STUDY OF HEALTH, RETIREMENT AND AGING

Introduction

- < Will the baby boomers become the first generation in recent memory to have lower living standards than their parents?
- < Will the widely anticipated early 21st century insolvency of the Medicare and Social Security trust funds actually happen?
- < Will it matter if it does happen?
- < Are people, especially the baby boom generation, saving enough to provide for their retirement?

To help answer these and similar questions, the National Institute on Aging is supporting the Survey Research Center at the University of Michigan in conducting a study of Health, Retirement, and Aging. The study started in 1992 with interviews of people age 51 to 61 and their spouses, and continued in 1993-4 with interviews of older people (70 and over, and their spouses). And because understanding change is so critical to the success of these studies, we have talked with the younger respondents again in 1994 and in 1996, and with the older ones in 1995-6.

Your participation is critical to the success of this research. Your willingness to answer questions about your life will enable us to form a more accurate picture of the day-to-day situation of mature Americans and help us to understand what really happens to people as they age. With this knowledge, new policies about retirement and aging--based on real experiences by real people--can be developed if necessary.

We want to thank you for taking part in these studies. In particular, we very much need and appreciate your continued involvement, since the information you provide becomes increasingly valuable as time goes by. For example, with information on different years for the same people we are able to compare the effect of health on work status as people pass age 62 (when they first become eligible for Social Security benefits) with the effect at age 58 or 59, when they are not eligible for Social Security. We can compare the impact of worsening or improving health on work status for those with private pensions and those without, those with high or low income, those who have dependent parents or children and those who do not, etc.

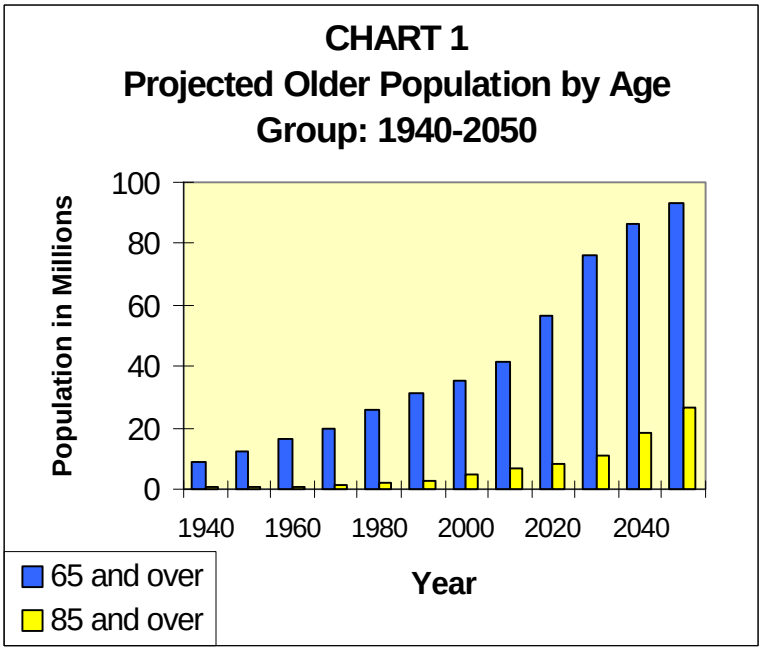
To show our appreciation, and because we thought you'd be interested, we'd like to share with you the history of these studies and tell you a bit more about them.

Why study health, retirement and aging?

Policy makers, the scientific community, and the media all seem to agree that the looming budgetary crisis in the Medicare and Social Security programs is one of the most important problems facing the U.S. But while everybody agrees that these are major problems and that we need to better understand the economic and social consequences of population aging, there is a lot of dispute over just exactly what the problem is and

how it might be fixed. Understanding the work, pension, health, insurance, and family factors affecting older Americans will mean a better-informed national debate on these issues.

Take a look at Chart 1 on the right, which has Census Bureau projections of the future size of the U.S. population 65 years of age and older and 85 years of age and older. What is immediately obvious is that the number (and proportion) of older people in the U.S. is going to explode in the half century starting with the millennium year of 2000, especially those 85 years of age and older. Between 2000 and 2050, the 65 and over population will almost triple, and between the same years the 85 and over population will go up by a factor of more than six! In percentage terms, the fraction of the population 65 and over will almost double, while the fraction 85 and over will quadruple.



What is causing this explosive growth in the number of aged people in the U.S.? Is the U.S. unique? Should we worry about it?

Why the explosive growth?

There are two major reasons for the explosive growth in the older population. First, we had a big increase in the number of children born in the U.S. between 1946 and 1964--what we usually call the "baby boom" generation. This huge increase in the number of babies has gradually worked its way through the popula-tion. By the year 2030 the entire baby boom cohort will have passed age 65, and the baby boom will become the "senior boom," marked by enormous growth in the number of 65+ year- olds. By 2050, the baby boom will result in a huge increase in the number of 85+ year-olds. In addition, and probably just as important, there have been steady gains in medical technology, increases in education, and changes in lifestyles (smoking, exercise, dieting, etc.) which mean that people are living longer than they used to. Not so long ago, it was rare that a person lived to be 65 or older; now, more than 80% of the population survives to age 65. That is the principal reason why the proportion of 85+ year-olds grows so rapidly--many more people are living to very advanced ages, and this trend is likely to continue.

To make the case even stronger, many population researchers believe that the numbers in Chart 1, which are based on guesses about population survival rates between now and 2050, are serious underestimates of the growth in older households by the year 2050.

Is the U.S. unique?

Other countries are facing the same explosion in population aging. In fact, countries like Japan, England, and Germany are aging at a faster rate than the U.S. At the same time people worldwide are living longer, birth rates are falling rapidly in many countries, including India, China,

and Mexico in the developing world. Together, longer life expectancy and falling birth rates mean that these and other countries will face rapid population aging similar to the U.S. in the not-too-distant future.

Should we worry about it?

The basic problem with the growing proportion of older people in the U.S. and other countries is that it has the potential for limiting the rise, or even causing some decline, in living standards. The simplest way to see that is to recognize that everyone in a population like the U.S. has to "eat" to survive, but only a part of the population is available to work in order to produce the "food." Think of "eating" as not just using up food, but using up things generally--cars, television sets, clothes, food, medical services, movies, banking services, etc. And think of the people in the "worker" category as those between the ages of, say, 18 and 65. It isn't that everyone between those ages works, since some people are still going to school while others retire at ages like 62, 60 or even 55--but the number of people between 18 and 65 provides a pretty good measure of how many people are available to produce the "food" which the entire population has available to "eat." In terms of numbers, if we define "eaters" as those who are living but don't work, there were about 4 or 5 times as many workers as eaters in 1950, but by 2050 that critical ratio will be more like 2 to 1. Thus there will be many fewer workers available to produce "food" relative to the population who wants to "eat," and unless productivity per worker rises sharply, there will be a much reduced supply of food per person available to be eaten.

Aging and Health

While everyone understands that, on average, health is likely to worsen at older ages, the actual pattern of health and aging may be surprising to many of you. Table 1 summarizes some data on health problems reported by various types of respondents. Health problems include high blood pressure or hypertension, diabetes, cancer, bronchitis or emphysema, heart condition or congestive heart failure, and stroke (arthritis, which is extremely common among all age groups, is not included here). Two groups of respondents are shown in the table; one of people in their 50s and 60s (to be exact, between 53 and 63), and the other of people in their 70s, 80s, and 90s (to be exact, people over the age of 72).

TABLE 1

Percent of Sample with Different Number of Health Problems		
# of Health Problems	Respondents in 50s & 60s	Respondents in 70s, 80s, & 90s
0	45.0%	33.1%
1	35.0%	30.0%
2	14.7%	22.5%
3	4.4%	10.6%
4	0.9%	3.3%
5	0.0%	0.5%
6	0.0%	0.1%
Total	100.0%	100.0%

While, on average, older people certainly have more health problems than younger, pre-retirement people, the differences are not that dramatic. For example, while 45% of the younger respondents report no health problems of any sort, fully 33% of the older respondents also report no health problems of any sort. And while 35% of the younger respondents report having only one of the

six health problems listed, just about 30% of the older respondents also report just a single health problem. In short, as people get older they do develop more health problems, but the older population is remarkably healthy, and is not much less healthy than the population 20 years younger.

Health and Medical Service Usage

Charts 2, 3 and 4 relate overall health status to the presence of specific health problems, and to medical expenditures. Here we are grouping people by their overall health status: excellent, very good, good, fair, or poor. For each of the groups we tabulate the total number of health problems (out of a total of seven medical conditions), as well as the 2-year total out-of-pocket expenditures (those not covered by health insurance) and 2-year total medical expenditures including those covered by health insurance. We show charts for respondents in their 50s and 60s, as well as for those in their 70s, 80s, and 90s.

None of the patterns are unexpected. In terms of numbers of specific health problems, respondents in their 50s and 60s who report that they are in poor health have literally 4 times as many health problems as similar respondents who report that they are in excellent health. The differences are not quite so extreme for respondents in their 70s, 80s, and 90s, although those with poor health have twice as many health problems as those in excellent health. Interestingly enough, there isn't much difference between respondents in their 50s and 60s and those in their 70s, 80s, and 90s in the number of health problems reported for those in poor or fair health.

In terms of expenditures, out-of-pocket expenditures just about double as we move from those in excellent health to those in poor health. The numbers are just about the same for respondents in their 50s and 60s, and those in

CHART 2
Number of Chronic Health Problems by Age and Self-Reported Health Status

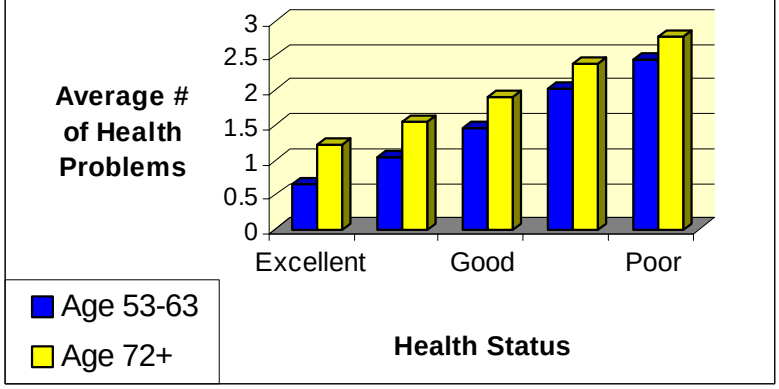


CHART 3
Out-of Pocket Health Expenditures by Age and Health Status

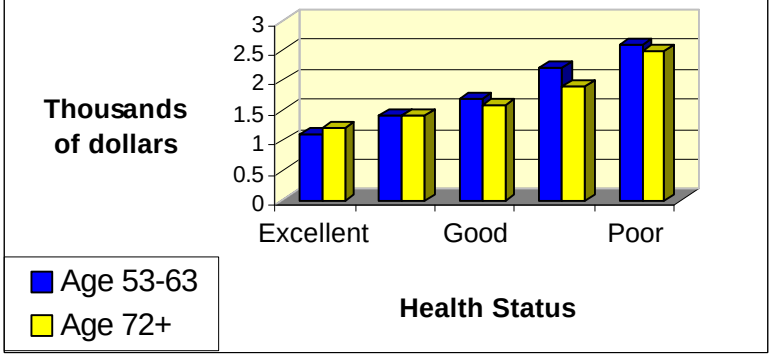
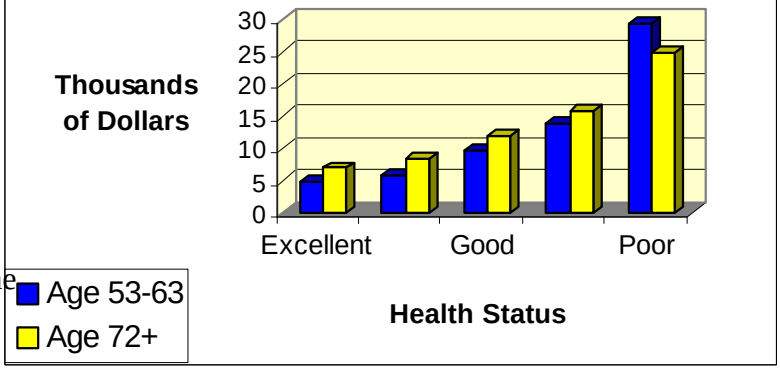


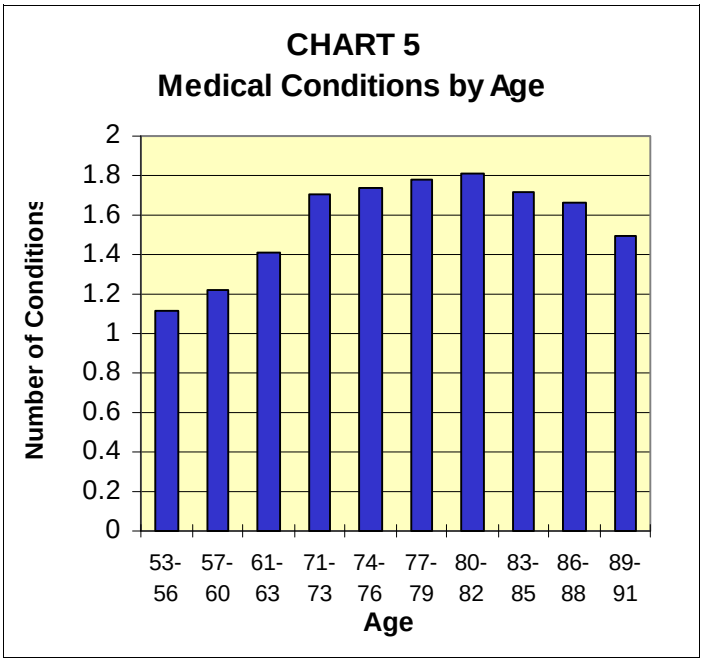
CHART 4
Total Health Expenditures, Including Those Covered By Insurance

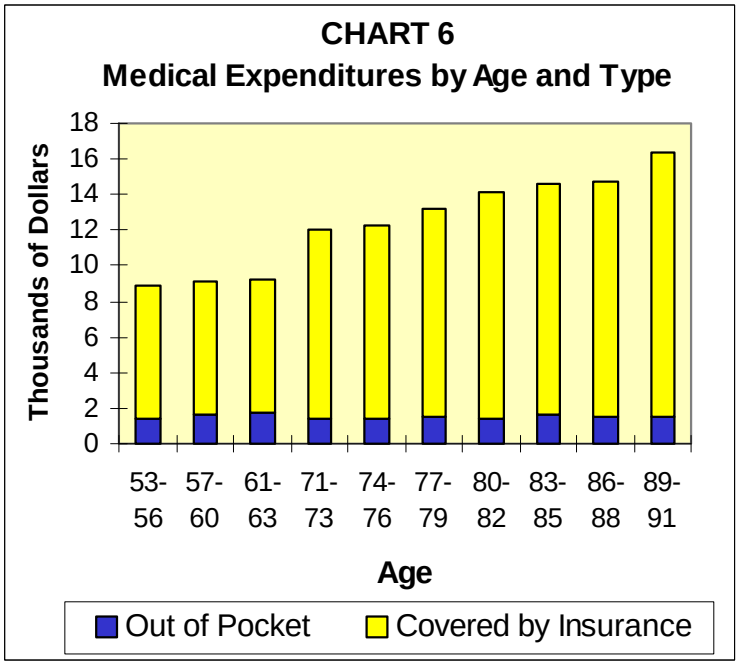


their 70s, 80s, and 90s. For total expenditures including those covered by health insurance, there is an enormous difference between those in poor health and those in excellent or very good health--for people in their 50s and 60s, those in poor health have almost $30,000 in expenditures for the 2-year period covered by these data, while those in excellent health spend a little less than $5,000. The differences are very large but not as extreme for respondents in their 70s, 80s, and 90s; expenditures for those in poor health are almost 4 times larger than for those in excellent health.

Curiously enough, differences by age are nowhere near as extreme as differences by self-reported health status. Charts 5 and 6 show the average number of health problems, and the average expenditures (both out-of-pocket and total, including those covered by health insurance) for respondents in three age groups in their 50s and 60s, and in seven more age groups in the 70s, 80s, and 90s. Although it is clear enough that older age brings on both more health problems and more total health expenditures (but not more out-of-pocket expenditures), the differences are much smaller than those associated with differences in self-reported health status. Interestingly enough, the average number of health problems actually declines slightly as respondents get into their 80s and early 90s compared to those in their 70s, probably because many people with substantial health problems fail to survive their 80s.

It is also worth noting that out-of-pocket health expenditures are lower for people in their 70s and 80s than for those in their 50s, probably because virtually everybody in their 70s and 80s is covered by Medicare, while there are still substantial numbers of people in their 50s who are not covered by health insurance. Total medical expenditures, including those covered by health insurance, rise substantially with age, from around $9,000 for respondents in their 50s and early 60s (again, over roughly a 2-year period), to between $12,000-$16,000 for respondents in their 70s and 80s.



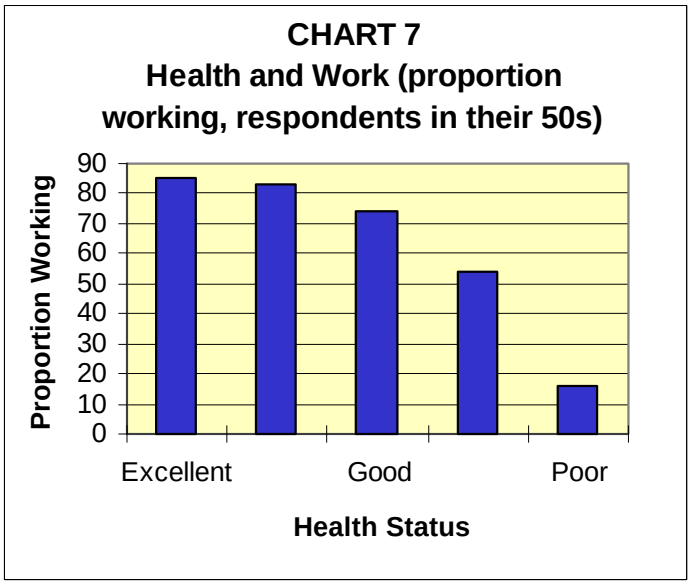


Health and Work

Respondent reports of their overall health status--excellent, very good, good, fair, or poor--appear to be the single most important predictor of work status for those in their 50s. For example, of those not yet eligible for Social Security benefits, 85% of those in excellent health were working, compared to only 16% of those in poor health (Chart 7).

As would be expected, the proportion of those between 51 and 61 who were working in 1992 declined both in 1994 and 1996, while the proportion retired rose substantially. Of those in excellent health, the proportion working dropped from 87% to 75% between 1992 and 1996, while for those in poor health the proportion working dropped from 23% to 13%. The retired proportion increased from 11% to 26% for the excellent health group, and from 15% to 35% for the poor health group.

Changes in health status have powerful effects on work status, and some of these effects are surprising. For example, those whose health worsened considerably show much lower levels of work activity than those whose health has always been poor, while those whose health improved considerably show higher levels of work activity than those whose health has always been good.



The majority of health changes are adverse. Over a third of those in fair health in 1994 reported in 1996 that their health had worsened, while only about 13% reported that their health had improved (the other 50% reported no change in health). The findings are similar for those in poor health in 1994, where over 50% reported in 1996 that their health had worsened compared to only about 12% who said their health had improved.

All of the results described above for the relation between health and work indicate the importance of being able to measure change over time for the same respondents in order to achieve any real understanding of the dynamics of the work, retirement, and the aging process.

Who is Conducting the HRA Study?

The HRA is the first research study in the past 20 years to examine the relationship between health, health changes, family help networks, and the job characteristics and finances of people nearing retirement age and in their post-retirement years. Its main source of funding is the National Institute on Aging (NIA), which is part of the National Institutes of Health. Additional support has been received from the Social Security Administration, the Pension and Welfare Benefits Administration at the Dept. of Labor, and the U.S. Department of Health and Human Services. Social and medical scientists (economists, demographers, medical doctors, gerontologists, sociologists, and psychologists) from universities across the nation, as well as researchers in several government agencies, have joined in the planning and implementation of the study. Representatives of the American Association of Retired Persons (AARP) have also contributed to its development.

As many of you will recall, interviewing for

the first phase of this research began in April, 1992. Almost 70,000 households were contacted to identify people born between 1931 and 1941, thus aged 51-61, along with their husbands or wives if they were married. By the time interviewing was completed in March 1993, over 12,600 people living in over 7,700 households had been selected and interviewed. This group of respondents was reinterviewed in 1994, and again in 1996, to see how things may have changed over time. A second phase of the study was begun in 1993, when we interviewed over 8,000 people born in 1923 or earlier, thus 70 years of age and older, or married to someone in that age range. These respondents were reinterviewed in 1995, again in order to observe change--a critically important feature of these studies.

Recent Developments and Future Plans

The Health, Retirement and Aging study will be talking with new respondents in 1998, in addition to reinterviewing our original respondents. The 1998 study will add new participants born between 1942 and 1947, thus between the ages of 51-56, to enable us to continue studying people in their early fifties (the original group will be between 57 and 67 by 1998). We also plan to fill in the age group that was not covered by either of the original studies--those born between 1924 and 1930, thus aged 68-74 in 1998.

By enlarging the study in this way, we will be able to compare the behavior of today's 51-56 year olds with the behavior of those who were initially interviewed at the same age and are now older. This will allow us to see how any change in government policy concerning Social Security and/or health care affects the behavior of people in different circumstances and age groups both before and after the change. This kind of on-going research and analysis is needed to explore the connection between public policy and individual behavior and to understand the retirement process.

If you would like to learn more about the HRA, we have included a "fact sheet" that gives some additional findings. We would also be pleased to have you write us or visit our web site at:

HTTP://WWW.UMICH.EDU/~HRSWWW

What have we learned from the Health, Retirement and Aging Study?

Retirement Decisions In General

< Early retirement decisions are strongly influenced by both physical and mental health status. More than half of men and one third of women who stop working before reaching the Social Security early retirement age of 62 report that health limits their capacity to work.

< About 3 out of 4 older workers indicate that they would prefer to reduce hours gradually rather than retire abruptly, yet the most common pattern of retirement is from full-time work to complete retirement. Research suggests this may be due to a lack of flexibility about work hours, which is understandable for some types of jobs, but on other jobs may be the result of employer attitudes about accommodating older workers who desire part-time work.

< In 1992 67% of all respondents, regardless of marital status, were working and 10% were retired. In 1996 only a little over half the respondents were working and the share of retired persons had almost tripled.

< While health insurance on the current job increases the chances that Hispanic and White women will continue full-time employment past 62, it is disability insurance that increases the probability of continued employment for Black women.

< About 20% of respondents reported a work-impairing disability when they were first interviewed in 1992, compared to about 24% in 1994. Of the former group, about four fifths remained disabled in 1994, while an additional 8% reported a new disability.

Health and Health Insurance

< About 90% of White respondents have health insurance at each of the three survey dates (1992, 1994 and 1996), and 82% are always covered; only 4% are never covered, and about 15% are covered at one of the dates, but not all three.

< Minorities have substantially less coverage than Whites. About 6% of Blacks and 17% of Hispanics are never covered by health insurance, while 25% of Blacks and 30% of Hispanics are covered sometimes but not always.

< The working poor are much less likely to have health insurance than others. About two in three low wage full-time workers lack employer-provided health insurance coverage, and close to a third lack any kind of health insurance coverage.

Income and Wealth

< Public and private pensions constituted roughly two-thirds of total income for respondents age 70 and over in 1992. Social Security accounted for the lion's share of their total income, increasing in relative importance with age.

< In the lowest fourth of income recipients, two-thirds of the households are not covered by any pension plan. About 95% of households in the highest fourth are covered by a pension, and over a quarter had more than one pension.

< While Social Security benefits represent almost half of the total income for both single and married elderly respondents (age 70+), private pensions make up less than 24 percent of total income.

< The great bulk of the income of respondents in their early 50s comes from work--some $40,000 out of about $48,000, on average. For respondents in the 70 and over age range, earnings from work comprise about 15% of income for

those between 70 and 74, and range from about 5% to essentially zero for those in older age groups.

< Income is very unevenly distributed among households in the 70 and over age range except for Social Security. Wage income is received only by the top 10% of the income distribution, interest and dividend income is effectively zero except for the top 25%, and pension income is received only by the top half of the income distribution.

< Assets are distributed much less equally than income, as is well known. For households in the 51-61 age range, while net worth or wealth on average is about $250,000, a household in the middle of the wealth distribution (with as many households poorer as richer; called the typical household) has about $100,000 of wealth (about 2 years' income for the average household) and only about $40,000 of wealth (roughly 1 year's income), not counting housing equity.

Blacks, Hispanics, and single women have much less wealth--especially wealth not counting housing equity--than other households.

< The typical Black or Hispanic household in the 51-61 age range has about $30,000 in total wealth compared to over $125,000 for others, and only about $5,000 in wealth minus housing equity, compared to over $50,000 for others.

< The typical single woman in the 51-61 age range has about $40,000 of total net worth, compared to almost $150,000 for typical married couple households, and only about $8,000 in net worth minus housing equity compared to over $60,000 for married couple households.

Differences in wealth are if anything even more pronounced among age 70 and over households than among those ages 51-61.

< The typical Black or Hispanic household in the 70+ age range has essentially no assets at all aside from housing equity, while for other households typical holdings aside from housing equity range from about $40,000 in the 70-74 age group down to about $10,000 in the 85 and over age group.

< The typical single woman has between $5,000-$8,000 of assets aside from housing equity, depending on age, compared to between $20,000-$55,000 for the typical couple household.

Although there are certainly many households in these age ranges with very small amounts of assets and thus no financial cushion against adverse events, there are many older households with substantial asset holdings.

< Among households in the 51-61 age range, the richest 10% have total net worth of at least $520,000. The richest 10% of Black and Hispanic households have net worth of at least $200,000, while the richest 10% of single women have net worth of at least $268,000.

< Among households in the 70 and over age range, the richest 10% have total net worth ranging from a bit over $460,000 to a little under $250,000, depending on age group. The richest 10% of Blacks and Hispanics have net worth ranging from at least $75,000 to at least $180,000, depending on age group. And the richest 10% of single women have net worth ranging from at least $295,000 to at least $188,000, depending on age group.

< For the 70 and over households, there are large differences by age group. Total net worth averages over $200,000 for those 70-74, a bit over $175,000 for those 75-79, about $140,000 for those 80-84, and a

little over $100,000 for those 85 and over. Similar differences show up for net worth minus housing equity.

It is unclear from the available data why these age differences exist. They could be due to the fact that older households are using up assets to maintain their living standards. Alternatively, they could result from differences in lifetime income--in the U.S., as in other countries, 70 year-old people have much higher lifetime earnings than 90 year-old people, and these differences could translate into differences in accumulated wealth.

Health and Wealth

One of the more surprising findings from the data is how strongly health, wealth and income are related. In particular, it appears that the health status of both spouses is equally strongly related to income and to wealth. For example:

- The average net worth or wealth of households where both husband and wife are in excellent health is more than ten times larger than that of households where both are in poor health.
- The average income of households where both spouses are in excellent health is more than four times larger than that of households where both are in poor health.
- While it is not entirely clear whether high income or wealth leads to more health care and thus better health, or whether better health leads to more work effort and thus more earnings and more savings--it appears that the link from health to work effort to income is stronger than the link from wealth to better health care to better health.

Intergenerational Transfers and Family Structure

Those with the greatest health care needs often have the fewest financial resources. They do, however, have approximately the same number of children as healthier respondents, and when no spouse is available, children provide time help. Among those with a health limitation, about 66 percent received personal help, and as the number of limitations increased, the likelihood of receiving care increased.

- Family and friends provide almost two thirds of the help received by the community based elderly and only 7% is paid care only. Children rarely give financial help to their parents.
- Time help is the most common type of help received by the elderly. Of the single elderly, about half get time help from children, and 15% live in co-residence with their children. Hispanics are more likely to help their parents by giving money and devoting time than other ethnic groups.
- Over one third of the unmarried frail respondents age 70+ receive no help. In married couples almost 40 percent of the help comes from the spouse and in 42 percent of the cases no help is received.
- Most married-couple respondents in the 51-61 age range have living parents, children, and grandchildren. More than half of these respondents give transfers of money to their children, but the reverse transfer (from children to parents) is quite rare--only about 5% of the parents receive transfers from children.
- Over 25% of female respondents provide 100 hours of grandchild care per year, and grandchild care for a sizable number of respondents is equivalent to a part-time job. Women are two and a half times more likely to provide grandchild care as men. Single grandmothers provide the most care, averaging 20 hours a week.
- Economic status does have some influence on who gets and who gives transfers. Parents who believe their children to be better off than they are less likely to give

transfers than other parents, and the children in these situations are more likely to give transfers to their parents. But the dominant direction of transfers is from parents to children regardless of differences in economic status.

For more information about the study, visit our website at:

HTTP://WWW.UMICH.EDU/~HRSWWW