Health Care

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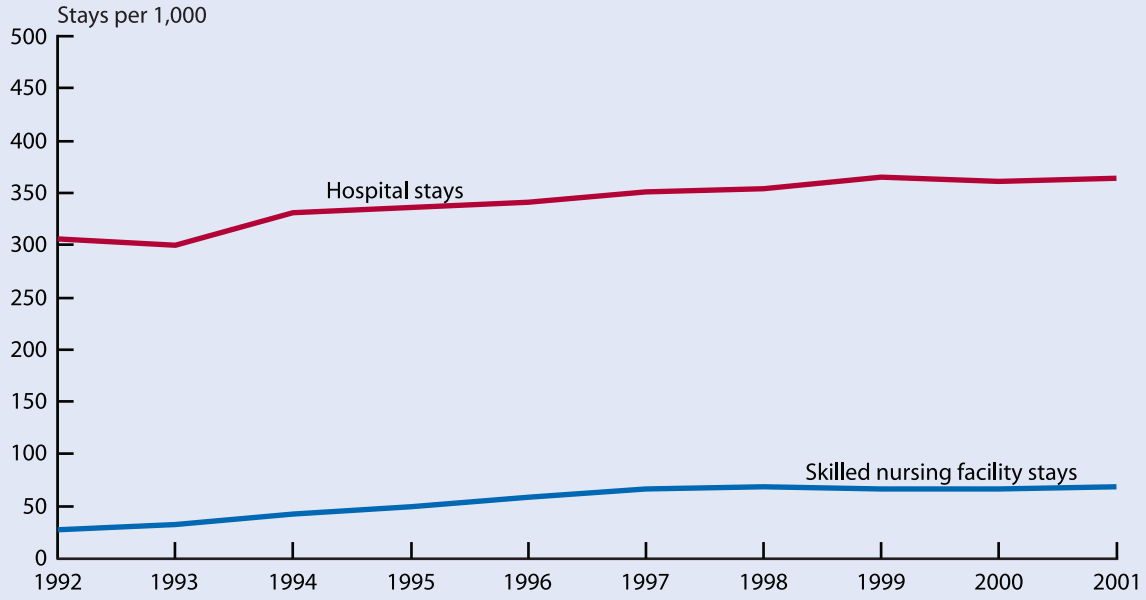
INDICATOR 28

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, and hospice services. Utilization rates for many services change over time because of changes in physician practice patterns, medical technology, Medicare payment amounts, and patient demographics.

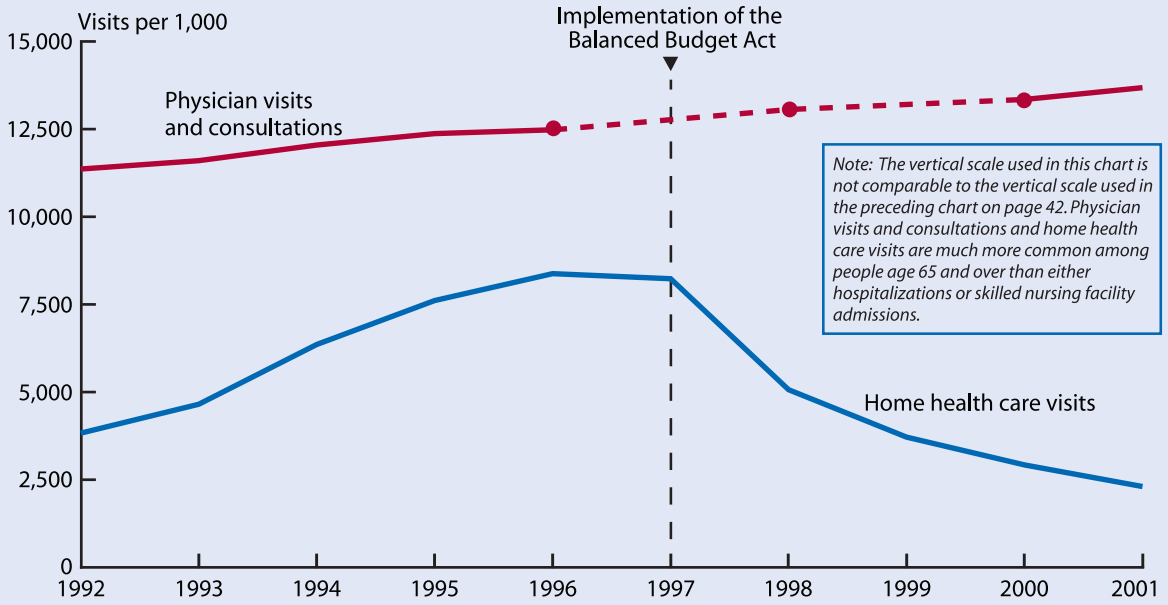
Medicare-covered hospital and skilled nursing facility stays per 1,000 Medicare enrollees age 65 and over in fee-for-service, 1992-2001



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

- Between 1992 and 1999 the hospitalization rate increased from 306 hospital stays per 1,000 Medicare enrollees to 365 per 1,000. The hospitalization rate remained essentially the same in 2000 and 2001. The average length of a hospital stay decreased from 8 days in 1992 to 6 days in 2001.
- Skilled nursing facility stays increased significantly from 28 per 1,000 Medicare enrollees in 1992 to 69 per 1,000 in 2001. Nearly all of the increase occurred from 1992 to 1997.

Medicare-covered physician and home health care visits per 1,000 Medicare enrollees age 65 and over in fee-for-service, 1992-2001



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

Note: Data are for Medicare enrollees in fee-for-service only. Physician visits and consultations include all settings, such as physician offices, hospitals, emergency rooms, and nursing homes. Beginning in 1994, managed care enrollees were excluded from the denominator of all utilization rates because utilization data are not available for them. Prior to 1994, managed care enrollees were included in the denominators; they comprised 7 percent or less of the Medicare population.

Reference population: These data refer to Medicare enrollees.

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

- The number of physician visits and consultations also increased. There were 11,359 visits and consultations per 1,000 Medicare enrollees in 1992, compared with 13,685 in 2001.
- The number of home health care visits per 1,000 Medicare enrollees increased rapidly from 3,822 in 1992 to 8,227 in 1997. Home health care use increased during this period in part because of an expansion in the coverage criteria for the Medicare home health care benefit.[52] Home health care visits declined after 1997 to 2,295 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.
- Use of skilled nursing facility and home health care increased markedly with age. In 2001, there were 26 skilled nursing facility stays per 1,000 Medicare enrollees age 65-74, compared with 203 per 1,000 enrollees age 85 and over. Home health care agencies made 1,082 visits per 1,000 enrollees age 65-74, compared with 5,475 per 1,000 for those age 85 and over.

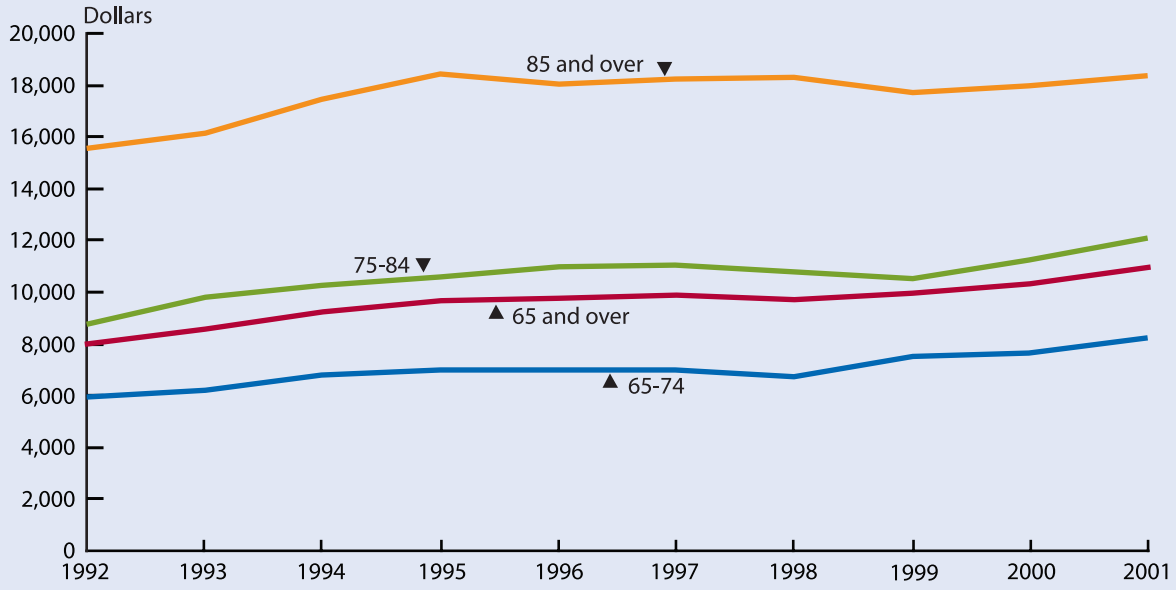
Data for this indicator's charts and bullets can be found in Tables 28a and 28b on page 101.

INDICATOR 29

Health Care Expenditures

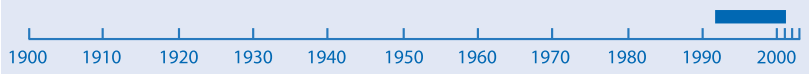
Older Americans use more health care than any other age group. Health care costs are increasing rapidly at the same time the Baby Boom generation is approaching retirement age.

Average annual health care costs for Medicare enrollees age 65 and over, in 2001 dollars, by age group, 1992-2001



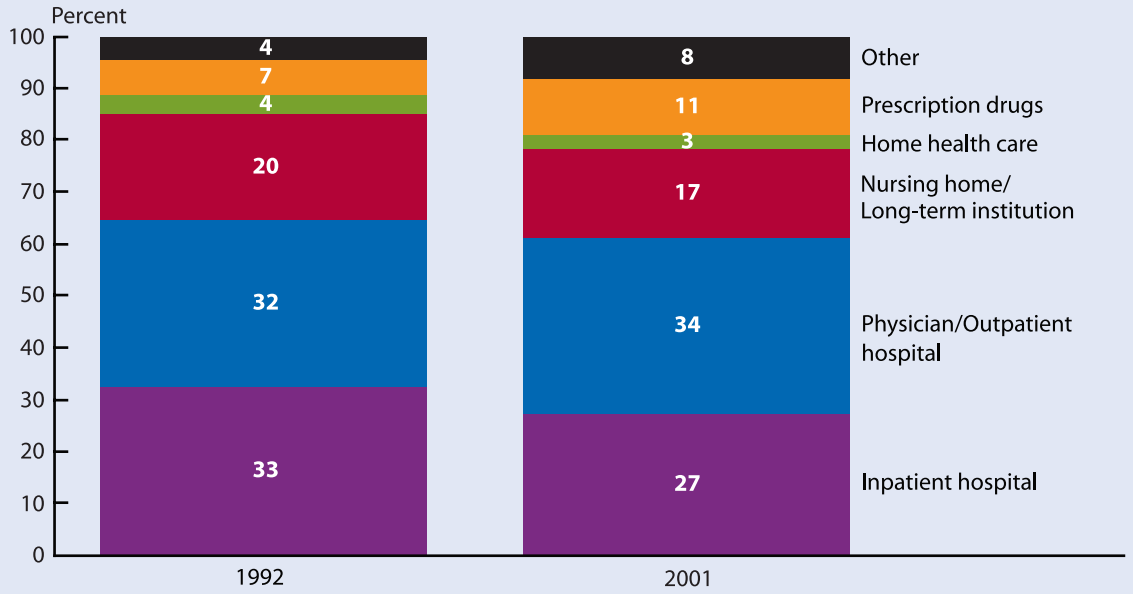
Note: Data include both out-of-pocket costs and costs covered by insurance. Dollars are inflation-adjusted to 2001 using the Consumer Price Index (Series CPI-U-RS).
Reference population: These data refer to Medicare enrollees.
Source: Centers for Medicare & Medicaid Services, Medicare Current Beneficiary Survey.

- After adjusting for inflation, health care costs increased significantly among older Americans from 1992 to 2001. Average costs were substantially higher with older ages.
- Average health care costs varied by demographic characteristics. Average costs among non-Hispanic blacks were $13,081 compared with $11,032 among non-Hispanic whites and $8,449 among Hispanics. Low income individuals incurred higher health care costs; those with less than $10,000 in income averaged $14,692 in health care costs whereas those with more than $30,000 in income averaged only $8,855.
- Costs also varied by health status. Individuals with no chronic conditions incurred $3,837 in health care costs on average. Those with five or more conditions incurred $15,784. Average costs among residents of nursing homes and other long-term care institutions were $46,810 compared with only $8,466 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 10 percent in 1992 to 5 percent in 1997 and remained relatively constant thereafter. The percentage who reported difficulty obtaining care varied between 2 percent and 3 percent.



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 2001



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 & Medicaid Services, Medicare Current Beneficiary Survey.

- Hospital and physician services were the largest components of health care costs. Nursing homes and other long-term care institutions accounted for 17 percent of total costs in 2001. Prescription drugs accounted for about 11 percent of health care costs.
- The mix of health care services changed between 1992 and 2001. Inpatient hospital care accounted for a lower share of costs in 2001 (27 percent compared with 33 percent in 1992). Prescription drugs increased in importance from 7 percent of costs in 1992 to 11 percent in 2001. "Other" costs (short-term institutions, hospice services, and dental care) also increased as a percentage of all costs (from 4 percent to 8 percent).
- The mix of services varied with age. The biggest difference occurred for nursing home and long-term institutional services; average costs were $6,968 among people age 85 and over, compared with just $516 for 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.

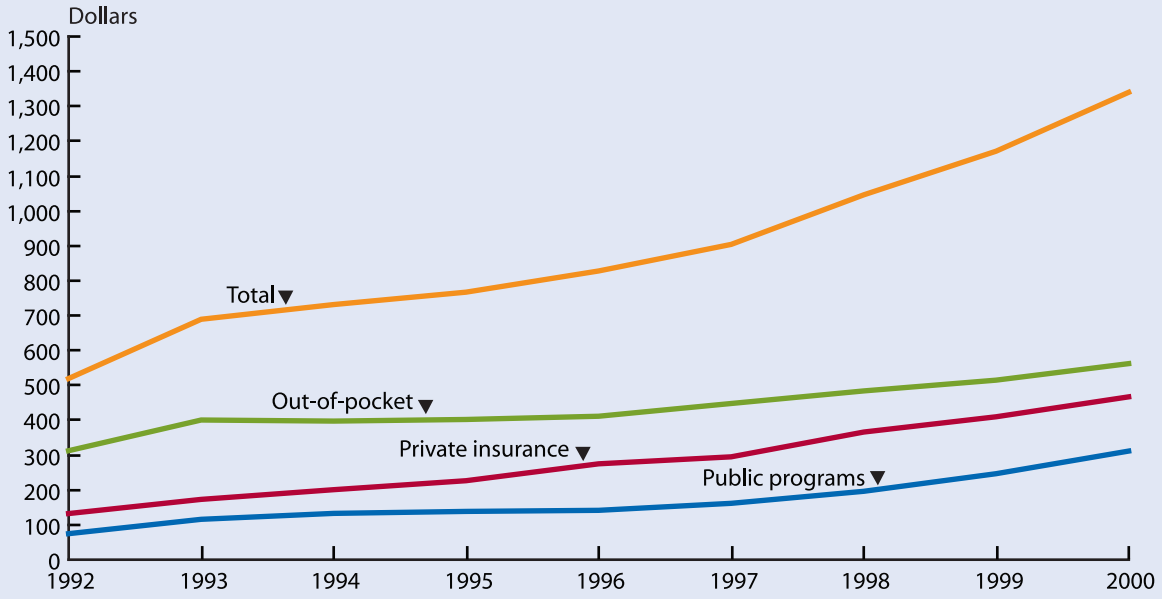
Data for this indicator's charts and bullets can be found in Tables 29a, 29b, 29c, 29d, and 29e on pages 101-103.

INDICATOR 30

Prescription Drugs

Prescription drug costs have increased rapidly in recent years, as more new drugs have become available. Lack of prescription drug coverage creates a financial hardship for many older Americans. Medicare currently does not cover most outpatient prescription drugs, although Medicare-approved prescription drug discount cards have recently become available. Medicare coverage of prescription drugs will begin in 2006.

Average annual prescription drug costs and sources of payment among noninstitutionalized Medicare enrollees age 65 and over, 1992-2000

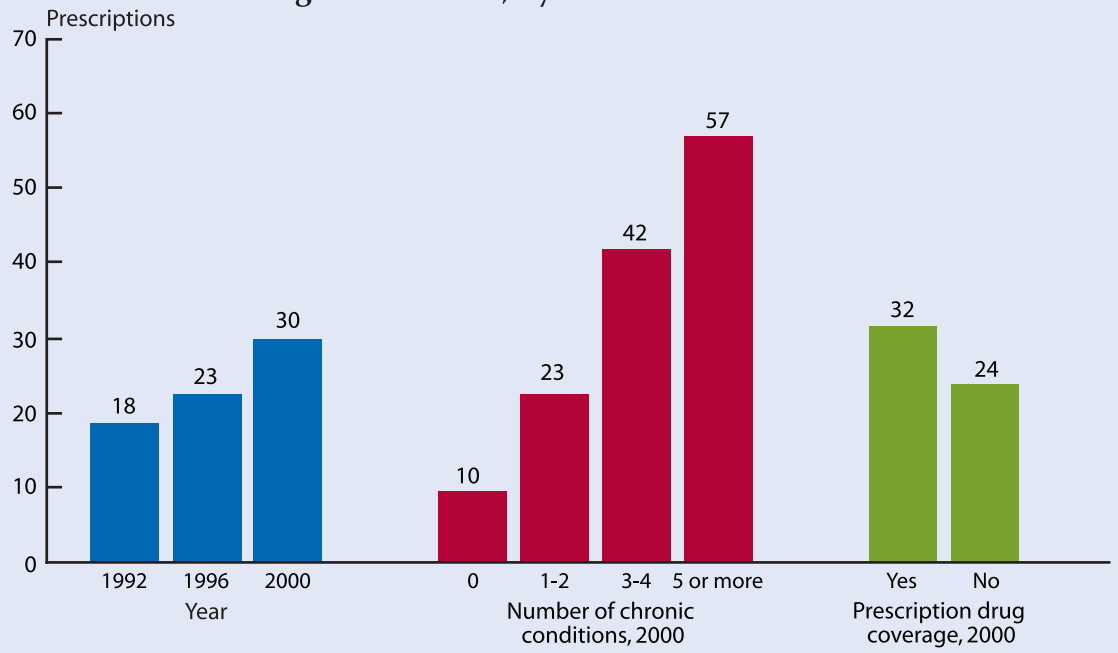


Note: Dollars have been inflation-adjusted to 2000 using the Consumer Price Index (Series CPI-U-RS). Public programs include Medicare, Medicaid, Department of Veterans Affairs, and other State and Federal programs.
Reference population: These data refer to Medicare enrollees.
Source: Centers for Medicare & Medicaid Services, Medicare Current Beneficiary Survey.

- Average prescription drug costs for older Americans increased rapidly throughout the 1990s, especially after 1997. Average costs per person were $1,340 in 2000.
- Average out-of-pocket costs also increased, though not as rapidly as total costs because more Medicare enrollees had supplemental drug coverage. Older Americans paid 60 percent of prescription drug costs out of pocket in 1992, compared with 42 percent in 2000. Private insurance covered 35 percent of prescription drug costs in 2000; public programs covered 23 percent.
- Costs varied significantly among individuals. Approximately 9 percent of older Americans incurred no prescription drug costs in 2000. Conversely, over 17 percent incurred prescription drug costs of $2,000 or more in that year.

Use of prescription drugs varies significantly by individual characteristics, including whether the person has prescription drug coverage. Those with multiple chronic conditions tend to be especially heavy users of prescription drugs.

Average annual number of filled prescriptions among noninstitutionalized Medicare enrollees age 65 and over, by selected characteristics



Note: Chronic conditions include cancer (other than skin cancer), stroke, diabetes, heart disease, hypertension, arthritis, and respiratory conditions (emphysema, asthma, chronic obstructive pulmonary disease). Prescription drug coverage includes people with partial year coverage. The number of filled pescriptions counts each refill separately.
Reference population: These data refer to Medicare enrollees.
Source: Centers for Medicare & Medicaid Services, Medicare Current Beneficiary Survey.

- The average number of filled prescriptions for older Americans increased from 18 prescriptions in 1992 to 30 prescriptions in 2000.
- Use of prescription drugs was much higher for individuals with multiple chronic conditions. People with no chronic conditions averaged 10 filled prescriptions in 2000; those with 5 or more conditions averaged 57 prescriptions.
- Prescription drug coverage was associated with a higher level of prescription drug use. In 2000, older Americans with prescription drug coverage averaged 32 filled prescriptions; those without drug coverage averaged 24 prescriptions.
- Lower income individuals used more prescription drugs. Those reporting an income of $10,000 or less in 2000 averaged 33 filled prescriptions; those reporting an income of $30,001 or more averaged 26 prescriptions.
- Prescription drug coverage was lower among older age groups, ranging from 79 percent of people age 65-74 to 72 percent of those age 85 and over. Medicare enrollees with incomes of $10,001-$20,000 had the lowest percentage with coverage (73 percent). The lowest income group (less than $10,001) had a slightly higher percentage with coverage (77 percent) because of eligibility for Medicaid.

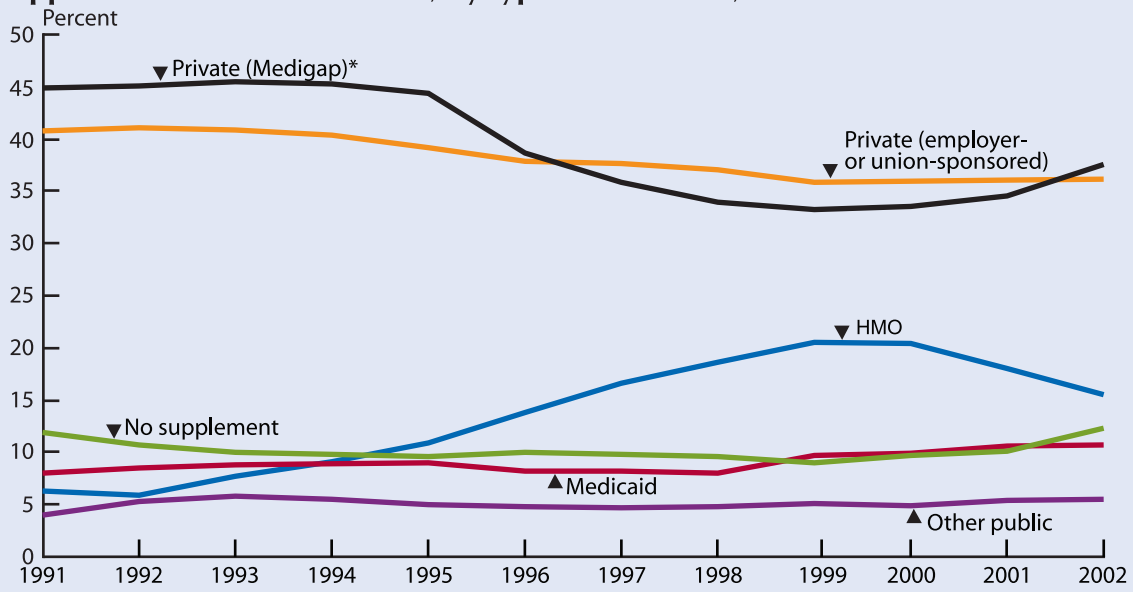
Data for this indicator's charts and bullets can be found in Tables 30a, 30b, 30c, and 30d on pages 103-105.

INDICATOR 31

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 to obtain services not covered by Medicare.

Percentage of noninstitutionalized Medicare enrollees age 65 and over with supplemental health insurance, by type of insurance, 1991-2002



*Includes people with private supplement of unknown sponsorship.

Note: 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 percent of enrollees).

Reference population: These data refer to Medicare enrollees.

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

- Most Medicare enrollees have a private insurance supplement, about equally split between employer-sponsored and Medigap-type policies. About 10 percent have Medicaid, and about 10 percent have no supplement. Enrollment in Medicare HMOs, which are usually equivalent to Medicare supplements because of their benefit structures, varied from 6 percent to 21 percent.
- HMO enrollment increased rapidly throughout the 1990s, then decreased beginning in 2000, as many HMOs withdrew from the Medicare program. The percentage with Medigap policies decreased in the late 1990s, then increased as enrollment in HMOs declined. The percentage of Medicare enrollees without a supplement was relatively constant but increased slightly in 2002 to 12 percent.
- While almost all older Americans have health insurance via Medicare, a significant proportion of people younger than age 65 have no health insurance. In 2002, 12 percent of people age 55-64 were uninsured. The percentage of people under age 65 not covered by health insurance varies by poverty status. In 2002, 28 percent of people age 55-64 who lived below the poverty level had no health insurance compared to 7 percent of people who had incomes greater than or equal to 200 percent of the poverty threshold.

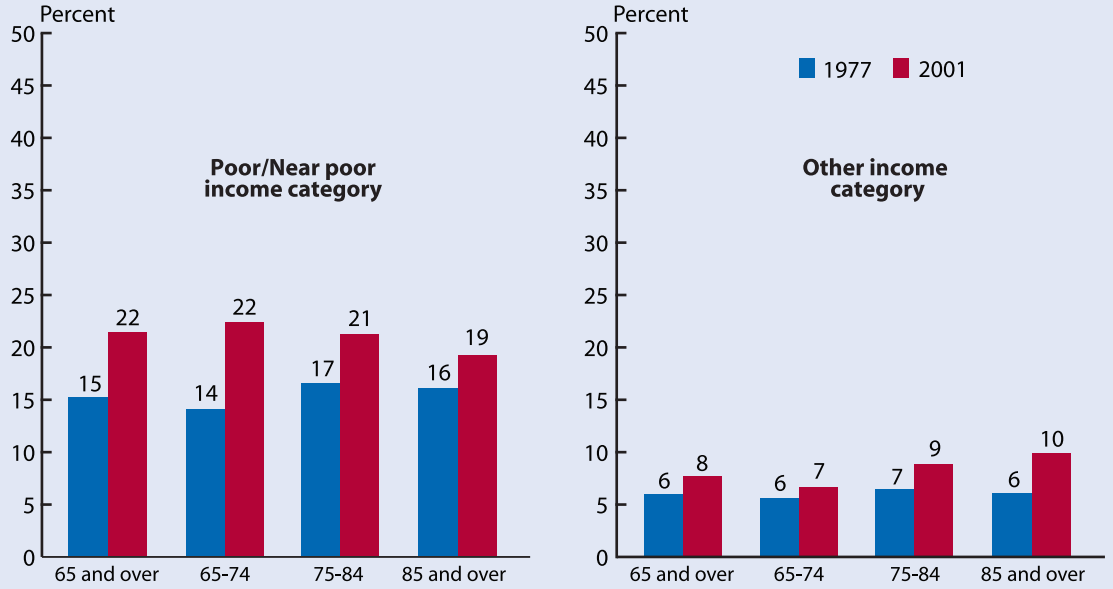
Data for this indicator's chart and bullets can be found in Tables 31a and 31b on pages 105 and 106.

INDICATOR 32

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.[53,54] The percentage of household income that is allocated to health care expenditures is a measure of health care expense burden placed on older people.

Out-of-pocket health care expenditures as a percentage of household income, among people age 65 and over,* by age and income category, 1977 and 2001



*Includes only people with out-of-pocket expenditures.

Note: Out-of-pocket health care expenditures exclude personal spending for health insurance premiums. Including expenditures for out-of-pocket premiums in the estimates of out-of-pocket spending would increase the percentage of household income spent on health care in all years. People are classified into the "poor/near poor" income category if their household income is below 125 percent of the poverty level; otherwise, people are classified into the "other" income category. The ratio of a person's out-of-pocket expenditures to their household income was calculated based on the person's per capita household income. For people whose ratio of out-of-pocket expenditures to income exceeded 100 percent, the ratio was capped at 100 percent.

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 2001 (83 percent to 95 percent, respectively).
- From 1977 to 2001, the percentage of household income that people age 65 and over with out-of-pocket spending allocated to out-of-pocket spending for health care services increased among those in the poor/near poor income category, from 15 percent to 22 percent. Out-of-pocket spending allocations also increased among people in the poor/near poor income category age 65-74 and 75-84 and among people in the other income category age 65-74, 75-84, and 85 and over. Increases were also seen for those in poor or fair health age 65-74 (from 10 percent in 1977 to 13 percent in 2001).
- In 2001, people age 85 and over were less likely than people age 65-74 to spend out-of-pocket dollars on dental services or office-based medical provider visits but more likely to spend out-of-pocket dollars on other health care (e.g., home health care and eyeglasses). Fifty-six percent of out-of-pocket health care service spending by people age 65 and over was used to purchase prescription drugs.

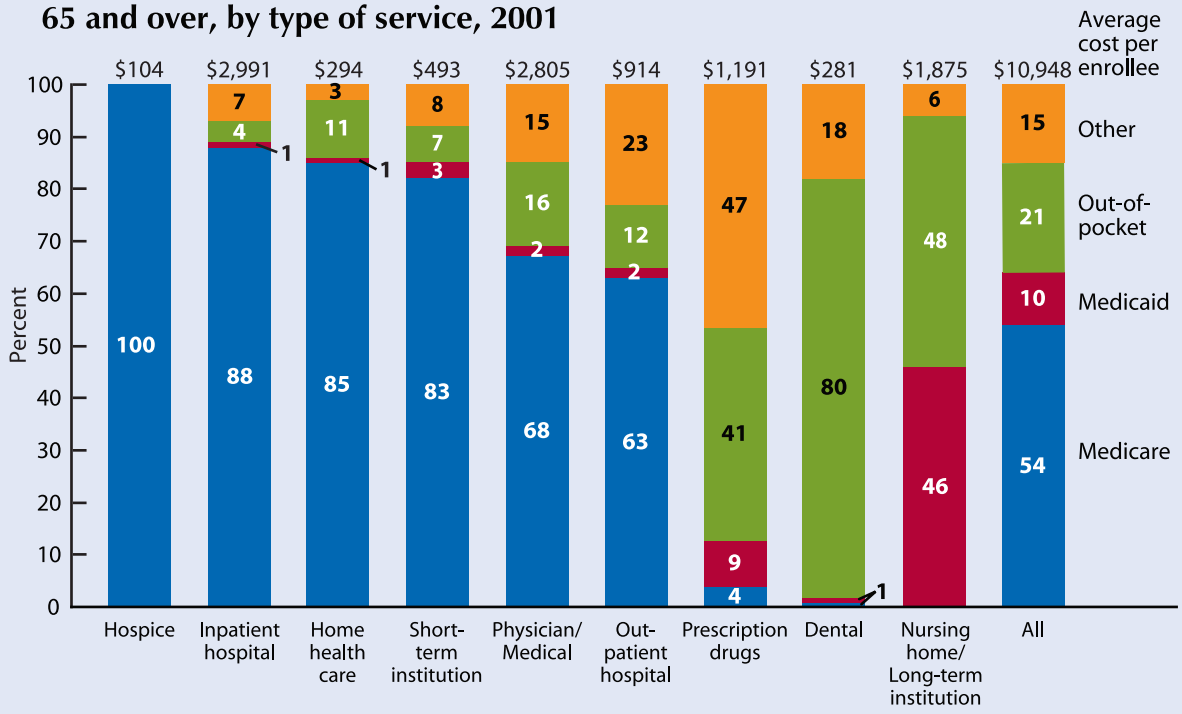
Data for this indicator's chart and bullets can be found in Tables 32a, 32b, and 32c on pages 106-108.

INDICATOR 33

Sources of Payment for Health Care Services

Medicare covers about half of the health care costs of older Americans. Medicare's payments are focused on acute care services such as hospitals and physicians. Nursing home care, prescription drugs, and dental care are primarily financed by other payers.

Sources of payment for health care services for Medicare enrollees age 65 and over, by type of service, 2001



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 & Medicaid Services, Medicare Current Beneficiary Survey.

- Medicare pays for slightly more than one-half (54 percent) of the health care costs of older Americans. Medicare finances most of their hospital and physician costs, as well as a majority of short-term institutional, home health, and hospice costs.
- Medicaid covers 10 percent of health care costs of older Americans, and other payers (primarily private insurers) cover another 15 percent. Older Americans pay 21 percent of their health care costs out of pocket.
- Forty-six percent of nursing home costs for older Americans are covered by Medicaid; another 48 percent of these costs are paid out of pocket. Forty-seven percent of prescription drug costs are covered by third party payers other than Medicare and Medicaid, consisting mostly of private insurers. Forty-one percent of prescription drug costs are paid out of pocket. About 80 percent of dental care received by older Americans is 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 percentage of health care costs out of pocket but use more services than individuals with higher incomes.

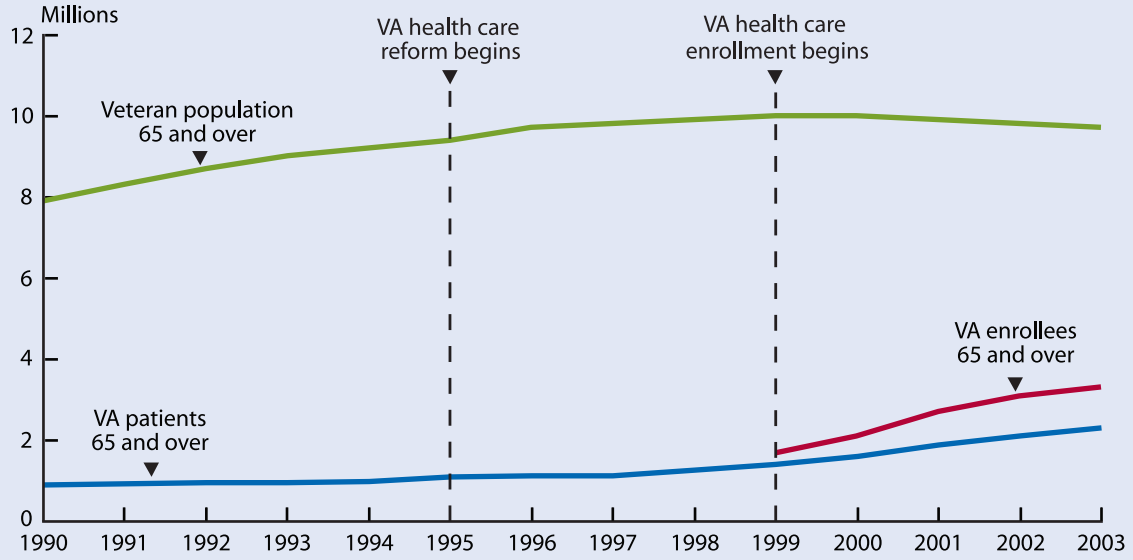
Data for this indicator's chart and bullets can be found in Tables 33a and 33b on pages 108 and 109.

INDICATOR 34

Veterans' Health Care

The number of veterans age 65 and over who receive health care from the Veterans Health Administration (VHA), within the Department of Veterans Affairs (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 prescription drug benefits, mental health services, long-term care (nursing home and community-based care), and specialized care for the disabled.

Total number of veterans age 65 and over who are enrolled in or receiving care from the Veterans Health Administration, 1990-2003



Note: Department of Veterans Affairs (VA) enrollees are veterans who have signed-up to receive health care from the Veterans Health Administration (VHA), and VA patients are enrollees who have received care in each year through VHA.
Reference population: These data refer to the total veteran population, VHA enrollment population, and VHA patient population.
Source: Department of Veterans Affairs, Office of the Actuary, Vet Pop 2001 adjusted by Census 2000, February 2003; VHA Enrollment and Patient Files.

- In 2003, approximately 2.3 million veterans age 65 and over received health care from VHA. An additional 1 million older veterans were enrolled to receive health care from VHA but did not use its services that year.
- Reforms and initiatives implemented by VA since 1995 have led to an increased demand for VHA health care services despite the short-term decline in the number of older veterans (see "Indicator 6: Older Veterans"). Some of those changes include: opening the system to all veterans (1995); implementing enrollment for VHA health care (1999); and reducing inpatient care with increased access to outpatient care and other services.
- An increasing number of older veterans are turning to VHA for their health care needs despite their potential eligibility for other sources of health care. VHA estimates that 91 percent of its patients age 65 and over are covered by Medicare Part A, 83 percent by Medicare Part B, 48 percent by Medigap, 8 percent by Medicaid, 14 percent by private insurance (excluding Medigap), and 7 percent by TRICARE for Life. About 4 percent have no public or private coverage at all.[55]

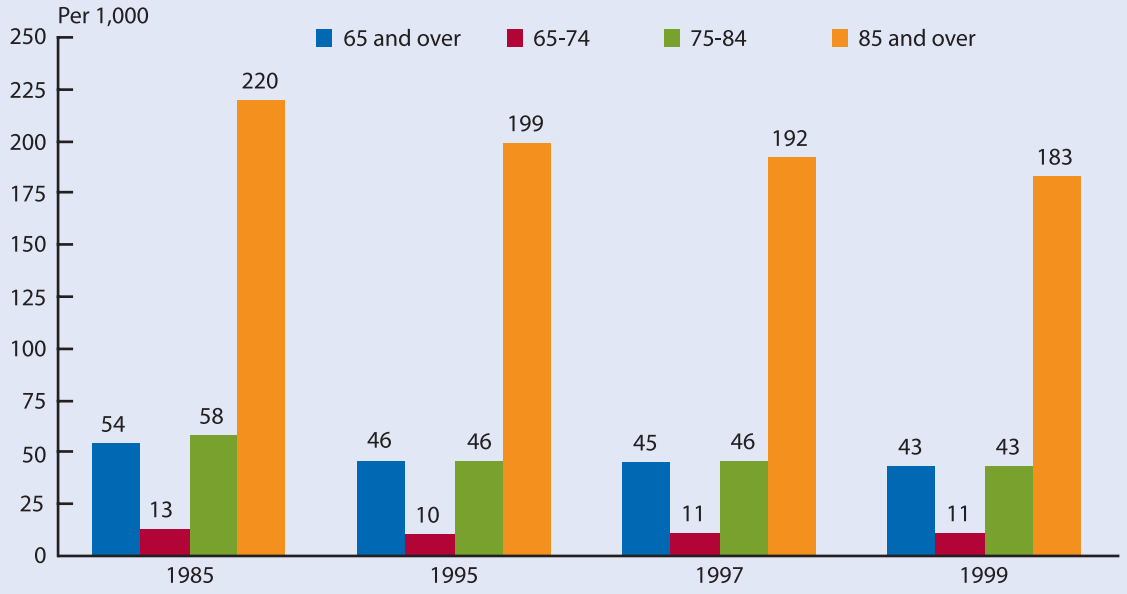
Data for this indicator's chart and bullets can be found in Table 34 on page 109.

INDICATOR 35

Nursing Home Utilization

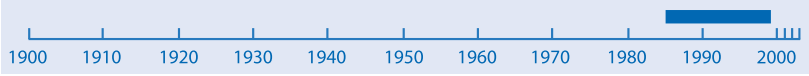
Residence in a nursing home is an alternative to long-term care provided in one's home or in other community settings. Recent declines in rates of nursing home residence may reflect broader changes in the health care system affecting older Americans. Other forms of residential care and services, such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

Rate of nursing home residence among people age 65 and over, by age group, 1985, 1995, 1997, and 1999

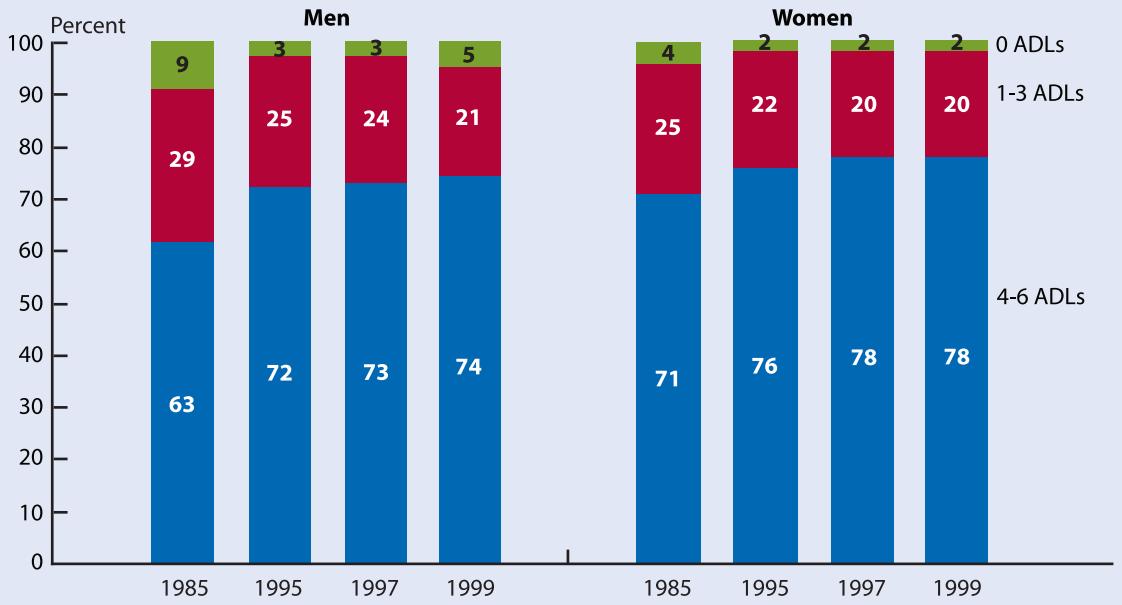


Note: Beginning in 1997, population figures are adjusted for net underenumeration using the 1990 National Population Adjustment Matrix from the U.S. Census Bureau. People residing in personal care or domiciliary care homes are excluded from the numerator.
Reference population: These data refer to the resident population.
Source: Centers for Disease Control and Prevention, National Center for Health Statistics, National Nursing Home Survey.

- In 1999, 11 people per 1,000 age 65-74 resided in nursing homes, compared with 43 people per 1,000 age 75-84 and 183 people per 1,000 age 85 and over.
- The total rate of nursing home residence among the older population declined between 1985 and 1999. In 1985, the age-adjusted nursing home residence rate was 54 people per 1,000 age 65 and over. By 1999 this rate had declined to 43 people per 1,000. Among people age 65-74, rates declined by 14 percent, compared with a 25 percent decline among people age 75-84 and a 17 percent decline among the population age 85 and over.
- Despite the decline in rates of nursing home residence, the number of nursing home residents age 65 and over has been increasing because of the rapid growth of the older population. Between 1985 and 1999 the number of current nursing home residents age 65 and over increased from 1.3 million to 1.5 million. In 1999, almost three-fourths (1.1 million) of older nursing home residents were women.



Percentage of nursing home residents age 65 and over receiving assistance with activities of daily living, by sex, 1985, 1995, 1997, and 1999



Note: The six activities of daily living (ADLs) included are bathing, dressing, eating, walking, toileting, and transferring in and out of bed or chairs. The resident's receipt of assistance with these activities refers to personal help received from facility staff at the time of the survey (for current residents) or the last time care was provided (for discharges). Help that a resident may receive from people who are not staff of the facility (e.g., family members, friends, or individuals employed directly by the patient and not by the facility) is not included.

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

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

- The percentage of nursing home residents receiving assistance with functional limitations increased between 1985 and 1999. In 1985, 95 percent of all residents age 65 and over received assistance with one or more activities of daily living (ADLs). In 1999, 97 percent of residents received such assistance.
- Nursing home residents are receiving greater levels of care and assistance. The majority of nursing home residents receive assistance with 4-6 ADLs (77 percent in 1999). The increase in receipt of assistance between 1985 and 1999 is greatest among residents receiving this level of assistance.
- Among the nursing home population, women are more likely than men to receive assistance with daily activities. In 1999, 5 percent of men who were nursing home residents did not receive assistance with any ADL. Less than half that many women received no such assistance (2 percent). This gender gap has narrowed over time, however. The increase over time in receipt of assistance for 4-6 ADLs is greatest among men.
- The latest data show few differences between Hispanics and non-Hispanics in the level of care received with ADLs and small differences between whites and blacks. Between 1985 and 1999, declines in the percentage receiving care with 0 and with 1-3 ADLs occurred for both white and black residents. Increases in the receipt of assistance occurred, however, for those requiring care with 4-6 ADLs—between 1985 and 1999, an increase of 8 percentage points for whites and 5 percentage points for blacks.

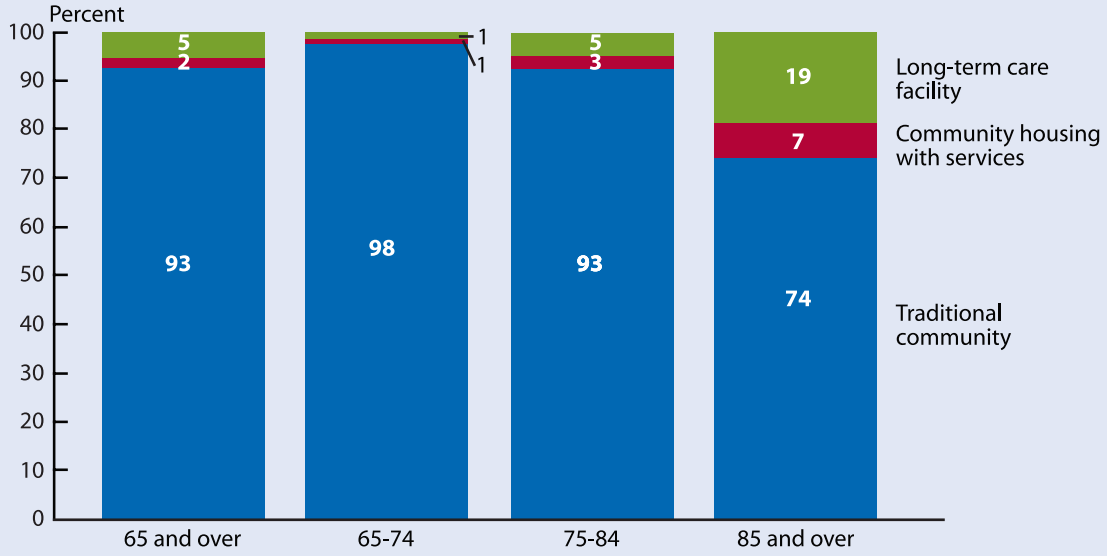
Data for this indicator's charts and bullets can be found in Tables 35a, 35b, and 35c on pages 110 and 111.

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 residing in selected residential settings, by age group, 2002



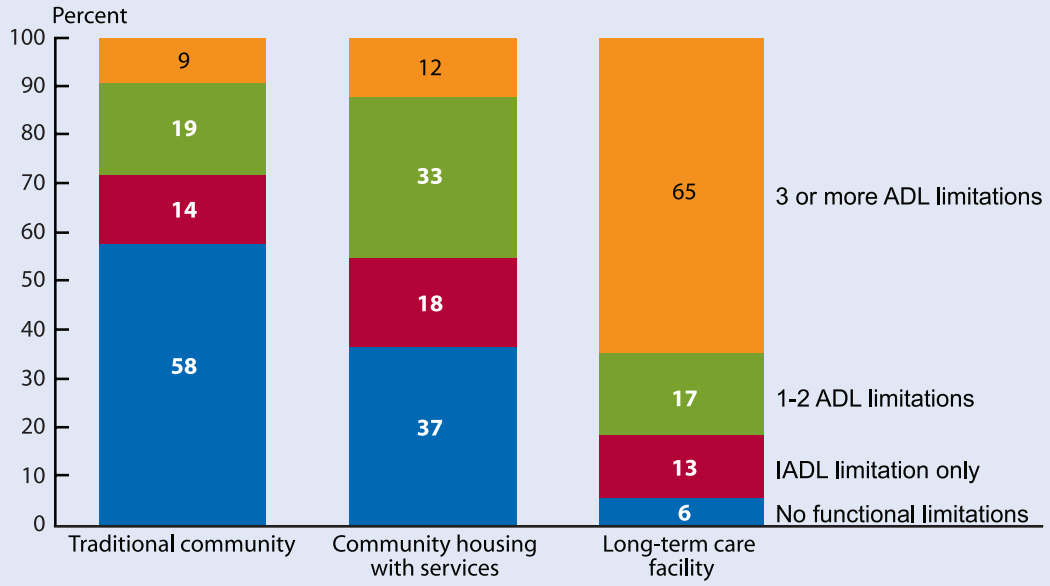
Note: Community housing with services applies to respondents who reported they lived in retirement communities or apartments, senior citizen housing, continuing care retirement facilities, assisted living facilities, staged living communities, board and care facilities/homes, and other similar situations, 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 is considered a long-term care facility if it is certified by Medicare or Medicaid; or has 3 or more beds and is licensed as a nursing home or other long-term care facility and provides at least one personal care service; or provides 24-hour, 7-day-a-week supervision by a caregiver.

Reference population: These data refer to Medicare enrollees.

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

- In 2002, 2 percent of the Medicare population age 65 and over resided in community housing with at least one service available. Approximately 5 percent resided in long-term care facilities. The percentage of people residing in community housing with services and in long-term care facilities was higher for the older age groups; among individuals age 85 and over, 7 percent resided in community housing with services, and 19 percent resided in long-term care facilities. Among individuals age 65-74, 98 percent resided in traditional community settings.
- Among residents of community housing with services, 86 percent reported access to meal preparation services, 80 percent reported access to housekeeping/cleaning services, 68 percent reported access to laundry services, and 47 percent reported access to help with medications. These numbers reflect percentages reporting availability of specific services but not necessarily the number that actually used these services.
- More than half of residents in community housing with services (53 percent) reported that there were separate charges for at least some services.

Percentage of Medicare enrollees age 65 and over with functional limitations, by residential setting, 2002



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 is considered a long-term care facility if it is certified by Medicare or Medicaid; or 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. 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. 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-five percent of individuals living in community housing with services had at least one activity of daily living (ADL) limitation compared with 28 percent of traditional community residents. Among long-term care facility residents, 81 percent had at least one ADL limitation. Thirty-seven percent of individuals living in community housing with services had no ADL or instrumental activity of daily living (IADL) limitations.
- The availability of personal services in residential settings may explain some of the observed decline in nursing home use. (See "Indicator 35: Nursing Home Utilization.")
- Residents of community housing with services tended to have slightly lower incomes than traditional community residents but higher incomes than long-term care facility residents. Almost one-quarter (24 percent) of residents of community housing with services had incomes of $10,000 or less in 2002, compared with 17 percent of traditional community residents and 43 percent of long-term care facility residents.
- Over one-half (53 percent) of people living in community housing with services reported they could continue living there if they needed substantial care.

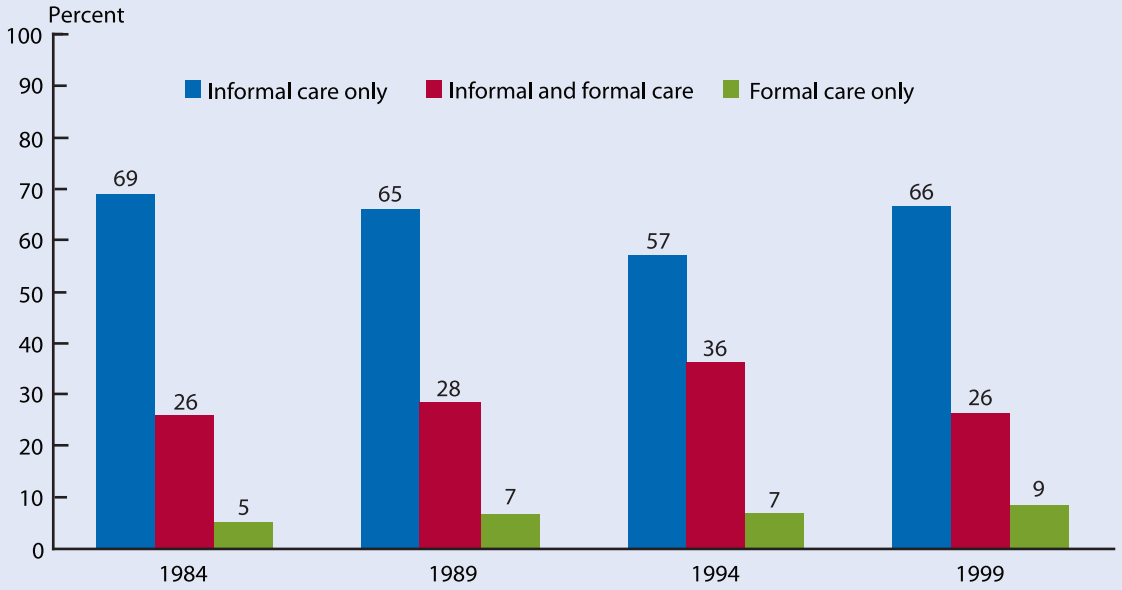
Data for this indicator's charts and bullets can be found in Tables 36a, 36b, 36c, 36d, and 36e on pages 112-114.

INDICATOR 37

Caregiving and Assistive Device Use

Although most long-term care spending in the United States is for nursing home and other institutionalized care, the majority of older people with disabilities live in the community and receive assistance from spouses, adult children, and other family members. Most of this care is unpaid, although an increasing number of older Americans with disabilities rely on a combination of unpaid and paid long-term care.

Distribution of Medicare enrollees age 65 and over receiving personal care for a chronic disability, by type of care, 1984, 1989, 1994, and 1999

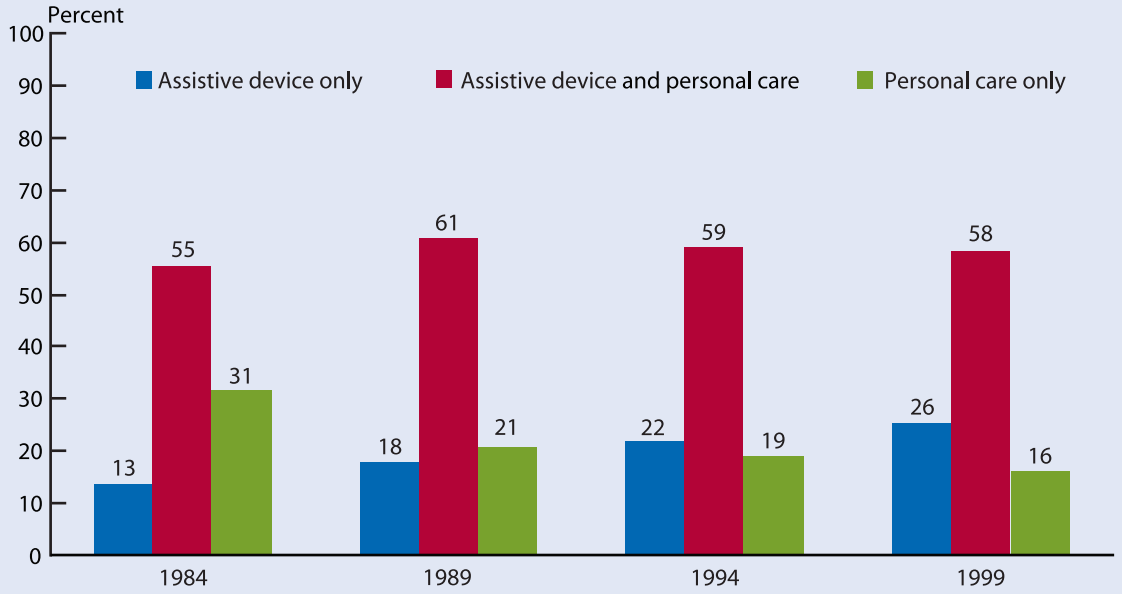


Note: Informal care refers to unpaid assistance provided to a person with a chronic disability living in the community. Formal care refers to paid assistance.
Reference population: These data refer to Medicare enrollees living in the community who report receiving personal care from a paid or unpaid helper for a chronic disability.
Source: National Long Term Care Survey.

- The percentage of older Americans who received personal care from a paid or unpaid source for a disability declined from 15 percent in 1984 to 11 percent in 1999. The number of older Americans who received such care also declined from 4.1 million to 3.7 million over this period.
- The proportion of older people with disabilities who received informal care, either alone or in combination with some formal care, exceeded 90 percent in all 4 years, although this proportion declined from 95 percent in 1984 to 92 percent in 1999.
- The use of informal care as an exclusive means of assistance declined between 1984 and 1994 from 69 percent to 57 percent and increased to 66 percent in 1999. This upward shift between 1994 and 1999 in reliance upon informal care only is accompanied by a decline in the use of both informal and formal care from 36 percent in 1994 to 26 percent in 1999.
- There was an increase in the proportion of older Americans with disabilities who rely solely on formal care for their personal assistance needs, rising from 5 percent in 1984 to 9 percent in 1999.

Possible reasons for the decline in the use of 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 older disabled people living in the community maintain their independence.

Distribution of Medicare enrollees age 65 and over using assistive devices and/ or receiving personal care for a chronic disability, 1984, 1989, 1994, and 1999



Note: Personal 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 enrollees living in the community who report receiving personal care from a paid or unpaid helper, or using assistive devices, or both, for a chronic disability.
Source: National Long Term Care Survey.

- The percentage of older Americans who either receive personal care or use assistive devices for a disability declined from 17 percent in 1984 to 15 percent in 1999. This occurred even though the number of these older Americans increased slightly from 4.7 million to 5 million over this period.
- Among older Americans who either receive personal care or use assistive devices for a disability, the proportion of those using an assistive device only increased from 13 percent to 26 percent while the proportion of those receiving personal care only declined from 31 percent to 16 percent between 1984 and 1999.
- Between 1984 and 1999, the proportion of people with lower levels of disability (limitations in 1-2 ADLS or in IADLs only) who were using assistive devices only increased while the proportion receiving personal care only decreased. In 1984, 14 percent of those with IADL limitations only and 22 percent of those with 1-2 ADL limitations used an assistive device only. The corresponding percentages in 1999 were 31 percent and 44 percent, respectively.

Data for this indicator's charts and bullets can be found in Tables 37a, 37b, 37c, and 37d on pages 114-116.