

Health Status

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Indicator 15: **Mortality**

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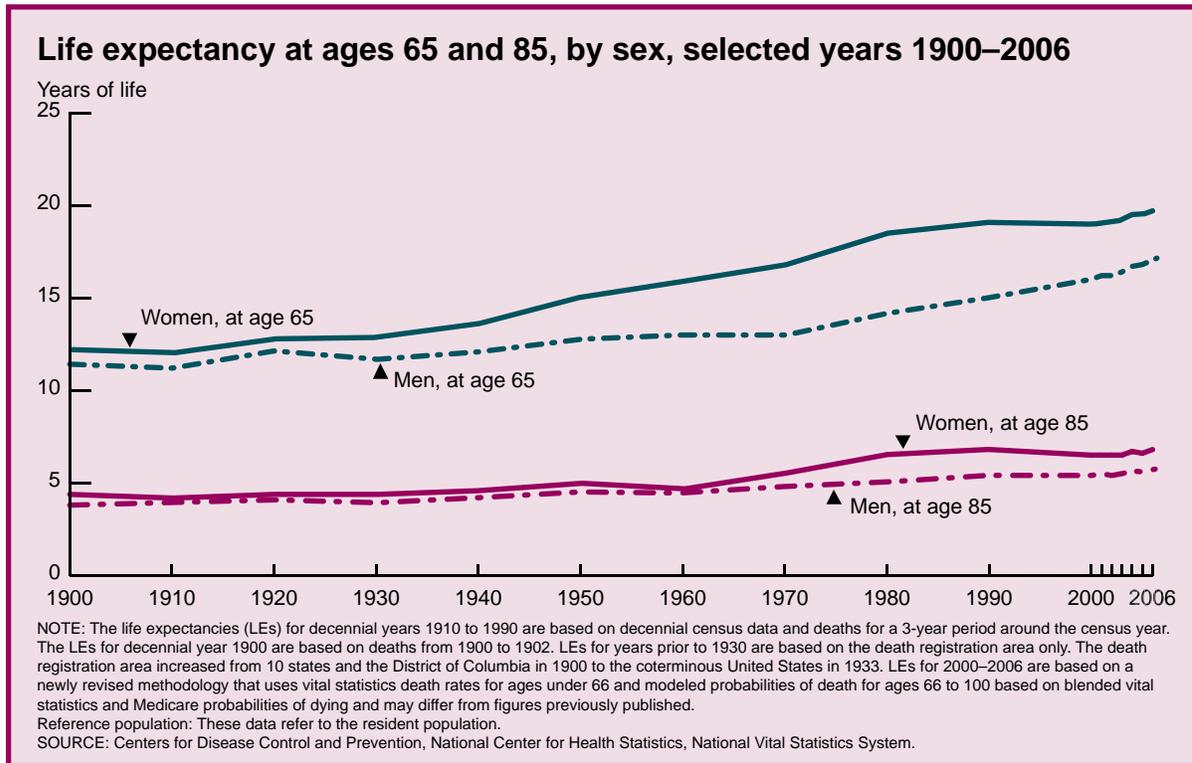
Indicator 19: **Depressive Symptoms**

Indicator 20: **Functional Limitations**

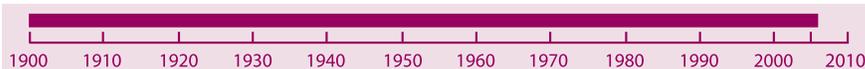
INDICATOR 14

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.

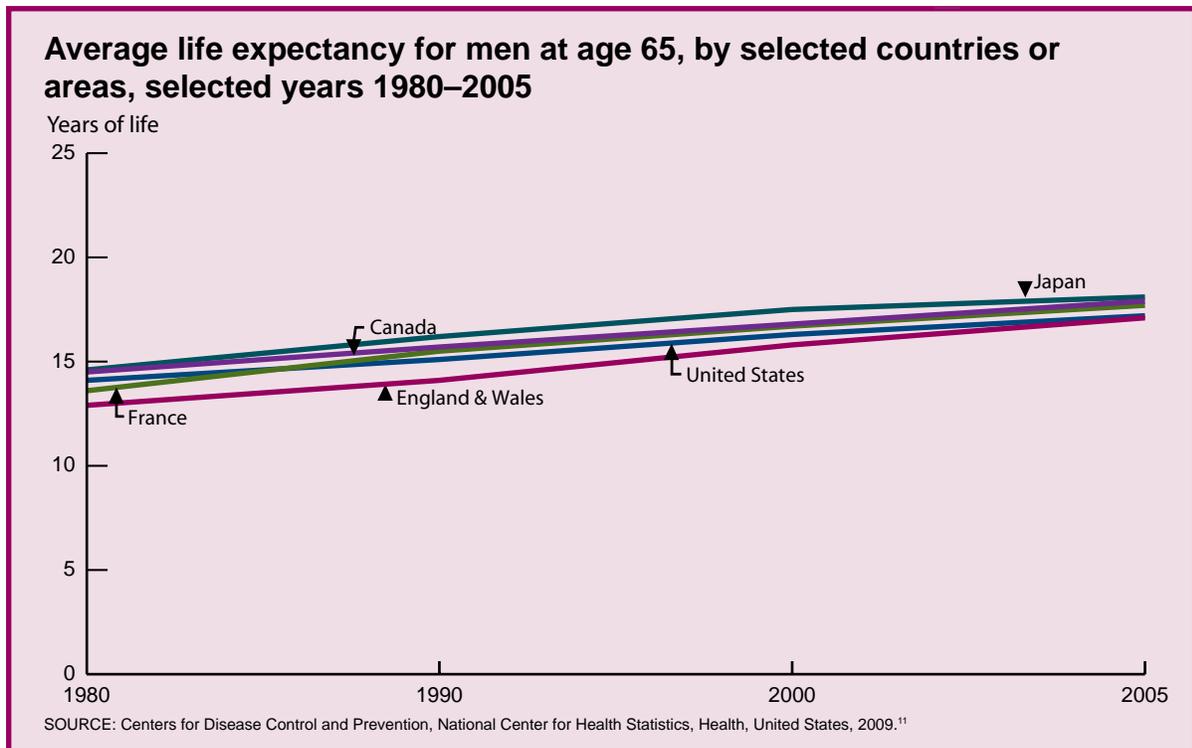
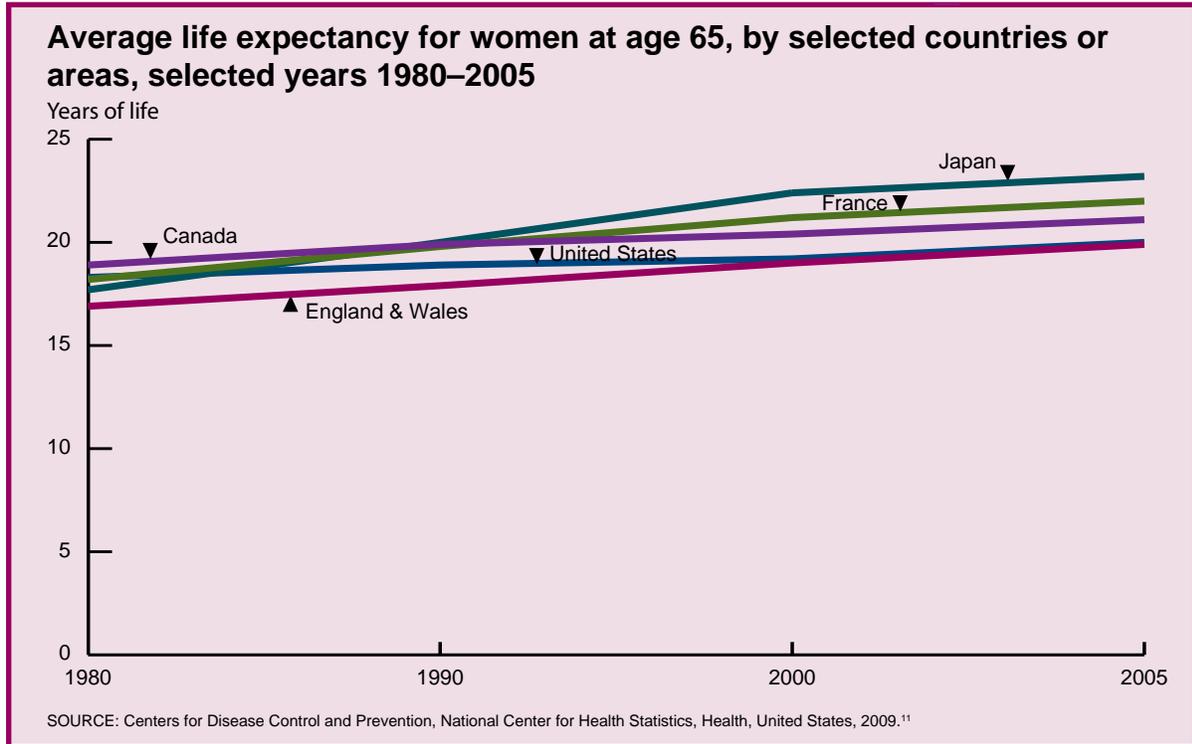


- ◆ Americans are living longer than ever before. Life expectancies at both age 65 and age 85 have increased. Under current mortality conditions, people who survive to age 65 can expect to live an average of 18.5 more years, about 4 years longer than people age 65 in 1960. The life expectancy of people who survive to age 85 today is 6.8 years for women and 5.7 years for men.
- ◆ Life expectancy varies by race, but the difference decreases with age. In 2006, life expectancy at birth was 5 years higher for white people than for black people. At age 65, white people can expect to live an average of 1.5 years longer than black people. Among those who survive to age 85, however, the life expectancy among black people is slightly higher (6.7 years) than white people (6.3 years).
- ◆ Life expectancy at age 65 in the United States is lower than that of many other industrialized nations. In 2005, women age 65 in Japan could expect to live on average 3.7 years longer than women in the United States. Among men, the difference was 1.3 years.

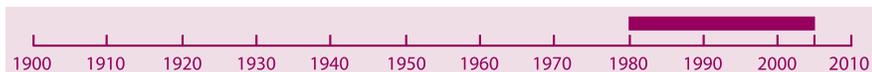


INDICATOR 14

Life Expectancy continued



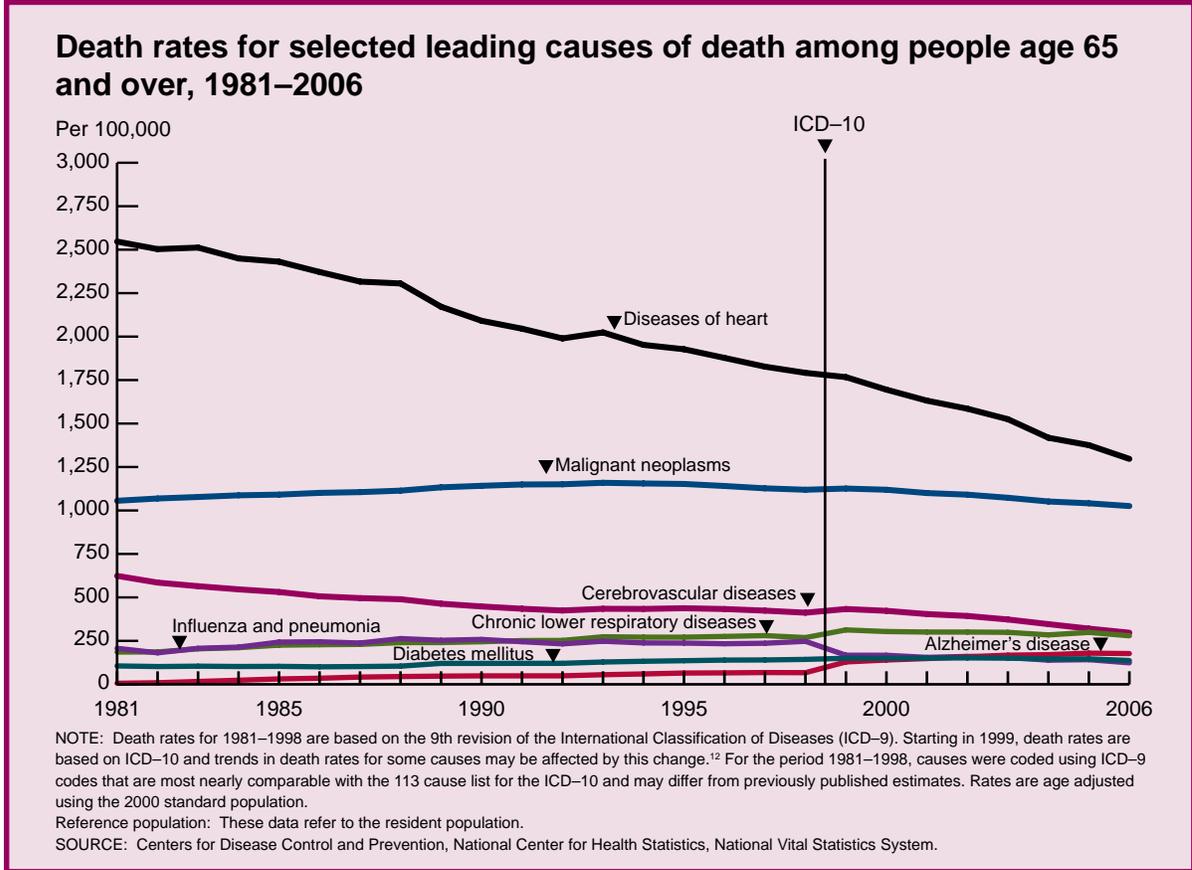
Data for this indicator's charts and bullets can be found in Tables 14a, 14b, and 14c on pages 93–94.



INDICATOR 15

Mortality

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



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

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

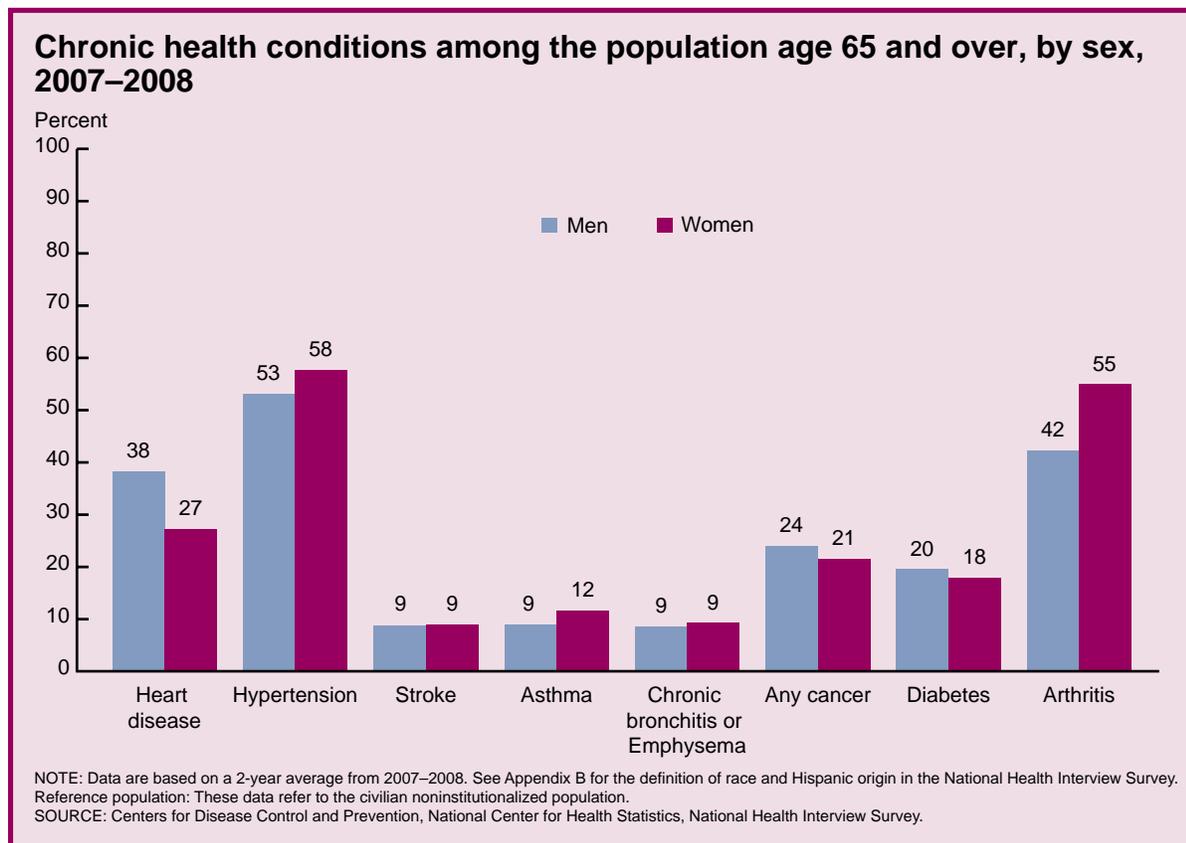
◆ Heart disease and cancer are the top two leading causes of death among all people age 65 and over, irrespective of sex, race, or Hispanic origin.

◆ Other causes of death vary among older people by sex and race and Hispanic origin. For example, men have higher suicide rates than do women at all ages, with the largest difference occurring at age 85 and over (43 deaths per 100,000 population for men compared with 3 per 100,000 for women). Non-Hispanic white men age 85 and over have the highest rate of suicide overall at 48 deaths per 100,000.¹³

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

Chronic Health Conditions

Chronic diseases are long-term illnesses that are rarely cured. Chronic diseases such as heart disease, stroke, cancer, and diabetes are among the most common and costly health conditions. Chronic health conditions negatively affect quality of life, contributing to declines in functioning and the inability to remain in the community.¹⁴ Many chronic conditions can be prevented or modified with behavioral interventions. Six of the seven leading causes of death among older Americans are chronic diseases. (See “Indicator 15: Mortality.”)



◆ The prevalence of certain chronic conditions differs by sex. Women report higher levels of arthritis and hypertension than men. Men report higher levels of heart disease and cancer.

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

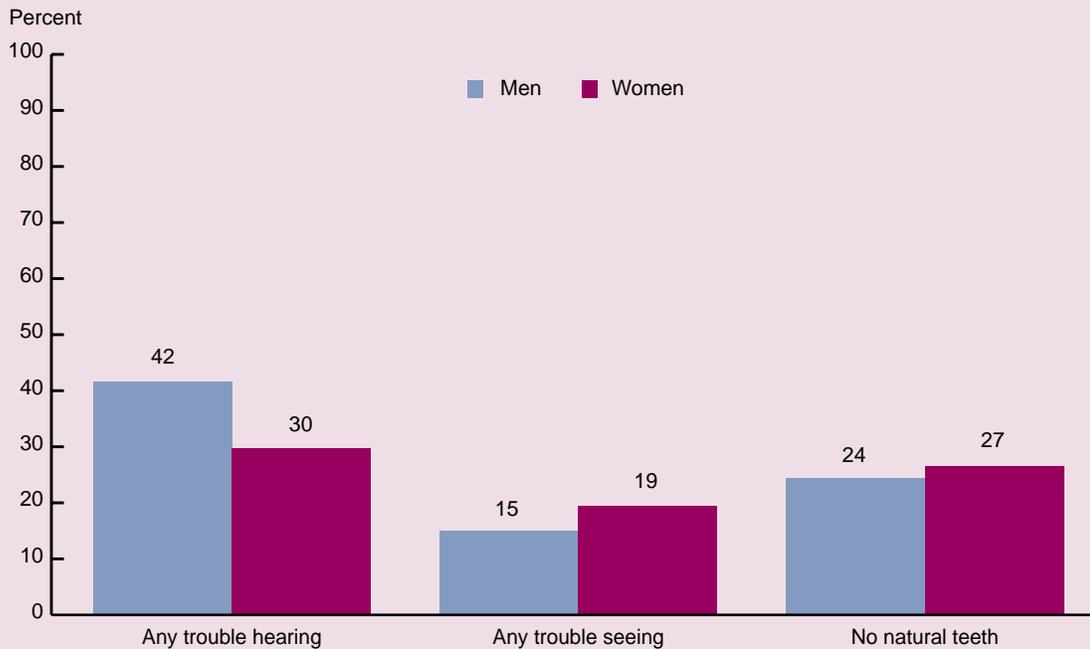
Data for this indicator’s chart and bullets can be found in Tables 16a and 16b on page 100.

INDICATOR 17

Sensory Impairments and Oral Health

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

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



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

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

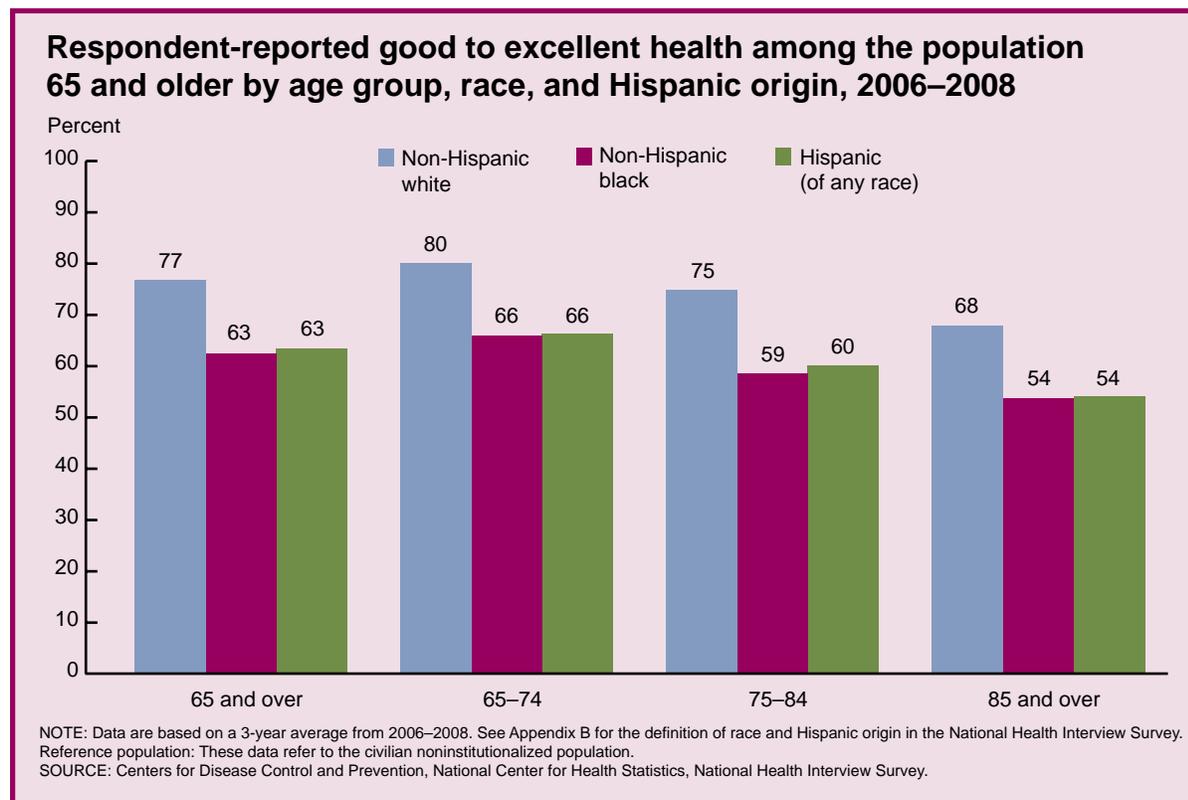
SOURCE: Centers for Disease Control and Prevention, National Center for Health Statistics, National Health Interview Survey.

- ◆ In 2008, 42 percent of older men and 30 percent of older women reported trouble hearing. The percentage with trouble hearing was higher for people age 85 and over (60 percent) than for people age 65–74 (28 percent). Eleven percent of all older women and 18 percent of all older men reported having ever worn a hearing aid.
- ◆ The prevalence of edentulism, having no natural teeth, was higher for people age 85 and over (34 percent) than for people age 65–74 (20 percent). Socioeconomic differences are large. Forty-two percent of older people with family income below the poverty line reported no natural teeth compared with 23 percent of people above the poverty threshold.
- ◆ Vision trouble affects 18 percent of the older population, 15 percent of men and 19 percent of women. Among people age 85 and over, 28 percent reported trouble seeing.

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

Respondent-Assessed Health Status

Asking people to rate their health as excellent, very good, good, fair, or poor provides a common indicator of health easily measured in surveys. It represents physical, emotional, and social aspects of health and well-being. Respondent-assessed health ratings of poor correlate with higher risks of mortality.¹⁵



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

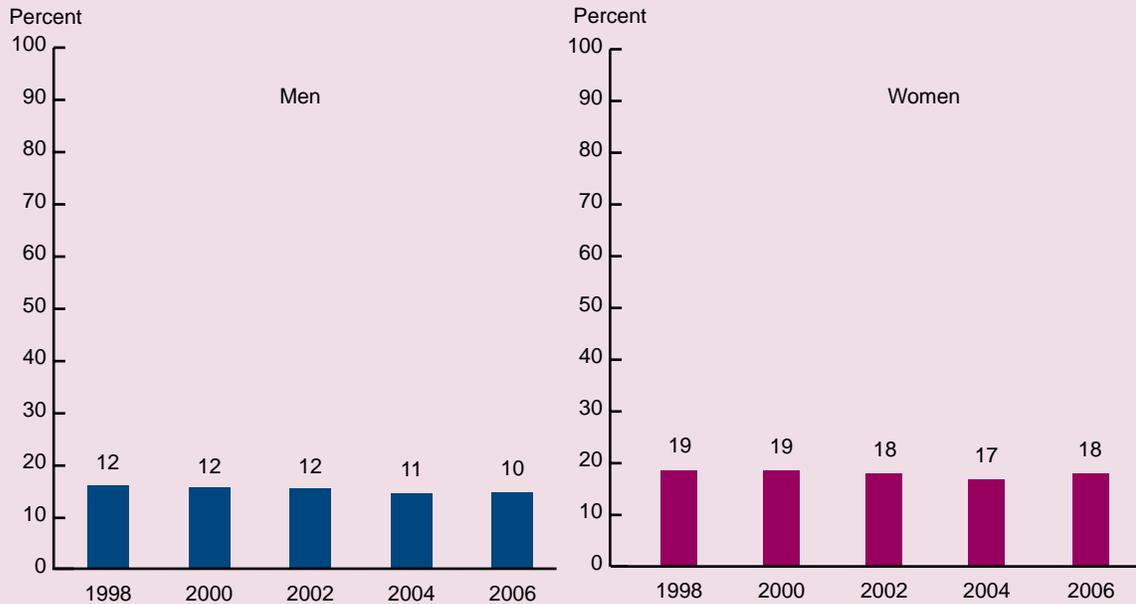
Data for this indicator's charts and bullets can be found in Table 18 on page 102

INDICATOR 19

Depressive Symptoms

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

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



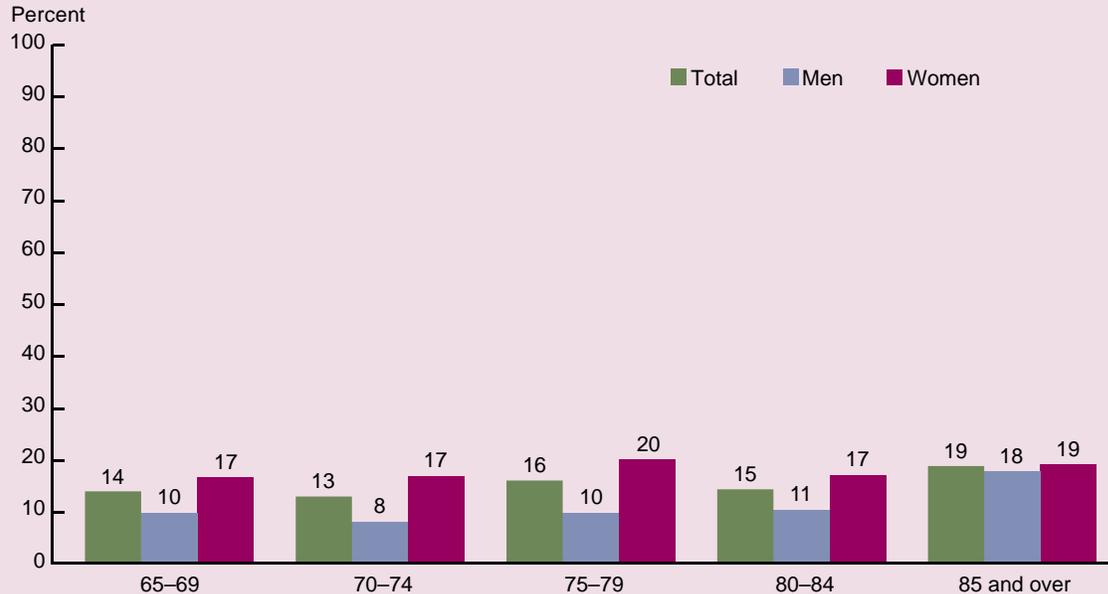
NOTE: The definition of "clinically relevant depressive symptoms" is four or more symptoms out of a list of eight depressive symptoms from an abbreviated version of the Center of Epidemiological Studies Depression Scale (CES-D) adapted by the Health and Retirement Study (HRS). The CES-D scale is a measure of depressive symptoms and is not to be used as a diagnosis of clinical depression. A detailed explanation concerning the "4 or more symptoms" cut-off can be found in the following documentation, <http://hrsonline.isr.umich.edu/docs/userg/dr-005.pdf>. Proportions are based on weighted data using the preliminary respondent weight from HRS 2006.
Reference population: These data refer to the civilian noninstitutionalized population.
SOURCE: Health and Retirement Study.

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

INDICATOR 19

Depressive Symptoms continued

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



NOTE: The definition of "clinically relevant depressive symptoms" is four or more symptoms out of a list of eight depressive symptoms from an abbreviated version of the Center of Epidemiological Studies Depression Scale (CES-D) adapted by the Health and Retirement Study (HRS). The CES-D scale is a measure of depressive symptoms and is not to be used as a diagnosis of clinical depression. A detailed explanation concerning the "4 or more symptoms" cut-off can be found in the following documentation, <http://hrsonline.isr.umich.edu/docs/userg/dr-005.pdf>. Proportions are based on weighted data using the preliminary respondent weight from HRS 2006.

Reference population: These data refer to the civilian noninstitutionalized population.
SOURCE: Health and Retirement Study.

◆ The prevalence of depressive symptoms is related to age. In 2006, the proportion of people age 65 and over with clinically relevant symptoms was higher for people age 85 and over (19 percent) than for people in any of the younger groups (13 to 16 percent).

◆ In 2006, the percentage of men 85 and over (almost 18 percent) reporting clinically relevant depressive symptoms was twice (or almost twice) that of men in any of the younger age groups (8–10 percent). Prevalence of depression among women age 65 and older did not follow this same pattern; the percentage of women reporting clinically relevant symptoms ranges between 17 percent and 20 percent, with women age 75–79 reporting the highest prevalence.

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

INDICATOR 20

Functional Limitations

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

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



NOTE: A residence is considered a long-term care facility if it is certified by Medicare or Medicaid; has 3 or more beds and is licensed as a nursing home or other long-term care facility and provides at least one personal care service; or provides 24-hour, 7-day-a-week supervision by a caregiver. ADL limitations refer to difficulty performing (or inability to perform for a health reason) one or more of the following tasks: bathing, dressing, eating, getting in/out of chairs, walking, or using the toilet. IADL limitations refer to difficulty performing (or inability to perform for a health reason) one or more of the following tasks: using the telephone, light housework, heavy housework, meal preparation, shopping, or managing money. Rates are age adjusted using the 2000 standard population. Data for 1992, 2001, and 2007 do not sum to the totals because of rounding.
Reference population: These data refer to Medicare enrollees.
SOURCE: Centers for Medicare and Medicaid Services, Medicare Current Beneficiary Survey.

- ◆ In 2007, 42 percent of people age 65 and over reported a functional limitation. Fourteen percent had difficulty performing one or more IADLs but had no ADL limitations. Approximately 25 percent had difficulty with at least one ADL and 4 percent were in a facility.
- ◆ The age-adjusted proportion of people age 65 and over with a functional limitation declined from 49 percent in 1992 to 42 percent in 2007. There was a steady decrease in the percent with limitations from 1992 until 1997. From 1997 to 2007 the overall levels have not significantly changed although a smaller proportion of

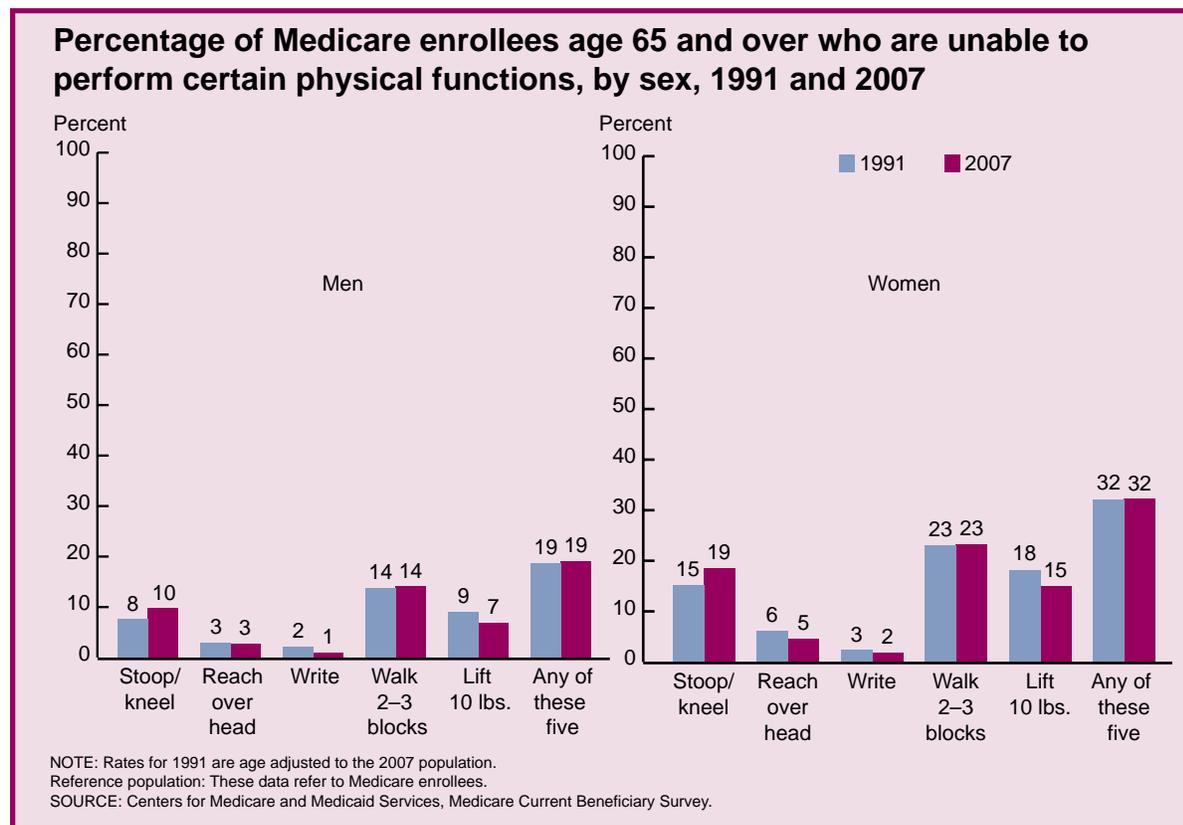
this population is in a facility compared with earlier years.

- ◆ Women have higher levels of functional limitations than men. In 2007, 47 percent of female Medicare enrollees age 65 and over had difficulty with ADLs or IADLs, or were in a facility, compared with 35 percent of male Medicare enrollees. Overall rates of decline since 1992 are similar for men and women; however, a higher proportion of women are in facilities compared with men.

INDICATOR 20

Functional Limitations continued

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



Older women reported more problems with physical functioning than older men. In 2007, 32 percent of women reported they were unable to perform at least one of five activities, compared with 19 percent of men.

Problems with physical functioning were more frequent at older ages. Among men aged 65–74, 13 percent reported they were unable to perform at least one of five activities, compared with 40 percent of men age 85 and over. Among women, 22 percent of those age 65–74 were unable to perform at least one activity, compared with 56 percent of those age 85 and over.

Physical functioning was not strongly related to race in 2007. Among men, 19 percent of non-Hispanic whites were unable to perform at least one activity, compared with 26 percent of non-Hispanic blacks. Among women, there were no significant differences among non-Hispanic whites, non-Hispanic blacks, and Hispanics, regarding ability to perform at least one activity.

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

