

Health Status

INDICATOR 14. Life Expectancy

INDICATOR 15. Mortality

INDICATOR 16. Chronic Health Conditions

INDICATOR 17. Sensory Impairments and Oral Health

INDICATOR 18. Respondent-Assessed Health Status

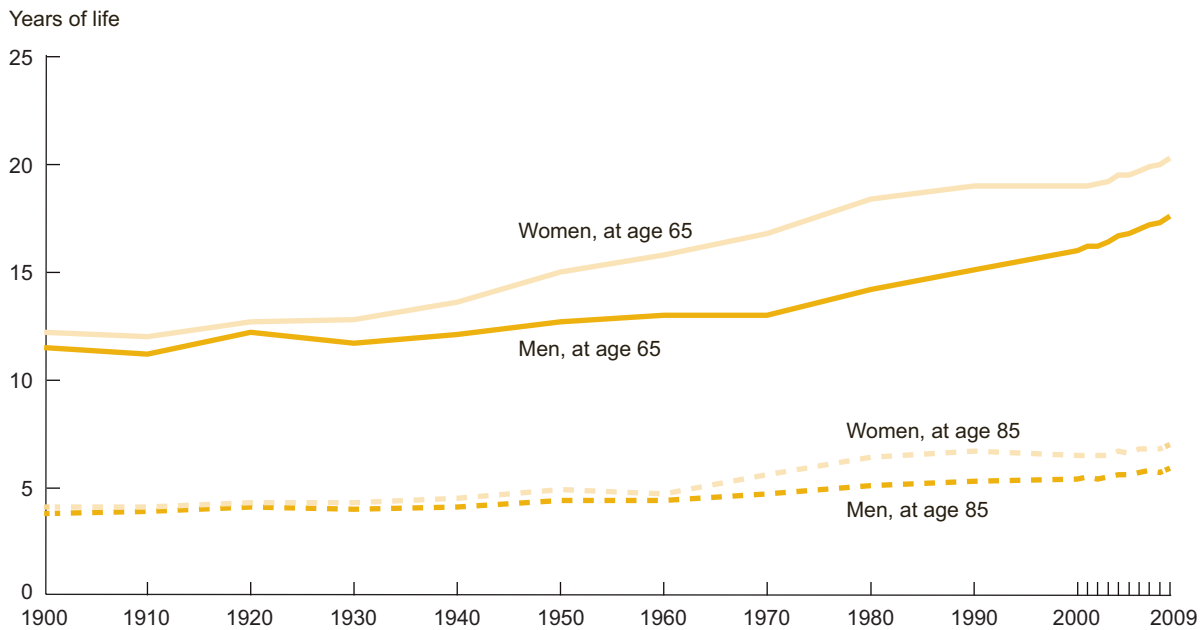
INDICATOR 19. Depressive Symptoms

INDICATOR 20. Functional Limitations

INDICATOR 14 Life Expectancy

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

Life expectancy at ages 65 and 85, by sex, selected years 1900–2009



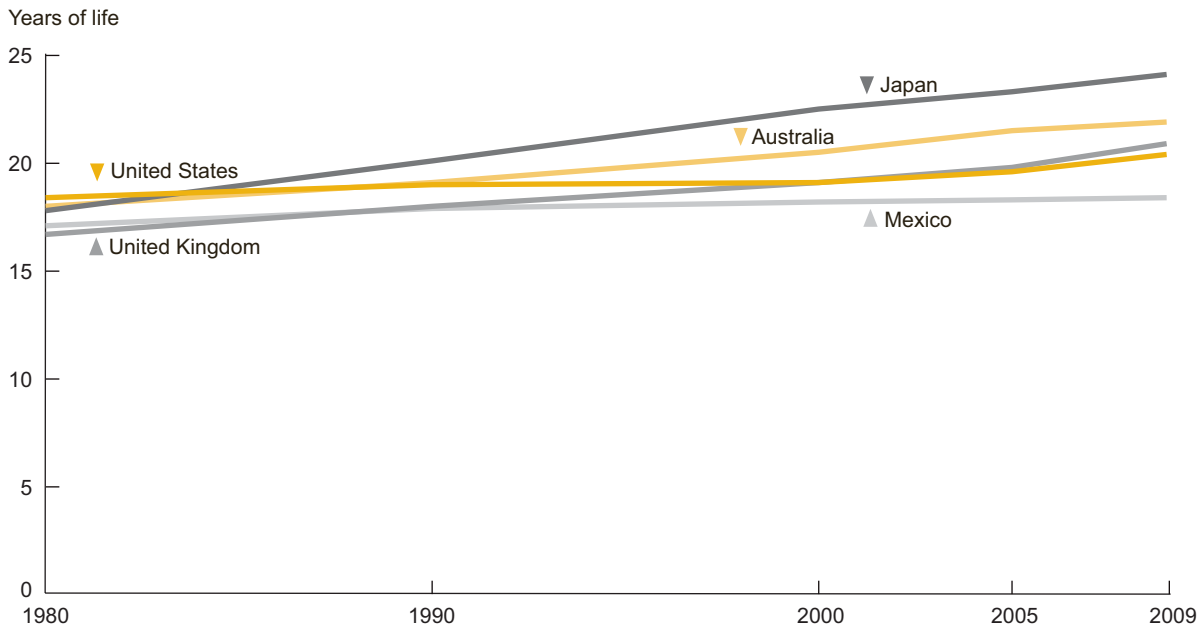
NOTE: The life expectancies (LEs) for decennial years 1910 to 1990 are based on decennial census data and deaths for a 3-year period around the census year. The LEs for decennial year 1900 are based on deaths from 1900 to 1902. LEs for years prior to 1930 are based on the death registration area only.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

Reference population: These data refer to the resident population.

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

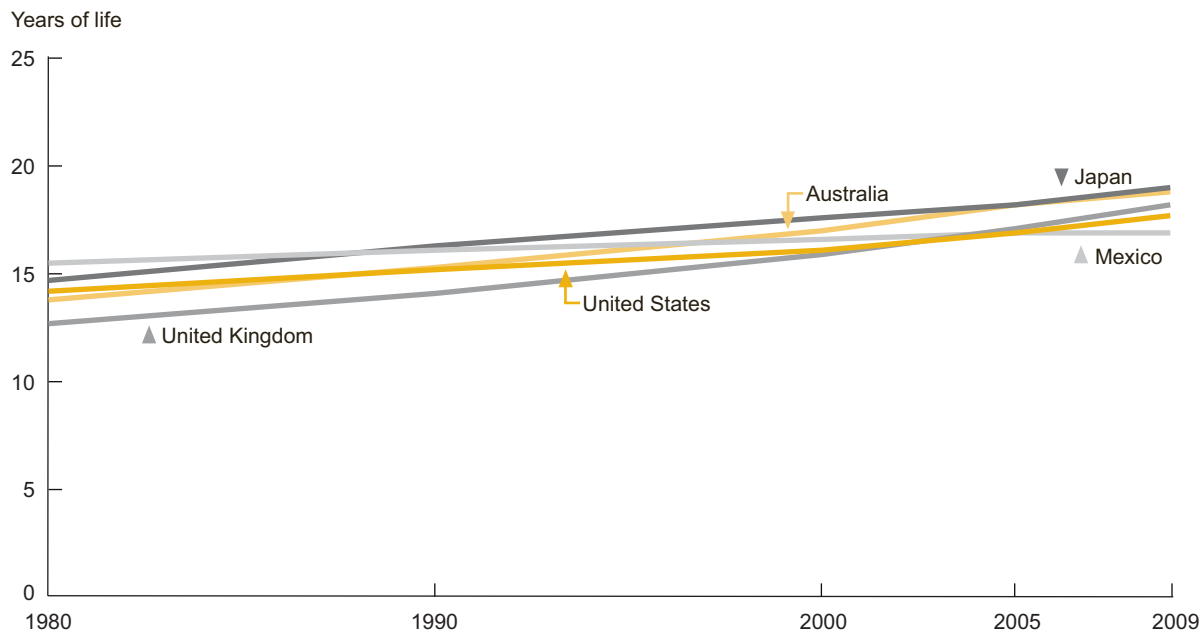
- Americans are living longer than ever before. Life expectancies at both age 65 and age 85 have increased. Under current mortality conditions, people who survive to age 65 can expect to live an average of 19.2 more years, nearly 5 years longer than people age 65 in 1960. In 2009, the life expectancy of people who survive to age 85 was 7 years for women and 5.9 years for men.
- Life expectancy varies by race, but the difference decreases with age. In 2009, life expectancy at birth was 4.3 years higher for White people than for Black people.
- At age 65, White people can expect to live an average of 1.3 years longer than Black people. Among those who survive to age 85, however, the life expectancy among Black people is slightly higher (6.8 years) than White people (6.6 years).
- Life expectancy at age 65 in the United States is lower than that of many other industrialized nations. In 2009, women age 65 in Japan could expect to live on average 3.7 years longer than women in the United States. Among men, the difference was 1.3 years.

Average life expectancy for women at age 65, by selected countries or areas, selected years 1980–2009



SOURCE: Organisation for Economic Co-operation and Development (OECD) Health Data 2011, OECD. StatExtracts, available from: <http://www.oecd.org>.

Average life expectancy for men at age 65, by selected countries or areas, selected years 1980–2009



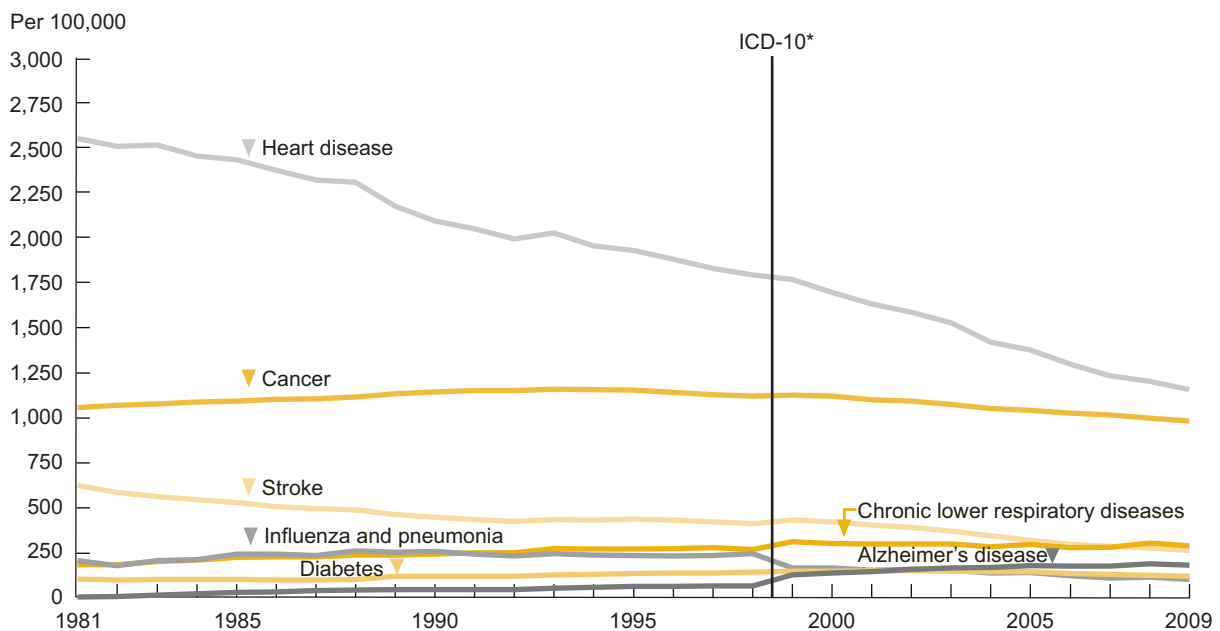
SOURCE: Organisation for Economic Co-operation and Development (OECD) Health Data 2011, OECD. StatExtracts, available from: <http://www.oecd.org>.

Data for this indicator's charts and bullets can be found in Tables 14a through 14c on pages 113–114.

INDICATOR 15 Mortality

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

Death rates for selected leading causes of death among people age 65 and over, 1981–2009



* Change calculated from 1999 when 10th revision of the International Classification of Diseases (ICD-10) was implemented.

NOTE: Death rates for 1981–1998 are based on the 9th revision of the International Classification of Diseases (ICD-9). Starting in 1999, death rates are based on ICD-10. For the period 1981–1998, causes were coded using ICD-9 codes that are nearly comparable with the 113 cause list for the ICD-10 and may differ from previously published estimates. Rates are age-adjusted using the 2000 standard population.

Reference population: These data refer to the resident population.

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

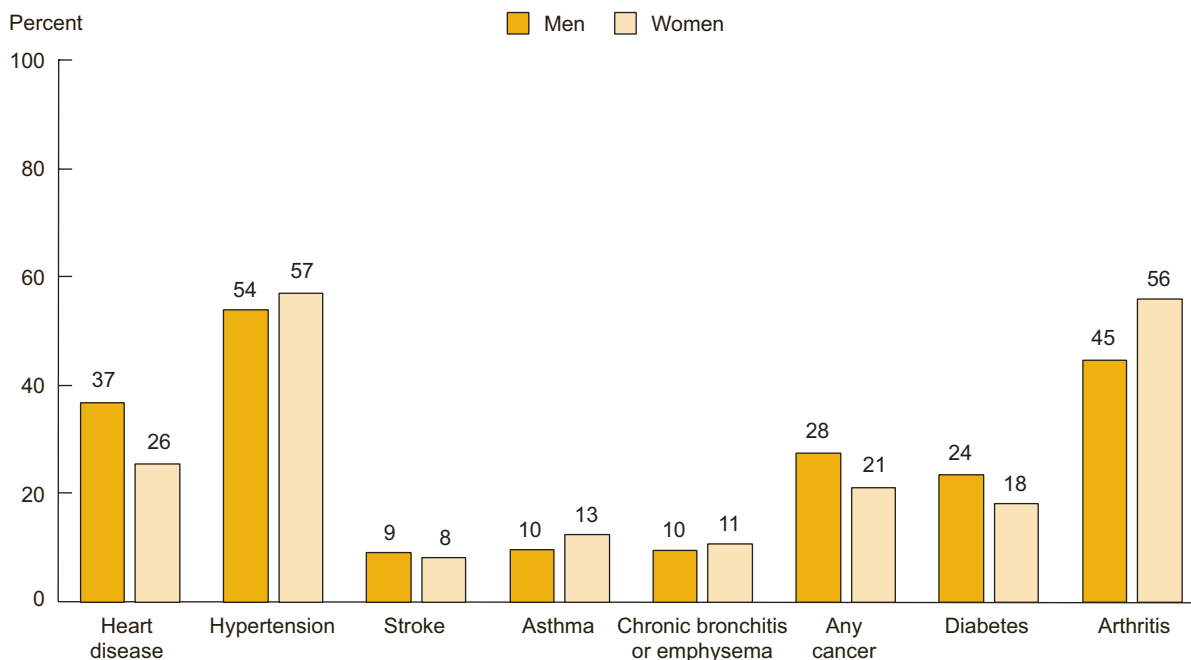
- In 2009, the leading cause of death among people age 65 and over was heart disease (1,156 deaths per 100,000 people), followed by cancer (982 per 100,000), chronic lower respiratory diseases (291 per 100,000), stroke (264 per 100,000), Alzheimer's disease (184 per 100,000), diabetes (121 per 100,000), and influenza and pneumonia (104 per 100,000).
- Between 1981 and 2009, age-adjusted death rates for all causes of death among people age 65 and over declined by 25 percent. Death rates for heart disease and stroke declined by more than 50 percent. Death rates for chronic lower respiratory diseases increased by 57 percent. Age-adjusted death rates for diabetes were higher in 2009 than in 1981 but have declined since 2001.
- Heart disease and cancer were the top two leading causes of death in 2009 among all people age 65 and over, irrespective of sex, race, or Hispanic origin. Diabetes was the 6th leading cause of death among non-Hispanic Whites, but the 4th leading cause among non-Hispanic Blacks and Hispanics.⁹
- Other causes of death varied among older people by sex and race and Hispanic origin. For example, men had higher suicide rates than women at all ages, with the largest difference occurring at age 85 and over (43 deaths per 100,000 people for men, compared with 3 per 100,000 for women). Non-Hispanic White men age 85 and over had the highest rate of suicide overall in 2009, at 47 deaths per 100,000.⁹

Data for this indicator's charts and bullets can be found in Table 15 on page 115.

INDICATOR 16 Chronic Health Conditions

Chronic diseases are long-term illnesses that are rarely cured. Chronic diseases such as heart disease, stroke, cancer, and diabetes are among the most common and costly health conditions. Chronic health conditions negatively affect quality of life, contributing to declines in functioning and the inability to remain in the community.¹⁰ Many chronic conditions can be prevented or modified with behavioral interventions. Six of the seven leading causes of death among older Americans are chronic diseases (see “Indicator 15: Mortality”).

Percentage of people age 65 and over who reported having selected chronic health conditions, by sex, 2009–2010



NOTE: Data are based on a 2-year average from 2009–2010.

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

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

- The prevalence of certain chronic health conditions differed by sex. Women reported higher levels of asthma, arthritis and hypertension than men. Men reported higher levels of heart disease, cancer, and diabetes.
- There were differences by race and ethnicity in the prevalence of certain chronic health conditions. In 2009–2010, among people age 65 and over, non-Hispanic Blacks reported higher levels of hypertension and diabetes than non-Hispanic Whites (69 percent compared with 54 percent for hypertension, and 32 percent compared with 18 percent

for diabetes). Hispanics also reported higher levels of diabetes (33 percent) than non-Hispanic Whites, but lower levels of arthritis (44 percent compared with 53 percent).

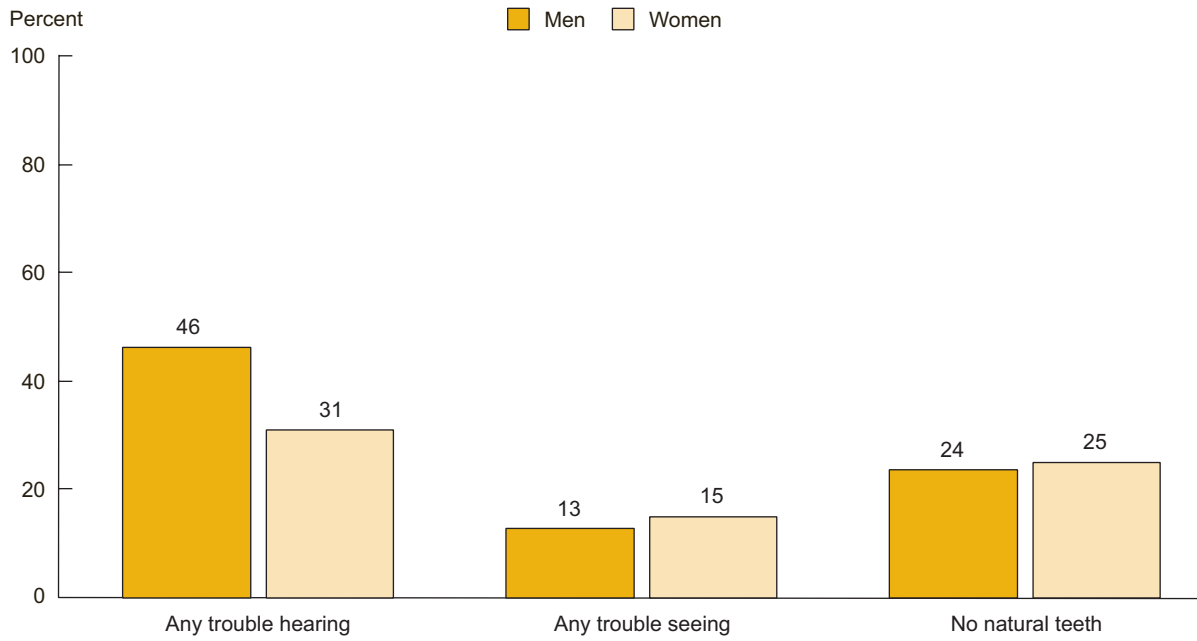
- The prevalence of diabetes increased for all racial and ethnic groups and for men and women. Overall, the prevalence of diabetes reported by persons age 65 and over increased from 13 percent in 1997–1998 to nearly 21 percent in 2009–2010.

Data for this indicator's charts and bullets can be found in Tables 16a and 16b on page 116.

INDICATOR 17 Sensory Impairments and Oral Health

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

Percentage of people age 65 and over who reported having any trouble hearing, trouble seeing, or no natural teeth, by sex, 2010



NOTE: Respondents were asked "WITHOUT the use of hearing aids or other listening devices, is your hearing excellent, good, a little trouble hearing, moderate trouble, a lot of trouble, or are you deaf?" For the purposes of this indicator, the category "Any trouble hearing" includes: "a little trouble hearing, moderate trouble, a lot of trouble, and deaf." Regarding their vision, respondents were asked "Do you have any trouble seeing, even when wearing glasses or contact lenses?" The category "Any trouble seeing" includes those who responded yes or in a subsequent question report themselves as blind. Lastly, respondents were asked in one question, "Have you lost all of your upper and lower natural (permanent) teeth?"

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

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

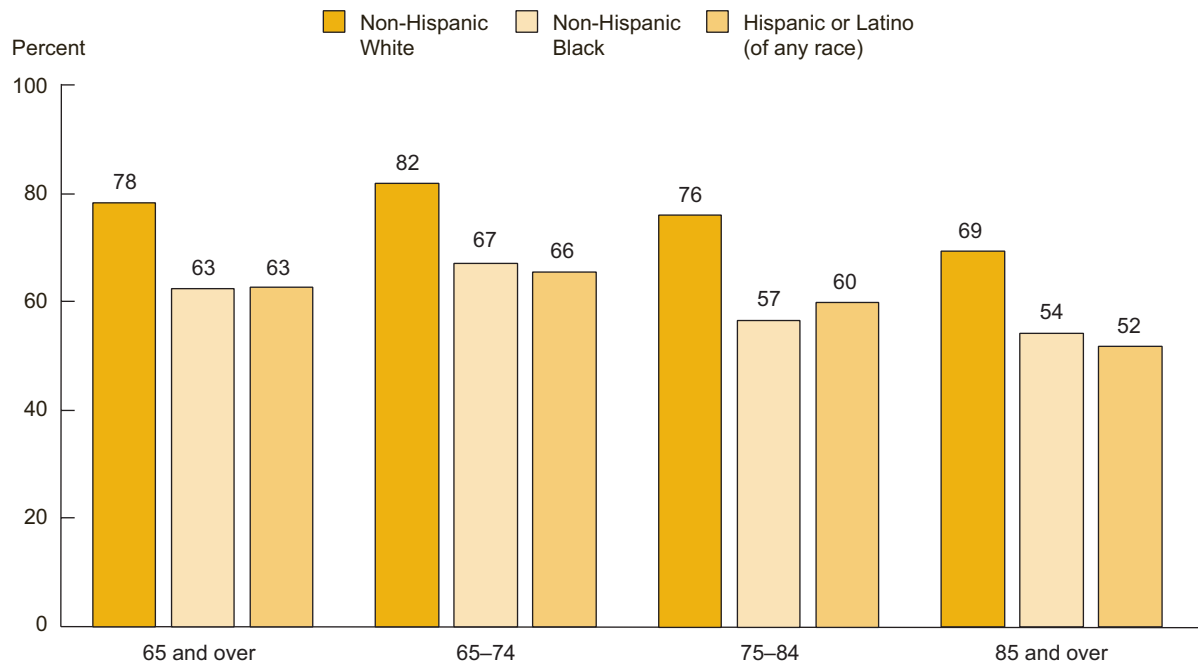
- In 2010, 46 percent of older men and 31 percent of older women reported trouble hearing. The percentage of older Americans with trouble hearing was higher for people age 85 and over (59 percent) than for people age 65–74 (31 percent). Eleven percent of all older women and 18 percent of all older men reported having ever worn a hearing aid.
- The prevalence of edentulism, having no natural teeth, was higher for people age 85 and over (33 percent) than for people age 65–74 (19 percent). Socioeconomic differences were large. Forty-two percent of older people with family income below the poverty line reported no natural teeth compared with 22 percent of people above the poverty threshold.
- Vision trouble affected 14 percent of the older population, 13 percent of men and 15 percent of women. Among people age 85 and over, 23 percent reported trouble seeing.

Data for this indicator's charts and bullets can be found in Tables 17a and 17b on page 117.

INDICATOR 18 Respondent-Assessed Health Status

Asking people to rate their health as excellent, very good, good, fair, or poor provides a common indicator of health easily measured in surveys. It represents physical, emotional, and social aspects of health and well-being. Respondent-assessed health ratings of poor correlate with higher risks of mortality.¹¹

Percentage of people age 65 and over with respondent-assessed good to excellent health status by age group and race and Hispanic origin, 2008–2010



NOTE: Data are based on a 3-year average from 2008–2010. See data sources for the definition of race and Hispanic origin in the National Health Interview Survey.

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

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

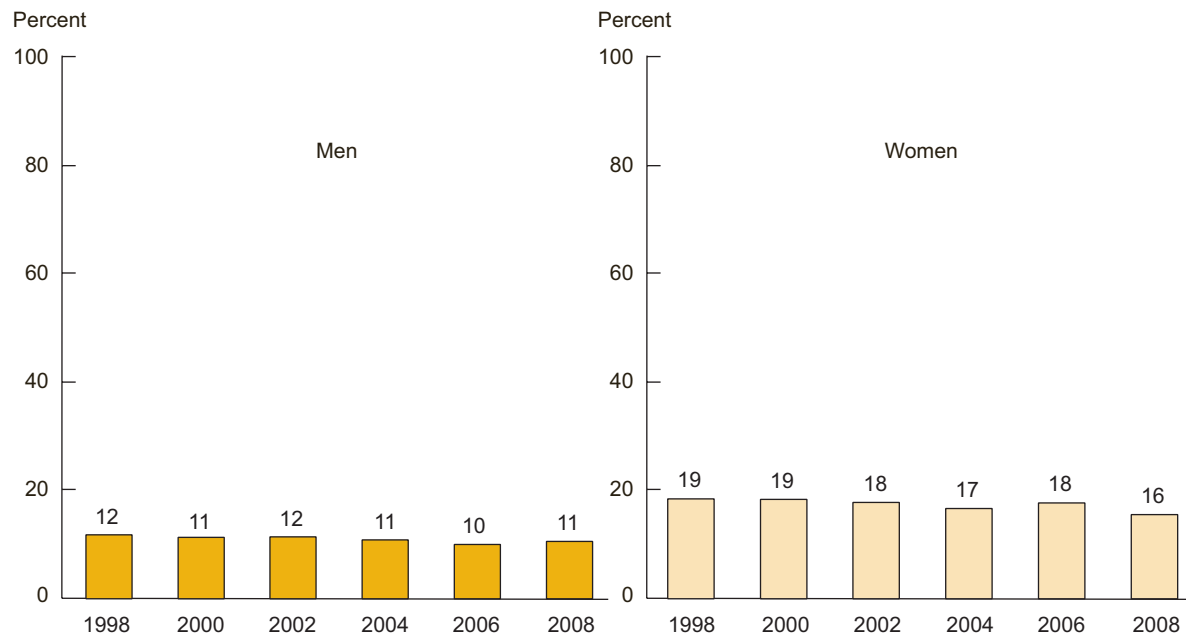
- During the period of 2008–2010, 76 percent of people age 65 and over rated their health as good, very good, or excellent. Older men and women reported similar levels of health.
- The proportion of people reporting good to excellent health was lower among the oldest age groups. Seventy-nine percent of those age 65–74 reported good or better health. At age 85 and over, 67 percent of people reported good or better health. This pattern was also evident within racial and ethnic groups.
- Regardless of age, older non-Hispanic White men and women were more likely to report good to excellent health than their non-Hispanic Black and Hispanic counterparts. Non-Hispanic Blacks and Hispanics were similar to one another in their positive health evaluations.

Data for this indicator's charts and bullets can be found in Table 18 on page 118.

INDICATOR 19 Depressive Symptoms

Depressive symptoms are an important indicator of general well-being and mental health among older adults. People who report many depressive symptoms often experience higher rates of physical illness, greater functional disability, and higher health care resource utilization.¹²

Percentage of people age 65 and over with clinically relevant depressive symptoms, by sex, selected years 1998–2008



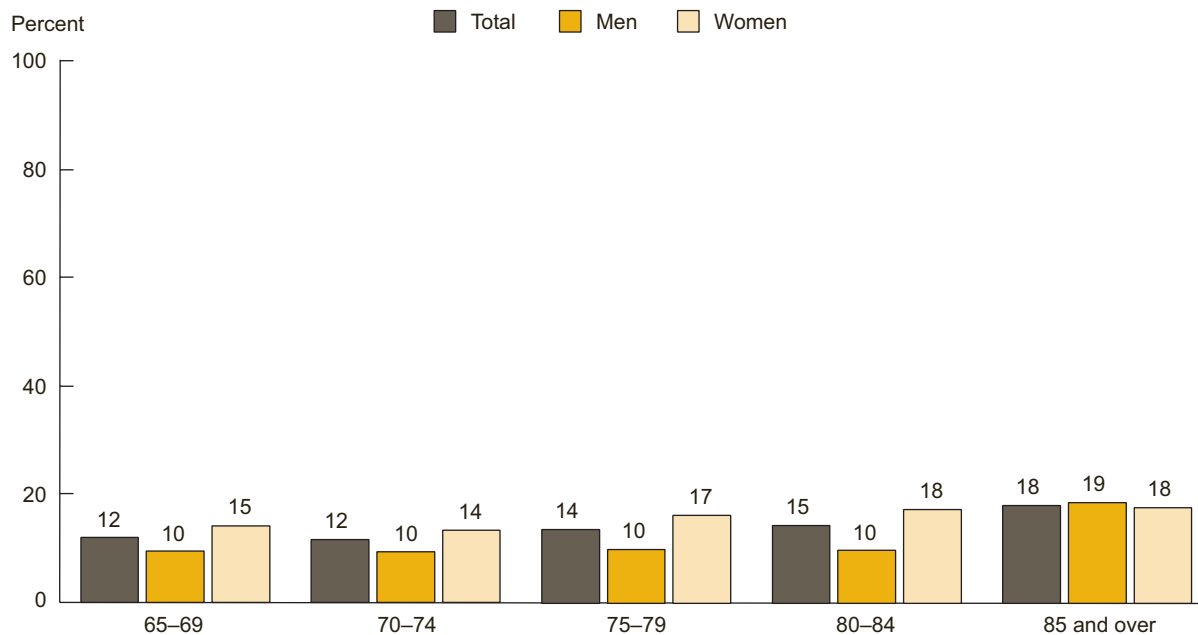
NOTE: The definition of “clinically relevant depressive symptoms” is four or more symptoms out of a list of eight depressive symptoms from an abbreviated version of the Center of Epidemiological Studies Depression Scale (CES-D) adapted by the Health and Retirement Study (HRS). The CES-D scale is a measure of depressive symptoms and is not to be used as a diagnosis of clinical depression. A detailed explanation concerning the “four or more symptoms” cut-off can be found in the following documentation: <http://hrsonline.isr.umich.edu/docs/userg/dr-005.pdf>. Proportions are based on weighted data using the preliminary respondent weight from HRS 2008.

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

SOURCE: Health and Retirement Study.

- Older women were more likely to report clinically relevant depressive symptoms than were older men. In 2008, 16 percent of women age 65 and over reported depressive symptoms compared with 11 percent of men. There was no significant change in this sex difference between 1998 and 2008.
- The percentage of people reporting clinically relevant symptoms remained relatively stable over the past few years. Between 1998 and 2008, the percentage of men who reported depressive symptoms ranged between 10 and 12 percent. For women, the percentage reporting these symptoms ranged between 16 and 19 percent.

Percentage of people age 65 and over with clinically relevant depressive symptoms, by age group and sex, 2008



NOTE: The definition of “clinically relevant depressive symptoms” is four or more symptoms out of a list of eight depressive symptoms from an abbreviated version of the Center of Epidemiological Studies Depression Scale (CES-D) adapted by the Health and Retirement Study (HRS). The CES-D scale is a measure of depressive symptoms and is not to be used as a diagnosis of clinical depression. A detailed explanation concerning the “four or more symptoms” cut-off can be found in the following documentation: <http://hrsonline.isr.umich.edu/docs/userg/dr-005.pdf>. Proportions are based on weighted data using the preliminary respondent weight from HRS 2008.

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

SOURCE: Health and Retirement Study.

- The prevalence of depressive symptoms was related to age. In 2008, the proportion of people age 65 and over with clinically relevant symptoms was higher for people age 85 and over (18 percent) than for people in any of the younger groups (12 to 15 percent).
- In 2008, the percentage of men 85 and over (19 percent) reporting clinically relevant depressive symptoms was almost twice that of men in any of the younger age groups (about

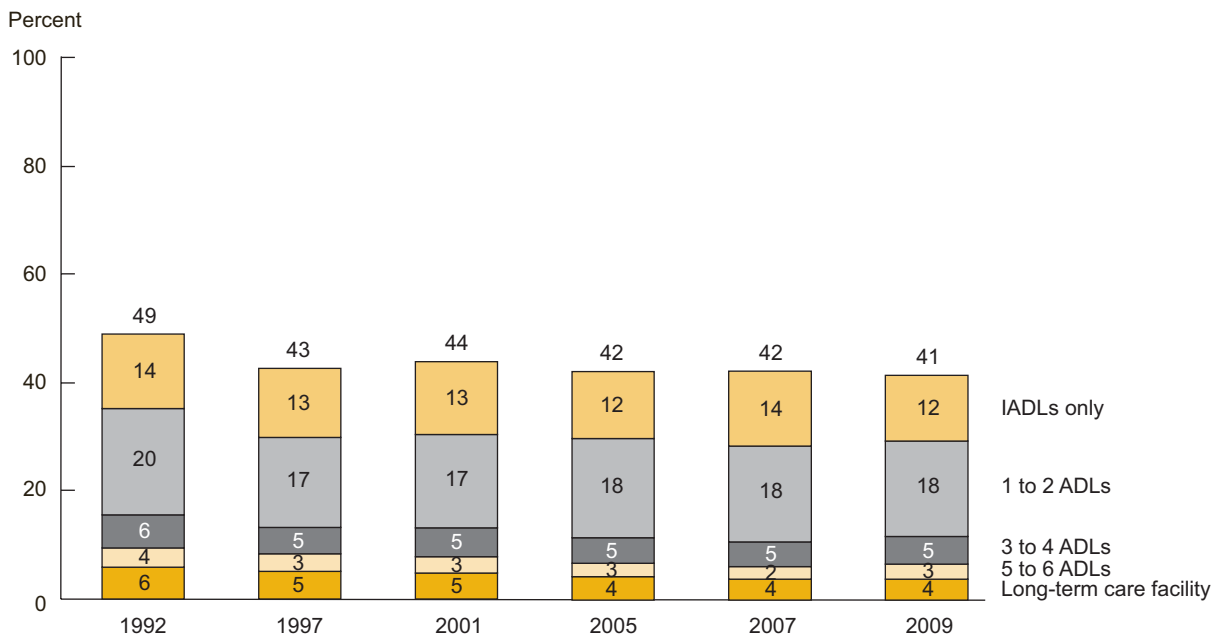
10 percent). Prevalence of depression among women age 65 and older did not follow this same pattern; the percentage of women reporting clinically relevant symptoms ranged between 14 percent and 18 percent, with little change across the age groups.

Data for this indicator’s charts and bullets can be found in Tables 19a and 19b on page 119.

INDICATOR 20 Functional Limitations

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

Percentage of Medicare enrollees age 65 and over who have limitations in activities of daily living (ADLs) or instrumental activities of daily living (IADLs), or who are in a long-term care facility, selected years 1992–2009



NOTE: A residence is considered a long-term care facility if it is certified by Medicare or Medicaid; has three or more beds, is licensed as a nursing home or other long-term care facility, and provides at least one personal care service; or provides 24-hour, 7-day-a-week supervision by a caregiver. ADL limitations refer to difficulty performing (or inability to perform for a health reason) one or more of the following tasks: bathing, dressing, eating, getting in/out of chairs, walking, or using the toilet. IADL limitations refer to difficulty performing (or inability to perform for a health reason) one or more of the following tasks: using the telephone, light housework, heavy housework, meal preparation, shopping, or managing money. Percents are age-adjusted using the 2000 standard population. Estimates may not sum to the totals because of rounding.

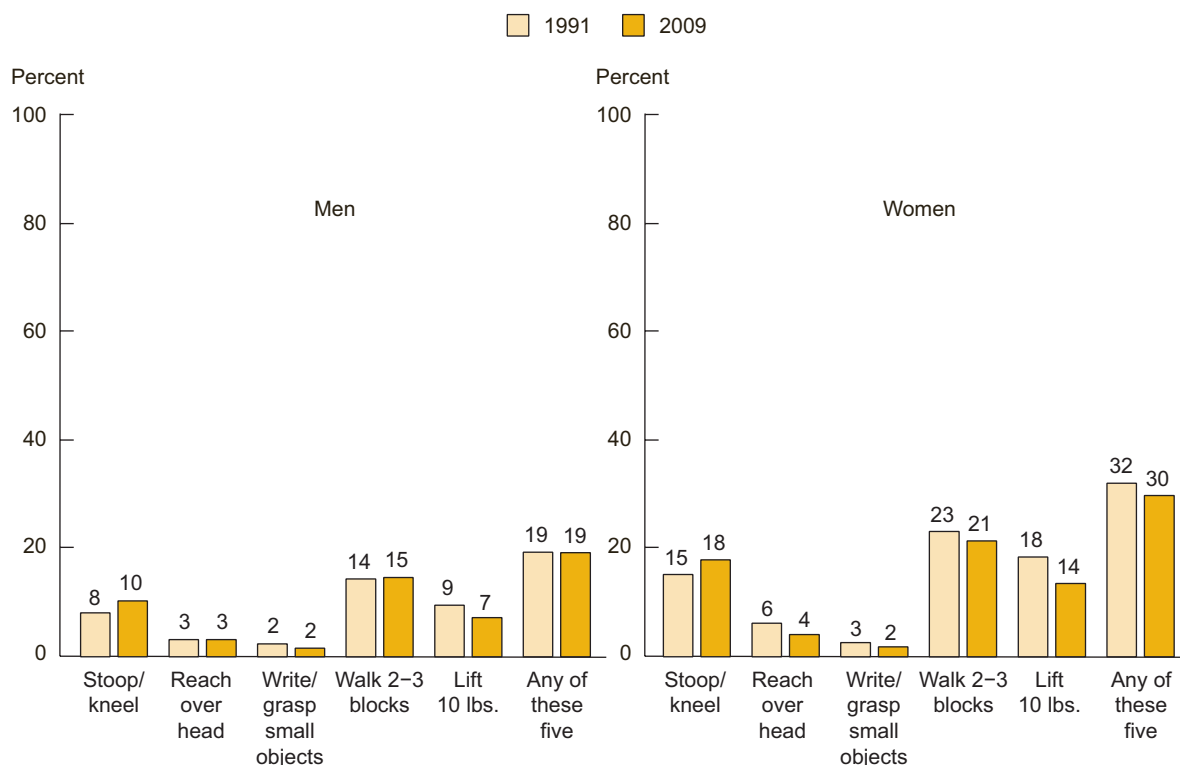
Reference population: These data refer to Medicare enrollees.

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

- In 2009, about 41 percent of people age 65 and over enrolled in Medicare reported a functional limitation. Twelve percent had difficulty performing one or more instrumental activities of daily living (IADLs) but had no activities of daily living (ADL) limitations. Approximately 25 percent had difficulty with at least one ADL and 4 percent were in a facility.
- The age-adjusted proportion of people age 65 and over with a functional limitation declined from 49 percent in 1992 to 41 percent in 2009. There was a decrease in the percent with limitations from 1992 to 1997.
- From 1997 to 2009, the overall levels did not significantly change, although a smaller proportion of this population was in a facility compared with earlier years.
- Women reported higher levels of functional limitations than men. In 2009, about 46 percent of female Medicare enrollees age 65 and over had difficulty with ADLs or IADLs, or were in a facility, compared with 35 percent of male Medicare enrollees. Overall rates of decline since 1992 were similar for men and women; however, a higher proportion of women were in facilities compared with men.

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

Percentage of Medicare enrollees age 65 and over who are unable to perform certain physical functions, by sex, 1991 and 2009



NOTE: Rates for 1991 are age-adjusted to the 2009 population.
 Reference population: These data refer to Medicare enrollees.
 SOURCE: Centers for Medicare and Medicaid Services, Medicare Current Beneficiary Survey.

- Older women reported more problems with physical functioning than older men did. In 2009, about 30 percent of women reported they were unable to perform at least one of five activities, compared with 19 percent of men.
- Problems with physical functioning were more frequent at older ages. Among men age 65–74, 13 percent reported they were unable to perform at least one of five activities, compared with 40 percent of men age 85 and over. Among women, 19 percent of those age 65–74 were unable to perform at least one activity, compared with 53 percent of those age 85 and over.
- Physical functioning was related to race and ethnicity in 2009. Among men, 18 percent of non-Hispanic Whites were unable to perform at least one activity, compared with 23 percent of non-Hispanic Blacks. Among women, 29 percent of non-Hispanic Whites were unable to perform at least one activity, compared with 33 percent of non-Hispanic Blacks.

Data for this indicator's charts and bullets can be found in Tables 20a through 20d on pages 120–121.