usda.gov/healthyeating.html>. Components 1–5 measure the degree to which a person’s diet conforms to the Pyramid serving recommendations for the five major food groups: grains, vegetables, fruits, milk, and meat/meat alternatives. Components 6–9 measure intake of fat, saturated fat, cholesterol, and sodium. Component 10 measures the degree of variety in a person’s diet. Scores for each component are given equal weight and added to calculate an overall HEI score with a maximum value of 100. An HEI score above 80 indicates a good diet, an HEI score between 51 and 80 signals a diet that needs improvement, and an HEI score below 51 indicates a poor diet. See Appendix C for the definition of poverty.

Reference population: These data refer to the civilian noninstitutionalized population.

Source: Centers for Disease Control and Prevention, National Center for Health Statistics, National Health and Nutrition Examination Survey.

INDICATOR 23 Dietary Quality continued**Table 23b. Average scores on a scale from 1 to 10, of people age 65 and over for components of the Healthy Eating Index (HEI), 1999–2000**

<i>HEI component</i>	<i>Average score</i>
Grains	6.4
Vegetables	6.4
Fruits	5.5
Milk	5.9
Meat	6.4
Total fat	6.9
Saturated fat	6.9
Cholesterol	8.1
Sodium	7.1
Variety	8.2
Total HEI	67.6

Note: These data were collected between 1999 and 2000. Dietary quality was measured using the Healthy Eating Index (HEI). The HEI consists of 10 components, each representing a different aspect of a healthful diet based on the U.S. Department of Agriculture's Food Guide Pyramid and the Dietary Guidelines for Americans. Components 1-5 measure the degree to which a person's diet conforms to the Pyramid serving recommendations for the five major food groups: grains, vegetables, fruits, milk, and meat/meat alternatives. Components 6-9 measure intake of fat, saturated fat, cholesterol and sodium. Component 10 measures the degree of variety in a person's diet. Scores for each component are given equal weight and added to calculate an overall HEI score with a maximum value of 100. An HEI score above 80 indicates a good diet, an HEI score between 51 and 80 signals a diet that needs improvement, and an HEI score below 51 indicates a poor diet.

Reference population: These data refer to the civilian noninstitutionalized population.

Source: Centers for Disease Control and Prevention, National Center for Health Statistics, National Health and Nutrition Examination Survey.

INDICATOR 24 Physical Activity**Table 24a. Percentage of people age 45 and over who reported engaging in regular leisure time physical activity, by age group, 1997–2002**

<i>Age group</i>	<i>1997-1998</i>	<i>1998-1999</i>	<i>1999-2000</i>	<i>2000-2001</i>	<i>2001-2002</i>
	Percent				
65 and over (age-adjusted)	20.3	20.1	21.1	21.5	21.4
45-64	29.1	28.2	28.9	29.8	30.1
65-74	24.9	25.0	26.0	26.7	26.4
75-84	17.0	15.9	17.3	17.7	18.0
85 and over	9.0	10.5	9.7	8.4	8.6

Note: Data are based on 2-year averages. "Regular leisure time physical activity" is defined as "engaging in light-moderate leisure time physical activity for greater than or equal to 30 minutes at a frequency greater than or equal to 5 times per week, or engaging in vigorous leisure time physical activity for greater than or equal to 20 minutes at a frequency greater than or equal to 3 times per week."

Reference population: These data refer to the civilian noninstitutionalized population.

Source: Centers for Disease Control and Prevention, National Center for Health Statistics, National Health Interview Survey.

INDICATOR 24 Physical Activity continued

Table 24b. Percentage of people age 65 and over who reported engaging in regular leisure time physical activity, by selected characteristics, 2001–2002

<i>Selected characteristic</i>	<i>Percent</i>
Men	25.6
Women	18.4
White, not Hispanic or Latino	22.8
Black, not Hispanic or Latino	13.0
Hispanic or Latino	13.6
Percent who engage in strengthening exercises	12.0

Note: Data are based on a 2-year average from 2001–2002. “Regular leisure time physical activity” is defined as “engaging in light-moderate leisure time physical activity for greater than or equal to 30 minutes at a frequency greater than or equal to 5 times per week, or engaging in vigorous leisure time physical activity for greater than or equal to 20 minutes at a frequency greater than or equal to 3 times per week.” See Appendix B for the definition of race and ethnicity in the National Health Interview Survey.

Reference population: These data refer to the civilian noninstitutionalized population.

Source: Centers for Disease Control and Prevention, National Center for Health Statistics, National Health Interview Survey.

INDICATOR 25 Obesity

Table 25. Body weight status among people age 65 and over, by sex and age group, selected years 1960–2002

<i>Sex and age group</i>	<i>1960-1962</i>	<i>1971-1974</i>	<i>1976-1980</i>	<i>1988-1994</i>	<i>1999-2002</i>
	Percent				
Underweight					
Both sexes					
65 and over	na	na	na	2.8	2.0
65-74	4.2	3.4	3.0	2.1	1.9
75 and over	na	na	na	3.9	2.2
Men					
65 and over	na	na	na	1.8	0.8
65-74	6.0	3.3	3.5	1.4	0.9
75 and over	na	na	na	2.6	0.6
Women					
65 and over	na	na	na	3.5	2.9
65-74	2.7	3.5	2.7	2.7	2.8
75 and over	na	na	na	4.7	3.1
Healthy weight					
Both sexes					
65 and over	na	na	na	37.1	29.1
65-74	40.7	41.3	39.7	33.8	24.8
75 and over	na	na	na	42.2	35.0
Men					
65 and over	na	na	na	33.8	26.4
65-74	46.2	42.1	42.3	30.1	22.8
75 and over	na	na	na	40.9	32.0
Women					
65 and over	na	na	na	39.6	31.2
65-74	36.4	40.6	37.8	37.0	26.4
75 and over	na	na	na	43.0	36.9

See footnotes at end of table.

INDICATOR 25 Obesity continued

Table 25. Body weight status among people age 65 and over, by sex and age group, selected years 1960–2002 (continued)

<i>Sex and age group</i>	<i>1960-1962</i>	<i>1971-1974</i>	<i>1976-1980</i>	<i>1988-1994</i>	<i>1999-2002</i>
	Percent				
Overweight					
Both sexes					
65 and over	na	na	na	60.1	68.8
65-74	55.1	55.3	57.2	64.1	73.3
75 and over	na	na	na	53.9	62.8
Men					
65 and over	na	na	na	64.4	72.8
65-74	47.8	54.6	54.2	68.5	76.2
75 and over	na	na	na	56.5	67.4
Women					
65 and over	na	na	na	56.9	65.9
65-74	60.9	55.9	59.5	60.3	70.9
75 and over	na	na	na	52.3	59.9
Obese					
Both sexes					
65 and over	na	na	na	22.2	29.8
65-74	17.5	17.2	17.9	25.6	35.9
75 and over	na	na	na	17.0	21.5
Men					
65 and over	na	na	na	20.3	26.5
65-74	10.4	10.9	13.2	24.1	31.9
75 and over	na	na	na	13.2	18.0
Women					
65 and over	na	na	na	23.6	32.2
65-74	23.2	22.0	21.5	26.9	39.3
75 and over	na	na	na	19.2	23.6

na Data not available.

Note: Data are based on measured height and weight. Height was measured without shoes; 2 pounds were deducted from data for 1960–1962 to allow for weight of clothing. Underweight is defined as having a body mass index (BMI) less than 18.5 kilograms/meter². Healthy weight is defined by a BMI of 18.5 to less than 25 kilograms/meter². Overweight is defined as having a BMI greater than or equal to 25; obese is defined by a BMI of 30 or greater. Percentages do not sum to 100 because the percentage of people who are obese is a subset of the percentage of those who are overweight. See Appendix C for the definition of BMI.

Reference population: These data refer to the civilian noninstitutionalized population.

Source: Centers for Disease Control and Prevention, National Center for Health Statistics, National Health and Nutrition Examination Survey.

INDICATOR 26 Cigarette Smoking

Table 26a. Percentage of people age 45 and over who are current cigarette smokers, by selected characteristics, selected years 1965–2002

Year	Total		White		Black or African American	
	45-64	65 and over	45-64	65 and over	45-64	65 and over
Men						
	Percent					
1965	51.9	28.5	51.3	27.7	57.9	36.4
1974	42.6	24.8	41.2	24.3	57.8	29.7
1979	39.3	20.9	38.3	20.5	50.0	26.2
1983	35.9	22.0	35.0	20.6	44.8	38.9
1985	33.4	19.6	32.1	18.9	46.1	27.7
1987	33.5	17.2	32.4	16.0	44.3	30.3
1988	31.3	18.0	30.0	16.9	43.2	29.8
1990	29.3	14.6	28.7	13.7	36.7	21.5
1991	29.3	15.1	28.0	14.2	42.0	24.3
1992	28.6	16.1	28.1	14.9	35.4	28.3
1993	29.2	13.5	27.8	12.5	42.4	*27.9
1994	28.3	13.2	26.9	11.9	41.2	25.6
1995	27.1	14.9	26.3	14.1	33.9	28.5
1997	27.6	12.8	26.5	11.5	39.4	26.0
1998	27.7	10.4	27.0	10.0	37.3	16.3
1999	25.8	10.5	24.5	10.0	35.7	17.3
2000	26.4	10.2	25.8	9.8	32.2	14.2
2001	26.4	11.5	25.1	10.7	34.3	21.1
2002	24.5	10.1	24.4	9.3	29.9	19.4
Women						
1965	32.0	9.6	32.7	9.8	25.7	7.1
1974	33.4	12.0	33.0	12.3	38.9	*8.9
1979	30.7	13.2	30.6	13.8	34.2	*8.5
1983	31.0	13.1	30.6	13.2	36.3	*13.1
1985	29.9	13.5	29.7	13.3	33.4	14.5
1987	28.6	13.7	29.0	13.9	28.4	11.7
1988	27.7	12.8	27.7	12.6	29.5	14.8
1990	24.8	11.5	25.4	11.5	22.6	11.1
1991	24.6	12.0	25.3	12.1	23.4	9.6
1992	26.1	12.4	25.8	12.6	30.9	*11.1
1993	23.0	10.5	23.4	10.5	21.3	*10.2
1994	22.8	11.1	23.2	11.1	23.5	13.6
1995	24.0	11.5	24.3	11.7	27.5	13.3
1997	21.5	11.5	20.9	11.7	28.4	10.7
1998	22.5	11.2	22.5	11.2	25.4	11.5
1999	21.0	10.7	21.2	10.5	22.3	13.5
2000	21.6	9.3	21.4	9.1	25.6	10.2
2001	21.4	†9.2	21.6	9.4	22.6	9.3
2002	21.1	8.6	21.5	8.5	22.2	9.4

* Estimates are considered unreliable. Data preceded by an asterisk have a relative standard error of 20-30 percent.

† The value for all women includes other races which have a very low rate of cigarette smoking. Thus, the weighted average for all women is slightly lower than that for white women.

Note: Data are based on household interviews of a sample of the civilian noninstitutionalized population. Data starting in 1997 are not strictly comparable with data for earlier years due to the 1997 NHIS questionnaire redesign. See Appendix B for the definition of race and ethnicity in the National Health Interview Survey.

Reference population: These data refer to the civilian noninstitutionalized population.

Source: Centers for Disease Control and Prevention, National Center for Health Statistics, National Health Interview Survey. Data are from the core questionnaire (1965) and the following questionnaire supplements: hypertension (1974), smoking (1979), alcohol and health practices (1983), health promotion and disease prevention (1985, 1990-1991), cancer control and cancer epidemiology (1987, 1992), occupational health (1988), and year 2000 objectives (1993-1995). Starting in 1997 data are from the family core and sample adult questionnaires.

INDICATOR 26 Cigarette Smoking continued**Table 26b. Cigarette smoking status of people age 18 and over, by sex and age group, 2002**

<i>Sex and age group</i>	<i>All current smokers</i>	<i>Every day smokers</i>	<i>Some day smokers</i>	<i>Former smokers</i>	<i>Non-smokers</i>
	Percent				
Both sexes	22.3	18.4	4.1	22.6	54.9
Men					
18-44	29.3	23.2	6.4	13.0	57.4
45-64	24.2	21.0	3.5	35.8	39.7
65 and over	10.0	9.1	1.0	56.5	33.4
Women					
18-44	23.0	18.8	4.4	13.2	63.6
45-64	20.9	17.8	3.3	23.4	55.6
65 and over	8.5	7.4	1.2	28.6	62.8

Note: Data are based on household interviews of a sample of the civilian noninstitutionalized population. Data for "All current smokers" do not match data in Table 26a because of rounding.

Reference population: These data refer to the civilian noninstitutionalized population.

Source: Centers for Disease Control and Prevention, National Center for Health Statistics, National Health Interview Survey.

INDICATOR 27 Air Quality**Table 27a. Percentage of people age 65 and over living in counties with "Poor air quality," 2000-2002**

<i>Pollutant measures</i>	<i>2000</i>	<i>2001</i>	<i>2002</i>
	Percent		
Particulate matter (PM 2.5)	27.3	24.3	19.4
8hr Ozone	26.2	37.5	45.7
Any standard	41.0	44.9	48.8

Note: The term "Poor air quality" is defined as air quality concentrations above the level of the National Ambient Air Quality Standards (NAAQS). The term "Any standard" refers to any NAAQS for ozone, particulate matter, nitrogen dioxide, sulfur dioxide, carbon monoxide, and lead. These are single-year observations and do not represent non-attainment calculations that are based on multiple years of data. For particulate matter (PM 2.5) estimates in 2000, the counties with air quality values above the level of NAAQS for PM 2.5 are based only on data collected for monitors with complete data for the entire year.

Reference population: These data refer to the resident population.

Source: U.S. Environmental Protection Agency, Office of Air Quality Planning and Standards, Air Quality System; U.S. Census Bureau, Population Projections, 2000-2002.

Table 27b. Counties with "Poor air quality" for any standard in 2002

Source: U.S. Environmental Protection Agency, Office of Air Quality Planning and Standards, Air Quality System; U.S. Census Bureau, Population Projections, 2002.

Data for this table can be found at <http://www.agingstats.gov>.

INDICATOR 28 Use of Health Care Services

Table 28a. Use of Medicare-covered health care services by Medicare enrollees age 65 and over, 1992–2001

Utilization measure	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001
	Rate per thousand									
Hospital stays	306	300	331	336	341	351	354	365	361	364
Skilled nursing facility stays	28	33	43	50	59	67	69	67	67	69
Physician visits and consultations	11,359	11,600	12,045	12,372	12,478	na	13,061	na	13,346	13,685
Home health care visits	3,822	4,648	6,352	7,608	8,376	8,227	5,058	3,708	2,913	2,295
	Days									
Average length of hospital stay	8.4	8.0	7.5	7.0	6.6	6.3	6.1	6.0	6.0	5.9

na Data not available.

Note: Data are for Medicare enrollees in fee-for-service only. Physician visits and consultations include all settings, such as physician offices, hospitals, emergency rooms, and nursing homes. Beginning in 1994, managed care enrollees were excluded from the denominator of all utilization rates because utilization data are not available for them. Prior to 1994, managed care enrollees were included in the denominators; they comprised 7 percent or less of the Medicare population.

Reference population: These data refer to Medicare enrollees.

Source: Centers for Medicare & Medicaid Services, Medicare claims and enrollment data.

Table 28b. Use of Medicare-covered home health and skilled nursing facility services by Medicare enrollees age 65 and over, by age group, 2001

Utilization measure	65-74	75-84	85 and over
	Rate per thousand		
Skilled nursing facility stays	26.2	81.4	203.0
Home health care visits	1,082	2,860	5,475

Note: Data are for Medicare enrollees in fee-for-service only.

Reference population: These data refer to Medicare enrollees.

Source: Centers for Medicare & Medicaid Services, Medicare claims and enrollment data.

INDICATOR 29 Health Care Expenditures

Table 29a. Average annual health care costs for Medicare enrollees age 65 and over, by age group, 1992–2001

Age group	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001
	Dollars									
65 and over	\$ 7,991	\$ 8,565	\$ 9,234	\$ 9,660	\$ 9,760	\$ 9,880	\$ 9,700	\$ 9,950	\$10,314	\$10,948
65-74	5,919	6,183	6,792	6,992	7,026	6,999	6,733	7,503	7,621	8,207
75-84	8,745	9,798	10,233	10,575	10,994	11,077	10,797	10,547	11,246	12,090
85 and over	15,582	16,142	17,436	18,413	18,009	18,209	18,320	17,680	17,996	18,353

Note: Data include both out-of-pocket costs and costs covered by insurance. Dollars are inflation-adjusted to 2001 using the Consumer Price Index (Series CPI-U-RS).

Reference population: These data refer to Medicare enrollees.

Source: Centers for Medicare & Medicaid Services, Medicare Current Beneficiary Survey.

INDICATOR 29 Health Care Expenditures continued**Table 29b. Major components of health care costs among Medicare enrollees age 65 and over, 1992 and 2001**

Cost component	1992		2001	
	Average cost in dollars	Percent	Average cost in dollars	Percent
Total	\$ 6,463	100	\$10,948	100
Inpatient hospital	2,106	33	2,991	27
Physician/Outpatient hospital	2,072	32	3,719	34
Nursing home/Long-term institution	1,323	20	1,875	17
Home health care	244	4	294	3
Prescription drugs	436	7	1,191	11
Other (Short-term institution/Hospice/Dental)	282	4	878	8

Note: Data include both out-of-pocket costs and costs covered by insurance. Dollars are not inflation-adjusted.

Reference population: These data refer to Medicare enrollees.

Source: Centers for Medicare & Medicaid Services, Medicare Current Beneficiary Survey.

Table 29c. Average annual health care costs among Medicare enrollees age 65 and over, by selected characteristics, 2001

Selected characteristic	Average cost in dollars
Total	\$10,948
Race and ethnicity	
White, not Hispanic or Latino	11,032
Black, not Hispanic or Latino	13,081
Hispanic or Latino	8,449
Other	9,031
Institutional status	
Community	8,466
Institution	46,810
Annual income	
\$0-\$10,000	14,692
10,001-20,000	11,249
20,001-30,000	10,152
30,001 or more	8,855
Chronic conditions	
0	3,837
1-2	6,685
3-4	11,878
5 or more	15,784

Note: Data include both out-of-pocket costs and costs covered by insurance. Chronic conditions include cancer (other than skin cancer), stroke, diabetes, heart disease, hypertension, arthritis, and respiratory conditions (emphysema, asthma, chronic obstructive pulmonary disease). See Appendix B for the definition of race and ethnicity in the Medicare Current Beneficiary Survey.

Reference population: These data refer to Medicare enrollees.

Source: Centers for Medicare & Medicaid Services, Medicare Current Beneficiary Survey.

INDICATOR 29 Health Care Expenditures continued

Table 29d. Major components of health care costs among Medicare enrollees age 65 and over, by age group, 2001

<i>Cost component</i>	<i>65-74</i>	<i>75-84</i>	<i>85 and over</i>
Average cost in dollars			
Total	\$ 8,207	\$12,090	\$18,353
Inpatient hospital	2,454	3,403	3,917
Physician/Outpatient hospital	3,352	4,178	3,832
Nursing home/Long-term institution	516	1,942	6,968
Home health care	147	316	803
Prescription drugs	1,169	1,301	957
Other (Short-term institution/Hospice/Dental)	569	950	1,876

Note: Data include both out-of-pocket costs and costs covered by insurance.

Reference population: These data refer to Medicare enrollees.

Source: Centers for Medicare & Medicaid Services, Medicare Current Beneficiary Survey.

Table 29e. Percentage of Medicare enrollees age 65 and over who reported problems with access to health care, 1992-2000

<i>Reported problem</i>	<i>1992</i>	<i>1993</i>	<i>1994</i>	<i>1995</i>	<i>1996</i>	<i>1997</i>	<i>1998</i>	<i>1999</i>	<i>2000</i>
Percent									
Difficulty obtaining care	3.1	2.6	2.6	2.6	2.3	2.4	2.4	2.8	2.9
Delayed getting care due to cost	9.8	9.1	7.6	6.8	5.5	4.8	4.4	4.7	4.8

Reference population: These data refer to noninstitutionalized Medicare enrollees.

Source: Centers for Medicare & Medicaid Services, Medicare Current Beneficiary Survey.

INDICATOR 30 Prescription Drugs

Table 30a. Average annual prescription drug costs and sources of payment among noninstitutionalized Medicare enrollees age 65 and over, 1992-2000

<i>Payment source</i>	<i>1992</i>	<i>1993</i>	<i>1994</i>	<i>1995</i>	<i>1996</i>	<i>1997</i>	<i>1998</i>	<i>1999</i>	<i>2000</i>
Average cost in dollars									
Total	\$ 519	\$ 689	\$ 731	\$ 767	\$ 827	\$ 904	\$1,046	\$1,171	\$1,340
Out-of-pocket	312	400	397	402	411	448	484	515	562
Private insurance	132	173	201	226	275	295	366	409	466
Public programs	75	116	133	138	141	161	196	247	311

Note: Dollars have been inflation-adjusted to 2000 using the Consumer Price Index (Series CPI-U-RS). Public programs include Medicare, Medicaid, Department of Veterans Affairs, and other State and Federal programs.

Reference population: These data refer to Medicare enrollees.

Source: Centers for Medicare & Medicaid Services, Medicare Current Beneficiary Survey.

INDICATOR 30 Prescription Drugs continued**Table 30b. Distribution of annual prescription drug costs among noninstitutionalized Medicare enrollees age 65 and over, 2000**

<i>Cost in dollars</i>	<i>Percent</i>
Total	100.0
\$0	8.9
1-499	30.0
500-999	20.6
1,000-1,499	13.7
1,500-1,999	9.6
2,000 or more	17.2

Reference population: These data refer to Medicare enrollees.

Source: Centers for Medicare & Medicaid Services, Medicare Current Beneficiary Survey.

Table 30c. Average annual number of filled prescriptions among noninstitutionalized Medicare enrollees age 65 and over, by selected characteristics

<i>Selected characteristic</i>	<i>Average number of filled prescriptions</i>
Year	
1992	18.4
1996	22.5
2000	29.7
Number of chronic conditions (2000)	
0	9.7
1-2	23.0
3-4	41.7
5 or more	57.2
Prescription drug coverage (2000)	
Yes	31.5
No	23.6
Income (2000)	
\$0-\$10,000	33.3
10,001-20,000	30.9
20,001-30,000	29.5
30,001 or more	26.2

Note: Chronic conditions include cancer (other than skin cancer), stroke, diabetes, heart disease, hypertension, arthritis, and respiratory conditions (emphysema, asthma, chronic obstructive pulmonary disease). Prescription drug coverage includes people with partial year coverage. The number of filled prescriptions counts each refill separately.

Reference population: These data refer to Medicare enrollees.

Source: Centers for Medicare & Medicaid Services, Medicare Current Beneficiary Survey.

INDICATOR 30 Prescription Drugs continued

Table 30d. Percentage of noninstitutionalized Medicare enrollees age 65 and over with prescription drug coverage, by selected characteristics, 2000

<i>Selected characteristic</i>	<i>Percent</i>
Total	77.5
Age	
65-74	79.1
75-84	76.8
85 and over	72.1
Number of chronic conditions	
0	70.9
1-2	75.2
3-4	81.8
5 or more	83.8
Income	
\$0-\$10,000	76.6
10,001-\$20,000	72.6
20,001-\$30,000	81.7
30,001 or more	80.0

Note: Chronic conditions include cancer (other than skin cancer), stroke, diabetes, heart disease, hypertension, arthritis, and respiratory conditions (emphysema, asthma, chronic obstructive pulmonary disease). Prescription drug coverage includes people with partial year coverage.

Reference population: These data refer to Medicare enrollees.

Source: Centers for Medicare & Medicaid Services, Medicare Current Beneficiary Survey.

INDICATOR 31 Sources of Health Insurance

Table 31a. Percentage of noninstitutionalized Medicare enrollees age 65 and over with supplemental health insurance, by type of insurance, 1991-2002

<i>Type of insurance</i>	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002
	Percent											
Private (employer- or union-sponsored)	40.7	41.0	40.8	40.3	39.1	37.8	37.6	37.0	35.8	35.9	36.0	36.1
Private (Medigap)*	44.8	45.0	45.4	45.2	44.3	38.6	35.8	33.9	33.2	33.5	34.5	37.5
HMO	6.3	5.9	7.7	9.1	10.9	13.8	16.6	18.6	20.5	20.4	18.0	15.5
Medicaid	8.0	8.5	8.8	8.9	9.0	8.2	8.2	8.0	9.7	9.9	10.6	10.7
Other public	4.0	5.3	5.8	5.5	5.0	4.8	4.7	4.8	5.1	4.9	5.4	5.5
No supplement	11.9	10.7	10.0	9.8	9.6	10.0	9.8	9.6	9.0	9.7	10.1	12.3

* Includes people with private supplement of unknown sponsorship.

Note: Estimates are based on enrollees' insurance status in the fall of each year. Categories are not mutually exclusive, (i.e., individuals may have more than one supplemental policy). Table excludes enrollees whose primary insurance is not Medicare (approximately 1 percent of enrollees).

Reference population: These data refer to Medicare enrollees.

Source: Centers for Medicare & Medicaid Services, Medicare Current Beneficiary Survey.

INDICATOR 31 Sources of Health Insurance continued**Table 31b. Percentage of people age 55-64 with health insurance coverage, by type of insurance and poverty status, 2002**

Type of Insurance	Total	Poverty threshold			
		99% or less	100-199%	200% or more	Unknown
		Percent			
Private	76.8	24.3	46.4	88.3	74.9
Medicaid	5.5	37.1	14.3	1.0	5.1
Medicare	3.4	7.4	10.6	1.6	4.0
Other coverage	2.6	3.2	2.4	2.6	2.5
Uninsured	11.6	28.0	26.1	6.5	13.6

Note: Poverty status is based on family income and family size using the U.S. Census Bureau's poverty thresholds. Below poverty (99% or less) is defined as people living below the poverty threshold. People living above poverty (100-199 percent) have incomes of 100 percent to less than 200 percent of the poverty threshold. People living above poverty (200 percent or more) have incomes of 200 percent of the poverty threshold or greater. Classification of health insurance is based on a hierarchy of mutually exclusive categories. People with more than one type of health insurance were assigned to the first appropriate category in the hierarchy. The category "uninsured" includes persons who had no coverage as well as those who had only Indian Health Service coverage or had only a private plan that paid for one type of service such as accidents or dental care.

Reference population: These data refer to the noninstitutionalized civilian population.

Source: Centers for Disease Control and Prevention, National Center for Health Statistics, National Health Interview Survey.

INDICATOR 32 Out-of-Pocket Health Care Expenditures**Table 32a. Percentage of people age 55 and over with out-of-pocket expenditures for health care service use, by age group, 1977, 1987, 1996, and 2001**

Age group	1977	1987	1996	2001
	Percent			
65 and over	83.3	88.6	92.4	94.7
55-64	81.9	84.0	89.6	90.4
65-74	83.4	87.9	91.8	94.1
75-84	83.8	90.1	92.9	95.6
85 and over	80.8	88.6	93.9	94.6

Note: Out-of-pocket health care expenditures exclude personal spending for health insurance premium(s). Data for the 1987 survey have been adjusted to permit comparability across years; for details see Zuvekas and Cohen.⁶⁴

Reference population: These data refer to the civilian noninstitutionalized population.

Source: Agency for Healthcare Research and Quality, Medical Expenditure Panel Survey (MEPS) and MEPS predecessor surveys.

INDICATOR 32 Out-of-Pocket Health Care Expenditures continued

Table 32b. Out-of-pocket health care expenditures as a percentage of household income, among people age 65 and over with out-of-pocket expenditures, by selected characteristics, 1977, 1987, 1996, and 2001

<i>Selected characteristic</i>	1977	1987	1996	2001
	Percent			
Total				
65 and over	8.1	9.4	8.0	9.9
55-64	5.9	6.2	5.5	6.8
65-74	7.3	7.7	7.1	8.5
75-84	9.4	11.5	8.7	11.2
85 and over	9.5	13.3	10.1	12.7
Income category				
Poor/near poor				
65 and over	15.2	17.3	16.5	21.5
55-64	21.9	20.6	19.3	25.3
65-74	14.1	15.3	17.3	22.3
75 - 84	16.6	19.8	16.2	21.2
85 and over	16.0	17.3	(B)	19.1
Other				
65 and over	5.8	7.7	6.0	7.6
55-64	4.3	4.3	3.5	4.6
65-74	5.6	6.5	5.3	6.5
75-84	6.5	9.1	6.7	8.8
85 and over	6.0	11.9	8.2	9.8
Health status category				
Poor or fair health				
65 and over	10.6	11.6	10.9	13.6
55 - 64	9.5	9.7	8.5	11.7
65 - 74	9.8	10.7	10.1	13.0
75 - 84	12.1	12.8	10.8	14.3
85 and over	(B)	12.9	(B)	13.9
Excellent, very good, or good health				
65 and over	6.9	7.7	6.3	7.5
55 - 64	4.5	4.7	4.4	4.8
65 - 74	6.1	5.7	5.7	6.1
75 - 84	8.0	10.2	7.2	8.9
85 and over	8.9	13.7	7.0	10.7

(B) Base is not large enough to produce reliable results.

Note: Out-of-pocket health care expenditures exclude personal spending for health insurance premiums. Including expenditures for out-of-pocket premiums in the estimates of out-of-pocket spending would increase the percentage of household income spent on health care in all years. People are classified into the "poor/near poor" income category if their household income is below 125 percent of the poverty level; otherwise, people are classified into the "other" income category. The poverty level is calculated according to the U.S. Census Bureau guidelines for the corresponding year. The ratio of a person's out-of-pocket expenditures to their household income was calculated based on the person's per capita household income. For people whose ratio of out-of-pocket expenditures to income exceeded 100 percent, the ratio was capped at 100 percent. People with no out-of-pocket expenditures were excluded from all calculations. Data from the 1987 survey have been adjusted to permit comparability across years; for details, see: Zuvekas and Cohen.⁶⁴

Reference population: These data refer to the civilian noninstitutionalized population.

Source: Agency for Healthcare Research and Quality, Medical Expenditure Panel Survey (MEPS) and MEPS predecessor surveys.

INDICATOR 32 Out-of-Pocket Health Care Expenditures continued**Table 32c. Distribution of total out-of-pocket health care expenditures among people age 65 and over with out-of-pocket expenditures, by type of health care services and age group, 2001**

Type of health care service	65 and over	65 - 74	75 - 84	85 and over
	Percent			
Hospital care	5.4	5.2	5.8	4.8
Office-based medical provider services	9.4	10.5	9.6	6.0
Dental services	13.0	15.6	11.9	8.3
Prescription drugs	56.0	57.2	58.9	45.1
Other health care	16.2	11.5	13.8	35.8

Note: Out-of-pocket health care expenditures exclude personal spending for health insurance premiums. Hospital care includes hospital inpatient care and care provided in hospital outpatient departments and emergency rooms. Office-based medical provider services includes services provided by medical providers in nonhospital-based medical offices or clinic settings. Dental services include care provided by any type of dental provider. Prescription drugs include prescribed medications purchased, including refills. Other health care includes care provided by home health agencies and independent home health providers and expenses for eyewear, ambulance services, orthopedic items, hearing devices, prostheses, bathroom aids, medical equipment, disposable supplies, and other miscellaneous services. The majority of expenditures in the "other" category are for home health services and eyeglasses. Figures may not sum to 100 percent because of rounding.

Reference population: These data refer to the civilian noninstitutionalized population.

Source: Agency for Healthcare Research and Quality, Medical Expenditure Panel Survey.

INDICATOR 33 Sources of Payment for Health Care Services**Table 33a. Sources of payment for health care services for Medicare enrollees age 65 and over, by type of service, 2001**

Service	Average cost per enrollee	Total	Medicare	Medicaid	OOP	Other
	Dollars					
Hospice	\$ 104	100	100	0	0	0
Inpatient hospital	2,991	100	88	1	4	7
Home health care	294	100	85	1	11	3
Short-term institution	493	100	83	3	7	8
Physician/Medical	2,805	100	68	2	16	15
Outpatient hospital	914	100	63	2	12	23
Prescription drugs	1,191	100	4	9	41	47
Dental	281	100	1	1	80	18
Nursing home/Long-term institution	1,875	100	0	46	48	6
All	10,948	100	54	10	21	15

Note: OOP refers to out-of-pocket payments. "Other" refers to private insurance, Department of Veterans Affairs, and other public programs.

Reference population: These data refer to Medicare enrollees.

Source: Centers for Medicare & Medicaid Services, Medicare Current Beneficiary Survey.

INDICATOR 33 Sources of Payment for Health Care Services continued

Table 33b. Sources of payment for health care services for Medicare enrollees age 65 and over, by income, 2001

<i>Income</i>	<i>Average cost</i>	<i>Total</i>	<i>Medicare</i>	<i>Medicaid</i>	<i>OOP</i>	<i>Other</i>
	Dollars		Percent			
All	\$10,948	100	54	10	21	15
\$0-\$10,000	14,692	100	50	27	16	7
10,001-20,000	11,249	100	58	8	21	13
20,001-30,000	10,152	100	56	3	24	17
30,001 or more	8,855	100	52	1	25	22

Note: OOP refers to out-of-pocket payments. "Other" refers to private insurance, Department of Veterans Affairs, and other public programs.

Reference population: These data refer to Medicare enrollees.

Source: Centers for Medicare & Medicaid Services, Medicare Current Beneficiary Survey.

INDICATOR 34 Veterans' Health Care

Table 34. Total number of veterans age 65 and over who are enrolled in or receiving health care from the Veterans Health Administration, 1990–2003

<i>Veteran population</i>	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003
	Number in millions													
Total	7.9	8.3	8.7	9.0	9.2	9.4	9.7	9.8	9.9	10.0	10.0	9.9	9.8	9.7
VA enrollees	na	na	na	na	na	na	na	na	na	1.7	2.1	2.7	3.1	3.3
VA patients	0.9	0.9	1.0	1.0	1.0	1.1	1.1	1.1	1.3	1.4	1.6	1.9	2.1	2.3

na Data not available.

Note: Department of Veterans Affairs (VA) enrollees are veterans who have signed-up to receive health care from the Veterans Health Administration (VHA), and VA patients are enrollees who have received care in each year through VHA.

Reference population: These data refer to the total veteran population, VHA enrollment population, and VHA patient population.

Source: Department of Veterans Affairs, Office of the Actuary, VetPop 2001 adjusted by Census 2000, February 2003; VHA Enrollment and Patient Files.

INDICATOR 35 Nursing Home Utilization**Table 35a. Rate of nursing home residence among people age 65 and over, by sex and age group, 1985, 1995, 1997, and 1999**

<i>Sex and age group</i>	<i>1985</i>	<i>1995</i>	<i>1997</i>	<i>1999</i>
Rate per thousand				
Both sexes				
65 and over	54.0	45.9	45.3	43.3
65-74	12.5	10.1	10.8	10.8
75-84	57.7	45.9	45.5	43.0
85 and over	220.3	198.6	192.0	182.5
Men				
65 and over	38.8	32.8	32.0	30.6
65-74	10.8	9.5	9.8	10.3
75-84	43.0	33.3	34.6	30.8
85 and over	145.7	130.8	119.0	116.5
Women				
65 and over	61.5	52.3	51.9	49.8
65-74	13.8	10.6	11.6	11.2
75-84	66.4	53.9	52.7	51.2
85 and over	250.1	224.9	221.6	210.5

Note: Rates for the 65 and over category are age-adjusted using the 2000 standard population. Beginning in 1997, population figures are adjusted for net underenumeration using the 1990 National Population Adjustment Matrix from the U.S. Census Bureau. People residing in personal care or domiciliary care homes are excluded from the numerator.

Reference population: These data refer to the resident population.

Source: Centers for Disease Control and Prevention, National Center for Health Statistics, National Nursing Home Survey.

Table 35b. Number of current nursing home residents age 65 and over, by sex and age group, 1985, 1995, 1997, and 1999

<i>Sex and age group</i>	<i>1985</i>	<i>1995</i>	<i>1997</i>	<i>1999</i>
Number in thousands				
Both sexes				
65 and over	1,318	1,423	1,465	1,469
65-74	212	190	198	195
75-84	509	512	528	518
85 and over	597	720	738	757
Men				
65 and over	334	357	372	378
65-74	81	79	81	84
75-84	141	144	159	150
85 and over	113	133	132	144
Women				
65 and over	984	1,066	1,093	1,092
65-74	132	111	118	111
75-84	368	368	369	368
85 and over	485	587	606	613

Reference population: These data refer to the population residing in nursing homes. People residing in personal care or domiciliary care homes are excluded.

Source: Centers for Disease Control and Prevention, National Center for Health Statistics, National Nursing Home Survey.

INDICATOR 35 Nursing Home Utilization continued

Table 35c. Percentage of nursing home residents age 65 and over receiving assistance with activities of daily living, by selected characteristics, 1985, 1995, 1997, and 1999

<i>Selected characteristic</i>	<i>1985</i>	<i>1995</i>	<i>1997</i>	<i>1999</i>
			Percent	
Total receiving assistance with 0 ADLs	5.0	2.2	2.2	3.0
Men	8.8	3.2	3.4	5.0
Women	3.8	1.9	1.8	2.4
White	5.1	2.2	2.2	3.1
Black or African American	3.7	2.1	2.0	2.5
Not Hispanic or Latino	5.1	2.3	2.2	3.0
Hispanic or Latino	2.5	2.1	1.2	3.0
Total receiving assistance with 1-3 ADLs	26.2	22.5	21.3	19.8
Men	28.8	25.0	23.8	20.7
Women	25.3	21.7	20.4	19.6
White	26.6	23.0	21.7	20.3
Black or African American	20.9	17.9	17.5	17.0
Not Hispanic or Latino	26.3	22.3	21.6	20.0
Hispanic or Latino	24.2	23.7	13.9	18.5
Total receiving assistance with 4-6 ADLs	68.8	75.3	76.6	77.2
Men	62.5	71.8	72.8	74.4
Women	70.9	76.4	77.8	78.1
White	68.3	74.8	76.1	76.6
Black or African American	75.5	80.0	80.5	80.5
Not Hispanic or Latino	68.7	75.4	76.2	77.0
Hispanic or Latino	73.4	74.2	84.9	78.5

Note: The six activities of daily living (ADLs) included are bathing, dressing, eating, walking, toileting, and transferring in and out of bed or chairs. The resident's receipt of assistance with these activities refers to personal help received from facility staff at the time of the survey (for current residents) or the last time care was provided (for discharges). Help that a resident may receive from people who are not staff of the facility (e.g., family members, friends, or individuals employed directly by the patient and not by the facility) is not included. See Appendix B for the definition of race and ethnicity in the National Nursing Home Survey.

Reference population: These data refer to the population residing in nursing homes. People residing in personal care or domiciliary care homes are excluded.

Source: Centers for Disease Control and Prevention, National Center for Health Statistics, National Nursing Home Survey.

INDICATOR 36 Residential Services

Table 36a. Percentage of Medicare enrollees age 65 and over residing in selected residential settings, by age group, 2002

<i>Residential setting</i>	<i>65 and over</i>	<i>65-74</i>	<i>75-84</i>	<i>85 and over</i>
Number in thousands				
All settings	32,814	16,104	12,391	4,319
Percent				
Total	100.0	100.0	100.0	100.0
Traditional community	92.7	97.8	92.6	74.3
Community housing with services	2.4	1.0	2.7	7.1
Long-term care facilities	4.8	1.3	4.7	18.6

Note: Community housing with services applies to respondents who reported they lived in retirement communities or apartments, senior citizen housing, continuing care retirement facilities, assisted living facilities, staged living communities, board and care facilities/homes, and similar situations, AND who reported they had access to one or more of the following services through their place of residence: meal preparation, cleaning or housekeeping services, laundry services, help with medications. Respondents were asked about access to these services but not whether they actually used the services. A residence is considered a long-term care facility if it is certified by Medicare or Medicaid; or has 3 or more beds and is licensed as a nursing home or other long-term care facility and provides at least one personal care service; or provides 24-hour, 7-day-a-week supervision by a caregiver.

Reference population: These data refer to Medicare enrollees.

Source: Centers for Medicare & Medicaid Services, Medicare Current Beneficiary Survey.

Table 36b. Percentage of Medicare enrollees age 65 and over with functional limitations, by residential setting, 2002

<i>Functional status</i>	<i>Traditional community</i>	<i>Community housing with services</i>	<i>Long-term care facility</i>
Percent			
Total	100.0	100.0	100.0
No functional limitations	58.3	36.7	6.3
IADL limitation only	14.0	17.9	12.5
1-2 ADL limitations	19.2	33.1	16.7
3 or more ADL limitations	8.5	12.3	64.6

Note: Community housing with services applies to respondents who reported they lived in retirement communities or apartments, senior citizen housing, continuing care retirement facilities, assisted living facilities, staged living communities, board and care facilities/homes, and similar situations, AND who reported they had access to one or more of the following services through their place of residence: meal preparation, cleaning or housekeeping services, laundry services, help with medications. Respondents were asked about access to these services but not whether they actually used the services. A residence is considered a long-term care facility if it is certified by Medicare or Medicaid; or has 3 or more beds and is licensed as a nursing home or other long term care facility and provides at least one personal care service; or provides 24-hour, 7-day-a-week supervision by a caregiver. IADL limitations refer to difficulty performing (or inability to perform, for a health reason) one or more of the following tasks: using the telephone, light housework, heavy housework, meal preparation, shopping, managing money. Only the questions on telephone use, shopping, and managing money are asked of long-term care facility residents. ADL limitations refer to difficulty performing (or inability to perform, for a health reason) the following tasks: bathing, dressing, eating, getting in/out of chairs, walking, toileting. Long-term care facility residents with no limitations may include individuals with limitations in certain IADLs: doing light or heavy housework or meal preparation. These questions were not asked of facility residents.

Reference population: These data refer to Medicare enrollees.

Source: Centers for Medicare & Medicaid Services, Medicare Current Beneficiary Survey.

INDICATOR 36 Residential Services continued

Table 36c. Availability of specific services among Medicare enrollees age 65 and over residing in community housing with services, 2002

<i>Persons residing in community housing with services who have access to...</i>	<i>Percent</i>
Total	100.0
Prepared meals	85.8
Housekeeping, maid, or cleaning services	80.4
Laundry services	68.2
Help with medications	46.6

Note: Community housing with services applies to respondents who reported they lived in retirement communities or apartments, senior citizen housing, continuing care retirement facilities, assisted living facilities, staged living communities, board and care facilities/homes, and similar situations, AND who reported they had access to one or more services listed in the table through their place of residence. Respondents were asked about access to these services but not whether they actually used the services.

Reference population: These data refer to Medicare enrollees.

Source: Centers for Medicare & Medicaid Services, Medicare Current Beneficiary Survey.

Table 36d. Annual income distribution of Medicare enrollees age 65 and over, by residential setting, 2002

<i>Income</i>	<i>Traditional community</i>	<i>Community housing with services</i>	<i>Long-term care facility</i>
	Percent		
Total	100.0	100.0	100.0
\$0-\$10,000	16.6	24.2	43.4
10,001-20,000	28.2	25.8	33.5
20,001-30,000	22.2	20.7	12.1
30,001 or more	33.0	29.3	11.1

Note: Community housing with services applies to respondents who reported they lived in retirement communities or apartments, senior citizen housing, continuing care retirement facilities, assisted living facilities, staged living communities, board and care facilities/homes, and similar situations, AND who reported they had access to one or more of the following services through their place of residence: meal preparation, cleaning or housekeeping services, laundry services, help with medications. Respondents were asked about access to these services but not whether they actually used the services. A residence is considered a long-term care facility if it is certified by Medicare or Medicaid; or has 3 or more beds and is licensed as a nursing home or other long-term care facility and provides at least one personal care service; or provides 24-hour, 7-day-a-week supervision by a caregiver. Table excludes data for respondents who reported only that their income was greater or less than \$25,000.

Reference population: These data refer to Medicare enrollees.

Source: Centers for Medicare & Medicaid Services, Medicare Current Beneficiary Survey.

INDICATOR 36 Residential Services continued**Table 36e. Characteristics of services available to Medicare enrollees age 65 and over residing in community housing with services, 2002**

<i>Selected characteristic</i>	<i>Percent</i>
Services included in housing costs	100.0
All included	46.7
Some included/some separate	37.9
All separate	15.4
Can continue living there if they need substantial services	100.0
Yes	53.0
No	47.0

Note: Community housing with services applies to respondents who reported they lived in retirement communities or apartments, senior citizen housing, continuing care retirement facilities, assisted living facilities, staged living communities, board and care facilities/homes, and similar situations, AND who reported they had access to one or more of the following services through their place of residence: meal preparation, cleaning or housekeeping services, laundry services, help with medications. Respondents were asked about access to these services but not whether they actually used the services.

Reference population: These data refer to Medicare enrollees.

Source: Centers for Medicare & Medicaid Services, Medicare Current Beneficiary Survey.

INDICATOR 37 Caregiving and Assistive Device Use**Table 37a. Distribution of Medicare enrollees age 65 and over receiving personal care for a chronic disability, by type of care, 1984, 1989, 1994, and 1999**

<i>Type of care</i>	<i>1984</i>	<i>1989</i>	<i>1994</i>	<i>1999</i>
	Number			
Total Medicare enrollees	27,967,944	30,871,346	33,125,154	34,459,236
Total Medicare enrollees receiving personal care	4,094,565	3,946,598	3,844,871	3,700,889
	Percent			
Total percentage of Medicare enrollees receiving personal care	14.6	12.8	11.6	10.7
Distribution of type of personal care	100.0	100.0	100.0	100.0
Informal only	68.9	64.5	57.1	65.5
Informal and formal	26.0	28.4	36.1	25.9
Formal only	5.1	7.1	6.8	8.5

Note: Informal care refers to unpaid assistance provided to a person with a chronic disability living in the community. Formal care refers to paid assistance.

Reference population: These data refer to Medicare enrollees living in the community who report receiving personal care from a paid or unpaid helper for a chronic disability.

Source: National Long Term Care Survey.

INDICATOR 37 Caregiving and Assistive Device Use continued

Table 37b. Distribution of Medicare enrollees age 65 and over receiving personal care for a chronic disability, by type of care and level of disability, 1984, 1989, 1994, and 1999

Level of disability	Informal care only	Informal and formal care	Formal care only	Total
				Percent
				Number in thousands
1984				
IADL only	79.4	15.6	5.0	1,219
1-2 ADLs	70.6	24.2	5.2	1,332
3-4 ADLs	62.7	30.8	6.5	711
5-6 ADLs	55.8	40.0	4.1	833
Total	68.9	26.0	5.1	4,095
1989				
IADL only	78.7	14.5	6.8	774
1-2 ADLs	69.9	22.5	7.6	1,338
3-4 ADLs	57.9	33.1	8.9	954
5-6 ADLs	50.9	44.4	4.7	880
Total	64.5	28.4	7.1	3,947
1994				
IADL only	77.6	16.4	6.0	746
1-2 ADLs	61.6	29.8	8.6	1,213
3-4 ADLs	53.1	39.1	7.8	914
5-6 ADLs	39.4	56.4	4.2	973
Total	57.1	36.1	6.8	3,845
1999				
IADL only	80.1	12.8	7.1	558
1-2 ADLs	75.8	16.1	8.1	1,086
3-4 ADLs	62.2	28.1	9.7	990
5-6 ADLs	50.6	40.8	8.6	1,068
Total	65.5	25.9	8.5	3,701

Note: Informal care refers to unpaid assistance provided to a person with a chronic disability living in the community. Formal care refers to paid assistance. IADL is instrumental activity of daily living. ADL is activity of daily living.

Reference population: These data refer to Medicare enrollees living in the community who report receiving personal care from a paid or unpaid helper for a chronic disability.

Source: National Long Term Care Survey.

INDICATOR 37 Caregiving and Assistance continued**Table 37c. Distribution of Medicare enrollees age 65 and over using assistive devices and/or receiving personal care for a chronic disability, by type of care, 1984, 1989, 1994, and 1999**

Type of care	1984	1989	1994	1999
	Number			
Total Medicare enrollees	27,967,944	30,871,346	33,125,154	34,459,236
Total Medicare enrollees receiving personal care or using assistive devices	4,730,434	4,820,323	4,911,958	4,990,968
	Percent			
Total percentage of Medicare enrollees receiving personal care or using assistive devices	16.9	15.6	14.8	14.5
Distribution of type of care	100.0	100.0	100.0	100.0
Assistive device only	13.4	18.1	21.7	25.8
Assistive device and personal care	55.4	60.8	59.0	58.4
Personal care only	31.1	21.1	19.3	15.8

Note: Personal care refers to paid or unpaid assistance provided to a person with a chronic disability living in the community.

Reference population: These data refer to Medicare enrollees living in the community who report either receiving personal care from a paid or unpaid helper, or using assistive devices, or both, for a chronic disability.

Source: National Long Term Care Survey.

Table 37d. Distribution of Medicare enrollees age 65 and over using assistive devices and/or receiving personal care for a chronic disability, by type of care and level of disability, 1984, 1989, 1994, and 1999

Level of disability	Assistive device only	Assistive device and personal care	Personal care only	Total
	Percent			Number in thousands
1984				
IADL only	14.1	20.8	65.1	1,419
1-2 ADLs	22.4	59.1	18.5	1,717
3-4 ADLs	6.7	80.5	12.7	762
5-6 ADLs	0.0	83.9	16.1	833
Total	13.4	55.4	31.1	4,730
1989				
IADL only	22.9	21.6	55.5	1,004
1-2 ADLs	30.0	52.9	17.1	1,912
3-4 ADLs	6.5	88.9	4.6	1,021
5-6 ADLs	0.3	90.1	9.6	883
Total	18.1	60.8	21.1	4,820
1994				
IADL only	24.2	23.1	52.7	984
1-2 ADLs	36.7	49.3	14.0	1,916
3-4 ADLs	11.9	81.1	7.0	1,037
5-6 ADLs	0.2	90.8	9.0	975
Total	21.7	59.0	19.3	4,912
1999				
IADL only	30.6	21.2	48.3	803
1-2 ADLs	44.3	44.4	11.3	1,951
3-4 ADLs	15.2	78.3	6.5	1,167
5-6 ADLs	0.3	90.2	9.6	1,070
Total	25.8	58.4	15.8	4,991

Note: Personal care refers to paid or unpaid assistance provided to a person with a chronic disability living in the community. IADL is instrumental activity of daily living. ADL is activity of daily living.

Reference population: These data refer to Medicare enrollees living in the community who report either receiving personal care from a paid or unpaid helper, or using assistive devices, or both, for a chronic disability.

Source: National Long Term Care Survey.

Appendix B: Data Source Descriptions

Consumer Expenditure Survey

The Consumer Expenditure Survey (CEX) is conducted for the Bureau of Labor Statistics by the U.S. Census Bureau. The survey contains both a Diary component and an Interview component. Data presented in this chartbook on housing expenditures are derived from the Interview component only. The proportions shown are derived from sample data and are not weighted to reflect the entire population.

In the Interview portion of the CEX, respondents are interviewed once every 3 months for 5 consecutive quarters. Respondents report information on consumer unit^a characteristics and expenditures during each interview. Income data are collected during the second and fifth interviews only.

The data presented are obtained from consumer units whose reference person^b is at least 65 years old. From all consumer units of this type, complete income reporters^c are selected. The data are then sorted by income and grouped into income quintiles, with the first quintile containing the lowest reported incomes.^d Annual expenditures are estimated by annualizing quarterly estimates (i.e., quarterly estimates are multiplied by four). The proportions of total out-of-pocket expenditures that are used for housing are then calculated separately for each income group.

Because of small sample sizes of consumer units with a reference person age 65 and over, these data may have large standard errors relative to their means; caution should be exercised when analyzing these results.

Race and Hispanic origin: Data from this survey are not shown by race and Hispanic origin in this report.

For more information, contact:

Division of Consumer Expenditure Surveys Staff

Phone: (202) 691-5132

E-mail: cexinfo@bls.gov

Internet: <http://www.bls.gov/cex>

^aThis term is used to describe members of a household related by blood, marriage, adoption, or other legal arrangement; single people who are living alone or sharing a household with others but who are financially independent; or two or more persons living together who share responsibility for at least two of three major types of expenses—food, housing, and other expenses. Students living in university-sponsored housing are also included in the sample as separate consumer units. For convenience, the term “household” may be substituted for the term “consumer unit.”

^bThis is the first person mentioned when the respondent is asked to name the person or people who own or rent the home in which the consumer unit resides.

^cIn general, complete income reporters are those families that provide a value for at least one major source of income, such as wages and salaries, self-employment income, and Social Security income. However, complete income reporters do not necessarily provide a full accounting of income from all sources.

^dIt is important to note that income does not necessarily include all sources of taxable income; for example, capital gains are not collected as income. Similarly, other sources of revenue (such as sales of jewelry, art, furniture, or other similar property) are not included in the definition of income used by the CEX Interview component.

Current Population Survey

The Current Population Survey (CPS) is a nationally representative sample survey of about 60,000 households conducted monthly for the Bureau of Labor Statistics (BLS) by the U.S. Census Bureau. The CPS core survey is the primary source of information on the labor force characteristics of the civilian noninstitutionalized population age 16 and over, including estimates of unemployment released every month by the BLS. Monthly CPS supplements provide additional demographic and social data. The Annual Social and Economic Supplement (ASEC), or March CPS Supplement, is the primary source of detailed information on income and poverty in the United States. The ASEC is used to generate the annual *Population Profile of the United States*, reports on geographical mobility and educational attainment, and detailed analyses of money income and poverty status.

Race and Hispanic origin: In 2003, for the first time CPS respondents were asked to identify themselves as belonging to one or more of the six racial groups (white, black, American Indian and Alaska Native, Asian, Native Hawaiian and other Pacific Islander, and Some Other Race); previously they were to choose only one. People who responded to the question on race by indicating only one race are referred to as the race alone or single-race population, and individuals who chose more than one of the race categories are referred to as the Two-or-More-Races population.

The CPS includes a separate question on Hispanic origin. Starting in 2003, people of Spanish/Hispanic/Latino origin could identify themselves as Mexican, Puerto Rican, Cuban, or Other Spanish/Hispanic/Latino. People of Hispanic origin may be of any race.

The 1994 redesign of the CPS had an impact on labor force participation rates for older men and women. (See “Indicator 11: Participation in the Labor Force.”) For more information on the effect of the redesign, see “The CPS After the Redesign: Refocusing the Economic Lens.”¹⁴

For more information regarding the CPS, its sampling structure and estimation methodology, see “Explanatory Notes and Estimates of Error.”⁶²

For more information, contact:
Division of Labor Force Statistics Staff
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E-mail: cpsinfo@bls.gov
Internet: <http://stats.bls.gov/cps/home.htm>

Decennial Census

Every 10 years, beginning with the first census in 1790, the United States government conducts a census, or count, of the entire population as mandated by the U.S. Constitution. The 1990 and 2000 censuses were taken April 1 of their respective years. As in several previous censuses, two forms were used: a short form and a long form. The short form was sent to every household, and the long form, containing the 100 percent questions plus the sample questions, was sent to approximately one in every six households.

The Census 2000 short form questionnaire included six questions for each member of the household (name, sex, age, relationship, Hispanic origin, and race) and whether the housing unit was owned or rented. The long form asked more detailed information on subjects such as education, employment, income, ancestry, homeowner costs, units in a structure, number of rooms, plumbing facilities, etc. Decennial censuses not only count the population but also sample the socioeconomic status of the population, providing a tool for the government, educators, business owners, and others to get a snapshot of the state of the Nation.

Race and Hispanic origin: In Census 2000, respondents were given the option of selecting one or more race categories to indicate their racial identities. People who responded to the question on race indicating only one of the six race categories (white, black, American Indian and Alaska Native, Asian, Native Hawaiian and other Pacific Islander, and Some Other Race) are referred to as the race alone or single-race population. Individuals who chose more than one of the race categories are referred to as the Two-or-More-Races population. The six single-race categories, which made up nearly 98 percent of all respondents, and the Two-or-More-Races category sum to the total population.¹ Because respondents were given the option of selecting one or more race categories to indicate their racial identities, Census 2000 data on race are not directly comparable with data from the 1990 or earlier censuses.

As in earlier censuses, Census 2000 included a separate question on Hispanic origin. In Census 2000, people of Spanish/Hispanic/Latino origin could identify themselves as Mexican, Puerto Rican, Cuban, or Other Spanish/Hispanic/Latino. People of Hispanic origin may be of any race.

For more information, contact:

Age and Special Populations Branch Staff

Phone: (301) 763-2378

<http://www.census.gov/main/www/cen2000.html>

Health and Retirement Study

The Health and Retirement Study (HRS) is a national panel study conducted by the University of Michigan's Institute for Social Research under a cooperative agreement with the National Institute on Aging. In 1992, the study had an initial sample of over 12,600 people from the 1931–1941 birth cohort and their spouses. The HRS was joined in 1993 by a companion study, Asset and Health Dynamics Among the Oldest Old (AHEAD), with a sample of 8,222 respondents born before 1924 who were age 70 and over and their spouses. In 1998, these two data collection efforts were combined into a single survey instrument and field period and were expanded through the addition of baseline interviews with two new birth cohorts: Children of the Depression Age (CODA—1924–1930) and War Babies (WB—1942–1947). Plans call for adding a new 6-year cohort of Americans entering their 50s every 6 years. In 2004, baseline interviews will be conducted with the Early Boomer birth cohort (1948–1953). The combined studies, which are collectively called HRS, have become a steady state sample that is representative of the entire U.S. population age 50 and over (excluding people who were resident in a nursing home or other institutionalized setting at the time of sampling). HRS will follow respondents longitudinally until they die (including following people who move into a nursing home or other institutionalized setting). All cohorts will be followed with biennial interviews.

The HRS is intended to provide data for researchers, policy analysts, and program planners who make major policy decisions that affect retirement, health insurance, saving, and economic well-being. The study is designed to explain the antecedents and consequences of retirement; examine the relationship between health, income, and wealth over time; examine life cycle patterns of wealth accumulation and consumption; monitor work disability; provide a rich source of interdisciplinary data, including linkages with administrative data; monitor transitions in physical, functional, and cognitive health in advanced old age; relate late-life changes in physical and cognitive health to patterns of spending down assets and income flows; relate changes in health to economic resources and intergenerational transfers; and examine how the mix and distribution of economic, family, and program resources affect key outcomes, including retirement, spending down assets, health declines, and institutionalization.

Race and Hispanic origin: Data from this survey are not shown by race and Hispanic origin in this report.

For more information, contact:
Health and Retirement Study Staff
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Internet: <http://hrsonline.isr.umich.edu>

Medical Expenditure Panel Survey

The Medical Expenditure Panel Survey (MEPS) is an ongoing annual survey of the civilian noninstitutionalized population that collects detailed information on health care use and expenditures (including sources of payment), health insurance, income, health status, access, and quality of care. MEPS, begun in 1996, is the third in a series of national probability surveys conducted by the Agency for Healthcare Research and Quality on the financing and use of medical care in the United States. MEPS predecessor surveys are the National Medical Care Expenditure Survey (NMCES) conducted in 1977 and the National Medical Expenditure Survey (NMES) conducted in 1987. Each of the three surveys (i.e., NMCES, NMES, and MEPS) used multiple rounds of in-person data collection to elicit expenditures and sources of payments for each health care event experienced by household members during the calendar year. To yield more complete information on health care spending and payment sources, followback surveys of health providers were conducted for a subsample of events in MEPS (and events in the MEPS predecessor surveys).

Since 1977, the structure of billing mechanism for medical services has grown more complex as a result of increasing penetration of managed care and health maintenance organizations and various cost-containment reimbursement mechanisms instituted by Medicare, Medicaid, and private insurers. As a result, there has been substantial discussion about what constitutes an appropriate measure of health care expenditures.⁶³ Health care expenditures presented in this report refer to what is actually paid for health care services. More specifically, expenditures are defined as the sum of direct payments for care received, including out-of-pocket payments for care received. This definition of expenditures differs somewhat from what was used in the 1987 NMES, which used charges (rather than payments) as the fundamental expenditure construct. To improve comparability of estimates between the 1987 NMES and the 1996 and 2001 MEPS, the 1987 data presented in this report were adjusted using the method described by Zuvekas and Cohen.⁶⁴ Adjustments to the 1977 data were considered unnecessary because virtually all of the discounting for health care services occurred after 1977 (essentially equating charges with payments in 1977).

Race and Hispanic origin: Data from this survey are not shown by race and Hispanic origin in this report.

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E-mail: mepsd@ahrq.gov
Internet: <http://www.meps.ahrq.gov>

Medicare Current Beneficiary Survey

The Medicare Current Beneficiary Survey (MCBS) is a continuous, multipurpose survey of a representative sample of the Medicare population designed to help the Centers for Medicare & Medicaid Services (CMS) administer, monitor, and evaluate the Medicare program. The MCBS collects information on health care use, cost, and sources of payment; health insurance coverage; household composition; sociodemographic characteristics; health status and physical functioning; income and assets; access to care; satisfaction with care; usual source of care; and how beneficiaries get information about Medicare.

MCBS data enable CMS to determine sources of payment for all medical services used by Medicare beneficiaries, including copayments, deductibles, and noncovered services; develop reliable and current information on the use and cost of services not covered by Medicare (such as prescription drugs and long-term care); ascertain all types of health insurance coverage and relate coverage to sources of payment; and monitor the financial effects of changes in the Medicare program. Additionally, the MCBS is the only source of multidimensional person-based information about the characteristics of the Medicare population and their access to and satisfaction with Medicare services and information about the Medicare program. The MCBS sample consists of Medicare enrollees in the community and in institutions.

The survey is conducted in three rounds per year, with each round being 4 months in length. MCBS has a multistage, stratified, random sample design and a rotating panel survey design. Each panel is followed for 12 interviews. In-person interviews are conducted using computer-assisted personal interviewing. Approximately 16,000 sample persons are interviewed in each round. However, because of the rotating panel design, only 12,000 sample persons receive all three interviews in a given calendar year. Information collected in the survey is combined with information from CMS administrative data files and made available through public-use data files.

Race and Hispanic origin: The MCBS defines race as white, black, Asian, Native Hawaiian or Pacific Islander, American Indian or Alaska Native, and other. People are allowed to choose more than one category. There is a separate question on whether the person is of Hispanic or Latino origin. The “other” category in Table 29c on page 102 consists of people who answered “no” to the Hispanic/Latino question and who answered something other than “white” or “black” to the race question. People who answer with more than one racial category are assigned to the “other” category.

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MCBS Staff

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National Health Interview Survey

The National Health Interview Survey (NHIS), conducted by the National Center for Health Statistics, is a continuing nationwide sample survey in which data are collected during personal household interviews. Interviewers collect data on illnesses, injuries, impairments, and chronic conditions; activity limitation caused by chronic conditions; utilization of health services; and other health topics. Information is also obtained on personal, social, economic, and demographic characteristics, including race and ethnicity and health insurance status. Each year the survey is reviewed, and special topics are added or deleted. For most health topics, the survey collects data over an entire year.

The NHIS sample includes an oversample of black and Hispanic people and is designed to allow the development of national estimates of health conditions, health service utilization, and health problems of the noninstitutionalized civilian population of the United States. The response rate for the ongoing part of the survey has been between 94 percent and 98 percent over the years. In 1997, the NHIS was redesigned; estimates beginning in 1997 are likely to vary slightly from those for previous years. The interviewed sample for 2002 consisted of 36,161 households, which yielded 93,386 persons in 36,831 families.

Race and Hispanic origin: Starting with data year 1999, race-specific estimates in the NHIS are tabulated according to 1997 Standards for Federal data on Race and Ethnicity and are not strictly comparable with estimates for earlier years. The single race categories for data from 1999 and later (shown in tables 15a, 20, 21a, 22, 24b, and 26a on pages 88, 93–95, 97, and 99) conform to 1997 Standards and are for people who reported only one racial group. Prior to data year 1999, data were tabulated according to the 1977 Standards and included people who reported one race or, if they reported more than one race, identified one race as best representing their race. In table 21a on page 94, estimates of non-Hispanic whites and non-Hispanic blacks in 1997 and 1998 are for people who reported only a single race. In table 26a on page 99, the white and black race groups include people of Hispanic origin.

Additional background and health data for adults are available in *Summary Health Statistics for the U.S. Population: National Health Interview Survey*.⁶⁵

For more information, contact:

NHIS staff

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E-mail: nchsquery@cdc.gov

Internet: <http://www.cdc.gov/nchs/nhis.htm>

National Health and Nutrition Examination Survey

The National Health and Nutrition Examination Survey (NHANES), conducted by the National Center for Health Statistics, is a family of cross-sectional surveys designed to assess the health and nutritional status of the noninstitutionalized civilian population through direct physical examinations and interviews. Each survey's sample was selected using a complex, stratified, multistage, probability sampling design. Interviewers obtain information on personal and demographic characteristics, including age, household income, and race and ethnicity directly from sample persons (or their proxies). In addition, dietary intake data, biochemical tests, physical measurements, and clinical assessments are collected.

The NHANES program includes the following surveys conducted on a periodic basis through 1994: the first, second, and third National Health Examination Surveys (NHES I, 1960–1962; NHES II, 1963–1965; and NHES III, 1966–1970); and the first, second, and third National Health and Nutritional Examination Surveys (NHANES I, 1971–1974; NHANES II, 1976–1980; and NHANES III, 1988–1994). Beginning in 1999, NHANES changed to a continuous data collection format without breaks in survey cycles. The NHANES program now visits 15 U.S. locations per year, surveying and reporting for approximately 5,000 people annually. The procedures employed in continuous NHANES to select samples, conduct interviews, and perform physical exams have been preserved from previous survey cycles. NHES I, NHANES I, and NHANES II collected information on persons 6 months to 74 years of age. NHANES III and later surveys include people age 75 and over.

With the advent of the continuous survey design (NHANES III), NHANES moved from a 6-year data release to a 2-year data release schedule. NHANES data-based indicators included in this report utilize both 2-year (1999–2000) and 4-year (1999–2002) estimates. The 1999–2000 estimates are based on a smaller sample size than estimates for earlier time periods and, therefore, are subject to greater sampling error.

Race and Hispanic origin: Data from this survey are not shown by race and Hispanic origin in this report.

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NHANES Staff
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Internet: <http://www.cdc.gov/nchs/nhanes.htm>

National Long Term Care Survey

The National Long Term Care Survey (NLTC) is a nationally representative longitudinal survey conducted by Duke University's Center for Demographic Studies under a cooperative agreement with the National Institute on Aging. The NLTC is designed to study changes in the health and functional status of Medicare beneficiaries age 65 and over. The survey began in 1982, and follow-up surveys have been conducted in 1984, 1989, 1994, and 1999. A sixth follow-up survey is scheduled to begin in October 2004.

The sample is drawn from Medicare beneficiary enrollment files, a nationally representative sample frame of both community and institutional residents. As sample persons are followed through the Medicare record system, virtually 100 percent of cases can be longitudinally tracked so that declines as well as improvements in health status may be identified, as well as the exact dates of death. NLTC sample persons are followed until death and are permanently and continuously linked to the Medicare record system from which they are drawn. Linkage to the Medicare Part A and B service records extends from 1982 through 2000 so that detailed Medicare expenditures and types of service use may be studied.

Through the careful application of methods to reduce nonsampling error, the surveys provide nationally representative data on the prevalence and patterns of functional limitations, both physical and cognitive; longitudinal and cohort patterns of change in functional limitation and mortality over 17 years; medical conditions and recent medical problems; health care services used; the kind and amount of formal and informal services received by impaired individuals and how it is paid for; demographic and economic characteristics such as age, race, sex, marital status, education, and income and assets; out-of-pocket expenditures for health care services and other sources of payment; and housing and neighborhood characteristics.

Race and Hispanic origin: Data from this survey are not shown by race and Hispanic origin in this report.

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National Nursing Home Survey

The National Nursing Home Survey (NNHS), conducted by the National Center for Health Statistics, is a continuing series of national sample surveys of nursing homes, their residents, and their staff. Six nursing home surveys have been conducted: 1973–1974, 1977, 1985, 1995, 1997, 1999; and a seventh is in the field: 2004. The 2004 NNHS has been redesigned and expanded to better meet the data needs of researchers and health care planners working in the long-term care field. In addition to other important new topics, the 2004 NNHS will include the first nationwide survey of nursing assistants, the group which provides the majority of direct care to the Nation's 1.6 million nursing home residents.

The survey collects information on nursing homes, their residents, discharges, and staff. Nursing homes are defined as facilities with three or more beds that routinely provide nursing care services. The 1977 and 1985 surveys included personal care or domiciliary care homes. Estimates presented

for 1977 include these types of facilities. Facilities may be certified by Medicare or Medicaid, or both, or not certified but licensed by the State as a nursing home. These facilities may be freestanding or nursing care units of hospitals, retirement centers, or similar institutions where the unit maintained financial and resident records separate from those of the larger institutions. The survey is based on interviews with administrators and staff and, in some years, self-administered questionnaires for a sample of about 1,500 facilities.

The NNHS provides information on nursing homes from two perspectives—that of the provider of services and that of the recipient. Provider data include characteristics such as size, ownership, Medicare/Medicaid certification, occupancy rate, days of care provided, and expenses. Recipient data are obtained on the residents' demographic characteristics, health status, and services received. Data are provided by a staff member, usually a nurse, familiar with the care provided to the resident. The nurse relies on the medical record and personal knowledge of the resident.

Race and Hispanic origin: Beginning in 1999 the instruction for the race item on the NNHS' Current Resident Questionnaire was changed so that more than one race could be recorded (American Indian/Alaska Native, Asian, black or African American, Native Hawaiian or other Pacific Islander, or white). In previous years only one racial category could be checked. Estimates in Table 35c on page 111 are for residents for whom only one race was recorded—black (or African American) or white. A resident is classified as Hispanic/Latino origin if he or she is of Mexican, Puerto Rican, Cuban, Central or South American, or other Spanish culture or origin, regardless of race, as reported by facility staff.

For more information, contact:

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National Survey of Veterans, 2001

The 2001 National Survey of Veterans (NSV) is a multipurpose survey used primarily to describe characteristics of the veteran population and of users and nonusers of Department of Veterans Affairs (VA) benefit programs. Survey topics include sociodemographic and economic characteristics, military background, health status measures, and VA and non-VA benefits usage. NSV was conducted by telephone with approximately 20,000 veterans, and interviews lasted an average of 35 minutes. The target population is all veterans residing in households in the United States and Puerto Rico. Because of the aging of the veteran population and the sampling methodology, a large portion (40 percent) of the sample is of veterans age 65 and over. The Department of Veterans Affairs Web site provides many data tables that classify veterans by age, including the 65 and over age group.

Race and Hispanic origin: Data from this survey are not shown by race and Hispanic origin in this report.

For more information, contact:

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Internet: <http://www.va.gov/vetdata/surveyresults/index.htm>

National Vital Statistics System

Through the National Vital Statistics System, the National Center for Health Statistics collects and publishes data on births, deaths, and prior to 1996, marriages and divorces occurring in the United States based on U.S. Standard Certificates. The Division of Vital Statistics obtains information on

births and deaths from the registration offices of each of the 50 States, New York City, the District of Columbia, Puerto Rico, the U.S. Virgin Islands, Guam, America Samoa, and Northern Mariana Islands. Geographic coverage for births and deaths has been complete since 1933. Demographic information on the death certificate is provided by the funeral director based on information supplied by an informant. Medical certification of cause of death is provided by a physician, medical examiner, or coroner. The mortality data file is a fundamental source of cause-of-death information by demographic characteristics and for geographic areas such as States. The mortality file is one of the few sources of comparable health-related data for smaller geographic areas in the United States and over a long time period. Mortality data can be used not only to present the characteristics of those dying in the United States but also to determine life expectancy and to compare mortality trends with other countries. Data for the entire United States refer to events occurring within the United States; data for geographic areas are by place of residence.

Race and Hispanic origin: Race and Hispanic origin are reported separately on the death certificate. Therefore, data by race shown in Tables 13b, 14b, and 14c (on pages 82 and 84–87) include people of Hispanic or non-Hispanic origin; data for Hispanic origin include people of any race.

For more information on the mortality data files, see Deaths: Leading causes for 2001.⁶⁶

For more information, contact:

Mortality Statistics Branch

Phone: (866) 441–NCHS

E-mail: nchsquery@cdc.gov

Internet: <http://www.cdc.gov/nchs/about/major/dvs/mortdata.htm>

Panel Study of Income Dynamics

The Panel Study of Income Dynamics (PSID) is a nationally representative, longitudinal study conducted by the University of Michigan's Institute for Social Research. It is a representative sample of U.S. individuals (men, women, and children) and the family units in which they reside. Starting with a national sample of 5,000 U.S. households in 1968, the PSID has reinterviewed individuals from those households annually from 1968 to 1997 and biennially thereafter, whether or not they are living in the same dwelling or with the same people. Adults have been followed as they have grown older, and children have been observed as they advance through childhood and into adulthood, forming family units of their own. Information about the original 1968 sample individuals and their current co-residents (spouses, cohabitators, children, and anyone else living with them) is collected each year. In 1990, a representative national sample of 2,000 Hispanic households, differentially sampled to provide adequate numbers of Puerto Ricans, Mexican Americans, and Cuban Americans, was added to the PSID database. With low attrition rates and successful recontacts, the sample size grew to almost 8,000 in 2003. PSID data can be used for cross-sectional, longitudinal, and intergenerational analyses and for studying both individuals and families.

The central focus of the data has been economic and demographic, with substantial detail on income sources and amounts, employment, family composition changes, and residential location. Based on findings in the early years, the PSID expanded to its present focus on family structure and dynamics as well as income, wealth, and expenditures. Wealth and health are other important contributors to individual and family well-being that have been the focus of the PSID in recent years.

The PSID wealth modules measure net equity in homes and nonhousing assets divided into six categories: other real estate and vehicles; farm or business ownership; stocks, mutual funds, investment trusts, and stocks held in IRAs; checking and savings accounts, CDs, treasury bills, savings bonds, and liquid assets in IRAs; bonds, trusts, life insurance, and other assets; and other debts. The PSID measure of wealth excludes private pensions and rights to future Social Security payments.

Race and Hispanic origin: The PSID asks respondents if they are white, black, American Indian, Aleut, Eskimo, Asian, Pacific Islander, or another race. Respondents are allowed to choose more than one category. They are coded according to the first category mentioned. Only respondents who classified themselves as white or black are included in Table 10 on page 79.

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Population Projections

The population projections for the United States are interim projections that take into account the results of Census 2000. These interim projections were created using the cohort-component method, which uses assumptions about the components of population change. They are based on Census 2000 results, official post-census estimates, as well as vital registration data from the National Center for Health Statistics. The assumptions are based on those used in the projections released in 2000 that used a 1998 population estimate base. Some modifications were made to the assumptions so that projected values were consistent with estimates from 2001 as well as Census 2000.

Fertility is assumed to increase slightly from current estimates. The projected total fertility rate in 2025 is 2.180, and it is projected to increase to 2.186 by 2050. Mortality is assumed to continue to improve over time. By 2050, life expectancy at birth is assumed to increase to 81.2 for men and 86.7 for women. Net immigration is assumed to be 996,000 in 2025 and 1,097,000 in 2050.

Race and Hispanic origin: Interim projections based on Census 2000 were also done by race and Hispanic origin. The basic assumptions by race used in the previous projections were adapted to reflect the Census 2000 race definitions and results. Projections were developed for the following groups: (1) non-Hispanic white alone, (2) Hispanic white alone, (3) black alone, (4) Asian alone, and (5) all other groups. The fifth category includes the categories of American Indian and Alaska Native, Native Hawaiian and Other Pacific Islanders, and all people reporting more than one of the major race categories defined by the Office of Management and Budget (OMB).

For a more detailed discussion of the cohort-component method and the assumptions about the components of population change, see “Methodology and Assumptions for the Population Projections of the United States: 1999 to 2100.”⁶⁷

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Survey of the Aged, 1963

The major purpose of the 1963 Survey of the Aged was to measure the economic and social situations of a representative sample of all people age 62 and over in the United States in 1963 in order to serve the detailed information needs of the Social Security Administration (SSA). The survey included a wide range of questions on health insurance, medical care costs, income, assets and liabilities, labor force participation and work experience, housing and food expenses, and living arrangements.

The sample consisted of a representative subsample (one-half) of the Current Population Survey (CPS) sample and the full Quarterly Household Survey. Income was measured using answers to 17 questions about specific sources. Results from this survey have been combined with CPS results from 1971 to the present in an income time-series produced by SSA.

Race and Hispanic origin: Data from this survey are not shown by race and Hispanic origin in this report.

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Survey of Demographic and Economic Characteristics of the Aged, 1968

The 1968 Survey of Demographic and Economic Characteristics of the Aged was conducted by the Social Security Administration (SSA) to provide continuing information on the socioeconomic status of the older population for program evaluation. Major issues addressed by the study include the adequacy of Old-Age, Survivors, Disability, and Health Insurance benefit levels, the impact of certain Social Security provisions on the incomes of the older population, and the extent to which other sources of income are received by older Americans.

Data for the 1968 Survey were obtained as a supplement to the Current Medicare Survey, which yields current estimates of health care services used and charges incurred by people covered by the hospital insurance and supplemental medical insurance programs. Supplemental questions covered work experience, household relationships, income, and assets. Income was measured using answers to 17 questions about specific sources. Results from this survey have been combined with results from the Current Population Survey from 1971 to the present in an income time-series produced by SSA.

Race and Hispanic origin: Data from this survey are not shown by race and Hispanic origin in this report.

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Survey of Veteran Enrollees' Health and Reliance Upon VA, 2003

The 2003 Survey of Veteran Enrollees' Health and Reliance Upon VA is the fourth in a series of surveys of veteran enrollees for VA health care conducted by the Veterans Health Administration (VHA), within the Department of Veterans Affairs (VA), under multiyear OMB authority. Previous surveys of VHA-enrolled veterans were conducted in 1999, 2000, and 2002. All four VHA surveys of enrollees consisted of telephone interviews with stratified random samples of enrolled veterans. In 2000, 2002, and 2003, the survey instrument was modified to reflect VA management's need for specific data and information on enrolled veterans.

As with the other surveys in the series, the 2003 Survey of Veteran Enrollees' Health and Reliance Upon VA sample was stratified by Veterans Integrated Service Network, enrollment priority, and type of enrollee (new or past user). Telephone interviews averaged 12-15 minutes in length. In the 2003 survey, interviews were conducted during August-September 2003. Of approximately 6.7 million eligible enrollees who had not declined enrollment as of December 31, 2002, some 42,000 completed interviews in the 2003 telephone survey.

VHA enrollee surveys provide a fundamental source of data and information on enrollees that cannot be obtained in any other way except through surveys and yet are basic to many VHA activities. The primary purpose of the VHA enrollee surveys is to provide critical inputs into VHA Health Care Services Demand Model enrollment, patient and expenditure projections, and the Secretary's enrollment level decision processes; however, data from the enrollee surveys find their way into a variety of strategic analysis areas related to budget, policy, or legislation.

VHA enrollee surveys provide particular value in terms of their ability to help identify not only who VA serves but also to help supplement VA's knowledge of veteran enrollees' demographic characteristics, including household income, health insurance coverage status, functional status (ADL and IADL limitations) and perceived health status, their other eligibilities and resources, their use of VA and non-VA health care services and "reliance" upon VA, and their potential future use of VA health care services.

Race and Hispanic origin: Data from this survey are not shown by race and Hispanic origin in this report.

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Appendix C: Glossary

Activities of daily living (ADLs): Activities of daily living (ADLs) are basic activities that support survival, including eating, bathing, and toileting. See *Instrumental activities of daily living (IADLs)*.

In the National Long Term Care Survey, ADLs include bathing, dressing, getting in or out of bed, getting around inside, toileting, and eating. Individuals are considered to have an ADL disability if they report receiving help or supervision, or using equipment, to perform the activity, or not performing the activity at all.

In the Medicare Current Beneficiary Survey, ADL disabilities are measured as difficulty performing (or inability to perform because of a health reason) the following activities: eating; getting in/out of chairs, walking, dressing, bathing, and toileting.

Asset income: Asset income includes money income reported in the Current Population Survey (CPS) from interest (on savings or bonds), dividends, income from estates or trusts, and net rental income. Capital gains are not included.

Assistive device: Assistive device refers to any item, piece of equipment, or product system, whether acquired commercially, modified, or customized, that is used to increase, maintain, or improve functional capabilities of individuals with disabilities.

Body mass index: Body mass index (BMI) is a measure of body weight adjusted for height, and correlates with body fat. A tool for indicating weight status in adults, BMI is generally computed using metric units and is defined as weight divided by height² or kilograms/meters². The categories used in this report are consistent with those set by the World Health Organization. For adults 20 years of age and over, underweight is defined as having a BMI less than 18.5; healthy weight is defined as having a BMI of at least 18.5 and less than 25; overweight is defined as having values of BMI equal to 25 or greater; and obese is defined as having BMI values equal to 30 or greater. To calculate your own body mass index, go to <http://www.nhlbisupport.com/bmi>. For more information about BMI, see “Clinical guidelines on the identification, evaluation, and treatment of overweight and obesity in adults.”⁶⁸

Cause of death: For the purpose of national mortality statistics, every death is attributed to one underlying condition, based on information reported on the death certificate and using the international rules for selecting the underlying cause of death from the conditions stated on the death certificate. The conditions that are not selected as underlying cause of death constitute the nonunderlying cause of death, also known as multiple cause of death. Cause of death is coded according to the appropriate revision of the *International Classification of Diseases (ICD)*. Effective with deaths occurring in 1999, the United States began using the Tenth Revision of the ICD (ICD-10). Data from earlier time periods were coded using the appropriate revision of the ICD for that time period. Changes in classification of causes of death in successive revisions of the ICD may introduce discontinuities in cause-of-death statistics over time. These discontinuities are measured using comparability ratios. These measures of discontinuity are essential to the interpretation of mortality trends. For further discussion, see the “Mortality Technical Appendix” available at <http://www.cdc.gov/nchs/about/major/dvs/mortdata.htm>.⁶⁹ See also comparability ratio; International Classification of Diseases; Appendix I, National Vital Statistics System, Multiple Cause-of-Death File.⁷⁰

Cause-of-death ranking: The cause-of-death ranking for adults is based on the *List of 113 Selected Causes of Death*. The top-ranking causes determine the leading causes of death. Certain causes on the tabulation lists are not ranked if, for example, the category title represents a group title (such as “Major cardiovascular diseases” and “Symptoms, signs, and abnormal clinical and laboratory findings, not elsewhere classified”) or the category title begins with the words “Other” and “All other.” In addition when a title that represents a subtotal (such as “Malignant neoplasm”) is ranked,

its component parts are not ranked. Causes that are tied receive the same rank; the next cause is assigned the rank it would have received had the lower-ranked causes not been tied (i.e., they skip a rank).

Chronic disability: In the National Long Term Care Survey, individuals are considered chronically disabled if they have at least one ADL or one IADL limitation that is expected to last 90 days or longer or they are institutionalized.

Cigarette smoking: Information about cigarette smoking in the National Health Interview Survey is obtained for adults age 18 and over. Although there has been some variation in question wording, smokers continue to be defined as people who have ever smoked 100 cigarettes and currently smoke. Starting in 1993, current smokers are identified based on “yes” responses to the following two questions: “Have you smoked at least 100 cigarettes in your entire life?” and “Do you now smoke cigarettes every day, some days, or not at all?” (revised definition). People who smoked 100 cigarettes and who now smoke every day or some days are defined as current smokers. Before 1992, current smokers were identified based on positive responses to the following two questions: “Have you smoked at least 100 cigarettes in your entire life?” and “Do you smoke now?” (traditional definition). In 1992, cigarette smoking data were collected for a half-sample with half the respondents (a one-quarter sample) using the traditional smoking questions and the other half of respondents (a one-quarter sample) using the revised smoking question. An unpublished analysis of the 1992 traditional smoking measure revealed that the crude percentage of current smokers age 18 and over remained the same as 1991. The statistics reported for 1992 combined data collected using the traditional and the revised questions. The information obtained from the two smoking questions listed above is combined to create the variables represented in Tables 26a and 26b on pages 99 and 100.

Current smoker: There are two categories of current smokers: people who smoke every day and people who smoke only on some days.

Former smoker: This category includes people who have smoked at least 100 cigarettes in their lifetimes but currently do not smoke at all.

Nonsmoker: This category includes people who have never smoked at least 100 cigarettes in their lifetime.

Death rate: The death rate is calculated by dividing the number of deaths in a population in a year by the midyear resident population. For census years, rates are based on unrounded census counts of the resident population as of April 1. For the noncensus years of 1981–1989 and 1991, rates are based on national estimates of the resident population as of July 1, rounded to the nearest thousand. Starting in 1992, rates are based on unrounded national population estimates. Rates for the Hispanic and non-Hispanic white populations in each year are based on unrounded state population estimates for States in the Hispanic reporting area. Death rates are expressed as the number of deaths per 100,000 people. The rate may be restricted to deaths in specific age, race, sex, or geographic groups or from specific causes of death (specific rate), or it may be related to the entire population (crude rate).

Dental services: This category covers expenses for any type of dental care provider, including general dentists, dental hygienists, dental technicians, dental surgeons, orthodontists, endodontists, and periodontists.

Disability: See *Activities of daily living (ADLs)*, *Chronic disability*, and *Instrumental activities of daily living (IADLs)*.

Earnings: Earnings are considered money income reported in the Current Population Survey from wages or salaries and net income from self-employment (farm and nonfarm).

Emergency room services: This category includes expenses for visits to medical providers seen in emergency rooms (except visits resulting in a hospital admission). These expenses include payments for services covered under the basic facility charge and those for separately billed physician services.

Fee-for-service: This is the method of reimbursing health care providers on the basis of a fee for each health service provided to the insured person.

Formal care: In the National Long Term Care Survey formal care is defined as paid personal assistance provided to a person with a chronic disability living in the community. See *Informal care*.

Group quarters: The Census Bureau classifies all people not living in households as living in group quarters. There are two types of group quarters: institutional (e.g., correctional facilities, nursing homes, and mental hospitals) and noninstitutional (e.g., college dormitories, military barracks, group homes, missions, and shelters).

Head of household: In the Consumer Expenditure Survey head of household is defined as the first person mentioned when the respondent is asked to name the person or persons who own or rent the home in which the consumer unit resides.

In the Panel Study of Income Dynamics (within each wave of data), each family unit has only one current head of household (Head). Originally, if the family contained a husband-wife pair, the husband was arbitrarily designated the Head to conform with Census Bureau definitions in effect at the time the study began. The person designated as Head may change over time as a result of other changes affecting the family. When a new Head must be chosen, the following rules apply: The Head of the family unit must be at least 16 years old and the person with the most financial responsibility for the family unit. If this person is female and she has a husband in the family unit, then he is designated as Head. If she has a boyfriend with whom she has been living for at least 1 year, then he is Head. However, if the husband or boyfriend is incapacitated and unable to fulfill the functions of Head, then the family unit will have a female Head.

Health care expenditures: In the Consumer Expenditure Survey, health care expenditures include out-of-pocket expenditures for health insurance, medical services, prescription drugs, and medical supplies.

In the Medicare Current Beneficiary Survey, health care expenditures include all expenditures for inpatient hospital, medical, nursing home, outpatient, dental, prescription drugs, home health care, and hospice services, including both out-of-pocket expenditures and expenditures covered by insurance. Personal spending for health insurance premiums is excluded.

In the Medical Expenditure Panel Survey (MEPS) and the data used from the MEPS predecessor surveys used in this report, health care expenditures refers to payments for health care services provided during the year. (Data from the 1987 survey have been adjusted to permit comparability across years; see Zuvekas and Cohen.⁶⁴) Out-of-pocket health care expenditures are the sum of payments paid to health care providers by the person, or the person's family, for health care services provided during the year. Health care services include: inpatient hospital, hospital emergency room, and outpatient department care; dental services; office-based medical provider services; prescription drugs; home health care; and other medical equipment and services. Personal spending for health insurance premium(s) is excluded.

Health maintenance organization (HMO): An HMO is a prepaid health plan delivering comprehensive care to members through designated providers, having a fixed monthly payment for health care services, and requiring members to be in a plan for a specified period of time (usually 1 year).

Healthy weight: See *Body mass index (BMI)*.

Hispanic origin: See specific data source descriptions in Appendix B.

Home health care/services/visits: Home health care is care provided to individuals and families in their places of residence for promoting, maintaining, or restoring health or for minimizing the effects of disability and illness, including terminal illness.

In the Medicare Current Beneficiary Survey and Medicare claims data, home health care refers to home visits by professionals including nurses, doctors, social workers, therapists, and home health aides.

In the Medical Expenditure Panel Survey, home health care services are considered any care provided by home health agencies and independent home health providers.

Hospice care: Hospice care is a program of palliative and supportive care services providing physical, psychological, social, and spiritual care for dying persons, their families, and other loved ones by a hospice program or agency. Hospice services are available in home and inpatient settings.

Hospital inpatient services: These services include room and board and all hospital diagnostic and laboratory expenses associated with the basic facility charge, payments for separately billed physician inpatient services, and emergency room expenses incurred immediately prior to inpatient stays. Expenses for reported hospital stays with the same admission and discharge dates are also included.

Hospital outpatient services: These services include expenses for visits to both physicians and other medical providers seen in hospital outpatient departments, including payments for services covered under the basic facility charge and those for separately billed physician services.

Hospital stays: Hospital stays refer to admission to and discharge from a short-stay acute care hospital.

Housing expenditures: In the Consumer Expenditure Survey's Interview Survey, housing expenditures include payments for mortgage interest; property taxes; maintenance, repairs, insurance, and other expenses; rent; rent as pay (reduced or free rent for a unit as a form of pay); maintenance, insurance, and other expenses for renters; and utilities.

Incidence: Incidence is the number of cases of disease having their onset during a prescribed period of time. It is often expressed as a rate. For example, the incidence of measles per 1,000 children ages 5 to 15 during a specified year. Incidence is a measure of morbidity or other events that occur within a specified period of time. See *Prevalence*.

Income: In the Current Population Survey, income includes money income (prior to payments for personal income taxes, Social Security, union dues, Medicare deductions, etc.) from: (1) money wages or salary; (2) net income from nonfarm self-employment; (3) net income from farm self-employment; (4) Social Security or railroad retirement; (5) Supplemental Security Income; (6) public assistance or welfare payments; (7) interest (on savings or bonds); (8) dividends, income

from estates or trusts, or net rental income; (9) veterans' payment or unemployment and worker's compensation; (10) private pensions or government employee pensions; and (11) alimony or child support, regular contributions from persons not living in the household, and other periodic income. Certain money receipts such as capital gains are not included.

In the Medicare Current Beneficiary Study, income is for the sample person, or the sample person and spouse if the sample person was married at the time of the survey. All sources of income from jobs, pensions, Social Security benefits, Railroad Retirement and other retirement income, Supplemental Security Income, interest, dividends, and other income sources are included.

Income categories: Two income categories were used to examine out-of-pocket health care expenditures using the MEPS and MEPS predecessor survey data. The categories were expressed in terms of poverty status (i.e., the ratio of the family's income to the Federal poverty thresholds for the corresponding year), which controls for the size of the family and the age of the head of the family. The income categories were (1) Poor and near poor and (2) Other income.

Poor and near poor income category includes people in families with income less than 100 percent of the poverty line, including those whose losses exceeded their earnings, resulting in negative income (i.e., the poor), as well as people in families with income from 100 percent to less than 125 percent of the poverty line (i.e., the near poor).

Other income category includes people in families with income greater than or equal to 125 percent of the poverty line. See *Income, household*.

Income, household: Household income from the Medical Expenditure Panel Survey and the MEPS predecessor surveys used in this report was created by summing personal income from each household member to create family income. Family income was then divided by the number of persons that lived in the household during the year to create per capita household income. Potential income sources asked about in the survey interviews include annual earnings from wages, salaries, withdrawals; Social Security and VA payments; Supplemental Security Income and cash welfare payments from public assistance; Temporary Assistance for Needy Families, formerly known as Aid to Families with Dependent Children (AFDC); gains or losses from estates, trusts, partnerships, C corporations, rent, and royalties; and a small amount of other income. See *Income categories*.

Income fifths: A population can be divided into groups with equal numbers of people based on the size of their income to show how the population differs on a characteristic at various income levels. Income fifths are five groups of equal size, ordered from lowest to highest income.

Informal care: In the National Long Term Care Survey, informal care is unpaid personal assistance provided to a person with a chronic disability living in the community. See *Formal care*.

Inpatient hospital: This category includes costs of room and board and all ancillary services associated with a hospital stay. It does not include costs of emergency room services or of separately billed physician services provided during the stay.

Institutions: The U.S. Census Bureau defines institutions as correctional institutions; nursing homes; psychiatric hospitals; hospitals or wards for chronically ill or for the treatment of substance abuse; schools, hospitals or wards for the mentally retarded or physically handicapped; and homes, schools, and other institutional settings providing care for children.⁵⁹ See *Population*.

Institutionalized population: See *Population*.

Instrumental activities of daily living (IADLs): IADLs are indicators of functional well-being that measure the ability to perform more complex tasks than the related activities of daily living (ADLs). See *Activities of daily living (ADLs)*.

In the National Long Term Care Survey, IADLs include light housework, laundry, meal preparation, grocery shopping, getting around outside, managing money, taking medications, and telephoning. Individuals are considered to have an IADL disability if they report using equipment to perform the activity or not performing the activity at all because of their health or a disability.

In the Medicare Current Beneficiary Survey, IADLs include difficulty performing (or inability to perform because of a health reason) the following activities: heavy housework, light housework, preparing meals, using a telephone, managing money, and shopping.

Long-term care facility: In the Medicare Current Beneficiary Survey, a long-term care facility: (1) is a residence certified by Medicare or Medicaid; or (2) has 3 or more beds and is licensed as a nursing home or other long-term care facility and provides at least one personal care service; or (3) provides 24-hour, 7 day-a-week supervision by a caregiver. See *Nursing home*.

Mammography: Mammography is an x-ray image of the breast used to detect irregularities in breast tissue.

Mean: The mean is an average of n numbers computed by adding the numbers and dividing by n .

Median: The median is a measure of central tendency, the point on the scale that divides a group into two parts.

Medicaid: This nationwide health insurance program is operated and administered by the States, with Federal financial participation. Within certain broad, Federally determined guidelines, States decide: who is eligible; the amount, duration, and scope of services covered; rates of payment for providers; and methods of administering the program. Medicaid pays for health care services, including nursing home care, for certain low income people. Medicaid does not cover all low-income people in every State. The program was authorized in 1965 by Title XIX of the Social Security Act.

Medicare: This nationwide program provides health insurance to people age 65 or older, people entitled to Social Security disability payments for 2 years or more, and people with end-stage renal disease, regardless of income. The program was enacted July 30, 1965, as Title XVIII, Health Insurance for the Aged of the Social Security Act, and became effective on July 1, 1966. Medicare covers acute care services and generally does not cover nursing homes or prescription drugs. Prescription drug coverage will begin in 2006.

Medicare Part A: Medicare Part A (Hospital Insurance) covers inpatient care in hospitals, critical access hospitals, and skilled nursing facilities (not custodial or long-term care). It also covers hospice and some home health care.

Medicare Part B: Medicare Part B (Medical Insurance) covers doctor's services, outpatient hospital care, and durable medical equipment. It also covers some other medical services that Medicare Part A does not cover, such as physical and occupational therapy and some home health care. Medicare Part B also pays for some supplies when they are medically necessary.

Medigap: See *Supplemental health insurance*.

National population adjustment matrix: The national population adjustment matrix adjusts the population to account for net underenumeration. Details on this matrix can be found on the U.S. Census Bureau Web site: <http://www.census.gov/population/www/censusdata/adjustment.html>.

Nursing home: In the National Nursing Home Survey, a nursing home is a facility with three or more beds that provides either nursing care or personal care (such as help with bathing, correspondence, walking, eating, using the toilet, or dressing) and/or supervision over such activities as money management, ambulation, and shopping. Facilities providing care solely to the mentally retarded and mentally ill are excluded. Facilities may be certified by Medicare or Medicaid, or both, or not certified but licensed by the State as a nursing home. These facilities may be freestanding or nursing care units of hospitals, retirement centers, or similar institutions where the unit maintained financial and resident records separate from those of the larger institutions. See *Long-term care facility*.

Obesity: See *Body mass index (BMI)*.

Office-based medical provider services: This category includes expenses for visits to medical providers seen in office-based settings or clinics.

Other health care: In the Medical Expenditure Panel Survey, other health care includes home health services (care provided by home health agencies and independent home health providers) and other medical equipment and services. The latter includes expenses for eyeglasses, contact lenses, ambulance services, orthopedic items, hearing devices, prostheses, bathroom aids, medical equipment, disposable supplies, alterations/modifications, and other miscellaneous items or services that were obtained, purchased, or rented during the year.

Other income: Other income is total income minus retirement benefits, earnings, asset income, and public assistance. It includes, but is not limited to, unemployment compensation, worker's compensation, alimony, and child support.

Out-of-pocket costs: These are costs that are not covered by insurance.

Overweight: See *Body mass index (BMI)*.

Pensions: Pensions include money income reported in the Current Population Survey from railroad retirement, company or union pensions, including profit sharing and 401(k) payments, IRAs, Keoghs, regular payments from annuities and paid-up life insurance policies, Federal government pensions, U.S. military pensions, and State or local government pensions.

Performance-based measures: In performance-based measures, a respondent attempts certain tasks or movements while ability is objectively assessed by a test administrator. These objective assessments are generally measured along a continuum in terms of speed, repetition, or capacity and normally are linked with a specific ability necessary for functioning in old age. Performance assessments can be categorized as measuring either the upper or lower body, and then further organized in terms of the specific function being assessed, such as mobility, range of motion, strength, balance, or gait speed.⁷¹

Personal assistance: In the National Long Term Care Survey, personal assistance refers to paid or unpaid assistance provided to a person with a chronic disability living in the community.

Physician/Medical: This category includes physician visits and consultations, lab tests, durable medical equipment, and medical supplies.

Physician/Outpatient hospital: This term refers to physician visits and consultations and hospital outpatient services.

Physician visits and consultations: In Medicare claims data, physician visits and consultations include visits and consultations with primary care physicians, specialists, and chiropractors in their offices, hospitals (inpatient and outpatient), emergency rooms, patient homes, and nursing homes.

Population: Data on populations in the United States are often collected and published according to several different definitions. Various statistical systems then use the appropriate population for calculating rates.

Resident population: The resident population of the United States includes people resident in the 50 States and the District of Columbia. It excludes residents of the Commonwealth of Puerto Rico and residents of the outlying areas under United States sovereignty or jurisdiction (principally American Samoa, Guam, Virgin Islands of the United States, and the Commonwealth of the Northern Mariana Islands). The definition of residence conforms to the criterion used in the Census 2000, which defines a resident of a specified area as a person "...usually resident" in that area. The resident population includes people resident in a nursing home and other types of institutional settings, but excludes the United States Armed Forces overseas, as well as civilian United States citizens whose usual place of residence is outside the United States. As defined in "Indicator 6: Older Veterans," the resident population includes Puerto Rico.

Resident noninstitutionalized population: The resident noninstitutionalized population is the resident population not residing in institutions. Institutions, as defined by the Census Bureau, include correctional institutions; nursing homes; psychiatric hospitals; hospitals or wards for chronically ill or for the treatment of substance abuse; homes and schools, hospitals or wards for the mentally retarded or physically handicapped; and homes, schools, and other institutional settings providing care for children. People living in noninstitutionalized group quarters are part of the resident noninstitutionalized population. Noninstitutionalized group quarters include group homes (i.e., community-based homes that provide care and supportive services); residential facilities "providing protective oversight ... to people with disabilities"; worker and college dormitories; military and religious quarters; and emergency and transitional shelters with sleeping facilities.⁵⁹

Civilian population: The civilian population is the United States resident population not in the active duty Armed Forces.

Civilian noninstitutionalized population: The civilian noninstitutionalized population is the civilian population not residing in institutions. Institutions, as defined by the Census Bureau, include correctional institutions; nursing homes; psychiatric hospitals; hospitals or wards for chronically ill or for the treatment of substance abuse; schools, hospitals or wards for the mentally retarded or physically handicapped; and homes, schools, and other institutional settings providing care for children. Civilians living in noninstitutionalized group quarters are part of the civilian noninstitutionalized population. Noninstitutionalized group quarters include group homes (i.e., "community based homes that provide care and supportive services"); residential facilities "providing protective oversight ... to people with disabilities"; worker and college dormitories; religious quarters; and emergency and transitional shelters with sleeping facilities.⁵⁹

Institutionalized population: The institutionalized population is the population residing in correctional institutions; nursing homes; psychiatric hospitals; hospitals or wards for chronically ill or for the treatment of substance abuse; schools, hospitals or wards for the mentally retarded or physically handicapped; and homes, schools, and other institutional settings providing care for children. People living in noninstitutionalized group quarters are part of the noninstitutionalized population. Noninstitutionalized group quarters include group homes (i.e., "community based homes that provide care and supportive services"); residential facilities "providing protective oversight ... to people with disabilities"; worker and college dormitories; military and religious quarters; and emergency and transitional shelters with sleeping facilities.⁵⁹

Poverty: The official measure of poverty is computed each year by the U.S. Census Bureau and is defined as being less than 100 percent of the poverty threshold (i.e., \$8,628 for one person age 65 and over in 2002).⁷² Poverty thresholds are the dollar amounts used to determine poverty status. Each family (including single-person households) is assigned a poverty threshold based upon the family's income, size of the family, and ages of the family members. All family members have the same poverty status. Several of the indicators included in this report include a poverty status measure. Poverty status (less than 100 percent of the poverty threshold) was computed for "Indicator 7: Poverty," "Indicator 16: Sensory Impairments and Oral Health," "Indicator 22: Mammography," and "Indicator 23: Dietary Quality" using the official U.S. Census Bureau definition for the corresponding year.

In addition, the following above-poverty categories are used in this report.

Indicator 8: Income: The income categories are derived from the ratio of the family's income (or an unrelated individual's income) to the poverty threshold. Being in poverty is measured as income less than 100 percent of the poverty threshold. Low income is between 100 percent and 199 percent of the poverty threshold (i.e., \$8,628 and \$17,255 for one person age 65 and over in 2002). Middle income is between 200 percent and 399 percent of the poverty threshold (i.e., between \$17,256 and \$34,511 for one person age 65 and over in 2002). High income is 400 percent or more of the poverty threshold.

Indicator 31: Sources of Health Insurance: Below poverty is defined as less than 100 percent of the poverty threshold. Above poverty is grouped into two categories: (1) 100 percent to less than 200 percent of the poverty threshold and (2) 200 percent of the poverty threshold or greater.

Indicator 34: Out-of-Pocket Health Care Expenditures: Below poverty is defined as less than 100 percent of the poverty threshold. People are classified into the poor/near poor income category if the person's household income is below 125 percent of the poverty level. People are classified into the other income category if the person's household income is equal to or greater than 125 percent of the poverty level.

Prescription drugs/medicines: In the Medicare Current Beneficiary Survey, prescription drugs are all prescription medications (including refills) except those provided by the doctor or practitioner as samples and those provided in an inpatient setting.

In the Medical Expenditure Panel Survey, prescription medicines include all prescribed medications initially purchased or otherwise obtained during the year, as well as any refills.

Prevalence: Prevalence is the number of cases of a disease, infected people, or people with some other attribute present during a particular interval of time. It is often expressed as a rate (e.g., the prevalence of diabetes per 1,000 people during a year). See *Incidence*.

Private supplemental health insurance: See *Supplemental health insurance*.

Public assistance: Public assistance is money income reported in the Current Population Survey from Supplemental Security Income (payments made to low-income persons who are age 65 or older, blind, or disabled) and public assistance or welfare payments, such as Temporary Assistance for Needy Families and General Assistance.

Quintiles: See *Income fifths*.

Race: See specific data source descriptions in Appendix B.

Rate: A rate is a measure of some event, disease, or condition in relation to a unit of population, along with some specification of time.

Reference population: The reference population is the base population from which a sample is drawn at the time of initial sampling. See *Population*.

Respondent-assessed health status: In the National Health Interview Survey, respondent-assessed health status is measured by asking the respondent, “Would you say [your/subject name’s] health is excellent, very good, good, fair, or poor?”

Short-term institution: This category includes skilled nursing facility stays and other short-term (non-hospital) facility stays.

Skilled nursing facility: This type of facility provides short-term skilled nursing care on an inpatient basis, following hospitalization. These facilities provide the most intensive care available outside of a hospital.

Social Security benefits: Social Security benefits include money income reported in the Current Population Survey from Social Security old-age, disability, and survivors’ benefits.

Standard population: A population in which the age and sex composition is known precisely, as a result of a census. A standard population is used as a comparison group in the procedure for standardizing mortality rates.

Supplemental health insurance: Supplemental health insurance is designed to fill gaps in the original Medicare plan coverage by paying some of the amounts that Medicare does not pay for covered services and may pay for certain services not covered by Medicare. Private Medigap is supplemental insurance individuals purchase themselves or through organizations such as AARP or other professional organizations and does not include HMOs, Medicaid, or employer-sponsored plans. Employer or union-sponsored supplemental insurance policies are provided through a Medicare enrollee’s former employer or union. Some Medicare beneficiaries enroll in HMOs and other managed care plans that provide many of the benefits of supplemental insurance, such as low copayments and coverage of services that Medicare does not cover.

TRICARE: TRICARE is the Department of Defense’s regionally managed health care program for active duty and retired members of the uniformed services, their families, and survivors.

TRICARE for Life: TRICARE for Life is TRICARE’s Medicare wraparound coverage (similar to traditional Medigap coverage) for Medicare-eligible uniformed services beneficiaries and their eligible family members and survivors.

Underweight: See *Body mass index (BMI)*.

Veteran: Veterans include those who served on active duty in the Army, Navy, Air Force, Marines, Coast Guard, uniformed Public Health Service, or uniformed National Oceanic and Atmospheric Administration; Reserve Force and National Guard called to Federal active duty; and those disabled while on active duty training. Excluded are those dishonorably discharged and those whose only active duty was for training or State National Guard service.

Vignette: A vignette is a description of a concrete level of ability on a given domain that individuals are asked to evaluate using the same question and response scale as the self-report question on that domain.

The Historical Experience of Three Cohorts of Older Americans: A Timeline of Selected Events

			1919 Cohort	Year	Event
			Born	1919	Influenza pandemic ends/Treaty of Versailles Women can vote
			5 years old	1920	
				1924	Stock market crashes
			Born	1929	
			5 years old	1934	Social Security Act
			15 years old	1935	
				1939	Pearl Harbor/U.S. enters WWII
			Born	1939	
			5 years old	1941	Baby Boom begins
			15 years old	1944	
			25 years old	1946	U.S. enters Korean War
				1949	
				1950	Polio vaccine Women age 62-64 eligible for reduced Social Security benefits Social Security Disability Insurance implemented
			15 years old	1954	
			25 years old	1955	Men age 62-64 eligible for reduced Social Security benefits Self-Employed Individual Retirement Act (Keogh Act)
			35 years old	1956	
				1957	U.S. enters Vietnam War; Civil Rights Act; Baby Boom ends Medicare and Medicaid established
			25 years old	1959	
				1961	First man on the moon
			35 years old	1962	
			45 years old	1964	Formula for Social Security cost-of-living adjustment established Social Security Supplemental Security Income implemented IRAs established
				1965	
				1969	Age Discrimination Act
			35 years old	1972	
			45 years old	1973	401(k)s established
			55 years old	1974	
				1975	Social Security eligibility age increased for full benefits Widows entitled to pension benefits if spouse was vested
			45 years old	1978	
			55 years old	1979	Mandatory retirement eliminated for most workers
				1983	
			65 years old	1984	Berlin Wall falls Americans with Disabilities Act
				1986	
				1989	Medicare payment policies changed by Balanced Budget Act
			55 years old	1990	
			65 years old	1994	Social Security earnings test eliminated for full retirement age September 11
			75 years old	1997	
				1999	Medicare prescription drug benefit passed
			65 years old	2000	
			75 years old	2001	
			85 years old	2003	
				2004	