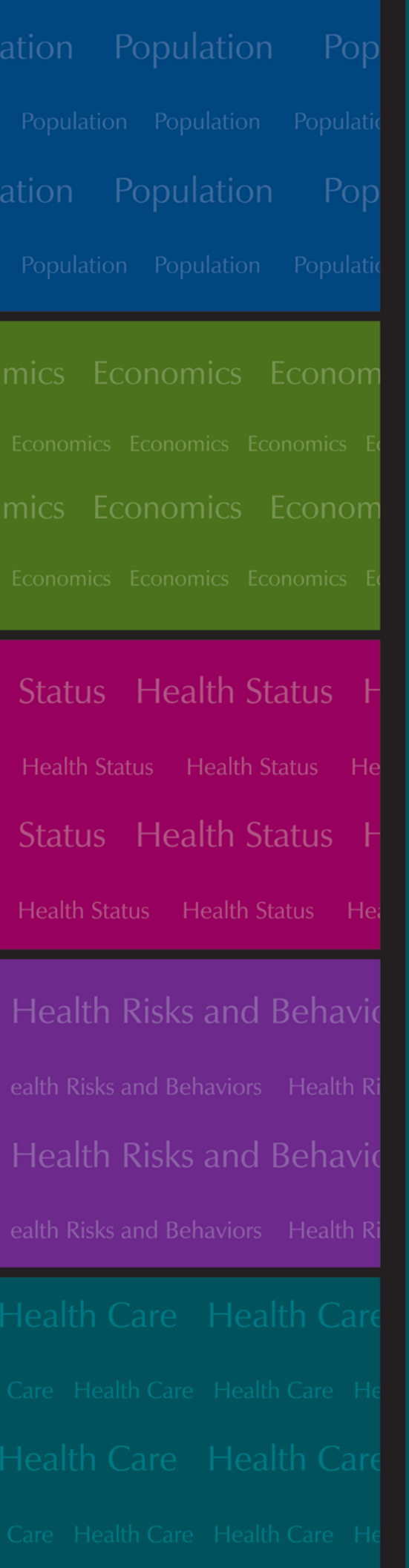

Older Americans 2008

Key Indicators of Well-Being

FEDERAL INTERAGENCY FORUM ON AGING RELATED STATISTICS

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 March 2008 are listed below.

Department of Commerce
U.S. Census Bureau
www.census.gov

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

Agency for Healthcare Research and Quality
www.ahrq.gov

Centers for Medicare and Medicaid Services
www.cms.hhs.gov

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

National Institute on Aging
www.nia.nih.gov

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

Substance Abuse and Mental Health Services Administration
www.samhsa.gov

Department of Housing and Urban Development
www.hud.gov

Department of Labor
Bureau of Labor Statistics
www.bls.gov

Employee Benefits Security Adminstration
www.dol.gov/ebsa

Department of Veterans Affairs
www.va.gov

Environmental Protection Agency
www.epa.gov

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

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

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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 emailing nchsquery@cdc.gov. This report is also available on the World Wide Web at www.agingstats.gov.

Older Americans 2008

Key Indicators of Well-Being

FEDERAL INTERAGENCY FORUM ON AGING RELATED STATISTICS

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 2008: Key Indicators of Well-Being (Older Americans 2008) presents a unified picture of our older population's health and well-being. It is the fourth 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.

The Forum is pleased to include in this edition a one-time special feature based on the health literacy component of the National Center for Education Statistics' 2003 National Assessment of Adult Literacy. This is the first-ever national assessment designed specifically to measure adults' ability to use literacy skills to read and understand health-related information.

This year's report also incorporates two new regular indicators: housing problems and use of time. The first, the ability to afford quality housing, is an issue fundamental to the well-being of all Americans. The second, how older people spend their time, resulted from a workshop the Forum cosponsored with the Gerontological Society of America. The short-term goal of the workshop was to help identify a new indicator on social activity to replace an earlier one based on a data source that has been discontinued. The long-term goal was to identify data needs that could lead to future collaborations. The Forum believes these two new indicators will enhance our portrait 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. This year, the Forum identified six areas where data are needed to develop new indicators: caregiving, elder abuse, functional limitations and disability, mental health, pension measures, and residential care. We also appreciate users' requests for greater detail for many existing indicators. The Forum continues to encourage 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 (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 2008: 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 Josefina Carbonell, Administration on Aging (AoA); Steven 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); Jean Lin Pao, Department of Housing and Urban Development (HUD); Joseph Piacentini, Employee Benefits Security Administration (EBSA); William Sanders, Environmental Protection Agency (EPA); Edward Sondik, National Center for Health Statistics (NCHS); Richard Suzman, National Institute on Aging (NIA); Steven Tingus, 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); Susan Grad, Social Security Administration (SSA); and Dat Tran, Department of Veterans Affairs (VA).

The following members of the Forum agencies reviewed the chartbook and provided valuable guidance and assistance: Frank Burns, AoA; Nancy Gordon, U.S. Census Bureau; Jennifer Madans, NCHS; Ruth Katz, ASPE; and Ray Vogel, VA.

The Forum's planning committee members include Saadia Greenberg, AoA; David Kashihara and D.E.B. Potter, AHRQ; Emy Sok, BLS; Karen Humes and Kevin Kinsella, U.S. Census Bureau; Gerald Riley, CMS; Meena Bavan and Cheryl Levine, HUD; Anja Decressin, EBSA; Kathy Sykes, EPA; Ellen Kramarow and Julie Dawson Weeks, NCHS; John Haaga, NIA; William Marton, ASPE; Rochelle Wilkie Martinez, OMB; Ingrid Goldstrom and Lisa Park, SAMHSA; Howard Iams, SSA; Linda Bergofsky and Christine Elnitsky, VA; and the Forum's Staff Director, Kristen Robinson.

In addition to the 15 agencies of the Forum, the Department of Agriculture (USDA) and the Department of Education (ED) were invited to contribute to this report. The Forum greatly appreciates the efforts of Patricia Guenther and WenYen Juan, Center for Nutrition Policy and Promotion, USDA; and Sheida White, National Center for Education Statistics, ED, in providing valuable information from their agencies.

Other staff members of Federal agencies who provided data and assistance include Jennifer Klocinski, AoA; Rachel Krantz-Kent and Geoffrey Paulin, BLS; Marcella Jones, U.S. Census Bureau; Rick Andrews, Franklin Eppig, Deborah Kidd, Chris McCormick, Maggie Murgolo, and Joseph Regan, CMS; Janet F. Cakir, EPA; Carolyn Lynch, HUD; Robert Anderson, Amy Bernstein, Liming Cai, Robin Cohen, Ginny Freid, Lauren Harris-Kojetin, Melonie Heron, James Lubitz, and Rhonda Robinson, NCHS; Elizabeth Hamilton and Vicky Cahan, NIA; Anne DeCesaro and Lynn Fisher, SSA; and Peter Ahn, Jin Kim, and Cathy Tomczak, VA.

The Forum is also indebted to the people outside the Federal government who contributed to this chartbook: Mohammed Kabeto, Kate McGonagle, Robert Schoeni, Frank Stafford, and David Weir, University of Michigan.

Member agencies of the Forum provided funds and valuable staff time to produce this report. NCHS and its contractor, NOVA Research Company, facilitated the production, printing, and dissemination of this report. Odell D. Eldridge, NOVA, designed the layout and supervised the overall presentation of the report, Kyung Park, NOVA, designed and produced the data tables, Megan M. Cox and Demarius V. Miller, CDC/CCHIS/NCHM/Division of Creative Services, Writer-Editor Services Branch, provided editorial oversight and review. Patricia L. Wilson, CDC/OCOO/MASO, managed the printing of the report.

About This Report

Introduction

Older Americans 2008: Key Indicators of Well-Being (Older Americans 2008) is the fourth 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.

While most of *Older Americans 2008* remains the same as earlier editions, two new indicators have been added and several existing indicators have been revised to provide a more complete picture of the health and well-being of older Americans. The two new indicators in this report are housing problems and use of time. The revised indicators include total expenditures (formerly housing expenditures), depressive symptoms, functional limitations (formerly disability), prescription drugs, nursing home utilization, and personal assistance and equipment (formerly caregiving and assistive device use). An indicator on memory impairment, which is no longer available, is listed as a data need under "Mental Health." In addition to these new and revised indicators, this report has been expanded to include a one-time special feature on two important issues facing many older Americans today—literacy and health literacy.

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 2008 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 38 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 2008 presents 38 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 2008 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.

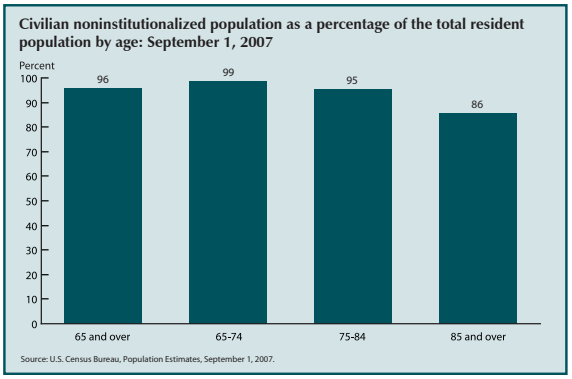
Data availability and analytical relevance may affect the specific age groups that are included for an indicator. For example, because of small sample sizes in some surveys, statistically reliable data for the population age 85 and over often are not available. Conversely, data from the population younger 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 2008* are not always comparable to indicators in *Older Americans 2000, 2004,* or *Update 2006*. 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 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 2007, 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 data in this report are based on a sample of the population and are, therefore, subject to sampling error. Standard tests of statistical significance have been used to determine whether the differences between populations exist at generally accepted levels of confidence or whether they occurred by chance. Unless otherwise noted, only 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 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 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 69). 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 2008* 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 67).

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 policymakers.
- 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 2008* or other Forum activities, contact:

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E-mail: agingforum@cdc.gov
Website: www.agingstats.gov

Older Americans on the Internet

Supporting material for this report can be found at 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,* and *2008*.

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 2006*).
- 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
www.aoa.gov/prof/Statistics/statistics.asp

A Profile of Older Americans
www.aoa.gov/prof/Statistics/profile/profiles.asp

Online Statistical Data on the Aging
www.aoa.gov/prof/Statistics/online_stat_data/online_stat_data.asp

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

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

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

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

Longitudinal Employer-Household Dynamics
Lehd.did.census.gov/led

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

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

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

Employee Benefits Security Administration
Publications and Reports
www.dol.gov/ebsa/publications/main.html#section8

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

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

National Center for Health Statistics
Aging Activities
www.cdc.gov/nchs/agingact.htm

Longitudinal Studies of Aging
www.cdc.gov/nchs/lsoa.htm

Health, United States
www.cdc.gov/nchs/hus.htm

National Institute on Aging
NIA Centers on the Demography of Aging
www.agingcenters.org/

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

Publicly Available Datasets for Aging-Related Secondary Analysis
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
www.aspe.hhs.gov/_/office_specific/daltcp.cfm

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

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

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

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

Other Resources
FedStats.Gov
www.fedstats.gov

Council of Professional Associations on Federal Statistics
www.copafs.org

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Highlights

Older Americans 2008: 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, 38 indicators (and one special feature) depict the well-being of older Americans in the areas of demographic characteristics, economic circumstances, overall health status, trends in 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 2006, there were an estimated 37 million people age 65 and over in the United States, accounting for just over 12 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 71.5 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 2007, 76 percent were high school graduates, and 19 percent had a bachelor's degree or more. (See "Indicator 4: Educational Attainment.")
- The number of men age 85 and over who are veterans has more than doubled between 1990 and 2000 from 150,000 to 400,000 and is projected to reach 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 60 percent in 2010. (See "Indicator 6: Older Veterans.")

Economics

Overall, most older people are enjoying more 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 in the low-income group. 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 2006, there was a decrease in the proportion of older people with income below poverty from 15 percent to 9 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 29 percent. (See "Indicator 8: Income.")
- In 2005, the median net worth of households headed by white people age 65 and over ($226,900) was 6 times that of older black households ($37,800). This difference is less than it was in 2003 when the median net worth of households headed by older white people was 8 times higher than that of households headed by older black people. (See "Indicator 10: Net Worth.")
- Labor force participation rates have risen among all women age 55 and over during the past four decades with a majority of the increase occurring after 1985. 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 2003 women age 65 in Japan could expect to live on average 3.2 years longer than women in the United States. Among men, the difference was 1.2 years. (See "Indicator 14: Life Expectancy.")
- The prevalence of certain chronic conditions differs by sex. Women report higher levels of arthritis (54 percent versus 43 percent) than men. Men report higher levels of heart disease (37 percent versus 26 percent) and cancer (24 percent versus 19 percent). (See "Indicator 16: Chronic Health Conditions.")
- Between 1992 and 2005, 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 is 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.

- 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 10 percent for those age 75 and over. (See "Indicator 28: Use of Time.")
- There was no significant change in the percentage of people age 65 and over reporting physical activity between 1997 and 2006. (See "Indicator 24: Physical Activity.")
- As with other age groups, the percentage of people age 65 and over who are obese has increased between 1988–1994 and 2005–2006, from 22 percent to 31 percent. 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 2005–2006. (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 55 percent in 2000 to 34 percent in 2006. (See "Indicator 27: Air Quality.")

Health Care

Overall, health care costs have risen dramatically for older Americans. In addition, between 1992 and 2004, the percentage of health care costs going to prescription drugs almost doubled from 8 percent to 15 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 coverage began in January 2006.

- After adjustment for inflation, health care costs increased significantly among older Americans from $8,644 in 1992 to $13,052 in 2004. (See "Indicator 30: Health Care Expenditures.")
- In 2004, as in the 4 previous years, over one-half of out-of-pocket health care spending (excluding health insurance premiums) by community dwelling people age 65 and over was used to purchase prescription drugs (from 54 percent in 2000 to 61 percent in 2004). (See "Indicator 33: Out-of-Pocket Health Care Expenditures.")

- The number of Medicare beneficiaries age 65 and over enrolled in Part D prescription drug plans increased from 18.2 million in June 2006 to 19.7 million in September 2007. In September 2007, two-thirds of enrollees were in stand-alone plans and one-third were in Medicare Advantage plans. In addition, approximately 6.5 million beneficiaries were covered by the Retiree Drug Subsidy in both years (See "Indicator 31: Prescription Drugs.")

Special Feature: Literacy and Health Literacy

Many older Americans have difficulty navigating the health care system because of their low rates of health literacy.

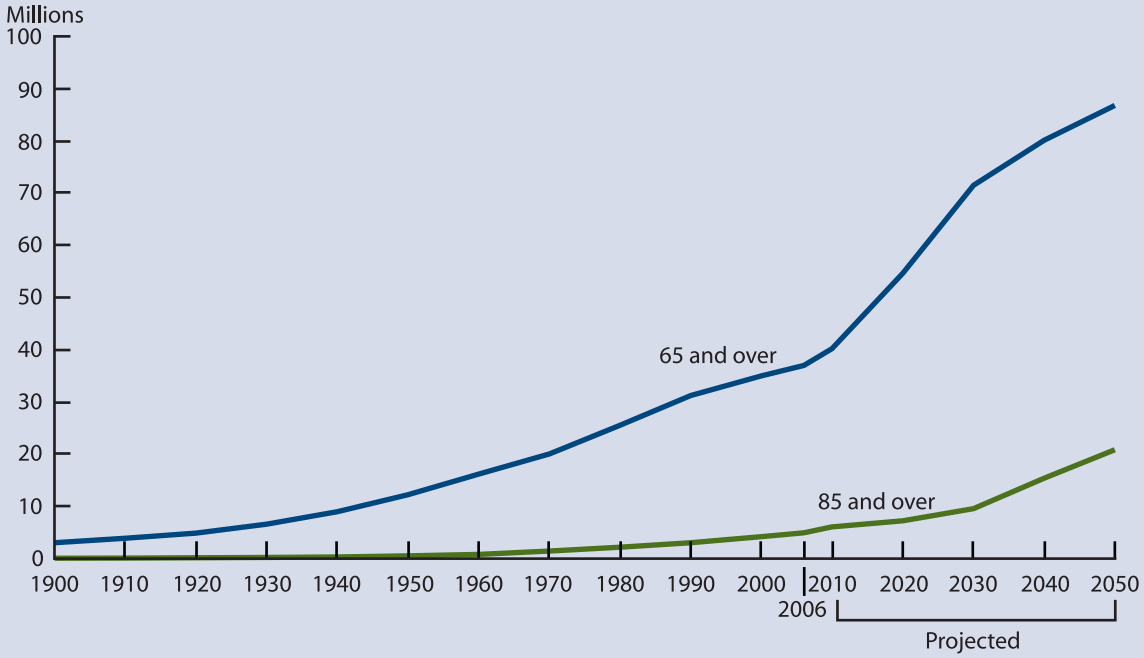
- Older Americans are proportionately more likely to have below basic health literacy than any other age group. Almost two-fifths (39 percent) of people age 75 and over have a health literacy level of below basic compared with 23 percent of people age 65–74, and 13 percent of people age 50–64. (See "Special Feature: Literacy and Health Literacy.")

Population

INDICATOR 1

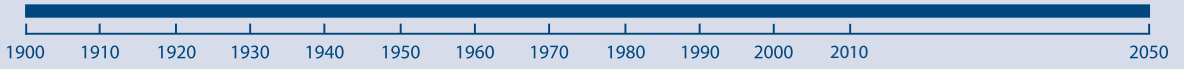
The growth of the population age 65 and over affects many aspects of our society, challenging policymakers, families, businesses, and health care providers, among others, to meet the needs of aging individuals.

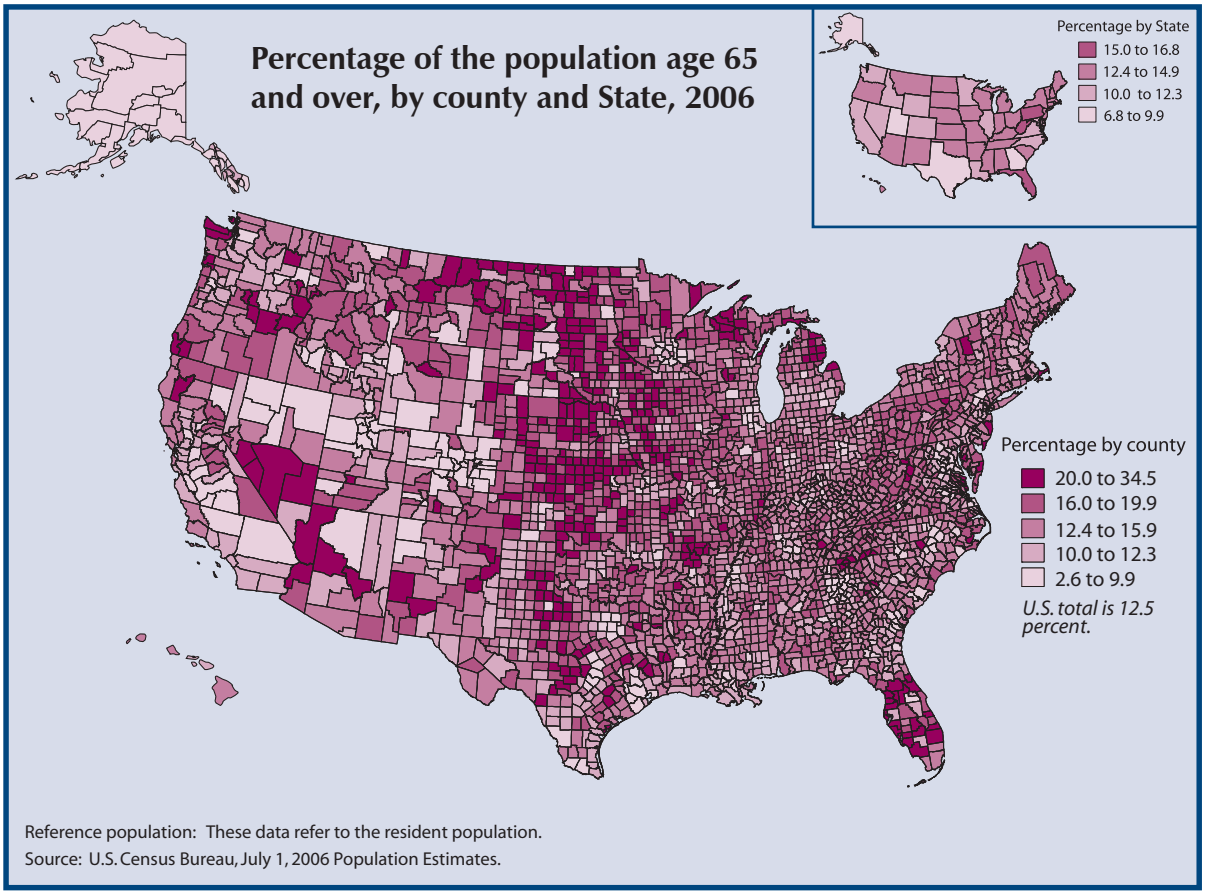
Number of people age 65 and over, by age group, selected years 1900–2006 and projected 2010–2050



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 2006, 37 million people age 65 and over lived in the United States, accounting for just over 12 percent of the total population. Over the 20th century, the older population grew from 3 million to 37 million. The oldest-old population (those age 85 and over) grew from just over 100,000 in 1900 to 5.3 million in 2006.
- 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 in 2000, growing from 35 million to 71.5 million and representing nearly 20 percent of the total U.S. population.
- The growth rate of the older population is projected to slow after 2030, when the last Baby Boomers enter the ranks of the older population. From 2030 onward, the proportion age 65 and over will be relatively stable, at around 20 percent, even though the absolute number of people age 65 and over is projected to continue to grow. The oldest-old population is projected to grow rapidly after 2030, when the Baby Boomers move into this age group.
- The U.S. Census Bureau projects that the population age 85 and over could grow from 5.3 million in 2006 to nearly 21 million by 2050. Some researchers predict that death rates at older ages will decline more rapidly than is reflected in the U.S. Census Bureau's projections, which could lead to faster growth of this population.[1–3]





Reference population: These data refer to the resident population.
Source: U.S. Census Bureau, July 1, 2006 Population Estimates.

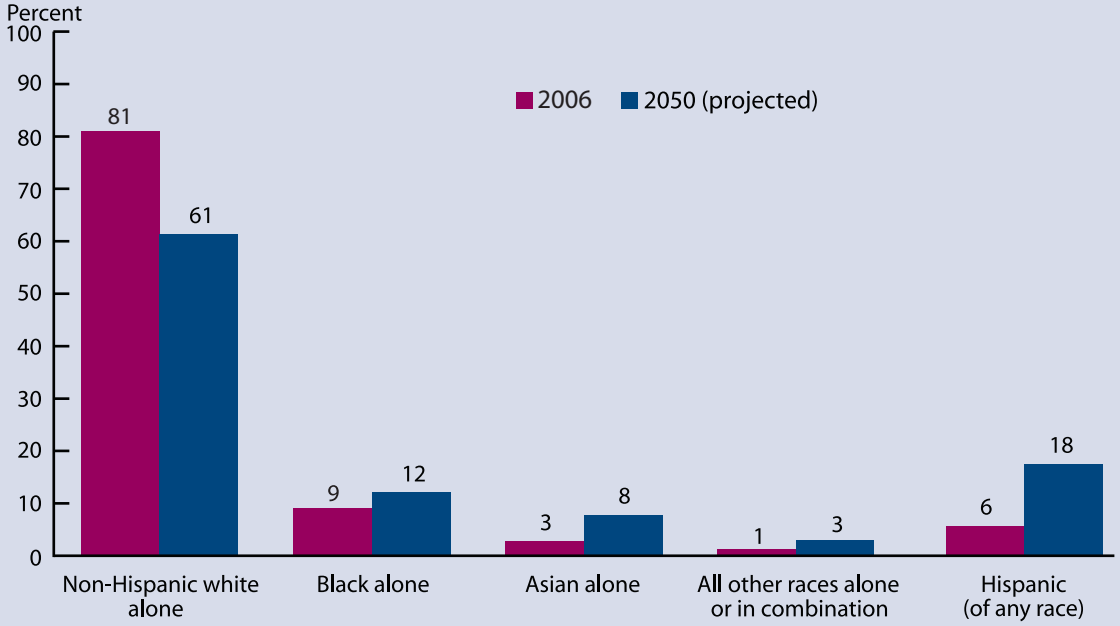
- The proportion of the population age 65 and over varies by State. This proportion is partly affected by State fertility and mortality levels and partly by the number of older and younger people who migrate to and from the State. In 2006, Florida had the highest proportion of people age 65 and over, 17 percent. Pennsylvania and West Virginia also had high proportions, over 15 percent.
- The proportion of the population age 65 and over varies even more by county. In 2006, 35 percent of McIntosh County, North Dakota, was age 65 and over, the highest proportion in the country. In several Florida counties, the proportion was over 30 percent. At the other end of the spectrum was Chattahoochee County, Georgia, with only 3 percent of its population age 65 and over.
- As in most countries of the world, older women outnumber older men in the United States, and the proportion that is female increases with age. In 2006, women accounted for 58 percent of the population age 65 and over and for 68 percent of the population age 85 and over.
- The United States is fairly young for a developed country, with just over 12 percent of its population age 65 and over. The older population made up more than 15 percent of the population in most European countries and nearly 20 percent in both Italy and Japan in 2006.

Data for this indicator's charts and bullets can be found in Tables 1a, 1b, 1c, 1d, 1e, and 1f on pages 74–77.

INDICATOR 2

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.

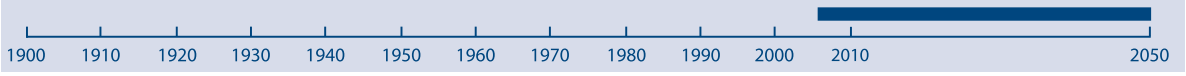
Population age 65 and over, by race and Hispanic origin, 2006 and projected 2050



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.

- In 2006, non-Hispanic whites accounted for 81 percent of the U.S. older population. Blacks made up 9 percent, Asians made up 3 percent, and Hispanics (of any race) accounted for 6 percent of the older population.
- Projections indicate that by 2050 the composition of the older population will be 61 percent non-Hispanic white, 18 percent Hispanic, 12 percent black, and 8 percent Asian.
- The older population among all racial and ethnic groups will grow; however, the older Hispanic population is projected to grow the fastest, from just over 2 million in 2005 to 15 million in 2050, and to be larger than the older black population by 2028. The older Asian population is also projected to experience a large increase. In 2006, just over 1 million older Asians lived in the United States; by 2050 this population is projected to be almost 7 million.

Data for this indicator's chart and bullets can be found in Table 2 on page 77.

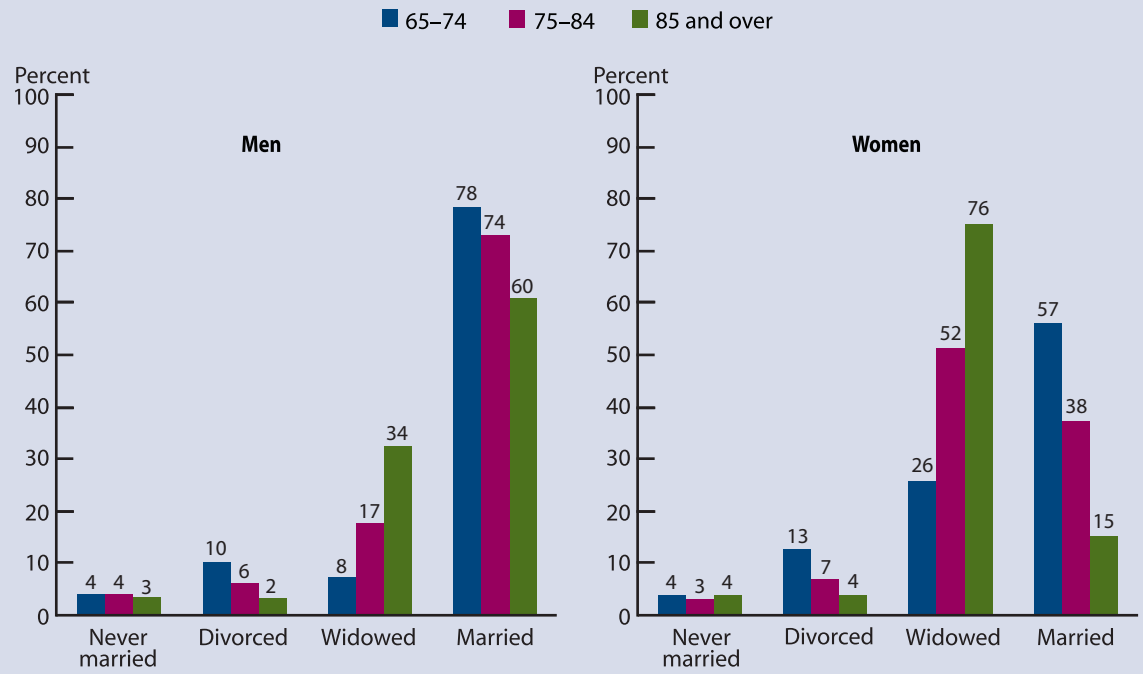


INDICATOR 3

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, 2007



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.

- In 2007, older men were much more likely than older women to be married. Over three-quarters (78 percent) of men age 65–74 were married, compared with over one-half (57 percent) of women in the same age group. The proportion married is lower at older ages: 38 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 (60 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 13 percent. The proportion widowed is higher at older ages, and the proportion widowed is higher for women than men. In 2007, 76 percent of women age 85 and over were widowed, compared with 34 percent of men.
- Relatively small proportions of older men (8 percent) and women (10 percent) were divorced in 2007. A small proportion of the older population had never married.

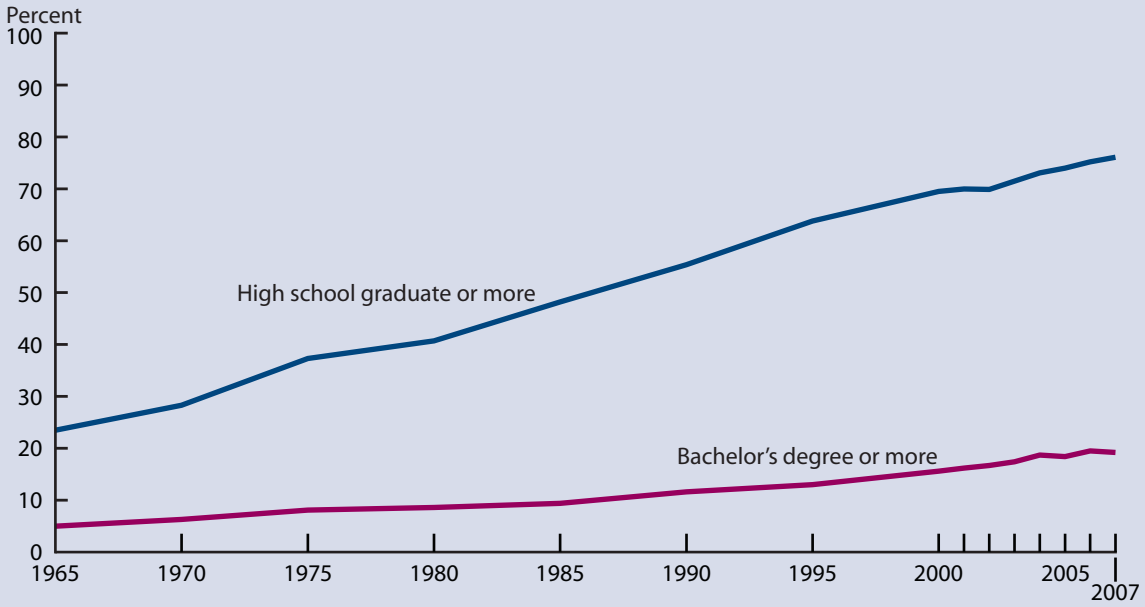
All comparisons presented for this indicator are significant at 0.10 confidence level. Data for this indicator's chart and bullets can be found in Table 3 on page 78.

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 1965–2007

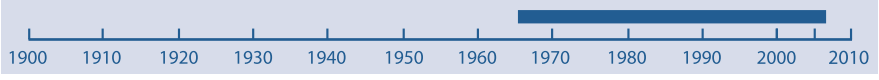


Note: A single question which asks for the highest grade or degree completed is now used to determine educational attainment. Prior to 1995, educational attainment was measured using data on years of school completed.

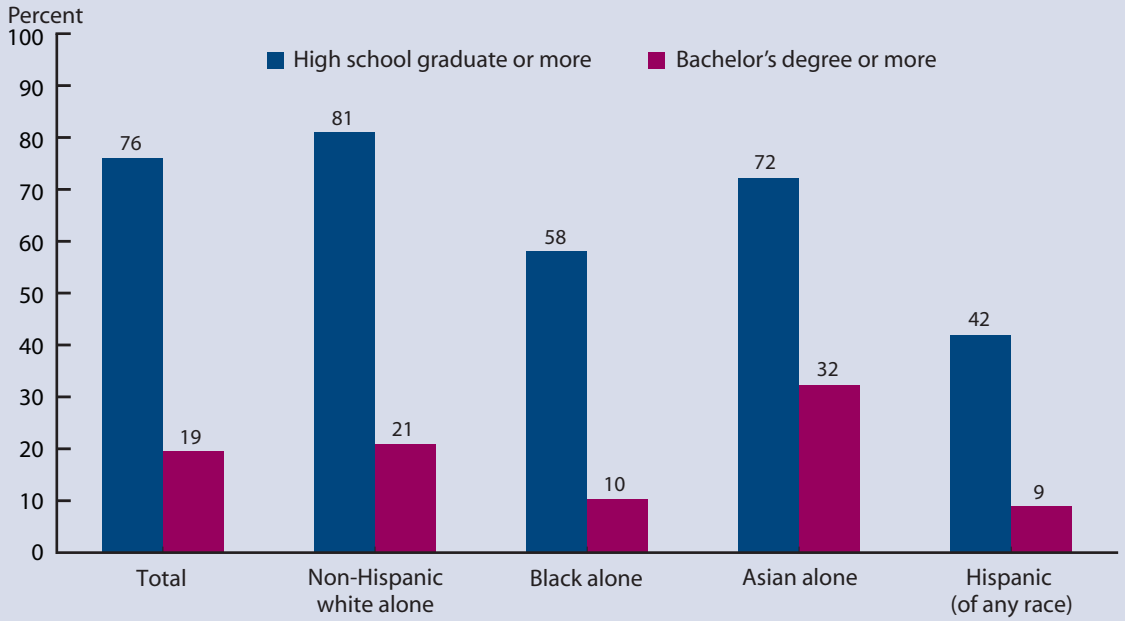
Reference population: These data refer to the civilian noninstitutionalized population.

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

- 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 2007, 76 percent were high school graduates, and 19 percent had a bachelor's degree or more.
- In 2007, about 76 percent of both older men and older women had at least a high school diploma. Older men attained at least a bachelor's degree more often than older women (25 percent compared with 15 percent). The gender gap in completion of a college education will narrow in the future because men and women in younger cohorts are earning college degrees at roughly the same rate.



Educational attainment of the population age 65 and over, by race and Hispanic origin, 2007



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

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

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

- Despite the overall increase in educational attainment among older Americans, substantial educational differences exist among racial and ethnic groups. In 2007, 81 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 (72 percent). In contrast, 58 percent of older blacks and 42 percent of older Hispanics had completed high school.

- In 2007, older Asians had the highest proportion with at least a bachelor's degree (32 percent). Almost 21 percent of older non-Hispanic whites had this level of education. The proportions were 10 percent and 9 percent, respectively, for older blacks and Hispanics.

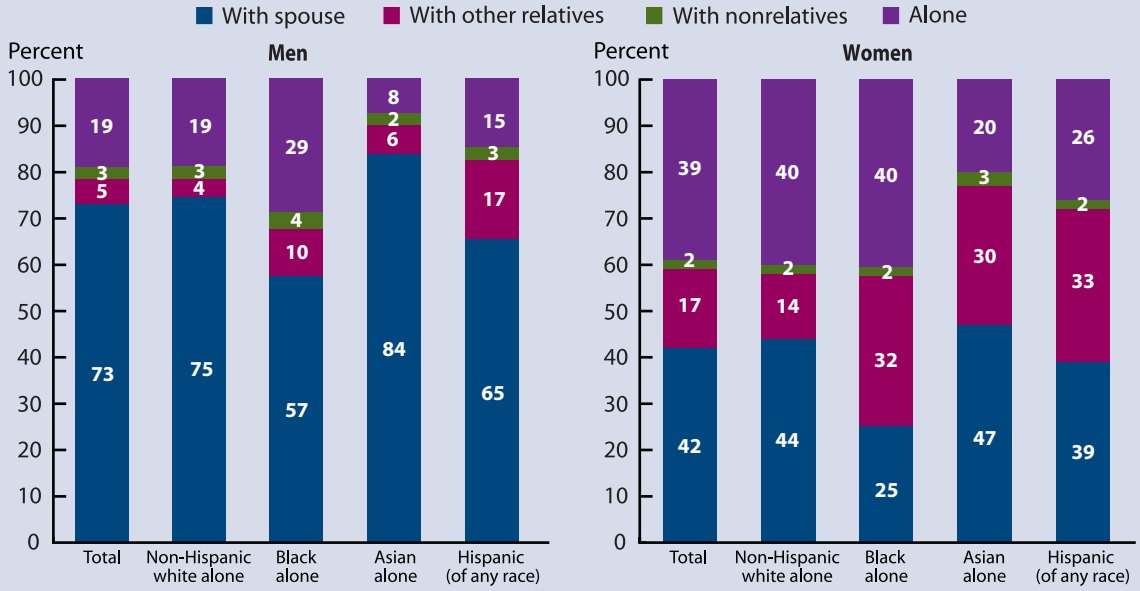
All comparisons presented for this indicator are significant at 0.10 confidence level. Data for this indicator's charts and bullets can be found in Tables 4a and 4b on page 78.

INDICATOR 5

Living Arrangements

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

Living arrangements of the population age 65 and over, by sex and race and Hispanic origin, 2007



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

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

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

- Older men were more likely to live with their spouse than were older women. In 2007, 73 percent of older men lived with their spouse while less than one-half (42 percent) of older women did. In contrast, older women were more than twice as likely as older men to live alone (39 percent and 19 percent, respectively).
- Living arrangements of older people differed by race and Hispanic origin. Older black, Asian, and Hispanic women were more likely than non-Hispanic white women to live with relatives other than a spouse. For example, in 2007, 30 percent of older Asian women, 32 percent of older black women, and 33 percent of older Hispanic women, compared with only 14 percent of older non-Hispanic white women, lived with other relatives. Older non-Hispanic white women and black women were more likely than women of other races to live alone (about 40 percent each, compared with 20 percent for older Asian women and 26 percent for older Hispanic women). Older black men lived alone more than three times as often as older Asian men (29 percent compared with 8 percent). Older Hispanic men were more likely (17 percent) than men of other races and ethnicities to live with relatives other than a spouse.

All comparisons presented for this indicator are significant at 0.10 confidence level. Data for this indicator's chart and bullets can be found in Tables 5a, 5b, and 7b on pages 79 and 82.

INDICATOR 6

Older Veterans

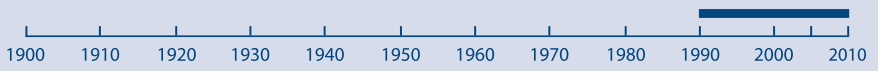
Veteran status of America's older population is associated with higher median family income, lower percentage of uninsured or coverage by Medicaid, higher percentage of functional limitations in activities of daily living or instrumental activities of daily living, greater likelihood of having any disability, 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 people age 65 and over who are veterans, by sex and age group, United States and Puerto Rico, 1990, 2000, and projected 2010

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, VetPop2004.

- 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. Because of the large Korean War and WWII veteran cohorts, the number of male veterans age 65 and over increased from 7.0 million in 1990 to 9.4 million in 2000.
- 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 has more than doubled between 1990 and 2000 from 150,000 to 400,000 and is projected to reach 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 60 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 95,000.

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



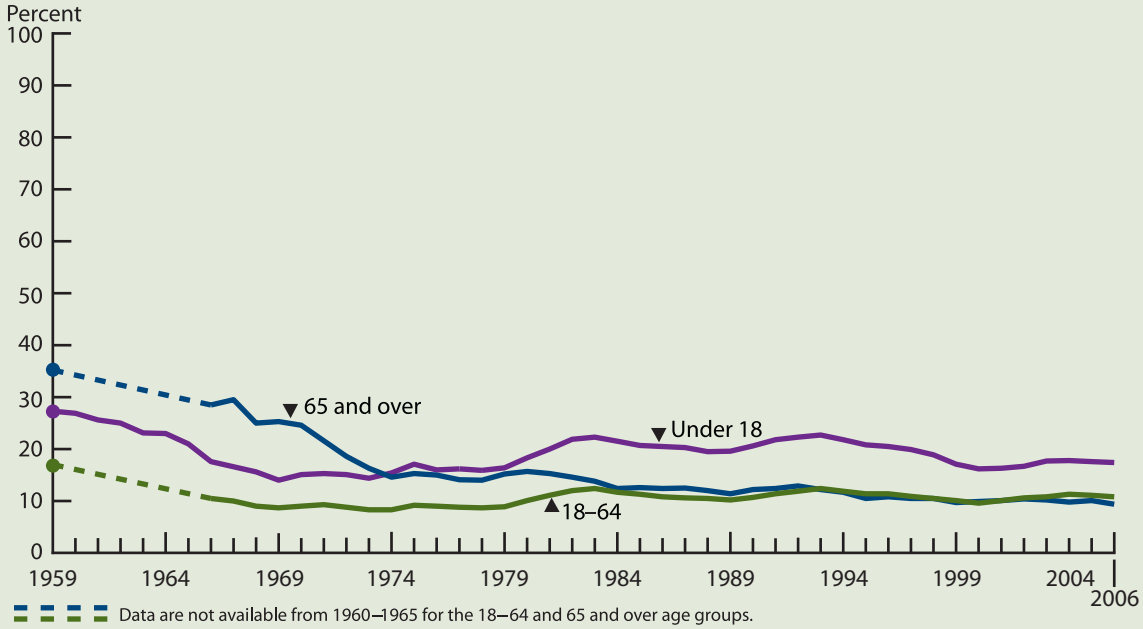
Economics

INDICATOR 7

Poverty

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

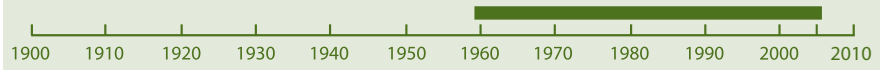
Poverty rate of the population, by age group, 1959–2006



Data are not available from 1960–1965 for the 18–64 and 65 and over age groups.
Reference population: These data refer to the civilian noninstitutionalized population.
Source: U.S. Census Bureau, Current Population Survey, Annual Social and Economic Supplement, 1960–2007.

- In 1959, 35 percent of people age 65 and over lived below the poverty threshold. By 2006, the proportion of the older population living in poverty had decreased dramatically to 9 percent.
- Relative levels of poverty among the different age groups have changed over time. In 1959, older people had the highest poverty rate (35 percent), followed by children (27 percent) and those in the working ages (17 percent). By 2006, the proportions of the older population and those of working age living in poverty were 9 percent and 11 percent respectively, while 17 percent of children lived in poverty.
- Poverty rates differed by age and sex among the older population. Older women (12 percent) were more likely than older men (7 percent) to live in poverty in 2006. People age 65–74 had a poverty rate of 9 percent, compared with 10 percent of those age 75 and over.
- Race and ethnicity are related to poverty among the older population. In 2006, older non-Hispanic whites were far less likely than older blacks and older Hispanics to be living in poverty—about 7 percent compared with 23 percent of older blacks and 19 percent of older Hispanics (not a statistically significant difference between the latter two groups). Older non-Hispanic white and black women had higher poverty rates than their male counterparts.

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

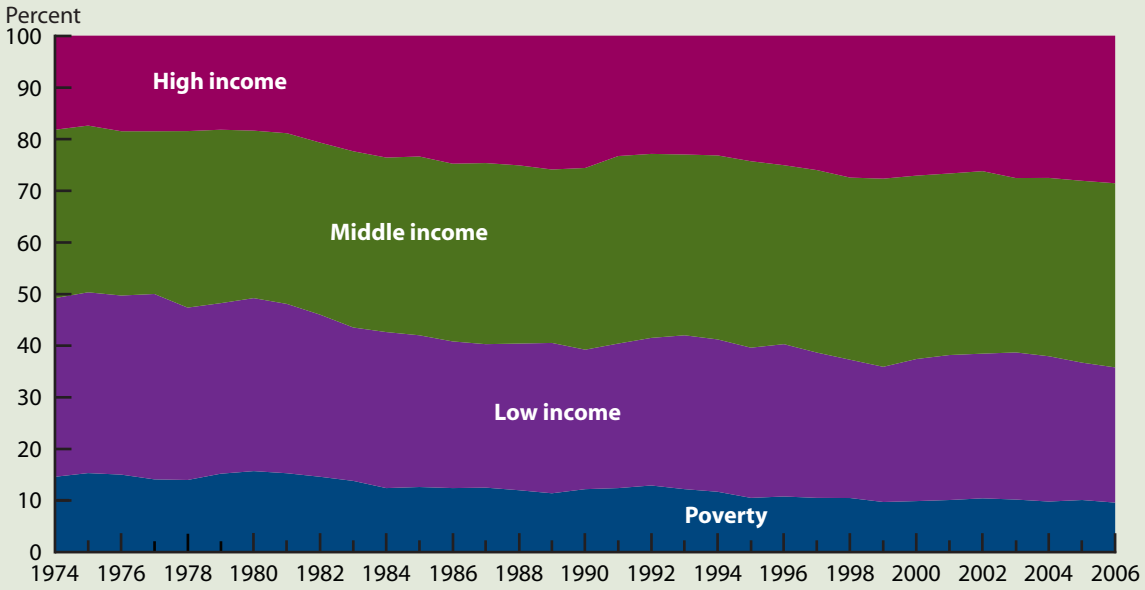


INDICATOR 8

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, 1974–2006



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, 1975–2007.

- Since 1974, the proportion of older people living in poverty and in the low-income group has generally declined so that, by 2006, 9 percent of the older population lived in poverty and 26 percent of the older population were in the low-income group.
- In 2006, people in the middle income group made up the largest share of older people by income category (36 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 29 percent in 2006.
- The trend in median household income of the older population has also been positive. In 1974, the median household income for householders age 65 and over was $19,086 when expressed in 2006 dollars. By 2006, the median household income had increased to $27,798.

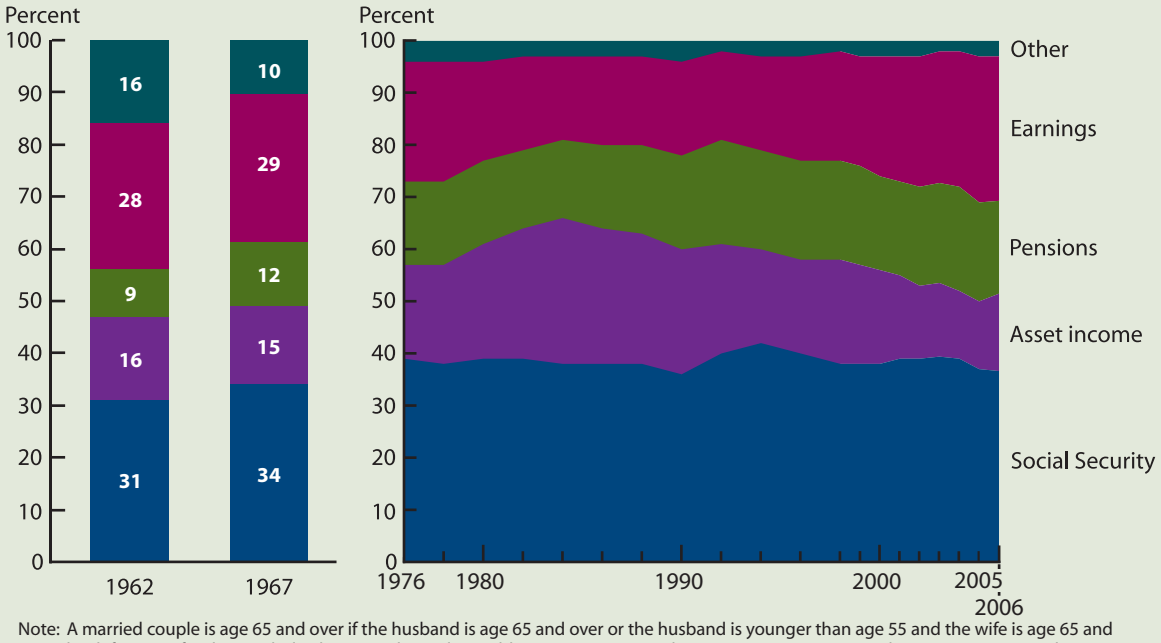
All comparisons presented for this indicator are significant at 0.10 confidence level. Data for this indicator's chart and bullets can be found in Tables 8a and 8b on pages 83–84.

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.

Distribution of sources of income for married couples and nonmarried people who are age 65 and over, selected years 1962–2006



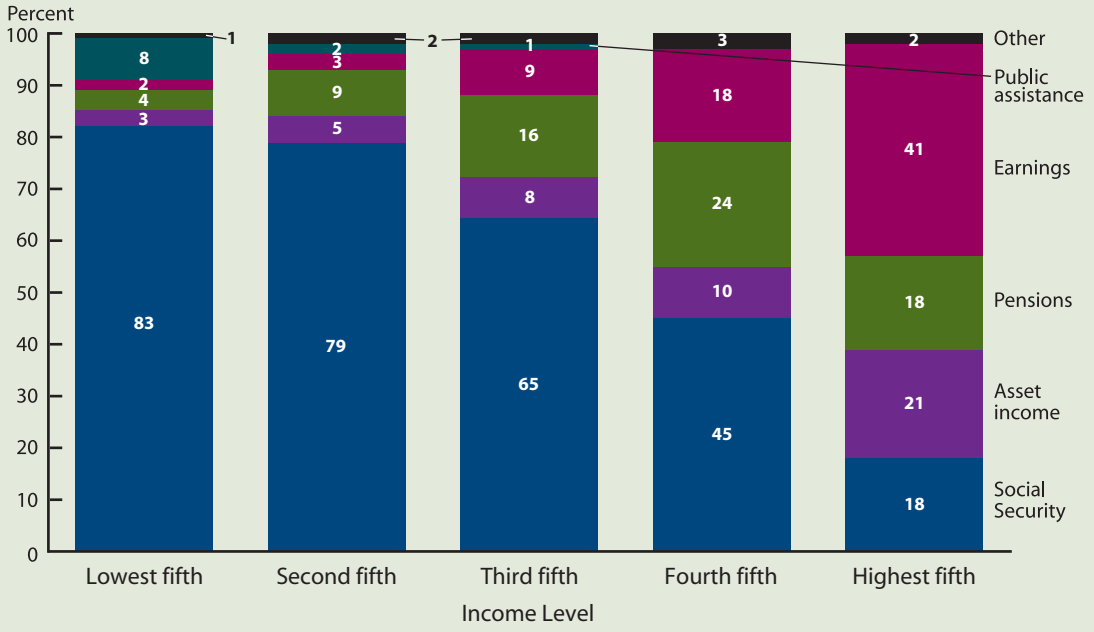
Note: A married couple is age 65 and over if the husband is age 65 and over or the husband is younger than age 55 and the wife is age 65 and over. The definition of "other" includes, but is not limited to, public assistance, unemployment compensation, worker's compensation, alimony, child support, and personal contributions.

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

Source: Social Security Administration, 1963 Survey of the Aged, 1968 Survey of Demographic and Economic Characteristics of the Aged; U.S. Census Bureau, Current Population Survey, Annual Social and Economic Supplement, 1977–2007.

- Since the early 1960s, Social Security has provided the largest share of aggregate income for older Americans. The share of income from pensions increased rapidly in the 1960s and 1970s and more gradually since then. The share of income from assets peaked in the mid–1980s and has generally declined since then. The share from earnings has had the opposite pattern—declining until the mid-1980s and generally increasing since then.
- In 2006, aggregate income for the population age 65 and over came largely from four sources. Social Security provided 37 percent, earnings accounted for 28 percent, pensions provided 18 percent, and asset income accounted for 15 percent.
- Ninety percent of people age 65 and over live in families with income from Social Security. Sixty percent are in families with income from assets, and almost one-half (45 percent) with income from pensions. About one-third (36 percent) are in families with earnings and 1 in 20 are in families receiving public assistance.
- Pension coverage expanded dramatically in the 2 decades after World War II, and private pensions accounted for an increasing proportion of income for older people during the 1960s and early 1970s. Since then, the coverage rate has been stable at about 50 percent of all private workers on their jobs.[6,7]

Sources of income for married couples and nonmarried people who are age 65 and over, by income quintile, 2006



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, unemployment compensation, worker's compensation, alimony, child support, and personal contributions. Quintile limits are $11,519 for the lowest quintile, $18,622 for the second quintile, $28,911 for the third quintile, $50,064 for the fourth qunitile, and open-ended for the highest quintile.

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

Source: U.S. Census Bureau, Current Population Survey, Annual Social and Economic Supplement, 2007.

- There has been a major shift in the type of pensions provided by employers, from defined-benefit plans (in which a specified amount is typically paid as a lifetime annuity) to defined-contribution plans such as 401(k) plans (in which the amount of the benefit varies depending on investment returns). Employers increasingly offer defined-contribution plans to employees. The percentage of private workers who participated in defined-benefit plans decreased from 32 percent in 1992–1993 to 21 percent in 2005.[7] Over the same period, participation in defined-contribution plans increased from 35 percent to 42 percent. In recent years, a growing number of employers have converted their defined-benefit plans to cash balance plans.
- 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 public assistance accounts for another 8 percent. For those whose income is in the highest income category, Social Security, pensions, and asset income each account for about one-fifth of aggregate income, and earnings account for the remaining two-fifths.
- For the population age 80 and over, a larger percentage of people lived in families with Social Security income (95 percent) and smaller percentage with earnings (20 percent), compared with the population age 65–69 (85 percent and 53 percent, respectively).

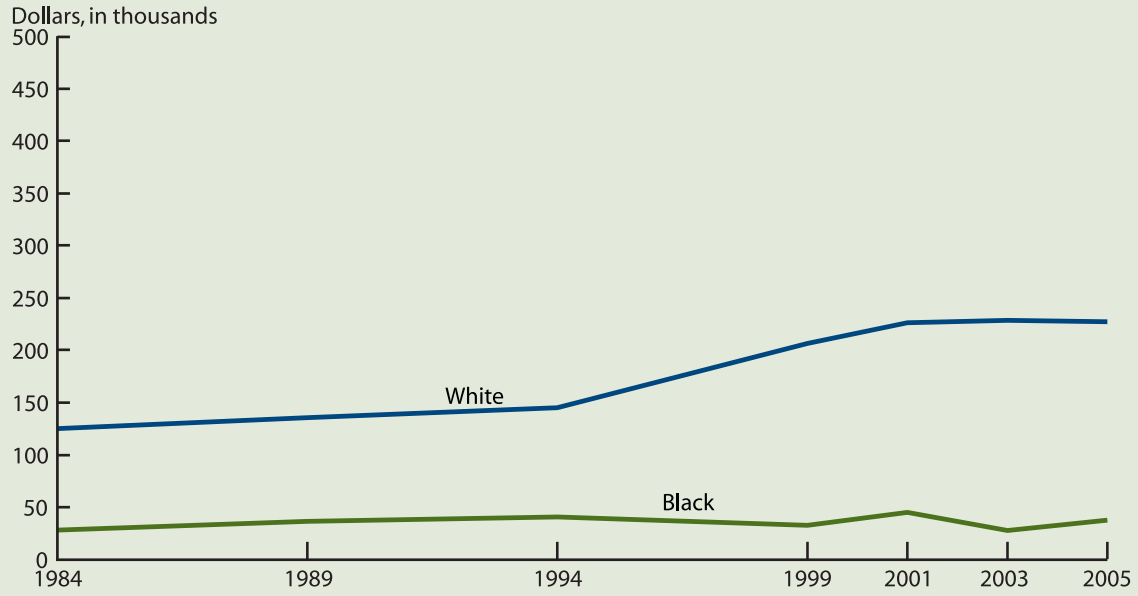
Data for this indicator's charts and bullets can be found in Tables 9a, 9b, and 9c on pages 85–86.

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, by race of head of household age 65 and over, in 2005 dollars, selected years 1984–2005

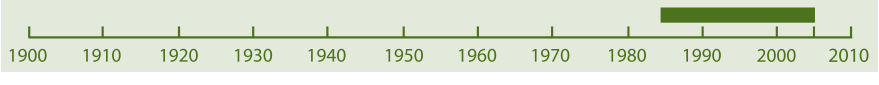


Note: Net worth data do not include pension wealth. This excludes private defined-contribution and defined-benefit plans as well as rights to Social Security wealth. Data for 1984–2003 have been inflation adjusted to 2005 dollars. See Appendix B for the definition of race and Hispanic origin in the Panel Study of Income Dynamics.

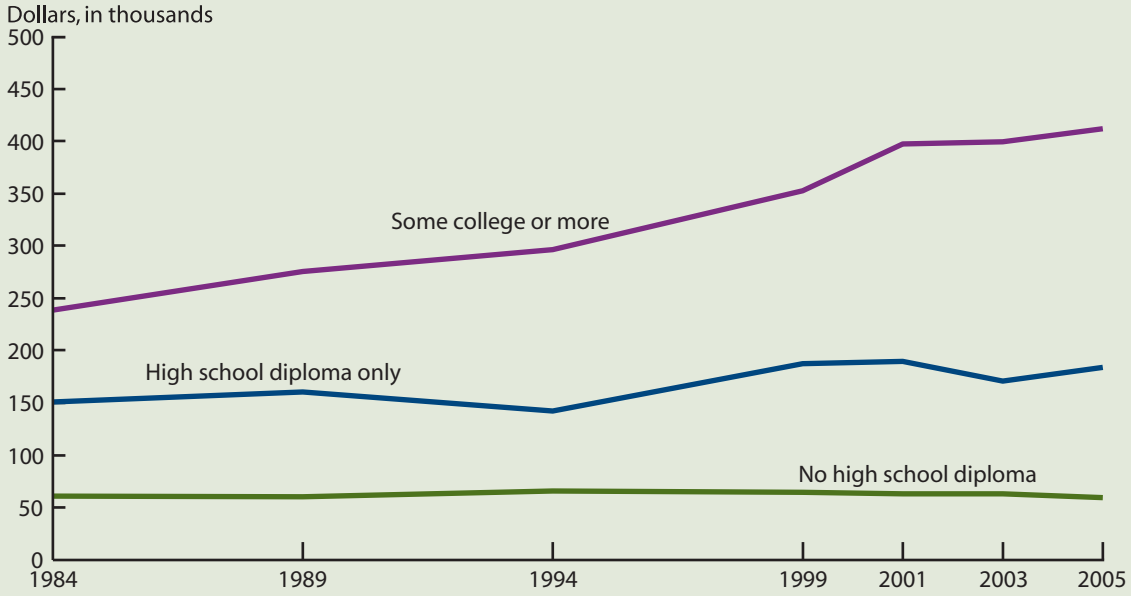
Reference population: These data refer to the civilian noninstitutionalized population.

Source: Panel Study of Income Dynamics.

- Between 1984 and 2005, the median net worth of households headed by white people age 65 and over increased 81 percent from $125,000 to $226,900. The median net worth of households headed by black people age 65 and over increased 34 percent from $28,200 to $37,800.
- In 1984, the median net worth of households headed by white people age 65 and over was 4 times that of households headed by black people. In 2005, the median net worth of older white households was 6 times that of older black households. This difference is less than it was in 2003 when the median net worth of households headed by older white people was 8 times higher than that of households headed by older black people.
- In 2005, the median net worth of households headed by married people age 65 and over ($328,300) was more than three times that of households headed by unmarried people ($104,000) in the same age group.
- Overall, between 1984 and 2005, the median net worth of households headed by people age 65 and over increased by 79 percent (from $109,000 to $196,000).



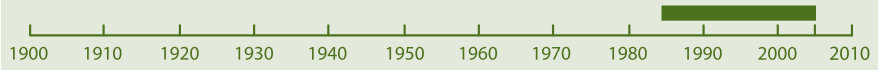
Median household net worth, by educational attainment of head of household age 65 and over, in 2005 dollars, selected years 1984–2005



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 1984–2003 have been inflation adjusted to 2005 dollars.
Reference population: These data refer to the civilian noninstitutionalized population.
Source: Panel Study of Income Dynamics.

- In 2005, households headed by people age 65 over with some college or more reported a median household net worth ($412,100) more than six times that of households headed by older people without a high school diploma ($59,500).
- Between 1984 and 2005, the median net worth of households headed by people age 65 and over without a high school diploma remained approximately the same, while the median net worth of households headed by people with some college or more increased by 72 percent.

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

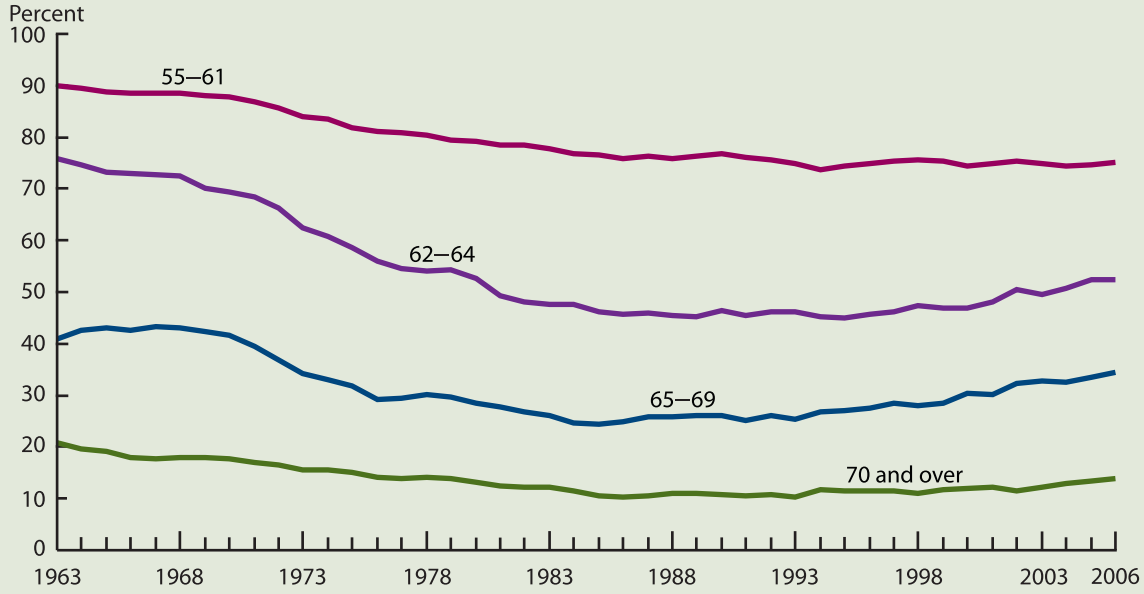


INDICATOR 11

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, 1963–2006



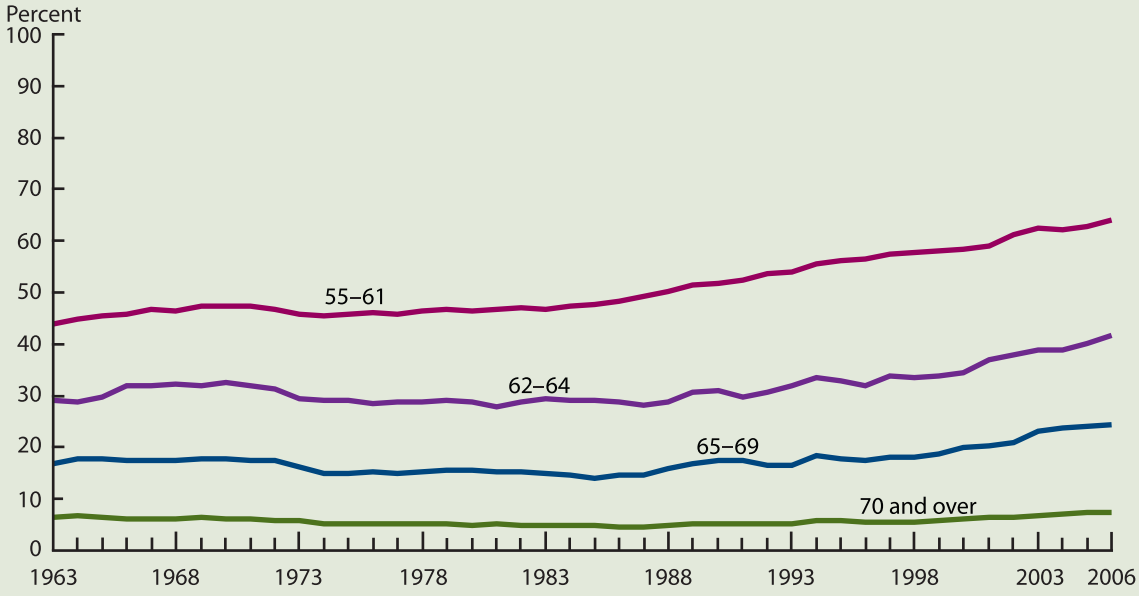
Note: Data for 1994 and later years are not strictly comparable with data for 1993 and earlier years due to a redesign of the survey and methodology of the Current Population Survey. Beginning in 2000, data incorporate population controls from Census 2000.

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

Source: Bureau of Labor Statistics, Current Population Survey.

- Between 1963 and 2006, labor force participation rates declined from 90 percent to 75 percent among men age 55–61. Over this period, participation rates declined from 76 percent to 52 percent for men age 62–64 and from 21 percent to 14 percent for men age 70 and over. For these age groups, most of the decline occurred prior to the early 1980s.
- The decline in labor force participation among older men before the 1980s has been attributed to several factors. The youngest age of eligibility for Social Security benefits was reduced from 65 to 62 in the early 1960s. Greater wealth also allowed older Americans to retire earlier.[8] The more recent stability of participation rates has been partially explained by the elimination of mandatory retirement laws, liberalization of the Social Security earnings test (the reduction of Social Security benefits as earnings exceed specified amounts), and gradual increases in the delayed retirement credit for Social Security beneficiaries.[9]
- While men age 65–69 also experienced an overall decline in labor force participation from 1963 to the mid–1980s, this group has gradually increased its participation rate in more recent years. The labor force participation rate for men age 65–69 showed a gradual decline from about 43 percent in the late 1960s to 24 percent in 1985. Their participation rate leveled off from the mid–1980s to the early 1990s, holding in the 24 percent to 26 percent range. From 1993 to 2006, the rate increased from 25 percent to 34 percent.

Labor force participation rates of women age 55 and over, by age group, annual averages, 1963–2006



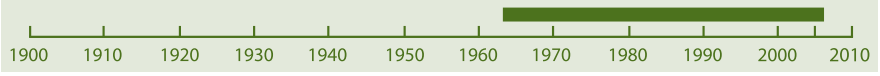
Note: Data for 1994 and later years are not strictly comparable with data for 1993 and earlier years due to a redesign of the survey and methodology of the Current Population Survey. Beginning in 2000, data incorporate population controls from Census 2000.

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

Source: Bureau of Labor Statistics, Current Population Survey.

- Labor force participation rates have risen among women age 55 years and over during the past 4 decades. The increase has been largest among women age 55–61, from 44 percent in 1963 to nearly 64 percent in 2006, 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 their participation rates began in the mid-1990s.
- Labor force participation rates for older women reflect changes in the work experience of successive generations of women. Many women now in their 60s and 70s did not work outside the home when they were younger, or they moved in and out of the labor force. As new cohorts of women approach older ages, they are participating in the labor force at higher rates than previous generations. As a result, in 2006, nearly 64 percent of women age 55–61 were in the labor force, compared with 44 percent of women age 55–61 in 1963. Over the same period, the labor force participation rate increased from 29 percent to 42 percent among women age 62–64 and from 17 percent to 24 percent among women age 65–69.
- The difference between labor force participation rates for men and women has narrowed over time. Among people age 55–61, for example, the gap between men's and women's rates in 2006 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.

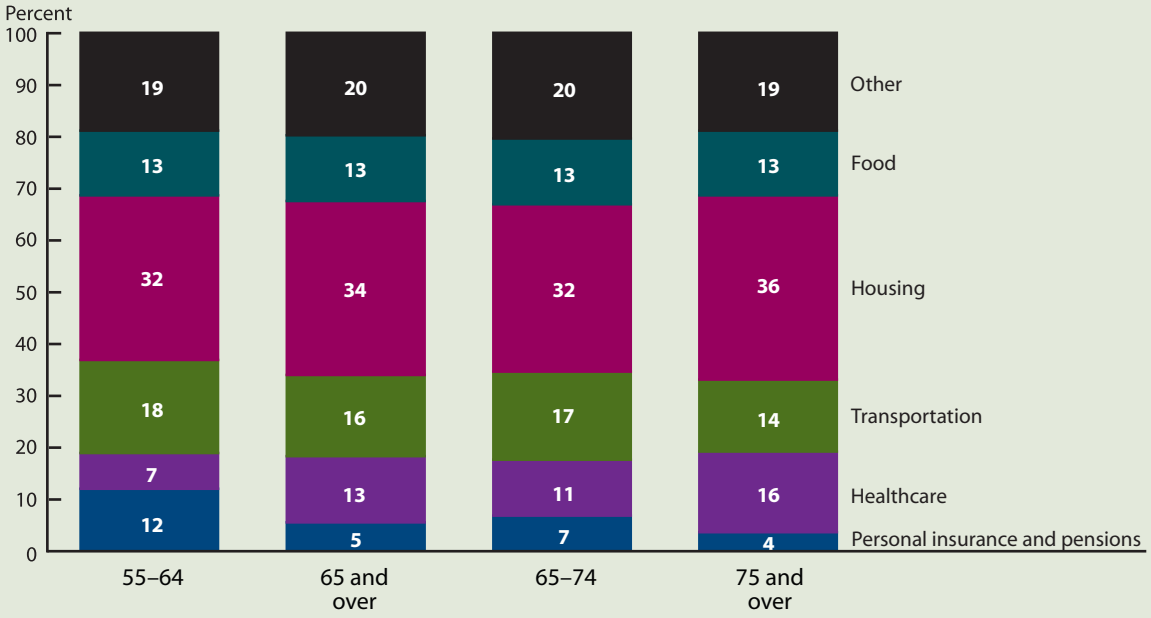


INDICATOR 12

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.

Percentage of total household annual expenditures by age of reference person, 2005



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.

- Households headed by people age 65 and over allocated about 34 percent of their total annual expenditures to housing expenses, the largest single component of annual expenditures. Transportation expenses accounted for about 16 percent of total spending. Food accounted for about 13 percent of total spending.
- About 13 percent of all expenditures in households headed by people age 65 and over were on healthcare expenses, which includes health insurance, medical services, drugs, and medical supplies. In comparison, the proportion of total expenditures on healthcare among households headed by people age 55–64 was 7 percent.
- Households headed by people age 55–64, allocated a larger share of total expenditures (12 percent) to personal insurance and pensions (including Social Security payroll taxes) than those headed by people age 65 and over (5 percent).

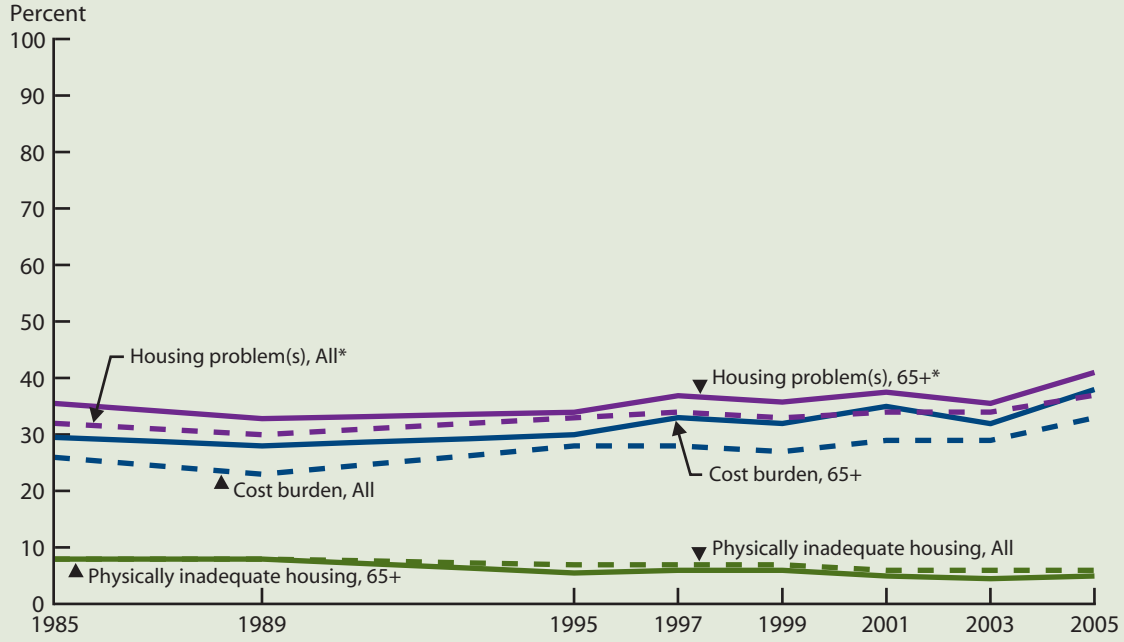
Data for this indicator's chart and bullets can be found in Table 12 on page 89.

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 households with residents age 65 and over that report housing problems, by type of problem, selected years 1985–2005



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

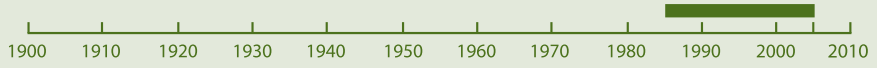
*Although crowded housing is not a common problem for older people (less than 1 percent), it is included as one of three possible housing problems under "housing problem(s)." See Tables 13a and 13b in Appendix A for more information.

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 2005, 41 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 the highest level since 1985. By comparison, the occurrence of such problems among all U.S. households was 37 percent in 2005.
- 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 more prevalent among the households with people age 65 and over. Between 1985 and 2005, housing cost burden for households with older people increased from 30 percent to 38 percent. By comparison, the prevalence of housing cost burden among all U.S. households increased from 26 percent in 1985 to 33 percent in 2005.
- 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 2005, 5 percent of households with people age 65 and over had inadequate housing, compared with 8 percent in 1985. In contrast, 6 percent of U.S. households overall reported living in physically inadequate housing during 2005 compared with 8 percent in 1985.

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



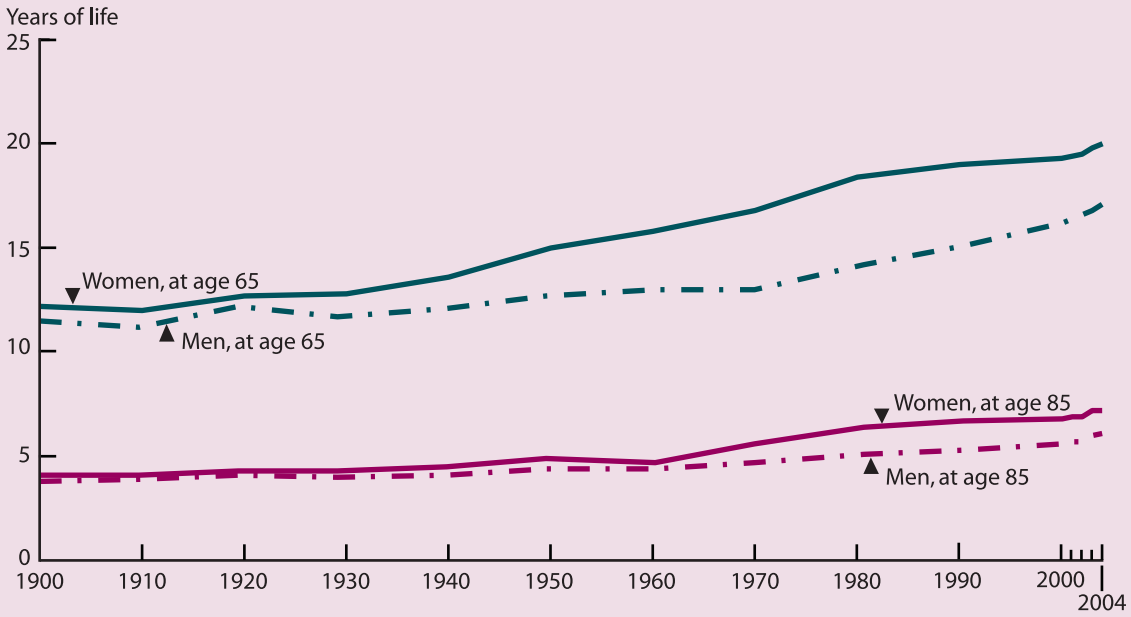
Health Status

INDICATOR 14

Life Expectancy

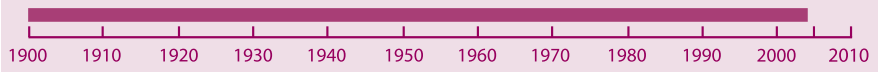
Life expectancy is a summary measure of the overall health of a population. It represents the average number of years of life remaining to a person at a given age if death rates were to remain constant. In the United States, improvements in health have resulted in increased life expectancy and contributed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

Life expectancy at ages 65 and 85, by sex, selected years 1900–2004

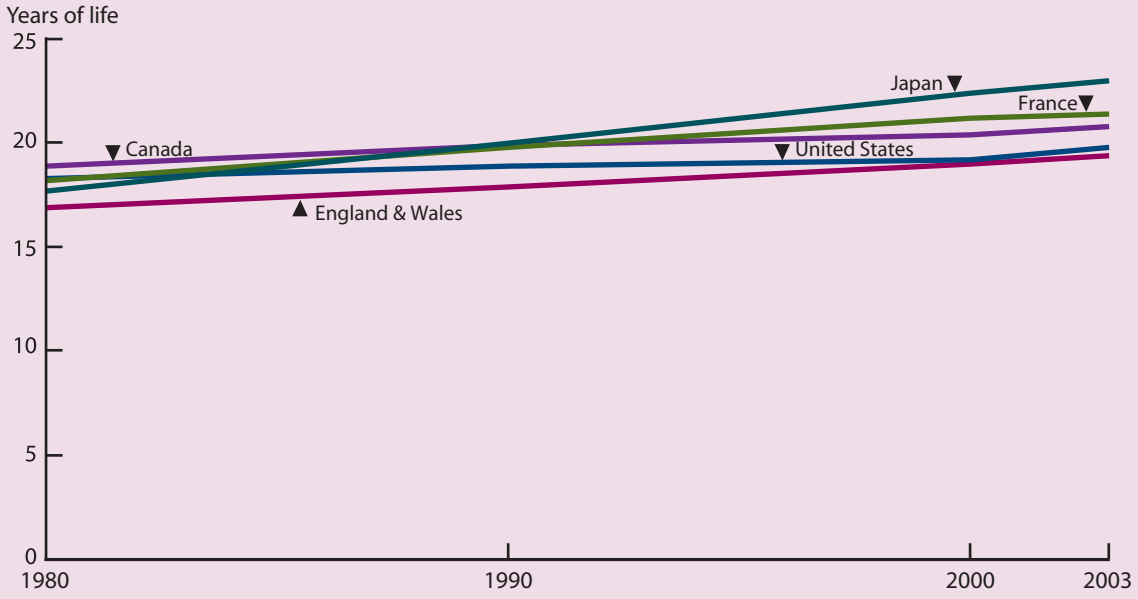


Reference population: These data refer to the resident population.
Source: Centers for Disease Control and Prevention, National Center for Health Statistics, National Vital Statistics System.

- 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 18.7 more years, almost 7 years longer than people age 65 in 1900. The life expectancy of people who survive to age 85 today is 7.2 years for women and 6.1 years for men.
- Life expectancy varies by race, but the difference decreases with age. In 2004, life expectancy at birth was 5.2 years higher for white people than for black people. At age 65, white people can expect to live an average of 1.6 years longer than black people. Among those who survive to age 85, however, the life expectancy among black people is slightly higher (7.1 years) than white people (6.7 years).
- Life expectancy at age 65 in the United States is lower than that of many other industrialized nations. In 2003, women age 65 in Japan could expect to live on average 3.2 years longer than women in the United States. Among men, the difference was 1.2 years.

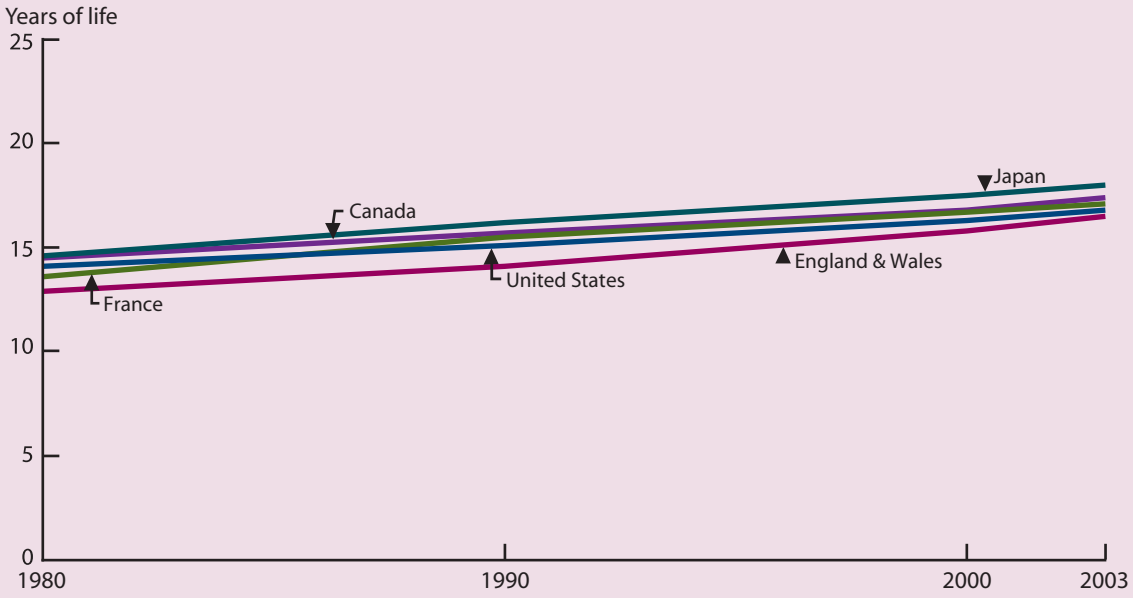


Average life expectancy for women at age 65, by selected countries or areas, selected years 1980–2003



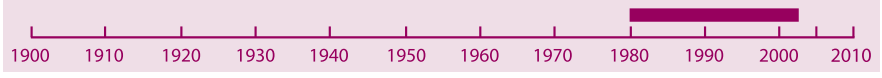
Source: Centers for Disease Control and Prevention, National Center for Health Statistics, *Health, United States, 2007.*[10]

Average life expectancy for men at age 65, by selected countries or areas, selected years 1980–2003



Source: Centers for Disease Control and Prevention, National Center for Health Statistics, *Health, United States, 2007.*[10]

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

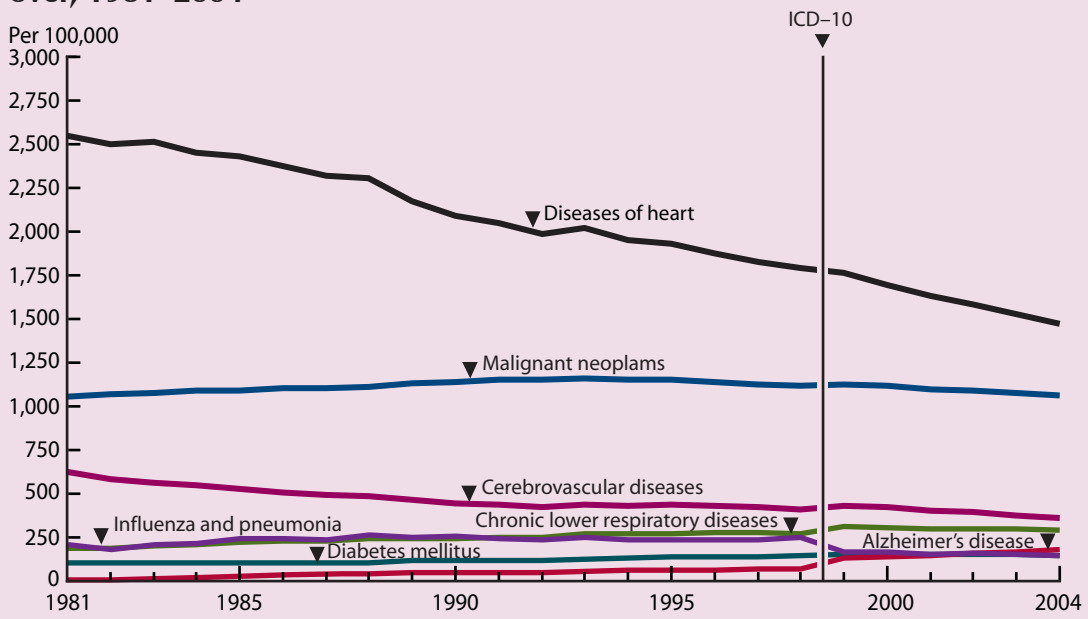


INDICATOR 15

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, 1981–2004



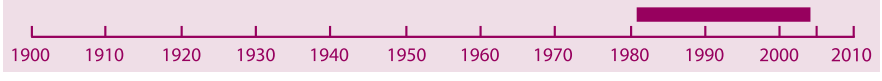
Note: Death rates for 1981–1998 are based on the 9th revision of the *International Classification of Diseases* (ICD–9). Starting in 1999, death rates are based on ICD–10 and trends in death rates for some causes may be affected by this change.[11] For the period 1981–1998, causes were coded using ICD–9 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 2004, the leading cause of death among people age 65 and over was diseases of heart (heart disease) (1,418 deaths per 100,000 people), followed by malignant neoplasms (cancer) (1,052 per 100,000), cerebrovascular diseases (stroke) (346 per 100,000), chronic lower respiratory diseases (284 per 100,000), Alzheimer's disease (171 per 100,000), diabetes mellitus (146 per 100,000), and influenza and pneumonia (139 per 100,000).
- Between 1981 and 2004, age adjusted death rates for all causes of death among people age 65 and over declined by 18 percent. Death rates for heart disease and stroke declined by approximately 44 percent. Age adjusted death rates for diabetes increased by 38 percent since 1981, and death rates for chronic lower respiratory diseases increased by 53 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 much higher suicide rates than those of women at all ages, with the largest difference occurring at age 85 and over (45 deaths per 100,000 population for men compared with 4 per 100,000 for women). Non-Hispanic white men age 85 and over have the highest rate of suicide overall at 50 deaths per 100,000.[12]

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

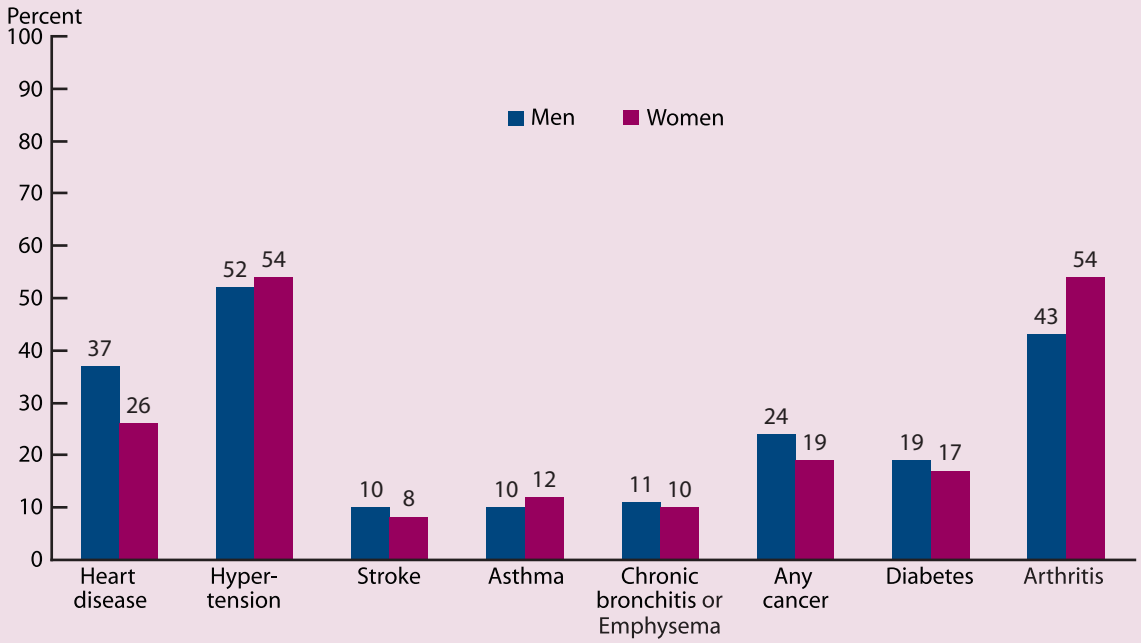


INDICATOR 16

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.[13] 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.")

Percentage of people age 65 and over who reported having selected chronic conditions, by sex, 2005–2006



Note: Data are based on a 2-year average from 2005–2006.
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 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 2005–2006, among people age 65 and over, non-Hispanic blacks report higher levels of hypertension and diabetes than non-Hispanic whites (70 percent compared with 51 percent for hypertension and 29 percent compared with 16 percent for diabetes). Hispanics also report higher levels of diabetes than non-Hispanic whites (25 percent compared with 16 percent), but similar levels of hypertension (54 percent and 51 percent, respectively) and lower levels of arthritis (40 percent compared with 50 percent).

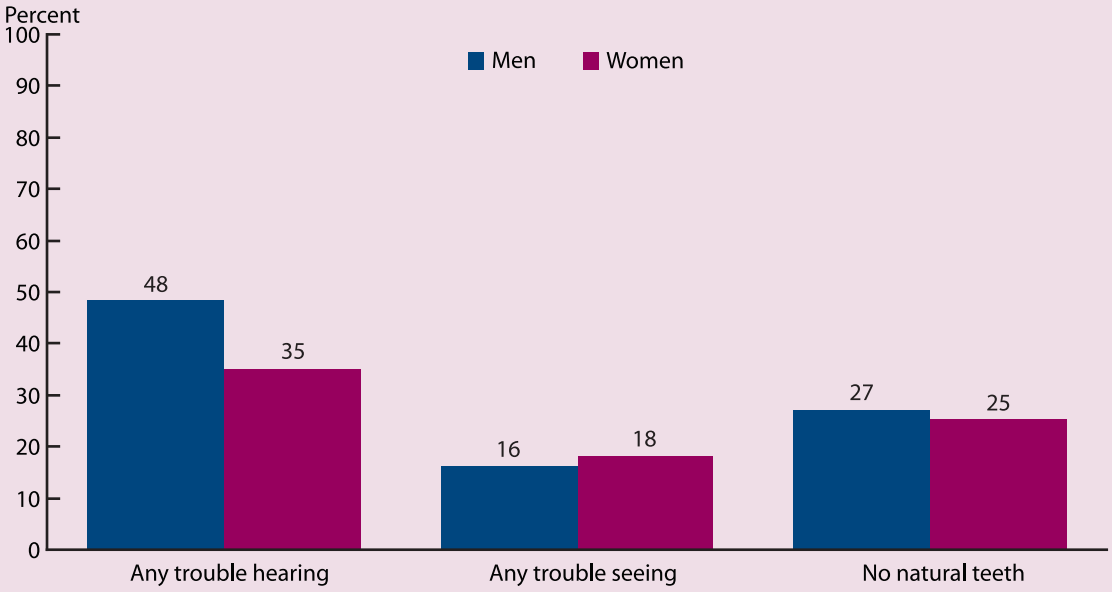
Data for this indicator's chart and bullets can be found in Tables 16a and 16b on page 100.

INDICATOR 17

Sensory Impairments and Oral Health

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

Percentage of people age 65 and over who reported having any trouble hearing, any trouble seeing, or no natural teeth, by sex, 2006



Note: Respondents were asked "Which statement best describes your hearing without a hearing aid: good, a little trouble, a lot of trouble, deaf?" For the purposes of this indicator the category "Any trouble hearing" includes "a little trouble, a lot of trouble, and deaf." Regarding their vision, respondents were asked "Do you have any trouble seeing, even when wearing glasses or contact lenses?" The category "Any trouble seeing" also 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 2006, close to one-half of older men and more than one-third of older women reported trouble hearing. The percentage with trouble hearing was higher for people age 85 and over (62 percent) than for people age 65–74 (32 percent). Ten percent of all older women and 18 percent of all older men reported having ever worn a hearing aid.
- Vision trouble affects 17 percent of the older population, 16 percent of men and 18 percent of women. Among people age 85 and over, 27 percent reported trouble seeing.
- The prevalence of edentulism, having no natural teeth, was higher for people age 85 and over (32 percent) than for people age 65–74 (23 percent). Socioeconomic differences are large. Thirty-nine percent of older people with family income below the poverty line reported no natural teeth compared with 26 percent of people above the poverty threshold.

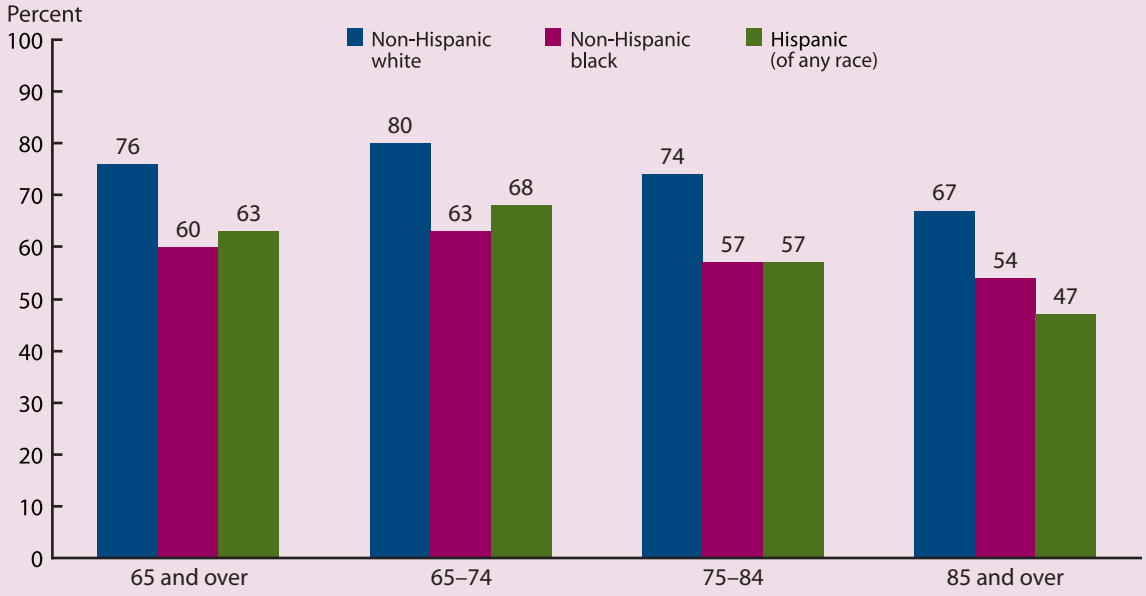
Data for this indicator's charts and bullets can be found in Tables 17a and 17b on page 101.

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]

Percentage of people age 65 and over who reported having good to excellent health, by age group and race and Hispanic origin, 2004–2006



Note: Data are based on a 3-year average from 2004–2006. 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 2004–2006, 74 percent of people age 65 and over rated their health as good or better. This has been true for the decades preceding 2004 as well; the majority of older people reported their health to be good to excellent.
- The proportion of people reporting good to excellent health decreases among the older age groups. Among men, 78 percent of those age 65–74 report good or better health. At age 85 and over, 63 percent of men report good or better ratings. This pattern is evident among women and 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, although among men age 85 and over, Hispanics have the lowest health ratings

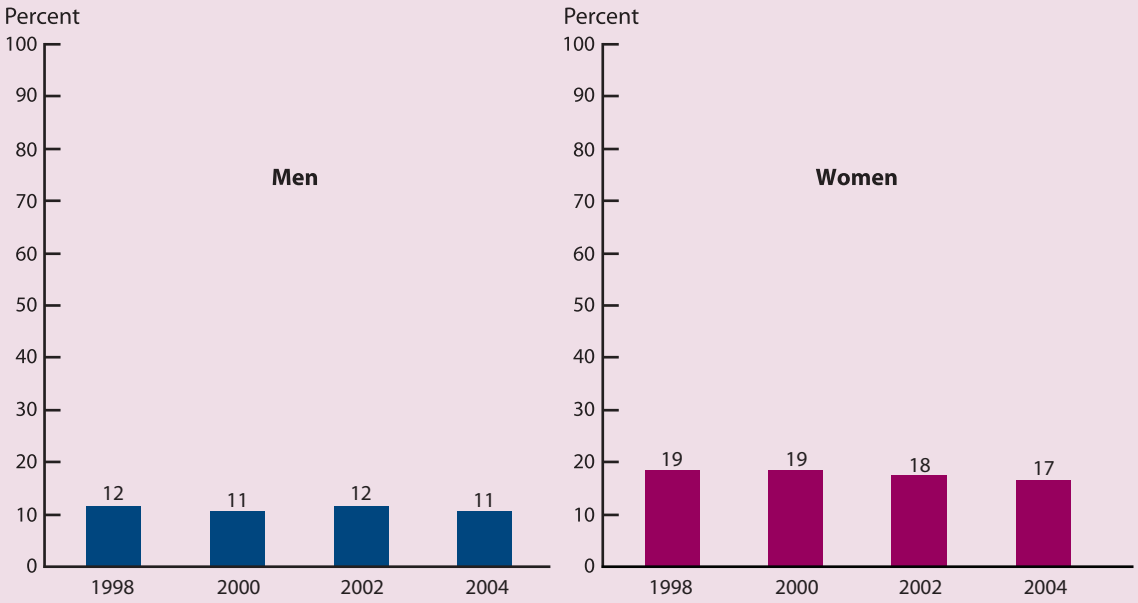
Data for this indicator's chart and bullets can be found in Table 18 on page 102.

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.[16,17]

Percentage of people age 65 and over with clinically relevant depressive symptoms, by sex, 1998–2004

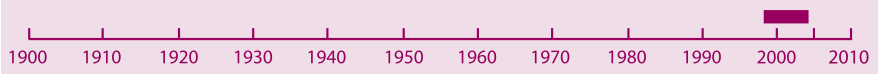


Note: The definition of "clinically relevant depressive symptoms" is four or more symptoms out of a list of eight depressive symptoms from an abbreviated version of the Center for Epidemiological Studies Depression Scale (CES-D) adapted by the Health and Retirement Study. The CES-D scale is a measure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

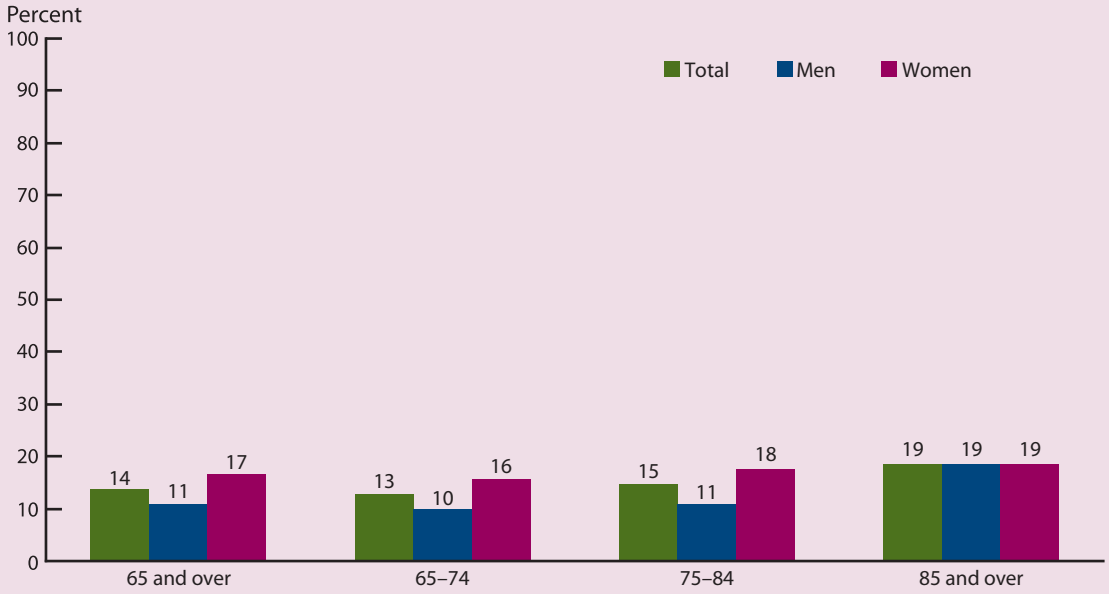
Reference population: These data refer to the civilian noninstitutionalized population.

Source: Health and Retirement Study.

- Older women are more likely to report clinically-relevant depressive symptoms than older men. In 2004, 17 percent of women age 65 and over reported depressive symptoms compared with 11 percent of men. There has been no significant change in this sex difference between 1998 and 2004.
- The percentage of people reporting clinically-relevant depressive symptoms has remained relatively stable over the past few years. Between 1998 and 2004, the percentage of men who reported depressive symptoms ranged between 11 percent and 12 percent. The percentage of women reporting depressive symptoms ranged between 17 and 19 percent.



Percentage of people age 65 and over with clinically relevant depressive symptoms, by age group and sex, 2004



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

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

Source: Health and Retirement Study.

- The prevalence of clinically-relevant depressive symptoms is related to age. In 2004, the proportion of people age 65 and over with clinically-relevant depressive symptoms was higher for people age 85 and over (19 percent) than for people age 65–74 (13 percent).
- In 2004, the percentage of women age 85 and over reporting depressive symptoms (19 percent) was almost 20 percent higher than the percentage of women age 65–74 (16 percent) reporting the same depressive symptoms. The percentage of men age 85 and over reporting clinically-relevant depressive symptoms (19 percent) is almost double the percentage of men age 65–74 (10 percent) reporting symptoms.
- Serious psychological distress is another measure of mental health. It identifies people who have a diagnosable mental disorder (such as schizophrenia, bipolar disorder, or severe forms of depression) resulting in functional impairment in major life activities.[18] In 2006, 2 percent of people age 65 and over reported experiencing symptoms of serious psychological distress.[19]
- Antidepressants can be an effective treatment for the specific illness of major depressive disorder.[20] The use of antidepressants among noninstitutionalized people age 65 and over increased from 9 percent in 1997 to 13 percent in 2002.[21]

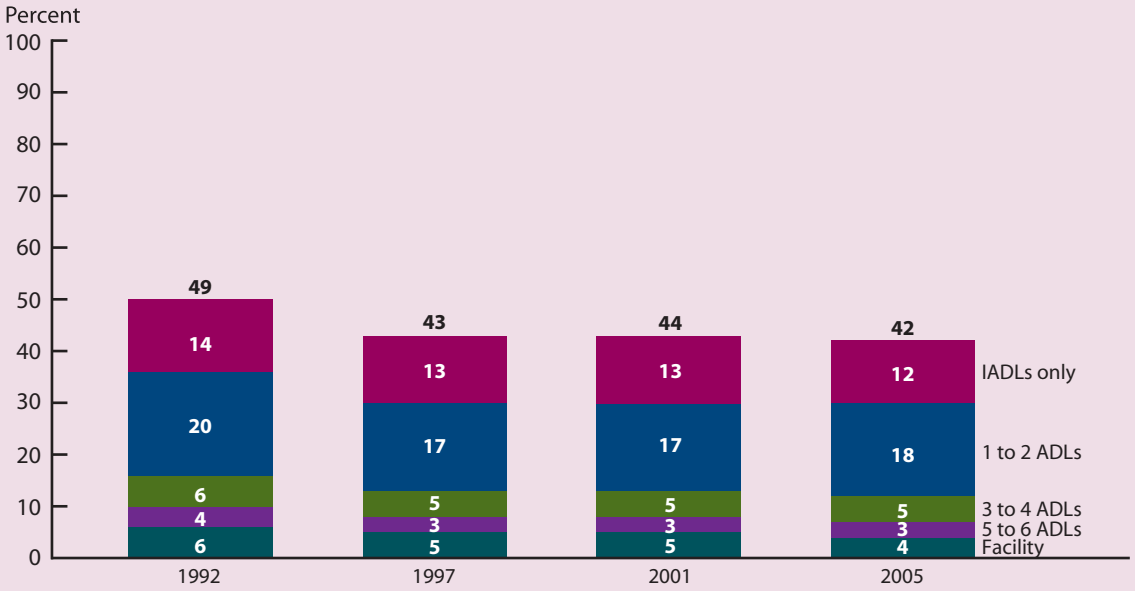
Data for this indicator's charts and bullets can be found in Tables 19a and 19b on page 103.

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 1992–2005

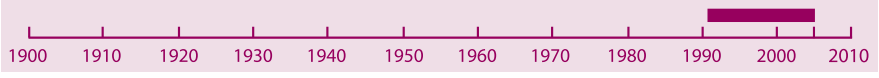


Note: The Medicare Current Beneficiary Survey has replaced the National Long Term Care Survey as the data source for this indicator. Consequently, the measurement of functional limitations (previously called disability) has changed from previous editions of *Older Americans*. A residence (or unit) is 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 non-family, paid 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 and 2001 do not sum to the totals because of rounding.

Reference: These data refer to Medicare enrollees.

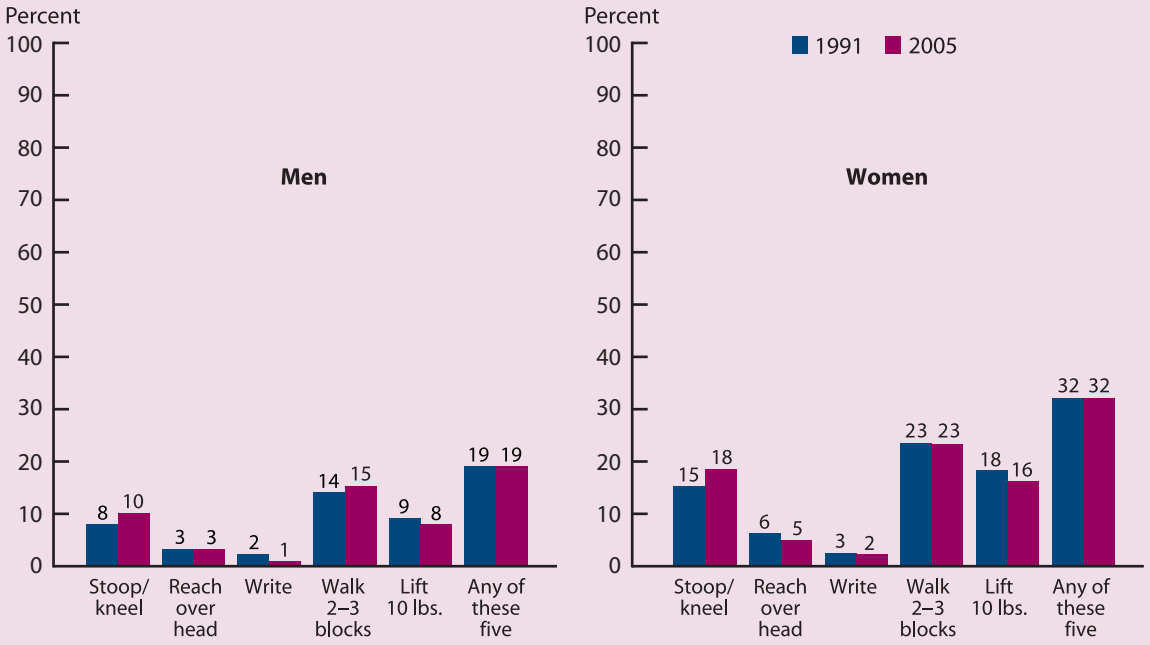
Source: Centers for Medicare and Medicaid Services, Medicare Current Beneficiary Survey.

- In 2005, more than two-fifths (42 percent) of people age 65 and over reported a functional limitation. Twelve percent had difficulty performing one or more IADLs (but no ADL limitation). Eighteen percent had difficulty with 1–2 ADLs, 5 percent had difficulty with 3–4 ADLs, 3 percent had difficulty with 5–6 ADLs, 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 2005. There was a steady decrease in the percent with limitations from 1992 until 1997. From 1997 to 2005 the overall levels have not significantly changed, although the decline in facility residence has continued.
- Women have higher levels of functional limitations than men. In 2005, 47 percent of female Medicare enrollees age 65 and over had difficulty with ADLs or IADLs, or were in an institution, compared with 35 percent of male Medicare enrollees. Rates of decline since 1992 are similar for men and women.



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

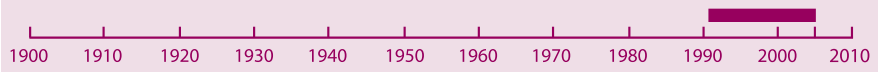
Percentage of Medicare enrollees age 65 and over who are unable to perform certain physical functions, by sex, 1991 and 2005



Note: Rates for 1991 are age adjusted to the 2005 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 2005, 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, 14 percent reported they were unable to perform at least one of five activities, compared with 38 percent of men aged 85 and over. Among women, 22 percent of those aged 65–74 were unable to perform at least one activity, compared with 56 percent of those aged 85 and over.
- Physical functioning was not strongly related to race in 2005. Among men, 19 percent of non-Hispanic whites were unable to perform at least one activity, compared with 24 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, and 20c on pages 104–105.



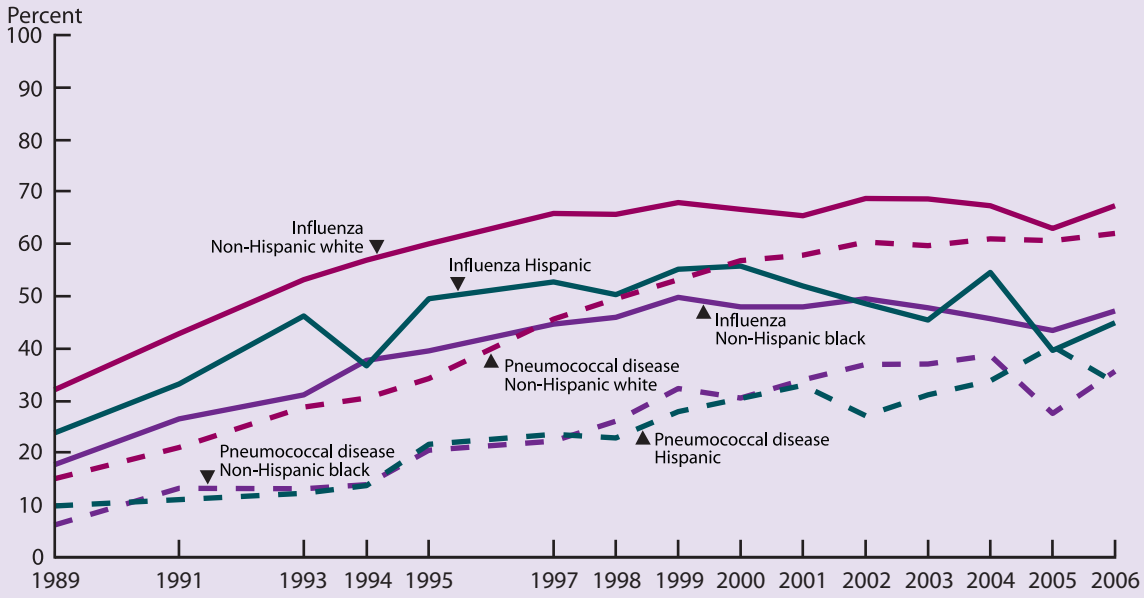
Health Risks and Behaviors

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.[22,23] Influenza vaccinations are given annually, and pneumococcal vaccinations are usually given once in a lifetime. The costs associated with these vaccinations are covered under Medicare Part B.

Percentage of people age 65 and over who reported having been vaccinated against influenza and pneumococcal disease, by race and Hispanic origin, selected years 1989–2006



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 2006, 64 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. Sixty-seven percent of non-Hispanic whites reported receiving a flu shot compared with 47 percent of non-Hispanic blacks and 45 percent of Hispanics.
- In 2006, 57 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 (62 percent) compared with non-Hispanic blacks (36 percent) or Hispanics (33 percent).

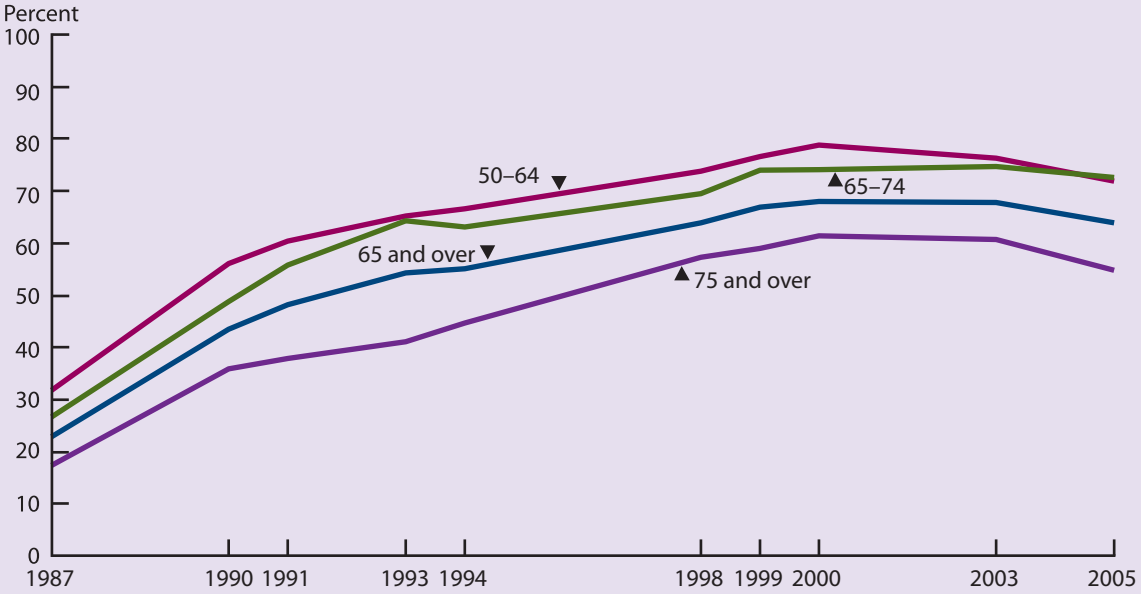
Data for this indicator's chart and bullets can be found in Tables 21a and 21b on page 106.

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 40 and over, especially for the 50–69 age group.[24]

Percentage of women age 50 and over who had a mammogram in the past 2 years, by age group, selected years 1987–2005



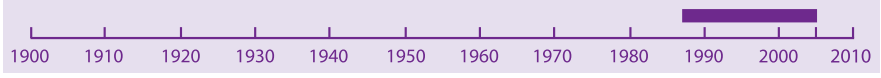
Note: Questions concerning use of mammography differed slightly on the National Health Interview Survey across the years for which data are shown. See Table 22 in Appendix A for more information.

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 64 percent in 2005. 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 2005, 52 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, 70 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 2005, 51 percent of women age 65 and over without a high school diploma reported having had a mammogram in the preceding 2 years, compared with 64 percent of women who had a high school diploma and 73 percent of women who had some college education.

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

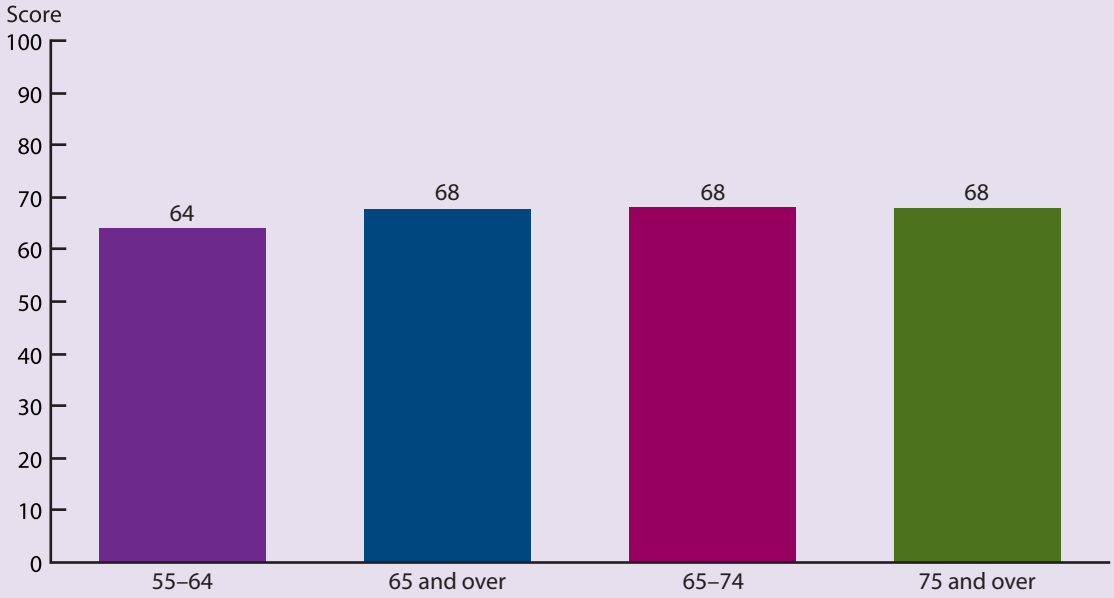


INDICATOR 23

Diet Quality

A healthful diet can reduce some major risk factors for chronic diseases, such as obesity, Type 2 diabetes, high blood pressure, and high blood cholesterol.[25] The Healthy Eating Index-2005 (HEI-2005) is a tool designed to measure compliance of diets with the key diet-quality recommendations of the 2005 Dietary Guidelines for Americans.[26]

Healthy Eating Index-2005 (HEI-2005) total scores for people age 55 and over, by age group, 2001–2002



Note: Diet quality was measured using the Healthy Eating Index-2005 (HEI-2005), which has 12 components. Each component represents a different aspect of a healthful diet according to the 2005 Dietary Guidelines for Americans. A higher score for each component represents a healthier diet. Dietary adequacy is addressed by Total Fruit; Whole Fruit (forms other than juice); Total Vegetables; Dark Green and Orange Vegetables and Legumes (cooked dry beans and peas); Total Grains; Whole Grains; Milk (all milk products and soy beverages); Meat and Beans (meat, poultry, fish, eggs, soybean products other than beverages, nuts, and seeds); and Oils (nonhydrogenated vegetable oils and oils in fish, nuts, and seeds). For the remaining three components—Saturated Fat; Sodium; and Calories from Solid Fat, Alcohol, and Added Sugar—higher scores reflect lower intakes. Diet quality, as opposed to quantity, is assessed by measuring intakes on a density, or per calorie, basis. Other health measures related to the Dietary Guidelines are physical activity (see Indicator 24) and obesity (see Indicator 25).

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, 2001–2002; U.S. Department of Agriculture, Center for Nutrition Policy and Promotion.

- In 2001–2002, the total HEI-2005 score for adults age 65 and over was 68 out of the maximum 100 points. There were no significant differences among the HEI-2005 total scores for adults age 55–64, 65–74, or 75 and over.
- HEI-2005 component scores for people age 65 and over indicate a need to increase intakes of a number of food groups. Most in need of improvement are intakes of whole grains; dark green and orange vegetables and legumes; and fat-free and lowfat milk and milk products. Other food groups needing increased intake are all types of vegetables and fruit. Oils, including those in fish, nuts, and seeds, should replace some solid fats. Decreased intakes are needed especially of sodium, saturated fat, and calories from foods and beverages with solid fats, added sugar, and alcohol.

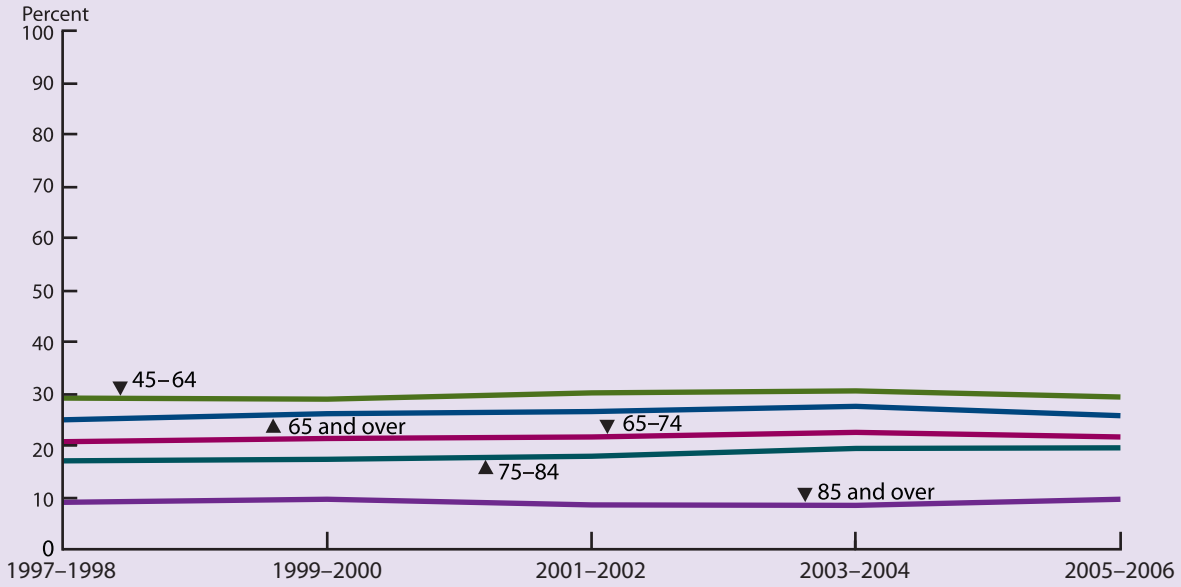
Data for this indicator's chart and bullets can be found in Table 23 on page 108.

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 enhances overall quality of life.[27,28] Research has shown that even among frail and very old adults, mobility and functioning can be improved through physical activity.[29]

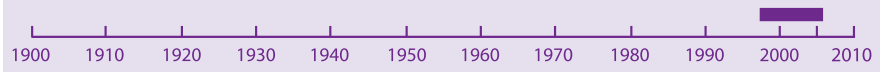
Percentage of people age 45 and over who reported engaging in regular leisure time physical activity, by age group, 1997–2006



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

- In 2005–2006, 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 26 percent among people age 65–74 to 10 percent among people age 85 and over. There was no significant change in the percentage reporting physical activity between 1997 and 2006.
- Men age 65 and over are more likely than women in the same age group to report engaging in regular leisure time physical activity (25 percent and 19 percent, respectively, in 2005–2006). Older non-Hispanic white people report higher levels of physical activity than non-Hispanic black people or Hispanics (23 percent compared with 16 percent for Hispanics and 14 percent for non-Hispanic blacks in 2005–2006).
- 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.[30] Thirteen percent of older people reported engaging in strengthening exercises in 2005–2006.

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



INDICATOR 25

Obesity

Obesity and overweight have reached epidemic proportions in the United States. Similar to cigarette smoking, obesity is a major cause of preventable disease and premature death.[31] 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.[32,33]

Percentage of people age 65 and over who are obese, by sex and age group, selected years 1988–2006

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 2005–2006, 37 percent of noninstitutionalized women age 65–74 and 24 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 follow 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 33 percent of men age 65–74 and 25 percent of men age 75 and over in 2005–2006.
- Over the past 7 years, the trend has leveled off, with no statistically significant change in obesity for older men or women between 1999–2000 and 2005–2006.

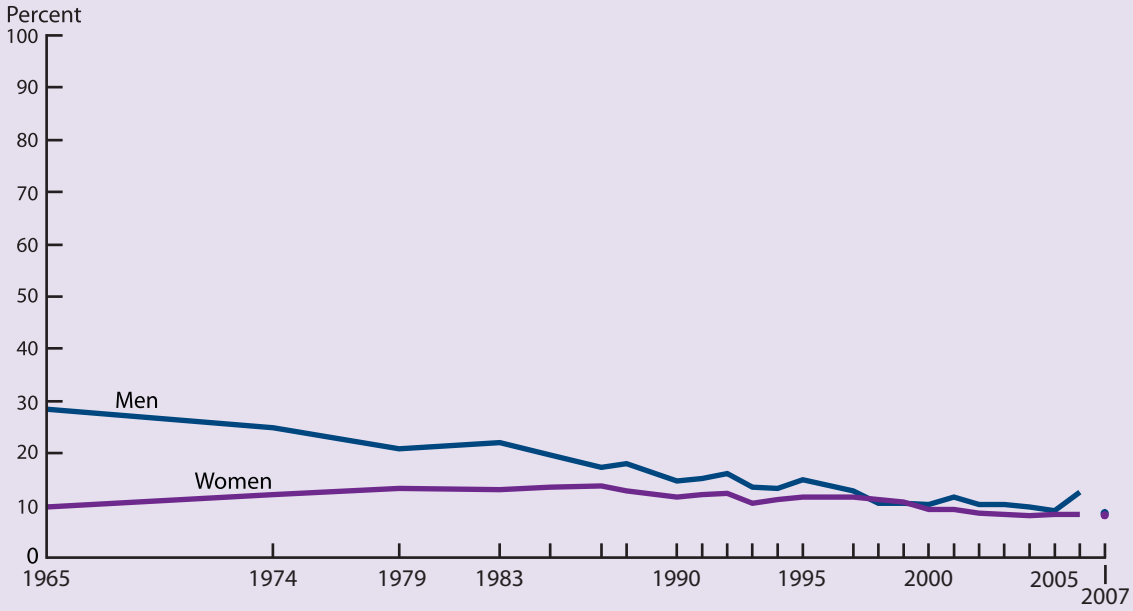
Data for this indicator's chart and bullets can be found in Table 25 on page 110.

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 53 percent between 1981 and 2004. See "Indicator 15: Mortality." This increase reflects, in part, the effects of cigarette smoking.[34]

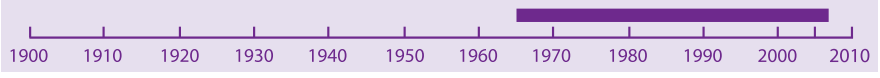
Percentage of people age 65 and over who are current cigarette smokers, by sex, selected years 1965–2007‡



‡ The 2007 estimates are based on Early Release National Health Interview Survey data collected January–June 2007, using preliminary weights.
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 dramatically in the four decades between 1965 and 2005. 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 9 percent in 2005). 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 2005.
- In 2006, however, the decline among older male smokers appeared to have reversed, with the percentage of current male smokers increasing to 13 percent. This observed increase for men in 2006 may be an anomaly as preliminary data for January–June 2007 show a return to the level in 2005 (9 percent). Among women of the same age, levels of cigarette smoking remained the same (8 percent in both 2006 and 2007).
- A large percentage of men and women age 65 and over are former smokers. In 2006, 51 percent of older men previously smoked cigarettes, while nearly 28 percent of women age 65 and over were former smokers.

Data for this indicator's chart and bullets can be found in Tables 26a and 26b on pages 111–112.

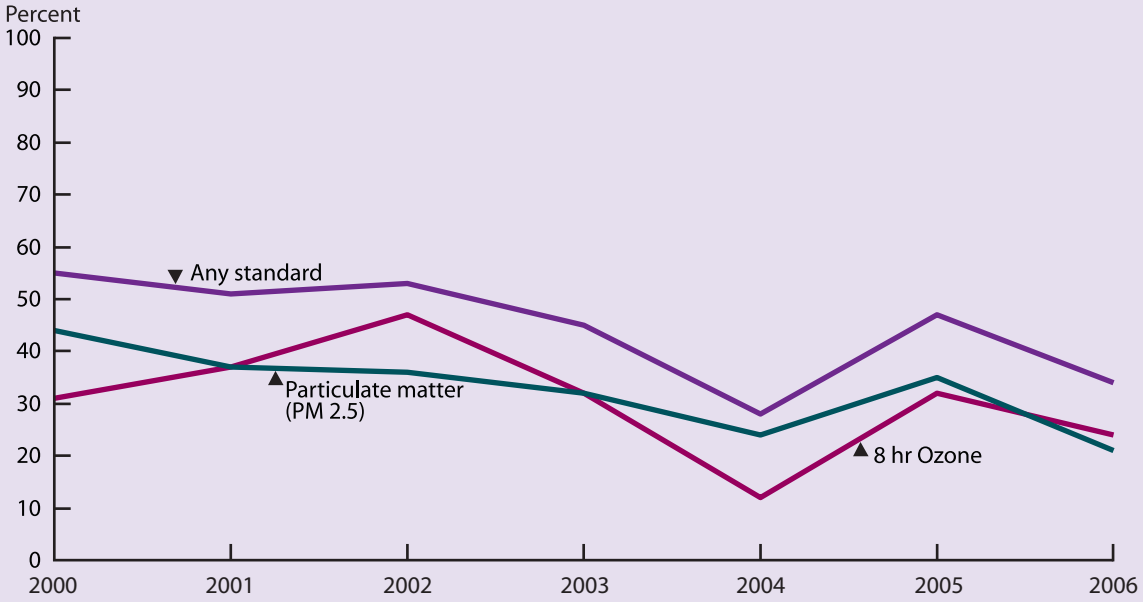


INDICATOR 27

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.[35–39] An important indicator for environmental health is the percentage of older adults living in areas that have measured air pollutant concentrations above the Environmental Protection Agency's (EPA) established standards. Ozone and particulate matter (PM) (especially smaller, fine particle pollution called PM 2.5) have the greatest potential to affect the health of older adults.

Percentage of people age 65 and over living in counties with "poor air quality," 2000–2006

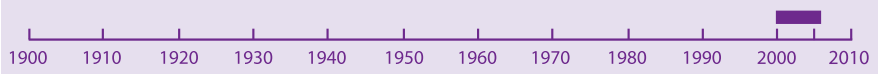


Note: The term "poor air quality" is defined as air quality concentrations above the level of the National Ambient Air Quality Standards (NAAQS). The term "any standard" refers to any NAAQS for ozone, particulate matter, nitrogen dioxide, sulfur dioxide, carbon monoxide, and lead. Data for previous years have been computed using the new daily PM 2.5 standard of 35 micrograms/m^3 to enable comparisons across time. This results in percentages that are not comparable to previous publications.

Reference population: These data refer to the resident population.

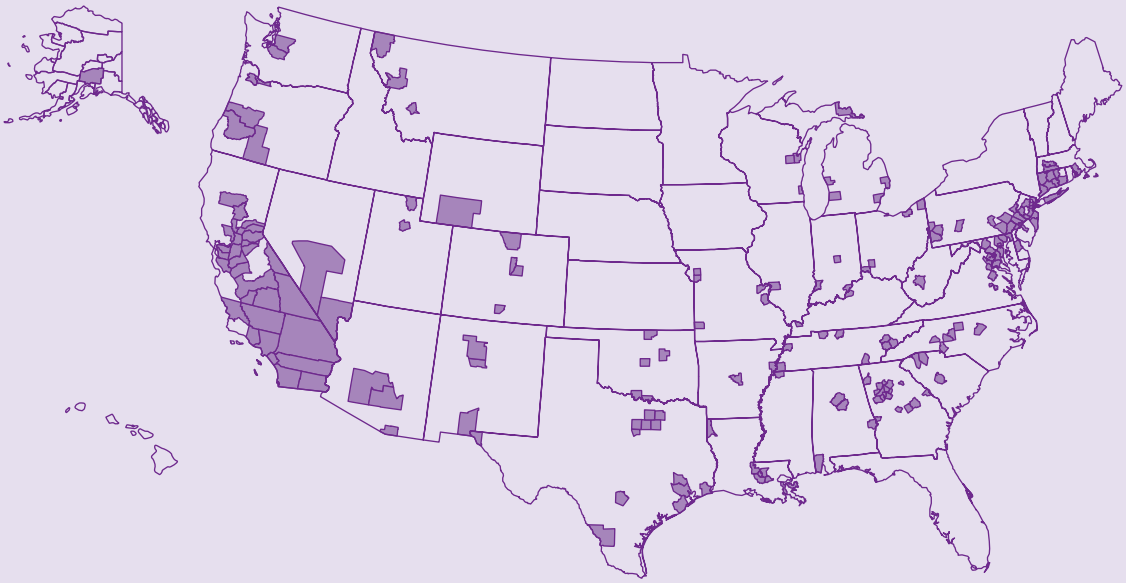
Source: U.S. Environmental Protection Agency, Office of Air Quality Planning and Standards, Air Quality System; U.S. Census Bureau, Population Projections, 2000–2006.

- In 2006, 24 percent of people age 65 and over lived in counties with poor air quality for ozone compared with 31 percent in 2000. Since the year 2000, ground level ozone pollution peaked in 2002 when the United States experienced a hot, dry summer climate that was particularly conducive to the formation of ground-level ozone.
- A comparison of 2000 and 2006 shows a reduction in PM 2.5. In 2000, 44 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 21 percent of people age 65 and over in 2006.
- The percentage of people age 65 and over living in counties that experienced poor air quality for any air pollutant decreased from 55 percent in 2000 to 34 percent in 2006.



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 Environmental Protection Agency (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 2006



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, 2000–2006.

- In 2006, nearly 38 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 113 million people lived in counties where monitored air in 2006 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.

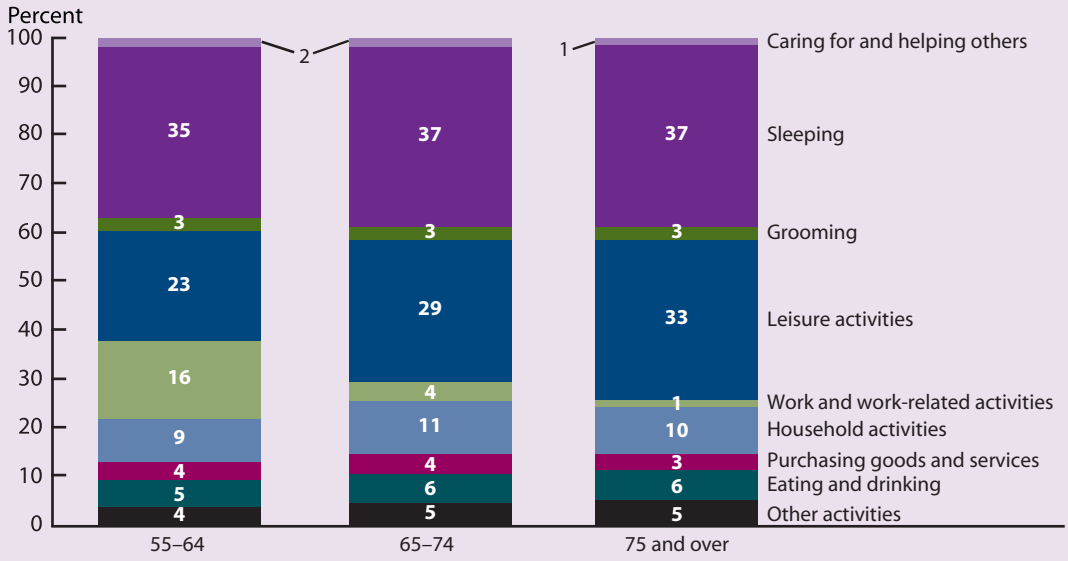
Data for this indicator's charts and bullets can be found in Tables 27a and 27b on pages 112–114.

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, 2006



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.

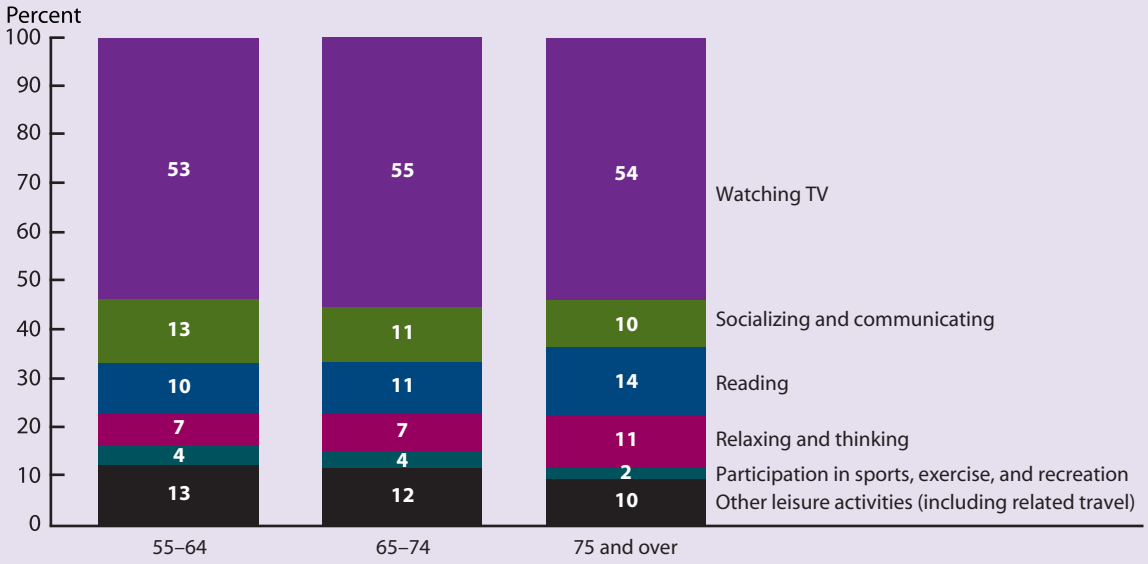
Reference population: These data refer to the civilian noninstitutionalized population.

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

- In 2006, older Americans spent on average more than one-quarter of their time in leisure (6.5 hours per day). This proportion increased with age: Americans age 75 and over spent 33 percent of their time in leisure compared with 23 percent for those age 55–64.
- On an average day, people age 55–64 spent 16 percent of their time (almost 4 hours) working or doing work-related activities compared with 4 percent (less than one hour) for people age 65–74 and 1 percent (less than 30 minutes) for people age 75 and over.

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, 2006



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—about 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 10 percent) and relaxing and thinking (11 percent versus 7 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 10 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 115.

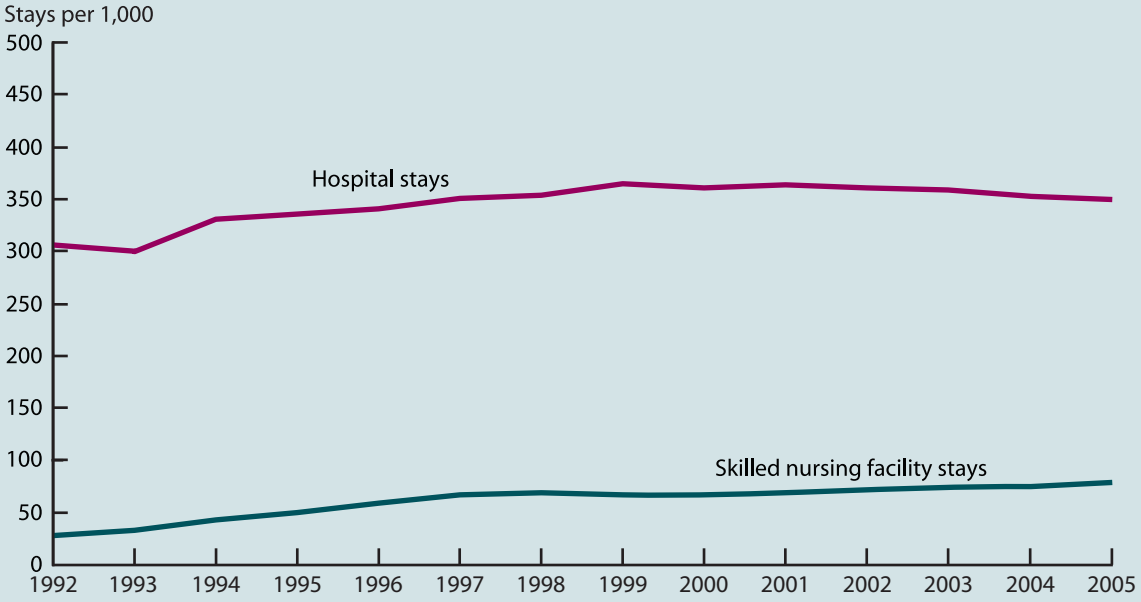
Health Care

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 policies, and patient demographics.

Medicare-covered hospital and skilled nursing facility stays per 1,000 Medicare enrollees age 65 and over in fee-for-service, 1992–2005

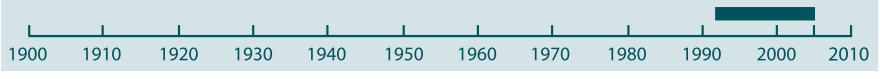


Note: Beginning in 1994, managed care enrollees were excluded from the denominator of all utilization rates because utilization data are not available for them. Prior to 1994, managed care enrollees were included in the denominators; they comprised 7 percent or less of the Medicare population.

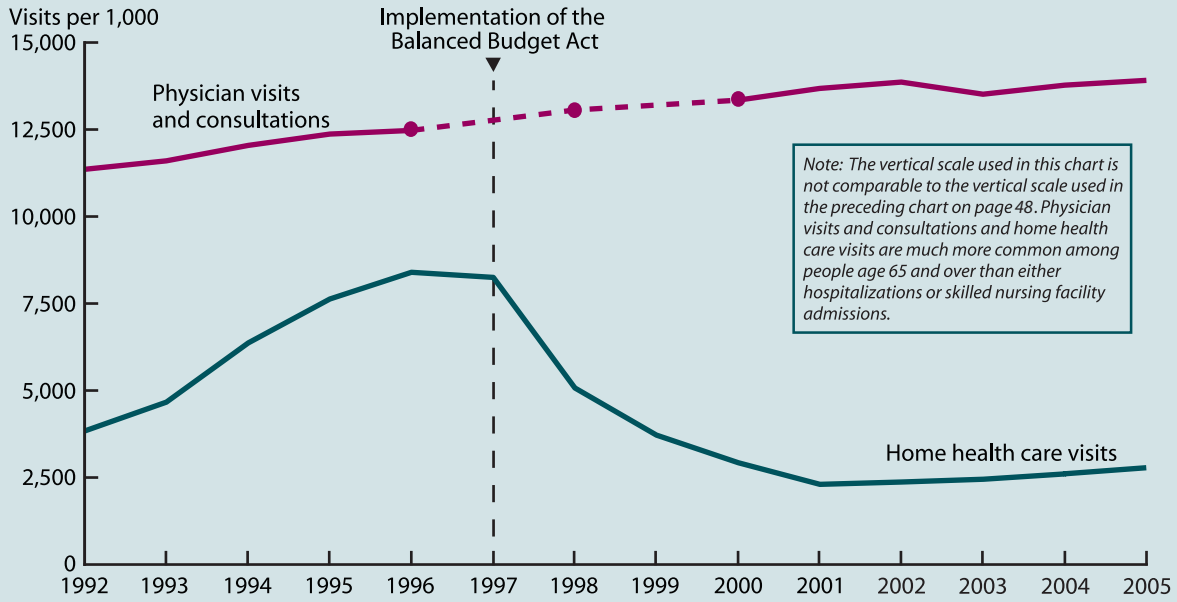
Reference population: These data refer to Medicare enrollees in fee-for-service.

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

- 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 350 per 1,000 enrollees in 2005. The average length of a hospital stay decreased from 8.4 days in 1992 to 5.7 days in 2005.
- Skilled nursing facility stays increased significantly from 28 per 1,000 Medicare enrollees in 1992 to 79 per 1,000 in 2005. Much of the increase occurred from 1992 to 1997.



Medicare-covered physician and home health care visits per 1,000 Medicare enrollees age 65 and over in fee-for-service, 1992–2005



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

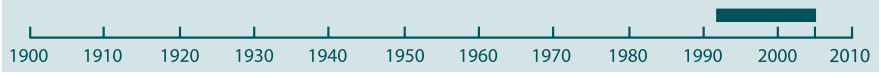
Note: Physician visits and consultations include all settings, such as physician offices, hospitals, emergency rooms, and nursing homes. The definition of physician visits and consultations changed beginning in 2003, resulting in a slightly lower rate. Beginning in 1994, managed care enrollees were excluded 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.

- 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 rapidly from 3,822 in 1992 to 8,227 in 1997. Home health care use increased during this period in part because of an expansion in the coverage criteria for the Medicare home health care benefit.[40] 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 2,770 per 1,000 enrollees in 2005.
- Use of skilled nursing facility and home health care increased markedly with age. In 2005, there were 30 skilled nursing facility stays per 1,000 Medicare enrollees age 65–74, compared with 228 per 1,000 enrollees age 85 or over. Home health agencies made 1,333 visits per 1,000 enrollees age 65–74, compared with 6,549 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 116.

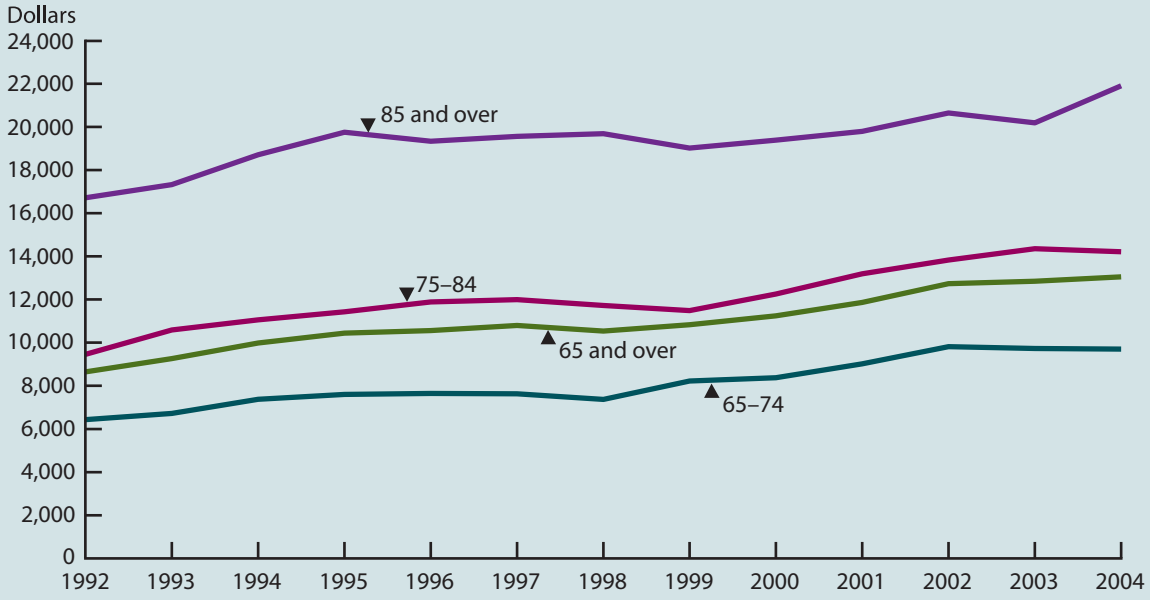


INDICATOR 30

Health Care Expenditures

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

Average annual health care costs for Medicare enrollees age 65 and over, in 2004 dollars, by age group, 1992–2004

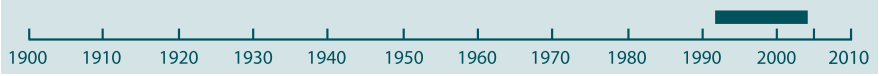


Note: Data include both out-of-pocket costs and costs covered by insurance. Dollars are inflation adjusted to 2004 using the Consumer Price Index (Series CPI-U-RS).

Reference population: These data refer to Medicare enrollees.

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

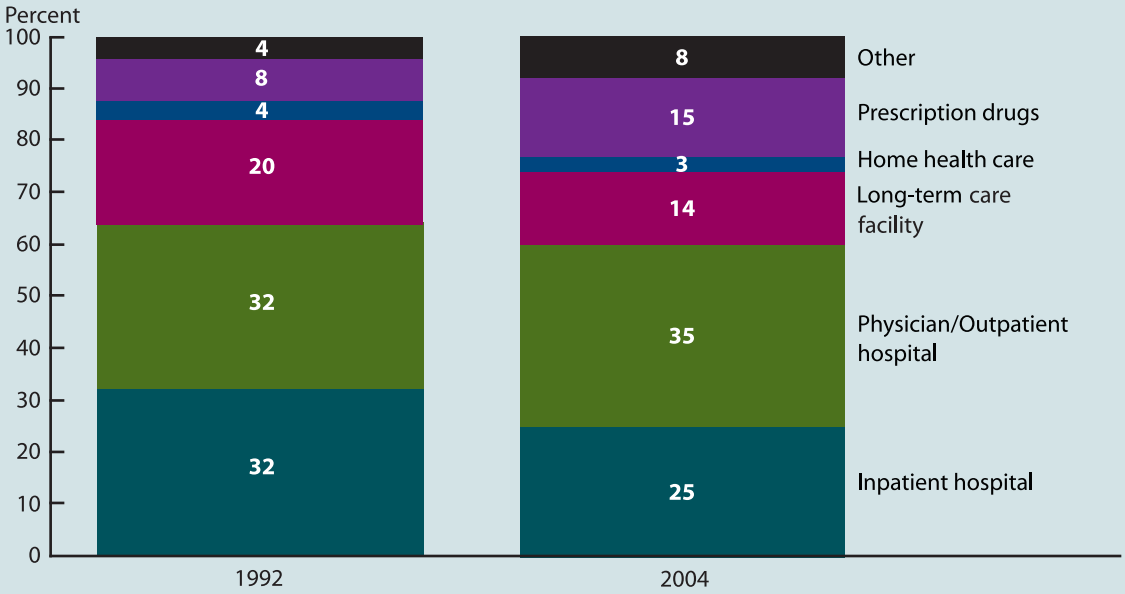
- After adjusting for inflation, health care costs increased significantly among older Americans from 1992 to 2004. Average costs were substantially higher at older ages.
- Average health care costs varied by demographic characteristics. Average costs among non-Hispanic blacks were $14,989 in 2004, compared with $13,101 among non-Hispanic whites and $11,962 among Hispanics. Low income individuals incurred higher health care costs; those with less than $10,000 in income averaged $16,766 in health care costs, whereas those with more than $30,000 in income averaged only $10,676.
- Costs also varied by health status. Individuals with no chronic conditions incurred $4,718 in health care costs on average. Those with five or more conditions incurred $20,334. Average costs among residents of long-term care facilities were $52,958, compared with only $10,448 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 2004



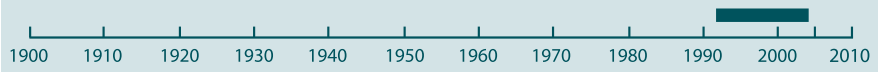
Note: Data include both out-of-pocket costs and costs covered by insurance. "Other" includes short-term institutions, hospice services, and dental care.

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 14 percent of total costs in 2004. Prescription drugs accounted for 15 percent of health care costs.
- The mix of health care services changed between 1992 and 2004. Inpatient hospital care accounted for a lower share of costs in 2004 (25 percent compared to 32 percent in 1992). Prescription drugs increased in importance from 8 percent of costs in 1992 to 15 percent in 2004. "Other" costs (short term institutions, hospice and dental care) also increased as a percentage of all costs (4 percent to 8 percent).
- The mix of services varied with age. The biggest difference occurred for long-term care facility services; average costs were $7,057 among people age 85 and over, compared with just $431 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 117–119.

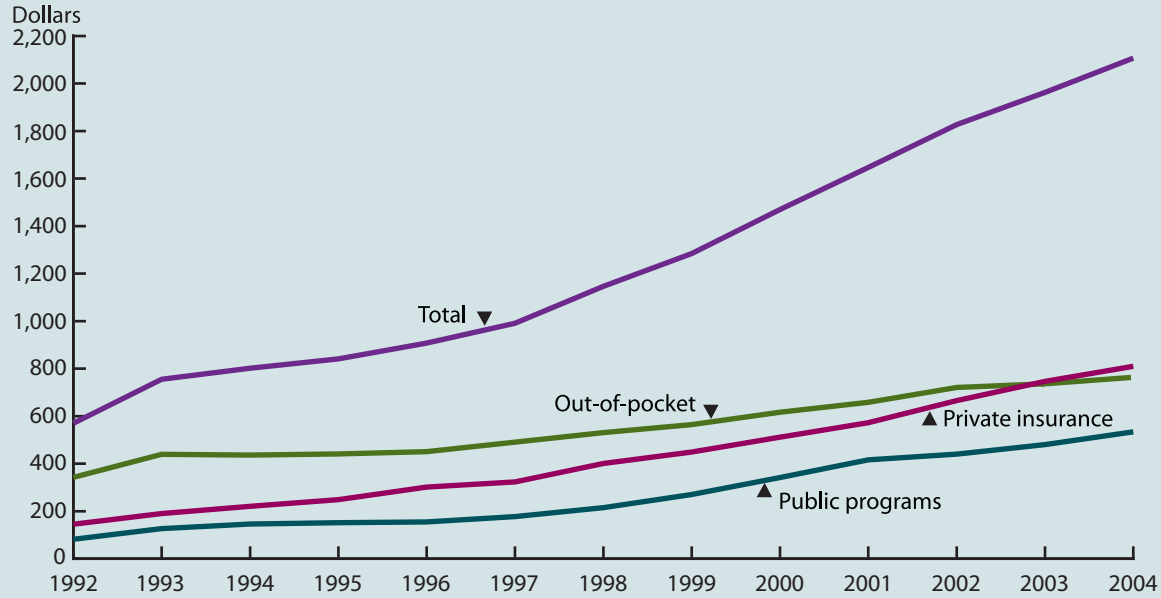


INDICATOR 31

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 and sources of payment among noninstitutionalized Medicare enrollees age 65 and over, 1992–2004

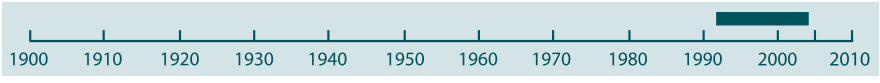


Note: Dollars have been inflation adjusted to 2004 using the Consumer Price Index (Series CPI-U-RS). Reported costs have been adjusted by a factor of 1.205 to account for underreporting of prescription drug use. Public programs include Medicare, Medicaid, Department of Veterans Affairs, and other State and Federal programs.

Reference population: These data refer to Medicare enrollees.

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

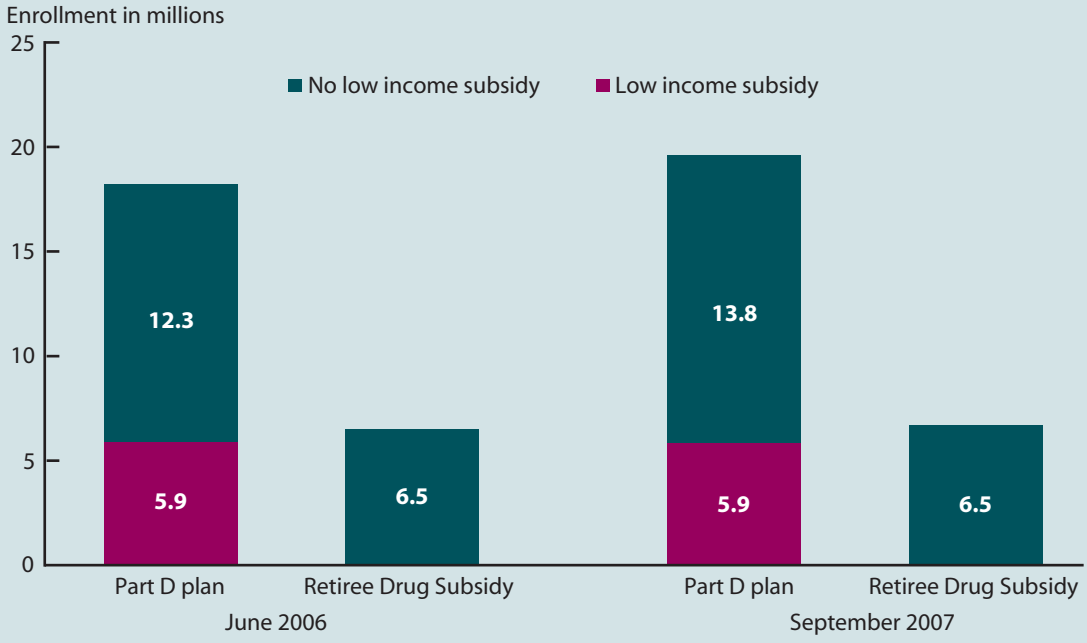
- Average prescription drug costs for older Americans have increased rapidly in recent years. Average costs per person were $2,107 in 2004.
- Average out-of-pocket costs also increased, though not as rapidly as total costs because private and public insurance covered more of the cost over time. Older 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

The purpose of this indicator is to provide a count of Medicare enrollees age 65 and over receiving drug coverage through Part D or in plans of former employers subsidized by Part D. Under Medicare Part D, beneficiaries may join a stand alone 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.

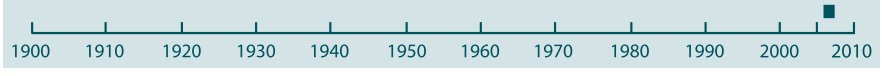
Number of Medicare enrollees age 65 and over who enrolled in a Part D prescription drug plan or were covered under the Retiree Drug Subsidy, June 2006 and September 2007



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

- The number of Medicare beneficiaries age 65 and over enrolled in Part D prescription drug plans increased from 18.2 million in June 2006 to 19.7 million in September 2007. In September 2007, two-thirds of enrollees were in stand-alone plans and one-third were in Medicare Advantage plans. In addition, approximately 6.5 million beneficiaries were covered by the Retiree Drug Subsidy in both years. 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, or current employer) or did not have drug coverage.
- In September 2007, 5.9 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 119–120.

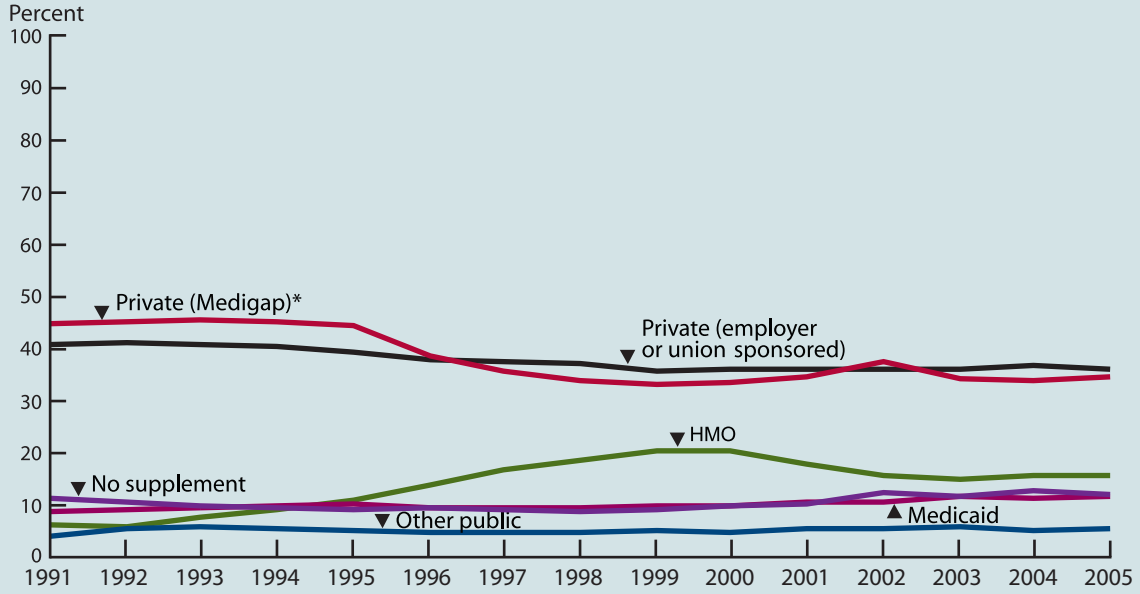


INDICATOR 32

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 one-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. Since January 2006, beneficiaries have had the option of receiving prescription drug coverage 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, 1991–2005



* Includes people with private supplement of unknown sponsorship.

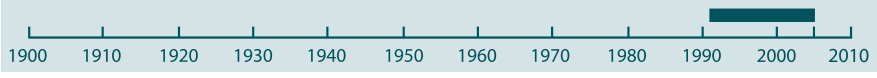
Note: HMO health plans include Health Maintenance Organizations (HMO), Preferred Provider Organizations (PPO), and private fee-for-service plans (PFFS). Not all types of plans were available in all years. Since 2003 these types of plans have been known collectively as Medicare Advantage. Estimates are 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; this is a change in methodology from that used in *Older Americans Update 2006* and produces different estimates for "Medicaid" and "No supplement" categories.

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 slightly over the last several years to about 12 percent in 2005. Enrollment in Medicare HMOs and similar health plans, which are usually equivalent to Medicare supplements because they offer extra benefits, varied between 6 percent and 21 percent. About 12 percent of Medicare enrollees report having no health insurance supplement.
- Enrollment in HMOs and similar health plans increased rapidly throughout the 1990s, then decreased beginning in 2000 as many HMOs withdrew from the Medicare program. The percent with Medigap policies decreased in the late 1990s as HMO enrollment increased. There was a slight increase in the percentage of Medicare enrollees without a supplement in 2002.

Data for this indicator's chart and bullets can be found in Tables 32a and 32b on pages 121–122.

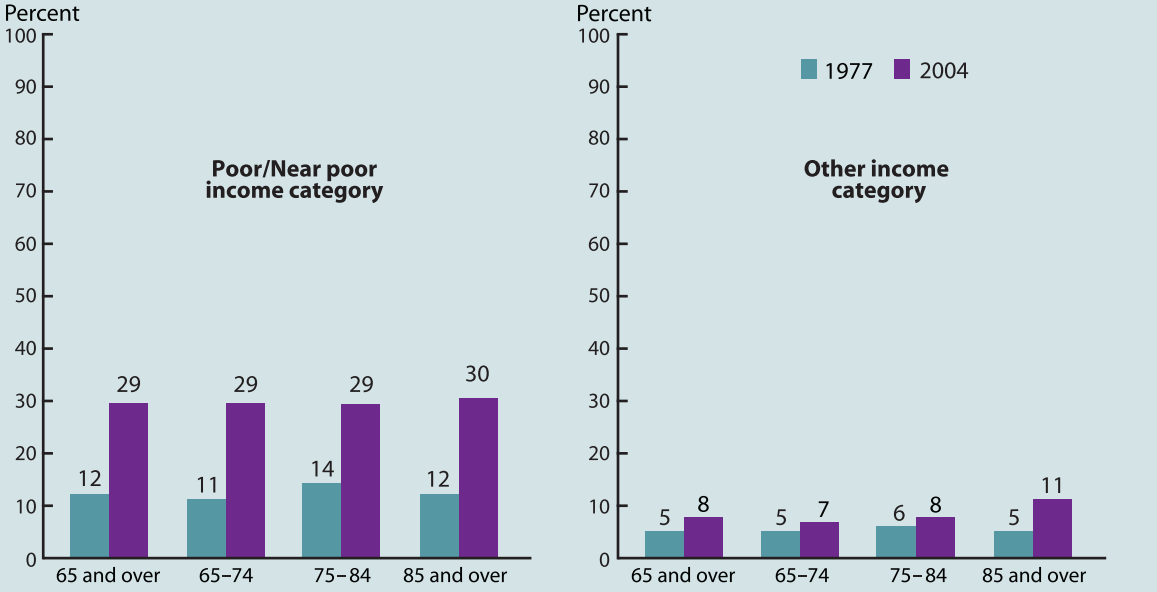


INDICATOR 33

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.[41,42] The percentage of household income that is allocated to health care expenditures is a measure of health care expense burden placed on older people.

Out-of-pocket health care expenditures as a percentage of household income, among people age 65 and over, by age and income category, 1977 and 2004



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 2004 (83 percent to 96 percent, respectively).
- From 1977 to 2004, 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 29 percent). Increases were also observed for those in poor or fair health, most notably among those age 85 and over (from 9 percent to 18 percent).
- In 2004, as in the 4 previous years, over one-half of out-of-pocket health care spending by people age 65 and over was used to purchase prescription drugs (from 54 percent in 2000 to 61 percent in 2004).
- In 2004, people age 85 and over were less likely than people age 65–74 to spend out-of-pocket dollars on dental services or office-based medical provider visits but more likely to spend out-of-pocket dollars on other health care (e.g., home health care and eyeglasses).

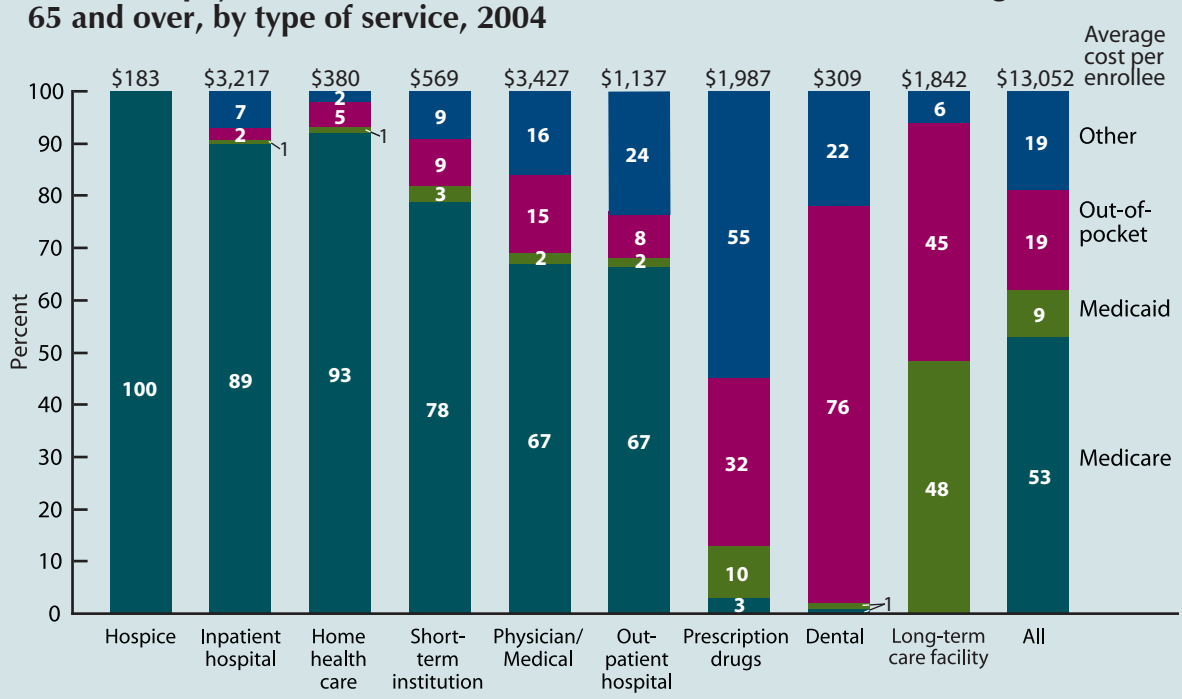
Data for this indicator's chart and bullets can be found in Tables 33a, 33b, and 33c on pages 122–124.

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, 2004



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 one-half (53 percent) of the health care costs of Medicare enrollees age 65 and over in 2004. 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 9 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 2004, 48 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. Fifty-five percent of prescription drug costs were covered by third party payers other than Medicare and Medicaid, consisting mostly of private insurers. Thirty-two percent of prescription drug costs were paid out-of-pocket. Seventy-six 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.

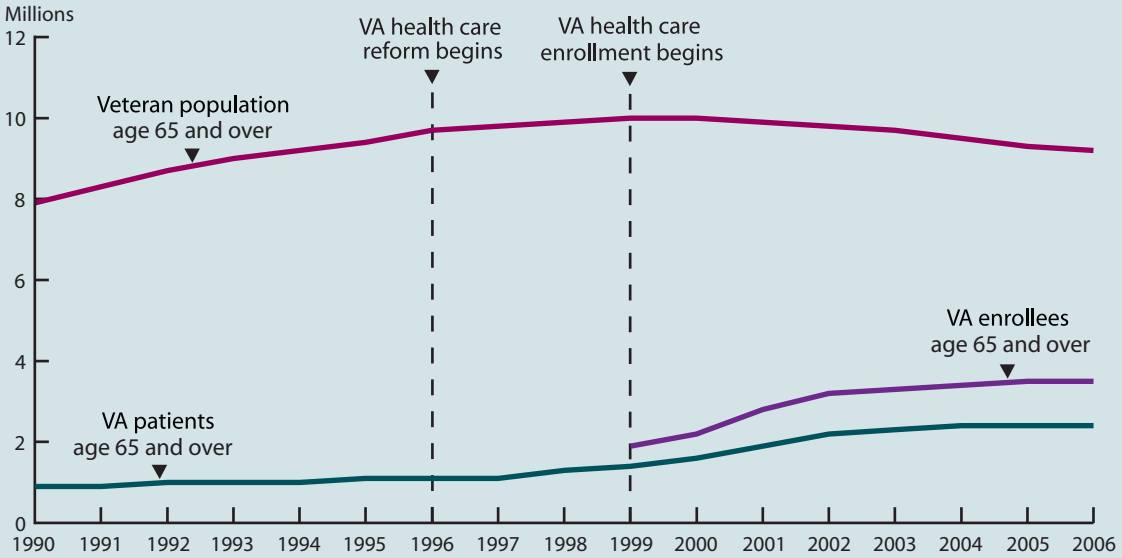
Data for this indicator's chart and bullets can be found in Tables 34a and 34b on page 125.

INDICATOR 35

Veterans' Health Care

The number of veterans age 65 and over who receive health care from the Veterans Health Administration (VHA) within the Department of Veterans Affairs 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.

Total number of veterans age 65 and over who are enrolled in or receiving care from the Veterans Health Administration, 1990–2006



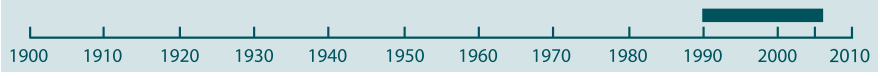
Note: Department of Veterans Affairs (VA) enrollees are veterans who have signed up to receive health care from the Veterans Health Administration (VHA). VA patients are veterans who have received care each year through VHA. Starting with 1999 data, the methods used to calculate VA patients differ from 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 2004 Version 1.0; Fiscal 2006 Year-end Office of the Assistant Deputy Under Secretary for Health for Policy and Planning Enrollment file linked with August 2007 VHA Vital Status data (including data from VHA, VA, Medicare, and SSA).

- In 2006, approximately 2.4 million veterans age 65 and over received health care from VHA. An additional 1.1 million older veterans were enrolled to receive health care from VHA but did not use its services in 2006.
- Reforms and initiatives implemented by 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 opening the system to all veterans (1996), implementing enrollment for VHA health care (1999), and enhancing availability of outpatient and community based care.
- An increasing number of older veterans are turning to VHA for their health care needs despite their potential eligibility for other sources of health care, most notably prescription drug coverage through Medicare. VHA estimates that 94 percent of its enrollees age 65 and over are covered by Medicare Part A, 74 percent by Medicare Part B, 51 percent by Medigap, 13 percent by Medicaid, 20 percent by private insurance (excluding Medigap), and 10 percent by TRICARE for Life. About 4 percent have no other public or private coverage.[43]

Data for this indicator's chart and bullets can be found in Table 35 on page 126.

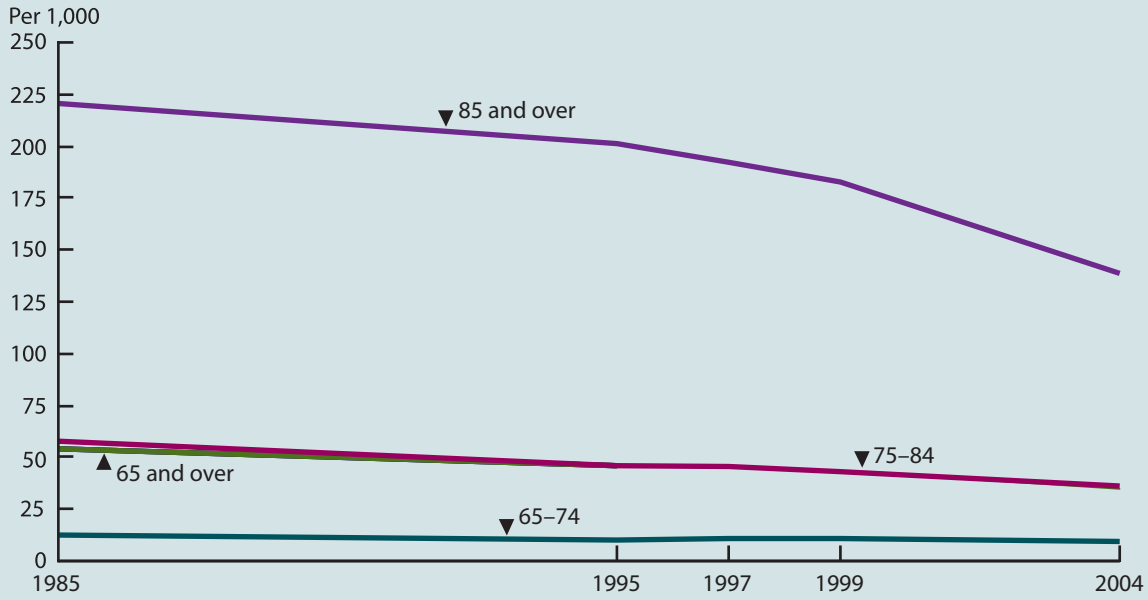


INDICATOR 36

Nursing Home Utilization

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

Rate of nursing home residence among people age 65 and over, by age group, selected years 1985–2004

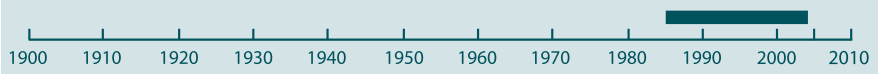


Note: Rates are calculated using estimates of the civilian population of the United States including institutionalized people. Population data are from unpublished tabulations provided by the U.S. Census Bureau. The 2004 population estimates are postcensal estimates as of July 1, 2004, based on Census 2000. For more information about the 2004 population estimates, see Kozak, DeFrances, and Hall.[44] Rates are age adjusted to the year 2000 population standard using the following three age groups: 65–74 years, 75–84 years, and 85 years and over. Residents are people on the roster of the nursing home as of the night before the survey. Residents for whom beds are maintained even though they may be away on overnight leave or in a hospital are included. People residing in personal care or domiciliary care homes are excluded.

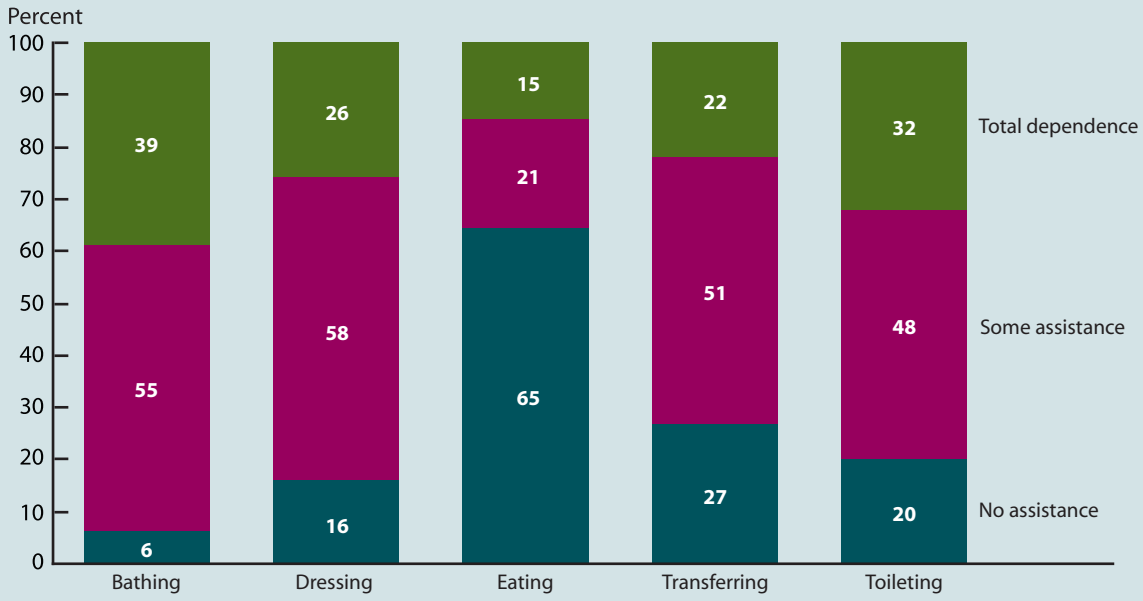
Reference population: These data refer to the resident population.

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

- In 2004, 9 people per 1,000 age 65–74 resided in nursing homes, compared with 36 people per 1,000 age 75–84 and 139 people per 1,000 age 85 and over.
- The total rate of nursing home residence among the older population declined between 1985 and 2004. In 1985, the age adjusted nursing home residence rate was 54 people per 1,000 age 65 and over. By 2004 this rate had declined to 35 people per 1,000. Among people age 65–74, rates declined by 24 percent, compared with a 37 percent decline among people age 75–84 and age 85 and over.
- Despite the decline in rates of nursing home residence, the number of nursing home residents age 65 and over had been increasing until recently because of the rapid growth of the older population. Between 1985 and 1999, the number of current nursing home residents age 65 and over increased from 1.3 million to 1.5 million but then declined to 1.3 million in 2004. In 2004, almost three-fourths (980,000) of older nursing home residents were women.



Percentage of nursing home residents age 65 and over, by amount of assistance with activities of daily living (ADLs), 2004



Note: Residents are people on the roster of the nursing home as of the night before the survey. Residents for whom beds are maintained even though they may be away on overnight leave or in a hospital are included. People residing in personal care or domiciliary care homes are excluded. Excludes residents for whom activities did not occur and unknowns. ADL self-performance is ascertained for residents' performance over all shifts during the last 7 days, not including setup of the activity. No assistance includes people who were coded as independent (no help or oversight –or– help/oversight provided only 1 or 2 times during last 7 days) or receiving supervision (oversight, encouragement or cueing provided 3 or more times during last 7 days). Some assistance includes people who were coded as limited assistance (resident highly involved in activity; received physical help in guided maneuvering of limbs or other nonweight bearing assistance 3 or more times –or– more help provided only 1 or 2 times during last 7 days) or extensive assistance (while resident performed part of activity, over last 7 day period, help of following type(s) provided 3 or more times: a) weight-bearing support and/or b) full staff performance during part (but not all) of last 7 days). Total dependence includes people who were coded as full staff performance of activity during entire 7 days.

Reference population: These data refer to the population residing in nursing homes.

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

- In 2004, the majority of nursing home residents age 65 and over received assistance with at least one activity of daily living (ADL). Levels of assistance provided for individual ADLs were high, from 94 percent for bathing to 73 percent for transferring. The only ADL for which the majority of residents received no assistance (65 percent) was eating.
- Among the nursing home population, women were more likely than men to require full assistance with daily activities. The percentage of women who were totally dependent in any one of the five activities was higher than that for men. Conversely, men were more likely to receive no assistance with daily activities.
- Older white nursing home residents were less likely than black residents or residents of other races to be dependent in daily activities. For example, nearly one-half of all black and other race residents were dependent in bathing, 46 percent for both, while 37 percent of white residents required total assistance. White residents were more likely to receive some intermediate level of assistance.

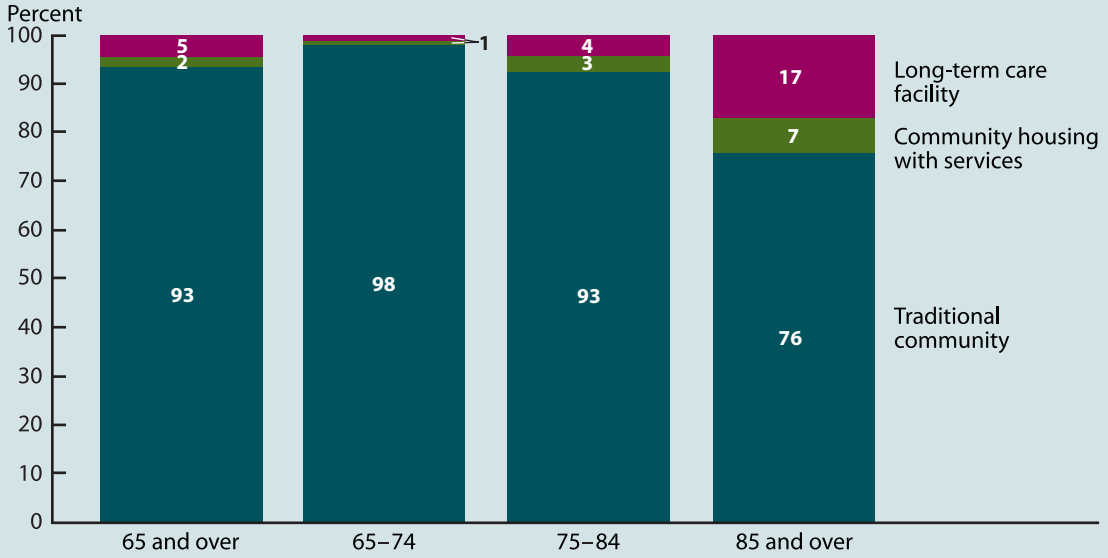
Data for this indicator's charts and bullets can be found in Tables 36a, 36b, and 36c on pages 127–129.

INDICATOR 37

Residential Services

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

Percentage of Medicare enrollees age 65 and over residing in selected residential settings, by age group, 2005



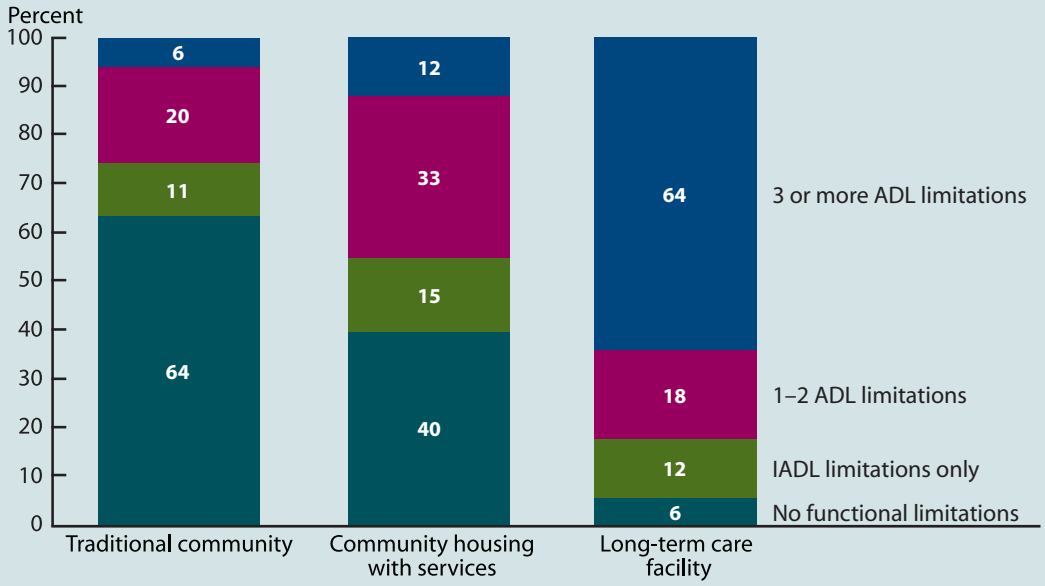
Note: Community housing with services applies to respondents who reported they lived in retirement communities or apartments, senior citizen housing, continuing care retirement facilities, assisted living facilities, staged living communities, board and care facilities/homes, and other similar situations, 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, or 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; 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 non-family, paid caregiver.

Reference population: These data refer to Medicare enrollees.

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

- In 2005, 2 percent of the Medicare population aged 65 and over resided in community housing with at least one service available. Approximately 5 percent resided in long-term care facilities. The percentage of people residing in community housing with services and in long-term care facilities was higher for the older age groups; among individuals age 85 and over, 7 percent resided in community housing with services, and 17 percent resided in long-term care facilities. Among individuals age 65–74, 98 percent resided in traditional community settings.
- Among residents of community housing with services, 86 percent reported access to meal preparation services, 82 percent reported access to housekeeping/cleaning services, 70 percent reported access to laundry services, and 45 percent reported access to help with medications. These numbers reflect percentages reporting availability of specific services, but not necessarily the number that actually used these services.
- More than one-half (54 percent) of residents in community housing with services reported that there were separate charges for at least some services.

Percentage of Medicare enrollees age 65 and over with functional limitations, by residential setting, 2005



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, or 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; 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 non-family, paid caregiver. Activities of Daily Living (ADLs) 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. Instrumental Activities of Daily Living (IADLs) 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. 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 26 percent of traditional community residents. Among long-term care facility residents, 82 percent had at least one ADL limitation. Forty 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 (see "Indicator 36: Nursing Home Utilization").
- Residents of community housing with services tended to have slightly lower incomes than traditional community residents, but higher incomes than long-term care facility residents. Twenty-two percent of residents of community housing with services had incomes of $10,000 or less in 2005, compared with 15 percent of traditional community residents and 40 percent of long-term care facility residents.
- Over one-half (52 percent) of people living in community housing with services reported they could continue living there if they needed substantial care.

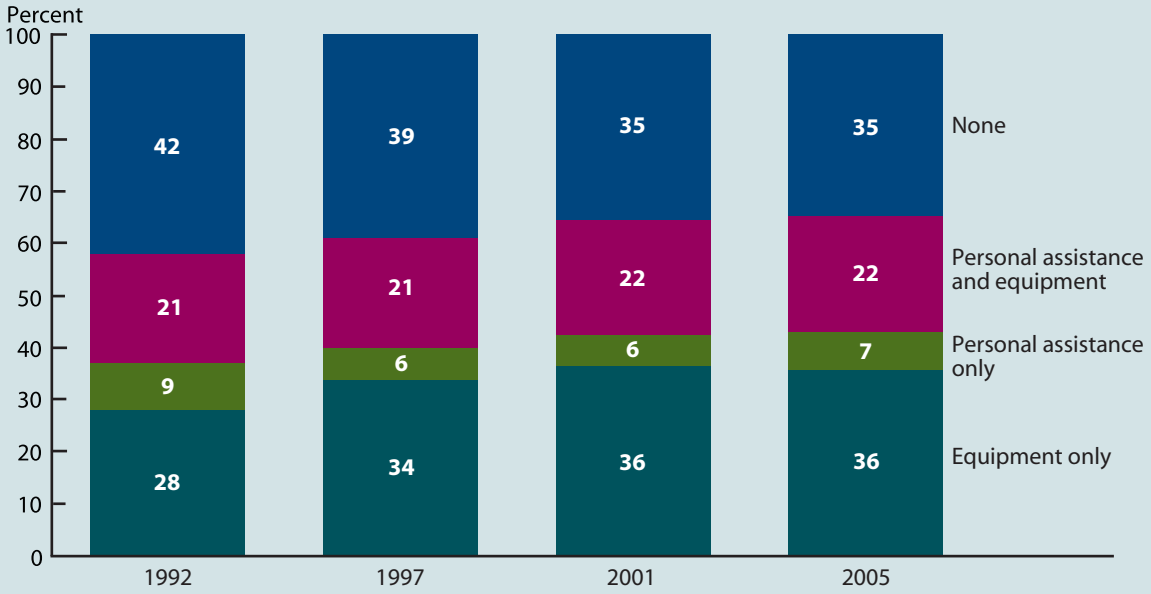
Data for this indicator's charts and bullets can be found in Tables 37a, 37b, 37c, 37d, and 37e on pages 130–132.

INDICATOR 38

Personal Assistance and Equipment

Possible reasons for the decline in nursing home rates (see "Indicator 36: Nursing Home Utilization") include improvements in the health and functioning of the older population, changes in household living arrangements (e.g., the move toward assisted living and other residential care alternatives), and greater use of personal assistance and/or special equipment that help older people living in the community maintain their independence.

Distribution of noninstitutionalized Medicare enrollees age 65 and over who have limitations in activities of daily living (ADLs), by type of assistance, selected years 1992–2005

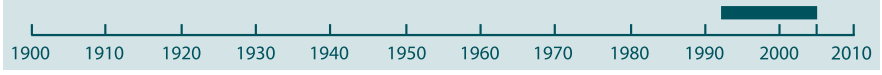


Note: The Medicare Current Beneficiary Survey has replaced the National Long Term Care Survey as the data source for this indicator. Consequently, the measurement of personal assistance and equipment has changed from previous editions of *Older Americans*. ADL limitations refer to difficulty performing (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 chart, 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 2005, 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 35 percent. More people are using equipment only—the percentage increased from 28 percent to 36 percent. The percentage of people who used personal assistance only decreased from 9 percent to 7 percent.
- In 2005, nearly two-thirds (65 percent) of people who had difficulty with one or more ADLs received personal assistance or used special equipment: 7 percent received personal assistance only, 36 percent used equipment only, and 22 percent used both personal assistance and equipment.



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 1992–2005

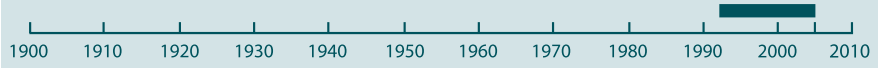
Note: The Medicare Current Beneficiary Survey has replaced the National Long Term Care Survey as the data source for this indicator. Consequently, the measurement of personal assistance has changed from previous editions of *Older Americans*. IADL limitations refer to difficulty performing (or inability 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 chart, 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 2005, more than three-fifths 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 (74 percent) than it was for people age 75–84 (67 percent) or people age 65–74 (63 percent).
- There was no significant change between 1992 and 2005 in the percentage of people (in any age group) who had difficulty with one or more IADLs and who received personal assistance. Men and women were equally likely to receive assistance.

Data for this indicator's charts and bullets can be found in Tables 38a and 38b on page 132.

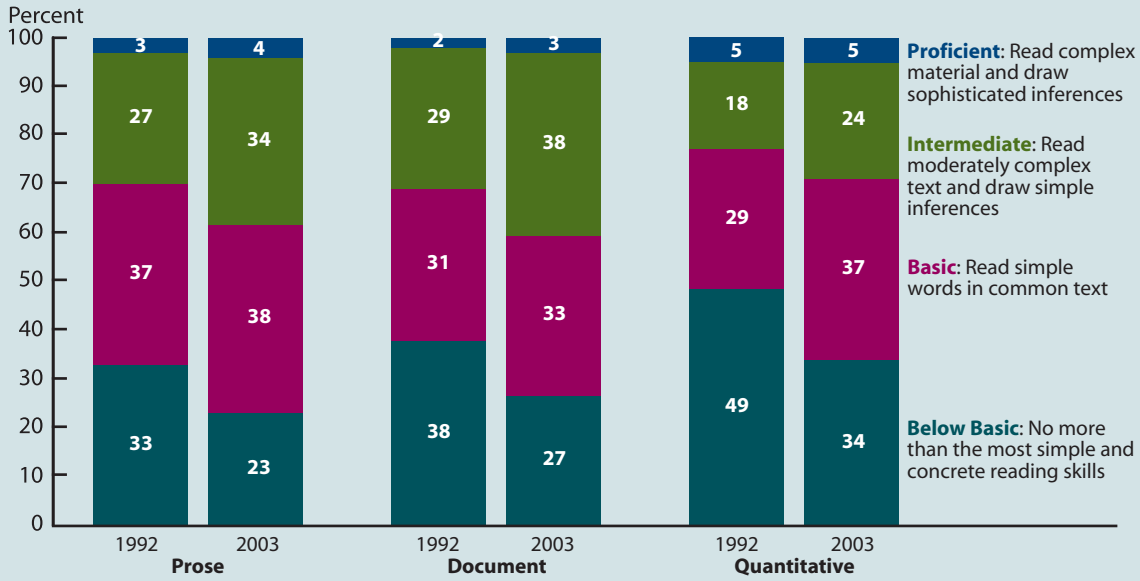


SPECIAL FEATURE

Literacy

Literacy is an important skill that enables people to communicate and function in society.[45] Everyday tasks such as reading a newspaper, balancing a checkbook, or applying for a job require an adequate level of literacy.

Percentage of people age 65 and over in each literacy performance level, by literacy component, 1992 and 2003

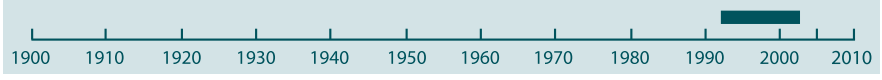


Note: Literacy is measured using three different components: prose literacy is the ability to search, comprehend, and use information from continuous texts (e.g., reading a newspaper); document literacy is the ability to search, comprehend, and use information from noncontinuous text (e.g., bus schedules); and quantitative literacy is the ability to identify and perform computations using numbers embedded in printed materials (e.g., calculating numbers in tax forms).

Reference population: These data refer to people residing in households or prisons.

Source: U.S. Department of Education, National Center for Education Statistics, National Assessment of Adult Literacy.

- The majority of older Americans face literacy challenges. In 2003, 60 percent of people age 65 and over had below basic or basic document and prose literacy, and 71 percent had below basic or basic quantitative literacy. Only 3 percent to 5 percent of older Americans had proficient literacy in any component.
- Between 1992 and 2003, the percentage of older Americans that had below basic prose, document, and quantitative literacy decreased significantly, from 33 percent to 23 percent for prose, from 38 percent to 27 percent for document, and from 49 percent to 34 percent for quantitative.

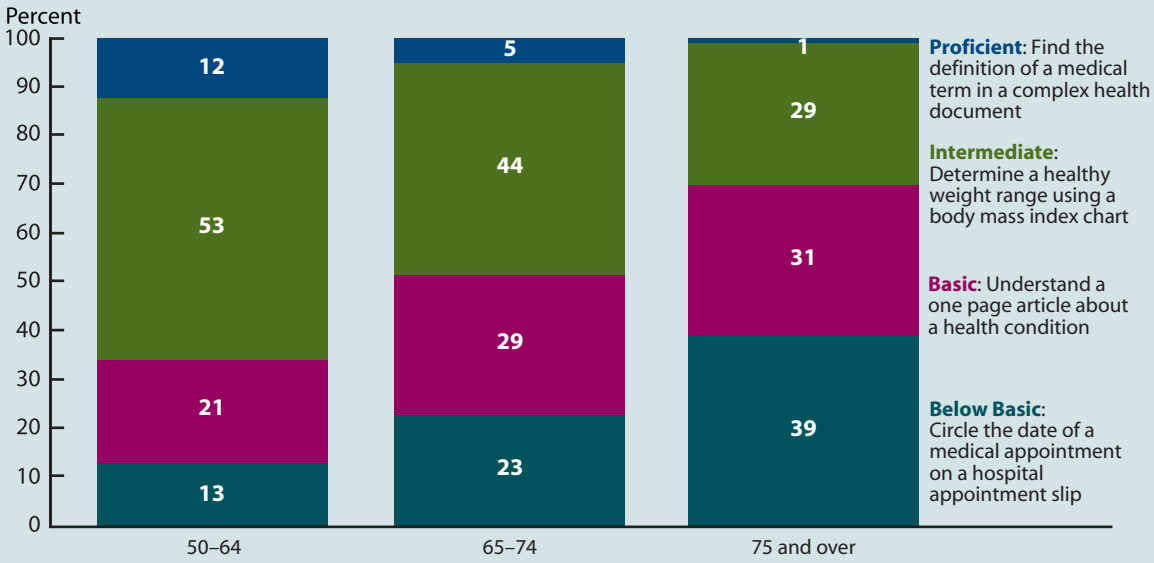


SPECIAL FEATURE

Health Literacy

Health literacy is the degree to which people have the capacity to obtain, process, and understand basic health information and services needed to make appropriate health decisions.[46-48] Adhering to prescription instructions, filling out a patient information form, or giving informed consent are specific tasks that require more than just an adequate level of literacy—they require an adequate level of health literacy.

Percentage of people age 50 and over in each health literacy performance level, by age group, 2003



Note: Health literacy is the ability to locate and understand health-related information and services and requires skills represented in the three general components defined on the previous page—prose, document, and quantitative literacy. Tasks used to measure health literacy were organized around three domains of health and health care information and services—clinical, prevention, and navigation of the health care system—and mapped to the performance levels (proficient, intermediate, basic, and below basic) based on their level of difficulty.

Reference population: These data refer to people residing in households or prisons.

Source: U.S. Department of Education, National Center for Education Statistics, National Assessment of Adult Literacy.

- Older adults are proportionately more likely to have below basic health literacy than any other age group. Almost two-fifths (39 percent) of people age 75 and over have a health literacy level of below basic compared with 23 percent of people age 65–74 and 13 percent of people age 50–64.
- Current levels of health literacy among people age 50-64 suggest fewer people 65 and over will have below basic levels of health literacy. This is important because poor health literacy is associated with cognitive decline among those age 80 and over, a group that is increasing in size.[49]

Data for this Special Feature's charts and bullets can be found in Special Feature Tables on page 133.

Data Needs

In *Older Americans 2004*, the Federal Interagency Forum on Aging-Related Statistics (Forum) identified 12 areas where more data were needed to support research and policy efforts. These areas included substantive topics as well as improved data collection methods and reporting. In this report, the Forum decided to focus the "Data Needs" section more narrowly on topics that could become new indicators, or improve existing indicators, if more or better data were available. The following six topics have been identified by the Forum as priority areas for indicator development: caregiving, elder abuse, functional limitations and disability, mental health, pension measures, and residential care. Either more national data are needed on the topic or there has been difficulty reaching consensus on relevant definitions and measurements.

Caregiving

There is growing recognition that family caregivers of older people with disabilities and/or moderate to severe cognitive impairment are under considerable strain. It is primarily informal (unpaid) family caregivers who provide the assistance that enables the great majority of chronically disabled older people to continue to live in the community rather than in specialized care facilities. It has been estimated that the annual economic value of informal eldercare exceeds national spending on formal (paid) care.[50] Disabled older people at risk of nursing home placement typically require at least 50 hours per week of personal assistance with functional activities.[51] Data are needed so that it will be possible to monitor the amount and sources of informal caregiving.

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.[52] There are no reliable national estimates of elder abuse, nor are the risk factors clearly understood. 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.

Functional Limitations 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 complex interactions with the environment. Furthermore, specific definitions of disability are used by some government agencies to determine eligibility for benefits. As a result, disability is often measured in different ways across surveys and censuses, 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. 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. Longitudinal data that can be used to monitor changes in patterns and in transitions in functional status are also needed.

Mental Health

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. There is also a need for more data and better measurement of the incidence and prevalence of Alzheimer's disease and other causes of dementia. Despite interest and increased efforts to track all of these disorders among older adults, obtaining national estimates has proven to be difficult. Research is underway to address the challenges in developing indicators of cognitive and mental health.

Pension Measures

As pension plans shift away from defined-benefit pensions and annuities to defined-contribution plans, irregular payments will become more important to older people's income. In the future, improved data measuring withdrawals

of money from these retirement investment accounts (deferred earned income in IRAs and 401ks) will lead to improved measurement of income and poverty for people age 65 and over.

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, we have little national data on the number and characteristics of facilities and the people living in these settings. Federal agencies associated with the Federal Interagency Forum on Aging-Related Statistics are therefore working together to design a new survey to obtain these estimates.

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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 1900–2006 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
Projections		
2010	40.2	6.1
2020	54.6	7.3
2030	71.5	9.6
2040	80.0	15.4
2050	86.7	20.9

Reference population: These data refer to the resident population.

Source: U.S. Census Bureau, 1900 to 1940, 1970, and 1980, U.S. Census Bureau, 1983, Table 42; 1950, U.S. Census Bureau, 1953, Table 38; 1960, U.S. Census Bureau, 1964, Table 155; 1990, U.S. Census Bureau, 1991, 1990 Summary Table File 1; 2000, U.S. Census Bureau, 2001, Census 2000 Summary File 1; Table 1: Estimates of the population by selected age groups for the United States and for Puerto Rico: July 1, 2006 (SC-EST2006-1); 2010 to 2050, International Programs Center, International Data Base, 2007.

Table 1b. Percentage of the population age 65 and over and 85 and over, selected years 1900–2006 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
Projections		
2010	13.0	2.0
2020	16.3	2.2
2030	19.6	2.6
2040	20.4	3.9
2050	20.6	5.0

Reference population: These data refer to the resident population.

Source: U.S. Census Bureau, 1900 to 1940, 1970, and 1980, U.S. Census Bureau, 1983, Table 42; 1950, U.S. Census Bureau, 1953, Table 38; 1960, U.S. Census Bureau, 1964, Table 155; 1990, U.S. Census Bureau, 1991, 1990 Summary Table File 1; 2000, U.S. Census Bureau, 2001, Census 2000 Summary File 1; Table 1: Estimates of the population by selected age groups for the United States and for Puerto Rico: July 1, 2006 (SC-EST2006-1); 2010 to 2050, International Programs Center, International Data Base, 2007.

Table 1c. Population of countries or areas with at least 10 percent of their population age 65 and over, 2006

	Population (number in thousands)		Percent
Country or Area	Total	65 and over	65 and over
Japan	127,515	25,954	20.4
Italy	58,134	11,450	19.7
Germany	82,422	16,018	19.4
Greece	10,688	2,027	19.0
Spain	40,398	7,170	17.7
Sweden	9,017	1,588	17.6
Belgium	10,379	1,809	17.4
Bulgaria	7,385	1,279	17.3
Estonia	1,324	228	17.2
Portugal	10,606	1,822	17.2
Austria	8,193	1,401	17.1
Croatia	4,495	754	16.8
Georgia	4,661	768	16.5
Latvia	2,275	373	16.4
Ukraine	46,620	7,628	16.4
Finland	5,231	846	16.2
France	63,329	10,238	16.2
United Kingdom	60,609	9,564	15.8
Slovenia	2,010	315	15.7
Switzerland	7,524	1,171	15.6
Lithuania	3,586	554	15.5
Denmark	5,451	828	15.2
Hungary	9,981	1,518	15.2
Serbia	10,140	1,544	15.2
Belarus	9,766	1,462	15.0
Norway	4,611	683	14.8
Romania	22,304	3,275	14.7
Luxembourg	474	69	14.6
Czech Republic	10,235	1,481	14.5
Bosnia and Herzegovina	4,499	647	14.4
Netherlands	16,491	2,349	14.2
Russia	142,069	20,196	14.2
Malta	400	55	13.7
Montenegro	692	95	13.7
Canada	33,099	4,407	13.3
Poland	38,537	5,128	13.3
Uruguay	3,443	454	13.2
Australia	20,264	2,649	13.1
Hong Kong S.A.R.	6,940	890	12.8
Puerto Rico	3,928	504	12.8
United States	298,444	37,196	12.5
Slovakia	5,439	653	12.0
New Zealand	4,076	481	11.8
Iceland	299	35	11.7
Cyprus	784	91	11.6
Ireland	4,062	470	11.6
Virgin Islands (U.S.)	109	12	11.2
Armenia	2,976	332	11.1
Macedonia	2,051	225	11.0
Moldova	4,334	465	10.7
Argentina	39,922	4,244	10.6
Cuba	11,362	1,181	10.4
Taiwan	22,782	2,279	10.0

Note: Table excludes countries and areas with less than 100,000 population.
Source: U.S. Census Bureau, International Data Base, 2007.

INDICATOR 1 Number of Older Americans continued

Table 1d. Percentage of the population age 65 and over, by State, July 1, 2006

State (Ranked alphabetically)	*Percent*	*State (Ranked by percentage)*	*Percent*
United States	12.4	United States	12.4
Alabama	13.4	Florida	16.8
Alaska	6.8	West Virginia	15.3
Arizona	12.8	Pennsylvania	15.2
Arkansas	13.9	North Dakota	14.6
California	10.8	Iowa	14.6
Colorado	10.0	Maine	14.6
Connecticut	13.4	South Dakota	14.2
Delaware	13.4	Rhode Island	13.9
District of Columbia	12.3	Arkansas	13.9
Florida	16.8	Montana	13.8
Georgia	9.7	Hawaii	14.0
Hawaii	14.0	Connecticut	13.4
Idaho	11.5	Nebraska	13.3
Illinois	12.0	Missouri	13.3
Indiana	12.4	Massachusetts	13.3
Iowa	14.6	Ohio	13.3
Kansas	12.9	Delaware	13.4
Kentucky	12.8	Oklahoma	13.2
Louisiana	12.2	Alabama	13.4
Maine	14.6	Vermont	13.3
Maryland	11.6	New York	13.1
Massachusetts	13.3	Kansas	12.9
Michigan	12.5	New Jersey	12.9
Minnesota	12.1	Wisconsin	13.0
Mississippi	12.4	Oregon	12.9
Missouri	13.3	Arizona	12.8
Montana	13.8	Kentucky	12.8
Nebraska	13.3	Tennessee	12.7
Nevada	11.1	South Carolina	12.8
New Hampshire	12.4	New Hampshire	12.4
New Jersey	12.9	Indiana	12.4
New Mexico	12.4	Michigan	12.5
New York	13.1	Mississippi	12.4
North Carolina	12.2	New Mexico	12.4
North Dakota	14.6	District of Columbia	12.3
Ohio	13.3	Wyoming	12.2
Oklahoma	13.2	North Carolina	12.2
Oregon	12.9	Minnesota	12.1
Pennsylvania	15.2	Illinois	12.0
Rhode Island	13.9	Louisiana	12.2
South Carolina	12.8	Idaho	11.5
South Dakota	14.2	Maryland	11.6
Tennessee	12.7	Washington	11.5
Texas	9.9	Virginia	11.6
Utah	8.8	Nevada	11.1
Vermont	13.3	California	10.8
Virginia	11.6	Colorado	10.0
Washington	11.5	Texas	9.9
West Virginia	15.3	Georgia	9.7
Wisconsin	13.0	Utah	8.8
Wyoming	12.2	Alaska	6.8

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, 2006 (SC-EST2006-01).

INDICATOR 1 Number of Older Americans continued

Table 1e. Percentage of the population age 65 and over, by county, 2006

Source: U.S. Census Bureau, July 1, 2006 Population Estimates.

Data for this table can be found at www.agingstats.gov.

Table 1f. Number and percentage of people age 65 and over and 85 and over, by sex, 2006

	Millions	Percent
65 and over		
Total	37,260,352	100.0
Men	15,656,876	42.0
Women	21,603,476	58.0
85 and over		
Total	5,296,817	100.0
Men	1,688,278	31.9
Women	3,608,539	68.1

Reference population: These data refer to the resident population.
Source: U.S. Census Bureau, Population Division, Table 2: Annual estimates of the population by selected age groups and sex for the United States: April 1, 2000 to July 1, 2006 (NC-EST2006-02).

INDICATOR 2 Racial and Ethnic Composition

Table 2. Population age 65 and over, by race and Hispanic origin, 2006 and projected 2050

Race and Hispanic origin	*2006 estimates*		*2050 projections*	
	Number	Percent	Number	Percent
Total	37,260,352	100.0	86,705,637	100.0
Non-Hispanic white alone	30,187,588	80.8	53,159,961	61.3
Black alone	3,167,986	8.5	10,401,575	12.0
Asian alone	1,176,599	3.2	6,776,033	7.8
All other races alone or in combination	413,355	1.1	2,328,390	2.7
Hispanic (of any race)	2,399,320	6.4	15,178,025	17.5

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

Reference population: These data refer to the resident population.

Source: U.S. Census Bureau, Population Estimates and Projections, 2006.

INDICATOR 3 Marital Status

Table 3. Marital status of the population age 65 and over, by age group and sex, 2007

Selected characteristic	*65 and over*	*65–74*	*75–84*	*85 and over*
		Percent		
Both sexes				
Married	57.7	66.8	52.7	30.6
Widowed	29.7	17.7	37.5	62.1
Divorced	8.7	11.4	6.4	3.6
Never married	3.9	4.1	3.5	3.7
Men				
Married	75.3	78.4	74.1	60.4
Widowed	13.1	7.7	16.6	34.2
Divorced	7.5	9.6	5.5	2.4
Never married	4.0	4.3	3.9	3.0
Women				
Married	44.5	56.9	37.8	15.4
Widowed	42.2	26.1	52.0	76.2
Divorced	9.6	13.0	7.0	4.2
Never married	3.7	4.0	3.2	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.

INDICATOR 4 Educational Attainment

Table 4a. Educational attainment of the population age 65 and over, selected years 1965–2007

Educational attainment	*1965*	*1970*	*1975*	*1980*	*1985*	*1990*	*1995*	*2000*	*2001*	*2002*	*2003*	*2004*	*2005*	*2006*	*2007*
								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
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

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.

Table 4b. Educational attainment of the population age 65 and over, by sex and race and Hispanic origin, 2007

Race and Hispanic origin	*High school graduate or more*	*Bachelor's degree or more*
	Percent	
Both sexes	76.1	19.2
Non-Hispanic white alone	81.1	20.5
Black alone	57.5	10.3
Asian alone	71.7	31.6
Hispanic (of any race)	42.2	9.0
Men	76.4	24.7
Women	75.9	15.0

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

INDICATOR 5 Living Arrangements

Table 5a. Living arrangements of the population age 65 and over, by sex and race and Hispanic origin, 2007

Selected characteristic	*With spouse*	*With other relatives*	*With nonrelatives*	*Alone*
		Percent		
Men				
Total	72.8	5.4	2.8	19.0
Non-Hispanic white alone	74.5	3.9	2.7	18.9
Black alone	57.4	10.1	3.7	28.8
Asian alone	83.7	6.3	2.4	7.7
Hispanic (of any race)	65.4	16.9	3.0	14.7
Women				
Total	42.2	17.2	2.0	38.6
Non-Hispanic white alone	44.3	13.5	2.0	40.3
Black alone	25.2	32.3	2.2	40.3
Asian alone	46.8	30.1	3.1	20.0
Hispanic (of any race)	38.8	33.4	2.1	25.8

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

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

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

Table 5b. Population age 65 and over living alone, by age group and sex, selected years 1970–2007

	Men		*Women*	
Year	*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

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

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

INDICATOR 6 Older Veterans

Table 6a. Percentage of people age 65 and over who are veterans, by sex and age group, United States and Puerto Rico,1990, 2000, and projected 2010

Year	65 and over		65–74		75–84		85 and over	
	Men	Women	Men	Women	Men	Women	Men	Women
	Percent							
Estimates								
1990	54.2	1.8	69.7	2.5	30.0	0.9	16.6	0.6
2000	64.3	1.7	65.2	1.1	70.9	2.7	32.6	1.0
Projections								
2010	49.8	1.3	42.0	1.0	60.6	1.1	59.6	2.3

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, VetPop2004.

Table 6b. Estimated and projected number of veterans age 65 and over, by sex and age group, United States and Puerto Rico, 1990, 2000, and projected 2010

	Estimates		Projections
	1990	2000	2010
	Number in thousands		
65 and over			
Total	7,312	9,723	8,889
Men	6,984	9,374	8,591
Women	328	349	298
65–74			
Total	5,954	5,628	4,300
Men	5,700	5,516	4,178
Women	254	112	121
75–84			
Total	1,195	3,667	3,322
Men	1,135	3,460	3,240
Women	60	207	81
85 and over			
Total	163	427	1,268
Men	150	398	1,173
Women	14	30	95

Reference population: These data refer to the resident population of the United States and Puerto Rico.
Source: Department of Veterans Affairs, VetPop2001 and VetPop2004.

INDICATOR 7 Poverty

Table 7a. Percentage of the population living in poverty, by age group, 1959–2006

Year	65 and over	Under 18	18–64	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	17.7	10.8	9.0	11.0	13.8
2004	9.8	17.8	11.3	9.3	9.7	12.5
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

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, 1960–2007.

INDICATOR 7 Poverty continued

Table 7b. Percentage of the population age 65 and over living in poverty, by selected characteristics, 2006

Selected characteristic	*65 and over*	*65 and over, living alone*	*65 and over, married couples*	*65–74*	*75 and over*
			Percent		
Both sexes					
Total	9.4	16.9	4.4	8.6	10.3
Non-Hispanic white alone	7.0	13.4	3.1	6.0	8.1
Black alone	22.8	34.3	10.9	21.3	24.9
Asian alone	12.0	23.0	10.1	9.2	15.3
Hispanic (of any race)	19.4	38.9	11.9	18.8	20.4
Men					
Total	6.6	12.4	4.5	6.9	6.2
Non-Hispanic white alone	4.5	8.7	3.1	4.5	4.4
Black alone	16.7	27.4	10.7	17.8	14.6
Asian alone	12.2	18.1	11.5	11.6	13.0
Hispanic (of any race)	17.6	35.2	12.4	18.1	16.7
Women					
Total	11.5	18.6	4.3	10.1	12.9
Non-Hispanic white alone	9.0	15.1	3.2	7.3	10.5
Black alone	26.7	37.5	11.2	23.9	30.2
Asian alone	11.8	24.4	8.2	7.5	17.0
Hispanic (of any race)	20.8	40.5	11.3	19.3	23.1

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

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

Source: U.S. Census Bureau, Current Population Survey, Annual Social and Economic Supplement, 2007.

INDICATOR 8 Income

Table 8a. Income distribution of the population age 65 and over, 1974–2006

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	28.4	33.8	27.6
2004	9.8	28.1	34.5	27.5
2005	10.1	26.6	35.2	28.1
2006	9.4	26.2	35.7	28.6

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. Income distribution 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, 1975–2007.

Table 8b. Median income of householders age 65 and over, in current and 2006 dollars, 1974–2006

Year	*Number (in thousands)*	*Current dollars*	*2006 dollars*
1974	14,263	5,292	19,086
1975	14,802	5,585	18,602
1976	14,816	5,962	18,780
1977	15,225	6,347	18,793
1978	15,795	7,081	20,083
1979	16,544	7,879	20,393
1980	16,912	8,781	20,457
1981	17,312	9,903	21,065
1982	17,671	11,041	22,149
1983	17,901	11,718	22,545
1984	18,155	12,799	23,657
1985	18,596	13,254	23,684
1986	18,998	13,845	24,301
1987	19,412	14,443	24,522
1988	19,716	14,923	24,440
1989	20,156	15,771	24,760
1990	20,527	16,855	25,206
1991	20,921	16,975	24,507
1992	20,682	17,135	24,126
1993	20,806	17,751	24,390
1994	21,365	18,095	24,343
1995	21,486	19,096	25,086
1996	21,408	19,448	24,886
1997	21,497	20,761	26,004
1998	21,589	21,729	26,842
1999	22,478	22,797	27,586
2000	22,469	23,083	27,026
2001	22,476	23,118	26,328
2002	22,659	23,152	25,947
2003	23,048	23,787	26,077
2004	23,151	24,516	26,169
2005	23,459	26,036	26,890
2006	23,729	27,798	27,798

Reference population: These data refer to the civilian noninstitutionalized population.
Source: U.S. Census Bureau, Current Population Survey, Annual Social and Economic Supplement, 1975–2007.

INDICATOR 9 Sources of Income

Table 9a. Distribution of sources of income for married couples and nonmarried people who are age 65 and over, selected years 1962–2006

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

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, 1977–2007.

Table 9b. Sources of income for married couples and nonmarried people who are age 65 and over, by income quintile, 2006

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	82.5	79.4	64.9	45.0	17.6
Asset income	3.3	4.9	7.7	10.0	20.8
Pensions	3.9	9.0	16.0	24.1	18.3
Earnings	1.6	3.4	8.7	18.1	41.3
Public assistance	7.5	1.7	0.5	0.2	0.1
Other	1.3	1.5	2.3	2.5	2.0

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. Quintile limits are $11,519, $18,622, $28,911, and $50,064.

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

Source: U.S. Census Bureau, Current Population Survey, Annual Social and Economic Supplement, 2007.

INDICATOR 9 Sources of Income continued

Table 9c. Percentage of people age 55 and over with family income from specified sources, by age group, 2006

Source of family income	55–61	62–64	Age 65 and over				
			Total	65–69	70–74	75–79	80 and over
Earnings	85.6	69.9	36.2	53.1	39.2	29.1	20.3
Wages and salaries	81.6	65.7	32.7	48.2	35.5	25.5	18.4
Self-employment	13.9	10.7	6.4	9.4	6.5	6.0	3.2
Retirement benefits	33.8	65.7	92.6	88.0	93.4	94.8	95.2
Social Security	21.5	55.4	89.9	84.6	91.3	92.4	92.7
Benefits other than Social Security	20.2	35.9	44.7	41.0	47.1	46.5	45.4
Other public pensions	9.1	14.6	15.6	14.8	15.2	16.2	16.3
Railroad Retirement	0.3	0.7	0.5	0.4	0.4	0.6	0.8
Government employee pensions	8.9	14.0	15.1	14.5	14.8	15.6	15.7
Military	1.7	2.3	2.2	1.8	2.4	2.7	2.1
Federal	2.0	3.0	4.0	3.6	4.0	3.7	4.8
State or local	5.5	9.4	9.6	9.7	9.2	10.0	9.5
Private pensions or annuities	12.0	23.1	31.9	29.1	34.6	33.1	31.6
Income from assets	60.6	60.8	60.1	61.6	60.5	59.8	58.3
Interest	58.3	58.3	57.6	59.1	57.9	57.5	55.9
Other income from assets	31.0	30.5	27.5	29.8	27.9	27.2	24.7
Dividends	26.8	26.2	23.1	25.0	23.4	23.0	20.6
Rent or royalties	9.3	9.1	8.7	9.6	8.6	8.9	7.6
Estates or trusts	0.3	0.2	0.3	0.3	0.3	0.2	0.3
Veterans' benefits	3.7	3.4	4.2	3.2	3.9	4.3	5.5
Unemployment compensation	4.9	3.3	1.4	2.1	1.7	1.1	0.8
Workers' compensation	1.6	1.3	0.7	1.1	0.6	0.5	0.4
Combined public assistance and noncash benefits	8.8	10.1	10.2	9.1	10.5	9.9	11.6
Public assistance	5.2	5.8	4.5	4.5	4.7	4.4	4.4
Supplemental Security Income	4.6	5.5	4.2	4.1	4.4	4.2	4.1
Other cash benefits	0.8	0.3	0.4	0.6	0.4	0.3	0.4
Noncash benefits	5.7	6.5	7.7	6.6	7.8	7.5	9.2
Food	3.9	4.1	3.4	3.7	3.5	3.4	3.1
Energy	1.5	1.6	2.3	1.9	2.5	2.1	2.6
Housing	2.0	3.0	4.0	3.1	3.8	4.1	5.2
Personal contributions	2.1	1.7	1.2	1.3	1.1	0.8	1.4
Number (thousands)	24,314	7,877	36,035	10,629	8,369	7,567	9,471

Reference population: These data refer to the civilian noninstitutionalized population.
Source: U.S. Census Bureau, Current Population Survey, Annual Social and Economic Supplement, 2007.

INDICATOR 10 Net Worth

Table 10. Median household net worth of head of household, by selected characteristics, in 2005 dollars, selected years 1984–2005

Selected characteristic	*1984*	*1989*	*1994*	*1999*	*2001*	*2003*	*2005*
				In dollars			
Age of family head							
65 and over	$109,000	$118,900	$131,800	$177,200	$198,300	$192,400	$196,000
45–54	129,700	115,400	117,300	104,300	107,000	107,000	108,300
55–64	139,700	175,600	183,800	168,800	182,000	185,700	201,000
65–74	128,100	148,100	152,900	206,300	226,100	207,500	218,500
75 and over	94,000	98,400	108,900	150,100	158,800	169,800	181,000
Marital status, family head age 65 and over							
Married	171,100	216,600	242,200	276,700	320,900	322,700	328,300
Unmarried	77,100	72,500	81,500	106,200	111,200	110,900	104,000
Race, family head age 65 and over							
White	125,000	135,500	145,000	206,300	226,100	228,200	226,900
Black	28,200	36,500	40,900	32,800	45,200	27,900	37,800
Education, family head age 65 and over							
No high school diploma	60,900	60,300	65,900	64,500	63,200	63,200	59,500
High school diploma only	150,900	160,500	142,300	187,600	189,700	170,900	184,000
Some college or more	238,700	275,600	296,500	352,900	397,500	399,600	412,100

Note: Median net worth is calculated using sample weights. Tests of statistical significance were performed on the mean household net worth. From 1984 to 1994, net equity in homes and nonhousing assets was divided into six categories: other real estate and vehicles; farm or business ownership; stocks, mutual funds, investment trusts, and stocks held in IRAs; checking and savings accounts, CDs, treasury bills, savings bonds, and liquid assets in IRAs; bonds, trust life insurance, and other assets; and debts. Starting in 1999, IRAs were measured as a separate category. Panel Study of Income Dynamics (PSID) net worth data do not include pension wealth. This excludes private defined-contribution and defined-benefit plans as well as rights to Social Security wealth. Data for 1984–2003 have been inflation adjusted to 2005 dollars. See Appendix B for the definition of race and Hispanic origin in the PSID.

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

Source: Panel Study of Income Dynamics.

INDICATOR 11 Participation in the Labor Force

Table 11. Labor force participation rates of people age 55 and over, by age group and sex, annual averages, 1963–2006

Year	Men				Women			
	55–61	62–64	65–69	70 and over	55–61	62–64	65–69	70 and over
	Percent							
1963	89.9	75.8	40.9	20.8	43.7	28.8	16.5	5.9
1964	89.5	74.6	42.6	19.5	44.5	28.5	17.5	6.2
1965	88.8	73.2	43.0	19.1	45.3	29.5	17.4	6.1
1966	88.6	73.0	42.7	17.9	45.5	31.6	17.0	5.8
1967	88.5	72.7	43.4	17.6	46.4	31.5	17.0	5.8
1968	88.4	72.6	43.1	17.9	46.2	32.1	17.0	5.8
1969	88.0	70.2	42.3	18.0	47.3	31.6	17.3	6.1
1970	87.7	69.4	41.6	17.6	47.0	32.3	17.3	5.7
1971	86.9	68.4	39.4	16.9	47.0	31.7	17.0	5.6
1972	85.6	66.3	36.8	16.6	46.4	30.9	17.0	5.4
1973	84.0	62.4	34.1	15.6	45.7	29.2	15.9	5.3
1974	83.4	60.8	32.9	15.5	45.3	28.9	14.4	4.8
1975	81.9	58.6	31.7	15.0	45.6	28.9	14.5	4.8
1976	81.1	56.1	29.3	14.2	45.9	28.3	14.9	4.6
1977	80.9	54.6	29.4	13.9	45.7	28.5	14.5	4.6
1978	80.3	54.0	30.1	14.2	46.2	28.5	14.9	4.8
1979	79.5	54.3	29.6	13.8	46.6	28.8	15.3	4.6
1980	79.1	52.6	28.5	13.1	46.1	28.5	15.1	4.5
1981	78.4	49.4	27.8	12.5	46.6	27.6	14.9	4.6
1982	78.5	48.0	26.9	12.2	46.9	28.5	14.9	4.5
1983	77.7	47.7	26.1	12.2	46.4	29.1	14.7	4.5
1984	76.9	47.5	24.6	11.4	47.1	28.8	14.2	4.4
1985	76.6	46.1	24.4	10.5	47.4	28.7	13.5	4.3
1986	75.8	45.8	25.0	10.4	48.1	28.5	14.3	4.1
1987	76.3	46.0	25.8	10.5	48.9	27.8	14.3	4.1
1988	75.8	45.4	25.8	10.9	49.9	28.5	15.4	4.4
1989	76.3	45.3	26.1	10.9	51.4	30.3	16.4	4.6
1990	76.7	46.5	26.0	10.7	51.7	30.7	17.0	4.7
1991	76.1	45.5	25.1	10.5	52.1	29.3	17.0	4.7
1992	75.7	46.2	26.0	10.7	53.6	30.5	16.2	4.8
1993	74.9	46.1	25.4	10.3	53.8	31.7	16.1	4.7
1994	73.8	45.1	26.8	11.7	55.5	33.1	17.9	5.5
1995	74.3	45.0	27.0	11.6	55.9	32.5	17.5	5.3
1996	74.8	45.7	27.5	11.5	56.4	31.8	17.2	5.2
1997	75.4	46.2	28.4	11.6	57.3	33.6	17.6	5.1
1998	75.5	47.3	28.0	11.1	57.6	33.3	17.8	5.2
1999	75.4	46.9	28.5	11.7	57.9	33.7	18.4	5.5
2000	74.3	47.0	30.3	12.0	58.3	34.1	19.5	5.8
2001	74.9	48.2	30.2	12.1	58.9	36.7	20.0	5.9
2002	75.4	50.4	32.2	11.5	61.1	37.6	20.7	6.0
2003	74.9	49.5	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

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, 2005

	45–54	*55–64*	*65 and over*	*65–74*	*75 and over*
Personal insurance and pensions	13.2	11.9	5.4	6.7	3.5
Healthcare	4.8	6.9	12.8	10.8	15.6
Transportation	17.5	18.0	15.7	17.0	13.9
Housing	30.9	31.8	33.6	32.3	35.6
Food	12.5	12.5	12.7	12.7	12.5
Other	21.1	18.9	19.8	20.4	18.9

Note: Other expenditures include apparel, personal care, entertainment, reading, education, alcohol, tabacco, 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.

INDICATOR 13 Housing Problems

Table 13a. Percentage of households with residents age 65 and over that report housing problems, by type of problem, selected years 1985–2005

	Households		*People**	
Households with a resident age 65 and over	*Numbers in 1000s*	*Percent*	*Numbers in 1000s*	*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

See footnotes at end of table.

INDICATOR 13 Housing Problems continued

Table 13a. Percentage of households with residents age 65 and over that report housing problems, by type of problem, selected years 1985–2005 *(continued)*

Households with a resident age 65 and over	Households		People*	
	Numbers in 1000s	Percent	Numbers in 1000s	Percent
		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
		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

*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 United States 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, and 2005 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 2005, Current Housing Reports, H150/05, U.S. Census Bureau, 2006. 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 homes 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 1985–2005

	Households		*People**	
Households with a resident age 65 and over	*Numbers in 1000s*	*Percent*	*Numbers in 1000s*	*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
		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

See footnotes at end of table.

Table 13b. Percentage of all U.S. households that report housing problems, by type of problem, selected years 1985–2005 *(continued)*

Households with a resident age 65 and over	Households		People*	
	Numbers in 1000s	*Percent*	*Numbers in 1000s*	*Percent*
		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

* 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 United States 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 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, and 2005 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 2005, Current Housing Reports, H150/05, U.S. Census Bureau, 2006. 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 homes 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 1900–2004

Age and sex	*1900*	*1910*	*1920*	*1930*	*1940*	*1950*	*1960*	*1970*	*1980*	*1990*	*2000*	*2001*	*2002*	*2003*	*2004*
								Years							
Birth															
Both sexes	49.2	51.5	56.4	59.2	63.6	68.1	69.9	70.8	73.9	75.4	77.0	77.2	77.3	77.4	77.8
Men	47.9	49.9	55.5	57.7	61.6	65.5	66.8	67.0	70.1	71.8	74.3	74.4	74.5	74.7	75.2
Women	50.7	53.2	57.4	60.9	65.9	71.0	73.2	74.6	77.6	78.8	79.7	79.8	79.9	80.0	80.4
At age 65															
Both sexes	11.9	11.6	12.5	12.2	12.8	13.8	14.4	15.0	16.5	17.3	18.0	18.1	18.2	18.4	18.7
Men	11.5	11.2	12.2	11.7	12.1	12.7	13.0	13.0	14.2	15.1	16.2	16.4	16.6	16.8	17.1
Women	12.2	12.0	12.7	12.8	13.6	15.0	15.8	16.8	18.4	19.0	19.3	19.4	19.5	19.7	20.0
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	6.4	6.5	6.5	6.6	6.8
Men	3.8	3.9	4.1	4.0	4.1	4.4	4.4	4.7	5.1	5.3	5.6	5.7	5.7	5.9	6.1
Women	4.1	4.1	4.3	4.3	4.5	4.9	4.7	5.6	6.4	6.7	6.8	6.9	6.9	7.0	7.2

Note: The life expectancies (LEs) for decennial years 1910 to 1990 are based on decennial census data and deaths for a 3-year period around the census year. The LEs for decennial year 1900 are based on deaths from 1900 to 1902. LEs for years prior to 1930 are based on the death registration area only. The death registration area increased from 10 States and the District of Columbia in 1900 to the coterminous United States in 1933. LEs for 2000 were computed using population counts from Census 2000. LEs for 2001–2004 were computed using 2000-based postcensal estimates.

Reference population: These data refer to the resident population.

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

Table 14b. Life expectancy, by age and race, 2004

	Total		*Men*		*Women*	
Age	*White*	*Black*	*White*	*Black*	*White*	*Black*
			Years			
Birth	78.3	73.1	75.7	69.5	80.8	76.3
At age 65	18.7	17.1	17.2	15.2	20.0	18.6
At age 85	6.7	7.1	6.0	6.3	7.1	7.5

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 14c. Average life expectancy at age 65, by sex and selected countries or areas, selected years 1980–2003

Years of life remaining for people who reach age 65	*Men*				*Women*			
	Year				*Year*			
	1980	*1990*	*2000*	*2003*	*1980*	*1990*	*2000*	*2003*
Australia	13.7	15.2	16.9	17.6	17.9	19.0	20.4	21.0
Austria	12.9	14.3	16.0	16.3	16.3	17.8	19.4	19.9
Belgium	13.0	14.3	15.5	15.8	16.9	18.5	19.5	19.7
Bulgaria	12.7	12.9	12.8	13.8	14.7	15.4	15.4	15.9
Canada	14.5	15.7	16.8	17.4	18.9	19.9	20.4	20.8
Chile	---	14.6	15.3	15.4	---	17.6	18.6	18.7
Costa Rica	16.1	17.1	17.2	17.7	18.1	19.3	19.6	20.0
Cuba	---	---	16.7	16.9	---	---	19.0	19.3
Czech Republic(1)	11.2	11.6	13.7	13.9	14.3	15.2	17.1	17.3
Denmark	13.6	14.0	15.2	15.5	17.6	17.8	18.3	18.6
England and Wales(2)	12.9	14.1	15.8	16.5	16.9	17.9	19.0	19.4
Finland	12.5	13.7	15.5	15.8	16.5	17.7	19.3	19.6
France	13.6	15.5	16.7	17.1	18.2	19.8	21.2	21.4
Germany(3)	13.0	14.0	15.7	16.1	16.7	17.6	19.4	19.6
Greece	14.6	15.7	16.3	16.8	16.8	18.0	18.3	18.9
Hong Kong	13.9	15.3	17.3	17.9	13.9	18.8	21.5	21.7
Hungary	11.6	12.0	12.7	13.0	14.6	15.3	16.5	16.9
Ireland	12.6	13.3	14.6	15.7	15.7	16.9	17.8	18.9
Israel	14.4	15.9	16.9	17.3	15.8	17.8	19.3	19.7
Italy	13.3	15.1	16.5	16.6	17.1	18.8	20.4	20.6
Japan	14.6	16.2	17.5	18.0	17.7	20.0	22.4	23.0
Netherlands	13.7	14.4	15.3	15.8	18.0	18.9	19.2	19.5
New Zealand	13.2	14.7	16.7	17.1	17.0	18.3	20.0	20.1
Northern Ireland(2)	11.9	13.7	15.3	16.1	15.8	17.5	18.5	19.1
Norway	14.3	14.6	16.0	16.7	18.0	18.5	19.7	20.1
Poland	12.0	12.7	13.6	13.9	15.5	16.9	17.3	17.9
Portugal	12.9	13.9	15.3	15.6	16.5	17.0	18.7	18.9
Romania	12.6	13.3	13.5	13.1	14.2	15.3	15.9	15.9
Russian Federation	11.6	12.1	11.1	10.7	15.6	15.9	15.2	14.9
Scotland(2)	12.3	13.1	14.7	15.2	16.2	16.7	17.8	18.2
Singapore	12.6	14.5	15.8	17.0	15.4	16.9	19.0	19.7
Slovakia(1)	12.3	12.2	12.9	13.3	15.4	15.7	16.5	16.9
Spain	14.8	15.4	16.6	16.8	17.9	19.0	20.4	20.7
Sweden	14.3	15.3	16.7	17.0	17.9	19.0	20.0	20.3
Switzerland	14.4	15.3	16.9	17.5	17.9	19.4	20.7	21.0
United States	14.1	15.1	16.3	16.8	18.3	18.9	19.2	19.8

--- 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, 2007*.[10] Therefore, it is inappropriate to infer global rankings from these data.

Source: Centers for Disease Control and Prevention, National Center for Health Statistics, *Health, United States, 2007*.[10]

INDICATOR 15 Mortality

Table 15a. Death rates for selected leading causes of death among people age 65 and over, 1981–2004

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	286.8	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
				Percentage change between 1981–2004				
	-17.8	-44.3	-0.4	-44.5	53.0	-32.9	38.0	*32.5

*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 Diseases* (ICD–9). Starting in 1999, death rates are based on ICD–10. For the period 1981–98, causes were coded using ICD–9 codes that are most nearly comparable with the 113 cause list for ICD–10 and may differ from previously published estimates. Population estimates for July 1, 2000, and July 1, 2001, are 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 www.cdc.gov/nchs/about/major/dvs/popbridge/popbridge.htm. Death rates for 1990–2001 may differ from those published elsewhere because of the use of the bridged intercensal and postcensal population estimates. Rates are age adjusted using the 2000 standard population.

Reference population: These data refer to the resident population.

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

INDICATOR 15 Mortality continued

Table 15b. Leading causes of death among people age 65 and over, by sex and race and Hispanic origin, 2004

	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	Cerebrovascular diseases	Cerebrovascular diseases
4	Cerebrovascular diseases	Cerebrovascular diseases	Diabetes mellitus	Chronic lower respiratory diseases	Diabetes mellitus	Diabetes mellitus
5	Diabetes mellitus	Influenza and pneumonia	Chronic lower respiratory diseases	Influenza and pneumonia	Chronic lower respiratory diseases	Chronic lower respiratory diseases
6	Influenza and pneumonia	Diabetes mellitus	Nephritis	Diabetes mellitus	Influenza and pneumonia	Influenza and pneumonia
7	Alzheimer's disease	Alzheimer's disease	Influenza and pneumonia	Nephritis	Unintentional injuries	Nephritis
8	Unintentional injuries	Unintentional injuries	Septicemia	Unintentional injuries	Nephritis	Unintentional injuries
9	Nephritis	Nephritis	Unintentional injuries	Alzheimer's disease	Liver disease	Alzheimer's disease
10	Septicemia	Parkinson's disease	Hypertension	Hypertension	Septicemia	Liver disease
11	Parkinson's disease	Septicemia	Alzheimer's disease	Septicemia	Alzheimer's disease	Septicemia
12	Pneumonitis	Pneumonitis	Pneumonitis	Parkinson's disease	Hypertension	Hypertension
13	Hypertension	Aortic aneurysm	Liver disease	Pneumonitis	Parkinson's disease	Parkinson's disease
14	Aortic aneurysm	Hypertension	Parkinson's disease	Aortic aneurysm	Pneumonitis	Pneumonitis
15	Liver disease	Liver disease	Aortic aneurysm	Benign neoplasms	Benign neoplasms	Benign neoplasms
16	Benign neoplasms	Benign neoplasms	Benign neoplasms	Liver disease	Aortic aneurysm	Aortic aneurysm
17	Suicide	Suicide	Atherosclerosis	Suicide	Atherosclerosis	Atherosclerosis
18	Atherosclerosis	Atherosclerosis	HIV	Viral hepatitis	Suicide	Suicide
19	Anemias	Anemias	Suicide	Atherosclerosis	Gallbladder disorders	Gallbladder disorders
20	Peptic ulcer	Peptic ulcer	Homicide	Peptic ulcer	[1]Nutritional deficiencies [1]Tuberculosis	Viral hepatitis

See footnotes at end of table.

Table 15b. Leading causes of death among people age 65 and over, by sex and race and Hispanic origin, 2004 *(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	Chronic lower respiratory diseases	Chronic lower respiratory diseases	Diabetes mellitus	Diabetes mellitus	Diabetes mellitus	Diabetes mellitus
5	Alzheimer's disease	Alzheimer's disease	Nephritis	Influenza and pneumonia	Chronic lower respiratory diseases	Alzheimer's disease
6	Influenza and pneumonia	Influenza and pneumonia	Alzheimer's disease	Chronic lower respiratory disease	Influenza and pneumonia	Influenza and pneumonia
7	Diabetes mellitus	Diabetes mellitus	Chronic lower respiratory disease	Alzheimer's disease	Unintentional injuries	Chronic lower respiratory disease
8	Nephritis	Unintentional injuries	Influenza and pneumonia	Unintentional injuries	Nephritis	Nephritis
9	Unintentional injuries	Nephritis	Septicemia	Nephritis	Alzheimer's disease	Unintentional injuries
10	Septicemia	Septicemia	Hypertension	Hypertension	Liver disease	Septicemia
11	Hypertension	Hypertension	Unintentional injuries	Septicemia	Septicemia	Hypertension
12	Pneumonitis	Parkinson's disease	Pneumonitis	Parkinson's disease	Hypertension	Liver disease
13	Parkinson's disease	Pneumonitis	Atherosclerosis	Pneumonitis	Pneumonitis	Pneumonitis
14	Atherosclerosis	Atherosclerosis	Benign neoplasms	Benign neoplasms	Atherosclerosis	Parkinson's disease
15	Benign neoplasms	Benign neoplasms	Aortic aneurysm	Aortic aneurysm	Parkinson's disease	Benign neoplasms
16	Aortic aneurysm	Aortic aneurysm	Parkinson's disease	Liver disease	Benign neoplasms	Atherosclerosis
17	Liver disease	Liver disease	Anemias	Atherosclerosis	[2]Aortic aneurysm [2]Nutritional deficiencies	Aortic aneurysm
18	Anemias	Anemias	Liver disease	Viral hepatitis		Gallbladder disorders
19	Nutritional deficiencies	Peptic ulcer	Nutritional deficiencies	Suicide	Gallbladder disorders	Viral hepatitis
20	Peptic ulcer	Nutritional deficiencies	Gallbladder disorders	Peptic ulcer	Peptic ulcer	Anemias

[1]For American Indian men, Nutritional deficiencies and Tuberculosis tied for 20th.
[2]For American Indian women, Aortic aneurysm and Nutritional deficiencies tied for 17th.

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 15 Mortality continued

Table 15c. Leading causes of death among people age 85 and over, by sex and race and Hispanic origin, 2004

	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	Cerebrovascular diseases	Cerebrovascular diseases
4	Chronic lower respiratory diseases	Chronic lower respiratory diseases	Influenza and pneumonia	Influenza and pneumonia	Influenza and pneumonia	Influenza and pneumonia
5	Influenza and pneumonia	Influenza and pneumonia	Chronic lower respiratory diseases	Chronic lower respiratory diseases	Chronic lower respiratory diseases	Chronic lower respiratory diseases
6	Alzheimer's disease	Alzheimer's disease	Nephritis	Diabetes mellitus	Unintentional injuries	Alzheimer's disease
7	Nephritis	Nephritis	Diabetes mellitus	Alzheimer's disease	Nephritis	Diabetes mellitus
8	Unintentional injuries	Unintentional injuries	Alzheimer's disease	Nephritis	Diabetes mellitus	Nephritis
9	Diabetes mellitus	Diabetes mellitus	Septicemia	Unintentional injuries	[1]Septicemia [1]Alzheimer's disease	Unintentional injuries
10	Pneumonitis	Pneumonitis	Hypertension	Pneumonitis		[2]Septicemia [2]Hypertension
11	Parkinson's disease	Parkinson's disease	Unintentional injuries	Hypertension	Pneumonitis	
12	Septicemia	Septicemia	Pneumonitis	Parkinson's disease	Parkinson's disease	Parkinson's disease
13	Hypertension	Hypertension	Parkinson's disease	Septicemia	Benign neoplasms	Pneumonitis
14	Atherosclerosis	Atherosclerosis	Atherosclerosis	Aortic aneurysm	Hypertension	Atherosclerosis
15	Benign neoplasms	Benign neoplasms	Benign neoplasms	Atherosclerosis	[1]Aortic aneurysm [1]Atherosclerosis [1]Gallbladder disorders	Benign neoplasms
16	Aortic aneurysm	Aortic aneurysm	Aortic aneurysm	Benign neoplasms		Aortic aneurysm
17	Suicide	Suicide	Nutritional deficiencies	Suicide		Liver disease
18	Anemias	Anemias	Anemias	Peptic ulcer	Hernia	Anemias
19	Nutritional deficiencies	Liver disease	Pneumoconioses	[3]Nutritional deficiencies [3]Tuberculosis	[1]Anemias [1]Liver disease [1]Nutritional deficiencies	[2]Gallbladder disorders [2]Suicide
20	[4]Gallbladder disorders [4]Liver disease	Gallbladder disorders	Peptic ulcer			

See footnotes at end of table.

Table 15c. Leading causes of death among people age 85 and over, by sex and race and Hispanic origin, 2004 *(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	Cerebrovascular diseases	Malignant neoplasms	Malignant neoplasms
3	Cerebrovascular diseases	Cerebrovascular diseases	Cerebrovascular diseases	Malignant neoplasms	Cerebrovascular diseases	Cerebrovascular diseases
4	Alzheimer's disease	Alzheimer's disease	Alzheimer's disease	Influenza and pneumonia	Alzheimer's disease	Alzheimer's disease
5	Influenza and pneumonia	Influenza and pneumonia	Diabetes mellitus	Alzheimer's disease	Influenza and pneumonia	Influenza and pneumonia
6	Chronic lower respiratory diseases	Chronic lower respiratory diseases	Influenza and pneumonia	Diabetes mellitus	Diabetes mellitus	Diabetes mellitus
7	Diabetes mellitus	Diabetes mellitus	Nephritis	Chronic lower respiratory diseases	Chronic lower respiratory diseases	Chronic lower respiratory diseases
8	Nephritis	Unintentional injuries	Hypertension	Hypertension	Nephritis	Hypertension
9	Unintentional injuries	Nephritis	Septicemia	Nephritis	Unintentional injuries	Nephritis
10	Hypertension	Hypertension	Chronic lower respiratory diseases	Unintentional injuries	Septicemia	Unintentional injuries
11	Septicemia	Septicemia	Unintentional injuries	Septicemia	Hypertension	Septicemia
12	Atherosclerosis	Atherosclerosis	Pneumonitis	Pneumonitis	Pneumonitis	Pneumonitis
13	Pneumonitis	Pneumonitis	Atherosclerosis	Parkinson's disease	Atherosclerosis	Atherosclerosis
14	Parkinson's disease	Parkinson's disease	Benign neoplasms	Atherosclerosis	Parkinson's disease	Parkinson's disease
15	Benign neoplasms	Benign neoplasms	Anemias	Aortic aneurysm	[5]Benign neoplasms [5]Nutritional deficiencies	Benign neoplasms
16	Aortic aneurysm	Aortic aneurysm	Nutritional deficiencies	Benign neoplasms		Gallbladder disorders
17	Anemias	Anemias	Parkinson's disease	Anemias	Gallbladder disorders	Anemias
18	Nutritional deficiencies	Nutritional deficiencies	Aortic aneurysm	Nutritional deficiencies	Liver disease	Aortic aneurysm
19	Peptic ulcer	Peptic ulcer	Gallbladder disorders	Peptic ulcer	[5]Anemias [5]Aortic aneurysm	Liver disease
20	Gallbladder disorders	Gallbladder disorders	Peptic ulcer	Liver disease		Nutritional deficiencies

[1]For American Indian men, Septicemia and Alzheimer's disease tied for 9th; Aortic aneurysm, Atherosclerosis, and Gallbladder disorders tied for 15th; and Anemias, Liver disease, and Nutritional deficiencies tied for 19th.
[2]For Hispanic men, Septicemia and Hypertension tied for 10th; and Gallbladder disorders and Suicide tied for 19th.
[3]For Asian or Pacific Islander men, Nutritional deficiencies and Tuberculosis tied for 19th.
[4]For all men, Gallbladder disorders and Liver disease tied for 20th.
[5]For American Indian women, Benign neoplasms and Nutritional deficiencies tied for 15th; and Anemias and Aortic aneurysm tied for 19th.

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, 2005–2006

	Heart disease	*Hyper-tension*	*Stroke*	*Asthma*	*Chronic bronchitis or Emphysema*	*Any cancer*	*Diabetes*	*Arthritis*
					Percent			
Total	30.9	53.3	9.3	10.6	10.0	21.1	18.0	49.5
Men	36.8	52.0	10.4	9.5	10.6	23.6	19.1	43.1
Women	26.4	54.3	8.4	11.5	9.5	19.3	17.3	54.4
White, not Hispanic or Latino	32.1	51.3	8.9	10.5	10.7	23.4	16.0	50.4
Black, not Hispanic or Latino	26.2	70.4	15.6	12.3	6.0	11.5	28.8	55.1
Hispanic or Latino	22.2	53.8	6.5	9.0	6.4	12.1	25.3	39.7

Note: Data are based on a 2-year average from 2005–2006. 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, 1997–2006

	Heart disease	*Hyper-tension*	*Stroke*	Emphy-sema	*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

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.

INDICATOR 17 Sensory Impairments and Oral Health

Table 17a. Percentage of people age 65 and over who reported having any trouble hearing, any trouble seeing, or no natural teeth, by selected characteristics, 2006

Sex	*Age and poverty status*	*Any trouble hearing*	*Any trouble seeing*	*No natural teeth*
		Percent		
Both sexes	65 and over	40.5	17.4	25.9
	65–74	31.9	13.6	22.8
	75–84	46.3	20.0	28.5
	85 and over	61.8	26.5	32.0
	Below poverty	36.6	26.0	39.4
	Above poverty	42.1	16.4	25.9
Men	65 and over	47.7	16.1	26.8
	65–74	40.8	11.9	22.8
	75–84	54.6	19.4	32.7
	85 and over	66.3	30.7	30.6
Women	65 and over	35.1	18.4	25.1
	65–74	24.3	15.1	22.7
	75–84	40.3	20.4	25.5
	85 and over	59.8	24.6	32.6

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

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

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

Table 17b. Percentage of people age 65 and over who reported ever having worn a hearing aid, 2006

Age group	*Both sexes*	*Men*	*Women*
		Percent	
65 and over	13.3	18.0	9.8
65–74	7.5	11.0	4.5
75–84	17.0	24.2	11.7
85 and over	28.6	40.4	23.3

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, 2004–2006

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	26.0	23.7	39.7	37.1
65–74	22.5	19.9	36.7	32.4
75–84	28.6	26.1	43.5	43.2
85 and over	34.2	32.6	45.7	52.9
Men				
65 and over	25.7	23.8	37.3	35.6
65–74	22.1	20.0	34.7	31.0
75–84	28.8	26.9	41.1	40.6
85 and over	36.8	35.1	45.4	65.0
Women				
65 and over	26.3	23.6	41.3	38.2
65–74	22.9	19.8	38.2	33.6
75–84	28.5	25.6	44.9	44.9
85 and over	32.9	31.3	45.8	
Good to excellent health				
Both sexes				
65 and over	74.0	76.3	60.3	62.9
65–74	77.5	80.1	63.3	67.6
75–84	71.4	73.9	56.5	56.8
85 and over	65.8	67.4	54.3	47.1
Men				
65 and over	74.3	76.2	62.7	64.4
65–74	77.9	80.0	65.3	69.0
75–84	71.2	73.1	58.9	59.4
85 and over	63.2	64.9	54.6	35.0
Women				
65 and over	73.7	76.4	58.7	61.8
65–74	77.1	80.2	61.8	66.4
75–84	71.5	74.4	55.1	55.1
85 and over	67.1	68.7	54.2	53.2

Note: Data are based on a 3-year average from 2004–2006. 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 1998–2004

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

Note: The definition of "clinically relevant depressive symptoms" is four or more symptoms out of a list of eight depressive symptoms from an abbreviated version of the Center for Epidemiological Studies Depression Scale (CES-D) adapted by the Health and Retirement Study (HRS). The CES-D scale is a measure of depressive symptoms and is not to be used as a diagnosis of clinical depression. A detailed explanation concerning the "4 or more symptoms" cut-off can be found in the following documentation: hrsonline.isr.umich.edu/docs/userg/dr-005.pdf. Proportions are based on weighted data using the preliminary respondent weight from HRS 2004.

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, 2004

	Both sexes	*Men*	*Women*
65 and over	14.4	11.0	16.8
65–74	13.1	9.7	15.6
75–84	14.8	10.6	17.7
85 and over	19.2	19.2	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 for Epidemiological Studies Depression Scale (CES-D) adapted by the Health and Retirement Study (HRS). The CES-D scale is a measure of depressive symptoms and is not to be used as a diagnosis of clinical depression. A detailed explanation concerning the "4 or more symptoms" cut-off can be found in the following documentation: hrsonline.isr.umich.edu/docs/userg/dr-005.pdf. Proportions are based on weighted data using the preliminary respondent weight from HRS 2004.

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 1992–2005

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

Note: The Medicare Current Beneficiary Survey has replaced the National Long Term Care Survey as the data source for this indicator. Consequently, the measurement of functional limitations (previously called disability) has changed from previous editions of *Older Americans*. 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.

Reference: 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 are unable to perform certain physical functions, by sex, 1991 and 2005

Function	*1991*	*2005*
	Percent	
Men		
Stoop/kneel	7.8	9.9
Reach over head	3.1	2.6
Write	2.2	1.3
Walk 2–3 blocks	14.0	14.6
Lift 10 lbs.	9.1	7.7
Any of these five	18.9	19.0
Women		
Stoop/kneel	15.2	18.1
Reach over head	6.2	5.1
Write	2.6	2.3
Walk 2–3 blocks	23.0	22.9
Lift 10 lbs.	18.3	15.5
Any of these five	32.1	31.9

Note: Rates for 1991 are age adjusted to the 2005 population.
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 any one of five physical functions, by selected characteristics, 2005

Selected characteristic	*Men*	*Women*
	Percent	
65–74	13.5	21.7
75–84	22.1	34.3
85 and over	38.3	55.9
White, not Hispanic or Latino	18.6	31.7
Black, not Hispanic or Latino	24.0	34.8
Hispanic or Latino (of any race)	20.7	32.5

Note: The five physical functions include stooping/kneeling, reaching over the head, writing, walking 2–3 blocks, and lifting 10 lbs. See Appendix B for the definition of race and Hispanic origin in the Medicare Current Beneficiary Survey.
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 1989–2006

Year	Influenza			Pneumococcal disease		
	Not Hispanic or Latino		Hispanic or Latino (of any race)	Not Hispanic or Latino		Hispanic or Latino (of any race)
	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

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, 2006

Selected characteristic	Influenza	Pneumococcal disease
	Percent	
Both sexes	64.2	57.1
Men	64.7	54.3
Women	63.8	59.2
65–74	60.3	52.3
75–84	68.7	64.2
85 and over	71.8	60.7
High school graduate or less	61.1	54.7
More than high school	69.6	61.3

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.

INDICATOR 22 Mammography

Table 22. Percentage of women who reported having had a mammogram within the past 2 years, by selected characteristics, selected years 1987–2005

	1987	1990	1991	1993	1994	1998	1999	2000	2003	2005
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
50–64	31.7	56.0	60.3	65.1	66.5	73.7	76.5	78.7	76.2	71.8
65 and over	22.8	43.4	48.1	54.2	55.0	63.8	66.8	67.9	67.7	63.8
65–74	26.6	48.7	55.7	64.2	63.0	69.4	73.9	74.0	74.6	72.5
75 and over	17.3	35.8	37.8	41.0	44.6	57.2	58.9	61.3	60.6	54.7
Race and Hispanic origin					Women age 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
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
Hispanic or Latino (of any race)	*	41.1	40.9	*35.7	48.0	59.0	67.2	68.3	69.5	63.8
Poverty										
Below 100 percent	13.1	30.8	35.2	41.7	43.2	51.9	57.6	54.8	57.0	52.3
100–199 percent	19.9	38.6	41.8	47.0	47.9	57.8	60.2	60.3	62.8	56.2
200 percent or more	29.7	51.5	57.8	64.3	64.9	70.1	72.5	75.0	72.6	70.1
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
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
Some college or more	32.3	56.7	57.9	64.8	64.3	71.3	77.1	74.1	75.1	73.0

*Estimates are considered unreliable. Data preceded by an asterisk have a relative standard error (RSE) of 20–30 percent. Data not shown have an RSE greater than 30 percent.

Note: Questions concerning use of mammography differed slightly on the National Health Interview Survey (NHIS) across the years for which data are shown. In 1987 and 1990, women were asked to report when they had their last mammogram. In 1991, women were asked whether they had a mammogram in the past 2 years. In 1993 and 1994, women were asked whether they had a mammogram within the past year, between 1 and 2 years ago, or over 2 years ago. In 1998, women were asked whether they had a mammogram a year ago or less, more than 1 year but not more than 2 years, or more than 2 years ago. In 1999, women were asked when they had their most recent mammogram in days, weeks, months, or years. In 1999, 10 percent of women in the sample responded "2 years ago,"and in this analysis, these women were coded as "within the past 2 years" although a response of "2 years ago" may include women whose last mammogram was more than 2 but less than 3 years ago. Thus, estimates for 1999 are overestimated to some degree in comparison with estimates in previous years. In 2000 and 2003, women were asked when they had their most recent mammogram (give month and year). Women who did not respond were given a followup question that used the 1999 wording, and women who did not answer the followup question were asked a second followup question that used the 1998 wording. In 2000 and 2003, 2 percent of women in the sample answered "2 years ago" using the 1999 wording, and they were coded as "within the past 2 years." Thus, estimates for 2000 and 2003 may be slightly overestimated in comparison with estimates for years prior to 1999. In 2005, women were asked the same series of mammography questions as in the 2000 and 2003 surveys, but the skip pattern was modified so that more women were asked the follow-up question using the 1998 wording. Because additional information was available for women who replied their last mammogram was 2 years ago, these women were not uniformly coded as having had a mammogram within the past 2 years. Thus, estimates for 2005 are more precise compared with estimates for 1999, 2000, and 2003 and are slightly lower than they would have been without this additional information. See Appendix B for the definition 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.

INDICATOR 23 Diet Quality

Table 23. Healthy Eating Index-2005 (HEI-2005) total and component scores for people age 55 and over, by age group, 2001–2002

HEI-2005 Component (Maximum Score)	*Age group*			
	55–64	*65 and over*	*65–74*	*75 and over*
Total fruit (5)	3.6	4.5	4.5	4.6
Whole fruit (5)	5.0	5.0	5.0	5.0
Total vegetables (5)	4.0	4.3	4.4	4.2
Dark green and orange vegetables and legumes (5)	1.7	2.2	2.3	1.9
Total grains (5)	5.0	5.0	5.0	5.0
Whole grains (5)	1.4	1.9	1.8	1.9
Milk (10)	5.4	5.8	5.5	6.1
Meat and Beans (10)	10.0	10.0	10.0	10.0
Oils (10)	7.8	7.5	7.8	7.5
Saturated fat (10)	6.5	7.1	7.2	7.2
Sodium (10)	3.9	3.2	3.4	3.0
Calories from Solid Fat, Alcohol, and Added Sugar (20)	9.7	11.2	11.1	11.3
Total HEI-2005 score (100)	64.0	67.7	68.0	67.8

Note: Diet quality was measured using the Healthy Eating Index-2005 (HEI-2005), which has 12 components. Each component represents a different aspect of a healthful diet according to the 2005 Dietary Guidelines for Americans. A higher score for each component represents a healthier diet. Dietary adequacy is addressed by Total Fruit; Whole Fruit (forms other than juice); Total Vegetables; Dark Green and Orange Vegetables and Legumes (cooked dry beans and peas); Total Grains; Whole Grains; Milk (all milk products and soy beverages); Meat and Beans (meat, poultry, fish, eggs, soybean products other than beverages, nuts, and seeds); and Oils (nonhydrogenated vegetable oils and oils in fish, nuts, and seeds). For the remaining three components—Saturated Fat; Sodium; and Calories from Solid Fat, Alcohol, and Added Sugar—higher scores reflect lower intakes.

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, 2001–2002; U.S. Department of Agriculture, Center for Nutrition Policy and Promotion.

INDICATOR 24 Physical Activity

Table 24a. Percentage of people age 45 and over who reported engaging in regular leisure time physical activity, by age group, 1997–2006

	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

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

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

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

Table 24b. Percentage of people age 65 and over who reported engaging in regular leisure time physical activity, by selected characteristics, 2005–2006

	Total	*Men*	*Women*
All	21.5	24.6	19.2
White, not Hispanic or Latino	22.7	25.8	20.4
Black, not Hispanic or Latino	13.5	17.7	10.4
Hispanic or Latino (of any race)	15.8	16.9	14.7
Percent who engage in strengthening exercises	12.7	13.8	12.0

Note: Data are based on a 2-year average from 2005–2006. "Regular leisure time physical activity" is defined as "engaging in light-moderate leisure time physical activity for greater than or equal to 30 minutes at a frequency greater than or equal to 5 times per week, or engaging in vigorous leisure time physical activity for greater than or equal to 20 minutes at a frequency greater than or equal to 3 times per week." See Appendix B for the definition of race and 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 25 Obesity

Table 25. Body weight status among people age 65 and over, by sex and age group, selected years 1976–2006

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

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.

INDICATOR 26 Cigarette Smoking

Table 26a. Percentage of people age 45 and over who are current cigarette smokers, by selected characteristics, selected years 1965–2007‡

	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	8.6	21.5	8.6	30.5	12.8
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	8.1	21.2	8.6	21.0	8.2

* 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.

‡The 2007 estimates are based on Early Release National Health Interview Survery (NHIS) data collected January–June 2007, using preliminary weights.

Note: Data starting in 1997 are not strictly comparable with data for earlier years because of the 1997 NHIS questionnaire redesign. Starting with 1993 data, current cigarette smokers were defined as ever smoking 100 cigarettes in their lifetime and now smoking everyday or some days. 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 26 Cigarette Smoking continued

Table 26b. Cigarette smoking status of people age 18 and over, by sex and age group, 2006

Sex and age group	All current smokers	Every day smokers	Some day smokers	Former smokers	Non-smokers
			Percent		
Both sexes	20.8	16.7	4.2	21.0	58.2
Men					
18–44	26.7	20.0	6.6	12.1	61.3
45–64	24.5	21.1	3.5	32.1	43.4
65 and over	12.6	10.4	2.2	51.1	36.2
Women					
18–44	20.6	15.9	4.7	11.3	68.2
45–64	19.3	16.5	2.8	22.0	58.7
65 and over	8.3	7.0	1.3	27.9	63.8

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," 2000–2006

Pollutant measures	2000	2001	2002	2003	2004	2005	2006
				Percent			
Particulate matter (PM 2.5)	44.0	37.3	35.7	32.2	23.8	35.0	21.2
8hr Ozone	31.0	37.1	46.7	32.5	11.7	32.1	24.2
Any standard	55.4	51.1	53.3	44.8	28.5	46.6	33.8

Note: The term "poor air quality" is defined as air quality concentrations above the level of the National Ambient Air Quality Standards (NAAQS). The term "any standard" refers to any NAAQS for ozone, particulate matter, nitrogen dioxide, sulfur dioxide, carbon monoxide, and lead. Data for previous years has been computed using the new daily PM 2.5 standard of 35 micrograms/m^3 to enable comparisons across time. 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. Census Bureau, Population Projections, 2000–2006.

Table 27b. Counties with "poor air quality" for any standard in 2006

State	County
Alabama	Mobile
Alabama	Russell
Alabama	Shelby
Alaska	Matanuska-Susitna
Arizona	Maricopa
Arizona	Pinal
Arizona	Santa Cruz
Arkansas	Crittenden
Arkansas	Pulaski
California	Alameda
California	Amador
California	Butte
California	Calaveras
California	Contra Costa
California	El Dorado
California	Fresno
California	Imperial
California	Inyo
California	Kern
California	Kings
California	Los Angeles
California	Merced
California	Mono
California	Nevada
California	Orange
California	Placer
California	Riverside
California	Sacramento
California	San Bernardino
California	San Diego
California	San Joaquin
California	San Luis Obispo
California	Santa Clara
California	Stanislaus
California	Sutter
California	Tehama
California	Tulare
California	Ventura
California	Yolo
Colorado	Alamosa
Colorado	Douglas
Colorado	Jefferson
Colorado	Larimer
Connecticut	Fairfield
Connecticut	Hartford
Connecticut	Litchfield
Connecticut	Middlesex
Connecticut	New Haven
Connecticut	New London
Connecticut	Tolland
Delaware	Kent
District of Columbia	District of Columbia
Georgia	Bibb
Georgia	Clarke
Georgia	Clayton
Georgia	Cobb
Georgia	Coweta
Georgia	DeKalb
Georgia	Douglas
Georgia	Fayette
Georgia	Floyd
Georgia	Fulton
Georgia	Gwinnett
Georgia	Henry
Georgia	Muscogee
Georgia	Richmond
Georgia	Rockdale
Georgia	Washington
Georgia	Wilkinson
Illinois	Madison
Indiana	Clark
Indiana	Knox
Indiana	Marion
Kentucky	Jefferson
Kentucky	McCracken
Louisiana	Ascension
Louisiana	Caddo
Louisiana	East Baton Rouge
Louisiana	Iberville
Louisiana	Jefferson
Louisiana	Pointe Coupee
Louisiana	St. Bernard
Louisiana	West Baton Rouge
Maryland	Anne Arundel
Maryland	Baltimore
Maryland	Baltimore City
Maryland	Cecil
Maryland	Charles
Maryland	Frederick
Maryland	Harford
Maryland	Montgomery
Maryland	Prince George's
Massachusetts	Bristol
Massachusetts	Dukes
Massachusetts	Hampden
Massachusetts	Hampshire
Michigan	Allegan
Michigan	Chippewa
Michigan	Muskegon
Michigan	St. Clair
Michigan	Wayne
Mississippi	DeSoto
Missouri	Clay
Missouri	Clinton
Missouri	Jasper
Missouri	Jefferson
Missouri	St. Charles
Missouri	St. Louis City
Montana	Lincoln
Montana	Missoula

See footnotes at end of table.

Table 27b. Counties with "poor air quality" for any standard in 2006 *(continued)*

State	County
Montana	Silver Bow
Nevada	Clark
Nevada	Nye
New Jersey	Bergen
New Jersey	Camden
New Jersey	Essex
New Jersey	Hudson
New Jersey	Hunterdon
New Jersey	Mercer
New Jersey	Middlesex
New Jersey	Monmouth
New Jersey	Morris
New Jersey	Ocean
New Jersey	Union
New Mexico	Bernalillo
New Mexico	Dona Ana
New Mexico	Sandoval
New York	Bronx
New York	Kings
New York	New York
New York	Richmond
New York	Suffolk
North Carolina	Catawba
North Carolina	Davidson
North Carolina	Guilford
North Carolina	Mecklenburg
North Carolina	Rowan
North Carolina	Wake
Ohio	Ashtabula
Ohio	Cuyahoga
Ohio	Hamilton
Ohio	Warren
Oklahoma	Creek
Oklahoma	Jefferson
Oklahoma	Kay
Oklahoma	Love
Oklahoma	Oklahoma
Oregon	Douglas
Oregon	Klamath
Oregon	Lane
Oregon	Multnomah
Oregon	Washington
Pennsylvania	Allegheny
Pennsylvania	Beaver
Pennsylvania	Berks
Pennsylvania	Bucks
Pennsylvania	Cambria
Pennsylvania	Chester
Pennsylvania	Dauphin
Pennsylvania	Delaware
Pennsylvania	Lancaster
Pennsylvania	Montgomery
Pennsylvania	Northampton
Pennsylvania	Philadelphia
Pennsylvania	Washington
South Carolina	Greenville
South Carolina	Lexington
South Carolina	Spartanburg
Tennessee	Blount
Tennessee	Dyer
Tennessee	Hamilton
Tennessee	Knox
Tennessee	Montgomery
Tennessee	Sevier
Tennessee	Shelby
Tennessee	Sumner
Texas	Bexar
Texas	Brazoria
Texas	Collin
Texas	Dallas
Texas	Denton
Texas	El Paso
Texas	Harris
Texas	Hood
Texas	Jefferson
Texas	Montgomery
Texas	Parker
Texas	Tarrant
Texas	Webb
Utah	Cache
Utah	Salt Lake
Virginia	Arlington
Virginia	Caroline
Virginia	Fairfax
Virginia	Henrico
Virginia	Prince William
Virginia	Stafford
Washington	King
Washington	Pierce
West Virginia	Brooke
West Virginia	Hancock
West Virginia	Kanawha
Wisconsin	Brown
Wisconsin	Milwaukee
Wisconsin	Outagamie
Wyoming	Sweetwater

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, 2000–2006.

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, 2006

Selected 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	8.4	35.0	8.9	36.9	9.0	37.4
Leisure activities	5.4	22.6	7.0	29.1	7.8	32.6
Work and work-related activities	3.8	15.8	0.9	3.9	0.3	1.4
Household activities	2.1	8.8	2.6	11.0	2.3	9.7
Caring for and helping others	0.4	1.9	0.4	1.8	0.3	1.4
Eating and drinking	1.3	5.5	1.4	6.0	1.5	6.2
Purchasing goods and services	0.9	3.8	0.9	3.9	0.8	3.3
Grooming	0.7	2.7	0.6	2.7	0.7	2.7
Other activities	1.0	4.0	1.2	4.8	1.3	5.3

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, 2006

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	13.1	0.8	11.1	0.8	9.7
Watching TV	2.9	53.4	3.8	55.1	4.2	53.6
Participation in sports, exercise, and recreation	0.2	4.1	0.3	3.5	0.2	2.3
Relaxing and thinking	0.4	6.6	0.5	7.4	0.9	10.9
Reading	0.6	10.1	0.8	10.9	1.1	13.9
Other leisure activities (including related travel)	0.7	12.7	0.8	11.9	0.8	9.7

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

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

INDICATOR 29 Use of Health Care Services

Table 29a. Use of Medicare-covered health care services by Medicare enrollees age 65 and over, 1992–2005

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				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

na Data not available.

Note: Data are for Medicare enrollees in fee-for-service only. Physician visits and consultations include all settings, such as physician offices, hospitals, emergency rooms, and nursing homes. 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.

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, 2005

Utilization measure	65–74	75–84	85 and over
	Rate per thousand		
Skilled nursing facility stays	30	92	228
Home health care visits	1,333	3,407	6,549

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 2004 dollars, by age group, 1992–2004

Year	Age			
	Total	65–74	75–84	85 and over
	Dollars			
1992	$8,644	$6,432	$9,459	$16,718
1993	9,262	6,719	10,587	17,327
1994	9,984	7,377	11,058	18,711
1995	10,444	7,599	11,429	19,756
1996	10,560	7,644	11,887	19,336
1997	10,796	7,627	11,993	19,561
1998	10,538	7,372	11,723	19,688
1999	10,831	8,222	11,485	19,020
2000	11,243	8,373	12,256	19,384
2001	11,865	9,021	13,194	19,795
2002	12,735	9,816	13,830	20,645
2003	12,846	9,728	14,357	20,186
2004	13,052	9,702	14,214	21,907

Note: Data include both out-of-pocket costs and costs covered by insurance. Dollars are inflation adjusted to 2004 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.

Table 30b. Major components of health care costs among Medicare enrollees age 65 and over, 1992 and 2004

Cost component	1992		2004	
	Average cost in dollars	Percent	Average cost in dollars	Percent
Total	$6,551	100	$13,052	100
Inpatient hospital	2,107	32	3,217	25
Physician/Outpatient hospital	2,071	32	4,565	35
Long-term care facility	1,325	20	1,842	14
Home health care	244	4	380	3
Prescription drugs	522	8	1,987	15
Other (Short-term institution/Hospice/Dental)	282	4	1,061	8

Note: Data include both out-of-pocket costs and costs covered by insurance. Dollars are not inflation adjusted.
Reference population: These data refer to Medicare enrollees.
Source: Centers for Medicare and Medicaid Services, Medicare Current Beneficiary Survey.

Table 30c. Average annual health care costs among Medicare enrollees age 65 and over, by selected characteristics, 2004

Selected characteristic	*Average cost in dollars*
Total	$13,052
Race and ethnicity	
White, not Hispanic or Latino	13,101
Black, not Hispanic or Latino	14,989
Hispanic or Latino (of any race)	11,962
Other	10,601
Institutional status	
Community	10,448
Institution	52,958
Annual income	
$0–$10,000	16,766
10,001–20,000	13,558
20,001–30,000	12,985
30,001 or more	10,676
Chronic conditions	
0	4,718
1–2	8,489
3–4	14,907
5 or more	20,334
Veteran status (men only)	
Yes	12,280
No	13,138

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

Reference population: These data refer to Medicare enrollees.

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

Table 30d. Major components of health care costs among Medicare enrollees age 65 and over, by age group, 2004

Cost component	*65–74*	*75–84*	*85 and over*
	Average cost in dollars		
Total	$9,702	$14,214	$21,907
Inpatient hospital	2,365	3,576	5,311
Physician/Outpatient hospital	4,172	5,074	4,592
Long-term care facility	431	1,774	7,057
Home health care	158	507	854
Prescription drugs	1,958	2,140	1,663
Other (Short-term institution/Hospice/Dental)	618	1,142	2,429

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

Reference population: These data refer to Medicare enrollees.

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

INDICATOR 30 Health Care Expenditures continued

Table 30e. Percentage of Medicare enrollees age 65 and over who reported problems with access to health care, 1992–2003

Reported problem	*1992*	*1993*	*1994*	*1995*	*1996*	*1997*	*1998*	*1999*	*2000*	*2001*	*2002*	*2003*
						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
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

Reference population: These data refer to noninstitutionalized Medicare enrollees.

Source: Medicare Current Beneficiary Survey (MCBS) Project. (December 2006). Health and Health Care of the Medicare Population: Data from the 2003 MCBS. Rockville, MD: Westat.

INDICATOR 31 Prescription Drugs

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

Payment source	*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 insurance	145	190	220	248	302	323	401	449	512	573	666	747	810
Public programs	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 (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.

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*
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.

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 claimed for Retiree Drug Subsidy payments, June 2006 and September 2007

Part D benefit categories	*June 2006*	*September 2007*
All Medicare enrollees age 65 and over	36,052,991	36,917,978
Enrollees in prescription drug plans	18,245,980	19,747,718
Type of plan		
Stand-alone plan	12,583,676	13,171,983
Medicare Advantage plan	5,662,304	6,575,735
Low income subsidy		
Yes	5,935,532	5,906,610
No	12,310,448	13,841,108
Retiree Drug Subsidy	6,498,163	6,454,729
Other	11,308,848	10,715,531

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 or more	2,772	3,502	3,862
Income			
Less than $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 (Series 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.

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, 1991–2005

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	8.0	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

* Includes people with private supplement of unknown sponsorship.

Note: HMO health plans include Heath Maintenance Organizations (HMO), Preferred Provider Organizations (PPO), and private fee-for-service plans (PFFs). 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 1–2 percent of enrollees). Medicaid coverage was determined from both survey responses and Medicare administrative records; this is a change in methodology from that used in *Older Americans Update 2006* and produces different estimates for "Medicaid" and "No supplement" categories.

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 continued

Table 32b. Percentage of people age 55–64 with health insurance coverage, by type of insurance and poverty status, 2006

Type of Insurance	Total	Poverty threshold		
		99 percent or less	100–199 percent	200 percent or more
		Percent		
Private	75.4	24.8	48.8	86.3
Medicaid	5.9	33.3	10.3	1.9
Medicare	4.3	9.4	12.2	2.2
Other coverage	3.5	2.6	5.4	3.3
Uninsured	10.8	29.9	23.3	6.2

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 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. People with more than one type of health insurance were assigned to the first appropriate category in the hierarchy. The category "uninsured" includes people who had no coverage as well as those who only had Indian Health Service coverage or had only a private plan that paid for one type of service such as accidents or dental care. Beginning in quarter 3 of 2004, two additional questions were added to the National Health Interview Survey insurance section to reduce potential errors in reporting of Medicare and Medicaid status. People age 65 and over not reporting Medicare coverage were asked explicitly about Medicare coverage, and people under age 65 with no reported coverage were asked explicitly about Medicaid coverage. For a further discussion of the impact of these additional questions see: Cohen and Martinez.[53]

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, selected years 1977–2004

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

Note: Out-of-pocket health care expenditures exclude personal spending for health insurance premium(s). Data for the 1987 survey have been adjusted to permit comparability across years; for details see Zuvekas and Cohen.[54]

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 65 and over with out-of-pocket expenditures, by selected characteristics, selected years 1977–2004

Selected characteristic	*1977*	*1987*	*1996*	*2000*	*2001*	*2002*	*2003*	*2004*
				Percent				
Total								
65 and over	7.2	8.8	8.4	9.1	10.0	10.8	11.6	11.6
55–64	5.2	5.8	7.1	7.0	7.6	7.1	7.3	7.5
55–61	5.1	5.7	6.2	6.1	6.9	6.6	6.9	7.1
62–64	5.5	5.9	9.5	9.3	9.6	8.5	8.4	8.8
65–74	6.4	7.2	7.7	8.1	8.7	9.5	9.2	10.7
75–84	8.8	11.0	9.0	10.4	11.4	11.9	13.4	11.8
85 and over	7.9	12.0	9.8	10.1	11.8	12.7	16.4	14.9
Income category								
Poor/near poor								
65 and over	12.3	15.8	19.2	22.6	23.5	27.6	27.8	29.3
55–64	16.1	18.1	30.0	29.9	31.2	27.1	29.9	30.0
55–61	17.5	19.8	27.6	28.1	29.6	26.5	30.0	29.6
62–64	13.3	14.0	34.3	(B)	34.9	28.5	29.9	30.9
65–74	11.0	13.7	21.6	24.4	25.7	27.7	23.4	29.0
75–84	14.4	19.0	18.3	22.9	23.3	28.4	30.2	29.4
85 and over	12.4	14.7	(B)	17.6	18.7	25.7	32.4	30.0
Other								
65 and over	5.4	7.0	5.6	6.3	7.3	7.2	8.0	8.1
55–64	3.9	3.7	3.2	3.4	4.2	4.1	4.5	4.1
55–61	3.7	3.4	2.9	3.1	3.9	3.8	4.2	4.0
62–64	4.2	4.6	3.8	4.3	5.3	5.0	5.5	4.8
65–74	5.0	5.9	4.9	5.6	6.2	6.4	6.9	7.4
75–84	6.2	8.4	6.3	6.9	8.4	8.2	9.1	8.2
85 and over	5.2	10.9	7.8	7.6	9.3	7.9	10.3	11.1
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
55–64	8.7	8.5	13.0	14.1	13.6	13.3	13.3	13.8
55–61	8.8	9.0	11.8	12.8	12.9	12.8	12.4	13.5
62–64	8.6	7.6	15.9	17.4	15.2	14.7	15.9	14.7
65–74	8.7	10.0	10.7	11.8	13.5	14.4	13.8	14.3
75–84	11.3	12.4	11.8	14.6	14.7	15.2	17.5	15.4
85 and over	8.9	12.2	(B)	13.8	13.2	13.5	19.5	17.9
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
55–64	3.9	4.6	5.0	4.0	5.2	4.6	5.0	5.0
55–61	3.9	4.5	4.1	3.5	4.8	4.4	4.9	4.5
62–64	4.1	4.9	7.3	5.6	6.6	5.6	5.4	6.4
65–74	5.3	5.4	6.3	6.2	6.2	7.1	6.9	8.9
75–84	7.5	9.7	7.2	7.5	9.1	9.6	10.7	9.3
85 and over	7.6	11.8	6.4	7.1	10.6	11.9	13.9	12.8

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

Note: Out-of-pocket health care expenditures exclude personal spending for health insurance premiums. Including expenditures for out-of-pocket premiums in the estimates of out-of-pocket spending would increase the percentage of household income spent on health care in all years. People are classified into the "poor/near poor" income category if their household income is below 125 percent of the poverty level; otherwise, people are classified into the "other" income category. The poverty level is calculated according to the U.S. Census Bureau guidelines for the corresponding year. The ratio of a person's out-of-pocket expenditures to their household income was calculated based on the person's per capita household income. For people who's 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 people with no out-of-pocket expenditures from the calculations (17 percent of the population age 65 and over in 1977, and 4.5 percent of the population age 65 and over in 2004). Data from the 1987 survey have been adjusted to permit comparability across years; for details, see Zuvekas and Cohen.[54]

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 65 and over, by type of health care services and age group, 2000–2004

Type of health care service, by year	*55–64*	*55–61*	*62–64*	*65 and over*	*65–74*	*75–84*	*85 and over*
2000							
Hospital care	8.5	7.5	*11.0	6.4	7.3	4.6	8.6
Office-based medical provider services	18.9	19.8	16.7	9.8	11.6	9.0	6.0
Dental services	20.0	21.3	17.0	15.8	17.5	15.9	9.6
Prescription drugs	44.7	44.0	46.5	53.6	57.1	51.5	48.0
Other health care	7.8	7.5	8.7	14.3	6.6	19.0	27.9
2001							
Hospital care	9.8	9.4	10.7	5.4	5.2	5.8	*4.8
Office-based medical provider services	19.8	19.9	19.7	9.4	10.5	9.6	6.0
Dental services	18.6	20.0	15.2	13.0	15.6	11.9	8.3
Prescription drugs	45.7	44.3	48.9	56.0	57.2	58.9	45.1
Other health care	6.1	6.4	5.5	16.2	11.5	13.8	*35.8
2002							
Hospital care	10.2	9.2	13.1	5.0	4.6	5.5	5.1
Office-based medical provider services	21.3	21.6	20.3	10.5	12.3	9.3	7.8
Dental services	18.1	18.3	17.7	14.0	17.6	12.3	6.2
Prescription drugs	43.8	43.5	44.7	58.2	57.9	56.6	65.5
Other health care	6.6	7.4	4.3	12.3	7.7	16.3	15.4
2003							
Hospital care	9.2	8.8	10.1	5.2	5.9	4.5	5.1
Office-based medical provider services	18.8	18.3	19.9	8.7	9.4	9.1	5.4
Dental services	16.7	16.7	16.9	11.8	14.5	9.5	9.5
Prescription drugs	48.5	49.0	47.5	58.3	61.3	54.5	59.8
Other health care	6.8	7.3	5.6	16.0	8.9	22.4	20.2
2004							
Hospital care	9.2	10.1	6.9	5.0	5.1	4.5	*5.9
Office-based medical provider services	20.1	18.7	23.6	10.1	12.4	9.2	5.3
Dental services	16.9	18.5	12.8	11.8	13.2	12.0	7.5
Prescription drugs	46.0	45.0	48.7	61.4	61.9	64.8	51.9
Other health care	7.8	7.7	8.1	11.8	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 nonhospital-based medical offices or clinic settings. Dental services include care provided by any type of dental provider. Prescription drugs include prescribed medications purchased, including refills. Other health care includes care provided by home health agencies and independent home health providers and expenses for eyewear, ambulance services, orthopedic items, hearing devices, prostheses, bathroom aids, medical equipment, disposable supplies, and other miscellaneous services. The majority of expenditures in the "other" category are for home health services and eyeglasses.

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

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

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, 2004

Service	*Average cost per enrollee*	*Total*	*Medicare*	*Medicaid*	*OOP*	*Other*
	Dollars			Percent		
Hospice	$183	100	100	0	0	0
Inpatient hospital	3,217	100	89	1	2	7
Home health care	380	100	93	1	5	2
Short-term institution	569	100	78	3	9	9
Physician/Medical	3,427	100	67	2	15	16
Outpatient hospital	1,137	100	67	2	8	24
Prescription drugs	1,987	100	3	10	32	55
Dental	309	100	1	1	76	22
Long-term care facility	1,842	100	0	48	45	6
All	13,052	100	53	9	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: Centers for Medicare and Medicaid Services, Medicare Current Beneficiary Survey.

Table 34b. Sources of payment for health care services for Medicare enrollees age 65 and over, by income, 2004

Income	*Average cost*	*Total*	*Medicare*	*Medicaid*	*OOP*	*Other*
	Dollars			Percent		
All	$13,052	100	53	9	19	19
$0-$10,000	16,766	100	53	25	14	8
10,001-20,000	13,558	100	53	11	20	17
20,001-30,000	12,985	100	57	2	21	21
30,001 or more	10,676	100	51	1	21	27

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: Centers for Medicare and Medicaid Services, 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, 1990–2006

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

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. Starting with 1999 data, 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 2004 Version 1.0; Fiscal 2006 Year-end Office of the Assistant Deputy Under Secretary for Health for Policy and Planning Enrollment file linked with August 2007 VHA Vital Status data (including data from VHA, VA, Medicare, and SSA).

INDICATOR 36 Nursing Home Utilization

Table 36a. Rate of nursing home residence among people age 65 and over, by sex and age group, selected years 1985–2004

Sex and age group	*1985*	*1995*	*1997*	*1999*	*2004*
			Rate per thousand		
Both sexes					
65 and over	54.0	46.4	45.4	43.3	34.8
65–74	12.5	10.2	10.8	10.8	9.4
75–84	57.7	46.1	45.5	43.0	36.1
85 and over	220.3	200.9	192.0	182.5	138.7
Men					
65 and over	38.8	33.0	32.0	30.6	24.1
65–74	10.8	9.6	9.8	10.3	8.9
75–84	43.0	33.5	34.6	30.8	27.0
85 and over	145.6	131.5	119.0	116.5	80.0
Women					
65 and over	61.5	52.8	52.0	49.8	40.4
65–74	13.8	10.7	11.6	11.2	9.8
75–84	66.4	54.3	52.7	51.2	42.3
85 and over	250.1	228.1	221.6	210.5	165.2
White					
65 and over	55.4	45.8	44.5	41.9	34.0
65–74	12.3	9.3	10.0	10.0	8.5
75–84	59.1	45.0	44.2	40.5	35.2
85 and over	228.7	203.2	192.4	181.8	139.4
Black					
65 and over	41.5	50.8	54.4	55.5	49.9
65–74	15.4	18.5	19.2	18.2	20.2
75–84	45.3	57.8	60.6	66.5	55.5
85 and over	141.5	168.2	186.0	182.8	160.7

Note: Rates are calculated using estimates of the civilian population of the United States including institutionalized people. Population data are from unpublished tabulations provided by the U.S. Census Bureau. The 2004 population estimates are postcensal estimates as of July 1, 2004, based on Census 2000. For more information about the 2004 population estimates, see the Technical Notes in Kozak, DeFrances, and Hall.[44] Age adjusted to the year 2000 population standard using the following three age groups: 65–74 years, 75–84 years, and 85 years and over. Residents are people on the roster of the nursing home as of the night before the survey. Residents for whom beds are maintained even though they may be away on overnight leave or in a hospital are included. People residing in personal care or domiciliary care homes are excluded. Numbers have been revised and differ from previous editions of *Older Americans*. See Appendix B for the definition of race and Hispanic origin in the National Nursing Home Survey.

Reference population: These data refer to the resident population.

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

INDICATOR 36 Nursing Home Utilization continued

Table 36b. Number of current nursing home residents age 65 and over, by sex and age group, selected years 1985–2004

Sex and age group	*1985*	*1995*	*1997*	*1999*	*2004*
			Number in thousands		
Both sexes					
65 and over	1,318	1,423	1,465	1,470	1,317
65–74	212	190	198	195	174
75–84	509	510	528	518	469
85 and over	597	724	738	757	674
Men					
65 and over	334	357	372	378	337
65–74	81	79	81	84	75
75–84	141	144	159	150	141
85 and over	113	133	132	144	121
Women					
65 and over	984	1,066	1,093	1,092	980
65–74	132	110	118	111	99
75–84	368	365	369	368	328
85 and over	485	590	606	613	554
White					
65 and over	1,227	1,272	1,295	1,280	1,149
65–74	188	154	161	157	134
75–84	474	451	464	441	406
85 and over	566	666	670	682	609
Black					
65 and over	82	123	137	146	145
65–74	22	30	31	30	35
75–84	31	47	52	59	55
85 and over	29	46	54	57	56

Note: Residents are people on the roster of the nursing home as of the night before the survey. Residents for whom beds are maintained even though they may be away on overnight leave or in a hospital are included. People residing in personal care or domiciliary care homes are excluded. Numbers have been revised and differ from previous editions of *Older Americans*. See Appendix B for the definition of race and ethnicity in the National Nursing Home Survey.

Reference population: These data refer to the population residing in nursing homes.

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

Table 36c. Percentage of nursing home residents age 65 and over, by amount of assistance with activities of daily living (ADLs), 2004

	Both Sexes	Men	Women	White	Black	Other
			Number			
Total nursing home residents	1,317,300	336,900	980,400	1,148,900	145,400	23,000
			Number and Percent			
Bathing						
Total	1,298,700	330,000	968,700	1,132,700	143,100	22,900
No assistance	6.3	8.2	5.7	6.2	6.8	*
Some assistance	55.2	56.4	54.8	56.4	47.2	42.2
Total dependence	38.5	35.4	39.5	37.4	46.0	46.4
Dressing						
Total	1,300,300	330,500	969,800	1,134,200	143,200	23,000
No assistance	15.6	17.2	15.0	15.7	14.0	*20.2
Some assistance	58.4	59.8	57.9	59.0	55.0	50.0
Total dependence	26.1	23.1	27.1	25.4	31.0	*29.9
Eating						
Total	1,302,400	331,600	970,800	1,136,400	143,200	22,900
No assistance	64.5	69.3	62.9	65.2	59.9	60.4
Some assistance	20.5	17.7	21.4	20.5	20.8	*15.1
Total dependence	15.0	13.0	15.7	14.3	19.3	*24.5
Transferring						
Total	1,293,900	329,000	964,900	1,128,600	142,600	22,700
No assistance	26.8	31.4	25.2	26.8	27.4	*24.0
Some assistance	51.2	50.0	51.6	52.3	43.5	45.7
Total dependence	22.0	18.6	23.1	20.9	29.0	*30.3
Toileting						
Total	1,297,800	330,500	967,300	1,132,700	142,300	22,800
No assistance	20.3	22.9	19.5	20.5	18.9	*20.9
Some assistance	48.0	48.4	47.8	48.9	41.5	41.8
Total dependence	31.7	28.7	32.7	30.6	39.6	37.3

*Estimate does not meet standard of reliability or precision because the sample size is less than 30. Estimates accompanied by an asterisk (*) indicate that the sample size is between 30 and 59, or the sample size is greater than 59, but has a relative standard error of 30 percent or more.

Note: Residents are people on the roster of the nursing home as of the night before the survey. Residents for whom beds are maintained even though they may be away on overnight leave or in a hospital are included. People residing in personal care or domiciliary care homes are excluded. Excludes residents for whom activities did not occur and unknowns. ADL self-performance is ascertained for residents' performance over all shifts during the last 7 days, not including setup of the activity. No assistance includes people who were coded as independent (no help or oversight -or- help/oversight provided only 1 or 2 times during last 7 days) or receiving supervision (oversight, encouragement or cueing provided 3 or more times during last 7 days). Some assistance includes people who were coded as limited assistance (resident highly involved in activity; received physical help in guided maneuvering of limbs or other nonweight bearing assistance 3 or more times -or- more help provided only 1 or 2 times during last 7 days) or extensive assistance (while resident performed part of activity, over last 7 day period, help of following type(s) provided 3 or more times: a) weight-bearing support and/or b) full staff performance during part (but not all) of last 7 days). Total dependence includes people who were coded as full staff performance of activity during entire 7 days. See Appendix B for the definition of race and Hispanic origin in the National Nursing Home Survey.

Reference population: These data refer to the population residing in nursing homes.

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

INDICATOR 37 Residential Services

Table 37a. Percentage of Medicare enrollees age 65 and over residing in selected residential settings, by age group, 2005

Residential setting	*65 and over*	*65–74*	*75–84*	*85 and over*
		Number in thousands		
All settings	33,394	16,116	12,703	4,575
		Percent		
Total	100.0	100.0	100.0	100.0
Traditional community	93.0	98.0	92.6	76.3
Community housing with services	2.4	0.7	3.1	6.8
Long-term care facilities	4.6	1.3	4.3	16.9

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, or help with medications. Respondents were asked about access to these services but not whether they actually used the services. A residence is considered a long-term care facility if it is certified by Medicare or Medicaid; has 3 or more beds and is licensed as a nursing home or other long-term care facility and provides at least one personal care service; or provides 24-hour, 7-day-a-week supervision by a caregiver.

Reference population: These data refer to Medicare enrollees.

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

Table 37b. Percentage of Medicare enrollees age 65 and over with functional limitations, by residential setting, 2005

Functional status	*Traditional community*	*Community housing with services*	*Long-term care facility*
		Percent	
Total	100.0	100.0	100.0
No functional limitations	63.6	39.6	5.8
IADL limitations only	10.6	14.9	11.9
1–2 ADL limitations	20.1	33.4	18.0
3 or more ADL limitations	5.7	12.2	64.4

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, or help with medications. Respondents were asked about access to these services but not whether they actually used the services. A residence is considered a long-term care facility if it is certified by Medicare or Medicaid; 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. Instrumental activities of daily living (IADLs) 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. Only the questions on telephone use, shopping, and managing money are asked of long-term care facility residents. Activities of daily living (ADLs) 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, or 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 long-term care facility residents.

Reference population: These data refer to Medicare enrollees.

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

Table 37c. Availability of specific services among Medicare enrollees age 65 and over residing in community housing with services, 2005

People residing in community housing with services who have access to...	*Percent*
Total	100.0
Prepared meals	85.6
Housekeeping, maid, or cleaning services	82.2
Laundry services	70.1
Help with medications	45.0

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 services listed in the table through their place of residence. Respondents were asked about access to these services but not whether they actually used the services.

Reference population: These data refer to Medicare enrollees.

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

Table 37d. Annual income distribution of Medicare enrollees age 65 and over, by residential setting, 2005

Income	*Traditional community*	*Community housing with services*	*Long-term care facility*
		Percent	
Total	100.0	100.0	100.0
$0–$10,000	15.0	22.1	40.1
10,001–20,000	26.9	27.2	31.9
20,001–30,000	21.5	21.4	13.9
30,001 or more	36.7	29.3	14.1

Note: Community housing with services applies to respondents who reported they lived in retirement communities or apartments, senior citizen housing, continuing care retirement facilities, assisted living facilities, staged living communities, board and care facilities/homes, and similar situations, AND who reported they had access to one or more of the following services through their place of residence: meal preparation, cleaning or housekeeping services, laundry services, or help with medications. Respondents were asked about access to these services but not whether they actually used the services. A residence is considered a long-term care facility if it is certified by Medicare or Medicaid; 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. 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 enrollees.

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

INDICATOR 37 Residential Services continued

Table 37e. Characteristics of services available to Medicare enrollees age 65 and over residing in community housing with services, 2005

Selected characteristic	*Percent*
Services included in housing costs	100.0
All included	46.5
Some included/some separate	40.4
All separate	13.1
Can continue living there if they need substantial services	100.0
Yes	51.8
No	48.2

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, or help with medications. Respondents were asked about access to these services but not whether they actually used the services.

Reference population: These data refer to Medicare enrollees.

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

INDICATOR 38 Personal Assistance and Equipment

Table 38a. Distribution of noninstitutionalized Medicare enrollees age 65 and over who have limitations in activities of daily living (ADLs), by type of assistance, selected years 1992–2005

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

Note: The Medicare Current Beneficiary Survey has replaced the National Long Term Care Survey as the data source for this indicator. Consequently, the measurement of personal assistance and equipment has changed from previous editions of *Older Americans*. 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 38b. 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 1992–2005

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

Note: The Medicare Current Beneficiary Survey has replaced the National Long Term Care Survey as the data source for this indicator. Consequently, the measurement of personal assistance has changed from previous editions of *Older Americans*. 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.

Literacy Table. Percentage of people age 65 and over in each literacy performance level, by literacy component, 1992 and 2003

	Prose		*Document*		*Quantitative*	
	1992	*2003*	*1992*	*2003*	*1992*	2003
Proficient	3	4	2	3	5	5
Intermediate	27	34	29	38	18	24
Basic	37	38	31	33	29	37
Below basic	33	23	38	27	49	34

Note: Literacy is measured using three different components: prose literacy is the ability to search, comprehend, and use information from continuous texts (e.g., reading a newspaper); document literacy is the ability to search, comprehend, and use information from noncontinuous texts (e.g., bus schedules); and quantitative literacy is the ability to identify and perform computations using numbers embedded in printed materials (e.g., calculating numbers in tax forms).

Reference population: These data refer to people residing in households or prisons.

Source: U.S. Department of Education, National Center for Education Statistics, National Assessment of Adult Literacy.

Health Literacy Table. Percentage of people age 50 and over in each health literacy performance level, by age group, 2003

	65 and over	*50–64*	*65–74*	*75 and over*
Proficient	3	12	5	1
Intermediate	38	53	44	29
Basic	30	21	29	31
Below basic	29	13	23	39

Note: Health literacy is the ability to locate and understand health-related information and services and requires skills represented in the three general components that make up literacy—prose, document, and quantitative literacy (see Literacy table above). Tasks used to measure health literacy were organized around three domains of health and health care information and services—clinical, prevention, and navigation of the health care system and mapped to the performance levels (proficient, intermediate, basic, and below basic) based on their level of difficulty.

Reference population: These data refer to people residing in households or prisons.

Source: U.S. Department of Education, National Center for Education Statistics, National Assessment of Adult Literacy.

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), 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: 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: 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: 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: 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 estimates of unemployment released every month by BLS. Monthly CPS supplements provide additional demographic and social data. The Annual Social and Economic Supplement (ASEC), or March CPS Supplement, is the primary source of detailed information on income and poverty in the United States. The ASEC is used to generate the annual Population Profile of the United States, reports on geographical mobility and educational attainment, and detailed analyses of money income and poverty status.

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

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

The 1994 redesign of the CPS had an impact on labor force participation rates for older men and women. (See "Indicator 11: Participation in the Labor Force.") For more information on the effect of the redesign, see "The CPS After the Redesign: Refocusing the Economic Lens."[55]

For more information regarding the CPS, its sampling structure and estimation methodology, see "Explanatory Notes and Estimates of Error."[56]

For more information, contact:
Bureau of Labor Statistics
Department of Labor
E-mail: cpsinfo@bls.gov
Phone: 202–691–6378
Website: 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: www.census.gov/main/www/cen2000.html

Health and Retirement Study

The Health and Retirement Study (HRS) is a national panel study conducted by the University of Michigan's Institute for Social Research under a cooperative agreement with the National Institute on Aging. In 1992, the study had an initial sample of over 12,600 people from the 1931–1941 birth cohort and their spouses. The HRS was joined in 1993 by a companion study, Asset and Health Dynamics Among the Oldest Old (AHEAD), with a sample of 8,222 respondents (born before 1924 who were age 70 and over) and their spouses. In 1998, these two data collection efforts were combined

into a single survey instrument and field period and were expanded through the addition of baseline interviews with two new birth cohorts: Children of the Depression Age (CODA: 1924–1930) and War Babies (WB: 1942–1947). Plans call for adding a new 6-year cohort of Americans entering their 50s every 6 years. In 2004, baseline interviews 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. 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.[57] 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.[54] 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 (2000–03), 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.

For more information, contact:
MEPS Project Director
E-mail: mepsprojectdirector@ahrq.hhs.gov
Phone: 301–427–1406
Website: www.meps.ahrq.gov/mepsweb

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 118 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:
MCBS Staff
E-mail: MCBS@cms.hhs.gov
Website: www.cms.hhs.gov/mcbs

The Research Data Assistance Center
E-mail: resdac@umn.edu
Phone: 888–973–7322
Website: www.resdac.umn.edu

National Assessment of Adult Literacy

The National Assessment of Adult Literacy, funded by the U.S. Department of Education and 12 States, was created in 1992 as a new measure of literacy. The aim of the survey was to profile the English literacy of adults in the United States based on their performance across a wide array of tasks that reflect the types of materials and demands they encounter in their daily lives.

To gather information on adults' literacy skills, trained staff interviewed a nationally representative sample of nearly 13,600 individuals age 16 and over during the first 8 months of 1992. These participants had been randomly selected to represent the adult population in the country as a whole. Black and Hispanic households were oversampled to ensure reliable estimates of literacy proficiencies and to permit analyses of the performance of these subpopulations. In addition, some 1,100 inmates from 80 Federal and State prisons were interviewed to gather information on the proficiencies of the prison population. In total, nearly 26,000 adults were surveyed.

Each survey participant was asked to spend approximately an hour responding to a series of diverse literacy tasks, as well as questions about his or her demographic characteristics, educational background, reading practices, and other areas related to literacy. Based on their responses to the survey tasks, adults received proficiency scores along three scales that reflect varying degrees of skill in prose, document, and quantitative literacy. The results of the 1992 survey were first published in a report, Adult Literacy in America (NCES 93-275), in September 1993.

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

For more information, contact:
Sheida White
National Center for Education Statistics
E-mail: Sheida.White@ed.gov
Website: nces.ed.gov/naal

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 2006 consisted of 29,204 households, which yielded 75,716 people in 29,868 families. More information on the survey methodology and content of NHIS can be found at 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 (shown in Tables 16a, 18, 21a, 22, 24b, and 26a on pages 100, 102, 106, 107, 109, and 111) conform to 1997 standards and are for people who reported only one racial group. Prior to data year 1999, data were tabulated according to the 1977 standards and included people who reported one race or, if they reported more than one race, identified one race as best representing their race. In Table 21a on page 106, estimates of non-Hispanic whites and non-Hispanic blacks in 1997 and 1998 are for people who reported only a single race. In Table 26a on page 111, the white and black race groups include people of Hispanic origin.

Additional background and health data for adults are available in *Summary Health Statistics for the U.S. Population: National Health Interview Survey*.[58]

For more information, contact:
NHIS staff
E-mail: nchsquery@cdc.gov
Phone: 866–441–6247
Website: 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.

For more information, contact:
NHANES
E-mail: nchsquery@cdc.gov
Phone: 866–441–6247
Website: www.cdc.gov/nchs/nhanes.htm

National Nursing Home Survey

The National Nursing Home Survey (NNHS), conducted by the National Center for Health Statistics, provides information on characteristics of nursing homes and their residents and staff. NNHS provides information on nursing homes from two perspectives: that of the provider of services and that of the recipient. Data about the facilities include characteristics such as bed size, ownership, affiliation, Medicare/Medicaid certification, specialty units, services offered, number and characteristics of staff, expenses, and charges. Data about the current residents include demographic characteristics, health status, level of assistance needed with activities of daily living, vision and hearing impairment, continence, services received, sources of payment, and discharge disposition (information on discharges was not collected in 1995 and 2004). The survey underwent a major redesign in 2004. New content added to the survey included medications, medical, mental health, and dental services offered or provided, end-of-life care and advance directives, education, specialty credentials, and length of service of key staff, turnover and stability of nursing staff, use of contract/agency staff, overtime shifts worked, wages and benefits, facility practices for immunization, dining, and use of mechanical lifting devices.

The initial NNHS, conducted in 1973–1974, included the universe of nursing homes that provided some level of nursing care and excluded homes providing only personal or domiciliary care. The 1977 and 1985 NNHS encompassed all types of nursing homes, including personal care and domiciliary care homes. The 1995, 1997, 1999, and 2004 NNHS also included only nursing homes that provided some level of nursing care and excluded homes providing only personal or domiciliary care, similar to the 1973–1974 survey.

The Nursing Assistant Supplement to the 2004 NNHS was designed to determine the likelihood that workers will continue in their present positions and the factors that affect those decisions, including job satisfaction, environment, training, advancement opportunities, benefits, working conditions, and personal or family demands. This first national survey of nursing assistants was conducted as a separate telephone interview with a sample of workers who provide nursing home residents assistance with activities of daily living (eating, transferring, toileting, dressing, and bathing).

Race and Hispanic origin: Starting with data year 1999, the instruction for the race item on the Current Resident Questionnaire was changed so that more than one race could be recorded. In previous years, only one racial category could be checked. Estimates for racial groups presented in this table are for residents for whom only one race was recorded. Estimates for residents where multiple races were checked are unreliable because of small sample sizes and are not shown. Other race includes Asian, Native Hawaiian or other Pacific Islander, American Indian or Alaska Native and multiple races.

For more information, contact:
E-mail: nchsquery@cdc.gov
Phone: 866–441–6247
Website: www.cdc.gov/nchs/nnhs.htm

National Vital Statistics System

Through the National Vital Statistics System, the National Center for Health Statistics collects and publishes data on births, deaths, and prior to 1996, marriages and divorces occurring in the United States based on U.S. standard certificates. The Division of Vital Statistics obtains information on births and deaths from the registration offices of each of the 50 States, New York City, the District of Columbia, Puerto Rico, the U.S. Virgin Islands, Guam, America Samoa, and Northern Mariana Islands. Geographic coverage for births and deaths has been complete since 1933. Demographic information on the death certificate is provided by the funeral director based on information supplied by an informant. Medical certification of cause of death is provided by a physician, medical examiner, or coroner. The mortality data file is a fundamental source of cause-of-death information by demographic characteristics and for geographic areas such as States. The mortality file is one of the few sources of comparable health-related data for smaller geographic areas in the United States and over a long time period. Mortality data can be used not only to present the characteristics of those dying in the United States but also to determine life expectancy and to compare mortality trends with other countries. Data for the entire United States refer to events occurring within the United States; data for geographic areas are by place of residence.

Race and Hispanic origin: Race and Hispanic origin are reported separately on the death certificate. Therefore, data by race shown in Tables 14b, 15b, and 15c (on pages 93 and 96–99) include people of Hispanic or non-Hispanic origin; data for Hispanic origin include people of any race.

For more information on the mortality data files, see "Deaths: Leading causes for 2004."[59]

For more information, contact:
Mortality Statistics Branch
E-mail: nchsquery@cdc.gov
Phone: 866–441–6247
Website: 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 Islanders, and all people reporting more than one of the major race categories defined by the Office of Management and Budget (OMB).

For a more detailed discussion of the cohort-component method and the assumptions about the components of population change, see "Methodology and Assumptions for the Population Projections of the United States: 1999 to 2100."[60] 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: 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, 2005

The 2005 Survey of Veteran Enrollees' Health and Reliance Upon VA is the fifth 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, and 2003. All five VHA surveys of enrollees consisted of telephone interviews with stratified random samples of enrolled veterans. In 2000, 2002, 2003, and 2005, 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 2005 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 15 minutes in length. In the 2005 survey, interviews were conducted from September 28, 2005, through December 12, 2005. Of approximately 6.7 million eligible enrollees who had not declined enrollment as of December 31, 2004, some 42,000 completed interviews in the 2005 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.

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

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Veteran Population Estimates and Projections (model name is VetPop2004, December 2004)

VetPop2004 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 www.nhlbisupport.com/bmi. For more information about BMI, see "Clinical guidelines on the identification, evaluation, and treatment of overweight and obesity in adults."[61]

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 www.cdc.gov/nchs/deaths.htm[62] See also comparability ratio; *International Classification of Diseases*; Appendix I, National Vital Statistics System, Multiple Cause-of-Death File.[63]

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) and in 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.

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

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

Emergency room services: 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.

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: 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).

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.[54]) 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 Literacy: The degree to which individuals have the capacity to obtain, process, and understand basic health information and services needed to make appropriate health decisions.[49]

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 in-patient hospital stays with the same admission and discharge dates and classified on the Medicare bill as "out-patient" 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 and 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 include 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.

Literacy: The ability to use printed and written information to function in society, to achieve one's goals, and to develop one's knowledge and potential.

Long-term care facility: In the Medicare Current Beneficiary Survey (MCBS) (Indicators 20 and 37), a residence (or unit) 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 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 Nursing home (Indicator 36), 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 postacute 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 postacute 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 doctor's services, outpatient hospital care, and durable medical equipment. It also covers some other medical services that Medicare Part A does not cover, such as physical and occupational therapy and some home health care. Medicare Part B also pays for some supplies when they are medically necessary.

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

Nursing home: In the 2004 National Nursing Home Survey (Indicator 36), a nursing home is a facility or unit licensed as a nursing home or a nursing facility by the State health department or some other State agency and having three or more beds. Facilities providing care solely to the mentally retarded and mentally ill are excluded. Facilities may be certified by Medicare or Medicaid, or both. These facilities may be freestanding or nursing care units of hospitals, retirement centers, or similar institutions where the unit maintained financial and resident records separate from those of the larger institutions. For the definition of a nursing home as used in the 1985 National Nursing Home Survey, see Appendix B under "National Nursing Home Survey." In the Medicare Current Beneficiary Survey (Indicators 30 and 34), the category "nursing home" is not a mutually exclusive category. See Skilled nursing facility (Indicator 29), Short-term institution (Indicators 30 and 34), and Long-term care facility (Indicators 20, 30, 34, and 37).

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.[64]

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.[64]

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., $9,669 for one person age 65 and over in 2006).[65] 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," and "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., $9,669 and $19,337 for one person age 65 and over in 2006). Middle income is between 200 percent and 399 percent of the poverty threshold (i.e., between $19,338 and $38,675 for one person age 65 and over in 2006). 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), Nursing home (Indicator 36), and Long-term care facility (Indicators 20, 30, 34, and 37).

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.

The Historical Experience of Three Cohorts of Older Americans: A Timeline of Selected Events 1923–2008

1943 Cohort	1933 Cohort	1923 Cohort	Year	Historical Events	Legislative Events
		Born	1923		
		5 years old	1928	***1929*** - Stock market crashes	
	Born		1933		***1934*** - Federal Housing Administration created by Congress; ***1935*** - Social Security Act passed; ***1937*** - U.S. Housing Act passed, establishing Public Housing
	5 years old	15 years old	1938		
Born			1943	***1941*** - Pearl Harbor; United States enters WWII	
5 years old	15 years old	25 years old	1948	***1945*** - Yalta Conference; Cold War begins ***1946*** - Baby Boom begins	
			1953	***1950*** - United States enters Korean War	
15 years old	25 years old	35 years old	1958	***1955*** - Nationwide polio vaccination program begins	***1956*** - Women age 62–64 eligible for reduced Social Security benefits; ***1957*** - Social Security Disability Insurance implemented; ***1959*** - Section 202 of the Housing Act established, providing assistance to older adults with low income; ***1961*** - Men age 62–64 eligible for reduced Social Security benefits; ***1962*** - Self-Employed Individual Retirement Act (Keogh Act) passed; ***1964*** - Civil Rights Act passed; ***1965*** - Medicare and Medicaid established; Older Americans Act passed; ***1967*** - Age Discrimination in Employment Act passed
			1963	***1964*** - United States enters Vietnam War; Baby Boom ends	
25 years old	35 years old	45 years old	1968	***1969*** - First man on the moon	
			1973		***1972*** - Formula for Social Security cost-of-living adjustment established; Social Security Supplemental Security Income legislation passed; ***1974*** - Employee Retirement Income Security Act (ERISA) passed; IRAs established; ***1975*** - Age Discrimination Act passed; ***1978*** - 401(k)s established
35 years old	45 years old	55 years old	1978		
			1983	***1980*** - First AIDS case is reported to the Centers for Disease Control and Prevention	***1983*** - Social Security eligibility age increased for full benefits; ***1984*** - Widows entitled to pension benefits if spouse was vested ***1986*** - Mandatory retirement eliminated for most workers; ***1987*** - Reverse mortgage market created by the HUD Home Equity Conversion Program ***1990*** - Americans with Disabilities Act passed
45 years old	55 years old	65 years old	1988	***1989*** - Berlin Wall falls ***1990*** - United States enters Persian Gulf War	
			1993		
55 years old	65 years old	75 years old	1998		***1996*** - Veterans' Health Care Eligibility Reform Act passed, creating access to community based long-term care for all enrollees; ***1997*** - Balanced Budget Act passed changing Medicare payment policies; ***2000*** - Social Security earnings test eliminated for full retirement age; ***2003*** - Medicare Modernization Act passed
			2003	***2001*** - September 11-Terrorists attack United States ***2003*** - United States enters Iraq war	***2005*** - Deficit Reduction Act passed realigning Medicaid incentives to provide noninstitutionalized long-term care; ***2006*** - Medicare presciption drug benefit implemented; Pension Protection Act passed
65 years old	75 years old	85 years old	2008	***2008*** - First Baby Boomers begin to turn 62 years old and become eligible for Social Security retired worker benefits	