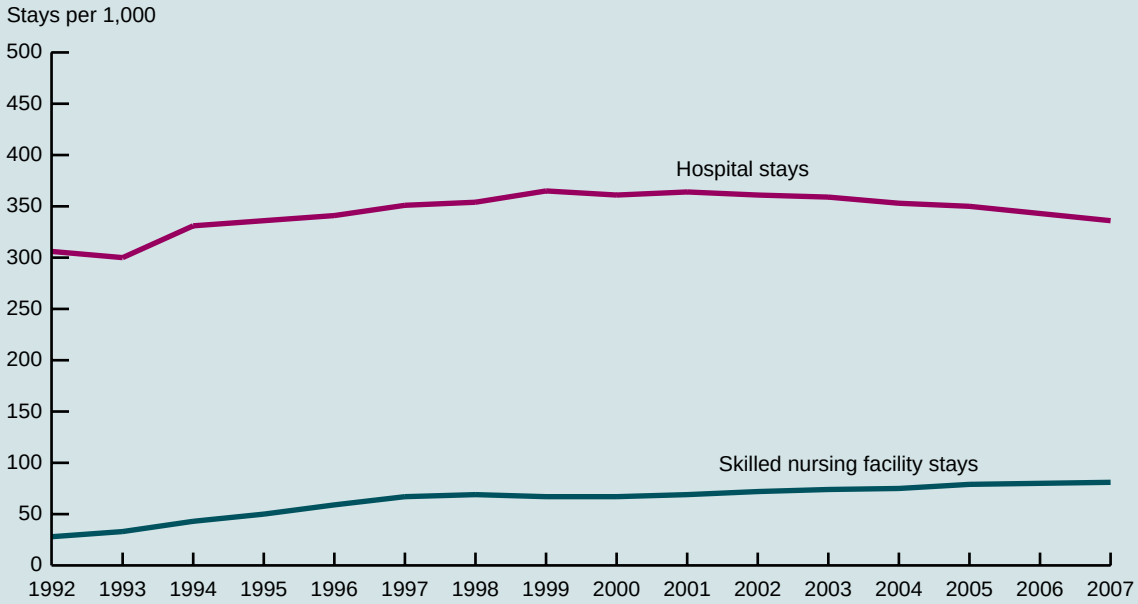
Health Care

INDICATOR 29

Use of Health Care Services

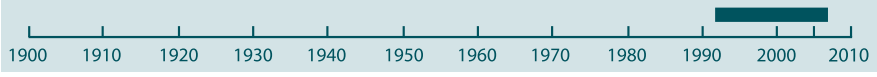
Most older Americans have health insurance through Medicare. Medicare covers a variety of services, including inpatient hospital care, physician services, hospital outpatient care, home health care, skilled nursing facility care, hospice services, and (beginning in January 2006) prescription drugs. Utilization rates for many services change over time because of changes in physician practice patterns, medical technology, Medicare payment amounts, and patient demographics.

Medicare-covered hospital and skilled nursing facility stays per 1,000 Medicare enrollees age 65 and over in fee-for-service, 1992–2007



NOTE: Beginning in 1994, managed care enrollees were excluded from the denominator of all utilization rates because utilization data are not available for them. Prior to 1994, managed care enrollees were included in the denominators; they comprised 7 percent or less of the Medicare population.
Reference population: These data refer to Medicare enrollees in fee-for-service.
SOURCE: Centers for Medicare and Medicaid Services, Medicare claims and enrollment data.

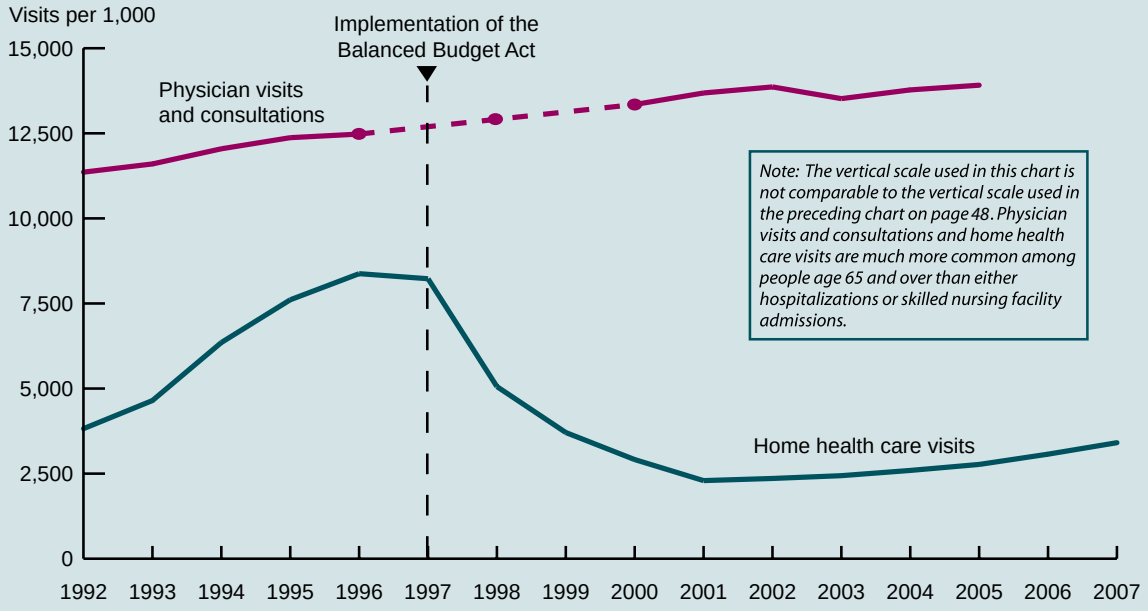
- Overall, between 1992 and 1999, the hospitalization rate increased from 306 hospital stays per 1,000 Medicare enrollees to 365 per 1,000. The rate then decreased to 336 per 1,000 enrollees in 2007. The average length of a hospital stay decreased from 8.4 days in 1992 to 5.6 days in 2007.
- Skilled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



INDICATOR 29

Use of Health Care Services continued

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

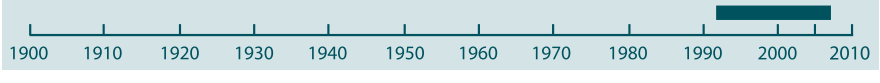


Data on physician visits and consultations are not available for 1997,1999, 2006, and 2007.

NOTE: Physician visits and consultations include all settings, such as physician offices, hospitals, emergency rooms, and nursing homes. The definition of physician visits and consultations changed beginning in 2003, resulting in a slightly lower rate. Beginning in 1994, managed care enrollees were excluded from the denominator of all utilization rates because utilization data are not available for them. Prior to 1994, managed care enrollees were included in the denominators; they comprised 7 percent or less of the Medicare population.
Reference population: These data refer to Medicare enrollees in fee-for-service.
SOURCE: Centers for Medicare and Medicaid Services, Medicare claims and enrollment data.

- Overall, between 1992 and 2005, the number of physician visits and consultations increased. There were 11,359 visits and consultations per 1,000 Medicare enrollees in 1992, compared with 13,914 in 2005.
- The number of home health care visits per 1,000 Medicare enrollees increased from 3,822 in 1992 to 8,376 in 1996. Home health care use increased during this period in part because of an expansion in the coverage criteria for the Medicare home health care benefit.[38] Home health care visits declined after 1997 to 2,295 per 1,000 enrollees in 2001. The decline coincided with changes in Medicare payment policies for home health care resulting from implementation of the Balanced Budget Act of 1997. The visit rate increased thereafter to 3,409 per 1,000 enrollees in 2007.
- Use of skilled nursing facility and home health care increased with age. In 2007, there were 32 skilled nursing facility stays per 1,000 Medicare enrollees age 65–74, compared with 227 per 1,000 enrollees age 85 and over. Home health agencies made 1,713 visits per 1,000 enrollees age 65–74, compared with 7,333 per 1,000 for those age 85 and over.

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

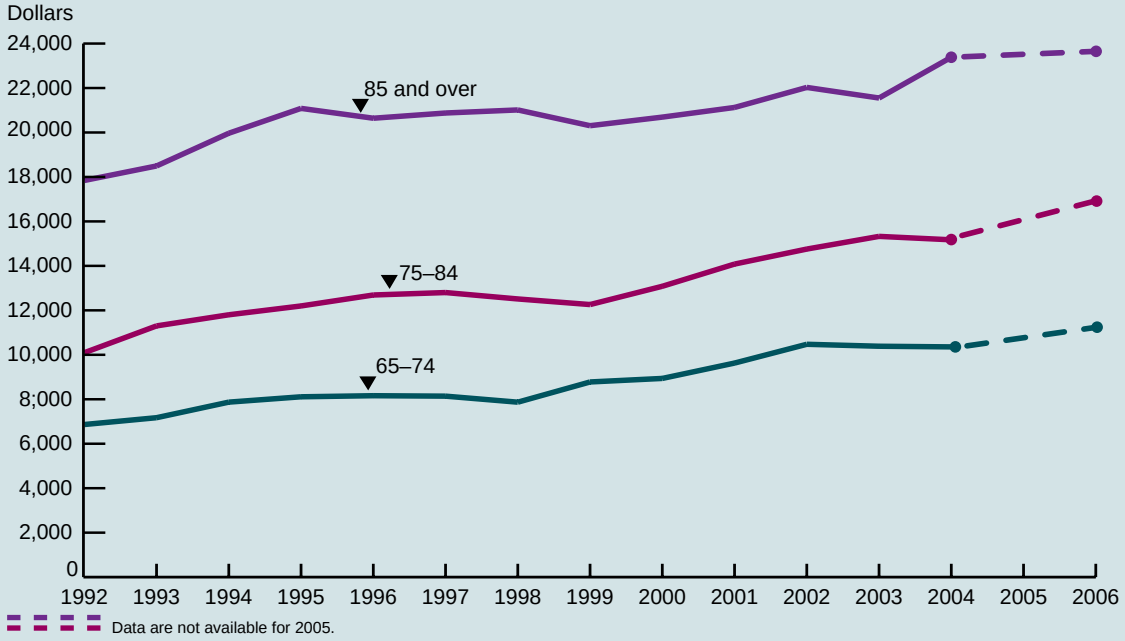


INDICATOR 30

Health Care Expenditures

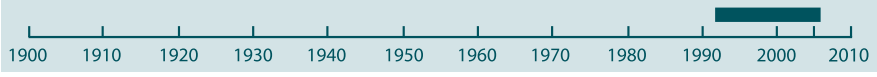
Older Americans use more health care than any other age group. Health care costs are increasing at the same time the baby boom generation is approaching retirement age.

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



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

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

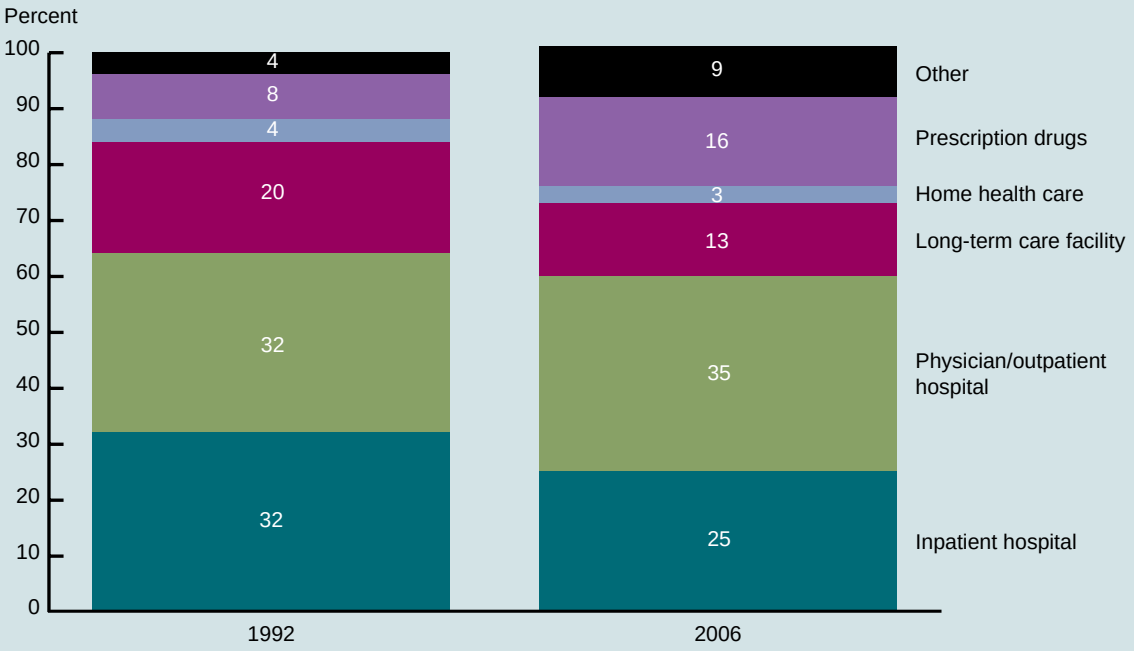


INDICATOR 30

Health Care Expenditures continued

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

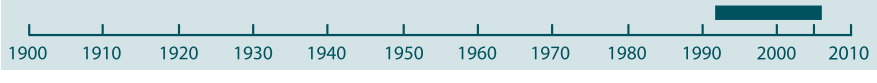
Major components of health care costs among Medicare enrollees age 65 and over, 1992 and 2006



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

- Hospital and physician services are the largest components of health care costs. Long-term care facilities accounted for 13 percent of total costs in 2006. Prescription drugs accounted for 16 percent of health care costs.
- The mix of health care services changed between 1992 and 2006. Inpatient hospital care accounted for a lower share of costs in 2006 (25 percent compared with 32 percent in 1992). Prescription drugs increased in importance from 8 percent of costs in 1992 to 16 percent in 2006. "Other" costs (short-term institutions, hospice and dental care) also increased as a percentage of all costs (4 percent to 9 percent).
- The mix of services varied with age. The biggest difference occurred for long-term care facility services; average costs were $7,182 among people age 85 and over, compared with just $547 among those age 65–74. Costs of home health care and "other" services also were higher at older ages. Costs of physician/outpatient services and prescription drugs did not show a strong pattern by age.

Data for this indicator's charts and bullets can be found in Tables 30a, 30b, 30c, 30d, and 30e on pages 120–122.

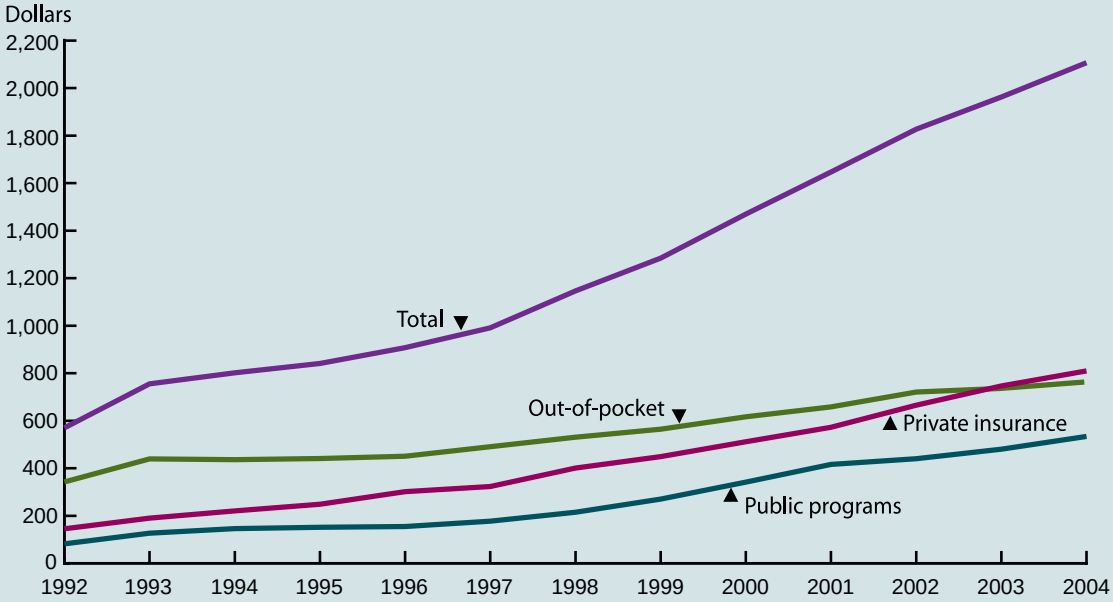


INDICATOR 31

Prescription Drugs

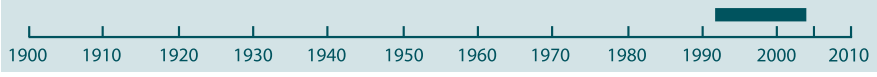
Prescription drug costs have increased rapidly in recent years, as more new drugs become available. Lack of prescription drug coverage has created a financial hardship for many older Americans. Medicare coverage of prescription drugs began in January 2006, including a low-income subsidy for beneficiaries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

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



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

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

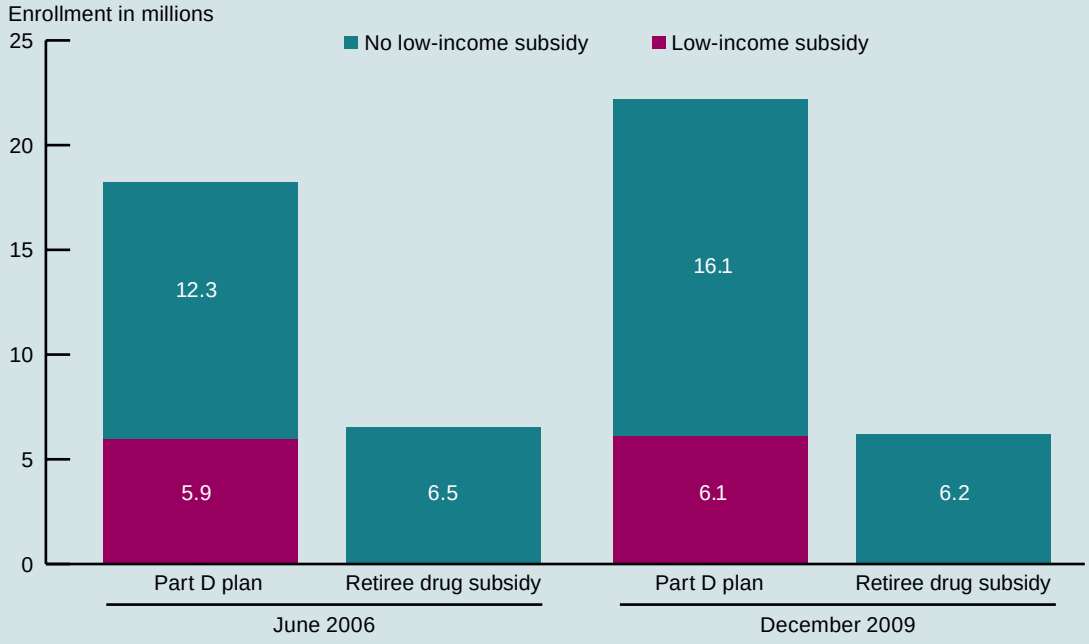


INDICATOR 31

Prescription Drugs continued

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

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



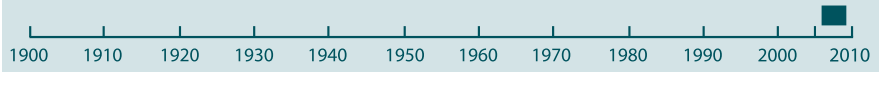
Reference population: These data refer to Medicare enrollees.
SOURCE: Centers for Medicare and Medicaid Services, Management Information Integrated Repository.

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

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

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

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

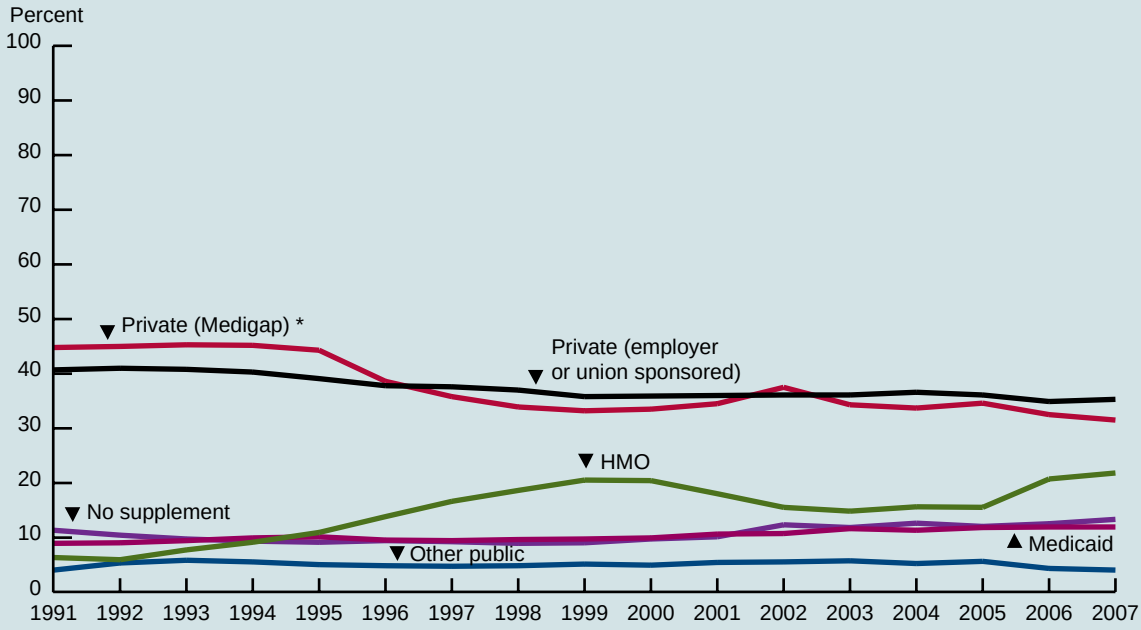


INDICATOR 32

Sources of Health Insurance

Nearly all older Americans have Medicare as their primary source of health insurance coverage. Medicare covers mostly acute care services and requires beneficiaries to pay part of the cost, leaving about half of health spending to be covered by other sources. Many beneficiaries have supplemental insurance to fill these gaps and pay for services not covered by Medicare. Prior to 2006, many beneficiaries received prescription drug coverage through supplemental insurance. Since January 2006, beneficiaries have had the option of receiving prescription drug coverage under Medicare through stand-alone prescription drug plans or through some Medicare Advantage health plans.

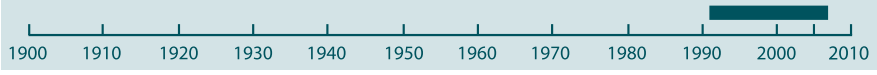
Percentage of noninstitutionalized Medicare enrollees age 65 and over with supplemental health insurance, by type of insurance, 1991–2007



* Includes people with private supplement of unknown sponsorship.
NOTE: HMO/health plans include Health Maintenance Organizations (HMOs), Preferred Provider Organizations (PPOs), and private fee-for-service plans (PFFSs). Not all types of plans were available in all years. Since 2003 these types of plans have been known collectively as Medicare Advantage. Estimates are based on enrollees' insurance status in the fall of each year. Categories are not mutually exclusive (i.e., individuals may have more than one supplemental policy). Chart excludes enrollees whose primary insurance is not Medicare (approximately 1 to 2 percent of enrollees). Medicaid coverage was determined from both survey responses and Medicare administrative records.
Reference population: These data refer to Medicare enrollees.
SOURCE: Centers for Medicare and Medicaid Services, Medicare Current Beneficiary Survey.

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

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

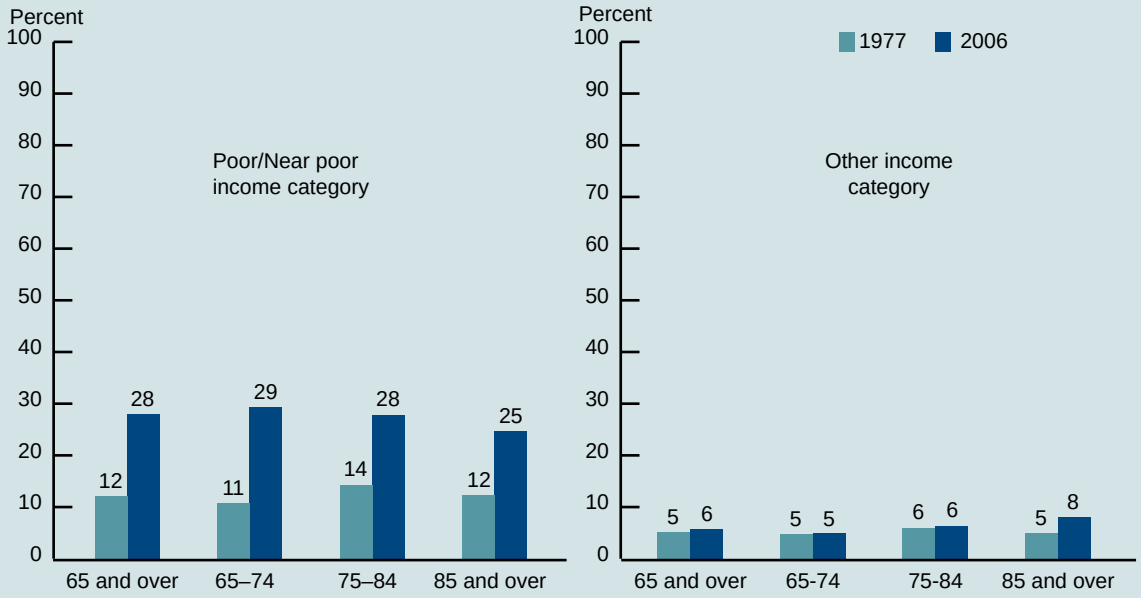


INDICATOR 33

Out-of-Pocket Health Care Expenditures

Large out-of-pocket expenditures for health care service use have been shown to encumber access to care, affect health status and quality of life, and leave insufficient resources for other necessities.[39,40] The percentage of household income that is allocated to health care expenditures is a measure of health care expense burden placed on older people.

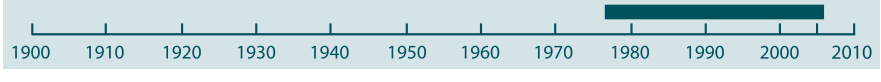
Out-of-pocket health care expenditures as a percentage of household income, among noninstitutionalized people age 65 and over, by age and income category, 1977 and 2006



NOTE: Out-of-pocket health care expenditures exclude personal spending for health insurance premiums. Including expenditures for out-of-pocket premiums in the estimates of out-of-pocket spending would increase the percentage of household income spent on health care in all years. People are classified into the "poor/near poor" income category if their household income is below 125 percent of the poverty level; otherwise, people are classified into the "other" income category. For people with no out-of-pocket expenditures the ratio of out-of pocket spending to income was set to zero. For additional details on how the ratio of out-of-pocket spending to income and the poverty level were calculated, see Table 33b in Appendix A.
Reference population: These data refer to the civilian noninstitutionalized population.
SOURCE: Agency for Healthcare Research and Quality, Medical Expenditure Panel Survey (MEPS), and MEPS predecessor surveys.

- The percentage of people age 65 and over with out-of-pocket spending for health care services increased between 1977 and 2006 (83 percent to 95 percent, respectively).
- From 1977 to 2006 the percentage of household income that people age 65 and over allocated to out-of-pocket spending for health care services increased among those in the poor/near poor income category from 12 percent to 28 percent. Increases were also observed for those in poor or fair health (from 10 percent to 13 percent) as well as for those in excellent, very good, or good health (from 6 percent to 8 percent).
- In 2006, as in the 6 previous years, over one-half of out-of-pocket health care spending by noninstitutionalized people age 65 and over was used to purchase prescription drugs. The percentage of out-of-pocket spending for prescription drugs increased from 2000 to 2004 (54 percent to 61 percent, respectively) then decreased starting in 2005.
- In 2006, people age 85 and over spent a lower proportion of out-of-pocket dollars than people age 65–74 on dental services and office-based medical provider visits but a higher proportion on other health care (e.g., home health care).

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

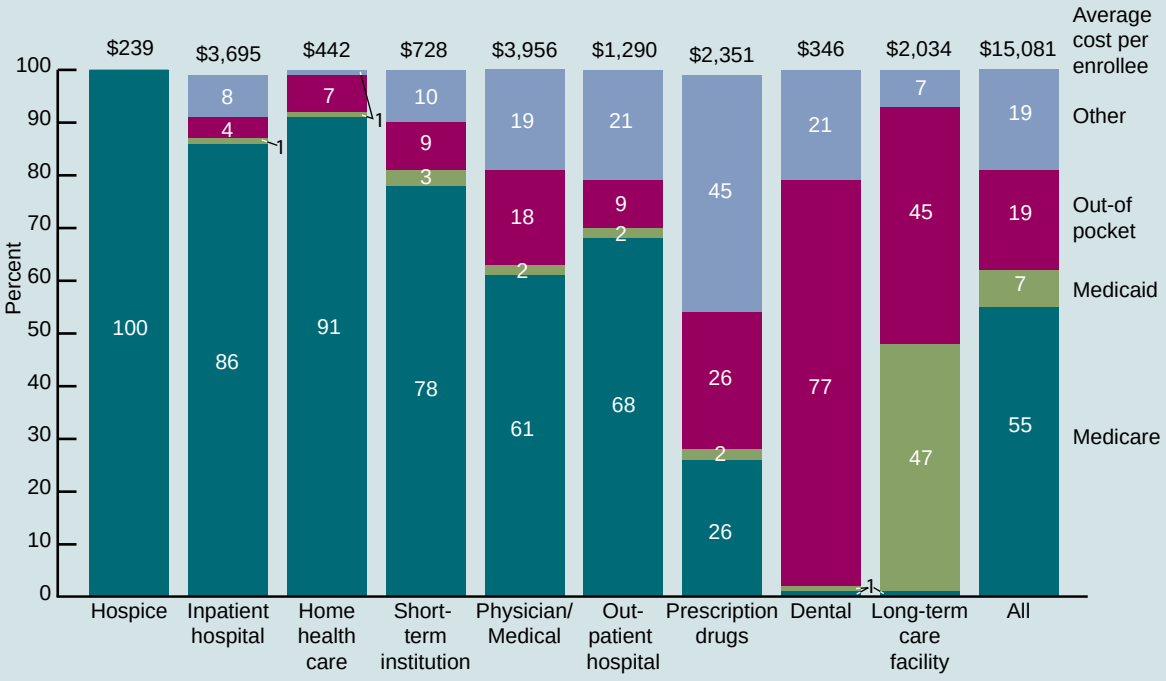


INDICATOR 34

Sources of Payment for Health Care Services

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

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



NOTE: "Other" refers to private insurance, Department of Veterans Affairs, and other public programs.
Reference population: These data refer to Medicare enrollees.
SOURCE: Centers for Medicare and Medicaid Services, Medicare Current Beneficiary Survey.

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

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

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

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

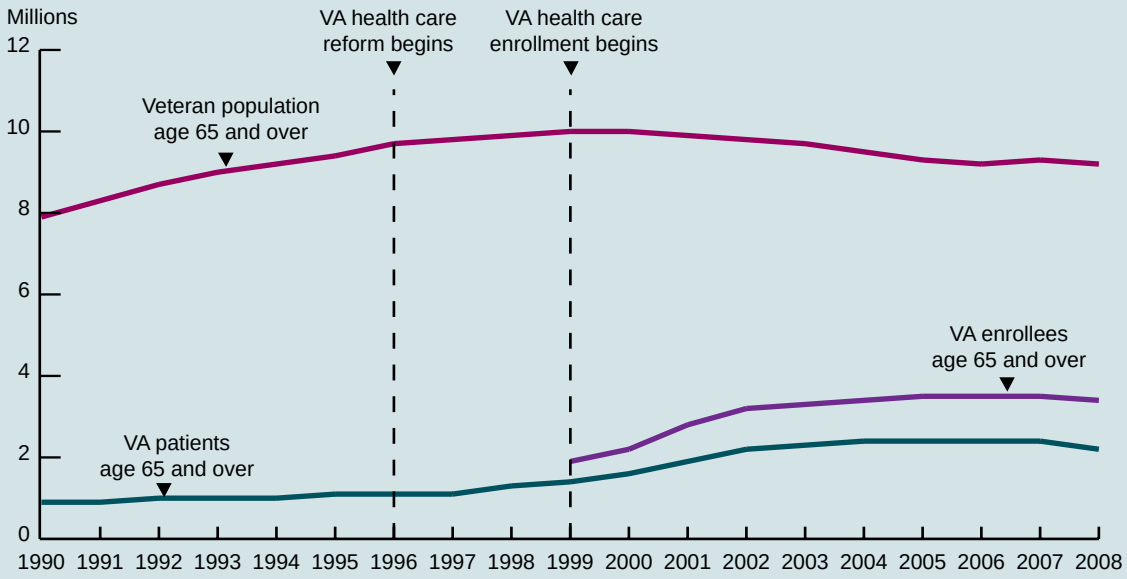
Data for this indicator's charts and bullets can be found in Tables 34a and 34b on page 129.

INDICATOR 35

Veterans' Health Care

The numbers of veterans age 65 and over who receive health care from the Veterans Health Administration (VHA), within the Department of Veterans Affairs (VA), has been steadily increasing. This increase may be because VHA fills important gaps in older veterans' health care needs not currently covered or fully covered by Medicare, such as mental health services, long-term care (nursing home care and community-based care), and specialized services for the disabled. In addition, as the largest integrated health care system in the country, VHA provides broader geographic access to these important services.

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



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

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

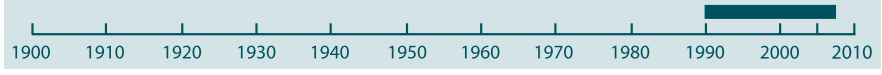
SOURCE: Department of Veterans Affairs, Veteran Population 2007; Fiscal 2009 Year-end Office of the Assistant Deputy Under Secretary for Health for Policy and Planning Enrollment file linked with September 2009 VHA Vital Status data (including data from VHA, VA, Medicare, and SSA).

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

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

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

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

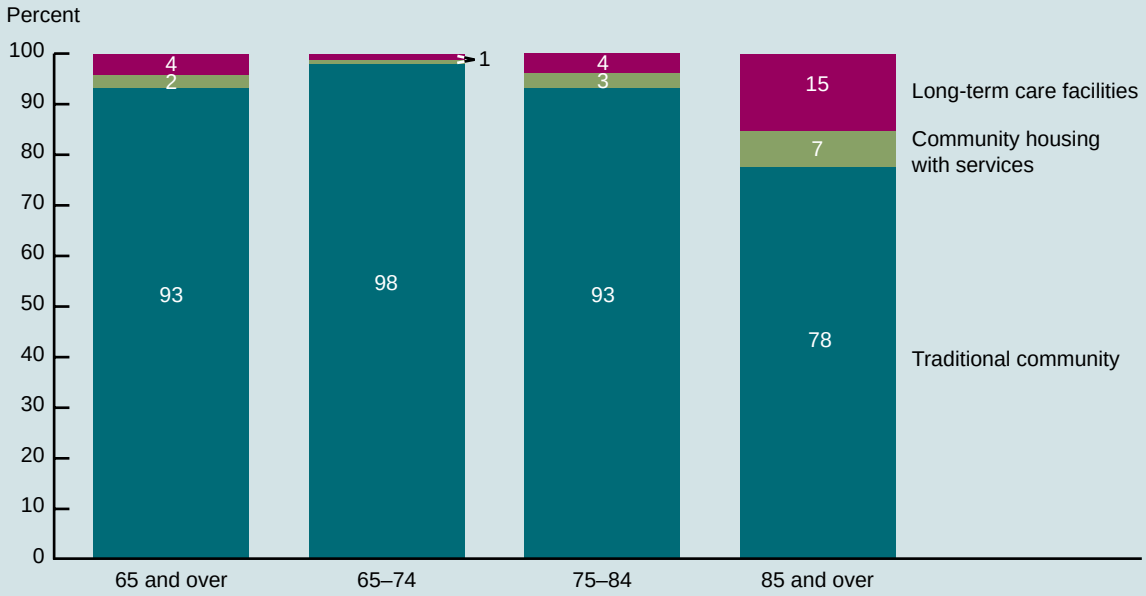


INDICATOR 36

Residential Services

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

Percentage of Medicare enrollees age 65 and over in selected residential settings, by age group, 2007



NOTE: Community housing with services applies to respondents who reported they lived in retirement communities or apartments, senior citizen housing, continuing care retirement facilities, assisted living facilities, staged living communities, board and care facilities/homes, and other similar situations, AND who reported they had access to one or more of the following services through their place of residence: meal preparation; cleaning or housekeeping services; laundry services; help with medications. Respondents were asked about access to these services, but not whether they actually used the services. A residence (or unit) is considered a long-term care facility if it is certified by Medicare or Medicaid; or has three or more beds and is licensed as a nursing home or other long-term care facility and provides at least one personal care service; or provides 24-hour, seven-day-a-week supervision by a non-family, paid caregiver.
Reference population: These data refer to Medicare enrollees.
SOURCE: Centers for Medicare and Medicaid Services, Medicare Current Beneficiary Survey.

- In 2007, 2 percent of the Medicare population age 65 and over resided in community housing with at least one service available. Four percent resided in long-term care facilities. The percentage of people residing in community housing with services and in long-term care facilities was higher for the older age groups; among individuals age 85 and over, 7 percent resided in community housing with services, and 15 percent resided in long-term care facilities. Among individuals age 65–74, 98 percent resided in traditional community settings.

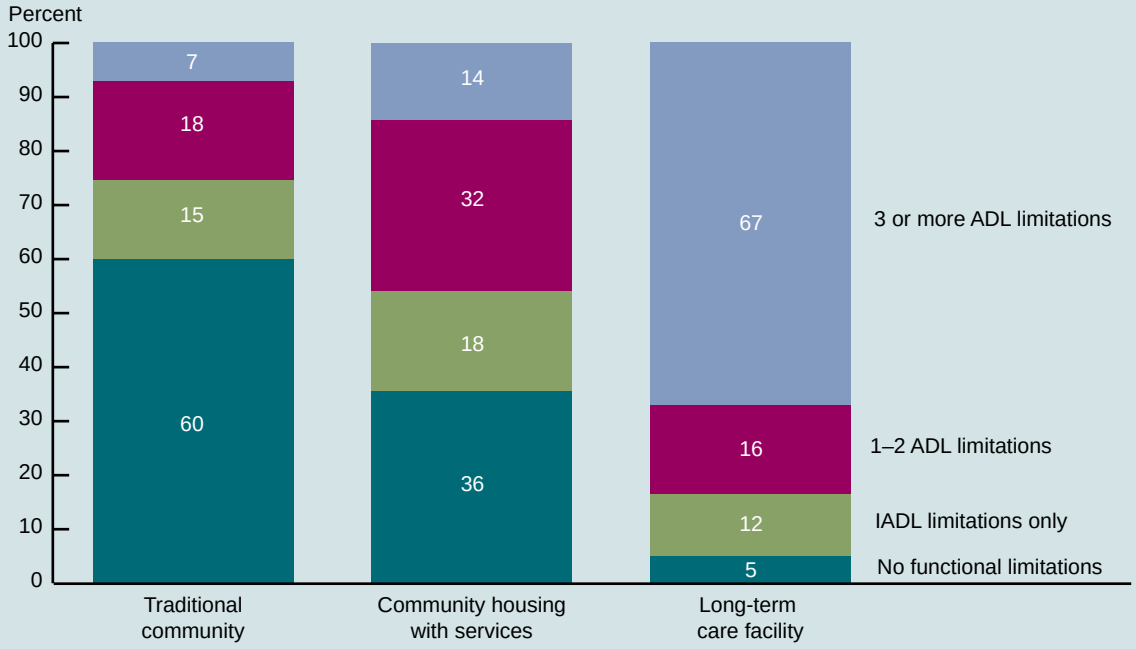
- Among residents of community housing with services, 87 percent reported access to meal preparation services; 84 percent reported access to housekeeping/cleaning services; 72 percent reported access to laundry services; and 51 percent reported access to help with medications. These numbers reflect percentages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

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

INDICATOR 36

Residential Services continued

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



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

- People living in community housing with services had more functional limitations than traditional community residents, but not as many as those living in long-term care facilities. Forty-six percent of individuals living in community housing with services had at least one activity of daily living (ADL) limitation compared with 25 percent of traditional community residents. Among long-term care facility residents, 83 percent had at least one ADL limitation. Thirty-six percent of individuals living in community housing with services had no ADL or instrumental activities of daily living (IADL) limitations.

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

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

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

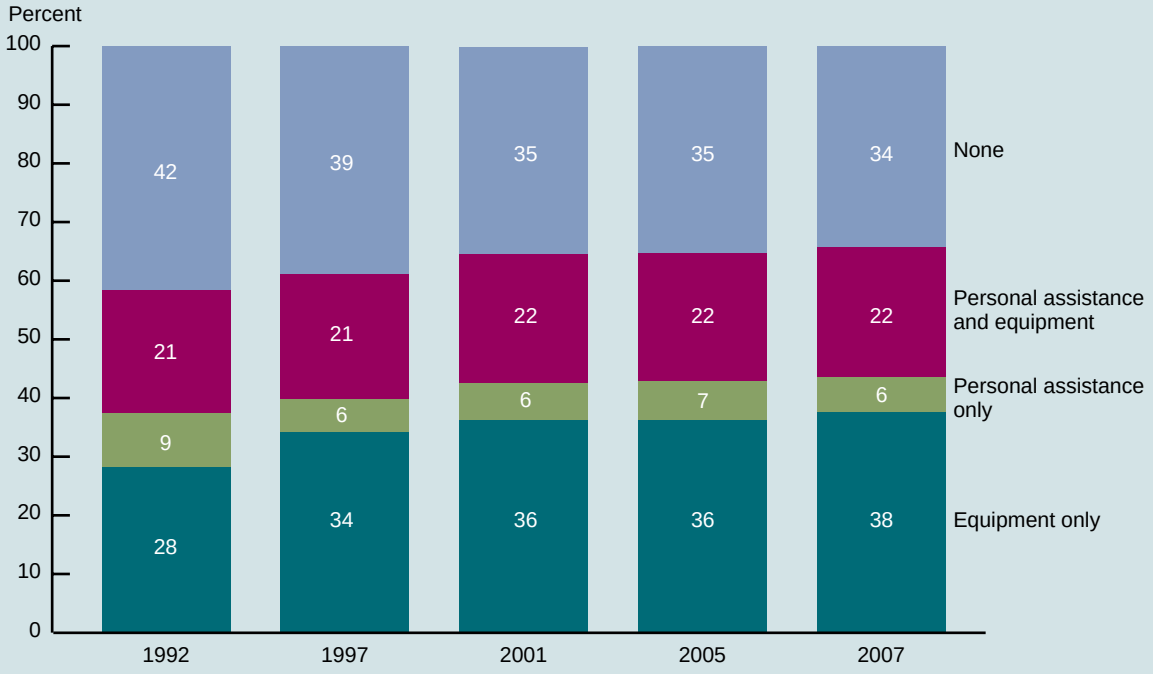
Data for this indicator's charts and bullets can be found in Tables 36a, 36b, 36c, 36d, and 36e on pages 131–132.

INDICATOR 37

Personal Assistance and Equipment

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

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

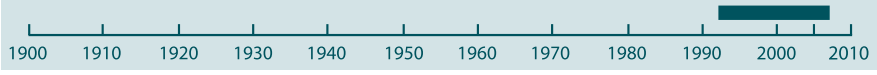


NOTE: ADL limitations refer to difficulty performing (or inability to perform for a health reason) one or more of the following tasks: bathing, dressing, eating, getting in/out of chairs, walking, or using the toilet. Respondents who report difficulty with an activity are subsequently asked about receiving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

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

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

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



INDICATOR 37

Personal Assistance and Equipment continued

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

NOTE: IADL limitations refer to difficulty performing (or inability to perform for a health reason) one or more of the following tasks: using the telephone, light housework, heavy housework, meal preparation, shopping, or managing money. Respondents who report difficulty with an activity are subsequently asked about receiving help from another person with the activity. In this table, personal assistance does not include supervision or special equipment.
Reference population: These data refer to noninstitutionalized Medicare enrollees who have limitations with one or more IADLs.
SOURCE: Centers for Medicare and Medicaid Services, Medicare Current Beneficiary Survey.

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

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