Older Americans 2010

Key Indicators of Well-Being

FEDERAL INTERAGENCY FORUM ON AGING RELATED STATISTICS

The Federal Interagency Forum on Aging-Related Statistics

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. Forum agencies as of July 2010 are listed below.

Department of Commerce
U.S. Census Bureau
http://www.census.gov

Department of Health and Human Services
Administration on Aging
http://www.aoa.gov

Agency for Healthcare Research and Quality
http://www.ahrq.gov

Centers for Medicare and Medicaid Services
http://www.cms.hhs.gov

National Center for Health Statistics
http://www.cdc.gov/nchs

National Institute on Aging
http://www.nia.nih.gov

Office of the Assistant Secretary for Planning and Evaluation
http://www.aspe.hhs.gov

Substance Abuse and Mental Health Services Administration
http://www.samhsa.gov

Department of Housing and Urban Development
http://www.hud.gov

Department of Labor
Bureau of Labor Statistics
http://www.bls.gov

Employee Benefits Security Adminstration
http://www.dol.gov/ebsa

Department of Veterans Affairs
http://www.va.gov

Environmental Protection Agency
http://www.epa.gov

Office of Management and Budget
Office of Statistical and Science Policy
http://www.whitehouse.gov/omb/inforeg/statpolicy.html

Social Security Administration
Office of Research, Evaluation, and Statistics
http://www.ssa.gov

Report availability: Single copies of this report are available at no charge through the National Center for Health Statistics while supplies last. Requests may be sent to the Information Dissemination Staff, National Center for Health Statistics, 3311 Toledo Road, Room 5412, Hyattsville, MD 20782. Copies may also be ordered by calling 1–866–441–NCHS (6247) or by e-mailing nchsquery@cdc.gov. This report is also available on the World Wide Web at http://www.agingstats.gov.

OLDER AMERICANS 2010

Key Indicators of Well-Being

Foreword

Americans age 65 and over are an important and growing segment of our population. Many federal agencies provide data on aspects of older Americans' lives, but it can be difficult to fit the pieces together. Thus, it has become increasingly important for policymakers and the general public to have an accessible, easy-to-understand portrait that shows how older Americans are faring.

Older Americans 2010: Key Indicators of Well-Being (Older Americans 2010) provides a comprehensive picture of our older population's health and well-being. It is the fifth chartbook prepared by the Federal Interagency Forum on Aging-Related Statistics (Forum), which now has 15 participating federal agencies. As with the earlier volumes, readers will find here an accessible compendium of indicators drawn from the most reliable official statistics. The indicators are again categorized into five broad groups: population, economics, health status, health risks and behaviors, and health care.

Many of the estimates reported in *Older Americans 2010* were collected in 2007 and 2008, the years straddling the large-scale financial downturn that began in December 2007. Thus, although this was an economically challenging time, the data reported in *Older Americans 2010* do not in all cases reflect this crisis. The Forum did produce a short report, *Data Sources on the Impact of the 2008 Financial Crisis on the Economic Well-being of Older Americans* at the end of 2009 that provides information about data sources that may shed light on the effects of the economic downturn on the well-being of older Americans.

While federal agencies currently collect and report substantial information on the population age 65 and over, there remain gaps in our knowledge. Two years ago, in *Older Americans 2008*, the Forum identified six data need areas: caregiving, elder abuse, functioning and disability, mental health, pension measures, and residential care. In *Older Americans 2010*, we provide updated information on the status of data availability for those specific areas and add a new call for data on end-of-life issues. We continue to appreciate users' requests for greater detail for many existing indicators of well-being. The Forum encourages extending age reporting categories, oversampling older racial and ethnic populations, collecting data at lower levels of geography, and including the institutionalized population in national surveys. By displaying what we know and do not know, this report challenges federal statistical agencies to do even better.

The *Older Americans* reports reflect the Forum's commitment to advancing our understanding of where older Americans stand today and what they may face tomorrow. I congratulate the Forum agencies for joining together to enhance their work and present the American people with a valuable tool. 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.

We invite you to suggest ways in which we can enhance this biennial portrait of older Americans. Please send comments to us at the Forum's website (http://www.agingstats.gov). I hope that our compendium will continue to be useful in your work.

Katherine K. Wallman
Chief Statistician
Office of Management and Budget

Acknowledgments

Older Americans 2010: 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, which include Edwin L. Walker, Administration on Aging (AoA); Steven B. Cohen, Agency for Healthcare Research and Quality (AHRQ); Thomas Nardone, Bureau of Labor Statistics (BLS); Howard Hogan, U.S. Census Bureau; Thomas Reilly, Centers for Medicare and Medicaid Services (CMS); Raphael W. Bostic, Department of Housing and Urban Development (HUD); Joseph Piacentini, Employee Benefits Security Administration (EBSA); Peter Grevatt, Environmental Protection Agency (EPA); Edward Sondik, National Center for Health Statistics (NCHS); Richard Suzman, National Institute on Aging (NIA); Ruth Katz, Office of the Assistant Secretary for Planning and Evaluation (ASPE), Department of Health and Human Services; Katherine K. Wallman, Office of Management and Budget (OMB); Daryl Kade, Substance Abuse and Mental Health Services Administration (SAMHSA); Manuel de la Puente, Social Security Administration (SSA); and Dat Tran, Department of Veterans Affairs (VA).

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The Forum's planning committee members include Saadia Greenberg, AoA; David Kashihara and D.E.B. Potter, AHRQ; Emy Sok, BLS; Amy Symens Smith and Wan He, U.S. Census Bureau; Gerald Riley, CMS; Meena Bavan and Cheryl Levine, HUD; Miranda Moore and Daniel Puskin, EBSA; Kathy Sykes, EPA; Ellen Kramarow and Julie Dawson Weeks, NCHS; Elizabeth Hamilton, NIA; Helen Zayac Lamont, ASPE; Rochelle Wilkie Martinez, OMB; Ingrid Goldstrom, Beth Han, and Jennifer Solomon, SAMHSA; Howard Iams, SSA; Dorothy Glasgow and Cathy Tomczak, VA; and the Forum's Staff Director, Elena M. Fazio.

In addition to the 15 agencies of the Forum, the Department of Agriculture (USDA) was invited to contribute to this report. The Forum greatly appreciates the efforts of Patricia Guenther, Hazel Hiza, and Kellie O'Connell, Center for Nutrition Policy and Promotion, USDA, in providing valuable information from their agency.

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About this Report

Introduction

Older Americans 2010: Key Indicators of Well-Being (Older Americans 2010) is the fifth 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. Once again, this report uses data from over a dozen national data sources to construct broad indicators of well-being for the older population and to monitor changes in these indicators over time. By following these data trends, more accessible information will be available to target efforts to improve the lives of older Americans.

With the exception of the indicator on nursing home utilization, for which new data are not available at this time, all indicators from the last edition reappear in *Older Americans 2010*. 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 2010 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 the following:

- 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 2010 presents 37 key indicators that measure critical aspects of older people's lives. The Forum chose these indicators because they meet the following criteria:

- 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 2010 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.

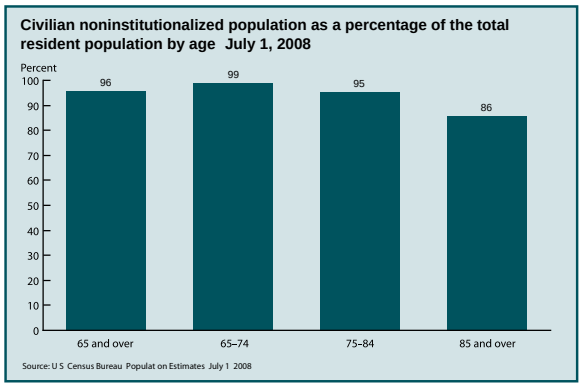
Data availability and analytical relevance may affect the specific age groups that are included for an indicator. For example, because of small sample sizes in some surveys, statistically reliable data for the population age 85 and over often are not available. Conversely, data from the population younger 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.

To standardize the age distribution of the 65 and over population across years, some estimates have been age adjusted by multiplying age-specific rates by age-specific weights. If an indicator has been age adjusted, it will be stated in the note under the chart(s) as well as under the corresponding table(s) in Appendix A.

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

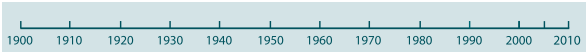
Updated indicators in *Older Americans 2010* are not always comparable to indicators in *Older Americans 2000, 2004, Update 2006,* or *Older Americans 2008*. The replication of certain indicators with updated data is sometimes difficult because of changes in data sources, definitions, questionnaires, and/or reporting categories. A comparability table is available on the Forum's website 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 2008, only 86 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 estimates 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 differences that are statistically significant at the 0.05 level 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 website 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 website 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 66). 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 2010* 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 63).

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 2010* or other Forum activities, contact:

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Website: http://www.agingstats.gov

Older Americans on the Internet

Supporting material for this report can be found at http://www.agingstats.gov. The website contains the following:

- Data for all of the indicators in Excel spreadsheets (with standard errors, when available).
- Data source descriptions.
- PowerPoint slides of the charts.
- A comparability table explaining the changes to the indicators that have taken place between *Older Americans 2000, 2004, Update 2006, Older Americans 2008, and Older Americans 2010*.

The Forum's website also provides:

- Ongoing federal data resources relevant to the study of the aging.
- Links to aging-related statistical information on Forum member websites.
- Other Forum publications (including *Data Sources on Older Americans 2009*).
- Workshop presentations, papers, and reports.
- Agency contacts.
- Subject area contact list for federal statistics.
- Information about the Forum.

Additional Online Resources

Administration on Aging
Statistics on the Aging Population
http://www.aoa.gov/AoARoot/Aging_Statistics/index.aspx

A Profile of Older Americans
http://www.aoa.gov/AoARoot/Aging_Statistics/Profile/index.aspx

Online Statistical Data on the Aging
http://www.aoa.gov/AoARoot/Aging_Statistics/Census_Population/census1990/Introduction.aspx

Agency for Healthcare Research and Quality
AHRQ Data and Surveys
http://www.ahrq.gov/data

Bureau of Labor Statistics
Bureau of Labor Statistics Data
http://www.stats.bls.gov/data

U.S. Census Bureau
Statistical Abstract of the United States
http://www.census.gov/compendia/statab

Age Data
http://www.census.gov/population/www/socdemo/age.html

Longitudinal Employer-Household Dynamics
http://lehd.did.census.gov/led/

Centers for Medicare and Medicaid Services
CMS Data and Statistics
http://www.cms.hhs.gov/home/rsds.asp

Department of Housing and Urban Development
Policy Development and Research Information Services
http://www.huduser.org/

Department of Veterans Affairs
Veteran Data and Information
http://www1.va.gov/vetdata

Employee Benefit Security Administration
EBSA's Research
http://www.dol.gov/ebsa/publications/research.html

Environmental Protection Agency
Aging Initiative
http://www.epa.gov/aging

Information Resources
http://www.epa.gov/aging/resources/index.htm

National Center for Health Statistics
Health Data Interactive
http://www.cdc.gov/nchs/hdi.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://www.agingcenters.org/

National Archive of Computerized Data on Aging
http://www.icpsr.umich.edu/NACDA

Publicly Available Datasets for Aging-Related Secondary Analysis
http://www.nia.nih.gov/researchinformation/scientificresources

Office of the Assistant Secretary for Planning and Evaluation, HHS
Office of Disability, Aging, and Long-Term Care Policy http://www.aspe.hhs.gov/_/office_specific/daltcp.cfm

Office of Management and Budget
Federal Committee on Statistical Methodology
http://www.fcsm.gov

Social Security Administration
Social Security Administration Statistical Information
http://www.ssa.gov/policy

Substance Abuse and Mental Health Services Administration
Office of Applied Studies
http://www.oas.samhsa.gov

Center for Mental Health Services
http://www.mentalhealth.samhsa.gov/cmhs/MentalHealthStatistics

Other Resources
FedStats.gov
http://www.fedstats.gov

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Highlights

Older Americans 2010: Key Indicators of Well-Being is one in a series of periodic reports to the Nation on the condition of older adults in the United States. The indicators assembled in this chartbook show the results of decades of progress. Older Americans are living longer and enjoying greater prosperity than any previous generation. Despite these advances, inequalities between the sexes and among income groups and racial and ethnic groups continue to exist. 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. In this report, 37 indicators depict the well-being of older Americans in the areas of demographic characteristics, economic circumstances, overall health status, health risks and behaviors, and cost and use of health care services. Selected highlights from each section of the report follow.

Population

The demographics of aging continue to change dramatically. The older population is growing rapidly, and the aging of the baby boomers, born between 1946 and 1964 (and who begin turning age 65 in 2011), will accelerate this growth. This larger population of older Americans will be more racially diverse and better educated than previous generations. Another significant trend is the increase in the proportion of men age 85 and over who are veterans.

- In 2008, there were an estimated 39 million people age 65 and over in the United States, accounting for just over 13 percent of the total population. The older population in 2030 is expected to be twice as large as in 2000, growing from 35 million to 72 million and representing nearly 20 percent of the total U.S. population. (See "Indicator 1: Number of Older Americans.")

- In 1965, 24 percent of the older population had graduated from high school, and only 5 percent had at least a bachelor's degree. By 2008, 77 percent were high school graduates or more, and 21 percent had a bachelor's degree or more. (See "Indicator 4: Educational Attainment.")

- The number of men age 85 and over who are veterans is projected to increase from 400,000 in 2000 to almost 1.2 million by 2010. The proportion of men age 85 and over who are veterans is projected to increase from 33 percent in 2000 to 66 percent in 2010. (See "Indicator 6: Older Veterans.")

Economics

Most older people are enjoying greater prosperity than any previous generation. There has been an increase in the proportion of older people in the high-income group and a decrease in the proportion of older people living in poverty, as well as a decrease in the proportion of older people in the low-income group just above the poverty line. Among older Americans, the share of aggregate income coming from earnings has increased since the mid-1980s, partly because more older people, especially women, continue to work past age 55. Finally, on average, net worth has increased almost 80 percent for older Americans over the past 20 years. Yet major inequalities continue to exist with older blacks and people without high school diplomas reporting smaller economic gains and fewer financial resources overall.

- Between 1974 and 2007, there was a decrease in the proportion of older people with income below poverty from 15 percent to 10 percent and with low income from 35 percent to 26 percent; and an increase in the proportion of people with high income from 18 percent to 31 percent. (See "Indicator 8: Income.")

- In 2007, the median net worth of households headed by white people age 65 and over ($280,000) was six times that of older black households ($46,000). This difference is less than in 2003 when the median net worth of households headed by older white people was eight times higher than that of households headed by older black people. (See "Indicator 10: Net Worth.") The large increase in net worth in past years may not continue into the future due to recent declines in housing values.

- Labor force participation rates have risen among all women age 55 and over during the past four decades. As new cohorts of baby boom women approach older ages they are participating in the labor force at higher rates than previous

generations. Labor force participation rates among men age 55 and over have gradually begun to increase after a steady decline from the early 1960s to the mid-1990s. (See "Indicator 11: Participation in the Labor Force.")

Health Status

Americans are living longer than ever before, yet their life expectancies lag behind those of other developed nations. Older age is often accompanied by increased risk of certain diseases and disorders. Large proportions of older Americans report a variety of chronic health conditions such as hypertension and arthritis. Despite these and other conditions, the rate of functional limitations among older people has declined in recent years.

- Life expectancy at age 65 in the United States is lower than that of many other industrialized nations. In 2005, women age 65 in Japan could expect to live on average 3.7 years longer than women in the United States. Among men, the difference was 1.3 years. (See "Indicator 14: Life Expectancy.")

- The prevalence of certain chronic conditions differs by sex. Women report higher levels of arthritis (55 percent versus 42 percent) than men. Men report higher levels of heart disease (38 percent versus 27 percent) and cancer (24 percent versus 21 percent). (See "Indicator 16: Chronic Health Conditions.")

- Between 1992 and 2007, the age-adjusted proportion of people age 65 and over with a functional limitation declined from 49 percent to 42 percent. (See "Indicator 20: Functional Limitations.")

Health Risks and Behaviors

Social and lifestyle factors can affect the health and well-being of older Americans. These factors include preventive behaviors such as cancer screenings and vaccinations along with diet, physical activity, obesity, and cigarette smoking. Health and well-being are also affected by the quality of the air where people live and by the time they spend socializing and communicating with others. Many of these health risks and behaviors have shown long-term improvements, even though recent estimates indicate no significant changes.

- There was no significant change in the percentage of people age 65 and over reporting physical activity between 1997 and 2008. (See "Indicator 24: Physical Activity.")

- As with other age groups, the percentage of people age 65 and over who are obese has increased since 1988–1994. In 2007–2008, 32 percent of people age 65 and over were obese, compared with 22 percent in 1988–1994. However, over the past several years, the trend has leveled off, with no statistically significant change in obesity for older men or women between 1999–2000 and 2007–2008. (See "Indicator 25: Obesity.")

- The percentage of people age 65 and over living in counties that experienced poor air quality for any air pollutant decreased from 52 percent in 2000 to 36 percent in 2008. (See "Indicator 27: Air Quality.")

- The proportion of leisure time that older Americans spent socializing and communicating—such as visiting friends or attending or hosting social events—declined with age. For Americans age 55–64, 13 percent of leisure time was spent socializing and communicating compared with 8 percent for those age 75 and over. (See "Indicator 28: Use of Time.")

Health Care

Overall, health care costs have risen dramatically for older Americans. In addition, between 1992 and 2006, the percentage of health care costs going to prescription drugs almost doubled from 8 percent to 16 percent, with prescription drugs accounting for a large percentage of out-of-pocket health care spending. To help ease the burden of prescription drug costs, Medicare Part D prescription drug costs, began in January 2006.

- After adjustment for inflation, health care costs increased significantly among older Americans from $9,224 in 1992 to $15,081 in 2006. (See "Indicator 30: Health Care Expenditures.")

- From 1977 to 2006, the percentage of household income that people age 65 and over allocated to out-of-pocket spending for health care services increased among those in the poor/near poor income category from 12 percent to 28 percent. (See "Indicator 33: Out-of-Pocket Health Care Expenditures.")

- The number of Medicare beneficiaries enrolled in Part D prescription drug plans increased from 18.2 million (51 percent of beneficiaries) in June 2006 to 22.2 million (57 percent of beneficiaries) in December 2009. In December 2009, 61 percent of plan enrollees were in stand-alone plans and 39 percent were in Medicare Advantage plans. In addition, approximately 6.2 million beneficiaries were covered by the Retiree Drug Subsidy (See "Indicator 31: Prescription Drugs.")

Population

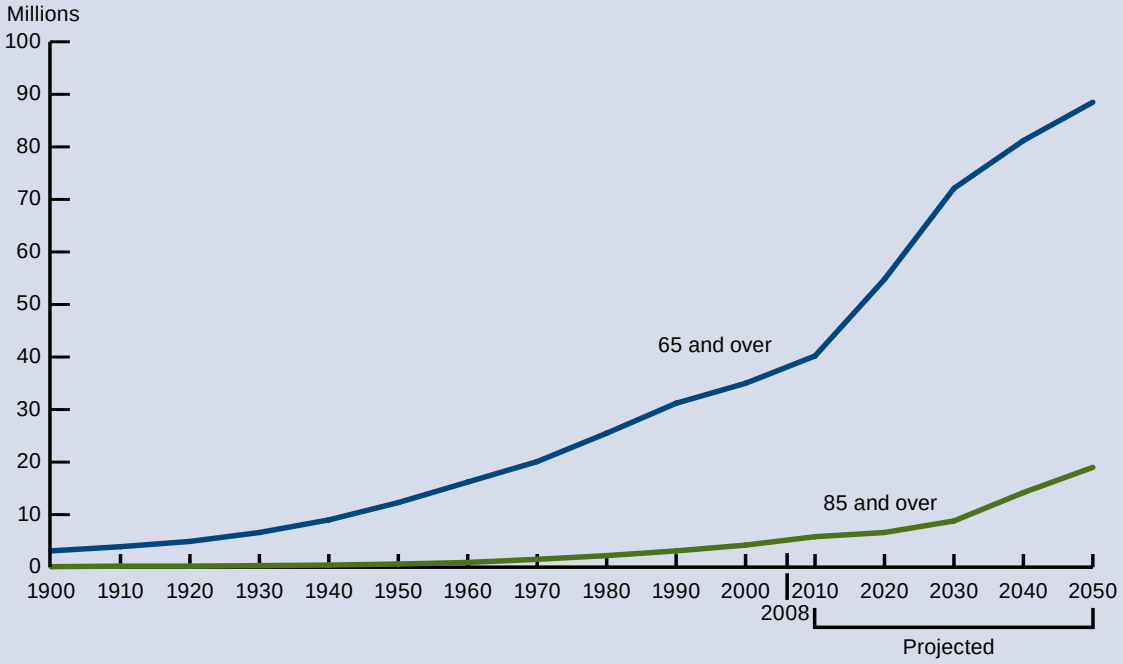
Indicator 1: **Number of Older Americans**
Indicator 2: **Racial and Ethnic Composition**
Indicator 3: **Marital Status**
Indicator 4: **Educational Attainment**
Indicator 5: **Living Arrangements**
Indicator 6: **Older Veterans**

INDICATOR 1

Number of Older Americans

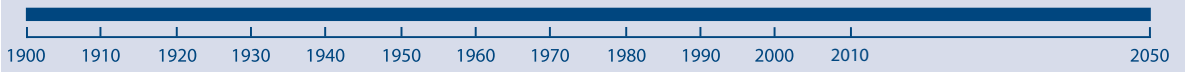
The growth of the population age 65 and over affects many aspects of our society, challenging policymakers, families, businesses, and health care providers, among others, to meet the needs of aging individuals.

Population age 65 and over and age 85 and over, selected years 1900–2008 and projected 2010–2050



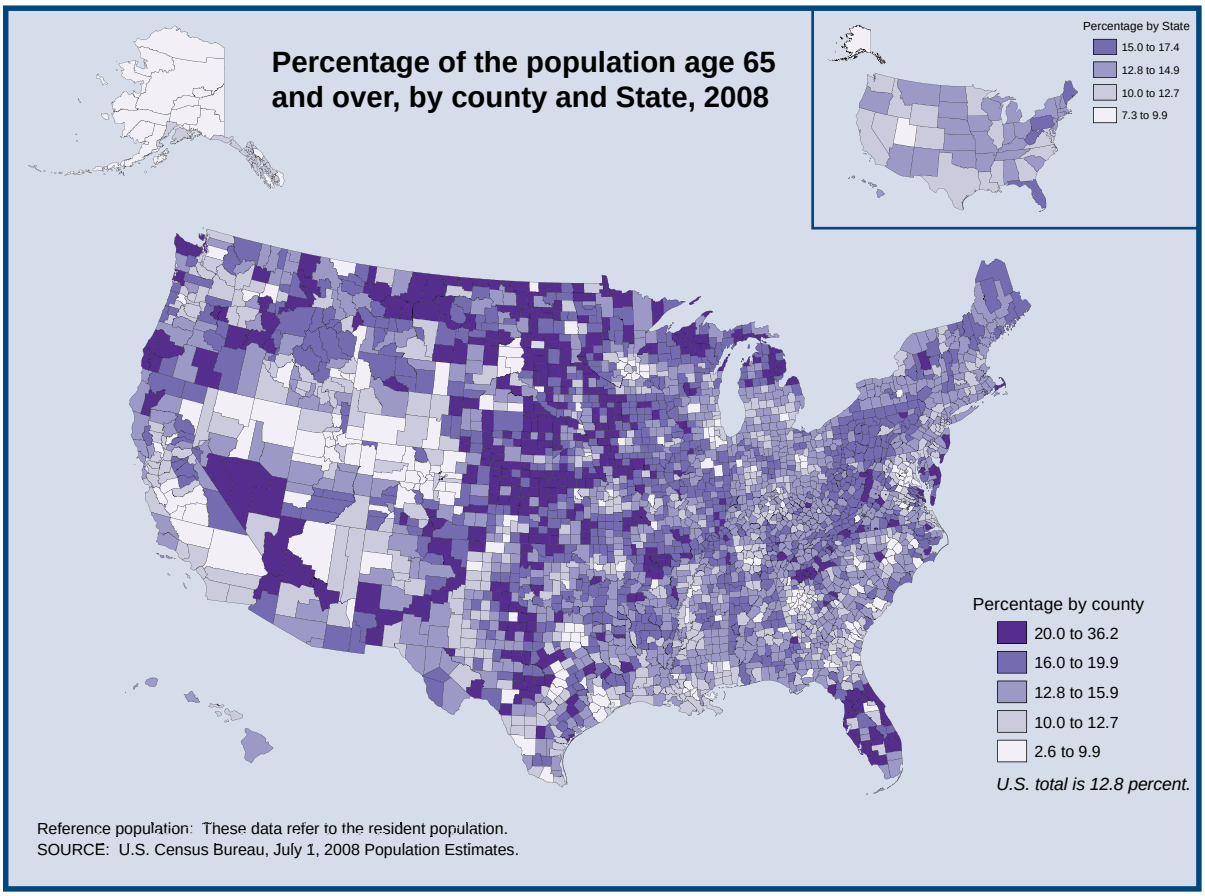
NOTE: Data for 2010–2050 are projections of the population.
Reference population: These data refer to the resident population.
SOURCE: U.S. Census Bureau, Decennial Census, Population Estimates and Projections.

- In 2008, 39 million people age 65 and over lived in the United States, accounting for 13 percent of the total population. The older population grew from 3 million in 1900 to 39 million in 2008. The oldest-old population (those age 85 and over) grew from just over 100,000 in 1900 to 5.7 million in 2008.
- 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 72 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, however, 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 5.7 million in 2008 to 19 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.[1–3]



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 2008, Florida had the highest proportion of people age 65 and over, 17 percent. Maine, 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 2008, 36 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 3 percent of its population age 65 and over.

- Older women outnumbered older men in the United States, and the proportion that is female increased with age. In 2008, women accounted for 58 percent of the population age 65 and over and for 67 percent of the population 85 and over.

- The United States is fairly young for a developed country, with 13 percent of its population aged 65 and over in 2008. Japan had the highest percent of 65 and over (22 percent) among countries with at least 100,000 population. The older population made up more than 15 percent of the population in most European countries, 20 percent in Germany and Italy.

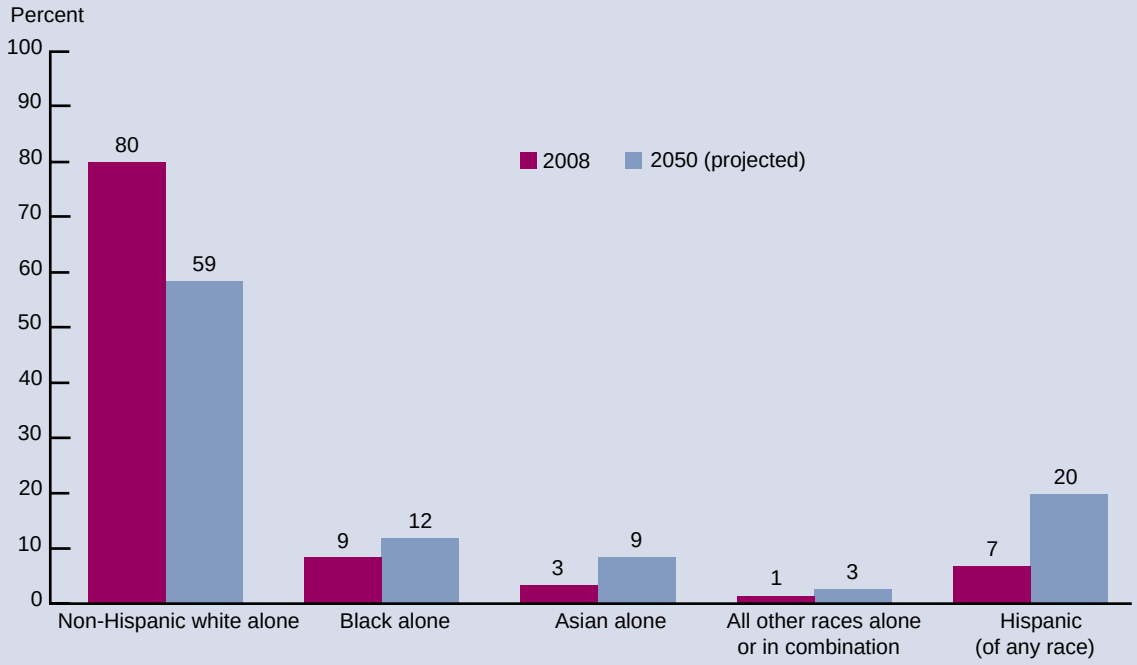
Data for this indicator's charts and bullets can be found in Tables 1a, 1b, 1c, 1d, 1e, and 1f on pages 72–76.

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.

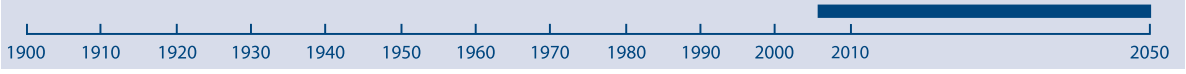
Population age 65 and over, by race and Hispanic origin, 2008 and projected 2050



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. 2008.

- In 2008, non-Hispanic whites accounted for 80 percent of the U.S. older population. Blacks made up 9 percent, Asians made up 3 percent, and Hispanics (of any race) accounted for 7 percent of the older population.
- Projections indicate that by 2050 the composition of the older population will be 59 percent non-Hispanic white, 20 percent Hispanic, 12 percent black, and 9 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 under 3 million in 2008 to 17.5 million in 2050, and to be larger than the older black population. The older Asian population is also projected to experience a large increase. In 2008, just over 1 million older Asians lived in the United States; by 2050 this population is projected to be almost 7.5 million.

Data for this indicator's charts and bullets can be found in Table 2 on page 76.

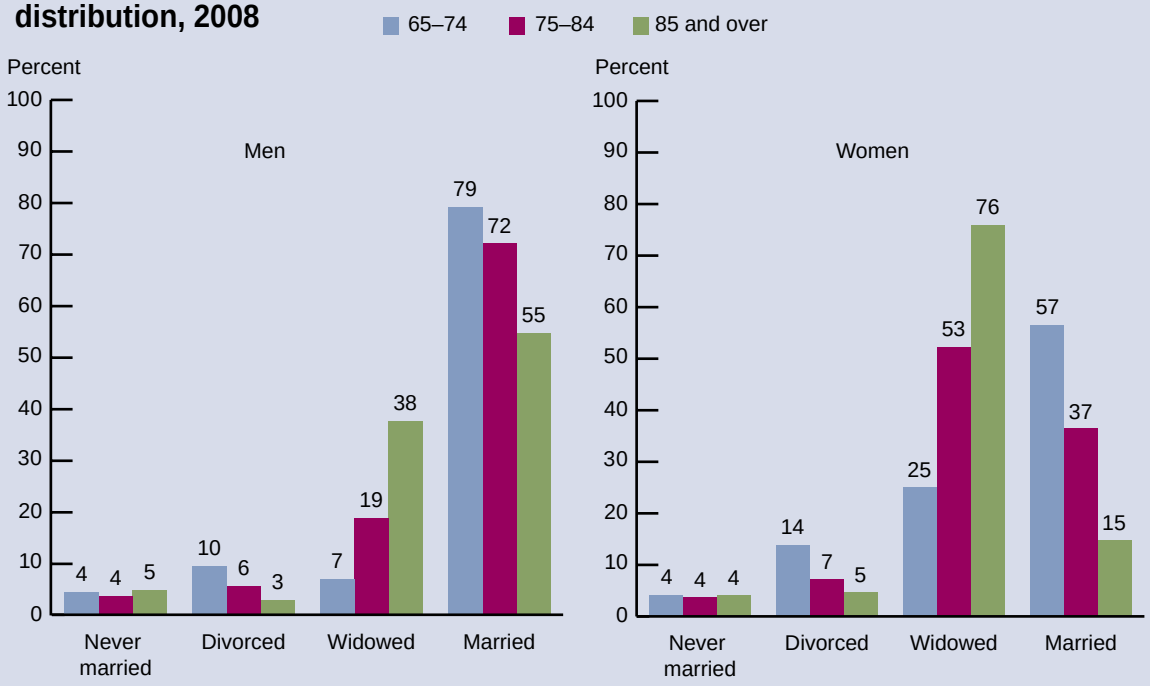


INDICATOR 3

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.

Marital status of the population age 65 and over, by age group and sex, percent distribution, 2008



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, 2008.

- In 2008, older men were much more likely than older women to be married. Over three-quarters of men age 65–74 were married, compared with over one-half (57 percent) of women in the same age group. The proportion married is lower at older ages: 37 percent of women age 75–84 and 15 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 (55 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, 42 percent compared with 14 percent. In 2008, 76 percent of women age 85 and over were widowed, compared with 38 percent of men.

- Relatively small proportions of older men (8 percent) and women (10 percent) were divorced in 2008. A smaller proportion (4 percent) of the older population had never married.

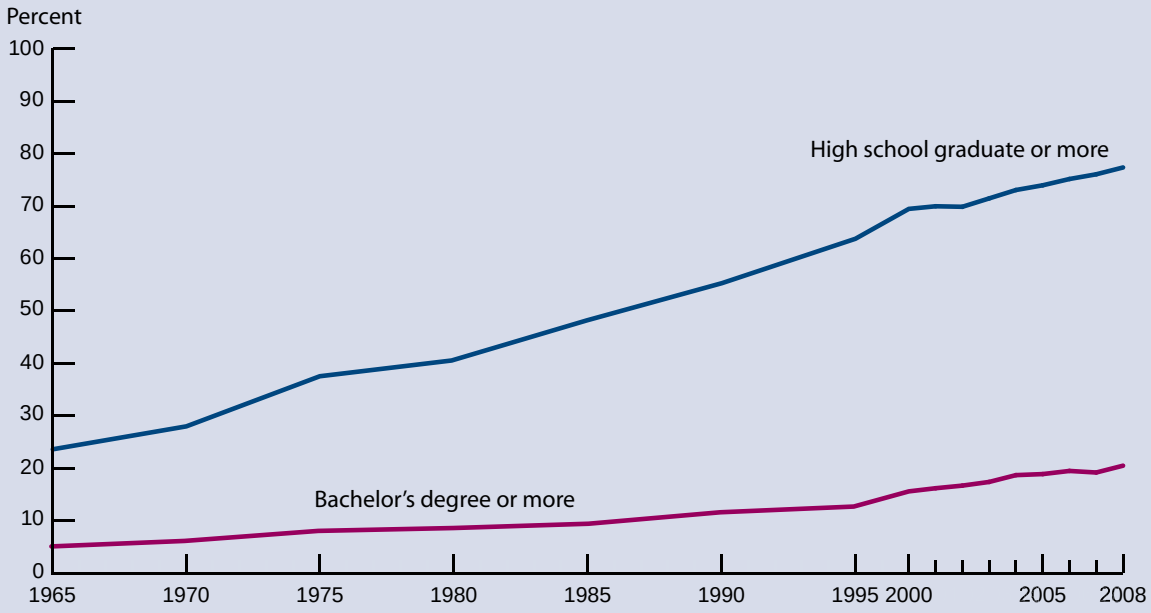
All comparisons presented for this indicator are significant at 0.10 confidence level. Data for this indicator's charts and bullets can be found in Table 3 on page 77.

INDICATOR 4

Educational Attainment

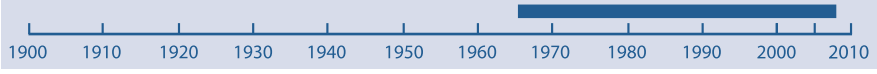
Educational attainment influences socioeconomic status, which in turn plays a role in well-being at older ages. Higher levels of education are usually associated with higher incomes, higher standards of living, and above-average health.

Educational attainment of the population age 65 and over, selected years 1965–2008



NOTE: A single question which asks for the highest grade or degree completed is now used to determine educational attainment. Prior to 1995, educational attainment was measured using data on years of school completed.
Reference population: These data refer to the civilian noninstitutionalized population.
SOURCE: U.S. Census Bureau, Current Population Survey, Annual Social and Economic Supplement, 1966–2008.

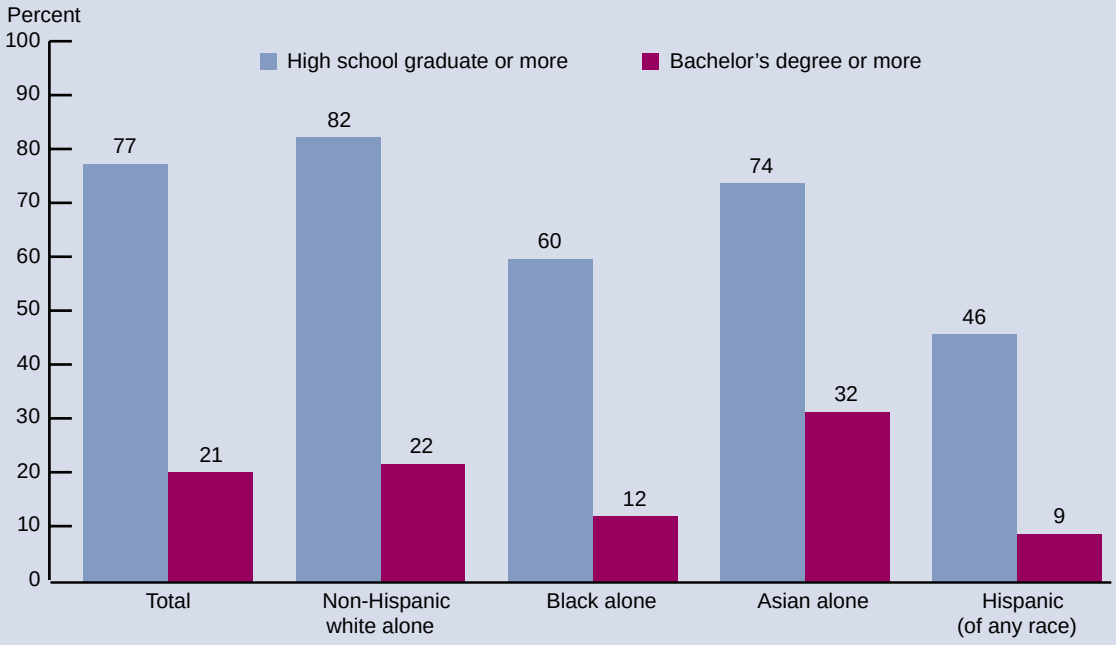
- In 1965, 24 percent of the older population had graduated from high school, and only 5 percent had at least a Bachelor's degree. By 2008, 77 percent were high school graduates or more, and 21 percent had a Bachelor's degree or more.
- In 2008, about 78 percent of older men and 77 percent of older women had at least a high school diploma. Older men attained at least a Bachelor's degree more often than older women (27 percent compared with 16 percent).



INDICATOR 4

Educational Attainment continued

Educational attainment of the population age 65 and over, by race and Hispanic origin, 2008



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, 2008.

- Despite the overall increase in educational attainment among older Americans, substantial educational differences exist among racial and ethnic groups. In 2008, 82 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 (74 percent). In contrast, 60 percent of older blacks and 46 percent of older Hispanics had completed high school.

- In 2008, older Asians had the highest proportion with at least a Bachelor's degree (32 percent). About 22 percent of older non-Hispanic whites had this level of education. The proportions were 12 percent and 9 percent, respectively, for older blacks and Hispanics.

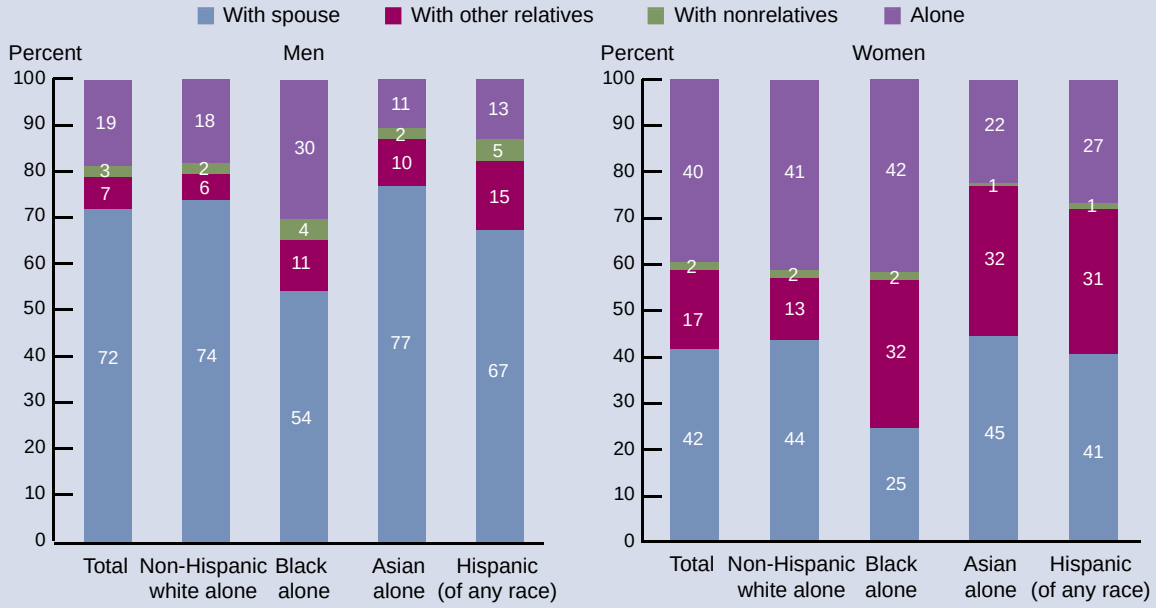
All comparisons presented for this indicator are significant at 0.10 confidence level. Data for this indicator's charts and bullets can be found in Tables 4a and 4b on pages 77–78.

INDICATOR 5

Living Arrangements

The living arrangements of America's older population 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.

Living arrangements of the population age 65 and over, by sex and race and Hispanic origin, percent distribution, 2008



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 do not include the noninstitutionalized group quarters population.
SOURCE: U.S. Census Bureau, Current Population Survey, Annual Social and Economic Supplement, 2008.

- In 2008, 72 percent of older men lived with their spouse while less than half (42 percent) of older women did. In contrast, older women were more than twice as likely as older men to live alone (40 percent and 19 percent, respectively).

- Older black, Asian, and Hispanic women were more likely than non-Hispanic white women to live with relatives other than a spouse. Older non-Hispanic white women and black women were more likely than women of other races to live alone (41 percent and 42 percent, respectively, compared with about 22 percent for older Asian women and 27 percent for older Hispanic women). The percentages of non-Hispanic white and black women living alone are not statistically different. Also, the percentages of older Asian and older Hispanic women living alone are not statistically different. Older black men lived alone about three times as often as older Asian men (30 percent compared with 11 percent). Older black men lived alone more often than older non-Hispanic white men (18 percent). The percentages of older Asian and older Hispanic men living alone (11 percent and 13 percent, respectively) are not statistically different.

- Older Hispanic men were more likely (15 percent) than non-Hispanic white men (6 percent) to live with relatives other than a spouse. The percentages of black, Asian, and Hispanic men (11 percent, 10 percent and 15 percent, respectively) living with relatives other than a spouse are not statistically different.

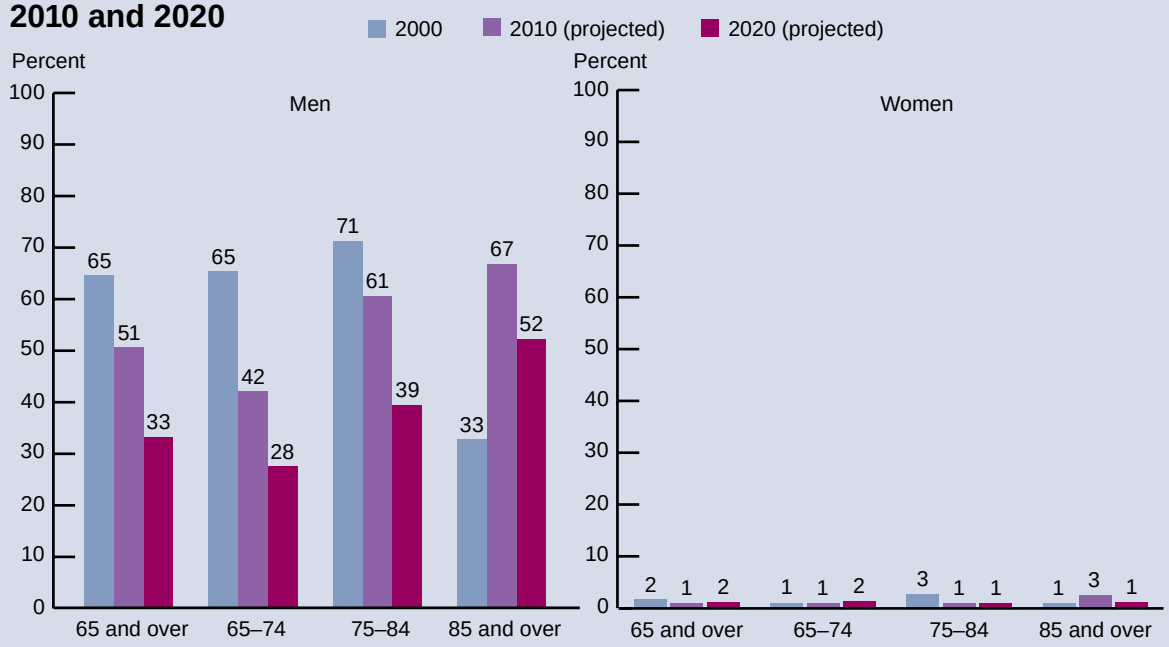
All comparisons presented for this indicator are significant at 0.10 confidence level. Data for this indicator's charts and bullets can be found in Tables 5a and 5b on pages 78–79.

INDICATOR 6

Older Veterans

Veteran status of America's older population is associated with higher median family income, lower percentage of uninsured or coverage by Medicaid, higher percentage of functional limitations in activities of daily living or instrumental activities of daily living, greater likelihood of having any disability, and less likelihood of rating their general health status as good or better.[4] The large increase in the oldest segment of the veteran population will continue to have significant ramifications on the demand for health care services, particularly in the area of long-term care.[5]

Percentage of population age 65 and over who are veterans, by sex and age group, United States and Puerto Rico, 2000 with projections for 2010 and 2020

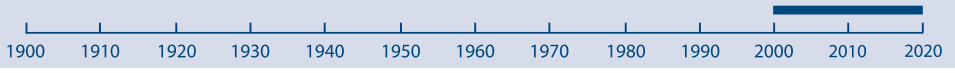


Reference population: These data refer to the resident population of the United States and Puerto Rico.

SOURCE: U.S. Census Bureau, Decennial Census and Population Projections; Department of Veterans Affairs, VetPop2007.

- According to Census 2000, there were 9.7 million veterans age 65 and over in the United States and Puerto Rico. Two of three men age 65 and over were veterans.
- More than 95 percent of veterans age 65 and over are male. As World War II veterans continue to die and Vietnam veterans continue to age, the number of veterans age 65 and over will gradually decline from 9.4 million in 2000 to a projected 8.1 million in 2020.
- The increase in the proportion of men age 85 and over who are veterans is striking. The number of men age 85 and over who are veterans is projected to increase from 400,000 in 2000 to almost 1.2 million by 2010. The proportion of men age 85 and over who are veterans is projected to increase from 33 percent in 2000 to 66 percent in 2010.
- Between 2000 and 2010, the number of female veterans age 85 and over is projected to increase from about 30,000 to 98,000 but is projected to decrease back to 50,000 by 2020.

Data for this indicator's chart and bullets can be found in Tables 6a and 6b on pages 79–80.



Economics

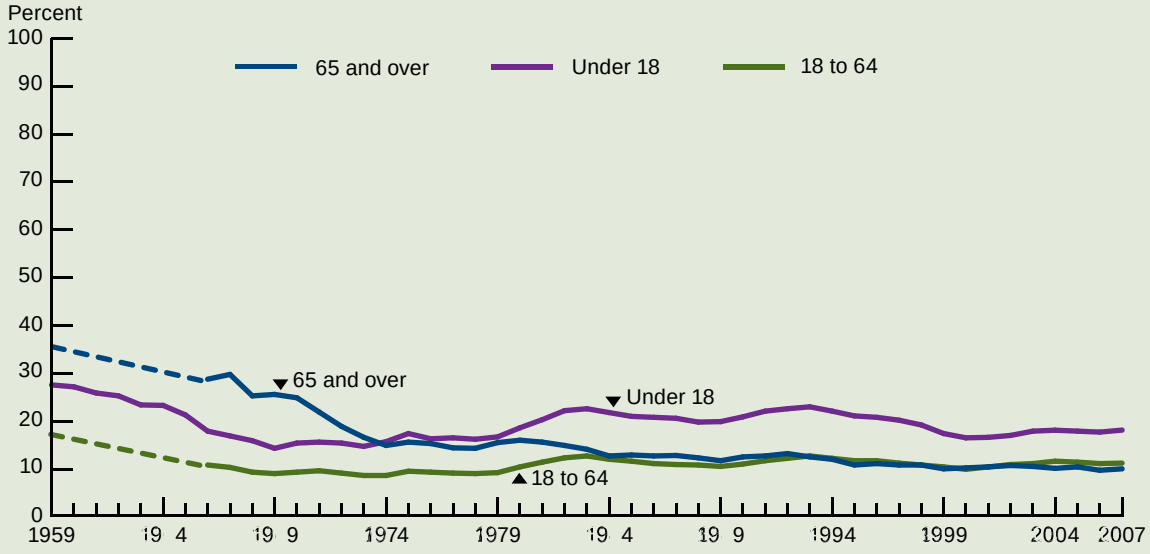
Indicator 7: **Poverty**
Indicator 8: **Income**
Indicator 9: **Sources of Income**
Indicator 10: **Net Worth**
Indicator 11: **Participation in the Labor Force**
Indicator 12: **Total Expenditures**
Indicator 13: **Housing Problems**

INDICATOR 7

Poverty

Poverty rates are 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, earned income tax credits, or 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.

Poverty rate of the population, by age group, 1959–2007



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. Poverty status in the Current Population Survey is based on prior year income.
Reference population: These data refer to the civilian noninstitutionalized population.
SOURCE: U.S. Census Bureau, Current Population Survey, Annual Social and Economic Supplement, 1960–2008.

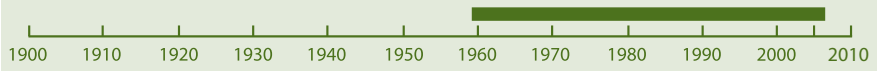
- In 1959, older people had the highest poverty rate (35 percent), followed by children (27 percent) and those in the working ages (17 percent). By 2007, the proportions of the older population and those of working age living in poverty were about 10 percent and 11 percent, respectively, while 18 percent of children lived in poverty.

- Older women (12 percent) were more likely than older men (7 percent) to live in poverty in 2007. People age 65–74 had a poverty rate of 9 percent, compared with 11 percent of those age 75 and over.

- Race and ethnicity are related to poverty among older men. In 2007, older non-Hispanic white men were less likely than older black men, older Hispanic men, and older Asian men to live in poverty—about 5 percent compared with 17 percent of older black men, 13 percent of older Hispanic men, and 10 percent of older, Asian men. However, the percentage of older Hispanic men is not significantly different than older black men or older Asian men.

- Older non-Hispanic white women (9 percent) and older Asian women (12 percent) were less likely than older black women (27 percent) and older Hispanic women (20 percent) to live in poverty. However, older non-Hispanic white women in poverty were not statistically different from Asian women in poverty.

All comparisons presented for this indicator are significant at 0.10 confidence level. Data for this indicator's charts and bullets can be found in Tables 7a and 7b on pages 81–82.

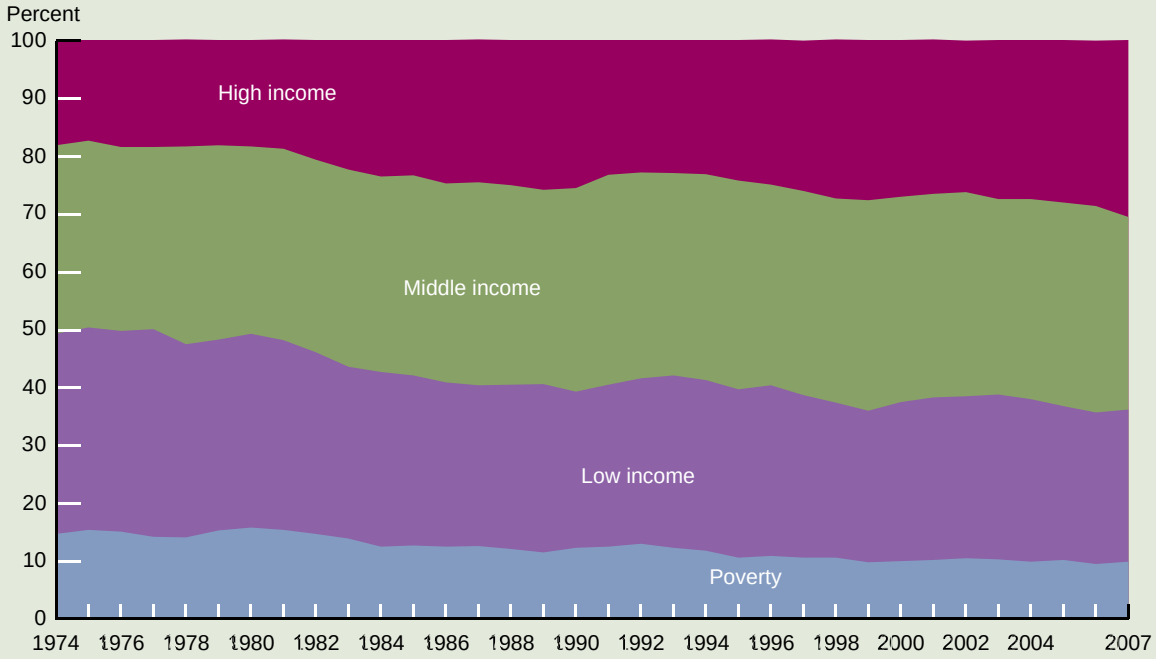


INDICATOR 8

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.

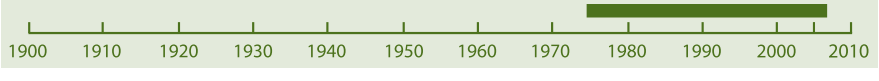
Income distribution of the population age 65 and over, 1974–2007



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, 1975–2008.

- Since 1974, the proportion of older people living in poverty and in the low income group has generally declined so that, by 2007, 10 percent of the older population lived in poverty and 26 percent of the older population were in the low income group.
- In 2007, people in the middle income group made up the largest share of older people by income category (33 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 31 percent in 2007.
- The trend in median household income of the older population also has been positive. In 1974, the median household income for householders age 65 and over was $20,838 when expressed in 2007 dollars. By 2007, the median household income had increased to $29,393.

All comparisons presented for this indicator are significant at 0.10 confidence level. Data for this indicator's charts and bullets can be found in Tables 8a and 8b on pages 83–84.

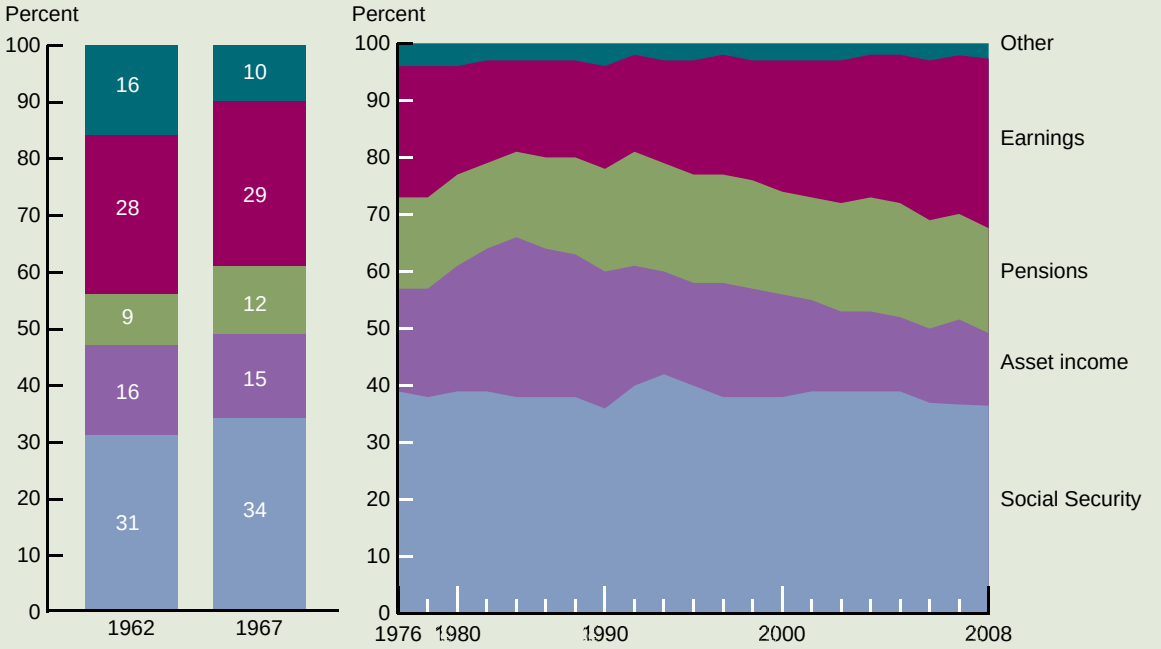


INDICATOR 9

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.

Sources of income for married couples and nonmarried people who are age 65 and over, percent distribution, selected years 1962–2008

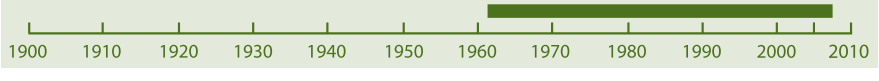


NOTE: A married couple is age 65 and over if the husband is age 65 and over or the husband is younger than age 55 and the wife is age 65 and over. The definition of "other" includes, but is not limited to, public assistance, unemployment compensation, workers compensation, alimony, child support, and personal contributions. Reference population: These data refer to the civilian noninstitutionalized population.
SOURCE: Social Security Administration, 1963 Survey of the Aged, and 1968 Survey of Demographic and Economic Characteristics of the Aged; U.S. Census Bureau, Current Population Survey, Annual Social and Economic Supplement, 1977–2009.

- 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 to a peak in 1992 and has fluctuated 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 2008, aggregate income for the population aged 65 and over came largely from four sources. Social Security provided 37 percent, earnings provided 30 percent, pensions provided 19 percent, and asset income accounted for 13 percent. About 89 percent of people age 65 and over live in families with income from Social Security. About three-fifths (59 percent) are in families with income from assets, and two-fifths (44 percent) with income from pensions. About two-fifths (38 percent) are in families with earnings. About 1 in 20 (5 percent) are in families receiving cash public assistance.

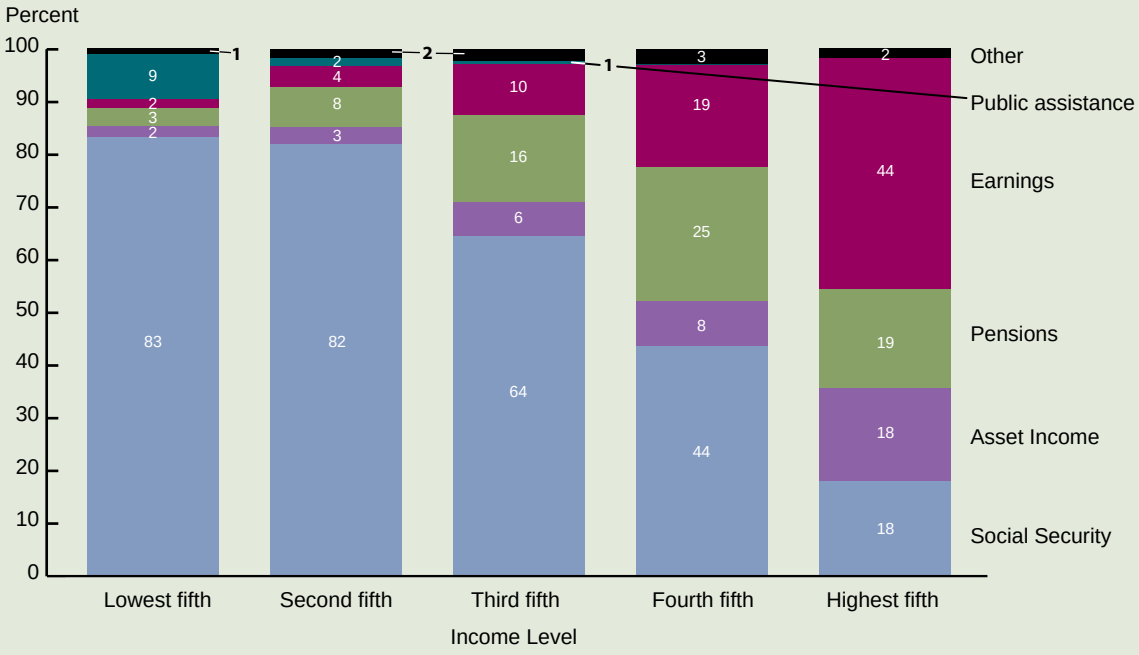
- Among married couples and nonmarried people age 65 and over in the lowest fifth of the income distribution, Social Security accounts for 83 percent of aggregate income, and cash public assistance for another 8 percent. For those whose income is in the highest income category, Social Security, pensions, and asset income each account for almost a fifth of aggregate income, and earnings accounts for the remaining two-fifths.



INDICATOR 9

Sources of Income continued

Sources of income for married couples and nonmarried people who are age 65 and over, by income quintile, percent distribution, 2008



NOTE: A married couple is age 65 and over if the husband is age 65 and over or the husband is younger than age 55 and the wife is age 65 and over. The definition of "other" includes, but is not limited to, public assistance, unemployment compensation, worker's compensation, alimony, child support, and personal contributions. Quintile limits are $12,082, $19,877, $31,303, and $55,889 for all units; $23,637, $35,794, $53,180, and $86,988 for married couples; and $9,929, $14,265, $20,187, and $32,937 for nonmarried persons.
Reference population: These data refer to the civilian noninstitutionalized population.
SOURCE: U.S. Census Bureau, Current Population Survey, Annual Social and Economic Supplement, 2009.

- For the population age 80 and over, a larger percentage lived in families with Social Security income (92 percent) and a smaller percentage had earnings (22 percent) compared to the population age 65–69 (83 percent and 55 percent, respectively).

- The financial situation of 2008 was the worst economic downturn since the Great Depression of the 1930s. This downturn could affect income received in 2008 by the population age 55 and over. People aged 50–64 may have been most affected by the downturn and people age 65 and over may have been least affected by the downturn.[6] Between the peak of October 9, 2007, and through January 2009, the Wilshire 5000 index of broad stock holdings decreased by 47 percent.[7] Retirement accounts of those 50 and over lost 18 percent of their value over the 12 months[8] and by May 2009, retirement accounts lost $2.7 trillion or 31 percent since September 2007.[9] The economic downturn also resulted in rising unemployment, decreasing spending, and falling housing prices with threats of foreclosure.[10] There is likely to be a negative impact on the economic well-being of current and future retirees although it is unclear the extent of the negative impact.[7]

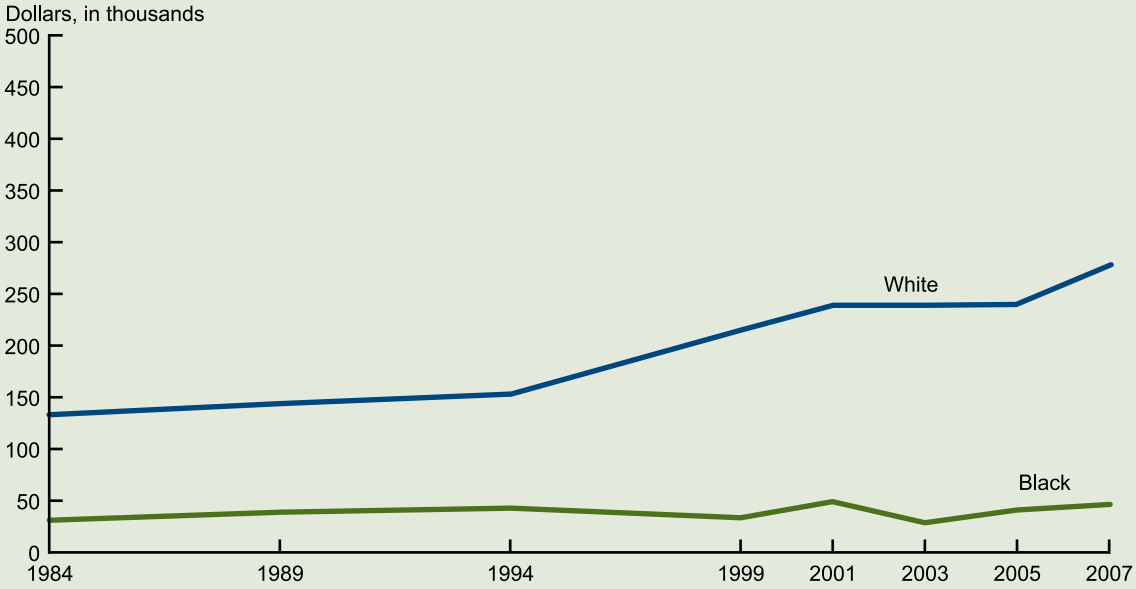
Data for this indicator's charts and bullets can be found in Tables 9a, 9b, and 9c on pages 85–86.

INDICATOR 10

Net Worth

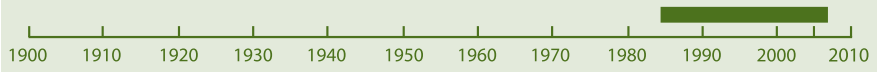
Net worth (the value of real estate, stocks, bonds, and other assets minus outstanding debts) is an important indicator of economic security and well-being. Greater net worth allows a family to maintain its standard of living when income falls because of job loss, health problems, or family changes such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

Median household net worth in 2007 dollars, by race of head of household age 65 and over, selected years 1984–2007



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. Data for 1984–2005 have been inflation adjusted to 2007 dollars. See Appendix B for the definition of race and Hispanic origin in the Panel Study of Income Dynamics.
Reference population: These data refer to the civilian noninstitutionalized population.
SOURCE: Panel Study of Income Dynamics.

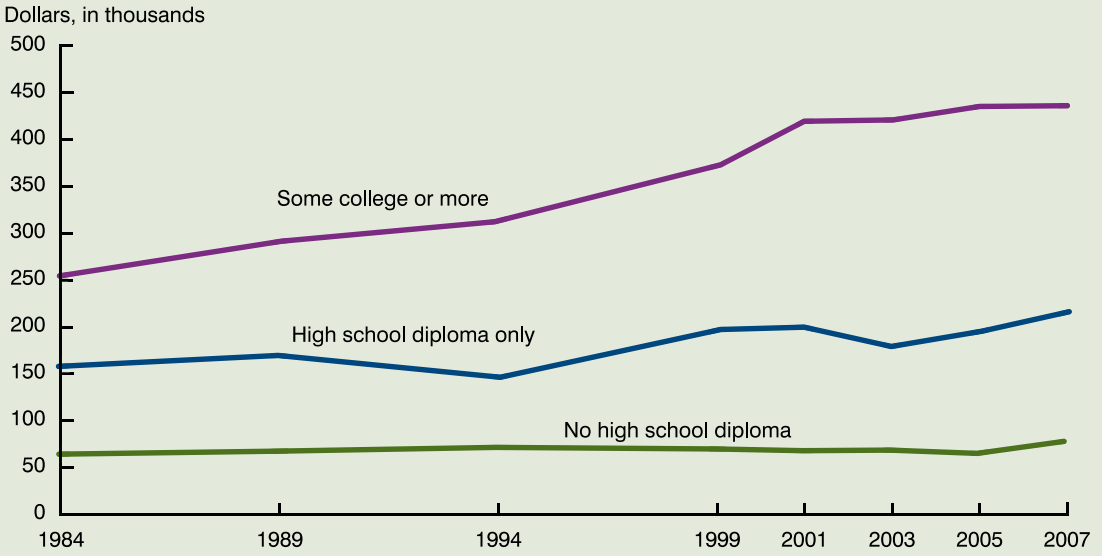
- Between 1984 and 2007, the median net worth of households headed by white people age 65 and over increased by 112 percent, from $131,800 to $280,000. The median net worth of households headed by black people age 65 and over increased 55 percent from $29,700 to $46,000.
- In 1984, the median net worth of households headed by white people age 65 and over was four times that of households headed by black people over 65. In 2007, the median net worth of older white households was six times that of older black households. This difference is less than it was in 2003, when the median net worth of white older households was eight times higher than older black households.
- In 2007, the median net worth of households headed by married people age 65 and older ($385,000) was more than 2.5 times that of households headed by unmarried people in the same age group ($152,000).



INDICATOR 10

Net Worth continued

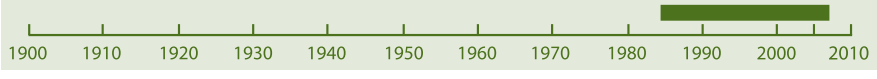
Median household net worth in 2007 dollars, by educational attainment of head of household, age 65 and over, selected years 1984–2007



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. Data for 1984–2005 have been inflation adjusted to 2007 dollars.
Reference population: These data refer to the civilian noninstitutionalized population.
SOURCE: Panel Study of Income Dynamics.

- Overall, between 1984 and 2007, the median net worth of households headed by people age 65 and older increased by 106 percent (from $114,900 to $237,000). The increase over the last two years, from 2005 to 2007, was 15 percent (from $206,600 to $237,000).
- In 2007, households headed by people age 65 and over with at least some college reported a median household net worth ($434,400) more than five times that of households headed by older people without a high school diploma ($78,000).
- Between 1984 and 2007, the median net worth of households headed by people age 65 and over without a high school diploma increased by 21 percent. Almost all of this increase occurred between 2005 and 2007; between 1984 and 2005, the median net worth in these households remained approximately the same. By contrast, between 1984 and 2007, the median net worth of older households headed by those with some college or more increased by 73 percent.

Data for this indicator's charts and bullets can be found in Table 10 on page 87.

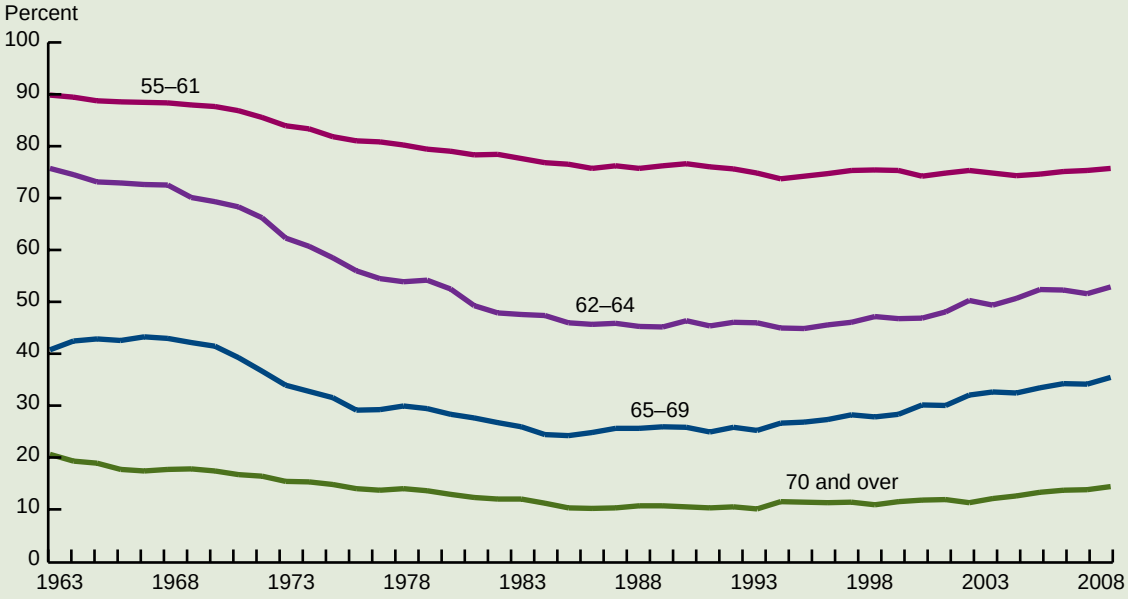


INDICATOR 11

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.

Labor force participation rates of men age 55 and over, by age group, annual averages, 1963–2008

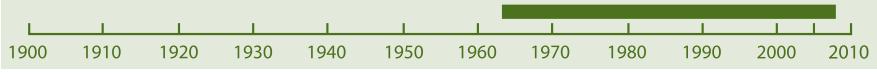


NOTE: Data for 1994 and later years are not strictly comparable with data for 1993 and earlier years due to a redesign of the survey and methodology of the Current Population Survey. Beginning in 2000, data incorporate population controls from Census 2000.
Reference population: These data refer to the civilian noninstitutionalized population.
SOURCE: Bureau of Labor Statistics, Current Population Survey.

- In 2008, the labor force participation rate for men age 55–61 was 76 percent, far below the rate in 1963 (90 percent). The participation rate for men age 62–64 declined from 76 percent in 1963 to a low of 45 percent in 1995, and has gradually increased since then. In 2008, the participation rate for men age 62–64 was 53 percent.

- Men age 65–69 also have experienced a gradual rise in labor force participation following a period of decline in the late 1960s and 1970s. The labor force participation rate for men age 65–69 declined from a high of 43 percent in 1967 to 24 percent in 1985. Their participation rate leveled off from the mid-1980s to the early 1990s and remained in the 24 to 26 percent range. Beginning in the mid-1990s, the labor force participation rate began to increase and reached 36 percent in 2008.

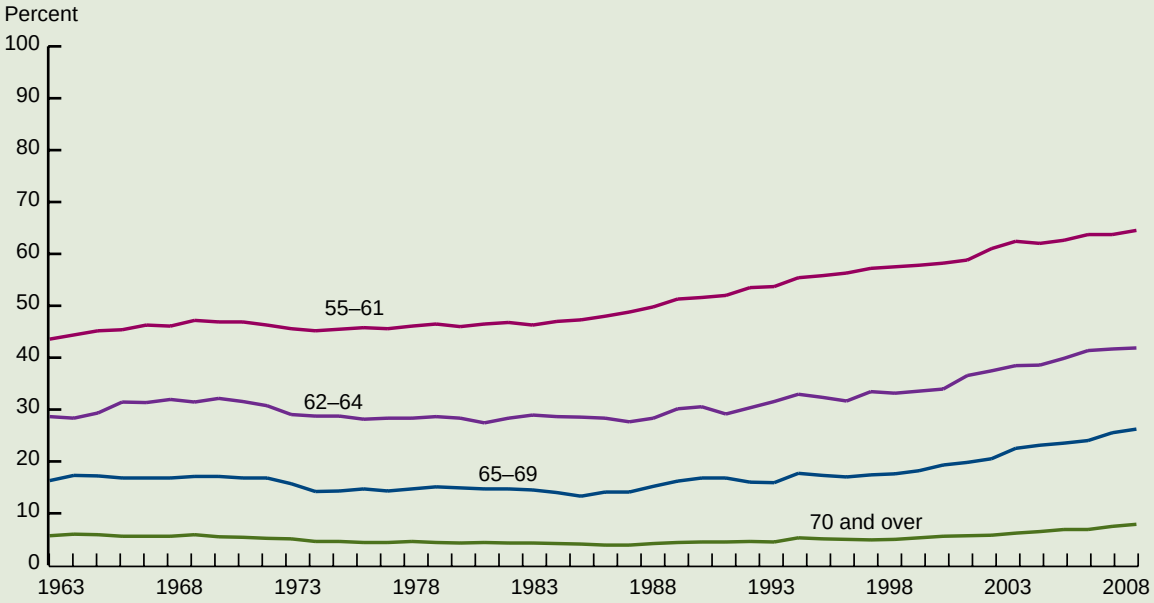
- The participation rate for men age 70 and over showed a similar pattern from 1963 to 2008. In 1993, the labor force participation rate for men age 70 and over reached a low of 10 percent after declining from 21 percent in 1963. Since reaching the lows of the mid-1990s, the participation rate for men age 70 and over has trended higher and reached 15 percent in 2008.



INDICATOR 11

Participation in the Labor Force continued

Labor force participation rates of women age 55 and over, by age group, annual averages, 1963–2008



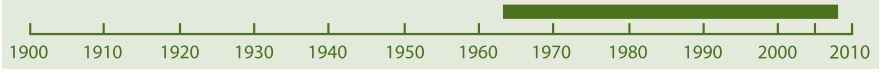
NOTE: Data for 1994 and later years are not strictly comparable with data for 1993 and earlier years due to a redesign of the survey and methodology of the Current Population Survey. Beginning in 2000, data incorporate population controls from Census 2000.
Reference population: These data refer to the civilian noninstitutionalized population.
SOURCE: Bureau of Labor Statistics, Current Population Survey.

- Among women age 55 and over, the labor force participation rate rose over the past 4 decades. The increase has been largest among women age 55–61, rising from 44 percent in 1963 to 65 percent in 2008, with a majority of the increase occurring after 1985. For women age 62–64, 65–69, and 70 years and over, most of the increase in labor force participation began in the mid-1990s.

- The labor force participation rate for older women reflects 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 baby boom women approach older ages, they are participating in the labor force at higher rates than previous generations. As a result, in 2008, 65 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 for women age 62–64 increased from 29 to 42 percent, while the rate for women age 65–69 increased from 17 percent to 26 percent.

- 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 2008 was 11 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 88.



INDICATOR 12

Total Expenditures

Expenditures are another indicator of economic well-being that show how the older population allocates resources to food, housing, health care, and other needs. Expenditures may change with changes in work status, health status, or income.

Household annual expenditures by expenditure category, by age of reference person, percent distribution, 2008

NOTE: Other expenditures include apparel, personal care, entertainment, reading, education, alcohol, tobacco, cash contributions, and miscellaneous expenditures. Data from the Consumer Expenditure Survey by age group represent average annual expenditures for consumer units by the age of reference person, who is the person listed as the owner or renter of the home. For example, the data on people age 65 and over reflect consumer units with a reference person age 65 or older. The Consumer Expenditure Survey collects and publishes information from consumer units, which are generally defined as a person or group of people who live in the same household and are related by blood, marriage, or other legal arrangement (i.e., a family), or people who live in the same household but who are unrelated and financially independent from one another (e.g., roommates sharing an apartment). A household usually refers to a physical dwelling, and may contain more than one consumer unit. However, for convenience the term "household" is substituted for "consumer unit" in this text.
Reference population: These data refer to the resident noninstitutionalized population.
SOURCE: Bureau of Labor Statistics, Consumer Expenditure Survey.

- Housing accounts for the largest share of total expenditures—one-third or more on average for all groups of households with reference person (i.e., a selected household owner or renter) age 55 or older. The share is largest (38 percent) for households with reference person age 75 and older, even though this group is the most likely to own without a mortgage.

- As a share of total expenditures, health care expenditures increase dramatically with age. For the 75 and older group, the share (14 percent) is twice as high as it is for the 55–64 year old group (7 percent), and is equal to the share the older group allocates to transportation (14 percent). For the 75 and older group, vehicle insurance accounts for nearly one-fourth of transportation expenditures, and for a larger share of total expenditures (3.3 percent) than drugs (2.4 percent) and medical supplies (0.5 percent) combined.

- Regardless of age group studied, the share of total expenditures allocated to food is about 12 to 13 percent. Food at home accounts for 7 to 8 percent of total expenditures, and food away from home accounts for 4 to 5 percent of expenditures.

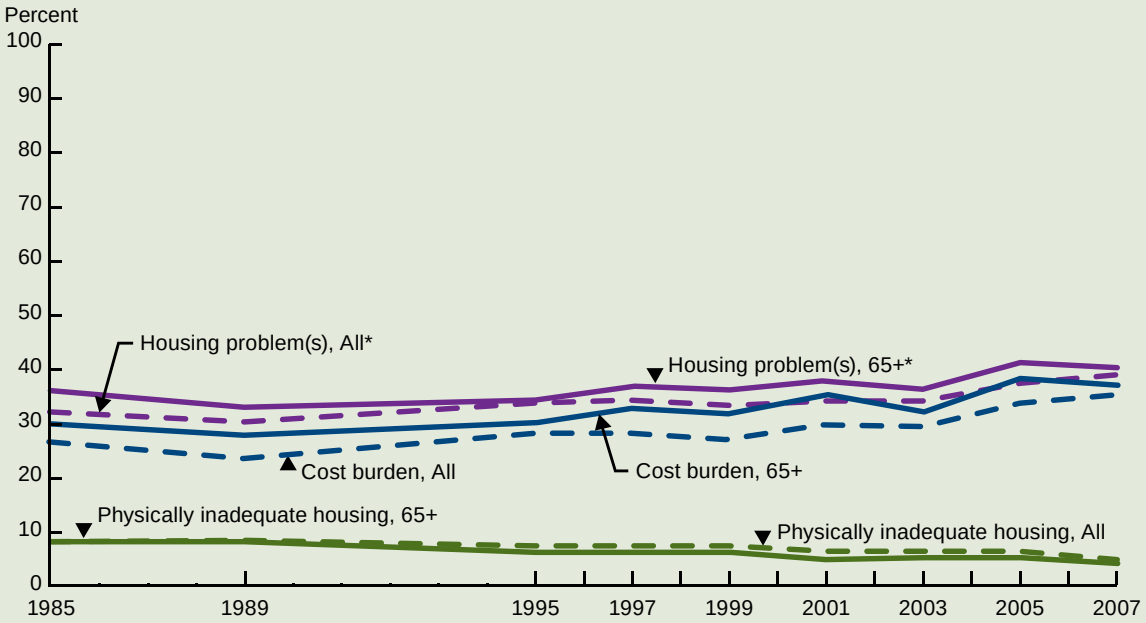
Data for this indicator's chart and bullets can be found in Table 12 on page 89.

INDICATOR 13

Housing Problems

Most older people live in adequate, affordable housing. For some, however, costly or physically inadequate housing can pose serious problems to an older person's physical or psychological well-being.

Percentage of all U.S. households and of households with any resident age 65 and over that report housing problems, by type of problem, selected years 1985–2007



(All) All U.S. households; (65+) U.S. households with one or more residents age 65 and over.

*Although crowded housing is not a common problem for older people (less than 1 percent), it is included as one of three possible housing problems under "housing problem(s)." See Tables 13a and 13b in Appendix A for more information.

Reference population: These data refer to the resident noninstitutionalized population. People residing in noninstitutional group homes are excluded.

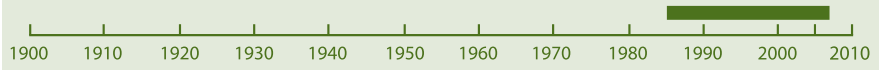
SOURCE: Department of Housing and Urban Development, American Housing Survey.

- In 2007, 40 percent of households with people age 65 and over had one or more of the following types of housing problems: housing cost burden, physically inadequate housing, and/or crowded housing. This is slightly higher than the occurrence of such problems among all U.S. households which was 39 percent in 2007.

- The prevalence of housing cost burden, or expenditures on housing and utilities that exceeds 30 percent of household income, has increased for all U.S. households but is slightly more prevalent among households with people age 65 and over in 2007. Between 1985 and 2007, housing cost burden for households with older people increased from 30 percent to 37 percent. By comparison, the prevalence of housing cost burden among all U.S. households increased from 26 percent in 1985 to 35 percent in 2007.

- Physically inadequate housing, or housing with severe or moderate physical problems such as lacking complete plumbing or having multiple upkeep problems, has become less common. In 2007, 4 percent of households with people age 65 and over had inadequate housing, compared with 8 percent in 1985. In contrast, 5 percent of U.S. households overall reported living in physically inadequate housing during 2007 compared with 8 percent in 1985.

Data for this indicator's charts and bullets can be found in Tables 13a and 13b on pages 89–92.



Health Status

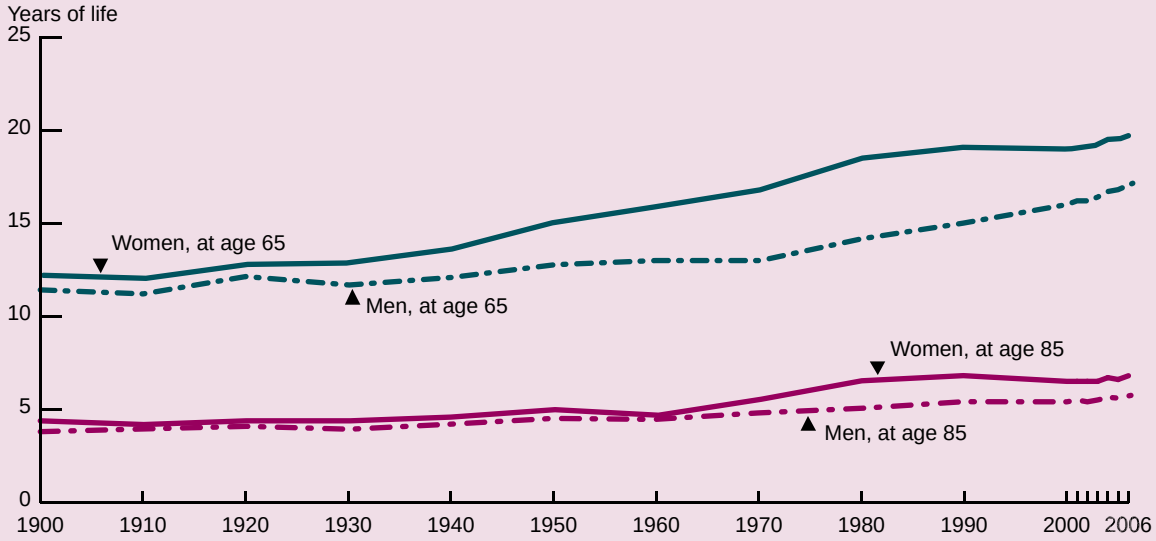
Indicator 14: **Life Expectancy**
Indicator 15: **Mortality**
Indicator 16: **Chronic Health Conditions**
Indicator 17: **Sensory Impairments and Oral Health**
Indicator 18: **Respondent-Assessed Health Status**
Indicator 19: **Depressive Symptoms**
Indicator 20: **Functional Limitations**

INDICATOR 14

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.

Life expectancy at ages 65 and 85, by sex, selected years 1900–2006

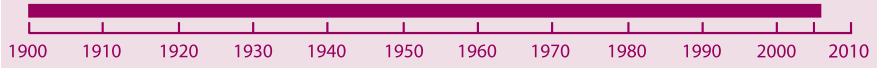


NOTE: The life expectancies (LEs) for decennial years 1910 to 1990 are based on decennial census data and deaths for a 3-year period around the census year. The LEs for decennial year 1900 are based on deaths from 1900 to 1902. LEs for years prior to 1930 are based on the death registration area only. The death registration area increased from 10 states and the District of Columbia in 1900 to the coterminous United States in 1933. LEs for 2000–2006 are based on a newly revised methodology that uses vital statistics death rates for ages under 66 and modeled probabilities of death for ages 66 to 100 based on blended vital statistics and Medicare probabilities of dying and may differ from figures previously published.
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.

- 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 18.5 more years, about 4 years longer than people age 65 in 1960. The life expectancy of people who survive to age 85 today is 6.8 years for women and 5.7 years for men.

- Life expectancy varies by race, but the difference decreases with age. In 2006, life expectancy at birth was 5 years higher for white people than for black people. At age 65, white people can expect to live an average of 1.5 years longer than black people. Among those who survive to age 85, however, the life expectancy among black people is slightly higher (6.7 years) than white people (6.3 years).

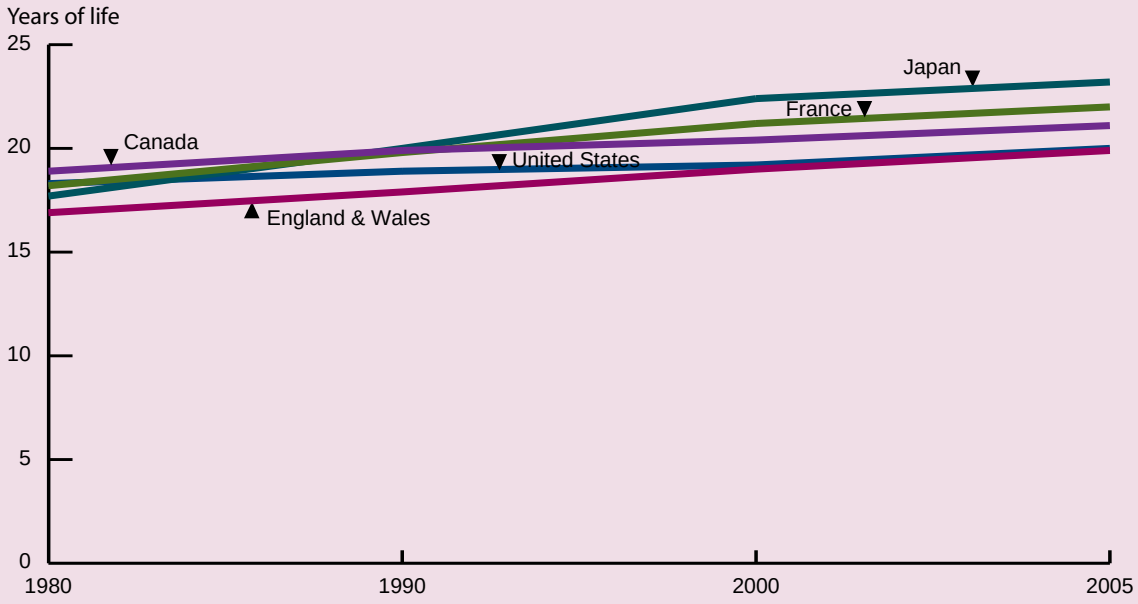
- Life expectancy at age 65 in the United States is lower than that of many other industrialized nations. In 2005, women age 65 in Japan could expect to live on average 3.7 years longer than women in the United States. Among men, the difference was 1.3 years.



INDICATOR 14

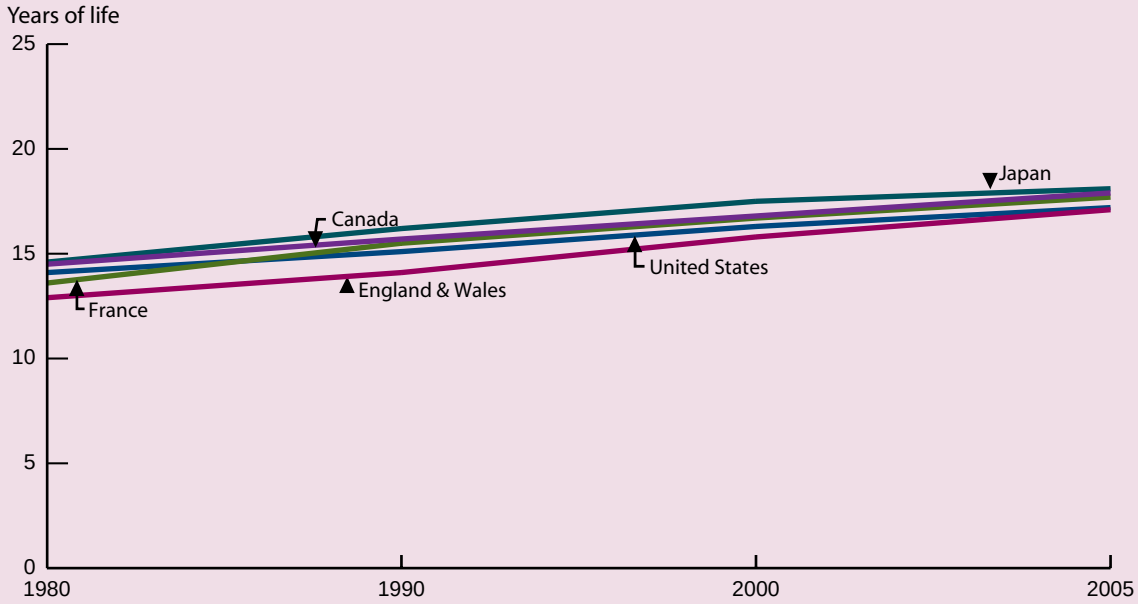
Life Expectancy continued

Average life expectancy for women at age 65, by selected countries or areas, selected years 1980–2005



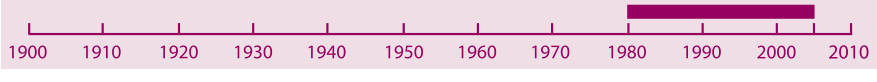
SOURCE: Centers for Disease Control and Prevention, National Center for Health Statistics, Health, United States, 2009.[11]

Average life expectancy for men at age 65, by selected countries or areas, selected years 1980–2005



SOURCE: Centers for Disease Control and Prevention, National Center for Health Statistics, Health, United States, 2009.[11]

Data for this indicator's charts and bullets can be found in Tables 14a, 14b, and 14c on pages 93–94.

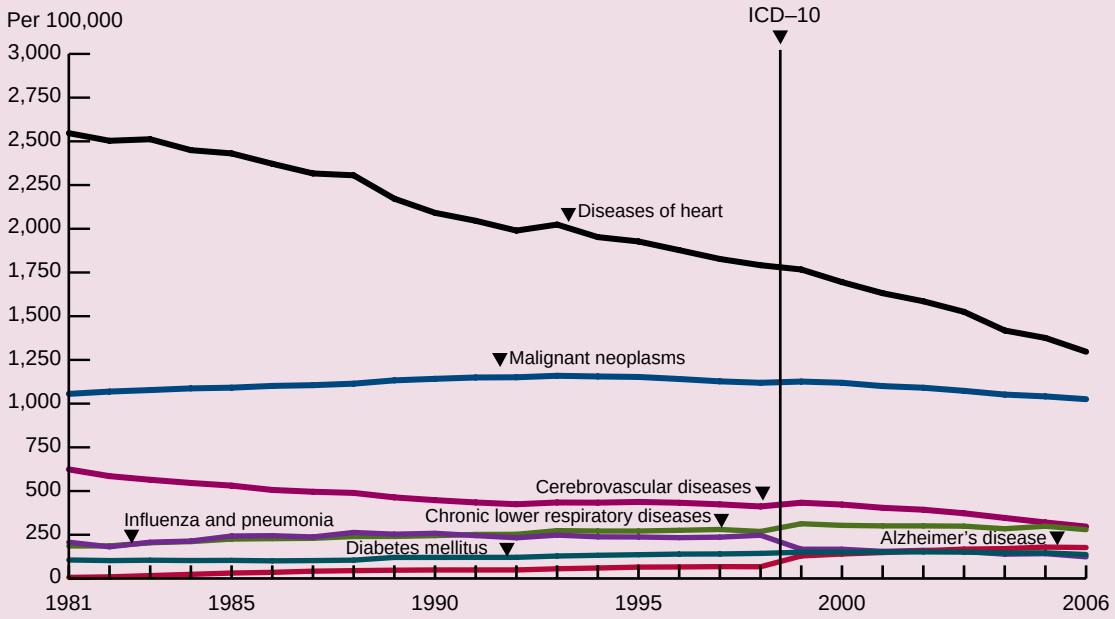


INDICATOR 15

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.

Death rates for selected leading causes of death among people age 65 and over, 1981–2006



NOTE: Death rates for 1981–1998 are based on the 9th revision of the International Classification of Diseases (ICD–9). Starting in 1999, death rates are based on ICD–10 and trends in death rates for some causes may be affected by this change.[12] For the period 1981–1998, causes were coded using ICD–9 codes that are most nearly comparable with the 113 cause list for the ICD–10 and may differ from previously published 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.

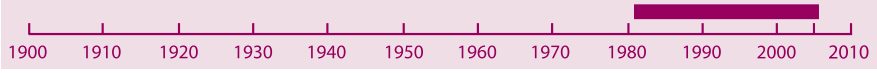
- In 2006, the leading cause of death among people age 65 and over was diseases of heart (heart disease) (1,297 deaths per 100,000 people), followed by malignant neoplasms (cancer) (1,025 per 100,000), cerebrovascular diseases (stroke) (297 per 100,000), chronic lower respiratory diseases (279 per 100,000), Alzheimer's disease (177 per 100,000), diabetes mellitus (137 per 100,000), and influenza and pneumonia (124 per 100,000).

- Between 1981 and 2006, age-adjusted death rates for all causes of death among people age 65 and over declined by 21 percent. Death rates for heart disease and stroke declined by about 50 percent. Age-adjusted death rates for diabetes increased by 29 percent since 1981, and death rates for chronic lower respiratory diseases increased by 50 percent.

- Heart disease and cancer are the top two leading causes of death among all people age 65 and over, irrespective of sex, race, or Hispanic origin.

- Other causes of death vary among older people by sex and race and Hispanic origin. For example, men have higher suicide rates than do women at all ages, with the largest difference occurring at age 85 and over (43 deaths per 100,000 population for men compared with 3 per 100,000 for women). Non-Hispanic white men age 85 and over have the highest rate of suicide overall at 48 deaths per 100,000.[13]

Data for this indicator's chart and bullets can be found in Tables 15a, 15b, and 15c on pages 95–99.

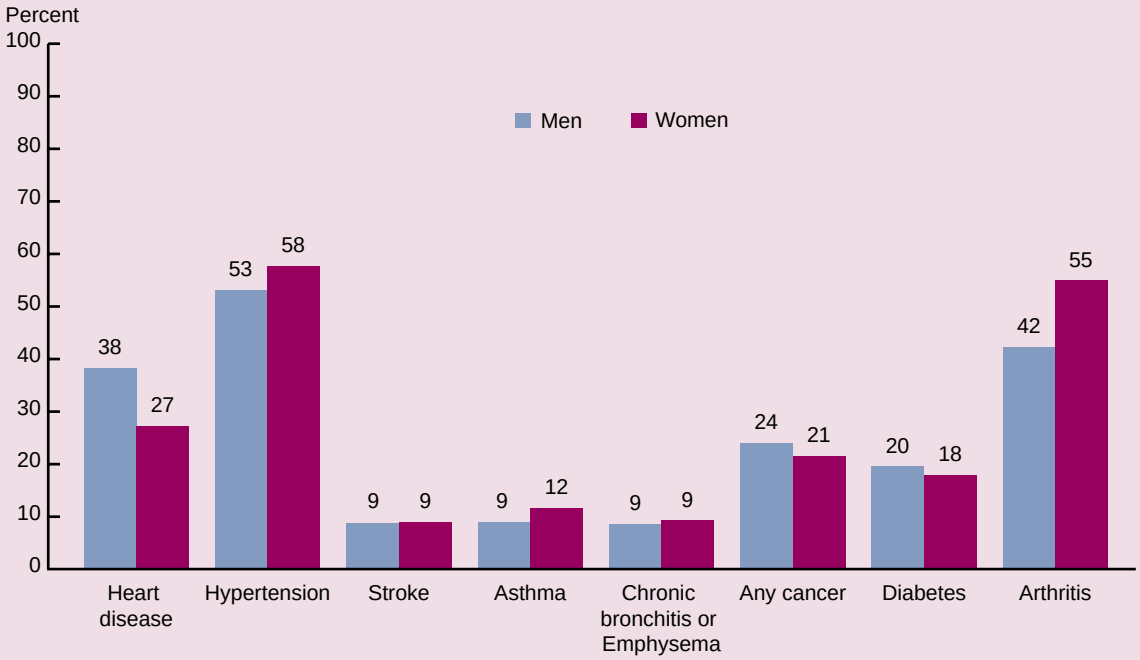


INDICATOR 16

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. Chronic health conditions negatively affect quality of life, contributing to declines in functioning and the inability to remain in the community.[14] Many chronic conditions can be prevented or modified with behavioral interventions. Six of the seven leading causes of death among older Americans are chronic diseases. (See "Indicator 15: Mortality.")

Chronic health conditions among the population age 65 and over, by sex, 2007–2008



NOTE: Data are based on a 2-year average from 2007–2008. See Appendix B for the definition of race and Hispanic origin 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.

- The prevalence of certain chronic conditions differs by sex. Women report higher levels of arthritis and hypertension than men. Men report higher levels of heart disease and cancer.
- There are differences by race and ethnicity in the prevalence of certain chronic conditions. In 2007–2008, among people age 65 and over, non-Hispanic blacks report higher levels of hypertension and diabetes than non-Hispanic whites (71 percent compared with 54 percent for hypertension and 30 percent compared with 16 percent for diabetes). Hispanics also report higher levels of diabetes than non-Hispanic whites (27 percent compared with 16 percent), but lower levels of arthritis (42 percent compared with 51 percent).

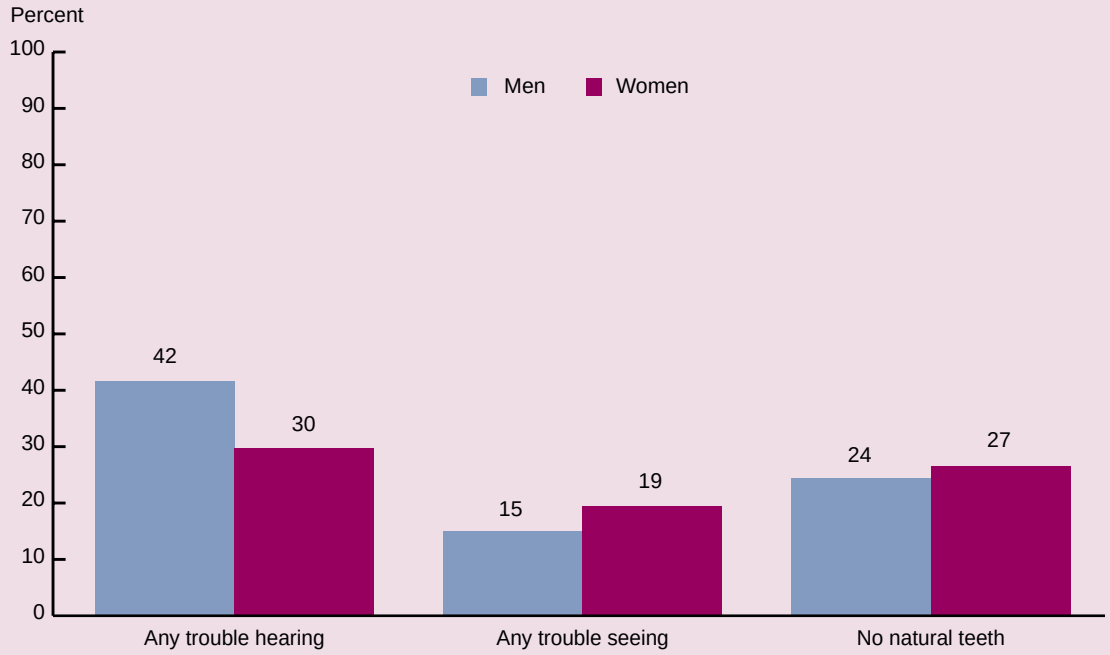
Data for this indicator's chart and bullets can be found in Tables 16a and 16b on page 100.

INDICATOR 17

Sensory Impairments and Oral Health

Vision and hearing limitations and oral health problems are often thought of as natural signs of aging. 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.

Limitations in hearing and vision, and no natural teeth, among the population 65 and over, by sex, 2008



NOTE: Respondents were asked "WITHOUT the use of hearing aids or other listening devices, is your hearing excellent, good, a little trouble hearing, moderate trouble, a lot of trouble, or are you deaf?" For the purposes of this indicator, the category "Any trouble hearing" includes: "a little trouble hearing, moderate trouble, a lot of trouble, and deaf." This question differs slightly from the question used to calculate the estimates shown in previous editions of *Older Americans*. 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 2008, 42 percent of older men and 30 percent 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 (28 percent). Eleven percent of all older women and 18 percent of all older men reported having ever worn a hearing aid.
- Vision trouble affects 18 percent of the older population, 15 percent of men and 19 percent of women. Among people age 85 and over, 28 percent reported trouble seeing.
- The prevalence of edentulism, having no natural teeth, was higher for people age 85 and over (34 percent) than for people age 65–74 (20 percent). Socioeconomic differences are large. Forty-two percent of older people with family income below the poverty line reported no natural teeth compared with 23 percent of people above the poverty threshold.

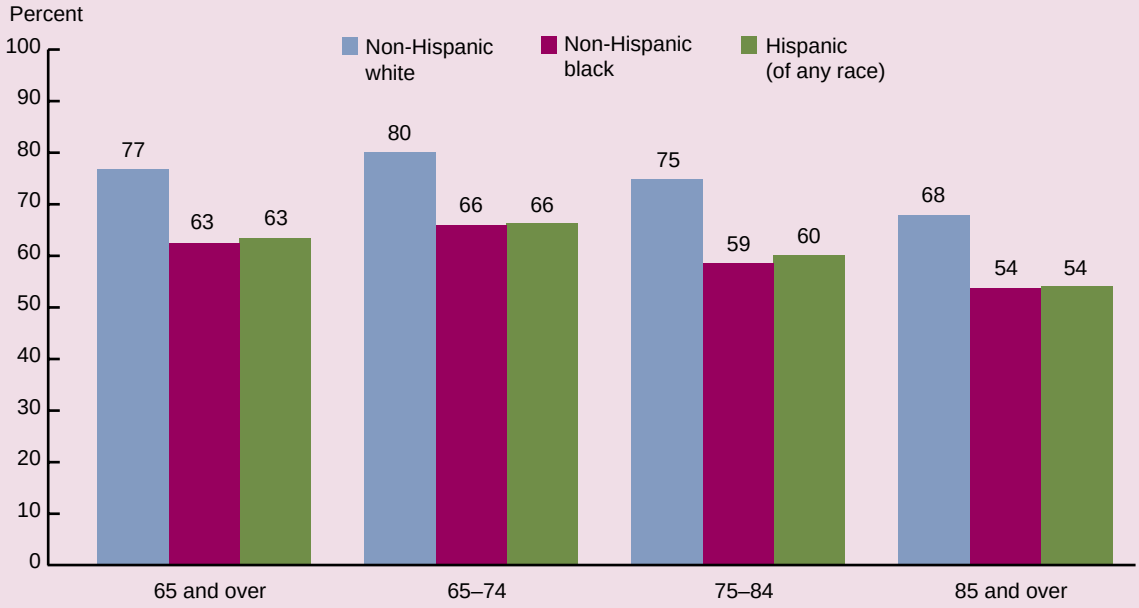
Data for this indicator's charts and bullets can be found in Tables 17a and 17b on page 101.

INDICATOR 18

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 poor correlate with higher risks of mortality.[15]

Respondent-reported good to excellent health among the population 65 and older by age group, race, and Hispanic origin, 2006–2008



NOTE: Data are based on a 3-year average from 2006–2008. See Appendix B for the definition of race and Hispanic origin 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.

- During the period 2006–2008, 75 percent of people age 65 and over rated their health as good, very good, or excellent. Older men and women report similar levels of health.
- The proportion of people reporting good to excellent health decreases among the oldest age groups. Seventy-eight percent of those age 65–74 report good or better health. At age 85 and over, 66 percent of people report good or better ratings. This pattern is also evident within race and ethnic groups.
- 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. Non-Hispanic blacks and Hispanics are similar to one another in their positive health evaluations.

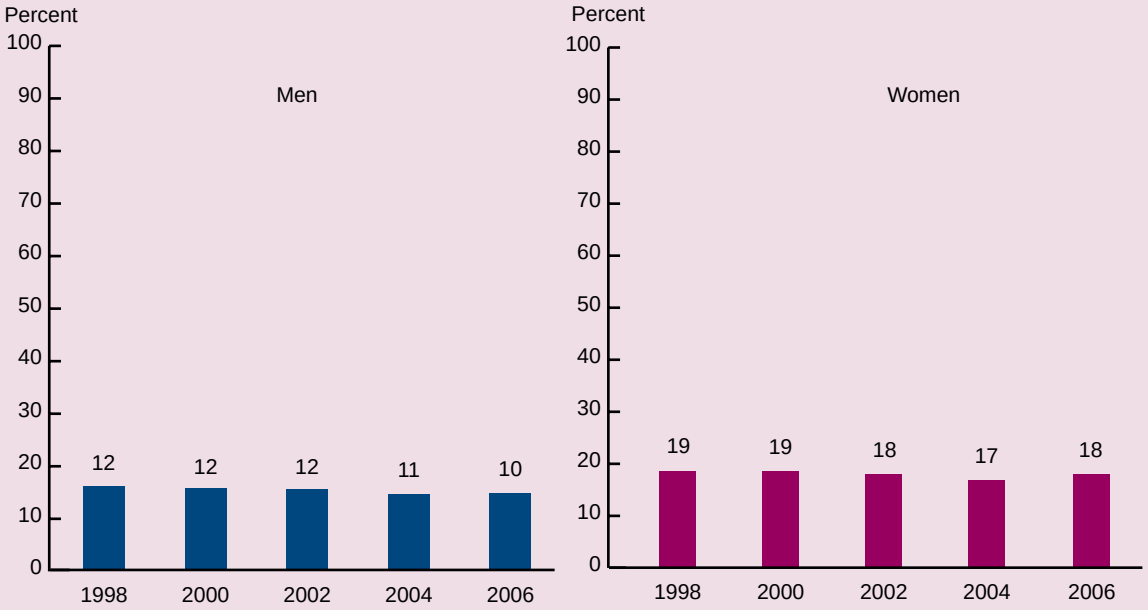
Data for this indicator's charts and bullets can be found in Table 18 on page 102

INDICATOR 19

Depressive Symptoms

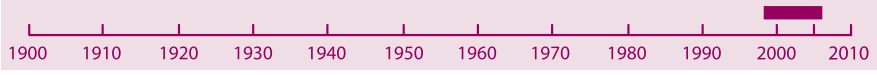
Depressive symptoms are an important indicator of general well-being and mental health among older adults. People who report many depressive symptoms often experience higher rates of physical illness, greater functional disability, and higher health care resource utilization.[16]

Clinically relevant depressive symptoms among the population age 65 and over, by sex, 1998–2006



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 of 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://hrsonline.isr.umich.edu/docs/userg/dr-005.pdf. Proportions are based on weighted data using the preliminary respondent weight from HRS 2006.
Reference population: These data refer to the civilian noninstitutionalized population.
SOURCE: Health and Retirement Study.

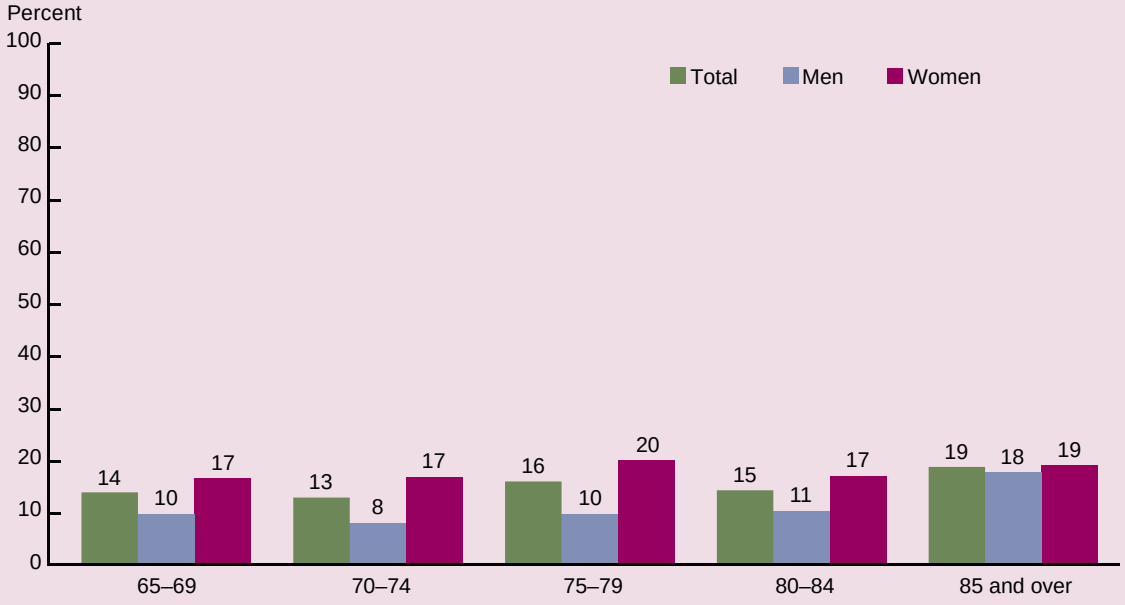
- Older women are more likely to report clinically relevant depressive symptoms than older men. In 2006, 18 percent of women age 65 and over reported depressive symptoms compared with 10 percent of men. There has been no significant change in this sex difference between 1998 and 2006.
- The percentage of people reporting clinically relevant symptoms has remained relatively stable over the past few years. Between 1998 and 2006, the percentage of men who reported depressive symptoms ranged between 10 and 12 percent. For women, the percentage reporting these symptoms ranged from 17 to 19 percent.



INDICATOR 19

Depressive Symptoms continued

Clinically relevant depressive symptoms among the population age 65 and over, by age group and sex, 1998–2006



NOTE: The definition of "clinically relevant depressive symptoms" is four or more symptoms out of a list of eight depressive symptoms from anabbreviated version of the Center of 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://hrsonline.isr.umich.edu/docs/userg/dr-005.pdf. Proportions are based on weighted data using the preliminary respondent weight from HRS 2006.
Reference population: These data refer to the civilian noninstitutionalized population.
SOURCE: Health and Retirement Study.

- The prevalence of depressive symptoms is related to age. In 2006, the proportion of people age 65 and over with clinically relevant symptoms was higher for people age 85 and over (19 percent) than for people in any of the younger groups (13 to 16 percent).
- In 2006, the percentage of men 85 and over (almost 18 percent) reporting clinically relevant depressive symptoms was twice (or almost twice) that of men in any of the younger age groups (8–10 percent). Prevalence of depression among women age 65 and older did not follow this same pattern; the percentage of women reporting clinically relevant symptoms ranges between 17 percent and 20 percent, with women age 75–79 reporting the highest prevalence.

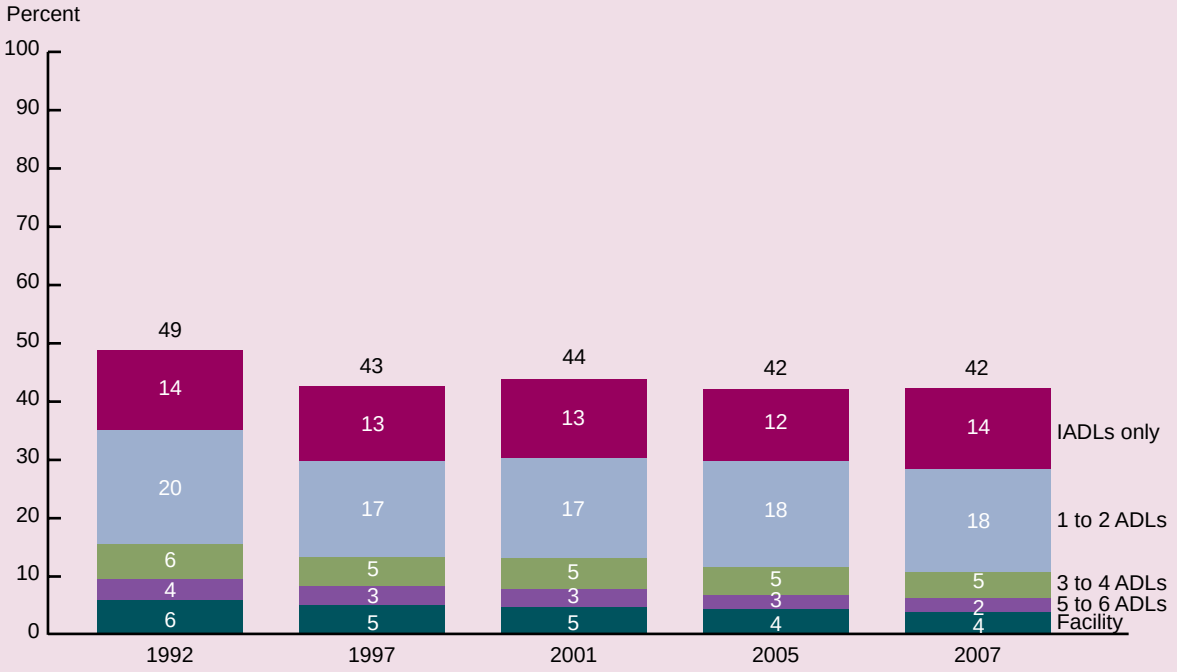
Data for this indicator's charts and bullets can be found in Tables 19a and 19b on page 103.

INDICATOR 20

Functional Limitations

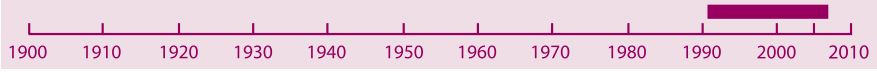
Functioning in later years may be diminished if illness, chronic disease, or injury limits physical and/or mental abilities. Changes in functional limitation rates have important implications for work and retirement policies, health and long-term care needs, and the social well-being of the older population.

Percentage of Medicare enrollees age 65 and over who have limitations in activities of daily living (ADLs) or instrumental activities of daily living (IADLs), or who are in a facility, selected years 1992–2007



NOTE: A residence is considered a long-term care facility if it is certified by Medicare or Medicaid; 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. ADL limitations refer to difficulty performing (or inability to perform for a health reason) one or more of the following tasks: bathing, dressing, eating, getting in/out of chairs, walking, or using the toilet. 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, or managing money. Rates are age adjusted using the 2000 standard population. Data for 1992, 2001, and 2007 do not sum to the totals because of rounding.
Reference population: These data refer to Medicare enrollees.
SOURCE: Centers for Medicare and Medicaid Services, Medicare Current Beneficiary Survey.

- In 2007, 42 percent of people age 65 and over reported a functional limitation. Fourteen percent had difficulty performing one or more IADLs but had no ADL limitations. Approximately 25 percent had difficulty with at least one ADL and 4 percent were in a facility.
- The age-adjusted proportion of people age 65 and over with a functional limitation declined from 49 percent in 1992 to 42 percent in 2007. There was a steady decrease in the percent with limitations from 1992 until 1997. From 1997 to 2007 the overall levels have not significantly changed although a smaller proportion of this population is in a facility compared with earlier years.
- Women have higher levels of functional limitations than men. In 2007, 47 percent of female Medicare enrollees age 65 and over had difficulty with ADLs or IADLs, or were in a facility, compared with 35 percent of male Medicare enrollees. Overall rates of decline since 1992 are similar for men and women; however, a higher proportion of women are in facilities compared with men.

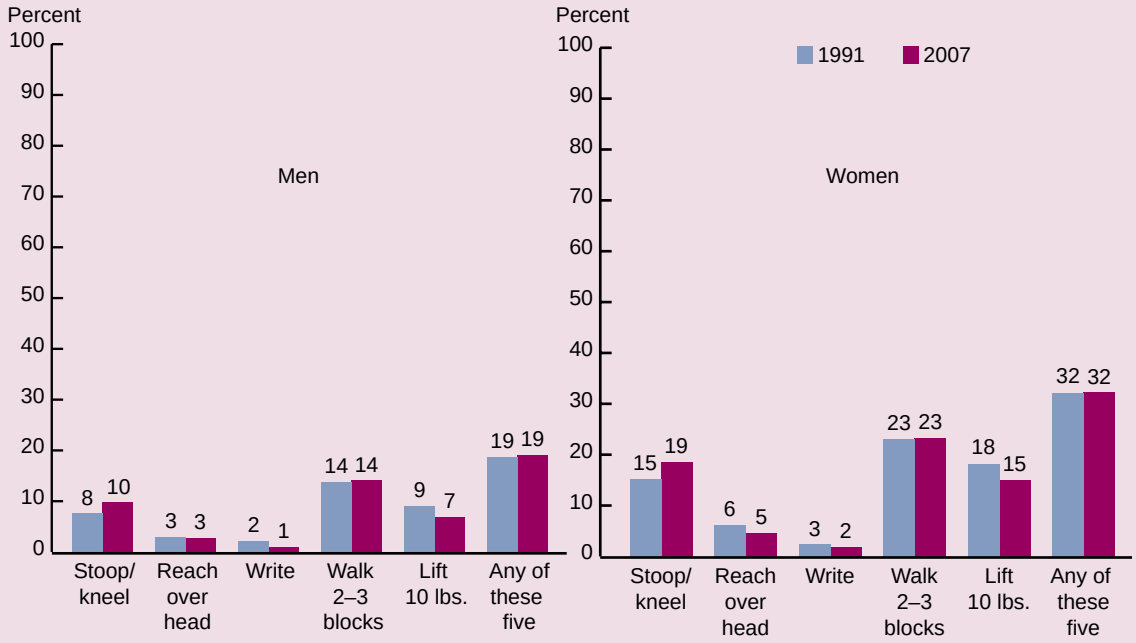


INDICATOR 20

Functional Limitations continued

In addition to activities of daily living (ADLs) and instrumental activities of daily living (IADLs), other measures can be used to assess physical, cognitive, and social functioning. Aspects of physical functioning such as the ability to lift heavy objects, walk two to three blocks, or reach up over one's head are more closely linked to physiological capabilities than are ADLs and IADLs, which also may be influenced by social and cultural role expectations and by changes in technology.

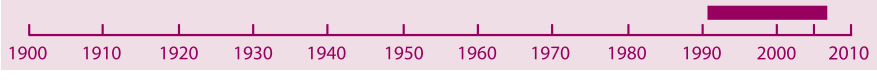
Percentage of Medicare enrollees age 65 and over who are unable to perform certain physical functions, by sex, 1991 and 2007



NOTE: Rates for 1991 are age adjusted to the 2007 population.
Reference population: These data refer to Medicare enrollees.
SOURCE: Centers for Medicare and Medicaid Services, Medicare Current Beneficiary Survey.

- Older women reported more problems with physical functioning than older men. In 2007, 32 percent of women reported they were unable to perform at least one of five activities, compared with 19 percent of men.
- Problems with physical functioning were more frequent at older ages. Among men aged 65–74, 13 percent reported they were unable to perform at least one of five activities, compared with 40 percent of men age 85 and over. Among women, 22 percent of those age 65–74 were unable to perform at least one activity, compared with 56 percent of those age 85 and over.
- Physical functioning was not strongly related to race in 2007. Among men, 19 percent of non-Hispanic whites were unable to perform at least one activity, compared with 26 percent of non-Hispanic blacks. Among women, there were no significant differences among non-Hispanic whites, non-Hispanic blacks, and Hispanics, regarding ability to perform at least one activity.

Data for this indicator's charts and bullets can be found in Tables 20a, 20b, 20c, and 20d on pages 104–105.



Health Risks and Behaviors

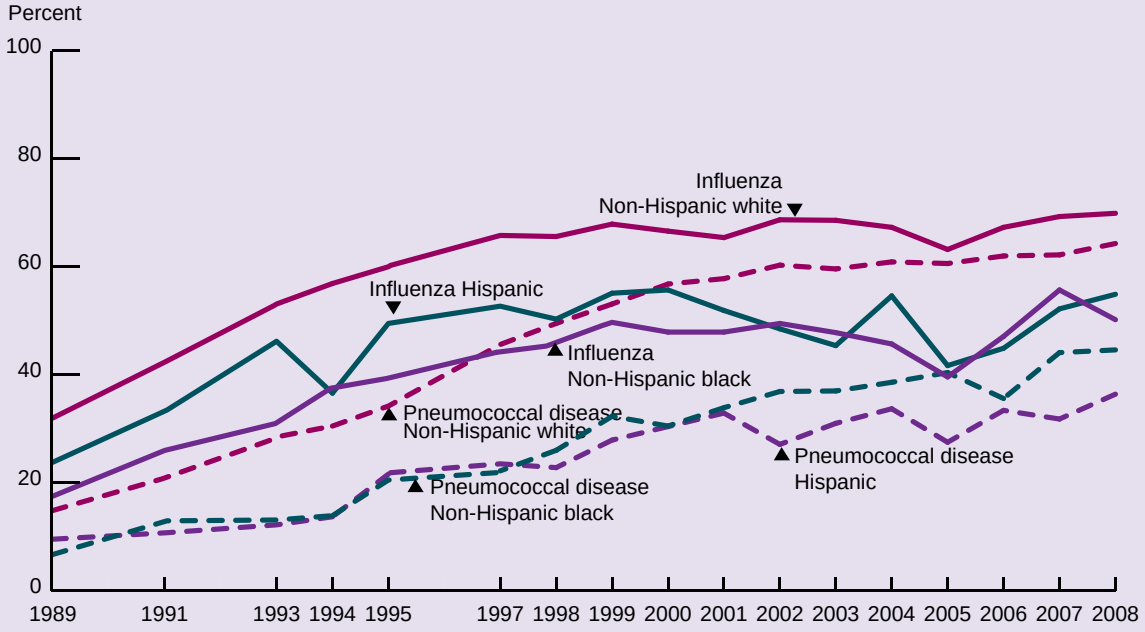
Indicator 21: **Vaccinations**
Indicator 22: **Mammography**
Indicator 23: **Diet Quality**
Indicator 24: **Physical Activity**
Indicator 25: **Obesity**
Indicator 26: **Cigarette Smoking**
Indicator 27: **Air Quality**
Indicator 28: **Use of Time**

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.[17,18] 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.

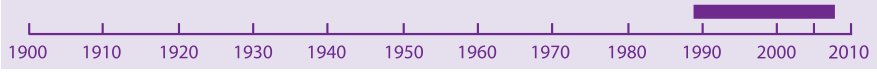
Percentage of population age 65 and over vaccinated against influenza and pneumococcal disease, by race and Hispanic origin, selected years 1989–2008



NOTE: For influenza, the percentage vaccinated consists of people who reported having a flu shot during the past 12 months and does not include receipt of nasal spray flu vaccinations. For pneumococcal disease, the percentage refers to people who reported ever having a pneumonia vaccination.
See Appendix B for the definition of race and Hispanic origin 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.

- In 2008, 67 percent of people age 65 and over reported receiving a flu shot in the past 12 months; however, there are differences by race and ethnicity. Seventy percent of non-Hispanic whites reported receiving a flu shot compared with 50 percent of non-Hispanic blacks and 55 percent of Hispanics.
- In 2008, 60 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 were more likely to have received a pneumonia vaccination (64 percent) compared with non-Hispanic blacks (45 percent) or Hispanics (36 percent).
- The percent of older people receiving vaccinations increases with age. In 2008, 79 percent of persons age 85 and older had received a flu shot compared with 73 percent among persons age 75–84 and 61 percent among persons age 65–74. For pneumonia vaccinations, 69 percent of persons 75–84 and 85 and older had ever received a pneumonia vaccination compared with 53 percent among persons 65–74.

Data for this indicator's charts and bullets can be found in Tables 21a and 21b on page 106.

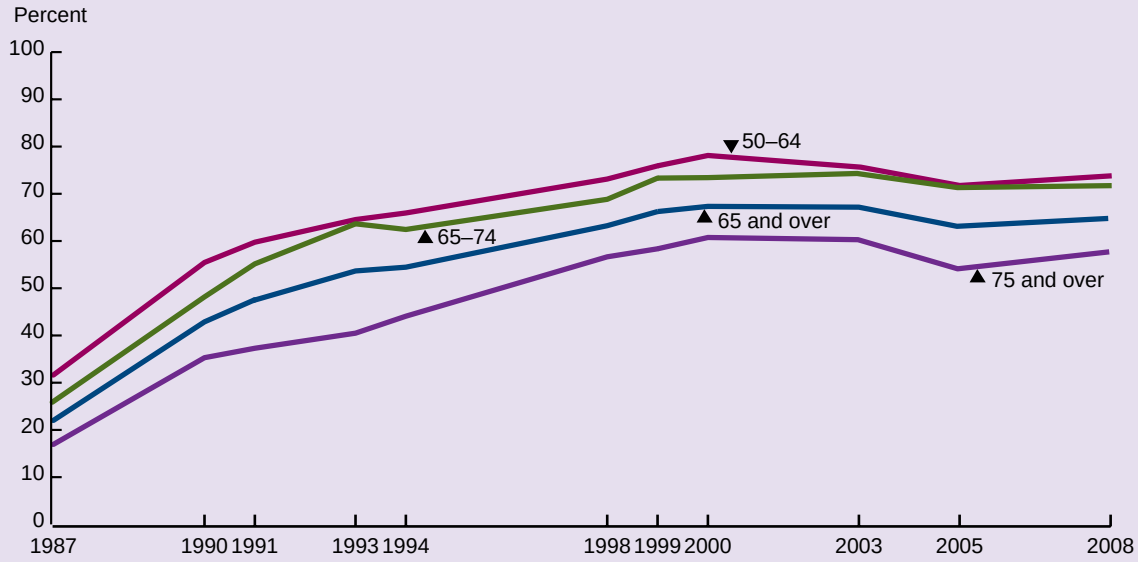


INDICATOR 22

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 50 to 74.[19]

Percentage of women age 50 and over who had a mammogram in the past 2 years, by age group, selected years 1987–2008



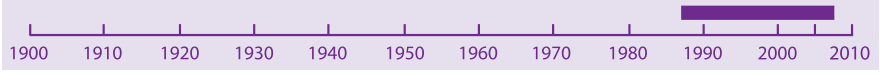
NOTE: Questions concerning use of mammography differed slightly on the National Health Interview Survey across the years for which data are shown. For details, see *Health, United States 2009*, Appendix II.
Reference population: These data refer to the civilian noninstitutionalized population.
SOURCE: Centers for Disease Control and Prevention, National Center for Health Statistics, National Health Interview Survey.

- 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 66 percent in 2008. 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 who were poor were less likely to have had a mammogram in the preceding 2 years than older women who were not poor. In 2008, 49 percent of women age 65 and over who lived in families with incomes less than 100 percent of the poverty threshold reported having had a mammogram. Among older women living in families with incomes 200 percent or more of the poverty threshold, 71 percent reported having had a mammogram.

- Older women without a high school diploma were less likely to have had a mammogram than older women with a high school diploma. In 2008, 49 percent of women age 65 and over without a high school diploma reported having had a mammogram in the preceding 2 years, compared with 66 percent of women who had a high school diploma and 76 percent of women who had at least some college education.

Data for this indicator's charts and bullets can be found in Table 22 on page 107.

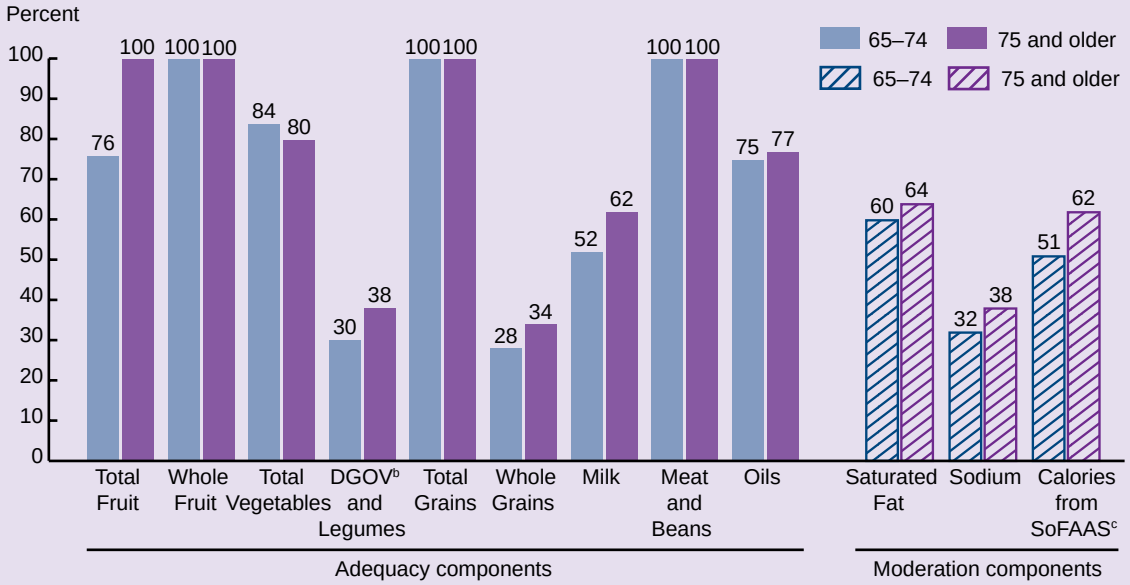


INDICATOR 23

Diet Quality

Nutrition plays a significant role in the health of older Americans. A healthful diet can reduce cardiometabolic risk factors, such as hypertension, diabetes, and obesity. The increase in the size of the older population is paralleled by an increase in the prevalence of chronic diseases, such as cardiovascular disease.[20] Since diet is a modifiable lifestyle factor, dietary improvement can lead to reduced disease risk and improved health in older adults. The Healthy Eating Index-2005 (HEI-2005)[21,22] measures how well diets conform to the recommendations of the 2005 Dietary Guidelines for Americans[23] and MyPyramid,[24] USDA's food guidance system (http://www.MyPyramid.gov).

Average dietary component scores as a percent of federal diet quality standards,[a] population age 65 and older, by age group, 2003–2004



[a]Federal diet quality standard is the Healthy Eating Index-2005; [b]Dark green and orange vegetables; [c]Solid fats, alcoholic beverages, and added sugars.
NOTE: The Healthy Eating Index-2005 (HEI-2005) comprises 12 components. Scores are averages across all adults and reflect long-term dietary intakes. The scores are expressed here as percentages of recommended dietary intake levels. A score corresponding to 100 percent indicates that the recommendation was met or exceeded, on average. A score below 100 percent indicates that average intake does not meet recommendations. Nine components of the HEI-2005 address nutrient adequacy. The remaining three components assess saturated fat, sodium, and calories from solid fats, alcoholic beverages, and added sugars, all of which should be consumed in moderation. For the adequacy components, higher scores reflect higher intakes; for the moderation components, higher scores reflect lower intakes because lower intakes are more desirable. For all components, a higher percentage indicates a higher-quality diet.
Reference population: These data refer to the resident noninstitutionalized population.
SOURCE: Centers for Disease Control and Prevention, National Center for Health Statistics, National Health and Nutrition Examination Survey, 2003–2004 and U.S. Department of Agriculture, Center for Nutrition Policy and Promotion, Healthy Eating Index-2005.

- In 2003–2004, the average diet of older Americans (age 65 and older) met or exceeded the federal diet quality standards for three components: whole fruit, total grains, and meat and beans; however, nine dietary components fell short.
- On average, the diets of Americans 75 years and older were superior in quality to the diets of their younger counterparts, ages 65–74, for total fruit, dark green and orange vegetables and legumes, whole grains, milk, and oils; however, for total vegetables, 65–74-year-olds fared better than those 75 and older. The diet quality standards were met or exceeded by both age groups for whole fruit, total grains, and meat and beans.
- Average intakes of saturated fat, sodium, and calories from solid fats, alcoholic beverages, and added sugars were too high and failed to meet the quality standards in both age groups.
- To meet federal guidelines, older Americans would need to reduce their intake of foods containing solid fats and added sugars, limit alcoholic beverages, and reduce their sodium (salt) intake. Healthier eating patterns would also include more vegetables, whole grains, oils, and nonfat/lowfat milk products.

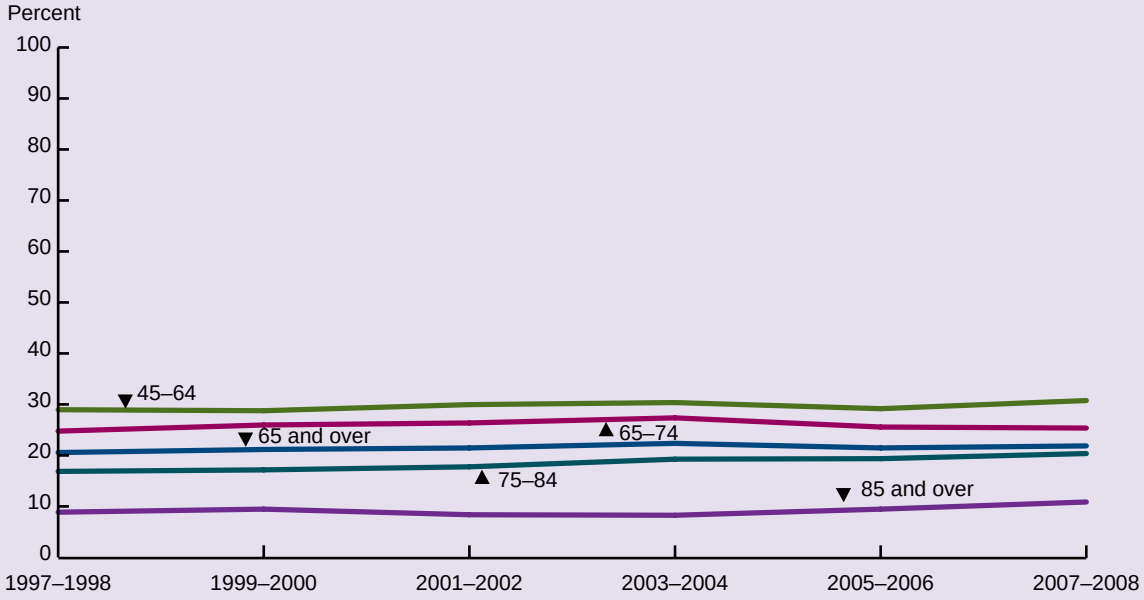
Data for this indicator's charts and bullets can be found in Table 23 on page 108.

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 enhance overall quality of life.[25,26] Research has shown that even among frail and very old adults, mobility and functioning can be improved through physical activity.[27]

Percentage of population age 45 and over who reported engaging in regular leisure time physical activity, by age group, 1997–2008



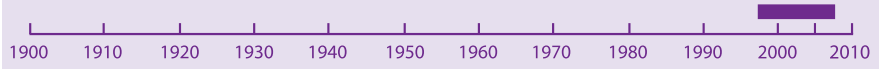
NOTE: Data are based on 2-year averages. "Regular leisure time physical activity" is defined as "engaging in light-moderate leisure time physical activity for greater than or equal to 30 minutes at a frequency greater than or equal to five times per week, or engaging in vigorous leisure time physical activity for greater than or equal to 20 minutes at a frequency greater than or equal to three 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 2007–2008, 22 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 25 percent among people age 65–74 to 11 percent among people age 85 and over. Although there was no significant change in the percentage reporting physical activity between 1997 and 2008 among all people 65 and over, there were small increases among people 75–84.

- Men age 65 and over are more likely than women in the same age group to report engaging in regular leisure time physical activity (27 percent and 18 percent, respectively, in 2007–2008). Older non-Hispanic white people report higher levels of physical activity than non-Hispanic black people (23 percent compared with 13 percent for non-Hispanic blacks in 2007–2008).

- 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.[28] Fourteen percent of older people reported engaging in strengthening exercises in 2007–2008.

Data for this indicator's charts and bullets can be found in Tables 24a and 24b on page 109.

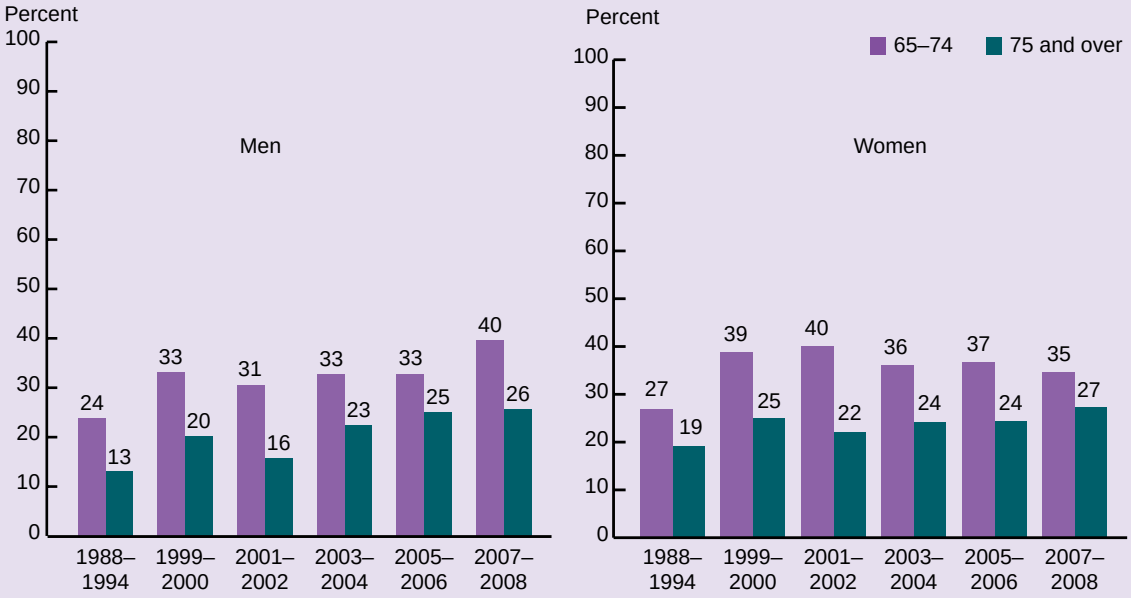


INDICATOR 25

Obesity

Similar to cigarette smoking, obesity is a major cause of preventable disease and premature death.[29] 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.[30,31]

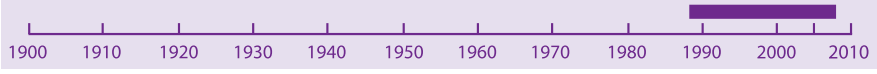
Percentage of population age 65 and over who are obese, by sex and age group, selected years 1988–2008



NOTE: Data are based on measured height and weight. Height was measured without shoes. Obese is defined by a Body Mass Index (BMI) of 30 kilograms/meter^2 or greater. 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.

- As with other age groups, the percentage of people age 65 and over who are obese has increased since 1988–1994. In 2007–2008, 32 percent of people age 65 and over were obese, compared with 22 percent in 1988–1994.
- In 2007–2008, 35 percent of women age 65–74 and 27 percent of women age 75 and over were obese. This is an increase from 1988–1994, when 27 percent of women age 65–74 and 19 percent of women age 75 and over were obese.
- Older men followed similar trends; 24 percent of men age 65–74 and 13 percent of men age 75 and over were obese in 1988–1994, compared with 40 percent of men age 65–74 and 26 percent of men age 75 and over in 2007–2008.
- Over the past 9 years, the trend has leveled off, with no statistically significant change in obesity for older men or women between 1999–2000 and 2007–2008.

Data for this indicator's charts and bullets can be found in Table 25 on page 110.

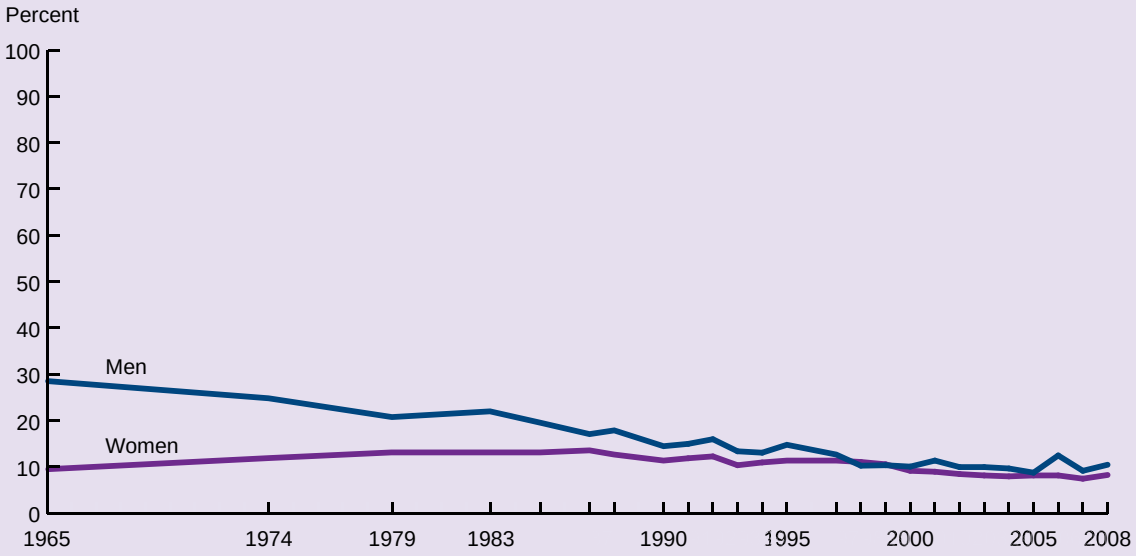


INDICATOR 26

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) increased 50 percent between 1981 and 2006. See "Indicator 15: Mortality." This increase reflects, in part, the effects of cigarette smoking.[32]

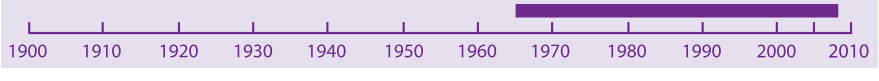
Percentage of people age 65 and over who are current cigarette smokers, by sex, selected years 1965–2008



NOTE: Data starting in 1997 are not strictly comparable with data for earlier years due to the 1997 National Health Interview Survey (NHIS) questionnaire redesign. Starting with 1993 data, current cigarette smokers were defined as ever smoking 100 cigarettes in their lifetime and smoking now on every day or some days. See Appendix B for the definiton of race and Hispanic origin 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.

- The percentage of older Americans who are current cigarette smokers declined between 1965 and 2008. Most of the decrease during this period is the result of the declining prevalence of cigarette smoking among men (from 29 percent in 1965 to 11 percent in 2008). For the same period, the percentage of women who smoke cigarettes has remained relatively constant, increasing slightly from 10 percent in 1965 before declining to 8 percent in 2008.
- Among older men, blacks have a higher rate of smoking than do whites (18 percent and 10 percent, respectively). The percentage of older women who smoke is similar among whites and African Americans.
- A large percentage of both men and women age 65 and over are former smokers. In 2008, 55 percent of older men previously smoked cigarettes, while 31 percent of women age 65 and over were former smokers.

Data for this indicator's charts and bullets can be found in Tables 26a, 26b, and 26c on pages 111–113.

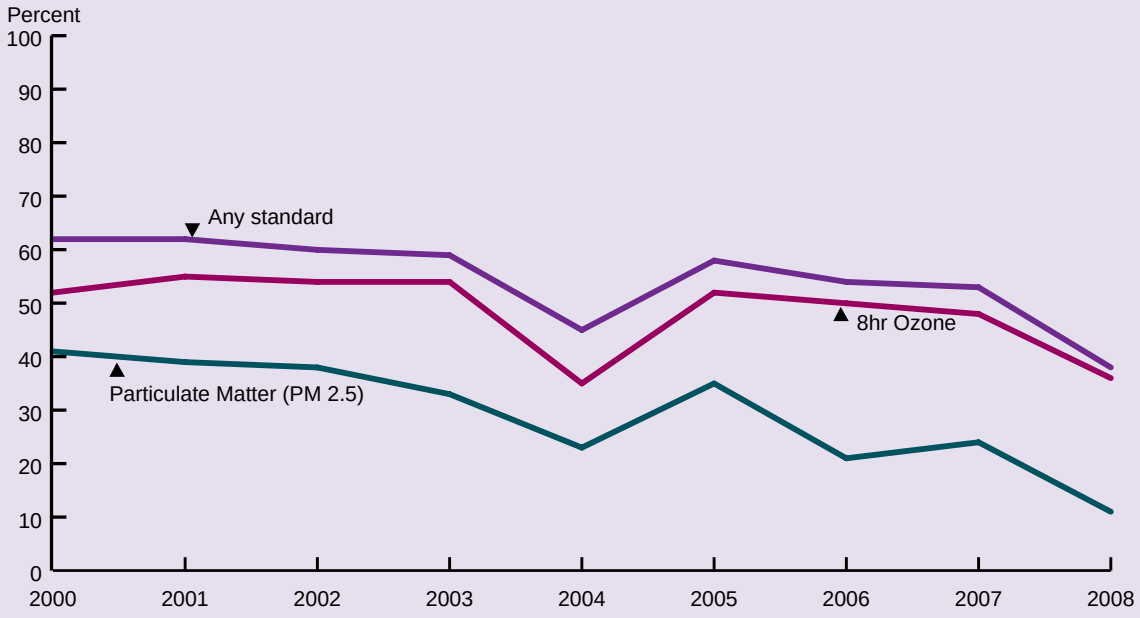


INDICATOR 27

Air Quality

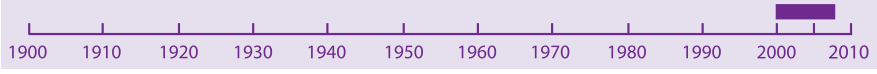
As people age, their bodies are less able to compensate for the effects of environmental hazards. Air pollution can aggravate heart and lung disease, leading to increased medication use, more visits to health care providers, admissions to emergency rooms and hospitals, and even death. An important indicator for environmental health is the percentage of older adults living in areas that have measured air pollutant concentrations above the level of the Environmental Protection Agency's (EPA) national 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.[33–37]

Percentage of people age 65 and over living in counties with "poor air quality," 2000–2008



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. In 2008, EPA strengthened the national standard for 8-hour ozone to 0.075 ppm and the national standard for lead to 0.15 µg/m3. This figure includes people living in counties that monitored ozone and lead concentrations above the new levels. This results in percentages that are not comparable to previous publications.
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., U.S. Census Bureau, Population Projections, 2000–2008.

- In 2008, 36 percent of people age 65 and over lived in counties with poor air quality for ozone compared with 52 percent in 2000.
- A comparison of 2000 and 2008 shows a reduction in PM 2.5. In 2000, 41 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 11 percent of people age 65 and over in 2008.
- The percentage of people age 65 and over living in counties that experienced poor air quality for any air pollutant decreased from 62 percent in 2000 to 38 percent in 2008.

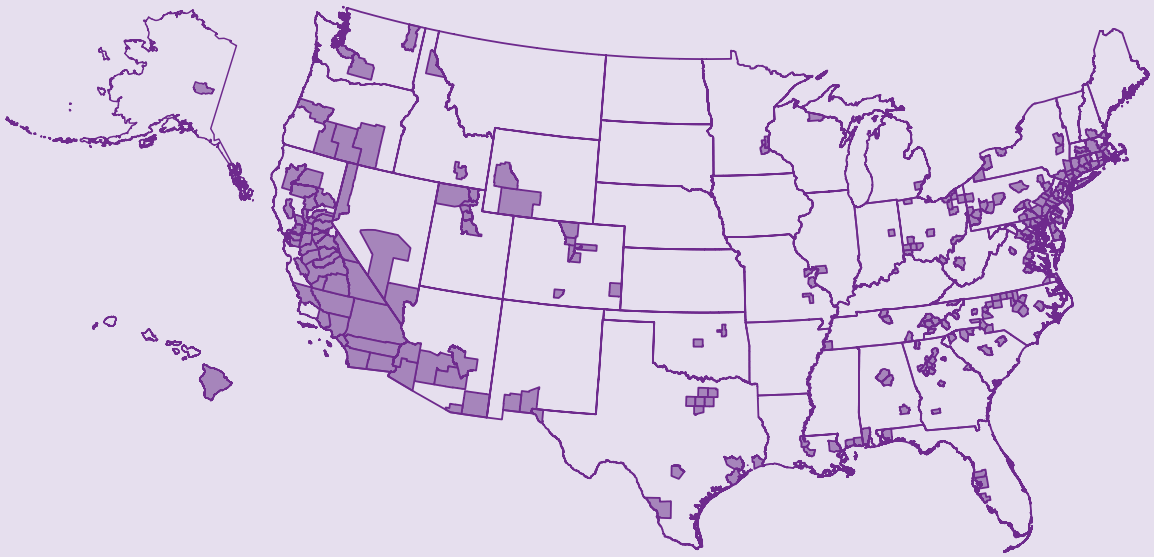


INDICATOR 27

Air Quality continued

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 meet the standards that have been set to protect human health.

Counties with "poor air quality" for any standard in 2008



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.
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, 2000–2008.

- In 2008, nearly 42 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 127 million people lived in counties where monitored air in 2008 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.

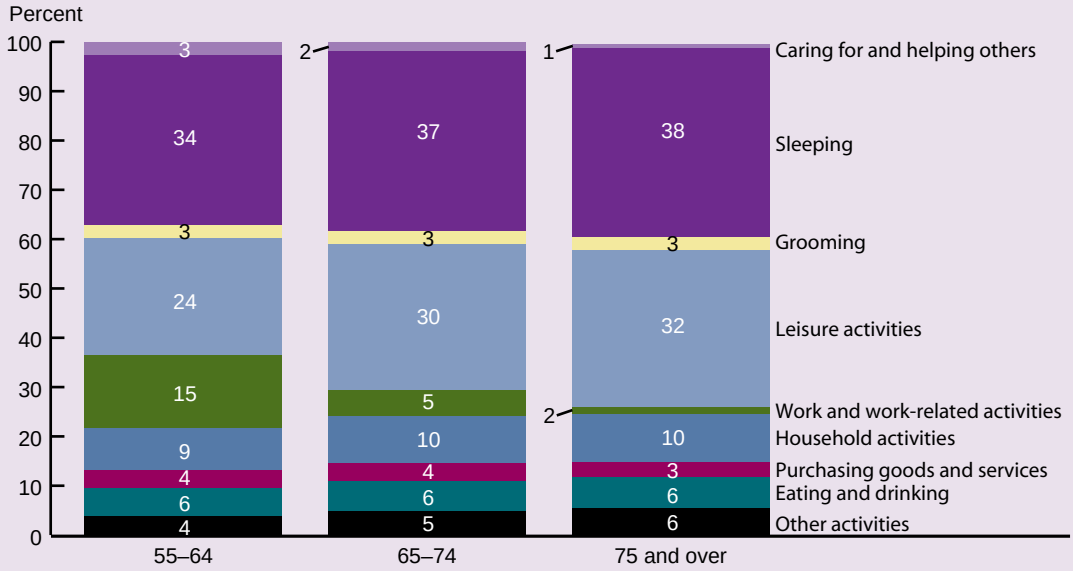
Data for this indicator's charts and bullets can be found in Tables 27a and 27b on pages 113–117.

INDICATOR 28

Use of Time

How individuals spend their time reflects their financial and personal situations, needs, or desires. Time-use data show that as Americans get older, they spend more of their time in leisure activities.

Percentage of day that people age 55 and over spent doing selected activities on an average day, by age group, 2008



NOTE: "Other activities" includes activities such as educational activities; organizational, civic, and religious activities; and telephone calls. Chart includes people who did not work at all.

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

SOURCE: Bureau of Labor Statistics, American Time Use Survey.

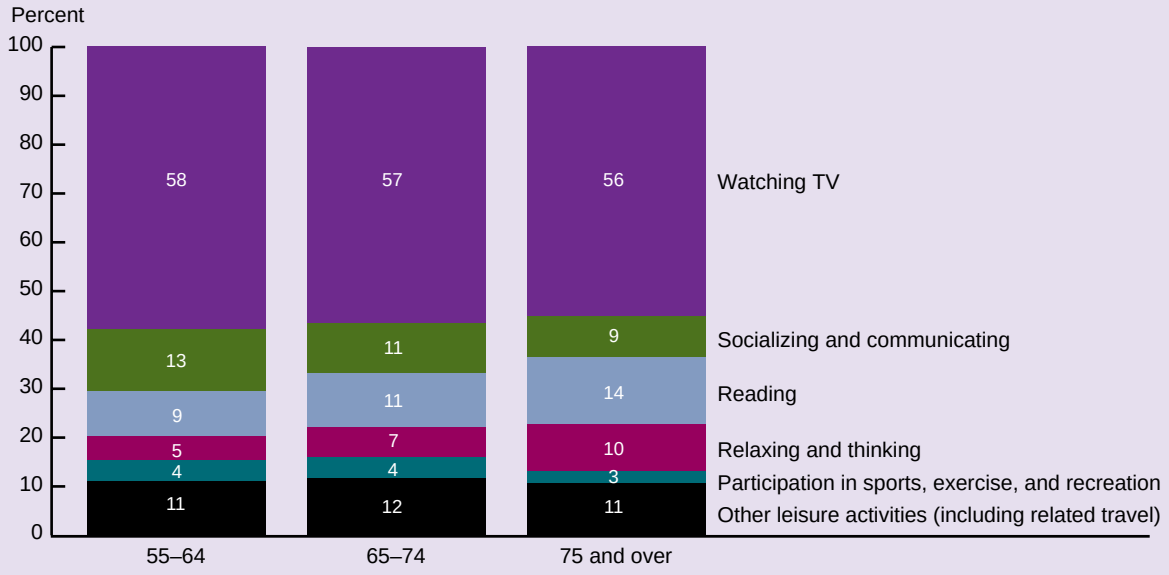
- In 2008, older Americans spent on average more than one-quarter of their time in leisure activities. This proportion increased with age: Americans 75 and over spent 32 percent of their time in leisure compared with 24 percent for those age 55–64.
- On an average day, people age 55–64 spent 15 percent of their time (about 4 hours) working or doing work-related activities compared with 5 percent (about one hour) for people age 65–74 and 2 percent (less than 30 minutes) for people age 75 and over.

INDICATOR 28

Use of Time continued

Leisure activities are those done when free from duties such as working, household chores, or caring for others. During these times, individuals have flexibility in choosing what to do.

Percentage of total leisure time that people age 55 and over spent doing selected leisure activities on an average day, by age group, 2008



Reference population: These data refer to the civilian noninstitutionalized population.
SOURCE: Bureau of Labor Statistics, American Time Use Survey.

- Watching TV was the activity that occupied the most leisure time—slightly more than one-half the total—for Americans age 55 and over.
- Americans age 75 and over spent a higher percentage of their leisure time reading (14 percent versus 9 percent) and relaxing and thinking (10 percent versus 5 percent) than did Americans age 55–64.
- The proportion of leisure time that older Americans spent socializing and communicating—such as visiting friends or attending or hosting social events—declined with age. For Americans age 55–64, 13 percent of leisure time was spent socializing and communicating compared to 8 percent for those age 75 and over.

Data for this indicator's charts and bullets can be found in Tables 28a and 28b on page 118.

Health Care

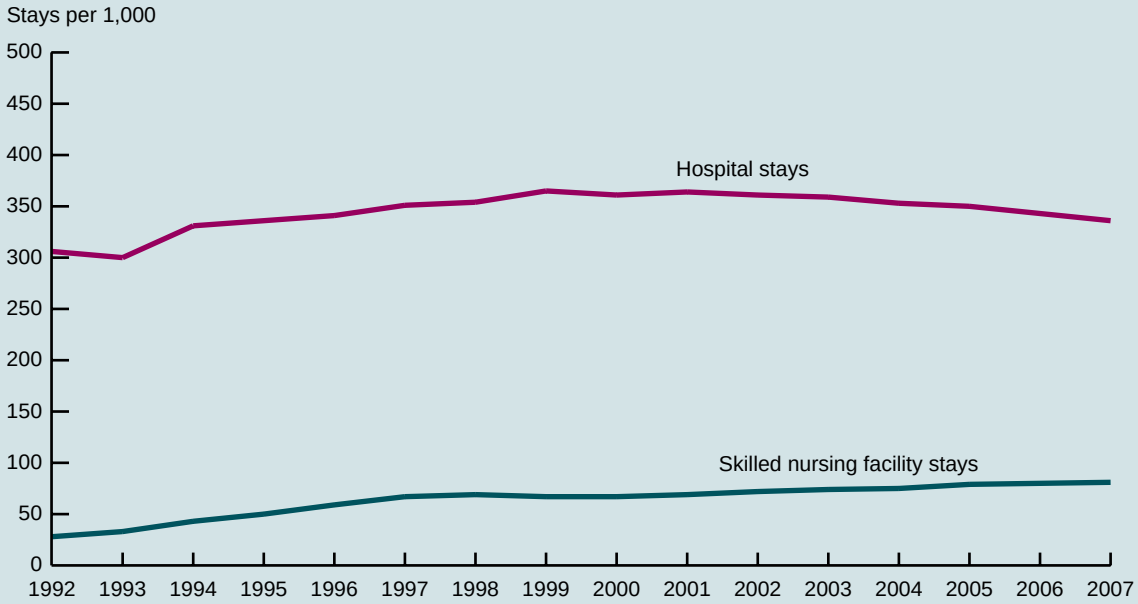
Indicator 29: **Use of Health Care Services**
Indicator 30: **Health Care Expenditures**
Indicator 31: **Prescription Drugs**
Indicator 32: **Sources of Health Insurance**
Indicator 33: **Out-of-Pocket Health Care Expenditures**
Indicator 34: **Sources of Payment for Health Care Services**
Indicator 35: **Veterans' Health Care**
Indicator 36: **Residential Services**
Indicator 37: **Personal Assistance and Equipment**

INDICATOR 29

Use of Health Care Services

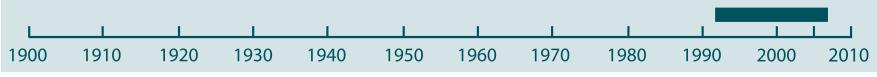
Most older Americans have health insurance through Medicare. Medicare covers a variety of services, including inpatient hospital care, physician services, hospital outpatient care, home health care, skilled nursing facility care, hospice services, and (beginning in January 2006) prescription drugs. Utilization 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, 1992–2007



NOTE: 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 in fee-for-service.
SOURCE: Centers for Medicare and Medicaid Services, Medicare claims and enrollment data.

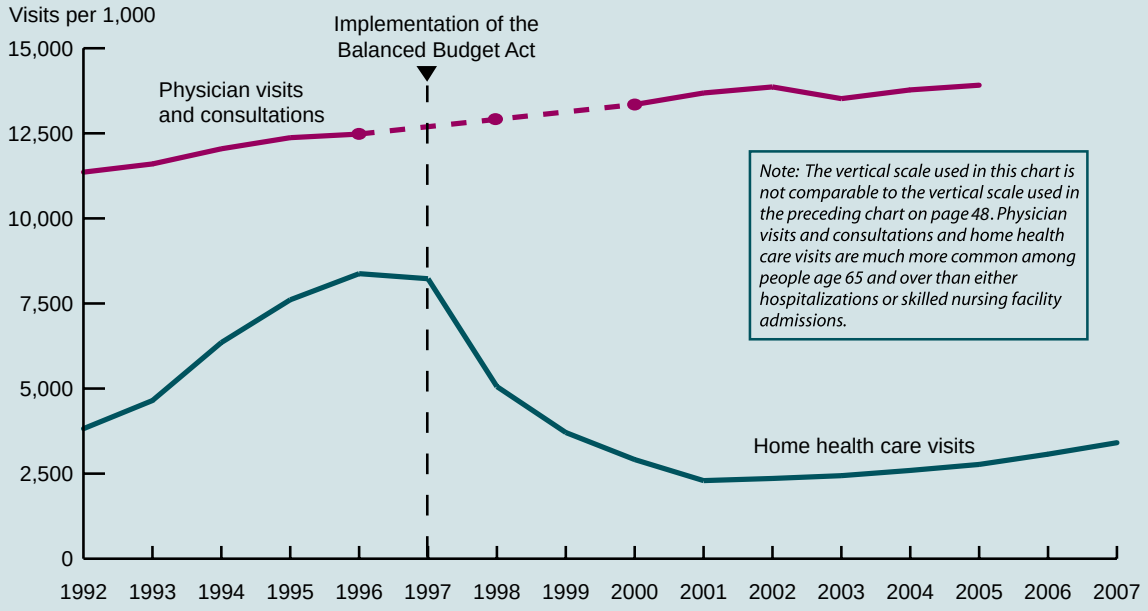
- Overall, between 1992 and 1999, the hospitalization rate increased from 306 hospital stays per 1,000 Medicare enrollees to 365 per 1,000. The rate then decreased to 336 per 1,000 enrollees in 2007. The average length of a hospital stay decreased from 8.4 days in 1992 to 5.6 days in 2007.
- Skilled nursing facility stays increased significantly from 28 per 1,000 Medicare enrollees in 1992 to 81 per 1,000 in 2007. Much of the increase occurred from 1992 to 1997.



INDICATOR 29

Use of Health Care Services continued

Medicare-covered physician and home health care visits per 1,000 Medicare enrollees age 65 and over in fee-for-service, 1992–2007

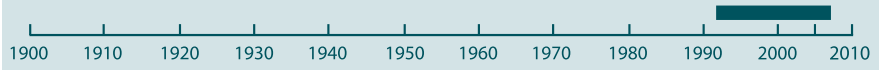


Data on physician visits and consultations are not available for 1997,1999, 2006, and 2007.

NOTE: Physician visits and consultations include all settings, such as physician offices, hospitals, emergency rooms, and nursing homes. The definition of physician visits and consultations changed beginning in 2003, resulting in a slightly lower rate. 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 in fee-for-service.
SOURCE: Centers for Medicare and Medicaid Services, Medicare claims and enrollment data.

- Overall, between 1992 and 2005, the number of physician visits and consultations increased. There were 11,359 visits and consultations per 1,000 Medicare enrollees in 1992, compared with 13,914 in 2005.
- The number of home health care visits per 1,000 Medicare enrollees increased from 3,822 in 1992 to 8,376 in 1996. 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.[38] Home health care visits declined after 1997 to 2,295 per 1,000 enrollees 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. The visit rate increased thereafter to 3,409 per 1,000 enrollees in 2007.
- Use of skilled nursing facility and home health care increased with age. In 2007, there were 32 skilled nursing facility stays per 1,000 Medicare enrollees age 65–74, compared with 227 per 1,000 enrollees age 85 and over. Home health agencies made 1,713 visits per 1,000 enrollees age 65–74, compared with 7,333 per 1,000 for those age 85 and over.

Data for this indicator's charts and bullets can be found in Tables 29a and 29b on page 119.

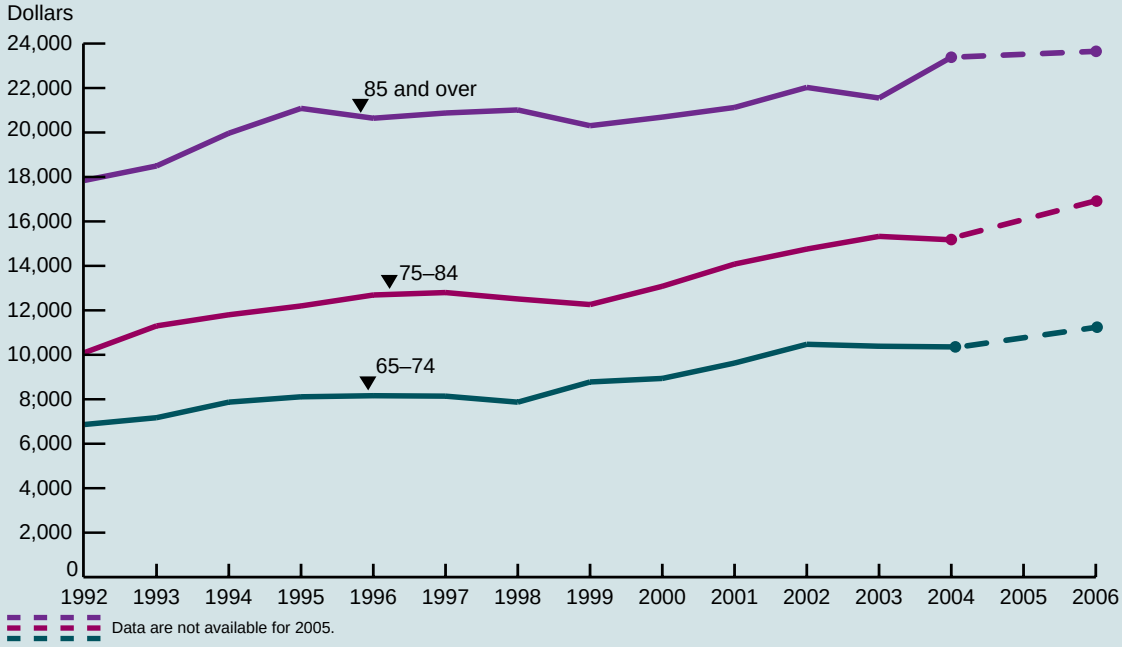


INDICATOR 30

Health Care Expenditures

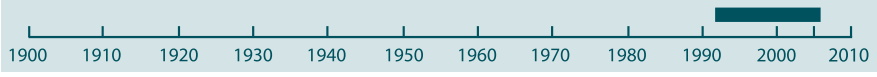
Older Americans use more health care than any other age group. Health care costs are increasing at the same time the baby boom generation is approaching retirement age.

Average annual health care costs for Medicare enrollees age 65 and over, by age group, 1992–2006



NOTE: Data include both out-of-pocket costs and costs covered by insurance.
Dollars are inflation-adjusted to 2006 using the Consumer Price Index (Series CPI-U-RS).
Reference population: These data refer to Medicare enrollees.
SOURCE: Centers for Medicare and Medicaid Services, Medicare Current Beneficiary Survey.

- After adjusting for inflation, health care costs increased significantly among older Americans from 1992 to 2006. Average costs rose substantially with age.
- Average health care costs varied by demographic characteristics. Average costs among non-Hispanic blacks were $18,098 in 2006, compared with $14,144 among Hispanics. Low-income individuals incurred higher health care costs; those with less than $10,000 in income averaged $21,033 in health care costs whereas those with more than $30,000 in income averaged only $12,440.
- Costs also varied by health status. Individuals with no chronic conditions incurred $5,186 in health care costs on average. Those with five or more conditions incurred $25,132. Average costs among residents of long-term care facilities were $57,022, compared with only $12,383 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 9.8 percent in 1992 to about 5 percent in 1997 and remained relatively constant thereafter. The percentage who reported difficulty obtaining care varied between 2 percent and 3 percent.

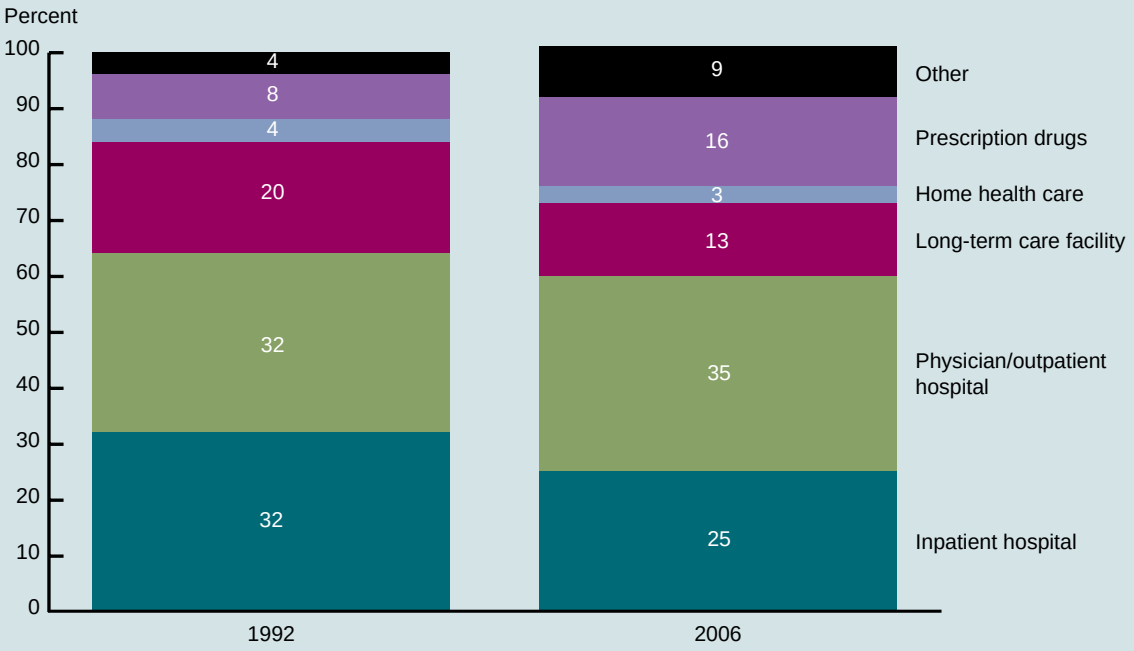


INDICATOR 30

Health Care Expenditures continued

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.

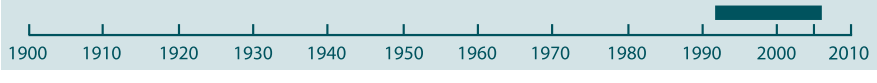
Major components of health care costs among Medicare enrollees age 65 and over, 1992 and 2006



NOTE: Data include both out-of-pocket costs and costs covered by insurance. "Other" includes short-term institutions, hospice services, and dental care.
Reference population: These data refer to Medicare enrollees.
SOURCE: Centers for Medicare and Medicaid Services, Medicare Current Beneficiary Survey.

- Hospital and physician services are the largest components of health care costs. Long-term care facilities accounted for 13 percent of total costs in 2006. Prescription drugs accounted for 16 percent of health care costs.
- The mix of health care services changed between 1992 and 2006. Inpatient hospital care accounted for a lower share of costs in 2006 (25 percent compared with 32 percent in 1992). Prescription drugs increased in importance from 8 percent of costs in 1992 to 16 percent in 2006. "Other" costs (short-term institutions, hospice and dental care) also increased as a percentage of all costs (4 percent to 9 percent).
- The mix of services varied with age. The biggest difference occurred for long-term care facility services; average costs were $7,182 among people age 85 and over, compared with just $547 among 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 30a, 30b, 30c, 30d, and 30e on pages 120–122.

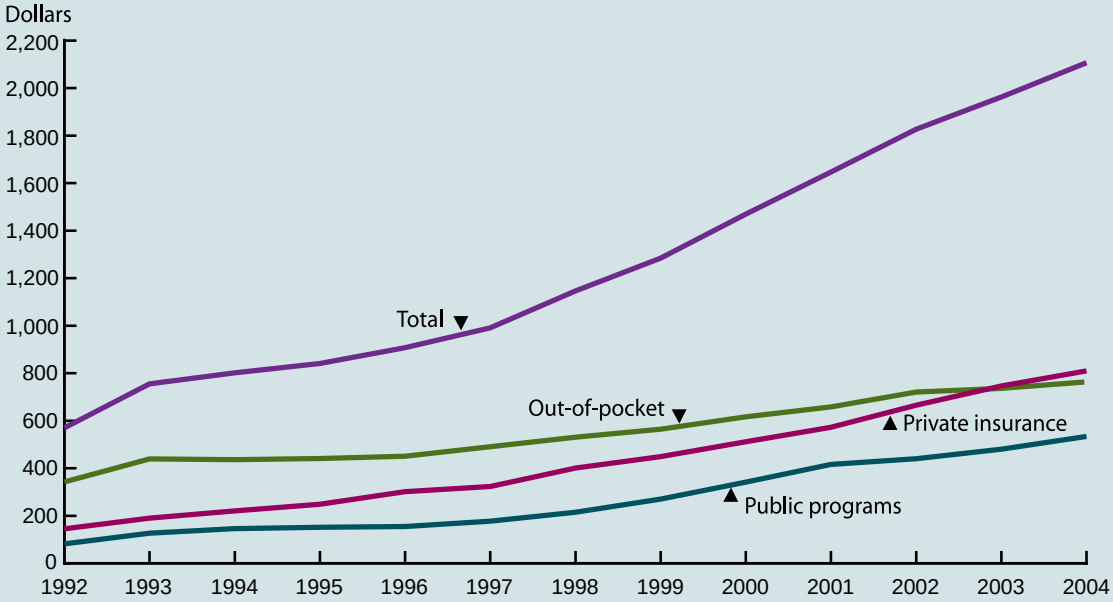


INDICATOR 31

Prescription Drugs

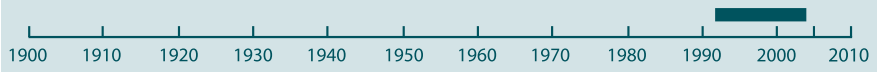
Prescription drug costs have increased rapidly in recent years, as more new drugs become available. Lack of prescription drug coverage has created a financial hardship for many older Americans. Medicare coverage of prescription drugs began in January 2006, including a low-income subsidy for beneficiaries with low incomes and assets.

Average annual prescription drug costs for noninstitutionalized Medicare enrollees age 65 and over, by sources of payment, 1992–2004



NOTE: Dollars have been inflation-adjusted to 2004 using the Consumer Price Index (Research Series). Reported costs have been adjusted by a factor of 1.205 to account for underreporting of prescription drug use. Public programs include Medicare, Medicaid, Department of Veterans Affairs, and other state and federal programs. Data for 2005 and 2006 were not available in time to include in this report.
Reference population: These data refer to Medicare enrollees.
SOURCE: Centers for Medicare and Medicaid Services, Medicare Current Beneficiary Survey.

- Average prescription drug costs for older Americans have increased rapidly in recent years. Average costs per person were $2,107 in 2004.
- Average out-of-pocket costs also increased, though not as much as total costs because private and public insurance covered more of the cost over time. Older Americans paid 60 percent of prescription drug costs out of pocket in 1992, compared with 36 percent in 2004. Private insurance covered 38 percent of prescription drug costs in 2004; public programs covered 25 percent.
- Costs varied significantly among individuals. Approximately 8 percent of older Americans incurred no prescription drug costs in 2004. About 24 percent incurred $2,500 or more in prescription drug costs that year.

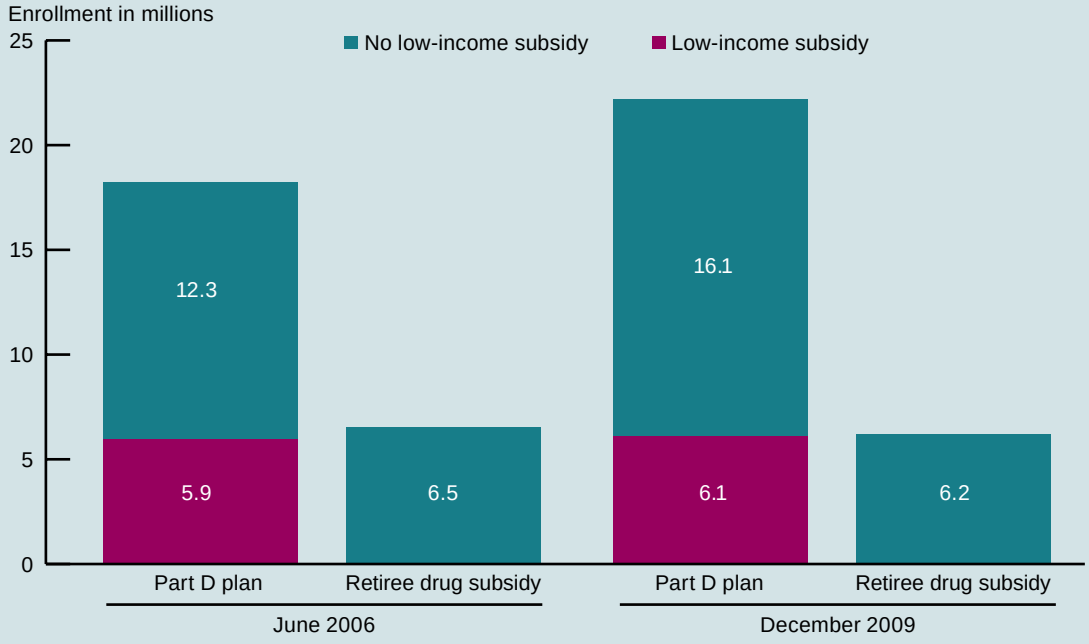


INDICATOR 31

Prescription Drugs continued

Under Medicare Part D, beneficiaries may join a standalone prescription drug plan or a Medicare Advantage plan that provides prescription drug coverage in addition to other Medicare-covered services. In situations where beneficiaries receive drug coverage from a former employer, the former employer may be eligible to receive a retiree drug subsidy from Medicare to help cover the cost of the drug benefit.

Number of Medicare enrollees age 65 and over who enrolled in a Part D prescription drug plan or were covered under the Retiree Drug Subsidy, June 2006 and December 2009



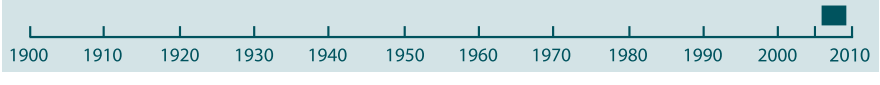
Reference population: These data refer to Medicare enrollees.
SOURCE: Centers for Medicare and Medicaid Services, Management Information Integrated Repository.

- The number of Medicare beneficiaries enrolled in Part D prescription drug plans increased from 18.2 million (51 percent of beneficiaries) in June 2006 to 22.2 million (57 percent of beneficiaries) in December 2009. In December 2009, 61 percent of plan enrollees were in standalone plans and 39 percent were in Medicare Advantage plans. Approximately 6.2 million beneficiaries were covered by the retiree drug subsidy. Beneficiaries who were not in Part D plans and not covered by the retiree drug subsidy either had drug coverage through another source (e.g., TRICARE, Federal Employees Health Benefits plan, Department of Veterans' Affairs, current employer) or did not have drug coverage.

- In December 2009, 6.1 million Part D enrollees were receiving low-income subsidies. Many of these beneficiaries had drug coverage through the Medicaid program prior to enrollment in Part D.

- Chronic conditions are associated with high prescription drug costs. In 2004, older Americans with no chronic conditions incurred average prescription drug costs of $800. Those with five or more chronic conditions incurred $3,862 in prescription drug costs on average.

Data for this indicator's charts and bullets can be found in Tables 31a, 31b, 31c and 31d on pages 122–123.

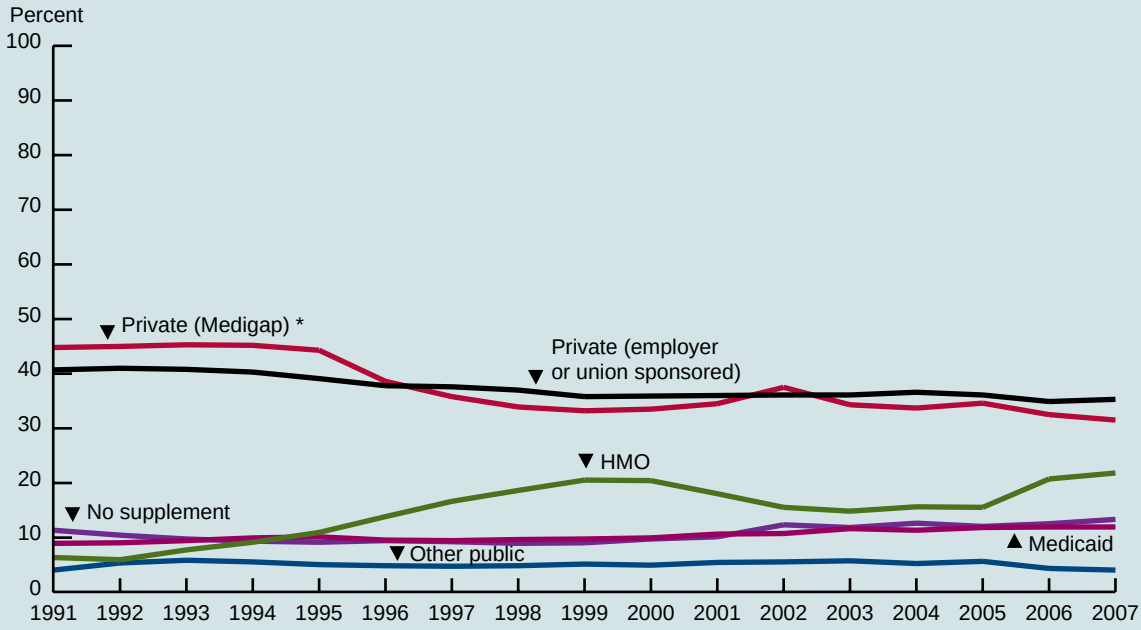


INDICATOR 32

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 pay for services not covered by Medicare. Prior to 2006, many beneficiaries received prescription drug coverage through supplemental insurance. Since January 2006, beneficiaries have had the option of receiving prescription drug coverage under Medicare through stand-alone prescription drug plans or through some Medicare Advantage health plans.

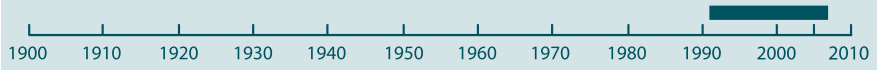
Percentage of noninstitutionalized Medicare enrollees age 65 and over with supplemental health insurance, by type of insurance, 1991–2007



* Includes people with private supplement of unknown sponsorship.
NOTE: HMO/health plans include Health Maintenance Organizations (HMOs), Preferred Provider Organizations (PPOs), and private fee-for-service plans (PFFSs). Not all types of plans were available in all years. Since 2003 these types of plans have been known collectively as Medicare Advantage. 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). Chart excludes enrollees whose primary insurance is not Medicare (approximately 1 to 2 percent of enrollees). Medicaid coverage was determined from both survey responses and Medicare administrative records.
Reference population: These data refer to Medicare enrollees.
SOURCE: Centers for Medicare and Medicaid Services, Medicare Current Beneficiary Survey.

- Most Medicare enrollees have a private insurance supplement, approximately equally split between employer-sponsored and Medigap policies. The percentage with Medicaid coverage has increased from 10 percent in 2000 to 12 percent in 2007. Enrollment in Medicare HMOs and other health plans, which are usually equivalent to Medicare supplements because they offer extra benefits, varied between 6 percent and 22 percent. About 13 percent of Medicare enrollees reported having no health insurance supplement in 2007.
- Enrollment in HMOs and other health plans increased in the 1990s, decreased from 2000 to 2003 (as many plans withdrew from the Medicare program), then increased again, following establishment of the Medicare Advantage program. The percent of Medicare enrollees without a supplement increased from 10 percent in 2000 to 13 percent in 2007.

Data for this indicator's charts and bullets can be found in Tables 32a and 32b on page 124.

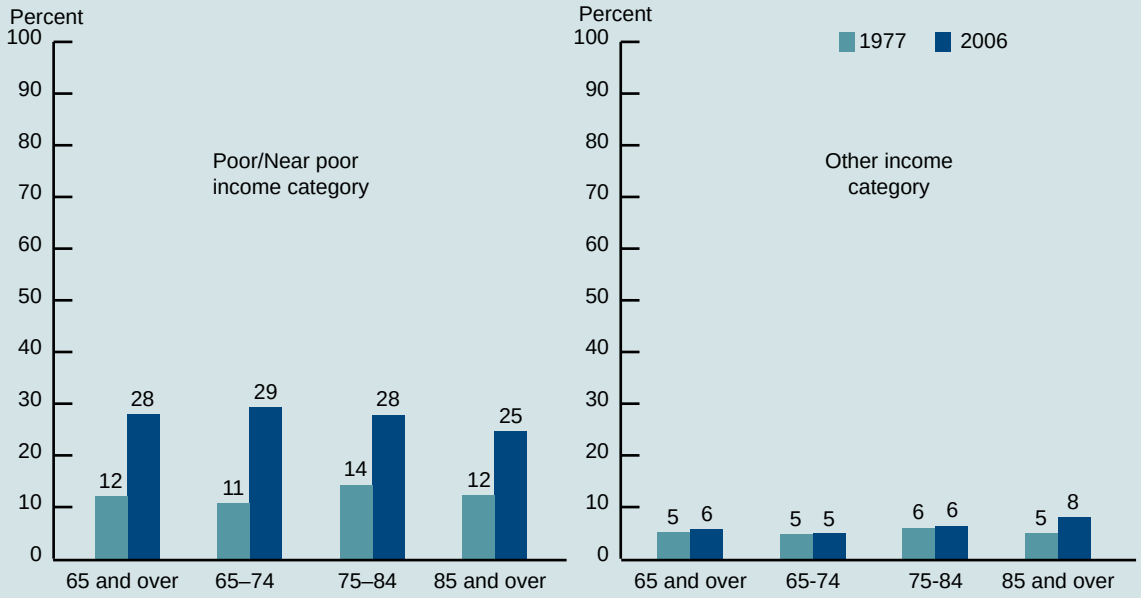


INDICATOR 33

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.[39,40] The percentage of household income that is allocated to health care expenditures is a measure of health care expense burden placed on older people.

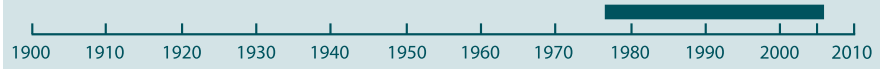
Out-of-pocket health care expenditures as a percentage of household income, among noninstitutionalized people age 65 and over, by age and income category, 1977 and 2006



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. For people with no out-of-pocket expenditures the ratio of out-of pocket spending to income was set to zero. For additional details on how the ratio of out-of-pocket spending to income and the poverty level were calculated, see Table 33b in Appendix A.
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 2006 (83 percent to 95 percent, respectively).
- From 1977 to 2006 the percentage of household income that people age 65 and over allocated to out-of-pocket spending for health care services increased among those in the poor/near poor income category from 12 percent to 28 percent. Increases were also observed for those in poor or fair health (from 10 percent to 13 percent) as well as for those in excellent, very good, or good health (from 6 percent to 8 percent).
- In 2006, as in the 6 previous years, over one-half of out-of-pocket health care spending by noninstitutionalized people age 65 and over was used to purchase prescription drugs. The percentage of out-of-pocket spending for prescription drugs increased from 2000 to 2004 (54 percent to 61 percent, respectively) then decreased starting in 2005.
- In 2006, people age 85 and over spent a lower proportion of out-of-pocket dollars than people age 65–74 on dental services and office-based medical provider visits but a higher proportion on other health care (e.g., home health care).

Data for this indicator's chart and bullets can be found in Tables 33a, 33b, and 33c on pages 125–128.

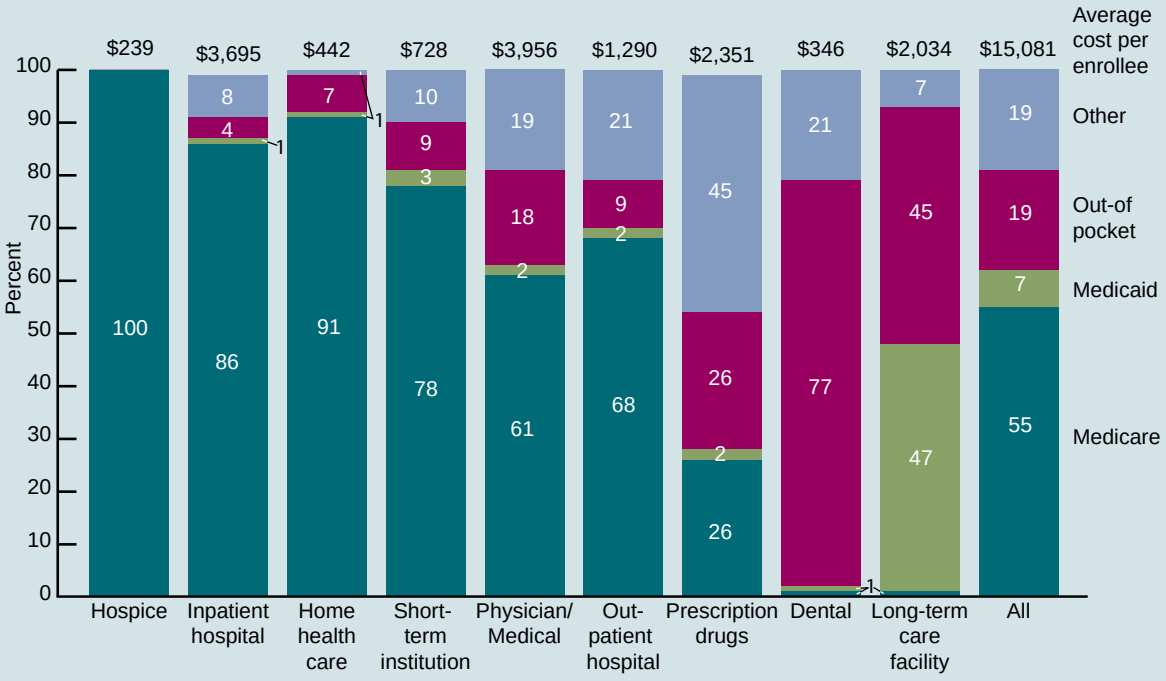


INDICATOR 34

Sources of Payment for Health Care Services

Medicare covers about one-half of the health care costs of Medicare enrollees age 65 and over. Medicare's payments are focused on acute care services such as hospitals and physicians. Nursing home care, prescription drugs, and dental care have been primarily financed out-of-pocket or by other payers. Medicare coverage of prescription drugs began in January 2006, including a low-income subsidy.

Sources of payment for health care services for Medicare enrollees age 65 and over, by type of service, 2006



NOTE: "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 and Medicaid Services, Medicare Current Beneficiary Survey.

- Medicare paid for slightly more than half (55 percent) of the health care costs of Medicare enrollees age 65 and over in 2006. Medicare finances most of their hospital and physician costs, as well as a majority of short-term institutional, home health, and hospice costs.

- Medicaid covered 7 percent of health care costs of Medicare enrollees age 65 and over, and other payers (primarily private insurers) covered another 19 percent. Medicare enrollees age 65 and over paid 19 percent of their health care costs out of pocket, not including insurance premiums.

- In 2006, 47 percent of long-term care facility costs for Medicare enrollees age 65 and over were covered by Medicaid; another 45 percent of these costs were paid out of pocket. Twenty-six percent of prescription drug costs for Medicare enrollees age 65 and over were covered by Medicare, 45 percent were covered by third-party payers other than Medicare and Medicaid (consisting mostly of private insurers), and 26 percent were paid out of pocket. Seventy-seven percent of dental care received by older Americans was 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 percent of health care costs out of pocket, but have a higher average cost for services than individuals with higher incomes.

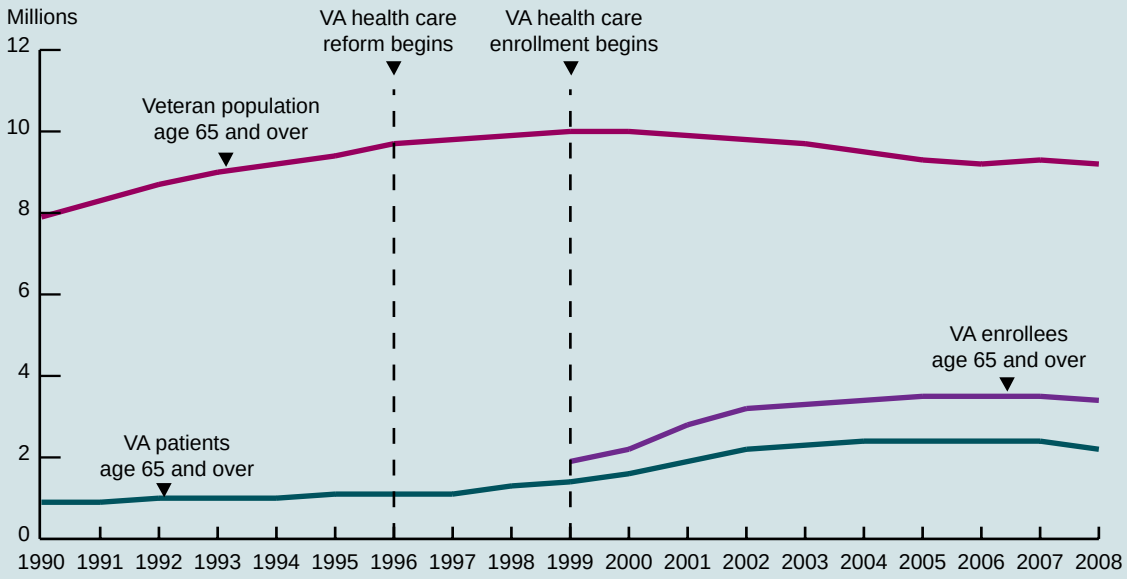
Data for this indicator's charts and bullets can be found in Tables 34a and 34b on page 129.

INDICATOR 35

Veterans' Health Care

The numbers 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 mental health services, long-term care (nursing home care and community-based care), and specialized services for the disabled. In addition, as the largest integrated health care system in the country, VHA provides broader geographic access to these important services.

Veterans age 65 and over enrolled in or receiving care from the Veterans Health Administration, 1990–2008



NOTE: Department of Veterans Affairs (VA) enrollees are veterans who have signed up to receive health care from the Veterans Health Administration (VHA). VA patients are veterans who have received care each year through VHA. The methods used to calculate VA patients differ from those used in *Older Americans 2004* and *Older Americans Update 2006*. Veterans who received care but were not enrolled in VA are now included in patient counts. VHA Vital Status files from the Social Security Administration (SSA) are now used to ascertain veteran deaths.

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

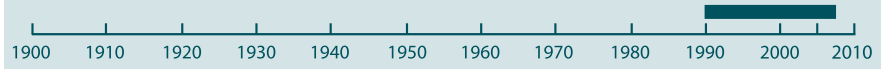
SOURCE: Department of Veterans Affairs, Veteran Population 2007; Fiscal 2009 Year-end Office of the Assistant Deputy Under Secretary for Health for Policy and Planning Enrollment file linked with September 2009 VHA Vital Status data (including data from VHA, VA, Medicare, and SSA).

- In 2008, approximately 2.2 million veterans age 65 and over received health care from the VHA. An additional 1.2 million older veterans were enrolled to receive health care from the VHA but did not use its services in 2008.

- Reforms and initiatives implemented by the VA since 1996 have led to an increased demand for VHA services among veterans despite the short-term decline in the numbers of older veterans (see "Indicator 6: Older Veterans"). Some of the changes include: implementing enrollment for VHA health care and opening the system to all veterans (1999) and reopening enrollment to Priority 8 veterans with incomes up to 110 percent of the Geographic Means Test/Veterans Means Test Thresholds (2009).

- Older veterans continue to turn to VHA for their health care needs, despite their eligibility for other sources of health care. VHA estimates that approximately one-third of its enrollees age 65 and over are enrolled in Medicare Part D. Approximately 22 percent of enrollees age 65 and over have some form of private insurance. Another 14 percent are enrolled in TRICARE for Life and 12 percent are eligible for Medicaid. In contrast, about 4 percent of VHA enrollees age 65 and over report having no other public or private coverage.[41]

Data for this indicator's chart and bullets can be found in Table 35 on page 130.

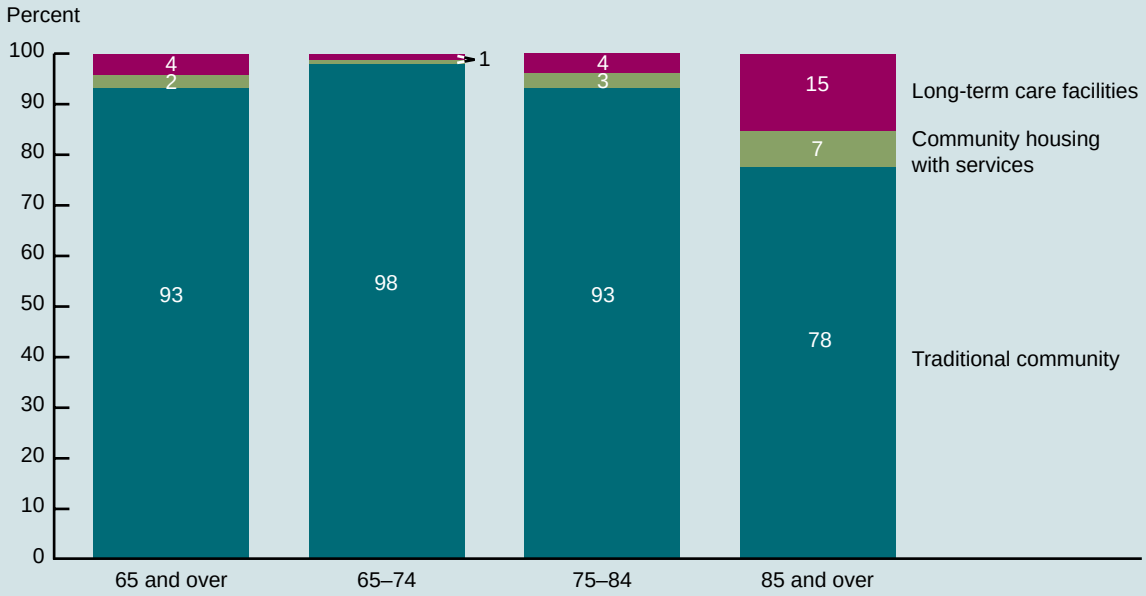


INDICATOR 36

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 in selected residential settings, by age group, 2007



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 (or unit) is considered a long-term care facility if it is certified by Medicare or Medicaid; or has three 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, seven-day-a-week supervision by a non-family, paid caregiver.
Reference population: These data refer to Medicare enrollees.
SOURCE: Centers for Medicare and Medicaid Services, Medicare Current Beneficiary Survey.

- In 2007, 2 percent of the Medicare population age 65 and over resided in community housing with at least one service available. Four 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 15 percent resided in long-term care facilities. Among individuals age 65–74, 98 percent resided in traditional community settings.

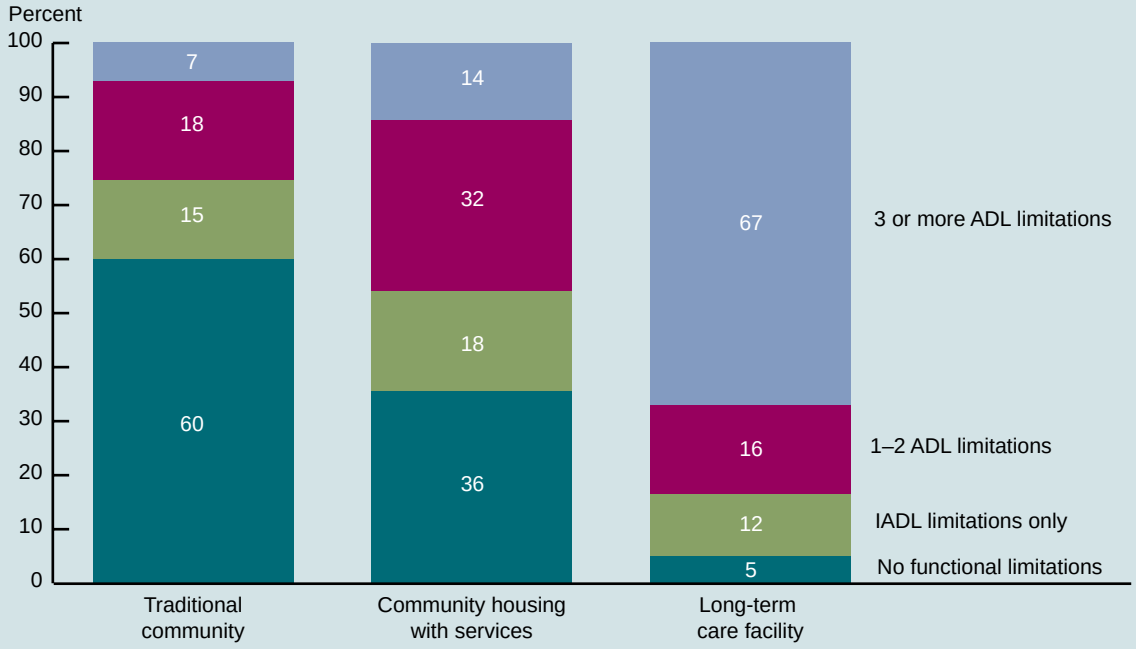
- Among residents of community housing with services, 87 percent reported access to meal preparation services; 84 percent reported access to housekeeping/cleaning services; 72 percent reported access to laundry services; and 51 percent reported access to help with medications. These numbers reflect percentages reporting availability of specific services, but not necessarily the number that actually used these services.

- Sixty-five percent of residents in community housing with services reported that there were separate charges for at least some services.

INDICATOR 36

Residential Services continued

Percentage of Medicare enrollees age 65 and over with functional limitations, by residential setting, 2007



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 (or unit) is considered a long-term care facility if it is certified by Medicare or Medicaid; or has three 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, seven-day-a-week supervision by a non-family, paid caregiver. Instrumental activities of daily living (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. Activities of daily living (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-six percent of individuals living in community housing with services had at least one activity of daily living (ADL) limitation compared with 25 percent of traditional community residents. Among long-term care facility residents, 83 percent had at least one ADL limitation. Thirty-six percent of individuals living in community housing with services had no ADL or instrumental activities of daily living (IADL) limitations.

- The availability of personal services in residential settings may explain some of the observed decline in nursing home use.

- Residents of community housing with services tended to have similar incomes to traditional community residents, and higher incomes than long-term care facility residents. Thirty-eight percent of long-term care facility residents had incomes of $10,000 or less in 2007, compared with 13–14 percent of traditional community residents and residents of community housing with services.

- Over one-half (56 percent) of people living in community housing with services reported they could continue living there if they needed substantial care.

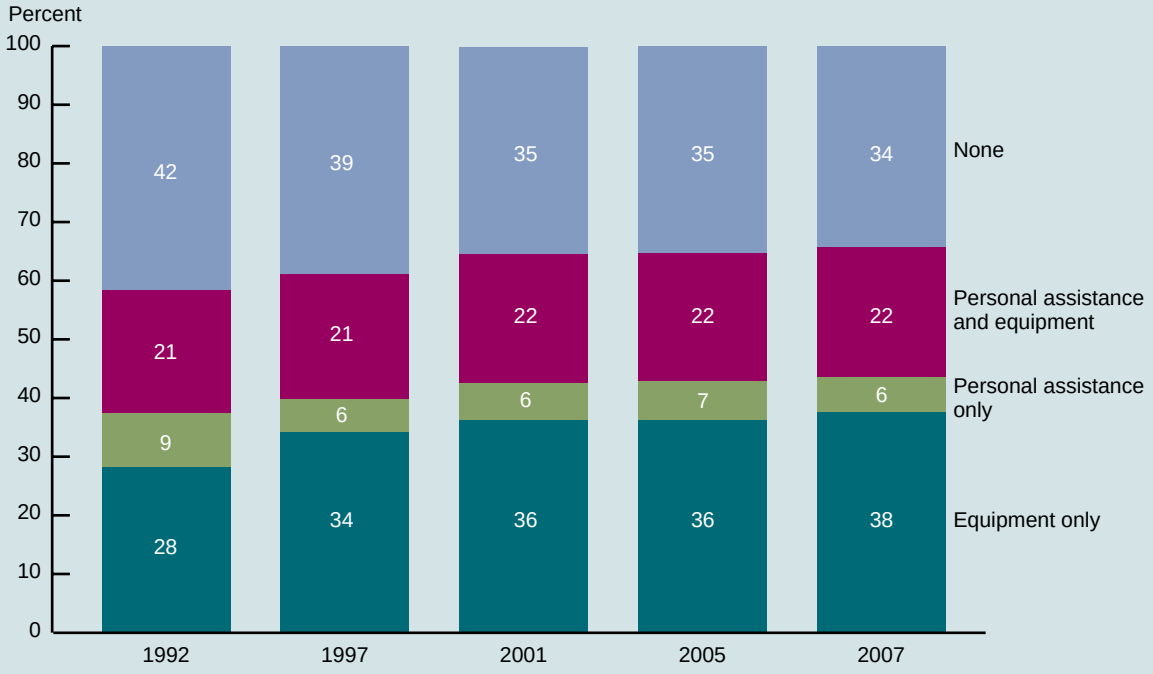
Data for this indicator's charts and bullets can be found in Tables 36a, 36b, 36c, 36d, and 36e on pages 131–132.

INDICATOR 37

Personal Assistance and Equipment

As the proportion of the older population residing in long-term care facilities has declined (see "Indicator 20: Functional Limitations"), the use of personal assistance and/or special equipment among those with limitations has increased. This assistance helps older people living in the community maintain their independence.

Percent distribution of noninstitutionalized Medicare enrollees age 65 and over who have limitations in activities of daily living (ADLs), by type of assistance, selected years 1992–2007

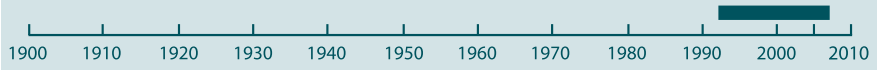


NOTE: ADL limitations refer to difficulty performing (or inability to perform for a health reason) one or more of the following tasks: bathing, dressing, eating, getting in/out of chairs, walking, or using the toilet. Respondents who report difficulty with an activity are subsequently asked about receiving help or supervision from another person with the activity and about using special equipment or aids. In this table, personal assistance does not include supervision. Reference population: These data refer to noninstitutionalized Medicare enrollees who have limitations with one or more ADLs.
SOURCE: Centers for Medicare and Medicaid Services, Medicare Current Beneficiary Survey.

- Between 1992 and 2007, the age-adjusted proportion of people age 65 and over who had difficulty with one or more ADLs and who did not receive personal assistance or use special equipment with these activities decreased from 42 percent to 34 percent. More people are using equipment only—the percentage increased from 28 percent to 38 percent. The percentage of people who used personal assistance only decreased from 9 percent to 6 percent.

- In 2007, two-thirds of people who had difficulty with one or more ADLs received personal assistance or used special equipment: 6 percent received personal assistance only, 38 percent used equipment only, and 22 percent used both personal assistance and equipment.

- In 2007, women and men with limitations in ADLs were equally likely to use special equipment only for help (38 percent). Men were more likely than women to receive no assistance, and women were more likely than men to receive a combination of personal assistance and equipment.



INDICATOR 37

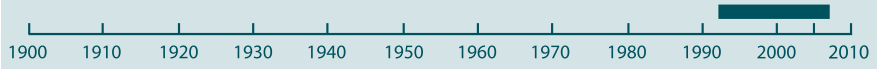
Personal Assistance and Equipment continued

Percentage of noninstitutionalized Medicare enrollees age 65 and over who have limitations in instrumental activities of daily living (IADLs) and who receive personal assistance, by age group, selected years 1992–2007

NOTE: 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, or managing money. Respondents who report difficulty with an activity are subsequently asked about receiving help from another person with the activity. In this table, personal assistance does not include supervision or special equipment.
Reference population: These data refer to noninstitutionalized Medicare enrollees who have limitations with one or more IADLs.
SOURCE: Centers for Medicare and Medicaid Services, Medicare Current Beneficiary Survey.

- In 2007, two-thirds of people age 65 and over who had difficulty with one or more IADLs received personal assistance. The percentage of people receiving personal assistance was higher for people age 85 and over (70 percent) than it was for people age 75–84 (66 percent) or people age 65–74 (65 percent).
- Among older people in 2007 who had difficulties with IADLs, there were no significant differences in the percentage of women and men who received personal assistance

Data for this indicator's charts and bullets can be found in Tables 37a and 37b on page 133.



Data Needs

In *Older Americans 2008*, the Federal Interagency Forum on Aging-Related Statistics (Forum) identified six areas where better data were needed to support research and policy efforts. In this report, the Forum updates those six areas, identifying new data sources when available, and provides information on one additional topic area. These topics have been identified by the Forum as priority areas for data collection efforts related to older Americans: caregiving, elder abuse, functioning and disability, mental health and cognitive functioning, pension measures, residential care, and end-of-life issues.

Caregiving

Informal (unpaid) family caregivers provide the majority of assistance that enables chronically disabled older people to continue to live in the community rather than in specialized care facilities. The annual economic value of informal eldercare exceeds national spending on formal (paid) care.[42] Many of these chronically disabled older adults have considerable needs, with some requiring at least 50 hours per week of personal assistance with functional activities.[43] Informal family caregivers of older people with high levels of personal care needs can face considerable strain providing such care. In recent years, it has become clear that data are needed to monitor the amount, sources, and outcomes of informal caregiving. In 2009, a new nationally representative data collection effort, the National Health and Aging Trends Study (NHATS), was funded. NHATS, a representative study of older adults, along with a supplemental survey of informal caregivers, will provide researchers and policy makers with improved national estimates of caregiving and its impact on care recipients and caregivers.

There remain data gaps across the spectrum of care providers. Recent data are not available for nursing homes or their residents or providers of home care or their clients. Data are also not available about newly emerging providers and it is not possible to combine information across all caregivers or all receivers of care.

Residential Care

A general shift in state Medicaid long-term care policy and independent growth in private-pay residential care has led to an increasing set of alternatives to home care and traditional skilled nursing facilities. Residential care outside of the traditional nursing home is provided in diverse settings (e.g., assisted living facilities, board and care homes, personal care homes, and continuing-care retirement communities). A common characteristic is that these places provide both housing and supportive services. Supportive services typically include protective oversight and help with instrumental activities of daily living (IADLs) such as transportation, meal preparation, and taking medications, and more basic activities of daily living (ADLs) such as eating, dressing, and bathing. Despite the growing role of residential care, there has been little national data on the number and characteristicsof facilities and the people living in these settings.

In *Older Americans 2008*, the Forum reported that federal agencies were working to design a new survey to obtain these estimates. As of 2010, the National Survey of Residential Care Facilities (NSRCF) is being fielded as the first-ever national survey of residential care providers. Residential care facilities include places such as: assisted living residences; board and care homes; and personal care homes that are licensed, registered, listed, certified, or otherwise regulated by a state. The NSRCF is designed to produce estimates of these places and their residents. It will allow for the identification of varied levels of supportive care and assistance by housing arrangement.

The NSRCF will fill a set of essential data gaps related to residential care facilities. Beyond residential care facilities, there remains a need for data to address questions about differences in health care costs by type of housing arrangement. For example, data are needed to assess how health care costs of older adults living in congregate housing settings compare to those that live in other settings.

Elder Abuse

In 1998, the Institute of Medicine at the National Academies reported a "paucity of research" on elder abuse and neglect, with most prior studies lacking empirical evidence.[44] In response to this report, the Committee on National Statistics and the Committee on Law and Justice convened an expert panel to review the risk and prevalence of elder abuse and neglect. The panel published its report in 2003, finding that there are no reliable national estimates of elder abuse, nor are the risk factors clearly understood.[45] 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.

Following the 2003 report, the National Institute on Aging funded a series of grants to develop survey methodologies for abuse and neglect surveillance. The CDC (with the assistance of the member agencies of the Elder Justice Working Group) has developed preliminary definitions for elder maltreatment as a first step in designing recommended data elements for use in elder maltreatment surveillance. Additionally, a new indicator is being included in the *Healthy People 2020* initiative, increasing the number of states that collect and publicly report incidences of elder maltreatment.

Functioning and Disability

Information on trends in functioning and 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 their multifaceted interactions with the environment. Furthermore, specific definitions of disability are used by some government agencies to determine eligibility for benefits. As a result, disability is often measured in different ways across surveys, and this has led to disparate 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. Longitudinal data that can be used to monitor changes in patterns and in transitions in functional status also are needed.

There are several current national and international activities that will result in greater depth and comparability in information on functioning and disability. Federal agencies continue to work together to find ways to compare existing measures of functioning and disability across different surveys and to develop new ways to measure this complicated, multidimensional concept. For example, the disability questions developed by an Interagency Workgroup for the American Community Survey are being adopted by other federal surveys. Methodological research on these newly developed disability measures is being conducted as part of the National Health Interview Survey. The new National Health and Aging Trends Study (NHATS) includes measures of disability and functional status that will capture multiple components of disability, including the intersection of environment and physical and cognitive functioning, as well as the relationship between limitations and overall health and quality of life. In response to a request from National Institute on Aging, the National Academies recently convened a panel to investigate additional ways to address these complex issues. Their workshop report describes a number of innovative ways to enhance comparability and improve validity across surveys and in different settings.[46]

International developments include work from the Washington Group on Disability Statistics, a UN-sponsored city group, and the Budapest Initiative on Health State, a UNECE-WHO-Eurostat task force, to develop comparable questions sets to measure functioning across a range of domains. The Washington Group also is developing questions to access the impact of environmental factors including assistive devices on participation in society. The questions developed by these groups are undergoing cognitive and operational testing at the U.S. National Center for Health Statistics. In addition, a set of nationally representative longitudinal studies of the older population provides tools to monitor the dynamics of disability using comparable or harmonized measures.[47]

Mental Health and Cognitive Functioning

Research that has helped differentiate mental disorders from "normal" aging has been one of the

more important achievements of recent decades in the field of geriatric health. Depression, anxiety, schizophrenia, and alcohol and drug misuse and abuse, if untreated, can be severely impairing, even fatal. Despite interest and increased efforts to track all of these disorders among older adults, obtaining national estimates has proven to be difficult. International efforts by the Washington Group on Disability Statistics and the Budapest Initiative on Measuring Health State are underway to develop comparable short sets of survey questions to measure cognitive and psychological functioning along with measures of sensory functioning, mobility, upper body functioning, pain, fatigue, communication, and learning.

While there are several studies which report estimates of the prevalence of Alzheimer's, one of the major barriers to reliable national estimates of prevalence is the lack of uniform diagnostic criteria among the national surveys that attempt to measure dementia or Alzheimer's. A meeting convened by the NIA in 2009 to describe the prevalence of Alzheimer's concluded that most of the variation in prevalence estimates is not driven primarily by the reliability of the measures or instruments per se but by systematic differences in the definition of dementia. Research is underway to address the challenges in developing consistent indicators of cognitive and mental health. Although not intended to be a platform for the diagnosis of neurological disorders, the NIH Toolbox on the Assessment of Neurological and Behavioral Functions will allow different epidemiological studies to collect harmonized or comparable measures on many domains of cognitive, emotional, motor, and sensory function.

Pension Measures

As pension plans shift away from defined-benefit pensions and annuities to defined contribution plans, official statistical sources on income and poverty fail to measure substantial amounts of retirement income formerly provided by defined-benefit pensions. The common practice is to transfer retirement plan accumulations to IRAs and to take the money out of IRAs as irregular payments. These payments are not included as money income in the most widely used government surveys. Improved measurement of withdrawals from retirement investment accounts (deferred income in IRAs and 401ks) would result in improved measurement of retirement income.

End-of-Life Issues

The end of life is recognized as a uniquely difficult time for patients and their families. Many issues tend to arise, including decisions about medical care; caregiving, both formal and informal; transitions in living arrangements among community, assisted living, and nursing homes; financial impacts; whether to use advance directives and living wills, etc. Documented problem areas include poor management of pain and symptoms; lack of communication by providers; decision-making processes regarding treatment; and insufficient attention to patient preferences.[48]

The end of life has been the subject of many studies and reports, including an Institute of Medicine (IOM) report in 2003 titled "Describing Death in America: What We Need to Know."[49] The IOM report documented many gaps in our knowledge on how well the needs of individuals near the end of life are being met. Some questions identified in the IOM report are:

- Where are people dying and how much of the end of their lives is spent in those settings?
- Who is providing care for them as they die? Do institutional settings support family presence at the end of life?
- Are physical and psychological symptoms being identified and treated (including but not limited to pain)?
- How many persons experience impaired cognitive function before death?
- How do patients and loved ones perceive their quality of life at various time points prior to death?
- Are loved ones supported through the grieving process?

To this end, there is a need for national data to monitor the experiences of older adults nearing death as well as those closely linked to these individuals. Information on some of these topics will be available with the release of *Health, United States, 2010,* which will include a special feature on death and dying.[50]

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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 1900–2008 and projected 2010–2050

Year	*65 and over*	*85 and over*
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
2005	36.8	5.1
2006	37.3	5.3
2007	37.9	5.5
2008	38.9	5.7
Projections		
2010	40.2	5.8
2020	54.8	6.6
2030	72.1	8.7
2040	81.2	14.2
2050	88.5	19.0

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; 2000, U.S. Census Bureau, 2001, Census 2000 Summary File; Table 2: Annual estimates of the resident population by sex and selected age groups for the U.S.: April 1, 2000 to July 1, 2008 (NC-EST2008-02); Table 2: Projections of the population by selected age groups and sex for the United States: 2010–2050 (NP2008–t2).

Table 1b. Percentage of the population age 65 and over and 85 and over, selected years 1900–2008 and projected 2010–2050

Year	*65 and over*	*85 and over*
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
2005	12.4	1.7
2006	12.4	1.8
2007	12.6	1.8
2008	12.8	1.9
Projections		
2010	13.0	1.9
2020	16.1	1.9
2030	19.3	2.3
2040	20.0	3.5
2050	20.2	4.3

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; 2000, U.S. Census Bureau, 2001, Census 2000 Summary File; Table 2: Annual estimates of the resident population by sex and selected age groups for the U.S.: April 1, 2000 to July 1, 2008 (NC-EST2008-02); Table 2: Projections of the population by selected age groups and sex for the United States: 2010-2050 (NP2008-t2).

Table 1c. Population of countries or areas with at least 10 percent of their population age 65 and over, 2008

Country or Area	Population (number in thousands)		Percent
	Total	65 and over	65 and over
Japan	127,288	27,494	21.6
Germany	82,370	16,515	20.0
Italy	58,145	11,657	20.0
Greece	10,723	2,048	19.1
Sweden	9,045	1,659	18.3
Spain	40,491	7,263	17.9
Austria	8,206	1,455	17.7
Estonia	1,308	230	17.6
Bulgaria	7,263	1,276	17.6
Belgium	10,404	1,818	17.5
Portugal	10,677	1,858	17.4
Croatia	4,492	763	17.0
Latvia	2,245	380	16.9
Serbia	7,414	1,249	16.8
Georgia	4,631	768	16.6
Finland	5,245	868	16.6
France	64,058	10,428	16.3
Slovenia	2,008	327	16.3
Ukraine	45,994	7,399	16.1
Lithuania	3,565	572	16.0
Switzerland	7,582	1,213	16.0
United Kingdom	60,944	9,736	16.0
Denmark	5,485	862	15.7
Hungary	9,931	1,545	15.6
Czech Republic	10,221	1,539	15.1
Norway	4,644	696	15.0
Canada	33,213	4,940	14.9
Luxembourg	486	72	14.7
Bosnia and Herzegovina	4,590	676	14.7
Belarus	9,686	1,425	14.7
Romania	22,247	3,271	14.7
Netherlands	16,645	2,433	14.6
Russia	140,702	19,858	14.1
Malta	404	56	13.9
Montenegro	678	93	13.7
Puerto Rico	3,954	540	13.7
Poland	38,501	5,148	13.4
Australia	21,007	2,794	13.3
Uruguay	3,478	462	13.3
Hong Kong S.A.R.	7,019	913	13.0
Virgin Islands (U.S.)	110	14	12.8
United States	304,060	38,870	12.8
New Zealand	4,173	526	12.6
Slovakia	5,455	671	12.3
Iceland	304	37	12.0
Ireland	4,156	491	11.8
Macedonia	2,061	232	11.3
Armenia	2,969	325	11.0
Cuba	11,424	1,251	10.9
Moldova	4,324	471	10.9
Argentina	40,482	4,353	10.8
South Korea	48,379	5,087	10.5
Taiwan	22,921	2,396	10.5
Aruba	102	11	10.4

NOTE: Table excludes countries and areas with less than 100,000 population.

SOURCE: U.S. Census Bureau, International Data Base, accessed on August 24, 2009.

Table 1d. Percentage of the population age 65 and over, by state, July 1, 2008

State (Listed alphabetically)	*Percent*	*State (Ranked by percentage)*	*Percent*
United States	12.8	United States	12.8
Alabama	13.8	Florida	17.4
Alaska	7.3	West Virginia	15.7
Arizona	13.3	Pennsylvania	15.3
Arkansas	14.3	Maine	15.1
California	11.2	Iowa	14.8
Colorado	10.3	Hawaii	14.8
Connecticut	13.7	North Dakota	14.7
Delaware	13.9	South Dakota	14.4
District of Columbia	11.9	Arkansas	14.3
Florida	17.4	Montana	14.2
Georgia	10.1	Rhode Island	14.1
Hawaii	14.8	Vermont	13.9
Idaho	12.0	Delaware	13.9
Illinois	12.2	Alabama	13.8
Indiana	12.8	Ohio	13.7
Iowa	14.8	Connecticut	13.7
Kansas	13.1	Missouri	13.6
Kentucky	13.3	Nebraska	13.5
Louisiana	12.2	Oklahoma	13.5
Maine	15.1	Massachusetts	13.4
Maryland	12.1	New York	13.4
Massachusetts	13.4	Wisconsin	13.3
Michigan	13.0	South Carolina	13.3
Minnesota	12.5	Oregon	13.3
Mississippi	12.6	Arizona	13.3
Missouri	13.6	New Jersey	13.3
Montana	14.2	Kentucky	13.3
Nebraska	13.5	Tennessee	13.2
Nevada	11.4	New Mexico	13.1
New Hampshire	12.9	Kansas	13.1
New Jersey	13.3	Michigan	13.0
New Mexico	13.1	New Hampshire	12.9
New York	13.4	Indiana	12.8
North Carolina	12.4	Mississippi	12.6
North Dakota	14.7	Minnesota	12.5
Ohio	13.7	North Carolina	12.4
Oklahoma	13.5	Wyoming	12.3
Oregon	13.3	Louisiana	12.2
Pennsylvania	15.3	Illinois	12.2
Rhode Island	14.1	Virginia	12.1
South Carolina	13.3	Maryland	12.1
South Dakota	14.4	Washington	12.0
Tennessee	13.2	Idaho	12.0
Texas	10.2	District of Columbia	11.9
Utah	9.0	Nevada	11.4
Vermont	13.9	California	11.2
Virginia	12.1	Colorado	10.3
Washington	12.0	Texas	10.2
West Virginia	15.7	Georgia	10.1
Wisconsin	13.3	Utah	9.0
Wyoming	12.3	Alaska	7.3
Puerto Rico	13.7	Puerto Rico	13.7

Reference population: These data refer to the resident population.

SOURCE: U.S. Census Bureau, Population Division, Table 1. Estimates of the population by selected age groups for the United States and Puerto Rico: July 1, 2008 (SC-EST2008–01).

INDICATOR 1 Number of Older Americans continued

Table 1e. Percentage of the population age 65 and over, by county, 2008

SOURCE: U.S. Census Bureau, July 1, 2008 Population Estimates
Data for this table can be found at http //www.agingstats.gov.

Table 1f. Number and percentage of people age 65 and over and 85 and over, by sex, 2008 (numbers in thousands)

Selected characteristics	*Number*	*Percent*
65 and over		
Total	38,870	100.0
Men	16,465	42.4
Women	22,405	57.6
85 and over		
Total	5,722	100.0
Men	1,864	32.6
Women	3,858	67.4

Reference population: These data refer to the resident population.

SOURCE: U.S. Census Bureau, Population Division, Table 2. Annual estimates of the resident population by sex and selected age groups for the U.S.: April 1, 2000 to July 1, 2008 (NC-EST2008-02).

INDICATOR 2 Racial and Ethnic Composition

Table 2. Population age 65 and over, by race and Hispanic origin, 2008 and projected 2050 (numbers in thousands)

Race and Hispanic origin	*2008 estimates*		*2050 projections*	
	Number	*Percent*	*Number*	*Percent*
Total	38,870	100.0	88,547	100.0
Non-Hispanic white alone	31,238	80.4	51,772	58.5
Black alone	3,315	8.5	10,553	11.9
Asian alone	1,295	3.3	7,541	8.5
All other races alone or in combination	522	1.3	2,397	2.7
Hispanic (of any race)	2,661	6.8	17,515	19.8

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 2008.

INDICATOR 3 Marital Status

Table 3. Marital status of the population age 65 and over, by age group and sex, 2008

Selected characteristics	*65 and over*	*65–74*	*75–84*	*85 and over*
Both sexes		Percent		
Total	100.0	100.0	100.0	100.0
Married	57.0	67.0	51.2	28.7
Widowed	29.8	16.8	38.6	62.9
Divorced	9.1	11.9	6.5	4.1
Never married	4.1	4.3	3.6	4.3
Men				
Total	100.0	100.0	100.0	100.0
Married	74.5	79.2	72.2	54.8
Widowed	13.8	6.9	18.7	37.7
Divorced	7.5	9.5	5.6	2.9
Never married	4.2	4.4	3.6	4.7
Women				
Total	100.0	100.0	100.0	100.0
Married	43.9	56.8	36.6	14.9
Widowed	41.8	25.1	52.5	76.2
Divorced	10.3	13.9	7.2	4.8
Never married	4.0	4.2	3.7	4.1

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, 2008.

INDICATOR 4 Educational Attainment

Table 4a. Educational attainment of the population age 65 and over, selected years 1965–2008

Educational attainment	*1965*	*1970*	*1975*	*1980*	*1985*	*1990*	*1995*	*2000*	*2001*	*2002*	*2003*	*2004*	*2005*	*2006*	*2007*	*2008*
								Percent								
High school graduate or more	23.5	28.3	37.3	40.7	48.2	55.4	63.8	69.5	70.0	69.9	71.5	73.1	74.0	75.2	76.1	77.4
Bachelor's degree or more	5.0	6.3	8.1	8.6	9.4	11.6	13.0	15.6	16.2	16.7	17.4	18.7	18.9	19.5	19.2	20.5

NOTE: A single question which asks for the highest grade or degree completed is now used to determine educational attainment. Prior to 1995, educational attainment was measured using data on years of school completed.
Reference population: These data refer to the civilian noninstitutionalized population.

SOURCE: U.S. Census Bureau, Current Population Survey, Annual Social and Economic Supplement, 2008.

INDICATOR 4 Educational Attainment continued

Table 4b. Educational attainment of the population age 65 and over, by race and Hispanic origin, 2008

Race and Hispanic Origin	*High school graduate or more*	*Bachelor's degree or more*
	Percent	
Both sexes	77.4	20.5
Non-Hispanic white alone	82.3	21.9
Black alone	59.8	12.3
Asian alone	73.8	31.5
Hispanic (of any race)	45.9	9.0
Men	77.9	26.7
Women	77.1	15.8

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, 2008.

INDICATOR 5 Living Arrangements

Table 5a. Living arrangements of the population age 65 and over, by sex and race and Hispanic origin, 2008

Selected characteristic	*With spouse*	*With other relatives*	*With nonrelatives*	*Alone*
Men		Percent		
Total	71.9	7.0	2.5	18.5
Non-Hispanic white alone	73.9	5.8	2.2	18.2
Black alone	54.2	11.2	4.4	30.2
Asian alone	76.9	10.3	2.2	10.6
Hispanic (of any race)	67.4	14.9	4.9	12.8
Women				
Total	41.7	17.1	1.8	39.5
Non-Hispanic white alone	43.6	13.4	1.8	41.1
Black alone	24.6	31.9	1.9	41.7
Asian alone	44.6	32.3	0.8	22.3
Hispanic (of any race)	40.6	31.4	1.3	26.7

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 do not include the noninstitutionalized group quarters population.

SOURCE: U.S. Census Bureau, Current Population Survey, Annual Social and Economic Supplement, 2008.

INDICATOR 5 Living Arrangements continued

Table 5b. Population age 65 and over living alone, by age group and sex, selected years 1970–2008

Year	Men		Women	
	65–74	*75 and over*	*65–74*	*75 and over*
	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
2004	15.5	23.2	29.4	49.9
2005	16.1	23.2	28.9	47.8
2006	16.9	22.7	28.5	48.0
2007	16.7	22.0	28.0	48.8
2008	16.3	21.5	29.1	50.1

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

SOURCE: U.S. Census Bureau, Current Population Survey, Annual Social and Economic Supplement, 2008.

INDICATOR 6 Older Veterans

Table 6a. Percentage of people age 65 and over who are veterans, by sex and age group, United States and Puerto Rico, 2000 and projected 2010 and 2020

Year	*65 and over*		*65–74*		*75–84*		*85 and over*	
	Men	*Women*	*Men*	*Women*	*Men*	*Women*	*Men*	*Women*
	Percent							
Estimates								
2000	64.3	1.7	65.2	1.1	70.9	2.7	32.6	1.0
Projections								
2010	50.3	1.3	41.8	1.0	60.3	1.1	66.5	2.5
2020	33.0	1.3	27.3	1.5	39.2	1.0	51.9	1.2

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

SOURCE: U.S. Census Bureau, Decennial Census and Population Projections; Department of Veterans Affairs, VetPop2007.

Table 6b. Estimated and projected number of veterans age 65 and over, by sex and age group, United States and Puerto Rico, 2000 and projected 2010 and 2020

	Estimates		*Projections*
	2000	*2010*	*2020*
65 and over		Number in thousands	
Total	9,723	9,132	8,555
Men	9,374	8,831	8,144
Women	349	302	411
65–74			
Total	5,628	4,336	4,430
Men	5,516	4,214	4,159
Women	112	122	271
75–84			
Total	3,667	3,421	2,841
Men	3,460	3,340	2,750
Women	207	82	90
85 and over			
Total	427	1,375	1,285
Men	398	1,277	1,235
Women	30	98	50

Reference population: These data refer to the resident population of the United States and Puerto Rico.
SOURCE: Department of Veterans Affairs, VetPop2007.

INDICATOR 7 Poverty

Table 7a. Percentage of the population living in poverty, by age group, 2007

Year	65 and over	Under 18	18 to 64	65–74	75–84	85 and over
			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
2003	10.2	17.6	10.8	9.0	11.0	13.8
2004	9.8	17.8	11.3	9.4	9.7	12.6
2005	10.1	17.6	11.1	8.9	10.9	13.4
2006	9.4	17.4	10.8	8.6	10.0	11.4
2007	9.7	18.0	10.9	8.8	9.8	13.0

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. Poverty status in the current Population Survey is based on prior year income.
Reference population: These data refer to the civilian noninstitutionalized population.

SOURCE: U.S. Census Bureau, Current Population Survey, Annual Social and Economic Supplement, 2008.

Table 7b. Percentage of the population age 65 and over living in poverty, by selected characteristics, 2007

Selected characteristic	*65 and over*	*65 and over, living alone*	*65 and over, married couples*	*65–74*	*75 and over*
			Percent		
Both Sexes					
Total	9.7	17.8	4.2	8.8	10.6
Non-Hispanic white alone	7.4	14.4	3.1	6.1	8.8
Black alone	23.2	33.5	9.6	23.5	22.8
Asian alone	11.3	31.3	7.4	9.4	14.1
Hispanic	17.1	35.7	10.8	16.5	18.0
Male					
Total	6.6	11.8	4.3	6.5	6.7
Non-Hispanic white alone	4.7	8.9	3.1	4.1	5.5
Black alone	16.8	21.5	10.2	20.3	11.0
Asian alone	9.9	26.5	8.2	8.7	12.0
Hispanic	13.3	24.1	11.8	13.1	13.6
Female					
Total	12.0	19.9	4.1	10.8	13.2
Non-Hispanic white alone	9.4	16.2	3.2	7.8	10.9
Black alone	27.3	39.0	8.7	25.8	29.2
Asian alone	12.4	33.0	6.4	10.1	15.4
Hispanic	20.0	39.8	9.6	19.2	21.2

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 details, 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, 2008.

Table 8a. Income distribution of the population age 65 and over, 1974–2007

Year	Poverty	Low income	Middle income	High income
		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
2003	10.2	28.5	33.8	27.5
2004	9.8	28.1	34.6	27.5
2005	10.1	26.6	35.2	28.1
2006	9.4	26.2	35.7	28.6
2007	9.8	26.3	33.3	30.6

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, 1975–2008.

Table 8b. Median income of householders age 65 and over, in current and 2007 dollars, 1974–2007

Year	*Number (in thousands)*	*Current dollars*	*2007 dollars*
1974	14,263	5,292	20,838
1975	14,802	5,585	20,322
1976	14,816	5,962	20,513
1977	15,225	6,347	20,542
1978	15,795	7,081	21,446
1979	16,544	7,879	21,777
1980	16,912	8,781	21,845
1981	17,312	9,903	22,495
1982	17,671	11,041	23,653
1983	17,901	11,718	24,076
1984	18,155	12,799	25,262
1985	18,596	13,254	25,292
1986	18,998	13,845	25,950
1987	19,412	14,443	26,186
1988	19,716	14,923	26,099
1989	20,156	15,771	26,441
1990	20,527	16,855	26,917
1991	20,921	16,975	26,170
1992	20,682	17,135	25,764
1993	20,806	17,751	26,046
1994	21,365	18,095	25,996
1995	21,486	19,096	26,789
1996	21,408	19,448	26,575
1997	21,497	20,761	27,769
1998	21,589	21,729	28,664
1999	22,478	22,797	29,458
2000	22,469	23,083	28,861
2001	22,476	23,118	28,115
2002	22,659	23,152	27,709
2003	23,048	23,787	27,847
2004	23,151	24,516	27,945
2005	23,459	26,036	28,715
2006	23,729	27,798	29,685
2007	24,113	28,305	29,393

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

SOURCE: U.S. Census Bureau, Current Population Survey, Annual Social and Economic Supplement, 1975–2008.

INDICATOR 9 Sources of Income

Table 9a. Distribution of sources of income for age units (married couples and nonmarried persons) 65 or older, 1962–2008

Year	Total	Social Security	Asset Income	Pensions	Earnings	Other
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
2003	100	39	14	19	25	2
2004	100	39	13	20	26	2
2005	100	37	13	19	28	3
2006	100	37	15	18	28	3
2008	100	37	13	19	30	3

NOTE: A married couple is age 65 and over if the husband is age 65 and over or the husband is younger than age 55 and the wife is age 65 and over.
Reference population: These data refer to the civilian noninstitutionalized population.

SOURCE: Social Security Administration, 1963 Survey of the Aged, and 1968 Survey of Demographic and Economic Characteristics of the Aged; U.S. Census Bureau, Current Population Survey, Annual Social and Economic Supplement, 1977–2009.

Table 9b. Sources of income for married couples and nonmarried people who are age 65 and over, by income quintile, 2008

Income Source	Lowest fifth	Second fifth	Third fifth	Fourth fifth	Highest fifth
			Percent		
Total	100.0	100.0	100.0	100.0	100.0
Social Security	83.2	81.8	64.4	43.6	17.9
Asset income	2.1	3.4	6.5	8.4	17.8
Pensions	3.3	7.5	16.4	25.5	18.7
Earnings	1.8	3.9	9.8	19.4	43.7
Public assistance	8.5	1.7	0.5	0.1	0.1
Other	1.1	1.7	2.3	2.9	1.8

NOTE: A married couple is age 65 and over if the husband is age 65 and over or the husband is younger than age 55 and the wife is age 65 and over. The definition of "other" includes, but is not limited to, public assistance, unemployment compensation, worker's compensation, alimony, child support, and personal contributions. Quintile limits are $12,082, $19,877, $31,303, and $55,889 for all units; $23,637, $35,794, $53,180, and $86,988 for married couples; and $9,929, $14,265, $20,187, and $32,937 for nonmarried persons.
Reference population: These data refer to the civilian noninstitutionalized population.

SOURCE: U.S. Census Bureau, Current Population Survey, Annual Social and Economic Supplement, 2009.

Table 9c. Percentage of people age 55 and over with family income from specified sources, by age group, 2008

Source of family income	55–61	62–64	Aged 65 or older				
			Total	65–69	70–74	75–79	80 or older
Earnings	85.7	72.3	38.2	55.2	40.5	30.0	22.0
Wages and salaries	82.1	68.2	35.1	50.9	36.9	27.2	20.6
Self-employment	12.6	11.3	5.9	9.2	6.4	4.7	2.5
Retirement benefits	33.0	62.0	91.3	86.6	92.9	93.4	94.1
Social Security	20.5	51.6	88.7	83.0	90.4	91.4	91.9
Benefits other than Social Security	19.8	33.8	44.0	43.0	44.9	45.1	43.8
Other public pensions	9.2	14.9	16.1	15.7	16.8	16.2	16.0
Railroad Retirement	0.3	0.5	0.6	0.4	0.4	0.6	1.0
Government employee pensions	8.9	14.3	15.6	15.3	16.4	15.7	15.1
Military	1.9	2.4	2.2	2.0	2.7	2.5	1.7
Federal	2.0	3.3	4.3	3.8	4.2	4.3	5.0
State or local	5.3	9.4	9.9	10.3	10.4	10.1	8.9
Private pensions or annuities	11.4	20.6	30.9	30.0	31.2	32.1	30.7
Income from assets	59.6	60.8	59.2	61.0	58.3	59.7	57.4
Interest	57.7	58.3	57.2	59.0	57.1	57.4	55.0
Other income from assets	25.7	27.8	24.8	26.8	24.5	25.4	22.4
Dividends	21.8	23.4	20.6	22.2	20.4	21.2	18.5
Rent or royalties	8.5	9.2	7.9	8.9	7.8	7.8	6.8
Estates or trusts	0.3	0.2	0.2	0.2	0.2	0.2	0.4
Veterans' benefits	3.8	4.4	4.2	3.5	3.7	4.8	5.1
Unemployment compensation	6.7	4.9	2.5	3.4	2.8	2.2	1.4
Workers' compensation	1.5	1.3	0.6	0.9	0.6	0.7	0.3
Cash public assistance and noncash benefits	10.3	10.4	11.7	10.2	12.4	11.8	12.7
Cash public assistance	5.8	5.4	4.8	4.1	5.9	4.8	4.6
Supplemental Security Income	5.2	4.8	4.5	3.8	5.6	4.5	4.4
Other	0.8	0.8	0.4	0.4	0.5	0.3	0.3
Noncash benefits	7.0	7.1	9.1	8.0	9.4	9.2	9.9
Food	5.0	4.5	4.5	4.6	5.1	4.4	4.0
Energy	2.1	2.6	2.8	2.6	2.9	2.7	3.2
Housing	2.4	2.5	4.3	3.4	4.3	4.5	5.3
Personal contributions	2.5	1.8	1.4	1.7	1.4	1.1	1.4
Number (thousands)	25,796	8,493	37,788	11,825	8,579	7,329	10,054

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

SOURCE: U.S. Census Bureau, Current Population Suvey, Annual Social and Economic Supplement, 2009.

INDICATOR 10 Net Worth

Table 10. Median household net worth of head of household, by selected characteristics, in 2007 dollars, selected years 1984–2007

Selected characteristic	1984	1989	1994	1999	2001	2003	2005	2007
	In dollars							
Age of family head								
65 and over	$114,900	$125,300	$138,900	$186,800	$209,000	$202,800	$206,600	$237,000
45–54	136,700	121,600	123,600	109,900	112,800	112,800	114,200	124,000
55–64	147,200	185,100	193,700	177,900	191,800	195,700	211,900	200,000
65–74	121,500	156,100	161,200	217,400	238,300	218,700	230,300	272,000
75 and over	99,100	103,700	114,800	158,200	167,400	179,000	190,800	215,000
Marital status, family head age 65 and over								
Married	180,300	228,300	225,300	291,600	338,200	340,100	346,000	385,000
Unmarried	81,300	76,400	85,900	111,900	117,200	116,900	109,600	152,000
Race, family head age 65 and over								
White	131,800	142,800	152,800	217,400	238,300	240,500	239,200	280,000
Black	29,700	38,400	43,100	34,600	47,600	29,400	39,800	46,000
Education, family head age 65 and over								
No high school diploma	64,200	63,600	69,500	68,000	66,600	66,600	62,700	78,000
High school diploma only	158,100	169,200	145,000	197,700	199,900	180,100	193,900	216,200
Some college or more	251,600	290,500	312,500	372,000	419,000	421,200	434,400	434,400

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. Data for 1984–2005 have been inflation adjusted to 2007 dollars. See Appendix B for the definition of race and Hispanic origin in the Panel Study of Income Dynamics.
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 of persons ages 55 and over by age group and sex, annual averages, 1963–2008

	Men				Women			
Year	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	49.5	32.8	12.3	62.5	38.6	22.7	6.4
2004	74.4	50.8	32.6	12.8	62.1	38.7	23.3	6.7
2005	74.7	52.5	33.6	13.5	62.7	40.0	23.7	7.1
2006	75.2	52.4	34.4	13.9	63.8	41.5	24.2	7.1
2007	75.4	51.7	34.3	14.0	63.8	41.8	25.7	7.7
2008	75.8	53.0	35.6	14.6	64.6	42.0	26.4	8.1

NOTE: Data for 1994 and later years are not strictly comparable with data for 1993 and earlier years due to a redesign of the survey and methodology of the Current Population Survey. Beginning in 2000, data incorporate population controls from Census 2000.
Reference population: These data refer to the civilian noninstitutionalized population.

SOURCE: Bureau of Labor Statistics, Current Population Survey.

INDICATOR 12 Total Expenditures

Table 12. Percentage of total household annual expenditures by age of reference person, 2008

	45–54	*55–64*	*65 and over*	*65–74*	*75 and over*
Personal insurance and pensions	12.8	12.7	5.0	6.3	3.2
Health care	4.8	7.0	12.5	11.5	13.9
Transportation	17.5	17.1	15.3	16.3	13.9
Housing	32.0	32.1	35.3	33.4	38.0
Food	12.6	11.6	12.7	12.9	12.4
Other	20.3	19.5	19.2	19.6	18.6

NOTE: Other expenditures include apparel, personal care, entertainment, reading, education, alcohol, tobacco, cash contributions, and miscellaneous expenditures. Data from the Consumer Expenditure Survey by age group represent average annual expenditures for consumer units by the age of reference person, who is the person listed as the owner or renter of the home. For example, the data on people age 65 and over reflect consumer units with a reference person age 65 or older. The Consumer Expenditure Survey collects and publishes information from consumer units, which are generally defined as a person or group of people who live in the same household and are related by blood, marriage, or other legal arrangement (i.e., a family), or people who live in the same household but who unrelated and financially independent from one another (e.g., roommates sharing an apartment). A household usually refers to a physical are dwelling, and may contain more than one consumer unit. However, for convenience the term "household" is substituted for "consumer "unit" in this text.
Reference population: These data refer to the resident noninstitutionalized population.

SOURCE: Bureau of Labor Statistics, Consumer Expenditure Survey.

INDICATOR 13 Housing Problems

Table 13a. Percentage of households with any resident age 65 and over that report housing problems, by type of problems, selected years 1985–2007

	Households		*People**	
Households with a resident age 65 and over	*Numbers in 1,000s*	*Percent*	*Numbers in 1,000s*	*Percent*
		1985		
Total	20,912	100	27,375	100
Number and percent with				
One or more of the housing problems	7,522	36	9,118	33
Housing cost burden (> 30 percent)	6,251	30	7,498	27
Physically inadequate housing	1,737	8	2,131	8
Crowded housing	193	1	238	1
		1989		
Total	22,017	100	29,372	100
Number and percent with				
One or more of the housing problems	7,315	33	8,995	31
Housing cost burden (> 30 percent)	6,056	28	7,394	25
Physically inadequate housing	1,706	8	2,117	7
Crowded housing	148	1	180	1
		1995		
Total	22,791	100	30,328	100
Number and percent with				
One or more of the housing problems	7,841	34	9,590	32
Housing cost burden (> 30 percent)	6,815	30	8,290	27
Physically inadequate housing	1,402	6	1,731	6
Crowded housing	150	1	199	1
		1997		
Total	22,975	100	30,776	100
Number and percent with				
One or more of the housing problems	8,566	37	10,715	35
Housing cost burden (> 30 percent)	7,642	33	9,539	31
Physically inadequate housing	1,321	6	1,592	5
Crowded housing	165	1	224	1

See footnotes at end of table.

INDICATOR 13

Housing Problems continued

Table 13a. Percentage of households with any resident age 65 and over that report housing problems, by type of problems, selected years 1985–2007 *(continued)*

Households with a resident age 65 and over	Households		People*	
	Numbers in 1,000s	Percent	Numbers in 1,000s	Percent
1999				
Total	23,589	100	31,487	100
Number and percent with				
One or more of the housing problems	8,534	36	10,750	34
Housing cost burden (> 30 percent)	7,635	32	9,641	31
Physically inadequate housing	1,337	6	1,627	5
Crowded housing	173	1	209	1
2001				
Total	24,038	100	31,935	100
Number and percent with				
One or more of the housing problems	9,154	38	11,577	36
Housing cost burden (> 30 percent)	8,312	35	10,501	33
Physically inadequate housing	1,269	5	1,567	5
Crowded housing	222	1	288	1
2003				
Total	24,140	100	32,163	100
Number and percent with				
One or more of the housing problems	8,718	36	10,967	34
Housing cost burden (> 30 percent)	7,794	32	9,808	30
Physically inadequate housing	1,230	5	1,516	5
Crowded housing	225	1	300	1
2005				
Total	24,983	100	33,268	100
Number and percent with				
One or more of the housing problems	10,153	41	12,649	38
Housing cost burden (> 30 percent)	9,400	38	11,672	35
Physically inadequate housing	1,188	5	1,486	4
Crowded housing	153	1	189	1
2007				
Total	25,828	100	34,306	100
Number and percent with				
One or more of the housing problems	10,252	40	12,573	37
Housing cost burden (> 30 percent)	9,618	37	11,756	34
Physically inadequate housing	1,108	4	1,362	4
Crowded housing	164	1	199	1

* Number of people age 65 and over. The American Housing Survey (AHS) universe is limited to the household population and excludes the population living in nursing homes, college dormitories, and other group quarters. The AHS is a representative sample of approximately 60,000 households in the U.S. and because it is a statistical sample, the estimates presented are subject to both sampling and nonsampling errors. Because the AHS is a household survey, its population estimates are likely to differ from estimates based on a population survey. The estimated number of households with a resident age 65 and over reflects changes in Census weights: 1985 and 1989 data are consistent with 1980 Census weights; 1995, 1997, 1999 data with 1990 Census weights; and 2001, 2003, 2005, and 2007 with 2000 Census weights.

NOTE: Data are available biennially for odd years. Housing cost burden is defined as expenditures on housing and utilities in excess of 30 percent of reported income. Physical problem categories include plumbing, heating, electricity, hallways, and upkeep. See definition in Appendix A of the American Housing Survey summary volume, American Housing Survey for the United States in 2007, Current Housing Reports, H150/07, U.S. Census bureau, 2008. Crowded housing is defined as housing in which there is more than one person per room in a residence. The subcategories for housing problems do not add to the total number with housing problems because a household may have more than one housing problem.
Reference population: These data refer to the resident noninstitutionalized population. People residing in noninstitutional group quarters, such as dormitories or fraternities, are excluded.

SOURCE: U.S. Census Bureau and the U.S. Department of Housing and Urban Development, American Housing Survey. Tabulated by U.S. Department of Housing and Urban Development.

Table 13b. Percentage of all U.S. households that report housing problems, by type of problem, selected years 1985–2007

	Households		*People**	
All U.S. households and persons	*Numbers in 1,000s*	*Percent*	*Numbers in 1,000s*	*Percent*
			1985	
Total	88,425	100	234,545	100
Number and percent with				
One or more of the housing problems	28,709	32	76,447	33
Housing cost burden (> 30 percent)	22,633	26	55,055	23
Physically inadequate housing	7,374	8	20,357	9
Crowded housing	2,496	3	15,071	6
			1989	
Total	93,683	100	248,028	100
Number and percent with				
One or more of the housing problems	28,270	30	75,430	30
Housing cost burden (> 30 percent)	21,690	23	52,449	21
Physically inadequate housing	7,603	8	20,694	8
Crowded housing	2,676	3	16,187	7
			1995	
Total	97,694	100	254,160	100
Number and percent with				
One or more of the housing problems	32,385	33	85,327	34
Housing cost burden (> 30 percent)	26,950	28	65,835	26
Physically inadequate housing	6,370	7	17,432	7
Crowded housing	2,554	3	15,375	6
			1997	
Total	99,487	100	257,542	100
Number and percent with				
One or more of the housing problems	33,402	34	86,559	34
Housing cost burden (> 30 percent)	27,445	28	65,997	26
Physically inadequate housing	6,988	7	18,441	7
Crowded housing	2,806	3	16,860	7
			1999	
Total	102,803	100	262,463	100
Number and percent with				
One or more of the housing problems	33,953	33	86,569	33
Housing cost burden (> 30 percent)	28,204	27	66,945	26
Physically inadequate housing	6,878	7	17,310	7
Crowded housing	2,571	3	15,563	6

See footnotes at end of table.

Table 13b. Percentage of all U.S. households that report housing problems, by type of problem, selected years 1985–2007 *(continued)*

All U.S. households and persons	Households: Numbers in 1,000s	Households: Percent	People*: Numbers in 1,000s	People*: Percent
		2001		
Total	105,435	100	269,102	100
Number and percent with				
One or more of the housing problems	35,937	34	91,948	34
Housing cost burden (> 30 percent)	30,253	29	71,950	27
Physically inadequate housing	6,611	6	16,709	6
Crowded housing	2,631	2	16,070	6
		2003		
Total	105,867	100	269,508	100
Number and percent with				
One or more of the housing problems	36,401	34	92,516	34
Housing cost burden (> 30 percent)	31,044	29	74,088	27
Physically inadequate housing	6,281	6	15,364	6
Crowded housing	2,559	2	15,589	6
		2005		
Total	108,901	100	277,085	100
Number and percent with				
One or more of the housing problems	40,779	37	102,921	37
Housing cost burden (> 30 percent)	35,835	33	85,542	31
Physically inadequate housing	6,199	6	14,846	5
Crowded housing	2,621	2	16,032	6
		2007		
Total	110,719	100	278,818	100
Number and percent with				
One or more of the housing problems	42,837	39	107,940	39
Housing cost burden (> 30 percent)	38,293	35	91,966	33
Physically inadequate housing	5,759	5	13,929	5
Crowded housing	2,529	2	15,433	6

* The American Housing Survey (AHS) universe is limited to the household population and excludes the population living in nursing homes, college dormitories, and other group quarters. The AHS is a representative sample of approximately 60,000 households in the U.S. and because it is a statistical sample, the estimates presented are subject to both sampling and nonsampling errors. Because the AHS is a household survey, its population estimates are likely to differ from estimates based on a population survey. The estimated number of households reflect changes in Census weights: 1985 and 1989 data are consistent with 1980 Census weights; 1995, 1997, 1999 data with 1990 Census weights; and 2001, 2003, 2005, and 2007 with 2000 Census weights.

NOTE: Data are available biennially for odd years. Housing cost burden is defined as expenditures on housing and utilities are in excess of 30 percent of reported income. Physical problem categories include plumbing, heating, electricity, hallways, and upkeep. See definition in Appendix A of the American Housing Survey summary volume, American Housing Survey for the United States in 2007, Current Housing Reports, H150/07, U.S. Census Bureau, 2008. Crowded housing is defined as housing in which there is more than one person per room in a residence. The subcategories for housing problems do not add to the total number with housing problems because a household may have more than one housing problem.
Reference population: These data refer to the resident noninstitutionalized population. People residing in noninstitutional group quarters, such as dormitories or fraternities, are excluded..

SOURCE: U.S. Census Bureau and the U.S. Department of Housing and Urban Development, American Housing Survey. Tabulated by U.S. Department of Housing and Urban Development.

INDICATOR 14 Life Expectancy

Table 14a. Life expectancy, by age and sex, selected years 1900–2006

Age and sex	1900	1910	1920	1930	1940	1950	1960	1970	1980	1990
						Years				
Birth										
Both sexes	49.2	51.5	56.4	59.2	63.6	68.1	69.9	70.8	73.9	75.4
Men	47.9	49.9	55.5	57.7	61.6	65.5	66.8	67.0	70.1	71.8
Women	50.7	53.2	57.4	60.9	65.9	71.0	73.2	74.6	77.6	78.8
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
Men	11.5	11.2	12.2	11.7	12.1	12.7	13.0	13.0	14.2	15.1
Women	12.2	12.0	12.7	12.8	13.6	15.0	15.8	16.8	18.4	19.0
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
Men	3.8	3.9	4.1	4.0	4.1	4.4	4.4	4.7	5.1	5.3
Women	4.1	4.1	4.3	4.3	4.5	4.9	4.7	5.6	6.4	6.7

See footnotes at end of table.

Table 14a. Life expectancy, by age and sex, selected years 1900–2006 *(continued)*

Age and sex	2000	2001	2002	2003	2004	2005	2006
				Years			
Birth							
Both sexes	76.8	76.9	76.9	77.1	77.5	77.4	77.7
Men	74.1	74.2	74.3	74.5	74.9	74.9	75.1
Women	79.3	79.4	79.5	79.6	79.9	79.9	80.2
At age 65							
Both sexes	17.6	17.7	17.8	17.9	18.2	18.2	18.5
Men	16.0	16.2	16.2	16.4	16.7	16.8	17.0
Women	19.0	19.0	19.1	19.2	19.5	19.5	19.7
At age 85							
Both sexes	6.1	6.1	6.1	6.1	6.3	6.2	6.4
Men	5.4	5.5	5.4	5.5	5.6	5.6	5.7
Women	6.5	6.5	6.5	6.5	6.7	6.6	6.8

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 2000–2006 are based on a newly revised methodology that uses vital statistics death rates for ages under 66 and modeled probabilities of death for ages 66 to 100 based on blended vital statistics and Medicare probabilities of dying and may differ from figures previously published.
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 14b. Life expectancy, by age and sex, 2006

	Total		Men		Women	
Age	White	Black	White	Black	White	Black
			Years			
Birth	78.2	73.2	75.7	69.7	80.6	76.5
At age 65	18.6	17.1	17.1	15.1	19.8	18.6
At age 85	6.3	6.7	5.7	5.9	6.7	7.1

NOTE: See Appendix B for the definition of race 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.

Table 14c. Average life expectancy at age 65, by sex and selected countries or areas, selected years 1980–2005

Years of life remaining for people who reach age 65	Men				Women			
	Year				Year			
	1980	1990	2000	2005	1980	1990	2000	2005
Australia	13.7	15.2	16.9	18.1	17.9	19.0	20.4	21.4
Austria	12.9	14.3	16.0	17.0	16.3	17.8	19.4	20.3
Belgium	12.9	14.3	15.6	16.6	16.9	18.8	19.7	20.2
Bulgaria	12.7	12.9	12.8	na	14.7	15.4	15.4	na
Canada	14.5	15.7	16.8	17.9	18.9	19.9	20.4	21.1
Chile	na	14.6	15.3	15.9	na	17.6	18.6	20.0
Costa Rica	16.1	17.2	17.2	18.1	18.1	19.5	19.7	20.7
Cuba	na	na	16.7	17.1	na	na	19.0	19.6
Czech Republic[1]	11.2	11.7	13.8	14.4	14.4	15.3	17.3	17.7
Denmark	13.6	14.0	15.2	16.1	17.6	17.8	18.3	19.1
England and Wales[2]	12.9	14.1	15.8	17.1	16.9	17.9	19.0	19.9
Finland	12.5	13.7	15.5	16.8	16.5	17.7	19.3	21.0
France	13.6	15.5	16.7	17.7	18.2	19.8	21.2	22.0
Germany[3]	13.0	14.0	15.7	16.9	16.7	17.6	19.4	20.1
Greece	14.6	15.7	16.3	17.2	16.8	18.0	18.3	19.4
Hong Kong	13.9	15.3	17.3	17.8	13.9	18.8	21.5	22.9
Hungary	11.6	12.0	12.7	13.1	14.6	15.3	16.5	16.9
Ireland	12.6	13.3	14.6	16.8	15.7	16.9	17.8	20.0
Israel	14.4	15.9	16.9	18.2	15.8	17.8	19.3	20.2
Italy	13.3	15.1	16.5	na	17.1	18.8	20.4	na
Japan	14.6	16.2	17.5	18.1	17.7	20.0	22.4	23.2
Netherlands	13.7	14.4	15.3	16.4	18.0	18.9	19.2	20.0
New Zealand	13.2	14.7	16.7	17.8	17.0	18.3	20.0	20.5
Northern Ireland[2]	11.9	13.7	15.3	16.6	15.8	17.5	18.5	19.5
Norway	14.3	14.6	16.0	17.2	18.0	18.5	19.7	20.9
Poland	12.0	12.7	13.6	14.4	15.5	16.9	17.3	18.6
Portugal	12.9	13.9	15.3	16.1	16.5	17.0	18.7	19.4
Romania	12.6	13.3	13.5	13.4	14.2	15.3	15.9	16.2
Russian Federation	11.6	12.1	11.1	11.0	15.6	15.9	15.2	15.4
Scotland[2]	12.3	13.1	14.7	15.8	16.2	16.7	17.8	18.6
Singapore	12.6	14.5	15.8	16.9	15.4	16.9	19.0	20.4
Slovakia[1]	12.3	12.2	12.9	13.2	15.4	15.7	16.5	16.9
Spain	14.8	15.4	16.6	17.3	17.9	19.0	20.4	21.3
Sweden	14.3	15.3	16.7	17.4	17.9	19.0	20.0	20.6
Switzerland	14.4	15.3	16.9	18.1	17.9	19.4	20.7	21.7
United States	14.1	15.1	16.0	16.8	18.3	18.9	19.2	19.5

na: Data not available.
[1]In 1993, Czechoslovakia was divided into two nations, the Czech Republic and Slovakia. Data for 1980 and 1990 refer to the respective Czech and Slovak regions of the former Czechoslovakia.
[2]Different geographic constituents of the United Kingdom may have separate statistical systems. This table includes data for three such areas: England and Wales, Northern Ireland, and Scotland.
[3] Data for 1980 and 1990 refer to the former Federal Republic of Germany (West Germany); from 2000 onwards, data refer to Germany after reunification.

NOTE: Countries or areas in this table have populations of at least one million and death registrations that are at least 90 percent complete. However, this table is not a comprehensive listing of all countries with these characteristics; for details see Health, United States, 2008. Estimates for the United States for 2000 and 2005 have been revised and may differ from figures previously published. See Table 14a.

SOURCE: Centers for Disease Control and Prevention, National Center for Health Statistics, Health, United States, 2008.

INDICATOR 15 Mortality

Table 15a. Death rates for selected leading causes of death among people age 65 and over, 1981–2006

Year	Total	Diseases of heart	Malignant neoplasm	Cerebrovascular diseases	Chronic lower respiratory diseases	Influenza and pneumonia	Diabetes mellitus	Alzheimer's disease
				Number per 100,000 population				
1981	5,713.9	2,546.7	1,055.7	623.8	185.8	207.2	105.8	6.0
1982	5,609.7	2,503.2	1,068.9	585.2	186.1	181.2	102.3	9.2
1983	5,685.4	2,512.0	1,077.5	564.4	204.3	207.2	104.4	16.3
1984	5,644.8	2,449.5	1,087.1	546.2	210.8	214.0	102.6	23.5
1985	5,693.8	2,430.9	1,091.2	531.0	225.4	242.9	103.4	31.0
1986	5,628.7	2,371.7	1,101.2	506.3	227.7	244.7	100.8	35.0
1987	5,577.7	2,316.4	1,105.5	495.9	229.7	237.4	102.3	41.8
1988	5,625.0	2,305.7	1,114.1	489.4	240.0	263.1	104.7	44.7
1989	5,456.9	2,171.8	1,133.0	463.7	240.2	253.3	120.4	47.3
1990	5,352.8	2,091.1	1,141.8	447.9	245.0	258.2	120.4	48.7
1991	5,290.7	2,045.6	1,149.5	434.7	251.7	245.1	120.8	48.7
1992	5,205.2	1,989.5	1,150.6	424.5	252.5	232.7	120.8	48.8
1993	5,348.6	2,024.0	1,159.2	434.5	273.6	247.9	128.4	55.3
1994	5,269.9	1,952.3	1,155.3	433.7	271.3	238.1	132.6	59.8
1995	5,264.7	1,927.4	1,152.5	437.7	271.2	237.2	135.9	64.9
1996	5,221.7	1,877.6	1,140.8	433.1	275.5	233.5	139.4	65.9
1997	5,178.9	1,827.2	1,127.3	423.8	280.2	236.3	140.2	67.7
1998	5,168.1	1,791.5	1,119.2	411.9	268.8	247.4	143.4	67.0
1999	5,220.0	1,767.0	1,126.1	433.2	313.0	167.4	150.0	128.8
2000	5,137.2	1,694.9	1,119.2	422.7	303.6	167.2	149.6	139.9
2001	5,044.1	1,631.6	1,100.2	404.1	300.7	154.9	151.1	148.3
2002	5,000.5	1,585.2	1,090.9	393.2	300.6	160.7	152.0	158.7
2003	4,907.2	1,524.9	1,073.0	372.8	299.1	154.8	150.7	167.7
2004	4,698.8	1,418.2	1,051.7	346.2	284.3	139.0	146.0	170.6
2005	4,676.0	1,375.7	1,041.3	320.3	298.8	141.9	146.5	179.3
2006	4,518.5	1,296.7	1,025.4	296.8	279.2	123.7	136.9	176.9
				Percentage change between 1981 and 2006				
	–20.9	–49.1	–2.9	–52.4	50.3	*–26.1	29.4	*37.3

*Change calculated from 1999 when ICD-10 was implemented.

NOTE: Death rates for 1981–1998 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 1981–1998, causes were coded using ICD-9 codes that are most nearly comparable with the 113 cause list for the ICD-10 and may differ from previously published estimates. Population estimates for July 1, 2000, and July 1, 2001, are postcensal 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/nvss/bridged_race.htm. Death rates for 1990–2001 may differ from those published elsewhere because of the use of the bridged intercensal and postcensal population estimates. Rates are age adjusted using the 2000 standard population. 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.

Table 15b. Leading causes of death among people age 65 and over, by sex and race and Hispanic origin, 2006

	All races	*White*	*Black*	*Asian or Pacific Islander*	*American Indian*	*Hispanic*
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	Chronic lower respiratory diseases	Chronic lower respiratory diseases	Cerebrovascular diseases	Cerebrovascular diseases	Diabetes mellitus	Cerebrovascular diseases
4	Cerebrovascular diseases	Cerebrovascular diseases	Diabetes mellitus	Chronic lower respiratory diseases	Chronic lower respiratory diseases	Diabetes mellitus
5	Diabetes mellitus	Diabetes mellitus	Chronic lower respiratory diseases	Influenza and pneumonia	Cerebrovascular diseases	Chronic lower respiratory diseases
6	Influenza and pneumonia	Alzheimer's disease	Nephritis	Diabetes mellitus	Unintentional injuries	Influenza and pneumonia
7	Alzheimer's disease	Influenza and pneumonia	Influenza and pneumonia	[2]Benign neoplasms [2]Unintentional injuries	Influenza and pneumonia	Nephritis
8	Unintentional injuries	Unintentional injuries	Septicemia		Nephritis	Unintentional injuries
9	Nephritis	Nephritis	Hypertension	Alzheimer's disease	Alzheimer's disease	Alzheimer's disease
10	Septicemia	Parkinson's disease	Unintentional injuries	Hypertension	Septicemia	Liver disease
11	Parkinson's disease	Septicemia	Alzheimer's disease	Septicemia	Liver disease	Septicemia
12	Pneumonitis	Pneumonitis	Pneumonitis	Parkinson's disease	Hypertension	Parkinson's disease
13	Hypertension	Hypertension	[1]Benign neoplasms [1]Parkinson's disease	Aortic aneurysm	Parkinson's disease	Hypertension
14	Aortic aneurysm	Aortic aneurysm		Pneumonitis	Pneumonitis	Pneumonitis
15	Benign neoplasms	Benign neoplasms	Liver disease	Benign neoplasms	Benign neoplasms	Benign neoplasms

[1]For black men, Benign neoplasms and Parkinson's disease tied for 13th.
[2]For Asian or Pacific Islander men, Benign neoplasms and Unintentional injuries tied for 7th.
[3]For American Indian women, Benign neoplasms and Pneumonitis tied for 13th.
NOTE: See Appendix B for the definition of race and Hispanic origin 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.

Table 15b. Leading causes of death among people age 65 and over, by sex and race and Hispanic origin, 2006 (continued)

	All races	*White*	*Black*	*Asian or Pacific Islander*	*American Indian*	*Hispanic*
	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	Diabetes mellitus	Cerebrovascular diseases
4	Chronic lower respiratory diseases	Chronic lower respiratory diseases	Diabetes mellitus	Diabetes mellitus	Cerebrovascular diseases	Diabetes mellitus
5	Alzheimer's disease	Alzheimer's disease	Nephritis	Influenza and pneumonia	Chronic lower respiratory diseases	Alzheimer's disease
6	Diabetes mellitus	Influenza and pneumonia	Alzheimer's disease	Alzheimer's disease	Alzheimer's disease	Chronic lower respiratory diseases
7	Influenza and pneumonia	Diabetes mellitus	Chronic lower respiratory diseases	Chronic lower respiratory diseases	Nephritis	Influenza and pneumonia
8	Nephritis	Unintentional injuries	Septicemia	Nephritis	Influenza and pneumonia	Nephritis
9	Unintentional injuries	Nephritis	Influenza and pneumonia	Unintentional injuries	Unintentional injuries	Unintentional injuries
10	Septicemia	Septicemia	Hypertension	Hypertension	Liver disease	Septicemia
11	Hypertension	Hypertension	Unintentional injuries	Septicemia	Septicemia	Hypertension
12	Parkinson's disease	Parkinson's disease	Pneumonitis	Parkinson's disease	Hypertension	Liver disease
13	Pneumonitis	Pneumonitis	Benign neoplasms	Pneumonitis	[3]Benign neoplasms [3]Pneumonitis	Parkinson's disease
14	Benign neoplasms	Benign neoplasms	Aortic aneurysm	Benign neoplasms		Pneumonitis
15	Atherosclerosis	Atherosclerosis	Atherosclerosis	Aortic aneurysm	Parkinson's disease	Benign neoplasms

[1]For black men, Benign neoplasms and Parkinson's disease tied for 13th.
[2]For Asian or Pacific Islander men, Benign neoplasms and Unintentional injuries tied for 7th.
[3]For American Indian women, Benign neoplasms and Pneumonitis tied for 13th.
NOTE: See Appendix B for the definition of race and Hispanic origin 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.

Table 15c. Leading causes of death among people age 85 and over, by sex and race and Hispanic origin, 2006

	All races	*White*	*Black*	*Asian or Pacific Islander*	*American Indian*	*Hispanic*
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	Influenza and pneumonia	Cerebrovascular diseases
4	Chronic lower respiratory diseases	Chronic lower respiratory diseases	Chronic lower respiratory diseases	Influenza and pneumonia	Diabetes mellitus	Chronic lower respiratory diseases
5	Alzheimer's disease	Alzheimer's disease	Influenza and pneumonia	Chronic lower respiratory diseases	[1]Alzheimer's disease [1]Chronic lower respiratory disease	Influenza and pneumonia
6	Influenza and pneumonia	Influenza and pneumonia	Nephritis	Alzheimer's disease		Alzheimer's disease
7	Nephritis	Nephritis	Alzheimer's disease	Diabetes mellitus	Cerebrovascular diseases	Diabetes mellitus
8	Unintentional injuries	Unintentional injuries	Diabetes mellitus	Nephritis	Nephritis	Nephritis
9	Diabetes mellitus	Diabetes mellitus	Septicemia	Unintentional injuries	[1]Pneumonitis [1]Unintentional injuries	Unintentional injuries
10	Parkinson's disease	Parkinson's disease	Hypertension	Hypertension		Parkinson's disease
11	Pneumonitis	Pneumonitis	Unintentional injuries	Pneumonitis	[1]Septicemia [1]Hypertension	Septicemia
12	Septicemia	Septicemia	Pneumonitis	Parkinson's disease		Hypertension
13	Hypertension	Hypertension	Benign neoplasms	Septicemia	Parkinson's disease	Pneumonitis
14	Benign neoplasms	Benign neoplasms	Atherosclerosis	Aortic aneurysm	Benign neoplasms	Benign neoplasms
15	Aortic aneurysm	Aortic aneurysm	Parkinson's disease	Benign neoplasms	Enterocolitis	Liver disease

[1]For American Indian men, Alzheimer's disease and Chronic lower respiratory disease tied for 5th; Pneumonitis and Unintentional injuries tied for 9th; and Septicemia and Hypertension tied for 9th.
[2]For American Indian women, Nephritis and Unintentional injuries tied for 9th; Septicemia and Parkinson's disease tied for 11th; and Atherosclerosis and Pneumonitis tied for 14th.
NOTE: See Appendix B for the definition of race and Hispanic origin 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.

Table 15c. Leading causes of death among people age 85 and over, by sex and race and Hispanic origin, 2006 (continued)

	All races	*White*	*Black*	*Asian or Pacific Islander*	*American Indian*	*Hispanic*
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	Alzheimer's disease	Alzheimer's disease	Alzheimer's disease	Influenza and pneumonia	Diabetes mellitus	Alzheimer's disease
5	Chronic lower respiratory diseases	Chronic lower respiratory diseases	Diabetes mellitus	Alzheimer's disease	Alzheimer's disease	Influenza and pneumonia
6	Influenza and pneumonia	Influenza and pneumonia	Nephritis	Diabetes mellitus	Influenza and pneumonia	Diabetes mellitus
7	Diabetes mellitus	Unintentional injuries	Influenza and pneumonia	Chronic lower respiratory diseases	Chronic lower respiratory diseases	Chronic lower respiratory diseases
8	Nephritis	Diabetes mellitus	Hypertension	Hypertension	Hypertension	Nephritis
9	Unintentional injuries	Nephritis	Septicemia	Nephritis	[2]Nephritis [2]Unintentional injuries	Hypertension
10	Hypertension	Hypertension	Chronic lower respiratory diseases	Unintentional injuries		Unintentional injuries
11	Septicemia	Septicemia	Unintentional injuries	Septicemia	[2]Septicemia [2]Parkinson's disease	Septicemia
12	Pneumonitis	Pneumonitis	Pneumonitis	Parkinson's disease		Pneumonitis
13	Parkinson's disease	Parkinson's disease	Atherosclerosis	Pneumonitis	Benign neoplasms	Parkinson's disease
14	Atherosclerosis	Atherosclerosis	Benign neoplasms	Benign neoplasms	[2]Atherosclerosis [2]Pneumonitis	Atherosclerosis
15	Benign neoplasms	Benign neoplasms	Aortic aneurysm	Aortic aneurysm		Benign neoplasms

[1]For American Indian men, Alzheimer's disease and Chronic lower respiratory disease tied for 5th; Pneumonitis and Unintentional injuries tied for 9th; and Septicemia and Hypertension tied for 9th.
[2]For American Indian women, Nephritis and Unintentional injuries tied for 9th; Septicemia and Parkinson's disease tied for 11th; and Atherosclerosis and Pneumonitis tied for 14th.
NOTE: See Appendix B for the definition of race and Hispanic origin 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 16 Chronic Health Conditions

Table 16a. Percentage of people age 65 and over who reported having selected chronic health conditions, by sex, 2007–2008

	Heart disease	*Hypertension*	*Stroke*	*Asthma*	*Chronic bronchitis or Emphysema*	*Any cancer*	*Diabetes*	*Arthritis*
					Percent			
Total	31.9	55.7	8.8	10.4	9.0	22.5	18.6	49.5
Men	38.2	53.1	8.7	8.9	8.6	23.9	19.5	42.2
Women	27.1	57.6	8.9	11.5	9.2	21.4	17.9	54.9
Non-Hispanic White	33.7	54.3	8.7	10.2	9.7	24.8	16.4	50.6
Non-Hispanic Black	27.2	71.1	10.8	11.3	5.9	13.3	29.7	52.2
Hispanic	23.8	53.1	7.7	10.9	6.2	12.4	27.3	42.1

NOTE: Data are based on a 2-year average from 2007–2008. See Appendix B for the definition of race and Hispanic origin 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 16b. Percentage of people age 65 and over who reported having selected chronic health conditions, 1997–2008

	Heart disease	*Hypertension*	*Stroke*	*Emphysema*	*Asthma*	*Chronic bronchitis*	*Any cancer*	*Diabetes*	*Arthritis*
					Percent				
1997–1998	32.3	46.5	8.2	5.2	7.7	6.4	18.7	13.0	na
1999–2000	29.8	47.4	8.2	5.2	7.4	6.2	19.9	13.7	na
2001–2002	31.5	50.2	8.9	5.0	8.3	6.1	20.8	15.4	na
2003–2004	31.8	51.9	9.3	5.2	8.9	6.0	20.7	16.9	50.0
2005–2006	30.9	53.3	9.3	5.7	10.6	6.1	21.1	18.0	49.5
2007–2008	31.9	55.7	8.8	5.1	10.4	5.4	22.5	18.6	49.5

na: Comparable data for arthritis not available prior to 2003–2004.

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.

Table 17a. Percentage of people age 65 and over who reported having any trouble hearing, trouble seeing, or no natural teeth, by selected characteristics, 2008

Sex	*Age and poverty status*	*Any trouble hearing*	*Any trouble seeing*	*No natural teeth*
		Percent		
Both sexes	65 and over	34.8	17.5	25.6
	65–74	27.8	14.3	20.4
	75–84	36.6	18.6	30.7
	85 and over	60.1	28.4	33.9
	Below poverty	28.2	23.8	41.8
	Above poverty	35.5	17.0	23.4
Men	65 and over	41.5	14.9	24.3
	65–74	36.0	11.3	19.2
	75–84	43.7	17.2	30.7
	85 and over	66.7	28.5	33.0
Women	65 and over	29.6	19.4	26.6
	65–74	20.7	16.9	21.4
	75–84	31.7	19.5	30.8
	85 and over	56.6	28.4	34.4

NOTE: Respondents were asked "WITHOUT the use of hearing aids or other listening devices, is your hearing excellent, good, a little trouble hearing, moderate trouble, a lot of trouble, or are you deaf?" For the purposes of this indicator, the category "Any trouble hearing" includes: "a little trouble hearing, moderate trouble, a lot of trouble, and deaf." This question differs slightly from the question used to calculate the estimates shown in previous editions of *Older Americans.* 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 17b. Percentage of people age 65 and over who reported ever having worn a hearing aid, 2008

Age group	*Both sexes*	*Men*	*Women*
		Percent	
65 and over	13.8	17.8	10.7
65–74	8.4	12.1	5.1
75–84	14.9	21.0	10.7
85 and over	34.2	40.6	30.8

NOTE: Respondents were asked "Do you now use a hearing aid(s)?" For those who responded no, they were also asked "Have you ever used a hearing aid(s) in the past?" Estimates in past editions of *Older Americans* were based on the answer to a single question of having ever worn a hearing aid.
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 18 Respondent-Assessed Health Status

Table 18. Respondent-assessed health status among people age 65 and over, by selected characteristics, 2006–2008

Selected characteristic	Total	Not Hispanic or Latino		Hispanic or Latino (of any race)
		White only	Black only	
Fair or poor health	Percent			
Both sexes				
65 and over	25.5	23.3	37.6	36.6
65–74	22.4	19.9	34.0	33.7
75–84	27.5	25.2	41.5	40.0
85 and over	33.7	32.1	46.3	46.0
Men				
65 and over	25.3	23.6	34.8	35.3
65–74	22.4	20.4	32.5	32.9
75–84	27.5	25.9	38.4	37.9
85 and over	35.1	33.7	42.0	46.9
Women				
65 and over	25.7	23.1	39.3	37.5
65–74	22.3	19.5	35.2	34.4
75–84	27.6	24.7	43.1	41.3
85 and over	32.9	31.3	47.9	45.5
Good to excellent health				
Both sexes				
65 and over	74.5	76.7	62.5	63.4
65–74	77.6	80.1	66.0	66.3
75–84	72.5	74.8	58.5	60.1
85 and over	66.4	67.9	53.7	54.0
Men				
65 and over	74.8	76.4	65.2	64.8
65–74	77.6	79.6	67.5	67.2
75–84	72.5	74.1	61.6	62.1
85 and over	64.9	66.3	58.0	53.1
Women				
65 and over	74.4	76.9	60.7	62.5
65–74	77.7	80.5	64.8	65.6
75–84	72.5	75.3	56.9	58.7
85 and over	67.1	68.7	52.1	54.5

NOTE: Data are based on a 3-year average from 2006–2008. See Appendix B for the definition of race and Hispanic origin 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 19 Depressive Symptoms

Table 19a. Percentage of people age 65 and over with clinically relevant depressive symptoms, by sex, selected years 1998–2006

	1998	*2000*	*2002*	*2004*	*2006*
Both sexes	15.9	15.6	15.4	14.4	14.6
Men	11.9	11.4	11.5	11.0	10.1
Women	18.6	18.5	18.0	16.8	17.9

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 of 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 "four or more symptoms" cut-off can be found in the following documentation, http //hrsonline.isr umich.edu/docs/userg/dr-005.pdf. Proportions are based on weighted data using the preliminary respondent weight from HRS 2006.
Reference population: These data refer to the civilian noninstitutionalized population.
SOURCE: Health and Retirement Study.

Table 19b. Percentage of people age 65 and over with clinically relevant depressive symptoms, by age group and sex, 2006

	Both sexes	*Men*	*Women*
65 and over	14.6	10.1	17.9
65–69	13.9	9.7	16.7
70–74	12.9	8.0	16.9
75–79	16.0	9.7	20.2
80–84	14.3	10.3	17.0
85 and over	18.8	17.8	19.2

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 of 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 "four or more symptoms" cut-off can be found in the following documentation, http //hrsonline.isr umich.edu/docs/userg/dr-005.pdf. Proportions are based on weighted data using the preliminary respondent weight from HRS 2006.
Reference population: These data refer to the civilian noninstitutionalized population.
SOURCE: Health and Retirement Study.

INDICATOR 20 Functional Limitations

Table 20a. Percentage of Medicare enrollees age 65 and over who have limitations in activities of daily living (ADLs) or instrumental activities of daily living (IADLs), or who are in a facility, selected years 1992–2007

	1992	*1997*	*2001*	*2005*	*2007*
IADLs only	13.7	12.7	13.4	12.3	13.8
1 to 2 ADLs	19.6	16.6	17.2	18.3	17.7
3 to 4 ADLs	6.1	4.9	5.3	4.7	4.5
5 to 6 ADLs	3.5	3.2	3.0	2.5	2.3
Facility	5.9	5.1	4.8	4.3	3.9
Total	48.8	42.5	43.7	42.1	42.2

NOTE: A residence is considered a long-term care facility if it is certified by Medicare or Medicaid; has three 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, seven-day-a-week supervision by a caregiver. ADL limitations refer to difficulty performing (or inability to perform for a health reason) one or more of the following tasks: bathing, dressing, eating, getting in/out of chairs, walking, or using the toilet. 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, or managing money. Rates are age adjusted using the 2000 standard population. Data for 1992, 2001, and 2007 do not sum to the totals because of rounding.
Reference population: These data refer to Medicare enrollees.

SOURCE: Centers for Medicare and Medicaid Services, Medicare Current Beneficiary Survey.

Table 20b. Percentage of Medicare enrollees age 65 and over who have limitations in activities of daily living (ADLs) or instrumental activities of daily living (IADLs), or who are in a facility, by sex, 2007

	Both Sexes	*Men*	*Women*
IADLs only	13.8	10.9	16.1
1 to 2 ADLs	17.7	16.3	18.8
3 to 4 ADLs	4.5	3.5	5.3
5 to 6 ADLs	2.3	2.0	2.4
Facility	3.9	2.5	4.7
Total	42.2	35.2	47.3

NOTE: A residence is considered a long-term care facility if it is certified by Medicare or Medicaid; 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, seven-day-a-week supervision by a caregiver. ADL limitations refer to difficulty performing (or inability to perform for a health reason) one or more of the following tasks: bathing, dressing, eating, getting in/out of chairs, walking, or using the toilet. 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, or managing money. Rates are age adjusted using the 2000 standard population. Data may not sum to the totals because of rounding.
Reference population: These data refer to Medicare enrollees.

SOURCE: Centers for Medicare and Medicaid Services, Medicare Current Beneficiary Survey.

Table 20c. Percentage of Medicare enrollees age 65 and over who are unable to perform certain physical functions, by sex, 1991 and 2007

Function	*1991*	*2007*
	Percent	
Men		
Stoop/kneel	7.8	10.1
Reach over head	3.1	3.0
Write/grasp small objects	2.3	1.3
Walk 2–3 blocks	14.0	14.3
Lift 10 bs.	9.2	7.0
Any of these five	18.9	19.3
Women		
Stoop/kneel	15.3	18.7
Reach over head	6.3	4.8
Write/grasp small objects	2.6	2.0
Walk 2–3 blocks	23.2	23.4
Lift 10 bs.	18.4	15.2
Any of these five	32.2	32.4

NOTE: Rates for 1991 are age adjusted to the 2007 population.
Reference population: These data refer to Medicare enrollees.
SOURCE: Centers for Medicare and Medicaid Services, Medicare Current Beneficiary Survey.

Table 20d. Percentage of Medicare enrollees age 65 and over who are unable to perform any one of five physical functions, by selected characteristics, 2007

Selected characteristic	*Men*	*Women*
Age	Percent	
65–74	13.0	21.8
75–84	23.1	35.1
85 and over	40.4	55.9
Race		
White, not Hispanic or Latino	18.9	31.9
Black, not Hispanic or Latino	25.6	35.4
Hispanic or Latino (any race)	20.0	33.3

NOTE: The five physical functions include stooping kneeling, reaching over the head, writing/grasping small objects, walking 2–3 blocks, and lifting 10 lbs.
Reference population: These data refer to Medicare enrollees.
SOURCE: Centers for Medicare and Medicaid Services, Medicare Current Beneficiary 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 1989–2008

	Influenza			Pneumococcal disease		
	Not Hispanic or Latino		Hispanic or Latino (of any race)	Not Hispanic or Latino		Hispanic or Latino (of any race)
Year	White	Black		White	Black	
1989	32.0	17.7	23.8	15.0	6.2	9.8
1991	42.8	26.5	33.2	21.0	13.2	11.0
1993	53.1	31.1	46.2	28.7	13.1	12.2
1994	56.9	37.7	36.6	30.5	13.9	13.7
1995	60.0	39.5	49.5	34.2	20.5	21.6
1997	65.8	44.6	52.7	45.6	22.2	23.5
1998	65.6	45.9	50.3	49.5	26.0	22.8
1999	67.9	49.7	55.1	53.1	32.3	27.9
2000	66.6	47.9	55.7	56.8	30.5	30.4
2001	65.4	47.9	51.9	57.8	33.9	32.9
2002	68.7	49.5	48.5	60.3	36.9	27.1
2003	68.6	47.8	45.4	59.6	37.0	31.0
2004	67.3	45.7	54.6	60.9	38.6	33.7
2005	63.2	39.6	41.7	60.6	40.4	27.5
2006	67.3	47.1	44.9	62.0	35.6	33.4
2007	69.3	55.7	52.2	62.2	44.1	31.8
2008	69.9	50.4	54.9	64.3	44.5	36.4

NOTE: For influenza, the percentage vaccinated consists of people who reported having a flu shot during the past 12 months and does not include receipt of nasal spray flu vaccinations. For pneumococcal disease, the percentage refers to people who reported ever having a pneumonia vaccination. See Appendix B for the definition of race and Hispanic origin 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, 2008

Selected characteristic	*Influenza*	*Pneumococcal disease*
	Percent	
Both sexes	67.1	60.0
Men	65.8	56.4
Women	68.1	62.8
65–74	60.8	52.5
75–84	72.7	68.6
85 and over	79.1	69.0
High school graduate or less	66.5	58.1
More than high school	68.0	62.9

NOTE: For influenza, the percentage vaccinated consists of people who reported having a flu shot during the past 12 months and does not include receipt of nasal spray flu vaccinations. 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.

Table 22. Percentage of women who reported having had a mammogram within the past 2 years, by selected characteristics, selected years 1987–2008

	1987	*1990*	*1991*	*1993*	*1994*	*1998*	*1999*	*2000*	*2003*	*2005*	*2008*
Age Groups						Women age 40 and over					
40–49	31.9	55.1	55.6	59.9	61.3	63.4	67.2	64.3	64.4	63.5	61.5
50–64	31.7	56.0	60.3	65.1	66.5	73.7	76.5	78.7	76.2	71.8	74.2
65 and over	22.8	43.4	48.1	54.2	55.0	63.8	66.8	67.9	67.7	63.8	65.5
65–74	26.6	48.7	55.7	64.2	63.0	69.4	73.9	74.0	74.6	72.5	72.6
75 and over	17.3	35.8	37.8	41.0	44.6	57.2	58.9	61.3	60.6	54.7	57.9
Race and Hispanic Origin						Women 65 and over					
White, not Hispanic or Latino	24.0	43.8	49.1	54.7	54.9	64.3	66.8	68.3	68.1	64.7	66.1
Black, not Hispanic or Latino	14.1	39.7	41.6	56.3	61.0	60.6	68.1	65.5	65.4	60.5	66.4
Hispanic or Latino	*	41.1	40.9	35.7	48.0	59.0	67.2	68.3	69.5	63.8	59.0
Poverty											
Poor	13.1	30.8	35.2	40.4	43.9	51.9	57.6	54.8	57.0	52.3	49.1
Near poor	19.9	38.6	41.8	47.6	48.8	57.8	60.2	60.3	62.8	56.1	59.4
Nonpoor	29.7	51.5	57.8	63.5	64.0	70.1	72.5	75.0	72.6	70.1	70.5
Education											
No high school diploma or GED	16.5	33.0	37.7	44.2	45.6	54.7	56.6	57.4	56.9	50.7	49.2
High school diploma or GED	25.9	47.5	54.0	57.4	59.1	66.8	68.4	71.8	69.7	64.3	65.7
Some college or more	32.3	56.7	57.9	64.8	64.3	71.3	77.1	74.1	75.1	73.0	75.6

* Estimates are considered unreliable.

NOTE: Questions concerning use of mammography differed slightly on the National Health Interview Survey across the years for which data are shown. For details, see *Health, United States 2009*, Appendix II.
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 Diet Quality

Table 23. Average dietary component scores as a percent of federal diet quality standards,[a] population age 65 and older, by age group, 2003–2004

Dietary Components	*Age group (Years)*		
	65 and older	*65–74*	*75 and older*
Total Healthy Eating Index-2005 score	65	63	67
Dietary Adequacy Components[a]			
Total Fruit	86	76	100
Whole Fruit	100	100	100
Total Vegetables	82	84	80
Dark Green and Orange Vegetables and Legumes	34	30	38
Total Grains	100	100	100
Whole Grains	32	28	34
Milk	56	52	62
Meat and Beans	100	100	100
Oils	76	75	77
Dietary Moderation Components[b]			
Saturated Fat	62	60	64
Sodium	34	32	38
Extra Calories[c]	55	51	62

[a]Higher scores reflect higher intakes
[b]Higher scores reflect lower intakes.
[c]Extra calories from other sources, such as solid fats, added sugars, and alcohol.

NOTE: The Healthy Eating Index-2005 (HEI-2005) comprises 12 components. Scores are averages across all adults and reflect long-term dietary intakes. The scores are expressed here as percentages of recommended dietary intake levels. A score corresponding to 100 percent indicates that the recommendation was met or exceeded, on average. A score below 100 percent indicates that average intake does not meet recommendations. Nine components of the HEI-2005 address nutrient adequacy. The remaining three components assess saturated fat, sodium, and calories from solid fats, alcoholic beverages, and added sugars, all of which should be consumed in moderation. For the adequacy components, higher scores reflect higher intakes; for the moderation components, higher scores reflect lower intakes because lower intakes are more desirable. For all components, a higher percentage indicates a higher-quality diet.

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

SOURCE: Centers for Disease Control and Prevention, National Center for Health Statistics, National Health and Nutrition Examination Survey, 2003–2004 and U.S. Department of Agriculture, Center for Nutrition Policy and Promotion, Healthy Eating Index-2005.

Table 24a. Percentage of people age 45 and over who reported engaging in regular leisure time physical activity, by age group, 1997–2008

	65 and over	*45–64*	*65–74*	*75–84*	*85 and over*
			Percent		
1997–1998	20.7	29.1	24.9	17.0	9.0
1999–2000	21.3	28.9	26.1	17.3	9.6
2001–2002	21.6	30.1	26.5	17.9	8.5
2003–2004	22.5	30.5	27.5	19.4	8.4
2005–2006	21.6	29.3	25.7	19.5	9.6
2007–2008	22.1	30.9	25.4	20.6	11.0

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 five 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 three 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.

Table 24b. Percentage of people age 65 and over who reported engaging in regular leisure time physical activity, by selected characteristics, 2007–2008

	Total	*Men*	*Women*
	Percent		
All	21.8	26.9	18.0
White, not Hispanic or Latino	22.8	27.6	19.1
Black, not Hispanic or Latino	12.5	17.4	9.5
Hispanic or Latino	21.0	28.3	15.9
Percent who engage in strengthening exercises	14.3	16.4	12.8

NOTE: Data are based on a 2-year average from 2007–2008."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 three 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 25 Obesity

Table 25. Body weight status among persons 65 years of age and over, by sex and age group, selected years 1976–2008

Sex and age group	1976–1980	1988–1994	1999–2000	2001–2002	2003–2004	2005–2006	2007–2008
Overweight				Percent			
Both sexes							
65 and over	na	60.1	69.0	69.1	70.5	68.6	71.2
65–74	57.2	64.1	73.5	73.1	74.0	73.8	73.7
75 and over	na	53.9	62.3	63.5	65.9	61.8	68.3
Men							
65 and over	na	64.4	73.3	73.1	72.1	73.9	77.1
65–74	54.2	68.5	77.2	75.4	76.6	79.5	78.8
75 and over	na	56.5	66.4	69.2	65.2	66.3	75.0
Women							
65 and over	na	56.9	65.6	66.3	69.2	64.6	66.8
65–74	59.5	60.3	70.1	71.3	71.7	69.4	69.8
75 and over	na	52.3	59.6	60.1	66.4	58.7	63.7
Obese							
Both sexes							
65 and over	na	22.2	31.0	29.2	29.7	30.5	32.2
65–74	17.9	25.6	36.3	35.9	34.6	35.0	36.9
75 and over	na	17.0	23.2	19.8	23.5	24.7	26.7
Men							
65 and over	na	20.3	28.7	25.3	28.9	29.7	33.7
65–74	13.2	24.1	33.4	30.8	33.0	32.9	39.9
75 and over	na	13.2	20.4	16.0	22.7	25.3	25.9
Women							
65 and over	na	23.6	32.9	32.1	30.4	31.1	31.1
65–74	21.5	26.9	38.8	40.1	36.1	36.7	34.6
75 and over	na	19.2	25.1	22.1	24.1	24.4	27.3

na: Data not available.
NOTE: Data are based on measured height and weight. Height was measured without shoes. Overweight is defined as having a body mass index (BMI) greater than or equal to 25 kilograms/meter^2. Obese is defined by a BMI of 30 kilograms/meter^2 or greater. 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.

Table 26a. Percentage of men age 45 and over who are current cigarette smokers, by selected characteristics, selected years 1965–2008

	Total		*White*		*Black or African American*	
Year	*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	29.8	19.4
2003	23.9	10.1	23.3	9.6	30.1	18.0
2004	25.0	9.8	24.4	9.4	29.2	14.1
2005	25.2	8.9	24.5	7.9	32.4	16.8
2006	24.5	12.6	23.4	12.6	32.6	16.0
2007	22.6	9.3	22.1	8.9	28.4	14.3
2008	24.8	10.5	24.0	9.9	33.6	17.5

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

NOTE: Data starting in 1997 are not strictly comparable with data for earlier years due to the 1997 NHIS questionnaire redesign. Starting with 1993 data, current cigarette smokers were defined as ever smoking 100 cigarettes in their lifetime and smoking now on every day or some days. See Appendix B for the definiton of race and Hispanic origin 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 26b. Percentage of women age 45 and over who are current cigarette smokers, by selected characteristics, selected years 1965–2008

	Total		*White*		*Black or African American*	
Year	*45–64*	*65 and over*	*45–64*	*65 and over*	*45–64*	*65 and over*
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	21.7	9.3	21.4	9.1	25.6	10.2
2001	21.4	†9.1	21.6	9.4	22.6	9.3
2002	21.1	8.6	21.5	8.5	22.2	9.4
2003	20.2	8.3	20.1	8.4	23.3	8.0
2004	19.8	8.1	20.1	8.2	20.9	6.7
2005	18.8	8.3	18.9	8.4	21.0	10.0
2006	19.3	8.3	18.8	8.4	25.5	9.3
2007	20.0	7.6	20.0	8.0	22.6	6.4
2008	20.5	8.3	20.9	8.6	21.3	8.1

*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 starting in 1997 are not strictly comparable with data for earlier years due to the 1997 NHIS questionnaire redesign. Starting with 1993 data, current cigarette smokers were defined as ever smoking 100 cigarettes in their lifetime and smoking now on every day or some days. See Appendix B for the definiton of race and Hispanic origin 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 26 Cigarette Smoking continued

Table 26c. Cigarette smoking status of people age 18 and over, by sex and age group, 2008

Sex and age group	All current smokers	Every day smokers	Some day smokers	Former smokers	Non-smokers
			Percent		
Both sexes	20.6	16.5	4.2	21.6	57.8
Men					
18–44	25.6	18.9	6.7	13.0	61.4
45–64	24.8	20.2	4.6	28.5	46.7
65 and over	10.5	8.9	1.6	54.6	34.9
Women					
18–44	20.6	16.8	3.8	11.9	67.5
45–64	20.5	17.4	3.1	22.4	57.1
65 and over	8.3	6.5	1.8	30.7	60.9

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," 2000–2008

Pollutant Measures	2000	2001	2002	2003	2004	2005	2006	2007	2008
					Percent				
Particulate Matter (PM 2.5)	41.0	39.0	38.0	33.0	23.0	35.0	21.0	24.0	11.0
8-hr Ozone	52.0	55.0	54.0	54.0	35.0	52.0	50.0	48.0	36.0
Any standard	62.0	62.0	60.0	59.0	45.0	58.0	54.0	53.0	38.0

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. In 2008, EPA strengthened the national standard for 8-hour ozone to 0 075 ppm and the national standard for lead to 0.15 µg/m3. This figure includes people living in counties that monitored ozone and lead concentrations above the new levels. This results in percentages that are not comparable to previous publications.
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., U.S. Census Bureau, Population Projections, 2000–2008.

Table 27b. Counties with "poor air quality" for any standard in 2008

State	County	State	County
Alabama	Jefferson County	California	Orange County
Alabama	Mobile County	California	Placer County
Alabama	P ke County	California	Plumas County
Alabama	She by County	California	Riverside County
Alaska	Fairbanks North Star Borough	California	Sacramento County
Arizona	Cochise County	California	San Benito County
Arizona	Gila County	California	San Bernardino County
Arizona	La Paz County	California	San Diego County
Arizona	Maricopa County	California	San Joaquin County
Arizona	Pinal County	California	San Luis Obispo County
Arizona	Santa Cruz County	California	Shasta County
Arizona	Yuma County	California	Solano County
California	Alameda County	California	Stanislaus County
California	Amador County	California	Sutter County
California	Butte County	California	Tehama County
California	Calaveras County	California	Trinity County
California	Contra Costa County	California	Tulare County
California	El Dorado County	California	Tuolumne County
California	Fresno County	California	Ventura County
California	Imperial County	California	Yolo County
California	Inyo County	Colorado	Adams County
California	Kern County	Colorado	Alamosa County
California	Kings County	Colorado	Boulder County
California	Lake County	Colorado	Douglas County
California	Los Angeles County	Colorado	Jefferson County
California	Madera County	Colorado	Larimer County
California	Mariposa County	Colorado	Prowers County
California	Merced County	Connecticut	Fairfield County
California	Mono County	Connecticut	Hartford County
California	Nevada County	Connecticut	Litchfield County

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.
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, 2000–2008.

Table 27b. Counties with "poor air quality" for any standard in 2008 *(continued)*

State	County	State	County
Connecticut	Middlesex County	Maryland	Prince George's County
Connecticut	New Haven County	Maryland	Baltimore city
Connecticut	New London County	Massachusetts	Bristol County
Connecticut	Tolland County	Massachusetts	Dukes County
Delaware	Kent County	Massachusetts	Essex County
Delaware	New Castle County	Massachusetts	Hampden County
Delaware	Sussex County	Massachusetts	Hampshire County
District of Columbia	District of Columbia	Massachusetts	Norfolk County
Florida	Hillsborough County	Massachusetts	Worcester County
Florida	Pasco County	Michigan	Wayne County
Florida	Santa Rosa County	Minnesota	Dakota County
Florida	Sarasota County	Minnesota	Ramsey County
Georgia	B bb County	Minnesota	Washington County
Georgia	Clarke County	Mississippi	Harrison County
Georgia	DeKalb County	Mississippi	Jackson County
Georgia	Dougherty County	Missouri	Iron County
Georgia	Douglas County	Missouri	Jefferson County
Georgia	Fayette County	Missouri	St. Charles County
Georgia	Fulton County	Missouri	St. Louis city
Georgia	Gwinnett County	Nevada	Clark County
Georgia	Hall County	Nevada	Nye County
Georgia	Henry County	Nevada	Washoe County
Georgia	Murray County	New Hampshire	Hillsborough County
Georgia	Richmond County	New Jersey	Bergen County
Georgia	Rockdale County	New Jersey	Camden County
Hawaii	Hawaii County	New Jersey	Cumberland County
Idaho	Power County	New Jersey	Gloucester County
Idaho	Shoshone County	New Jersey	Hudson County
Illinois	Madison County	New Jersey	Hunterdon County
Indiana	Delaware County	New Jersey	Mercer County
Kentucky	Oldham County	New Jersey	Middlesex County
Louisiana	Iberville Parish	New Jersey	Monmouth County
Louisiana	Pointe Coupee Parish	New Jersey	Morris County
Louisiana	St. Tammany Parish	New Jersey	Ocean County
Maryland	Anne Arundel County	New Jersey	Passaic County
Maryland	Baltimore County	New Mexico	Dona Ana County
Maryland	Calvert County	New Mexico	Luna County
Maryland	Carroll County	New York	Albany County
Maryland	Cecil County	New York	Bronx County
Maryland	Charles County	New York	Chautauqua County
Maryland	Harford County	New York	Dutchess County
Maryland	Kent County	New York	Erie County
Maryland	Montgomery County	New York	Monroe County

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.
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, 2000–2008.

Table 27b. Counties with "poor air quality" for any standard in 2008 *(continued)*

State	County	State	County
New York	New York County	Ohio	Warren County
New York	Orange County	Ohio	Washington County
New York	Putnam County	Oklahoma	Oklahoma County
New York	Queens County	Oklahoma	Tulsa County
New York	Saratoga County	Oregon	Harney County
New York	Suffolk County	Oregon	Klamath County
New York	Westchester County	Oregon	Lake County
North Carolina	Alexander County	Oregon	Lane County
North Carolina	Caswell County	Pennsylvania	Adams County
North Carolina	Davie County	Pennsylvania	Allegheny County
North Carolina	Durham County	Pennsylvania	Armstrong County
North Carolina	Forsyth County	Pennsylvania	Beaver County
North Carolina	Franklin County	Pennsylvania	Berks County
North Carolina	Graham County	Pennsylvania	Bucks County
North Carolina	Granville County	Pennsylvania	Chester County
North Carolina	Guilford County	Pennsylvania	Clearfield County
North Carolina	Haywood County	Pennsylvania	Dauphin County
North Carolina	Johnston County	Pennsylvania	Delaware County
North Carolina	Lincoln County	Pennsylvania	Indiana County
North Carolina	Mecklenburg County	Pennsylvania	Lackawanna County
North Carolina	New Hanover County	Pennsylvania	Lancaster County
North Carolina	Person County	Pennsylvania	Lehigh County
North Carolina	Pitt County	Pennsylvania	Lycoming County
North Carolina	Rockingham County	Pennsylvania	Mercer County
North Carolina	Rowan County	Pennsylvania	Monroe County
North Carolina	Union County	Pennsylvania	Montgomery County
North Carolina	Wake County	Pennsylvania	Northampton County
North Carolina	Yancey County	Pennsylvania	Perry County
Ohio	Butler County	Pennsylvania	Philadelphia County
Ohio	Clinton County	Pennsylvania	Washington County
Ohio	Cuyahoga County	Pennsylvania	York County
Ohio	Franklin County	Rhode Island	Providence County
Ohio	Fulton County	Rhode Island	Washington County
Ohio	Geauga County	South Carolina	Cherokee County
Ohio	Hamilton County	South Carolina	Darlington County
Ohio	Lake County	South Carolina	Pickens County
Ohio	Lawrence County	South Carolina	Richland County
Ohio	Montgomery County	South Carolina	Spartanburg County
Ohio	Stark County	Tennessee	Blount County
Ohio	Summit County	Tennessee	Hamilton County
Ohio	Trumbull County	Tennessee	Knox County

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.
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, 2000–2008.

Table 27b. Counties with "poor air quality" for any standard in 2008 *(continued)*

State	County	State	County
Tennessee	Loudon County	Virginia	Arlington County
Tennessee	Sevier County	Virginia	Caroline County
Tennessee	Shelby County	Virginia	Charles City County
Tennessee	Sullivan County	Virginia	Chesterfield County
Tennessee	Sumner County	Virginia	Fairfax County
Tennessee	Wilson County	Virginia	Hanover County
Texas	Bexar County	Virginia	Henrico County
Texas	Brazoria County	Virginia	Loudoun County
Texas	Collin County	Virginia	Madison County
Texas	Dallas County	Virginia	Hampton city
Texas	Denton County	Virginia	Norfolk city
Texas	El Paso County	Virginia	Suffolk city
Texas	Harris County	Virginia	Virginia Beach city
Texas	Jefferson County	Washington	Pierce County
Texas	Johnson County	Washington	Stevens County
Texas	Parker County	Washington	Yakima County
Texas	Tarrant County	West Virginia	Brooke County
Texas	Webb County	West Virginia	Hancock County
Utah	Box Elder County	West Virginia	Kanawha County
Utah	Cache County	Wisconsin	Vilas County
Utah	Davis County	Wyoming	Sublette County
Utah	Salt Lake County	Wyoming	Sweetwater County
Utah	Utah County		
Utah	Weber County		

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.
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, 2000–2008.

INDICATOR 28 Use of Time

Table 28a. Percentage of day that people age 55 and over spent doing selected activities on an average day, by age group, 2008

Selected leisure activities	55–64		65–74		75 and over	
	Average hours per day	Percent of day	Average hours per day	Percent of day	Average hours per day	Percent of day
Sleeping	8.3	34.4	8.8	36.5	9.1	38.1
Leisure activities	5.7	23.6	7.1	29.7	7.6	31.7
Work and work-related activities	3.5	14.7	1.2	5.1	0.4	1.5
Household activities	2.1	8.7	2.3	9.5	2.3	9.7
Caring for and helping others	0.6	2.5	0.4	1.7	0.2	0.9
Eating and drinking	1.3	5.6	1.5	6.1	1.5	6.3
Purchasing goods and services	0.9	3.6	0.9	3.8	0.8	3.1
Grooming	0.7	2.8	0.6	2.6	0.7	2.8
Other activities	1.0	4.1	1.2	5.0	1.4	5.6

NOTE: "Other activities" includes activities such as educational activities; organizational, civic and religious activities; and telephone calls.
Table includes people who did not work at all.
Reference population: These data refer to the civilian noninstitutionalized population.
SOURCE: Bureau of Labor Statistics, American Time Use Survey.

Table 28b. Percentage of total leisure time that people age 55 and over spent doing selected leisure activities on an average day, by age group, 2008

Selected leisure activities	55–64		65–74		75 and over	
	Average hours per day	Percent of day	Average hours per day	Percent of day	Average hours per day	Percent of day
Socializing and communicating	0.7	12.5	0.7	10.2	0.6	8.3
Watching TV	3.3	57.8	4.0	56.3	4.2	55.2
Participation in sports, exercise, and recreation	0.2	4.1	0.3	4.2	0.2	2.3
Relaxing and thinking	0.3	5.0	0.4	6.3	0.7	9.7
Reading	0.5	9.3	0.8	11.0	1.0	13.7
Other leisure activities (including related travel)	0.6	11.3	0.8	11.9	0.8	10.9

Reference population: These data refer to the civilian noninstitutionalized population.
SOURCE: Bureau of Labor Statistics, American Time Use Survey.

Table 29a. Use of Medicare-covered health care services by Medicare enrollees age 65 and over, 1992–2007

Year	Utilization Measure				
	Hospital stays	Skilled nursing facility stays	Physician visits and consultations	Home health care visits	Average length of hospital stay
	Rate per thousand enrollees				Days
1992	306	28	11,359	3,822	8.4
1993	300	33	11,600	4,648	8.0
1994	331	43	12,045	6,352	7.5
1995	336	50	12,372	7,608	7.0
1996	341	59	12,478	8,376	6.6
1997	351	67	na	8,227	6.3
1998	354	69	13,061	5,058	6.1
1999	365	67	na	3,708	6.0
2000	361	67	13,346	2,913	6.0
2001	364	69	13,685	2,295	5.9
2002	361	72	13,863	2,358	5.9
2003	359	74	13,519	2,440	5.8
2004	353	75	13,776	2,594	5.7
2005	350	79	13,914	2,770	5.7
2006	343	80	na	3,072	5.6
2007	336	81	na	3,409	5.6

na: Data not available.
NOTES: 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. The definition of physician visits and consultations changed beginning in 2003, resulting in a slightly lower rate. 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% or less of the Medicare population.
Reference population: These data refer to Medicare enrollees.
SOURCE: Centers for Medicare and Medicaid Services, Medicare claims and enrollment data.

Table 29b. Use of Medicare-covered home health and skilled nursing facility services by Medicare enrollees age 65 and over, by age group, 2007

Utilization measure	Age		
	65–74	75–84	85 and over
	Rate per 1,000 enrollees		
Skilled nursing facility stays	32	94	227
Home health care visits	1,713	4,156	7,333

NOTE: Data are for Medicare enrollees in fee-for-service only.
Reference population: These data refer to Medicare enrollees.
SOURCE: Centers for Medicare and Medicaid Services, Medicare claims and enrollment data.

INDICATOR 30 Health Care Expenditures

Table 30a. Average annual health care costs for Medicare enrollees age 65 and over, in 2006 dollars, by age group, 1992–2006

Year	Age			
	Total	65–74	75–84	85 and over
	Dollars			
1992	$9,224	$6,864	$10,094	$17,841
1993	9,886	7,171	11,300	18,494
1994	10,653	7,871	11,800	19,966
1995	11,146	8,111	12,197	21,084
1996	11,273	8,160	12,690	20,641
1997	11,522	8,140	12,800	20,876
1998	11,247	7,869	12,512	21,014
1999	11,562	8,778	12,260	20,305
2000	12,001	8,937	13,082	20,691
2001	12,663	9,628	14,081	21,126
2002	13,588	10,473	14,756	22,027
2003	13,714	10,385	15,327	21,550
2004	13,932	10,356	15,172	23,384
2005	na	na	na	na
2006	15,081	11,287	16,855	23,664

na: Data not available.
NOTES: Data include both out-of-pocket costs and costs covered by insurance. Dollars are inflation-adjusted to 2006 using the Consumer Price Index (Series CPI-U-RS).
Reference population: These data refer to Medicare enrollees.
SOURCE: Medicare Current Beneficiary Survey.

Table 30b. Major components of health care costs among Medicare enrollees age 65 and over, 1992 and 2006

Cost component	1992		2006	
	Average cost in dollars	Percent	Average cost in dollars	Percent
Total	$6,551	100	$15,081	100
Inpatient hospital	2,107	32	3,695	25
Physician/outpatient hospital	2,071	32	5,246	35
Nursing home/long-term institution	1,325	20	2,034	13
Home health care	244	4	442	3
Prescription drugs	522	8	2,351	16
Other (short-term institution/hospice/dental)	282	4	1,313	9

NOTES: 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: Medicare Current Beneficiary Survey.

Table 30c. Average annual health care costs among Medicare enrollees age 65 and over, by selected characteristics, 2006

Characteristics	*Average cost in dollars*
Total	$15,081
Race and ethnicity	
Non-Hispanic white	$14,980
Non-Hispanic black	$18,098
Hispanic	$14,144
Other	$13,350
Institutional status	
Community	$12,383
Institution	$57,022
Annual income	
< $10,000	$21,033
$10,000–$20,000	$16,674
$20,001–$30,000	$13,881
$30,001 and over	$12,440
Chronic conditions	
0	$5,186
1–2	$9,971
3–4	$16,936
5 and over	$25,132
Veteran status (men only)	
Yes	$14,424
No	$15,114

NOTE: Data include both out-of-pocket costs and costs covered by insurance. See Appendix B for the definition of race and Hispanic origin in the Medicare Current Beneficiary Survey. Chronic conditions include cancer (other than skin cancer), stroke, diabetes, heart disease, hypertension, arthritis, and respiratory conditions (emphysema, asthma, chronic obstructive pulmonary disease). Annual income includes that of respondent and spouse.
Reference population: These data refer to Medicare enrollees.

SOURCE: Medicare Current Beneficiary Survey.

Table 30d. Major components of health care costs among Medicare enrollees age 65 and over, by age group, 2006

	Age		
Cost component	*65–74*	*75–84*	*85 and over*
	Average cost in dollars		
Total	$11,287	$16,855	$23,664
Inpatient hospital	2,763	4,403	5,150
Physician/outpatient hospital	4,738	6,051	5,070
Nursing home/long-term institution	547	1,969	7,182
Home health care	216	479	1,115
Prescription drugs	2,370	2,508	1,935
Other (short-term institution/hospice/ dental)	654	1,446	3,211

NOTE: Data include both out-of-pocket costs and costs covered by insurance.
Reference population: These data refer to Medicare enrollees.

SOURCE: Medicare Current Beneficiary Survey.

INDICATOR 30 Health Care Expenditures continued

Table 30e. Percentage of noninstitutionalized Medicare enrollees age 65 and older who reported problems with access to health care, 1992–2005

Reported problems	*1992*	*1993*	*1994*	*1995*	*1996*	*1997*	*1998*	*1999*	*2000*	*2001*	*2002*	*2003*	*2004*	*2005*
	Percent													
Difficulty obtaining care	3.1	2.6	2.6	2.6	2.3	2.4	2.4	2.8	2.9	2.8	2.5	2.3	2.3	2.5
Delayed getting care due to cost	9.8	9.1	7.6	6.8	5.5	4.8	4.4	4.7	4.8	5.1	6.1	5.3	5.3	4.8

Reference population: These data refer to Medicare enrollees.
SOURCE: Medicare Current Beneficiary Survey.[1]
[1]MCBS Project. (2008). Health and Health Care of the Medicare Population: Data from the 2005 Medicare Current Beneficiary Survey. (Prepared under contract to the Centers for Medicare and Medicaid Services). Rockville, MD: Westat.

INDICATOR 31 Prescription Drugs

Table 31a. Average prescription drug costs and sources of payment among noninstitutionalized Medicare enrollees age 65 and over, 1992–2004

	1992	*1993*	*1994*	*1995*	*1996*	*1997*	*1998*	*1999*	*2000*	*2001*	*2002*	*2003*	*2004*
	Average cost in dollars												
Total	$570	$756	$802	$841	$907	$991	$1,147	$1,284	$1,469	$1,647	$1,827	$1,963	$2,107
Out of pocket	343	439	436	441	451	491	530	565	616	658	721	736	763
Private	145	190	220	248	302	323	401	449	512	573	666	747	810
Public	82	127	146	152	155	177	215	270	341	416	441	480	534

NOTE: Dollars have been inflation-adjusted to 2004 using the Consumer Price Index (Series CPI-U-RS). Reported costs have been adjusted by a factor of 1.205 to account for underreporting of prescription drug use. Public programs include Medicare, Medicaid, Department of Veterans Affairs, and other state and federal programs. Data for 2005 and 2006 were not available in time to include in this report.
Reference population: These data refer to Medicare enrollees.
SOURCE: Centers for Medicare and Medicaid Services, Medicare Current Beneficiary Survey.

Table 31b. Distribution of annual prescription drug costs among noninstitutionalized Medicare enrollees age 65 and over, 2004

Cost in dollars	*Percent of enrollees*
Total	100.0
$0	7.8
1–499	20.0
500–999	16.3
1,000–1,499	12.8
1,500–1,999	11.0
2,000–2,499	8.2
2,500 or more	23.9

NOTE: Reported costs have been adjusted by a factor of 1 205 to account for underreporting of prescription drug use. Data for 2005 and 2006 were not available in time to include in this report.
Reference population: These data refer to Medicare enrollees.
SOURCE: Centers for Medicare and Medicaid Services, Medicare Current Beneficiary Survey.

Table 31c. Number of Medicare enrollees age 65 and over who enrolled in Part D prescription drug plans or who were covered by retiree drug subsidy payments, June 2006 and December 2009

Part D benefit categories	*June 2006*	*December 2009*
All Medicare enrollees age 65 or over	36,052,991	38,909,142
Enrollees in prescription drug plans	18,245,980	22,183,470
Type of plan		
Stand-alone plan	12,583,676	13,530,371
Medicare Advantage plan	5,662,304	8,653,099
Low-income subsidy		
Yes	5,935,532	6,086,550
No	12,310,448	16,096,920
Retiree drug subsidy	6,498,163	6,187,111
Other	11,308,848	10,538,561

Reference population: These data refer to Medicare enrollees.
SOURCE: Centers for Medicare and Medicaid Services, Management Information Integrated Repository.

Table 31d. Average prescription drug costs among noninstitutionalized Medicare enrollees age 65 and over, by selected characteristics, 2000, 2002, and 2004

Characteristic	*2000*	*2002*	*2004*
		Average cost in dollars	
Number of chronic conditions			
0	$551	$650	$800
1–2	1,153	1,417	1,741
3–4	2,030	2,459	2,845
5 and over	2,772	3,502	3,862
Annual income			
<$10,001	1,383	1,838	1,938
$10,001–$20,000	1,402	1,749	2,080
$20,001–$30,000	1,571	1,892	2,138
More than $30,000	1,520	1,850	2,189

NOTE: Dollars have been inflation adjusted to 2004 using the Consumer Price Index (CPI-U-RS). Reported costs have been adjusted by a factor of 1.205 to account for underreporting of prescription drug use. Chronic conditions include cancer (other than skin cancer), stroke, diabetes, heart disease, hypertension, arthritis, and respiratory conditions (emphysema/asthma/chronic obstructive pulmonary disease). Annual income includes that of respondent and spouse. Data for 2005 and 2006 were not available in time to include in this report.
Reference population: These data refer to Medicare enrollees.
SOURCE: Centers for Medicare and Medicaid Services, Medicare Current Beneficiary Survey.

INDICATOR 32 Sources of Health Insurance

Table 32a. Percentage of noninstitutionalized Medicare enrollees age 65 and over with supplemental health insurance, by type of insurance, 1991–2007

Year	Types of supplemental insurance					
	Private (employer or union sponsored)	*Private (Medigap)**	*HMO*	*Medicaid*	*Other public*	*No supplement*
	Percent					
1991	40.7	44.8	6.3	8.9	4.0	11.3
1992	41.0	45.0	5.9	9.0	5.3	10.4
1993	40.8	45.3	7.7	9.4	5.8	9.7
1994	40.3	45.2	9.1	9.9	5.5	9.3
1995	39.1	44.3	10.9	10.1	5.0	9.1
1996	37.8	38.6	13.8	9.5	4.8	9.4
1997	37.6	35.8	16.6	9.4	4.7	9.2
1998	37.0	33.9	18.6	9.6	4.8	8.9
1999	35.8	33.2	20.5	9.7	5.1	9.0
2000	35.9	33.5	20.4	9.9	4.9	9.7
2001	36.0	34.5	18.0	10.6	5.4	10.1
2002	36.1	37.5	15.5	10.7	5.5	12.3
2003	36.1	34.3	14.8	11.6	5.7	11.8
2004	36.6	33.7	15.6	11.3	5.2	12.6
2005	36.1	34.6	15.5	11.8	5.6	12.0
2006	34.9	32.5	20.7	11.9	4.3	12.5
2007	35.3	31.5	21.8	11.9	4.0	13.3

* Includes people with private supplement of unknown sponsorship.

NOTE: HMOs include Health Maintenance Organizations (HMOs), Preferred Provider Organizations (PPOs), and private fee-for-service plans (PFFSs). Not all types of plans were available in all years. Since 2003 these types of plans have been known collectively as Medicare Advantage. 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 to 2 percent of enrollees). Medicaid coverage was determined from both survey responses and Medicare administrative records.
Reference population: These data refer to Medicare enrollees.

SOURCE: Centers for Medicare and Medicaid Services, Medicare Current Beneficiary Survey.

Table 32b. Percentage of people age 55–64 with health insurance coverage, by type of insurance and poverty status, 2008

Type of Insurance	Total	Poverty Threshold		
		99 percent or less	*100–199 percent*	*200 percent*
Private	73.6	16.4	40.0	85.3
Medicaid	6.6	39.8	14.5	1.8
Medicare	4.3	7.6	13.6	2.4
Other coverage	3.7	5.2	5.2	3.3
Uninsured	11.8	31.0	26.7	7.2

NOTE: Poverty status is based on family income and family size using the U.S. Census Bureau's poverty thresholds. Below poverty (99 percent or less) is defined as people living below the poverty threshold. People living above poverty are divided between those with incomes between 100–199 percent of the poverty threshold and those with incomes of 200 percent or more of the poverty threshold. A multiple imputation procedure was performed for the missing family income data (unknown poverty). A detailed description of the multiple imputation procedure is available from http://www.cdc.gov/nchs/nhis htm via the Imputed Income Files link under data year 2006. Classification of health insurance is based on a hierarchy of mutually exclusive categories. Health insurance categories are mutually exclusive. Persons who reported both Medicaid and private coverage are classified as having private coverage. Starting with 1997 data, state-sponsored health plan coverage is included as Medicaid coverage. Starting with 1999 data, coverage by the Children's Health Insurance Program (CH P) is included with Medicaid coverage. In addition to private and Medicaid, the Other Insurance category includes military and other government. Persons not covered by private insurance, Medicaid, CHIP, state-sponsored or other government-sponsored health plans (starting in 1997), Medicare, or military plans are considered to have no health insurance coverage. Persons with only Indian Health Service coverage are considered to have no health insurance coverage.
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 33 Out-of-Pocket Health Care Expenditures

Table 33a. Percentage of people age 55 and over with out-of-pocket expenditures for health care service use, by age group, 1977, 1987, 1996, 2000–2006

Age Group	*1977*	*1987*	*1996*	*2000*	*2001*	*2002*	*2003*	*2004*	*2005*	*2006*
					Percent					
65 and over	83.3	88.6	92.4	93.6	94.7	94.4	94.7	95.5	95.0	95.0
55–64	81.9	84.0	89.6	90.2	90.4	90.9	90.4	90.0	90.5	88.9
55–61	81.6	83.9	89.5	89.4	90.2	90.7	89.6	89.5	89.6	88.4
62–64	82.6	84.3	89.7	92.4	91.1	91.3	92.7	91.6	93.3	90.6
65–74	83.4	87.9	91.8	93.3	94.1	94.4	93.7	95.1	94.2	94.1
75–84	83.8	90.0	92.9	93.5	95.6	94.6	95.7	95.8	96.1	96.2
85 and over	80.8	88.6	93.9	95.2	94.6	93.8	95.8	96.3	95.1	95.5

NOTE: Out-of-pocket health care expenditures exclude personal spending for health insurance premiums. Data for the 1987 survey have been adjusted to permit comparability across years; for details, see Zuvekas and Cohen.[51]
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.

Table 33b. Out-of-pocket health care expenditures as a percentage of household income, among people age 55 and over, by selected characteristics, 1977, 1987, 1996, 2000–2006

Selected Characteristic	*1977*	*1987*	*1996*	*2000*	*2001*	*2002*	*2003*	*2004*	*2005*	*2006*
Total						Percent				
65 and over	7.2	8.8	8.4	9.1	10.0	10.8	11.6	11.6	10.9	10.0
55–64	5.2	5.8	7.1	7.0	7.6	7.1	7.3	7.5	7.1	7.1
55–61	5.1	5.7	6.2	6.1	6.9	6.6	6.9	7.1	6.7	6.6
62–64	5.5	5.9	9.5	9.3	9.6	8.5	8.4	8.8	8.2	8.5
65–74	6.4	7.2	7.7	8.1	8.7	9.5	9.2	10.7	9.2	9.1
75–84	8.8	11.0	9.0	10.4	11.4	11.9	13.4	11.8	12.5	10.5
85 and over	7.9	12.0	9.8	10.1	11.8	12.7	16.4	14.9	13.0	12.2
Income Category										
Poor/near poor										
65 and over	12.3	15.8	19.2	22.6	23.5	27.6	27.8	29.3	27.6	28.1
55–64	16.1	18.1	30.0	29.9	31.2	27.1	29.9	30.0	27.7	28.8
55–61	17.5	19.8	27.6	28.1	29.6	26.5	30.0	29.6	27.9	27.7
62–64	13.3	14.0	34.3	(B)	34.9	28.5	29.9	30.9	27.3	31.5
65–74	11.0	13.7	21.6	24.4	25.7	27.7	23.4	29.0	26.2	29.4
75–84	14.4	19.0	18.3	22.9	23.3	28.4	30.2	29.4	28.6	27.9
85 and over	12.4	14.7	(B)	17.6	18.7	25.7	32.4	30.0	28.6	24.9
Low/middle/high										
65 and over	5.4	7.0	5.6	6.3	7.3	7.2	8.0	8.1	7.4	6.0
55–64	3.9	3.7	3.2	3.4	4.2	4.1	4.5	4.1	4.2	4.0
55–61	3.7	3.4	2.9	3.1	3.9	3.8	4.2	4.0	3.9	3.8
62–64	4.2	4.6	3.8	4.3	5.3	5.0	5.5	4.8	5.3	4.8
65–74	5.0	5.9	4.9	5.6	6.2	6.4	6.9	7.4	6.2	5.2
75–84	6.2	8.4	6.3	6.9	8.4	8.2	9.1	8.2	8.8	6.5
85 and over	5.2	10.9	7.8	7.6	9.3	7.9	10.3	11.1	8.2	8.2

Table 33b. Out-of-pocket health care expenditures as a percentage of household income, among people age 55 and over, by selected characteristics, 1977, 1987, 1996, 2000–2006 *(continued)*

Selected Characteristic	*1977*	*1987*	*1996*	*2000*	*2001*	*2002*	*2003*	*2004*	*2005*	*2006*
						Percent				
Health Status Category										
Poor or fair health										
65 and over	9.5	11.0	11.7	13.1	13.9	14.6	16.0	15.2	15.5	12.9
55–64	8.7	8.5	13.0	14.1	13.6	13.3	13.3	13.8	12.7	13.2
55–61	8.8	9.0	11.8	12.8	12.9	12.8	12.4	13.5	11.8	12.9
62–64	8.6	7.6	15.9	17.4	15.2	14.7	15.9	14.7	15.3	14.0
65–74	8.7	10.0	10.7	11.8	13.5	14.4	13.8	14.3	14.3	13.1
75–84	11.3	12.4	11.8	14.6	14.7	15.2	17.5	15.4	17.1	13.0
85 and over	8.9	12.2	(B)	13.8	13.2	13.5	19.5	17.9	14.5	12.2
Excellent, very good, or good health										
65 and over	6.1	7.1	6.6	6.7	7.6	8.4	8.9	9.4	8.1	8.2
55–64	3.9	4.6	5.0	4.0	5.2	4.6	5.0	5.0	4.9	4.8
55–61	3.9	4.5	4.1	3.5	4.8	4.4	4.9	4.5	4.6	4.3
62–64	4.1	4.9	7.3	5.6	6.6	5.6	5.4	6.4	5.6	6.3
65–74	5.3	5.4	6.3	6.2	6.2	7.1	6.9	8.9	6.6	7.1
75–84	7.5	9.7	7.2	7.5	9.1	9.6	10.7	9.3	9.2	8.8
85 and over	7.6	11.8	6.4	7.1	10.6	11.9	13.9	12.8	11.9	12.2

(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 "low/middle/high" 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. For people with out-of-pocket expenditures and with zero income (or negative income) the ratio was set at 100 percent. For people with no out-of-pocket expenditures the ratio was set to zero. These methods differ from what was used in *Older Americans 2004,* which excluded persons with no out-of-pocket expenditures from the calculations (17 percent of the population 65 and older in 1977, and 4.5 percent of the population age 65 and older in 2004). Data from the 1987 survey have been adjusted to permit comparability across years; for details see Zuvekas and Cohen.[51]
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.

Table 33c. Distribution of total out-of-pocket health care expenditures among people age 55 and over, by type of health care services and age group, 2000–2006

Type of health care service, by year	*65 and over*	*55–64*	*55–61*	*62–64*	*65–74*	*75–84*	*85 and over*
2000							
Hospital care	6.4	8.5	7.5	*11.0	7.3	4.6	8.6
Office-based medical provider services	9.8	18.9	19.8	16.7	11.6	9.0	6.0
Dental services	15.8	20.0	21.3	17.0	17.5	15.9	9.6
Prescription drugs	53.6	44.7	44.0	46.5	57.1	51.5	48.0
Other health care	14.3	7.8	7.5	8.7	6.6	19.0	27.9
2001							
Hospital care	5.4	9.8	9.4	10.7	5.2	5.8	*4.8
Office-based medical provider services	9.4	19.8	19.9	19.7	10.5	9.6	6.0
Dental services	13.0	18.6	20.0	15.2	15.6	11.9	8.3
Prescription drugs	56.0	45.7	44.3	48.9	57.2	58.9	45.1
Other health care	16.2	6.1	6.4	5.5	11.5	13.8	*35.8
2002							
Hospital care	5.0	10.2	9.2	13.1	4.6	5.5	5.1
Office-based medical provider services	10.5	21.3	21.6	20.3	12.3	9.3	7.8
Dental services	14.0	18.1	18.3	17.7	17.6	12.3	6.2
Prescription drugs	58.2	43.8	43.5	44.7	57.9	56.6	65.5
Other health care	12.3	6.6	7.4	4.3	7.7	16.3	15.4
2003							
Hospital care	5.2	9.2	8.8	10.1	5.9	4.5	5.1
Office-based medical provider services	8.7	18.8	18.3	19.9	9.4	9.1	5.4
Dental services	11.8	16.7	16.7	16.9	14.5	9.5	9.5
Prescription drugs	58.3	48.5	49.0	47.5	61.3	54.5	59.8
Other health care	16.0	6.8	7.3	5.6	8.9	22.4	20.2
2004							
Hospital care	5.0	9.2	10.1	6.9	5.1	4.5	*5.9
Office-based medical provider services	10.1	20.1	18.7	23.6	12.4	9.2	5.3
Dental services	11.8	16.9	18.5	12.8	13.2	12.0	7.5
Prescription drugs	61.4	46.0	45.0	48.7	61.9	64.8	51.9
Other health care	11.8	7.8	7.7	8.1	7.4	9.5	29.5

* Indicates the relative standard error is greater than 30 percent.

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 include services provided by medical providers in non-hospital-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 might 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 (MEPS).

Table 33c. Distribution of total out-of-pocket health care expenditures among people age 55 and over, by type of health care services and age group, 2000–2006 *(continued)*

Type of health care service, by year	*65 and over*	*55–64*	*55–61*	*62–64*	*65–74*	*75–84*	*85 and over*
2005							
Hospital care	5.4	12.2	12.8	10.8	5.1	5.7	5.4
Office-based medical provider services	11.4	19.6	19.6	19.9	11.4	12.3	8.7
Dental services	15.3	15.7	16.3	14.3	19.4	12.6	9.8
Prescription drugs	57.8	45.9	44.7	49.0	57.9	59.1	53.3
Other health care	10.1	6.5	6.7	6.1	6.2	10.4	22.7
2006							
Hospital care	7.2	*17.7	9.4	*35.2	6.6	5.9	12.2
Office-based medical provider services	12.3	19.8	20.9	17.4	14.1	11.0	9.5
Dental services	16.2	13.9	15.4	10.6	19.7	15.3	7.6
Prescription drugs	51.1	43.2	48.5	32.0	51.5	53.2	45.2
Other health care	13.2	5.5	5.8	4.9	8.1	14.7	25.5

* Indicates the relative standard error is greater than 30 percent.

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 include services provided by medical providers in non-hospital-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 might 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 (MEPS).

INDICATOR 34 Sources of Payment for Health Care Services

Table 34a. Sources of payment for health care services for Medicare enrollees age 65 and over, by type of service, 2006

Service	*Average cost*	*Total*	*Medicare*	*Medicaid*	*OOP*	*Other*
	Dollars			Percent		
Hospice	$239	100	100	0	0	0
Inpatient hospital	3,695	100	86	1	4	8
Home health care	442	100	91	1	7	1
Short-term institution	728	100	78	3	9	10
Physician/medical	3,956	100	61	2	18	19
Outpatient hospital	1,290	100	68	2	9	21
Prescription drugs	2,351	100	26	2	26	45
Dental	346	100	1	1	77	21
Long-term care facility	2,034	100	1	47	45	7
All	15,081	100	55	7	19	19

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: Medicare Current Beneficiary Survey.

Table 34b. Sources of payment for health care services for Medicare enrollees age 65 and over, by income, 2006

Income	*Average cost*	*Total*	*Medicare*	*Medicaid*	*OOP*	*Other*
	Dollars			Percent		
All	$15,081	100	55	7	19	19
< $10,000	21,033	100	56	21	13	10
$10,000–$20,000	16,674	100	57	8	19	17
$20,001–$30,000	13,881	100	57	3	21	20
$30,001 and over	12,440	100	51	1	23	25

NOTE: Income refers to annual income of respondent and spouse. 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: Medicare Current Beneficiary Survey.

INDICATOR 35 Veterans' Health Care

Table 35. Total number of veterans age 65 and over who are enrolled in or receiving health care from the Veterans Health Administration, 1990–2008

Year	*Total*	*VA enrollees*	*VA patients*
		Number in millions	
1990	7.9	na	0.9
1991	8.3	na	0.9
1992	8.7	na	1.0
1993	9.0	na	1.0
1994	9.2	na	1.0
1995	9.4	na	1.1
1996	9.7	na	1.1
1997	9.8	na	1.1
1998	9.9	na	1.3
1999	10.0	1.9	1.4
2000	10.0	2.2	1.6
2001	9.9	2.8	1.9
2002	9.8	3.2	2.2
2003	9.7	3.3	2.3
2004	9.5	3.4	2.4
2005	9.3	3.5	2.4
2006	9.2	3.5	2.4
2007	9.3	3.5	2.4
2008	9.2	3.4	2.2

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). VA patients are veterans who have received care each year through VHA. The methods used to calculate VA patients differ from what was used in *Older Americans 2004* and *Older Americans Update 2006*. Veterans who received care but were not enrolled in VA are now included in patient counts. VHA Vital Status files from the Social Security Administration (SSA) are now used to ascertain veteran deaths.
Reference population: These data refer to the total veteran population, VHA enrollment population, and VHA patient population.

SOURCE: Department of Veterans Affairs, Veteran Population 2007; Fiscal 2009 Year-end Office of the Assistant Deputy Under Secretary for Health for Policy and Planning Enrollment file linked with September 2009 VHA Vital Status data (including data from VHA, VA, Medicare, and SSA).

INDICATOR 36 Residential Services

Table 36a. Percentage of Medicare enrollees age 65 and over residing in selected residential settings, by age group, 2007

Residential setting	Age			
	65 and over	65–74	75–84	85 and over
	Number in thousands			
All settings	34,207	16,867	12,429	4,912
	Percent			
Total	100.0	100.0	100.0	100.0
Traditional community	93.3	97.9	93.3	77.6
Community housing with services	2.4	0.8	2.9	7.0
Long term care facilities	4.2	1.3	3.8	15.4

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 (or unit) is considered a long-term care facility if it is certified by Medicare or Medicaid or has three 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, seven-day-a-week supervision by a non-family, paid caregiver.
Reference population: These data refer to Medicare beneficiaries.

SOURCE: Centers for Medicare and Medicaid Services, Medicare Current Beneficiary Survey.

Table 36b. Percentage of Medicare enrollees age 65 and over with functional limitations, by residential setting, 2007

Functional status	Traditional community	Community housing with services	Long-term care facility
		Percent	
Total	100.0	100.0	100.0
No functional limitations	60.0	35.6	5.0
IADL limitation only	14.6	18.4	11.6
1–2 ADL limitations	18.3	31.7	16.4
3 or more ADL limitations	7.1	14.2	67.0

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. A residence (or unit) is considered a long term care facility if it is certified by Medicare or Medicaid; or has three 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, seven-day-a-week supervision by a non-family, paid caregiver. Instrumental activities of daily living (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. activities of daily living (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 beneficiaries.

SOURCE: Centers for Medicare and Medicaid Services, Medicare Current Beneficiary Survey.

Table 36c. Availability of specific services among Medicare enrollees age 65 and over residing in community housing with services, 2007

Persons residing in community housing with services who have access to...	Percent
Prepared meals	86.9
Housekeeping, maid, or cleaning services	83.9
Laundry services	71.9
Help with medications	51.4

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 beneficiaries.

SOURCE: Centers for Medicare and Medicaid Services, Medicare Current Beneficiary Survey.

Table 36d. Annual income distribution of Medicare enrollees age 65 and over, by residential setting, 2007

Income	*Traditional community*	*Community housing with services*	*Long-term care facility*
		Percent	
Total	100.0	100.0	100.0
$0–$10,000	13.1	14.0	38.2
$10,001–$20,000	24.5	28.3	38.8
$20,001–$30,000	20.6	16.9	10.2
$30,001 or more	41.8	40.8	12.8

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 (or unit) is considered a long-term care facility if it is certified by Medicare or Medicaid; or has three 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, seven-day-a-week supervision by a non-family, paid caregiver. Income refers to annual income of respondent and spouse. 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 beneficiaries.

SOURCE: Centers for Medicare and Medicaid Services, Medicare Current Beneficiary Survey.

Table 36e. Characteristics of services available to Medicare enrollees age 65 and over residing in community housing with services, 2007

Selected characteristic	*Percent*
Services included in housing costs	100.0
All included	34.5
Some included/some separate	52.1
All separate	13.4
Can continue living there if they need substantial services	100.0
Yes	56.5
No	43.5

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 beneficiaries.

SOURCE: Centers for Medicare and Medicaid Services, Medicare Current Beneficiary Survey.

INDICATOR 37 Personal Assistance and Equipment

Table 37a. Distribution of noninstitutionalized Medicare enrollees age 65 and over who have limitations in activities of daily living (ADLs), by types of assistance, selected years 1992–2007

	1992	*1997*	*2001*	*2005*	*2007*
Personal assistance only	9.2	5.6	6.3	6.6	6.0
Equipment only	28.3	34.2	36.3	36.3	37.6
Personal assistance and equipment	20.9	21.4	22.0	21.9	22.1
None	41.6	38.8	35.3	35.2	34.3

NOTE: ADL limitations refer to difficulty performing (or inability to perform for a health reason) one or more of the following tasks: bathing, dressing, eating, getting in/out of chairs, walking, or using the toilet. Respondents who report difficulty with an activity are subsequently asked about receiving help or supervision from another person with the activity and about using special equipment or aids. In this table, personal assistance does not include supervision.
Reference population: These data refer to noninstitutionalized Medicare enrollees who have limitations with one or more ADLs.

SOURCE: Centers for Medicare and Medicaid Services, Medicare Current Beneficiary Survey.

Table 37b. Percentage of noninstitutionalized Medicare enrollees age 65 and over who have limitations in instrumental activities of daily living (IADLs) and who receive personal assistance, by age group, selected years 1992–2007

	1992	*1997*	*2001*	*2005*	*2007*
65–74	58.9	61.8	60.9	62.7	65.4
75–84	63.2	63.2	66.5	67.4	66.0
85 and over	69.2	71.1	73.7	74.0	69.7

NOTE: 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, or managing money. Respondents who report difficulty with an activity are subsequently asked about receiving help from another person with the activity. In this table, personal assistance does not include supervision or special equipment.
Reference population: These data refer to noninstitutionalized Medicare enrollees who have limitations with one or more IADLs.

SOURCE: Centers for Medicare and Medicaid Services, Medicare Current Beneficiary Survey.

Appendix B: Data Source Descriptions

Air Quality System

The Air Quality System (AQS) contains ambient air pollution data collected by the U.S. Environmental Protection Agency (EPA) and state, local, and tribal air pollution control agencies. Data on criteria pollutants consist of air quality measurements collected by sensitive equipment at thousands of monitoring stations located across all 50 states, plus the District of Columbia, Puerto Rico, and the U.S. Virgin Islands. Each monitor measures the concentration of a particular pollutant in the air. Monitoring data indicate the average pollutant concentration during a specified time interval, usually 1 hour or 24 hours. AQS also contains meteorological data, descriptive information about each monitoring station (including its geographic location and its operator), and data quality assurance or quality control information. The system is administered by EPA, Office of Air Quality Planning and Standards, Information Transfer and Program Integration Division, located in Research Triangle Park, N.C.

For more information, contact:
David Mintz
U.S. Environmental Protection Agency
Phone: 919–541–5224
Website: http://www.epa.gov/air/data/aqsdb.html

American Housing Survey

The American Housing Survey (AHS) was mandated by Congress in 1968 to provide data for evaluating progress toward "a decent home and a suitable living environment for every American family." It is the primary source of detailed information on housing in the United States and is used to generate a biennial report to Congress on the conditions of housing in the United States, among other reports. The survey is conducted for the Department of Housing and Urban Development by the U.S. Census Bureau. The AHS encompasses a national survey and 21 metropolitan surveys and is designed to collect data from the same housing units for each survey. The national survey, a representative sample of approximately 60,000 housing units, is conducted biennially in odd-numbered years; the metropolitan surveys, representative samples of 3,500 housing units, are conducted in odd-numbered years on a 6-year cycle. The AHS collects data about the inventory and condition of housing in the United States and the demographics of its inhabitants. The survey provides detailed data on the types of housing in the United States and its characteristics and conditions; financial data on housing costs, utilities, mortgages, equity loans, and market value; demographic data on family composition, income, education, and race; and information on neighborhood quality and recent movers.

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

For more information, contact:
Cheryl Levine
U.S. Department of Housing and Urban Development
E-mail: Cheryl.A.Levine@hud.gov
Phone: 202–402–3928
Website: http://www.census.gov/hhes/www/ahs.html

American Time Use Survey

The American Time Use Survey (ATUS) is a nationally representative sample survey conducted for the Bureau of Labor Statistics by the U.S. Census Bureau. The ATUS measures how people living in the United States spend their time. Estimates show the kinds of activities people do and the time they spent doing them by sex, age, educational attainment, labor force status, and other characteristics, as well as by weekday and weekend day.

ATUS respondents are interviewed one time about how they spent their time on the previous day, where they were, and whom they were with. The survey is a continuous survey, with interviews conducted nearly every day of the year and a sample that builds over time. About 13,000 members of the civilian noninstitutionalized population age 15 and over are interviewed each year.

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

For more information, contact:
American Time Use Survey Staff
E-mail: atusinfo@bls.gov
Phone: 202–691–6339
Website: http://www.bls.gov/tus

Consumer Expenditure Survey

The Consumer Expenditure Survey (CE) 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 are integrated before publication. The data presented in this chartbook are derived from the integrated data available on the CE website. The published data are weighted to reflect the U.S. population.

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

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

For more information, contact:
E-mail: CEXINFO@bls.gov
Phone: 202–691–6900
Website: http://www.bls.gov/cex

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 a comprehensive body of monthly data on the labor force, employment, unemployment, persons not in the labor force, hours of work, earnings, and other demographic and labor force characteristics.

In most months, CPS supplements provide additional demographic and social data. The Annual Social and Economic Supplement (ASEC) 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 is the primary source of detailed information on income and poverty in the United States. The ASEC, historically referred to as the March supplement, now is conducted in February, March, and April with a sample of about 100,000 addresses. The questionnaire asks about income from more than 50 sources and records up to 27 different income amounts, including receipt of many noncash benefits, such as food stamps and housing assistance.

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."[52]

For more information regarding the CPS, its sampling structure, and estimation methodology, see "Explanatory Notes and Estimates of Error."[53]

For more information, contact:
Bureau of Labor Statistics
Department of Labor
E-mail: cpsinfo@bls.gov
Phone: 202–691–6378
Website: http://www.bls.gov/cps
Additional Website: http://www.census.gov/cps

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.

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. 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
Phone: 301–763–2378
Website: 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 (1924–1930) and War Babies (1942–1947). Plans call for adding a new 6-year cohort of Americans entering their 50s every 6 years. In 2004, baseline interviews were conducted with the Early Boomer birth cohort (1948–1953). Telephone follow-ups are conducted every second year, with proxy interviews after death. Beginning in 2006, one-half of this sample has an enhanced face-to-face interview that includes the collection of physical measures and biomarker collection. The Aging, Demographics, and Memory Study (ADAMS) is a supplement to HRS with the specific aim of conducting a population-based study of dementia.

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 resided 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).

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
E-mail: hrsquest@isr.umich.edu
Phone: 734–936–0314
Website: 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, which began 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. The current MEPS Household Component (HC) sample is drawn from respondents to the National Health Interview Survey (NHIS) conducted by the National Center for Health Statistics (NCHS). 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.[54] 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.[51] 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).

A number of quality-related enhancements were made to the MEPS beginning in 2000, including the fielding of an annual adult self-administered questionnaire (SAQ). This questionnaire contains items on patient satisfaction and accountability measures from the Consumer Assessment of Healthcare Providers and Systems (CAHPS®; previously known as the Consumer Assessment of Health Plans), the SF-12 physical and mental health assessment tool, EQ-5D EuroQol 5 dimensions with visual scale (2000–2003), and several attitude items. Starting in 2004, the K-6 Kessler mental health distress scale and the PH2 two-item depression scale were added to the SAQ.

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

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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 and 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 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. A sample of approximately 16,000 people are interviewed in each round. However, because of the rotating panel design, only 12,000 people 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 30c on page 121 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.

For more information, contact:
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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. NHIS is the principal source of information on the health of the civilian, noninstitutionalized, household population of the United States. 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. The survey is reviewed each year, core questionnaire items are revised every 10–15 years (with major revisions occurring in 1982 and 1997), and special topics are added or deleted annually.

In 2006, a new sample design was implemented. This design, which is expected to be in use through 2014, includes all 50 states and the District of Columbia, as the previous design did. Oversampling of the black and Hispanic populations has been retained in 2006 to allow for more precise estimation of health characteristics in these growing minority populations. The new sample design also oversamples the Asian population. In addition, the sample adult selection process has been revised so that when black, Hispanic, or Asian people age 65 and over are

present, they have an increased chance of being selected as the sample adult. The new design reduces the size of NHIS by approximately 13 percent relative to the previous sample design. The interviewed sample for 2008 consisted of 28,709 households, which yielded 74,236 people in 29,421 families. More information on the survey methodology and content of NHIS can be found at http://www.cdc.gov/nchs/nhis.htm.

Race and Hispanic origin: Starting with data year 1999, race-specific estimates in 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 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.

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Phone: 866–441–6247
Website: 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 people 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. Estimates for 1999–2000, and later, 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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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, American 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 in this report for the entire United States refer to events occurring within the 50 states and the District of Columbia; 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 14b, 15b, and 15c include people of Hispanic or non-Hispanic origin; data for Hispanic origin include people of any race.

For more information, contact:
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Website: http://www.cdc.gov/nchs/deaths.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 coresidents (spouses, cohabitors, children, and anyone else living with them) is collected each year. In 1997 and 1999, in order to enhance the representativeness of the study, a refresher sample of 511 post 1968 immigrant families was added to the PSID. With low attrition rates and successful recontacts, the sample size grew to approximately 8,330 as of 2007. 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 87.

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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 postcensus 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 Pacifc Islander, 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."[55] While this paper does not incorporate the updated assumptions made for the interim projections, it provides a more extensive treatment of the earlier projections, released in 2000, on which the interim series is based.

For more information, contact:
Population Projections Branch
Phone: 301–763–2428
Website: http://www.census.gov/population/www/projections/popproj.html

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, 2008

The 2008 Survey of Veteran Enrollees' Health and Reliance Upon VA is the seventh in a series of surveys of veteran enrollees for the Department of Veterans Affairs (VA) health care conducted by the Veterans Health Administration (VHA), within the VA, under multiyear Office of Management and Budget authority. Previous surveys of VHA-enrolled veterans were conducted in 1999, 2000, 2002, 2003, 2005, and 2007. All seven VHA surveys of enrollees consisted of telephone interviews with stratified random samples of enrolled veterans. From 2000 on, 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 2008 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 17 minutes in length. In the 2008 survey, interviews were conducted beginning on September 25, 2008, over a course of 11 weeks. Of approximately 7.3 million eligible enrollees who had not declined enrollment as of April 30, 2008, some 42,000 completed interviews in the 2008 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' sociodemographic, economic, and health characteristics, including household income, health insurance coverage status, functional status (limitations in activities of daily living and instrumental activities of daily living), perceived health status, race and ethnicity, employment status, smoking status, period of service and combat status, 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.

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Veteran Population Estimates and Projections (model name is VetPop2007 (December 2007)

VetPop2007 provides estimates and projections of the veteran population by age groups and other demographic characteristics at the county and state levels. Veteran estimates and projections were computed using a cohort-component approach, whereby Census 2000 baseline data were adjusted forward in time on the basis of separations from the Armed Forces (new veterans) and expected mortality.

Race and Hispanic origin: Data from this model 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 Medicare Current Beneficiary Survey, ADL disabilities are measured as difficulty performing (or inability to perform because of a health reason) one or more of the following activities: eating, getting in/out of chairs, walking, dressing, bathing, or toileting.

Asset income: Asset income includes money income reported in the Current Population Survey 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 height^2 or kilograms/meters^2. 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."[56]

Cash balance pension plan: A hybrid pension plan that looks like a defined-contribution plan but actually is a defined-benefit plan, a responsibility of the employer. In a cash balance plan, an employer establishes an account for employees, contributes to the account, guarantees a return to the account, and pays a lump sum benefit from the account at job termination.

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/data/statab/techap99.pdf.

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).

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 by asking 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 one-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 in 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 111 and 112.

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 through 1996. Beginning in 1997, all states reported Hispanic origin. 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: In the Medicare Current Beneficiary Survey (Indicators 30 and 34), the Medical Expenditure Panel Survey (MEPS), and the data used from the MEPS predecessor surveys used in this report (Indicator 33) this category covers expenses for any type of dental care provider, including general dentists, dental hygienists, dental technicians, dental surgeons, orthodontists, endodontists, and periodontists.

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: In the Medical Expenditure Panel Survey (MEPS) and the data used from the MEPS predecessor surveys used in this report (Indicator 33), 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. In the Medicare Current Beneficiary Survey (Indicators 30 and 34) emergency room services are included as a hospital outpatient service unless they are incurred immediately prior to a hospital stay, in which case they are included as a hospital inpatient service.

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.

Functional Limitations: See Activities of daily living (ADLs) and Instrumental activities of daily living (IADLs).

Group quarters: For Census 2000, the U.S. Census Bureau classified 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 people 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 U.S. 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 (Indicator 12), health care expenditures include out-of-pocket expenditures for health insurance, medical services, prescription drugs, and medical supplies. In the Medicare Current Beneficiary Survey (Indicators 30 and 34), health care expenditures include all expenditures for inpatient hospital, medical, nursing home, outpatient (including emergency room visits), 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 (Indicator 33), 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.[51]) 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).

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 (Indicators 29, 30, and 34), home health care refers to skilled nursing care, physical therapy, speech language pathology services, occupational therapy, and home health aide services provided to homebound patients. In the Medical Expenditure Panel Survey (Indicator 33), home health care services are classified into the "Other health care" category and are considered any paid formal care provided by home health agencies and independent home health providers. Services can include visits by professionals including nurses, doctors, social workers, and therapists, as well as home health aids, homemaker services, companion services, and home-based hospice care. Home care provided free of charge (informal care by family members) is not included.

Hospice care/services: 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. In the Medicare Current Beneficiary Survey (MCBS) (Indicators 30 and 34) hospice care includes only those services provided as part of a Medicare benefit. In MCBS Indicator 30 (Medicare) hospice services are included as part of the "Other" category. In MCBS Indicator 34 (Medicare) hospice services

are included as a separate category. In the Medical Expenditure Panel Survey (MEPS) (Indicator 33) hospice care provided in the home (regardless of the source of payment) is included in the "Other health care" category, while hospice care provided in an institutional setting (e.g., nursing home) is excluded from the MEPS universe.

Hospital care: Hospital care in the Medical Expenditure Panel Survey (Indicator 33) includes hospital inpatient care and care provided in hospital outpatient departments and emergency rooms. Care can be provided by physicians or other health practitioners; payments for hospital care include payments billed directly by the hospital and those billed separately by providers for services provided in the hospital.

Hospital inpatient services: In the Medicare Current Beneficiary Survey (Indicators 30 and 34) hospital inpatient services include room and board and all hospital diagnostic and laboratory expenses associated with the basic facility charge, and emergency room expenses incurred immediately prior to inpatient stays. Expenses for hospital stays with the same admission and discharge dates are included if the Medicare bill classified the stay as an "inpatient" stay. Payments for separate billed physician inpatient services are excluded. In the Medical Expenditure Panel Survey (Indicator 33) 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 in the Medicare Current Beneficiary Survey (Indicators 30 and 34) include visits to both physicians and other medical providers seen in hospital outpatient departments or emergency rooms (provided the emergency room visit does not result in an inpatient hospital admission), as well as diagnostic laboratory and radiology services. Payments for these services include those covered under the basic facility charge. Expenses for inpatient hospital stays with the same admission and discharge dates and classified on the Medicare bill as "outpatient" are also included. Separately billed physician services are excluded.

Hospital stays: Hospital stays in the Medicare claims data (Indicator 29) refers to admission to and discharge from a short-stay acute care hospital.

Housing cost burden: In the American Housing Survey, housing cost burden is defined as expenditures on housing utilities in excess of 30 percent of reported income.

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 people 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 Medical Expenditure Panel Survey (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 (MEPS) 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 people 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; 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.

Inpatient hospital: See Hospital inpatient services.

Institutions: For Census 2000, the U.S. Census Bureau defined 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.[64] 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 Medicare Current Beneficiary Survey. IADLs are measured as difficulty performing (or inability to perform because of a health reason) one or more of the following activities: heavy housework, light housework, preparing meals, using a telephone, managing money, or shopping.

Long-term care facility: In the Medicare Current Beneficiary Survey (MCBS) (Indicators 20 and 36), a residence (or unit) is considered a long-term care facility if it is certified by Medicare or Medicaid; has three 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 non-family, paid caregiver. In MCBS (Indicators 30 and 34), a long-term care facility excludes "short-term institutions" (e.g., sub-acute care) stays. See Short-term institution (Indicators 30 and 34), and Skilled nursing home (Indicator 29).

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, community-based supports, and 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 and over, 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 post-acute care settings such as rehabilitation and long-term care hospitals, and generally does not cover nursing home care. Prescription drug coverage began in 2006.

Medicare Advantage: See Medicare Part C.

Medicare Part A: Medicare Part A (Hospital Insurance) covers inpatient care in hospitals, critical access hospitals, skilled nursing facilities, and other post-acute care settings such as rehabilitation and long-term care hospitals. It also covers hospice and some home health care.

Medicare Part B: Medicare Part B (Medical Insurance) covers doctors' 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.

Medicare Part C: With the passage of the Balanced Budget Act of 1997, Medicare beneficiaries were given the option to receive their Medicare benefits through private health insurance plans, instead of through the original Medicare plan (Parts A and B). These plans were known as "Medicare+Choice" or "Part C" plans. Pursuant to the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, the types of plans allowed to contract with Medicare were expanded, and the Medicare Choice program became known as "Medicare Advantage." In addition to offering comparable coverage to Part A and Part B, Medicare Advantage plans may also offer Part D coverage.

Medicare Part D: Medicare Part D subsidizes the costs of prescription drugs for Medicare beneficiaries. It was enacted as part of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) and went into effect on January 1, 2006. Beneficiaries can obtain the Medicare drug benefit through two types of private plans: beneficiaries can join a Prescription Drug Plan (PDP) for drug coverage only or they can join a Medicare Advantage plan (MA) that covers both medical services and prescription drugs (MA-PD). Alternatively, beneficiaries may receive drug coverage through a former employer, in which case the former employer may qualify for a retiree drug subsidy payment from Medicare.

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 website: http://www.census.gov/population/www/censusdata/adjustment.html.

Obesity: See Body mass index.

Office-based medical provider services: In the Medical Expenditure Panel Survey (Indicator 33) this category includes expenses for visits to physicians and other health practitioners seen in office-based settings or clinics. Other health practitioner includes audiologists, optometrists, chiropractors, podiatrists, mental health professionals, therapists, nurses, and physician's assistants, as well as providers of diagnostic laboratory and radiology services. Services provided in a hospital based setting, including outpatient department services, are excluded.

Other health care: In the Medicare Current Beneficiary Survey (Indicator 34), this category includes "short-term institution," "hospice," and "dental" services. In the Medical Expenditure Panel Survey (MEPS) (Indicator 33) other health care includes "home health services" (formal 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.

Outpatient hospital: See Hospital outpatient services.

Out-of-pocket health care costs: These are health care costs that are not covered by insurance.

Overweight: See Body mass index.

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.

Physician/Medical services: In the Medicare Current Beneficiary Survey (Indicator 34), this category includes visits to a medical doctor, osteopathic doctor, and health practitioner as well as diagnostic laboratory and radiology services. Health practitioners include audiologists, optometrists, chiropractors, podiatrists, mental health professionals, therapists, nurses, paramedics, and physician's assistants. Services provided in a hospital-based setting, including outpatient department services, are included.

Physician/Outpatient hospital: In the Medicare Current Beneficiary Survey (Indicator 30), this term refers to "physician/medical services" combined with "hospital outpatient services."

Physician visits and consultations: In Medicare claims data (Indicator 29) 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 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 U.S. Armed Forces overseas, as well as civilian U.S. 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. For Census 2000, institutions, as defined by the U.S. Census Bureau, included 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 noninstitutional group quarters are part of the resident noninstitutionalized population. For Census 2000, noninstitutional group quarters included 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.[64]

Civilian population: The civilian population is the U.S. resident population not in the active duty Armed Forces.

Civilian noninstitutionalized population: The civilian noninstitutionalized population is the

civilian population not residing in institutions. For Census 2000, institutions, as defined by the U.S. Census Bureau, included 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 noninstitutional group quarters are part of the civilian noninstitutionalized population. For Census 2000, noninstitutional group quarters included 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.[57]

Institutionalized population: For Census 2000, the institutionalized population was 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 noninstitutional group quarters are part of the noninstitutionalized population. For Census 2000, noninstitutional group quarters included 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.[57]

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., $9,944 for one person age 65 and over in 2007).[58] 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 8: Income," "Indicator 17: Sensory Impairments and Oral Health," "Indicator 22: Mammography," and "Indicator 32: Sources of Health Insurance," "Indicator 33: Out-of-Pocket Health Care Expenditures" 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., $9,944 and $19,887 for one person age 65 and over in 2007). Middle income is between 200 percent and 399 percent of the poverty threshold (i.e., between $19,888 and $39,775 for one person age 65 and over in 2007). High income is 400 percent or more of the poverty threshold.

Indicator 22: Mammography and Indicator 32: 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 33: 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 (Indicators 30, 31, 34) and in the Medical Expenditure Panel Survey (Indicator 33) 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.

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 people who are age 65 and over, 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?" The respondent answers for all household members including himself or herself.

Short-term institution: This category in the Medicare Current Beneficiary Survey (Indicators 30 and 34) includes skilled nursing facility stays and other short-term (e.g., sub-acute care) facility stays (e.g., a rehabilitation facility stay). Payments for these services include Medicare and other payment sources. See Skilled nursing facility (Indicator 29), Nursing facility (Indicator 36), and Long-term care facility (Indicators 20, 30, 34, and 37.

Skilled nursing facility stays: Skilled nursing facility stays in the Medicare claims data (Indicator 29) refers to admission to and discharge from a skilled nursing facility, regardless of the length of stay. See Skilled nursing facility (Indicator 29).

Skilled nursing facility: A skilled nursing facility (SNF) as defined by Medicare (Indicator 29) provides short-term skilled nursing care on an inpatient basis, following hospitalization. These facilities provide the most intensive care available outside of inpatient acute hospital care. In the Medicare Current Beneficiary Survey (Indicators 30 and 34) "skilled nursing facilities" are classified as a type of "short-term institution." See Short-term institution (Indicators 30 and 34), and Long-term care facility (Indicators 20, 30, 34, and 36).

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. Employer-or union-sponsored supplemental insurance policies are provided through a Medicare enrollee's former employer or union. For dual-eligible beneficiaries, Medicaid acts as a supplemental insurer to Medicare. 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.

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.

Veterans' health care: Health care services provided by the Veterans Health Administration (Indicator 35) includes preventive care, ambulatory diagnosis and treatment, inpatient diagnosis and treatment and medications and supplies. This includes home- and community-based services (e.g., home health care) and long-term care institutional services (for those eligible to receive these services).

The Historical Experience of Three Cohorts of Older Americans: A Timeline of Selected Events 1923–2010