

Council on Children & Families

A Research Brief on the Status of Older Adults in New York State

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HEALTH OF OLDER ADULTS IN NEW YORK

In Greek mythology, Tithonus was a mortal who fell in love with Eos, the goddess of dawn. When Eos realized her beloved would age and die, she begged Zeus to grant him immortal life. Zeus granted Tithonus immortality, but did not grant him eternal youth, leaving Tithonus to age for eternity.

New Yorkers, like Tithonus, are living longer and, naturally, this longevity brings with it concern regarding the quality of one's life during those additional years. Older adults, generally optimistic about aging (1), recognize good health is a key contributor to vital aging and, in fact, nine in ten individuals 65 years or older feel that taking care of one's health is paramount to improving the quality of life as one ages (2). This research brief examines the physical wellbeing of New Yorkers 50 years and older, focusing on personal decisions and public policies that contribute to the ability of older adults to age well and remain in good health.

Health Status of Older Adults—

The percent of individuals 50 years and older describing their health as 'very good' or 'excellent' declined from 1994 to 2002¹, particularly among men 65 to 74 years old. Considerable disparities in health ratings were observed between members of minority and non-minority groups.

- In 2002, 43 percent of New Yorkers 50 years and older rated their health as 'very good' or 'excellent.' The favorable ratings reflected a 10 percent decline from 1994 when about half (48%) the individuals in this age group described their health favorably.
- A drop in favorable ratings was observed for both men and women with the greatest decrease noted among men 65 to 74 years old (48% rated health 'very good' or 'excellent' in 1994 compared to 39% in 2002).
- About 3 in 8 Hispanic individuals (38%) rated their health as 'very good' or 'excellent' in 1994 and this decreased to 2 in 8 (25%) in 2002.
- One in 4 individuals 50 years and older rated their health as 'fair' or 'poor' with noticeable differences between minority and non-minority groups. About one in three African Americans (34%) rated their

¹Data reported in this brief are drawn from National Center for Health Statistics Data Warehouse on Trends in Health and Aging, available online at www.cd.gov/nchs/agingact.htm. Data points reported reflect the mid-year of three-year averages (i.e., 1994 data are based on three-year averages of 1993 to 1995 data; 2002 data are based on three-year averages for 2001 to 2003 and so on).

health unfavorably and one in two Hispanic individuals (53%) did likewise as compared to about one in five (21%) non-minority members.

Self-reports of health status are important for policy and program planners for a number of reasons. First, these indicators provide a composite measure of individuals' well-being and allow us to assess older adults' level of physical ability, functional assessment and severity of health problems (3). Second, individuals' perceptions of health are linked to mortality and functional ability, even after controlling for objective health measurements, levels of education and demographic indicators (4, 5, 6). Lastly, perceptions of health status are related to healthcare needs and service utilization (7), which, in turn, can influence the aging experience for individuals and is of particular concern given the health disparities observed across racial groups of older adults in New York state.

Modifiable Risk Factors

It has been shown that age-related diseases such as arthritis, dementia, diabetes, heart disease, high blood pressure, and various cancers can be offset by healthful lifestyle decisions (8, 9, 10). Healthy behaviors that include adequate physical activity, being within a healthy weight range, and not smoking decrease the likelihood of developing debilitating chronic conditions as we age and can delay disability up to 10 years (8, 9, 10, 11).

Physical Activity—

Greater physical activity was reported among individuals in all age groups.

- Physical activity occurred at higher rates among adults in all age groups. In 2002, almost seven in ten individuals 50 years and older (69%) reported they participate in physical activity². This reflects a 19 percent change from 1995 when 58 percent reported being active.
- Both men and women reported an increase in physical activity with the greatest increase among women 50 to 64 years.
- Members of minority and non-minority groups reported an increase in physical activity from 1995 to 2002; however, members of minority groups are less likely than non-minority members to participate in physical activity. This discrepancy was consistent across all age categories (50 to 64; 65 to 74; 75 years and older).

Numerous medical benefits are associated with regular physical activity. These benefits include increased longevity, reduction in strokes, protection from Parkinson's disease, higher physical health scores, improved sleep and cognition, positive mental health, reduction in heart disease, hypertension, diabetes and arthritis (12, 13, 14, 15, 16). Additionally, routine exercise is tied to increased balance and flexibility, which can help prevent falls (17)—the cause of death in 2001 for 15.8 per 100,000 New Yorkers 50 years or older (18). Individuals who exercise regularly experience less muscle and joint pain in older age than less active individuals (19), pointing to the need for strategies that promote active lifestyles among younger New Yorkers. In 2003, approximately 65 percent of New York's high school students reported they participated in strenuous physical exercise or at least three days within a given 7 day period (20).

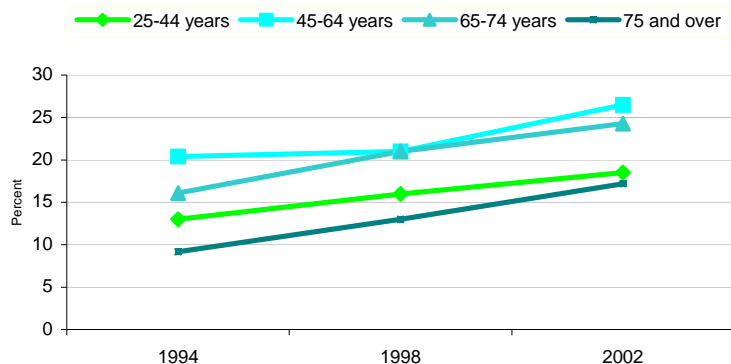
² Respondents were asked the question: " In the past 2 weeks have you done any of the following exercises, sports, or physically active hobbies?"

Healthy Weight—

Obesity rates increased despite a rise in physical activity—about one in four individuals 50 years or older is obese.

- From 1994 to 2002, the percent of adults 50 years and older identified as obese³ increased 44 percent, from about one in six individuals (17%) to one in four (24%). During this time period, an increase in obesity was observed in all age groups, with the greatest change among individuals who were least likely to be obese—individuals 75 years and older. The percent of adults in this age group who are obese shifted from 9 percent in 1994 to 17 percent in 2002. (Figure 1).
- The rise in obesity was observed among both genders and all major racial groups (Caucasian, African American, and Hispanic).
- With regard to gender, the greatest percent change was seen among women 75 years and older (9% obese in 1994 compared to 20% in 2002—a 114 percent change).
- With respect to racial groups, Hispanic individuals who are 50 years and older show the greatest percent increase during the 8-year period, more than doubling the percent of individuals identified as obese (an increase from 14 to 32 percent).
- African American individuals tend to have the highest percent of individuals 50 years and older identified as obese (36%). This pattern is consistent in all age categories, including individuals 25 to 44 years old (29% obese).
- Increasing obesity rates are also observed among New Yorkers' younger residents. Approximately one in five (19%) New Yorkers 25 to 44 years was identified as obese in 2002—a 42 percent increase from 1994 when about one in eight (13%) was classified as such (Figure 1). Results of a 2001 survey of high school students indicate 16 percent of male students and five percent of female students were overweight (21).

Figure 1. Obesity Among New York Adults



Source: National Center for Health Statistics, Data Warehouse on Trends in Health and Aging, BRFSS Data, <http://www.cdc.gov/nchs/agingact.htm>.

Obesity can increase one's chance of having hypertension or high blood cholesterol—major risk factors for two leading causes of death in New York state. This modifiable risk factor has been linked to diabetes, cardiovascular disease, physical disabilities and various cancers. (10, 22, 23). Additionally, the increases seen in Americans' life expectancy may be offset by five years due to the rising rates of obesity (24, 25).

Obesity rates also impact healthcare costs. Obese adults have higher mean inpatient expenses; the highest mean prescribed medicine expenses; and higher mean total expenses when compared to adults classified as normal- or overweight (26). It has been estimated that health care costs of obese individuals increases 36 percent and medication costs by 77 percent when compared to individuals with normal range weight (27).

³ Obesity is determined by one's body mass index. (BMI). BMI is calculated as an individual's weight in pounds divided by height in inches squared, multiplied by 703. Persons with a body mass index of 25.0 to 29.9 are considered overweight; those with a BMI equal to or greater than 30.0 are classified as obese.

Smoking—

About one in seven (15%) individuals 50 years and older currently smokes.

- In 2002, approximately 15 percent of individuals 50 years and older reported they smoked with another 37 percent identifying themselves as former smokers. Most smokers were in the age group of 50 to 64 year olds (20%).
- Women 50 years and older were more likely than their male counterparts to report they never smoked (55% of women compared to 36% of men). Almost half of the men in this age category reported they were former smokers (48%).
- Members of minority groups were least likely to smoke—about three in five members reported they never smoked.
- Between 1994 and 2002, little change was observed regarding any decline in smoking by age group, gender or race.
- Due to the addictive nature of smoking, policy efforts have been made to encourage young adults to never begin smoking. In 2000, one in four (26%) individuals 25 to 44 years old reported smoking, with the highest percentage of smokers among White individuals in this age group (29% compared to 22% among African American and Hispanic individuals). About 30 percent of men and 22 percent of women in this age group reported smoking. Additionally, results from a 2001 survey of New York high school students indicated 30 percent of students reported smoking cigarettes (21).

Tobacco use is the cause of 80 percent of deaths each year in the United States and cigarette smoking in particular has been identified as the single most preventable cause of premature death in the nation with deaths from chronic disease attributed primarily to cigarette smoking (21). Risk of death due to coronary heart disease was 52 percent greater among older individuals who smoke cigarettes than individuals who never smoked, those who quit, or current smokers of pipes or cigars. (28). When effects of alcohol and tobacco were compared, results indicated moderate alcohol consumption reduced the risk of mortality; however, tobacco use doubled such risk (29). While smoking is less likely among older individuals, the decline by age may be due to the fact that smoking is strongly linked to premature death (30).

The ill effects of smoking can be reduced if individuals quit. Heart disease and the risk of lung cancer decrease among older adults who quit smoking; however, risk reduction is greater among younger individuals who quit smoking, demonstrating the importance of prevention strategies directed toward all age groups (31).

Chronic Conditions and Disabilities

Chronic conditions are singled out as the major cause of illness, disability, and death in the United States (32). It is estimated the cost of chronic conditions will reach up to \$864 billion by 2040 with chronic conditions among older adults being more costly, disabling and difficult to treat (32). Although chronic conditions are among the most prevalent and costly diseases, they are also among the most preventable.

Workforce participation is another aspect of well-being influenced by chronic conditions. We have learned that labor force participation and earnings are lower among individuals with chronic conditions (33), two factors that influence the resources available to individuals as they age. Chronic conditions also impact family members since family members are the individuals most likely to modify their own lives to care for those with chronic conditions. Elderly caregivers who have a chronic illness themselves and experience stress related to their caregiving responsibilities have a 63 percent higher mortality rate than their non-caregiving peers (34). These supports are linked to overall healthcare costs since the strength or weakness of a disabled, chronically ill, or older person's informal support system is a better predictor of nursing home placement than that person's own physical or mental health status (35).

Diabetes—

About one in seven New York residents 50 years and older has been diagnosed with diabetes. This chronic condition is more common among men, members of minority groups, and older individuals within this age cohort.

- In 2002, approximately one in seven individuals 50 years and older (14%) reported being diagnosed with diabetes, with the highest percentage among the subgroup of individuals 75 years and older (17%). Individuals 75 years and older were 40 percent more likely to have diabetes than individuals 50 to 64 year olds.
- Men 50 years and older are somewhat more likely than women to report being diagnosed with diabetes (15% among men compared to 13% among women).
- During the period of 1994 to 2002, two groups showing the greatest increase in diagnoses were men 65 to 74 years old (increased from 11 to 19 percent) and women 75 years and older (increased from 9 to 16 percent).
- African American individuals 50 years and older are most likely to have diabetes (about 1 in 4) when compared to individuals who are White or Hispanic (about 1 in 10 and 1 in 5 respectively).

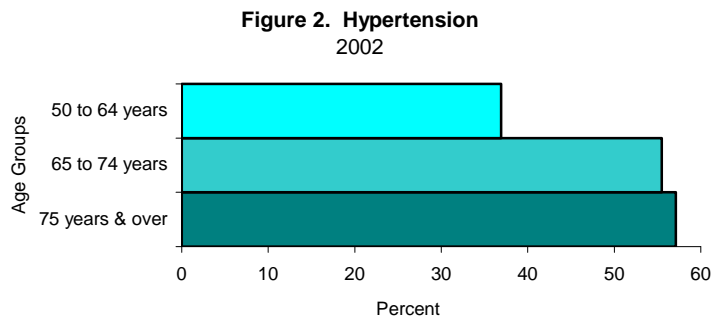
Diabetes can have a number of detrimental results, including permanent damage to blood vessels (36). Individuals with this condition are also at greater risk for bone fractures (37) and nursing home residents with this chronic condition are four times more likely to fall than non-diabetic residents (38).

Diabetes ranks second to hypertension as the condition for which most people visit a physician and it is estimated that one of every four Medicare dollars is spent on healthcare for individuals with diabetes (36). Higher levels of educational attainment are associated with greater treatment compliance while physical activity and reduction in overweight are two factors that actually can reduce the development of diabetes (39, 40).

Hypertension—

Hypertension, a condition for about four in nine individuals 50 years and older, is most common among older adults and members of minority groups.

- About one in every two members of a minority group has hypertension (African Americans 54%; Hispanics 51%)— rates higher than non-minority members (Caucasians 44%).
- Adults 75 years and older have the highest proportion of individuals with hypertension (Figure 2). The proportion of individuals 75 years and older with hypertension increased 37percent from 1994 to 2002.
- Individuals 75 years and older are 55 percent more likely than their younger cohorts of 50 to 64 year olds to have this chronic condition.



Source: National Center for Health Statistics, Data Warehouse on Trends in Aging—BRFSS Data, <http://www.cdc.gov/nchs/agingact.htm>

Hypertension is closely linked with risk of atherosclerosis (30). Treating hypertension in older patients significantly decreases the risks for stroke, heart attack, and cardiovascular death (41, 42). If left untreated, hypertension affects all organ systems and can shorten one’s life expectancy by 10 to 20 years (43). Risk factors for hypertension include being overweight, having high cholesterol, smoking and lack of exercise (10).

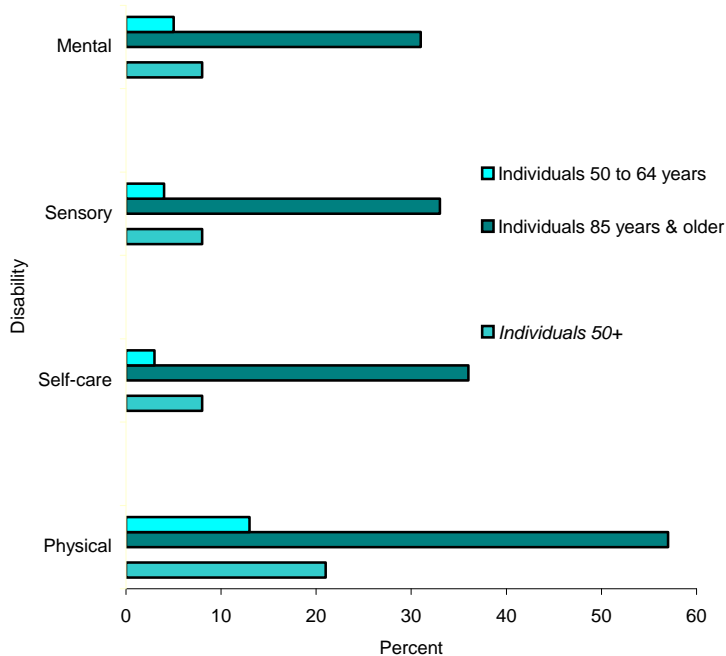
A comparison of health expenditures of individuals with and without hypertension indicates that annual median costs for adults with hypertension are four times greater than those without this chronic condition. The greatest expenditure differences for these two groups were related to prescription costs and hospital stays (43).

Disabilities Among Older Adults—

About one in three New Yorkers 50 years and older (34%) reports having a disability—typically a physical disability.

- A physical disability was the most frequently noted type of disability reported among individuals 50 years and older. About one in five adults (21%) has a physical disability and the likelihood of having *any* type of disability increases with age. For example, physical disabilities increase about four-fold from 13 percent among individuals 50 to 64 years up to 57 percent among individuals 85 years and older. Self-care disabilities increase 12-fold from 3 to 36 percent. (Figure 3.)
- While about one in four individuals 50 to 64 years old (27%) reports having a disability, this escalates to three in four (73%) among individuals 85 years and older.
- A higher percentage of women than men 85 years and older report having self-care disabilities (40% for women vs. 25% for men). This difference is considerable given that women in this age category outnumber men four to one. Additionally, women are more likely than men to live alone, making home-based services more necessary.
- Physical disabilities are higher among minority group members, particularly those in older age categories. For example, 41 percent of individuals 65 to 74 years who are members of a minority group report having a physical disability compared to 31 percent of their non-minority counterparts.

Figure 3. Types of Disabilities by Age Groups



Source: US Census Bureau, Census 2000 Public Use Microdata Sample (PUMS)

Individuals who experienced severe disabilities with daily living tend to have out-of-pocket medical expenses four times greater than individuals without such disabilities and expenses are greatest among

individuals who live alone (44). Most often these individuals are older women, who are more likely to have lower incomes. This group is least able to afford such expenses given that they have lower workforce participation rates and tend to assume the responsibilities and costs associated with care of other aging family members. Additionally, studies indicate older, disabled women are less likely than men to receive home care services (45), which have been linked with a reduction in admissions to long-term care (46).

Conclusion

The anticipated increase in the number of older adults in New York state will greatly impact public health services and our ability to deliver those services. CDC estimates that healthcare costs will increase 25 percent by 2030 (47) at which point one in every three New York residents will be 50 years or older (48). These expected changes raise concerns surrounding the ability of older adults to pay for healthcare. For instance, recent survey findings of individuals 50 years and older indicate that approximately one in four (27%) older adults has sufficient resources to pay for long-term care expenses totaling \$150,000 over the course of a three-year period leaving *three* in four that could *not* (49). We also know that retirees' healthcare premiums of former employers increased 25 percent in 2004, making it more difficult for older adults to maintain their retirement savings (50). Financial burden of healthcare services may be complicated further by the fact that many of New York's older residents live in rural areas where health care services are less accessible, more costly to provide, and where availability of specialized services is less likely.

Medical costs, which are eroding the savings of retirees (51), are making it more difficult for adults in the workforce to save for their retirement. When faced with higher medical bills, one in four households report reductions in retirement-savings contributions while almost half (48%) report reductions in other savings (52). Automatic 401K plans have been identified as one means for employers to help employees save for their future. Additionally, policies that increase the number of higher paying jobs, promote women's workforce participation, and improve the educational attainment of New York's students are needed since these factors have been shown to help older adults prepare for retirement and pay for health care costs (53).

Health promotion strategies directed toward all age groups represent another important means to stem rising health care costs since the behaviors that place people at risk of disease often begin earlier in life (54). Of particular concern is the rise in obesity observed among children and young adults. Communities designed to promote exercise and healthy lifestyles can benefit the general population while age appropriate programs that promote physical activity and balance are beneficial to the overall health of older adults. Additionally, helping all individuals develop accurate expectations for aging is essential in view of the fact that those who perceive aging as an inevitable decline in well-being are least likely to participate in physical activity. Individuals with a more informed view tend to engage in activities that serve to promote their physical well-being throughout their lives (55). Lastly, consideration must be given to at-risk populations, particularly children with adverse childhood experiences and members of minority groups. Health strategies must couple effective treatments and best practices with opportunities for prevention (56, 57, 58, 59, 60).

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