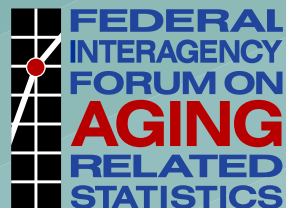


# OLDER AMERICANS 2000:

KEY INDICATORS OF WELL-BEING

Population Economics Health Status Health Risks and Behaviors Health Care



# **OLDER AMERICANS 2000:**

**KEY INDICATORS OF WELL-BEING**

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# Foreword

**A**mericans age 65 or older are an important and growing segment of our population. Many Federal agencies provide data on various aspects of the challenges confronting older Americans. Because these data come from multiple agencies, it is sometimes difficult to understand how this group is faring overall. In light of the anticipated growth of this segment of our population, it is increasingly important for policymakers and the general public to have an accessible, easy to understand portrait that shows how older Americans are doing. This new interagency report, *Older Americans 2000: Key Indicators of Well-Being (Older Americans)*, provides a unified picture of the health and well-being of our older population.

This is the first chartbook prepared by the Interagency Forum on Aging-Related Statistics (Forum), a coalition of nine Federal agencies (Administration on Aging; Bureau of Labor Statistics; Census Bureau; Health Care Financing Administration; National Center for Health Statistics; National Institute on Aging; Office of Management and Budget; Office of the Assistant Secretary for Planning and Evaluation, Department of Health and Human Services; and Social Security Administration). The work of the Forum also benefitted from substantial contributions by the Bureau of Justice Statistics, Department of Justice; the National Highway Traffic Safety Administration, Department of Transportation; and the Center for Nutrition Policy and Promotion, Department of Agriculture.

This publication provides 31 key indicators about older Americans, categorized into five broad groups: population, economics, health status, health risks and behaviors, and health care. While Federal agencies currently collect and report substantial information on the population age 65 and older, there remain several important areas where there are gaps in our knowledge. This chartbook concludes with a discussion of data needs that the Forum has identified. By displaying what the government knows, and what it does not know, this report challenges the Federal statistical agencies to do even better.

The agencies participating in the Forum should be congratulated on the effort that went into creating *Older Americans*. They joined together to give the American people a valuable tool for tracking the condition of those who are age 65 or older, and for making policy decisions that will affect them. The Forum anticipates publishing additional volumes of this chartbook on a periodic basis, every three to five years.


We hope you will find this compendium a useful contribution to your work, and invite you to suggest ways we can enhance this portrait of our population age 65 and older. Please send comments to us at the Forum's Website ([www.agingstats.gov](http://www.agingstats.gov)).

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# Acknowledgments

 *lder Americans 2000: 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 chartbook working group and reviewed by the Forum's organizing members.

The Forum's chartbook working group members include Saadia Greenberg, Administration on Aging; Ryan Helwig and Diane Herz, Bureau of Labor Statistics; Victoria Velkoff and Jane Lawson Dye (until 1999), Census Bureau; Gerald Riley, Health Care Financing Administration; Ellen Kramarow and Julie Dawson Weeks, National Center for Health Statistics; Rose Maria Li, National Institute on Aging; William Marton, Office of the Assistant Secretary for Planning and Evaluation (Department of Health and Human Services); Virginia de Wolf, Office of Management and Budget; and Susan Grad, Social Security Administration. The Forum's Staff Director, Kristen Robinson (National Center for Health Statistics), and Presidential Management Intern, Andrea Pernack, provided leadership and coordination for the chartbook working group. Their knowledge and expertise, coupled with their considerable energy, enthusiasm, patience, and persistence, were fundamental to the success of this new endeavor.

In addition to the nine organizing agencies of the Forum, agencies in the Department of Agriculture (USDA), the Department of Justice (DOJ), and the Department of Transportation (DOT) were invited to contribute to this report. The Forum greatly appreciates the efforts of Nadine Sahyoun, Center for Nutrition Policy and Promotion, USDA; Patsy Klaus, Bureau of Justice Statistics, DOJ; and Esther Wagner, National Highway Traffic Safety Administration, DOT, in providing valuable information from their agencies.

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Other staff members of Federal agencies who provided data and assistance include Geoffrey Paulin, Bureau of Labor Statistics; Valerie Lawson, Census Bureau; Paul Eggers and David Gibson, Health Care Financing Administration; Yelena Gorina and Laurie Pratt, National Center for Health Statistics; Vicky Cahan, National Institute on Aging; Emil Loomis, Suzanne Payne, and Mikki Waid, Social Security Administration; and Arthur Kennickell, Board of Governors of the Federal Reserve.

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The National Center for Health Statistics provided overall leadership and coordination for the production of this report. The Social Security Administration, the Office of the Assistant Secretary for Planning and Evaluation (Department of Health and Human Services), and the National Institute on Aging provided financial support for this report. Other members of the Forum provided valuable staff and administrative support.

The report was produced under a contract to the Population Reference Bureau. Mark Mather coordinated and managed the project. Theresa Kilcourse designed and produced the report. Lisa Hisel provided editorial oversight and review. John Haaga and Ellen Carnevale provided general oversight.

The HCR Consulting Group provided administrative assistance for many of the Forum's meetings.

# About This Report

**I**n an effort to describe the overall status of the U.S. population age 65 and older, the Federal Interagency Forum on Aging-Related Statistics (Forum) has produced *Older Americans 2000: Key Indicators of Well-Being (Older Americans)*. This new report focuses on several important areas in the lives of older people—population, economics, health status, health risks and behaviors, and health care.

*Older Americans* is the first in a continuing series of reports the Forum plans to produce. Federal agencies have collaborated to create a comprehensive set of indicators that can be followed over time. By following these data trends, more accessible information will be available to target efforts that can improve the lives of older Americans.

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* is designed to present data in a nontechnical, user-friendly format; it complements other more technical and comprehensive reports produced by the Forum agencies. The report includes 31 indicators that are divided 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 on p. viii.

Each indicator includes:

- an introductory paragraph that describes the relevance of the indicator to the well-being of the older population;
- one or more charts that graphically display analyses of the data; and

- bulleted highlights of salient findings from the data and other sources.

The data used to develop each indicator 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* presents a selected set of key indicators that measure critical aspects of older people's lives. The Forum chose these indicators because they are:

- easy to understand by a wide range of audiences;
- based on reliable, nationwide, official data (collected or sponsored by Federal or state governments);
- 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; and
- representative of large segments of the aging population, rather than one particular group.

## Considerations When Examining the Indicators

*Older Americans* generally addresses the U.S. population age 65 and older. Mutually exclusive age groups (e.g., ages 65 to 74, 75 to 84, and age 85 and older) are reported whenever possible. Because life expectancy is increasing and larger numbers of people will be entering older age cohorts, future reports will aim to include information on the population ages 85 to 94 and 95 and older.

Data availability and analytical relevance may affect the specific age groups that are

included for an indicator. For example, the first and second Supplements on Aging (see Data Source Descriptions) collected data only on the population age 70 and older. Because of small sample sizes in some surveys, statistically reliable data for the population age 85 and older often are not available. Conversely, data from the population younger than age 65 sometimes are included if they help in the interpretation of the indicator. For example, in “Indicator 10: Participation in the Labor Force,” a comparison with a younger population enhances the interpretation of the labor force trends among people age 65 or older.

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

Data are presented for mutually exclusive racial and ethnic groups whenever possible. Hispanic origin classification is provided when the data are available. When racial groups are listed *without* the “non-Hispanic” classification, both Hispanics and non-Hispanics are included in those racial groups. Data for racial groups that comprise a smaller proportion of the population (e.g., American Indian and Alaska Native, Asian and Pacific Islander) are included whenever sample sizes are large enough to allow reliable statistical estimates.

The reference population for the indicators sometimes differs. Whenever possible, the indicators include data on the resident population (i.e., people living in the community and people living in institutions). However, some indicators show data only for the civilian noninstitutional population. Because the older population residing in nursing homes is excluded from samples based on the noninstitutional population, caution should be exercised when attempting to generalize the findings from these data sources to the entire population age 65 and older. The reference population (the base population sampled at the time of enrollment) for each indicator in this report is clearly labeled and defined in the glossary.

Data are age-adjusted when this is the standard procedure used by the Forum agency contributing the data.

In the charts, tick marks along the x-axis indicate years for which data are available. The range of years presented in each chart is not standardized because data availability

is not uniform across the different data sources used in this report.

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

## Sources of Data

The data used to create each chart 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 also is available in the 1999 publication *Data Base News in Aging*, which can be obtained from the Forum’s Staff Director.

Sometimes, 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 (p. 53). 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* 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. While 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 (p. 51). By identifying and highlighting these data needs, the Forum—as well as other policymakers, researchers, and service providers—will be better able to focus their future efforts.

## About the Federal Interagency Forum on Aging-Related Statistics

In 1986, the National Institute on Aging, in cooperation with the National Center for Health Statistics and the Census Bureau, established the Federal Interagency Forum on Aging-Related Statistics to foster collaboration among Federal agencies that produce or use statistical data on the older popula-

tion. Over a period of several years, the Forum played a key role in improving aging-related data by encouraging cooperation and data sharing among different agencies, furthering professional collaboration across different fields, and compiling aging-related statistical data in a centralized location. The meetings of the Forum helped promote a number of important developments, including the establishment of the Health and Retirement Study and the Study of Asset and Health Dynamics Among the Oldest Old; the comparison of disability measures across national surveys;<sup>1</sup> the acceptance of more standardized age categories; and the collection and presentation of statistics on more narrowly defined age and race categories.

In response to changes in the Federal statistical system, the Forum was reorganized in 1998. As part of this reorganization, the Administration on Aging, Bureau of Labor Statistics, Health Care Financing Administration, Office of the Assistant Secretary for Planning and Evaluation (Department of Health and Human Services), Office of Management and Budget, and Social Security Administration were invited to become organizing members of the Forum.

The inaugural meeting of the “new” Forum was held in March 1999. At this meeting, the organizing members agreed that the Forum should focus its efforts on developing an indicators chartbook, exploring opportunities to integrate data for research applications, and initiating projects to improve measurement methods and data quality.

## Mission of the Forum

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; and
- addressing concerns regarding collection, access, and dissemination of data.

## Financial Support of the Forum

The work of the Forum is currently funded by the Office of Demography of Aging, National Institute on Aging, National Institutes of Health. Valuable staff support is provided by all members of the Forum.

## Where to Find More Information About Forum Activities

If you would like more information about *Older Americans* or the Federal Interagency Forum on Aging-Related Statistics, contact the Forum’s staff director:

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# Highlights

**T**he indicators assembled in this chart-book show the results of decades of progress. At the beginning of a new century, older Americans are living longer and enjoying greater prosperity than any previous generation. Despite these advances, persistent inequalities between the sexes, income classes, and racial and ethnic groups continue to exist. The rapid growth of the older population over the next 50 years will intensify the need for policymakers, researchers, and community leaders to better understand the health and economic needs of older Americans.

## 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, will accelerate this growth. Both the number and the proportion of older people relative to the rest of the population are increasing. This increase in the size of the older population is accompanied by rapid growth in the population age 85 and older, as well as increasing racial and ethnic diversity among all older people.

- In 2000, there are an estimated 35 million persons age 65 or older in the United States, accounting for almost 13 percent of the total population. The older population is expected to double over the next 30 years to 70 million by the year 2030. Over the next 50 years, the population age 85 and older is expected to grow faster than any other age group. (See Indicator 1.)
- Women make up 58 percent of the population age 65 and older and 70 percent of the population age 85 and older. Older women are less likely than older men to be currently married and are more likely to live alone. In 1998, about 41 percent of older women were living alone, compared with 17 percent of older men. (See Indicators 1, 3, and 5.)
- The older population will become more racially and ethnically diverse during the

next 50 years. Non-Hispanic whites make up 84 percent of the population age 65 and older in 2000, and this is expected to decline to 64 percent by 2050. (See Indicator 2.)

- The current generation of older Americans is more highly educated than previous cohorts of older persons, and this trend will continue. In 1998, about 11 percent of older women and 20 percent of older men were college graduates. (See Indicator 4.)

## Economics

Generally, the economic status of older people has improved markedly over the past few decades. Poverty rates have declined and there has been a substantial increase in net worth for many older Americans. Still, major disparities exist, with older blacks and older women reporting fewer financial resources.

- The percentage of older persons living in poverty declined from about 35 percent in 1959 to 11 percent in 1998. (See Indicator 6.)
- In 1998, Social Security provided over 80 percent of income for older Americans with the lowest levels of income. For those in the highest income category, Social Security accounted for approximately 20 percent of total income. (See Indicator 8.)
- Between 1984 and 1999, the median net worth of households headed by older persons increased by about 70 percent. But there are large disparities in net worth. Households headed by older black persons had median net worth of about \$13,000 in 1999, compared with \$181,000 among households headed by older white persons. (See Indicator 9.)
- Between 1963 and 1999, labor force participation rates for men ages 62 to 64 declined from 76 percent to 47 percent, but participation rates increased from 29 percent to 34 percent for women in this age group. (See Indicator 10.)

- The burden of housing costs relative to all expenditures declines as income increases. In 1998, low-income households headed by persons age 65 or older allocated an average of 36 percent of all expenditures to basic housing, compared with high-income households, which spent an average of 26 percent. (See Indicator 11.)

## Health Status

The increase in life expectancy during the 20th century has been a remarkable achievement. Older age, however, is accompanied by increased risk of certain diseases and disorders. Significant proportions of older Americans suffer from a variety of chronic health conditions such as arthritis or hypertension. Despite these and other conditions, the rate of disability among older people has declined in recent years.

- Americans are living longer than ever before. If mortality rates remain constant, persons age 65 in 2000 are expected to live another 18 years, on average, compared with persons age 65 in 1900 who had a remaining life expectancy of 12 years. Life expectancy at age 65 is almost 2 years greater for whites than for blacks. (See Indicator 12.)
- The leading causes of death for older Americans are heart disease, cancer, and stroke (respectively). Mortality rates for heart disease and stroke have declined by about a third since 1980. The mortality rates for cancer have risen slightly over the same period. (See Indicator 13.)
- In 1995, about 58 percent of persons age 70 or older reported having arthritis, 45 percent reported having hypertension, and 21 percent reported having heart disease. (See Indicator 14.)
- In 1998, the percentage of older Americans with moderate or severe memory impairment ranged from about 4 percent among persons ages 65 to 69 to about 36 percent among persons age 85 or older. About 23 percent of persons age 85 or older reported severe symptoms of depression. (See Indicators 15 and 16.)
- The percentage of older Americans with a chronic disability declined from 24 percent in 1982 to 21 percent in 1994. In 1994, about 25 percent of older women reported disabilities, compared with 16 percent of older men. (See Indicator 18.)

## Health Risks and Behaviors

The social and behavioral aspects of life for older Americans can make a difference in health and well-being. Most older people report being socially active, which may contribute to their emotional and physical health. However, other measured aspects of social and health behaviors may threaten health, including the failure of many older adults to engage in physical activity, to have healthy diets, or to be vaccinated against influenza and pneumococcal disease.

- The majority of persons age 70 or older reported engaging in some form of social activity during a two-week period. About two out of every three persons age 70 or older reported that they were satisfied with their level of social activities. (See Indicator 19.)
- In 1995, about one third of older Americans reported a sedentary lifestyle (i.e., no leisure-time physical activities in a two-week period). (See Indicator 20.)
- From 1994 to 1996, a higher proportion of the population age 65 and older (21 percent) had diets that were rated “good” compared with persons ages 45 to 64 (13 percent). Even so, a majority of older persons reported diets that were poor (13 percent) or needed improvement (67 percent). (See Indicator 23.)
- Older persons are much less likely to be victims of both violent and property crime than persons ages 12 to 64. (See Indicator 24.)

## Health Care

Health care expenditures and use of services among older people are closely associated with age and disability status. There are large differences, for example, in health expenditures and use of services between persons ages 65 to 69 and persons age 85 or older. Older persons of all ages are generally satisfied with their health care and report few difficulties in obtaining health care services.

- In 1996, the average annual expenditure on health care (both out-of-pocket expenditures and expenditures covered by insurance) was \$5,864 among persons ages 65 to 69, compared with \$16,465 among persons age 85 or older. (See Indicator 25.)

- Although dollar expenditures increase with income, the relative burden of health care costs is much higher among lower- and middle-income households compared with higher income households. (See Indicator 27.)
- Among Medicare beneficiaries not enrolled in HMOs (82 percent of all beneficiaries in 1998), the rate of hospital admissions during the year increased from 307 per 1,000 in 1990 to 365 per 1,000 in 1998. However, the average length of stay in a hospital declined from 9 days to 6 days during the same time period. (See Indicator 29.)
- In 1997, about 1.5 million older persons (4 percent of the population age 65 or older) resided in nursing homes. This represents a decline since the mid-1980s in the proportion of older people living in nursing homes. Three-fourths of nursing home residents were women in 1997. Though a smaller proportion of older people were residents of nursing homes in 1997 compared with 1985, those who were in nursing homes were more likely to have serious functional limitations, such as incontinence, difficulty eating, or mobility limitation. (See Indicator 30.)
- The percentage of older Americans living in the community and receiving home care for disabilities declined from 18 percent in 1982 to 15 percent in 1994. Of those who received care in 1994, 64 percent relied exclusively on informal (unpaid) care, 8 percent received only formal care, and 28 percent received a combination of informal and formal care. (See Indicator 31.)

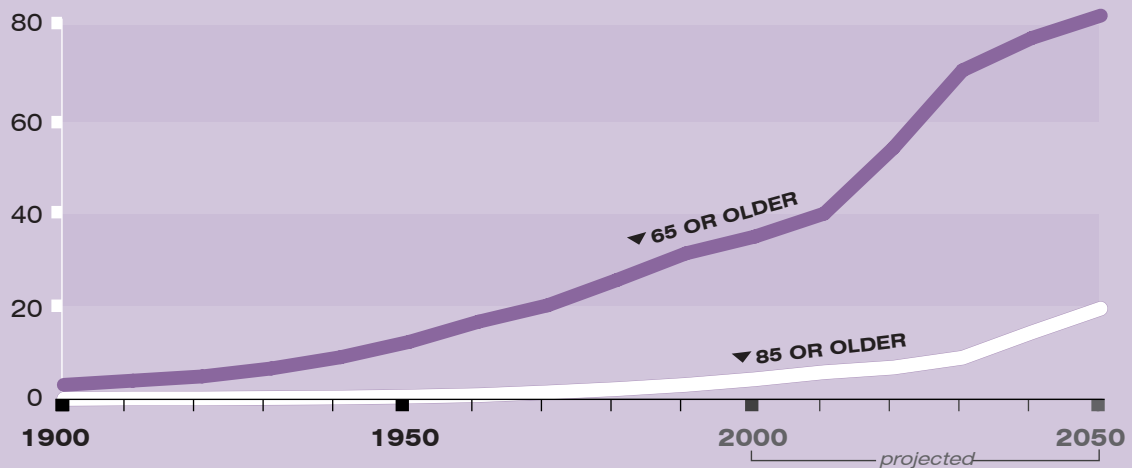
# Population



## Number of Older Americans

**T**he growth of the population age 65 and older has affected every aspect of our society, presenting challenges as well as opportunities to policymakers, families, businesses, and health care providers.

**Total number of persons age 65 or older, by age group, 1900 to 2050, in millions**

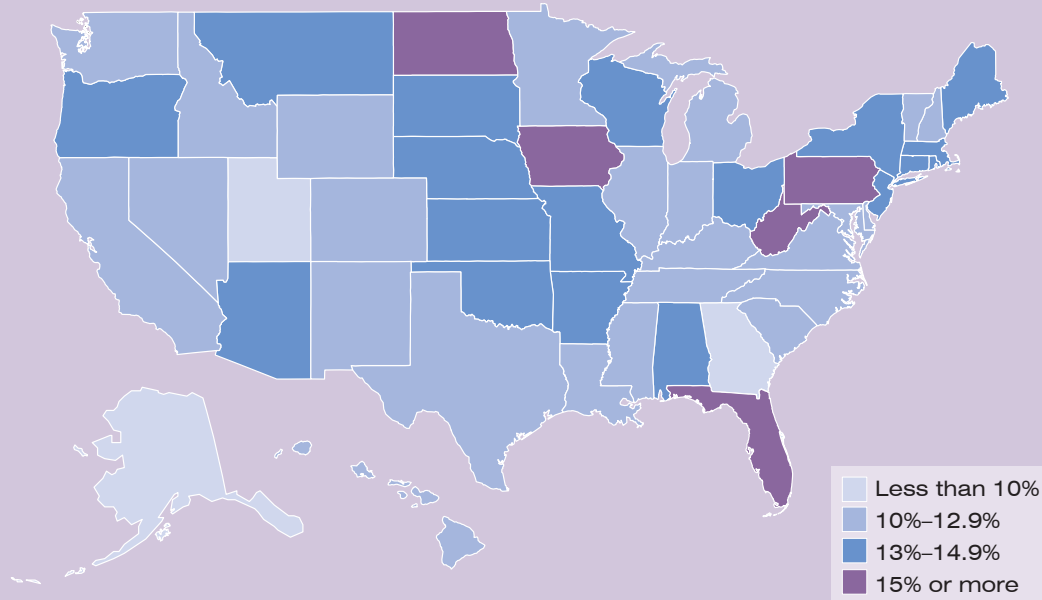


Note: Data for the years 2000 to 2050 are middle-series projections of the population. Reference population: These data refer to the resident population.

Source: U.S. Census Bureau, Decennial Census Data and Population Projections.

- In 2000, there are an estimated 35 million people age 65 or older in the United States, accounting for almost 13 percent of the total population. The number of older Americans has increased more than ten-fold since 1900, when there were 3 million people age 65 or older (4 percent of the total population). Despite the growth of the older population, the United States is a relatively young country when compared with other developed nations. In many industrialized countries, older persons account for 15 percent or more of the total population.
- In 2011, the “baby boom” generation will begin to turn 65, and by 2030, it is projected that one in five people will be age 65 or older. The size of the older population is projected to double over the next 30 years, growing to 70 million by 2030.
- As in most countries of the world, there are more older women than older men in the United States, and the proportion of the population that is female increases with age. In 2000, women are estimated to account for 58 percent of the population age 65 and older and 70 percent of the population age 85 and older.<sup>2</sup>
- The population age 85 and older is currently the fastest growing segment of the older population. In 2000, an estimated 2 percent of the population is age 85 and older. By 2050, the percentage in this age group is projected to increase to almost 5 percent of the U.S. population. The size of this age group is especially important for the future of our health care system, because these individuals tend to be in poorer health and require more services than the younger old.
- Projections by the U.S. Census Bureau suggest that the population age 85 and older could grow from about 4 million in 2000 to 19 million by 2050. Some researchers predict that death rates at older ages will decline more rapidly than reflected in the Census Bureau’s projections, which could result in faster growth of this population.<sup>3</sup>

### Percentage of the population age 65 and older, by state, 2000



Note: Data for the year 2000 are middle-series projections of the population.  
 Reference population: These data refer to the resident population.  
 Source: U.S. Census Bureau, Population Projections.

- The proportion of the population age 65 and older varies among states. This proportion is partly affected by the state mortality rate and the number of older persons who migrate to a state. It is also affected by the number of younger persons who move to other states. In 2000, the states with the highest proportions of older persons are Florida, West Virginia, Pennsylvania, Iowa, and North Dakota.
- There are about 65,000 people age 100 or older in 2000, and the number of cen-

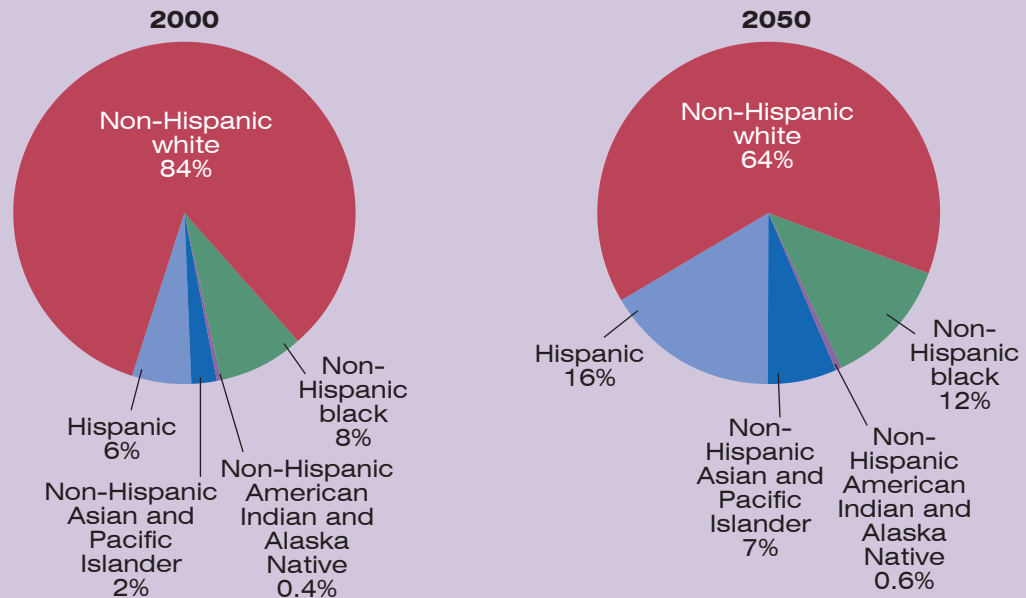
tenarians is projected to grow quickly so that there may be as many as 381,000 by 2030.<sup>4</sup> Research on the demographics of centenarians, along with clinical, biomedical, and genetic measures, may provide clues to the factors associated with their exceptional longevity.

*Data for this indicator can be found in Tables 1a, 1b, 1c, and 1d on pages 56 to 58.*

## Racial and Ethnic Composition

**A**s 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 past century. Over the next 50 years, programs and services for the older population will require greater flexibility to meet the demands of a diverse and changing population.

### Projected distribution of the population age 65 and older, by race and Hispanic origin, 2000 and 2050



Note: Data are middle-series projections of the population. Hispanics may be of any race.  
Reference Population: These data refer to the resident population.  
Source: U.S. Census Bureau, Population Projections.

■ In 2000, an estimated 84 percent of people age 65 or older are non-Hispanic white, 8 percent are non-Hispanic black, 2 percent are non-Hispanic Asian and Pacific Islander, and less than 1 percent are non-Hispanic American Indian and Alaska Native. Hispanic persons are estimated to make up 6 percent of the older population. By 2050, the percentage of the older population that is non-Hispanic white is expected to decline from 84 percent to 64 percent. Hispanic persons are projected to account for 16 percent of the older population; 12 percent of the population is projected to be

non-Hispanic black; and 7 percent of the population is projected to be non-Hispanic Asian and Pacific Islander.

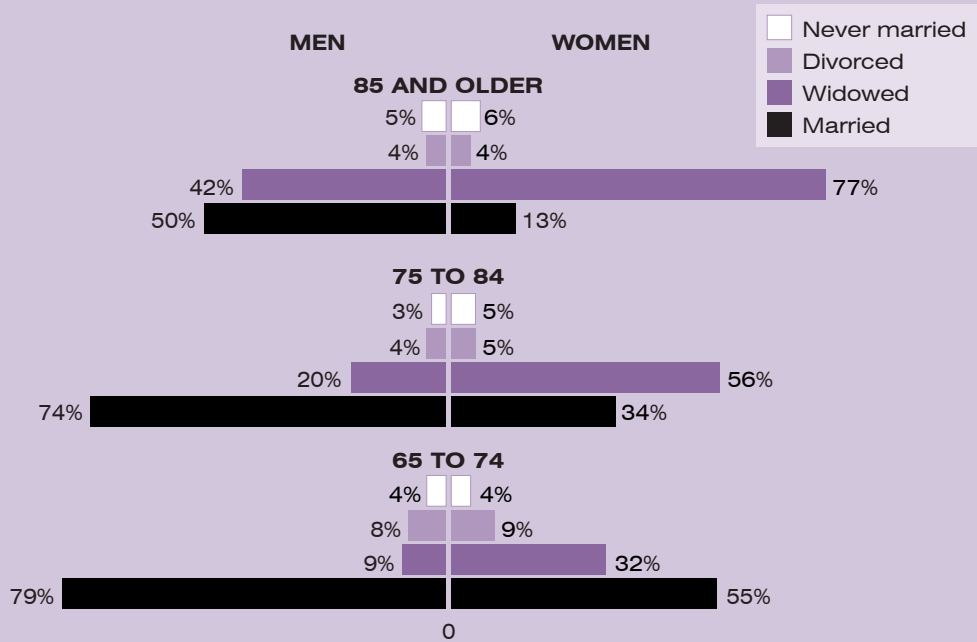
■ Although the older populations will increase among all racial and ethnic groups, the Hispanic older population is projected to grow the fastest, from about 2 million in 2000 to over 13 million by 2050. In fact, by 2028, the Hispanic population age 65 and older is projected to outnumber the non-Hispanic black population in that age group.<sup>5</sup>

*Data for this indicator can be found in Tables 2a and 2b on page 59.*

## Marital Status

**M**arital status can strongly affect a person’s emotional and economic well-being by influencing living arrangements and availability of caregivers among older Americans with an illness or disability.

**Marital status of the population age 65 and older, by age group and sex, 1998**



Reference population: These data refer to the civilian noninstitutional population.  
 Source: March Current Population Survey.

- In 1998, 79 percent of men ages 65 to 74 were married, compared with 55 percent of women in the same age group. Among persons age 85 or older, about 50 percent of men were married, compared with only 13 percent of women.
- Older women are much more likely to be widowed than are older men due to a combination of factors, including sex differences in life expectancy, the tendency for women to marry men who are slightly older, and higher remarriage rates for

older widowed men than widowed women.<sup>6</sup> In 1998, about 77 percent of women age 85 or older were widowed, compared with 42 percent of men.

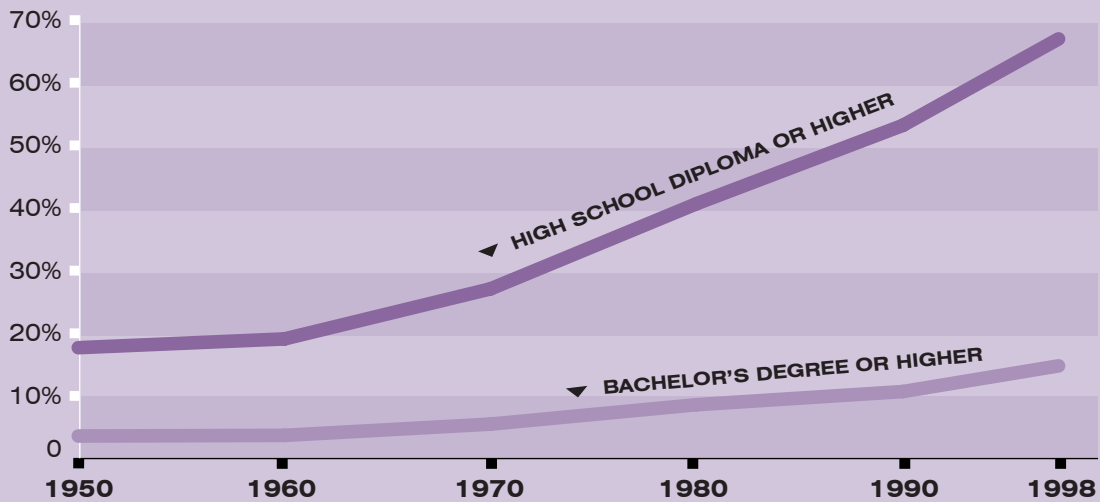
- In 1998, about 7 percent of the older population was divorced, and only a small percentage of the older population had never married (4 percent of men and 5 percent of women).

*Data for this indicator can be found in Table 3 on page 60.*

## Educational Attainment

**E**ducational attainment influences socioeconomic status, and thus can play 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 status among older Americans.

**Percentage of the population age 65 and older with high school diploma or higher and bachelor's degree or higher, 1950 to 1998**

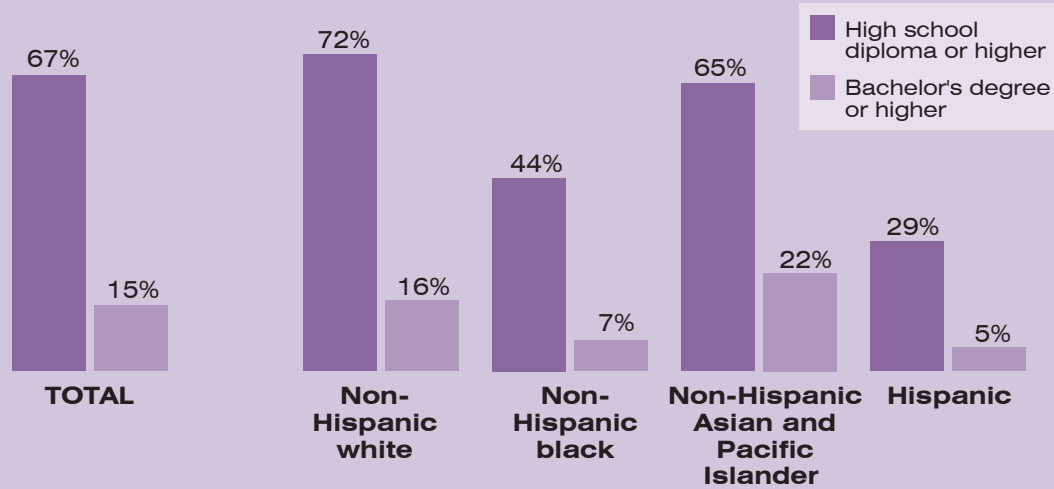


Reference population: Data for 1980 and 1998 refer to the civilian noninstitutional population. Data for other years refer to the resident population.

Source: Population Census volumes 1950, 1960, 1970, and 1990; and March Current Population Survey, 1980 and 1998.

- In 1950, only 18 percent of America's older population had finished high school. By 1998, about 67 percent of people age 65 or older had completed high school. The percentage of older Americans with at least a bachelor's degree increased from 4 percent in 1950 to almost 15 percent in 1998.
- In 1998, about 20 percent of older men had a bachelor's degree or higher, compared with 11 percent of older women. About two-thirds of both men and women had finished high school.<sup>7</sup>

**Percentage of the population age 65 and older with a high school diploma or higher and bachelor's degree or higher, by race and Hispanic origin, 1998**



Note: Hispanics may be of any race.

Reference Population: These data refer to the civilian noninstitutional population.

Source: March Current Population Survey.

■ Despite the overall increase in educational attainment among older Americans, there are still substantial educational differences among racial and ethnic groups. In 1998, about 72 percent of the non-Hispanic white population age 65 and older had finished high school, compared with 65 percent of the non-Hispanic Asian and Pacific Islander older population, 44 percent of the non-Hispanic black older

population, and 29 percent of the Hispanic older population.

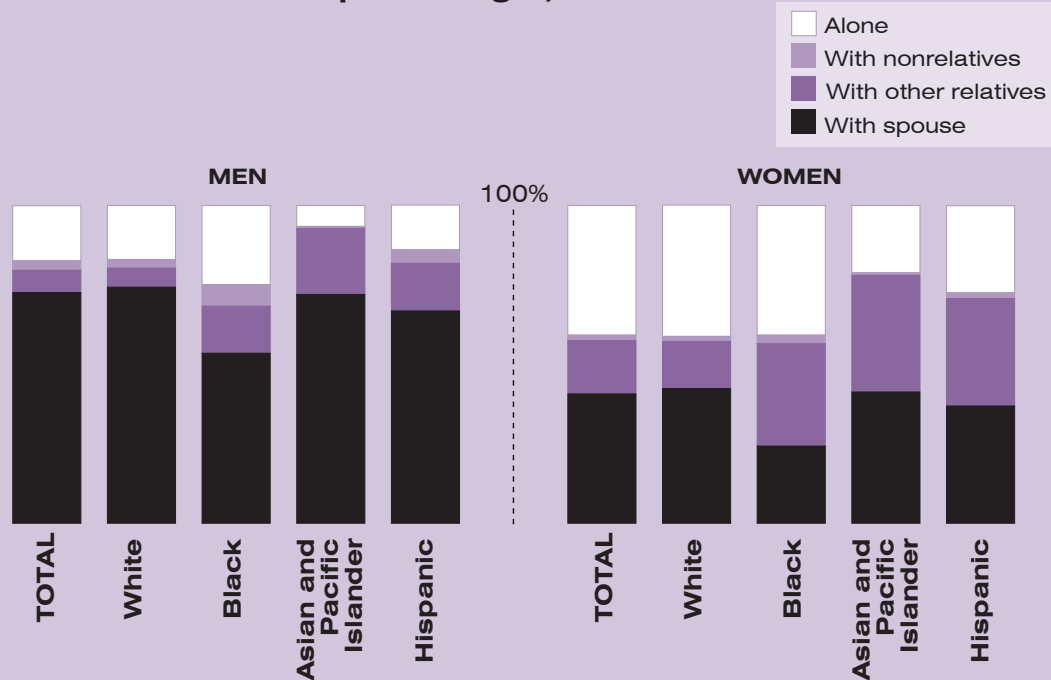
■ In 1998, 16 percent of non-Hispanic white older Americans had a bachelor's degree or higher, compared with 22 percent of older non-Hispanic Asian and Pacific Islanders.

*Data for this indicator can be found in Tables 4a and 4b on page 61.*

## Living Arrangements

**L**ike marital status, the living arrangements of America's older population are important because they are closely linked to income, health status, and the availability of caregivers. Older persons who live alone are more likely to be in poverty and experience health problems, compared with older persons who reside with a spouse or relative.<sup>8</sup>

### Living arrangements of the population age 65 and older, by sex and race and Hispanic origin, 1998



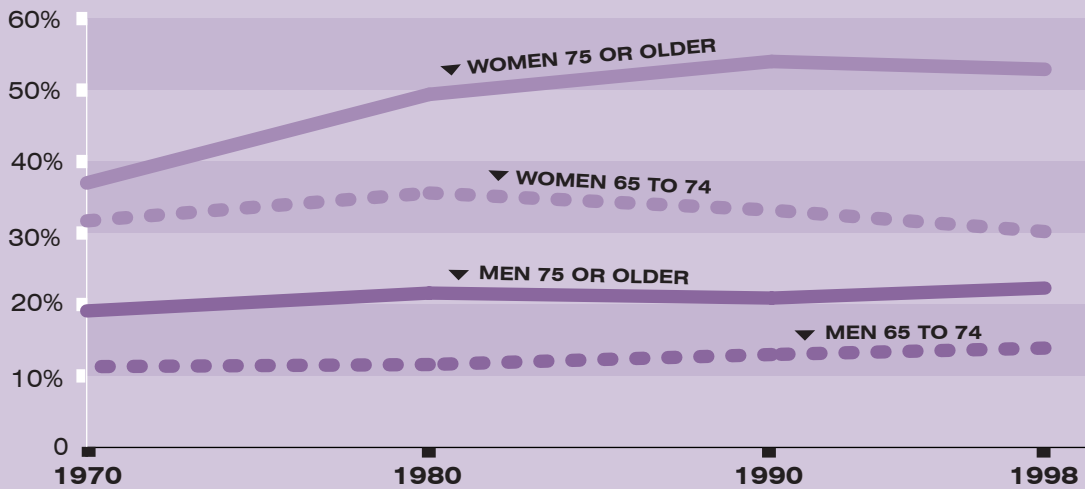
Note: Hispanics may be of any race.

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

Source: March Current Population Survey.

- In 1998, 73 percent of older men lived with their spouses, 7 percent lived with other relatives, 3 percent lived with nonrelatives, and 17 percent lived alone.
- Older women are more likely to live alone than are older men. In 1998, older women were as likely to live with a spouse as they were to live alone, about 41 percent each. Approximately 17 percent of older women lived with other relatives and 2 percent lived with nonrelatives.
- Living arrangements among older women also vary by race and Hispanic origin. In 1998, about 41 percent of older white and older black women lived alone, compared with 27 percent of older Hispanic women and 21 percent of older Asian and Pacific Islander women. While 15 percent of older white women lived with other relatives, approximately one third of older black, Asian and Pacific Islander, and Hispanic women lived with other relatives.

### Percentage of the population age 65 and older living alone, by age group and sex, 1970 to 1998



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

Source: U.S. Census Bureau, Current Population Survey Reports, "Marital Status and Living Arrangements: March 1994," P20-484, and March 1998 (Update), P20-514.

- The percentage of women age 75 or older who live alone increased from 37 percent in 1970 to 53 percent in 1998. The percentage of women ages 65 to 74 who live alone has fluctuated over time, from 32 percent in 1970, to 36 percent in 1980, to 30 percent in 1998.
- Poverty rates are higher for older women who live alone than they are for older

women who live with a spouse. In 1998, about 19 percent of white older women who lived alone were in poverty and approximately half of older black and Hispanic women who lived alone were in poverty.<sup>9</sup>

*Data for this indicator can be found in Tables 5a and 5b on page 62.*

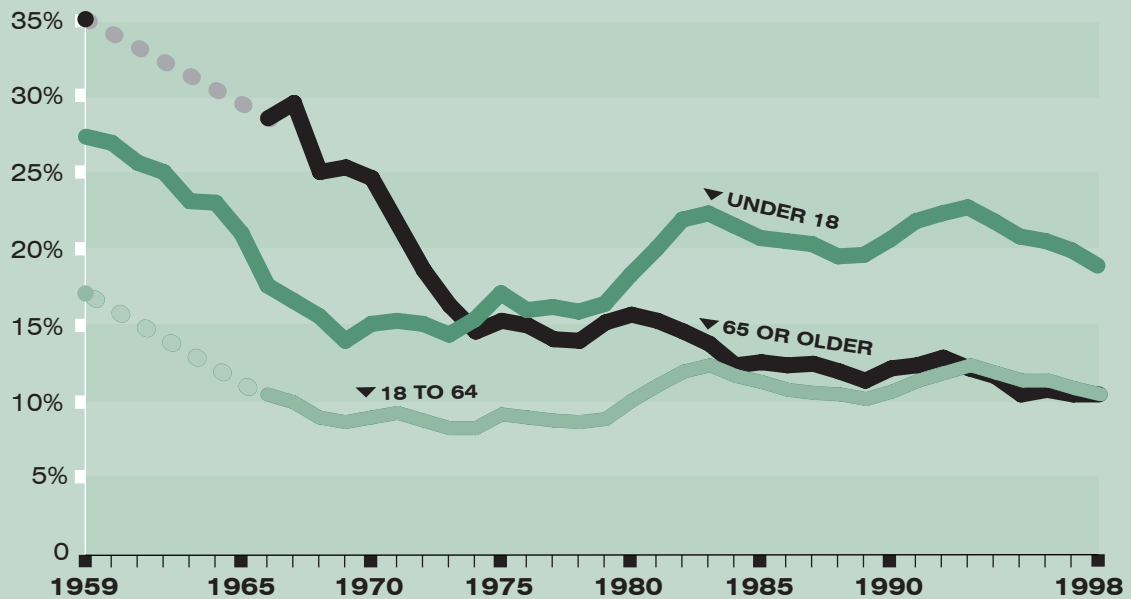


# Economics

## Poverty

The official measure of poverty is based on a family's annual money income. To determine who is poor, the U.S. Census Bureau compares family income with a set of poverty thresholds, which vary by family size and composition. Persons identified as living in poverty are at risk of having inadequate resources for food, housing, health care, and other needs.

### Percentage of the population living in poverty, by age group, 1959 to 1998



Note: Dashed lines indicate years for which data are not available. See page 64 for a description of the measurement of poverty.

Reference Population: These data refer to the civilian noninstitutional population.

Source: March Current Population Survey.

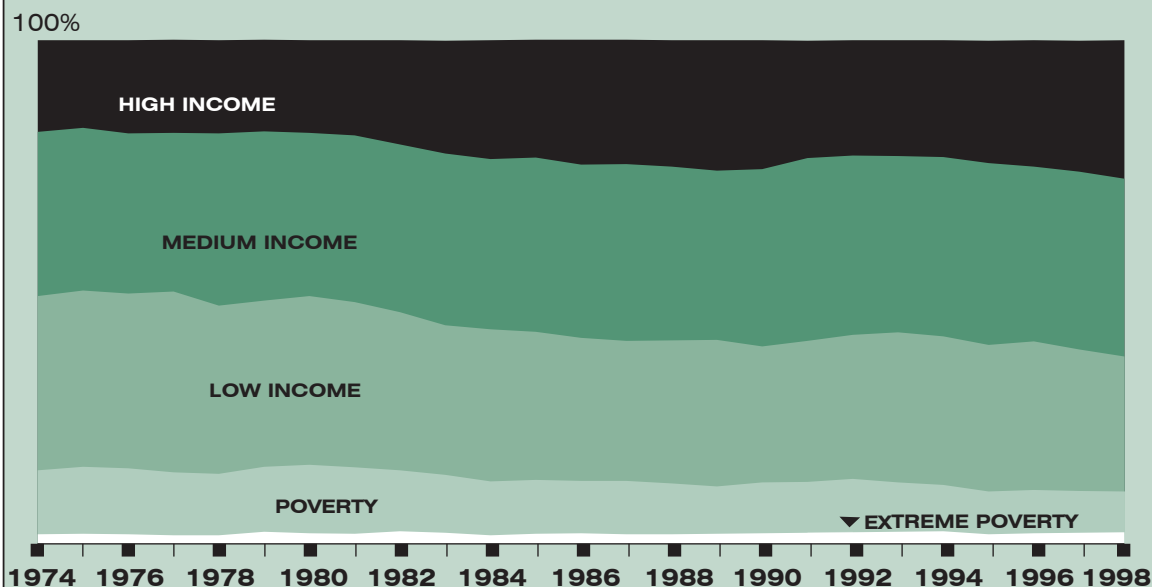
- In 1959, 35 percent of persons age 65 or older lived in families with money income below the poverty line. By 1998, the percentage of the older population living in poverty had declined to 11 percent.
- The relative poverty rates of the older population (age 65 or older), persons of working age (age 18 to 64), and children (under age 18) have changed dramatically. In 1959, older persons had the highest poverty rate (35 percent), followed by children (27 percent), and working-age persons (17 percent). By 1998, an equal percentage of the older population and working-age persons lived in poverty (11 percent), while the poverty rate of children remained at a relatively high level (19 percent).
- Among older Americans, the poverty rate is higher at older ages. In 1998, poverty rates were 9 percent for persons ages 65 to 74, 12 percent for persons ages 75 to 84, and 14 percent for persons age 85 or older.
- Among the older population, poverty rates are higher among women (13 percent) than among men (7 percent), among the nonmarried (17 percent) compared with the married (5 percent), and among minorities compared with non-Hispanic white persons. In 1998, divorced black women ages 65 to 74 had a poverty rate of 47 percent, one of the highest rates for any subgroup of older Americans.<sup>10</sup>

Data for this indicator can be found in Tables 6a and 6b on pages 63 and 64.

## Income Distribution

**T**he percentage of persons living below the poverty line does not give a complete picture of the changing economic situation of older Americans. Analyzing the income distribution of the population age 65 and older provides important insights into the economic well-being of this population.

### Income distribution of the population age 65 and older, 1974 to 1998



Note: The income classes are derived from the ratio of the family's income to the family's poverty threshold. Extreme poverty is less than 50 percent of the poverty threshold. Poverty is between 50 and 99 percent of the poverty threshold. Low income is between 100 and 199 percent of the poverty threshold. Medium income is between 200 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 noninstitutional population.

Source: March Current Population Survey.

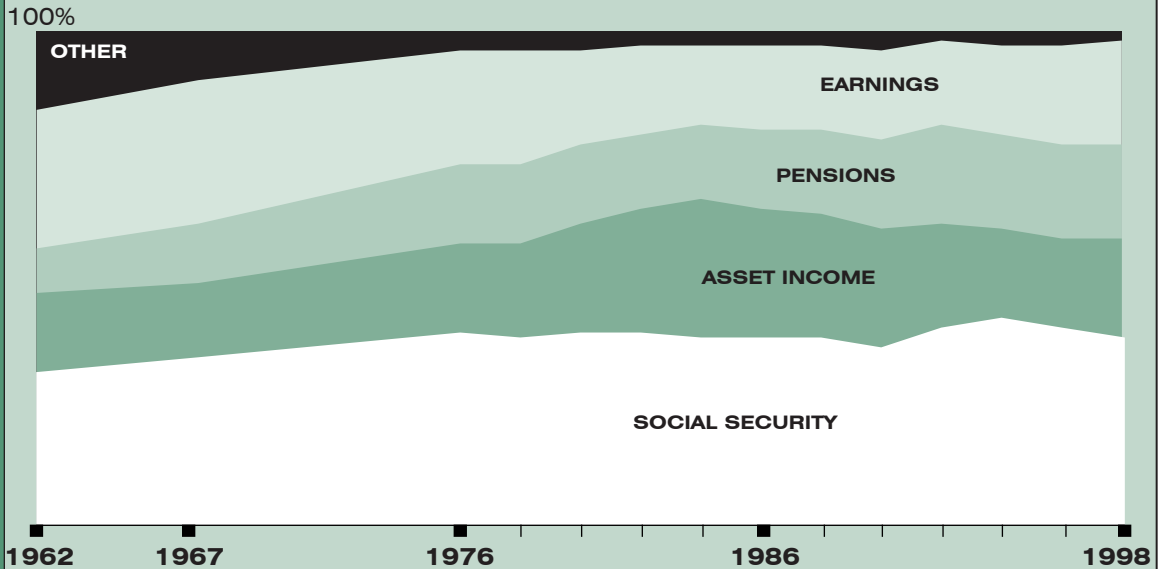
- Since 1974, the percentage of older persons in extreme poverty has been fairly constant at around 2 percent. The percentage in poverty declined from 13 percent in 1974 to 8 percent in 1998. The percentage of older persons in the low-income group declined from 35 percent in 1974 to 27 percent in 1998. The medium- and high-income groups together accounted for half of all older persons in 1974, but accounted for almost two-thirds of older persons in 1998.
- In 1998, persons with medium income made up the largest share of older persons by income group (35 percent). Equal shares of older persons were in families with low and high income (27 percent).
- In 1998, persons age 75 or older were as likely as those ages 65 to 74 to be extremely poor, more likely to be poor or low-income (40 percent, compared with 27 percent), and less likely to be medium- or high-income (58 percent, compared with 70 percent).<sup>11</sup>

*Data for this indicator can be found in Table 7 on page 65.*

## Sources of Income

**M**ost 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 the population age 65 and older, 1962 to 1998

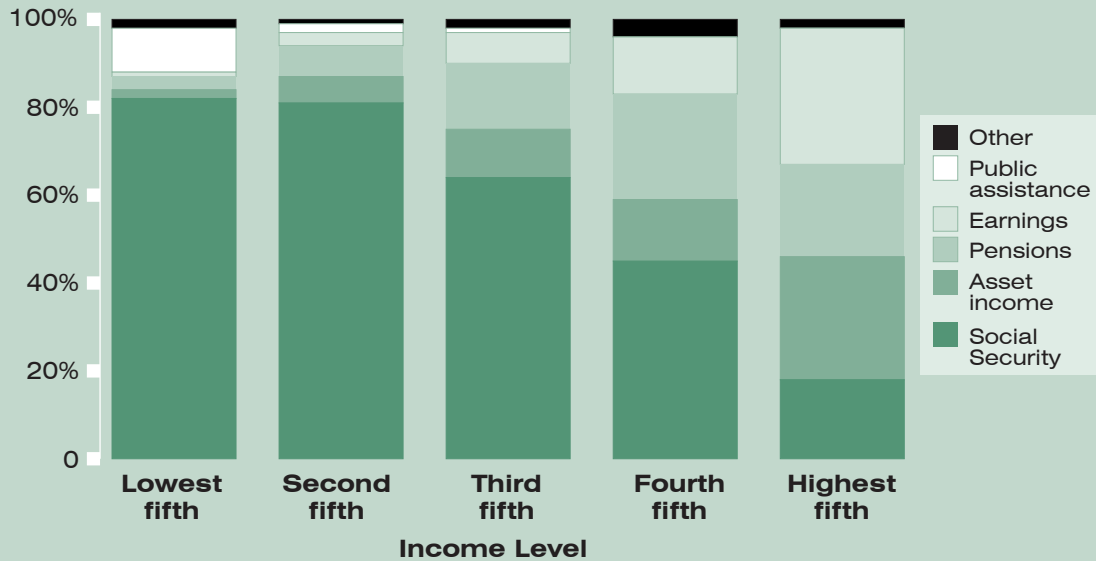


Reference population: These data refer to the civilian noninstitutional population.

Source: March Current Population Survey; Survey of the Aged and Survey of Demographic and Economic Characteristics of the Aged.

- Since the early 1960s, the proportion of income for older Americans derived from Social Security and pensions has increased, and the proportion from earnings has declined. The share of income from assets peaked in the mid-1980s and has generally declined since then.
- In 1998, Social Security benefits provided about two-fifths of the income of older persons; and asset income, pensions and personal earnings each provided about one-fifth of total income.
- Pension coverage expanded dramatically in the two decades after World War II, and private pensions accounted for an increasing proportion of income for older persons during the 1960s and early 1970s. Since then, the coverage rate has been stable at about 50 percent of all workers on their current jobs.<sup>12</sup>
- There has been a major shift in the type of pensions provided by employers, from defined-benefit plans (in which a specified benefit amount is typically paid as a lifetime annuity), to defined-contribution plans such as 401(k) plans (in which the amount of the future benefit varies depending on investment earnings). In 1975, only 6 percent of private sector employees depended primarily on defined-contribution plans for their employer-sponsored pension. By 1994, this had increased to 21 percent. Over the same period, primary coverage under defined-benefit plans fell from 39 percent to 24 percent.<sup>13</sup>

### Sources of income among persons age 65 or older, by income level, 1998



Reference population: These data refer to the civilian noninstitutional population.  
 Source: March Current Population Survey.

■ Among older Americans in the lowest fifth of the income distribution, Social Security accounts for 82 percent of income, and public assistance accounts for another 10 percent. For those whose income is in the highest income category, Social Security and pensions each account for about a fifth of income, and asset income and earnings each account

for about 30 percent of total income.

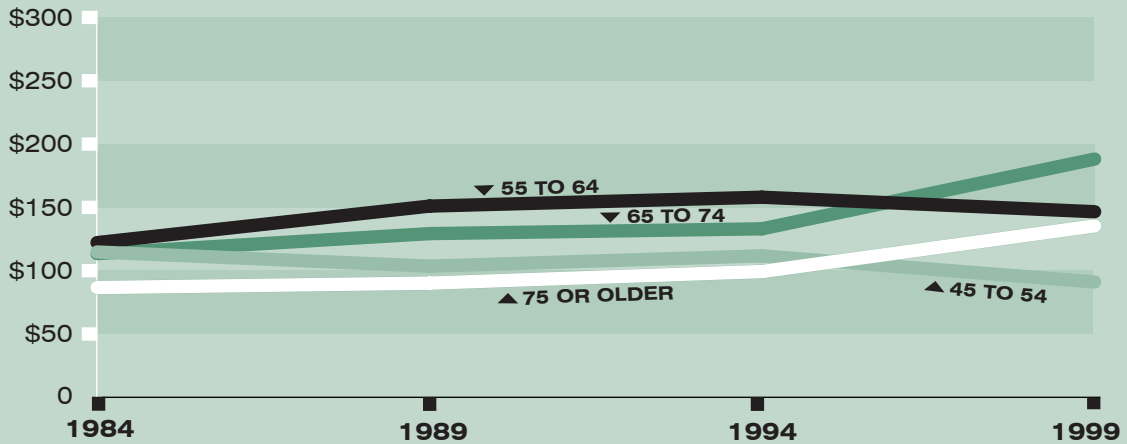
■ For persons age 85 or older, Social Security and assets account for a larger proportion of total income, and earnings and pensions a smaller proportion, compared with persons ages 65 to 69.<sup>14</sup>

*Data for this indicator can be found in Tables 8a and 8b on page 66.*

## Net Worth

**N**et 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 age of head of household, in thousands of 1999 dollars, 1984 to 1999



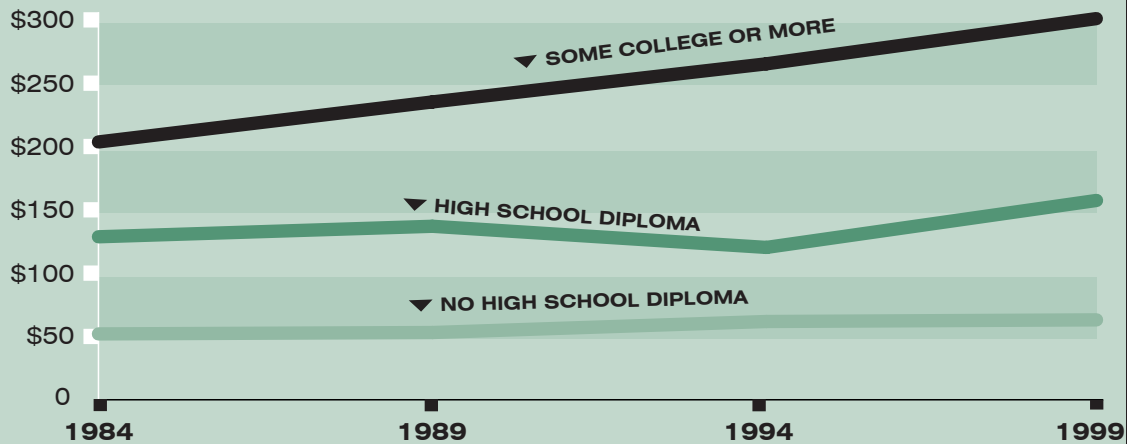
Note: Net worth data exclude the present value of future pension payments for persons nearing retirement.

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

Source: Panel Study of Income Dynamics.

- Between 1984 and 1999, the median net worth among households headed by persons age 65 or older increased by 69 percent, while the median net worth for households headed by persons ages 45 to 54 declined by 23 percent over the same period. Although there is general agreement that net worth among households headed by older persons has increased over time, different data sources disagree about the size of this increase.<sup>15</sup>
- Most striking is the disparity in net worth between black and white households headed by older Americans. In 1999, median net worth among older black households was estimated to be about \$13,000, compared with \$181,000 among older white households.

**Median household net worth by educational attainment of head of household age 65 or older, in thousands of 1999 dollars, 1984 to 1999**



Note: Net worth data exclude the present value of future pension payments among persons nearing retirement.

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

Source: Panel Study of Income Dynamics.

■ In 1999, household heads age 65 or older with at least some college reported a median household net worth more than four times that of heads of household without a high school diploma.

■ Between 1984 and 1999, the median net worth for households headed by persons

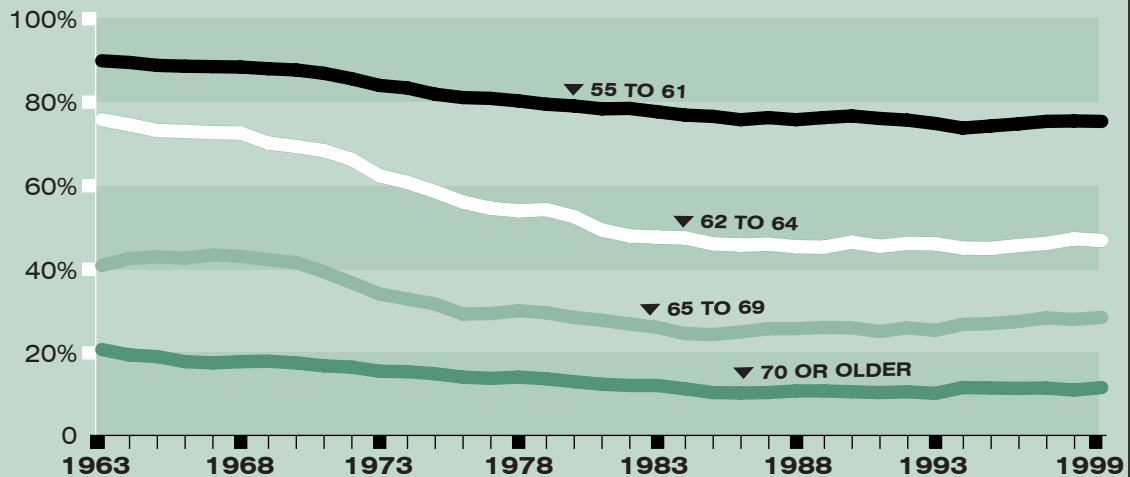
without a high school diploma increased by only 21 percent, compared with a 48 percent increase among households headed by persons with at least some college.

*Data for this indicator can be found in Table 9 on page 67.*

## Participation in the Labor Force

**T**he labor force participation rate is the percentage of a group that is in the labor force—that is, 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 to the community that work often provides.

### Labor force participation rates of men age 55 or older, by age group, annual averages, 1963 to 1999



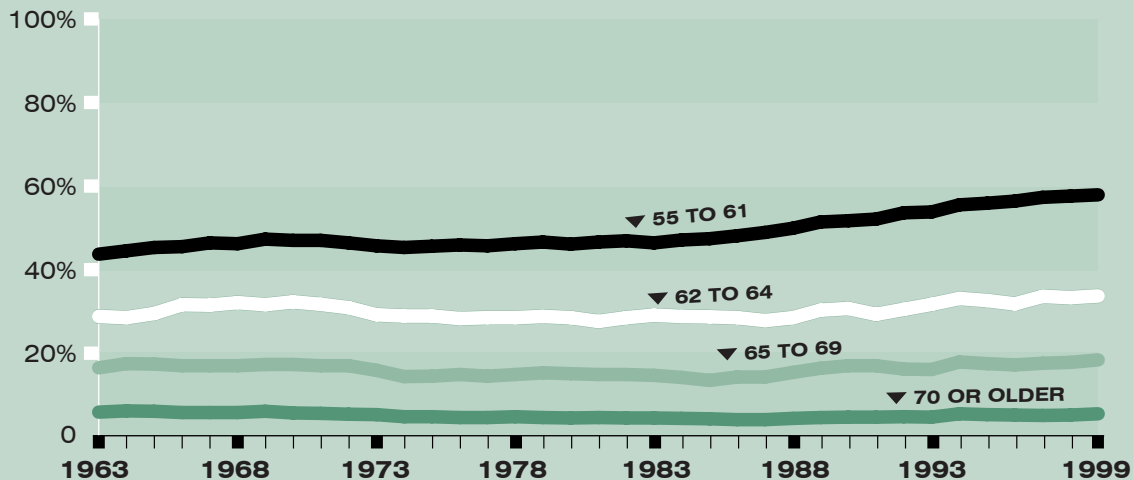
Reference population: These data refer to the civilian noninstitutional population.  
Source: Current Population Survey.

- Between 1963 and 1999, labor force participation rates declined from 90 percent to 75 percent among men ages 55 to 61, and declined from 76 percent to 47 percent among men ages 62 to 64. The participation rate for men age 70 or older declined from 21 percent in 1963 to less than 12 percent in 1999. Most of these declines occurred prior to 1980.
- The decline in labor force participation before the 1980s has been attributed to several factors. The youngest age of eli-

gibility for Social Security benefits was dropped from 65 to 62 in the early 1960s. Greater wealth also allowed older Americans to retire earlier.<sup>16</sup> The more recent stability of participation rates has been 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.<sup>17</sup>



### Labor force participation rates of women age 55 or older, by age group, annual averages, 1963 to 1999



Reference population: These data refer to the civilian noninstitutional population.  
Source: Current Population Survey.

- In contrast to the rates for men, labor force participation rates have risen among most women age 55 or older during recent decades. The increase was greatest among women ages 55 to 61. Rates have been stable at about 5 percent among women age 70 or older.
- 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.<sup>18</sup> 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 1999, 58 percent of

women ages 55 to 61 were in the labor force, compared with 44 percent of women ages 55 to 61 in 1963. The labor force participation rate increased from 29 percent to 34 percent among women ages 62 to 64.

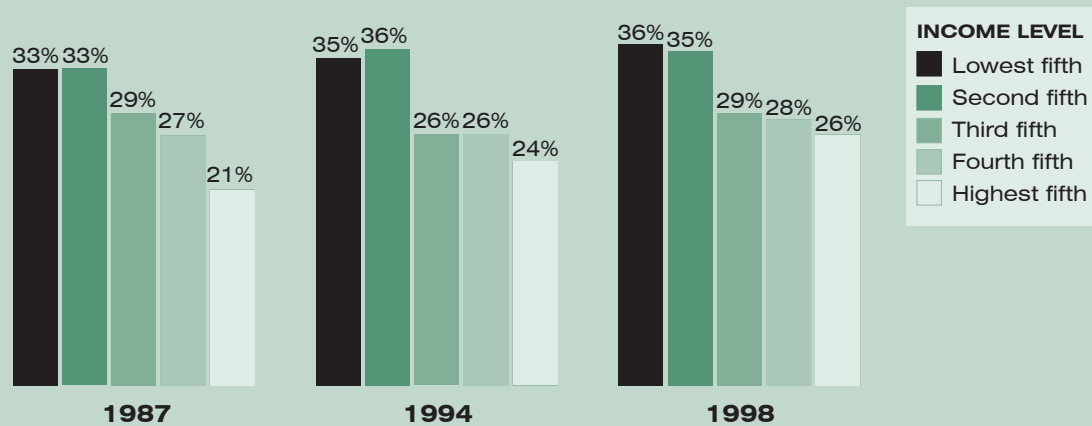
- As a result of the decline in men's labor force participation and the stability or increase in women's participation, there has been a substantial narrowing of the difference in labor force participation between men and women. Among persons ages 65 to 69, the gap between men's and women's rates in 1999 was 10 percentage points, compared with 24 percentage points in 1963.

*Data for this indicator can be found in Table 10 on page 68.*

## Housing Expenditures

**M**ost older people live in adequate, affordable housing,<sup>19</sup> but some older Americans need to allocate a large proportion of their total expenditures to housing. When housing expenditures comprise a relatively high proportion of total expenditures, less money is available for health care, savings, and other vital goods and services.

### Percentage of total annual expenditures allocated to housing costs in households headed by persons age 65 or older, by income level, 1987, 1994, and 1998



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

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

Source: Consumer Expenditure Survey.

- Between 1987 and 1998, the percentage of expenditures devoted to housing rose slightly among households headed by older Americans in all but the middle income category, which remained the same.
- In 1998, households with the lowest level of income spent an average of \$4,686 on housing while households with the highest level of income spent \$10,119 on average for housing.
- The burden of housing costs relative to all expenditures declines as income increases.

es. Among households headed by persons age 65 or older, those with income in the bottom fifth of the income distribution in 1998 allocated an average of 36 percent of all expenditures to basic housing. That proportion fell to 29 percent for those in the middle income fifth, and to 26 percent for those in the top fifth of the income distribution.

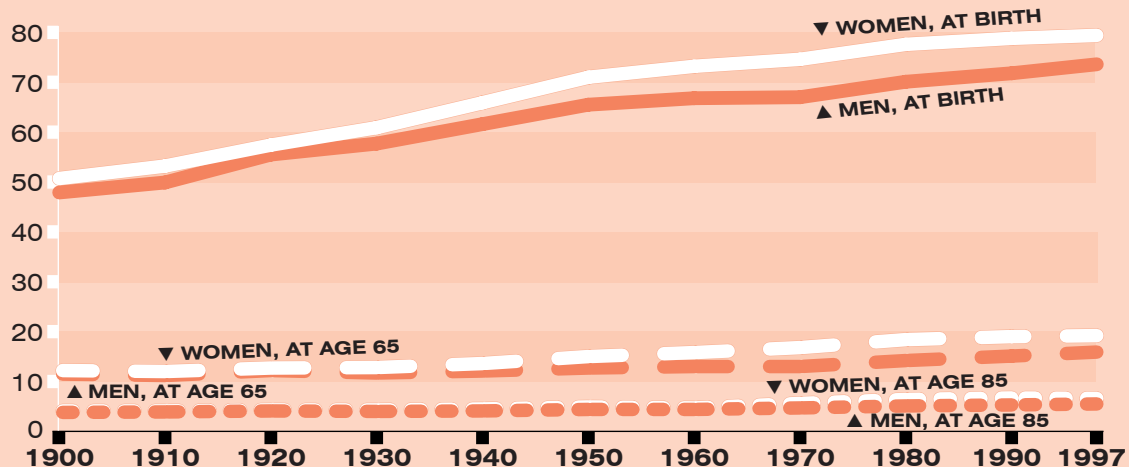
*Data for this indicator can be found in Table 11 on page 69.*

# Health Status

## Life Expectancy

**L**ife 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 by age group and sex, in years, 1900 to 1997



Reference population: These data refer to the resident population.  
Source: National Vital Statistics System.

- Americans are living longer than ever before. In 1900, life expectancy at birth was about 49 years. By 1960, life expectancy had increased to 70 years, and in 1997, life expectancy at birth was 79 years for women and 74 years for men.
- Life expectancies at ages 65 and 85 have also increased. Under current mortality conditions, people who survive to age 65 can expect to live an average of nearly 18 more years, more than five years longer than persons age 65 in 1900. The life expectancy of persons who survive to age 85 today is about 7 years for women and 6 years for men.
- Educational attainment is associated with higher life expectancy. The life expectancy of high school graduates at age 65 is approximately one year longer than the life expectancy at that age for persons who did not graduate from high school.<sup>20</sup>
- Life expectancy varies by race, but the difference decreases with age. In 1997, life expectancy at birth was 6 years higher for white persons than for black persons. At age 65, white persons can expect to live an average of 2 years longer than black persons. Among those who survive to age 85, however, the life expectancy among black persons is slightly higher than among white persons. The declining race differences in life expectancy at older ages are a subject of debate. Some research shows that age misreporting may have artificially increased life expectancy for black persons, particularly when birth certificates were not available.<sup>21</sup> Other research, however, suggests that black persons who survive to the oldest ages may be healthier than white persons and have lower mortality rates.<sup>22</sup>

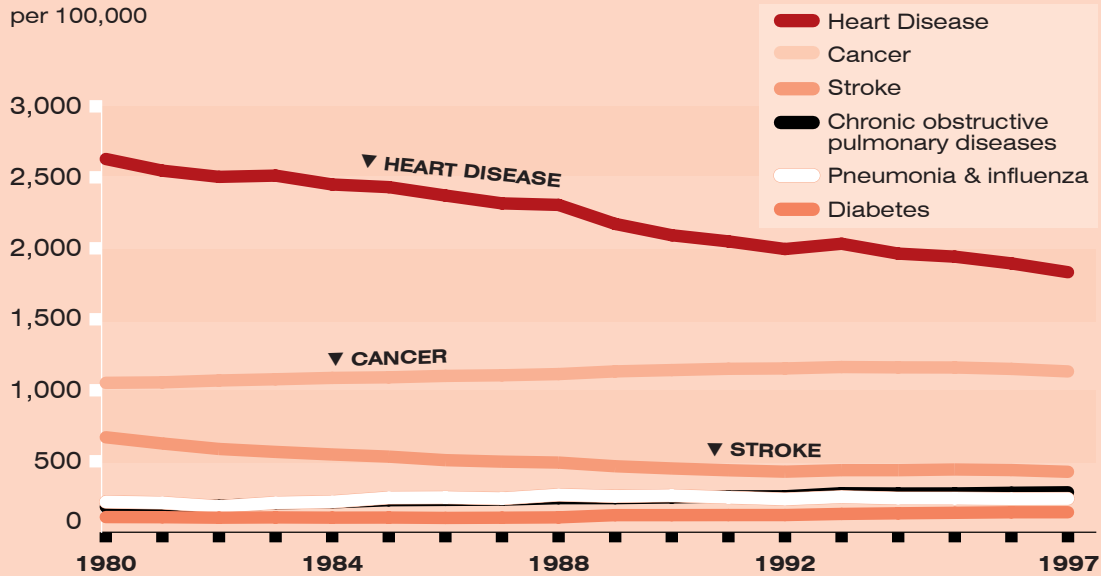
*Data for this indicator can be found in Tables 12a and 12b on page 70.*

## 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 persons age 65 or older, 1980 to 1997

per 100,000



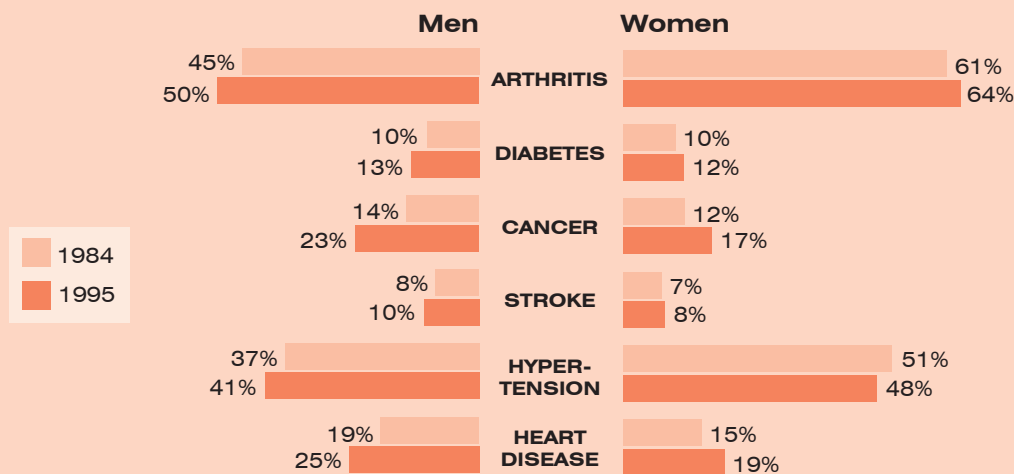
Note: Rates are age-adjusted using the 2000 standard population.  
Reference population: These data refer to the resident population.  
Source: National Vital Statistics System.

- Between 1980 and 1997, age-adjusted death rates for heart disease and stroke declined by approximately one-third. Death rates for cancer and pneumonia and influenza increased slightly over the same period. Age-adjusted death rates for diabetes increased by 32 percent since 1980, and death rates for chronic obstructive pulmonary diseases increased by 57 percent.
  - In 1997, the leading cause of death among persons age 65 or older was heart disease (1,832 deaths per 100,000 persons), followed by cancer (1,133 per 100,000), stroke (426 per 100,000), chronic obstructive pulmonary diseases (281 per 100,000), pneumonia and influenza (237 per 100,000), and diabetes (141 per 100,000). Among persons age 85 or older, heart disease was responsible for 40 percent of all deaths.<sup>23</sup>
  - In 1997, death rates were higher for older men than for older women at every age except the very oldest, persons age 95 or older, for whom men's and women's rates were nearly equal.<sup>24</sup>
  - The relative importance of certain causes of death varied according to sex and race and Hispanic origin. For example, in 1997, diabetes was the third leading cause of death among American Indian and Alaska Native men and women age 65 or older, the fourth leading cause of death among older Hispanic men and women, and ranked sixth among older white men and women and older Asian and Pacific Islander men.
  - Alzheimer's disease was the sixth leading cause of death among white women age 85 or older; however, it was less common among black women in the same age group or men of either race.
- Data for this indicator can be found in Tables 13a, 13b, and 13c on pages 71 to 73.*

## Chronic Health Conditions

**C**hronic diseases are long-term illnesses that are rarely cured. These diseases can become a significant health and financial burden to not only those persons who have them, but also their families and the nation's health care system. Chronic conditions such as arthritis, diabetes, and heart disease negatively affect quality of life, contributing to declines in functioning and the inability to remain in the community.<sup>25</sup> Five of the six leading causes of death among older Americans are chronic diseases. (See "Indicator 13: Mortality.")

### Percentage of persons age 70 or older who reported having selected chronic conditions, by sex, 1984 and 1995



Note: 1984 percentages are age-adjusted to the 1995 population.  
Reference population: These data refer to the civilian noninstitutional population.  
Source: Supplement on Aging and Second Supplement on Aging.

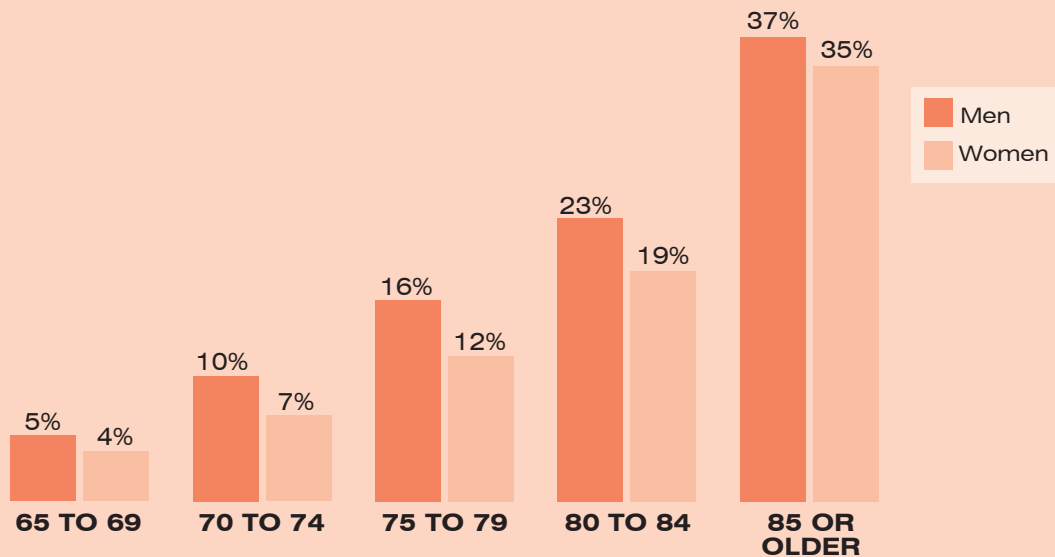
- Between 1984 and 1995, the prevalence of stroke increased by 1 percentage point, diabetes by 2 percentage points, arthritis by 3 percentage points, heart disease by 5 percentage points, and cancer by 7 percentage points. The prevalence of hypertension remained fairly constant over this period. These trends are generally evident among older persons regardless of age, sex, or race and Hispanic origin.
- In 1995, about 58 percent of persons age 70 or older reported having arthritis, 45 percent reported having hypertension, and 21 percent reported having heart disease. Other chronic diseases included cancer (19 percent), diabetes (12 percent), and stroke (9 percent). About 64 percent of older women reported having arthritis, 48 percent reported having hypertension, and 19 percent reported having heart disease. Older men were less likely to report having arthritis (50 percent) and hypertension (41 percent), but were more likely to report having heart disease (25 percent). Men were also more likely to have had cancer (23 percent), compared with women (17 percent).
- The prevalence of chronic conditions also varies by race and ethnicity in the older population. In 1995, arthritis was reported by 67 percent of non-Hispanic black persons, 58 percent of non-Hispanic white persons, and 50 percent of Hispanic persons. Non-Hispanic black persons were also more likely to report having diabetes, stroke, and hypertension than either non-Hispanic white persons or Hispanic persons. Cancer was reported by 21 percent of non-Hispanic white persons, compared with 9 percent of non-Hispanic black persons, and 11 percent of Hispanic persons.

Data for this indicator can be found in Table 14 on page 74.

## Memory Impairment

**M**emory skills are important to general cognitive functioning, and declining scores on tests of memory are indicators of general cognitive loss for older adults. Low cognitive functioning (i.e., memory impairment) is a major risk factor for entering a nursing home.<sup>26</sup>

**Percentage of persons age 65 or older with moderate or severe memory impairment, by age group and sex, 1998**



Note: Definition of moderate or severe memory impairment: four or fewer words recalled (out of 20) on combined immediate and delayed recall tests.  
 Reference population: These data refer to the civilian noninstitutional population.  
 Source: Health and Retirement Study.

■ The prevalence of moderate or severe memory impairment is slightly lower among older women than among older men. In 1998, memory impairment occurred among 35 percent of women age 85 or older, compared with 37 percent of men in the same age group.

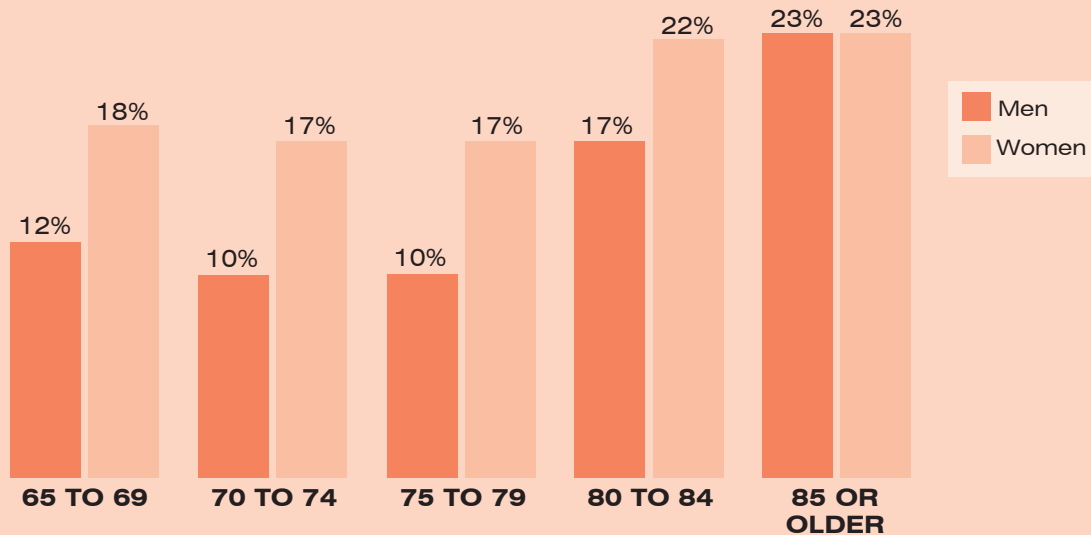
■ In 1998, the percentage of older adults with moderate or severe memory impairment ranged from about 4 percent among persons ages 65 to 69 to about 36 percent among persons age 85 or older.

*Data for this indicator can be found in Table 15 on page 75.*

## Depressive Symptoms

**D**epressive symptoms are an important indicator of general well-being and mental health among older Americans. Higher levels of depressive symptoms are associated with higher rates of physical illness, greater functional disability, and higher health care resource utilization.<sup>27</sup>

### Percentage of persons age 65 or older with severe depressive symptoms, by age group and sex, 1998



Note: Definition of severe depressive symptoms: four or more symptoms out of a list of eight depressive symptoms from an abbreviated version of the Center of Epidemiologic Studies Depression Scale (CES-D) adapted by the Health and Retirement Study.

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

Source: Health and Retirement Study.

■ Women between the ages of 65 and 84 are more likely than men to have severe depressive symptoms. Among persons age 85 or older, men and women have a similar prevalence of severe depressive symptoms.

■ In 1998, about 15 percent of persons ages 65 to 69, 70 to 74, and 75 to 79 had

severe symptoms of depression, compared with 21 percent of persons ages 80 to 84, and 23 percent of persons age 85 or older.

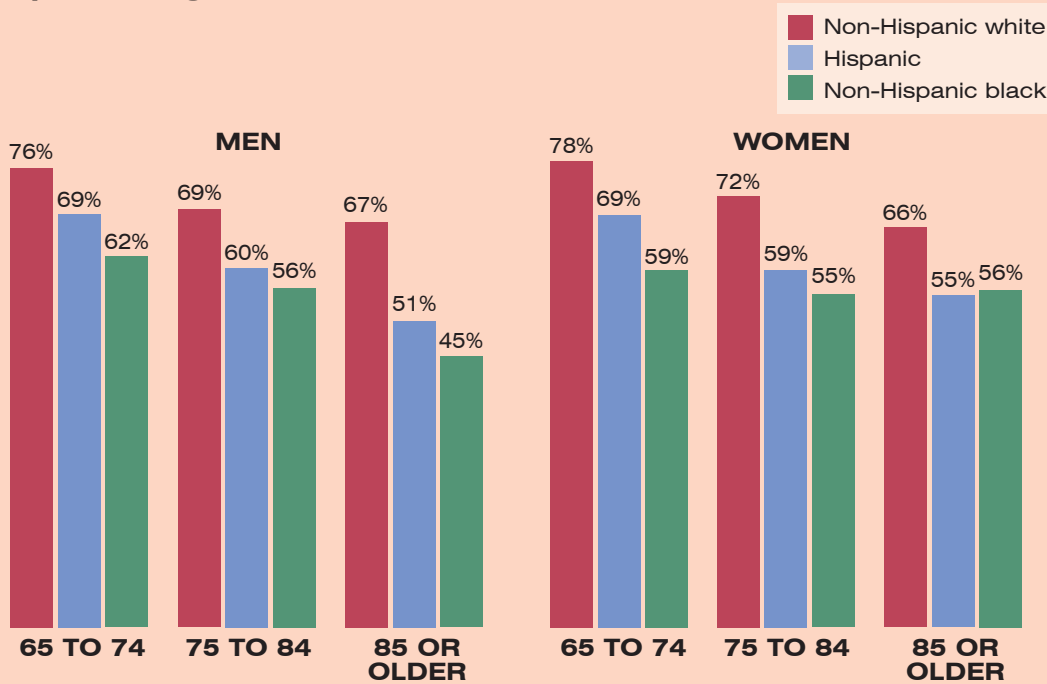
*Data for this indicator can be found in Table 16 on page 76.*



## Self-Rated Health Status

**A**sking people to rate their own 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. Good to excellent self-reported health correlates with lower risk of mortality.<sup>28</sup>

**Percentage of persons age 65 or older who reported having good to excellent health, by age group, sex, and race and Hispanic origin, 1994 to 1996**



Note: Data are based on a three-year average from 1994 to 1996. Hispanics may be of any race. Reference population: These data refer to the civilian noninstitutional population. Source: National Health Interview Survey.

- During the period 1994 to 1996, 72 percent of older Americans reported their health as good, very good, or excellent. Women and men reported comparable levels of health status.
- Positive health evaluations decline with age. Among non-Hispanic white men ages 65 to 74, 76 percent reported good to excellent health, compared with 67 percent among non-Hispanic white men age 85 or older. A similar decline with

age was reported by non-Hispanic black and Hispanic older men, and by women, with the exception of non-Hispanic black women.

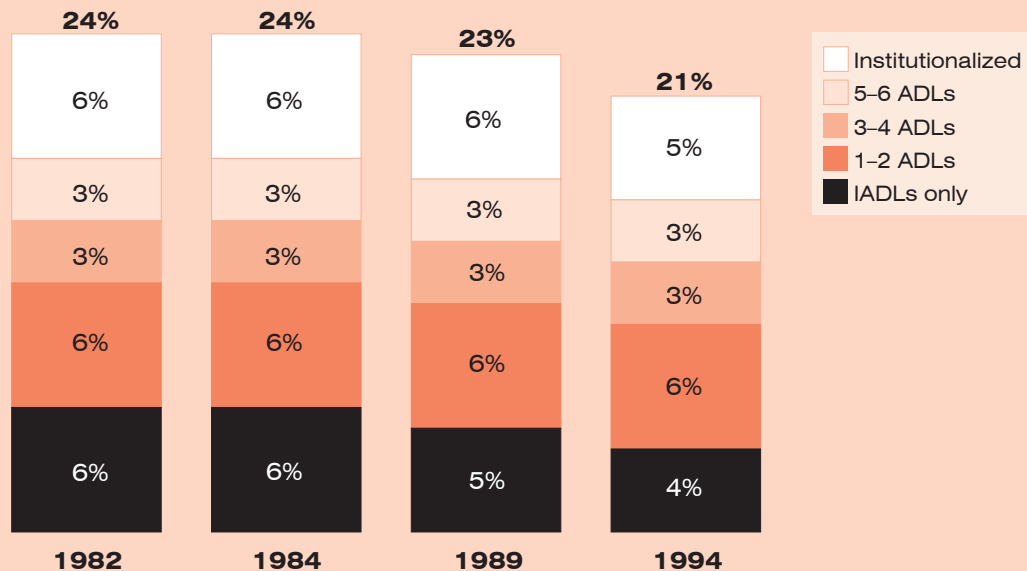
- Among older men and women in every age group, non-Hispanic black and Hispanic persons were less likely to report good health than non-Hispanic white persons.

*Data for this indicator can be found in Table 17 on page 77.*

## Disability

**F**unctioning in later years may be diminished if illness, chronic disease, or injury limits physical and/or mental abilities. Changes in disability rates have important implications for work and retirement policies, health and long-term care needs, and the social well-being of the older population. By monitoring and understanding these trends, policymakers are better able to make informed decisions.

### Percentage of Medicare beneficiaries age 65 or older who are chronically disabled, by level and category of disability, 1982 to 1994



Note: National Long Term Care Survey researchers group tasks of daily living into two categories: activities of daily living (ADLs) such as eating, getting in and out of bed, getting around inside, dressing, bathing, and toileting; and instrumental activities of daily living (IADLs) such as heavy housework, light housework, laundry, preparing meals, shopping for groceries, getting around outside, traveling, managing money, and using a telephone. A person is considered to have an ADL or IADL disability if he or she is unable to perform the activity, uses active help to perform the activity, uses equipment, or requires standby help. A person is considered chronically disabled if he or she has one ADL limitation, one IADL limitation, or is institutionalized, and if any of these conditions has lasted or is expected to last 90 days.

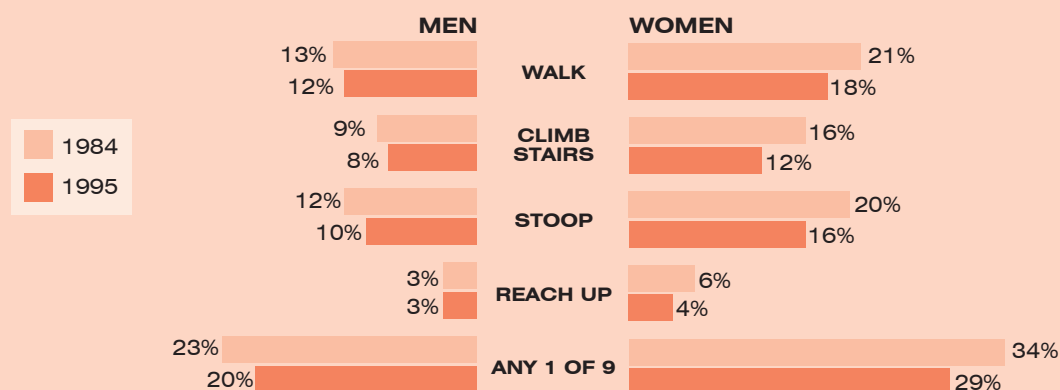
Reference population: These data refer to Medicare beneficiaries.

Source: National Long Term Care Survey.

- The proportion of Americans age 65 or older with a chronic disability declined from 24 percent in 1982 to 21 percent in 1994.
- Despite the decline in rates, the number of older Americans with chronic disabilities increased by about 600,000 from 6.4 million in 1982 to 7 million in 1994. This is because the overall population of older persons was growing fast enough to outweigh the decline in disability rates. However, if disability rates had not declined from 1982 to 1994, then the disabled population would have increased by almost 1.5 million bringing the total number of older Americans with chronic disabilities close to 7.9 million.
- There was a decline in disability rates for both sexes since 1982, when 27 percent of older women and 20 percent of older men had a chronic disability. By 1994, about 25 percent of older women and 16 percent of older men had a chronic disability.

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

**Percentage of persons age 70 or older who are unable to perform certain physical functions, by sex, 1984 and 1995**



Note: The nine physical functioning activities are: walking a quarter mile; walking up ten steps without resting; standing or being on your feet for about two hours; sitting for about two hours; stooping, crouching or kneeling; reaching up over your head; reaching out as if to shake someone's hand; using your fingers to grasp or handle; lifting or carrying something as heavy as ten pounds. A person is considered disabled if he or she is unable to perform an activity alone and without aids. Rates for 1984 are age-adjusted to the 1995 population.

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

Source: Supplement on Aging and Second Supplement on Aging.

- Between 1984 and 1995, older Americans reported improvements in physical functioning in the ability to walk a quarter mile, climb stairs, reach up over one's head, and stoop, crouch or kneel. Both men and women reported improvements in each of these categories.
- The percentage unable to perform at least one of nine physical activities without assistance or special equipment was higher among women than men but declined for both groups: from 23 percent to 20 percent among men and from 34 percent to 29 percent among women.
- In 1995, older black persons were more likely than older white persons to be unable to perform at least one of nine physical activities (33 percent and 25 percent, respectively).

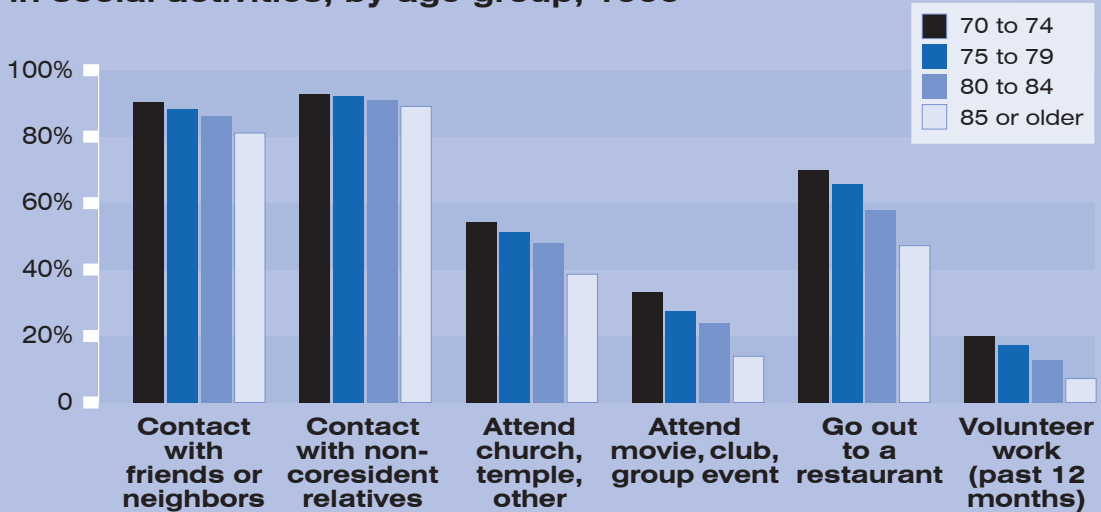
*Data for this indicator can be found in Tables 18a, 18b, and 18c on pages 78 and 79.*

# Health Risks and Behaviors

## Social Activity

**M**en and women benefit from social activity at older ages. Those who continue to interact with others tend to be healthier, both physically and mentally, than those who become socially isolated. Interactions with friends and family members can provide emotional and practical support that enable older persons to remain in the community and reduce the likelihood they will need formal health care services.

### Percentage of persons age 70 or older who reported engaging in social activities, by age group, 1995



Note: This indicator uses data from a sample of persons age 70 or older who were asked if they had engaged in any of a list of five common social activities during the preceding two weeks, or if they had performed volunteer work during the preceding twelve months.

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

Source: Second Supplement on Aging.

- The majority of persons age 70 or older reported engaging in some form of social activity in the past two weeks. Interactions with family were the most common type of interaction reported—92 percent of older persons got together with a non-coresident family member. A slightly smaller percentage reported getting together with friends and neighbors (88 percent). Half of all older persons reported going out to church or temple for services or other activities.
- The percentage reporting social activities declines with age. The percentage reporting volunteer work in the past year declined from 20 percent among persons

ages 70 to 74 to 7 percent among persons age 85 or older. About one-third of persons ages 70 to 74 reported attending a movie, sports event, club, or other group event in the preceding two weeks, while fewer than 14 percent of persons age 85 or older did so. The majority of persons even at the oldest ages reported some interactions outside the home.

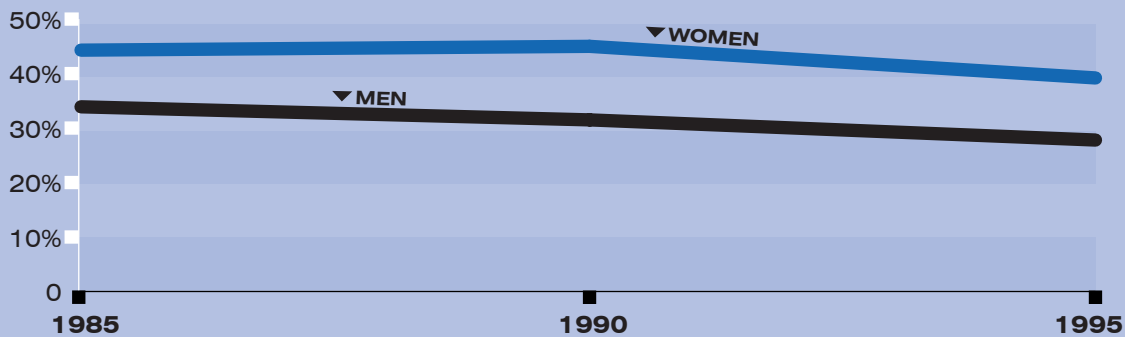
- The majority of both men and women, approximately two out of three, felt that there was enough social activity in their lives.

Data for this indicator can be found in Tables 19a and 19b on page 80.

## Sedentary Lifestyle

**P**hysical activity is beneficial for the health of people of all ages, including the older 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.<sup>29</sup> Research has shown that even among frail and very old adults, mobility and functioning can be improved through physical activity.<sup>30</sup>

### Percentage of persons age 65 or older who reported having a sedentary lifestyle, by sex, 1985, 1990, and 1995



Note: Sedentary lifestyle is defined as engaging in no leisure-time physical activity (exercises, sports, physically active hobbies) in a two-week period.

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

Source: National Health Interview Survey.

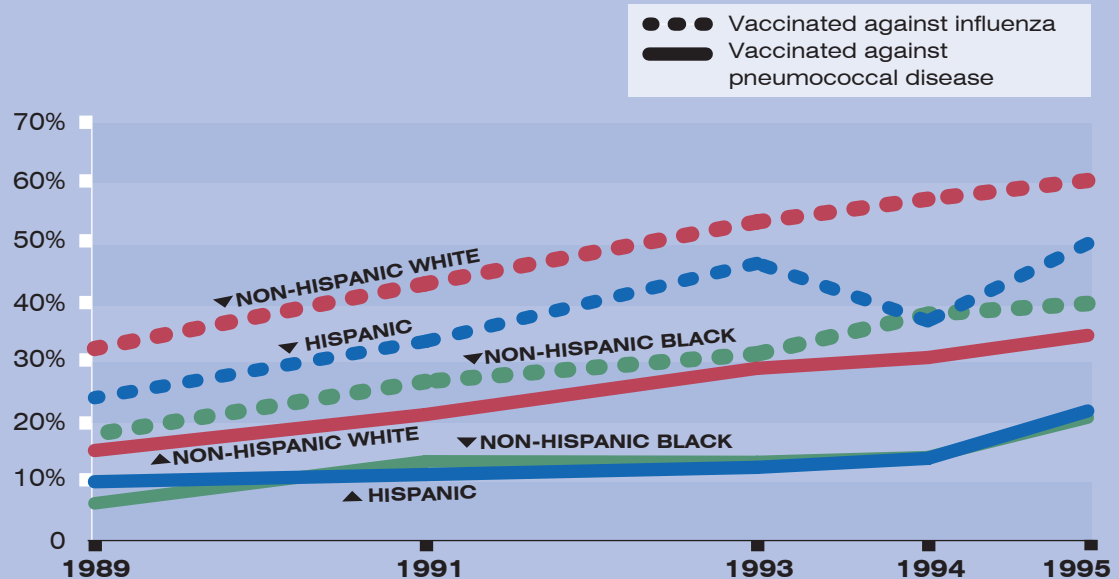
- The percentage of older persons who were sedentary declined between 1985 and 1995, from 34 percent to 28 percent among men and from 44 percent to 39 percent among women.
- In 1995, 34 percent of persons age 65 or older had a sedentary lifestyle. Women were more likely than men to have a sedentary lifestyle.
- In 1995, the most common types of exercise among older Americans were light to moderate activities such as walking, gardening, and stretching.<sup>31</sup>

*Data for this indicator can be found in Table 20 on page 81.*

## Vaccinations

**V**accinations against influenza and pneumococcal disease are recommended for older Americans, who are at increased risk for complications from these diseases compared with younger individuals.<sup>32</sup> Influenza vaccinations are given annually, while pneumococcal vaccinations are usually given once in a lifetime. The costs associated with these vaccinations are covered under Medicare Part B.

### Percentage of persons age 65 or older who reported having been vaccinated against influenza and pneumococcal disease, by race and Hispanic origin, 1989 to 1995



Note: Hispanics may be of any race. For influenza, the percent vaccinated consists of persons who reported having a flu shot during the past 12 months. For pneumococcal disease, the percent refers to persons who reported ever having a pneumonia vaccination.

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

Source: National Health Interview Survey.

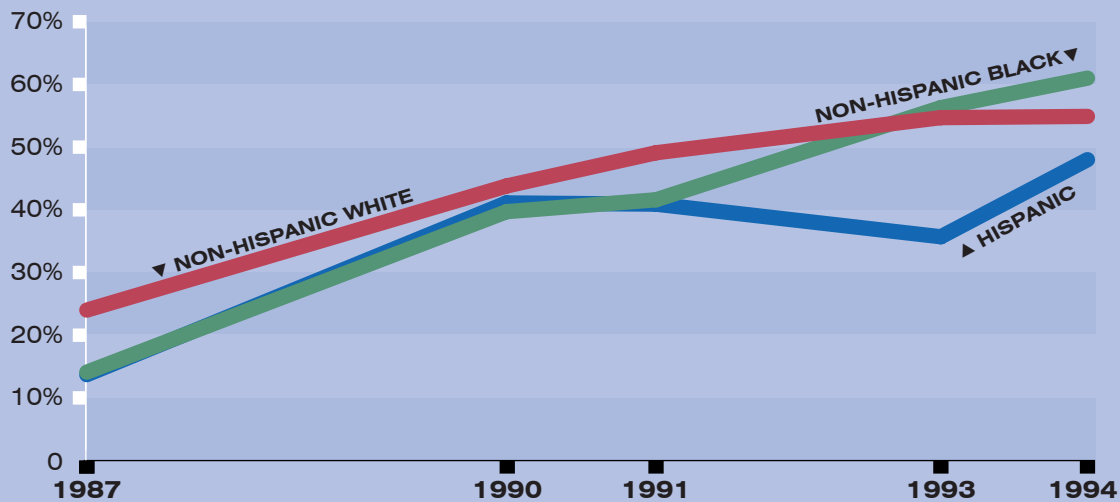
- Healthy People 2000, a national effort to improve health through establishing health objectives and measuring progress, set targets of 60 percent coverage for both influenza and pneumococcal vaccinations among older Americans.<sup>33</sup> Between 1989 and 1995, the percentage of non-Hispanic white persons who were vaccinated against influenza increased from 32 percent to 60 percent. Over the same period, influenza vaccination rates increased from 18 percent to 40 percent among older non-Hispanic black persons and from 24 percent to 50 percent among older Hispanic persons.
- Vaccination rates also increased for pneumococcal disease, but none of the racial or ethnic groups have reached the 60 percent target.
- During the period 1993 to 1995, the level of vaccination for both influenza and pneumococcal disease was similar among older women and men. Persons ages 75 to 84 had slightly higher levels of vaccination coverage than persons ages 65 to 74 and persons age 85 or older.

Data for this indicator can be found in Tables 21a and 21b on page 82.

## Mammography

**H**ealth care services and screenings can help to prevent disease or detect it at an early, treatable stage. Mammography has been shown to be effective in reducing breast cancer mortality among women ages 50 to 65 and some experts recommend screenings at older ages as well.

**Percentage of women age 65 or older who had a mammogram in the past two years, by race and Hispanic origin, 1987 to 1994**



Note: Hispanics may be of any race.

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

Source: National Health Interview Survey.

- Among women age 65 or older, the percentage who had a mammogram within the preceding two years increased from 23 percent in 1987 to 55 percent in 1994.
- The percentage of women who had a mammogram increased among all racial and ethnic groups. Until recently, non-Hispanic white women were the most like-

ly to report having had a mammogram, but in 1994 non-Hispanic black women were more likely to report having had a mammogram (61 percent) than either non-Hispanic white women (55 percent) or Hispanic women (48 percent).

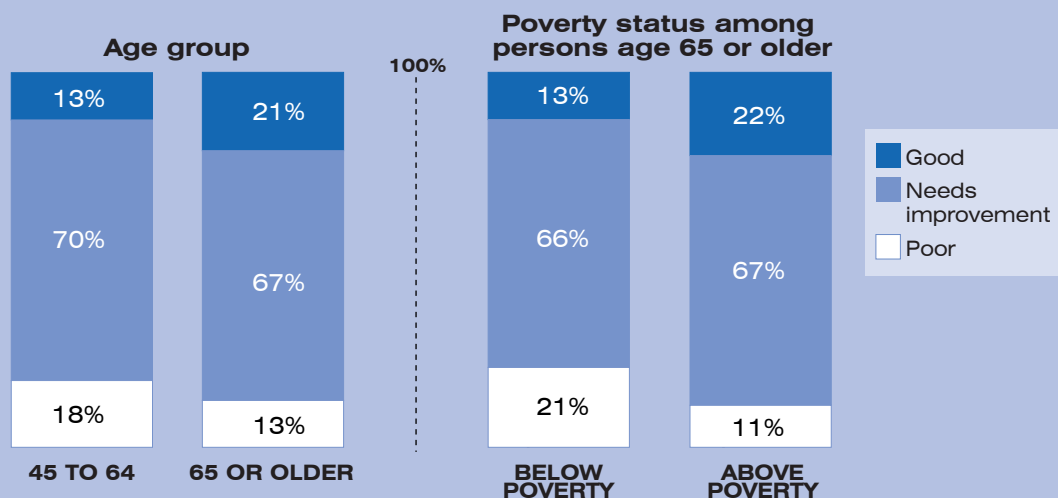
*Data for this indicator can be found in Table 22 on page 83.*



## Dietary Quality

**D**ietary quality plays a major role in preventing or delaying the onset of chronic diseases. The Healthy Eating Index (HEI) is a summary measure of dietary quality. The HEI consists of 10 components, each representing a different aspect of a healthful diet based on the U.S. Department of Agriculture's Food Guide Pyramid and the Dietary Guidelines for Americans. Scores for each component are given equal weight and added to calculate an overall HEI score with a maximum value of 100. An HEI score above 80 indicates a good diet, an HEI score between 51 and 80 signals a diet that needs improvement, and an HEI score below 51 indicates a poor diet.<sup>34</sup>

### Dietary quality ratings of persons age 45 or older, as measured by the Healthy Eating Index, by age group and poverty status, 1994 to 1996



Note: Dietary quality was measured using the Healthy Eating Index. See "Indicator 6: Poverty" for information on the definition of poverty. The data were collected between 1994 and 1996. Reference population: These data refer to the civilian noninstitutional population. Source: Continuing Survey of Food Intakes by Individuals.

- Diets were rated "good" for a higher percentage of the population age 65 and older (21 percent) than for persons ages 45 to 64 (13 percent). Even so, a majority of older persons reported diets that needed improvement (67 percent).
- Older persons living in poverty were more likely to report a poor diet (21 percent) than were older persons living above the poverty level (11 percent).
- Older persons' scores were lowest for the components of the Healthy Eating Index measuring daily servings of fruit and milk products. Older persons' scores were best for the components of the index measuring cholesterol intake and the variety of the diet.

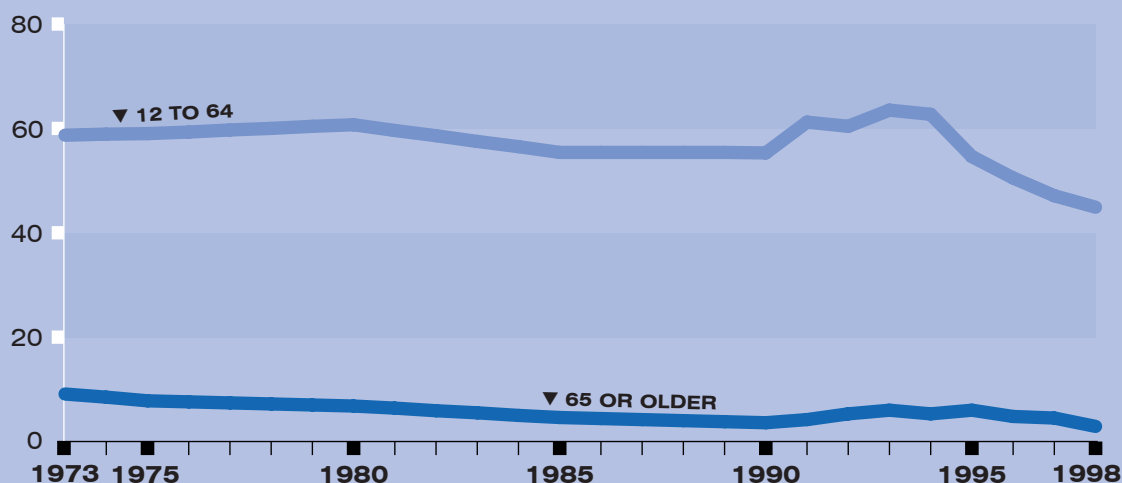
*Data for this indicator can be found in Tables 23a and 23b on page 84.*

## Criminal Victimization

**T**he fear of crime is an important concern among persons of all ages. Although older persons may be more fearful of violent crime, they are more likely to be victims of property crime.

### Violent crime rate by age of victim, 1973 to 1998

per 1,000



Note: Violent crime includes murder, rape, robbery, aggravated and simple assault. Since 1992, sexual assault has also been included.

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

Source: National Crime Victimization Survey and Uniform Crime Reports.

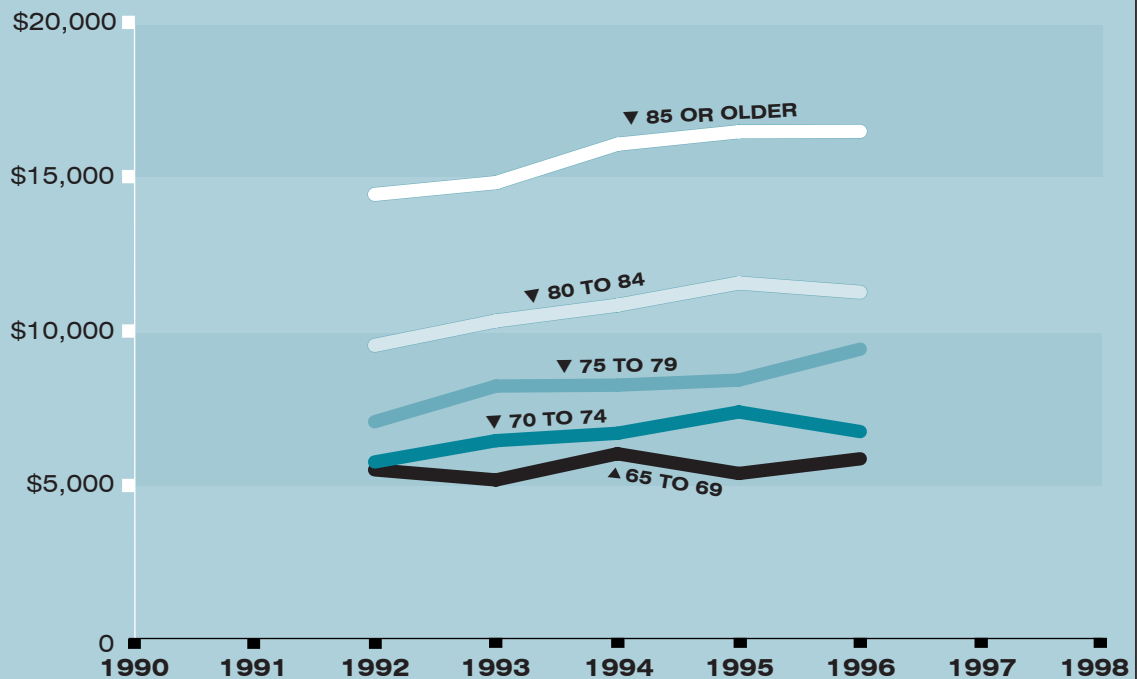
- Violent crime rates against persons age 65 or older declined from 9 per 1,000 older persons in 1973 to 3 per 1,000 in 1998.
  - In 1998, persons age 65 or older were much less likely to be victims of violent crimes (3 per 1,000) than were persons ages 12 to 64 (45 per 1,000).
  - Among persons in all age groups, most measured crime was property crime. Property crime rates have fallen in recent decades. Among households headed by older persons, 88 per 1,000 were victims of property crimes in 1998, down from 205 per 1,000 households in 1973.
  - Households headed by persons age 65 or older were much less likely to be victims of property crime than were households headed by persons under age 65 (88 per 1,000 for older households, compared with 249 per 1,000 for younger households in 1998).
- Data for this indicator can be found in Table 24 on page 85.*

# Health Care

## Health Care Expenditures

**H**ealth care can be a major expense for older Americans, especially for individuals with limited income who have a chronic condition or disability. Expenditures on health care include the cost of physicians' services, hospitalizations, home health care, nursing home care, medications, and any other goods and services used in the treatment or prevention of disease.

**Average health care expenditures among Medicare beneficiaries age 65 or older, in 1996 dollars, by age group, 1992 to 1996**



Note: Data include both out-of-pocket expenditures and expenditures covered by insurance.  
Reference population: These data refer to Medicare beneficiaries.  
Source: Medicare Current Beneficiary Survey.

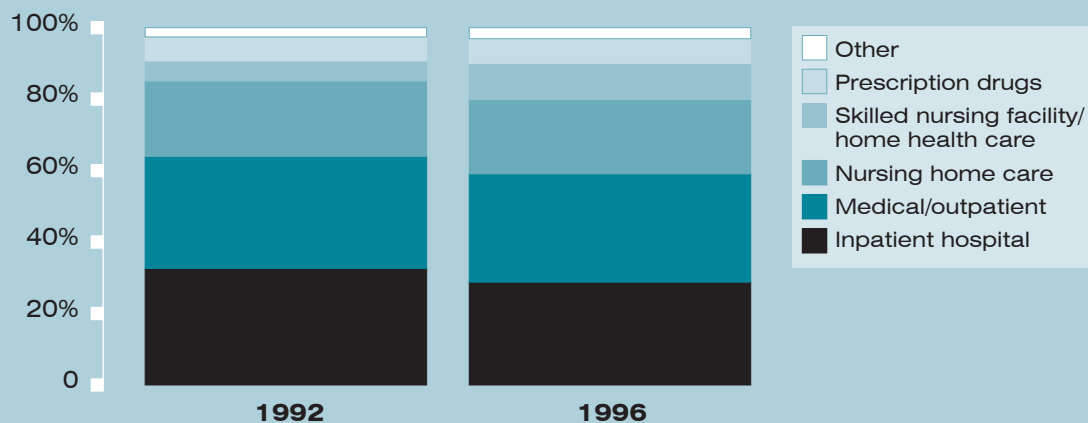
- In 1996, the average annual expenditure on health care was \$5,864 among persons ages 65 to 69, compared with \$9,414 among persons ages 75 to 79, and \$16,465 among persons age 85 or older.
- In 1996, older Americans living in institutions incurred \$38,906 in annual health care expenditures on average, compared with \$6,360 among older persons living in the community. Nursing home care accounted for 64 percent of the total expenditures of the institutional population.
- Between 1992 and 1996 there was a slight increase in average annual health care expenditures among older Americans in every age category.
- In a given year, health care expenditures tend to be concentrated among a relatively small group of individuals. In 1996, 1 percent of Medicare beneficiaries age 65 or older incurred 13 percent of the health care expenditures in that age group. The top 5 percent of enrollees with the highest expenditures incurred 37 percent of all health care expenditures.

*Data for this indicator can be found in Tables 25a, 25b, 25c, and 25d on pages 86 and 87.*

## Components of Health Care Expenditures

**H**ealth care expenditures 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 expenditures among Medicare beneficiaries age 65 or older, 1992 and 1996



Note: Data include both out-of-pocket expenditures and expenditures covered by insurance. "Other" expenditures consist of dental and hospice expenses.  
Reference population: These data refer to Medicare beneficiaries.  
Source: Medicare Current Beneficiary Survey.

- The percentage of health care expenditures spent on inpatient hospital care declined from 33 percent in 1992 to 29 percent in 1996. Expenditures on skilled nursing facility care and home health care increased from 6 percent to 10 percent over the same period, and prescription drug expenditures remained stable, at approximately 7 percent.

- In 1996, about 46 percent of health care expenditures among persons age 85 or older went to nursing home care, compared with 7 percent among persons ages 65 to 69. Expenditures on skilled nursing facility care and home health care were also higher among persons age 85 or older. Older Americans under age 85 spent proportionately more money on inpatient hospital services, medical/outpatient services, and prescription drugs, although their absolute expenditure levels for these services were lower than those of persons age 85 or older.

- Patterns of health care expenditures also varied by income level. Persons age 65 or

older in the bottom fifth of the income distribution incurred proportionately higher expenditures for nursing home and skilled nursing facility or home health care, compared with higher-income individuals. In contrast, older Americans with lower income incurred proportionately lower expenditures for medical/outpatient services and prescription drugs.

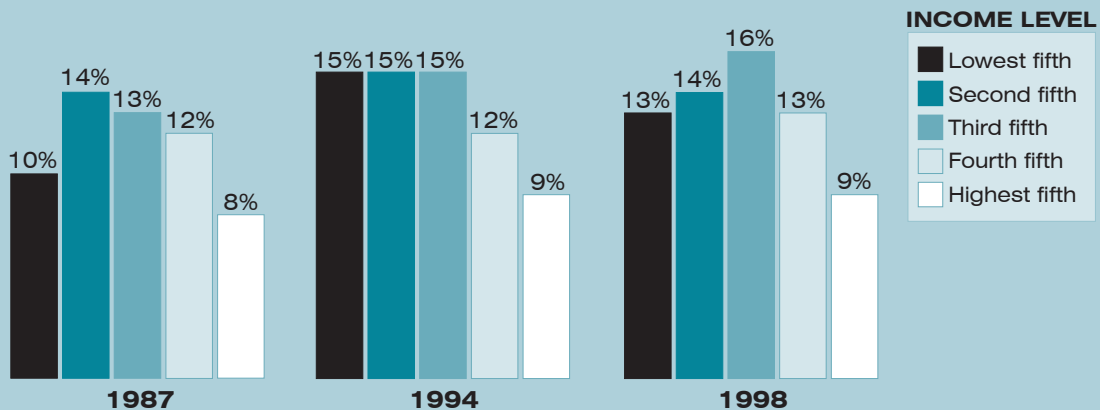
- In 1996, about 69 percent of all noninstitutionalized Medicare beneficiaries had prescription drug coverage through an HMO, Medicaid eligibility, a private Medicare supplement, or other sources. Beneficiaries who did not have prescription drug coverage had lower total drug expenditures (out-of-pocket expenses and expenses covered by insurance combined) than beneficiaries who had coverage. However, out-of-pocket expenditures for prescription drugs were 83 percent higher for beneficiaries who lacked coverage, on average, than for those who had drug coverage.<sup>35</sup>

Data for this indicator can be found in Tables 26a and 26b on page 88.

## Out-of-Pocket Health Care Expenditures

The proportion of out-of-pocket expenditures that is allocated to health care indicates the burden placed on older persons by health care expenses. Data on out-of-pocket health care expenditures by income level provide information on how this burden varies for households with different financial resources.

### Percentage of total out-of-pocket expenditures allocated to health care costs in households headed by persons 65 or older, by income level, 1987, 1994, and 1998



Reference population: These data refer to the resident noninstitutional population.  
Source: Consumer Expenditure Survey.

- In 1998, annual out-of-pocket expenditures on health care—which include expenditures on health insurance, medical services and supplies, and prescription drugs—ranged from 9 percent to 16 percent of total expenditures among households headed by older persons at different levels of income.

- Average dollar expenditures on health care increase with income. In 1998, households headed by older persons in the bottom fifth of the income distribution spent an average of \$1,654 per year on health care, compared with \$3,614 among households in the top fifth of the income distribution.

- Although dollar expenditures increase with income, the relative burden of

health care costs is much higher among lower-income households and households in the middle of the income distribution. In 1998, households in the bottom fifth spent an average of 13 percent of their expenditures on health care. Those in the middle fifth spent an average of 16 percent, and those in the top fifth spent 9 percent.

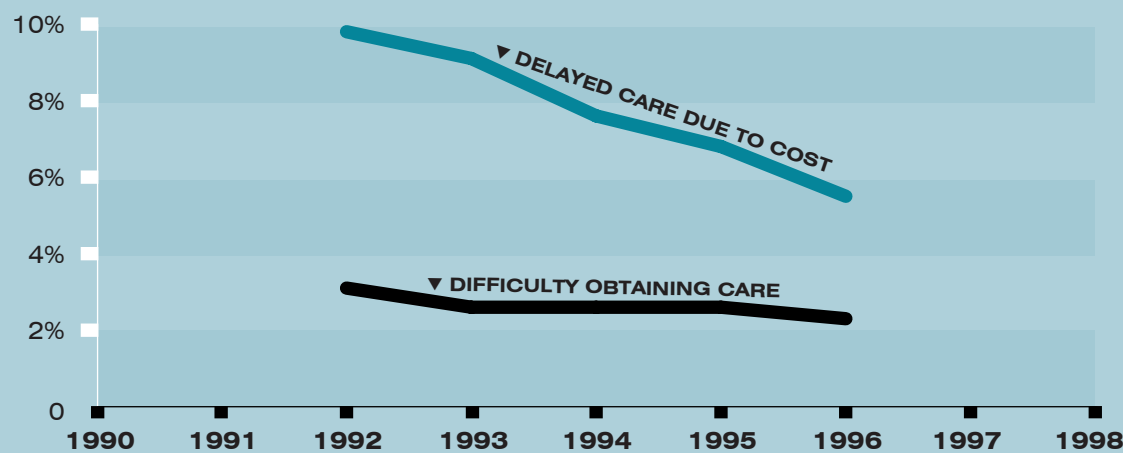
- Over the past decade, the share of out-of-pocket expenditures spent by the older population on health care increased slightly for all income groups.

*Data for this indicator can be found in Table 27 on page 89.*

## Access to Health Care

**A**ccess to health care is determined by a variety of factors related to the cost, quality, and availability of health care services. Over 96 percent of older Americans are covered by Medicare, which provides affordable coverage for most acute health care services. However, health care users also require a reliable source of care that is provided without major inconvenience.

### Percentage of Medicare beneficiaries age 65 or older who reported having had problems with access to health care, 1992 to 1996



Reference population: These data refer to noninstitutional Medicare beneficiaries.  
Source: Medicare Current Beneficiary Survey.

- In 1996, only 2 percent of Medicare enrollees reported difficulty in obtaining health care, down from 3 percent in 1992. The percentage of Medicare enrollees who reported that they delayed using health care because of cost declined from 10 percent in 1992 to 6 percent in 1996.
- In 1996, about 7 percent of persons ages 65 to 74 reported delays in obtaining health care due to cost, compared with 5 percent of persons ages 75 to 84, and 3 percent of persons age 85 or older.

- Access to health care varied by race. In 1996, the percentage of older Americans who reported delays due to cost was highest among non-Hispanic black persons (10 percent), followed by Hispanic persons (7 percent), and non-Hispanic white persons (5 percent). About 2 percent of non-Hispanic white persons reported difficulty in obtaining health care, compared with 4 percent of non-Hispanic black persons and 3 percent of Hispanic persons.

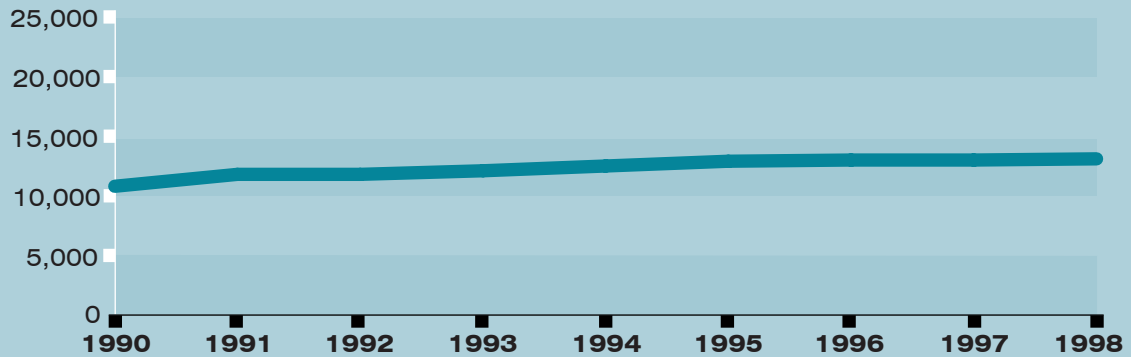
*Data for this indicator can be found in Tables 28a and 28b on page 90.*

## Use of Health Care Services

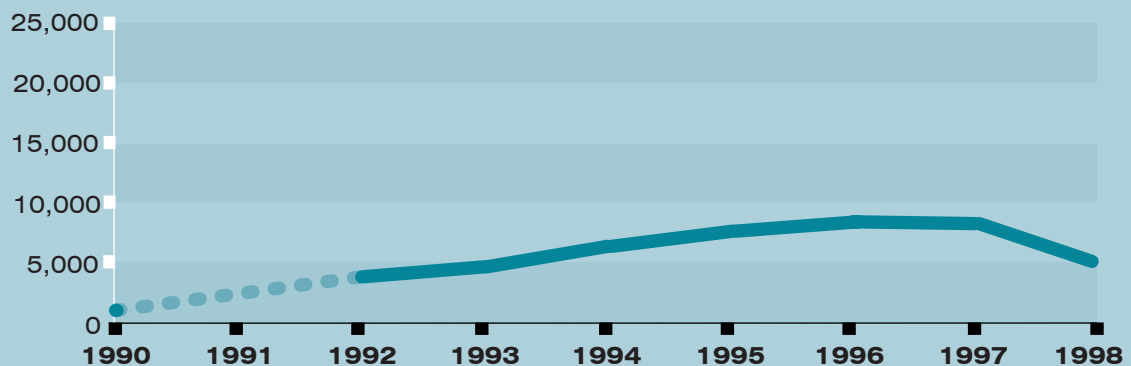
**M**ost older Americans have access to health care through Medicare. Medicare provides access to a variety of services, including inpatient hospital care, physician care, outpatient care, home health care, and care at a skilled nursing facility. However, the types of health care services that older Americans receive under Medicare have changed over the past decade.

### Rates of health care service usage by Medicare beneficiaries age 65 or older, 1990 to 1998 (per 1,000)

#### PHYSICIAN VISITS AND CONSULTATIONS



#### HOME HEALTH VISITS



Note: Dashed lines indicate years for which data are not available. Data for 1998 should be considered preliminary. For home health visits utilization rates for 1994-1998 exclude HMO enrollees from the numerator and denominator because utilization data are not available for this group. Prior to 1994, HMO enrollees were included in the denominator, causing utilization rates to be understated. Prior to 1994, HMO enrollees represented 7 percent or less of the Medicare population; in 1998 they represented 18 percent. For physicians visits, data on HMO enrollees are excluded for all years.

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

Source: Medicare claims and enrollment data.

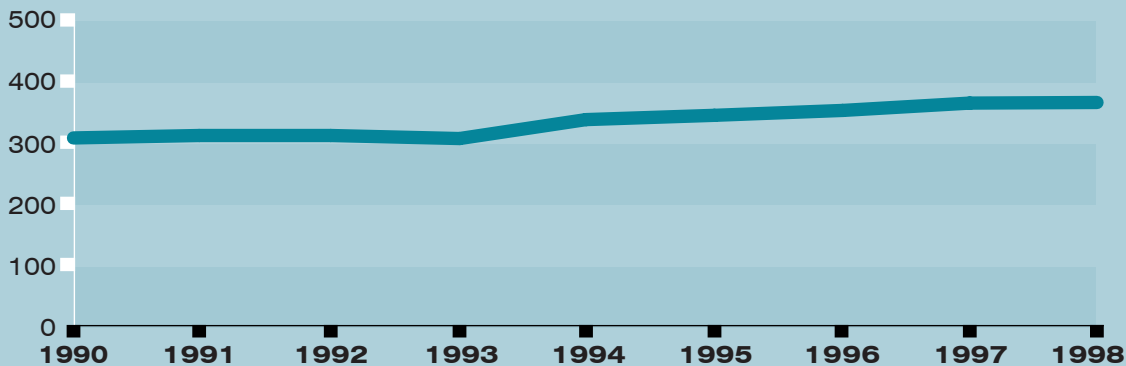
- Physician visits and consultations increased from 10,800 per 1,000 beneficiaries in 1990 to 13,100 per 1,000 in 1998.
- Use of home health services increased substantially from 2,141 home health visits per 1,000 enrollees in 1990 to 8,227 visits per 1,000 in 1997. Home health care use increased during this period in

part because of an expansion in the coverage criteria for the Medicare home health benefit.<sup>36</sup> In 1998, home health visits from Medicare claims dropped to 5,058 per 1,000 beneficiaries, following implementation of the Balanced Budget Act, which changed Medicare payment policies for home health care services.

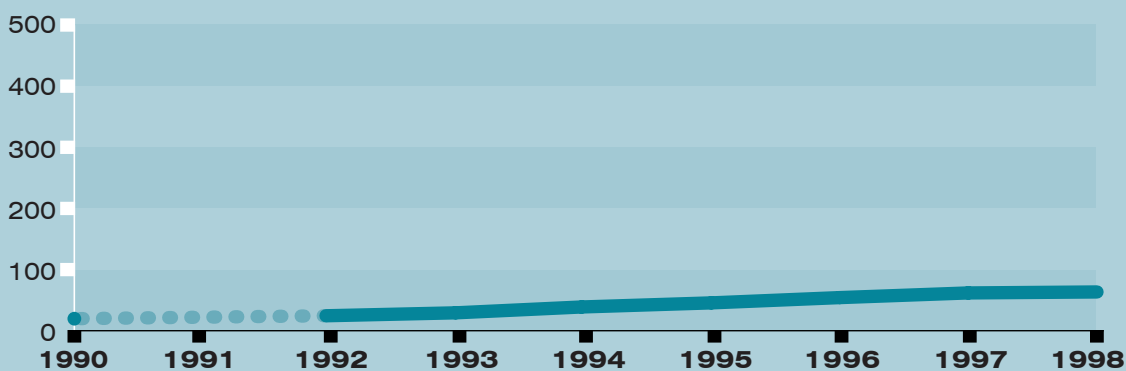


### Rates of health care service usage by Medicare beneficiaries age 65 or older, 1990 to 1998 (per 1,000)

#### HOSPITALIZATIONS



#### SKILLED NURSING FACILITY ADMISSIONS



Note: Dashed lines indicate years for which data are not available. Data for 1998 should be considered preliminary. For hospitalizations and skilled nursing facility admissions, utilization rates for 1994-1998 exclude HMO enrollees from the numerator and denominator because utilization data are not available for this group. Prior to 1994, HMO enrollees were included in the denominator, causing utilization rates to be understated. Prior to 1994, HMO enrollees represented 7 percent or less of the Medicare population; in 1998 they represented 18 percent.

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

Source: Medicare claims and enrollment data.

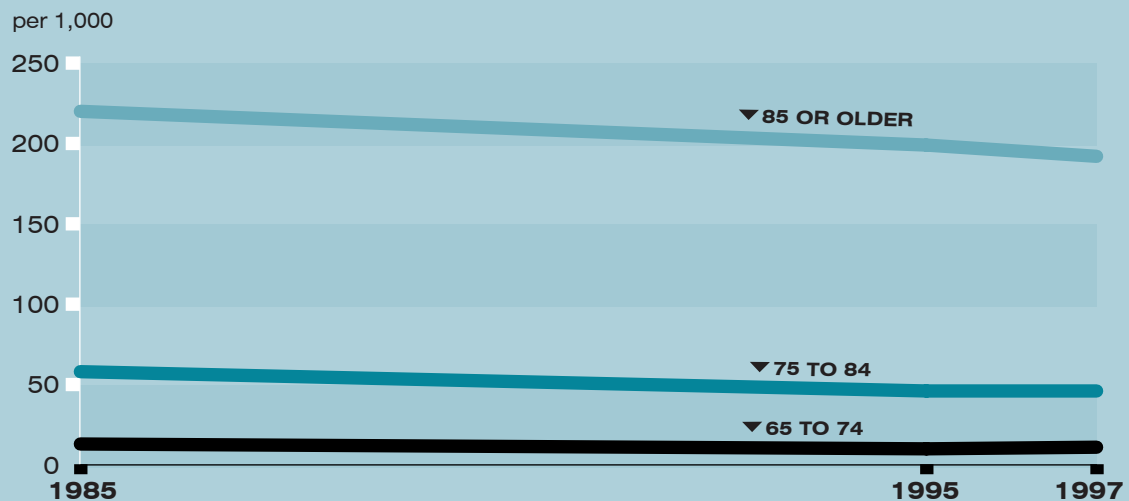
- Between 1990 and 1998, there was a moderate increase in the hospitalization rate from 307 hospitalizations per 1,000 Medicare enrollees in 1990 to 365 per 1,000 in 1998. Although the rate of hospital admissions increased, the average length of hospital stay declined from 9 days in 1990 to 6 days in 1998. (Note: Readers should use caution in comparing these trends with those shown on the facing page because of differences in the vertical scales. Physician visits and consultations and home health visits are much more common among persons age 65 or older than either hospitalizations or skilled nursing facility admissions.)
- Skilled nursing facility admissions also increased from 23 admissions per 1,000 enrollees in 1990 to 69 per 1,000 enrollees in 1998.
- Use of home health care and skilled nursing facility care increased markedly with age. In 1998, home health agencies made 2,350 home health visits per 1,000 enrollees ages 65 to 74, compared with 12,709 among persons age 85 or older. Skilled nursing facility admissions per 1,000 were 27 for persons ages 65 to 74 and 200 for persons age 85 or older.

*Data for this indicator can be found in Tables 29a and 29b on page 91.*

## Nursing Home Utilization

**R**esidence 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. Declines in disability among the older population may also have contributed to this trend.

### Rate of nursing home residence among persons age 65 or older, by age group, 1985, 1995, and 1997



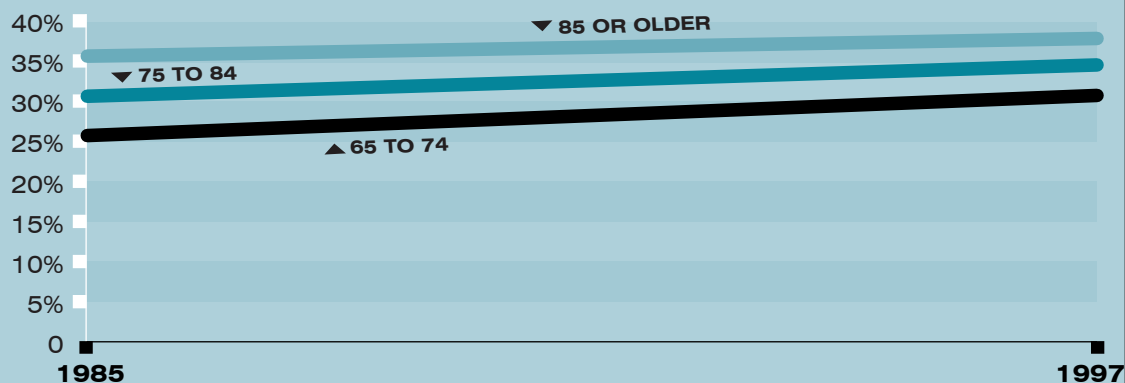
Note: In 1997 population, figures are adjusted for net underenumeration using the 1990 National Population Adjustment Matrix from the U.S. Census Bureau. Persons residing in personal care or domiciliary care homes are excluded.

Reference population: These data refer to the resident population.

Source: National Nursing Home Survey.

- In 1997, only 11 persons per 1,000 ages 65 to 74 resided in nursing homes, compared with 46 per 1,000 persons ages 75 to 84 and 192 persons per 1,000 age 85 or older. About half of older nursing home residents in 1997 were age 85 or older.
- The total rate of nursing home residence among the older population declined between 1985 and 1997. In 1985, the age-adjusted nursing home residence rate was 54 persons per 1,000 age 65 or older. By 1997 this rate had declined to 45 persons per 1,000. Among persons ages 65 to 74, rates declined by 14 percent, compared with a 21 percent decline among persons ages 75 to 84, and a 13 percent decline among the population age 85 and older.
- Older women at all ages had higher rates of nursing home residence than men. In 1997, three-fourths of the nursing home residents were women.
- Assisted-living facilities can provide an alternative to long-term care in a nursing home. A recent national study of assisted-living facilities found that there were 11,472 assisted-living facilities nationwide, accommodating 558,400 residents.<sup>37</sup> Assisted-living administrators estimated that 24 percent of their residents received assistance with three or more activities of daily living, such as bathing, dressing, and mobility. They estimated that about one-third of the residents had moderate to severe cognitive impairment.<sup>38</sup>

**Percentage of nursing home residents age 65 or older who are incontinent and dependent in mobility and eating, by age group, 1985 and 1997**



Note: Residents dependent in mobility and eating require the assistance of a person or special equipment. Residents who are incontinent have difficulty in controlling bowels and/or bladder or have an ostomy or indwelling catheter. Persons residing in personal care or domiciliary care homes are excluded. Reference population: These data refer to the population residing in nursing homes. Source: National Nursing Home Survey.

■ Over the past decade, there has been an increase in the percentage of nursing home residents with functional limitations. Between 1985 and 1997, the percentage of nursing home residents age 65 or older who were incontinent increased from 55 percent to 65 percent, the percentage who were dependent in eating increased from 41 percent to 45 percent, and the percentage who were dependent in mobility increased from 76 percent to 79 percent. The percentage who were limited in all three of these functions increased from 33 percent to 36 percent over this period.

■ In 1997, the percentage of nursing home residents who were limited in all three

areas was higher among women (36 percent) than men (34 percent); however, between 1985 and 1997, the increase in the percentage was greater among men (20 percent) than among women (6 percent).

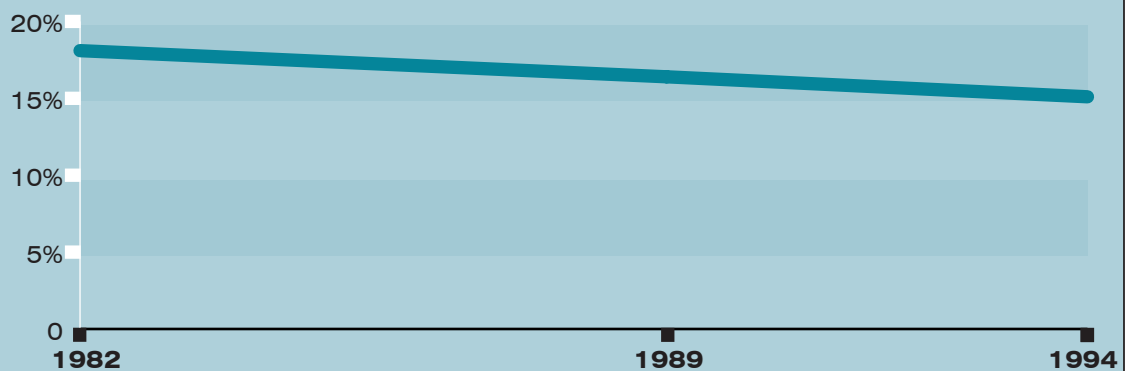
■ Between 1985 and 1997 the increase in rates of functional limitation in all three areas was also higher among nursing home residents ages 65 to 74 (19 percent) than among residents ages 75 to 84 (13 percent) or residents age 85 or older (6 percent).

*Data for this indicator can be found in Tables 30a, 30b, and 30c on pages 92 and 93.*

## Home Care

**A**lthough most long-term care spending in the United States is for nursing home and other institutional care, the majority of older persons with disabilities live in the community and receive assistance from spouses, adult children, and other family members. Most of this care is informal and unpaid, although there is an increasing number of older Americans with disabilities who are relying on a combination of informal and formal long-term care. The aging of the population will increase the demand for long-term care in the community and raises important questions about who will provide this care and how it will be financed.

### Percentage of Medicare beneficiaries age 65 or older receiving home care for a chronic disability, 1982, 1989, and 1994



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

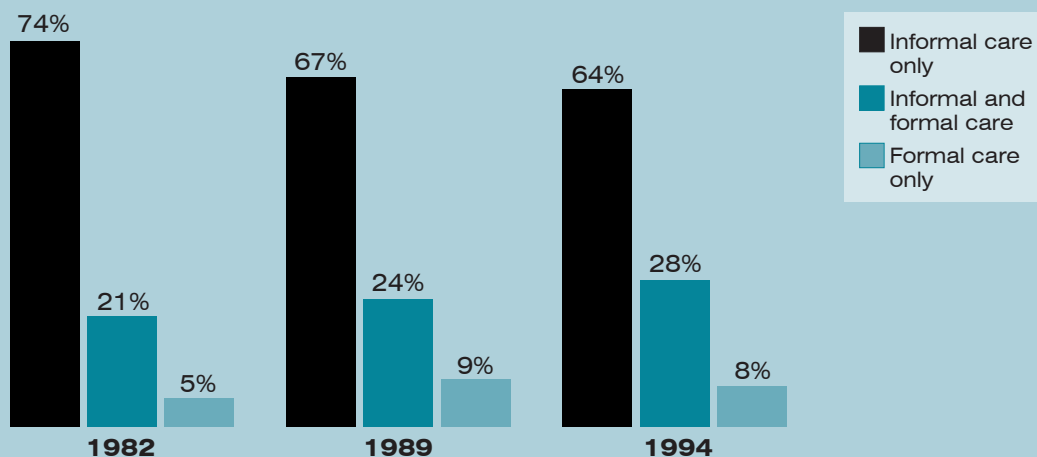
Reference population: These data refer to Medicare beneficiaries.

Source: National Long Term Care Survey.

- The percentage of older Americans who received community-based care for a disability declined from 18 percent in 1982 to 15 percent in 1994. This occurred even though there was a slight increase in the number of older Americans who received assistance (from 4.6 million to 4.7 million).
- Possible reasons for the decline in long-term care in the community include

improvements in the health and disability of the older population, changes in household living arrangements (e.g., the move toward assisted living and other residential care alternatives), and greater use of special equipment and assistive devices that help to maintain older disabled persons' independence in the community.<sup>39</sup>

### Distribution of Medicare beneficiaries age 65 or older receiving home care for a chronic disability, by type of assistance, 1982, 1989, and 1994



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

Reference population: These data refer to Medicare beneficiaries who are receiving community-based care for a disability.

Source: National Long Term Care Survey.

- Although most of the home care received by older persons with disabilities is unpaid, the use of informal care as an exclusive means of assistance is declining. The percentage of older Americans with disabilities who received only informal care declined from 74 percent in 1982 to 64 percent in 1994, while the percentage of older persons who received both informal and formal care increased from 21 percent to 28 percent over this period.
- The increase in the use of a combination of informal and formal services was greatest among older Americans with

the most severe disabilities.<sup>40</sup>

- The increase in the use of paid care may reflect changes in the health of the older population, increases in the financial resources of older Americans, greater preference to supplement health care with formal services, and programmatic changes in Medicare (e.g., liberalization of coverage rules under the home health benefit) and Medicaid (e.g., expansion of home and community-based services).<sup>41</sup>

*Data for this indicator can be found in Tables 31a and 31b on pages 94 and 95.*

# Data Needs

**I**n preparing this report, the Federal Interagency Forum on Aging-Related Statistics (Forum) identified several areas where more data are needed to support research and policy efforts. The Forum's observations complement suggestions that were reported at a National Academy of Sciences' workshop on how to improve data on aging.<sup>42</sup>

## Extending the age-reporting categories

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

## Gathering information on older minorities

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

essential to adequately study the well-being of older minorities.

## Improving measures of disability

Information on trends in disability is critical for monitoring the health and well-being of the older population. However, the concept of disability encompasses many different dimensions of health and functioning, and complex interactions with the environment. Furthermore, specific definitions of disability are used by some government agencies to determine eligibility for benefits. As a result, disability has been measured in different ways across surveys and censuses, and this has led to conflicting estimates of the prevalence of disability. To the extent possible, population-based surveys designed to broadly measure disability in the older population should use a common conceptual framework. At a minimum, questions designed to measure limitations in Activities of Daily Living (ADLs), Instrumental Activities of Daily Living (IADLs), physical functioning, and other activities should use consistent wording and response categories whenever possible.

## Including the institutional population in national surveys

Because of the complex methodological issues involved with collecting data from people in institutions (along with the associated high costs), the institutional population is often not included in "nationally representative" surveys. According to the Census Bureau, the institutional population "Includes persons under formally authorized, supervised care or custody in institutions at the time of enumeration. Such persons are classified as 'patients or inmates' of an institution regardless of the availability of nursing or medical care, the length of stay, or the number of persons in the institution."<sup>43</sup> Because this definition includes people in nursing homes, psychiatric hospitals, and long-term care facilities, this becomes a critical issue for researchers who are interested in studying the entire older population.

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

The use of assisted-living facilities, board and care homes, continuing-care retirement communities, and other types of facilities as alternatives to long-term care in a nursing home has grown over the last fifteen years. Current surveys and censuses that include information on the entire older population rarely distinguish between these types of “institutional” residences. As a result, there is a lack of information on the characteristics of older persons in different residential care settings and their service use and health care needs. Perhaps more importantly, there is little information on the costs, duration, and transitions into and between different long-term care settings. Researchers and policymakers should consider developing consistent definitions of residential settings and include these on surveys of the entire population.

### **Gathering national statistics on elder abuse**

The Institute of Medicine reports a “paucity of research” on elder abuse and neglect, with most prior studies lacking empirical evidence.<sup>44</sup> In fact, there are no reliable, national estimates of elder abuse, nor are the risk factors clearly understood. Most studies have been cross-sectional and have not investigated the natural history of abuse. The need for a national study of elder abuse and neglect is supported by the growing number of older people, increasing public awareness of the problem, new legal requirements for reporting abuse, and advances in questionnaire design.

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

One of the major successes of the 20th century is the increase in longevity and improved health of the older population. As life expectancy increases, the importance of effectively treating chronic diseases and reducing disability becomes ever greater. Understanding the underlying reasons for the improvements in longevity and functioning is a critical first step to further advances toward these goals. To this end,

information is needed to understand the long-term improvements in the health of the older population stemming from better nutrition, increased access to medical care, improvements in the public health infrastructure, changes in lifestyles, better treatment of chronic diseases through new medical procedures and pharmaceuticals, and use of assistive devices and other technology.

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

Collecting data on economic well-being is often a difficult task. Many survey respondents do not know their incomes or are unwilling to share this information with interviewers. This can result in missing data for a large proportion of respondents. A related problem with the collection of economic data is that most surveys use only income-based measures. This type of survey methodology does not capture the accumulated wealth (including the value of future pension payments) and assets on which many older persons rely. New methods to gather income and wealth data are coming into use and are being refined, and their use should be encouraged in surveying older people. These methods are aimed at providing a better understanding of the total financial picture of older Americans facing retirement and those already retired, specifically at including information on individual retirement accounts and 401(k) and Keogh plans.

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

While much is known about the safety issues of crash involvement and fatality rates of older people, more information is needed on the effects of transportation on the quality of life. The ability to move freely from place to place, while often taken for granted, is as crucial to the well-being of older people as it is to the rest of the population. For example, access to quality health care is effectively removed if an older person cannot get from his or her home to a medical facility. More data are needed on the number of trips older people take and the types of transportation they use. This critical information will aid policymakers in planning for the transportation needs of older Americans.

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# Appendix A: Detailed Tables

## INDICATOR 1 NUMBER OF OLDER AMERICANS

**TABLE 1A | TOTAL NUMBER OF PERSONS AGE 65 OR OLDER BY AGE GROUP, 1900 TO 2050, IN MILLIONS**

	65 OR OLDER	65 OR OLDER	85 OR OLDER	85 OR OLDER
1900	3.1	3.1	0.1	0.1
1910	4.0	4.0	0.2	0.2
1920	4.9	4.9	0.2	0.2
1930	6.6	6.6	0.3	0.3
1940	9.0	9.0	0.4	0.4
1950	12.3	12.3	0.6	0.6
1960	16.6	16.6	0.9	0.9
1970	20.1	20.1	1.5	1.5
1980	25.5	25.5	2.2	2.2
1990	31.2	31.2	3.1	3.1
	<b>(MIDDLE-SERIES PROJECTIONS)</b>	<b>(HIGH-SERIES PROJECTIONS)</b>	<b>(MIDDLE-SERIES PROJECTIONS)</b>	<b>(HIGH-SERIES PROJECTIONS)</b>
2000	34.8	34.9	4.3	4.3
2010	39.7	40.5	5.8	5.9
2020	53.7	56.2	6.8	7.3
2030	70.3	75.7	8.9	10.1
2040	77.2	87.1	14.3	16.8
2050	82.0	98.3	19.4	23.9

Reference population: These data refer to the resident population.

Source: U.S. Census Bureau, 1900-1980, 1980 Census of Population, General Population Characteristics, United States Summary (PC80-1-B1); 1990, 1990 Census of Population, General Population Characteristics, United States Summary (CP-1-1); and 2000-2050, Population Projections of the United States by Age, Sex, Race, Hispanic Origin, and Nativity: 1999 to 2100; published January 2000, [www.census.gov/population/www/projections/natproj.html](http://www.census.gov/population/www/projections/natproj.html).

**TABLE 1B | PERCENTAGE OF THE POPULATION AGE 65 AND OLDER AND AGE 85 AND OLDER, 1900 TO 2050**

	65 OR OLDER	65 OR OLDER	85 OR OLDER	85 OR OLDER
1900	4.1	4.1	0.2	0.2
1910	4.3	4.3	0.2	0.2
1920	4.7	4.7	0.2	0.2
1930	5.4	5.4	0.2	0.2
1940	6.9	6.9	0.3	0.3
1950	8.2	8.2	0.4	0.4
1960	9.2	9.2	0.5	0.5
1970	9.9	9.9	0.7	0.7
1980	11.3	11.3	1.0	1.0
1990	12.6	12.6	1.2	1.2
	<b>(MIDDLE-SERIES PROJECTIONS)</b>	<b>(HIGH-SERIES PROJECTIONS)</b>	<b>(MIDDLE-SERIES PROJECTIONS)</b>	<b>(HIGH-SERIES PROJECTIONS)</b>
2000	12.7	12.6	1.6	1.6
2010	13.2	13.0	1.9	1.9
2020	16.5	15.9	2.1	2.1
2030	20.0	18.5	2.5	2.5
2040	20.5	18.3	3.8	3.5
2050	20.3	17.8	4.8	4.3

Reference population: These data refer to the resident population.

Source: U.S. Census Bureau, 1900-1980, 1980 Census of Population, General Population Characteristics, United States Summary (PC80-1-B1); 1990, 1990 Census of Population, General Population Characteristics, United States Summary (CP-1-1); and 2000-2050, Population Projections of the United States by Age, Sex, Race, Hispanic Origin, and Nativity: 1999 to 2100; published January 2000, [www.census.gov/population/www/projections/natproj.html](http://www.census.gov/population/www/projections/natproj.html).

**TABLE 1C | PERCENTAGE OF THE POPULATION AGE 65 AND OLDER, BY COUNTRY, 2000**

AUSTRIA	15.6
BELARUS	13.6
BELGIUM	17.1
BULGARIA	16.5
CANADA	12.6
CROATIA	15.4
CZECH REPUBLIC	13.8
DENMARK	14.9
ESTONIA	14.7
FINLAND	14.9
FRANCE	16.1
GERMANY	16.5
GREECE	17.2
HUNGARY	14.6
ICELAND	11.9
IRELAND	11.3
ITALY	18.2
JAPAN	17.0
LATVIA	15.3
LITHUANIA	13.4
NETHERLANDS	13.7
NORWAY	15.3
POLAND	12.2
PORTUGAL	15.5
ROMANIA	13.5
RUSSIA	12.6
SPAIN	16.8
SWEDEN	17.2
SWITZERLAND	15.2
UKRAINE	13.9
UNITED KINGDOM	15.7
UNITED STATES	12.7

Source: U.S. Census Bureau, International Programs Center, International Data Base.

**TABLE 1D | PERCENTAGE OF THE POPULATION AGE 65 AND OLDER, BY STATE, 2000**

<b>ALPHABETICALLY</b>	<b>PERCENT</b>	<b>RANKED BY PERCENTAGE</b>	
UNITED STATES	12.7		
ALABAMA	13.1	FLORIDA	18.1
ALASKA	5.8	WEST VIRGINIA	15.6
ARIZONA	13.2	PENNSYLVANIA	15.6
ARKANSAS	14.3	IOWA	15.2
CALIFORNIA	10.4	NORTH DAKOTA	15.0
COLORADO	10.8	RHODE ISLAND	14.8
CONNECTICUT	14.0	ARKANSAS	14.3
DELAWARE	12.6	SOUTH DAKOTA	14.2
DISTRICT OF COLUMBIA	13.2	CONNECTICUT	14.0
FLORIDA	18.1	NEBRASKA	14.0
GEORGIA	9.9	OKLAHOMA	14.0
HAWAII	12.5	OREGON	13.9
IDAHO	11.7	MAINE	13.7
ILLINOIS	12.3	MISSOURI	13.6
INDIANA	12.6	MASSACHUSETTS	13.6
IOWA	15.2	MONTANA	13.5
KANSAS	13.5	OHIO	13.5
KENTUCKY	12.7	KANSAS	13.5
LOUISIANA	11.8	NEW JERSEY	13.3
MAINE	13.7	WISCONSIN	13.2
MARYLAND	11.2	ARIZONA	13.2
MASSACHUSETTS	13.6	DISTRICT OF COLUMBIA	13.2
MICHIGAN	12.4	ALABAMA	13.1
MINNESOTA	12.3	NEW YORK	13.0
MISSISSIPPI	12.2	NORTH CAROLINA	12.7
MISSOURI	13.6	KENTUCKY	12.7
MONTANA	13.5	DELAWARE	12.6
NEBRASKA	14.0	INDIANA	12.6
NEVADA	11.7	TENNESSEE	12.5
NEW HAMPSHIRE	11.6	HAWAII	12.5
NEW JERSEY	13.3	SOUTH CAROLINA	12.4
NEW MEXICO	11.1	MICHIGAN	12.4
NEW YORK	13.0	MINNESOTA	12.3
NORTH CAROLINA	12.7	ILLINOIS	12.3
NORTH DAKOTA	15.0	MISSISSIPPI	12.2
OHIO	13.5	VERMONT	11.8
OKLAHOMA	14.0	LOUISIANA	11.8
OREGON	13.9	WYOMING	11.8
PENNSYLVANIA	15.6	NEVADA	11.7
RHODE ISLAND	14.8	WASHINGTON	11.7
SOUTH CAROLINA	12.4	IDAHO	11.7
SOUTH DAKOTA	14.2	NEW HAMPSHIRE	11.6
TENNESSEE	12.5	VIRGINIA	11.3
TEXAS	10.4	MARYLAND	11.2
UTAH	9.2	NEW MEXICO	11.1
VERMONT	11.8	COLORADO	10.8
VIRGINIA	11.3	TEXAS	10.4
WASHINGTON	11.7	CALIFORNIA	10.4
WEST VIRGINIA	15.6	GEORGIA	9.9
WISCONSIN	13.2	UTAH	9.2
WYOMING	11.8	ALASKA	5.8

Note: Data are middle-series projections of the population.

Reference population: These data refer to the resident population.

Source: U.S. Census Bureau, Population Projections for States by Selected Age Groups and Sex: 1995 to 2025, available online at: [www.census.gov/population/www/projections/stproj.html](http://www.census.gov/population/www/projections/stproj.html) (accessed April 7, 2000).

INDICATOR 2 **RACIAL AND ETHNIC COMPOSITION**

**TABLE 2A | PROJECTED DISTRIBUTION OF THE POPULATION AGE 65 AND OLDER, BY RACE AND HISPANIC ORIGIN, 2000 AND 2050**

	<b>2000</b>	<b>2050</b>
TOTAL	100.0	100.0
NON-HISPANIC WHITE	83.5	64.2
NON-HISPANIC BLACK	8.1	12.2
NON-HISPANIC AMERICAN INDIAN AND ALASKA NATIVE	0.4	0.6
NON-HISPANIC ASIAN AND PACIFIC ISLANDER	2.4	6.5
HISPANIC	5.6	16.4

Note: Data are middle-series projections of the population. Hispanics may be of any race.

Reference population: These data refer to the resident population.

Source: U.S. Census Bureau, Population Projections of the United States by Age, Sex, Race, Hispanic Origin, and Nativity: 1999 to 2100; published January 2000, [www.census.gov/population/www/projections/natproj.html](http://www.census.gov/population/www/projections/natproj.html).

**TABLE 2B | PROJECTED POPULATION AGE 65 AND OLDER, BY RACE AND HISPANIC ORIGIN, 2000 AND 2050, IN THOUSANDS**

	<b>2000</b>	<b>2050</b>
TOTAL	34,836	81,999
NON-HISPANIC WHITE	29,097	52,684
NON-HISPANIC BLACK	2,827	9,997
NON-HISPANIC AMERICAN INDIAN AND ALASKA NATIVE	152	530
NON-HISPANIC ASIAN AND PACIFIC ISLANDER	822	5,366
HISPANIC	1,938	13,422

Note: Data are middle-series projections of the population. Hispanics may be of any race.

Reference population: These data refer to the resident population.

Source: U.S. Census Bureau, Population Projections of the United States by Age, Sex, Race, Hispanic Origin, and Nativity: 1999 to 2100; published January 2000, [www.census.gov/population/www/projections/natproj.html](http://www.census.gov/population/www/projections/natproj.html).

INDICATOR 3 **MARITAL STATUS**

**TABLE 3 | MARITAL STATUS OF THE POPULATION AGE 65 AND OLDER, BY AGE GROUP AND SEX, 1998**

	TOTAL	MARRIED	WIDOWED	DIVORCED	NEVER MARRIED
<b>TOTAL</b>					
65 OR OLDER	100.0	56.6	32.5	6.7	4.3
65 TO 74	100.0	65.8	21.6	8.4	4.2
75 TO 84	100.0	49.8	41.1	4.7	4.3
85 OR OLDER	100.0	25.9	65.2	3.7	5.2
<b>MEN</b>					
65 OR OLDER	100.0	75.1	14.9	6.1	3.8
65 TO 74	100.0	79.2	8.9	7.8	4.1
75 TO 84	100.0	73.5	19.6	3.7	3.2
85 OR OLDER	100.0	49.9	42.1	3.6	4.5
<b>WOMEN</b>					
65 OR OLDER	100.0	42.9	45.2	7.1	4.7
65 TO 74	100.0	54.9	31.9	8.9	4.3
75 TO 84	100.0	34.1	55.6	5.4	5.0
85 OR OLDER	100.0	13.4	77.3	3.7	5.5

Reference population: These data refer to the civilian noninstitutional population.  
 Source: March Current Population Survey.

INDICATOR 4 **EDUCATIONAL ATTAINMENT**

**TABLE 4A | PERCENTAGE OF THE POPULATION AGE 65 AND OLDER WITH A HIGH SCHOOL DIPLOMA OR HIGHER AND BACHELOR'S DEGREE OR HIGHER, 1950 TO 1998**

	1950	1960	1970	1980	1990	1998
HIGH SCHOOL DIPLOMA OR HIGHER	17.7	19.1	27.1	40.7	53.2	67.0
BACHELOR'S DEGREE OR HIGHER	3.6	3.7	5.5	8.6	10.7	14.8

Reference population: Data for 1980 and 1998 refer to the civilian noninstitutional population. Data for other years refer to the resident population.

Source: Population Census Volumes 1950, 1960, 1970, and 1990; March Current Population Survey, 1980 and 1998.

**TABLE 4B | PERCENTAGE OF THE POPULATION AGE 65 AND OLDER WITH A HIGH SCHOOL DIPLOMA OR HIGHER AND BACHELOR'S DEGREE OR HIGHER, BY RACE AND HISPANIC ORIGIN, 1998**

	HIGH SCHOOL DIPLOMA OR HIGHER	BACHELOR'S DEGREE OR HIGHER
TOTAL	67.0	14.8
NON-HISPANIC WHITE	71.6	16.0
NON-HISPANIC BLACK	43.7	7.0
NON-HISPANIC ASIAN AND PACIFIC ISLANDER	65.1	22.2
HISPANIC	29.4	5.4

Note: Hispanics may be of any race.

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

Source: March Current Population Survey.



INDICATOR 5 **LIVING ARRANGEMENTS**

**TABLE 5A | LIVING ARRANGEMENTS OF THE POPULATION AGE 65 AND OLDER, BY SEX AND RACE AND HISPANIC ORIGIN, 1998**

	WITH SPOUSE	WITH OTHER RELATIVES	WITH NON-RELATIVES	ALONE
<b>MEN</b>				
TOTAL	72.6	7.0	3.0	17.3
WHITE	74.3	6.0	2.7	17.0
BLACK	53.5	14.8	6.8	24.9
ASIAN AND PACIFIC ISLANDER	72.0	20.8	0.6	6.6
HISPANIC	66.8	15.0	4.3	14.0
<b>WOMEN</b>				
TOTAL	40.7	16.8	1.7	40.8
WHITE	42.4	14.8	1.6	41.3
BLACK	24.3	32.2	2.7	40.8
ASIAN AND PACIFIC ISLANDER	41.3	36.7	0.8	21.2
HISPANIC	36.9	33.8	1.8	27.4

Note: Hispanics may be of any race.

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

Source: March Current Population Survey.

**TABLE 5B | PERCENTAGE OF THE POPULATION AGE 65 AND OLDER LIVING ALONE, BY AGE GROUP AND SEX, 1970 TO 1998**

	1970	1980	1990	1998
<b>MEN</b>				
65 TO 74	11.3	11.6	13.0	13.9
75 OR OLDER	19.1	21.6	20.9	22.3
<b>WOMEN</b>				
65 TO 74	31.7	35.6	33.2	30.2
75 OR OLDER	37.0	49.4	54.0	52.9

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

Source: U.S. Census Bureau, Current Population Survey Reports, "Marital Status and Living Arrangements: March 1994" (P20-484) and March 1998 (Update) (P20-514).

INDICATOR 6 **POVERTY**

**TABLE 6A | PERCENTAGE OF THE POPULATION LIVING IN POVERTY, BY AGE GROUP, 1959 TO 1998**

	<b>UNDER 18</b>	<b>18 TO 64</b>	<b>65 OR OLDER</b>	<b>65 TO 74</b>	<b>75 TO 84</b>	<b>85 OR OLDER</b>
1959	27.3	17.0	35.2	—	—	—
1960	26.9	—	—	—	—	—
1961	25.6	—	—	—	—	—
1962	25.0	—	—	—	—	—
1963	23.1	—	—	—	—	—
1964	23.0	—	—	—	—	—
1965	21.0	—	—	—	—	—
1966	17.6	10.5	28.5	—	—	—
1967	16.6	10.0	29.5	—	—	—
1968	15.6	9.0	25.0	—	—	—
1969	14.0	8.7	25.3	—	—	—
1970	15.1	9.0	24.6	—	—	—
1971	15.3	9.3	21.6	—	—	—
1972	15.1	8.8	18.6	—	—	—
1973	14.4	8.3	16.3	—	—	—
1974	15.4	8.3	14.6	—	—	—
1975	17.1	9.2	15.3	—	—	—
1976	16.0	9.0	15.0	—	—	—
1977	16.2	8.8	14.1	—	—	—
1978	15.9	8.7	14.0	—	—	—
1979	16.4	8.9	15.2	—	—	—
1980	18.3	10.1	15.7	—	—	—
1981	20.0	11.1	15.3	—	—	—
1982	21.9	12.0	14.6	12.4	17.4	21.2
1983	22.3	12.4	13.8	11.9	16.7	21.3
1984	21.5	11.7	12.4	10.3	15.2	18.4
1985	20.7	11.3	12.6	10.6	15.3	18.7
1986	20.5	10.8	12.4	10.3	15.3	17.6
1987	20.3	10.6	12.5	9.9	16.1	18.9
1988	19.5	10.5	12.0	10.0	14.6	17.8
1989	19.6	10.2	11.4	8.8	14.6	18.5
1990	20.6	10.7	12.2	9.7	14.9	20.2
1991	21.8	11.4	12.4	10.6	13.9	18.9
1992	22.3	11.9	12.9	10.6	15.2	19.9
1993	22.7	12.4	12.2	10.0	14.2	19.7
1994	21.8	11.9	11.7	10.1	12.8	18.0
1995	20.8	11.4	10.5	8.6	12.3	15.7
1996	20.5	11.4	10.8	8.8	12.5	16.5
1997	19.9	10.9	10.5	9.2	11.3	15.7
1998	18.9	10.5	10.5	9.1	11.6	14.2

— = 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 level. For more detail, see U.S. Census Bureau, Series P-60, No. 207. For information on the measurement of poverty see note on p. 64.

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

Source: March Current Population Survey.

**TABLE 6B | PERCENTAGE OF PERSONS AGE 65 OR OLDER LIVING IN POVERTY, BY SELECTED CHARACTERISTICS, 1998**

TOTAL	10.5
MEN	7.2
WOMEN	12.8
MARRIED	4.9
NONMARRIED	17.4
NON-HISPANIC WHITE	8.2
NON-HISPANIC BLACK	26.4
NON-HISPANIC ASIAN AND PACIFIC ISLANDER	16.0
HISPANIC	21.0

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 level. For more detail, see U.S. Census Bureau, Series P-60, No. 207. For information on the measurement of poverty see note below.

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

Source: March Current Population Survey.

### THE MEASUREMENT OF POVERTY

The measurement of poverty used in this report is the official poverty measure used by the U.S. Census Bureau. A person is living below poverty if the person lives in a family with before-tax cash income below a defined level of need, called the poverty line. The official poverty line in use today was devised in the early 1960s based on the minimum cost of what was considered to be a nutritionally adequate diet. As originally defined, the poverty index signified the inability of families to afford the basic necessities of living, based on the budget and spending patterns of those Americans with an average standard of living. Since then the poverty line has been updated annually for inflation using the consumer price index for all urban consumers. The poverty line depends on the size of the family and the number of children in the family.

A 1995 report by the National Research Council recommended changing the definition of both the poverty thresholds and the resources that are used to measure poverty. Its recommendations included the following:

**Defining income.** On the one hand, the definition of family income should be expanded to include other important resources of purchasing power, such as the earned income credit, food stamps, and housing subsidies. On the other hand, some necessary expenditures that reduce a family's resources available for basic consumption needs should be subtracted from income, such as taxes, necessary child care and other work-related expenditures, child support payments, and out-of-pocket medical expenditures.

**Setting a threshold.** Poverty thresholds should be adjusted to provide a more accurate measure of family income requirements. First, the consumption bundle used to derive thresholds should be based on food, clothing, and shelter, not food consumption alone. Second, thresholds should reflect regional variations in housing costs. Third, thresholds should be adjusted for family size in a more consistent way than is currently done. Finally, thresholds should be updated to reflect changes in expenditure patterns over time.

A recent Census Bureau report used key elements of the National Research Council proposal to estimate alternative poverty rates from 1990 to 1997. The new measure accounts for medical out-of-pocket expenditures and uses an alternative type of threshold definition from that under the official measure. The new measure tends to decrease the relative poverty rate of persons living alone and those with few medical out-of-pocket expenditures, and to increase the relative poverty rate for persons living with a relative or spouse and those with high medical out-of-pocket expenditures. The Social Security Administration has done an analysis of the experimental measure specifically for the older population.

**Sources:** Fisher, G. (1992). The development and history of the poverty thresholds. *Social Security Bulletin* 55 (4); Citro, C.F. and Michael, R.T. (Eds.). (1995). *Measuring poverty: A new approach*. Washington, DC: National Academy Press; Short, K., Garner, T., Johnson, D. and Doyle, P. (June 1999). *Experimental Poverty Measures: 1990-1997*. U.S. Census Bureau, *Current Population Reports* P60-205. Washington, DC: U.S. Government Printing Office; Olsen, K.A. (1999). Application of experimental poverty measures to the aged. *Social Security Bulletin* 62(3).

INDICATOR 7 **INCOME DISTRIBUTION**

**TABLE 7 | INCOME DISTRIBUTION OF THE POPULATION AGE 65 AND OLDER, 1974 TO 1998**

	<b>EXTREME POVERTY</b>	<b>POVERTY</b>	<b>LOW INCOME</b>	<b>MEDIUM INCOME</b>	<b>HIGH INCOME</b>
1974	1.9	12.7	34.6	32.6	18.2
1975	2.0	13.3	35.0	32.3	17.4
1976	1.9	13.1	34.7	31.8	18.5
1977	1.7	12.5	35.9	31.5	18.5
1978	1.7	12.2	33.4	34.2	18.5
1979	2.4	12.9	33.0	33.6	18.2
1980	2.1	13.6	33.5	32.4	18.4
1981	2.0	13.2	32.8	33.1	18.9
1982	2.5	12.1	31.4	33.3	20.7
1983	2.2	11.5	29.7	34.1	22.4
1984	1.7	10.7	30.2	33.8	23.6
1985	2.0	10.7	29.4	34.6	23.4
1986	2.1	10.4	28.4	34.4	24.8
1987	1.9	10.6	27.8	35.1	24.7
1988	1.9	10.1	28.4	34.5	25.1
1989	2.0	9.4	29.1	33.6	25.9
1990	2.1	10.1	27.0	35.2	25.6
1991	2.2	10.1	28.0	36.3	23.3
1992	2.3	10.6	28.6	35.6	22.9
1993	2.4	9.8	29.8	35.0	23.0
1994	2.5	9.2	29.5	35.6	23.2
1995	1.9	8.5	29.1	36.1	24.3
1996	2.1	8.6	29.5	34.7	25.1
1997	2.2	8.3	28.1	35.3	26.0
1998	2.3	8.1	26.8	35.3	27.5

Note: The income classes are derived from the ratio of the family's income to the family's poverty threshold. Extreme poverty is less than 50 percent of the poverty threshold (i.e., \$3,909 for one person age 65 or over in 1998). Poverty is between 50 and 99 percent of the poverty threshold (i.e., between \$3,909 and \$7,817 for one person age 65 or over in 1998). Low income is between 100 and 199 percent of the poverty threshold (i.e., between \$7,818 and \$15,635 for one person age 65 or over in 1998). Medium income is between 200 and 399 percent of the poverty threshold (i.e., between \$15,636 and \$31,271 for one person age 65 or over in 1998). High income is 400 percent or more of the poverty threshold.

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

Source: March Current Population Survey.

INDICATOR 8 **SOURCES OF INCOME**

**TABLE 8A | DISTRIBUTION OF SOURCES OF INCOME FOR THE POPULATION AGE 65 AND OLDER, 1962 TO 1998**

	TOTAL	SOCIAL SECURITY	ASSET INCOME	PENSIONS	EARNINGS	OTHER
1962	100	31	16	9	28	16
1967	100	34	15	12	29	10
1976	100	39	18	16	23	4
1978	100	38	19	16	23	4
1980	100	39	22	16	19	4
1982	100	39	25	15	18	3
1984	100	38	28	15	16	3
1986	100	38	26	16	17	3
1988	100	38	25	17	17	3
1990	100	36	24	18	18	4
1992	100	40	21	20	17	2
1994	100	42	18	19	18	3
1996	100	40	18	19	20	3
1998	100	38	20	19	21	2

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

Source: March Current Population Survey, Survey of the Aged, and Survey of Demographic and Economic Characteristics of the Aged.

**TABLE 8B | SOURCES OF INCOME AMONG PERSONS AGE 65 OR OLDER, BY INCOME LEVEL, 1998**

	LOWEST FIFTH	SECOND FIFTH	THIRD FIFTH	FOURTH FIFTH	HIGHEST FIFTH
TOTAL	100	100	100	100	100
SOCIAL SECURITY	82.1	80.5	63.8	45.2	18.3
ASSET INCOME	2.4	6.1	10.5	13.7	27.9
PENSIONS	3.3	6.6	14.9	24.4	20.5
EARNINGS	0.7	3.2	7.3	13.1	31.1
PUBLIC ASSISTANCE	9.8	1.8	0.7	0.2	0.0
OTHER	1.8	1.8	2.8	3.3	2.1

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

Source: March Current Population Survey.

INDICATOR 9 **NET WORTH**

**TABLE 9 | MEDIAN HOUSEHOLD NET WORTH, BY SELECTED CHARACTERISTICS, IN THOUSANDS OF 1999 DOLLARS, 1984 TO 1999**

	1984	1989	1994	1999
<b>AGE OF HEAD OF HOUSEHOLD</b>				
45 TO 54	\$ 110.6	\$ 98.5	\$ 107.3	\$ 85.0
55 TO 64	118.6	149.8	157.4	145.0
65 TO 74	109.2	126.3	130.4	190.0
65 OR OLDER	93.0	101.5	112.4	157.6
75 OR OLDER	80.2	84.0	93.9	132.9
<b>MARITAL STATUS, HEAD OF HOUSEHOLD AGE 65 OR OLDER</b>				
MARRIED	\$ 145.9	\$ 184.8	\$ 204.6	\$ 234.0
UNMARRIED	65.7	61.8	70.8	83.7
<b>RACE, HEAD OF HOUSEHOLD AGE 65 OR OLDER</b>				
BLACK	\$ 24.0	\$ 30.2	\$ 41.6	\$ 13.0
WHITE	105.3	115.6	125.9	181.0
<b>EDUCATION, HEAD OF HOUSEHOLD AGE 65 OR OLDER</b>				
NO HIGH SCHOOL DIPLOMA	\$ 52.0	\$ 53.1	\$ 61.8	\$ 63.1
HIGH SCHOOL DIPLOMA ONLY	128.7	137.0	120.3	157.4
SOME COLLEGE OR MORE	203.6	235.2	265.3	301.0

Note: Medians are calculated using sample weights. The survey measures 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 survey measure of net worth excludes the present value of future private pensions and rights to future Social Security payments.

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

Source: Panel Study of Income Dynamics.

INDICATOR 10 **PARTICIPATION IN THE LABOR FORCE**

**TABLE 10 | LABOR FORCE PARTICIPATION RATES OF PERSONS AGE 55 OR OLDER, BY AGE GROUP AND SEX, ANNUAL AVERAGES, 1963 TO 1999**

	MEN				WOMEN			
	55 TO 61	62 TO 64	65 TO 69	70 OR OLDER	55 TO 61	62 TO 64	65 TO 69	70 OR OLDER
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	32.6	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

Reference population: These data refer to the civilian noninstitutional population.  
Source: Current Population Survey.

INDICATOR 11 HOUSING EXPENDITURES

**TABLE 11 | PERCENTAGE OF TOTAL ANNUAL EXPENDITURES ALLOCATED TO HOUSING COSTS IN HOUSEHOLDS HEADED BY PERSONS AGE 65 OR OLDER, BY INCOME LEVEL, 1987 TO 1998**

	1987	1989	1992	1994	1996	1998
<b>PERCENTAGE ALLOCATED TO HOUSING</b>						
LOWEST FIFTH	33.4%	34.8%	37.5%	34.5%	36.2%	36.0%
SECOND FIFTH	33.0	31.4	32.5	35.5	34.0	35.3
THIRD FIFTH	28.8	28.3	30.0	26.3	29.8	28.7
FOURTH FIFTH	26.7	23.9	26.1	26.4	28.9	28.0
HIGHEST FIFTH	20.5	21.8	23.3	23.6	24.1	25.8
<b>AVERAGE EXPENDITURES ON HOUSING</b>						
LOWEST FIFTH	\$ 2,842	\$ 3,076	\$ 3,813	\$ 3,919	\$ 4,309	\$ 4,686
SECOND FIFTH	3,410	3,648	4,161	4,885	4,891	5,743
THIRD FIFTH	3,525	4,232	4,853	4,834	5,753	5,930
FOURTH FIFTH	4,186	4,739	5,737	6,575	6,826	7,147
HIGHEST FIFTH	5,403	7,010	7,625	8,925	9,791	10,119
<b>AVERAGE TOTAL EXPENDITURES</b>						
LOWEST FIFTH	\$ 8,502	\$ 8,835	\$ 10,172	\$ 11,375	\$ 11,900	\$ 13,032
SECOND FIFTH	10,332	11,617	12,784	13,747	14,378	16,252
THIRD FIFTH	12,232	14,965	16,189	18,401	19,315	20,696
FOURTH FIFTH	15,676	19,788	22,011	24,894	23,647	25,509
HIGHEST FIFTH	26,301	32,117	32,659	37,757	40,602	39,170

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

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

Source: Consumer Expenditure Survey.



INDICATOR 12 **LIFE EXPECTANCY****TABLE 12A | LIFE EXPECTANCY BY AGE GROUP AND SEX, IN YEARS, 1900 TO 1997**

	1900	1910	1920	1930	1940	1950	1960	1970	1980	1990	1997
<b>LIFE EXPECTANCY AT BIRTH</b>											
TOTAL	49.2	51.5	56.4	59.2	63.6	68.1	69.9	70.8	73.9	75.4	76.5
MEN	47.9	49.9	55.5	57.7	61.6	65.5	66.8	67.0	70.1	71.8	73.6
WOMEN	50.7	53.2	57.4	60.9	65.9	71.0	73.2	74.6	77.6	78.8	79.4
<b>LIFE EXPECTANCY AT AGE 65</b>											
TOTAL	11.9	11.6	12.5	12.2	12.8	13.8	14.4	15.0	16.5	17.3	17.7
MEN	11.5	11.2	12.2	11.7	12.1	12.7	13.0	13.0	14.2	15.1	15.9
WOMEN	12.2	12.0	12.7	12.8	13.6	15.0	15.8	16.8	18.4	19.0	19.2
<b>LIFE EXPECTANCY AT AGE 85</b>											
TOTAL	4.0	4.0	4.2	4.2	4.3	4.7	4.6	5.3	6.0	6.2	6.3
MEN	3.8	3.9	4.1	4.0	4.1	4.4	4.4	4.7	5.1	5.3	5.5
WOMEN	4.1	4.1	4.3	4.3	4.5	4.9	4.7	5.6	6.4	6.7	6.6

Note: The estimates for decennial years are based on decennial census data and deaths for a three-year period around the census year. Life expectancy estimates 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.

Reference population: These data refer to the resident population.

Source: National Vital Statistics System.

**TABLE 12B | LIFE EXPECTANCY BY AGE GROUP AND RACE, IN YEARS, 1997**

	WHITE	BLACK
LIFE EXPECTANCY AT BIRTH	77.1	71.1
LIFE EXPECTANCY AT AGE 65	17.8	16.1
LIFE EXPECTANCY AT AGE 85	6.2	6.4

Reference population: These data refer to the resident population.

Source: National Vital Statistics System.

INDICATOR 13 **MORTALITY**

**TABLE 13A | DEATH RATES FOR SELECTED LEADING CAUSES OF DEATH AMONG PERSONS AGE 65 OR OLDER, 1980 TO 1997 (PER 100,000)**

	HEART DISEASE	CANCER	STROKE	CHRONIC OBSTRUCTIVE PULMONARY DISEASES	PNEUMONIA & INFLUENZA	DIABETES
1980	2,629	1,052	669	179	214	107
1981	2,547	1,056	625	186	207	106
1982	2,503	1,069	587	186	181	102
1983	2,512	1,078	566	204	207	104
1984	2,450	1,087	548	211	214	103
1985	2,431	1,091	533	226	243	103
1986	2,372	1,101	508	228	245	101
1987	2,316	1,106	497	230	237	102
1988	2,306	1,114	491	240	263	105
1989	2,172	1,133	465	240	253	120
1990	2,092	1,142	449	245	258	120
1991	2,049	1,151	436	252	245	121
1992	1,995	1,154	427	253	233	121
1993	2,032	1,164	437	275	249	129
1994	1,963	1,161	437	273	239	133
1995	1,941	1,160	442	273	239	137
1996	1,894	1,150	438	278	236	141
1997	1,832	1,133	426	281	237	141
PERCENT CHANGE 1980-97	-30.3	7.7	-36.3	57.0	10.7	31.8

Note: Rates are age-adjusted using the 2000 standard population.  
 Reference population: These data refer to the resident population.  
 Source: National Vital Statistics System.

**TABLE 13B | LEADING CAUSES OF DEATH AMONG PERSONS AGE 65 OR OLDER, BY SEX AND RACE AND HISPANIC ORIGIN, 1997**

	WHITE	BLACK	ASIAN AND PACIFIC ISLANDER	AMERICAN INDIAN AND ALASKA NATIVE	HISPANIC
<b>MEN</b>					
1.	HEART DISEASE	HEART DISEASE	HEART DISEASE	HEART DISEASE	HEART DISEASE
2.	CANCER	CANCER	CANCER	CANCER	CANCER
3.	STROKE	STROKE	STROKE	DIABETES	STROKE
4.	COPD	COPD	PNEUMONIA & INFLUENZA	STROKE	DIABETES
5.	PNEUMONIA & INFLUENZA	PNEUMONIA & INFLUENZA	COPD	COPD	PNEUMONIA & INFLUENZA
6.	DIABETES	DIABETES	DIABETES	PNEUMONIA & INFLUENZA	COPD
7.	UNINTENTIONAL INJURIES	NEPHRITIS	UNINTENTIONAL INJURIES	UNINTENTIONAL INJURIES	UNINTENTIONAL INJURIES
8.	NEPHRITIS	UNINTENTIONAL INJURIES	NEPHRITIS	CHRONIC LIVER DISEASE AND CIRRHOSIS	CHRONIC LIVER DISEASE AND CIRRHOSIS
9.	ALZHEIMER'S DISEASE	SEPTICEMIA	HYPERTENSION	NEPHRITIS	NEPHRITIS
10.	SEPTICEMIA	HYPERTENSION	SEPTICEMIA	SEPTICEMIA	SEPTICEMIA
	NUMBER OF DEATHS FROM ALL CAUSES				
	704,603	69,898	10,441	2,485	24,988
<b>WOMEN</b>					
1.	HEART DISEASE	HEART DISEASE	HEART DISEASE	HEART DISEASE	HEART DISEASE
2.	CANCER	CANCER	CANCER	CANCER	CANCER
3.	STROKE	STROKE	STROKE	DIABETES	STROKE
4.	COPD	DIABETES	PNEUMONIA & INFLUENZA	STROKE	DIABETES
5.	PNEUMONIA & INFLUENZA	PNEUMONIA & INFLUENZA	DIABETES	PNEUMONIA & INFLUENZA	PNEUMONIA & INFLUENZA
6.	DIABETES	COPD	COPD	COPD	COPD
7.	ALZHEIMER'S DISEASE	NEPHRITIS	UNINTENTIONAL INJURIES	UNINTENTIONAL INJURIES	UNINTENTIONAL INJURIES
8.	UNINTENTIONAL INJURIES	SEPTICEMIA	NEPHRITIS	NEPHRITIS	CHRONIC LIVER DISEASE AND CIRRHOSIS
9.	NEPHRITIS	HYPERTENSION	HYPERTENSION	SEPTICEMIA	NEPHRITIS
10.	ATHERO- SCLEROSIS	UNINTENTIONAL INJURIES	SEPTICEMIA	CHRONIC LIVER DISEASE AND CIRRHOSIS	ALZHEIMER'S DISEASE
	NUMBER OF DEATHS FROM ALL CAUSES				
	844,062	85,445	9,363	2,575	26,383

Note: COPD=Chronic obstructive pulmonary diseases. Hispanics may be of any race.

Reference population: These data refer to the resident population.

Source: National Vital Statistics System.

**TABLE 13C | LEADING CAUSES OF DEATH AMONG PERSONS AGE 85 OR OLDER, BY SEX AND RACE AND HISPANIC ORIGIN, 1997**

	WHITE	BLACK	ASIAN AND PACIFIC ISLANDER	AMERICAN INDIAN AND ALASKA NATIVE	HISPANIC
<b>MEN</b>					
1.	HEART DISEASE	HEART DISEASE	HEART DISEASE	HEART DISEASE	HEART DISEASE
2.	CANCER	CANCER	CANCER	CANCER	CANCER
3.	STROKE	STROKE	STROKE	STROKE	PNEUMONIA & INFLUENZA
4.	PNEUMONIA & INFLUENZA	PNEUMONIA & INFLUENZA	PNEUMONIA & INFLUENZA	PNEUMONIA & INFLUENZA	STROKE
5.	COPD	COPD	COPD	COPD	COPD
6.	UNINTENTIONAL INJURIES	NEPHRITIS	DIABETES	DIABETES	DIABETES
7.	DIABETES	DIABETES	UNINTENTIONAL INJURIES	UNINTENTIONAL INJURIES	UNINTENTIONAL INJURIES
8.	NEPHRITIS	SEPTICEMIA	NEPHRITIS	NEPHRITIS	NEPHRITIS
9.	ALZHEIMER'S DISEASE	UNINTENTIONAL INJURIES	HYPERTENSION	SEPTICEMIA	ALZHEIMER'S DISEASE
10.	ATHERO- SCLEROSIS	HYPERTENSION	ALZHEIMER'S DISEASE	HYPERTENSION	SEPTICEMIA
	NUMBER OF DEATHS FROM ALL CAUSES				
	177,227	13,767	2,699	468	5,671
<b>WOMEN</b>					
1.	HEART DISEASE	HEART DISEASE	HEART DISEASE	HEART DISEASE	HEART DISEASE
2.	STROKE	CANCER	STROKE	STROKE	CANCER
3.	CANCER	STROKE	CANCER	CANCER	STROKE
4.	PNEUMONIA & INFLUENZA	PNEUMONIA & INFLUENZA	PNEUMONIA & INFLUENZA	PNEUMONIA & INFLUENZA	PNEUMONIA & INFLUENZA
5.	COPD	DIABETES	COPD	DIABETES	DIABETES
6.	ALZHEIMER'S DISEASE	SEPTICEMIA	DIABETES	COPD	COPD
7.	DIABETES	NEPHRITIS	UNINTENTIONAL INJURIES	UNINTENTIONAL INJURIES	ALZHEIMER'S DISEASE
8.	UNINTENTIONAL INJURIES	HYPERTENSION	HYPERTENSION	ALZHEIMER'S DISEASE	ATHEROSCLEROSIS
9.	ATHERO- SCLEROSIS	COPD	SEPTICEMIA	SEPTICEMIA	NEPHRITIS
10.	NEPHRITIS	ALZHEIMER'S DISEASE	NEPHRITIS	ATHERO- SCLEROSIS	UNINTENTIONAL INJURIES
	NUMBER OF DEATHS FROM ALL CAUSES				
	368,037	28,348	2,813	709	9,232

Note: COPD=Chronic obstructive pulmonary diseases. Hispanics may be of any race.

Reference population: These data refer to the resident population.

Source: National Vital Statistics System.

INDICATOR 14 **CHRONIC HEALTH CONDITIONS**

**TABLE 14 | PERCENTAGE OF PERSONS AGE 70 OR OLDER WHO REPORTED HAVING SELECTED CHRONIC CONDITIONS, BY SELECTED CHARACTERISTICS, 1984 AND 1995**

	1984	1995		1984	1995
<b>TOTAL</b>			<b>80 TO 84</b>		
ARTHRITIS	55.0	58.1	ARTHRITIS	57.3	61.4
DIABETES	9.9	12.0	DIABETES	10.8	11.0
CANCER	12.4	19.4	CANCER	15.2	20.2
STROKE	7.8	8.9	STROKE	9.6	10.4
HYPERTENSION	45.6	45.0	HYPERTENSION	48.6	47.8
HEART DISEASE	16.4	21.4	HEART DISEASE	20.0	23.0
<b>MEN</b>			<b>85 OR OLDER</b>		
ARTHRITIS	44.9	49.5	ARTHRITIS	53.3	64.1
DIABETES	9.9	12.9	DIABETES	6.5	8.0
CANCER	13.8	23.4	CANCER	13.1	19.0
STROKE	8.3	10.4	STROKE	10.9	13.2
HYPERTENSION	36.8	40.5	HYPERTENSION	44.4	45.2
HEART DISEASE	18.7	24.7	HEART DISEASE	16.4	25.4
<b>WOMEN</b>			<b>NON-HISPANIC WHITE</b>		
ARTHRITIS	61.1	63.8	ARTHRITIS	54.3	57.9
DIABETES	10.0	11.5	DIABETES	8.9	10.9
CANCER	11.6	16.7	CANCER	13.4	21.0
STROKE	7.3	7.9	STROKE	7.5	8.6
HYPERTENSION	50.8	48.0	HYPERTENSION	44.3	44.0
HEART DISEASE	14.9	19.2	HEART DISEASE	17.1	22.0
<b>70 TO 74</b>			<b>NON-HISPANIC BLACK</b>		
ARTHRITIS	55.0	54.4	ARTHRITIS	64.6	67.2
DIABETES	10.8	13.4	DIABETES	17.0	20.4
CANCER	11.1	18.5	CANCER	4.6	9.1
STROKE	6.0	7.1	STROKE	10.8	12.2
HYPERTENSION	44.8	43.7	HYPERTENSION	59.3	58.7
HEART DISEASE	15.6	18.9	HEART DISEASE	11.5	18.5
<b>75 TO 79</b>			<b>HISPANIC</b>		
ARTHRITIS	54.1	58.3	ARTHRITIS	50.6	50.2
DIABETES	9.7	12.6	DIABETES	17.4	17.4
CANCER	11.9	20.2	CANCER	6.2	10.5
STROKE	7.6	8.7	STROKE	8.3	9.6
HYPERTENSION	45.2	44.9	HYPERTENSION	46.9	42.0
HEART DISEASE	15.2	22.0	HEART DISEASE	13.3	17.0

Note: Hispanics may be of any race. 1984 percentages are age-adjusted to the 1995 population.  
 Reference population: These data refer to the civilian noninstitutional population.  
 Source: Supplement on Aging and Second Supplement on Aging.

INDICATOR 15 **MEMORY IMPAIRMENT**

**TABLE 15 | PERCENTAGE OF PERSONS AGE 65 OR OLDER WITH MODERATE OR SEVERE MEMORY IMPAIRMENT, BY AGE GROUP AND SEX, 1998**

	MODERATE OR SEVERE MEMORY IMPAIRMENT			SEVERE MEMORY IMPAIRMENT		
	TOTAL	MEN	WOMEN	TOTAL	MEN	WOMEN
65 TO 69	4.4	5.3	3.8	0.9	0.8	0.9
70 TO 74	8.3	10.1	6.9	2.1	2.6	1.8
75 TO 79	13.5	16.2	11.7	5.2	6.4	4.4
80 TO 84	20.1	22.8	18.5	7.6	9.2	6.7
85 OR OLDER	35.8	37.3	35.0	18.3	19.6	17.6

Note: Definition of moderate or severe memory impairment: Four or fewer words recalled (out of 20) on combined immediate and delayed recall tests. Persons are described as having severe memory impairment if two or fewer words are recalled. Respondents who reported "don't know" on either the immediate or delayed recall test (implying that they were unable to recall any words) were assigned a score of zero for that test. Respondents who refused to participate in either test are excluded from the analysis.

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

Source: Health and Retirement Study.

INDICATOR 16 **DEPRESSIVE SYMPTOMS**

**TABLE 16 | PERCENTAGE OF PERSONS AGE 65 OR OLDER WITH SEVERE DEPRESSIVE SYMPTOMS, BY AGE GROUP AND SEX, 1998**

	<b>TOTAL</b>	<b>MEN</b>	<b>WOMEN</b>
65 TO 69	15.4	12.1	18.0
70 TO 74	14.3	10.3	17.2
75 TO 79	14.6	10.4	17.4
80 TO 84	20.5	17.1	22.4
85 OR OLDER	22.8	22.5	23.0

Note: Definition of severe depressive symptoms: four or more symptoms out of a list of eight depressive symptoms from an abbreviated version of the Center of Epidemiologic Studies Depression Scale (CES-D) adapted by the Health and Retirement Study.

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

Source: Health and Retirement Study.

INDICATOR 17 **SELF-RATED HEALTH STATUS**

**TABLE 17 | PERCENTAGE OF PERSONS AGE 65 OR OLDER WHO REPORTED GOOD TO EXCELLENT HEALTH, BY AGE GROUP, SEX, AND RACE AND HISPANIC ORIGIN, 1994 TO 1996**

	ALL PERSONS	NON-HISPANIC WHITE	NON-HISPANIC BLACK	HISPANIC
<b>TOTAL</b>				
65 OR OLDER	72.2	74.0	58.4	64.9
<b>MEN</b>				
65 OR OLDER	72.0	73.5	59.3	65.4
65 TO 74	74.6	76.3	61.6	68.7
75 TO 84	68.3	69.4	56.4	59.7
85 OR OLDER	65.0	67.3	45.0	50.9
<b>WOMEN</b>				
65 OR OLDER	72.4	74.3	57.8	64.6
65 TO 74	75.2	77.5	59.3	68.5
75 TO 84	69.8	71.7	55.3	59.3
85 OR OLDER	65.1	66.4	56.0	55.1

Note: Data are based on a three-year average from 1994 to 1996. Hispanics may be of any race.  
 Reference population: These data refer to the civilian noninstitutional population.  
 Source: National Health Interview Survey.



INDICATOR 18 **DISABILITY**

**TABLE 18A | PERCENTAGE OF MEDICARE BENEFICIARIES AGE 65 OR OLDER WHO ARE CHRONICALLY DISABLED, BY LEVEL AND CATEGORY OF DISABILITY, 1982 TO 1994**

	1982	1984	1989	1994
<b>TOTAL</b>				
LEVEL AND TYPE OF DISABILITY				
IADLS ONLY	5.5	5.8	4.7	4.3
1-2 ADLS	6.4	6.5	6.3	5.8
3-4 ADLS	2.8	2.9	3.5	3.2
5-6 ADLS	3.4	3.1	2.8	2.8
INSTITUTIONAL	5.7	5.5	5.5	5.1
TOTAL	23.7	23.7	22.7	21.1
TOTAL MEDICARE POPULATION (IN THOUSANDS)	26,920	28,060	30,870	33,130
<b>MEN</b>				
LEVEL AND TYPE OF DISABILITY				
IADLS ONLY	5.0	5.0	4.2	3.8
1-2 ADLS	5.1	4.8	4.5	4.3
3-4 ADLS	2.2	2.3	2.8	2.1
5-6 ADLS	3.3	2.9	2.3	2.2
INSTITUTIONAL	3.8	3.4	3.6	3.2
TOTAL	19.5	18.4	17.4	15.5
TOTAL MEDICARE POPULATION (IN THOUSANDS)	10,590	11,050	12,410	13,410
<b>WOMEN</b>				
LEVEL AND TYPE OF DISABILITY				
IADLS ONLY	5.8	6.4	5.0	4.6
1-2 ADLS	7.2	7.5	7.6	6.8
3-4 ADLS	3.1	3.2	4.0	3.9
5-6 ADLS	3.5	3.2	3.0	3.2
INSTITUTIONAL	6.9	6.9	6.7	6.4
TOTAL	26.5	27.2	26.2	24.9
TOTAL MEDICARE POPULATION (IN THOUSANDS)	16,340	17,010	18,460	19,710

Note: National Long Term Care Survey researchers group tasks of daily living into two categories: activities of daily living (ADLs) such as eating, getting in and out of bed, getting around inside, dressing, bathing, and toileting; and instrumental activities of daily living (IADLs) such as heavy housework, light housework, laundry, preparing meals, shopping for groceries, getting around outside, traveling, managing money, and using a telephone. A person is considered to have an ADL or IADL disability if he or she is unable to perform the activity, uses active help to perform the activity, uses equipment, or requires standby help. A person is considered chronically disabled if he or she has one ADL limitation, one IADL limitation, or is institutionalized, and if any of these conditions has or is expected to last 90 days.

Reference population: These data refer to Medicare beneficiaries.

Source: National Long Term Care Survey.

**TABLE 18B | PERCENTAGE OF PERSONS AGE 70 OR OLDER WHO ARE UNABLE TO PERFORM CERTAIN PHYSICAL FUNCTIONS, BY SEX, 1984 AND 1995**

	1984	1995
<b>MEN</b>		
WALK	12.9	12.3
CLIMB STAIRS	9.3	8.2
STOOP, CROUCH, OR KNEEL	11.5	9.7
REACH UP	3.4	3.0
ANY ONE OF NINE	22.5	19.6
<b>WOMEN</b>		
WALK	20.9	17.8
CLIMB STAIRS	16.0	12.3
STOOP, CROUCH, OR KNEEL	20.2	16.3
REACH UP	5.6	3.9
ANY ONE OF NINE	34.3	28.9

Note: Rates for 1984 are age-adjusted to the 1995 population. The nine physical functioning activities are: walking a quarter mile; walking up ten steps without resting; standing or being on your feet for about two hours; sitting for about two hours; stooping, crouching or kneeling; reaching up over your head; reaching out as if to shake someone's hand; using your fingers to grasp or handle; lifting or carrying something as heavy as ten pounds. A person is considered disabled if he or she is unable to perform an activity alone and without aids.

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

Source: Supplement on Aging, Second Supplement on Aging.

**TABLE 18C | PERCENTAGE OF PERSONS AGE 70 OR OLDER WHO ARE UNABLE TO PERFORM ANY ONE OF NINE PHYSICAL FUNCTIONS, BY SEX AND RACE, 1995**

	WHITE	BLACK
TOTAL	24.6	32.6
MEN	19.2	26.9
WOMEN	28.2	36.0

Note: The nine physical functioning activities are: walking a quarter mile; walking up ten steps without resting; standing or being on your feet for about two hours; sitting for about two hours; stooping, crouching or kneeling; reaching up over your head; reaching out, as if to shake someone's hand; using your fingers to grasp or handle; lifting or carrying something as heavy as ten pounds. A person is considered disabled if he or she is unable to perform an activity alone and without aids.

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

Source: Supplement on Aging, Second Supplement on Aging.

INDICATOR 19 **SOCIAL ACTIVITY**

**TABLE 19A | PERCENTAGE OF PERSONS AGE 70 OR OLDER WHO REPORTED ENGAGING IN SOCIAL ACTIVITIES, BY AGE GROUP AND SEX, 1995**

	70 OR OLDER	70 TO 74	75 TO 79	80 TO 84	85 OR OLDER
<b>TOTAL</b>					
CONTACT WITH FRIENDS OR NEIGHBORS	87.9	90.5	88.3	86.3	81.1
CONTACT WITH NON-CORESIDENT RELATIVES	91.9	92.9	92.2	91.0	89.1
ATTEND CHURCH, TEMPLE, OTHER	50.3	54.2	51.4	47.9	38.6
ATTEND MOVIE, SPORTS EVENT, CLUB, GROUP EVENT	27.4	33.2	27.6	24.0	13.9
GO OUT TO A RESTAURANT	63.6	70.0	65.8	58.0	47.2
VOLUNTEER WORK (PAST 12 MONTHS)	16.3	20.0	17.3	12.7	7.2
<b>MEN</b>					
CONTACT WITH FRIENDS OR NEIGHBORS	85.4	88.0	86.0	82.6	77.4
CONTACT WITH NON-CORESIDENT RELATIVES	90.0	90.7	90.0	89.6	87.8
ATTEND CHURCH, TEMPLE, OTHER	47.5	51.3	47.3	44.2	37.0
ATTEND MOVIE, SPORTS EVENT, CLUB, GROUP EVENT	27.8	33.1	27.8	22.8	12.6
GO OUT TO A RESTAURANT	66.5	70.7	69.8	60.8	47.7
VOLUNTEER WORK (PAST 12 MONTHS)	14.8	17.2	15.8	11.6	6.8
<b>WOMEN</b>					
CONTACT WITH FRIENDS OR NEIGHBORS	89.5	92.5	89.9	88.5	82.8
CONTACT WITH NON-CORESIDENT RELATIVES	93.1	94.6	93.7	91.9	89.6
ATTEND CHURCH, TEMPLE, OTHER	52.1	56.5	54.3	50.1	39.3
ATTEND MOVIE, SPORTS EVENT, CLUB, GROUP EVENT	27.2	33.3	27.5	24.7	14.4
GO OUT TO A RESTAURANT	61.7	69.4	63.0	56.3	47.0
VOLUNTEER WORK (PAST 12 MONTHS)	17.3	22.2	18.4	13.3	7.4

Reference population: These data refer to the civilian noninstitutional population.  
Source: Second Supplement on Aging.

**TABLE 19B | PERCENTAGE OF PERSONS AGE 70 OR OLDER WHO REPORTED BEING SATISFIED WITH THEIR LEVEL OF SOCIAL ACTIVITY, BY SEX, 1995**

	TOTAL	MEN	WOMEN
ABOUT ENOUGH	63.9	63.3	64.4
TOO MUCH	2.3	2.4	2.2
WOULD LIKE TO BE DOING MORE	21.2	19.0	22.7

Reference population: These data refer to the civilian noninstitutional population.  
Source: Second Supplement on Aging.

INDICATOR 20 **SEDENTARY LIFESTYLE**

**TABLE 20 | PERCENTAGE OF PERSONS AGE 65 OR OLDER WHO REPORTED HAVING A SEDENTARY LIFESTYLE, BY SEX, 1985, 1990, AND 1995**

	<b>1985</b>	<b>1990</b>	<b>1995</b>
TOTAL	40.0	39.4	34.4
MEN	33.9	31.5	27.8
WOMEN	44.3	45.0	39.2

Note: Sedentary lifestyle is defined as engaging in no leisure-time physical activity (exercises, sports, physically active hobbies) in a two-week period.

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

Source: National Health Interview Survey.

INDICATOR 21 **VACCINATIONS**

**TABLE 21A | PERCENTAGE OF PERSONS AGE 65 OR OLDER WHO REPORTED HAVING BEEN VACCINATED AGAINST INFLUENZA AND PNEUMOCOCCAL DISEASE, BY RACE AND HISPANIC ORIGIN, 1989 TO 1995**

	1989	1991	1993	1994	1995
<b>INFLUENZA</b>					
NON-HISPANIC WHITE	32.0	42.8	53.1	56.9	60.0
NON-HISPANIC BLACK	17.7	26.5	31.1	37.7	39.5
HISPANIC	23.8	33.2	46.2	36.6	49.5
<b>PNEUMOCOCCAL DISEASE</b>					
NON-HISPANIC WHITE	15.0	21.0	28.7	30.5	34.2
NON-HISPANIC BLACK	6.2	13.2	13.1	13.9	20.5
HISPANIC	9.8	11.0	12.2	13.7	21.6

Note: Hispanics may be of any race. For influenza, the percent vaccinated consists of persons who reported having a flu shot during the past 12 months. For pneumococcal disease, the percent refers to persons who reported ever having a pneumonia vaccination.

Reference Population: These data refer to the civilian noninstitutional population.

Source: National Health Interview Survey.

**TABLE 21B | PERCENTAGE OF PERSONS AGE 65 OR OLDER WHO REPORTED HAVING BEEN VACCINATED AGAINST INFLUENZA AND PNEUMOCOCCAL DISEASE, BY SEX AND AGE GROUP, 1993 TO 1995**

	INFLUENZA	PNEUMOCOCCAL DISEASE
<b>SEX</b>		
MEN	56.2	30.4
WOMEN	53.5	28.5
<b>AGE GROUP</b>		
65 TO 74	52.6	27.7
75 TO 84	58.7	32.6
85 OR OLDER	54.4	28.7

Note: Data are based on a three-year average from 1993 to 1995. For influenza, the percent vaccinated consists of persons who reported having a flu shot during the past 12 months. For pneumococcal disease, the percent is persons who reported ever having a pneumonia vaccination.

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

Source: National Health Interview Survey.

INDICATOR 22 **MAMMOGRAPHY**

**TABLE 22 | PERCENTAGE OF WOMEN AGE 65 OR OLDER WHO REPORTED HAVING HAD A MAMMOGRAM WITHIN THE PAST TWO YEARS, BY RACE AND HISPANIC ORIGIN, 1987 TO 1994**

	<b>1987</b>	<b>1990</b>	<b>1991</b>	<b>1993</b>	<b>1994</b>
TOTAL	22.8	43.4	48.1	54.2	55.0
NON-HISPANIC WHITE	24.0	43.8	49.1	54.7	54.9
NON-HISPANIC BLACK	14.1	39.7	41.6	56.3	61.0
HISPANIC	13.7	41.1	40.9	35.7	48.0

Note: Questions concerning use of mammography differed slightly on the National Health Interview Survey 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 two years. In 1993 and 1994 women were asked whether they had a mammogram within the past year, between one and two years ago, or over two years ago. Hispanics may be of any race.

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

Source: National Health Interview Survey.

INDICATOR 23 **DIETARY QUALITY**

**TABLE 23A | DIETARY QUALITY RATINGS AMONG PERSONS AGE 45 OR OLDER, AS MEASURED BY THE HEALTHY EATING INDEX, BY AGE GROUP AND POVERTY STATUS, 1994 TO 1996**

	AGE GROUP		POVERTY STATUS AMONG PERSONS AGE 65 OR OLDER	
	45 TO 64	65 OR OLDER	BELOW POVERTY	ABOVE POVERTY
TOTAL	100.0	100.0	100.0	100.0
GOOD	12.6	20.9	12.6	22.2
NEEDS IMPROVEMENT	69.5	66.6	66.1	66.6
POOR	17.8	12.5	21.3	11.2

Note: The Healthy Eating Index consists of 10 components. Components 1 to 5 measure the degree to which a person's diet conforms to the Pyramid serving recommendations for the five major food groups: grains, vegetables, fruits, milk, and meat/meat alternatives. Components 6 to 9 measure intake of fat, saturated fat, cholesterol and sodium. Component 10 measures the degree of variety in a person's diet. High component scores indicate intakes close to recommended ranges or amounts; low component scores indicate less compliance with recommended ranges or amounts. These data were collected between 1994 and 1996. See "Indicator 6: Poverty" for information on the definition of poverty.

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

Source: Continuing Survey of Food Intakes by Individuals.

**TABLE 23B | AVERAGE SCORES OF PERSONS AGE 65 OR OLDER FOR COMPONENTS OF THE HEALTHY EATING INDEX, 1994 TO 1996**

1. GRAINS	6.4
2. VEGETABLES	6.5
3. FRUITS	5.3
4. MILK PRODUCTS	4.9
5. MEAT	6.4
6. TOTAL FAT	7.0
7. SATURATED FAT	6.9
8. CHOLESTEROL	8.2
9. SODIUM	7.5
10. VARIETY OF DIET	8.1
HEALTHY EATING INDEX	67.2

Note: The Healthy Eating Index consists of 10 components. Components 1 to 5 measure the degree to which a person's diet conforms to the Pyramid serving recommendations for the five major food groups: grains, vegetables, fruits, milk, and meat/meat alternatives. Components 6 to 9 measure intake of fat, saturated fat, cholesterol and sodium. Component 10 measures the degree of variety in a person's diet. High component scores indicate intakes close to recommended ranges or amounts; low component scores indicate less compliance with recommended ranges or amounts. These data were collected between 1994 and 1996.

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

Source: Continuing Survey of Food Intakes by Individuals.

INDICATOR 24 **CRIMINAL VICTIMIZATION**

**TABLE 24 | VIOLENT AND PROPERTY CRIME RATES, BY AGE OF VICTIM, 1973 TO 1998**

	VIOLENT CRIME (PER 1,000 PERSONS)		PROPERTY CRIME (PER 1,000 HOUSEHOLDS)	
	12 TO 64	65 OR OLDER	12 TO 64	65 OR OLDER
1973	58.7	9.1	544.0	204.7
1974	59.2	9.2	582.7	202.2
1975	59.0	7.8	586.5	214.3
1976	59.5	8.1	565.3	210.1
1977	62.2	8.0	564.4	203.3
1978	61.8	8.2	554.4	190.0
1979	63.7	6.0	585.8	195.8
1980	60.7	6.8	576.6	202.0
1981	65.0	7.9	552.3	224.7
1982	63.7	6.1	519.0	182.8
1983	57.9	5.7	469.1	174.7
1984	57.4	5.0	443.0	162.5
1985	55.4	4.6	436.5	142.8
1986	53.1	4.5	424.7	141.5
1987	54.5	5.0	433.5	149.8
1988	55.8	4.3	424.1	143.9
1989	54.7	4.1	422.9	145.7
1990	55.3	3.6	400.7	136.8
1991	61.2	4.2	409.9	149.7
1992	60.4	5.3	383.1	126.7
1993	63.5	6.0	378.0	133.4
1994	62.7	5.3	360.2	126.4
1995	54.6	6.0	326.3	116.7
1996	50.5	4.8	308.1	105.7
1997	47.1	4.5	278.5	95.7
1998	44.9	2.9	249.4	88.4

Note: Violent crime includes murder, rape, robbery, and aggravated and simple assault. Since 1992, sexual assault has also been included. Property crime includes household burglary, motor vehicle theft, and property theft. Data prior to 1992 have been weighted to partially account for these changes. A complete description of the survey methodology, including changes that were made when the survey was redesigned, can be found in *Criminal Victimization in the United States, 1993*, NCJ-151657.

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

Source: National Crime Victimization Survey and Uniform Crime Reports.



INDICATOR 25 **HEALTH CARE EXPENDITURES**

**TABLE 25A | AVERAGE HEALTH CARE EXPENDITURES AMONG MEDICARE BENEFICIARIES AGE 65 OR OLDER, IN 1996 DOLLARS, BY AGE GROUP, 1992 TO 1996**

	1992	1993	1994	1995	1996
65 TO 69	\$ 5,506	\$ 5,179	\$ 6,028	\$ 5,389	\$ 5,864
70 TO 74	5,761	6,451	6,690	7,380	6,744
75 TO 79	7,063	8,219	8,248	8,412	9,414
80 TO 84	9,535	10,328	10,836	11,555	11,258
85 OR OLDER	14,424	14,805	16,049	16,452	16,465

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

Reference population: These data refer to Medicare beneficiaries.

Source: Medicare Current Beneficiary Survey.

**TABLE 25B | AVERAGE HEALTH CARE EXPENDITURES AMONG MEDICARE BENEFICIARIES AGE 65 OR OLDER, BY SELECTED CHARACTERISTICS, 1996**

TOTAL \$ 8,742

**AGE GROUP**

65 TO 69	\$ 5,864
70 TO 74	6,744
75 TO 79	9,414
80 TO 84	11,258
85 OR OLDER	16,465

**SEX**

MEN	\$ 8,335
WOMEN	9,028

**RACE**

NON-HISPANIC WHITE	\$ 8,756
NON-HISPANIC BLACK	9,794

**LEVEL OF INCOME**

LOWEST FIFTH	\$12,602
SECOND FIFTH	9,790
THIRD FIFTH	7,635
FOURTH FIFTH	7,367
HIGHEST FIFTH	6,371

**INSTITUTIONAL STATUS**

NONINSTITUTIONAL	\$ 6,360
INSTITUTIONALIZED PART OR ALL OF YEAR	38,906

Note: Sample sizes were too small to present results for other race categories.

Reference population: These data refer to Medicare beneficiaries.

Source: Medicare Current Beneficiary Survey.

**TABLE 25C | PERCENTAGE OF HEALTH CARE EXPENDITURES INCURRED BY MEDICARE BENEFICIARIES AGE 65 OR OLDER, BY LEVEL OF EXPENDITURES, 1996**

SPENDING LEVEL	PERCENTAGE OF HEALTH CARE EXPENDITURES INCURRED
TOP 1 PERCENT	12.9
TOP 5 PERCENT	37.2
TOP 10 PERCENT	55.6

Note: Data include both out-of-pocket expenditures and expenditures covered by insurance.  
 Reference population: These data refer to Medicare beneficiaries.  
 Source: Medicare Current Beneficiary Survey.

**TABLE 25D | DISTRIBUTION OF HEALTH CARE EXPENDITURES AMONG MEDICARE BENEFICIARIES AGE 65 OR OLDER, BY INSTITUTIONAL STATUS, 1996**

	NONINSTITUTIONAL POPULATION	INSTITUTIONAL POPULATION
TOTAL	100.0	100.0
INPATIENT HOSPITAL	35.5	14.9
MEDICAL/OUTPATIENT	39.9	10.5
NURSING HOME	0.0	63.7
SKILLED NURSING FACILITY/HOME HEALTH	10.2	9.9
PRESCRIPTION DRUGS	10.2	0.2
OTHER	4.2	0.8

Note: Data include both out-of-pocket expenditures and expenditures covered by insurance. "Other" expenditures consist of dental and hospice expenses.  
 Reference population: These data refer to Medicare beneficiaries.  
 Source: Medicare Current Beneficiary Survey.

INDICATOR 26 **COMPONENTS OF HEALTH CARE EXPENDITURES**

**TABLE 26A | MAJOR COMPONENTS OF HEALTH CARE EXPENDITURES AMONG MEDICARE BENEFICIARIES AGE 65 OR OLDER, 1992 AND 1996**

	1992	1996
TOTAL	100.0	100.0
INPATIENT HOSPITAL	32.6	28.8
MEDICAL/OUTPATIENT	31.4	30.3
NURSING HOME CARE	21.1	20.8
SKILLED NURSING FACILITY/HOME HEALTH CARE	5.6	10.1
PRESCRIPTION DRUGS	6.7	6.9
OTHER	2.6	3.1

Note: Data include both out-of-pocket expenditures and expenditures covered by insurance. "Other" expenditures consist of dental and hospice expenses.

Reference population: These data refer to Medicare beneficiaries.

Source: Medicare Current Beneficiary Survey.

**TABLE 26B | DISTRIBUTION OF MAJOR COMPONENTS OF HEALTH CARE EXPENDITURES AMONG MEDICARE BENEFICIARIES AGE 65 OR OLDER, BY AGE GROUP AND INCOME LEVEL, 1996**

AGE GROUP					
	65 TO 69	70 TO 74	75 TO 79	80 TO 84	85 OR OLDER
AVERAGE EXPENDITURE	\$5,864	\$6,744	\$9,414	\$11,258	\$16,465
TOTAL	100.0	100.0	100.0	100.0	100.0
INPATIENT HOSPITAL	34.3	33.3	31.4	25.8	19.3
MEDICAL/OUTPATIENT	38.5	37.8	32.0	26.9	16.9
NURSING HOME CARE	6.5	8.6	15.2	26.5	46.1
SKILLED NURSING FACILITY/ HOME HEALTH CARE	5.4	7.1	11.6	13.1	13.3
PRESCRIPTION DRUGS	10.7	9.0	6.9	5.4	2.8
OTHER	4.6	4.2	2.8	2.3	1.6
INCOME LEVEL					
	LOWEST FIFTH	SECOND FIFTH	THIRD FIFTH	FOURTH FIFTH	HIGHEST FIFTH
AVERAGE EXPENDITURE	\$12,602	\$9,790	\$7,635	\$7,367	\$6,371
TOTAL	100.0	100.0	100.0	100.0	100.0
INPATIENT HOSPITAL	24.9	29.5	32.3	32.2	26.9
MEDICAL/OUTPATIENT	21.3	28.6	35.2	35.3	38.8
NURSING HOME CARE	35.9	22.2	12.6	10.8	10.4
SKILLED NURSING FACILITY/ HOME HEALTH CARE	12.5	11.5	8.7	9.0	6.5
PRESCRIPTION DRUGS	4.2	6.1	8.3	8.8	9.8
OTHER	1.2	2.2	2.9	3.9	7.5

Note: Data include both out-of-pocket expenditures and expenditures covered by insurance. "Other" expenditures consist of dental and hospice expenses.

Reference population: These data refer to Medicare beneficiaries.

Source: Medicare Current Beneficiary Survey.

INDICATOR 27 **OUT-OF-POCKET HEALTH CARE EXPENDITURES**

**TABLE 27 | PERCENTAGE OF TOTAL OUT-OF-POCKET EXPENDITURES ALLOCATED TO HEALTH CARE COSTS IN HOUSEHOLDS HEADED BY PERSONS AGE 65 OR OLDER, BY INCOME LEVEL, 1987 TO 1998**

	1987	1989	1992	1994	1996	1998
<b>PERCENTAGE ALLOCATED TO HEALTH CARE</b>						
LOWEST FIFTH	10.4%	11.6%	13.5%	14.8%	12.5%	12.7%
SECOND FIFTH	13.5	14.4	15.8	15.4	14.4	13.9
THIRD FIFTH	12.7	14.6	14.9	14.7	14.6	15.6
FOURTH FIFTH	12.3	13.2	13.2	12.0	13.3	13.3
HIGHEST FIFTH	7.9	8.0	9.4	8.9	8.6	9.2
<b>AVERAGE EXPENDITURES ON HEALTH CARE</b>						
LOWEST FIFTH	\$ 886	\$ 1,029	\$ 1,375	\$ 1,685	\$ 1,488	\$ 1,654
SECOND FIFTH	1,390	1,670	2,022	2,112	2,064	2,265
THIRD FIFTH	1,550	2,185	2,413	2,700	2,828	3,228
FOURTH FIFTH	1,926	2,613	2,911	2,990	3,152	3,398
HIGHEST FIFTH	2,065	2,566	3,086	3,376	3,483	3,614
<b>AVERAGE TOTAL EXPENDITURES</b>						
LOWEST FIFTH	\$ 8,502	\$ 8,835	\$10,172	\$11,375	\$11,900	\$ 13,032
SECOND FIFTH	10,332	11,617	12,784	13,747	14,378	16,252
THIRD FIFTH	12,232	14,965	16,189	18,401	19,315	20,696
FOURTH FIFTH	15,676	19,788	22,011	24,894	23,647	25,509
HIGHEST FIFTH	26,301	32,117	32,659	37,757	40,602	39,170

Note: Expenditures on health care, for purposes of this report, include out-of-pocket spending on health insurance, medical services and supplies, and prescription drugs. Quintiles are used to define the five levels of income. In this analysis, the term "household" is used in place of "consumer unit." A consumer unit is used to describe members of a household related by blood, marriage, adoption, or other legal arrangement; single persons who are living alone or sharing a household with others but who are financially independent; or two or more persons living together who share responsibility for at least two of three major types of expenses—food, housing, and other expenses. The income distribution was determined for the subset of all consumer units where the reference person was age 65 or older.

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

Source: Consumer Expenditure Survey.

INDICATOR 28 **ACCESS TO HEALTH CARE**

**TABLE 28A | PERCENTAGE OF MEDICARE BENEFICIARIES AGE 65 OR OLDER WHO REPORTED PROBLEMS WITH ACCESS TO HEALTH CARE, 1992 TO 1996**

	1992	1993	1994	1995	1996
PERCENT REPORTING DIFFICULTY OBTAINING CARE	3.1	2.6	2.6	2.6	2.3
PERCENT REPORTING THEY DELAYED GETTING CARE DUE TO COST	9.8	9.1	7.6	6.8	5.5

Reference population: These data refer to noninstitutional Medicare beneficiaries.  
Source: Medicare Current Beneficiary Survey.

**TABLE 28B | ACCESS TO AND SATISFACTION WITH HEALTH CARE AMONG MEDICARE BENEFICIARIES AGE 65 OR OLDER, BY AGE GROUP AND RACE AND HISPANIC ORIGIN, 1996**

**AGE GROUP**

	TOTAL	65 TO 74	75 TO 84	85 OR OLDER
PERCENT REPORTING DIFFICULTY OBTAINING CARE	2.3	2.7	1.7	2.2
PERCENT REPORTING THEY DELAYED GETTING CARE DUE TO COST	5.5	6.5	4.5	3.0
PERCENT REPORTING THEY WERE UNSATISFIED OR VERY UNSATISFIED WITH HEALTH CARE	3.0	2.8	3.1	4.0

**RACE AND HISPANIC ORIGIN**

	TOTAL	NON-HISPANIC WHITE	NON-HISPANIC BLACK	HISPANIC
PERCENT REPORTING DIFFICULTY OBTAINING CARE	2.3	2.1	3.8	2.9
PERCENT REPORTING THEY DELAYED GETTING CARE DUE TO COST	5.5	5.0	9.6	7.3
PERCENT REPORTING THEY WERE UNSATISFIED OR VERY UNSATISFIED WITH HEALTH CARE	3.0	2.9	2.5	3.7

Reference population: These data refer to noninstitutional Medicare beneficiaries.  
Source: Medicare Current Beneficiary Survey.

INDICATOR 29 **USE OF HEALTH CARE SERVICES**

**TABLE 29A | RATES OF HEALTH CARE SERVICE USAGE BY MEDICARE BENEFICIARIES AGE 65 OR OLDER, 1990 TO 1998 (PER 1,000)**

<b>USE OF SERVICES</b>									
<b>TYPE OF SERVICE</b>	<b>1990</b>	<b>1991</b>	<b>1992</b>	<b>1993</b>	<b>1994</b>	<b>1995</b>	<b>1996</b>	<b>1997</b>	<b>1998</b>
HOSPITALIZATION	307	311	311	306	337	344	352	364	365
HOME HEALTH VISITS	2,141	—	3,822	4,648	6,352	7,608	8,376	8,227	5,058
SKILLED NURSING FACILITY ADMISSIONS	23	—	28	33	43	50	59	67	69
PHYSICIAN VISITS AND CONSULTATIONS	10,800	11,800	11,800	12,100	12,500	12,900	13,000	13,000	13,100
AVERAGE LENGTH OF HOSPITAL STAY (DAYS)	8.8	8.6	8.3	7.9	7.4	6.9	6.5	6.2	6.1

— = NOT AVAILABLE

Note: Data for 1998 should be considered preliminary. Some data for 1991 are not available (—). For hospitalizations, home health visits, and skilled nursing facility admissions, utilization rates for 1994–1998 exclude HMO enrollees from the numerator and denominator because utilization data are not available for this group. Prior to 1994, HMO enrollees were included in the denominators causing utilization rates to be understated. Prior to 1994, HMO enrollees represented 7 percent or less of the Medicare population; in 1998 they represented about 18 percent. For physician visits, data on HMO enrollees are excluded for all years.

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

Source: Medicare claims and enrollment data.

**TABLE 29B | USE OF HOME HEALTH AND SKILLED NURSING FACILITY SERVICES BY MEDICARE BENEFICIARIES AGE 65 OR OLDER, BY AGE GROUP, 1998**

	<b>65 TO 74</b>	<b>75 TO 84</b>	<b>85 OR OLDER</b>
HOME HEALTH VISITS PER 1,000 ENROLLEES	2,350	6,262	12,709
SKILLED NURSING FACILITY ADMISSIONS PER 1,000 ENROLLEES	27	83	200

Note: Data for 1998 should be considered preliminary.

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

Source: Medicare claims and enrollment data.

INDICATOR 30 **NURSING HOME UTILIZATION****TABLE 30A | RATE OF NURSING HOME RESIDENCE AMONG PERSONS AGE 65 OR OLDER, BY SEX AND AGE GROUP, 1985, 1995, AND 1997 (PER 1,000)**

	1985	1995	1997
<b>TOTAL</b>			
65 OR OLDER	54.0	45.9	45.3
65 TO 74	12.5	10.1	10.8
75 TO 84	57.7	45.9	45.5
85 OR OLDER	220.3	198.6	192.0
<b>MEN</b>			
65 OR OLDER	38.8	32.8	32.0
65 TO 74	10.8	9.5	9.8
75 TO 84	43.0	33.3	34.6
85 OR OLDER	145.7	130.8	119.0
<b>WOMEN</b>			
65 OR OLDER	61.5	52.3	51.9
65 TO 74	13.8	10.6	11.6
75 TO 84	66.4	53.9	52.7
85 OR OLDER	250.1	224.9	221.6

Note: Rates for 65 or older category are age-adjusted using the 2000 standard population. In 1997 population, figures are adjusted for net underenumeration using the 1990 National Population Adjustment Matrix from the U.S. Census Bureau.  
Reference population: These data refer to the resident population. Persons residing in personal care or domiciliary care homes are excluded.  
Source: National Nursing Home Survey.

**TABLE 30B | NUMBER OF NURSING HOME RESIDENTS AGE 65 OR OLDER, BY SEX AND AGE GROUP, 1985, 1995, AND 1997, IN THOUSANDS**

	1985	1995	1997
<b>TOTAL</b>			
65 OR OLDER	1,318	1,423	1,465
65 TO 74	212	190	198
75 TO 84	509	512	528
85 OR OLDER	597	720	738
<b>MEN</b>			
65 OR OLDER	334	357	372
65 TO 74	81	79	81
75 TO 84	141	144	159
85 OR OLDER	113	133	132
<b>WOMEN</b>			
65 OR OLDER	984	1,066	1,093
65 TO 74	132	111	118
75 TO 84	368	368	369
85 OR OLDER	485	587	606

Reference population: These data refer to the population residing in nursing homes. Persons residing in personal care or domiciliary care homes are excluded.  
Source: National Nursing Home Survey.

**TABLE 30C | PERCENTAGE OF NURSING HOME RESIDENTS AGE 65 OR OLDER WHO ARE INCONTINENT AND DEPENDENT IN MOBILITY AND EATING, BY AGE GROUP AND SEX, 1985 AND 1997**

	DEPENDENT MOBILITY		INCONTINENT		DEPENDENT EATING		DEPENDENT MOBILITY, EATING, AND INCONTINENT	
	1985	1997	1985	1997	1985	1997	1985	1997
<b>TOTAL</b>								
65 OR OLDER	75.7	79.3	55.0	64.9	40.9	45.1	32.5	35.7
65 TO 74	61.2	73.1	42.9	59.2	33.5	42.1	25.7	30.7
75 TO 84	70.5	77.1	55.1	64.3	39.4	44.8	30.6	34.5
85 OR OLDER	83.3	82.6	58.1	66.9	43.9	46.1	35.6	37.8
<b>MEN</b>								
65 OR OLDER	71.2	76.3	54.2	65.0	36.0	42.8	28.0	33.6
65 TO 74	55.8	72.3	38.8	60.1	32.8	42.7	24.1	32.9
75 TO 84	65.7	75.1	54.4	65.9	32.6	43.7	25.5	34.6
85 OR OLDER	79.2	78.3	58.1	65.6	39.2	42.1	30.9	33.0
<b>WOMEN</b>								
65 OR OLDER	77.3	80.2	55.4	64.8	42.4	45.6	33.9	35.9
65 TO 74	64.5	73.7	45.4	58.6	34.0	41.6	26.7	29.2
75 TO 84	72.3	78.0	55.3	63.6	42.0	45.3	32.6	34.4
85 OR OLDER	84.3	83.5	58.1	67.2	45.0	46.9	36.7	38.8

Note: Residents dependent in mobility and eating require the assistance of a person or special equipment. Residents who are incontinent have difficulty in controlling bowels and/or bladder or have an ostomy or indwelling catheter. Rates for the 65 or older category are age-adjusted using the 1995 National Nursing Home Survey population.

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

Source: National Nursing Home Survey.



INDICATOR 31 **HOME CARE**

**TABLE 31A | PERCENTAGE OF MEDICARE BENEFICIARIES AGE 65 OR OLDER WHO RECEIVED HOME CARE FOR A CHRONIC DISABILITY, BY TYPE OF ASSISTANCE, 1982, 1989, AND 1994**

	1982	1989	1994
<b>PERCENTAGE RECEIVING CARE</b>			
	18.1	16.4	15.1
<b>TYPE OF ASSISTANCE</b>			
TOTAL	100.0	100.0	100.0
INFORMAL CARE ONLY	73.6	66.6	64.3
INFORMAL AND FORMAL CARE	21.0	24.4	28.0
FORMAL CARE ONLY	5.4	9.0	7.8

Note: Home care refers to paid or unpaid assistance provided to a person with a chronic disability, living in the community.  
 Reference population: These data refer to Medicare beneficiaries.  
 Source: National Long Term Care Survey.

**TABLE 31B | DISTRIBUTION OF TYPES OF ASSISTANCE AMONG MEDICARE BENEFICIARIES AGE 65 OR OLDER WHO RECEIVED HOME CARE FOR A CHRONIC DISABILITY, BY LEVEL OF DISABILITY, 1982, 1989, AND 1994**

	INFORMAL CARE ONLY	INFORMAL AND FORMAL CARE	FORMAL CARE ONLY	TOTAL NUMBER (IN THOUSANDS)
<b>1982</b>				
LEVEL OF DISABILITY:				
IADLS ONLY	80.8	12.1	7.1	1,687
1 ADL	74.5	19.8	5.7	1,068
2 ADLS	68.6	25.3	6.1	569
3 ADLS	66.0	29.3	4.7	341
4 ADLS	65.4	32.1	2.6	394
5 ADLS	65.3	33.2	1.5	548
TOTAL	73.6	21.0	5.4	4,607
<b>1989</b>				
LEVEL OF DISABILITY:				
IADLS ONLY	77.7	12.6	9.7	1,509
1 ADL	69.0	20.5	10.5	1,153
2 ADLS	61.1	26.9	12.0	734
3 ADLS	58.7	34.8	6.5	519
4 ADLS	53.3	41.2	5.5	479
5 ADLS	54.4	41.6	4.0	399
TOTAL	66.6	24.4	9.0	4,793
<b>1994</b>				
LEVEL OF DISABILITY:				
IADLS ONLY	78.3	12.2	9.5	1,488
1 ADL	64.9	24.4	10.7	1,114
2 ADLS	62.8	30.0	7.3	745
3 ADLS	57.4	37.2	5.4	443
4 ADLS	51.1	46.2	2.6	434
5 ADLS	41.4	55.3	3.3	512
TOTAL	64.3	28.0	7.8	4,736

Note: Home care refers to paid or unpaid assistance provided to a person with a chronic disability living in the community. See "Indicator 18: Disability" for information on the definition of disability.

Reference Population: These data refer to Medicare beneficiaries.

Source: National Long Term Care Survey.

# Appendix B: Data Source Descriptions

## Consumer Expenditure Survey

The Consumer Expenditure Survey is conducted by the Bureau of Labor Statistics. The survey contains both a diary component and an interview component. Data presented in this chart-book on both out-of-pocket health care and housing expenditures are derived from the interview component only. The proportions shown are derived from sample data and are not weighted to reflect the entire population.

In the interview portion of the Consumer Expenditure Survey, respondents are interviewed once every three months for five consecutive quarters. Respondents report information on consumer unit<sup>1</sup> characteristics and expenditures during each interview. Income data are collected during the second and fifth interviews only.

The data presented are obtained from consumer units whose reference person<sup>2</sup> is at least 65 years old. From all consumer units of this type, complete income reporters<sup>3</sup> are selected. The data are then sorted by income, and grouped into income quintiles, with the first quintile containing the lowest reported incomes.<sup>4</sup> Annual expenditures are estimated by “annualizing” quarterly estimates. (That is, quarterly estimates are multiplied by four.) The proportions of total out-of-pocket expenditures that are used for health care and housing are then calculated separately for each income group.

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

### Definitions:

For the purposes of this report, housing is defined as “basic housing” (i.e., shelter and utilities). Shelter includes payments for mortgage principal, interest and charges; property taxes; maintenance, repairs, insurance, and other expenses; and rent; rent as pay; and maintenance, insurance, and other expenses for renters. “Basic housing” is defined to include utilities because some renters have these costs included in their rent; furthermore, they are a cost that most consumer units incur to provide a tolerable living environment, whether it be for heating and cooling, cooking, or lighting. Other expenses that are included in the Consumer Expenditure Interview Survey definition of housing, such as furniture and appliances, are not included in the current definition, because they are not purchased frequently. This is especially true for older consumers.

Health care expenditures include out-of-pocket expenditures for health insurance, medical services, and prescription drugs and medical supplies.

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## Continuing Survey of Food Intakes by Individuals

The Continuing Survey of Food Intakes by Individuals (CSFII) is designed to measure what Americans eat and drink. Uses of the survey include: monitoring the nutritional adequacy of American diets, measuring the impact of food fortification on nutrient intakes, developing

1. This term is used to describe members of a household related by blood, marriage, adoption, or other legal arrangement; single persons who are living alone or sharing a household with others but who are financially independent; or two or more persons living together who share responsibility for at least two of three major types of expenses—food, housing, and other expenses. Students living in university-sponsored housing are also included in the sample as separate consumer units. For convenience, the term “household” may be substituted for “consumer unit.”
2. This is the first person mentioned when the respondent is asked to name the person or persons who own or rent the home in which the consumer unit resides.
3. In general, “complete” reporters of income are those families that provide a value for at least one major source of income, such as wages and salaries, self-employment income, and Social Security income. However, even “complete” reporters of income do not necessarily provide a full accounting of income from all sources.
4. It is important to note that income does not necessarily include all sources of taxable income; for example, capital gains are not collected as “income.” Similarly, other sources of revenue (such as sales of jewelry, art, furniture, or other similar property) are not included in the definition of income used by the Consumer Expenditure Interview Survey.

dietary guidance and related programs, estimating exposure of population groups to food contaminants, evaluating the nutritional impact of food assistance programs, and assessing the need for agricultural products. The 1994–96 CSFII sample consisted of individuals residing in households and included oversampling of the low-income population. In each of the three survey years, respondents were asked to provide, through in-person interviews, food intake data on two nonconsecutive days, with both days of intake collected by the 24-hour recall method.

This report uses CSFII data to calculate the Healthy Eating Index (HEI), a summary measure of dietary quality. The HEI consists of 10 components, each representing a different aspect of a healthful diet based on the U.S. Department of Agriculture’s Food Guide Pyramid and the Dietary Guidelines for Americans. Components 1 to 5 measure the degree to which a person’s diet conforms to the Pyramid serving recommendations for the five major food groups: grains, vegetables, fruits, milk, and meat/meat alternatives. Components 6 and 7 measure fat and saturated fat consumption. Components 8 and 9 measure cholesterol and sodium intake, and component 10 measures the degree of variety in a person’s diet. High component scores indicate intakes close to recommended ranges or amounts; low component scores indicate less compliance with recommended ranges or amounts. Scores for each component are given equal weight and added to calculate an overall HEI score with a maximum value of 100. An HEI score above 80 implies a good diet, an HEI score between 51 and 80 implies a diet that needs improvement, and an HEI score below 51 implies a poor diet.

For more information on CSFII 1989–91, see: Tippet, K.S., Mickle, S.J., Goldman, J.D., et al. (1995). *Food and Nutrient Intakes by Individuals in the United States, 1 day, 1989–91*. U.S. Department of Agriculture, Agricultural Research Service, NFS Rep. No. 91-2.

For more information on CSFII 1994–96, see: Tippet, K.S., and Cypel, Y.S. (Eds.) (1998). *Design and Operation: The Continuing Survey of Food Intakes by Individuals and the Diet and Health Knowledge Survey, 1994–96*. U.S. Department of Agriculture, Agricultural Research Service, NFS Rep. No. 96-1.

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## Current Population Survey

The Current Population Survey (CPS) is a nationally representative sample survey of about 50,000 households conducted monthly for the Bureau of Labor Statistics by the U.S. Census Bureau.

The CPS core survey is the primary source of information on the employment characteristics of the civilian noninstitutional population age 16 and older, including estimates of unemployment released every month by the Bureau of Labor Statistics.

In 1994, the questionnaire for the CPS was redesigned, and the computer-assisted personal interviewing method was implemented. In addition, the 1990 census-based population controls, with adjustments for the estimated population undercount, were also introduced.

Monthly CPS supplements provide additional demographic and social data. The Annual Demographic Survey, or March CPS supplement, is the primary source of detailed information on income and work experience in the United States. The Annual Demographic Survey 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.

For more information regarding the CPS, its sampling structure, and estimation methodology, see: *Employment and Earnings* 47 (1), 235-252. U.S. Department of Labor, Bureau of Labor Statistics. January 2000.

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## Health and Retirement Study

The Health and Retirement Study (HRS) is a national panel study being conducted by the University of Michigan Institute for Social Research under a cooperative agreement with the National Institute on Aging. The study had an initial sample in 1992 of over 12,600 persons from the 1931–1941 birth cohort and their spouses. The HRS was joined in 1993 by a companion study, Assets and Health Dynamics Among the Oldest Old (AHEAD), with a sample of 8,222 respondents born before 1924 who were age 70 or older 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—the Children of the Depression Age (CODA—1924 to 1930) and the War Babies (WB—1942 to 1947). Plans call for adding a new 6-year cohort of Americans entering their 50s every 6 years. In 2004, baseline interviews will be conducted with the Early Boomer birth cohort (1948 to 1953). The combined studies, which are collectively called HRS, have become a “steady state” sample that is representative of the entire U.S. population over age 50. HRS will follow respondents longitudinally until they die. All cohorts will be followed with biennial interviews.

The HRS is intended to provide data for researchers, policy analysts, and program planners who are making major policy decisions that affect retirement, health insurance, saving, and economic well-being. The objectives of the study are: 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; examine the relationship of 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.

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## Medicare Current Beneficiary Survey

The Medicare Current Beneficiary Survey (MCBS) is a continuous, multipurpose survey of a representative sample of the Medicare population designed to aid the Health Care Financing Administration’s (HCFA) administration, monitoring and evaluation of 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.

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

The MCBS sample consists of Medicare enrollees whether in the community or in an institution. The survey is conducted in three rounds per year, with each round being four months in length. MCBS has a multistage stratified random sample design and a rotating panel survey

design. Each panel is followed for 12 interviews. In-person interviews are conducted using computer-assisted personal interviewing. Approximately 16,000 sample persons are interviewed in each round. However, because of the rotating panel design, only 12,000 sample persons receive all three interviews in a given calendar year.

Information collected in the survey is combined with information from HCFA's administrative data files and made available through public use data files. The Access to Care data file combines survey responses from the fall round of the MCBS with complete calendar year Medicare claims data; it does not contain health care use and cost data reported by the respondents. Access to Care data files are available within a year of the close of the subject calendar year. The complete medical use, cost, and source of payment data file takes twice as long to produce because it requires complex editing and imputation activities which are built upon an event-level match of survey-based information with Medicare claims and administrative data.

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For Medicare data questions: (410) 786-3689

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Internet: [www.hcfa.gov/mcbs/Default.asp](http://www.hcfa.gov/mcbs/Default.asp) or [www.hcfa.gov/stats/stats.htm](http://www.hcfa.gov/stats/stats.htm)

## National Crime Victimization Survey

The National Crime Victimization Survey (NCVS) is the nation's primary source of information on criminal victimization. Each year data are collected by the U.S. Census Bureau for the Bureau of Justice Statistics, Department of Justice, from a nationally representative sample of about 43,000 households comprising more than 80,000 persons age 12 or older on the frequency, characteristics, and consequences of criminal victimization in the United States. The survey measures rape, sexual assault, robbery, simple and aggregated assault, personal larceny, property theft, household burglary, and motor vehicle theft for the population as a whole, as well as for demographic groups in the population including the population age 65 or older, men and women, members of various racial groups, and persons living in cities, suburbs and rural areas. Victims are also asked characteristics of the crimes including whether they reported the incident to the police and, in instances of personal violent crimes, the characteristics of the perpetrator. The NCVS provides the largest national forum for victims to describe the impact of crime and the characteristics of violent offenders. It has been ongoing since 1973 and was redesigned in 1992.

A complete description of the survey methodology, including changes that were made when the survey was redesigned, can be found in *Criminal Victimization in the United States*, 1993, NCJ-151657.

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## National Health Interview Survey

The National Health Interview Survey (NHIS) is a continuing nationwide sample survey of the civilian noninstitutional population conducted by the National Center for Health Statistics. Each week a probability sample of the civilian noninstitutional population of the United States is interviewed by personnel of the U.S. Census Bureau. Data are collected through personal household interviews. Interviewers obtain information on personal and demographic characteristics, including race and ethnicity, by self-reporting or as reported by a household informant. Data about illnesses, injuries, impairments, chronic and acute conditions, activity limitation, utilization of health services, and other health topics are also collected.

The interview is comprised of a core set of questions, which are repeated each year, and a set of topical supplements, which change from year to year. Each year, the survey is reviewed and special topics are added or deleted. For most health topics, the survey collects data over an entire year. The sample includes an oversampling of black and Hispanic persons. The response rate for the ongoing part of the survey has been between 94 and 98 percent over the years. In 1995, interviewers collected information for the core questionnaire on 102,467 persons, including 11,955 persons age 65 or older.

Descriptions of the survey design, the methods used in estimation, and the general qualifications of the data are presented in:

Massey, J.T., Moore, T.F., Parsons, V.L., and Tadros, W. (1989). Design and estimation for the National Health Interview Survey, 1985-1994. *Vital and Health Statistics*, 2 (110). Hyattsville, MD: National Center for Health Statistics.

Benson, V. and Marano, M. (1998). Current estimates from the National Health Interview Survey, 1995., 10 (199). Hyattsville, MD: National Center for Health Statistics.

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### National Long Term Care Survey

The 1982, 1984, 1989, and 1994 National Long Term Care Surveys (NLTCs) are nationally representative surveys of Medicare beneficiaries age 65 or older with chronic functional disabilities. The samples drawn from the Medicare beneficiary enrollment files are nationally representative of both community and institutional residents. As sample persons are followed through the Medicare record system, virtually 100 percent of cases can be longitudinally tracked so that declines as well as improvements in health status may be identified, as well as the exact dates of death. NLTCs sample persons are followed until death and are permanently and continuously linked to the Medicare record system from which they are drawn. Linkage to the Medicare Part A and B service records extend from 1982 through 1995, so that detailed Medicare expenditures and types of service use may be studied.

Through the careful application of methods to reduce nonsampling error, the surveys provide nationally representative data on: the prevalence and patterns of functional limitations, both physical and cognitive; longitudinal and cohort patterns of change in functional limitation and mortality over 12 years; medical conditions and recent medical problems; health care services used; the kind and amount of formal and informal services received by impaired individuals and how it is paid for; demographic and economic characteristics such as age, race, sex, marital status, education and income and assets; out-of-pocket expenditures for health care services and other sources of payment; and housing and neighborhood characteristics.

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### National Nursing Home Survey

The National Nursing Home Survey (NNHS) is a continuing series of national sample surveys of nursing homes, their residents, and their staff. Five nursing home surveys have been conducted: 1973 to 1974, 1977, 1985, 1995, and 1997.

The survey collects information on nursing homes, their residents, discharges, and staff. Nursing homes are defined as facilities with three or more beds that routinely provide nursing care services. In 1973-74, 1985, 1995, and 1997, the survey excluded personal care or domiciliary care homes. Facilities may be certified by Medicare or Medicaid, or not certified but licensed by the state as a nursing home. These facilities may be freestanding or nursing care units of hospitals, retirements centers, or similar institutions where the unit maintained financial and resident records separate from those of the larger institutions. The survey is based on self-administered questionnaires and interviews with administrators and staff in a sample of about 1,500 facilities.

The National Nursing Home Survey 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 size, ownership, Medicare/Medicaid certification, occupancy



rate, days of care provided, and expenses. For recipients, data are obtained on demographic characteristics, health status, and services received. Resident data are provided by a nurse familiar with the care provided to the resident. The nurse relies on the medical record and personal knowledge of the resident.

For more information on the 1985 NNHS, see: Hing, E., Sekscenski E, Strahan, G. (1985). The National Nursing Home Survey: 1985 summary for the United States. National Center for Health Statistics. *Vital Health Statistics*, 13(97).

For more information on the 1995 NNHS, see: Strahan, G. (1997). An overview of nursing homes and their current residents: Data from the 1995 National Nursing Home Survey. Advance data from vital and health statistics; no 280. Hyattsville, Maryland: National Center for Health Statistics.

For more information on the 1997 NNHS, see: Gabrel, C. (2000). An overview of nursing home facilities: Data from the 1997 National Nursing Home Survey. National Center for Health Statistics. Advance data from *Vital and Health Statistics*; no. 311. Hyattsville, Maryland: National Center for Health Statistics.

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## National Vital Statistics System

Through the National Vital Statistics System, the National Center for Health Statistics (NCHS) collects and publishes data on births, deaths, marriages, and divorces in the United States. The Division of Vital Statistics obtains information on births and deaths from the registration offices of all states, New York City, the District of Columbia, Puerto Rico, the U.S. Virgin Islands, and Guam. 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.

U.S. Standard Certificates of Death are revised periodically, allowing careful evaluation of each item and addition, modification, and deletion of items. Since 1989, revised standard certificates have included items on educational attainment and Hispanic origin of decedents as well as improvements in the medical certification of cause of death. Standard certificates recommended by NCHS are modified in each registration area to serve the area's needs. However, most certificates conform closely in content and arrangement to the standard certificate, and all certificates contain a minimum data set specified by NCHS.

Death rates by race and Hispanic origin are based on information from death certificates (numerators of the rates) and on population estimates from the U.S. Census Bureau (denominators of the rates). Race and Hispanic origin are reported by the funeral director as provided by an informant, often the surviving next of kin, or, in the absence of an informant, on the basis of observation. Race and Hispanic origin data from the census are self-reported by the respondent. To the extent that race and Hispanic origin classification is inconsistent between these two data sources, death rates will be biased. Studies have shown that persons self-reported as American Indian and Alaska Native, Asian and Pacific Islander, or Hispanic on census and survey records may sometimes be reported as white or non-Hispanic on the death certificate, resulting in an underestimation of deaths and death rates for the American Indian and Alaska Native, Asian and Pacific Islander, and Hispanic groups. Bias also results from undercounts of some population groups in the census, particularly young black and white males and older persons, resulting in an overestimation of death rates. The net effects of misclassification and under coverage result in overstated death rates for the white population and black population estimated to be 1 percent and 5 percent, respectively; and understated death rates for other population groups estimated as follows: American Indian and Alaska Natives, 21 percent; Asian and Pacific Islanders, 11 percent; and Hispanics, 2 percent.

For more information, see: Rosenberg, H.M., Maurer, J.D., Sorlie, P.D., Johnson, N.J., et al. (1999). Quality of death rates by race and Hispanic origin: A summary of current research, 1999. National Center for Health Statistics. *Vital Health Statistics*, 2 (128).

For more information on mortality data, see: National Center for Health Statistics. (1996). Technical Appendix, *Vital Statistics of the United States, 1992*, Vol. II, Mortality, Part A, DHHS Pub. No. (PHS) 96-1101, Public Health Service. Washington. U.S. Government Printing Office, or visit the NCHS home page at [www.cdc.gov/nchs/](http://www.cdc.gov/nchs/).

For more information, contact:

Mortality Statistics Branch  
Division of Vital Statistics  
National Center for Health Statistics  
Centers for Disease Control and Prevention  
Department of Health and Human Services  
Phone: (301) 458-4666  
Internet: [www.cdc.gov/nchs/nvss.htm](http://www.cdc.gov/nchs/nvss.htm)

## Panel Study of Income Dynamics

The Panel Study of Income Dynamics is a longitudinal study of 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 every year from 1968 to 1997 and will interview them every other year after 1999, whether or not they are living in the same dwelling or with the same people. Adults have been followed as they have grown older, and children have been observed as they advance through childhood and into adulthood, forming family units of their own. Information about the original 1968 sample individuals and their current co-residents (spouses, cohabitators, children, and anyone else living with them) is collected each year. In 1990, a representative national sample of 2,000 Hispanic households, differentially sampled to provide adequate numbers of Puerto Rican, Mexican-American, and Cuban-Americans, was added to the PSID database. With low attrition rates and successful recontacts, the sample size has grown to almost 8,700 in 1995. 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.

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Internet: [www.isr.umich.edu/src/psid/](http://www.isr.umich.edu/src/psid/)

## Population Projections

National population projections begin with recent population estimates by age, race, and Hispanic origin. These statistics are then projected forward to 2100, based on assumptions about fertility, mortality, and international migration. Low-, middle-, and high-growth assumptions are made for each of these components. The current middle-series assumptions are:

In the short-term (from 1999 to 2025), each racial and ethnic group's fertility levels will reach target fertility rates determined by birth expectations data and demographic theory.

After 2025, each racial and ethnic group's fertility rates are assumed to move regularly toward replacement level, reaching 2.1 in 2150.

Mortality differentials among racial and ethnic groups are assumed to narrow, so that by 2100 the age-specific death rates of the groups will be much closer together than what is observed today. The sex differential is also assumed to narrow by 2100.

Migration is assumed to vary over time based on current trends in migration and also changes in labor force needs.

For more information, see: Hollmann, F., Mulder, T.J., and Kallan, J.E., (January 2000). *Methodology and Assumptions for the Population Projections of the United States: 1999 to 2100*. Population Division Working Paper No. 38, U.S. Census Bureau.

For information on the methodology and assumptions behind the state population projections see: Campbell, P.R., (1996). *Population Projections for States by Age, Sex, Race, and Hispanic Origin: 1995 to 2025*, U.S. Bureau of the Census, Population Division, PPL-47.

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## Supplement on Aging

The Supplement on Aging (SOA), conducted by NCHS with the support of the National Institute on Aging, is a survey of noninstitutional persons age 70 or older who were interviewed originally as part of the 1984 core National Health Interview Survey (NHIS). The sample size is 7,527, and the sample is representative of the 1984 U.S. population age 70 and older. In addition, the SOA was administered to 8,621 sample persons ages 55 to 69 to obtain information about persons just prior to their retirement. The SOA includes measures of health and functioning, chronic conditions, housing and long term care, family structure and living arrangements, and social activities. It serves as the baseline for the Longitudinal Study on Aging (LSOA) which followed the original 1984 cohort through subsequent interviews in 1986, 1988, and 1990 and is continuing with passive mortality follow-up.

Descriptions of the survey design, the methods used in estimation, and the general qualifications of the data are presented in:

Fitti, J.E. and Kovar, M.G. (1987). The Supplement on Aging to the 1984 National Health Interview Survey. *Vital and Health Statistics*, 1 (21). Hyattsville, MD: National Center for Health Statistics.

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## Second Supplement on Aging

The Second Supplement on Aging (SOA II), conducted by NCHS with the support of the National Institute on Aging, is a survey of noninstitutional persons age 70 or older who were interviewed originally as part of the 1994 core National Health Interview Survey (NHIS). The sample size is 9,447. The SOA II includes measures of health and functioning, chronic conditions, use of assistive devices, housing and long term care, and social activities. It was designed to replicate the 1984 NHIS Supplement on Aging to examine whether changes have occurred in the health and functioning of the older population between the mid-1980s and the mid-1990s. The 1984 Supplement on Aging served as the baseline for the Longitudinal Study on

Aging (LSOA) which followed the original 1984 cohort through subsequent interviews in 1986, 1988, and 1990 and is continuing with passive mortality follow-up. The SOA II serves as the baseline for the Second Longitudinal Study on Aging (LSOA II).

The SOA II was implemented as part of the National Health Interview Survey on Disability (NHIS-D), which was designed in order to understand disability, estimate the prevalence of certain conditions, and provide baseline statistics on the effects of disabilities. The NHIS-D was conducted in two phases. Phase 1 of the NHIS-D collected information from the household respondent at the time of the 1994 NHIS core interview and was used as a screening instrument for Phase 2 of the NHIS-D. The screening criteria were broadly defined, and more than 50 percent of persons age 70 or older were included in the Phase 2 NHIS-D interviews. Persons age 70 or older who were not included in Phase 2 NHIS-D received the SOA II survey instrument, which was a subset of questions from the NHIS-D.

While the 1994 NHIS core and NHIS-D Phase 1 interviews took place in 1994, Phase 2 of the NHIS-D was conducted as a follow-up survey, 7 to 17 months after the core interviews. In the calculation of weights, therefore, the post-stratification adjustment was based on the population control counts from July 1, 1995, roughly the midpoint of the Phase 2 survey period. As a result, the SOA II sample, based on all 1994 NHIS core participants age 70 or older at the time of the Phase 2 NHIS-D interviews, is representative of the 1995 noninstitutional population age 70 and older.

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Internet: [www.cdc.gov/nchs/about/otheract/aging/lsoa.htm](http://www.cdc.gov/nchs/about/otheract/aging/lsoa.htm)

### 1963 Survey of the Aged

The major purpose of the 1963 Survey of the Aged was to measure the economic and social situations of a representative sample of all persons age 62 or older in the United States in 1963 in order to serve the detailed information needs of the Social Security Administration. 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 results from the CPS from 1971 to the present in an income time-series produced by the Social Security Administration.

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### 1968 Survey of Demographic and Economic Characteristics of the Aged

The 1968 Survey of Demographic and Economic Characteristics of the Aged was conducted by the Social Security Administration 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 (OASDHI) 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 persons

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 the Social Security Administration.

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## Uniform Crime Reports

The Federal Bureau of Investigation's (FBI) Uniform Crime Reports (UCR) Program, which began in 1929, collects information on the following crimes reported to law enforcement authorities: homicide, forcible rape, robbery, aggravated assault, burglary, larceny-theft, motor vehicle theft, and arson. Arrests are reported for 21 additional crime categories. There may be slight differences between these estimates and those published annually by the FBI, since the data files are updated on a periodic basis as additional data become available.

The UCR data are compiled from monthly law enforcement reports or individual crime incident records transmitted directly to the FBI or to centralized state agencies that then report to the FBI. In 1997, law enforcement agencies active in the UCR Program represented approximately 254 million United States inhabitants—95 percent of the total population. The UCR Program provides crime counts for the nation as a whole, as well as for regions, states, counties, cities, and towns. This permits studies among neighboring jurisdictions and among those with similar populations and other common characteristics.

UCR findings for each calendar year are published in a preliminary release in the spring, followed by a detailed annual report, *Crime in the United States*, issued the following calendar year. In addition to crime counts and trends, this report includes data on crimes cleared, persons arrested (age, sex, and race), law enforcement personnel (including the number of sworn officers killed or assaulted), and the characteristics of homicides (including age, sex, and race of victims and offenders, victim-offender relationships, weapons used, and circumstances surrounding the homicides). Other special reports are also available from the UCR Program.

For more information, contact:

Uniform Crime Reports  
Programs Support Section  
Criminal Justice Information Services Division  
Federal Bureau of Investigation  
1000 Custer Hollow Road  
Clarksburg, West Virginia 26306  
Phone: (304) 625-4995  
Internet: [www.fbi.gov/ucr.htm](http://www.fbi.gov/ucr.htm)

# Appendix C: Glossary

**Activities of daily living (ADLs):** Activities of daily living (ADLs) are basic activities that support survival, including eating, bathing, and toileting. In the National Long Term Care Survey, ADLs (designed to measure functional ability) include: eating, getting in and out of bed, getting around inside, dressing, bathing, and toileting. A person is considered disabled on an ADL activity if he or she is unable to perform the activity, uses active help, uses equipment, or requires standby help. See related *Instrumental Activities of Daily Living (IADLs)*.

**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.

**Assisted-living facility:** Assisted living is a model of residential care that blends many of the characteristics of the nursing home and community-based long term care. Assisted-living facilities offer older persons a choice in terms of living accommodations and service arrangements.

**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 reported conditions. Since 1979, the International Classification of Diseases, Ninth Revision (ICD-9) has been used for coding cause of death. 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. For further information, see Technical Appendix in National Center for Health Statistics. (1994). *Vital Statistics of the United States, 1990*, Volume II, Mortality, Part A. DHHS Pub. No. (PHS) 95-1101, Public Health Service, Washington, DC: U.S. Government Printing Office.

**Cause-of-death ranking:** Cause-of-death ranking for adults is based on the “List of 72 Selected Causes of Death, HIV Infection, and Alzheimer’s Disease.” The List of 72 Selected Causes of Death was adapted from one of the special lists for mortality tabulations recommended by the World Health Organization for use with the Ninth Revision of the International Classification of Diseases. Two group titles—“Major cardiovascular diseases” and “Symptoms, signs, and ill-defined conditions”—are not ranked based on the list of 72 selected causes. In addition, category titles that begin with the words “other” and “all other” are not ranked. The remaining category titles are ranked according to number of deaths to determine the leading causes of death. When one of the titles that represent a subtotal is ranked (for example, unintentional injuries), its component parts are not ranked (in this case, motor vehicle crashes and all other unintentional injuries).

**Centenarians:** Persons age 100 or older.

**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 to 1989 and 1991, rates are based on national estimates of the resident population, as of July 1, rounded to the nearest thousand. Starting in 1992, rates are based on unrounded national population estimates. Rates for the Hispanic and non-Hispanic white populations in each year are based on unrounded state population estimates for states in the Hispanic reporting area. Death rates are expressed as the number of deaths per 100,000 persons. 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).

**Disability:** Disability refers to the temporary or long-term reduction of a person's capacity to function. The concept of disability encompasses many different dimensions of health and functioning, and the complex interactions with one's environment. The International Classification of Functioning and Disability (ICIDH-2) classifies functioning at the levels of body or body part, whole person, and whole person in social context. Accordingly, disablements are losses or abnormalities of bodily function and structure (impairments), limitations of activities (disabilities), or restrictions in participation (formerly called handicaps). See [www.who.int/icidh](http://www.who.int/icidh) for more information on the World Health Organization's definition of disability.

**Domiciliary care home:** Domiciliary care homes primarily provide supervisory care but also provide one or two personal services.

**Earnings:** Earnings is money income reported in the Current Population Survey from wages or salaries, net income from nonfarm self-employment, and net income from farm self-employment.

**Educational attainment:** Educational attainment refers to the highest level of school completed or highest degree received. For persons who attended school beyond high school, highest degree is recorded, rather than years in college.

**Expenditures:** See *Health care expenditures* and *Housing expenditures*.

**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.

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

**Health care expenditures:** As defined in the Consumer Expenditure Survey, health care expenditures include out-of-pocket expenditures for health insurance, medical services, prescription drugs, and medical supplies. As defined in the Medicare Current Beneficiary Survey, health care expenditures include all expenditures for inpatient hospital, medical, nursing home, outpatient, dental, prescription drugs, home health care, and hospice services, including both out-of-pocket expenditures and expenditures covered by insurance.

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

**Healthy Eating Index:** The Healthy Eating Index (HEI) is a summary measure of dietary quality. The HEI consists of 10 components, each representing different aspects of a healthful diet based on the U.S. Department of Agriculture's Food Guide Pyramid and the Dietary Guidelines for Americans. Components 1 to 5 measure the degree to which a person's diet conforms to the Pyramid serving recommendations for the five major food groups: grains, vegetables, fruits, milk, and meat/meat alternatives. Components 6 and 7 measure fat and saturated fat consumption. Components 8 and 9 measure cholesterol and sodium intake, and component 10 measures the degree of variety in a person's diet. Scores for each component are given equal weight and added to calculate an overall HEI score with a maximum value of 100. High component scores indicate intakes close to recommended ranges or amounts; low component scores indicate less compliance with recommended ranges or amounts. An HEI score above 80 implies a good diet, an HEI score between 51 and 80 implies a diet that needs improvement, and an HEI score below 51 implies a poor diet.

**Hispanic origin:** Hispanic origin includes persons of Mexican, Puerto Rican, Cuban, Central and South American, and other or unknown Spanish origins. Persons of Hispanic origin may be of any race. See related *Race*.

**Home care:** Paid or unpaid assistance provided to a person with a chronic disability or illness, living in the community.

**Home health care:** Home health care is care provided to individuals and families in their place 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 and enrollment data, home health care refers to home visits by professionals including nurses, doctors, social workers, therapists, and home health aides.

**Household head:** See *Head of household*.

**Housing expenditures:** As defined in the Consumer Expenditure Survey, housing expenditures include: payments for mortgage principal, interest, and charges; property taxes; maintenance, repairs, insurance, and other expenses; rent; rent as pay (reduced or free rent for a unit as a form of pay); 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 related *Prevalence*.

**Income:** As defined 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 workmen's compensation; (10) private pensions or government employee pensions; (11) alimony or child support, regular contributions from persons not living in the household, and other periodic income. Certain money receipts such as capital gains are not included.

**Income fifths:** A population can be divided into groups with equal numbers of persons 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 services:** As defined in the Medicare Current Beneficiary Survey, inpatient hospital services refers to services provided in acute-care hospitals.

**Institutional population:** See *Population*.

**Instrumental activities of daily living (IADLs):** Instrumental activities of daily living (IADLs) are indicators of functional well-being that measure the ability to perform more complex tasks. In the National Long Term Care Survey, IADLs include: heavy housework; light housework; laundry; preparing meals; shopping for groceries; getting around outside; traveling; managing money; and using a telephone. A person is considered disabled on an IADL activity (with the exception of "getting around outside") if he or she does not do the activity because of a disability or health problem. A person is considered disabled on the "getting around outside" activity if he or she requires active help, uses equipment, or cannot get around outside at all because of a health or disability problem. See *Activities of daily living (ADLs)*.

**Labor force participation rate:** The proportion of a particular population group that is in the labor force—that is, either working (employed) or actively looking for work (unemployed).

**Life expectancy:** Life expectancy is the average number of years of life remaining to a person at a particular age and is based on a given set of age-specific death rates, generally the mortality conditions existing in the period mentioned. Life expectancy may be determined by race, sex, or other characteristics using age-specific death rates for the population with that characteristic.

**Marital status:** The marital status classification in the Current Population Survey identifies four major categories: single (never married), married, widowed, and divorced. The "married" category is divided into married, spouse present; married, spouse absent; and separated. In the Economics section, "married" includes only the married spouse present.

**Median:** A measure of central tendency. The simplest division of a set of measurements is into two parts—the lower and the upper half. The point on the scale that divides the group in this way is called the "median."

**Medicaid:** This nationwide health care 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 provides health care services for certain low-income persons. Medicaid does not provide health services to all low-income people in every state. The program was authorized in 1965 by Title XIX of the Social Security Act.

**Medical/outpatient services:** Medical/outpatient services refer to services provided by physicians, laboratories, clinics, emergency rooms, hospital outpatient departments, and providers of medical equipment and supplies.

**Medicare:** This is a nationwide health insurance program providing health insurance to people age 65 or older, people entitled to Social Security disability payments for 2 years or more, and people with end-stage renal disease, regardless of income. The program was enacted July 30, 1965, as Title XVIII, Health Insurance for the Aged of the Social Security Act, and became effective on July 1, 1966. It consists of two separate but coordinated programs, hospital insurance (Part A) and supplementary medical insurance (Part B). Medicare generally does not cover nursing homes or prescription drugs.

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

**Net worth:** As defined in the Panel Study of Income Dynamics, net worth is the value of real estate, stocks, bonds, and other assets minus outstanding debts.

**Nursing home:** As defined in the National Nursing Home Survey, a nursing home is an establishment with three or more beds that provides nursing or personal care services to the older population, infirm, or chronically ill.

**Nursing home care:** As defined in the Medicare Current Beneficiary Survey, nursing home care refers to long-term, personal care provided in long-term care facilities.

**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, IRA's, 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 visits and consultations:** As defined in Medicare claims and enrollment data, physician visits and consultations include visits and consultations with primary care physicians, specialists, and chiropractors in their offices, hospitals (inpatient and outpatient), emergency rooms, patient homes, and nursing homes.

**Population:** Data on populations in the United States are often collected and published according to several different definitions. Various statistical systems then use the appropriate population for calculating rates.

**Resident population:** The resident population of the United States includes persons resident in the 50 States and the District of Columbia. It excludes residents of the Commonwealth of Puerto Rico, and residents of the outlying areas under United States sovereignty or jurisdiction (principally American Samoa, Guam, Virgin Islands of the United States, and the Commonwealth of the Northern Mariana Islands). The definition of residence conforms to the criterion used in the 1990 census, which defines a resident of a specified area as a person "...usually resident" in that area. The resident population excludes the United States Armed Forces overseas, as well as civilian United States citizens whose usual place of residence is outside the United States.

**Civilian population:** The civilian population is the United States resident population not in the active duty Armed Forces.

**Civilian noninstitutional population:** The civilian noninstitutional population is the civilian population not residing in institutions. Institutions include correctional institutions, detention homes, and training schools for juvenile delinquents; homes for the older population and dependent (for example, nursing homes and convalescent homes); homes for dependent and neglected children; homes and schools for the mentally or physically handicapped; homes for unwed mothers; psychiatric, tuberculosis, and chronic disease hospitals; and residential treatment centers.

**Resident noninstitutional population:** The resident noninstitutional population is the resident population not residing in institutions. Institutions include correctional institutions, detention homes, and training schools for juvenile delinquents; homes for the older population and dependent (for example, nursing homes and convalescent homes); homes for dependent and neglected children; homes and

schools for the mentally or physically handicapped; homes for unwed mothers; psychiatric, tuberculosis, and chronic disease hospitals; and residential treatment centers.

**Institutional population:** The institutional population is the population residing in correctional institutions, detention homes, and training schools for juvenile delinquents; homes for the older population and dependent (for example, nursing homes and convalescent homes); homes for dependent and neglected children; homes and schools for the mentally or physically handicapped; homes for unwed mothers; psychiatric, tuberculosis, and chronic disease hospitals; and residential treatment centers.

**Poverty level:** Poverty statistics are based on definitions originally developed by the Social Security Administration. These include a set of money income thresholds that vary by family size and composition. Poverty thresholds are based on money income and do not include non-cash benefits, such as food stamps. Families or individuals with income below their appropriate thresholds are classified as below the poverty level. These thresholds are updated annually by the U.S. Census Bureau to reflect changes in the Consumer Price Index for all urban consumers (CPI-U). For example, the average poverty threshold for a family of four was \$13,359 in 1990, \$16,036 in 1996, and \$16,660 in 1998. For more information, see: Money Income of Households, Families, and Persons in the United States, 1996. U.S. Census Bureau. *Current Population Reports*. P-60. Washington, DC: U.S. Government Printing Office.

**Prescription drugs:** As defined in the Medicare Current Beneficiary Survey, prescription drugs are all prescription medications 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 persons, or persons with some other attribute present during a particular interval of time. It is often expressed as a rate (for example, the prevalence of diabetes per 1,000 persons during a year). See related *Incidence*.

**Public assistance:** Public assistance is money income reported in the Current Population Survey from Supplemental Security Income (payments made to low-income persons who are age 65 or older, blind, or disabled), and public assistance or welfare payments, such as Temporary Assistance for Needy Families and General Assistance.

**Quintiles:** See *Income fifths*.

**Race:** Data used in this chartbook generally classified individuals into the following racial groups: American Indian and Alaska Native, Asian and Pacific Islander, black, and white. Depending on the data source, the classification by race may be based on self-classification or on observation by an interviewer or other persons filling out the questionnaire. See related *Hispanic origin*.

**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*.

**Self-rated health status:** Health status was measured in the National Health Interview Survey by asking the respondent, "Would you say \_\_\_\_\_'s health is excellent, very good, good, fair, or poor?"

**Skilled nursing facility:** Skilled nursing facilities provide short-term skilled nursing care on an inpatient basis, following hospitalization. These facilities provide the most intensive care available outside of a hospital.

**Social Security benefits:** Social Security benefits include money income reported in the Current Population Survey from Social Security old-age, disability, and survivors' benefits.

**Standard population:** A population in which the age and sex composition is known precisely, as a result of a census. A standard population is used as a comparison group in the procedure for standardizing mortality rates.